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TESTIMONY

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Health Policy Commission & Joint Committee on Health Care Financing

Testimony Regarding the Potential Modification of the 2027 Healthcare Cost Growth Benchmark

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On behalf of our member hospitals and health systems, affiliated physician practices, and statewide healthcare interests, the Massachusetts Health & Hospital Association (MHA) appreciates the opportunity to offer comments on the state's 2027 healthcare cost growth benchmark to the Health Policy Commission (HPC) and the Joint Committee on Health Care Financing as they deliberate a potential modification to the benchmark. MHA and our members are proud to be your partner as we pursue a shared mission of affordable, accessible, world-class care for every patient.

As our state conducts this annual exercise, hospitals are caught between two realities. They are caught between the urgent needs of their patients and workforce and the need to invest and prepare for the future. They are caught between the demands of affordability and the mission of accessibility. And they are caught between a benchmark process that was intended to align with the state economy but is unfortunately no longer tied to that reality. Massachusetts' ability to meaningfully address costs in a way that protects our coveted healthcare system will depend on our ability to bridge these divides and do things differently – including a modernized approach to the benchmark itself.

The 2024 period being examined as part of this year's benchmark process was an extraordinarily challenging year for the local hospital community. The headline was that healthcare spending growth exceeded the benchmark. Hospitals welcome fair evaluation but we also urge a further look at the related headlines, including the context and the results surrounding the benchmark.

- **Massachusetts did in fact meet the overarching goal of aligning healthcare spending growth with state economic growth.** The Massachusetts economy grew at a rate of 5.5% in the same period.
- **Massachusetts outperformed the nation in terms of healthcare spending growth**. Healthcare spending grew at a lower rate in the commonwealth compared to the nation's healthcare spending growth rate of 6.1% on a per capita basis[1].
- **Affordability challenges are everywhere.** As the Center for Health Information and Analysis (CHIA) reports, housing, food, and childcare are all growing at similar rates. This

[1] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

context matters as healthcare does not happen in a vacuum, and we agree that all these affordability challenges must be addressed.

- **Most importantly, Massachusetts met our fundamental mission of providing the highest-quality, most accessible care for all patients.** Our world-class healthcare system ranks top in the country.[2]

We accomplished this together while navigating new challenges in 2024, including a $200 million deficit in the Health Safety Net and the Steward Health Care bankruptcy. Some of the consequences to healthcare providers included a majority of hospital health systems operating in the red; 74% of hospital health systems lost money on their operations in 2024, according to CHIA.[3]

These trends have only intensified for patients and providers since 2024. The cost of health insurance continues to increase by double digits, well above economic growth rates.[4] We know many of our local health insurance partners have been experiencing financial pressures of their own – especially due to pharmaceutical spending. That pressure has unfortunately led to more aggressive tactics in limiting and denying services – measures that increase provider burnout, waste billions in administrative expenses and, worse, make it challenging for patients to access care. As the largest employer in the state, the hospital sector feels the pains of increased premiums and healthcare spending more than most.

It is also notable that CHIA has now identified 20% of hospital outpatient spending is driven by pharmaceutical costs. This means the two major spending categories CHIA found to have the highest rate of growth are directly tied to pharmaceutical spending.

Because of these factors and ongoing cost pressures, two-thirds of hospital health systems are still operating at a loss in FY2026 despite tough decision-making related to their operations.

Regarding setting the 2027 healthcare cost benchmark, absent modification by the HPC and the legislature, the default benchmark is the Potential Gross State Product (PGSP). This technical component of the process does not receive as much fanfare but one could argue it holds more weight. **For 14 years in a row, PGSP has been set at 3.6% with no apparent connection to actual economic growth in the state. MHA believes it is time to break this cycle and create a modernized benchmark that aligns with actual economic conditions**. We support the concepts included in H.3196/S.2047 that call for a historical growth rate in gross state product to be calculated using the most recent 10-year period that would serve as the default healthcare cost benchmark. Like today, the HPC could still recommend a benchmark that is different. However, the benchmark would be tied initially to state economic activity as Chapter 224 intended.

Beyond measurement and benchmarking, the most important objective will be doing the difficult work – together – to address affordability challenges in a way that maintains high-quality, accessible

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[2] https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance
[3] https://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2024-annual-report/Hospital-Financial-Performance-2024-Report.pdf
[4] https://www.bostonglobe.com/2025/11/28/business/health-insurance-premium-massachusetts/

care for all. MHA applauds the legislature, HPC, and Healey-Driscoll Administration's latest efforts to focus on healthcare affordability.

For hospitals and health systems, bending the cost curve starts with being empowered to deliver new types of care – often outside of more expensive settings. It means simplifying administrative burdens and building a more nimble, supported workforce. It will require an intense focus on the root input costs that are driving healthcare finances. Hospitals are pursuing each of these improvements already, but they need continued support from policymakers and other elements of the healthcare system to create scalable, lasting change.

Despite all of these challenges, and thanks to the exhaustive work and difficult decision-making among our healthcare providers and policymakers, Massachusetts boasts the number-one healthcare system in the nation – including in access and healthy outcomes. Beyond lifesaving care, hospitals serve as the backbone of the state's economy, supporting 450,000 jobs and $94 billion in economic activity at a time when many other sectors are forced to pull back.

Through the rest of this testimony included in the attachment, we have outlined three key areas:

1. Core cost pressures for hospitals and health systems (page 4)
2. Controlling costs and promoting affordability (page 6)
3. The flaws in the current benchmark process and a potential solution (page 8)

We hope these insights are helpful as you consider how to approach the benchmark and other healthcare issues this year. MHA and our members remain strongly invested in controlling costs and improving affordability, and we look forward to being your partner in creating the change that patients, providers, and every element of the healthcare system deserves. Please do not hesitate to reach out with any questions or to discuss these ideas further.

Sincerely,

Daniel McHale
Senior Vice President, Healthcare Finance & Policy
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MHA Supporting Testimony
Regarding the Potential Modification of the
2027 Healthcare Cost Growth Benchmark

CORE COST PRESSURES FOR HOSPITALS & HEALTH SYSTEMS

There are real and unavoidable drivers of cost growth for hospitals, with pharmacy spending and other rising input costs leading the way. Also, an aging population and sicker patients in need of longer stays are affecting hospital operations and finances as never before. Looking forward to 2027 and beyond, increased cost pressures will remain for labor and prescription drugs, as well as for other supplies and utilities that likely will be compounded by inflation, tariffs, supply chain disruptions, and federal threats to healthcare funding and health insurance coverage. The commonwealth's Health Safety Net program for the uninsured is also in serious deficiency; absent further funding relief, the program will experience a $300 million deficit. **Taken together, these dynamics – many of which are beyond the control of hospitals – will lead to even further financial instability and will affect the provision of care.**

- As the 2026 CHIA Annual Report shows, the **statewide median operating margin for acute care hospitals was -2.0 percent** in FY2024, a decrease of 2.2 percentage points from the prior year, with 59% of hospitals reporting negative operating margins.

- 2024 margins for hospital health systems, which incorporate the financial performance of hospital affiliated physician groups, were at a bleak -2.7%; **74% of hospital systems lost money on their operations.**

- While CHIA's latest data shows improvement, two-thirds of hospital health systems continue to operate in the negative in early FY2026.

- **Healthcare does not happen in a vacuum; it is subject to the same economic pressures – including inflation – as every other sector.** Unlike other sectors, providers cannot simply pass along increases to patients, meaning they must absorb those increases on their own. Government payers limit their inflation updates, either providing no or insufficient rate increases to account for inflation. Commercial payer reimbursement also does not necessarily track with annual cost pressures facing hospitals given that providers typically negotiate new contracts with health plans for multiple years.

- The One Big Beautiful Bill Act (OB3) **puts coverage for up to 300,000 current Medicaid recipients at risk**. OB3 imposes stricter eligibility checks every six months and "community engagement" (work) requirements for recipients. The state estimates that Massachusetts will lose $3.5 billion annually once all of the healthcare provisions included in OB3 are in place by FY2028.

- These federal cuts **will place tremendous pressure on the Health Safety Net**, which has run enormous, ever-increasing funding shortfalls that are born solely by hospitals. MHA anticipates the program could experience a nearly $300 million funding shortfall in FY2026 –

a figure that could as much as triple in subsequent years, making it one of the most pressing financial challenges facing Massachusetts hospitals.

- Hospital labor expenses account for more than 60% of a hospital's operating costs, yet salary and wage growth pressures are not fully accounted for in the cost growth benchmark. **Temporary staffing costs reached $1.25 billion in 2024.** While a recent MHA survey shows the percentage of hours worked by temporary nurses declined 42% between 2023 and 2024, the need for traveler/agency labor is still four times higher than pre-pandemic 2019 levels.

- Double-digit vacancy rates remain high for nurses critical to patient care, including LPNs, as well as for many other patient-facing roles, **meaning hospitals are investing significant resources to recruit and retain talented caregivers.**

- According to CHIA's 2026 Annual Report, in 2024, **prescription drug spending gross of rebates represented the largest share of overall total healthcare expenditure spending growth** in 2024. Pharmacy spending increased 10.1% to $12.3 billion in 2024, following a 10.9% increase the previous year. Drugs also comprise more than one-fifth of all hospital outpatient spending – $2.4 billion in 2024.

- **Caring for an older population contributes to expense growth**. Patients discharged from hospitals who are 65 years or older now make up 46% of all patients, a 10.5% increase compared to 2019.[5] Enrollment trends also align with the changing demographics, with enrollment in Medicare (including dual eligibles) 16.4% higher compared to 10 years ago.[6] Conversely, private commercial insurance is down -9.4%. Elderly care is more complex and expensive than care for those under 65. According to data from the Centers for Medicare and Medicaid Services (CMS), total personal healthcare per-capita spending for those 65 years and older is 2.4 times greater than adults 19 to 64 years of age[7].

- **Patient needs are changing and they are staying longer in hospitals.** According to the most recent CHIA report for hospital inpatient statistics, hospital inpatient average length of stay is now 5.5 days, which represents a 12.5% increase compared to 2019. Because hospitals are essentially paid based on a per discharge basis, rather than length of stay, this growing trend has become highly disruptive to hospitals' financial stability. Additionally, the HPC's Cost Trends Hearing in 2024 noted that 48% of patients in hospital emergency departments with behavioral health diagnoses remained for longer than 12 hours.

- Massachusetts hospitals – like those across the nation – are experiencing a capacity crisis. On any given day, there are upwards of 2,000 or more patients "stuck" in hospital beds since they cannot access the behavioral health or post-acute care they need. MHA estimates that hospitals are **spending more than $400 million each year for this extra, unpaid care.**

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[5] https://www.chiamass.gov/massachusetts-acute-care-hospital-inpatient-discharge-reporting
[6] https://www.chiamass.gov/enrollment-in-health-insurance/
[7] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

- Massachusetts hospitals and physician practices incur as much as **$1.75 billion in unnecessary administrative costs from billing- and insurance-related practices each year**. The HPC, in its 2026 report on healthcare claim denials found that the average overall denial rate by insurers was 20.4%, meaning that approximately one out of every five claims submitted to a fully insured health insurer in Massachusetts was denied[8]. Furthermore, across insurers, a large percentage of the claims were denied for administrative reasons: duplicate claim or coverage, incomplete claim, coding error, or other administrative denial. These are important findings that validate the costs of administrative complexity and the need to focus on eliminating the barriers and reducing the burdens to simultaneously reduce costs. **The tangled web of administrative processes that health insurers have put in place is, in too many cases, delaying necessary patient care, adding to the financial pressures on the system, and contributing to clinician burnout**.

Of the items mentioned above, hospitals and health systems have little or no ability to control the following:

- Inflation of supplies, including double-digit pharmaceutical expense growth
- Coverage and funding reductions from OB3
- Increased, unsustainable pressure on the Health Safety Net
- Traveler healthcare worker costs that can run 2-3 times normal salary ranges
- The aging population with more complex health needs
- Capacity issues that result in “stuck patients” and unfunded care
- Spurious denied claims, excessive prior authorizations, and other wasteful administrative costs.

CONTROLLING COSTS & PROMOTING AFFORDABILITY

Hospitals are using every lever in their reach to overhaul healthcare costs by advancing strategies that simultaneously improve affordability and strengthen operational sustainability. They are doing this in the context of ensuring that they are still able to maintain Massachusetts’ standing as the number-one healthcare system in the nation in a variety of measures including in access and healthy outcomes.

- Models such as mobile integrated health, Hospital at Home, and telehealth shift care to lower cost, patient-preferred settings while reducing avoidable utilization and improving capacity management.

- Continued investment in technology – particularly AI-enabled tools for clinical decision support, care coordination, revenue cycle, and workforce optimization – improves productivity, standardizes processes, and reduces administrative burden.

- Hospitals are closely examining and streamlining their own administrative processes to eliminate unnecessary costs and alleviate the strains on both patients and employees. Greater standardization across health plans on prior authorization, billing, and quality reporting could

[8] https://masshpc.gov/news/press-release/hpc-finds-one-five-commercial-health-care-claims-were-denied-2024

further lower frictional costs and free clinical and administrative resources for patient care.

- In the MassHealth program, hospital health systems through their ACOs are supporting primary care practices in numerous innovative programs. The level of work is significant in supporting practices to undertake new capitation payments and financial risk, as well as to meet MassHealth practice standards. Through this model, health system ACOs are supporting primary care practices to integrate behavioral health, and expand appointment hours, pediatric expertise, and the enhanced family medicine services they provide. Hospital health systems also support primary care practices with complex case management and other population health strategies.

- Hospital health system ACOs provide significant support to help coordinate care for patients across the care continuum, especially for those with chronic conditions and behavioral health conditions. Hospital health system ACOs also play important roles in screening patients for health-related social needs such as food insecurity/access to healthy food as well as housing-related needs. ACOs, hospitals, and primary practices are working together in the commonwealth's effort to address health equity by improving patient demographic data, screening for disability accommodation needs, improving provider disability competencies, and working with healthcare partners to reduce clinical outcome disparities.

- Hospitals are embracing alternative payment methodologies that hold hospitals accountable for total cost of care, employ shared savings/downside risk, and incentivize care coordination and prevention, while reducing avoidable utilization.

- As an example, the HPC's February 2025 report on ACOs stated, "Through these value-based payment arrangements, ACOs are driving delivery system innovations and strategies to deliver higher-value care, even as ACOs navigate challenges in meeting quality and cost targets[9]. Insights gained from the HPC's ACO Certification program show that the ACO model continues to be an important vehicle for care delivery improvement in the Commonwealth."

Hospitals are also engaging and investing in a number of efforts to strengthen the workforce:

- A sustained focus on recruitment, retention, and pipeline development – paired with redesigned care teams – positions hospitals to reduce reliance on premium contract labor, stabilize staffing, and reinvest savings into innovation, access, and long-term financial resilience.
- Investing in strategies, programs and initiatives to boost employee wellbeing and reduce burnout among both clinical and non-clinical staff. (Retention saves money over replacing lost staff and productivity.)
- Building and expanding career ladders to upskill their workers, which is both a recruitment and retention strategy.
- Meanwhile, numerous systems have been forced to make difficult decisions to reduce non-patient-facing positions as a strategy to address financial pressures.

[9] https://masshpc.gov/publications/datapoints-series/issue-28-aco-verview-key-insights-hpc-certified-accountable-care

THE BENCHMARK PROCESS: ITS FLAWS AND SOLUTIONS

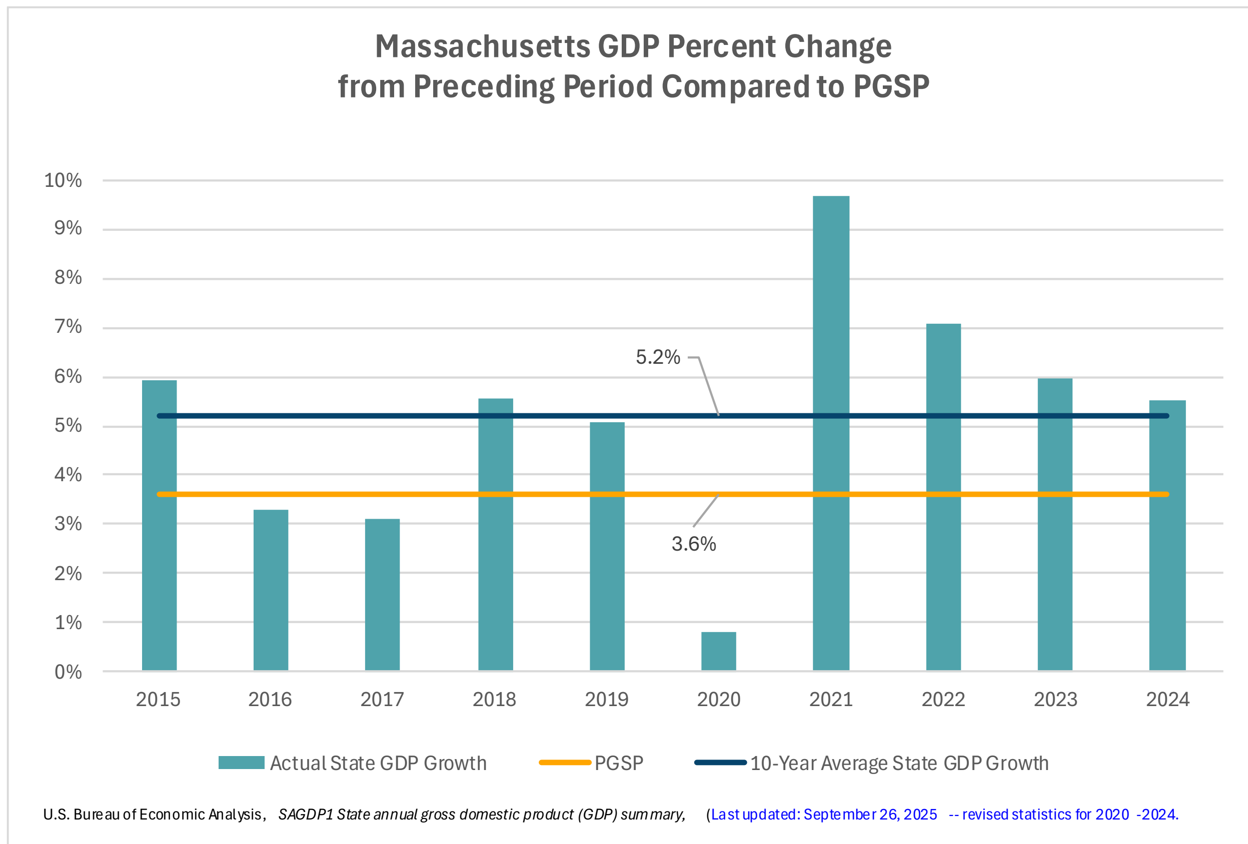
MHA maintains the need for a modernized benchmark approach that can better reflect actual economic conditions and more effectively inform policymakers. It has become increasingly clear that using a benchmark growth rate that does not account for the fundamental factors affecting the sector's cost pressures – or even the Massachusetts economy – creates an ineffective target and incomplete conversation. For the past 14 years, the commonwealth has not linked the benchmark to Massachusetts' actual economic activity. Instead, the commonwealth has measured healthcare spending against a growth rate that was determined in 2012 and reaffirmed annually each year thereafter at the same amount. This means the tool is disconnected from the on-the-ground realities of today's healthcare system – especially during periods of distress, such as pandemics, the collapse of the Steward Health Care system, or rapidly increasing pharmaceutical and labor costs. Simply put, the current benchmark is outdated and is setting Massachusetts up for systemic failure should its reform not be addressed.

- The benchmark's companion component, PGSP, has been determined to be 3.6% each year, failing to meet the intent of the state's 2012 cost containment law to align healthcare cost growth with overall state economic growth. Throughout the years, the healthcare cost benchmark has always defaulted to the PGSP as the basis, including a five-year period with a statutory requirement for the benchmark to be set at 0.5% below PGSP.

- CHIA's latest Annual Report shows an increase of 5.7% in total healthcare expenditures for the commonwealth between 2023 and 2024. While this spending growth exceeds the 3.6% benchmark, it would be misguided to simply conclude the commonwealth missed its target given the target itself is flawed.

- The timing and circumstances between when the benchmark's growth standard is set and when it is measured means it ignores current healthcare dynamics and trends. Without acknowledging this gap, the HPC benchmark and measurement process will forever be caught both in the past and future, but never with a fair or accurate eye on the present.

- The healthcare cost growth benchmark has also been referenced inappropriately in the market. Despite the HPC clearly stating that the "healthcare cost growth benchmark is not a hard cap on spending growth or provider-specific prices," MHA continues to hear from providers that commercial payers will reference the benchmark as a cap.



CAPTION: For the past three years, the state's gross product grew 5.5% in 2024, 6.0% in 2023, 7.1% in 2022, and 9.6% in 2021. Thus, the 5.7% cost growth from 2023-2024 is in line with the state's GDP growth.

A BENCHMARK SOLUTION

MHA is advocating that, in the best interest of policymakers and all elements of the healthcare sector, the state's healthcare cost benchmark-setting process be revisited and transitioned to a method that relies on data and historical experience. Two pieces of legislation heard by the Revenue Committee, H.3196 and S.2047, reform the reference benchmark that is used to inform HPC's healthcare cost growth benchmark to base it on historical state economic growth. Under this proposed approach, a historical growth rate in gross state product would be calculated using the most recent 10-year period and would serve as the default healthcare cost benchmark. Like today, the HPC would still have the ability to recommend a benchmark that is different. However, the benchmark would be tied initially to state economic activity, as Chapter 224 intended.

In Summary

The Massachusetts hospital community is dedicated to providing high-quality care and universal access for patients, while at the same time ensuring affordability and healthcare system effectiveness. While a state-established benchmark may be viewed as a helpful tool in monitoring and mitigating the growth of healthcare expenses, the existing Massachusetts measure is no longer a viable mechanism due to all the real-time factors outlined in this testimony. **It is clear that the current healthcare cost growth benchmark – including its connection to PGSP– has lost its relevancy. It is now time for state leaders and healthcare stakeholders to come together and adopt a more meaningful, modernized approach to measuring cost growth, ensuring access, improving affordability, and sustaining a vibrant healthcare provider system.**

The lingering effects of a global pandemic, workforce shortages, extreme inflation, high energy costs, health inequities, and, most recently, the bankruptcy of a large hospital health system are all factors that exist outside of – and not within – the benchmark. While these issues may be discussed during the benchmark hearing, the process still defaults to measuring healthcare spending against a flat, arbitrary 3.6% mark that also fails to align with the intended comparison to state economic growth.

On the ground, patients are now sicker and older than before and staying in hospitals longer. Worker wages increase to keep up with the cost of living and to remain competitive. Hospitals, health systems, and other providers are struggling financially to the point that it is affecting their workforce, the services they provide, and their ability to innovate. There are significant threats to our overall healthcare system emanating from the federal level that will put into serious question the future funding of Medicare, Medicaid, and subsidized insurance programs. The federal 340B Drug Discount program that provides essential savings to safety net providers is a target by many that could reduce funding support for healthcare providers. And the state's Health Safety Net program for the uninsured is in financial jeopardy, which will have consequences for all hospitals. As the HPC and legislature look forward to setting goals for healthcare spending in 2027, MHA and the hospital community hope to work with the commonwealth to address each of these urgent pressures and revise our collective approach to ensuring healthcare remains modern, affordable, accessible, and prepared for the needs of today's patients and caregivers.