MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Care Cost Growth Benchmark Frequently Asked Questions

March 2026

Chapter 224 of the Acts of 2012 established a first-in-the-nation target for sustainable health care spending growth in Massachusetts. The **health care cost growth benchmark** is a statewide target for the rate of growth of total health care expenditures that is set by the Massachusetts Health Policy Commission (HPC). Since the enactment of this landmark cost containment law, eight states (including Massachusetts) have established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.

1. What is the health care cost growth benchmark, and how does it relate to prices?

The benchmark is used to measure and encourage the containment of, or slowing of, health care cost growth. The benchmark is a statewide target for the rate of ***growth*** of total health care expenditures (THCE) that is indexed to a projection of the Commonwealth's long-term economic growth. THCE is defined as the annual per capita sum of all health care expenditures in the Commonwealth from public and private sources. The benchmark **does not cap price or spending growth** but is designed as a measurable goal to track our state's progress and to motivate collective action to moderate health care spending growth over time.

To learn more, please see episode 6 of the HPC Shorts series: The Massachusetts Health Care Cost Growth Benchmark.

2. How does the HPC set the benchmark?

The HPC hosts an annual Health Care Cost Growth Benchmark Hearing in conjunction with the state Legislature's Joint Committee on Health Care Financing. At the hearing, the HPC Board and committee members review testimony, data, and feedback from health care market participants, stakeholders, and other interested parties regarding the state's performance against the benchmark. This includes findings from the Massachusetts Center for Health Information and Analysis' (CHIA) annual report on THCE growth in the Commonwealth.

The HPC Board then votes to determine the benchmark for the next calendar year during a public meeting by April 15. Each year, the HPC Board must decide whether to set the benchmark at the default rate of PGSP, or can modify the benchmark rate to any amount deemed reasonable, subject to legislative review.

3. How has the Commonwealth performed against the cost growth benchmark over time?

Spending has often exceeded the benchmark, which mirrors the performance of the health care market in Massachusetts. Massachusetts has averaged annual THCE growth of 4.3% from 2012 to 2024. This is **higher than Potential Gross State Product (PGSP)**, which has been set at 3.6% in every year of the process, and the average annual benchmark of 3.4%.

4. What is the relationship between the growth benchmark and inflation?

The law defines the default benchmark growth rate in relation to PGSP, defined as the "long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle." By design, **PGSP takes inflation over time into account**. In January 2026, PGSP was once again set at 3.6% through the Commonwealth's consensus revenue process.

5. How are individual providers and health plans held accountable for their spending growth in relation to the benchmark?

Each year, CHIA confidentially refers health plans and provider organizations to the HPC based on their attributed spending growth. CHIA's referral methodology[1] employs two bright-line numerical tests based on health status adjusted (HSA) total medical expense (TME) growth. However, spending in excess of CHIA thresholds **simply triggers referral and further review by the HPC.** Referred health plans and provider organizations are not subject to any automatic actions or a PIP based on these bright-line thresholds.

The HPC then performs a **multi-factor review** of each referred entity and provides opportunities for entities to confidentially provide data and insights into their performance. The HPC can require an entity to file a Performance Improvement Plan (PIP) if, taking all factors into account, it finds that its cost growth was excessive, and that the entity's cost growth threatens the ability of the Commonwealth to meet the benchmark.

6. Are acute care hospitals, specialists, nursing homes, and other providers referred to the HPC for their spending performance?

No. Under existing law, CHIA is required to base its referral on entities' growth in HSA TME. The TME metric reflects "the total cost of care for the patient population associated with a provider group based on allowed claims…" and can therefore only be attributed to **primary care providers**, which does not include other providers such as hospitals or ambulatory surgery centers. Therefore, other provider types are not referred by CHIA.

7. Are pharmaceutical manufacturers, pharmacy benefit managers, and other market participants held accountable for their performance against the benchmark?

No. Under existing law, CHIA cannot refer pharmaceutical manufacturers or pharmacy benefit managers to the HPC because these entities do not constitute providers or provider organizations, nor do they have TME.

The HPC has separate authority to review the value and pricing of high-cost drugs referred to it by MassHealth.

8. Can the HPC set differential growth benchmarks for different types of entities?

No. State law requires that the HPC set a single, statewide target for THCE growth. Each year, the HPC must decide whether to set the benchmark at the default statutory rate, which is 3.6% (the PGSP growth rate), or modify the benchmark rate to be higher or lower.

At the same time, the HPC must take differential factors into account in the application of the benchmark in the PIPs process. In assessing provider and health plan performance and determining which entities may be required to file and implement a PIP, **the HPC evaluates multiple factors**, including **baseline levels and growth in size, spending, pricing, utilization, financial measures, populations served, payer mix, and factors outside an entity's control**.

9. Has the HPC's review evolved to account for changing market dynamics?

Yes. The HPC's review **process is flexible** and accounts for market disruptions and other circumstances outside of individual entities' control that may impact their performance. Past examples of such circumstances that the HPC sought to account for in its process include the launch of the MassHealth ACO program, the introduction of high-cost Hepatitis C drugs, and the COVID-19 pandemic. In future review cycles, the HPC anticipates examining

[1] https://www.chiamass.gov/methodology-for-referring-health-care-entities-to-the-hpc/

ongoing impact of the COVID-19 pandemic, including rebounding utilization and price increases, as well as enrollment changes (e.g., MassHealth Redetermination).

Further, the PIPs process requires the HPC to give entities **an opportunity to provide their own data** and explanation for spending trends before voting to require a PIP.

10. Has the HPC made recommendations to update and evolve the underlying statute and the Commonwealth's approach to advancing affordability?

Yes. The HPC has recommended several legislative changes in its annual cost trends reports, including updating CHIA's statutory referral standard; incorporating accountability for the pharmaceutical sector; increasing transparency into the health care market, particularly for-profit entities; establishing affordably standards for health plans; and increasing investment in primary care and behavioral health care over time.

While work remains to address the affordability challenges faced by Massachusetts residents, the Legislature and the Healey-Driscoll Administration have implemented policy aligned with the HPC's recommendations in recent years. Two significant health care laws were enacted in January 2025: Chapters 342 and 343 of the Acts of 2024. Noteworthy components of these laws include the establishment of the HPC Office of Pharmaceutical Policy and Analysis (OPPA) to analyze trends related to pharmaceutical access, affordability, and spending in the Commonwealth, the establishment of the HPC Office of Health Resource Planning (OHRP) to evaluate the supply and distribution of health care resources across the Commonwealth, the establishment of the Primary Care Access, Delivery, and Payment Task Force (PCTF), co-chaired by the HPC and Executive Office of Health and Human Services, to issue recommendations to improve the Commonwealth's primary care system, and changes to the HPC's market oversight authority.

The HPC remains committed to advancing health care affordability in Massachusetts. The HPC's 2025 Annual Health Care Cost Trends Report and Policy Recommendations called on policymakers and health care leaders to **recommit to the health care cost growth benchmark** and convene to develop a consensus on a comprehensive set of reforms, consistent with the long-standing Massachusetts values of shared responsibility and shared sacrifice, for a greater good.