

HEARING TO DETERMINE THE 2025

HEALTH CARE COST GROWTH BENCHMARK



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




CHAPTER 224 OF THE ACTS OF 2012



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




GOAL



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



VISION



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

- The HPC sets a **prospective target** for controlling the growth of total health care expenditures across all payers (public and private) and is tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a hard cap on spending growth or provider-specific prices** but is a measurable goal for moderating excessive health care spending growth and **advancing health care affordability**.
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans (PIPs)** and submit to public monitoring.
- A PIP of an individual provider or health plan may be required only after a **retrospective, comprehensive, and multi-factor review** of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

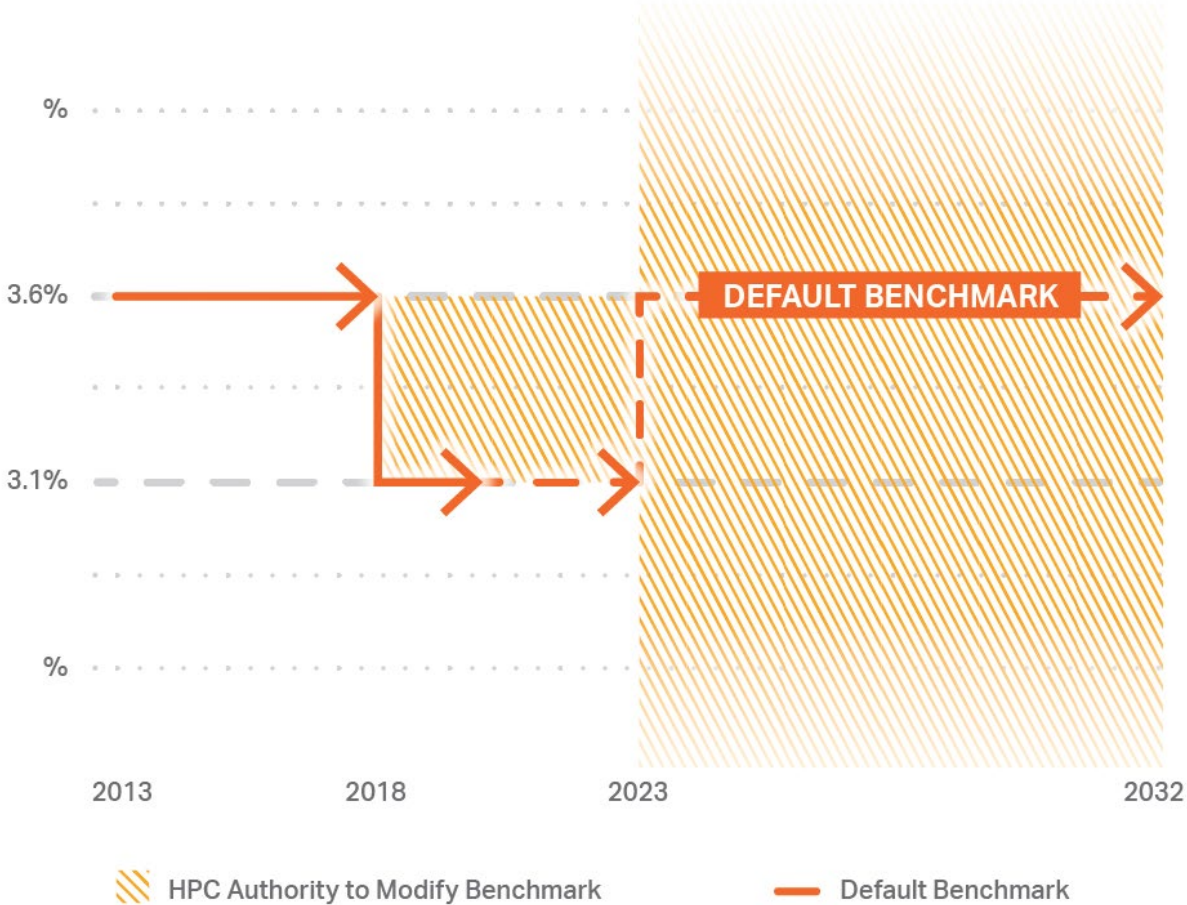
Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

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



1-5 years	Benchmark established by law at PGSP (3.6%)
6-10 years	Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.
10-20 years	Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



Accountability for the Health Care Cost Growth Benchmark: An Overview



Step 1: Benchmark

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



Step 2: Data Collection

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



Step 4: HPC Analysis

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



Step 3: CHIA Referral

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



Step 5: Decision to Require a PIP

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



Step 6: PIP Implementation

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

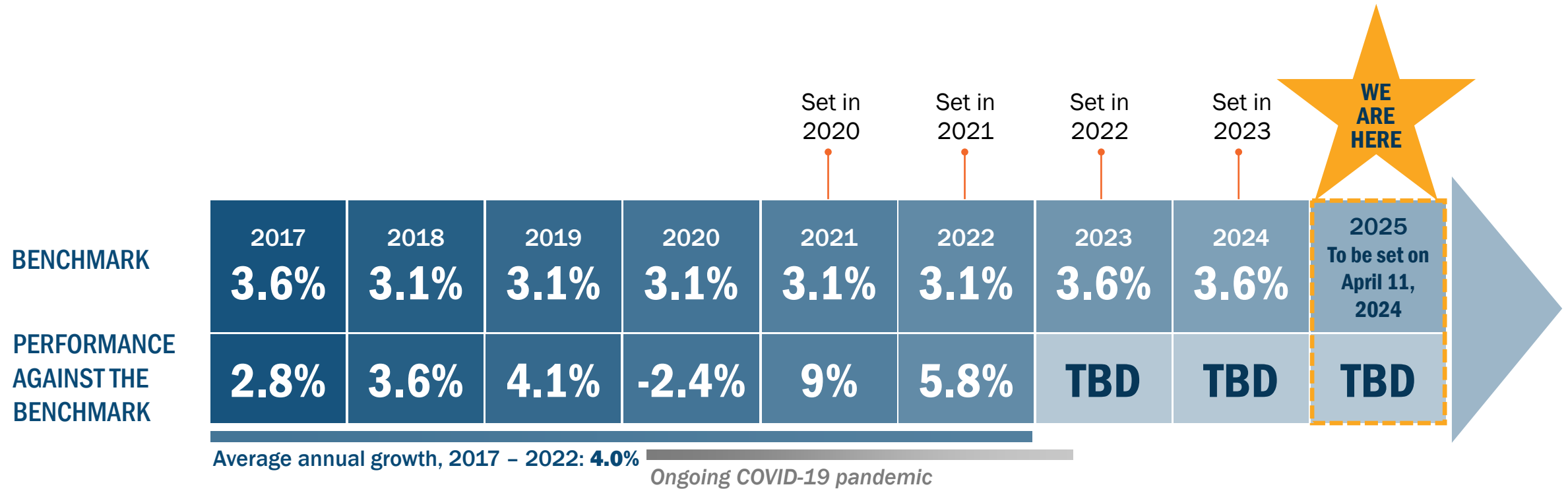
CHIA’s referral of entities is based on a bright-line test of their spending growth, whereas the HPC is charged with contextualizing that growth for each referred entity.



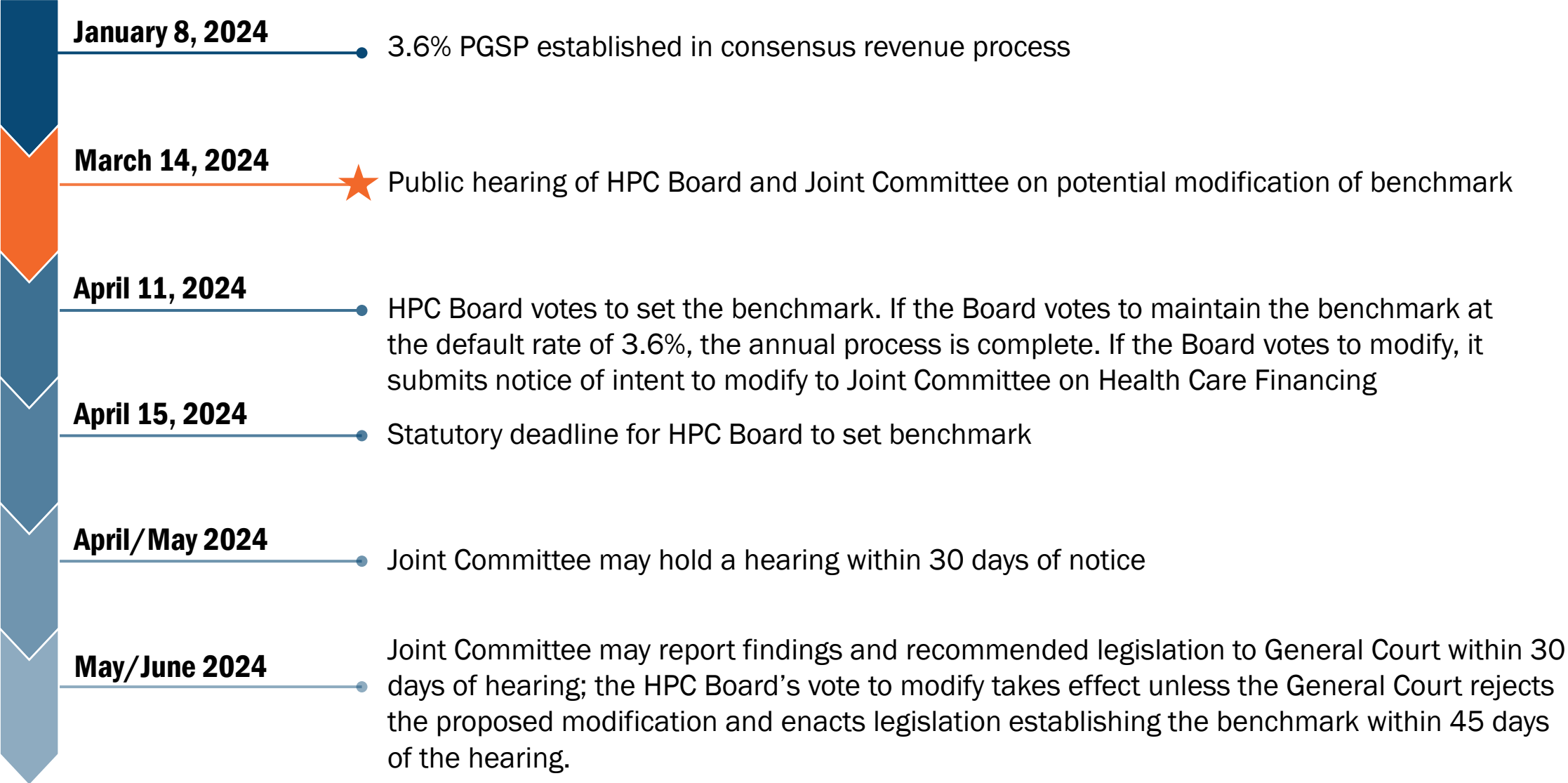
The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies **significant concerns** about the Entity’s costs and determines that a Performance Improvement Plan could result in **meaningful, cost-saving reforms**.

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

The health care cost growth benchmark is set prospectively for the upcoming calendar year, while actual performance is measured retrospectively.



Benchmark Modification Process: 2024 Timeline



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

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

