MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

June 5, 2025

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

Recognition of HPC Board Members

Implementation Updates: Chapters 342 and 343 of the Acts of 2024

2025 Health Care Cost Trends Report Preview: Improving Affordability and Predictability in Cost Sharing

Market Transaction Reviews

Moving Massachusetts Upstream (MassUP) Investment Program: Final Report

Executive Director's Report

Next HPC Board Meeting: July 24, 2025

Adjourn

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

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Adjourn

VOTE

Approval of Minutes from April 17, 2025, Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on **April 17, 2025**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

RECOGNITION OF HPC BOARD MEMBERS

Implementation Updates: Chapters 342 and 343 of the Acts of 2024

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Adjourn

Recognition of Dr. David Cutler

- With appreciation for **over 12 years of service** to the Commonwealth, the HPC recognizes **Dr. David Cutler**.
- Commissioner Cutler was originally appointed by Attorney General Martha Coakley in 2012 and reappointed by then-Attorney General Maura Healey.
- Dr. Cutler is **the longest serving commissioner on the HPC Board** and has held the seat reserved for a health economist since the founding of the HPC.
- HPC staff and commissioners past and present express their sincere **gratitude for Dr. Cutler's countless contributions** to the work and mission of the HPC.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Recognition of HPC Board Members

IMPLEMENTATION UPDATES: CHAPTERS 342 AND 343 OF THE ACTS OF 2024

- New Office of Pharmaceutical Policy and Analysis
- New Office of Health Resource Planning

2025 Health Care Cost Trends Report Preview: Improving Affordability and Predictability in Cost Sharing

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Adjourn

Key Legislative Components

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

Recently enacted legislation provides new tools to address health care cost growth and promote affordability.

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
- **Establishes the Office of Pharmaceutical Policy and Analysis at the Health Policy Commission.**

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
- **Establishes the Office of Health Resource Planning at the Health Policy Commission.**

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Recognition of HPC Board Members

Implementation Updates: Chapters 342 and 343 of the Acts of 2024

NEW OFFICE OF PHARMACEUTICAL POLICY AND ANALYSIS

- New Office of Health Resource Planning

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New Office of Pharmaceutical Policy and Analysis

Chapter 342 of the Acts of 2024 establishes a new **Office of Pharmaceutical Policy and Analysis (OPPA)** within the HPC.

OPPA's key responsibilities include:

- **Collecting and analyzing pharmaceutical spending data** and information to examine pharmaceutical costs and access and issue recommendations on matters related to prescription drug policy;
- Publishing an **annual report** on trends related to access, affordability, and spending on pharmaceutical drugs in the Commonwealth addressing the **underlying drivers of pharmaceutical drug spending**; and
- Conducting an annual payer survey on **pharmaceutical access and plan design**, including tiering, cost-sharing, and utilization management techniques.

OPPA will also manage the HPC's **review of high-cost drugs referred by MassHealth** following failed negotiations with drug manufacturers.

Matthew Frank, Director of the Office of Pharmaceutical Policy and Analysis

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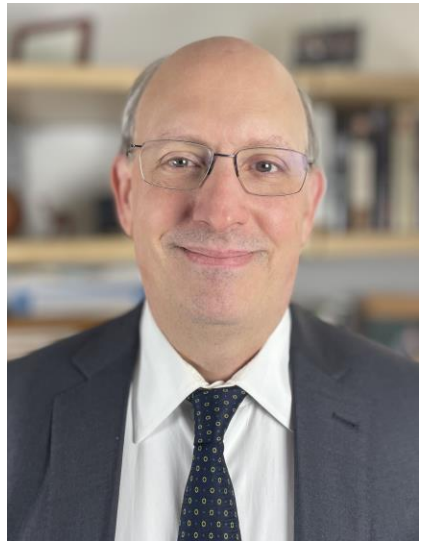

HPC » **Offices and Task Forces** » Office of Pharmaceutical Policy and Analysis

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Resources and Related Work

Office of Pharmaceutical Policy and Analysis

Overview

The Office of Pharmaceutical Policy and Analysis (OPPA) was established with the goal of conducting nation-leading research and developing key policy recommendations related to pharmaceutical drug access and affordability, serving as the hub of expertise on pharmaceutical drug policy for the Commonwealth.

The main functions of OPPA are to collect and analyze pharmaceutical spending data and information, develop and share reports and cutting-edge analyses of trends related to access, affordability, and spending on pharmaceutical drugs in the Commonwealth, and issue recommendations on pivotal matters related to pharmaceutical policy.

Resources and Related Work

- Establishing Statute: **Chapter 342 of the Acts of 2024**
- **DataPoints Issue #11: Insulin Price Growth and Patient Out-of-Pocket Spending**, 2019
- **DataPoints Issue #12: Cracking Open the Black Box of Pharmacy Benefit Managers**, 2019
- **Review of Third-Party Specialty Pharmacy Use for Clinician-Administered Drugs**, 2019
- **Prescription Drug Coupon Study: Report to the Massachusetts Legislature**, 2020
- **DataPoints Issue #27: Blockbuster GLP-1 Weight-Loss Drugs in Massachusetts**, 2024

https://masshpc.gov/offices-and-task-forces/oppa

New DataPoints Issue #29: Polypharmacy Trends in Massachusetts

- Pharmaceutical spending has been a major driver of health care spending growth in recent years, contributing to affordability challenges among Massachusetts residents.
- A new DataPoints issue explores **polypharmacy, or the concurrent use of five or more prescription medications,** among commercially-insured Massachusetts adults.
- The HPC found that the rate of polypharmacy is growing in Massachusetts, mirroring national trends; in 2022, **over one-in-ten of adults (11.2%) with any prescription drug use experienced polypharmacy** (+5 prescriptions).
- Polypharmacy is most common among older adults and individuals with chronic conditions.
- These trends present opportunities for providers and payers to **ensure adequate medication management and coordination**.

tinyurl.com/HPC-datapoints-29

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Recognition of HPC Board Members

Implementation Updates: Chapters 342 and 343 of the Acts of 2024

- New Office of Pharmaceutical Policy and Analysis

NEW OFFICE OF HEALTH RESOURCE PLANNING

2025 Health Care Cost Trends Report Preview: Improving Affordability and Predictability in Cost Sharing

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Adjourn

Kara Vidal, Director of the Office of Health Resource Planning

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https://masshpc.gov/offices-and-task-forces/ohrp

HPC » **Offices and Task Forces** » Office of Health Resource Planning

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Office of Health Resource Planning

Overview

The Office of Health Resource Planning (OHRP) was established with the goal of identifying and addressing service gaps and challenges in the Massachusetts health care system while fostering patient-centered care.

As the entity leading the first Massachusetts state health planning effort in over a decade, the OHRP applies rigorous data collection and analytic techniques to evaluate health care resource access and needs. OHRP investigates and reports on the factors that drive the misalignment of supply and need and makes policy recommendations to promote the appropriate supply and equitable distribution of services.

The OHRP is responsible for developing a **state health resource plan** to identify existing resources and the anticipated needs of the Commonwealth related to health care services, providers, programs, facilities, and workforce. Among the stated goals of the plan are maintaining and improving the quality of and access to health care services; ensuring a stable and adequate health care workforce; meeting the health care cost growth benchmark; supporting innovative health care delivery and alternative payment models; avoiding unnecessary duplication of health care resources; and advancing health equity and addressing health disparities.

Resources and Related Work

- Establishing Statute: **Chapter 343 of the Acts of 2024**

Massachusetts is a well-resourced state, but the health care landscape is changing rapidly, with the potential for significant impacts on patient access.

- Massachusetts ranks highly in **health care resources per capita** in many categories, including primary care physicians, specialists, behavioral health clinicians, psychiatric hospital beds, and total hospital beds. However:
  - **Resource distribution across the state is variable**
  - **Proximity to health care resources does not guarantee access** to those resources
- Additionally, Massachusetts has experienced **several recent, significant changes in its healthcare resources**:
  - The bankruptcy of Steward Health Care and the closures of Carney Hospital and Nashoba Valley Medical Center
  - Expansion of inpatient services at several hospitals and the impending construction of a new oncology hospital
  - A severely strained primary care landscape
  - Unexpected closures of North Adams Regional Hospital, Quincy Medical Center, Norwood Hospital, and (temporarily) Signature Brockton Hospital, and Compass Medical Group
  - A series of pediatric, behavioral health, and labor and delivery hospital unit closures
  - Increasing hospital length of stay, leading to hospital and ED capacity constraints
- **The Commonwealth has tools to track and, in some cases, address changes.** e.g., through facility licensure, determination of need, material change notice, and essential service closure authorities. However, these authorities are narrow in scope and often focused on a specific change.
- These ongoing, rapid changes to the MA healthcare landscape raise questions as to how overall supply and distribution of services is changing, and whether MA residents have **equitable access to affordable, high-quality healthcare**.

New Office of Health Resource Planning

Chapter 343 of the Acts of 2024 establishes a new **Office of Health Resource Planning (OHRP)** within the HPC.

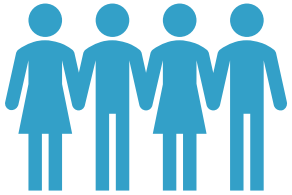
OHRP's key responsibilities and authorities include:

- Developing a **State Health Resource Plan.**
- Conducting **focused assessments of supply, distribution, and capacity** in relation to projected need of a specific health care service and making recommendations to address the drivers of disparities and misalignment of need.
- Conducting at least 1 **annual public hearing** seeking input on the development of the plan and any focused assessment under development.

OHRP will also manage the **Massachusetts Registration of Provider Organizations (MA-RPO) Program**, a data collection and transparency effort that collects data on the largest provider organizations in the Commonwealth.

State Health Resource Plan Overview

The goal of the **State Health Resource Plan** is to promote the **appropriate and equitable distribution of health care resources** across geographic regions of the commonwealth. The plan must identify:



The anticipated needs for health care services, providers, programs, and facilities

The existing health care resources, providers, programs, and facilities available to meet those needs

The projected resources necessary to meet those anticipated needs

Recommendations for the appropriate supply and distribution of resources, on a statewide and regional basis

Recommendations for any further legislative or regulatory state action

Chapter 343 lays out how the plan should support the Commonwealth's goals.

- Maintaining and improving the **quality of and access to** health care services;
- Ensuring a stable and adequate **health care workforce**;
- Meeting the **health care cost growth benchmark** established pursuant to section 9;
- Supporting **innovative health care delivery and alternative payment models** as identified by the commission;
- Avoiding **unnecessary duplication** of health care resources;
- Advancing **health equity** and addressing **health disparities**;
- Integrating **oral health, mental health, behavioral health and substance use disorder** treatment services with overall medical care;
- Aligning **housing, health care, and home care** to improve overall health outcomes and reduce costs;
- Tracking trends in utilization and promoting the **best standards of care**; and
- Ensuring **equitable access** to health care resources across geographic regions of the Commonwealth.

Health Care Resource Planning is a Marathon

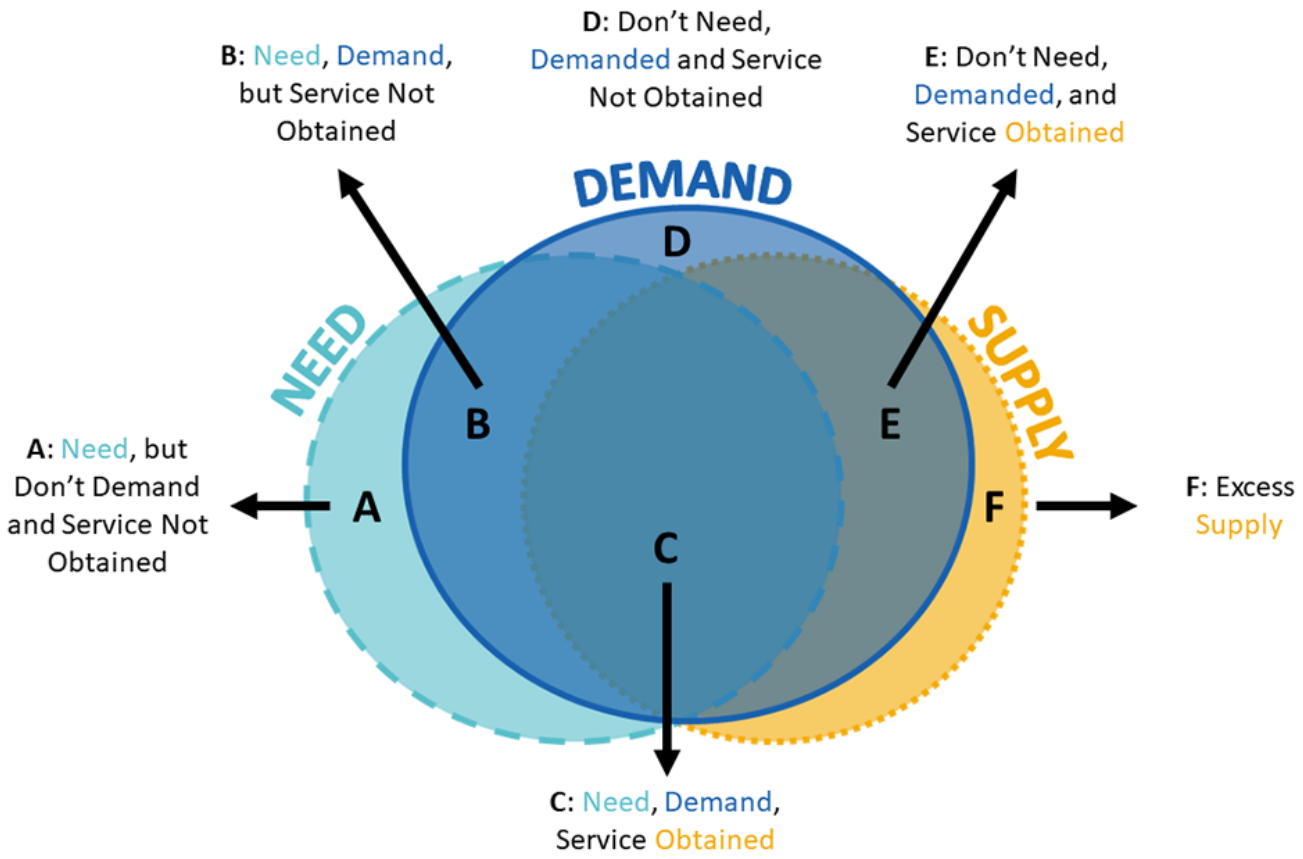


Figure: Gaetano Forte, MS Why Health Workforce Projections are Worth Doing. Association of American Medical Colleges. 2023. Available at: https://www.aamcresearchinstitute.org/our-work/issue-brief/why-health-workforce-projections-are-worth-doing. Figure originally adapted from Figure 2 in Safarishahrbijari A. *Workforce forecasting models: a systematic review.* J Forecast. 37(7): 739-753.

- Developing **robust methodologies** for measuring health care resource need and capacity is a complex, time-intensive process, with many interrelated and confounding factors.
- **Supply**: In addition to facility, technology and workforce counts, planners need information on total capacity and percent of capacity currently in use.
- **Need**: Planners may use methods to adjust utilization rates for potential overuse or underuse of services.
- **Access**: Planners may consider how access barriers beyond geographic proximity impact findings.
- **Projections**: Only once baseline need and capacity are well measured can credible future projections be attempted.

OHRP's Focus Areas for 2025 and 2026

Strategic Planning

- Defining goals and workplans
- Building out staff capacity
- Procuring expert consultants
- Reaching out to experts and other states engaged in health planning activities (e.g., CT, RI)
- Planning for stakeholder and community engagement

Health Planning

- Evaluating methodologies for assessing and projecting need
- Developing the scope of first 5-year State Health Resource Plan, due 1/1/2027
- Providing analytics for Massachusetts' Maternal Health Access Task Force
- Considering priority service lines for any focused assessments

Data Planning

- Compiling key data sources
- Identifying data gaps
- Developing approaches to fill data gaps
- Preparation for 2025 MA-RPO data collection
- Advising DPH on Health Care Resource Inventory development

Maternal Health Focus Area

The HPC and DPH are co-chairing the **Maternal Health Access and Birthing Patient Safety Task Force**, which will study:

- Past **essential services closures** for inpatient maternity units and acute-level birthing centers;
- **Closures of community-based, office-based and preventative maternal health care**, including family planning services, obstetrics and gynecology services and midwifery services;
- Patient **quality and safety considerations** of essential service closures of maternal care units; and
- **Demographic information** on patient populations whose access has been most affected by past closures of or current limitations on the availability of maternal care services.

OHRP is contributing to the task force's analytic work.

MA-RPO Program – 2025 Filing Updates

Chapter 343 of the Acts of 2024 made several updates to the MA-RPO program that increase state oversight of **private equity in health care** and support the Commonwealth's **health planning** efforts. In response to these statutory changes, the MA-RPO program is updating the reporting requirements for the 2025 data collection cycle.

Guidance

- The MA-RPO Program is releasing Guidance regarding:
  - **Changes to the registration threshold**, which was changed from $25 million in commercial, Medicare Advantage, and MMCO net patient service revenue (NPSR) to $25 million in NPSR from all payers; and
  - **Expansion of the provider types required to register.** Current registrants include hospital systems, physician groups and behavioral health providers.
- Beginning in 2025, registration will be required for other **non-acute hospitals, urgent care centers, ambulatory surgery centers, freestanding imaging facilities, and clinical laboratories** with more than $25 million in NPSR.
- The Guidance will be posted on the HPC's website and a link will be emailed to the HPC listserv.
- The HPC anticipates updating the RPO regulation (958 CMR 6.00, *Registration of provider organizations)* to fully implement the new requirements later this year.

MA-RPO Program – 2025 Filing Updates

Chapter 343 of the Acts of 2024 made several updates to the MA-RPO program that increase state oversight of **private equity in health care** and support the Commonwealth's **health planning** efforts. In response to these statutory changes, the MA-RPO program is updating the reporting requirements for the 2025 data collection cycle.

Public Comment

- The MA-RPO Program is also releasing **draft updates to the 2025 reporting specifications** for public comment. The proposed requirements add information on:
  - Provider organizations' relationships with **significant equity investors** (SEI), **health care real estate investment trusts** (REIT), and **management services organizations** (MSO).
  - **Advanced Practice Providers (APP)** and **behavioral health clinicians** employed by the provider organization.
- The draft requirements will be available on the HPC's website and circulated to current registrants shortly. Comments may be submitted via email to HPC-RPO@mass.gov.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Recognition of HPC Board Members

Implementation Updates: Chapters 342 and 343 of the Acts of 2024

2025 HEALTH CARE COST TRENDS REPORT PREVIEW: IMPROVING AFFORDABILITY AND PREDICTABILITY IN COST SHARING

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2025 Health Care Cost Trends Report: Outline and Today's Presentation

- **Massachusetts Spending Performance and Affordability of Care** *Findings presented at the Benchmark Hearing on March 13, 2025*
- **Focus on Affordability: Improving Affordability and Predictability in Cost Sharing** *Findings presented at the HPC Board meeting on June 5, 2025*
- **Chartpacks**
  - Primary Care and Behavioral Health
  - Price Trends and Variation
  - Hospital Utilization
  - Post-Acute Care
  - Provider Organization Performance Variation
- **Performance Dashboard**
- **Policy Recommendations**

2025 Health Care Cost Trends Report: Focus on Affordability

This preview from the HPC's 2025 Health Care Cost Trends Report examines patient cost sharing in Massachusetts, focusing on opportunities to improve benefit design to address **affordability** and **access**.

Two primary topics:

- Improving cost sharing benefit design
- Prevalence of cost sharing for ACA preventive services

Outline

I. Trends in Cost Sharing and Opportunities to Improve Benefit Design

Background

Trends in Cost Sharing

- Overall
- By Category of Service

Spotlight on Key Settings of Care

Policy Considerations

II. Cost Sharing for Preventive Services

Outline

I. Trends in Cost Sharing and Opportunities to Improve Benefit Design

Background

Trends in Cost Sharing

- Overall
- By Category of Service

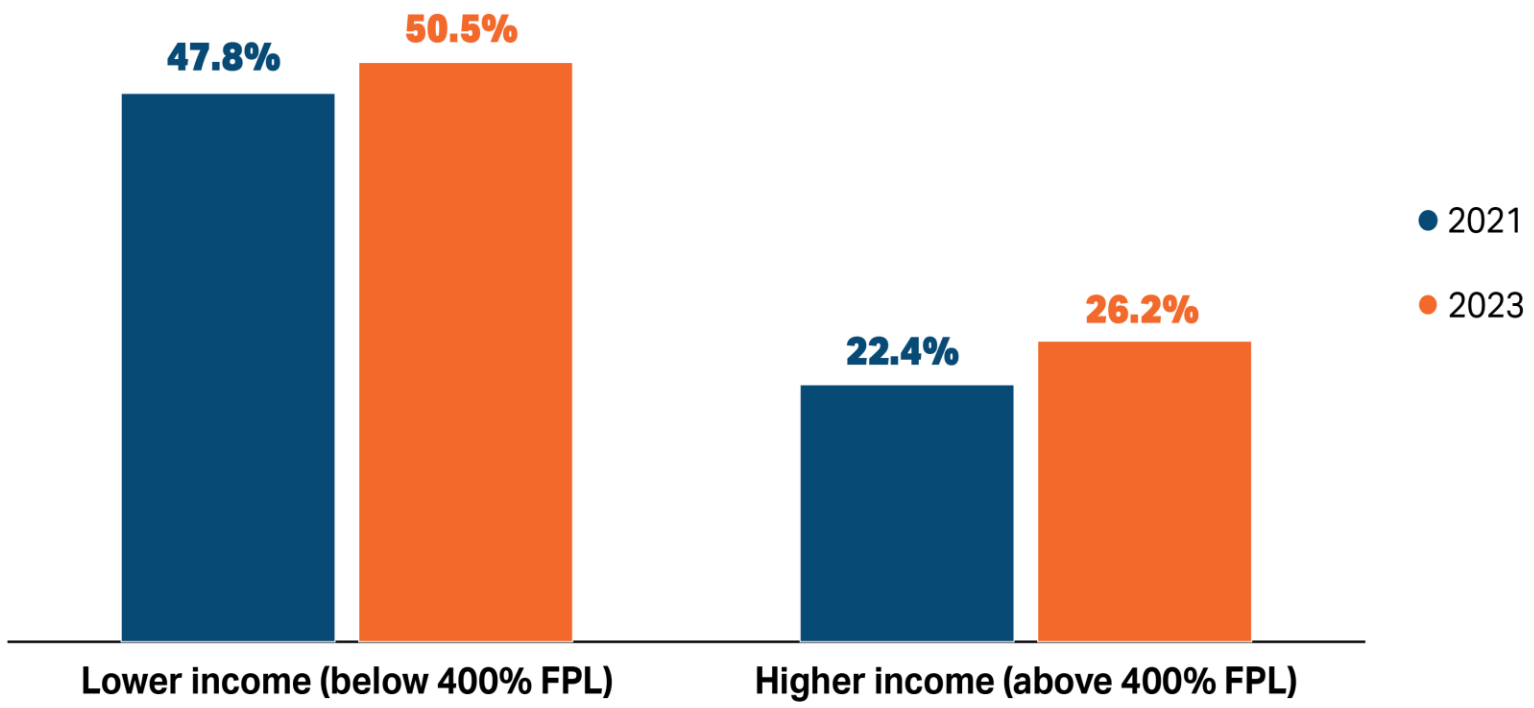
Spotlight on Key Settings of Care

Policy Considerations

II. Cost Sharing for Preventive Services

Health care affordability challenges are increasing for all Massachusetts residents.

Percentage of residents with employer-sponsored coverage and with any of four affordability issues noted in the sidebar, 2021 and 2023



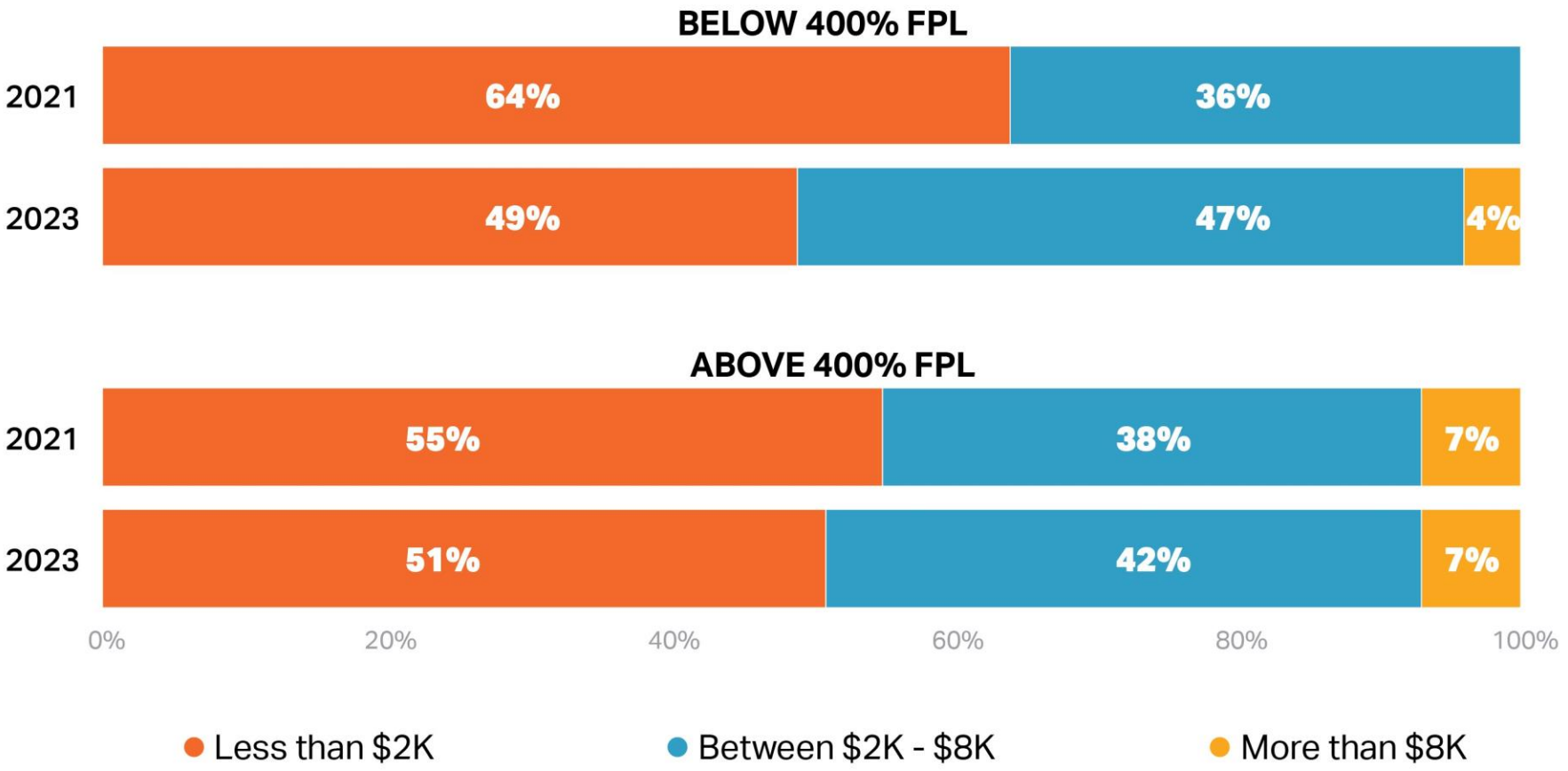
An affordability issue is defined as any of the following:

- High share of income spent out-of-pocket on health care.
- Any unmet need for care due to cost.
- Problems paying medical bills.
- Any medical debt.

Notes: Massachusetts residents on employer sponsored insurance with continuous coverage in the previous twelve months only. Children and Seniors were excluded.
Federal poverty level is based on the median income of the resident's zip code.
Sources: HPC analysis of Massachusetts Center for Health Information and Analysis 2021 and 2023 Massachusetts Health Insurance Surveys.

Reflecting these affordability challenges, medical debt among commercially-insured Massachusetts residents is also increasing.

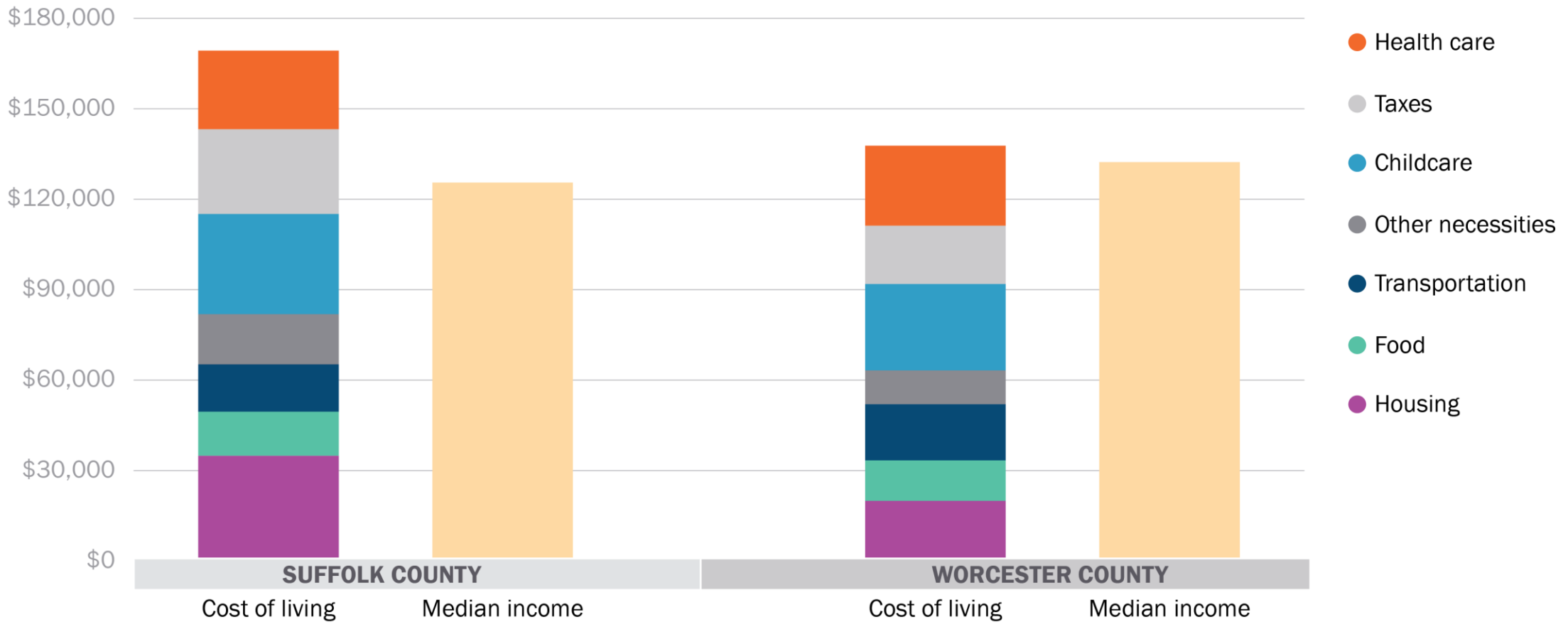
Total amount of outstanding medical debt among those paying off medical bills over time for residents with private coverage, 2021 and 2023



Notes: Massachusetts residents on employer sponsored insurance with continuous coverage in the previous twelve months only. Children and seniors were excluded. Federal poverty level is based on the median income of the resident's zip code.
Sources: HPC analysis of Massachusetts Center for Health Information and Analysis, 2021 and 2023 Massachusetts Health Insurance Surveys.

This health care affordability crisis contributes to a cost of living that exceeds the 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



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.
Sources: HPC's analysis of Economic Policy Institute Family Budget Calculator, January 2025 and AHRQ Medical Expenditure Panel Survey, Insurance Component, 2023.

Policy Background: Opportunities for Improving Cost Sharing

Massachusetts policymakers have sought to address the **high and growing burden of out-of-pocket heath care spending** ("cost sharing") 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 (~4.8%), starting in January 2026.[1]
- 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.[2]

Efforts to constrain or reduce health care cost sharing should be **paired with policy reforms to address the underlying drivers of health care spending to ensure premiums do not increase** and to improve health care affordability overall.

In addition to efforts to reduce total cost sharing dollars, **improving cost sharing benefit design to increase predictability and minimize financial risk** of cost sharing is an important complement to these policy efforts.

1. Governor Healey and Lt. Governor Kim Driscoll. Healey-Driscoll Administration limits deductibles and co-pays to control health costs for patients. Press release. May 15, 2025. Available at: https://www.mass.gov/news/healey-driscoll-administration-limits-deductibles-and-co-pays-to-control-health-costs-for-patients
2. See DOI filing guidance 2025-J. March 12, 2025.

Shifting health care premium costs to patients through cost sharing has been a key feature of health insurance design in the U.S.

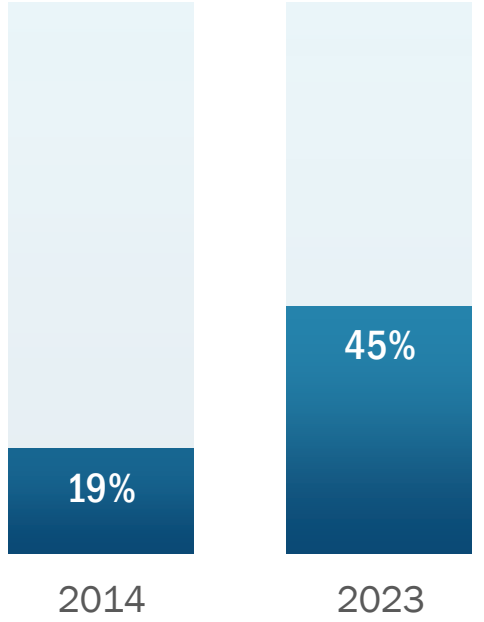
- Cost sharing refers to the **portion of health care costs that a patient pays directly "out of pocket"** for the services they use. Insurance (premiums) covers the remaining portion. The main forms of cost sharing are:
  - **Copayments**: patient pays a **fixed dollar amount** for a service, regardless of the cost of the service; a patient's benefit handbook typically contains a list of copayment per service.
  - **Coinsurance**: patient pays a **percentage of the cost** of the service.
  - **Deductible**: patient pays the **full cost of services** until the deductible amount (reset annually) is met before insurer begins to pay for covered services, where copayments and coinsurance still apply.
- Cost sharing is mainly used to **offset premiums**, thereby shifting health care spending to patients when they use care.
- In addition to offsetting premiums, cost sharing can further other goals, at least in theory:
  - **Discourage overuse** of health care resources of limited value ("skin in the game" or "moral hazard").
  - **Steer patients** toward higher value care by varying cost sharing and **encouraging patients to shop** for lower cost providers.
  - For cost sharing to serve these goals, patients should be able to estimate their cost sharing obligation in advance of receiving a service to inform their decision-making.

Typical cost sharing design, especially the use of deductibles, has generally not led to more judicious use of health care resources.

A large body of literature demonstrates that **cost sharing reduces care use, including essential and needed care**.[1]

Research indicates that the deductible is the most problematic form of cost sharing, and its use has grown in prevalence and dollar amount.

The percentage of commercially-insured **Massachusetts residents enrolled in high-deductible health plans** (HDHPs, deductibles more than $1,400 single/$2,800 family) **increased from 19% to 45% from 2014 to 2023.**[2]

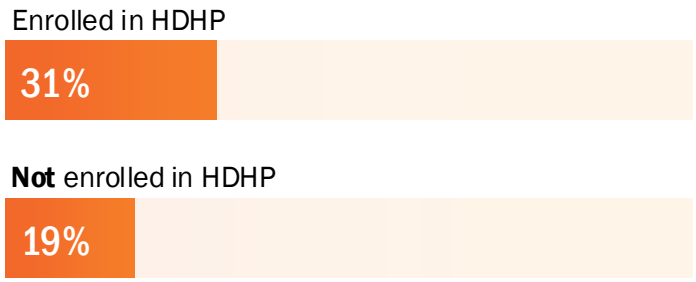


1. Keeler EB. Effects of cost sharing on use of medical services and health. J Med Pract Manage. 1992;8:317-21.; Chandra A, Flack E, Obermeyer Z. The health costs of cost sharing. The Quarterly Journal of Economics. 2024 Nov;139(4):2037-82.; Sinaiko AD, Mehrotra A, Sood N. Cost-sharing obligations, high-deductible health plan growth, and shopping for health care: enrollees with skin in the game. JAMA Internal Medicine. 2016 Mar 1;176(3):395-7.
2. According to the latest Massachusetts employer survey from the Center for Health Information and Analysis (CHIA), over half of high-deductible plans included either a health reimbursement account or a health savings account. Average employer contributions for family plans were $3,480 and $1,255 for HRAs and HSAs, respectively, in 2024.

Increasing use of deductibles has driven care avoidance and higher medical debt.

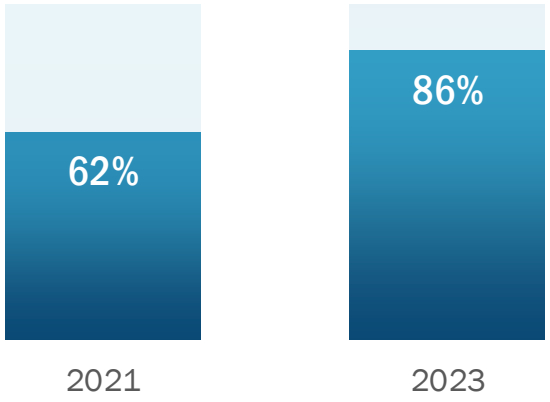
Deductibles represent a convenient vehicle to offset premium increases and patients may be attracted to plans with a higher deductible due to lower premium. **Yet deductibles result in unpredictable and often large bills** for patients, even for routine care services, leading to **avoided care and eroding the financial protection** that insurance aims to provide.

Percent avoiding needed care



Residents enrolled in HDHPs were more likely to avoid needed care due to cost than those in conventional plans (31% to 19%), according to data from CHIA's Massachusetts Health Insurance survey.[1]

The percentage of lower-income residents with private coverage in Massachusetts who said **deductibles were the source of their medical debt** increased from **62% in 2021 to 86% in 2023**.[2]



Percent saying deductibles were the source of medical debt

Researchers have found that **HDHPs are more likely to exacerbate debt and bankruptcy for Black and Hispanic families than for White families**, who have more assets to cover a large unexpected health care bill.[3] Low income Black and Hispanic families with HDHPs but no savings accounts had median financial assets of $2,200 and $2,000, well below the average family coverage deductible.

1. CHIA. Affordability issues are more common in high deductible health plans. March 2021. Available at: https://www.chiamass.gov/assets/docs/r/pubs/2021/Inside-Look-High-Deductible-Plans.pdf
2. HPC analysis of CHIA's 2023 Massachusetts Health Insurance Survey.
3. Zewde N, Rodriguez SR, Glied SA. High-Deductible Health Insurance May Exacerbate Racial And Ethnic Wealth Disparities: Article examines high-deductible health insurance impact on racial and ethnic wealth disparities. Health Affairs. 2024 Oct 1;43(10):1455-63.

The HPC's analysis of cost sharing in Massachusetts among patients with commercial insurance focuses on issues associated with deductibles.

RESEARCH GOAL

- This research explores cost sharing across settings of care to better understand the burden of cost sharing for Massachusetts residents with commercial insurance, focusing on the impact of deductibles.

DATA AND METHODS

- The HPC used the Massachusetts All-Payer Claims Database v2023 (MA APCD) from 2019-2023, including medical and pharmacy claims from six large commercial payers in Massachusetts.[1]
- Medical and pharmacy services were grouped into large care categories 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. Care categories include:
  - Inpatient (including professional and facility), ambulatory, pharmacy (prescription drugs), care received out-of-network, and all other care (DME, SNF, hospice, home health, and ambulance services).
  - Ambulatory care was further divided into sub-categories of care.
- Analysis includes Massachusetts residents ages 0-64 with 12 months of medical and pharmacy coverage and any utilization (spending).

1. Blue Cross Blue Shield, Harvard Pilgrim Health Care, Tufts, Health New England, United Healthcare, and MGB Health Plan. Anthem was excluded due to lack of pharmacy claims.

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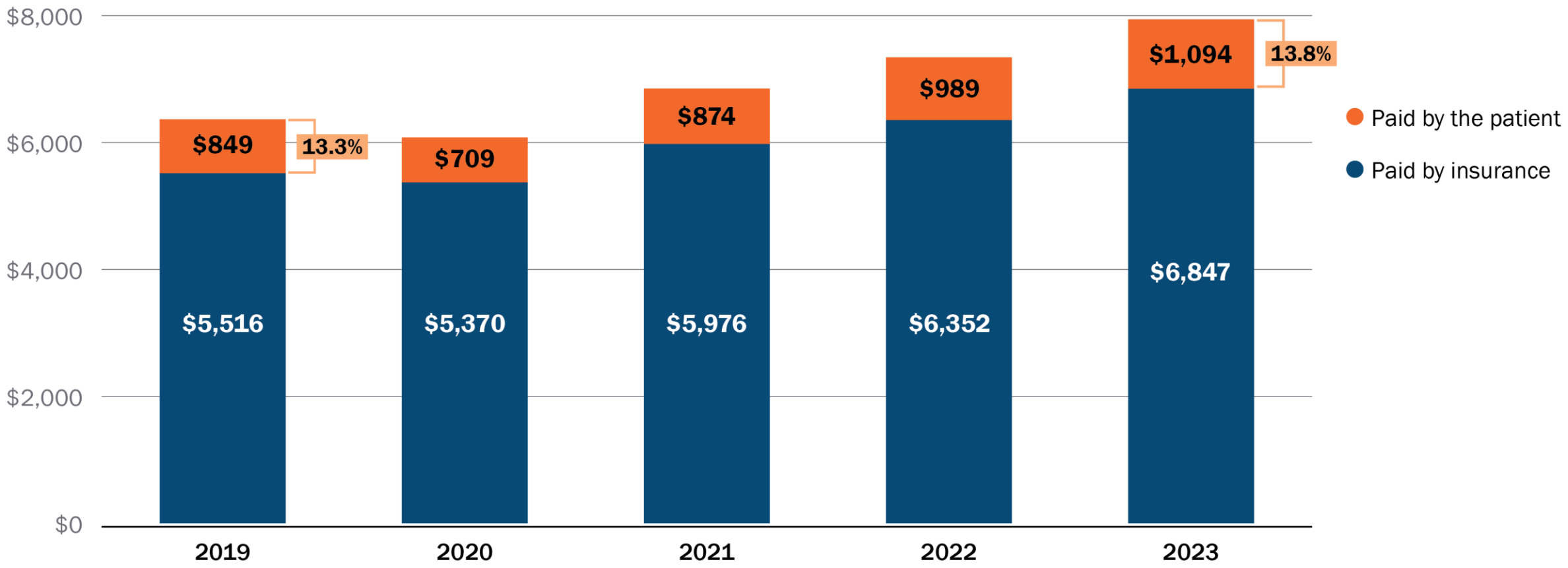
Average annual cost sharing per person grew from $849 in 2019 to $1,049 in 2023 (a 29% increase), faster than insurer-paid spending (24%).

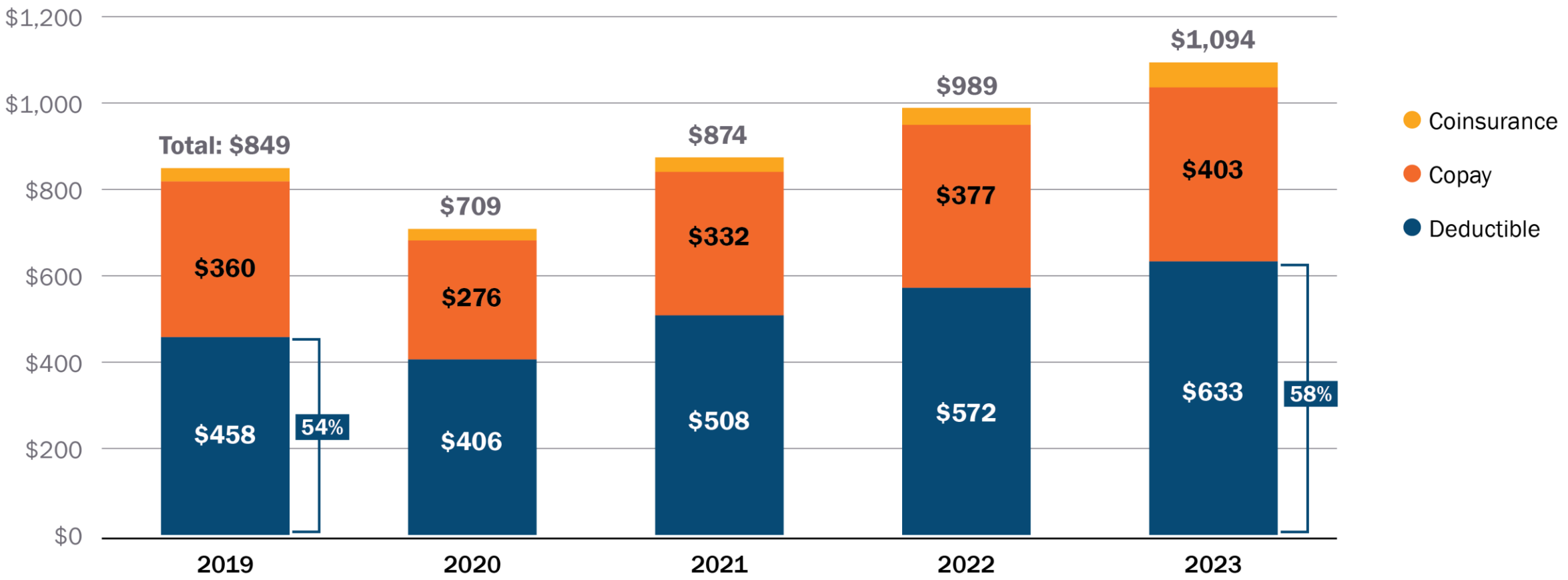
Commercial spending per member per year by insurer and patient paid amounts, 2019-2023



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.

Deductible spending grew 38% from 2019 to 2023 while spending on copayments grew 12%, resulting in a cost sharing composition that is increasingly tilted towards deductibles.

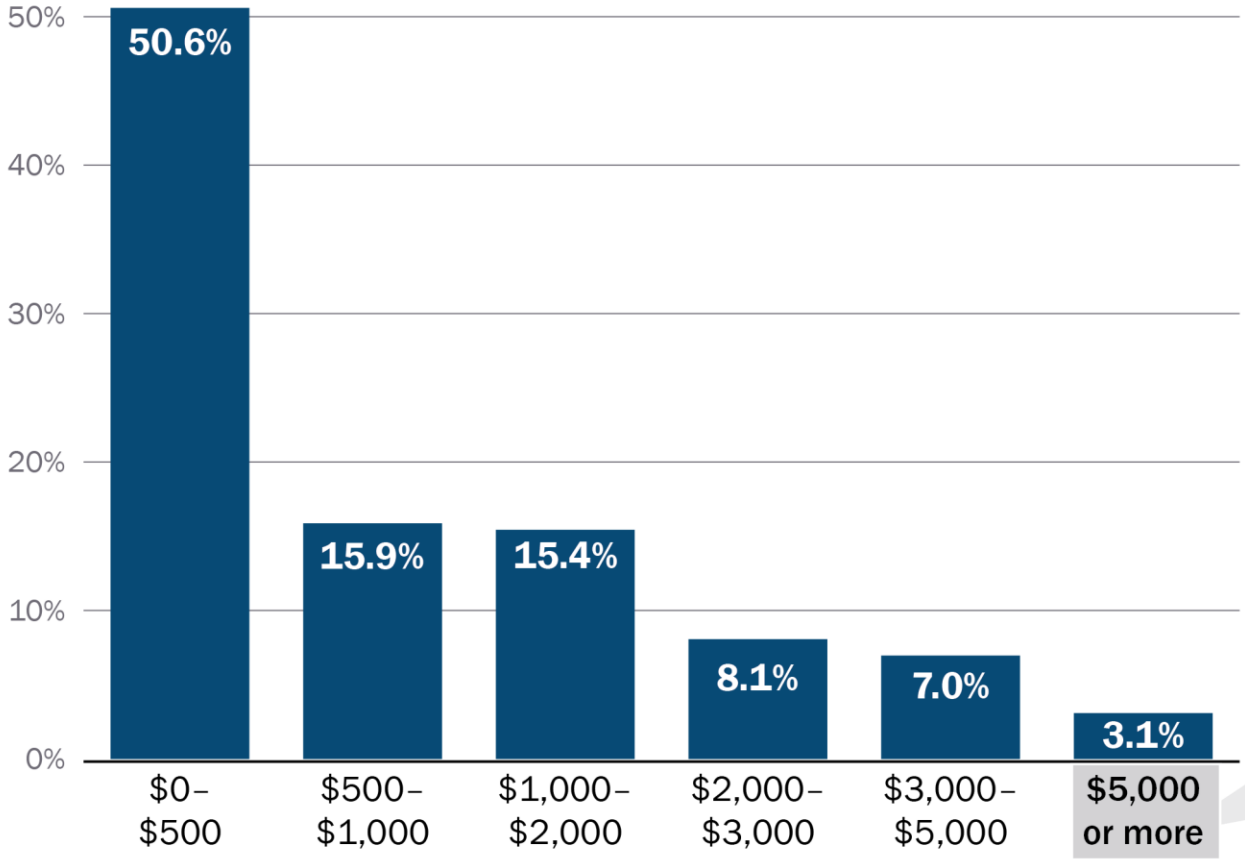
Cost sharing per member per year by the type of cost sharing, 2019-2023



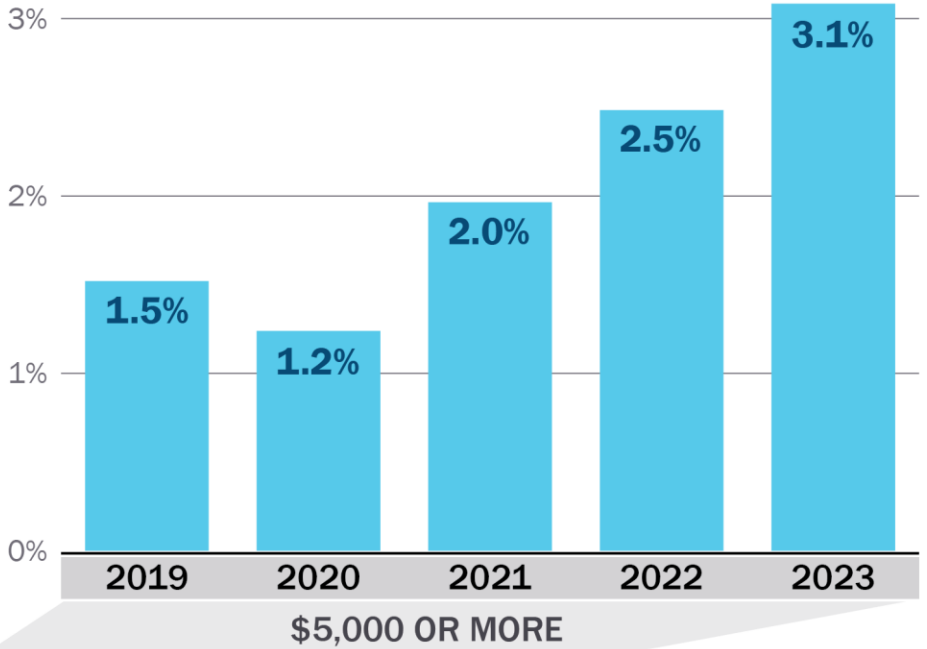
Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

10% of residents paid more than $3,000 annually in cost sharing in 2023; those paying $5,000 or more doubled from 2019 (1.5%) to 2023 (3.1%).

Distribution of out-of-pocket spending per member, 2023



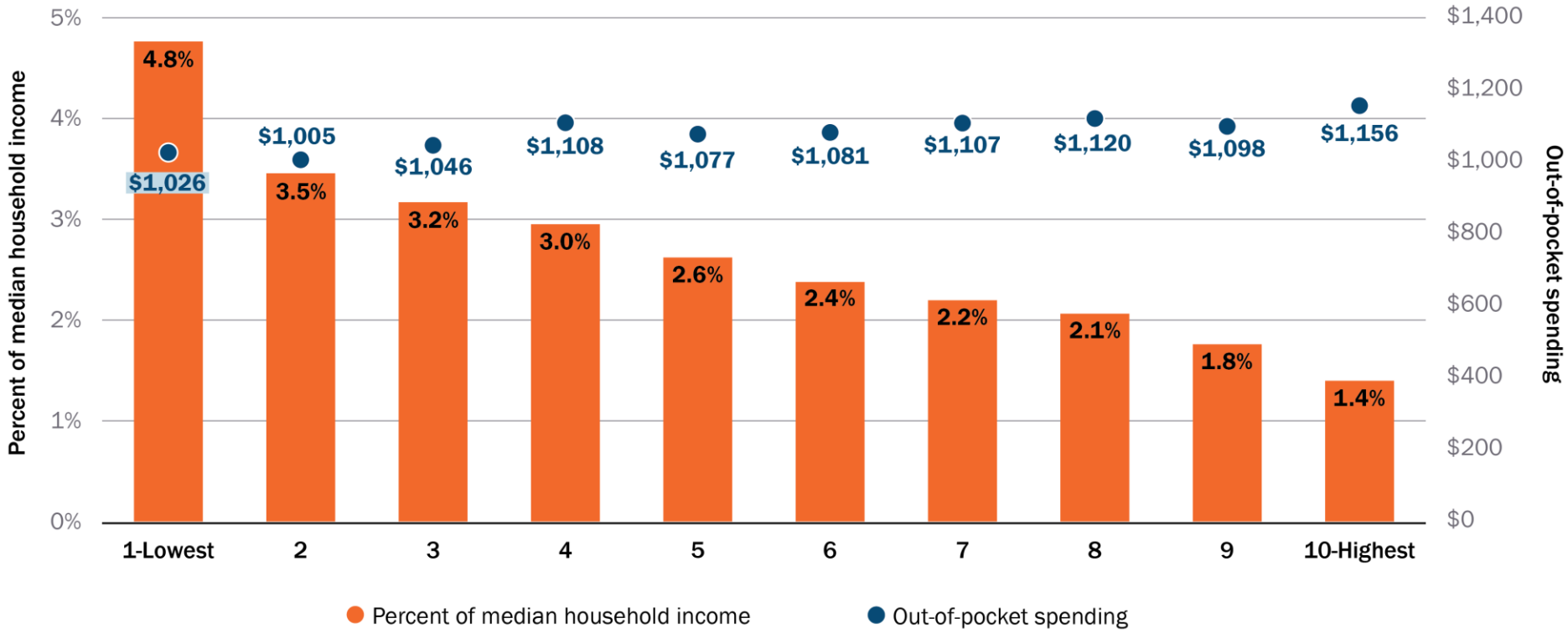
Percentage of members with $5,000 or more of out-of-pocket expenses, 2019-2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. 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 out-of-pocket maximum was $9,100 for an individual and $18,200 for a family.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

Out-of-pocket spending is similar across income levels but is higher relative to median household income for residents in low-income areas.

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



Annual averages are shown in the figure. A large medical bill can pose a significant financial risk for households with lower incomes at a point in time, particularly a bill that was not anticipated. For example, a $500 bill would represent about 20% of the monthly take-home pay for a household with a $50,000 annual salary; if savings were not available, paying this bill would require debt or trade-offs in household necessities.

Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Cost sharing as a percentage of household income was derived by multiplying average out-of-pocket spending per member by 2.4 (assuming 2.4 individuals per household) and dividing by median household income at the zip code level. Final percentages are population weighted averages. Income groupings represent population-weighted deciles based on median household income of zip code sourced from U.S. Census Bureau American Community Survey 5-year estimates.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

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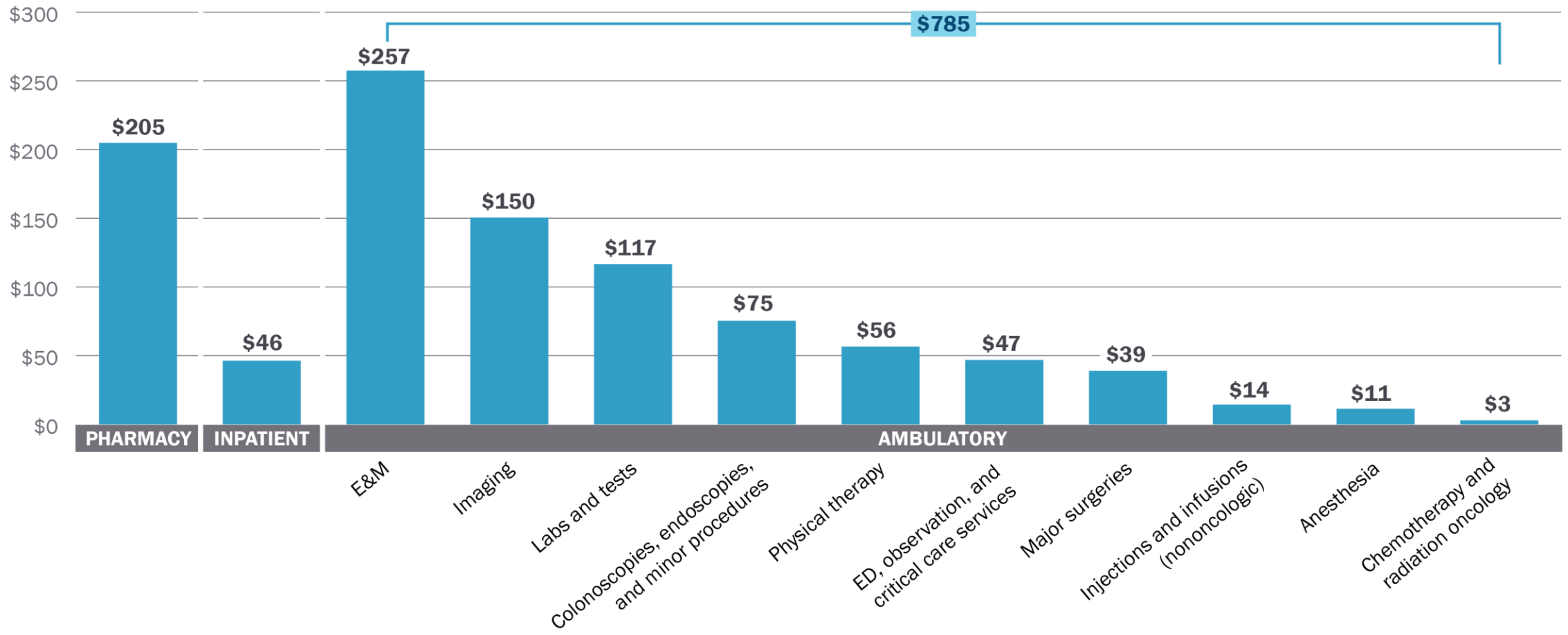
The types of services that contribute most to a patient's annual cost sharing outlay reflect the frequency of service use and the amount of cost sharing paid per use.

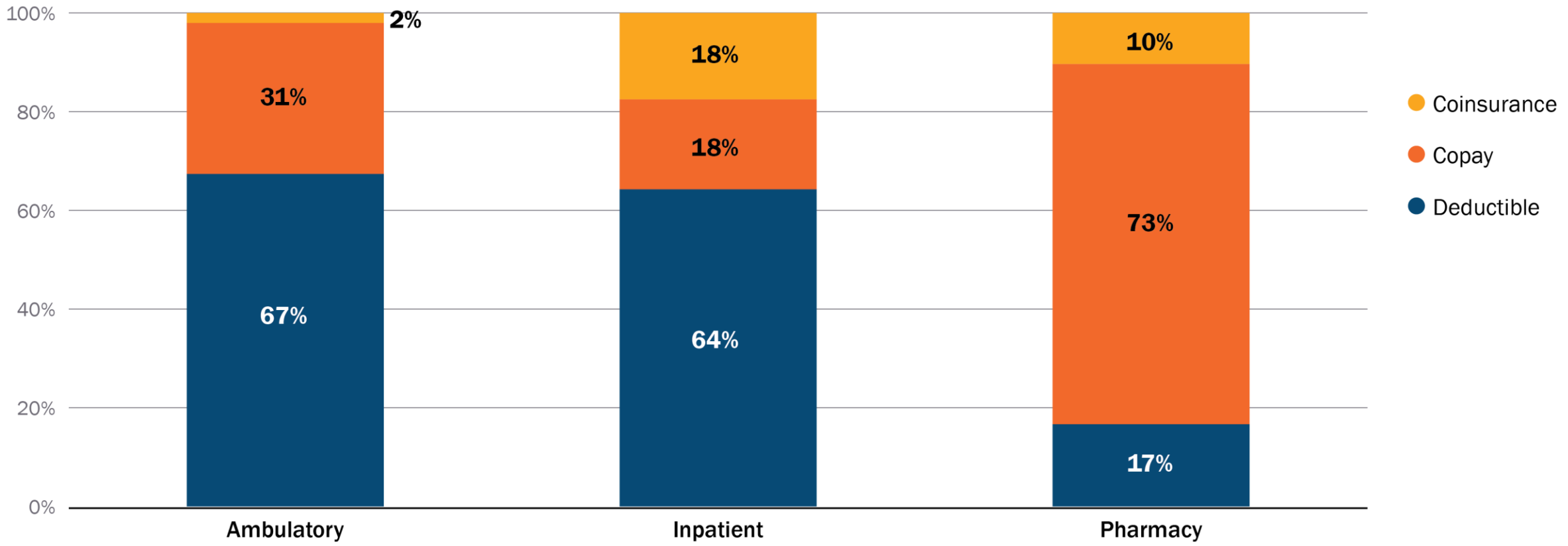
Cost sharing per member per year by service category, 2023



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. Categories with small spending amounts are omitted (e.g., out-of-network care). 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.

Most cost sharing for ambulatory and inpatient care comes through deductible spending – which leads to highly variable cost sharing for care episodes.

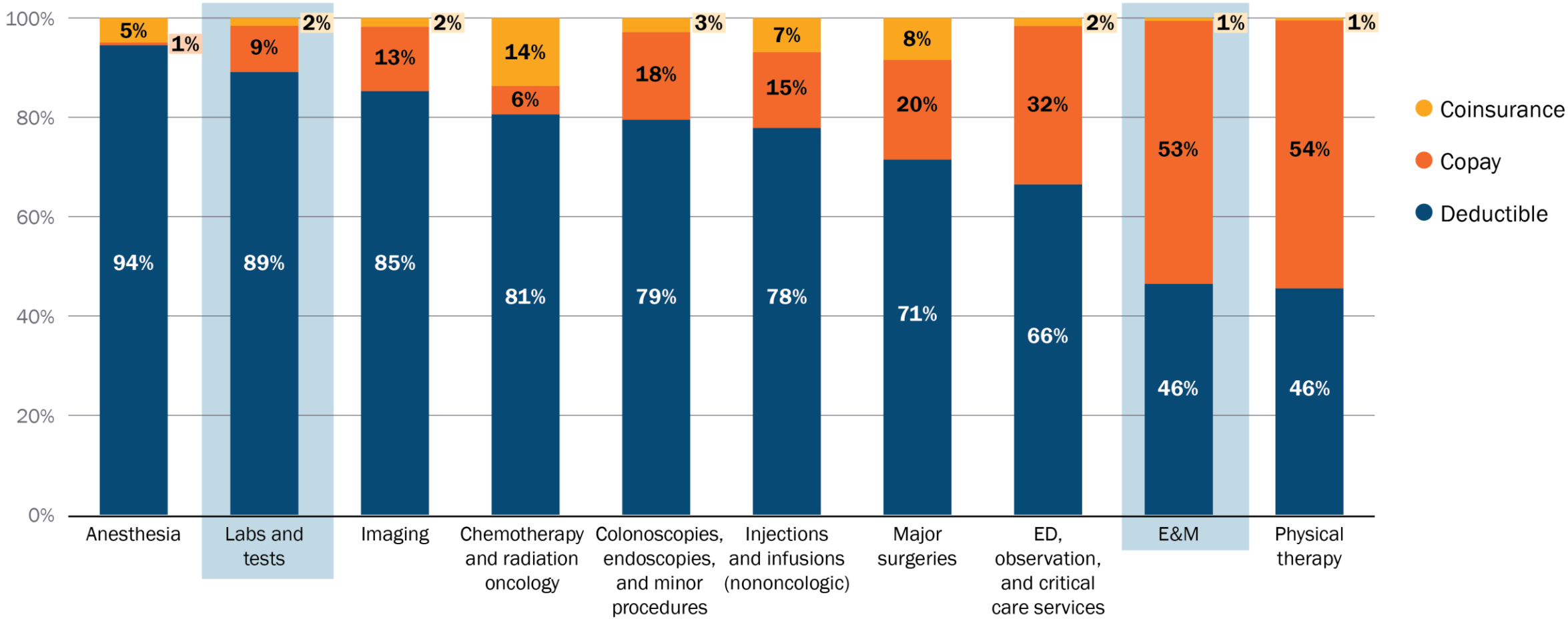
Distribution of deductible, copay, and coinsurance spending by service category, 2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. For care received out-of-network, deductible spending 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.

Among ambulatory services, the share of cost sharing represented by deductible spending varies widely, reflecting differences by service in benefit design and price.

Distribution of deductible, copay, and coinsurance spending by 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. A small number of uncategorized ambulatory services are not shown. 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.

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The HPC's analysis focused on three key settings of care where the deductible can lead to issues of affordability and financial uncertainty.

INPATIENT HOSPITAL

- High cost sharing is likely and very high cost sharing is possible, with significant impact on affordability

EMERGENCY DEPARTMENT

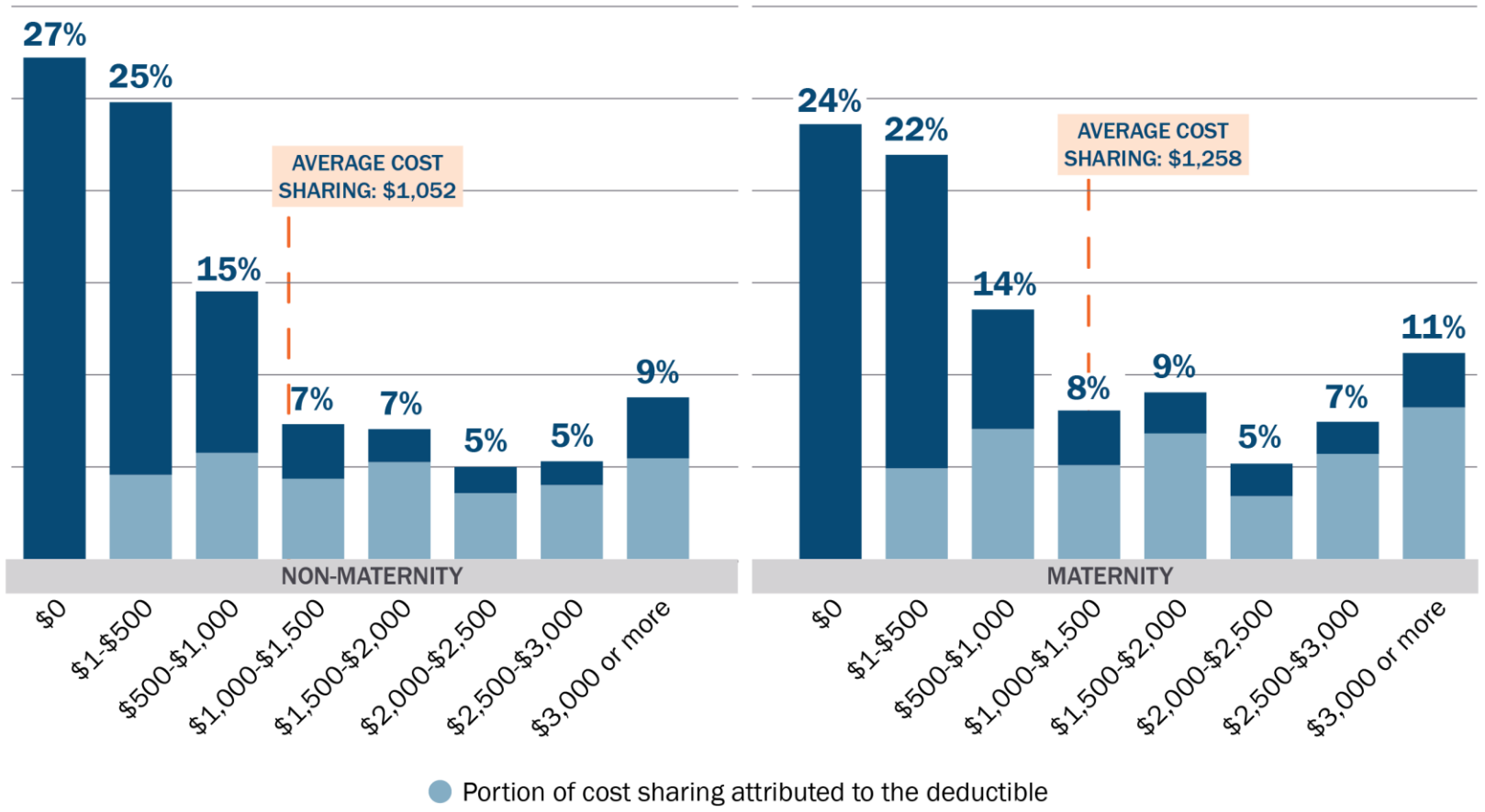
- Wide variation in cost sharing, with the potential for large bills, particularly depending on the services patients receive
- Patients have little to no ability to decide which services they receive in the ED

ROUTINE CARE

- After paying a copay for a visit, patients are unlikely to anticipate cost sharing for other primary care services that occur during the visit
- Unexpected cost sharing can drive a chilling effect leading to future care avoidance

Some residents paid $0 in cost sharing for inpatient stays, while others pay more than $3,000 – mostly due to deductibles.

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

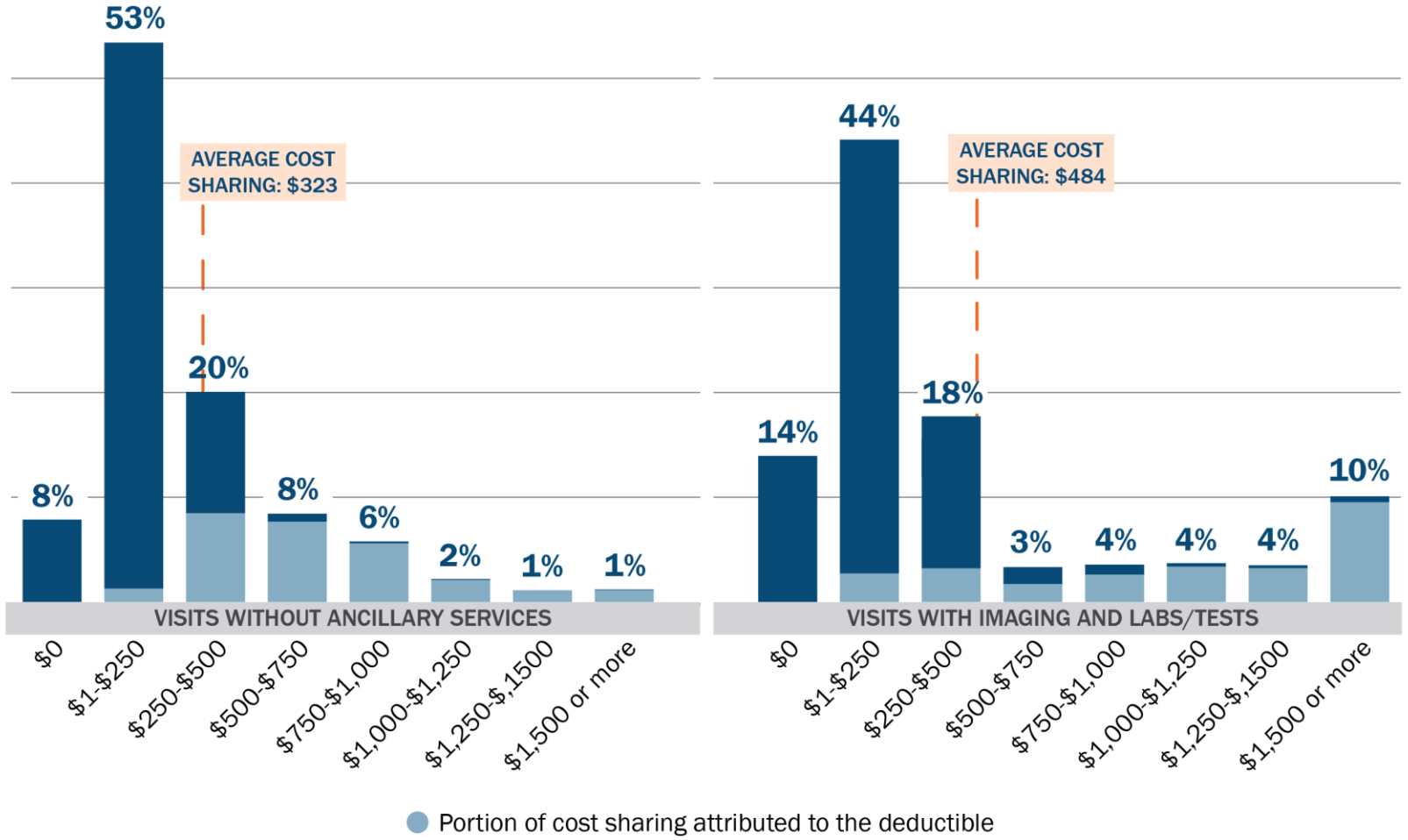


Notes: Data represents cost sharing for both facility and professional claims that occurred during an inpatient stay. Maternity stays include newborns and were defined as having an APR-DRG MDC of 14 or 15. Percentages labeled represent the share of inpatient stays within a given range of cost sharing per stay.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

For non-maternity stays with cost sharing over $3,000, 62% of the cost sharing amount was attributable to deductible spending; this figure was 74% for maternity stays.

Cost sharing for ED visits is highly variable when imaging and lab tests are involved. In those cases, 10% of patients paid more than $1,500 out of pocket, largely due to deductibles.

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



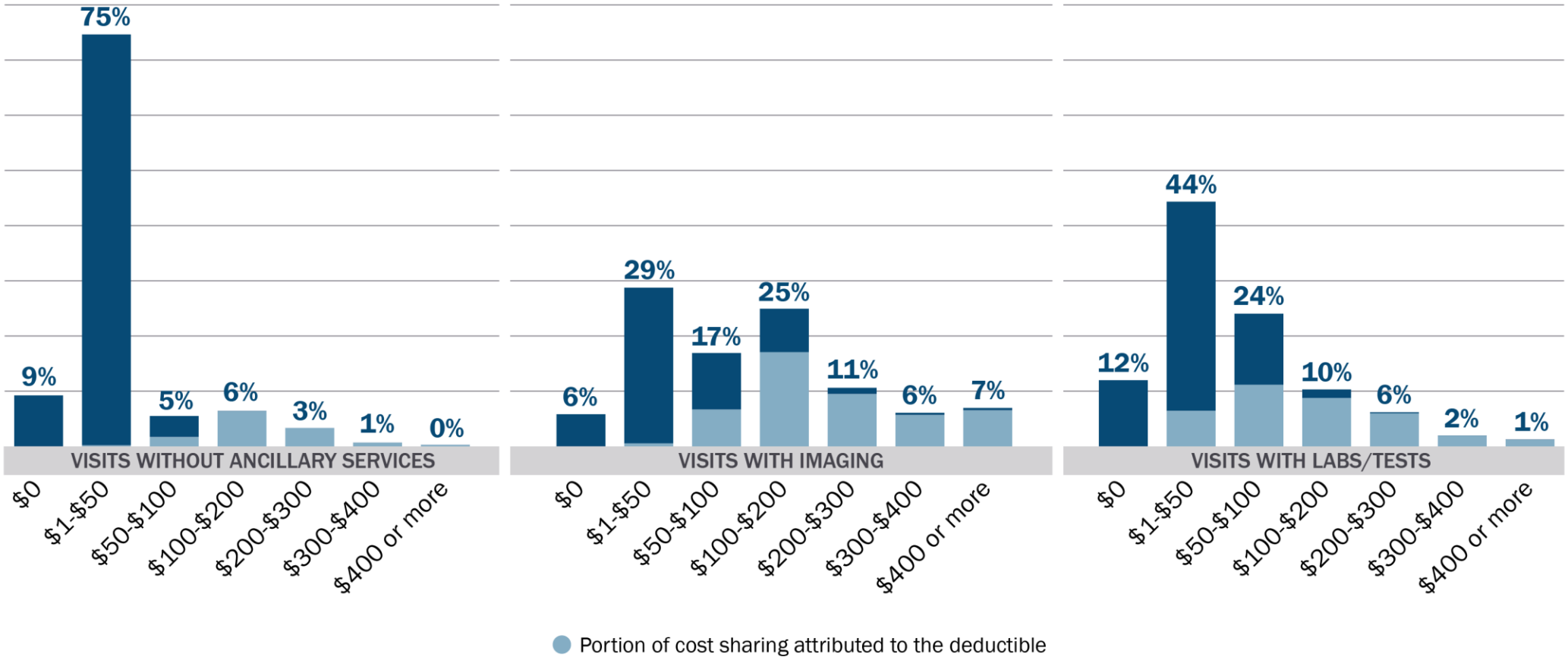
Notes: Episodes were defined as same person and date of service as an emergency department visit procedure code (99281-99285). Episodes were dropped if they occurred on the same day for the same person as an observation or inpatient stay. ED visits without ancillary services represented 17% of all ED visits. ED visits with imaging and labs/tests represented 16% of all ED visits.

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

- Compared to an ED visit with no ancillary services, the likelihood of $1,500 or more in cost sharing increased 10-fold when imaging and labs/tests were performed, which are generally outside of a patient's control.
- For visits with imaging and labs/tests and cost sharing over $1,500, nearly all the total cost sharing amount was attributed to the deductible (94%).

Cost sharing for typical office visits can also vary by hundreds of dollars, largely due to deductibles on ancillary services that patients may not be able to anticipate.

Distribution of cost sharing for evaluation and management (E&M) problem visits for ten selected diagnoses, 2023

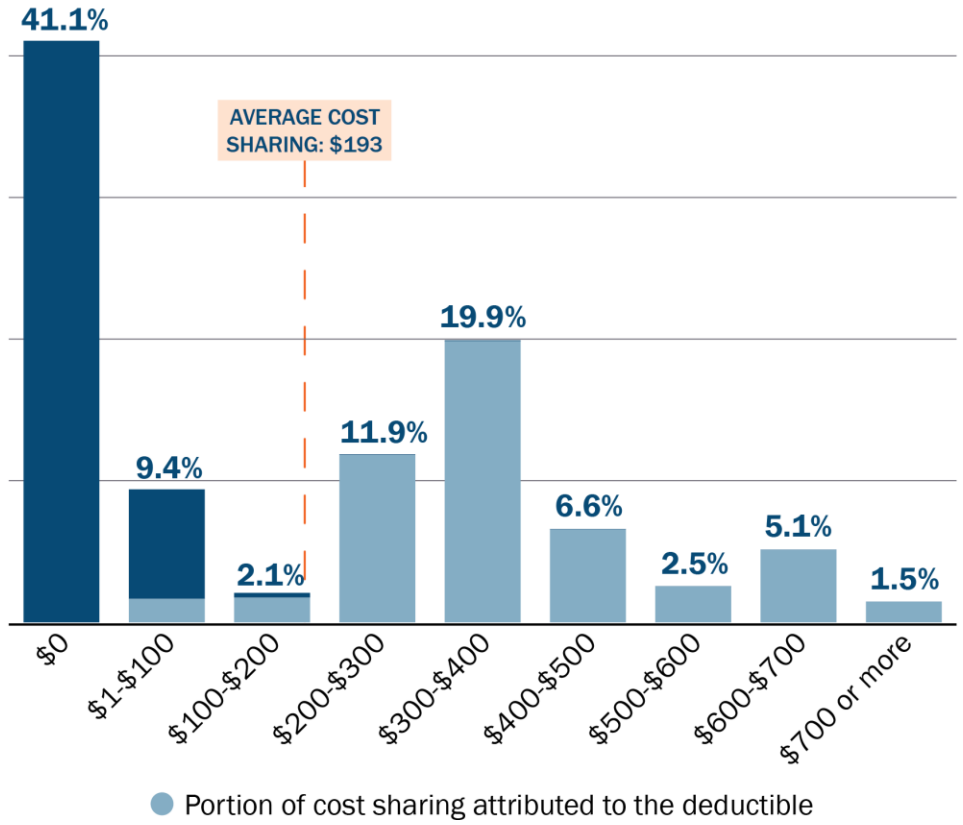


Notes: Data represents episodes at ambulatory settings for ten principal diagnoses (F41, J02, F90, F33, M25, I10, M54, R05, H66, E66). Episodes were defined as same person and date of service as an E&M problem visit procedure code (99201-99215). Episodes were dropped if they occurred on the same day for the same person as an emergency department visit, major surgery, chemotherapy, or other preventive visit. Out of E&M problem visits examined for the selected diagnoses visits without ancillary services represented 51%, visits with imaging represented 5%, and visits with labs/tests represented 20% of the total.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

Bacterial vaginosis (BV) case study: Cost sharing for a common lab test provided in a primary care visit ranges from $0 to more than $500 for many patients.

CLINICAL PATH	COST SHARING
Patient has uncomfortable symptoms including burning during urination; schedules a doctor's visit	
Patient pays a copay for the doctor's visit	$25
Doctor asks the patient to provide a urine sample and performs a swab	
Doctor receives results the next day, calls the patient with the BV diagnosis, and sends a prescription to a pharmacy	
Patient pays a copay for the prescription; her symptoms begin improving	$10
30 days later, patient receives a bill for the BV lab test, which was subject to her deductible	$193
TOTAL COST SHARING	**$228**

Distribution of cost sharing for a diagnostic test for bacterial vaginosis (BV), 2023



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.

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Considerations for a More Consumer-Friendly Cost Sharing Design

- **Health insurers**, along with employers and brokers, should **consider patient access and affordability in cost sharing design**.
- **Cost sharing should be predictable** in advance of receiving a service, **transparent,** and **easy to understand**, enabling patients to make informed choices and to make a financial plan, such as seeking financial assistance in advance where available.
  - **Deductibles and co-insurance should be minimized and redistributed in the form of copayments**.
- Cost sharing for **primary care and chronic disease management services should be minimized**.
- Higher versus lower cost sharing can be used to impact patient decision-making in **specific cost-effective care choices** such as higher value treatment alternatives or sites of care.

Examples from Payers and Public Employers: Innovative Cost Sharing Benefit Designs

Massachusetts Health Connector

- Pilot for 2024 and 2025 expanded income eligibility requirements from 300% of the Federal Poverty Level (FPL) to 500% of FPL.
- Plan design has **no deductibles, and no cost sharing for routine care** such as lab tests, E&M visits, common imaging services, and prescriptions for chronic diseases like diabetes and hypertension.
- One in five members surveyed reported accessing preventive care that had previously been deferred; one in ten picked up medications that were not taken or delayed before.[2]

> "I can now go to the doctor without second guessing how much it will cost me. It's given me peace of mind. On my former plan, I was always stressed about medical bills, even for very basic, preventive tests."
>
> - Expansion member reaction[1]

Minnesota state employee plan

- Employees must select a primary care clinic that manages their care; clinics are placed into cost sharing tiers based on their total medical expenses (TME).
- Employee premiums are the same across all tiers, but **deductibles, copays, and maximum out-of-pocket cost vary substantially by tier** (for example, family plan deductibles range from $500 in tier 1 to $3,000 in tier 4).[3]

1. Massachusetts Health Connector. ConnectorCare expansion pilot report. August 2024. Available at: https://betterhealthconnector.com/wp-content/uploads/ConnectorCare-Pilot-Expansion-Report-082624.pdf
2. Massachusetts Health Connector. ConnectorCare expansion status update. Board meeting, July 11, 2024. Available at: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2024/07-11-24/ConnectorCare-Expansion-Status-Update-071124.pdf
3. Dowd B, McDonald T. Affordable commercial health insurance is available—if we want It. Health Affairs Forefront. 2025. Available at: https://www.healthaffairs.org/content/forefront/affordable-commercial-health-insurance-available-if-we-want

Examples from Payers and Private Sector Employers: Innovative Cost Sharing Benefit Designs

- **Surest** (an insurance offering under United healthcare):
  - **No deductibles or coinsurance**; no cost sharing for lab tests and common imaging services associated with primary care visits.
  - **Copayments are fixed for every episode of care**, even if unforeseen complications arise; patients identify cost sharing via an app.
  - Copayments are higher for higher-priced providers and higher cost settings of care; internal analysis suggests significant savings.[1]
  - Approximately 1 million members enrolled throughout the U.S. including fully and self-insured.[1] Working to be made available in the Massachusetts fully-insured market soon. Other insurers are also experimenting with similar designs.
- **Cost Plus Wellness** (by Mark Cuban):
  - **No cost sharing**; employer contracts directly with hospitals and clinics – providers accept lower rates in exchange for lower financial risk and lower administrative burden.[2]

1. Based on HPC communications with Surest Health Plan.
2. Killpack K. Mark Cuban says 'this is single-payer': How his healthcare model could transform the U.S. healthcare system. Yahoo Finance. December 31, 2024. Available at: https://finance.yahoo.com/news/mark-cuban-says-single-payer-153015416.html

Deductibles could be reduced or shifted to copays to allow for more predictability in cost sharing. Potential scenarios are modeled below.

EXAMPLE SCENARIO 1: Cap deductible spending at $500 per person

- By itself, this would increase premiums by roughly 6%. This increase could be offset in several ways, e.g.:
  - **Limiting excessive prices** for certain types of care including inpatient stays, imaging, lab services, administered drugs and some specialty procedures.[1] Other policy reforms could also achieve off-setting savings. [2]
  - **Shifting deductible spending to copays**
    - As an example, HPC modeled converting the eliminated deductible spending to copays for inpatient stays, outpatient surgeries, branded prescription drugs, labs, E&M visits and imaging. This involved, for example, average copays of $500 for major outpatient surgery, $600 for inpatient stays, and $22 for prescription drugs.
    - These copays imply higher cost sharing for some patients but lower for others; all patients would benefit from the **predictability of fixed, up-front copayments** for their care.
    - Copayments can also be adjusted to support value: HPC found that cost sharing for knee replacement surgery was **less** than cost sharing for an average course of physical therapy (~$250) for 45% of patients from 2019-2023.

EXAMPLE SCENARIO 2: Eliminate deductible spending for primary care evaluation and management visits.

- By itself, this would increase premiums by roughly 0.3%.[3] This spending could be offset by the reforms noted above.

1. See HPC's Annual Cost Trends Report, 2023, Chapter 3. Price limits on the services mentioned at 200% of Medicare rates reduced overall health care spending by 4.5%. But this is an underestimate of ultimate savings because the modeling was limited to the subset of procedures in these categories for which a comparison Medicare price could be identified.
2. See HPC's Annual Cost Trends Report, 2023, Chapter 4, Policy Recommendation. See also HPC's Opportunities for Savings in Health Care Report, 2018.
3. This estimate does not include deductibles associated with ancillary services that may occur as part of an E&M visit.

Massachusetts Policy Options to Improve Cost Sharing Predictability and Affordability

- **The Commonwealth should foster the offering of health insurance products with consumer-friendly benefit design.**
  - Consumer-friendly benefit design encompasses a variety of features; in particular, the HPC's analysis highlights the **need for products that reduce or eliminate deductibles -- especially for routine care -- and use a more predictable copay-based benefit design. This design would redistribute cost sharing dollars, rather than raising premiums.**
  - Competition from new market products (such as the entry of products currently available in other states, or the development of new products from payers currently operating in Massachusetts) could support the development and growth of innovative offerings.
  - Leadership from the GIC, the Connector, the DOI, and large employers could facilitate the development of these marketing 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; in addition, standards could be developed to designate consumer-friendly benefit design; this designation could help employers find these products and help employees choose between plans.

Massachusetts Policy Options to Improve Cost Sharing Predictability and Affordability, Continued

- Even with more predictable benefit design, patients may incur high hospital bills. **Improving affordability in cost sharing may also require targeted policy to protect low-income patients from the largest bills.**
  - **Massachusetts could consider joining the growing number of states that have passed legislation requiring non-profit hospitals to provide a minimum level of charity care and reduce medical 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.[1]
  - The HPC supports the **MA AGO 2024 report** recommendations on consumer protections for hospital financial assistance, including standardizing eligibility requirements.[2]
- **Reducing high and growing prices of care must remain a policy priority.** Rising cost sharing and deductibles reflects rising underlying health care spending, driven in large part by growing prices.
  - The HPC has made numerous recommendations to reduce the root causes of spending growth.
  - The GIC could be a national leader in combining consumer-friendly benefit design with reasonable price constraints.

1. Santos T, et al. Oregon Community Benefit Reform Influenced Not-For-Profit Hospitals' Charity Care And Medical Debt Write-Off: Health Affairs. 2025 Feb 1;44(2):196-205.
2. Office of Attorney General Andrea Joy Campbell. 2024 examination of health care cost trends. Available at: https://www.mass.gov/doc/examination-of-health-care-cost-trends-2024/download.

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- Diabetes Screening
- Colonoscopy
- Preventive Visit Episodes
- Conclusion

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The ACA Preventive Care Mandate

- **Since 2010, the Patient Protection and Affordable Care Act (ACA) has required private commercial health insurance plans to cover certain preventive services without patient cost sharing.** Cost sharing has been found to contribute to reduced use of both low- and high-value services when it is applied across the board. The preventive care mandate of the ACA therefore seeks to facilitate and encourage the use of high-value preventive services by exempting them from cost sharing.[1-5]
- As of 2023, 179 million U.S. residents, or about 55%, had private commercial health insurance; in Massachusetts in 2023, that share was nearly 60%.[6]
- The ACA defines preventive services that must be covered without cost sharing as those recommended by any of four groups:[7,8]
  - The United States Preventive Service Task Force (USPSTF)
  - The Advisory Committee on Immunization Practices (ACIP)
  - The Bright Futures Project of the Health Resources and Services Administration (HRSA) and the American Academy of Pediatrics
  - The Women's Preventive Services Initiative (WPSI) of HRSA and the American College of Obstetricians and Gynecologists

1 RAND. 40 Years of the RAND Health Insurance Experiment. Available at: https://www.rand.org/health-care/projects/HIE-40.html
2. Wong MD, et al. Effects of cost sharing on care seeking and health status: results from the Medical Outcomes Study. American Journal of Public Health. 2001 Nov;91(11):1889-94.
3. Chandra A, Flack E, Obermeyer Z. The health costs of cost sharing. The Quarterly Journal of Economics. 2024 Nov;139(4):2037-82
4. Agarwal R, Mazurenko O, Menachemi N. High-deductible health plans reduce health care cost and utilization, including use of needed preventive services. Health Affairs. 2017 Oct 1;36(10):1762-8.
5. Cogan JA. The Affordable Care Act's Preventive Services Mandate: Breaking Down the Barriers to Nationwide Access to Preventive Services. Public Health Reform. 2011.
6. Kaiser Family Foundation. Health Insurance Coverage of the Total Population. Available at: https://www.kff.org/other/state-indicator/total-population/
7. Seiler N, Malcarney MB, Horton K, Dafflitto S. Coverage of clinical preventive services under the Affordable Care Act: from law to access. Public Health Reports. 2014 Nov;129(6):526-32.
8. Health Resources and Services Administration. Women's preventive services guidelines. Available at: https://www.hrsa.gov/womens-guidelines

More than a decade after the passage of the ACA, patients often continue to pay cost sharing for preventive care.

- While the preventive care mandate has had positive impacts on patients' use of care and out-of-pocket spending, **an estimated 40.3% of preventive care visits in the U.S. overall incur out-of-pocket costs**, at a median cost of $113.[1]
- **Cost sharing for preventive services persists due to the fragmented system in which it is being implemented**.[2,3]
  - Providers face substantial payer variation in preventive services billing requirements because each payer determines how to operationalize the preventive care mandate in its own coverage.
  - Preventive care guidelines have changed over time, especially with new medications, and the federal government has issued periodic clarifications about the mandate since 2010.
  - Fully implementing the preventive care mandate requires payers and providers to be up to date on the latest state and federal guidance, for payers to clearly communicate their coding requirements to providers, and for providers to bill correctly for each service and for each payer, all of which represent opportunities for confusion, error, and the continued application of cost sharing.
- **There are also several situations in which the ACA permits cost sharing for preventive care**, such as when an office visit and a preventive service provided at the visit are billed separately (cost sharing may be applied only to the former), or to a branded medication with a generic equivalent provided to a patient with no demonstrated medical need for the branded version.[4,5]
- The preventive care mandate aims to facilitate patients' use of high-value preventive services, a goal which may be undermined by persistent cost sharing. Patients who expect to pay for care are less likely to use it – especially patients with lower incomes, who can least afford an unexpected medical bill.[6]

1. Hoagland A, Yu O, Horný M. Inequities in Unexpected Cost-Sharing for Preventive Care in the United States. American Journal of Preventive Medicine. 2025 Jan 1;68(1):5-11.
2. National Association of Insurance Commissioners. Preventive services coverage and cost sharing protections are Inconsistently and Inequitable Implemented: Considerations for Regulators. August 2023.
3. Centers for Medicare & Medicaid Services. Fact sheets & frequently asked questions (FAQs). Available at: https://www.cms.gov/marketplace/resources/fact-sheets-faqs#Affordable%20Care%20Act
4. Kaiser Family Foundation. Preventive services covered by private health plans under the Affordable Care Act. August 2015. Available at: https://files.kff.org/attachment/preventive-services-covered-by-private-health-plans-under-the-affordable-care-act-fact-sheet
5. Centers for Medicare & Medicaid Services. Affordable Care Act Implementation FAQs - Set 12. Available at: https://www.cms.gov/ccijo/resources/fact-sheets-and-faqs/aca_implementation_faqs12
6. Hoagland A, Yu O, Horný M. Inequities in Unexpected Cost-Sharing for Preventive Care in the United States. American Journal of Preventive Medicine. 2025 Jan 1;68(1):5-11.

HPC Analysis of Cost Sharing for Preventive Services in Massachusetts

RESEARCH GOAL

- This research explores cost sharing for a set of ACA preventive services among commercially-insured Massachusetts residents.

DATA AND METHODS

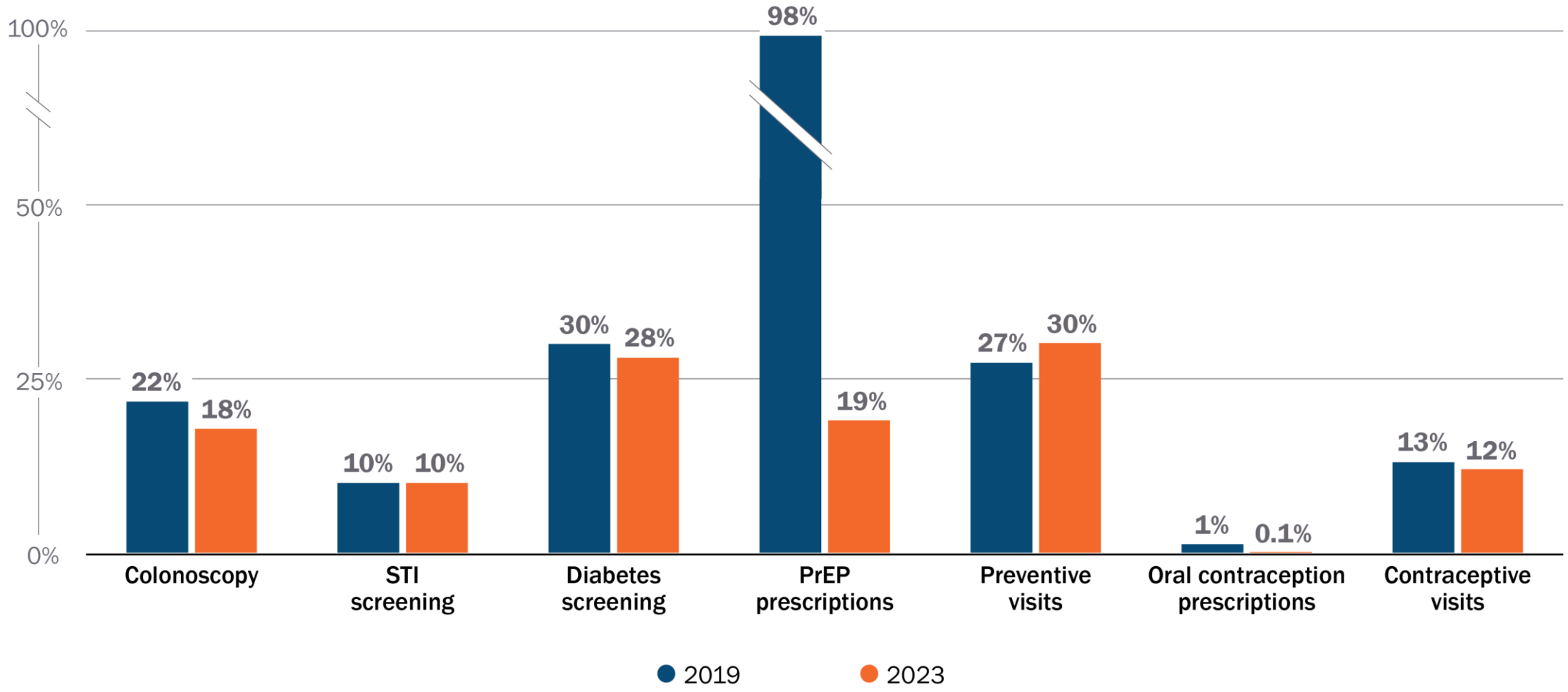
- The HPC used the Massachusetts All-Payer Claims Database v2023 (MA APCD) from 2019-2023, including medical and pharmacy claims from seven large commercial payers in Massachusetts.[1]
- The preventive services explored are examples of those covered under the ACA as USPSTF services with an "A" or "B" rating, recommended by WPSI, or recommended by the Bright Futures project, and that have been identified in research literature as frequently having cost sharing:
  - **Colonoscopy, diabetes screening,** STI screening, contraception, PrEP, and **preventive visit episodes**
- For each service, the HPC defined methodologies in the claims data to identify services for analysis as conservatively as possible: 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)

1. Anthem, Blue Cross Blue Shield, Harvard Pilgrim Health Care, Tufts, Health New England, United Healthcare, and MGB Health Plan. Anthem was excluded from prescription drug analysis due to lack of pharmacy claims.

Outline

Preventive services vary in their prevalence of cost sharing and in how rates of cost sharing have changed over time.

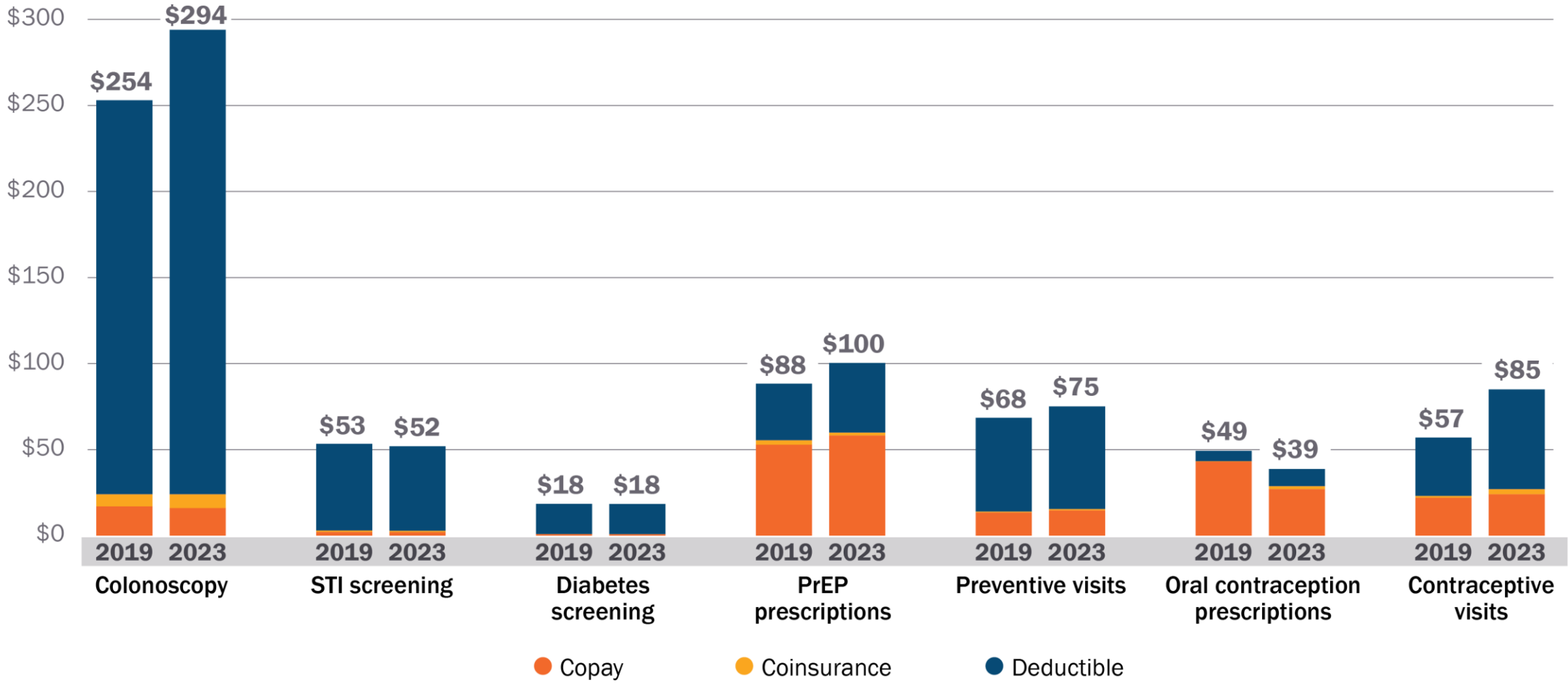
Share of preventive services with cost sharing, 2019-2023



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 prescriptions with cost sharing, average cost sharing amounts range from about $18 for diabetes screening to nearly $300 for colonoscopy.

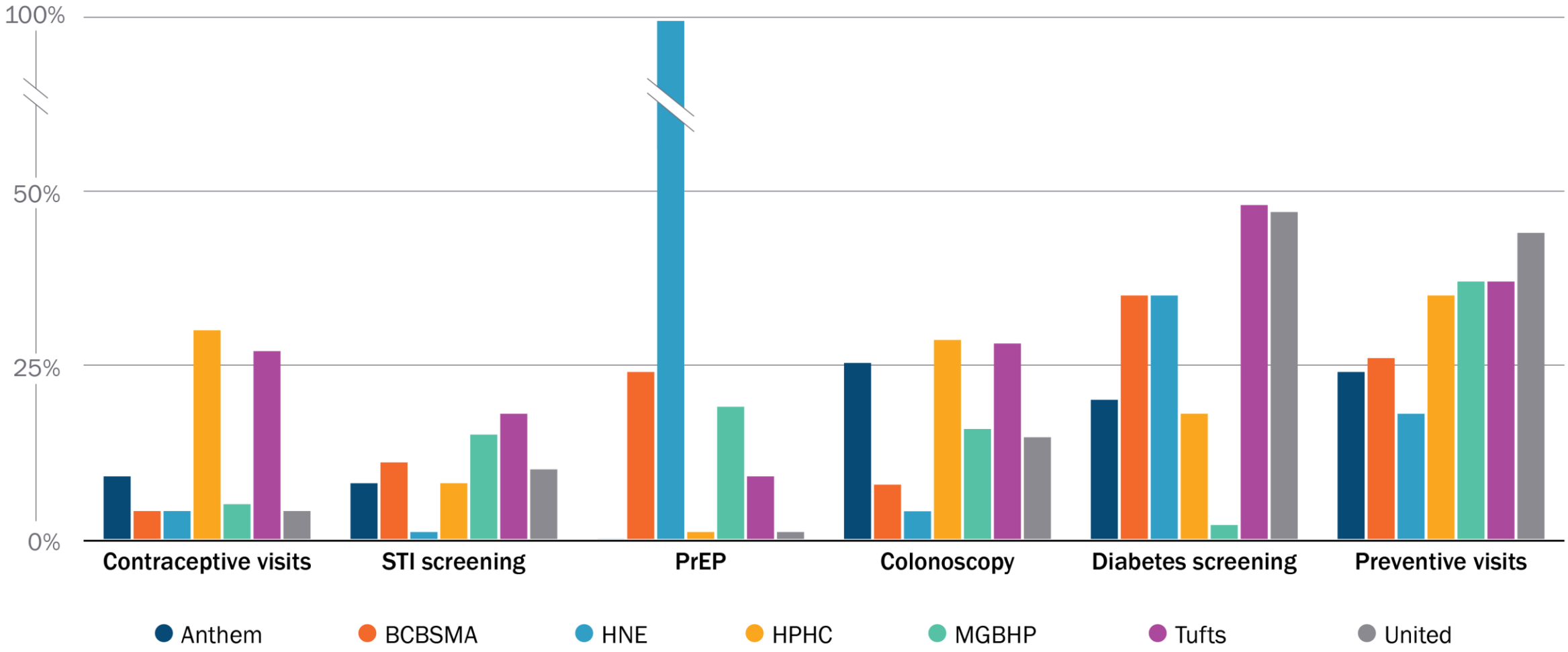
Average cost sharing amounts per service among services with any cost sharing, 2019 and 2023



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

There is also variation by payer in the share of services with cost sharing.

Share of preventive services with cost sharing by payer, 2023



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

Outline

I. Trends in Cost Sharing and Opportunities to Improve Benefit Design

II. Cost Sharing for Preventive Services

- Background
- Overall Results
- **Diabetes Screening**
- Colonoscopy
- Preventive Visit Episodes
- Conclusion

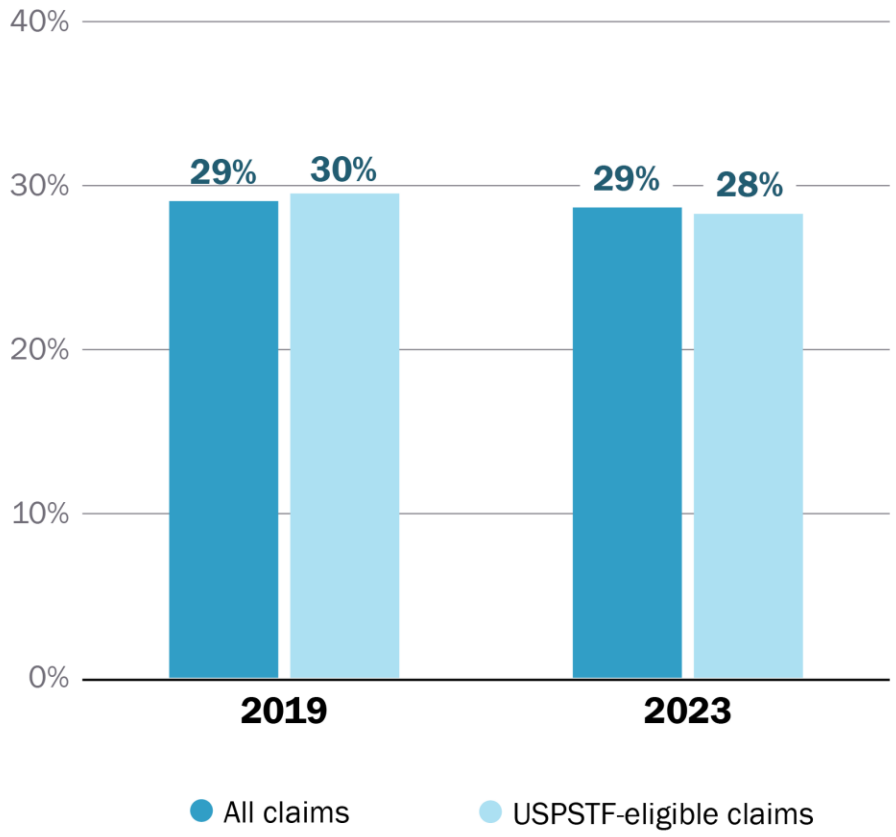
Coverage of Preventive Diabetes Screening

- The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity, effective for plan years starting after August 1, 2022.
- This is an expansion of a previous recommendation, which recommended diabetes screening in adults aged 40 to 70 years with overweight or obesity.
- This analysis considered screenings performed for adults between ages 40-64 (2019 through 2022) or 35-64 (2023) with a diagnosis code for "overweight" or "obesity," but without a diagnosis code for pregnancy or diabetes, to be "USPSTF-eligible."

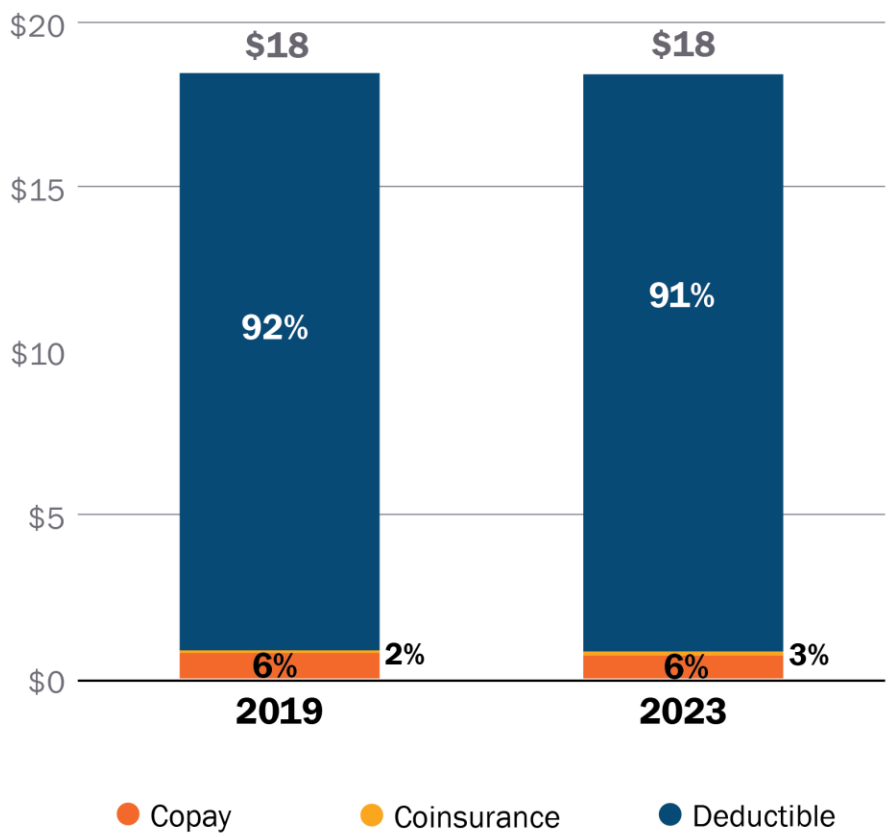
Sources: 111th U.S. Congress. Patient Protection and Affordable Care Act. Mar. 23, 2010. United States Preventive Services Task Force. Prediabetes and Type 2 Diabetes: Screening. Aug. 24, 2021. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes

Approximately one-third of claims for diabetes screening had cost sharing, largely in the form of deductible spending.

Share of claims for diabetes screening with cost sharing, by USPSTF status, 2019 and 2023



Average cost sharing amount for USPSTF-eligible diabetes screenings, by component, among claims with any cost sharing, 2019 and 2023



Notes: Claims for diabetes screening for individuals between the ages of 40 and 64, with a diagnosis code for overweight or obesity attached to the encounter were considered "USPSTF-eligible." Claims with diagnosis codes for pregnancy or for individuals with a history of diabetes were not considered to be USPSTF-eligible.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019 and 2023.

Outline

I. Trends in Cost Sharing and Opportunities to Improve Benefit Design

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Coverage of Colonoscopy

Cost sharing is waived for preventive services with “A” or “B” grade recommendations from the USPSTF. As of 2021, colorectal cancer screening for **persons aged 50-75** have a grade A (“substantial net benefit”) and screenings for **persons aged 45-49** have a grade B (“moderate net benefit”).[1]

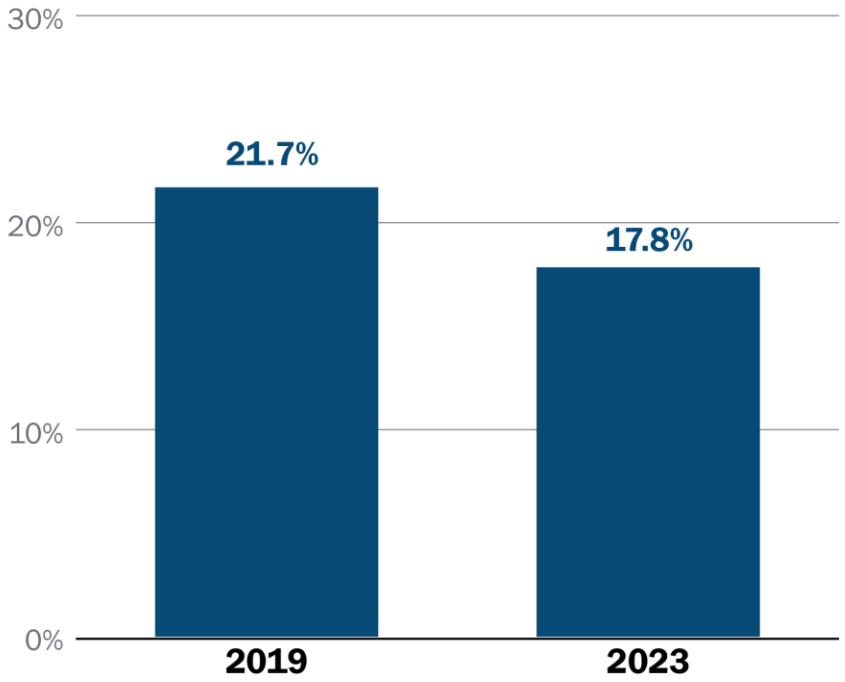
Additional CMS and HHS guidance from 2013 to 2020 has clarified that “cost sharing may not be imposed for **items and services that are an integral part of performing the colonoscopy**,” including:[2]

- Required specialist consultation prior to the screening procedure
- Bowel preparation medications prescribed for the screening procedure
- Anesthesia services performed in connection with a preventive colonoscopy
- Polyp removal performed during the screening procedure
- Pathology exam on a polyp biopsy performed as part of the screening procedure
- Colonoscopy following positive or abnormal findings identified by a stool-based or direct visualization screening test (e.g., sigmoidoscopy or CT colonography)

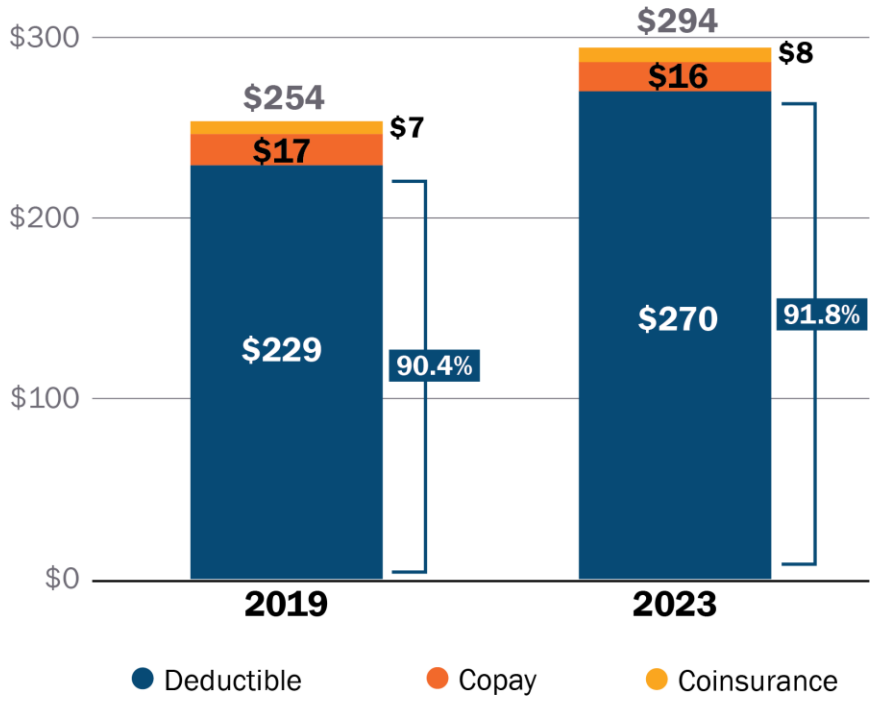
1. U.S. Preventive Services Task Force (USPSTF; 2021). “Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement.” Health Affairs. JAMA. 2021;325(19):1965-1977. doi:10.1001/jama.2021.6238;
2. U.S. Health and Human Services (HHS). FAQs about Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation. January 10, 2022.

The share of patients with cost sharing for preventive colonoscopy declined from 2019 to 2023. Patients who paid cost sharing for colonoscopy in 2023 paid nearly $300 on average.

Proportion of preventive colonoscopy encounters with any cost sharing, 2019 - 2023



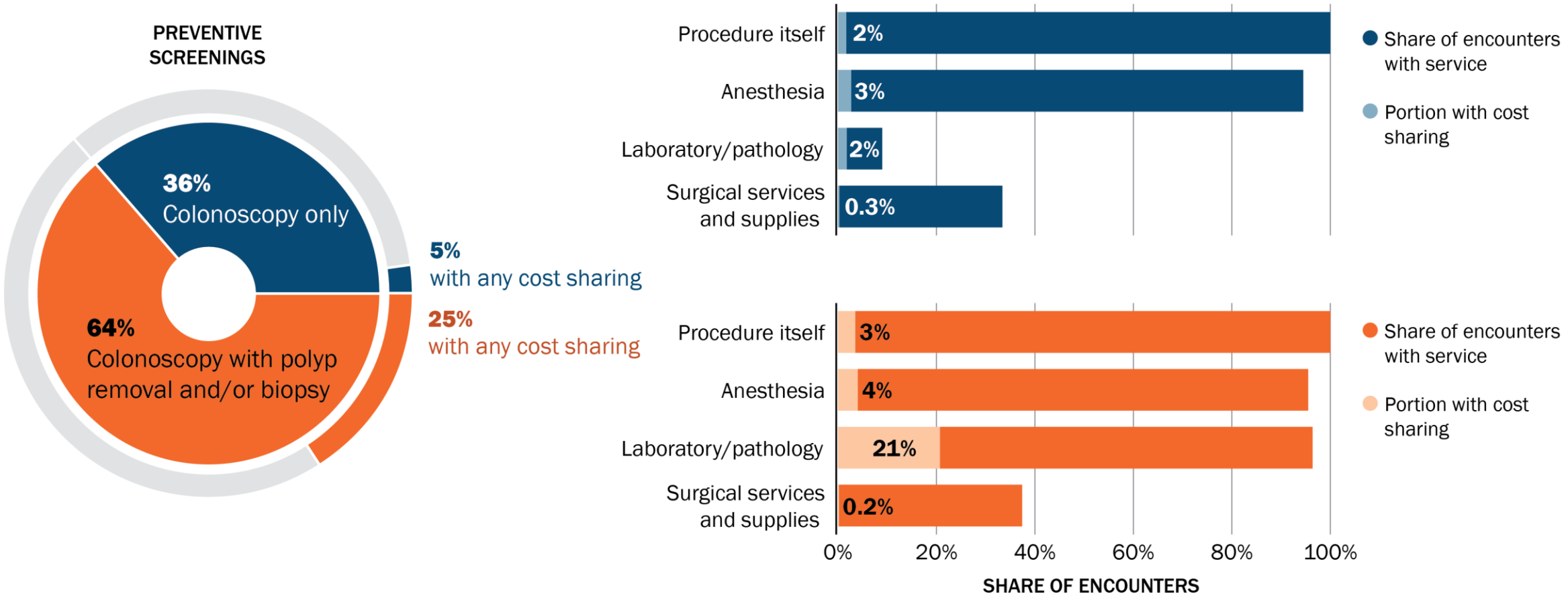
Average cost sharing among colonoscopies with any cost sharing, 2019 – 2023



Notes: Based on encounters for services provided same day. Includes members of average risk, aged 45 to 65, with full-year coverage, and on commercial insurance only. 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 ICD10 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.

Most cost sharing for colonoscopy occurred via lab and pathology claims for patients who had a polyp removal or biopsy procedure.

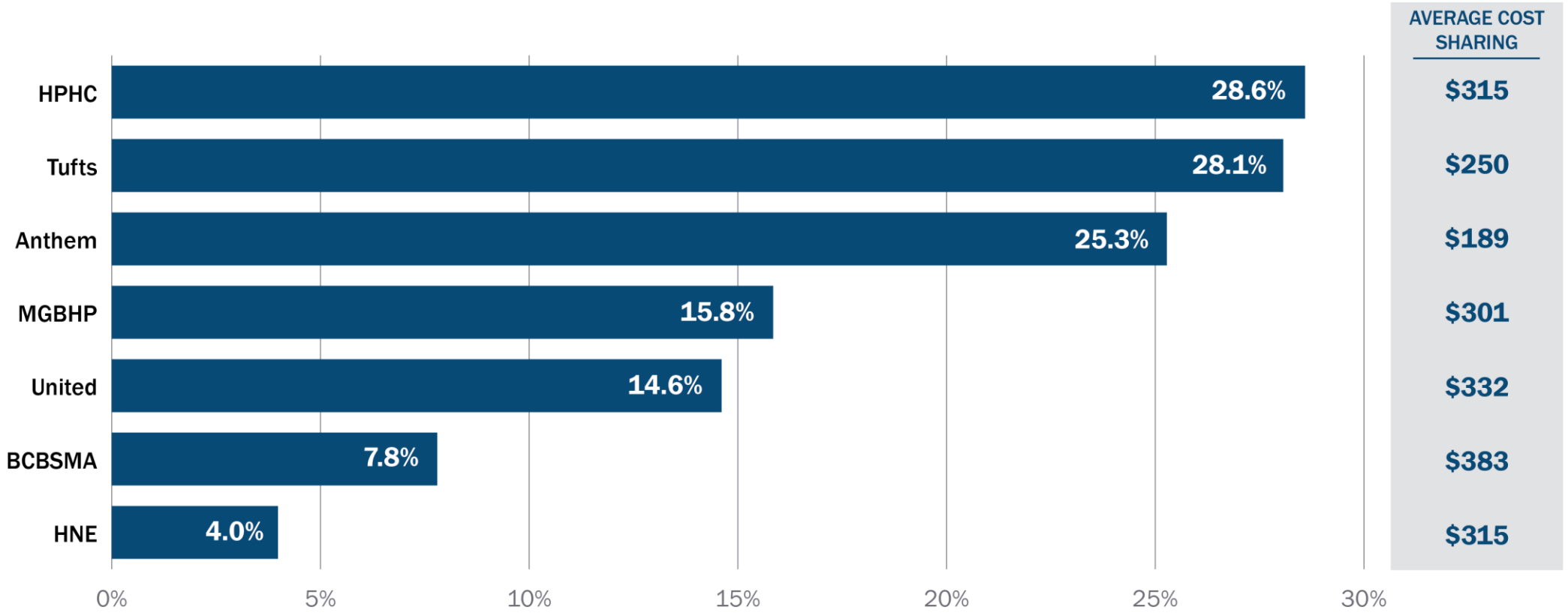
Source of cost sharing for preventive colonoscopy encounters, 2023



Notes: Based on encounters for services provided same day. Includes members of average risk, aged 45 to 65, with full-year coverage, and on commercial insurance only. 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 ICD10 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.

The prevalence of cost sharing for screening colonoscopy and average cost to patients varies widely by payer.

Prevalence of cost sharing for colonoscopy by payer and average cost sharing per encounter among encounters with any cost sharing, 2023



Notes: Based on encounters for services provided same day. Includes members of average risk, aged 45 to 65, with full-year coverage, and on commercial insurance only. 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.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

Outline

Coverage of Preventive Visits

Multiple ACA recommending institutions recommend coverage of preventive visits (well visits, physicals):

- The Bright Futures Project of HRSA and the American Academy of Pediatrics recommends annual well visits for children and adolescents from birth through age 21 (with more frequent visits recommended for children under age 3).[1]
- The Women's Preventive Services Initiative (WPSI) of HRSA and the American College of Obstetricians and Gynecologists recommend annual well-woman visits "beginning in adolescence and continuing across the lifespan".[2]
- There is no explicit requirement for coverage for preventive visits for males over age 21.

During the preventive visit, the patient can receive services other than the "well visit service" for which the ACA allows cost sharing, including problem-based care and labs:

- Evaluation and management (E&M) services for "problem-based care" may occur when a patient discusses a concern such as pain, a rash, or symptoms of a chronic condition. Guidance allows the provider to bill separately for a problem-based visit (for which standard patient cost sharing would apply), in addition to the preventive visit.[3]
- Lab tests, procedures, or other services may have cost sharing if they are not covered preventive services.

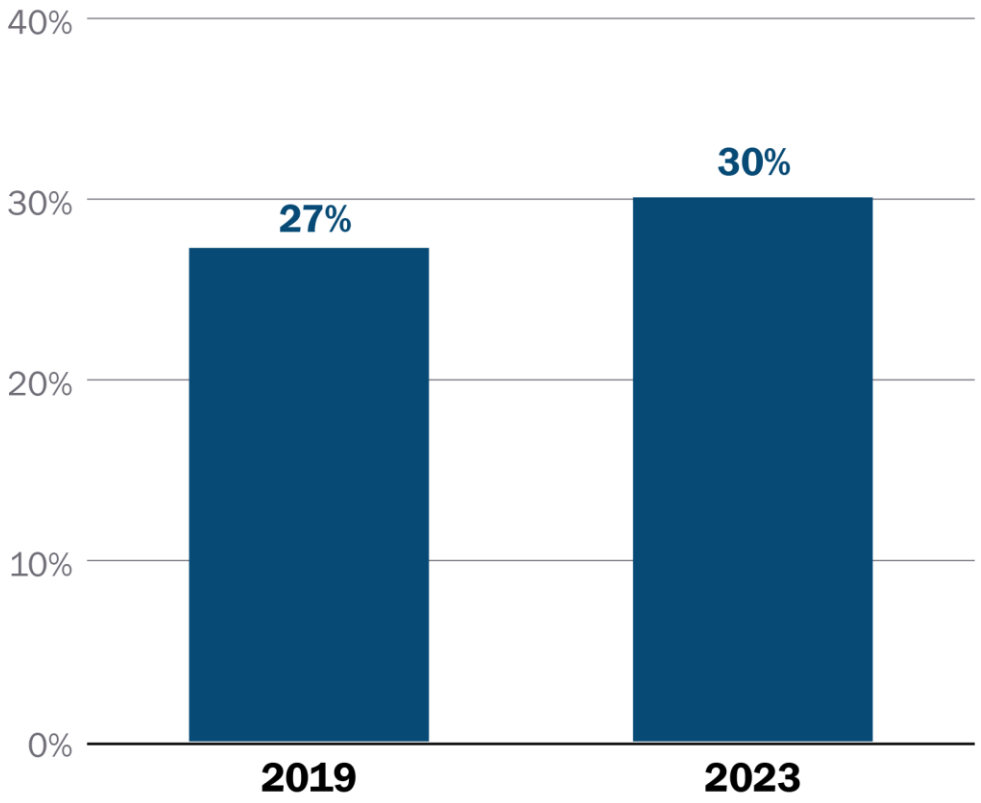
Provider groups sometimes issue notices to patients that addressing problem-based concerns during a preventive visit can result in cost sharing.[4]

The HPC examined cost sharing associated with all services during the preventive visit episode.

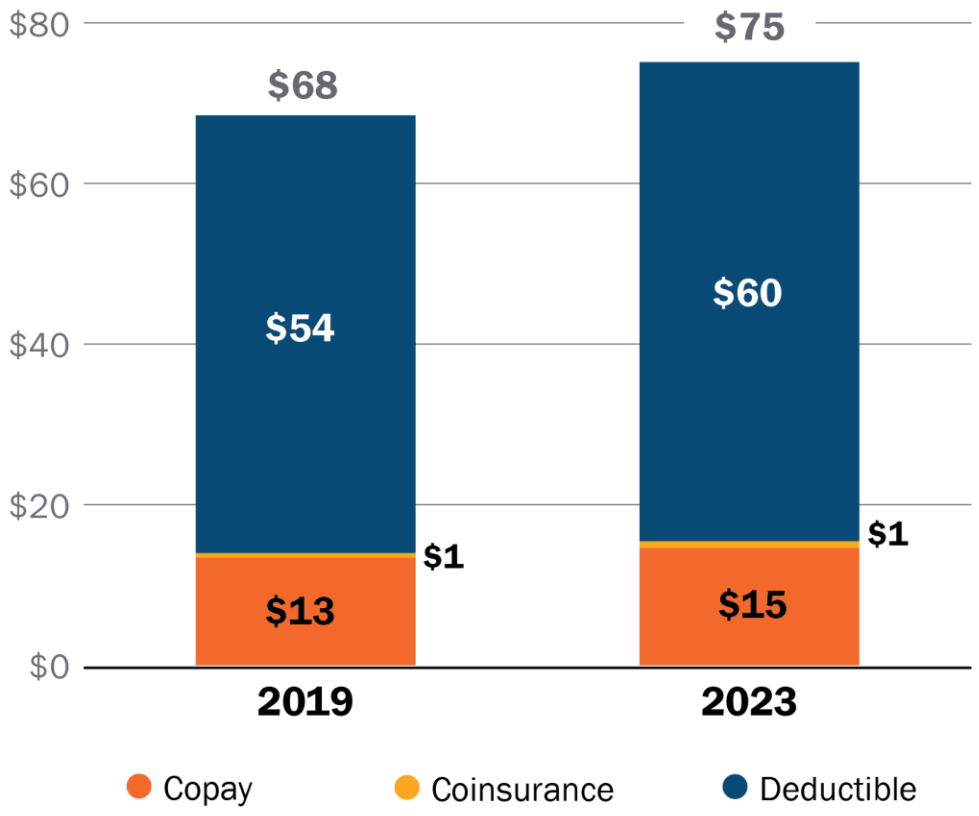
1. American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
2. Health Resources and Services Administration. Women's preventive services guidelines. Available at: https://www.hrsa.gov/womens-guidelines
3. American Medical Association. Can physicians bill for both preventive and E/M services in the same visit? Available at: https://www.ama-assn.org/practice-management/cpt/can-physicians-bill-both-preventive-and-em-services-same-visit
4. See e.g., Atrius Health. Helpful patient billing tips. Available at: https://www.atriushealth.org/patient-information/insurance-and-billing/billing/helpful-patient-billing-tips

One-quarter to one-third of preventive visit episodes have cost sharing. Patients who experience cost sharing pay about $75 on average, mostly due to deductibles.

Share of preventive visits with any cost sharing, 2019 and 2023



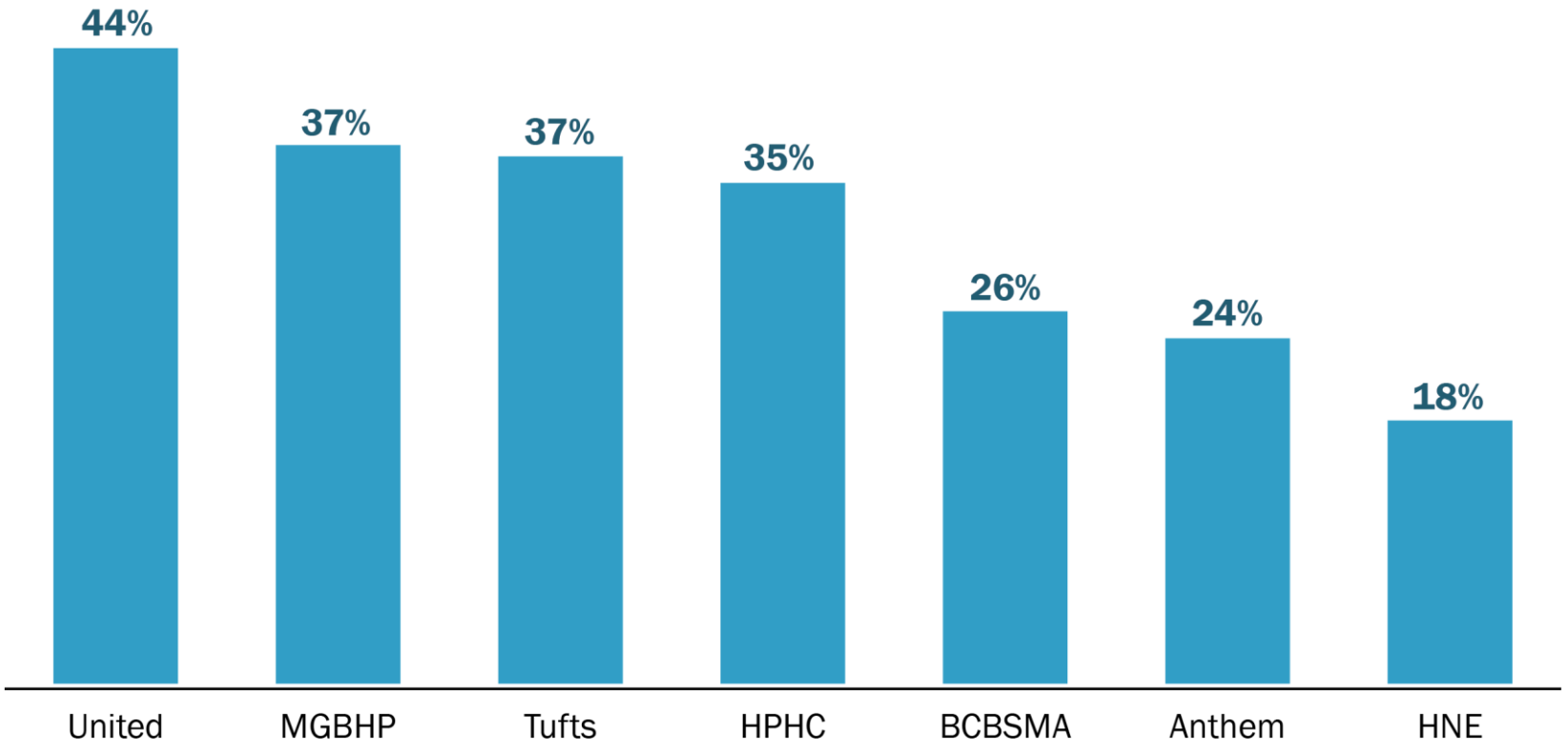
Average cost sharing amounts for preventive visits with any cost sharing, 2019 and 2023



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 visits 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.

Cost sharing for preventive visit episodes varies by payer, from about 18% of visits covered by Health New England to 45% of visits covered by United in 2023.

Share of preventive visits with cost sharing by payer, 2023

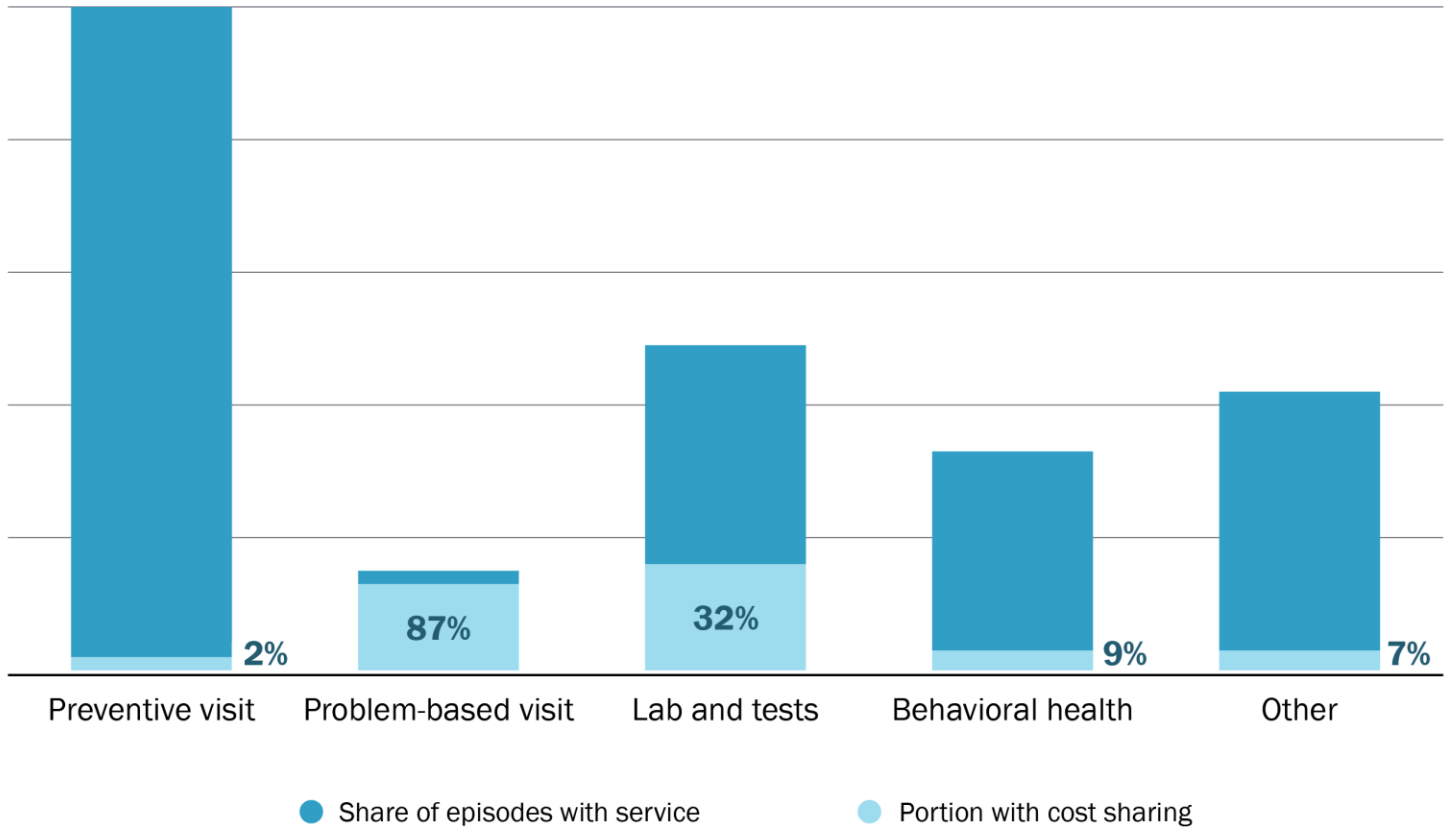


Notes: Includes commercial members ages 0-64 with full year medical coverage. Includes care provided in Massachusetts office, hospital outpatient department, ambulatory surgical center, retail clinic, or lab settings including Current Procedural Terminology (CPT) codes 99381-99387, 99391-99397, G0438-G0439, 99432, 99461, 99420, 99429. Preventive visits 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 CHIA All-Payer Claims Database v2023

- Average cost sharing amounts for preventive visits with cost sharing also vary widely, ranging from **$50 for HNE to $107 for MGBHP** as of 2023.

Problem-based codes and labs are the most common sources of cost sharing during preventive visit episodes.

Share of preventive visit episodes including codes for preventive visits, problem-based visits, labs and tests, 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.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

- **Patients with chronic conditions are about twice as likely as patients without chronic conditions to have a preventive visit episode that includes a problem-based code**, and as a result are more likely to pay cost-sharing for preventive visit episodes (38%) than people without chronic conditions (26%)

Outline

Despite federal mandates, cost sharing for ACA-covered preventive services remains common.

- Except for oral contraceptive prescriptions, **all preventive medications and services have some instances of cost-sharing.** The prevalence of cost-sharing for most services has remained relatively stable over time, suggesting that **some cost-sharing for preventive services is the current baseline in the Commonwealth**.
- Patients most often had cost sharing on services subject to their **deductibles**, suggesting opportunities for improvement in cost sharing benefit design.
- There are **many reasons patients may have cost sharing for preventive services**:
  - Each payer determines how to operationalize the mandate for its own coverage.
  - Payers must stay up to date on frequent updates to federal guidance, and update billing requirements accordingly.
  - Providers may make coding mistakes, particularly given each payer's potentially unique coding requirements.
- Unexpected bills for preventive care may **deter patients from using high-value preventive services** and erode their trust in the health care system and their relationship with their primary care provider and health plan.
- 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 facilitate patient use of this high-value care.
  - The HPC has been working collaboratively with the DOI to understand the root cause of these results. The findings can inform whether additional regulatory inquiries and compliance guidance are warranted.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Recognition of HPC Board Members

Implementation Updates: Chapters 342 and 343 of the Acts of 2024

2025 Health Care Cost Trends Report Preview: Improving Affordability and Predictability in Cost Sharing

MARKET TRANSACTION REVIEWS

- Notices of Material Change
- UMass Memorial Health: Proposed Transactions
- Beth Israel Lahey Health: Retrospective Cost and Market Impact Review of Merger **(VOTE)**

Moving Massachusetts Upstream (MassUP) Investment Program: Final Report

Executive Director's Report

Next HPC Board Meeting: July 24, 2025

Adjourn

Agenda

Call to Order

Approval of Minutes **(VOTE)**

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2025 Health Care Cost Trends Report Preview: Improving Affordability and Predictability in Cost Sharing

Market Transaction Reviews

NOTICES OF MATERIAL CHANGE

- UMass Memorial Health: Proposed Transactions
- Beth Israel Lahey Health: Retrospective Cost and Market Impact Review of Merger **(VOTE)**

Moving Massachusetts Upstream (MassUP) Investment Program: Final Report

Executive Director's Report

Next HPC Board Meeting: July 24, 2025

Adjourn

Since 2013, the HPC has reviewed 188 market changes.

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Physician group merger, acquisition, or network affiliation	42	22%
Formation of a contracting entity	40	21%
Clinical affiliation	36	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	32	17%
Acute hospital merger, acquisition, or network affiliation	31	16%
Change in ownership or merger of corporately affiliated entities	6	3%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

- The proposed acquisition of the oncology testing business of **BioReference Health, LLC**, a New Jersey-based subsidiary of for-profit OPKO Health, Inc. that operates 10 laboratory facilities nationwide, by **Laboratory Corporation of America Holdings, Inc.**, a publicly traded, multinational provider of laboratory services.

- A proposal by UMass Memorial Health Care (UMass) to merge **Marlborough Hospital**, a UMass community hospital, into **UMass Memorial Medical Center**, making Marlborough a licensed campus of the UMass academic medical center.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

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Market Transaction Reviews

- Notices of Material Change

UMASS MEMORIAL HEALTH: PROPOSED TRANSACTIONS

- Beth Israel Lahey Health: Retrospective Cost and Market Impact Review of Merger **(VOTE)**

Moving Massachusetts Upstream (MassUP) Investment Program: Final Report

Executive Director's Report

Next HPC Board Meeting: July 24, 2025

Adjourn

UMass-Marlborough Transaction Overview

Proposed Transaction:
UMass Memorial Medical Center, Inc. (Medical Center) and Marlborough Hospital (Marlborough) are proposing to merge. Following the proposed transaction, Marlborough would no longer be an independently licensed community hospital. Marlborough would become a licensed campus of the Medical Center. Both entities are currently subsidiaries of UMass Memorial Health Care, Inc. (UMMHC).

- **The parties state that the proposed transaction would**:[1, 2]
  - Provide Marlborough patients with greater access to tertiary & quaternary care, Hospital at Home, and a wider set of specialty and subspecialty services
  - Improve access, quality, and health outcomes through an integrated medical staff, more efficient care coordination, and improved access to inpatient and specialty services
- **UMMHC also claims that**:[3]
  - The merger is necessary to improve Marlborough's staffing, as Marlborough is increasingly relying on contracted services and has incomplete coverage across many service lines.
  - The merger would make it easier for patients to be transferred between Marlborough and the Medical Center, and for Marlborough patients to receive teleconsultation from Medical Center staff. This would generate savings for payers and patients and would allow the Medical Center to alleviate some of its capacity pressures.

Source: [1] UMass-Marlborough MCN; [2] Marlborough-UMass MCN; [3] UMass Response to DoN Questions

Background on the Parties: UMass Memorial Health Care (UMMHC) and UMass Memorial Medical Center

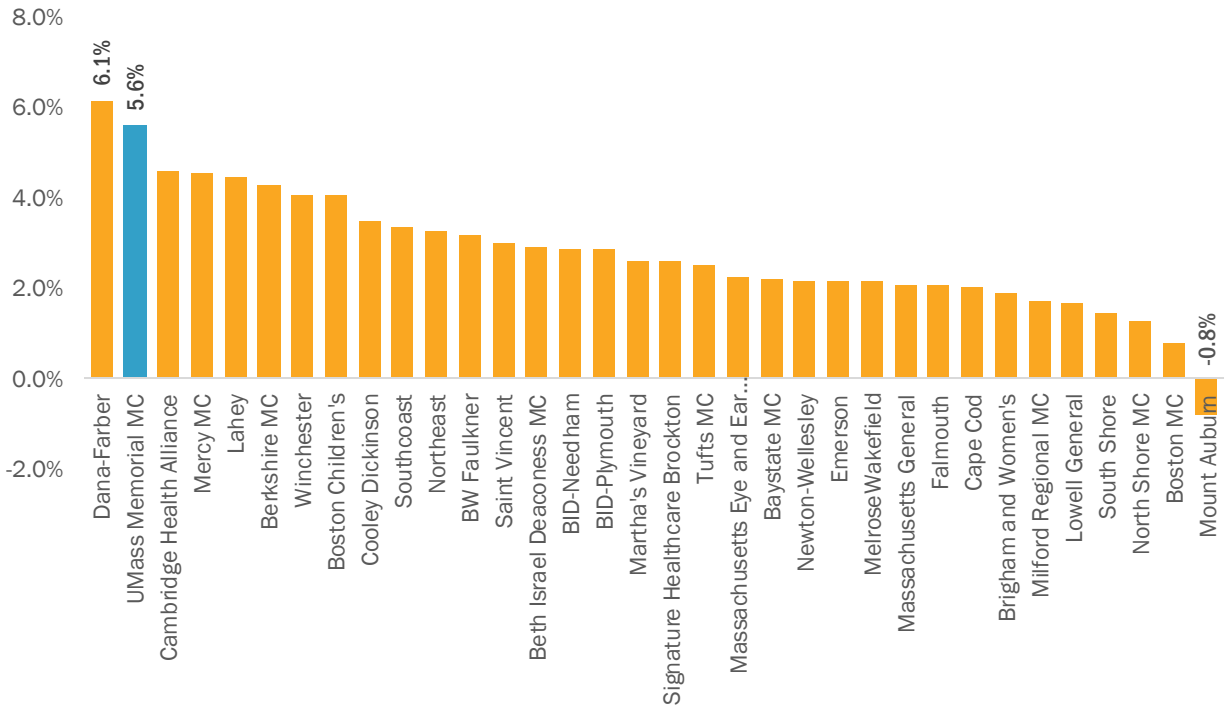
- UMMHC is a nonprofit corporation that owns and operates an integrated health care system in Central Massachusetts, including one academic medical center (UMass Memorial Medical Center) in Worcester and four community hospitals (Harrington Hospital, HealthAlliance-Clinton Hospital, Milford Regional Medical Center, and Marlborough Hospital)
  - In FY24, UMMHC and its affiliates had **$3.95B** in total assets and an operating revenue of **$4.30B**[1]
  - UMMHC is the **dominant provider in Central MA** and the **third-largest hospital system in the state** after MGB and BILH, with a commercial inpatient market share of 53.4% in its primary service area and 8.54% statewide[2]
- **UMass Memorial Medical Center** is UMMHC's AMC and largest hospital, with **801 beds** (4th largest in MA)[3]
  - Occupancy rate of **92.1%** in FY23 and a public payer mix of **68.2%**
  - Among the six AMCs in Massachusetts, the Medical Center has the **third highest statewide (cross-payer) relative price level**, after Mass. General Hospital and Brigham and Women's Hospital.[4]
- UMMHC has also had some of the highest price increases in MA in recent years.[5]
- UMMHC has also been growing, acquiring two community hospitals in recent years, each of which were anticipated to increase spending to some degree.

Source: [1] UMass Audited Financial Statements; [2] HPC analysis of hospital discharge data; [3] UMass Memorial Medical Center FY23 CHIA Hospital Profile; [4] CHIA Relative Price Databook 2022; [5] HPC analysis of All-Payer Claims Database

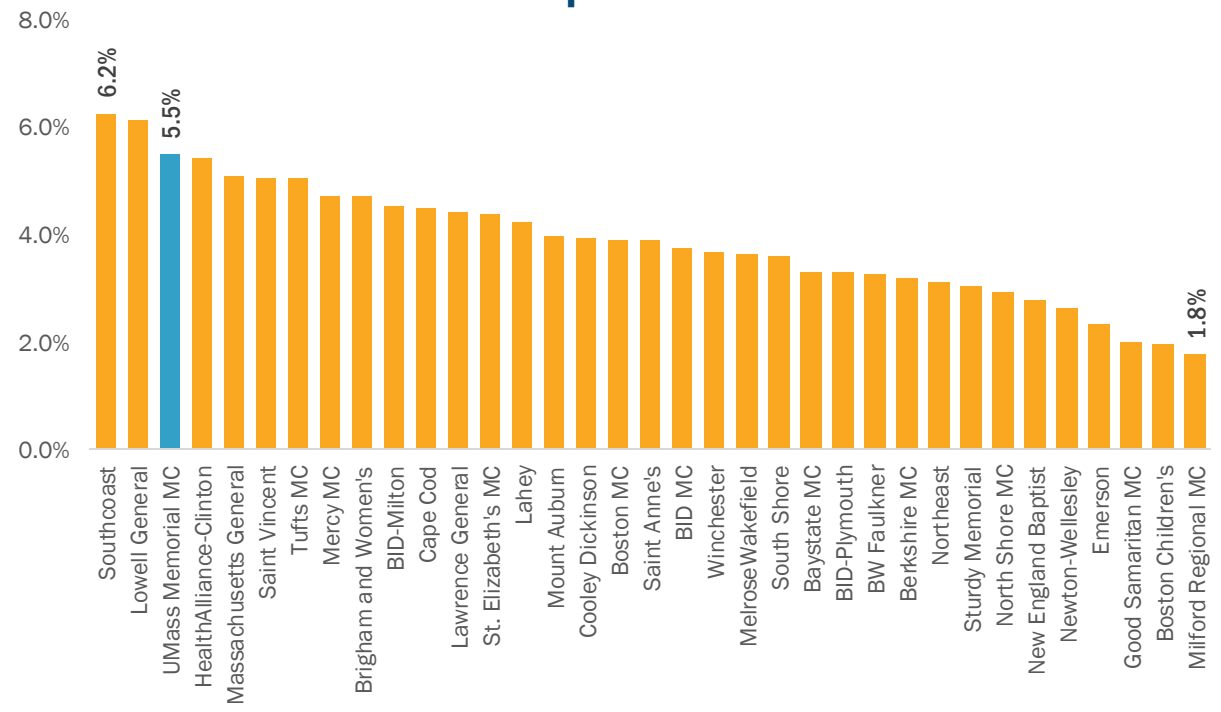
UMass Memorial Medical Center Average Annual Price Growth

- UMass Memorial Medical Center has **had one of the highest observed annual price increases** among MA hospitals from 2019 to 2023, with an average annual increase of 5.6% for HOPD and 5.5% for inpatient prices.

HOPD



Inpatient



- In the most recent year of data (2022-2023), UMass Memorial Medical Center had the **highest price increase for both HOPD and inpatient prices among the 35 largest Massachusetts hospitals**.

Source: HPC Analysis of All-Payer Claims Database

Background on the Parties: Marlborough Hospital

- Marlborough Hospital (Marlborough) is a non-profit hospital operating in Marlborough and owned by UMMHC
  - Marlborough is a **79-bed** community hospital[1]
    - Reported an occupancy rate of **76.8%** and a public payer mix of **68.5%** in FY23[2]
    - Similar commercial payer mix (**27%**) to the Medical Center (**29%**)
    - Higher outpatient NPSR (**$60M**) than inpatient (**$38M**)
  - Marlborough is staffed by physicians from UMass Memorial Medical Group. These physicians also staff the Medical Center and receive the same professional rates at all facilities.[3]
  - UMMHC negotiates facility rates for Marlborough as well as the Medical Center, but the commercial rates are different for each facility.
    - The Medical Center has a statewide commercial cross-payer relative price (S-RP) of 1.11, while Marlborough has a S-RP of 0.97.[4]
- UMass Memorial Cancer Center is located at Marlborough and is currently on the Medical Center's license.[5]
- The parties have stated that Marlborough has experienced staffing challenges in recent years, resulting in incomplete coverage in several service lines including Anesthesia, General Surgery, and Urology.[3]

Source: [1] MCN Filing; [2] Marlborough Hospital FY23 CHIA Hospital Profile; [3] UMass Response to DoN Questions; [4] CHIA Relative Price Databook 2022; [5] Massachusetts Registration of Provider Organizations 2023

Past MCNs for UMass Community Hospital Acquisitions

UMMHC has grown in recent years. The HPC previously reviewed two community hospital acquisitions by UMMHC:

Acquisition of Harrington Hospital (2021)

- The HPC's review found that the transaction would increase inpatient market concentration in Harrington's primary service area (PSA), but the impacts on bargaining leverage would likely be small.
- The HPC also found that spending for some payers could increase if Harrington prices rose to match UMass's community hospital rates, but for most services, Harrington's prices were already equal or higher.

Acquisition of Milford Regional Medical Center (2024)

- The HPC's review found a likelihood of increased spending and increased market concentration, with an estimated spending impact of $2.5M to $4.7M.
- However, Milford's financial circumstances put it at risk of closure or reduced services, and acquisition by UMass would provide it with needed financial support to maintain necessary service lines.
- UMass confirmed that it will comply with conditions of approval for the associated DoN application.

HPC estimates that the Marlborough merger is likely to modestly increase commercial spending but will be at least partially offset by savings and access improvements.

- If Marlborough adopts the Medical Center's commercial prices, **spending will increase by approximately $5.0M to $6.7M** annually[1]
  - By repricing 2022 discharges and HOPD visits at Marlborough to the Medical Center's rates for major commercial payers, we estimate an annual increase of $2.9M for inpatient services and $2.1M for outpatient services, for a total of $5.0M. By utilizing more recent internal payment data from UMass, we estimate a higher $6.7M spending impact for inpatient and outpatient care.
  - UMass stated that it is **committed to working in good faith with all commercial payers** to address any questions or concerns they have related to the merger, including addressing concerns about pricing impact in the course of contract negotiations.
- There is also a potential for savings that could offset some of the spending impact, particularly due to avoided costs for transfers. For instance, post-transaction, ambulance rides between Marlborough and the Medical Center would be paid for by UMass rather than payers or patients. This could generate an estimated **$644K to $2.1M in savings** based on the volume of transfers in past years.
- The merger may also improve access by alleviating staffing challenges at Marlborough that may otherwise force Marlborough to limit or end additional service lines, and by allowing patients to more easily move between the Medical Center and Marlborough, helping to alleviate capacity constraints at the Medical Center.
  - In FY23, the Medical Center had an occupancy rate of 92% compared to Marlborough's 77%.[2]

Balancing these considerations, the HPC elected not to conduct a Cost and Market Impact Review but expects to continue to monitor UMMHC's actions in the market.

Source: [1] Analysis of 2022 CHIA Relative Price data; [2] CHIA Hospital Profiles

Related Determination of Need (DoN) Reviews

- UMass filed a DoN application for the merger of the Medical Center and Marlborough on February 13th, 2025, the same day that the notice of material change was filed. DPH's review of this application is ongoing.
  - As a party of record in the DoN process, the HPC submitted a comment to DPH on April 11th stating that the HPC was reviewing the transaction and expected the transaction to have some spending impact.
  - The HPC's review is now complete and these public findings may be considered by DPH in its review.
- On March 4th, 2025, UMass also filed a related DoN application, proposing to add proton therapy services at the UMass Memorial Cancer Center at Marlborough Hospital at a cost of **$53.6 million**. This proposal was not subject to direct HPC review but notes:
  - Currently, MGH is the only Massachusetts provider offering proton therapy services, but proton therapy centers are being developed in both Rhode Island and Connecticut.
  - The application states that the project would increase access to proton therapy in Central MA, reduce spending due to lower prices than the proton therapy service at MGH, reduce expenses incurred in traveling to receive this treatment, and improve UMass's recruitment and retention of high-quality clinical talent.
  - However, proton beam therapy is a substantially higher cost service than traditional radiation, and research comparing the efficacy of these services for different populations is ongoing. To date, clinical applications of proton therapy have remained somewhat limited.

Source: UMass DoN Application and Related Materials; UMass 2023 Annual Cost Trend Hearing Pre-Filed Testimony; UMass 2025 Cost Growth Benchmark Hearing Pre-Filed Testimony

Material Change Notices Currently Under Review

The proposed acquisition of **Vibra Hospital of Western Massachusetts**, the for-profit owner and operator of both an inpatient long term acute care hospital and a skilled nursing facility in Rochdale, Massachusetts, by **Everest Hospital, LLC**, a newly formed Massachusetts corporation in coordination with Nielk Equities, LLC.

RECEIVED SINCE 4/17/2025

The proposed acquisition of **River Valley Counseling Center**, an affiliate of Valley Health Systems based in Holyoke, by **ServiceNet**, a non-profit human service agency in Western MA that provides mental health, substance use, vocational, and other services.

A proposed contracting affiliation between **Pediatric Physicians' Organization at Children's**, a contracting organization partially owned by Children's Hospital Corporation, and **Children's Health Care**, a 9-physician primary care pediatric group with locations in Newburyport and Haverhill.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

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- Notices of Material Change
- UMass Memorial Health: Proposed Transactions

BETH ISRAEL LAHEY HEALTH: RETROSPECTIVE COST AND MARKET IMPACT REVIEW OF MERGER (VOTE)

Moving Massachusetts Upstream (MassUP) Investment Program: Final Report

Executive Director's Report

Next HPC Board Meeting: July 24, 2025

Adjourn

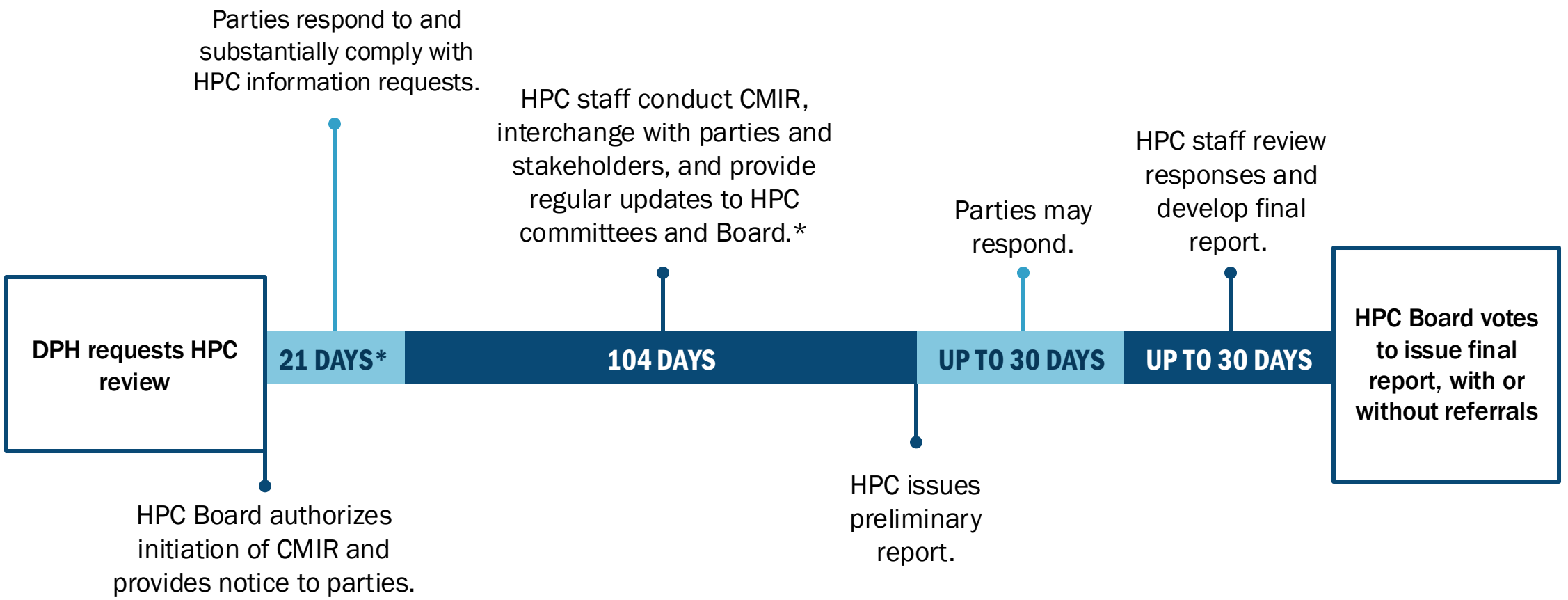
Request for a Retrospective Beth Israel Lahey Health Cost and Market Impact Review

Beth Israel Lahey Health

In 2019, Beth Israel Lahey Health was formed through the merger of Lahey Health System; CareGroup and its component parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; and Seacoast Regional Health Systems.

- That merger and the related contracting affiliations was the subject of a Cost and Market Impact Review (CMIR), DoN review by DPH, and an investigation by the Office of the Attorney General.
- The merger was approved by DPH, subject to multiple DoN conditions, and the Attorney General entered into an Assurance of Discontinuance with the parties setting forth additional conditions, including a 7-year price cap.
- The conditions of the DoN included a requirement that DPH could request, and BILH would submit to, a CMIR by the HPC if the HPC had not otherwise conducted a CMIR within five years. **DPH made this request to the HPC in May.**
- The CMIR would examine the impacts of the formation of BILH on **health care spending, market dynamics, quality of care, and equitable access to care**. As in all CMIRs, the HPC will conduct its independent, data-driven review by examining confidential information provided by BILH and other market participants, as well as all available data on measures of health care costs, prices, quality, and access in Massachusetts.

Timeline for CMIR Review



* The parties may request extensions to this timeline which may likewise affect the timing of the report

VOTE

Authorization of Initiation of Cost and Market Impact Review of Beth Israel Lahey Health

MOTION

That the Commission hereby authorizes the initiation of a cost and market impact review of the creation of Beth Israel Lahey Health, at the request of the Department of Public Health under Condition 11 of DoN application No. NEWCO 17082413-TO, pursuant to section 13 of chapter 6D of the Massachusetts General Laws and 958 CMR 7.00.

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MOVING MASSACHUSETTS UPSTREAM (MASSUP) INVESTMENT PROGRAM: FINAL REPORT

Executive Director's Report

Next HPC Board Meeting: July 24, 2025

Adjourn

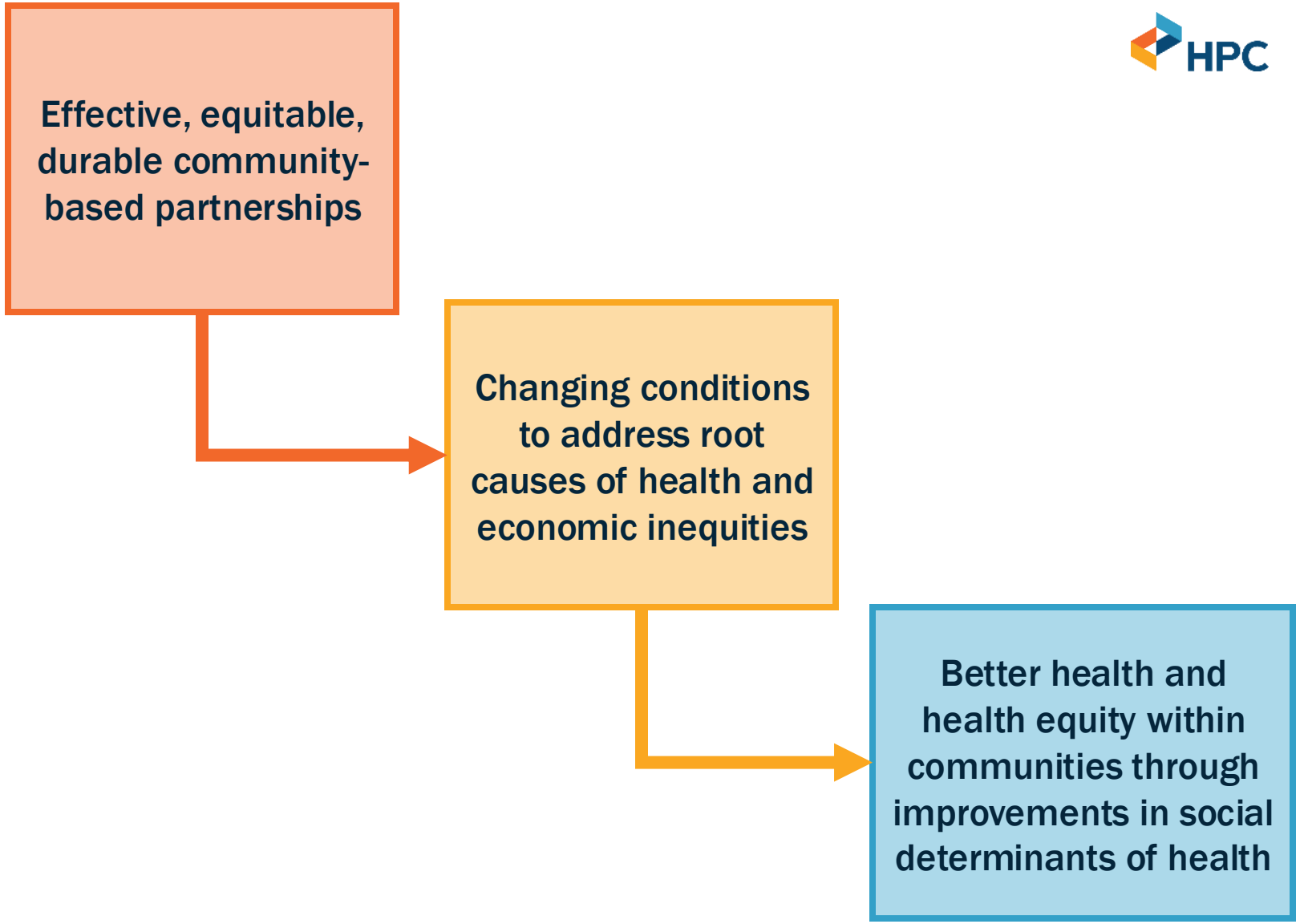
MassUP Program at a Glance

The Moving Massachusetts Upstream (MassUP) Investment Program funded four **partnerships between hospitals and community-based organizations** (CBOs) that worked together to **address a social, environmental, or economic challenge** affecting health in their communities.

Key Parameters

- Four awards of up to $650,000 each, funded by the HPC and Department of Public Health
- Implemented over ~3 years (September 2020 – late 2023)
- Cross-sector partnerships selected one social determinant of health in their community and executed “upstream” activities to address it

MassUP Change Model



MassUP Partnerships

Awardee and Partnership	Community	SDOH of Focus
Cooley Dickinson Health Care: Hampshire County Food Policy Council	Hampshire County	Food Systems and Security
Heywood Hospital: HEAL Winchendon – Economic Empowerment	Town of Winchendon	Economic Stability and Mobility
Mass General Hospital: Cross-City Coalition	Cities of Chelsea, Revere	Economic Stability and Mobility
Mercy Medical Center: Springfield EATS (Equity, Advocacy, Transformation, and Systems)	Springfield neighborhoods	Food Systems and Security

MassUP Partnerships Developed New Community Institutions

HAMPSHIRE COUNTY FOOD POLICY COUNCIL

An organization enabling residents to lead efforts to improve the food system and food security in the Hampshire County

- Established a **consensus-based governance and operational model** to maximize resident voice
- Created working groups on **food policy, vision, education, communication,** and others
- Leveraged some MassUP funding to establish a **small grant program** to support local projects

THE HUB WINCHENDON, MA

A venue in Winchendon for new economic and related community activities

- **Site for commerce:** Makerspace and "Makers Alley" pop up fairs, youth-run Sunshine Café
- **Site for services: food** pantry, thrift store, and Winchendon Community Action Committee
- **Site for other community gatherings:** events, trainings, and bowling

MassUP Partnerships Increased Civic Participation

Engagement

Some partnerships helped activate residents and local leaders to get engaged in local affairs and governing bodies

- Engaging with HEAL led **six residents to join Town of Winchendon or regional committees and councils**
- **CCC's** early childhood education work **brought together more than 40 providers and local leaders** to create a proposal for changes to the City of Revere's ordinances

Advocacy

All partnerships took part in **policy advocacy** work beyond their immediate community

- **State:** State house education days; regularly engaging legislators and staff
- **Federal:** 2022 White House Conference on Hunger, Nutrition and Health

MassUP Partnerships Enabled Greater Alignment and Coordination Between Community Organizations

Springfield EATS' partners prioritized strategic coordination to improve resident use of SNAP/HIP benefits.

Focused on simplifying enrollment, educating local organizations to register eligible clients, and expanding access to locations where clients could enroll in and use SNAP/HIP benefits.

Springfield EATS partner orgs distributing food boxes in Springfield, MA

Springfield EATS reported increases in:

- CBO clients enrolled in SNAP and HIP
- Staff trained to help clients enroll in benefits
- Access to fresh foods for clients of the partner organizations

Additional Lessons Learned in MassUP

Practical steps to reinforce their upstream mission propelled and unified partnerships.

Partnerships working upstream face many challenges, particularly when confronted with significant immediate community needs.

Downstream work can further upstream goals when undertaken strategically.

Pre-existing relationships between organizations were usually helpful but caused challenges in some cases.

Building fruitful working relationships required intentional effort.

Collectively establishing strategic planning and decision-making processes built partnership cohesion.

Partnerships benefitted from having dedicated staff in a variety of roles.

Effective resident engagement required clear leadership opportunities, skill-building, and power-sharing.

When effectively engaged, residents added unique value.

Hospitals were effective partners, playing a variety of roles and providing tangible supports.

The sustainability of upstream work is fostered by and depends on more than continued funding.

Partnerships seeking to work upstream face many challenges, particularly when confronted with significant immediate community needs.

"As frontline organizations (early care, healthcare, urban agriculture, youth development, food policy/advocacy, emergency food/wrap around services), **all partners needed to pivot to adapt to emerging pandemic protocols and provide safe access to food** to a rapidly growing group of residents who needed it."

-Springfield EATS Program Update, April 2023

- COVID-19 pandemic was an unanticipated crisis for MassUP partner organizations
- Community-based organizations were stretched in two directions, and experience increased staff turnover, upheaval in operations
- Grief and burnout throughout communities increased the challenges of engaging residents

Two Things that Helped Some Partnerships Maintain Upstream Focus

1. Active, consistent use of mission/vision statements to guide decisions

> "The HEAL Collaborative is a community movement for long-lasting, upstream change to improve the health and quality of life for Winchendon and Gardner residents. Our Collaborative engages community members, local institutions, and external partners in holistically building our communities' assets, creating greater social inclusion, shifting power, and ensuring that we have a sustainable collective impact."

heal
HOPE EMPOWER ACCESS LOVE

2. Downstream work—when strategically integrated

Hospitals were effective partners in MassUP.

CONNECTIONS

Using their professional connections to promote the partnerships' work, such as setting up meetings with state legislature staff

RESOURCES

Providing organizational resources and capabilities that might be lacking among CBOs, including serving as fiscal agents and/or sponsors for grants and other opportunities

VISIBILITY

Using their visibility and name recognition within the community to bring attention and credibility to the partnership and its work

EMPOWERING OTHERS

Modeling a commitment to, and thereby helping to ensure, community empowerment by putting their organizational power behind shared partnership goals and activities rather than pursuing their own agenda within the partnership

Effective engagement of residents took effort—and yielded high value.

Effective resident engagement…

…REQUIRED

- Significant investment by partnership staff
- Careful planning and facilitation
- Balancing resident interests and needs with partnership constraints

…LOOKED LIKE

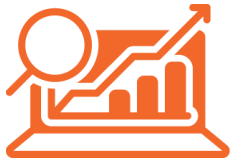
- Formal leadership roles and equitable decision-making
- Skill development support
- Stipends and other resources to support participation
- Partnership flexibility and responsiveness over time

…AND ULTIMATELY LED TO

- Specific projects, proposed and spearheaded by residents
- Improvements in partnerships' understanding of community needs
- New connections within the community

MassUP partnerships worked toward sustainability throughout the implementation period.

Securing New Funding



All partnerships reported they or their partners identified or received **additional funding** from federal, state, local, or private/philanthropic sources to continue MassUP or complementary work beyond 2023.

Building Connections

Partnerships deepened ties within their original sectors and expanded their connectors to new sector.

Partnerships reported making **new connections to between 33 and 116 organizations.**

Partnerships that have continued past MassUP invested the most in:

- Maintaining and community a strong upstream vision and mission.
- Engaging new individuals and organizations in the partnership's work and activities.
- Prioritizing the development and empowerment of resident leaders.

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Next HPC Board Meeting: July 24, 2025

Adjourn

Maternal Health Access and Birthing Patient Safety Task Force

- On **Wednesday, April 2**, the Maternal Health Task Force met for the first time in the Altman Conference Center.

- Members discussed the **existing resources** available to their organizations required to fulfill the task force's legislative mandate and what is missing from these resources.
- The Office of Health Resource Planning (OHRP) and the Research and Cost Trends team are collaborating with the MHTF co-chairs to **develop a report outline and qualitative data collection plan**.
- The next meeting of the MHTF will take place on **June 24** and will be livestreamed on the HPC's website.

Primary Care, Access, Delivery, and Payment Task Force

- The first meeting of the **Primary Care, Access, Delivery, and Payment Task Force (PCTF)** was held on April 16.

- Two workgroups were established to give task force members **an opportunity to participate in deeper discussions** around specific task force deliverables: the **Data and Research Workgroup and the Workforce Workgroup**
- The upcoming meetings of the full PCTF meetings are scheduled for **June 17**, **July 22**, and **September 17**.
- The first task force deliverables are due **September 15**:
  - Define primary care services, codes and providers
  - Develop a standardized set of data and reporting requirements for private and public payers, providers, and provider organizations.

HPC Summer Fellowship Program

The HPC Fellowship Program affords students the opportunity to develop a stand-alone policy or research project within one of the HPC's five departments. Fully embedded into the HPC, fellows attend staff and team meetings, and manage their time to ensure they meet outlined project benchmarks and present the findings from their project to the entire agency at the end of the summer.

- 10-week program starting in June and ending in August.
- Must be enrolled in a full-time master's, PhD, law, or medical program.
- Paid $32/hour for a total of up to $12,000.

2025 HPC Summer Fellows

Amy Bolton
Research and Cost Trends
Tufts University School of Medicine and Tufts Friedman School of Nutrition Science and Policy

Samurah Curry
Chief of Staff
Seton Hall University

Haley Director
Research and Cost Trends
University of Pittsburgh School of Public Health

Lydia Goldthwait
Health Care Transformation and Innovation
Boston University School of Public Health

Kristen Gottlieb
Research and Cost Trends
Harvard T.H. Chan School of Public Health

Helena Hailemicheal
Health Care Transformation and Innovation
Boston University School of Public Health

Nadia Hill
Behavioral Health Workforce Center
Boston University School of Public Health

Annabelle Lee
Market Oversight and Health Planning
Harvard University T.H. Chan School of Public Health

Molly Little
Legal
New England Law - Boston

Taylor Zevanove
Market Oversight and Health Planning
Boston University School of Public Health

AcademyHealth 2025 Annual Research Meeting

Eight research posters prepared by the HPC were selected through a competitive process to be highlighted at this year's **Academy Health Annual Research Meeting**. The AcademyHealth Annual Research meeting is the preeminent, national gathering of the health policy researchers and experts. Each one of the HPC's posters highlights research into health care spending and utilization, or findings from HPC investment programs.

- Anyone Home? The Landscape of Hospital at Home in Massachusetts
- Examining Discrimination Faced by Black Doulas Serving Black Birthing People and its Impacts on Work Efficacy and Career Longevity
- Examining Preventative Colorectal Cancer Screening Trends: Provider Price Variation and Cost Drivers
- Impacts of a Cross-System Care Coordination Program for Pregnant Individuals with Opioid Use Disorder and Substance Exposed Newborns
- The Impact of Mental Health Emergency Department Boarding on Spending and Follow-up Care
- Prevalence of Cost-Sharing for HIV Pre-Exposure Prophylaxis and its Relationship to Medication Adherence
- Unpredictability of Consumer Cost Sharing Among Commercially-Insured Massachusetts Residents
- Utilization and Spending Impact of GLP-1 Medications in the Massachusetts Commercial Market, 2018-2024

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NEXT HPC BOARD MEETING: JULY 24, 2025

Adjourn

Upcoming Meetings

HPC BOARD MEETING

- Thursday, July 24, 2025
  12:00 – 3:00 PM

MATERNAL HEALTH TASK FORCE

- Tuesday, June 24, 2025
  12:00 – 2:00 PM

PRIMARY CARE TASK FORCE

- Thursday, June 12, 2025 – *Workforce Workgroup*
  11:00 AM – 12:30 PM
- Tuesday, June 17, 2025
  10:00 AM – 12:00 PM
- Thursday, July 10, 2025 – *Data and Research Workgroup*
  11:00 AM- 12:30PM
- Tuesday, July 22, 2025
  10:00 AM – 12:00 PM

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Schedule of Next HPC Board Meeting – July 24, 2025

ADJOURN