

# Primary Care Task Force: Data and Research Workgroup

November 18, 2025



**MASSACHUSETTS**  
HEALTH POLICY COMMISSION



**EOHHS**

# Agenda



Call to Order



## **UP NEXT: Approval of Minutes: July 10, 2025 (VOTE)**

Center for Health Information and Analysis (CHIA) Spring 2026 Primary Care Dashboard Data Specifications

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

Statutory Deliverable #5: Assess the impact of health plan design on health equity and patient access to primary care services

Upcoming PCTF Meeting: Wednesday, December 3, 2025

Adjourn

# VOTE

## Approval of Minutes from the July 10, 2025 Primary Care Access, Delivery, and Payment Task Force Data and Research Workgroup Meeting

### MOTION

That the Primary Care Access, Delivery, and Payment Task Force Data and Research Workgroup hereby approves the minutes of the meeting held on July 10, 2025, as presented.

# Primary Care Task Force: Data and Research Workgroup Members



**Workgroup Chair David Seltz, Executive Director, Massachusetts Health Policy Commission**

**Workgroup Co-Chair Ryan Schwarz, MD, MBA, Chief, Office of Accountable Care and Behavioral Health, MassHealth**

- **Senator Cindy Friedman**, Chair, Joint Committee on Health Care Financing
- **Michael Caljouw**, Massachusetts Commissioner of Insurance
- **Lauren Peters**, JD, Executive Director, Center for Health Information and Analysis
- **Suzanne Curry**, Director of Policy Initiatives, Health Care For All
- **Mark Friedberg, MD, MPP**, Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts
- **Judith Melin, MA, MD, FACP**, Governor, Massachusetts Chapter of the American College of Physicians; Internal Medicine, Beth Israel Lahey Health
- **Lora Pellegrini, JD, President and CEO**, Massachusetts Association of Health Plans
- **Barbra G. Rabson, MPH, President and CEO**, Massachusetts Health Quality Partners Dr. Black and Wayne

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# Massachusetts Primary Care Dashboard

PCTF Data and Research Workgroup

November 18, 2025



# Dashboard Overview

## BACKGROUND

- CHIA and MHQP developed the primary care dashboard to inform targeted policy solutions and investments. The dashboard includes 6 domains.
- Next iteration planned for **June 2026**
- General Dashboard Guidelines:
  - Report summary level data.
  - Data should be timely; no older than 2-3 years than current dashboard.
  - Utilize additional data sources for validation where possible.
  - Additional trend data or stratifications to be reported in the primary care interactive workbook (e.g., Tableau).





# Metric Considerations

By Domain

# Care Domain

## METRICS FOCUSED ON UTILIZATION AND QUALITY OF PRIMARY CARE

### 2026 Proposed New Metrics

- Prenatal and Postpartum Care: [HEDIS](#)
- Patient-Clinician Trust: [MHQP Patient Experience Survey](#)
- Substance Use Assessment in Primary Care: [HEDIS](#)
- Primary Care Visits with a Primary Diagnosis for a Mental Health Condition or Developmental Disorder: [HPC Cost Trends](#)

#### Childhood Immunization Status (Combination 10)

Percentage of children 2 years of age who received all recommended doses of the HEDIS combination 10 vaccinations by their 2nd birthday.

#### Screenings (Adult, Commercial)

Colorectal cancer  
Members 45-75 years of age.  
Breast cancer  
Women 50-74 years of age.  
Cervical cancer  
Women 21-64 years of age.

#### Well-Child Visits, First 15 Months

Percentage of commercially insured children in MA who had 6 or more well-child visits on or before their 15-month birthday.

#### Patient-Provider Communication (MassHealth)

MA patient-reported experiences of patient-provider communication in primary care visits in MA for MassHealth members, based on aggregate survey responses on a 0-100 scale.

#### Adult Influenza Vaccinations

Percentage of MA adults (18+) who received the seasonal influenza vaccination in the past 12 months.

#### Patient-Provider Communication (Commercial)

MA patient-reported experiences of patient-provider communication in primary care visits in MA for commercially insured members, based on aggregate survey responses on a 0-100 scale.

#### Behavioral Health Screening (Adult, MassHealth)

MA patient-reported experiences of being screened for depression and anxiety during a primary care visit for MassHealth members based on aggregate survey responses, on a 0-100 scale.

#### Chronic Disease Control (Commercial)

Controlling High Blood Pressure  
Members 18-85 with hypertension, whose blood pressure is controlled (higher is better).  
Diabetes-HbA1c Poor Control  
Members 18-75 with diabetes whose most recent HbA1c level was >9% (lower is better)

#### Behavioral Health Screening (Adult, Commercial)

MA patient-reported experiences of being screened for depression and anxiety during a primary care visit for commercially insured members, based on aggregate survey responses on a 0-100 scale.

# Access Domain

## METRICS FOCUSED ON ACCESS TO PRIMARY CARE

### 2026 Proposed New Metrics

- Accepting New Patients: [CHIA MHIS](#)
- MA Primary Care Physicians by Geography: [APCD](#)

#### Difficulty Obtaining Necessary Health Care

Percentage of MA residents who reported that they had difficulty obtaining necessary health care in the past 12 months.

#### Primary Care Access (Commercial)

MA patient-reported experiences of primary care access for commercially insured members, based on aggregate survey responses on a 0-100 scale.

#### Primary Care Access (MassHealth)

MA patient-reported experiences of primary care access for MassHealth members, based on aggregate survey responses on a 0-100 scale.

#### Residents With a Primary Care Provider

Percentage of MA residents who reported that they have a primary care provider.

#### Usual Source of Care

Percentage of MA residents who reported that they have a usual source of care.

#### Usual Source of Care by Setting

Percentage of MA residents who reported that they have a usual source of care, by type of care setting.

2023 data

#### Preventive Care Visit

Percentage of MA residents who reported that they had a visit to a general doctor, nurse practitioner, physician's assistant, or midwife for preventive care in the past 12 months.

#### FQHC Patients Served

Percentage of MA residents who received medical care at a Federally Qualified Health Center (FQHC).

# Capacity Domain

## METRICS FOCUSED ON PRIMARY CARE WORKFORCE AND PIPELINE

### 2026 Proposed New Metrics

- Primary Care Workforce Survey Data: CHIA [Upcoming Publication](#)
  - Clinician characteristics (e.g., clinician age, race, and ethnicity)

### Considerations

- Additional Workforce measures

#### Percentage of Primary Care Physicians

Percentage of Massachusetts-based physicians who practice in primary care.

#### Percentage of Primary Care Physicians Age 65 or Older

Percentage of Massachusetts-based physicians who practice in primary care and are age 65 or older.

#### Percentage of Primary Care Physicians Leaving Primary Care

Percentage of primary care physicians in Massachusetts who no longer provide primary care services.

#### Primary Care Physicians per Population

Number of physicians working in primary care per 100,000 Massachusetts residents.

#### Primary Care Physician Assistants per Population

Number of physician assistants (PAs) working in primary care per 100,000 Massachusetts residents.

#### Primary Care Nurse Practitioners

Total number of nurse practitioners (NPs) working in primary care in Massachusetts.

#### Percentage of Massachusetts Medical School Graduates Entering Primary Care

Percentage of Massachusetts medical and osteopathic physicians practicing in primary care 6 to 8 years after graduation.

#### Primary Care Physician Salary

Estimated average annual salary for a family medicine physician and a pediatrician in Massachusetts compared with the average salary range across all Massachusetts physicians.

# Finance Domain

## METRICS FOCUSED ON SPENDING FOR PRIMARY CARE

### 2026 Proposed New Stratification

- Primary Care Spending: [CHIA Payer Reported PCBH Data](#)
  - Percent of total and total primary care spending stratified by primary care service categories.

#### Primary Care Spending

Spending on primary care services as a percentage of total medical spending by insurance category and on a per member per month (PMPM) basis.

#### Managed Member Months Under an APM

The share of Massachusetts resident member months whose care is paid for under an alternative payment method (APM), which provide incentives to reduce overall costs (e.g., reduce unnecessary services and provide care in the most appropriate setting) while maintaining or improving quality.



## For Discussion

### FUTURE CONSIDERATIONS

#### **What measures should be included in future iterations of the Dashboard?**

- Examples:
  - Additional spending or utilization measures
  - Additional Access measures - wait times to appointments, practices accepting new patients
  - Additional Capacity measures - self-reported burnout among PCPs, admin burden, medical assistant/clinician ratio, turnover rates
  - Measures related to Concierge Medicine/Direct Care, Urgent Care



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# Questions?



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DELIVERABLE	STATUTORY DEADLINE
 1 Define primary care services, codes, and providers (complete)	September 15, 2025
2 Develop a standardized set of data and reporting requirements for private and public payers, providers and provider organizations	September 15, 2025
3 Establish a primary care spending target for private and public health care payers that reflects the cost to deliver evidence-based, equitable and culturally competent primary care	December 15, 2025
4 Propose payment models to increase public and private reimbursement for primary care services	March 15, 2026
<b>5 Assess the impact of health plan design on health equity and patient access to primary care services</b>	<b>March 15, 2026</b>
6 Monitor and track the needs of and service delivery to residents of the Commonwealth	May 15, 2026
7 Create short-term and long-term workforce development plans to increase the supply and distribution of and improving working conditions of primary care clinicians and other primary care workers	May 15, 2026

# Trends in Cost Sharing

# Policy Background: Opportunities for Improving Cost Sharing

- Massachusetts policymakers have sought to address the **high and growing burden of out-of-pocket health 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.<sup>1</sup>
  - 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.<sup>2</sup>
- 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.

# 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.
- In recent years, as underlying health care spending has grown, insurers and employers have increasingly turned to higher cost sharing (mainly deductibles) **in an attempt to mitigate premium increases**.

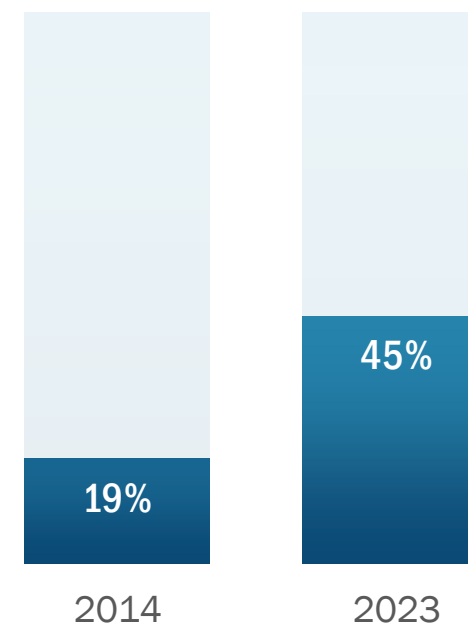
# Typical cost sharing design, especially the use of deductibles, has generally not led to more judicious use of health care resources.



A large body of literature demonstrates that **cost sharing reduces care use, including essential and needed care.**<sup>1</sup>

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.**<sup>2</sup>



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.

# 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

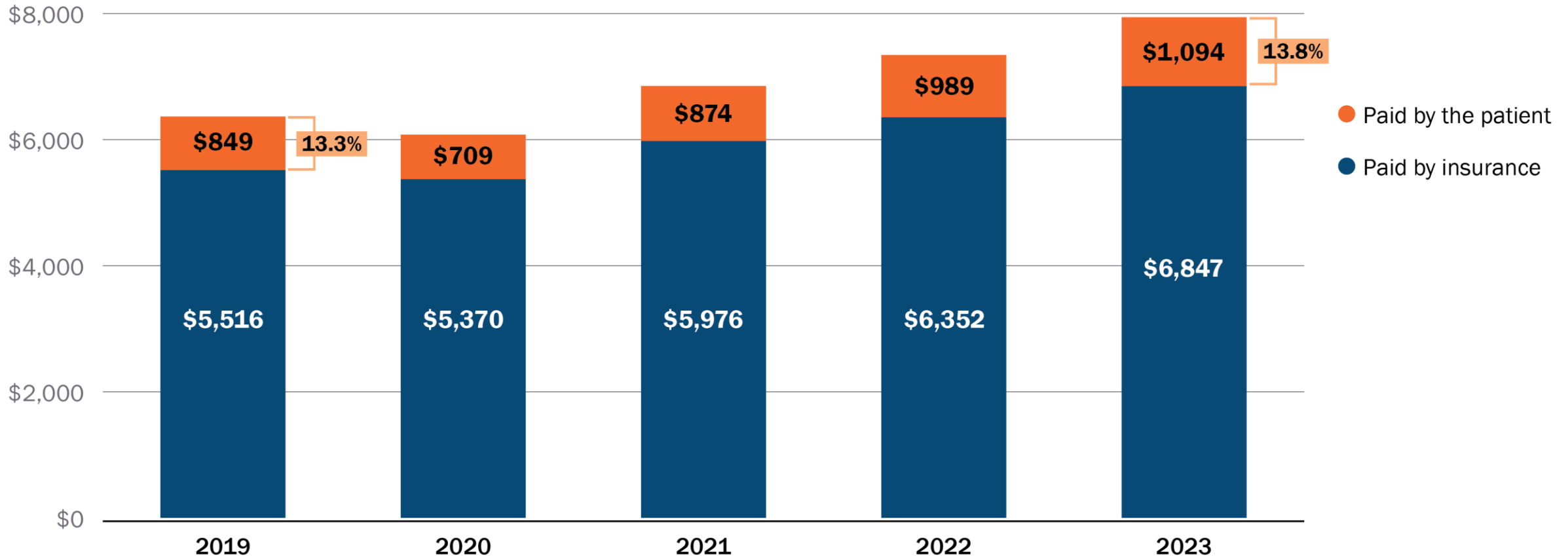
- The HPC used the Massachusetts All-Payer Claims Database v2023 (MA APCD) from 2019-2023, including medical and pharmacy claims from six large commercial payers in Massachusetts.<sup>1</sup>
- Medical and pharmacy services were grouped into large care categories using the Restructured Berenson-Eggers 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.

# 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

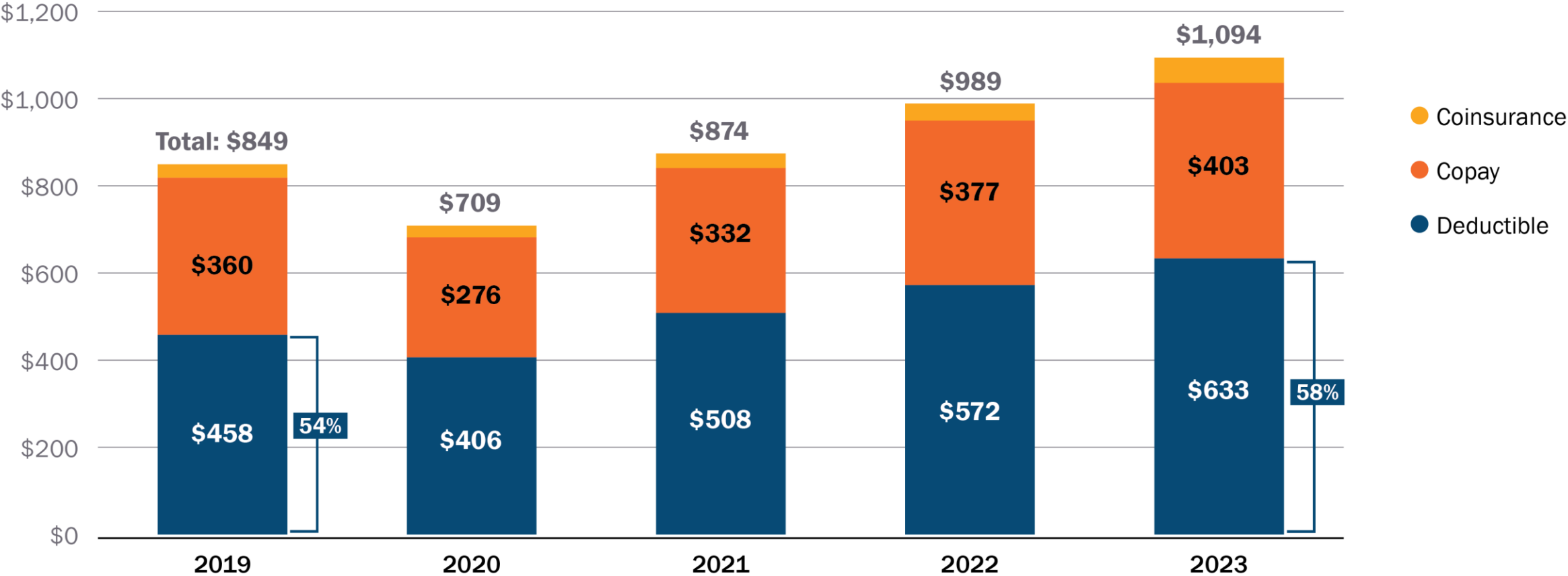


Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Pharmacy spending is net of rebates.  
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

# 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

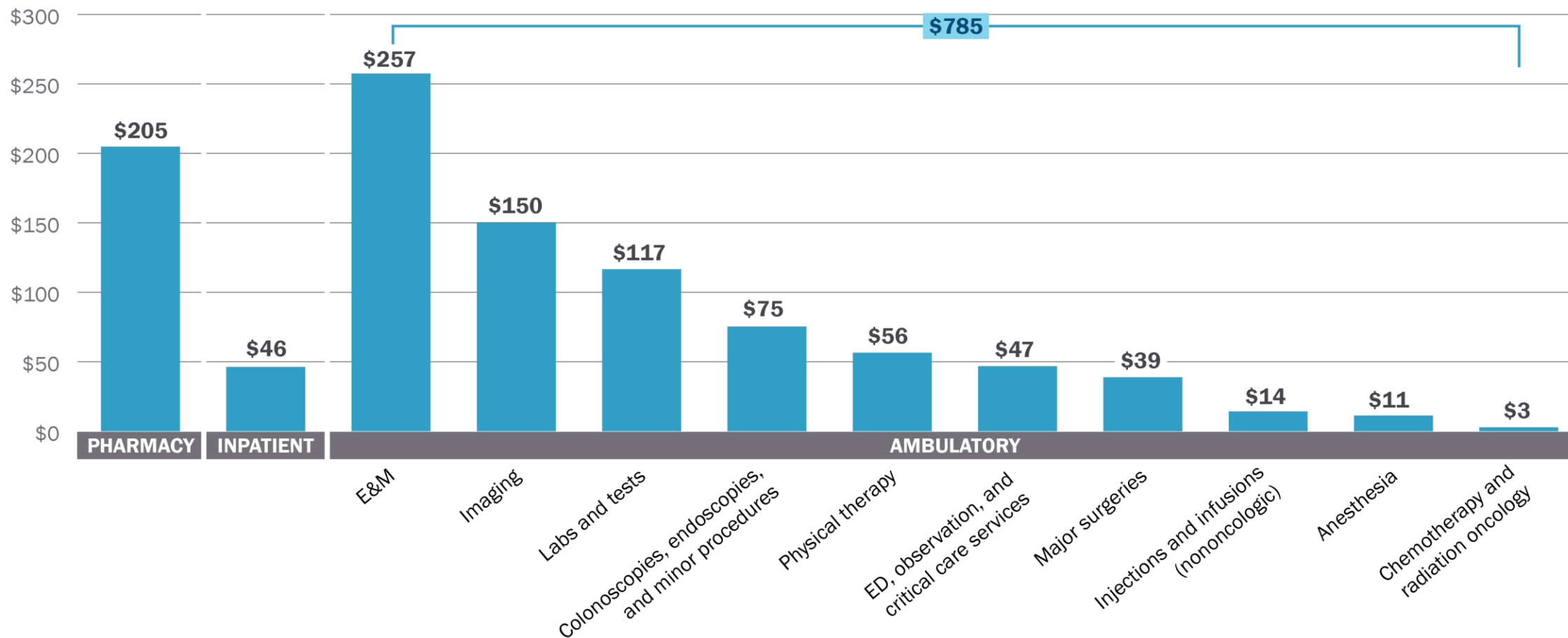


Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

# 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

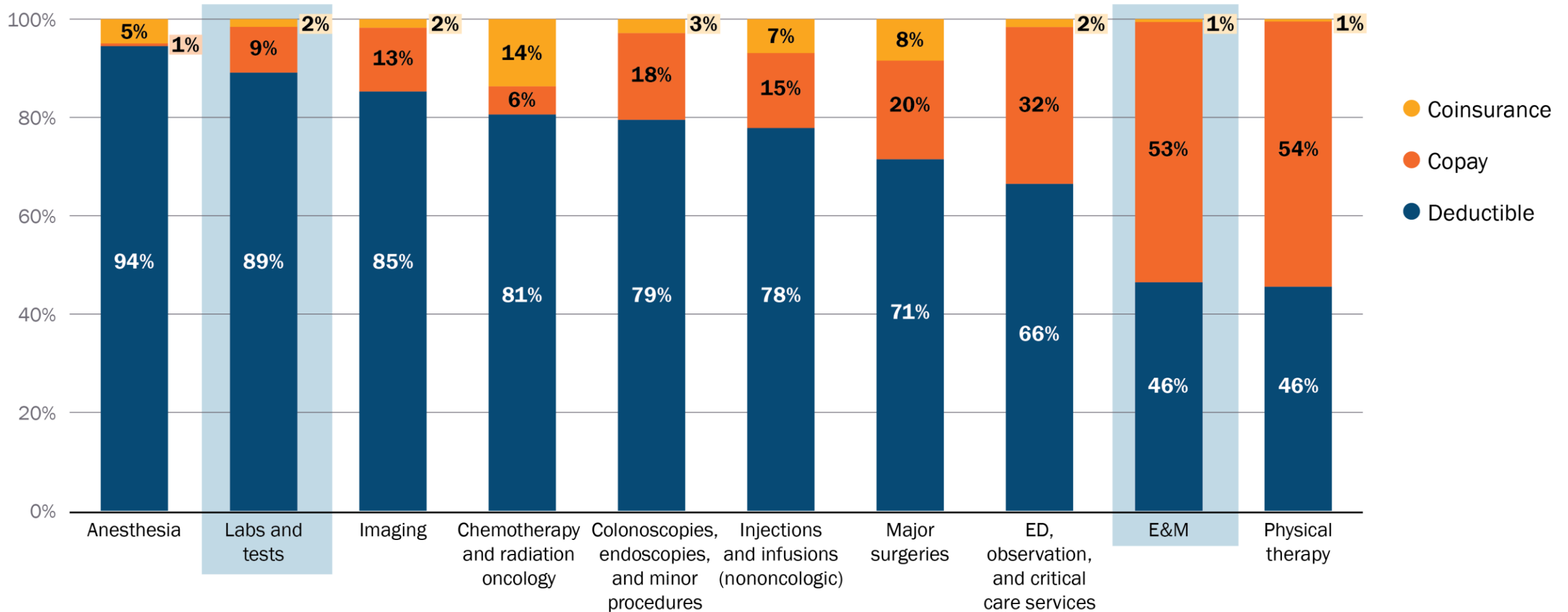


Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. Categories with 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.

# 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



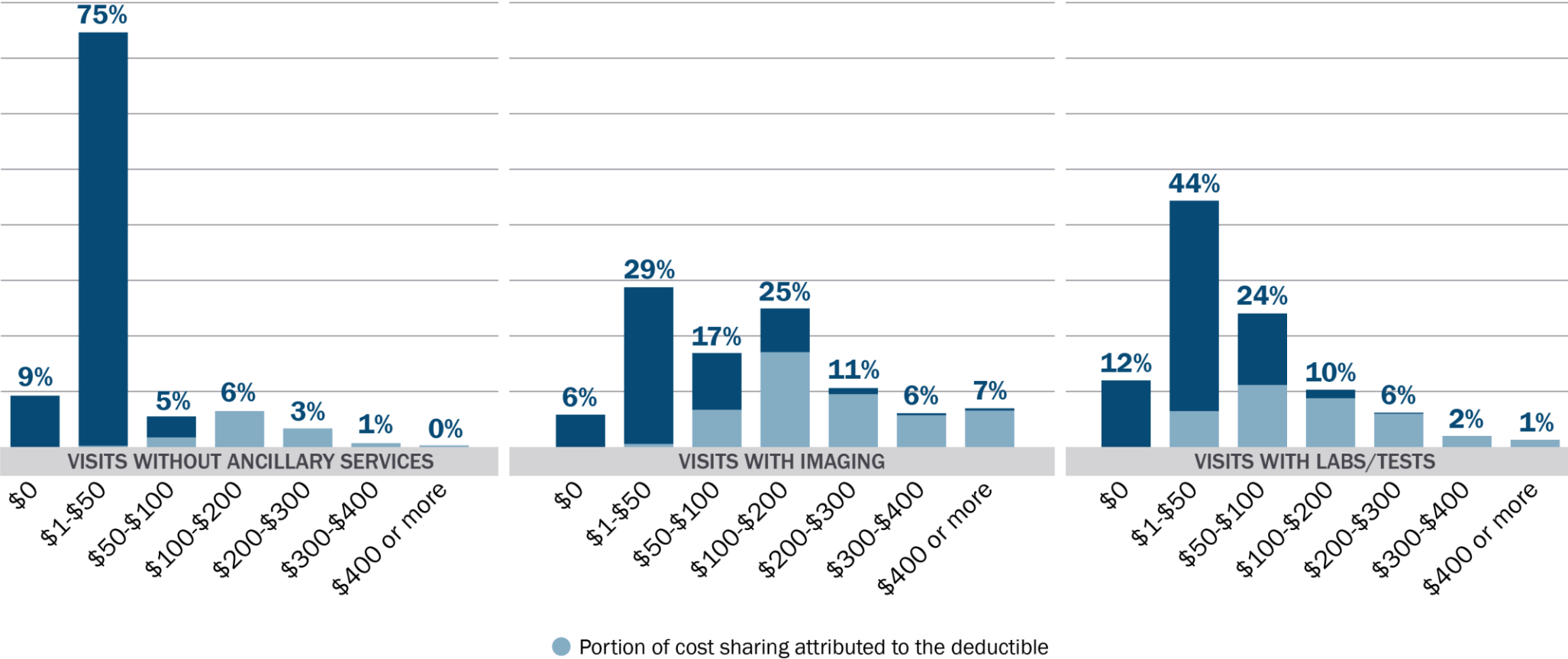
Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. A small number of uncategorized ambulatory services are not shown. E&M refers to evaluation and management and includes behavioral health services.

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

# 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



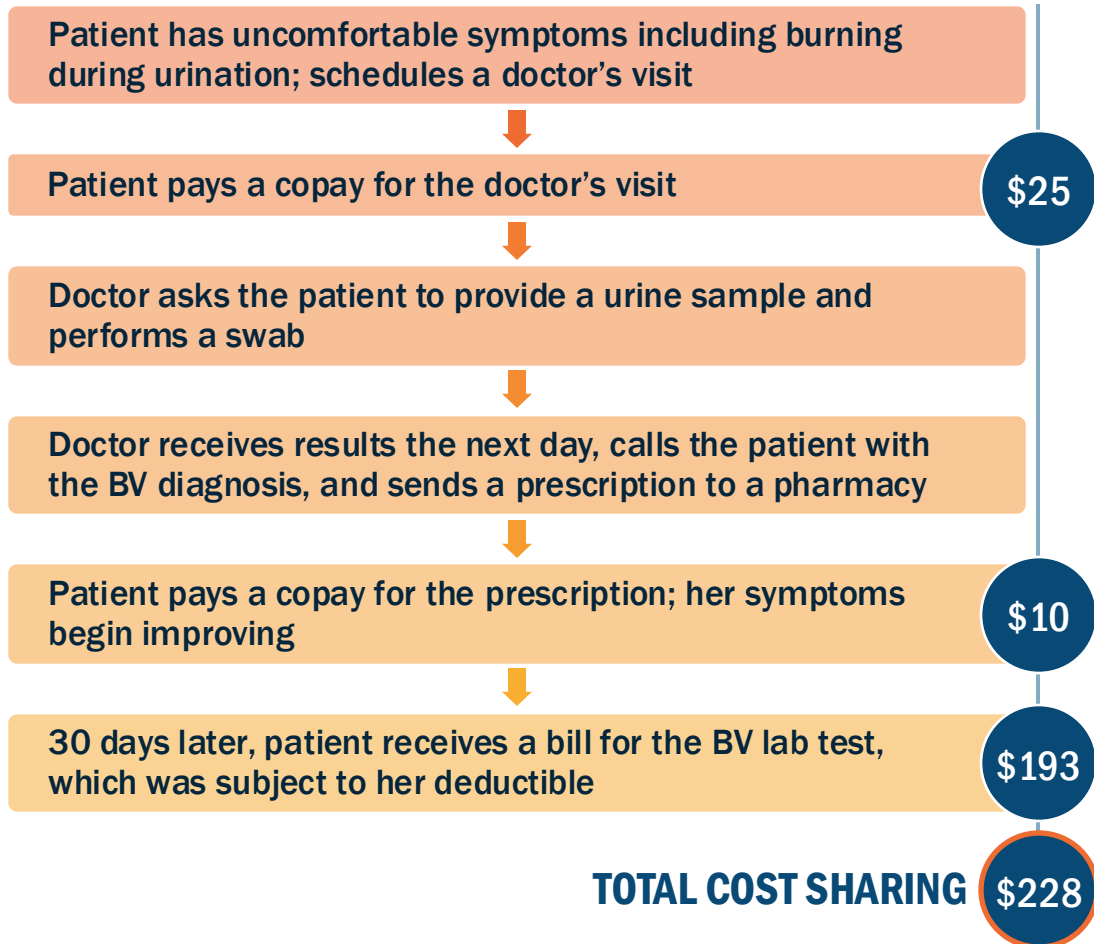
Notes: Data represents episodes at ambulatory settings for ten principal diagnoses (F41, J02, F90, F33, M25, I10, M54, R05, H66, E66). Episodes were defined as same person and date of service as an E&M problem visit procedure code (99201-99215). Episodes were dropped if they occurred on the same day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

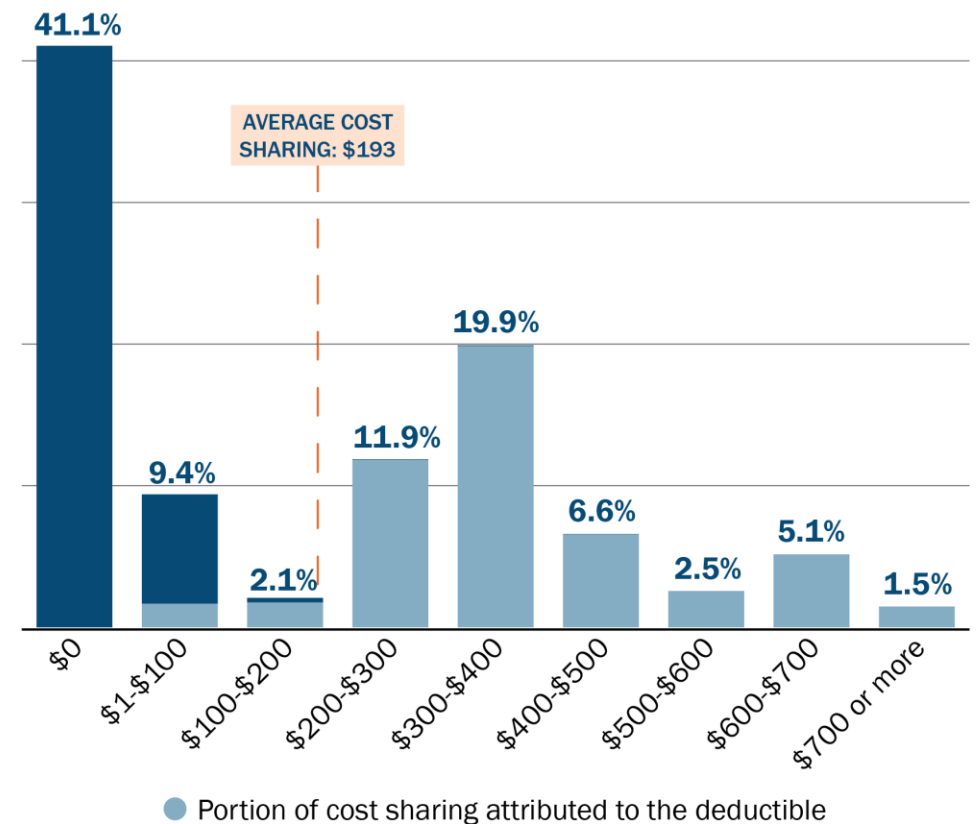
# Bacterial vaginosis (BV) case study: Cost sharing for a common lab test provided in a primary care visit ranges from \$0 to more than \$500 for many patients.

## CLINICAL PATH

## COST SHARING



## 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.

# Cost Sharing for Preventive Services

- **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.<sup>1-5</sup>
- 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%.<sup>6</sup>
- The ACA defines preventive services that must be covered without cost sharing as those recommended by any of four groups:<sup>7,8</sup>
  - 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, Daffitto 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.<sup>1</sup>
- **Cost sharing for preventive services persists due to the fragmented system in which it is being implemented.**<sup>2,3</sup>
  - 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.<sup>4,5</sup>
- 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.<sup>6</sup>

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 inequitably 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/cioo/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.

## 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.<sup>1</sup>
- 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.

# 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).<sup>1</sup>
- 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”.<sup>2</sup>
- There is no explicit requirement for coverage for preventive visits for males over age 21.

1. American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: [https://downloads.aap.org/AAP/PDF/periodicity\\_schedule.pdf](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>

# Coverage of Preventive Visits (cont.)



- **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.<sup>1</sup>
  - 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.<sup>2</sup>
- The HPC examined cost sharing associated with all services during the preventive visit episode.

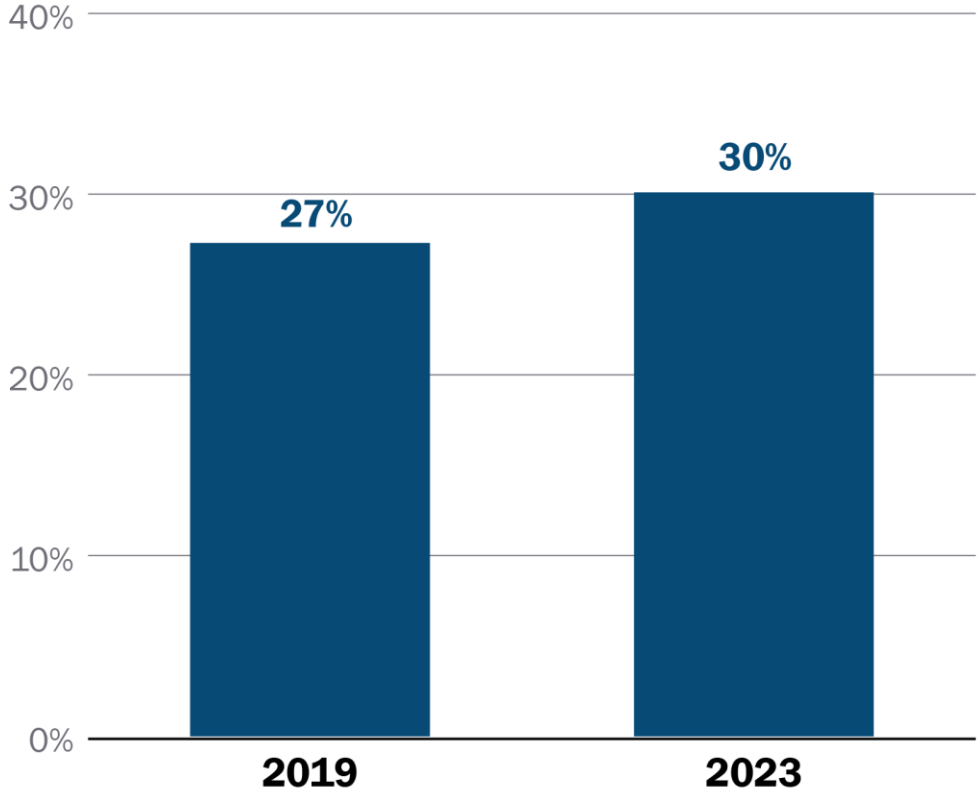
1. American Medical Association. Can physicians bill for both preventive and E/M services in the same visit? Available at: <https://www.ama-assn.org/practice-management/cpt/can-physicians-bill-both-preventive-and-em-services-same-visit>

2. 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>

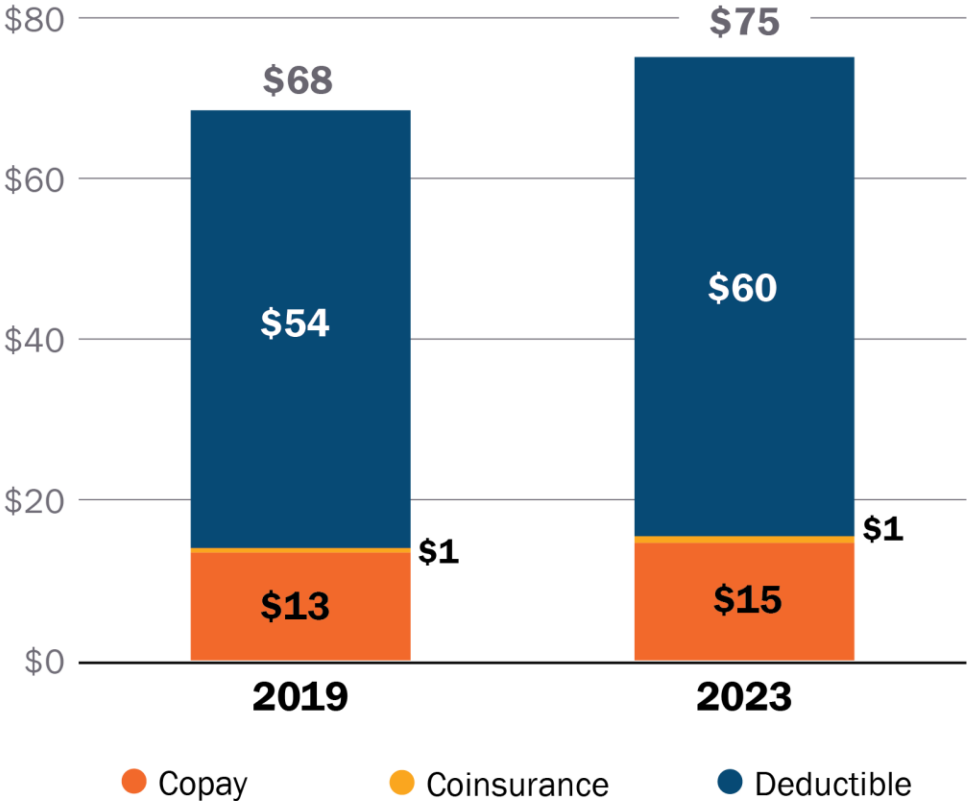
# One-quarter to one-third of preventive visit episodes have cost sharing. Patients who experience cost sharing pay about \$75 on average, mostly due to deductibles.



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

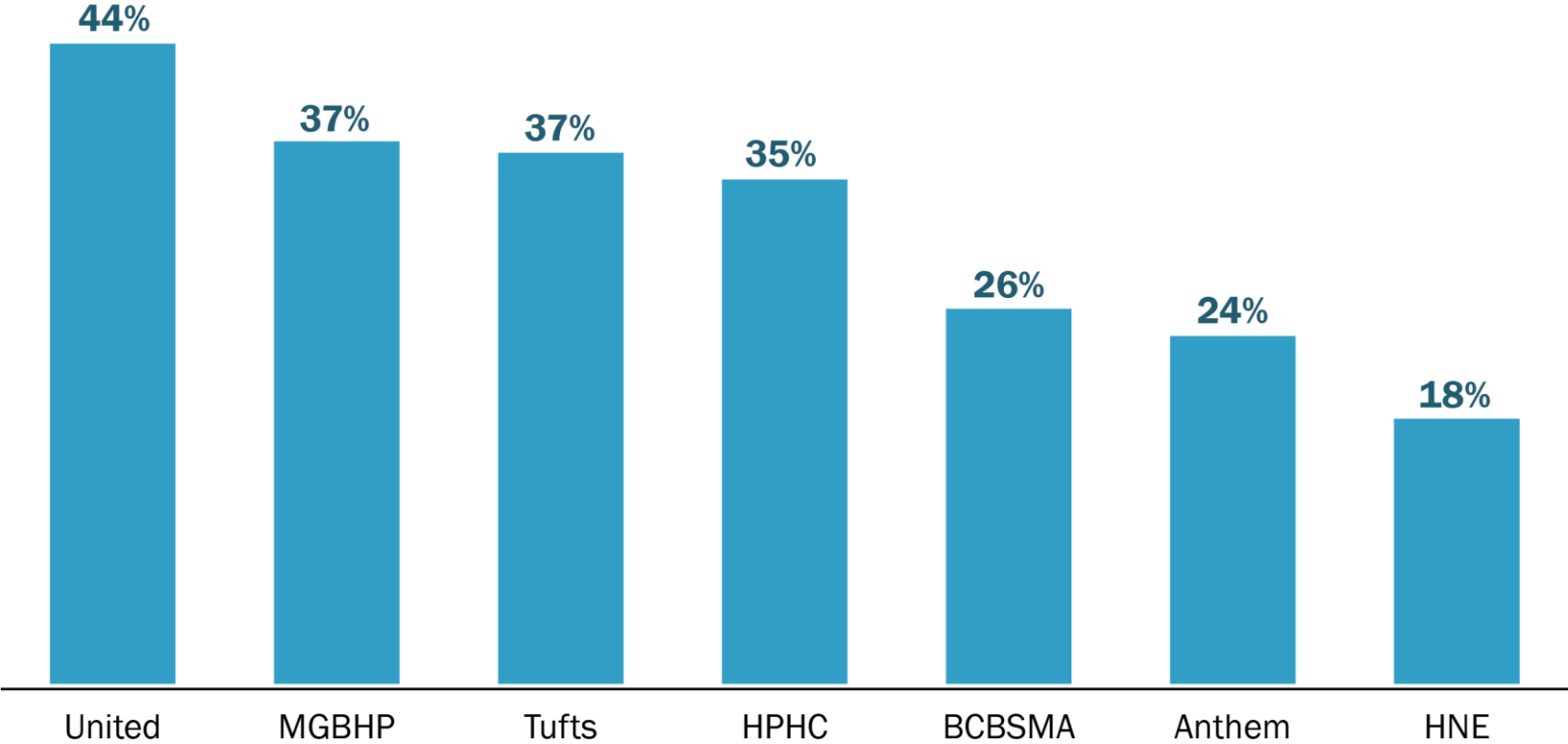


Notes: Includes commercial members ages 0-64 with full year medical coverage. Preventive visit episodes identified as same-person, same-day episodes of care provided in Massachusetts office, hospital outpatient department, ambulatory surgical center, retail clinic, or lab settings including Current Procedural 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



➤ 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.

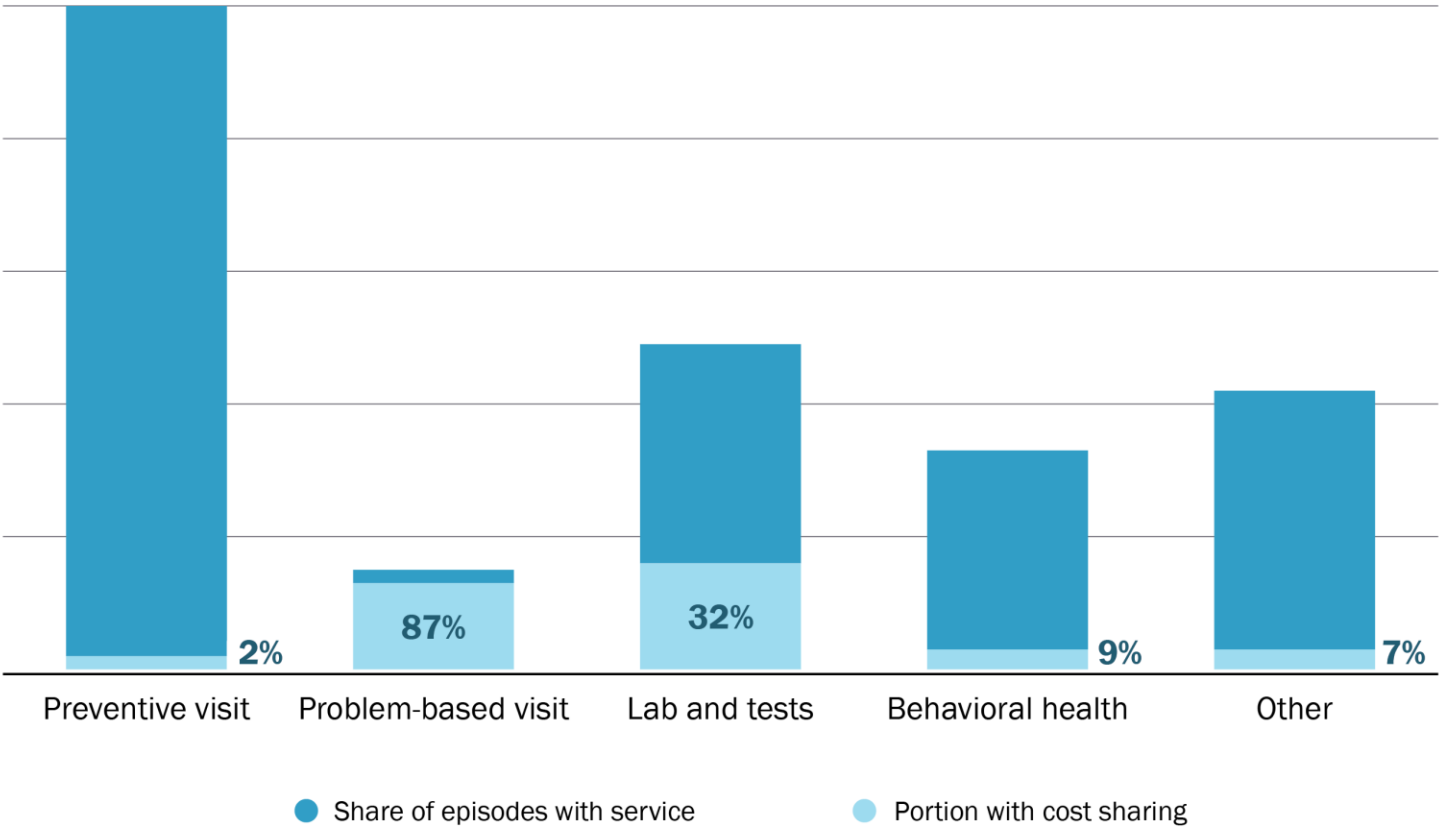
Notes: Includes commercial members ages 0-64 with full year medical coverage. Includes care provided in Massachusetts office, hospital outpatient department, ambulatory surgical center, retail clinic, or lab settings including Current Procedural Terminology (CPT) codes 99381-99387, 99391-99397, G0438-G0439,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

# 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



➤ **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%)**

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.

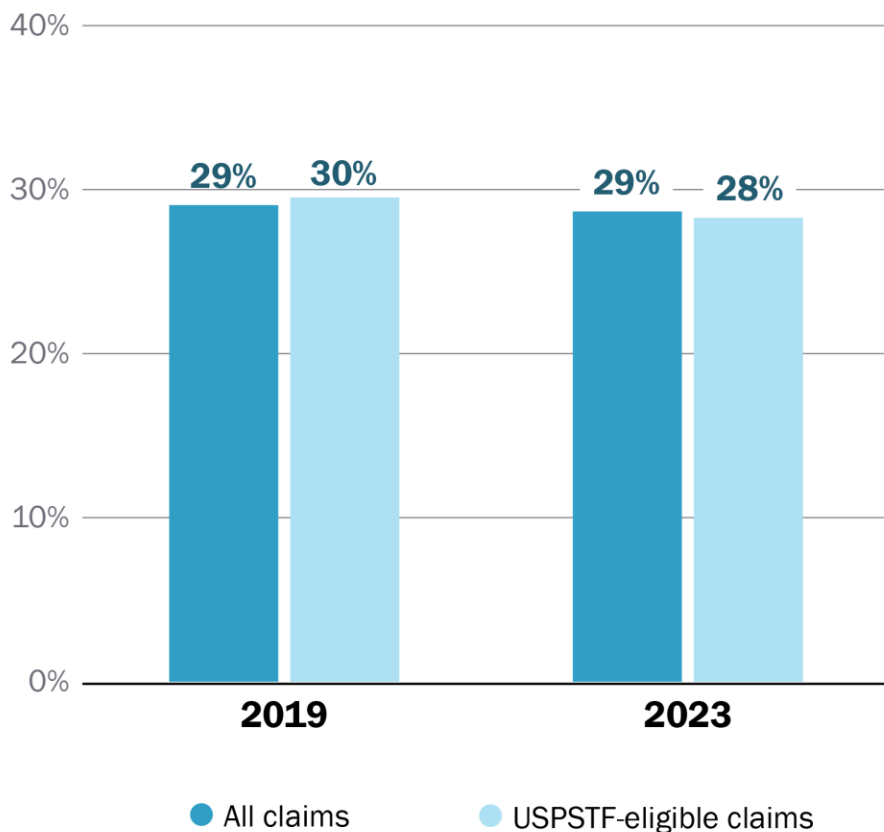
# Coverage of Preventive Diabetes Screening

- 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."

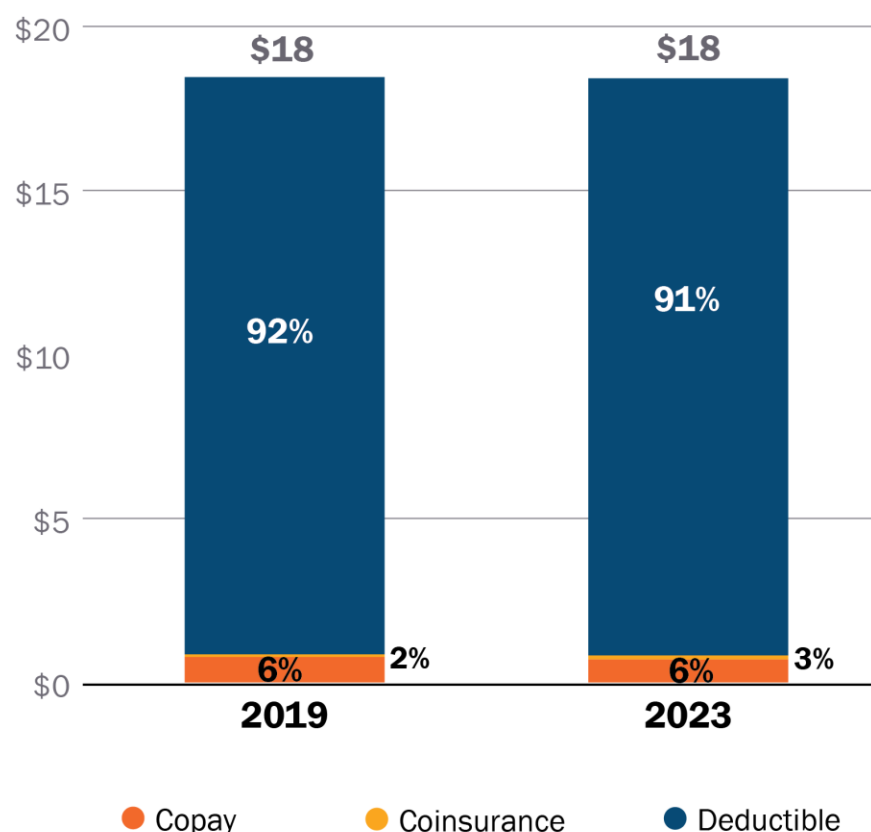
# Approximately one-third of claims for diabetes screening had cost sharing, largely in the form of deductible spending.



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.

# Conclusion

## 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.

## ➤ 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 deductible 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.

## ➤ 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 are lower when employees choose lower TME providers** (for example, family plan deductibles range from \$500 in tier 1 to \$3,000 in tier 4).<sup>1</sup>

## ➤ 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**; patients know cost sharing up-front via an app. Copayments are higher for higher-priced providers and higher cost settings of care.

1. 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>

# 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.<sup>1</sup> Other policy reforms could also achieve off-setting savings.<sup>2</sup>
  - **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 from 2019-2023, nearly 30% of patients faced **more** cost sharing for a course of PT than for knee replacement surgery (\$400)

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

- By itself, this would increase premiums by roughly 0.3%.<sup>3</sup> 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.

- **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.**
- 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.**
- **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.

# Agenda



Call to Order

Approval of Minutes: July 10, 2025 (VOTE)

Center for Health Information and Analysis (CHIA) Spring 2026 Primary Care Dashboard Data Specifications

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



**UP NEXT: Statutory Deliverable #5: Assess the impact of health plan design on health equity and patient access to primary care services**

Upcoming PCTF Meeting: Wednesday, December 3, 2025

Adjourn

# Discussion: Statutory Deliverable #5



DELIVERABLE	STATUTORY DEADLINE
✓ 1 Define primary care services, codes, and providers (complete)	September 15, 2025
2 Develop a standardized set of data and reporting requirements for private and public payers, providers and provider organizations	September 15, 2025
3 Establish a primary care spending target for private and public health care payers that reflects the cost to deliver evidence-based, equitable and culturally competent primary care	December 15, 2025
4 Propose payment models to increase public and private reimbursement for primary care services	March 15, 2026
<b>5 Assess the impact of health plan design on health equity and patient access to primary care services</b>	<b>March 15, 2026</b>
6 Monitor and track the needs of and service delivery to residents of the Commonwealth	May 15, 2026
7 Create short-term and long-term workforce development plans to increase the supply and distribution of and improving working conditions of primary care clinicians and other primary care workers	May 15, 2026

## **Discussion of Statutory Deliverable #5: Assess the impact of health plan design on health equity and patient access to primary care services**

- If we were to redesign cost sharing to facilitate access to primary care, what would we change?
- What should cost sharing benefit design ideally look like for primary care to facilitate patient access and reduce provider administrative burden?
- What other features of insurance benefit design should we consider to support patient access, and what should they look like?

# Agenda



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Statutory Deliverable #5: Assess the impact of health plan design on health equity and patient access to primary care services



**UP NEXT: Upcoming PCTF Meeting: Wednesday, December 3, 2025**

Adjourn

# Upcoming Meeting



## **Primary Care Task Force Meeting**

**Wednesday, December 3, 2025**

10:00 AM – 12:00 PM (Location TBA)