

2025 Pre-Filed Testimony **PAYERS**



As part of the
*Annual Health Care
Cost Trends Hearing*

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the [2024 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2024, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission. All submissions are public record and will be posted to the [HPC's website](#).

You may receive questions from both the HPC and the Office of the Attorney General (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact relevant staff at the information below.

HPC CONTACT INFORMATION

For any inquiries regarding HPC questions, please contact:
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THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), and residents paying \$5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark](#) and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on members and purchasers, coverage and access to care, providers, in addition to premiums and out-of-pocket costs? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

Blue Cross Blue Shield of Massachusetts (Blue Cross) has been closely monitoring the changes in federal policy. We are seeing a targeting of public health, including questions around vaccine safety, coverage losses through MassHealth and the Connector, and research funding losses for universities, hospitals, biotech and the life sciences industries. The financial impact of those changes for Massachusetts is staggering, and we will all have to come together to consider how we continue to improve health care access and affordability. As we did with the COVID-19 pandemic and recent bankruptcy of Steward Healthcare, we must come together to collaborate on a path forward.

State Activities

We are already seeing examples of this collaboration through the state's quick actions on coverage of routine vaccines after the changes with the Advisory Committee on Immunization Practices and Centers for Disease Control recommendations. Blue Cross is committed to covering routine vaccines for our members and we welcomed the recent actions by the Department of Public Health and Division of Insurance to ensure coverage and access to routine vaccines. We have taken steps to educate members on their benefits to ensure that they know that our vaccine coverage is based on medical evidence as well as guidelines and vaccine specific recommendation from the Massachusetts Department of Public Health and national medical specialty organizations.

The Blue Cross Blue Shield of Massachusetts Foundation has been closely examining the impacts on the MassHealth program, which will face significant eligibility and financing cuts. Blue Cross is participating in the Stakeholder Engagement Forum convened by MassHealth and the Connector and will continue to as we navigate these challenges. As a health care community, we will be faced with difficult decisions.

The federal government shutdown has introduced another layer of uncertainty in an already fragile health care market. Blue Cross supports the extension of the enhanced Advanced Premium Tax Credits (APTCs) that are currently scheduled to end in December. We have been working with the Blue Cross Blue Shield Association to advocate for the extension of APTCs. Should the APTCs expire, there will be significant impacts to premiums both in Massachusetts and nationally. Blue Cross is very mindful of the start of open enrollment on November 1 and is hopeful for a resolution before that time.

Blue Cross is tracking additional policy impacts from the federal government shutdown. When federal funding ended September 30, 2025, so too did the Medicare telehealth and hospital-at-home waivers. Blue Cross is supportive of reinstating these waivers, and we continue to cover telehealth visits for our Medicare members.

Ongoing Massachusetts Trends

Blue Cross is keeping a pulse on federal impacts, while continuing to remain focused on affordability for our customers and members. The impact of the federal policy changes will exacerbate the persistent affordability issues that Massachusetts is experiencing, which will add to the impacts on access. As we have detailed in our pre-filed testimony for the last few years, trends continue to increase, and we are now seeing the highest medical trends in more than 15 years. A recent *Health Affairs* Forefront series article examined the economic toll of high commercial provider prices, including the deepening socioeconomic and racial disparities. The article reviews independent economic research that has found little to no evidence to support the claims that commercial rates must be higher to make up for underpayments from public payers, but instead that unchecked growth of provider market power has led to high and varying commercial prices.

In Massachusetts, we have continued to see provider consolidation and expansion. Many of the large systems continue to expand their presence, with major acquisitions increasing their market share and geographic dominance. Consolidation and expansion are occurring with no consideration of the entities' performance against the health care cost growth benchmark or strong conditions limiting overall price growth. This type of growing leverage will continue to strain the health care system, with increasing demands for higher prices which in turn impact affordability, access, premiums, and out-of-pocket costs.

Massachusetts should consider whether mergers and other transactions should be reviewed more closely to address antitrust impacts, and whether prices should be directly regulated. Additionally, policymakers should consider whether any existing policies limit lower-cost, higher value alternatives for purchasers and how to incentivize these products. For example, Massachusetts providers have the right to opt out of tiered networks, which has significantly limited the ability to design low-cost products and limited their growth. Whether this policy continues to support the Commonwealth's goals should be considered by the Health Policy Commission and the legislature. Additionally, a default out-of-network rate could have a significant impact on affordability as more affordable products are designed and introduced to the market.

As we have offered in previous Cost Trends pre-filed testimony and detailed in Question 2, state health planning will play a critical role in helping Massachusetts understand the current landscape and what will be necessary for the future as we consider what services, sites of service, locations, provider types, and other factors will be necessary to support access and affordability moving forward. The Blue Cross Blue Shield Foundation released a report in April 2025 examining what health planning tools could support the state, and we look forward to learning more from the HPC's Office of Health Resource Planning.

While the impact of the federal government policy changes will be significant, Massachusetts has a lot of opportunities to address affordability and stabilize the market independent of those changes. The Commonwealth should use this as an opportunity to reexamine how we are going to address the consistent and growing issue of affordability.

2. Many Massachusetts health care providers continue to face significant workforce challenges. What policy, payment, or health care system reforms does your organization recommend to better sustain, strengthen, and diversify the health care workforce in Massachusetts?

Workforce and financial challenges throughout the health care market directly affect our affordability efforts and our members' ability to receive care without interruption. As noted in previous pre-filed testimony, hospitals and providers throughout Massachusetts have approached rate negotiations in the recent years with increasingly higher requests, citing workforce issues among other items. This year's negotiations are no different.

As we included in last year's pre-filed testimony, long-range health planning would allow the state to build on the many strengths of our health care system with a clearer understanding of evolving needs and resources. We are looking forward to the work being done by the Health

Policy Commission's Office of Health Resource Planning. Their work will equip policy makers, payers, and providers with the ability to make more informed decisions and monitor and evaluate progress in meeting goals for affordability, access, quality, and equity. Health planning will allow us to understand how demographic changes may impact the number and types of clinicians that will be needed to meet the needs of the Commonwealth. This is critical information to address the current workforce challenges.

While the Office of Health Resource planning is underway, there are other steps that the Commonwealth should consider taking. Blue Cross supports expanding the scope of practice for health care professionals to allow existing providers to fill much-needed gaps in the workforce. As one example, we strongly support expanded scope of practice for physician assistants. Blue Cross also supports Massachusetts entering medical interstate licensing compacts to ease the entry of health care professionals from around the country into Massachusetts. We applaud the Healey-Driscoll Administration for including in the Economic Development bill a pathway for international physicians to practice in Massachusetts.

We provide more details in our response to Question 4 below, but Blue Cross is actively participating in the Primary Care Taskforce convened by the Health Policy Commission as they look at ways to increase and support the primary care workforce.

As our provider partners face workforce challenges, Blue Cross has worked hard to streamline administrative functions. We are constantly evaluating our processes to identify areas where we can ease burdens on our clinician partners. In addition to the prior authorization work detailed in Question 3, we have also looked for ways to utilize technology, including using an online portal for authorization requests which is available 24/7 and more efficient than paper requests, and increasing our ability to utilize provider system EMRs to eliminate the need to submit clinical support for authorization requests. We will continue to examine additional ways to address administrative simplification.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What are the most meaningful steps you are taking to reduce administrative complexity that provides little value to patient care? What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs and the administrative costs of providing care borne by providers and others?

Ensuring that our members have access to safe, effective, affordable care is our top priority. Blue Cross uses prior authorization tools to improve the quality and safety of care for the people we serve. We work collaboratively with our members and clinicians to ensure that members have access to safe and effective treatments, while providing consumers with the best value for their premium dollars. Without prior authorization, health care premiums would increase. In fact, a recent study by Milliman concluded that removing prior authorization altogether could result in premium increases in the commercial market nationally totaling between \$43 billion and \$63 billion, which translates to \$240-\$360 annually per member additional premiums. The report also estimated higher out of pocket costs for members if prior authorization was removed.

In June 2025, Blue Cross and Blue Shield companies, along with some national insurers, announced a series of commitments to simplify prior authorization, with a focus on making it faster, more seamless and more streamlined. Many BCBS companies, including Blue Cross Blue Shield of Massachusetts, have reduced the scope of services subject to prior authorization in the past several years. Blue Cross has removed prior authorization requirements for certain services such as habilitation services and home care. As part of the prior authorization commitments, we will examine ways to further reduce the use of in-network prior authorization for certain medical services, fast-track responses for electronic prior authorization requests, provide personalized support, and create a more seamless process for people who switch health insurance companies.

At Blue Cross, 98% of claims do not require prior authorization, but prior authorization remains an important step for high-risk, high-cost care decisions. Prior authorization decisions are made by doctors, nurses, and other clinically qualified experts and guided by nationwide best practices for care. This year, we conducted a detailed review of the services for which we require prior authorization, including a comparison with other plans. We found that we require prior authorization for fewer services than most national plans, as well as some other regional Blue Cross plans.

We use technology and automation to streamline the prior authorization process to ensure our members receive safe, high-quality, and cost-effective care quickly. In 2022, we completed a successful proof-of-concept pilot called "Fast Pass". Fast Pass automated the prior authorization process and in turn alleviates administrative burden, decreases clinical review time, and increases clinician satisfaction. We are now implementing technologies that work to scale the turnaround time reductions we observed in Fast Pass including improving our provider portal, creating a provider look up tool, automating the collection of clinical data, creating decision support, and automated approval where appropriate.

To help expedite the decision-making process where prior authorization is required, we have remote access to electronic medical records so clinicians don't have to send us documentation, and we can review clinical documents without disruption. Additionally, our provider portal allows practices to submit their request at any time. Blue Cross utilizes certain auto-authorization rules where we approve certain cases depending on the diagnosis and CPT code.

We recently launched a simple (no registration or login required) look up tool for provider practices to inquire if prior authorization is required and check the status on a previously requested prior authorization. This eliminates the need for faxes and calls, and the look up tool has more than 20,000 inquiries per month.

One of the strongest policy options Blue Cross supports to address administrative burden is a clinical data exchange. Timely sharing and aggregation of patient data could drive health system improvement in many areas, including prior authorization automation and other administrative burden relief. We have seen through our partnership with remote access to medical records, that having access to clinical information quickly leads to faster reviews, and reductions in burden. Additionally, clinical data exchange could help the Commonwealth better understand outcomes and total costs which could lead to better care coordination, clinical quality improvement, and outcome-based payment models. Sharing this type of information is crucial to address not only administrative burden, but to provide affordable, high-quality care to Massachusetts residents.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. What specific actions or investments is your organization pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your members? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms does your organization recommend to enhance equitable access to high-quality primary care services?

Blue Cross recognizes the importance of strong primary care, which is why we made it the anchor of our Alternative Quality Contracts (AQC) agreements. Additionally, we launched the Collaborative Care Model a few years ago which offers financial incentives for primary care physicians to integrate mental health care into their practices with the goal of improving our members' physical and mental health outcomes.

Blue Cross is a proud member of the Primary Care Taskforce convened by the Health Policy Commission and looks forward to working with the legislature as they consider a bill to strengthen primary care in Massachusetts. As we consider affordability, it is important that

investments are made without increasing overall costs. We support the creation of a primary care board comprised of those with relevant skills and experience in primary care, allowing that board of experts' flexibility in the approach, and aligning incentives for primary care providers.

Massachusetts should examine the primary care reform policies in Arkansas, Colorado, Delaware, Rhode Island, and Washington to consider what has worked well and what policies have not. While there have been some successes, broad increases in access have not been achieved in these states, and Massachusetts will want to avoid adding costs to the system without clear areas of cost reduction, without impacting access or quality.

As discussed in Question 1, the Massachusetts market continues to consolidate, and more primary care practices are becoming part of larger systems and academic medical centers. This phenomenon should be examined by the Commonwealth to understand whether this improves primary care access and the impact on provider prices. We should also have more financial transparency around how dollars are distributed within larger organizations to ensure that appropriate funding is going towards primary care. This will be essential for any primary care reform to ensure that any targeted primary care spending in fact goes directly to primary care.

In recent years, Blue Cross has worked with innovative providers to look for new ways to provide primary care. We offer options that include no-cost visits for specific services like CVS MinuteClinic, and most of our commercial plans include a virtual care team feature, which has a \$0 cost share for virtual primary care with Firefly Health. This value-based virtual primary care provider offers lower costs, integrated mental health, and multiple communication changes, including video, chat and text. We are also working with innovative ACOs like Aledade and Vytalize, and more focused primary care like Folx, a LGBTQ-specialized virtual health care provider. We also continue to contract with more virtual first providers, like CloseKnit. Our members have more options than ever on how and where they would like to get their primary care.

5. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state's health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents. Please describe the current and anticipated pharmaceutical trends (and detail the potential impact on health care spending) in the next three to five years, including but not limited to information about anticipated trends in utilization, new medications and therapies, and price increases for brand name and generic drugs. What specific actions is your organization taking to address these trends and to balance patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and members?

Pharmacy spending is increasing at an unsustainable rate. While CHIA's most recent report showed that in 2023 pharmacy spending gross of rebates made up the largest share of total health care expenditure (THCE) spending, increasing by 11.6% over the previous year, the more recent trends we are seeing show an even higher trend. In 2024, Blue Cross' commercial pharmacy spending trend increased 18.6% and we are seeing similar high trends in 2025. As we detailed in last year's pre-filed testimony, part of this was due to the increase in GLP-1s. In 2024, GLP-1s alone accounted for 11.6% of commercial pharmacy trend gross of rebates. We anticipate these high pharmacy trends to continue even after we no longer offer coverage for GLP-1s for weight loss in 2026.

Blue Cross is working with other Blues plans to establish outcomes-based arrangements with drug makers to ensure that patients are getting the right medications at affordable prices. We are also exploring different contracting models for high-cost treatments like gene therapies and cancer drugs. We know that these treatments can greatly benefit members, but we anticipate significant growth in the future which will impact affordability. The health care system will need to consider how to address these high-cost drugs and the impact they will have on employers and members and consider alternative ways to pay for them.

Blue Cross has been exploring policy solutions to address pharmaceutical spending, including a pharmacy drug affordability board (PDAB) to review high-cost prescription drugs, assess affordability for consumers and payers, and to set upper payment limits. Seven states currently have PDABs and there is much to learn about their early success. Other states have also found benefits to bulk purchasing of high cost drugs. The state should consider potential benefits in Massachusetts for bulk purchasing.

6. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

We are at a crisis point when it comes to health care affordability in our state. Health care costs are growing at the fastest rate in more than 20 years, with spending up in almost every category, from hospitalizations to drug costs to outpatient visits. This pressure on our employer customers and plan members is not sustainable.

At the same time, we are projecting more than \$1 billion in operating losses between 2024-2026. This is the first time in recent history that we have sustained significant back-to-back net losses. If we are unable to accurately price our products, especially in the merged market, our losses will deepen and our ability to invest in technology, care innovations, and local partnerships will be reduced.

As we have expressed in previous pre-filed testimony, we have seen rate demands in our provider contract negotiations that are more than 3-5 times the health care cost growth benchmark. The Center for Medicine in the Public Interest released a report in June 2025 showing that over the past 25 years, hospital prices have increased more than 250%, outpacing both medical inflation and the overall economy. Blue Cross has in the past considered prices above what we would like in order to build an adequate network for our employer customers and members. While commercial claims trend, including pharmacy costs, has been increasing over 12% in the last year, Blue Cross has tightly controlled our administrative costs, growing 0-2% and remaining flat this year. Blue Cross understands that bold action is needed.

A few months ago, in my capacity as President and CEO of Blue Cross, I sent a message to the physician and hospital network on health care affordability and the impact it is having on employers, families, and individuals. The message was that we are strengthening our focus on building a more affordable system and to do that, we have to hold our average increases for our network below the state's health care cost growth benchmark of 3.6%. In the message, we encouraged providers to partner with us in innovative ways to control costs. This message was met with mixed responses, but we have remained committed to remaining under benchmark in this year's contract negotiations, which has led to some difficult discussions and decisions. As some of you may be aware, we have sent letters to our members and providers indicating that UMass Memorial may not be part of our network in 2026. The negotiations continue, and we hope to come to resolution before January 1, 2016, but these are the types of challenges we will see in the market as we strive for affordability. As a health plan, we are constantly balancing the needs of access for our patients with affordability.

As the HPC has shown year after year, spending growth continues to surpass the benchmark. The most recent year evaluated (2022-2023) had the highest growth rate in HPC's history, outside of the COVID rebound years (2020-21). Data presented at the 2025 benchmark hearing show that Massachusetts spending growth exceeded the national rate in 2021 and 2023. In 2023, all sectors had growth above benchmark, with the commercial sector experiencing a 7.8% increase. We anticipate that all spending trends will continue and get worse over the next few years.

In addition to the policy steps detailed in Question 1, Blue Cross reiterates the suggestions made in previous pre-filed testimony to restore the effectiveness of the benchmark and to focus on affordability.

First, the state's cost containment benchmark should apply to the entities driving much of the cost growth in the system -- the hospitals, health systems, and pharmaceutical companies -- who are not currently tested against the benchmark. As the HPC detailed in their recent board meeting, average price increases were the largest for inpatient services from 2019-2023 at 17.3% compared to the 10.6% increase for office visits. Having a broader application of the benchmark would bring all stakeholders to the table and align incentives to transform the system. In addition to understanding the cost of care at hospitals, both on a unit cost and a cost per case basis, hospitals should be evaluated on their efficiency with their resources, whether they are doing low-value care, and the quality of care being delivered. As we have discussed with both the HPC and the Center for Health Information and Analysis over the last few years, there are potential approaches to identify catchment areas for hospitals or establishing provider-hospital relationships and setting a total cost of care for those patients. With the state's help in truly holding entities accountable, we can accelerate work to address the concerning trends we are seeing.

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

Additionally, approvals for Material Change Notices with the HPC and Determination of Need applications with Department of Public Health should be tied to meeting the benchmark and price growth conditions for approval should be considered.

All of us in the healthcare market need to explore ways to live within a budget for health care services. Some states have had success setting price controls, including Vermont, Rhode Island and Maryland. While Massachusetts may choose a different path, we must explore innovative approaches to help catalyze meaningful change.

This is the moment to rethink how healthcare is delivered in Massachusetts – and all ideas to solve this affordability crisis should and must be considered.

TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2021 to 2024 according to the format and parameters provided as **HPC Payer Exhibit** (attached) with all applicable fields completed. Please explain the portion of actual observed allowed claims trends that are due to (a) changing demographics of your population; (b) benefit buy down; and/or (c) change in health status/risk scores of your population for each year. Please note where any such trends would be reflected (e.g., unit cost, utilization, provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

Please see HPC Payer Exhibit attached.

2. Reflecting on current medical expenditure trends your organization has been observing in 2025 to date, which trend or contributing factor is most concerning or challenging?

Unit Cost

Similar to last year, providers continue to request unit cost increases well above the benchmark during negotiations. At the extreme, we have seen provider proposals with 30–50% rate increases over three years. This dynamic has already increased—and will continue to increase—total medical expense trends beyond the benchmark level.

The unit cost pressures Blue Cross experienced between 2019 and 2024 are part of an emerging and very concerning trend. Reductions in government reimbursements, and continued provider consolidation in certain geographies, are only exacerbating the issue. Recognizing that unit cost continues to be almost one half of total cost of care trends, Blue Cross had a strong track record for many years of keeping unit cost trend near or below 2%. In more recent provider negotiations, we have seen a shift in providers' commitment to cost containment. Many providers have sought to leverage unit cost increases that significantly exceed the benchmark. These continuing dynamics have added approximately 2% to overall commercial medical expenditure trend, which accounts for approximately \$150 in premium dollars per year for a commercial member. This remains a primary driver of medical trend as we look beyond 2024.

Utilization

Utilization is up across key categories, including more office visits, procedures, and behavioral health services, as well as higher use of expensive chemotherapy drugs. We anticipate that capacity expansion at outpatient clinics and outpatient surgery facilities will continue current utilization trends.

Severity

We are observing higher medical intensity and severity, including shifts to higher-cost sites of service and greater use of higher-intensity services (e.g., MRI vs. X-ray), and increased use of provider programs to maximize revenue through coding and billing practices. We anticipate the current intensity and severity trend to accelerate, driven by continued coding intensity – whether through AI assisted or traditional coding practices.

Pharmaceutical Costs

Pharmacy spending continues to be the significant driver of healthcare trend, led by utilization of GLP-1 medications. In addition, costs associated with the category of pharmaceuticals delivered in a provider setting continue to increase significantly, largely driven by increases in both the cost and mix of chemotherapy drugs and non-chemotherapy related specialty drugs administered in a facility setting.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

- Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available “price transparency tool.” In the table below, please provide available data regarding the number of individuals who sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2021-2025			
Year		Aggregate Number of Inquiries via Website and App	Aggregate Number of Inquiries via Telephone or In- Person
CY2021	Q1	33,157	155
	Q2	29,811	170
	Q3	32,840	145
	Q4	33,325	128
CY2022	Q1	38,806	92
	Q2	33,423	117
	Q3	35,520	104
	Q4	35,802	134
CY2023*	Q1	33,885	190
	Q2	31,808	168
	Q3	30,541	145
	Q4	31,489	153
CY2024	Q1	42,094	260
	Q2	35,266	211
	Q3	35,665	245

	Q4	35,105	224
CY2025	Q1	41,202	219
	Q2	38,457	148
	Q3	38309	123
	TOTAL:	666,504	3,131

--- End of BCBSMA Responses ---

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Sarah Iselin". The signature is fluid and cursive, with a long horizontal stroke at the end.

Sarah Iselin

President and Chief Executive Officer

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2021	2.8%	9.9%	1.7%	1.7%	16.7%
CY 2022	3.0%	-0.5%	0.3%	0.3%	3.2%
CY 2023	4.0%	0.4%	0.4%	2.9%	7.6%
CY 2024	3.7%	3.5%	0.1%	1.4%	8.8%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. **These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.**

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

5. Note that the data and trends above are limited to claim experience for Massachusetts residents in Commercial plans whose primary coverage is with BCBSMA and include both non-pharmacy and pharmacy claim expenses. Membership for CY's 2021-2023 is based on all BCBSMA Massachusetts medical members in Commercial products, irrespective of whether they have pharmacy coverage with BCBSMA. Starting in 2024, the pharmacy claims PMPM is based on applicable membership that purchases pharmacy coverage from BCBSMA. Additionally, pharmacy claims are adjusted for manufacturer rebates not being passed through claims. FEP and Host membership/claims is excluded for all CY's.

6. Although overall benefit buydowns have stayed fairly constant over the past three years, there was a modest increase in benefit buydowns observed in 2024 versus 2023 driven by the large group segment. The large group segment benefit buydowns were deeper than in 2023 due to churn from new sales and terminations.

7. Changes in health status are estimated using DxCG risk score. Overall risk score declined in 2020 due to the deferral of care resulting from the Covid 19 pandemic. The risk score returned to previous levels beginning in 2021 and have been slowly accelerating each year since. Changes can potentially impact all components of trend except unit cost.

8. Note that CY 2020 and 2021 trends are significantly impacted by the deferral of care and subsequent return to care resulting from the Covid-19 pandemic and do not represent a run rate trend

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

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

Emerging 2025 trends point to total trend accelerating into double digits, potentially reflecting contributions from both utilization and mixes across medical and drug spend.