Performance of the Massachusetts Health Care System

MARCH 26

Annual Report

CENTER FOR HEALTH INFORMATION AND ANALYSIS

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KEY FINDINGS

Annual Report 2026

Total Health Care Expenditures (THCE) in Massachusetts totaled $83.3 billion in 2024. From 2023 to 2024, THCE per capita increased 5.7% to $11,663.

Among employer groups, member cost-sharing was highest for employees at small and mid-size organizations ($117 and $92 per member per month [PMPM], respectively) and increased by more than 8% in 2024. These employer groups also had the highest premiums.

Pharmacy and hospital outpatient spending drove THCE growth in 2024. Pharmacy spending increased $1.5 billion (9.8%) and hospital outpatient increased $1.1 billion (7.5%).

Fully insured premiums for those with employer-sponsored insurance (ESI) rose 4.8% to $683 PMPM in 2024. Within ESI, the mid-size group experienced the largest premium growth, increasing 5.5% to $697 PMPM.

KEY FINDINGS

Annual Report 2026

Disrupting a long-term growth trend, high-deductible health plan (HDHP) enrollment decreased across all sectors except mid-size employer groups in 2024, with jumbo groups experiencing the largest proportional decrease of 7.7 percentage points. This trend was seen across multiple payers.

The statewide acute hospital median total margin decreased 1.6 percentage points, from 2.2% in hospital fiscal year (HFY) 2023 to 0.6% in HFY 2024. The statewide median operating margin was -2.0% while the median non-operating margin was 1.6%.

While affordability issues persisted for many Massachusetts residents and their families in 2025 with 40.3% of residents reporting issues paying for health care, the burden was greatest for Black and Hispanic residents (54.1% and 47.3%, respectively).

Inpatient discharges and emergency department visits have stabilized in the past few years, remaining below pre-pandemic levels, while average length of stay (ALOS) has declined, most notably to 4.6 hours in the emergency department as of June 2025.

Executive Summary

Each year, pursuant to M.G.L. c. 12C, the Center for Health Information and Analysis (CHIA) examines the performance of the Massachusetts health care system and reports on trends in costs, coverage, and quality indicators to inform policymaking. This report primarily focuses on data through 2024. Select hospital utilization and financial measures are included through June 2025, where possible.

In 2024, the Massachusetts health care landscape underwent substantial changes, impacting the health care experience of individuals and families. For the first time since 2020, MassHealth was required to reconfirm eligibility for all members, disenrolling more than 350,000 individuals in 2023 and 2024. Most of these residents were able to access low-cost coverage through ConnectorCare, which also launched a pilot program expanding eligibility and enabling more families to receive affordable health care coverage. At the same time, residents continued to face health care affordability challenges as cost increases for health care and other household necessities outpaced growth in wages and salaries. As shown in publicly available data for 2025 premiums, the downstream impact of the 2024 experience resulted in accelerated premium increases for private health insurance in 2025, continuing an unsustainable trend for Massachusetts residents—and the health care system—that is expected to be further exacerbated in 2026 due to federal policy changes. Amid these changes, the state exceeded the health care cost growth benchmark for the fourth year in a row.

Across the health care delivery system, 2024 was marked by continued challenges. Most health plans reported financial losses as health care spending outpaced the premiums collected. Hospitals and health systems relied on non-operating revenue for stability, with fewer than half of hospitals reporting positive operating margins. Though initial data for 2025 suggests an improvement, these

overall trends mask persistent resource disparities among payers and providers. Additionally in 2024, Massachusetts navigated the Steward Health Care bankruptcy that resulted in 2 hospitals closing and 5 hospitals—along with a related physician network—transitioning to new operators (an eighth Steward facility, Norwood Hospital, has been closed since it flooded in 2020). This crisis strained resources, impacted access to care, and reduced trust in the health care system.

This report presents an integrated view of health care spending trends, access and affordability, hospital utilization and financial performance, behavioral health indicators, and key quality metrics. The analysis included in this report draws from multiple CHIA datasets to present a holistic picture of the performance of the health care system and impacts on Massachusetts residents.

Total Health Care Expenditures

In 2024, health care spending per resident reached $11,663, a 5.7 percent increase from 2023.[1] Massachusetts THCE totaled $83.3 billion in 2024. This represents an increase of $5.2 billion from 2023, during which the state's population increased 0.9 percent.[2]

On a service category level, all claims-based service categories experienced growth from 2023 to 2024. Prescription drug spending amounted to $12.3 billion in 2024 and represented the largest share of THCE spending growth net of prescription drug rebates, accounting for 23.2 percent of the growth. Hospital outpatient services amounted to $15.3 billion in 2024 and accounted for 21.8 percent of THCE growth net of prescription drug rebates. Notably, drugs administered in a hospital outpatient setting composed 20.8 percent of all hospital outpatient spending in 2024. Spending for other professional services delivered by non-physician providers was the third-largest driver of THCE growth by service category, increasing $781.1 million in 2024 and accounting for 16.0 percent of growth net of prescription drug rebates.

From 2023 to 2024, membership increased in both the private commercial and Medicare insurance categories (2.2 percent and 1.7 percent, respectively). MassHealth membership declined by 12.3 percent during this period.

Access and Affordability

Despite boasting near-universal health care coverage statewide, Massachusetts residents face growing health care affordability challenges from rising health care costs, including multi-year increases in premiums and member cost-sharing (copayments, coinsurance, and deductibles).

From 2022 to 2024, health care expenses grew faster than Massachusetts wages and salaries. Health care costs are just one type of household expense to consider

for Massachusetts residents; growth in spending for other necessities, such as housing, food, and childcare, increased even faster than health care costs, which can further strain household budgets and affect individuals' and families' ability to afford health care.

Monthly health care premiums and out-of-pocket costs are shaped by the type of plan in which members enroll as well as how members access health insurance—such as through their employer or the insurance marketplace (i.e., the Massachusetts Health Connector)—which ultimately affect members' overall ability to afford care. In 2023 and 2024, substantial shifts in enrollment occurred across the individual purchaser market sector, primarily due to both the resumption of MassHealth redetermination processes and the ConnectorCare expansion pilot program that raised income eligibility, allowing more residents to access lower-cost coverage.

Premiums paid by members and employer groups that offer health insurance fund the majority of private commercial health care spending. From 2023 to 2024, fully insured premiums across both individual purchasers and employer-sponsored insurance (ESI) increased 2.9 percent to $649 per member per month (PMPM) following a 5.9 percent increase the prior year. Among employer-sponsored plans only, fully insured premiums grew 4.8 percent in 2024, which followed a 6.0 percent increase the year before.

In addition to monthly premium costs, health care affordability is impacted by member cost-sharing expenses. In 2024, total private commercial member cost-sharing (inclusive of both fully and self-insured plans) increased 4.4 percent to $71 PMPM following a 7.6 percent increase in 2023.

For members covered by employer-sponsored plans, premiums and cost-sharing varied by market sector, with smaller group employers experiencing greater cost pressures. For example, members enrolled in plans offered by small and mid-size employers had a smaller proportion of their medical costs covered by their health plans (83.5 percent and 86.5 percent, respectively) in 2024 despite paying similar or higher monthly premiums than members enrolled in plans offered by larger employer groups. Furthermore, the small and mid-size group sectors had the fastest growth in member cost-sharing PMPM among employer-sponsored plans between 2023 and 2024 (10.1 percent and 8.9 percent, respectively).

These trends are attributable in part to the variation in the number and types of plans offered to employees across employer sizes, affecting employee plan choice, cost-sharing, and services covered. Employees at small and mid-size employers have more limited choices compared with their counterparts at larger employers. While more than two-thirds of employers (66.8 percent) offer health insurance benefits, small and mid-size employers were

more likely to offer only 1 health plan and more likely to offer only high-deductible health plans (HDHPs) than larger employers.

In accordance with federal Internal Revenue Service rules, an HDHP was defined as a plan with a deductible greater than or equal to $1,600 for single coverage in 2024. As a share of the private commercial market, HDHP enrollment declined in 2024 to 36.5 percent (approximately 1.6 million Massachusetts members), diverging from a long-term growth trend since 2014. HDHP enrollment fell across all market sectors except mid-size groups and continued to be highest among unsubsidized individual purchasers (82.3 percent), small group employers (74.3 percent), and mid-size group employers (70.0 percent). The overall growth in HDHP enrollment over nearly a decade has raised concerns about affordability and impacts on members' access to care.

These trends in premiums, member cost-sharing, and HDHP enrollment impact the ability of Massachusetts families to pay for needed health care. In 2025, 2 in 5 Massachusetts residents (40.3 percent) reported that they had issues affording health care for their families within the past 12 months. The burden of affordability issues was greater for Black and Hispanic residents, with 54.1 percent and 47.3 percent of Black and Hispanic residents, respectively, reporting at least 1 affordability issue in the past 12 months compared with 37.3 percent of White residents.

Moreover, 1 in 8 residents reported that their family held medical debt in 2025, with nearly all residents attributing the debt to cost-sharing while all family members were insured.

Private Commercial Insurance

Total expenditures for members enrolled in private commercial health plans, which include fully and self-insured coverage, increased 10.8 percent from 2023 to 2024, accounting for nearly 60 percent of the growth in THCE. During the same period, private commercial enrollment increased 2.2 percent, with most growth in the ConnectorCare program. On a PMPM basis, private commercial health care expenditures increased 8.5 percent.

Hospital outpatient and pharmacy spending were the largest private commercial service categories. From 2023 to 2024, commercial hospital outpatient spending increased 9.5 percent, resulting in a 7.2 percent increase PMPM. Before accounting for rebates, pharmacy spending increased 17.4 percent overall and 14.9 percent PMPM. Pharmacy spending net of rebates similarly increased 17.3 percent overall and 14.9 percent PMPM. Outside of pharmacy, other medical spending increased the fastest among commercial service categories, growing 13.6 percent (11.2 percent PMPM) from 2023 to 2024. Spending for physician, hospital inpatient, other professional, and non-claims service categories all increased in 2024, as well.

Health insurance premiums are set prospectively based on historical data and projected growth in claims and administrative costs. Premium revenue is used to cover member health care expenses (i.e., claims costs) as well as general administrative costs (e.g., taxes, fees, salaries, and broker commissions, hereafter referred to as "non-medical expenses") and contributions to surplus. The 2024 premiums were largely calculated in early 2023 using 2022 health care spending data and projections of future utilization, unit costs, and other factors impacting premium rate development. In 2024, 90.7 percent of premium revenue was used to pay for fully insured members' medical care. The remaining 9.3 percent was less than payers' costs for plan administration and other expenses, resulting in average financial losses for payers across the fully insured market, a reversal in trends from recent years.

Public Insurance Programs

MassHealth expenditures represented 28.2 percent of total THCE in 2024. Spending increased 5.6 percent overall and 20.4 percent PMPM. In April 2023, MassHealth resumed the eligibility redetermination process, resulting in a 12.3 percent annual decrease in membership in 2024. This was the first yearly enrollment decline since 2019 and resulted in a MassHealth population with more complex health needs (i.e. higher acuity).

Both enrollment and expenditures declined for Primary Care ACO (PCACO) and Primary Care Clinician (PCC) plans. Conversely, Accountable Care Partnership Plans and Managed Care Organization (ACPP/MCO) plans as well as fee-for-service (FFS) coverage faced increasing expenditures despite the decline in enrollment, resulting in PMPM increases of 19.1 percent and 23.6 percent, respectively. Only the Senior Care Options (SCO), Program of All-inclusive Care for the Elderly (PACE), and One Care programs collectively experienced increases in both enrollment and expenditures.

Among service categories, other medical was the largest claims-based category, accounting for $4.5 billion in 2024. This was a 9.8 percent increase compared with 2023 and represented the largest contributor to MassHealth's overall increase in expenditures (32.4 percent). These services include long-term care, home health, community health, and dental services. Long-term care, home health, and community health accounted for 85.4 percent of the category's growth.

Total Medicare spending increased 5.1 percent from 2023 to 2024 accompanied by a 1.7 percent increase in overall enrollment, resulting in 3.4 percent PMPM growth. Medicare Advantage spending increased at a faster rate than original Medicare (15.7 percent and 2.1 percent, respectively) as the share and number of members enrolling in Medicare Advantage plans continued to grow.

From 2023 to 2024, total spending increased across all claims-based Medicare service categories. Hospital inpatient spending was the largest category, increasing 4.8 percent (3.0 percent PMPM). Of the claims-based categories with more than $1.0 billion attributed to them in 2024, hospital outpatient spending experienced the fastest growth, increasing 7.4 percent (5.6 percent PMPM).

Provider and Health System Trends

Over the past several years, hospitals have experienced fluctuations in utilization—comprising discharges and visits—and average length of stay (ALOS), which may contribute to ongoing capacity challenges. These pressures were further compounded by the Steward Health Care bankruptcy filing and the subsequent closure of 2 hospitals.

Utilization in all acute care hospital settings inpatient, emergency department (ED), and outpatient observation—increased after declining during the COVID-19 pandemic and has remained stable for the past few years, though volumes remain below pre-pandemic levels. Conversely, ALOS increased through the pandemic and has since declined.

The statewide acute hospital median total margin decreased 1.6 percentage points, from 2.2 percent in hospital fiscal year (HFY) 2023 to 0.6 percent in HFY 2024. The statewide median operating margin was -2.0 percent in HFY 2024, a decrease of 2.2 percentage points, while the median non-operating margin remained stable at 1.6 percent.

Aggregate acute hospital total operating revenue increased 6.5 percent while aggregate expenses increased 6.8 percent from HFY 2023 to HFY 2024. Aggregate revenue exceeded aggregate operating expenses by $59.0 million. In HFY 2024, workforce spending represented 41.5 percent of acute hospitals' total expenses, down from 43.3 percent in HFY 2023. Temporary labor expenses represented 5.9 percent of workforce expenditures, a 2.3 percentage point decrease from HFY 2023.

In HFY 2025 year-to-date (YTD) data available through June 30, 2025, acute hospitals reported a statewide median total margin of 2.7 percent. The median operating margin was 1.8 percent during this period while the median non-operating margin was 0.9 percent. This period reflects 9 months of fiscal year data for most hospitals.

In calendar year (CY) 2024, there were 328 skilled nursing facilities that accepted publicly aided residents with a total of 38,685 licensed beds. The overall system-level occupancy rate, which is a measure of utilization based on licensed bed capacity, was 83.9 percent, remaining steady compared with the CY 2023 system-level occupancy rate of 83.8 percent.

Behavioral Health

Expanded access to behavioral health services in Massachusetts has increased residents' ability to obtain outpatient and inpatient care for mental health (MH) and

substance use disorder (SUD) conditions, contributing to higher utilization of these services. However, affordability challenges persist for many residents seeking behavioral health care. For example, more than 1 in 6 Massachusetts residents reported paying for their most recent behavioral visit entirely out of pocket, most commonly for reasons related to providers accepting insurance coverage.

In 2024, nearly of a quarter of Massachusetts residents had a behavioral health diagnosis, similar to the prior year. MassHealth accounted for the highest percentage of members with a behavioral health diagnosis in 2024 at 32.7 percent, followed by commercial at 22.4 percent and Medicare Advantage at 13.5 percent. In 2024, 22.4 percent of total MassHealth expenditures were attributed to behavioral health while 8.1 percent of total commercial and 2.3 percent of total Medicare Advantage expenditures were attributed to behavioral health, similar proportions to 2023.

Among commercially insured members, behavioral health spending was higher for pediatric patients than for adults. The inverse was true for MassHealth, for which behavioral health spending was higher for adults than for pediatric patients driven by higher adult utilization of SUD inpatient services.

Private commercial and Medicare Advantage plan members had higher proportional out-of-pocket spending for mental health services than for other service types, reflecting shifts in product design and increased MH and SUD claims across both facility and professional settings.

Inpatient discharges related to behavioral health at acute and non-acute hospitals have stabilized in recent years following volume fluctuations through the COVID-19 pandemic.

Alternative Payment Methods and Quality Metrics

Alternative payment methods (APMs) shift payer-provider insurance contracts from traditional FFS models to value-based payments. In Massachusetts, the most common APMs are global budgets, which set spending targets for a comprehensive set of health care services to be delivered to a defined population. Between 2023 and 2024, APM adoption declined slightly across commercial and Medicare Advantage markets while continuing to increase for MassHealth ACPP/MCO contracts. Notably, after remaining stable at approximately 40 percent since 2016, the share of private commercial health plan members enrolled in APMs declined to 35.1 percent in 2024.

Similar to APM spending targets, quality metrics also support value-based care and highlight opportunities to improve patient experiences and outcomes. Quality metrics are routinely integrated into global budget contracts, ensuring that payment incentives are directly tied to provider performance on priority measures.

This report presents payers' adherence to the Commonwealth's

recommended Aligned Measure Set in their APM contracts with providers. The Aligned Measure Set identifies a selection of high-priority quality measures for use in specific provider contracts to promote aligned accountability across payers and providers. Across participating payers, the overall adherence to the Commonwealth's recommended Aligned Measure Set in APM contracts increased to 96 percent in 2024, indicating improved alignment since CHIA began collecting this data in 2019.

Statewide scores on a subset of Aligned Measure Set metrics are also reported, including clinical quality and commercial patient-reported experiences in primary care settings. While the statewide rates provided in this report are valuable for monitoring overall performance on priority quality metrics, CHIA publishes provider-specific results in the **Quality of Care in the Commonwealth: Select Clinical Quality and Patient Experience Measures dashboard**.

New in this year's Annual Report, CHIA presents 2024 private commercial clinical quality data and patient experience survey results stratified by race and ethnicity. Analysis of the clinical quality scores reveals potential racial and ethnic disparities in measure performance across all 4 major quality domains: behavioral health, chronic conditions, pediatrics, and preventive care. This report also includes results from private commercial members surveyed on their experiences with primary care visits. Despite high statewide scores in 2024, statistically significant differences in scores across race and ethnicity were found in key patient experience domains, including Communication and Office Staff. Measures with lower statewide scores exhibit even larger statistically significant disparities between certain racial and ethnic groups. Findings from a similar survey of members enrolled in MassHealth Accountable Care Organizations (including ACPPs and PCACOs) are presented in this report; however, results are not stratified.

For a detailed review of CHIA's health equity-focused quality reporting, explore the **Equity in Quality of Care** report. ■

Executive Summary Notes

1. The 5.7 percent increase in THCE per capita is gross of rebates and does not account for prescription drug rebates received by payers.
2. In determining total population of Massachusetts, CHIA has historically referred to the American Community Survey (ACS) 1-year estimates due to their static nature. However, starting in this report, CHIA now refers to the Census Bureau's Population Estimates Program (PEP), which is updated yearly. This is to ensure the usage of the most up-to-date estimates available.

KEY FINDINGS

Total Health Care Expenditures

THCE PER CAPITA TREND

5.7%

THCE per capita was $11,663, an increase of 5.7%—above the health care cost growth benchmark but a deceleration from the prior year's growth of 8.6%. Overall THCE increased $5.2 billion from 2023.

Pharmacy spending continued to drive THCE spending growth in 2024, increasing by $1.5 billion (9.8%) over 2023. After adjusting for rebates, pharmacy spending increased by $1.1 billion, accounting for 23.2% of overall net THCE growth.

Hospital outpatient services was the second-largest source of THCE spending growth (21.8% of overall net THCE growth) in 2024, increasing $1.1 billion. An estimated one-fifth of hospital outpatient spending was for provider-administered drugs.

From 2023 to 2024, commercial spending grew 10.8% (8.5% PMPM), Medicare 5.1% (3.4% PMPM), and MassHealth 5.6% (20.4% PMPM). Enrollment in the commercial market increased for the first time since the pandemic, growing by 2.2%. Medicare enrollment increased at 1.7%. MassHealth enrollment decreased 12.3% due to redeterminations.

Total Health Care Expenditures

A key provision of the Massachusetts health care cost containment law, Chapter 224 of the Acts of 2012, was the establishment of a benchmark against which the annual change in health care spending growth would be evaluated.

CHIA is charged with calculating Total Health Care Expenditures (THCE) and comparing its per capita (per resident) growth with the health care cost growth benchmark set by the Health Policy Commission.

From 2013 to 2017, the health care cost growth benchmark was set at 3.6 percent. For the 2018 to 2022 performance periods, the benchmark was set at 3.1 percent. In 2023, the benchmark returned to 3.6 percent.[1]

THCE encompasses health care expenditures for Massachusetts residents from public and private sources, including all categories of medical expenses and all non-claims-related payments to providers; all patient cost-sharing amounts, such as deductibles and copayments; and the cost of administering private health insurance (called the net cost of private health insurance or NCPHI). It does not include out-of-pocket payments for goods and services not covered by health insurance, such as over-the-counter medicines, nor does it include standalone vision and dental plans.*

* THCE was developed to support comparison to the Commonwealth's health care cost growth benchmark and accompanying accountability framework for health care payers and providers. By design, THCE does not fully account for the financial burden of health care on Massachusetts residents. For example, it does not include out-of-pocket payments for goods and services not covered by health insurance (such as over-the-counter medicines), nor does it include spending or premium amounts for standalone vision and dental plans. As a result, THCE for Massachusetts has consistently been lower than federal estimates of personal health expenditures and may also differ from other similar estimates of health care spending created for other purposes.

Throughout this chapter, THCE is broken down into its major components: commercial, Medicare, MassHealth, NCPHI, and other public program spending.

Per member per month (PMPM) spending for commercial, Medicare, and MassHealth was calculated using total component spending divided by total component membership. However, THCE per capita was calculated using THCE divided by the Massachusetts population, sourced from the U.S. Census Bureau's Population Estimates Program Vintage 2025 data.[2] Due to differences in the numerators and denominators, PMPM spending by component cannot be used to calculate THCE per capita. ■

Total Health Care Expenditures

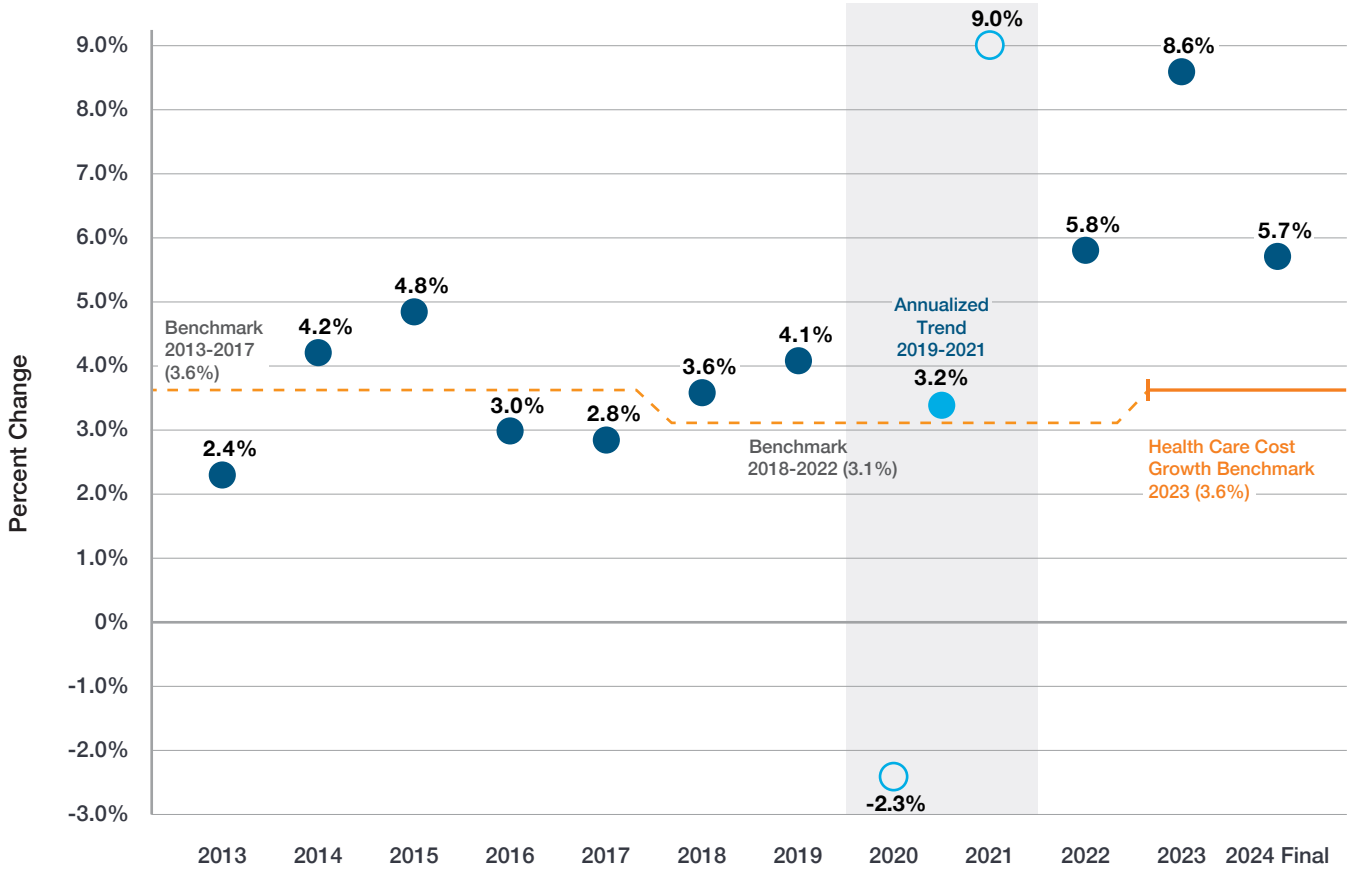
From 2023 to 2024, THCE increased 6.7% overall and 5.7% per capita. This was above the health care cost growth benchmark. THCE per capita growth decelerated compared with last year's trend (8.6%), which was the second-highest 1-year growth trend since measurement began in 2013. Nevertheless, THCE per capita growth has exceeded the benchmark for the past 4 years.

In 2024, the 5.7% per capita THCE increase was larger than that of the Massachusetts economy (5.5%), annual average weekly wages (5.0%), and regional inflation (3.2%).[3,4,5] Nationally, the estimated increase in health care spending was 7.2% in 2024, outpacing the 5.3% average growth rate in national gross domestic product (GDP).[6]

Pharmacy spending both gross and net of rebates represented the largest driver of gross THCE growth. Gross of rebates, pharmacy spending accounted for 28.2% ($1.5 billion) of the total increase from 2023 to 2024. After adjusting for rebates, pharmacy spending represented 23.2% of net THCE growth.

Spending on hospital outpatient services was the second-largest portion of gross THCE growth (20.4%) in 2024, increasing $1.1 billion.[7] The third-largest contributor to THCE growth in 2024 was other professional services (14.9%), which includes services provided by a licensed practitioner other than a physician,[8] such as nurse practitioners, psychologists, and community health centers, among others.

Per Capita Total Health Care Expenditure Trends, 2013-2024



Total Health Care Expenditures per capita increased 5.7% from 2023 to 2024, above the health care cost growth benchmark, and faster than annual average weekly wages.

Source: Payer-reported data to CHIA and other public sources.

Notes: THCE per capita calculated using Massachusetts state population sourced from U.S. Census Bureau's Population Estimates Program vintage 2025 data. THCE does not include federal funding for public health activities or any COVID-19 relief funds distributed from federal government directly to hospitals and health systems. THCE does include COVID-19 supplemental payments distributed by MassHealth.

Total Health Care Expenditures

Massachusetts THCE totaled $83.3 billion in 2024. This represents an increase of $5.2 billion from 2023, during which the state's population increased 0.9%.[9] THCE spending per resident reached $11,663 per capita in 2024, a 5.7% increase from 2023.

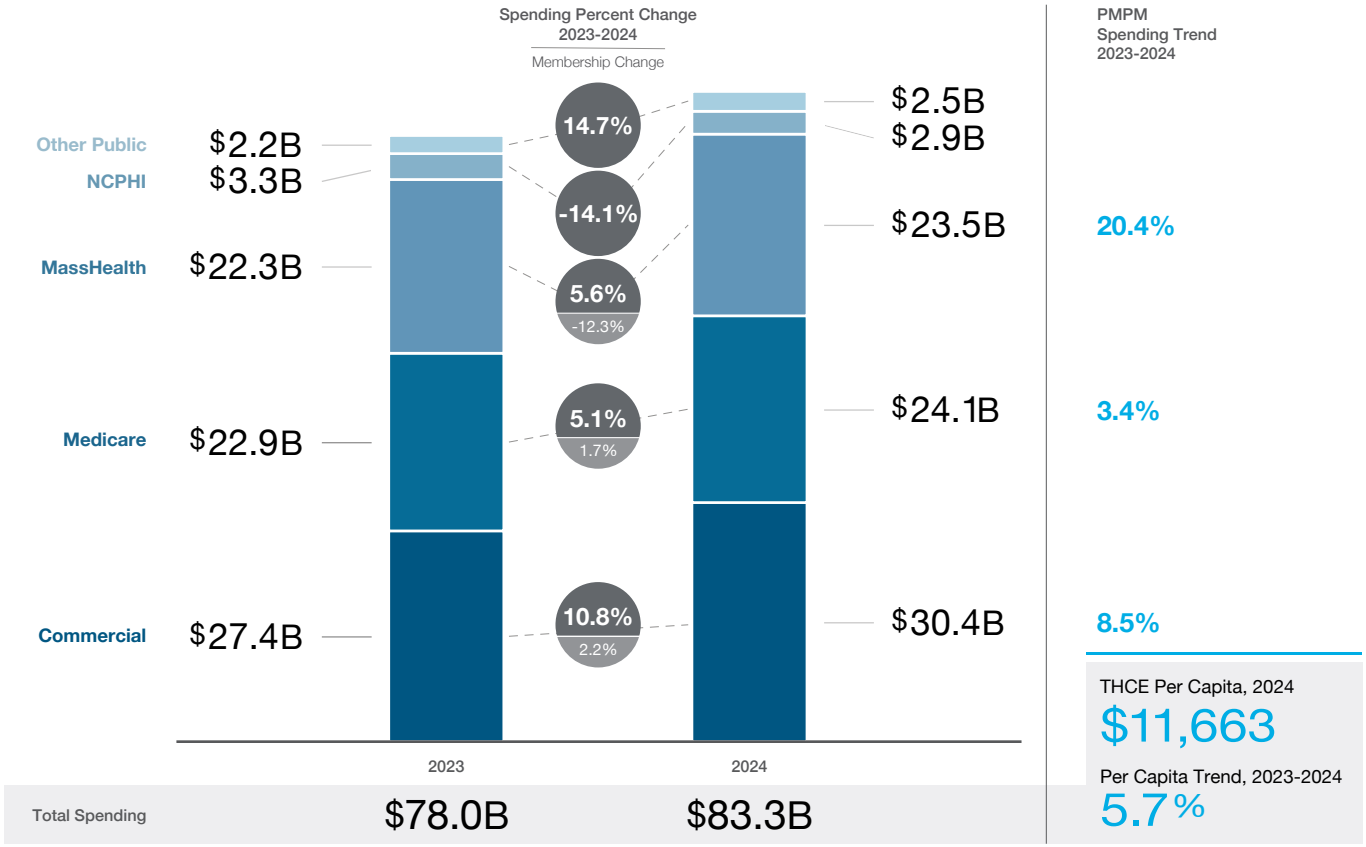
Total commercial spending increased 10.8% to $30.4 billion in 2024. After 4 years of declining enrollment, commercial enrollment increased 2.2% in 2024, with this growth mostly concentrated in the ConnectorCare program.[10] On a per member per month (PMPM) basis, commercial spending increased 8.5% from 2023 to 2024.

Medicare spending increased 5.1% in 2024, totaling $24.1 billion, while Medicare membership increased 1.7% during this time period. Overall, Medicare spending grew 3.4% PMPM from 2023 to 2024.

MassHealth spending increased 5.6% in 2024, totaling $23.5 billion. MassHealth enrollment decreased by 12.3% in 2024, the first yearly enrollment decline since 2019. MassHealth resumed redetermination processes in April 2023, disenrolling ineligible individuals for the first time since March 2020. As membership shifted, the MassHealth population in 2024 had higher overall acuity than in 2022 and 2023. Concurrently, MassHealth spending increased 20.4% PMPM in 2024, an acceleration from 8.9% in 2023. Excluding all supplemental payments, MassHealth spending related to member care increased 19.3% PMPM.

NCPHI declined 14.1% in 2024 after increasing 6.5% the previous year. NCPHI tends to fluctuate year to year as health insurance premiums are set prospectively based on historical data and actuarial assumptions.

Components of Total Health Care Expenditures by Insurance Category, 2023-2024



THCE totaled $83.3 billion or $11,663 per resident in 2024.

Source: Payer-reported data to CHIA and other public sources.

Notes: Percent changes calculated based on non-rounded expenditure amounts. THCE per capita calculated using Massachusetts state population sourced from U.S. Census Bureau's Population Estimates Program vintage 2025 data. See databook for detailed information.

Total Health Care Expenditures

Within the commercial insurance market, private payers offer a variety of insurance product types that vary by the provider networks offered, referral requirements, and cost-sharing levels, among other factors.

From 2023 to 2024, commercial spending increased 10.8% overall and 8.5% PMPM, similar to the PMPM growth between 2022 and 2023 (8.6% PMPM). Membership in private commercial plans increased by 2.2% in 2024—reversing prior years' declines and coinciding with MassHealth redeterminations.

Health maintenance organization (HMO) plans, which require members to select a primary care provider to manage care, continued to be the most common commercial insurance product among Massachusetts residents. In 2024, HMO membership increased the fastest of all plans at 4.5% as spending increased 12.5%, resulting in a 7.7% increase in PMPM spending.

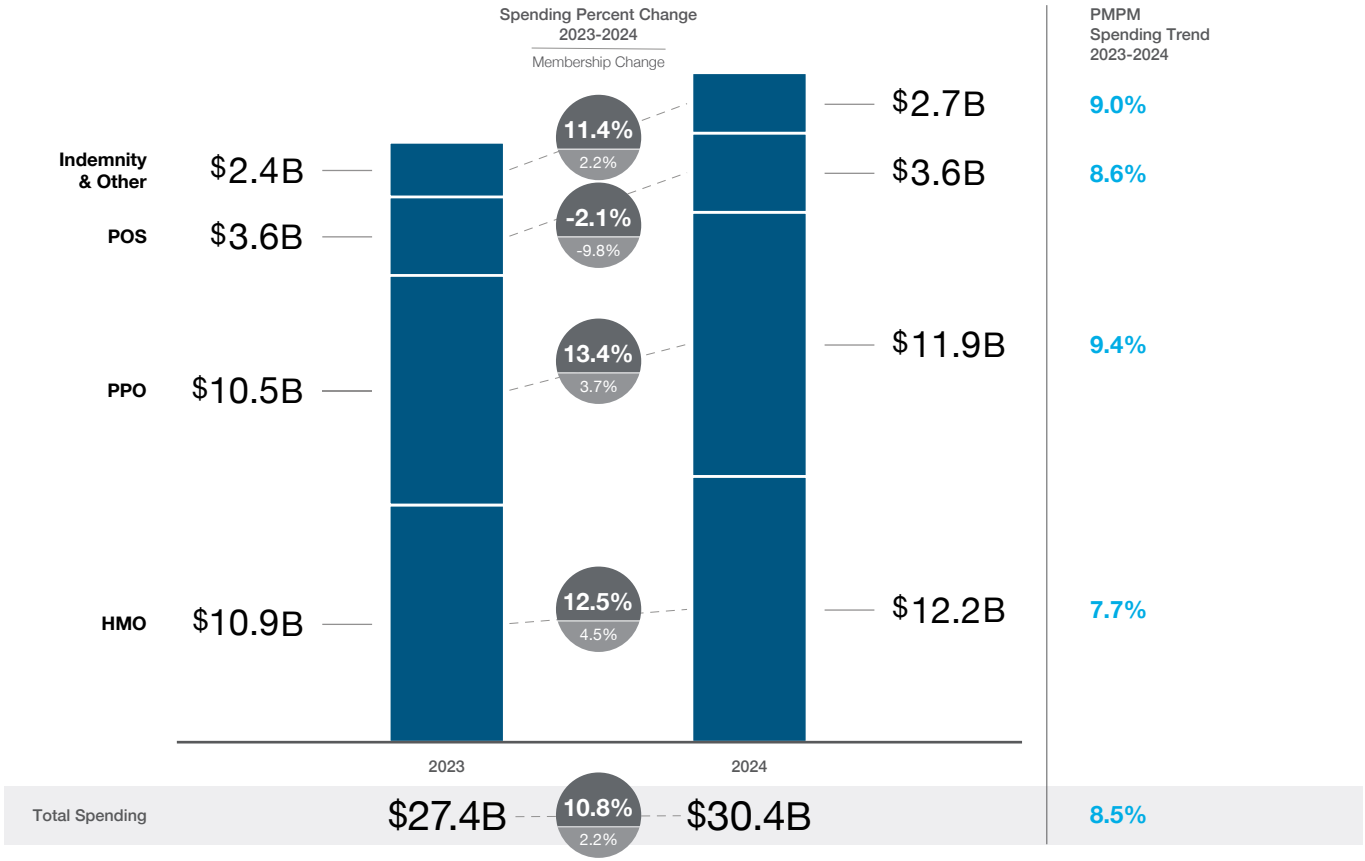
Preferred provider organization (PPO) plans, which allow members to schedule visits without a referral, experienced a 3.7% increase in membership accompanied by a 13.4% increase in spending, resulting in a 9.4% increase in PMPM spending.

Point-of-service (POS) plans, which offer both in-network and out-of-network coverage options, experienced a decrease in both membership and spending (9.8% and 2.1%, respectively).

Membership continued to increase in indemnity and other plans, growing 2.2% in 2024. Spending increased 11.4%, resulting in a 9.0% increase in PMPM spending. Wellpoint, which offers plans only through the Massachusetts Group Insurance Commission (GIC), represents more than a third of total indemnity and other product type membership and spending.

Components of Total Health Care Expenditures:
Private Commercial Insurance by Product Type, 2023-2024

THCE COMPONENTS Detailed View



From 2023 to 2024, commercial spending increased 10.8% accompanied by a 2.2% increase in membership, resulting in an 8.5% increase in PMPM spending overall.

Source: Payer-reported data to CHIA and other public sources.

Notes: For additional information on commercial enrollment trends, see CHIA's Enrollment Trends reporting. For commercial partial-claim data, CHIA estimates spending by product type by multiplying share of member months reported in TME data by estimated total commercial partial-claim expenditures. Percent changes calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

Within the Medicare program, eligible individuals choose between traditional Medicare coverage administered by the federal government ("Original Medicare") and Medicare Advantage products managed by private insurers. Most Massachusetts beneficiaries receive coverage through Original Medicare (71.6% in 2024). However, the share of members enrolled in Medicare Advantage plans continued to grow, from 26.7% in 2023 to 28.4% in 2024.

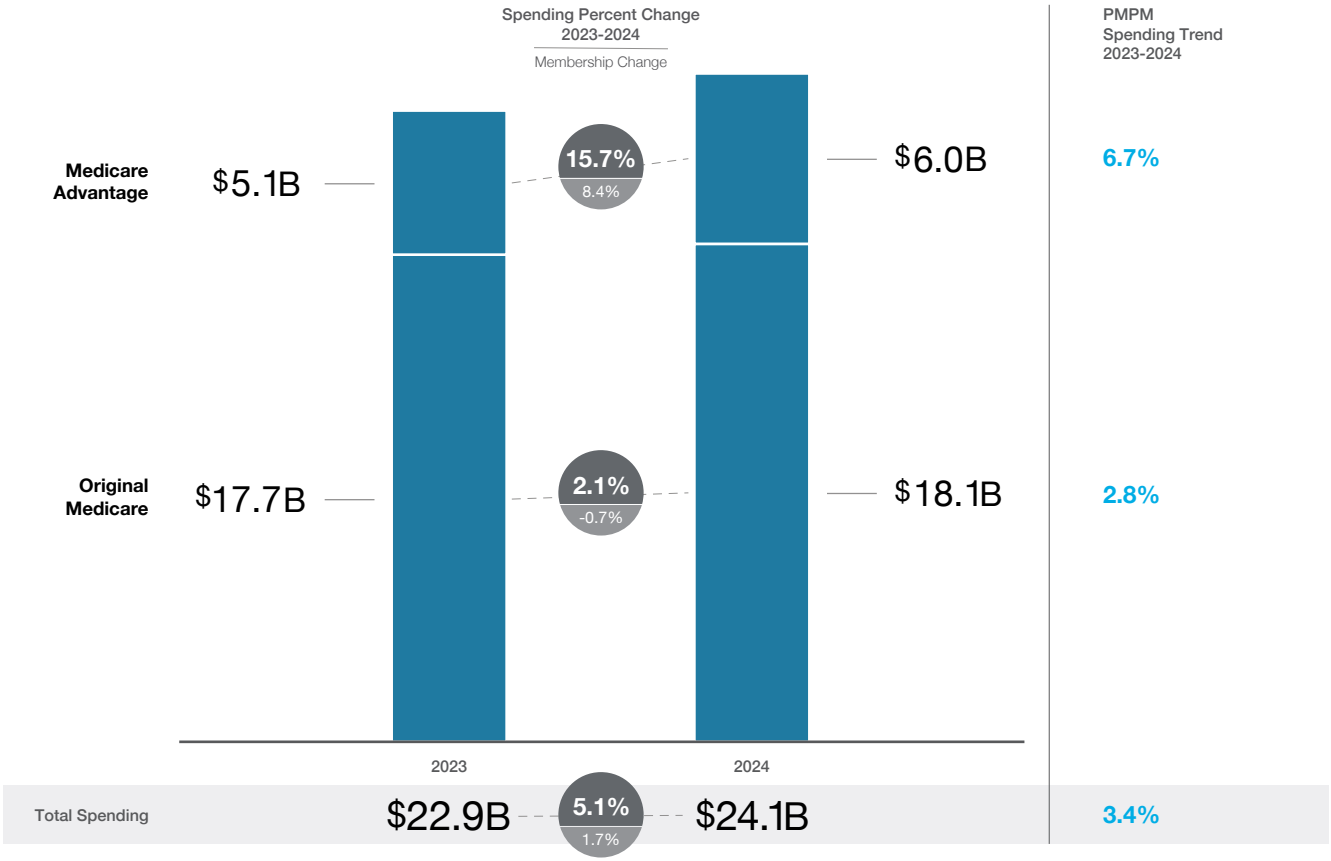
In 2024, approximately 1.3 million Massachusetts residents were enrolled in Medicare, the federal health insurance program for people age 65 and older as well as those with long-term disabilities. Total Medicare enrollment in Massachusetts increased 1.7% from 2023 to 2024, accompanied by a 5.1% increase in expenses, resulting in 3.4% spending growth PMPM.

Membership in Original Medicare declined by 0.7% and spending increased by 2.1% in 2024, resulting in a 2.8% PMPM increase. This is lower than the national trend, which reflected an increase of 4.9% PMPM in 2024.[11]

The growth observed in Medicare Advantage membership has been partially attributed to additional benefits as well as consolidated Parts B and D premium payments offered by Medicare Advantage plans that are not offered with Original Medicare.[12] Medicare Advantage enrollment increased by 8.4% and spending increased 15.7% from 2023 to 2024. This resulted in a 6.7% increase in PMPM spending.

Components of Total Health Care Expenditures:
Medicare by Program Type, 2023-2024

THCE COMPONENTS Detailed View



From 2023 to 2024, Medicare spending increased 5.1% overall and 3.4% PMPM. Growth was faster among Medicare Advantage plans, which increased 6.7% PMPM.

Source: Payer-reported data to CHIA and other public sources.

Notes: For additional information on enrollment in Medicare programs, see CHIA's Enrollment Trends reporting. Original Medicare includes Part D expenditures for traditional Medicare enrollees. In THCE, beneficiaries dually eligible for Medicare and Medicaid and enroll in plans specifically designed to better coordinate their care (e.g., Senior Care Options) are included in MassHealth spending; as a result, share of spending attributable to Medicare may not be comparable to figures published by other sources. Percent changes calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

Approximately 2.1 million Massachusetts residents relied on MassHealth for either primary or partial/secondary medical coverage in 2024. From 2023 to 2024, MassHealth spending increased 5.6% while membership decreased 12.3%, resulting in a 20.4% increase in PMPM spending. This represented the first year of MassHealth membership declines since the COVID-19 pandemic due to eligibility redeterminations resuming in April 2023 onward.[13] MassHealth's 2024 trends reflect a deceleration in spending growth overall but faster increases on a PMPM basis compared with 2023.

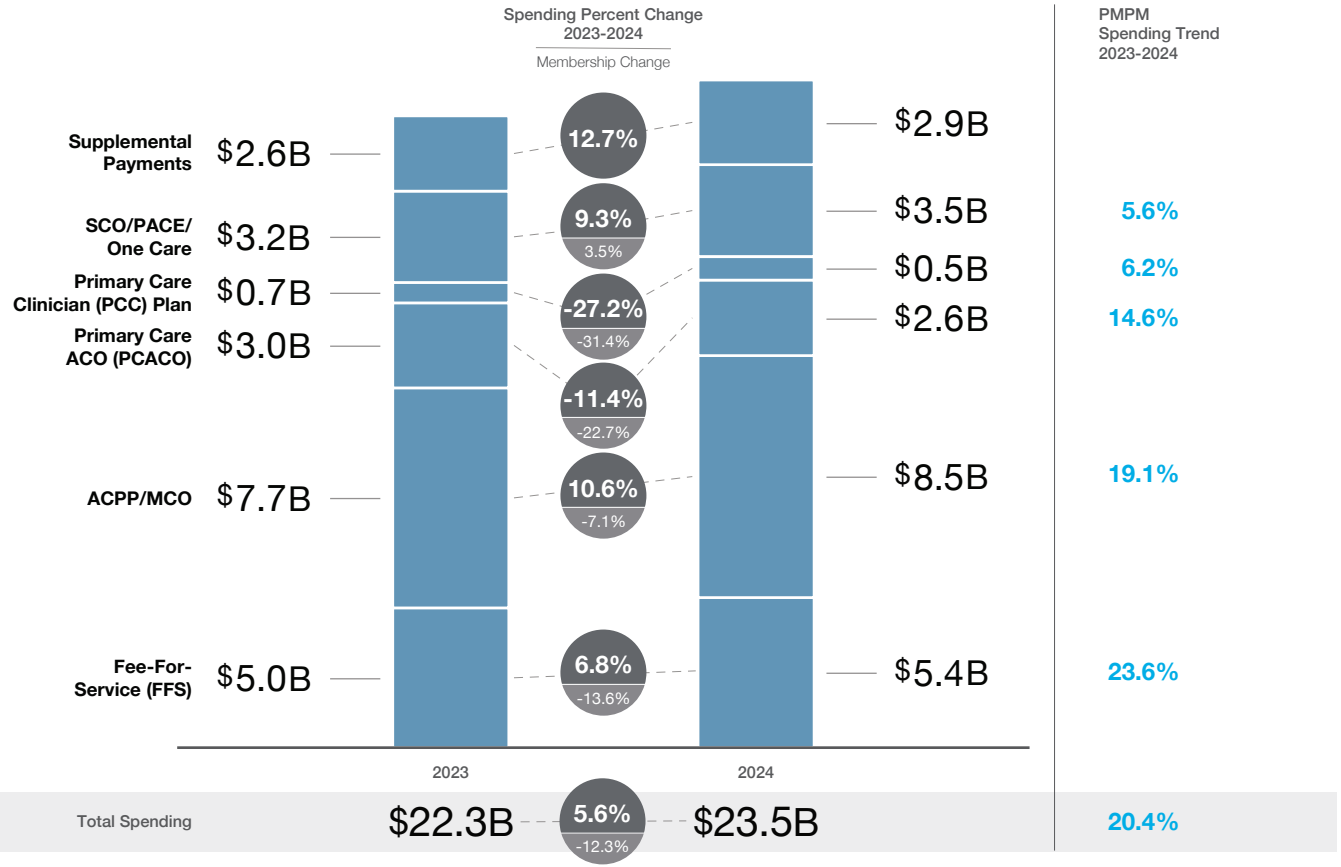
In 2024, enrollment declined for MassHealth FFS (13.6%), PCACO (22.7%), and PCC (31.4%) plans, but increased 3.5% for SCO, PACE, and One Care plans combined.[14] MassHealth FFS had the highest PMPM increase at 23.6%, as spending increased 6.8%.[15]

While ACPP/MCO plans also showed a decline in enrollment (7.1%), spending grew 10.6%, resulting in a 19.1% increase in PMPM spending and representing 65.7% of the overall MassHealth spending increase in 2024.[16] Approximately 66% of members with MassHealth primary coverage were enrolled in an ACPP or MCO in 2024.

MassHealth supplemental payments increased 12.7% from 2023 to 2024, representing 26.3% of the overall MassHealth increase. In 2024, MassHealth administered $277 million in one-time payments to support continuity of access to high public payer acute hospitals during Steward Health Care's ownership transition.[17] Additionally, MassHealth continued to administer supplemental payments focused on health equity incentives ($92.5 million increase from 2023) and hospital base rate increases ($60.0 million increase from 2023), both funded by a hospital assessment plus federal matching dollars.[18]

Components of Total Health Care Expenditures:
MassHealth by Program Type, 2023-2024

THCE COMPONENTS Detailed View



From 2023 to 2024, MassHealth spending increased 5.6%, accompanied by the first decline in overall membership (12.3%) since 2020.

Source: Payer-reported data to CHIA and other public sources.

Notes: In this report, CHIA refers to what were formerly called MassHealth ACO-A plans as ACPPs (Accountable Care Partnership Plans) and MassHealth ACO-B plans as PCACOs (Primary Care ACOs) to align with current MassHealth naming conventions. For additional information on enrollment in MassHealth programs, see CHIA's **Enrollment Trends** reporting. MassHealth programs for dually eligible members include Senior Care Options (SCO) for members age 65 and older; the Program of All-inclusive Care for the Elderly (PACE) for members 55 and older; and One Care for members ages 21 to 64. One-third of dually eligible members are captured in PACE/SCO/One Care programs, with remaining receiving MassHealth coverage through fee-for-service programs. Percent changes calculated based on non-rounded expenditure amounts. MassHealth enhanced payment rates distributed to hospitals, certain health care facilities (e.g., skilled nursing facilities), physicians, and other professionals through claims payments reflected in relevant spending categories reported here. See **databook** for detailed information.

Total Health Care Expenditures

NCPHI captures the administrative costs of private health insurance and is broadly defined as the difference between the premiums health plans receive on behalf of Massachusetts residents and the expenditures for covered benefits incurred for those same members. NCPHI balances are used to maintain reserves and pay general administrative expenses and broker commissions as well as taxes and fees. For more information on how payers use premium funds, see page 79.

Premiums are set prospectively based on historical data and actuarial assumptions; as a result, NCPHI fluctuates from year to year depending on how closely the actuarial projections match actual spending on health care services.

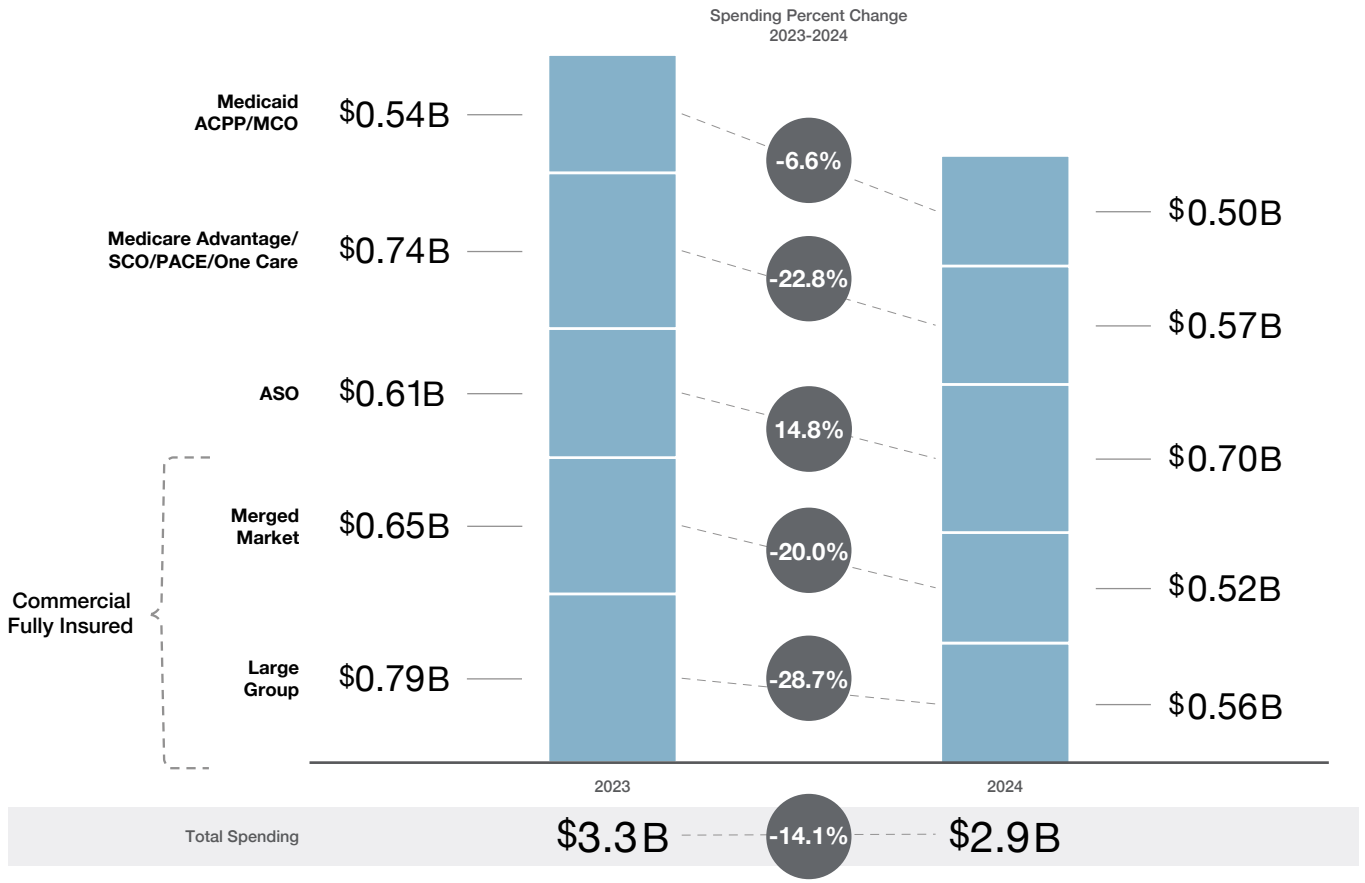
From 2023 to 2024, total NCPHI declined 14.1% after increasing 6.5% the prior year. In 2024, NCPHI declined across all markets except for the private commercial self-insured ASO market, which increased 14.8%.[19]

In the private commercial market, NCPHI declined for the large group market at 28.7% and the merged market at 20.0%. Commercial payers attributed this to higher than anticipated claims trends, driven by key cost drivers such as increased utilization of GLP-1 drugs.

NCPHI for commercially managed Medicare Advantage, SCO, PACE, and One Care plans declined 22.8%, which some payers attributed to increasing utilization of supplemental benefits. Certain payers also cited the decline of their star ratings, which resulted in lower quality and performance-based federal bonus payments from CMS.[20, 21] NCPHI for commercially managed Medicaid ACPP/MCO plans declined 6.6%, which many payers attributed to continuing eligibility redeterminations and the resulting changes in market risk profile and member acuity.

Components of Total Health Care Expenditures:
Net Cost of Private Health Insurance by Market Sector, 2023-2024

THCE COMPONENTS
Detailed View



From 2023 to 2024, NCPHI declined 14.1% following a 6.5% increase the prior year.

Source: Massachusetts medical loss ratio reports from Massachusetts Division of Insurance; federal medical loss ratio reports provided to Center for Consumer Information and Insurance Oversight and received via Massachusetts insurers.

Notes: Larger group combines fully insured mid-size, large, and jumbo groups. ASO (self-insured) reflects fees collected by payers for administrative services only. Medical loss ratio rebates and premium credits paid to members were subtracted from premiums in calculation of NCPHI. See databook for detailed information.

Total Health Care Expenditures

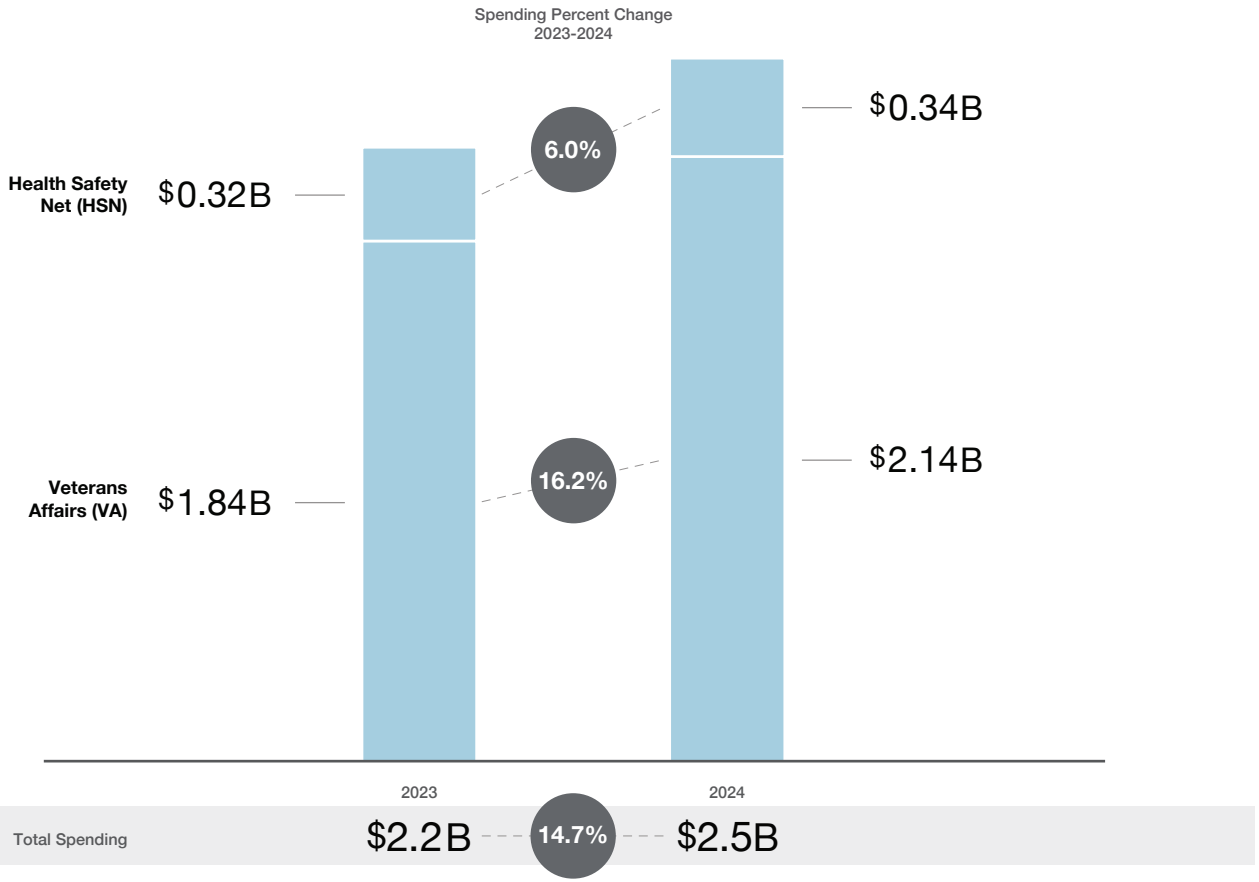
The U.S. Department of Veterans Affairs (VA), through its Veterans Health Administration division, provides health care for certain eligible U.S. military veterans.

Medical spending for Massachusetts veterans increased 16.2% from 2023 to 2024. National VA medical spending mirrored this growth, increasing 14.4% in 2024 (data not shown).[22] This national increase was largely driven by the Promise to Address Comprehensive Toxics (PACT) Act, which was signed into federal law in 2022. This was a significant expansion of VA health care and disability compensation for veterans exposed to burn pits or other environmental exposures. Other initiatives with increased investment included medical research and treatment for traumatic brain injuries, brain health, cancer and precision oncology, and mental health.[23]

The Health Safety Net (HSN) pays acute care hospitals and community health centers (CHCs) for medically necessary health care services provided to eligible low-income Massachusetts residents who are uninsured or underinsured.[24] Total HSN provider payments increased 6.0% from 2023 to 2024. Approximately $102.8 million of HSN payments were made to CHCs in 2023, accounting for 30.1% of total HSN payments. Total payments to CHCs increased 19.1% between 2023 and 2024.

Components of Total Health Care Expenditures:
Other Public Programs, 2023-2024

THCE COMPONENTS Detailed View



Health care spending for the Veterans Health Administration increased 16.2% in 2024; Health Safety Net expenditures increased 6.0%.

Source: Payer-reported data to CHIA and other public sources.

Notes: HSN spends and reports on hospital fiscal year. Percent changes calculated based on non-rounded expenditure amounts. See databook and technical appendix for detailed information.

Total Health Care Expenditures

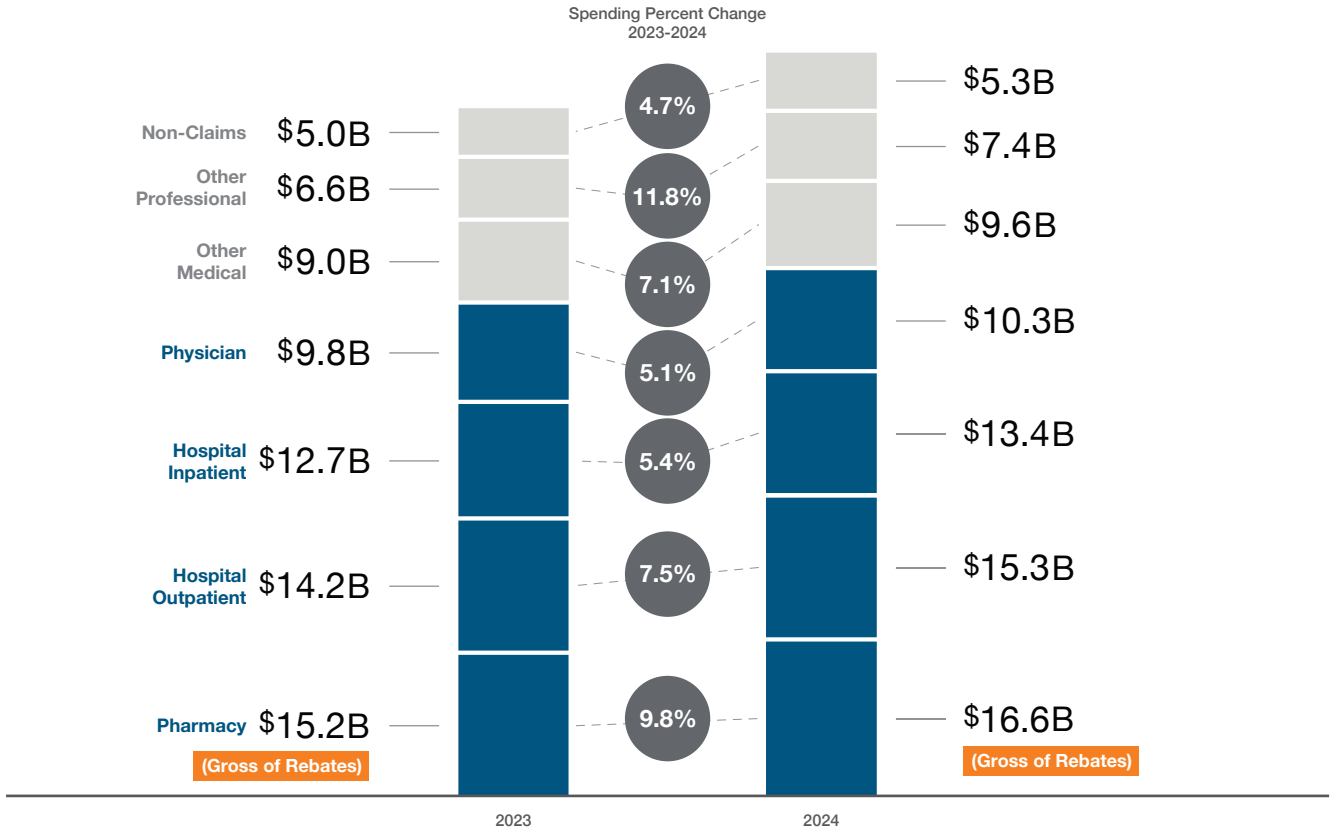
In 2024, prescription drug spending gross of rebates—before accounting for rebates received retroactively by health plans—represented the largest share of overall THCE spending in 2024. Gross pharmacy spending increased 9.8%, accounting for 28.2% of overall THCE growth in 2024.[25]

Spending for other professional services, which includes care provided by a licensed practitioner other than a physician (such as a nurse practitioner or psychologist), increased the fastest among all categories at 11.8% in 2024. This growth was driven in part by increased utilization of behavioral health care services.[26] For more information on behavioral health spending, see page 95.

Total hospital spending increased by 6.5% ($1.8 billion), with inpatient and outpatient expenditures together totaling $28.7 billion in 2024. Separately, hospital outpatient spending increased 7.5% and hospital inpatient spending increased 5.4% from 2023 to 2024. Other medical spending, which includes services like skilled nursing facilities, home health services, durable medical equipment, or freestanding diagnostic services, increased 7.1% in 2024. Spending on physician services, reflecting both specialty and primary care, grew by 5.1%, the lowest trend among the claims-based service categories.

Non-claims spending experienced the slowest growth rate in 2024, increasing by 4.7% in 2024. MassHealth supplemental payments comprised 55.3% of all non-claims spending in 2024. Excluding MassHealth supplemental payments, non-claims spending declined 3.7% in 2024.

Total Health Care Expenditures by Service Category:
Gross of Prescription Drug Rebates, 2023-2024



In 2024, pharmacy spending gross of rebates accounted for the largest share of THCE spending and increased by 9.8% over the previous year.

Source: Payer-reported data to CHIA and other public sources.

Notes: Excludes net cost of private health insurance, VA, and HSN. Percent changes calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

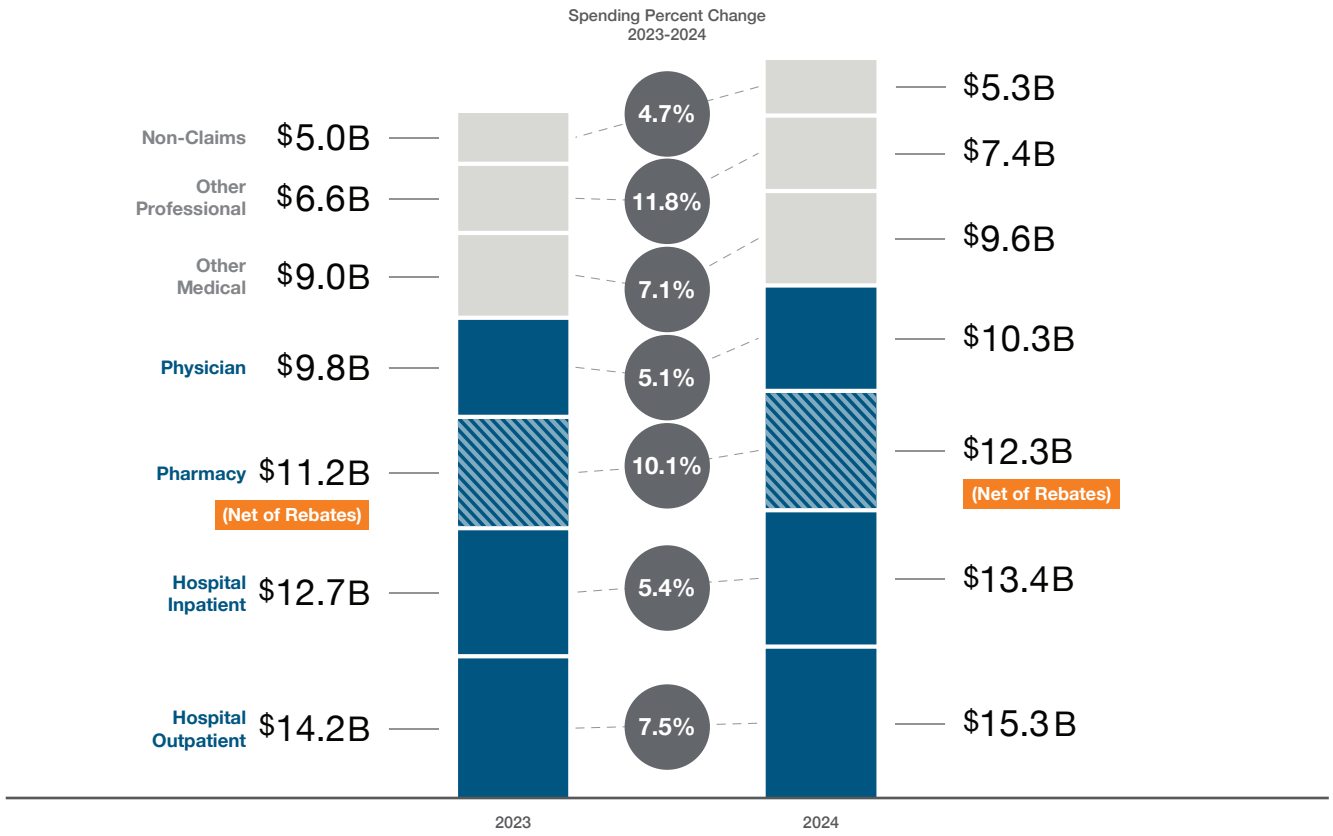
Pharmacy expenditures represent spending covered by a member's prescription drug benefit. It does not include spending associated with drugs administered in other care settings such as a hospital or physician's office. Vaccinations, including those provided in a pharmacy setting, may be included in the pharmacy expenditure category if they are covered by a member's prescription drug benefit.

Both public and private payers negotiate with drug manufacturers to receive rebates on their members' prescription drug utilization. In 2024, rebates accounted for a $4.3 billion reduction in gross pharmacy expenditures, positioning hospital outpatient services as the largest THCE service category on a net of rebate basis. Hospital outpatient spending also reflects drugs when they are administered in health care settings; for more information on provider-administered drugs, see page 30.

Net of prescription drug rebates, pharmacy spending increased 10.1% to $12.3 billion in 2024, following a 10.9% increase the previous year. Pharmacy spending grew faster net of prescription drug rebates than gross of prescription drug rebates in 2024 (10.1% vs. 9.8%). This was a result of a slight decrease in rebates as a proportion of overall pharmacy spending from 2023 to 2024 (26.3% vs. 26.0%).

Prescription drug rebates grew 8.7% in 2024. This increase was largely attributable to rebate growth in the commercial market, which grew 17.5%. However, commercial rebates as a proportion of overall pharmacy spending remained steady from 2023 to 2024. For more information on prescription drug rebates and their impact on spending, see page 37.

Total Health Care Expenditures by Service Category:
Net of Prescription Drug Rebates, 2023-2024



Net of prescription drug rebates, pharmacy spending increased 10.1% from 2023 to 2024 but dropped to the third-largest THCE service category, behind hospital outpatient and hospital inpatient services.

Source: Payer-reported data to CHIA and other public sources.

Notes: Excludes net cost of private health insurance, VA, and HSN. Percent changes calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

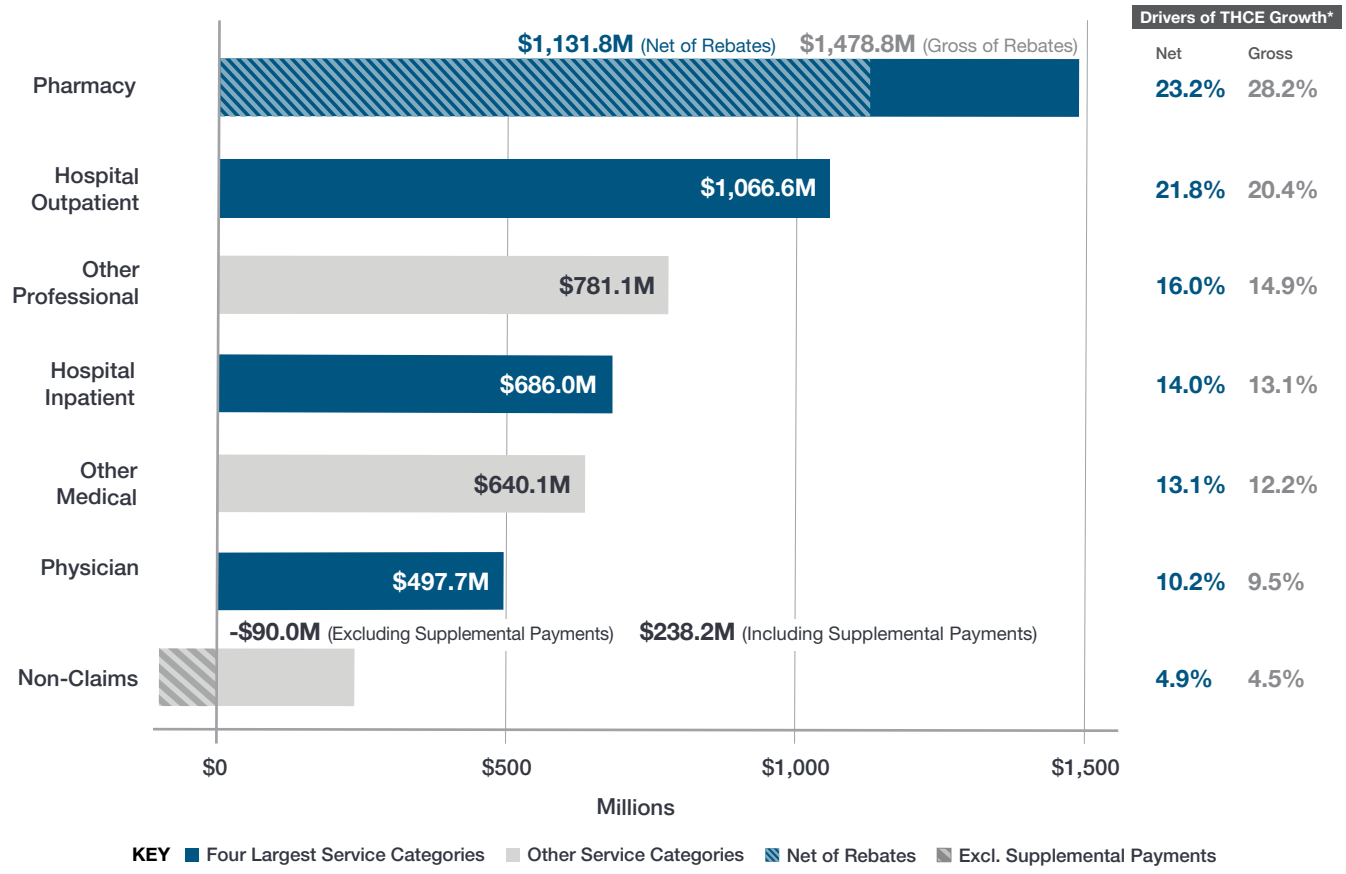
From 2023 to 2024, THCE in Massachusetts increased by $5.2 billion gross of prescription drug rebates and $4.9 billion net of rebates.

Pharmacy spending was the largest component of spending increases in 2024, both gross and net of rebates. Gross of rebates, pharmacy spending grew $1.5 billion. Net of rebates, pharmacy spending remained the top driver of THCE growth, increasing $1.1 billion in 2024 and representing 23.2% of net THCE growth.

Hospital outpatient services accounted for 21.8% of the increase in THCE net of prescription drug rebates. While both hospital outpatient and inpatient spending increased in 2024, inpatient spending only contributed to 14.0% of THCE growth net of prescription drug rebates. As reported in CHIA's Acute Hospital Case Mix Database dashboards, inpatient and emergency department utilization as well as outpatient observation visits remained relatively steady from 2023 to 2024. For more information on hospital inpatient discharges, see page 88. For information on hospital financial performance in 2024, see page 92.

Spending for other professional services was the third-largest service category driver of THCE growth, increasing $781.1 million in 2024 and accounting for 16.0% of the increase in THCE net of prescription drug rebates. Non-claims spending experienced the slowest growth in 2024, increasing by $238.2 million.

Change in Total Health Care Expenditures by Service Category, 2023-2024



Pharmacy spending drove THCE growth in 2024, increasing $1.5 billion gross and $1.1 billion net of rebates.

*Not all THCE spending can be attributed to service categories; therefore, gross and net percentages presented in visual will not sum to 100%.

Source: Payer-reported data to CHIA and other public sources.

Notes: Excludes net cost of private health insurance, VA, and HSN. For detailed information about how expenses were grouped into service categories, see technical appendix.

Total Health Care Expenditures

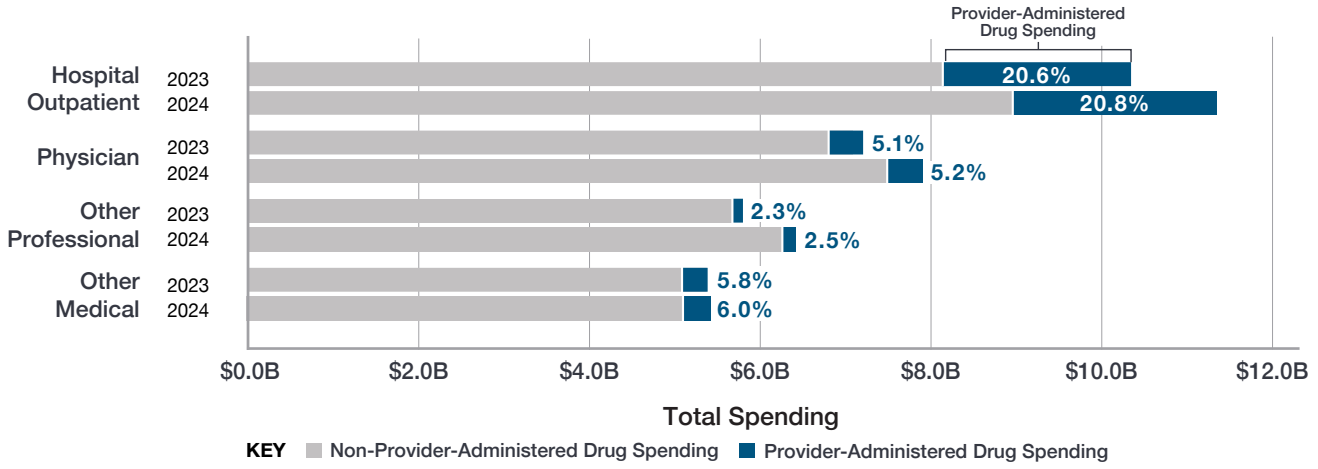
Unlike the prescription drugs captured in the pharmacy service category, some medications are covered by the medical benefit and administered by a provider in a health care setting. This page explores this provider-administered drug spending, which consists of non-oncologic injections and infusions, chemotherapy drugs, and vaccines administered in a setting other than a retail pharmacy setting. The spending on provider-administered drugs was captured within the THCE service category in which it was administered. In 2024, spending for provider-administered drugs totaled $3.3 billion for commercial, MassHealth, and Medicare Advantage members.

Provider-administered drugs composed more than one-fifth of all hospital outpatient spending—$2.4 billion in 2024, representing the largest service category proportion. Provider-administered drug spending as a proportion of overall hospital outpatient spending remained relatively steady, increasing slightly from 20.6% in 2023 to 20.8% in 2024. Provider-administered drug spending was a smaller portion of physician, other professional, and other medical spending in 2024 (5.2%, 2.5%, and 6.0%, respectively).[27]

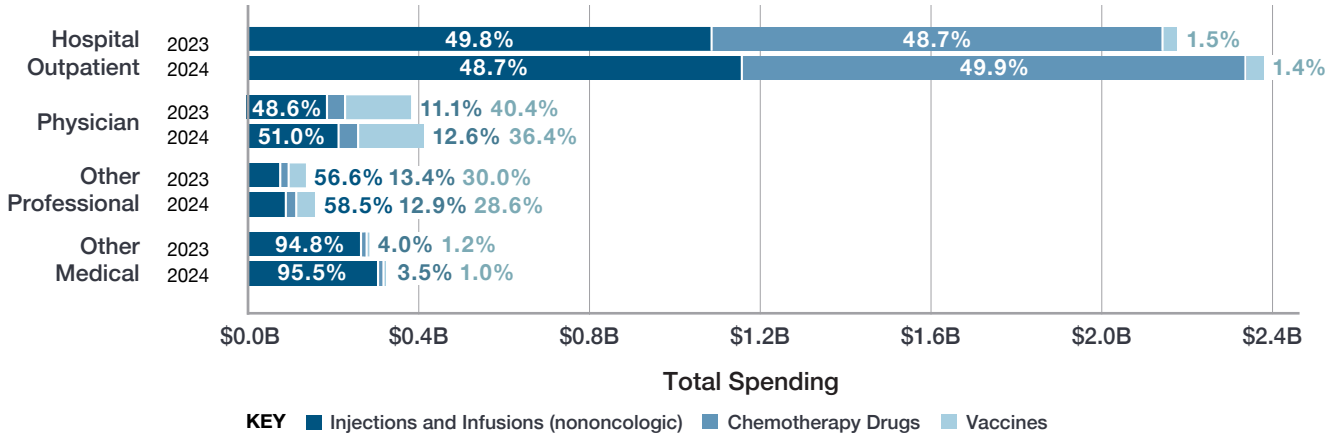
In 2024, the $2.4 billion of hospital outpatient provider-administered drug spending was 48.7% non-oncologic injections and infusions and 49.9% chemotherapy drugs, with vaccines making up 1.4% of the total. In contrast, vaccines were 36.4% of physician provider-administered drug spending, chemotherapy was 12.6%, and the remaining 51.0% was non-oncologic injections and infusions. Non-oncologic injections and infusions composed the majority of other professional and other medical spending in 2024 (58.5% and 95.5%, respectively).

Commercial, MassHealth, and Medicare Advantage Provider-Administered Drug Spending, 2023-2024

Provider-Administered Drugs as Percentage of Total Service Category Spending



Provider-Administered Drug Spending by Pharmaceutical Type



Provider-administered drugs composed more than one-fifth of hospital outpatient spending at $2.4 billion in 2024, representing the largest service category proportion.

Source: Payer-reported data to CHIA.

Notes: Payers were provided with list of relevant HCPCS/CPT codes to capture their medical pharmacy spending from CHIA.[28] Hospital inpatient not included.[29] SCO/PACE/One Care program spending not included.

Total Health Care Expenditures

Commercial spending totaled $30.4 billion in 2024, representing 36.5% of THCE. Overall, commercial spending grew 10.8% and membership increased 2.2% in 2024.

Hospital outpatient spending remained the largest commercial service category in 2024, increasing 9.5% overall and 7.2% PMPM.

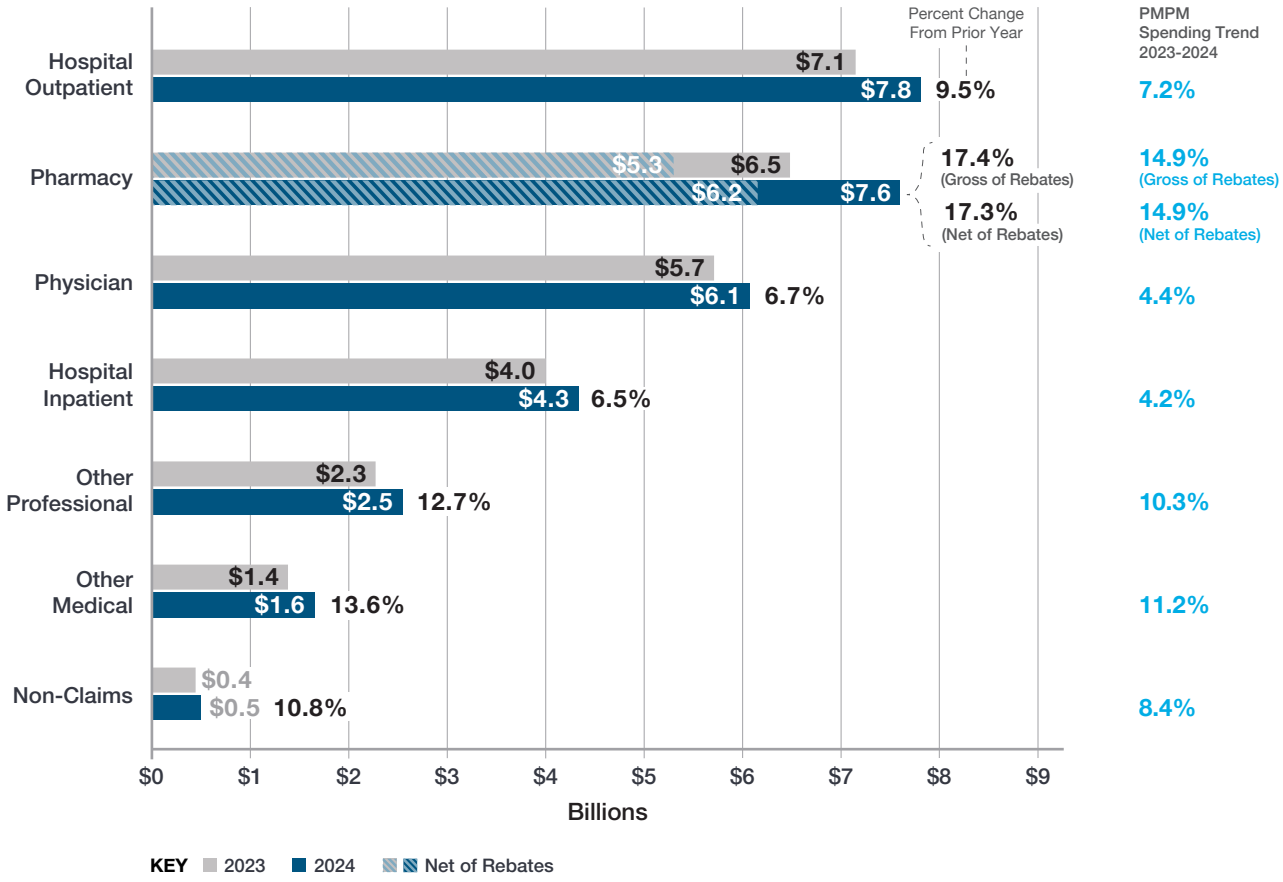
For the third consecutive year, pharmacy spending experienced double-digit PMPM growth and drove increases in overall commercial spending. It represented 38.0% ($1.1 billion) of total commercial spending increases gross of rebates and 33.2% ($912 million) net of rebates. Commercial pharmacy spending grew at the same rate both gross and net of prescription drug rebates, increasing 14.9% PMPM, and remains the second-largest commercial service category in terms of overall spending. In testimony submitted to the Massachusetts Health Policy Commission, commercial payers cited GLP-1 medications and specialty drugs as drivers in rising medical expenditures.[30]

Spending for physician services was the third-largest spending category and increased 6.7% overall and 4.4% PMPM.

Other professional spending increased by 12.7% overall and 10.3% on a PMPM basis in 2024. In testimony submitted to the Health Policy Commission, payers cited behavioral health service utilization as a cost driver.[31] For more information on behavioral health spending, see page 95.

Other medical was the smallest claims-based spending category in 2024 with $1.6 billion in spending. Between 2023 to 2024, other medical spending increased 13.6% overall and 11.2% PMPM, capturing claims-based services that are not otherwise included in other categories.[32]

Components of Total Health Care Expenditures:
Commercial Spending by Service Category, 2023-2024



Commercial pharmacy spending both gross and net of rebates increased 14.9% PMPM, contributing to more than one-third of total commercial spending growth in 2024.

Source: Payer-reported data to CHIA and other public sources.

Notes: For commercial partial-claim data, CHIA estimates spending by product type by multiplying share of member months reported in TME data by estimated total commercial partial-claim expenditures. Excludes net cost of private health insurance. Percent changes calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

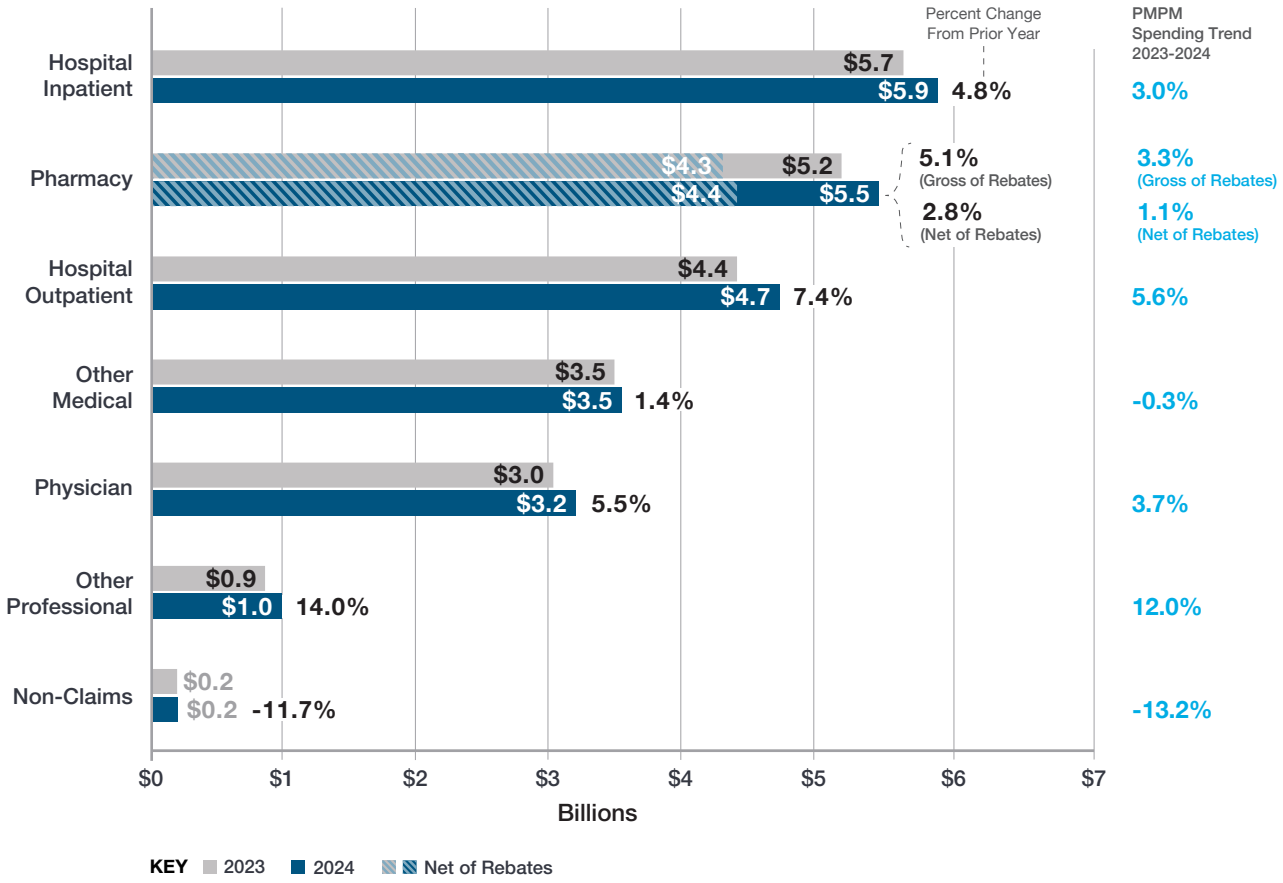
Medicare spending totaled $24.1 billion in 2024, representing 28.9% of THCE. Overall, Medicare spending grew 5.1% and enrollment increased 1.7%.

Hospital inpatient continued to be the largest service category for Medicare in 2024 with $5.9 billion in spending. Hospital inpatient spending in 2024 grew 4.8% overall and 3.0% PMPM, accounting for 23.0% of total Medicare spending in 2024.[33]

Pharmacy represented the third-largest contributor to Medicare's overall increase in expenditures, accounting for 22.5% of growth.[34] Gross of rebates, pharmacy spending grew 5.1% overall and 3.3% PMPM in 2024. Net of rebates, pharmacy spending grew 2.8% overall and 1.1% PMPM. This represents a deceleration from 2023, when pharmacy spending increased 12.5% (11.5% PMPM) gross of rebates and 13.3% (12.3% PMPM) net of rebates.

Hospital outpatient expenditures increased 7.4% overall and 5.6% PMPM and represented the largest contributor to overall Medicare spending increases, with the $327.7 million increase accounting for 27.8% of total Medicare spending growth in 2024.[35]

Components of Total Health Care Expenditures:
Medicare Spending by Service Category, 2023-2024



In 2024, increases in spending for hospital inpatient and outpatient services accounted for half of total Medicare spending growth.

Source: Payer-reported data to CHIA and other public sources.

Notes: Percent changes calculated based on non-rounded expenditure amounts. See databook for detailed information.

Total Health Care Expenditures

MassHealth spending totaled $23.5 billion in 2024, representing 28.2% of THCE. Overall, MassHealth spending grew 5.6% while membership decreased 12.3% in 2024 due to redeterminations.

In 2024, non-claims spending increased 4.9% (19.5% PMPM). This growth was driven by hospital-based supplemental payments funded by a hospital assessment and federal matching dollars as well as one-time payments to support continuity of access to Steward Health Care hospitals. Steward filed for bankruptcy in May 2024, transferring ownership of 5 hospitals and closing 2.[36]

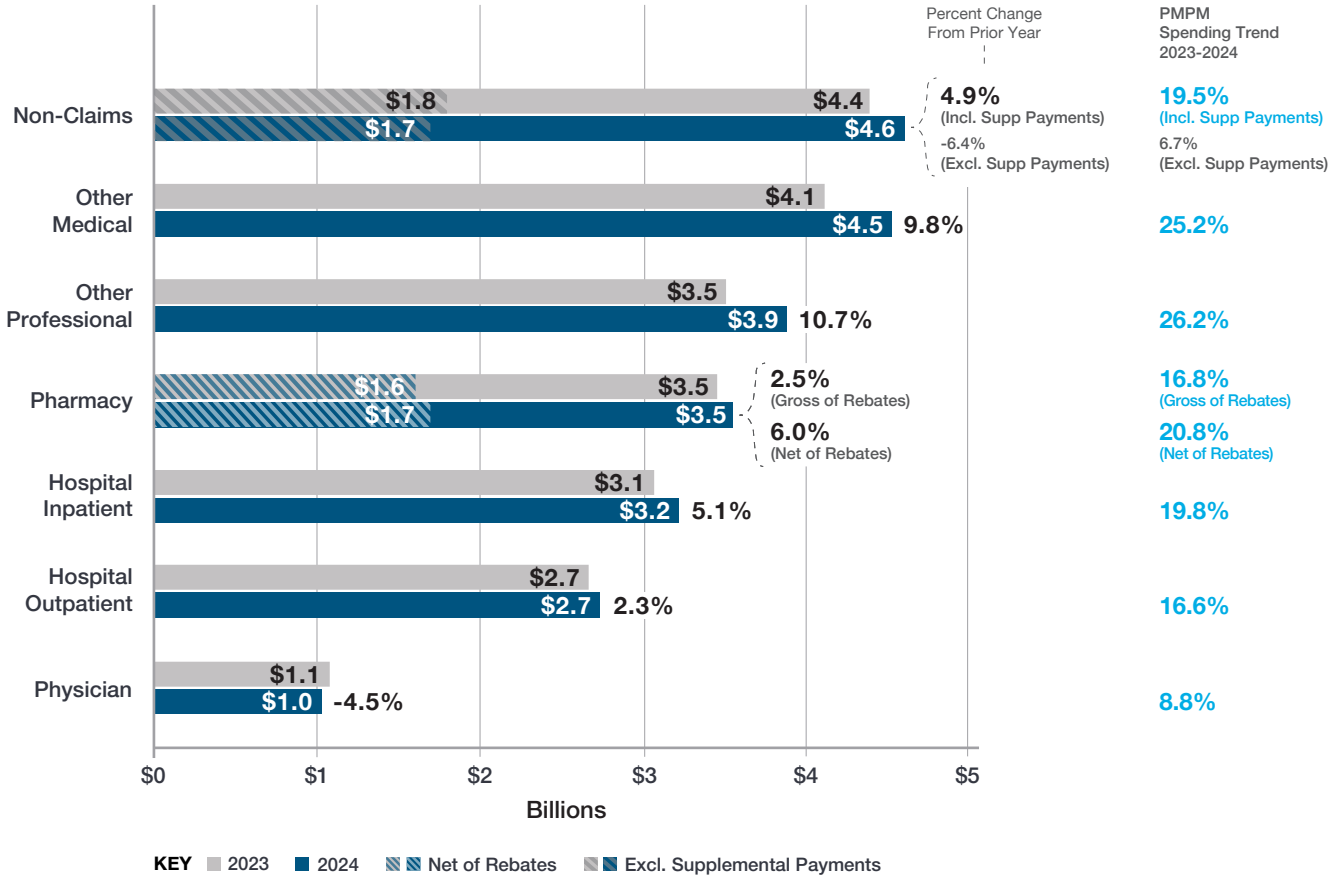
Other medical represented the largest contributor to MassHealth's overall increase in expenditures, accounting for 32.4% of growth.[37] These services include long-term care, home health, community health, and dental.[38] Other medical increased by 9.8% overall and 25.2% PMPM. Long-term care, home health, and community health made up 85.4% of the category's growth.

Other professional contributed to 30.1% of MassHealth's overall growth in 2024.[39] Spending grew by 10.7% overall and 26.2% PMPM, in part driven by increased behavioral health spending; see page 99 for more information.

In 2024, growth in pharmacy spending net of rebates outpaced the growth in pharmacy spending gross of rebates. Net spending increased faster than gross spending in part due to increased unit prices for pharmaceuticals as well as increased utilization of high net cost drugs, which outpaced the amount received by MassHealth in rebates. MassHealth also began covering GLP-1s in 2024, which are high-cost drugs.[40]

The Primary Care Sub-Capitation program continued to shift payments for primary care providers from claims-based methods to non-claims, reflected in the 4.5% decline in MassHealth physician spending in 2024.[41]

Components of Total Health Care Expenditures:
MassHealth Spending by Service Category, 2023-2024



In 2024, spending on other medical accounted for 32.4% of the growth in MassHealth expenditures. This increase in other medical can largely be attributed to long-term care, home health, and community health, which made up 85.4% of the category's growth.

Source: Payer-reported data to CHIA and other public sources.

Notes: Percent changes calculated based on non-rounded expenditure amounts. Supplemental payments reflected in non-claims service category. See databook for detailed information. Additionally, net pharmacy spending growth can outpace gross pharmacy spending growth if increases in rebates do not keep pace with increases in gross pharmacy spending.

Total Health Care Expenditures

The commercial, Medicare, and MassHealth components of THCE reflect spending by both Massachusetts residents and their health plans. When accessing health care services, members often pay copayments, coinsurance, or deductibles—collectively known as member cost-sharing—in addition to the amount paid by their health plan. From 2023 to 2024, payments made by members increased 5.1%, from $5.2 billion to $5.5 billion, while payments made by health plans for health care services grew 7.5%. Member cost-sharing as a proportion of total commercial, MassHealth, and Medicare spending remained steady at 7.5% in 2023 and 7.4% in 2024.

In the commercial market, growth in payer-paid claims outpaced that of member cost-sharing in 2024. Total payer spending increased 11.1% while member cost-sharing increased 7.8%. The share of total commercial spending attributable to member cost-sharing slightly decreased from 10.0% in 2023 to 9.7% in 2024; however, commercial members also faced rising premiums from 2023 to 2024. For more information on affordability, see the Access and Affordability chapter.

Medicare member cost-sharing increased by 2.4% from 2023 to 2024, representing an additional $60.1 million in member-paid spending. For Medicare Advantage, the proportion of spending attributable to member cost-sharing was slightly lower; approximately 6.9% of total Medicare Advantage spending was attributable to member cost-sharing compared with 11.9% of Original Medicare spending (data not shown). Original Medicare beneficiaries may have additional coverage to offset cost-sharing expenditures; this coverage is not reflected in the data.[42]

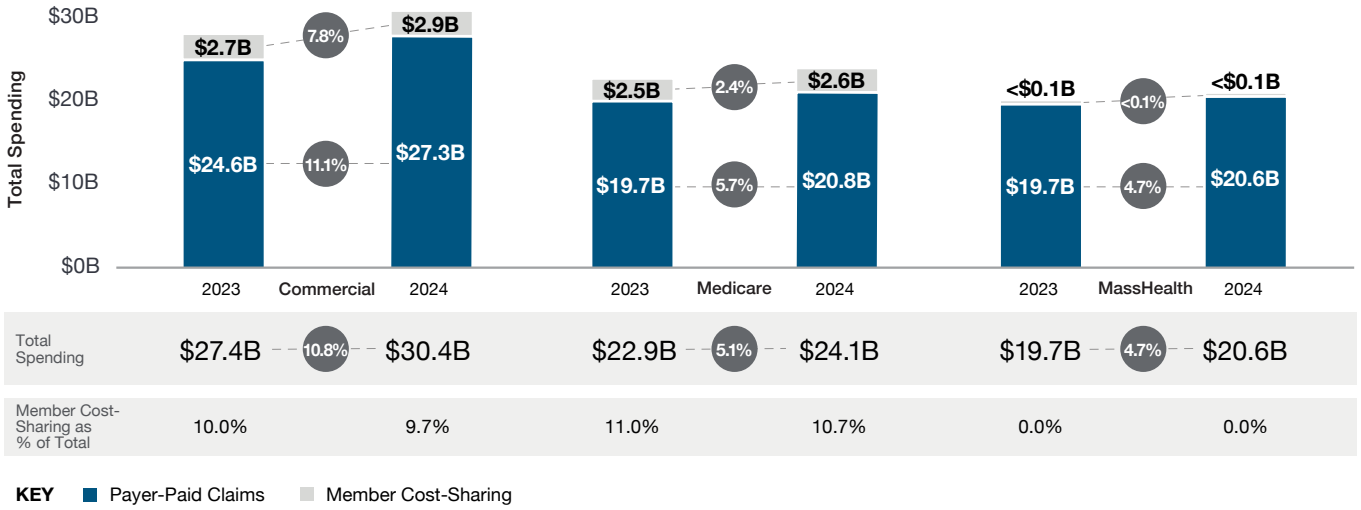
MassHealth members have little to no cost-sharing, totaling $128,410 or 0.001% of total MassHealth spending in 2024.

Components of Total Health Care Expenditures:
Member Cost-Sharing, 2023-2024

Commercial, Medicare, MassHealth: Total Spending and Member Cost-Sharing

	2023	2024	% Change
Member Cost-Sharing	$5.2B	$5.5B	5.1%
Total Spending	$70.0B	$75.0B	7.5%
Member Cost-Sharing as % of Total	7.5%	7.4%	N/A

Member Cost-Sharing by THCE Component



Payments made by members increased 5.1% between 2023 and 2024, from $5.2 billion to $5.5 billion; payments made by health plans for health care services grew 7.5%.

Source: Payer-reported data to CHIA and other public sources.

Notes: To capture member cost-sharing for commercial partial-claim population, CHIA applied commercial full member cost-sharing percentage to adjusted (grossed-up) THCE commercial partial-claim total expenses, by payer. Commercial member cost-sharing presented in this chapter may not match values in Affordability chapter due to differences in sourcing and adjustment methodologies. MassHealth supplemental payments not captured.

Total Health Care Expenditures

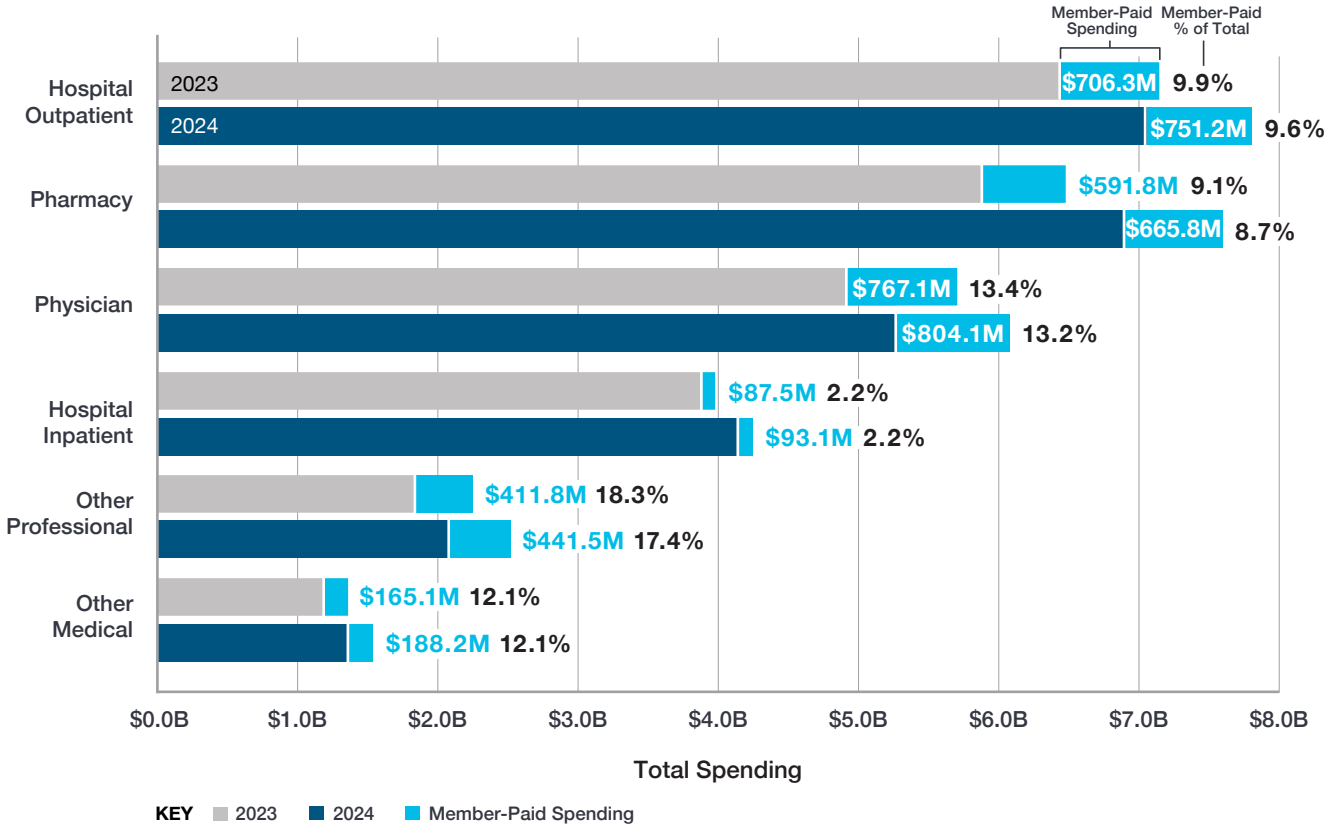
In the commercial market, growth in payer-paid claims outpaced that of member cost-sharing in 2024. Total payer spending increased 11.1% while member cost-sharing increased 7.8%. In 2024, the ConnectorCare program expanded income eligibility requirements to include 51,000 additional Massachusetts residents, 30% of whom were previously enrolled in MassHealth. This allowed more individuals to access commercial coverage with low-cost premiums and no deductibles, as well as access to certain chronic condition medications with no copay.[43]

Commercial members were responsible for the largest portion of spending on other professional services, which includes care provided by a licensed practitioner other than a physician, at 17.4% ($441 million), followed by physician services at 13.2% ($804 million) in 2024.

Pharmacy spending growth drove overall increases in commercial spending; member-paid spending represented 8.7% of total pharmacy spending in 2024, a slight decline from 9.1% in 2023.

In 2024, member-paid spending represented 9.6% of total hospital outpatient spending and amounted to $751 million. Members paid the lowest proportion of costs for hospital inpatient services, representing 2.2% of total inpatient spending ($93 million). Member-paid spending represented 12.1% of other medical spending ($188 million).

Commercial Member Cost-Sharing by Service Category, 2023-2024



Residents with commercial insurance paid the largest share of costs for other professional (17.4%) and physician (13.2%) service categories in 2024.

Source: Payer-reported data to CHIA.

Notes: Due to data collection updates, CY 2023 data contains estimated service member cost-sharing for payers that did not submit prior years of data using market level percentages of CY 2023 data; calculated using 81% of membership in commercial market. To capture member cost-sharing for commercial partial-claim population, CHIA applied commercial full member cost-sharing percentage to adjusted (grossed-up) THCE commercial partial-claim total expenses, by payer.

Total Health Care Expenditures

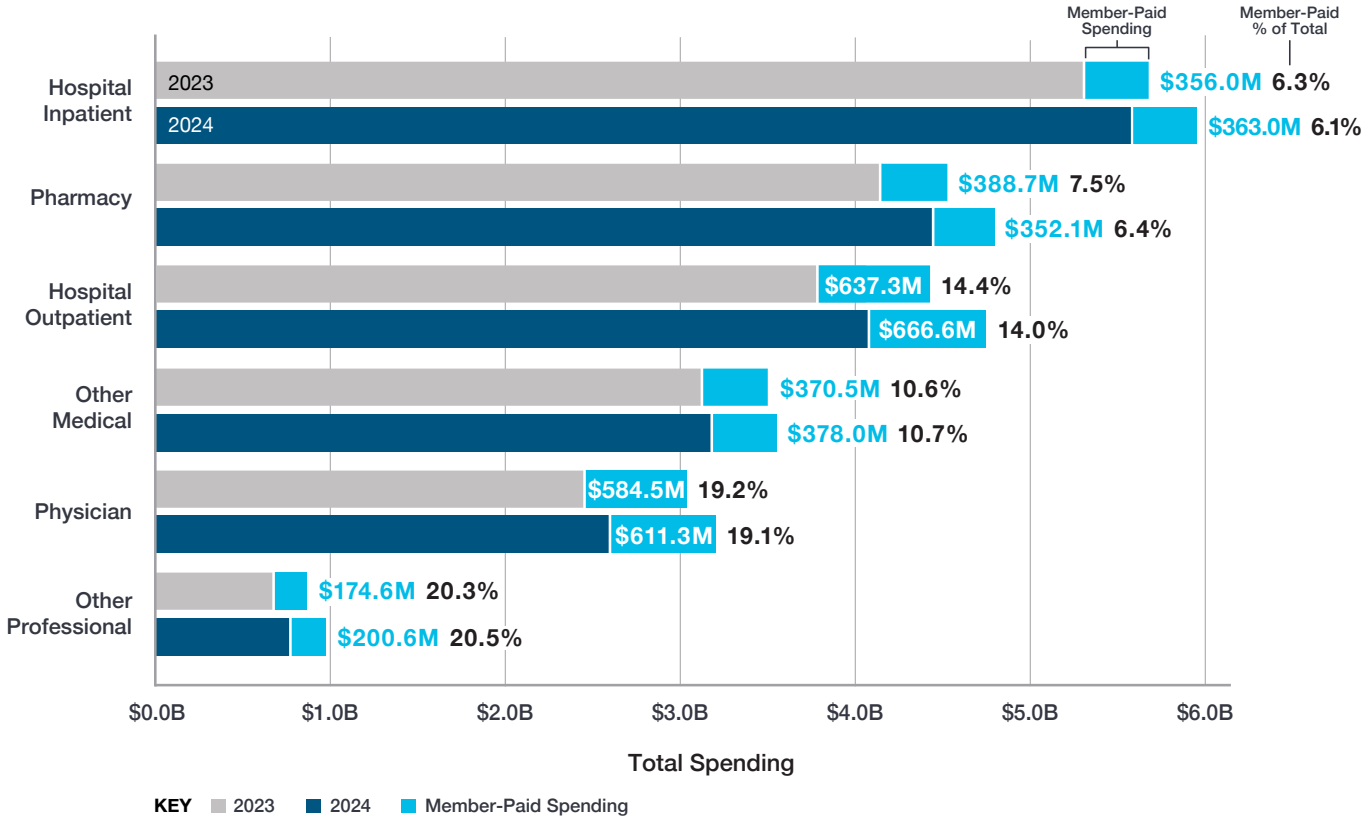
In 2024, 71.6% of Massachusetts Medicare enrollees were enrolled in Original Medicare and 28.4% were enrolled in Medicare Advantage. Total member cost-sharing for Original Medicare and Medicare Advantage combined increased by $60.1 million (2.4%) from 2023 to 2024 and accounted for 10.7% of overall Medicare spending.

Hospital inpatient and pharmacy represented Medicare's 2 largest service categories, and both had similar member cost-sharing proportions. Member-paid spending represented 6.1% ($363 million) of total hospital inpatient spending and 6.4% ($352 million) of total pharmacy spending.[44]

In 2024, Medicare member-paid spending represented 19.1% ($611 million) of spending for physician services and 14.0% ($667 million) for hospital outpatient care. This was driven by member cost-sharing proportions for Original Medicare, where member-paid spending represented 23.3% of physician and 17.1% of hospital outpatient spending (data not shown). In comparison, Medicare Advantage member-paid spending represented 8.8% of physician and 6.6% of hospital outpatient spending (data not shown). Physician and hospital outpatient services are covered under Original Medicare Part B, with a 20% cost-sharing payment structure and no out-of-pocket maximum cap after reaching their Part B deductible ($240 in 2024). However, Original Medicare enrollees can also enroll in supplemental plans to help cover member cost-sharing responsibilities, which was not captured in this data. Nationally, 94% of eligible Medicare beneficiaries are enrolled in a supplemental coverage plan, Medicare Advantage, or another managed care plan.[45,46]

Other professional spending represented the smallest portion of total Medicare spending but had the highest member-paid proportion at 20.5% ($201 million).

Medicare Member Cost-Sharing by Service Category, 2023-2024



Massachusetts Medicare beneficiaries paid the largest share of costs for other professional (20.5%) and physician (19.1%) service categories in 2024.

Source: Payer-reported data to CHIA and other public sources.

Notes: Due to data collection updates, CY 2023 data contains estimated service member cost-sharing for payers that did not submit prior years of data using market level percentages of CY 2023 data; calculated using 93.8% of the Medicare Advantage market.

A Closer Look: Prescription Drug Spending and Rebates

In recent years, retail pharmacy expenditures have been a leading contributor to the increase in health care spending in the Commonwealth. This trend has been a function of multiple factors, including increasing drug utilization, the introduction of new specialty medicines, and unit price growth.

Quantifying pharmacy expenditures is complicated by prescription drug rebates and a complex pharmacy supply chain. Prescription drug rebates, which include discounts, various price concessions, and refunds for a portion of the price of the drugs, are paid by pharmaceutical manufacturers to pharmacy benefit managers (PBMs) and health plans. Health plans use PBMs to manage their drug formularies by negotiating prices with pharmacies and rebates with manufacturers. Rebates are paid retroactively based on the PBM's or PBM client's formulary placement for the manufacturer's drug and their patients' drug utilization. For prescription drugs with rebates, the price the PBM pays for the drug is lower than the list price, which allows the PBM to share some—or all—of the rebate with health plans. However, as these are retroactive rebate arrangements, the point-of-sale price the patient pays at the pharmacy is based on the list price.

A newer rebate model of point-of-sale rebates shifts the cost savings directly to patients by offering instant discounts on prescription drugs, with rebates applied at the pharmacy counter. However, adoption of this rebate model remains limited in Massachusetts. Of the 14 payers included in the Prescription Drug Rebate data for 2024, only 3 reported offering point-of-sale rebates. CHIA measures pharmacy expenditures both before retroactive rebates are applied to the payer pharmacy expense (gross of prescription drug rebates) and with rebates applied (net of prescription drug rebates).

CHIA collects aggregate prescription drug expenditures and rebates via the Prescription Drug Rebate data

submission. Payers reported all rebates received from manufacturers regardless of whether they were transferred by the PBM retroactively or at the point of sale and regardless of the rebate's type of payment (e.g., refund or price concession) when applied. CHIA also collects prescription drug spending and rebates by payer-reported drug category (specialty, brand, and generic). The distinctions between specialty, brand, and generic are defined under the terms of a payer's contract with its PBM and may vary across payers.

In the commercial market, specialty drugs represented the majority of overall drug spending (56.8%), followed by brand drugs at 35.1%. In 2024, 31.4% of expenditures for specialty drugs were returned to payers in the form of rebates compared with 39.2% for brand drugs. Despite generic drugs representing the smallest portion of drug spending (8.1%), they represent more than 80% of prescription drug utilization.[47]

This section estimates the amount of rebates that payers received from manufacturers and how those rebates might have impacted the amount payers ultimately spent on prescription drugs. As in prior years, THCE reflects the amounts that payers and members paid to pharmacies at the point of sale with no rebates applied. However, rebate dollars reported by payers can be deducted from claims expenses to estimate THCE net of prescription drug rebates. Net of prescription drug rebates, THCE per capita was $11,057 in 2024, a 5.6% increase from 2023.

Additional CHIA Resources on Prescription Drugs

CHIA's interactive dashboard and detailed dataset analyze commercial prescription drug use and spending in the Commonwealth, identifying drivers of pharmacy expenditures, including high-volume and high-cost drugs. For more information, see CHIA's **Commercial Prescription Drug Use and Spending Report**.

In 2025, Massachusetts legislation amended CHIA's authority to require reporting from PBMs.[48] With the first report expected later in 2026, this new data collection facilitates analysis of drug utilization and reimbursement, wholesale acquisition costs, and formulary structures, including maximum allowable cost lists and utilization management; it also provides insights into PBM business practices such as spread pricing, post sale adjustments and clawbacks, rebates, and administrative service fees. For more information, see CHIA's **PBM data** collection. ■

Total Health Care Expenditures

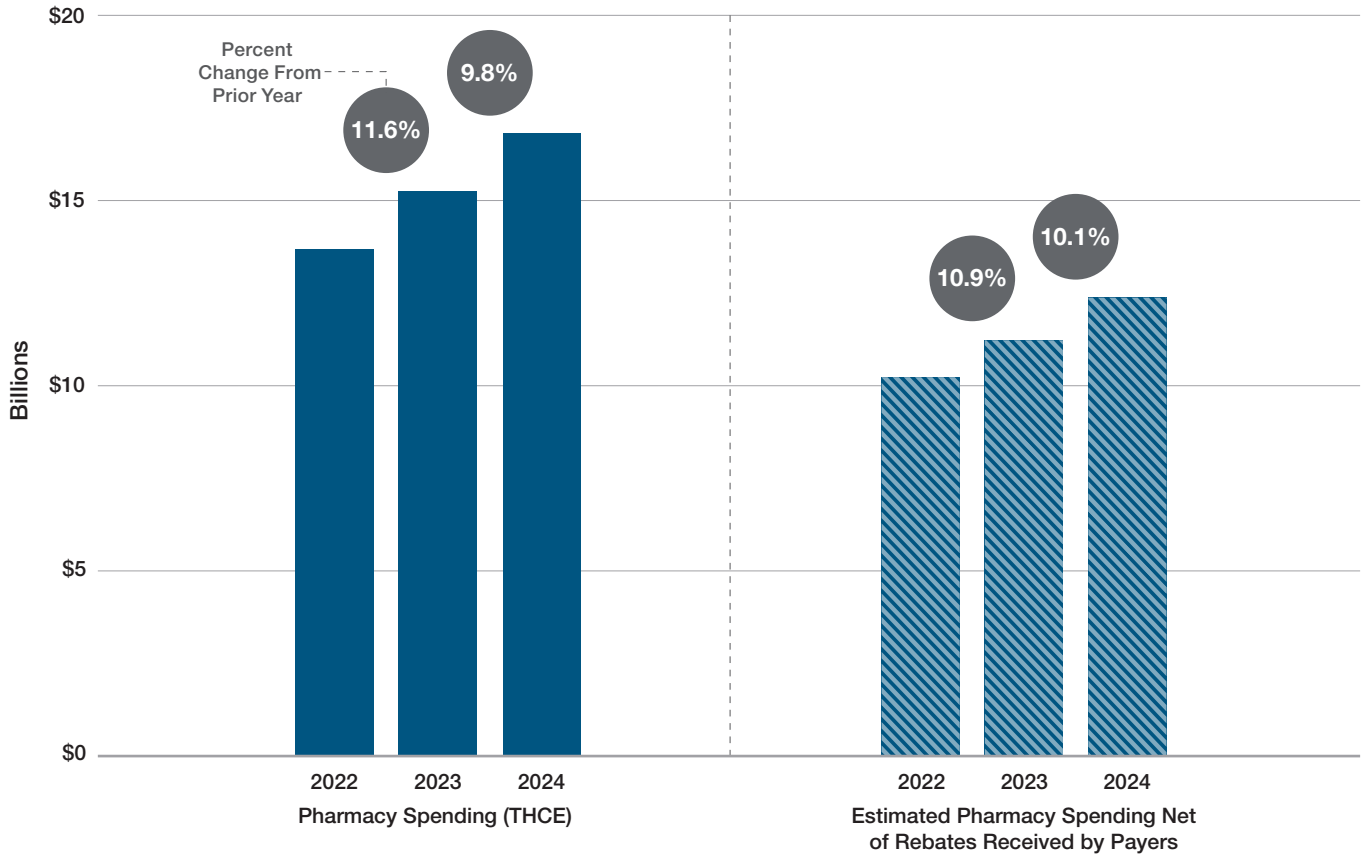
THCE reflects gross prescription drug expenditures, which represent payer payments to pharmacies, along with member cost-sharing. Both public and private payers, commonly through pharmacy benefit managers (PBMs), negotiate with drug manufacturers to receive rebates based in part on their members' prescription drug utilization. Additionally, federal law dictates minimum requirements for rebates to state Medicaid programs. These rebates reduce payers' total expenses for prescription drugs.

In 2024, gross prescription drug expenditures totaled $16.6 billion, a 9.8% increase from 2023 and a 22.5% cumulative increase from 2022. Net of rebates, pharmacy spending grew to $12.3 billion in 2024, up 10.1% from 2023 and a 22.2% cumulative increase from 2022. At 8.7%, prescription drug rebates grew more slowly than gross pharmacy spending in 2024, which resulted in a net spending growth rate 0.3 percentage point greater than that of gross spending. Overall, rebates grew from $3.5 billion in 2022 to $4.3 billion in 2024, a 23.6% cumulative increase (data not shown).

MassHealth works to reduce net prescription drug costs by negotiating directly with drug manufacturers for supplemental rebates and through its Unified Pharmacy Product List (UPPL), which designates preferred products with the lowest net costs. MassHealth reported the highest rebate percentage of all plans in 2024 (50.9%), a decrease from 2023 (52.5%). MassHealth net pharmaceutical spending continued to grow year over year due in part to a growth in average unit prices and utilization of higher-cost pharmaceuticals (data not shown).

For the commercial market, rebates increased at a similar rate to overall pharmacy spending growth, while Medicare's rebate growth outpaced overall pharmacy growth (data not shown).

Estimated Impact of Rebates on Pharmacy Spending and Growth, 2022-2024



Prescription drug rebates increased 23.6% between 2022 and 2024, reducing overall payer prescription drug spending by $4.3 billion in 2024.

Source: Payer-reported data to CHIA.

Notes: Total pharmacy payments reported by payers in THCE may include prescription drug price concessions or discounts transmitted at point of sale, including coverage gap discounts. Pharmacy spending net of rebates estimates impact of reducing total pharmacy costs to payers by retrospective rebates, in addition to any price discounts included in THCE. See technical appendix for more information.

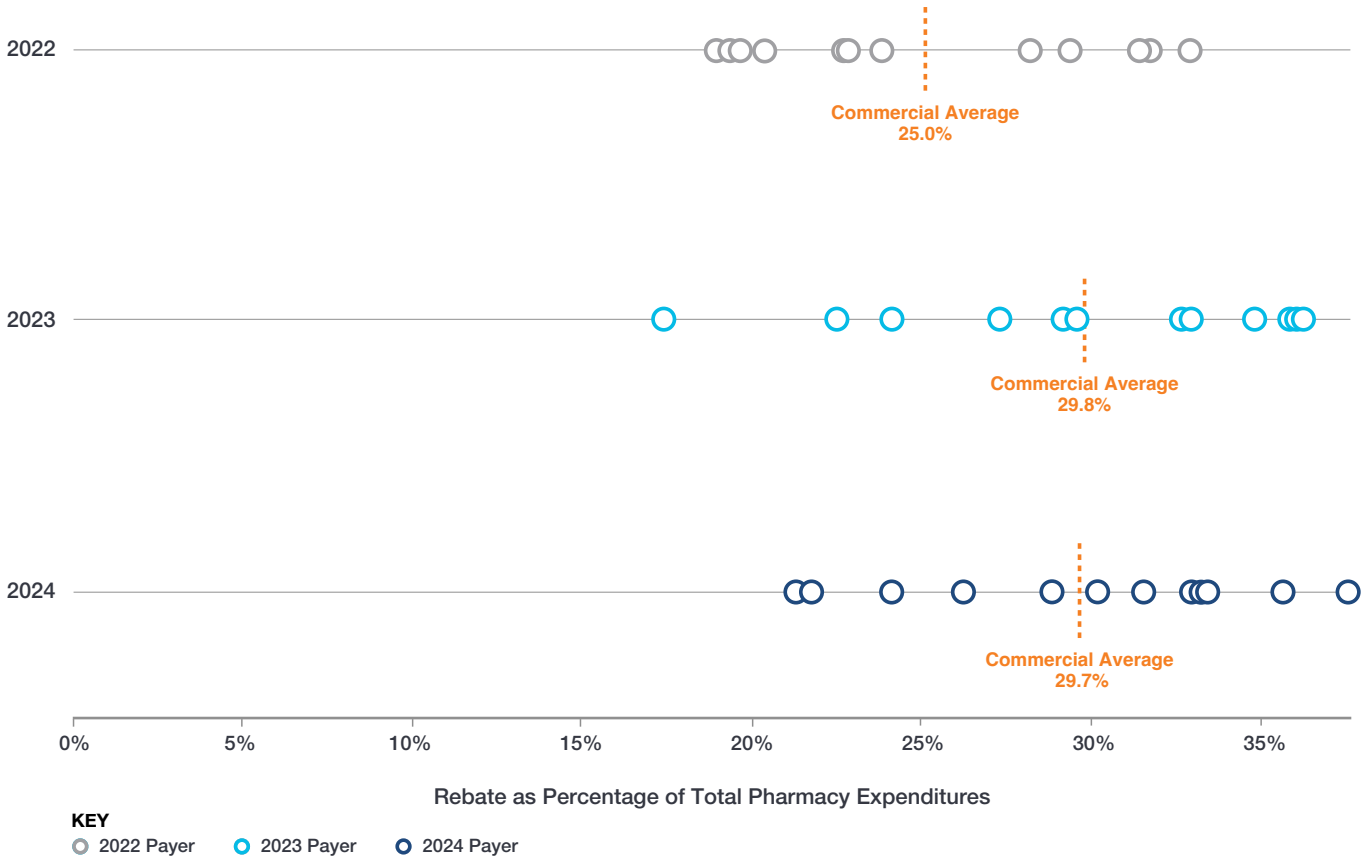
Total Health Care Expenditures

On average, commercial payers received 29.7% of pharmacy spending back from manufacturers in the form of rebates in 2024, often via PBMs. This was a slight decrease (0.1 percentage point) from 2023 but a cumulative increase of 4.7 percentage points from 2022. Across commercial payers, the range of rebate proportions decreased from 18.8 percentage points in 2023 to 16.3 percentage points in 2024.

Variation in payer-reported rebate proportions may be driven by several factors, including member demographics, utilization trends, coverage decisions, and market power. Variation may also be influenced by payer-PBM contracts. For example, changes in utilization of particular drugs from the payer's drug formulary, often influenced by the PBM contract, may impact a payer's rebate proportion.

For some individual payers, changes in rebate proportion may be attributed to switching PBMs. Between 2022 and 2024, 4 commercial payers reported a change in their contracted PBM. In 2024, the 3 PBMs contracted most often by commercial payers were Optum Rx, CVS Caremark and Express Scripts. Payers reported utilizing PBMs for a mix of services, including claims processing, drug formulary management, and manufacturer drug rebate contracting.

Range of Payer-Reported Commercial Rebates as a Percentage of Gross Pharmacy Expenditures, 2022-2024



Across the commercial market in 2024, an average of 29.7% of pharmacy expenditures were returned to payers in the form of rebates.

Source: Payer-reported data to CHIA.

Notes: Average rebate percentages determined by taking mean of payer rebate percentages, calculated as reported rebate amount divided by reported pharmaceutical expenditures. See technical appendix for more information.

Total Health Care Expenditures Notes

1. Pursuant to M.G.L. c. 6D, Section 9, the benchmark for 2023 and beyond will be established by law at a default rate of potential gross state product (PGSP). Detailed information available at https://masshpc.gov/cost-containment/benchmark.
2. U.S. Census Bureau, "State Population Totals and Components of Change: 2020-2025," accessed Feburary 18, 2026, https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html.
3. U.S. Bureau of Economic Analysis, "SASUMMARY State annual summary statistics: personal income, GDP, consumer spending, price indexes, and employment," accessed Wednesday, February 18, 2026, https://apps.bea.gov/itable/?ReqID=70&step=1&acrdn=1&_gl=1.
4. U.S. Bureau of Labor Statistics, "Quarterly Census of Employment and Wages," accessed February 16, 2026, https://www.bls.gov/cew/downloadable-data-files.htm.
5. U.S. Bureau of Labor Statistics, "Databases, Tables & Calculators by Subject: All items in Boston-Cambridge-Newton, MA-NH, all urban consumers, not seasonally adjusted," accessed January 18, 2026, https://data.bls.gov/timeseries/CUURS11ASA0?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true.
6. Centers for Medicare and Medicaid Services, "National health expenditure data," accessed February 5, 2026, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.
7. Hospital outpatient spending contributed to 21.8% of net THCE growth.
8. Other professional spending contributed to 16.0% of net THCE growth.
9. In determining total population of Massachusetts, CHIA has historically referred to the American Community Survey (ACS) 1-year estimates due to their static nature. However, starting in this report, CHIA now refers to the Census Bureau's Population Estimates Program (PEP), which is updated yearly. This is to ensure the usage of the most up-to-date estimates available.
10. For more information about health insurance enrollment among Massachusetts residents, see CHIA's Enrollment Trends publications.
11. National trends in Medicare spending are estimated based on data reported to CHIA by Centers for Medicare and Medicaid Services.
12. Tricia Newman, Meredith Freed, and Jeannie Biniek, "10 Reasons Why Medicare Advantage Enrollment Is Growing and Why It Matters," *Kaiser Family Foundation*, January 30, 2024, https://www.kff.org/medicare/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/.
13. MassHealth enrollment peaked in June 2023 and then started to decline. For additional insight on MassHealth redeterminations, see the MassHealth Redeterminations Dashboard.
14. MassHealth FFS stands for fee-for-service, PCACO stands for Primary Care ACO, and PCC stands for Primary Care Clinician (PCC) plan.
15. Approximately 84.5% of MassHealth Fee-For-Service (FFS) members have other insurance coverage, and MassHealth serves as the secondary payer.
16. Only a small portion of Accountable Care Partnership Plan (ACPP)/Managed Care Organization (MCO) membership is attributed to MCOs; ACPPs represented 94.0% of ACPP/MCO membership in 2024.
17. These high public payer acute hospitals refer to former Steward Health Care facilities. For more information on the transition, visit https://www.mass.gov/info-details/steward-health-care-transition-to-the-new-operators.
18. MassHealth, *MassHealth Hospital Assessment Update* (Boston, January 2022), https://www.mass.gov/doc/hospital-assessment-fy23-fact-sheet/download.
19. ASO stands for administrative services only.
20. Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, "Medicare Advantage Quality Bonus Payments Will Total at Least $12.7 Billion in 2025," *Kaiser Family Foundation*, June 12, 2025, https://www.kff.org/medicare/medicare-advantage-quality-bonus-payments/.
21. CMS stands for Centers for Medicare and Medicaid Services.
22. National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, "Geographic Distribution of VA Expenditures (GDX) Report," October 30th, 2025, https://www.va.gov/vetdata/expenditures.asp.
23. U.S. Department of Veterans Affairs, *U.S. Department of Veterans Affairs FY2024 Budget Submission*, (Washington D.C., March 2023), https://www.va.gov/budget/docs/summary/fy2024-va-budget-in-brief.pdf.
24. For more on the Health Safety Net, see the Health Safety Net website.
25. Pharmacy spending contributed to 23.2% of net THCE growth.
26. Massachusetts Health Policy Commission, "2024 Cost Trends Hearing Testimony," accessed January 7, 2026, https://masshpc.gov/meetings/annual-cost-trends-hearing/2024-cth/testimony.
27. Hospital inpatient not included due to billing differences such as bundled payments. As a result, only 0.1% of hospital inpatient spending was attributed to provider administered drugs in 2024 ($8.8 million).

Total Health Care Expenditures Notes

28. HCPCS stands for Healthcare Common Procedure Coding System. CPT stands for Current Procedural Terminology.

29. Hospital Inpatient was excluded due to billing differences such as bundled payments.

30. See note 26.

31. Ibid.

32. This includes, but is not limited to, skilled nursing facilities, home health services, durable medical equipment, and optical services.

33. Hospital inpatient consisted 26.2% of Medicare's spending growth between 2023 to 2024 net of rebates.

34. Pharmacy spending contributed to 11.7% of Medicare growth net of rebates.

35. Hospital outpatient consisted 31.7% of Medicare's spending growth between 2023 to 2024 net of rebates.

36. For more information on Steward Healthcare transitions and closures, visit https://www.mass.gov/steward-health-care-transitions.

37. Other medical drove 32.1% of MassHealth's spending increase between 2023 to 2024 net of rebates.

38. Other medical in the context of MassHealth refers solely to long-term care, home health and community health, and dental. However, this differs for data submitted by commercial payers and Medicare FFS. In the context of commercial payers, this category includes (but is not limited to) skilled nursing facility services, home health services, durable medical equipment, freestanding diagnostic facility services, hearing aid services, optical services, and otherwise unclassifiable claims as determined by the payer. For Medicare, this category solely includes skilled nursing facility services, home health, hospice, non-hospital outpatient, durable medical equipment, and other suppliers.

39. Other professional drove 29.8% of MassHealth's spending increase between 2023 to 2024 net of rebates.

40. MassHealth, *Pharmacy Facts: Current Information for Pharmacists about the MassHealth Pharmacy Program* (Boston, November 2024), https://www.mass.gov/doc/pharmacy-facts-235-november-19-2024-0/download.

41. MassHealth, "MassHealth Primary Care Sub-Capitation: Program Overview," accessed January 7, 2026, https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview.

42. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, D.C., March 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf.

43. Massachusetts Health Connector, *ConnectorCare Expansion Pilot* (Boston, August 2024), https://betterhealthconnector.com/wp-content/uploads/ConnectorCare-Pilot-Expansion-Report-082624.pdf.

44. Note that Medicare's incurred program payments and member cost-sharing does not sum to the total spending presented in the 'Medicare Spending by Service Category' graphic. Other payments included in total expenditures include non-covered plan paid amounts and third-party payments made on behalf of the beneficiary such as other TrOOP (e.g., State Pharmacy Assistance Program, charities) and Patient Liability Reduction Due to Other Payer Amount - PLRO (e.g., group health plans, workers' compensation, and governmental programs).

45. See note 42.

46. Commonly obtained through Medicaid, a former employer, and/or a Medigap plan they purchased themselves. This data is not incorporated.

47. Center for Health Information and Analysis, "Prescription Drugs," accessed June 6, 2024, https://www.chiamass.gov/prescription-drugs.

48. General Court of the Commonwealth of Massachusetts, "An Act Relative to Pharmaceutical Access, Costs and Transparency," accessed January 7, 2024, https://malegislature.gov/Bills/193/S3012.

KEY FINDINGS

Access and Affordability

Fully insured premiums grew more slowly in 2024 (2.9%) than in prior years (5.9% in 2023), driven by enrollment shifts in the individual purchaser sector to lower-premium ConnectorCare plans. Premiums for individual purchaser plans declined 0.1% overall, while premiums for employer-sponsored plans increased 4.8%.

Disrupting a long-term growth trend, the average percentage of members enrolled in an HDHP decreased across all sectors except mid-size employer groups in 2024, with jumbo groups experiencing the largest proportional decrease at 7.7 percentage points.

Among small and mid-size employer groups, employers and employees faced heightened cost pressures: member cost-sharing was highest for these employees ($117 PMPM and $92 PMPM, respectively) and increased by more than 8% in 2024. These employer groups also had the highest premiums.

Nearly one-third of Massachusetts residents (28.4%) went without needed care due to cost in 2025, more common among Black and Hispanic residents vs. White residents (35.8% and 37.8%, respectively, vs. 25.9%).

Despite nearly universal health insurance coverage, 13.5% of Massachusetts residents had family medical debt in 2025. Residents with debt often cut back on or took money out of their savings (62.5%), and many (42.4%) were contacted by a collection agency.

Access and Affordability

Although Massachusetts boasts near universal health care coverage statewide, residents face growing health care affordability concerns due to rising health care costs, including multi-year increases in premiums, copayments, coinsurance, and deductibles.

Between 2022 and 2024, health insurance costs grew faster than wages and salaries as well as regional inflation. Simultaneous increases in spending for other household essentials, such as food, housing, and childcare, further contribute to the challenges Massachusetts residents and their families face as health care costs rise. Moreover, the burden of increased health care costs impacts both employers and employees, especially among small and mid-size employers who have more limited plan offerings than their larger counterparts. In combination, these factors can result in disparate financial burdens on specific demographic populations, particularly for certain racial and ethnic groups and those with lower family incomes.

To present a more complete picture of health care spending and corresponding challenges from the consumer perspective, this chapter combines data on member insurance coverage and costs with survey responses from employers, individuals, and families about their experiences offering, financing, and accessing health care. Metrics presented in this chapter represent some, but not all, of the financial impact of health care costs on Massachusetts residents and employers.

Data Sources and Methodology

A. Private Commercial Health Insurance Data

CHIA obtains and analyzes data on enrollment, member cost-sharing, and the cost of coverage for Massachusetts private commercial health insurance.[1] Payers submit data by market sector, product type (HMO, PPO, POS), funding type (fully or self-insured), and benefit design type (HDHP, tiered network, limited network). Unless otherwise indicated, data in this

chapter citing "payer-reported data to CHIA" highlights membership and cost trends for members covered under private commercial contracts established in Massachusetts (which may include non-Massachusetts residents) and includes both fully and self-insured members.[2] This is the same population included in the Commercial Payer Trends chapter.

A.1 Member Cost-Sharing

Member cost-sharing encompasses all medical expenses allowed under a member's plan but not paid for by a payer, employer, or state cost-sharing reduction (CSR) subsidy and includes costs like deductibles, copayments, and coinsurance. Copayments and coinsurance are based on service utilization, while deductibles and out-of-pocket maximums are set at the time of enrollment. Figures in this chapter include members who incurred minimal medical costs and members who experienced substantial medical costs. They do not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines or vision and dental care that may be covered by a standalone policy). Member cost-sharing also does not account for employer offsets, such as employer contributions to health reimbursement arrangements (HRAs) or health savings accounts (HSAs).

A.2 Premiums

Private commercial insurance is administered through employers. Plans are provided on a contract basis and may be fully insured or self-insured, with different costs associated with each funding method.

- The cost for providing fully insured coverage is measured by the monthly premium, in exchange for which the payer assumes all financial risk (beyond plan cost-sharing) associated with members' eligible medical expenses during the contract period.

- For self-insured coverage, the employer retains the financial risk for medical claims costs while contracting with a payer or third-party administrator to design and administer health plans for its employees and their dependents.

CHIA collects premiums data only for private commercial members who are fully insured, which represented 37.6 percent of private commercial membership in 2024. For fully insured coverage, CHIA reports the full premium amount collected by health plans, including member contributions, employer contributions (for employer plans), and federal and state premium credits and subsidies (for plans sold to individual purchasers). Fully insured premiums are reported net of medical loss ratio rebates (for more information, see page 82). In 2024, the most recent year for which survey data was available, Massachusetts employees contributed 24 percent to

27 percent, on average, to their premium coverage costs.[3] Reported premiums reflect a range of enrollment and plan design decisions by members and employers, including changing plans during open enrollment to mitigate anticipated premium increases.

A.3 Enrollment

Private commercial health insurance enrollment data reflects members covered under private commercial contracts established in Massachusetts (regardless of whether the member resides in Massachusetts), accounting for approximately 4.3 million contract lives in 2024. While most private commercial members are covered under employer-sponsored insurance (ESI), some individuals purchase plans for themselves and their families via the Health Connector, through intermediaries, or directly from insurers. In this report, these members are referred to as "individual purchasers." Depending on their income and other eligibility factors, qualifying Massachusetts residents may purchase ConnectorCare plans that include state CSR subsidies, premium subsidies, and federal advance premium tax credits (APTCs). Other members whose household income disqualify them from ConnectorCare plans may still receive APTCs based on federal affordability standards; they are identified as "APTC-only members" and are grouped under "unsubsidized individual purchasers" throughout this report unless otherwise indicated. Chapter results do not include data for student health plans offered by colleges and universities unless otherwise noted. The **dataset** that accompanies this report contains additional information on these populations as well as expanded enrollment and financial data for the private commercial market.

B. Massachusetts Health Insurance Survey Data

The Massachusetts Health Insurance Survey (MHIS) is a biennial, statewide, population-based survey of noninstitutionalized Massachusetts residents. It is designed to track health insurance coverage, health care access and use, and health care affordability for Massachusetts residents and their families.

The MHIS asks residents about difficulties paying family medical bills in the past 12 months, medical debt held by themselves or family members in the household, the amount and share of family income spent on out-of-pocket health care costs in the past 12 months, and whether the resident or their family chose to go without health care that they felt was needed in the past 12 months due to the cost of that care. In the MHIS, out-of-pocket health care costs encompass direct spending by residents and their families on deductibles, copays, and coinsurance for benefits covered by their health insurance and their spending on medical, dental, and vision services not covered by insurance. Residents were also asked to include out-of-pocket costs owed for

care received over the past 12 months that had not yet been paid. The MHIS does not include premiums for health insurance in the out-of-pocket calculation. Additionally, the survey asks privately insured residents whether their insurance plan is a high-deductible health plan (HDHP), defined by the Internal Revenue Service as having an annual deductible of at least $1,650 for single coverage or $3,300 for family coverage in 2025, and enrollment in tax-advantaged health savings accounts (such as health savings accounts and health reimbursement arrangements).

Estimates reported in this chapter are from the **2025 MHIS**, which was fielded in English and Spanish from January through April 2025 and collected data on 5,365 residents and their families. All estimates provided in this chapter are weighted to provide population-based estimates for all noninstitutionalized residents of the Commonwealth. Additional information about the design of the MHIS is available in the **MHIS methodology report**.

C. Massachusetts Employer Survey

The Massachusetts Employer Survey (MES) is a statewide survey conducted biennially that tracks health insurance offerings, employee enrollment rates, health insurance premiums, employer premium contributions, plan characteristics, and employer decision-making. Estimates reported in this chapter are from the 2024 MES, which was fielded from April to July 2024. The final survey data included responses from 1,066 employers with establishments located in Massachusetts. Federal, state, and other public employers as well as private employers with fewer than 3 employees in the state were excluded. Estimates provided in this chapter are weighted to account for discrepancies in sample selection and response rates. Post-stratification by employer size and industry was also implemented. Cost-sharing estimates are weighted by covered employees and do not include dependents. For additional details about the MES results and methodology, refer to the **2024 MES report**. ■

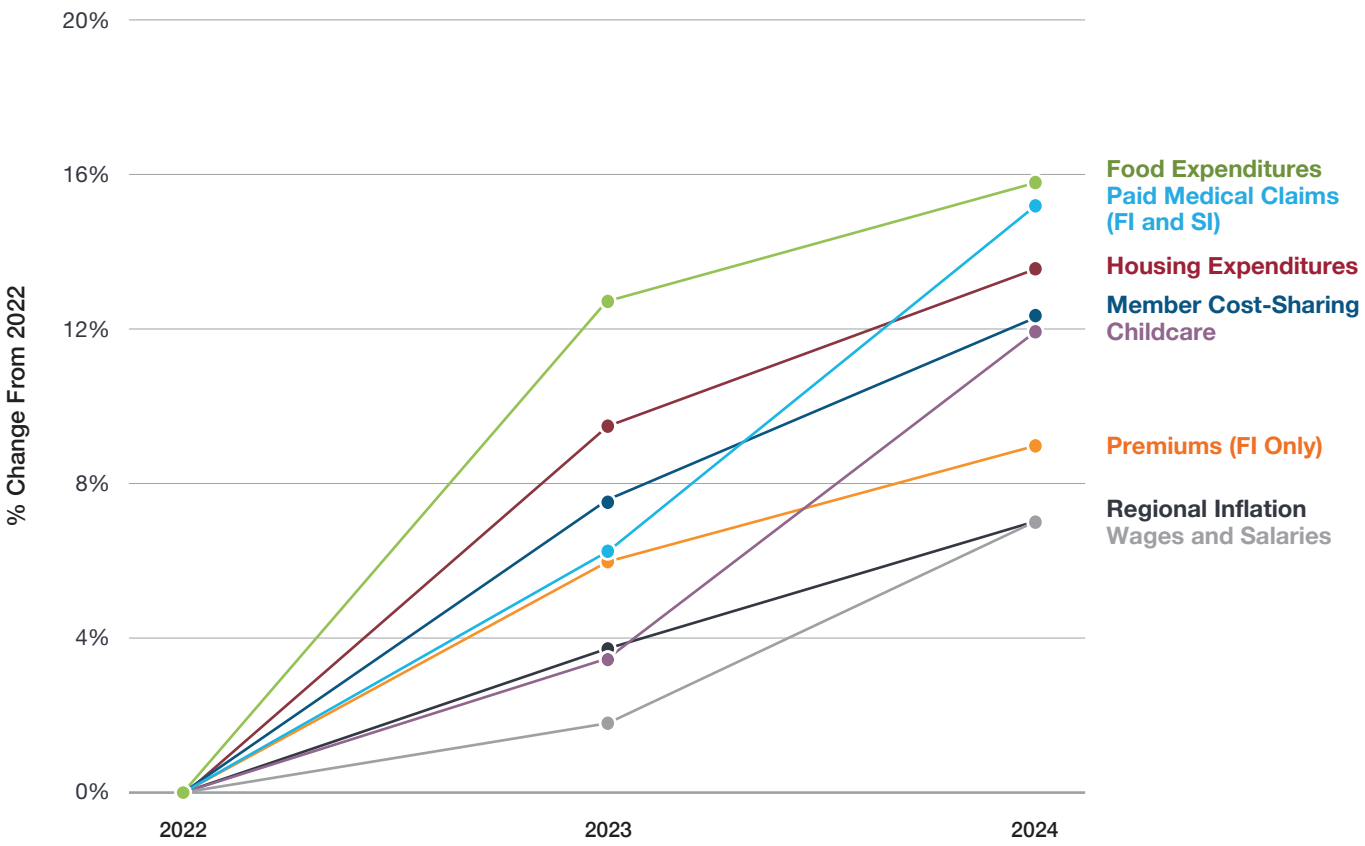
Access and Affordability

Health care is only one component of essential expenses for Massachusetts residents. Growth in spending categories such as housing, food, and childcare often strain household budgets, impacting the ability of individuals and families to afford health care. Affordability issues can also be exacerbated by external economic pressures, from price inflation to wage and salary trends. Therefore, health care cost trends must be evaluated within the context of these broader economic circumstances.

From 2022 to 2024, cumulative health care expenses for members ("member cost-sharing") rose 12.3% while premiums grew 9.0%. Additionally, paid medical claims (the portion of claims covered by health plans and self-insured [SI] employers) grew 15.2% during this time. As paid medical claims rise at a faster rate, payers are expected to offset this cost increase by raising members' premiums.[4]

In addition to the rise in health care costs, spending on other household needs continued to grow. The average expenditures for food in New England increased the fastest, growing 15.8% between 2022 and 2024, followed by average housing expenditures in New England (13.6%) and average cost of center-based childcare in Massachusetts (11.9%). Simultaneously, regional inflation increased 7.0% between 2022 and 2024. The costs for all measures included in this analysis increased faster than the total wages and salaries of Massachusetts employees, which grew by 7.0% between 2022 and 2024.

Affordability in Context, 2022-2024



Spending on monthly premiums, member cost-sharing, and household essentials such as childcare, housing, and food all increased faster than wages and salaries from 2022 to 2024, illustrating widespread affordability issues in Massachusetts.

Source: Payer-reported data to CHIA, Bureau of Labor Statistics, and Child Care Aware of America.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Claims amounts adjusted for pharmacy rebates reported by payers. Trends in member cost-sharing, premiums, and paid medical claims calculated based on underlying per member per month metrics; metrics not scaled to account for benefit carve-outs, which may vary by plan. Measures presented on this page reflect New England regional estimates unless otherwise noted. See technical appendix.

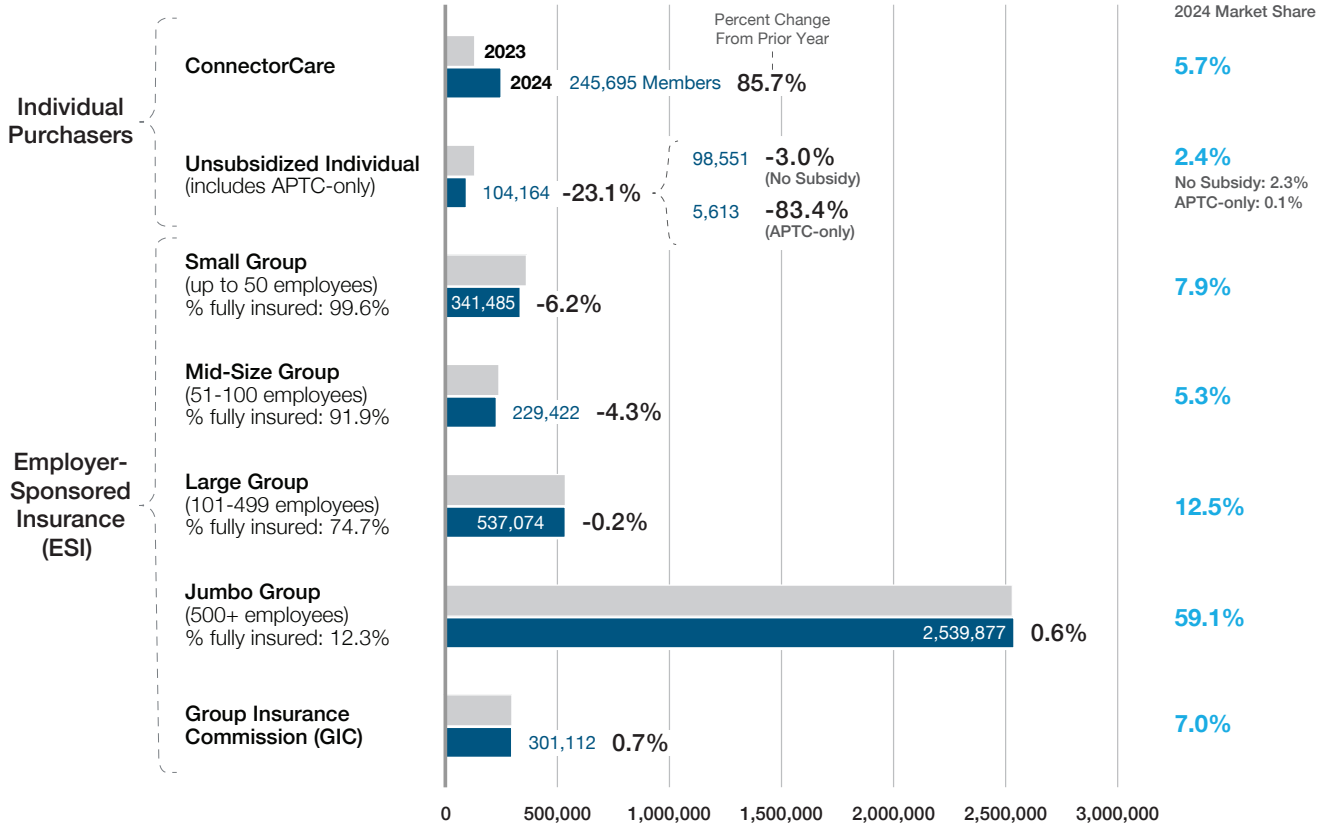
Access and Affordability

Members' health care costs and access are often determined by the health insurance enrollment choices available to them. In 2024, enrollment in private commercial insurance issued in Massachusetts increased by 1.5%, slightly slower than the 2023 increase (1.6%).[5] ESI enrollment remained similar to prior years at almost 4 million members (an overall 0.4% decline between 2023 and 2024). The slight decline in ESI enrollment from 2023 to 2024 was driven by minimal growth within the jumbo group sector and declines in the mid-size (4.3%) and small group (6.2%) sectors. In 2024, enrollment in jumbo group plans grew by only 0.6% compared with 3.7% growth in 2023 while the continued decrease in small group enrollment follows a trend seen since 2014.

In 2024, membership in individual purchaser plans increased 30.7% overall, a result of an 85.7% increase in ConnectorCare enrollment partially offset by a 23.1% decline in unsubsidized individual (including APTC-only) plan enrollment.[6,7,8] The substantial shifts in enrollment across these sectors were driven by the resumption of MassHealth redetermination processes in April 2023 and the ConnectorCare pilot expansion program that launched in January 2024.[9] More than 192,000 individuals who were disenrolled from MassHealth subsequently enrolled in Health Connector insurance marketplace plans between May 2023 and December 2024, with 65% of these individuals remaining enrolled through December 2024.[10] The ConnectorCare pilot expansion also resulted in an 83.4% decrease in APTC-only enrollment, as many of these members newly qualified for ConnectorCare coverage.

For more information on health insurance enrollment in Massachusetts, including Medicare and MassHealth coverage, see CHIA's Enrollment Trends reporting.

Enrollment by Market Sector, 2023-2024



Overall private commercial enrollment grew 1.6% in 2024, with the most substantial increase in ConnectorCare enrollment due to program eligibility expansions.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Annual enrollment reported as average membership within each year, derived by dividing payer-submitted member months by 12. Members in "No Subsidy" population may include those with unknown public subsidy status. GIC did not offer fully insured coverage. Percent (%) fully insured indicates the share of the total membership covered by fully insured plans versu self-insured plans. See technical appendix.

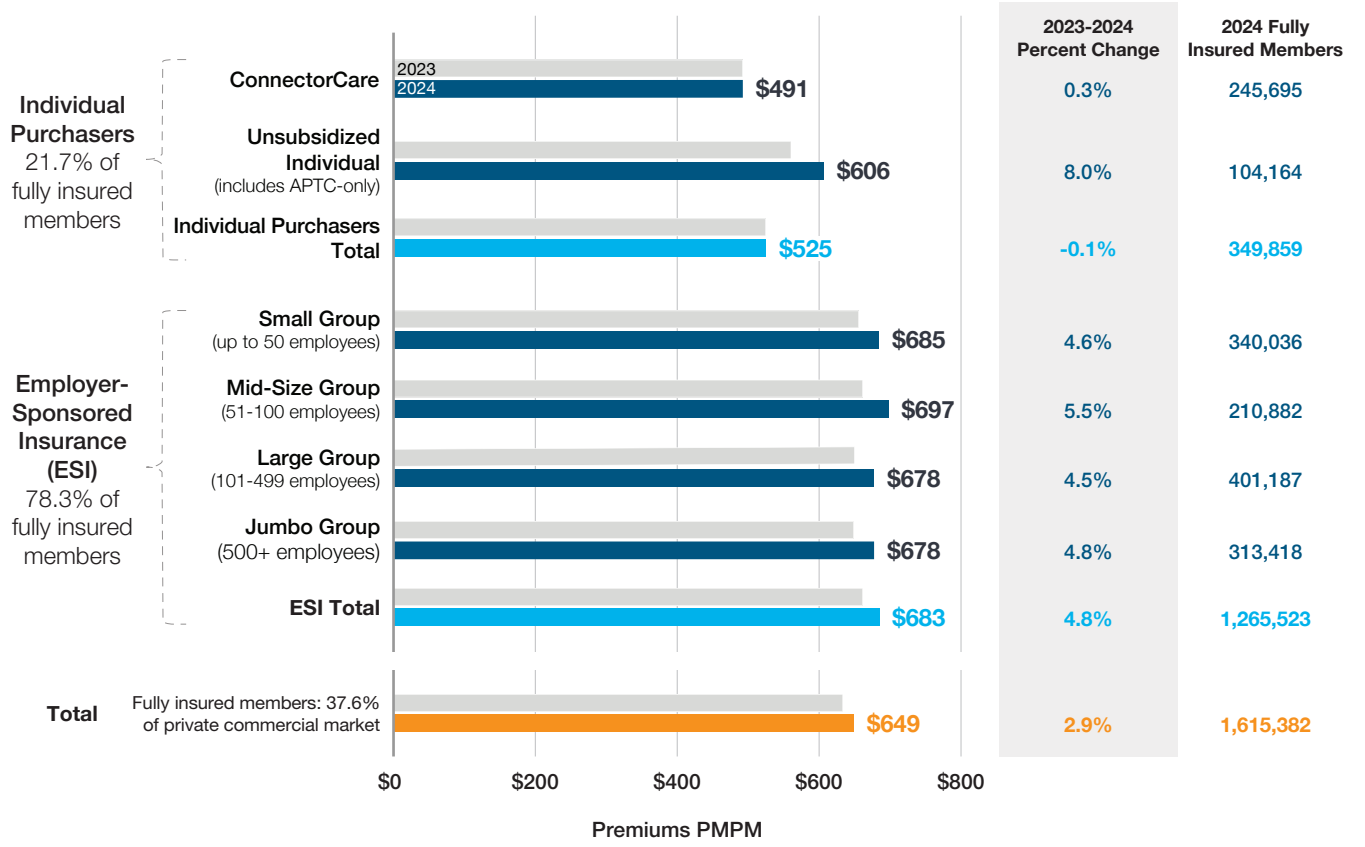
Access and Affordability

Health insurance premiums fund the majority of commercial health care spending, and they are a key expense shouldered by members and—for ESI plans—employers.[11,12] Premiums vary due to differences in benefits, network, and other factors. From 2023 to 2024, fully insured premiums rose 2.9% to $649 PMPM, after a 5.9% increase the prior year. This overall growth in premiums slowed as a result of an increase in members with low premiums through the ConnectorCare program. Across ESI plans, the average fully insured premium increased 4.8% from $652 to $683 PMPM, following a 6.0% increase the previous year. For individual purchasers, the average fully insured premium decreased 0.1% from $526 to $525 PMPM. Since 2014, fully insured premiums have increased 45.8% from $445 PMPM.[13]

Among ESI sectors in 2024, large employers had the lowest premium growth rate (4.5%) and one of the lowest average premiums ($678 PMPM); mid-size employers had the highest premium growth rate (5.5%) and highest average premium ($697 PMPM). Premiums were similar across employer sizes in 2024; yet, on average, employees at smaller firms paid a greater share (24% to 30%) of the total monthly premium than those at larger firms (24% to 26%) (data not shown).[14]

On average, individual purchasers had lower premiums compared with members who had employer-sponsored coverage. However, unsubsidized individual purchaser premiums increased 8.0% in 2024 to $606 PMPM, the fastest growth across all commercial market sectors including ESI. ConnectorCare base premiums (before subsidies) were the lowest of any market sector in 2024 ($491 PMPM) and increased the slowest at 0.3%. During this period, enhanced state and federal subsidies lowered ConnectorCare members' premium contributions, improving the affordability of health coverage.[15]

Fully Insured Premiums by Market Sector, 2023-2024



Between 2023 and 2024, fully insured premiums across individual purchaser sectors declined 0.1% overall, while premiums for employer-sponsored plans increased 4.8% overall.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums net of MLR rebates and reflect fully insured premiums only. Premiums not scaled to account for benefit carve-outs, which may vary by plan. Unsubsidized individual purchasers include some members receiving APTCs (which would reduce members' contributions below reported premium amounts). GIC did not offer fully insured coverage. See technical appendix.

Access and Affordability

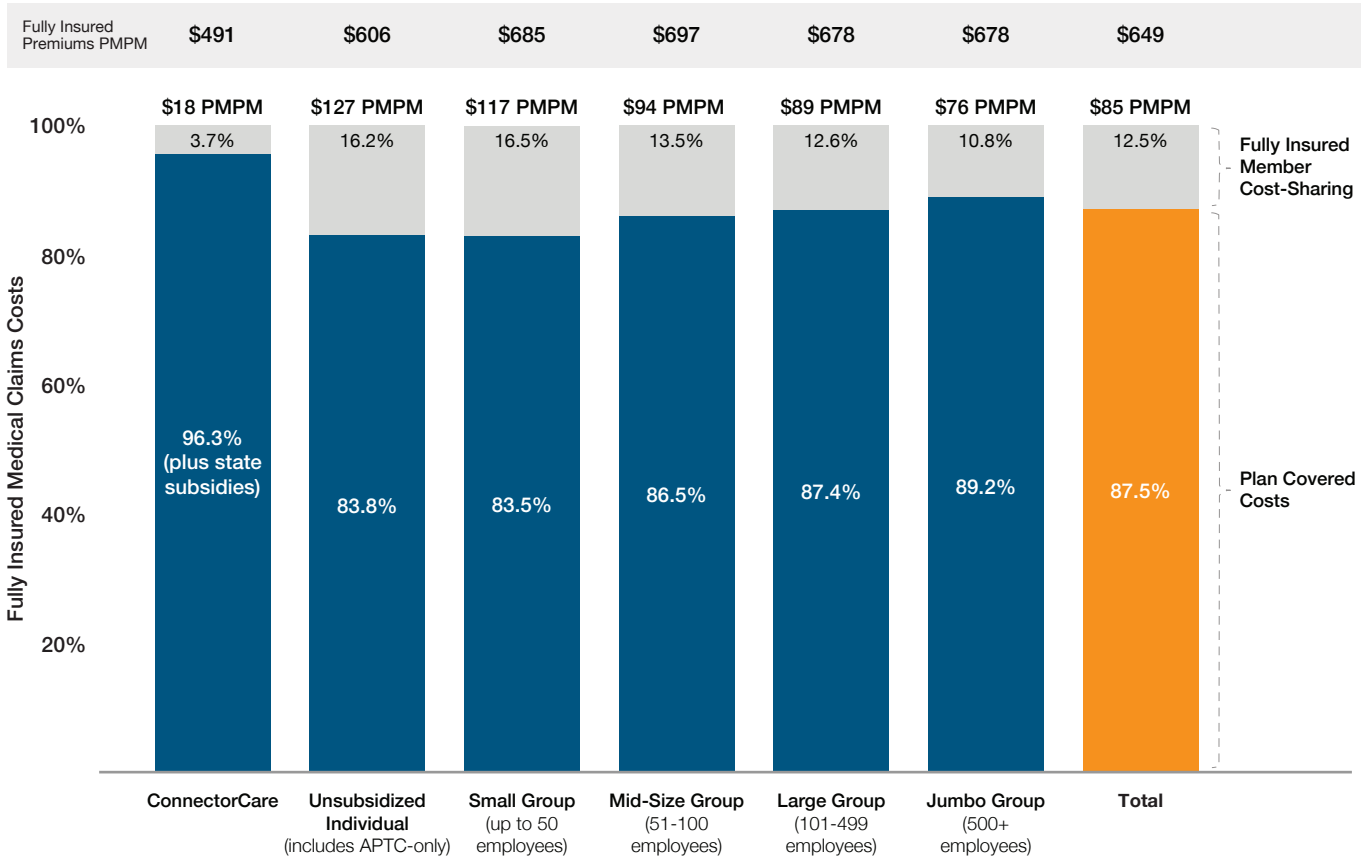
Insurance purchasers (members and/or employers) compare and balance health plan premiums with potential out-of-pocket costs (member cost-sharing). Some purchasers may choose plans with lower premiums and higher deductibles, lowering initial costs but leaving members at risk of high medical bills in the future. Others may prefer higher monthly premiums in exchange for plans that cover a greater percentage of costs when medical services are used. CHIA's "benefit level" metric quantifies the percentage of medical costs covered by fully insured commercial health plans.

In 2024, Massachusetts fully insured health plans paid an average of 87.5% of medical and prescription drug costs for benefits included in the member's health insurance plans. This proportion is higher than in prior years (86.7% in 2023, 87.2% in 2022), reflecting the increased enrollment in ConnectorCare plans, which tend to cover a larger share of medical costs. From 2023 to 2024, the total benefit levels remained relatively consistent for all market segments except unsubsidized individuals, which increased by 1.9 percentage points.

Benefit levels varied across private commercial market sectors. ConnectorCare members had the highest proportion (96.3%) of medical costs covered by their health plans (including state CSR subsidies). Federal and state subsidies assist ConnectorCare members with lower cost-sharing and increase benefit level coverage.[16] Members in small and mid-size employer groups had a smaller proportion of medical costs covered by their health plans compared with members in larger employer groups despite paying similar or higher monthly premiums.[17]

Benefit levels are one of many factors that influence premiums, which also include provider network size, experience rating, and efficiencies of scale.

Fully Insured Benefit Levels by Market Sector, 2024



Members enrolled in health plans from small and mid-size employer groups paid higher monthly premiums and a higher share of their health care expenses compared with members from large and jumbo employer groups.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums net of MLR rebates and reflect fully insured premiums only. Premiums not scaled to account for benefit carve-outs, which may vary by plan. Claims amounts adjusted for pharmacy rebates reported by payers. Unsubsidized individual purchasers include some members receiving APTCs (which would reduce members' contributions below reported premium amounts). See technical appendix.

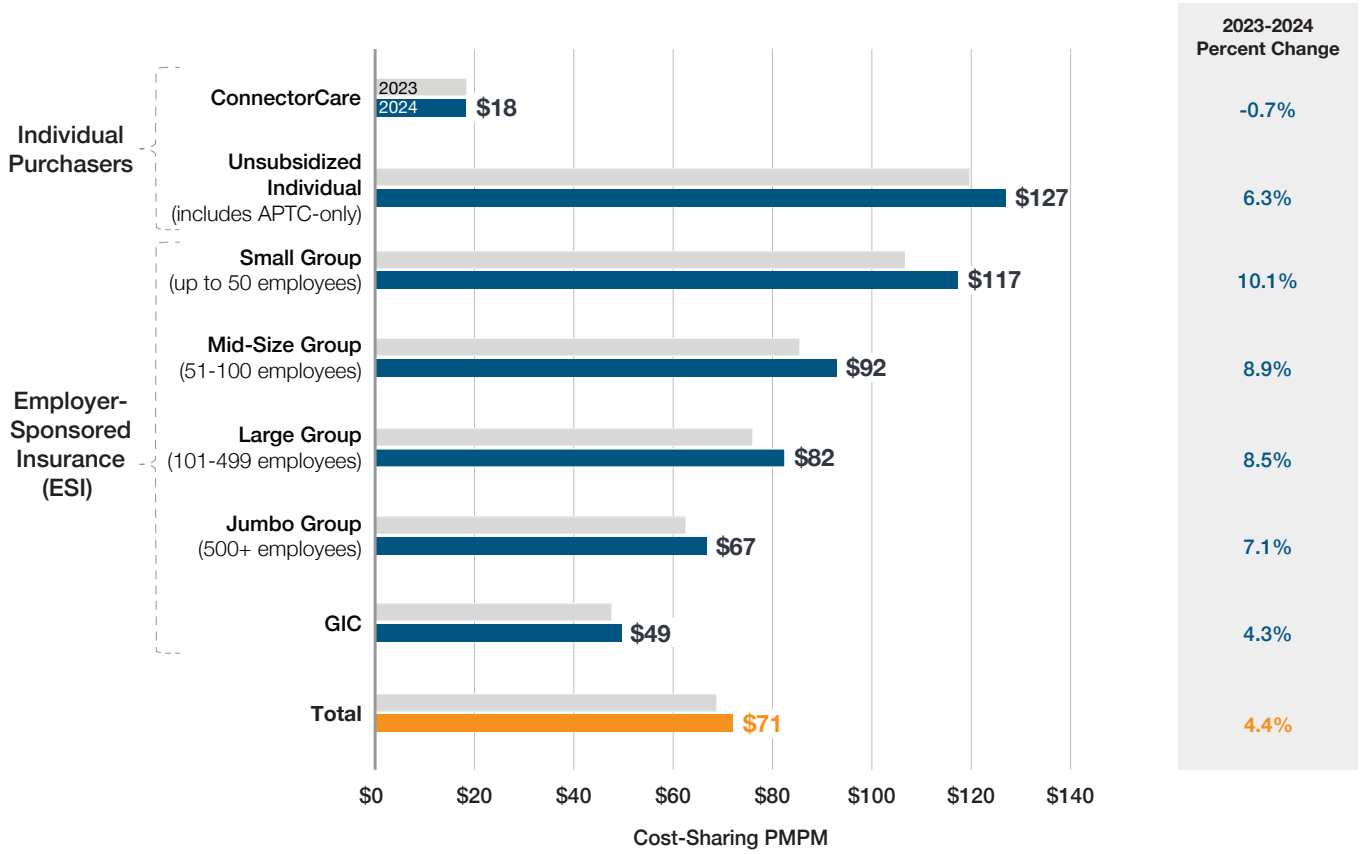
Access and Affordability

From 2023 to 2024, cost-sharing for Massachusetts commercial contract members (fully and self-insured) increased 4.4% to $71 PMPM, following a 7.6% increase the prior year. Cost-sharing amounts for individuals purchasing coverage without subsidies rose to $127 PMPM in 2024, a 6.3% increase from 2023. Unsubsidized individual purchasers buy non-ConnectorCare plans from the Massachusetts Health Connector or directly from payers and often have income levels surpassing eligibility thresholds for state health insurance subsidies.[18] These purchasers have consistently had the highest member cost-sharing of any market sector since CHIA started measuring this population.

In 2024, ConnectorCare cost-sharing was $18 PMPM, similar to the prior year, remaining below pre-pandemic levels ($20 PMPM in 2019).[19] In 2023 and 2024, ConnectorCare plans maintained $0 copays for primary care and behavioral health services as well as for certain medications to manage chronic conditions.[20]

Among ESI sectors, small and mid-size group employers continued to have the highest cost-sharing amounts among all group sizes in 2024 at $117 PMPM and $92 PMPM, respectively. Cost-sharing also increased the fastest for members in the small group (10.1%) and mid-size group (8.9%) sectors. As presented on page 55, smaller group plans had higher rates of HDHP enrollment, contributing to higher member cost-sharing. The GIC continued to have the lowest member cost-sharing of any ESI group at $49 PMPM in 2024.

Private Commercial Member Cost-Sharing by Market Sector, 2023-2024



From 2023 to 2024, the average member cost-sharing PMPM increased by 4.4%, with small, mid-size, and large group employers experiencing the fastest increases.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents and includes fully and self-insured data. Cost-sharing amounts not scaled to account for benefit carve-outs, which may vary by plan. Claims amounts adjusted for pharmacy rebates reported by payers. Unsubsidized individual purchasers include some members receiving APTCs (which would reduce members' contributions below reported premium amounts). See technical appendix.

Access and Affordability

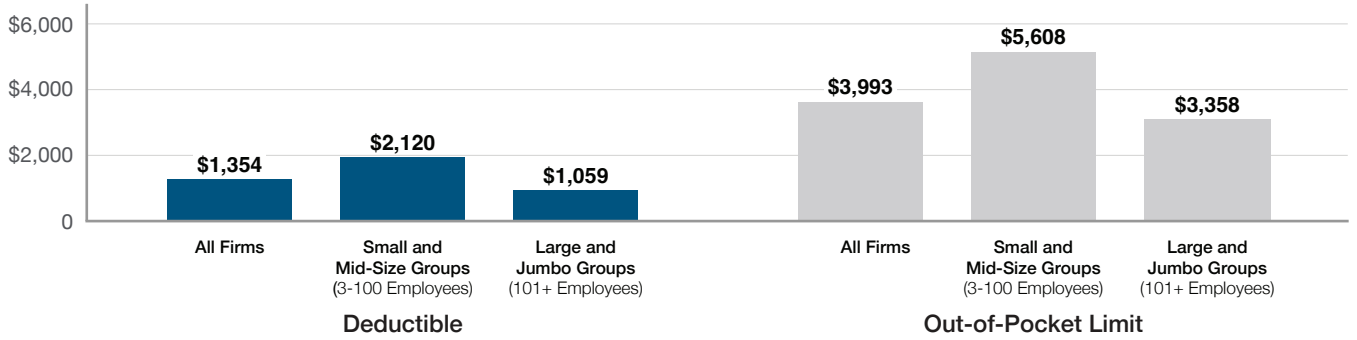
The increase in annual deductibles, out-of-pocket limits, and copayments compound affordability challenges for residents enrolled in private commercial insurance. In 2024, across all private commercial enrollees, 19.4% of members had deductibles of $2,500 or greater, up from 17.8% in 2023 (data not shown). Additionally, 50.6% of members had out-of-pocket limits of $5,000 or greater, relatively consistent with prior years (data not shown).[21]

In 2024, among employees enrolled in a single coverage plan with a deductible, the average annual deductible was $1,354. Average annual deductibles were twice as high for employees at small and mid-size employers relative to large and jumbo employers ($2,120 vs. $1,059). The average out-of-pocket limit for employees with single coverage in Massachusetts was $3,993, but much higher for employees at small and mid-size employers compared with large and jumbo employers ($5,608 vs. $3,358).

While copayments for medical services were similar among plans offered by employer size, copayments for emergency department visits, inpatient admissions, and both preferred and non-preferred brand drugs were substantially higher for employees at small and mid-size employers than at large and jumbo employers.

Average Annual Deductibles, Out-of-Pocket Limits, and Copayments for Single Coverage, 2024

Average Annual Deductibles and Out-of-Pocket Limits for Single Coverage by Firm Size



Copayments by Firm Size

	All Firms	Small and Mid-Size Groups (3-100 Employees)	Large and Jumbo Groups (101+ Employees)
PCP Office Visit	$24	$26	$23
Mental Health Office Visit	$31	$33	$30
ED Visit	$219	$300	$193
Inpatient Admission	$330	$476	$279
Generic Drug	$12	$13	$12
Non-Preferred Brand Drug	$63	$84	$57
Preferred Brand Drug	$36	$44	$33
Specialty Drug	$97	$121	$87

Deductibles, out-of-pocket limits, and select copayments were higher for employees at small and mid-size employers compared with employees at large and jumbo employers.

Source: 2024 Massachusetts Employer Survey (MES).

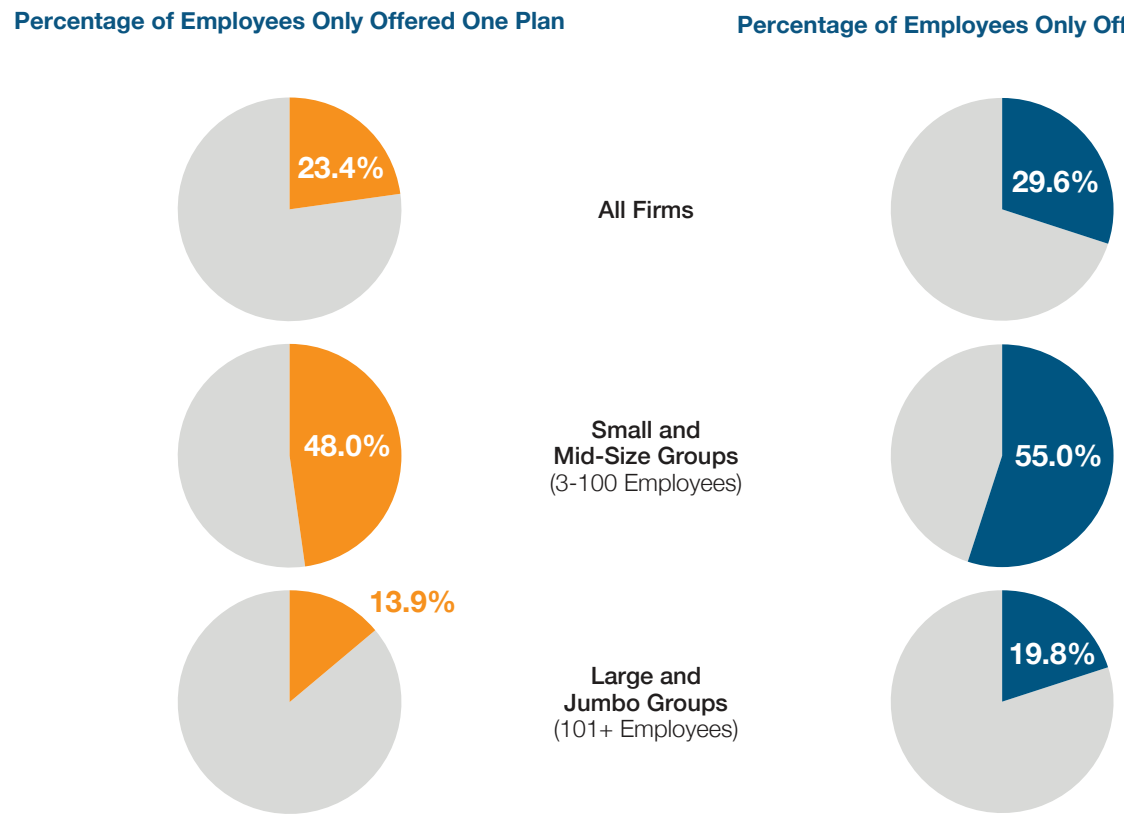
Notes: Cost-sharing amounts based on in-network providers for single coverage health plans. Deductibles reported for plans with covered employees enrolled in single coverage plans that include deductibles. Average deductibles and out-of-pocket limits based on weighted average of largest enrolled plan at each firm. Copayment amounts based on weighted average of covered employees in all plans offered at firm (up to 5 plans). Out-of-pocket limit is maximum that enrollee pays for covered services in plan year; after enrollee spends this amount on deductibles, copayments, and coinsurance, health plan pays 100% of costs of covered benefits. $0 copays for inpatient visits excluded from average. Public employees and firms with fewer than 3 employees not included in this data.

Access and Affordability

The number and types of plans offered to employees vary considerably by employer size, which affects employee plan choice, cost-sharing, and services covered, among other things. Employees at small and mid-size employers have more limited choices compared with their counterparts at larger employers. Nearly half of employees (48.0%) at small and mid-size employers that offered insurance were offered only 1 health plan, and more than half (55.0%) were exclusively offered HDHPs.

While most Massachusetts employers offer health insurance to their employees, decisions about whether to offer health insurance and which health plans to select have important implications for the health care marketplace and are primarily driven by cost. Among the 66.8% of employers that chose to offer insurance in 2024, 90.5% reported the cost of the plan as the most important factor for selecting a health insurance carrier or plan (data not shown). For the 33.2% of employers that did not offer insurance, nearly one-third (31.9%) identified high costs as a top reason, only preceded by not being required due to their size and that their employees are covered by another plan (data not shown).

Employee Plan Offerings, 2024



Employees at smaller companies have limited plan choices compared with those at larger organizations. More than half of employees at small and mid-size employers were only offered HDHPs.

Source: 2024 Massachusetts Employer Survey (MES).

Notes: 2024 IRS deductible thresholds for high-deductible health plans were $1,600 for single coverage and $3,200 for family coverage. 2024 MES collected plan type information for up to 5 plans offered by firms. Rates adjusted by employee weights. Public employees and firms with fewer than 3 employees not included in this data.

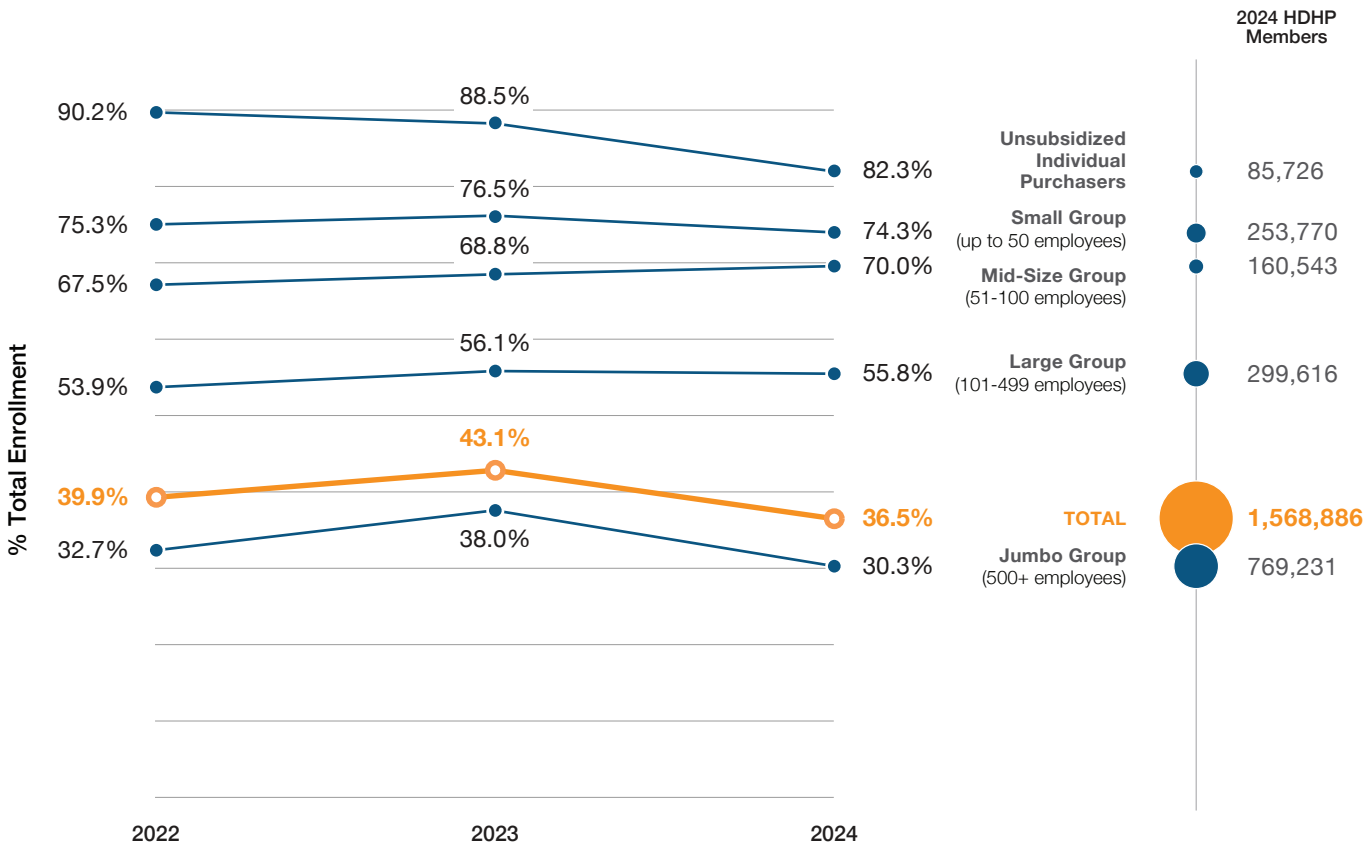
Access and Affordability

In 2024, nearly 1.6 million Massachusetts members (36.5%) were enrolled in HDHPs with individual deductible levels of at least $1,600. In 2024, enrollment in HDHPs decreased among multiple payers and in almost every market sector where they were offered, apart from the mid-size group sector. This breaks a long-term growth trend since 2014, when only 19.0% of Massachusetts members were enrolled in an HDHP.[22] CHIA survey data also suggests that the recent decline in HDHP enrollment in Massachusetts is due to declines at larger firms.[23] As concerns over health care affordability persist, employers may be offering more health plan options beyond HDHPs to improve employee recruitment and retention.[24]

While HDHPs can lower members' monthly premiums, these members risk greater out-of-pocket costs. To help offset out-of-pocket costs for those enrolled in an HDHP, employer groups may offer access to tax-deferred Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) options. More than one-third of employer groups that include HDHP options offered them with an accompanying HSA or HRA, though larger firms were more likely to offer these savings options than smaller firms.[25]

The largest decrease in proportional HDHP enrollment was seen among members in the jumbo group sector, which declined by 7.7 percentage points, followed by a 6.2 percentage point decrease in HDHP enrollment for unsubsidized individual purchasers. Enrollment in HDHPs for the small, mid-size, and large group sectors remained relatively stable in 2024 compared with 2023, with small and large groups seeing slight decreases in enrollment and the mid-size group seeing a slight increase.

HDHP Enrollment by Market Sector, 2022-2024



Disrupting a long-term growth trend, HDHP enrollment decreased across all ESI plans except mid-size groups, with jumbo groups experiencing the largest proportional decrease of 7.7 percentage points from 2023 to 2024.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents and includes fully and self-insured data. HDHPs defined by IRS individual plan deductible threshold ($1,400 in 2022, $1,500 in 2023, $1,600 in 2024). ConnectorCare and GIC trends not shown as HDHPs not offered to members. Unsubsidized individual purchasers include federal APTC-only members who do not qualify for ConnectorCare Plans or state subsidies.

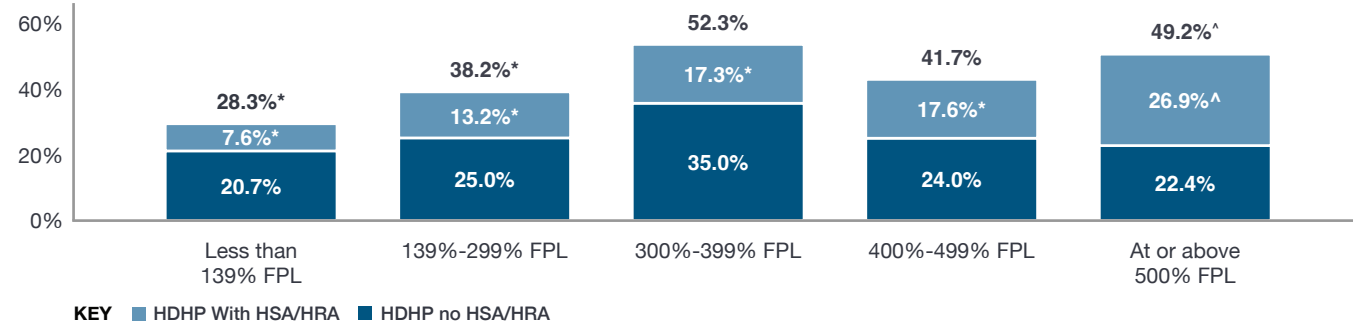
Access and Affordability

Despite paying lower premiums, individuals enrolled in HDHPs may have more issues affording their health care expenses, and the impact of affordability challenges may vary across populations. In 2025, between 25% and 50% of privately insured residents were enrolled in HDHPs across family income levels. HDHP enrollment was less common for residents with a family income below 299% of the federal poverty level (FPL) than those with a family income at or above 500% FPL. However, residents may enroll in tax-advantaged savings accounts like HSAs or HRAs to offset health care expenses. Those with a family income at or above 500% FPL were more likely than any other income group to report being enrolled in an HDHP with an HSA or HRA.

The burden of affordability issues was greater for residents enrolled in HDHPs who have family incomes below 500% FPL than for those with family incomes at or above 500% FPL. Among those enrolled in HDHPs, 16.1% of residents with a family income at or above 500% FPL reported having medical debt or problems paying family medical bills; that rate is almost double for those with a family income from 400% to 499% FPL (29.2%), and it triples for family incomes at 399% FPL and below (48.2% to 49.6%). Further, among those enrolled in HDHPs, about 1 in 4 residents with a family income at or above 500% FPL reported an unmet need for health care in their family due to cost, compared with nearly 1 in 2 residents with family incomes below 139% FPL.

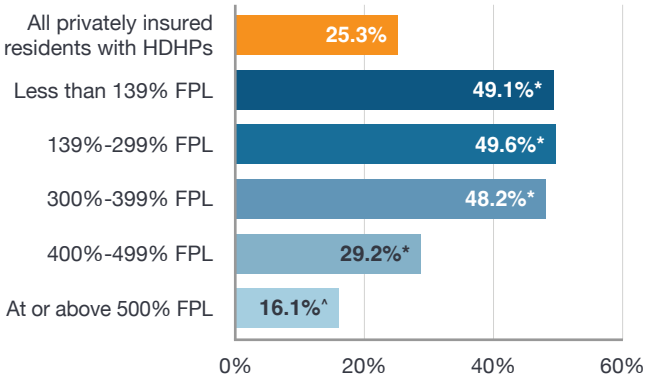
Enrollment in HDHPs with Savings Options and Affordability Issues Among Privately Insured Massachusetts Residents by Family Income, 2025

Enrollment in HDHPs With Savings Options Among Privately Insured Residents

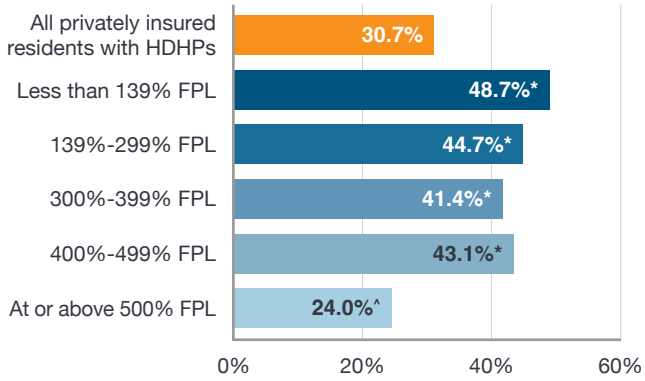


Affordability Issues Among Privately Insured Residents With HDHPs

Medical Debt or Problems Paying Family Medical Bills



Unmet Need for Health Care in Family Due to Cost



Residents with lower family incomes who were enrolled in commercial HDHP plans were less likely to have health care savings accounts to offset health care expenses.

^ Reference group. *Difference from estimate for "At or above 500% FPL" (reference group) statistically significant at 5% level.

Source: 2025 Massachusetts Health Insurance Survey (MHIS).

Notes: Estimates on this page limited to privately insured residents with commercial health insurance coverage, which includes employer-sponsored insurance (ESI), Health Connector plans, and non-group health insurance plans bought directly from an insurance company. Income reported from 2024; for family of 4 in 2024, 139% FPL was $43,000, 300% FPL was $94,000, 400% FPL was $125,000, and 500% FPL was $156,000, rounded to nearest thousand. "Any unmet need in family for health care due to cost" includes the following unmet needs: doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment.

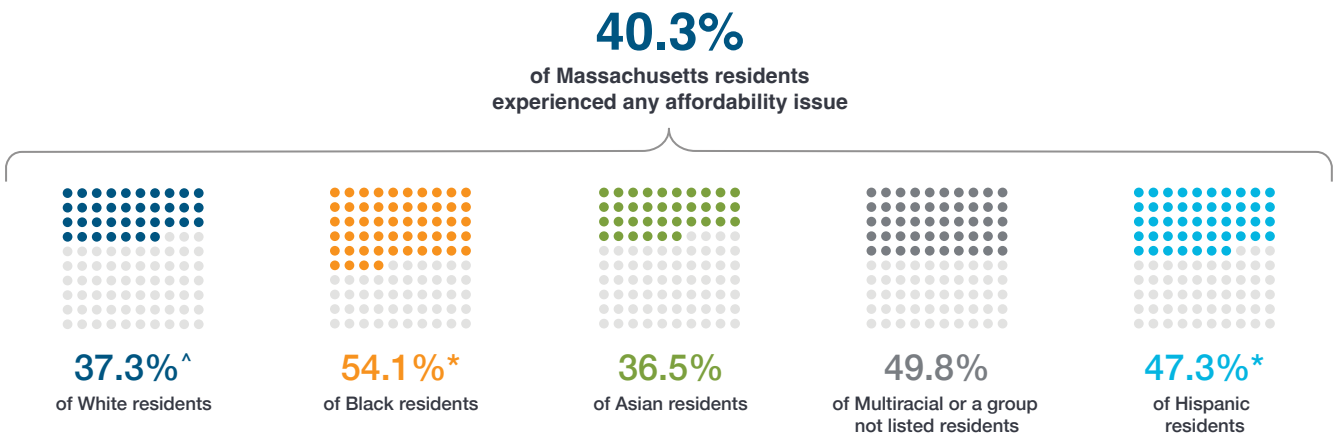
Access and Affordability

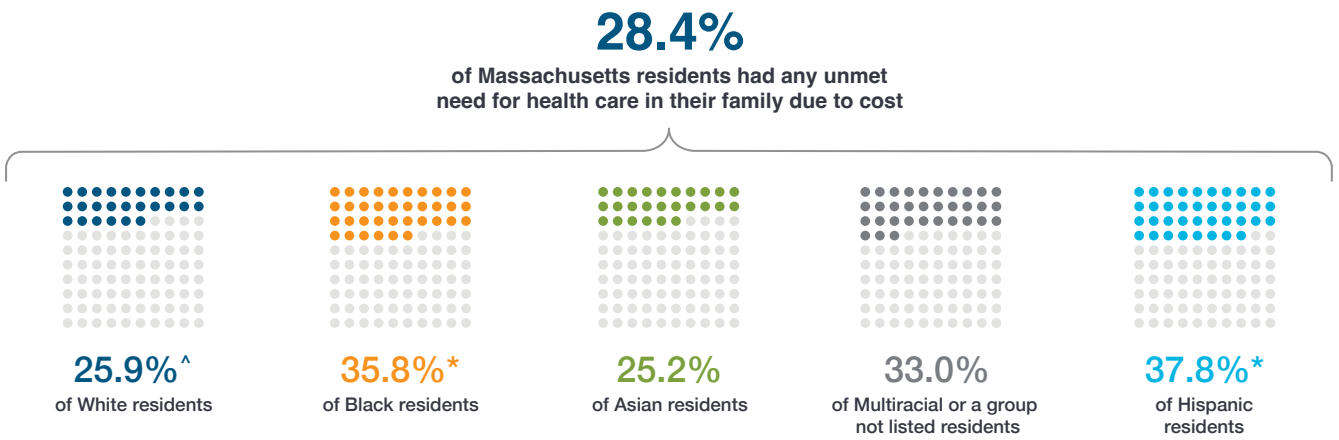
With the costs of health insurance continuing to increase in Massachusetts, residents and their families are experiencing a wide range of issues paying for their health care expenses. Families may have difficulties paying their medical bills in full or over time, forgo necessary care due to the cost of that care, or spend a disproportionately high share of their family income on medical expenses.

In 2025, 2 in 5 Massachusetts residents (40.3%) reported that their families faced any affordability issue within the past 12 months. The burden of affordability issues was greater for Black residents (54.1%) and Hispanic residents (47.3%) relative to White residents (37.3%).

Additionally, nearly one-third (28.4%) of residents or their immediate family members reported that they went without needed care in 2025 due to cost. Hispanic residents and Black residents were more likely to report any unmet health care need in their family compared with White residents (37.8% and 35.8%, respectively, vs. 25.9%).

Affordability Issues Among Massachusetts Residents and Their Families by Race and Ethnicity, 2025





While affordability issues persisted for many Massachusetts residents and their families, the burden was greater for Hispanic residents and Black residents.

^Reference group. *Difference from estimate for "White residents" (reference group) statistically significant at 5% level.

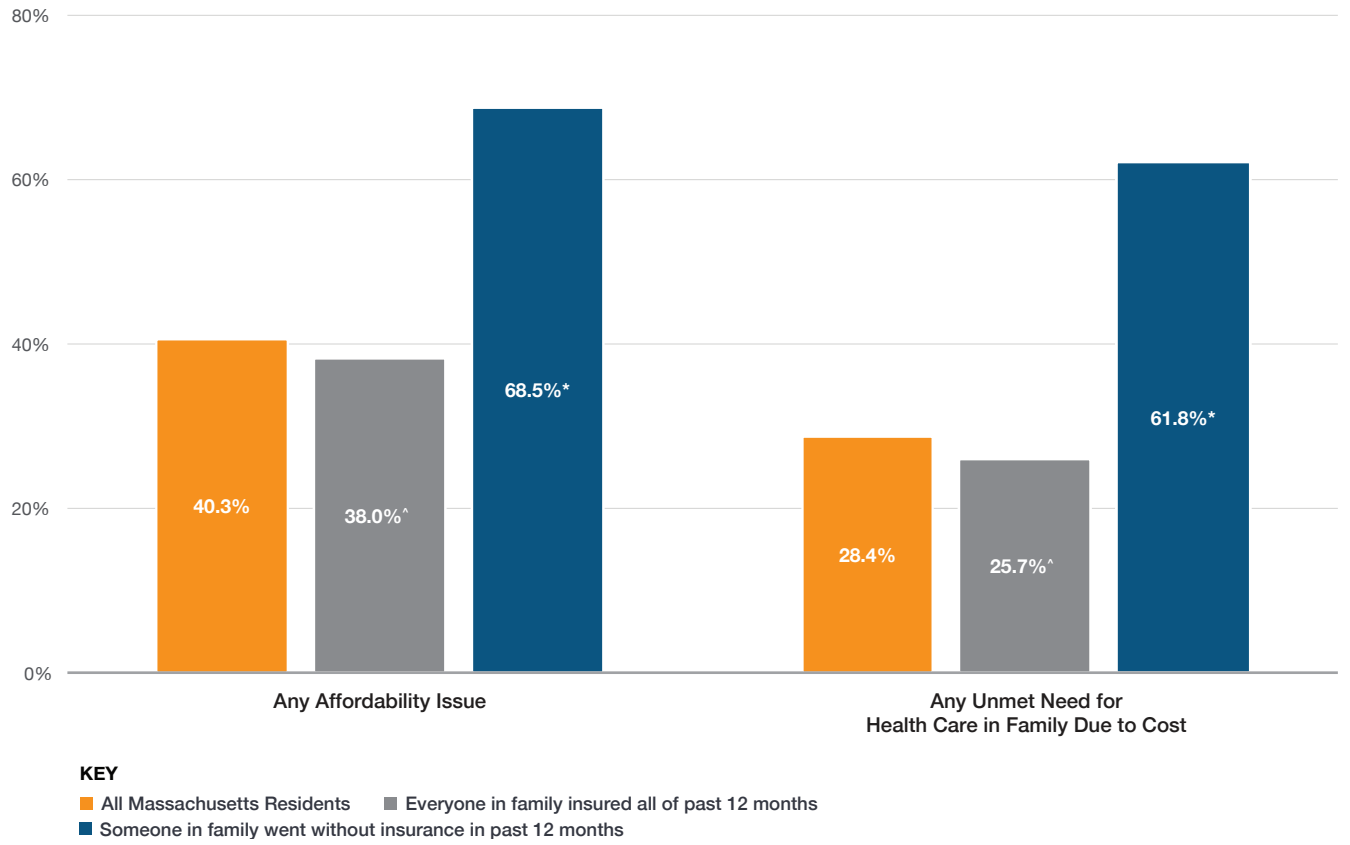
Source: 2025 Massachusetts Health Insurance Survey (MHIS).

Notes: "Any affordability issue" defined as reporting any of the following: problems paying family medical bills in past 12 months; family medical debt at time of survey; spending high share of family income in past 12 months on out-of-pocket health care expenses; and any unmet need in family for health care due to cost in past 12 months. "Any unmet need in family for health care due to cost" includes the following unmet needs: doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment.

Access and Affordability

Residents whose family members were uninsured at any time in the past 12 months are particularly susceptible to affordability issues. In 2025, these residents reported higher rates of facing at least 1 affordability issue compared with those whose family members were always insured over the past 12 months (68.5% vs. 38.0%, respectively). Additionally, they were more than twice as likely to forgo necessary care due to cost compared with those whose family members were always insured (61.8% vs. 25.7%, respectively).

Affordability Issues Among Massachusetts Residents and Their Families by Health Insurance Status, 2025



Residents with a family member who was uninsured at any time in the past 12 months were more likely to report any affordability issue and unmet health care need due to cost than residents whose family members were always insured.

^Reference group. *Difference from estimate for "Everyone in family insured all of past 12 months" (reference group) statistically significant at 5% level.

Source: 2025 Massachusetts Health Insurance Survey (MHIS).

Notes: "Any affordability issue" defined as reporting any of the following: problems paying family medical bills in past 12 months; family medical debt at time of survey; spending high share of family income in past 12 months on out-of-pocket health care expenses; and any unmet need in family for health care due to cost in past 12 months. "Any unmet need in family for health care due to cost" includes the following unmet needs: doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment.

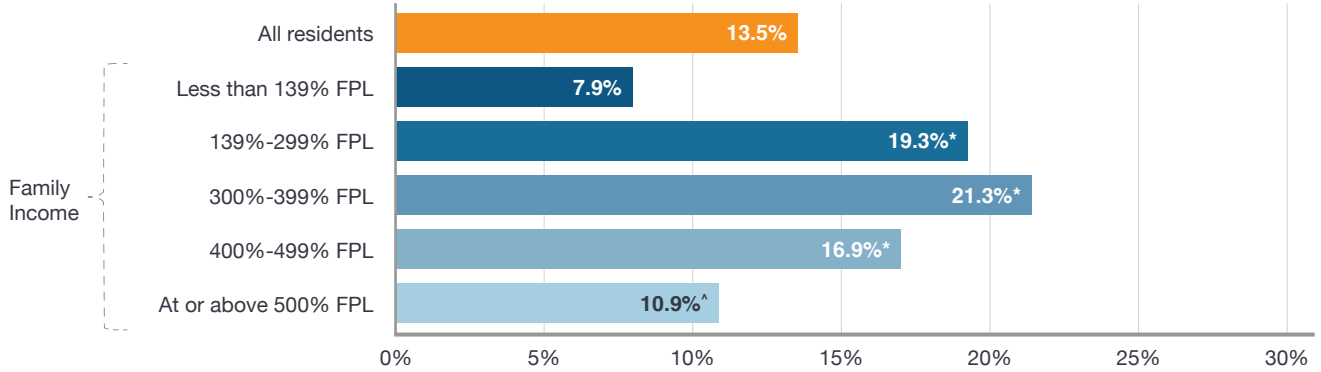
Access and Affordability

In 2025, 1 in 8 Massachusetts residents (13.5%) reported that their family held medical debt, defined as medical bills being paid over time. Residents in the highest and lowest income groups reported the lowest rates of medical debt (7.9% for those below 139% FPL and 10.9% for those at or above 500% FPL). The share of residents reporting medical debt was highest among those with family incomes 139% to 299% FPL (19.3%), 300% to 399% FPL (21.3%), and 400% to 499% FPL (16.9%). This relationship between income and medical bills being paid over time may reflect that MassHealth has eliminated all copays and cost-sharing for members below 139% FPL, protecting families with MassHealth coverage from high out-of-pocket expenses. Additionally, ConnectorCare has eliminated copays for its members for primary care and behavioral health care as well as for specific drugs treating hypertension, diabetes, asthma, and coronary artery disease.[26]

In 2025, 9 out of 10 residents who reported family medical debt (89.6%) indicated that all their medical debt was incurred for care obtained while they and all family members had insurance coverage. Most Massachusetts residents who reported family medical debt and whose families had health insurance coverage when all bills were incurred reported that the debt was for payments required by their health insurance: Around three-quarters (71.9%) reported that they held medical debt from health plan deductible payments, and more than half (55.5%) reported medical debt from copayments or coinsurance. More than half of residents with medical debt (56.7%) reported that they held medical debt from care not covered by their health plan.

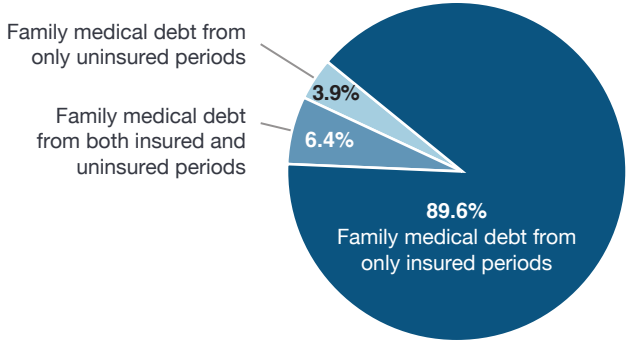
Medical Debt Among Massachusetts Residents and Their Families by Family Income, 2025

Medical Debt Among Massachusetts Residents and Their Families by Family Income



^ Reference group.
* Difference from estimate for reference group statistically significant at 5% level.

Insurance Status at Time Medical Debt Was Incurred



Costs Contributing to Debt
- Deductibles (71.9% of residents)
- Copays/coinsurance (55.5% of residents)
- Care not covered (56.7% of residents)

In 2025, 1 in 8 Massachusetts residents reported that their family held medical debt, with nearly all attributing it to cost-sharing while all family members were insured.

Source: 2025 Massachusetts Health Insurance Survey (MHIS).

Notes: Income reported from 2024; for family of 4 in 2024, 139% FL was $43,000, 300% FPL was $94,000, 400% FPL was $125,000, and 500% FPL was $156,000, rounded to nearest thousand. Insurance status is among residents who reported family medical bills being paid off over time; costs contributing to debt is among residents with debt from only insured periods.

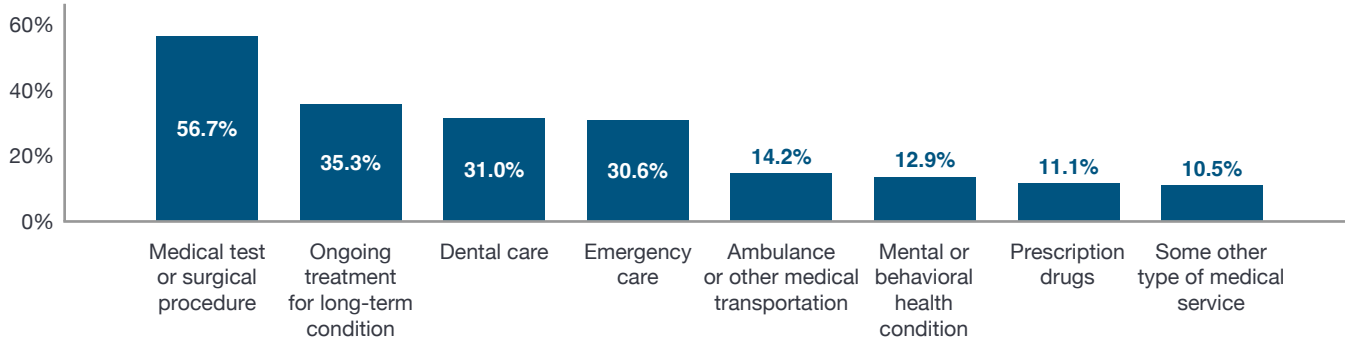
Access and Affordability

Medical tests or surgical procedures were the most reported type of care or service that led to medical debt, reported by 56.7% of Massachusetts residents with family medical debt in 2025. Other common sources of bills being paid over time were treatment for a long-term health problem or chronic condition (35.3%), dental care (31.0%), and emergency care (30.6%).

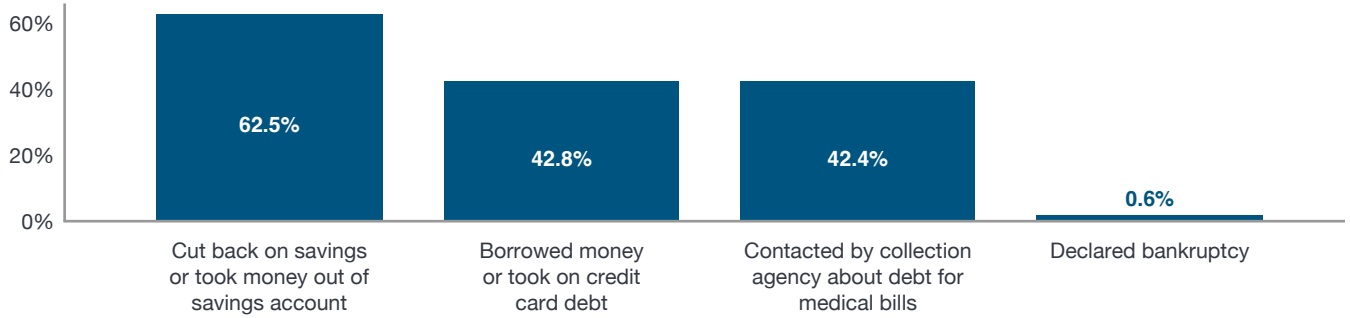
Nearly two-thirds of residents with medical debt reported cutting back on savings or taking money out of a savings account to pay for medical bills (62.5%), while two-fifths reported borrowing money or taking on credit card debt to pay medical bills (42.8%). Two-fifths of Massachusetts residents with medical debt (42.4%) reported being contacted by a collection agency about their medical debt.

Types of Care That Led to Family Medical Debt and Consequences of That Debt Among Massachusetts Residents and Their Families, 2025

Types of Care and Services That Led to Family Medial Debt



Consequences of Medical Debt



Medical tests and procedures were the most common source of medical debt, and 2 in 5 residents with medical debt were contacted by a collection agency in 2025.

Source: 2025 Massachusetts Health Insurance Survey (MHIS).

Notes: Among residents who reported having family medical bills being paid over time. Categories listed above not mutually exclusive; residents were asked to select all applicable options.

Access and Affordability Notes

1. Results based on commercial contract member data provided by Aetna, Blue Cross Blue Shield of Massachusetts (BCBSMA), Cigna, Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Mass General Brigham Health Plan (MGBHP, formerly AllWays), Tufts Health Plan (Tufts), Tufts Health Public Plans (THPP), UnitedHealthcare, Wellpoint (formerly UniCare), and WellSense (formerly Boston Medical Center Health Plan/ BMCHP). Payers with fewer than 50,000 Massachusetts primary medical enrollees were not required to submit data.
2. Massachusetts contract members may reside inside or outside Massachusetts; contract members who live out of state are most often covered through a Massachusetts-based employer.
3. Center for Health Information and Analysis, *2024 Massachusetts Employer Survey Summary of Results* (Boston, December 2024), https://www.chiamass.gov/massachusetts-employer-survey.
4. Premiums for individual and small group plans offered in the Merged Market increased by an average of 7.9% for 2025 and 13.4% for 2026. For more information on the 2025 and 2026 health insurance rates, see https://www.mass.gov/info-details/2025-health-insurance-rates and https://www.mass.gov/info-details/2026-health-insurance-rates.
5. Within the Access and Affordability chapter, private commercial enrollment reflects Massachusetts contract membership (situs-based) data, which may include non-Massachusetts residents. Results may differ from THCE data points, which model per capita expenditures based on Massachusetts residents only.
6. Unsubsidized individual purchasers are individuals who purchase non-ConnectorCare plans from the Massachusetts Health Connector or directly from payers and who often have income levels surpassing eligibility thresholds for state health insurance subsidies.
7. Unsubsidized and APTC-only individuals are combined for reporting within the Access and Affordability chapter.
8. The implementation of the American Rescue Plan Act (ARPA) in March 2021 and subsequent federal legislation expanded eligibility for purchasers to receive APTCs and increased the amounts of credits through 2025. These increases were driven by growth in subsidized individual purchaser membership in ConnectorCare, as some residents who were determined ineligible for MassHealth enrolled in ConnectorCare. MassHealth resumed redetermination processes in April 2023 to reassess member eligibility when federal requirements for continuous coverage ended. See CHIA's Enrollment Trends reporting for more information.
9. The pilot ConnectorCare expansion program raised income eligibility from 300% to 500% of the Federal Poverty Level (FPL), allowing more residents to access lower cost coverage.

   Massachusetts Health Connector, *Report to the Massachusetts Legislature: Activities and Accomplishments of the Massachusetts Workplace* (Boston, 2025), https://betterhealthconnector.com/wp-content/uploads/Health-Connector-Annual-Report-2024.pdf.
10. Massachusetts Health Connector, *Connected to Coverage: Member Transitions to the Health Connector During the Medicaid Redeterminations Process* (Boston, July 2025), https://www.mahealthconnector.org/wp-content/uploads/health-connector-public-health-emergency-unwind-report-july-2025.pdf.
11. The data on this page reflects fully insured plans only, representing 36.7% of enrollees in private commercial insurance issued in Massachusetts in 2024.
12. All premiums presented in this chart reflect the total set premium, including member contributions, employer contributions (for ESI), and federal and state premium credits and subsidies (for plans sold to individual purchasers).
13. Reported 2014 premiums were scaled by the Percent of Benefits Not Carved Out, which is not CHIA's current methodology. The impact of this difference on the premiums metric is small because benefit carve-outs are not common for fully insured coverage. Data does not account for inflation. For more information, see the 2017 Annual Report and corresponding technical appendix at https://www.chiamass.gov/annual-report.
14. See note 3.
15. Massachusetts Health Connector, *Report to the Massachusetts Legislature: Activities and Accomplishments of the Massachusetts Marketplace* (Boston, 2025), https://www.mahealthconnector.org/wp-content/uploads/Health-Connector-Annual-Report-2024.pdf.
16. Ibid.
17. The average premium metric is not adjusted for differences in demography, geography, risk score, network reimbursement, and other pricing factors by market segment.
18. Unsubsidized individuals who earn too much to qualify for ConnectorCare plans or state health insurance subsidies may still receive federal APTCs based on federal affordability standards.

Access and Affordability Notes

19. Center for Health Information and Analysis, *2023 Annual Report on the Performance of the Massachusetts Health Care System* (Boston, March 2023), https://www.chiamass.gov/annual-report.

20. Massachusetts Health Connector, "ConnectorCare members can get medications for some health conditions with no co-pay," accessed August 28, 2025, https://www.mahealthconnector.org/learn/plan-information/connectorcareplans/connectorcare-medication-guide.

21. Reported private commercial enrollment by deductible and out-of-pocket level may incorporate student health membership, which is excluded elsewhere in this chapter. For more information on private commercial enrollment by deductible and out-of-pocket level, see the databook.

22. Center for Health Information and Analysis, *2017 Annual Report on the Performance of the Massachusetts Health Care System* (Boston, September 2017), https://www.chiamass.gov/annual-report.

23. See note 3.

24. National survey data suggests that changes in employer-sponsored health plan offerings may be contributing to this shift in HDHP enrollment. As concerns over health care affordability persist, employers may be offering more health plan options beyond HDHPs to improve employee recruitment and retention.

Employment Benefit Research Institute, "Enrollment in Consumer-Driven Health Plans Remains Steady" (Washington, D.C., August 2025), https://www.ebri.org/docs/default-source/fast-facts-(public)/ff-542-cehcs8-14aug25.pdf?sfvrsn=ad09052f_1.

25. See note 3.

26. See note 20.

KEY FINDINGS

Total Medical Expenses and Alternative Payment Methods

BCBSMA, HPHC, and THPP—the 3 largest Massachusetts-based payers—reported the highest unadjusted TME trends in 2024.

Half of the largest managing provider groups had HSA TME trends above the 3.6% growth benchmark in at least 2 payer networks in 2024.

HSA TME per member per month spending continued to increase in 2024 for most commercial payers, with 7 of 11 payers reporting trends above the 3.6% health care cost growth benchmark.

In 2024, APM adoption declined slightly across commercial and Medicare Advantage markets while continuing to increase for MassHealth ACPP/MCO contracts.

Total Medical Expenses and Alternative Payment Methods

In addition to measuring the Commonwealth's total health care expenditures (THCE), CHIA monitors health care spending by private commercial and privately administered Medicaid and Medicare plans and their members. The total medical expenses (TME) data included in this chapter enables a more detailed examination of spending drivers within health plans and among provider organizations that manage patients' care.

TME represents the total amount paid to providers for health care services delivered to a payer's member population, expressed on a PMPM basis for Massachusetts residents. TME includes amounts paid by the payer as well as member cost-sharing, all categories of covered medical expenses, and all non-claims-related payments to providers, including provider performance payments. This chapter focuses on TME data reported by private commercial and privately administered Medicaid and Medicare plans. For private commercial payers specifically, TME is presented for members for whom the payer has access to and is able to report on all claims and non-claims expenses (referred to as "commercial full-claim" in this report). In this chapter, payers are referred to by their names as of 2025.

TME data is examined and reported on a health status adjusted (HSA) basis for each payer's member population in addition to reporting unadjusted aggregate trends. HSA TME adjusts for differences in member illness burden and expected medical costs associated with members' recorded diagnoses. The tools used for adjusting TME for covered members' health status vary among payers, which prevents comparison of HSA TME levels across payers; unadjusted TME can be used, however, to show payer differences in TME levels and growth. This chapter includes aggregate HSA scores by payer to better understand trends in reported health status scores and medical spending in the years following the COVID-19 pandemic.

In this chapter, HSA and unadjusted TME trends are displayed by payer and also by managing provider group within the networks of the 3 largest payers; TME for all reported provider groups can be found in the databook.

In addition to spending levels and trends, CHIA collects information about the payment arrangements between payers and providers. Historically, most health care services have been paid using a fee-for-service (FFS) model. Chapter 224 of the Acts of 2012 set goals to increase the adoption of alternative payment methods (APMs), payment arrangements in which some of the financial risk associated with the delivery of medical care as well as the management of health conditions is shifted from payers to providers. Generally, APMs are intended to give providers new incentives to control overall costs (e.g., reducing unnecessary services and providing services in the most appropriate setting) while maintaining or improving quality. To minimize administrative burden and focus quality improvement efforts on high-value measures and health care priorities, the Massachusetts Aligned Measure Set includes quality measures recommended for use in global budget-based risk contract APMs. The Commonwealth currently relies on voluntary adoption of this Aligned Measure Set by providers and commercial payers; however, legislation signed in 2025 requires CHIA to establish a measure set for mandatory adoption (Chapter 343: An Act Enhancing the Market Review Process), which will further advance alignment in APMs.

This chapter reports on 2024 TME and APMs using the following metrics:

TME: Total expenditures for health care services each year divided by the number of member months in the payer's population.

HSA TME: TME adjusted to reflect differences in the health status of member populations.

Managing provider group TME: TME for members required by their insurance plan to select a primary care provider (PCP) and for members attributed to a PCP as part of a contract between the payer and provider.

APM adoption: The share of member months associated with a primary care provider whose case is paid for under an alternative payment contract with the reporting payer.

Aligned Measure Set Overall Adherence Rate: The proportion of all quality measures in each payer's global budget-based risk contracts that are endorsed in the Massachusetts Aligned Measure Set.

Aligned Measure Set Core Adherence Rate: The proportion of global budget-based risk contracts that incorporate all Core quality measures from the Massachusetts Aligned Measure Set. ■

Total Medical Expenses and Alternative Payment Methods

To examine health care spending differences among private commercial health plans (hereafter referred to as "commercial"), CHIA calculates TME PMPM. The results on this page reflect actual payments made to providers without adjusting for differences in the health status of a payer's member population.

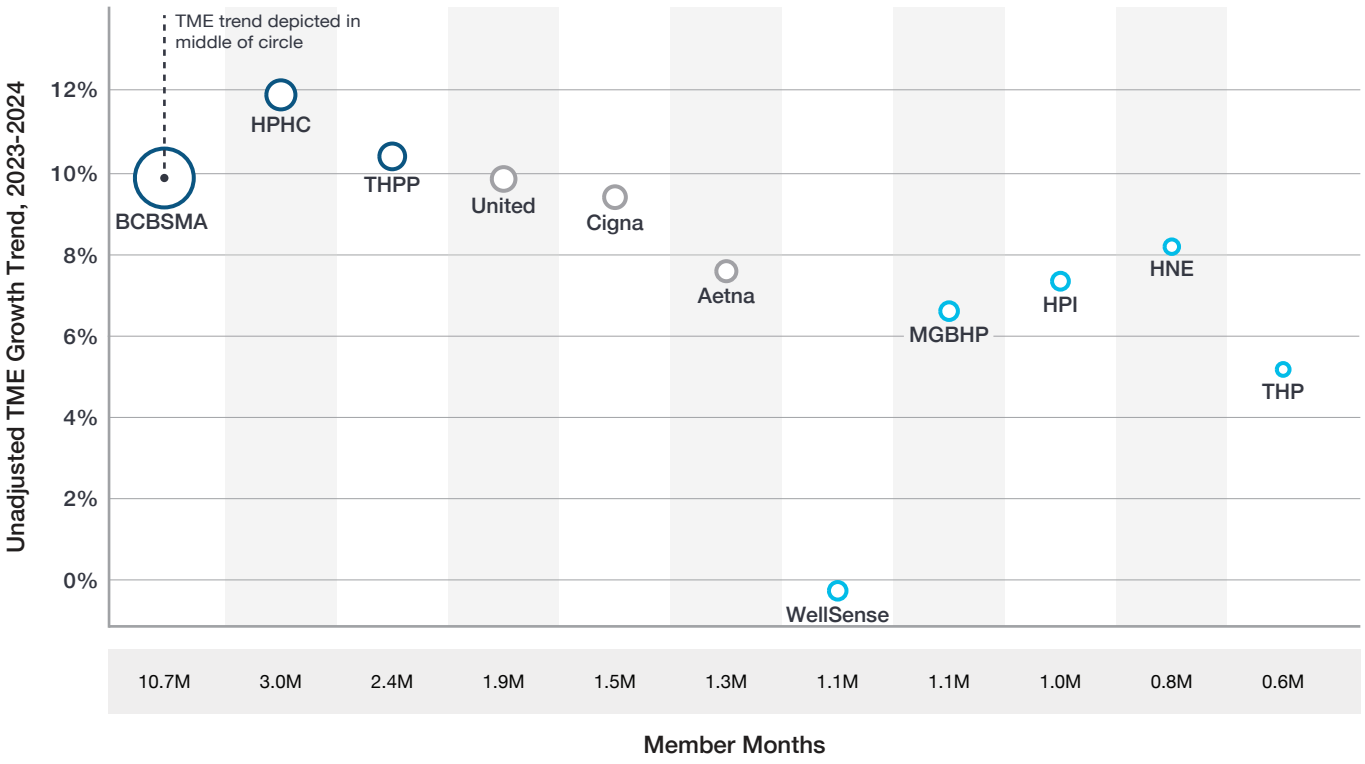
In 2024, commercial THCE increased by 8.5% PMPM, similar to the increase seen in 2023 (8.6%). For additional information on THCE, see page 17.

In 2024, 5 of the 11 commercial payers reported higher increases in unadjusted TME PMPM than the prior year. The 3 largest Massachusetts-based payers—Blue Cross Blue Shield of Massachusetts (BCBSMA), Harvard Pilgrim Health Care (HPHC), and Tufts Health Public Plan (THPP) represented 62.9% of commercial full-claim members in 2024—reported unadjusted TME PMPM trends of 9.9%, 11.9%, and 10.4%, respectively. Combining all Point32Health entities (HPHC, Health Plans Inc. [HPI], Tufts Health Plan [THP], and THPP) resulted in TME PMPM growth of 8.3% in 2024.

Overall commercial full-claim membership increased by 1.5% from 2023 to 2024, with WellSense (71.0%) and THPP (23.6%) reporting the greatest increases. THPP and WellSense cover large shares of the individual purchasers market, which saw an influx of members in 2024 due to the ConnectorCare expansion pilot and MassHealth redeterminations. WellSense reported a 0.2% decline in unadjusted TME PMPM, which they attributed to an influx of new, healthier members with lower utilization.

The 3 national payers (UnitedHealthcare, Cigna, and Aetna) reported declines in commercial full-claim member months and increases in unadjusted TME PMPM trends of 9.9%, 9.4%, and 7.6%, respectively.

Trends in Commercial Unadjusted TME by Payer, 2023-2024



Circles are scaled to reflect member months. Payers are presented based on number of member months from left to right (largest to smallest).

BCBSMA, HPHC, and THPP—the 3 largest Massachusetts-based payers—reported the highest unadjusted TME trends in 2024.

Source: Payer-reported TME data to CHIA.

Notes: This analysis includes commercial full-claim data only, representing members for whom payer has access to and is able to report on all claims expenses, accounting for 63.3% of total commercial member months in 2024. Fallon was excluded from analysis after discontinuing most commercial products in 2021; in 2024, Fallon reported only 0.1 million commercial member months. HPHC, Tufts, THPP, and HPI merged in 2021 but continued to report data as separate entities. In 2024, Point32Health entities continued to shift membership, with THP migration of large group market enrollment to HPHC, leading to a 56.4% decline in THP membership and a 14.4% increase in HPHC membership.

Total Medical Expenses and Alternative Payment Methods

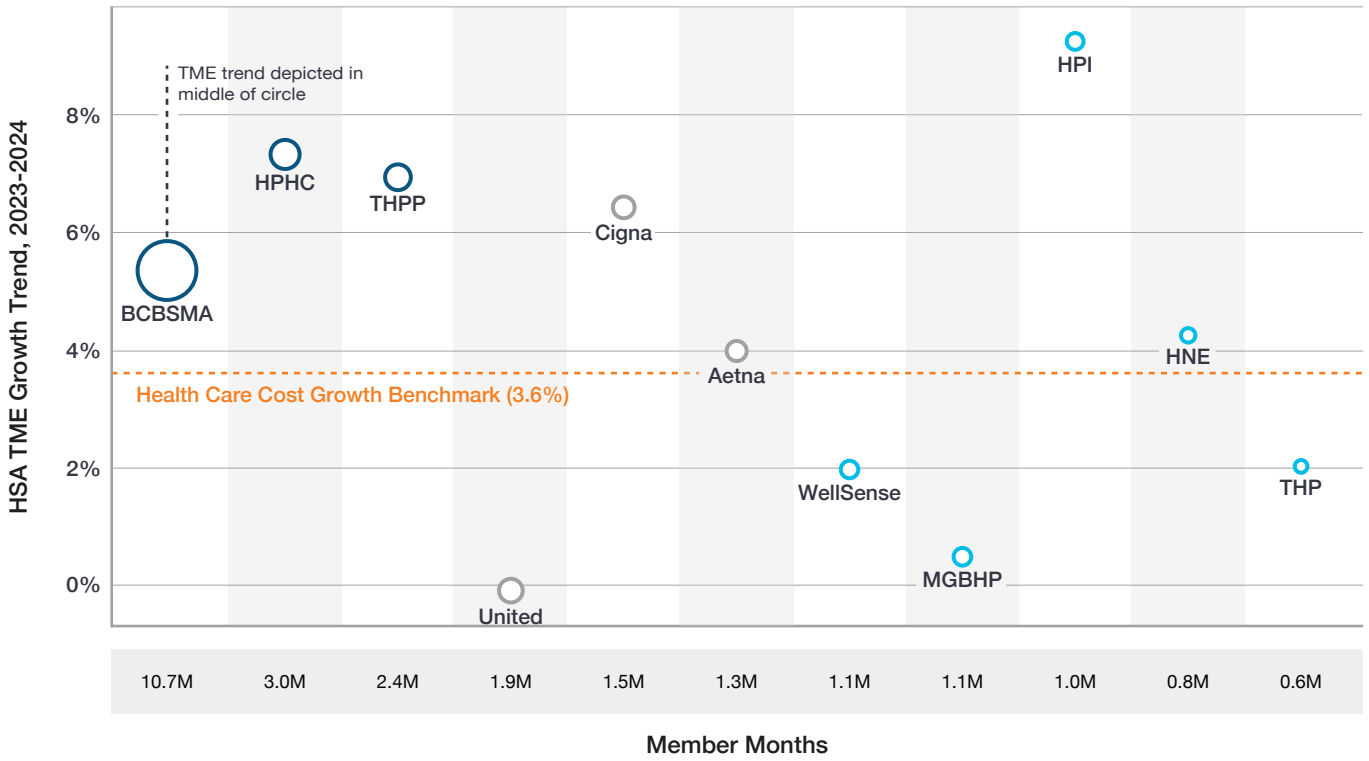
CHIA examines HSA TME for each payer's member population, which accounts for differences in member illness burden. A payer's HSA TME is reported on a PMPM basis and is used to measure performance against the health care cost growth benchmark. In 2024, the benchmark was set at 3.6%.

From 2023 to 2024, 7 of the 11 commercial payers displayed reported HSA TME growth above the 3.6% benchmark, representing 81.5% of commercial full-claim members. BCBSMA, HPHC, and THPP reported HSA TME trends of 5.4%, 7.3%, and 6.9%, respectively. HPI, a Point32Health entity composed of self-insured plans, reported the largest growth in HSA TME at 9.3%.

For more information on commercial service category spending drivers, see page 31.

UnitedHealthcare, WellSense, Mass General Brigham Health Plan (MGBHP), and THP all reported HSA TME trends below the benchmark.

Trends in Commercial HSA TME by Payer, 2023-2024



Circles are scaled to reflect member months. Payers are presented based on number of member months from left to right (largest to smallest).

Seven of the 11 commercial payers reported HSA TME trends above the 3.6% health care cost growth benchmark in 2024, including the 3 largest Massachusetts-based payers.

Source: Payer-reported TME data to CHIA.

Notes: Tools used for adjusting TME based on health status of covered members vary among payers and therefore adjustments are not directly comparable across payers. See databook for a list of health status adjustment tools used for data presented in this report. These trends are based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. This analysis includes commercial full-claim data only, reflecting members for whom payer has access to and is able to report on all claims expenses, accounting for 63.3% of total commercial member months in 2024. Fallon was excluded from analysis after discontinuing most commercial products in 2021. HPHC, Tufts, THPP, and HPI merged in 2021 but continued to report data as separate entities. In 2024, Point32Health entities continued to shift membership, with THP migration of large group market enrollment to HPHC, leading to a 56.4% decline in THP membership and a 14.4% increase in HPHC membership.

Total Medical Expenses and Alternative Payment Methods

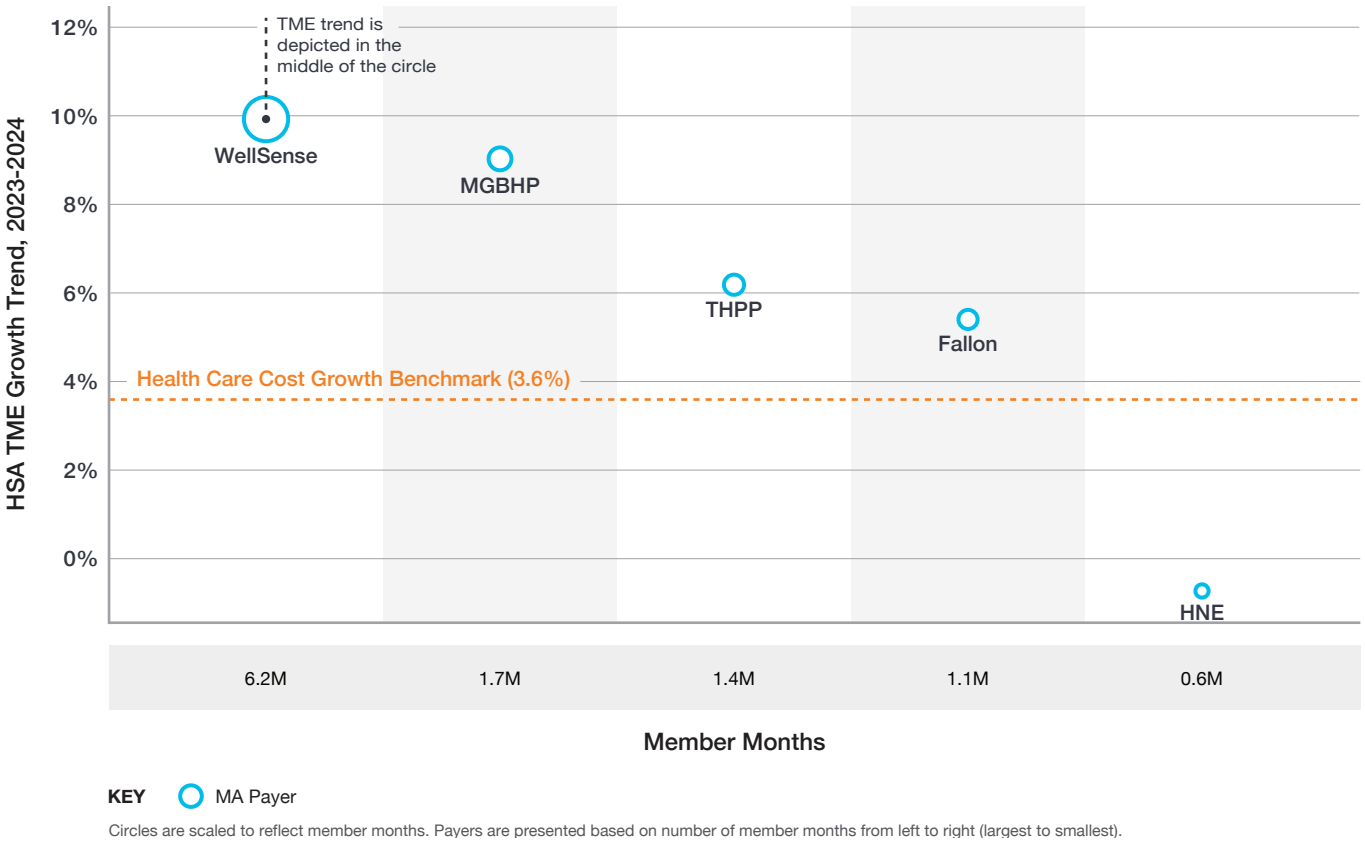
This chart displays MassHealth plans administered by commercial payers, called Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs). All 5 payers shown on the chart provide ACPP plans; THPP and WellSense also provide MCO plans.[1]

In 2024, ACPP/MCO TME trends continued to reflect the effects of the MassHealth redetermination process, which resumed in April 2023. MassHealth redeterminations led to a substantial decline in MassHealth membership, with the remaining population reflecting higher clinical acuity contributing to increased utilization across services. MCO membership declined 30.4% from 2023 to 2024, and ACPP membership declined 4.6%. Additionally, MassHealth reprocured its value-based care contracts effective April 2023, resulting in 15 available ACPP plans, compared with 13 prior to April 2023. These redetermination and reprocurement processes led to membership shifts and significant changes in population risk profiles in many payers' ACPP/MCO plans, limiting the validity of year-over-year comparisons. Among ACPP/MCO payers, WellSense and MGBHP reported membership increases of 0.2% and 10.8%, respectively, while THPP (36.9%), Fallon (14.9%), and Health New England (HNE) (7.3%) reported decreases.

From 2023 to 2024, 4 of 5 ACPP/MCO payers reported PMPM trends in HSA TME above the 3.6% cost growth benchmark. WellSense reported the largest increase in HSA TME at 9.9%, followed by MGBHP at 9.0%, THPP at 6.2%, and Fallon at 5.4%. HNE reported a 0.7% decrease in HSA TME. For more information on MassHealth service category spending drivers, see page 33.

On an unadjusted basis, MassHealth ACPP/MCO TME by payer increased by a range of 14.9% to 38.7%, coinciding with increases in risk scores by a range of 4.5% to 30.6%.

Trends in MassHealth ACPP/MCO HSA TME by Payer, 2023-2024



Circles are scaled to reflect member months. Payers are presented based on number of member months from left to right (largest to smallest).

In 2024, 4 of 5 MassHealth ACPP/MCO payers reported HSA TME trends above the 3.6% growth benchmark, as these plans continue to be impacted by population shifts from MassHealth redeterminations.

Source: Payer-reported TME data to CHIA.

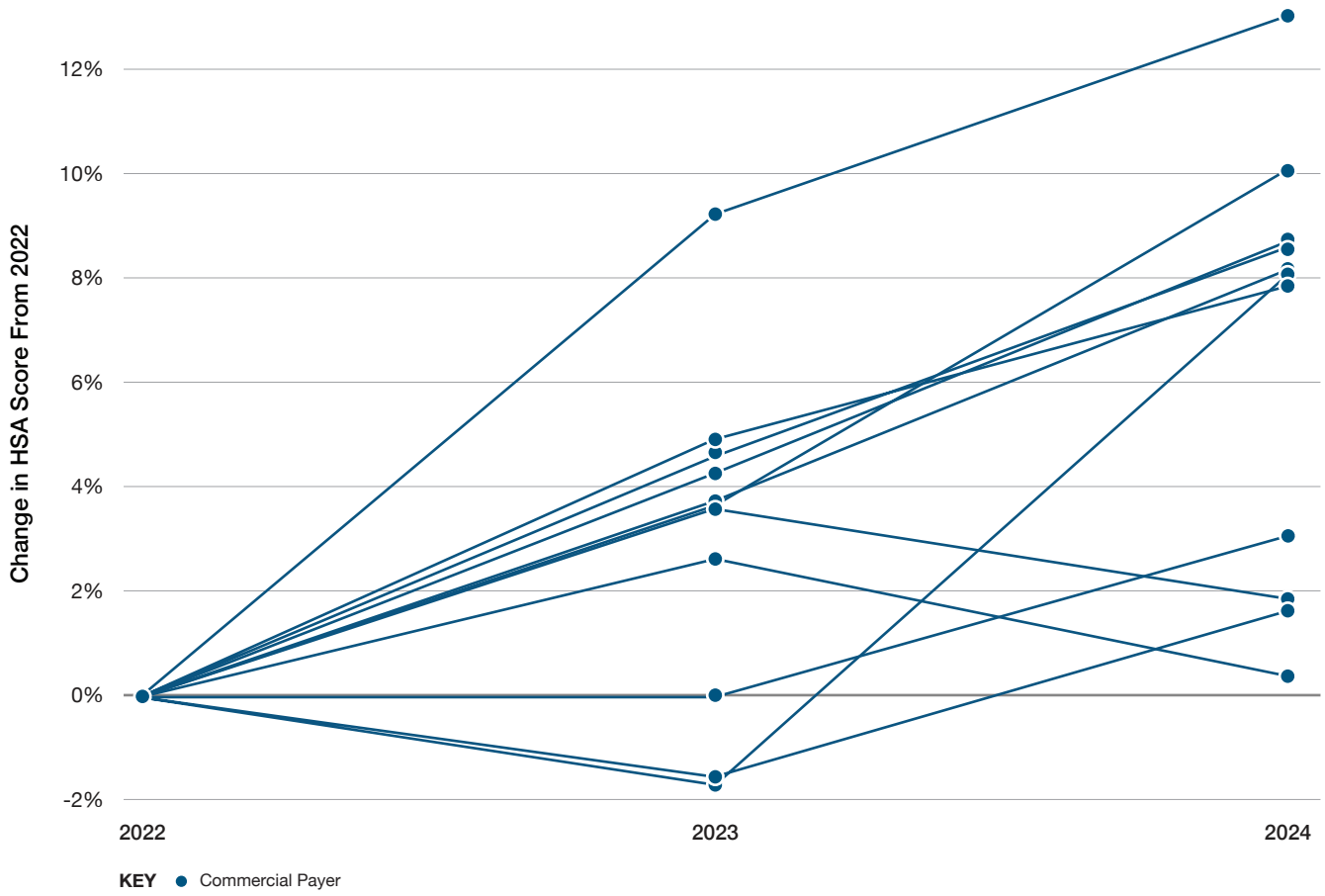
Notes: CHIA now refers to MassHealth ACO-A plans as ACPPs to align with current MassHealth naming conventions. Tools used for adjusting TME based on health status of covered members vary among payers and therefore adjustments are not directly comparable across payers. See **databook** for list of health status adjustment tools used for data presented in this report. These trends based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale.

Total Medical Expenses and Alternative Payment Methods

Payers use risk scores to contextualize spending to account for differences in the health and expected medical spending of a population. CHIA aggregates payer-reported HSA scores to calculate HSA TME spending growth, the metric used to determine payer and provider growth in relation to the health care cost growth benchmark. Payers use a variety of tools to assign HSA scores to patient populations, and therefore scores cannot be compared across payers. These tools draw upon patient demographics and diagnoses generally recorded by providers to predict spending. Broadly, higher HSA scores are intended to indicate more complex health needs and increased anticipated medical costs. However, scores can be affected by variations in coding as well as socioeconomic factors and barriers to care, which decrease health care utilization and captured diagnosis codes.[2,3]

From 2022 to 2024, commercial payers reported cumulative increases in risk scores ranging from 0.4% to 13.0%. Risk scores for 6 of these payers (72.3% membership in 2024) have steadily increased since 2022, while 1 payer (2.3% market share) increased after showing no change from 2022 to 2023. Two payers (17.1% market share) reported increases in risk scores in 2024 after reporting declines in 2023. Two of 11 (8.2% market share) commercial payers reported a decrease in risk scores from 2023 to 2024 after increases the prior year.

Change in Aggregate HSA Scores by Commercial Payer, 2022-2024



From 2022 to 2024, commercial payers reported cumulative increases in risk scores ranging from 0.4% to 13.0%.

Source: Payer-reported TME data to CHIA.

Notes: Tools used for adjusting TME based on health status of covered members vary among payers and therefore adjustments not directly comparable across payers; however, each payer reported consistent tool and version across the 3-year period for their own lines of business. One line of business excluded from analysis. See databook for list of health status adjustment tools used for data presented in this report. Commercial trends shown here reflect commercial full-claim data only.

Total Medical Expenses and Alternative Payment Methods

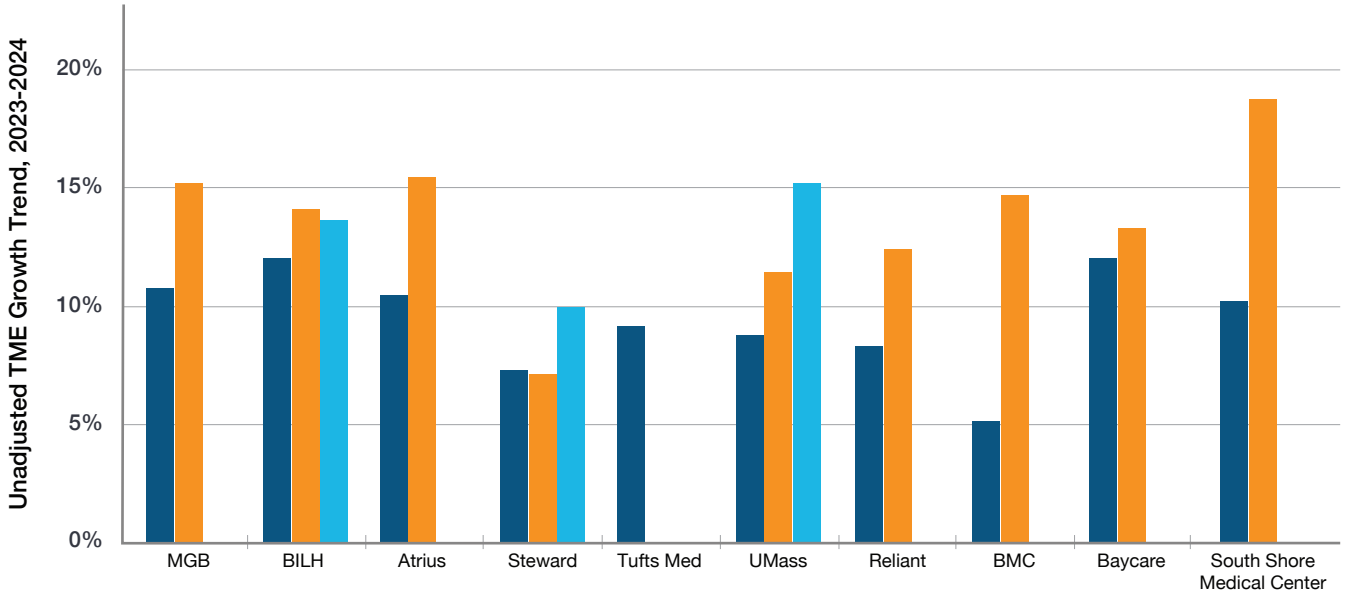
Managing provider groups, often multi-specialty practices including primary care providers (PCPs), are responsible for coordinating the care of their members. TME measures the PMPM total medical spending for commercial members prospectively attributed to a PCP within the managing provider group's practice.

This chart displays unadjusted TME PMPM data for the 10 largest provider groups within the networks of BCBSMA, HPHC, and THPP.[4] In 2024, the data shown represents 52.1% of the total commercial full-claim non-pediatric managed member months. THPP attributes members to only 3 of the top 10 provider groups; it widely implements limited network plans, intending to be more affordable by restricting coverage to a smaller group of in-network providers.[5]

Within BCBSMA's network, Baycare had the highest unadjusted TME PMPM growth at 12.1% and Boston Medical Center Management Service (BMC) the lowest at 5.1%. Within HPHC, South Shore Medical Center had the highest growth at 18.8% and Steward the lowest at 7.2%. Provider groups within THPP's network experienced unadjusted TME growth ranging from 10.0% (Steward) to 15.2% (UMass).[6]

Overall membership of patients attributed to the 10 largest provider groups remained relatively steady in 2024 across the 3 largest Massachusetts payers (1.9%) and across all payers (0.4%) (data not shown). Among these 3 payers, only BCBSMA reported attributed members to Tufts Medicine Integrated Network (Tufts Med). Tufts Med is newly in the top 10 provider groups as BCBSMA members were shifted from New England Quality Care Assurance (NEQCA) in 2023.[7]

Trends in Managing Physician Group Commercial Unadjusted TME, 2023-2024



	MGB	BILH	Atrius	Steward	Tufts Med	UMass	Reliant	BMC	Baycare	South Shore Medical Center
BCBSMA, HPHC, and THPP Share of Group's Managed Member Months	85.6%	81.4%	78.3%	86.2%	88.9%	94.6%	81.0%	52.5%	54.8%	100.0%
Total Managed Member Months in 2024	2.7M	2.1M	1.7M	1.2M	0.7M	0.5M	0.5M	0.4M	0.4M	0.3M

KEY BCBSMA HPHC THPP

The 10 largest provider groups had increases in unadjusted TME PMPM spending across the top 3 Massachusetts-based payers, ranging from 5.1% to 18.8%.

Source: Payer-reported TME data to CHIA.

Notes: Data reported here based on final 2023-2024 commercial full-claim TME data, both for members whose plan requires selection of PCP as well as for members attributed to PCP under contract between payer and provider group, such as PPO APM. These trends based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. In 2024, HPHC did not report any membership under Tufts Med. THPP did not report any membership under Baycare, BMC, Reliant, South Shore Medical Center, or Tufts Med.

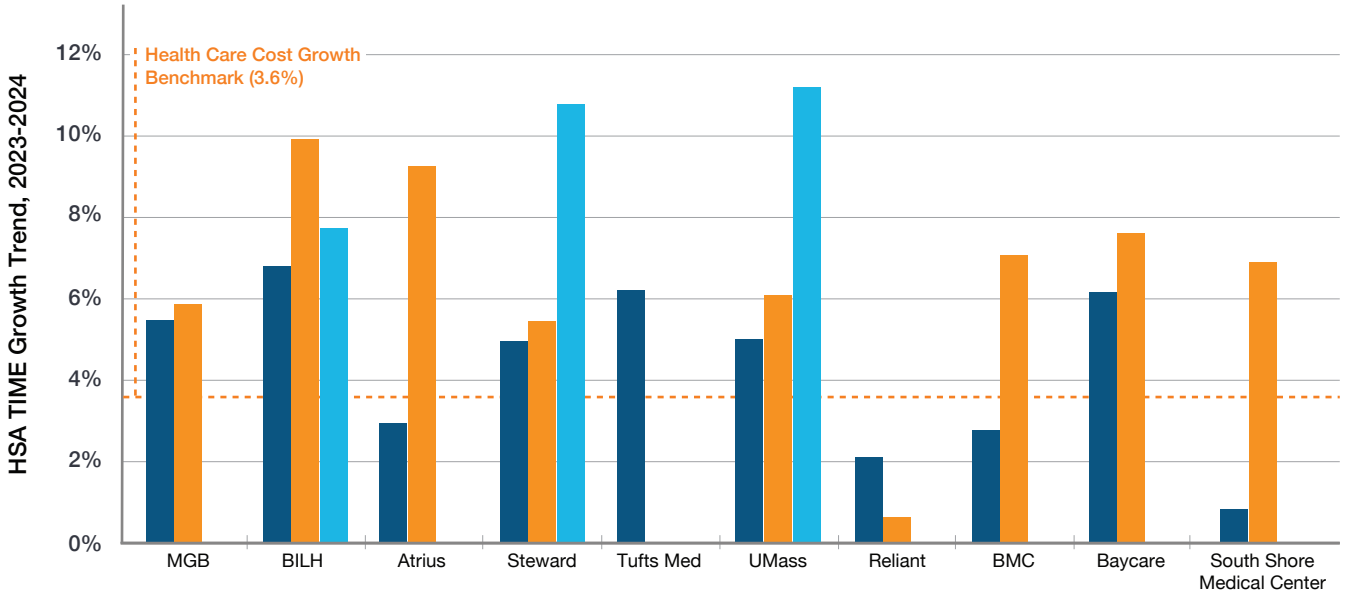
Total Medical Expenses and Alternative Payment Methods

CHIA examined HSA TME PMPM spending trends for the 10 largest provider groups within the BCBSMA, HPHC, and THPP networks. THPP attributes members to only 3 of the top 10 provider groups; it widely implements limited network plans, intending to be more affordable by restricting coverage to a smaller group of in-network providers. In 2024, THPP attributed 28.0% of commercial full-claim managed member months to the top 10 providers, compared with 80.9% for BCBSMA and 77.2% for HPHC. Within BCBSMA, attributed membership decreased for 5 of 10 provider groups. HPHC reported a decline in membership growth for 1 provider group, while THPP reported growth for all provider groups.

In 2024, 9 of 10 provider groups had increases in HSA TME that exceeded the 3.6% health care cost growth benchmark in at least 1 of the 3 payer networks. Within BCBSMA, 6 of 10 provider groups had HSA TME growth above the benchmark, with Beth Israel Lahey Health (BILH) having the largest growth at 6.7%. Within HPHC, 8 of 9 provider groups with attributed members showed HSA TME trends exceeding the benchmark; BILH had the largest growth rate at 9.9%. Within THPP, all 3 provider groups had growth rates exceeding the benchmark; increases in THPP's network exceeded those in BCBSMA's and HPHC's networks across all provider groups except BILH.

In 2024, BILH, Steward, UMass, Baycare, and Mass General Brigham (MGB) exceeded the benchmark in all payer networks in which they had attributed membership.

Trends in Managing Provider Group Commercial HSA TME, 2023-2024



	MGB	BILH	Atrius	Steward	Tufts Med	UMass	Reliant	BMC	Baycare	South Shore Medical Center
BCBSMA, HPHC, and THPP Share of Group's Managed Member Months	85.6%	81.4%	78.3%	86.2%	88.9%	94.6%	81.0%	52.5%	54.8%	100.0%
Total Managed Member Months in 2024	2.7M	2.1M	1.7M	1.2M	0.7M	0.5M	0.5M	0.4M	0.4M	0.3M

KEY BCBSMA HPHC THPP

Five of the 10 largest provider groups had HSA TME trends above the 3.6% health care cost growth benchmark in at least 2 payer networks in 2024.

Source: Payer-reported TME data to CHIA.

Notes: Data reported here based on final 2023-2024 commercial full-claim TME data, both for members whose plan requires selection of PCP as well as for members attributed to PCP under contract between payer and provider group, such as PPO APM. Tools used for adjusting TME based on health status of covered members vary among payers and therefore adjustments not comparable across payers. See databook for more information. These trends based on expenditures that reflect payments to providers and are gross of prescription drug rebates received by health plans after point of sale. In 2024, HPHC did not report any membership under Tufts Med. THPP did not report any membership under Baycare, BMC, Reliant, South Shore Medical Center, or Tufts Med.

Total Medical Expenses and Alternative Payment Methods

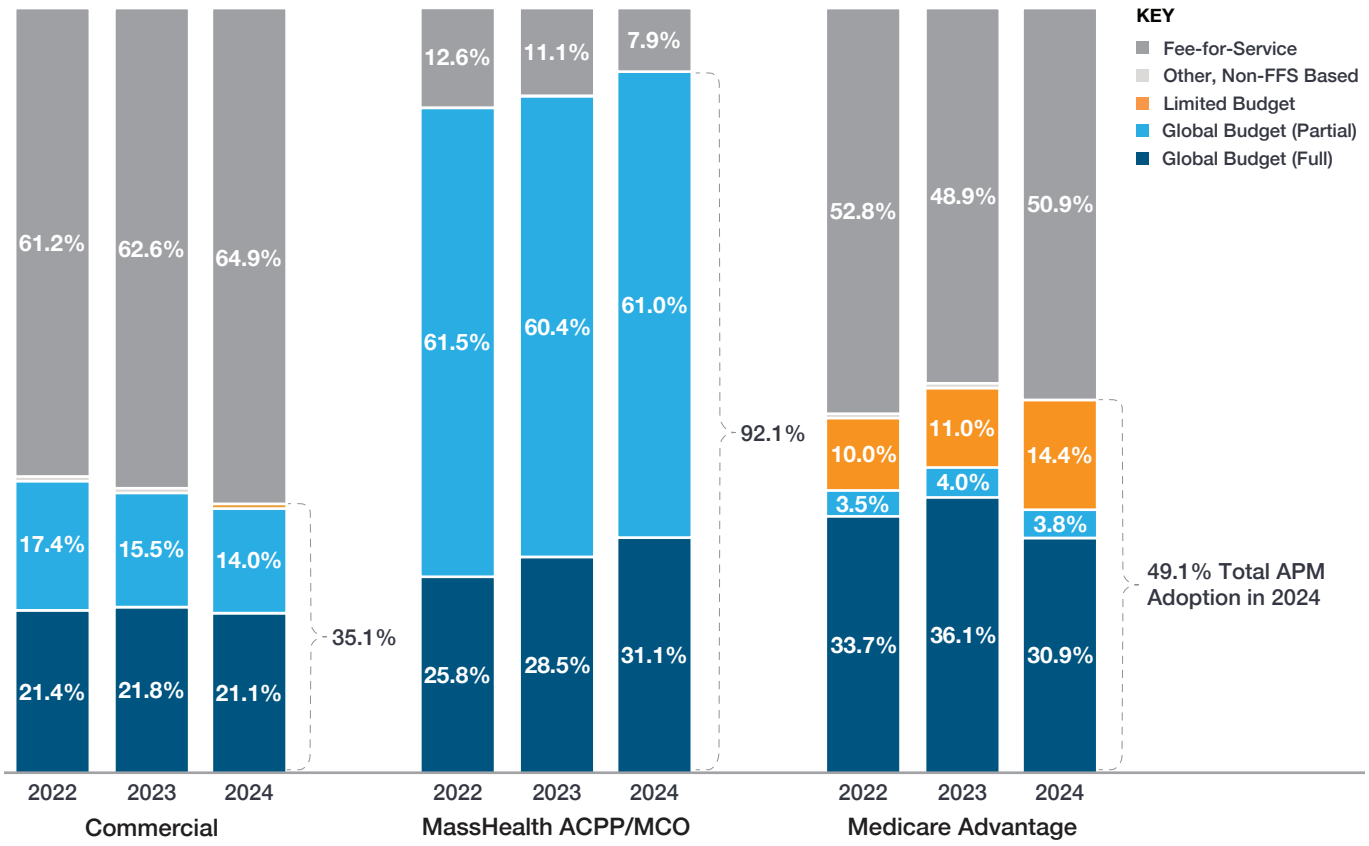
Payers and providers use APMs to promote coordinated care and create incentives to control costs while maintaining or improving quality.

In 2024, in the private commercial market, most members (64.9%) continued to have care paid for under FFS arrangements. Notably, in 2024, market-wide commercial APM adoption decreased from 37.4% to 35.1% after remaining consistent since 2016. This decline was driven in part by THP reporting fee-for-service only for remaining commercial members in 2024; MGBHP, THPP, and WellSense reported APM adoption declines of more than a percentage point from 2023 to 2024. For more information on payer-specific APM adoption, see the databook.

From 2022 to 2024, MassHealth APM adoption among ACPPs and MCOs remained high, with 92.1% of members covered under APM arrangements in 2024. Medicare Advantage APM adoption decreased by 2.0 percentage points in 2024, with reported decreases by MGBHP, Tufts, and UnitedHealthcare.

Global budget payment arrangements accounted for nearly all commercial and MassHealth ACPP and MCO APM arrangements and 70.6% of Medicare Advantage APM arrangements in 2024; 89.3% of all global budget payment arrangements had both upside and downside risk while 7.0% were shared savings only.[8] By insurance category, 82.1% of commercial, 100% of ACPP and MCO, and 86.9% of Medicare Advantage global budget payment arrangements had both upside and downside risk.

APM Adoption by Insurance Category, 2022-2024



In 2024, APM adoption declined slightly across commercial and Medicare Advantage markets while continuing to increase for Medicaid ACPP/MCO contracts.

Source: Payer-reported TME data to CHIA.

Notes: Membership under APMs measured by share of member months associated with PCP engaged in alternative payment contract with reporting payer. Global partial budget APMs reflect arrangements in which provider group not held accountable for certain services, often pharmacy and behavioral health expenses. Global full budget APMs hold providers accountable for comprehensive set of services.

Total Medical Expenses and Alternative Payment Methods

Global budgets, the most common form of APM in Massachusetts, typically include incentives based on provider organizations' performance on a set of health care quality measures. While quality measurement is valuable for patient care and payment, a lack of alignment on the specific measures used in contracts is a source of administrative burden in the health care system, contributing to clinician burnout and dilution of quality improvement efforts.[9] To address these concerns, the EOHHS Quality Measure Alignment Taskforce has annually recommended an Aligned Measure Set ("Measure Set") for use in global budget contracts.[10]

To approximate the payer contracts affected by the Measure Set, the table "Member Months by Payer and Percentage of Member Months in Global Budget Payment Methods" provides the percentage of private commercial and MassHealth ACPP/MCO membership attributed to these types of arrangements.[11]

"Overall Adherence to Aligned Measure Set" indicates the extent to which payers are using only measures that are endorsed in the Measure Set within risk contracts.[12,13] In 2024, 96% of measures aggregated across all participating payer contracts were part of the Measure Set. For commercial contracts, 94% of measures utilized were endorsed in the Measure Set. These rates have increased since CHIA began collecting data in 2019.

While the rate described above monitors adherence to the requirement that contracts include only endorsed measures, true adherence to the Measure Set requires adoption of all Core quality measures in every contract. The aggregate rate in the "Core Set Adherence" table reveals that across the participating payers' contracts, 66% use all 6 Core measures in the 2024 Measure Set.[14]

Adherence to the Aligned Measure Set in Global Budget-Based Risk Contracts, 2024

Member Months by Payer and Percentage of Member Months in Global Budget Payment Methods

		BCBSMA	HPHC	MGBHP	HNE	THP	WellSense	UHC	Wellpoint
Commercial	Total Member Months (MMs)	16.0M	5.4M	2.6M	1.1M	0.9M	1.1M	3.4M	1.4M
	% of MMs in Global Budget APMs	60.1%	37.5%	10.4%	71.4%	0.0%	5.4%	0.0%	76.4%
MassHealth (ACPP/MCO)	Total Member Months (MMs)			1.7M	0.6M		6.2M		
	% of MMs in Global Budget APMs			100%	100%		92.3%		

Overall Adherence to the Aligned Measure Set (Use of Endorsed Measures in Contracts)

Year	Aggregate	Commercial Only	MassHealth	BCBSMA	HPHC	MGBHP	HNE	THP	WellSense	UHC
2022	84%	78%	100%	84%	81%	78%	70%	75%	57%	39%
2023	93%	89%	100%	99%	86%	83%	76%	80%	57%	40%
2024	96%	94%	100%	99%	99%	83%	84%	N/A	73%	63%

Core Set Adherence (Use of All Core Measures in All Contracts)

2022	70%	100%	82%	77%	35%	46%	39%	25%	25%
2023	66%	83%	97%	55%	39%	19%	30%	17%	17%
2024	66%	83%	94%	36%	40%	22%	N/A	17%	0%

In 2024, payer adherence to the Aligned Measure Set continued to increase to 96% in aggregate; however, core set adherence has room for improvement with 5 of 7 participating payers reporting scores of 40% or below.

Source: Payer-reported Quality Measure Catalog data and payer-reported TME data provided to CHIA.

Notes: Refer to CHIA's 2025 Quality Measure Catalog executive summary for methodology behind Overall and Core Set adherence rate calculations and for information about participating payers. Visit EOHHS Quality Measure Alignment Taskforce website for more information about voluntary public/private collaborative initiative, and check Standard Quality Measure Set (SQMS) for updates as implementation of mandatory set develops in 2026. Member months (MMs) represent number of members participating in plan over specified period of time expressed in months of membership. Commercial totals include both commercial full claims and commercial partial claims. MMs reported for commercial payers who submitted 2024 Quality Measure Catalog for commercial lines of business—Tufts' contracts under THP brand presented but not its Connector plans offered through THPP. THP's global budget contracts also began migrating to HPHC, therefore no data presented for its 2024 contracts. UnitedHealthcare reported no global budget APMs in 2024 TME data but has indicated use of global budget contracts in 2024 through Quality Measure Catalog submission; their MMs included for market share reference.

Total Medical Expenses and Alternative Payment Methods Notes

1. In this chapter, Accountable Care Partnership Plan (ACPP)/Managed Care Organization (MCO) data is combined at the payer level. However, only a small portion of membership is attributed to MCOs; ACPPs represented 94.0% of ACPP/MCO membership in 2024.
2. Office of the Attorney General, "2022 Health Care Cost Trends Report: Health Scores and Access Barriers," accessed December 20, 2025, https://www.mass.gov/info-details/2022-health-care-cost-trends-report#health-scores-and-access-barriers.
3. Additional information on the impact of the variations in coding methodologies on HSA scores provided by the Massachusetts Health Policy Commission; see https://www.mass.gov/doc/risky-business-comparative-modeling-of-commercial-population-risk-adjustment-equations/download.
4. TME for all reporting payers and provider groups is available in this report's dataset. The top 10 provider groups were identified by the total number of commercial full-claim, attributed (PCP types 1 and 2), non-pediatric member months. BCBSMA, HPHC, and THPP had the most commercial full claim member months attributed to the 10 largest provider groups across 2023 and 2024. In 2024, BCBSMA, HPHC, and THPP represented 82.1% of commercial full-claim, attributed member months for the 10 largest provider groups.
5. Additional information on Massachusetts insurance affordability can be viewed in the Access and Affordability chapter of CHIA's Annual Report; see page 43. Limited network adoption can be viewed in the Coverage Costs and Cost-Sharing dataset.
6. In 2024, Steward Health Care declared bankruptcy. Steward's physician network was sold to Rural Healthcare Group, now known as Revere Medical. However, payers continued to attribute members to Steward Medical Group and Steward Network Services under existing contractual arrangements.
7. In 2024, HPHC did not report any membership under Tufts Med and instead continued to report membership under NEQCA, with an unadjusted TME trend of 12.8%. In 2024, THPP began reporting membership under NEQCA, and both HPHC and THPP contract with NEQCA and Tufts Med as distinct entities.
8. In a two-sided risk model, providers share in cost savings if they stay below a target budget for their population's care and share in the losses at a pre-negotiated rate if their costs exceed the target budget. Providers are often eligible to keep a larger proportion of savings if they agree to share in any costs above the benchmark.
9. Health Policy Commission, "2016 Cost Trends Hearing Testimony," accessed January 11, 2025, https://masshpc.gov/meetings/annual-costtrends-hearings/2016-cth/testimony.
10. The Commonwealth currently relies on voluntary adoption of this Aligned Measure Set by providers and commercial payers; however, legislation signed in 2025 requires CHIA to establish a measure set for mandatory adoption (Chapter 343: An Act Enhancing the Market Review Process), which is policy under development. CHIA will continue to report on voluntary adoption of the Aligned Measure Set until new requirements are effective.
11. The data source for membership in global budget contracts is separate from the data source for quality measures used in global budget-based risk contracts. As a result, there may be slight differences in the populations (e.g., member month data includes only Massachusetts residents). While this member month data may not capture all contracts that should incorporate the Measure Set, it is included as a contextual estimation of the proportion of payer contracts affected by adherence to the Measure Set.
12. Full implementation of the Measure Set requires inclusion of all Core Set measures in contracts as outlined in the Implementation Parameters documentation.
13. Certain measures are endorsed for MassHealth contracts only because the Taskforce determined they are appropriate for the population. Since the MassHealth Measure Set is slightly different than the commercial Measure Set, we also include a cross-payer rate for commercial only.
14. See CHIA's Quality Measure Catalog publication (updated August 2025) for details about the composition of the Measure Set, measure use in contracts for 2021-2025, and information about measure stratification by race, ethnicity, and/or language.

KEY FINDINGS

Commercial Payer Trends

In 2024, 90.7% of premiums were used to pay for members' medical care. The remaining 9.3% went toward non-medical expenses and payer surplus; this proportion was smaller than in the 2 prior years but similar to 2021.

In 2024, payers reported an aggregate loss of $13 PMPM, a reversal of trends from recent years where, in aggregate, the payers had reported surpluses.

Payer non-medical expenses and surplus dropped 26.9% in the merged market and 25.3% for plans sold to larger employers in 2024 because medical claims costs grew faster than premiums in both markets.

Commercial Payer Trends

CHIA analyzes federally reported data on Massachusetts payers' administrative costs in the private commercial health insurance market as part of its efforts to monitor and profile overall health plan spending. This chapter covers the period from 2022 to 2024.[1]

For fully insured lines of business, which made up 37.6 percent of private commercial enrollment in 2024, CHIA reports data on the proportion of premium dollars not spent on member medical claims by market segment (employer size). The "merged market" refers to plans sold to individual purchasers and small group employers, while "larger group" (employers with more than 50 employees) refers to mid-size, large, and jumbo group employers combined. Payers use these funds to cover administrative expenses, broker commissions, taxes, and fees. Premiums in this chapter are reported net of any required Medical Loss Ratio (MLR) rebates.

Plans sold to individual purchasers and small groups in the Massachusetts merged market are subject to the Affordable Care Act's risk adjustment program, which was designed to stabilize premiums and protect against adverse selection. In 2018, the Centers for Medicare and Medicaid Services (CMS) added a national high-cost risk pool to its risk adjustment methodology to subsidize a portion of the expenses for members with claims costs in excess of $1 million using fees collected from payers offering risk-adjustment-covered plans.[2] Within this chapter, reported claim amounts in the merged market reflect the impact of the risk adjustment program.

This chapter uses federal MLR data, which payers report to CMS. Although data is sourced from federal MLR filings, the purpose and calculation of reported non-medical expense components and surplus in this report differ significantly from those of the federal MLR metric. The federal MLR reports a payer's rebate position using

a 3-year average of financial data and making allowable adjustments without consideration of rebates paid in prior years. CHIA calculates an annual financial loss ratio, which was developed using actuarial methods and principles. Data reported within this chapter is not sufficient to determine whether payers met federal MLR thresholds. See page 82 for more detail.

The same federal MLR data is used in CHIA's net cost of private health insurance (NCPHI) calculation. However, there are 2 key adjustments made for NCPHI: 1) while this Commercial Payer Trends chapter excludes data for self-insured plans, NCPHI includes them; and 2) while this chapter represents all members with plans contracted in Massachusetts regardless of where they live, NCPHI represents only Massachusetts resident enrollment. NCPHI decreased 14.1% from 2023 to 2024. For more information, see page 25. ■

Commercial Payer Trends

In 2024, like in past years, BCBSMA remained the largest commercial payer with 43.7% of the Commonwealth's commercial contract membership.[3] However, payer market share varied across market sectors.

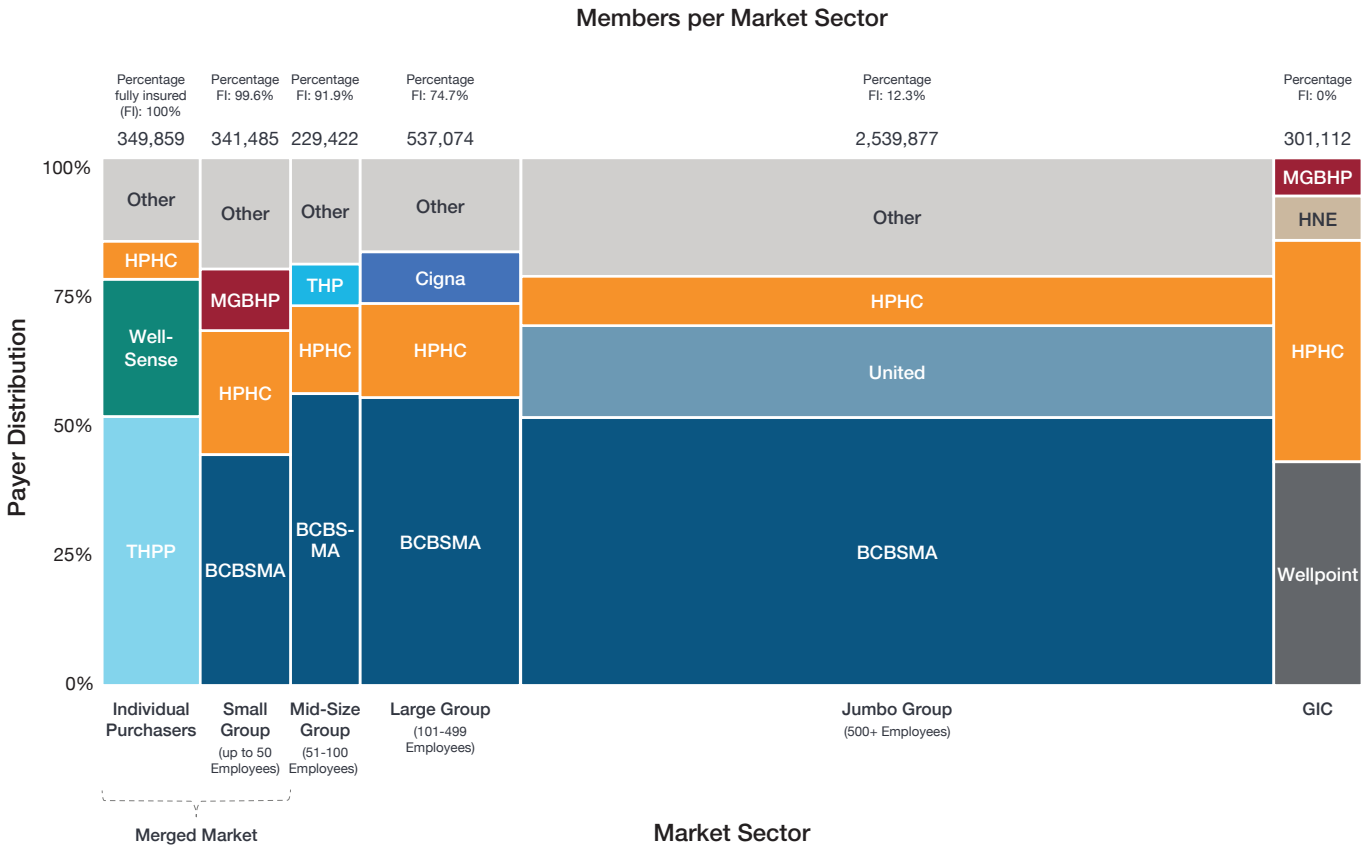
In every employer-sponsored insurance (ESI) market sector (i.e., excluding individual purchasers), other than the GIC, BCBSMA maintained the largest market share. After BCBSMA, HPHC had the second-largest private commercial market share (14.0%), followed by UnitedHealthcare (12.0%) and Cigna (6.8%). Within the jumbo group market sector specifically, HPHC became the third-largest payer, replacing Cigna after Point32Health migrated large group members to HPHC.

HPHC and Tufts (including THPP) merged at the start of 2021 to form Point32Health, though their plans continued to submit data separately. In 2024, these entities combined represented the second-largest membership of any payer with 21.1% of the commercial market. Because of this, Point32Health holds notable portions of the market share for individual purchasers (58.0%), small group (31.3%), mid-size group (24.6%), large group (22.4%), and the GIC (42.3%).

Nearly 85% of GIC members were enrolled in plans offered by HPHC (42.3%) and Wellpoint (formerly UniCare; 42.3%), a subsidiary of Elevance Health. Tufts left the GIC market in 2024 as Point32Health migrated GIC members to HPHC.

Among individual purchasers, WellSense and THPP, which historically have served MassHealth ACPP/MCO members, together enrolled more than three-fourths (77.0%) of the market sector in 2024, including ConnectorCare members.

Largest Payers by Market Sector, 2024



In 2024, BCBSMA remained the largest commercial payer with 43.7% of the Commonwealth's commercial contract membership.

Source: Payer-reported data to CHIA.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. THPP reported separately from parent company, Tufts. Annual enrollment reported as average membership within each year, derived by dividing payer-submitted member months by 12. GIC listed separately on this page but included in jumbo group on subsequent pages. See technical appendix for more information.

Commercial Payer Trends

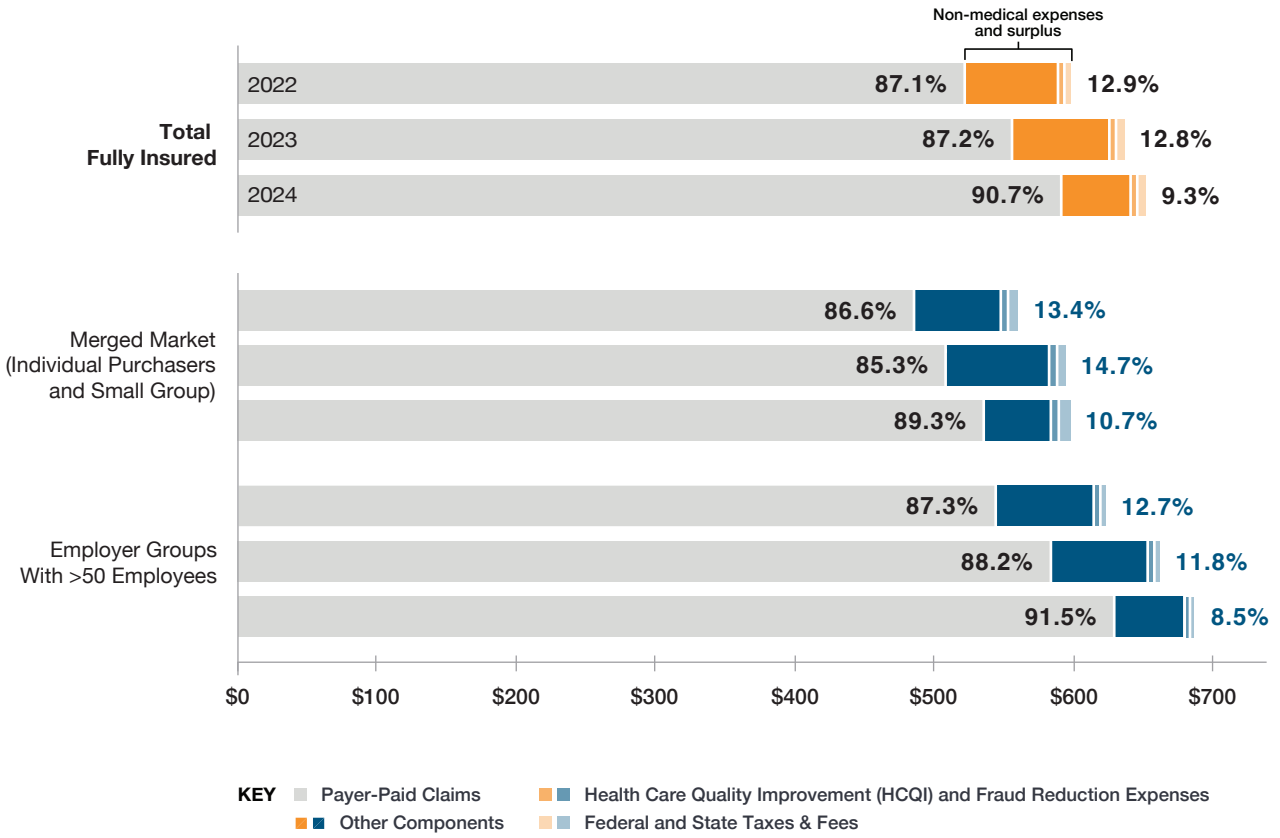
Premiums are set prospectively using data from prior years, which impacts the funds available to payers for non-medical expenses and surplus. The 2024 premiums were largely calculated in early 2023 based primarily on 2022 health care spending data and projections of future utilization, unit costs, and other factors impacting premium rate development.

In 2024, 90.7% of premium revenue was used to pay for fully insured members' medical care.[4] The remaining 9.3% was less than payers' costs for plan administration and other expenses, resulting in average losses across the fully insured market. The proportion of premium revenue available to cover the cost of non-medical expenses and surplus was smaller in 2024 than in recent years as well as prior to the COVID-19 pandemic (12.8% in 2023 and 12.9% in 2022; 12.0% in 2019). It was most similar to the 2021 experience (9.6%), when health care utilization also outpaced actuarial projections.

The proportion of premium funds that remained after medical claims were paid in 2024 was 10.7% in the merged market and 8.5% for plans sold to larger employers (>50 employees).

Note: The payer-paid claims percentages reported on this page are distinct from their federal MLRs. The federal MLR formula treats health care quality improvement (HCQI) and fraud reduction expenses as well as taxes and fees differently than CHIA's annual financial loss ratio does. See page 82.

Fully Insured Payer Use of Premiums by Market Segment, 2022-2024



The proportion of non-medical expenses and payer surplus decreased to 9.3% in 2024, smaller than in recent years but similar to 2021 (9.6%) when utilization was also higher than actuarial projections.

Source: Payer-reported MLR data submitted to CMS.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums net of MLR rebates, and payer-paid claims reduced to account for cost-sharing reduction (CSR) subsidies. See technical appendix for more information.

Commercial Payer Trends

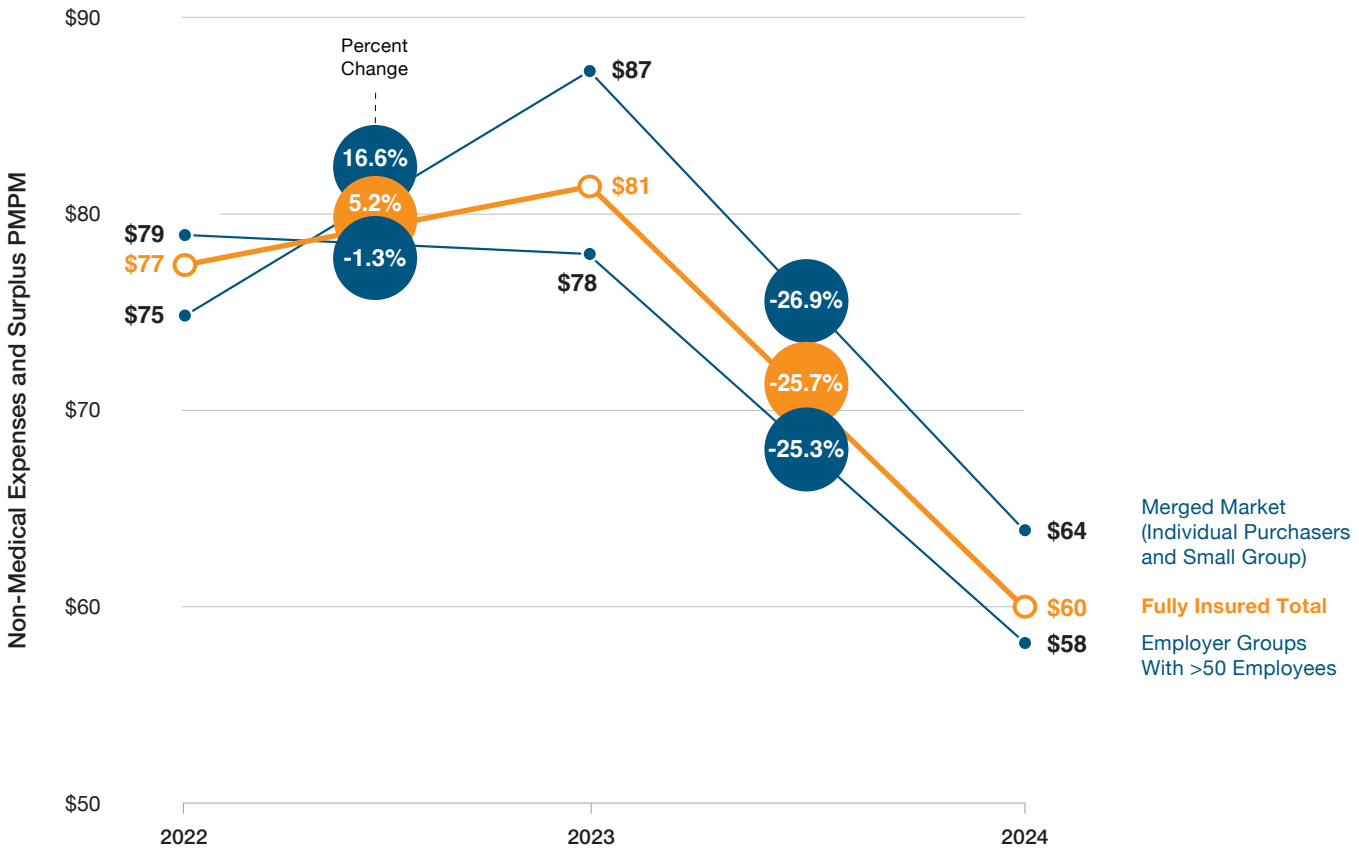
The portion of premium revenue used by payers for non-medical expenses and surplus typically fluctuates from year to year as actual market conditions test assumptions made by health plan actuaries, but these fluctuations have been more drastic in recent years due to the impacts of the COVID-19 pandemic and rebound utilization in 2021. While non-medical expenses and surplus increased from 2021 to 2023, it decreased in 2024 for both the Massachusetts merged market and plans sold to larger employers.

In 2024, total non-medical expenses and surplus across the private commercial fully insured market decreased 25.7% to $60 PMPM, following a 5.2% increase (from $77 to $81 PMPM) in 2023. In total, payers paid more than $75.6 million in MLR rebates to individuals and employers for the 2024 reporting year based on their combined premiums and claims experiences from 2022 to 2024 (see page 82).

Non-medical expenses and surplus in the merged market decreased 26.9% to $64 PMPM as overall medical claims cost increases (5.2%) far outpaced premium growth (0.5%) in 2024. For more information on this decrease in the merged market, see page 81. Similarly, non-medical expenses and surplus for larger group plans declined 25.3% to $58 PMPM as medical claims costs grew 8.0% and premiums increased 4.0%.

These results apply to members with insurance policies contracted in Massachusetts; the same data was used to calculate NCPHI for Massachusetts residents enrolled in fully insured commercial plans. See NCPHI results on page 25.

Fully Insured Non-Medical Expenses and Surplus by Market Segment, 2022-2024



Non-medical expenses and surplus dropped 26.9% in the merged market and 25.3% for plans sold to larger employers in 2024.

Source: Payer-reported MLR data submitted to CMS.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums net of MLR rebates. Percent changes calculated based on non-rounded amounts. Values not adjusted for inflation. See technical appendix for more information.

Commercial Payer Trends

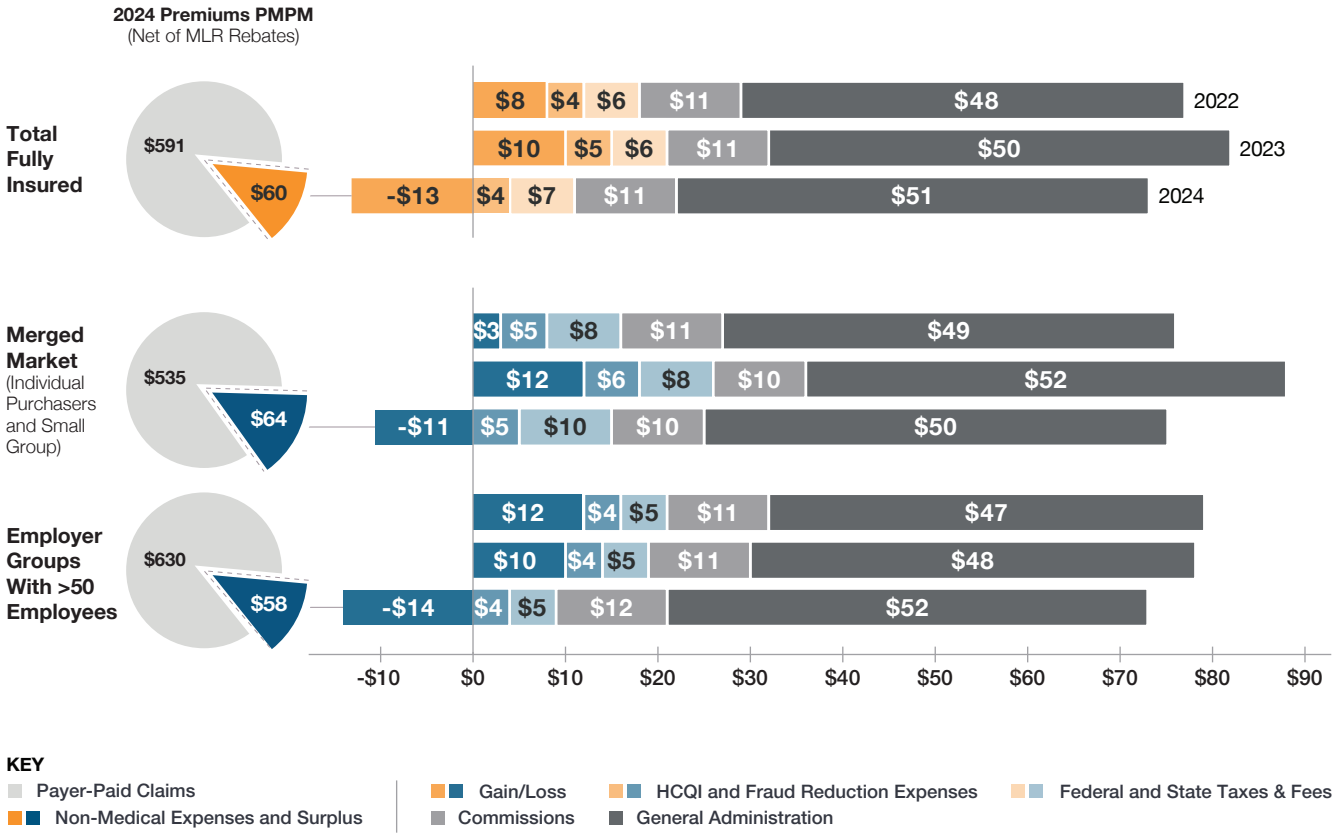
Consistent with prior years, general administration represented the largest component of non-medical expenses and surplus at $51 PMPM out of the total $60 PMPM not spent on claims in 2024. Spending on general administration included costs for plan design, claims administration, cost containment, customer service, and employee wages. Administrative costs were slightly lower in the merged market ($50 PMPM) compared with larger group plans ($52 PMPM).

After covering other expenses, payers reported losses of $13 PMPM in aggregate across the fully insured market in 2024, a $23 PMPM decrease from 2023 gains (surplus). In the merged market, $12 PMPM surpluses in 2023 declined to $11 PMPM losses in 2024. For plans sold to larger groups, payers reported a similar trend ($10 PMPM gain in 2023 to $14 PMPM loss in 2024). Some payers noted higher-than-expected claims costs due to factors such as increased GLP-1 utilization and the impact of MassHealth eligibility redeterminations on the composition of the merged market population,[5] resulting in the observed losses in 2024.

These figures are market-wide averages as gains and losses varied by payer and market segment (data not shown). In the merged market, 4 payers (representing 81.8% of merged market membership) reported losses; the largest PMPM shifts in gains/losses were reported by Fallon ($62 PMPM surplus in 2023, $10 PMPM surplus in 2024) and WellSense ($43 PMPM surplus in 2023, $2 PMPM loss in 2024).

For plans sold to larger groups, 4 payers (representing 90.0% of the larger group market membership) reported losses in 2024; of these, HPHC ($7 PMPM loss in 2023, $51 PMPM loss in 2024) and Aetna ($33 PMPM surplus in 2023, $2 PMPM loss in 2024) had the largest changes PMPM. For more information and payer-specific data, refer to the associated databook.

Fully Insured Non-Medical Expense Components and Surplus by Market Segment, 2022-2024



In 2024, payers reported an aggregate loss of $13 PMPM, a reversal of trends from recent years.

Source: Payer-reported MLR data submitted to CMS.

Notes: Based on Massachusetts contract membership, which may include non-Massachusetts residents. Reported premiums net of MLR rebates, and payer-paid claims reduced to account for cost-sharing reduction (CSR) subsidies. Enrollment figures in this chapter based on payer-reported MLR data and may differ from prior chapters. See technical appendix for more information.

Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio

What is the federal Medical Loss Ratio (MLR) Report?

A federal MLR report is filed annually by each health insurance company to describe the proportion of premiums collected that goes toward patient care vs. administrative costs. The federal MLR measures a payer's position relative to the rebate standard. Health insurance consumers with fully insured coverage are protected by federal and state laws that require payers to spend a minimum percentage of collected premiums on medical care. The percentage of premiums spent on medical care, or federal MLR, is calculated within a licensed payer and market segment to determine a 3-year average.

In Massachusetts, if a payer's federal MLR falls below 88 percent in the merged market or below 85 percent in the fully insured larger group market over a 3-year period, that payer is required to issue rebates to consumers for the unused premium dollars. For the purposes of determining federal MLR rebate amounts, spending on health care quality improvement (HCQI) and fraud reduction count toward medical care, while taxes and fees are subtracted from premiums. In addition, the federal MLR formula does not consider any rebates paid in prior years, and further adjustments are allowed to reflect the size of the population and whether premium rates are pooled across licenses.

How do claims percentages reported in this chapter differ from the federal MLR?

Payer-paid claims percentages in this chapter are based on CHIA's annual financial loss ratio formula, which was developed in accordance with actuarial methods and principles. While the federal MLR and CHIA's annual financial loss ratio use the same source data, the calculation and intended purpose of the 2 ratios are distinct.

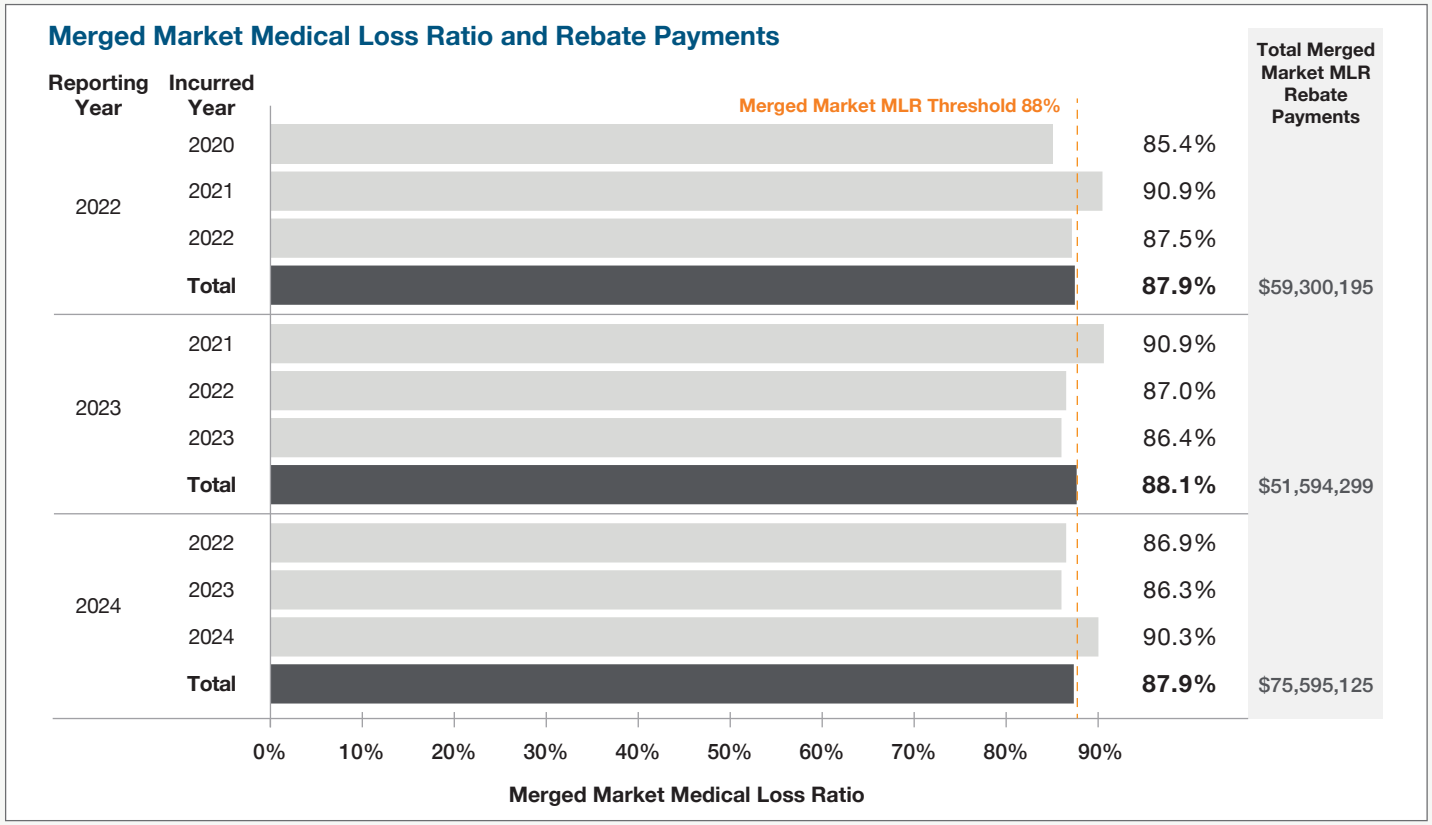
CHIA's annual financial loss ratio was designed to measure how much of a payer's premium revenue goes toward non-medical expenses and surplus in a given year. Unlike MLR, the annual financial loss ratio does not count HCQI and fraud reduction as claims expenses; taxes and fees are not subtracted from premiums; and premiums are reduced by the total amount of MLR rebates paid in that reporting year. The annual financial loss ratio is calculated for a given year within the merged market, within the fully insured larger group, and in total across all payers. For all these reasons, payer-paid claims percentages reported in this chapter cannot be used to determine whether federal MLR thresholds were met.

Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio

	Federal Medical Loss Ratio	CHIA's Annual Financial Loss Ratio
Purpose	Determine compliance with MLR thresholds and calculate MLR rebate amounts, if applicable	Measure percentages of premiums spent on members' medical costs and retained for other expenses
Population	By licensed payer By fully insured market segment	Across payers By and across fully insured market segments
Time Period	Average over 3 calendar years	1 calendar year
HCQI and Fraud Reduction Expenses	Added to incurred claims*	Not considered
MLR Rebates	Not considered	Subtracted from earned premiums
Taxes & Fees	Subtracted from earned premiums	Not considered
Simplified Formula	$\frac{\sum_{i=2022}^{2024} (\text{Incurred Claims*} + \text{HCQI} + \text{Fraud Reduction Expenses})_i}{\sum_{i=2022}^{2024} (\text{Earned Premiums} - \text{Taxes \& Fees})_i}$ Note: The federal MLR formula considers other financial amounts and adjustment factors not shown here.	$\frac{\text{Incurred Claims*}}{\text{Earned Premiums} - \text{MLR Rebates}}$

*Incurred claims minus pharmacy rebates, minus CSR subsidy payments, and net of risk adjustment and high-cost risk pool payments.

Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio



Due to normal fluctuations in underwriting cycles, the MLR calculation is based on data from a rolling 3-year period.

Across all payers, the 3-year aggregated merged market MLR in the 2022 reporting year was 87.9 percent, falling just below the 88 percent threshold. In the 2023 reporting year, the merged market MLR met and exceeded the threshold at 88.1 percent. For the 2024 reporting year, the merged market again fell below the threshold at 87.9 percent.

While the percentages above represent the entire merged market, federal MLR is calculated and regulated at the licensed payer level. Any licensed payer that did not meet the MLR threshold for a given reporting year paid rebates to consumers. The annual totals of MLR rebates paid by all payers in the merged market are shown above.

Commercial Payer Trends Notes

1. Chapter results are based on commercial contract member data submitted to CHIA and publicly available medical loss ratio (MLR) reports submitted to CMS for the 2022, 2023, and 2024 reporting years. The following payers were included in analysis: Aetna, Blue Cross Blue Shield of Massachusetts (BCBSMA), Cigna, Fallon Health, Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Mass General Brigham Health Plan (MGBHP, formerly AllWays), Tufts Health Plan (Tufts), Tufts Health Public Plans (THPP), UnitedHealthcare, Wellpoint (formerly UniCare), and WellSense (formerly BMCHP).
2. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program," *Federal Register* 81, No. 246 (December 22, 2016): 94080, https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018.
3. Commercial contract membership includes contracts established in Massachusetts (which may include non-Massachusetts residents), both fully and self-insured populations, and excludes MassHealth and Medicare populations.
4. The payer-paid claims percentages reported on this page are distinct from federal MLR. The federal MLR formula treats health care quality improvement (HCQI) and fraud reduction expenses, as well as taxes and fees, differently than CHIA's annual financial loss ratio does. See page 83.
5. In April 2023, MassHealth resumed eligibility redeterminations in accordance with the end of the federal continuous coverage requirements that were implemented in response to the COVID-19 public health emergency. Payers reported in communications to CHIA that MassHealth enrollment shifts affected membership in the merged market, resulting in increased population acuity and driving higher claims costs. For more information, see CHIA's Enrollment Trends reporting and the MassHealth Redetermination Dashboard.

KEY FINDINGS

Provider and Health System Trends

Acute care utilization in the inpatient and emergency department settings has been stable since FFY 2023.

Following a period of increase from FFY 2020 through FFY 2023, the average length of stay across all acute care settings has declined, most notably to 4.6 hours in the emergency department as of June 2025.

In HFY 2024, the statewide acute hospital median total margin was 0.6% while the statewide median operating margin was -2.0%. Both decreased compared with the prior year.

After a downward trend in nursing facility occupancy between CY 2019 and 2020, system-level occupancy rates have been increasing, reaching 83.9% in CY 2024.

Provider and Health System Trends

Utilization trends in both acute and post-acute settings, as well as the financial performance of hospitals, are key indicators of the overall sustainability of our health system. This chapter presents information about hospital and skilled nursing facility utilization and hospital financial performance.

The first section provides trends for total volume and average length of stay (ALOS) for acute hospital inpatient discharges, emergency department visits, and outpatient observation visits from October 2019 to June 2025 using data from the acute hospital Case Mix databases.

The second section outlines trends in financial performance among acute hospitals for hospital fiscal years (HFY) 2020-2024 as well as a preview of HFY 2025 with year-to-date (YTD) financial data through June 30, 2025. This section also includes a comparison of annual aggregate acute hospital operating revenue and expenses since HFY 2020. This data is sourced from hospital financial reporting to CHIA and reflects both federal and state COVID-related funding that was distributed to hospitals and reported as operating revenue.

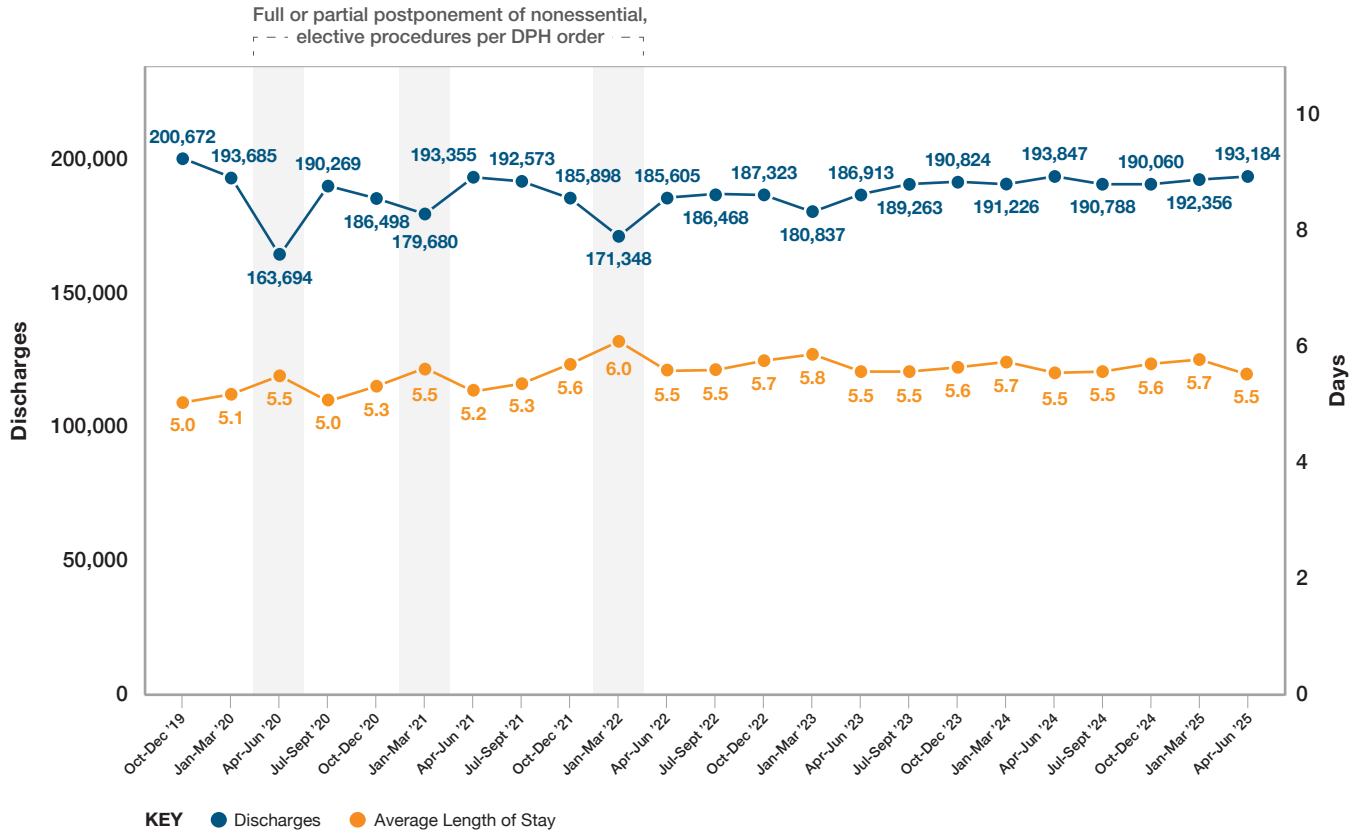
Finally, this chapter includes an overview of skilled nursing facility occupancy and capacity trends utilizing cost report data submitted to CHIA. ■

Provider and Health System Trends

Total acute care hospital inpatient discharges declined during the COVID-19 pandemic. Inpatient discharge volume has remained relatively stable since April 2022.

Inpatient ALOS increased through March 2022 but has since declined. ALOS has remained at about 5.6 days for the past few years.

Total Acute Care Hospital Inpatient Discharges, October 2019-June 2025



Overall discharges remain lower than pre-pandemic levels, and ALOS has hovered around 5.6 days for the past 2 years.

Source: Hospital Inpatient Discharge Database (HIDD), October 2019-June 2025.

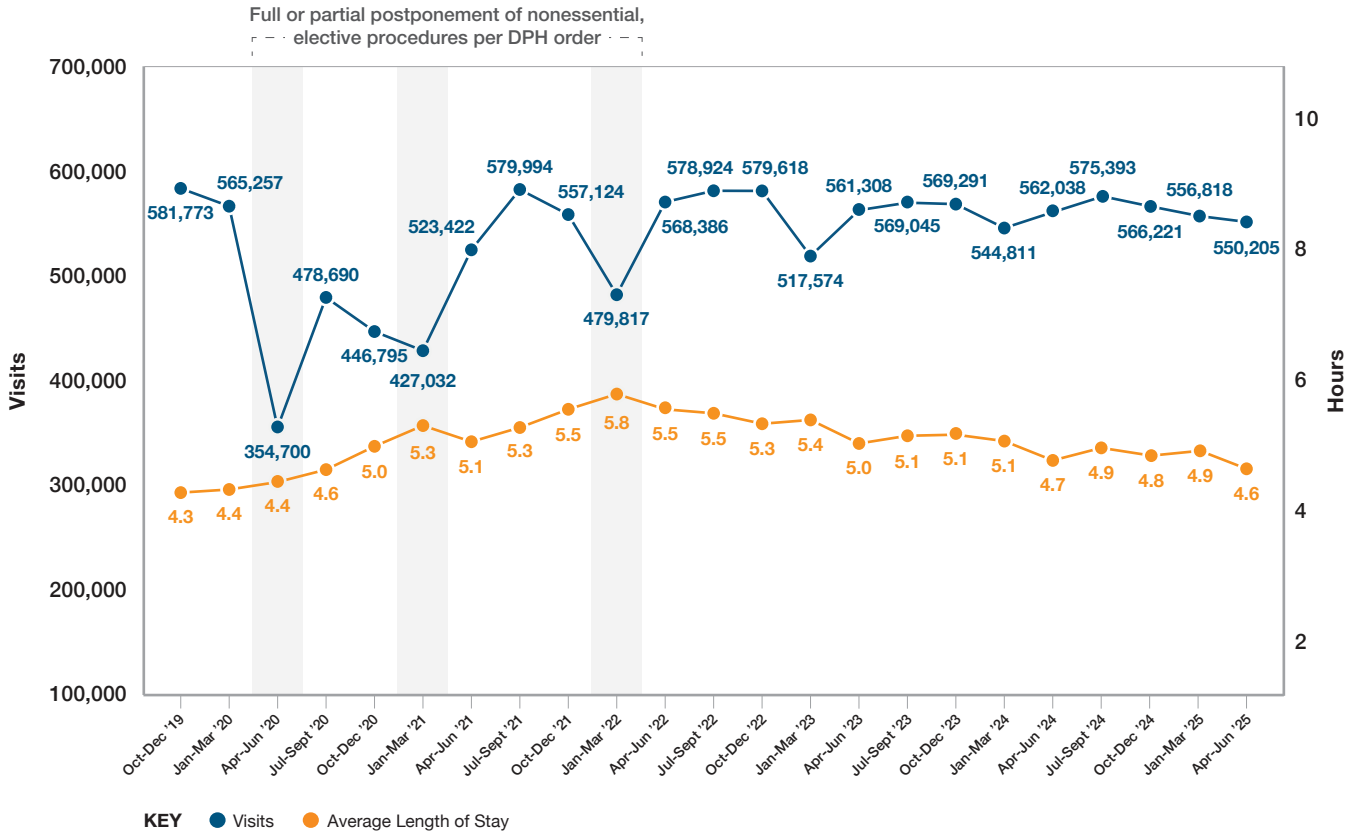
Notes: Federal fiscal years (FFY) run from October 1 through September 30. Average length of stay (ALOS) calculated as difference in number of days between discharge date and admission date. Hospital inpatient discharge data for partial FFY 2025 (October 2024-June 2025) not considered final and subject to change. See CHIA website for most up-to-date information on inpatient utilization.

Provider and Health System Trends

Treat-and-release emergency department visits have remained stable since the end of FFY 2023 following a period of fluctuation during the COVID-19 pandemic. The number of visits has not surpassed pre-pandemic volume.

While ALOS was less than 4.5 hours in the period prior to the COVID-19 pandemic, it rose through early 2022, peaking at 5.8 hours. Since then, ALOS has decreased to 4.6 hours, its lowest since the end of FFY 2020.

Total Acute Care Hospital Emergency Department Treat-and-Release Visits, October 2019-June 2025



ALOS in the emergency department has steadily declined since the height of the pandemic; as of June 2025, ALOS was at its lowest since the end of FFY 2020.

Source: Emergency Department Database (EDD), October 2019-June 2025.

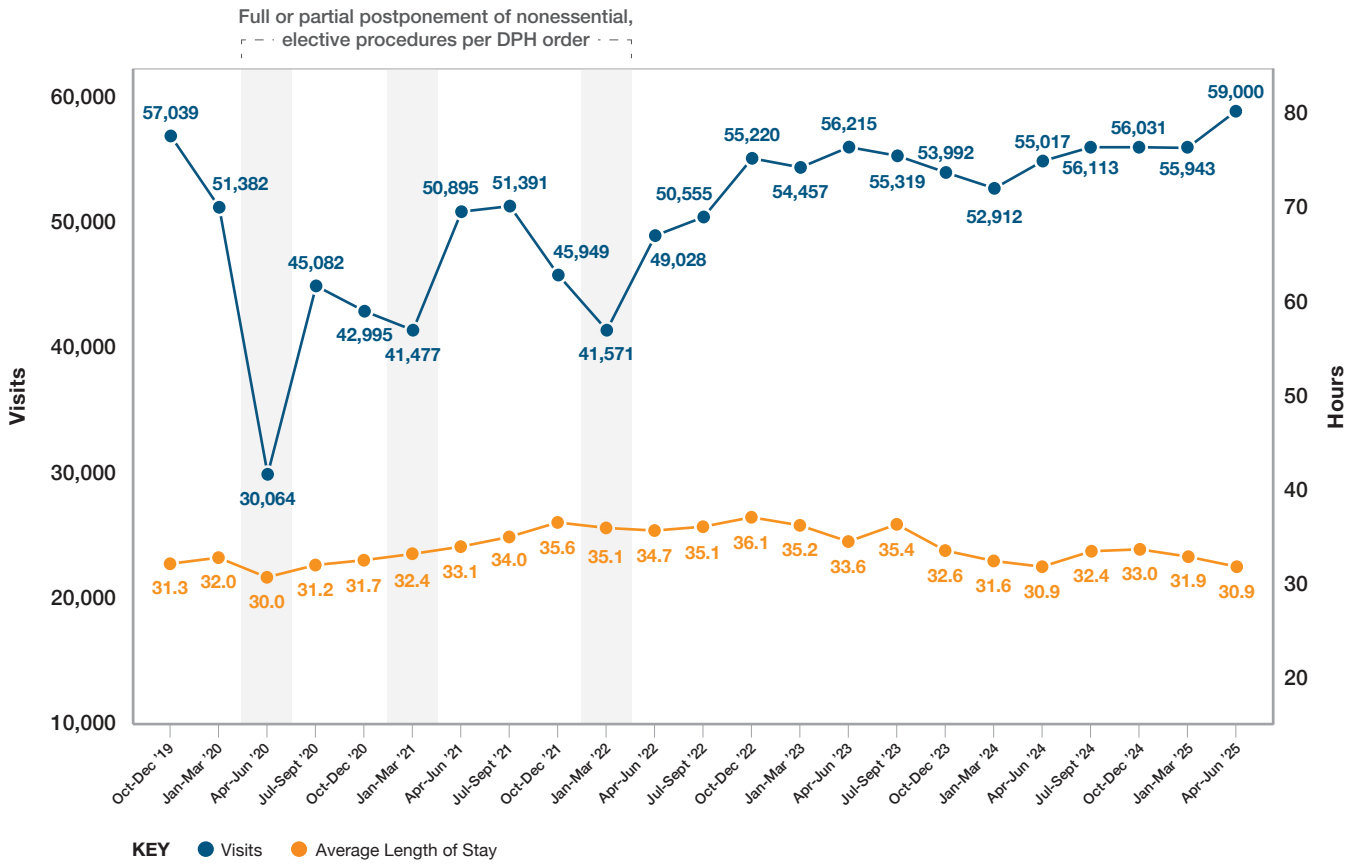
Notes: Federal fiscal years (FFY) run from October 1 through September 30. Average length of stay (ALOS) calculated as difference in number of hours between discharge time and admission time. Several hospitals resubmitted data from FFY 2023 through March 2024 to reclassify certain ED visits; emergency visit data from these hospitals reclassified to observation data for visits that began in emergency department but ended in outpatient observation stay. EDD data for partial FFY 2025 (October 2024-June 2025) not considered final and subject to change. See CHIA website for most up-to-date information on emergency department utilization.

Provider and Health System Trends

Observation visits, like emergency department visits, are classified as outpatient care and may serve a variety of functions, including the assessment of patients who may require additional diagnostics or therapeutic treatment beyond care in the emergency department but who do not require admission to the inpatient setting. Adults most commonly have observation visits for symptoms such as nonspecific chest pain, syncope (commonly referred to as fainting), or abdominal pain. Between October 2019 and June 2025, approximately 62% of observation visits originated in the emergency department and 32% of those observation visits resulted in inpatient admission (data not shown).

Outpatient observation visits have returned to pre-pandemic levels as of April-June 2025 following a period of fluctuating volume during the COVID-19 pandemic. Following a peak ALOS of 36.1 hours from October-December 2022, observation ALOS has since decreased to 30.9 hours for April-June 2025.

Total Acute Care Hospital Outpatient Observation Visits, October 2019-June 2025



Following a period of decreased utilization during the COVID-19 pandemic, the volume of outpatient observation visits has returned to pre-pandemic levels.

Source: Outpatient Observation Database (OOD), October 2019-June 2025.

Notes: Federal fiscal years (FFY) run from October 1 through September 30. Average length of stay (ALOS) calculated as difference in number of hours between discharge time and admission time. Several hospitals resubmitted data from FFY 2023 through March 2024 to reclassify certain outpatient observation visits; observation visit data from these hospitals includes visits that began in emergency department but ended in outpatient observation stay. OOD data for partial FFY 2025 (October 2024-June 2025) not considered final and subject to change. See CHIA website for most up-to-date information on outpatient utilization.

Provider and Health System Trends

Total margin reflects the excess of total revenues over total expenses, including both operating and non-operating activities, as a percentage of total revenue. The margins include COVID-19 relief funding reported as operating revenue as well as unrealized gains or losses reported as non-operating revenue.

The statewide acute hospital median total margin decreased by 1.6 percentage points, from 2.2% in HFY 2023 to 0.6% in HFY 2024. Thirty-three of 59 acute hospitals (56%) reported positive total margins in HFY 2024.

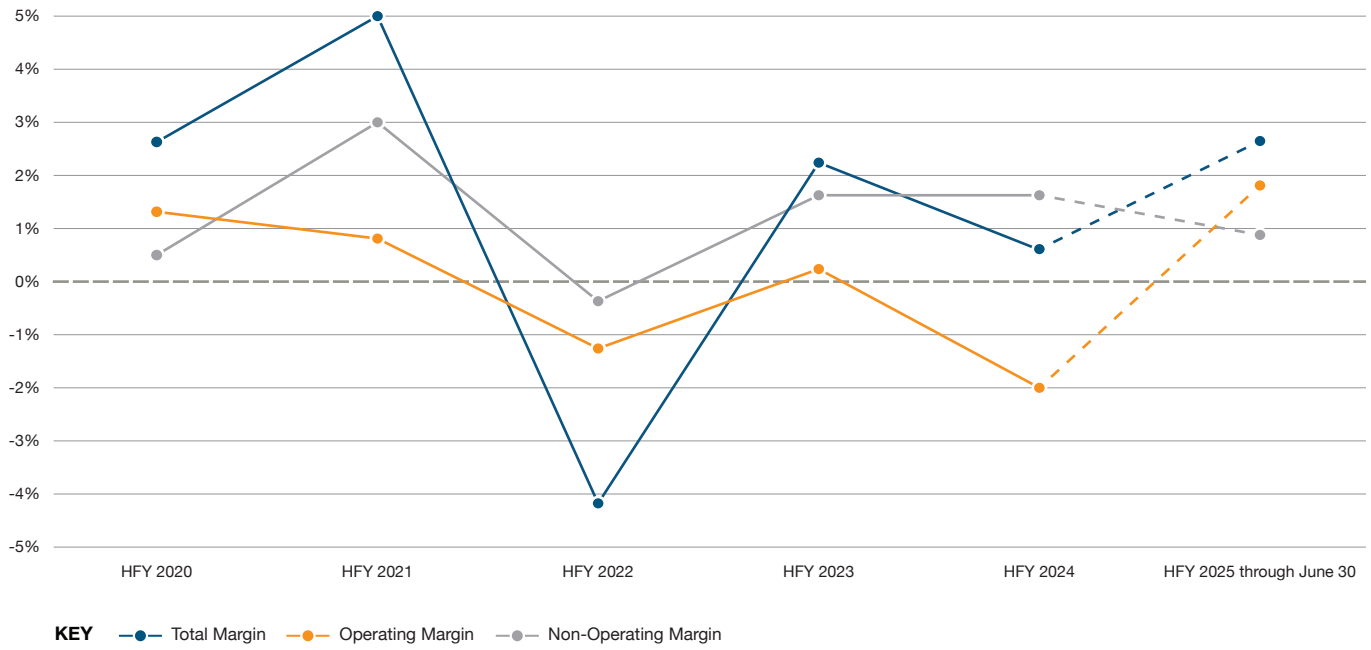
Operating margin reflects the excess of operating revenues over operating expenses, including patient care and other activities, as a percentage of total revenue. The statewide acute hospital median operating margin decreased from 0.2% in HFY 2023 to -2.0% in HFY 2024. Twenty-four of 59 acute hospitals (41%) reported positive operating margins in HFY 2024.

Non-operating margins include items that are not related to operations, such as investment income, contributions, gains from the sale of assets, and other unrelated business activities. The statewide median non-operating margin remained stable at 1.6% from HFY 2023 to HFY 2024.

Steward Health Care declared bankruptcy in HFY 2024, affecting hospital median margins in that year. For hospital-specific information, see the HFY 2024 Massachusetts Hospital and Health System Annual Financial Performance Report.

In HFY 2025 data through June 30, 2025, the statewide median total margin was 2.7%. Of the 56 hospitals included, 43 (77%) reported positive total margins while 35 (63%) reported positive operating margins.

Statewide Acute Hospital Median Total, Operating, and Non-Operating Margin Trends



Statewide Median	HFY 2020	HFY 2021	HFY 2022	HFY 2023	HFY 2024	HFY 2025 through June 30
Total Margin	2.6%	5.0%	-4.2%	2.2%	0.6%	2.7%
Operating Margin	1.3%	0.8%	-1.3%	0.2%	-2.0%	1.8%
Non-Operating Margin	0.5%	3.0%	-0.4%	1.6%	1.6%	0.9%

The acute hospital median total margin in HFY 2024 was 0.6%, a decrease of 1.6 percentage points from the prior fiscal year. The acute hospital median operating margin was -2.0%, a decrease of 2.2 percentage points.

Source: Standardized annual and quarterly financial statements reported to CHIA.

Provider and Health System Trends

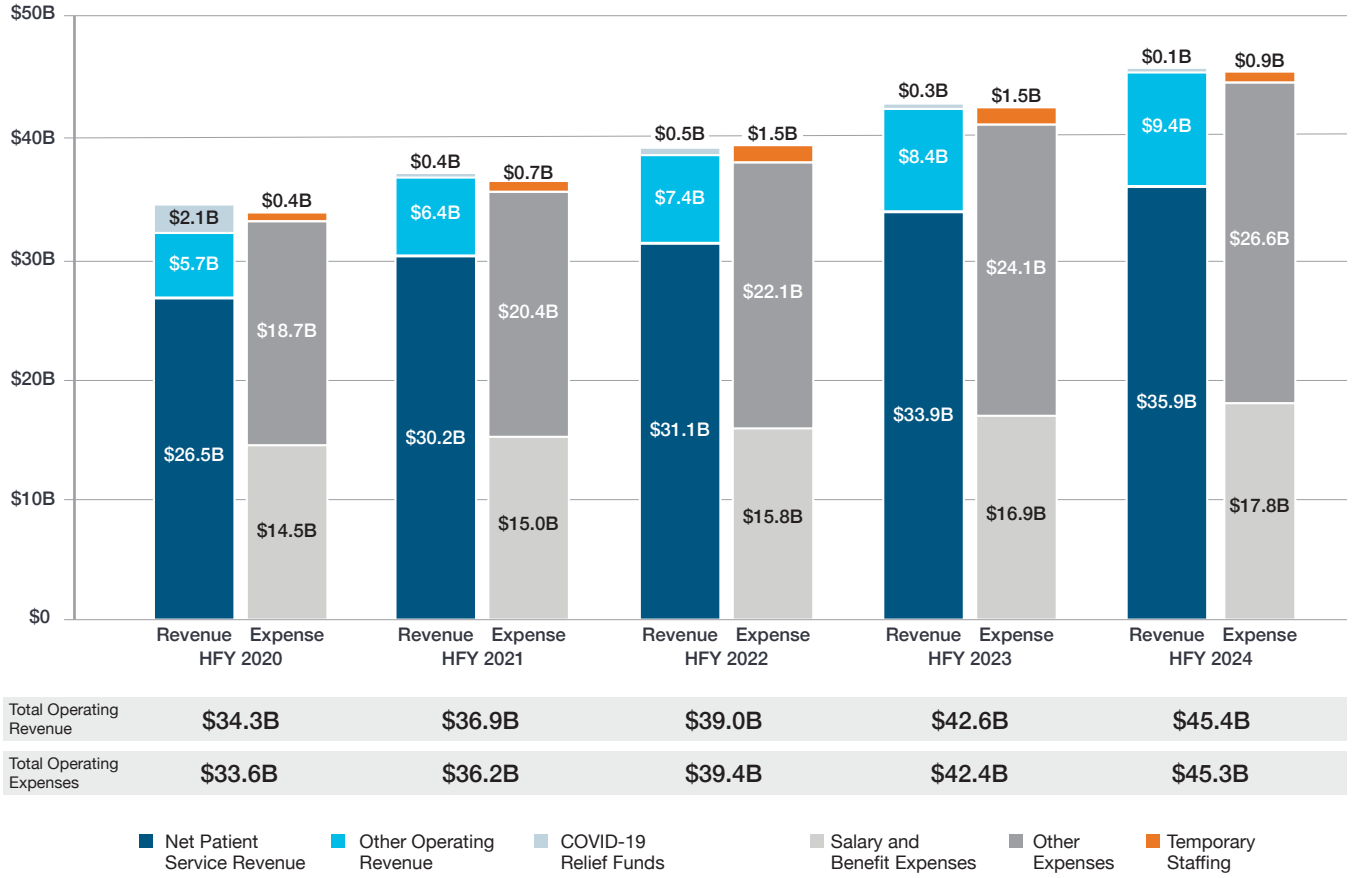
Aggregate total operating revenue increased by $2.8 billion (6.5%) from HFY 2023 to HFY 2024, with aggregate net patient service revenue, the most significant component of operating revenue, increasing by $2.0 billion (6.0%) over the prior fiscal year. Aggregate expenses increased $2.9 billion (6.8%) in HFY 2024 compared with the prior fiscal year. In HFY 2024, operating revenue exceeded expenses by $58.8 million in aggregate.

Aggregate workforce spending at acute hospitals, represented by salary, benefits, and temporary labor costs, increased by $0.4 billion (2.1%) in HFY 2024 compared with HFY 2023. This is a moderation of the growth rate in HFY 2023 from the prior year (5.8%). In HFY 2024, temporary labor costs continued to decline, decreasing 37.0% from HFY 2023.

Aggregate spending on other operating costs, including supplies, depreciation, interest, and other operating expenses, increased by $2.5 billion (10.4%). This is slightly higher than the growth rate in HFY 2024 from the prior year (9.0%).

Hospitals reported $52.8 million in COVID-19 relief funds in their HFY 2024 operating revenue compared with $343.6 million in HFY 2023.

Acute Hospital Operating Revenue and Expense Trends



	HFY 2020	HFY 2021	HFY 2022	HFY 2023	HFY 2024
Total Operating Revenue	$34.3B	$36.9B	$39.0B	$42.6B	$45.4B
Total Operating Expenses	$33.6B	$36.2B	$39.4B	$42.4B	$45.3B

In HFY 2024, aggregate operating revenue exceeded aggregate expenses by $58.8 million at acute hospitals.

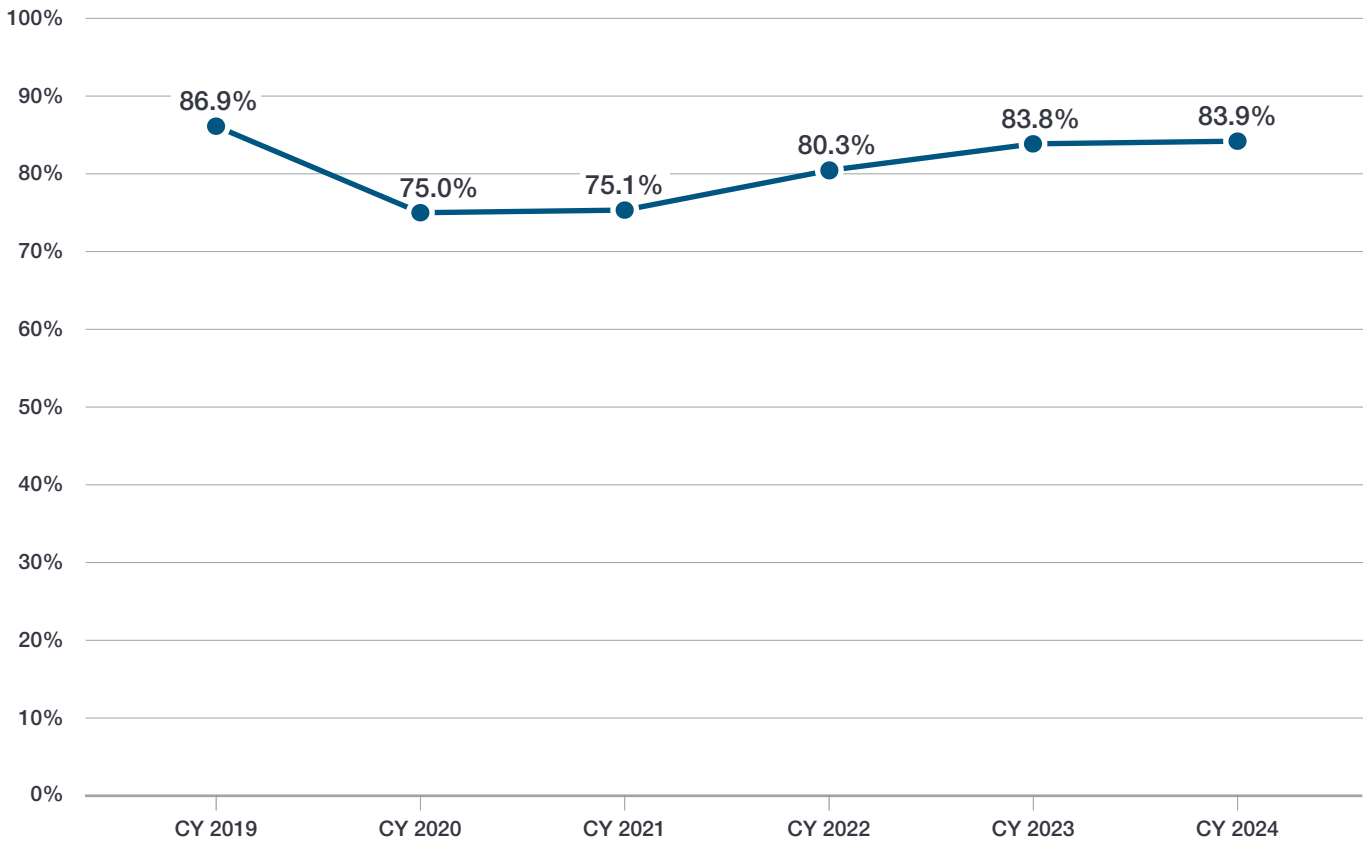
Source: Standardized annual and quarterly financial statements reported to CHIA.

Provider and Health System Trends

Occupancy rates are used to examine the actual utilization of a facility compared with the total number of licensed beds. Occupancy rates can be an indicator of financial stability as higher occupancy generates increased revenue to offset both fixed and variable expenses. The system-level occupancy rates depicted here measure the total occupied beds across all nursing facilities as a percentage of total licensed beds for a given year.

Nursing facility occupancy decreased by 11.9 percentage points between CY 2019 and CY 2020, falling to 75.0%, driven in part by impacts of the COVID-19 pandemic. Since then, the system-level occupancy rate has increased to 83.9%.

Skilled Nursing Facility System-Level Occupancy Rates, CY 2019-2024



In CY 2024, system-level occupancy remained steady compared with CY 2023, increasing by 0.1 percentage point to 83.9%.

Source: Skilled Nursing Facility Cost Reports (HCF-1/SNF-CR) reported to CHIA.

Notes: Nursing facility data is as reported by facilities that submit cost reports to CHIA. Private pay facilities that do not accept Medicaid are not included. "Licensed beds" is used in the denominator of occupancy calculation and refers to the number of beds on license issued to the facility by the Massachusetts Department of Public Health (DPH), representing total maximum capacity of the facility allowed under that license; this may be greater than the actual number of beds a facility has staffed and available for use at a given time.

Provider and Health System Trends

In CY 2024, there were 328 nursing facilities that served MassHealth or other publicly aided residents in Massachusetts. While the aggregate system-level occupancy rate was 83.9%, the median facility occupancy rate statewide was 87.8%.

Excluding Dukes and Nantucket Counties (which only had 1 facility each in 2024), Franklin County had the fewest nursing facilities and licensed beds with 3 total facilities and 306 beds. Middlesex County had the highest number of total facilities (67) and licensed beds (8,108).

Excluding the 2 counties with only 1 facility each, Norfolk County had the lowest median occupancy rate among all counties in 2024 at 82.3% across 33 nursing facilities. Suffolk County had the highest median occupancy rate at 92.9% across 20 facilities.

The median occupancy rate increased statewide by 2.4% and in all but 3 counties between CY 2023 and CY 2024. The closure of 6 facilities in Barnstable, Essex, Hampshire, Plymouth, and Suffolk counties and the corresponding decrease in licensed beds is also reflected in the table.

Skilled Nursing Facility Total Facilities, Total Beds, and Median Occupancy by County, CY 2024

County	Total Facilities	Licensed Beds	Median Occupancy
Barnstable	15	1,641	87.3%
Berkshire	12	1,291	92.1%
Bristol	28	3,698	86.2%
Dukes	1	61	47.9%
Essex	43	4,870	86.4%
Franklin	3	306	91.3%
Hampden	24	2,814	90.0%
Hampshire	5	635	88.3%
Middlesex	67	8,108	88.7%
Nantucket	1	45	75.2%
Norfolk	33	3,672	82.3%
Plymouth	27	3,278	86.4%
Suffolk	20	2,450	92.9%
Worcester	49	5,816	90.5%
Statewide	**328**	**38,685**	**87.8%**

KEY Increase >10% compared with CY 2023 | Decrease between 5% and 10% compared with CY 2023 | Decrease >10% compared with CY 2023

Nursing facility median occupancy increased statewide and in 11 out of 14 counties between CY 2023 and CY 2024.

Source: Skilled Nursing Facility Cost Reports (HCF-1/SNF-CR) reported to CHIA.

Notes: Nursing facility data is as reported by facilities that submit cost reports to CHIA. Private pay facilities that do not accept Medicaid are not included. "Licensed beds" is used in the denominator of occupancy calculation and refers to the number of beds on license issued to the facility by DPH, representing total maximum capacity of the facility allowed under that license; this may be greater than the actual number of beds a facility has staffed and available for use at a given time.

KEY FINDINGS

Behavioral Health

In 2024, spending on behavioral health services represented 8.1% of commercial, 22.4% of MassHealth, and 2.3% of Medicare Advantage total health care spending, similar proportions to 2023.

Outpatient services accounted for more than half of mental health spending for commercial (51.8%) and MassHealth (53.1%) members, but only a quarter (25.5%) for Medicare Advantage.

Inpatient services accounted for the largest proportion of commercial (42.2%) and Medicare Advantage (42.4%) substance use disorder (SUD) spending and about one-third of MassHealth SUD spending (31.2%).

The number of inpatient discharges for patients with a primary behavioral health diagnosis has remained stable over the past 2 years.

More than 1 in 6 insured residents who had a behavioral health care visit in the past 12 months paid for their most recent visit entirely out of pocket, primarily for reasons related to insurance coverage.

Behavioral Health

Massachusetts residents seeking behavioral health (BH) care can face unique challenges that make accessing, affording, and maintaining treatment difficult, leading to worse health outcomes for patients. These challenges include a fragmented provider and coverage system, high out-of-pocket costs, workforce shortages, and continuing stigma associated with mental health (MH) and substance use disorder (SUD) treatment.

Over the past 4 years, the Commonwealth has enacted several policy changes to address these challenges. In 2022, Massachusetts enacted the Mental Health ABC Act: Addressing Barriers to Care—aimed at expanding access to behavioral health care services and supporting the behavioral health workforce. In addition, this legislation charged CHIA with monitoring "costs, cost trends, price, quality, utilization, and patient outcomes related to behavioral health service subcategories… including mental health, substance use disorder, outpatient, inpatient, services for children, services for adults, and provider type."[1]

The Massachusetts Roadmap for Behavioral Health Reform was implemented in 2023 to enhance access to mental health and substance use disorder services across the state. Key components of this roadmap include the creation of a behavioral health helpline for 24/7 access to services, an extended network of community behavioral health centers, and access to behavioral health urgent care centers.[2]

This chapter provides an overview of behavioral health care in Massachusetts for calendar years 2023 and 2024. It examines total spending by insurers and patients for MH and SUD services by age group for pediatric (ages 0-17) and adult (ages 18-64) populations. This chapter highlights behavioral health spending trends that cover MH and SUD services delivered in several care settings, including

inpatient, emergency department, and outpatient settings delivered by both behavioral health and non-behavioral health care providers. In addition, this chapter includes information on behavioral health utilization in both acute and non-acute hospitals. This chapter also examines access challenges from the patient perspective, including prevalence of residents paying for behavioral health visits entirely out of pocket or forgoing such care altogether.

In addition to the data points included in this chapter, CHIA publishes a **Primary Care and Behavioral Health Spending report** and a **Behavioral Health Dashboard**. Both of these publications include BH-specific data points reflecting statewide results, payer- and provider-specific data, and utilization metrics.

Data Sources and Methodology

Results reported in this chapter utilize several data sets, including a survey of Massachusetts residents, aggregate data reported by payers, provider-reported cost reports, and hospital-reported discharge- and visit-level datasets.

Based on CHIA's published list of ICD-10 diagnosis codes, members with a mental health or substance use disorder principal diagnosis at any point throughout the specified reporting period are captured in this data to quantify trends in behavioral health utilization and spending. Through CHIA's primary care and behavioral health data collection requirements, a crosswalk of CPT (Current Procedural Terminology), revenue, and point of service codes were utilized by payers to report and categorize BH-specific spending. For additional details on diagnoses and code lists for services classified as behavioral health, see the primary care and behavioral health data specifications.[3]

Behavioral health spending data reported in this chapter reflects payments for MH and SUD services that are covered by a member's health insurance plan and does not include services privately paid for by patients outside of their insurance coverage. BH-specific spending measures represent payments across private commercial insurance, MassHealth, and Medicare Advantage lines of business. Payers that submitted only CY 2024 spending data were excluded from service category level analyses due to comparability concerns resulting from updates to CHIA's PCBH data specification manual in 2025. Utilization measures for acute and non-acute behavioral health hospitals are inclusive of patients with all types of private and public insurance, including MassHealth, Medicare, and self-pay.

Estimates reported for any unmet need for BH care due to cost and out-of-pocket spending on BH visits come from the 2025 Massachusetts Health Insurance Survey (MHIS). The MHIS was fielded in English and Spanish from January through April 2025 and collected data on 5,365 residents and their families. All estimates

provided in this chapter are weighted to provide population-based estimates for the noninstitutionalized resident population of the Commonwealth. Additional information about the survey design is available in the **MHIS methodology report**.

More detailed information about behavioral health in Massachusetts can be found in other CHIA reports, including reports on **Massachusetts Acute Hospital Case Mix Databases** and the **Behavioral Health and Specialty Care Hospital Profiles**. ■

Behavioral Health

In 2024, the proportion of private commercially insured members with a behavioral health diagnosis decreased slightly by 0.2 percentage point to 22.4%. Private commercial spending on behavioral health services (MH and SUD combined) represented 8.1% of total medical spending in 2024, consistent with 2023. Total behavioral health spending PMPM increased 11.1% from $54 PMPM in 2023 to $60 PMPM in 2024, in part driven by increased utilization of behavioral health services.[4] MH services represented the majority of private commercial behavioral health spending at $50 PMPM (6.8% of total spending) compared with $10 PMPM for SUD services (1.3% of total spending).

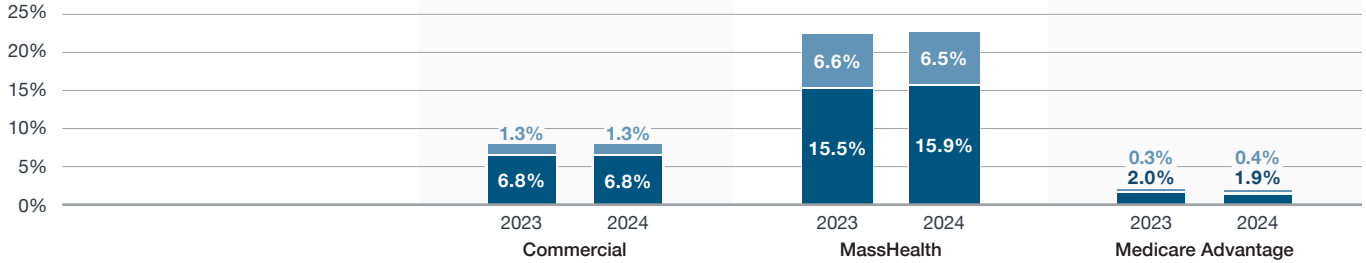
MassHealth had both the highest BH diagnosis prevalence across insurance categories, at 32.7% in 2024 (a 3.6 percentage point increase from 2023), and the highest percentage of spending on behavioral health services. In 2024, MassHealth annual enrollment declined for the first time since 2019 due to eligibility redetermination processes; as membership shifted, the MassHealth population in 2024 had higher overall acuity than in prior years. BH spending accounted for 22.4% of total MassHealth spending in 2024. On a PMPM basis, behavioral health spending increased from $142 PMPM in 2023 to $172 PMPM in 2024 (21.1% increase). During 2023 and 2024, the Commonwealth launched Community Behavioral Health Centers (CBHCs) and Behavioral Health Urgent Care (BHUC) Centers to provide better access to care, which received enhanced payments from MassHealth.[5]

In 2024, 13.5% of Medicare Advantage members had a BH diagnosis, a 3.3 percentage point decrease from 2023; however, the 2.3% of total Medicare Advantage spending attributed to behavioral health services was consistent with 2023. Mental health spending increased from $24 to $26 PMPM while SUD spending increased from $4 to $5 PMPM.

Behavioral Health Spending and Diagnosis Prevalence by Insurance Category, 2023-2024

	Commercial		MassHealth		Medicare Advantage	
	2023	2024	2023	2024	2023	2024
Total Member Months	39.8M	40.6M	17.2M	15.0M	4.1M	4.5M
% Members With MH Diagnosis	21.2%	21.0%	24.1%	27.4%	14.4%	11.5%
% Members With SUD Diagnosis	1.3%	1.4%	5.0%	5.2%	2.4%	2.0%
% Members With BH Diagnosis	**22.6%**	**22.4%**	**29.1%**	**32.7%**	**16.8%**	**13.5%**
Total PMPM	$673	$733	$645	$769	$1,242	$1,329
MH PMPM	$46	$50	$100	$122	$24	$26
SUD PMPM	$9	$10	$43	$50	$4	$5
Behavioral Health PMPM	**$54**	**$60**	**$142**	**$172**	**$29**	**$31**

Percentage of Total Expenditures



% Total Expenditures	**8.1%**	**8.1%**	**22.1%**	**22.4%**	**2.3%**	**2.3%**

KEY ■ MH ■ SUD

In 2024, spending on behavioral health services represented 8.1% of commercial, 22.4% of MassHealth, and 2.3% of Medicare Advantage total health care spending, similar to 2023.

Source: Payer-reported data to CHIA.

Notes: Data for Original Medicare not available for this analysis. For commercial partial-claim data, CHIA estimated pharmacy spending by service type. MassHealth-submitted data includes data for members for which MassHealth is primary payer, including ACPP, MCO, PCACO, PCC, and FFS delivery systems. FFS members with dual eligiblity, third party liability, or limited coverage, and SCO, PACE, and One Care members, are not included. Data may not tie to Total Health Care Expenditures chapter. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had MH or SUD principal diagnosis at any point during reporting year. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

Across all MassHealth programs, direct spending on members' behavioral health care totaled $2.7 billion in 2024, an increase from $2.5 billion in 2023. Additionally, MassHealth BH-related supplemental payments totaled $81 million in 2024, funding community-high public payer BH hospital programs and behavioral health quality incentive (BHQI) programs.

In April 2023, MassHealth initiated its redetermination process that disenrolled ineligible individuals following the end of federal continuous coverage protections and simultaneously reprocured Accountable Care Partnership Plan (ACPP) and Primary Care Accountable Care Organization (PCACO) contracts.[6,7] These changes impacted the member composition of MassHealth overall and within each program; the MassHealth population in 2024 had higher overall acuity than in prior years. Notably, the percentage of members with behavioral health diagnoses increased in all reported programs from 2023 to 2024.

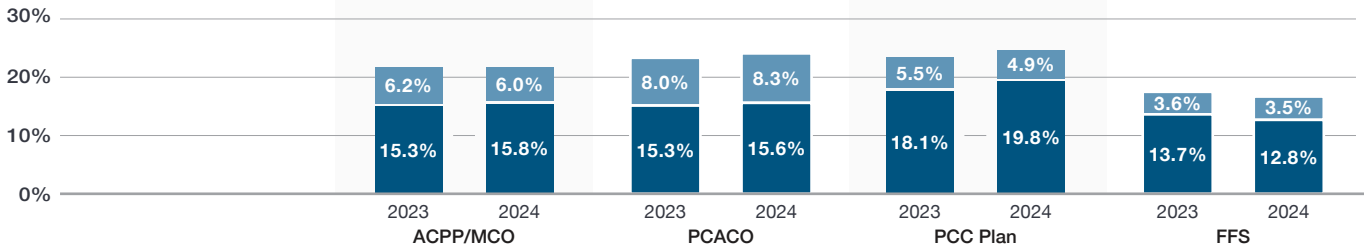
ACPP/MCO plans, which had the highest percentage of members with a behavioral health diagnosis (33.6% in 2024, a 3.6 percentage point increase from 2023), reported that spending on BH services was 21.8% of total medical spending in 2024. ACPP/MCO behavioral health spending increased to $169 PMPM, driven by an increase in spending on mental health services from $100 PMPM to $123 PMPM.

BH services accounted for 24.0% of PCACO total spending, increasing from $147 PMPM to $179 PMPM. BH spending under the Primary Care Clinician (PCC) plan was similar at 24.7% in 2024. The MassHealth fee-for-service (FFS) delivery system had the lowest proportion of BH spending (16.3% of total FFS in 2024) and the lowest behavioral health per-member spending ($139 PMPM).

MassHealth Behavioral Health Spending and Diagnosis Prevalence by Program Type, 2023-2024

	ACPP/MCO		PCACO		PCC Plan		FFS	
	2023	2024	2023	2024	2023	2024	2023	2024
Total Member Months	11.8M	11.0M	4.4M	3.4M	0.9M	0.6M	1.2M	1.0M
% Members With MH Diagnosis	25.4%	28.8%	20.9%	23.6%	22.1%	25.4%	11.4%	13.8%
% Members With SUD Diagnosis	4.6%	4.8%	6.0%	6.6%	4.5%	4.6%	2.0%	2.6%
% Members With BH Diagnosis	**30.0%**	**33.6%**	**26.9%**	**30.3%**	**26.6%**	**30.0%**	**13.5%**	**16.4%**
Total PMPM	$652	$779	$634	$748	$622	$700	$576	$852
MH PMPM	$100	$123	$97	$117	$113	$138	$79	$109
SUD PMPM	$40	$47	$50	$62	$34	$34	$21	$30
Behavioral Health PMPM	**$140**	**$169**	**$147**	**$179**	**$147**	**$173**	**$100**	**$139**
Behavioral Health Spending	**$1.7B**	**$1.9B**	**$650.7M**	**$616.6M**	**$136.9M**	**$104.1M**	**$124.3M**	**$133.0M**

Percentage of Total Expenditures



	ACPP/MCO		PCACO		PCC Plan		FFS	
% Total Expenditures	**21.5%**	**21.8%**	**23.2%**	**24.0%**	**23.6%**	**24.7%**	**17.3%**	**16.3%**

KEY ■ MH ■ SUD

In 2024, ACPP/MCO plans reported the highest proportion of members with a BH diagnosis (33.6%) and the highest total behavioral health spending.

Source: Payer-reported data to CHIA.

Notes: MassHealth data includes programs administered by MassHealth directly, including ACPP, MCO, PCACO, PCC, and FFS delivery systems. FFS members with dual eligiblity, third party liability, or limited coverage, and SCO, PACE, and One Care members, are not included. ACPP/MCO diagnosis prevalence sourced from data submitted by commercial payers. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had MH or SUD principal diagnosis at any point during reporting year. Totals do not include any MassHealth supplemental payments. As a result, data may not tie to Total Health Care Expenditures chapter. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

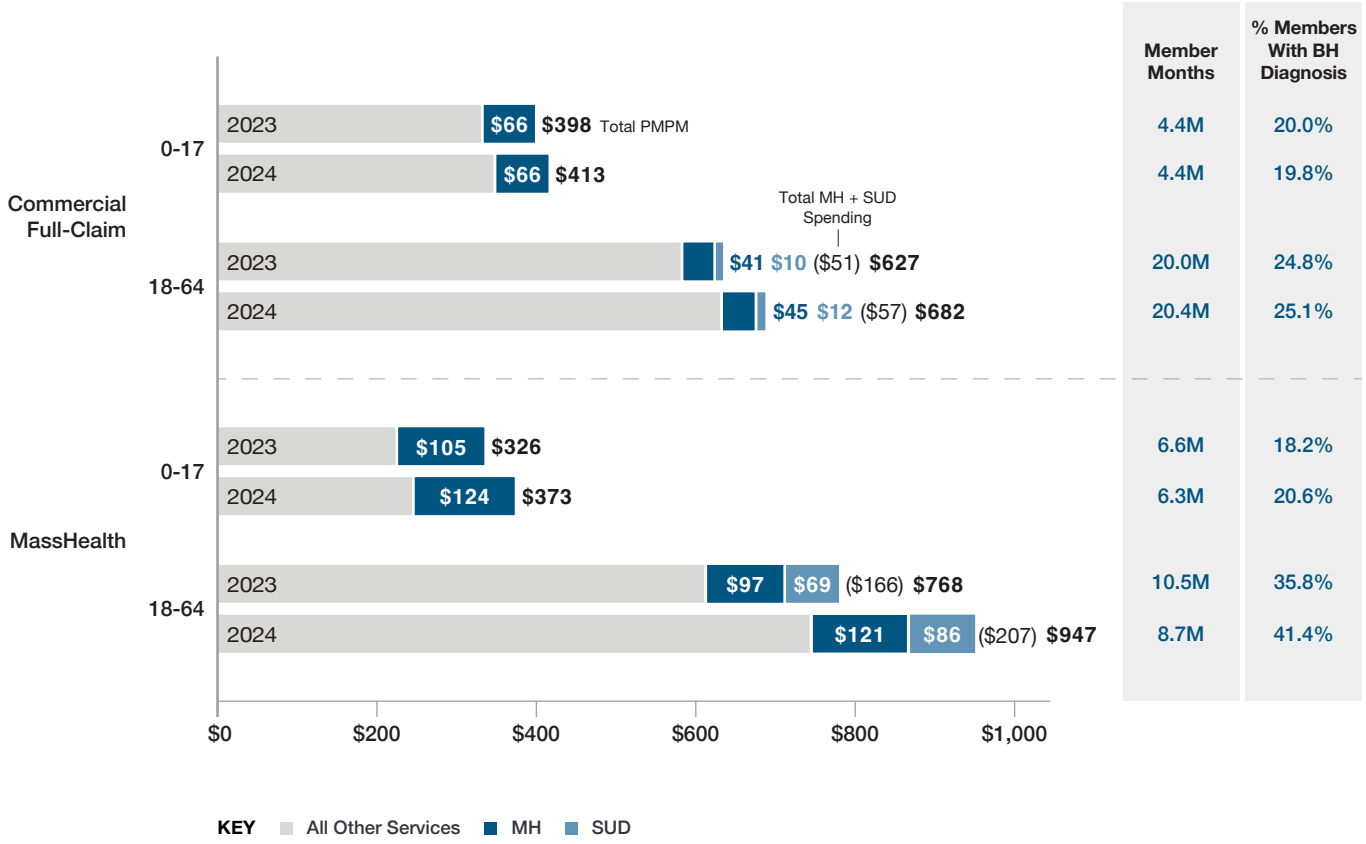
Among pediatric (ages 0-17) commercial members, the proportion with a BH diagnosis decreased slightly from 20.0% in 2023 to 19.8% in 2024, while the proportion of adult (ages 18-64) members with a BH diagnosis increased from 24.8% to 25.1% over the same period.

Behavioral health spending PMPM represented 16.0% of total health care spending for pediatric commercial members, consistent with 2023. However, BH spending PMPM represented 8.4% for adult members in 2024, a slight increase from 2023 (8.1%). BH spending was higher for pediatric commercial members in total, with $66 PMPM reported for mental health care and less than $1 PMPM for SUD services, consistent with 2023. For adult members, MH spending averaged $45 PMPM and SUD spending $12 PMPM, a slight increase from 2023 ($41 PMPM and $10 PMPM, respectively).

The percentage of pediatric MassHealth members with a primary behavioral health diagnosis increased from 18.2% in 2023 to 20.6% in 2024. Among adult MassHealth members, 41.4% had a primary behavioral health diagnosis in 2024, an increase from 35.8% in 2023.

MassHealth BH spending for members ages 0-17 accounted for 33.2% of total health care spending compared with 21.9% for adults. For the pediatric members, MH spending increased from $105 PMPM in 2023 to $124 PMPM in 2024, while SUD spending was less than $1 PMPM each year. MassHealth members ages 18-64 reported higher behavioral health spending PMPM than pediatric members, driven by higher spending on SUD services ($86 PMPM) for adult members in 2024.

Behavioral Health Expenditures by Age Group, 2023-2024



	Member Months	% Members With BH Diagnosis
Commercial Full-Claim, 0-17, 2023	4.4M	20.0%
Commercial Full-Claim, 0-17, 2024	4.4M	19.8%
Commercial Full-Claim, 18-64, 2023	20.0M	24.8%
Commercial Full-Claim, 18-64, 2024	20.4M	25.1%
MassHealth, 0-17, 2023	6.6M	18.2%
MassHealth, 0-17, 2024	6.3M	20.6%
MassHealth, 18-64, 2023	10.5M	35.8%
MassHealth, 18-64, 2024	8.7M	41.4%

On a PMPM basis, commercial members ages 0-17 had higher behavioral health spending than adults while MassHealth adults had higher behavioral health spending than pediatric members, driven by use of SUD services.

Source: Payer-reported data to CHIA.

Notes: Medicare Advantage data not depicted because of low membership reported for members younger than 65. Commercial results include commercial full-claim data only, reflecting members for whom payer has access to and is able to report on all claims expenses, accounting for approximately 63% of total commercial member months in 2024 for payers included in this analysis. Data may not tie to Total Health Care Expenditures chapter. "All Other Services" includes primary care services and services for all specialties other than behavioral health. SUD spending for both commercial and MassHealth pediatric patients totaled <$1 PMPM and is not shown. Member months and PMPM values may not tie to data presented on page 100 due to low membership volume reported in age groups not represented in graph (commercial 65+ and MassHealth 65+).

Behavioral Health

Mental health services are delivered in a variety of health care settings, including inpatient hospitals, residential treatment, intensive outpatient programs, and outpatient office visits. Spending for services in these settings differed across insurance categories.

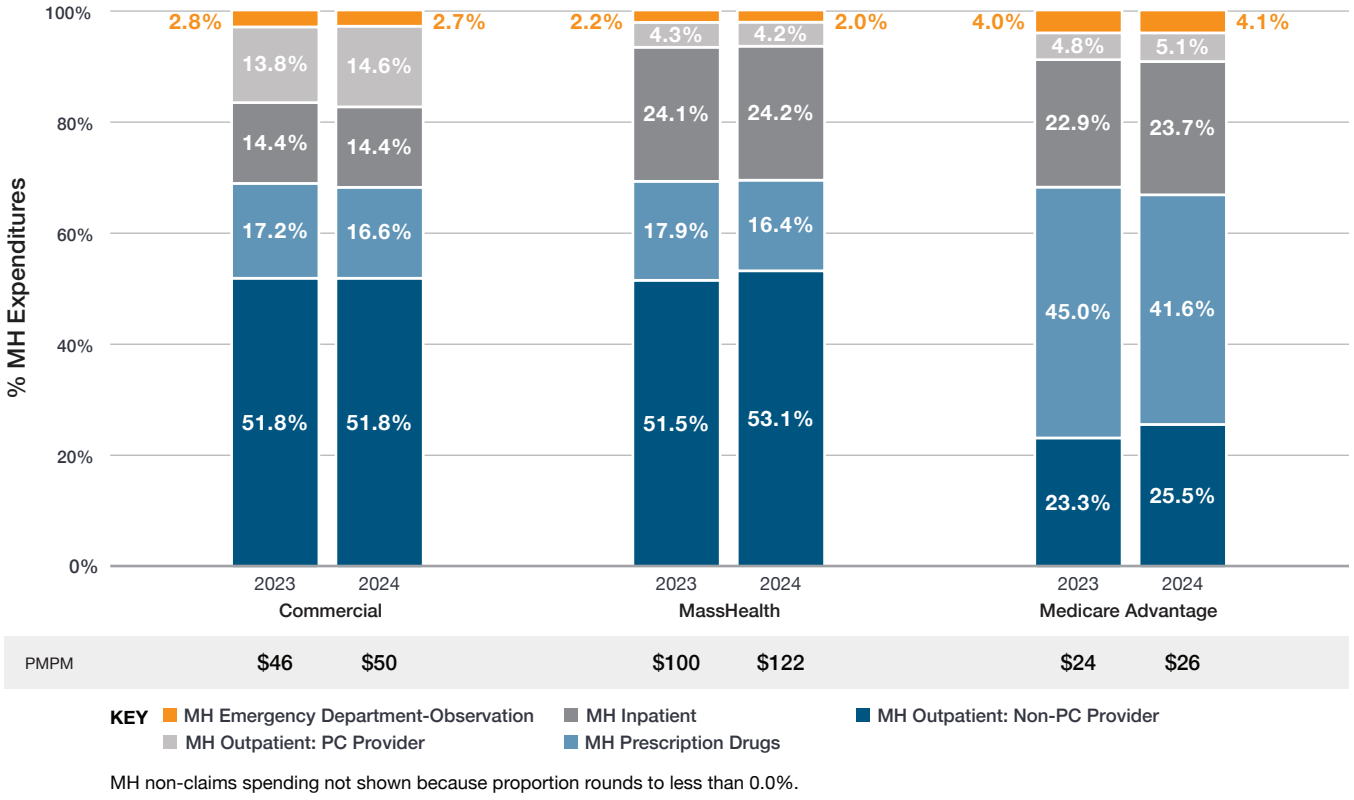
In 2024, outpatient services delivered by a behavioral health or other specialist provider accounted for more than half of MH spending for commercial (51.8%) and MassHealth (53.1%) but only 25.5% for Medicare Advantage. Spending for MH outpatient services delivered by a behavioral health or other specialist provider increased for both MassHealth and Medicare Advantage (1.6 and 2.2 percentage points, respectively). In 2023, CMS expanded coverage for behavioral health services, driving the increase in MassHealth and Medicare Advantage spending on MH outpatient services delivered by a behavioral health or other specialist provider.[8]

Mental health outpatient services provided by a primary care provider as a proportion of total MH spending increased to 14.6% for commercial and 5.1% for Medicare Advantage members in 2024.[9] MH outpatient services provided by a primary care provider decreased slightly by 0.1 percentage point for MassHealth.[10]

Inpatient services accounted for similar proportions of overall mental health spending for MassHealth (24.2%) and Medicare Advantage (23.7%) members but a smaller share of commercial MH spending (14.4%).

Prescription drugs accounted for 16.6% of commercial and 16.4% of MassHealth MH spending in 2024. Mental health prescription drugs accounted for the largest share of any Medicare Advantage MH service category spending at 41.6% in 2024.

Mental Health Spending by Service Category, 2023-2024



MH non-claims spending not shown because proportion rounds to less than 0.0%.

Outpatient MH services provided by a behavioral health or other specialist provider accounted for more than half of MH spending for commercial and MassHealth members in 2024, while prescription drugs accounted for the greatest proportion of MH spending for Medicare Advantage members.

Source: Payer-reported data to CHIA.

Notes: For commercial partial-claim data, CHIA estimated pharmacy spending by service type. MassHealth-submitted data includes data for members for which MassHealth is primary payer, including ACPP, MCO, PCACO, PCC, and FFS delivery systems. FFS members with dual eligiblity, third party liability, or limited coverage, and SCO, PACE, and One Care members, are not included. Due to comparability concerns resulting from updates to CHIA's PCBH data specification manual in 2025, the following payers are excluded from this analysis: Aetna, Fallon, HPI, HNE, and WellSense; as a result, data may not tie to Total Health Care Expenditures chapter. MH non-claims spending not shown because the proportion rounds to less than 0.0%. Analysis represents data from commercial payers that submitted CY 2023 and CY 2024 data, representing approximately 85% of commercial market, 47% of commercially administered ACPP/MCO market, and 79% of Medicare Advantage market. MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had MH or SUD principal diagnosis at any point during reporting year. "Outpatient services delivered by a behavioral health or other specialist provider" refers to services provided by non-primary care provider. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

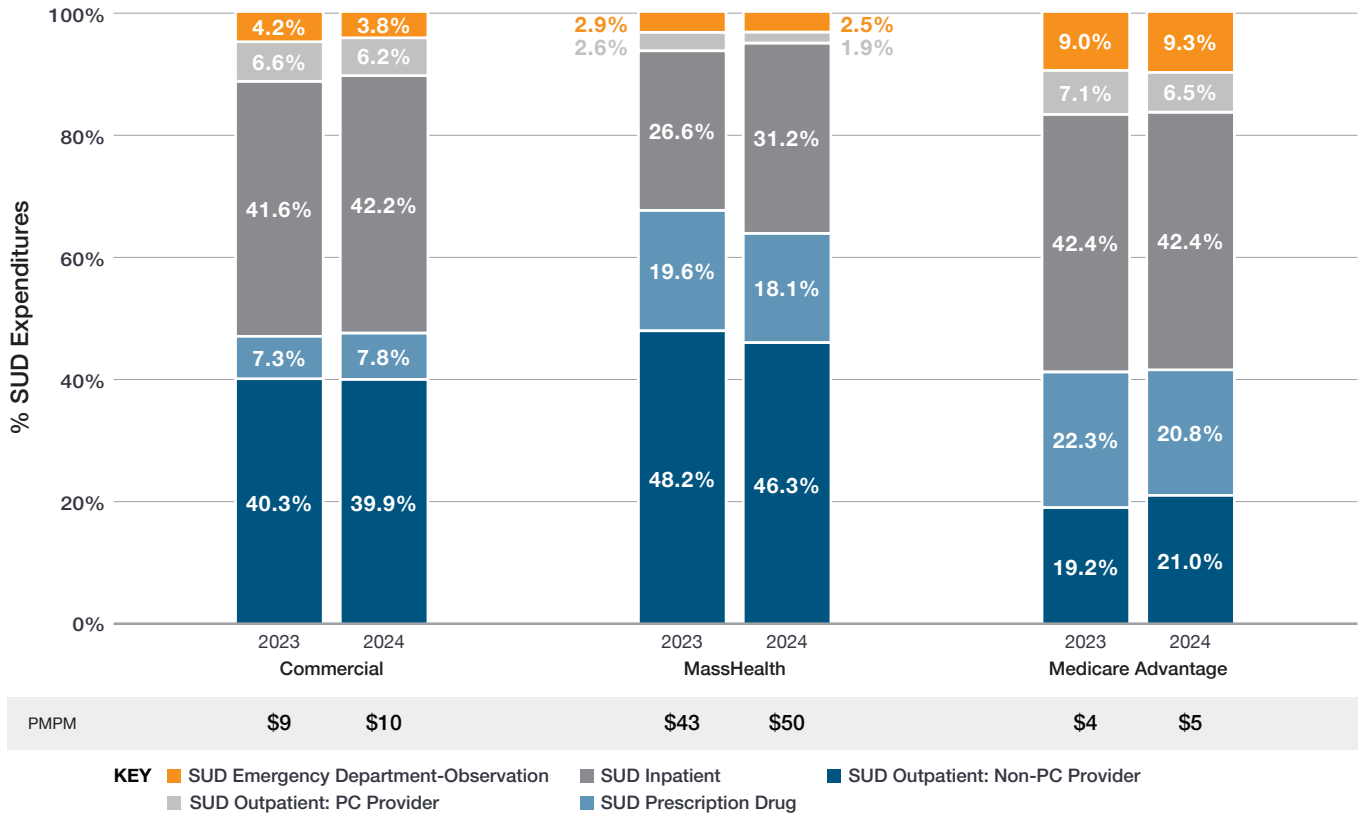
While more than half of mental health spending was for outpatient services among both commercial and MassHealth members, spending for SUD services varied by setting across insurance categories.

In 2024, inpatient services represented the largest portion of commercial and Medicare Advantage SUD spending, accounting for 42.2% of total commercial and 42.4% of Medicare Advantage SUD spending; inpatient services accounted for 31.2% of MassHealth SUD spending. While the proportion of total SUD spending on inpatient services increased for commercial and MassHealth from 2023 to 2024, it remained consistent for Medicare Advantage.

In 2024, the proportion of spending on SUD outpatient services provided by a behavioral health or other specialist provider, such as medication assisted treatment, decreased slightly for commercial (0.4 percentage point) and MassHealth (1.5 percentage points), though it remained the largest SUD service category for MassHealth (46.3%). Spending for SUD outpatient services provided by a behavioral health or other specialist increased for Medicare Advantage members by 1.9 percentage points.

SUD prescription drug spending as a proportion of total SUD spending decreased over the reporting period for MassHealth, partly driven by an increase in the proportion of spending on SUD inpatient services.

Substance Use Disorder Spending by Service Category, 2023-2024



In 2024, inpatient services accounted for the largest proportion of commercial and Medicare Advantage SUD spending (42.2% and 42.4%, respectively), while outpatient services provided by a behavioral health or other specialist accounted for the largest proportion of MassHealth SUD spending (46.3%).

Source: Payer-reported data to CHIA.

Notes: For commercial partial-claim data, CHIA estimated pharmacy spending by service type. MassHealth-submitted data includes data for members for which MassHealth is primary payer, including ACPP, MCO, PCACO, PCC, and FFS delivery systems. FFS members with dual eligiblity, third party liability, or limited coverage, and SCO, PACE, and One Care members, are not included. Due to comparability concerns resulting from updates to CHIA's PCBH data specification manual in 2025, the following payers excluded from this analysis: Aetna, Fallon, HPI, HNE, WellSense; as a result, data may not tie to Total Health Care Expenditures chapter. Analysis represents data from commercial payers that submitted CY 2023 and CY 2024 data, representing approximately 85% of commercial market, 47% of commercially administered ACPP/MCO market, and 79% of Medicare Advantage market.MH and SUD diagnosis prevalence not mutually exclusive and reflect members who had mental health or SUD principal diagnosis at any point during reporting year. "Outpatient services provided by a behavioral health or other specialist provider" refers to services provided by non-primary care provider. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. See technical appendix for additional information.

Behavioral Health

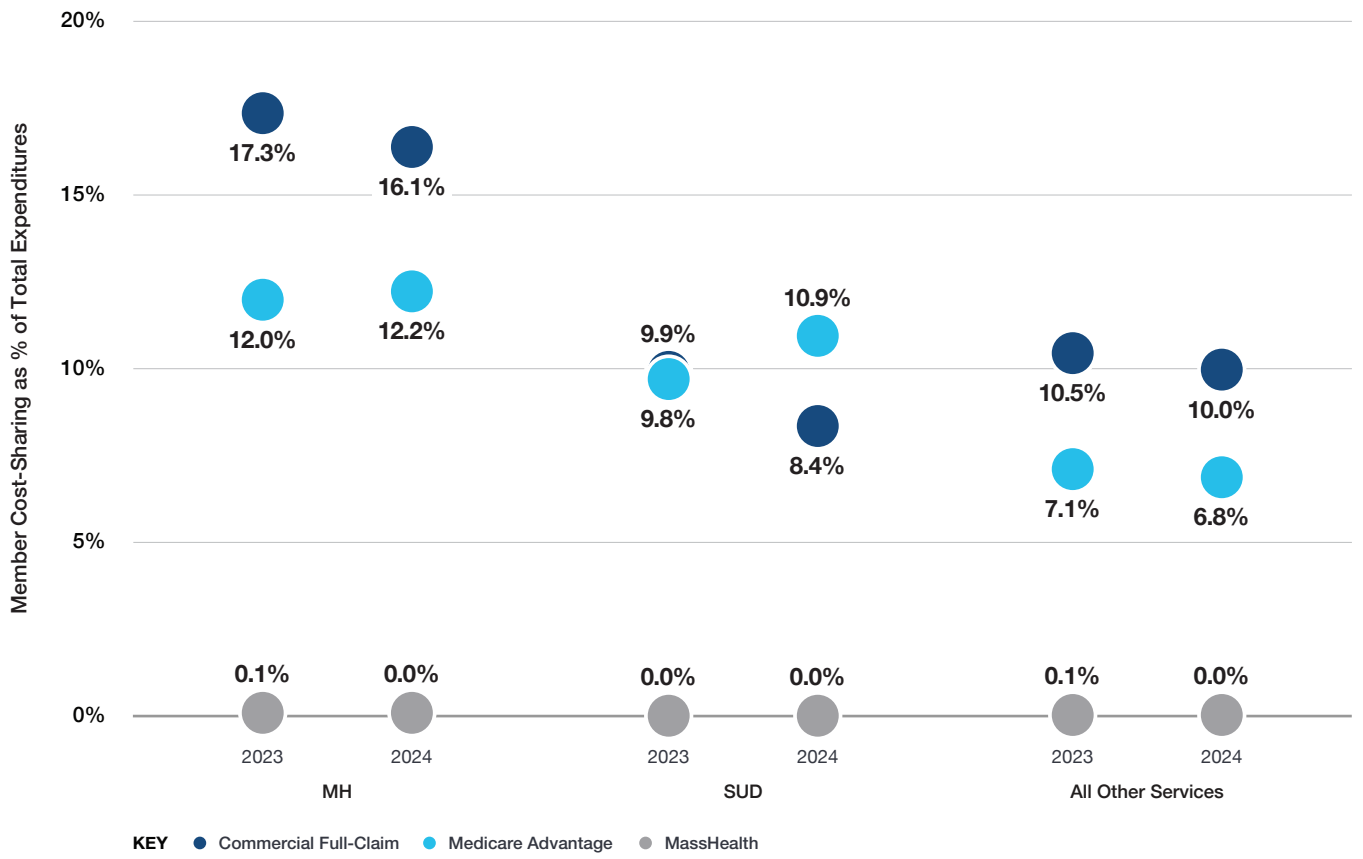
Member cost-sharing includes copayments, coinsurance, and deductibles, representing payments for covered health care services for which the member is financially responsible. This graphic reflects cost-sharing metrics as a proportion of total payments for mental health, substance use disorder, and all other medical services (i.e., services not classified as MH or SUD) that were paid for by members in 2023 and 2024. Fully out-of-pocket member payments for behavioral health care not covered by insurance are not reflected on this page; see page 111 for more information about residents' experiences with entirely out-of-pocket behavioral health expenses.

In 2024, commercial members were responsible for 16.1% of MH spending and 8.4% of SUD spending for services covered by insurance. Commercial member cost-sharing as a proportion of total spending on BH services decreased 1.2 percentage points for MH and 1.4 percentage points for SUD from 2023 to 2024. Cost-sharing for all other services also saw a slight decrease for commercial (0.5 percentage point) and for Medicare Advantage (0.3 percentage point). The overall decline in the proportion of commercial member cost-sharing was in part driven by the ConnectorCare expansion pilot in 2024, as 51,000 additional Massachusetts members were able to access commercial coverage with low-cost copays and no deductibles.[11]

Medicare Advantage members were responsible for a lower proportion of MH spending (12.2%) but a higher proportion of SUD spending (10.9%) than commercial members.

Member cost-sharing responsibilities are substantially lower for MassHealth members due to federal and state limits on member cost-sharing for certain members and services.[12]

Member Cost-Sharing for Behavioral Health Services by Insurance Category, 2023-2024



In 2024, commercial and Medicare Advantage members continued to have higher cost-sharing for mental health services than for SUD and all other services.

Source: Payer-reported data to CHIA.

Notes: This analysis includes commercial full-claim data only, representing members for whom payer has access to and is able to report on all claims expenses, accounting for approximately 63% of total commercial member months in CY 2024 for payers included in this analysis. Totals do not include any MassHealth supplemental payments. Totals may not sum due to rounding. "All Other Services" includes primary care services and services for all specialties other than mental health and substance use disorder care. See technical appendix for additional information.

Behavioral Health

Behavioral health spending is reported by 4 provider types: facility, professional physician, professional other, and unclassified provider. “Facility” behavioral health spending represents the facility or non-professional components of care, such as room and board at an inpatient behavioral health facility or a CBHC. “Professional physician” includes medical doctor and doctor of osteopathic medicine providers such as psychiatrists, child/adolescent psychiatrists, and addiction medicine physicians. “Professional other” represents non-physician clinicians such as psychologists, mental health counselors, social workers, or psychiatric advanced practice nurses. “Unclassified provider” reflects services that are not attributed to a specific licensed provider or applicable facility.

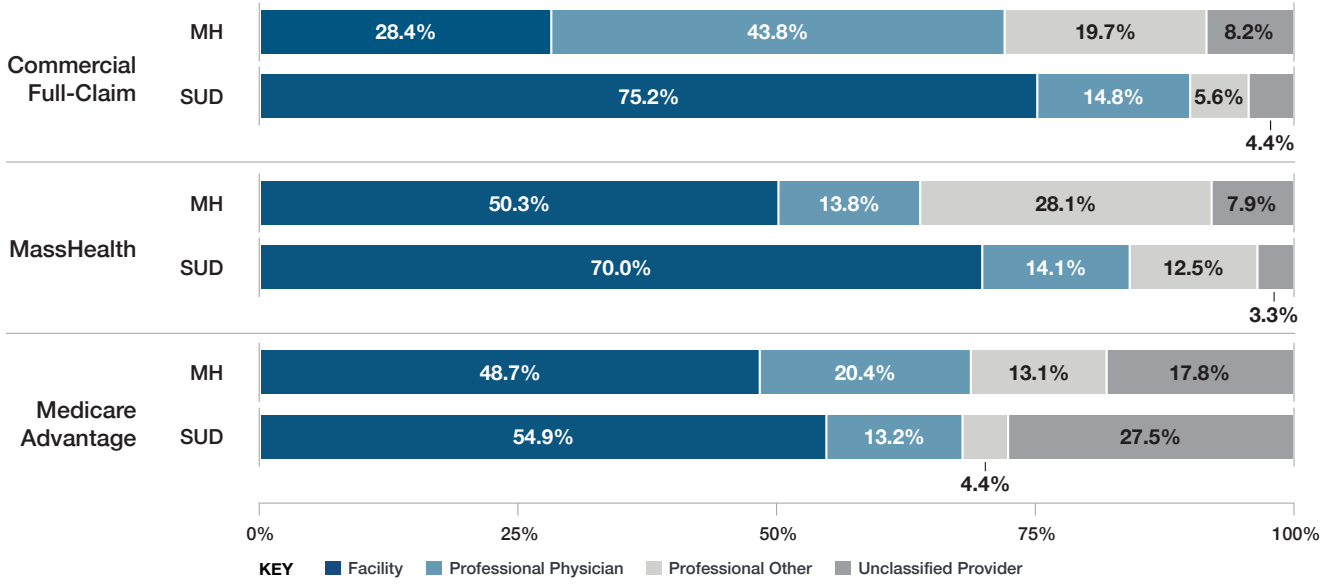
In 2024, provider type spending varied for commercial, MassHealth ACPP/MCO, and Medicare Advantage for mental health services. The highest proportion of commercial MH spending was among the professional physician provider type (43.8%), whereas MassHealth ACPP/MCO and Medicare Advantage had the highest proportion for facility (50.3% and 48.7%, respectively).

In 2024, facility providers accounted for the highest share of spending on SUD services for commercial (75.2%), MassHealth ACPP/MCO (70.0%), and Medicare Advantage (54.9%).[13]

Behavioral Health Spending by Provider Type, 2024

	Commercial Full-Claim		MassHealth		Medicare Advantage	
	MH PMPM	SUD PMPM	MH PMPM	SUD PMPM	MH PMPM	SUD PMPM
Facility	$11.1	$6.4	$52.1	$25.9	$7.7	$2.4
Professional Physician	$17.0	$1.3	$14.3	$5.2	$3.2	$0.6
Professional Other	$7.8	$0.5	$29.1	$4.7	$2.1	$0.2
Unclassified Provider	$3.2	$0.4	$8.1	$1.2	$2.8	$1.2

Percent of Total Expenditures by Provider Type



Mental health services delivered by a physician had the largest share of provider type spending for commercial members, while mental health services delivered in a facility like a hospital or health center accounted for half of MassHealth and Medicare Advantage. SUD service spending was concentrated in facilities across all insurance categories.

Source: Payer-reported data to CHIA.

Notes: Commercial results include commercial full-claim data only, reflecting members for whom payer has access to and is able to report on all claims expenses, accounting for approximately 63% of total commercial member months in 2024 for payers included in this analysis. Prescription drug data was excluded from this chart as it is not associated with a specific provider type. See technical appendix for additional information.

Behavioral Health

Acute hospitals contain a majority of medical surgical, pediatric, obstetric, and nursery beds. Acute hospitals with behavioral health units have beds specifically designated for the treatment of BH patients and were reported as distinct cost centers in the hospital cost report.

Freestanding behavioral health hospitals often provide MH and SUD services.

SUD facilities focus solely on substance use, providing detoxification and other services on an inpatient basis. There is currently 1 privately owned SUD facility in Massachusetts.

State-operated facilities included in this data are operated by the Department of Mental Health (DMH) to provide behavioral health care for those with otherwise limited access to facilities providing such care.

Massachusetts Hospital Inpatient Statistics, HFY 2024

	Number of Hospitals/ Facilities	Total Licensed Beds	Total Staffed Beds	Median Percentage Occupancy	Median Average Length of Stay (Days)
Acute Hospitals BH Units	32	1,278	939	85.3%	15.7
Freestanding BH Units	14	1,769	1,666	91.8%	16.3
SUD Facilities	1	114	114	86.3%	6.8
State-Operated Facilities	5	461	461	98.4%	70.1

Source: Hospital Cost Reports submitted to CHIA.

Notes: These state-operated facilities' beds do not include DMH beds at DPH hospitals.

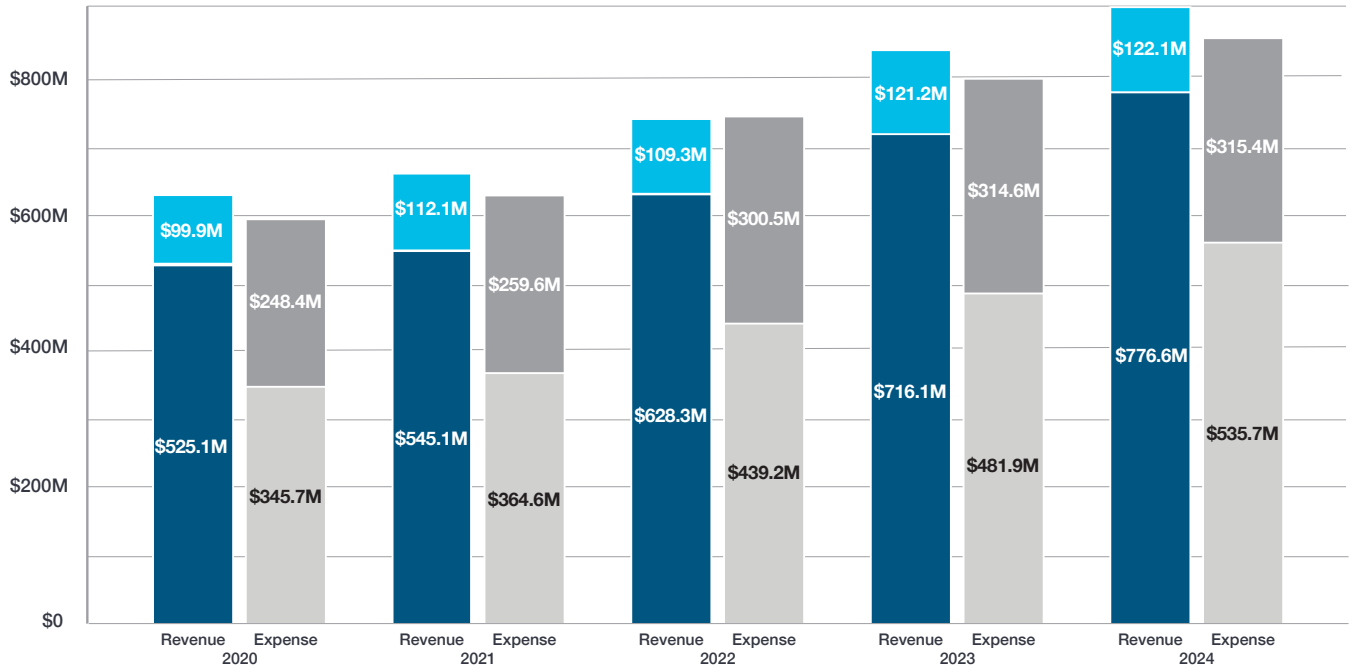
Behavioral Health

Aggregate total operating revenue at freestanding behavioral health hospitals increased by $61.4 million (7.3%) from HFY 2023 to HFY 2024, with aggregate net patient service revenue—the most significant component of operating revenue—increasing by $60.5 million (8.4%) compared with the prior fiscal year. In HFY 2024, operating revenue exceeded expenses by $47.6 million in aggregate.

Aggregate expenses increased $54.6 million (6.9%) in HFY 2024 compared with the prior fiscal year. Workforce spending at behavioral health hospitals, represented by salary and benefits, increased by $53.8 million (11.1%) and represented 62.9% of total expenses in HFY 2024.

Spending on other operating costs, including depreciation, interest, Health Safety Net assessment, and other operating expenses, increased $0.7 million (0.2%).

Freestanding Behavioral Health Hospital Operating Revenue and Expense Trends, HFY 2020-2024



	2020	2021	2022	2023	2024
Total Operating Revenue	$625.0M	$657.2M	$737.6M	$837.3M	$898.7M
Total Operating Expenses	$594.1M	$624.2M	$739.7M	$796.5M	$851.1M

Net Patient Service Revenue | Other Operating Revenue | Salary and Benefit Expenses | Other Expenses

In HFY 2024, aggregate operating revenue at freestanding behavioral health hospitals exceeded expenses by $47.6 million.

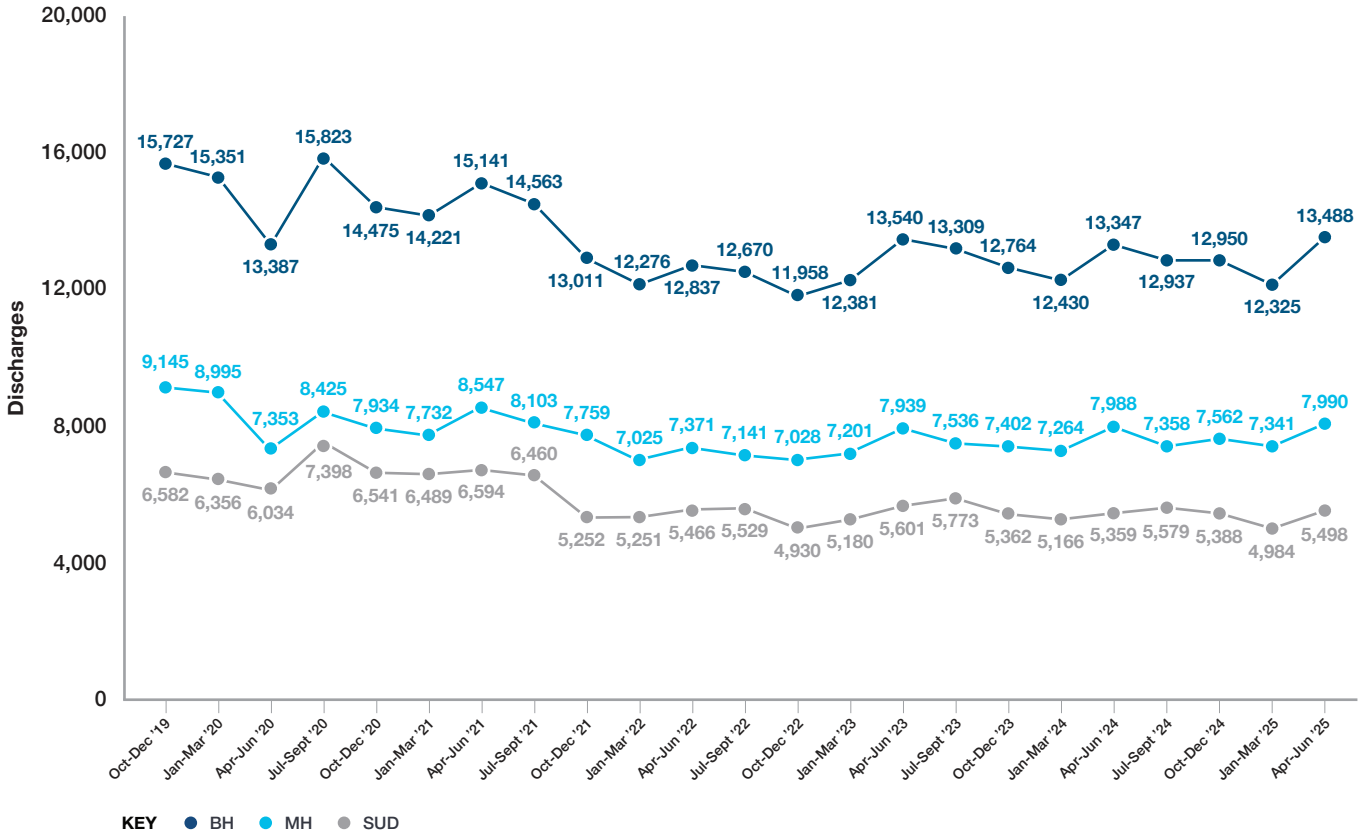
Source: Hospital Cost Reports submitted to CHIA.

Behavioral Health

At acute care hospitals, inpatient discharges with a primary behavioral health diagnosis account for about 7% to 8% of all inpatient discharges. Nearly 60% of inpatient discharges with a primary behavioral health diagnosis are associated with a primary mental health condition and the remainder are associated with a primary substance use diagnosis.

Similar to total inpatient discharge trends, inpatient discharges associated with a primary BH diagnosis have increased since the COVID-19 pandemic but remain lower than pre-pandemic levels as of June 2025.

Acute Care Hospital Behavioral Health Inpatient Discharge Trends, October 2019-June 2025



Inpatient discharges for patients with a primary BH diagnosis remain lower than pre-pandemic levels and have been stable for the past 2 years.

Source: Hospital Inpatient Discharge Database (HIDD), October 2019-June 2025.

Notes: Data source includes only acute care hospitals; it does not include private BH hospitals, SUD facilities, or DMH-operated facilities. For this analysis, discharges categorized into clinically meaningful independent BH categories based on listed primary diagnosis codes using Clinical Classification Software Refined (CCSR) for ICD-10-CM diagnoses. Only inpatient discharges among patients age 2 and older included in this analysis. See CHIA website for most up-to-date information on inpatient utilization. Hospital inpatient discharge data for partial FFY 2025 (October 2024-June 2025) not considered final and subject to change.

Behavioral Health

Among pediatric inpatient discharges for behavioral health conditions, the most common primary diagnoses in FFY 2024 were mood-related conditions, such as major depressive disorders. Other common conditions included trauma-related disorders, such as post-traumatic stress disorder (PTSD), and self-harm/suicidal ideation. Discharges for MH conditions were more common in this age group than discharges for SUD.

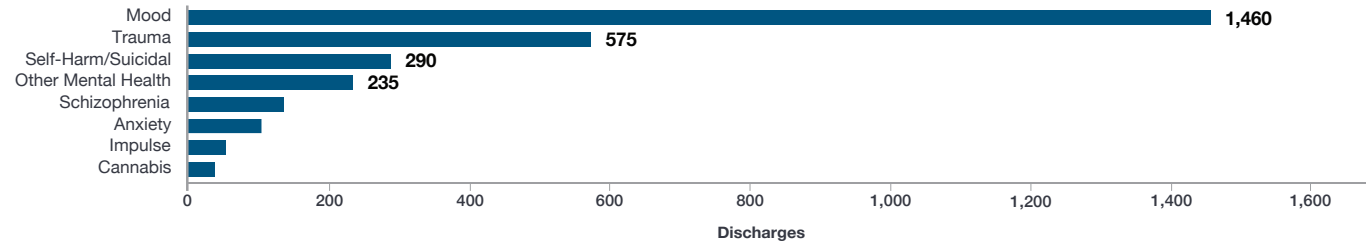
Among adult inpatient discharges for behavioral health conditions, the most common primary diagnoses were alcohol and mood-related disorders. Other common conditions included those associated with schizophrenia and other psychotic disorders, sedative use disorders, trauma-related disorders, and self-harm/suicidal ideation.

More than 80% of all inpatient discharges with a primary behavioral health diagnosis were among non-elderly adults ages 18-64 (data not shown).

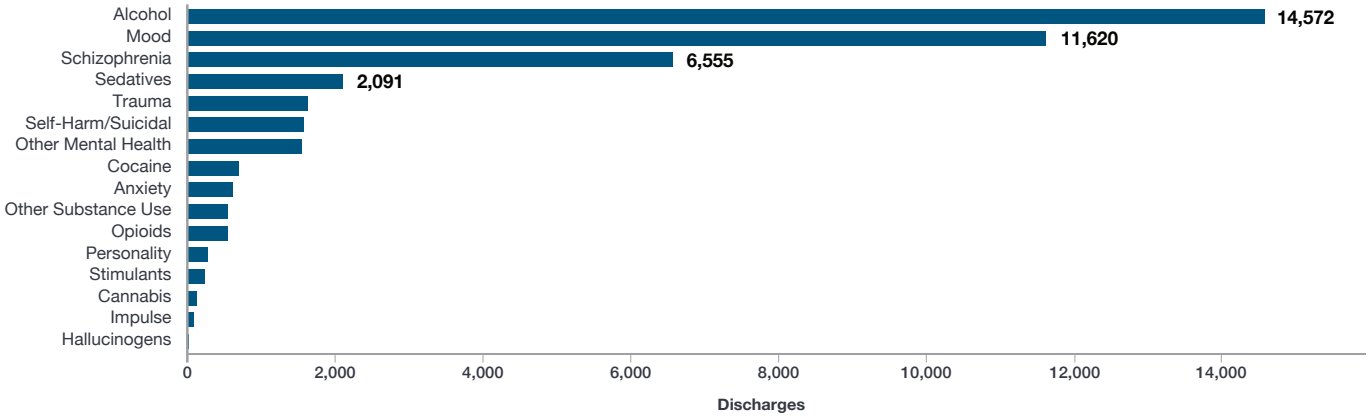
Among inpatient discharges for behavioral health care at acute care hospitals, mood-related conditions were the most common diagnoses among the pediatric population in FFY 2024; alcohol- and mood-related conditions were the most common diagnoses among adults age 18 and older.

Acute Care Hospital Behavioral Health Inpatient Discharge Characteristics by Age Group, FFY 2024

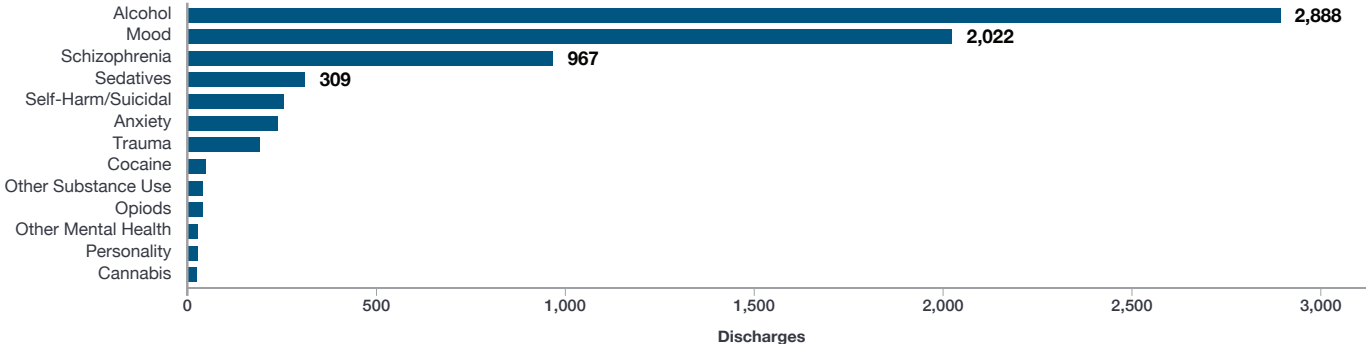
Patients Ages 2-17



Patients Ages 18-64



Patients Age 65+



Source: Hospital Inpatient Discharge Database (HIDD), FFY 2024.

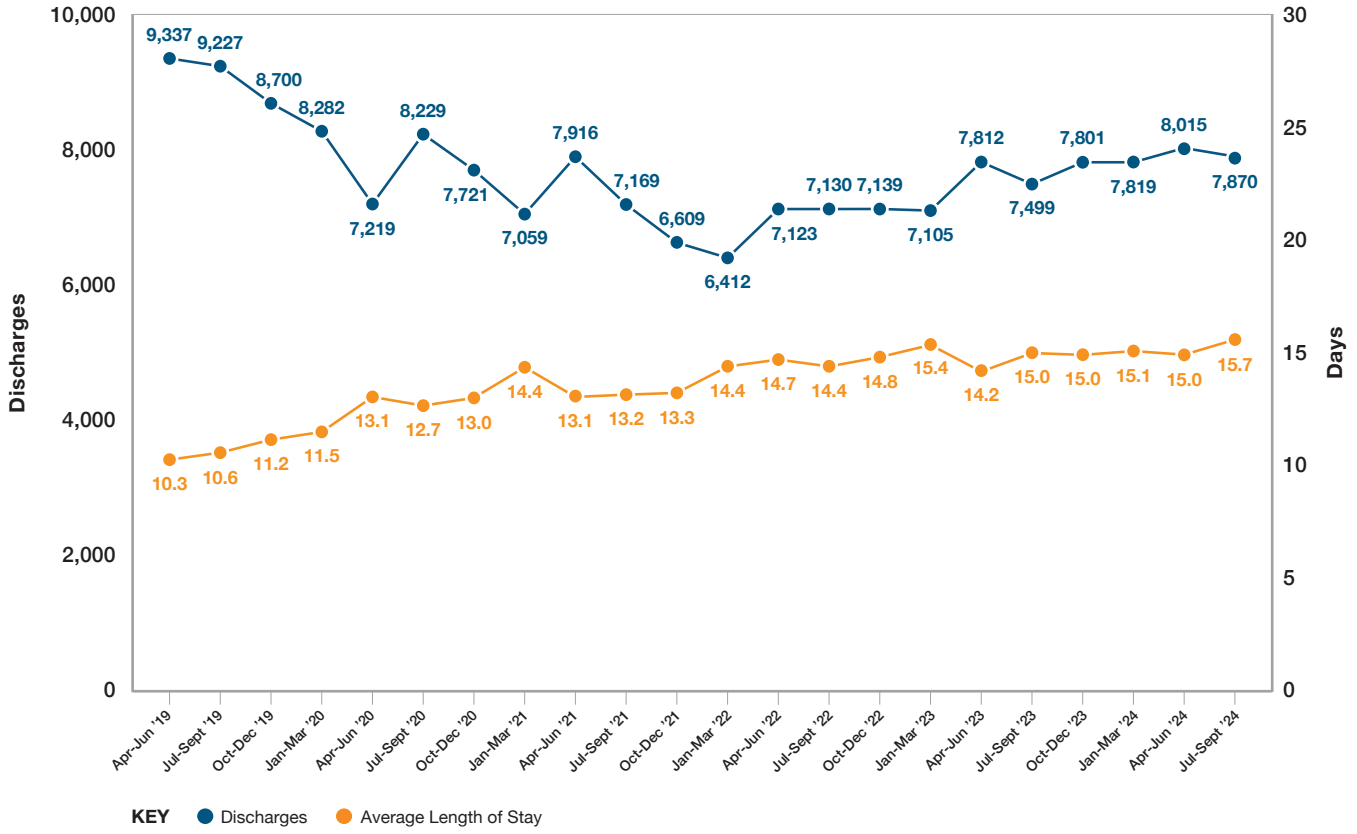
Notes: Data source includes only acute care hospitals; it does not include private BH hospitals, SUD facilities, or DMH-operated facilities. For this analysis, discharges categorized into clinically meaningful independent BH categories based on listed primary diagnosis codes using Clinical Classification Software Refined (CCSR) for ICD-10-CM diagnoses. Only inpatient discharges among patients age 2 and older included in this analysis.

Behavioral Health

Starting in FFY 2018, CHIA has collected data from select non-acute behavioral health hospitals. This data complements that from acute care hospitals by providing an in-depth look at the BH inpatient population served by these institutions.

Discharges from inpatient BH hospitals decreased during peak periods of the COVID-19 pandemic. While discharges have increased since the COVID-19 pandemic, they remain lower than pre-pandemic levels, mirroring trends for BH discharges observed at acute care hospitals. This is likely a result of ongoing capacity changes for behavioral health care (e.g., occupancy and bed availability) as well as discharge bottlenecks. The average length of stay at BH hospitals has increased over time, from 10.3 days in April-June 2019 to 15.7 days in July-September 2024.

Non-Acute Behavioral Health Hospital Inpatient Discharge Trends, April 2019-September 2024



Non-acute behavioral health hospital inpatient discharges remain lower than pre-pandemic levels, but ALOS continues to increase.

Source: Behavioral Health Inpatient Hospital Discharge Database (BHID), April 2019-September 2024.

Notes: Data from 13 non-acute BH hospitals and facilities required to submit data to CHIA quarterly. Certain hospitals exempt from submitting (had too few admissions, considered part of acute care hospital, or considered chronic care or rehabilitation hospital). DMH-operated facilities excluded from this analysis namely (Cape Cod & Islands Community Mental Health Center, Corrigan Mental Health Center, Solomon Carter Fuller Mental Health Center, Taunton State Hospital, and Worcester State Hospital). For more information, see CHIA website.

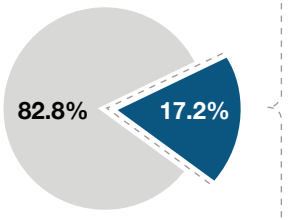
Behavioral Health

More than 1 in 6 insured residents who had a behavioral health care visit in the past 12 months paid for their most recent visit entirely out of pocket. The most common reasons for paying entirely out of pocket were related to insurance coverage: One-third of residents (33.0%) reported that their provider did not accept any health insurance, and one-quarter (27.1%) indicated that their insurance plan was not accepted by their preferred provider.

In 2025, 5.4% of Massachusetts residents age 5 and older reported having an unmet need for behavioral health care in the past 12 months due to the cost of that care. Substantially more residents reported that they had an unmet need for mental health care (5.2%) than an unmet need for SUD care or treatment (1.0%). Barriers to reporting, including social stigma, criminalization of substance use and the underdiagnosis or misdiagnosis of SUDs, may lead to undercounting the true rates of MH and SUD unmet need in Massachusetts.

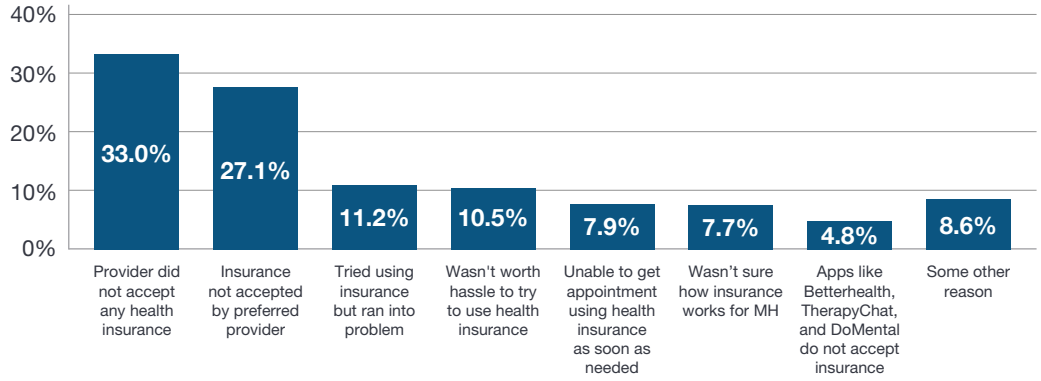
Behavioral Health Access and Affordability Challenges Among Massachusetts Residents, 2025

Out-of-Pocket Spending on Most Recent BH Visit

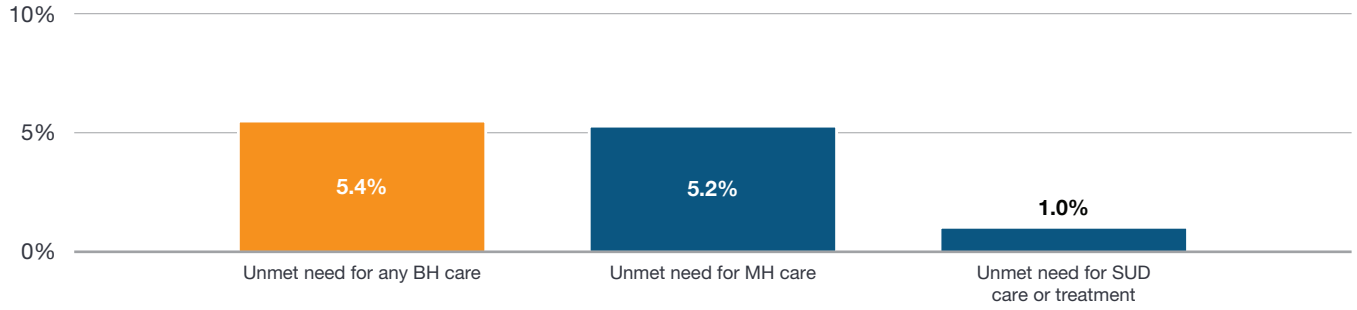


KEY
- Paid for BH entirely OOP
- Did not pay for BH entirely OOP

Reasons for Paying Entirely Out of Pocket for Behavioral Health Care



Unmet Need for Behavioral Health Care Due to Cost Over Past 12 Months



More than 1 in 6 insured residents who had a behavioral health care visit in the past 12 months paid for their most recent visit entirely out of pocket.

Source: 2025 Massachusetts Health Insurance Survey (MHIS).

Notes: Categories listed above not mutually exclusive; residents were asked to select all applicable options. Questions about mental health asked of residents age 5 and older; questions about alcohol and substance use disorder care asked of residents age 12 and older. Estimate for paying entirely out of pocket is among residents with behavioral health care visit; reasons for paying entirely out of pocket limited to residents who paid entirely out of pocket. Unmet need for behavioral health care due to cost includes mental health care and alcohol or substance use disorder care. Exceedingly few residents (n=21) reported substance use visit without also reporting mental health visit. Behavioral health care includes mental health care and/or substance use disorder care among residents age 5 and older.

Behavioral Health Notes

1. General Court of the Commonwealth of Massachusetts, "Session Law Acts of 2022, Chapter 177: An Act Addressing Barriers to Care for Mental Health," accessed January 29, 2024, https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177.
2. Blue Cross Blue Shield of Massachusetts Foundation, *Massachusetts Roadmap for Behavioral Health Reform: Overview and Implementation Update* (Boston, August 2024), https://www.bluecrossmafoundation.org/publication/massachusetts-roadmap-behavioral-health-reform-overview-and-implementation-update.
3. Center for Health Information and Analysis, "Payer Data Reporting: Primary and Behavioral Health Care Expenditures," accessed January 9, 2025, https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures.
4. Massachusetts Health Policy Commission, "2024 Cost Trends Hearing Testimony," accessed January 7, 2026, https://masshpc.gov/meetings/annual-cost-trends-hearing/2024-cth/testimony.
5. MassHealth, *Managed Care Entity Bulletin 108* (Boston, January 2024), https://www.mass.gov/doc/managed-care-entity-bulletin-108-updates-to-minimum-rates-for-mental-health-centers-and-to-provider-billing-rules-for-gj-modifier-0/download.
6. Center for Health Information and Analysis, "Enrollment in Health Insurance," accessed January 14, 2025, https://www.chiamass.gov/enrollment-in-health-insurance.
7. MassHealth, *MassHealth Enrollment Guide* (Boston, January 2025), https://www.mass.gov/doc/masshealth-enrollment-guide-2/download.
8. In 2022, CMS issued its final 2023 physician fee schedule ruling that introduced new BH services and permitted BH services be delivered under general supervision of a physician or non-physician practitioner by licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), expanding access to BH care.

   U.S. Department of Health and Human Services, "Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and COVID-19 Interim," Federal Register Vol. 87, No. 222 (November 2022), https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf.
9. The increases may be due in part to recent policy changes including commercial coverage of annual Behavioral Health Wellness Examinations as of January 2024, https://www.mass.gov/doc/bulletin-2024-02-content-of-behavioral-health-wellness-examinations-according-to-chapter-177-of-the-acts-of-2022-chapter-177-issued-january-16-2024/download.
10. In 2023, MassHealth implemented the Primary Care Sub-Capitation Program for providers participating in MassHealth's ACO programs. Under this model, more payments are shifted from claims-based methods to non-claims, including payments for behavioral health care.
11. The expansion increased enrollment in ConnectorCare plans associated with lower cost-sharing than unsubsidized commercial coverage. As a result, out-of-pocket spending among commercially insured individuals declined in the aggregate.
12. Commonwealth of Massachusetts, "MassHealth Copay Information For Members," accessed January 14, 2025, https://www.mass.gov/info-details/masshealth-copayment-information-for-members.
13. Many payers stated an increase in service utilization for SUD, leading to high facility provider spending.

KEY FINDINGS

Quality of Care

When stratified by patient ethnicity or race, significant differences in 2024 performance on clinical quality measures highlight disparities in all 4 care domains: behavioral health, chronic conditions, pediatrics, and preventive care.

In 2024, more than two-thirds of the 53 reporting hospitals performed well on the nursing workforce metrics—37 of the reporting hospitals achieved the standard for total nursing care hours per patient day, and 35 hospitals achieved the standard for RN hours per patient day.

During 2024 primary care visits, commercial patient-reported experiences were significantly lower among adult Asian and Black patients compared with White patients for 7 of the 9 care composite measures.

Quality of Care

Amid growing concerns about the health of primary care across the Commonwealth,[1] information about health care quality is vital to ensure a high-value health care system and monitor the impact of system changes on patient outcomes. CHIA monitors and reports on health care quality using measures selected from the Massachusetts Aligned Measure Set ("Measure Set")—a set of quality measures for voluntary adoption by private and public payers and providers, specifically for use in global budget-based risk contracts—that aim to reduce administrative burden and focus quality improvement efforts on meaningful, high-priority measures.[2,3] This section covers several measures included in the 2024 Measure Set, including commercial and MassHealth member-reported experiences and select Healthcare Effectiveness Data and Information Set (HEDIS®) clinical quality metrics.

Because the Measure Set is designed for use in global budget-based contracts, which might not include measures specific to hospital care, hospital-based measures have not been considered for inclusion in the Measure Set to date. However, in acknowledgment of the importance of hospital quality measurement and transparency in health care system monitoring, CHIA reports on patient-reported experiences in hospital settings as well as measures of hospital quality and safety standards from the Leapfrog Group. CHIA will provide additional reporting on hospital-wide adult all-payer readmissions later this year using the Massachusetts Hospital Inpatient Discharge Database.

This chapter summarizes the performance of Massachusetts primary care providers and acute care hospitals on select metrics related to quality and safety at a statewide level. These measures cross different domains of quality assessment, presenting results on clinical care, patient-reported experiences, maternity-related care, and hospital adherence to standards for nursing workforce and hand hygiene.

While this statewide lens is important for tracking areas of care to prioritize, it is also critical to stratify quality metrics to identify potential disparities that may be linked to sociodemographic characteristics like race and ethnicity.[4,5] New to this publication, CHIA is reporting 2024 commercial patient experience survey and HEDIS clinical quality results stratified by race and ethnicity. As measure stratification has grown over the past 2 years, the data indicates that for several metrics, statewide performance is not necessarily reflective of performance within racial and ethnic groups, highlighting inequities in the quality of care across the Commonwealth.[6,7,8] HEDIS clinical quality measures stratified by race and ethnicity are a useful resource to support identification of strengths and persistent disparities in primary care delivery in Massachusetts, especially in the areas of preventive screenings and pediatric care.[9] This report includes 17 of the 20 HEDIS measures endorsed by the 2024 Measure Set.[10]

Although the measures in this report do not fully evaluate the quality of health care in Massachusetts, the included data focuses on several important aspects of care that help inform quality improvement efforts. ■

Quality of Care

Significant differences in the 2024 HEDIS scores stratified by race highlight disparities and inequities in measures across all 4 care domains: behavioral health, chronic conditions, pediatrics, and preventive care.

When stratified by race, scores for Black patients were significantly worse than scores for White patients for 9 of the 17 measures. Black patients had the largest disparities for Mental Illness 7-Day ED Follow-Up (12.4 percentage points lower) and Mental Illness 7-Day Hospitalization Follow-Up (14.3 percentage points lower) compared with White patients. Additionally, the score for Glycemic Status Assessment among Black patients with diabetes was nearly double the score among White patients (28.8% vs. 15.1%, respectively; a lower score is better for this measure), indicating worse control of hemoglobin A1C levels among Black patients. Scores for Black patients were also significantly lower than for White patients for measures of pediatric and adolescent well-care visits and for breast and colorectal cancer screenings.

Compared with scores for White patients, those for Asian patients were significantly lower for 4 measures and significantly higher for 3 measures. Mental Illness 7-Day Hospitalization Follow-Up had the largest difference (15.5 percentage points) between the score for Asian patients (51.9%) and White patients (67.4%).

For a detailed review of HEDIS scores stratified by race, refer to CHIA's Equity in Quality of Care report.

Statewide Scores on Select Primary Care Clinical Quality Measures by Race, 2024

		Overall Statewide Score	Race		
Behavioral Health	Mental Illness 7-Day ED Follow-Up	74.8%	64.5%	65.4%^	77.8%
	Mental Illness 7-Day Hospitalization Follow-Up	65.3%	51.9%^	53.2%^	67.4%
	Pharmacotherapy for Opioid Use Disorder	40.0%	38.5%		
	IET: SUD Treatment - Engagement Phase	12.7%	4.9%^	10.2%	13.1%
Chronic Condition Care	Asthma Medication Ratio	81.2%	81.3%	81.4%	87.6%
	Controlling High Blood Pressure	77.2%	75.0%	78.7%	
	Diabetes - Eye Exams	67.9%	68.0%	68.6%	69.6%
	Diabetes - Kidney Health Evaluation	66.8%	64.9%^	68.5%	71.5%^
	Diabetes - Glycemic Status Assessment†	19.0%	15.1%	28.8%^	
Pediatric/ Adolescent Care	Well-Child Visits - First 15 Months	95.0%	91.7%^	95.5%	95.6%
	Well-Care Visits - 3-11 Years	92.1%	88.8%^	92.4%	92.9%
	Well-Care Visits - 12-17 Years	89.2%	84.1%^	89.6%	90.4%
	Adolescent Immunizations - Combo 2	53.6%	53.5%	54.4%	65.0%^
Screening/ Preventative Care	Postpartum Care	87.3%	87.1%	87.6%	87.9%
	Breast Cancer Screening	85.7%	83.5%^	85.6%	86.5%
	Timeliness of Prenatal Care	78.5%	76.9%	77.6%	79.7%
	Colorectal Cancer Screening	73.3%	70.2%^	70.6%^	74.7%

KEY Asian Black White

^ Statistically significant difference from reference group.

† For most measures, a higher score is better; however, a lower score is better for Diabetes-Glycemic Status Assessment.

When stratified by race, significant differences in the 2024 HEDIS scores highlight disparities in all 4 included care domains: behavioral health, chronic conditions, pediatrics, and preventive care.

Source: Massachusetts Health Quality Partners (MHQP).

Notes: Scores out of 100. Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS), developed by and registered trademark of National Committee for Quality Assurance (NCQA). Population sampled from commercially insured enrollees in HMO and POS products in participating health plans (MGBHP, BCBSMA, Point32Health [HPHC/THP], and HNE), excluding plans sold on Health Connector. Data for populations with N<30 were suppressed. Statistically significant ("significant") differences are relative to reference group (White for race) at 5% level. Age range for Colorectal Cancer Screening changed in 2022, so scores for this measure may reflect some adaptation to new specification. Measurement periods vary somewhat by measure, but in general "2024 score" refers to performance during calendar year 2024. See databook for specific measure reporting periods and technical appendix for descriptions of included measures.

Quality of Care

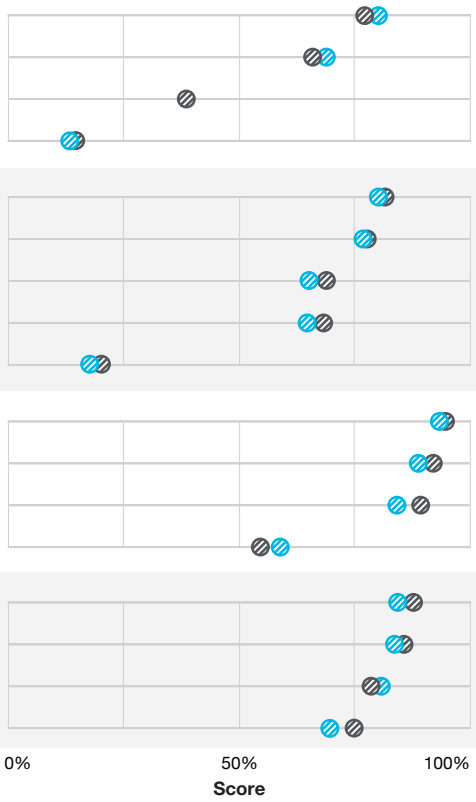
Similar to the race-stratified scores, significant differences in 2024 HEDIS scores stratified by ethnicity highlighted disparities and inequities across all 4 care domains: behavioral health, chronic conditions, pediatrics, and preventive care.

When stratified by ethnicity, scores for Hispanic patients were significantly lower for 7 of the 17 included measures than for non-Hispanic patients. The significant differences were found in measures within chronic condition care, pediatric/adolescent care and screening/preventive care domains. Well-Care Visits – 12-17 Years had the largest statistically significant difference (84.9% for Hispanic patients, 90.0% for non-Hispanic patients). By contrast, Hispanic patients had higher scores for Adolescent Immunizations than non-Hispanic patients.

For a detailed review of HEDIS scores stratified by ethnicity, refer to CHIA's Equity in Quality of Care report.

Statewide Scores on Select Primary Care Clinical Quality Measures by Ethnicity, 2024

		Overall Statewide Score	Ethnicity	
Behavioral Health	Mental Illness 7-Day ED Follow-Up	**74.8%**	75.2%	79.6%
	Mental Illness 7-Day Hospitalization Follow-Up	**65.3%**	65.3%	68.8%
	Pharmacotherapy for Opioid Use Disorder	**40.0%**	37.4%	
	IET: SUD Treatment - Engagement Phase	**12.7%**	11.7%	12.8%
Chronic Condition Care	Asthma Medication Ratio	**81.2%**	80.9%	81.5%
	Controlling High Blood Pressure	**77.2%**	77.1%	77.8%
	Diabetes - Eye Exams	**67.9%**	64.5%^	69.0%
	Diabetes - Kidney Health Evaluation	**66.8%**	64.2%^	68.0%
	Diabetes - Glycemic Status Assessment†	**19.0%**	16.8%	18.6%
Pediatric/ Adolescent Care	Well-Child Visits - First 15 Months	**95.0%**	94.2%	95.4%
	Well-Care Visits - 3-11 Years	**92.1%**	89.3%^	92.6%
	Well-Care Visits - 12-17 Years	**89.2%**	84.9%^	90.0%
	Adolescent Immunizations - Combo 2	**53.6%**	53.9%	58.5%^
Screening/ Preventative Care	Postpartum Care	**87.3%**	85.1%^	87.8%
	Breast Cancer Screening	**85.7%**	84.4%^	86.3%
	Timeliness of Prenatal Care	**78.5%**	79.0%	81.3%
	Colorectal Cancer Screening	**73.3%**	69.7%^	74.6%



KEY Non-Hispanic Hispanic

^ Statistically significant difference from reference group.

† For most measures, a higher score is better; however, a lower score is better for Diabetes-Glycemic Status Assessment.

When stratified by ethnicity, Hispanic patients reported significantly lower scores for 7 of the 17 HEDIS measures in 2024.

Source: Massachusetts Health Quality Partners (MHQP).

Notes: Scores out of 100. Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS), developed by and registered trademark of National Committee for Quality Assurance (NCQA). Population sampled from commercially insured enrollees in HMO and POS products in participating health plans (MGBHP, BCBSMA, Point32Health [HPHC/THP], and HNE), excluding plans sold on Health Connector. Data for populations with N<30 were suppressed. Statistically significant ("significant") differences are relative to reference group (non-Hispanic for ethnicity) at 5% level. Age range for Colorectal Cancer Screening changed in 2022, so scores for this measure may reflect some adaptation to new specification. Measurement periods vary somewhat by measure, but in general "2024 score" refers to performance during calendar year 2024. See databook for specific measure reporting periods and technical appendix for descriptions of included measures.

Quality of Care

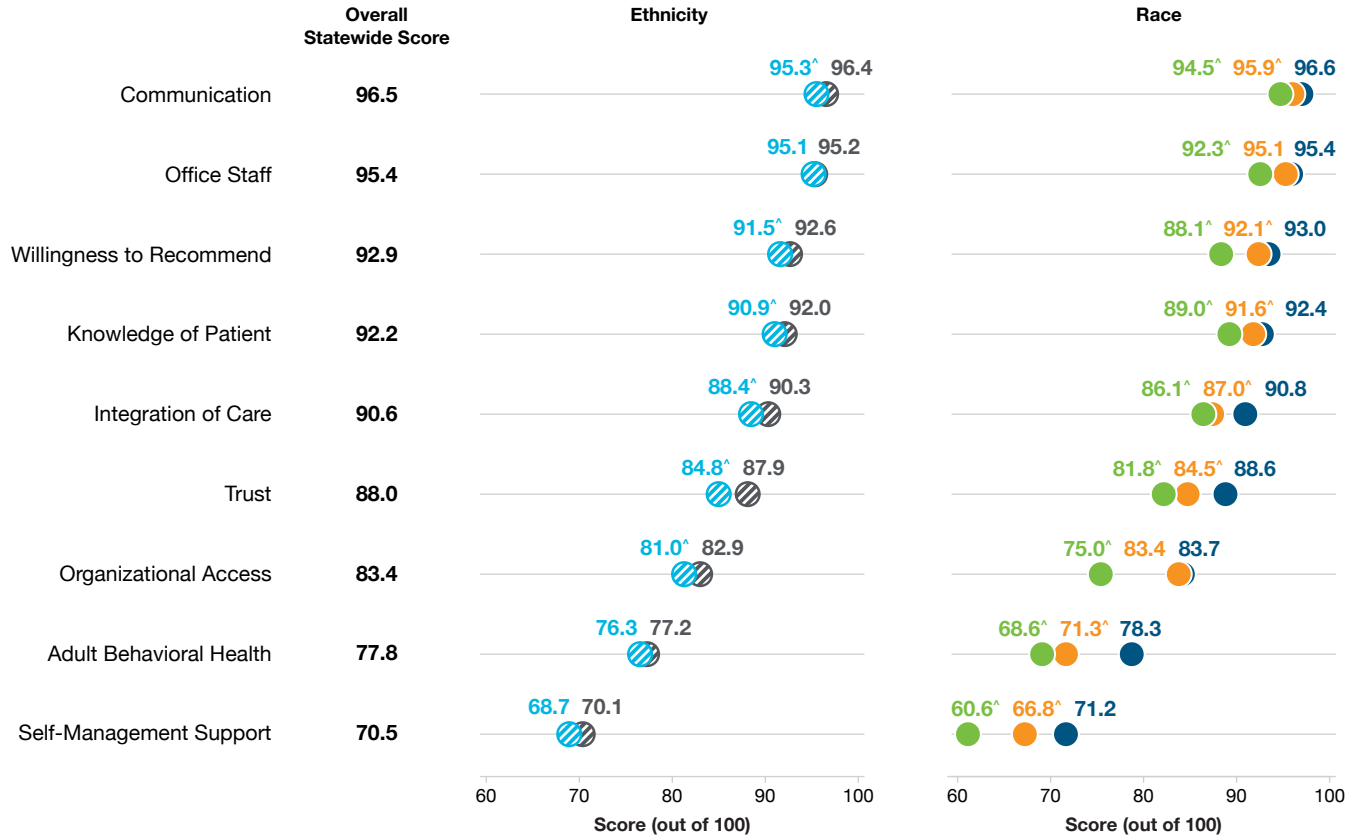
Massachusetts Health Quality Partners (MHQP) issues an annual survey to adult commercial health plan members who had a primary care visit during the measurement period to ask about their experiences.[11] Scores for the composite measures ("composites") reflect members' responses aggregated across multiple related survey questions.

New to the Annual Report, CHIA is reporting results of patient experiences with primary care stratified by race and ethnicity. Examination of stratified results is essential for identifying inequities that statewide results may mask.

When stratified by ethnicity, non-Hispanic adults rated their experiences significantly higher for 6 of the 9 patient care composites compared with Hispanic adults in 2024. The largest difference was for Trust, in which non-Hispanic patients' rating (87.9) was 3.1 points higher than Hispanic patients' rating (84.8). Communication had the highest score among both non-Hispanic and Hispanic patients (96.4 and 95.3 out of 100, respectively). Self-Management Support had the lowest score among both ethnicities (70.1 and 68.7 out of 100, respectively).

Compared with White patients, Asian patients rated their experiences significantly lower for all 9 composites while Black patients rated their experiences significantly lower for 7 of 9 composites. However, there were patterns across racial groups in the ratings for each of the composites. Communication had the highest score among Asian, Black, and White patients (94.5, 95.9, and 96.6 out of 100, respectively). Scores for Self-Management Support were the lowest among Asian, Black, and White patients (60.6, 66.8, and 71.2 out of 100, respectively).

Commercial Member Primary Care Patient-Reported Experiences for Adults by Race and Ethnicity, 2024



KEY Non-Hispanic Hispanic Asian Black White

^ Statistically significant difference from reference group.

When stratified by race, patient-reported experiences with primary care providers were significantly lower for Asian patients than White patients for all 9 survey composites. Scores for Black patients were significantly lower than White patients for 7 of the 9 composites.

Source: Massachusetts Health Quality Partners (MHQP) Patient Experience Survey (PES).

Notes: Data includes adult patients age 18+. Survey conducted on sample of commercial health plan members. Statistically significant ("significant") differences are relative to reference group (non-Hispanic for ethnicity; White for race) at 5% level. See technical appendix for specific survey questions.

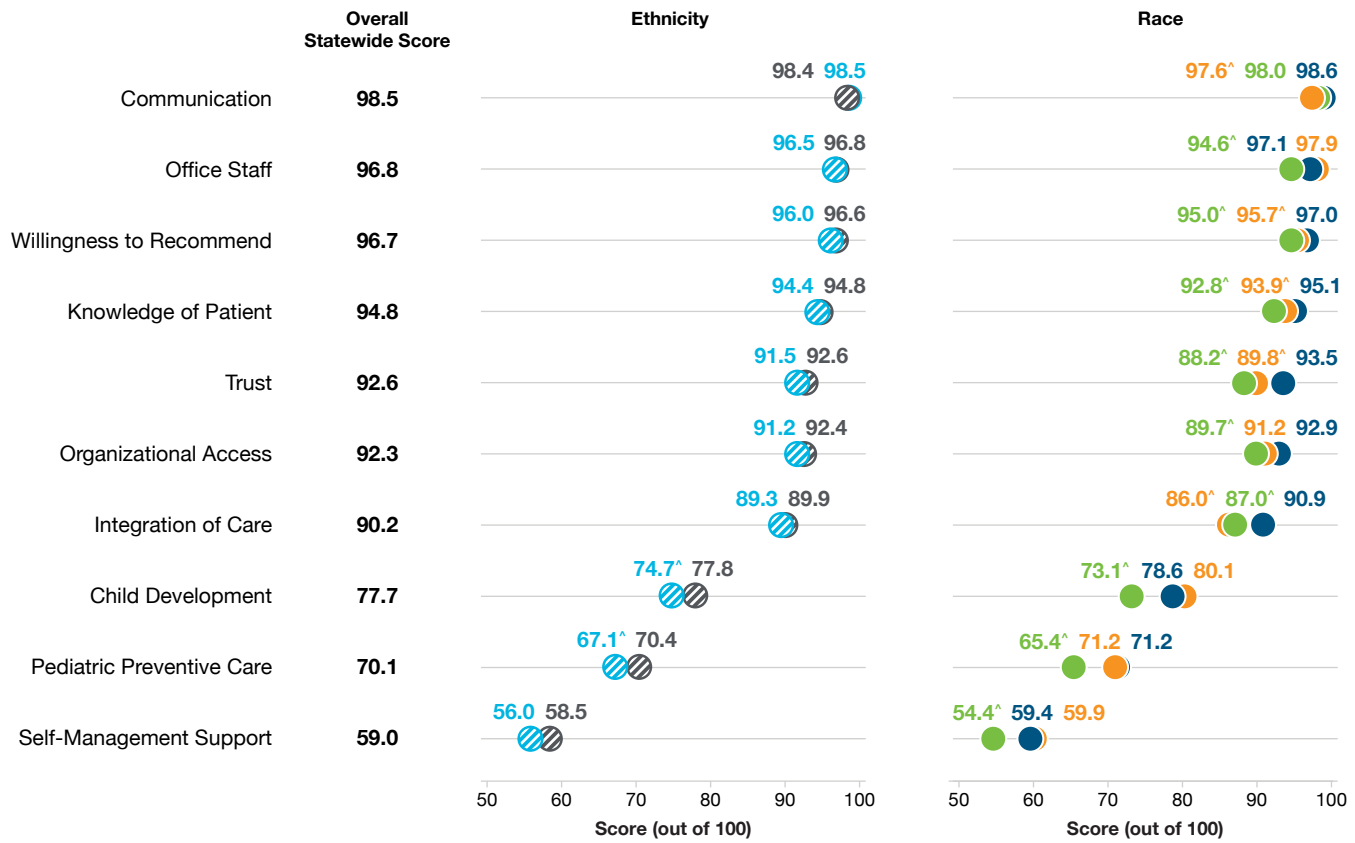
Quality of Care

In addition to the adult patient experience survey, MHQP also issues a pediatric patient experience survey, which is similar to the adult survey and is completed by caregivers who took a child to see a primary care provider. Communication was the highest-scoring composite for pediatric visits for most ethnic and racial groups, while Self-Management Support had the lowest scores across all ethnic and racial groups in 2024.

Statistically significant differences in ratings by ethnicity were found for 2 of the 10 composites: Child Development and Pediatric Preventive Care. Caregivers of Hispanic pediatric patients rated their experiences with Child Development at 74.7, 3.1 points lower than caregivers of non-Hispanic pediatric patients. There was an even larger difference in ratings for the Pediatric Preventive Care composite, with caregivers of Hispanic pediatric patients rating their experiences at 67.1 and their non-Hispanic counterparts rating their experiences at 70.4, a 3.3-point difference.

Caregivers of Asian pediatric patients reported the lowest scores of any racial group on all composites except Communication (98.0 out of 100) and Integration of Care (87.0 out of 100). Asian patients also had significantly lower scores than White patients for 9 of the 10 composites. Caregiver ratings for Black patients were significantly lower than for White patients for 5 of the composites. The largest difference was for the Integration of Care composite with caregivers of Black patients rating their experiences at 86.0, 4.9 points lower than ratings from caregivers of White patients.

Commercial Member Primary Care Patient-Reported Experiences for Pediatrics by Race and Ethnicity, 2024



KEY Non-Hispanic Hispanic Asian Black White

^ Statistically significant difference from reference group.

In 2024, caregivers for Asian pediatric patients reported significantly lower ratings for their primary care visits compared with caregivers for White pediatric patients in 9 of the 10 pediatric patient experience composites.

Source: Massachusetts Health Quality Partners (MHQP) Patient Experience Survey (PES).

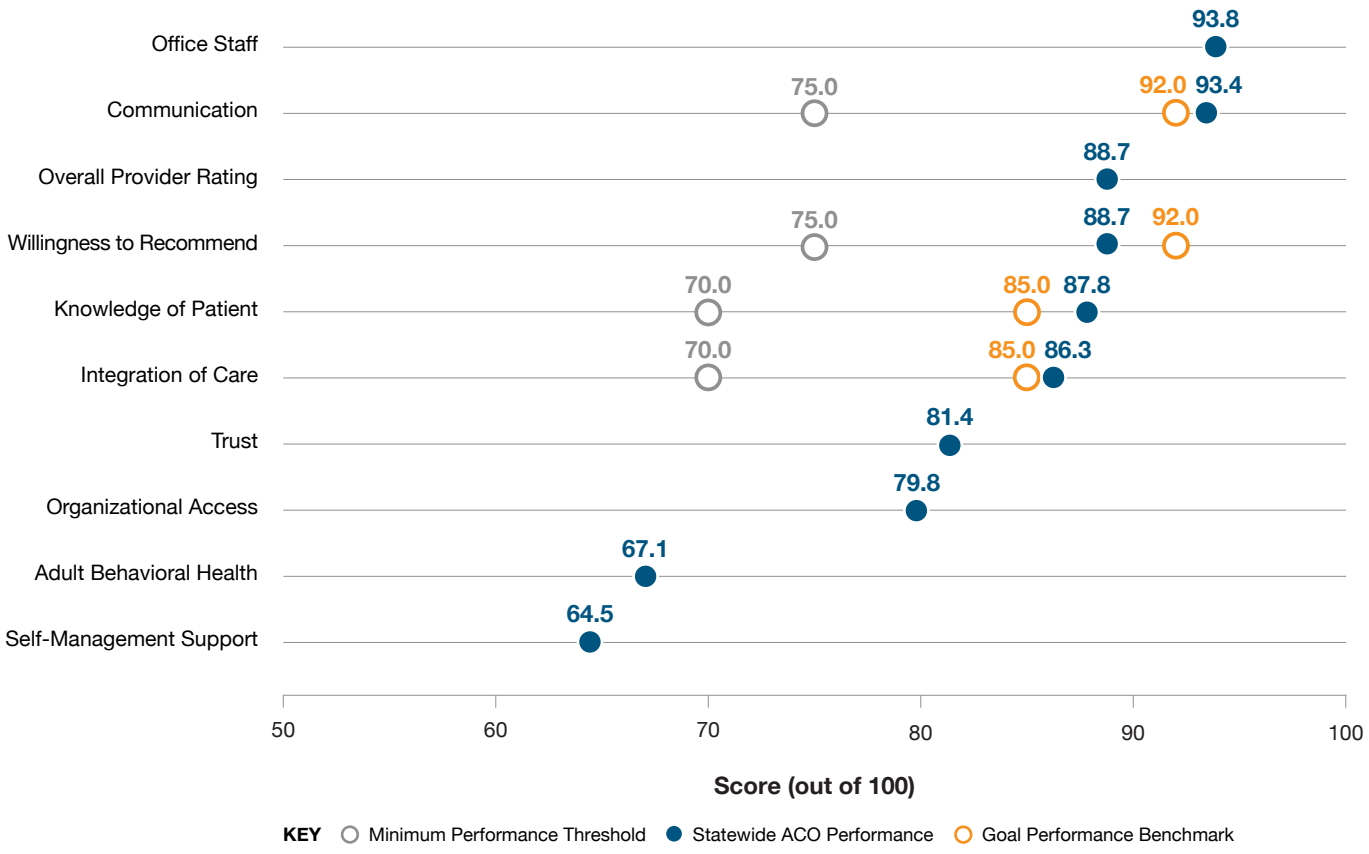
Notes: Data includes pediatric patients ages 0-17; parent or caregiver was surveyed on patient's behalf. Survey conducted on sample of commercial health plan members. Statistically significant ("significant") differences are relative to reference group (non-Hispanic for ethnicity; White for race) at 5% level. See technical appendix for specific survey questions.

Quality of Care

MassHealth issued a primary care Member Experience Survey to a sample of adult members with care managed by an Accountable Care Organization (ACO) who had a primary care visit in 2024. For 4 of the care composites in the survey, MassHealth establishes a minimum performance threshold and a goal performance benchmark, which are used in some components of the pay-for-performance ACO quality incentive model. The threshold performance benchmark is a minimum level of expected performance an ACO must achieve to be eligible for quality incentives, and the goal benchmark rewards high performance as identified by MassHealth. MassHealth ACO primary care providers surpassed the threshold performance minimum for all applicable measures and surpassed the goal benchmarks for 3 of the 4 applicable measures (Communication, Knowledge of Patient, and Integration of Care). Scores for these 3 measures surpassed their respective goals in 2023 as well, indicating sustained improvement for ACO performance.

Overall, adult patients expressed positive experiences with their primary care providers in 2024, with the highest score for interactions with Office Staff (93.8 out of 100) and the lowest scores for Adult Behavioral Health (67.1 out of 100) and Self-Management Support (64.5 out of 100). MassHealth ACO scores are similar to, but slightly lower than, comparable surveys of members covered under commercial health plans in 2024 (see pages 118-119 for commercial PES results).

MassHealth ACO Member Primary Care Patient-Reported Experiences for Adults, 2024



Patient-reported experiences scored above the goal set by MassHealth for 3 of the 4 applicable measures: Communication (93.4 out of 100), Knowledge of Patient (87.8), and Integration of Care (86.3).

Source: Massachusetts Health Quality Partners (MHQP) MassHealth Member Experience Survey.

Notes: Data includes adult patients age 18+. Survey conducted on sample of MassHealth ACO plan members and fielded May-August 2025. According to CHIA's September 2025 Enrollment Trends Report, MassHealth ACO (i.e., ACPP and PCACO plans) members represented 55.6% of total MassHealth membership in December 2024. See technical appendix for specific survey questions.

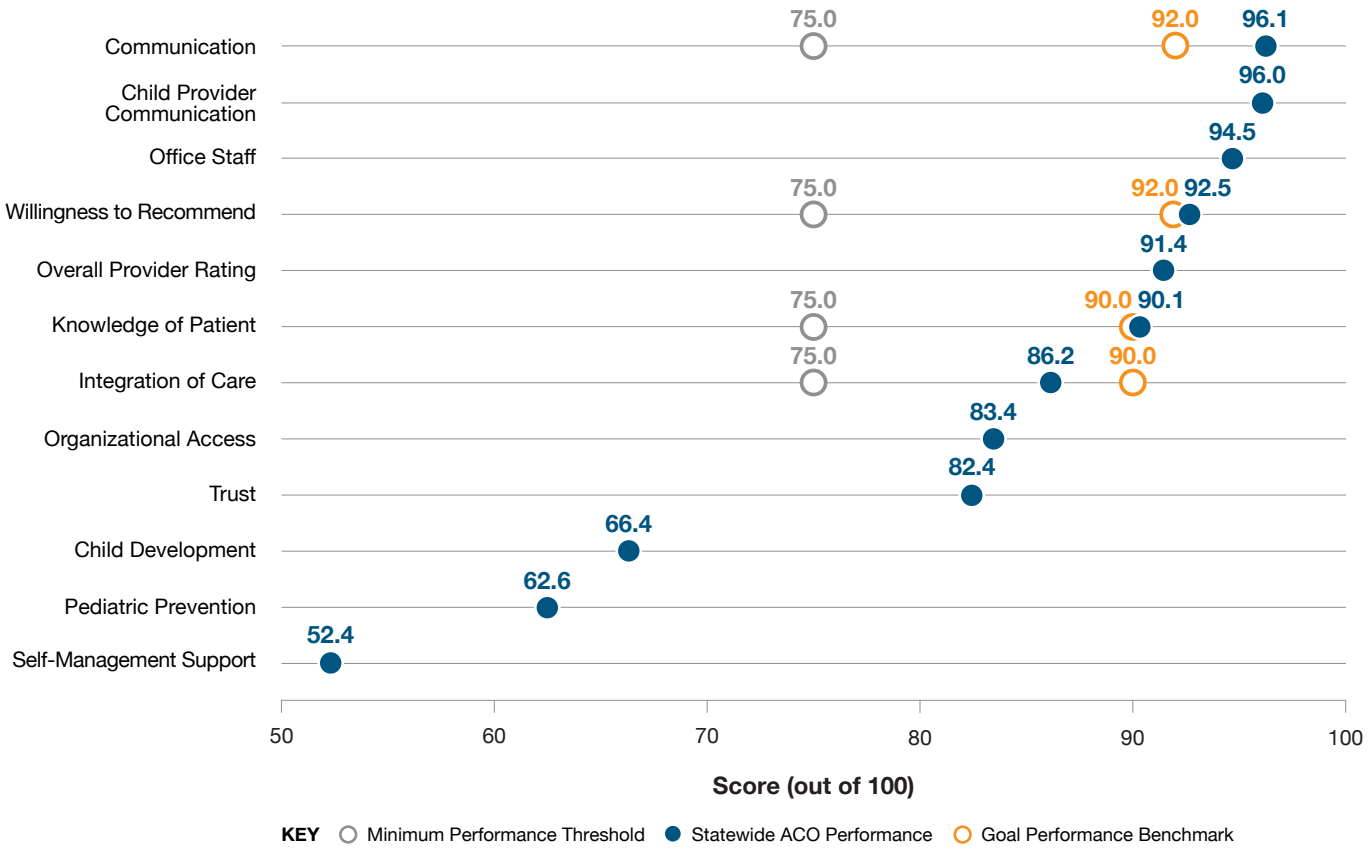
Quality of Care

Similar to adult patient-reported experiences with MassHealth ACO primary care providers, caregivers of pediatric patients reported highest experience ratings for the Communication and Child Provider Communication measures of care (96.1 and 96.0 out of 100 points, respectively).

Among the 4 applicable measures, all surpassed MassHealth's minimum performance threshold with scores more than 10 points above the threshold rate. Additionally, 3 of the 4 achieved the goal score set by MassHealth: Communication (96.1 out of 100), Willingness to Recommend (92.5), and Knowledge of Patient (90.1). MassHealth set the same goals for these 3 measures in 2022 and 2023; no measures surpassed the goal in 2022, but 2 measures surpassed the goal the following year, indicating notable improvement for ACO performance over recent years.

As observed in the adult MassHealth ACO member population, caregivers for patients receiving pediatric care reported the lowest satisfaction on Self-Management Support (52.4 out of 100). Pediatric Prevention and Child Development also scored below 70 at 62.6 and 66.4, respectively, identifying opportunities for improvement in pediatric patient experiences.

MassHealth ACO Member Primary Care Patient-Reported Experiences for Pediatrics, 2024



In 2024, pediatric patient-experience scores surpassed MassHealth goals for 3 of the 4 applicable measures: Communication (96.1 out of 100), Willingness to Recommend (92.5), and Knowledge of Patient (90.1).

Source: Massachusetts Health Quality Partners (MHQP) MassHealth Member Experience Survey.

Notes: Data includes pediatric patients ages 0-17; parent or caregiver was surveyed on patient's behalf. Survey conducted on sample of MassHealth ACO (i.e., ACPP and PCACO plans) members and fielded May-August 2025. See technical appendix for specific survey questions.

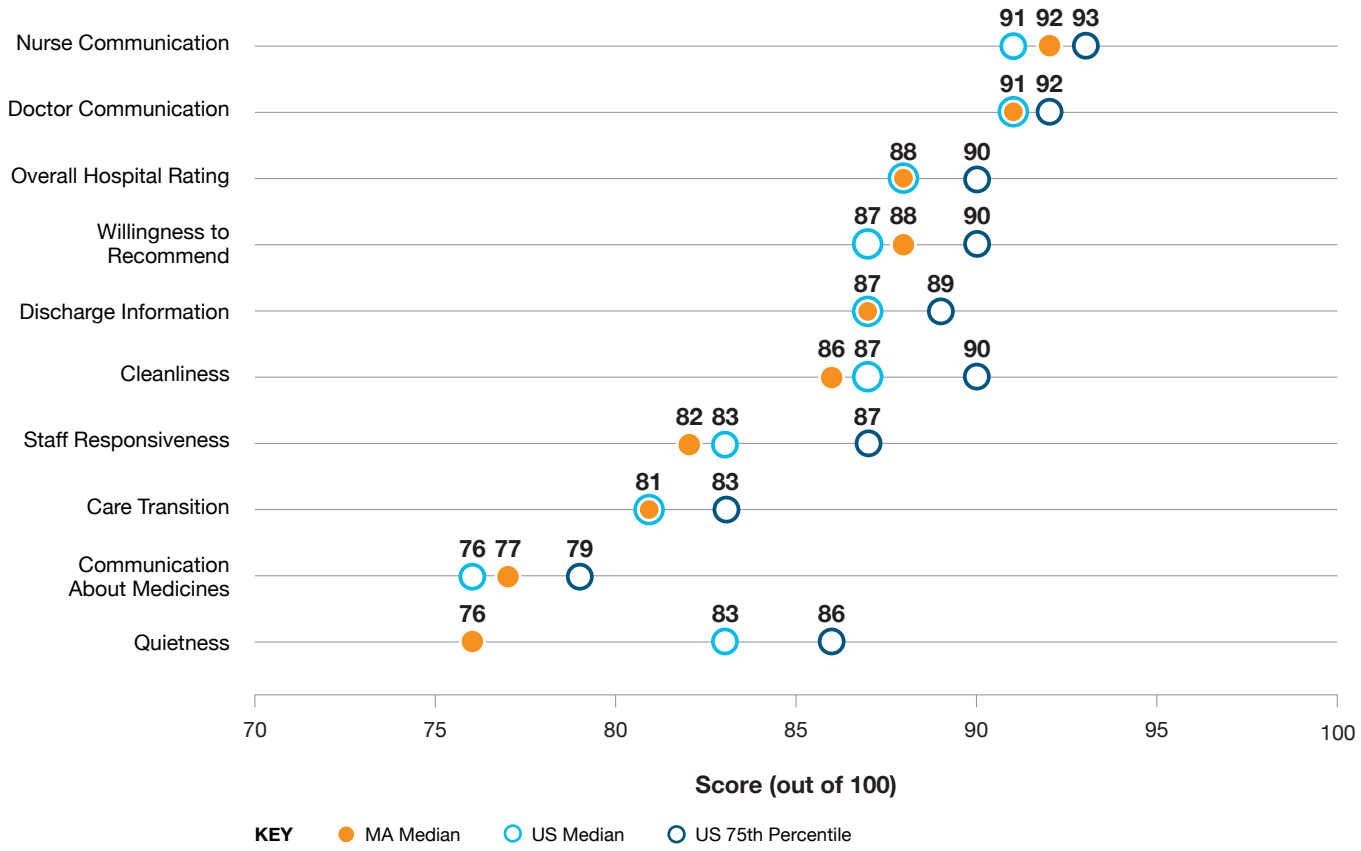
Quality of Care

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asks discharged patients questions about their experience of care at a recent acute hospital stay with questions related to 10 care composite measures. Measures of patient satisfaction are an important reflection of whether provided care met patients' needs in addition to identifying which care experiences matter most to consumers in order to direct quality improvement efforts.[12]

On 4 of the 10 care composites collected for 2024, median patient experience ratings of Massachusetts hospitals were similar to median patient experience ratings at hospitals nationally. Massachusetts median scores were below national medians for 3 composites and exceeded the national median for the remaining 3 composites.

In Massachusetts, the median score for Overall Hospital Rating was 88 out of 100, equal to the national median score. The median score in Massachusetts for Willingness to Recommend was also 88, scoring slightly above the national median score for the same composite. Massachusetts patients rated Doctor Communication and Nurse Communication above other composites of care (median scores of 91 and 92 out of 100, respectively). Statewide median scores were lowest for Quietness (of hospital environment) and Communication About Medicines (76 and 77 out of 100, respectively). In addition, Quietness had the largest gap in ratings between the statewide median score of 76 and the national median and 75th percentile scores (7 and 10 points, respectively). See the technical appendix for detailed descriptions of each patient care composite.

Patient-Reported Experience During Acute Hospital Admission, 2024



The median patient-reported experience ratings of Massachusetts hospitals were similar to median ratings nationally on most measures; like prior years, communication with nurses and doctors continued to have the highest satisfaction ratings in 2024.

Source: Centers for Medicare and Medicaid Services (CMS) Care Compare.

Notes: Data includes all payers and adult patients age 18+.

Quality of Care

In Massachusetts, childbirth is the most common reason for hospital admission. To reduce potentially harmful and unnecessary maternity procedures, the Leapfrog Group—a national nonprofit watchdog organization—sets standards and collects voluntary data from hospitals to measure performance. The Leapfrog standard recommends that no more than 23.6% of women with low-risk pregnancies deliver via cesarean section (C-section) each year. Additionally, Leapfrog identifies 5% or below as the target for the share of childbirths in which episiotomies are performed.

The reporting hospitals performed well on the episiotomy measure—all 33 achieved this standard. However, only 5 of the hospitals achieved the standard for C-sections, indicating potential overuse of the procedure among low-risk pregnancies.

Rates of Maternity-Related Procedures Relative to Leapfrog Standards by Hospital, 2024

Leapfrog Standard	C-Section ≤ 23.6%	Episiotomy ≤ 5.0%
Achieved Two Standards (5 Hospitals)		
Beth Israel Deaconess Hospital Plymouth	18.0%	1.9%
Beverly Hospital	22.7%	2.3%
Lowell General Hospital - Main Campus	20.2%	1.7%
Mount Auburn Hospital	22.3%	1.9%
Sturdy Memorial Hospital	23.0%	3.9%

KEY

- Achieved the Standard
- Considerable Achievement
- Some Achievement
- Limited Achievement

All 33 reporting acute care hospitals in Massachusetts achieved the episiotomy standard for reducing unnecessary maternity care, but only 5 achieved the standard for C-section deliveries among low-risk pregnancies.

Leapfrog Standard	C-Section ≤ 23.6%	Episiotomy ≤ 5.0%
Achieved One Standard (28 Hospitals)		
Anna Jaques Hospital	31.1%	1.4%
Baystate Franklin Medical Center	26.2%	2.2%
Baystate Medical Center	32.0%	1.0%
Berkshire Medical Center	30.9%	1.4%
Beth Israel Deaconess Medical Center	30.4%	1.3%
Boston Medical Center	39.2%	1.0%
Boston Medical Center - Brighton	32.5%	1.7%
Boston Medical Center South	38.7%	1.4%
Brigham and Women's Hospital	28.8%	2.9%
Cape Cod Hospital	26.9%	0.5%
CHA Cambridge Hospital	27.2%	1.0%
Charlton Memorial Hospital	29.0%	2.2%
Cooley Dickinson Hospital	26.2%	2.9%
Emerson Hospital	26.2%	2.2%
Fairview Hospital	26.1%	2.4%
Holy Family Hospital - Methuen	34.8%	4.4%
Lawrence General Hospital	27.6%	2.0%
Massachusetts General Hospital	29.5%	1.6%
Melrose-Wakefield Hospital	33.7%	3.8%
Mercy Medical Center	28.3%	1.7%
Newton-Wellesley Hospital	26.3%	3.1%
Salem Hospital	26.4%	3.1%
South Shore Hospital	31.8%	3.2%
St. Luke's Hospital	26.5%	1.7%
Tufts Medical Center	28.8%	1.0%
UMass Memorial Medical Center - Memorial Campus	24.9%	2.1%
UMass Memorial Health Milford Regional Medical Center	28.7%	4.7%
Winchester Hospital	24.5%	2.0%

Source: Leapfrog Group Hospital Survey.

Notes: Data based on voluntary hospital reporting; does not include all Massachusetts hospitals. Data includes all payers and all ages. "Considerable Achievement," "Some Achievement," and "Limited Achievement" refer to how close rate was to recommendation, with "Considerable Achievement" indicating rate close to recommendation and "Limited Achievement" indicating greater deviation from recommendation. See technical appendix for information on Leapfrog's standards and scoring methodologies.

Quality of Care

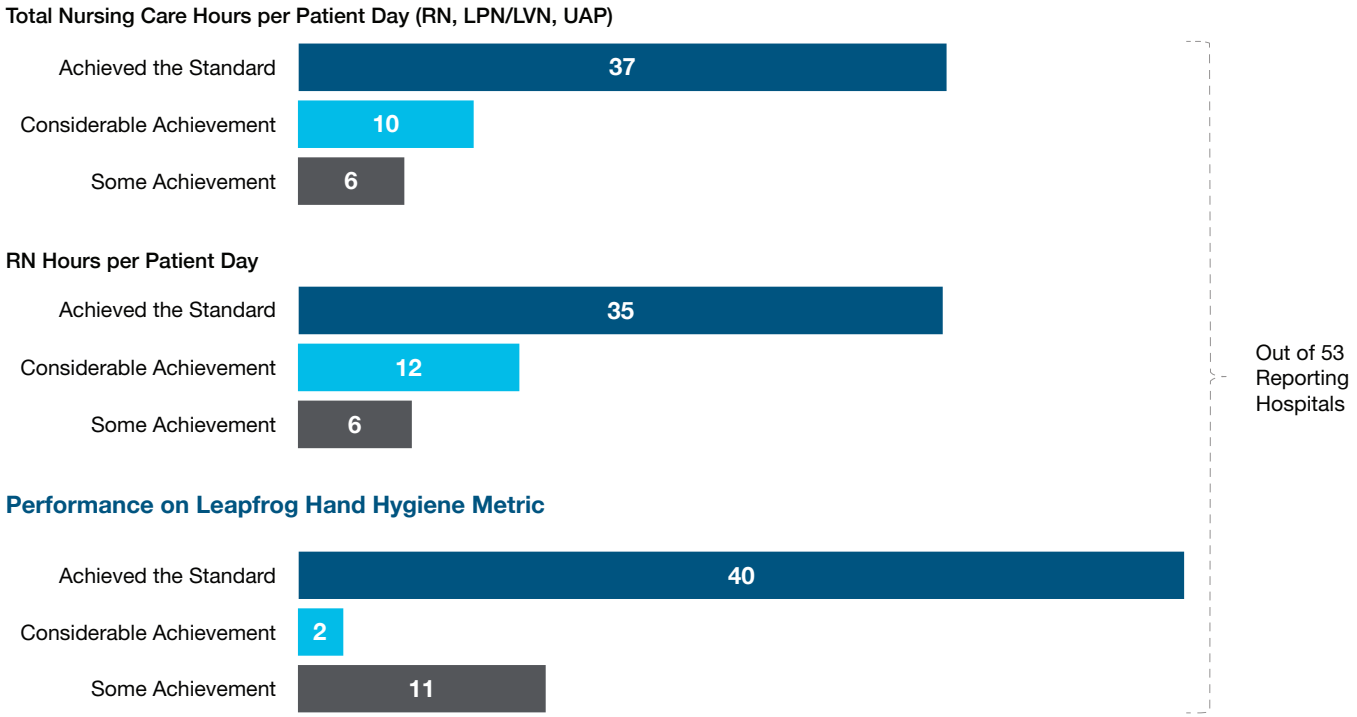
There are many aspects of a hospital's operations that contribute to overall quality and safety of care. Studies have examined the relationship between nurse staffing and patient outcomes, and evidence continues to grow supporting an association between increased nursing hours per patient day and lower odds of patient mortality, lower rates of patient falls and pressure ulcers, shorter hospital stays, and higher patient satisfaction.[13,14,15]

This report includes a subset of Leapfrog's Hospital Survey Nursing Workforce measures, focusing on Total Nursing Care Hours per Patient Day and Registered Nurse (RN) Hours per Patient Day. The Hand Hygiene score is based on performance on 5 domains of hand hygiene: monitoring, feedback, training and education, infrastructure, and culture.

In 2024, 37 of the 53 reporting hospitals achieved the standard for Total Nursing Care Hours per Patient Day, and 35 achieved the standard for RN Hours per Patient Day. Reporting hospitals performed well on the Hand Hygiene metric—40 out of 53 achieved Leapfrog's standard. Eleven hospitals reported "some achievement" in all hand hygiene domains, indicating opportunities for improvement. Hospital-specific results are available in the databook.

Hospital Adherence to the Leapfrog Standards for Nursing Workforce and Hand Hygiene, 2024

Performance on Leapfrog Nursing Workforce Metrics



Performance on Leapfrog Hand Hygiene Metric

In 2024, more than two-thirds of the 53 reporting hospitals performed well on Nursing Workforce quality metrics; 37 achieved the standard for Total Nursing Care Hours per Patient Day and 35 for RN Hours per Patient Day.

Source: Leapfrog Group Hospital Survey.

Notes: Data based on voluntary hospital reporting; does not include all Massachusetts hospitals. Data includes all payers and ages. Total Nursing Care Hours per Patient Day includes all nursing staff with direct patient care responsibilities, including registered nurses (RN), licensed vocational/practical nurses (LVN/LPN), and unlicensed assistive personnel (UAP). See technical appendix for information on Leapfrog's standards and scoring methodologies.

Quality of Care Notes

1. Massachusetts Health Policy Commission, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action* (Boston, January 2025), https://masshpc.gov/sites/default/files/HPC%20Chartpack_A%20Dire%20Diagnosis%20-%20The%20Declining%20Health%20of%20Primary%20Care%20in%20MA_0.pdf.
2. A complete list of measures included in each year's Aligned Measure Set is available from https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce-archived-materials.
3. The Commonwealth currently relies on voluntary adoption of this Aligned Measure Set by providers and commercial payers; however, legislation signed in 2025 requires CHIA to establish a measure set for mandatory adoption (Chapter 343: An Act Enhancing the Market Review Process), which will further advance alignment in APMs.
4. Massachusetts Department of Public Health, *Strategic Plan to Advance Racial Equity: 2024-2028* (Boston, March 2024), https://www.mass.gov/doc/2024-strategic-plan-to-advance-racial-equity/download.
5. Massachusetts Department of Public Health, *2017 Massachusetts State Health Assessment* (Boston, October 2017), https://www.mass.gov/files/documents/2017/11/03/2017%20MA%20SHA%20final%20compressed.pdf.
6. NCQA, "Health Equity Resource Center," accessed January 23, 2026, https://www.ncqa.org/health-equity/.
7. Blue Cross Blue Shield of Massachusetts, "Health Equity Report," accessed January 23, 2026, https://www.bluecrossma.org/myblue/equity-in-health-care/health-equity-report.
8. Massachusetts Health Quality Partners, "MHQP's Statewide Survey Shows Patients Continue to Experience Racial and Ethnic Disparities in Massachusetts," accessed January 23, 2026, https://www.mhqp.org/2024/02/25/statewide-survey-shows-patients-continue-to-experience-racial-and-ethnic-disparities-in-massachusetts/.
9. HEDIS® is a tool developed by NCQA and is widely used by payers and providers to assess health care quality and drive improvement.
10. Some measures include multiple components that are scored separately. CHIA reports each component when possible, so the total number of measures included in the report and dataset is greater than the 20 HEDIS measures noted. For details about which measures include multiple components, see the technical appendix.
11. The Aligned Measure Set encourages payers and providers to measure patients' experiences with primary care providers by using this survey. More information about the Measure Set is available throughout this chapter and the Total Medical Expenses and Alternative Payment Methods chapter.
12. Elysia Larson, Jigyasa Sharma, Meghan A. Bohren, and Özge Tunçalp, "When the patient is the expert: measuring patient experience and satisfaction with care," *Bulletin of the World Health Organization* 97, no. 8 (2019): 563-569, https://pmc.ncbi.nlm.nih.gov/articles/PMC6653815/.
13. Leapfrog Group, *Factsheet: Nursing Workforce* (Washington, D.C., April 2025), https://ratings.leapfroggroup.org/sites/default/files/2025-03/2025%20Nursing%20Workforce%20Factsheet.pdf.
14. Jeannette A Rogowski, Douglas Staiger, Thelma Patrick, Jeffrey Horbar, Michael Kenny, and Eileen T. Lake, "Nurse staffing and NICU infection rates," *JAMA Pediatrics* 167, no. 5 (2013): 444-450, https://jamanetwork.com/journals/jamapediatrics/fullarticle/1669323.
15. Taina Pitkääho, Pirjo Partanen, Merja H. Miettinen, and Katri Vehviläinen-Julkunen, "The relationship between nurse staffing and length of stay in acute-care: a one-year time-series data," *Journal of Nursing Management* 24, no. 5 (2016): 571-579, https://pubmed.ncbi.nlm.nih.gov/26833964/.

Index of Acronyms

ACA	Affordable Care Act
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan
ALOS	Average Length of Stay
APM	Alternative Payment Method
APTC	Advance Premium Tax Credit
ARPA	American Rescue Plan Act
ASO	Administrative Services Only
BCBSMA	Blue Cross Blue Shield of Massachusetts
BH	Behavioral Health
BHID	Behavioral Health Inpatient Hospital Discharge Database
BHQI	Behavioral Health Quality Incentive
BHUC	Behavioral Health Urgent Care
BIDCO	Beth Israel Deaconess Care Organization
BILH	Beth Israel Lahey Health
BMC	Boston Medical Center
BMCHP	Boston Medical Center HealthNet Plan
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CBHC	Community Behavioral Health Center
CCSR	Clinical Classification Software Refined
CHC	Community Health Center
CHIA	Center for Health Information and Analysis
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CSR	Cost-Sharing Reduction
CY	Calendar Year
DMH	Department of Mental Health
DPH	Department of Public Health
ED	Emergency Department
EDD	Emergency Department Database
EOHHS	Executive Office of Health and Human Services
ESI	Employer-Sponsored Insurance
FFCRA	Families First Coronavirus Response Act
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FI	Fully Insured
FPL	Federal Poverty Level

Index of Acronyms (continued)

GDP	Gross Domestic Product
GIC	Group Insurance Commission
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCPCS	Healthcare Common Procedure Coding System
HCQI	Health Care Quality Improvement
HDHP	High-Deductible Health Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HFY	Hospital Fiscal Year
HHA	Home With Home Health Agency Care
HIDD	Hospital Inpatient Discharge Database
HMO	Health Maintenance Organization
HNE	Health New England
HPHC	Harvard Pilgrim Health Care
HPI	Health Plans, Inc.
HPP	High Public Payer
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
HSA	Health Status Adjusted
HSN	Health Safety Net
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IRS	Internal Revenue Service
MA	Massachusetts
MCO	Managed Care Organization
MES	Massachusetts Employer Survey
MGB	Mass General Brigham Community Physicians Organization
MGBHP	Mass General Brigham Health Plan
MGL	Massachusetts General Law
MH	Mental Health
MHIS	Massachusetts Health Insurance Survey
MHQP	Massachusetts Health Quality Partners
MLR	Medical Loss Ratio
MM	Member Month
NCPHI	Net Cost of Private Health Insurance
NCQA	National Committee for Quality Assurance
NEQCA	New England Quality Care Alliance
NPSR	Net Patient Service Revenue
NQF	National Quality Forum

Index of Acronyms (continued)

OOD	Outpatient Observation Database
OOP	Out of Pocket
PACE	Programs of All-Inclusive Care for the Elderly
PACT Act	Promise to Address Comprehensive Toxics Act (Federal)
PBM	Pharmacy Benefit Manager
PCACO	Primary Care Accountable Care Organization
PCC	Primary Care Clinician
PCP	Primary Care Provider
PES	Patient Experience Survey
PMPM	Per Member Per Month
POS	Point of Service
PPO	Preferred Provider Organization
PTSD	Post-Traumatic Stress Disorder
SCO	Senior Care Options
SFY	State Fiscal Year
SHCE	Supplemental Health Care Exhibit
SI	Self-Insured
SNF	Skilled Nursing Facility
SQMS	Standard Quality Measure Set
SUD	Substance Use Disorder
THCE	Total Health Care Expenditures
THP	Tufts Health Plan
THPP	Tufts Health Public Plans
TME	Total Medical Expenses
UHC	UnitedHealthcare
UPPL	Unified Pharmacy Product List
VA	Veterans Affairs
YTD	Year-to-Date

Glossary of Terms

Accountable Care Organization (ACO): Group of health care providers that contracts with a payer to assume responsibility for the delivery of care to its attributed patients and for those patients' health outcomes.

Accountable Care Partnership Plan (ACPP): A type of ACO for MassHealth members, formerly known as ACO-A plans. Managed care organizations (MCO) and a group of primary care providers (PCPs) create a full health care network that includes PCPs, specialists, behavioral health providers, and hospitals. Members must use the plan's network.

Administrative Services Only (ASO): Commercial payers that perform administrative services for self-insured (SI) employers. Services can include plan design and network access, claims adjudication and administration, and/or population health management.

Advance Premium Tax Credit (APTC): Federal tax credits available to those with incomes below 400% of the federal poverty level (FPL) who enrolled in plans sold on the Health Connector. Credits may be applied directly to premiums to lower the member's monthly payments or may be paid in a lump sum as part of the member's tax return. APTC amounts are calculated by comparing the individual's income to the cost of the second-cheapest silver tier plan available to them. If the cost of that plan exceeds a specified percentage of the member's income, the federal government pays the difference in APTCs.

Affordability Issues: In the Massachusetts Health Insurance Survey (MHIS), affordability issues are defined as reporting any of the following issues: problems paying family medical bills in the past 12 months; having family medical bills at the time of the survey that are being paid over time, also known as family medical debt; spending a high share of family income on out-of-pocket health care expenses, defined as 5% or more of income for families below 200% of the federal poverty level (FPL) or 10% or more of income for other families, in the past 12 months; or having any unmet need for health care in the family due to cost in the past 12 months.

Aligned Measure Set: A set of quality measures for voluntary adoption by private and public payers and providers, specifically for use in global budget-based risk contracts, which aims to reduce administrative burden and focus quality improvement efforts on meaningful and high priority measures. The Measure Set was developed and is updated annually by the Quality Measure Alignment Taskforce.

Alternative Payment Method (APM): A payment method used by a payer to reimburse a health care provider that is not solely based on the fee-for-service model. As part of the design of these payment methods, some of the financial risk associated with the delivery of medical care as well as the management of health conditions is shifted from payers to providers. Generally, APMs are intended to give providers new incentives to control overall costs (e.g., reduce

Glossary of Terms (continued)

unnecessary services and provide services in the most appropriate setting) while maintaining or improving quality.

Annualized Trend: Calculates a smooth spending trend across multiple years, also known as compound annual trend. Due to large fluctuations in utilization and spending attributed to the COVID-19 pandemic, CHIA used the annualized trend to examine per capita spending for 2019 to 2021, calculated as (2021 Value/2019 Value)^(1/2)-1.

Benefit Level: A measure of the proportion of covered medical expenses paid by the insurance plan. Actuarial values may be estimated by several different methods; see the **technical appendix** for the method used in this report.

Coinsurance: A percentage of allowed health care service costs that a member in a health insurance plan pays after meeting their deductible (see definition below). Coinsurance is a cost-sharing method set by health care plans that is applicable until the annual out-of-pocket maximum is reached.

ConnectorCare: A type of qualified health plan (QHP) offered through the Health Connector, the Commonwealth's marketplace for health and dental insurance, with lower monthly premiums and cost-sharing for those with household incomes at or below 300% of the federal poverty level (FPL). In 2024 eligibility was expanded on a pilot basis to households up to 500% of the FPL.

Copayment: A fixed and out-of-pocket cost paid by a member in a health insurance plan for covered services. Copayment amounts at the point of service are fixed, typically set by health insurance plans based on the product type. A member's annual copayment total is based on service utilization. Copayments generally do not factor into a member's annual deductible spending (see definition below) but do count towards a member's annual out-of-pocket maximum. Also referred to as a copay.

Cost-Sharing: The amount of an allowed claim that the member is responsible for paying. This includes any copayments, deductibles, and coinsurance payments for the services received. Cost-sharing does not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines, vision, and dental care).

Cost-Sharing Reduction (CSR) Subsidies: Payments made by the federal government and/or the Commonwealth of Massachusetts directly to ConnectorCare payers to lower copayments and eliminate deductibles and coinsurance in ConnectorCare plans.

Deductible: A fixed annual spending amount a member pays to a health insurance plan for covered health care services prior to coinsurance benefits being applied to those costs and separate from copayments (see definition above).

Glossary of Terms (continued)

Dually Eligible Beneficiary/Patient: A person who is enrolled in both Medicaid and Medicare.

Employer-Sponsored Insurance (ESI): Health insurance plans purchased by employers on behalf of their employees as part of an employee benefit package.

Fully Insured (FI): A fully insured employer contracts with a payer to pay for eligible medical costs for its employees and dependents in exchange for a pre-set annual premium, reducing the financial responsibility and risk for the employer.

Funding Type: The segmentation of health plans into 2 types—fully insured and self-insured—based on how they are funded.

Group Insurance Commission (GIC): The organization that provides health benefits to state employees and retirees in Massachusetts.

Health Care Cost Growth Benchmark (Benchmark): The projected annual percentage change in the Total Health Care Expenditures (THCE) measure, as established by the Health Policy Commission (HPC). The benchmark is tied to growth in the Massachusetts economy, calculated as the potential gross state product (PGSP). For 2023 and beyond, the benchmark is established by law at a default rate of PGSP, though the HPC Board can modify it to any amount deemed reasonable, subject to legislative review.

Health Connector: The Commonwealth's state-based health insurance marketplace where individuals, families, and small businesses can purchase health plans directly from insurers.

Health Savings Account (HSA): Medical savings accounts available to employees enrolled in a high-deductible health plan (HDHP). Pre-tax contributions can be made by both employees and employers and can be used to pay for qualified medical expenses. Unspent funds roll over year to year and job to job.

Health Reimbursement Arrangement (HRA): A savings account funded on a pre-tax basis by an employer with no contribution from the employee; the funds are not portable from job to job. Employees may use the funds for medical care or services.

High-Deductible Health Plan (HDHP): As defined by the IRS, a health plan with an individual plan deductible exceeding $1,400 in 2021-2022; $1,500 in 2023; $1,600 in 2024; and $1,650 in 2025. For a family plan, HDHPs are those with a deductible exceeding $2,800 for 2021-2022; $3,000 for 2023; $3,200 for 2024; and $3,300 for 2025. HDHPs typically offer lower monthly premiums for members.

Health Maintenance Organization (HMO): An insurance plan with a closed network of providers outside of which coverage is not provided, except in emergencies. These

Glossary of Terms (continued)

plans generally require members to coordinate care through a primary care provider (PCP).

Individual Purchasers: Health insurance plans purchased by individuals that are not offered by an employer and directly through the health insurance marketplace. Individual purchasers are categorized into 2 different types: ConnectorCare (see definition above) purchasers and unsubsidized individual purchasers.

Limited Network: A health insurance plan that offers members access to a reduced or selective provider network that is smaller than the payer's most comprehensive provider network within a defined geographic area and from which the payer may choose to exclude from participation other providers who participate in the payer's general or regional provider network. This definition, like that contained within Massachusetts Division of Insurance regulation 211 CMR 152.00, does not require a plan to offer a specific level of cost (premium) savings to qualify as a limited network plan.

Managing Physician Group Total Medical Expenses: Measure of the total health care spending of members whose plans require the selection of a primary care provider associated with a physician group or who are attributed to a primary care provider pursuant to a contract between a payer and provider.

Market Sector: Average employer or group size segregated into the following categories: individual purchasers, small group (up to 50 employees), mid-size group (51-100 employees), large group (101-499 employees), and jumbo group (500+ employees). In the small group market segment, only those small employers that meet the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04 are included; otherwise, they are categorized within mid-size.

Medical Debt: In the Massachusetts Health Insurance Survey (MHIS), medical debt is defined as a family reporting to pay medical bills over time when the survey was conducted.

Medical Loss Ratio (MLR): As established by the Division of Insurance, MLR is the sum of a payer's incurred medical expenses, their expenses for improving health care quality, and their expenses for deductible fraud, abuse detection, and recovery services, all divided by the difference of premiums minus taxes and assessments. This ratio is calculated within a licensed payer and market segment over a 3-year average.

Merged Market: The combined health insurance market within which both individual purchaser and small group plans are purchased (see "Market Sector" above).

Net Cost of Private Health Insurance (NCPHI): For the private insurance market, it is the cost of administering

Glossary of Terms (continued)

health insurance or the difference between the premiums health plans receive and the expenditures for covered benefits incurred for the same members.

Net Prescription Drug Spending: Payments made by a health plan to pharmacies for members' prescription drugs minus rebates received by the health plan from manufacturers.

Out-of-Pocket Expenses: Spending by an individual consumer on deductibles, copays, and coinsurance for benefits covered by insurance, and all spending on non-covered medical, dental, and vision services (including prescription drugs) that the individual pays for directly. Out-of-pocket expenses do not include member-paid premiums for health insurance.

Percent of Benefits Not Carved Out: The estimated percentage of a comprehensive package of benefits (e.g., pharmacy, behavioral health) that are accounted for within a payer's reported claims.

Per Member Per Month (PMPM): The average per member spending on medical services each month within the stated insurance type.

Pharmacy Benefit Manager (PBM): A business or entity that provides management services for prescription drugs on behalf of a health plan sponsor. Services include, but are not limited to, negotiation of the price of prescription drugs, including rebates, discounts, or other price concessions. Services can also include managing any aspect of a prescription drug benefit, such as formulary administration, processing and payment of claims, drug utilization review, prior authorization requests, and data administration and billing services.

Point-of-Service (POS): Insurance plans that generally require members to coordinate care through a primary care provider (PCP) and offer both in-network and out-of-network coverage options.

Preferred Provider Organization (PPO): An insurance plan that identifies a network of "preferred providers" while allowing members to obtain coverage outside the network, typically with higher levels of cost-sharing. PPOs generally do not require enrollees to select a primary care provider (PCP).

Premium: A fixed monthly payment to a health insurance plan for health insurance coverage. The monthly premium is often a shared expense paid by members, employer groups that offer health insurance, and state subsidies (if the member is eligible). Premiums are set by health insurance plans prospectively based on historical data and projected growth in claims and administrative costs.

Premium Retention: The difference between the total premiums collected by payers (net of medical loss ratio rebates) and the total spent by payers on incurred medical claims. Also known as non-medical expenses and surplus.

Glossary of Terms (continued)

Premiums, Earned, Net of MLR Rebates: The total gross premiums earned after removing medical loss ratio (MLR) rebates incurred during the year (though not necessarily paid during the year), including any portion of the premium that is paid to a third party (e.g., Connector fees, reinsurance).

Prescription Drug Rebate: A refund for a portion of the price of a prescription drug. Such refunds are paid retrospectively and typically negotiated between the drug manufacturer and pharmacy benefit manager (PBM), which may share a portion of the refunds with clients such as insurers, self-funded employers, and public insurance programs. The refunds can be structured in a variety of ways, and refund amounts vary significantly by drug and payer.

Prevention Quality Indicators: A set of indicators that assess the rate of hospitalizations for "ambulatory care sensitive conditions," conditions for which high-quality preventive, outpatient, and primary care can potentially prevent complications, more severe disease, and/or the need for hospitalization. These indicators calculate rates of potentially avoidable hospitalizations in the population and can be risk-adjusted.

Primary Care Accountable Care Organization (PCACO): A type of ACO plan for MassHealth members, formerly known as ACO-B plans. A group of primary care providers (PCPs) form an ACO that contracts directly with MassHealth to provide primary care and other services to MassHealth members.

Primary Care Sub-Capitation Program: A program implemented by MassHealth in 2023 to provide participating primary care practices with a fixed, per member per month (PMPM) payment for a defined set of primary care services, replacing traditional fee-for-service (FFS) reimbursement. The program is designed to increase investment in primary care, especially within ACO participating and hospital-based practices, and to support a shift toward more team-based, integrated models of care. By offering predictable prospective payments, the program aims to improve patient experience, quality of care, and the sustainability of primary care practices.

Product Type: The segmentation of health plans along the lines of provider networks. Plans are classified into 1 of 4 mutually exclusive categories in this report: health maintenance organizations (HMO), point-of-service (POS), preferred provider organizations (PPO), and other.

Qualified Health Plan (QHP): A health plan certified by the Health Connector to meet benefit and cost-sharing standards.

Risk Adjustment: The Affordable Care Act program that transfers funds between payers offering health insurance plans in the merged market to balance out enrollee health status (risk).

Self-Insured (SI): A self-insured employer takes on the financial responsibility and risk for its employees' and employee-

Glossary of Terms (continued)

dependents' medical claims, paying claims and administrative service fees to payers or third-party administrators.

Standard Quality Measure Set (SQMS): A standard set of measures of health care provider quality and health system performance, recommended by the Commonwealth's Statewide Quality Advisory Committee. The Committee's recommendations draw from the extensive body of existing, standardized, and nationally recognized quality measures.

Tax-Advantaged Savings Accounts: A special account or fund that individuals can use to pay for their medical expenses, such as a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).

Tiered Network Health Plans: Insurance plans that segment their provider networks into tiers, typically based on differences in the quality and/or cost of care provided. Tiers are not considered separate networks but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan simply splitting benefits by in-network versus out-of-network; a tiered network will have varying degrees of payments for in-network providers.

Total Health Care Expenditures (THCE): A measure of total spending for health care in the Commonwealth. Chapter 224 of the Acts of 2012 defines THCE as the annual per capita sum of all health care expenditures in the Commonwealth from public and private sources, including (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health-status-adjusted total medical expenses reported by CHIA; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in regulations promulgated by CHIA.

Total Medical Expenses (TME): The total medical spending for a member population based on allowed claims for all categories of medical expenses and all non-claims-related payments to providers. TME is expressed on a per member per month basis.

Treat-and-Release Emergency Department (ED) Visit: An emergency department visit not resulting in an inpatient admission or an outpatient observation stay at the same facility.

Unmet Need in Family for Health Care Due to Cost: Health care that a resident or a family member living in the household perceived as necessary but decided to forgo in the past 12 months due to the cost of that care. This includes doctor care; nurse practitioner, physician assistant, or midwife care; specialist care; mental health care or counseling; substance use care or treatment; prescription drugs; dental care; vision care; and medical equipment.

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