November 3, 2025

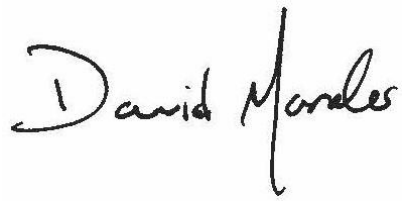
Dear Heath Policy Commission,

I, David Morales, General Manager of Wellpoint, am duly authorized and empowered to represent Wellpoint for the purposes of this testimony submitted to the Massachusetts Health Policy Commission (HPC) and the Office of the Attorney General (AGO) pursuant to M.G.L. c. 6D, § 8.

I hereby affirm that the foregoing testimony, including all accompanying materials, has been prepared and submitted under my direction. To the best of my knowledge and belief, the information contained herein is true, accurate, and complete.

This testimony is signed under the pains and penalties of perjury.

Signed,



David Morales
General Manager
Wellpoint

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?

Located in Woburn, Massachusetts, Wellpoint (formerly UniCare), a wholly owned subsidiary of Elevance Health, serves as a health plan administrator for the Massachusetts Group Insurance Commission (GIC). We proudly administer health benefits for more than 200,000 Commonwealth and municipal employees, retirees, and their dependents. In Massachusetts, Wellpoint's sole focus is supporting the GIC and advancing its mission to deliver high-quality, affordable and equitable care for members.

Wellpoint values this ongoing dialogue around healthcare affordability. We share a collective commitment with policymakers, providers, and employers to ensure that Massachusetts residents have access to high-quality, affordable care. As in prior years, the primary drivers of rising healthcare costs remain:

- **Provider consolidation** that increases prices without corresponding improvements in quality or outcomes.
- **Escalating prescription drug spending**, fueled by expanded utilization, new and extended therapies, patent gaming, and state mandates.

To address these systemic cost pressures, Wellpoint continues to advance initiatives designed to improve outcomes and enhance affordability:

- **Advancing Whole Health** – Addressing members' physical, behavioral, and social needs holistically, in partnership with providers, to deliver care in the most appropriate setting.
- **Contracting for Outcomes** – Implementing value-based payment models that align incentives with quality, affordability, and member experience.
- **Collaborating for Success** – Equipping providers with data, tools, and insights to support timely, evidence-based care decisions.
- **Connecting for Health** – Integrating services across pharmacy, behavioral health, social support, and home-based care for members with complex needs.

Achieving sustainable affordability requires collaboration that extends beyond payers and providers. We encourage Massachusetts policymakers to consider the following legislative reforms that would directly support cost containment and transparency efforts statewide.

- **Address anti-competitive contracting practices:** Wellpoint recommends prohibiting anti-competitive provisions in contracts between carriers and providers, including all-or-nothing clauses, anti-tiering clauses, and anti-steering clauses. These reforms will strengthen competition among providers and enable health plans to pursue network and access innovations that improve affordability and choice.

- **Prohibit hospital dishonest billing at off-campus, non-hospital facilities:** Some hospitals bill at higher "hospital" rates for services performed at off-campus, non-hospital facilities — increasing costs without clinical justification. Wellpoint recommends legislation requiring hospitals to:
    - Use the unique National Provider Identifier (NPI) for each off-campus facility, and
    - Submit claims for these services on the CMS 1500 paper form and as a HIPAA X12 837P electronic claim (for professional, not institutional, services).

  These reforms would ensure services are reimbursed at the appropriate rate and promote transparency regarding where care is delivered. Indiana and Maine have already enacted similar laws.

- **Prohibit unwarranted facility fees:** Facility fees—charges for overhead costs added to standard service billing—are increasingly common as hospitals acquire independent practices and ambulatory surgical centers. Since most health plans prohibit in-network

providers from charging these fees, including the GIC, out-of-network providers often balance bill patients for these fees, leading to unexpected out-of-pocket costs for consumers.

Wellpoint recommends that Massachusetts prohibit facility fees except for:

- Services performed on a hospital campus;
- Care delivered in a licensed emergency department; and,
- Emergency services provided at a licensed satellite emergency facility.

Hospitals that bill facility fees should also be required to provide written notice to patients in advance. These measures protect consumers from unexpected out-of-pocket costs and promote pricing transparency.

- **Reevaluate and limit benefit mandates:** Massachusetts currently requires coverage for more than 50 specific treatments and services, some exceeding evidence-based national guidelines. A 2025 Massachusetts Association of Health Plans (MAHP) study found these mandates add approximately $2.5 billion annually to premiums — roughly 17 cents of every premium dollar. An additional $1 billion in premium costs is expected from new mandates enacted in 2024. To date, 188 state mandated benefit bills have been filed during the 2025-2026 legislative session.[1]

  While each individual mandate may appear modest, their cumulative impact significantly increases costs for all residents. Policymakers should carefully assess proposed mandates and weigh their aggregate financial impact on consumers and the Commonwealth's affordability goals.

- **Reform the Determination of Need (DoN) process:** Current DoN laws restrict entry of new, lower-cost providers and reinforce incumbent monopolies. Wellpoint supports modernizing the DoN process to:
  - Encourage market competition by enabling innovative, cost-effective providers to enter the market, and
  - Prevent unnecessary hospital expansion by requiring providers to demonstrate genuine need.

[1] Massachusetts Association of Health Plans, "The Impact of State Mandated Benefits on Health Care Premiums in Massachusetts." September 2024. Available at: https://www.mahp.com/publications/

Streamlining the DoN process would expand access to affordable, high-quality care and reduce the need for patients to travel out of state for services—an increasing trend among Massachusetts residents seeking lower-cost imaging and other outpatient care services in New Hampshire, a state with no certificate of need laws.[2]

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?

Wellpoint shares the Commonwealth's commitment to sustaining, strengthening, and diversifying the health care workforce—particularly in primary care, which serves as the foundation of a high-performing, equitable health system. We fully support efforts to make the primary care office the central hub for well-coordinated, evidence-based care, where consumers receive the right care, at the right time, in the right setting, and with the right experience.

However, to achieve this vision, broader delivery system reforms are needed to address current challenges and modernize how primary care is delivered and utilized in Massachusetts.

- Persistent primary care workforce shortages are limiting access and creating care bottlenecks.
- Limited office availability drives patients to higher-cost settings. When primary care offices are closed on weekends or backlogged for extended periods, consumers often turn to specialists, urgent care centers, emergency departments, or retail clinics for issues that could be addressed in a primary care setting.

These access barriers increase system costs and fragment care coordination, undermining both quality and affordability goals.

To strengthen the Commonwealth's health care workforce and build a sustainable primary care system, Wellpoint recommends that policymakers:

[2] See New Hampshire Bulletin, "Some Massachusetts doctors are sending patients to New Hampshire for imaging. Here's why." October 1, 2025. Available at: https://newhampshirebulletin.com/2025/10/01/some-massachusetts-doctors-are-sending-patients-to-new-hampshire-for-imaging-heres-why/

- Expand and support independent primary care practices through targeted tax incentives, loan repayment programs, small-business grants, and low-interest loans to help clinicians establish and sustain practices—particularly in rural and underserved urban areas.
- Partner with medical schools and community hospitals to increase the number of primary care residency slots and expand training programs in community-based settings, ensuring new clinicians are trained where they are most needed.
- Broaden the scope of practice for nurse practitioners (NPs) and physician assistants (PAs) to allow them to practice at the top of their licenses and operate independently where appropriate.

3. As we work together to build a stronger, more sustainable health care workforce, it is essential to balance reform goals with the realities of current workforce capacity and utilization patterns. By expanding the provider pipeline, modernizing scope-of-practice laws, and supporting independent, community-based primary care, Massachusetts can strengthen its workforce, improve access, and advance whole-person care for all residents. 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?

At Wellpoint, we are committed to reducing administrative complexity and fostering collaborative, technology-enabled relationships with care providers. Our goal is to remove friction from the health care system so clinicians can focus on what matters most—delivering high-quality, coordinated care to patients.

We continue to advance digital integration, automation, and data transparency to streamline processes, accelerate decision-making, and minimize administrative tasks that add cost without improving patient outcomes.

- **Simplifying Administrative Tasks through Digital Enablement:** Administrative processes often require providers to collect, verify, and track extensive patient and plan data—frequently via manual or paper-based methods. These tasks divert time from patient care and increase operational costs.

To address this, Wellpoint offers providers access to digital platforms such as Availity, which deliver real-time, accurate plan and patient information directly at the point of care. In 2024 alone, Elevance Health's digital platforms supported approximately 206 million monthly inquiries, freeing up valuable provider time for direct patient engagement and improving overall administrative efficiency.

- **Advancing Data Connectivity for a Seamless Care Experience:** Through Health OS, Elevance Health's digital interoperability platform, Wellpoint connects providers, payers, and consumers with real-time, bidirectional data sharing.

  Health OS integrates data from:
  - Four of the largest electronic medical record (EMR) systems;
  - Ten state Health Information Exchanges (HIEs); and,
  - Eleven major admit-discharge-transfer (ADT) vendors.

  This infrastructure combines claims, eligibility, provider demographics, clinical data, social drivers of health, and patient screening information—creating a holistic, real-time view that reduces administrative back-and-forth, supports timely decisions, and drives better health outcomes. These diverse data sets are used in alignment with all application laws and regulations to develop agile and scalable digital solutions that streamline and accelerate processes for both care providers and payers.

- **Leveraging Electronic Medical Record (EMR) integration to streamline authorizations.** Integration with EMRs allows Wellpoint to automatically access required clinical information to support utilization management processes. For example, when prior authorization (PA) requests are incomplete, our connected systems can locate necessary clinical documentation, confirm medical necessity, and approve authorizations more efficiently—reducing provider workload and accelerating patient access to care.

- **Simplifying prior authorization (PA) protects patient safety and controls costs.** PA is an important safeguard to ensure that patients receive appropriate, evidence-based care in the right setting. Many of the PA requests we receive still come via phone, fax, or paper. We have invested in digital solutions that enable and encourage care providers to use electronic PA (ePA) submission and workflow services. These ePA tools streamline submission and

decision workflows, replacing phone, fax, and paper-based methods with fast, digital transactions.

In June 2025, Elevance Health joined AHIP and the Blue Cross Blue Shield Association (BCBSA) in a voluntary commitment to six industrywide reforms that modernize PA. For more details, please see the AHIP press release.[3]

To help payers reduce administrative complexity that adds cost but little value to patient care, we ask that Massachusetts policymakers support the following legislative and policy reforms:

- Support payer use of evidence-based utilization management tools, including PA, which safeguard quality and affordability.
- Require and promote provider adoption of Application Programming Interfaces (APIs)—which payers are federally mandated to build—to enable seamless digital data exchange, including for PA workflows.
- Encourage innovation and technology adoption that advances interoperability, reduces paperwork, and enhances care coordination.

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 Wellpoint, expanding access to primary care and behavioral health services is foundational to our strategy for improving affordability and quality. It is well established that strong, continuous primary care —integrated with behavioral health — improves health outcomes, reduces health disparities, and lowers the total cost of care.

Wellpoint has taken a proactive, multi-faceted approach to expanding access, enhancing care coordination, and improving the overall experience for our members. We have partnered with more than three dozen primary care, urgent care, community health, and digital PCPs across Massachusetts. Our main objectives are to strengthen member access to primary and direct-to-

[3] AHIP press release, "Health Plans Take Action to Simplify Prior Authorization." June 23, 2025. Available at: https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization.

member care solutions, while prioritizing prevention, wellness, and access to primary care as key levers to slow the annual rate of cost growth.

Wellpoint also launched Primary Care Centers of Excellence in collaboration with several independent PCP organizations in Massachusetts, including a community health center. Community health centers provide access to high-quality, comprehensive primary care at a lower cost; however, data shows that commercially insured members rarely utilize them. We are confident that value-based arrangements with these health centers will expand access to affordable primary care, enhance member choice and strengthen the capacity of health centers to grow and sustain their infrastructure.

Wellpoint's Case Management and Digital Engagement programs connect members to the right care at the right time through personalized outreach and virtual tools. Members enrolled in care management receive support from multidisciplinary teams that provide individualized coaching, care navigation, and seamless connectivity to digital platforms and partner resources, including:

- Sydney Health – mobile access to benefits, care management, and personalized guidance;
- LiveHealth Online – virtual visits for primary and behavioral health needs;
- TytoCare – remote clinical assessment and monitoring; and,
- AIM Specialty Health – evidence-based care management.

Through these connections, we strengthen care continuity and empower members to take an active role in their health, driving better outcomes, greater engagement, and a lower total cost of care.

As discussed above, we recommend that policymakers enact reforms and incentives to (1) increase the number of PCPs, and (2) expand Massachusetts' scope of practice laws for mid- level practitioners. As we work together toward this shared goal, it is important to be mindful of current constraints on the primary care workforce, how primary care is delivered today, and the sites of service consumers rely on for their primary care.

We are also concerned that some mental health professionals choose not to participate in insurer networks and instead serve only patients who will pay out-of-pocket. Wellpoint makes every effort to contract with high-quality mental health professionals; however, some decline to join our network for several reasons:

- Practice capacity and administrative burden - Some mental health professionals are in small or solo practices with limited administrative support and may be reluctant to manage the administrative requirements associated with joining networks or increasing patient volume.
- Reimbursement preferences - Some providers decline to contract in-network at reasonable rates, preferring to serve self-pay patients.
- High demand - Highly sought-after providers often see little incentive to contract with insurers when they already have sufficient demand from patients willing to pay out-of-pocket.
- Patient preferences - Some patients choose to seek care out-of-network based on individual preferences, such as provider reputation or convenience.
- Provider practices – In some cases, out-of-network providers, particularly those offering low quality or fraudulent services, engage in aggressive or misleading marketing and patient recruitment tactics that may violate applicable laws and regulations

Wellpoint has asked policymakers to promote bilateral accountability between providers and payers, with a focus on care quality and self-pay arrangements. We also recommend establishing reporting requirements for providers to monitor adherence to evidence-based practices and to promote provider accountability.

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?

While Wellpoint does not administer the prescription drug benefit for the GIC, rising drug costs continue to be a significant health care cost driver. These escalating costs stem from several underlying factors that can be addressed through targeted Commonwealth and federal policy reforms:

- **Persistent brand pricing power and delayed competition:** Pharmaceutical manufacturers often employ strategies such as patent thicketing, evergreening, and product hopping to extend market exclusivity and potentially delay generic competition. These practices may

create overlapping patents for minor drug modifications making incremental changes to secure new patents, or introducing reformulated versions, while steering patients and providers away from the original product.

- **Higher utilization:** The rising prevalence of chronic conditions, evolving standards of care, and direct-to-consumer consumer advertising continue to drive increased demand for prescription drugs.
- **Rapid pipeline growth in high-cost therapies:** The expansion of cell and gene therapies, along with other high-cost specialty products—often priced in the six- or seven-figure range—is accelerating, displacing lower-cost alternatives and introducing volatility for purchasers.
- **Indication expansion for existing brands:** Widely used therapies, such as those in the GLP-1 class, are being approved for additional conditions, broadening eligible populations and increasing spend. For example, certain GLP-1 medications may eventually receive approval for treating Alzheimer's disease and peripheral arterial disease (PAD), conditions affecting approximately 10% of U.S. adults 65 or older and 20-50% of U.S. adults with diabetes, respectively.
- **State mandates limiting care management:** Certain state-level coverage mandates impede payers' ability to manage care effectively and ensure that consumers receive the right care, at the right place, and at the right time.

The following reforms would benefit Massachusetts residents by lowering the cost of care:

- **Protect the use of specialty pharmacies to lower drug costs.** Support specialty pharmacy distribution models that ship patient-specific medications directly to the site of care. These models help reduce drug costs by avoiding the provider "buy-and-bill" pathway, which often involves significant markups and creates incentives to administer more expensive therapies.
- **Address drug manufacturers' abuse of charitable organizations and copay coupons:** Charitable organizations established by or affiliated with drug manufacturers should operate independently and serve patients – not the financial interests of the manufacturers themselves. Drug companies can provide legitimate and meaningful assistance to patients by contributing to truly independent charities that assist patients in need. In contrast, copay coupons often obscure the high prices set by manufacturers, encouraging patients to use more expensive brands instead of equally effective, less expensive generics and brand alternatives, and undermine a key market mechanism that helps contain drug prices.

- **Increase drug cost transparency:** Drug manufacturers should be required to disclose prices at the time of product launch and whenever list prices increase and to report any time limits or duration restrictions associated with patient assistance programs.

  Massachusetts policymakers should also mandate pharmacy reporting to the National Average Drug Acquisition Cost (NADAC) database. NADAC is a benchmark used by state Medicaid programs and other health plans to reimburse pharmacies for prescription drug costs. Currently, NADAC reporting is voluntary; however, some states have enacted laws mandating pharmacy participation and requiring the inclusion of off-invoice discounts and price concessions. Because reporting is voluntary, current NADAC values are often inflated, as pharmacies may not disclose lower acquisition costs. One study found that mandating NADAC reporting from all pharmacies could generate more than $10 billion in savings for state Medicaid programs over ten years, driven by lower per-unit costs when all retail pharmacies participate in the survey.[4]
- **Rescind any willing (or any willing specialty) pharmacy laws.** Payers rely on selective pharmacy networks to promote quality care, ensure safety, and contain costs. "Any willing pharmacy" laws undermine these efforts by requiring inclusion of all pharmacies willing to accept contract terms, reducing incentives for pharmacies to offer competitive pricing or enhanced services. Any willing pharmacy requirements in Massachusetts limit health insurers' ability to manage pharmacy quality and costs effectively.

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?

Wellpoint's value-based care arrangements are designed to drive increased preventive care, reward care providers for high-quality outcomes, promote evidence-based care, and encourage care providers to improve their patients' experiences with the health care system. We are committed to accelerating the adoption of value-based care – particularly through shared-risk arrangements. Data

[4] 3 Axis Advisors Issue Brief, "The billions in prescription drug savings from enhancements to NADAC." May 11, 2021. Available at: https://www.3axisadvisors.com/projects/2021/5/11/enhancements-to-nadac

shows that shared-risk arrangements lead to better and more equitable health outcomes, greater patient and care provider satisfaction, improved access, and more affordable care.

Healthcare payers can help close the gap between spending and health outcomes by adopting payment arrangements that reward clinical excellence, efficiency, and positive patient experiences. Wellpoint's value-based care programs advance this goal through the use of industry-standard metrics and market-specific benchmarks for Medical Loss Ratio (MLR) and Healthcare Effectiveness Data and Information Set (HEDIS) performance.

Elevance Health, Wellpoint's parent company, partners with many high-performing provider groups and health care systems nationwide through shared-risk, value-based arrangements. We recognize, however, that these arrangements may not always be the appropriate value-based model for smaller, independent provider practices. To support these providers, we enable them to contract with National Value Partners which operate as accountable care organizations in shared-risk arrangements with our affiliated health plans.

National Value Partners assume financial risk on behalf of independent care providers, enabling them to better manage patient populations through data-driven insights, advanced analytics, and workflow transformation support, all while minimizing potential financial exposure from unexpectedly high medical costs.

We urge Massachusetts policymakers to advance pro-competition, market-based policies such as the Determination of Need (DoN) reforms discussed above. Increased competition will expand patient choice, empowering individuals to access the care they need, when they need it – at a price they can afford.

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.

Observed allowed claims trend has been depressed slightly by changing demographics. Wellpoint's GIC population has been fairly steady over the years 2020 to 2024, but we have seen our average age decrease slightly over the last few years (estimated impact between -1% and 0%). The impact of benefit changes is also minimal, as the benefit structure of our plans has been fairly constant. The impact has been < 0.2% in each year. Changes in health status risk had a minimal impact on trends in 2022 and 2023. In 2024, it increased trend by about 3%, ex-aging. Going back to 2021, risk scores did increase significantly, but the trend was skewed based on COVID-related impacts to utilization patterns. These trends would impact utilization, provider mix, and service mix / severity.

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
CY 2021	-1.1%	18.0%	-1.8%	-1.5%	13.0%
CY 2022	2.4%	-6.0%	2.3%	7.5%	5.9%
CY 2023	2.3%	-0.8%	0.9%	6.2%	8.7%
CY 2024	2.0%	1.7%	-0.7%	0.6%	3.8%

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.

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?

Wellpoint has observed similar themes in 2024 and 2025:

- Continued pressure due to provider consolidations;
- Increases in utilization of services, with the increase in behavioral health most significant; and
- Increasing severity / mix impacts, especially with respect to outpatient services and professional visits.

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**	3,705	
	Q2	5,472	
	Q3	4,908	
	Q4	4,500	
CY2024	**Q1**	4,594	
	Q2	5,105	
	Q3	7,688	
	Q4	6,132	
CY2025	**Q1**	4,748	
	Q2	5,421	
	TOTAL:	52,273	

*Note: Includes online inquiries.

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
CY 2021	-1.1%	18.0%	-1.8%	-1.5%	13.0%
CY 2022	2.4%	-6.0%	2.3%	7.5%	5.9%
CY 2023	2.3%	-0.8%	0.9%	6.2%	8.7%
CY 2024	2.0%	1.7%	-0.7%	0.6%	3.8%

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.