MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2027

HEALTH CARE COST GROWTH BENCHMARK

Agenda

Welcome
Deborah Devaux, Chair, Massachusetts Health Policy Commission (HPC)

Opening Remarks
Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing
Representative John Lawn, Chair, Joint Committee on Health Care Financing

Benchmark Modification Process
David Seltz, Executive Director, HPC

Center for Health Information and Analysis (CHIA) *Annual Report on the Performance of the Massachusetts Health Care System*
Andrew Jackmauh, Acting Executive Director, CHIA

Massachusetts Spending Trends: Drivers and Implications for Affordability
David Auerbach, Ph.D., Senior Director of Research and Cost Trends, HPC

Public Testimony

Closing Remarks

Adjourn

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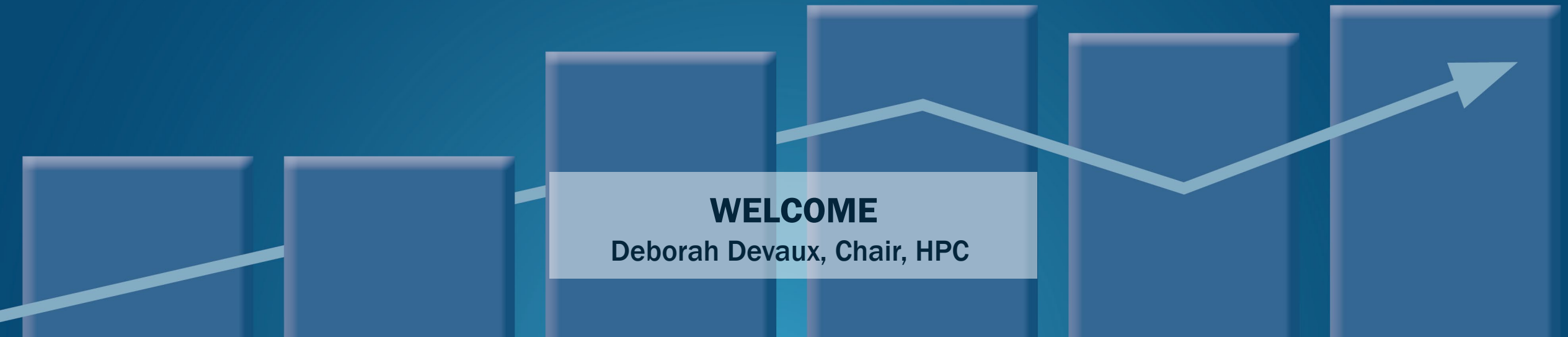

WELCOME

Deborah Devaux, Chair, HPC

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OPENING REMARKS

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BENCHMARK MODIFICATION PROCESS

David Seltz, Executive Director, HPC

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent**, **innovative, and equitable** health care system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

The Health Care Cost Growth Benchmark: Key Definitions

TOTAL HEALTH CARE EXPENDITURES

- The HPC sets a **prospective target** for moderating the per capita growth of **total health care expenditures** across all payers (public and private) and is tied to the state's long-term economic growth rate, potential gross state product (PGSP). *See sidebar.*
- **Total health care expenditures (THCE)** includes:
  - All categories of medical expenses and all non-claims related payments to providers
  - All patient cost-sharing amounts, such as deductibles and copayments
  - Administrative cost of private health insurance

POTENTIAL GROSS STATE PRODUCT (PGSP)

PGSP is established in law as a part of the benchmark process. PGSP is an estimate of the output a state would achieve if all its resources were employed at a sustainable rate, consistent with steady growth and stable inflation.

PGSP is intended to reflect the **long-run average growth rate of the Commonwealth's economy**, excluding fluctuations due to the business cycle.

- Similar to the consensus revenue process, in January the **Governor, House, and Senate convene to review expert economic forecasts** and determine the per capita growth rate of PGSP for the next calendar year.
- By definition, and as intended by policymakers, PGSP is a **stable and predictable economic measure.**
- PGSP includes an estimated forecast of two components **1) future real GDP growth per capita and 2) inflation.**

The Health Care Cost Growth Benchmark: Facts and Myths

WHAT THE BENCHMARK IS

- **A target** to monitor and evaluate the growth of total health care expenditures in the state and the long-term overall performance of the health care system.
- **A measurable yardstick** to motivate and catalyze public and private collective action to improve **health care affordability and access.**
- A method for **enhancing transparency of the health care system** so that market participants, policymakers, and the general public can examine the drivers contributing to higher health costs for government, businesses, and residents and **respond with data-driven public and private action**.
- A **long-term framework** to track and moderate excessive spending *growth* in line with long term economic indicators. The goal is to improve health outcomes and **promote high-quality, affordable, and accessible health care for all residents**.

WHAT THE BENCHMARK IS NOT

- **It is not a government cap** on total health care expenditures, prices, premiums, or payments. It is a target for measurement.
- **It is not a punitive measure**. THCE growth above benchmark alone does not automatically trigger penalties or other negative consequences to the health care system or individual organizations. The HPC may require a performance improvement plan of an individual health care provider or plan only after a comprehensive, multi-factor review of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.
- It is not a measure of **internal costs or operating revenue/expenses** of health care providers. It is a measure of health care expenditures for attributed patients.
- It is not a single solution to addressing health care affordability challenges within Massachusetts. The benchmark process provides **critical information and data** to inform other policy initiatives to improve affordability and access.

The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

1-5 years

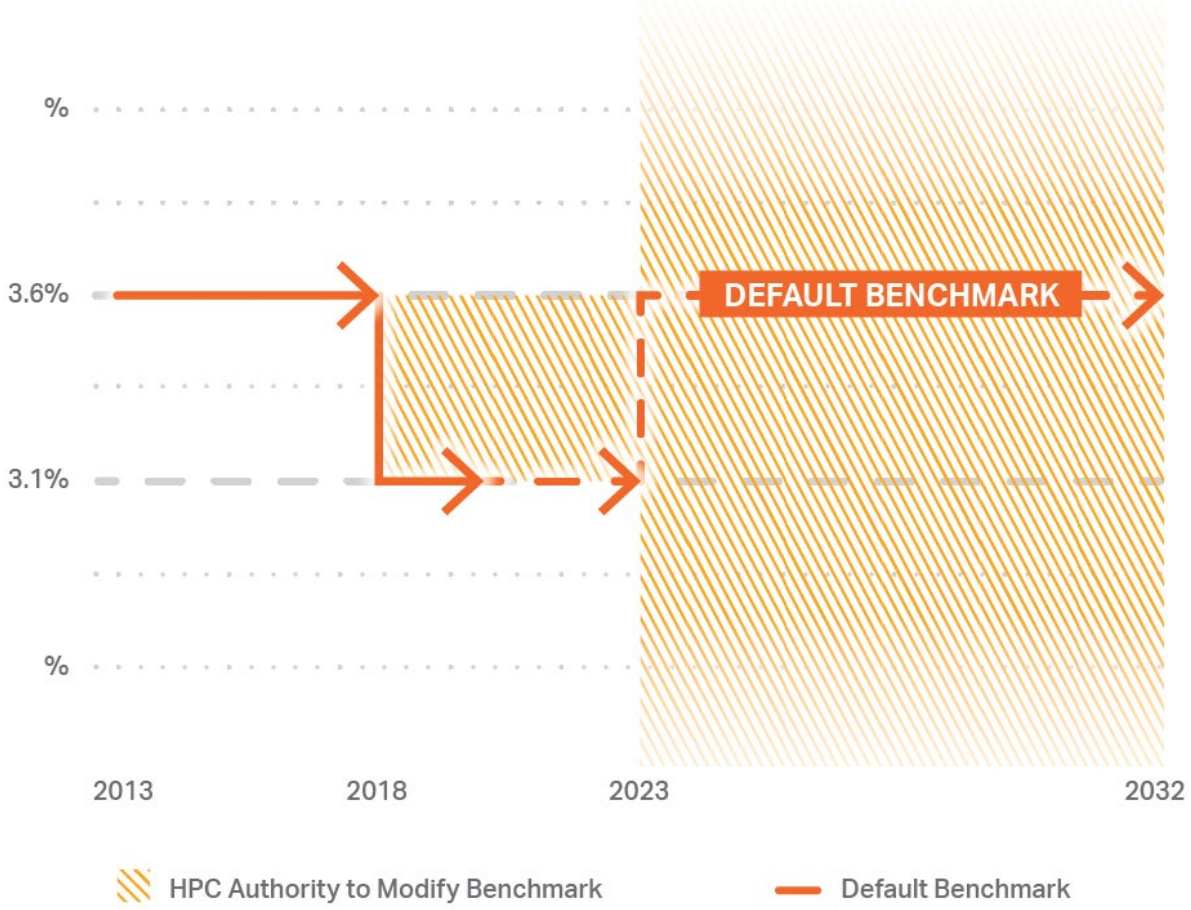
Benchmark established by law at potential gross state product (PGSP) (3.6%)

6-10 years

Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.

10-20 years

Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



Benchmark Modification Process: Key Steps

HPC PROCESS TO MODIFY

- The HPC's Board must hold a **public hearing** prior to making any modification of the benchmark.
- The hearing considers **data** and **stakeholder testimony** on whether modification of the benchmark is warranted.
- Members of the Joint Committee on Health Care Financing participate in the hearing.
- If the HPC's Board votes to maintain the benchmark at the default rate of 3.6%, the **annual process is complete.**
- If the HPC's Board votes to modify the benchmark to any other rate, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee **for further legislative review.**

HPC FACTORS FOR REVIEW

In addition to reviewing the latest CHIA report and public testimony, the HPC reviews available data and information from an extensive range of sources in considering whether a modification is warranted. This includes reviewing:

- A broad range of **current health care trends**, including spending, utilization, pricing, patient acuity, capacity, premiums, cost-sharing, coverage, and provider/payer financial performance. If available, MA performance is compared to the U.S.
- Other **current and forecasted economic trends**, in areas such as inflation, labor costs, economic output, and household income, including those specific to the health sector.
- Surveys that measure **health care affordability challenges** for residents and businesses and the rate of residents who report difficulty receiving needed care due to cost.

Benchmark Modification Process: 2026 Timeline

December 16, 2025

3.6% PGSP established in consensus revenue process

April 1, 2026

Public hearing of HPC Board and Joint Committee on potential modification of benchmark

April 16, 2026

The HPC Board votes to set the benchmark. If the Board votes to maintain the benchmark at the default rate of 3.6%, the annual process is complete. If the Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing.

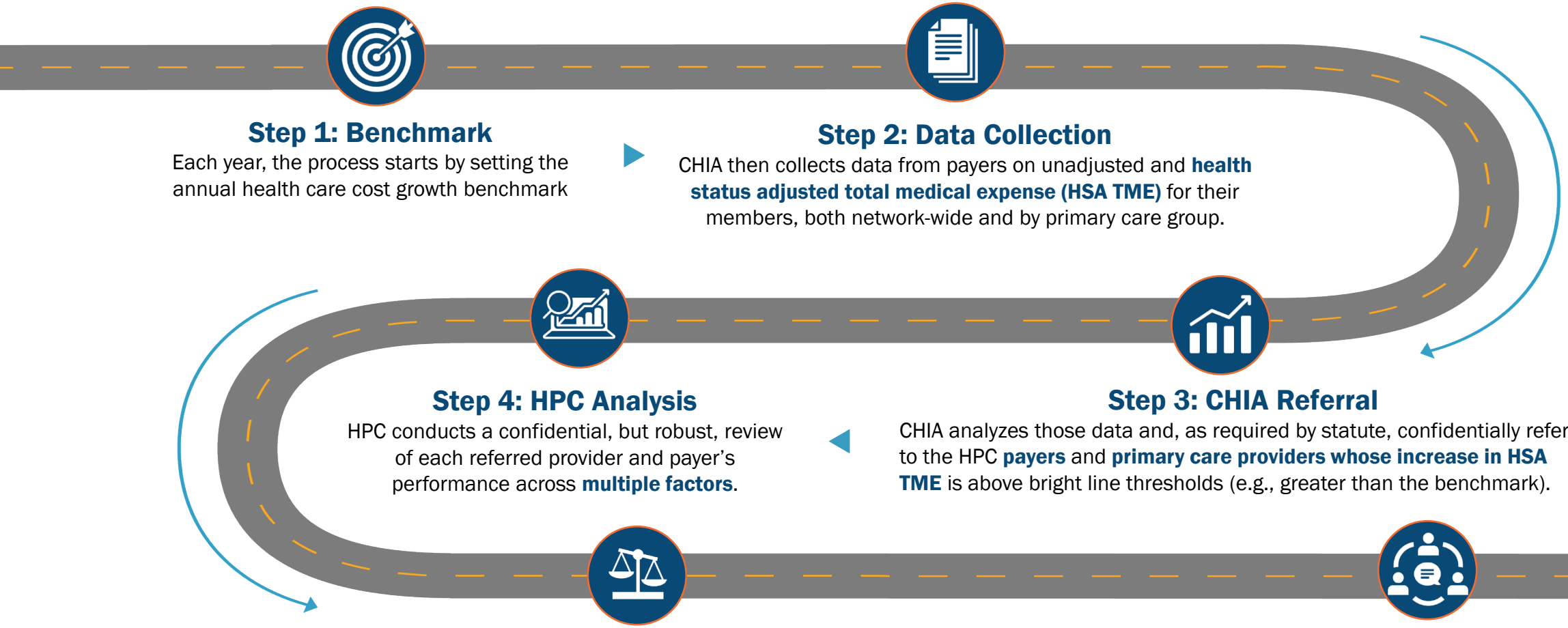
May 2026

Joint Committee may hold a hearing within 30 days of notice

May/June 2026

Joint Committee may report findings and recommended legislation to General Court within 30 days of hearing; the HPC Board's vote to modify takes effect unless the General Court rejects the proposed modification and enacts legislation establishing the benchmark within 45 days of the hearing.

Accountability for the Health Care Cost Growth Benchmark: An Overview



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC **payers** and **primary care providers whose increase in HSA TME** is above bright line thresholds (e.g., greater than the benchmark).

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**.

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

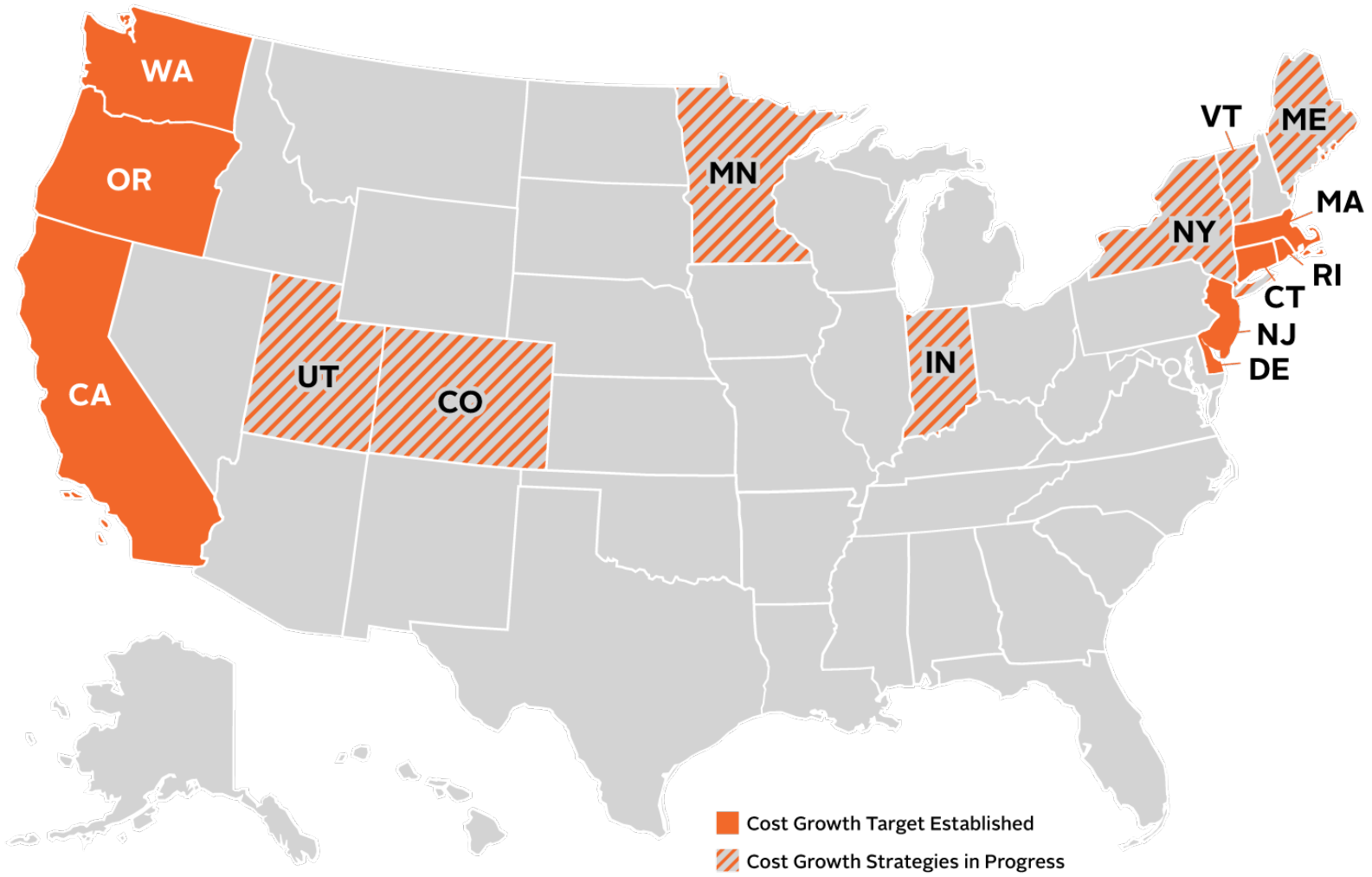
CHIA's referral of entities is based on a bright-line test of their spending growth, whereas the HPC is charged with contextualizing that growth for each referred entity.

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan (PIP) if, after a review of regulatory factors, it identifies **significant concerns** about the entity's costs and determines that a PIP could result in **meaningful, cost-saving reforms**.

REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.

Many other states are going beyond the Massachusetts model and are adopting new strategies to promote transparency, oversight, and accountability.



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

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CENTER FOR HEALTH INFORMATION AND ANALYSIS (CHIA) *ANNUAL REPORT ON THE PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM*

Andrew Jackmauh, Acting Executive Director and Chief of Staff, CHIA

Findings From CHIA's 2026 Annual Report

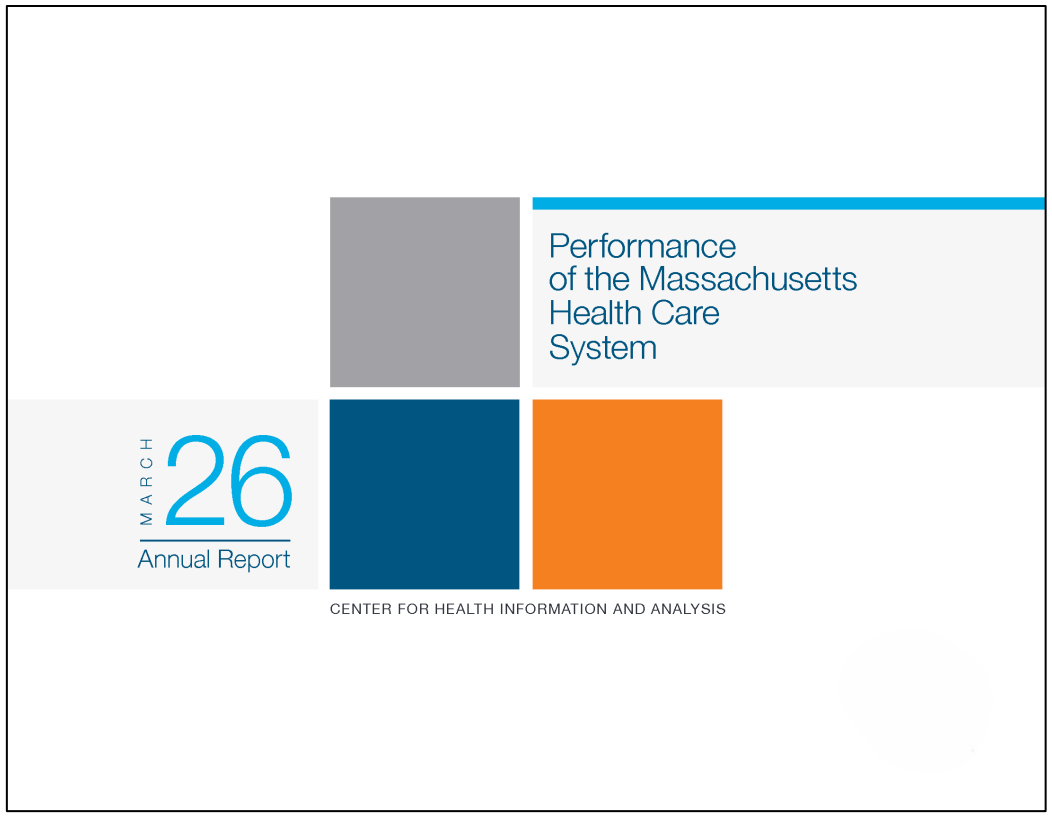
HPC Health Care Cost Growth Benchmark Hearing

Andrew Jackmauh ■ April 1, 2026

Annual Report Released March 2026

DATA PERIOD 2024

- Comprehensive look at MA health care system performance
- **Consequential events:**
  - Post-pandemic recalibration
  - MassHealth redeterminations
  - ConnectorCare expansion pilot
  - Steward Hospital bankruptcy
- Increased pressure on residents, employers, payers, and providers



$83.3 Billion

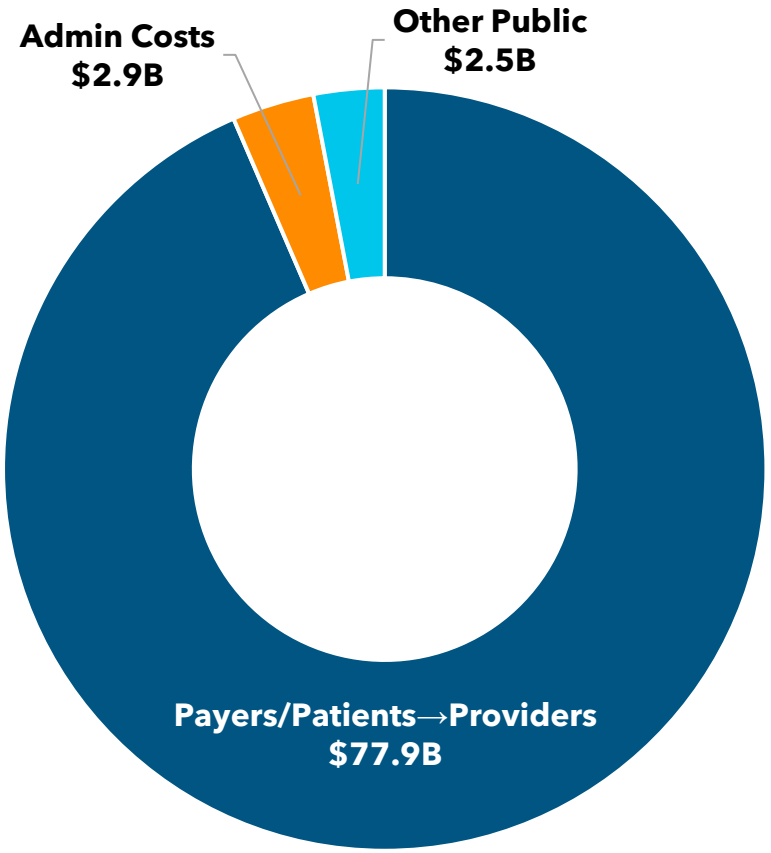
total health care expenditures, 2024

$83.3 Billion

TOTAL HEALTH CARE EXPENDITURES, 2024

- ✓ Payments from payers/patients to providers
- ✓ Health plan administration costs
- ✓ Other public health care programs
- ✓ Impacted by utilization, price, market leverage, payment design

- ✗ *Does not include over-the-counter or payments for non-covered services*



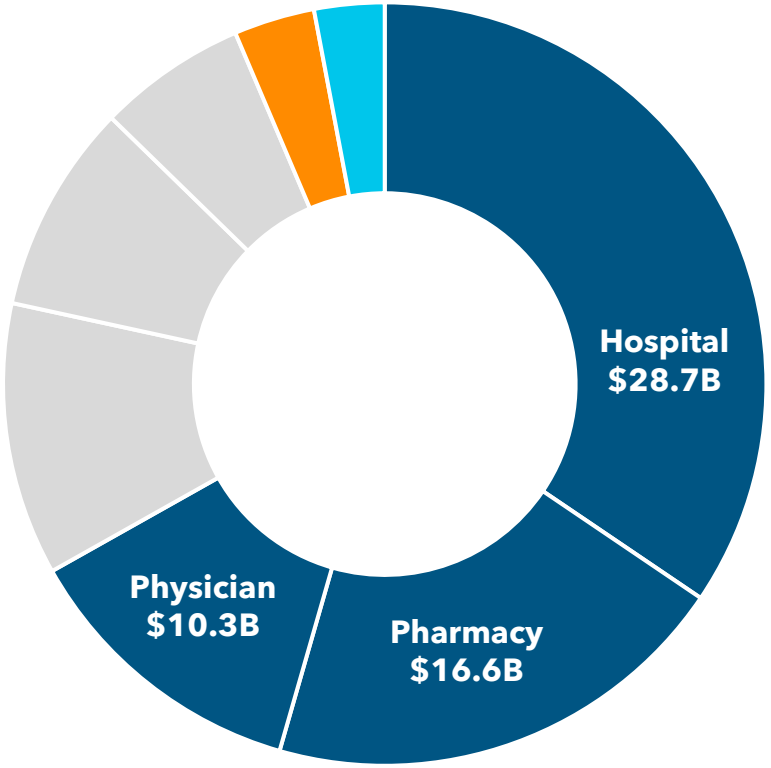
Total Spending $83.3B

$83.3 Billion

TOTAL HEALTH CARE EXPENDITURES, 2024

Highest spending categories:

- Hospital (outpatient + inpatient)
- Pharmacy
- Physician



$83.3 Billion

TOTAL HEALTH CARE EXPENDITURES, 2024

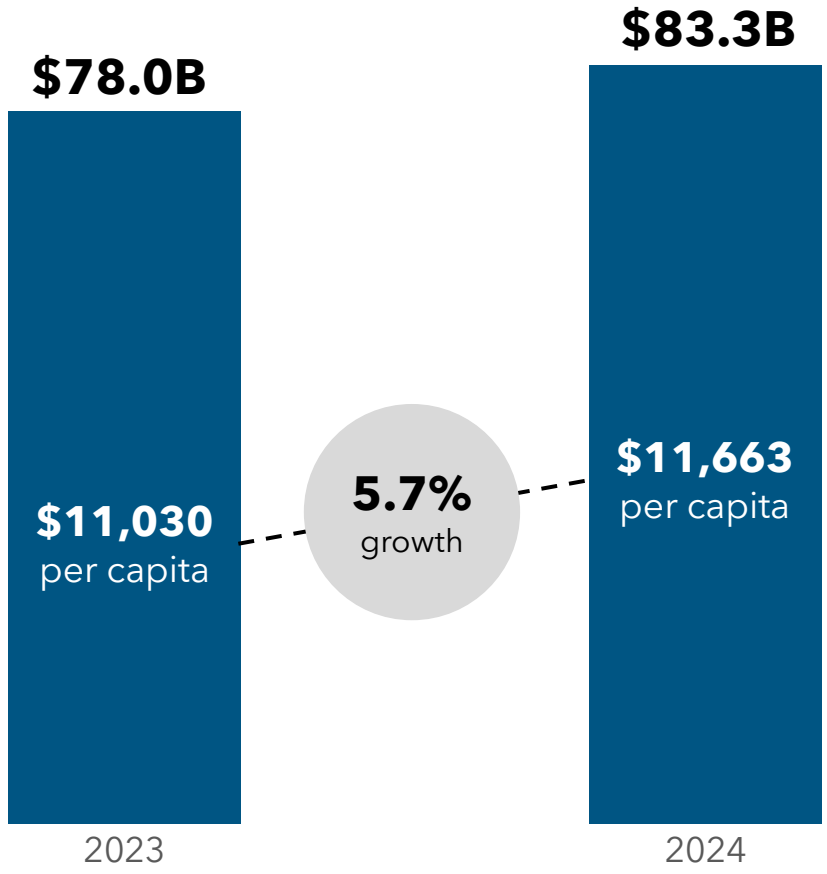
$11,663 spending per person

For a family of 4, could cover one or more major annual expenses:

- Housing
- Childcare
- Groceries + transportation

5.7% growth from 2023

- Exceeded health care cost growth benchmark (3.6%)



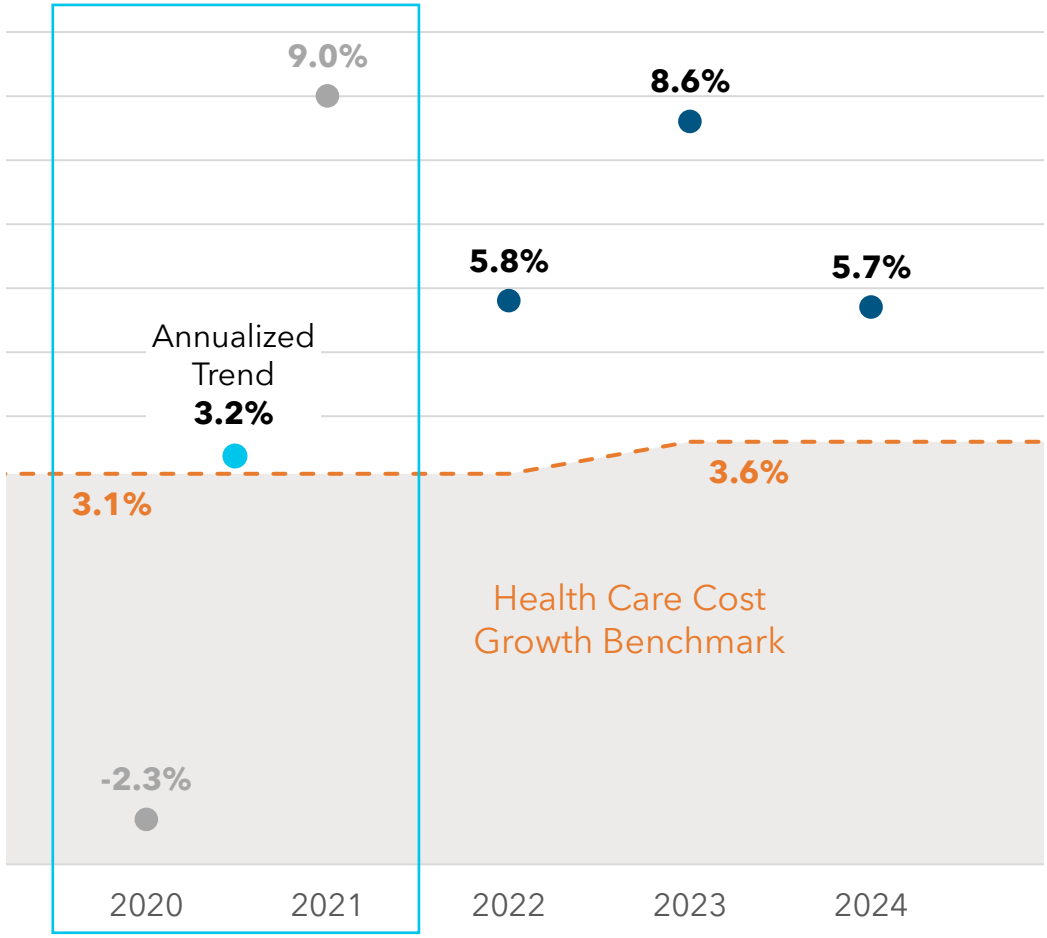
4 Years Running

exceeded health care cost growth benchmark

4 Years Running

EXCEEDED HEALTH CARE COST GROWTH BENCHMARK

- THCE per capita growth above target fourth year in a row in 2024
- Outside of pandemic period, benchmark not met since 2017



More Than 4%

increase in premiums and cost-sharing

More Than 4%

INCREASE IN PREMIUMS AND COST-SHARING

4.8% rise in ESI premiums

- Impacts nearly one-third of residents with commercial health insurance

More Than 4%

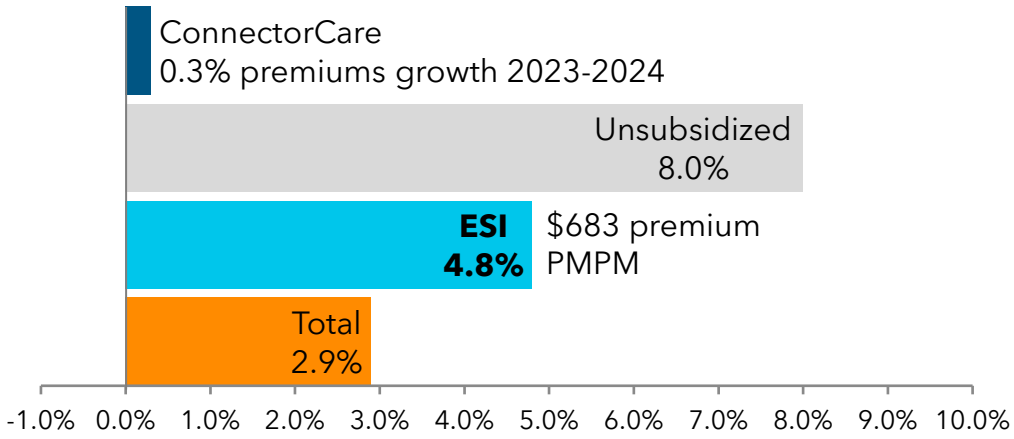
INCREASE IN PREMIUMS AND COST-SHARING

4.8% rise in ESI premiums

- Impacts nearly one-third of residents with commercial health insurance

Lower overall premium trend driven by ConnectorCare

- Increased enrollment
  - MassHealth redeterminations
  - ConnectorCare expansion pilot
- Minimal change in premiums



More Than 4%

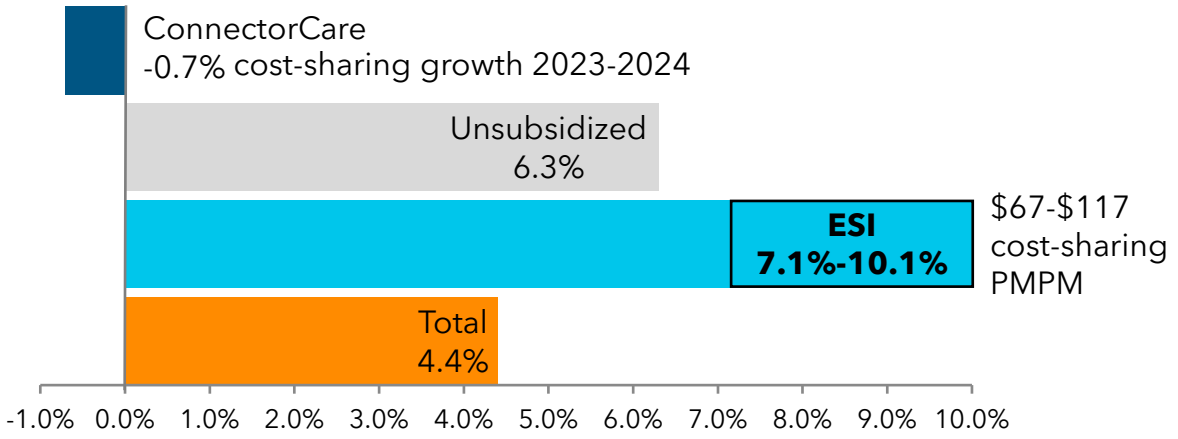
INCREASE IN PREMIUMS AND COST-SHARING

4.4% rise in member cost-sharing

- Significantly higher for ESI members

Bottom line:

- Residents paid more
- Employer costs increased
- Plans lost money and hospital margins were narrow



More Than 4%

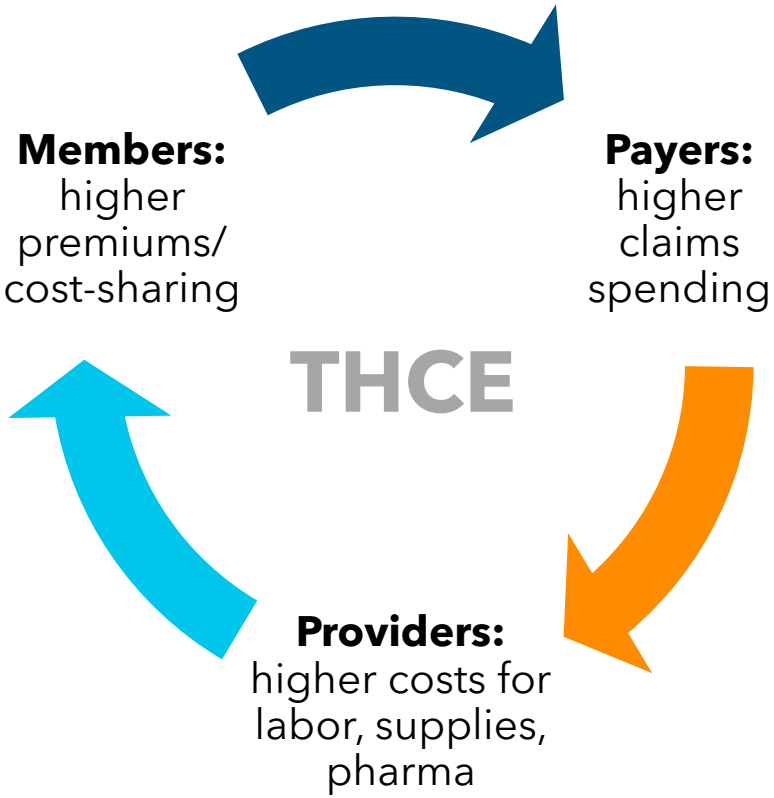
INCREASE IN PREMIUMS AND COST-SHARING

Health Plans (Payers)

- Collected more in premiums
- Spent more than expected on medical claims
- Average $13 loss PMPM

Hospitals (Providers)

- Billed more for medical claims
- Had higher labor and material costs
- Median operating margin -2.0%



40% of Residents

experience affordability issues within the family

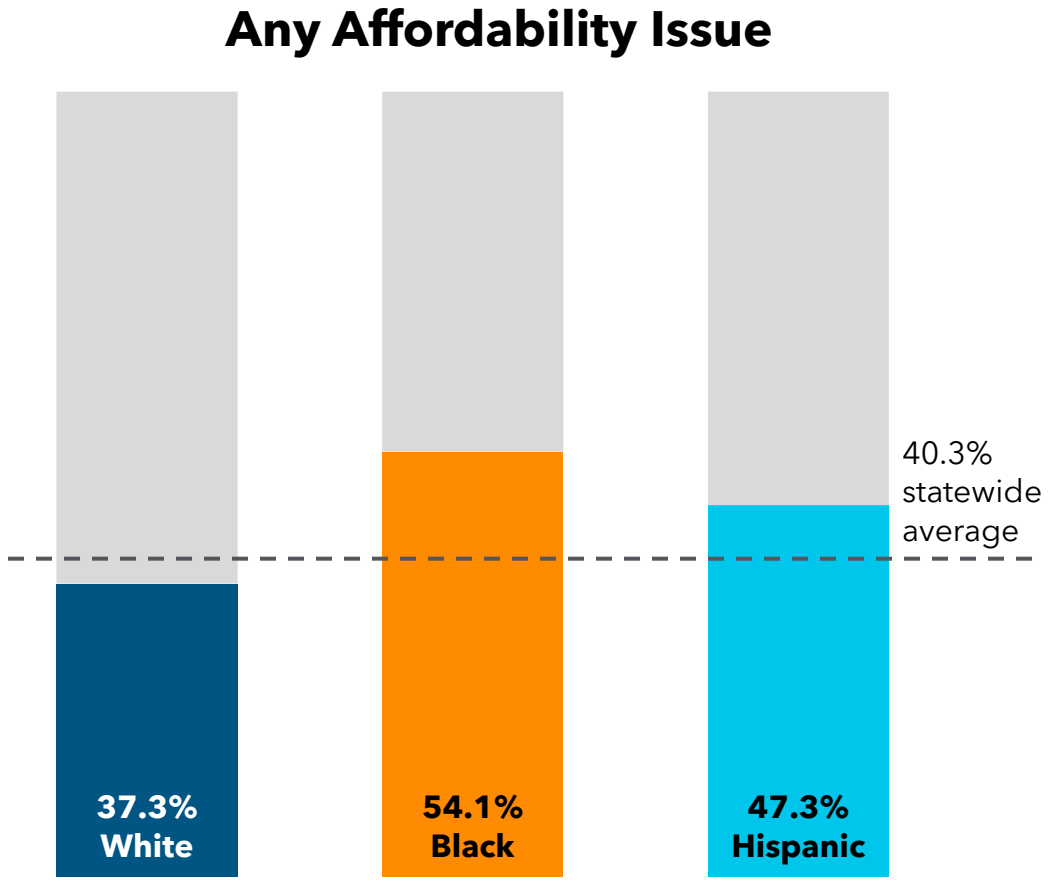
40% of Residents

EXPERIENCE AFFORDABILITY ISSUES WITHIN THE FAMILY

2 in 5 residents statewide:

- Have problems paying medical bills
- Forgo needed care due to cost
- Spend high share of income on out-of-pocket costs

Black/Hispanic residents shoulder more of the burden

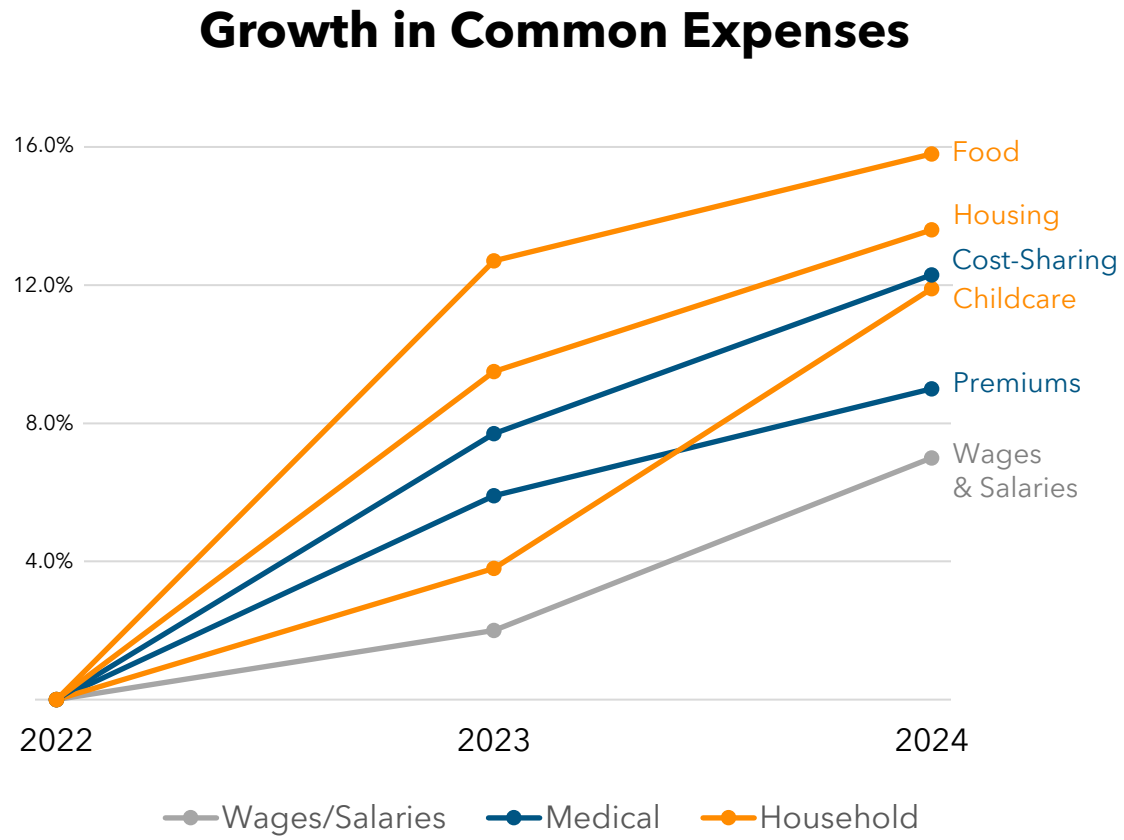


40% of Residents

EXPERIENCE AFFORDABILITY ISSUES WITHIN THE FAMILY

Medical expenses (premiums, cost-sharing) grew faster than wages/salaries

Household expenses (childcare, housing, food) also grew faster than wages/salaries



$83.3B

2024 total health care expenditures

4 Years

exceeded cost growth benchmark

>4%

increase in premiums and cost-sharing

40%

residents with affordability issues

Questions?

THANK YOU

Andrew Jackmauh,
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chiamass.gov

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MASSACHUSETTS SPENDING TRENDS: DRIVERS AND IMPLICATIONS FOR AFFORDABILITY

David Auerbach, Ph.D.,
Senior Director of Research and Cost Trends, HPC

Presentation Outline

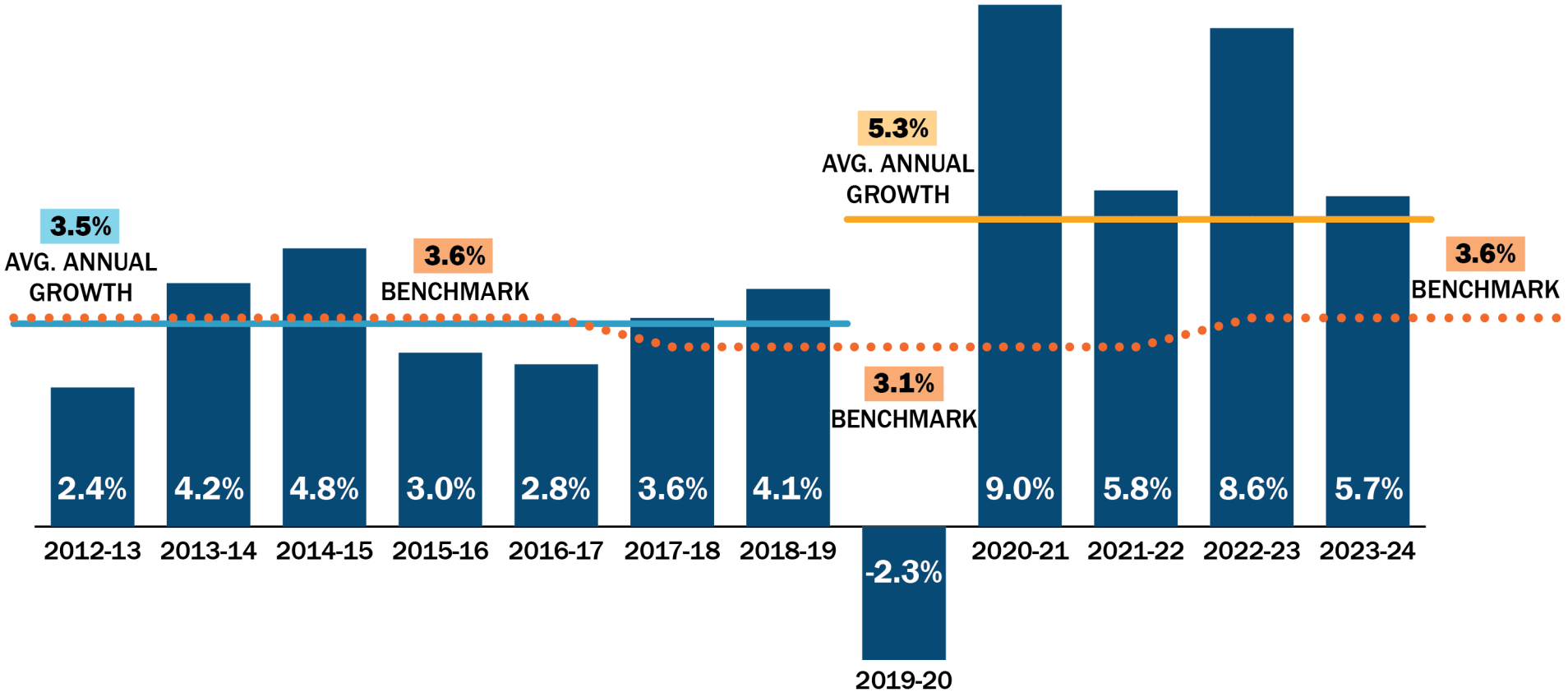
UP NEXT: Cost Trends and Drivers

Other Notable Trends

Affordability of Care

Total health care spending growth in Massachusetts averaged 3.5% from 2012 to 2019 but has risen to 5.3% from 2019 to 2024.

Annual growth in total health care expenditures per capita in Massachusetts, 2012-2024

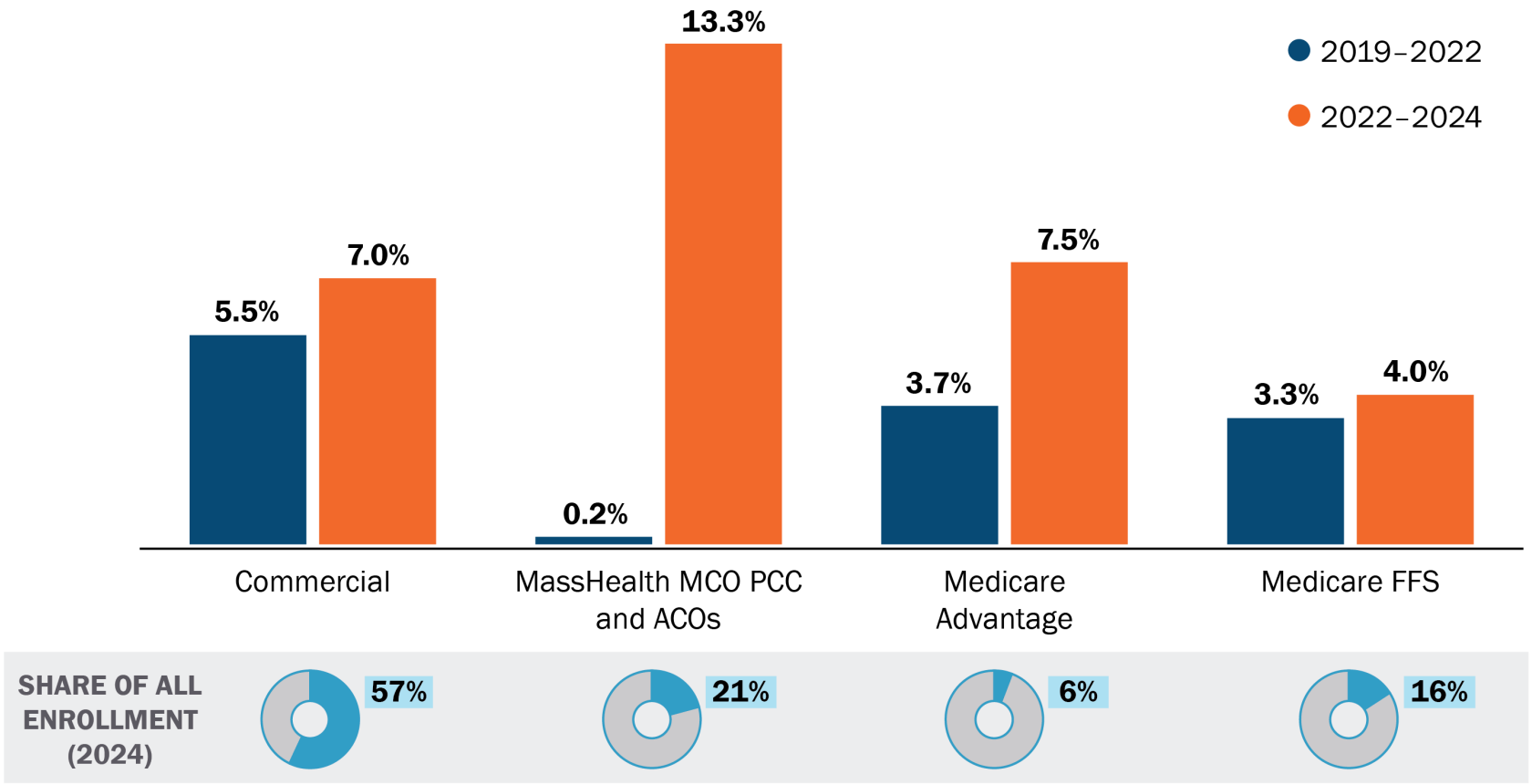


- Health care spending growth averaged **3.5%** from 2012-2019 and **5.3%** from 2019-2024.

Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System 2013-2026.

Spending growth accelerated for all payers in 2023 and 2024 but the commercial sector accounts for almost 70% of spending over the benchmark since 2019.

Average annual growth in spending per member by market segment, 2019-2022 and 2022-2024

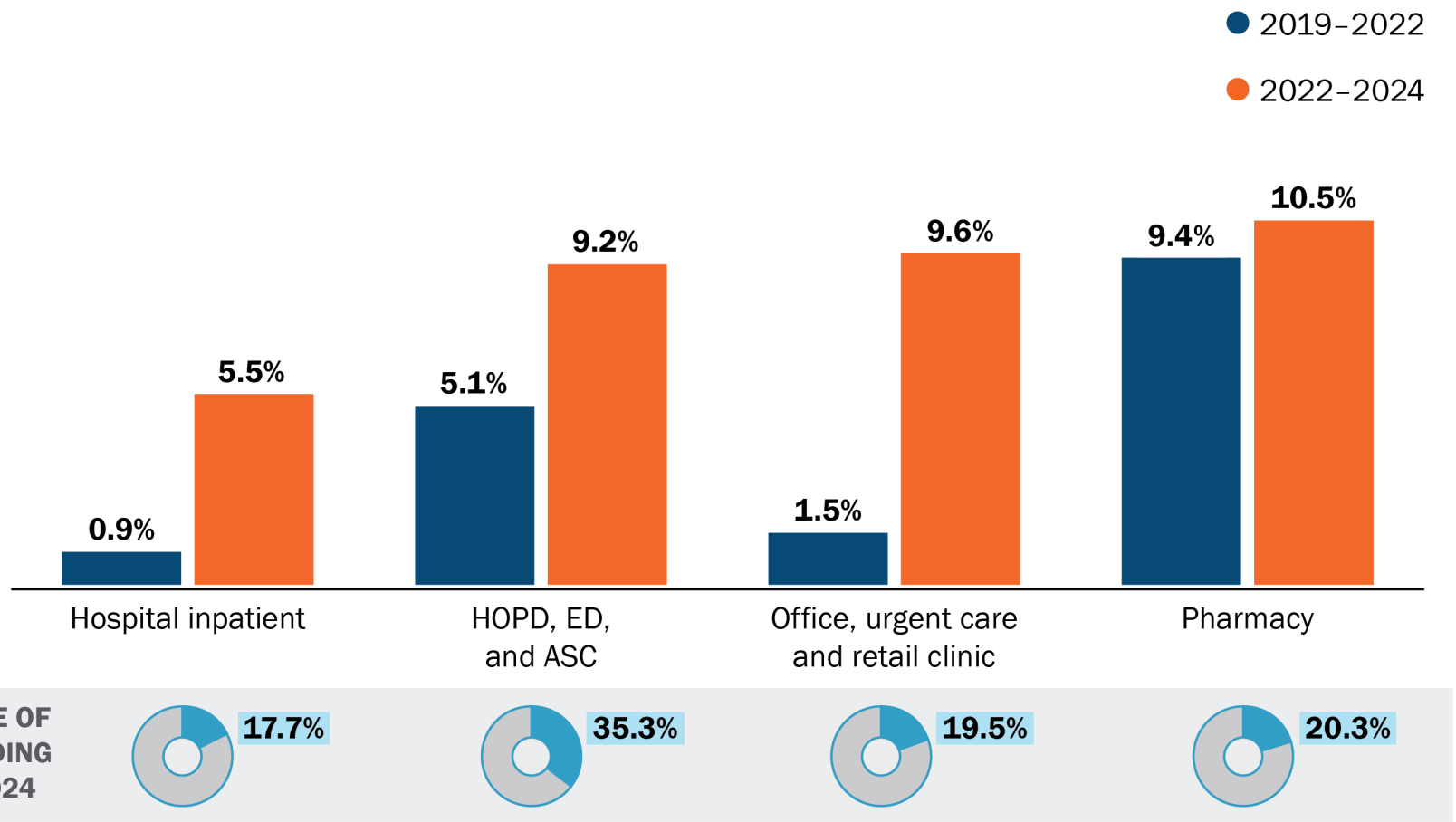


Notes: Commercial spending includes net cost of private health insurance and is net of prescription drug rebates. MassHealth includes only full coverage enrollees in the Primary Care Clinician (PCC), Accountable Care Organization (ACO-A, ACO-B), and Managed Care Organization (MCO) programs.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA), Annual Report on the Performance of the Massachusetts Health Care System, and Centers for Medicare and Medicaid Services data, special data request. The commercial spending figure in the sidebar extrapolates CHIA THCE data with assumption that full commercial market comprises 4 million members in 2022 and 2024.

- Commercial spending in Massachusetts grew by approximately $4.6 billion from 2022 to 2024.

Commercial spending growth accelerated in all care settings from 2022 to 2024.

Average annual growth in commercial spending per enrollee by site of care, 2019-2022 and 2022-2024

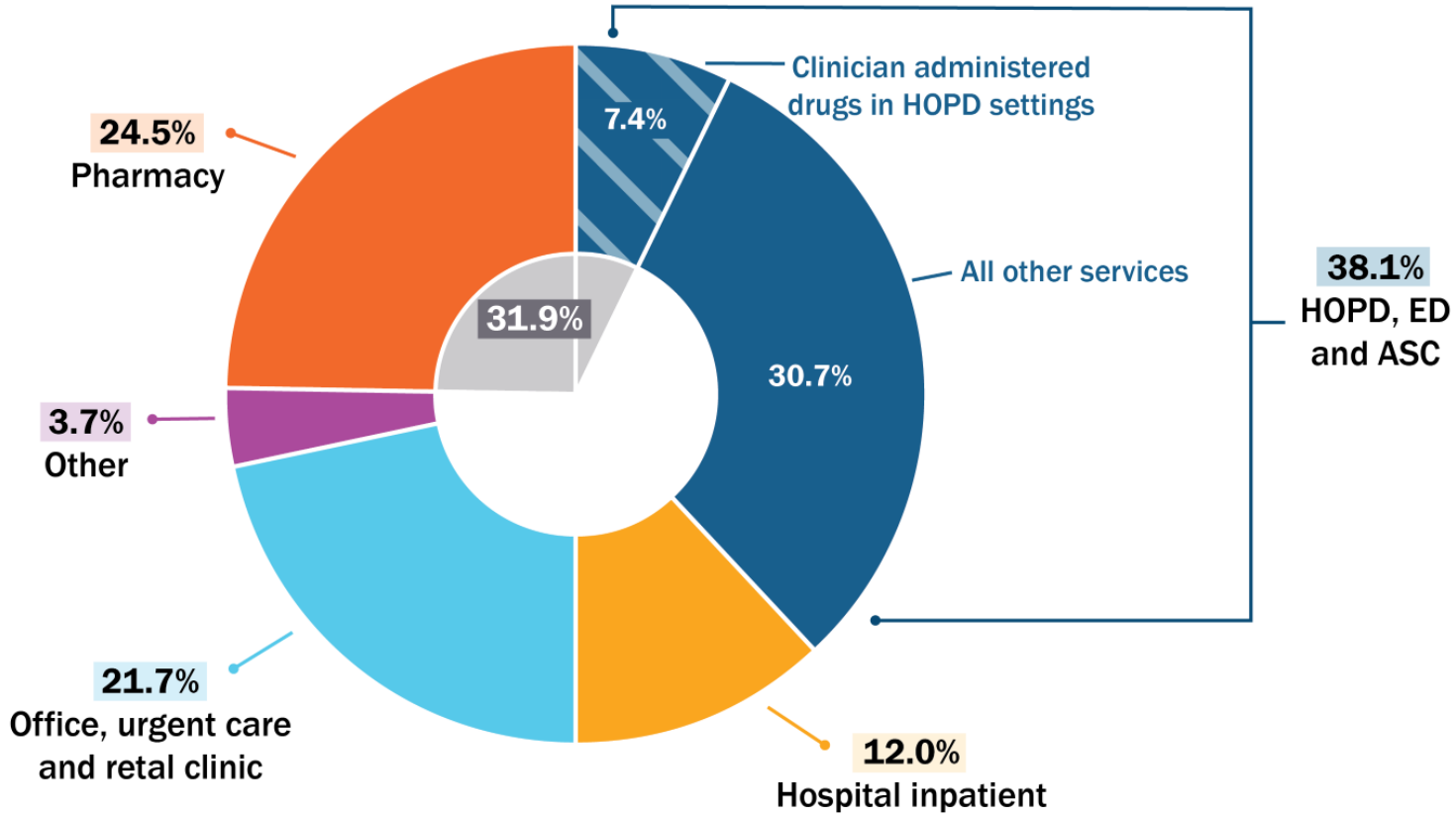


- Hospital outpatient department (HOPD) spending comprises 89% of the spending in the HOPD, emergency department (ED), and ambulatory surgery center (ASC) category in 2024.

Notes: Pharmacy spending is net of rebates. Share of spending does not sum to 100% as sites of care with smaller spending amounts are not shown. Spending includes both professional and facility amounts where applicable.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023 (2019-2022) and V2024 (2022-2024).

Hospital outpatient spending accounted for the largest proportion of commercial spending growth from 2022-2024, followed by pharmacy spending.

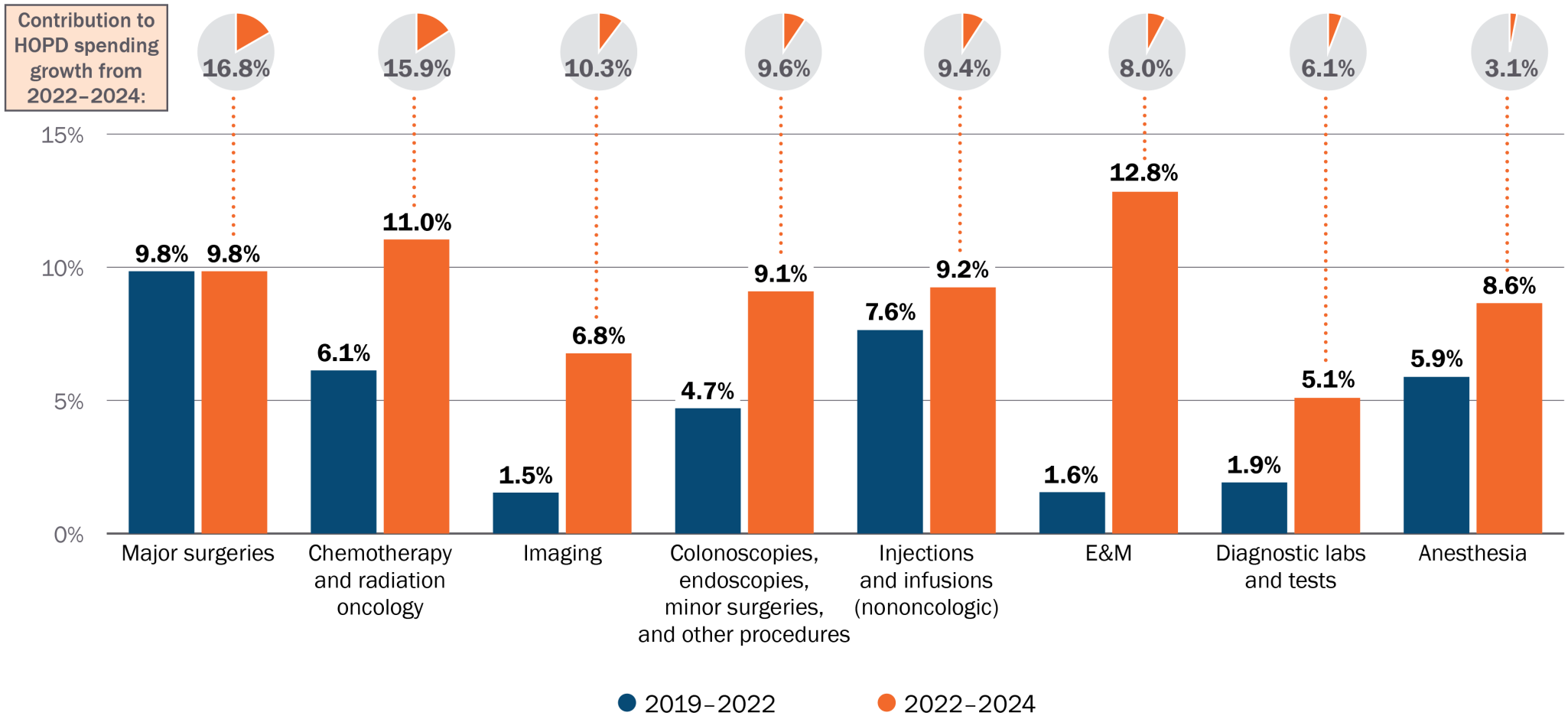
Contribution to growth in commercial spending per enrollee from 2022-2024 by site of care



Notes: Pharmacy spending is net of rebates. Spending includes both professional and facility amounts where applicable.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2024, 2022-2024.

The biggest drivers of hospital outpatient spending growth were major surgeries, chemotherapy, and imaging.

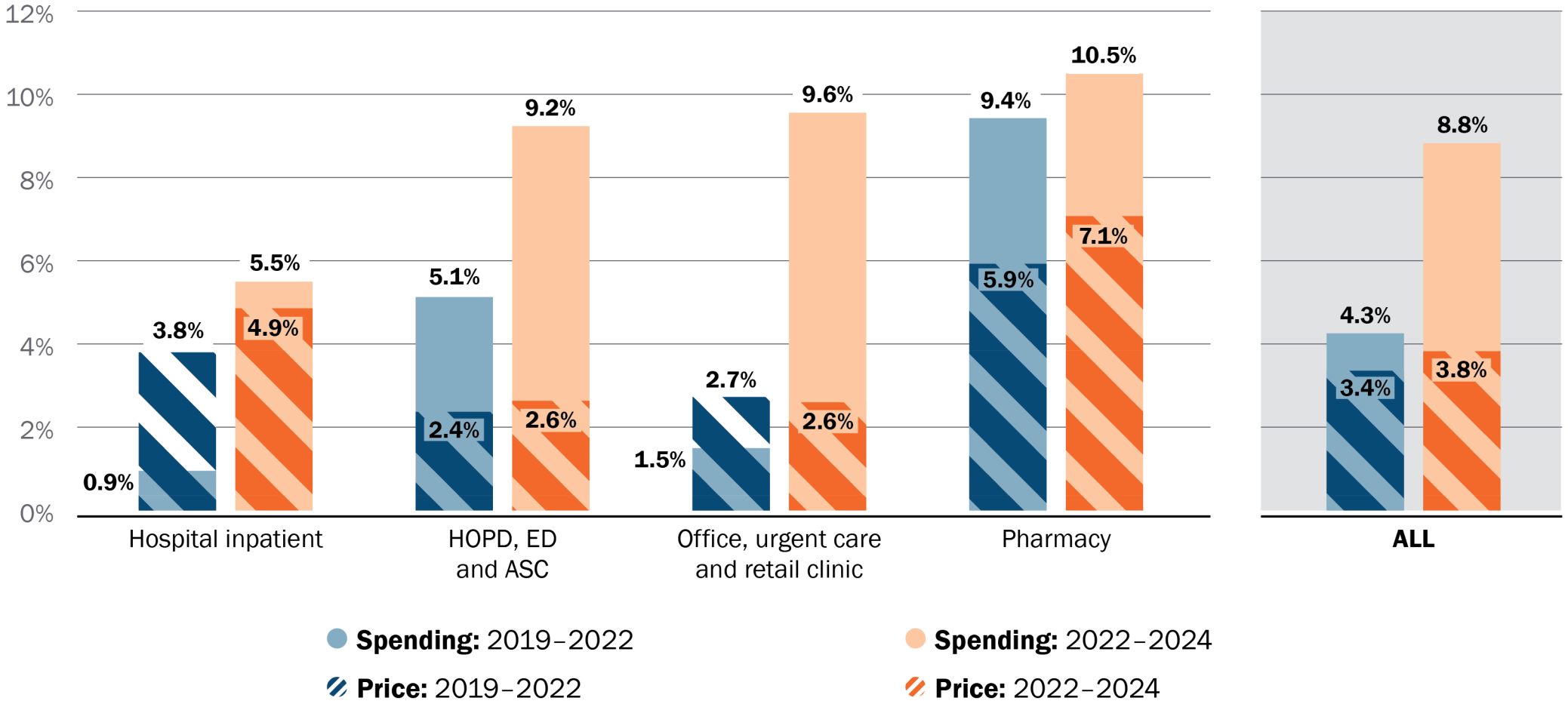
Average annual growth in commercial spending per enrollee for major categories of hospital outpatient department (HOPD) care, 2019-2022 and 2022-2024



Notes: E&M = evaluation and management services. Includes spending from Massachusetts acute hospitals only. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. Categories with small spending amounts are omitted (e.g., durable medical equipment). Spending on COVID tests and vaccines are excluded. Percentages for growth contributions do not sum to 100% due to omitted categories and the exclusion of ASC spending.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023 (2019-2022) and V2024 (2022-2024).

Price growth has accelerated in almost all categories of care. From 2022-2024, other factors also contributed substantially to spending growth.

Average annual growth in commercial spending per enrollee and prices by site of care, 2019-2022 and 2022-2024



Notes: Pharmacy spending and price growth is net of rebates. Spending and price growth include both professional and facility amounts where applicable. Inpatient price growth excludes behavioral health and newborn stays. Sites of care with low spending amounts are not shown and are excluded from spending and price growth - thus data presented in the "ALL" category does not equal the full commercial market as in earlier slides.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023 (2019-2022) and V2024 (2022-2024).

These other factors include some greater utilization, coding at higher levels of severity, and shifts to higher-priced settings and treatments.

More utilization of the same type of care

- From 2022-2024 there were modest annual increases in provider office visits (4.4%), hospital inpatient stays (0.6%), and ED visits (1.7%).

Shift in coding trends to higher levels of severity

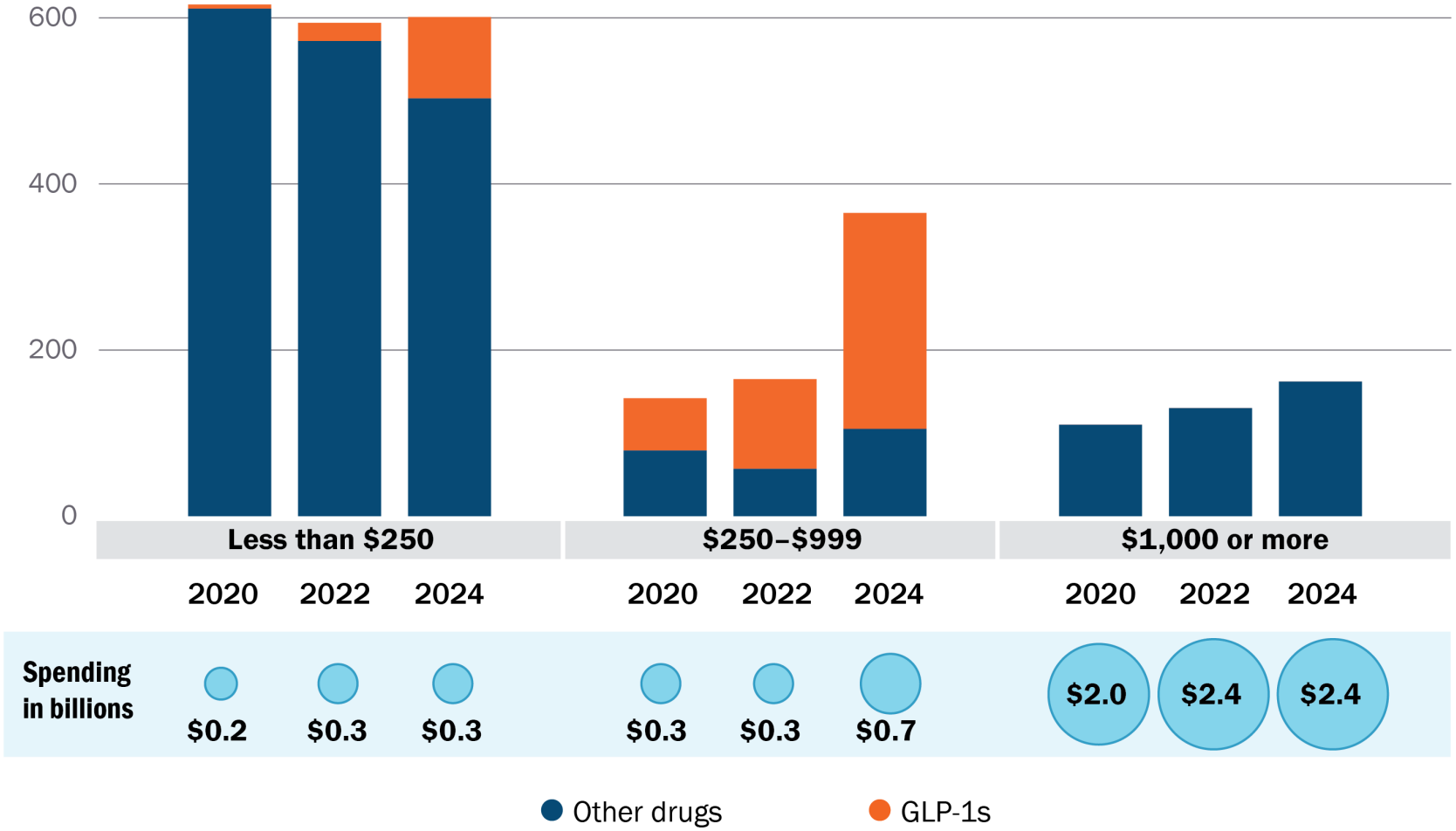
More utilization of high-priced care, sometimes in place of lower-priced alternatives

- Examples include:
  - Shifts toward higher-priced hospital-administered drugs and prescription drugs
  - Shifts toward higher-cost imaging modalities[1]
  - Shifts to higher-cost care settings for routine colonoscopy[2]
  - Increasing rates of C-section delivery for low-risk births[2]
  - Rapid growth in volume of high-cost treatment options such as cardiac ablation (prices range from $28,000 to $86,000) in management of atrial fibrillation

Notes:
1) HPC analysis found that higher-priced imaging modalities used in cancer treatment (e.g. PET) increased in volume the most from 2022 to 2024 while lower-priced forms of imaging increased the least or declined.
2) The HPC reported on these shifts in its 2024 Annual Cost Trends Report. https://masshpc.gov/sites/default/files/2024_Cost_Trends_Report.pdf

Prescription drug spending growth was driven by increased use of GLP-1s and shifts toward the highest-priced drugs.

Number of 30-day equivalent branded prescriptions per 1,000 members by net price per prescription, 2020-2024

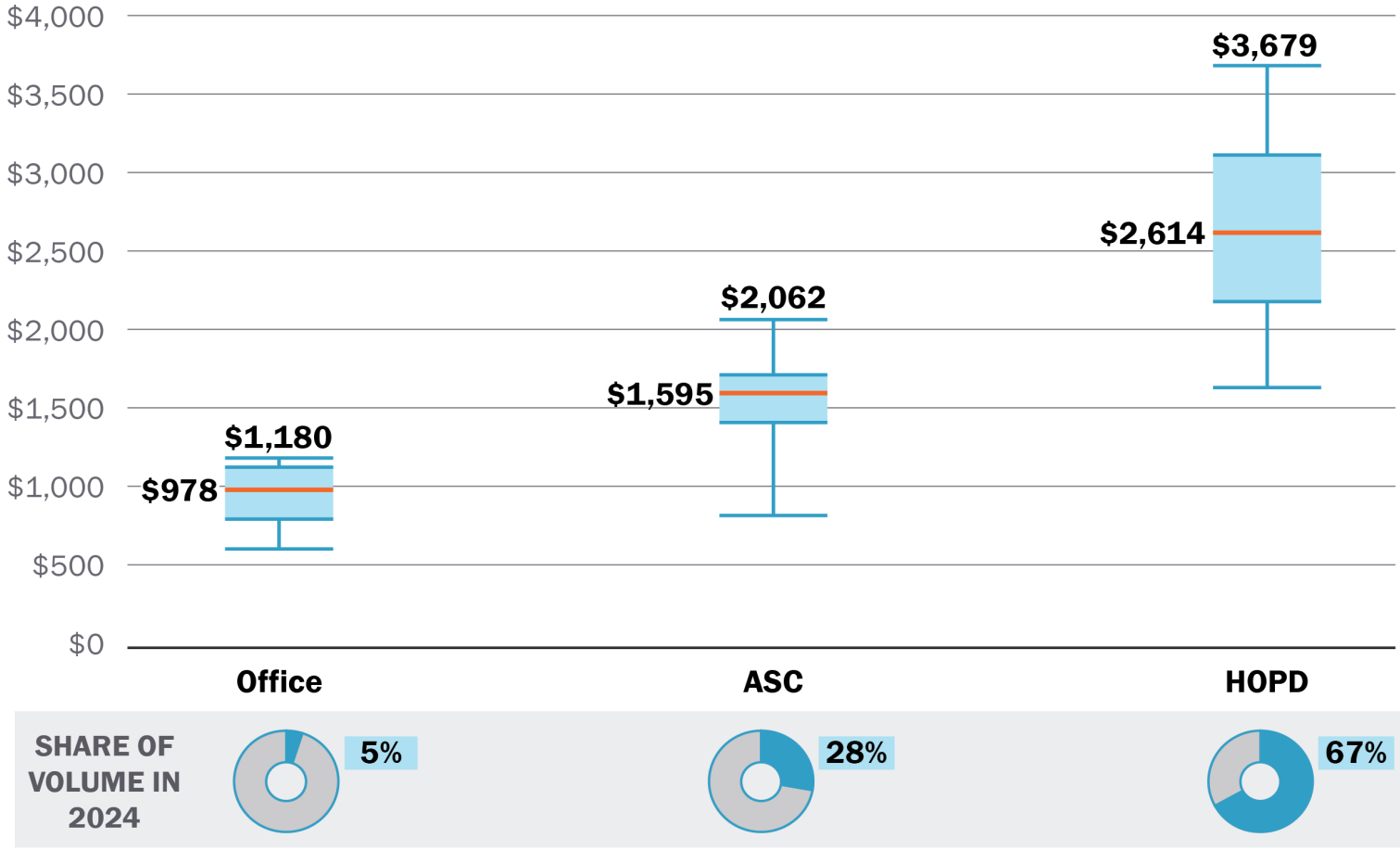


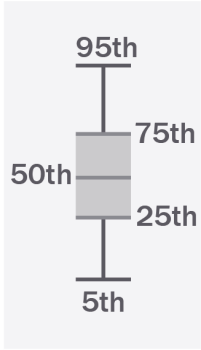
- Nearly half of prescription drug spending growth from 2020 to 2024 reflects increased use of prescriptions priced **over $1,000 per prescription**.

Notes: Excludes claims for branded drugs without SSR Health rebate estimates, vaccines, and non-drug items. Data from BCBSMA excluded.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2024, 2020-2024 and SSR Health US Brand Rx Net Pricing Tool.

The price of a colonoscopy with biopsy is much higher, and more variable, in hospital outpatient departments. Volume is shifting toward this higher-cost setting.

Price of a colonoscopy with biopsy in Massachusetts in 2024 by setting of care





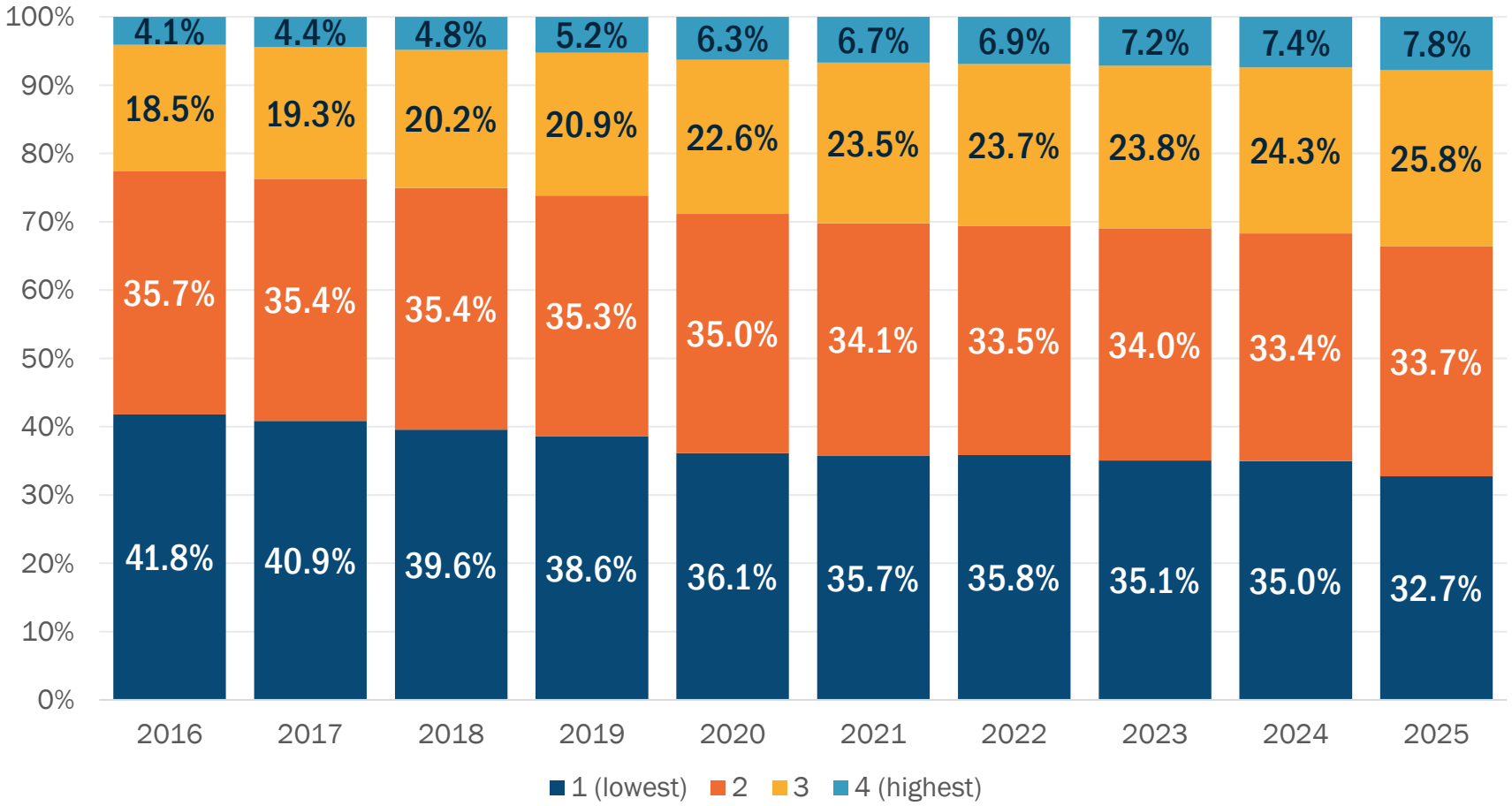
The share of colonoscopies performed in HOPDs increased from 64% to 67% between 2022 and 2024.

- Colonoscopy prices ranged from $601 to $3,679 with average prices in hospital outpatient departments 64% higher than in ASCs and 167% higher than in office settings.

Notes: HOPD = Hospital outpatient department. ASC = Ambulatory surgical center. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Data are for Colonoscopy with removal of lesions (CPT 45385, 'Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique').
Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2024, 2022-2024

The proportion of hospital admissions for commercial patients that were coded at the highest severity level nearly doubled from 2016 to 2025, increasing spending.

Percentage of commercial admissions coded at each APR-DRG severity level, 2016-2025



Notes: Severity groups and typical payment amounts were defined using all-payer refined diagnosis-related groups (APR-DRG) and patient severity of illness (SOI) on a four-level severity scale, with 4 being the highest acuity. The research findings included within this report were produced using the 3M™ APR Software. The data is comprised of all medical inpatient stays at acute care hospitals in Massachusetts, excluding behavioral health stays, transfers, stays where patients died, and extremely long lengths of stay. Graph only includes patients under 65 years of age.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database FY2016 – FY2024, preliminary FY2025 and FY2026q1.

- The average age of commercial hospital patients declined from 2016 to 2025.
- The number of admissions coded at level 4 grew 61% from 2016 to 2025.
- Researchers have estimated that up to two-thirds of the increase in hospitalized patient acuity is explained by coding behavior, not necessarily by changes in patient health.[1]

(1) Crespin, Daniel, et al. Health Affairs 43 (12) (2024): 1619-1627. See also https://oig.hhs.gov/reports/all/2021/trend-toward-more-expensive-inpatient-hospital-stays-in-medicare-emerged-before-covid-19-and-warrants-further-scrutiny/ and Massachusetts Health Policy Commission, Annual Cost Trends Report, 2019.

Presentation Outline

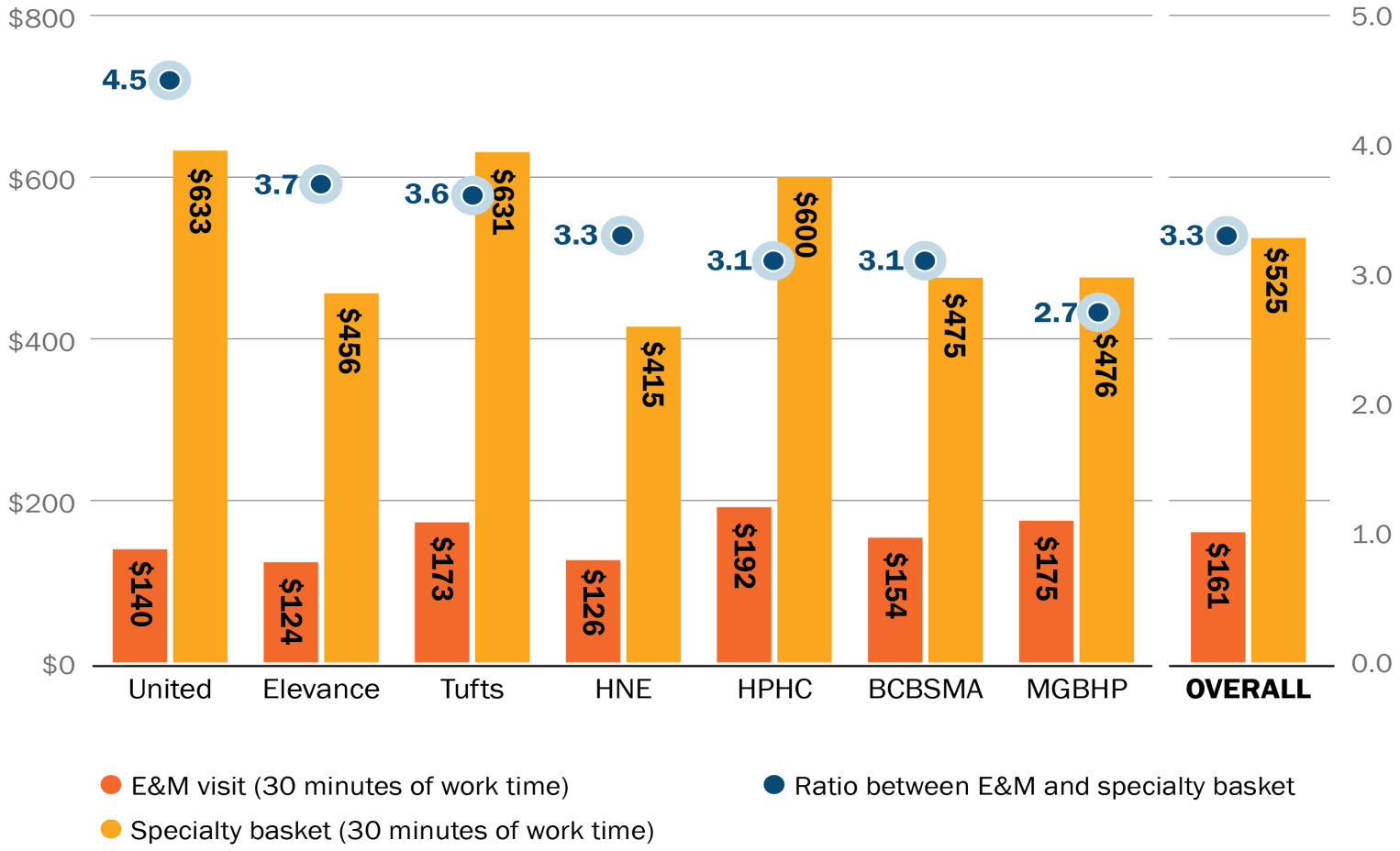
Cost Trends and Drivers

UP NEXT: Other Notable Trends

Affordability of Care

Insurers pay between 2.7 and 4.5 times more for specialist procedures than for regular physician office visits that take the same amount of clinician time.

Average price (and ratio) paid by insurer for 30 minutes of work time for a basket of specialist services and for a common primary care evaluation and management (E&M) visit also representing 30 minutes of work time

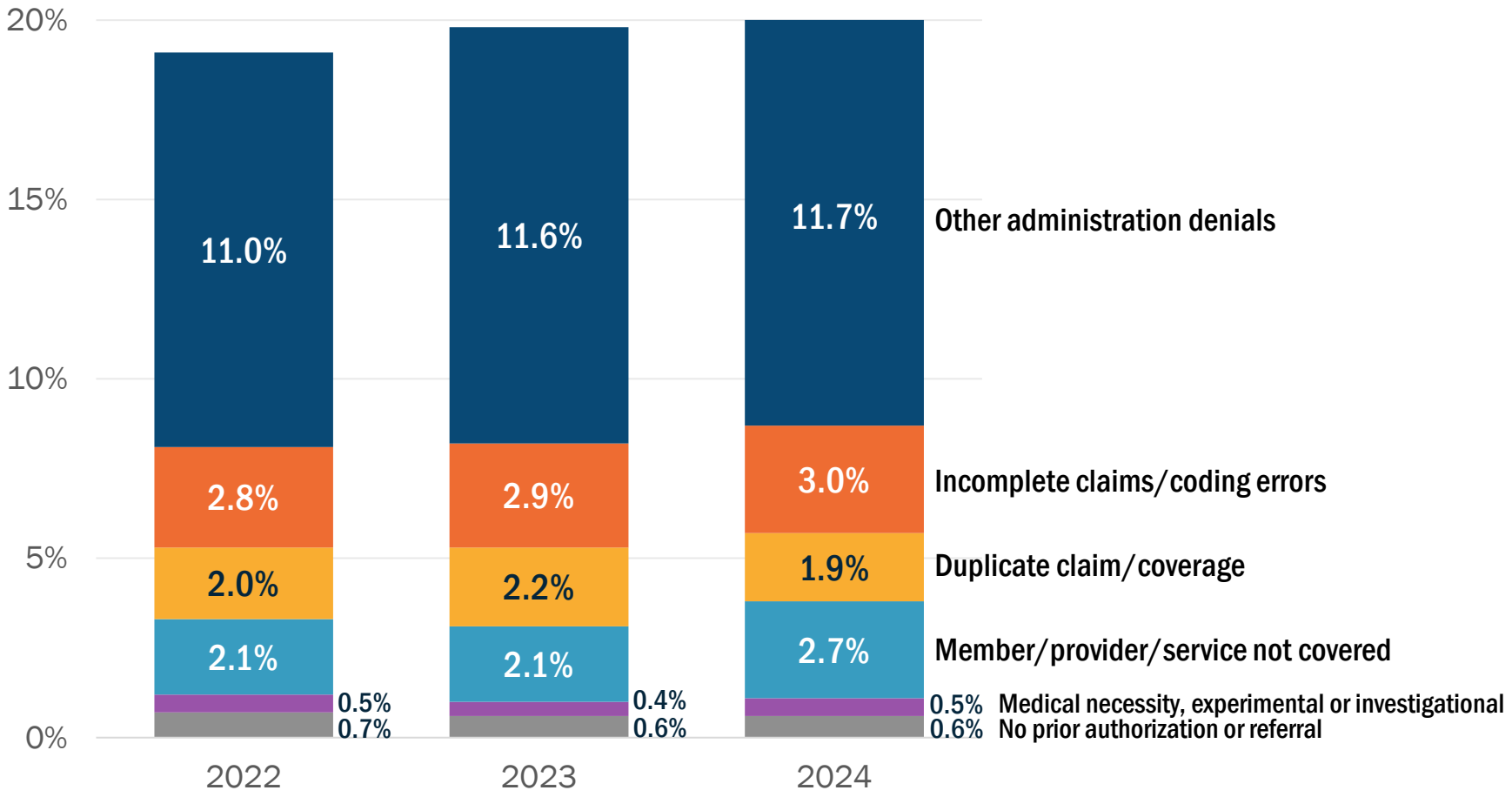


Notes: E&M = evaluation & management visit. "E&M visit" reflects average allowed amount for a 20-minute E&M visit with an established patient (CPT 99213) (30 minutes of work). "Specialty basket" reflects average of average prices paid for select specialty procedures performed in an ambulatory setting (30 minutes of work).
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2023. Details can be found here: https://masshpc.gov/sites/default/files/2024_cth-technical-appendix.pdf

- The specialty services shown include office-based procedures such as injections, tests, wound repair and other minor procedures.
- The payment ratio between the specialty basket and the E&M (evaluation and management) visit remained relatively constant from 2019-2023.

About 20% of claims are denied by insurers, with more than half for administrative reasons.

Percent of total claims denied by denial reason, 2022-2024



Notes: The denominator is total reported claim lines (both paid and denied) in each calendar year. Results include all categories of claims reported at the claim line level and all payers that reported data. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Sources: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000. See https://masshpc.gov/publications/datapoints-series/issue-33-evidence-administrative-complexity-health-insurance-claim.

- Other administrative denials ranged from 3% of all claims (Fallon) to 29% (United).

Presentation Outline

Cost Trends and Drivers

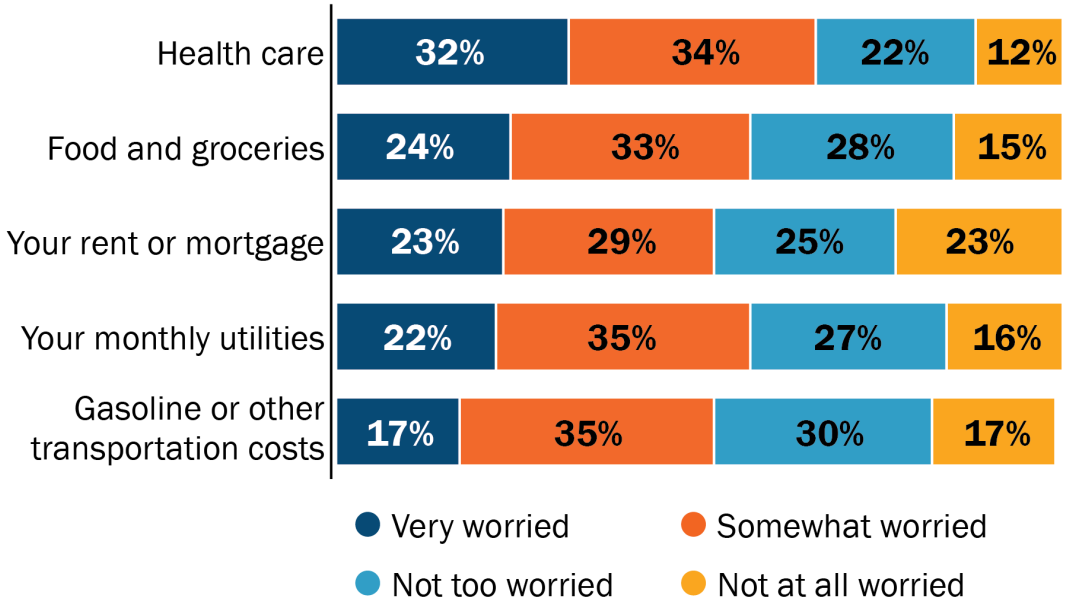
Other Notable Trends

UP NEXT: Affordability of Care

Health care affordability is the top worry among households across the country.

Health Care Costs Are the Top Household Expense the Public Worries About

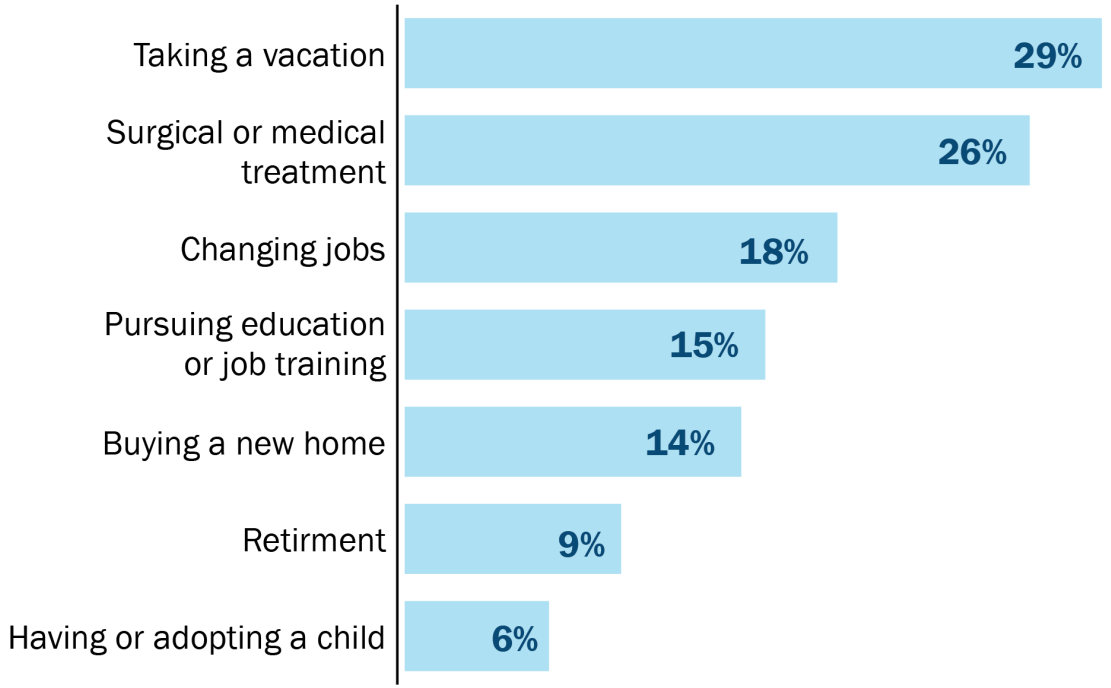
How worried, if at all, are you about being able to afford each of the following for you and your family?



Note: Health care includes the cost of health insurance and out-of-pocket costs for things like office visits and prescription drugs. Monthly utilities include electricity or heat. See topline for full question wording.

Share of U.S. Adults Who Say They Postponed Life Events in the Past Four Years Due to Health Costs

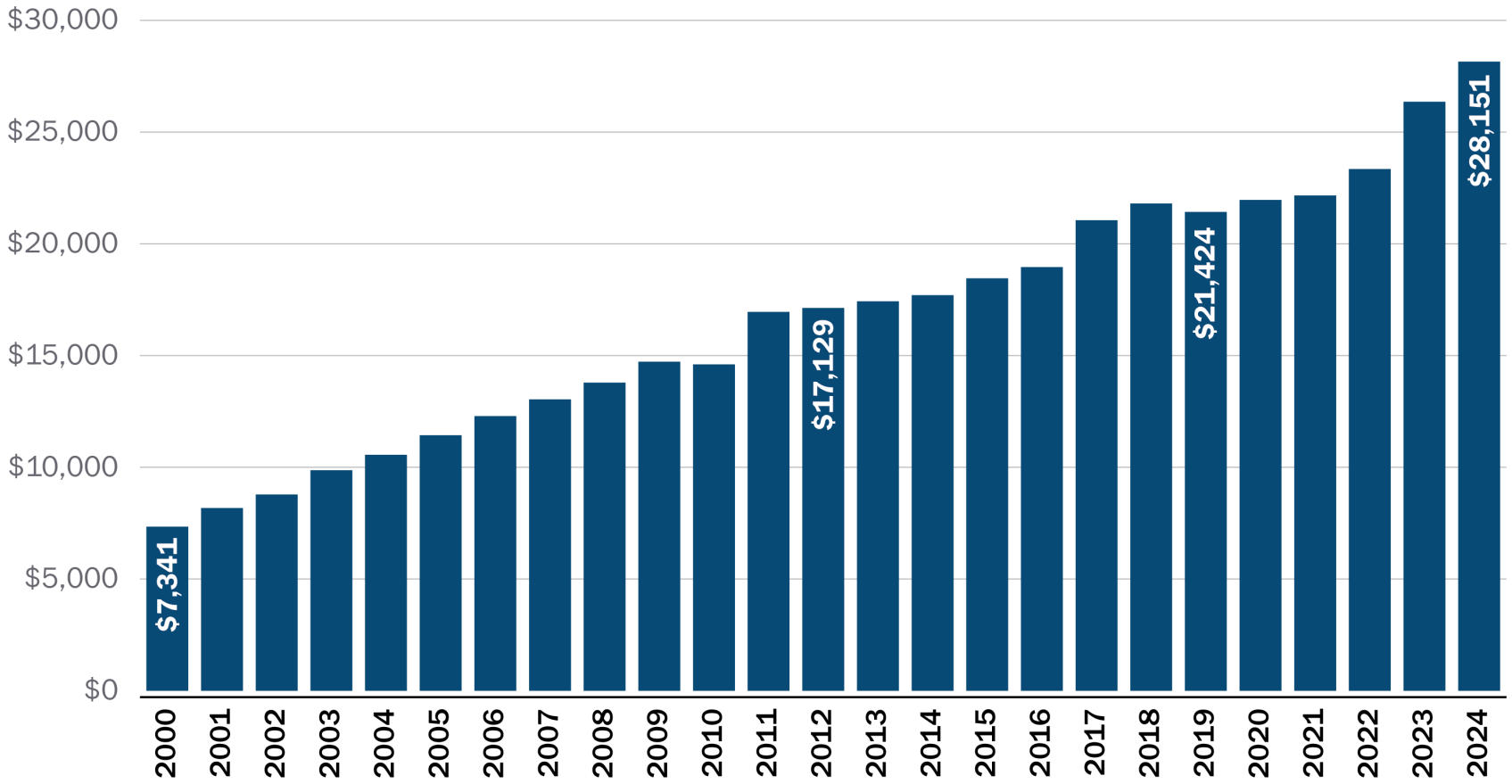
Survey of 5,600 adults conducted Oct. 22 to Dec. 27, 2025



Sources: KFF Health Tracking Poll, January 2026. https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/.
West Health-Gallup, Axios Visuals. "What Americans sacrifice due to high health costs." March 12, 2026. https://www.axios.com/2026/03/12/healthcare-costs-america-survey-sacrifices

Family health insurance premiums in Massachusetts have grown from $7,000 to over $28,000 per year and were the highest in the U.S. in 2024.

Average family health insurance premium in Massachusetts for employer-based coverage including employer and employee contribution



Sources: Commercial spending and premiums data are based on HPC's analysis of Center for Health Information and Analysis Annual Reports. Labor costs are sourced from the Bureau of Labor Statistics, Economic Cost Index. CPI is from the Bureau of Labor Statistics data for the Boston area MSA. Income distributions are from the American Community Survey and the Current Population Survey, Annual Social and Economic Supplement.

- Premiums grew 31% from 2019 to 2024 (vs 20% in the rest of the U.S.) and would reach **$50,000** by 2031 at recent rates of growth.
- 2024 premiums **exceeded $37,000** for 10% of families.
- **Future increases may be even larger.** Premium growth in the merged market was 7.9% in 2025 and **11.5%** in 2026, the largest increase since at least 2019.

Including out of pocket spending, the average cost of health care for a Massachusetts family exceeded $32,000 in 2024.

$28,151
Average premium

$4,318
Average out of pocket spending

$32,469
Annual family health care cost

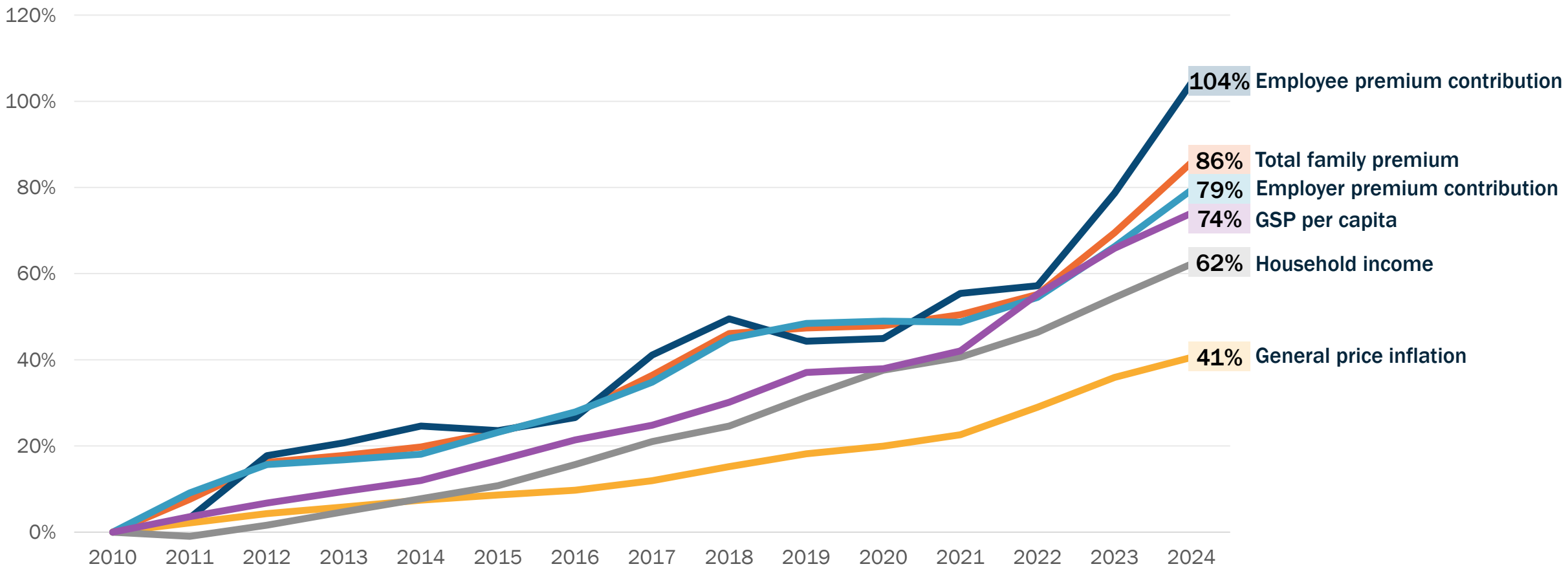
$2,706
Monthly cost per family

Premiums are even higher for employees of small businesses.

Notes: Cost sharing amount based on data on cost sharing relative to premium payments in from CHIA's Annual Report, 2024. Source: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey-Insurance Component and Center for Health Information and Analysis, Annual Report, 2024; Kaiser Family Foundation/HRET Annual employer health benefits survey.

Growth in health insurance premiums has exceeded the growth in Massachusetts household income, state economic growth, and inflation.

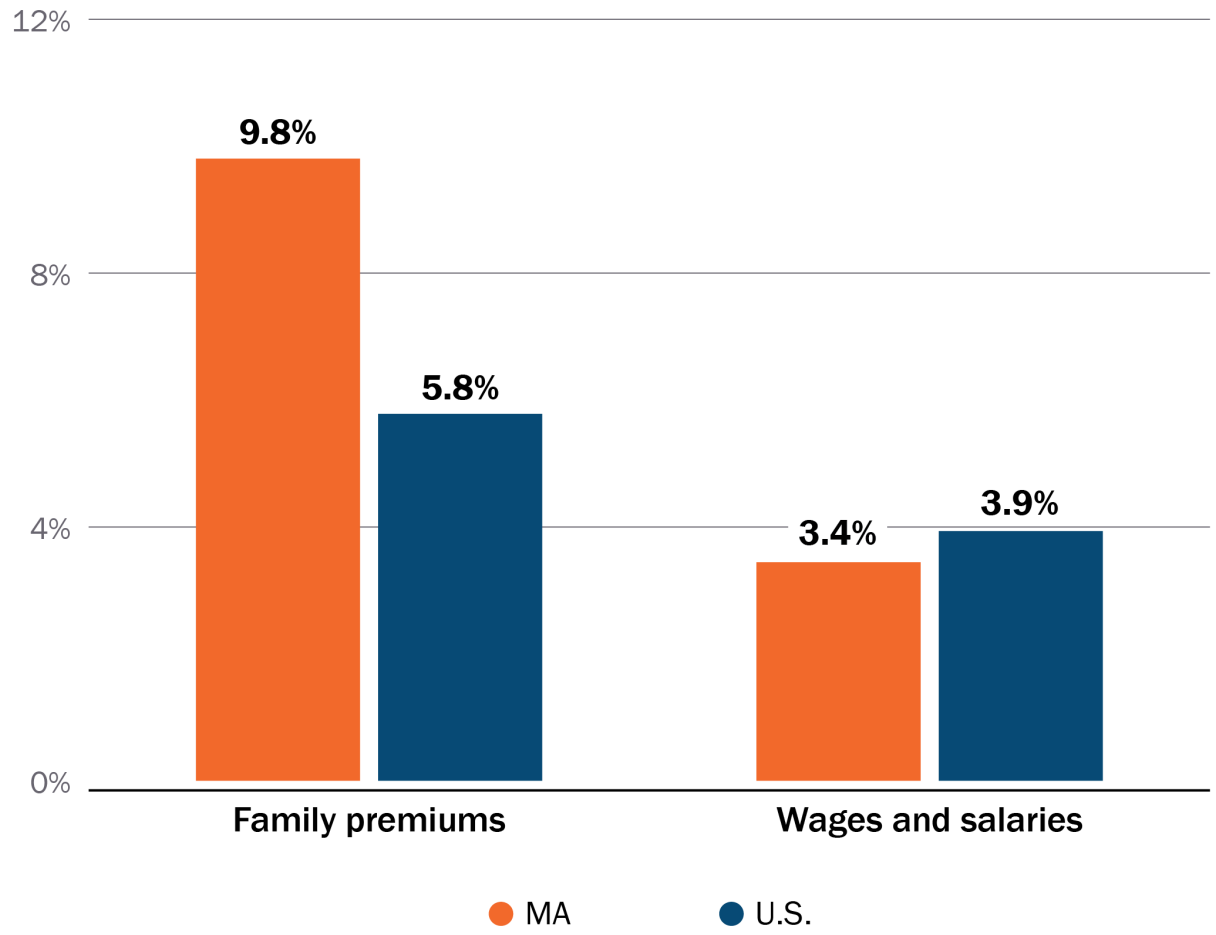
Cumulative growth since 2010 of various health care and economic indicators in Massachusetts



Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, American Community Survey, and Bureau of Labor Statistics (CPI-U for the Boston/Newton/Cambridge metro area). Data points represent the average of the year shown and the previous year to smooth out trends.

Massachusetts had higher premium growth combined with slower wage growth than the rest of the country from 2022 to 2024.

Percentage growth from 2022 to 2024 in family premiums and average wages in Massachusetts

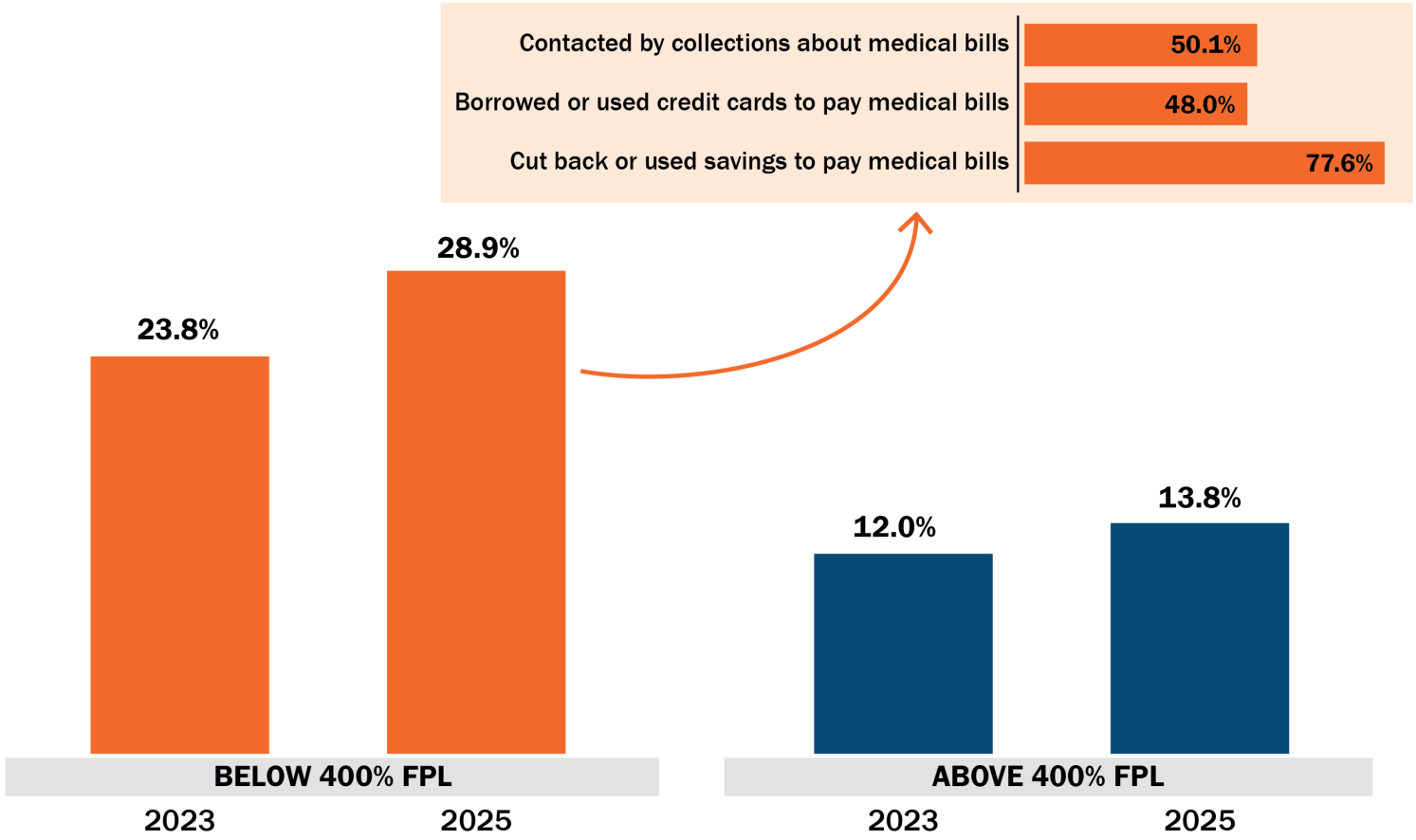


Sources: Commercial spending and premiums data are based on HPC's analysis of Center for Health Information and Analysis Annual Reports. Labor costs are sourced from the Bureau of Labor Statistics, Economic Cost Index. CPI is from the Bureau of Labor Statistics data for the Boston area MSA. Income distributions are from the American Community Survey and the Current Population Survey, Annual Social and Economic Supplement.

- When employers or municipalities pay more for employee and dependent health insurance, they have **less remaining for wages or hiring new workers**.

A growing number of Massachusetts residents with private insurance are paying off medical bills over time. Most have had to cut back on savings to pay the bills.

Percentage of residents with employer-sponsored coverage reporting that they are paying off medical bills over time, by income; and consequences of medical debt among those with income less than 4 times the federal poverty level (FPL) in 2025



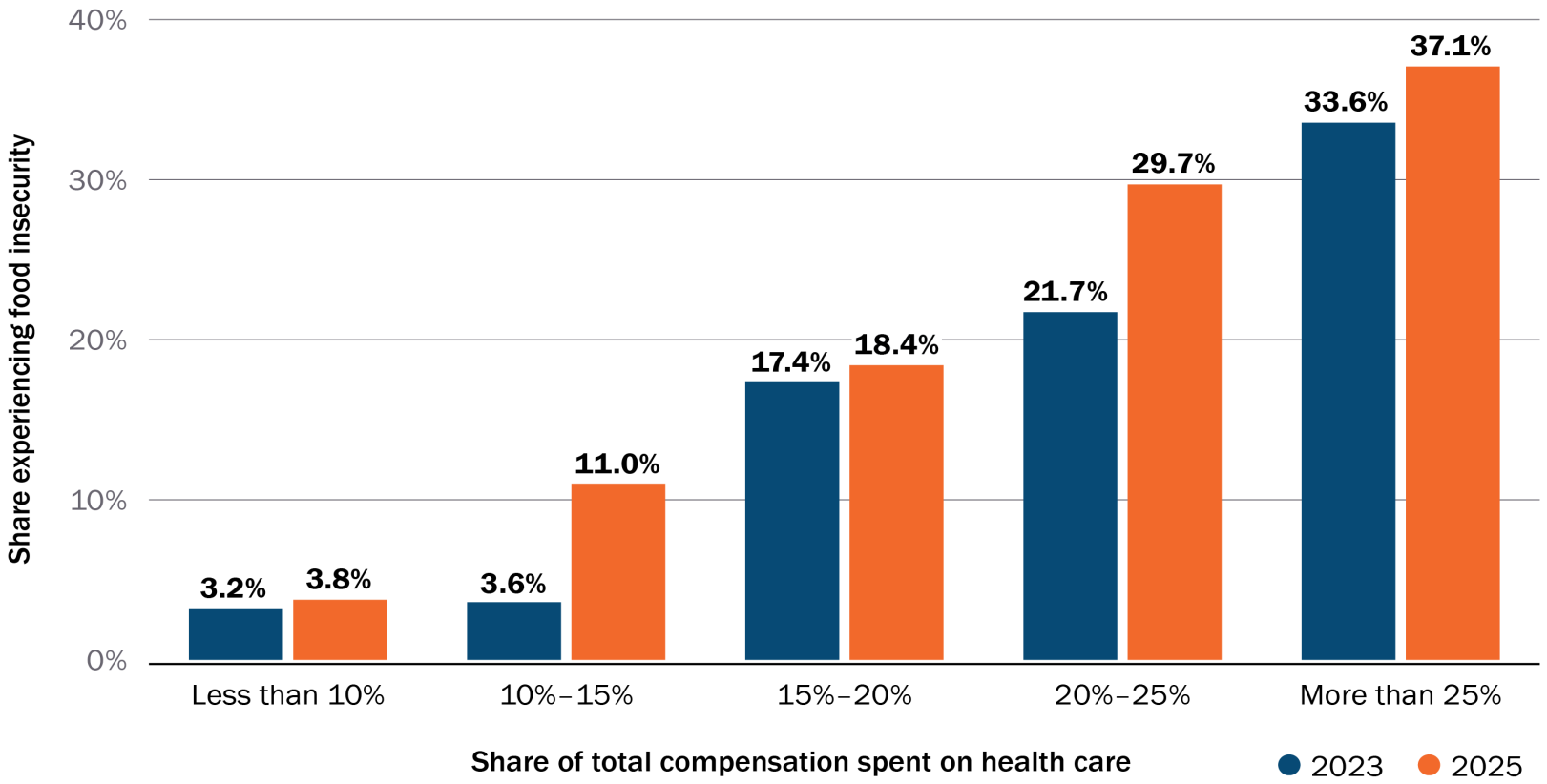
Sources: Commercial spending and premiums data are based on HPC's analysis of Center for Health Information and Analysis Annual Reports. Labor costs are sourced from the Bureau of Labor Statistics, Economic Cost Index. CPI is from the Bureau of Labor Statistics data for the Boston area MSA. Income distributions are from the American Community Survey and the Current Population Survey, Annual Social and Economic Supplement.

1) Consumer Financial Protection Bureau: https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf

- Medical debt comprises more than half of all consumer debt nationally.[1]
- In 2025, the largest contributors to medical debt among commercially-insured Massachusetts residents were:
  - Medical test or surgical procedures (56%)
  - Emergency department visits (52%)
  - Treatment for chronic/long-term conditions (40%)

Higher health care spending as a portion of a family's income is also associated with greater food insecurity.

Share of population that is food insecure by health care share of compensation for families with private insurance coverage

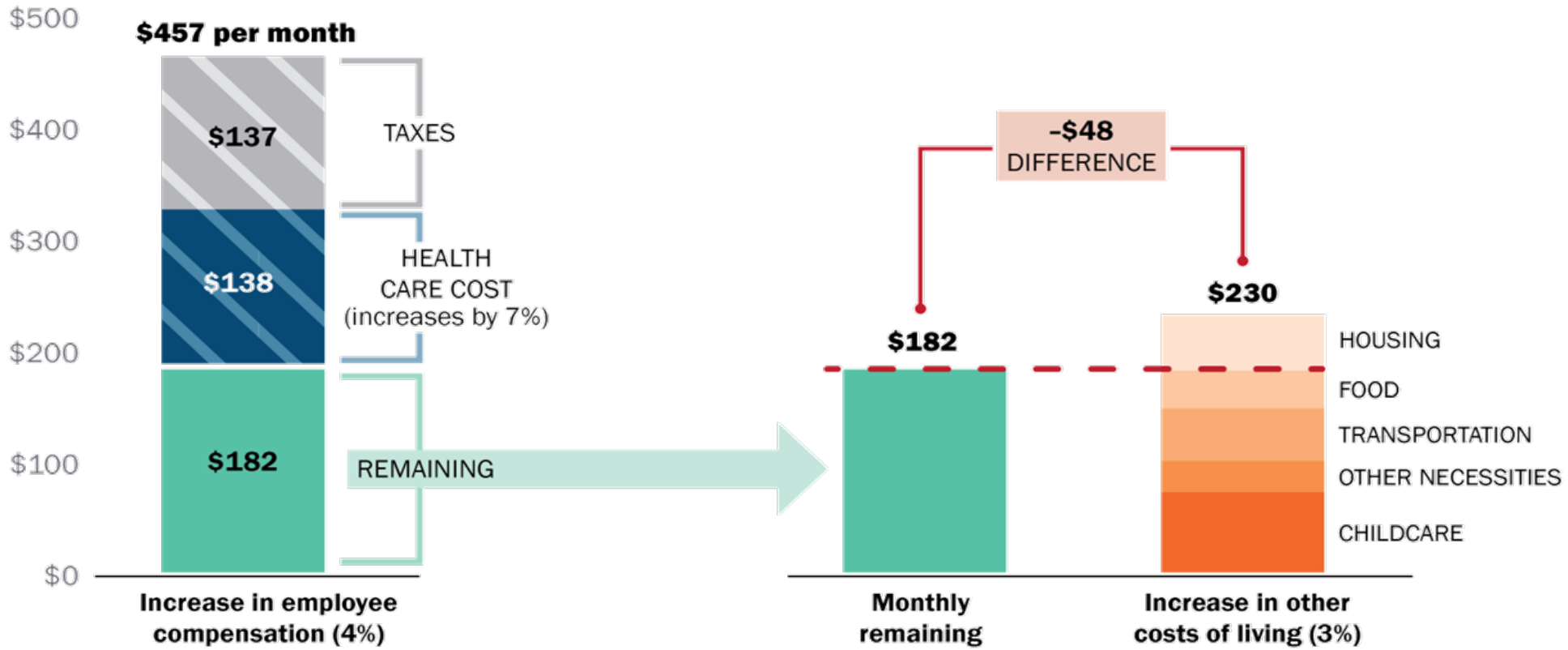


Notes: Includes all families with employer-sponsored insurance (ESI) with a family plan who had full-year coverage. Senior-headed households and those below 139% of the Federal Poverty Level (FPL) were excluded. Total health spending includes both average employee and employer payments toward health insurance premiums, as well as average out-of-pocket (OOP) spending. OOP represents money paid that is not covered by health insurance and does not include premium payments. Total compensation includes total family income and average employer payments toward health insurance premiums. 2025 premiums estimated based on average observed growth rate from 2015-2024.
Source: HPC's analysis of CHIA Massachusetts Health Insurance Survey, 2023 and 2025. Premium and contribution amounts from AHRQ Medical Expenditure Panel Survey. USDA. Food Security in the U.S. https://ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us; Feeding America's Map the Meal Gap. https://map.feedingamerica.org/county/2023/overall/Massachusetts.

- A food insecure household is one with limited ability to acquire adequate food, such as reporting being unable to afford balanced meals, cutting the size of meals, or being hungry because of too little money for food.
- Food insecurity in Massachusetts reached **11.5% (about 800,000 people)** in 2023.

At 7% annual growth in health care costs, a typical worker with family health coverage would see about 40% of their raise absorbed by health care.

Change in monthly income and expenses for a Massachusetts family with family coverage and earnings of $122,000 with a 4% increase in total compensation from their employer, a 3% increase in prices of other goods and a 7% increase in premiums and out of pocket spending, 2024



Notes: Data based on a two-parent, two-child family in 2024 with total earnings of $122,000 and coverage through their employer. Health care costs reflect 2024 data. Employer contribution to health care premium is included in income. Calculation assumes 75% of employer premium payments are reflected as a deduction from total employee compensation for the employee shown. Prices for all other items are assumed to increase 3%. Marginal tax rate is assumed to be 30%. A 4% raise is slightly above average employee compensation increases in the Boston area in 2024.
Source: HPC's analysis of Economic Policy Institute Family Budget Calculator, January 2025 and AHRQ Medical Expenditure Panel Survey, Insurance Component, 2024. Bureau of Labor Statistics CPI-U for Massachusetts and the Employment Cost Index for the Boston metro area and Massachusetts Division of Insurance.

In 2025, Chapters 342 and 343 of the Acts of 2024 were signed into law, providing new tools to advance health care affordability, access, and equity.

An Act relative to pharmaceutical access, costs, and transparency

- Improved state **oversight of the pharmaceutical industry**, including pharmacy benefit managers (PBMs)
- **Capped out-of-pocket costs** for drugs to treat asthma, diabetes, and certain common heart conditions
- Established the **Office of Pharmaceutical Policy and Analysis** (OPPA) within the HPC

An Act enhancing the market review process

- Strengthened state **oversight of private equity** investment in health care
- Reinvigorated **statewide health planning** with increased data collection and agency coordination
- Established the **Office of Health Resource Planning** (OHRP) within the HPC

Health Policy Commission 2025 Policy Recommendations

In 2026, policymakers and health care leaders should **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 public good. **Massachusetts should once again be the national leader in reimagining our health care system from the status quo to one capable of delivering affordable, accessible, and equitable care for all residents.**

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2027

HEALTH CARE COST GROWTH BENCHMARK

PUBLIC TESTIMONY

MASSACHUSETTS
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HEARING TO DETERMINE THE 2027

HEALTH CARE COST GROWTH BENCHMARK

CLOSING REMARKS