

HPC DATAPOINTS

Examining the True Costs of Care: Patient Cost Sharing in Massachusetts

Deductibles can result in large bills that are difficult to anticipate in advance, even for common services.
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Cost sharing design can be improved, even while holding premiums constant.
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BACKGROUND

Health care affordability [ranks](#) as a top concern among Massachusetts residents, as growth in health insurance premiums and out-of-pocket health care spending continues to squeeze household budgets and prevent spending in other areas. Out-of-pocket health care spending (cost sharing) can create particular financial challenges as it often cannot be anticipated. In response, consumers may forgo care, incur medical debt, or cut back on other necessities. New and ongoing research from the HPC has demonstrated that this burden is growing for Massachusetts residents.

Particular features of cost sharing benefit design can exacerbate financial harm to consumers, specifically the deductible structures that are common in commercial insurance design. Deductibles, which have grown as consumers and employers have sought to mitigate high annual premium increases, can result in large bills that are difficult for consumers to anticipate in advance, even for common primary care services. This coverage model places consumers with limited savings at particular risk of financial harm. Cost sharing structures can be redesigned to make patients' bills more predictable and to support affordable access to primary care, even while holding total out-of-pocket costs and premiums constant.

WHAT'S A PREMIUM, DEDUCTIBLE, COINSURANCE, OR COPAYMENT?

Premium: A monthly amount the consumer pays for coverage, whether they receive services or not.

Copayments (copays): Patient pays a fixed dollar amount for a service, regardless of the price of the service.

Coinsurance: The patient and the insurer both pay a percentage of the total price of the service (e.g., the patient pays 20% and the insurer covers 80%).

Deductible: Patient pays the full price of services until a set amount is met; after the patient meets the deductible, copayments and coinsurance may still apply. A high deductible health plan (HDHP) is health coverage with a higher annual deductible than typical health plans. For 2026, the Internal Revenue Service (IRS) defines an HDHP as having a deductible of more than \$1,700 per person or \$3,400 per family.

As with premiums, patient cost sharing reflects the underlying cost of health care, which continues to grow at an unsustainable rate. Efforts to constrain or reduce cost sharing should therefore be paired with policies to address the underlying drivers of health care spending to ensure that premiums do not increase. In this issue of the DataPoints series, the Massachusetts Health Policy Commission (HPC) examines trends in cost sharing for Massachusetts commercially-insured residents, highlighting the issues associated with deductibles. This work is explored in more detail in the [2025 HPC Cost Trends Report](#).

This is a printable version of DataPoints. The online version features interactive graphics that show additional information, and is available on the HPC's website at masshpc.gov/publications/datapoints

METHODS

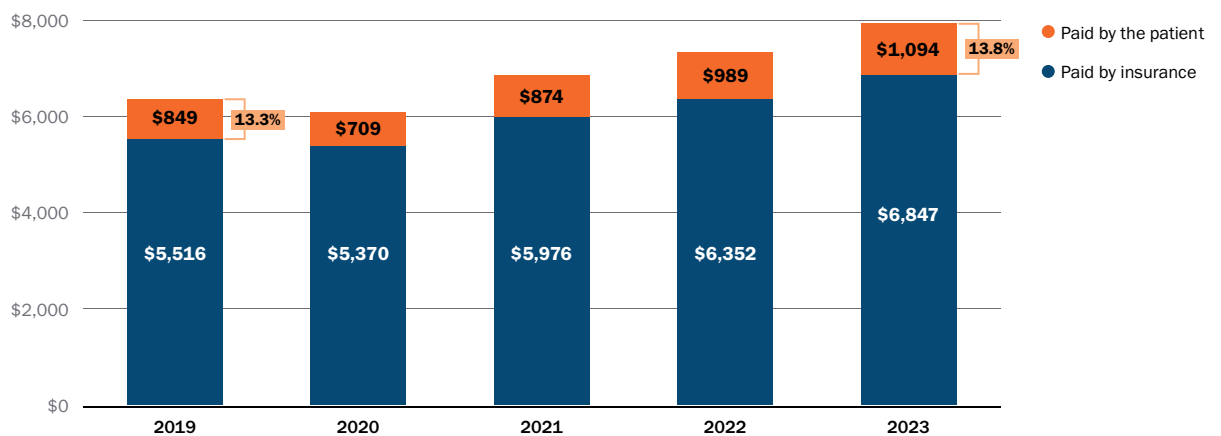
The HPC used the Massachusetts All-Payer Claims Database (APCD) from 2019 to 2023, including medical and pharmacy claims from six large commercial health plans in Massachusetts.ⁱ Broad service categories included inpatient care (including professional and facility spending), ambulatory care, pharmacy, care received out-of-network, and all other care.ⁱⁱ Ambulatory care was further divided into sub-categories of care. Analysis included Massachusetts residents aged 0-64 with 12 months of medical and pharmacy coverage and any utilization (spending).

FINDINGS

From 2019 to 2023, average commercial cost sharing grew 29% from \$849 per member per year to \$1,094, faster than the growth in insurer-paid amounts (24%).ⁱⁱⁱ Cost sharing as a share of total spending (patient paid amounts + insurer-paid amounts) grew from 13.3% in 2019 to 13.8% in 2023.

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Commercial spending per member per year, 2019-2023



NOTES: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Pharmacy spending is net of rebates.

SOURCES: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

The exhibit below displays cost sharing per member per year by type of cost sharing, including coinsurance, copayment, and deductible spending. The dominant form of cost sharing was the deductible, which represented 58% of all cost sharing in 2023, an increase from 54% in 2019.

Compared to average annual copay spending, which grew 12% from 2019 to 2023, deductibles grew 38% over this period. The growth in deductibles means the composition of cost sharing is increasingly shifting to the type of out-of-pocket spending that is most unpredictable for patients.

In 2023, commercial members paid an average \$1,094 in cost sharing.
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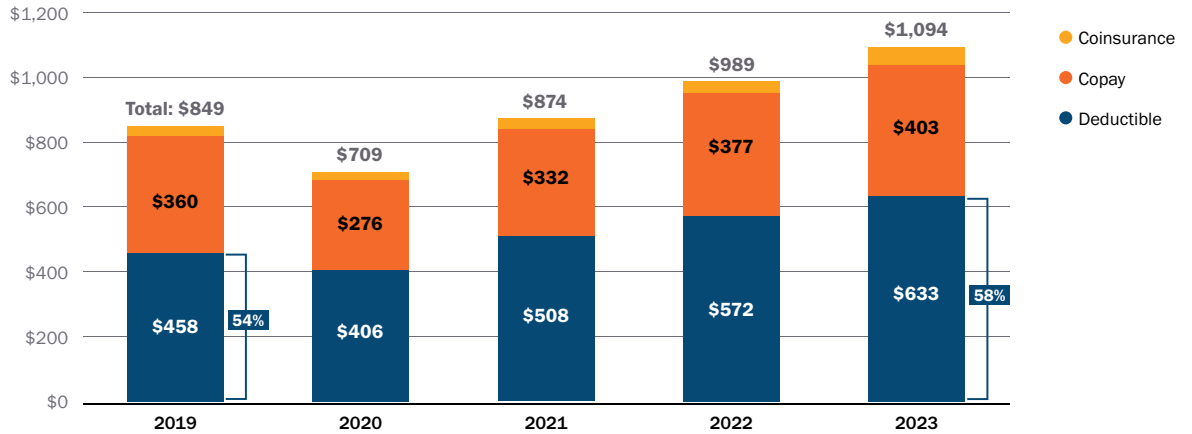
i The sample from V2023, which includes Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, Health New England, United Healthcare, and Mass General Brigham Health Plan, represents 33% of the Massachusetts commercial market.

ii All other care includes durable medical equipment (DME), skilled nursing facility (SNF), hospice, home health, and ambulance services.

iii These figures differ from those reported by CHIA, which estimated the average annual cost sharing per member in the Massachusetts commercial market to be \$816 in 2023. The lower estimate may reflect CHIA's inclusion of members who had insurance coverage but no health care spending (thus no cost sharing), certain plans with lower cost sharing, such as subsidized ConnectorCare plans, and plans with carved-out benefits that are not accounted for in the totals. In contrast, the HPC estimate includes only those members with full year medical and pharmacy coverage.

While annual cost sharing averaged nearly \$1,100 in 2023, the out-of-pocket amounts that individual Massachusetts commercial members paid varied significantly, reflecting differences in health care utilization as well as benefit design. Half of members incurred less than \$500 in annual cost sharing (50.6%), while 10.1% paid more than \$3,000. The share of members paying \$5,000 or more per year in cost sharing was 3.1% in 2023, which was double the share in 2019 (1.5%).

Cost sharing per member per year by cost sharing type, 2019-2023



NOTES: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization.

SOURCES: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

Deductibles represented 58% of all cost sharing in 2023.

The exhibit below shows average annual cost sharing per member by service category in 2023. These amounts reflect the frequency of use of each service and the amount of cost sharing required per use, the latter of which is determined by the insurer’s benefit design.

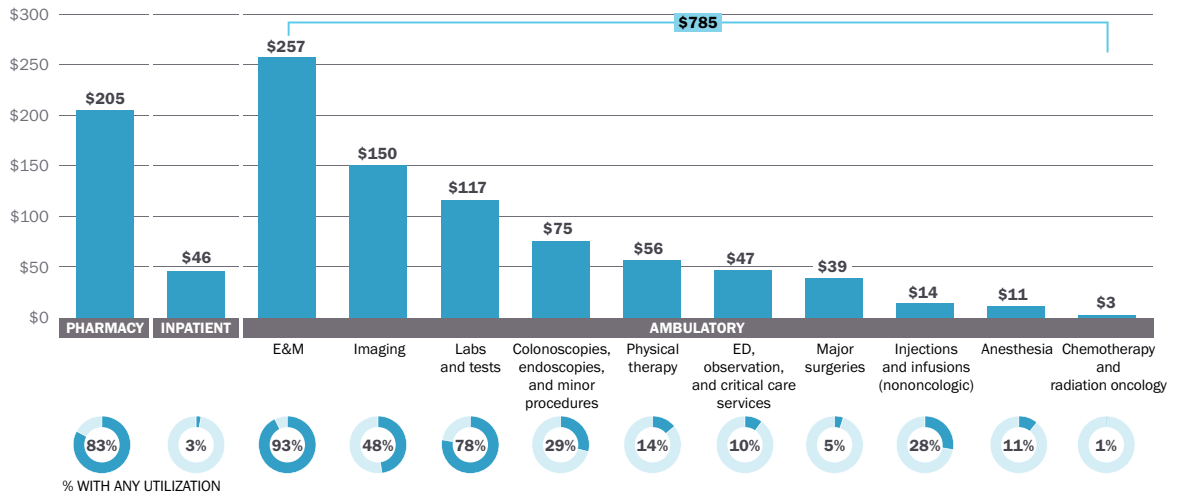
For example, while inpatient stays are costly services with high cost sharing on average, they occur rarely, resulting in low average annual cost sharing for this care category (\$46 per member per year in 2023). In contrast, lab tests are relatively inexpensive yet used by most patients and used frequently, resulting in higher average annual cost sharing (\$117 per member per year in 2023).

Within ambulatory settings, where patients incurred the most cost sharing on average, the share of cost sharing represented by deductibles varied widely, reflecting differences in benefit design and the price of services. For example, the use of copayments is relatively common for evaluation & management (E&M) visits (doctor’s office visits), where 53% of cost sharing came from copays in 2023 and 46% came from deductibles. In contrast, deductibles comprised 89% of cost sharing for lab tests in 2023.

As benefit design drives the patient experience of cost sharing, services like lab tests that have both high utilization frequency and high deductible use mean that many patients receive unpredictable bills for these services, potentially multiple times a year.

Lab tests are both utilized frequently and are often subject to deductibles, meaning that many patients receive unpredictable bills for these services.

Cost sharing per member per year and percentage of members with utilization by service category, 2023



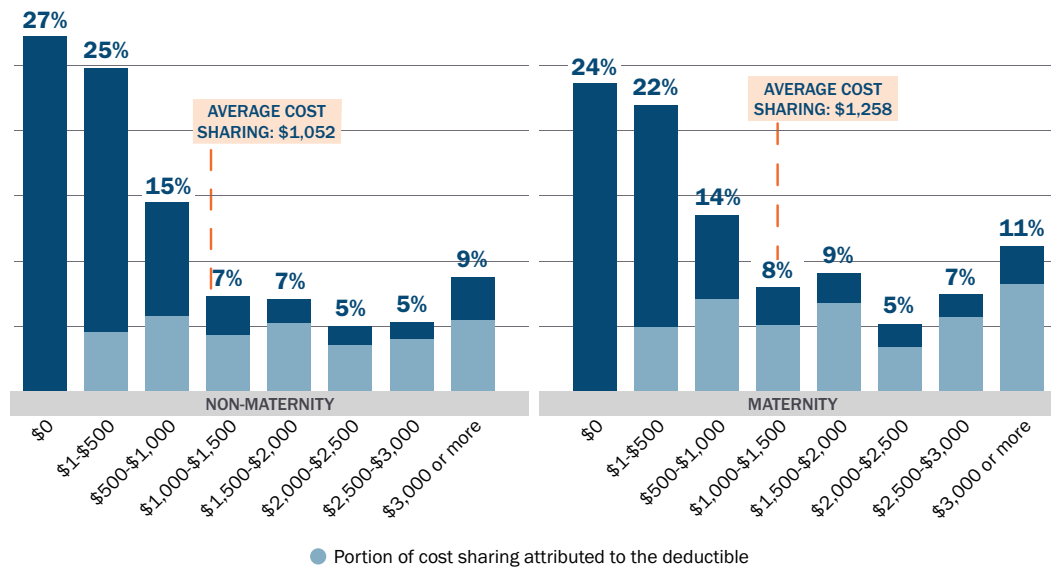
NOTES: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. E&M = evaluation and management and includes ambulatory behavioral health services, which accounted for \$71 in annual cost sharing of the \$257 shown in the exhibit. Annual average cost sharing per member for out-of-network care was \$32 and \$25 for all other care (data not shown).

SOURCES: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

INPATIENT STAYS

Inpatient care is generally the setting that can produce the largest bills for patients. The exhibit below shows the distribution of cost sharing for inpatient stays in 2023 and highlights the significant variation in how much patients paid out-of-pocket for both maternity stays (i.e., labor and delivery) and non-maternity inpatient stays. While roughly a quarter of stays had no cost sharing, about 10% of stays had cost sharing of \$3,000 or more (with patients paying an average of roughly \$4,300 out of pocket for those stays). Among inpatient stays where cost sharing was over \$3,000, average cost sharing was \$4,266 for maternity stays and \$4,393 for non-maternity stays in 2023. Most of this spending is due to deductibles.

Distribution of cost sharing for maternity and non-maternity inpatient stays, 2023



Inpatient care generally produces the largest bills for patients. About 10% of stays had cost sharing of \$3,000 or more.

NOTES: Data represents cost sharing for both facility and professional claims that occurred during an inpatient stay. Maternity stays include newborns and were defined as having an APR-DRG major diagnostic category (MDC) of 14 or 15.

SOURCES: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

When a doctor's office visit included a lab test, average cost sharing for the visit was \$74. For about 10% of visits, patients owed more than \$200.

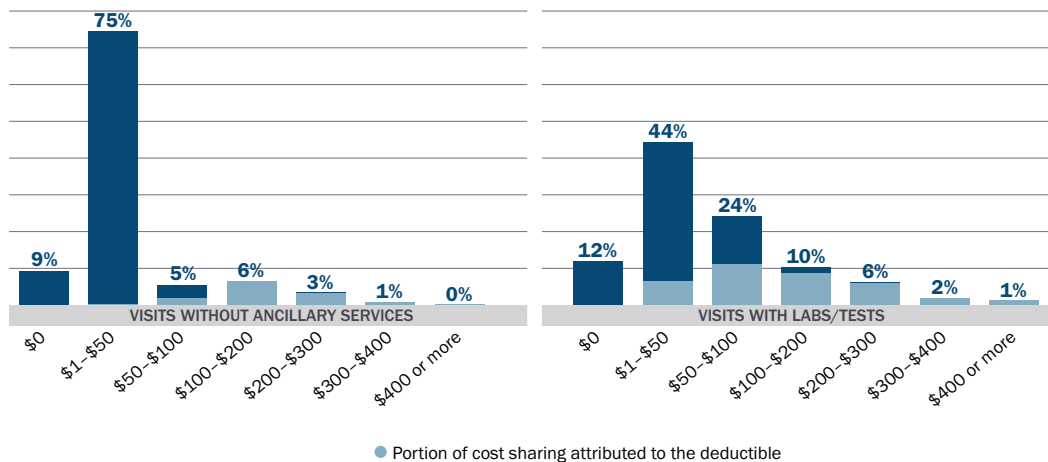
ROUTINE CARE

Deductibles can also lead to unpredictable and potentially high patient bills when patients seek primary care services. For certain high deductible health plans (HDHPs), the full deductible must be met before the insurer begins coverage for any service, including doctor's office visits. However, for other types of plans, a common benefit design is applying a copay for the doctor's office visit itself, while applying a deductible for ancillary services that the patient receives during the visit, such as lab tests or simple imaging.

The exhibit below shows the distribution of cost sharing for E&M visits (doctor's office visits) for ten common clinical diagnoses (e.g., sore throat, back pain, cough), categorized by the use of ancillary services, such as imaging and labs.

For visits that did not have any ancillary services (representing 51% of all E&M visits), cost sharing averaged \$45 in 2023, with 84% of visits having less than \$50 in cost sharing. When the visit included a lab test, average cost sharing for the visit rose to \$74, with roughly 10% of visits resulting in patients owing more than \$200 for the visit.

Distribution of cost sharing for evaluation and management (E&M) problem visits for ten common clinical diagnoses, 2023



NOTES: Data represents episodes at ambulatory settings for ten principal diagnoses (F41, J02, F90, F33, M25, I10, M54, R05, H66, E66). Episodes were defined as same person and date of service as an E&M problem visit procedure code (99201-99215). Episodes were dropped if they occurred on the same day for the same person as an emergency department visit, major surgery, chemotherapy, or other preventive visit.

SOURCES: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

In the common benefit design of covering co-occurring routine care services under different cost sharing types (e.g., copay for the visit itself, deductible for ancillary services), after patients pay a copay for a doctor's visit, they may not anticipate further cost sharing for the visit. However, because lab tests are subject to the deductible in many commercial health plans, a simple and common clinical episode at the doctor's office can result in hundreds of dollars in unexpected out-of-pocket costs.

For example, cost sharing for a bacterial vaginosis (BV) test – a common infection among women of reproductive age – averaged \$193. In 2023, 9% of BV tests had cost sharing of more than \$500. Nearly all cost sharing (98%) for BV tests was deductible spending.

Cost sharing for lab tests is often unexpected, because patients are unlikely to know in advance of a sick visit whether they will receive a test, or which test. Even if a patient was able to obtain prices during the visit, they are already in the doctor's office, and therefore leaving the office to "shop" for a better price is not realistic.

The Massachusetts Health Policy Commission (HPC)

is an independent state agency charged with monitoring health care cost trends and making policy recommendations to improve the affordability of health care for all residents of the Commonwealth. Through data-driven analysis, actionable policy insights, public accountability, and innovative investments, the HPC seeks to improve health care delivery, lower costs, and reduce health disparities.

HPC DataPoints is a series of online briefs that spotlight new research and data findings relevant to the HPC's mission to drive down the cost of health care. It showcases brief overviews and interactive graphics on relevant health policy topics. The analysis underlying these briefs is conducted by HPC staff. To view all HPC DataPoints, visit our [website](#).

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In addition to presenting financial challenges for many patients, these unexpected bills can lead patients to avoid primary care in the future. This avoidance may result in more costly downstream healthcare use, such as ED visits or treatment for an exacerbated condition, or the condition may resolve on its own at the expense of prolonged patient illness.

POLICY CONSIDERATIONS

In contrast to typical high deductible plan models, plans could have consumer-friendly cost sharing models, even while holding constant the same total cost sharing dollars and premium levels. Principles for such consumer-centric models include:

- Cost sharing should be predictable, transparent, and easy to understand.
- Deductibles and coinsurance should be minimized or eliminated — especially for primary care services — and redistributed in the form of copayments.
- Cost sharing for primary care, including provider visits and related ancillary services such as lab tests, should be affordable.
- Value-based insurance design is compatible with consumer-friendly cost sharing design. Higher versus lower cost sharing can be effective in situations where the patient can realistically make value-based decisions, such as certain high-cost imaging, higher value treatment alternatives, or sites of care.
- Plan designs should consider the patient user experience, including consideration for patient behavioral factors, such as how patients save for a future expense.

For detailed policy recommendations on patient cost sharing, please see the HPC's [2025 Health Care Cost Trends Report](#).