HEARING PARTICIPANTS AND PRESENTING STAFF

Board of Commissioners, Health Policy Commission

David Seltz, Executive Director, Health Policy Commission

Dr. David Auerbach, Director of Research and Cost Trends, Health Policy Commission

Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing

Representative John Lawn, Chair, Joint Committee on Health Care Financing

Honorable Members, Joint Committee on Health Care Financing

Ray Campbell, Executive Director, Center for Health Information and Analysis

Ashley Storms, Associate Director, Health Informatics and Reporting, CHIA

Erin Bonney, Payer-Provider Performance Manager, CHIA

Dr. Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy and Director of the Healthcare Markets and Regulation Lab, Department of Health Care Policy, Harvard Medical School
HEARING ON THE POTENTIAL MODIFICATION OF THE
HEALTH CARE COST GROWTH BENCHMARK

UP NEXT
KEYNOTE: The Role of Prices in the Health Care Spending Growth
Dr. Michael Chernew, Harvard Medical School
The Role of Prices in the Health Care Spending Growth

Michael Chernew
High Health Care Spending is a Problem

- Strains public budgets
- Puts downward pressure on wages
  - And tax revenue as a result
- Distorts labor markets
- Encourages less generous coverage
  - Imposes risk on individuals
  - Discourages use of needed health care
Basic model of health care spending

- Prices
  - Input Costs
  - Administrative Fees
  - Provider Profits
- Insurer Competition
- Provider Competition and Local Practice Pattern
- Utilization
  - Low and High Value Care
- Spending on Health Care
- Premiums
Measures Used to Assess the Impact of Interventions to Reduce Low-Value Care: a Systematic Review


Perspective Roundtable
Avoiding Low-Value Care

Atul A. Gawande, M.D., M.P.H., Carrie H. Colla, Ph.D., Scott D. Halpern, M.D., Ph.D., M.Bioethics, and Bruce E. Landon, M.D., M.B.A., M.Sc.

Trends in Low-Value Health Service Use and Spending in the US Medicare Fee-for-Service Program, 2014-2018

John N. Mafi, MD, MPH; Rachel O. Reid, MD, MS; Lesley H. Baseman, BA; Scot Hickey, MS; Mark Totten, MS; Denis Agniel, PhD; A. Mark Fendrick, MD; Catherine Sarkisian, MD, MSPH; Cheryl L. Damberg, PhD
REDUCE PRICES PAID FOR CARE

Reduce utilization
Increases in prices explain recent spending growth

➔ On balance it's unlikely quality justifies price
Problems w/ Health Care Markets are Ubiquitous

- Provider consolidation
- Insurance distortions
- Adverse selection
- Inability to observe quality
- Failures of agency
Even Wonderful Things Sometimes Need Guidance
Options

- Promote competition
  - Slow
  - Unproven success

- Public option
  - Blunt instrument
  - A lot of market distortions
  - Large price cuts

- Set Prices
  - Heavy government hand
  - Raise prices for some

- Eliminate blatant market failures
  - Surprise billing
  - ‘excessive’ prices
Three Prongs

- Cap FFS prices
- Cap FFS price growth
- Flexible oversight
Design Options

- Cap as a function commercial prices (local or adjusted national)
  - Another option: Medicare price

- Limit to out of network
  - Lighter touch
  - More politically appealing
  - Will spillover to in network

- Allow somewhat faster growth for low price providers
Implementation Considerations

- Caps can be adjusted
  - Nibble at the top
- Price regulation sets a limit at a contract/provider level
- Enforcement is complex
  - No standard pricing
  - Payment outside of the claims system
  - ERISA issues
  - Shifting price increases to services with room to rise
- Provider revenue concerns
- Must include mechanisms to make sure savings passed on to consumers
HEARING ON THE POTENTIAL MODIFICATION OF THE HEALTH CARE COST GROWTH BENCHMARK

UP NEXT
PRESENTATION: Benchmark Modification Process
David Seltz, Executive Director, Health Policy Commission
HEARING ON THE POTENTIAL MODIFICATION OF THE HEALTH CARE COST GROWTH BENCHMARK

Benchmark Modification Process
David Seltz, Executive Director, Health Policy Commission
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 and innovative healthcare system that is accountable for producing better health and better care at a lower cost for all the people of the Commonwealth.
Health Care Cost Growth Benchmark

A target for controlling the growth of total health care expenditures across all payers (public and private) is set to the state’s long-term economic growth rate.

Health care cost growth benchmark:

<table>
<thead>
<tr>
<th>Period</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 - 2017</td>
<td>3.6%</td>
</tr>
<tr>
<td>2017 - 2021</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Health care providers and health plans that exceed the benchmark may be required by the HPC to implement a **Performance Improvement Plan** and submit to strict public monitoring.

**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.

**YEARS**

1–5

- Benchmark established by law at PGSP (3.6%)

6–10

- 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

- Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.
Benchmark Modification Process: Key Steps

**HPC PROCESS TO MODIFY**

- The HPC’s Board must hold a public hearing prior to making any modification of the benchmark.
- Hearing must consider data and stakeholder testimony on whether modification of the benchmark is warranted.
- Members of the Joint Committee on Health Care Financing may participate in the hearing.
- If the HPC’s Board votes to maintain the benchmark at the default rate of 3.1%, the annual process is complete.
- If the HPC’s Board votes to modify the benchmark to some number between 3.1% and 3.6%, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee for further legislative review.

**POTENTIAL LEGISLATIVE REVIEW**

- Following notice from the HPC of an intent to modify, the Joint Committee must hold a public hearing within 30 days.
- The Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing.
- The General Court must act within 45 days of public hearing or the HPC Board’s modification of the benchmark takes effect.
3.1% PGSP established in consensus revenue process

Public hearing of HPC Board and Joint Committee on potential modification of benchmark

Board votes whether to modify benchmark; if Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing

Statutory deadline for Board to set benchmark

Joint Committee holds a hearing within 30 days of notice

Joint Committee reports findings and recommended legislation to General Court within 30 days of hearing; Legislature has 45 days from hearing to enact legislation which may establish benchmark; if no legislation is enacted, the Board’s vote to modify takes effect.
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 3: CHIA Referral
CHIA analyzes those data and 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 4: HPC Analysis
HPC conducts a confidential review of each referred provider and payer’s performance across multiple factors.

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 than $500,000 can be assessed as a last resort in certain circumstances.
Five states have now established statewide health care cost growth targets, with many additional states considering similar proposals.

- Established health care cost growth targets
- Made a commitment to establish a health care cost growth target
- Actively considering health care cost growth targets
The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

**RESEARCH AND REPORT**
Investigate, analyze, and report trends and insights

**WATCHDOG**
Monitor and intervene when necessary to assure market performance

**PARTNER**
Engage with individuals, groups, and organizations to achieve mutual goals

**CONVENE**
Bring together stakeholder community to influence their actions on a topic or problem
HEARING ON THE POTENTIAL MODIFICATION OF THE
HEALTH CARE COST GROWTH BENCHMARK

UP NEXT
PRESENTATION:
Ray Campbell, Executive Director, CHIA
Ashley Storms, Associate Director of Health Informatics and Reporting, CHIA
Erin Bonney, Payer-Provider Performance Manager, CHIA
Performance of the Massachusetts Health Care System

Annual Report
March 2021
Agenda

- Overview
- Total Health Care Expenditures
- Medicare Trends
- MassHealth Trends
- Private Commercial Insurance Trends
Overview

- Role of CHIA’s *Annual Report*
- Acknowledgements
  - Data submitters
  - CHIA’s staff + actuaries
- Publication package
  - Executive summary + chartbook
  - Datasets + technical documentation
- New analyses
  - Expanded reporting on Payer Use of Funds
  - MassHealth Patient Experience Survey
## Total Health Care Expenditures (THCE)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Care Expenditures, 2019</td>
<td>$64.1B</td>
</tr>
<tr>
<td>THCE per capita, 2019</td>
<td>$9,294</td>
</tr>
<tr>
<td>Growth rate per capita, 2019</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
THCE growth per capita exceeded the health care cost growth benchmark in 2019.

For more information, see page 24 of CHIA’s Annual Report
Expenditures grew across all categories from 2018, except for NCPHI. Commercial expenditures grew the fastest among the three main market sectors.

For more information, see page 13 of CHIA’s Annual Report.
From 2018 to 2019, expenditures accelerated across all major service categories, with the highest growth in pharmacy spending.

For more information, see page 19 of CHIA’s Annual Report.
Total Health Care Expenditures
Spending by Service Category: Net of Prescription Drug Rebates, 2018-2019

Net of prescription drug rebates, pharmacy spending grew 3.0% from 2018 to 2019.

<table>
<thead>
<tr>
<th>Category</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Claims</td>
<td>$2.6B</td>
<td>$5.5%</td>
</tr>
<tr>
<td>Other Professional</td>
<td>$4.8B</td>
<td>$8.7%</td>
</tr>
<tr>
<td>Other Medical</td>
<td>$7.3B</td>
<td>$0.0%</td>
</tr>
<tr>
<td>Pharmacy (Net of Rebates)</td>
<td>$8.1B</td>
<td>$3.0%</td>
</tr>
<tr>
<td>Physician</td>
<td>$9.6B</td>
<td>$4.3%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>$11.2B</td>
<td>$6.3%</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>$11.6B</td>
<td>$3.8%</td>
</tr>
</tbody>
</table>

For more information, see page 20 of CHIA’s Annual Report.
Total Health Care Expenditure Components

Medicare

$19.2B  Expenditures, 2019

5.2%  Expenditures, 2018-2019

2.5%  Beneficiaries, 2018-2019

For more information, see page 15 of CHIA’s Annual Report
Medicare
Spending by Program, 2018-2019

Expenditures grew faster for Medicare Advantage beneficiaries than traditional Medicare, in part due to increasing enrollment.

For more information, see page 15 of CHIA’s Annual Report
Total Health Care Expenditure Components

MassHealth

$15.7B Expenditures, 2019

2.8% Expenditures, 2018-2019

-2.9% Members, 2018-2019

For more information, see page 16 of CHIA’s Annual Report
Overall MassHealth spending increased 2.8% between 2018 and 2019.
MassHealth APM adoption increased each year from 2017 to 2019, while commercial adoption held steady.
Total Health Care Expenditure Components

Commercial Insurance

$24.9B
Expenditures, 2019

5.7%
Expenditure, 2018-2019

0.4%
Member Months, 2018-2019

For more information, see page 14 of CHIA’s Annual Report
Expenditures increased for all product types other than POS plans.
Enrollment in high deductible health plans continued to grow, while tiered and limited network enrollment remained stable.
HDHP enrollment continued to grow steadily across nearly all market sectors, with the fastest growth among jumbo group employers.

For more information, see page 52 of CHIA’s Annual Report
While average member cost-sharing growth slowed from 2018 to 2019 (+2.8%), this trend was limited to larger employer groups.

For more information, see page 66 of CHIA’s Annual Report
Commercial Insurance
Fully-Insured Premiums by Market Sector, 2017-2019

Average premiums increased by 2.2% from 2018 to 2019, slower than in the prior year (+5.7%).

For more information, see page 57 of CHIA’s Annual Report
Fully-insured premium retention decreased from 13.4% in 2018 to 12.0% in 2019 as claims costs grew at a faster rate than premiums.

Note: These payer-paid claims percentages are distinct from federal MLR. For more information, see pages 74-77 of CHIA's Annual Report.
Member cost-sharing and premiums increased at a faster rate than wages and inflation between 2017 and 2019.
HEARING ON THE POTENTIAL MODIFICATION OF THE
HEALTH CARE COST GROWTH BENCHMARK

Report on State Spending Performance
Dr. David Auerbach, Director of Research and Cost Trends, HPC
SECTION I.

Massachusetts Spending Trends Through 2019
Growth in total health care spending accelerated the past two years and exceeded the benchmark in 2018 and 2019.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012-2019

Average annual spending growth between 2012 and 2019: 3.59%

Notes: 2018-2019 spending growth is preliminary.
Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2020.
Since 2010, spending growth in Massachusetts has been 0.6% lower on average than the national trend, following a similar pattern.

Massachusetts and national annual per-capita total health care spending growth, 2000-2019

Notes: U.S. data includes Massachusetts. Massachusetts 2018-2019 spending growth estimate is preliminary.
Commercial medical spending growth remained below the U.S. rate in 2019, continuing a multi-year trend.

Notes: Commercial spending in Massachusetts includes only members for whom “full-claims” data is submitted to CHIA, excluding roughly the one-third of the market with carveouts (“partial-claims”) for whom carved-out spending is not submitted to CHIA. Spending growth for these members was higher in 2018 and 2019 than the full-claims members. When these members are included with actuarial completion (estimates of what their full spending would be), the growth in commercial spending per member in 2018 and 2019 would be higher than shown and closer to the US level. U.S. data include Massachusetts.

Massachusetts 2018-2019 spending growth estimate is preliminary. Commercial spending is net of prescription drug rebates. Net cost of private health insurance is excluded.

Hospital outpatient and physician spending were key drivers of commercial spending growth in 2019.

Percentage annual growth in spending per capita for commercial members, 2016-2019

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>1.8%</td>
<td>4.3%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>0%</td>
<td>4.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Physician and Other Professionals</td>
<td>1.9%</td>
<td>6.4%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1.1%</td>
<td>3.1%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other Medical</td>
<td>-2.0%</td>
<td>7.1%</td>
<td>-3.7%</td>
</tr>
<tr>
<td>Non-Claims</td>
<td>-5.3%</td>
<td>6.0%</td>
<td>-5.2%</td>
</tr>
</tbody>
</table>

Hospital spending accounted for 54% of spending growth in 2018-2019.

Notes: Pharmacy spending is net of rebates. Hospital spending includes facility spending only. Professional spending associated with hospital care is included in “Physician and other professionals”. Other medical category includes long-term care, dental and home health and community health. Non-claims spending represents capitation-based payments.

Sources: Payer reported TME data to CHIA and other public sources; HPC analysis of data from Center for Health Information and Analysis Annual Report, 2020.
Medicare spending growth was driven by hospital outpatient and prescription drug spending, which both grew at nearly twice the national rate.

Annual percentage growth in spending per Medicare beneficiary, Massachusetts and the U.S., 2018-2019

Notes: U.S. data includes Massachusetts. Growth in spending by service category reflects all Fee-for-Service Medicare beneficiaries. Prescription drug spending is calculated per enrollee in Medicare Part D and is not net of rebates. All other categories of spending reflect growth per beneficiary in either Part A or Part B. Sources: Centers for Medicare and Medicaid Services, 2019.
Commercial payment rates for hospital outpatient services vary threefold across Massachusetts hospitals, often well exceeding Medicare rates.

Aggregate commercial hospital outpatient payments to hospital relative to what they would have received from Medicare, 2016-2018

Data from supplemental data files included in the report, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative by Christopher Whaley et al, https://www.rand.org/pubs/research_reports/RR4394.html. Data represent aggregate spending from 2016-2018. Analysis based on commercial claims-level data contributed by self-insured employers and private health plans. Authors simulated Medicare payments using 3M software that applied Medicare payment rules to claims data. Data based on more than 100,000 services provided in MA hospitals. Hospitals excluded from figure if fewer than 250 services.
Increases in visits are also driving hospital outpatient spending growth. In 2019, 71% of the increase in visits occurred at AMCs.

Number of hospital outpatient visits (all payers) by hospital cohort, FY2015-FY2019

- Academic Medical Center: 16% increase from 2015-2019
- Community High Public Payer Hospital: -2% increase from 2015-2019
- Teaching Hospital: -5% increase from 2015-2019
- Community Hospital: 8% increase from 2015-2019
- Specialty Hospital: 22% increase from 2015-2019

3.7% increase in all visits from 2018-2019

Data from the Massachusetts Center for Health Information and Analysis, Acute Hospital Profiles, 2015-9. [https://www.chiamass.gov/hospital-profiles/](https://www.chiamass.gov/hospital-profiles/). Outpatient visits are reported by the hospitals.
SECTION II.
Affordability of Care
Massachusetts family health insurance premiums are above the national average and highest for the smallest employers.

Annual premium for family coverage, including employer and employee contribution, Massachusetts and the U.S., 2019

Notes: U.S. data include Massachusetts. Employer premiums are averages based on a large sample of employers within each state.

Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey 2019.
For a typical Massachusetts family with employer coverage, $2,242 per month is spent on health care, leaving little income for other necessities.

Monthly spending on health care, 2020

**Base scenario:**
- Deductibles, copays, other OOP: $292
- Insurance premium (employer and employee):
  - Hospital inpatient: $275
  - Hospital outpatient: $279
  - Physician and other professional: $424
- Prescription drugs: $525
- Other: $313

**Total spent on health care:** $2,242

**Remaining income after taxes and other necessities:**
- $666 left for everything else

**Lost one month of income in 2020:**
- Remaining income after taxes and other necessities: $2,058
- Deficit: $183

Scenarios based on a family of four in Worcester county, Massachusetts. Family budget information from Economic Policy Institute estimates of typical family of two adults and two children. [https://www.epi.org/resources/budget/](https://www.epi.org/resources/budget/). Income information from published 1-year tables from the American Community Survey from 2019, Worcester metro area, median family income. Employer premium amounts are from the Agency for HealthCare Resources Medical Expenditure Panel Survey for 2019. The employer premium contribution is added to family income and are assumed to be untaxed. Income and premiums are grown to 2020 levels based on an assumption of 3.1% growth. Out of pocket spending and the breakdown of spending by category is derived from the breakdown of commercial spending by category according to the Massachusetts Center for Health Information and Analysis’ annual reports for 2018 and 2019.
Since 2013, deductibles have grown 40% in Massachusetts and, as of 2019, 35% of residents had high deductible plans.

Average deductible for single coverage plans with a deductible, Massachusetts and the U.S., 2013-2019

The percentage of Massachusetts residents with high-deductible plans in Massachusetts grew from 28.5% in 2017 to 35.1% in 2019, including 67% of those in small businesses.

Massachusetts residents with high deductible health plans often face serious issues with affordability of care.

Percent of privately-insured Massachusetts residents with affordability issues, 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Low Deductible</th>
<th>High Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>All privately insured residents</td>
<td>39%</td>
<td>52%*</td>
</tr>
<tr>
<td>No chronic conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income over 300% FPL</td>
<td>29%</td>
<td>41%*</td>
</tr>
<tr>
<td>Income below 300% FPL</td>
<td>49%</td>
<td>70%</td>
</tr>
<tr>
<td>One or more chronic conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income over 300% FPL</td>
<td>38%</td>
<td>56%*</td>
</tr>
<tr>
<td>Income below 300% FPL</td>
<td>68%</td>
<td>84%</td>
</tr>
</tbody>
</table>

* Indicates a statistically significant difference from the low deductible plan.
Residents with high deductible plans are twice as likely to go without needed care or prescription drugs because of cost.

Percent of privately-insured Massachusetts who said they went without needed doctor care, specialist care, mental health care or prescription drugs, 2019

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher Income</td>
<td>non-HDHP</td>
<td>9.1%</td>
</tr>
<tr>
<td></td>
<td>HDHP</td>
<td>19.4%</td>
</tr>
<tr>
<td>Lower Income</td>
<td>non-HDHP</td>
<td>16.9%</td>
</tr>
<tr>
<td></td>
<td>HDHP</td>
<td>29.1%</td>
</tr>
<tr>
<td>HDHP and Lower Income</td>
<td>White</td>
<td>27.6%</td>
</tr>
<tr>
<td></td>
<td>Black, Hispanic, or other/multiple races</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

HPC analysis of data from the Massachusetts Health Insurance Survey (MHIS) administered by the Massachusetts Center for Health Information and Analysis. Low-income is defined as family income below 400% of the US Federal Poverty Level. People of color include those who identify as Black, Hispanic, or other/multiple races. The question asked, “Because of cost, did you go without needed ___ care” where the categories for types of care included those noted above as well as vision care, dental care, medical equipment, or care from an NP, PA or CNM. Population includes commercially-insured adults ages 18-64 with continuous coverage for the 12 months of 2019.
SECTION III.

National Trends in 2020
National health spending dropped precipitously in April of 2020 and gradually resumed, with different patterns by service category.

Changes in national health care spending, by category, relative to January, 2020

Overall health care spending in 2020 was below 2019, particularly for hospital and nursing home care, while spending grew for pharmacy and home health.

Although hospital spending fell in 2020, hospital prices grew significantly. Physician prices also accelerated.

National growth in average prices for the 12-month period shown, by sector, all payers unless otherwise indicated

<table>
<thead>
<tr>
<th></th>
<th>Hospital (all)</th>
<th>Hospital (commercial only)</th>
<th>Physician and clinical services</th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017–2018</td>
<td>1.9%</td>
<td>2.4%</td>
<td>0.8%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>2018–2019</td>
<td>2.5%</td>
<td>2.3%</td>
<td>1.1%</td>
<td>2.5%</td>
</tr>
<tr>
<td>2019–2020</td>
<td>4.2%</td>
<td>5.7%</td>
<td>3.2%</td>
<td>-2.4%</td>
</tr>
</tbody>
</table>

Nationally, commercial hospital prices grew rapidly toward the end of 2020.

National growth in commercial hospital prices relative to the same month, 12 months prior, Altarum Institute.
Nationally, health insurance premiums grew 3.9% in 2020.

Annual growth in employer health insurance premiums for single coverage

Premium data based on survey of employers. Premium data collected in the first half of the year shown.
PUBLIC TESTIMONY
## Public Testimony

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liz Leahy</td>
<td>Massachusetts Association of Health Plans</td>
</tr>
<tr>
<td>Deb Wilson</td>
<td>Lawrence General Hospital</td>
</tr>
<tr>
<td>Alex Sheff</td>
<td>Health Care for All</td>
</tr>
<tr>
<td>Kim Hollon</td>
<td>Signature Healthcare</td>
</tr>
<tr>
<td>Jon Hurst</td>
<td>Retailers of Massachusetts</td>
</tr>
<tr>
<td>Susan Fendell</td>
<td>Mental Health Legal Advisors Committee</td>
</tr>
<tr>
<td>Lauren Omartian</td>
<td>Massachusetts resident</td>
</tr>
<tr>
<td>Chris Carlozzi</td>
<td>NFIB Massachusetts</td>
</tr>
<tr>
<td>Thomas Brown</td>
<td>Massachusetts resident</td>
</tr>
</tbody>
</table>