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MHA COMMENTS IN RESPONSE TO DOI MERGED MARKET PROPOSED RATES

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The Massachusetts Health & Hospital Association (MHA), on behalf of its member hospitals and health systems, appreciates the opportunity to offer our perspective regarding the proposed increase in merged market (small group and individual market) health insurance premiums for 2026. MHA would also like to acknowledge the Division of Insurance (DOI)'s focus on affordability throughout this annual process and express our continued commitment to partnering around patient-centric solutions.

Given the focus on hospitals and health systems during DOI's June 17 public information session, these comments are intended to provide DOI with important perspective regarding: (1) underlying – and worsening – provider cost pressures; and (2) the actions hospitals and health systems are taking to promote affordability for patients, and collaborative solutions the commonwealth can embrace that are responsive to today's environment.

Last month, Massachusetts health plans that offer products in the merged market submitted their proposed rate changes to the DOI for rates effective January 2026. The proposed rate increases, subject to the Division's review and approval, ranged from 9.9% to 16.2%; the average proposed rate increase across the eight plans doing business in the merged market was 13.4% (by comparison, the Division approved an average 7.8% increase for 2025). It is important to note that:

- Among the reasons for the increases cited by health plans were increased pharmacy spending (in particular GLP-1s and high-cost specialty drugs), as well as upward pressure on provider reimbursements resulting from inflation and labor shortages.
- Rate increases are not unique to Massachusetts. They are being seen around the country, with Massachusetts on the "lower end" of the spectrum, as UnitedHealthcare's representative stated at the June 17 session. Rhode Island, for instance, is reporting larger increases than those proposed locally.
- During the public information session, several plans cited the uncertainty of tariffs and changes in the ACA as contributing to premium increases. It is notable that in other states, a major factor impacting the requested increase this year is that the Enhanced Advance Premium Tax Credits that are set to expire on December 31, 2025 unless renewed by Congress.

We share the above concerns expressed by health plans, as these underlying factors are also contributing to a challenging environment for hospitals and other care providers.

A Fragile System: Increasing Provider Cost Pressures

Affordability issues are, in many ways, a symptom of the deeper healthcare crisis that MHA and its members have been highlighting for the past five-plus years. Meaningful, long-term cost solutions will depend on our commonwealth's ability to address these fundamental issues.

The sobering reality is that the entire Massachusetts healthcare system finds itself in an increasingly fragile state. Providers have experienced dire financial challenges since the onset of COVID, and health plans are now reporting losses of their own. On the hospital side, the Center of Health Information and Analysis (CHIA) found that the statewide

median hospital operating margin was in the red (negative-0.7%) as of the end of 2024. A significant majority of reporting hospital and health systems (76%), which include affiliated physician practices, experienced negative operating margins.

This bleak financial picture for hospitals has a number of root causes that are likely to persist into 2026 and beyond. Cost pressures will remain for labor and prescription drugs, as well as for other supplies and utilities that will likely be compounded by uncertainty around inflation, tariffs, and supply chain disruptions. Many of these are factors that a hospital cannot directly control. We offer expanded commentary on these hospital expense drivers below.

Workforce, Capacity, and the Health Safety Net

As health plan leaders referenced at the June 17 session, hospital labor costs are rising. Labor accounts for more than 60% of hospitals' operating costs and given the shortage of healthcare workers in Massachusetts, providers must offer increased wages and incentives to recruit and retain talented individuals. According to CHIA's hospital financial reporting, hospital health system wages and salaries grew at 7.0% in 2023. For a consistent cohort of 44 hospitals that reported data in Q1 of FY24 and FY25, salary and benefit expenses increased by 7.3%. Without adequate staffing, hospitals cannot maintain the life-saving access patients deserve.

Meanwhile, hospitals continue to navigate severe capacity constraints, exacerbated by throughput bottlenecks and a lack of community-based healthcare services. This dynamic will continue to place upward pressure on wages while also driving up the volume of unreimbursed care hospitals provide as patients remain stuck in acute care facilities and are unable to be discharged (already a $400 million expense for Massachusetts hospitals each year).

The commonwealth's Health Safety Net program for the uninsured is also in serious deficiency: MHA anticipates the program could experience up to a $290 million funding shortfall in FY2026. These growing deficits are shouldered by hospitals alone, without support from other elements of the healthcare system, and they are a major contributor to the financial turmoil that provider organizations are experiencing.

Increasing Pharmaceutical Costs

Health plans also cited the pressure that increasing pharmaceutical costs have on their operating performance and need for future rate increases. Hospitals are burdened by the same dynamic. According to CHIA, net of rebates, pharmacy spending increased $1 billion or 10% year over year in 2023. In 2024, BCBSMA reported an operating loss of over $400 million, much of which it attributed to a surge in GLP-1 medication expenses. In outpatient hospital settings, pharmacy expenses represent a major component of services delivered, including chemotherapy, antibiotics, and treatment for hemophilia. New, expensive, and growing treatments like cell and gene therapies are also administered in hospitals. Increased pharmaceutical expenses are a major driver of hospitals' cost growth, which are often not supported with commensurate reimbursement, thus contributing to hospital financial losses.

Changing Patient Demographics

As some insurers have experienced, hospitals are increasingly feeling the effects of changing patient demographics. Patients are generally sicker, older, and in need of longer hospital stays, as is evident in CHIA's hospital utilization statistics. Patients discharged from hospitals who are 65 years or older now make up 46% of all patients, a 10.5% increase compared to 2019. Caring for this population is, of course, more complex and expensive than care for those under 65. According to data from the Centers for Medicare and Medicaid Services, total personal healthcare per-capita spending for those 65 years and older is 2.4 times greater than adults 19 to 64 years of age.

The effect of the population becoming older, as well as other factors such as prioritizing inpatient care for more acute conditions and transitioning care to outpatient settings, has caused hospital stays to become longer. Patients are also staying longer due to challenges in the discharge process, including difficulties finding placements in post-hospital care settings. According to the most recent CHIA hospital utilization data, hospital inpatient average length of stay is now 5.54 days, which represents a 12% increase compared to 2019.

This changing case mix – complex, Medicare-based medical admissions with longer lengths of stay and lower unit payment levels – is driving operating losses experienced among our state's hospitals.

Uncertainty from the Federal Government

According to the Healey-Driscoll Administration, the reconciliation bill passed by House Republicans in May would cut $1.75 billion in federal funding from MassHealth and the Massachusetts Health Connector Marketplace. This would result in more than 250,000 Massachusetts residents losing healthcare coverage (including approximately 85,000 from the Connector alone) under those programs. The bill emerging from the Senate includes even more profound cuts. Cuts of this magnitude would have an impact well beyond those covered under MassHealth and the Connector. Nursing homes, community health centers, and hospitals would be faced with cutting services or considering their very viability. Healthcare jobs would be put at risk. And, again, costs for everyone would increase as more uninsured people seek care in emergency rooms, further straining providers, limiting access to services for all, and threatening healthcare outcomes.

Beyond eligibility and health coverage losses, there are a variety of significant limitations and cuts being considered by Congress that will negatively affect the financing of the Medicaid program and in turn, healthcare providers – especially safety net hospitals. Healthcare-related taxes and Medicaid State Directed Payment (SDP) programs are used to support the cost of providing care in the MassHealth program and have been targeted by Congress as well as the Trump Administration. Cuts and restrictions to these mechanisms would hinder the commonwealth's ability to finance Medicaid payments to healthcare providers, which would have devastating effects on safety net providers, healthcare coverage, and access to services in the MassHealth program.

Actions and Opportunities to Improve Quality and Manage Cost

Massachusetts hospitals and health systems remain committed to offering lifesaving care and partnering with health plans and government officials to promote a more affordable delivery system. We offer the following key actions and opportunities for the Division's consideration.

Hospital Efforts to Address Affordability

Hospitals and health systems recognize their role in making healthcare affordable. Below are just some of the steps they are taking:

- Clinical Innovation and Efficiency Initiatives
  - Reducing unnecessary, low value, and duplicative care.
  - Expanding innovative programs outside the hospital (such as telehealth, hospital at home, remote patient monitoring, and mobile integrated health) that keep people outside of more expensive care settings.
  - Expanding the use of care navigators to avoid duplicative services and improve care coordination.

- Site of Care Emphasis
  - Steering patients to lower-costs settings whenever possible, including the creation and promotion of urgent care facilities as alternatives to emergency departments.

- Workforce Management
  - Working to expand the entire behavioral health workforce to integrate with primary care clinicians and offer additional sites of care to mitigate emergency department overcrowding.
  - Growing the primary care workforce to expand preventive care and thus reduce downstream need for inpatient and specialty care.
  - Scaling back reliance on travel labor, which was necessitated by COVID response efforts.

- Patient Engagement
  - Facilitating patient enrollment in financial assistance or Medicaid programs.
  - Addressing social determinants of health to avoid eventual hospitalizations.

- Payment Innovation
    - Engaging with health plans in value-based contracting initiatives across commercial, Medicare, and Medicaid lines of business to promote the delivery of high quality, affordable care.

Desire to Collaborate with Health Plans to Reduce Administrative Waste

While hospitals are committed to investing in the solutions noted above, they are forced to allocate precious resources to counter health plan practices that do not improve healthcare quality. These well-publicized efforts include: challenging denied claims; repeatedly responding to health plan requests for "additional information"; trying to comply with the tremendous variation in different plans' policies, requirements, and benefit design; and attempting to collect patient liability for services driven by increasingly "lean" benefit offerings, often unsuccessfully, resulting in growing hospital bad debt. A February 2025 report from Kodiak Solutions showed:

- Growing initial and final claim denials by all payers;
- Increasing initial request for information claim denials by commercial health plans and by Medicare Advantage plans; and
- Commercially insured patients owing more out of pocket but paying less of their share of their medical bills.

Even if the claims are ultimately paid, initial denials still cost hospitals, health systems, and medical providers extensive resources to overturn. The Kodiak national report mirrors MHA's own 2023 "Better Care, Lower Costs" report, which showed that Massachusetts hospitals and physician practices incur as much as $1.75 billion in unnecessary administrative costs from billing- and insurance-related practices each year. MHA and our partners in the physician and patient advocate communities have repeatedly called upon health plans to address and remediate these practices so that hospitals are paid fairly for services provided in good faith to health plan members.

Partnering with the Healey-Driscoll Administration

MHA appreciates the steps taken by the Healey administration and the Division of Insurance to limit the growth of deductibles and co-payments to the rate of medical inflation. In addition to controlling patients' out-of-pocket expenses, this action will reduce hospital bad debt, a prominent driver of hospital operating losses. We are committed to working with state officials to advance this important initiative.

In addition to the steps that hospitals and health systems are taking, the Health Policy Commission has established the new Office of Health Resource Planning (OHRP), which is tasked with promoting the appropriate and equitable distribution of healthcare resources across geographic regions of the commonwealth. The statutory requirements for OHRP include supporting innovative delivery of care and alternative payment models, avoiding unnecessary duplication of resources, advancing health equity, and ensuring a stable and adequate healthcare workforce – all of which should help to address access and affordability.

Chapter 342 of the Acts of 2024 also established a new Office of Pharmaceutical Policy and Analysis (OPPA) within the HPC. OPPA will be responsible for collecting and analyzing pharmaceutical spending data, publishing an annual report on trends related to access, affordability, and spending on pharmaceuticals, and managing the review of high cost drugs referred by MassHealth. It is expected that recommendations from OPPA will lend transparency to pharmaceutical spending and pricing as well as provide stakeholders with data to address costs.

MHA and our member hospitals strongly support the creation of OHRP and OPPA, and we look forward to partnering with these new offices going forward to advance their important missions.

Promoting Transparency

Although health plans are required to post information summarizing their submissions, there is still an opportunity to expand transparency for healthcare cost drivers. As Health Care For All noted at the June 17 session, DOI should seek further clarification from plans around variation in medical trend across the market as well as the significant variation in

administrative costs with no clear explanation. MHA agrees that additional clarification is warranted and that more transparency would lead to better understanding of what is driving premium requests.

Policy Solutions

MHA and its members agree that rising costs of healthcare must continue to be addressed, and in a manner that is thoughtful, responsive to the extreme pressures provider organizations are facing, and does not inadvertently compromise access to care for patients. With all hospitals and health systems facing financial headwinds and growing uncertainty, simply cutting payments is not a sustainable solution and will have numerous unintended consequences. MHA and our members are advocating for a collaborative approach that is built around the needs of patients and common-sense solutions – rather than assigning blame or rehashing age-old debates that have prevented progress in the past.

We support these important policy solutions:

- Addressing the fundamental crises shaping the state's healthcare system – particularly around capacity, access, and financial stability.
- Recognizing and addressing the costs of funding our state's safety net, including the Medicaid program and Health Safety Net, the latter of which faces a historic funding deficiency that requires shared responsibility to resolve.
- Easing administrative burdens, particularly those that drive up costs and challenge patient access.
- Ensuring providers have the flexibilities to deliver care where and when it is needed.
- Empowering and reimbursing care delivered outside of hospitals (such as telehealth, hospital-at-home, and mobile integrated health).
- Greater transparency and accountability for *every* part of the healthcare system, including new market entries and the industries behind some of the highest rates of cost growth. This includes pharmacy benefit managers and pharmaceutical manufacturers.
- Compiling and analyzing state-collected insurance data in a meaningful, transparent way.

Payers, providers, pharmaceutical companies, and other key stakeholders must work together to reduce administrative complexity, invest in the healthcare workforce, strengthen primary and behavioral healthcare, ensure network adequacy, and consider expanding alternative payment methodologies in addition to those solutions outlined above. While it may take time for some of these recommendations to come to bear, collaboration can achieve improved outcomes, streamlined processes, and ultimately lower costs for all.