Attached please find Point32Health's written pre-filed testimony for the 2025 Cost Trends Hearing. I am legally authorized and empowered to represent Point32Health and this testimony is signed under the pains and penalties of perjury.

Subscribed and sworn to, this thirty-first of October, 2025.

Patrick Gilligan

Chief Executive Officer

MASSACHUSETTS
HEALTH POLICY COMMISSION

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

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?

Estimates from the Congressional Budget Office and the Kaiser Family Foundation show that Massachusetts is expected to experience a 2% decline in covered lives because of recent federal actions. State officials estimate that as many as 300,000 Massachusetts residents will lose their existing coverage through the Health Connector and MassHealth over the next five years. As the largest health plan in Massachusetts that serves every segment of the population, we know that some of our members will not be able to obtain coverage through other programs due to their financial circumstances. We know that the changes will disproportionately impact low-income residents, individuals with disabilities, older adults and communities of color that already face structural barriers to care. Research consistently shows that even short coverage gaps lead to delayed care, increased avoidable hospitalizations, and higher total medical costs. The ongoing government shutdown-related lapses in community programming will compound disparities, with many individuals who rely on our social safety net services losing that access altogether. The coverage losses will greatly strain the entire Massachusetts healthcare system, and all stakeholders must work together to keep people enrolled when they are still eligible for government programs by streamlining eligibility requirements and leveraging technology. We expect that the risk pool for the merged market will deteriorate as the people who were previously eligible for Advanced Premium Tax Credits (APTCs) were generally healthier, leaving a sicker risk pool behind as they lose coverage. This will increase premiums for individuals and small businesses. More people will seek uncompensated care from providers and further stress the Health Safety Net Trust Fund, which is already in a financial shortfall annually. As the state faces a decline in federal revenue, which is projected to grow to as much as $3 billion annually in the next five years, we expect that there will be difficult decisions to make about eligibility for government programs and the benefits offered by those programs. If providers

face revenue shortfalls from government programs, it's possible and maybe likely that they will seek to mitigate those losses with increases in revenue from commercial products, which will continue to pressure high and rising health care costs in Massachusetts. Employers are no longer in a position where they can fund deficiencies in government rates through commercial insurance premiums. In 2023, total health care expenditures reached $78.1 billion, an 8.6% increase from 2022 and more than double the 3.6% growth benchmark set by the Health Policy Commission (HPC). Price growth, combined with more recent utilization spikes, continues to drive spending, led by unit-cost increases for hospitals and prescription drugs. Hospital outpatient and inpatient spending alone totaled $26.6 billion, including an 8.3% rise in outpatient expenditures from 2022 to 2023. We have taken critical steps throughout this year to address our own cost structure and to become a more efficient organization. We implore all stakeholders in Massachusetts to do the same. We cannot continue to operate in the same way and to pay for the same things and expect different results. With fewer resources for everyone, we must address the real cost drivers in the system and acknowledge that almost 90 percent of every insurance premium dollar collected in Massachusetts goes to direct care for members. In previous pre-filed testimony, we have consistently made recommendations to improve affordability, many of which are aligned with recommendations that the HPC itself has made. These policy suggestions include eliminating facility fees, establishing reasonable default rates for out-of-network services, addressing excessive hospital pricing, modifying how the cost growth benchmark is implemented and enforced (specifically reviewing hospital TME and the aggregate price levels of hospitals), and controlling pharmaceutical pricing. As we continue to navigate the challenging environment created by evolving federal policy changes, it is time we move forward with a real affordability agenda.

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?

• Modernize scope of practice, particularly for primary care. Opportunities exist to modernize scope of practice laws to fully leverage the capabilities of nurse practitioners, physician assistants, and other advanced practice clinicians as part of a team-based, high value primary care system. As described in our response below, provider systems also vary in whether lower-level practitioners can be assigned patient panels, which is a barrier for primary care delivery. • Scale and integrate telehealth models, particularly for behavioral health and primary care in order to relieve barriers to access care. Many patients still face long wait times, fragmented care between virtual and in-person settings and inequitable access to digital tools. Encouraging virtual-first models where initial screening, triage, and follow-up are delivered virtually by design, into primary care, urgent care, and specialty behavioral health workflows can improve capacity. Many clinicians cite burnout, scheduling rigidity and geographic limits as barriers to full participation – according to a recent study in Health Affairs, virtual and hybrid work options can extend provider capacity by 20-30%. • Explore multi-state licensure compacts for areas of high need – nursing, primary care,

behavioral health. Expanding participation in interstate licensure compacts would strengthen Massachusetts' health care workforce, improve access to care across state lines, and enhance telehealth delivery. Joining the Interstate Medical Licensure Compact (IMLC), now adopted by more than 35 states, would streamline licensure for physicians and primary care providers and expand access, particularly in underserved regions. • Enhance state health care workforce data collection and analysis. Massachusetts should take concrete steps to strengthen health care 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%, would generate more complete and timely information on licensed professionals and help with healthcare planning. 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.

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?

We are committed to advancing our interoperability roadmap and capabilities, which include initiatives focused on enhancing electronic quality measurement, improving connectivity, and facilitating data exchanges for administrative processes like prior authorization. • Our data exchange and usability strategy is to align with NCQA's newly proposed standards and aim to drive quality measurement improvements and advance care coordination. To enable this strategy, we are enhancing our existing interoperability infrastructure using improved Application Programming Interfaces (APIs) and Fast Healthcare Interoperability Resources (FHIR) standards. This will facilitate ease of connectivity and ensure that our systems remain current with regulations issued by Medicaid and Medicare agencies. • Prior Authorization Automation. We are on track to meet interoperability and prior authorization requirements, which aim to improve the exchange of health information and prior authorization processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, and Qualified Health Plan issuers. We are well aligned with the goal of the mandate to reduce overall payer and provider burden and to improve patient access to health information while continuing CMS's drive toward interoperability in the health care market. We have are implementing APIs that enable providers to access patient data, including claims and encounter data. The rule also emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. We are well positioned to meet reporting milestones set forth for 2026, as well as the API requirements that need to be met by January 1, 2027. • Active Membership and Participation in New England Healthcare Exchange Network (NEHEN) 3.0: Point32Health,

along with other founding members, including large provider organizations, actively participates in NEHEN 3.0 planning efforts to reduce administrative burdens, advance Prior Authorization automation, and improve EMR/EHR connectivity. As a part of these efforts, we welcome continued discussions on capabilities of the Epic Payer platform, an avenue suggested by at least one large provider organization. We are committed to engaging with provider partners and other stakeholders to ensure that our interoperability efforts are aligned with industry standards and best practices. These engagements will involve regular communication, feedback sessions, and collaborative initiatives, ultimately enhancing connectivity, improving patient outcomes, and reducing provider burden. • 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. Earlier this year, we announced that we would join the prior authorization commitment made by health plans across the country through America's Health Insurance Plans (AHIP). Specifically, plans agreed:• By January 1, 2027, participating insurers will work toward a standardized and transparent electronic prior authorization process using FHIR APIs. This is intended to increase efficiency and speed up turnaround times for approvals; • Reducing the number of medical services requiring prior authorization. This reduction is expected to be demonstrated by January 1, 2026, and will be based on the needs of local markets; • By 2027, at least 80% of electronic prior authorization approvals for medical services will be decided in real-time, provided all necessary clinical documentation is submitted; and • When a patient switches health plans, the new insurer will honor existing prior authorizations for 90 days for benefit-equivalent in-network services. This provision takes effect on January 1, 2026, to prevent delays during care transitions. In addition to the steps outlined above, we regularly review our medical policies and remove services that require prior authorization if those services have high approval rates, a significant volume of requests and have a low probability of overuse or waste. This results in the regular removal (at least annually) of both medical services and drugs from our prior authorization list. That said, prior authorization remains one of our most meaningful tools to address the spiraling costs of healthcare, and we remain concerned about policy efforts to broadly wipe away or severely restrict plans' ability to conduct appropriate authorization reviews. A Milliman study released last year by MAHP demonstrated that removing all prior authorization could increase commercial premiums in Massachusetts by as much as 23%, or $130 per member per month, when accounting for the sentinel effect. A more meaningful and productive strategy is to move forward with urgency on interoperability, including facilitating health plan access to the EMR systems of providers. This policy would ease a lot of administrative back and forth on several operational processes like prior authorization (the majority of which is still conducted via fax), quality measurement, and risk adjustment (medical record review) and improve how the healthcare system functions for all parties.

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?

We recognize the need for an effective primary care system that promotes preventative care and believe that the health care system (and public policy) must shift resources away from specialist-based hospital care to support primary care. Actions we have taken to support the primary care delivery system, include: 1) We annually look at reimbursement rates for commonly-used CPT codes and when possible increase reimbursement rates for specific provider cohorts, including primary care; 2) We have quality incentives which deliver additional funds to primary care through a spectrum of value-based contracts with additional non-quality based incentives; 3) When possible, we provide higher increases to primary care providers, including mid-level providers, over specialists. This strategy is muted, somewhat, because large systems control their funds flow and many of their doctors are employed and salaried. Even if we work in negotiations to increase the unit price trend on primary care, we have no control over provider compensation models; 4) Our quality program provides financial incentives for provider organizations to identify two HEDIS measures where their patient population shows a gap in performance between a disparate group compared to a non-disparate patients; 5) We conduct quarterly performance reviews with provider groups and consult on best practices to improve their performance, if applicable. These quarterly meetings and the annual settlements of value-based arrangements offer valuable information on the progress of the network as well as future value-based models; and 6) We provide our members with access to primary care through various channels: traditional primary care physicians, NPs and PAs, urgent care, retail clinics, telemedicine solutions, OB-GYN, etc. We develop networks to ensure that members have adequate choices and options as consumer expectations (or regulations) change. In terms of policy, we must start with a focus on affordability and recognition that spending on healthcare in Massachusetts is already high and is increasing at an unsustainable level. With many primary care providers employed by the larger, better-capitalized provider systems, we must think about shifting resources rather than adding new dollars. It would be beneficial if large systems were required to report out on their percentage of revenue spent on primary care versus specialty care, in a manner similar to the payer reporting that exists now. Other policy changes that could be beneficial include: Supporting advanced practice nurses having patient panels. In our experience, some systems are less flexible than others in permitting lower level practitioners to have panels; continued investment in workforce development and loan repayment programs; enhancing the Determination of Need and Cost and Market Impact Review processes so that any approvals of system consolidation or acquisitions were tied to specific and measurable investments in team-based care models.

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?

We recognize that prescription drug spending continues to be a significant driver of overall health care cost growth in the Commonwealth. In 2023, prescription drug spending in Massachusetts grew by 10%, a rate that significantly outpaced the state's health care cost growth benchmark. This acceleration contributes to affordability challenges, barriers to medication access, and exacerbates health disparities across our member population. Current and Anticipated Pharmaceutical Trends (3–5 Years) • Utilization Growth: We anticipate continued increases in utilization, particularly in specialty drug categories such as oncology, inflammatory conditions, rare diseases, and gene therapies. The rising demand for GLP-1 receptor agonists—used in diabetes and anti-obesity treatment—is a notable contributor. Expanded indications and earlier treatment initiation are also driving higher utilization trends. • Pipeline Expansion: The FDA pipeline includes a growing number of high-cost therapies, including cell and gene therapies, biologics, and precision medicines. These innovations offer clinical promise but pose affordability challenges due to their price points and long-term budget impact. • Price Inflation: Brand-name drugs: We expect ongoing annual price increases of approximately 4% or more, often exceeding general inflation—particularly for protected brands with limited competition. Generic drugs: While generics typically offer cost savings, market consolidation and supply chain disruptions have led to price volatility in certain categories. Impact on Health Care Spending: These trends are expected to place sustained upward pressure on both pharmacy and total medical spending. Specialty drugs, while representing a small share of total prescriptions, already account for a disproportionate share of pharmacy spend— a dynamic that is projected to intensify. Additionally, the shift of high-cost therapies from inpatient to outpatient and home settings may further amplify budgetary impact. Point32Health's Strategic Actions to address these challenges while maintaining access and affordability: Point32Health is implementing a multi-pronged strategy that includes: • Formulary Management: Our Pharmacy & Therapeutics Committee rigorously evaluates new therapies for clinical efficacy, safety, and cost-effectiveness. In 2026, this includes strategic updates such as the exclusion of weight loss GLP-1s from coverage, promotion of biosimilar preferred products, and formulary tiering to encourage high-value prescribing. We continue to use prior authorization and step therapy to ensure appropriate use where permitted. • Clinical Program Optimization: We continue to invest in clinical programs that promote evidence-based prescribing, medication adherence, and deprescribing where appropriate. • Specialty Drug Oversight: We partner with

our PBM to manage specialty drug utilization and provide care management for specific disease states. • Affordability Initiatives: We are actively implementing manufacturer copay assistance programs for specialty drugs, leveraging rebate strategies, and deploying targeted member education campaigns to mitigate out-of-pocket costs. • Health Equity Focus: We assess medication access through an equity lens, identifying gaps and tailoring interventions to support underserved populations with the aim of improving health outcomes while reducing costs. • Value-Based Contracting: We are expanding our use of outcomes-based agreements with pharmaceutical manufacturers to align payment with clinical performance. To address the rising pharmacy trend, we consistently review our offerings, the industry landscape, our marketplace, clinical practice guideline updates, and approved as well as pipeline pharmaceuticals, and we make adjustments as needed. In 2025, we implemented several programs to counteract high pharmacy trend: • Copay Card Solution – Reduces health plan and employer drug spend by shifting drug cost liability from the plan sponsor to the drug manufacturer, while preserving the integrity of the pharmacy benefit design. • Orphan Drug Program – Offers individualized longitudinal care to members helping address impact to cost, safety and efficacy concerns through therapy optimization and deprescribing. • Medical Drug Step Therapy (for Commercial plans) - Medical Drug Step Therapy is a tool to encourage the clinically proven use of first-line therapies covered under the medical benefit and to ensure the utilization of the most therapeutically appropriate and cost-effective agents first before other treatments may be covered. • New Core Formularies – New regional specific formularies by segment to offer market competitive formularies in each of the segments and states in which we participate. • Oral Oncology Split Fill Program – Helps avoid Oncology early-discontinuation waste by filling half the prescription twice a month rather than the full prescription once a month for the first 3 months. • Oversupply Prevention Edit - A surplus limit will be applied to prescription drug claims to prevent stockpiling of high-cost medications. We continue to evolve its pharmacy benefit strategy to meet the changing needs of our members and employer partners. In 2026, we are implementing targeted enhancements to our weight loss medication coverage and formulary management practices to ensure access to high-value therapies while maintaining affordability and clinical integrity. • Strategic Formulary Management – Excludes weight loss GLP-1 therapies from coverage to mitigate cost growth and prioritize clinical value across the member population, while offering behavior modification programs (BMP) to support long-term weight health through behavior change and reduce reliance on pharmacologic interventions. • Strategic Formulary Creation/Maintenance – Implements a dual formulary approach to Large Group market by introducing a new formulary option that excludes all weight loss medications, while maintaining access through an alternative formulary that covers weight-loss medications to meet consumer demand and offer transparent pricing choices. • Autoimmune Biosimilar Strategy – Promotes preferred biosimilar products to enhance affordability and sustainability while maintaining therapeutic equivalence. These updates are part of our broader commitment to pharmacy affordability, clinical excellence, and member-centered care. We remain focused on delivering a pharmacy benefit that is responsive to innovation, grounded in evidence, and aligned with the financial goals of our employer partners.

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?

We share the HPC's concern about rising health care costs and their impact on families, employers, and the sustainability of coverage. We are committed to taking steps to meaningfully impact the cost of care as well as to reduce our own administrative costs to become a more efficient organization. We have many initiatives underway that are designed to reduce our TME expense. These include: expanding and strengthening our portfolio of medical and pharmacy policies; advancing medical and infusion site-of-service strategies; continuing investments in payment integrity capabilities ; expanding our care management model based on specific medical conditions; and introducing risk agreements in our behavioral health network. In addition, we have had reductions in workforce with a cumulative workforce reduction of over 8% this year, amid significant financial losses for the organization and declining membership. While we are committed to making affordable health care available to all Massachusetts residents, we must recognize that health plans alone cannot achieve affordability. For years, state agencies have identified the unrelenting growth in the prices charged by hospitals, physicians, and pharmaceutical manufacturers as the primary drivers of health care costs and premium growth in the Commonwealth. Despite numerous policy recommendations made by the HPC to promote affordability, there has been virtually no legislative action in this area. Massachusetts health plans are subject to the most rigorous oversight in the country, which impacts revenues, profit margins and administrative costs. Through its rate review process, the Division of Insurance caps administrative expenses included in premium rates and was recently granted explicit authority to consider affordability in the rate-review process. Every proposed rate is subject to extensive actuarial scrutiny, DOI review, and public listening sessions. Plans must justify each component of their filings – provider payments, pharmaceutical trends, state mandated benefits, and administrative costs – with transparent data and documentation that the Division publishes on its website. Health plans also face a 1.9% cap on contributions to surplus and must spend 88 cents of every premium dollar on medical care, the highest Medical Loss Ratio standard in the nation. This level of oversight, transparency and regulation simply does not exist for the rest of the participants in the healthcare system. Everyone must do their part to become more efficient in order to improve the healthcare system. We believe it is time to create meaningful oversight and accountability to ensure all actors move toward this goal.

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.

On average, the aging of the population adds about 1% to 2% to trend annually, while the health status of the population increased by 2% to 5% per year, depending on the line of business (including demographics changes). Other factors such as greater employee cost sharing may have been suppressing utilization trends during that time. The impact of these changes (which are not normally exclusive) is seen in the utilization and service mix trend. Point32Health has observed a similar rate of benefit buy down in each year over this time-period. Unit cost for HPHC and THPP is suppressed due to the increases in pharmacy rebates in the measure. The higher trends in 2021 are the result of service suppression during the pandemic. For THPP specifically, the 2023 utilization trends are largely the results of lower acuity associated with redetermined Medicaid members joining the Plan.

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?

Trends being observed in 2025 to date that are most concerning or challenging include: • Continued demand for excessive unit price increases by providers and pharmaceutical manufacturers • High Cost Claims (claims over $100K) are driving increased inpatient facility surgery and medical trends •Musculoskeletal procedures, particularly hip and knee arthroplasties, are driving increased outpatient facility trends • Increased number of oncology cases and oncology drugs including immunotherapies and chemotherapies are driving higher outpatient facility trends • GLP-1s for weight loss continue to impact our pharmacy trends in 2025. As noted elsewhere in our responses, GLP-1s for weight loss will be excluded from coverage starting on 1/1/2026 • Increased utilization of behavioral health impacting offices visits, inpatient facility, and outpatient facility trends.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. 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**	4,789	80
	Q2	5,793	70
	Q3	7,457	82
	Q4	7,041	90
CY2024	**Q1**	7,271	85
	Q2	5,478	53
	Q3	4,252	45
	Q4	4,155	50
CY2025	**Q1**	4,445	39
	Q2	3,204	46
	TOTAL:	**53,885**	**640**

Please note, that the data includes all licensed Point32Health entities

HPC Payer Exhibit 1

All cells should be completed by carrier

Tufts Direct

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines, Tufts Health Public Plans Direct only

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2021	3.7%	14.7%		2.0%	21.2%
CY 2022	3.9%	-4.5%		3.2%	2.4%
CY 2023	2.3%	-5.2%		6.2%	2.9%
CY 2024	2.0%	4.4%		2.1%	8.7%

Note: Provider and Service mix trends are all included in the Service mix column

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 utilization or cost trends.

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 utilization or cost trends.

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 well as Total trend.

HPC Payer Exhibit 1

Tufts Health Plan Commercial

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
CY 2021	1.8%	19.4%		-4.6%	16.0%
CY 2022	3.3%	-6.3%		6.0%	2.6%
CY 2023	2.1%	-0.4%		3.1%	4.9%
CY 2024	1.6%	4.2%		-4.3%	1.3%

Notes: Provider and Service mix trends are all included in the Service mix column

For THP Commercial MA fully insured + self-insured, membership was 176,188 in December 2023 versus 76,836 in December 2024 as membership migrated t

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.

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HPC Payer Exhibit 1

Harvard Pilgrim Commercial

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
CY 2021	-1.0%	21.7%	N.A.	-4.5%	15.0%
CY 2022	1.5%	-2.5%	N.A.	2.3%	1.2%
CY 2023	2.0%	0.9%	N.A.	6.1%	9.1%
CY 2024	2.1%	4.9%	N.A.	2.6%	9.9%

Notes: Provider and Service mix trends are all included in the Service mix column

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 utilization or cost trends.
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 utilization or cost trends.
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 well as Total trend.