

SENT VIA EMAIL TO: HPC-Testimony@mass.gov

October 31, 2025

David Seltz, Executive Director
Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street
Boston, MA 02116

Dear Mr. Seltz:

On behalf of Mass General Brigham Health Plan, I want to thank you for the opportunity to provide written testimony in accordance with the Health Policy Commission's request received on October 3, 2025, as provided for in Massachusetts General Law, chapter 6D §8.

Included with this cover letter is a copy of our Pre-Filed Testimony response in the attached submission template. As a legally authorized and empowered representative of Mass General Brigham Health Plan, I have signed under the penalties of perjury, that the testimony, including **HPC Payer Exhibit 1_Mass General Brigham Health Plan**, is to the best of my knowledge, complete and accurate.

Sincerely,



Alice Moore
Senior Vice President
Legal, Regulatory Affairs & Compliance

AEM

2025 Pre-Filed Testimony
PAYERS



As part of the
*Annual Health Care
Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the [2024 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on Friday, October 31, 2025, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2024, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission. All submissions are public record and will be posted to the [HPC's website](#).

You may receive questions from both the HPC and the Office of the Attorney General (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact relevant staff at the information below.

HPC CONTACT INFORMATION

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at
HPC-Testimony@mass.gov or
lois.johnson@mass.gov.

AGO CONTACT INFORMATION

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov
or (617) 963-2021.

THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), and residents paying \$5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants.

In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark](#) and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on members and purchasers, coverage and access to care, providers, in addition to premiums and out-of-pocket costs? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

Mass General Brigham Health Plan was founded by community-based organizations almost 40 years ago. Today, Mass General Brigham Health Plan serves commercial, Medicaid, and Medicare Advantage members. As part of Mass General Brigham, we are combining world-class care and comprehensive coverage to deliver exceptional member experiences.

Building on our community focus, Mass General Brigham Health Plan will offer two Dual Eligible Special Needs Plans (D-SNP) for individuals eligible for both Medicare and Medicaid beginning January 1, 2026.

While our commitment to members across all markets remains strong, recent federal actions will impact the areas in which we operate.

Two clear challenges include:

- (1) recent federal changes in Medicaid; and
- (2) the ongoing need for Congress to extend critical federal subsidies known as Enhanced Premium Tax Credits (EPTCs) for individuals and families enrolling through the Massachusetts Health Connector that are set to expire at the end of 2025. Without congressional action, these enhanced subsidies will sunset, leading to significant premium increases and the potential loss of coverage for many.

Medicaid policy changes

The Medicaid (MassHealth) program is under tremendous strain, including the ongoing challenge of program rate inadequacy for prior years' performance. The chronic underfunding of MassHealth payment is creating severe deficits and cash flow constraints that threaten operational stability and long-term viability. This will be exacerbated by the

anticipated MassHealth budget shortfall for FY26 and impending loss of federal funding through H.R. 1. To strengthen the MassHealth program, it is critical for the state to help address the systemic market underfunding in MassHealth for both Accountable Care Organizations (ACOs) and Duals (including the One Care and Senior Care Options) programs through targeted remedies.

We urge policymakers to find state funds to fill the gap left by federal cuts under H.R. 1 to the MassHealth program. MassHealth is critical to providing equitable access to care for Massachusetts residents. It is estimated the state will lose up to \$1.7B annually when the federal cuts are fully implemented in FY28, according to the Massachusetts Taxpayers Foundation. Many providers and Medicaid plans are already facing financial challenges, and Medicaid rates have failed to keep up with the cost of medical inflation.

Additionally, H.R. 1 created new eligibility checks and work requirements for Medicaid. We encourage the Commonwealth to continue to minimize the administrative burden of new MassHealth eligibility criteria, including redeterminations every six months and work requirements. To ensure that otherwise eligible individuals do not lose coverage for failure to comply with the demands of new reporting, we encourage the state to make needed investments in technology and public outreach, including enrollment coordinators, to help individuals comply with these new mandates.

Enhanced Premium Tax Credits

The Enhanced Premium Tax Credits (EPTCs) has been an invaluable tool that has helped to support affordability in the marketplace. Without congressional action, leaders have warned that tens of thousands of healthcare consumers on the Health Connector could face higher premiums for the same level of coverage. To continue our collective commitment to universal health insurance coverage, a continuation of EPTCs is essential to preserving access to health care for Massachusetts families. We urge lawmakers and all stakeholders to support a continuation of EPTCs to maintain the coverage gains we enjoy today.

Mass General Brigham Health Plan is providing stability for our customers by ensuring continued access to convenient, affordable, and high-quality care. We are working closely with both MassHealth and the Health Connector to quickly respond to federal changes and address anticipated challenges. This includes implementing Massachusetts-specific healthcare protections and requirements that support evidence-based care, while providing a variety of solutions to help manage healthcare costs and expand access to care for our members when and where they need it most.

We appreciate the opportunity to offer items for policymakers to consider that may safeguard the Massachusetts healthcare system against potential risks from federal policy shifts. Federal policy changes of this magnitude will have an impact on all lines of business. In addition to the recommended support for crucial government programs noted above, policymakers and stakeholders should continue work to advance affordability reforms. One

example is establishing a reasonable moratorium on new legislative coverage mandates that would increase healthcare premiums until the Commonwealth can demonstrate adherence to the healthcare cost growth benchmark or we reach a time when healthcare trends and inflation return to normalcy. The continued and consistent passage of new legislative mandates is exacerbating affordability challenges. With seven new mandates in recent years adding nearly \$1 billion in spending and hundreds more under consideration, the Commonwealth must first bring existing costs under control. Affordability cannot improve if new unfunded mandates continue to outpace the state's own benchmark goals.

2. Many Massachusetts health care providers continue to face significant workforce challenges. What policy, payment, or health care system reforms does your organization recommend to better sustain, strengthen, and diversify the health care workforce in Massachusetts?

Across the healthcare industry, providers are facing unprecedented strain through workforce challenges due to staffing shortages, as well as increasing labor and supply costs related to the highest inflation in decades. These economic pressures, combined with an increasing number of patients covered by underfunded government payer programs, have led to significant cost pressures for providers and commercial payers.

To address ongoing workforce challenges, we recommend the following reforms:

- **Scale and integrate virtual-first and hybrid telehealth models.** Many patients still face long wait times and fragmented care between virtual and in-person settings. Encouraging payers and providers to support virtual-first models where initial screening, triage, and follow-up are delivered virtually by design can help to improve primary care, urgent care, and specialty behavioral health workflows. According to a recent study in *Health Affairs*, virtual and hybrid work options can extend provider capacity by 20-30%. Adoption of value-based arrangements that reward improved access, quality, and continuity over volume is also vital to meet the promise of telehealth: cost-savings without impacting quality.
- **Require fully interoperable electronic health records with payer access for quality measurement, prior authorization, and care management.** Massachusetts should support the adoption of fully interoperable electronic health record (EHR) systems that exchange data seamlessly across care settings and with health plans. Despite major investments in digitization, interoperability remains inconsistent across hospitals, physician groups, and behavioral health providers, resulting in fragmented care coordination and duplicative administrative work that consumes valuable clinician and support staff time. All healthcare stakeholders will benefit when EHRs can communicate across systems and share information with payers in real time.
- **Enhance state health care workforce data collection and analysis.** Massachusetts can take steps to strengthen and streamline healthcare workforce data collection and standardization to better guide policy and funding decisions. Embedding workforce surveys directly into the professional licensing process, similar to Oregon

and California, where surveys are required for renewal and achieve response rates above 80%, could generate more complete and timely information on licensed professionals. In addition, expanding data collection to include non-licensed workers, such as community health workers, home health aides, and medical assistants, through partnerships with certification boards or existing reporting systems would help capture a fuller picture of the workforce. Using standardized data elements like those in the Cross-Profession Minimum Data Set (CPMDS) and aligning definitions of full-time employment, provider types, and demographic reporting across states would make Massachusetts data more actionable.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What are the most meaningful steps you are taking to reduce administrative complexity that provides little value to patient care? What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs and the administrative costs of providing care borne by providers and others?

Mass General Brigham Health Plan is working with our provider partners to reduce administrative complexity. Our goal is to support access to affordable and high-quality care for our members, while also recognizing that our tools can be improved to further benefit providers.

We have made significant system investments to allow automated clinical data exchange between Mass General Brigham Health Plan and its provider network. The automatic receipt of clinical data helps us to gather supporting information for care gaps that providers are closing and further streamline collaboration.

As part of an integrated healthcare system, we can deepen our level of support for providers through administrative simplification and improved access to care and coverage. This work also includes building integrated care models with the system's population health team to extend the reach of primary care providers beyond the clinical setting through personalized care plans and extensive care management resources.

Supporting Efficient Collaboration Between Providers and Mass General Brigham Health Plan

Prior authorizations play a crucial role in promoting the consistent use of evidence-based medical therapies across healthcare systems. This support is especially valuable in overcoming variability within practice patterns. Starting in 2026, Mass General Brigham Health Plan is enhancing its prior authorization process by deploying automation tailored to the workflows of different practice environments. We use this approach to streamline prior authorization requests, enabling clinicians to initiate, track, and receive decisions directly

within their electronic health record system. In addition, we leverage industry standard messaging to facilitate secure and efficient exchange of prior authorization information, ensuring interoperability and timely responses. This ensures that all providers, regardless of their EHR platform, benefit from a more efficient and standardized prior authorization process, reducing administrative requirements, and supporting consistent, evidence-based care delivery.

Additionally, we are pursuing administrative simplification by supporting collective efforts in the following areas:

- **Collaborative Standardization.** Through the Mass Collaborative – a voluntary organization comprised of the Massachusetts Association of Health Plans, the Massachusetts Health & Hospital Association, the Massachusetts Medical Society, and Blue Cross Blue Shield of Massachusetts - plans and providers have jointly developed uniform prior authorization forms across all behavioral health services, prescription drugs, imaging, autism, and post-acute care, simplifying workflows statewide.
- **Protecting Affordability and Safety.** As identified by Milliman in 2023, eliminating or restricting prior authorization would raise commercial premiums by 9.1% to 23.3% (+2.2-\$5.6 billion annually) and Medicaid capitation by 3.9% to 15.5% (+0.4% - \$1.6 billion). This demonstrates that prior authorization preserves affordability by preventing unnecessary and low value utilization.
- **Enhancing the Patient and Provider Experience.** As mentioned above, EHR-integrated automation delivers real-time decisions at the point of care, reducing the turnaround time from days to seconds. Standardized digital forms and automated approvals can replace phone and fax transactions, cutting administrative time per request significantly. Member-facing digital portals and cost-estimator tools also improve the understanding of benefits for customers and reduce repetitive documentation.

Policy Recommendations and Cost Savings

- **Adoption of Fast Healthcare Interoperability Resources (FHIR)-based electronic Prior Authorization (ePA) standards consistent with CMS rules statewide.** This will enable real-time, automated determinations directly within providers' EHR systems, reducing manual work, phone calls, and fax transactions. ePA will ensure that prior authorization requests, clinical data, and decisions flow electronically between payers and providers in a single, interoperable framework.
- **Streamline provider to payer communication/information exchange.** Hospitals and health systems should provide direct secure messaging to payers through the same EHR clinical interface used for clinical correspondence; and mandate the elimination of fax-based correspondence by 2027. The American Journal of Managed Care has reported that fax and call-based transactions are 5-10x more expensive and lengthen decision times by 3-5 days on average.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. What specific actions or investments is your organization pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your members? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms does your organization recommend to enhance equitable access to high-quality primary care services?

At Mass General Brigham Health Plan, we recognize that primary care is the cornerstone of a sustainable and equitable healthcare system. Integrating behavioral health and medical care is a priority. Increased investment in primary care is a critical strategy to improve care coordination, patient outcomes, and access to high-quality, team-based care across the Commonwealth.

Mass General Brigham Health Plan is actively pursuing the following initiatives to improve access to quality care:

- **Value-Based Primary Care Models:** We continue to partner with primary care providers through value-based contracts that reward outcomes, care coordination, and patient satisfaction rather than volume of services.
- **Integrated Behavioral Health Services:** We continue to partner with our behavioral health providers to investigate collaborative care models that integrate mental health screening, treatment, and follow-up.
- **Telehealth Expansion:** We are investing in digital platforms that enable virtual care and behavioral health visits, particularly in rural and underserved areas. Our network continues to include hybrid and virtual primary care practices.
- **Social Determinants of Health (SDOH) Screening:** We are partnering with community workers to screen for housing, food insecurity, transportation, and other SDOH factors.

To ensure accountability and continuous improvement, Mass General Brigham Health Plan tracks to the following programs and standards:

- **Clinical Quality Metrics:** Healthcare Effectiveness Data and Information Set (HEDIS) scores, preventive care rates, and chronic disease management indicators.
- **Behavioral Health Integration:** Rates of depression screening, follow-up care, and collaborative care participation.
- **Access Measures:** Appointment availability, telehealth utilization, geographic coverage.
- **Member Experience:** Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, Net Promoter Scores, and grievance trends.
- **Health Equity Dashboards:** Stratified data by race, ethnicity, language, and geography to identify and address disparities.

We look forward to reviewing the recommendations of the multi-stakeholder Primary Care Task Force created under Chapter 343 of the Acts of 2024, *An Act enhancing the market review process*. We would suggest that success will require new ideas that address the needs of the patients served and should include provider perspective and flexibility.

5. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state's health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents. Please describe the current and anticipated pharmaceutical trends (and detail the potential impact on health care spending) in the next three to five years, including but not limited to information about anticipated trends in utilization, new medications and therapies, and price increases for brand name and generic drugs. What specific actions is your organization taking to address these trends and to balance patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and members?

Like other stakeholders across the healthcare industry, Mass General Brigham Health Plan has continued to experience increased prescription drug cost trends. These include the uptick in utilization of GLP-1s, as well as additional indications for other existing high cost and specialty drugs.

We have also observed an increasing prevalence of generic equivalents that launch at a price similar to the name-brand drug. In some situations, it is more cost effective for a health plan to prefer the brand drug over the generic, which serves to increase the brand utilization rate. Additionally, drug mix continues to be a cost driver as more members are prescribed specialty medications, either as a replacement or in addition to lower cost non-specialty therapeutics. In some cases, these prescriptions are clinically appropriate and necessary as members have exhausted all alternative lower cost options.

Recent federal actions may also increase commercial pharmacy trends. Federal tariffs could increase overall unit cost pricing, as much of the current pharmaceutical supply is imported. In addition, federal negotiation of drug pricing for Medicare may drive net prices for commercial products as drug manufacturers attempt to recover margin in less regulated lines of business.

Health plans have been increasingly challenged with managing pharmacy spend and overall trend due to unsustainable high pricing by manufacturers. We support the regulatory engagement of underlying drug pricing, at the federal and state level, which contributes to increased spending and affordability issues.

Mass General Brigham Health Plan has taken several steps to help manage the cost of prescription drugs, including the frequent review of prescription drug formularies to encourage the use of lower cost and clinically appropriate options. In addition, we continue to offer our popular Care Complement benefit that waives cost-sharing for certain services to provide flexibility to try alternative treatments for pain management and chronic conditions.

6. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

Mass General Brigham Health Plan is committed to promoting access to affordable health coverage to residents of the Commonwealth through our commercial, Medicare Advantage, and Medicaid lines of business, and our new dual-eligible plans in 2026. As part of Mass General Brigham's integrated healthcare system, we are working to manage total cost of care while ensuring that residents of the Commonwealth have access to high-value care across a spectrum of quality providers.

We have a strong commitment to affordability and offer a range of affordable products across commercial and government-based programs. In addition to our commercial business, Mass General Brigham Health Plan has expanded coverage in government programs, including the launch of Medicare Advantage in January 2023 and the Mass General Brigham Accountable Care Organization (ACO) in April 2023, covering over 140,000 members. Mass General Brigham Health Plan has been a longstanding participant in Connector Care and has worked closely with our provider system to provide affordable options for health care consumers.

- Government Programs – Investment in strong government programs is critical to address overall healthcare affordability. Specifically, strengthening support for Medicare and Medicaid reimbursement will ensure sustainable government programs. The call for government program support also applies to continued assistance for individuals in the form of subsidies, such as those in ConnectorCare.
- Commercial - Our comprehensive portfolio of commercial products includes innovative solutions that support affordability such as Allies - a narrow network product designed to encourage care in the community setting , Choice Easy Tier - a tiered network product that incentivizes care in lower cost, high-quality settings, as well as innovative value-based insurance design features such as Care Complement which reduces cost barriers for members by offering a \$0 copay for some services that help members manage pain and other chronic conditions.

Regulation of Level Funded offerings to Small Group Customers

Lastly, we are concerned about the destabilizing impact of recent federal policy combined with emerging market trends in the small group market. In Massachusetts, the Health Connector has estimated that H.R. 1 will cause approximately 85,000 to 100,000

healthcare consumers to lose access to subsidies. The loss of subsidies will limit access to marketplace coverage, leading to higher consumer costs and instability in the risk pool.

The combination of federal policy changes with recent marketplace behavior whereby small businesses are increasingly opting for level funded options is a cause of concern. The continued growth and aggressive marketing of self-funded or level-funded offerings in the commercial small group market and the resulting deterioration of the fully insured merged market. One of the key drivers for increases in commercial premium for individuals and small businesses in Massachusetts is the spike in self-insured membership for the small group market segment in recent years, from less than 2% in 2021 to over 10% in 2025. Over 80% of small group self-funded enrollment is with national carriers, often through level funded solutions, which have low stop-loss thresholds and mimic fully insured products.

At a 'micro-level,' level-funded products can provide a lower cost option for some small groups. However, at a 'macro-level', increased penetration of level funded products in the small group market will remove lower utilizing smaller groups from the insured risk pool and drive up overall merged market rates.

- Level funded products select “good risk” through medical underwriting
- These products are not subject to the 88% medical loss ratio (MLR) rebate requirement
- Typical targets are small groups (20+ employees); but offered to groups down to 2-5 enrolled
- More generally, if claims experience worsens and thereby the affordability of the level funded products, impacted employers can return to the fully insured guaranteed issue merged market
- Further, these products are not required to comply with state mandates (such as infertility treatments) nor meet formulary or other requirements that merged market carriers are required to cover under requirements for fully insured carriers, and do not have the protections guaranteed by state regulation of fully insured products.

Ultimately, the result is a deterioration of the merged market risk pool which could quickly become a market of last resort, worsening affordability for all individuals and small groups.

According to the National Association of Benefits and Insurance Professionals, 32 States have taken action to regulate stop loss or other related levers associated with level funded products while Massachusetts and 18 other states have not. We encourage Massachusetts policymakers, in concert with the Division of Insurance, to take action to regulate level funded products in a manner that protects the merged market and its more vulnerable small group participants.

TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2021 to 2024 according to the format and parameters provided as **HPC Payer Exhibit** (attached) with all applicable fields completed. Please explain the portion of actual observed allowed claims trends that are due to (a) changing demographics of your population; (b) benefit buy down; and/or (c) change in health status/risk scores of your population for each year. Please note where any such trends would be reflected (e.g., unit cost, utilization, provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

| Year | Unit Cost | Utilization | Provider Mix | Provider/Service Mix | Total | Change in risk | RA TME Trend |
|---------|-----------|-------------|--------------|----------------------|-------|----------------|--------------|
| CY 2021 | 1.6% | 15.6% | N/A | -7.7% | 8.4% | 10.3% | -1.9% |
| CY 2022 | 2.1% | -3.0% | N/A | 4.0% | 3.0% | -0.4% | 3.4% |
| CY 2023 | 3.3% | 0.4% | N/A | 5.9% | 9.8% | 3.7% | 5.9% |
| CY 2024 | 3.4% | 5.8% | N/A | -2.3% | 6.9% | 6.1% | 0.8% |

Mass General Brigham Health Plan's expenditure trends summary table above and attached as **HPC Payer Exhibit 1 – Mass General Brigham Health Plan**.

Increases in utilization have been the primary driver of higher trend in 2024. This is consistent with the higher acuity of the insured population. We have added the change in risk to the table above. Medicaid redetermination efforts led to significant changes in populations across markets, and it is likely that the higher risk scores that we are observing are a function of this movement. In addition, increased penetration of self-insured type arrangements - especially in small groups where the proportion of self-insured has risen from 2% to 10% over the past five years - may be leading to deterioration of the merged market-insured risk pool, which is reflected in our experience.

Changes in benefit design impact - (1) What is covered, (2) What member cost sharing is applied, and (3) How the cost sharing impacts utilization and mix of services. Only items (1) and (3) are reflected in allowed trends through Center for Health and Information and Analysis (CHIA) requirements, so, the impact of changes in member cost-sharing is not explicitly identified. Without any benefit buy downs, overall trend would be higher than observed, driven by increased utilization.

2. Reflecting on current medical expenditure trends your organization has been observing in 2025 to date, which trend or contributing factor is most concerning or challenging?

Recent trends continue to rise, with the largest cost driver continuing to be prescription drugs (e.g., brand name and specialty, as well as medical pharmacy), and chemotherapies and infusion therapies. Underlying these increases are the expansion of indications for specialty pharmacy as well as introduction of new costly therapies. We also continue to see higher utilization of outpatient services and surgeries, driven by higher acuity, and substantial increases in behavioral health utilization across settings.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

- Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available “price transparency tool.” In the table below, please provide available data regarding the number of individuals who sought this information.

| Health Care Service Price Inquiries Calendar Years (CY) 2023-2025 | | |
|--|---------------------------------------|--|
| Year | Aggregate Number of Written Inquiries | Aggregate Number of Inquiries via Telephone or In-Person |
| CY2023 | Q1 | 6415 |
| | Q2 | 6258 |
| | Q3 | 6571 |
| | Q4 | 7403 |
| CY2024 | Q1 | 7302 |
| | Q2 | 4315 |
| | Q3 | 5117 |
| | Q4 | 5589 |
| CY2025 | Q1 | 8779 |
| | Q2 | 5028 |
| TOTAL: | 62,837 | 991 |

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed **Total Allowed Medical Expenditure** Trend by Year

Fully-insured and self-insured product lines

| Year | Unit Cost | Utilization | Provider Mix | Service Mix | Total | Change in risk |
|---------|-----------|-------------|--------------|-------------|-------|----------------|
| CY 2021 | 1.6% | 15.6% | N/A | -7.7% | 8.4% | 10.3% |
| CY 2022 | 2.1% | -3.0% | N/A | 4.0% | 3.0% | -0.4% |
| CY 2023 | 3.3% | 0.4% | N/A | 5.9% | 9.8% | 3.7% |
| CY 2024 | 3.4% | 5.8% | N/A | -2.3% | 6.9% | 6.1% |

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. **These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.**
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilizati
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as