2024 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 **Monday, November 4, 2024**, 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 2023, 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.

AGO CONTACT INFORMATION	HPC CONTACT INFORMATION
For any inquiries regarding AGO questions, please contact: Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.	For any inquiries regarding HPC questions, please contact: General Counsel Lois Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

You are receiving 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 either HPC or AGO staff at the information below.

THE 2024 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 2024 Health Care Cost Trends Hearing will take place in a period of significant upheaval and reflection for the Commonwealth's health care system. The bankruptcy and dissolution of Steward Health Care, previously the third largest hospital system in Massachusetts, led to substantial disruptions to the state's health care market and has taken a significant toll on communities, patients, provider organizations, and health care workers across the region. This market instability is occurring while many providers across the health care continuum are still struggling to adapt to a post-pandemic "new normal" state, wrestling with capacity

constraints, financial volatility, administrative burdens, and workforce recruitment and retention challenges.

At the same time, an increasing number of Massachusetts residents are struggling with health care affordability and medical debt. Massachusetts has the second highest family health insurance premiums in the country. The average annual cost of health care for a family exceeds $29,000 (including out of pocket spending). Recently, more than half of residents surveyed cited the cost of health care as the most important health care issue, far surpassing those that identified access or quality. Due to high costs, 40 percent of survey respondents said they are putting off seeing a doctor or going to a hospital. These affordability challenges are disproportionally borne by populations of color, and those in Massachusetts with less resources, contributing to widening disparities in access to care and health outcomes. The annual cost of inequities experienced by populations of color in Massachusetts is estimated to exceed $5.9 billion and is growing every year. These challenges require bold action to move the health care system from the status quo to a new trajectory.

This year, in the wake of the considerable harm caused by the bankruptcy of Steward Health Care and other recent market disruptions, the HPC is focusing the 2024 Cost Trends Hearing on moving forward, from crisis to stability, and building a health care system that is more affordable, accessible, and equitable for all residents of Massachusetts.

Since 2012, pre-filed written testimony has afforded the HPC an opportunity to engage more deeply with Massachusetts health care market participants. In addition to pre-filed written testimony, the annual 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. Reflecting on the health care market disruptions in Massachusetts in recent years, including the bankruptcy of Steward Health Care and related closures, what have been the most significant impacts of these disruptions on your members, your network(s), and your organization?

The past year has demonstrated the fragility of the Massachusetts health care system and the need for interventions to create a more sustainable market for all. The unanticipated closure of Compass Medical Group and the bankruptcy of Steward Health Care are causing significant disruptions in the market and for BCBSMA members. We have seen wait times for hospital emergency care rise and escalating throughput issues have resulted in some members staying in the hospital longer than necessary; that dynamic also is driving higher costs. For example, South Shore Hospital and other hospitals in certain areas have seen increases in admissions and visits due to recent closures; the Massachusetts Health and Hospital Association has reported South Shore Hospital's emergency department volume has increased 27%. We also have seen member disruptions due to these closures. For example, members who were outpatients of clinicians at Compass Medical Group, Carney Hospital and Nashoba Valley have lost their longstanding access to care in critical specialties including mental health and primary care. Because Compass Medical Group closed without warning, patients lost access to medical records, which in some cases led to clinicians performing unnecessary and costly tests.

It cannot be underscored enough that these issues take time and resources away from other important work. For the Steward bankruptcy, BCBSMA has set up a cross functional team to ensure that more than 300,000 impacted members continue to have access to care during and after the transition. For example: When Carney Hospital and Nashoba Valley closed, the team personally called members who had procedures scheduled at those facilities to make sure they could get the care they needed elsewhere. BCBSMA also reached out to the more than 12,000 members who relied on these two hospitals or their doctors for care. In addition to expanding access to urgent care, we relaxed our prior authorization requirements to make it easier for members to transition to new providers. We also expedited credentialing and billing requirements so providers could transition to new facilities. Our network management teams are actively working with the new owners to ensure that contracts and systems are in place to support our relationship moving forward.

2. Please identify and briefly describe any policy, payment, or health care market reforms your organization would recommend to better protect the Massachusetts health care system from predatory actors, strengthen market oversight and transparency, and ensure greater stability moving forward.

The Steward bankruptcy is hugely disruptive for Massachusetts and state action should be taken to reduce the likelihood of future events like this. Steward's leaders were more motivated by profit than by mission and were able to effectively strip an entire hospital system of resources, leaving our communities and our entire state at huge risk. The solutions are not obvious. The questions we need to ask are how to prevent this from happening again through enhanced planning and oversight.

Long-range health planning would allow the state to build on the many strengths of our health care system with a clearer understanding of evolving needs and resources. It would equip policy makers, payers, and providers with the ability to make more informed decisions and monitor and evaluate progress in meeting goals for affordability, access, quality, and equity. It would provide a framework to explore questions such as: What will demographic changes mean for the number and types of clinicians that will be needed? How will the aging population affect the type and level of care needed? How many inpatient beds will Massachusetts need? How should they be distributed across the state and are there technological advancements that allow care to be received in the community or at home? We have asked our Foundation to take a close look at this as well.

The state also must update its decade-old market oversight and transparency process to reflect and accommodate increased consolidation in the market, investment by new for-profit entities, and new types of care.

For instance, the state should expand the current Material Change Notice (MCN) process to include additional parties, such as private equity, and to ensure **all** significant transactions are reviewed by the Health Policy Commission (HPC). The state also should require additional market transactions to go through a broader Cost and Market Impact Review (CMIR) to allow a deeper examination of potential impacts. The more rigorous process would allow the state to set conditions for certain transactions, such as requiring additional reporting over time. While we are pleased that Rural Healthcare Group, the new purchaser of Stewardship Health, has committed to complying with transparency and market oversight by the HPC, we believe enforceable conditions for such transactions would have benefited the Commonwealth as another private equity organization enters the market. Had this advanced review and oversight been in place years ago, some of the

Steward Health Care changes could have been examined more closely by Massachusetts regulators and there may have been early warning signs of the company's instability. We should be mindful not to overcorrect in response to an access crisis created by the Steward bankruptcy. We need to be careful and intentional, so that we don't stifle innovation and expansions of lower cost options, such as ambulatory surgical centers, especially in community settings. What we need to do is understand what the state's needs look like moving forward, which is why health care planning will be vital to the process.

The state should modernize its outdated review process for health system facility expansions as well, coordinating the work of the HPC, CHIA, and the Department of Public Health. We have seen costs rise with increased provider consolidation and the expansion of high-cost providers into service areas where lower-cost, high-quality providers already serve the community. The Attorney General's Office has found in numerous Cost Trends Reports that commercial market share shifting toward high-priced providers is a key driver of overall health care costs. A comprehensive analysis by the HPC during the DPH Determination of Need (DoN) review, like HPC's CMIR analysis, will help ensure the delivery of cost-effective, high--quality health care across the state. The DoN program should be aligned with the long-term health infrastructure planning work referenced above to ensure essential services are not reduced without available capacity in other areas or expanded where it is not necessary.

These changes would help increase the state's oversight, while sending a strong message of accountability to current participants and those considering entering our market.

3. Reflecting on consistent HPC findings showing increasing health care affordability challenges, growing difficulties accessing needed care, and widening health disparities based on race, ethnicity, and income among Massachusetts residents, what are your organization's top two to three strategies for addressing these trends? What are the most significant challenges to implementing these strategies?

Making health care affordable, accessible and equitable is BCBSMA's No. 1 priority. In a BCBSMA survey conducted by Beacon Research, we found that over 40% (or two in five) Massachusetts residents reported putting off seeing a doctor or going to the hospital due to the cost of care. This includes half of younger and less affluent residents. With respect to access, while these data suggest most residents have a usual source of care (almost 90% of residents indicate they do), over 40% reported having difficulty accessing care. Both of these challenges – affordability and access – are exacerbated for people of color and for people with lower incomes.

The KFF 2024 Employer Health Benefit Survey found the cost of employer health insurance rose 7% nationwide for the second straight year, maintaining a growth rate not seen in more than a decade. During the same period, inflation increased 3.2% and employee wages increased 4.5%. Our employer customers and members cannot afford these increases, yet we see costs continuing to increase in 2025 and multi-year contracts have locked in post-pandemic provider price increases.

Cost growth is driven by three major factors: 1) rapidly rising prices charged by providers and drug companies; 2) Increased utilization of certain costly services and medications (including obesity drugs) and 3) use of high-priced sites of care. We are tackling all three of these problems in order to lower costs for our customers and members.

First, in contract negotiations, BCBSMA is standing firm in rejecting proposals by some physicians and hospitals in its network for rate increases 3-5 times above the state's cost containment benchmark. While labor costs and inflation present challenges to all health care stakeholders, these large price increases are not consistent with BCBSMA's affordability goals, our employer customer and members' expectations, or the state's health care cost targets. However, BCBSMA sometimes must consider prices above what we would like in order to build an adequate network for our employer customers and members. We believe the state should have the power to report on a **hospital** and system's specific total medical spending, reports that now exist only for health plans and doctor groups. This would allow the state to see increases that are not just associated with primary care physicians who are taking risks, getting a truer picture of cost increases across the system.

In addition to strongly negotiating unit cost increases in contract renewals, BCBSMA is addressing health inequities in contracts. Building off the health equity work detailed in last year's Pre-Filed Testimony, BCBSMA is seeing success in a value-based focus on health equity. Nearly all the major health systems in the state, who collectively provide care to over 800,000 (65%) of BCBSMA's in-state members, are now incentivized and rewarded for making progress on reducing health inequities under BCBSMA contracts. BCBSMA was the first health plan in Massachusetts — and among the nation's first – to introduce these contracts, which explicitly link financial incentives to achieving measurable improvements in health equity. BCBSMA also is seeing promising early results from providers who are, under these incentives, starting to produce measurable improvements in health equity gaps. This work remains a top priority for BCBSMA.

Despite our progress in health equity, higher costs mean higher cost-sharing which disproportionately hurts consumers in communities of color. BCBSMA's role is to balance

provider price demands with what employers and consumers can afford and maintain equitable access to care. This is becoming more challenging.

Second, pharmacy spending is increasing at an unsustainable rate. BCBSMA is working with other Blues plans to establish outcomes-based arrangements with drug makers and ensure that patients are getting the right medications at affordable prices. We have saved approximately $20 million at this early stage, benefiting our customers and members. We are also exploring different contracting models for high-costs treatments like gene therapies and cancer drugs. We know that these treatments can greatly benefit members, but we anticipate significant growth in the future which will impact affordability. The system will need to consider how to address these high-cost drugs and the impact they have on employers and members and consider alternative ways to pay for them.

The HPC has examined the trends of GLP-1s in Massachusetts between 2018-2023, finding that total commercial spending on GLP-1s was projected to surpass $270 million, more than double the spending in 2022. Based on BCBSMA's experience, we believe these may be underestimates; we have seen spending continue to accelerate in 2024 and expect the same in 2025. In the first 9 months of 2024, we spent $145 million on these drugs. This dramatic trend is a significant concern that we are working to address.

Lastly, BCBSMA is bringing new kinds of health care providers into our value-based network that offer lower costs and more convenient alternatives for our members. These clinical innovators offer lower costs and broader access to our members in areas including mental health, musculoskeletal issues, women's health, diabetes care, pharmacy, and more. BCBSMA offers options that include no-cost visits for specific services like CVS MinuteClinic, and most of our commercial plans include a virtual care team feature, which has a $0 cost share for virtual primary care with Firefly and Carbon Health, as noted in previous Cost Trends testimony. These value-based virtual primary care providers offer lower costs, integrated mental health, and multiple communication channels, including video, chat and text.

4. Please identify and briefly describe any policy, payment, or health care system reforms your organization would recommend to achieve a health care system that is more affordable, accessible, and equitable in Massachusetts.

The state's 12-year-old cost growth benchmark served as an effective tool to constrain prices in its early years but has since become powerless.

As the HPC's 2024 Trends report found, spending growth has surpassed the benchmark for the last few years. The most recent year evaluated (2021-2022) had the highest growth rate in a decade. These trends will continue and get worse over the next few years. Health care spending is accelerating at the fastest rate in 13 years, at an 8% trend in the group market according to PwC's Health Research Institute, and at an 8-10% trend in our own data, nearly triple the rate of economic growth. Without some bold action, affordability and health equity will be unattainable. As a health plan, changing the trajectory of health care spending trend is our most important job, but ultimately, we cannot address the root causes alone. All of us – plans, providers, employers, government – must come together in this moment and find new ways to work together.

To restore its effectiveness, BCBSMA suggests the following changes to the benchmark and associated tools.

First, the state's cost containment benchmark should apply to the entities driving much of the cost growth in the system: the hospitals, health systems and pharmaceutical companies who are not currently tested against the benchmark. Having a broader application of the benchmark would bring all stakeholders to the table and align incentives to transform the system. With the state's help in truly holding entities accountable, we can accelerate work to address the concerning trends we are seeing.

Second, when an entity surpasses the benchmark, the state's Performance Improvement Plan (PIP) process should be applied to ensure its costs come down in subsequent years. When an entity is under a PIP, the HPC should monitor its unit costs and increases over time to ensure that cost containment is a sustainable focus. This level of transparency will add accountability for lower costs. The PIP monitoring, enforcement, and evaluation can be a strong regulatory signal that the Commonwealth requires a focus on affordability, accessibility, and equity from all of the market's participants. While the HPC can currently fine up to $500,000 for non-compliance with a PIP, additional penalties should be considered to ensure that the PIP process has significant power to ensure that cost growth is moderated.

The trends we are seeing are significant and we anticipate they will continue into 2025 and beyond, which will not be captured in data for this hearing for a few years. As a community, we need to come together to decide what services we value and how we are going to pay for them. Massachusetts has previously explored re-insurance pools for high-cost services. As we continue to see concerning trends, especially in the pharmaceutical

space, reinsurance pools should be considered as a mechanism to cover some of the risk currently being borne by our customers and members.

We are hopeful that before the end of the legislative session, there will be action on the legislative proposals that contain many of these policy changes and those included in our response to Question 2. Additionally, we continue to be a proud member of the Health Equity Compact and support their legislation that would address some of the root causes of health inequities across the Commonwealth. As the new legislative session begins next year, new ideas and tools should be considered, and we will be an active member in these discussions.

TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts fora calendar years 2020 to 2023 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2020 to 2023, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. 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.

Please see attached HPC Payer Exhibit 1

2. Reflecting on current medical expenditure trends your organization is observing in 2024 to date, which trend or contributing factor is most concerning or challenging?

Unit Cost

As noted above, providers continue to request unit cost increases well above benchmark during negotiations. At the extreme, we have seen provider proposals with a 30-50% rate increase over 3 years. This dynamic has already and will continue to increase total medical expense trends, beyond the benchmark level.

The unit cost pressures BCBSMA has experienced between 2019 and 2023 are part of an emerging and very concerning trend. Recognizing that unit cost is almost one half of Total Cost of Care trends, BCBSMA had a strong track record for many years of keeping unit cost trend near or below 2%. In more recent provider negotiations, we have seen a

shift in providers' commitment to cost containment. Many providers have worked to leverage unit cost increases that significantly exceed the benchmark. These continuing dynamics have added approximately 2% to overall commercial medical expenditure trend, which accounts approximately $150 in premium dollars per year for a commercial member. This troubling development is accelerating as we look beyond 2023 trends.

Pharmaceutical Costs

Pharmaceutical costs continue to be a significant driver of healthcare trend, particularly, the rising utilization of GLP-1 drugs and the rising use and rates of drug infusions in the provider setting. GLP-1 utilization rose significantly in 2023 and contributed nearly 1 percentage point to overall medical expenditure trend. Our 7.7% trend in 2023 represents approximately $450 million for our commercial insured business, and GLP-1s alone represent about $50 million of that additional spending compared to the prior year. In addition, costs associated with the category of pharmaceuticals delivered in a provider setting increased significantly, largely driven by increases in both the cost and mix of chemotherapy drugs and non-chemotherapy related specialty drugs administered in a facility setting.

We anticipate trends associated with this category to continue at current high levels. We expect the impact of GLP-1 spend on overall trend to double in 2024. In 2023 we spent $75 million on GLP-1s and in 2024 actual spend will be close to $200 million. Based on the current rates and the current course, we believe we could spend more than $300 million on GLP-1s alone in 2025. We also note the continued proliferation of high-cost cell and gene therapies which we anticipate will continue to add to trend pressures in the future.

Behavioral Health Costs

Since the advent of the COVID-19 pandemic, we have experienced consistent double-digit growth in outpatient behavioral health spend. This is largely driven by increased access to behavioral health providers, reduced stigma around behavioral health care, and increased reimbursement to behavioral health providers. BCBSMA notes this not to necessarily highlight a concern, but in the spirit of highlighting significant drivers of health care trends that are likely to continue.

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 that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2022-2024			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2022	**Q1**	38806	92
	Q2	33423	117
	Q3	35520	104
	Q4	35802	134
CY2023	**Q1**	33885	190
	Q2	31808	168
	Q3	30541	145
	Q4	31489	153
CY2024	**Q1**	42094	260
	Q2	35266	211
	TOTAL:	348634	1574

2. When developing benefit plan options for employer groups, do you consider point-of-service cost-sharing affordability separately from premium affordability? If so, how do you do this and what metrics and data sources do you use?

When we develop benefit plan options for employer groups, we evaluate the cost of the benefits using actuarial tools, which measure the relative impact of cost share changes on underlying net claims. The cost of benefits, along with underlying claims experience, claims trend, and administrative expenses, determine the premium charged for the plan option. The affordability at the point-of-services is directly related to the affordability of the premium, As the point-of-service cost increases, the premium decreases, and vice versa in the product structure. The true underlying cost of projected allowed claims and expenses remains the same.

We are exploring options for point-of-service cost sharing changes, including lower co-pays for providers that we consider lower costs and higher value in our networks.

3. Are there any accommodations you offer to providers in consideration of point-of service cost sharing bad debt under your global risk arrangements? For instance, is the full allowable amount (i.e., both the insurer and the member portions) charged against the global budget even if the provider was never able to collect the member portion? Please provide details.

BCBSMA charges the full allowable amount to the global budget primarily because there is no mechanism for us to know whether the provider collected the member portion.

We would note that BCBSMA has taken steps to eliminate member liability for some services which can assist with limiting potential bad debt. For example, we launched our virtual primary care option with Carbon Health and Firefly Health, which have a $0 cost share for primary care and mental health visits with designated virtual care team clinicians. This option eliminates the need for providers to collect the member portion.

---- End of BCBSMA Responses ----

I affirm that the facts contained in the preceding responses are true to the best of my knowledge. This document is signed under the pains and penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that the facts stated with respect to such matters are true.

Sincerely,

Sarah Iselin

President and Chief Executive Officer

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 2020	2.7%	-4.7%	-0.3%	-0.3%	-2.7%
CY 2021	2.8%	9.8%	1.7%	1.7%	16.7%
CY 2022	3.0%	-0.5%	0.3%	0.3%	3.2%
CY 2023	4.0%	0.4%	0.4%	2.9%	7.7%

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.
5. Note that the data and trends above are limited to claim experience for Massachusetts residents in Commercial plans whose primary coverage is with BCBSMA and include both non-pharmacy and pharmacy claim expenses. Membership is based on all BCBSMA Massachusetts medical members in Commercial products, irrespective of whether they have pharmacy coverage with BCBSMA. FEP and Host membership/claims is excluded
6. Although overall benefit buydowns have stayed fairly constant over the past three years, there was a slight increase observed in 2023 versus 2022 driven by the large group PPO segment. The large group PPO segment benefit buydowns were not as deep as in past years due to churn from new sales and terminations.
7. Changes in health status are estimated using DxCG risk score. Overall risk score declined in 2020 due to the deferral of care resulting from the Covid 19 pandemic. The risk score returned to previous levels beginning in 2021 and have been slowly accelerating each year since. Changes can potentially impact all components of trend except unit cost.
8. Note that CY 2020 and 2021 trends are significantly impacted by the deferral of care and subsequent return to care resulting from the Covid-19 pandemic and do not represent a run rate trend

NOTE: The Health Policy Commission trend methodology set forth in this question reflects benefit buy downs. In order to respond reliably for each year requested, in its response BCBSMA has used the unit cost trends consistent with CHIA TME submissions for all years. In a change to last years submission, the components of trend have been updated for 2023 to reflect current environmental dynamics. Provider mix and utilization are based on a recent analysis of components of trend and severity is estimated as the total trend net of unit cost, provider mix and severity.

For CY 2020-CY 2022, a consistent allocation methodology based on historical analysis was used to allocate the total trend across provider mix and severity components and utilization was calculated as the total trend net of unit cost, provider mix and severity . Also note that the trends above are not directly comparable to the THCE annual cost benchmark set by CHIA. The THCE includes administrative expenses and operating margins for Commercial plans in addition to the total medical expense. Additionally, the THCE is adjusted for changes in health status whereas the total medical expenses above are not.

As 2024 trends are emerging, an increase in utilization is being observed which may impact next years components of trend