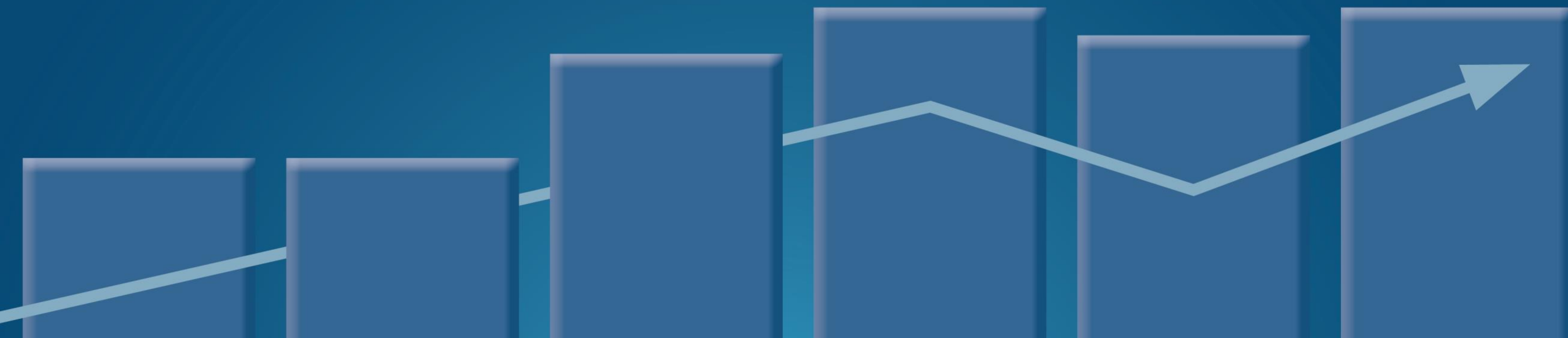
MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2026

HEALTH CARE COST GROWTH BENCHMARK



Agenda

HPC

Background on the Health Care Cost Growth Benchmark and Modification Process

David Seltz, Executive Director, HPC

Center for Health Information and Analysis (CHIA) Annual Report on the Performance of the Massachusetts Health Care System

Lauren Peters, Executive Director, CHIA

Massachusetts Spending Trends: Drivers and Implications for Affordability

Dr. David Auerbach, Senior Director of Research and Cost Trends, HPC

Yue Huang, Senior Manager, Research and Cost Trends, HPC

Public Testimony (Advance Sign-up Only)

Adjourn

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2026

HEALTH CARE COST GROWTH BENCHMARK

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

HPC

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent**, **innovative, and equitable** health care system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

The Health Care Cost Growth Benchmark: Key Definitions

HPC

TOTAL HEALTH CARE EXPENDITURES

- The HPC sets a **prospective target** for moderating the per capita growth of **total health care expenditures** across all payers (public and private) that is initially linked to the state's long-term economic growth rate, potential gross state product (PGSP). *See sidebar.*
- **Total health care expenditures (THCE)** includes:
  - All categories of medical expenses and all non-claims related payments to providers
  - All patient cost-sharing amounts, such as deductibles and copayments
  - Administrative cost of private health insurance

POTENTIAL GROSS STATE PRODUCT (PGSP)

PGSP is an estimate of the economic output a state would achieve if all its resources were employed at a sustainable rate, consistent with steady growth and stable inflation.

PGSP is intended to reflect the **long-run average growth rate of the Commonwealth's economy**, excluding fluctuations due to the business cycle.

- Similar to the consensus revenue process, in January the **Governor, House, and Senate convene to review expert economic forecasts** and determine the per capita growth rate of PGSP for the next calendar year.
- By definition, and as intended by policymakers, PGSP is a **stable and predictable economic measure.**
- Although an economy can temporarily produce more than its potential level of output, that can come at the cost of rising inflation.

Background on the Health Care Cost Growth Benchmark

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WHAT THE BENCHMARK IS

- **A target** to track and evaluate the **growth** of total health care expenditures in the state and the long-term overall performance of the health care system.
- **A measurable goal** to catalyze public and private collective action to improve **health care affordability and access.**
- A method for **enhancing transparency of the health care system** so that market participants, policymakers, and the general public can examine what is contributing to higher health costs for government, businesses, and residents.
- A **long-term framework** to track and identify unsustainable *spending growth* and opportunities for improvement. The overall goal is to improve health outcomes and **promote high-quality, affordable, and accessible health care for all residents**.

WHAT THE BENCHMARK IS NOT

- **A cap** on total health care spending, prices, premiums, or payments. It is a target for sustainable spending growth.
- **A punitive measure.** THCE growth above benchmark alone does not automatically trigger penalties or other negative consequences to the health care system or individual organizations. The HPC may require a performance improvement plan of an individual health care provider or plan only after a comprehensive, multi-factor review of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.
- A measure of **internal costs or operating expenses** of health care providers. It is a measure of health care spending for patients.
- A single solution to addressing health care affordability challenges within Massachusetts. The benchmark process provides **critical information and data** to inform other policy initiatives to improve affordability and access.

The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

1-5 years

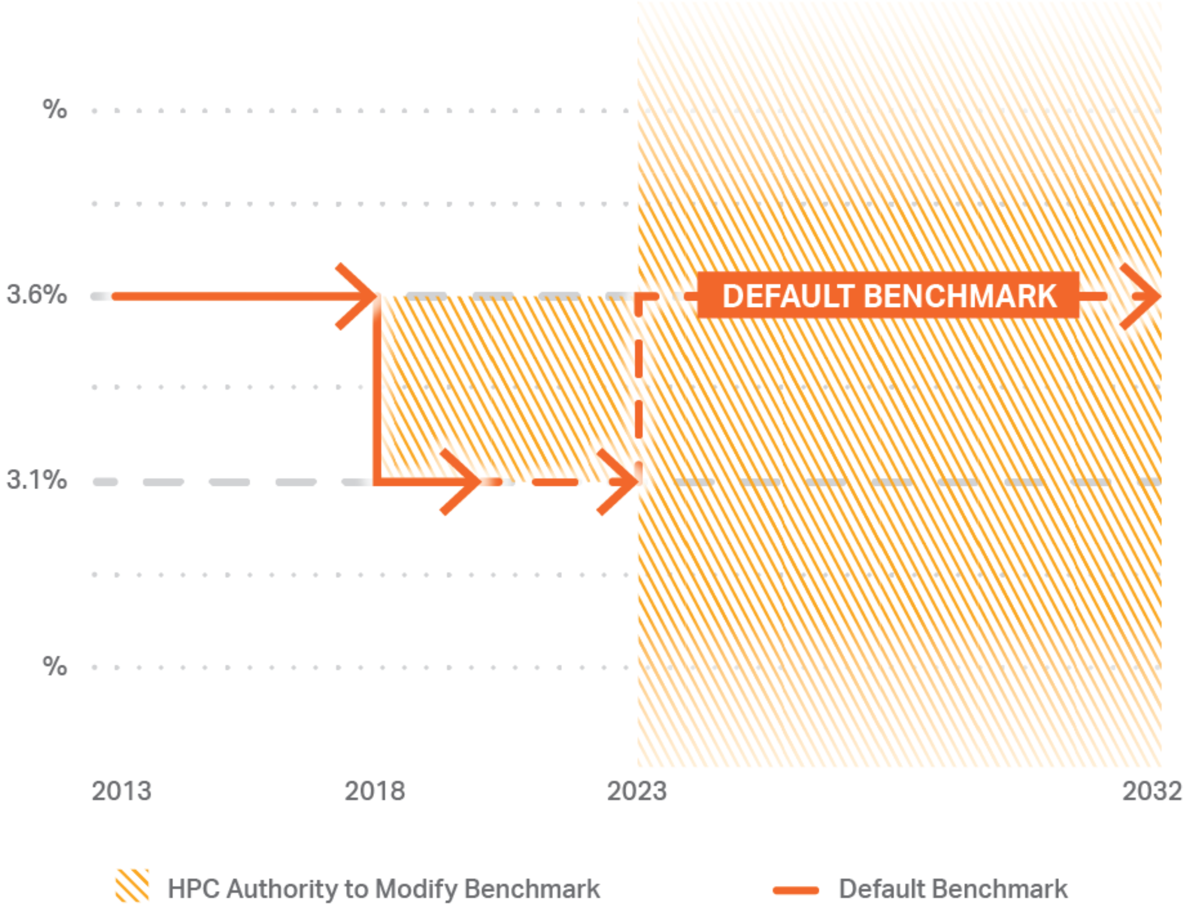
Benchmark established by law at potential gross state product (PGSP) (3.6%)

6-10 years

Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.

10-20 years

Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



Benchmark Modification Process: Key Steps

HPC

HPC PROCESS TO MODIFY

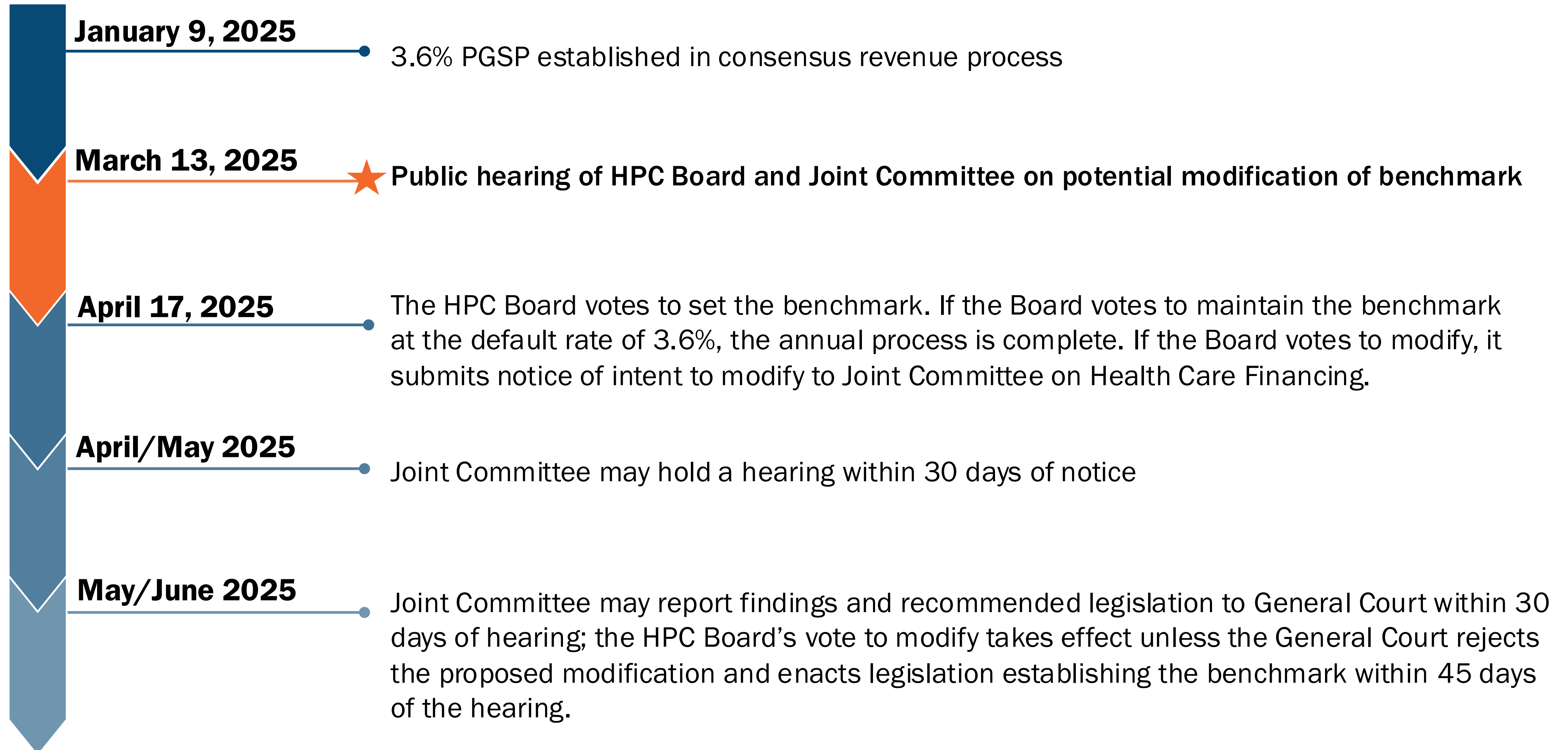
- The HPC's Board must hold a **public hearing** prior to making any modification of the benchmark.
- The hearing considers data and stakeholder testimony on whether modification of the benchmark is warranted.
- Members of the **Joint Committee on Health Care Financing** participate in the hearing.
- If the HPC's Board votes to maintain the benchmark at the default rate of 3.6%, the **annual process is complete.**
- If the HPC's Board votes to modify the benchmark to any other rate, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee **for further legislative review.**

HPC FACTORS FOR REVIEW

In addition to reviewing the latest CHIA report and public testimony, the HPC reviews available data and information from an extensive range of sources in considering whether a modification is warranted. This includes reviewing:

- A broad range of **current health care trends**, including spending, utilization, pricing, patient acuity, capacity, premiums, cost-sharing, coverage, and provider/health plan financial performance. If available, MA performance is compared to the U.S. and similar states.
- Other **current and forecasted economic trends**, in areas such as inflation, labor costs, economic output, and household income, including those specific to the health sector.
- Data and survey information on **health care affordability** for residents and businesses, including the rate of residents who report difficulty receiving needed care due to cost.

Benchmark Modification Process: 2025 Timeline



Accountability for the Health Care Cost Growth Benchmark: An Overview

Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC **payers** and **primary care providers whose increase in HSA TME** is above bright line thresholds (e.g., greater than the benchmark).

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**.

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

CHIA's referral of entities is based on a bright-line test of their spending growth, whereas the HPC is charged with contextualizing that growth for each referred entity.

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan (PIP) if, after a review of regulatory factors, it identifies **significant concerns** about the entity's costs and determines that a PIP could result in **meaningful, cost-saving reforms**.

	REGULATORY FACTORS
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

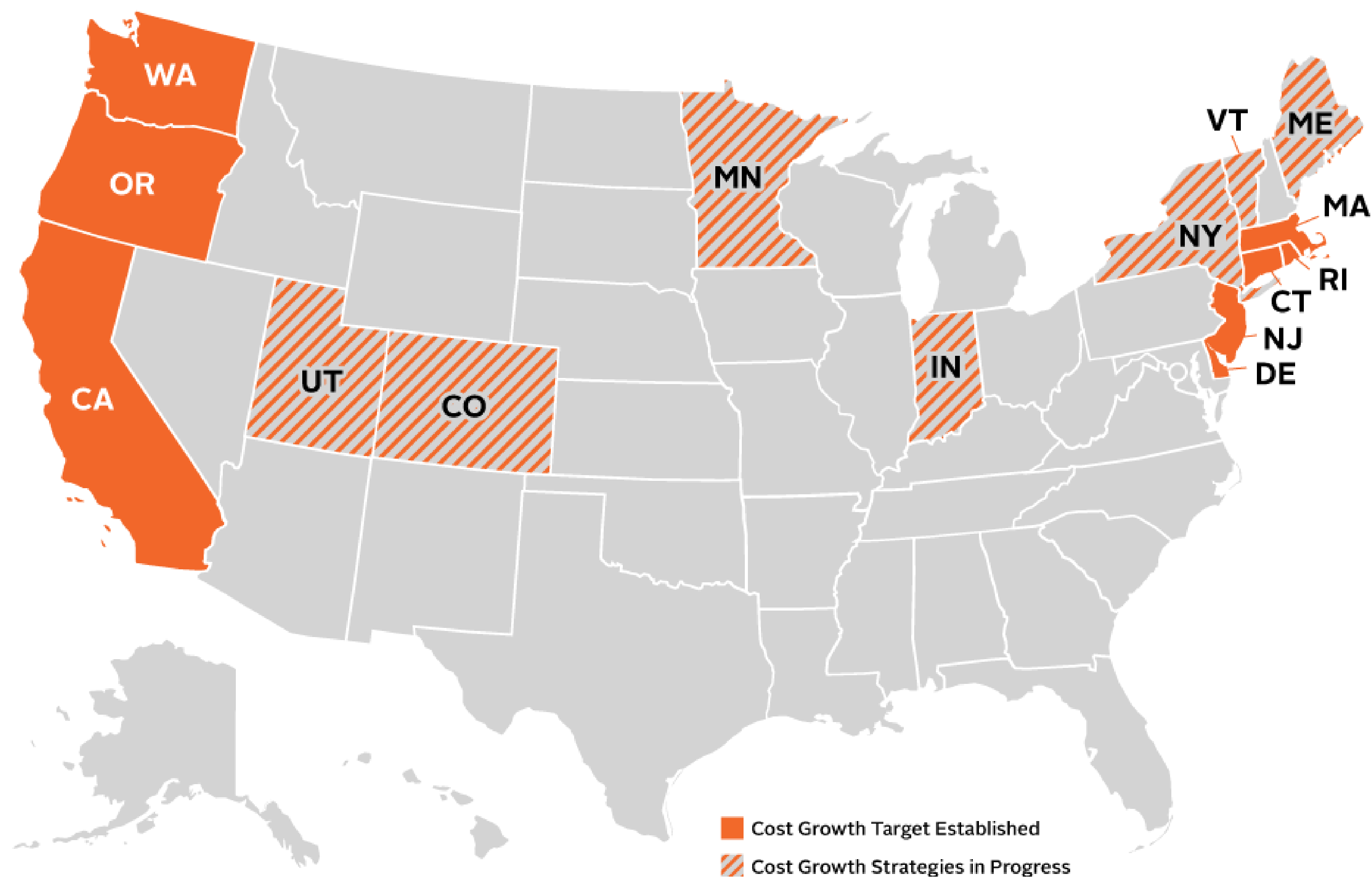
In December 2024, the HPC determined that the first-in-the-nation state-mandated performance improvement plan for health care spending was successful.

- In January 2022, the HPC Board **voted unanimously** to require Mass General Brigham (MGB) to develop a PIP to reduce cost growth, finding:
  - MGB **regularly had spending growth above the benchmark** and higher absolute spending levels for its patients than most other systems.
  - **Price and mix** were the primary drivers of MGB's spending growth, not utilization.
- MGB's PIP included **ten strategies** and a total savings target of $176.7 million over the 18-month period.
- In December 2024, the HPC voted to conclude MGB's PIP, finding that MGB **achieved its savings target** and that MGB's spending growth was meaningfully reduced.

MGB Strategy	PIP Savings Target ($M)	Reported Total Savings by MGB ($M)
Price Reductions		
Reducing Outpatient Rates	$86.8	$85.3
Mass General Waltham Rates	$19.2	$24.8
Reducing ConnectorCare Rates	$17.9	$29.5
Other Insurance Discount	$1.5	$3.3
Reducing Utilization		
Integrated Care Management Program	$23.0	$24.9
SNF Utilization Reduction	$13.4	$7.3
MGB Health Plan Utilization Management	$1.5	$1.5
MRI and CT Utilization	$6.5	$14.4
Shifting Care to Lower Cost Sites		
Home Hospital	$1.9	$0.9
Virtual Care Discount	$5.1	$5.4
Total	**$176.7**	**$197.1**

Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.

Many other states are going beyond the Massachusetts model and are adopting new strategies to promote transparency, oversight, and accountability.



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

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HEALTH CARE COST GROWTH BENCHMARK

Performance of the Massachusetts Health Care System

March 13, 2025

CHIA

Introduction

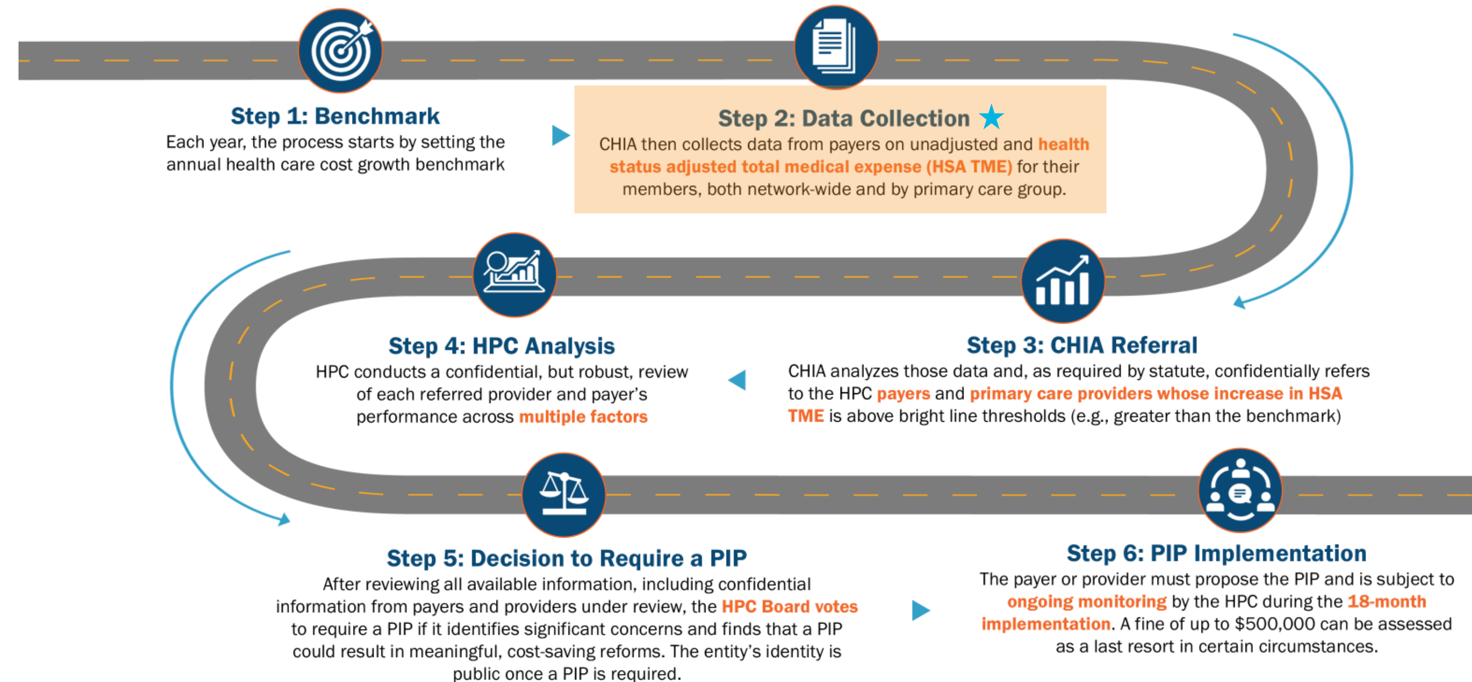
- Established under Chapter 224 of the Acts of 2012 as an independent agency charged with **collecting, analyzing, and disseminating health care information**
  - *Resource to policymakers, researchers, industry at large*
  - *Health Policy Commission (HPC) established as policy counterpart*

- CHIA **collects and maintains multiple data assets** including but not limited to All-Payer Claims Database (APCD), Hospital Case Mix, provider financials and cost reports, surveys (e.g., health insurance, workforce, employer), and payer aggregate data

- Data supports a **variety of analytics and reporting** including but not limited to:
  - *Measurement of health care spending*
  - *Hospital utilization rates and financial performance*
  - *Mandated benefit reviews*
  - *Priority initiatives related to health care workforce and trends in primary care*

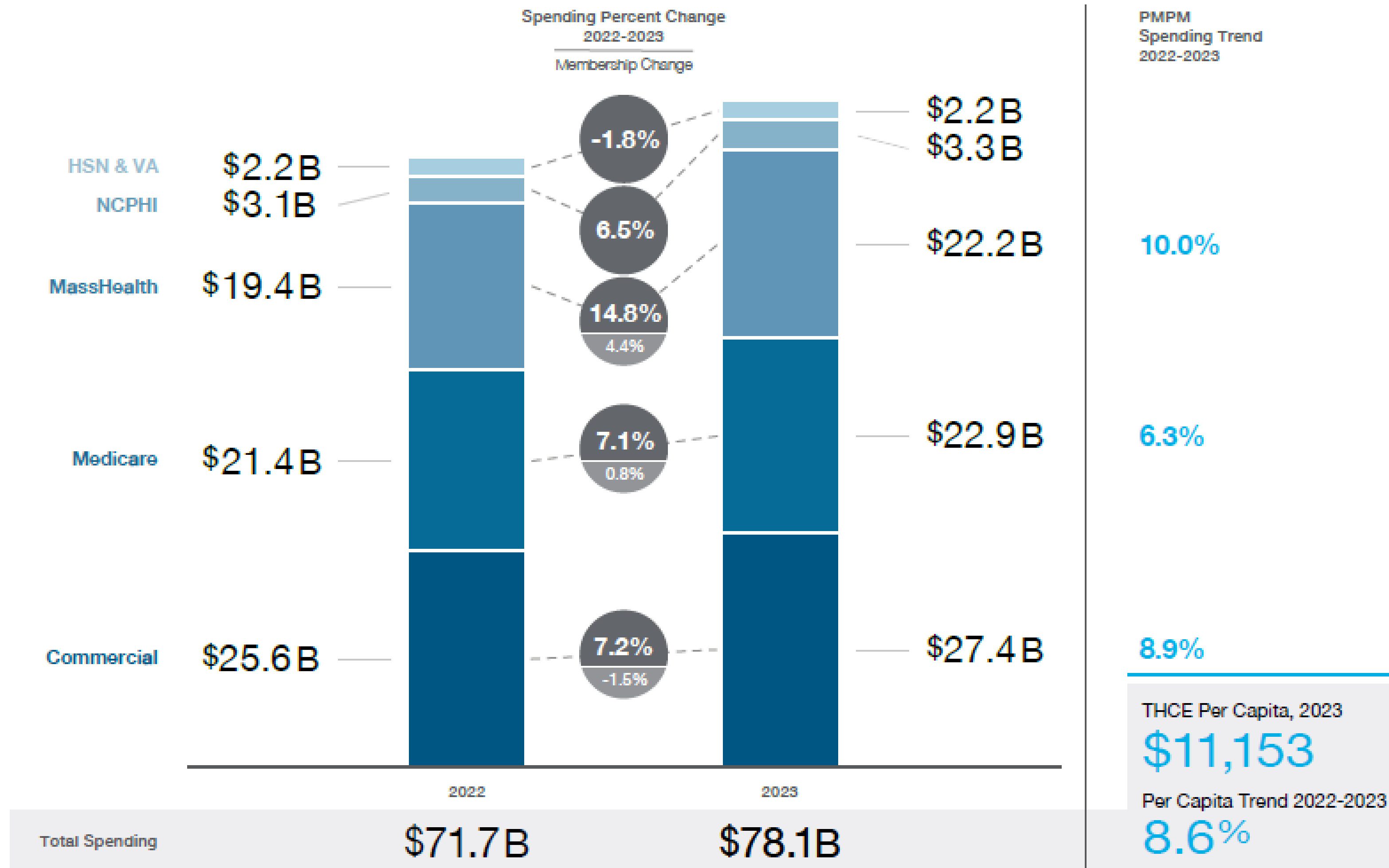
Introduction (Cont.)

- CHIA's **Annual Report on the Performance of the Massachusetts Health Care System** is the agency's most comprehensive examination of health care cost, coverage, and quality trends.
- The report includes the calculation of **Total Health Care Expenditures (THCE)** and payer and provider performance relative to the health care cost growth benchmark.



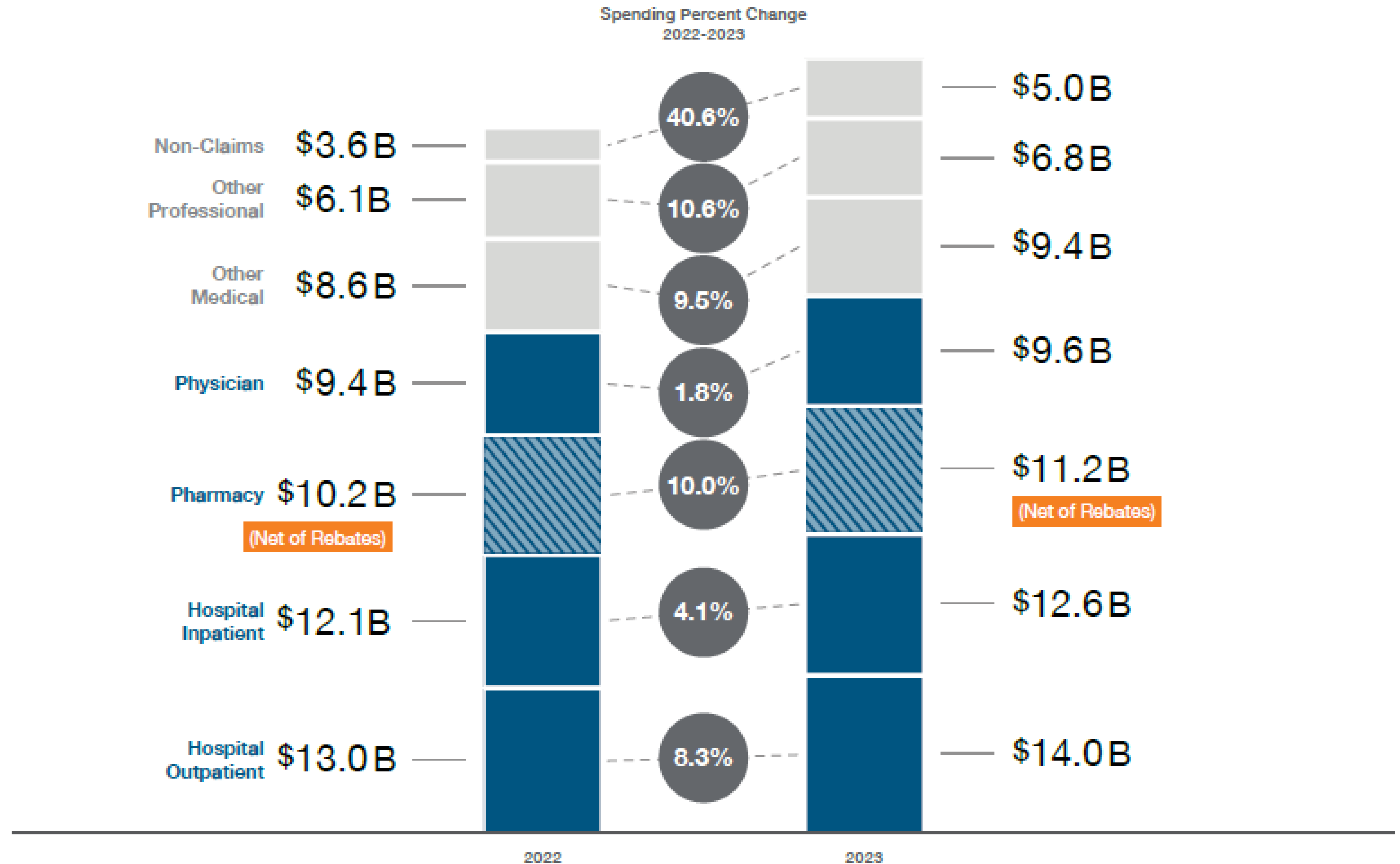
Total Health Care Expenditures

Components of Total Health Care Expenditures, 2022-2023



THCE increased 8.6%, totaling $78.1 billion or $11,153 per resident in 2023.

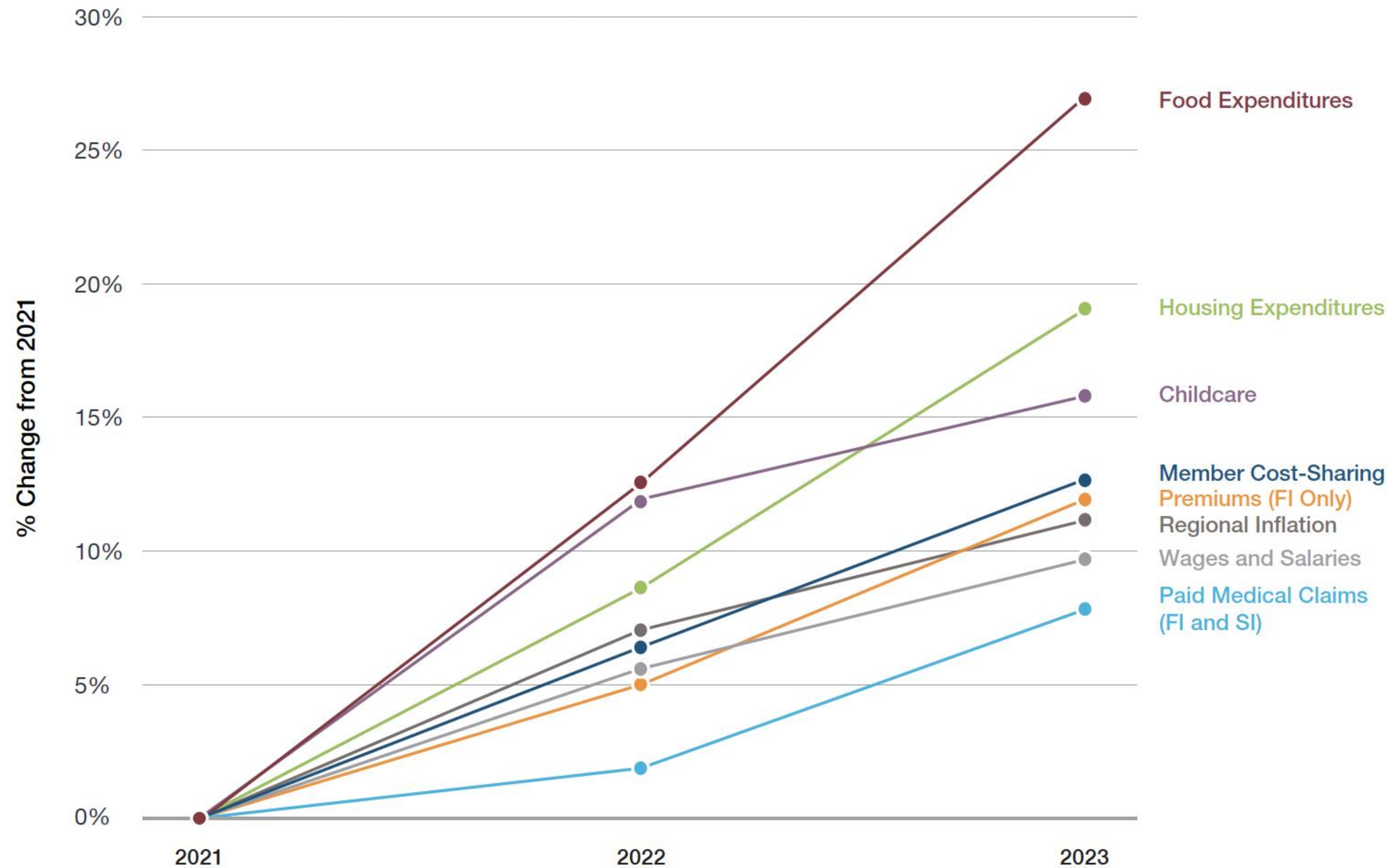
Spending by Service Category: Net of Prescription Drug Rebates, 2022-2023



Non-claims, hospital outpatient, and pharmacy were the top drivers of spending growth, each increasing by more than $1 billion in 2023.

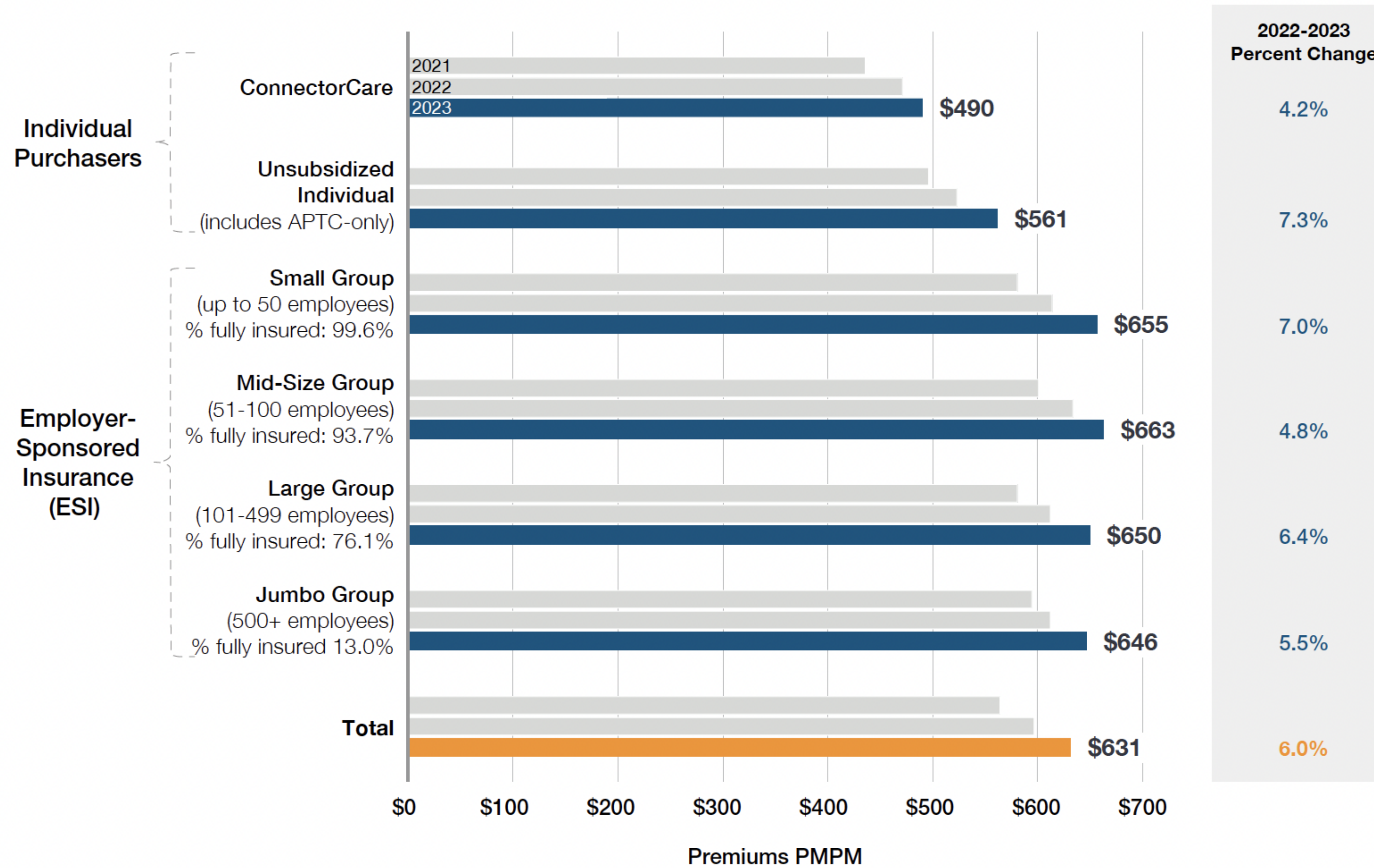
Affordability

Affordability in Context, 2021-2023



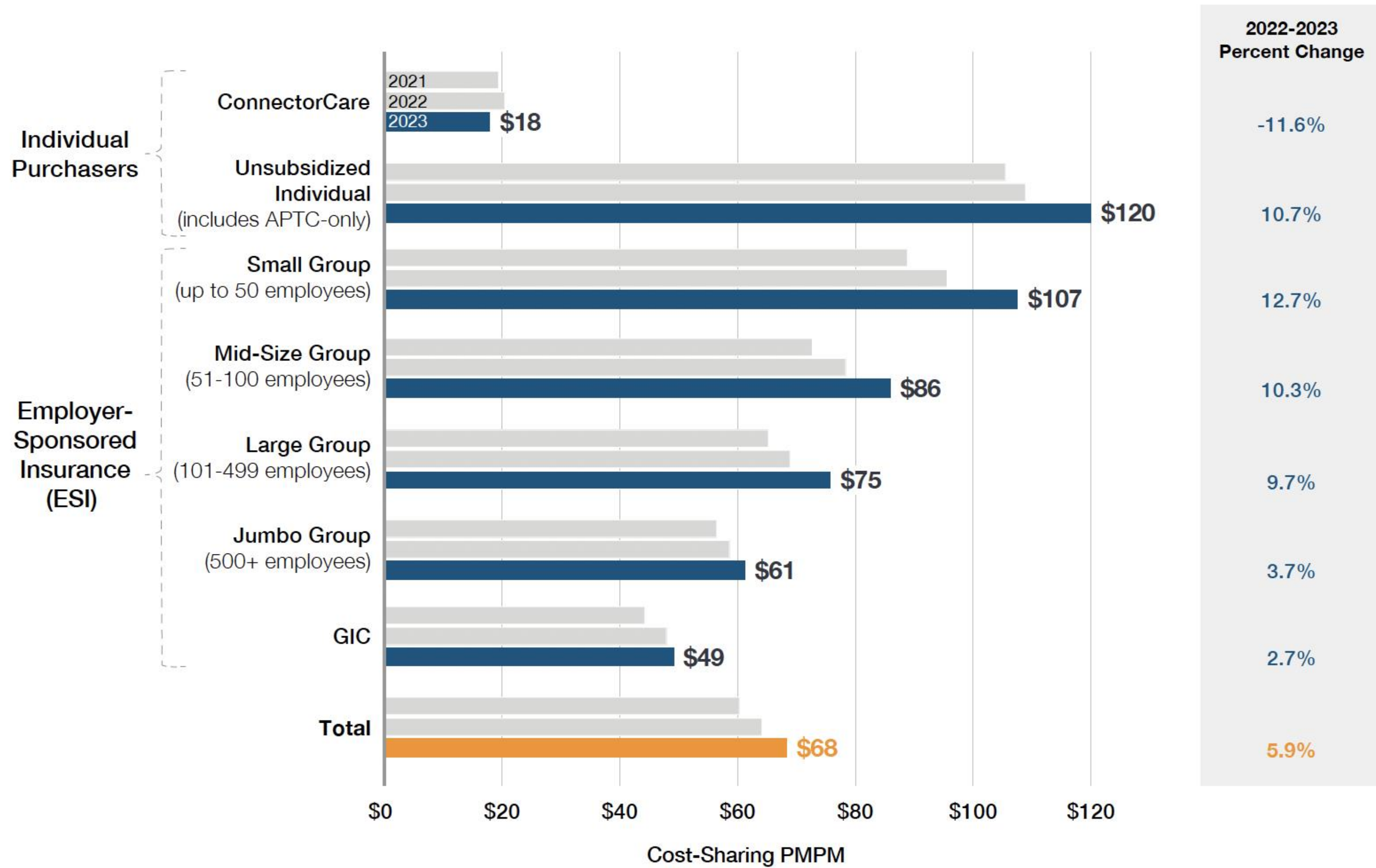
From 2021-2023, premiums and cost-sharing increased faster than wages and salaries as well as regional inflation.

Fully Insured Premiums by Market Sector, 2021-2023



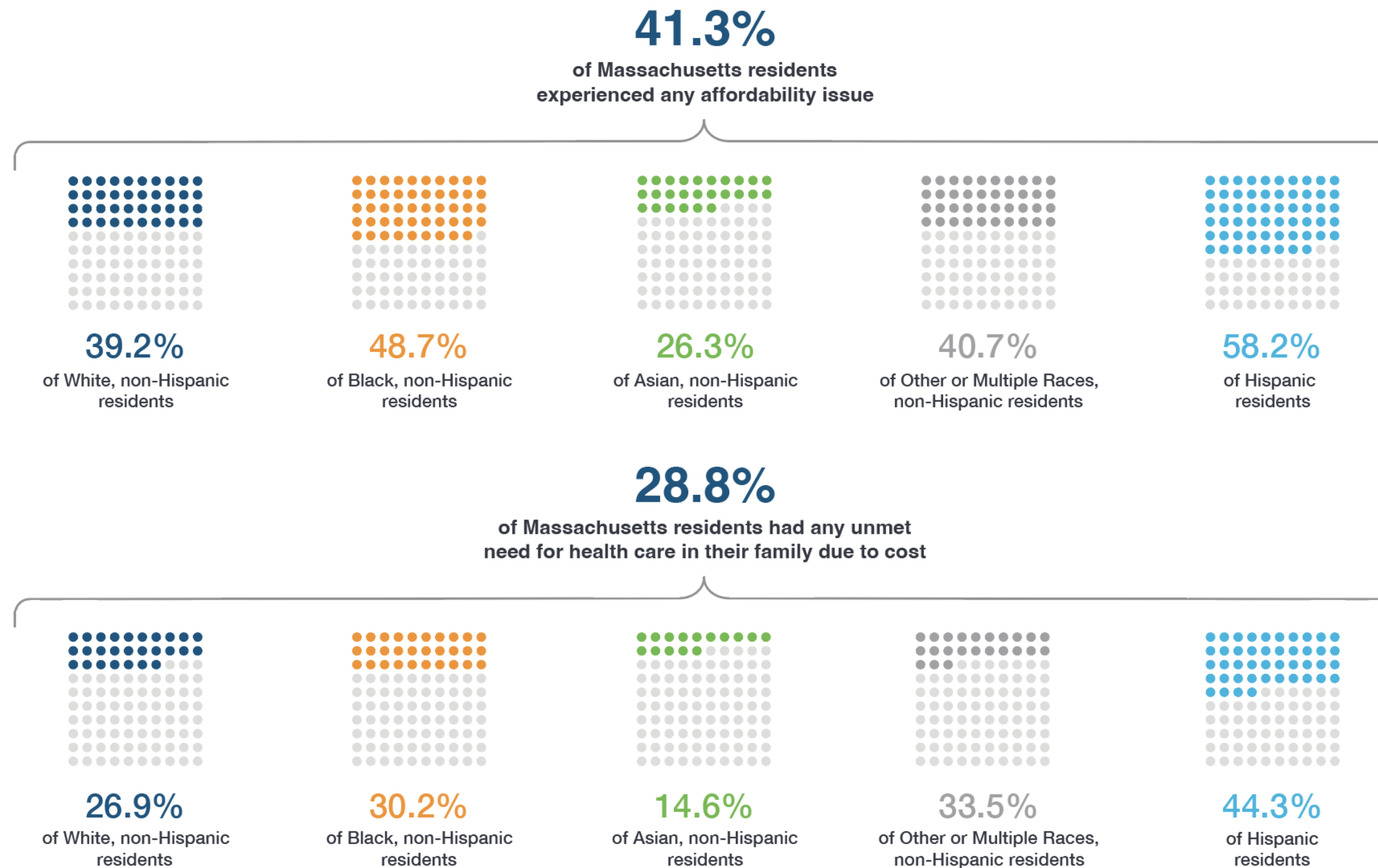
The Unsubsidized Individual and Small Group market sectors had the highest premium growth in 2023.

Member Cost-Sharing by Market Sector, 2021-2023



In 2023, member cost-sharing increased the fastest in the same two market sectors (Unsubsidized Individual and Small Group).

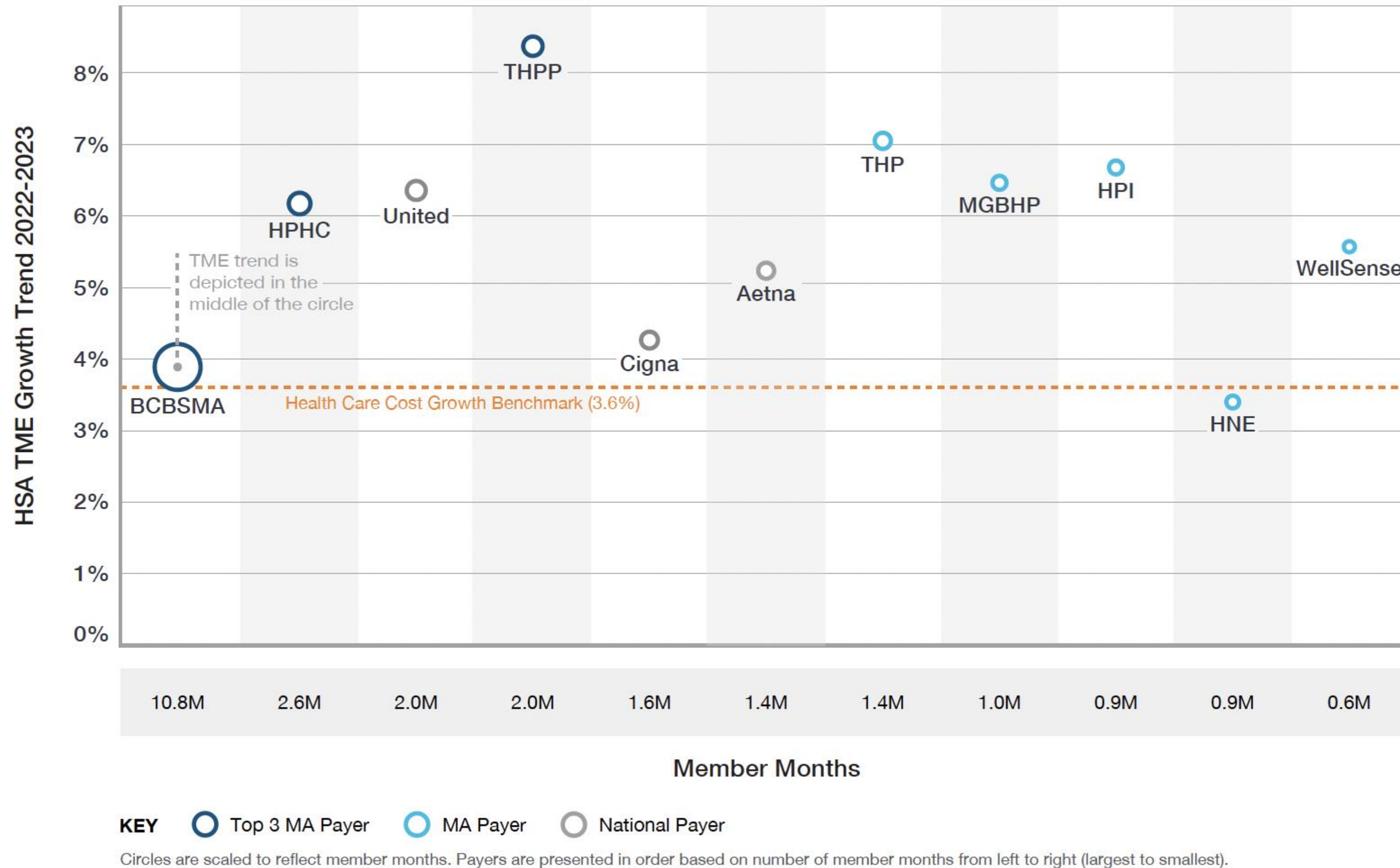
Affordability Issues Among Residents, by Race and Ethnicity, 2023



Health care affordability challenges disproportionately burden Hispanic residents and non-Hispanic Black residents.

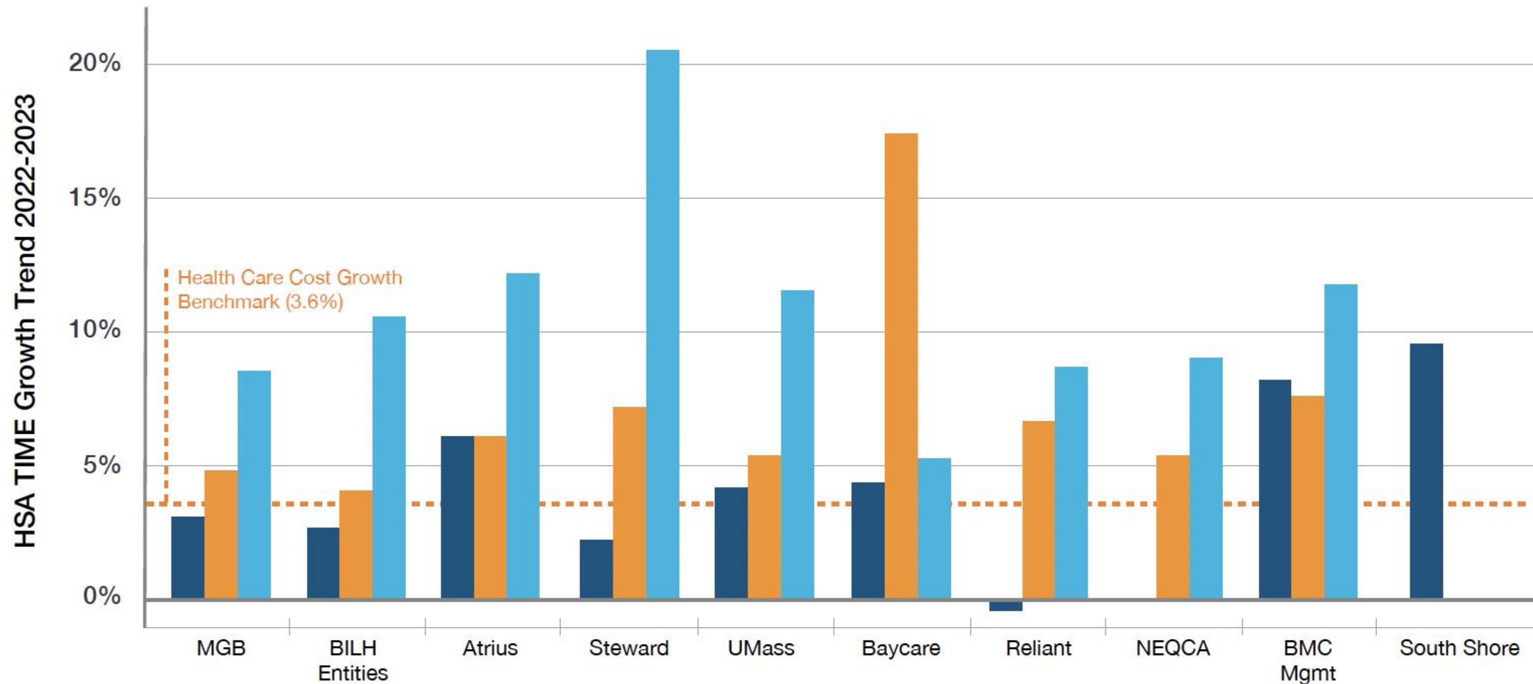
Payer & Provider TME Trends

Trends in Commercial HSA TME by Payer, 2022-2023



Nearly all (10 of 11) commercial payers reported health care spending above the 3.6% benchmark in 2023.

Trends in Managing Physician Group Commercial HSA TME, 2022-2023



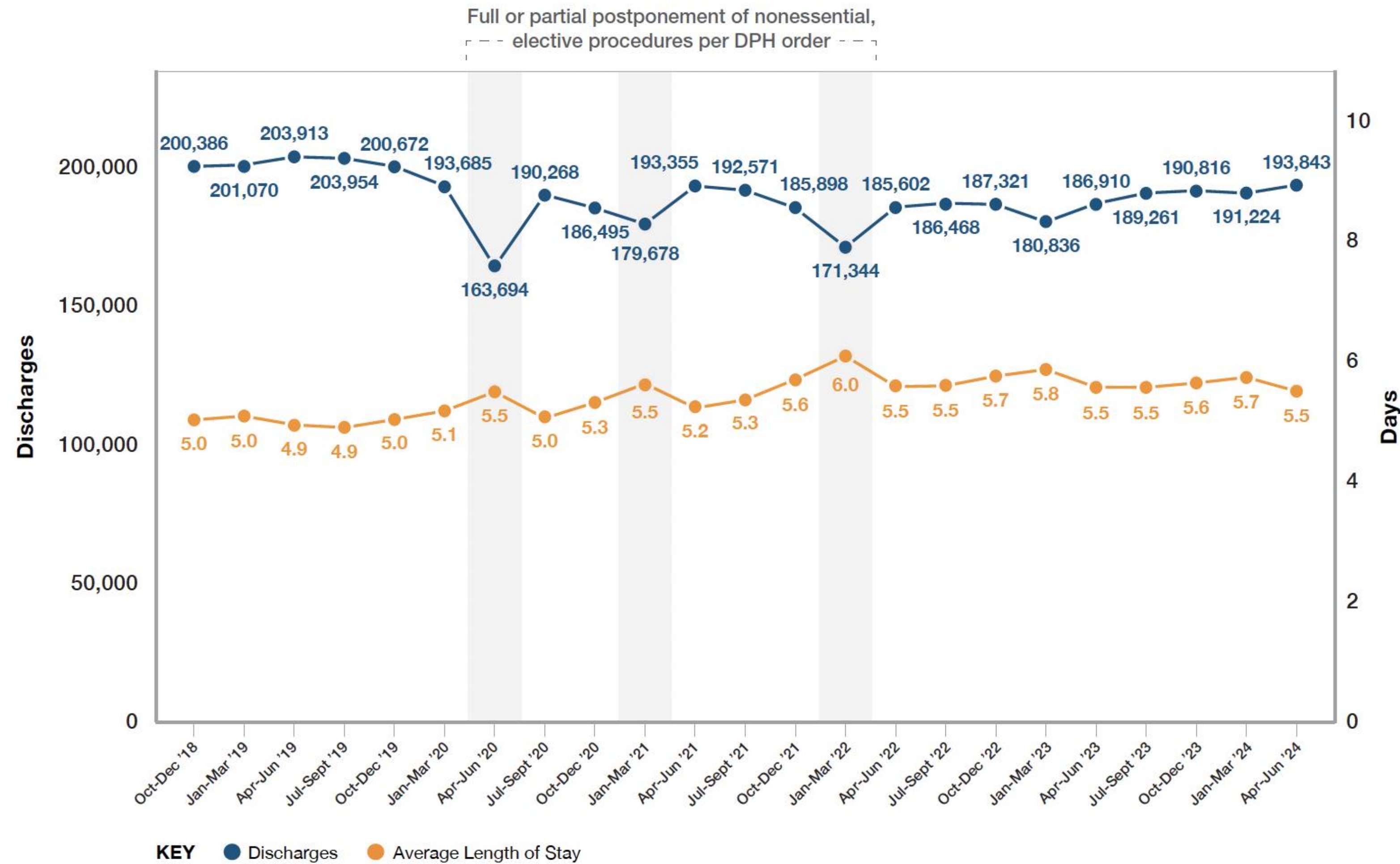
	MGB	BILH Entities	Atrius	Steward	UMass	Baycare	Reliant	NEQCA	BMC Mgmt	South Shore
BCBSMA, HPHC, and THP Share of Group's Managed Member Months	90.8%	75.6%	86.3%	70.6%	87.3%	53.3%	91.1%	54.9%	68.7%	100.0%
Total Managed Member Months in 2023	2.8M	2.1M	1.6M	1.3M	0.7M	0.5M	0.5M	0.4M	0.3M	0.3M

KEY ■ BCBSMA ■ HPHC ■ THP

Nearly all (9 of 10) of the largest physician groups reported health care spending above the 3.6% benchmark in 2023.

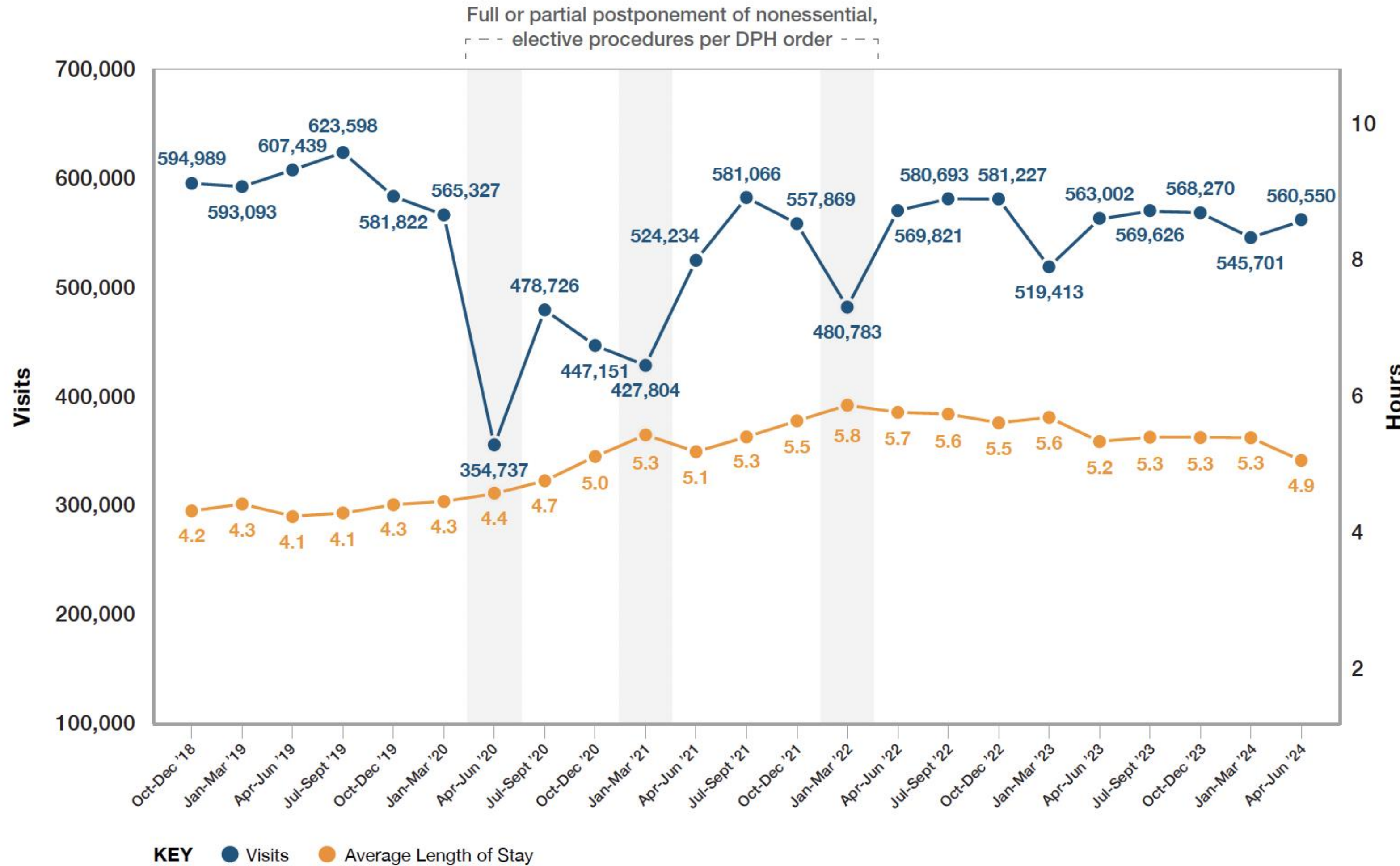
Hospital Trends

Total Acute Care Hospital Inpatient Discharges, October 2018-June 2024



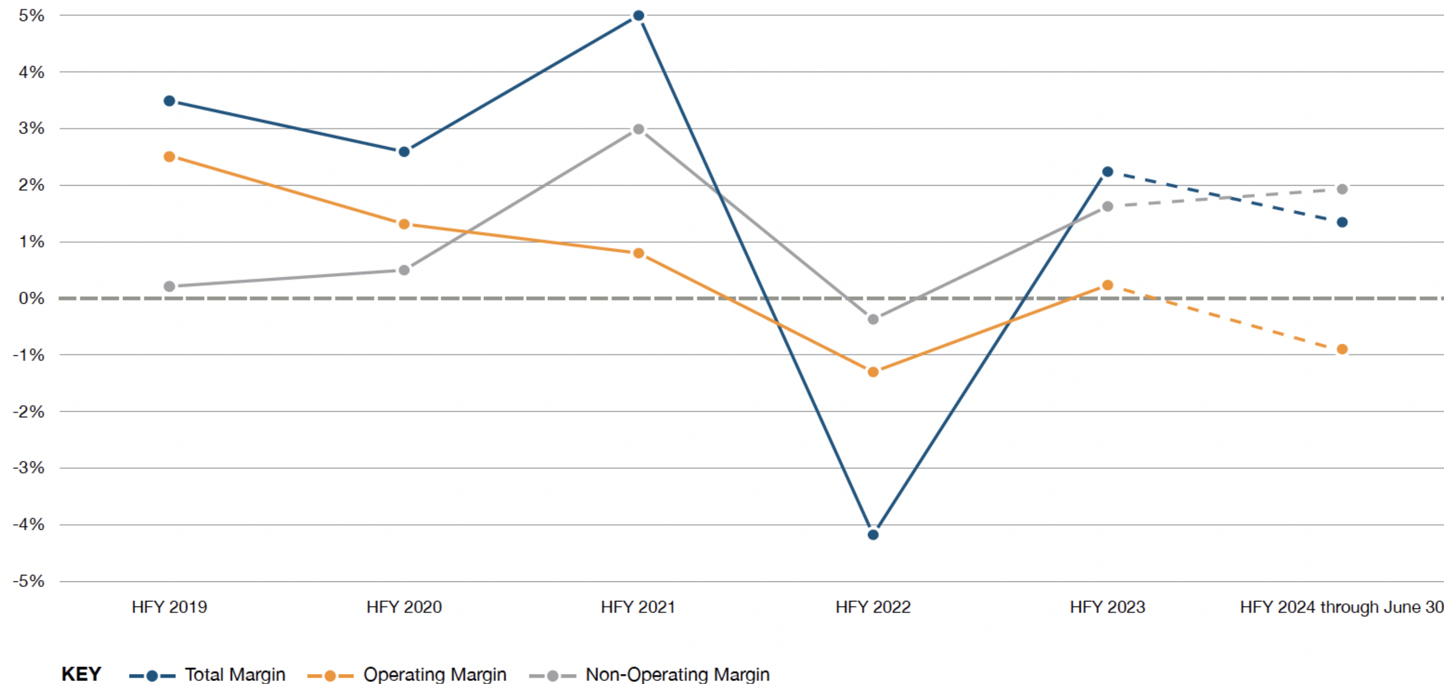
Inpatient discharges are lower, while the average length of stay is >10% higher, than pre-pandemic levels.

Total Acute Care Hospital Emergency Department Treat-and-Release Visits, October 2018-June 2024



ED visits are lower, while the average length of stay is >10% higher, than pre-pandemic levels.

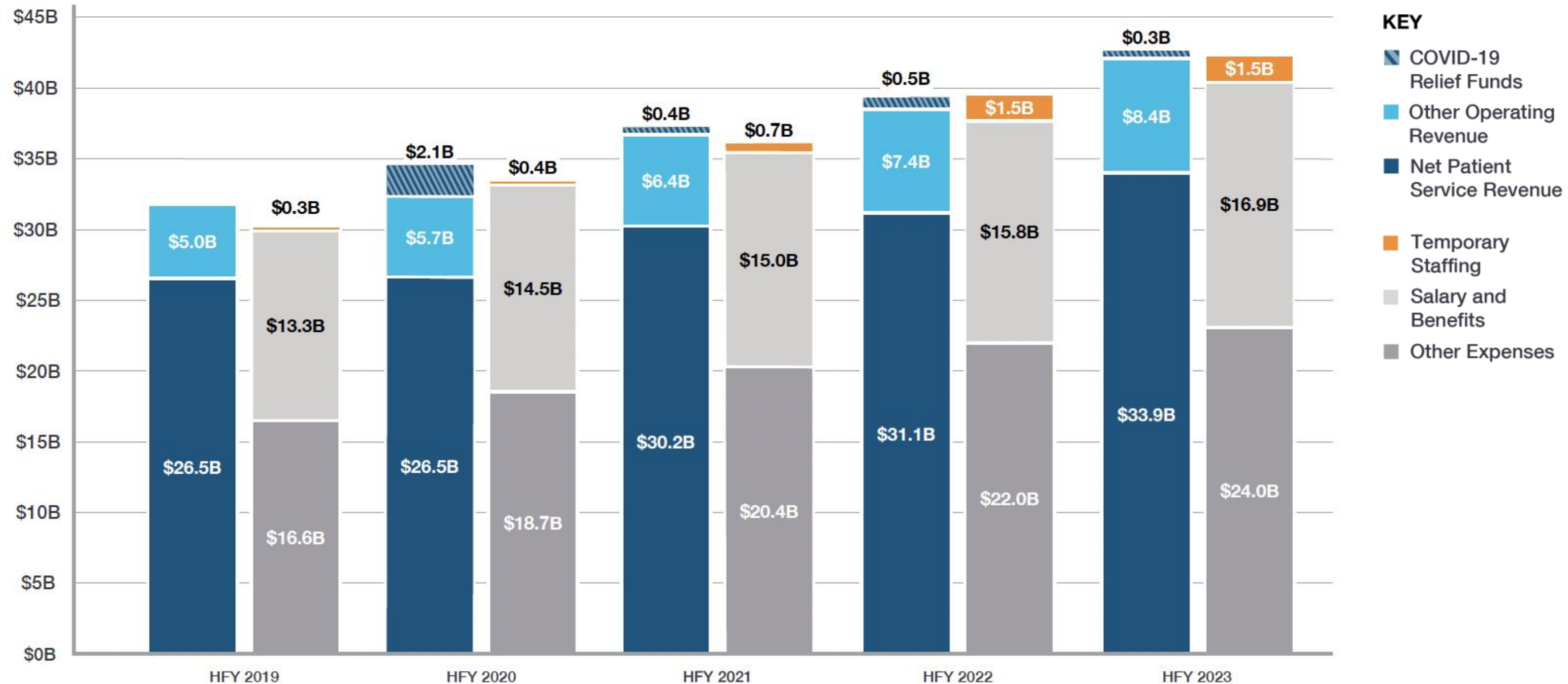
Acute Hospital Profitability Trends



Statewide Median	HFY 2019	HFY 2020	HFY 2021	HFY 2022	HFY 2023	HFY 2024 through June 30
Total Margin	3.5%	2.6%	5.0%	-4.2%	2.2%	1.4%
Operating Margin	2.5%	1.3%	0.8%	-1.3%	0.2%	-0.9%
Non-Operating Margin	0.2%	0.5%	3.0%	-0.4%	1.6%	1.9%

Through June 2024, acute hospital profitability has declined following a 6.4 percentage point increase in HFY 2023.

HFY 2019-2023 Hospital Operating Revenue and Expense Trends



	HFY 2019	HFY 2020	HFY 2021	HFY 2022	HFY 2023
Total Operating Revenue	$31.5B	$34.3B	$37.0B	$39.0B	$42.6B
Total Expenses	$30.3B	$33.7B	$36.2B	$39.4B	$42.4B

In HFY 2023, acute hospital aggregate operating revenues exceeded aggregate expenses by $190 million.

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MASSACHUSETTS SPENDING TRENDS: DRIVERS AND IMPLICATIONS FOR AFFORDABILITY

Dr. David Auerbach, Senior Director of Research and Cost Trends, HPC
Yue Huang, Senior Manager, Research and Cost Trends, HPC

Presentation Outline

HPC

1. Recent Spending Trends
2. Drivers of Commercial Spending
   a. Overall Drivers
   b. Hospital Outpatient Department Spending
   c. Prescription Drug Spending
3. Other Notable Trends in the Commercial Market
4. Implications of Recent Spending Growth for Affordability of Health Care

Presentation Outline

HPC

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Health care spending growth in Massachusetts averaged 3.5% from 2012 to 2019 but has risen to 5.2% from 2019 to 2023.

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

Period	Growth
2012-13	2.4%
2013-14	4.2%
2014-15	4.8%
2015-16	3.0%
2016-17	2.8%
2017-18	3.6%
2018-19	4.1%
2019-20	-2.3%
2020-21	9.0%
2021-22	5.8%
2022-23	8.6%

3.5% AVG. ANNUAL GROWTH

3.6% BENCHMARK

5.2% AVG. ANNUAL GROWTH

3.1% BENCHMARK

3.6% BENCHMARK

- Growth averaged **4.1%** over the entire 2012-2023 period.

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

After being consistently below the national average, Massachusetts' health care spending growth has exceeded the national rate in two of the past three years.

Annual growth in per capita health care spending from the previous year to the year shown, Massachusetts and the U.S., 2006-2023

10%
8%
6%
4%
2%
0%
-2%
-4%

2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

MA
U.S.

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.

All market segments grew faster than the benchmark in 2023, yet the commercial sector accounts for most (78%) above-benchmark spending since 2019.

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
2022-2023	7.8%	9.2%	9.2%	6.2%
2019-2023, average annual growth	6.1%	2.3%	5.1%	4.1%
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. In 2023, MassHealth introduced the Primary Care Sub-Capitation Program, which provides fixed PMPM payments for primary care services to MassHealth ACOs. This spending accounted for 16.7% of total MCO/ACO-A spending growth and may explain the large spending increase in MassHealth.

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.

Commercial spending also grew more slowly than the national rate from 2013-2019 but growth in both Massachusetts and the U.S. has been faster since 2019.

Annual growth in per-enrollee commercial health care spending, Massachusetts and the U.S., 2006-2023

20%
15%
10%
5%
0%
-5%

2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

U.S.
MA

Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2023 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis Annual Report on the Performance of the Massachusetts Health Care System 2014-2023.

In 2023, Massachusetts had the 2nd highest family health insurance premiums in the U.S.

Average annual family health insurance premium for employer-sponsored coverage including employer and employee contribution, 2023

10% of family premiums in Massachusetts exceeded $36,000

Notes: Results based on a survey of employers. Massachusetts and New York had identical premiums in the survey.
Sources: Agency for Healthcare Research and Quality Medical Expenditure Panel Survey (MEPS) Insurance Component 2023.

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Commercial spending growth continues to be driven by prices more than utilization overall, with accelerating prices each year according to one large payer.

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

	2017	2018	2019	2020	2021	2022	2023
Price	1.7%	2.1%	2.3%	2.7%	2.8%	3.0%	4.0%
Utilization	0.0%	1.0%	0.1%	-4.7%	9.8%	-0.5%	0.4%

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

Spending increased substantially for all major categories of care in 2023, with hospital outpatient (HOPD) and pharmacy being the top drivers from 2019-2023.

Average annual growth in commercial spending per enrollee by site of care, 2022-2023 and 2019-2023

Site of care	2022-2023	2019-2023, average annual growth	Share of spending in 2023
Hospital inpatient	6.7%	2.3%	18.4%
HOPD, ED, and ASC	11.0%	6.6%	35.8%
Office, urgent care and retail clinic	8.8%	3.3%	19.2%
Pharmacy	8.6%	8.6%	19.3%

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, full claims only). HPC analysis of CHIA All-Payer Claims Database V2023, 2019-2023 (spending at other sites).

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Hospital outpatient departments provide a wide range of services, many of which can also be provided in other care settings.

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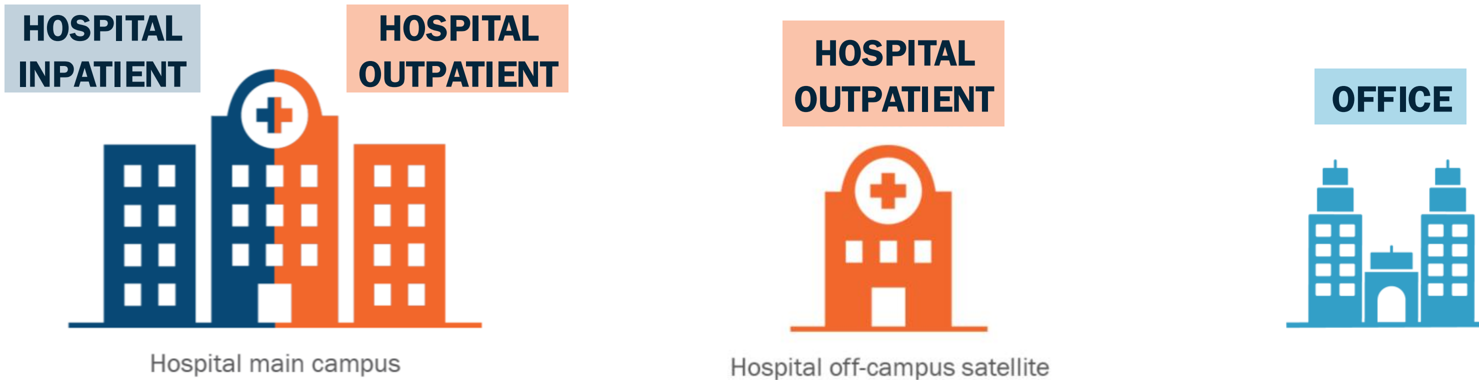
Hospital Inpatient: Overnight stay, emergency or planned admission
Hospital Outpatient: Same-day procedure, billed under hospital license with facility fee



Examples of services:

INPATIENT

- Heart attack
- Septic shock

INPATIENT OR OUTPATIENT

- Hip replacement
- Bariatric surgery
- Hysterectomy

OUTPATIENT OR OFFICE

- Evaluation and management visits
- Imaging
- Endoscopies
- Drug infusions

$$$ Higher prices ← → **Lower prices $**

- Massachusetts residents receive **42% more care in hospital outpatient settings** (HOPDs) than the national average.[1]
- For care that can be provided in HOPD or office settings, **prices and cost sharing are typically twice as high or more in the HOPD.**
- Patients may be unaware they are receiving care in a HOPD and receive **higher cost-sharing** bills.

1. Massachusetts Health Policy Commission. 2024 Cost Trends Report, Hospital Utilization chartpack. Oct 2024.

Within HOPD spending categories, the biggest drivers were major surgeries (9.8% annual growth from 2019-2023), chemotherapy (8.9%) and injections and infusions (9.7%).

Commercial spending per member per year for HOPD services by type of service, 2019-2023

9.8% per year
2.8%
8.9%
6.2%
3.7%
9.7%
3.9%
6.3%

$400
$350
$300
$250
$200
$150
$100
$50
$0

Major surgeries
Imaging
Chemotherapy and radiation oncology
Colonoscopies, endoscopies, minor surgeries, and other procedures
Diagnostic labs and tests
Injections and infusions (nononcologic)
E&M
Anesthesia

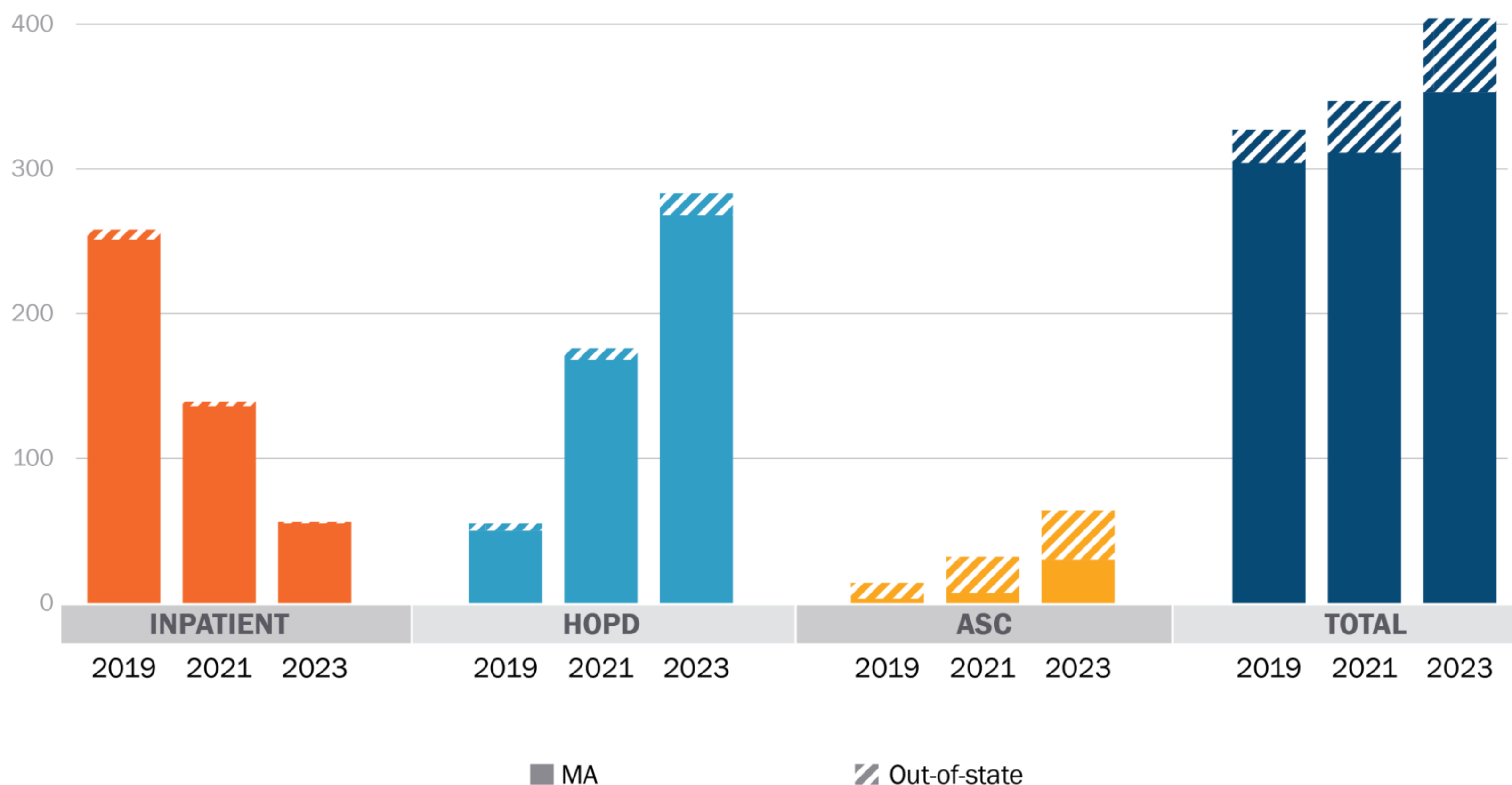
2019
2021
2023

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.

The increase in major surgery spending partly reflects a shift of surgeries from inpatient settings, as seen for hip and knee replacement surgery.

HPC

Number of elective hip and knee replacements by setting of care per 100K commercial members, 2019-2023

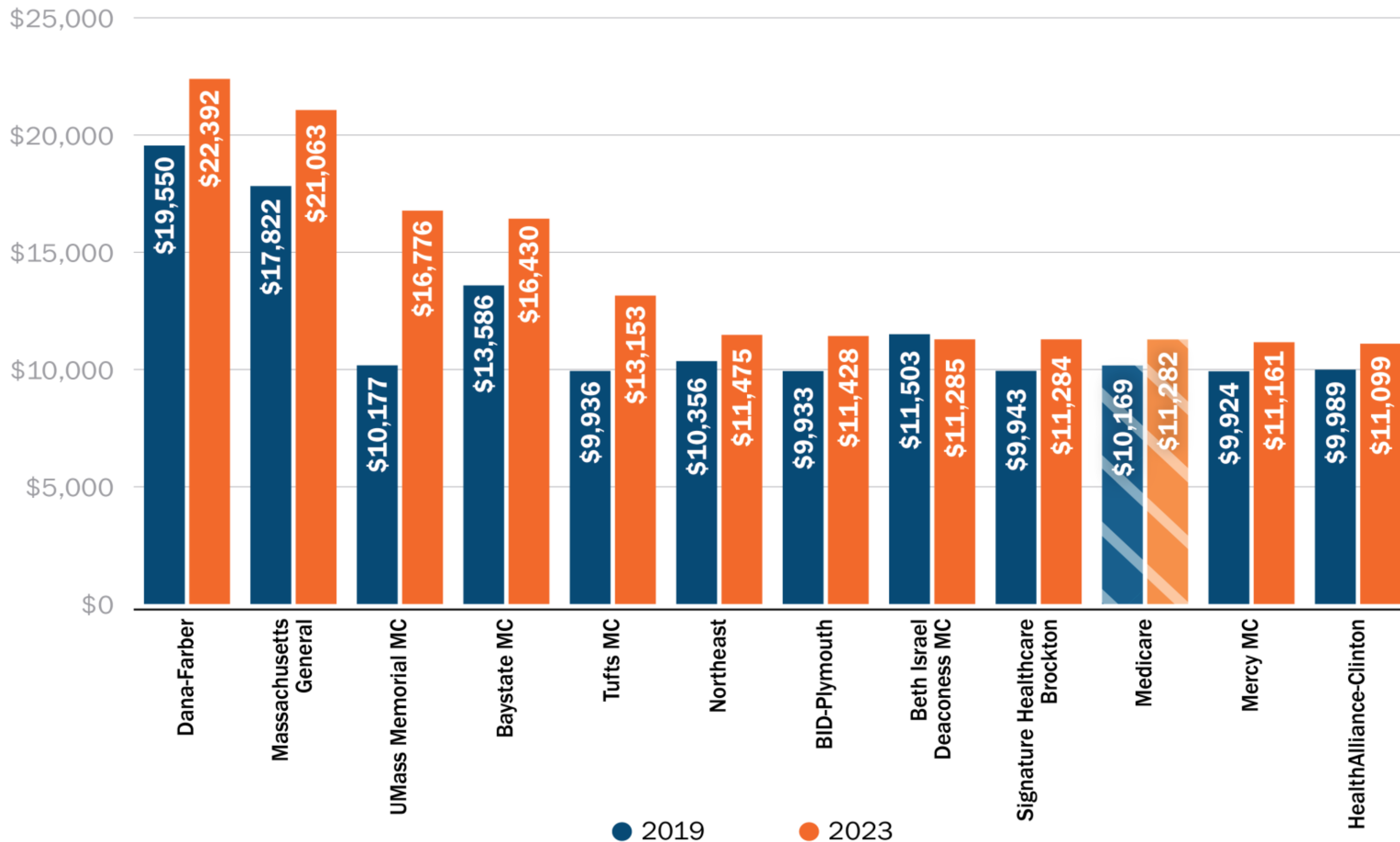


- This shift from inpatient to outpatient settings for hip and knee replacement accounts for about **0.8 percentage points of 2019-2023 annual HOPD spending** growth.
- A large portion (46% in 2023) of ASC hip and knee replacements for Massachusetts residents occurs **out of state.**

Notes: New England Baptist Surgical Center HOPD that converted to 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.

HOPD spending has also been driven by price increases for clinician-administered drugs, such as for chemotherapy.

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 (2019 and 2023).

- Prices reflect both drug acquisition costs and additional negotiated payments to the hospital.
- 0.4 percentage points of the annual HOPD spending increase from 2019-2023 is due to higher spending on Keytruda, which also reflects expanded use.

Massachusetts residents receive more care in higher-priced HOPD versus office-based settings than in the U.S. overall, as illustrated by Medicare spending data.

Average annual growth in Medicare FFS spending, select categories, 2019-2023

	MA	U.S.
Hospital inpatient	0.7%	0.7%
Hospital outpatient	4.3%	3.4%
Physician & other professional	2.9%	4.5%

- In Massachusetts in 2023, **HOPD spending exceeded physician spending** among Medicare beneficiaries. The reverse is true in the U.S. overall.
- Combined spending across the two categories is higher in Massachusetts.

Sources: HPC analysis of Centers for Medicare and Medicaid Services data, special data request.

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Increasing prescription drug spending in 2023 was primarily due to immunosuppressants, with large contributions from the hormone classes and chemotherapy.

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

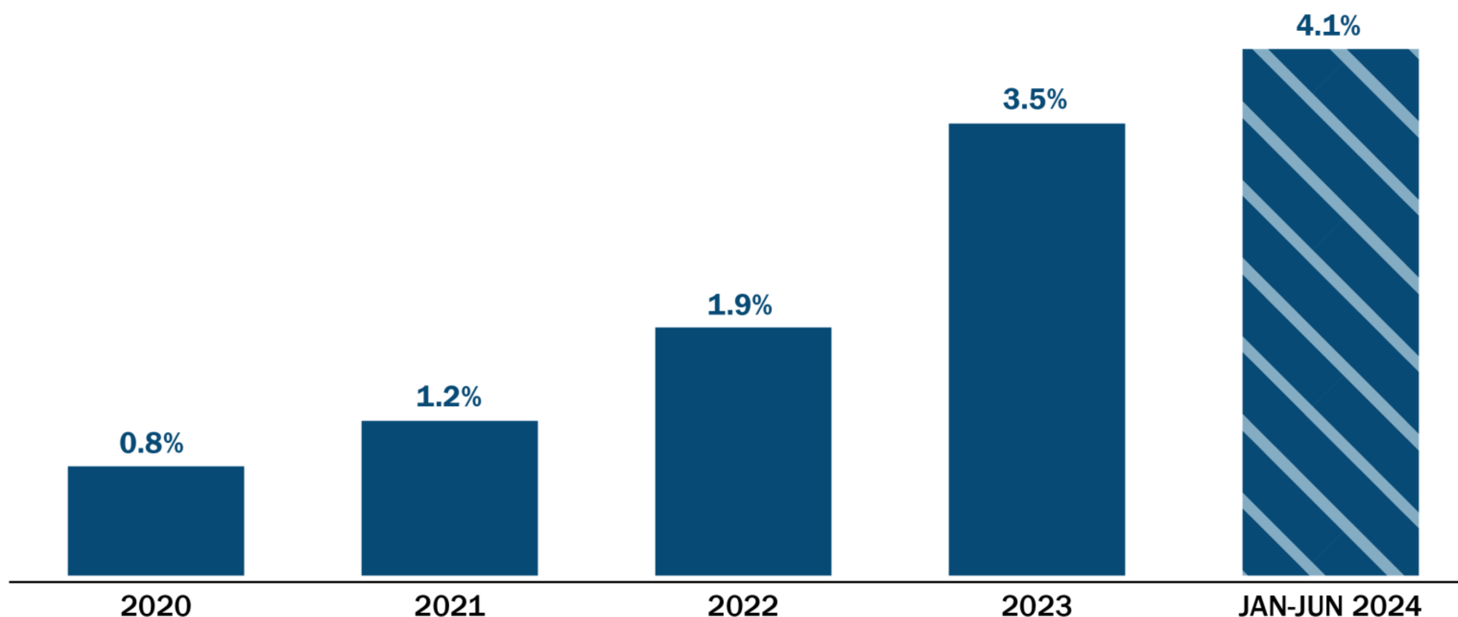
	Immunosuppressants	Hormones & synthetic substances (e.g., insulin)	Chemotherapy (i.e. antineoplastic agents)	Central nervous system agents	Anti-infective agents
2022	$472	$160	$167	$146	$89
2023	$590	$215	$203	$159	$93
Change	25.0%	34.0%	21.4%	9.2%	5.1%
SHARE OF CLAIMS IN 2023	1.3%	16.0%	0.7%	31.6%	10.1%

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/document-topic/part-d/

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

The percentage of Massachusetts residents using GLP-1 medications has grown 5-fold since 2020, from 0.8% to 4.1%.

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). Analysis for the sidebar texts includes commercially-insured members of all ages. Pharmacy spending is net of rebate.

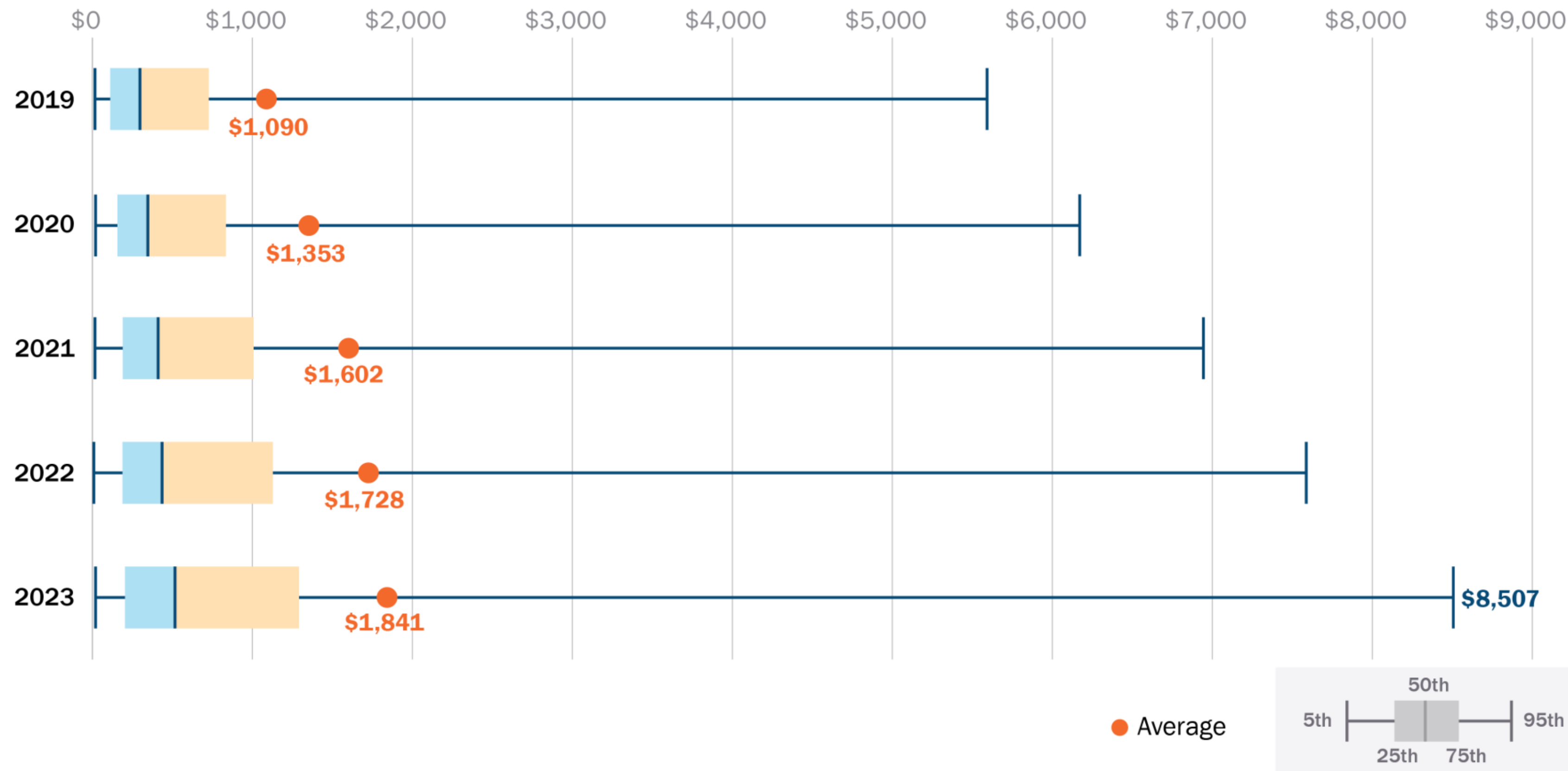
Sources: HPC analysis of Massachusetts Enhanced All-Payer Claims Database, 2020-2024 (for exhibit). HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database, V2023 2022-2023 (for sidebar statistic). CHIA Annual Report on the Performance of the Massachusetts Health Care System 2024 (for commercial spending and average commercial rebates). GLP-1 rebates were sourced from the following two publications: Hernandez I, Sullivan SD. Net prices of new antiobesity medications. Obesity. 2024 Mar;32(3):472-5. Ippolito BN, Levy JF. Estimating the cost of new treatments and diabetes and obesity. American Enterprise Institute. Sep 2023. Available at: https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208

- In 2023, **5.5% of all commercial prescription drug spending** (net of rebates) was attributable to GLP-1 medications.
- The **increase in spending for GLP-1 medications** between 2022 and 2023 added 3 percentage points to commercial prescription drug spending growth (net) and 0.6 percentage points to overall commercial spending growth.

Average commercial gross spending per prescription for branded drugs increased 69% from 2019 to 2023, with 5% of prescriptions exceeding $8,507 in 2023.

HPC

Gross spending distribution per branded prescription, 2019-2023



- **The price of generic drugs has remained stable,** with average spending of $29 per prescription in 2019 and $34 in 2023.

Notes: Claims with implausible spending values were excluded. Vaccines and non-drug items (e.g., diabetes test strips) were excluded.
Sources: HPC analysis of the Center for Health Information and Analysis All-Payer Claims database, V2023 2019-2023.

Average out of pocket spending for a 30-day supply of prescription drugs for several common chronic conditions doubled from 2021 to 2023.

Average cost sharing per prescription (30-day supply) for selected classes of drugs, 2019-2023

	2019	2020	2021	2022	2023	
Antiarthritic drugs	$115	$121	$141	$207	$287	149.2%
MS drugs	$111	$117	$124	$171	$260	133.7%
Non insulin diabetes	$59	$62	$64	$67	$66	13.3%
Insulin	$52	$54	$48	$46	$42	-18.8%

$300 $250 $200 $150 $100 $50 $0

Notes: Drugs were identified based on lists or clinical guidelines published by the Arthritis Foundation, American College of Rheumatology, American Diabetes Association, and National MS society. Clinician-administered drugs, which are typically covered under a plan's medical benefits, are excluded.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims database, V2023 2019-2023.

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Primary care spending grew about half as fast from 2019 to 2023 (13.3%) as other medical spending (23.4%), accounting for a declining share of all spending.

Growth in per member per year primary care spending relative to all other medical services, 2019 - 2023

$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0

13.3%
$479
$543
PRIMARY CARE
2019 2020 2021 2022 2023

23.4%
$4,466
$5,508
OTHER MEDICAL SERVICES
2019 2020 2021 2022 2023

X%
Total growth 2019-2023

Notes: Analysis restricted to members under age 65 and those with prescription drug coverage.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023.

Health insurer general administrative costs, which represent roughly 8% of premium costs, have been steadily increasing since 2019.

Payer non-medical expenses by category, per member per year, in the fully-insured market, 2019-2023

Category	2019	2020	2021	2022	2023
GENERAL ADMINISTRATION (29%)	$463	$484	$539	$571	$595
BROKER COMMISSIONS (6%)	$120	$120	$126	$134	$128
PROFIT/LOSS	$43	$224	-$139	$100	$124

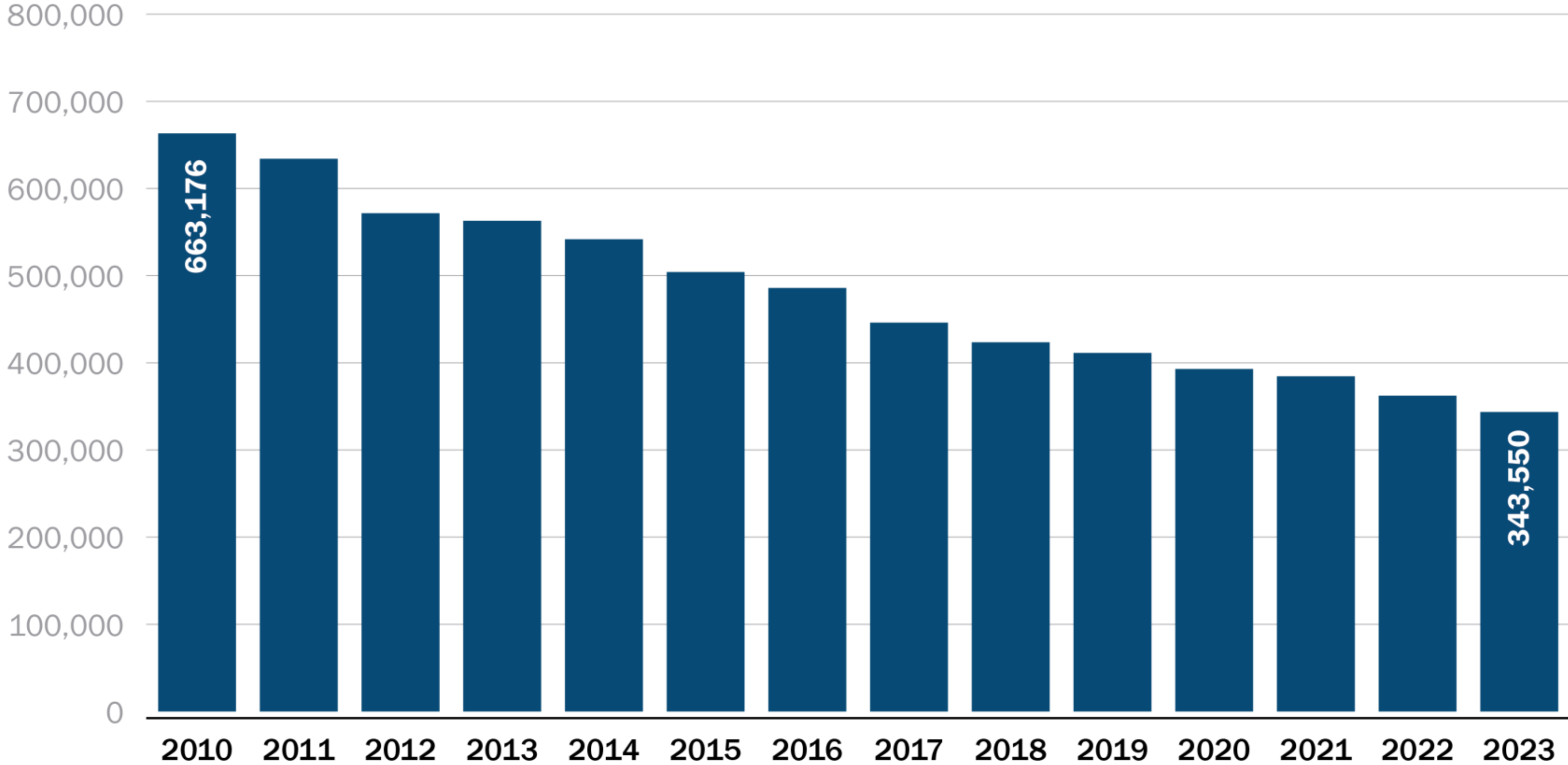
Notes: Data reflect the fully-insured market only. Exhibit does not show two other categories of non-medical expenses, which are federal and state taxes & fees and HCQI and fraud reduction expenses. Claims cost per member per year was $6,664 in 2023. Insurer administrative spending in the merged market is subject to state and federal medical loss ratio standards.

Sources: HPC analysis of Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2021-2025.

- The increase in general administration from 2022 to 2023 contributed 0.3 percentage points to premium growth.
- Administrative costs among the five largest commercial plans varied in 2023 **from $432 to $876** per member per year.

Enrollment in private health insurance through small businesses has declined by half since 2010.

Small group enrollment, employer-sponsored insurance only, 2010–2023

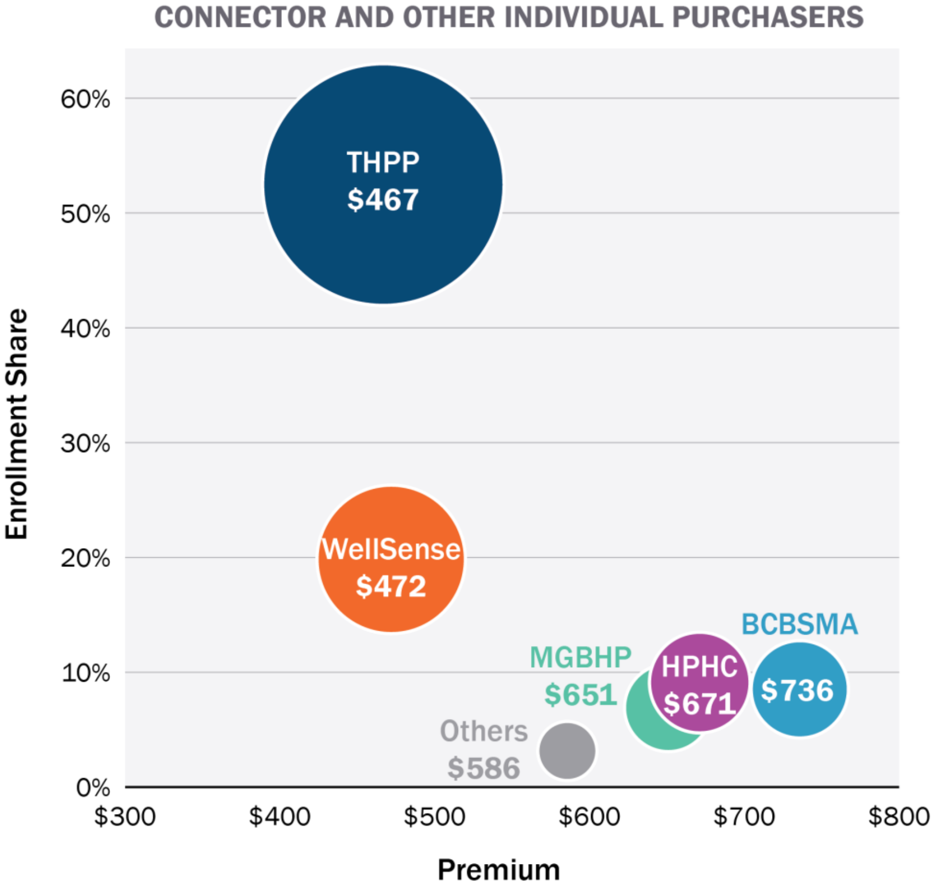


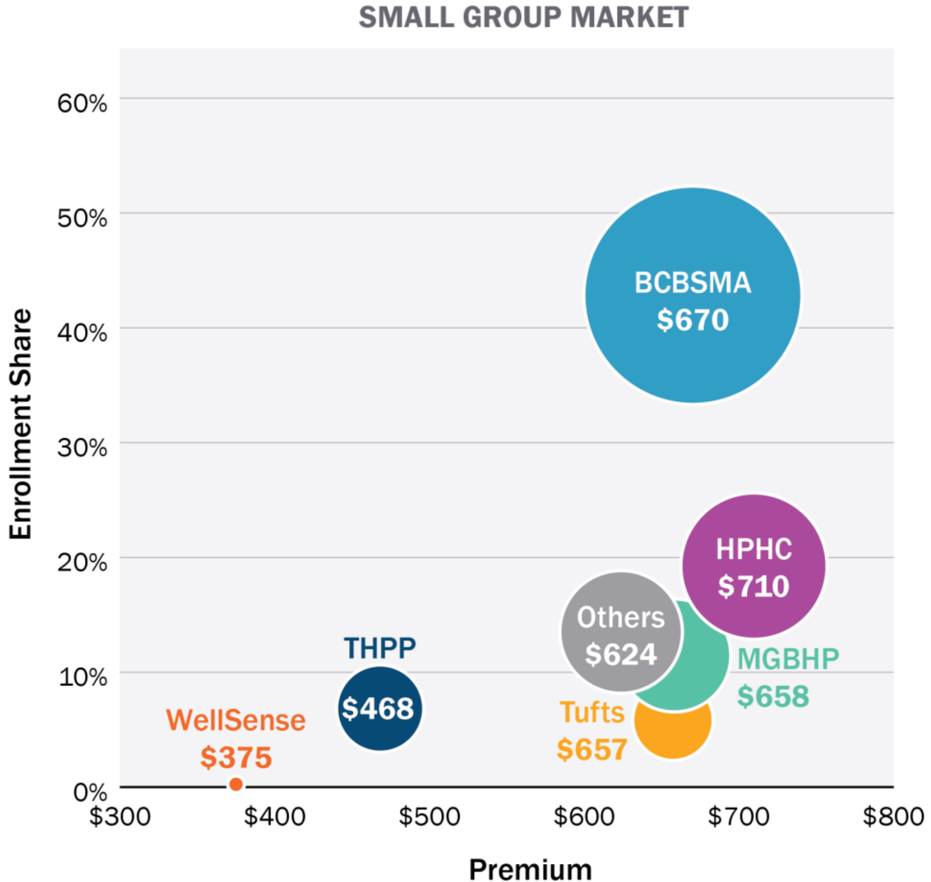
- Small group **premiums increased 7% in 2023.**
- **Cost-sharing increased 12.7%** for these **members.**
- 76.5% of members are enrolled in **high-deductible plans.**

Notes: Enrollment reflects membership in commercial carriers and health maintenance organizations.
Source: HPC's analysis of enrollment data from Massachusetts Division of Insurance, Individual/Small Group Membership Report, 2010-2023.

Most residents who obtain coverage via the Connector or individual market elect lower-cost plans, unlike the small group market where most firms only offer one plan.

Enrollment share and premium for Connector and other individual purchasers vs the small group market, 2023





Notes: Premiums are shown per member per month. Bubble size is proportional to enrollment.
Source: Data underlying the Center for Health Information and Analysis' Annual Report, 2025.

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Since the benchmark was established in 2012, growth in the cost of health insurance for families in MA has slowed significantly. However, premium growth still outpaced inflation, and employee costs grew more than twice as fast as income after 2012.

Average annual growth of various quantities in Massachusetts from 2000-2012 and 2012-2023.

	2000-2012	2012-2023
Family premium	7.3%	4.0%
Employee contribution	9.6%	4.8%
Employer contribution	6.6%	3.7%
CPI	2.5%	2.5%
Median household income	2.7%	3.9%
Per capita GDP	3.2%	4.2%

Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, American Community Survey, and Bureau of Labor Statistics

Growth in health insurance premiums has exceeded growth in key state economic indicators from 2010 to 2023.

Cumulative growth since 2010 of various health care and economic indicators in Massachusetts

80%
70%
60%
50%
40%
30%
20%
10%
0%
-10%

2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

78.7% Employee contribution
69.5% Family premium
66.3% Employer contribution
65.9% Per capita GDP
54.5% Median household income
35.9% CPI

Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, American Community Survey, and Bureau of Labor Statistics

Since 2019, commercial health care spending, premiums, and out of pocket costs have exceeded input costs and income growth, particular for residents with lower income.

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

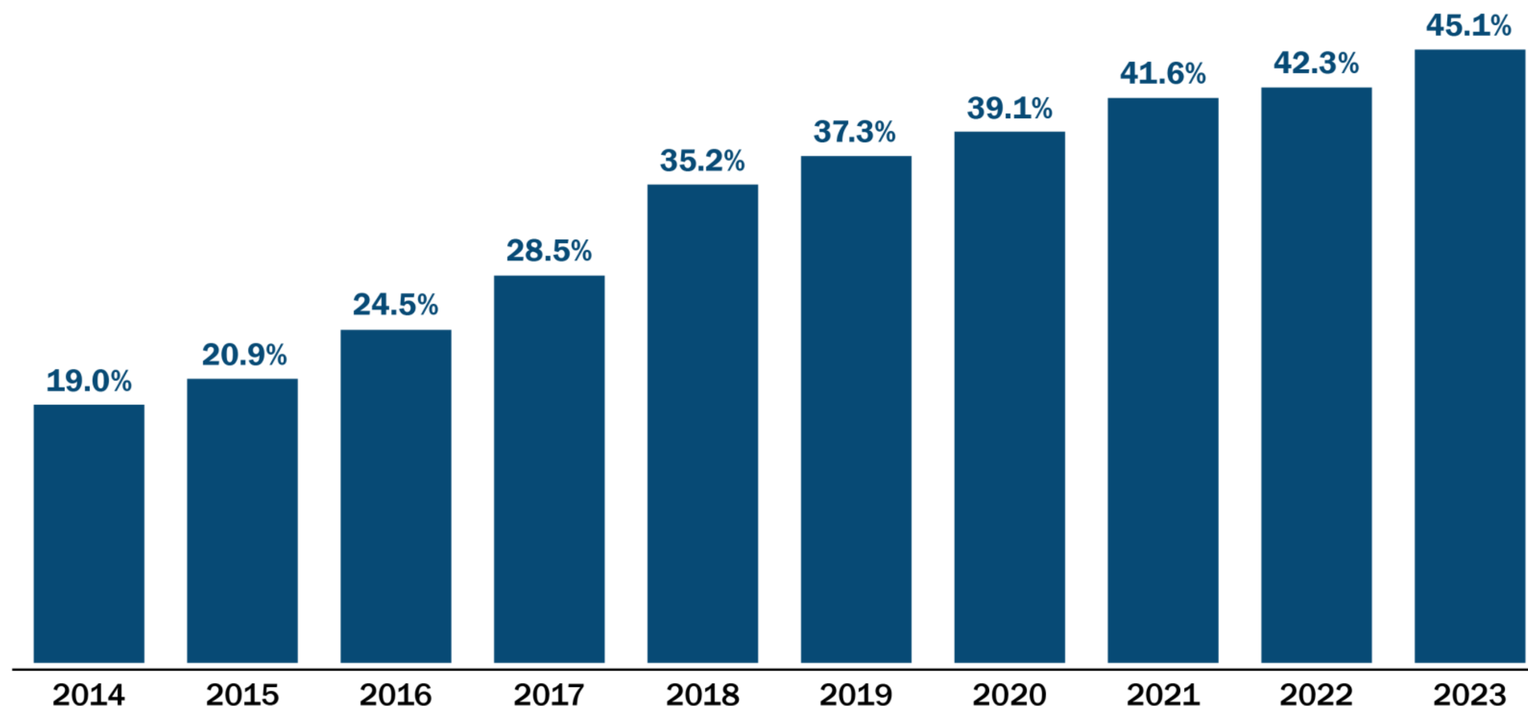
Category	Measure	2022-2023	2019-2023, average annual growth
HEALTH CARE SPENDING	Commercial health care spending	7.8%	6.1%
HEALTH CARE SPENDING	Fully insured premiums	6.0%	5.1%
INPUT COSTS	Labor costs	4.2%	3.9%
INPUT COSTS	Overall CPI	3.7%	3.8%
INCOME	Median household income	5.1%	3.9%
INCOME	40th percentile income	3.7%	2.7%

Sources: Commercial spending 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.

- The burden of rising health care costs is **not felt equally among residents.**
- Income among those at the 95th percentile rose **more than twice as fast** as those at the 40th percentile.
- **Income inequality has worsened in Massachusetts,** which ranked 48th (third greatest inequality) in the nation in 2023.

The percentage of commercially-insured Massachusetts residents enrolled in high-deductible plans increased from 19% to 45% from 2014 to 2023.

Percentage of Massachusetts commercial enrollees with a high-deductible health plan, 2014-2023

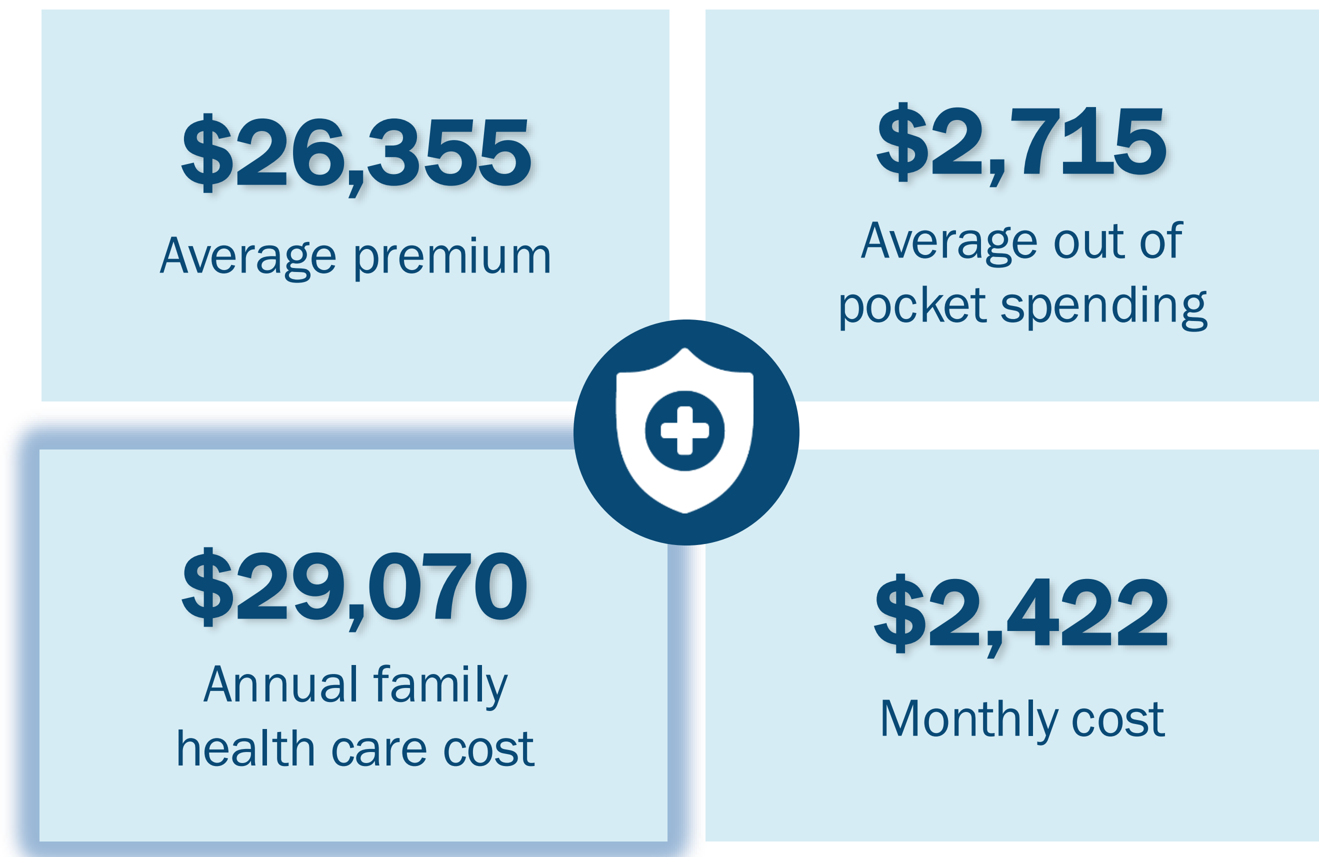


- The average deductible for a family plan rose from **$2,377 in 2014 to $3,128 in 2023.**
- State-conducted survey data from CHIA shows that those with high-deductible plans are **more likely to report having medical debt** (19.5% vs. 11.6%)[1].

1.https://www.chiamass.gov/assets/docs/r/pubs/2021/Inside-Look-High-Deductible-Plans.pdf

Notes: High-deductible plans are defined federally as a plan having a single/family deductible of $1,250/$2,500 in 2013-2014; $1,300/$2,600 in 2015-2017; $1,350/$2,700 in 2018-2019, $1,400/$2,800 for 2020-2022 and $1500/$3,000 for 2023. GIC plans do not allow high deductibles.
Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2016-2025.

Including out of pocket spending, the average cost of health care for a Massachusetts family exceeded $29,000 in 2023.



Family premiums grew an additional 7% nationally in 2024

Notes: Cost sharing amount based on data on cost sharing relative to premium payments in from CHIA's Annual Report, 2024. Source: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey-Insurance Component and Center for Health Information and Analysis, Annual Report, 2024; Kaiser Family Foundation/HRET Annual employer health benefits survey.

High health care costs contribute to a cost of living that exceeds median income for middle class families across Massachusetts.

Cost of living expenses and income for a two-parent, two-child family in two Massachusetts counties, 2024

$180,000
$150,000
$120,000
$90,000
$60,000
$30,000
$0

Health care
Taxes
Childcare
Other necessities
Transportation
Food
Housing

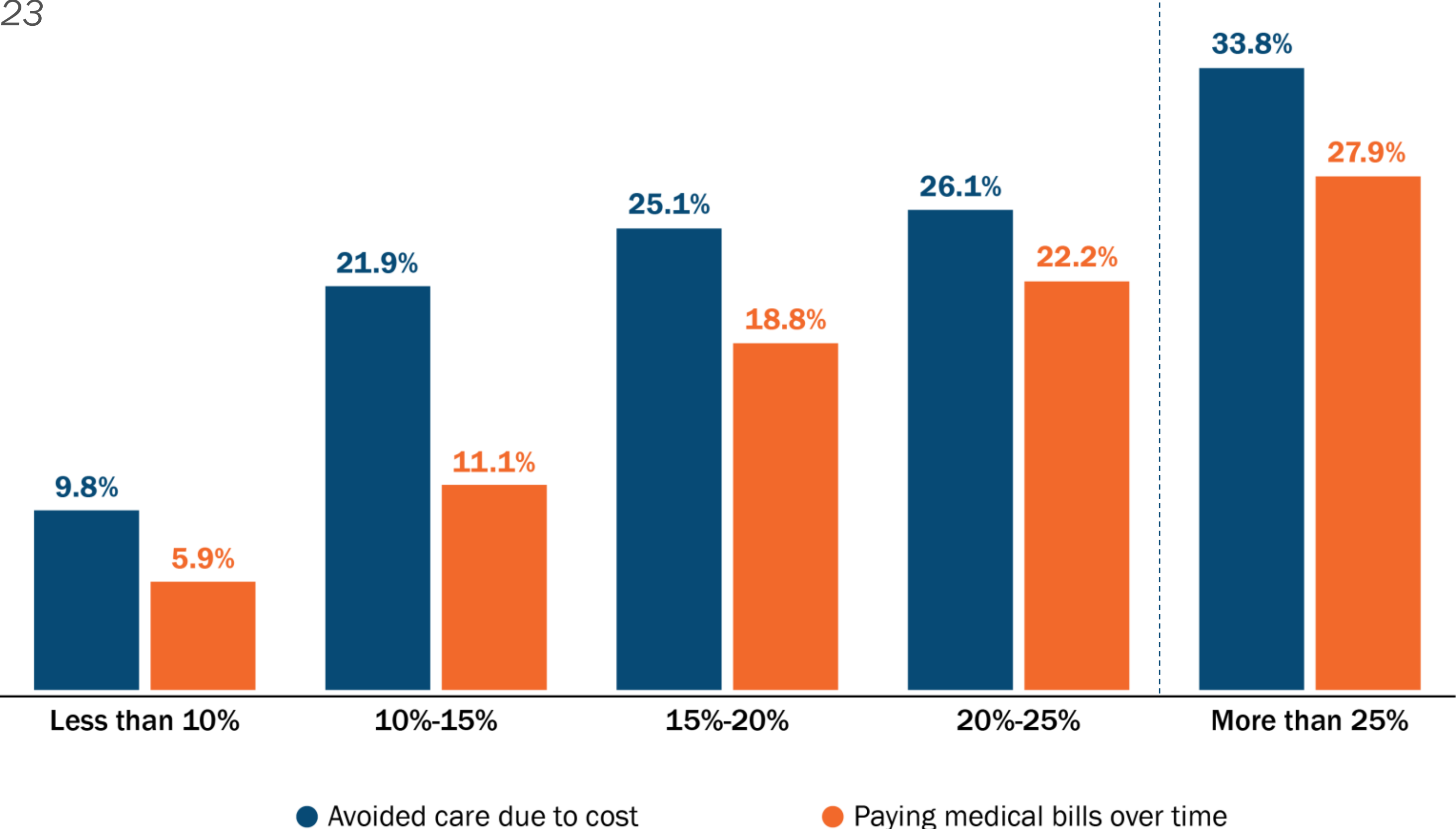
SUFFOLK COUNTY
Cost of living
Median income

WORCESTER COUNTY
Cost of living
Median income

Notes: Budget data in 2024 dollars. Data based on a two-parent, two-child family. Health care costs reflect average family premiums and out of pocket spending for Massachusetts families with employer-sponsored coverage. Employer contribution to health care premium is included in income.
Source: HPC's analysis of Economic Policy Institute Family Budget Calculator, January 2025 and AHRQ Medical Expenditure Panel Survey, Insurance Component, 2023.

Care avoidance and medical debt increase as health care consumes a larger portion of income – particularly once health care exceeds 25% of income.

Percentage of surveyed respondents indicating each health care affordability issue by health care share of income, 2023

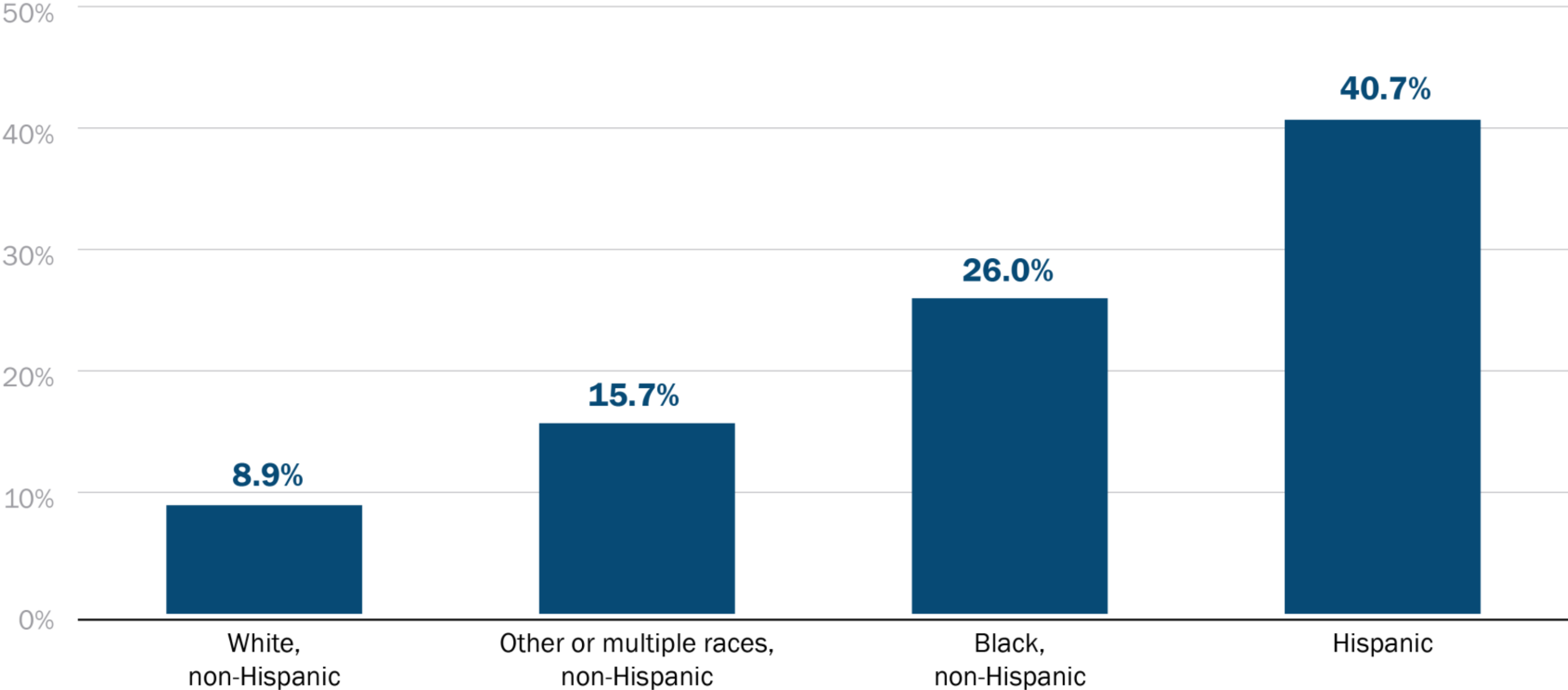


- A 25% health care share of income reflects a typical Massachusetts household with employer-based family coverage and $80,000 in household income.
- Those with a health care share above 25% were also **more likely to report an avoidable ED visit** (56% vs 33%), which may be related to putting off needed care.

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. 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.

Hispanic families with private coverage were far more likely to contribute more than a quarter of their total income to health care.

Percent of residents with private coverage and with a health care share of income over 25% by race/ethnicity, 2023



- By region, the proportion of residents with a health care share of income above 25% was highest in Western MA (32%) the Cape and Islands (20%), and Metro Boston (18%).

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. 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.

If commercial spending continues to grow at the current rate, an average family would see a reduction in take-home pay of more than $600 per month by 2030.

Projected monthly take-home pay after taxes and health care costs for an average Massachusetts household with employer-based coverage and 3.6% annual growth in total compensation from their employer under two scenarios of premium growth.

	2022	2023	2024	2025	2026	2027	2028	2029	2030
7% premium growth, 2024-2030	$5,294	$5,540	$5,686	$5,833	$5,981	$6,131	$6,281	$6,432	$6,583
3.6% premium growth, 2024-2030	$5,294	$5,618	$5,821	$6,030	$6,247	$6,472	$6,705	$6,947	$7,197

$614 per month

Notes: This analysis assumes out of pocket spending also grows at the rate of premium growth shown. 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).

Chapters 342 and 343 of the Acts of 2024 were signed into law on January 8, 2025.

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An Act relative to pharmaceutical access, costs, and transparency

- Improves state oversight of the pharmaceutical industry, including pharmacy benefit managers (PBMs)
- Caps out-of-pocket costs for drugs to treat asthma, diabetes, and certain common heart conditions

An Act enhancing the market review process

- Strengthens state oversight of private equity investment in health care
- Requires statewide health planning with increased data collection and agency coordination

Key Legislative Components

HPC

HPC BOARD MEMBERSHIP AND APPOINTMENT CHANGES

STRENGTHENS MARKET OVERSIGHT AUTHORITY

REVITALIZES STATE HEALTH PLANNING

CREATES PHARMACEUTICAL OVERSIGHT

ENHANCED INTERAGENCY COORDINATION

ESTABLISHES INTERAGENCY PRIMARY CARE TASK FORCE

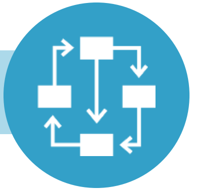
Provisions of Chapters 342 and 343 of the Acts of 2024 have expanded Massachusetts' oversight of health care and pharmaceutical spending.

HPC

Office of Pharmaceutical Policy and Analysis

A new HPC Office of Pharmaceutical Policy and Analysis (OPPA) will be established to **collect and analyze pharmaceutical spending data**, produce reports and analyses of pharmaceutical costs and access, and issue recommendations on prescription drug policy.

Pharmacy Benefit Manager Licensure



The Division of Insurance (DOI) is authorized to **regulate and license pharmacy benefit managers** (PBMs) operating in Massachusetts on a three-year cycle, increasing oversight of the industry and collection of ownership and spending data.

Prescription Drug Co-Pay Caps

Fully-insured, MassHealth, and Group Insurance Commission health plans will be required to **cap out-of-pocket costs** for drugs identified to treat asthma, diabetes, and prevalent heart conditions.

DOI Affordability Standards

DOI will be required to **consider affordability to consumers and purchasers** of health insurance in the division's examination of rates submitted for approval by insurers.

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2026

HEALTH CARE COST GROWTH BENCHMARK