Performance of the Massachusetts Health Care System

MARCH 25

Annual Report

CENTER FOR HEALTH INFORMATION AND ANALYSIS

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Contents

Executive Summary 6

Total Health Care Expenditures 17

Per Capita Total Health Care Expenditure Trends, 2013-2023 19

Components of Total Health Care Expenditures, 2022-2023 20

Components of Total Health Care Expenditures: Private Commercial Insurance by Product Type, 2022-2023 21

Components of Total Health Care Expenditures: Medicare by Program Type, 2022-2023 22

Components of Total Health Care Expenditures: MassHealth by Program Type, 2022-2023 23

Components of Total Health Care Expenditures: Net Cost of Private Health Insurance by Market Sector, 2022-2023 24

Components of Total Health Care Expenditures: Other Public Programs, 2022-2023 25

Total Health Care Expenditures by Service Category, 2022-2023: Gross of Prescription Drug Rebates 26

Total Health Care Expenditures by Service Category, 2022-2023: Net of Prescription Drug Rebates 27

Change in Total Health Care Expenditures by Service Category, 2022-2023 28

Commercial Spending by Service Category, 2022-2023 29

Medicare Spending by Service Category, 2022-2023 30

MassHealth Spending by Service Category, 2022-2023 31

Member Cost-Sharing for Massachusetts Residents, 2022-2023 32

Estimated Impact of Rebates on Pharmacy Spending and Growth, 2021-2023 33

Rebate Percentage of Total Pharmacy Expenditures, 2021-2023 34

Access & Affordability 36

Affordability in Context, 2021-2023 41

Enrollment by Market Sector, 2021-2023 42

Fully Insured Premiums by Market Sector, 2021-2023 43

Contents (continued)

Fully Insured Benefit Levels by Market Sector, 2023 . . . 44
Private Commercial Member Cost-Sharing by Market Sector, 2021-2023 . . . 45
Employee Plan Offerings, 2024 . . . 46
HDHP Enrollment by Market Sector, 2021-2023 . . . 47
Average Annual Deductibles, Out-of-Pocket Limits, and Copayments for Single Coverage, 2024 . . . 48
Affordability Issues Among Massachusetts Residents and Their Families by Race and Ethnicity, 2023 . . . 49
Affordability Issues Among Massachusetts Residents and Their Families by Health Status, 2023 . . . 50
Affordability Issues Among Privately Insured Massachusetts Residents Enrolled in HDHPs by Race and Ethnicity, 2023 . . . 51

Total Medical Expenses and Alternative Payment Methods . . . 53
Trends in Commercial Unadjusted TME by Payer, 2022-2023 . . . 56
Trends in Commercial HSA TME by Payer, 2022-2023 . . . 57
Trends in MassHealth MCO and ACO-A HSA TME by Payer, 2022-2023 . . . 58
Change in Aggregate Commercial HSA Scores by Payer, 2021-2023 . . . 59
Trends in Managing Physician Group Commercial Unadjusted TME, 2022-2023 . . . 60
Trends in Managing Physician Group Commercial HSA TME, 2022-2023 . . . 61
Adoption of Alternative Payment Methods by Insurance Category, 2021-2023 . . . 62
Adherence to Aligned Measure Set in Global Budget-Based Risk Contract APMs, 2023 . . . 63

Commercial Payer Trends . . . 65
Largest Payers by Market Sector, 2023 . . . 68
Fully Insured Payer Use of Premiums by Market Segment, 2021-2023 . . . 69
Fully Insured Non-Medical Expenses and Surplus by Market Segment, 2021-2023 . . . 70
Fully Insured Non-Medical Expense Components and Surplus by Market Segment, 2021-2023 . . . 71
Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio . . . 72

Contents (continued)

Provider and Health System Trends 76

Total Acute Care Hospital Inpatient Discharges, October 2018-June 2024 78

Total Acute Care Hospital Emergency Department Treat-and-Release Visits, October 2018-June 2024 79

Total Acute Care Hospital Outpatient Observation Discharges, October 2018-June 2024 80

Statewide Acute Hospital Median Total, Operating, and Non-Operating Margin Trends, HFY 2019-HFY 2024 through June 2024 . . 81

Hospital Operating Revenue and Expense Trends, HFY 2019-2023 82

Nursing Facility Occupancy Rates, System Level, CY 2019-2023 83

Total Facilities, Total Beds, and Median Occupancy by County, CY 2023 84

Behavioral Health 85

Behavioral Health Spending and Diagnosis Prevalence by Insurance Category, 2022-2023 89

MassHealth Behavioral Health Spending and Diagnosis Prevalence by Program Type, 2022-2023 90

Behavioral Health Expenditures by Age Group, 2022-2023 91

Mental Health Spending by Service Category, 2022-2023 92

Substance Use Disorder Spending by Service Category, 2022-2023 93

Member Cost-Sharing for Behavioral Health Services by Insurance Category, 2022-2023 94

Behavioral Health Hospital Utilization, HFY 2023 95

Acute Care Hospital Behavioral Health Inpatient Discharge Trends, October 2018-June 2024 96

Acute Care Hospital Behavioral Health Inpatient Discharges by Age Group, FFY 2023 97

Non-Acute Behavioral Health Hospital Inpatient Discharge Trends, April 2019-June 2024 98

Behavioral Health Access and Affordability Challenges Among Massachusetts Residents, 2023 99

Quality of Care 101

Statewide Scores on Select Primary Care Clinical Quality Measures, 2022-2023 104

Primary Care Patient-Reported Experiences for Adults, 2022-2023 105

Contents (continued)

Primary Care Patient-Reported Experiences for Pediatrics, 2022-2023 106
MassHealth ACO Member Primary Care Patient-Reported Experiences for Adults, 2023 107
MassHealth ACO Member Primary Care Patient-Reported Experiences for Pediatrics, 2023 108
Trends in Statewide All-Payer Adult Acute Hospital Readmissions, SFY 2011-2023. 109
Patient-Reported Experience During Acute Hospital Admission, 2023 110
Rates of Maternity-Related Procedures Relative to Performance Targets, by Hospital, 2023 111
Hospital Adherence to the Leapfrog Standards for Nursing Workforce and Hand Hygiene, 2023 112

Index of Acronyms 114

Glossary of Terms 117

KEY FINDINGS

Annual Report 2025

Total Health Care Expenditures (THCE) in Massachusetts totaled $78.1 billion in 2023. From 2022 to 2023, THCE per capita increased 8.6% to $11,153 per resident.

Pharmacy spending growth and new MassHealth supplemental payments drove THCE growth in 2023; pharmacy spending net of rebates increased by $1.0 billion (10.0%), and MassHealth administered $1.5 billion in new payments to hospitals to support key initiatives in quality and health equity, funded by a hospital assessment and federal matching dollars.

Between 2021 and 2023, growth in member cost-sharing (12.9%) and fully insured premiums (12.1%) outpaced the growth in Massachusetts wages and salaries (9.7%).

Among employer groups, member cost-sharing was highest for small and mid-size firms ($107 PMPM and $86 PMPM, respectively) and increased by more than 10% in 2023, driven by higher enrollment in high-deductible health plans (HDHPs).

KEY FINDINGS

Annual Report 2025

While affordability issues remained pervasive for many Massachusetts residents (41.3%), the burden of affordability issues was greater for Hispanic residents (58.2%) and non-Hispanic Black residents (48.7%) in 2023.

The statewide acute hospital median total margin increased by 6.4 percentage points, from -4.2% in hospital fiscal year (HFY) 2022 to 2.2% in HFY 2023. The statewide median operating margin was 0.2% while the median non-operating margin was 1.6%.

Acute care utilization has moderated since the COVID-19 pandemic, with inpatient discharges and emergency department visits increasing but still below pre-pandemic levels, and average length of stay decreasing but still above pre-pandemic levels as of June 2024.

Most clinical quality scores were similar from 2022 to 2023, but some measures in the Chronic Condition Care domain improved notably, such as blood pressure control and diabetes care.

Executive Summary

Each year, pursuant to M.G.L. c. 12C, the Center for Health Information and Analysis (CHIA) examines the performance of the Massachusetts health care system and reports on trends in costs, coverage, and quality indicators to inform policymaking. This report primarily focuses on data through 2023. Select hospital utilization and financial measures are included through June 2024, where possible.

In 2023, there were several factors impacting the Massachusetts health care system, including lasting effects of the COVID-19 pandemic. MassHealth continuous coverage protections ended on March 31, 2023, at which time MassHealth began redeterminations to disenroll ineligible individuals for the first time since March 2020, resulting in shifts in enrollment and spending across public and private insurance programs. At the same time, MassHealth administered $1.5 billion in new performance-based incentive programs and base rate increases, financed by an updated hospital assessment and federal matching funds. However, 2023 was also a period defined by provider closures, including the unexpected shuttering of several urgent and primary care clinics, as well as the discontinuation of essential maternity, behavioral health, and pediatric services at certain provider sites.[1] These closures exacerbated existing capacity constraints and disrupted ongoing patient care. Additionally, Massachusetts residents and employers continued to face rising premiums and cost-sharing, illustrating pervasive affordability issues in the Commonwealth as spending growth for health care and other household necessities outpaced growth in wages and salaries.

This report presents results on health care spending trends, access and affordability, hospital utilization and financial performance, behavioral health trends, and key quality metrics. The analyses included in this report leverage metrics across multiple CHIA datasets to

present a complete picture of the performance of the health care system and the downstream impacts on Massachusetts residents.

Total Health Care Expenditures

Total Health Care Expenditures (THCE) in Massachusetts totaled $78.1 billion in 2023, or $11,153 per resident. THCE per capita increased 8.6 percent from 2022 to 2023, more than double the health care cost growth benchmark (3.6 percent). This growth is the second highest one-year growth trend since measurement began in 2013, slightly below the 9.0 percent growth rate seen in 2021 when there was a sharp rebound in health care spending following the pandemic.

On a service category level, all claims-based service categories experienced growth from 2022 to 2023. Between 2022 and 2023, hospital outpatient spending increased 8.3 percent and hospital inpatient spending increased 4.1 percent; together, hospital services represented the greatest share of THCE (36.6 percent) and increased 6.3 percent combined. Nearly half of overall THCE growth was attributable to increases in pharmacy and non-claims expenditures; pharmacy spending continued to increase on both a gross (11.6 percent) and net-of-rebates (10.0 percent) basis, while non-claims payments increased 40.6 percent in 2023.

The growth in non-claims spending was driven by new MassHealth hospital supplemental payments and policy initiatives; 23.1 percent ($1.5 billion) of THCE growth in 2023 was attributable to the supplemental payments, which were financed by a combination of an updated hospital assessment and federal matching funds. These payments supported new performance-based incentives focused on hospital quality and health equity as well as Medicaid hospital base rate increases. Additionally, in 2023 MassHealth began the Primary Care Sub-Capitation Program, which shifted payments from claims-based to non-claims-based spending and led to rapid growth in MCO/ACO-A non-claims spending. Due to this shift, spending on physician services experienced the most moderate growth rate, increasing just 1.8 percent in 2023.

From 2022 to 2023, membership in the commercial market continued to decline while membership in MassHealth increased. Commercial membership fell 1.5 percent in 2023, marking the fourth consecutive year of decline. Enrollment in MassHealth continued to grow in 2023, increasing by 4.4 percent, albeit a slower rate than 2022. Medicare enrollment remained stable from 2022 to 2023 (0.8 percent increase).

Access and Affordability

Although Massachusetts boasts near-universal health care coverage statewide, residents face growing health care affordability concerns from rising health care costs,

including multi-year increases in premiums and member cost-sharing (copayments, coinsurance, and deductibles).

From 2021 to 2023, health insurance premiums and member cost-sharing grew faster than statewide wages and salaries. For Massachusetts residents and employees, health care costs are just one type of household expense to consider; growth in spending for other necessities, such as housing, food, and childcare, increased even faster than health care costs, which can further strain household budgets and affect individuals' and families' abilities to afford health care.

How members access health insurance—such as through their employer or the insurance marketplace—and the type of plan in which they enroll influences their monthly premiums and potential out-of-pocket costs, in turn affecting their overall ability to afford care. Premiums (paid by members and employer groups that offer health insurance) fund the majority of commercial health care spending. From 2022 to 2023, fully insured premiums increased 6.0 percent to $631 per member per month (PMPM), following a 5.7 percent increase the prior year. In addition to monthly premiums costs, health care affordability is impacted by member cost-sharing expenses. Between 2022 and 2023, total (fully and self-insured) private commercial member cost-sharing increased 5.9 percent to $68 PMPM.

For members covered by employer-sponsored plans, the cost of premiums and cost-sharing varied by market sector, with smaller group size employers experiencing greater cost pressures. For example, members enrolled in plans offered by small and mid-size employers had a smaller proportion of their medical costs covered by their health plans (83.4 percent and 86.4 percent, respectively) in 2023 despite paying similar or higher monthly premiums, compared with members enrolled in plans offered by larger employer groups. Furthermore, the small and mid-size group sectors had the fastest growth in member cost-sharing PMPM among employer-sponsored plans between 2022 and 2023 (12.7 percent and 10.3 percent, respectively).

These trends are, in part, attributable to the variation in the number and types of plans offered to employees across employer sizes, affecting employee plan choice, cost-sharing, and services covered, among other factors. Employees at small and mid-size employers have more limited choices compared with their counterparts at larger employers. With more than two-thirds (66.8 percent) of employers offering health insurance benefits, small and mid-size employers were more likely to offer only one health plan and more likely to offer only high-deductible health plans (HDHPs) compared with larger employers.

In 2023, more than 1.9 million Massachusetts members were enrolled in HDHPs, representing 45.1 percent of the

private commercial market. In accordance with federal Internal Revenue Service rules, an HDHP was defined as a plan with a deductible greater than or equal to $1,500 for single coverage in 2023. HDHP enrollment was highest among unsubsidized individual purchasers (88.5 percent), small group employers (76.5 percent), and mid-size group employers (70.1 percent). The persistent growth in HDHP enrollment has raised concerns about affordability and impacts on members' access to care.

These trends in premiums, member cost-sharing, and HDHP enrollment impact the ability of Massachusetts families to pay for needed health care. In 2023, 2 in 5 Massachusetts residents (41.3 percent) reported that their families faced any health care affordability issue within the past 12 months. The burden of affordability issues was more pronounced among certain demographic populations; for instance, 48.7 percent of non-Hispanic Black residents and 58.2 percent of Hispanic residents reported experiencing any affordability issue within the past 12 months, compared with 39.2 percent of non-Hispanic White residents. Among Massachusetts households, those with a family member in fair or poor health or with activity limitations were nearly twice as likely to report affordability issues in the past 12 months compared with households with all family members in good or excellent health (56.6 percent versus 31.3 percent, respectively).

Private Commercial Insurance

Total expenditures for members enrolled in private commercial health plans, which include self- and fully insured coverage, increased 7.2 percent from 2022 to 2023. During the same period, private commercial enrollment declined 1.5 percent, resulting in an 8.9 percent increase in PMPM spending.

Hospital outpatient and pharmacy spending were the largest private commercial service categories. From 2022 to 2023, commercial hospital outpatient spending increased 7.5 percent, resulting in a 9.2 percent increase PMPM. Pharmacy spending—gross of rebates—increased 11.7 percent (13.4 percent PMPM). Net of rebates, pharmacy spending increased 7.4 percent overall, and 9.0 percent PMPM. Other professional spending increased the fastest among commercial service categories from 2022 to 2023, growing 12.7 percent (14.4 percent PMPM). Spending for physician, hospital inpatient, other medical, and non-claims service categories all increased in 2023, as well.

Health insurance premiums are set prospectively based on historical data and projected growth in claims and administrative costs. Premium revenues are used to cover member health care expenses (i.e., claims costs) as well as general administrative costs (e.g., taxes, fees, and broker commissions, hereafter referred to as "non-medical expenses") and contributions to surplus. The 2023 premiums

were largely calculated in early 2022 using 2021 health care spending data and projections of future utilization, unit costs, and other factors impacting premium rate development. In 2023, after paying for members' health care expenses, the funds available to health plans to cover non-medical expenses and contributions to surplus increased 5.2 percent to $81 PMPM, following a 42.9 percent increase between 2021 and 2022. Of note, however, there was a divergence in trends between the merged market (individual and small group purchasers) and large group market segments. While the large group market segment experienced a slight decrease in overall non-medical expenses and surplus PMPM, the merged market's increase in specifically the gains (surplus) portion of non-medical expenses and surplus drove the overall 5.2 percent growth in the commercial market.

Public Insurance Programs

Total MassHealth expenditures, representing 28.5 percent of total THCE, increased 14.8 percent from 2022 to 2023. This increase was largely driven by increases in non-claims spending, which grew by 48.2 percent to $4.3 billion in 2023. During this time period, MassHealth began the redeterminations process and, separately, reprocured Accountable Care Organizations (ACOs). These factors contributed to a 4.4 percent increase in membership, a slower growth rate compared with 2022 (9.4 percent).

In 2023, non-claims spending surpassed other medical services to make up the largest portion of MassHealth spending. Most of the non-claims increase was attributable to $1.5 billion in new supplemental payments made to hospitals, funded by an updated hospital assessment and federal matching dollars; these include incentive payments focused on clinical quality and health equity as well as Medicaid hospital base rate increases. This, in combination with the termination of COVID-19-related supplemental payments, resulted in an overall net increase of $875 million in supplemental payments. Non-claims spending also increased in 2023 due to MassHealth's launch of the Primary Care Sub-Capitation Program, which shifted a significant amount of claims-based payments to non-claims-based spending, providing fixed PMPM payments for certain primary care services to participating MassHealth ACOs.

With the beginning of the Primary Care Sub-Capitation Program, more primary care providers were paid through non-claims payments instead of claims-based payments. As a result, MassHealth physician spending declined 10.2 percent overall and 13.9 percent PMPM from 2022 to 2023.

Other medical services, which include long-term care and home and community-based services, represented the second largest MassHealth service category and

increased 14.8 percent (10.0 percent PMPM) in 2023. MassHealth pharmacy spending increased 9.8 percent (5.2 percent PMPM) gross of rebates and 17.0 percent (12.1 percent PMPM) net of rebates. In addition to minimum rebates required under federal law, MassHealth maximizes rebates to reduce net prescription drug costs by negotiating directly with drug manufacturers for supplemental rebates and through its Unified Pharmacy Product List.

Total Medicare spending increased 7.1 percent from 2022 to 2023, accompanied by a 0.8 percent increase in overall enrollment, resulting in 6.3 percent PMPM growth. Medicare Advantage spending increased at a faster rate than original Medicare (17.0 percent vs. 4.5 percent, respectively) as the share and number of members enrolling in Medicare Advantage plans continued to grow.

From 2022 to 2023, total spending increased across all Medicare service categories. Hospital inpatient spending was the largest category, increasing 3.6 percent (2.9 percent PMPM). Pharmacy spending gross and net of rebates experienced the fastest growth across service categories, increasing 12.7 percent (11.8 percent PMPM) gross of rebates and 10.8 percent (10.0 percent PMPM) net of rebates.

Provider and Health Systems Trends

Over the past five years, hospitals have faced sustained capacity challenges despite fluctuations in utilization (discharges and visits) and average length of stay (ALOS)

Utilization in all acute care hospital settings—inpatient, emergency department (ED), and outpatient observation—declined during the COVID-19 pandemic, with the steepest declines coinciding with peak periods of COVID-19 cases in the Commonwealth. Utilization has increased since the COVID-19 pandemic but inpatient discharges and ED visits remain lower than pre-pandemic levels. Conversely, ALOS increased through the COVID-19 pandemic and has since declined but remains higher than pre-pandemic levels.

The statewide acute hospital median total margin increased by 6.4 percentage points, from -4.2 percent in hospital fiscal year (HFY) 2022 to 2.2 percent in HFY 2023. The statewide median operating margin was 0.2 percent, an increase of 1.5 percentage points, while the median non-operating margin was 1.6 percent, an increase of 2.0 percentage points.

Acute hospital aggregate total operating revenue increased by 9.4 percent while aggregate expenses increased 7.6 percent from HFY 2022 to HFY 2023. Aggregate revenues exceeded aggregate operating expenses by $190 million. In HFY 2023, workforce spending represented 43.3 percent of acute hospitals' total expenses, consistent with prior years. Temporary labor expenses represented 8.2 percent of workforce expenditures, a 0.7 percentage point decrease from HFY 2022.

In HFY 2024 year-to-date (YTD) data available through June 30, 2024, acute hospitals reported a statewide median total margin of 1.4 percent. The median operating margin was -0.9 percent during this period while the median non-operating margin was 1.9 percent. This period reflects 9 months of fiscal year data for most hospitals.

In calendar year (CY) 2023, there were 334 nursing facilities that accepted publicly aided residents, with a total of 39,256 licensed beds. The overall system-level occupancy rate, which is a measure of utilization based on licensed bed capacity, was 83.8 percent, a modest increase over the CY 2022 system-level occupancy of 80.3 percent.

Behavioral Health

Massachusetts residents seeking behavioral health care, including treatment for mental health (MH) and substance use disorders (SUD), can face unique access and affordability challenges. In 2023, the percentage of Massachusetts residents with a behavioral health diagnosis varied across commercial, MassHealth, and Medicare Advantage insurance categories. MassHealth accounted for the highest percentage of members with a behavioral health diagnosis in 2023 at 28.0 percent, followed by commercial at 23.5 percent and Medicare Advantage at 19.5 percent. In 2023, spending on behavioral health services represented 22.1 percent of total MassHealth spending compared with 7.7 percent for commercial and 2.5 percent for Medicare Advantage. Consistent across insurance categories, MH represented a majority of behavioral health diagnoses and spending compared with SUD in 2022 and 2023. Among commercially insured members, behavioral health spending was higher for pediatric members than for adults, while the inverse was true for MassHealth members; behavioral health spending was higher for MassHealth adult members than for pediatric members, driven by higher adult utilization of SUD services.

Consistent across both data years, private commercial and Medicare Advantage plan members were responsible for a higher portion of out-of-pocket costs for MH services than for all other service types.

Similar to total acute care utilization, inpatient discharges for patients with a primary behavioral health diagnosis and discharges at behavioral health hospitals decreased during peak periods of the COVID-19 pandemic and remain below pre-pandemic levels as of June 2024.

Alternative Payment Methods and Quality

Alternative payment methods (APMs) shift payer-provider insurance contracts away from the traditional fee-for-service model toward a value-based payment system. The most common APMs in Massachusetts are global budgets, which establish spending targets for a comprehensive set of health care services to be delivered to a specified

population. Between 2022 and 2023, APM adoption remained relatively stable for commercial payers and MassHealth while APM adoption for Medicare Advantage increased by 3.8 percentage points. Notably, the proportion of private commercial health plan members covered by APMs has remained around 40 percent since 2016.

Like APM spending targets, quality metrics also support value-based care and highlight opportunities to improve patient experiences and outcomes. Quality metrics are often incorporated into global budget contracts between payers and providers, where payment incentives are linked to performance on certain measures.

This report presents payers' adherence to the Commonwealth's recommended Aligned Measure Set in their APM contracts with providers. The goal of the Aligned Measure Set is to prioritize the use of meaningful quality measures and promote aligned accountability across payers and providers. Statewide scores on a subset of Aligned Measure Set measures are reported, including metrics of clinical quality and patient-reported experiences in primary care settings.

For most clinical quality measures with two years of data, 2023 performance was similar to results in 2022, though there were some notable improvements in the Chronic Condition Care domain including a 6.6-point increase for a blood pressure control measure and improvements for diabetes management measures. This report also includes results from the 2023 MassHealth Member Experience Survey, which was issued to samples of MassHealth ACO members in early 2023 with a recent primary care visit. Findings from a similar survey of members enrolled in private commercial health plans are also presented in this report as well as data on hospital performance metrics including readmissions rates, patient experience ratings following hospital visits, maternity care, nursing workforce, and hospital adherence to hand hygiene safe practices.

While the statewide rates provided in this report are valuable for monitoring overall performance on priority quality metrics, CHIA publishes provider-specific results on the **Select Clinical Quality and Patient Experience Measures dashboard**. Additionally, CHIA will publish an inaugural health equity-focused quality report in 2025 that will include statewide results stratified by race and ethnicity for select clinical quality measures and commercial Patient Experience Survey responses to examine disparities in the quality of care across the Commonwealth. ■

Executive Summary Notes

1. The data included in this report is primarily reflective of the health care landscape in 2023. The metrics in this publication predate the closure of Carney Hospital and Nashoba Valley Medical Center (August 2024) and the change in ownership of St. Elizabeth's Medical Center, Good Samaritan Medical Center, Saint Anne's Hospital, Morton Hospital and Holy Family Hospital (October 2024).

KEY FINDINGS

Total Health Care Expenditures

THCE PER CAPITA

8.6%

THCE was $78.1 billion in 2023, an increase of $6.4 billion from 2022. THCE per capita increased 8.6% from 2022 to 2023—more than double the 3.6% health care cost growth benchmark and the second highest growth rate since measurement began in 2013.

Pharmacy spending continued to drive THCE spending growth in 2023, increasing by $1.6 billion (11.6%) over 2022. After adjusting for rebates, pharmacy spending increased by $1.0 billion, accounting for 17.5% of overall net THCE growth.

From 2022 to 2023, commercial spending grew 7.2% (8.9% PMPM), Medicare 7.1% (6.3% PMPM), and MassHealth 14.8% (10.0% PMPM). Enrollment in the commercial market continued to decline while Medicare remained relatively stable. MassHealth enrollment increased 4.4%, a slower rate than previous years.

New MassHealth payments made to hospitals in 2023 accounted for 23.1% ($1.5 billion) of THCE growth. New hospital supplemental payments were financed by a combination of a hospital assessment and federal matching funds. These payments supported key MassHealth initiatives, such as performance-based hospital incentives focused on quality and health equity and hospital base rate increases. Excluding these new supplemental payments in 2023, THCE per capita increased by 6.6% from 2022 to 2023.

Total Health Care Expenditures

A key provision of the Massachusetts health care cost containment law, Chapter 224 of the Acts of 2012, was the establishment of a benchmark against which the annual change in health care spending growth is evaluated.

The Center for Health Information and Analysis (CHIA) is charged with calculating Total Health Care Expenditures (THCE) and comparing its per capita (per resident) growth with the health care cost growth benchmark, as set by the Health Policy Commission.[1]

From 2013 to 2017, the health care cost growth benchmark was set at 3.6 percent. For the 2018 to 2022 performance periods, the benchmark was set at 3.1 percent. In 2023, the benchmark returned to 3.6 percent.[2]

THCE encompasses health care expenditures for Massachusetts residents from public and private sources, including all categories of medical expenses and all non-claims-related payments to providers; all patient cost-sharing amounts, such as deductibles and copayments; and the cost of administering private health insurance (called the net cost of private health insurance or NCPHI). It does not include out-of-pocket payments for goods and services not covered by health insurance, such as over-the-counter medicines, nor does it include standalone vision and dental plans.

Throughout this chapter, THCE is broken down into its major components—commercial, Medicare, MassHealth, NCPHI, and other public program spending.

Per member per month (PMPM) spending for commercial, Medicare, and MassHealth was calculated using total component spending divided by total component membership. However, THCE per capita was calculated using THCE divided by the Massachusetts population, sourced from the U.S. Census Bureau. Due to differences in the numerators and denominators, PMPM spending by component cannot be used to calculate THCE per capita. ■

Total Health Care Expenditures

From 2022 to 2023, THCE per capita increased 8.6%, more than double the 3.6% health care cost growth benchmark. This growth represents one of the highest 1-year growth trends since measurement began in 2013, second to the 9.0% growth rate seen in 2021, when there was a sharp rebound in health care spending following a decline in 2020 due to the COVID-19 pandemic.

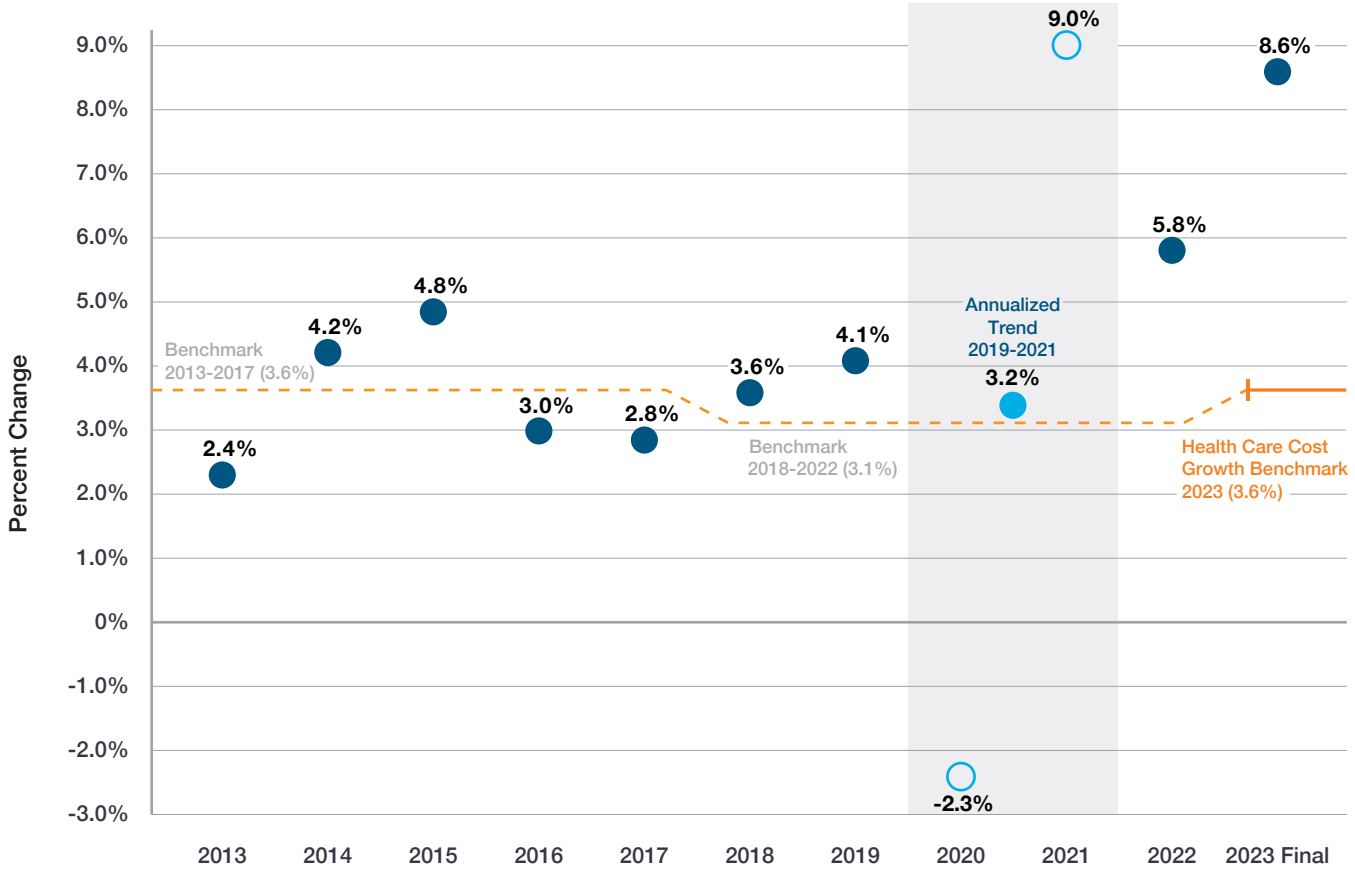
In 2023, the 8.6% per capita THCE increase was higher than that of the Massachusetts economy (5.8%), regional inflation (3.7%), and total wages and salaries of Massachusetts employees (3.3%).[3,4]

Pharmacy spending gross of rebates represented the largest portion of THCE growth, accounting for 24.7% of the total increase ($1.6 billion) from 2022 to 2023. After adjusting for rebates, pharmacy spending represented 17.5% of net THCE growth.

Approximately 23.1% of THCE growth ($1.5 billion) was attributable to new MassHealth supplemental payments to hospitals in 2023. These payments, funded by a hospital assessment, supported new performance-based incentives focused on hospital quality and health equity as well as hospital base rate increases.[5] Excluding the new payments, THCE per capita increased 6.6% from 2022 to 2023.

National health care spending increased 7.5% in 2023, outpacing the average growth rate in national gross domestic product (GDP) at 6.1%.[6]

Per Capita Total Health Care Expenditure Trends, 2013-2023



Total Health Care Expenditures per capita increased 8.6% from 2022 to 2023, more than double the health care cost growth benchmark.

Source: Payer-reported data to CHIA and other public sources.

Notes: THCE per capita was calculated using the Massachusetts state population sourced from the U.S. Census Bureau. THCE does not include federal funding for public health activities nor any COVID-19 relief funds distributed from the federal government directly to hospitals and health systems. THCE does include COVID-19 supplemental payments distributed by MassHealth.

Total Health Care Expenditures

Massachusetts THCE totaled $78.1 billion in 2023. This represented an increase of $6.4 billion from 2022, during which the size of the state's population remained relatively unchanged. THCE spending per resident continued to increase, reaching $11,153 per capita in 2023, an 8.6% increase from 2022.

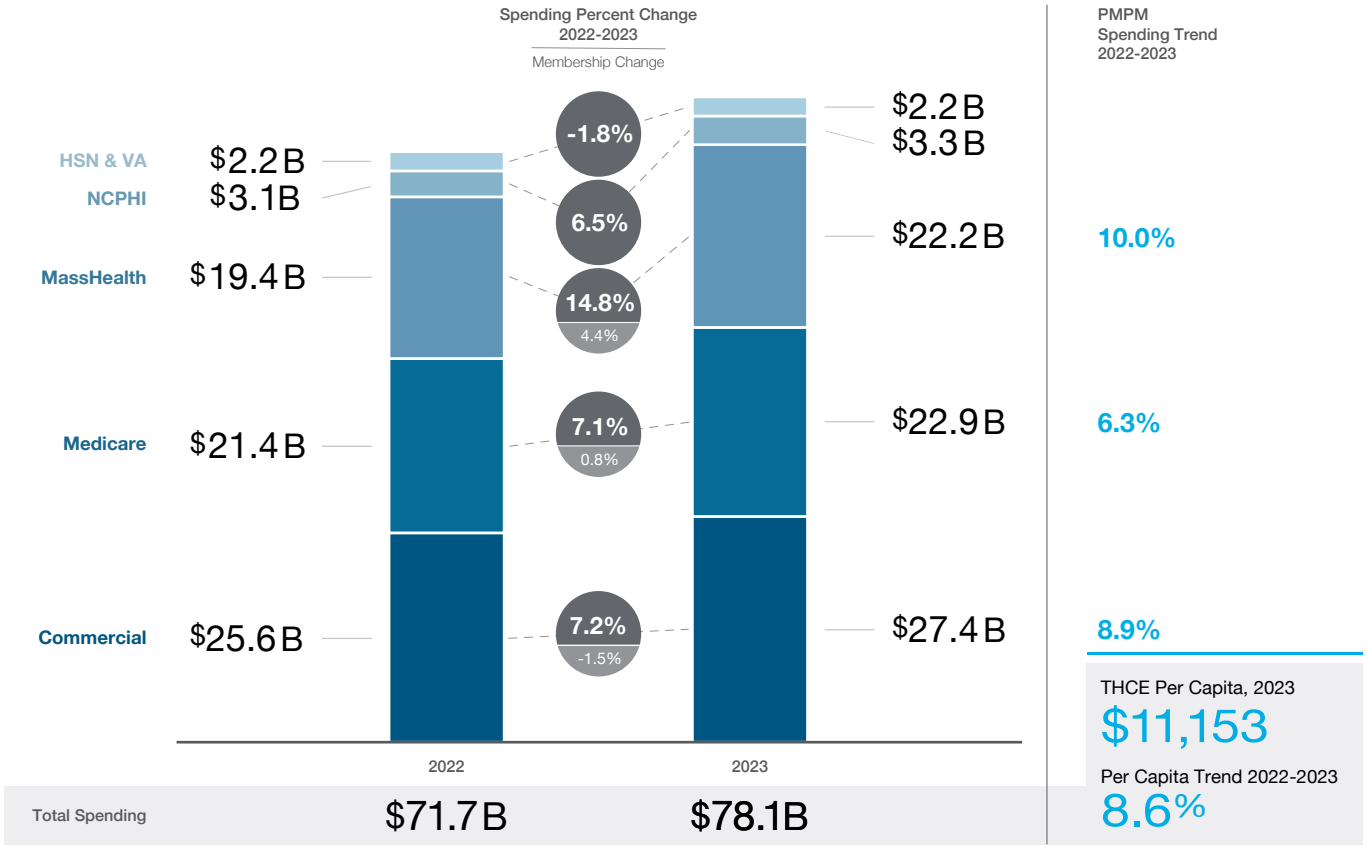
Total commercial spending increased 7.2% to $27.4 billion in 2023. For the fourth year in a row, enrollment declined, falling 1.5% in 2023, resulting in an 8.9% increase in PMPM spending.

Medicare spending totaled $22.9 billion in 2023, increasing 7.1% from 2022. Medicare membership remained relatively stable, increasing 0.8% in 2023, resulting in 6.3% PMPM spending growth.

MassHealth spending increased 14.8% in 2023, totaling $22.2 billion. Approximately 51.5% of this increase was due to new supplemental funding in 2023, including $1.5 billion in new hospital-based payments. MassHealth continuous coverage protections ended on March 31, 2023, when MassHealth began redeterminations to disenroll ineligible individuals for the first time since March 2020. Enrollment in MassHealth decelerated in 2023, increasing 4.4%, compared with a 9.4% increase in 2022. On a PMPM basis, MassHealth spending increased 10.0% in 2023. Excluding the new supplemental payments, MassHealth spending increased 7.2% (2.7% PMPM).[7]

NCPHI growth slowed to 6.5% in 2023 after increasing 29.2% the previous year. This trend reflects a return to pre-pandemic growth rates following several years of volatility due to the impacts of the COVID-19 pandemic on the health care system.

Components of Total Health Care Expenditures, 2022-2023



THCE totaled $78.1 billion or $11,153 per resident in 2023.

Source: Payer-reported data to CHIA and other public sources.

Notes: Percent changes are calculated based on non-rounded expenditure amounts. THCE per capita was calculated using the Massachusetts state population sourced from the U.S. Census Bureau. THCE does not include federal funding for public health activities nor any COVID-19 relief funds distributed from the federal government directly to hospitals and health systems. THCE does include COVID-19 supplemental payments distributed by MassHealth. See databook for detailed information.

Total Health Care Expenditures

Within the commercial insurance market, private payers offer a variety of insurance product types that vary by the provider networks offered, referral requirements, and cost-sharing levels, among other factors.

From 2022 to 2023, commercial spending increased 7.2% overall and 8.9% on a PMPM basis. Membership in private commercial plans continued to decline, decreasing by 1.5%.

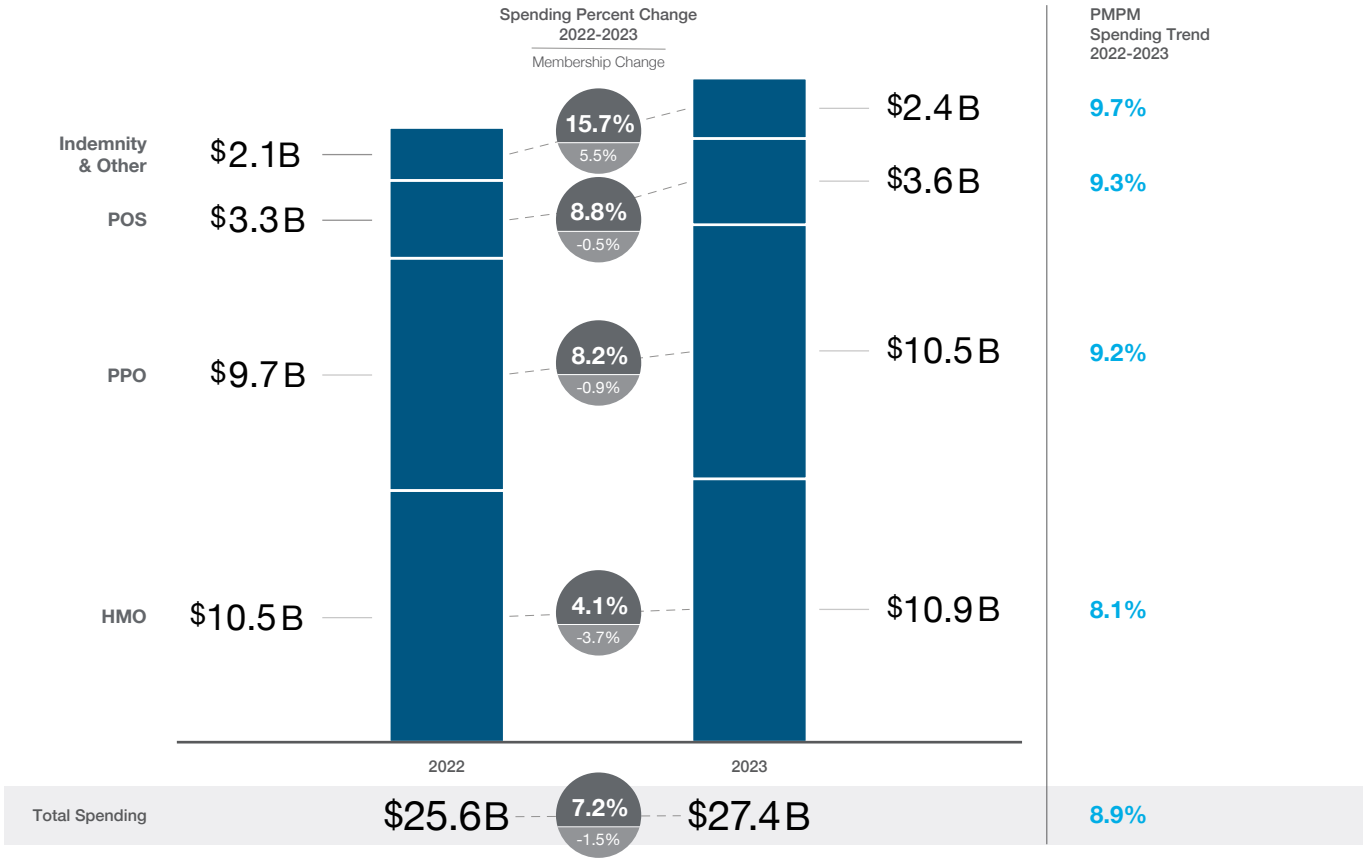
Health maintenance organization (HMO) plans continued to be the most common commercial insurance product among Massachusetts residents. These plans require members to select a primary care provider to manage care. Membership in these plans decreased the fastest, by 3.7% from 2022 to 2023, resulting in an 8.1% increase in PMPM spending.

Preferred provider organization (PPO) plans, which allow members to schedule visits without a referral, experienced a 0.9% decline in membership accompanied by an 8.2% increase in spending, which resulted in a 9.2% increase in PMPM spending. Point-of-service (POS) plans, which offer both in-network and out-of-network coverage options, experienced similar trends.

Membership increased in indemnity and other plans for the third year, by 5.5% in 2023. Spending increased 15.7%, resulting in a 9.7% increase in PMPM spending. These growth rates were largely driven by Wellpoint, which offers plans only through the Massachusetts Group Insurance Commission (GIC) and represents more than a third of total indemnity and other membership and spending.

Components of Total Health Care Expenditures:
Private Commercial Insurance by Product Type, 2022-2023

THCE COMPONENTS Detailed View



From 2022 to 2023, commercial spending increased 7.2% accompanied by a 1.5% decline in membership, resulting in an 8.9% increase in PMPM spending.

Source: Payer-reported data to CHIA and other public sources.

Notes: For additional information on commercial enrollment trends, see CHIA's Enrollment Trends reporting. For commercial partial-claim data, CHIA estimates spending by product type by multiplying share of member months reported in TME data by estimated total commercial partial-claim expenditures. Percent changes are calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

In 2023, approximately 1.3 million Massachusetts residents were enrolled in Medicare, the federal health insurance program for people age 65 and older as well as for individuals with long-term disabilities. Total Medicare enrollment increased 0.8% from 2022 to 2023, accompanied by a 7.1% increase in expenses, resulting in 6.3% spending growth PMPM.

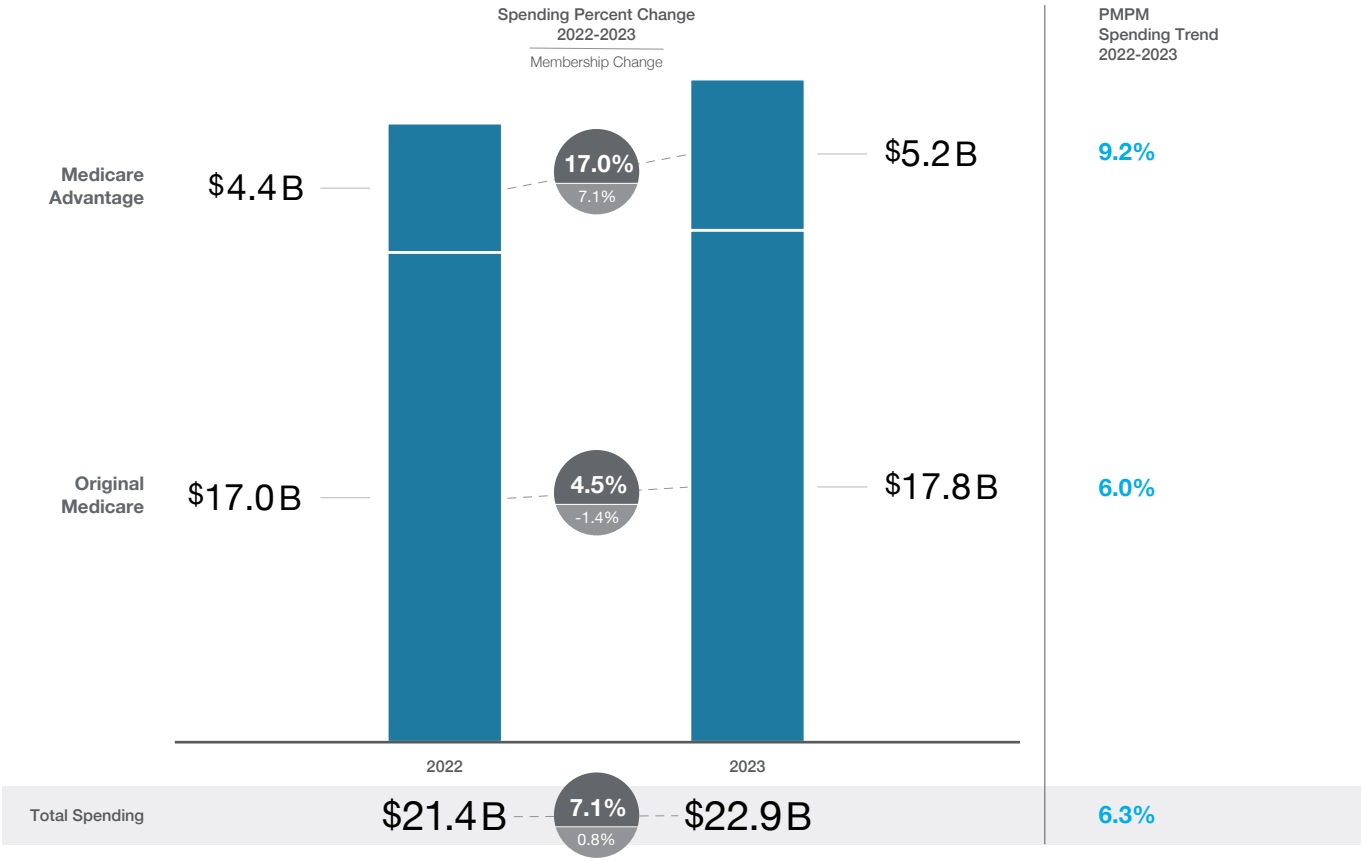
Within Medicare, eligible individuals choose between traditional Medicare coverage administered by the federal government ("Original Medicare") and Medicare Advantage products managed by private insurers. Most Massachusetts beneficiaries receive coverage through Original Medicare (73.5% in 2023). However, the share of members enrolling in Medicare Advantage plans continued to grow, from 25.0% in 2022 to 26.5% in 2023.

The growth observed in Medicare Advantage membership has been partially attributed to benefits offered by Medicare Advantage plans that are not offered with Original Medicare as well as the absence of a separate premium for Part D coverage.[8] Medicare Advantage enrollment increased by 7.1% and spending increased 17.0%, resulting in a 9.2% increase in PMPM spending from 2022 to 2023.

Membership in Original Medicare declined by 1.4%, mirroring a trend seen nationwide (-2.6%). Spending, however, increased by 4.5% in 2023, outpacing national spending growth (3.3%).[9] This resulted in a 6.0% PMPM spending increase.

Components of Total Health Care Expenditures:
Medicare by Program Type, 2022-2023

THCE COMPONENTS Detailed View



From 2022 to 2023, Medicare spending increased 7.1% overall and 6.3% PMPM.

Source: Payer-reported data to CHIA and other public sources.

Notes: For additional information on enrollment in Medicare programs, see CHIA's **Enrollment Trends** reporting. Original Medicare includes Part D expenditures for traditional Medicare enrollees. In THCE, beneficiaries who are dually eligible for Medicare and Medicaid and enroll in plans specifically designed to better coordinate their care (e.g., Senior Care Options) are included in MassHealth spending. As a result, the share of spending attributable to Medicare may not be comparable to figures published by other sources. Percent changes are based on non-rounded expenditure amounts. See **databook** for detailed information.

Total Health Care Expenditures

Approximately 2.3 million Massachusetts residents relied on MassHealth for either primary or partial/secondary medical coverage in 2023. From 2022 to 2023, MassHealth spending increased by 14.8% while membership increased 4.4%, resulting in a 10.0% increase in PMPM spending.

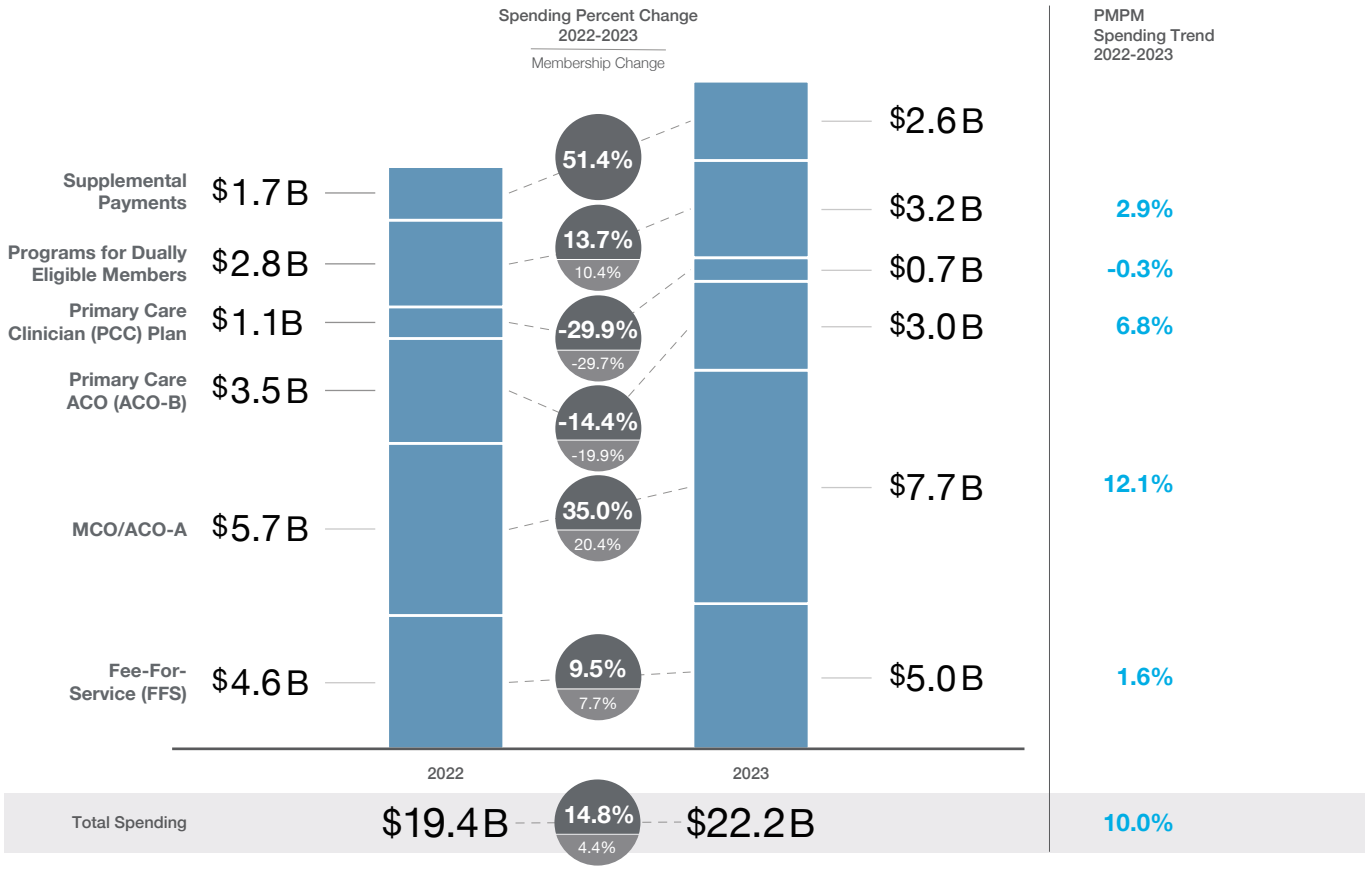
MassHealth MCO/ACO-A enrollment increased 20.4% following the reprocurement of ACO contracts effective April 1, 2023. Enrollment in PCC and ACO-B plans declined 29.7% and 19.9%, respectively. Eligibility redeterminations, which began in April 2023, further contributed to fluctuations in MassHealth enrollment and tempered the overall growth in enrollment (4.4% from 2022 to 2023 compared with 9.4% the prior year).[10]

MCO/ACO-A spending increased the fastest among program types, growing 35.0% (12.1% PMPM), largely due to a reallocation of members from ACO-B and PCC plans to MCO/ACO-As.

Supplemental payments continued to be a major driver of MassHealth spending in 2023, increasing 51.4%, or $875 million. MassHealth administered $1.5 billion in new supplemental payments to hospitals funded by a hospital assessment plus federal matching dollars; these include incentive payments focused on clinical quality ($250 million) and health equity ($350 million) as well as Medicaid hospital base rate increases ($650 million).[11] This spending was offset by the termination of certain COVID-19-related payments in 2023 ($621.5 million in 2022).

Components of Total Health Care Expenditures:
MassHealth by Program Type, 2022-2023

THCE COMPONENTS Detailed View



In 2023, MassHealth spending growth was driven by an $875 million increase in supplemental payments, including the launch of new incentive programs for health equity and clinical quality and increases to Medicaid hospital base rates.

Source: Payer-reported data to CHIA and other public sources.

Notes: Members of MCO-Administered ACOs (ACO-C) are counted within the MCO population in 2022. For additional information on enrollment in MassHealth programs, see CHIA's Enrollment Trends reporting. MassHealth programs for dually eligible members include Senior Care Options (SCO) for members age 65 and older; the Program of All-inclusive Care for the Elderly (PACE) for members 55 and older; and One Care, for members ages 21 to 64. One-third of dually eligible members are captured in the PACE/SCO/One Care programs, with the remaining receiving MassHealth coverage through fee-for-service (FFS) programs. Percent changes are calculated based on non-rounded expenditure amounts. From 2020 through 2022, MassHealth provided COVID-19 relief funding to providers. Enhanced payment rates were distributed to hospitals, certain health care facilities (e.g., skilled nursing facilities), physicians, and other professionals through claims payments and are reflected in the relevant spending categories reported here. See databook for detailed information.

Total Health Care Expenditures

NCPHI captures the administrative costs of private health insurance for Massachusetts residents and is broadly defined as the difference between the premiums health plans receive on behalf of Massachusetts residents and the expenditures for covered benefits incurred for those same members. NCPHI balances are used to pay general administrative expenses and broker commissions as well as taxes and fees. For more information on how payers use premium funds, see page 65.

Premiums are set prospectively based on historical data and actuarial assumptions; as a result, NCPHI fluctuates from year to year depending on how closely actuarial projections match actual spending on health care services.

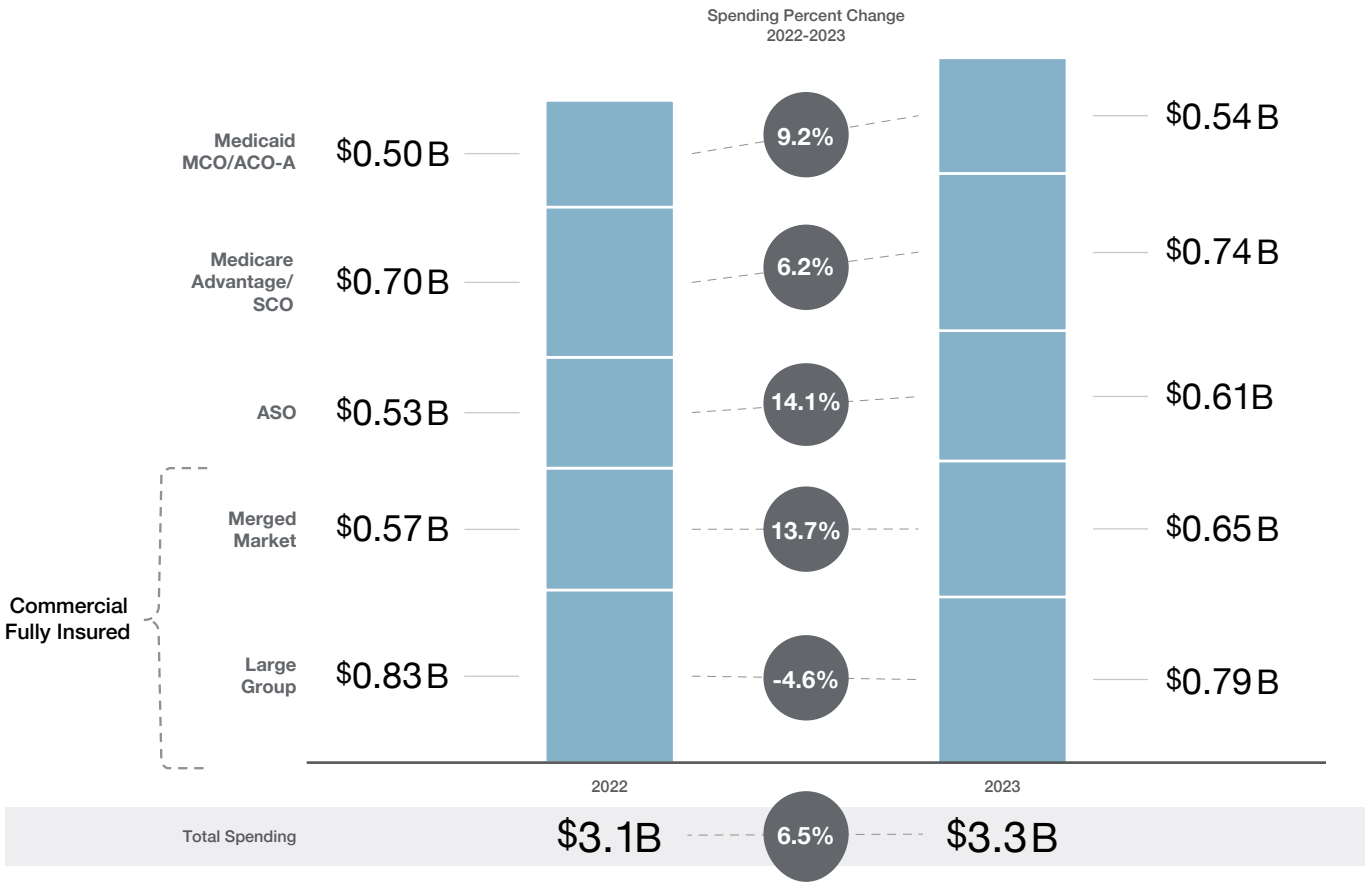
From 2022 to 2023, NCPHI growth slowed to 6.5% following a 29.2% increase the previous year. The trend in 2023 reflects a normalization of NCPHI growth after several volatile years of change due to the impacts of the COVID-19 pandemic on the health care system.

In the private commercial market, the self-insured (administrative services only or ASO) and merged market sectors experienced the largest annual growth rates in NCPHI in 2023, increasing 14.1% and 13.7%, respectively. The large group fully insured market reported a decline in NCPHI (-4.6%).

NCPHI for commercially managed Medicaid (MCO/ACO-A) and Medicare Advantage/SCO plans continued to grow in 2023, increasing 9.2% and 6.2%, respectively. This annual growth in NCPHI is attributed to higher average enrollment in 2023 compared with 2022.

Components of Total Health Care Expenditures:
Net Cost of Private Health Insurance by Market Sector, 2022-2023

THCE COMPONENTS Detailed View



From 2022 to 2023, NCPHI growth slowed to 6.5% following several years of volatility due to the COVID-19 pandemic.

Source: Massachusetts Medical Loss Ratio Reports are from Massachusetts Division of Insurance. Federal Medical Loss Ratio Reports are provided to the Center for Consumer Information and Insurance Oversight and received via Massachusetts insurers.

Notes: NCPHI Large Group combines the fully insured mid-size, large, and jumbo groups. The self-insured category (ASO) reflects fees collected by payers for administrative services only. Medical loss ratio rebates and premium credits paid to members were subtracted from premiums in the calculation of NCPHI. See **databook** for detailed information.

Total Health Care Expenditures

The U.S. Department of Veterans Affairs, through its Veterans Health Administration division, provides health care for certain eligible U.S. military veterans.

Medical spending for Massachusetts veterans decreased 1.9% from 2022 to 2023 after increasing 18.5% in 2022 amid the enactment of the VA PACT Act, which expanded VA health care and benefits to eligible veterans.[12] National VA medical spending, however, continued to increase, growing 5.1% in 2023 (data not shown).[13]

The Health Safety Net (HSN) pays acute care hospitals and community health centers (CHCs) for medically necessary health care services provided to eligible low-income Massachusetts residents who are uninsured or underinsured.[14] Total HSN provider payments decreased 1.3% from 2022 to 2023. Approximately $86.3 million of HSN payments were made to CHCs in 2023, accounting for 26.8% of total HSN payments. This represents a 10.1% increase in total payments made to CHCs compared with 2022.

Components of Total Health Care Expenditures:
Other Public Programs, 2022-2023

THCE COMPONENTS Detailed View

Health care spending for the Veterans Health Administration declined by 1.9% in 2023; Health Safety Net expenditures decreased by 1.3%.

Source: Payer-reported data to CHIA and other public sources.

Notes: HSN spends and reports on the hospital fiscal year (HFY). Percent changes are calculated based on non-rounded expenditure amounts. See databook and technical appendix for detailed information.

Total Health Care Expenditures

In 2023, prescription drug spending—before accounting for rebates received retrospectively by health plans—represented the largest share of overall THCE spending in 2023. Gross pharmacy spending increased 11.6%, accounting for 24.7% of THCE growth in 2023.

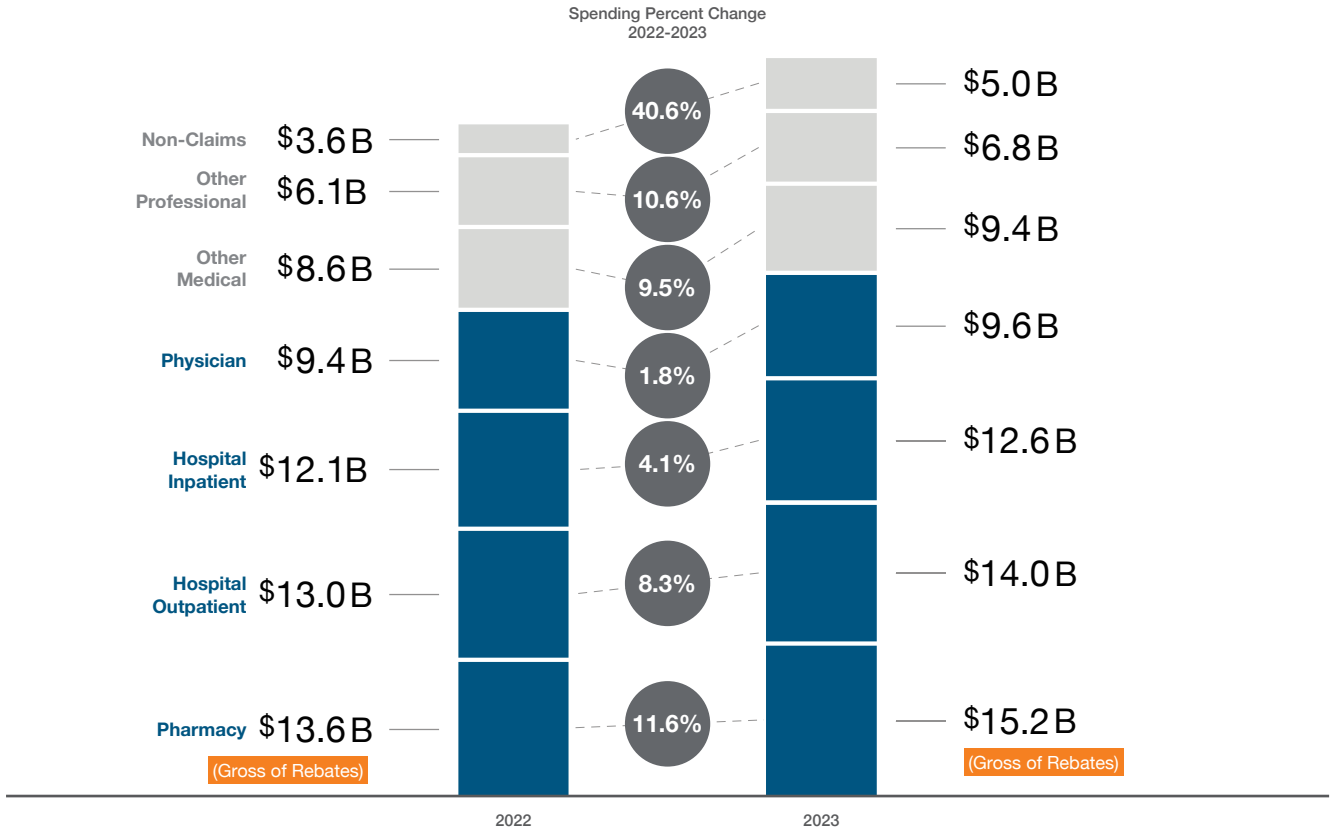
Non-claims spending experienced the fastest spending growth among these categories from 2022 to 2023, increasing by 40.6% due to new MassHealth policy initiatives and supplemental payments. Excluding all supplemental payments, total non-claims payments related to member care increased 30.7%.

Spending for other professional services, which includes care provided by a licensed practitioner other than a physician (such as a nurse practitioner or psychologist), increased 10.6% in 2023. This growth was driven by an increased demand for and utilization of behavioral health care services. For more information on behavioral health spending, see page 85.

Total hospital spending increased by 6.3% ($1.6 billion), with inpatient and outpatient expenses together totaling $26.6 billion in 2023. Independently, hospital outpatient spending increased 8.3% from 2022 to 2023, and hospital inpatient spending increased by 4.1%.

Physician spending experienced the slowest growth rate in 2023 compared with other service categories, increasing by just 1.8%.

Total Health Care Expenditures by Service Category, 2022-2023:
Gross of Prescription Drug Rebates



In 2023, pharmacy spending gross of rebates made up the largest share of THCE spending and increased by 11.6% over the previous year.

Source: Payer-reported data to CHIA and other public sources.

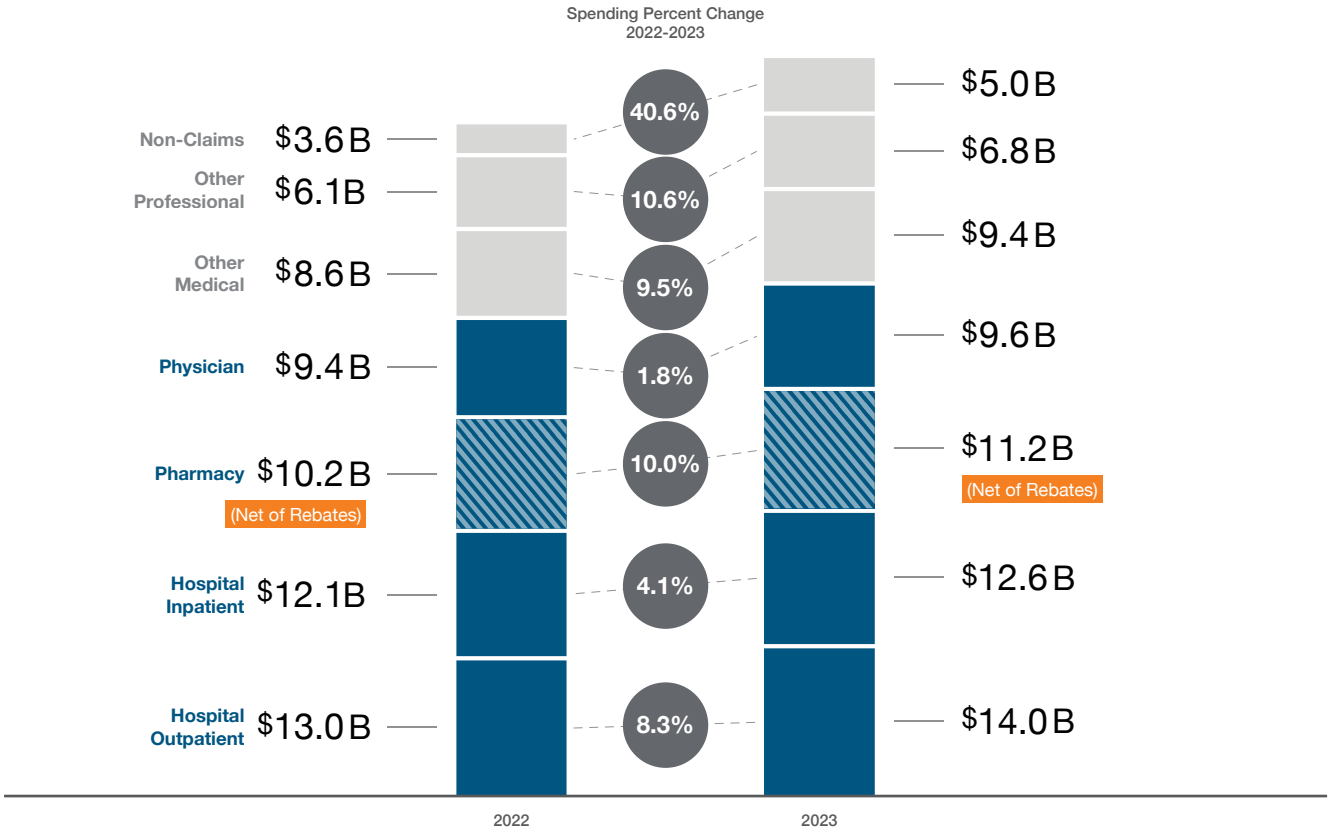
Notes: Excludes net cost of private health insurance, VA, and HSN. Percent changes are calculated based on non-rounded expenditure amounts. Categories are ordered according to 2023 total dollar amounts. See databook for detailed information.

Total Health Care Expenditures

Pharmacy expenditures represent spending covered by a member's prescription drug benefit. Other service categories may include additional spending associated with drugs that are administered in other care settings such as a hospital or physician's office, which are not included under the pharmacy service category. Vaccinations, including those provided in a pharmacy setting, may be included in the pharmacy expenditure category if they are covered by a member's prescription drug benefit.

Both public and private payers negotiate with drug manufacturers to receive rebates on their members' prescription drug utilization. In 2023, rebates accounted for a $4.0 billion reduction in gross pharmacy expenditures. Net of prescription drug rebates, pharmacy spending increased 10.0% to $11.2 billion in 2023, following an 8.5% increase the previous year. Prescription drug rebates grew 16.3% between 2022 and 2023, faster than the growth rate seen the previous year (10.4%). This is largely attributable to the growth in rebates in the commercial market, which grew 35.2% in 2023. For more information on prescription drug rebates and their impact on spending, see page 33.

Total Health Care Expenditures by Service Category, 2022-2023:
Net of Prescription Drug Rebates



Net of prescription drug rebates, pharmacy spending increased 10.0% from 2022 to 2023.

Source: Payer-reported data to CHIA and other public sources.

Notes: Excludes net cost of private health insurance, VA, and HSN. Percent changes are calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

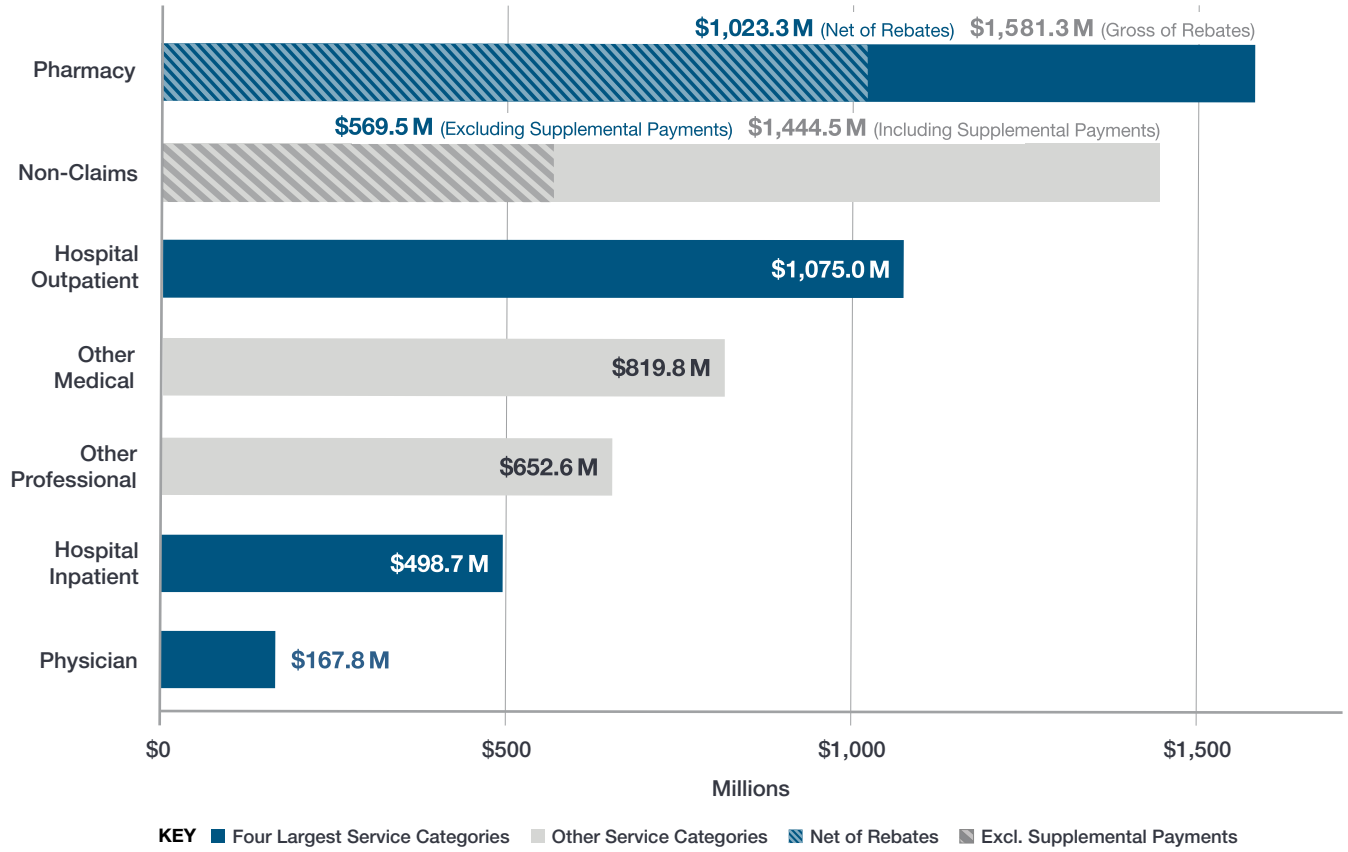
From 2022 to 2023, THCE in Massachusetts increased by $6.4 billion gross of pharmacy rebates and $5.8 billion net of rebates. Pharmacy spending gross of rebates was the largest component of medical expenditure increases in 2023, growing $1.6 billion. Net of rebates, pharmacy spending remained a large driver of THCE growth, increasing $1.0 billion over 2022 and representing 17.5% of net THCE growth.

Non-claims payments were the second largest contributor to gross THCE increases in 2023, increasing $1.4 billion. After accounting for drug rebates, non-claims payments were the largest contributor, accounting for 25.3% of net THCE growth. Non-claims payments include MassHealth supplemental payments, which provided $1.5 billion in new funding to support quality and health equity programs and increased hospital base rates. Excluding all supplemental payments in 2022 and 2023, non-claims-related to member care increased $569.5 million.

Hospital outpatient and inpatient spending both increased in 2023, by $1.1 billion and $499 million, respectively. As reported in CHIA's Acute Hospital Case Mix Database Dashboards, inpatient and emergency department utilization remained relatively steady from 2022 to 2023; however, there was a slight increase in outpatient observation visits. For more information on hospital inpatient discharges, see page 78. For further information on hospital financial performance in 2023, see page 81.

Physician spending experienced the slowest growth in 2023, increasing by $168 million.

Change in Total Health Care Expenditures by Service Category, 2022-2023



Non-claims, including supplemental payments, along with hospital outpatient and pharmacy spending net of rebates all increased by more than $1 billion from 2022 to 2023.

Source: Payer-reported data to CHIA and other public sources.

Notes: Excludes net cost of private health insurance, VA, and HSN. For detailed information about how expenses were grouped into service categories, see technical appendix.

Total Health Care Expenditures

Commercial spending totaled $27.4 billion in 2023, representing 35.1% of THCE. Overall, the commercial market experienced a 1.5% decrease in membership.

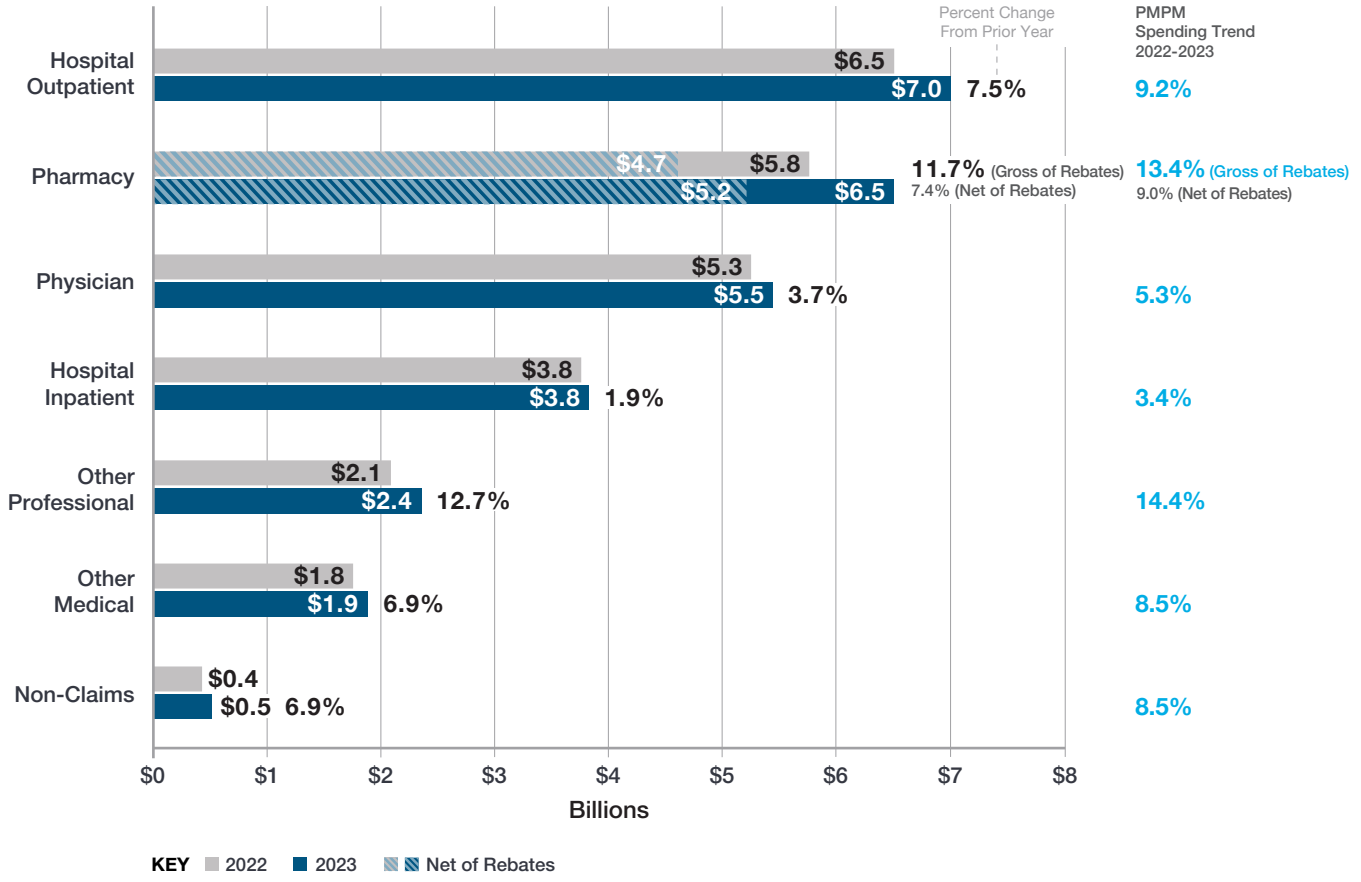
Hospital outpatient spending remained the largest commercial service category in 2023, increasing 7.5% overall and 9.2% PMPM and accounted for 26.4% ($486.9 million) of the total commercial spending increase. Combining inpatient and outpatient, total hospital spending increased 5.5% overall and 7.1% PMPM.

Gross of rebates, pharmacy spending increased 11.7%, or 13.4% PMPM. Net of rebates, pharmacy spending increased 7.4%, or 9.0% PMPM. Growth in pharmacy spending gross of rebates was the largest contributor to overall commercial spending increases representing 26.4% of total commercial spending increases ($677.3 million). Net of rebates, pharmacy spending was the second largest contributor to total net commercial spending ($359.4 million).

Other professional spending increased by 12.7% overall and 14.4% on a PMPM basis in 2023. Growth in other professional spending can be attributed to increased demand for and utilization of behavioral health services. For more information on behavioral health spending, see page 85.

Non-claims spending increased by 6.9% in 2023, largely driven by growth in non-claims risk settlements and incentive program payments.

Commercial Spending by Service Category, 2022-2023



Increases in hospital outpatient and pharmacy spending contributed to more than half of overall commercial spending growth in 2023.

Source: Payer-reported data to CHIA and other public sources.

Notes: For commercial partial-claim data, CHIA estimates spending by product type by multiplying share of member months reported in TME data by estimated total commercial partial-claim expenditures. Excludes net cost of private health insurance. Percent changes are calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

Medicare spending totaled $22.9 billion in 2023, representing 29.4% of THCE. Total enrollment in Medicare increased 0.8% in 2023.

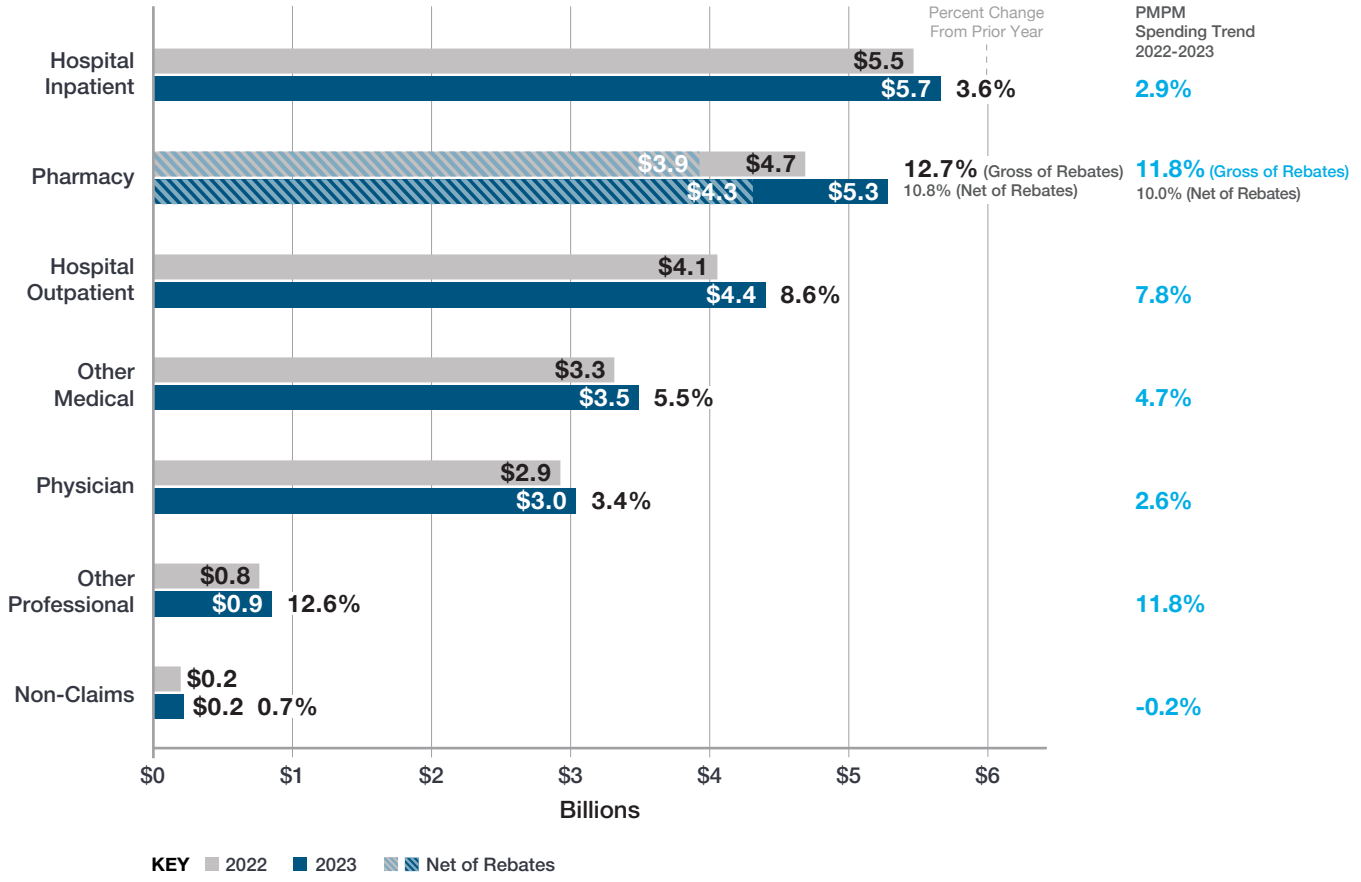
Pharmacy spending gross of rebates was the fastest-growing Medicare claims-based service category in 2023, experiencing double-digit PMPM growth rates for the first time. Net of rebates, pharmacy spending grew 10.8% overall and 10.0% PMPM from 2022 to 2023. Gross of rebates, Medicare pharmacy spending increased 12.7%, or 11.8% PMPM. Growth in pharmacy spending was the largest contributor to overall Medicare spending increases, representing 31.4% ($422 million) on a net basis and 39.1% ($594 million) on a gross basis.

Hospital inpatient continued to be the largest service category for Medicare in 2023, totaling $5.7 billion in spending. Hospital inpatient spending in 2023 grew 3.6% overall and 2.9% PMPM. Hospital inpatient spending accounted for 24.7% of total Medicare spending in 2023.

Hospital outpatient expenditures continued to grow in 2023, increasing by 8.6% overall and 7.8% PMPM. This $349 million increase in outpatient spending accounted for 23.0% of total Medicare spending growth in 2023. This growth outpaced the trend seen nationally, as Original Medicare hospital outpatient expenditures only increased 2.1% from 2022 to 2023.

Other professional spending increased 12.6% overall and 11.8% PMPM in 2023. This mirrors the growth rate seen nationally, as national Original Medicare showed a 16.8% increase in overall other professional spending.

Medicare Spending by Service Category, 2022-2023



Increases in spending for pharmacy and hospital outpatient services accounted for more than half of total Medicare spending growth in 2023.

Source: Payer-reported data to CHIA and other public sources.

Notes: Percent changes are calculated based on non-rounded expenditure amounts. Net pharmacy spending growth can outpace gross pharmacy spending growth if increases in rebates do not keep pace with increases in gross pharmacy spending. See databook for detailed information.

Total Health Care Expenditures

MassHealth spending totaled $22.2 billion in 2023, representing 28.5% of THCE. Amid policy changes impacting enrollment during 2023—MassHealth resumed eligibility determinations and, separately, reprocured ACOs—overall MassHealth membership increased 4.4%. In 2023, MassHealth also introduced the Primary Care Sub-Capitation Program, which provides fixed PMPM payments for certain primary care services to participating MassHealth ACOs.[15]

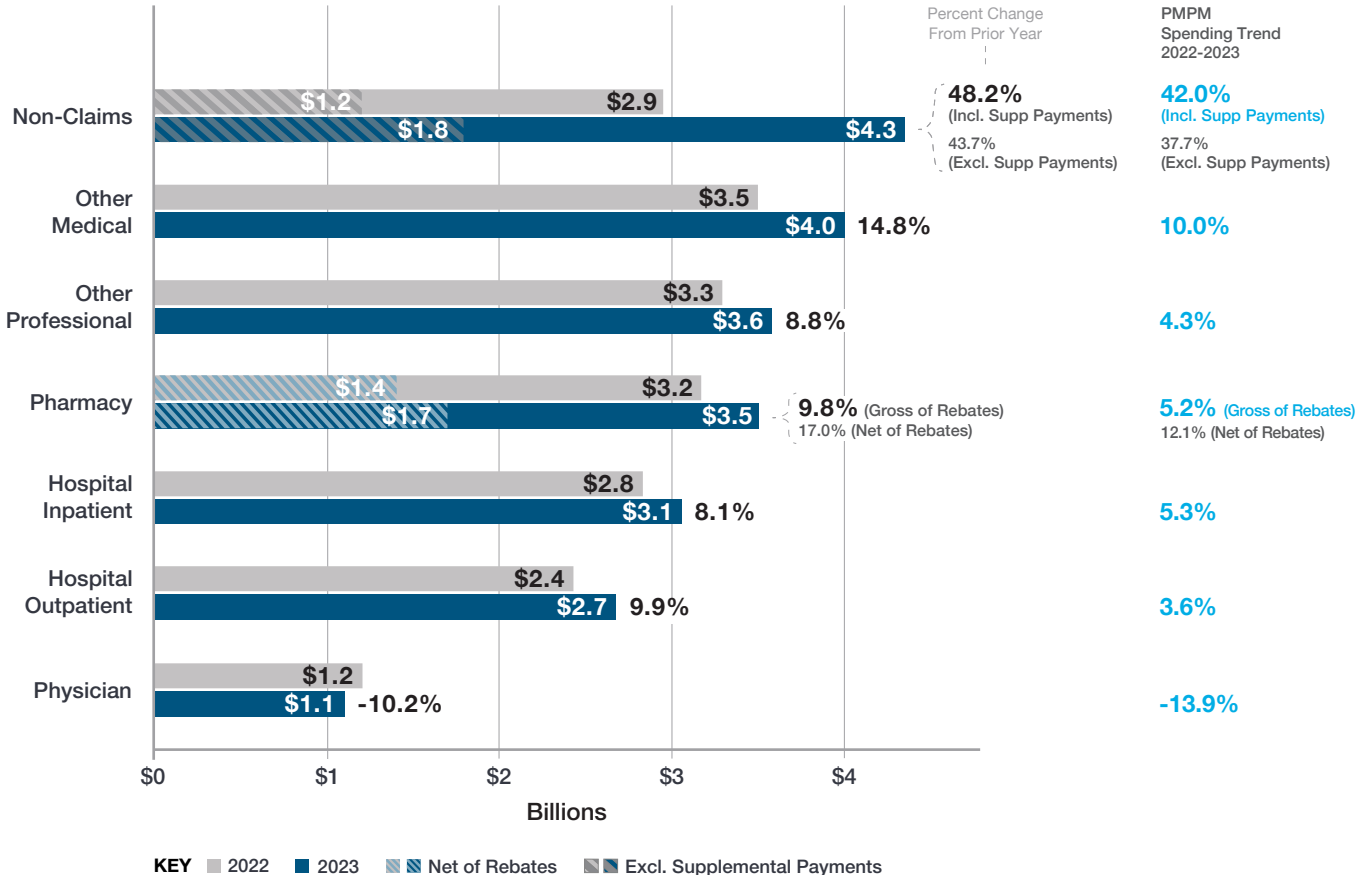
Non-claims spending surpassed other medical services to make up the largest portion of MassHealth spending in 2023. Overall non-claims spending increased 48.2% (42.0% PMPM) and experienced the fastest growth rate of all service categories. A large portion of this increase was due to new hospital-based supplemental payments funded by an updated hospital assessment and federal matching dollars and the move to Primary Care Sub-Capitation in 2023. The Primary Care Sub-Capitation program shifted payments from claims spending to non-claims and prompted significant growth in MCO/ACO-A non-claims spending (490.4%) in 2023.

With the beginning of the Primary Care Sub-Capitation Program, more primary care providers were paid through non-claims payments, instead of claims-based payments. As a result, physician spending declined 10.2% overall and 13.9% PMPM from 2022 to 2023.

From 2022 to 2023, growth in MassHealth pharmacy spending net of rebates outpaced the growth in gross pharmacy spending. MassHealth stated that net spending grew faster than gross spending as the increase in price and utilization of high-cost drugs outpaced the amount achieved in rebates.

Other medical expenditures, which include long term care and home health services, increased by 14.8% overall and 10.0% PMPM.

MassHealth Spending by Service Category, 2022-2023



New hospital supplemental payments drove increases in non-claims spending; the new Primary Care Sub-Capitation Program also prompted a shift of spending from physician claims to non-claims.

Source: Payer-reported data to CHIA and other public sources.

Notes: Percent changes are calculated based on non-rounded expenditure amounts. From 2020 through 2022, MassHealth provided COVID-19 relief funding to providers. Enhanced payment rates were distributed to hospitals, certain health care facilities (e.g., skilled nursing facilities), physicians, and other professionals through claims payments and are reflected in the relevant spending categories reported here. Supplemental payments are reflected in the non-claims service category. See databook for detailed information.

Total Health Care Expenditures

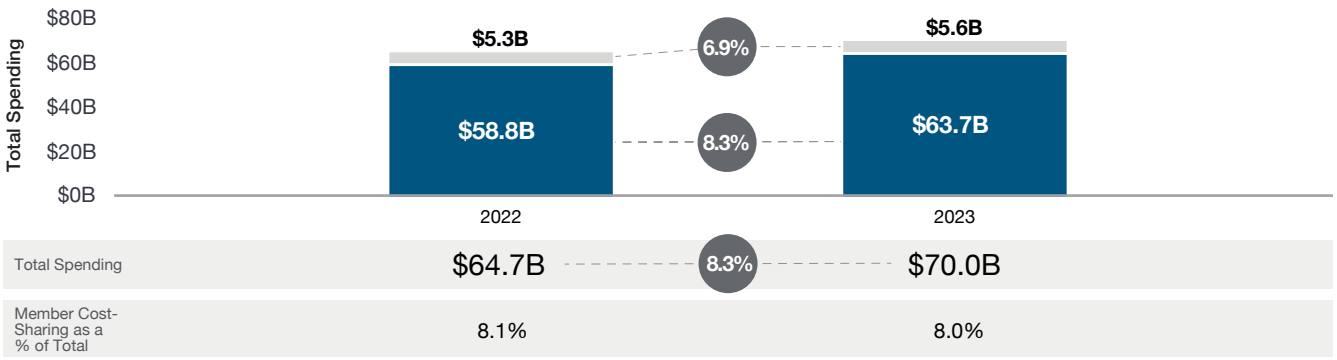
Commercial, MassHealth, and Medicare total health care expenditures reflect spending by both Massachusetts residents and their health plans. When accessing health care services, members often pay copayments, coinsurance, or deductibles—collectively known as member cost-sharing—in addition to the amount paid by their health plan. From 2022 to 2023, payments made by health plans for health care services grew 8.3% while the payments made by Massachusetts residents increased 6.9%, from $5.3 billion to $5.6 billion. Member cost-sharing as a proportion of total commercial, MassHealth, and Medicare spending remained relatively steady at 8.1% in 2022 and 8.0% in 2023.

In the commercial market, growth in total member cost-sharing outpaced that of payer-paid claims in 2023. Total payer-paid spending increased 7.1% while member cost-sharing increased by 8.3%, equating to an additional $234.1 million in member-paid spending. The share of total commercial spending attributable to member cost-sharing remained relatively stable (+0.1 percentage point); however, commercial members also faced increasing premiums from 2022 to 2023. For more information on affordability, see page 36.

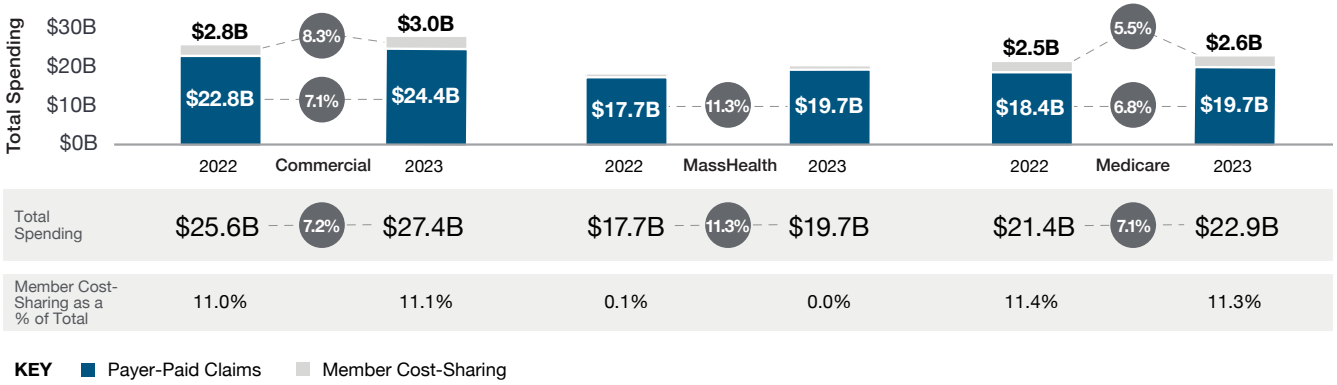
Medicare member cost-sharing increased by 5.5% from 2022 to 2023, accounting for 11.3% of total Medicare spending and resulting in an additional $135.2 million in member-paid spending. For Medicare Advantage alone, however, the proportion of spending attributable to member cost-sharing was slightly lower; approximately 8.6% of total Medicare Advantage spending was attributable to member cost-sharing compared with 12.1% of Original Medicare spending (data not shown).

MassHealth members have little to no cost-sharing, totaling $8.6 million or 0.04% of total MassHealth spending in 2023.

Member Cost-Sharing for Massachusetts Residents, 2022-2023



Member Cost-Sharing by THCE Component, 2022-2023



Commercial member cost-sharing increased faster than payer-paid claims, with the increase contributing $234 million to THCE growth.

Source: Payer-reported data to CHIA and other public sources.

Notes: To capture member cost-sharing for commercial partial population, CHIA applied commercial full member cost-sharing percentage to adjusted (or "grossed-up") THCE commercial partial total expenses, by payer. Commercial member cost-sharing presented in this chapter may not match values in affordability chapter due to differences in sourcing and adjustment methodologies. For more information on adjustment process, see commercial partial gross-up revised methodology. This analysis does not include MassHealth supplemental payments in total spending.

Total Health Care Expenditures

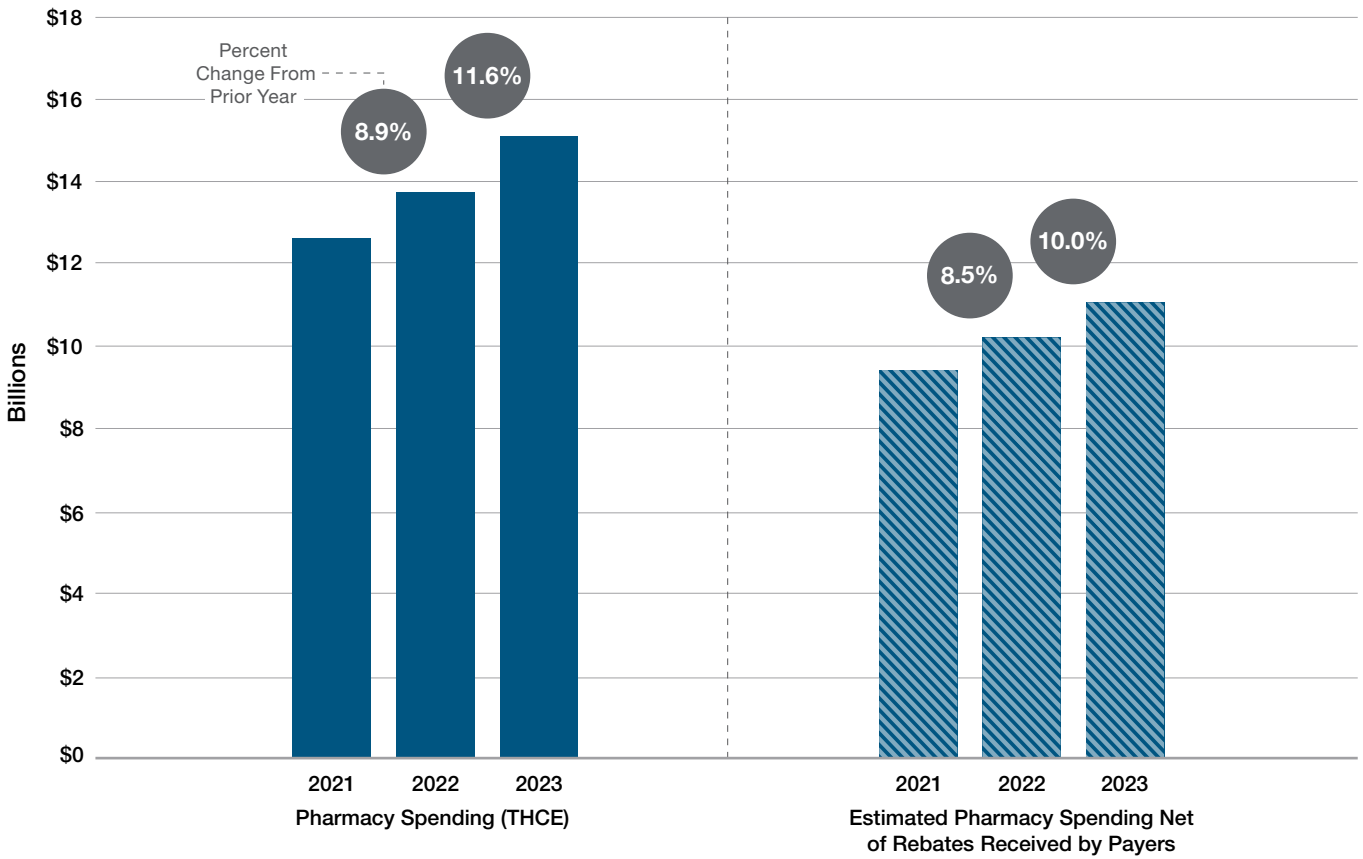
THCE reflects gross prescription drug expenditures, which represent payer payments to pharmacies along with member cost-sharing. Both public and private payers, commonly through pharmacy benefit managers (PBMs), negotiate with drug manufacturers to receive rebates based in part on their members' prescription drug utilization. Additionally, federal law dictates minimum requirements for rebates to state Medicaid programs and allows private payers that offer Medicaid plans to negotiate supplemental rebates as well. These rebates reduce payer total expenses for prescription drugs.

In 2023, gross prescription drug expenditures totaled $15.2 billion, an 11.6% increase from $13.6 billion in 2022 and a 21.6% cumulative increase from 2021. Net of rebates, pharmacy spending grew to $11.2 billion in 2023, up 10.0% from $10.2 billion in 2022 and a 19.3% cumulative increase from 2021. Prescription drug rebates are estimated to have grown over the past 3 years, from $3.1 billion in 2021 to $4.0 billion in 2023.

MassHealth maximizes rebates to reduce net prescription drug costs by negotiating directly with drug manufacturers for supplemental rebates and through its Unified Pharmacy Product List (UPPL), which designates preferred products with the lowest net costs. In 2023, MassHealth reported the highest rebate percentage of all plans (52.1%), a decrease from 2022 (55.1%). MassHealth stated that net spending grew faster than gross spending, driven by increases in price and utilization of high-cost drugs, outpacing the rebates paid back to MassHealth.

For more information on prescription drug trends, see CHIA's report on Commercial Prescription Drug Use & Spending.

Estimated Impact of Rebates on Pharmacy Spending and Growth, 2021-2023



Across all payer types, prescription drug rebates increased from $3.1 billion in 2021 to $4.0 billion in 2023.

Source: Payer-reported data to CHIA.

Notes: Total pharmacy payments reported by payers in THCE may include prescription drug price concessions or discounts transmitted at point of sale, including coverage gap discounts. Pharmacy spending net of rebates estimates impact of reducing total pharmacy costs to payers by retrospective rebates, in addition to any price discounts included in THCE. See technical appendix for more information.

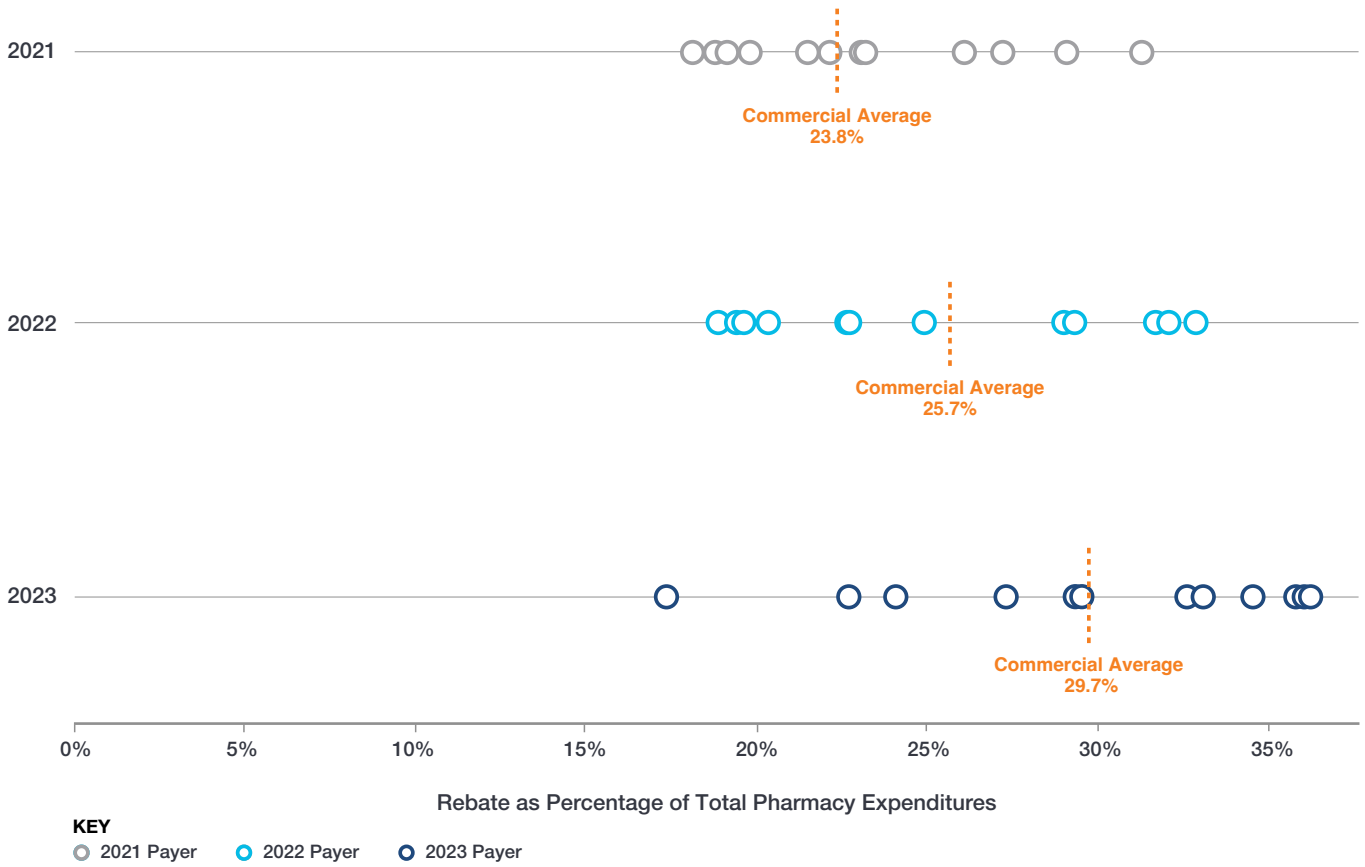
Total Health Care Expenditures

On average, commercial payers received 29.7% of pharmacy spending back from manufacturers, often via PBMs, in the form of rebates in 2023, a 4.0 percentage point increase from 2022. From 2022 to 2023, 2 payers had a decrease in rebate percentage, 7 payers had a slight increase, and 3 payers had an increase of 10 percentage points or more.

The growing variation in payer-reported rebate proportions may be driven by several factors, including member demographics, utilization trends, coverage decisions, and market power. In addition, variation may be driven by the complexity and variability of payer-PBM contracts. For some individual payers, increases in their rebate proportion were due to changing PBMs.

In 2023, 2 payers reported rebate proportions within 2 percentage points of the average commercial rebate proportion compared with 1 payer in 2022 and 4 payers in 2021. The range of commercial rebate proportions has increased from 14 percentage points in 2022 to nearly 19 percentage points in 2023.

Rebate Percentage of Commercial Pharmacy Expenditures, 2021-2023



Across the commercial market in 2023, 29.7% of pharmacy expenditures were returned to payers in the form of rebates on average.

Source: Payer-reported data to CHIA.

Notes: Overall rebate percentages determined by comparing reported rebate amounts from all commercial payers to reported pharmacy expenditures in Total Medical Expenditures by commercial payers. See technical appendix for more information.

Total Health Care Expenditures Notes

1. Detailed methodology and data sources for THCE are available in the technical appendix.
2. Pursuant to M.G.L. c. 6D, Section 9, the benchmark for 2023 and beyond will be established by law at a default rate of potential gross state product (PGSP). Detailed information available at https://masshpc.gov/cost-containment/benchmark.
3. Public data sourced from the U.S. Bureau of Economic Analysis and the U.S. Bureau of Labor Statistics.
4. U.S. Bureau of Economic Analysis and Federal Reserve Bank of St. Louis, "Total Wages and Salaries in Massachusetts [MAWTOT]," accessed January 21, 2025, https://fred.stlouisfed.org/series/MAWTOT.
5. Additional information on the Hospital Assessment Updates proposed for the FY 2023 budget can be found at https://www.mass.gov/doc/hospital-assessment-fy23-fact-sheet/download. For more information on the regulatory authority, see https://www.mass.gov/regulations/101-CMR-51400-hospital-assessment-0.
6. National health care spending was measured by the Centers for Medicare & Medicaid Services' (CMS) National Health Care Expenditure Accounts.
7. Center for Health Information and Analysis, "Enrollment in Health Insurance," accessed January 9, 2025, https://www.chiamass.gov/enrollment-in-health-insurance.
8. Tricia Neuman, Meredith Freed, and Jeannie Fuglesten Biniek, "10 Reasons Why Medicare Advantage Enrollment is Growing and Why It Matters," *Kaiser Family Foundation*, January 30, 2024, https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/.
9. National trends in Medicare spending are estimated based on data reported to CHIA by CMS.
10. MassHealth enrollment peaked in June 2023 and then started to decline. For additional insight on MassHealth redeterminations, see the MassHealth Redeterminations Dashboard at https://www.mass.gov/info-details/masshealth-redetermination-dashboard.
11. For more information on MassHealth Quality and Incentive programs, visit https://www.mass.gov/masshealth-quality-and-equity-incentive-programs.
12. For more information on the PACT Act, visit https://www.va.gov/files/2022-12/PACT-Act-Understanding-Health-Care-and-Benefits.pdf.
13. U.S. Department of Veterans Affairs, "National Center for Veterans Analysis and Statistics: Fiscal Year 2023," accessed January 9, 2025, https://www.va.gov/vetdata/expenditures.asp.
14. For more information on Health Safety Net, visit https://www.mass.gov/orgs/health-safety-net.
15. For more information on the MassHealth Primary Care Sub-Capitation program, visit https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview.

KEY FINDINGS

Access & Affordability

Between 2021 and 2023, growth in member cost-sharing PMPM (12.9%) and fully insured premiums PMPM (12.1%) outpaced the growth in Massachusetts wages and salaries (9.7%).

Within the commercial insurance market, fully insured premiums continued to increase across all sectors in 2023. Premiums for unsubsidized individual purchasers grew the fastest at 7.3% to $561 PMPM.

Among employer groups, small and mid-size group employers and employees faced heightened cost pressures. Member cost-sharing was highest for small and mid-size employer groups ($107 PMPM and $86 PMPM, respectively) and increased by more than 10% in 2023, driven by higher enrollment in HDHPs.

While affordability issues remained pervasive for many Massachusetts residents and their families (41.3%), the burden was greater for certain populations. In 2023, 48.7% of non-Hispanic Black residents and 58.2% of Hispanic residents reported any affordability issue in the past 12 months.

Access & Affordability

Although Massachusetts boasts near universal health care coverage statewide, residents face growing health care affordability concerns due to rising health care costs, including multiyear increases in premiums, copayments, coinsurance, and deductibles.

Between 2021 and 2023, health insurance costs grew faster than both wage and salary costs and regional inflation. Simultaneous increases in spending for other household essentials, such as housing, food, and childcare, further exemplify how the rising cost of health care can pose a significant challenge to Massachusetts residents and their families. Moreover, the burden of increased health care costs impacts both employers and employees, especially among small and mid-size employers, who have more limited plan offerings than their larger counterparts. In combination, these factors can result in disparate financial burdens on specific demographic populations, particularly for certain racial and ethnic groups and those in poor health.

To present a more complete picture of health care spending and corresponding challenges from the consumer perspective, this chapter combines data on member insurance coverage and costs with survey responses from individuals, families, and employers about their experiences offering, financing, and accessing health care. Metrics presented in this chapter represent some, but not all, of the financial impact of health care costs on Massachusetts residents and employers.

Data Sources and Methodology

A. Private Commercial Health Insurance Data

CHIA collects and analyzes data on enrollment, member cost-sharing, and the cost of coverage for Massachusetts private commercial health insurance.[1] Payers submit data by market sector, product type (HMO, PPO, POS), funding type (fully or self-insured), and benefit design type (HDHP, tiered network, limited network). Unless otherwise noted, data citing “payer-reported data to CHIA” in this chapter

highlights membership and cost trends for members covered under private commercial contracts established in Massachusetts (which may include non-Massachusetts residents) and include both fully and self-insured members.[2] This is the same population included in CHIA's reporting on payer use of funds in the Commercial Payer Trends chapter.

A.1 Member Cost-Sharing

Member cost-sharing encompasses all medical expenses allowed under a member's plan but not paid for by a payer, employer, or state cost-sharing reduction (CSR) subsidy and includes costs like deductibles, copayments, and coinsurance. Copayments and coinsurance are based on service utilization, while deductibles and out-of-pocket maximums are set at enrollment before actual claims experiences. Figures in this chapter include members who incurred few to no medical costs as well as those who may have experienced substantial medical costs. They do not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines or vision and dental care that may be covered by a standalone policy). Member cost-sharing also does not account for employer offsets, such as employer contributions to health reimbursement arrangements (HRAs) or health savings accounts (HSAs).

A.2 Premiums

Private commercial insurance is administered on either a fully insured or self-insured contract basis, with employers facing different sets of costs for each funding method.

- The cost for providing fully insured coverage is measured by the monthly premium, in exchange for which the payer assumes all financial risk associated with members' eligible medical expenses during the contract period.
- For self-insured coverage, the employer retains the financial risk for medical claims costs while contracting with a payer or third-party administrator to design and administer health plans for its employees and their dependents.

CHIA only collects premiums data for private commercial members who are fully insured, which represents 37.6 percent of private commercial membership in 2023. For fully insured coverage, CHIA reports the full premium amount collected by health plans inclusive of member contributions, employer contributions (for employer plans), and federal and state premium credits and subsidies (for plans sold to individual purchasers). Fully insured premiums are reported net of Medical Loss Ratio (MLR) rebates (for more information, see page 72). In 2024, the most recent year for which survey data was available, Massachusetts employees contributed 24 percent to 27 percent, on average, to their premium coverage costs.[3]

Reported premiums reflect a range of enrollment and plan design decisions by members and employers, including changing plans during open enrollment to mitigate anticipated premium increases.

A.3 Enrollment

Private commercial health insurance enrollment data reflects members covered under private commercial contracts established in Massachusetts, accounting for approximately 4.2 million contract lives in 2023.

While the majority of private commercial members are covered under employer-sponsored insurance (ESI), some individuals purchase plans for themselves and their families via the Health Connector, through intermediaries, or directly from insurers. In this report, these members are referred to as "individual purchasers." Depending on income and other eligibility factors, qualifying Massachusetts residents may purchase ConnectorCare plans that include state CSR subsidies and premium subsidies, as well as federal Advance Premium Tax Credits (APTCs). Other members who earn too much to qualify for ConnectorCare plans may still receive APTCs based on federal affordability standards; they are identified as "APTC-only members" and are grouped under "unsubsidized individual purchasers" throughout this report unless otherwise noted.

Chapter results do not include data for student health plans offered by colleges and universities, unless otherwise noted. The **dataset** that accompanies this report contains more information on these populations as well as expanded enrollment and financial data for the private commercial market.

B. Massachusetts Health Insurance Survey Data

The Massachusetts Health Insurance Survey (MHIS) is a biennial, statewide, population-based survey of noninstitutionalized Massachusetts residents. It is designed to track and monitor health insurance coverage, health care access and use, and health care affordability for Massachusetts residents and their families.

The MHIS examines health care affordability by asking residents about any difficulties paying family medical bills in the past 12 months, any medical debt held by themselves or family members in the household, the amount and share of family income spent on out-of-pocket health care costs in the past 12 months, and whether the resident or their family chose to forgo health care that the resident felt was needed in the past 12 months due to the cost of that care. In the MHIS, out-of-pocket health care costs include direct spending by residents and their families on deductibles, copays, and coinsurance for benefits covered by their health insurance as well as their spending on medical, dental, and vision services not covered by insurance. Residents

were also asked to include out-of-pocket costs owed for care received over the past 12 months that had not yet been paid. The MHIS does not include premiums for health insurance in the out-of-pocket calculation. In addition, the survey asks private commercially insured residents whether their insurance plan is a high-deductible health plan (HDHP), defined by the Internal Revenue Service as having an annual deductible more than $1,500 for single coverage or $3,000 for family coverage in 2023.

Estimates reported in this chapter are from the 2023 MHIS, which was fielded in English and Spanish from April to August 2023 and collected data on 5,266 residents and their families. All estimates provided in this chapter are weighted to provide population-based estimates for the noninstitutionalized resident population of the Commonwealth. Additional information about the design of the MHIS is available in the MHIS methodology report.

C. Massachusetts Employer Survey

The Massachusetts Employer Survey (MES) is a statewide survey conducted biennially that tracks and monitors health insurance offerings, employee take-up rates, health insurance premiums, employer contribution amounts, plan characteristics, and employer decision-making.

Estimates reported in this chapter are from the 2024 MES, which was fielded from April to July 2024. The final survey data included responses from 1,066 firms with establishments located in Massachusetts. Federal, state, and other public employers as well as employers with fewer than 3 employees in the state were excluded. Estimates provided in this chapter are weighted to address differences in sample selection and response rates. Post-stratification by firm size and industry was also implemented. Cost-sharing estimates are weighted by covered employees and do not include dependents. For additional details about the MES results and methodology, refer to the 2024 MES report. ■

Access & Affordability

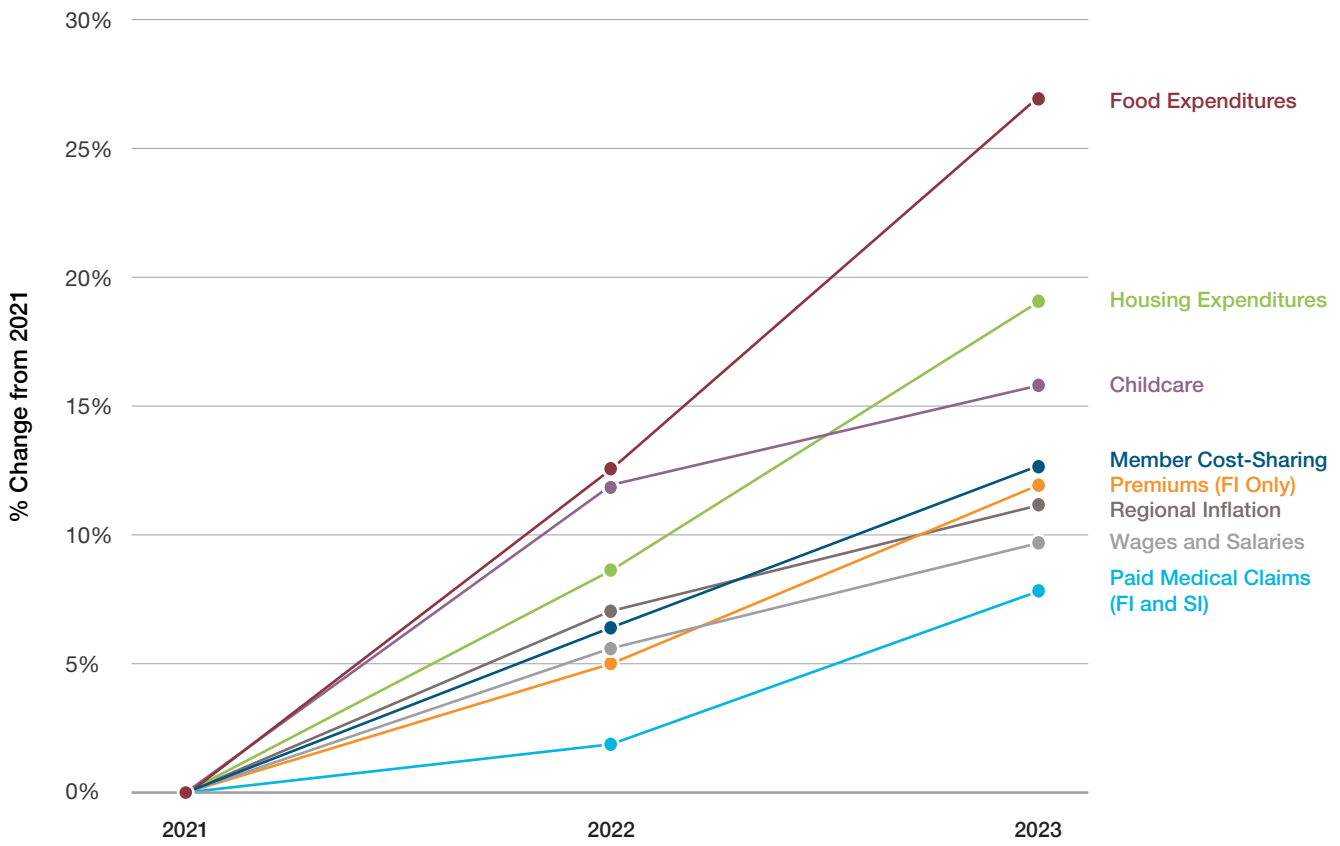
Health care is just one of many necessary expenses for Massachusetts residents. Growth in other spending categories such as housing, food, and childcare can strain household budgets, impacting individuals' and families' ability to afford health care. Affordability issues can also be exacerbated by broader economic pressures, from overall price inflation to trends in wages and salaries. Health care cost trends should be assessed in the context of these circumstances.

Between 2021 and 2023, commercial members' health care cost-sharing (12.9%) and insurance premiums (12.1%) grew faster than the portion of medical claims covered by payers and self-insured (SI) employers (8.1%). This trend in commercial health care cost-sharing growth outpacing payer-paid medical claims was consistent for both members with health plans issued in Massachusetts (shown here) and Massachusetts residents (see page 32).

Among spending for other household needs, average expenditures for food in New England increased the fastest, growing 26.8% between 2021 and 2023, followed by average housing expenditures in New England (19.0%) and average cost of center-based childcare in Massachusetts (15.8%). At the same time, regional inflation increased 11.1% between 2021 and 2023.

Other than medical claims, the costs for all measures included in this analysis increased faster than the total wages and salaries of Massachusetts employees, which grew by 9.7% between 2021 and 2023.

Affordability in Context, 2021-2023



Member spending on monthly premiums, member cost-sharing, and household needs (like food and housing) all increased faster than wages and salaries from 2021 to 2023, illustrating pervasive affordability issues in Massachusetts.

Source: Payer-reported data to CHIA, Federal Reserve Economic Data (FRED), Bureau of Labor Statistics, Child Care Aware of America.

Notes: Based on Massachusetts contract-membership, which may include non-Massachusetts residents. Claims amounts adjusted for pharmacy rebates reported by payers. Trends in member cost-sharing, premiums, and paid medical claims are calculated based on underlying per member per month metrics. These metrics are not scaled to account for benefit carve-outs, which may vary by plan. Fallon fell below membership threshold for reporting and did not submit data for CY 2022 or CY 2023. Data for Fallon included in CY 2021. Measures presented on this page reflect New England regional estimates unless otherwise noted. See technical appendix.

Access & Affordability

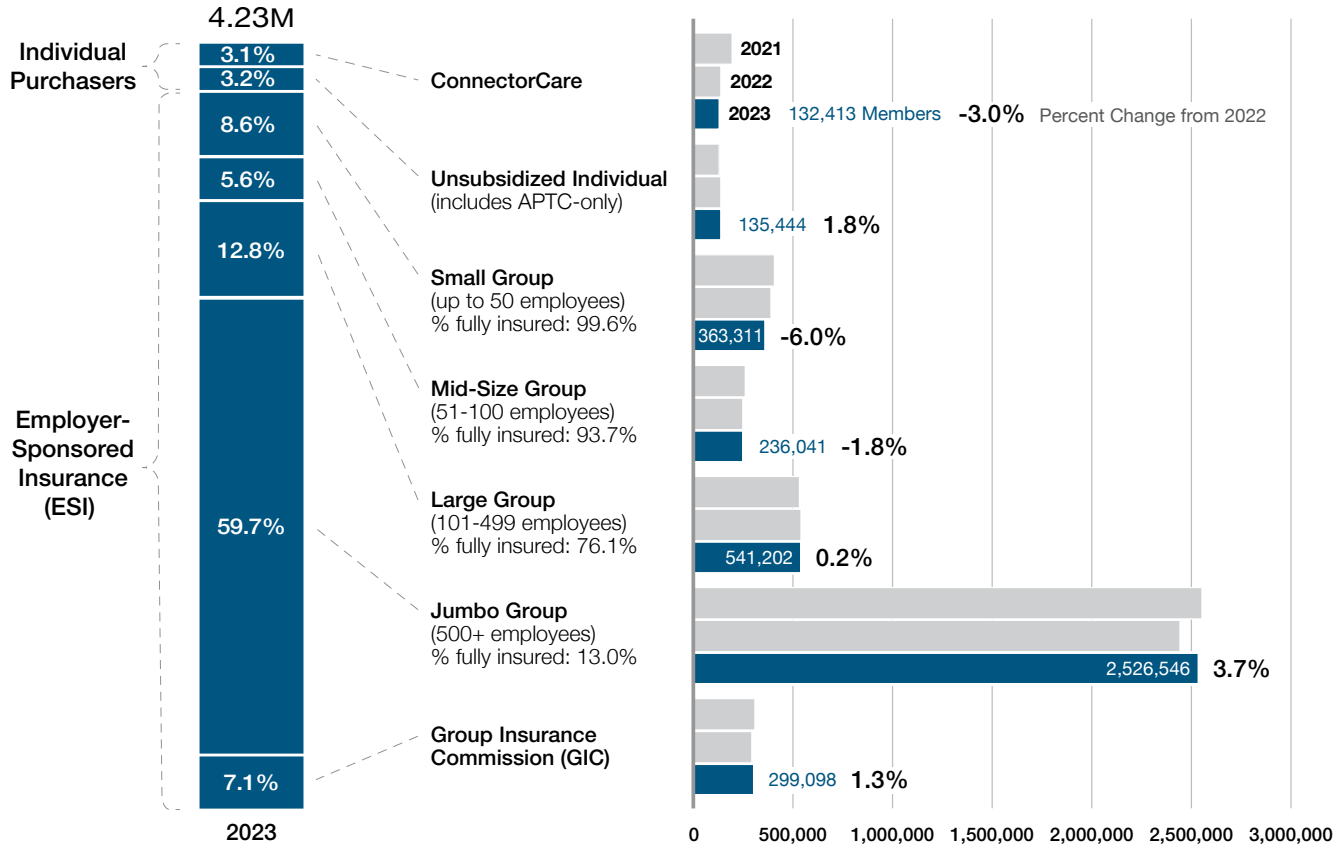
Members' health care costs and access are often influenced by the health insurance enrollment choices available to them. Enrollment in commercial insurance issued in Massachusetts increased 1.6% in 2023 after declining 4.4% the previous year.[4] Growth was driven by employer-sponsored insurance (ESI) enrollment, which increased 1.8% in 2023.

In 2023, nearly 4 million members were enrolled in ESI coverage. Membership in plans offered by jumbo group employers, which represented 59.7% of the total commercial market, increased by 3.7% from 2022 to 2023. During the same period, enrollment in small group health plans decreased by 6.0%, continuing a trend since 2014.

In 2023, the individual purchaser sector declined in membership, falling 0.6%, after declining 14.9% in 2022.[5] Among individual purchasers, membership in subsidized ConnectorCare plans declined 3.0% in 2023 while unsubsidized individual plan membership increased 1.8%.[6,7]

Between 2020 and 2023, enrollment trends—particularly in ConnectorCare—were impacted by federal coverage requirements for MassHealth. The resumption of MassHealth eligibility redeterminations in April 2023, during which MassHealth began disenrolling ineligible individuals or those with insufficient information, resulted in subsequent enrollment shifts from MassHealth private commercial plans, including ConnectorCare plans. According to MassHealth, of the residents who were determined ineligible for MassHealth coverage and became eligible for a Health Connector plan, approximately one-quarter signed up for a Connector plan.[8] For more information on health insurance enrollment in Massachusetts, including Medicare and MassHealth coverage, see CHIA's Enrollment Trends reporting.

Enrollment by Market Sector, 2021-2023



Overall private commercial enrollment grew 1.6% to more than 4.2 million members in 2023, following a decline in 2022 of 4.4%.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract-membership, which may include non-Massachusetts residents. Annual enrollment reported as average membership within each year, derived by dividing payer-submitted member months by 12. GIC did not offer fully insured coverage. Fallon fell below membership threshold for reporting and did not submit data for CY 2022 or CY 2023. Data for Fallon included in CY 2021. See technical appendix.

Access & Affordability

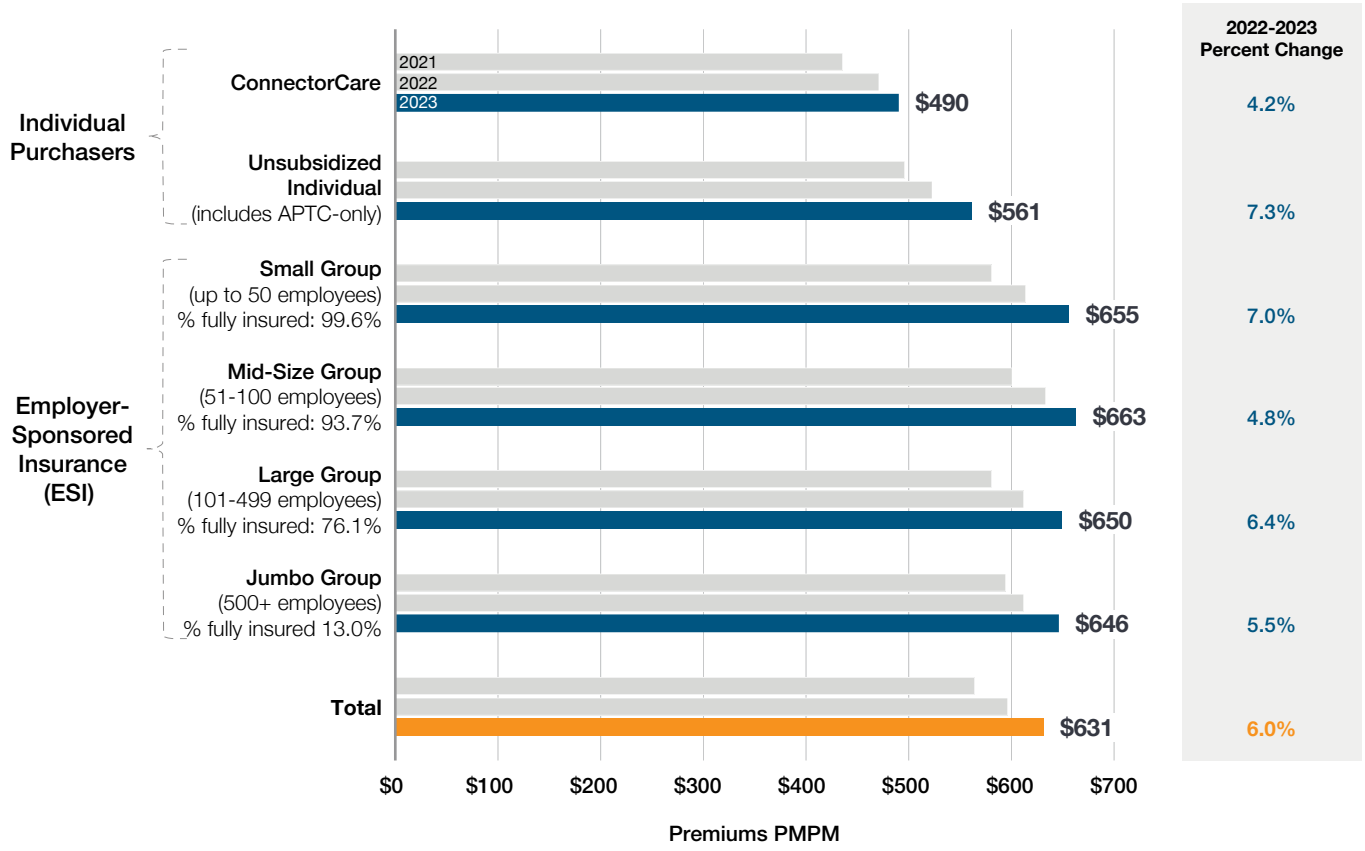
Health insurance premiums fund the majority of commercial health care spending, and are a key expense shouldered by members and—for ESI plans—employers.[9] Between 2022 and 2023, fully insured premiums increased 6.0% to $631 PMPM, following a 5.7% increase the previous year. Since 2014, fully insured premiums have increased 41.9% from $445 PMPM.[10]

Among ESI sectors, the mid-size employer group had the lowest premium growth rate at 4.8% in 2023 while having the highest average premium at $663 PMPM. The small group sector had the highest ESI premium growth rate at 7.0%, and the jumbo group sector had the lowest average ESI premium at $646 PMPM in 2023.

While average ESI premium levels were similar across most employer size categories in 2023 ($646-$663 PMPM), employer survey data suggests that, on average, employees of smaller firms tend to be responsible for paying a larger proportion (24% to 30%) of their total monthly premiums than employees of larger firms (24% to 26%).[11]

On average, individual purchasers enrolled in plans with lower premiums compared with members with employer-sponsored coverage. Premiums will vary due to differences in benefit richness, network, and other factors. Unsubsidized individual purchaser premiums increased 7.3% between 2022 and 2023 to $561 PMPM, the fastest growth across all commercial market sectors including ESI. ConnectorCare base premiums (before subsidies) were the lowest of any market sector in 2023 ($490 PMPM) and increased the slowest at 4.2%. During this period, enhanced state and federal subsidies lowered ConnectorCare members' premium contributions and improved the affordability of health coverage.[12]

Fully Insured Premiums by Market Sector, 2021-2023



Fully insured premiums increased across all market sectors, with overall premiums increasing 6.0% from 2022 to 2023.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract-membership, which may include non-Massachusetts residents. Reported premiums are net of MLR rebates and reflect fully insured premiums only. Premiums not scaled to account for benefit carve-outs, which may vary by plan. Unsubsidized individual purchasers include some members receiving APTCs (which would reduce members' contributions below reported premium amounts). GIC did not offer fully insured coverage. Fallon fell below membership threshold for reporting and did not submit data for CY 2022 or CY 2023. Data for Fallon included in CY 2021. See technical appendix.

Access & Affordability

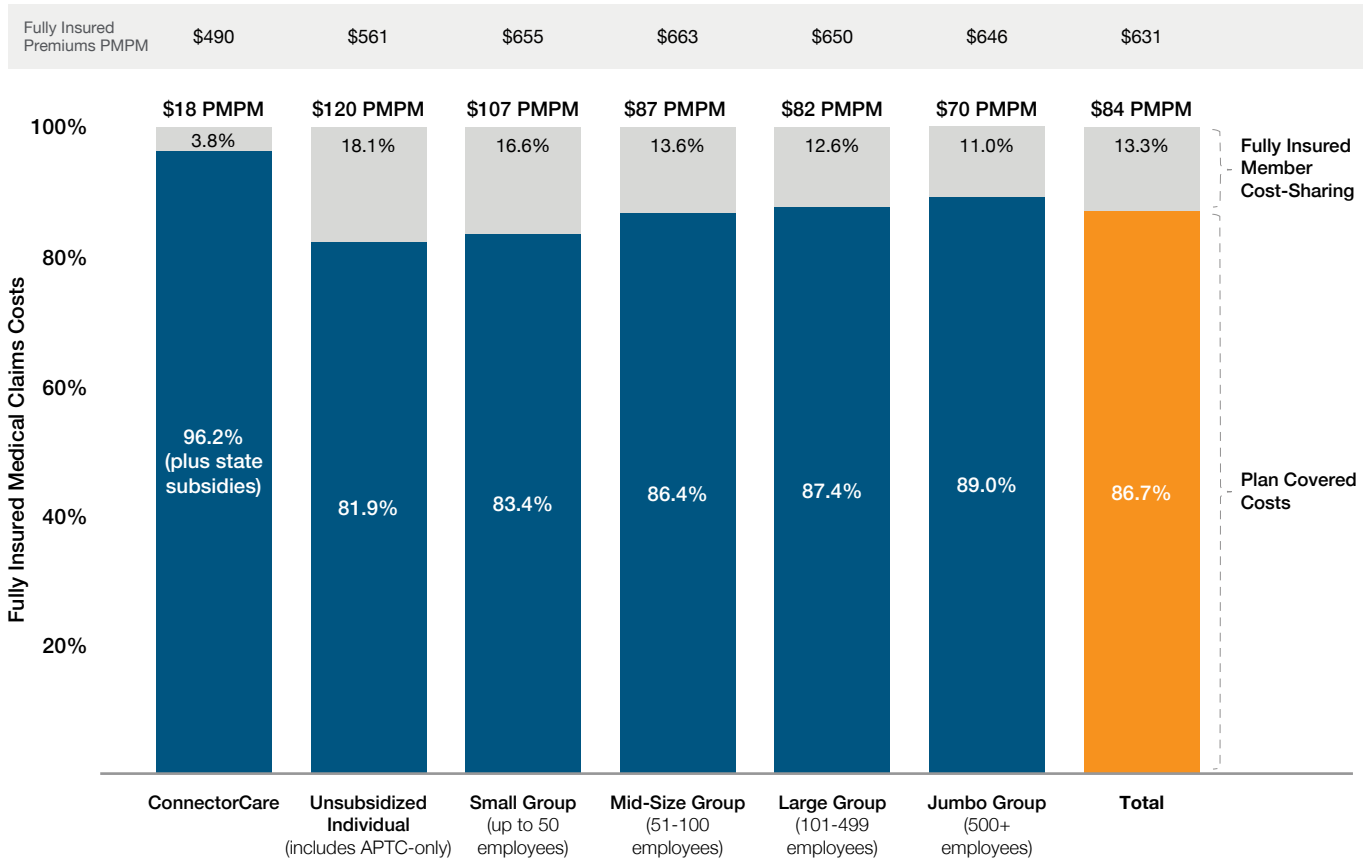
Insurance purchasers (members and/or employers) compare and balance health plan premiums with potential out-of-pocket costs (member cost-sharing). Some may choose plans with lower premiums and higher deductibles, lowering up-front costs but leaving members at risk of high medical bills in the future. Others may prefer higher monthly premiums in exchange for plans that cover a greater percentage of costs when medical services are used. CHIA's "benefit level" metric quantifies the percentage of medical costs covered by fully insured commercial health plans.

In 2023, Massachusetts fully insured health plans paid on average 86.7% of medical and prescription drug costs for benefits included in the member's medical insurance. The average fully insured benefit level decreased from 2021 to 2023, with the total benefit level at 87.9% in 2021 and 87.2% in 2022, a trend consistent across all market sectors except ConnectorCare.

Benefit levels varied across private commercial market sectors. ConnectorCare members had the highest proportion (96.2%) of medical costs covered by their health plans (including state CSR subsidies). With assistance from state subsidies, ConnectorCare members experience lower and more affordable member cost-sharing, resulting in increased benefit level coverage.[13] Members enrolled in smaller employer plans had a smaller proportion of their medical costs covered by their health plans compared with members enrolled in larger employer groups, despite members paying similar or higher monthly premiums.[14]

Benefit levels are one of many factors that influence premiums, which also include provider network size, experience rating, and efficiencies of scale.

Fully Insured Benefit Levels by Market Sector, 2023



Despite paying higher monthly premiums, members enrolled in health plans from small and mid-size employer groups had a smaller share of their medical costs covered by their plans, resulting in higher member cost-sharing.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract-membership, which may include non-Massachusetts residents. Reported premiums are net of MLR rebates and reflect fully insured premiums only. Premiums not scaled to account for benefit carve-outs, which may vary by plan. Claims amounts adjusted for pharmacy rebates reported by payers. Unsubsidized individual purchasers include some members receiving APTCs. Fallon fell below membership threshold for reporting and did not submit data for CY 2022 or CY 2023. Data for Fallon included in CY 2021. See technical appendix.

Access & Affordability

From 2022 to 2023, cost-sharing for Massachusetts commercial contract members increased 5.9% to $68 PMPM, which followed a 6.5% increase the prior year.

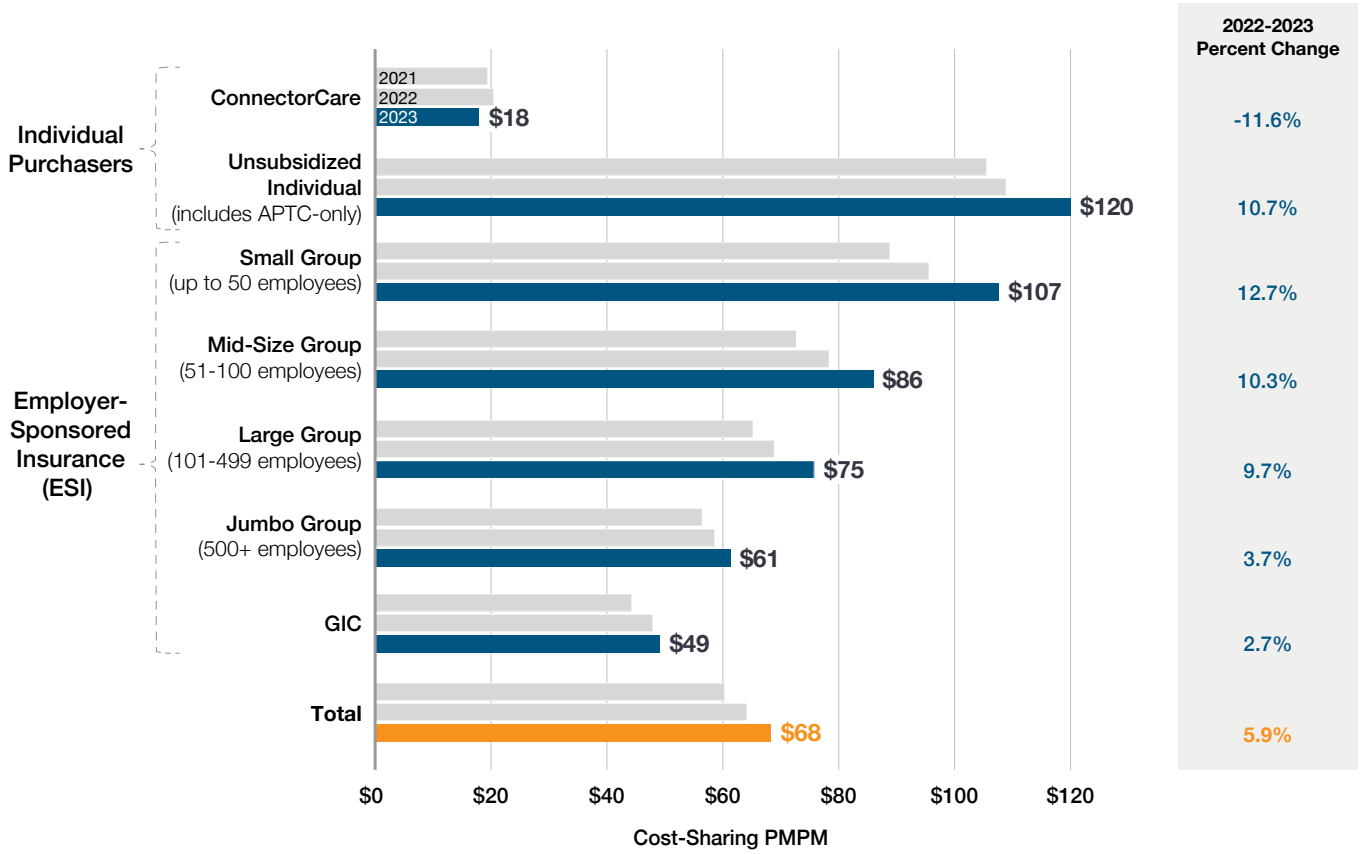
Unsubsidized individual purchasers are individuals who purchase non-ConnectorCare plans from the Massachusetts Health Connector or directly from payers and who often have income levels surpassing eligibility thresholds for state health insurance subsidies.[15] These purchasers have consistently had the highest member cost-sharing of any market sector since CHIA started measuring this population. Unsubsidized member cost-sharing amounts rose to $120 PMPM in 2023, a 10.7% increase from 2022.

Across all market sectors, ConnectorCare was the only sector to experience a decline in cost-sharing, decreasing 11.6% to $18 PMPM in 2023, falling below pre-pandemic levels ($20 PMPM in 2019).[16] During this time, cost-sharing for certain medications related to the management of chronic conditions was eliminated for ConnectorCare plans.[17]

Among employer-sponsored insurance sectors, small and mid-size group market sectors continued to have the highest cost-sharing amounts among all employer group sizes in 2023 at $107 PMPM and $86 PMPM, respectively. Cost-sharing also increased the fastest for members in the small group (12.7%) and mid-size group (10.3%) market sectors. As presented on page 47, smaller group plans had higher rates of HDHP enrollment, contributing to higher member cost-sharing.

The GIC continued to have the lowest member cost-sharing of any ESI group at $49 PMPM in 2023.

Private Commercial Member Cost-Sharing by Market Sector, 2021-2023



From 2022 to 2023, total member cost-sharing PMPM increased by 5.9%, with cost-sharing growing the fastest among unsubsidized individual purchasers and the small group and mid-size group market sectors.

Source: Payer-reported data to CHIA.

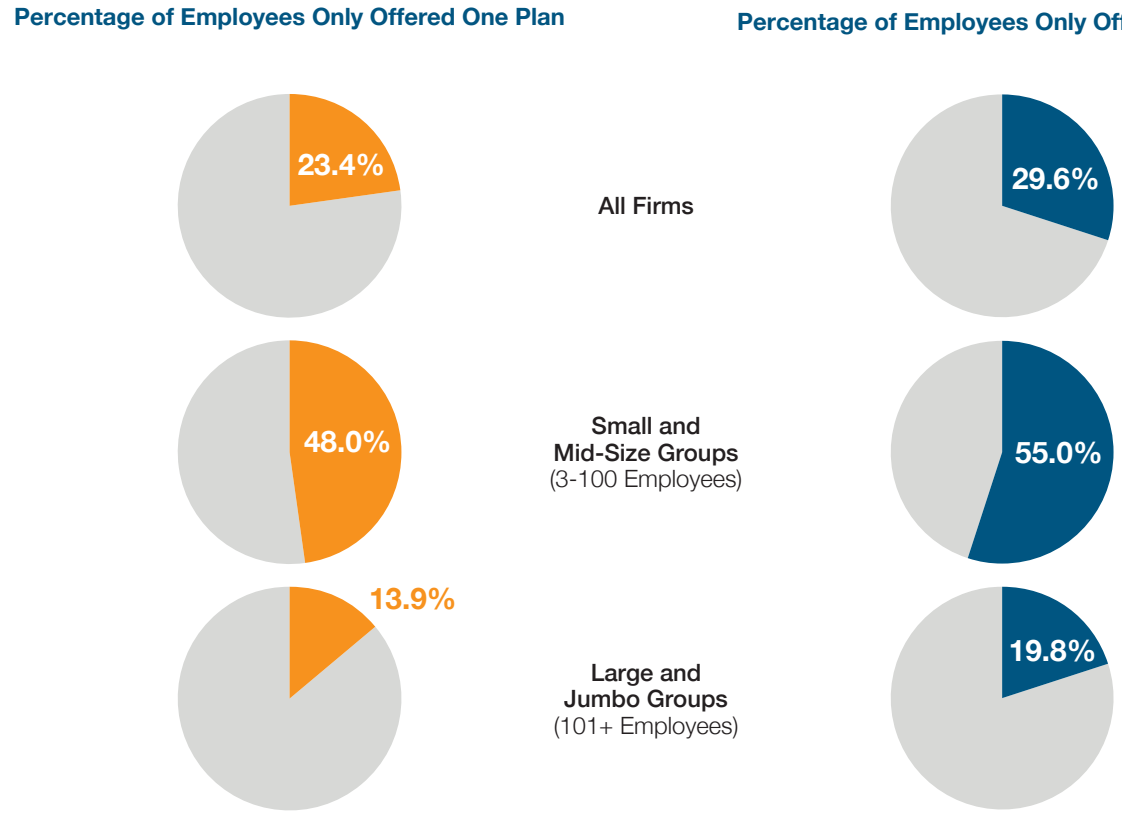
Notes: Based on Massachusetts contract-membership, which may include non-Massachusetts residents, and includes fully and self-insured data. Cost-sharing amounts not scaled to account for benefit carve-outs, which may vary by plan. Claims amounts adjusted for pharmacy rebates reported by payers. Unsubsidized individual purchasers include some members receiving APTCs. Fallon fell below membership threshold for reporting and did not submit data for CY 2022 or CY 2023. Data for Fallon included in CY 2021. See technical appendix.

Access & Affordability

While most Massachusetts employers offer health insurance to their employees, decisions about whether to offer health insurance and which health plans to select have important implications for the health care marketplace, and are primarily driven by cost. Among the 66.8% of employers who chose to offer insurance in 2024, 90.5% reported the cost of the plan as the most important factor for selecting a health insurance carrier or plan (data not shown). For the 33.2% of employers who did not offer insurance, nearly one-third (31.9%) identified high costs as a top reason (data not shown).

The number and types of plans offered to employees vary considerably by employer size, which affects employee plan choice, cost-sharing, and services covered, among other things. Employees at small and mid-size employers have more limited choices compared with their counterparts at larger employers. Nearly half (48.0%) of employees at small and mid-size employers that offered insurance were offered only 1 health plan, and more than half (55.0%) were exclusively offered high-deductible health plans (HDHPs).

Employee Plan Offerings, 2024



Employees at small and mid-size employers have limited plan choice compared with those at larger employers. More than half of employees at small and mid-size employers were only offered HDHPs.

Source: 2024 Massachusetts Employer Survey.

Notes: 2024 IRS deductible thresholds for high-deductible health plans were $1,600 for single coverage and $3,200 for family coverage. 2024 MES collected plan type information for up to five plans offered by firms. Rates adjusted by employee weights. Public employees and firms with fewer than 3 employees not included in this data.

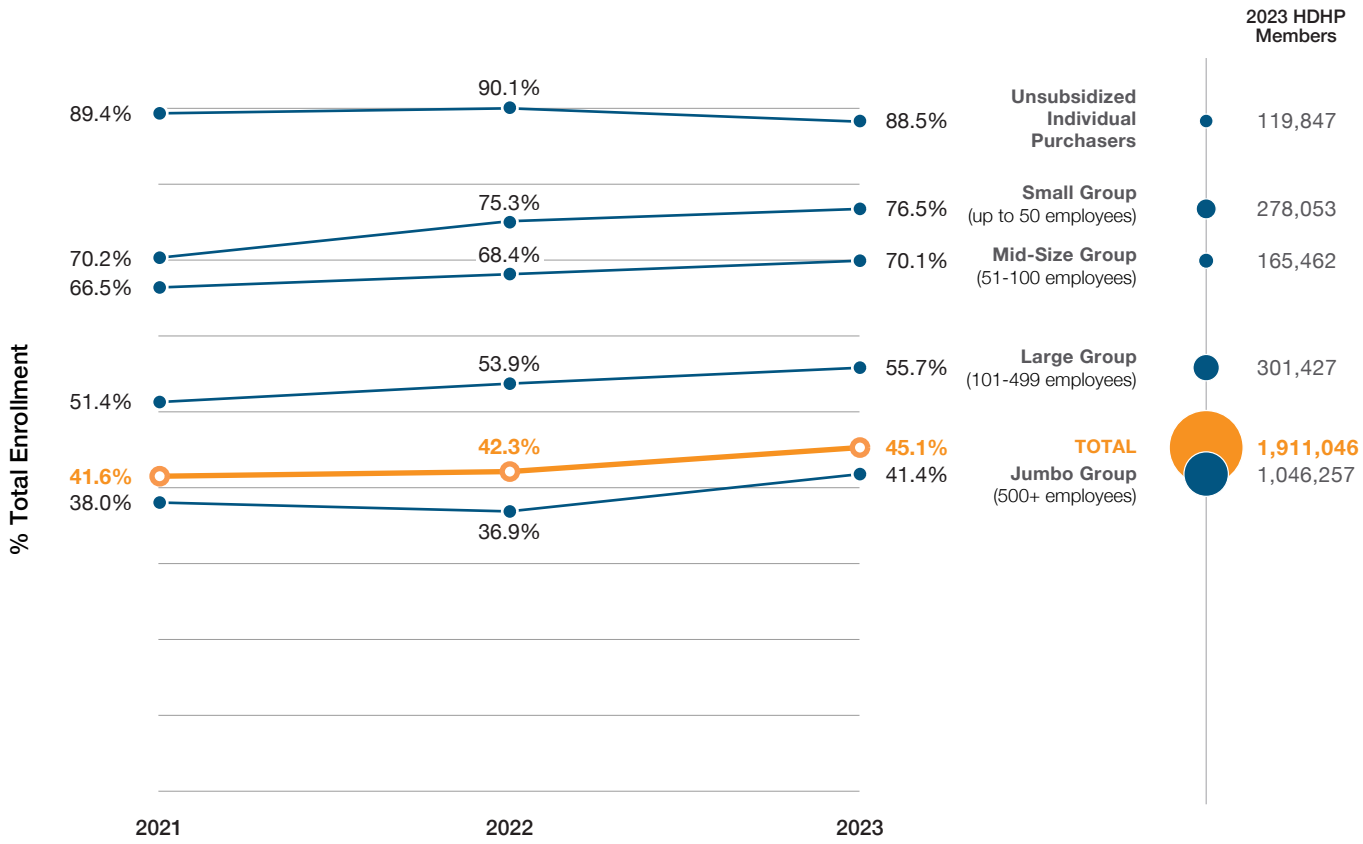
Access & Affordability

In 2023, more than 1.9 million Massachusetts members (45.1%) were enrolled in HDHPs with individual deductible levels of at least $1,500. This continued a long-term growth trend that has increased every year since 2014, when only 19.0% of Massachusetts members were enrolled in an HDHP.[18] In 2023, enrollment in HDHPs increased in almost every market sector where they were offered with the exception of unsubsidized individual purchasers (-1.7 percentage points), and HDHP enrollment grew fastest in the jumbo group sector (4.5 percentage points).

Although the majority of HDHP members in 2023 received coverage through large or jumbo group employers, the proportion of members enrolled in HDHPs tended to increase as group size decreased, with 88.5% of unsubsidized individual purchasers and more than two-thirds of members covered through small and mid-size employers (70.1% and 76.5%, respectively) enrolled in an HDHP. HDHPs were not offered to GIC or ConnectorCare members.

While HDHPs can lower members' monthly premiums, HDHP members face greater out-of-pocket costs. To help offset out-of-pocket costs, employer groups may offer access to tax-deferred Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) options. More than one-third of employer groups that offer health insurance benefits offered HDHPs with an accompanying HSA or HRA option, though larger firms were more likely to offer a savings option than smaller firms.[19]

HDHP Enrollment by Market Sector, 2021-2023



HDHP enrollment increased across all ESI plans in 2023, with jumbo groups experiencing the largest proportional increase (4.5 percentage points) after declining the prior year.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract-membership, which may include non-Massachusetts residents, and includes fully and self-insured data. HDHPs defined by IRS individual plan deductible threshold, which was $1,400 in 2021 and 2022 and $1,500 in 2023. ConnectorCare and GIC trends not shown as these members not offered HDHPs. Unsubsidized individual purchasers include federal APTC-only members who do not qualify for ConnectorCare Plans and state subsidies. Enrollment data for Fallon excluded.

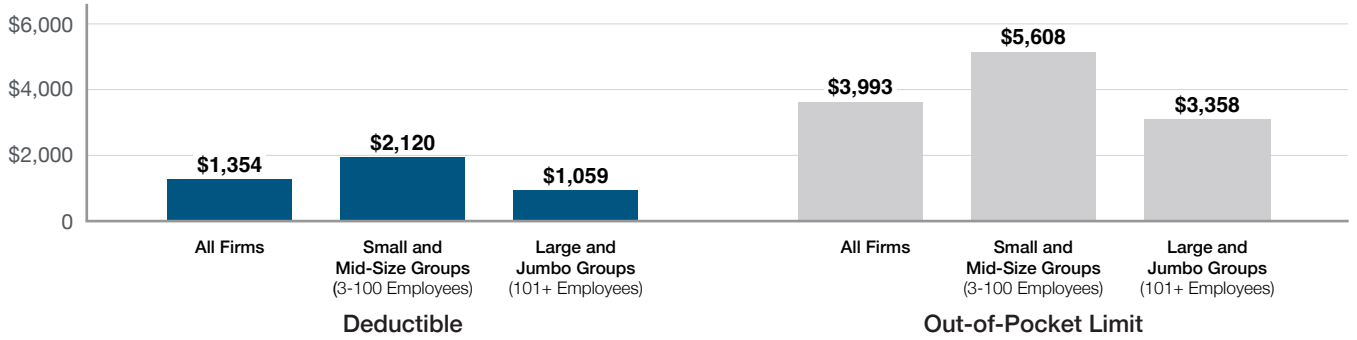
Access & Affordability

At the same time that HDHP enrollment increased, annual deductibles, out-of-pocket limits, and copayments increased, compounding affordability challenges. In 2023, across all private commercial enrollees, 17.4% of members had deductibles of $2,500 or greater, up from 15.8% in 2021 (data not shown). Additionally, 47.2% of members had out-of-pocket limits of $5,000 or greater, relatively consistent with prior years (data not shown).[20]

In 2024, the average annual deductible for single coverage was $1,354 among employers offering plans with deductibles. Average annual deductibles were twice as high at small and mid-size employers relative to large and jumbo employers ($2,120 vs. $1,059). The average out-of-pocket limit for single coverage in Massachusetts was $3,993, but much higher at small and mid-size employers compared with large and jumbo employers ($5,608 vs. $3,358). While copayments for medical services were similar among plans offered by employer size, copayments for emergency department (ED) visits, inpatient admissions, and non-generic prescription drugs were substantially higher at small and mid-size employers than at large and jumbo employers.

Average Annual Deductibles, Out-of-Pocket Limits, and Copayments for Single Coverage, 2024

Average Annual Deductibles and Out-of-Pocket Limits for Single Coverage



Copayments by Firm Size

	All Firms	Small and Mid-Size Groups (3-100 Employees)	Large and Jumbo Groups (101+ Employees)
PCP Office Visit	$24	$26	$23
Mental Health Office Visit	$31	$33	$30
ED Visit	$219	$300	$193
Inpatient Visit	$330	$476	$279
Generic Drug	$12	$13	$12
Non-Preferred Brand Drug	$63	$84	$57
Preferred Brand Drug	$36	$44	$33
Specialty Drug	$97	$121	$87

Deductibles, out-of-pocket limits, and select copayments were higher for employees at small and mid-size employers compared with employees at large and jumbo employers.

Source: 2024 Massachusetts Employer Survey.

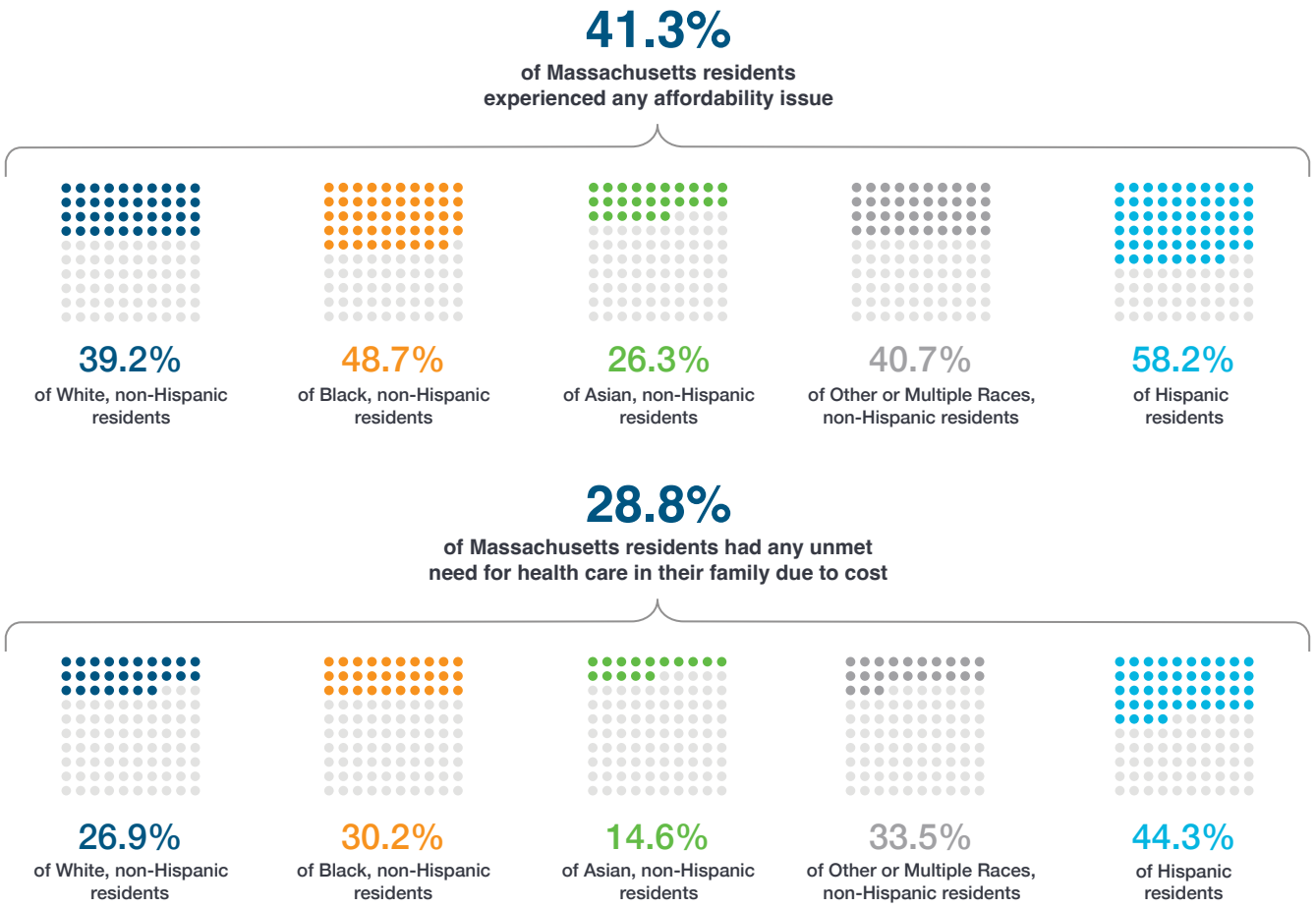
Notes: Cost-sharing amounts shown based on in-network providers for single coverage health plans. Deductibles reported for plans with covered employees enrolled in single coverage plans that include deductibles. Average deductibles and out-of-pocket limits based on weighted average of largest enrolled plan at each firm. Copayment amounts based on weighted average of covered employees in all plans offered at firm (up to 5 plans). Out-of-pocket limit is maximum that enrollee pays for covered services in plan year. After enrollee spends this amount on deductibles, copayments, and coinsurance, health plan pays 100% of costs of covered benefits. $0 copays for inpatient visits excluded from average. Public employees and firms with fewer than 3 employees not included in this data.

Access & Affordability

With the rising costs of health insurance driven by premium and cost-sharing increases in recent years, Massachusetts residents and their families are experiencing a wide range of issues paying for their health care expenses. Families may have difficulties paying family medical bills in full or over time, forgo necessary care due to the cost of that care, or spend a disproportionately high share of their family income on medical expenses. In 2023, 2 in 5 Massachusetts residents (41.3%) reported that their families faced any affordability issue within the past 12 months. Furthermore, the burden of affordability issues was greater for non-Hispanic Black residents (48.7%) and Hispanic residents (58.2%) relative to non-Hispanic White residents (39.2%).

Additionally, nearly one-third (28.8%) of residents or their immediate family members reported that they went without needed care in 2023 due to cost. Hispanic residents were more likely to report any unmet health care need in their family compared with non-Hispanic White residents (44.3% vs. 26.9%).

Affordability Issues Among Massachusetts Residents and Their Families by Race and Ethnicity, 2023



While affordability issues remained pervasive for many Massachusetts residents and their families, the burden was greater for Hispanic residents and non-Hispanic Black residents in 2023.

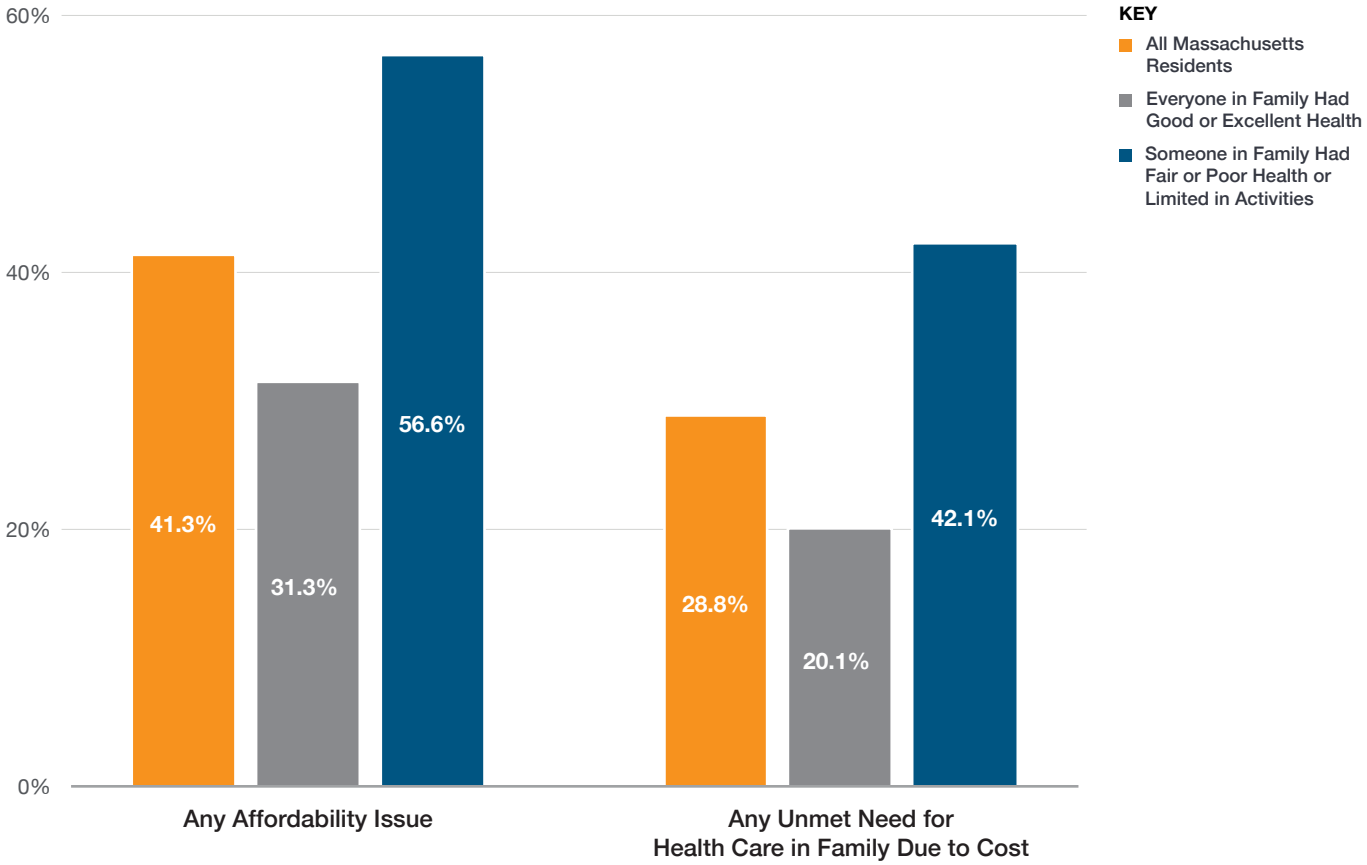
Source: 2023 Massachusetts Health Insurance Survey.

Notes: "Any affordability issue" is defined as reporting any of the following issues: problems paying family medical bills in past 12 months; family medical debt at the time of survey; spending a high share of family income in past 12 months on out-of-pocket health care expenses; and any unmet need in family for health care due to cost in past 12 months. "Any unmet need in family for health care due to cost" includes the following family unmet needs due to cost: doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment.

Access & Affordability

Residents in poorer health are particularly susceptible to affordability issues. In 2023, residents who had someone in their family in fair or poor health or with activity limitations were nearly twice as likely to report any affordability issue in the past 12 months compared with residents whose family members were all in good or excellent health (56.6% vs. 31.3%). Additionally, residents with family members in fair or poor health or with activity limitations were more than twice as likely to forgo necessary care due to cost compared with those in good or excellent health (42.1% vs. 20.1%).

Affordability Issues Among Massachusetts Residents and Their Families by Health Status, 2023



In 2023, residents who had someone in their family in fair or poor health or with activity limitations were about twice as likely to experience any affordability issue and have unmet health care needs due to cost than residents whose family members were all in good or excellent health.

Source: 2023 Massachusetts Health Insurance Survey.

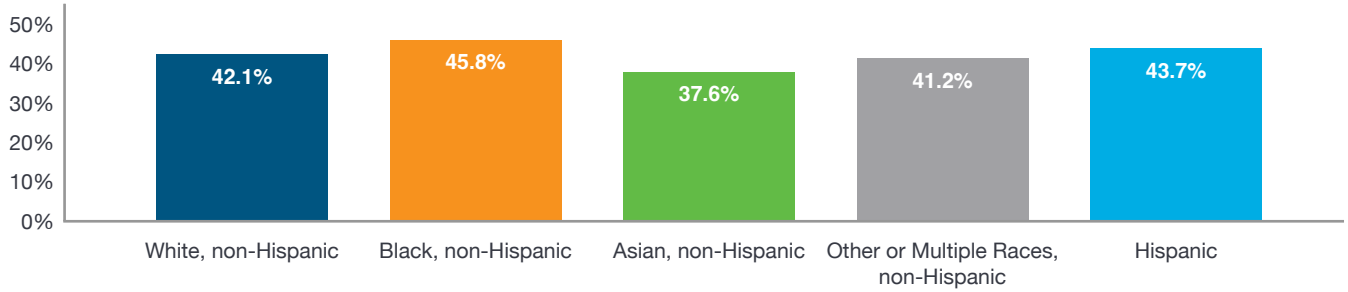
Notes: "Any affordability issue" is defined as reporting any of the following issues: problems paying family medical bills in past 12 months; family medical debt at the time of survey; spending a high share of family income in past 12 months on out-of-pocket health care expenses; and any unmet need in family for health care due to cost in past 12 months. "Any unmet need in family for health care due to cost" includes the following family unmet needs due to cost; doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment. "Limited in activities" includes residents who report activity limitations because of physical, mental, or emotional problems.

Access & Affordability

Despite having lower premiums, individuals enrolled in HDHPs may be susceptible to issues affording their health care; such affordability challenges vary across populations. In 2023, a similar share of private commercially insured residents were enrolled in HDHPs across racial and ethnic groups. However, among those enrolled in HDHPs, the burden of affordability issues was greater for non-Hispanic Black and Hispanic residents relative to non-Hispanic White residents. Among those enrolled in HDHPs, 39.7% of non-Hispanic Black and 35.7% of Hispanic residents reported having medical debt or problems paying family medical bills, compared with 20.3% of non-Hispanic White residents. Additionally, among HDHP enrollees, nearly 1 in 3 non-Hispanic Black residents and Hispanic residents reported any unmet need for health care in their family due to cost.

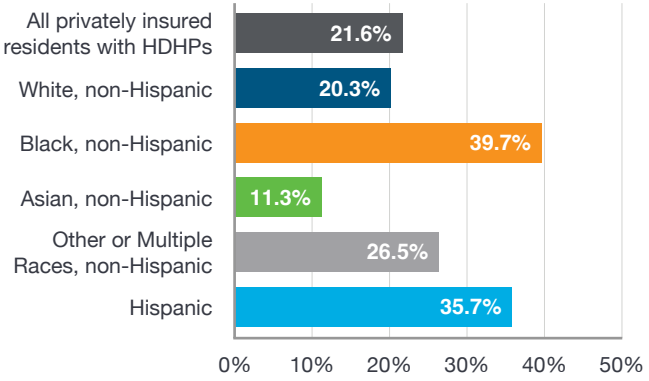
Affordability Issues Among Privately Insured Massachusetts Residents Enrolled in HDHPs by Race and Ethnicity, 2023

HDHP Enrollment Among Private Commercially Insured Residents

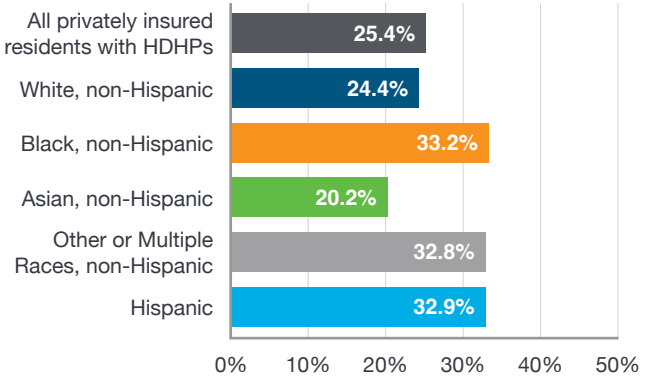


Among Private Commercially Insured Residents Enrolled in HDHPs

Medical Debt or Problems Paying Family Medical Bills



Unmet Need for Health Care in Family Due to Cost



While HDHP enrollment was similar across racial and ethnic groups, non-Hispanic Black residents and Hispanic residents were more likely to report medical debt or problems paying medical bills (39.7% and 35.7%, respectively) relative to non-Hispanic White residents (20.3%).

Source: 2023 Massachusetts Health Insurance Survey.

Notes: 2023 IRS deductible thresholds for high-deductible health plans were $1,500 for single coverage and $3,000 for family coverage. Estimates on this page limited to residents with private health insurance coverage, which includes employer-sponsored insurance, Health Connector Plans, and non-group health insurance plans bought directly from an insurance company. "Any unmet need in family for health care due to cost" includes the following family unmet needs due to cost: doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment.

Access & Affordability Notes

1. Results based on commercial contract member data provided by Aetna, Blue Cross Blue Shield of Massachusetts (BCBSMA), Cigna, Fallon Health (CY 2021), Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Mass General Brigham Health Plan (MGBHP, formerly AllWays), Tufts Health Plan (Tufts), Tufts Health Public Plans (THPP), UnitedHealthcare, Wellpoint (formerly UniCare), and WellSense (formerly Boston Medical Center Health Plan/BMCHP). Payers with fewer than 50,000 Massachusetts primary medical enrollees were not required to submit data.
2. Massachusetts contract members may reside inside or outside Massachusetts; contract members who live out-of-state are most often covered through a Massachusetts-based employer.
3. Center for Health Information and Analysis, *2024 Massachusetts Employer Survey Summary of Results* (Boston, December 2024), https://www.chiamass.gov/massachusetts-employer-survey.
4. Within the Access and Affordability chapter, private commercial enrollment reflects Massachusetts contract membership (situs-based) data, which may include non-Massachusetts residents. Results may differ from THCE data points, which model per capita expenditures based on Massachusetts residents only.
5. Although individual purchaser enrollment declined overall in 2023, enrollment began increasing midway through 2023. These increases were driven by growth in subsidized individual purchaser membership in ConnectorCare, as some residents who were determined ineligible for MassHealth enrolled in ConnectorCare. MassHealth resumed redetermination processes in April 2023 to reassess member eligibility when federal requirements for continuous coverage ended. See CHIA's Enrollment Trends reporting for more information.
6. Unsubsidized and APTC-only individuals are combined for reporting within the Access and Affordability chapter.
7. The implementation of the American Rescue Plan Act (ARPA) in March 2021 and subsequent federal legislation expanded eligibility for purchasers to receive APTCs and increased the amounts of credits through 2025.
8. MassHealth, *January 2024 Update on MassHealth Redetermination* (Boston, February 2024), https://www.mass.gov/doc/january-2024-key-takeaways/download.
9. All premiums presented in this chart reflect the total set premium, including member contributions, employer contributions (for ESI), and federal and state premium credits and subsidies (for plans sold to individual purchasers).
10. Reported 2014 premiums were scaled by the Percent of Benefits Not Carved Out, which is not CHIA's current methodology. The impact of this difference on the premiums metric is small because benefit carve-outs are not common for fully insured coverage. Data does not account for inflation. For more information, see the 2017 Annual Report and corresponding technical appendix at https://www.chiamass.gov/annual-report.
11. Center for Health Information and Analysis, *2024 Massachusetts Employer Survey Summary of Results* (Boston, December 2024), https://www.chiamass.gov/massachusetts-employer-survey. Ranges reflect the average proportion of employer contributions across different single and family coverage types.
12. Massachusetts Health Connector, *Report to the Massachusetts Legislature: Activities and Accomplishments of the Massachusetts Marketplace Fiscal Year 2023* (Boston, 2024), https://betterhealthconnector.com/wp-content/uploads/Health-Connector-Annual-Report-2023.pdf.
13. Ibid.
14. The average premium metric is not adjusted for differences in demography, geography, risk score, network reimbursement, and other pricing factors by market segment.
15. Unsubsidized individuals who earn too much to qualify for ConnectorCare plans or state health insurance subsidies may still receive federal APTCs based on federal affordability standards.
16. Center for Health Information and Analysis, *2023 Report on the Performance of the Massachusetts Health Care System* (Boston, 2023), https://www.chiamass.gov/annual-report.
17. Ibid.
18. Center for Health Information and Analysis, *2017 Annual Report* (Boston, September 2017), https://www.chiamass.gov/annual-report.
19. Center for Health Information and Analysis, *2024 Massachusetts Employer Survey Summary of Results* (Boston, December 2024), https://www.chiamass.gov/massachusetts-employer-survey.
20. Reported private commercial enrollment by deductible and out-of-pocket level may incorporate student health membership, which is excluded elsewhere in this chapter. For more information on private commercial enrollment by deductible and out-of-pocket level, see the databook.

KEY FINDINGS

Total Medical Expenses and Alternative Payment Methods

Unadjusted TME PMPM growth accelerated in 2023 for all commercial payers compared with the prior year.

In 2023, all MassHealth MCO/ACO-A payers reported HSA TME trends above the 3.6% cost growth benchmark as populations shifted due to MassHealth redeterminations and ACO contract changes, limiting the validity of year-over-year comparisons.

Health Status Adjusted (HSA) TME PMPM spending continued to increase in 2023 for most commercial payers, with 10 payers reporting trends above the 3.6% health care cost growth benchmark.

Nine of the 10 largest physician groups reported HSA TME trends above the 3.6% growth benchmark in at least 2 payer networks in 2023.

Total Medical Expenses and Alternative Payment Methods

In addition to measuring the Commonwealth's total health care expenditures (THCE), CHIA monitors health care spending of private commercial and privately administered Medicaid and Medicare plans and their members as well as provider organizations. The Total Medical Expenses (TME) data included in this chapter enables a more detailed examination of spending drivers within health plans and among provider organizations that manage patients' care.

TME represents the total amount paid to providers for health care services delivered to a payer's member population, expressed on a PMPM basis for Massachusetts residents. TME includes amounts paid by the payer as well as member cost-sharing, all categories of covered medical expenses, and all non-claims-related payments to providers, including provider performance payments. This chapter focuses on TME data reported by private commercial and privately administered Medicaid and Medicare plans. For private commercial payers specifically, TME is presented for members for whom the payer has access to and is able to report on all claims and non-claims expenses (referred to as "commercial full-claim" in this report). In this chapter, payers are referred to by their names as of 2024.

TME data is examined and reported on a health status adjusted (HSA) basis for each payer's member population in addition to reporting unadjusted aggregate trends. HSA TME adjusts for differences in member illness burden and expected medical costs associated with members' recorded diagnoses. The tools used for adjusting TME for health status of a payer's covered members vary among payers, which prevents comparison of HSA TME levels across payers; unadjusted TME can be used, however, to show payer differences in TME levels and growth. HSA and unadjusted TME trends are reported by payer and managing physician group for the 10 largest managing physician groups within the networks of the

3 largest payers. Additionally, CHIA continues to report on aggregate HSA scores by payer to better understand trends in reported health status scores and medical spending in the years following the COVID-19 pandemic.

In addition to spending levels and trends, CHIA collects information about the payment arrangements between payers and providers. Historically, most health care services have been paid using a fee-for-service (FFS) model. Chapter 224 of the Acts of 2012 set goals to increase the adoption of alternative payment methods (APMs), payment arrangements in which some of the financial risk associated with the delivery of medical care as well as the management of health conditions is shifted from payers to providers. Generally, APMs are intended to give providers new incentives to control overall costs (e.g., reduce unnecessary services and provide services in the most appropriate setting) while maintaining or improving quality. The EOHHS Quality Measure Alignment Taskforce recommends use of the quality measures in the Massachusetts Aligned Measure Set in global budget-based risk contract APMs to minimize administrative burden and focus quality improvement efforts on high-value measures and health care priorities.

This chapter reports on 2023 TME and APMs using the following metrics:

TME: Total expenditures for health care services each year divided by the number of member months in the payer's population.

Health Status Adjusted (HSA) TME: TME adjusted to account for differences in member illness burden and medical costs of member populations.

Managing Physician Group TME: TME for members required by their insurance plan to select a primary care provider (PCP) and for members attributed to a PCP as part of a contract between the payer and provider.

APM Adoption: The share of member months associated with a primary care provider whose case is paid for under an alternative payment contract with the reporting payer.

Aligned Measure Set Payer Adherence Rate: The proportion of all quality measures in each payer's global budget-based risk contracts that are endorsed in the Massachusetts Aligned Measure Set. ■

Total Medical Expenses and Alternative Payment Methods

To examine health care spending differences among private commercial health plans (hereafter referred to as "commercial"), CHIA calculates total medical expenses (TME) PMPM. The results on this page reflect actual payments made to providers without adjusting for differences in the health status of a payer's member population.

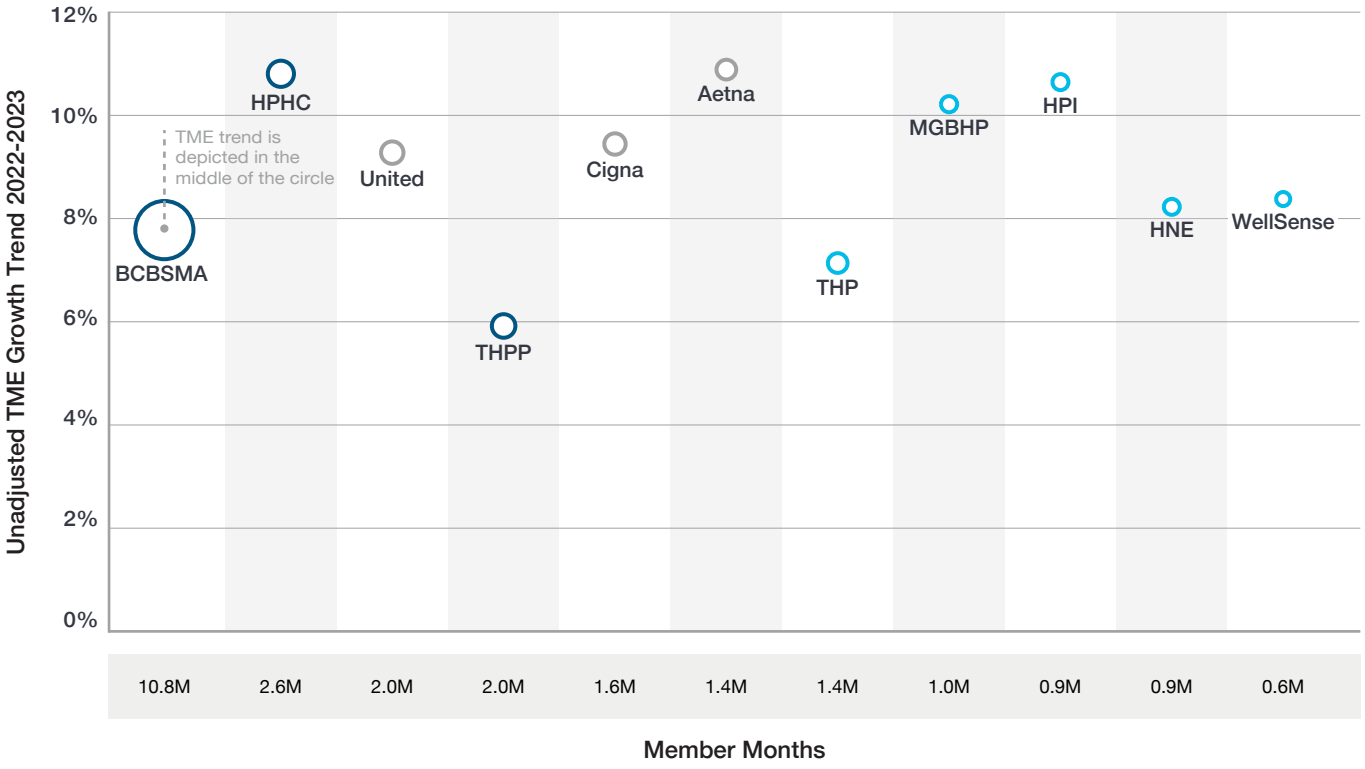
From 2022 to 2023, commercial THCE increased by 8.9% PMPM, more than 2 times the increase in 2022 (4.0%). For additional information on THCE, see page 18.

In 2023, all 11 commercial payers shown reported higher increases in unadjusted TME PMPM than in 2022. The 3 largest Massachusetts-based commercial payers—Blue Cross Blue Shield of Massachusetts (BCBSMA), Harvard Pilgrim Health Care (HPHC), and Tufts Health Public Plan (THPP), which represented 60.9% of commercial full-claim members in 2023—reported unadjusted TME PMPM trends of 7.7%, 10.7%, and 5.9%, respectively.

Overall commercial full-claim membership decreased by 1.6% from 2022 to 2023. In 2023, Point32Health, which owns HPHC, Health Plans Inc. (HPI), Tufts Health Plan (THP), and THPP, migrated commercial small group and Group Insurance Commission (GIC) membership from THP to HPHC, contributing to a 35.4% decline in THP membership. Combining all Point32Health entities resulted in a TME PMPM growth of 7.7% for Point32Health in 2023.

Consistent with the prior year, the 3 national payers (Aetna, Cigna, and UnitedHealthcare) reported increases in commercial full-claim member months. Aetna reported the largest increase in unadjusted TME PMPM in 2023 at 10.8%.

Trends in Commercial Unadjusted TME by Payer, 2022-2023



Circles are scaled to reflect member months. Payers are presented in order based on number of member months from left to right (largest to smallest).

Unadjusted TME growth accelerated for all 11 commercial payers in 2023 compared with the prior year.

Source: Payer-reported TME data to CHIA.

Notes: This analysis includes commercial full-claims data only. Commercial full-claims data represents members for whom payer has access to and is able to report on all claims expenses, accounting for 63.7% of total commercial member months in 2023. HPHC, Tufts, THPP, and Health Plans Inc. (HPI) merged in 2021 but continued to report data as separate entities. Fallon was excluded from the analysis after discontinuing most commercial products in 2021. As of June 2022, BMCHP does business as WellSense for all products. As of January 2023, AllWays rebranded to Mass General Brigham Health Plan (MGBHP).

Total Medical Expenses and Alternative Payment Methods

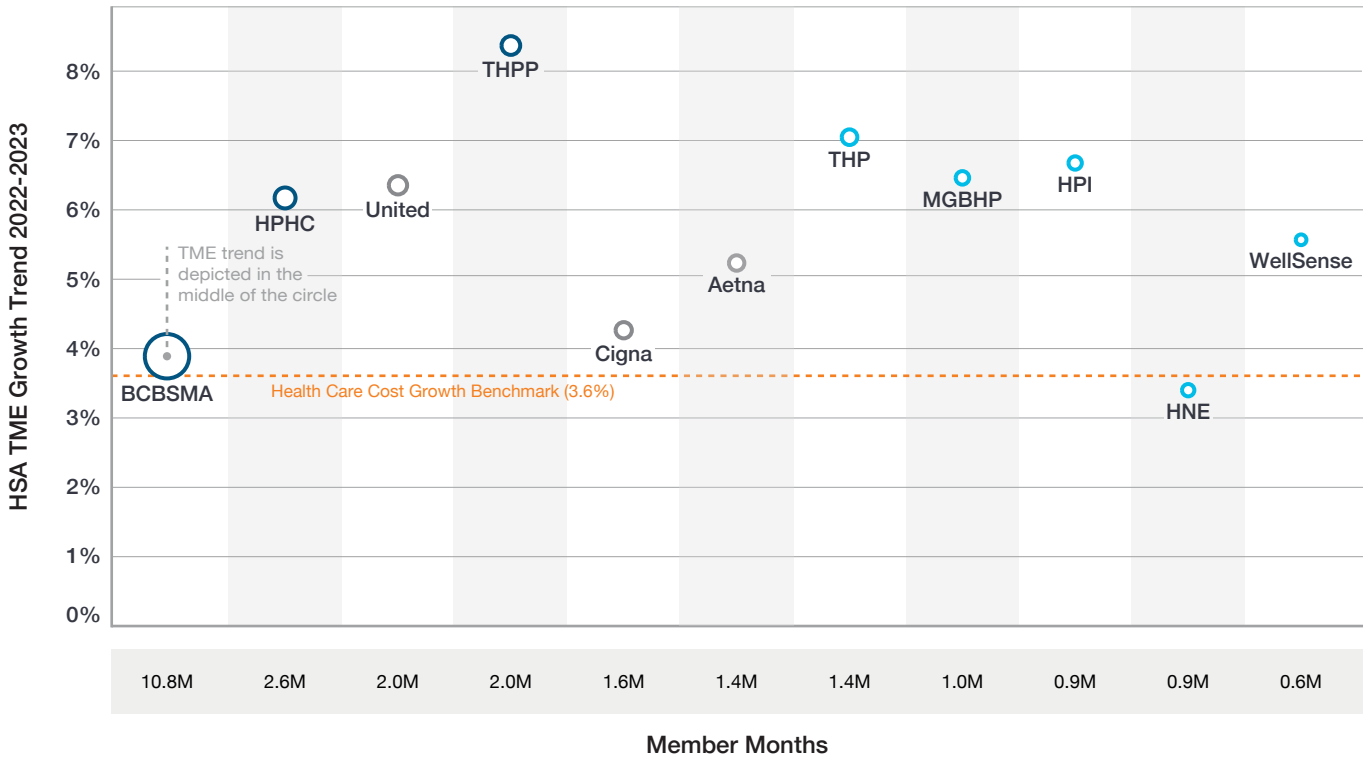
CHIA examines TME on a health status adjusted (HSA) basis for each payer's member population, which accounts for differences in member illness burden and medical costs. A payer's HSA TME is reported on a PMPM basis and is used to measure performance against the health care cost growth benchmark. In 2023, the benchmark was set at 3.6%.

From 2022 to 2023, 10 of the 11 commercial payers shown reported HSA TME growth above the 3.6% benchmark. THPP, the third largest Massachusetts-based payer, reported the largest growth in HSA TME at 8.4%. BCBSMA, HPHC, and THP reported HSA TME trends of 3.9%, 6.2%, and 7.0%, respectively.

For more information on commercial service category spending drivers, see page 29.

HNE was the only commercial payer with an HSA TME trend below the benchmark (3.4%).

Trends in Commercial HSA TME by Payer, 2022-2023



Circles are scaled to reflect member months. Payers are presented in order based on number of member months from left to right (largest to smallest).

Ten of the 11 commercial payers reported health status adjusted TME trends above the 3.6% health care cost growth benchmark in 2023.

Source: Payer-reported TME data to CHIA.

Notes: Tools used for adjusting TME for health status of a payer's covered members vary among payers and therefore adjustments are not directly comparable across payers. See **databook** for a list of health status adjustment tools used for data presented in this report. These trends are based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. This analysis includes commercial full-claims data only, reflecting members for whom payer has access to and is able to report on all claims expenses, accounting for 63.7% of total commercial member months in 2023. HPHC, Tufts, THPP, and Health Plans Inc. (HPI) merged in 2021 but continued to report data as separate entities. Fallon was excluded from analysis after discontinuing most commercial products in 2021. As of June 2022, BMCHP does business as WellSense for all products. As of January 2023, AllWays rebranded to Mass General Brigham Health Plan (MGBHP).

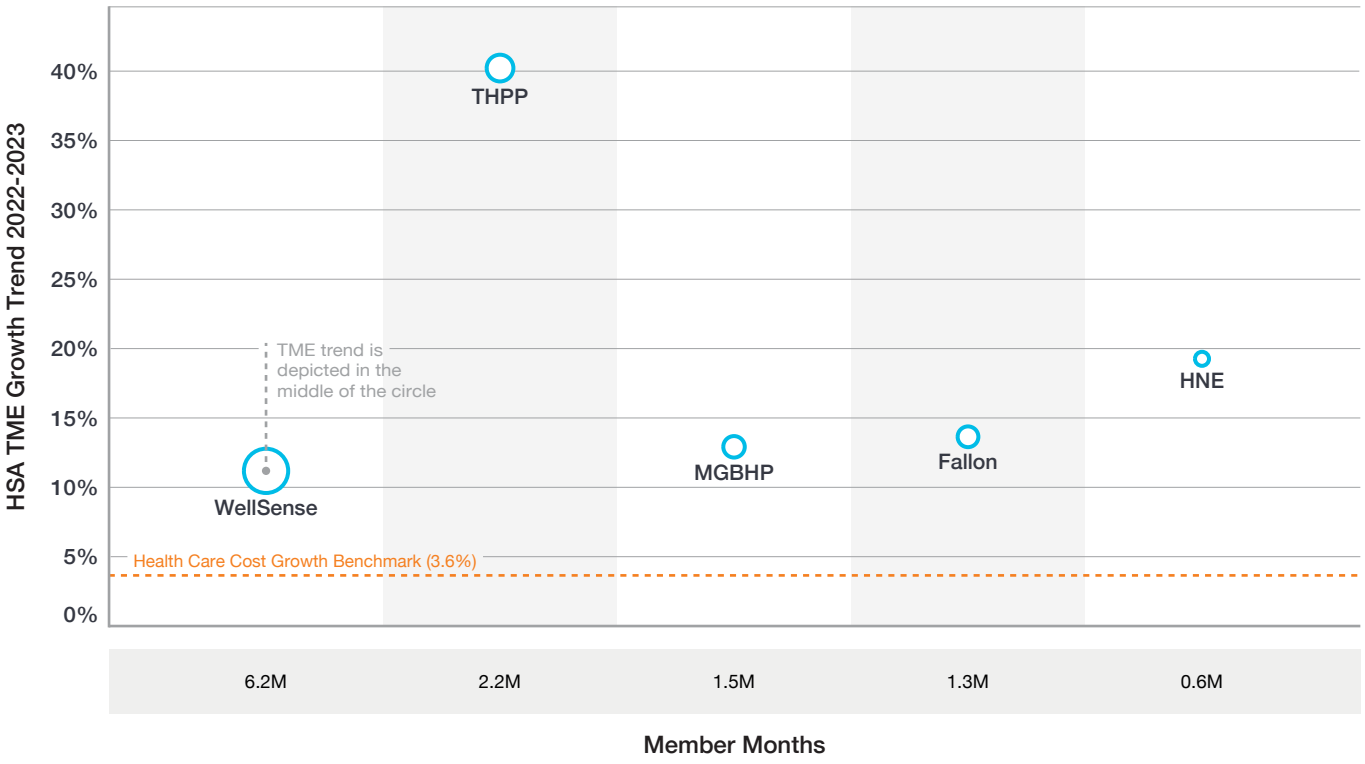
Total Medical Expenses and Alternative Payment Methods

In April 2023, temporary federal continuous coverage requirements ended and MassHealth resumed its redetermination process for the first time since March 2020. Separately, MassHealth reprocured its Accountable Care Organization (ACO) contracts effective April 2023, resulting in 15 available ACO-A plans, compared with 13 prior to April 2023.[1] These redetermination and reprocurement processes led to membership shifts and significant changes in population risk profiles in many payers' MCO/ACO-A plans, limiting the validity of year-over-year comparisons.

From 2022 to 2023, all MCO/ACO-A payers reported trends in HSA TME PMPM above the 3.6% cost growth benchmark. THPP reported the largest increase in HSA TME at 40.0%, followed by HNE at 19.1%, Fallon at 13.5%, MGBHP at 12.7%, and WellSense at 11.0%. THPP reported a 44.6% (1.8 million member months) decline in MCO/ACO-A membership in 2023 due to a combination of redeterminations, discontinuation of 3 ACO contracts, and the launch of 2 new contracts.

Due to ACO contracting changes, some payers covered substantially different populations in 2023 than in 2022. MGBHP launched an ACO with Mass General Brigham providers, resulting in a 196.6% growth (1.0 million member months) in MGBHP ACO membership. WellSense had a membership growth of 86.6% (2.8 million member months) as it doubled its number of ACO-A plans from 4 to 8. HNE membership increased 8.8% (50,000 member months) but stated that due to redeterminations and reprocurements, their population overturned by more than 50%, with the acuity of these populations differing significantly.

Trends in MassHealth MCO and ACO-A HSA TME by Payer, 2022-2023



Circles are scaled to reflect member months. Payers are presented in order based on number of member months from left to right (largest to smallest).

In 2023, all MassHealth MCO/ACO-A payers reported HSA TME trends above the 3.6% cost growth benchmark as populations shifted due to MassHealth redeterminations and ACO contract changes, limiting the validity of year-over-year comparisons.

Source: Payer-reported TME data to CHIA.

Notes: Tools used for adjusting TME for health status of a payer's covered members vary among payers and therefore adjustments are not directly comparable across payers. See **databook** for a list of health status adjustment tools used for data presented in this report. These trends are based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. As of June 2022, BMCHP does business as WellSense for all products. As of January 2023, AllWays rebranded to Mass General Brigham Health Plan (MGBHP).

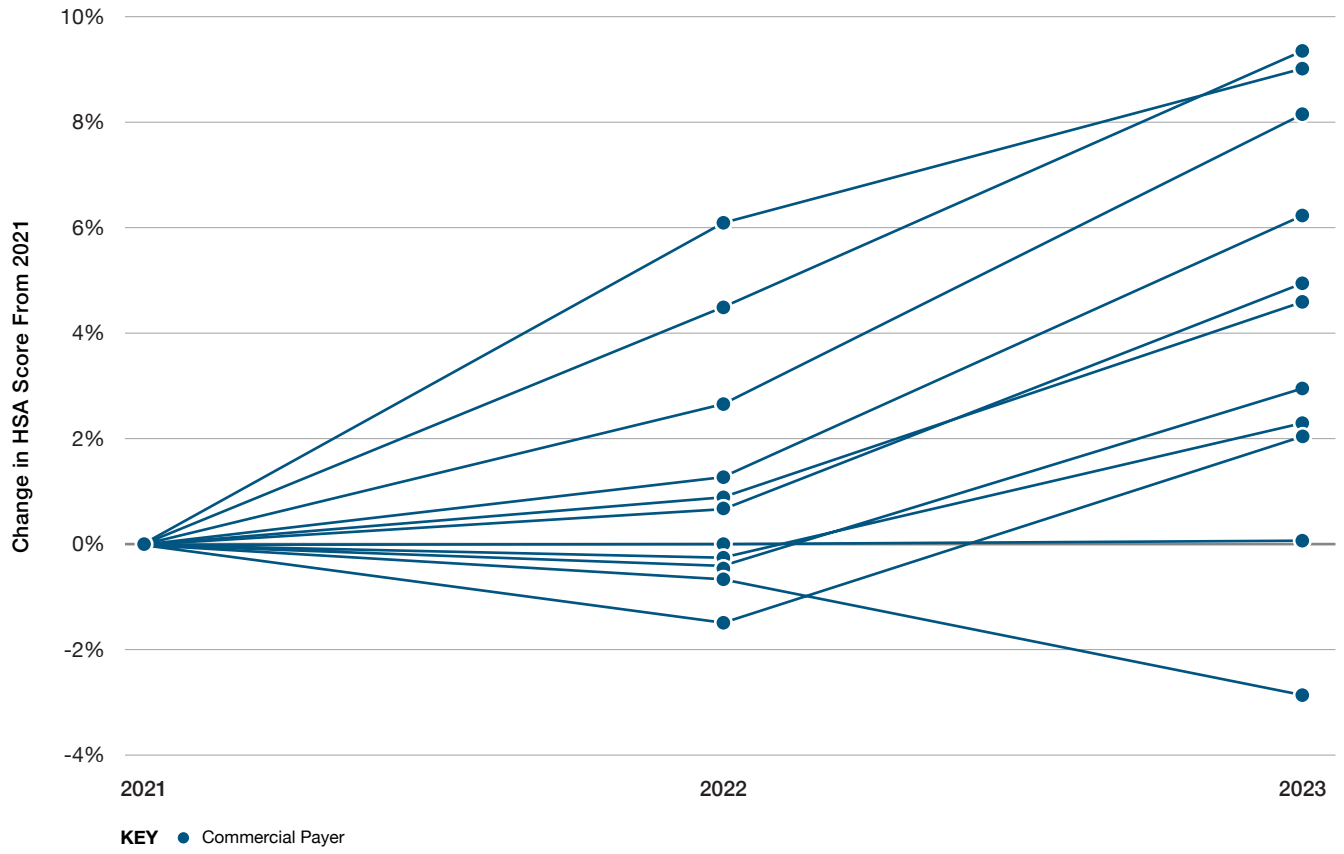
Total Medical Expenses and Alternative Payment Methods

Payers use risk scores to contextualize spending to account for differences in the health and expected medical spending of a population. CHIA aggregates payer-reported HSA scores to calculate HSA TME spending growth, the metric used to determine payer and provider growth in relation to the health care cost growth benchmark. Payers use a variety of tools to assign HSA scores to patient populations, and therefore scores cannot be compared across payers. These tools draw upon patient demographics and diagnoses generally recorded by providers to predict spending. Broadly, higher HSA scores are intended to indicate higher illness burdens and anticipated medical costs. However, scores can be affected by variations in coding as well as socioeconomic factors and barriers to care, which decrease health care utilization and captured diagnosis codes.[2,3]

From 2021 to 2023, 10 of 11 commercial payers reported increases in risk scores, ranging from 0.1% to 9.4%.

Increases in risk scores moderate HSA TME PMPM growth by adjusting for the severity and health care needs of the population incurring medical expenses when calculating a PMPM amount.

Change in Aggregate Commercial HSA Scores by Payer, 2021-2023



In 2023, 10 of 11 commercial payers reported increased HSA scores, with the largest increase being 9.4%.

Source: Payer-reported TME data to CHIA.

Notes: Tools used for adjusting TME for health status of a payer's covered members vary among payers, and therefore adjustments are not directly comparable across payers. One line of business was excluded from analysis. See databook for a list of health status adjustment tools used for data presented in this report. Commercial trends shown here reflect commercial full-claims data only.

Total Medical Expenses and Alternative Payment Methods

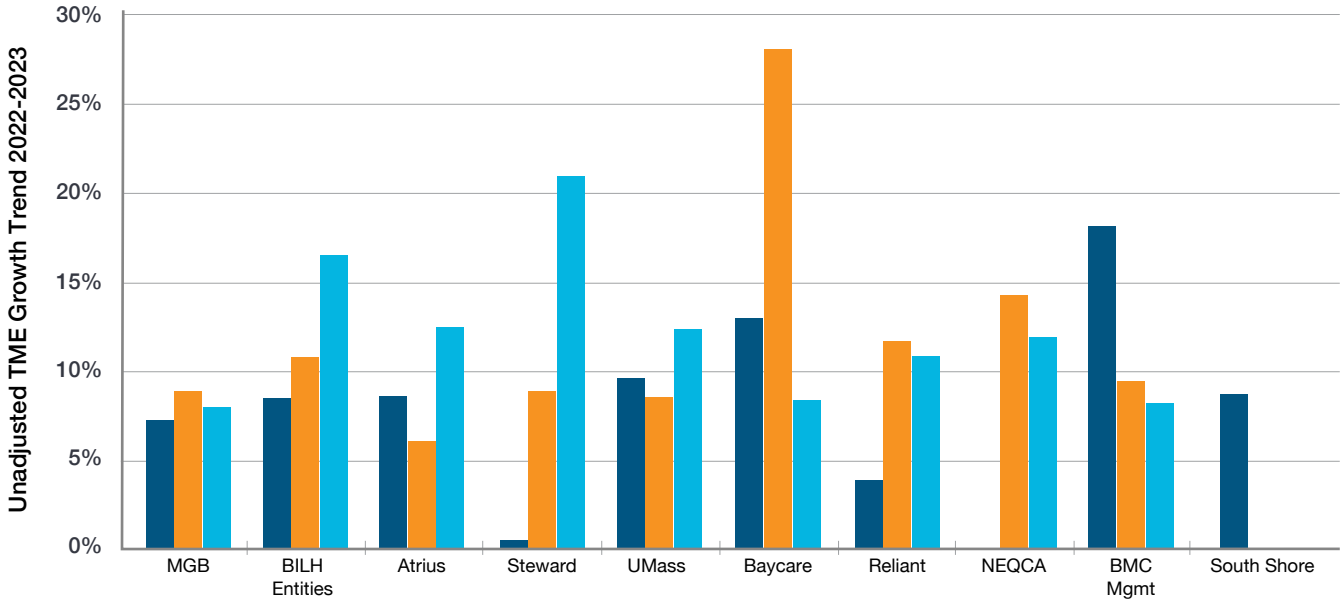
Managing physician groups, often multi-specialty practices including primary care providers (PCPs), are responsible for coordinating the care of their members. TME measures the PMPM total medical spending for commercial members prospectively attributed to a PCP within the managing physician group's practice.

CHIA examined unadjusted TME PMPM data for the 10 largest physician groups within the networks of BCBSMA, HPHC, and THP.[4] In 2023, the data shown represents 52.2% of the total commercial full-claim managed member months, a decline from 56.6% in 2022.

Within BCBSMA's network, Boston Medical Center Management Service (BMC Mgmt) had the largest unadjusted TME PMPM growth at 18.2% and Steward the smallest at 0.6%. Within HPHC, Baycare had the highest growth at 27.9% and Atrius the lowest at 6.1%. Physician groups within THP's network experienced unadjusted TME growth ranging from 8.0% (MGB) to 21.0% (Steward).

Overall membership of patients attributed to the 10 largest physician groups declined in 2023 across the networks of BCBSMA, HPHC, and THP (-10.2%) and across all payers (-8.8%) as overall commercial full-claim membership declined. Within BCBSMA, membership decreased in 4 of 9 physician groups. BCBSMA did not report data for New England Quality Care Assurance (NEQCA) in 2023; these members were shifted to Tufts Medicine Integrated Network (not shown). HPHC reported membership growth for 8 of 9 physician groups; all 9 physician groups within THP experienced membership declines. HPHC's and THP's opposing membership trends correlated with the migration of commercial members from THP to HPHC. Among these 3 payers, only BCBSMA reported attributed members to South Shore Medical Group.

Trends in Managing Physician Group Commercial Unadjusted TME, 2022-2023



	MGB	BILH Entities	Atrius	Steward	UMass	Baycare	Reliant	NEQCA	BMC Mgmt	South Shore
BCBSMA, HPHC, and THP Share of Group's Managed Member Months	90.8%	75.6%	86.3%	70.6%	87.3%	53.3%	91.1%	54.9%	68.7%	100.0%
Total Managed Member Months in 2023	2.8M	2.1M	1.6M	1.3M	0.7M	0.5M	0.5M	0.4M	0.3M	0.3M

KEY BCBSMA HPHC THP

The 10 largest physician groups had increases in unadjusted TME PMPM spending across the networks of BCBSMA, HPHC, and THP.

Source: Payer-reported TME data to CHIA.

Notes: Data reported here is based on final 2022-2023 commercial full-claim TME data, both for members whose plan requires selection of a PCP as well as for members who were attributed to a PCP pursuant to a contract between payer and physician group, such as a PPO APM. These trends are based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. In 2023, THP and HPHC did not report any members attributed to South Shore Medical Group. BCBSMA did not report any membership under NEQCA in 2023, shifting these members to Tufts Medicine Integrated Network.

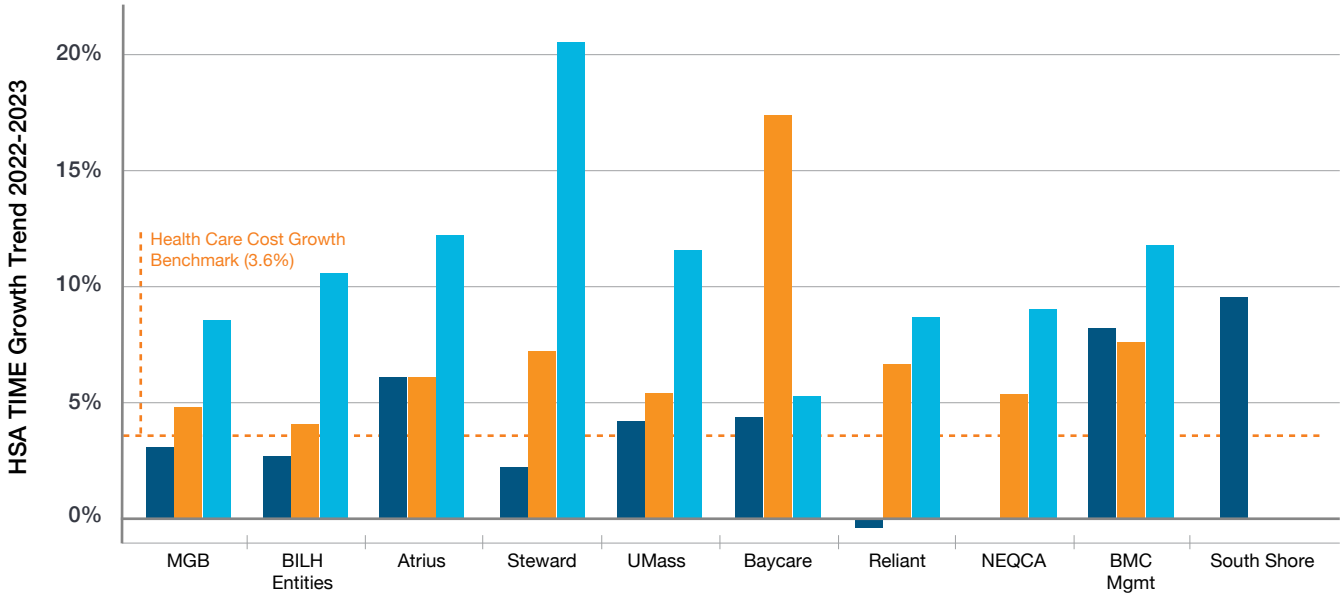
Total Medical Expenses and Alternative Payment Methods

CHIA examined HSA TME PMPM spending trends for the 10 largest physician groups within the BCBSMA, HPHC, and THP networks.

In 2023, all 10 physician groups experienced increases in HSA TME that exceeded the 3.6% health care cost growth benchmark in at least 1 of the 3 payer networks. Within BCBSMA, 5 of 9 physician groups experienced HSA TME growth above the benchmark, with South Shore Medical Center having the largest growth at 9.5%. Within HPHC, all 9 physician groups with attributed members showed HSA TME trends exceeding the benchmark; Baycare experienced the largest growth rate at 17.4%, with HPHC attributed membership to Baycare increasing 37.9% in 2023. Within THP, all 9 physician groups experienced growth rates exceeding the benchmark; increases in THP's network exceeded those in BCBSMA's and HPHC's networks across all physician groups except Baycare.

In 2023, Atrius, UMass, Baycare, and BMC Mgmt exceeded the benchmark in all 3 payer networks. Mass General Brigham (MGB), BILH, Steward, Reliant, and NEQCA exceeded the benchmark in 2 payer networks.

Trends in Managing Physician Group Commercial HSA TME, 2022-2023



	MGB	BILH Entities	Atrius	Steward	UMass	Baycare	Reliant	NEQCA	BMC Mgmt	South Shore
BCBSMA, HPHC, and THP Share of Group's Managed Member Months	90.8%	75.6%	86.3%	70.6%	87.3%	53.3%	91.1%	54.9%	68.7%	100.0%
Total Managed Member Months in 2023	2.8M	2.1M	1.6M	1.3M	0.7M	0.5M	0.5M	0.4M	0.3M	0.3M

KEY BCBSMA HPHC THP

Nine of the 10 largest physician groups reported HSA TME trends above the 3.6% health care cost growth benchmark in at least 2 payer networks in 2023.

Source: Payer-reported TME data to CHIA.

Notes: Data reported here is based on final 2022-2023 commercial full-claim TME data, both for members whose plan requires selection of a PCP as well as for members who were attributed to a PCP pursuant to a contract between payer and physician group, such as a PPO APM. Tools used for adjusting TME for health status of a payer's covered members vary among payers, and therefore HSA TME is not comparable across payers. See databook for more information. These trends are based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. In 2023, THP and HPHC did not report any membership under South Shore Medical Group. BCBSMA did not report any membership under NEQCA in 2023, shifting these members to Tufts Medicine Integrated Network.

Total Medical Expenses and Alternative Payment Methods

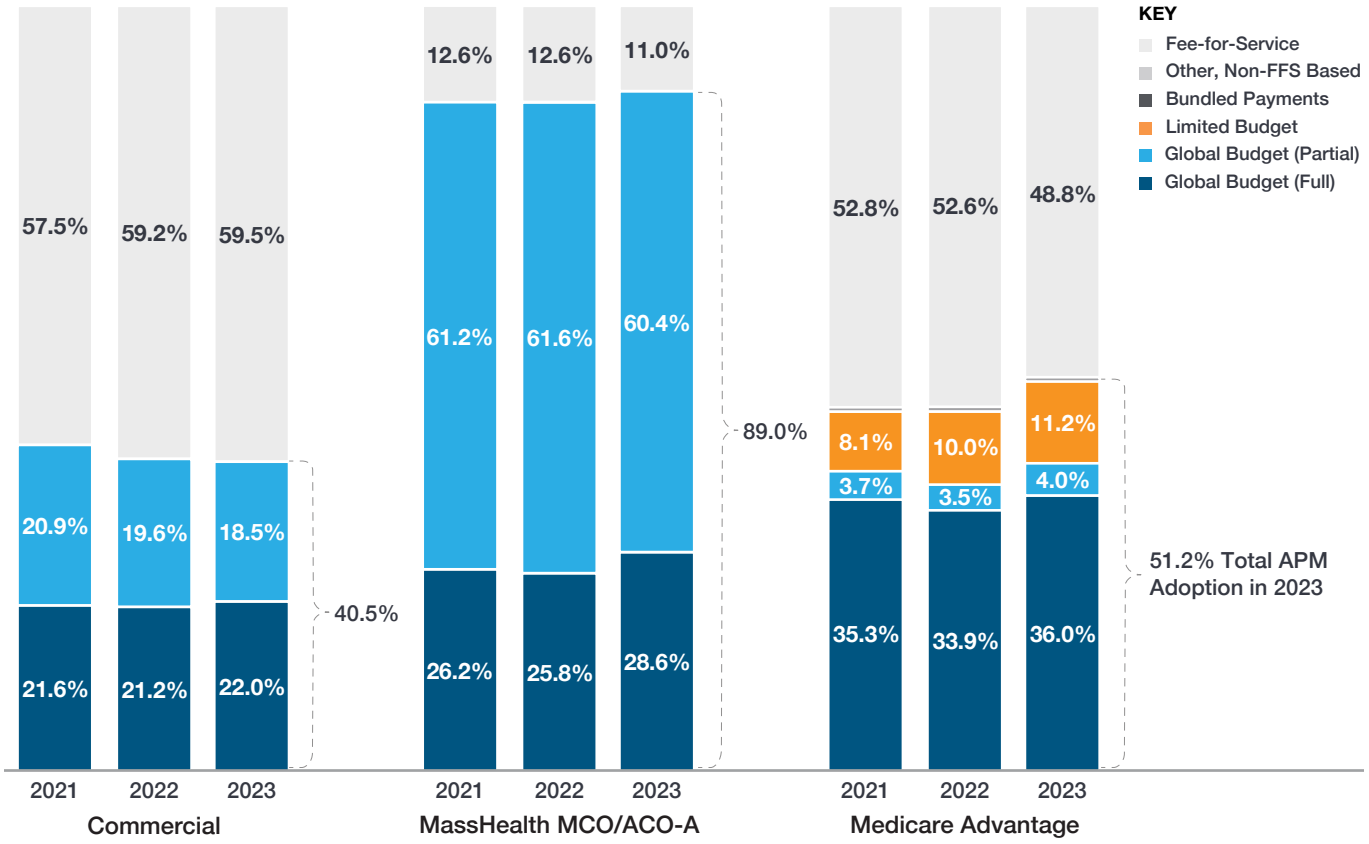
Payers and providers use APMs to promote coordinated care and create incentives to control costs while maintaining or improving quality. APMs include contracted payment arrangements such as global budgets, limited budgets, bundled payments, and other non-FFS based payments.

In 2023, in the private commercial market, most members (59.5%) continued to have care paid for under fee-for-service (FFS) arrangements. Market-wide commercial APM adoption has remained constant since 2016 at approximately 40%.

From 2021 to 2023, MassHealth MCO and ACO-A APM adoption remained high, with 89.0% of members covered under APM arrangements in 2023. Medicare Advantage APM adoption increased by 3.8 percentage points in 2023, with reported membership increases under full global budget and limited budget payment contracts, particularly by Aetna, United, and Tufts.

Global budget payment arrangements accounted for nearly all commercial and MassHealth MCO and ACO-A APM arrangements and 77.1% of Medicare Advantage APM arrangements in 2023; 92.7% of global payment arrangements had both upside and downside risk while 7.3% were shared savings only.

Adoption of Alternative Payment Methods by Insurance Category, 2021-2023



In 2023, APM adoption remained relatively stable across commercial and Medicaid MCO/ACO-A contracts while increasing slightly in Medicare Advantage.

Source: Payer-reported TME data to CHIA.

Notes: Membership under APMs is measured by share of member months associated with a primary care provider engaged in an alternative payment contract with reporting payer. Global partial APMs reflect arrangements in which physician group is not held accountable for certain services, often pharmacy and behavioral health expenses. Global full APMs hold providers accountable for a comprehensive set of services.

Total Medical Expenses and Alternative Payment Methods

Global budgets are the most common form of APM in the Commonwealth and typically include incentives based on provider organizations' performance on a set of health care quality measures. While accountability to quality metrics is valuable, a lack of alignment on the specific measures used in risk contracts is a major source of administrative burden in the health care system, contributing to clinician burnout and dilution of quality improvement efforts.[5] In response to these concerns, the EOHHS Quality Measure Alignment Taskforce annually recommends an Aligned Measure Set ("Measure Set") for use in global budget contracts.

The table "Member Months by Payer and Percentage of Member Months in Global Budget Payment Methods" provides 2023 member months for payers that indicated use of global budgets across their private commercial and Medicaid MCO/ACO-A contracts and the percentage of their membership attributed to these types of arrangements, as an approximation of payer contracts affected by the Measure Set.[6]

The "Fidelity to Aligned Measure Set" table includes overall and payer-specific adherence rates since data collection began in 2019. The overall rate includes all payers who submitted a catalog while the commercial only rate excludes MassHealth.[7] While there are other considerations for true implementation of the Measure Set, this rate highlights the extent to which payers are limiting the measures used in contracts to those that are endorsed in the Measure Set.[8] For example, the overall adherence rate of 93% means that across all participating payer contracts, only 7% of measures used are not part of the measure set. See CHIA's Quality Measure Catalog publication (updated June 2024) for details about the composition of the Measure Set, measure use in contracts for 2021-2024, and information about measure stratification by race, ethnicity, and/or language.

Adherence to Aligned Measure Set in Global Budget-Based Risk Contract APMs, 2023

Member Months by Payer and Percentage of Member Months in Global Budget Payment Methods, 2023

Payer	Commercial Total Member Months (MMs)	Medicaid (MCO/ACO-A) Total Member Months (MMs)	Commercial % MMs in Global Budget APMs	Medicaid (MCO/ACO-A) % MMs in Global Budget APMs
BCBSMA	15.9M		61.1%	
HPHC	4.6M		62.2%	
United (UHC)	3.3M		0.0%	
MGBHP	2.5M	1.5M	11.5%	100%
THP	2.3M		52.2%	
HNE	1.2M	0.6M	71.1%	91.5%
WellSense	0.6M	6.2M	6.8%	89.0%

Fidelity to Aligned Measure Set, 2019-2023

Year	Overall	Commercial Only	MassHealth	BCBSMA	HPHC	MGBHP	THP	HNE	WellSense	UHC
2019	65%	54%	100%	47%	45%	N/A	61%	35%	59%	N/A
2020	72%	56%	100%	62%	53%	N/A	56%	42%	57%	N/A
2021	84%	71%	100%	81%	85%	N/A	65%	38%	67%	N/A
2022	84%	78%	100%	84%	81%	78%	75%	70%	57%	39%
2023	93%	89%	100%	99%	86%	83%	80%	76%	57%	40%

In 2023, most payers continued to improve the proportion of Measure Set measures used in contracts, with 2 of the 7 reporting commercial payers achieving greater than 85% fidelity.

Source: Payer-reported Quality Measure Catalog data and payer-reported TME data provided to CHIA.

Notes: Refer to CHIA's 2024 Quality Measure Alignment Catalog executive summary for methodology behind "Fidelity to the Aligned Measure Set" calculations and for information about participating payers. Visit EOHHS Quality Measure Alignment Taskforce website for more information about public/private collaborative initiative. Member months (MMs) represent number of members participating in a plan over a specified period of time expressed in months of membership. Commercial totals include both commercial full claims and commercial partial claims. MMs are reported for commercial payers who submitted a 2023 Quality Measure Catalog for commercial lines of business—Tufts' commercial business (THP) is presented but not its public plans (THPP). United (UHC) reported no global budget APMs in 2023 TME data but has indicated use of global budget contracts in 2023 through Quality Measure Catalog submission; their MMs are included for market share reference.

Total Medical Expenses and Alternative Payment Methods Notes

1. MassHealth reprocured its ACO contracts effective April 1, 2023, with 15 available ACO-A plans. Prior to April 1, 2023, there were 13 ACO-A plans. Five ACO-A contracts were discontinued, 7 were created or newly reprocured under different entities, and 8 were reprocured and continued. For additional information on these changes, see CHIA's Enrollment Trends report.
2. Additional information on the impact of the variations in coding methodologies on HSA scores provided by the Massachusetts Health Policy Commission; see https://www.mass.gov/doc/risky-business-comparative-modeling-of-commercial-population-risk-adjustment-equations/download.
3. Massachusetts Office of the Attorney General, "2022 Health Care Cost Trends Report: Health Scores and Access Barriers" (Boston, 2022), https://www.mass.gov/info-details/2022-health-care-cost-trends-report#health-scores-and-access-barriers.
4. The top 10 physician groups were identified by the total number of commercial full-claim, attributed (PCP types 1 and 2), non-pediatric member months. BCBSMA, HPHC, and THP had the most commercial full attributed member months for the largest 10 physician groups across 2022 and 2023. In 2023, BCBSMA, HPHC, and THP represented 81.0% of commercial full attributed member months for the largest 10 physician groups.
5. Health Policy Commission, "2016 Cost Trends Hearing Testimony," accessed January 11, 2025, https://masshpc.gov/meetings/annual-cost-trends-hearings/2016-cth/testimony.
6. The data source for membership in global budget contracts is separate from the data source for quality measures used in global budget-based risk contracts. As a result, there may be slight differences in the populations (e.g., member month data includes only Massachusetts residents). While this member month data may not capture all contracts that should incorporate the Measure Set, it is included as a contextual estimation of the proportion of payer contracts affected by adherence to the Measure Set.
7. Certain measures are endorsed for MassHealth contracts only because the Taskforce determined they are appropriate for the population. Since the MassHealth Measure Set is slightly different than the commercial Measure Set, we also include a cross-payer rate for commercial only.
8. Full implementation of the Measure Set requires inclusion of all Core Set measures in contracts as outlined in the Implementation Parameters documentation.

KEY FINDINGS

Commercial Payer Trends

In 2023, 87.2% of premiums were used to pay for members' medical care, with the remaining 12.8% ($81 PMPM) going towards non-medical expenses and surplus. This 12.8% proportion is in line with the prior year and pre-pandemic levels.

After paying fully insured members' medical claims, $81 PMPM remained from premiums in 2023 for non-medical expenses and surplus, a 5.2% increase from 2022. This represented the first single-digit trend since 2020, indicating some stabilization of the market.

The merged market's non-medical expenses and surplus grew 16.6% to $87 PMPM. Conversely, non-medical expenses and surplus for larger group plans declined 1.3% to $78 PMPM.

In 2023, payers reported an aggregate surplus (gain) of $10 PMPM, a slight increase compared with what was reported in 2022 ($8 PMPM), driven by gains in the merged market.

Commercial Payer Trends

CHIA analyzes federally reported data on Massachusetts payers' administrative costs in the private commercial health insurance market as part of its efforts to monitor and profile overall health plan spending. This chapter covers the period from 2021 to 2023.[1]

For fully insured lines of business, which made up 37.7 percent of private commercial enrollment in 2023, CHIA reports data on the proportion of premium dollars not spent on member medical claims by market segment (employer size). The "merged market" refers to plans sold to individual purchasers and small group employers, while "larger group" (or employer groups with >50 employees) refers to mid-size, large, and jumbo groups combined. Payers use these funds to cover administrative expenses, broker commissions, taxes, and fees. Premiums in this chapter are reported net of any required Medical Loss Ratio (MLR) rebates.

Plans sold to individual purchasers and small groups in the Massachusetts merged market are subject to the ACA's risk adjustment program, which was designed to stabilize premiums and protect against adverse selection. In 2018, the Centers for Medicare and Medicaid Services (CMS) added a national high-cost risk pool to its risk adjustment methodology to subsidize a portion of the expenses for members with claims costs in excess of $1 million using fees collected from payers offering risk-adjustment-covered plans.[2] Within this chapter, reported claims amounts in the merged market reflect the impact of the risk adjustment program.

The Commercial Payer Trends chapter uses federal MLR data, which payers report to CMS. Although data is sourced from federal MLR filings, the purpose and calculation of reported non-medical expense components and surplus in this report differ significantly from those of the federal MLR metric. The federal MLR reports a payer's rebate position using a 3-year average of financial data

and making allowable adjustments without consideration of rebates paid in prior years. CHIA calculates an annual financial loss ratio, which was developed using actuarial methods and principles. Data reported within this chapter is not sufficient to determine whether payers met federal MLR thresholds. See page 72 for more detail.

The same federal MLR data is used both in this Commercial Payer Trends chapter and for CHIA's Net Cost of Private Health Insurance (NCPHI). However, there are 2 key adjustments made for NCPHI: 1) while the Commercial Payer Trends chapter excludes data for self-insured plans, NCPHI includes them, and 2) while the Commercial Payer Trends represents all members with plans contracted in Massachusetts, NCPHI only represents Massachusetts resident enrollment. NCPHI increased 6.5 percent from 2022 to 2023. For more information, see page 24. ■

Commercial Payer Trends

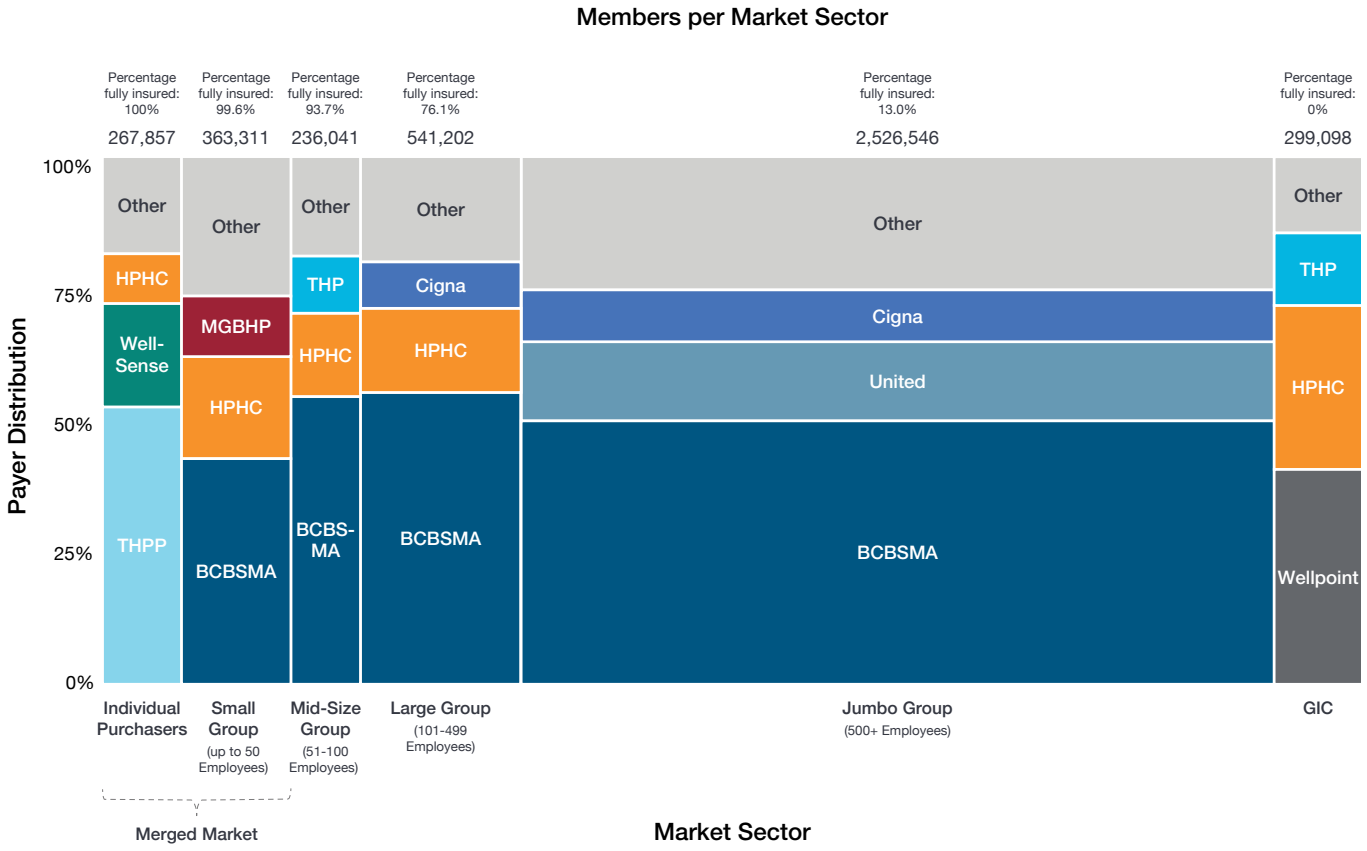
In 2023, BCBSMA remained the largest commercial payer with 44.1% of the Commonwealth's commercial contract membership.[3] However, payer market share varied across market sectors. Other than the GIC, BCBSMA maintained the largest market share in every employer-sponsored insurance (ESI) market sector; following BCBSMA in market share were HPHC (12.3%), UnitedHealthcare (10.8%), and Cigna (7.0%). HPHC became the second-largest payer in the small group market sector and replaced BCBSMA as the third-largest payer in the individual purchasers market sector.

HPHC and THP (including THPP) merged at the start of 2021 to form Point32Health, although their plans continued to submit data separately. In 2023, these entities combined represented the second-largest membership of any payer, with 21.7% of the commercial market. Because of this, Point32Health holds notable portions of the market share for individual purchasers (61.6%), small group (31.9%), mid-size group (26.9%), large group (23.9%), and the GIC (45.1%).

More than 1 in 3 GIC members (40.5%) enrolled in plans offered by Wellpoint (formerly UniCare), a subsidiary of Elevance Health.

WellSense and THPP, which historically have served MassHealth members, together enrolled nearly three-fourths (72.3%) of individual purchasers in 2023 (including ConnectorCare members).

Largest Payers by Market Sector, 2023



BCBSMA maintained nearly half of the market share in all ESI market sectors except GIC, and HPHC replaced Tufts as the second largest payer in the small group market.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. HPHC (including HPI) and Tufts entities (THP and THPP) formally merged in 2021 to form Point32Health; HPHC, THP, and THPP continue to report data as separate entities (HPI data is reported under HPHC). Annual enrollment is reported as average membership within each year, derived by dividing payer-submitted member months by 12. In 2022, Fallon stopped offering most of its commercial plans, except for its Community Care small group product and individual products; as a result, Fallon fell below membership threshold for reporting and did not submit data for CY 2023. See technical appendix.

Commercial Payer Trends

Premiums are set prospectively using data from prior years, which impacts the funds available to payers for non-medical expenses and surplus. The 2023 premium rates were developed in early 2022 using historical spending data (primarily through 2021) and projected changes in utilization, unit costs, and other factors.

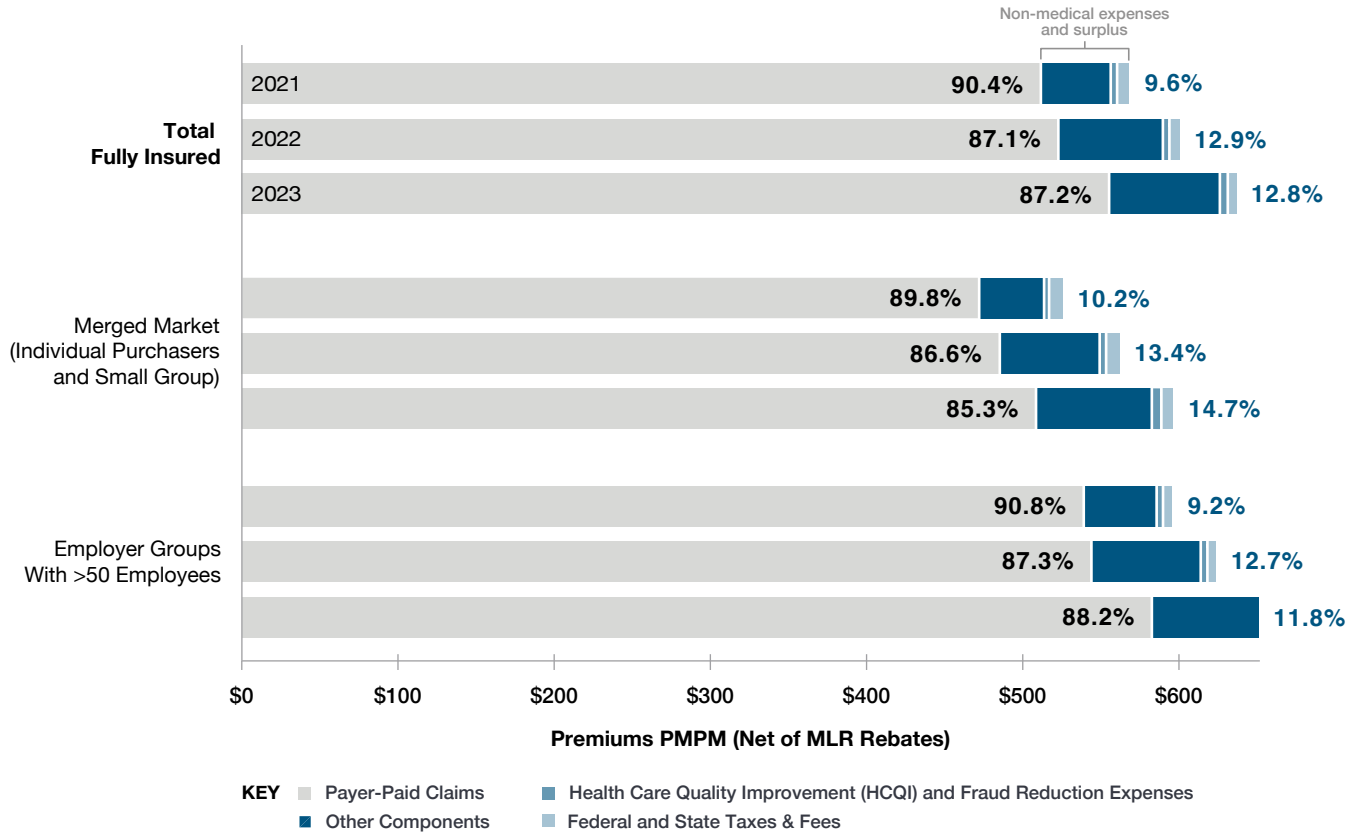
In 2023, 87.2% of premiums were used to pay for fully insured members' medical care.[4] Payers used the remaining 12.8% for plan administration and other expenses, with residual funds representing surplus (gain). This proportion of premium revenue reflecting non-medical expenses and surplus aligns with 2022 data as well as pre-pandemic years (12.0% in 2019 and 12.9% in 2022).

The percentage of premiums going towards non-medical expenses and surplus were uniquely low in 2021 (9.6%) due to rebounding health care utilization post-pandemic. Premiums had already been set, and thus the higher-than-expected utilization left a smaller portion remaining for non-medical expenses and surplus.

The proportion of premium funds that remained after medical claims were paid in 2023 varied slightly across the fully insured market sectors; the proportion in the merged market was 14.7%, and 11.8% for plans sold to larger employers.

Note: The payer-paid claims percentages reported on this page are distinct from federal MLR. The federal MLR formula treats health care quality improvement (HCQI) and fraud reduction expenses as well as taxes and fees differently than CHIA's annual financial loss ratio does. See page 72.

Fully Insured Payer Use of Premiums by Market Segment, 2021-2023



The proportion of non-medical expenses and payer surplus remained relatively steady at 12.8% in 2023, in line with 2022 and pre-pandemic levels.

Source: Payer-reported MLR data submitted to CMS.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums are net of MLR rebates, and payer-paid claims have been reduced to account for cost-sharing reduction (CSR) subsidies. See technical appendix.

Commercial Payer Trends

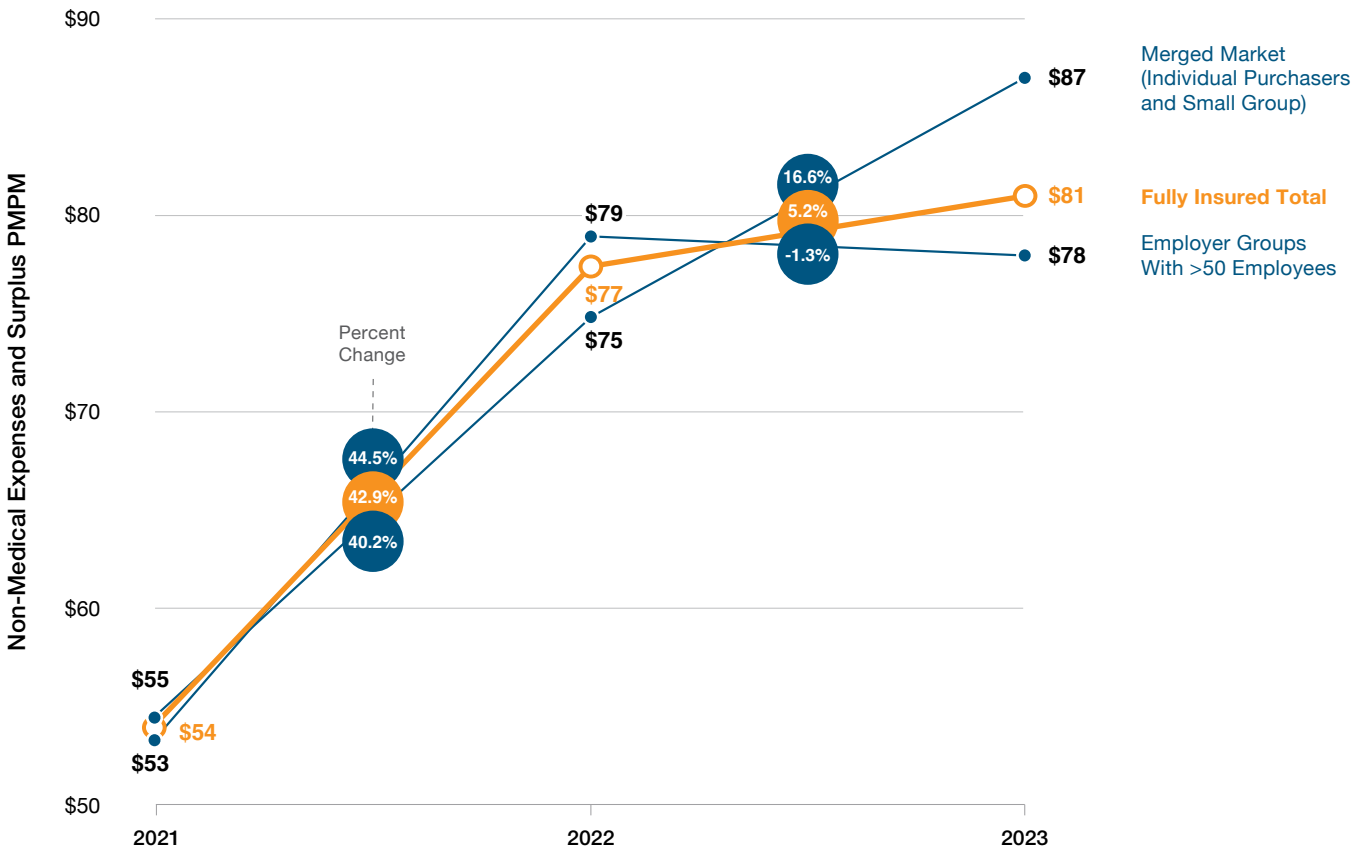
Non-medical expenses and surplus typically fluctuate from year to year as actual market conditions test assumptions made by health plan actuaries, but these fluctuations have been more drastic in recent years due to the impact of the COVID-19 pandemic. The pandemic caused extraordinary circumstances within the health care system, which contributed to unusually low health care spending in 2020 followed by rebounding utilization and claims spending in 2021. While non-medical expenses and surplus substantially increased from 2021 to 2022, the overall growth slowed from 2022 to 2023. However, overall market trends mask some differences between the Massachusetts merged market and plans sold to larger employers.

In 2023, total non-medical expenses and surplus across the private commercial fully insured market increased 5.2% from 2022 to $81 PMPM, following a 42.9% increase (from $54 to $77 PMPM) between 2021 and 2022. In total, payers paid nearly $51.6 million in MLR rebates to individuals and employers in 2023 (see page 72).

In 2023, non-medical expenses and surplus in the merged market grew by 16.6% from 2022 to $87 PMPM as overall premium growth (6.2%) outpaced medical claims cost growth (4.5%). Conversely, non-medical expenses and surplus for larger group plans declined 1.3% to $78 PMPM.

These results apply to members with insurance policies contracted in Massachusetts; the same data was used to calculate NCPHI for Massachusetts residents enrolled in commercial fully insured plans. See NCPHI results on page 24.

Fully Insured Non-Medical Expenses and Surplus by Market Segment, 2021-2023



Non-medical expenses and surplus were higher in the merged market ($87 PMPM) than for plans sold to larger employers ($78 PMPM) in 2023.

Source: Payer-reported MLR data submitted to CMS.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums are net of MLR rebates. Percent changes are calculated based on non-rounded amounts. Values have not been adjusted for inflation. See technical appendix.

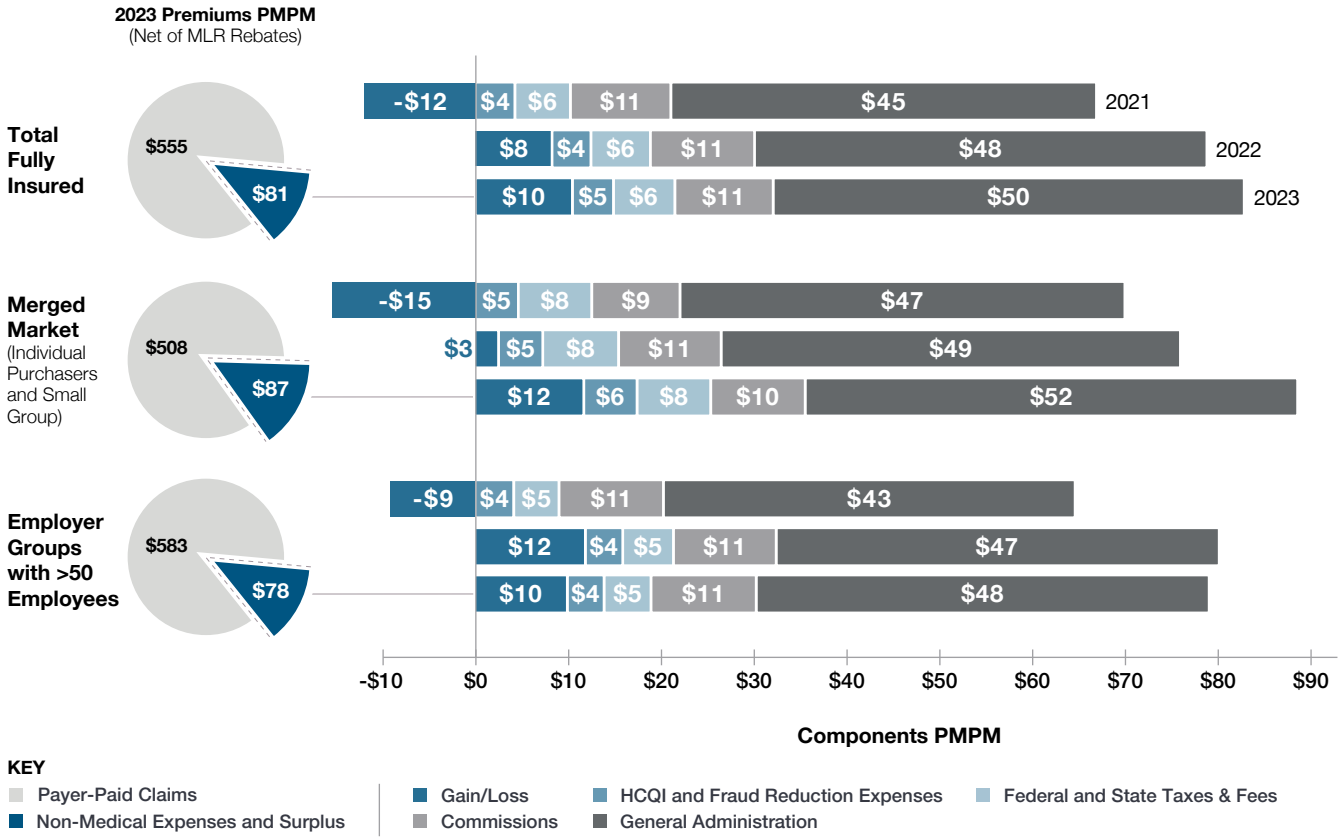
Commercial Payer Trends

Consistent with prior years, general administration represented the largest component of non-medical expenses and surplus at $50 PMPM out of the total $81 PMPM not spent on claims in 2023. Spending for general administration included costs for plan design, claims administration, cost containment, customer service, and employee wages. Administrative costs were slightly higher in the merged market ($52 PMPM) compared with larger group plans ($48 PMPM). These differences may reflect efficiencies gained from administering larger accounts.

After covering other expenses, payers reported gains (surplus) of $10 PMPM in aggregate across the fully insured market in 2023, a $2 PMPM increase from 2022. In the merged market, these gains grew from $3 PMPM in 2022 to $12 PMPM in 2023. Payers in the merged market are permitted to build a maximum allowable contribution-to-surplus of 1.9% into their premium rate filing per the Division of Insurance (DOI). Despite the notable increase in gains between 2022 and 2023, $12 PMPM was 1.9% of the average earned premium adjusted for MLR rebates. In contrast, the $3 PMPM average gain in 2022 for the merged market was just 0.5% of that year's average earned premium adjusted for MLR rebates.[5] For plans sold to larger groups, payers reported a decrease in gains ($12 PMPM in 2022 to $10 PMPM in 2023).

These figures are market-wide averages, and gains and losses varied by payer and market segment (not shown). In the merged market, BCBSMA and WellSense experienced the largest increases in surplus from 2022 to 2023, while MGBHP consistently experienced one of the largest surpluses year to year. For more information on payer-specific data, refer to the associated databook.

Fully Insured Non-Medical Expense Components and Surplus by Market Segment, 2021-2023



In 2023, payers reported an aggregate gain of $10 PMPM, a slight increase compared with gains reported in 2022 ($8 PMPM).

Source: Payer-reported MLR data submitted to CMS.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums are net of MLR rebates, and payer-paid claims have been reduced to account for cost-sharing reduction (CSR) subsidies. Enrollment figures in this chapter are based on payer-reported MLR data and may differ from prior chapters. See technical appendix.

Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio

What is the federal Medical Loss Ratio (MLR) Report?

The purpose of the federal MLR report is to measure a payer's rebate position. Health insurance consumers with fully insured coverage are protected by federal and state laws that require payers to spend a minimum percentage of collected premiums on medical care. The percentage of premiums spent on medical care, or federal MLR, is calculated within a licensed payer and market segment over a 3-year average.

In Massachusetts, if a payer's federal MLR falls below 88 percent in the merged market or below 85 percent in the fully insured larger group market over a 3-year period, that payer is required to issue rebates to consumers for the unused premium dollars. For the purposes of determining federal MLR rebate amounts, spending on health care quality improvement (HCQI) and fraud reduction count toward medical care while taxes and fees are subtracted from premiums. In addition, the federal MLR formula does not consider any rebates paid in prior years, and further adjustments are allowed to reflect the size of the population and whether premium rates are pooled across licenses.

How do claims percentages reported in this chapter differ from federal MLR?

Payer-paid claims percentages in this chapter are based on CHIA's annual financial loss ratio formula, which was developed in accordance with actuarial methods and principles. While the federal MLR and CHIA's annual financial loss ratio use the same source data, the calculation and intended purpose of the 2 ratios are distinct.

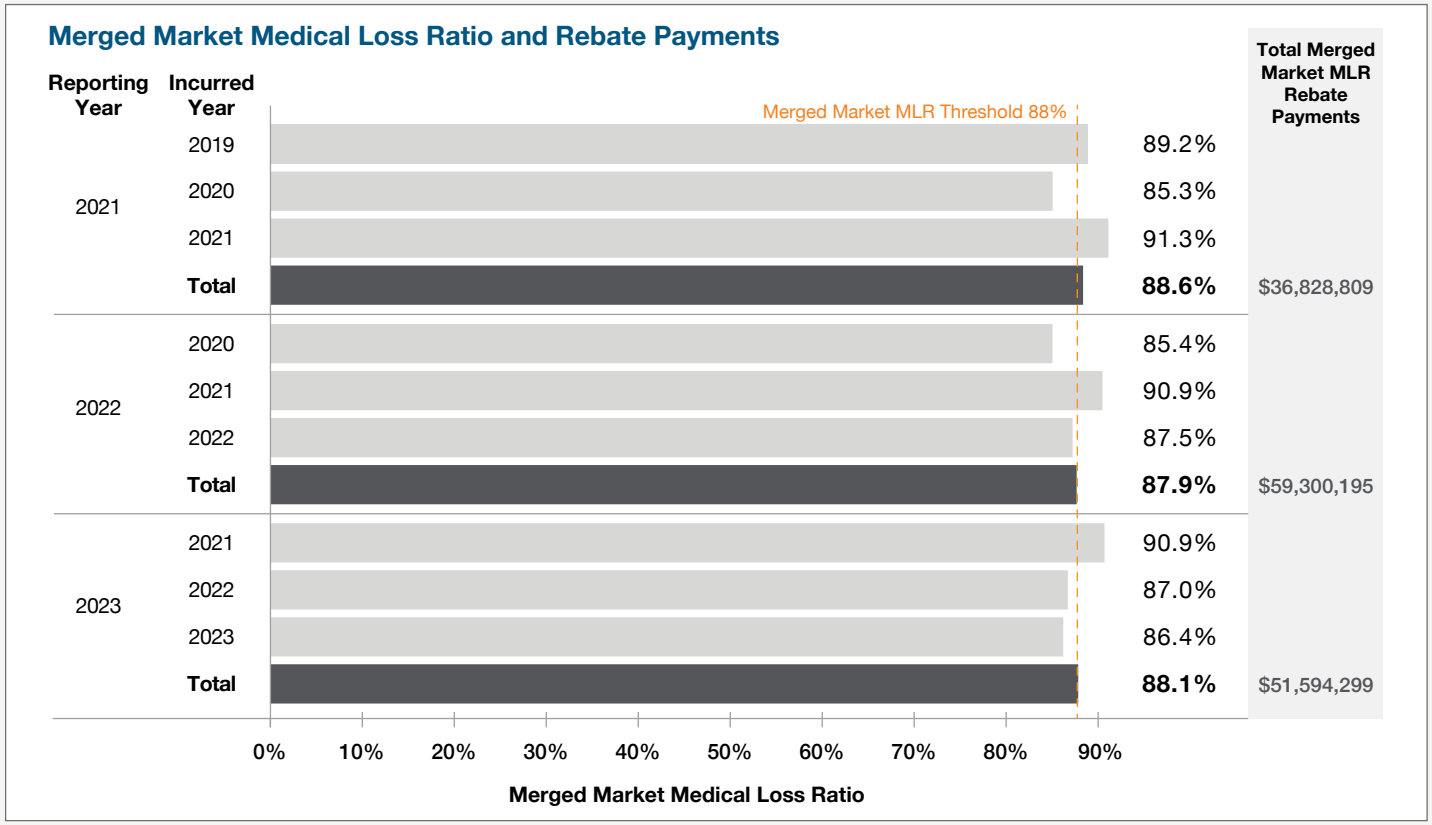
CHIA's annual financial loss ratio was designed to measure how much of a payer's premium revenue goes toward non-medical expenses and surplus in a given year. Unlike MLR, the annual financial loss ratio does not count HCQI and fraud reduction as claims expenses; taxes and fees are not subtracted from premiums; and premiums are reduced by the total amount of MLR rebates paid in that reporting year. The annual financial loss ratio is calculated for a given year within the merged market, within the fully insured larger group, and in total across all payers. For all these reasons, payer-paid claims percentages reported in this chapter cannot be used to determine whether federal MLR thresholds were met.

Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio

	Federal Medical Loss Ratio	CHIA's Annual Financial Loss Ratio
Purpose	Determine compliance with MLR thresholds and calculate MLR rebate amounts, if applicable	Measure percentages of premiums spent on members' medical costs and retained for other expenses
Population	By licensed payer By fully insured market segment	Across payers By and across fully insured market segments
Time Period	Average over 3 calendar years	1 calendar year
HCQI and Fraud Reduction Expenses	Added to incurred claims*	Not considered
MLR Rebates	Not considered	Subtracted from earned premiums
Taxes & Fees	Subtracted from earned premiums	Not considered
Simplified Formula	$\frac{\sum_{i=2021}^{2023} (\text{Incurred Claims*} + \text{HCQI} + \text{Fraud Reduction Expenses})_i}{\sum_{i=2021}^{2023} (\text{Earned Premiums} - \text{Taxes \& Fees})_i}$ Note: The federal MLR formula considers other financial amounts and adjustment factors not shown here.	$\frac{\text{Incurred Claims*}}{\text{Earned Premiums} - \text{MLR Rebates}}$

*Incurred claims minus pharmacy rebates, minus CSR subsidy payments, and net of risk adjustment and high cost risk pool payments.

Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio



Due to normal fluctuations in underwriting cycles, the MLR calculation is based on data from a rolling 3-year period.

Across all payers, the 3-year aggregated merged market MLR for the 2021 reporting year met and exceeded the 88 percent threshold at 88.6 percent. The merged market MLR in the 2022 reporting year aggregated to 87.9 percent, falling just below that threshold. In the 2023 reporting year, the merged market MLR once again met and exceeded the threshold at 88.1 percent.

While the percentages above represent the entire merged market, federal MLR is calculated and regulated at the licensed payer level. Any licensed payer that did not meet the MLR threshold for a given reporting year paid rebates to consumers. The annual totals of MLR rebates paid by all payers in the merged market are shown above.

Commercial Payer Trends Notes

1. Chapter results are based on commercial contract member data submitted to CHIA and publicly available medical loss ratio (MLR) reports submitted to CMS for the 2021, 2022, and 2023 reporting years. The following payers were included in analysis: Aetna, Blue Cross Blue Shield of Massachusetts (BCBSMA), Cigna, Fallon Health, Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Mass General Brigham Health Plan (MGBHP, formerly AllWays), Tufts Health Plan (THP), Tufts Health Public Plans (THPP), UnitedHealthcare, and WellSense (formerly BMCHP).
2. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program," *Federal Register* 81, no. 246 (2016): 94,058-94,153, https://www.govinfo.gov/content/pkg/FR-2016-12-22/pdf/2016-30433.pdf.
3. Commercial contract membership includes contracts established in Massachusetts (which may include non-Massachusetts residents), both fully and self-insured populations, and excludes MassHealth and Medicare populations.
4. The payer-paid claims percentages reported on this page are distinct from federal MLR. The federal MLR formula treats health care quality improvement (HCQI) and fraud reduction expenses, as well as taxes and fees, differently than CHIA's annual financial loss ratio does. See page 72.
5. If a company's Risk-based Capital (RBC) falls below 300% for four consecutive quarters, the contribution-to-surplus maximum is increased to 2.5% as opposed to 1.9%. For the formal definition, see URL. Massachusetts Division of Insurance, *211 CMR 66.00: Small Group Health Insurance* (February 2023), https://www.mass.gov/doc/211-cmr-66-small-group-health-insurance/download.

KEY FINDINGS

Provider and Health System Trends

Acute care utilization in the inpatient and emergency department settings has increased since the COVID-19 pandemic but remains below pre-pandemic levels as of June 2024.

While the average length of stay (ALOS) across all acute care settings rose through the COVID-19 pandemic, ALOS has since decreased but remains higher than pre-pandemic levels as of June 2024.

In hospital fiscal year 2023, aggregate operating revenues exceeded aggregate operating expenses at acute care hospitals, contributing to a positive statewide median hospital total margin.

After a downward trend in nursing facility occupancy, system-level occupancy rates have been increasing since calendar year (CY) 2020 reaching 83.8% in CY 2023.

Provider and Health System Trends

Utilization trends in both acute and post-acute settings, as well as the financial performance of hospitals, are key indicators of the overall sustainability of our health system. This chapter presents information about hospital and nursing facility utilization and hospital financial performance. The first section provides trends for total volume and average length of stay (ALOS) for acute hospital inpatient discharges, emergency department visits, and outpatient observation visits from October 2018 to June 2024, using data from the **Acute Hospital Case Mix Database**.

The second section outlines trends in financial performance among acute hospitals for hospital fiscal years (HFY) 2019 to 2023 as well as a preview of HFY 2024 with YTD financial data through June 30, 2024. This section also includes a comparison of annual aggregate acute hospital operating revenue and expenses since HFY 2019. These data are sourced from hospital financial reporting to CHIA and reflect both federal and state COVID-related funding that was distributed to hospitals and reported as operating revenue.

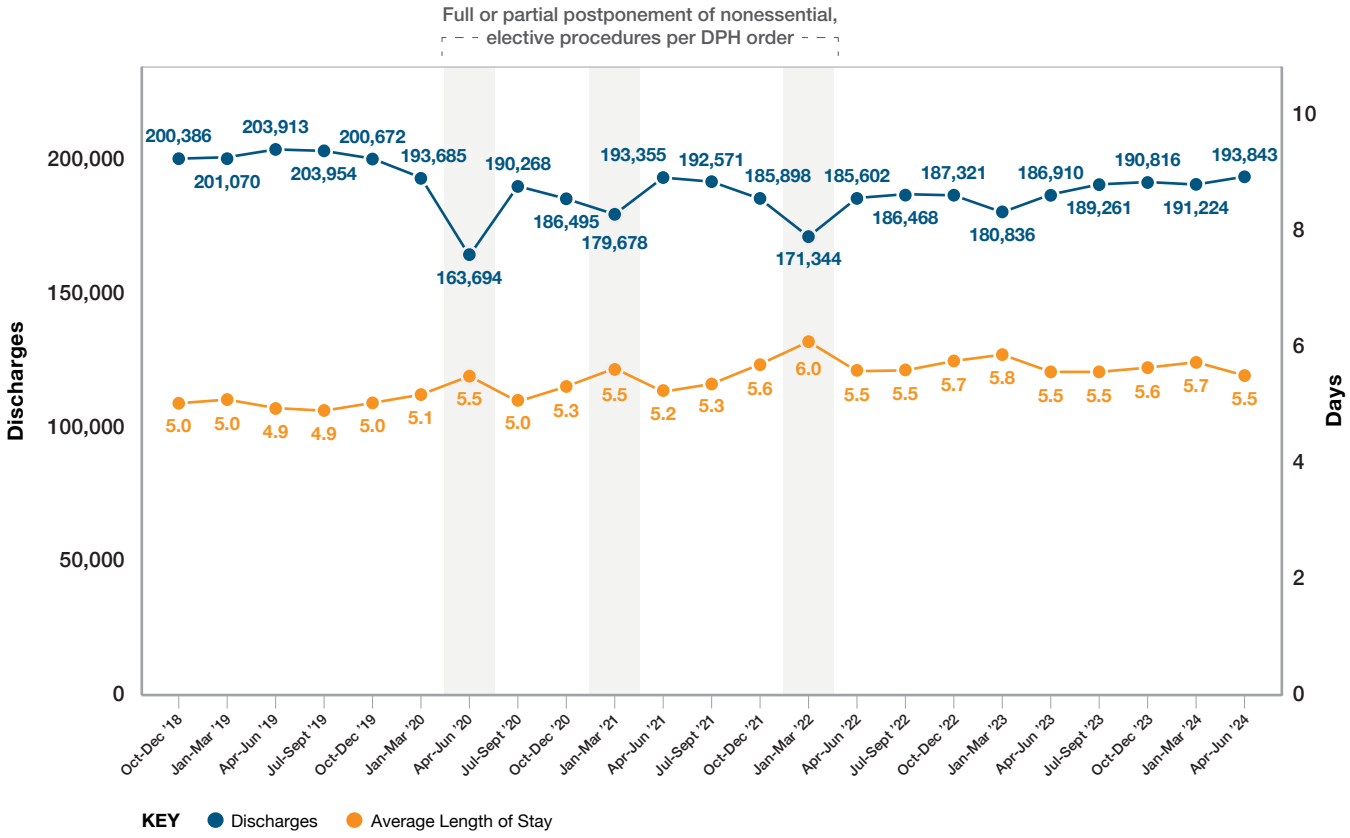
Finally, this chapter includes an overview of nursing facility occupancy and capacity trends utilizing cost report data submitted to CHIA. ■

Provider and Health System Trends

Total acute care hospital inpatient discharges were relatively stable in federal fiscal year (FFY) 2019. Inpatient discharges declined during the COVID-19 pandemic, most notably during “waves” of increased COVID-19 cases, from April-June 2020, January-March 2021, and January-March 2022. From April-June 2024, there were more than 193,000 inpatient discharges at acute care hospitals in Massachusetts, almost 5% lower than the same period in 2019.

ALOS increased from 5.0 days prior to the pandemic to a peak of 6.0 days during the COVID-19 pandemic. ALOS has since decreased but remains higher than pre-pandemic levels. From April-June 2024, ALOS was 5.5 days, 12% higher than the same period in 2019. These trends may be attributed to throughput challenges, such as placement in post-acute care settings, and shifts in inpatient acuity.

Total Acute Care Hospital Inpatient Discharges, October 2018-June 2024



Inpatient discharges at acute care hospitals have increased following the COVID-19 pandemic but remain lower than FFY 2019, while ALOS has decreased but remains higher than FFY 2019.

Source: Hospital Inpatient Discharge Database (HIDD), October 2018-June 2024.

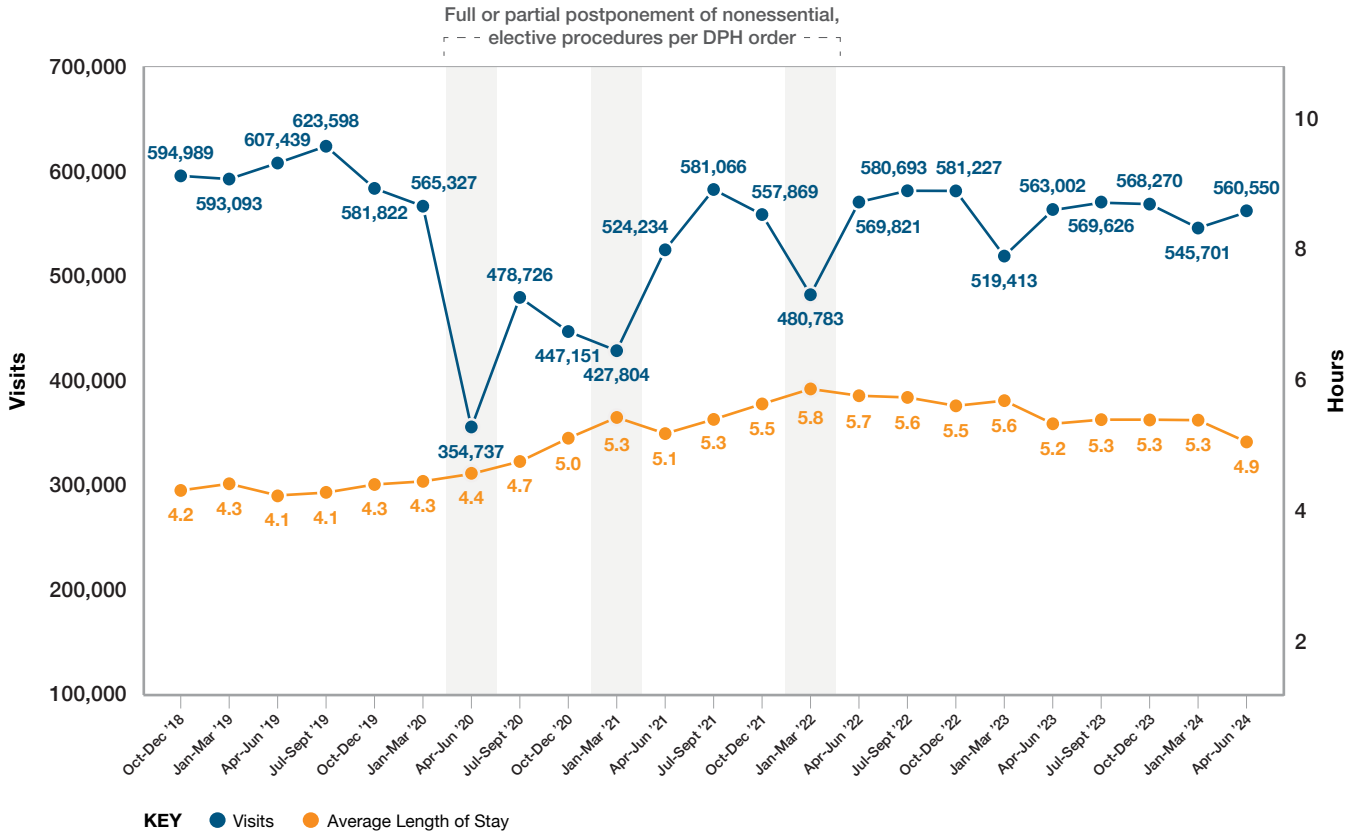
Notes: Federal fiscal years run from October 1 through September 30. ALOS calculated as difference in number of days between discharge date and admission date. HIDD data for FFY 2024 (October 2023-June 2024) are not considered final and are subject to change. See CHIA website for the most up-to-date information on inpatient utilization.

Provider and Health System Trends

Similar to inpatient trends, treat-and-release ED visits fell during the COVID-19 pandemic following a period of relative stability in FFY 2019. The number of ED visits fell sharply in April 2020 and has since fluctuated quarter to quarter. From April-June 2024, there were more than 560,000 ED visits, about 8% lower than the same period in 2019.

ALOS increased through the COVID-19 pandemic and has since decreased but remains higher than pre-pandemic levels. From April-June 2024, ALOS was 4.9 hours, about 20% higher than the same period in 2019.

Total Acute Care Hospital Emergency Department Treat-and-Release Visits, October 2018-June 2024



ALOS in the emergency department has decreased since the COVID-19 pandemic but remains higher than FFY 2019.

Source: Emergency Department Database (EDD), October 2018-June 2024.

Notes: ALOS calculated as difference in number of hours between discharge time and admission time. Several hospitals resubmitted data from FFY 2023 through March 2024 to reclassify certain ED visits. Emergency visit data from these hospitals have been reclassified to observation data for visits that began in emergency department but ended in outpatient observation stay. EDD data for FFY 2024 (October 2023-June 2024) not considered final and subject to change. See CHIA website for the most up-to-date information on emergency department utilization.

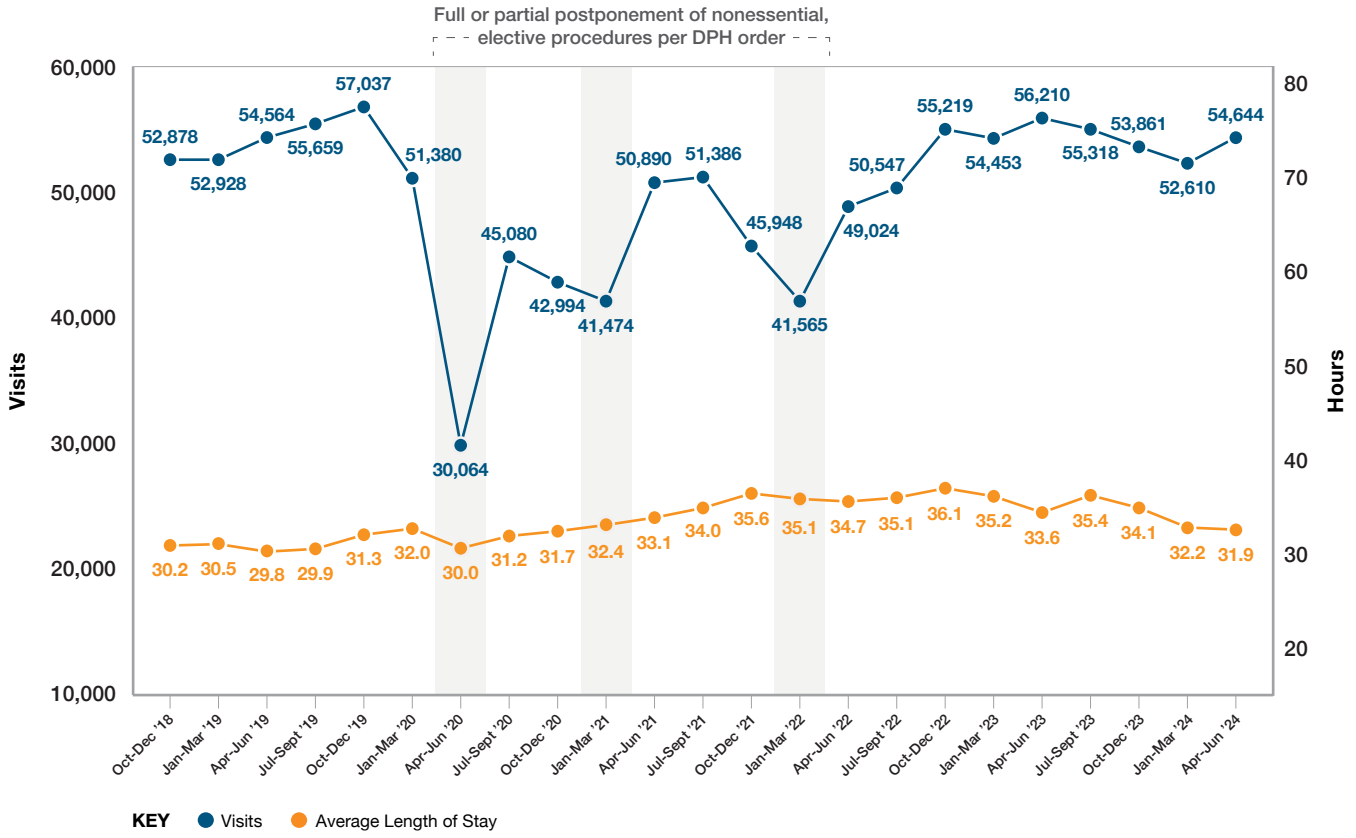
Provider and Health System Trends

Observation visits, like ED visits, are classified as outpatient care and may serve a variety of functions, including the assessment of patients who may require additional diagnostics or therapeutic treatment beyond care in the emergency department but do not require admission to the inpatient setting. Adults most commonly have observation visits for symptoms such as nonspecific chest pain, syncope (commonly referred to as fainting), or abdominal pain.

Like all other acute care utilization during the COVID-19 pandemic, the volume of observation visits fell sharply, especially during periods coinciding with peaks in COVID-19 cases. Since October 2022, observation visits have rebounded to pre-pandemic levels, with nearly 55,000 observation visits between April and June 2024, similar to the same period in 2019.

Observation ALOS increased through December 2022, peaking at 36.1 hours. ALOS has since decreased to 31.9 hours from April-June 2024, but remains 7% higher than the same period in 2019.

Total Acute Care Hospital Outpatient Observation Discharges, October 2018-June 2024



Following a period of decreased utilization during the COVID-19 pandemic, the volume of outpatient observation visits has returned to pre-pandemic levels.

Source: Outpatient Observation Database (OOD), October 2018-June 2024.

Notes: ALOS calculated as difference in number of hours between discharge time and admission time. Several hospitals resubmitted data from FFY 2023 through March 2024 to reclassify certain ED and outpatient observation visits. Observation visit data from these hospitals now include visits that began in emergency department but ended in outpatient observation stay. OOD data for FFY 2024 (October 2023-June 2024) not considered final and subject to change. See CHIA website for the most up-to-date information on outpatient utilization.

Provider and Health System Trends

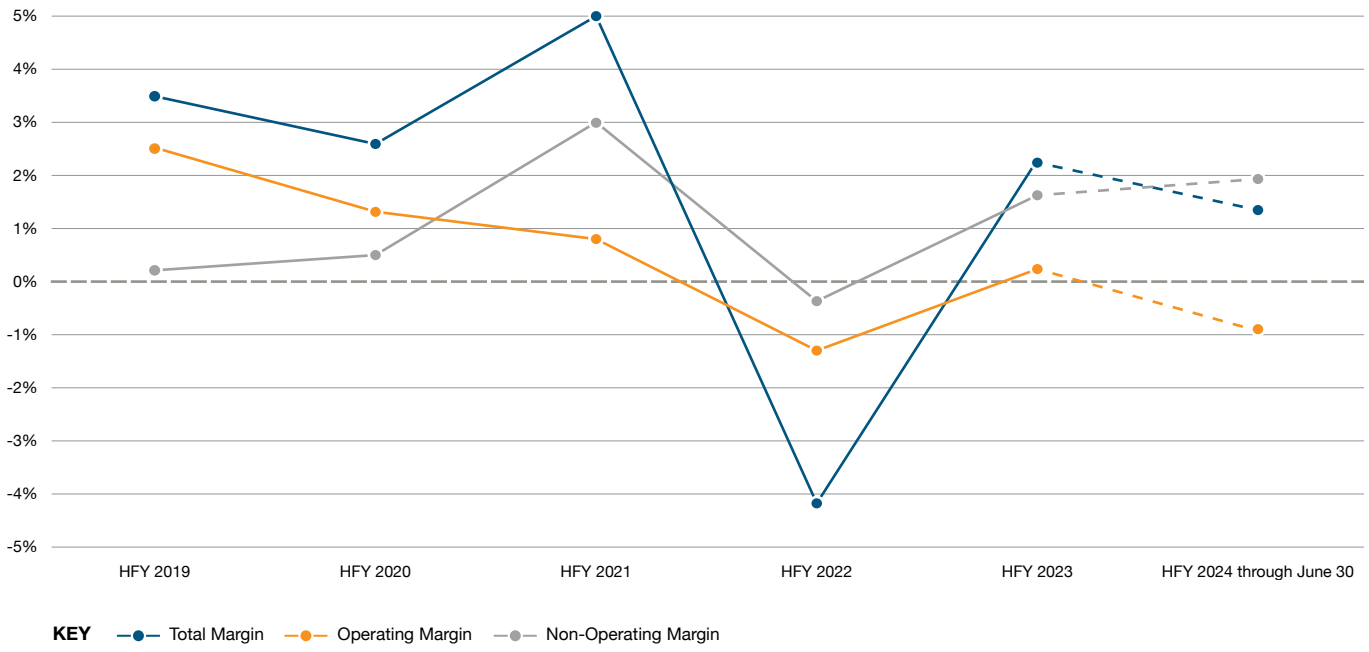
Total margin reflects the excess of total revenues over total expenses, including operating and non-operating activities, as a percentage of total revenue. The margins include COVID-19 relief funding reported as operating revenue as well as unrealized gains or losses reported as non-operating revenue.

The statewide acute hospital median total margin increased by 6.4 percentage points, from -4.2% in HFY 2022 to 2.2% in HFY 2023. Thirty-eight of 60 (63%) acute hospitals reported positive total margins in HFY 2023. In addition to non-operating activities, these margins include $343.6 million in COVID-19 relief funding.

The statewide acute hospital median operating margin increased from -1.3% in HFY 2022 to 0.2% in HFY 2023, and the statewide median non-operating margin increased from -0.4% to 1.6% during this period. Thirty-two of 60 (53%) acute hospitals reported positive operating margins in HFY 2023.

In the HFY 2024 data through June 30, 2024, the statewide median total margin was 1.4%. Of the 58 hospitals included in the data through June 30, 2024, 35 (60%) reported positive total margins, while 25 (43%) hospitals reported positive operating margins.

Statewide Acute Hospital Median Total, Operating, and Non-Operating Margin Trends, HFY 2019-HFY 2024 through June 2024



Statewide Median	HFY 2019	HFY 2020	HFY 2021	HFY 2022	HFY 2023	HFY 2024 through June 30
Total Margin	3.5%	2.6%	5.0%	-4.2%	2.2%	1.4%
Operating Margin	2.5%	1.3%	0.8%	-1.3%	0.2%	-0.9%
Non-Operating Margin	0.2%	0.5%	3.0%	-0.4%	1.6%	1.9%

The median acute hospital total margin in HFY 2023 was 2.2%, an increase of 6.4 percentage points from the prior fiscal year. The median acute hospital operating margin was 0.2%, an increase of 1.5 percentage points.

Source: Standardized annual and quarterly financial statements reported to CHIA.

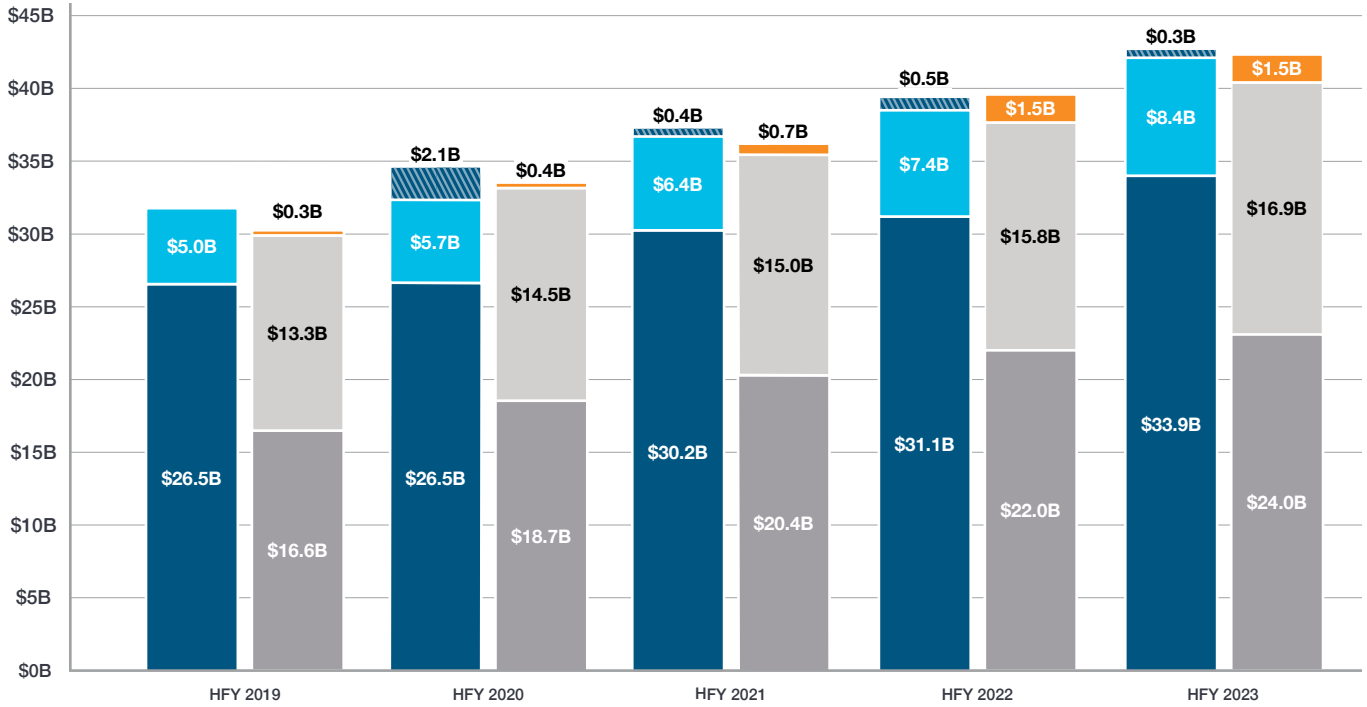
Provider and Health System Trends

Aggregate total operating revenue increased by $3.6 billion (9.4%) from HFY 2022 to HFY 2023, with aggregate net patient service revenue, the most significant component of operating revenue, increasing by $2.8 billion (8.9%). Aggregate expenses increased $3.0 billion (7.6%) compared with the prior fiscal year. In HFY 2023, acute hospital aggregate operating revenues exceeded aggregate expenses by $190 million.

Hospitals reported $343.6 million in COVID-19 relief funds in their operating revenue in HFY 2023 compared with $467.6 million in HFY 2022.

Aggregate workforce spending at acute hospitals, comprising salary and benefits and temporary labor costs, increased $1.0 billion (5.8%) in HFY 2023 compared with the prior hospital fiscal year. Temporary labor expenses represented 8.2% of workforce expenditures in HFY 2023, a 0.7 percentage point decrease from HFY 2022. Total workforce spending represented 43.3% of total expenses, consistent with prior years.

Hospital Operating Revenue and Expense Trends, HFY 2019-2023



	HFY 2019	HFY 2020	HFY 2021	HFY 2022	HFY 2023
Total Operating Revenue	$31.5B	$34.3B	$37.0B	$39.0B	$42.6B
Total Expenses	$30.3B	$33.7B	$36.2B	$39.4B	$42.4B

KEY: Net Patient Service Revenue; Other Operating Revenue; COVID-19 Relief Funds; Other Expenses; Salary and Benefits; Temporary Staffing

In HFY 2023, aggregate operating revenues exceeded aggregate expenses by $190 million at acute hospitals.

Source: Standardized annual and quarterly financial statements reported to CHIA.

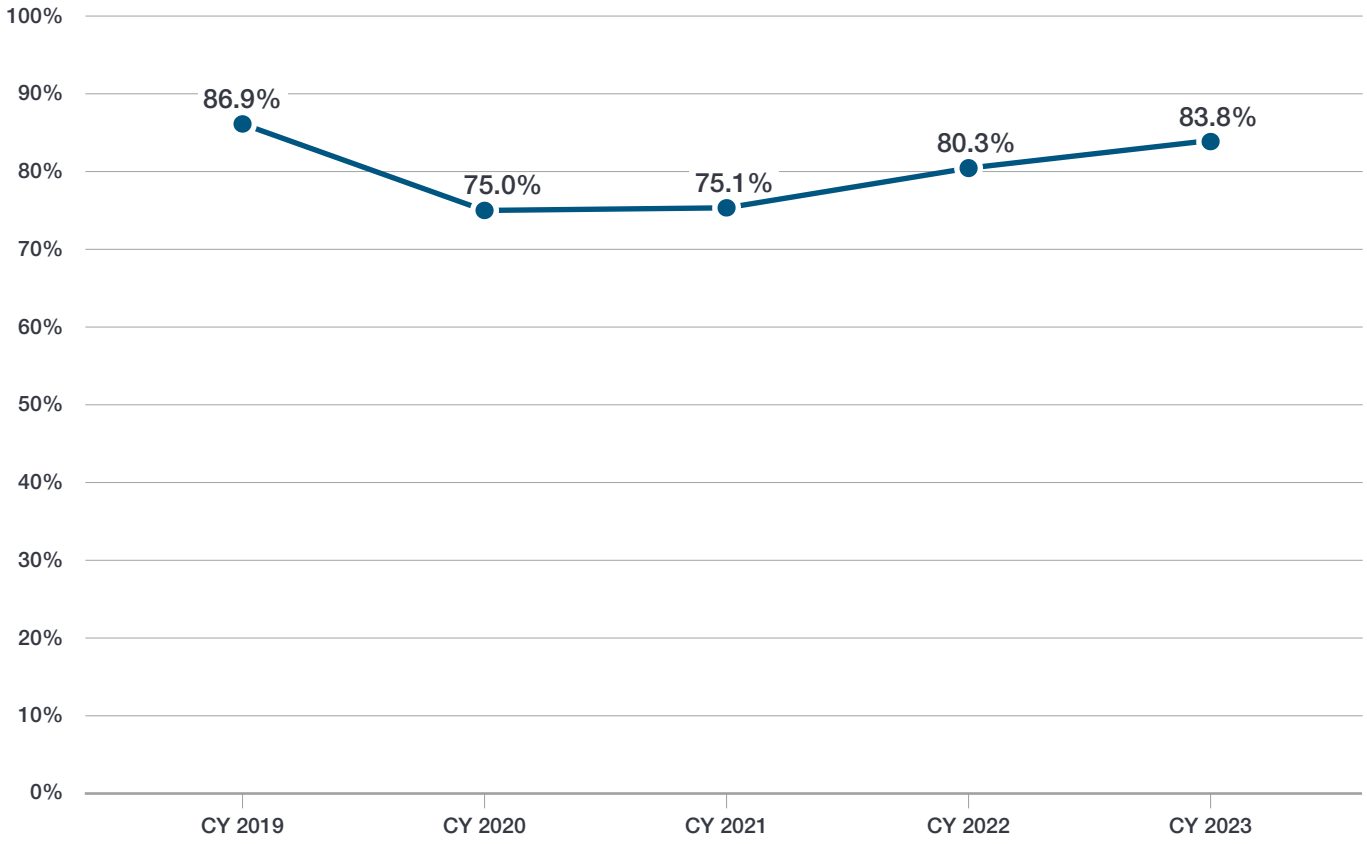
Notes: Alternative payment methods and net assets released from restrictions included in other operating revenue.

Provider and Health System Trends

Occupancy rates are used to examine the actual utilization of a facility compared with the total number of licensed beds. Occupancy rates can be an indicator of financial stability as higher occupancy generates increased revenues to offset both fixed and variable expenses. The system-level occupancy rates depicted here measure the total occupied beds across all nursing facilities as a percentage of total licensed beds for a given year.

Nursing facility occupancy decreased by 11.9 percentage points between CY 2019 and 2020, falling from 86.9% to 75.0%, driven in part by impacts of the COVID-19 pandemic. Since then, the system-level occupancy rate has been increasing year over year.

Nursing Facility Occupancy Rates, System Level, CY 2019-2023



In CY 2023, system-level occupancy increased to 83.8% from the prior year occupancy rate of 80.3%.

Source: Skilled Nursing Facility Cost Reports (HCF-1/SNF-CR) reported to CHIA.

Notes: Nursing facility data used on this page and next is as reported by facilities that submit cost reports to CHIA; private pay facilities that do not accept Medicaid not included. Where occupancy measures are presented on this page (aggregate occupancy) and next page (median occupancy), "licensed beds" is used in denominator of occupancy calculation. The term "licensed beds" refers to number of beds on license issued to facility by Massachusetts Department of Public Health and represents total maximum capacity of facility allowed under that license. This may be greater than actual number of beds facility has staffed and available for use at a given time.

Provider and Health System Trends

In 2023, there were 334 total nursing facilities that served MassHealth or other publicly aided residents in Massachusetts. While the aggregate system-level occupancy rate was 83.8%, the median facility occupancy rate statewide was 85.8%.

Excluding the 2 counties with only 1 facility each, in 2023, Franklin County had the fewest nursing facilities and licensed beds with 3 total facilities and 306 beds. Middlesex County had the highest number of total facilities (67) and licensed beds (8,086). Excluding Dukes County (which only has 1 facility), Barnstable County had the lowest median occupancy rate among all counties in 2023, at 79.1% across 16 nursing facilities. Worcester County had the highest median occupancy rate at 90.7% across 49 facilities.

The median occupancy rate statewide and in all but 1 county increased between 2022 and 2023. The statewide median occupancy rate increased by more than 5% compared with 2022, as did the county-level median occupancy rate for 6 out of 14 counties. The closure of 4 facilities in Hampden County and the corresponding decrease to licensed beds in that county is also reflected in the table.

Total Facilities, Total Beds, and Median Occupancy by County, CY 2023

County	Total Facilities	Licensed Beds	Median Occupancy
Barnstable	16	1,769	79.1%
Berkshire	12	1,291	89.8%
Bristol	28	3,698	85.5%
Dukes	1	61	47.8%
Essex	45	4,936	84.4%
Franklin	3	306	89.8%
Hampden	24	2,814	88.0%
Hampshire	6	755	88.8%
Middlesex	67	8,086	86.0%
Nantucket	1	45	82.6%
Norfolk	33	3,672	81.5%
Plymouth	28	3,321	84.8%
Suffolk	21	2,688	89.3%
Worcester	49	5,814	90.7%
Statewide	**334**	**39,256**	**85.8%**

KEY Increase >10% compared with CY 2022 | Increase between 5% and 10% compared with CY 2022 | Decrease >10% compared with CY 2022

Nursing facility median occupancy increased statewide and in 13 out of 14 counties between CY 2022 and CY 2023.

KEY FINDINGS

Behavioral Health

In 2023, behavioral health spending represented 7.7% of total private commercial health spending, 22.1% for MassHealth, and 2.5% for Medicare Advantage.

Inpatient discharges for patients with a primary behavioral health diagnosis in 2024 were more than 20% lower than pre-pandemic levels.

More than 1 in 7 Massachusetts residents reported paying for their most recent behavioral visit entirely out of pocket, most commonly for reasons related to insurance coverage.

Spending on mental health outpatient services increased in 2023 and accounted for 55.1% of commercial, 51.3% of MassHealth, and 22.0% of Medicare Advantage mental health spending.

Substance use disorder (SUD) inpatient services accounted for the largest proportion of commercial (43.9%) and Medicare Advantage (41.8%) total SUD spending and less than one-third of MassHealth SUD spending.

Behavioral Health

Massachusetts residents seeking behavioral health (BH) care can face unique challenges that make accessing, financing, and maintaining treatment difficult, leading to worse health outcomes for patients. These challenges include a fragmented provider and coverage system, high out-of-pocket costs, workforce shortages, and continuing stigma associated with mental health (MH) and substance use disorders (SUD).

Over the past 4 years, the Commonwealth has enacted several policy changes to address these challenges. In 2022, Massachusetts enacted the Mental Health ABC Act: Addressing Barriers to Care—aimed at expanding access to behavioral health care services and supporting the behavioral health workforce. In addition, this legislation charged CHIA with monitoring "costs, cost trends, price, quality, utilization, and patient outcomes related to behavioral health service subcategories… including mental health, substance use disorder, outpatient, inpatient, services for children, services for adults, and provider type."[1]

The Massachusetts Roadmap for Behavioral Health Reform was implemented in 2023 to enhance access to mental health and substance use disorder services across the state. Key components of this roadmap include the creation of a behavioral health helpline for 24/7 access to services, an extended network of community behavioral health centers, and access to behavioral health urgent care centers.[2]

This chapter provides an overview of behavioral health care in Massachusetts with data starting in CY 2022. It examines total spending by insurers and patients for MH and SUD services by age group for pediatric (0-17) and adult populations (18-64). This chapter highlights behavioral health spending trends that covers MH and SUD services delivered in several care settings, including inpatient, emergency

department, and outpatient settings delivered by both primary care and non-primary care providers. In addition, this chapter includes information on behavioral health utilization in both acute and non-acute hospitals through June 2024. Finally, this chapter provides a look at access and affordability challenges from the resident perspective including prevalence of residents paying for behavioral health visits entirely out of pocket or forgoing such care altogether.

In addition to the data points accompanied by this chapter, CHIA publishes a Primary Care and Behavioral Health Spending report and a Behavioral Health Dashboard. Both the report and dashboard include BH-specific data points reflecting statewide results, payer- and provider-specific data, and utilization metrics. For more information, see the **Primary Care and Behavioral Health Care Spending Report** and **Behavioral Health Dashboard** online.

Data Sources and Methodology

Results reported in this chapter utilize several data sets, including a survey of residents, aggregate data reported by payers, provider-reported cost reports, as well as hospital-reported discharge- and visit-level datasets.

Based on CHIA's published list of ICD-10 diagnosis codes, members with a mental health or substance use disorder primary diagnosis at any point throughout the specified reporting period are captured in this data to quantify trends in behavioral health utilization and total spending.

Through CHIA's primary care and behavioral health data collection requirements, a crosswalk of CPT, revenue, and point of service codes were utilized by payers to report and categorize BH-specific spending. For additional details on diagnoses and code lists for services classified as behavioral health, see the primary care and behavioral health data specifications.[3]

Behavioral health spending data reported in this chapter reflect payments for MH and SUD services that are limited to those covered by a member's health insurance plan and do not include services paid for privately by patients outside of their insurance coverage. BH-specific spending measures represent payments for behavioral health services across private commercial insurance, MassHealth, and Medicare Advantage lines of business. Utilization measures for acute care and behavioral health hospitals are inclusive of patients with all types of private and public insurance, including MassHealth, Medicare, and self-pay.

Estimates reported for any unmet need for BH care and out-of-pocket spending on BH visits come from the 2023 Massachusetts Health Insurance Survey (MHIS). The MHIS was fielded in English and Spanish from April to August 2023 and collected data on 5,266 residents and their families. All estimates provided in this chapter are weighted to provide population-based estimates for the noninstitutionalized resident population of the

Commonwealth. Additional information about the design of the MHIS is available in the **MHIS methodology report**.

More detailed information about behavioral health in Massachusetts can be found in other CHIA reports, including **Behavioral Health and Readmissions in Massachusetts Acute Care Hospitals**, **Primary Care and Behavioral Health Spending**, and the **Behavioral Health and Specialty Care Hospital Profiles**. ■

Behavioral Health

In 2023, the percentage of private commercially insured members with a behavioral health diagnosis increased 1.0 percentage point from 2022, to 23.5%. Private commercial spending on behavioral health services (MH and SUD combined) represented 7.7% of total spending in 2023, relatively consistent with 2022. MH services represented the majority of private commercial behavioral health spending at $45 PMPM (6.4% of total spending) compared with $9 PMPM for SUD services (1.2% of total spending).

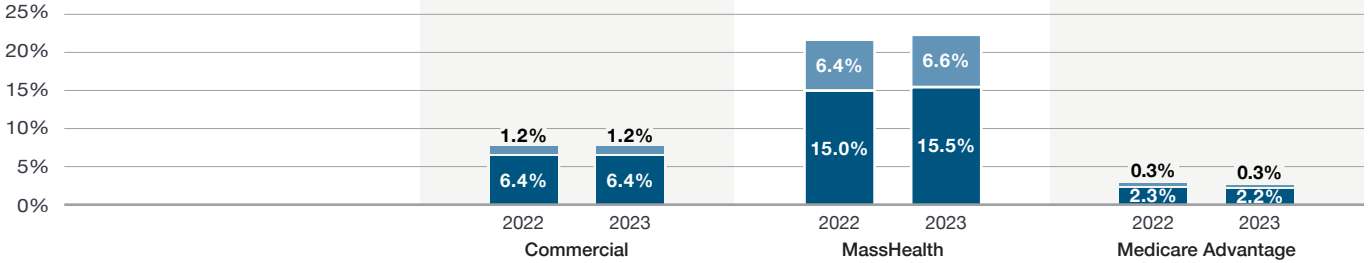
MassHealth had the highest BH diagnosis prevalence across insurance categories, at 28.0% in 2023, and the highest percentage of spending on behavioral health services. BH spending accounted for 22.1% of total MassHealth spending in 2023, an increase of 0.7 percentage point from 2022. On a PMPM basis, behavioral health spending increased from $126 PMPM in 2022 to $141 PMPM in 2023.

In 2023, 19.5% of Medicare Advantage members had a BH diagnosis, an increase from 17.9% in 2022; 2.5% of total Medicare Advantage spending was attributed to behavioral health services, with 2.2% for MH and 0.3% for SUD services. Mental health PMPM spending remained consistent across both years at $27 PMPM, while SUD PMPM spending increased from $3 PMPM in 2022 to $4 PMPM in 2023.

Behavioral Health Spending and Diagnosis Prevalence by Insurance Category, 2022-2023

	Commercial		MassHealth		Medicare Advantage	
	2022	2023	2022	2023	2022	2023
Total Member Months	37.1M	36.5M	17.8M	18.4M	2.8M	3.0M
% Members with MH Diagnosis	21.1%	22.1%	23.8%	23.0%	15.8%	17.2%
% Members with SUD Diagnosis	1.4%	1.4%	5.5%	4.9%	2.1%	2.3%
% Members with BH Diagnosis	**22.5%**	**23.5%**	**29.3%**	**28.0%**	**17.9%**	**19.5%**
Total PMPM	$625	$690	$591	$641	$1,152	$1,261
Mental Health PMPM	$40	$45	$89	$99	$27	$27
SUD PMPM	$8	$9	$38	$42	$3	$4
Behavioral Health PMPM	**$48**	**$53**	**$126**	**$141**	**$30**	**$31**

Percentage of Total Expenditures



	Commercial		MassHealth		Medicare Advantage	
% of Total Expenditures	**7.6%**	**7.7%**	**21.4%**	**22.1%**	**2.6%**	**2.5%**

KEY ■ MH ■ SUD

In 2023, spending on behavioral health services represented 7.7% of commercial, 22.1% of MassHealth, and 2.5% of Medicare Advantage total health care spending.

Source: Payer-reported data to CHIA.

Notes: Data for Original Medicare not available for this analysis. For commercial partial-claim data, CHIA estimated pharmacy spending by service type. MassHealth-submitted data includes data for members for which MassHealth is primary payer, including fee-for-service (FFS) (excluding FFS dual eligibility, FFS with third-party liability, FFS limited), MCO/ACO-A, ACO-B, and PCC program types. United and United Medicare Advantage excluded from this analysis due to data quality concerns. Analysis represents data from commercial payers that submitted CY 2022 and CY 2023 data representing approximately 92% of commercial market, 100% of commercially administered MCO/ACO-A market, and 72% of Medicare Advantage market. As a result, data may not tie to Total Health Care Expenditures chapter. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had MH or SUD principal diagnosis at any point during reporting year. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

Across all MassHealth programs, spending for members on behavioral health services totaled $2.6 billion in 2023, an increase from $2.3 billion in 2022. Additionally, MassHealth BH-related supplemental payments totaled $155.7 million in 2023, funding high public payer BH hospital programs and Behavioral Health Quality Incentive (BHQI) programs.

In April 2023, MassHealth initiated its redetermination process that disenrolled ineligible individuals following the end of federal continuous coverage protections and at the same time reprocured ACO-A and ACO-B contracts.[4,5] These changes impacted the member composition of MassHealth overall and within each program.

MCO/ACO-A plans reported proportion of total spending on BH services was 22.0% in 2023. MCO/ACO-A behavioral health spending increased to $143 PMPM, driven by an increase in MH service spending from $88 PMPM to $101 PMPM.

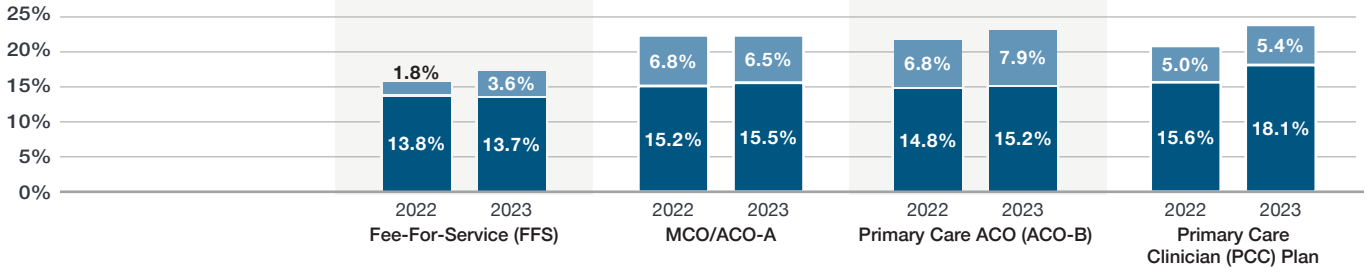
In 2023, 26.6% of primary care clinician (PCC) plan members had a behavioral health diagnosis, a decline of 3.7 percentage points from 2022. BH services accounted for 23.5% of PCC total spending, driven by a high proportion of MH spending (18.1%, $112 PMPM). MassHealth fee-for-service (FFS) reported the lowest proportion of BH spending (17.3% of FFS in 2023), though this was an increase of 1.7 percentage points from 2022.

Behavioral health services accounted for 23.1% of Primary Care ACO (ACO-B) total spending in 2023, increasing from $128 PMPM to $146 PMPM. Primary Care ACO (ACO-B) plans experienced the largest decline in membership (1.1 million members) across MassHealth program types.

MassHealth Behavioral Health Spending and Diagnosis Prevalence by Program Type, 2022-2023

	Fee-For-Service (FFS)		MCO/ACO-A		Primary Care ACO (ACO-B)		Primary Care Clinician (PCC) Plan	
	2022	2023	2022	2023	2022	2023	2022	2023
Total Member Months	1.1M	1.2M	9.8M	11.8M	5.5M	4.4M	1.4M	0.9M
% Members with MH Diagnosis	12.7%	11.7%	25.4%	25.1%	23.0%	20.9%	24.8%	22.1%
% Members with SUD Diagnosis	1.9%	2.0%	5.5%	4.9%	6.0%	6.0%	5.5%	4.5%
% Members with BH Diagnosis	**14.5%**	**13.7%**	**30.9%**	**30.0%**	**29.0%**	**26.9%**	**30.3%**	**26.6%**
Total PMPM	$588	$590	$583	$652	$595	$632	$641	$622
Mental Health PMPM	$81	$81	$88	$101	$88	$96	$100	$112
SUD PMPM	$11	$21	$40	$42	$40	$50	$32	$34
Behavioral Health PMPM	**$92**	**$102**	**$128**	**$143**	**$128**	**$146**	**$132**	**$146**
Behavioral Health Spending	**$98.6M**	**$124.6M**	**$1,257.3M**	**$1,698.2M**	**$708.8M**	**$649.4M**	**$185.6M**	**$137.2M**

Percentage of Total Expenditures



	Fee-For-Service (FFS)		MCO/ACO-A		Primary Care ACO (ACO-B)		Primary Care Clinician (PCC) Plan	
% of Total Expenditures	**15.6%**	**17.3%**	**22.0%**	**22.0%**	**21.6%**	**23.1%**	**20.6%**	**23.5%**

KEY MH SUD

In 2023, MCO/ACO-A plans reported the highest proportion of members with a BH diagnosis as well as the highest total spending for behavioral health among MassHealth plans.

Source: Payer-reported data to CHIA.

Notes: MassHealth data includes programs administered by MassHealth directly (fee-for-service [FFS][excluding FFS dual eligibility, FFS with third-party liability, FFS limited], Primary Care ACOs [ACO-B], Primary Care Clinician [PCC]) and those administered by commercial health plans (Accountable Care Partnerships [ACO-A], Managed Care Organizations [MCO]). As a result, data may not tie to Total Health Care Expenditures chapter. MCO/ACO-A diagnosis prevalence sourced from data submitted by commercial payers. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had MH or SUD principal diagnosis at any point during reporting year. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

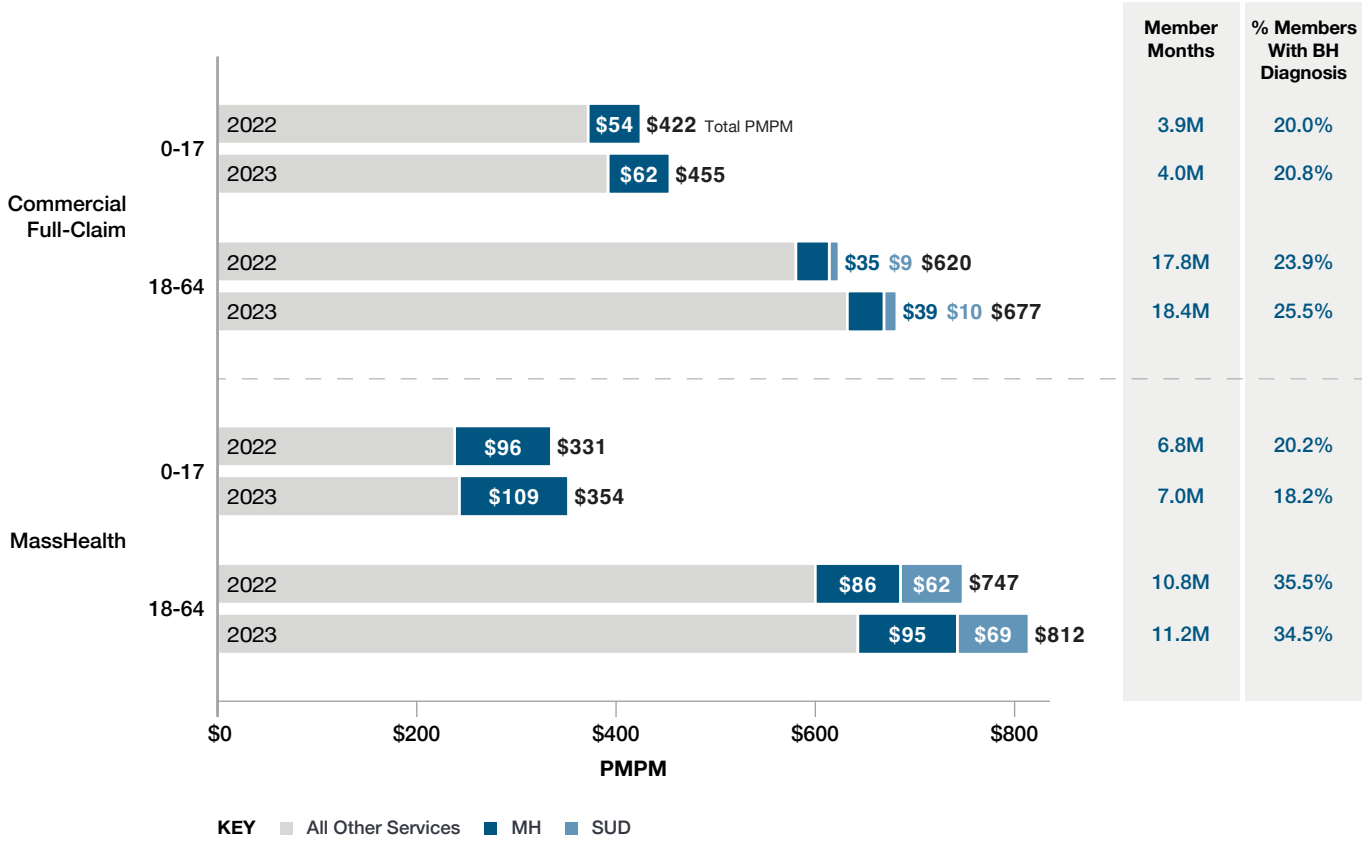
The proportion of commercially insured members with a behavioral health diagnosis increased for both pediatric (0-17) and adult (18-64) members in 2023. The proportion of pediatric commercial members with a BH diagnosis increased slightly from 20.0% in 2022 to 20.8% in 2023, while the proportion of adult members increased from 23.9% to 25.5%.

Behavioral health spending PMPM represented 13.8% of total health care spending for pediatric commercial members compared with 7.2% for adult members in 2023. BH spending was higher for commercial members ages 0-17 in total, with $62 PMPM reported for mental health care and less than $1 PMPM for SUD services, compared with adult members for whom MH spending averaged $39 PMPM and SUD spending $10 PMPM.

The percentage of pediatric MassHealth members ages 0-17 with a primary behavioral health diagnosis decreased from 20.2% in 2022 to 18.2% in 2023. Among adult MassHealth members, 34.5% had a behavioral health diagnosis in 2023 compared with 35.5% in 2022.

MassHealth BH spending for members ages 0-17 accounted for 30.8% of total health care spending compared with 20.2% for adults. For these pediatric members, MH spending increased from $96 PMPM in 2022 to $109 PMPM in 2023, while SUD spending was less than $1 PMPM for both years. MassHealth members ages 18-64 reported higher behavioral health spending PMPM than pediatric members driven by higher spending on SUD services ($69 PMPM) in 2023 for adult members.

Behavioral Health Expenditures by Age Group, 2022-2023



On a PMPM basis, commercial members ages 0-17 had higher behavioral health spending compared with adults while MassHealth adults had higher behavioral health spending driven by SUD services.

Source: Payer-reported data to CHIA.

Notes: Medicare Advantage data not depicted because of low membership reported for members younger than 65. Commercial results include commercial full-claim data only, reflecting members for whom payer has access to and is able to report all claims expenses, accounting for approximately 64% of total commercial member months in 2023 for payers included in this analysis. United and United Medicare Advantage excluded from this analysis due to data quality concerns. "All Other Services" includes primary care services and services for all specialties other than behavioral health. Member months and PMPM values may not tie to data presented on page 90 due to low membership volume reported in age groups not represented in graph (e.g., commercial 65+). Non-claims spending data from 1 payer is not included in this PMPM analysis due to inability to report non-claims spending by age group.

Behavioral Health

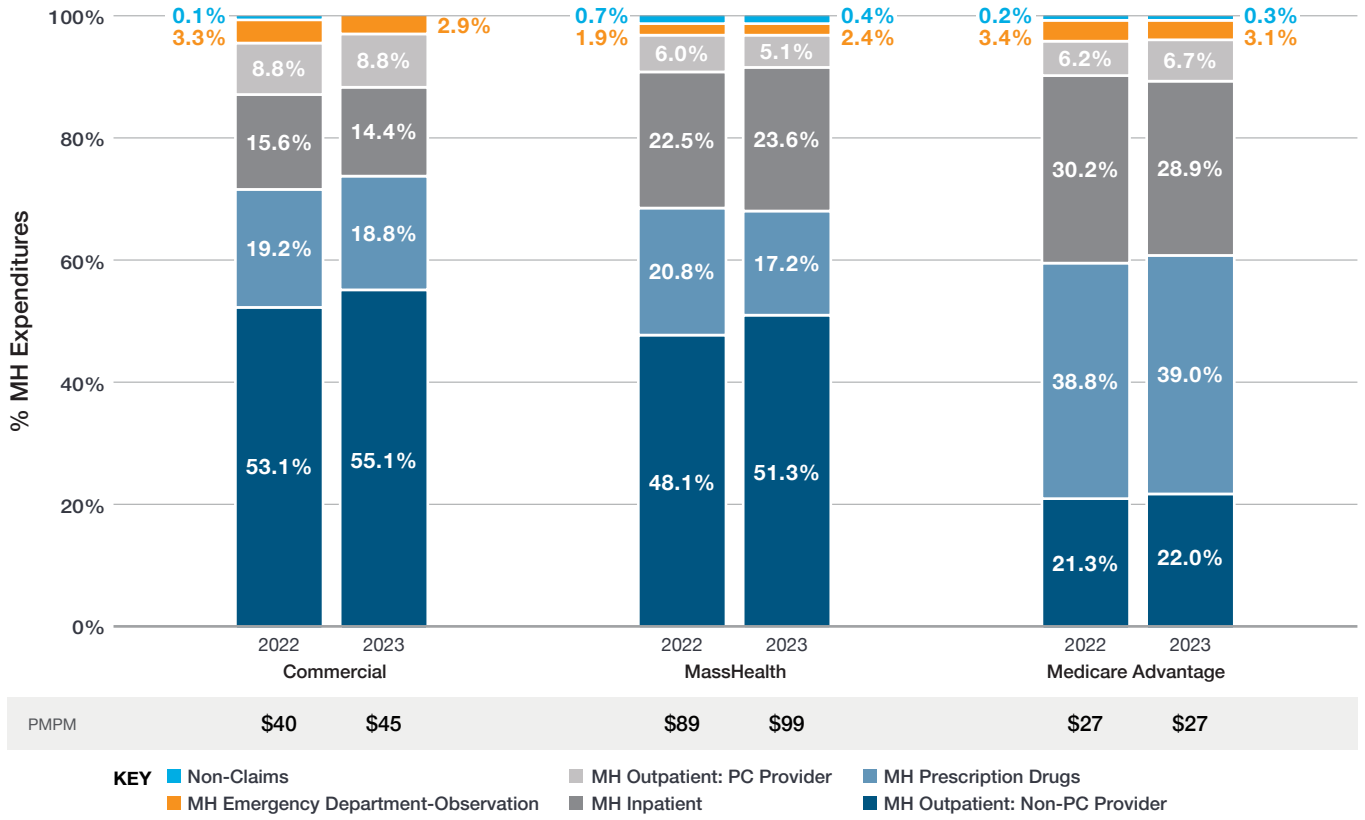
Mental health services are delivered in a variety of health care settings, including inpatient hospitals, residential treatment, intensive outpatient programs, and outpatient office visits. Spending on services in these settings differed across insurance categories.

In 2023, outpatient services delivered by a behavioral health or other specialist provider accounted for more than half of MH spending for commercial (55.1%) and MassHealth (51.3%) but only 22.0% for Medicare Advantage members. Spending for MH outpatient services delivered by a behavioral health or other specialist provider increased for both MassHealth (3.2 percentage points) and Medicare Advantage members (0.7 percentage point). In 2022, the Centers for Medicare and Medicaid Services (CMS) expanded coverage for behavioral health services, driving the increase in MassHealth and Medicare Advantage spending on MH outpatient services delivered by a behavioral health or other specialist provider.[6]

Mental health outpatient services provided by a primary care (PC) provider remained relatively stable from 2022 to 2023 within insurance categories, at 8.8% for commercial, 5.1% for MassHealth, and 6.7% for Medicare Advantage members.

Inpatient services accounted for similar proportions of overall mental health spending for MassHealth (23.6%) and Medicare Advantage (28.9%) members, but a smaller share of commercial members' MH spending (14.4%). Prescription drugs to treat mental health conditions accounted for 18.8% of commercial and 17.2% of MassHealth MH spending in 2023. Notably, mental health prescription drug spending accounted for the largest share of Medicare Advantage MH service category spending at 39.0% in 2023.

Mental Health Spending by Service Category, 2022-2023



Outpatient MH services provided by a BH or other specialist provider accounted for more than half of MH spending for commercial and MassHealth members in 2023 while prescription drug spending accounted for the greatest proportion of MH spending for Medicare Advantage members.

Source: Payer-reported data to CHIA.

Notes: For commercial partial-claim data, CHIA estimated pharmacy spending by service type. MassHealth-submitted data includes data for members for which MassHealth is primary payer, including fee-for-service (FFS) (excluding FFS dual eligibility, FFS with third-party liability, FFS limited), MCO/ACO-A, ACO-B, and PCC program types. United and United Medicare Advantage excluded from this analysis due to data quality concerns. Analysis represents data from commercial payers that submitted CY 2022 and CY 2023 data representing approximately 92% of commercial market, 100% of commercially administered MCO/ACO-A market, and 72% of Medicare Advantage market. As a result, data may not tie to Total Health Care Expenditures chapter. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had MH or SUD principal diagnosis at any point during reporting year. Outpatient services provided by a behavioral health or other specialist provider refers to services provided by a non-primary care provider. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

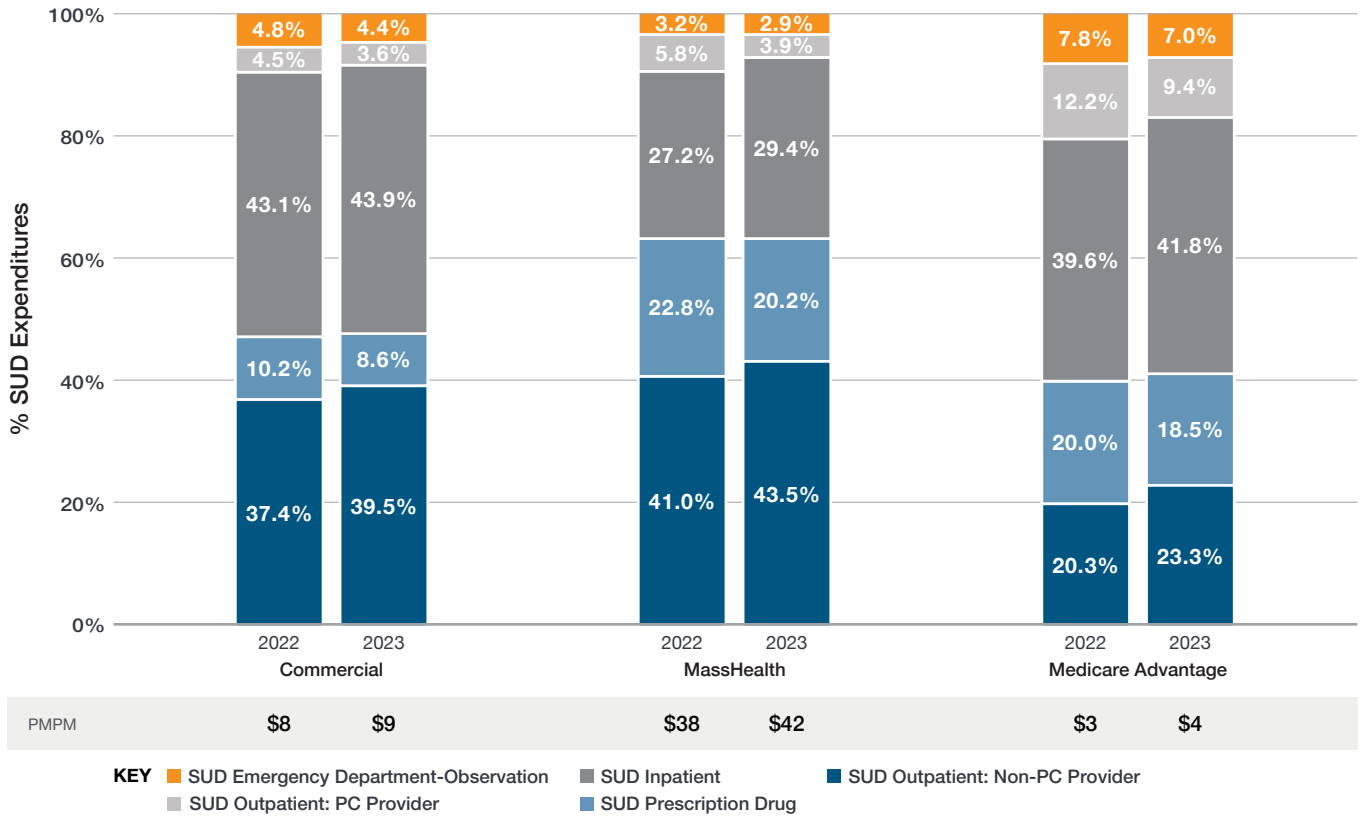
While more than half of mental health spending was for outpatient services among both commercial and MassHealth members, spending for SUD services varied by setting across insurance categories.

In 2023, SUD inpatient services represented the largest portion of commercial and Medicare Advantage SUD spending, accounting for 43.9% of total commercial SUD spending and 41.8% of Medicare Advantage SUD spending. However, SUD inpatient care represented only 29.4% of MassHealth SUD spending. Across all 3 insurance categories, the proportion of total SUD spending on inpatient services increased from 2022 to 2023.

In 2023, the proportion of SUD outpatient services provided by a behavioral health or other specialist provider increased across all insurance categories, accounting for 39.5% of commercial, 43.5% of MassHealth, and 23.3% of Medicare Advantage SUD spending.

SUD prescription drug spending as a proportion of total SUD spending decreased over the reporting period across all insurance categories, partly driven by an increase in the proportion of spending on SUD inpatient and outpatient services.

Substance Use Disorder Spending by Service Category, 2022-2023



In 2022 and 2023, SUD inpatient services accounted for the largest proportion of commercial and Medicare Advantage total SUD spending (43.9% and 41.8%, respectively) but less than one-third of MassHealth SUD spending (29.4%).

Source: Payer-reported data to CHIA.

Notes: For commercial partial-claim data, CHIA estimated pharmacy spending by service type. MassHealth-submitted data includes data for members for which MassHealth is primary payer, including fee-for-service (FFS) (excluding FFS dual eligibility, FFS with third-party liability, FFS limited), MCO/ACO-A, ACO-B, and PCC program types. United and United Medicare Advantage are excluded from this analysis due to data quality concerns. Analysis represents data from commercial payers that submitted CY 2022 and CY 2023 data representing approximately 92% of commercial market, 100% of commercially administered MCO/ACO-A market, and 72% of Medicare Advantage market. As a result, data may not tie to Total Health Care Expenditures chapter. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had mental health or SUD principal diagnosis at any point during reporting year. Outpatient services provided by a behavioral health or other specialist provider refers to services provided by a non-primary care provider. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

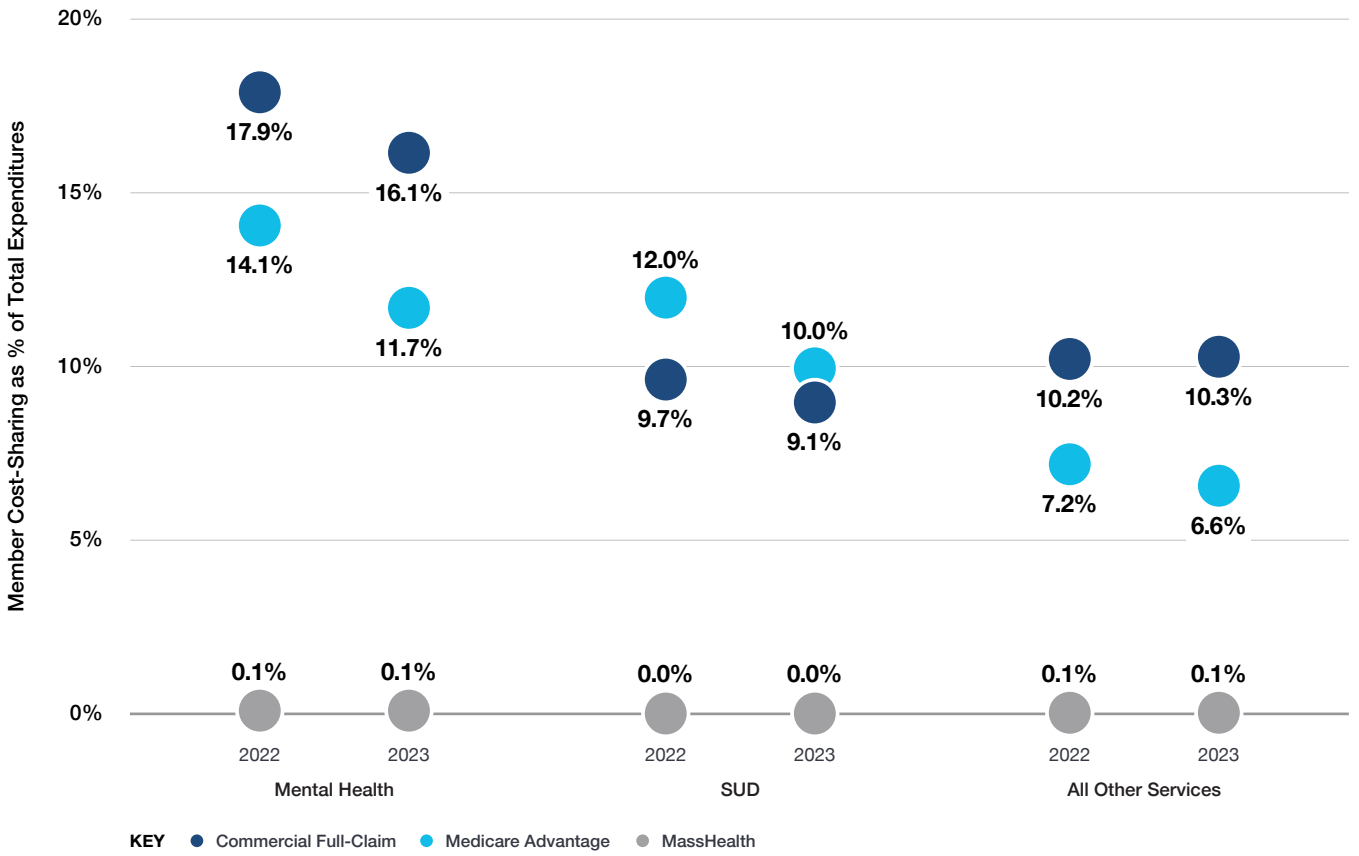
Member cost-sharing includes copayments, coinsurance, and deductibles, representing payments for covered health care services for which the member is financially responsible. This graphic reflects cost-sharing metrics as a proportion of total payments for mental health, substance use disorder, and all other medical services (e.g., services not classified as MH or SUD) that were paid for by members in 2022 and 2023. Fully out-of-pocket member payments for behavioral health care not covered by insurance are not reflected on this page; see page 99 for more information about residents' experiences with entirely out-of-pocket behavioral health expenses.

In 2023, commercial members were responsible for 16.1% of MH spending and 9.1% of SUD spending for services covered by insurance. Commercial member cost-sharing as a proportion of total spending on BH services decreased 1.8 percentage points for MH care and 0.6 percentage point for SUD services from 2022 to 2023, in contrast to a slight increase in the cost-sharing proportion for all other services.

Medicare Advantage members were responsible for a lower percentage of MH spending (11.7%) but a higher proportion of SUD spending (10.0%) than commercial members.

Member cost-sharing responsibilities are substantially lower for MassHealth members due to federal and state limits on member cost-sharing for certain members and services.[7]

Member Cost-Sharing for Behavioral Health Services by Insurance Category, 2022-2023



In 2023, commercial members were responsible for a higher proportion of mental health spending while Medicare Advantage members were responsible for a higher proportion of SUD spending.

Source: Payer-reported data to CHIA.

Notes: This analysis includes commercial full-claim data only, reflecting members for whom payer has access and ability to report all claims expenses, which accounted for approximately 92% of total commercial member months in CY 2023 for payers included in this analysis. United and United Medicare Advantage are excluded from this analysis due to data quality concerns. Analysis represents data from commercial payers that submitted CY 2022 and CY 2023 data. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. "All Other Services" includes primary care services and services for all specialties other than behavioral health. See technical appendix for additional information.

Behavioral Health

Acute hospitals contain a majority of medical surgical, pediatric, obstetric, and nursery beds. Acute hospitals with behavioral health units have beds specifically designated for the treatment of BH patients and were reported as distinct cost centers in the hospital cost report. Freestanding BH hospitals provide MH and SUD services. SUD facilities focus solely on substance use, providing detoxification and other services on an inpatient basis. There is currently 1 privately owned SUD facility in Massachusetts. State-operated facilities included in this data are operated by the Department of Mental Health (DMH) to provide behavioral health care for those with otherwise limited access to facilities providing such care.

Behavioral Health Hospital Utilization, HFY 2023

	Number of Hospitals/ Facilities	Total Licensed Beds	Total Staffed Beds	Median Percentage Occupancy	Median Average Length of Stay (Days)
Acute Hospitals BH Units	35	1,213	1,121	80.7%	16.0
Freestanding BH Units	13	1,665	1,574	87.6%	15.4
SUD Facilities	1	114	114	71.9%	6.7
State-Operated Facilities	5	457	455	98.7%	60.2

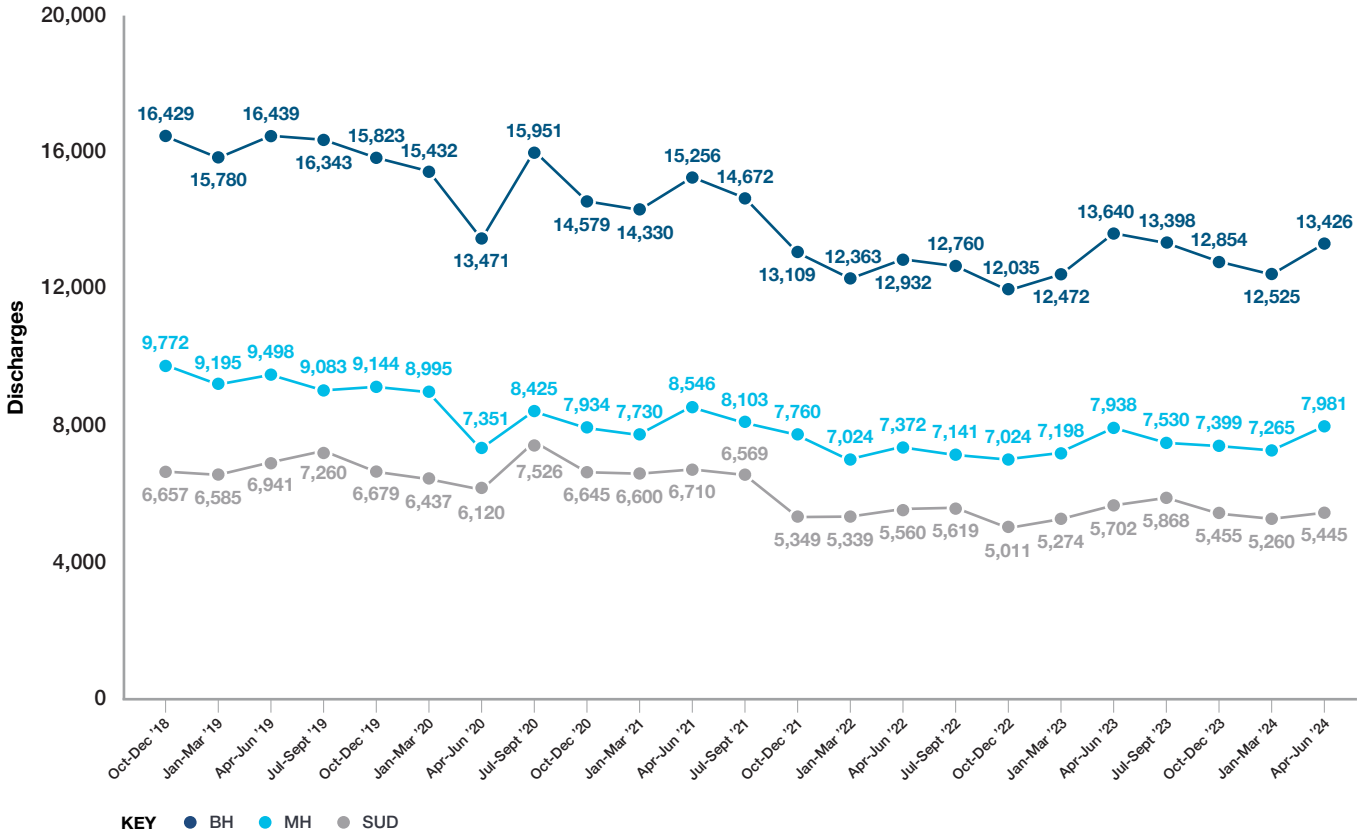
Source: Hospital cost reports submitted to CHIA.

Behavioral Health

At acute care hospitals, inpatient discharges with a primary BH diagnosis account for less than 10% of all inpatient discharges, with more discharges attributable to mental health conditions than substance use disorders. As total inpatient discharges decreased at acute care hospitals in the wake of the COVID-19 pandemic, so too did the number of inpatient discharges with a primary BH diagnosis.

Similar to total inpatient discharges, inpatient discharges associated with a primary BH diagnosis remain lower than prior to the pandemic. From April-June 2024, there were almost 13,500 inpatient discharges with a primary BH diagnosis, 22% lower than the same period in 2019. This may reflect systemic capacity issues, including hospital staffing shortages and, subsequently, limited availability of beds and inpatient services for patients with BH needs.

Acute Care Hospital Behavioral Health Inpatient Discharge Trends, October 2018-June 2024



Inpatient discharges for patients with a primary behavioral health diagnosis in 2024 were more than 20% lower than pre-pandemic levels.

Source: Hospital Inpatient Discharge Database (HIDD), October 2018-June 2024.

Notes: Data source includes only acute care hospitals. It does not include private BH hospitals, SUD facilities, or Department of Mental Health-operated facilities. For this analysis, discharges were categorized into clinically meaningful independent BH categories based on listed primary diagnosis codes using Clinical Classification Software Refined (CCSR) for ICD-10-CM diagnoses. Only inpatient discharges among patients ages 2 and older were included in this analysis. See CHIA website for the most up-to-date information on inpatient utilization. HIDD data for FFY 2024 (October 2023-June 2024) not considered final and subject to change.

Behavioral Health

Among pediatric inpatient discharges for BH conditions, the most common primary diagnoses in FFY 2023 were mood-related conditions, such as major depressive disorders. Other common conditions included trauma-related disorders, such as post-traumatic stress disorder (PTSD), and self-harm/suicidal ideation. Discharges for mental health conditions were more common in this age group than discharges for substance use disorders.

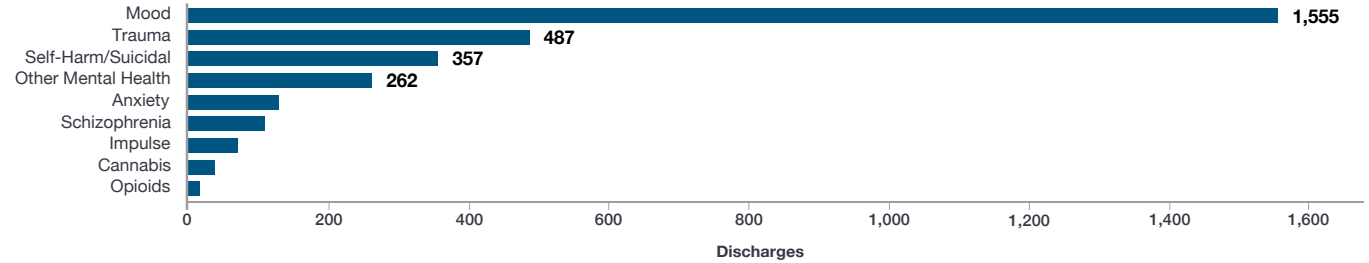
Among adult inpatient discharges for BH conditions, the most common primary diagnoses were alcohol and mood-related disorders. Other common conditions included those associated with schizophrenia and other psychotic disorders, opioid-related disorders, trauma-related disorders, and self-harm/suicidal ideation.

More than 80% of all inpatient discharges with a primary BH diagnosis were among non-elderly adults ages 18-64 (not shown).

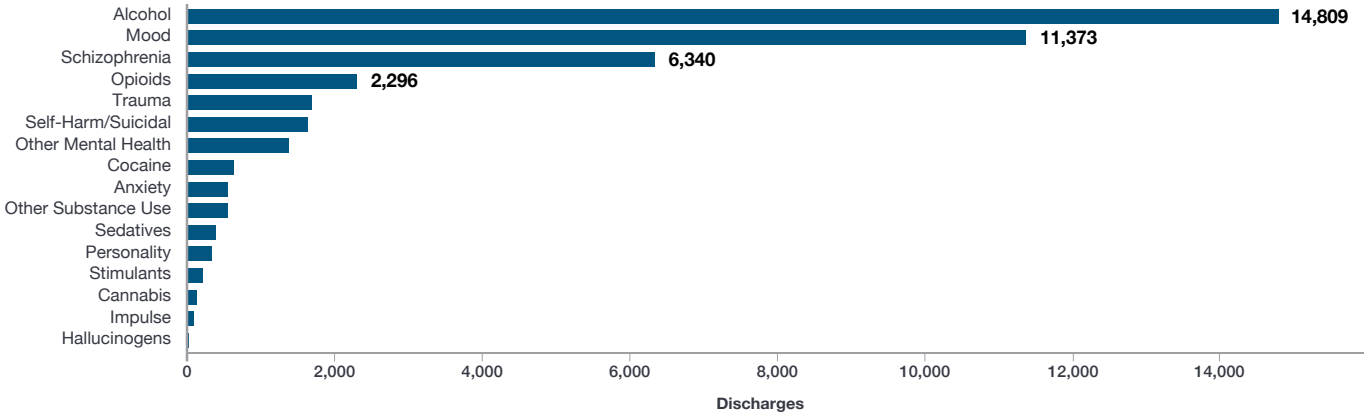
Among inpatient discharges for behavioral health at acute care hospitals, mood-related conditions were the most common behavioral health diagnoses among the pediatric population; alcohol- and mood-related conditions were the most common diagnoses among adults age 18 and older.

Acute Care Hospital Behavioral Health Inpatient Discharges by Age Group, FFY 2023

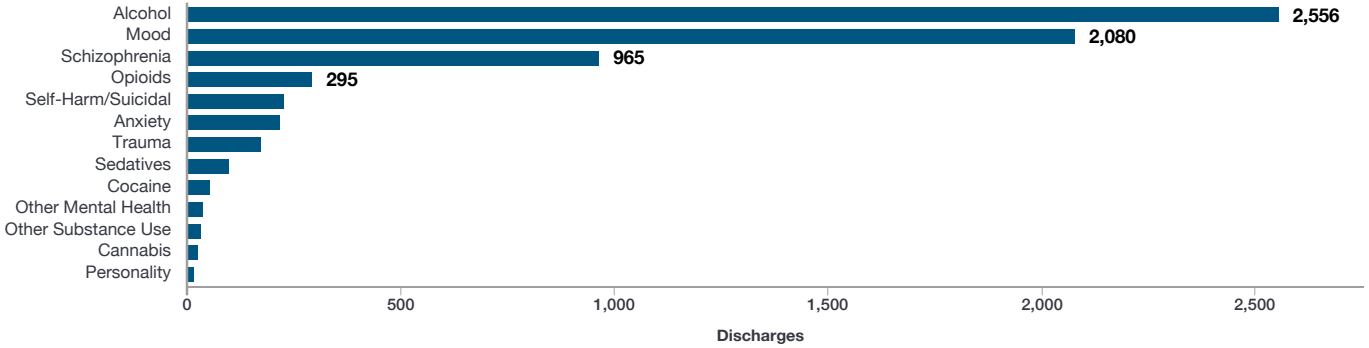
Patients Ages 2-17



Patients Ages 18-64



Patients Age 65+



Source: Hospital Inpatient Discharge Database (HIDD), October 2022-September 2023.

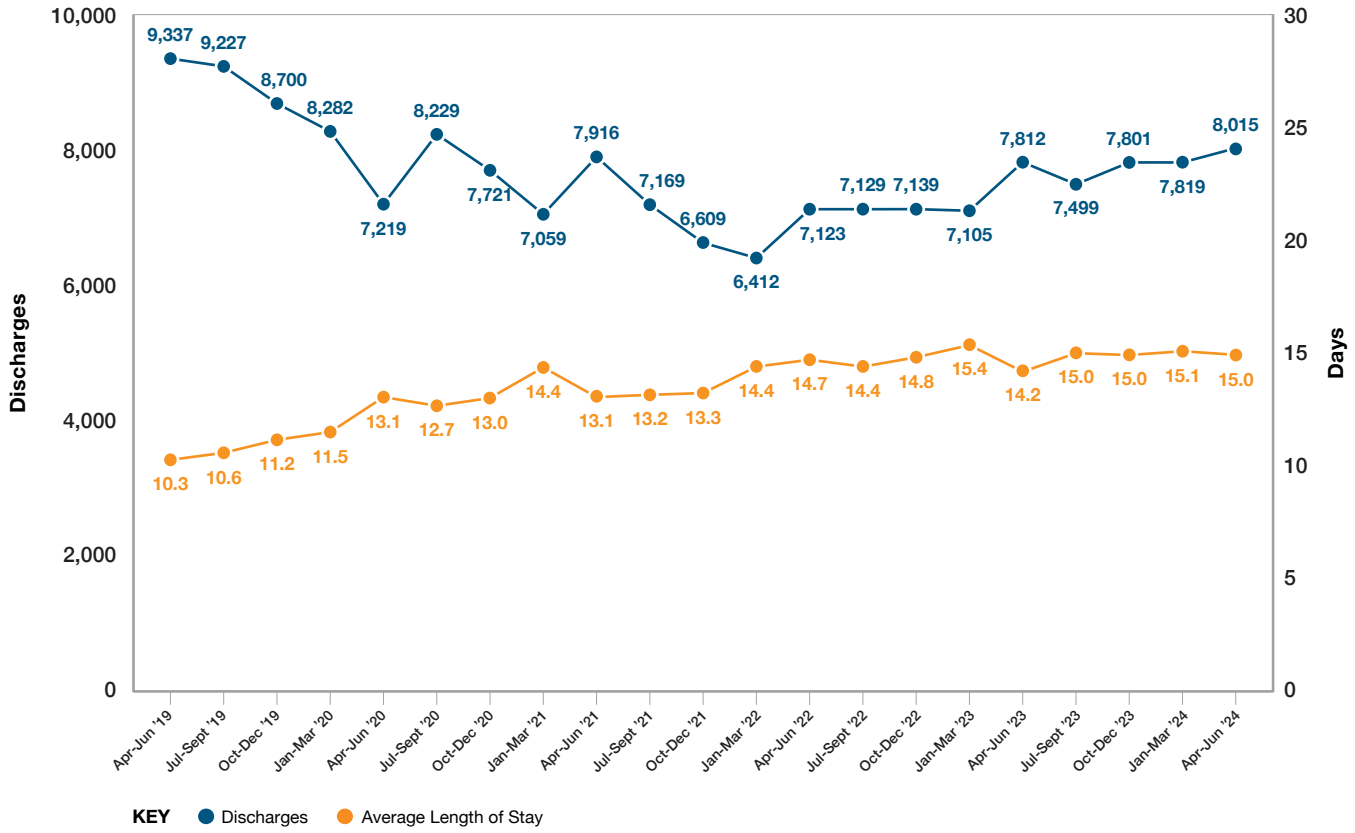
Notes: Data source includes only acute care hospitals. It does not include private BH hospitals, SUD facilities, or Department of Mental Health-operated facilities. For this analysis, discharges were categorized into clinically meaningful independent BH categories based on listed primary diagnosis codes using Clinical Classification Software Refined (CCSR) for ICD-10-CM diagnoses. Only inpatient discharges among patients age 2 and older were included in this analysis.

Behavioral Health

Starting in FFY 2018, CHIA has collected data from select non-acute BH hospitals. These data complement those from acute care hospitals by providing an in-depth look at the BH inpatient population served by these institutions.

Inpatient discharges from BH hospitals decreased during peak periods of the COVID-19 pandemic. While discharges have increased since the COVID-19 pandemic, they remain lower than early 2019, mirroring trends for BH discharges observed at acute care hospitals. The ALOS at BH hospitals increased through early 2023 and has since decreased but remains higher than pre-pandemic levels. Between April-June 2024, the ALOS was 15.0 days, more than 45% higher than the same period in 2019.

Non-Acute Behavioral Health Hospital Inpatient Discharge Trends, April 2019-June 2024



As of June 2024, inpatient discharges at BH hospitals were 14% lower and ALOS was more than 45% higher than pre-pandemic levels.

Source: Preliminary data from Behavioral Health Inpatient Hospital Discharge Database (BHID), April 2019-June 2024.

Notes: Data from 13 non-acute BH hospitals and facilities required to submit data to CHIA quarterly. Certain hospitals exempt from submitting if a) had too few admissions, b) considered part of acute care hospital, or c) considered chronic care or rehabilitation hospital. Hospitals controlled by Department of Mental Health not included, namely Cape Cod & Islands Community Mental Health Center, Corrigan Mental Health Center, Solomon Carter Fuller Mental Health Center, Taunton State Hospital, and Worcester State Hospital. Data considered preliminary pending hospital verification reports and CHIA data processing. For more information, see CHIA website.

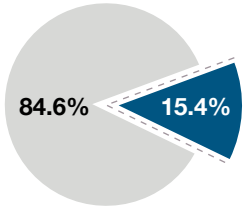
Behavioral Health

While access to BH care has expanded in recent years, many Massachusetts residents continue to struggle with accessing affordable care for MH and SUD conditions. According to payer-reported data to CHIA, nearly a quarter (24.7%) of Massachusetts residents with health insurance coverage have a BH diagnosis (data not shown). From the MHIS, 21.6% of Massachusetts residents age 5 and older reported having a visit with a BH provider within the past 12 months (data not shown). Of those who reported having a BH visit, 15.4% reported that they paid for their most recent visit with a BH provider entirely out of pocket. The most reported reasons for paying entirely out of pocket were related to insurance coverage, including that their provider did not accept any insurance (36.0%) or that their insurance plan was not accepted by their preferred provider (28.0%).

Additionally, in 2023, 9.9% of Massachusetts residents reported forgoing needed BH care in the past 12 months, with 9.2% reporting unmet need for mental health care and 2.2% reporting unmet need for SUD care or treatment. These rates of forgone care are likely an undercount due to various reporting barriers, including social stigma, criminalization of substance use, SUD underdiagnosis or misdiagnosis, and shortages of BH providers.

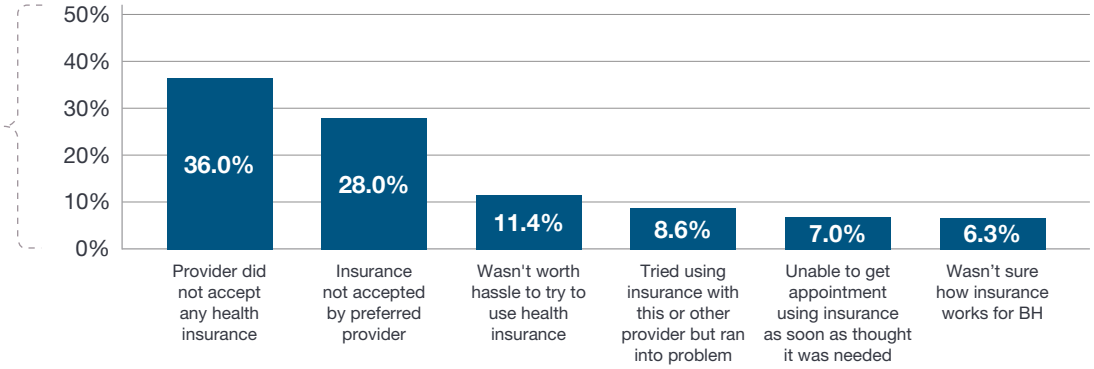
Behavioral Health Access and Affordability Challenges Among Massachusetts Residents, 2023

Out-of-Pocket Spending on Most Recent BH Visit

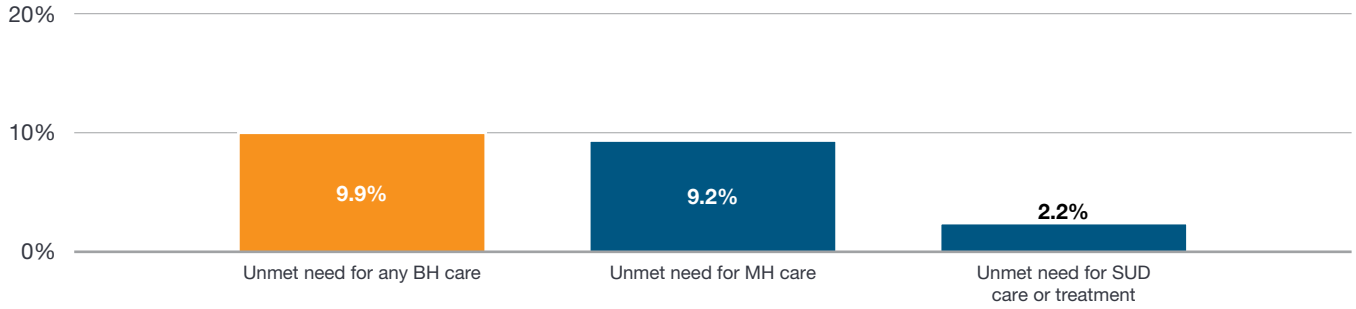


KEY
- Paid for BH entirely OOP
- Did not pay for BH entirely OOP

Reasons for Paying Entirely Out of Pocket on Most Recent BH Visit



Unmet Need for Behavioral Health Care for Any Reason Over Past 12 Months



More than 1 in 7 Massachusetts residents reported paying for their most recent behavioral health visit entirely out of pocket, most commonly for reasons related to insurance coverage.

Source: 2023 Massachusetts Health Insurance Survey.

Notes: Visits for BH care include visits to MH professional and visits for alcohol or SUD care or treatment. These include visits provided via telehealth. Questions about mental health asked of residents ages 5 and older; questions about alcohol and SUD care and treatment asked of residents ages 11 and older. Categories for out-of-pocket payment not mutually exclusive; residents were asked to select all applicable options.

Behavioral Health Notes

1. General Court of the Commonwealth of Massachusetts, "Session Law Acts of 2022, Chapter 177: An Act Addressing Barriers to Care for Mental Health," accessed January 29, 2024, https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177.
2. Blue Cross Blue Shield of Massachusetts Foundation, *Massachusetts Roadmap for Behavioral Health Reform: Overview and Implementation Update* (Boston, August 2024), https://www.bluecrossmafoundation.org/publication/massachusetts-roadmap-behavioral-health-reform-overview-and-implementation-update.
3. Center for Health Information and Analysis, "Payer Data Reporting: Primary and Behavioral Health Care Expenditures," accessed January 9, 2025, https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures.
4. Center for Health Information and Analysis, "Enrollment in Health Insurance," accessed January 14, 2025, https://www.chiamass.gov/enrollment-in-health-insurance.
5. MassHealth, *MassHealth Enrollment Guide* (January 2025), https://www.mass.gov/doc/masshealth-enrollment-guide-2/download.
6. In 2022, CMS issued its final 2023 physician fee schedule ruling that introduced new behavioral health services and permitted BH services be delivered under general supervision of a physician or non-physician practitioner by licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), expanding access to behavioral health care. See U.S. Department of Health and Human Services, "Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and COVID-19 Interim," *Federal Register* Vol. 87, No. 222 (November 2022), https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf.
7. Commonwealth of Massachusetts, "MassHealth Copay Information For Members," accessed January 14, 2025, https://www.mass.gov/info-details/masshealth-copayment-information-for-members.

KEY FINDINGS

Quality of Care

Most HEDIS scores were similar from 2022 to 2023, but some measures in the Chronic Condition Care domain improved notably, including a 6.6-point increase for Controlling High Blood Pressure.

Patients rated their experiences with primary care providers highest for communication with providers and lowest for questions related to support with self-managing their health, consistent with prior years.

The adult acute hospital readmission rate was 16.0% in SFY 2023, consistent with previous years. The readmission rate for commercially insured patients has been increasing for the past several years.

Five of the 32 reporting Massachusetts acute care hospitals achieved the Leapfrog Group's maternity care standard, which recommends that no more than 23.6% of women with low-risk pregnancies deliver via cesarean section.

Quality of Care

As health care affordability issues persist amid growing concerns about the health of primary care across the Commonwealth,[1] information about health care quality is vital to attain and ensure a high-value health care system and monitor the impact of system changes on patient outcomes. CHIA monitors and reports on health care quality using measures selected from the Commonwealth's Aligned Measure Set ("measure set")—a set of quality measures for voluntary adoption by private and public payers and providers, specifically for use in global budget-based risk contracts—which aims to reduce administrative burden and focus quality improvement efforts on meaningful and high-priority measures. The measure set was developed and is updated annually by the **Quality Measure Alignment Taskforce** ("Taskforce"), which includes individuals with quality measurement expertise from provider organizations, commercial and Medicaid managed care plans, academic institutions, state agencies, and consumer advocacy organizations.

This section covers several measures included in the 2023 measure set, including commercial and MassHealth member-reported experiences and select Healthcare Effectiveness Data and Information Set (HEDIS®) clinical quality metrics.

To date, the Taskforce has not considered hospital-based measures for inclusion in the measure set because it is designed for use in global budget-based contracts, which may not include measures specific to hospital care. However, in acknowledgment of the importance of hospital quality measurement and transparency in health care system monitoring, CHIA measures hospital adult and pediatric readmission rates using the **Massachusetts Hospital Inpatient Discharge Database**.

This chapter summarizes the performance of Massachusetts primary care providers and acute care hospitals on select metrics related to quality and safety at

a statewide level. These measures cross different domains of quality assessment, presenting results on clinical care, hospital readmissions, patient-reported experiences, maternity-related care, and hospital adherence to standards for nursing workforce and hand hygiene. While this statewide lens is important for tracking areas of care to prioritize, quality metrics should be stratified to identify potential disparities that may be linked to sociodemographic characteristics, like race and ethnicity.[2,3] As measure stratification has grown over the past 2 years, the data indicate that for several metrics, statewide performance is not necessarily reflective of performance stratified by race and ethnicity, highlighting inequities in the quality of care across the Commonwealth.[4,5,6]

CHIA is preparing a follow-up report for publication later this year to examine the overall findings included here through a health equity lens, including statewide performance for select HEDIS and commercial Patient Experience Survey (PES) measures stratified by race and ethnicity. The report will also include hospital performance on the Leapfrog Group's health equity measure for both the collection of patient demographic data to enable stratification and availability of culturally informed staff training.

While the measures in this report do not fully evaluate the quality of health care in Massachusetts, the data presented focus on several important aspects of care that help inform quality improvement efforts. ■

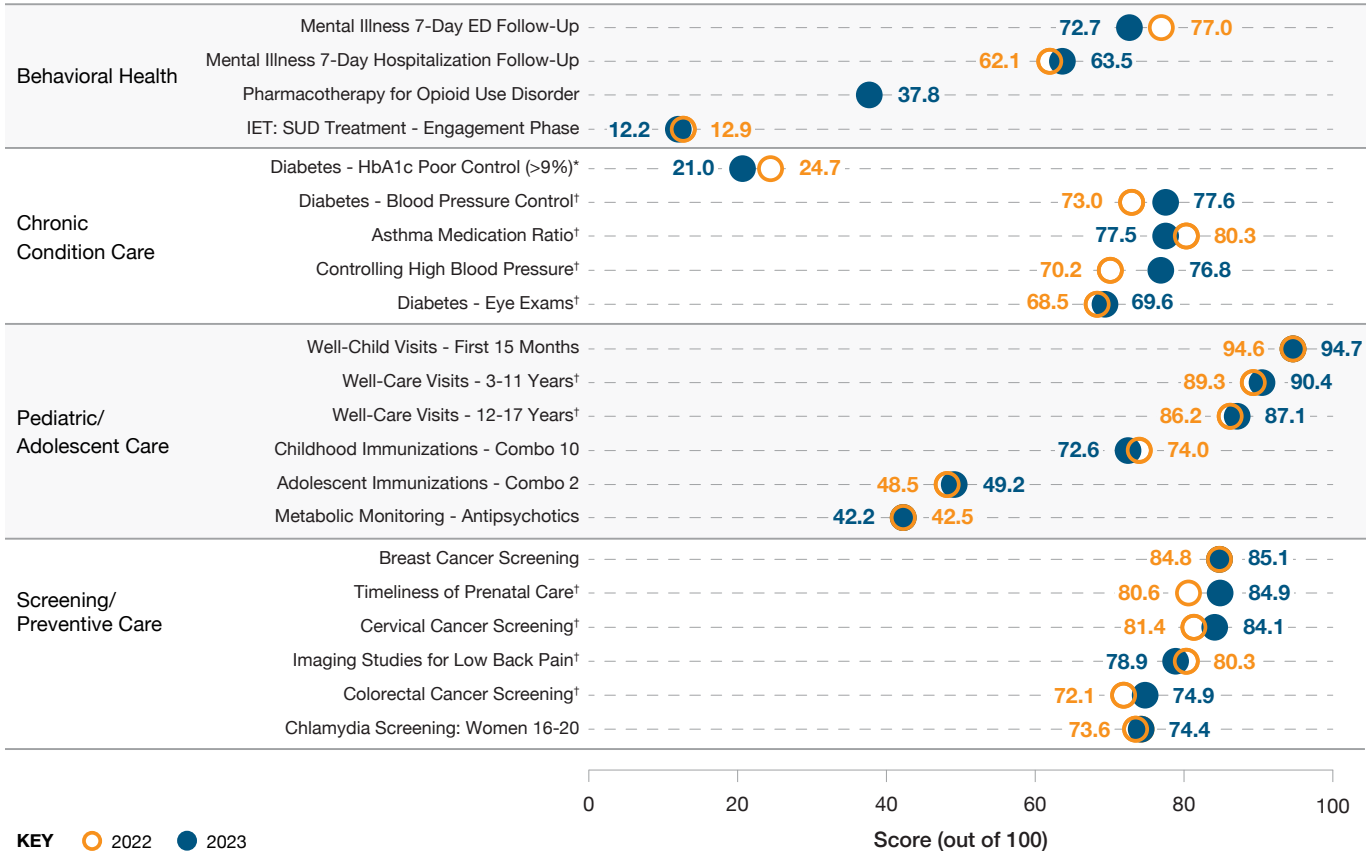
Quality of Care

The 2023 Massachusetts Aligned Measure Set comprises 30 measures that are endorsed for use in global budget APMs, 21 of which were drawn from HEDIS. This report and the accompanying databook include 2023 statewide scores for all 21 of the endorsed HEDIS measures that are in the measure set.[7] For most measures, a higher score is better; however, note that a lower score is better for HbA1c Poor Control (>9%).

Most scores were similar in 2023 compared with 2022, when both years of data were available. There were some notable improvements, particularly in the Chronic Condition Care domain, including a 3.7-point decrease (improvement) for diabetes patients with poor HbA1c control (HbA1c >9%) from 24.7 in 2022 to 21.0 in 2023. Scores in this domain also improved 4.6 points for blood pressure control among diabetes patients (73.0 in 2022 to 77.6 in 2023) and 6.6 points for the general population blood pressure control measure (70.2 in 2022 to 76.8 in 2023). In the Behavioral Health domain, performance on the measure of follow-up within 7 days after an emergency department visit for mental illness decreased 4.3 points from 77.0 in 2022 to 72.7 in 2023.

While this chart highlights some high-level findings to identify broad opportunities for improvement, it is also essential to examine results stratified by race and ethnicity to consider potential disparities and identify inequities that these statewide results may mask. CHIA will publish newly available performance stratified by race and ethnicity for a subset of HEDIS measures later this year.

Statewide Scores on Select Primary Care Clinical Quality Measures, 2022-2023



Most HEDIS scores were similar from 2022 to 2023, but some measures in the Chronic Condition Care domain improved notably, including a 6.6-point increase for Controlling High Blood Pressure.

Source: Massachusetts Health Quality Partners (MHQP). Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS) developed by National Committee for Quality Assurance (NCQA). Population is sampled from commercially insured enrollees in HMO and POS products (excluding plans sold on Health Connector) in participating health plans (MGBHP, BCBSMA, Point32Health [HPHC/THP], and HNE). HEDIS is registered trademark of NCQA.

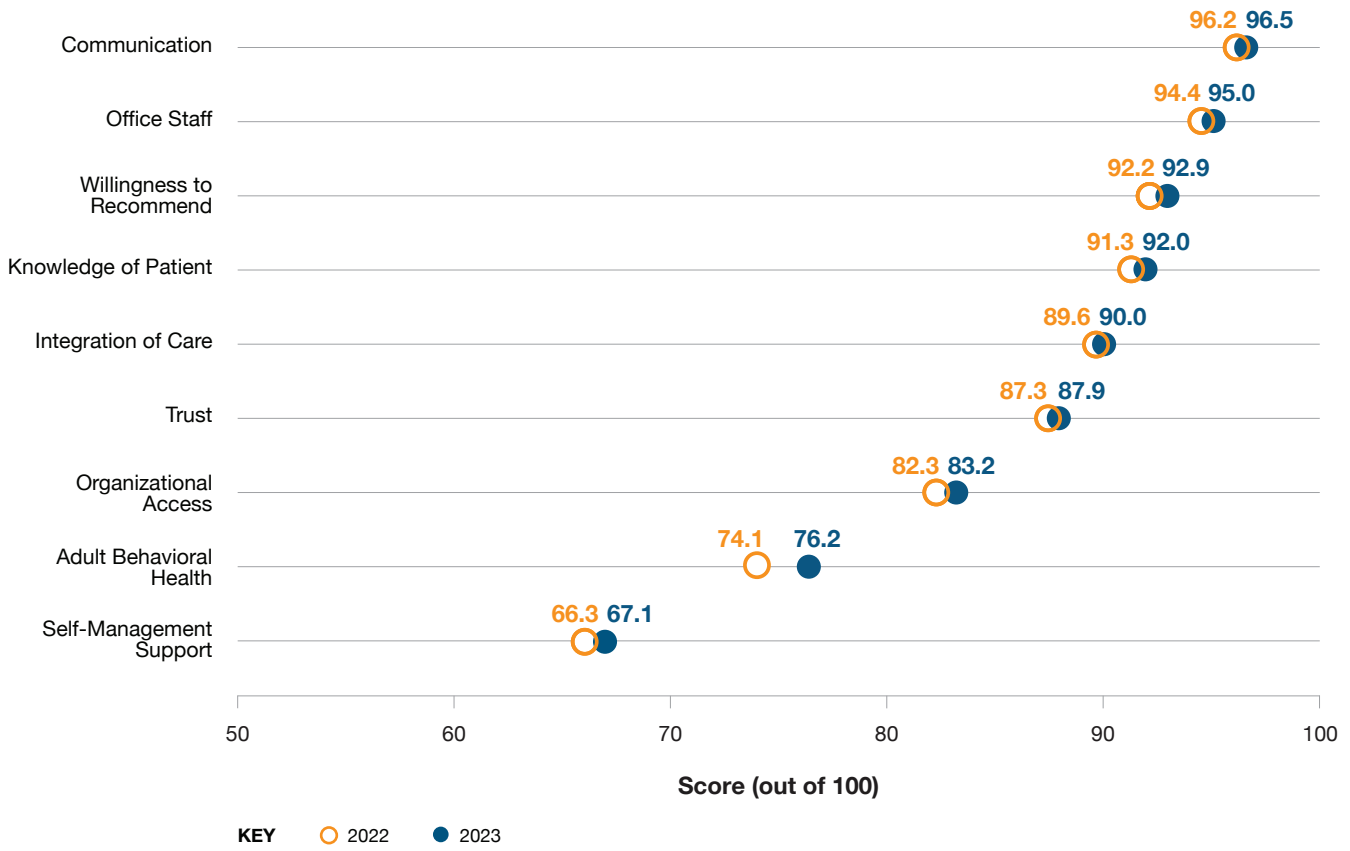
Notes: Scores are out of 100. *A higher score is better for all measures ***except*** Diabetes—HbA1c Poor Control (>9%); a lower score is better for this measure. †Differences between 2022 and 2023 scores for these measures are statistically significant. Pharmacotherapy for Opioid Use Disorder collected for first time this year, so only 2023 score available. Age range for Colorectal Cancer Screening changed in 2022, so scores for this measure may reflect some adaptation to new specification. Measurement periods vary somewhat by measure, but in general "2023 score" refers to performance during calendar year 2023. See databook for specific measure reporting periods. See technical appendix for descriptions of included measures.

Primary Care Patient-Reported Experiences for Adults, 2022-2023

Massachusetts Health Quality Partners (MHQP) issues an annual survey to commercial health plan members who have had a primary care visit during the measurement period to ask patients about their experiences with primary care. The survey is a measure included in the Aligned Measure Set. More information about the measure set is available throughout this chapter and on the EOHHS Quality Measure Alignment Taskforce website.

Overall, adult patient ratings of their experiences during Massachusetts primary care visits in 2023 were very similar to 2022 ratings. As in previous years, patients rated their primary care experiences lowest in the patient care composites related to behavioral health and self-management support (76.2 and 67.1 out of 100, respectively) and highest for communication and their experiences with office staff (96.5 and 95.0, respectively).

While this report highlights some high-level results of the Patient Experience Survey to identify broad opportunities for improvement, MHQP's Measured Equity program has made available statewide results stratified by race and ethnicity. Examination of stratified results is essential for considering potential disparities and identifying inequities that these statewide results may mask. Later this year, CHIA will publish a follow-up report on health equity in quality of care that examines commercial patient experience scores stratified by race and ethnicity.



The patient-reported ratings of experiences with primary care providers were highest for Communication and lowest for Self-Management Support, consistent with prior years.

Source: MHQP Patient Experience Survey (PES).

Notes: Data includes adult patients age 18+. Survey conducted on sample of commercial health plan members. Adult Behavioral Health composite refers to how patients answered questions about provider engagement with patients to talk about their behavioral health needs. Self-Management Support composite (adult) refers to how patients answered questions about provider engagement with patients to talk about their goals for their health and things that make it hard to take care of their health. See technical appendix for specific survey questions.

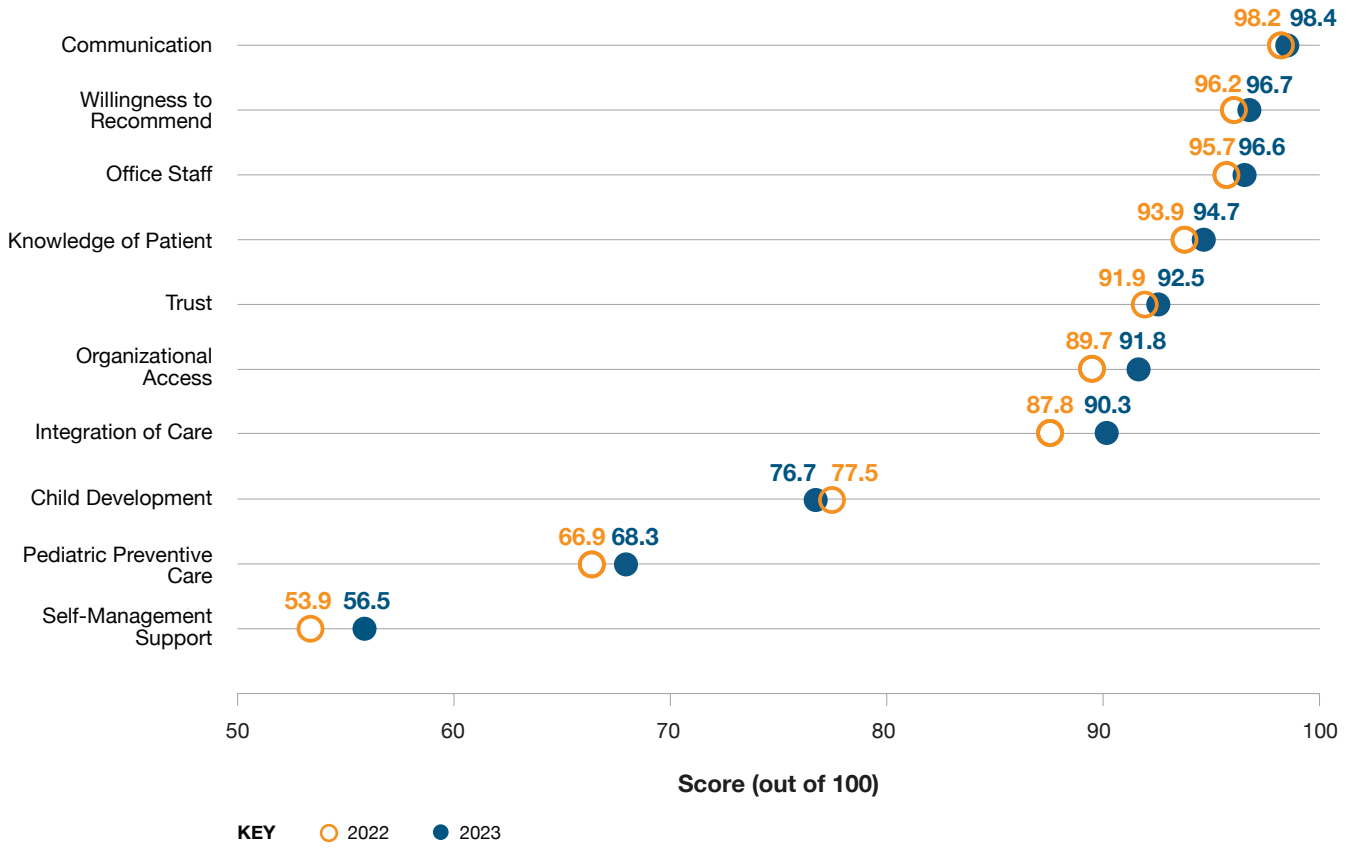
Quality of Care

Similar to adult patient-reported experiences with primary care providers, Communication was the highest-scoring measure for pediatric visits in 2023, followed by Willingness to Recommend (98.4 and 96.7 out of 100, respectively).

Caregivers rated pediatric visit experiences similarly in 2023 compared with 2022—the largest change was a 2.6-point improvement in caregivers' experiences of Self-Management Support, from 53.9 in 2022 to 56.5 in 2023.

Consistent with prior years, in 2023, caregivers reported the lowest ratings for their experiences in Self-Management Support (56.5), which refers to how supported the caregiver feels in independently managing the pediatric patient's care, and in Pediatric Preventive Care (68.3), which refers to patients' caregivers responses about provider engagement addressing the child's home environment (e.g., exercise, food, screen time, safety, etc.).

Primary Care Patient-Reported Experiences for Pediatrics, 2022-2023



Caregiver ratings of pediatric primary care visits were generally stable between 2022 and 2023, with the greatest improvement in experiences with Self-Management Support (53.9 to 56.5).

Source: MHQP Patient Experience Survey (PES).

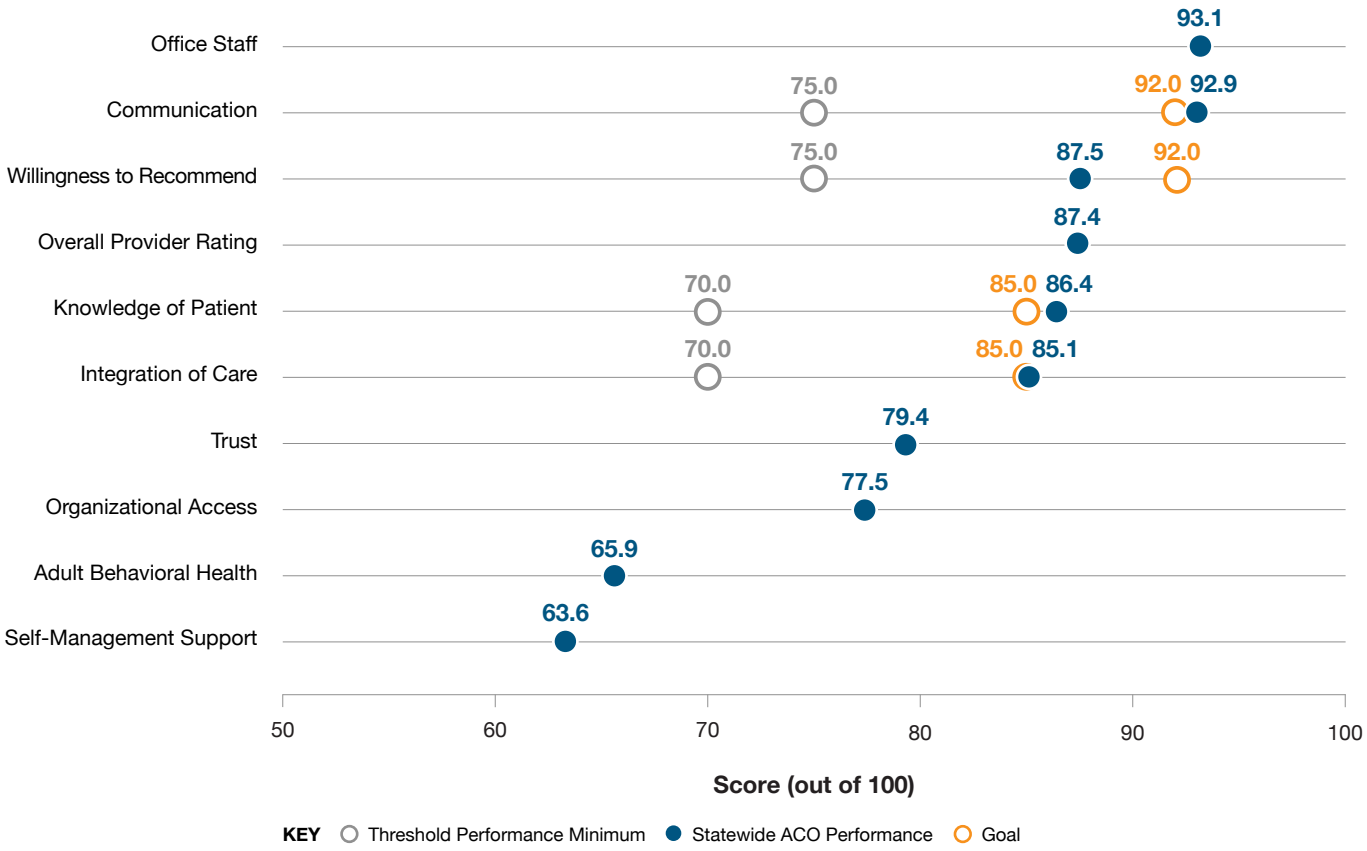
Notes: Data includes pediatric patients ages 0-17; parent or caregiver was surveyed on patient's behalf. Survey conducted on sample of commercial health plan members. See technical appendix for specific survey questions.

Quality of Care

MassHealth issued a primary care Patient Experience Survey (PES) to a sample of adult members with care managed by an ACO who had a primary care visit in 2023. For a subset of the care composites in the survey, MassHealth established a threshold performance minimum and a goal performance benchmark, which are used in some components of the pay-for-performance ACO quality incentive model. The threshold performance benchmark is a minimum level of expected performance an ACO must achieve to be eligible for quality incentives, and the goal benchmark rewards high performance as identified by MassHealth. MassHealth ACO primary care providers surpassed the threshold performance minimum for all applicable measures and surpassed the goal benchmarks for 3 of the 4 applicable measures (Communication, Knowledge of Patient, and Integration of Care). In 2022, MassHealth had set the same goals for the same 4 measures and no measure surpassed the goal, so this indicates notable improvement for ACO performance.

Overall, adult patients expressed positive experiences with their primary care providers in 2023, with the highest score for interactions with the office staff (93.1 out of 100) and the lowest score for support self-managing their health (63.6). MassHealth ACO scores are similar to, but slightly lower than, comparable surveys of members covered under commercial health plans in 2023 (see pages 105-106 for commercial PES results).

MassHealth ACO Member Primary Care Patient-Reported Experiences for Adults, 2023



Patient-reported experiences scored above the goal set by MassHealth for 3 of the 4 applicable measures—Communication (92.9), Knowledge of Patient (86.4), and Integration of Care (85.1).

Source: MHQP MassHealth Member Experience Survey (MES).

Notes: Data includes adult patients age 18+. Survey conducted on sample of MassHealth ACO plan members and fielded May-August 2024. According to the March 2025 Enrollment Trends Report, MassHealth ACO-A and ACO-B plan members comprised 56.5% of total MassHealth membership in December 2023. Adult Behavioral Health composite refers to how patients answered questions about provider engagement with patients to talk about their behavioral health needs. Self-Management Support composite (adult) refers to how patients answered questions about provider engagement with patients to talk about their goals for their health and things that make it hard to take care of their health. See technical appendix for specific survey questions.

Quality of Care

Similar to adult patient-reported experiences with MassHealth ACO primary care providers, pediatric visits scored highest for the Communication and Child Provider Communication measures of care (95.7 and 95.3 out of 100 points, respectively).

Among the 4 applicable measures, all surpassed the minimum performance threshold with scores at least 10 points higher than the threshold rate. Additionally, 2 of the 4 surpassed the goal score set by MassHealth: Communication (95.7) and Integration of Care (85.2). In 2022, MassHealth had set the same goals for the same 4 measures and no measure surpassed the goal, so this indicates notable improvement for ACO performance.

As observed in the adult population, caregivers of patients receiving pediatric care reported the lowest satisfaction for Self-Management Support (52.4). Pediatric Prevention and Child Development also scored below 70 at 61.7 and 65.7, respectively, identifying opportunities for improvement in pediatric patient experiences.

MassHealth ACO Member Primary Care Patient-Reported Experiences for Pediatrics, 2023

In 2023, pediatric patient experience scores surpassed the MassHealth-set goals for 2 of the 4 applicable measures—Communication (95.7) and Integration of Care (85.2).

Source: MHQP MassHealth Member Experience Survey (MES).

Notes: Data includes pediatric patients ages 0-17; parent or caregiver was surveyed on patient's behalf. Survey conducted on sample of MassHealth ACO plan members and was fielded May-August 2024. Self-Management Support composite (pediatric) refers to how supported caregiver feels in independently managing pediatric patient's care. Pediatric Prevention measure refers to how patients answered questions about provider engagement with patients to talk about their child's home environment (addressing exercise, food, computer, safety, etc.). See technical appendix for specific survey questions.

Quality of Care

In 2023, the statewide all-payer readmission rate at acute hospitals was 16.0%. After an initial period of decline from 2011 to 2014, all-payer readmission rates increased from 2014 to 2020. Since 2020, the readmission rate has remained consistent.

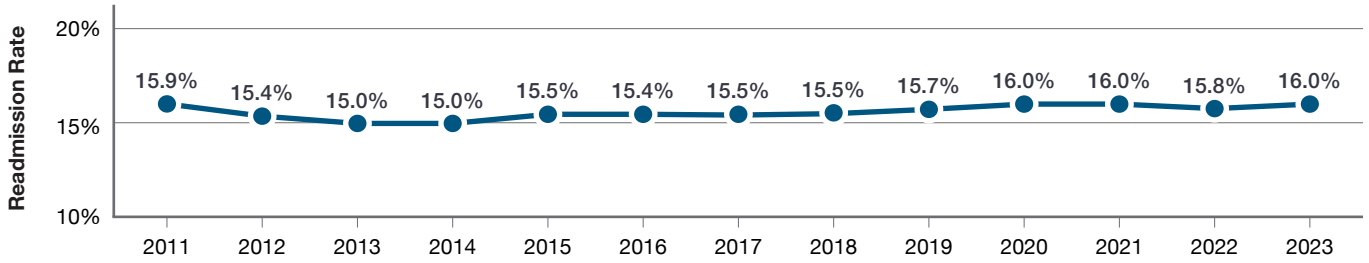
Dually eligible patients, or patients who are enrolled in both Medicare and Medicaid, had the highest rate of readmission (21.7%) in 2023, followed by patients with Medicaid only and Medicare only (16.4% and 15.8%, respectively).

Commercially insured patients had the lowest readmission rate (9.9%), but the readmission rate for this group has increased over the past several years.

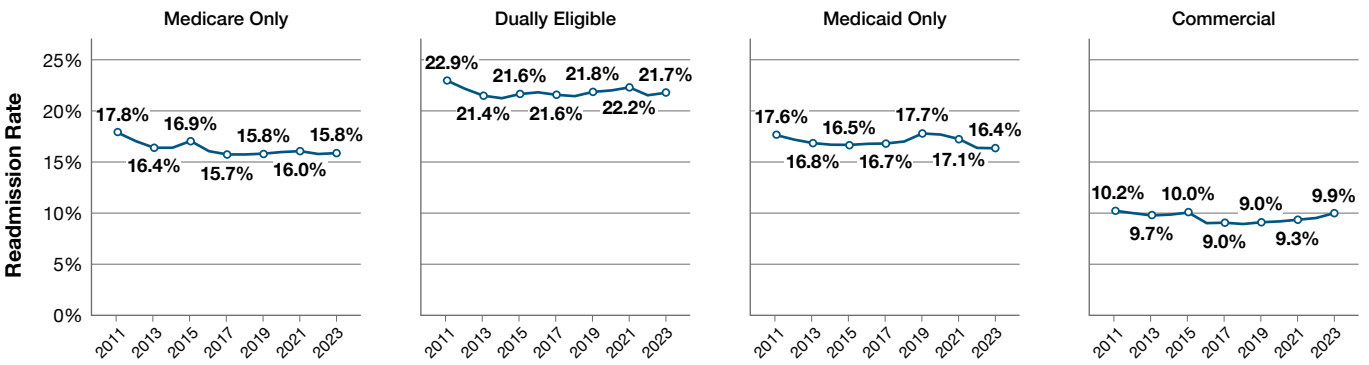
Regardless of dual eligibility, Medicare patients accounted for the most readmissions by volume of any payer group (59%; data not shown).

Trends in Statewide All-Payer Adult Acute Hospital Readmissions, SFY 2011-2023

Statewide Trend



Payer Type Trends



The adult acute hospital readmission rate was 16.0% in SFY 2023, consistent with previous years. The readmission rate for commercially insured patients has been increasing for the past several years.

Source: Massachusetts Hospital Inpatient Discharge Database, July 2010 to June 2023.

Notes: Adult readmission measure adapted from 2024 Yale/CMS hospital-wide readmission measure, v13.0, covering all-cause, all-payer unplanned readmissions, excluding discharges for obstetric, primary psychiatric, rehabilitative, or cancer treatment. Self-pay and other payer type categories not included due to small number of discharges.

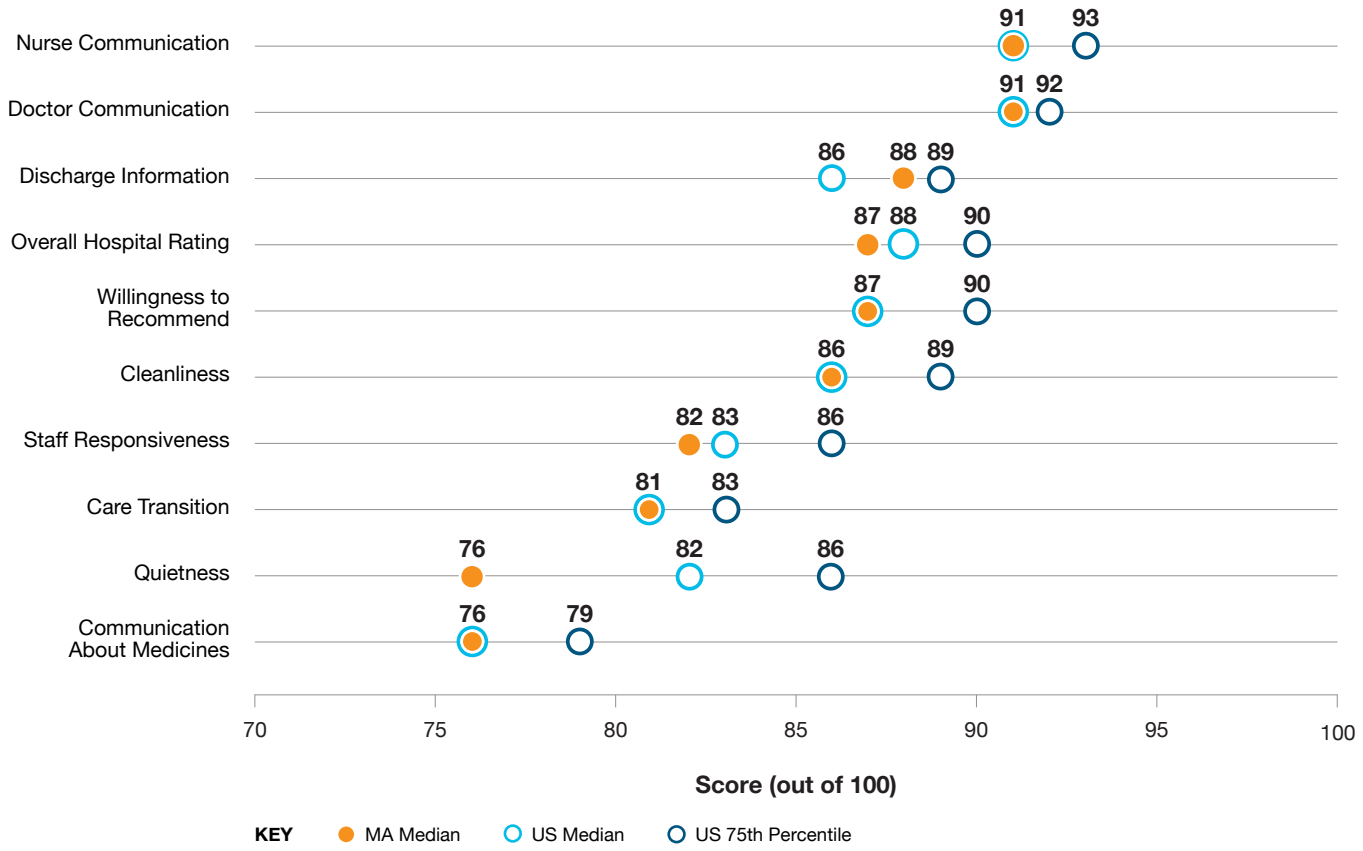
Quality of Care

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asks discharged patients questions about their recent acute hospital stay and provides information about the consumer experience of care. Measures of patient satisfaction are an important reflection of whether provided care met patients' needs in addition to identifying which care experiences matter most to consumers to focus quality improvement efforts.[8]

On 6 of the 10 care composites collected for CY 2023, patient experience ratings of Massachusetts hospitals were similar to the median patient experience ratings at hospitals nationally. Massachusetts scores were below national medians for 3 composites, and exceeded the national median for only 1 composite. Patient experience ratings of Massachusetts hospitals continued to fall below the patient experience ratings of the top-performing (75th percentile) hospitals nationally.

The median score in Massachusetts for both Overall Hospital Rating and Willingness to Recommend was 87 out of 100, which is similar to the national median scores. Massachusetts patients rated communication with nurses and doctors more highly than other composites of care (median score 91 out of 100 for each). Statewide median scores were lowest for quietness of hospital environment and communication about medicines (76 out of 100 for each care composite). See the technical appendix for detailed descriptions of each patient care composite.

Patient-Reported Experience During Acute Hospital Admission, 2023



The patient-reported experience ratings of Massachusetts hospitals were generally similar to the median ratings nationally on most measures, noting highest satisfaction in communication with nurses and doctors.

Source: CMS Hospital Compare.

Notes: Includes all payers and patients age 18+.

Quality of Care

Childbirth is the most common reason for a hospital admission in Massachusetts. To reduce potentially harmful and unnecessary maternity procedures, the Leapfrog Group—a national nonprofit watchdog organization—sets standards and collects voluntary data from hospitals to measure performance. The Leapfrog standard recommends that no more than 23.6% of women with low-risk pregnancies deliver via cesarean section (C-section). Additionally, Leapfrog identifies 5% or below as the target for the share of childbirths in which episiotomies are performed.

In 2023, 5 of the 32 reporting hospitals achieved both the C-section and episiotomy measure maternity care standards; 4 reporting hospitals achieved neither standard. The remaining 23 hospitals achieved only the episiotomy standard.

Hospitals performed well on the episiotomy measure—28 of the 32 reporting hospitals achieved this standard. However, only 5 hospitals achieved the standard for the C-section measure, indicating potential overuse of the procedure among low-risk pregnancies.

Rates of Maternity-Related Procedures Relative to Performance Targets, by Hospital, 2023

Leapfrog Standard	C-Section ≤ 23.6%	Episiotomy ≤ 5.0%
Achieved Both Standards (5 Hospitals)		
Beth Israel Deaconess Hospital Plymouth	20.5%	1.2%
Beverly Hospital	15.0%	1.7%
Cape Cod Hospital	20.6%	1.0%
Lowell General Hospital - Main Campus	19.5%	1.3%
Mount Auburn Hospital	21.3%	2.4%
Achieved Neither Standard (4 Hospitals)		
Holy Family Hospital - Methuen	30.5%	5.3%
Salem Hospital	33.6%	5.5%
St. Elizabeth's Medical Center	34.3%	5.3%
Sturdy Memorial Hospital	26.2%	8.1%

KEY

- Achieved the Standard
- Considerable Achievement
- Some Achievement
- Limited Achievement

Five of the 32 reporting Massachusetts acute care hospitals achieved both the C-section and episiotomy standards for reducing unnecessary maternity care, and they are the only hospitals that achieved the standard for C-section deliveries among low-risk pregnancies.

Leapfrog Standard	C-Section ≤ 23.6%	Episiotomy ≤ 5.0%
Achieved One Standard (23 Hospitals)		
Anna Jaques Hospital	34.7%	2.9%
Baystate Franklin Medical Center	24.3%	2.8%
Baystate Medical Center	30.4%	1.3%
Berkshire Medical Center	24.6%	0.0%
Beth Israel Deaconess Medical Center	34.3%	1.3%
Boston Medical Center	36.0%	1.3%
Brigham and Women's Hospital	27.4%	2.6%
CHA Cambridge Hospital	25.6%	2.1%
Charlton Memorial Hospital	28.4%	1.9%
Cooley Dickinson Hospital	29.2%	3.9%
Emerson Hospital	28.2%	2.7%
Fairview Hospital	28.9%	0.0%
Lawrence General Hospital	32.9%	1.7%
Massachusetts General Hospital	25.2%	1.7%
Melrose-Wakefield Hospital	26.3%	3.5%
Mercy Medical Center	25.5%	2.8%
Milford Regional Medical Center	29.6%	0.3%
Newton-Wellesley Hospital	26.4%	2.6%
South Shore Hospital	31.9%	3.5%
St. Luke's Hospital	30.1%	2.2%
Steward Good Samaritan Medical Center	26.2%	3.4%
Tufts Medical Center	31.6%	2.1%
Winchester Hospital	29.7%	1.2%

Source: Leapfrog Group Hospital Survey. Based on voluntary hospital reporting; does not include data from all Massachusetts hospitals.

Notes: Data includes all payers, all ages. See technical appendix for information on Leapfrog's standards and scoring methodologies. Considerable, Some, and Limited Achievement refer to how close rate was to recommendation, with Considerable Achievement indicating rate only slightly higher than recommendation and Limited Achievement indicating greater deviation. Previous publications included measure of Early Elective Deliveries, which was removed from 2024 Leapfrog Group Hospital Survey; data is no longer available. See technical appendix for information on Leapfrog's standards and scoring methodologies.

Quality of Care

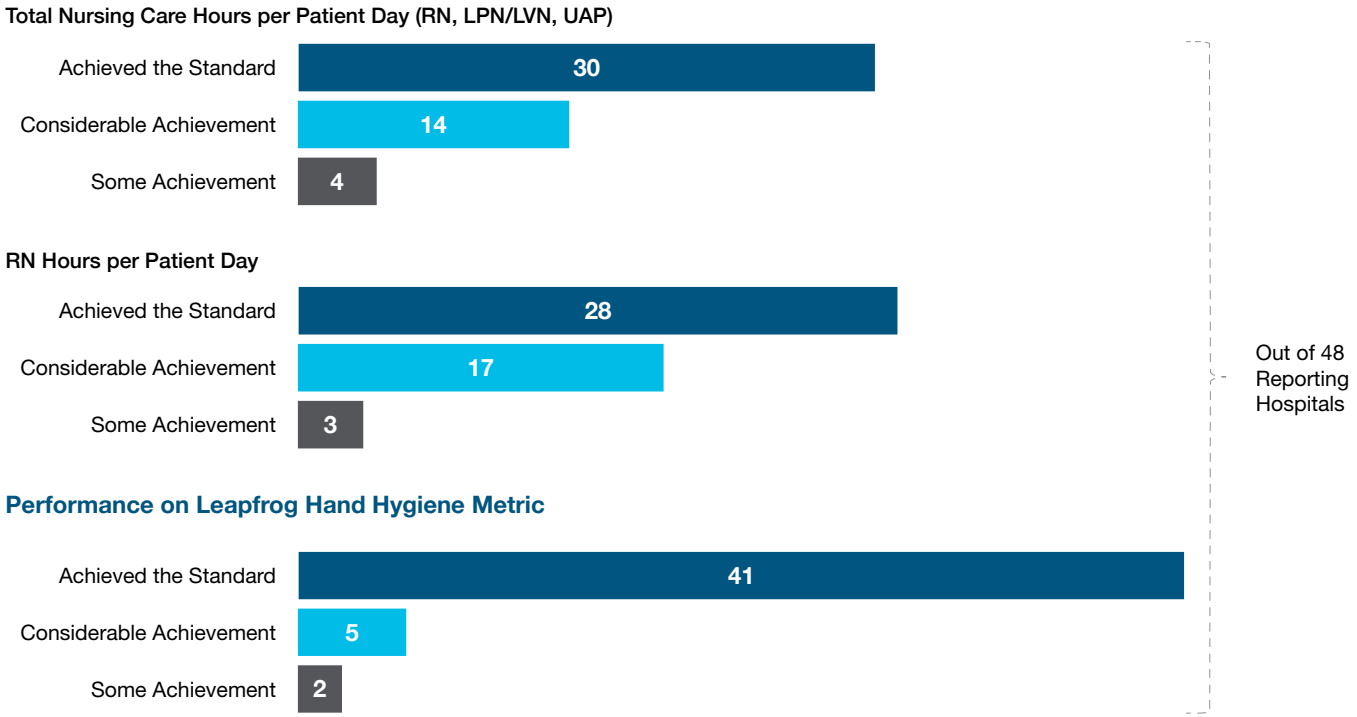
There are many aspects of a hospital's operations that contribute to overall quality and safety of care. Studies have examined the relationship between nurse staffing and patient outcomes, and evidence continues to grow that supports an association between increased nursing hours per patient day with lower odds of patient mortality, lower rates of patient falls and pressure ulcers, shorter hospital stays, and higher patient satisfaction.[9,10,11]

This report includes a subset of Leapfrog's Hospital Survey Nursing Workforce measures, focusing on Total Nursing Care Hours per Patient Day and Registered Nurse (RN) Hours per Patient Day. The Hand Hygiene score is based on performance on 5 domains of hand hygiene: monitoring, feedback, training and education, infrastructure, and culture.

In 2023, 30 of the 48 reporting hospitals achieved the standard for Total Nursing Care Hours per Patient Day, and 28 achieved the standard for RN Hours per Patient Day. Hospitals performed well on the Hand Hygiene metric—41 of the 48 reporting hospitals achieved Leapfrog's standard, which emphasizes hospital monitoring and feedback practices. However, several hospitals did report only "some achievement" in all domains, indicating opportunities for improvement. Hospital-specific results are available in the databook, and details about Leapfrog's standards and scoring are available in the technical appendix.

Hospital Adherence to the Leapfrog Standards for Nursing Workforce and Hand Hygiene, 2023

Performance on Leapfrog Nursing Workforce Metrics



Performance on Leapfrog Hand Hygiene Metric

In 2023, hospitals made progress toward the Nursing Workforce metrics—30 of the 48 reporting hospitals achieved the standard for Total Nursing Care Hours per Patient Day and 28 hospitals achieved the standard for RN Hours per Patient Day.

Source: Leapfrog Group Hospital Survey. Based on voluntary hospital reporting; does not include data from all Massachusetts hospitals.

Notes: Data includes all payers, all ages. Total Nursing Care Hours per Patient Day includes all nursing staff with direct patient care responsibilities, including RN, licensed vocational/practical nurses (LVN/ LPN), and unlicensed assistive personnel (UAP). See technical appendix for information on Leapfrog's standards and scoring methodologies.

Quality of Care Notes

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6. Massachusetts Health Quality Partners, "MHQP's Statewide Survey Shows Patients Continue to Experience Racial and Ethnic Disparities in Massachusetts" (February 2024), accessed January 25, 2025, https://www.mhqp.org/2024/02/25/statewide-survey-shows-patients-continue-to-experience-racial-and-ethnic-disparities-in-massachusetts/.
7. Some measures include multiple components that are scored separately. CHIA reports each component when possible, so the total number of measures included in the report and dataset is greater than the 21 measures noted. For details about which measures include multiple components, see the technical appendix.
8. Elysia Larson, Jigyasa Sharma, Meghan A. Bohren, and Özge Tunçalp, "When the patient is the expert: measuring patient experience and satisfaction with care," *Bulletin of the World Health Organization* 97, no. 8 (2019): 563-569, https://pmc.ncbi.nlm.nih.gov/articles/PMC6653815/pdf/BLT.18.225201.pdf.
9. Leapfrog Group, *Factsheet: Nursing Workforce* (April 2023), https://ratings.leapfroggroup.org/sites/default/files/inline-files/2023%20Nursing%20Workforce%20Factsheet.pdf.
10. Taina Pitkäaho, Pirjo Partanen, Merja H. Miettinen, and Katri Vehviläinen-Julkunen, "The relationship between nurse staffing and length of stay in acute-care: a one-year time-series data," *Journal of Nursing Management* 24, no. 5 (2016): 571-579, https://pubmed.ncbi.nlm.nih.gov/26833964/.
11. Jeannette A Rogowski, Douglas Staiger, Thelma Patrick, Jeffrey Horbar, Michael Kenny, and Eileen T. Lake, "Nurse staffing and NICU infection rates," *JAMA Pediatrics* 167, no. 5 (2013): 444-450, https://jamanetwork.com/journals/jamapediatrics/fullarticle/1669323.

Index of Acronyms

ACA	Affordable Care Act
ACO	Accountable Care Organization
ALOS	Average Length of Stay
APM	Alternative Payment Method
APTC	Advance Premium Tax Credit
ARPA	American Rescue Plan Act
ASO	Administrative Services Only
BCBSMA	Blue Cross Blue Shield of Massachusetts
BH	Behavioral Health
BHID	Behavioral Health Hospital Inpatient Discharge Database
BIDCO	Beth Israel Deaconess Care Organization
BILH	Beth Israel Lahey Health
BMC	Boston Medical Center
BMCHP	Boston Medical Center HealthNet Plan
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CCSR	Clinical Classifications Software Refined
CHIA	Center for Health Information and Analysis
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CSR	Cost-Sharing Reduction
CY	Calendar Year
DMH	Department of Mental Health
ED	Emergency Department
EDD	Emergency Department Database
ESI	Employer-Sponsored Insurance
FFCRA	Families First Coronavirus Response Act
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FPL	Federal Poverty Level
GIC	Group Insurance Commission
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCQI	Health Care Quality Improvement
HDHP	High-Deductible Health Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HFY	Hospital Fiscal Year
HHA	Home Health Agency
HIDD	Hospital Inpatient Discharge Database
HMO	Health Maintenance Organization

Index of Acronyms (continued)

HNE	Health New England
HPHC	Harvard Pilgrim Health Care
HPI	Health Plans, Inc.
HPP	High Public Payer
HSA	Health Status Adjusted
HSN	Health Safety Net
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IRS	Internal Revenue Service
MA	Massachusetts
MCO	Managed Care Organization
MGB	Mass General Brigham Community Physicians Organization
MGBHP	Mass General Brigham Health Plan
MGL	Massachusetts General Law
MES	Massachusetts Employer Survey
MH	Mental Health
MHIS	Massachusetts Health Insurance Survey
MHQP	Massachusetts Health Quality Partners
MLR	Medical Loss Ratio
NCPHI	Net Cost of Private Health Insurance
NCQA	National Committee for Quality Assurance
NEQCA	New England Quality Care Alliance
NPSR	Net Patient Service Revenue
NQF	National Quality Forum
OOD	Outpatient Observation Database
OOP	Out-of-Pocket
PACE	Program of All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Managers
PCC	Primary Care Clinician
PCP	Primary Care Provider
PES	Patient Experience Survey
PMPM	Per Member Per Month
POS	Point-of-Service
PPO	Preferred Provider Organization
PTSD	Post-Traumatic Stress Disorder
RN	Registered Nurse
SCO	Senior Care Options
SFY	State Fiscal Year
SHCE	Supplemental Health Care Exhibit

Index of Acronyms (continued)

SHIP PA	Student Health Insurance Plan Premium Assistance
SI	Self-Insured
SNF	Skilled Nursing Facility
SQMS	Standard Quality Measure Set
SUD	Substance Use Disorder
THCE	Total Health Care Expenditures
THP	Tufts Health Plan
THPP	Tufts Health Public Plans
TME	Total Medical Expenses
UPPL	Unified Pharmacy Product List
VA	Veterans Affairs

Glossary of Terms

Accountable Care Organization (ACO): Group of health care providers that contracts with a payer to assume responsibility for the delivery of care to its attributed patients and for those patients' health outcomes.

Administrative Services Only (ASO): Commercial payers that perform administrative services for self-insured employers. Services can include plan design and network access, claims adjudication and administration, and/or population health management.

Advance Premium Tax Credit (APTC): Federal tax credits available to those with incomes below 400% of the Federal Poverty Level (FPL) who enrolled in plans sold on the Health Connector. Credits may be applied directly to premiums to lower the member's monthly payments or may be paid in a lump sum as a part of the member's tax return. APTC amounts are calculated by comparing the individual's income with the cost of the second-cheapest silver tier plan available to them. If the cost of that plan exceeds a specified percentage of the member's income, the federal government pays the difference in APTCs.

Affordability Issues: In the Massachusetts Health Insurance Survey, affordability issues are defined as reporting any of the following: problems paying family medical bills in the past 12 months; having family medical bills at the time of the survey that are being paid over time, also known as family medical debt; spending a high share of family income on out-of-pocket health care expenses, defined as 5% or more of income for families below 200% of the Federal Poverty Level or 10% or more of income for other families, in the past 12 months; or having any unmet need for health care in the family due to cost in the past 12 months.

Aligned Measure Set: A set of quality measures for voluntary adoption by private and public payers and providers, specifically for use in global budget-based risk contracts, which aims to reduce administrative burden and focus quality improvement efforts on meaningful and high-priority measures. The measure set was developed and is updated annually by the Quality Measure Alignment Taskforce.

Alternative Payment Methods (APMs): Payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis. As part of the design of these payment methods, some of the financial risk associated with the delivery of medical care as well as the management of health conditions is shifted from payers to providers. Generally, APMs are intended to give providers new incentives to control overall costs (e.g., reduce unnecessary services and provide services in the most appropriate setting) while maintaining or improving quality.

Annualized Trend: Calculates a smooth spending trend across multiple years, also known as compound annual trend. CHIA used the annualized trend to examine per

Glossary of Terms (continued)

capita spending for 2019 to 2021, calculated as (2021 Value/2019 Value)^(1/2)-1.

Benefit Level: A measure of the proportion of covered medical expenses paid by insurance. Actuarial values may be estimated by several different methods; for the method used in this report, see the technical appendix.

ConnectorCare: A type of qualified health plan offered through the Health Connector, the Commonwealth's marketplace for health and dental insurance, with lower monthly premiums and cost-sharing for those with household incomes at or below 300% of the Federal Poverty Level (FPL).

Cost-Sharing: The amount of an allowed claim that the member is responsible for paying. This includes any copayments, deductibles, and coinsurance payments for the services rendered. Cost-sharing does not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines, vision, and dental care).

Cost-Sharing Reduction (CSR) Subsidies: Payments made by the federal government and/or the Commonwealth of Massachusetts directly to ConnectorCare payers to lower copayments and eliminate deductibles and coinsurance in ConnectorCare plans.

Dually Eligible Beneficiary/Patient: A person who is enrolled in both Medicaid and Medicare.

Employer-Sponsored Insurance (ESI): Health insurance plans purchased by employers on behalf of their employees as part of an employee benefit package.

Fully Insured: A fully insured employer contracts with a payer to pay for eligible medical costs for its employees and dependents in exchange for a pre-set annual premium.

Funding Type: The segmentation of health plans into 2 types—fully insured and self-insured—based on how they are funded.

Group Insurance Commission (GIC): The organization that provides health benefits to state employees and retirees in Massachusetts.

Health Care Cost Growth Benchmark (Benchmark): The projected annual percentage change in Total Health Care Expenditure (THCE) measure in the Commonwealth, as established by the Health Policy Commission (HPC). The benchmark is tied to growth in the state's economy, the potential gross state product (PGSP). For 2023 and beyond, the benchmark will be established by law at a default rate of PGSP, though the HPC Board can modify to any amount deemed reasonable, subject to legislative review.

Glossary of Terms (continued)

Health Connector: The Commonwealth's state-based health insurance marketplace where individuals, families, and small businesses can purchase health plans from insurers.

Health Maintenance Organizations (HMOs): Insurance plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. These plans generally require members to coordinate care through a primary care physician.

High-Deductible Health Plan (HDHP): As defined by the IRS, a health plan with an individual plan deductible exceeding $1,400 in 2021-2022; $1,500 in 2023; and $1,600 in 2024. For a family plan, HDHPs are those with a deductible exceeding $2,800 for 2021-2022; $3,000 for 2023; and $3,200 for 2024.

Limited Network: A health insurance plan that offers members access to a reduced or selective provider network, which is smaller than the payer's most comprehensive provider network within a defined geographic area and from which the payer may choose to exclude from participation other providers who participate in the payer's general or regional provider network. This definition, like that contained within Massachusetts Division of Insurance regulation 211 CMR 152.00, does not require a plan to offer a specific level of cost (premium) savings in order to qualify as a limited network plan.

Managing Physician Group Total Medical Expenses: Measure of the total health care spending of members whose plans require the selection of a primary care provider associated with a physician group, or who are attributed to a primary care provider according to a contract between a payer and provider.

Market Sector: Average employer or group size segregated into the following categories: individual purchasers, small group (up to 50 employees), mid-size group (51-100 employees), large group (101-499 employees), and jumbo group (500+ employees). In the small group market segment, only those small employers that met the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04 were included; otherwise, they were categorized within mid-size.

Medical Loss Ratio (MLR): As established by the Division of Insurance: the sum of a payer's incurred medical expenses, their expenses for improving health care quality, and their expenses for deductible fraud, abuse detection, and recovery services, all divided by the difference of premiums minus taxes and assessments. This ratio is calculated within a licensed payer and market segment over a 3-year average.

Merged Market: The combined health insurance market within which both individual (non-group) and small group plans are purchased.

Glossary of Terms (continued)

Net Prescription Drug Spending: Payments made to pharmacies for members' prescription drugs minus rebates received by the health plan from manufacturers.

Out-of-Pocket Expenses: Out-of-pocket expenses include spending by an individual consumer on deductibles, copays, and coinsurance for benefits covered by insurance, and all spending on non-covered medical, dental, and vision services that the individual pays for directly. Out-of-pocket expenses do not include premiums for health insurance.

Percent of Benefits Not Carved Out: The estimated percentage of a comprehensive package of benefits (e.g., pharmacy, behavioral health) that are accounted for within a payer's reported claims.

Point-of-Service (POS): Insurance plans that generally require members to coordinate care through a primary care physician and offer both in-network and out-of-network coverage options.

Preferred Provider Organizations (PPOs): Insurance plans that identify a network of "preferred providers" while allowing members to obtain coverage outside of the network, though typically with higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician.

Premium Retention: The difference between the total premiums collected by payers (net of MLR rebates) and the total spent by payers on incurred medical claims. Also known as non-medical expenses and surplus.

Premiums, Earned, Net of MLR Rebates: The total gross premiums earned after removing medical loss ratio rebates incurred during the year (though not necessarily paid during the year), including any portion of the premium that is paid to a third party (e.g., Connector fees, reinsurance).

Prescription Drug Rebate: A refund for a portion of the price of a prescription drug. Such refunds are paid retrospectively and typically negotiated between the drug manufacturer and pharmacy benefit managers, who may share a portion of the refunds with clients that may include insurers, self-funded employers, and public insurance programs. The refunds can be structured in a variety of ways, and refund amounts vary significantly by drug and payer.

Prevention Quality Indicators: A set of indicators that assess the rate of hospitalizations for "ambulatory care sensitive conditions," conditions for which high-quality preventive, outpatient, and primary care can potentially prevent complications, more severe disease, and/or the need for hospitalizations. These indicators calculate rates of potentially avoidable hospitalizations in the population and can be risk-adjusted.

Glossary of Terms (continued)

Product Type: The segmentation of health plans along the lines of provider networks. Plans are classified into one of four mutually exclusive categories in this report: Health Maintenance Organizations, Point-of-Service, Preferred Provider Organizations, and Other.

Qualified Health Plans (QHPs): A health plan certified by the Health Connector to meet benefit and cost-sharing standards.

Risk Adjustment: The Affordable Care Act program that transfers funds between payers offering health insurance plans in the merged market to balance out enrollee health status (risk).

Self-Insured (SI): A self-insured employer takes on the financial responsibility and risk for its employees' and employee-dependents' medical claims, paying claims and administrative service fees to payers or third-party administrators.

Standard Quality Measure Set (SQMS): The Commonwealth's Statewide Quality Advisory Committee recommends quality measures annually for the state's Standard Quality Measure Set. The Committee's recommendations draw from the extensive body of existing, standardized, and nationally recognized quality measures.

Tiered Network Health Plans: Insurance plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan simply splitting benefits by in-network vs. out-of-network; a tiered network will have varying degrees of payments for in-network providers.

Total Health Care Expenditures (THCE): A measure of total spending for health care in the Commonwealth. Chapter 224 of the Acts of 2012 defines THCE as the annual per capita sum of all health care expenditures in the Commonwealth from public and private sources, including (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by CHIA; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in regulations promulgated by CHIA.

Total Medical Expenses (TME): The total medical spending for a member population based on allowed claims for all categories of medical expenses and all non-claims-related payments to providers. TME is expressed on a per member per month basis.

Glossary of Terms (continued)

Treat-and-Release Emergency Department (ED) Visit: An emergency department visit not resulting in an inpatient admission or an outpatient observation stay at the same facility.

Unmet Need in Family for Health Care Due to Cost: Health care that a resident or a family member living in the household perceived as necessary but decided to forgo in the past 12 months due to the cost of that care. This includes the following types of health care: doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; or medical equipment.

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