MASSACHUSETTS
HEALTH POLICY COMMISSION

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2025

ANNUAL HEALTH CARE COST TRENDS REPORT AND POLICY RECOMMENDATIONS

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CHAPTER 1:

INTRODUCTION

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INTRODUCTION

The Massachusetts Health Policy Commission's (HPC) 2025 annual Cost Trends Report is issued in a time of heightened challenges to both health care affordability and coverage for Massachusetts residents. Massachusetts residents and employers face some of the highest health care costs in the nation, as health care costs continue to outpace growth in income, inflation, and health care input costs. Increasing numbers of residents are responding to these growing costs by avoiding care, incurring medical debt, and putting off other necessities. At the same time, federal policies will lead to the loss of public health insurance coverage for many Massachusetts residents and, without action on subsidies, many more residents will face significantly increased Connector premiums. This will compound the financial instability of high public payer hospitals and community health centers that disproportionately serve these patients.

With the availability of 2023 data for this report, it is increasingly clear that the current spending growth trends largely reflect new dynamics of the health care system in a post COVID-19 pandemic time period. Indeed, these dynamics appear to be intensifying beyond 2023. In 2024, Massachusetts employer-based family premiums accelerated to lead the nation at $28,151,[i] while approved average premium increases for the merged market – which includes small businesses and individuals buying health insurance on their own – for 2025 and 2026 are at the highest rates in recent years, at 7.9% and 11.0% respectively.[ii] Affordability challenges for some Massachusetts residents may be further exacerbated in the years to come by the loss of Medicaid coverage and Marketplace changes resulting from recent federal action.[iii]

As in past reports, in this report the HPC identifies several consistent contributors to these trends, including price growth as high as 10% or more for some health care providers and service categories, the expansion of high-cost, high-intensity treatments in place of effective lower-cost alternatives, and rising prescription drug prices. These trends put upward pressure on premiums which, in turn, lead employers and employees to turn to plans with higher cost sharing to mitigate the premium increases, particularly in the form of higher deductibles.

The special examination chapters in this year's report focus on cost sharing, focusing on both the levels of cost sharing and the features of cost sharing benefit design that can exacerbate harm to consumers. **Chapter 3** highlights the continued rise in out-of-pocket spending amounts and the prevalence of deductibles. Deductibles can result in large bills that are difficult for consumers to anticipate in advance, even for common primary care services. This coverage model places consumers with limited savings at particular risk of financial harm, as well as increasing the likelihood of forgoing needed care. **Chapter 4** focuses on cost sharing for ACA-covered preventive services in Massachusetts. Even in cases where the ACA mandate permits cost sharing, when patients do not anticipate cost sharing, receiving an unexpected bill may deter them from using high-value health services and undermine their trust that other preventive services will be covered. Together, these chapters underscore that cost sharing levels and benefit design matter to patient health and well-being. Consumer-friendly cost sharing benefit design offers important protections and improvements for patients and represents an opportunity for innovation in Massachusetts. Yet cost sharing levels – and the crisis in healthcare affordability more broadly – will only be solved through addressing the root causes of spending growth directly.

These challenges will require bold action to move the health care system from the status quo to a new, more affordable, sustainable, and equitable trajectory.

HOW THE REPORT IS ORGANIZED

The report includes material presented in a narrative report and a graphic chartpack. This report is informed by sources including the data and research of the Center for Health Information and Analysis (CHIA), as well as by presentations and testimony submitted during the HPC's 2025 Annual Health Care Cost Trends Hearing. **Chapter 2** of the report compares health care cost growth in 2023 to the state's health care cost growth benchmark, discusses trends and levels of health care spending in Massachusetts and the nation overall, highlights drivers of spending growth, and examines trends in health care affordability for residents of the Commonwealth. **Chapter 3** explores commercial cost sharing trends to better understand the burden of cost sharing for Massachusetts commercially-insured residents, highlighting the issues associated with deductibles. **Chapter 4** examines cost sharing for ACA-covered preventive services in Massachusetts, where some examples of cost sharing observed would be permitted under the preventive care mandate, while other examples appear to contradict it. **Chapter 5** presents the HPC's policy Recommendations,

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i Agency for Healthcare Research and Quality. MEPS-IC Data Tools – Medical Expenditure Panel Survey (MEPS) Insurance Component (IC). Available at: https://datatools.ahrq.gov/meps-ic/

ii Commonwealth of Massachusetts. 2026 health insurance rates. Available at: https://www.mass.gov/info-details/2026-health-insurance-rates

iii Blue Cross Blue Shield of Massachusetts Foundation. BCBSMA Foundation Report Estimates Major Medicaid Coverage Losses from "Big Beautiful Bill". 3 Sep 2025. Available at: https://www.bluecrossmafoundation.org/about-us/news-updates/bcbsma-foundation-report-estimates-major-medicaid-coverage-losses-big

which are focused this year on the systemic reforms necessary to put the Massachusetts health care system on a more affordable, accessible, and equitable trajectory.

The chartpack updates and presents new insights on annual topics reported by the HPC. Topics presented in the chartpack include trends and variation in prices across a range of services, spending and use of primary care and behavioral health care, and areas for improvement in care delivery, such as decreasing avoidable hospital inpatient and emergency department visits and maximizing value and access for post-acute care. The chartpack also explores variation in practice patterns by provider organization, including use of low value care services. Additional data on practice patterns by provider organization is published in an interactive Tableau format on the HPC's website.

WHAT IS THE ROLE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION?

Established in 2012, the agency maintains a permanent staff to fulfill its statutory responsibilities and is accountable to an 11-member Board of Commissioners. HPC staff and commissioners work collaboratively to oversee and improve the performance of the Massachusetts health care system.

In January 2025, two new health care laws were enacted to strengthen health care market oversight, address rising prescription drug costs, and enhance the transparency and accountability of the Commonwealth's health care system. This significant legislation expands the HPC's oversight authority, including the establishment of two new offices within the agency: the Office of Pharmaceutical Policy and Analysis and the Office of Health Resource Planning.

Key responsibilities of the organization include:

- Setting the health care cost growth benchmark
- Assessing and enforcing provider and payer performance relative to the health care cost growth benchmark
- Issuing data-informed, actionable policy recommendations to improve health care affordability and guide the future of health care reform in Massachusetts
- Analyzing the impact of health care market mergers, acquisitions, and other transactions on cost, quality, access, and equity
- Serving as the hub of expertise on pharmaceutical drug policy in Massachusetts, providing policy recommendations based on pharmaceutical data and drug affordability and access analysis
- Evaluating the supply and distribution of health care resources across the Commonwealth, using robust data analysis and strategic planning to promote the alignment of resources with population needs
- Conducting research and making data-informed policy recommendations to strengthen the behavioral health workforce in Massachusetts
- Collecting and disseminating key information about the structure and functioning of Massachusetts health care providers through the Registration of Provider Organizations
- Creating care delivery standards for Accountable Care Organizations
- Investing in innovative care models
- Administering independent external reviews of insurer medical necessity denials and risk-based provider organization decisions, as well as open enrollment waivers

The HPC also co-chairs two legislatively-mandated task forces in the Commonwealth: the Primary Care Access, Delivery, and Payment Task Force, charged with issuing recommendations to stabilize and improve primary care access, delivery, and payment; and the Maternal Health Access and Birthing Patient Safety Task Force, charged with reporting on the availability of maternal health services, financial investment in maternal health care, and the impact of past essential services closures.

CHAPTER 2:

TRENDS IN SPENDING AND CARE DELIVERY

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TRENDS IN SPENDING AND CARE DELIVERY

EXECUTIVE SUMMARY

Total per capita health care expenditures in Massachusetts grew 8.6% in 2023, exceeding the 3.6% benchmark for that year. Growth averaged 5.2% annually from 2019 to 2023.

Spending grew 7.8% per person in 2023 for the 60% of Massachusetts residents with commercial coverage. At the same time, the number of residents who are commercially-insured declined 10% from 2019 to 2023. As in prior years, commercial spending growth was mostly driven by higher prices for care. However, unlike the past several years, use of more care – and more intensive, more expensive care – also increased in 2023, leading to historically high spending growth.

By category of care, hospital outpatient department (11% growth) and prescription drug spending (8.6% growth) continued to drive commercial spending growth more than other categories. Hospital outpatient department spending growth was particularly driven by higher prices and wider usage of administered drugs such as Keytruda, and higher volume of surgeries such as cardiac ablation which seeks to relieve symptoms of cardiac arrythmia with procedure prices ranging from $29,000 to $75,000. Prescription drug spending growth was driven by a near-doubling in use of GLP-1 drugs (accounting for more than a third of prescription drug spending growth in 2023) and growth in spending on immunosuppressants such as Humira which, by themselves, accounted for more than a third of commercial drug spending in 2023 (net of rebates) and exceeded all spending on primary care.

Growth in health insurance premiums and out-of-pocket spending from these sources leaves Massachusetts families with less to spend each month on all other priorities. At current rates of health care cost growth (7%), an average family would have $614 less to spend each month on everything other than health care in 2030 compared to what they would have if health care spending growth were limited to 3.6% annually. ►

The Commonwealth's landmark health care cost containment law, Chapter 224 of the Acts of 2012,[1] establishes a benchmark for sustainable growth in health care spending, recognizing that containing spending growth is critical to easing the burden of health care spending on government, households, and businesses. Chapter 224 directs the Massachusetts Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA) to monitor health care spending growth annually relative to the benchmark, which is indexed to the rate of the Commonwealth's long-term economic growth (potential gross state product, or PGSP). The HPC is charged with analyzing trends and drivers in health care spending (see **Sidebar: Factors underlying health care spending**) and making policy recommendations. This chapter describes those trends through 2023, including a discussion of their implication for affordability of care among Massachusetts residents.

From 2013 to 2017, the benchmark for annual health care spending growth was set by law at the rate of PGSP for those years, or 3.6%. From 2018 to 2022, the law set the benchmark at a default rate of PGSP minus 0.5, or 3.1%, but the HPC had the authority to increase it to as high as 3.6%. From 2023 onward, the default rate is PGSP and the HPC has authority to adjust it as appropriate after a hearing and notice to the legislature. On April 13, 2022, the HPC's board voted to set the benchmark at the PGSP default rate of 3.6% for spending growth for 2022 to 2023 – the period of focus for much of the data presented in this chapter.

This chapter reviews recent spending trends in Massachusetts and includes trends from 2022 to 2023, as well as from 2019 to 2023 in some cases. Trends from 2022 to 2023 largely reflect post-pandemic dynamics in the health care system while the longer-run trends (2019 to 2023) allow for a broader sense of the drivers of spending that impact premiums and the affordability of care for residents of the Commonwealth.[i]

The Commonwealth examines health care spending growth against the benchmark by calculating the change in Total Health Care Expenditures (THCE) per state resident. CHIA calculates THCE using data from the state and federal governments as well as data reported by health insurers. THCE includes health care spending by individuals (e.g., copayments, coinsurance, and insurance deductibles), health insurers (e.g., claims, administrative expenses, incentive payments), the state (e.g., MassHealth), and the federal government (e.g., MassHealth and Medicare). CHIA reported that total spending in Massachusetts increased by $6.4 billion in 2023, from $71.7 billion in 2022 to $78.1 billion.[ii,2] Per capita THCE in Massachusetts was $11,153 in 2023, an 8.6% increase from 2022 which exceeded the health care cost growth benchmark of 3.6% set by the HPC.[iii]

FACTORS UNDERLYING HEALTH CARE SPENDING

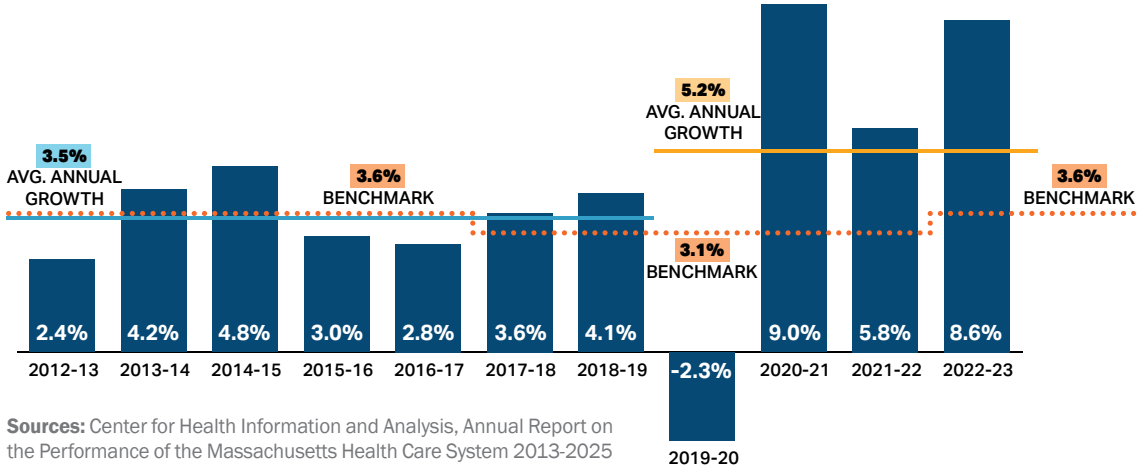
Total health care spending is a function of the price of health care services as well as the utilization of those services. Utilization, in turn, is affected by both the number of people receiving health care services and the frequency, type, care setting, and intensity of the services provided. The HPC's Cost Trends Report examines the latest available data regarding changes in both price and utilization in Massachusetts, as well as factors that may explain and contextualize recent trends in health care spending. This report largely focuses on aspects of the health care system that can be influenced by policymakers and market participants in the state rather than population health factors such as aging of the population that are beyond the scope of this report.

i While the main impacts of COVID-19 on spending and utilization occurred in 2020 and 2021, they were not entirely absent in 2022. For example, hospitals were required to reduce their volume of elective surgeries to no more than 50% of their 2019 volume between February 14 and February 28 in 2022 to accommodate a surge of COVID-19 admissions during the Omicron wave.

ii The spending totals reported by CHIA do not include pandemic-related supplemental funding from the federal government such as via the CARES Act, the Paycheck Protection Program, or the American Rescue Plan Act in 2022. There was no pandemic-related federal funding in 2023. It does include COVID-19 supplemental payments distributed by MassHealth.

iii The increase in THCE from 2022 to 2023 was reported as $6.4 billion, or 8.9%. The 8.6% reported increase in THCE per capita represents the combination of this 8.9% increase in spending and a 0.3% increase in Massachusetts' resident population from 2022 to 2023 as reported by the U.S. Census Bureau.

Exhibit 2.1. Annual growth in total health care expenditures per capita in Massachusetts, 2012-2023



Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System 2013-2025

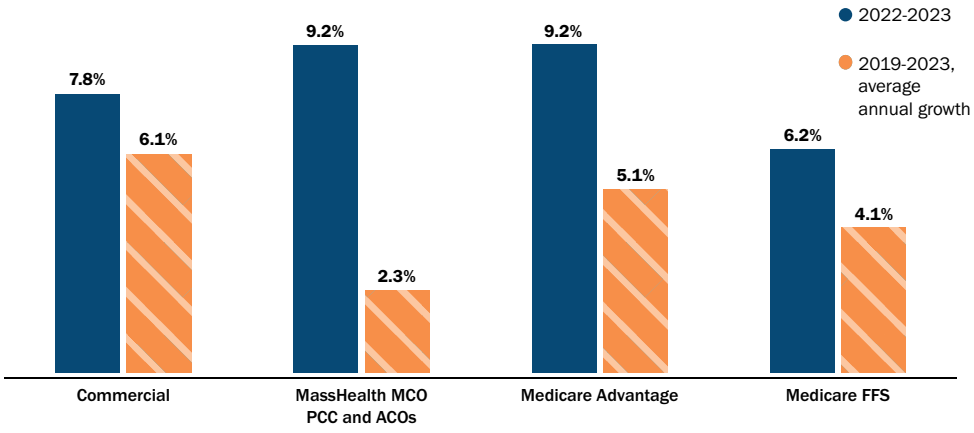
Including the 2023 increase, THCE growth per capita exceeded the benchmark in five of the past six years and averaged 5.2% annually from 2019 to 2023 (see **Exhibit 2.1**). Overall, for the 11 years since the passage of Chapter 224 for which THCE growth has been evaluated (2012 to 2023), average annual spending growth has been 4.1%.

MASSACHUSETTS SPENDING TRENDS FROM 2022-2023

The growth in spending of 8.6% in 2023 was the highest recorded since measurement against the benchmark began in 2012 with the exception of 2021, where spending growth reflected a "bounce back" in the use of care following depressed utilization during the height of the COVID-19 pandemic in 2020. Spending growth from 2022 to 2023 was also impacted by a net increase in MassHealth supplemental payments to hospitals of $875 million. Growth in THCE per capita would have been 7.4% absent this increase.[iv]

Spending per enrollee grew rapidly in all market segments from 2022 to 2023 (see **Exhibit 2.2**) including the commercial market (7.8%), MassHealth (9.2%), Medicare (9.2% and 6.2% for enrollees in Medicare Advantage and Medicare FFS, respectively).

Exhibit 2.2. Annual growth (2022-2023) and average annual growth (2019-2023) in spending per enrollee by market, with total enrollment change (2019-2023)



	Commercial	MassHealth MCO PCC and ACOs	Medicare Advantage	Medicare FFS
ENROLLMENT CHANGE (2019-2023)	-10.0%	30.7%	39.4%	-5.0%

Notes: Commercial spending includes net cost of private health insurance and is net of prescription drug rebates. MassHealth includes only full coverage enrollees in the Primary Care Clinician (PCC), Accountable Care Organization (ACO-A, ACO-B), and Managed Care Organization (MCO) programs. Figures are not adjusted for changes in health status.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA), Annual Report on the Performance of the Massachusetts Health Care System, 2023-2025 and Centers for Medicare and Medicaid Services data, special data request.

iv This increase of $875 million is the net of approximately $1.5 billion in additional supplemental spending offset by approximately $600 million in COVID-related spending provided in 2022 that did not occur in 2023. This spending amount does not account for hospital assessments that finance a portion of the spending.

By category of care (for all payers), prescription drug spending and hospital outpatient department (HOPD) spending again drove overall spending increases (10.0% net of rebates and 8.3%, respectively), as they did in 2022. However, one difference from 2022 that explains part of the higher spending growth in 2023 was that hospital inpatient spending reversed from negative growth in 2022 (-1.4%) to positive growth in 2023 (4.1%).[3]

The acceleration of spending growth in Massachusetts in 2023 was also observed in the nation as a whole (**Exhibit 2.3**).

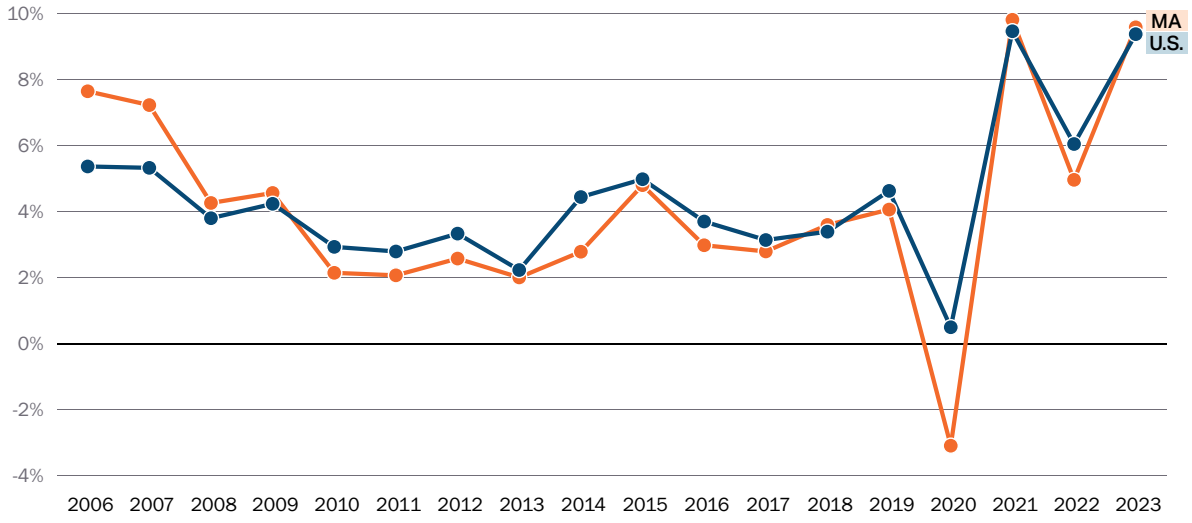
Some portion of the spending pattern observed in **Exhibit 2.3** over the last several years likely represents swings in utilization due to the COVID-19 pandemic – the drop in 2020 followed by a resurgence in 2021 followed by a small deceleration in 2022 (albeit with growth still at a historically high level). Yet the increase in 2023 may reflect a new period of high spending growth, with growth in 2021 and 2023 being the highest since before 2006. More recent data supports this forecast. For example, the Massachusetts merged market insurer approved rate increases averaged 4.8% for the 2024 plan year, 7.9% for the 2025 plan year and 11.5% for the 2026 plan year.[v,4,5]

To further understand the drivers of recent health care spending growth through 2023, the next sections analyze spending growth in detail, focusing on the commercial market which has accounted for 78% of above-benchmark spending since 2019.

MASSACHUSETTS COMMERCIAL SPENDING TRENDS FROM 2019-2023

The HPC first describes the distinct trends in prices (that is, the amount paid for a given service) and utilization (the number of people using care and the amount of care used) and then discusses spending drivers by category of care.[vi]

Exhibit 2.3. Annual growth in total health care spending per capita in Massachusetts and the U.S., 2006-2023



Notes: U.S. data includes Massachusetts. Massachusetts and U.S. data exclude federal and state supplemental COVID-19 relief funding.

Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2023 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis (CHIA), Total Health Care Expenditures, 2014-2023.

v These figures represent the average enrollment-weighted increases in premiums submitted to the Massachusetts Division of Insurance for the plan years shown as approved for insurers for their members covered in the individual and small group markets in Massachusetts, which are merged for purposes of rate setting. These increases represent premium growth for members covered by the same plans with the same benefits and reflect insurers' estimates of how much it will cost them to cover medical spending and administrative costs for the upcoming year for their current membership.

vi This trend decomposition omits trends in 'intensity' of care which was discussed in HPC's 2024 Annual Cost Trends Report and is included in some of the detailed analysis that follows.

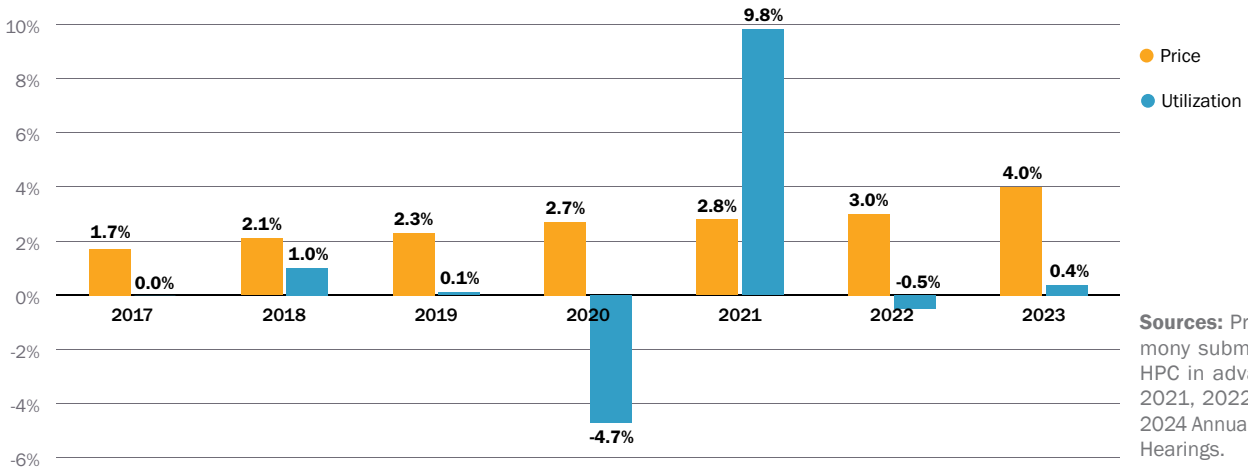
Commercial spending growth: prices versus utilization of care

Rising prices have been responsible for the majority of Massachusetts' commercial spending growth rather than increasing utilization over the past decade–and this continues to be the case. For example, data from one large payer in the commercial market from 2017 to 2023 illustrates this pattern (see **Exhibit 2.4**).

Aside from the disruption in care in 2020 and 2021 due to the COVID-19 pandemic, overall utilization rates have been relatively steady and essentially unchanged from year to year while prices have increased each year to an increasing degree, with a jump to 4.0% growth from 2022 to 2023.

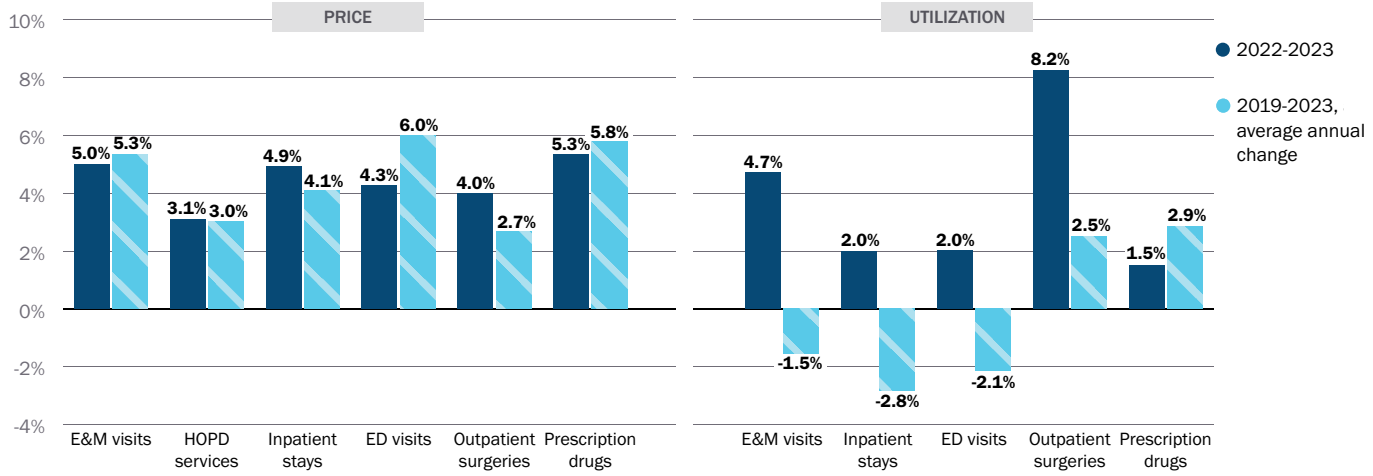
The HPC's more detailed analysis below reaches a similar conclusion, although with some nuances (see **Exhibit 2.5**).

Exhibit 2.4. Payer-reported percent change in commercial prices (unit cost) and utilization for a large Massachusetts insurer from previous year to year shown



Sources: Pre-filed testimony submitted to the HPC in advance of the 2021, 2022, 2023 and 2024 Annual Cost Trends Hearings.

Exhibit 2.5. Annual change (2022-2023) and average annual change (2019-2023) in prices and per-member utilization of key service categories for the Massachusetts commercial population



Notes: Price growth includes professional and facility spending where applicable. Utilization reflects the appropriate unit of analysis for each category e.g., encounters for E&M visits. Evaluation and management (E&M) visits include visits that occurred in physician offices. Emergency department (ED) price growth includes ancillary services. Inpatient stays exclude behavioral health and newborn stays. Prescription drug price growth is net of rebates. See technical appendix for more details.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023.

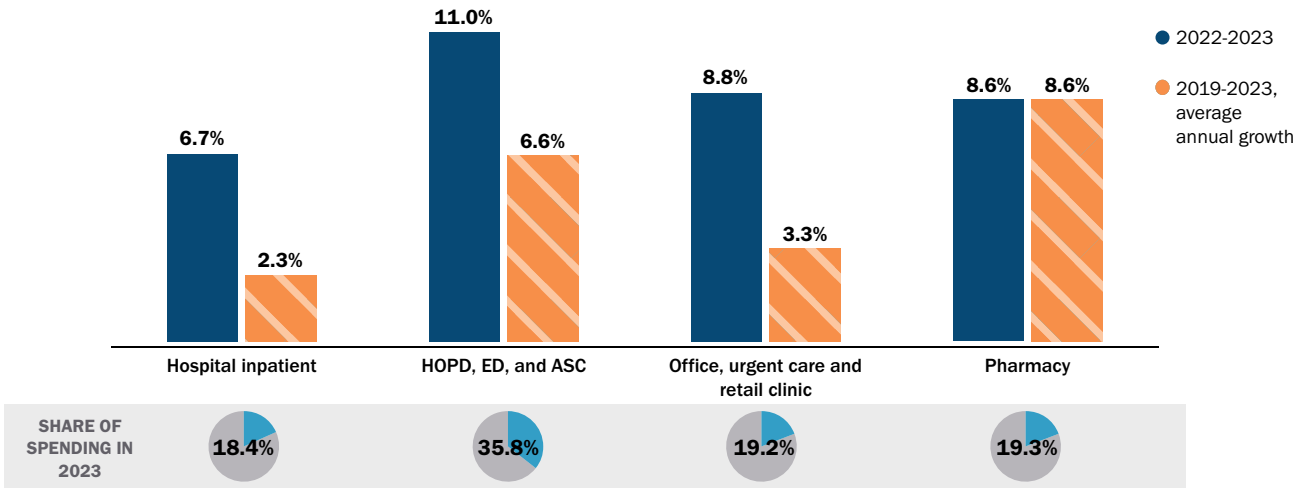
As shown in the left portion of the figure, prices for all categories of care–from HOPD services, emergency department (ED) visits, evaluation and management (E&M) visits, inpatient stays and prescription drugs–increased on the order of 4% to 6% each year from 2019 to 2023. Price increases in 2023 were similar to the longer-run average. The amount of care used (utilization), on the other hand, has either declined from 2019 to 2023 (i.e., E&M visits, ED visits and inpatient stays) or increased modestly (i.e., outpatient surgeries and prescription drugs) – revealing price increases as the major driver of spending growth. Importantly, however, 2023 also saw an uptick in utilization in many categories of care compared to the overall 2019 to 2023 trend. This dynamic can also be observed in **Exhibit 2.4**, with overall utilization slightly negative in 2022 and slightly positive in 2023. This uptick, combined with slightly larger price increases in 2023, led to faster commercial spending growth in 2023. Similar dynamics were observed in other states.[6]

Commercial spending growth: category of care

We consider commercial spending growth trends by category of care (**Exhibit 2.6**) to further understand drivers of commercial spending growth. From 2019 to 2023, commercial spending grew 6.1% annually (see **Exhibit 2.2**), nearly double the benchmark rate. That high rate of spending growth was driven the most by HOPD spending,[vii] (6.6% annually from 2019 to 2023 and 11.0% in 2023) and pharmacy spending (8.6% annually from 2019 to 2023 and in 2023).

Because HOPD spending accounts for a large portion of commercial health care spending (35.8% of spending in 2023, see **Exhibit 2.6**), its high rate of growth in 2023 accounted for nearly half of all commercial spending growth from 2022 to 2023. Spending occurring in office-type settings (such as physician's offices and urgent care centers) grew unusually rapidly in 2023 (8.8%) but on average, growth averaged a more modest 3.3% from 2019 to 2023. Hospital inpatient spending growth had also been slow from 2019 to 2022, reflecting the net effect of rising prices offset by a reduction in the number of inpatient admissions. However, hospital inpatient spending grew 6.7% in 2023 due to higher prices and a 2.0% increase in admissions from 2022 to 2023 (see **Exhibit 2.5**).

Exhibit 2.6. Annual growth (2022-2023) and average annual growth (2019-2023) in commercial spending per enrollee by site of care



Notes: Pharmacy spending is net of rebates. Share of spending does not sum to 100% as sites of care with smaller spending amounts are not shown. Spending amounts in all hospital categories include both professional and facility spending.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA), Total Medical Expenditures, 2019-2023 (pharmacy spending). HPC analysis of CHIA All-Payer Claims Database V2023 2019-2023 (spending at other sites).

vii HOPD spending in HPC's analysis also includes emergency department (ED) spending and spending at ambulatory surgery centers (ASCs). ED spending comprised 7.0% of HOPD spending in 2023 while ASCs comprised 2.9% of HOPD spending – thus, they are relatively minor contributors to this broad category.

Growth in hospital outpatient department spending

The next section further explores the increase in HOPD spending and its outsized effect of commercial spending and premiums. Growth in HOPD spending beyond 3.6% raised commercial premiums approximately 2.4%. **Exhibit 2.7** subdivides HOPD spending into major subcategories and displays recent growth in each.

The three fastest-growing categories driving HOPD spending growth were non-oncologic injections and infusions, chemotherapy and radiation oncology, and major surgeries, each of which grew between 9% and 10% each year from 2019 to 2023. These three categories accounted for more than half of HOPD spending growth from 2021 to 2023.

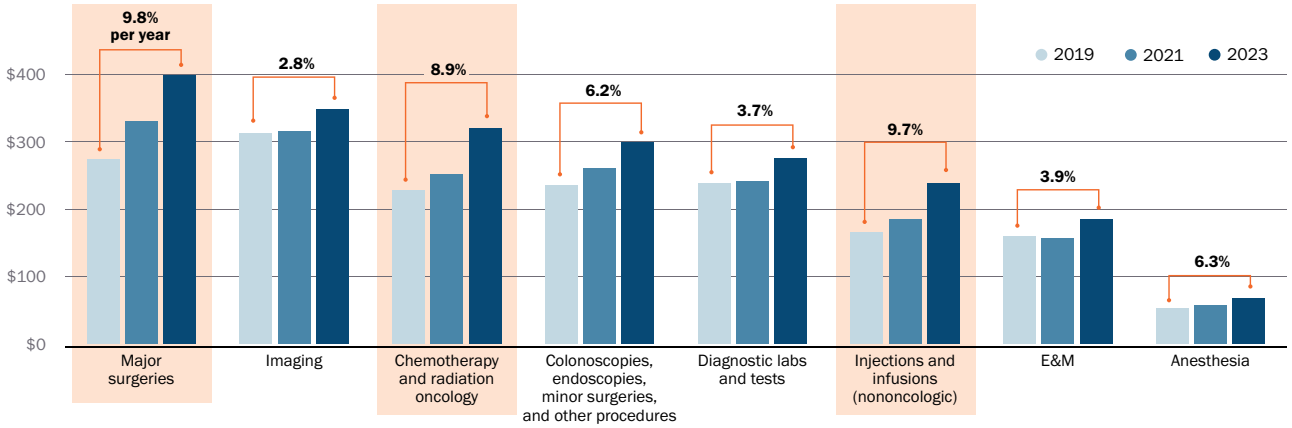
Major surgery

One known driver of HOPD spending in the major surgery subcategory is the shift in setting of major joint replacement surgeries (largely knee and hip replacements) from the inpatient to the outpatient setting (see **Exhibit 2.8**).

The exhibit shows hip and knee replacement surgeries shifting almost entirely from inpatient to outpatient (and ASC) settings between 2019 and 2023, along with an increase in the total number of operations performed. The data also show a small but growing amount of these surgeries taking place at ASCs in other states, suggesting potential limitations to ASC capacity in Massachusetts. This shift is cost-saving for any given surgery, as procedures performed in HOPDs and ASCs are generally lower-priced than those performed in inpatient settings (See **Price Chartpack**). Yet, the increased volume of these surgeries accounted for roughly 12% of HOPD spending growth from 2019 to 2023.

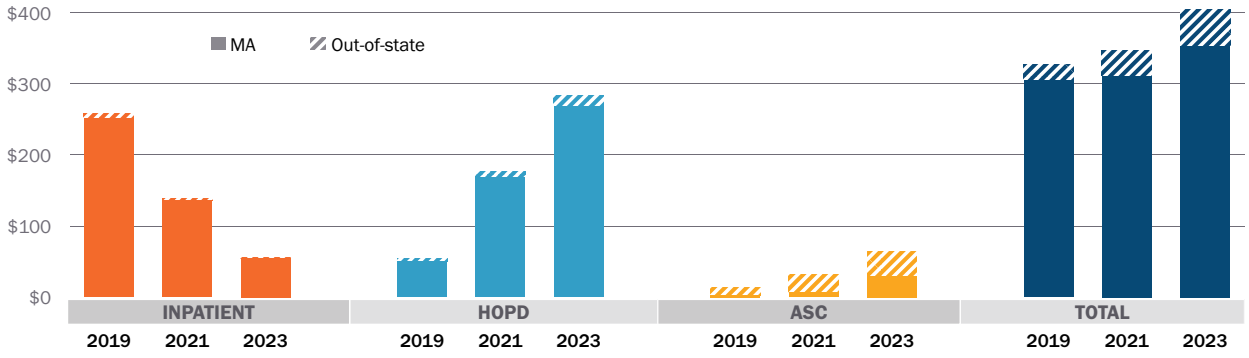
Aside from this example, the majority of the increase in spending on major HOPD surgeries stems from a combination of 1) increases in

Exhibit 2.7. Commercial spending per member per year for major categories of hospital outpatient department care, 2019-2023



Notes: E&M = evaluation and management services. Includes spending from Massachusetts acute hospitals only. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. Categories with small spending amounts are omitted (e.g., durable medical equipment). Spending on COVID tests and vaccines are excluded.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023.

Exhibit 2.8. Number of elective hip and knee replacements by setting of care per 100,000 commercial members, 2019-2023



Notes: New England Baptist Surgical Center HOPD that converted to an ASC is assigned to the HOPD category throughout the analysis period.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023.

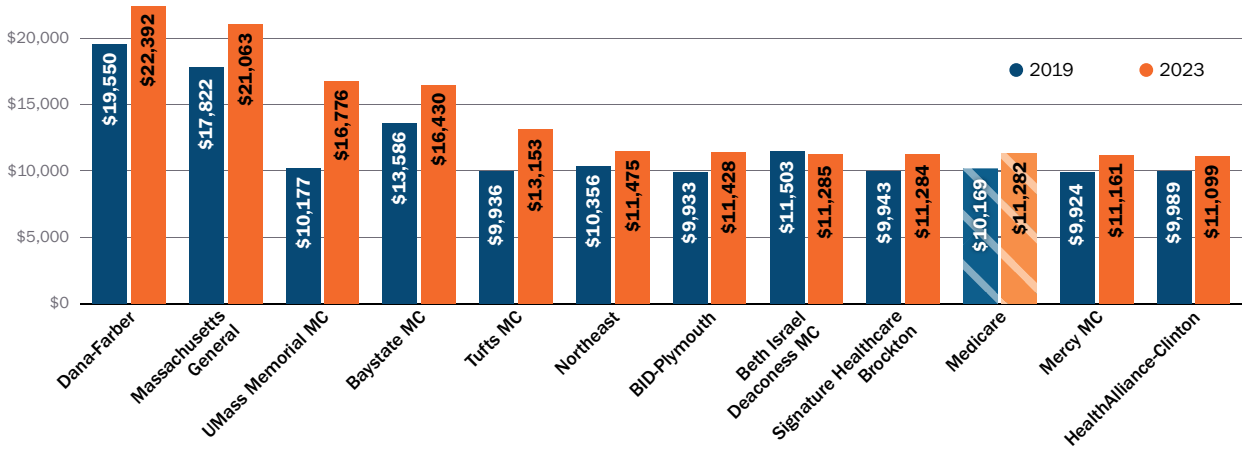
prices and 2) shifts toward higher-priced surgeries being performed. From 2019 to 2023, the average amount paid per major outpatient surgery increased 27% while the number of surgeries performed increased 10%. The 27% increase represents both increases in price for the same surgery and a shift toward more intensive surgeries with higher prices. For example, the proportion of major surgeries performed with a price exceeding $20,000 more than doubled, from 5.8% of surgeries in 2019 to 12.0% in 2023.[viii]

This trend is typified by cardiac ablation surgery, which, by itself, accounted for approximately $161 million in commercial spending statewide in 2023, up from $114 million in 2019. Cardiac ablation is an intensive intervention that aims to reduce the occurrence and symptoms of atrial fibrillation and atrial flutter by creating scarring in targeted areas of the patient's heart tissue to help prevent abnormal rhythms. Cardiac ablation had an average procedure price of $48,000 in 2023 (with prices at different facilities ranging from $29,000 to $75,000) not including pre- and post-operative visit spending.[ix] While the procedure also aims to reduce long term outcomes such as stroke and mortality as well as symptoms, evidence of long-term success on those outcomes is mixed.[7,8,9] Furthermore, the surgery is often unsuccessful and is sometimes repeated multiple times on a patient.[x] Nevertheless, volume is expected to increase partly due to a recent joint decision by the American College of Cardiology, the American Hospital Association, the American College of Clinical Pharmacists and the Heart Rhythm Society to declare cardiac ablation as a first line therapy for patients rather than a choice after consideration of drug-based alternative therapies.[10]

Drugs administered in HOPD settings

The other major categories that have driven HOPD spending since 2019 are chemotherapy/radiation oncology and non-oncologic injections and infusions. To an even greater extent than for major surgery, spending on these services is driven by higher spending per person treated, not more people treated: between 2019 and 2023, spending per person receiving care increased 44% for chemotherapy and 43% for injections and infusions, while the number of people receiving any care in these categories changed by -2% and 1%, respectively. To illustrate how price increases drive spending in this category, **Exhibit 2.9** shows average amounts paid by insurers and patients for the same drug, cancer immunotherapy drug Keytruda (pembrolizumab), when administered at different hospitals in 2019 and 2023, compared to the Medicare price.

Exhibit 2.9. Average commercial price of cancer immunotherapy drug Keytruda by hospital, 2019 and 2023



Notes: Facilities listed are limited to those with at least 20 commercial encounters delivered in 2019 and 2023. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. The price shown is for a standard dose of Keytruda (200 mg or 200 billable units). Data are for Keytruda (CPT J9271, 'Injection, pembrolizumab, 1 mg).

Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2023 2019 and 2023. HPC analysis of information from the Centers for Medicare and Medicaid Services, ASP Drug Pricing Files (October 2019 and October 2023).

viii To remove the effect of price increases from this calculation, surgeries were characterized as having prices over or under $20,000 based on their average price across all of 2019-2023. Another way to measure surgery intensity is in the relative value units (RVUs) associated with the main surgical procedure. The average RVUs per surgery increased from 8.8 in 2019 to 9.6 in 2023.

ix This range represents the 5th and 95th percentile of prices for the most common procedure code for cardiac ablation (93656).

x One recent trial of cardiac ablation versus drug therapy found ablation to meet a $100,000-per-QALY threshold for cost effectiveness based on a gain of 0.27 QALYs (but not based on total life years gained of less than 0.1 years); however, this calculation assumed a $26,000 procedure cost. This cost effectiveness threshold would not have been met given average amounts paid by Massachusetts residents as noted. See Chew, Derek S., et al. "Cost-effectiveness of catheter ablation versus antiarrhythmic drug therapy in atrial fibrillation: the CABANA randomized clinical trial." Circulation 146.7 (2022): 535-547.

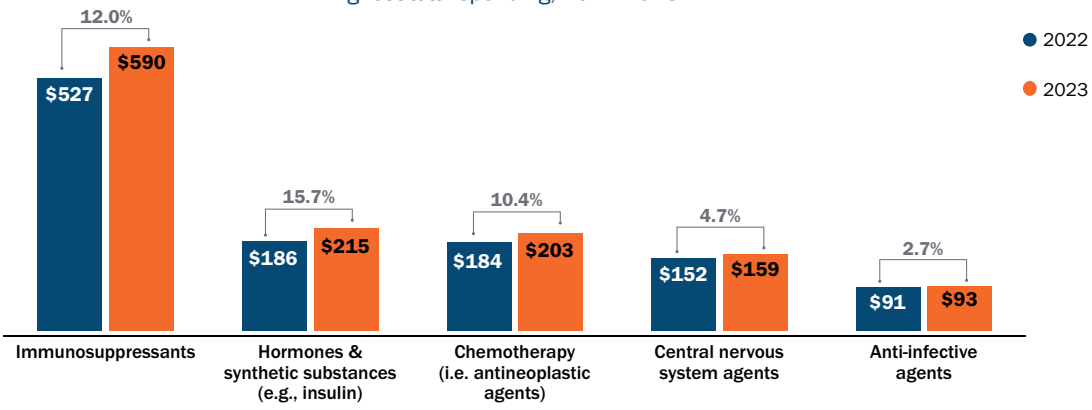
The Medicare price for Keytruda increased 11% from 2019 to 2023, reflecting manufacturer price increases over this time.[xi] In the commercial market, prices for clinician-administered drugs are determined through negotiation between the provider and insurer. The average commercial price increase among all hospitals with sufficient volume for analysis in both years was 18%. The highest price increase was for UMass Memorial Medical Center (65%). In all, increased prices for Keytruda accounted for 5.6% of the total increase in HOPD spending from 2019 to 2023. Spending on Keytruda also increased due to wider application of the drug to more patients.[xii] The number of unique commercially-insured patients receiving Keytruda increased 90% from 2019 to 2023.

A final driver of HOPD spending growth is the provision of services in HOPD settings that can safely be provided in provider office settings, where prices for services are typically far lower (for both Medicare and private insurers; see **Price Chartpack**). Previous work by the HPC has found that these "crossover" services are more likely to be provided in HOPD settings in Massachusetts than in other states.[11] An indicator that this dynamic may have grown is that HOPD spending among Massachusetts Medicare beneficiaries increased 18% from 2019 to 2023 (from $2,884 to $3,418 per person) while professional spending increased to a lesser extent (12%, from $2,751 to $3,088). This trend was the opposite in the U.S. overall, with slower growth in HOPD spending (14%, from $2,233 to $2,555) than for professional spending (19%, from $3,080 to $3,677). As a result of these differential trends, HOPD spending among Massachusetts Medicare beneficiaries exceeded professional spending in 2023 while the reverse was true in the U.S. overall.

Growth in pharmaceutical spending

Pharmaceutical spending was the next major driver of commercial spending growth from 2019 to 2023 and particularly from 2022 to 2023. Pharmaceutical spending includes prescription drugs and other items covered under a patient's pharmacy benefit (such as those filled at a retail pharmacy) and does not include drugs covered under a patient's medical benefit (such as most clinician-administered drugs). Pharmaceutical spending growth beyond 3.6% contributed one additional percentage point of commercial spending growth in 2023. In the 2024 Annual Cost Trends report, the HPC provided additional detail behind high recent growth of pharmaceutical spending. That analysis found that the immunosuppressant category of prescription drugs was the top therapeutic class that drove spending growth from 2018 to 2022.[12] Spending again increased substantially in this category of prescription drugs in 2023 as shown in **Exhibit 2.10**.

Exhibit 2.10. Estimated per member per year net spending by therapeutic classes with the highest total spending, 2022-2023



SHARE OF CLAIMS IN 2023	1.3%	16.0%	0.7%	31.6%	10.1%

Notes: Therapeutic class based on Red Book. Spending is net of rebates. Rebates were sourced from the Medicare Payment Advisory Commission July 2024 Data Book, Section 10: Prescription drugs. Available at: https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_Sec10_SEC.pdf

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims database, V2023, 2022-2023.

xi The HPC estimated manufacturer prices based on average sales price (ASP), which increased 11% between 2019 and 2023. Medicare reimbursement for Part B drugs is generally ASP + 6%.

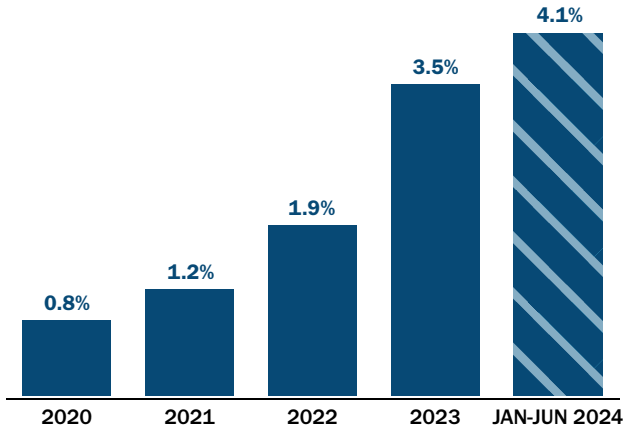
xii Another relevant factor relates to the 340B Drug Pricing Program. A growing body of evidence suggests that the 340B program is driving increased use of certain high-cost clinician-administered drugs by hospitals because of higher margins associated with higher cost drugs. See, e.g., Horn D. The incentive to treat: Physician agency and the expansion of the 340B drug pricing program. Journal of Health Economics. 2025 May 1;101:102971.

As in prior years, the increase in prescription drug spending was driven by branded drugs, with an average price (gross of rebates) of $1,841 per prescription, a 6.6% increase from 2022, and with 5.0% of branded drug prescriptions exceeding $8,500.[xiii] These higher prices also mean patients pay more out of pocket for prescription drugs in addition to higher premiums. From 2022 to 2023, the average out of pocket spending for 30-day supply of common anti-arthritic drugs and multiple sclerosis drugs increased 39% (from $207 to $287) and 52% (from $171 to $260).[xiv]

Also notable in this category of spending is the dramatic rise in use of GLP-1 drugs (see **Exhibit 2.11**), with the percentage of commercial residents filling any GLP-1 prescription almost doubling from 1.9% in 2022 to 3.5% in 2023.

With this rise, by 2023, 5.5% of all commercial prescription drug spending (net of rebates) was attributable to GLP-1 medications (up from 3.0% in 2022).[xv] The increase in use of GLP-1 medications between 2022 and 2023 contributed 34.6% of commercial prescription drug spending growth (net of rebates) and 8.1% of overall commercial spending growth. GLP-1 spending is expected to continue to grow in 2024 and 2025. However, the GLP-1 market is highly dynamic: shortages of GLP-1 medications ended in 2025; potentially lower cost versions of GLP-1 medications are under FDA review; and drug manufacturers have also announced new pricing agreements and programs, among other factors. Moreover, while there is not yet empirical data on the potential long-term health benefits and associated health care savings, a recent study by the Institute for Clinical and Economic Review (ICER) found GLP-1 medications to be generally cost effective based on a $100,000 per quality-adjusted life year threshold, but often not based on a $50,000 threshold.[13] Nonetheless, insurers continue to grapple with the significant total spending associated with GLP-1 medications since the high prevalence of obesity translates to a potentially very large volume of users, and a number of insurers have announced plans to discontinue coverage for weight loss in 2026 in part to manage the growing costs of this class of drugs.[14,15]

Exhibit 2.11. Percent of commercially-insured adults who had at least one GLP-1 prescription that year, January 2020 to June 2024



Notes: The following medications were included: Victoza, Saxenda, Trulicity, Ozempic, Rybelsus, Wegovy, and Mounjaro. Exhibit includes prescriptions among commercially-insured members between 18 and 64 years of age and with 12 months of medical and pharmacy coverage that year (6 months in 2024).

Sources: HPC analysis of Massachusetts Enhanced All-Payer Claims Database, 2020-2024.

Taken together, the increases in prices for health care services along with increases in use of care, particularly high-cost care, led to the highest rate of overall and commercial spending growth since the passage of Chapter 224 with the exception of the post-COVID-19 rebound in 2021. Final approved premium rate increases in the merged market were 7.9% for 2025 and 11.5% for 2026, suggesting that the spending increases observed in 2023 may continue.[4,5] Nationally, the Kaiser Family Foundation employer survey recorded the same 7% premium increase for family coverage in 2024 as was observed in 2023.[16] The next section discusses the implications of these trends for individuals, families, and employers who pay for this care.

xiii Based on HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, V2023 2022-2023. Claims with implausible spending values were excluded, such as negative values. Vaccines and non-drug items (e.g., diabetes tests strips) were excluded. Prices shown do not account for manufacturer rebates and other price concessions offered to payers. The 2025 CHIA annual report found that rebates as a percent of pharmacy spending grew to 29.7% in 2023 from 25.7% in 2022.

xiv Based on HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database, V2023 2021-2023. Drugs were identified based on lists of clinical guidelines published by the Arthritis Foundation, American College of Rheumatology, and National MS Society. Clinician-administered drugs, which are typically covered under a plan's medical benefit, were excluded.

xv HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database, V2023 2022-2023.

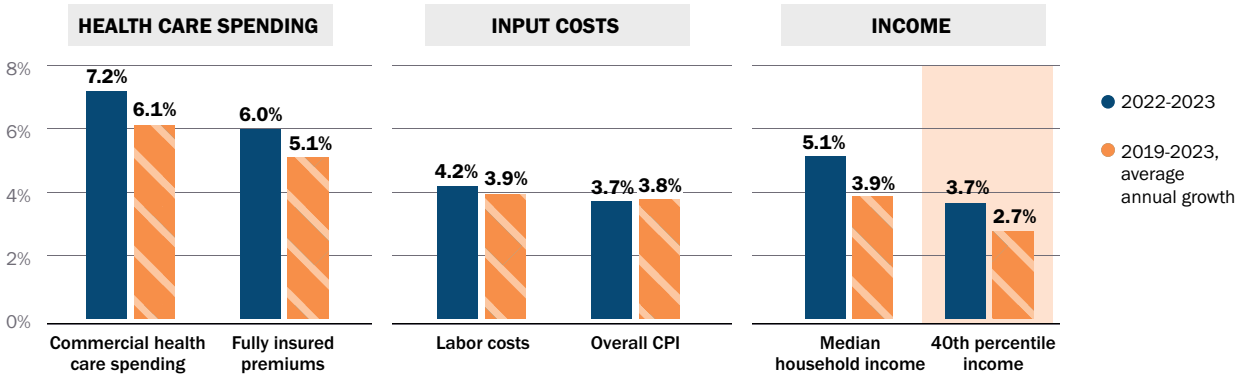
AFFORDABILITY OF CARE

The rapid growth in commercial health care spending from 2019 to 2023, including health care premiums and cost sharing, added further strain to Massachusetts residents' ability to afford health care while meeting other essential needs. This is illustrated by **Exhibit 2.12**, which shows that increases in health care spending have significantly outstripped growth in income over the last several years. Increases in premiums and health care spending also surpassed increases in labor costs and general inflation.

For individuals with income just under the statewide average (40th percentile), commercial health care spending and premiums have increased nearly twice as fast as their income, meaning that health care spending is increasingly consuming income that would otherwise be needed to cover household necessities that are also increasing in price such as childcare, food and housing.

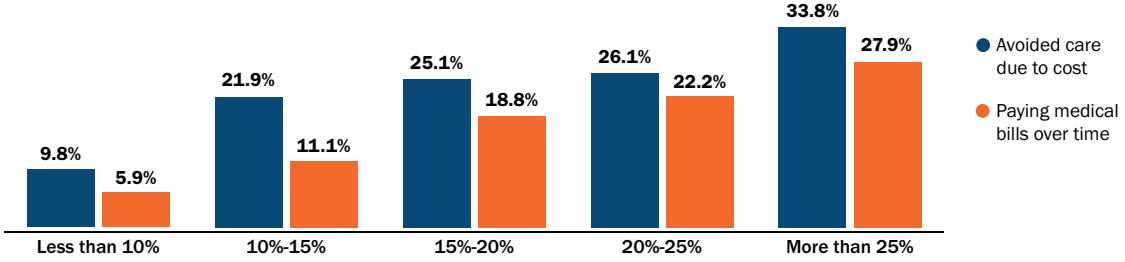
As there are limited opportunities to find cheaper commercial health care coverage (for example, roughly half of employees of small and medium-sized companies are only offered one plan and premiums do not vary extensively from health insurer to health insurer),[xvi] one of the few avenues of recourse available to patients to limit their health care spending is avoiding using care altogether. **Exhibit 2.13** shows the percentage of Massachusetts residents with employer sponsored coverage who reported avoiding care due to cost. Residents are arrayed from left to right based on the percentage of their income consumed by health care spending including premium payments and out of pocket spending.

Exhibit 2.12. Percentage growth from 2022 to 2023 and 2019-2023 (average annual) for various quantities in Massachusetts



Sources: TME and premiums data are based on HPC's analysis of Center for Health Information and Analysis Annual Reports. Labor costs are sourced from the Bureau of Labor Statistics, Economic Cost Index. CPI is from the Bureau of Labor Statistics data for the Boston area MSA. Income distributions are from the American Community Survey and the Current Population Survey, Annual Social and Economic Supplement.

Exhibit 2.13. Percentage of surveyed respondents indicating each health care affordability issue by health care share of compensation, 2023



Notes: Includes all families on employer-sponsored insurance (ESI) with a family plan who had full-year coverage. Senior-headed households and those below 139% of the Federal Poverty Level (FPL) were excluded. ESI represents insurance received through work or a union. Insurance status is self-reported in the survey. Total health spending includes both average employee and employer payments toward health insurance premiums, as well as average out-of-pocket (OOP) spending. OOP represents money paid that is not covered by health insurance and does not include premium payments. Total compensation includes total family income and average employer payments toward health insurance premiums.
Sources: HPC's analysis of Center for Health Information and Analysis 2023 Massachusetts Health Insurance Survey. Premium and contribution amounts from AHRQ Medical Expenditure Panel Survey, 2023.

xvi See p. 46, CHIA Annual Report, 2025 (available at: https://www.chiamass.gov/assets/2025-annual-report/2025-Annual-Report.pdf. Also, in the databooks associated with the report (with the exception of Tufts Health Public Plan and Wellsense, which have significantly lower premiums due in part to excluding particular high-priced providers from their networks) premiums for the remaining insurers vary by less than 8%. See Tab 2.14.

The figure shows that, as more of a family's income is devoted to health care spending (whether due to higher health insurance premiums and out of pocket spending and/or lower income), the members are more likely to avoid using health care due to cost. Similarly, the proportion of families paying off medical bills over time also increases as more of the family's income is devoted to health care spending. Both metrics suggest that health care affordability becomes particularly strained when more than a quarter of income is spent on health care. This threshold was already exceeded in 2023 by more than 40% of Hispanic residents in Massachusetts with private coverage, along with 26% of Black residents and 9% of White residents.

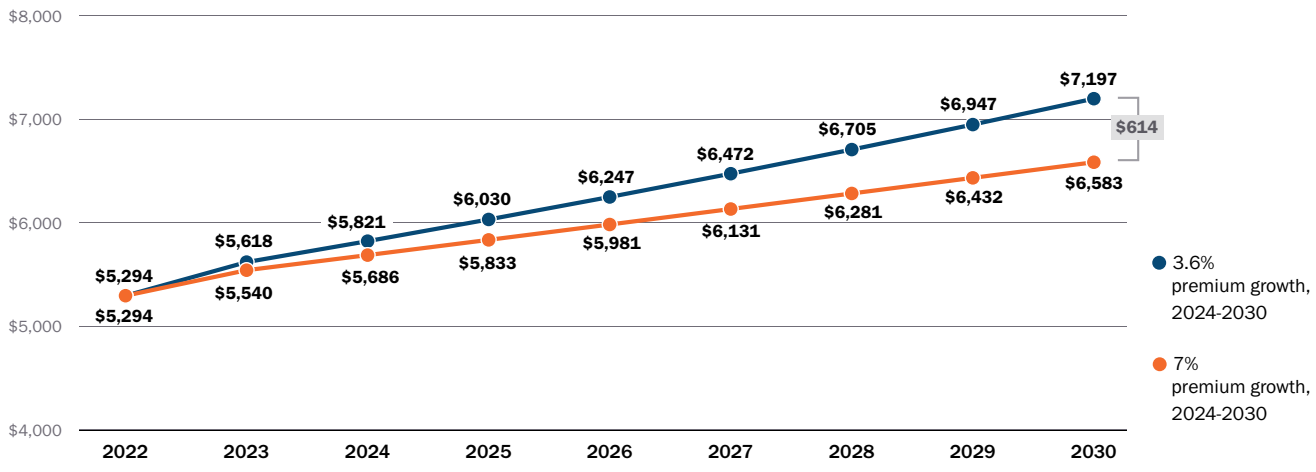
If health insurance premiums and out of pocket spending continue to rise faster than income, which appears likely, more families will exceed this critical affordability threshold. This is further illustrated by **Exhibit 2.14** which shows a typical Massachusetts' family's after-tax take home pay (after paying for health insurance and out of pocket health care spending) under two scenarios: 1) premiums and out of pocket spending grow 7% annually (orange line) in accordance with recent trends, or 2) premiums and out of pocket spending grow 3.6% annually (blue line) in accordance with the benchmark.

In the scenario in which health care premiums rise at the benchmark rate (the blue line in **Exhibit 2.14**), monthly take-home pay rises from $5,294 to $7,197 for an average family, an increase of $1,903 per month from 2022 to 2030. On the other hand, if health insurance premiums and out of pocket spending continue to rise 7% annually, employers may not be able to offer as generous (or any) wage increases to their employees, using some of these dollars to pay their portion of health insurance premiums for their employees instead (or to pay health care costs directly if they are self-insured). Monthly take-home pay after taxes and after health care payments would rise $1,290 per month (from $5,294 to $6,583) under this scenario rather than $1,903 per month. In other words, excess health care spending beyond the benchmark would absorb nearly a third of income growth in just eight years, leaving a typical family with $614 less per month to spend on other priorities.

In all, these findings show concerning trends for the Commonwealth: rising health insurance premiums and out of pocket costs leading to more residents going without needed care, paying off increasingly large medical bills, and needing to devote a higher share of their income to health care while leaving less for other priorities. While some of these added costs may reflect additional utilization or intensive treatments bringing therapeutic value for patients, findings from the HPC's 2024 report suggest this is not always the case.[12]

The next section of this report provides an in-depth analysis of trends and sources of out-of-pocket spending in Massachusetts including recommendations for how insurers and employers could reform benefit design to mitigate some of the negative impacts of this spending on patients and families without raising premiums.

Exhibit 2.14. Projected monthly after-tax, after health care take home pay for an average Massachusetts household with employer-based coverage under two scenarios of premium growth



Assumes OOP spending also grows at the rate of premium growth shown and that total employer compensation increases 3.6% annually. Assumes that an employee taking up family coverage from their employer bears the full cost of the employee premium contribution and 75% of the employer contribution to their premium as reduced wages (with the remainder spread across the employer's workforce in general).

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CHAPTER 3:

TRENDS IN COST SHARING AND OPPORTUNITIES TO IMPROVE BENEFIT DESIGN IN MASSACHUSETTS

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EXECUTIVE SUMMARY

Growth in health insurance premiums and out-of-pocket health care spending continues to squeeze household budgets. Out-of-pocket health care spending (cost sharing) can create particular financial challenges as it often can't be anticipated. As with premiums, patient cost sharing reflects underlying health care costs, which continue to grow at rates that outpace income growth. However, features of cost sharing benefit design can exacerbate financial harm to consumers, specifically the deductible structures that are increasingly common in commercial insurance design. Deductibles can result in large bills that are difficult for consumers to anticipate in advance, even for common primary care services. This coverage model places consumers with limited savings at particular risk of financial harm.

The HPC explored cost sharing across settings of care to better understand the burden of cost sharing for Massachusetts commercially-insured residents, highlighting the issues associated with deductibles. Using the CHIA Massachusetts All-Payer Claims Database (APCD), the HPC found that from 2019 to 2023, average commercial cost sharing grew 29% from $849 per member per year to $1,094, faster than the growth in insurer-paid amounts (24%). The dominant form of cost sharing was the deductible, which represented 58% of all cost sharing in 2023, an increase from 54% in 2019. The growth in deductibles means the composition of cost sharing is increasingly shifting to the type of out-of-pocket spending that is most unpredictable for patients. Annual cost sharing averaged nearly $1,100 in 2023, with amounts varying significantly, reflecting differences in health care utilization and benefit design. Half of members incurred less than $500 in annual cost sharing (51%), while 10% paid more than $3,000.

Average annual cost sharing per member by service category reflects the frequency of use of each service and the amount of cost sharing required per use. Inpatient stays are relatively uncommon, but tend to produce the largest bills for patients. The HPC found that cost sharing varied substantially: roughly a quarter of stays had no cost sharing in 2023, while about 10% of stays had cost sharing of $3,000 or more (with patients paying an average of roughly $4,300 out-of-pocket for those stays). Most of the high spending was due to deductibles. Patients incurred the highest average annual cost sharing on ambulatory care, due to the high frequency of use. E&M visits were the service with the highest per member per year cost sharing, at an average $257, with roughly half of cost sharing paid through copays. As benefit design drives the patient experience of cost sharing, ambulatory services like lab tests that have both high utilization frequency and high deductible use mean that many patients receive unpredictable bills for these services, potentially multiple times a year.

In contrast to typical high deductible plan models, plans could have consumer-friendly cost sharing models, even while holding constant the same total cost sharing dollars and premium levels. Payers and employers, in public and private sectors, have been increasingly developing innovative cost sharing benefit designs that incorporate consumer friendly principles. These analyses support recommendations to reconsider cost sharing benefit design to minimize financial harm, support access to care, and make health care easier for all patients to navigate. ►

Health care affordability ranks as a top concern among Massachusetts residents.[1] As health care spending in the Commonwealth continues to rise substantially, growth in both health insurance premiums and cost sharing is squeezing household budgets.[i] Premiums are fixed costs in a household's monthly budget, whether deducted from an employee's paycheck or paid directly to the insurer, while out-of-pocket health care spending (cost sharing) are variable costs that often can't be anticipated. If these costs pose a financial challenge, the consumer may forgo care, incur medical debt, or cut back on other necessities. Indeed, in 2023, 50.5% of low-to-moderate income Massachusetts residents with employer-sponsored insurance reported having at least one of these affordability issues, as did 26.2% of higher income residents, according to the Center for Health Information and Analysis (CHIA) Massachusetts Health Insurance Survey (MHIS).[ii] Both of these figures worsened from 2021 to 2023.

Massachusetts policymakers have increasingly sought to address the high and growing burden of out-of-pocket costs facing patients through recent legislative and regulatory action. The Healey-Driscoll Administration recently issued regulatory guidance through the Division of Insurance (DOI) that requires payers to limit the growth of deductibles and copays at the rate of medical inflation (approximately 4.8%), starting in January 2026. Chapters 342 of the Acts of 2024 capped out-of-pocket costs for certain drugs identified to treat asthma, diabetes, and prevalent heart conditions. Chapter 343 of the Acts of 2024 directed the DOI to consider affordability to consumers and purchasers of health insurance in the Division's examination of rates submitted for approval by insurers.

As with premiums, patient cost sharing reflects underlying health care costs, which continue to grow steeply. Efforts to constrain or reduce cost sharing should therefore be paired with policy reforms to address the underlying drivers of health care spending to ensure that premiums do not increase. At the same time, particular features of cost sharing benefit design exacerbate financial harm to consumers, in particular the deductible structures that are common in commercial insurance design. Deductibles can result in large bills that are difficult for consumers to anticipate in advance, even for common primary care services. This coverage model places consumers with limited savings at particular risk of financial harm and can create a chilling effect on seeking care. In addition to unpredictable amounts, while copays can be paid at the time of care, deductibles result in patients receiving one or multiple bills after the care is provided, increasing administrative burden for patients. Cost sharing structures can be redesigned to make patients' bills more predictable and to support affordable access to primary care, even while holding total out-of-pocket costs and premiums constant.

In this report, the Health Policy Commission (HPC) explored cost sharing across settings of care to better understand the burden of cost sharing for Massachusetts commercially-insured residents, highlighting the issues associated with deductibles. These analyses support recommendations to reconsider cost sharing benefit design to minimize financial harm, support access to care, and make health care easier for all patients to navigate.

Cost sharing

Health insurance benefit design refers to the rules set by health plans, consistent with federal and state regulations, that determine what services are covered, which providers are in the member's network, and patient financial obligations when using care. Cost sharing refers to the portion of the total amount of money that health care providers receive in exchange for providing a health care service (i.e. the "price" of the service or "allowed amount") that a patient pays directly "out-of-pocket."[iii] Health plans pay the remaining portion. For example, an insurance plan and a physician group may negotiate that the group will be paid $100 for a certain type of doctor visit; then, given the details of a given patient's insurance benefit plan, the physician group collects $20 directly from the patient at the time of the visit and bills the insurance plan for the remaining $80.

The main forms of cost sharing are:

- Copayments (copays): Patient pays a fixed dollar amount for a service, regardless of the price of the service.
- Coinsurance: Patient pays a percentage of the total price of the service (e.g. the patient pays 20% and the insurer covers 80%).
- Deductible: Patient pays the full price of services until a set amount is met; after the patient meets the deductible, copayments and coinsurance may still apply.

The use of these forms of cost sharing as well as their associated amounts can be adjusted by insurers to achieve certain goals. For example, if a plan had no cost sharing, in the above example, the patient pays nothing at the time of the visit and the plan pays the full $100 to the physician group. If all services were this way, premiums (which reflect the sum of the amounts insurers expect

i Insurers' approved rate increases in the individual and small group markets averaged 11.5% for 2026. See: https://www.mass.gov/info-details/2026-health-insurance-rates#final-merged-market-rates-effective-for-2026/. Massachusetts family premiums were highest in the U.S. in 2024 at $28,151 annually. See https://datatools.ahrq.gov/meps-ic/.

ii HPC analysis of data from the Center for Health Information and Analysis (CHIA) Massachusetts Health Insurance Survey (MHIS).

iii The HPC uses the term price in this case, although health care services sometimes include a bundle of individual services, for example, an inpatient hospital stay for which patients typically pay a single copayment. Sometimes this price is alternatively referred to as "cost", that is, the patient's or payer's cost of care.

to pay) would be higher and patients who use more care would pay the same amount out-of-pocket as patients who use less care. Alternatively, if the patient paid $50 out-of-pocket for the visit and the plan paid $50, premiums would be lower, and the burden of health care spending would fall more heavily on those who use more care rather than being shared more evenly. Thus, all else equal, increasing cost sharing reduces health insurance premiums by placing more of the burden of health care spending on patients when they use care, rather than via health insurance premium payments from members and employers.

In addition to the goal of reducing premiums, another often-stated goal of cost sharing is to discourage overuse of health care resources of limited value and steer patients towards higher-value services or lower-priced, high-value providers. Indeed, academic literature finds that differentiated copays can, in some instances, steer patients to some extent toward higher-value care choices.[2] However, for cost sharing to influence patient behavior, patients must be able to estimate their cost sharing obligations in advance of receiving a service so they can use this information to inform their choices. Deductibles and coinsurance do not support these goals since patients do not typically know their out-of-pocket liability before care is delivered. Price information remains inaccessible for most consumers, despite transparency efforts from payers and governments; research also suggests that consumers with high deductible plans are no more likely than consumers with other types of insurance to engage in price shopping for medical care.[3]

More generally, with a few exceptions, researchers find that higher amounts of cost sharing do not spur patients toward more judicious use of health care resources; rather, they tend to cut back similarly on both higher-value and lower-value care.[4,5,6,7,8,9,10] In a notable recent example, researchers found that the increase in cost sharing experienced by Medicare beneficiaries as they reached the full-price "donut hole" portion of the Part D prescription drug benefit, akin to a deductible, led to a 14% increase in mortality due to beneficiaries' cutting back on medications for chronic conditions.[9]

Deductibles

While cost sharing in any form can lead to financial hardship and avoided care for patients, the deductible poses unique affordability challenges for patients, in addition to undermining the potential for cost sharing to steer patient behavior based on value. Deductibles applied to each individual claim have long been used in fire, auto, and other insurance products designed to cover catastrophic losses in order to reduce premiums and deter small claims, which can entail high administrative and processing costs relative to the amount of the claim. This concept was gradually incorporated into health insurance plan design starting in the 1950s, although with deductibles that reset annually rather than for each claim.[11] A series of federal legislation in the 1990s and early 2000s introduced health savings accounts (HSA) – tax-advantaged savings accounts to help individuals save and pay for qualified medical expenses – to pair with high deductible plans (see **Sidebar: HSAs, HRAs, and HDHPs**), which encouraged the adoption of high deductible plans.

Over time, deductibles have grown in prevalence and dollar amount nationwide. In Massachusetts, the percentage of commercially-insured residents enrolled in high deductible health plans (HDHPs), defined in 2023 as plans with deductibles of more than $1,400 per person or $2,800 per family, increased from 19% to 45% from 2014 to 2023. According to CHIA's latest Massachusetts employer survey, over half of high deductible plans included either an HSA or health reimbursement arrangement (HRA). When there was an employer contribution to these accounts, the average contribution for family plans in 2024 was $1,255 and $3,480, for HSAs and HRAs, respectively.

HSAS, HRAS, AND HDHPS

High deductible health plan (HDHP): An HDHP is health coverage with a higher annual deductible than typical health plans. For 2026, the Internal Revenue Service (IRS) defines an HDHP as having a deductible of more than $1,700 per person or $3,400 per family. A plan may be designated as an IRS-eligible HDHP, which allows patients to contribute to a HSA and also has certain requirements. The main requirement is that the patient must meet the entire deductible before the insurer pays anything, with the exception of ACA-mandated preventive services and any other essential health benefits, for which the patient pays no cost sharing. An HDHP that is not an IRS-eligible HDHP does not need to meet this requirement.

Health savings account (HSA): An HSA is a tax-advantaged savings account to pair with an HDHP to pay for qualified medical expenses. Contributions are not taxed, interest grows tax-free, and patients do not pay taxes on withdrawals from the account. Contributions carry over from year to year and between jobs. The member, their employer, or any other party can contribute to a patient's HSA.

Health reimbursement arrangement (HRA): An HRA is an employer-owned and employer-funded account in which an employer makes tax-deductible contributions that the employee can use to pay for qualified medical expenses on a tax-free basis.

In response to rising health care spending, payers and employers often seek to mitigate large premium increases by increasing cost sharing, thus shifting risk (and responsibility for spending) away from the plan and onto the consumer. Raising the annual deductible represents a conceptually and actuarially straightforward mechanism to accomplish this goal (as opposed to considering alternatives for the design and allocation of cost sharing that could achieve the same overall premium-lowering effect). Consumers are then often only offered a choice between higher deductibles versus higher premiums; given this choice, many patients are attracted to high deductible plans in order to pay lower premiums. However, high deductible plans are a model with significant flaws for many of today's health care consumers. While the health insurance deductible may have been adapted from the auto insurance deductible, auto insurance is designed for insurance to be used only for catastrophic claims; the driver is encouraged to pay outside their insurance for all routine maintenance and minor unexpected needs, particularly since the deductible threshold for insurance coverage applies to each claim. In contrast, high deductible plans shift insurance risk from the plan to the consumer for all care, including primary care services, which is inconsistent with the health promotion goals of today's health insurance. Health insurance deductibles also do not provide consistent incentives for value-based choices, since health insurance deductibles are set on an annual basis, rather than a per claim basis.[iv]

Furthermore, the rise of high deductible plans occurred in the context of high-income patients who could contribute to HSAs, or those who work for employers able to make generous contributions to such accounts. For consumers in certain circumstances such as these, high deductible plans may continue to be an attractive option. In contrast, high deductible plans may be a poor fit for other consumers who may not have other lower premium alternatives. In particular, the application of high deductible models from higher-income populations to a broader population exacerbates the potential for financial risk, since deductibles result in potentially large bills even for common health care needs. An unexpected bill for a few hundred dollars for a primary care visit would be an annoyance for some and a financial crisis for others, in the context of nearly 40% of Americans reporting not being able to fully cover an unexpected $400 expense with cash or its equivalents.[12] Research suggests that HDHPs are more likely to exacerbate bankruptcy for Black and Hispanic families than for White families, who on average have significantly more assets to draw on to cover a large, unexpected health care bill. One study found that low-income Black and Hispanic families with HDHPs (with no HSAs) had median financial assets of $2,200 and $2,000, respectively, which are well below the average family coverage deductible.[13]

In Massachusetts, residents enrolled in HDHPs were more likely to avoid needed care due to cost than those in conventional plans (31% to 19%, according to CHIA's 2023 Massachusetts Health Insurance Survey), and these affordability issues were disproportionally worse for low-income residents and residents of color in HDHPs. The same survey also identified that deductibles are increasingly the main cause of medical debt among Massachusetts residents. In 2021, 62% of commercially-insured residents with income below four times the federal poverty level (FPL) who had medical debt said that the debt was for care that was paid for as part of a deductible; by 2023, that percentage had risen to 86%.[v]

The HPC analysis that follows highlights the variation and unpredictability of bills that patients might receive for a range of key health care services.

METHODS

The HPC used the CHIA Massachusetts All-Payer Claims Database (APCD) V2023 from 2019 to 2023, including medical and pharmacy claims from six large commercial payers in Massachusetts.[vi] Medical claims were categorized using the Restructured Berenson-Eggers Type of Service (BETOS) Classification System and Agency for Health Care Research and Quality (AHRQ) Surgery Flags Software, with minor modifications. Broad service categories included inpatient care (including professional and facility spending), ambulatory care, pharmacy, care received out-of-network, and all other care.[vii] Ambulatory care was further divided into sub-categories of care. Analysis included Massachusetts residents aged 0-64 with 12 months of medical and pharmacy coverage and any utilization (spending).[viii] Details on methodology, including care categories, can be found in the **Technical Appendix**.

iv For example, if a patient exceeds the deductible in January, there is no additional incentive to seek lower-cost care for the remainder of the year.

v See *Center for Health Information and Analysis. Findings from the 2023 Massachusetts Health Insurance Survey. June 2024.* Some results based on HPC analysis of CHIA MHIS data.

vi The sample, which includes Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, Health New England, United Healthcare, and Mass General Brigham Health Plan, represents 33% of the Massachusetts commercial market. Elevance (previously Anthem) was excluded due to lack of pharmacy claims.

vii Pharmacy spending includes prescription drugs and other services covered under members' pharmacy benefit, such as vaccine services. All other care includes durable medical equipment, skilled nursing facility, hospice, home health, and ambulance services.

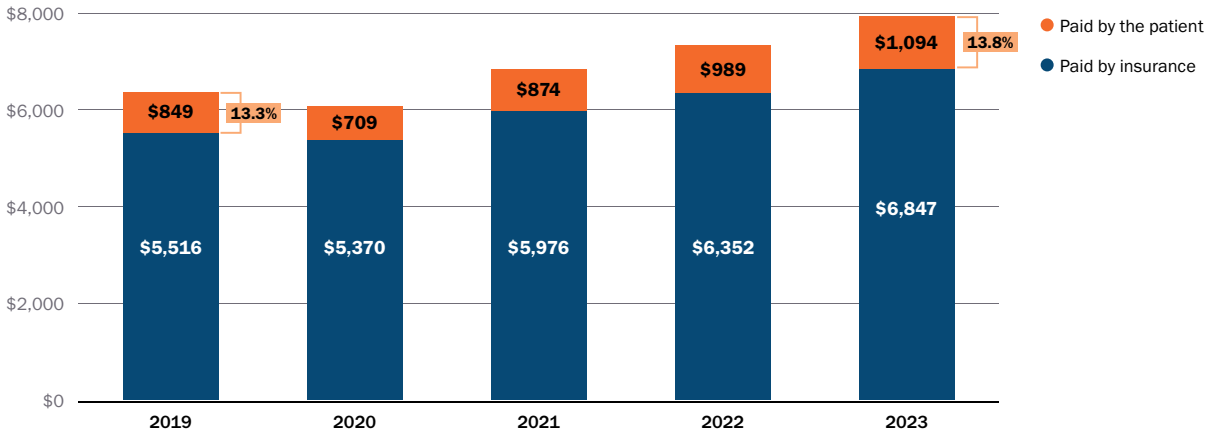
viii This restriction eliminates approximately 7% of patients from the analysis who had no observable utilization in 2023.

Findings: Trends in cost sharing

From 2019 to 2023, average commercial cost sharing grew 29% from $849 per member per year to $1,094 (see **Exhibit 3.1**), faster than the growth in insurer-paid amounts (24%).[ix] Cost sharing as a share of total spending (patient paid amounts + insurer-paid amounts) therefore grew from 13.3% in 2019 to 13.8% in 2023.

Exhibit 3.2 displays cost sharing per member per year by type of cost sharing, including coinsurance, copayment, and deductible spending. The dominant form of cost sharing was the deductible, which represented 58% of all cost sharing in 2023, an increase from 54% in 2019. Compared to average annual copay spending, which grew 12% from 2019 to 2023, deductibles grew 38% over this period. The growth in deductibles means the composition of cost sharing is increasingly shifting to the type of out-of-pocket spending that is most unpredictable for patients.

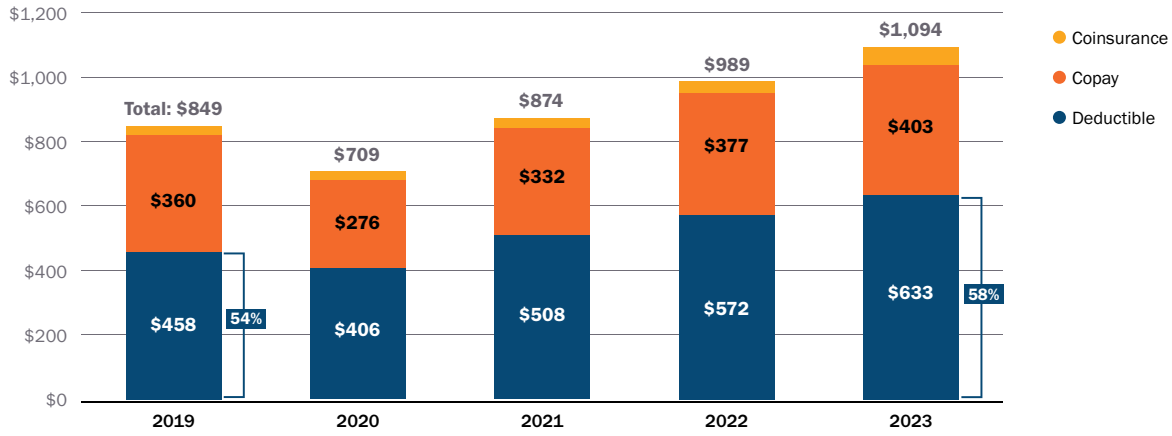
Exhibit 3.1. Commercial spending per member per year, 2019-2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Pharmacy spending is net of rebates.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

Exhibit 3.2. Cost sharing per member per year by cost sharing type, 2019-2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization.

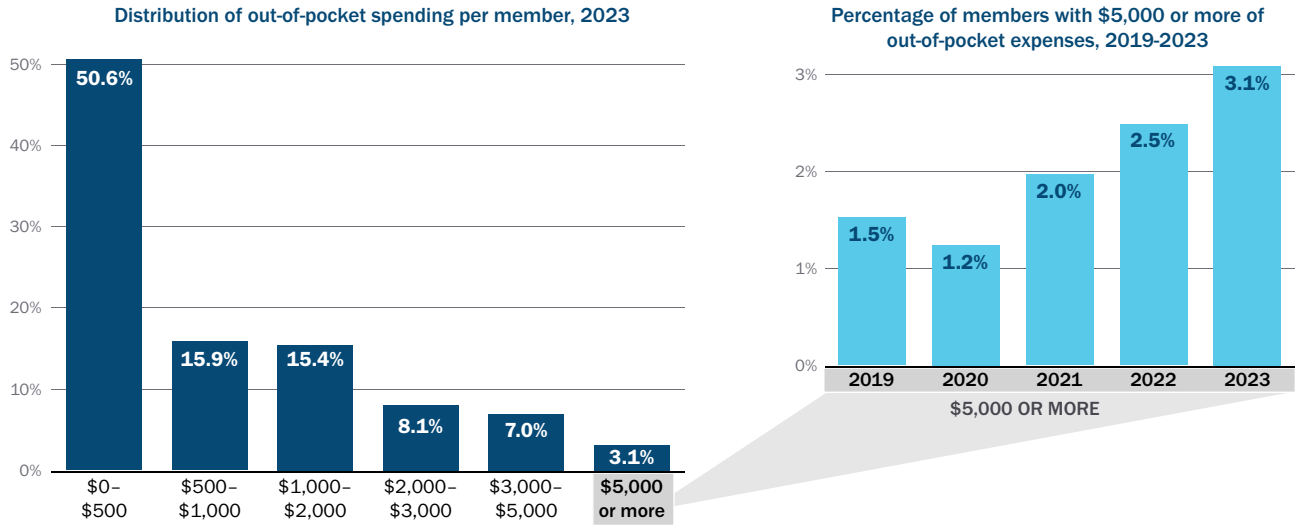
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

ix These figures differ from those reported by CHIA, which estimated the average annual cost sharing per member in the Massachusetts commercial market to be $816 in 2023. The lower estimate may reflect CHIA's inclusion of members who had insurance coverage but no health care spending (thus no cost sharing), certain plans with lower cost sharing, such as subsidized ConnectorCare plans, and plans with carved-out benefits that are not accounted for in the totals. In contrast, the HPC estimate includes only those members with full year medical and pharmacy coverage.

While annual cost sharing averaged nearly $1,100 in 2023, the out-of-pocket amounts that individual Massachusetts commercial members paid varied significantly, reflecting differences in health care utilization as well as benefit design. Half of members incurred less than $500 in annual cost sharing, while 10% paid more than $3,000 (see **Exhibit 3.3**). The share of members paying $5,000 or more per year in cost sharing was 3.1% in 2023, which was double the share in 2019.[x]

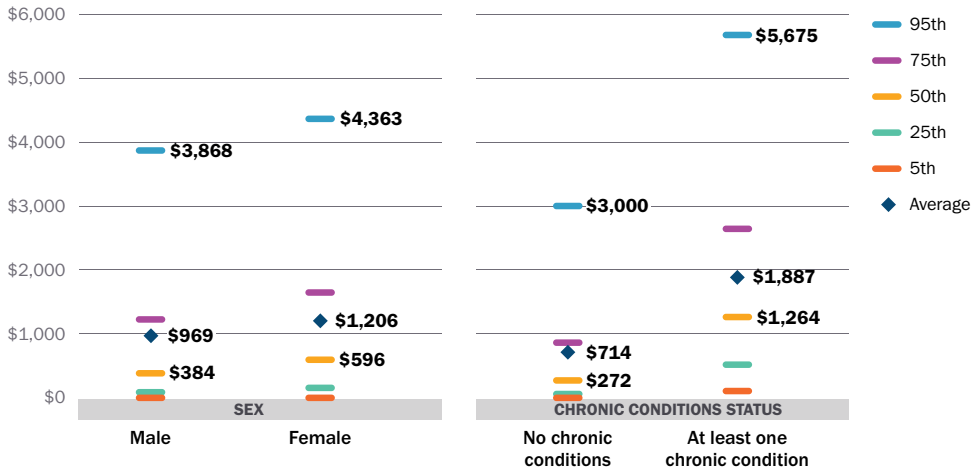
Cost sharing varied by patient characteristics and health status. On average, members with at least one chronic condition paid over 2.5 times the cost sharing of those without ($1,887 versus $714) in 2023 (see **Exhibit 3.4**). Cost sharing was also higher and more variable for women compared to men, generally reflecting more utilization, especially during reproductive age (see **Technical Appendix** for cost sharing by age and sex, as well as by each select chronic condition.)

Exhibit 3.3. Distribution of cost sharing per member per year in 2023; percent of members with $5,000 or more in cost sharing per year, 2019-2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

Exhibit 3.4. Distribution of cost sharing per member by sex and chronic condition status, 2023



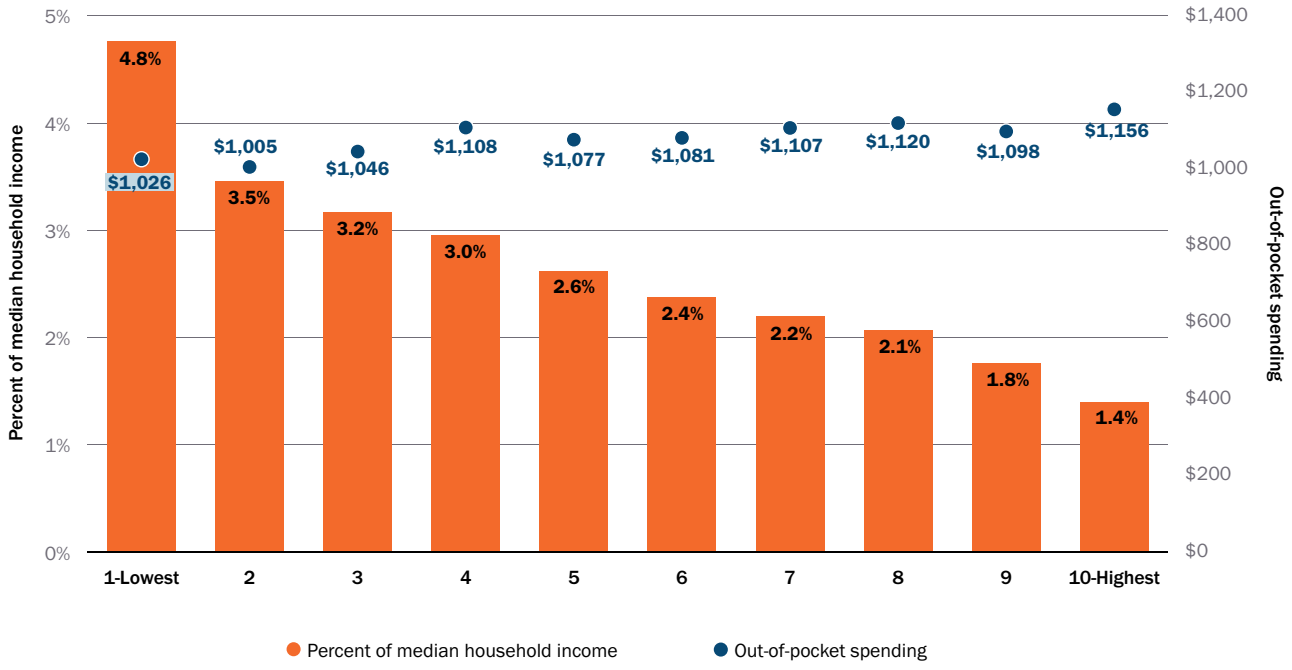
Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Chronic conditions analyzed included AIDS/HIV, asthma, arthritis, cancer, cardiovascular conditions, diabetes, epilepsy, hypertension, mood disorders, multiple sclerosis, psychosis, renal disorders, and substance use disorder. In 2023, 32% of members had at least one of the chronic conditions analyzed.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

x Federal law requires most health plans to impose an annual limit on member cost sharing, typically referred to as an out-of-pocket maximum. After members exceed their out-of-pocket maximum, plans are required to pay for all in-network covered services without cost sharing. In 2023, the federal out-of-pocket maximum was $9,100 for an individual and $18,200 for a family.

The HPC also analyzed differences in cost sharing by income, based on the median income of a patient's zip code. While average commercial out-of-pocket spending was similar across community income levels, the amount represented a higher burden for lower-income members. Average cost sharing for members living in the lowest income-zip code decile represented 4.8% of median family income in those areas, in contrast to 1.4% for members living in the highest income-zip code decile (see **Exhibit 3.5**).[xi] These results are generally consistent with findings from other research in Massachusetts, such as the recent health care cost trends report from the Massachusetts Office of the Attorney General (AGO).[14] In addition to disparities in annual impact, a large medical bill can pose a significant financial risk at the point in time it is received for households with lower incomes, particularly a bill that was not anticipated. For example, a $500 bill may represent about 15% of the monthly take-home pay for a household with a $50,000 annual salary;[xii] if savings were not available, paying this bill would require using debt or making trade-offs in household necessities.

Exhibit 3.5. Cost sharing as a percentage of household income and average out-of-pocket spending per member by community income decile, 2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Income groupings represent population-weighted deciles based on median income of zip code sourced from U.S. Census Bureau American Community Survey 5-year estimates. Income data are at the family level. To convert cost sharing for individuals to a family amount, the individual amounts are multiplied by 2.4, the average household size in Massachusetts according to data from the US Census Bureau.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

xi The HPC also found that out-of-pocket spending as a share of total health care spending was similar between the lowest- and highest-income areas, while a higher share of cost sharing was attributed to the deductible among higher-income areas compared to lower-income areas (59.8% and 56.5%, respectively.)

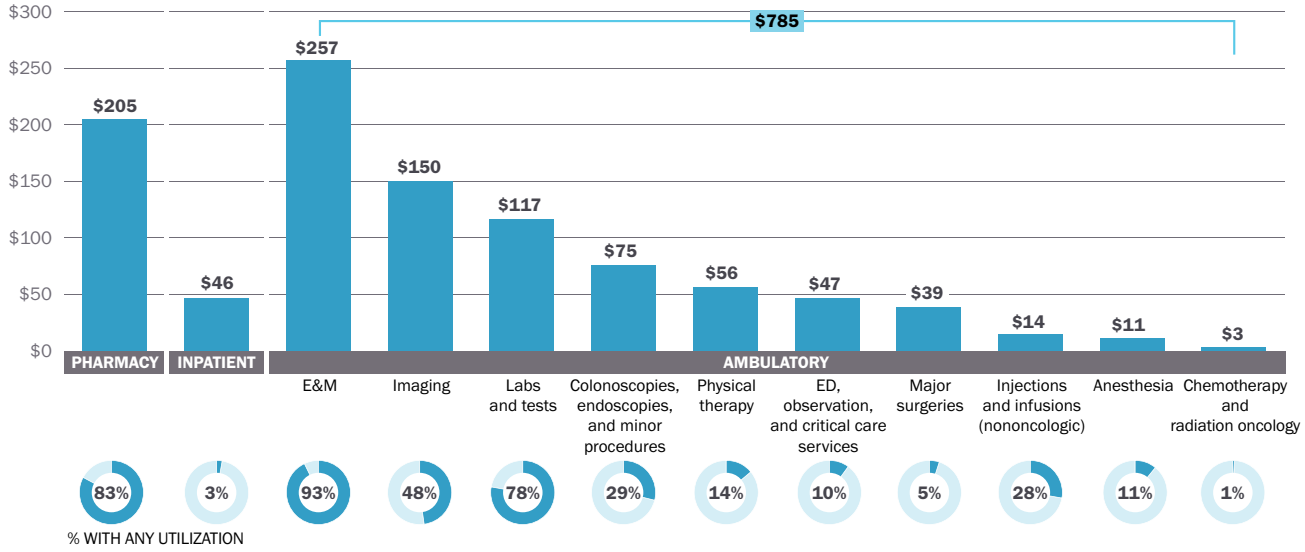
xii Estimate assumes typical tax rates for a family with this income and private employer-based health insurance.

Cost sharing by type of service

Exhibit 3.6 shows average annual cost sharing per member by service category in 2023. These amounts reflect the frequency of use of each service and the amount of cost sharing required per use, the latter of which is determined by the insurer's benefit design. For example, while inpatient stays are costly services with high cost sharing on average, they occur rarely, resulting in low average annual cost sharing for this care category ($46 per member per year in 2023). In contrast, lab tests are comparatively inexpensive yet used by most patients and frequently, resulting in higher average annual cost sharing ($117 per member per year in 2023). See **Technical Appendix** for more information on differences in utilization, spending, and cost sharing by these service categories.

By service category, there was considerable variation in the distribution of coinsurance, copay, and deductible, reflecting differences in plan benefit design. For example, deductibles constituted the largest share of cost sharing for ambulatory and inpatient care, at 67% and 64% respectively, whereas copayments represented 73% of pharmacy cost sharing (see **Exhibit 3.7**). As deductibles and coinsurance represent the most unpredictable forms of cost sharing, these results suggest that care received at ambulatory and inpatient settings can most often lead to highly variable cost sharing for patients.

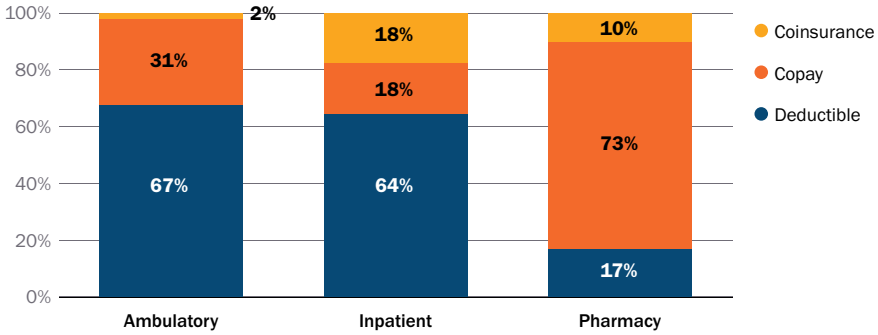
Exhibit 3.6. Cost sharing per member per year and percentage of members with utilization by service category, 2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. E&M = evaluation and management and includes ambulatory behavioral health services, which accounted for $71 in annual cost sharing of the $257 shown in the exhibit. Annual average cost sharing per member for out-of-network care was $32 and $25 for all other care (data not shown).

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

Exhibit 3.7. Distribution of cost sharing by cost sharing type and service category, 2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. For care received out-of-network, deductible represents 64% of cost sharing, while coinsurance represents 27% (data not shown).

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

Within ambulatory settings, where patients incurred the most cost sharing on average (see **Exhibit 3.6**), the share of cost sharing represented by deductibles varied widely by service, reflecting differences in benefit design and the price of services. For example, the use of copayments is relatively common for services such as physical therapy and evaluation & management (E&M visits), where 53% of cost sharing came from copays in 2023 (see **Exhibit 3.8**). In contrast, deductibles comprised 89% of cost sharing for lab tests and 85% of cost sharing for imaging in 2023. As benefit design drives the patient experience of cost sharing, services like lab tests that have both high utilization frequency and high deductible use mean that many patients receive unpredictable bills for these services, potentially multiple times a year. In the next section, the HPC highlights the unique challenges that the deductible poses for patients to navigate and afford care.

Spotlight on deductibles

HPC analysis focused on three key settings of care where the deductible can lead to financial challenges: inpatient hospital, emergency department, and routine care (primary care).[xiii]

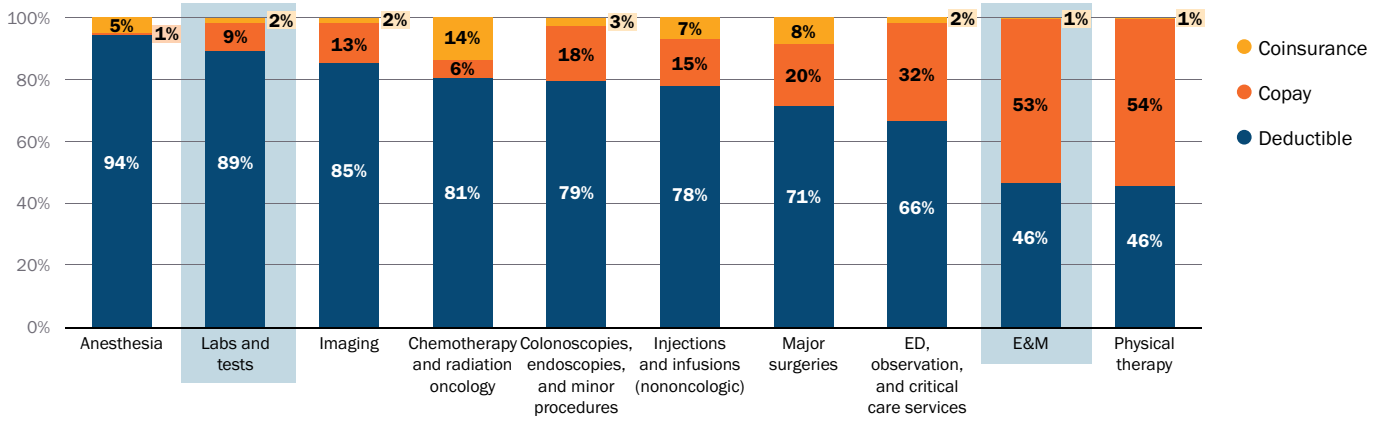
Inpatient stays

Inpatient care is generally the setting that can produce the largest bills for patients. Given the high and growing levels of deductibles, patients may face bills for hundreds or thousands of dollars for these high-cost services. **Exhibit 3.9** shows the distribution of cost sharing for inpatient stays in 2023 and highlights the significant variation in how much patients paid out-of-pocket for both maternity stays (i.e., labor and delivery) and non-maternity inpatient stays. While roughly a quarter of stays had no cost sharing, about 10% of stays had cost sharing of $3,000 or more.[xiv] Deductibles represented the largest portion of cost sharing, accounting for 68% of total cost sharing for maternity stays and 61% of total cost sharing for non-maternity stays. For stays with cost sharing over $3,000, 74% and 62% of the total cost sharing was attributed to the deductible for maternity and non-maternity stays, respectively. The MA AGO's recent report found that while hospital outpatient services resulted in more patients going into debt, inpatient services led to patients having higher amounts of debt – among patients with debt from inpatient services, the average amount of debt was $2,315 in 2022.[14]

Emergency department

ED services can also lead to potentially large medical bills, with significant variation in bill amounts due to deductibles, and patients have the least ability to plan for these expenses. Patients generally cannot plan or shop where they receive emergency care, nor can they save in anticipation of an unscheduled service. Furthermore, once they are in the ED, patients have little to no ability to meaningfully consider which services they receive. Some insurance plan designs include a fixed copayment for the ED visit itself, while

Exhibit 3.8. Distribution of cost sharing by cost sharing type and ambulatory service category, 2023



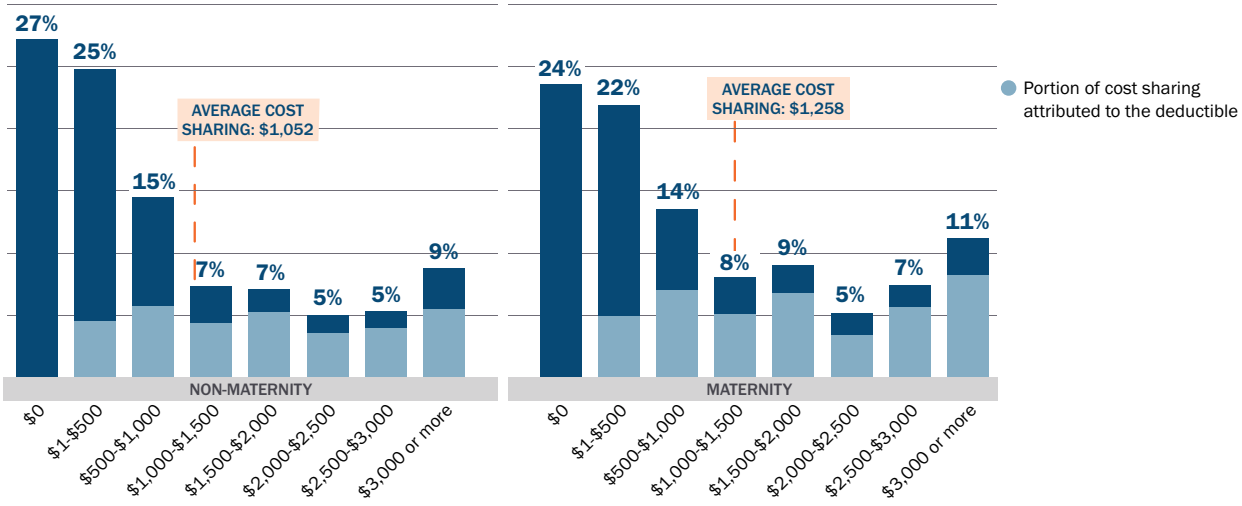
Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. E&M refers to evaluation and management and includes behavioral health services.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

xiii For this research, the HPC did not limit analysis to a strict definition of primary care services (e.g., by restricting to specific primary care provider types) but considered services that are predominantly primary care services. Therefore, the HPC uses the more general term of routine care in this analysis.

xiv Average cost sharing among inpatient stays where cost sharing was over $3,000 was $4,266 for maternity stays and $4,393 for non-maternity stays in 2023.

ancillary services that occur as a part of the visit, such as imaging or lab tests, are subject to the deductible. As shown in **Exhibit 3.10**, for ED visits without any additional services rendered, which represented 17% of all ED visits, the average cost sharing was $323 per visit in 2023, and 1% of such ED visits incurred $1,500 or more in cost sharing. When visits included both imaging and lab tests (representing 16% of all ED visits), the average cost sharing was $484, with the likelihood of $1,500 or more in cost sharing increasing 10-fold to 10%. As with inpatient stays, deductibles drive the total cost sharing amounts for large bills; 93% of the total cost sharing amount was attributed to deductibles for ED visits with cost sharing over $1,500.

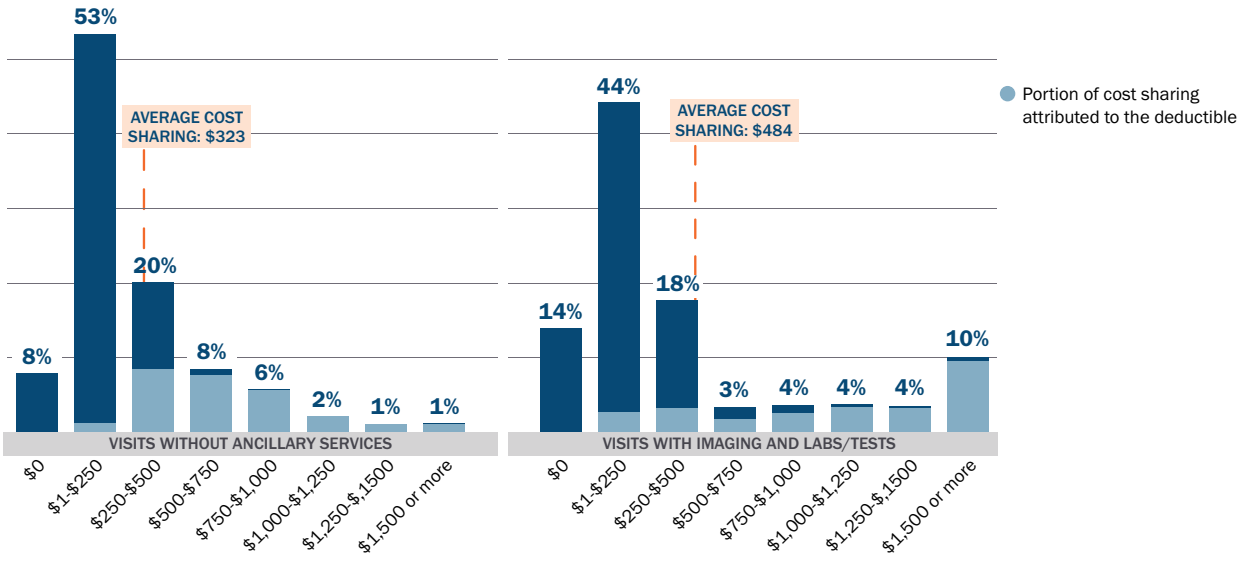
Exhibit 3.9. Distribution of cost sharing for maternity and non-maternity inpatient stays, 2023



Notes: Data represents cost sharing for both facility and professional claims that occurred during an inpatient stay. Maternity stays include newborns and were defined as having an APR-DRG major diagnostic category (MDC) of 14 or 15.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

Exhibit 3.10. Distribution of cost sharing for emergency department (ED) visits, 2023



Notes: Visits were defined as same person and date of service as an emergency department visit procedure code (99281-99292). Visits were dropped if they occurred on the same day for the same person as an observation or inpatient stay.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

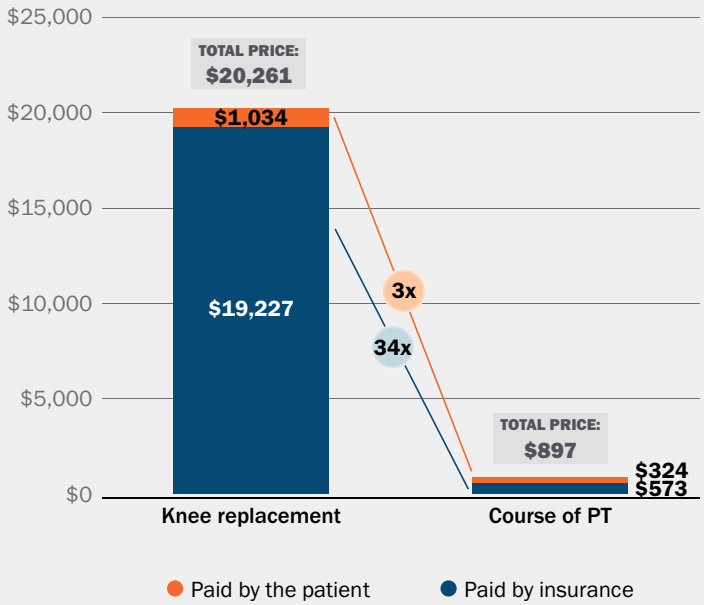
THE ROLE OF COST SHARING IN DRIVING HIGHER-VALUE CARE

While this report largely focuses on the lack of predictability and affordability in patient cost sharing driven by the use of the deductible, another issue in typical commercial health plan benefit design is that cost sharing can also work against patients and providers making higher-value care choices. The HPC's 2024 Cost Trends Report discussed at length the variation in intensity of care – the choice of a higher- versus lower-resource approach to treat a given medical condition or event, which can result from shifts in health care technology, as well as variation in provider practices. The HPC presents the following example in which the typical cost sharing structure may not be optimally aligned with value:

Knee osteoarthritis is characterized by knee joint pain related to changes in the tissue and cartilage, which can lead to discomfort, stiffness, and swelling. Several medical approaches are typically used in response, ranging in intensity from physical therapy (PT) to total replacement of the knee joint (arthroplasty). Evidence and guidelines support the use of PT, which may resolve the pain on its own (and avert the need for surgery) and can also improve outcomes if a knee replacement is ultimately warranted,[15] representing a cost-effective choice for many patients. However, common commercial benefit design and cost sharing can work against PT. The HPC found that while the average total price of a knee replacement was 23 times that of a course of PT, average cost sharing was only three times higher (see **Exhibit 3.11**). In fact, including the finding that many patients pay no cost sharing for a knee replacement episode, the HPC estimated that nearly 30% of patients would face *more* cost sharing for a course of PT than for knee replacement surgery. If a patient tried PT before surgery, they would typically pay cost sharing for both, adding a further disincentive to consider PT as the first choice treatment.

While clinicians play the most important role in steering patients toward clinically appropriate high-value care choices, insurance benefit design can offer additional incentives by raising cost sharing for lower-value care and reducing cost sharing for high-value care accordingly. At a minimum, cost sharing design should not discourage the use of higher-value care.

Exhibit 3.11. Average total price with cost sharing for a knee replacement (2022) and a course of PT (2019-2023)



Notes: Members were limited to those with a diagnosis for knee osteoarthritis and were assigned a treatment category based on care received one year after initial diagnosis. A course of PT includes spending for members with 10 to 20 PT encounters. The average number of PT encounters for patients who only received PT for knee osteoarthritis was 19 and the median was 12.

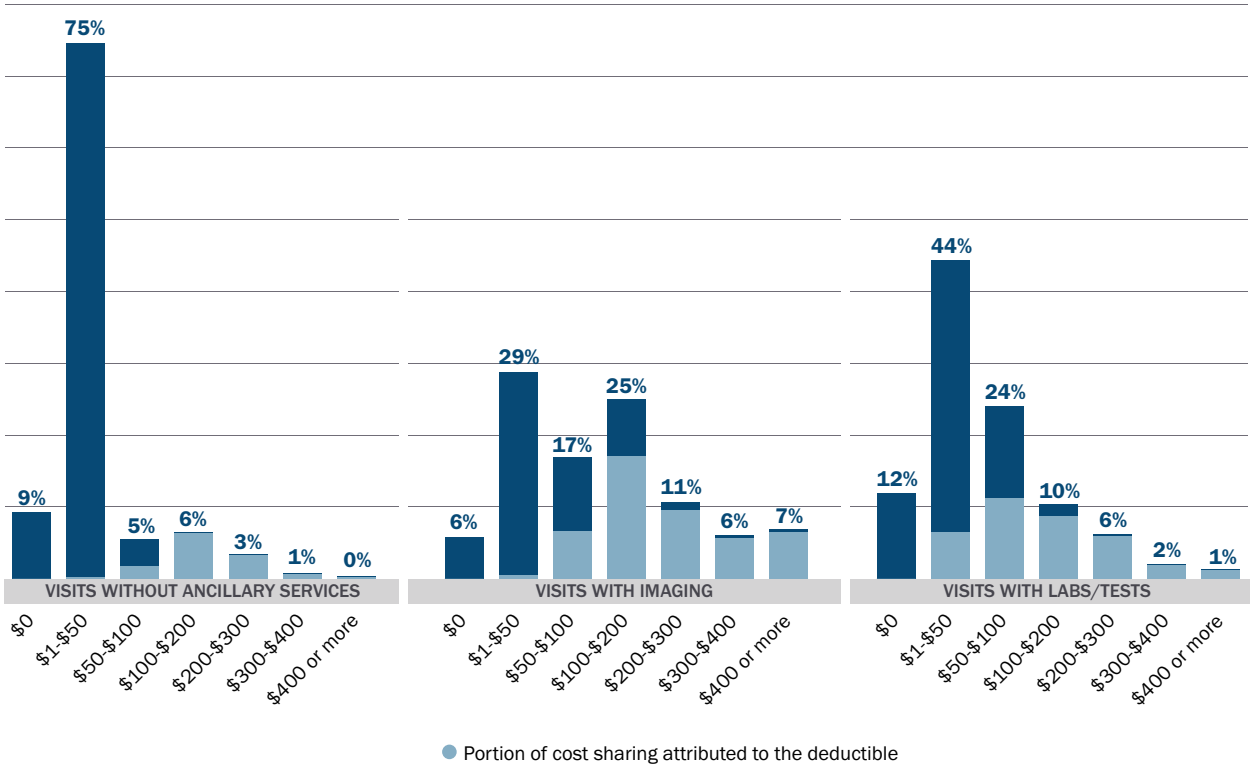
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023

Routine care

The negative impacts associated with deductibles are not limited to infrequent and high intensity services like ED visits and inpatient care. Even when patients seek primary care, deductibles can lead to unpredictable and potentially large bills. For certain HDHPs, the full deductible must be met before the insurer begins coverage for any service, including doctor's office visits. However, for other types of plans, a common benefit design is applying a copay for the doctor's office visit itself, while applying a deductible for ancillary services that the patient receives during the visit, such as lab tests or simple imaging.

Exhibit 3.12 shows the distribution of cost sharing for E&M visits for ten common clinical diagnoses (e.g., sore throat, back pain, cough), categorized by the use of ancillary services. For visits that did not have any ancillary services (representing 51% of all E&M visits), cost sharing averaged $45 in 2023, with 84% of visits having less than $50 in cost sharing. When the visit included an imaging procedure or a lab test, average cost sharing for the visit rose to $149 and $74, respectively, with some patients incurring more than $400 in out-of-pocket spending.

Exhibit 3.12. Distribution of cost sharing for evaluation and management (E&M) problem visits for ten common clinical diagnoses, 2023



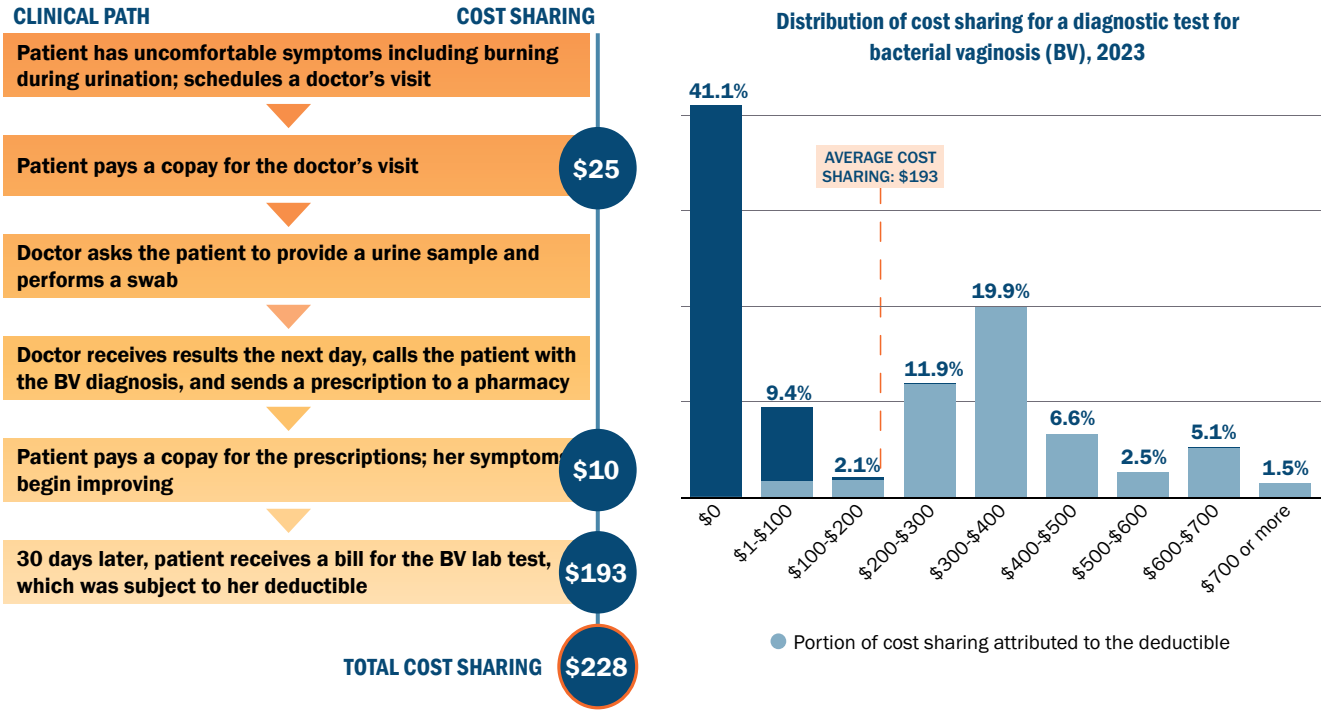
Notes: Data represents visits at ambulatory settings for ten principal diagnoses (F41, J02, F90, F33, M25, I10, M54, R05, H66, E66). Episodes were defined as same person and date of service as an E&M problem visit procedure code (99201-99215). Visits were dropped if they occurred on the same day for the same person as an emergency department visit, major surgery, chemotherapy, or other preventive visit.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

In the common benefit design of covering co-occurring routine care services under different cost sharing types (e.g. copay for the visit itself, deductible for ancillary services), after patients pay a copay for a doctor's visit, they may not anticipate further cost sharing for the visit. **Exhibit 3.13** presents a case study to further demonstrate the variability and unpredictability in cost sharing in primary care due to the deductible. Bacterial vaginosis (BV) is a common infection, particularly among women of reproductive age. BV can be easily diagnosed through a vaginal swab and subsequent lab test and treated with a short course of antibiotics. However, because lab tests are subject to the deductible in many commercial health plans, a simple and common clinical episode at the doctor's office can result in hundreds of dollars in unexpected out-of-pocket costs. In 2023, the average cost sharing for a BV test was $193, considerably more than the typical copay for the associated E&M visit. While 41.1% of tests did not incur any cost sharing (either because the patient had already met their deductible and other cost sharing obligation or because the test was not subject to any cost sharing based on the benefit design), nearly half incurred cost sharing of more than $100, including 9.1% of tests that had cost sharing of more than $500. Nearly all cost sharing (98%) for BV tests was in the form of the deductible.

This case study illustrates a financial experience familiar to many patients, where seeking care for common and easily treatable conditions can cost a patient hundreds of dollars unexpectedly. For example, even if patients are able to interpret their schedule of benefits to understand that lab tests are subject to a deductible, they are unlikely to know in advance of the visit that they would receive a test. Patients may not recognize that the vaginal swab the doctor requests to investigate symptoms represents a lab test, and it would also be nearly impossible for them to get an accurate estimate of price during the doctor's visit to inform whether to proceed with the test. Even if a patient was able to obtain prices, they are already in the doctor's office, and therefore leaving the office to "shop" for a better price is not realistic. In addition to presenting financial challenges for many patients, these unexpected bills can create a chilling effect that leads patients to avoid primary care in the future. This avoidance may result in more costly downstream healthcare use, such as ED visits or treatment for an exacerbated condition, or the condition may resolve on its own at the expense of prolonged patient suffering.

Exhibit 3.13. Bacterial vaginosis case study



Notes: Cost sharing amounts for the E&M visit and prescription drugs are illustrative but are based on the typical cost sharing for the service. Data represents encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Labs that occurred during an emergency department visit are excluded. Data are for CPT 81514, 'Infectious disease, bacterial vaginosis and vaginitis, DNA algorithmic analyses.' For group $1-$100, 18% of cost sharing is attributed to the deductible. For group $100-$200, 85% of cost sharing is attributed to the deductible. For all higher cost sharing groups, all or nearly all cost sharing is attributed to the deductible.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

POLICY CONSIDERATIONS

Based on the findings in this report and other insights from the literature and innovative government and private programs, this section describes several broad considerations for what consumer-friendly cost sharing design could look like, lists prominent examples in practice that exemplify some of these considerations, provides modeling exercises that add additional context and implications for what it would mean to reduce reliance on deductibles, and includes the HPC's policy recommendations on this topic.

Considerations for consumer-friendly cost sharing design

In contrast to typical high deductible plan models, plan designs for cost sharing that are more consumer-centric reflect the following core principles:[xv]

- Cost sharing should be predictable, transparent, and easy to understand.
  - These qualities enable patients to make informed choices and to make a financial plan, such as seeking financial assistance in advance where available.
- Deductibles and coinsurance should be minimized or eliminated especially for primary care services and redistributed in the form of copayments.
- Cost sharing for primary care services, including chronic disease management, should be affordable. These services include provider visits, as well as the common services that occur during visits such as basic lab tests.
- Value-based insurance design is compatible with consumer-friendly cost sharing design. Higher-versus lower-cost sharing can be effective for impacting patient decision-making in specific cost-effective care choices such as certain high-cost imaging, higher-value treatment alternatives, or sites of care.
  - In designing where to apply cost sharing differentials, payers should consider whether the patient can realistically make value-based decisions for a service in question. For services where a patient cannot reasonably make decisions (e.g. imaging in the ED), payers should consider provider-facing incentives (e.g. financial incentives or peer comparisons) to impact utilization rather than differential patient cost sharing.
- Plan designs should consider the patient user experience, including consideration for behavioral factors of how patients save for a new expense (e.g. it is easier for patients to save for a future expense of a known amount than for a unexpected amount for a routine service), how patients may or may not be able to consider value in decision making (e.g. high-intensity imaging services are generally less time sensitive and easier for patients to consider and potentially shop for than lab tests to diagnose active symptoms), and the patient administrative burden associated with navigating the payment of bills (e.g. a single episode-based payment is far less burdensome than multiple bills for individual services that occur during an episode).[16]

Examples of innovations in benefit design

Payers and employers, in public and private sectors, have been increasingly developing innovative cost sharing benefit designs that incorporate consumer-friendly principles.

Massachusetts Health Connector expansion pilot

In a two-year pilot for 2024 and 2025, the Massachusetts Health Connector expanded income eligibility requirements from 300% FPL to 500% FPL for a health insurance product with lower premiums, no deductible, low copayments, no copayments for common lab tests, and access to prescriptions at no cost to members for medication for chronic illness such as diabetes, asthma, and hypertension. A member survey found that 88% of respondents used their new coverage, and one in five used preventive services that they had previously deferred.[17]

Minnesota state employee health plan

Employees participating in Minnesota's State Employees Group Insurance Program (SEGIP) must select a primary care practice that is responsible for the employee's total cost of care. Practices are placed into cost sharing tiers based on risk-adjusted total costs. Employee premiums are the same across all tiers, but employees who choose practices with higher costs face higher cost sharing. Deductibles, copays, and maximum out-of-pocket costs vary substantially by tier. For example, annual family plan deductibles range from $500 in Tier 1 to $3,000 in Tier 4.[18,19] More than 80% of SEGIP members choose practices in the lower two cost sharing tiers. Primary care practices have a strong financial incentive to reduce total costs of care to remain competitive and prevent losing patients to lower-cost practices. After SEGIP informs practices of their initial tier assignment, practices have the opportunity to discount their prices to move to a lower tier. Approximately 25% of practices provide price discounts, generally in the 10% to 20% range.[19]

xv Principles in this section draw on materials developed by HealthCare Value Hub on consumer-friendly cost sharing design, including https://archive.healthcarevaluehub.org/advocate-resources/publications/rethinking-consumerism-healthcare-benefit-design.

Surest

Surest, an employer insurance offering from United Healthcare, uses a fully copayment-based model with no deductibles or coinsurance. Copays are fixed for each episode of care, even if unforeseen complications arise. For example, birthing episodes have the same cost sharing regardless of the method of delivery. Lab tests and low-cost imaging services (e.g., x-ray, ultrasound) associated with a primary care visit are included in the copay for the visit. Patients can determine their cost sharing via a mobile application, available before they seek providers for care. Copayments are higher for higher-priced providers and higher-cost settings of care; copays can vary substantially by provider and by service. Company internal analysis suggests significant savings, both for employers and for patients, driven by patient shifts to lower-cost providers and settings of care (e.g. urgent care vs ED, ambulatory surgical center vs HOPD) and shifts to higher-value treatment options (e.g. physical therapy vs surgical procedures).[xvi,20] Approximately 1 million members are enrolled in Surest nationwide, including fully- and self-insured. Surest is slated to enter the Massachusetts market in 2026.

Cost Plus Wellness

The employee health plan for Mark Cuban Cost Plus Drugs, an online discount pharmacy, negotiates directly with hospitals and clinics. There are no cost sharing obligations for employees, eliminating the need for providers to collect copays from patients. In exchange for lower financial risk and lower administrative burden, providers accept lower reimbursement rates.

Modeling reducing reliance on deductibles

The HPC's analysis has shown that high deductibles represent one of the most problematic forms of cost sharing. Reducing deductibles would lead to increases in premiums, all else equal, but these increases could be offset by other activity to reduce health care spending or through targeted increases in copayments which could leave total cost sharing unchanged, but would increase predictability for individuals and families.

As an example, the HPC calculated the financial impact of capping commercial deductible spending at $500 per person using the APCD. Reducing current deductibles to this level without increasing other forms of cost sharing would raise premiums by roughly 6%. This increase could be partially or entirely offset in several ways. One would be to reduce health care prices for services, such as limiting prices to 200% of a Medicare benchmark for inpatient stays, imaging, lab services, clinician-administered drugs and certain specialty procedures. The HPC has modeled such price reductions in previous work and found that savings of this magnitude are achievable and, because only the highest prices are affected, this strategy would not adversely impact lower-priced providers.[21] Another approach is to convert deductible spending to copays for certain services, consistent with the approach noted above and used in some plans such as Surest. The HPC found that the premium increase resulting from capping deductibles at $500 could be offset with fixed copayments across a range of services, for example, such that average copays would be roughly $500 for major outpatient surgery, $600 for inpatient stays, and $23 for prescription drugs. These copays imply higher cost sharing for some patients but lower for others. All patients would likely benefit from the predictability of fixed, up-front copayments for their care.

A more modest approach is to focus on reducing the deductible in primary care. The HPC modeled a limited definition of primary care services, focusing on primary care E&M visits in offices and outpatient departments (patients could still incur deductible costs for lab tests and other services that occur during those visits). The HPC estimated that eliminating deductible spending for these visits would increase premiums by roughly 0.3%, all else equal. This premium increase could be offset through mechanisms noted earlier.[xvii]

TARGETED RECOMMENDATIONS RELATED TO COST SHARING

The HPC makes the following recommendations to improve the predictability of cost sharing, reduce medical debt, improve the affordability of care and enhance the efficiency and experience of patients struggling to navigate a complex health care system.

The Commonwealth should foster the offering of health insurance products with consumer-friendly benefit design.

Consumer-friendly benefit design encompasses a number of features. In particular, the HPC's analysis highlights the need for insurance products that reduce or eliminate deductibles – especially for primary care services – and that use a more predictable copay-based benefit design. This design would redistribute cost sharing dollars, rather than raising premiums, maintaining the same actuarial values.

xvi In its pre-filed testimony submission for the 2025 Cost Trends Hearing, United cited that members enrolled in Surest have saved an average of 50% on out-of-pocket costs compared to traditional plans. Available at: https://masshpc.gov/sites/default/files/2025cth_pft_payer_UHC.pdf

xvii Massachusetts House bill H1309, introduced in the current legislative session, would require that E&M services be included as part of an insurer's basic benefits package, which would exempt these services from deductibles and require $0 cost sharing.

The entry and market traction of consumer-friendly products requires payer innovation, as well as effort and coordination from multiple stakeholders. Competition from new market products could support the development and growth of innovative offerings, such as the entry of products currently available in other states, or the development of new products from payers currently operating in Massachusetts. Leadership from the Group Insurance Commission (GIC), the Connector, the DOI, brokers and large employers could facilitate the development of these market offerings, which can ultimately increase demand from a broader employer base. For example, demand from the largest employers encourages payers to invest in developing these products. Standards could be developed to designate consumer-friendly benefit design; this designation could help employers find these products and help employees choose between plans.

Low-income patients should have greater financial protection from high hospital bills.

Even with more predictable benefit design, patients may face large bills for certain services, with hospital care generally generating the highest bills, given that these are generally the highest-cost services. Therefore, in addition to benefit design changes, improving affordability in cost sharing may require targeted policy to protect low-income patients from the largest bills.

Massachusetts should join the growing number of states that have passed legislation requiring nonprofit hospitals to provide more charity care and reduce bad debt for low-income patients. For example, Oregon's model includes patient financial assistance requirements, medical debt protections, a hospital-specific minimum community benefit spending floor, and robust reporting requirements.[22] While a recent study suggests that a reduction in patient medical debt after the debt is incurred (i.e. debt forgiveness) may slightly increase the chance of patients not paying other medical debt (a 1.1 percentage point increase),[23] a focus on meaningful patient assistance requirements in exchange for hospital nonprofit status could reduce the need for patients to go into debt for their medical care in the first place, as well as help curb harmful medical debt collection practices. A report by The Lown Institute found that 77% of Massachusetts nonprofit hospitals spent less on financial assistance and community investments than the estimated value of their tax benefits in 2021.[24] In its 2024 Examination of Health Care Cost Trends report, the MA AGO highlighted a number of recommendations to increase consumer protections around providers' financial assistance policies, including standardizing eligibility requirements and applying assistance to cost sharing and deductibles for eligible patients, as well as recommendations regarding medical debt collection practices.[14] These recommendations from the AGO's report are critical components to minimizing toxic financial harm from cost sharing.

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CHAPTER 4:

COST SHARING FOR PREVENTIVE SERVICES IN MASSACHUSETTS

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COST SHARING FOR PREVENTIVE SERVICES IN MASSACHUSETTS

EXECUTIVE SUMMARY

In an effort to encourage the use of high-value preventive services, the federal Patient Protection and Affordable Care Act (ACA) requires private commercial health plans to cover certain preventive services without patient cost sharing. Although the preventive care mandate has helped to facilitate the use of preventive services and has reduced patient cost sharing since the ACA was passed in 2010, many patients continue to pay out-of-pocket costs for ACA-covered preventive services, both nationally and in Massachusetts. To understand this element of cost sharing in the Commonwealth, the HPC explored cost sharing for a set of ACA-covered preventive services among Massachusetts residents with commercial insurance from 2019-2023: colonoscopy, diabetes screening, sexually-transmitted infection (STI) screening, contraception (including oral contraceptive prescriptions and contraception service encounters), pre-exposure prophylaxis for HIV prevention (PrEP), and preventive visits.

The HPC found that the prevalence of cost sharing for the selected services varied widely by service, ranging from 0.1% of oral contraception prescriptions to 30% of preventive visit episodes in 2023. With the exception of PrEP prescriptions, which became an ACA-covered service in 2019, the rate of cost sharing for each service was fairly steady from 2019-2023. Lab tests were a frequent source of cost sharing, including preventive screenings for diabetes and STIs and as part of colonoscopies and preventive visit episodes. Cost sharing amounts billed to patients in 2023 ranged from $18 (diabetes screening) to nearly $300 (colonoscopy), with cost sharing amounts increasing over time for most services. For medications, cost sharing was mostly in the form of copays, while for other services, most cost sharing was through deductibles. There was also substantial variation by payer in the share of each service with cost sharing.

Some amount of cost sharing for preventive services appears to be the current baseline in the Commonwealth. While some examples of cost sharing observed in this chapter would be permitted under the preventive care mandate, other examples appear to contradict it. Patient cost sharing that is inconsistent with the mandate may be due to payer methods of operationalizing the mandate for certain services, frequent federal regulatory updates and clarifications that payers must determine how to implement, and provider coding irregularities that may be due to the complexity of billing for preventive services. When patients do not anticipate paying cost sharing, receiving an unexpected bill may deter them from using health services and undermine their trust that preventive care will actually be covered. Addressing the challenge of cost sharing for preventive care will help reduce administrative complexity for providers and increase transparency, predictability, and affordability for patients. ►

Since 2010, the Patient Protection and Affordable Care Act (ACA) has required private commercial health insurance plans to cover certain preventive care services without patient cost sharing, including copays, coinsurance, and deductibles.[1] There is substantial evidence that the imposition of cost sharing leads to reduction in use of both low- and high-value care when it is applied to all kinds of services.[2,3,4,5] The preventive care mandate of the ACA seeks to facilitate the use of high-value preventive services by exempting them from cost sharing.[6]

The ACA preventive care mandate applies to all plans, including individual, small-group, large-group, and self-insured plans, whether offered by employers or on state marketplaces – with the exception of "grandfathered" plans that were in place at the time the ACA was enacted in 2010 and have not substantially changed since then.[7,i] As of 2023, 179 million U.S. residents, or about 55%, had commercial health insurance; in Massachusetts in 2023, that share was nearly 60%.[8] Most Massachusetts residents with commercial insurance should be eligible to access preventive care without cost sharing.[ii]

The ACA defines preventive services that must be covered without cost sharing as those recommended by any of the four expert bodies shown in **Exhibit 4.1**. Covered services include routine immunizations, screenings for conditions such as cancer, high blood pressure, diabetes, and sexually transmitted infections (STIs), certain medications, and others.[9,10] Each body reviews its recommendations regularly and may update its recommendations over time, such as by adding a new topic, or a new population for an existing topic.[11,12,13]

The ACA preventive care mandate has had positive impacts on patients' use of care and out-of-pocket spending. Studies on the first few years after the ACA was passed indicate that the preventive care mandate contributed to increased rates of routine checkups and flu vaccines for commercially-insured adults, as well as increased use of the most cost-effective contraceptive methods, such as intra-uterine devices (IUDs).[14,15] The mandate also resulted in decreased costs to patients: the share of commercially-insured women with zero cost sharing for birth control increased from 15% to 67%, with patients saving an average of $250 a year; likewise, from 2011 to 2012 alone, out-of-pocket spending dropped by 56% for well-child visits and by 74% for screening mammography.[16,17,18] Research also indicates that the preventive care mandate has increased the use of services such as colonoscopy and mammography among Black and Hispanic Americans, though studies differ on the degree to which racial and ethnic disparities in service use have persisted post-ACA because screening rates have risen across all groups.[19,20]

Exhibit 4.1. Recommending expert bodies and services covered by the ACA preventive care mandate

EXPERT BODY	COVERED SERVICES	IN EFFECT
United States Preventive Services Task Force (USPSTF)	Services with an "A" or "B" rating indicating evidence that the services have moderate or substantial health benefit (e.g., cancer screenings, HIV prevention medication)	Plan years beginning on or after September 23, 2010
Advisory Committee on Immunization Practices (ACIP)	Routine immunizations (e.g., immunizations for influenza, HPV, hepatitis A and B)	
The Bright Futures Project of the Health Resources and Services Administration (HRSA) and the American Academy of Pediatrics	Routine screening and preventive services for infants, children, and adolescents (e.g., well-child visits, lead exposure screening)	
The Women's Preventive Services Initiative (WPSI) of HRSA and the American College of Obstetricians and Gynecologists	Preventive services for women not addressed by other recommending organizations (e.g., contraception, breastfeeding services)	Plan years beginning on or after August 1, 2012

i Enrollment in grandfathered plans has steadily declined nationally since the passage of the ACA. While more than half of U.S. workers with employer-sponsored health coverage were in grandfathered plans in 2011, only 13% were in such plans as of 2019. See Kaiser Family Foundation. 2019 Employer Health Benefits Survey. September 25, 2019. https://www.kff.org/report-section/ehbs-2019-section-13-grandfathered-health-plans/

ii The ACA preventive care mandate permits religious exemptions for several types of employers. Religious organizations (e.g., churches) may opt out of providing coverage for contraception, and if they do opt out, their employees may pay cost sharing for contraception. Likewise, religiously-affiliated nonprofits (e.g., universities, hospitals) and closely held for-profit organizations may opt out of providing full coverage for contraception, and if they do, their employees' health plans must make separate payments for employees' contraceptive coverage, which should then be covered without cost sharing if in-network. See https://www.healthcare.gov/coverage/birth-control-benefits/ and https://journalofethics.ama-assn.org/article/religious-exemptions-insurance-coverage-and-patient-clinician-relationship/2014-11

At the same time, in practice under the ACA preventive care mandate, patients may pay out-of-pocket costs for preventive care in ways that are allowable and consistent with the mandate and in ways that may be inconsistent with the mandate as the result of complicated dynamics. As of 2018, approximately one-fifth to one-third of Americans with employer-sponsored insurance were charged cost sharing for preventive services, with patients most likely to pay for preventive visits, contraception, and preventive screenings.[21] An estimate from 2017-2020 found that 40.3% of all preventive care visits in the U.S. continued to incur out-of-pocket costs, at a median cost of $113, and with Asian and non-Hispanic Black patients who paid cost sharing paying 5.3% and 22.6% more than non-Hispanic White patients, respectively.[22]

There are several scenarios in which the ACA permits patient cost sharing for preventive care. These include situations when a problem-based visit and a preventive service provided at that visit are billed separately (cost sharing may be applied to the former but not the latter) or when a service is provided by an out-of-network clinician when an in-network clinician is available; cost sharing may also be properly applied to a treatment that results from a preventive service, and to the provision of branded medication when there is a generic equivalent and no demonstrated medical need for the branded version.[7,23] As a result of ongoing challenges with implementing the preventive care mandate, the federal government has regularly issued guidance, clarifications, and responses to frequently asked questions about the mandate since 2010.[24]

Even in cases where cost sharing is permitted under the ACA, being charged for preventive services could lead to patient confusion given the expectation of full coverage, especially during a primary care visit, and have a chilling effect on seeking timely preventive care. This latter effect is borne out in the research literature: patients enrolled in high deductible health plans were found to increase their use of preventive services less than those enrolled in other types of plans after the implementation of the ACA, indicating that patients who expect to pay for preventive care are less likely to use it.[25] The chilling effect of cost sharing may also have inequitable impacts. When patients with lower incomes incur cost sharing for preventive care, they have been found to pay more than those with higher incomes, making preventive care cost sharing an especially strong deterrent to care use among patients with lower incomes, who can least afford an unexpected medical bill.[22]

Preventive care cost sharing in the Commonwealth

Similar to national findings, the ACA preventive care mandate has reduced patient cost sharing in Massachusetts. For example, the implementation of the ACA was associated with a continuous decrease in cost sharing for preventive cancer screenings in the Commonwealth.[26] However, similar to national trends, cost sharing for preventive services in Massachusetts persists: as of 2018, the latest year for which the HPC could identify published literature, approximately 10% of all Massachusetts residents with employer-sponsored insurance paid out-of-pocket costs for some preventive care.[21]

THE FUTURE OF THE ACA PREVENTIVE CARE MANDATE: LEGAL CHALLENGES

There have been thousands of legal challenges posed to the ACA as a whole since its passage, and to the preventive care mandate specifically – especially the aspects to which employers may claim religious objections, such as the requirement to provide coverage for contraceptives.[27,28,29,30,31] In June, 2025, the United States Supreme Court decision in Braidwood Management v. Kennedy affirmed the constitutionality of the manner in which the members of the USPSTF are appointed (i.e., by the Secretary of Health and Human Services) and thus the legality of their recommendations.[32] At the same time, appointed members of the USPSTF and such recommendations are subject to change.[33,34,35]

In Massachusetts, Chapter 28 of the Acts of 2023 requires fully-+insured commercial plans and plans offered to public employees to cover "federally-defined preventive care" with no cost sharing.[36] Specifically, this law requires coverage without cost sharing of all preventive services that were not subject to cost sharing as recommended by the expert bodies in **Exhibit 4.1** on or before July 1, 2023, as well as the preventive services these bodies currently recommend. The Massachusetts legislation relies on the decisions of the expert bodies in **Exhibit 4.1** for coverage of new or evolving preventive care. However, this law acts as a backstop requirement of coverage for preventive services, as recommended on or before July 1, 2023, with no cost sharing in Massachusetts should the recommendations made by the expert bodies in **Exhibit 4.1** be curtailed by the federal administration. The Massachusetts Division of Insurance (DOI) is required to issue guidance for and ensure compliance with Chapter 28 of the Acts of 2023, and in the event of changes at the federal level, DOI could clarify the Commonwealth's mandate for payers.

METHODS

This analysis explores cost sharing for a set of ACA-covered preventive services among Massachusetts residents with commercial insurance. The HPC used the Massachusetts All-Payer Claims Database v2023 (MA APCD) from 2019-2023, including medical and pharmacy claims from seven large commercial payers in Massachusetts: Elevance (formerly Anthem), Blue Cross Blue Shield of Massachusetts (BCBSMA), Health New England (HNE), Harvard Pilgrim Health Care (HPHC), Mass General Brigham Health Plan (MGBHP), Tufts Health Plan (Tufts), and United Healthcare (United). The preventive services explored in this chapter are examples of those covered under the ACA as USPSTF services with an "A" or "B" rating or those recommended by WPSI, as well as preventive visits for children as recommended by the Bright Futures project, and that are highlighted in the research literature as being likely to have cost sharing: colonoscopy, diabetes screening, STI screening, contraception (including oral contraceptive prescriptions and contraception service encounters), pre-exposure prophylaxis for HIV prevention (PrEP), and preventive visits.

For each service, the HPC developed methodologies as conservatively as possible to identify claims for analysis: including only individuals eligible to receive each service without cost sharing according to ACA policy, and only services provided for prevention (i.e., excluding services provided for diagnosis or chronic condition surveillance). Methodologies are included with discussion of the specific services.

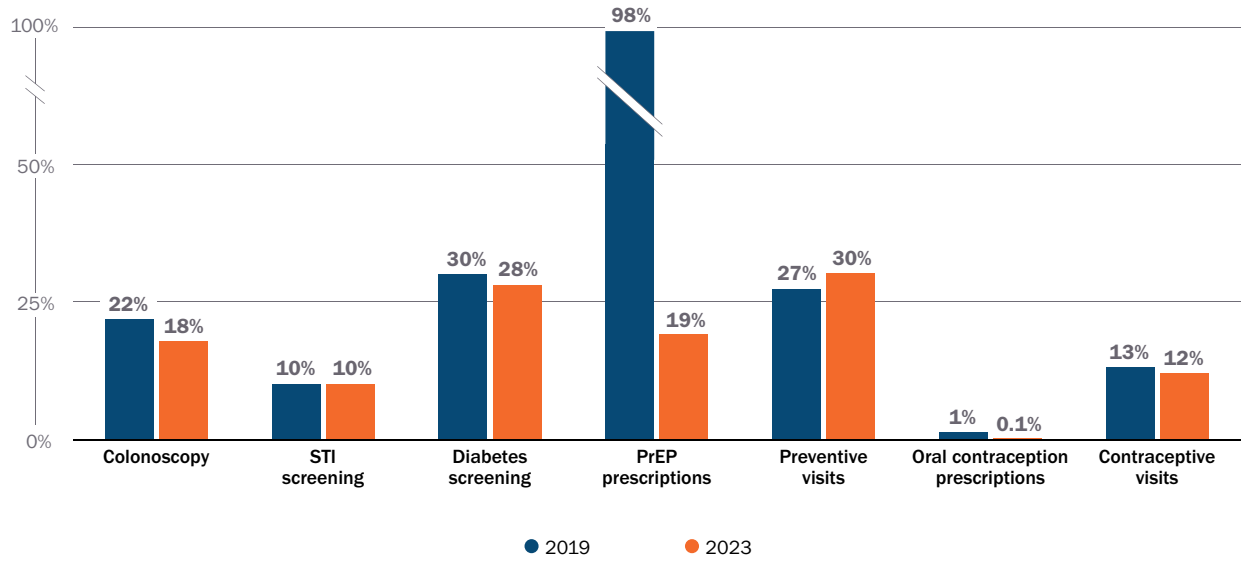
Coverage for preventive visits is distinct from coverage for other services: when patients have preventive visits (also called "check-ups," "well visits," or "physicals"), the ACA requires coverage for the preventive visit code and any covered preventive services that occur during the checkup, but permits cost sharing for any non-covered services that may occur during the visit. As a result, the policy implications of any cost sharing for preventive services will vary by service. For most services, instances of cost sharing may suggest issues with implementing ACA policy or a potential lack of compliance with ACA policy. However, for preventive visits, instances of cost sharing may suggest that what is permitted under ACA policy could cause confusion and other challenges for patients.

FINDINGS

Overview

The prevalence of cost sharing varied by service (**Exhibit 4.2**). With the notable exception of PrEP prescriptions, the rate of cost sharing for each service has been fairly steady in recent years.

Exhibit 4.2. Share of preventive services with cost sharing, 2019 and 2023



Notes: See Technical Appendix for methodology.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019 and 2023.

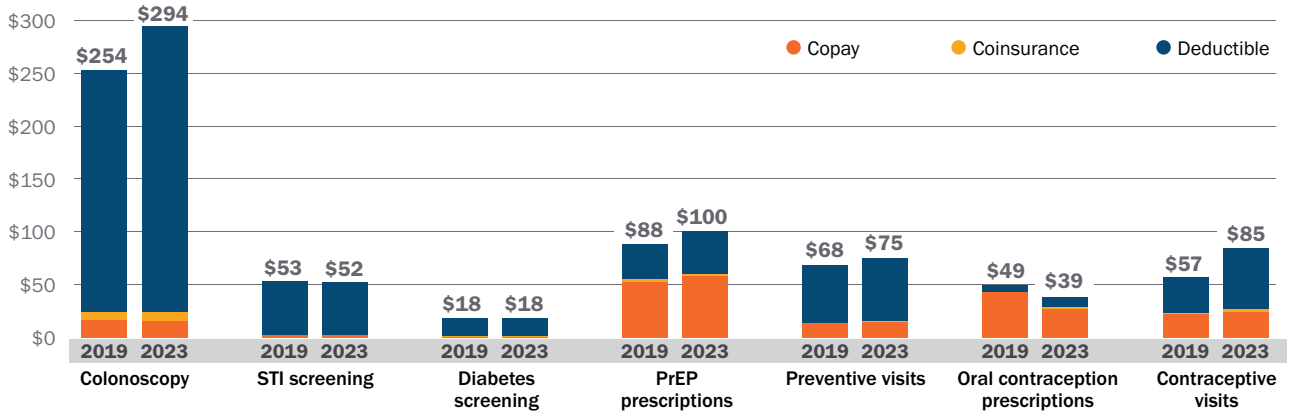
Among services and medications with cost sharing, average cost sharing amounts ranged from about $18 for diabetes screening to nearly $300 for colonoscopy, with cost sharing amounts paid increasing over time for most services (**Exhibit 4.3**). For medications, cost sharing was mostly in the form of copays; for other services, most cost sharing was through deductibles.

Across all services, there is substantial variation in the prevalence of cost sharing by payer (**Exhibit 4.4**). For example, 2% of diabetes screenings covered by MGBHP had cost sharing, compared to 48% of those covered by Tufts.

Colonoscopy

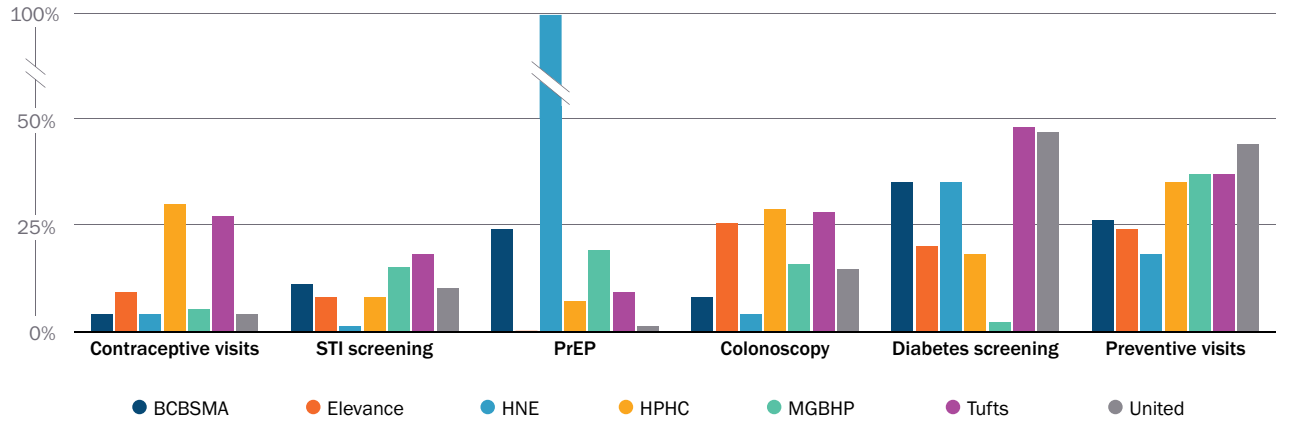
Colorectal cancer is a leading cause of death in the U.S.: cancer is second only to cardiovascular disease as a cause of death in the U.S., and colon and rectal cancers together account for the second-largest share of U.S. cancer deaths.[37] Several screening methods are covered preventive services under the ACA, as recommended by the USPSTF. Among these are colonoscopy, in which a physician visually inspects the colon and lower gastrointestinal tract for polyps, lesions, and other signs of cancer.[iii]

Exhibit 4.3. Average cost sharing amounts per service among services with any cost sharing, 2019 and 2023



Notes: See Technical Appendix for methodology.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019 and 2023.

Exhibit 4.4. Share of preventive services with cost sharing by payer, 2023



Notes: Elevance excluded from PrEP results due to lack of pharmacy claims. Elevance Health was formerly Anthem. Oral contraceptive prescriptions excluded due to <1% of all prescriptions having cost sharing in 2023. See Technical Appendix for methodology and a table with values.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

iii In addition to colonoscopy and other direct visualization methods, stool-based screening methods are also recommended by the USPSTF. Stool-based methods, such as gFOBT, FIT, and sDNA-FIT, test for the presence of blood, antibodies, and other biomarkers. Clinical guidelines recommend that positive results from a stool-based screening should be followed by a colonoscopy for confirmation. Among the commercially-insured Massachusetts population in 2022, stool-based methods represented 41% of colorectal cancer screenings. See the Health Policy Commission 2024 Cost Trends Report (October 2024) for more information. In 2023, the HPC found that, for example, 2.5% of screening encounters with FIT had cost sharing; of these, cost sharing amounts averaged $39.

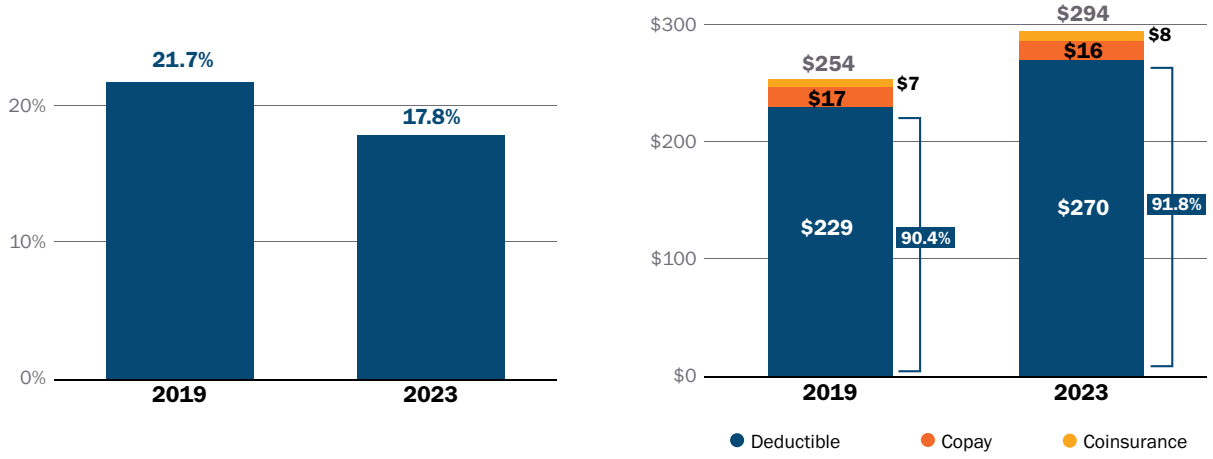
The USPSTF has recommended colonoscopy for colorectal cancer screening for persons ages 50-75 with an "A" rating since 2008, and in 2021 expanded its recommendation to persons ages 45-49 with a "B" rating.[38,39,40] As recommended, patients with no symptoms and an average level of risk (for example, no personal or family history of colorectal cancer) should receive a colonoscopy every 10 years. In addition to the procedure itself, a colonoscopy encounter can also include anesthesia services, medical and surgical supplies, lab tests, pathology services, prescription drugs, and other services. As a result, for a routine screening colonoscopy, claims may come for numerous services provided by multiple types of clinicians, including the gastroenterologist who performs the colonoscopy, the anesthesiologist, the facility where the colonoscopy is performed, or the pathology lab if a polyp was discovered or a biopsy was conducted.

Even though colonoscopy is a long-established ACA preventive service, the Centers for Medicare & Medicaid Services (CMS) has released additional guidance around cost sharing for colorectal cancer screenings every two to three years since the passage of the ACA, suggesting an ongoing lack of clarity about how the various services involved in a screening colonoscopy should be covered. Much of the guidance has involved clarifying that services "integral" to performing the colonoscopy should be covered without cost sharing.[41,42] The 2022 guidance further detailed that such integral services include pre-procedure specialist consultation, bowel preparation medications, anesthesia, polyp removal during the colonoscopy, and pathology exams on polyps removed during the colonoscopy.[43]

The HPC explored cost sharing for screening colonoscopies provided in an office, hospital outpatient department (HOPD), or ambulatory surgical center (ASC). The HPC grouped colonoscopy with other types of direct visualization (sigmoidoscopy, CT colonography). To distinguish colonoscopies used for preventive screening (as opposed to colonoscopies used for diagnosis), the HPC applied a conservative approach, excluding patients with personal or family history of colorectal cancer or those with certain chronic conditions[44] and only including colonoscopies billed with a procedure code, diagnosis code, or procedure modifiers indicating the provision of an ACA-covered preventive service.

The share of preventive colonoscopy encounters with cost sharing fell between 2019 and 2023, from about 22% to about 18% (**Exhibit 4.5**). For those patients with any cost sharing in 2023, average cost sharing was approximately $300. Nearly all (92%) cost sharing was paid under the deductible.

Exhibit 4.5. Preventive colonoscopy encounters with any cost sharing and average cost sharing amounts for colonoscopies with cost sharing, 2019 and 2023

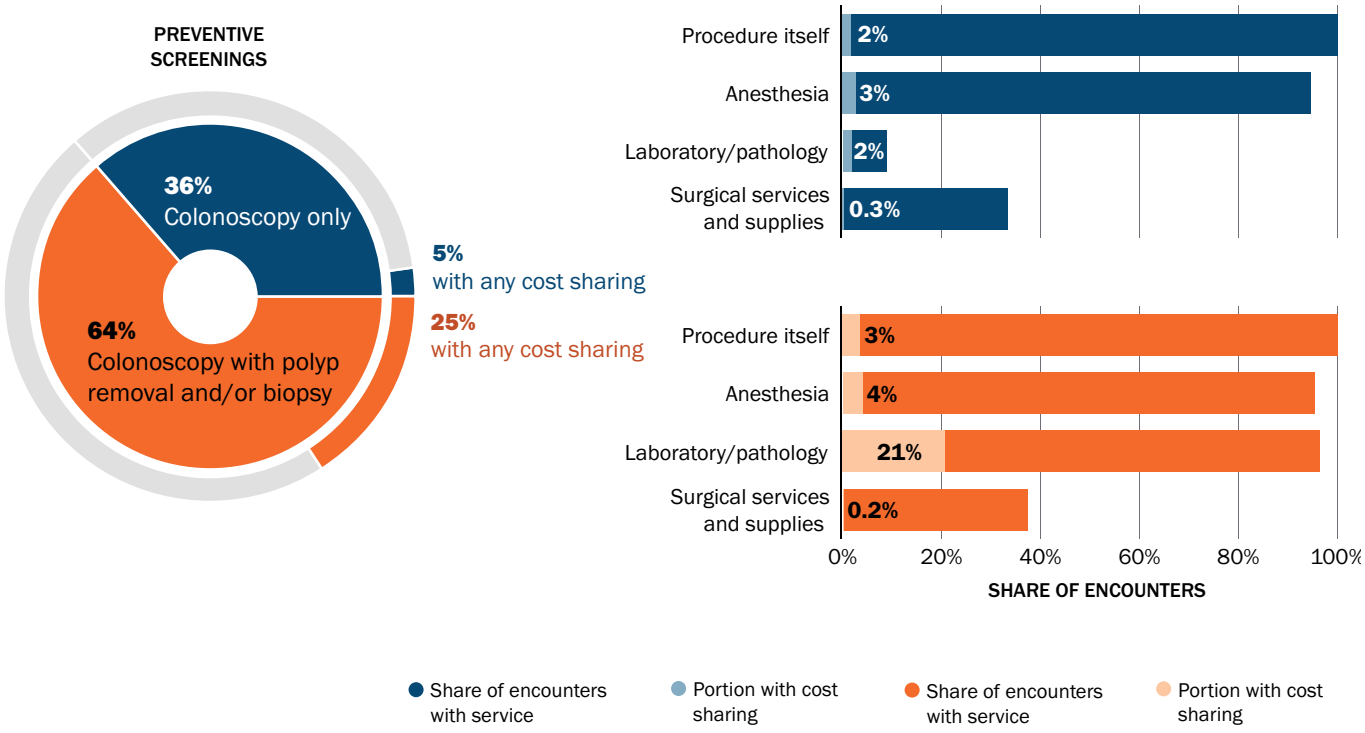


Notes: Based on encounters for services provided on the same day. Includes members of average risk, aged 45 to 65, with full-year coverage. Preventive screenings were identified using CPT procedure codes for colonoscopy, procedure modifier 33 (ACA-compliant preventive procedure), PT (screening procedure converted to diagnostic), or certain ICD-10 diagnosis or CPT G- and Z-codes indicating a screening for colorectal cancer. Colonoscopy includes other types of direct visualization (Sigmoidoscopy, CT colonography). Screenings provided in inpatient, emergency department, or urgent care settings were excluded. Extreme outliers for total encounter spending were trimmed. Figures may reflect rounding and may not add up to the overall annual average.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019 and 2023.

During a screening colonoscopy, the provider may discover and remove a polyp. While CMS guidance has clarified that this occurrence should still be considered a preventive service without cost sharing, the HPC found that this type of encounter is associated with a substantially higher likelihood of cost sharing compared to a screening colonoscopy that did not result in polyp removal. Encounters for colonoscopy without lesion or polyp removal (colonoscopy only) represented about 36% of screening colonoscopy encounters, 5% of which had cost sharing. Encounters for colonoscopy with lesion or polyp removal (sometimes also including biopsy) represented about 64% of screening colonoscopies, 25% of which had cost sharing (**Exhibit 4.6**). Despite regular clarification of the details of coverage for screening colonoscopy, the HPC found that cost sharing is often applied to services during both types of colonoscopies that are listed in CMS guidance as "integral" to the screening encounter. The most common source of colonoscopy cost sharing is lab/pathology services. Most colonoscopy encounters with lesion or polyp removal include lab/pathology services, and of these, about 21% had cost sharing for those lab/pathology services.

Exhibit 4.6. Source of cost sharing for preventive colonoscopy encounters, 2023



Notes: Based on encounters for services provided on the same day. Includes members of average risk, aged 45 to 65, with full-year coverage. Preventive screenings were identified using CPT procedure codes for colonoscopy, procedure modifier 33 (ACA-compliant preventive procedure), PT (screening procedure converted to diagnostic), or certain ICD-10 diagnosis or CPT G- and Z-codes indicating a screening for colorectal cancer. Colonoscopy includes other types of direct visualization (Sigmoidoscopy, CT colonography). Screenings provided in inpatient, emergency department, or urgent care settings were excluded.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

There was substantial variation in the prevalence of cost sharing for colonoscopy by commercial payer, ranging from 4% of encounters covered by HNE to about 29% of encounters covered by HPHC in 2023 (**Exhibit 4.7**). Among encounters with cost sharing, the average cost sharing amounts also varied, ranging from $189 (Elevance) to $383 (BCBSMA).

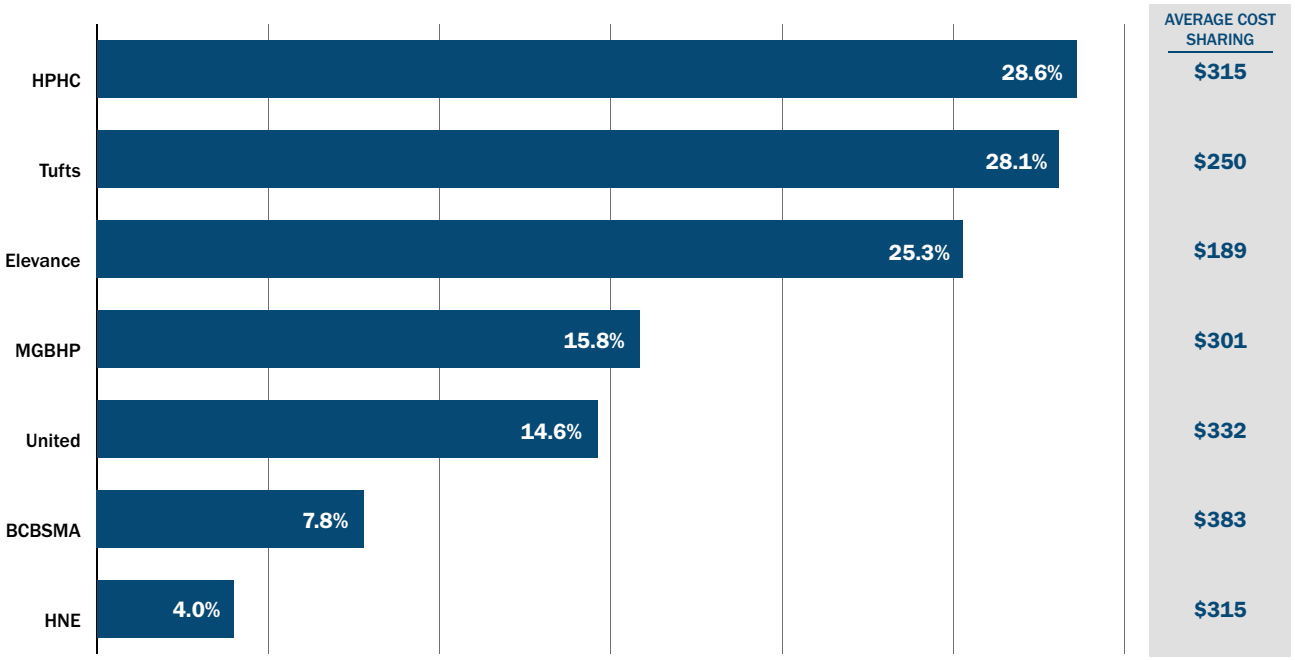
The prevalence of cost sharing for colonoscopy also varied by site of care. Seventy-two percent of screening colonoscopies took place in HOPDs, 23% at ASCs and 4% at offices, and there were notably different rates of cost sharing at each site of care: 19% of colonoscopies performed in HOPDs had cost sharing, compared to 13% in ASCs, and 32% in offices. Despite greater prevalence of cost sharing, patients who received care at offices paid the lowest cost sharing amounts, paying an average of $260, compared to $294 at HOPDs and $313 at ASCs.

Diabetes screening

Diabetes is associated with an increased risk of cardiovascular disease, liver disease, and kidney failure, but these risks can be reduced through early intervention. To facilitate timely detection and treatment, the USPSTF recommends screening for prediabetes and Type 2 diabetes in adults ages 35 to 70 with a diagnosis of overweight or obesity. The most recent update, in 2021, expanded the eligible population to include individuals ages 35-39 (from a previous recommendation that covered individuals ages 40-70), and was effective for plan dates starting on or after August 24, 2022.[45]

The HPC explored cost sharing for diabetes screenings, defining "USPSTF-eligible" screenings as those performed for adults ages 40-64 for 2019-2022 and for adults ages 35-64 in 2023 with a diagnosis of overweight or obesity who were not pregnant and did not have an existing diabetes diagnosis.

Exhibit 4.7. Prevalence of cost sharing for colonoscopy by payer, 2023



Notes: Based on encounters for services provided on the same day. Includes members of average risk, aged 45 to 65, with full-year coverage. Preventive screenings were identified using procedure modifier 33 (ACA-compliant preventive procedure), PT (screening procedure converted to diagnostic), or certain CPT G- and Z-codes indicating a screening for colorectal cancer. Colonoscopy includes other types of direct visualization (Sigmoidoscopy, CT colonography). Screenings provided in inpatient, emergency department, or urgent care settings were excluded. Extreme outliers for total encounter spending were trimmed. Elevance Health was formerly Anthem.

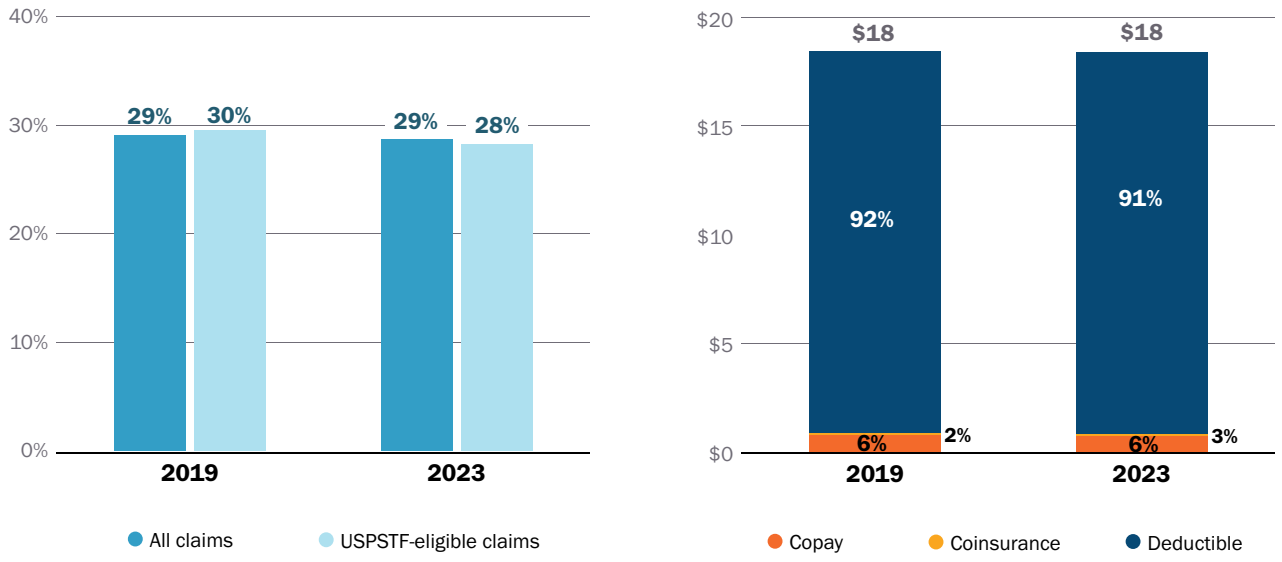
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

In both 2019 and 2023, approximately 30% of USPSTF-eligible diabetes screening claims had cost sharing, as did about 30% of all claims for diabetes screening regardless of whether they included diagnoses of overweight or obesity, suggesting that how claims should be coded to ensure coverage without cost sharing may be unclear (**Exhibit 4.8**). The HPC also performed a more conservative analysis that explored diabetes screenings only for those age 40 and older and with a diagnosis code specifying that the screening was not diagnostic and found that about 20% of claims still had cost sharing.

Patients with cost sharing for diabetes screenings paid $18 on average in 2023, nearly always under a deductible. However, the prevalence of cost sharing and average cost sharing amounts varied by payer. Diabetes screenings covered by MGBHP were least likely to have cost sharing, but MGBHP patients with cost sharing paid the most: 2% of MGBHP-covered diabetes screenings had cost sharing, at an average cost of about $25. In contrast, 48% of Tufts claims and 47% of United claims for diabetes screening had cost sharing, with Tufts patients paying an average of $22 and United patients paying an average of $14.

USPSTF-eligible screenings performed in an office setting were more likely to incur cost sharing than those that occurred in a HOPD (37% vs. 24% in 2023). This trend was generally present across payers. In addition, USPSTF-eligible screenings that occurred on the same day as a preventive visit were less likely to incur cost sharing than those that occurred on the same day as a problem-based visit (23% vs 31% of visits in 2023) (see later section on preventive visits for more information).

Exhibit 4.8. Share of claims for diabetes screening with cost sharing by USPSTF status and average cost sharing amount for USPSTF-eligible diabetes screenings, among claims with any cost sharing, 2019 and 2023



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019 and 2023.

STI screening

The USPSTF recommends six STI screenings for which plans should not impose cost sharing. The population recommended for preventive STI screening varies for each STI; further, some of the criteria are somewhat subjective (e.g. "increased risk") and difficult to ascertain in claims data without knowing each payer's coding requirements. Thus, the HPC used a conservative approach to identify claims with a high likelihood of being preventive (**Exhibit 4.9**). For example, the USPSTF recommends that HIV screening be provided without cost sharing to individuals between ages 15-65, anyone older than 65 or younger than 15 at increased risk, and any pregnant persons; due to the limitations of commercial claims data, the HPC defined the population eligible for preventive HIV screening as all adults. Similarly, the USPSTF recommends that pregnant persons and individuals at increased risk receive syphilis screening with zero cost sharing; the HPC defined the population eligible for preventive syphilis screening as pregnant persons. Furthermore, to ensure that only preventive screenings (as opposed to diagnostic screenings) were included for analysis, the HPC excluded screenings associated with common symptoms of STI infection, such as rash, pelvic and perineal pain, and enlarged lymph nodes (see exhibit notes for complete list).

Exhibit 4.9. Summary of recommended STI screenings, covered populations, and populations studied

	Chlamydia and Gonorrhea	Hepatitis B	Hepatitis C	HIV	Syphilis
Recommendation Effective Date	September 22, 2014	February 15, 2004 (Pregnancy) June 18, 2014 (All Others)	March 2, 2020	June 11, 2019	July 15, 2004
Covered Population	• Women under 25 • Women over 25, including pregnant persons at increased risk	• Adults and adolescents at increased risk of infection • Pregnant persons, at first prenatal visit	• Adults between the ages of 18 and 79	• Pregnant persons • Individuals between 15 and 65 • Younger adolescents and older adults at increased risk	• Pregnant persons • Individuals at increased risk
Operationalized for Analysis	All adult women (ages 18-64)	Pregnant adults (ages 18-64); pregnancy defined as diagnosis code for pregnancy present on encounter	All adults (ages 18-64)	All adults (ages 18-64)	Pregnant adults (ages 18-64); pregnancy defined as diagnosis code for pregnancy present on encounter
	Does not have diagnosis code for common STI symptoms associated with encounter (same person/day): diseases of male genital organs (N40 – N53), inflammatory diseases of female pelvic organs (N70 – N77), noninflammatory disorders of female genital tract (N80 – N89), pelvic and perineal pain (R10.2), paresthesia of skin (burning, itching, prickling) (R20.2), other disturbances of skin sensation (R20.8), rash and other nonspecific skin eruption (R21), symptoms and signs involving the genitourinary system (R30 – R39), enlarged lymph nodes (R59)				

For all types of STI screenings taken together, 10% of USPSTF-eligible screenings had cost sharing in 2023, approximately the same share as in 2019. For screenings with cost sharing, patients paid an average of $52 per test in 2023 (**Exhibit 4.10**). Deductible spending was the most common form of cost sharing: 87% of screenings with cost sharing had deductible spending.

The rate of cost sharing varied substantially by test type. Only 1% of hepatitis B screening claims had cost sharing in 2023, compared to 15% and 17% of claims for HIV and syphilis screening, respectively (**Exhibit 4.11**).

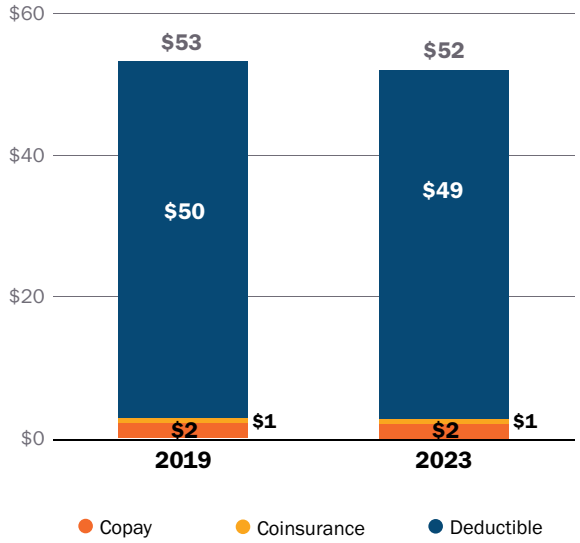
The prevalence of cost sharing also varied by payer. Individuals covered by HNE rarely had cost sharing (1% of USPSTF-eligible claims in 2023), while individuals covered by Tufts or MGBHP were more likely to have cost sharing (18% and 15% in 2023, respectively) (**Exhibit 4.12**). While the distribution of test types was similar across payers, payers varied in the rate of cost sharing by test type. For example, HPHC, MGBHP, and Tufts each imposed cost sharing on over 35% of syphilis screenings, while BCBSMA, HNE, United, and Elevance imposed cost sharing on fewer than 5% of syphilis screenings (see technical appendix for additional data). In addition, patients had different rates of cost sharing depending on the type of visit during which the screening occurred, with 15% of screenings at problem-based visits incurring cost sharing, compared to 7% of screenings that took place at preventive visits.

Contraception

The ACA preventive care mandate requires commercial insurers to cover without cost sharing at least one form of contraception in each FDA-approved category as well as related services.[23,46,47] Coverage for contraception under the ACA has been associated with a number of trends nationally, including markedly reduced cost sharing payments, increased adherence to contraception, increased use of highly cost-effective methods, a decrease in unintended pregnancies, and narrowing income disparities in unintended pregnancy rates.[15,17,48] Prior HPC research among residents of the Commonwealth found that from 2011 to 2014, the share of oral contraceptive prescriptions with patient cost sharing dropped from 98% to 7%; by 2020, that share had fallen to 2%.[49,50]

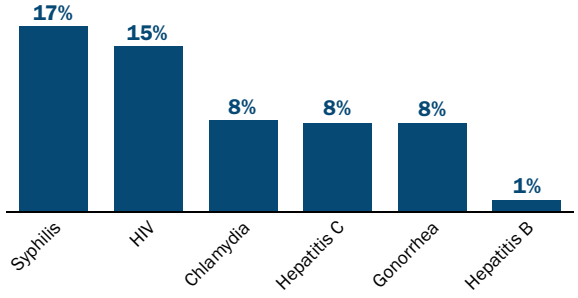
HRSA has frequently updated guidance on the contraceptive coverage mandate since 2010, including clarifying in 2021 that the mandate covers contraceptive counseling, initiation of contraceptive use, and follow-up care.[51,52] However, confusion has persisted among payers about application of the mandate, including which contraceptive methods must be covered to satisfy the requirement to cover at least one per FDA-approved category, or when plans are required to implement frequently updated guidance.[53,54] In Massachusetts in 2020, over 10% of patients paid cost sharing for

Exhibit 4.10. Average cost sharing amount per STI screening, among USPSTF-eligible STI screening claims with any cost sharing, 2019 and 2023



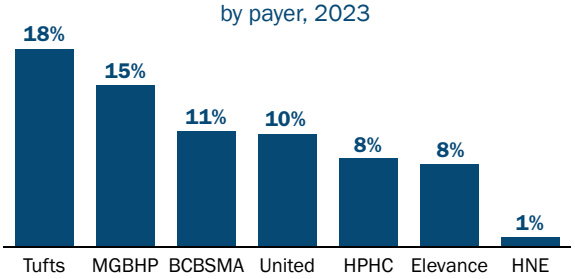
Source: HPC analysis of Massachusetts All-Payer Claims Database, v2023, 2019 and 2023.

Exhibit 4.11. Share of STI screening claims with cost sharing by test type, 2023



Source: HPC analysis of Massachusetts All-Payer Claims Database, V2023, 2023.

Exhibit 4.12. Share of STI screening claims with cost sharing by payer, 2023



Notes: Elevance Health was formerly Anthem.

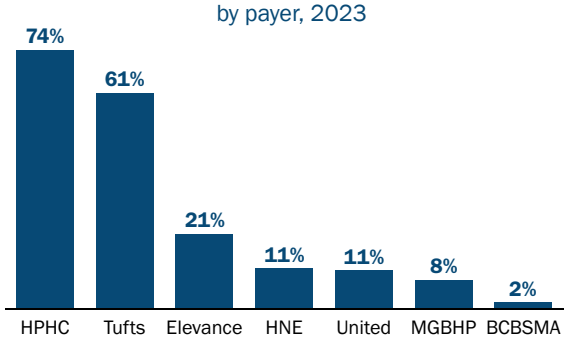
Source: HPC analysis of Massachusetts All-Payer Claims Database, V2023, 2023.

IUD services (including insertion, removal, and the IUD itself), subdermal contraceptive implant services, contraceptive counseling, and IUD follow-up services, and nearly one-third of IUD follow-up services had cost sharing.[50]

The HPC explored cost sharing for oral contraceptive prescriptions, as well as contraceptive encounters for IUD insertion and removal, subdermal contraceptive implant insertion and removal, contraceptive options counseling, and IUD follow-up care, which may include verifying that the IUD was placed correctly. For oral contraceptive prescriptions, the prevalence of cost sharing has gone from negligible to nearly nonexistent over time, falling from 1.2% of prescriptions in 2019 to 0.1% in 2023.[iv] The small share of patients who continue to pay cost sharing for oral contraceptive prescriptions pay $40-50 on average, mostly due to copays. For contraceptive service encounters, 12% of encounters for IUDs, subdermal contraceptive implants, counseling, or IUD follow-up services had cost sharing in 2023. Patients with cost sharing for contraceptive encounters have been paying more on average over time, with cost sharing amounts rising from $66 in 2019 to $95 in 2023, largely due to deductibles.

Cost sharing continues to be most likely for visits for IUD follow-up care. In 2023, about 30% of IUD follow-up visits incurred cost sharing, compared to 12% of visits for IUD insertion or removal, 8% of visits for implant insertion or removal, and 1% of counseling encounters. Coverage of IUD follow-up care also varied substantially by payer: 74% of IUD follow-up encounters covered by HPHC and 61% of those covered by Tufts had cost sharing in 2023, compared to 2% to 21% of encounters covered by other payers (**Exhibit 4.13**). In 2023, patients who paid cost sharing for IUD follow-up care paid $82 on average.

Exhibit 4.13. IUD follow-up encounters with cost sharing by payer, 2023



Note: IUD follow-up encounters identified using ICD-10 code Z30.431. Elevance Health was formerly Anthem.

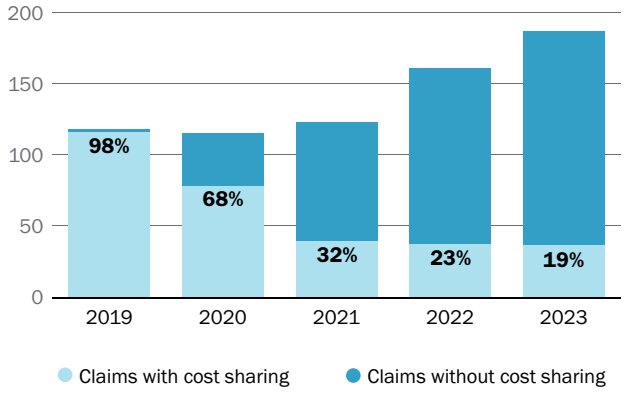
Source: HPC analysis of Massachusetts All-Payer Claims Database, V2023, 2023.

PrEP

PrEP is the use of antiretroviral medication to prevent HIV infection, and is highly effective at preventing HIV acquisition when taken daily.[55] As recommended by the USPSTF with an "A" rating starting in 2019, individuals at risk of HIV acquisition should be offered PrEP without cost sharing, with payers required to cover at least one form of PrEP without cost sharing as of plan years beginning on or after June 30, 2020.[56] There are two branded versions of oral PrEP,[v] Truvada and Descovy; a generic version of Truvada became available in 2020. In 2021, federal guidance clarified that plans were permitted to impose cost sharing on branded PrEP if a generic equivalent was available, and were also required to waive cost sharing for patients with a demonstrated medical need for the branded version.[57] The Massachusetts Division of Insurance (DOI) issued a bulletin stating that Massachusetts payers must be in compliance with the updated federal guidance no later than September 17, 2021.[58] Further federal guidance issued in 2024 clarified that cost sharing would not be permitted for Descovy beginning in plan years starting on or after August 31, 2024.[59] For this analysis, the HPC included claims for Truvada, Descovy, or emtricitabine/tenofovir disoproxil fumarate (generic Truvada) for individuals between the ages of 18-64, without a diagnosis code for HIV/AIDS and without claims for other antiretroviral medications associated with HIV treatment.

With the implementation of the USPSTF guidance and introduction of a generic product, the prevalence of cost sharing for PrEP dropped markedly between 2019 and 2023, from 98% of claims for a 30-day supply to 19% (**Exhibit 4.14**).

Exhibit 4.14. Total claims for any oral PrEP medication per 10,000 individuals, standardized to a 30-day supply, and share of claims with any form of cost sharing, 2019-2023



Source: HPC analysis of Massachusetts All-Payer Claims Database, V2023, 2019-2023.

iv This drop was almost entirely due to changes in one payer's coverage policy of one branded medication (lo loestrin fe).

v Apretude, an injectable PrEP drug, was also approved in late 2021; however, due to the small number of claims for this drug in 2022 and 2023, the HPC excluded this drug from the analysis.

By drug, 83% of prescriptions that had cost sharing in 2023 were for Descovy, the branded version of PrEP that does not have a generic equivalent (**Exhibit 4.15**). Rates of cost sharing for Descovy were similar to those for Truvada, with 78% of Descovy claims and 76% of Truvada claims having cost sharing; 4% of generic PrEP claims had cost sharing.[vi]

Cost sharing for PrEP varied widely by payer, ranging from 1% of United claims for PrEP, to 25% of BCBSMA claims, to 100% of HNE claims for PrEP.[vii] This payer variation seems related to, though not fully explained by, each payer's share of claims for generic and branded PrEP. For example, 93% of United PrEP claims were for the generic, compared to 76% of BCBSMA claims. However, 86% of HNE PrEP claims were for the generic (see technical appendix for data).

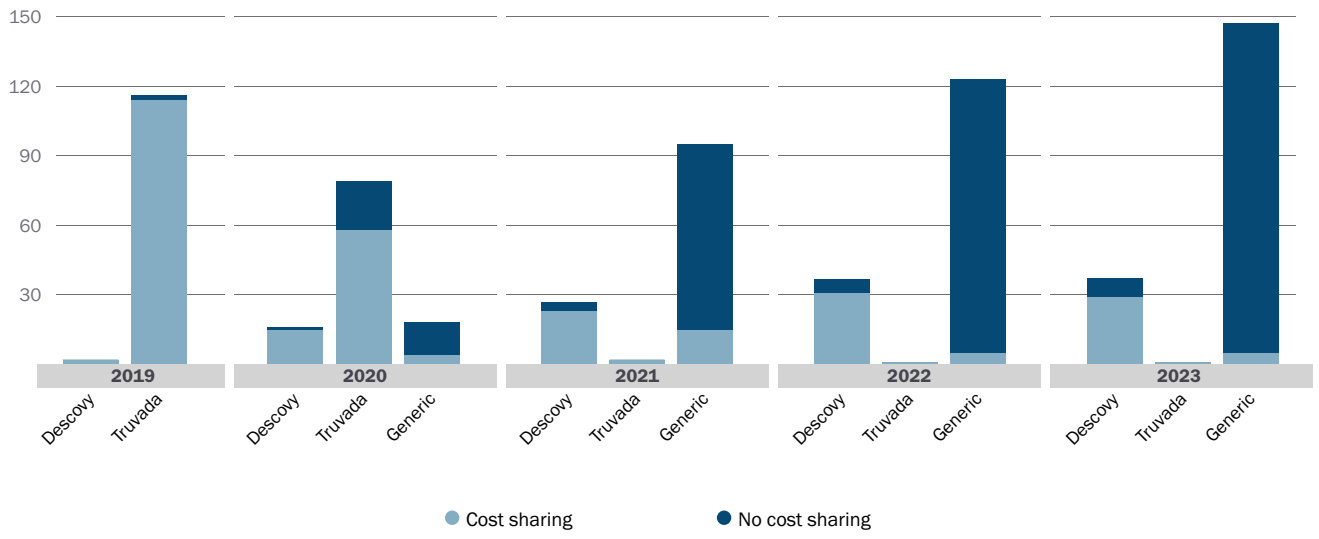
Cost sharing averaged $100 per month in 2023 for those with any cost sharing. This $100 reflects $58 in copay spending, about $2 in coinsurance spending, and about $41 in deductible spending. Almost all (96%) of claims with cost sharing had a copay, about 1% of claims had coinsurance, about 5% of claims with cost sharing had a deductible payment. While few patients had cost sharing for PrEP under their deductibles, cost sharing was very high for those who did (an average $748). Cost sharing for a 30-day supply in 2023 averaged $110 for Descovy, $129 for Truvada, and $30 for the generic.

Research suggests that patient cost sharing is associated with decreased medication adherence.[60] The HPC sought to estimate the association between cost sharing and adherence to PrEP, and found that patients with cost sharing had lower rates of adherence than those with no cost sharing (85% vs 94%, see technical appendix for details).

Preventive visits

Multiple ACA recommending institutions recommend coverage without cost sharing of preventive visits – also called "well visits," "physicals," or "checkups" – under the ACA. The Bright Futures project recommends annual preventive visits for children and adolescents from birth through age 21 (with more frequent visits recommended for children under age 3), while WPSI recommends annual well-woman visits beginning in adolescence and continuing

Exhibit 4.15. Total claims for PrEP per 10,000 individuals and share of claims with any form of cost sharing, by drug, normalized to 30-day supply, 2019-2023



Source: HPC analysis of Massachusetts All-Payer Claims Database, V2023, 2019-2023.

vi Gilead, the manufacturer of both Descovy and Truvada, offers a coupon in Massachusetts to cover patient cost sharing for Descovy, offsetting the cost sharing liability a patient may have. Prior to the market entry of generic Truvada, Gilead also offered a coupon in Massachusetts for Truvada. Massachusetts law prohibits manufacturers from offering coupons for a branded drug that has an AB rated generic equivalent. See https://www.gileadadvancingaccess.com/patient

vii The HPC performed a sensitivity analysis that removed criteria distinguishing PrEP as a preventive service versus for treatment (that is, removing exclusion criteria of diagnosis codes for HIV/AIDS or claims for other antiretroviral medications used to treat HIV). When expanding this analysis to all claims for Descovy, Truvada, or generic PrEP, 98% of claims for PrEP medications covered by HNE in 2023 had cost-sharing.

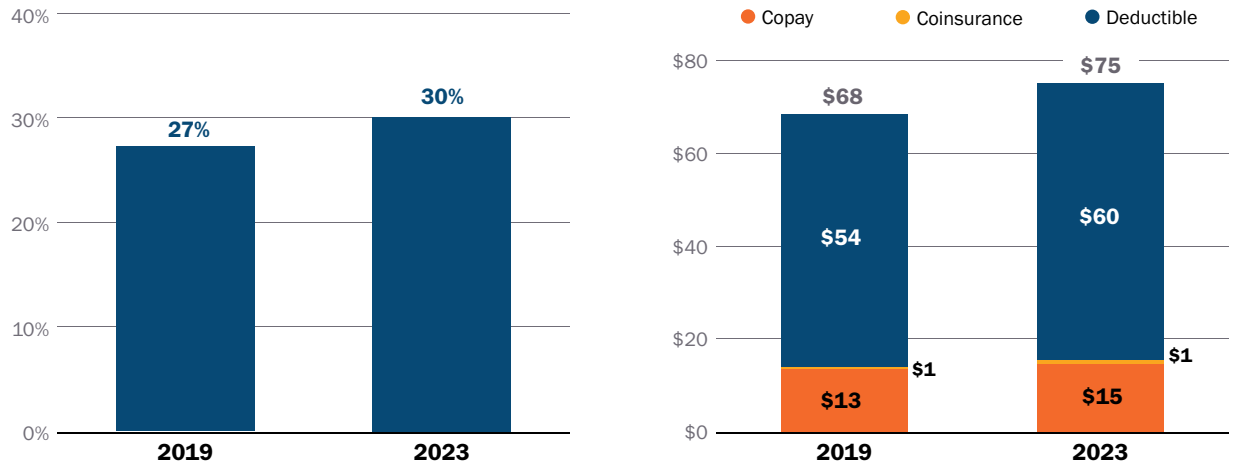
through adulthood.[10,61] There appears to be no explicit requirement under the ACA for preventive visit coverage for males over age 21.

The preventive visit can involve a wide variety of screening services, and often includes other preventive services such as vaccinations, tobacco cessation counseling, and certain lab tests for which the ACA mandates coverage, such as the diabetes screening tests discussed earlier. However, the ACA mandate to waive cost sharing for preventive visits does not extend to all services that may occur during the visit. A common area of services for which patients incur cost sharing during a preventive visit are lab tests that may be ordered to monitor a patient's health but which are not ACA preventive screenings, such as tests to monitor the effect of a medication. Another important area is evaluation and management (E&M) services for "problem-based care," in which the patient may bring up a concern about an issue outside of preventive screening, such as a concern about pain, a rash, or symptoms of a chronic condition. Guidance allows clinicians to bill separately for addressing such concerns, by billing a separate problem-based visit – for which standard patient cost sharing would apply – in addition to the preventive visit.[62,63] Provider groups in Massachusetts sometimes issue notices to patients that addressing problem-based concerns during a preventive visit episode can result in cost sharing.[64]

The HPC examined cost sharing associated with preventive visits, defining a "preventive visit episode" as all services that a patient incurred on the same day as a preventive visit. If a patient has cost sharing for a preventive visit episode, the cost sharing may be for the preventive visit itself, a problem-based visit billed on the same day, or other services such as lab tests that occurred on the same day as the preventive visit.

The HPC found that 30% of patients had cost sharing for a preventive visit episode in 2023, up from 27% in 2019. Patients with cost sharing in 2023 paid about $75 on average, mostly due to deductibles (**Exhibit 4.16**). Cost sharing was more common for adults than for children: 40% of preventive visit episodes for adults had cost sharing in 2023, compared to 17% of preventive visit episodes for children. Adult men tended to have higher rates of cost sharing for preventive visit episodes than adult women (39% versus 35%).

Exhibit 4.16. Share of preventive visit episodes with any cost sharing and average cost sharing amounts for preventive visit episodes with any cost sharing, 2019 and 2023



Notes: Includes commercial members ages 0-64 with full year medical coverage. Preventive visit episodes identified as same-person, same-day episodes of care provided in Massachusetts office, hospital outpatient department, ambulatory surgical center, retail clinic, or lab settings including Current Procedural Terminology (CPT) codes 99381-99387, 99391-99397, G0438-G0439, 99432, 99461, 99420, 99429. Preventive visit episodes with total allowed amounts lower than 20% of the median or higher than 10 times the median excluded from analyses of cost sharing amounts.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019 and 2023.

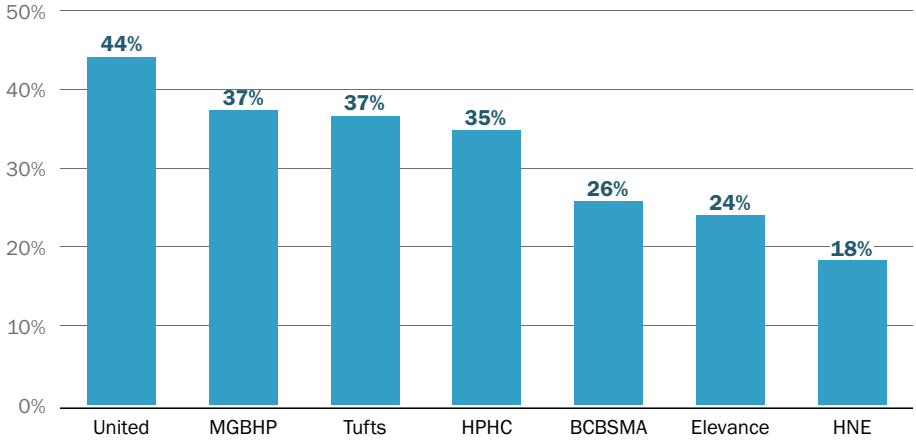
The prevalence of cost sharing for preventive visit episodes varied by payer, from about 18% of episodes covered by HNE to 44% of episodes covered by United in 2023 (**Exhibit 4.17**). When preventive visit episodes do have cost sharing, average cost sharing amounts also varied widely, ranging from $50 for HNE to $107 for MGBHP.

The HPC investigated sources of cost sharing during preventive visit episodes, including the presence of problem-based codes on the same day as preventive visits, and found that problem-based codes and labs were the most common sources of cost sharing for preventive visit episodes (**Exhibit 4.18**).

Preventive visit episodes where a problem-based visit is also billed have gradually become more common – though still a small share of preventive visit episodes overall – growing from 10% of preventive visit episodes in 2019 to 15% in 2023. When a preventive visit episode had a problem-based code, the episode nearly always had cost sharing: 87% of preventive episodes with a problem-based code had cost sharing in 2023. Additionally, patients with chronic conditions were about twice as likely as patients without chronic conditions to have a preventive visit episode that included a problem-based code, meaning that people with chronic conditions were consistently more likely to pay cost sharing for their checkups: 38% of preventive visit episodes for people with chronic conditions had cost sharing in 2023, compared to 26% for people without chronic conditions.[viii] Additionally, 49% of preventive visit episodes in 2023 included lab services, and nearly one-third of such episodes had cost sharing.

viii Chronic conditions studied include AIDS/HIV, asthma, arthritis, cancer, cardiovascular disease, diabetes, epilepsy, hypertension, mood disorder, multiple sclerosis, and psychosis.

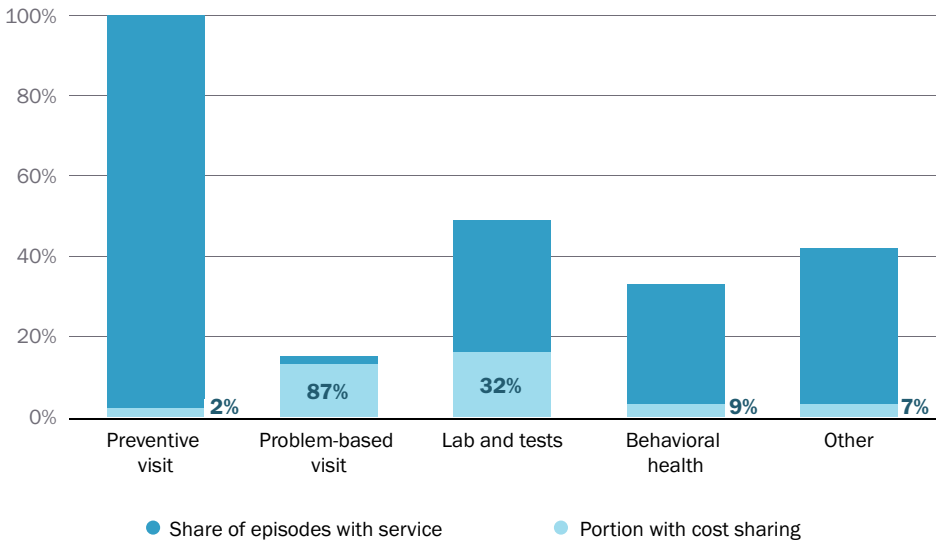
Exhibit 4.17. Share of preventive visit episodes with cost sharing by payer, 2023



Notes: Includes commercial members ages 0-64 with full year medical coverage. Includes care provided in Massachusetts office, hospital outpatient department, ambulatory surgical center, retail clinic, or lab settings including Current Procedural Terminology (CPT) codes 99381-99387, 99391-99397, G0438-G0439, 99432, 99461, 99420, 99429. Elevance Health was formerly Anthem.

Sources: HPC analysis of CHIA All-Payer Claims Database V2023, 2023.

Exhibit 4.18. Share of preventive visit episodes including codes for preventive visits, problem-based visits, lab services, behavioral health services, and other services, and share of each with cost sharing, 2023



Notes: Includes commercial members ages 0-64 with full year medical coverage. Includes care provided in Massachusetts office, hospital outpatient department, ambulatory surgical center, retail clinic, or lab settings including Current Procedural Terminology (CPT) codes 99381-99387, 99391-99397, G0438-G0439, 99432, 99461, 99420, 99429. Problem-based visits identified with CPT codes 99201-99215, 99241-99245. Berenson-Eggers Type of Service (BETOS) codes used to identify labs and tests and behavioral health services.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

Discussion

With the exception of oral contraceptive prescriptions, all preventive medications and services explored in this chapter had some instances of cost sharing. Some of the cost sharing observed in this chapter is clearly permitted under the ACA (e.g. cost sharing for problem-based services that occur during a preventive visit episode). Other examples appear to be inconsistent with the ACA preventive care mandate, including in cases where there is specific CMS guidance stating that they should be covered (e.g. cost sharing for IUD follow-up care or for pathology services for screening colonoscopy). The prevalence of cost sharing for most services has remained relatively stable over time, suggesting that some amount of cost sharing for preventive services is the current baseline in the Commonwealth.

There are several reasons why patients may have cost sharing that appears to be inconsistent with ACA mandates. One notable reason is variation in payer requirements: each payer determines how to operationalize the mandate in its own coverage, and different payers often have unique billing requirements for each service. According to a 2023 report from the National Association of Insurance Commissioners (NAIC), plan guidance on how providers should code preventive services is inconsistently available, often incomplete, and exists in varying amounts of detail for different services.[65] For instance, plan guidance may lack the specific codes providers should use to bill a service as preventive as opposed to diagnostic, or lack references to the current clinical guidelines that would inform payer policy and provider billing practices. Similarly, providers may also make coding mistakes that lead a service to be billed as diagnostic rather than preventive, or may fail to meet payer-specific coding criteria needed to designate a service as preventive. While some level of coding errors may be inevitable, variation in payer requirements for how to code preventive services increases the complexity of billing, which in turn increases the chances that providers will make coding errors that result in cost sharing for patients. This is especially likely because payer requirements for coding can vary significantly for the same preventive service.[ix] Payer variation and lack of clarity has resulted in patients being billed for services that should be covered with no cost.[21,65,66,67] Billing differently for the same service when covered by different payers also represents administrative burden for providers, who may subsequently face the further administrative burden of fielding questions and concerns from patients who have received unanticipated bills. Fully implementing the preventive care mandate requires payers and providers to be up to date on the latest federal guidance, for payers to clearly and consistently communicate their coding requirements to providers, and for providers to bill correctly for each service and for each payer, all of which represent ongoing potential for confusion, error, and the continued application of cost sharing.

Regardless of the cause, when patients do not anticipate paying cost sharing, receiving an unexpected bill can deter them from using future health services, including preventive care. Even minor amounts of cost sharing can send a message to patients to not trust that any preventive service will actually be free and may discourage patients – especially those with lower incomes – from seeking preventive care. Although permitted under the ACA, cost sharing for problem-based care received as part of regular preventive visits has the potential to be particularly harmful. Ideally patients would use their regular checkups to bring up any issues or concerns – to both have those concerns addressed in a timely way and ensure that their primary care providers have a full understanding of their health – but policy currently penalizes patients for doing so by charging them cost sharing. This not only undermines the goals of the preventive care mandate, but the patient-provider relationship in primary care.

Additionally, the findings in this chapter highlight that when patients face cost sharing for preventive care, the amount they owe can vary widely, suggesting opportunities for improvement in cost sharing benefit design. For the services the HPC examined, cost sharing tended to appear on types of services that are typically subject to a patient's deductible, rather than covered by copays. Lab tests in particular are a frequent source of cost sharing across the services explored in this chapter, including preventive screenings for diabetes and STIs and as part of colonoscopies and preventive visit episodes. Furthermore, patients may receive bills for multiple services that occur during a preventive care episode.

ix For example, two large Massachusetts payers offer different coding guidelines for colorectal cancer screening, both of which also differ from the recommendations of the American Medical Association's Private Payer Coding Guide. The preventive service billing guide for one large Massachusetts payer lists a set of Current Procedural Terminology (CPT) codes that may be billed and specifies that for the service to be covered as preventive, either CPT code modifier 33 or a different modifier plus one diagnosis code must be present. Another large Massachusetts payer lists a set of CPT codes that may be billed, along with over 100 diagnosis codes, any one of which must be present for the service to be billed as preventive – and notes that modifier 33 can be included but is not used to determine whether the service should be treated as preventive. The American Medical Association's 2020 Private Payer Coding Guide recommends a set of CPT codes to use for screening colonoscopy, along with modifier 33, and does not recommend using any diagnosis code as part of billing. See https://www.ama-assn.org/system/files/2020-09/private-payer-coding-guide.pdf

The previous chapter, **Opportunities for Improvement in Benefit Design**, explores deductibles in more detail, and also highlights innovations in benefit design in which patients have a single copayment for an episode of care. Simplifying cost sharing benefit design could help reduce billing errors and patients receiving bills for preventive services.

TARGETED RECOMMENDATIONS RELATED TO COST SHARING

More than a decade after the passage of the ACA, payment for preventive services is complex for providers and confusing for patients, who often continue to pay cost sharing for services that should be fully covered. Addressing this challenge will help reduce administrative complexity for providers and increase transparency, predictability, and affordability for patients.

The Commonwealth should work to reduce or eliminate complexity in how preventive services are covered. Stakeholders – including payers, providers, and government agencies – may need to develop new approaches to simplification and oversight to ensure preventive services are covered as intended and to facilitate patient use of this high-value care. The DOI should continue to provide clear guidance for coverage of preventive services and require uniform standards across Massachusetts plans to ensure compliance with the ACA and Massachusetts state law.

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CHAPTER 5:

2025 HEALTH CARE COST TRENDS REPORT POLICY RECOMMENDATIONS

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Massachusetts has a long history of coming together and becoming a model for the country in key moments of crisis in health care. From Massachusetts' expansion of insurance coverage in 2006 (Chapter 58), to the establishment of the nation's first health care cost growth benchmark in 2012 (Chapter 224), policymakers and key stakeholders have worked together to advance nation-leading policy solutions to systemic health care challenges. More recently, this cooperative spirit enabled the coordinated response required during the COVID-19 pandemic, the swift action needed to prevent dire outcomes following the bankruptcy and dissolution of Steward Health Care, and the will to enact recent legislation to better protect the system from future bad actors and plan for a system that put patients first. For the past twenty years, the Commonwealth has repeatedly met crises in health care with collaboration, compromise, and decisive policy action.

The Commonwealth now confronts another pivotal moment in health care. Ongoing and unsustainable increases in health care costs coupled with recent federal actions both threaten the stability of the health care system and endanger two of the state's core health policy goals over the past several decades: **affordability and access**. These challenges urgently demand renewed collective action and, to the extent Massachusetts takes bold action to address these challenges, Massachusetts once again has the opportunity to lead the nation.

Today, Massachusetts residents and employers face some of the highest health care costs in the nation. In 2024, Massachusetts employer-based family premiums accelerated to the highest in the nation at $28,151. Increases to health care premiums have now outpaced growth in wages and inflation for many years, and such increases are accelerating rather than moderating. Approved average premium increases for the merged market (which includes small businesses and individuals buying health insurance on their own) for 2025 and 2026 are at the highest rates in recent years,7.9% and 11.5% respectively.

Furthermore, as documented in this report, consumer cost-sharing is growing even faster than premiums, primarily in higher deductibles. These high and rising premium and out-of-pocket costs are impacting increasing numbers of Massachusetts residents, resulting in many avoiding needed care, incurring medical debt, and/or putting off the purchase of other necessities.

In Massachusetts, residents enrolled in high-deductible health plans (HDHPs) were more likely to avoid needed care due to cost than those in conventional plans (31% to 19%, according to CHIA's 2023 Massachusetts Health Insurance Survey[i]), and affordability issues were disproportionally worse for low-income residents and residents of color enrolled in HDHPs. The same survey also identified that deductibles are increasingly the main cause of medical debt among Massachusetts residents.

In addition to rising premiums and out-of-pocket costs, without federal action to extend enhanced premium tax credits, over 300,000 Massachusetts residents purchasing coverage through the Health Connector could pay even more for their health insurance premiums, with some seeing premiums double or triple. Unless spending growth is contained, the ability of employers and residents to sustain commercial coverage – on or off the Connector — is in peril.

Exacerbating this strain, recent federal action will lead to the loss of public health insurance coverage for many Massachusetts residents, compounding the financial instability of high public payer hospitals and community health centers that disproportionately serve these patients. The adequacy of Massachusetts support for such providers from the Health Safety Net Fund will be tested if the underlying growth in health care costs is not moderated to a more sustainable rate in the years to come.

Unaddressed, these profound challenges to health care affordability and health care access in the Commonwealth will also exacerbate existing disparities in health outcomes, especially for low-income communities, people of color, LGBTQ+ individuals, and other populations in the Commonwealth, which will further increase spending. The Blue Cross Blue Shield of Massachusetts Foundation estimated that avoidable health care spending due to health inequities totals $1.5 billion each year, underscoring the imperative to confront these interrelated challenges.

i https://www.chiamass.gov/massachusetts-health-insurance-survey

THE HEALTH POLICY COMMISSION RECOMMENDS THAT:

In 2026, policymakers and health care leaders should recommit to the health care cost growth benchmark and convene to develop a consensus on a comprehensive set of reforms, consistent with the long-standing Massachusetts values of shared responsibility and shared sacrifice, for a greater public good. Massachusetts should once again be the national leader in reimagining our health care system from the status quo to one capable of delivering affordable, accessible, and equitable care for all residents.

The Health Policy Commission further recommends that any meaningful effort to improve health care affordability should address the following known drivers of health care costs, as documented by this and past Cost Trends Reports:

1. **ADMINISTRATIVE COMPLEXITY.** Within Massachusetts and nationally, there is significant administrative complexity in health care that adds costs without improving value or accessibility of care. The costs of such complexity are borne by payers and providers and, ultimately, passed on to employers and residents of the Commonwealth in the form of higher premiums and cost sharing and diverts time and resources that could otherwise be devoted to patient care and from other activities that improve health. Excessive complexity also drives provider consolidation and workforce burnout and presents a barrier to value-based clinical decisions. The Commonwealth should take action to dramatically reduce these costs by adopting policies that reduce, standardize, centralize, and/or automate common administrative tasks, prioritizing those that impede care for patients and burden primary care clinicians and support staff (e.g., prior authorization).

2. **HEALTH CARE PRICES.** Prices continue to be a primary driver of health care spending growth in Massachusetts and there is persistent, significant variation in prices between Massachusetts providers for the same sets of services without commensurate differences in quality. This dynamic continues to divert resources away from high-value providers in the community, many of which serve a higher proportion of patients with public coverage (who will be disproportionately impacted by future coverage disruptions), toward generally larger and more well-resourced systems that typically serve a higher proportion of patients with commercial coverage. Many states are implementing policy solutions that seek to limit excessive prices for services above a fair, reasonable threshold or to moderate price growth to a sustainable rate. The Commonwealth should consider these approaches and others to address excessive prices for which a competitive market have failed to meaningfully constrain prices and other policies such as reducing unwarranted price differences for routine health care services tied to the site of care.

3. **PHARMACEUTICAL SPENDING.** Net of rebates, pharmacy spending per enrollee grew an average of 8.6% per year from 2019 to 2023, contributing significantly to the state's overall health care cost growth rate. The uptake of blockbuster drugs (e.g., GLP-1s) and the introduction of new high-priced specialty drugs and gene therapies, among many other market developments, suggest these spending trends will continue. Recent legislative action established new tools for enhancing the transparency and oversight of pharmaceutical manufacturers and pharmacy benefit managers (PBMs), including through the HPC's new Office of Pharmaceutical Policy and Analysis (OPPA) and the Division of Insurance (DOI). These new authorities represent a critical first step in identifying policy opportunities that can deliver savings and recommending reforms that can improve pharmaceutical market functioning. In addition to considering policies implemented by other states, the Commonwealth should consider recommendations developed in the coming year by OPPA and DOI.

4. **LOW VALUE CARE AND AVOIDABLE UTILIZATION.** HPC research shows that Massachusetts residents receive a substantial and costly amount of care that is recognized by clinicians as not based on evidence and typically unnecessary for any patient (low value care), and that the provision of such care by provider organizations varies widely. This care not only adds to premiums and out-of-pocket spending, but it adds considerable time and health risk burdens to patients and absorbs health care resources from providers that could be devoted to care that is truly needed. The Commonwealth should encourage providers and payers to adopt strategies to reduce low value care and avoidable emergency department (ED) use, ED boarding, and readmissions, and shift lower acuity care to the most appropriate setting. Fundamental to the success of these efforts is to expand access to primary care and behavioral health care. Limited access to primary care can lead to potentially avoidable ED and inpatient hospital use and is associated higher spending and worse patient outcomes, especially for patients managing chronic conditions. The Commonwealth should take immediate action on the recommendations of the **Primary Care Access, Payment, and Delivery Task Force,** aimed at rebalancing

spending to prioritize primary care (including pediatric care), rebuilding the primary care workforce, unlocking innovative care delivery and payment models, and ensuring timely patient access to high-quality care. In addition to primary care, there should be continued support and investment in the broader Massachusetts health care workforce, which continues to experience disruption, with high turnover and shortages of care providers in many roles throughout the care continuum, especially in behavioral health care and long-term care. These workforce trends have resulted in patient access issues, interruptions to care continuity, bottlenecks in transitions, and discharge delays, all of which impede efforts to ensure patients receive the right care in the right place at the right time.

The HPC is committed to supporting these efforts with data insights and independent policy leadership.

THE WORK AHEAD FOR THE HPC

In 2026, the HPC will continue to develop its oversight and planning capabilities, as authorized in the two significant health care laws passed in January 2025 (Chapters 342 and 343 of the Acts of 2024), drive primary care and maternal health care reforms through the Primary Care Access, Payment, and Delivery Task Force and the Maternal Health Access and Birthing Patient Safety Task Force, and execute its core statutory mandates to monitor health care spending trends and provide actionable policy insights.

Through the new Office of Pharmaceutical Policy and Analysis (OPPA), the HPC will be analyzing data and information from pharmacy benefit managers (PBMs) for the first time and will issue its first annual report, including recommendations on pivotal matters related to pharmaceutical policy. OPPA will also provide greater insight into the objective value of medicines and treatments, including the impact of pharmaceuticals on medical spending and health outcomes,

Through the new Office of Health Resource Planning (OHRP), the HPC will contribute a comprehensive study of maternity service closures and capacity assessment in support of the Maternal Health Access and Birthing Patient Safety Task Force's final report. OHRP will lead the Commonwealth's first comprehensive state health planning initiative in decades, using robust data analysis and strategic planning to promote the alignment of health care resources with population needs.

Through the new Behavioral Health Workforce Center (BHWC), the HPC will issue a comprehensive analysis of payments for behavioral health services by both private and public payers and recommendations for payment policies that can develop and sustain the Commonwealth's behavioral health workforce. In a forthcoming policy brief, the BHWC highlights actionable strategies for reducing barriers to obtaining licensure and certification in select behavioral health professions.

LIST OF TECHNICAL APPENDICES

1 Acute Care Hospitals in Massachusetts by Type of Hospital

2 Trends in Spending and Care Delivery

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Under the leadership of Dr. David Auerbach, the HPC's Research and Cost Trends department conducted the analyses and prepared the annual cost trends report and chartpacks. They are as follows: Dr. Sasha Albert, Charlotte Burlingame, Jaylen Clark, Alicia Duran, Dr. Katya Fonkych, Dr. Carolina Herrera, Yue Huang, Amanda Katchmar, Lyden Marcellot, Dr. Laura Nasuti, Sara Sadownik, and Yunge Xiao. Ashley Johnston designed the report.

Many additional HPC staff contributed significantly to the report from each of the HPC's departments: Office of the Chief of Staff (led by Hannah Kloomok), Office of the General Counsel (led by Lois Johnson), Health Care Transformation and Innovation (led by Catherine Harrison and Tayler Bungo), and Market Oversight and Transparency (led by Kate Scarborough Mills). The HPC received input and guidance from a number of clinical and policy experts, including Michal Horný, PhD, Assistant Professor of Health Policy and Management, School of Public Health & Health Sciences, University of Massachusetts Amherst, and Michael Thompson, PhD, MPH, Assistant Professor in the Section of Health Services Research and Quality, Department of Cardiac Surgery, University of Michigan Medical School.

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MASSACHUSETTS
HEALTH POLICY COMMISSION

ABOUT THE MASSACHUSETTS HEALTH POLICY COMMISSION

Established in 2012, the agency maintains a permanent staff to fulfill its statutory responsibilities and is accountable to an 11-member Board of Commissioners. HPC staff and commissioners work collaboratively to oversee and improve the performance of the Massachusetts health care system.

In January 2025, two new health care laws were enacted to strengthen health care market oversight, address rising prescription drug costs, and enhance the transparency and accountability of the Commonwealth's health care system. This significant legislation expands the HPC's oversight authority, including the establishment of two new offices within the agency: the Office of Pharmaceutical Policy and Analysis and the Office of Health Resource Planning.

Key responsibilities of the organization include:

- Setting the health care cost growth benchmark
- Assessing and enforcing provider and payer performance relative to the health care cost growth benchmark
- Issuing data-informed, actionable policy recommendations to improve health care affordability and guide the future of health care reform in Massachusetts
- Analyzing the impact of health care market mergers, acquisitions, and other transactions on cost, quality, access, and equity
- Serving as the hub of expertise on pharmaceutical drug policy in Massachusetts, providing policy recommendations based on pharmaceutical data and drug affordability and access analysis
- Evaluating the supply and distribution of health care resources across the Commonwealth, using robust data analysis and strategic planning to promote the alignment of resources with population needs
- Conducting research and making data-informed policy recommendations to strengthen the behavioral health workforce in Massachusetts
- Collecting and disseminating key information about the structure and functioning of Massachusetts health care providers through the Registration of Provider Organizations
- Creating care delivery standards for Accountable Care Organizations
- Investing in innovative care models
- Administering independent external reviews of insurer medical necessity denials and risk-based provider organization decisions, as well as open enrollment waivers

The HPC also co-chairs two legislatively-mandated task forces in the Commonwealth: the Primary Care Access, Delivery, and Payment Task Force, charged with issuing recommendations to stabilize and improve primary care access, delivery, and payment; and the Maternal Health Access and Birthing Patient Safety Task Force, charged with reporting on the availability of maternal health services, financial investment in maternal health care, and the impact of past essential services closures.

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