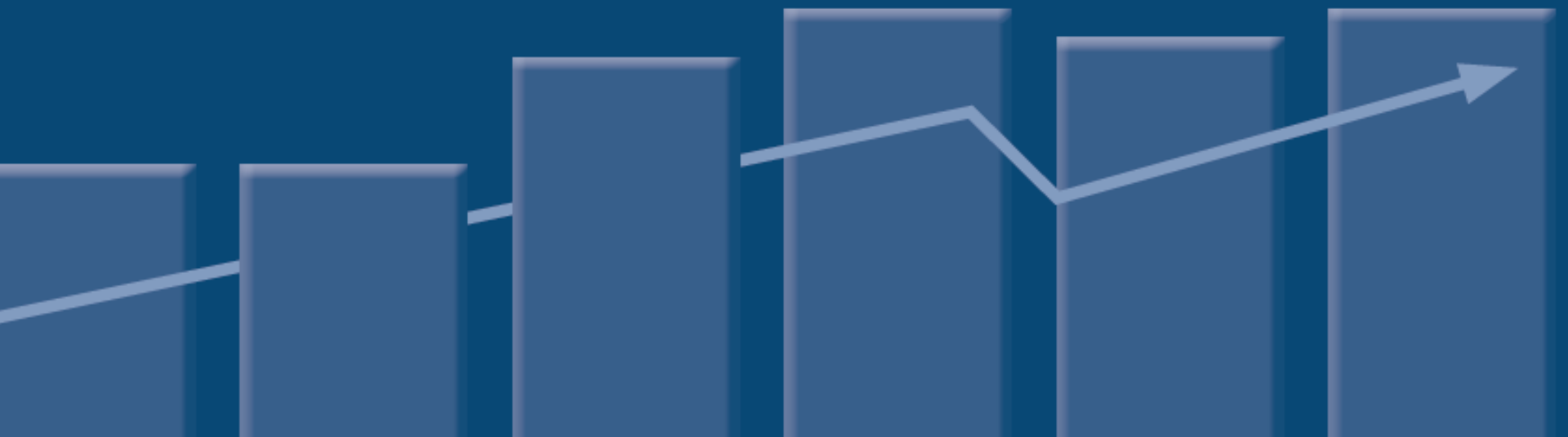
MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK



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

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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

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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

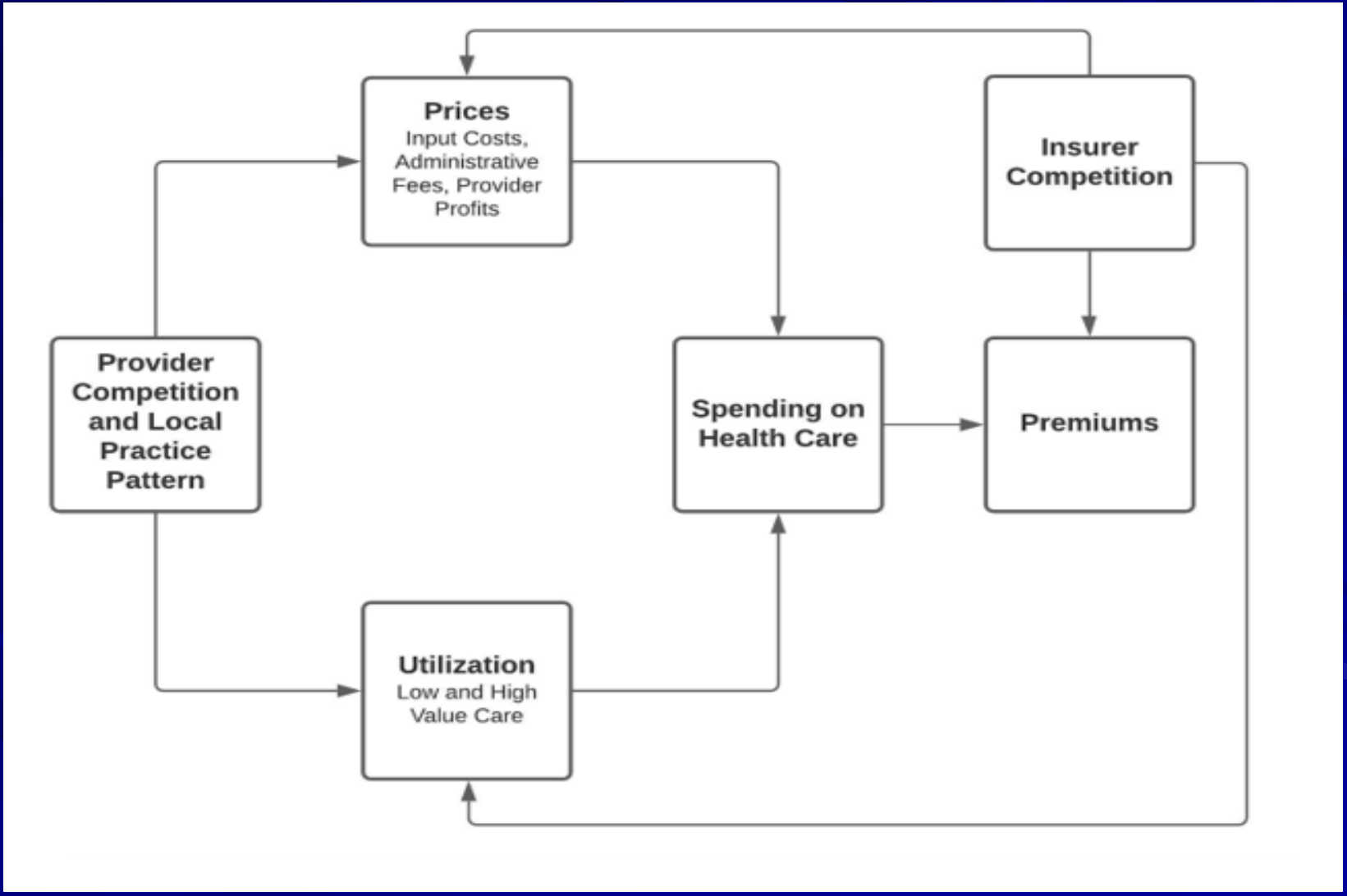
The Role of Prices in the Health Care Spending Growth

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



Review Article | Published: 27 June 2019

Measures Used to Assess the Impact of Interventions to Reduce Low-Value Care: a Systematic Review

Jennifer K. Maratt MD, MS, Eve A. Kerr MD, MPH, Mandi L. Klamerus MPH, Shannon E. Lohman BS, Whit Froehlich BA, R. Sacha Bhatia MD, MBA & Sameer D. Saini MD, MS

Perspective Roundtable FREE PREVIEW

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.

JAMA Network Open | Original Investigation | Health Policy

February 16, 2021

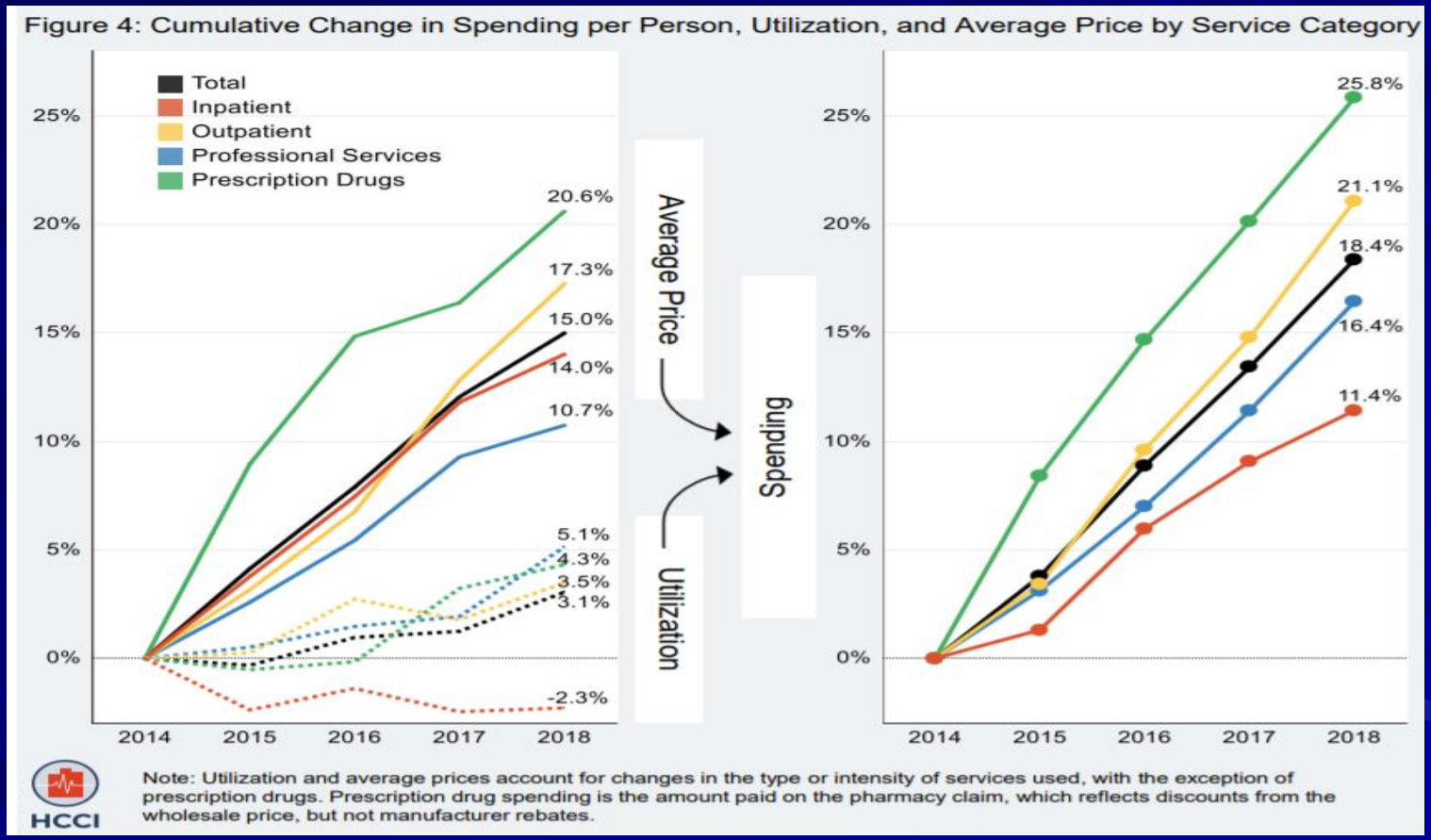
Trends in Low-Value Health Service Use and Spending in the US Medicare Fee-for-Service Program, 2014-2018

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 utilization

REDUCE PRICES PAID FOR CARE

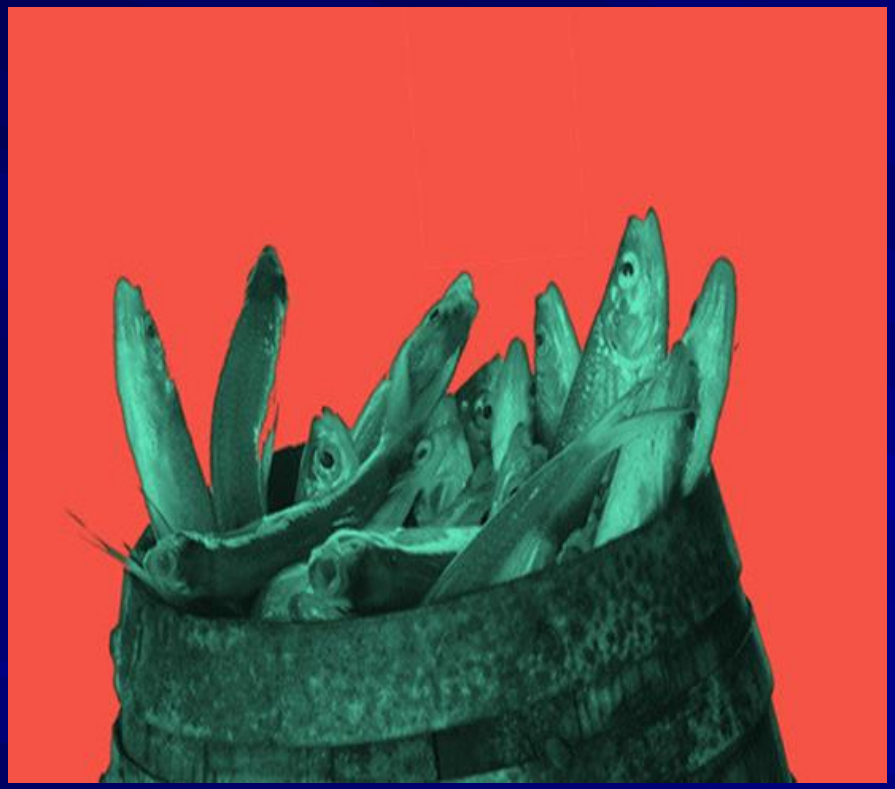
Increases in prices explain recent spending growth



➔ On balance it's unlikely quality justifies price

Health Care Cost Institute "2018 Health Care Cost and Utilization Report"
https://healthcostinstitute.org/images/pdfs/HCCI_2018_Health_Care_Cost_and_Utilization_Report.pdf

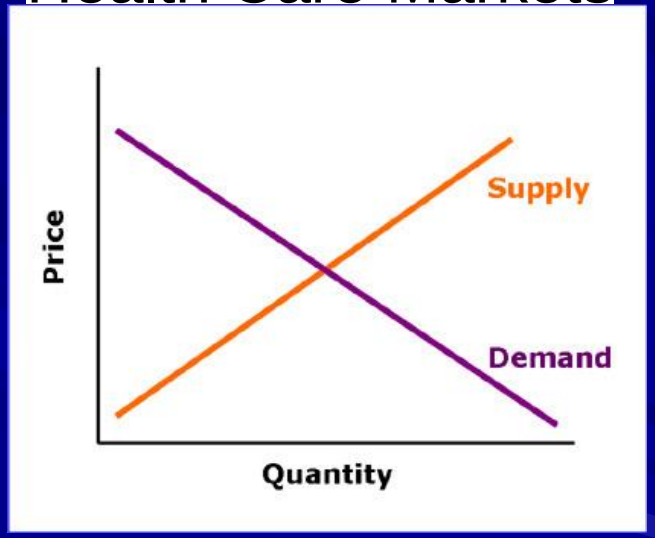
Problems w/ Health Care Markets are Ubiquitous



- Provider consolidation
- Insurance distortions
- Adverse selection
- Inability to observe quality
- Failures of agency

Even Wonderful Things Sometimes Need Guidance

Health Care Markets

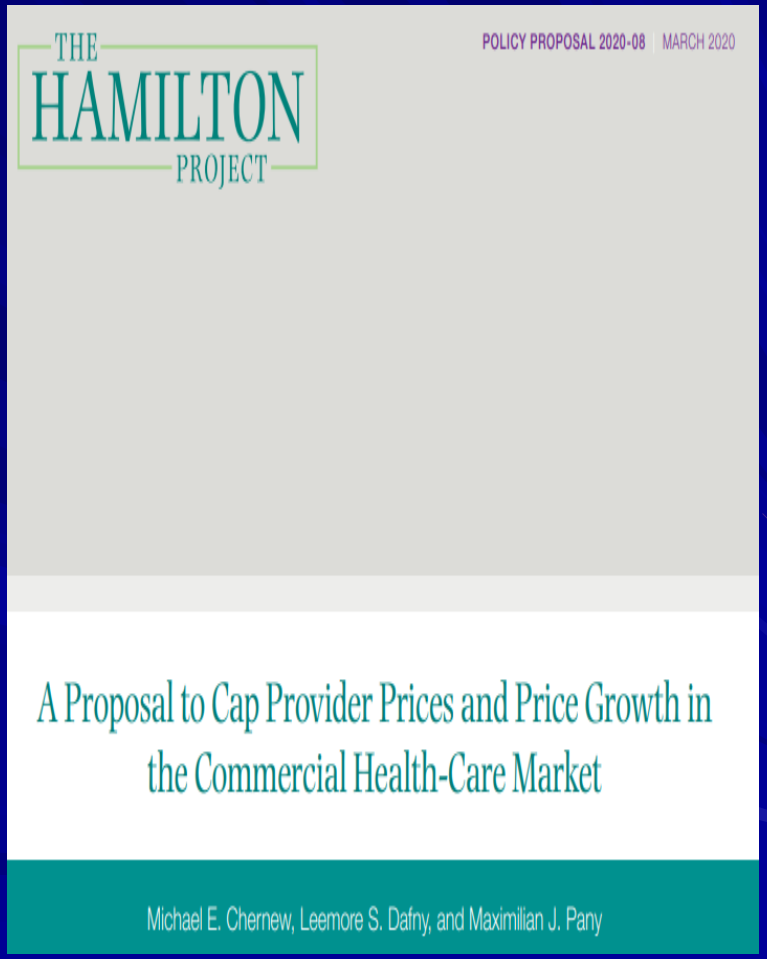


Options

- 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

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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

MASSACHUSETTS
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

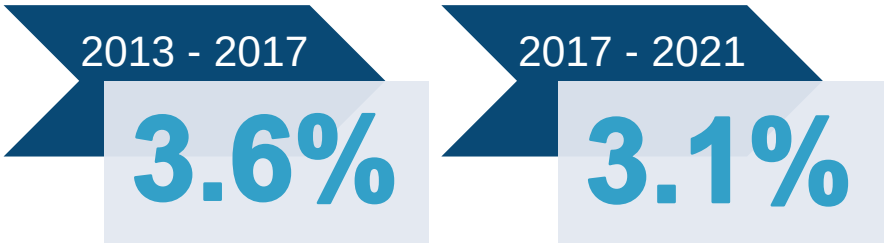
A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

HPC

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:



- 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

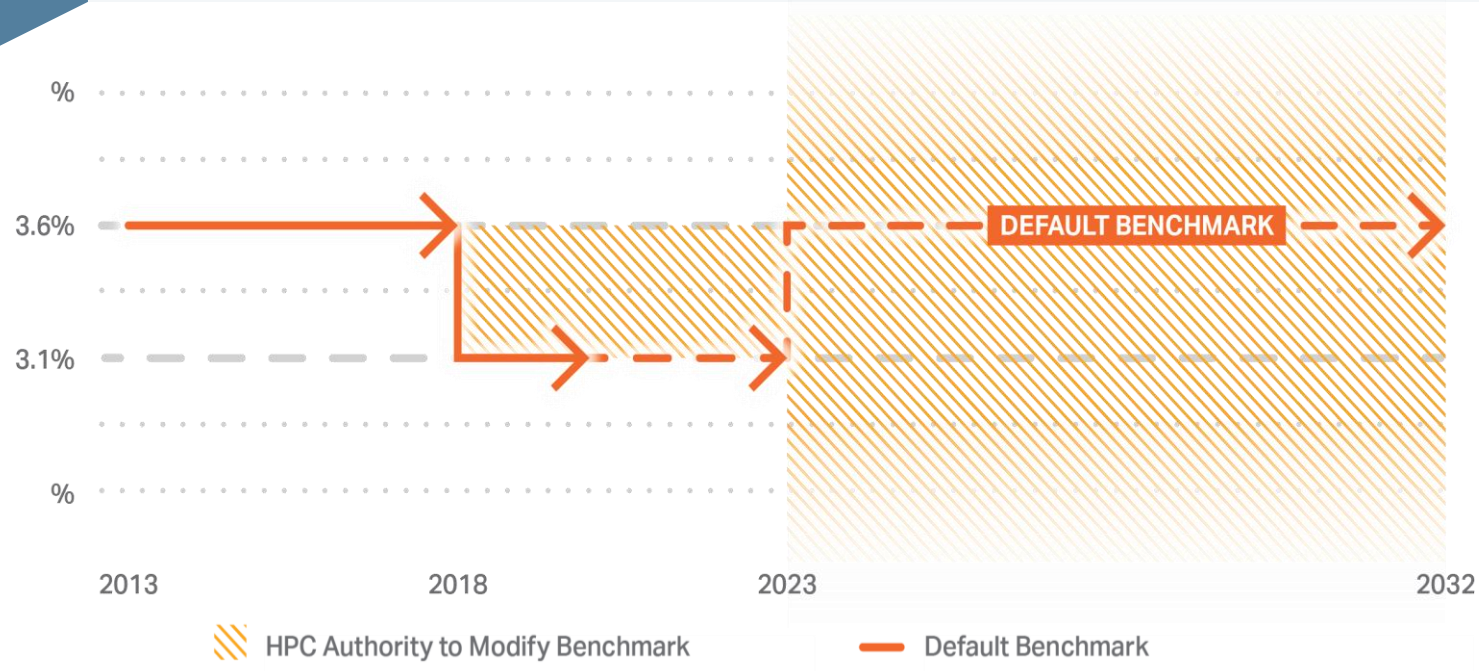
Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

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.



HPC

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.

Benchmark Modification Process: 2021 Timeline

January 15, 2021

3.1% PGSP established in consensus revenue process

March 25, 2021

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

April 14, 2021

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

April 15, 2021

Statutory deadline for Board to set benchmark

April/May 2021

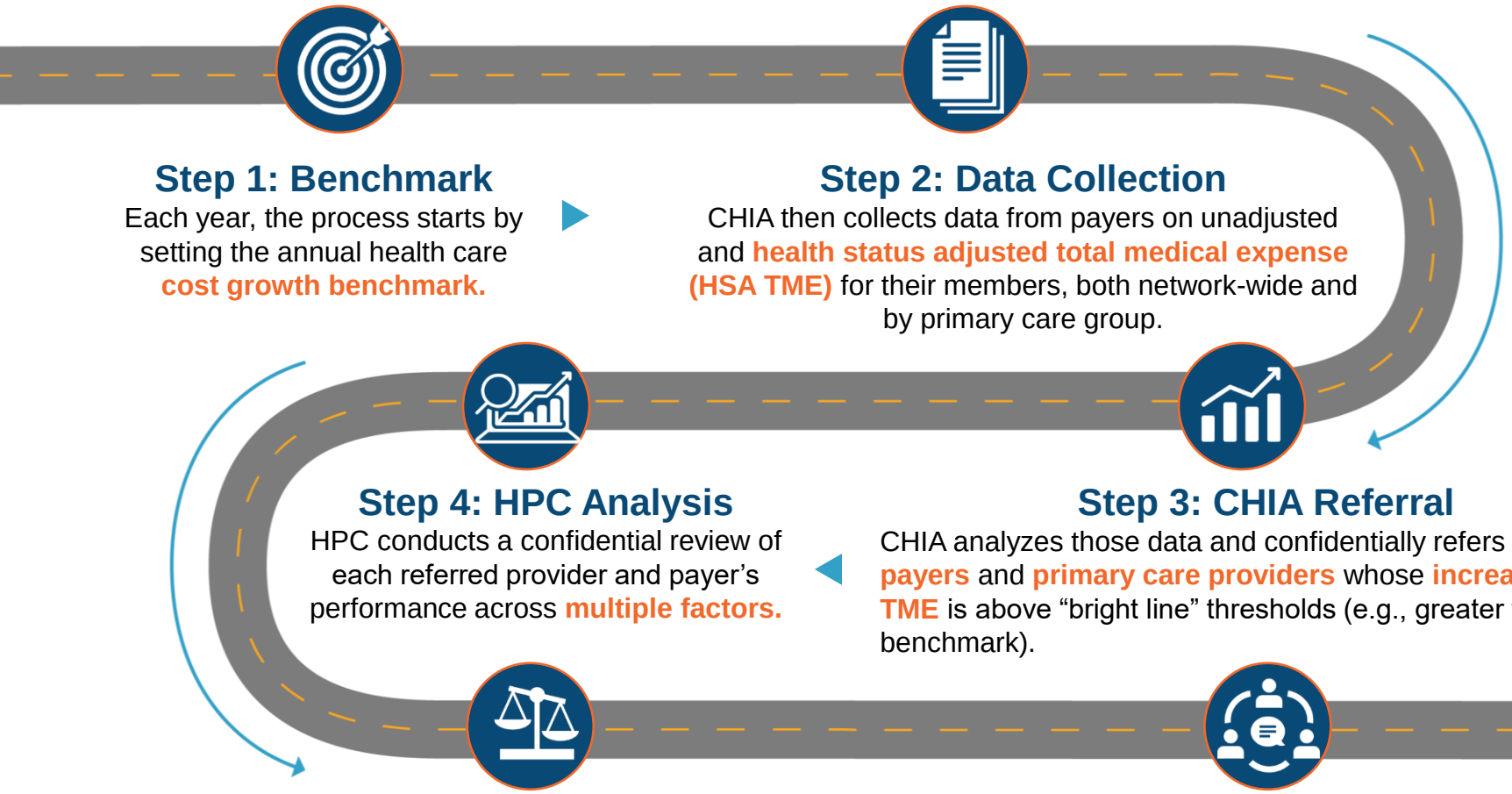
Joint Committee holds a hearing within 30 days of notice

May/June 2021

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.

HPC

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

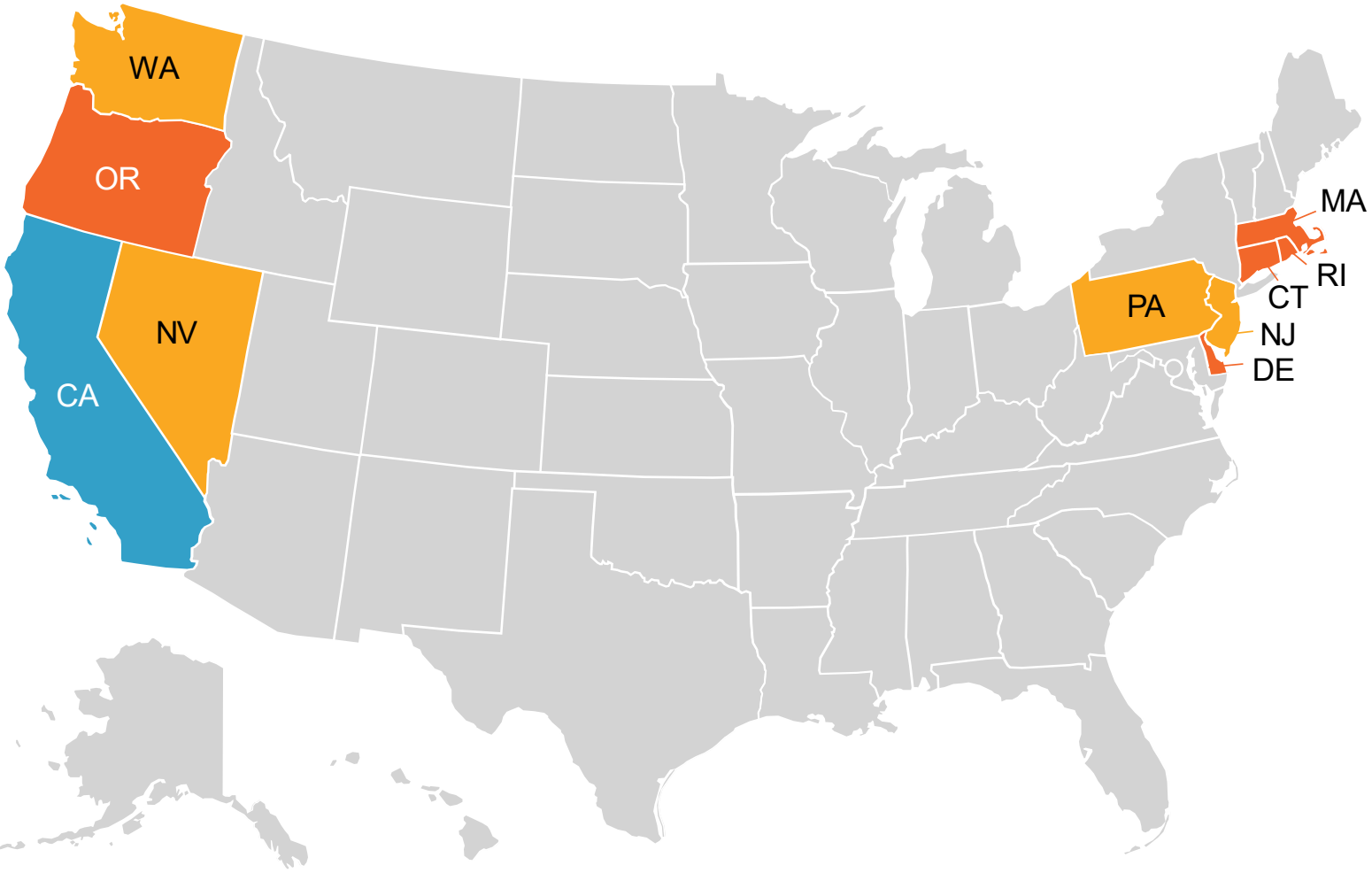
After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once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

HPC

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

HPC

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

MASSACHUSETTS
HEALTH POLICY COMMISSION

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

CENTER FOR HEALTH INFORMATION AND ANALYSIS

CHIA.

Agenda

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

Overview

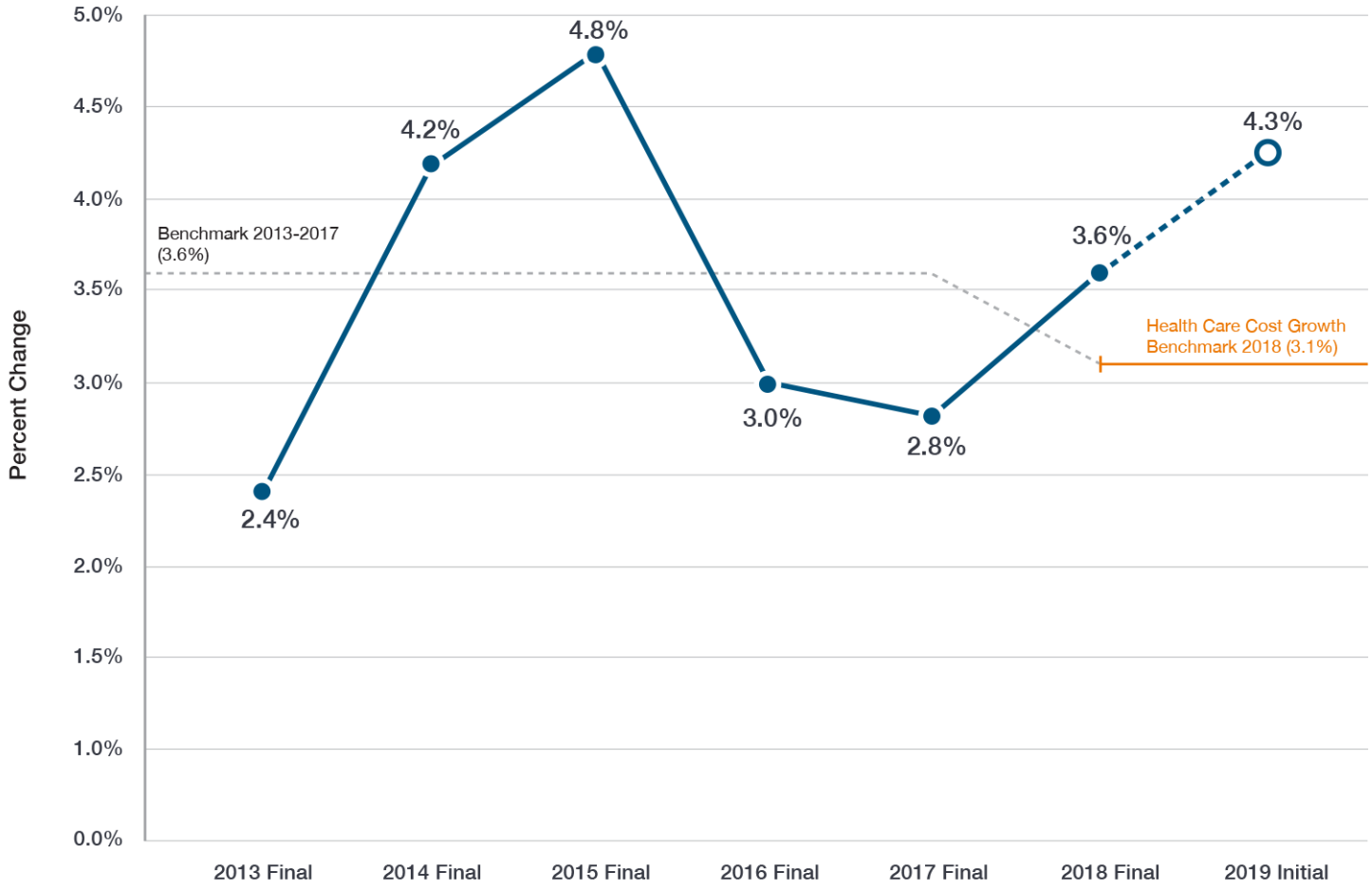
- Role of CHIA's *Annual Report*
- Acknowledgements
  - Data submitters
  - CHIA's staff + actuaries
- Publication package
  - Executive summary + chartbook
  - Datasets + technical documentation
- New analyses
  - Expanded reporting on Payer Use of Funds
  - MassHealth Patient Experience Survey

Total Health Care Expenditures (THCE)

$64.1B	Total Health Care Expenditures, 2019
$9,294	THCE per capita, 2019
4.3%	Growth rate per capita, 2019

Total Health Care Expenditures

Trends, 2013-2019



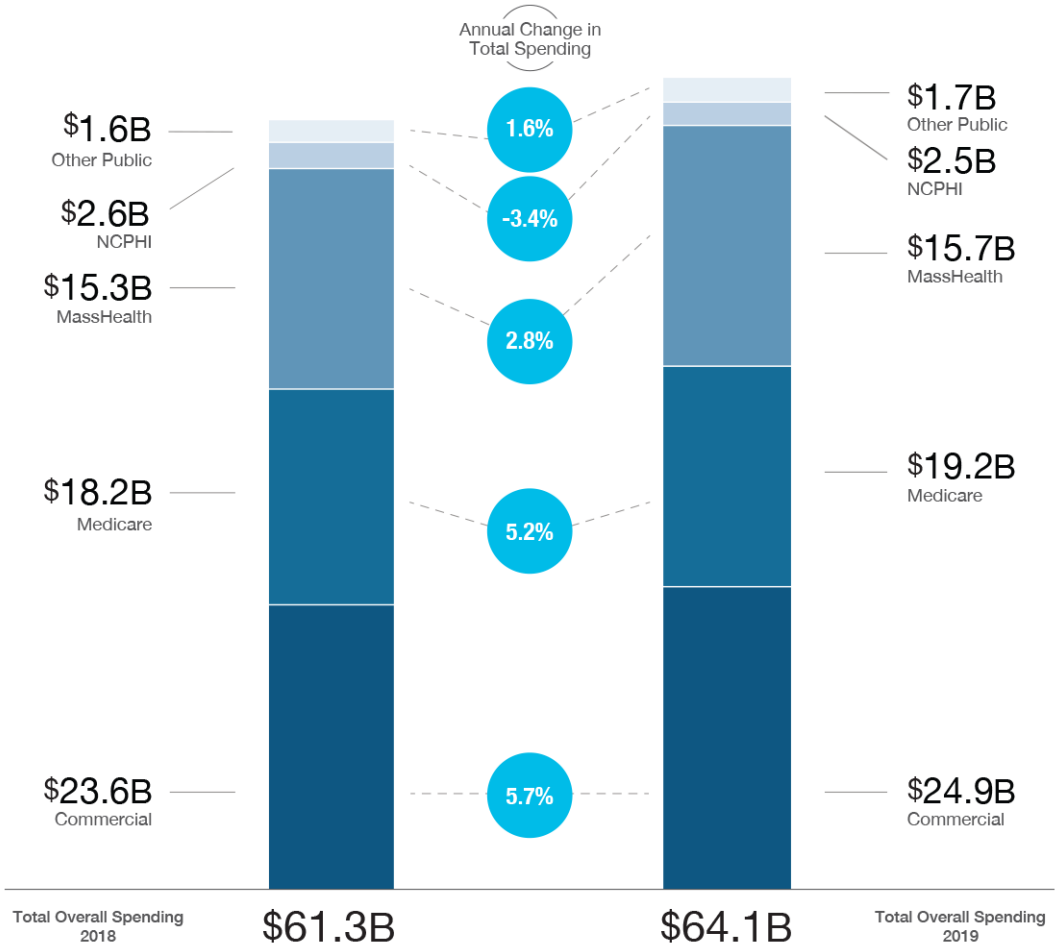
THCE growth per capita exceeded the health care cost growth benchmark in 2019.

For more information, see page 24 of CHIA's *Annual Report*

CHIA.

Total Health Care Expenditures

Components, 2019



$9,294

THCE per capita

4.3%

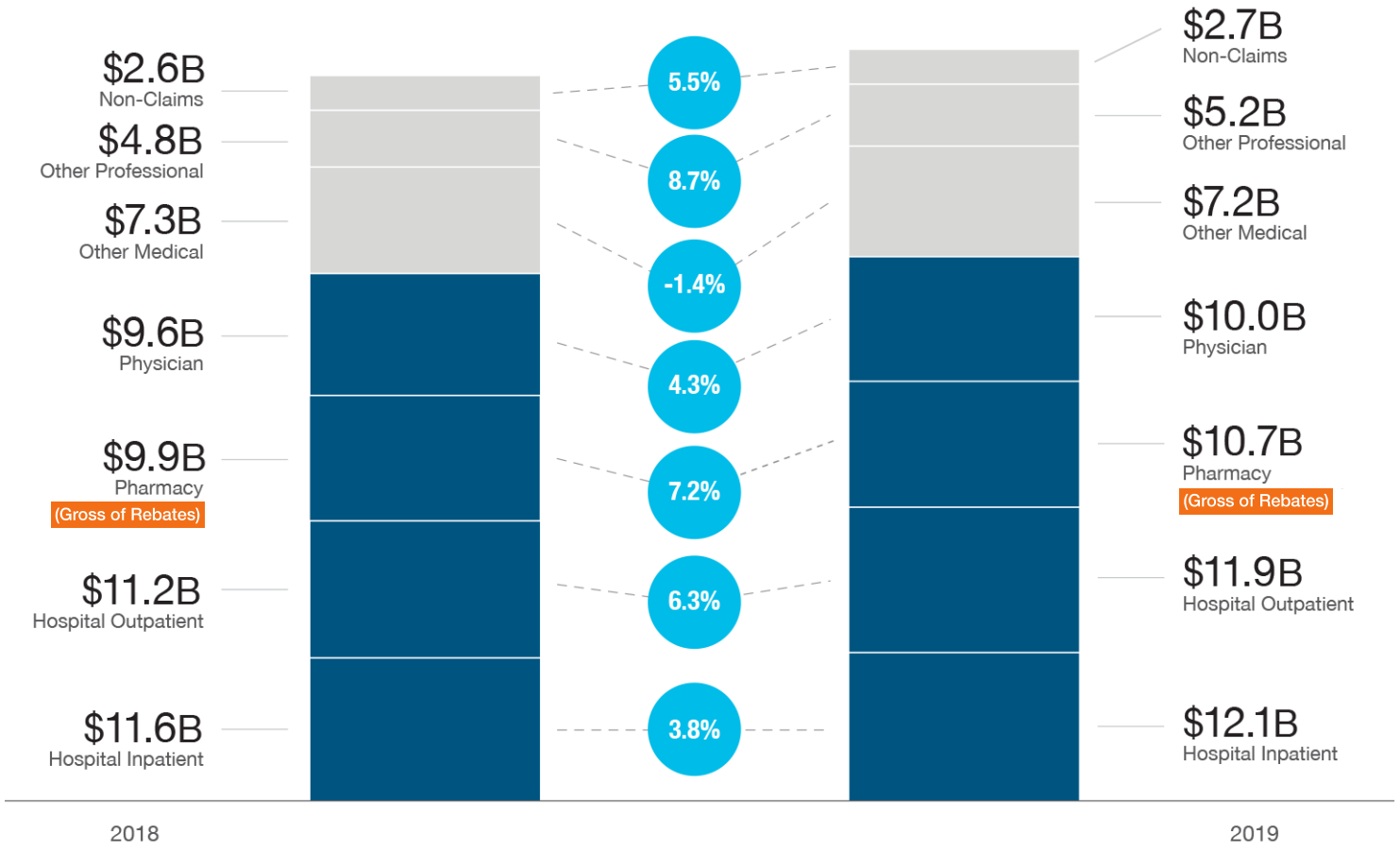
Per capita trend 2018-2019

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*

Total Health Care Expenditures

Spending by Service Category: Gross of Prescription Drug Rebates, 2018-2019

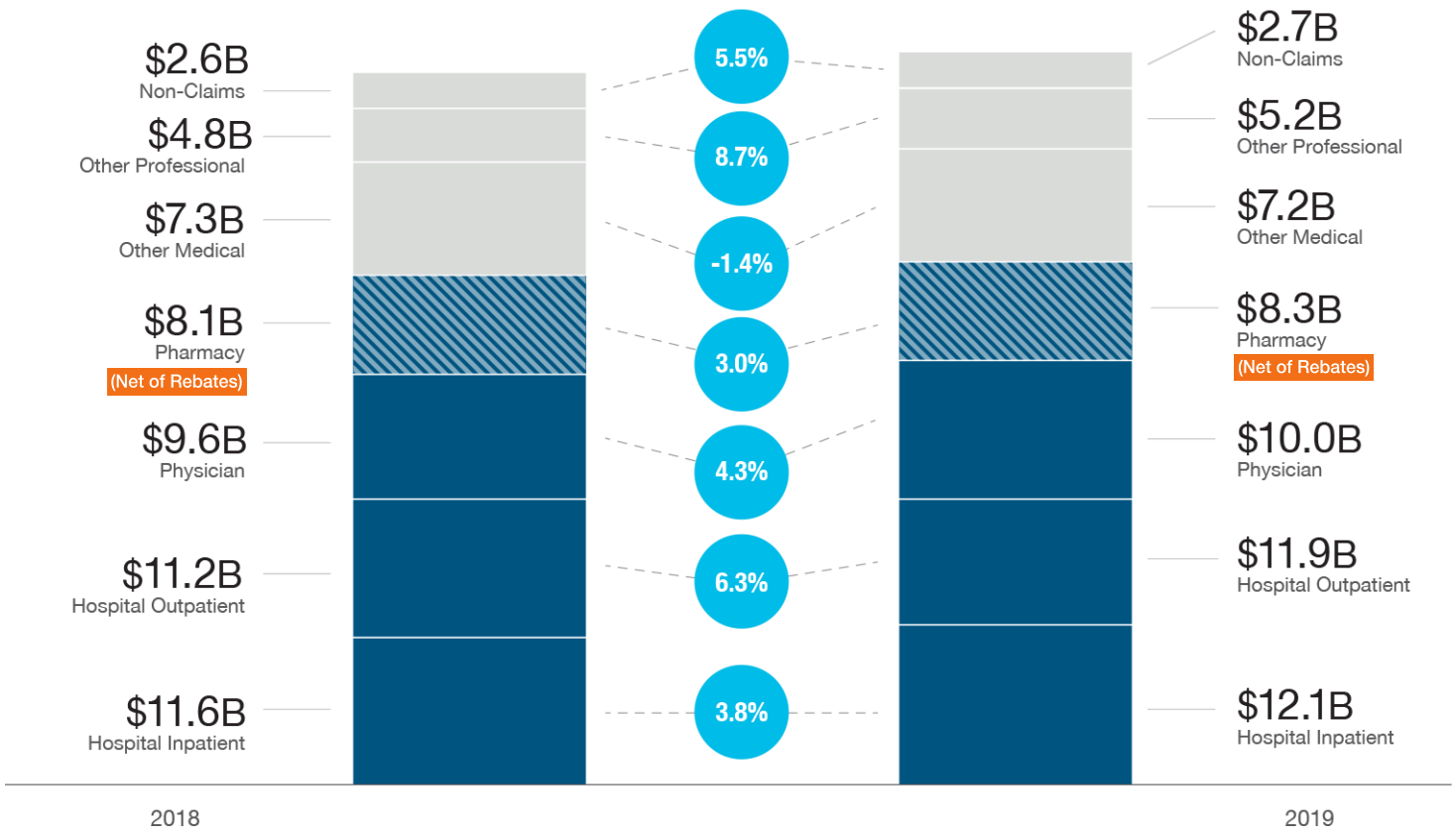


From 2018 to 2019, expenditures accelerated across all major service categories, with the highest growth in pharmacy spending.

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.

For more information, see page 20 of CHIA's *Annual Report*

CHIA.

Total Health Care Expenditure Components

Medicare

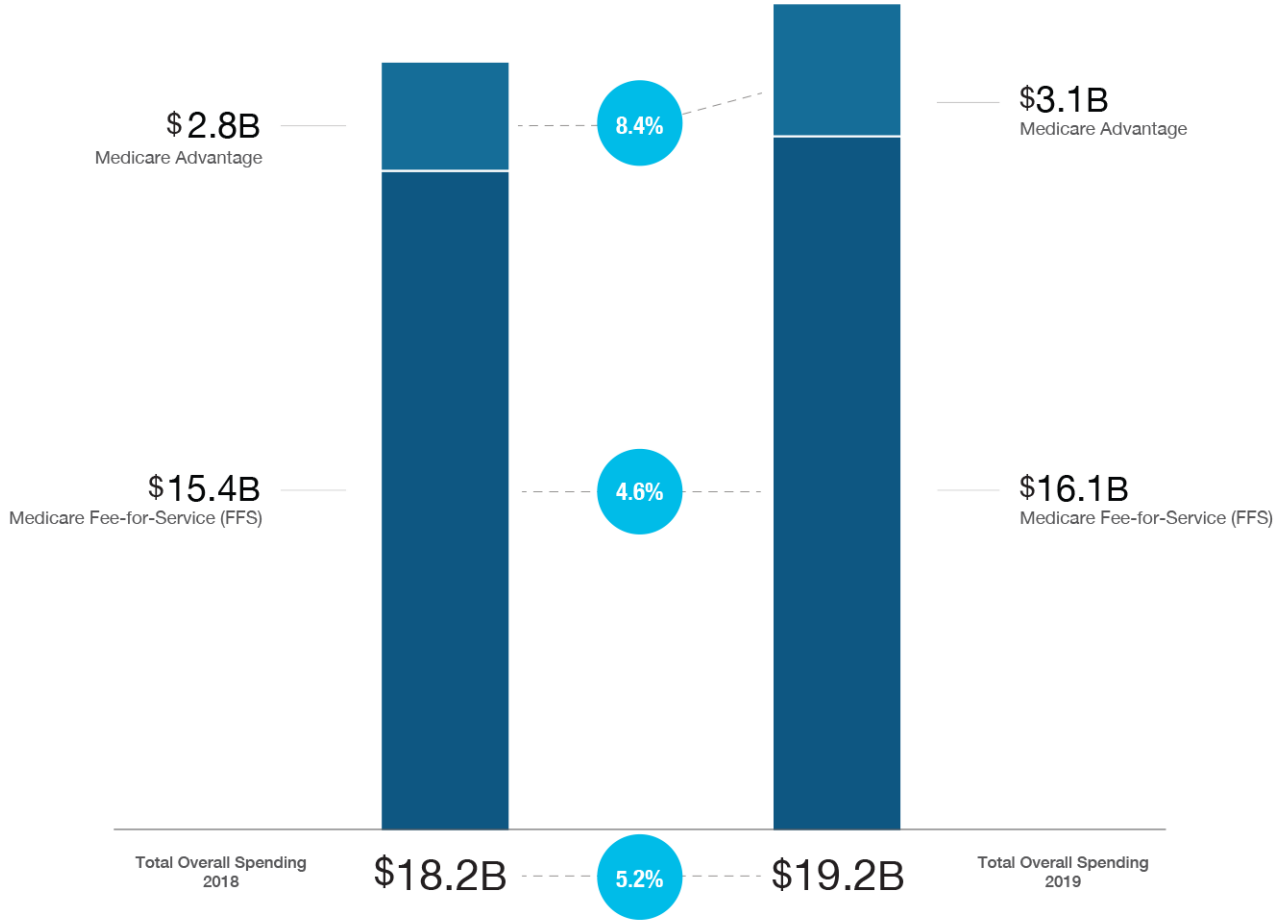
$19.2B Expenditures, 2019

5.2% Expenditures, 2018-2019

2.5% Beneficiaries, 2018-2019

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*

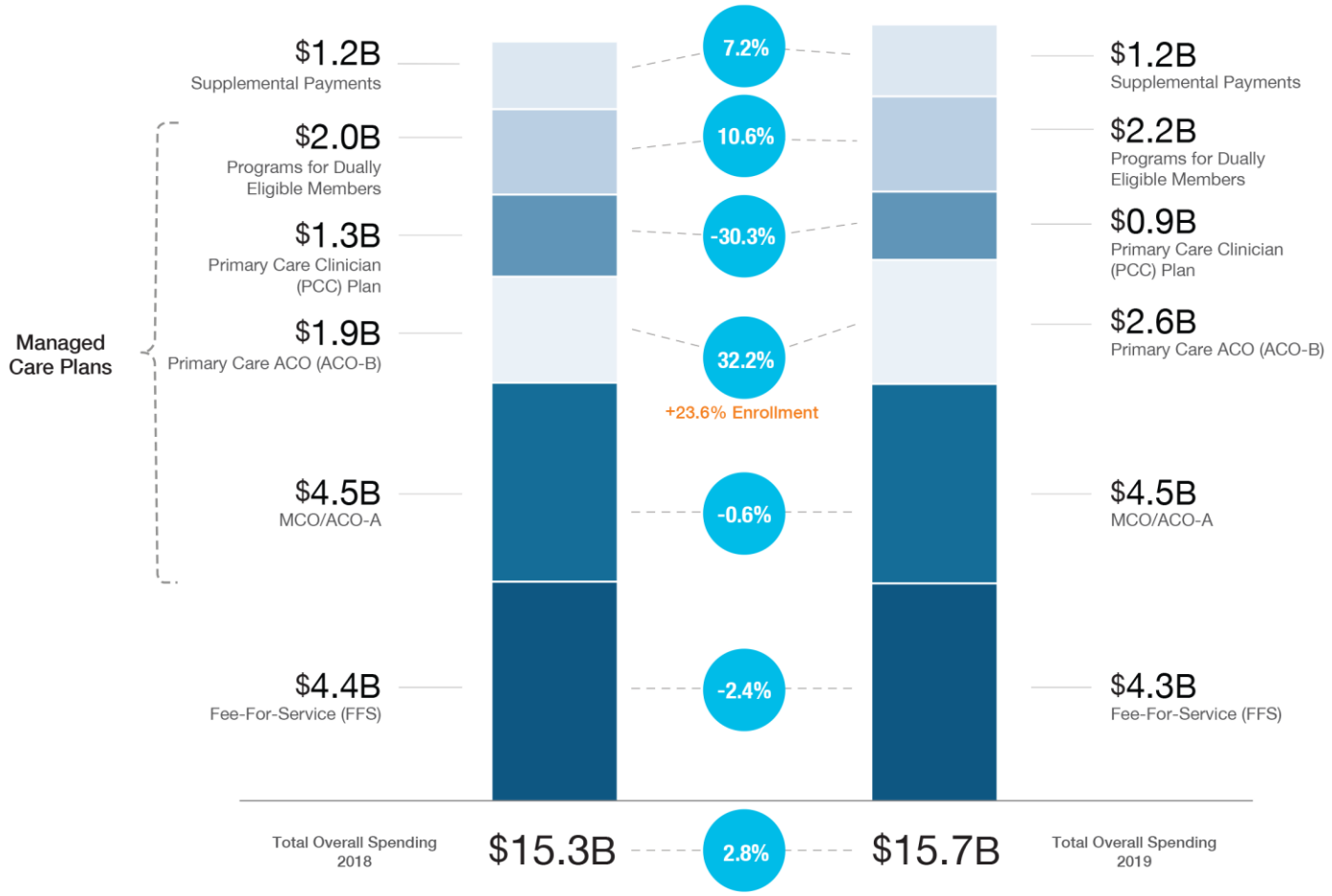
Total Health Care Expenditure Components

MassHealth

$15.7B	Expenditures, 2019
2.8%	Expenditures, 2018-2019
-2.9%	Members, 2018-2019

MassHealth

Spending by Program, 2018-2019

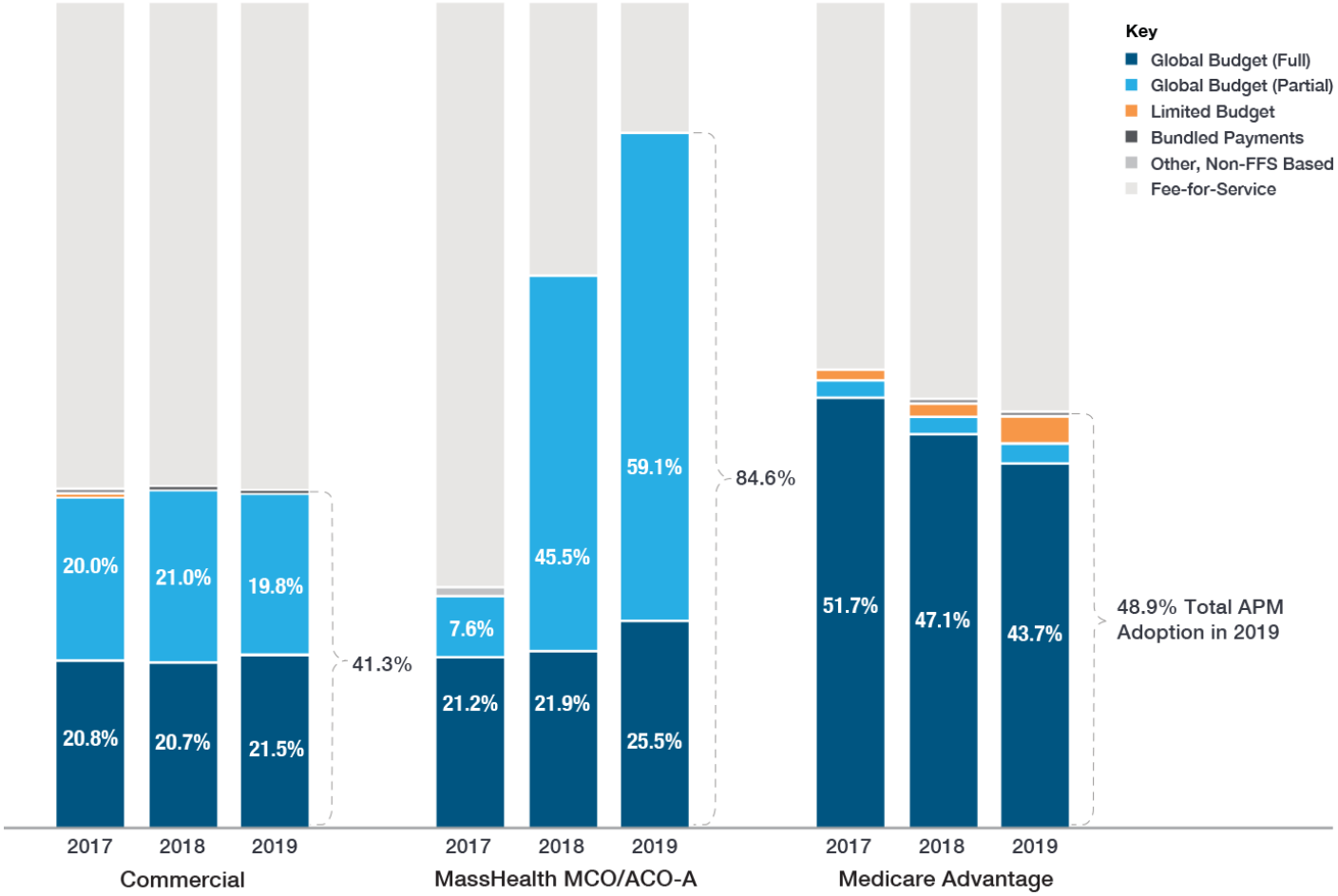


Overall MassHealth spending increased 2.8% between 2018 and 2019.

For more information, see page 16 of CHIA's *Annual Report*

Alternative Payment Methods

APM Adoption by Insurance Category, 2017-2019



MassHealth APM adoption increased each year from 2017 to 2019, while commercial adoption held steady.

For more information, see page 35 of CHIA's *Annual Report*

Total Health Care Expenditure Components

Commercial Insurance

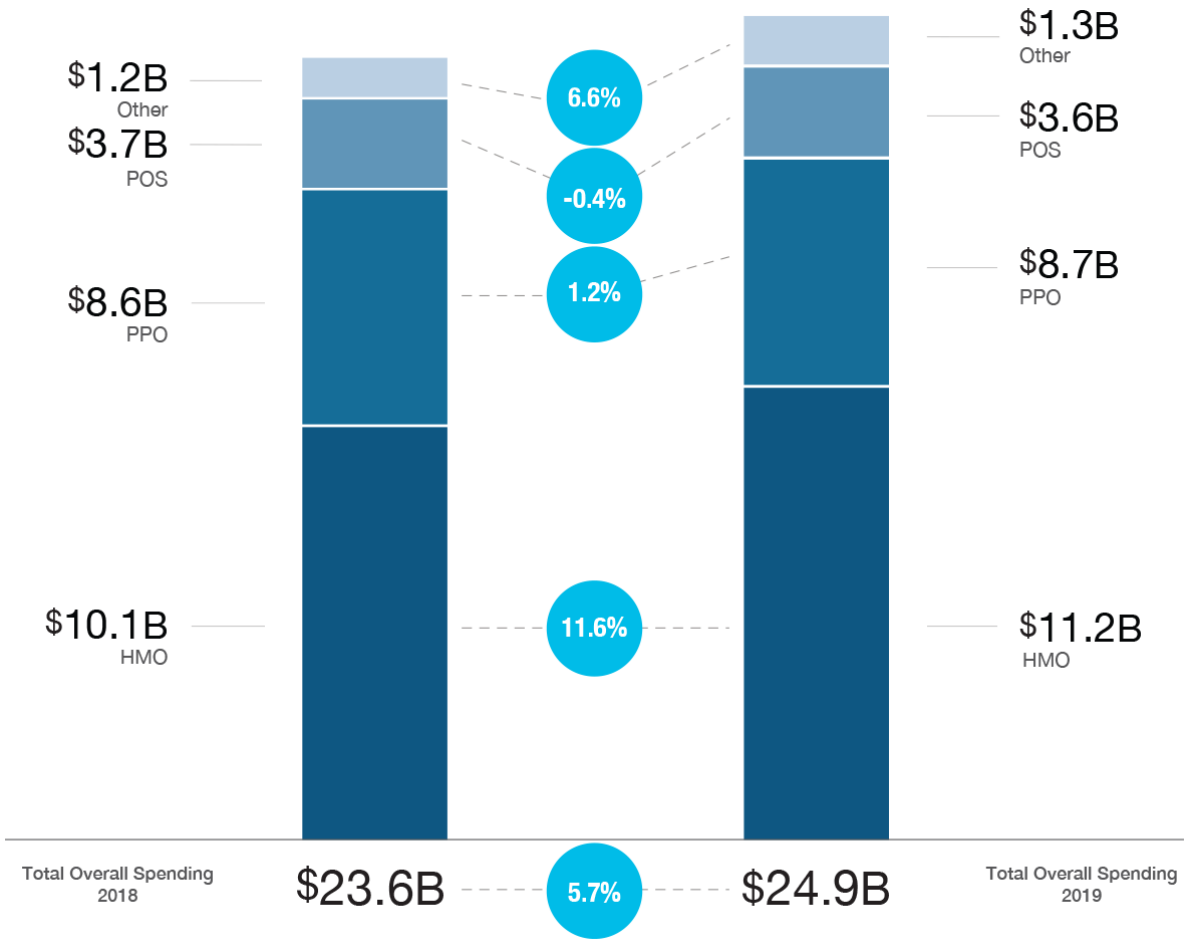
$24.9B Expenditures, 2019

5.7% Expenditure, 2018-2019

0.4% Member Months, 2018-2019

Commercial Insurance

Spending by Product Type, 2018-2019

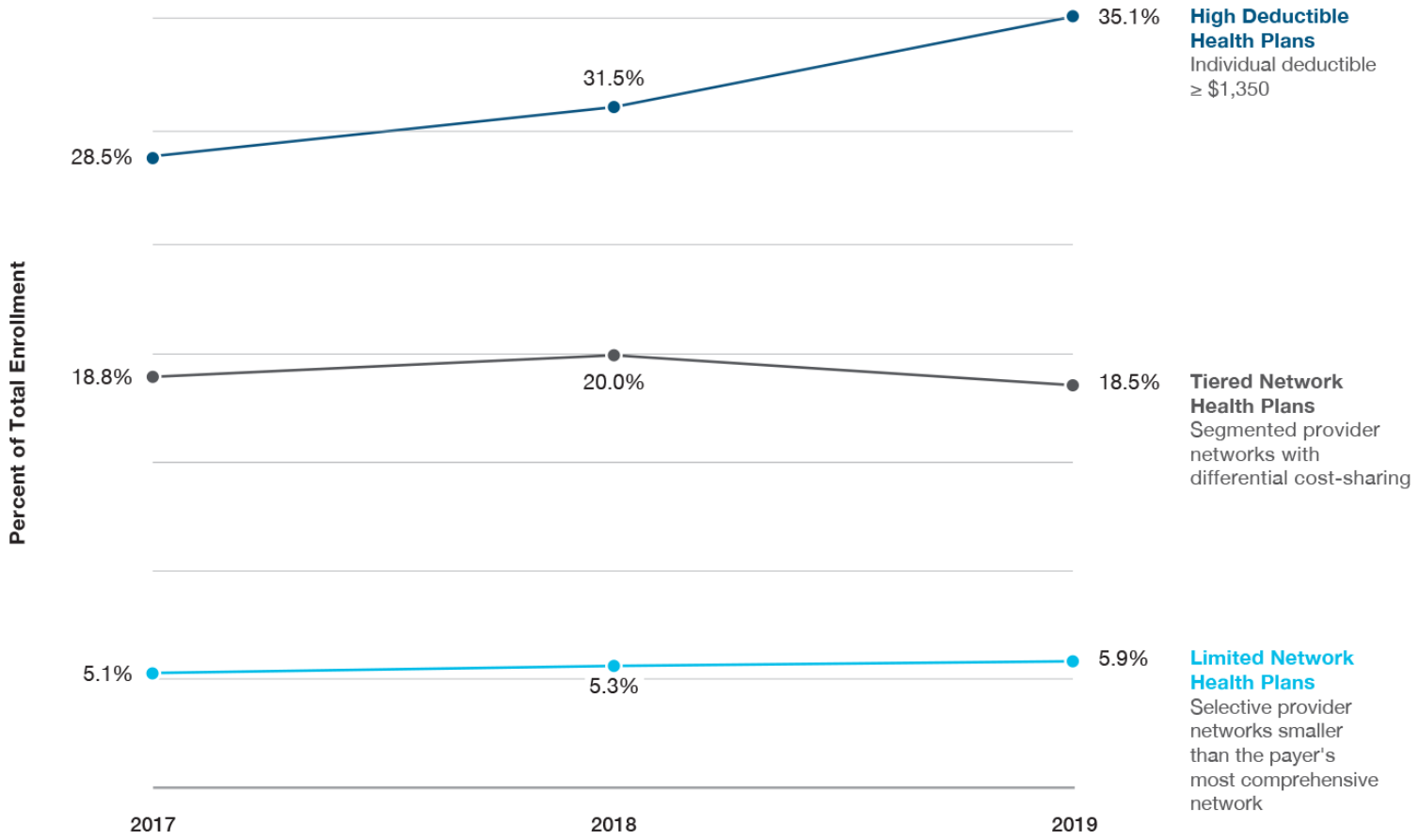


Expenditures increased for all product types other than POS plans.

For more information, see page 14 of CHIA's *Annual Report*

Commercial Insurance

Benefit Design, 2017-2019

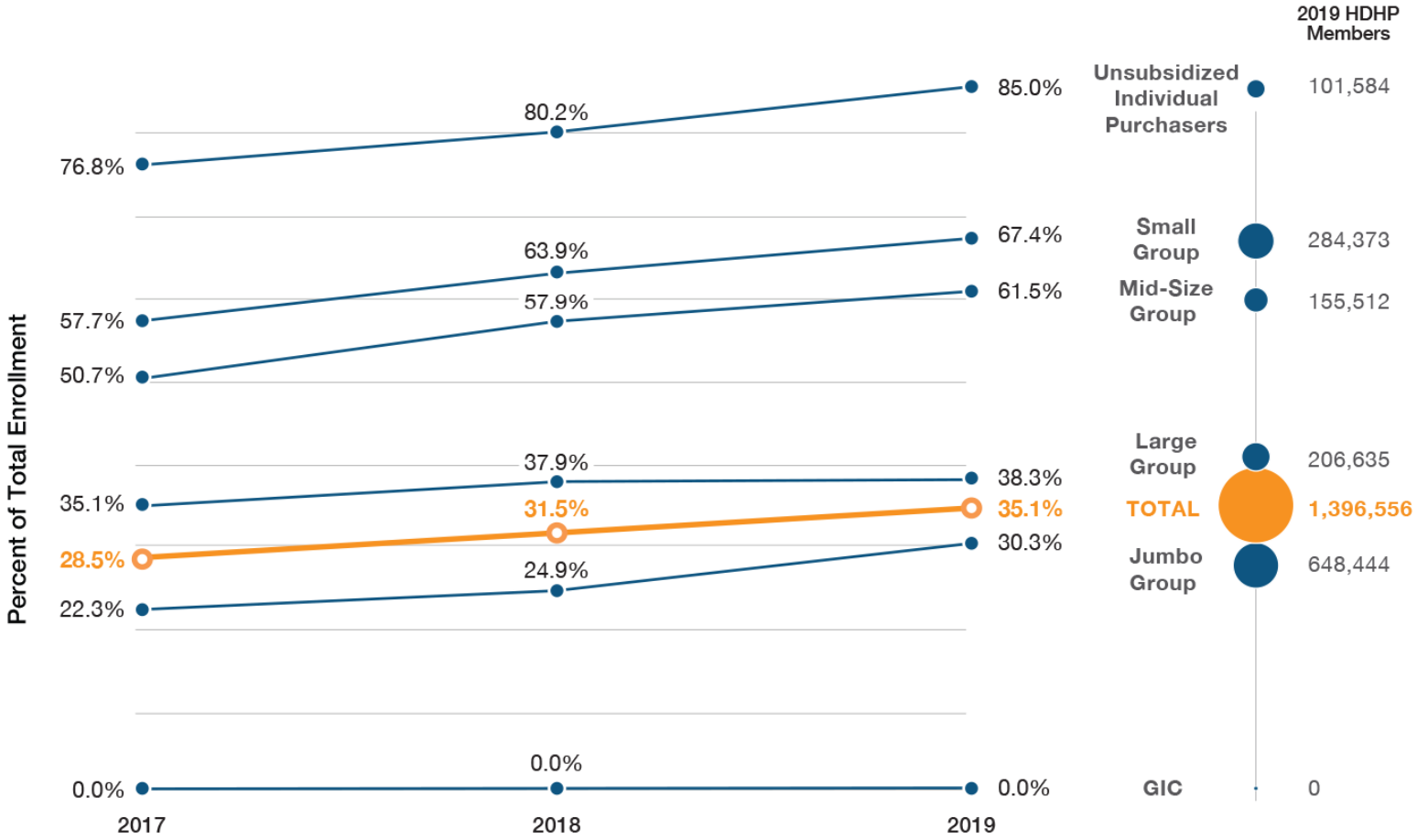


Enrollment in high deductible health plans continued to grow, while tiered and limited network enrollment remained stable.

For more information, see page 51 of CHIA's *Annual Report*

Commercial Insurance

High Deductible Health Plans by Market Sector, 2017-2019

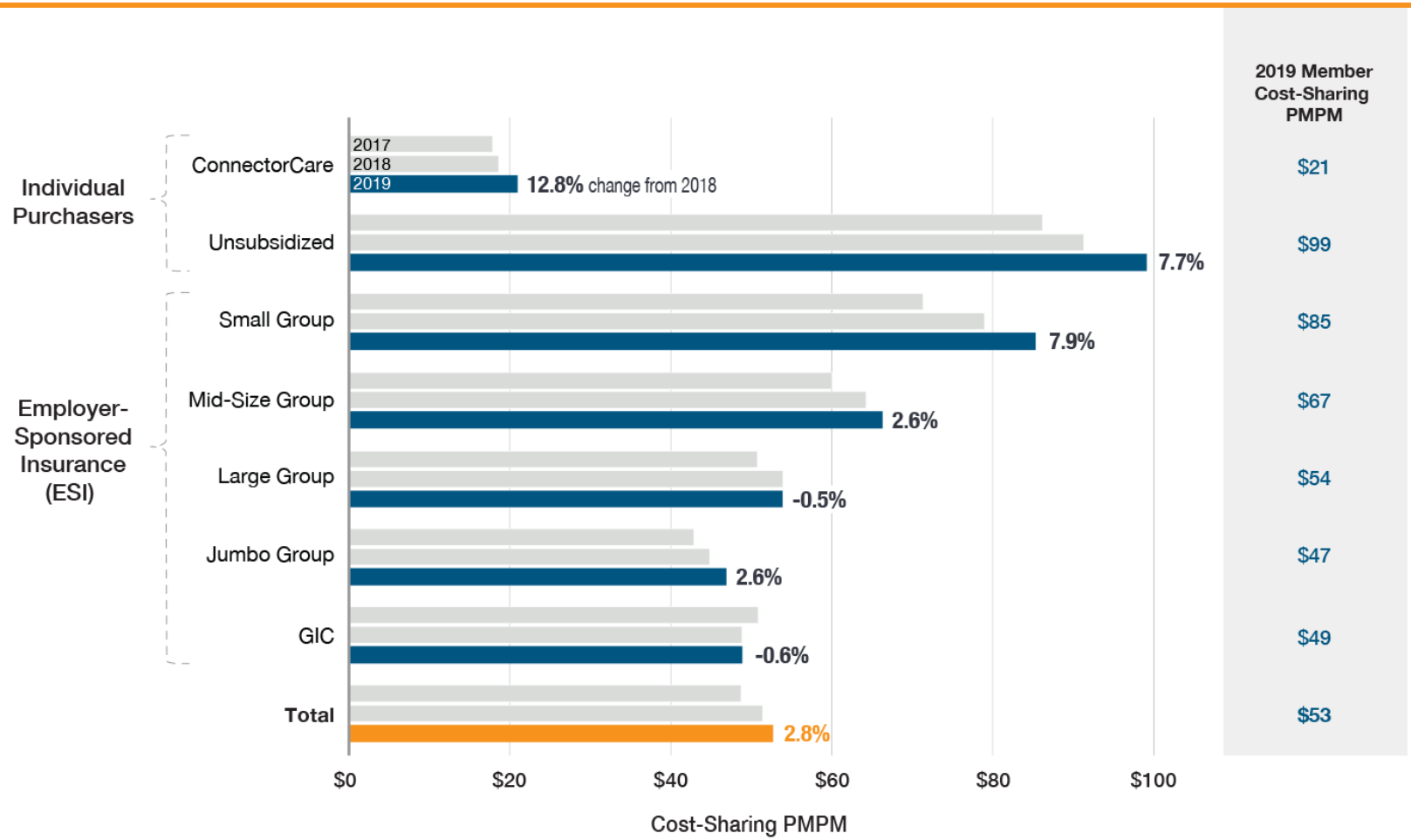


HDHP enrollment continued to grow steadily across nearly all market sectors, with the fastest growth among jumbo group employers.

For more information, see page 52 of CHIA's *Annual Report*

Commercial Insurance

Cost-Sharing by Market Sector, 2017-2019

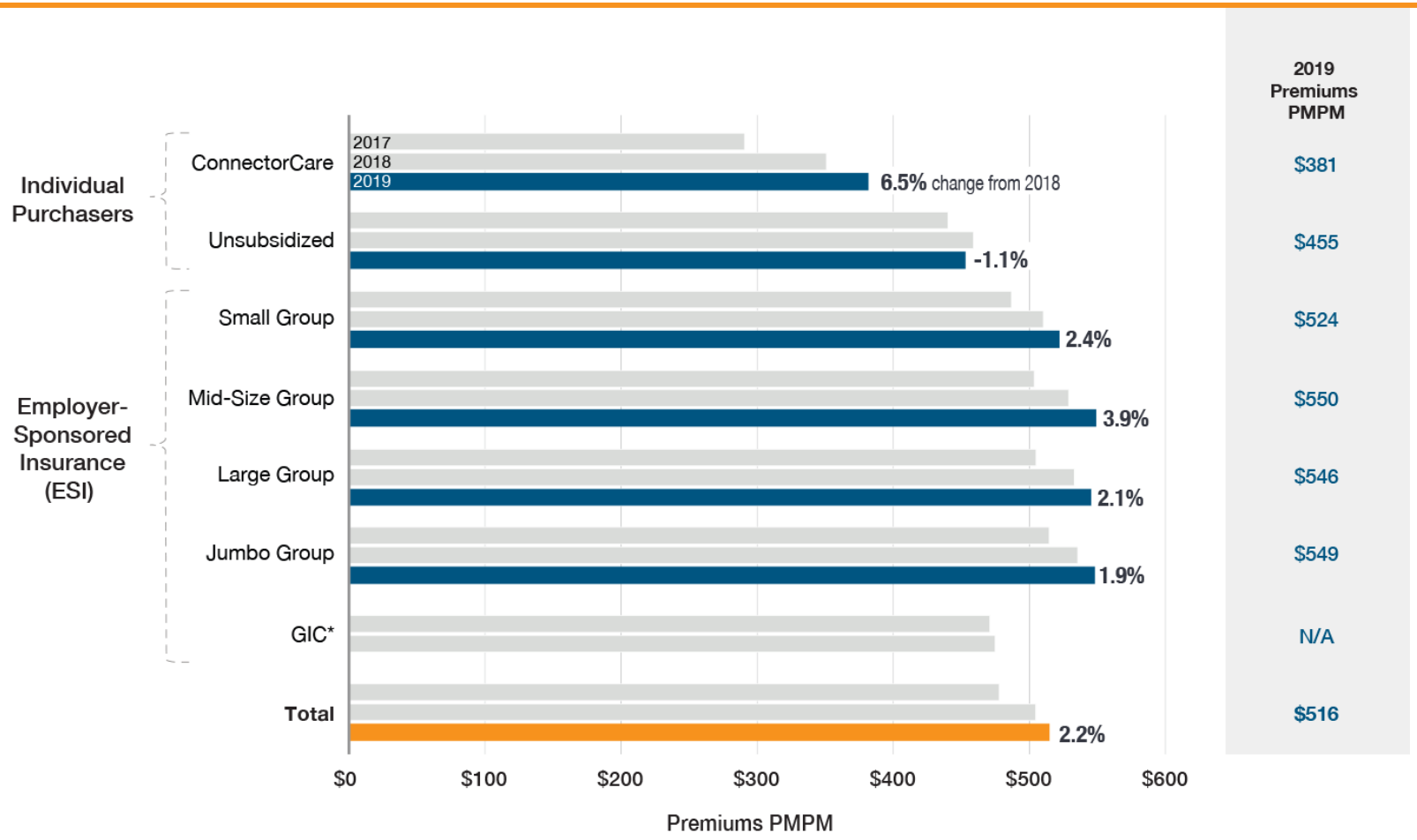


While average member cost-sharing growth slowed from 2018 to 2019 (+2.8%), this trend was limited to larger employer groups.

For more information, see page 66 of CHIA's *Annual Report*

Commercial Insurance

Fully-Insured Premiums by Market Sector, 2017-2019

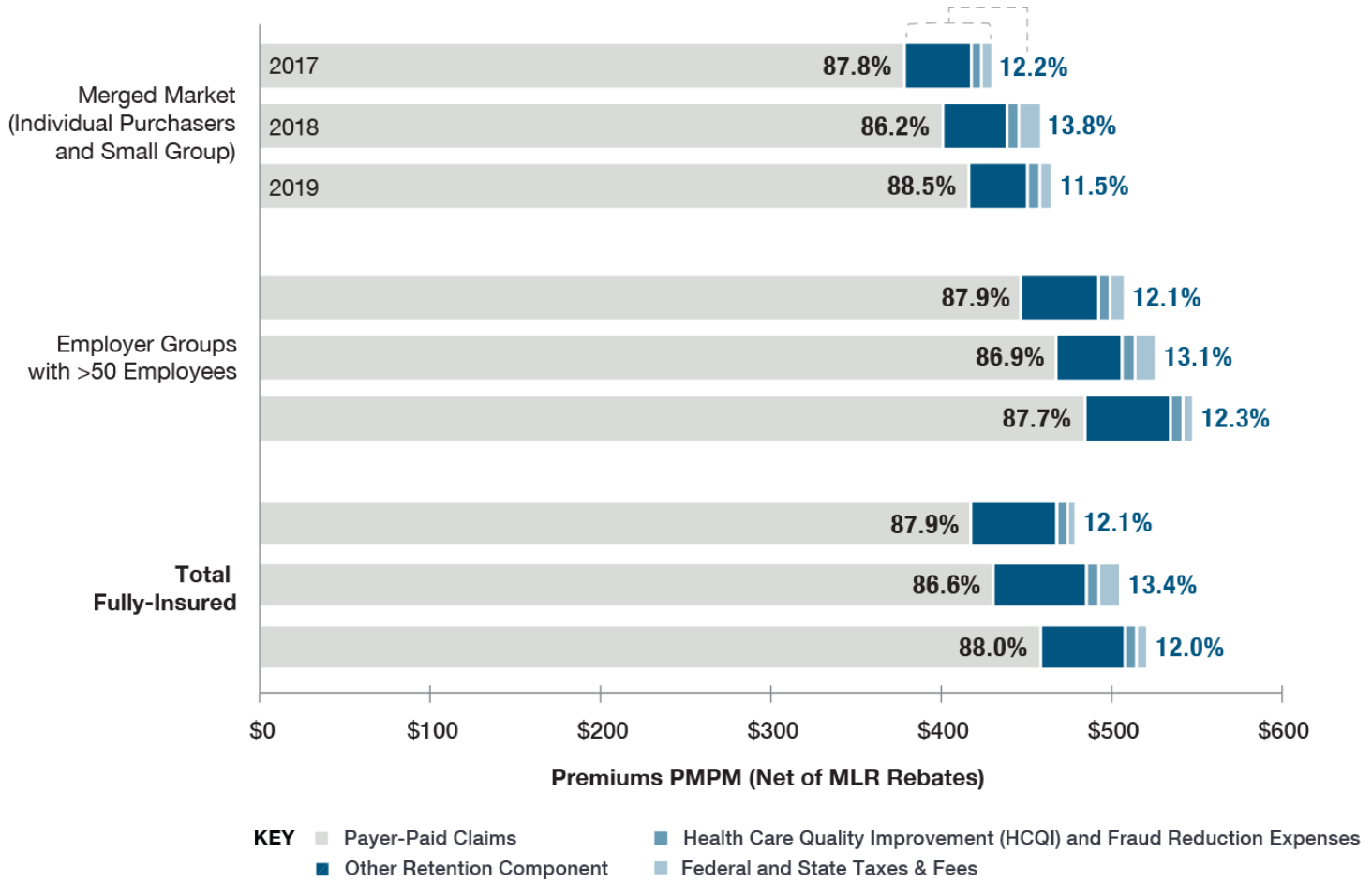


Average premiums increased by 2.2% from 2018 to 2019, slower than in the prior year (+5.7%).

For more information, see page 57 of CHIA's *Annual Report*

Commercial Insurance

Payer Use of Premiums by Market Segment, 2017-2019

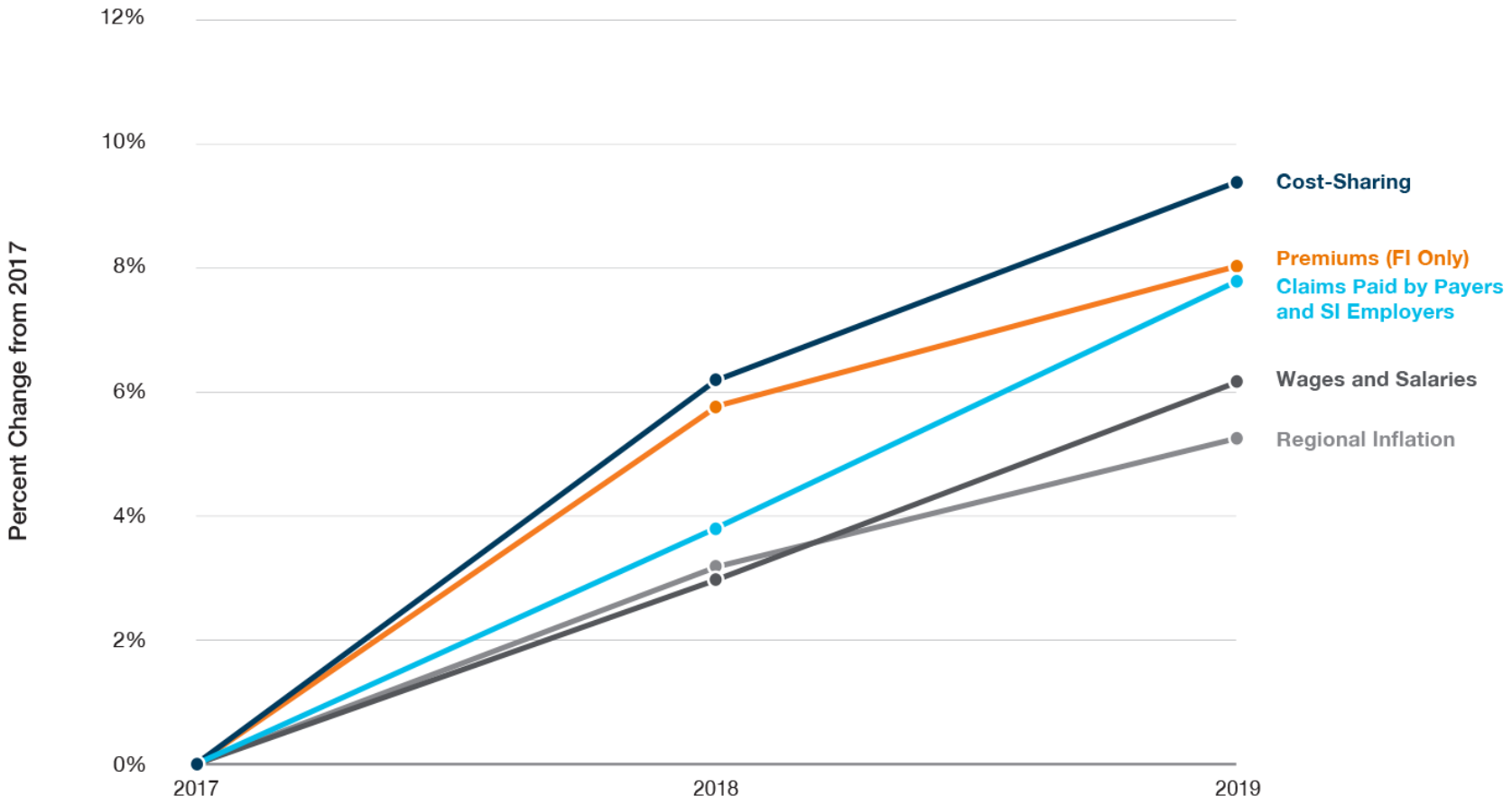


Fully-insured premium retention decreased from 13.4% in 2018 to 12.0% in 2019 as claims costs grew at a faster rate than premiums.

Note: These payer-paid claims percentages are distinct from federal MLR. For more information, see pages 74-77 of CHIA's *Annual Report.*

Commercial Insurance

Affordability Trends, 2017-2019



Member cost-sharing and premiums increased at a faster rate than wages and inflation between 2017 and 2019.

For more information, see page 69 of CHIA's *Annual Report*

CHIA.

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HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK

UP NEXT

PRESENTATION: Report on State Spending Performance

Dr. David Auerbach, Director of Research and Cost Trends, HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK

Report on State Spending Performance

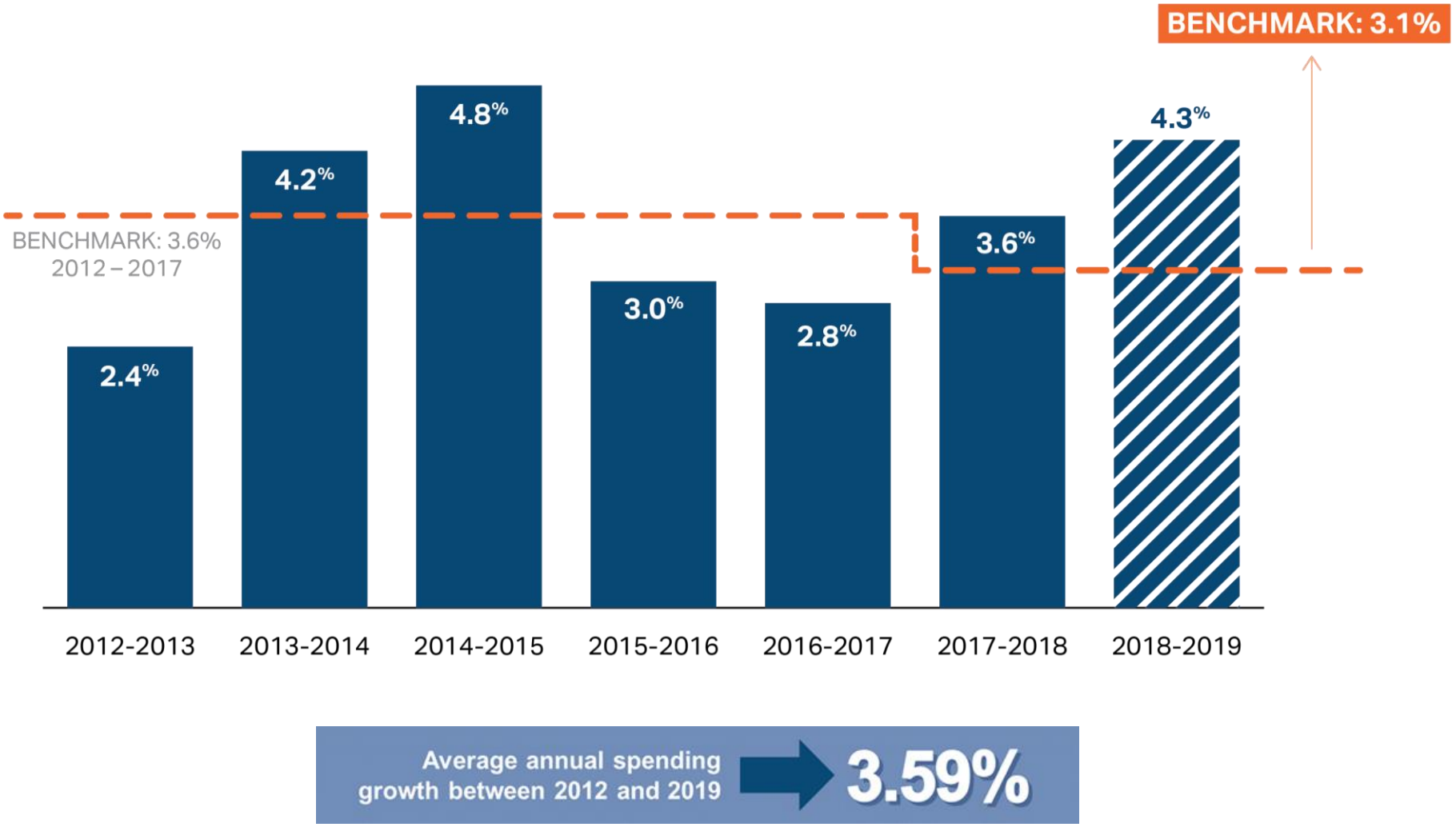
Dr. David Auerbach, Director of Research and Cost Trends, HPC

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.

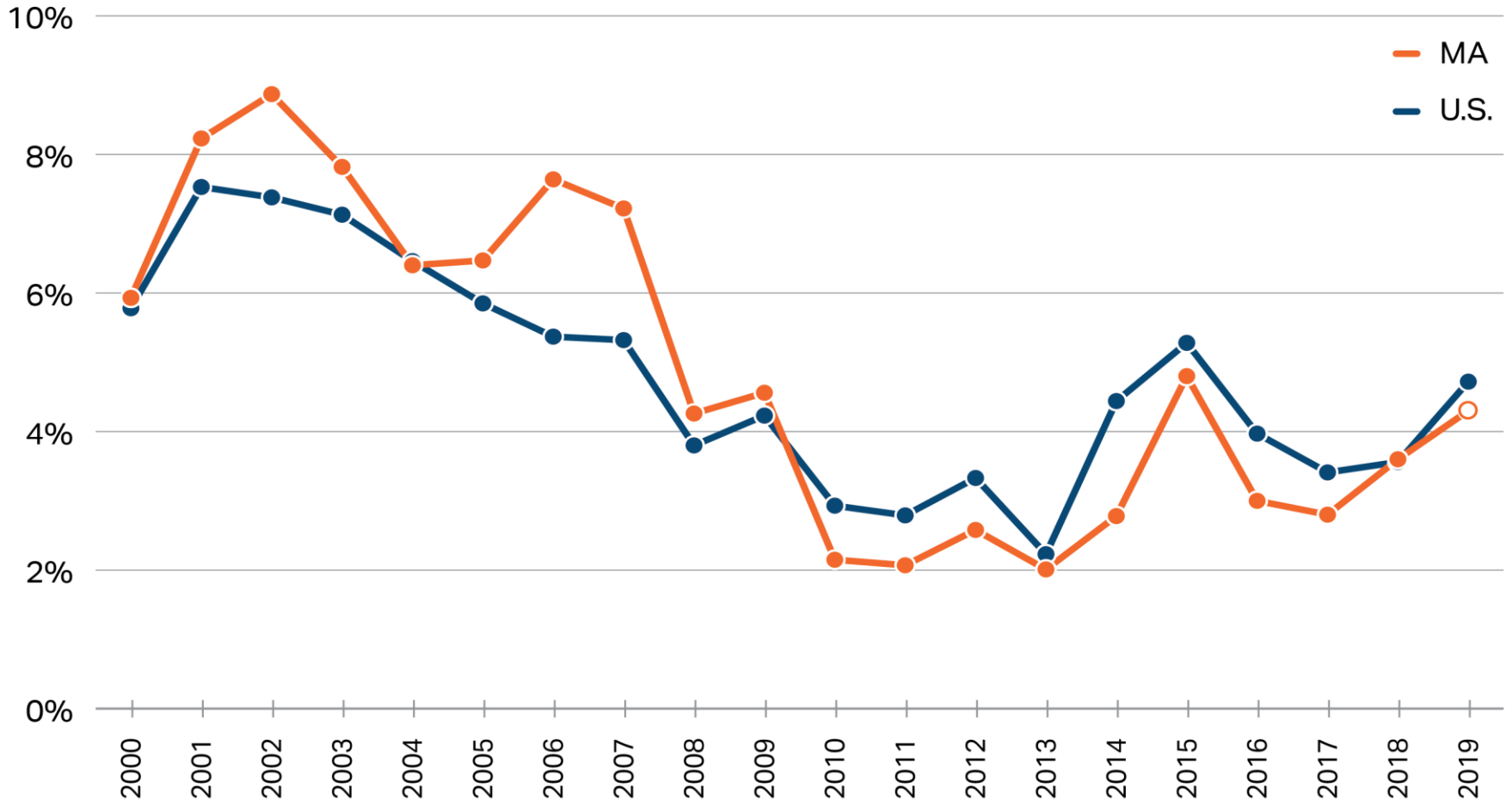
Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012-2019



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.

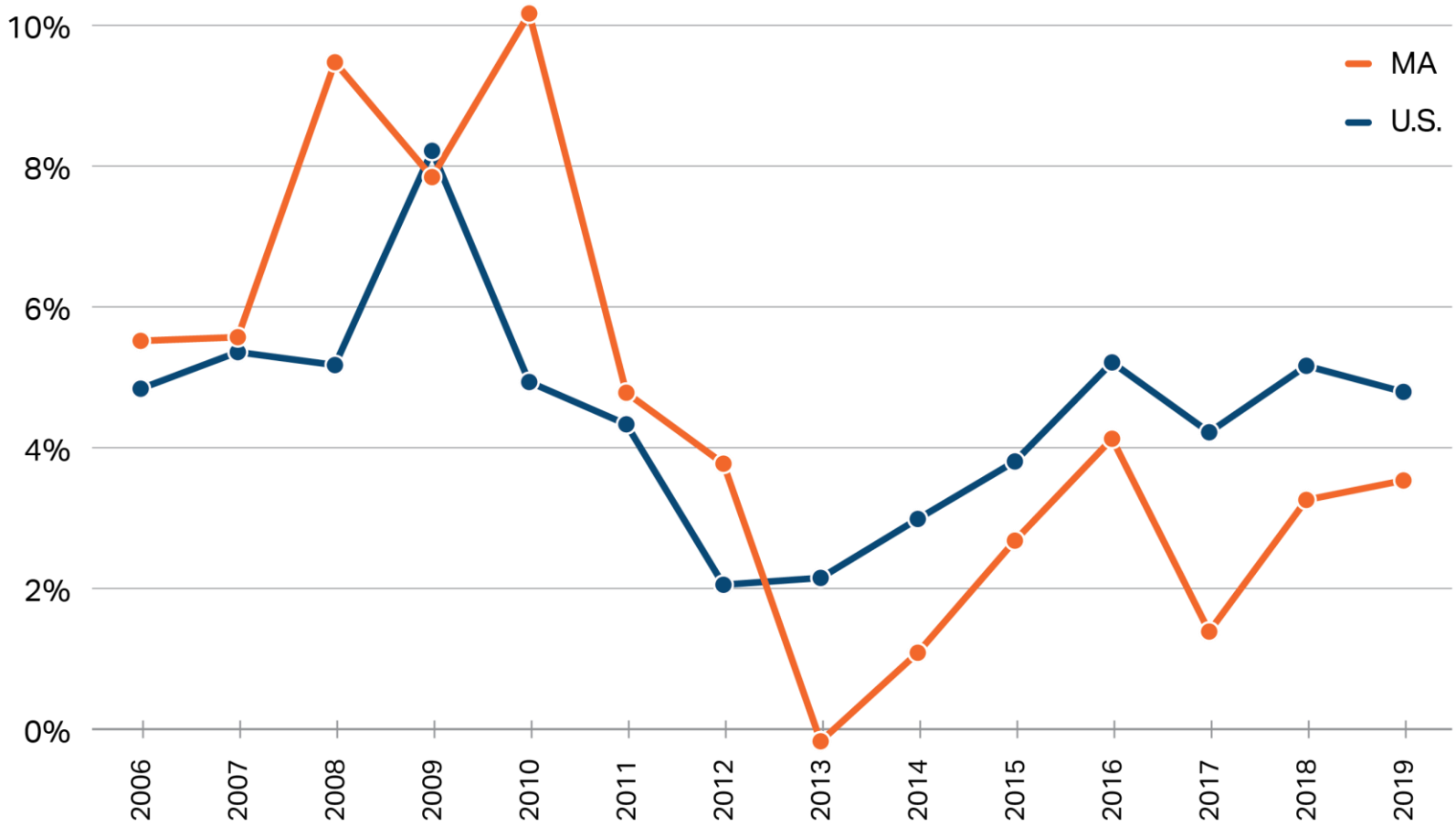
Massachusetts and national annual per-capita total health care spending growth, 2000-2019



Notes: U.S. data includes Massachusetts. Massachusetts 2018-2019 spending growth estimate is preliminary.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2019 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2019

Commercial medical spending growth remained below the U.S. rate in 2019, continuing a multi-year trend.

Annual growth in Massachusetts (full-claims only) and national commercial health care spending per member, 2006-2019



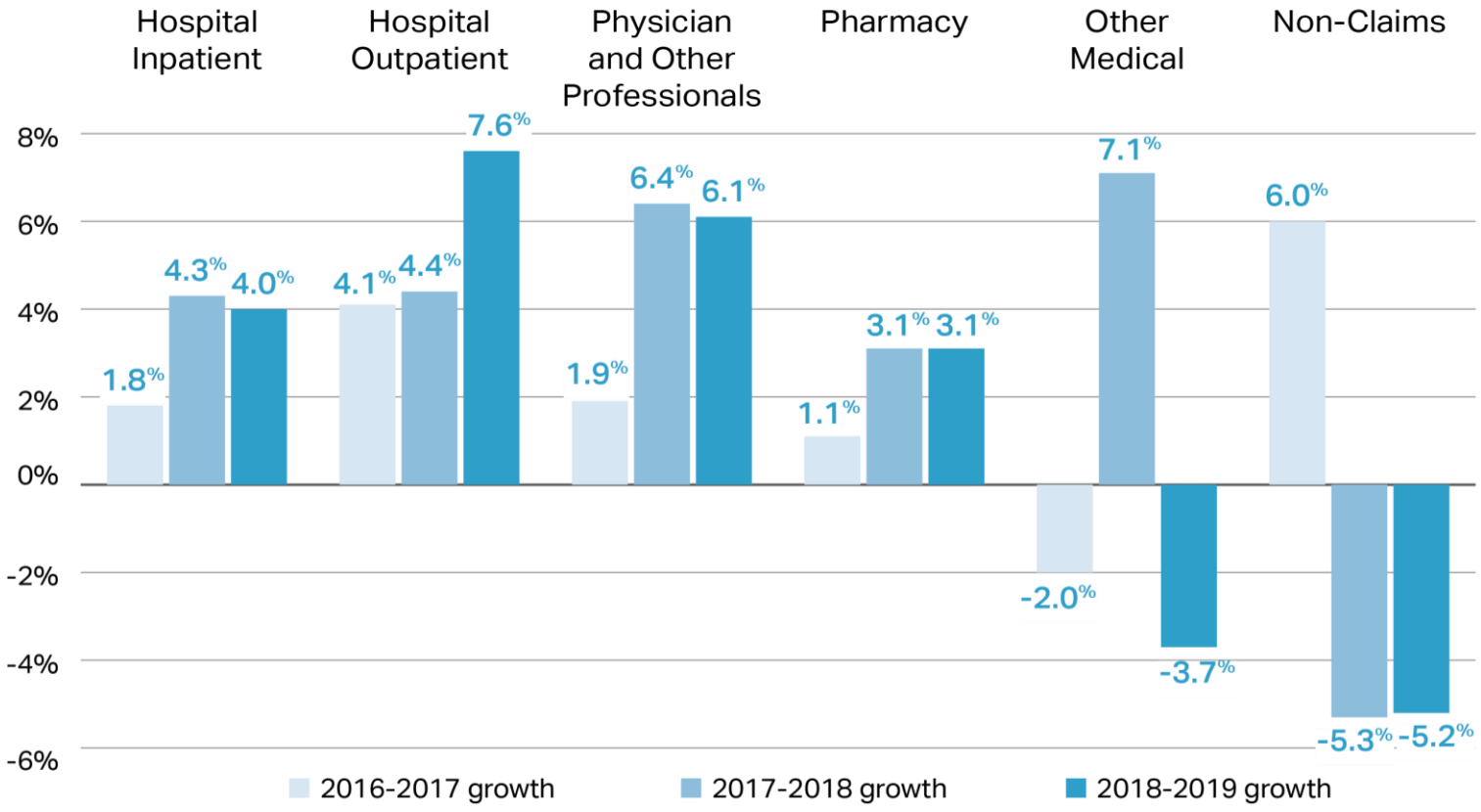
Notes: Commercial spending in Massachusetts includes only members for whom "full-claims" data is submitted to CHIA, excluding roughly the one-third of the market with carveouts ("partial-clams") for whom carved-out spending is not submitted to CHIA. Spending growth for these members was higher in 2018 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.

Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2019 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2019.

HPC

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



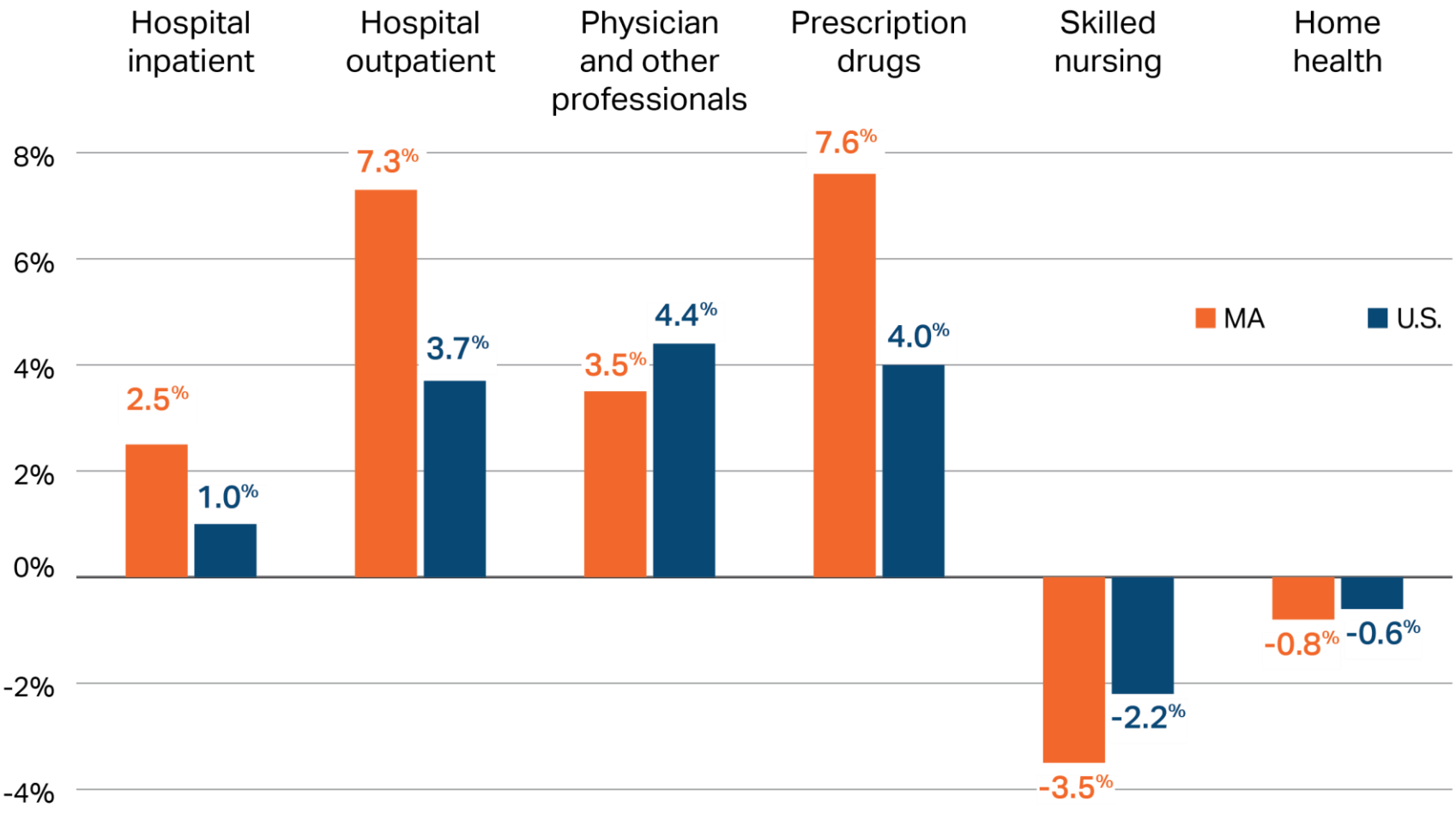
Hospital spending accounted for **54%** of spending growth in 2018-2019.

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.

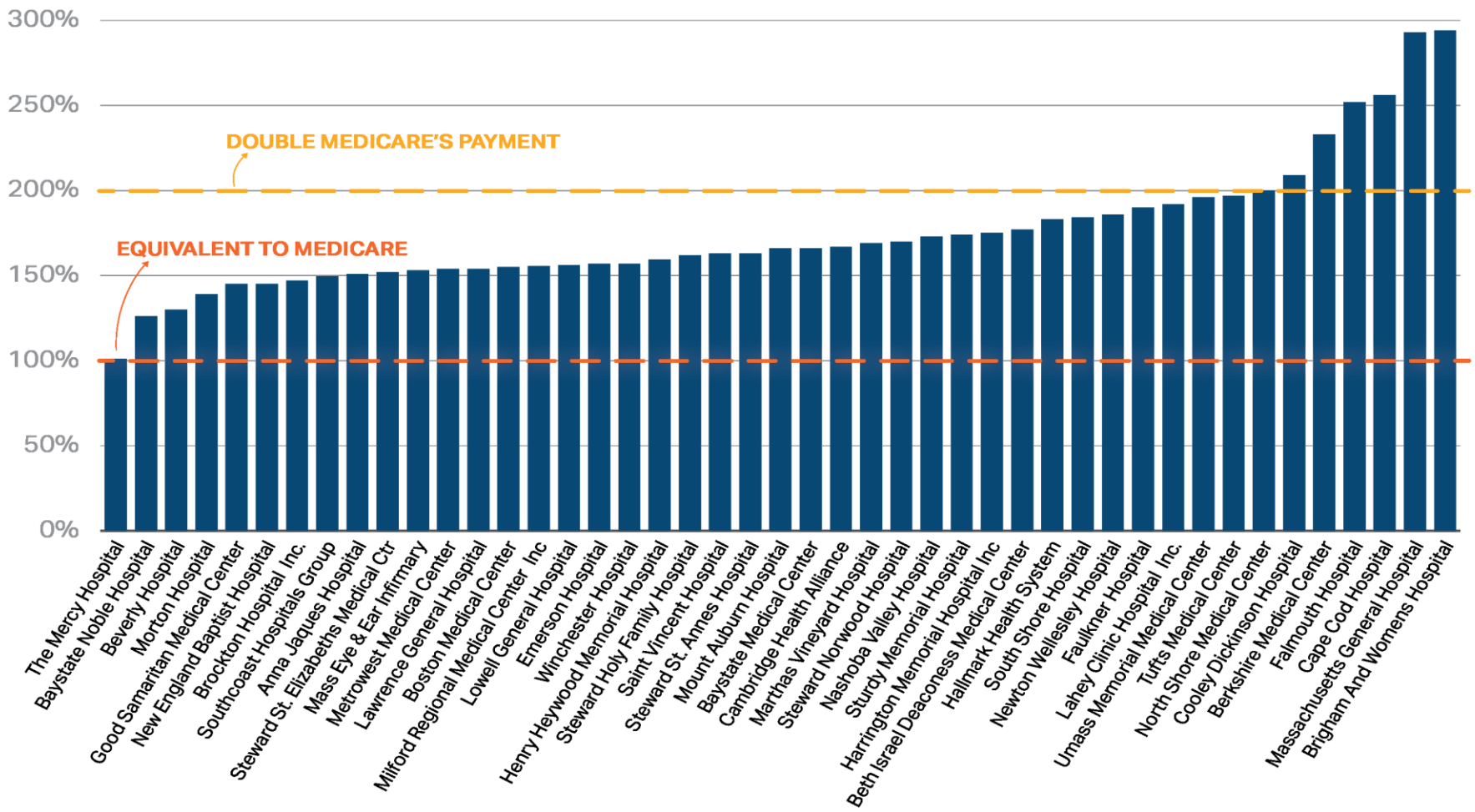
Annual percentage growth in spending per Medicare beneficiary, Massachusetts and the U.S., 2018-2019



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

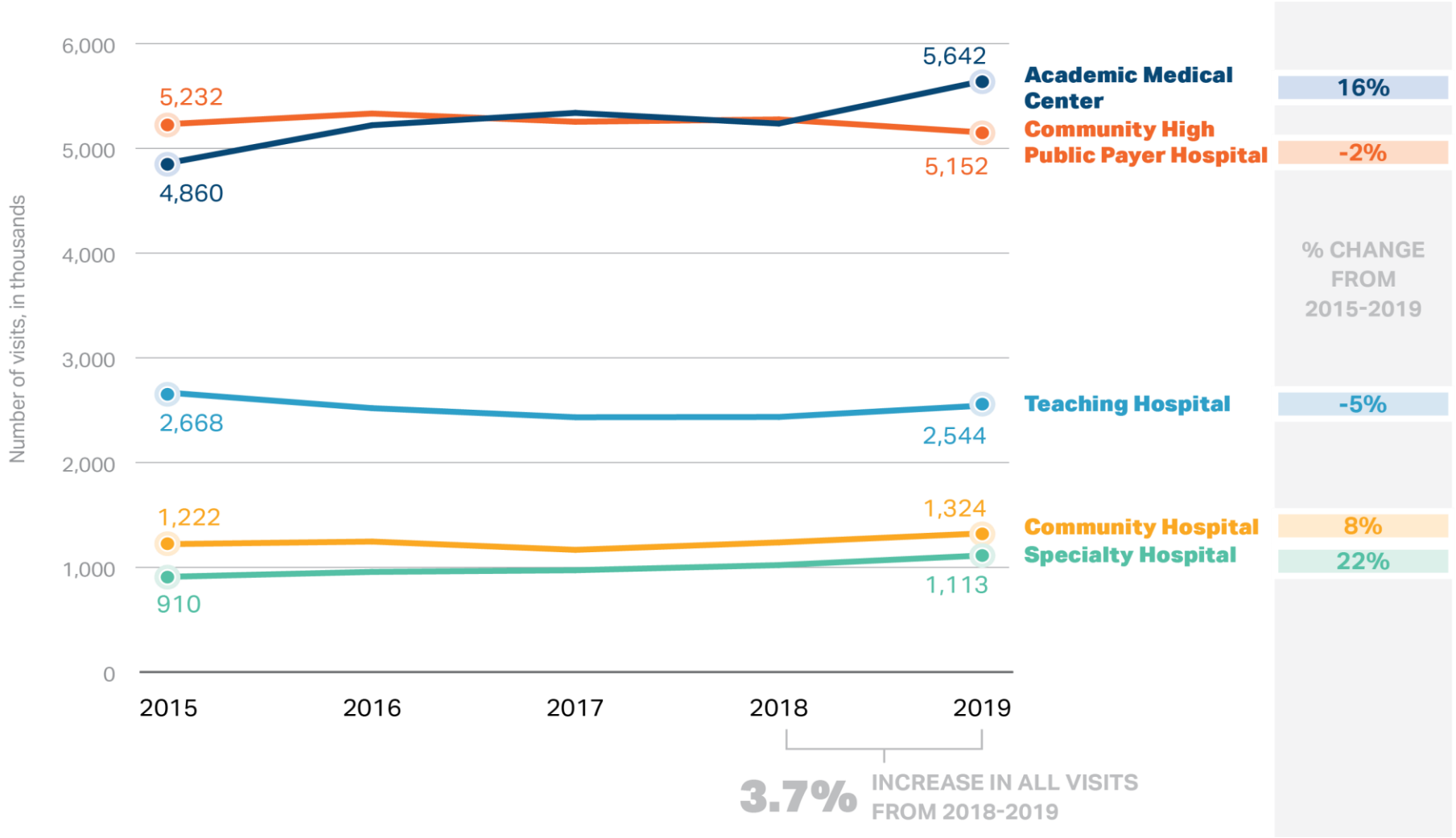


Data from supplemental data files included in the report, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative by Christopher Whaley et al, https://www.rand.org/pubs/research_reports/RR4394.html. Data represent aggregate 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.

HPC

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



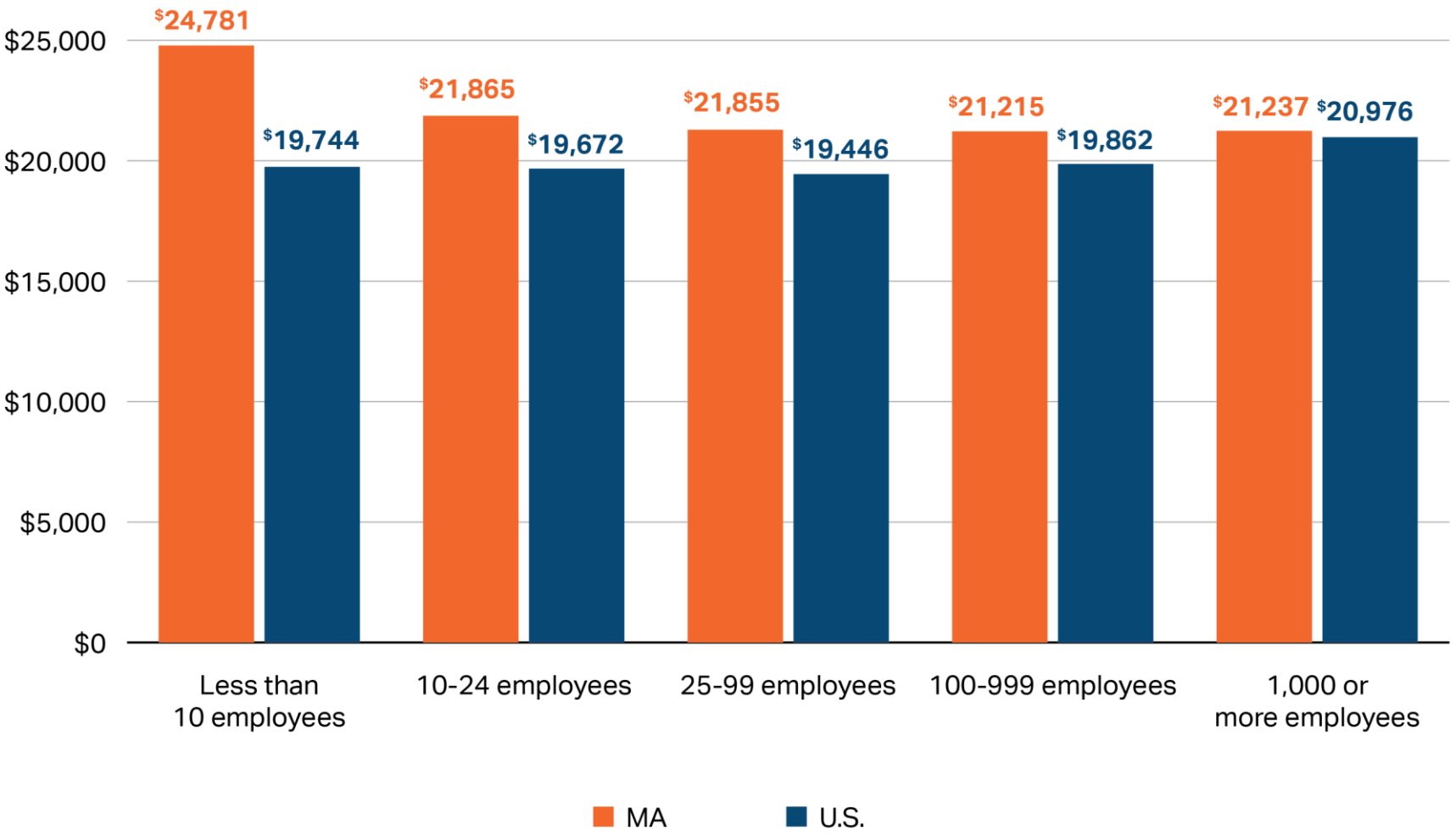
Data from the Massachusetts Center for Health Information and Analysis, Acute Hospital Profiles, 2015-9. https://www.chiamass.gov/hospital-profiles/. Outpatient visits are reported by the hospitals.

Section II.

Affordability of Care

Massachusetts family health insurance premiums are above the national average and highest for the smallest employers.

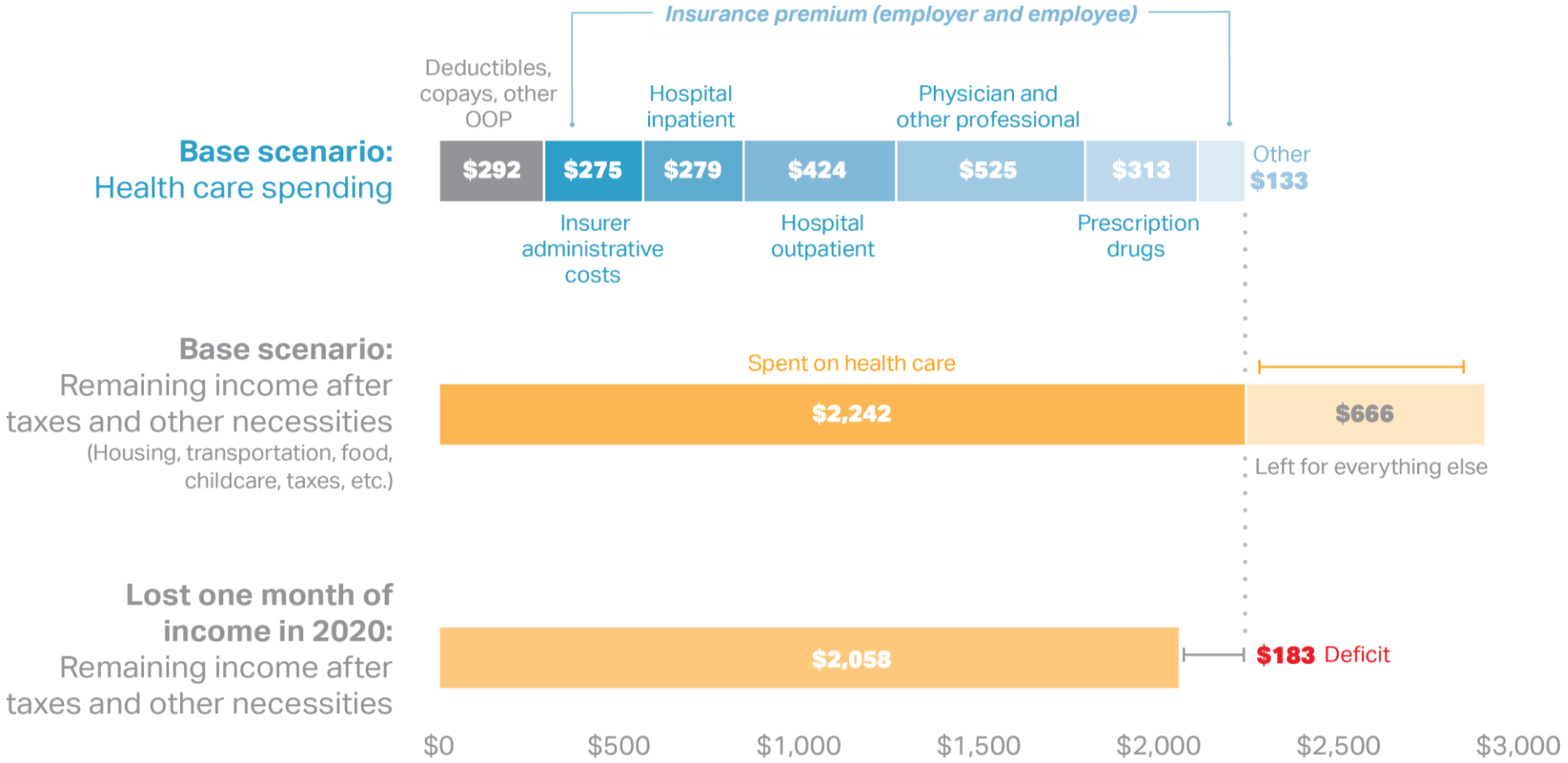
Annual premium for family coverage, including employer and employee contribution, Massachusetts and the U.S., 2019



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

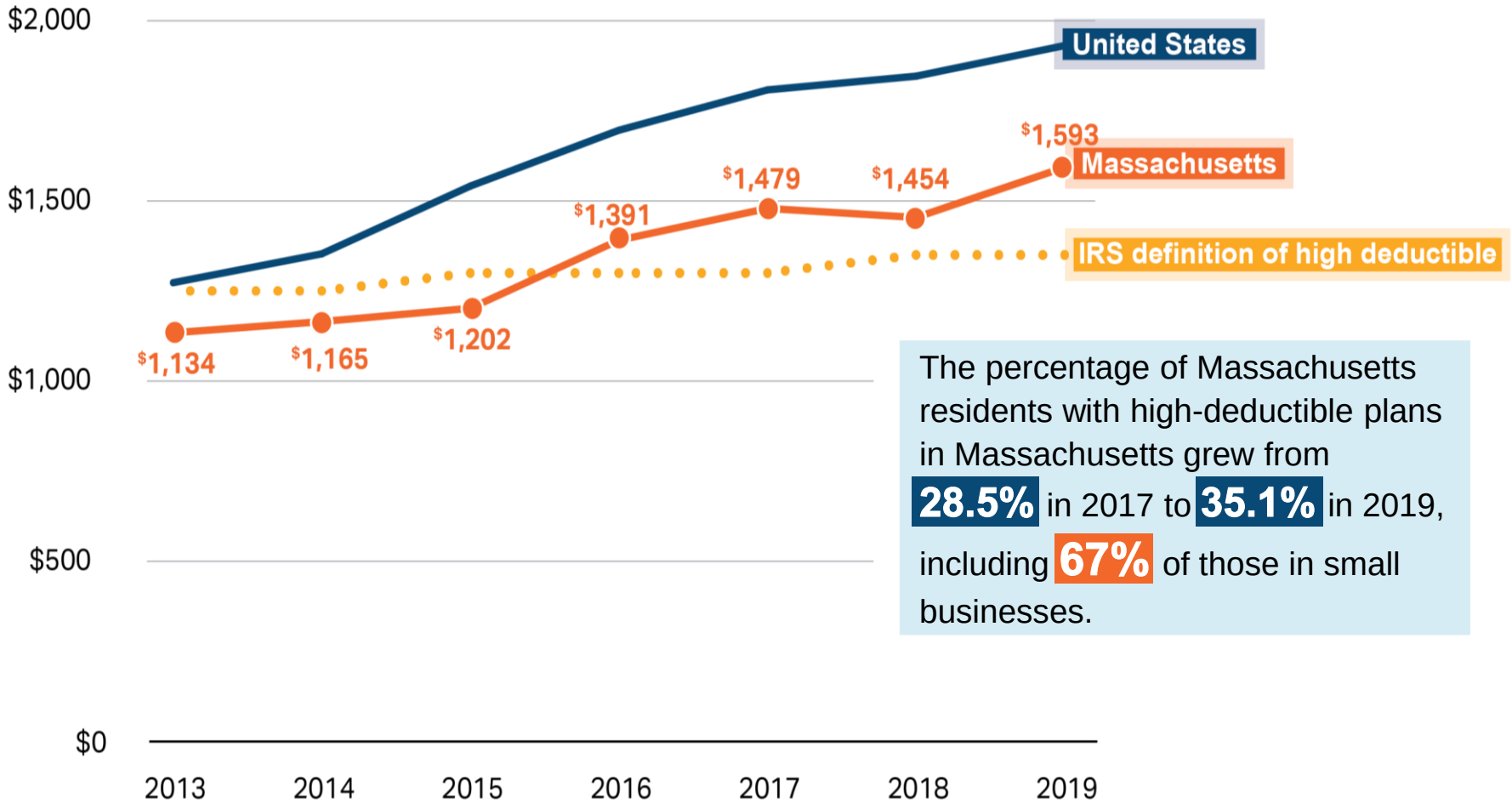


Scenarios based on a family of four in Worcester county, Massachusetts. Family budget information from Economic Policy Institute estimates of typical family of two adults and two children. https://www.epi.org/resources/budget/. Income information from published 1-year tables from the American Community 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.

HPC

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



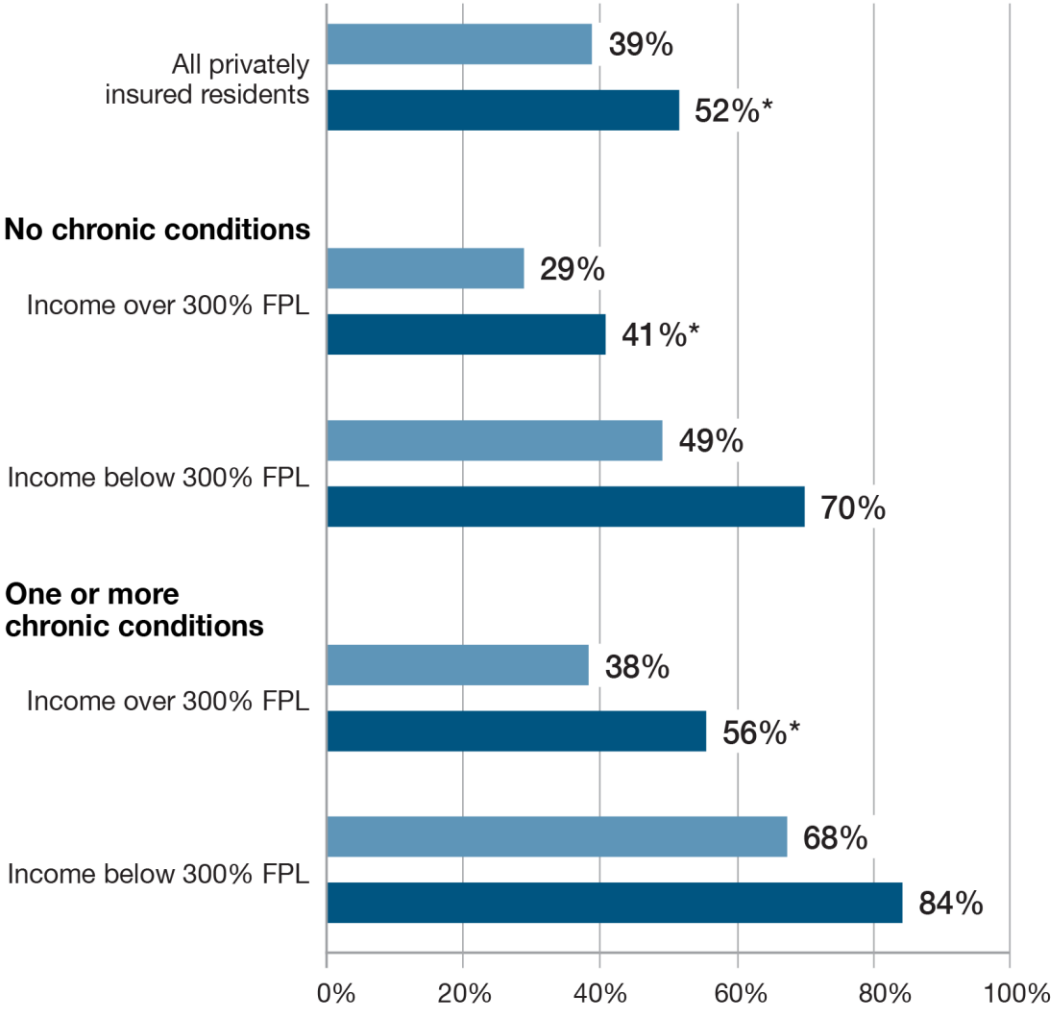
The percentage of Massachusetts residents with high-deductible plans in Massachusetts grew from **28.5%** in 2017 to **35.1%** in 2019, including **67%** of those in small businesses.

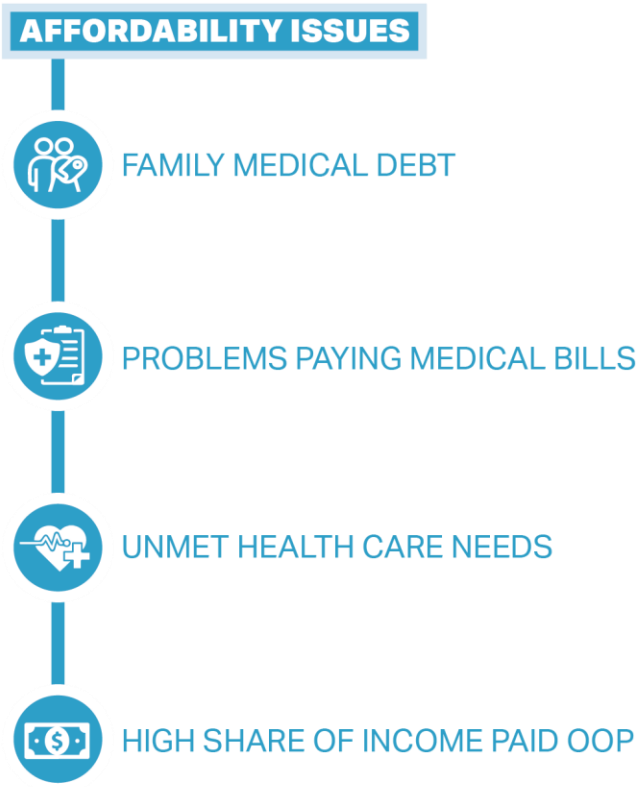
Notes: U.S. data include Massachusetts. Deductibles are averages based on a large sample of employers within each state.

Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey 2013-2019. Internal Revenue Service, 2013-2019. Center for Health Information and Analysis, Annual Report, 2020.

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

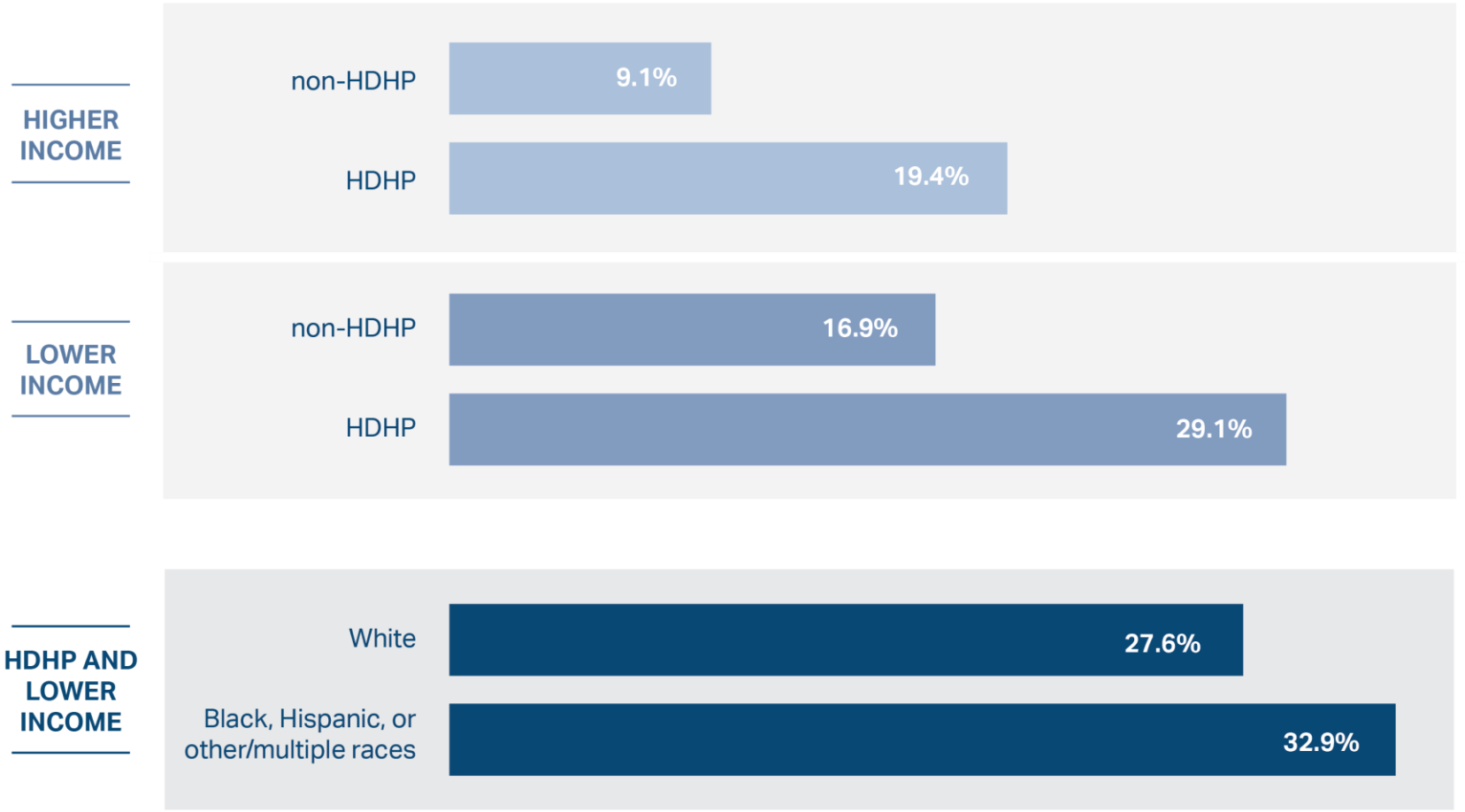




Data from the Massachusetts Health Insurance Survey (MHIS), Massachusetts Center for Health Information and Analysis, "AN INSIDE LOOK: Affordability Issues are More Common in High Deductible Health Plans Findings from the Massachusetts Health Insurance Survey (MHIS)".

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



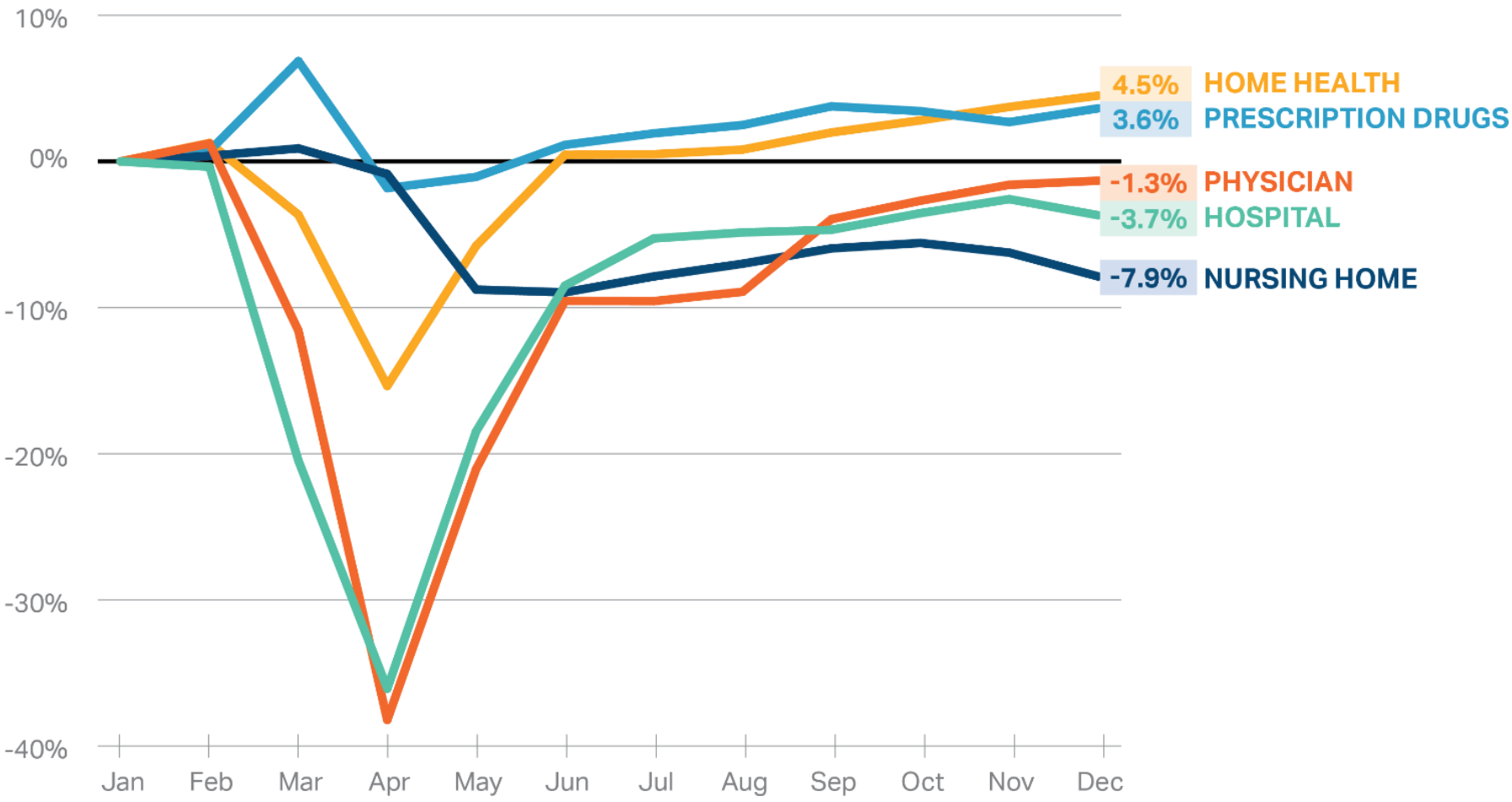
HPC analysis of data from the Massachusetts Health Insurance Survey (MHIS) administered by the Massachusetts Center for Health Information and Analysis. Low-income is defined as family income below 400% of the US Federal Poverty Level. People of color include those who identify as Black, Hispanic, or 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.

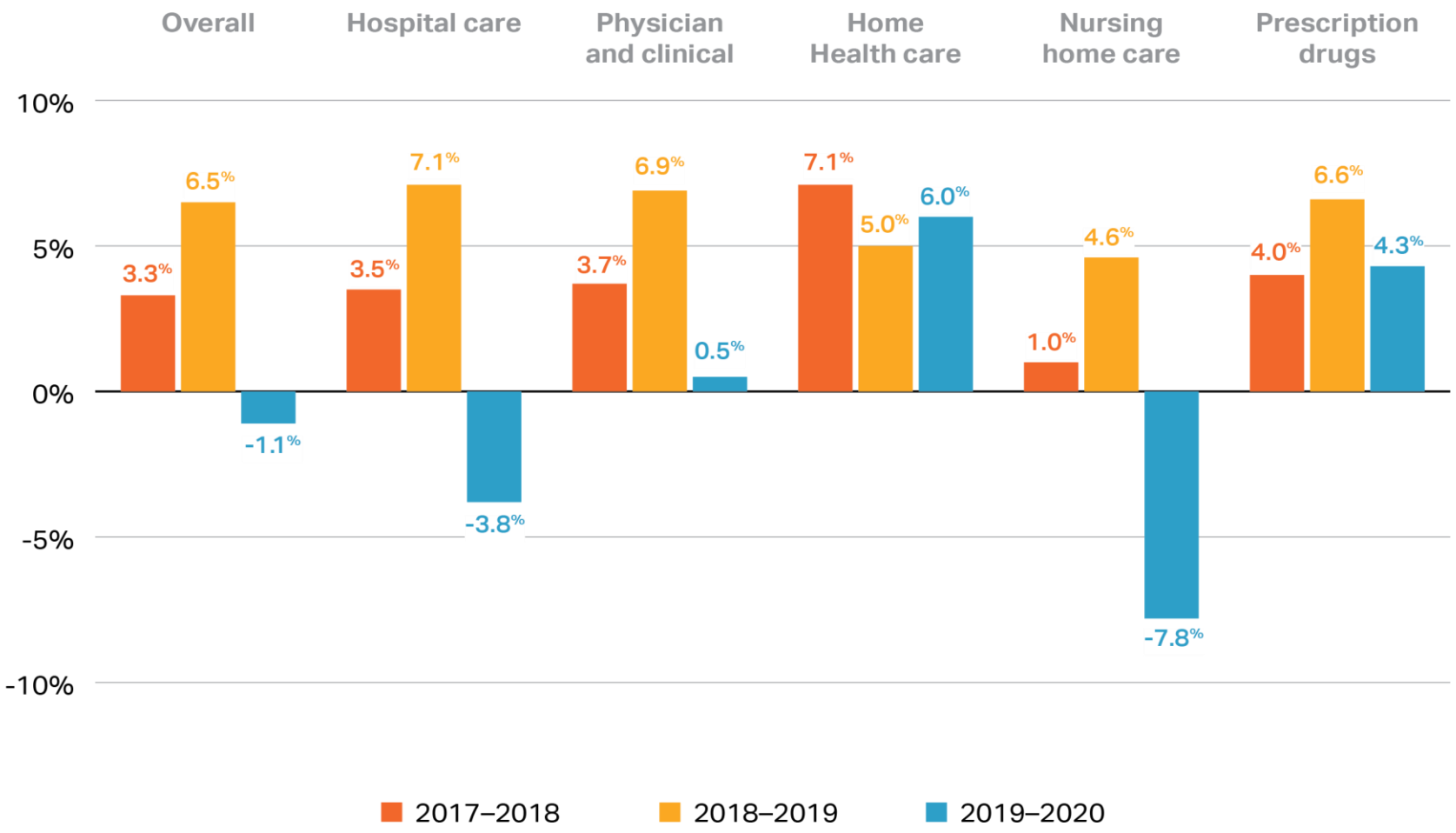
Changes in national health care spending, by category, relative to January, 2020



Data from the Altarum Institute. https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Spending-Brief_February_2021.pdf. Underlying data from the US Bureau of Economic Analysis.

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

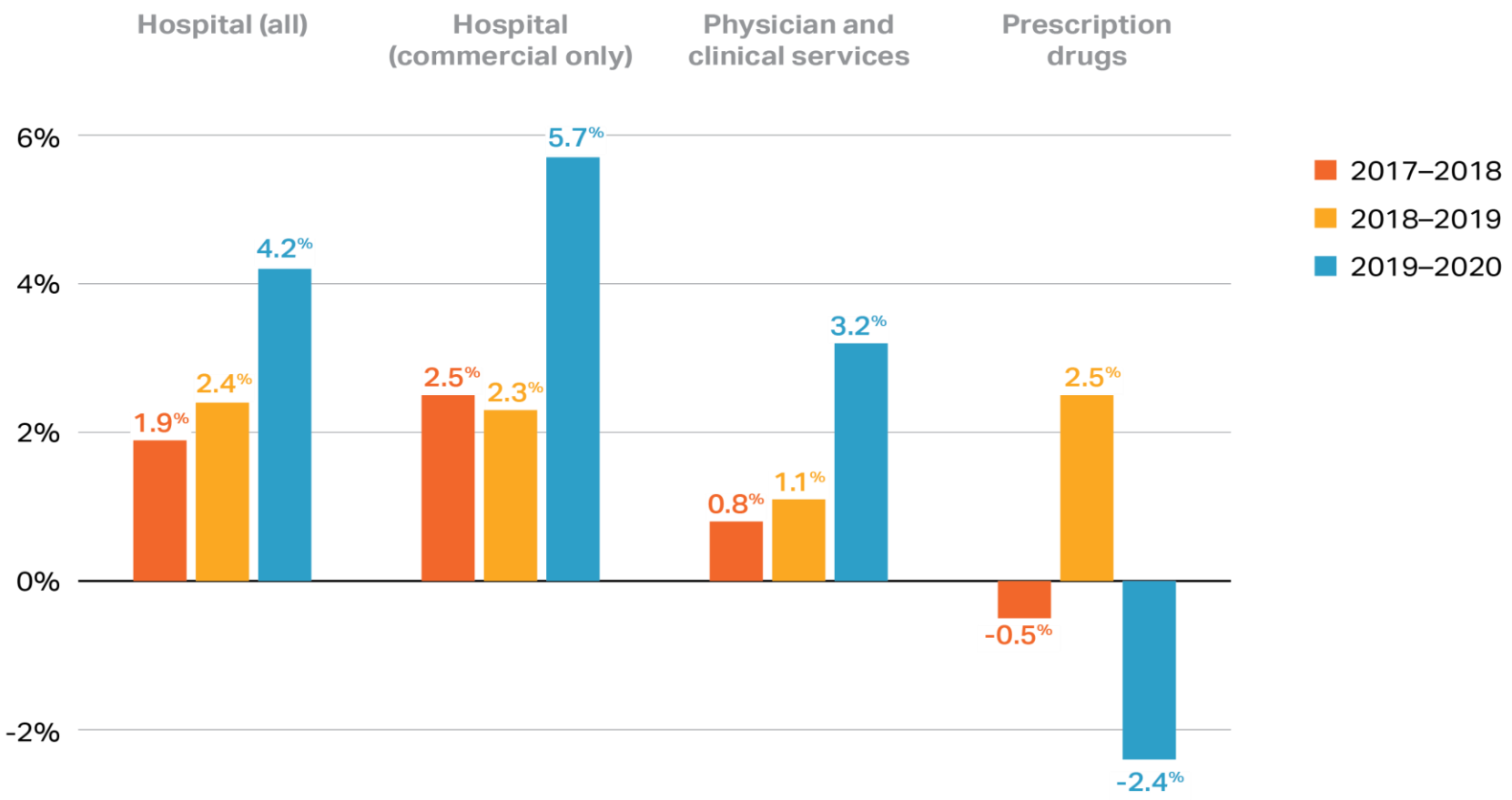
National growth in health care spending for the 12-month period shown, by sector, all payers



Data from the Altarum Institute. https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Spending-Brief_February_2021.pdf. See Exhibit 5. Underlying data from the US Bureau of Economic Analysis. Data represent growth in spending from December to December for the years indicated.

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

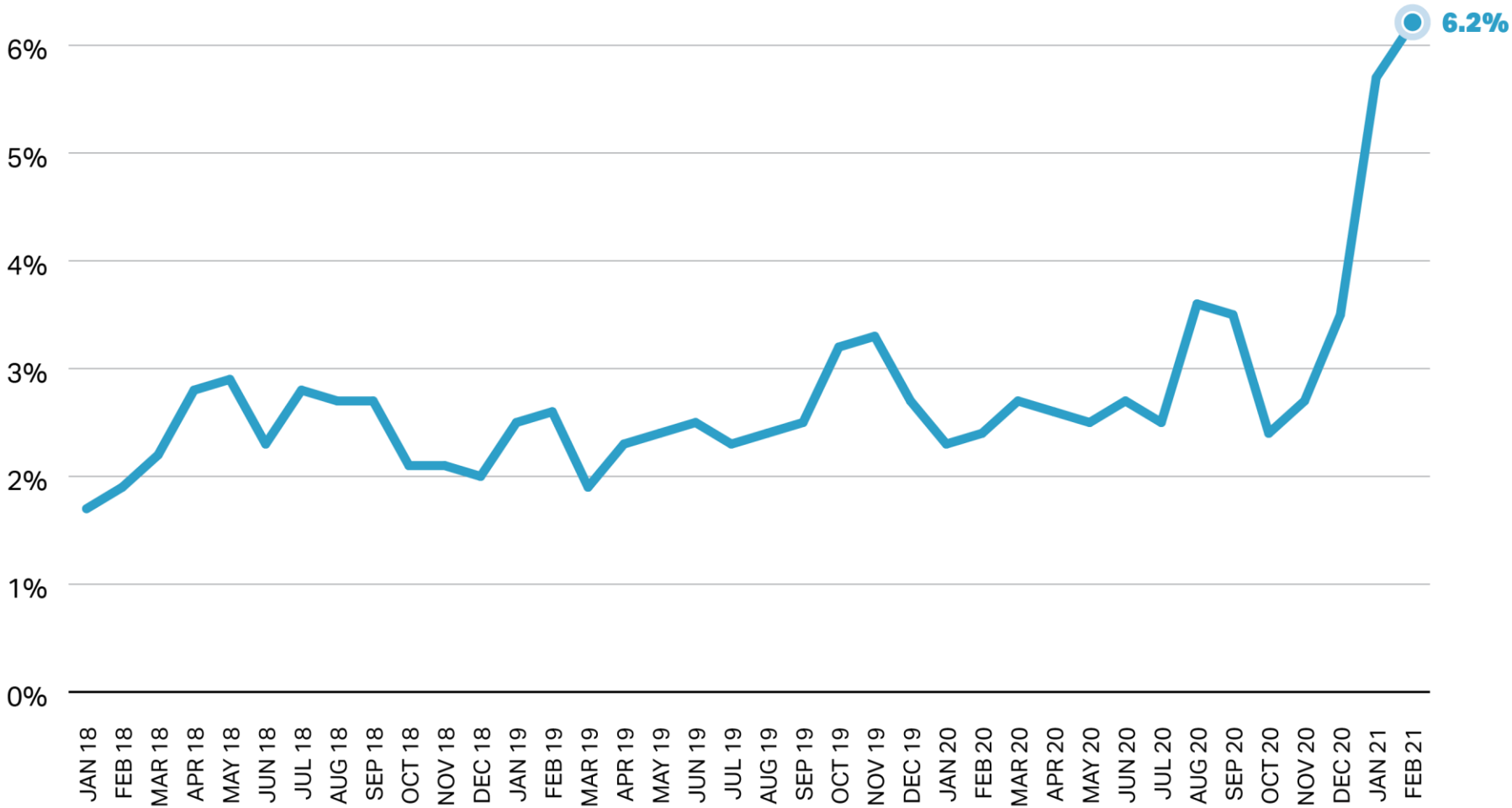
National growth in average prices for the 12-month period shown, by sector, all payers unless otherwise indicated



Data from the Altarum Institute. https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Price-Brief_February_2021.pdf. Underlying data from the US Bureau of Labor Statistics. Data represents growth from January to January, for example, from January 2020 to January 2021 in the case of the most recent series.

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

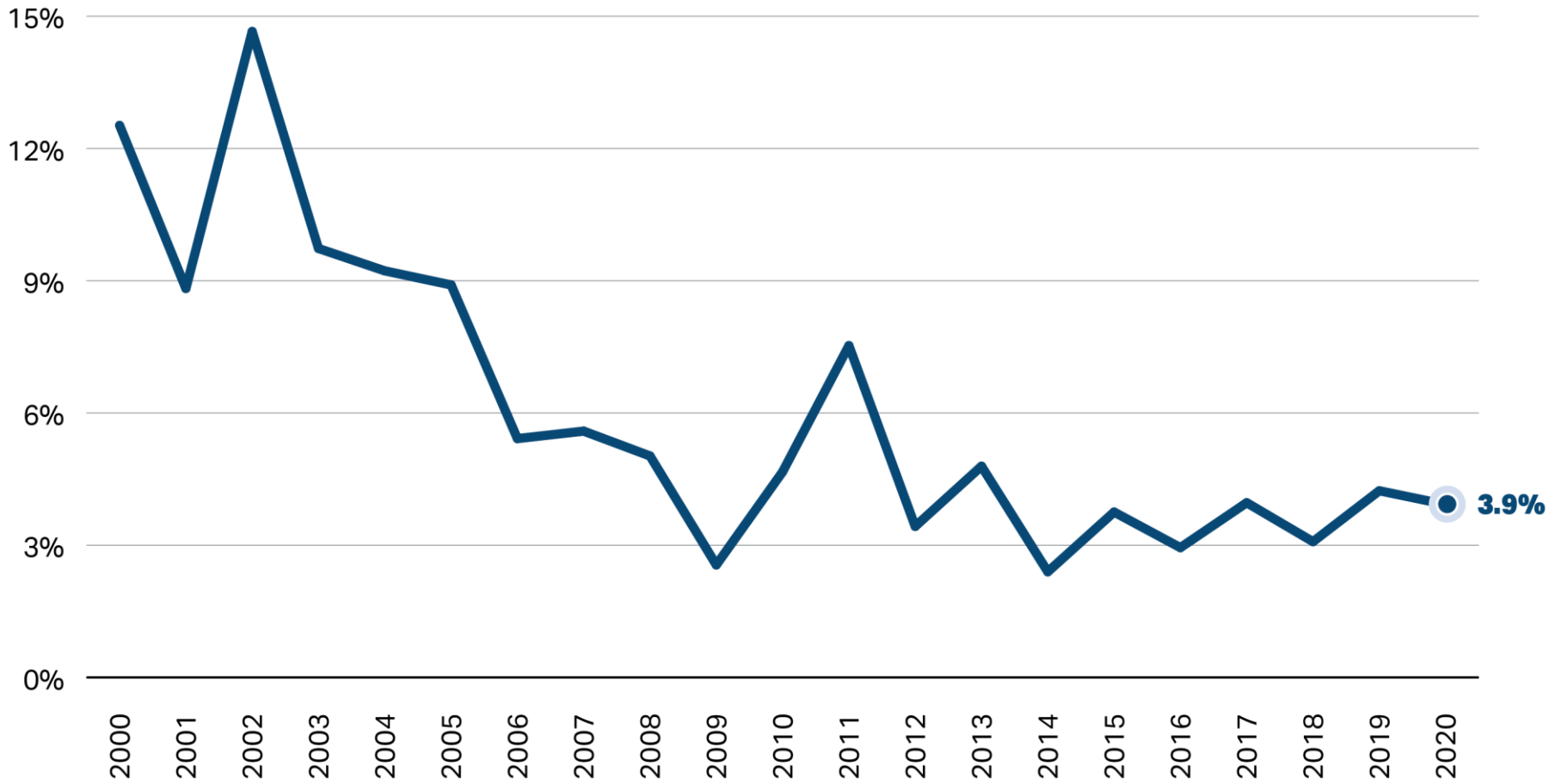
National growth in commercial hospital prices relative to the same month, 12 months prior, Altarum Institute



Altarum Institute, Health Sector Economic Briefs. Data based on publication of Feb 19, 2021 – underlying data provided to the HPC by the Altarum Institute. https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Price-Brief_February_2021.pdf

Nationally, health insurance premiums grew 3.9% in 2020.

Annual growth in employer health insurance premiums for single coverage



Kaiser Family Foundation/HRET Employer-based premium annual survey, http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf. Premium data based on survey of employers. Premium data collected in the first half of the year shown.

Public Testimony

Public Testimony

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