MASSACHUSETTS Health & Hospital ASSOCIATION

TESTIMONY

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Testimony Regarding the Potential Modification of the 2026 Healthcare Cost Growth Benchmark

Health Policy Commission & Joint Committee on Health Care Financing
March 14, 2025

On behalf of our member hospitals and health systems, affiliated physician practices, and other healthcare interests, the Massachusetts Health & Hospital Association (MHA) appreciates this opportunity to offer comments on the state's 2026 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. Hospitals remain strongly committed to healthcare affordability and the goals of Chapter 224 enacted more than a decade ago, but MHA and our members across the state continue to share serious concerns about the benchmark setting-and-evaluation process in connection with current realities, patient needs, and future challenges.

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 — nor even the Massachusetts economy — creates an unattainable target. Further, focusing solely on this unrealistic benchmark prevents us from having meaningful conversations about real healthcare reform, which is desperately needed. As every corner of our system plunges deeper into crisis and patients are left bearing the brunt, both in their efforts to access care and the hopes that their care will be affordable, now is the time to put our collective efforts into true delivery system transformation that benefits patients and providers alike. Simply put: the current benchmark is unachievable, and our continued focus on it is setting us up for systemic failure should it not be addressed immediately.

The benchmark – and its companion component, Potential Gross State Product (PGSP) – are set arbitrarily and held flat to 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. The overall benchmark and evaluation process is also plagued by the fact it does not account for meaningful economic circumstances, fluctuations in government funding and policy, global factors such as a pandemic, and local market influences. It is now exceedingly evident that the benchmark process is broken and needs to be modernized to reflect the current economic climate.

MHA greatly values data from the Center for Health Information and Analysis (CHIA) and welcomes an in-depth discussion on the state of today's healthcare economics, including how the commonwealth can support patients, caregivers, and a healthcare system that is struggling in the face of tremendous challenges. CHIA's new Annual Report shows an increase of 8.6% in total healthcare expenditures for the commonwealth between 2022 and 2023. 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. There are real and unavoidable drivers of cost growth for hospitals, with pharmacy spending leading the way. Medicaid supplemental payments were also identified as a major contributor, but it is important to note this new spending supports quality and equity incentives Massachusetts hospitals earned through a

nation-leading 1115 Waiver, with zero impact on state funding and commercial health insurance spending given it is financed by hospitals and the federal government.

Of note, combined hospital inpatient and outpatient growth stood at 6.3%, a rate that closely mirrored the state's total economic growth (5.8%) in that timeframe. Again, given the serious cost pressures that hospitals were facing during the years in question, it is not surprising that combined inpatient and outpatient hospital medical expense growth exceeded 3.6% — a decade-old, arbitrary measure. FY2023 presented continued cost pressures for healthcare providers, including increasing labor and pharmaceutical expenses. Hospital health systems also continued to struggle with intensifying administrative burdens, patient capacity, and throughput challenges – all of which come with their own increased costs. And it is clear that an aging population and sicker patients in need of longer stays are now affecting hospital operations and finances.

The sobering reality is that the Massachusetts healthcare system finds itself in an increasingly in a fragile state. Hospital financial performance in FY2023, following one of the worst years on record, remained poor, with 47% of hospitals operating in the negative. CHIA found that the statewide median hospital operating margin was only 0.2% for FY2023. This trend unfortunately worsened in 2024, with the statewide operating margin dipping into the negative (-0.9%) as of June 30 of last year. Of greater concern, 16 out of 22 hospital health systems (73%) experienced negative operating margins in 2023.[1]

Looking forward to 2026 and beyond, increased cost pressures will remain for labor and prescription drugs, as well as for other supplies and utilities that will likely be compounded by inflation, tariffs, and supply chain disruptions. Healthcare providers are also very concerned with federal threats to healthcare funding and health insurance coverage through Medicaid and subsidized insurance programs. Potential reductions will not only affect these specific programs, but the ability of healthcare providers to maintain care services to *all* patients. Closer to home, the commonwealth's Health Safety Net program for the uninsured is also in serious deficiency; MHA anticipates the program could experience a $260 million funding shortfall in FY2026. Taken together, these dynamics could lead to even further financial instability among all hospitals.

A Flawed Process: Potential Gross State Product & the Default Healthcare Cost Benchmark

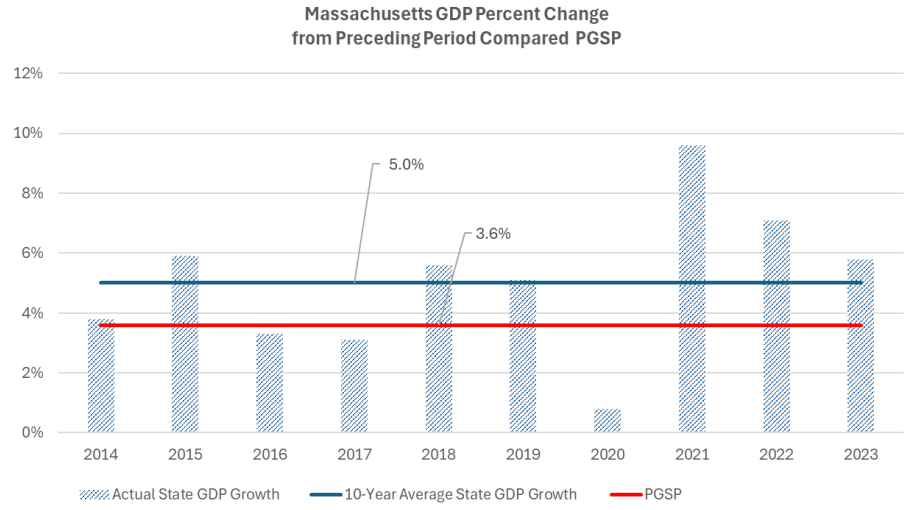
Chapter 224 had good intentions of tying the healthcare cost benchmark to the state's economic growth rate. However, for the past 10 years, the commonwealth has not linked the benchmark to Massachusetts' actual economic activity. Instead, the commonwealth has measured healthcare spending against a stagnant growth rate that is set arbitrarily and does not factor in actual economic growth. This means the tool is disconnected from the on-the-ground realities of today's healthcare system – especially during periods of distress.

Each year, the HPC board establishes a healthcare cost growth benchmark for the next calendar year. Unless the HPC recommends an alternative benchmark that the legislature approves, the benchmark is equal to the growth rate of PGSP.[2] The PGSP growth benchmark is therefore the commonwealth's default healthcare cost growth benchmark unless the HPC recommends a different amount. Throughout the years, the healthcare cost benchmark always has 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.

[1] https://www.chiamass.gov/hospital-and-hospital-system-quarterly-and-annual-financial-data/
[2] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6D/Section9

Given that the state relies on the state-defined PGSP process as the basis for determining the healthcare cost benchmark, it is critical to understand this part of the benchmark setting process and how it relates to *actual* economic activity in the state. As part of the annual process to determine a consensus revenue forecast estimate for the following year's state budget, the Executive Office for Administration and Finance and the House and Senate Committees on Ways and Means determine the PGSP growth benchmark for the following year, as required by section 7H 1/2 of chapter 29 of the General Laws.[3]

For more than a decade since the benchmark's creation in 2012, state policymakers always have determined the PGSP to be 3.6%. **However, for the last decade the *actual* growth in the gross state product typically exceeded the PGSP amount determined each year.** According to the U.S. Bureau of Economic Analysis,[4] Massachusetts GDP growth has averaged 5.0% for the past 10 years. In seven of those years, the actual state GDP growth has exceeded the PGSP amount – and therefore also the healthcare cost benchmark. For the past three years, the state's gross product grew 5.8% in 2023, 7.1% in 2022, and 9.6% in 2021. During the pandemic, the state's economy did not grow given the shutdown and limitations across the commonwealth.



Source: U.S. Bureau of Economic Analysis, "SAGDP1 State annual gross domestic product (GDP) summary" (accessed Thursday, March 6, 2025).

It is indisputable that the PGSP process is no longer an appropriate way of setting the default cost benchmark. A modernized approach would ensure our state is assessing the healthcare system's performance in the most accurate way possible. In turn, it would better inform the state's policy priorities and outlook on future trends.

For these reasons, MHA is now advocating for this important component of the state's healthcare cost benchmark-setting process to be revisited and transitioned to a method that relies on data and historical experience. H.3196 and S.2047 reform the reference benchmark that is used to inform HPC's healthcare cost growth benchmark so that it is based 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.

[3] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIII/Chapter29/Section7H%201~2
[4] U.S. Bureau of Economic Analysis, "SAGDP1 State annual gross domestic product (GDP) summary" (accessed Thursday, March 6, 2025).

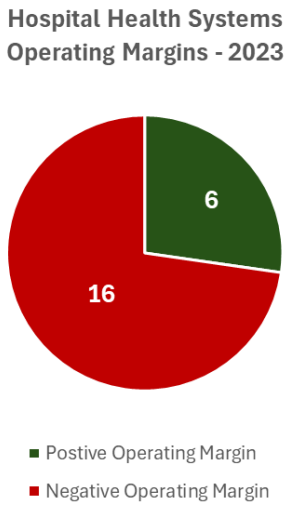
Application of the Healthcare Cost Benchmark

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. For instance, because there is a two-year lag before CHIA publishes its annual report on cost growth for the time period in question, any healthcare entities that the HPC requires to file Performance Improvement Plans (PIPs) would be doing so based solely on circumstances from three years prior.

The healthcare cost growth benchmark has also been referenced inappropriately in the market. Despite the HPC clearly stating that the "health care cost growth benchmark is not a hard cap on spending growth or provider-specific prices," we continue to hear from providers that commercial payers will reference the benchmark as a cap.[5] In addition to reforming the benchmark itself, it is important that HPC and policymakers continue to reiterate that the benchmark is intended to inform measuring cost growth and is not a rate-setting mechanism between healthcare providers and payers.

Hospital & Health System Finances

As this week's CHIA report shows, hospital operating margins are extremely low and represent how fragile the state's healthcare system has become. The statewide median operating margin was 0.2%, meaning the typical hospital barely had operating revenues to cover the cost of delivering care to patients. When incorporating hospital affiliated physician groups, the picture is much bleaker. Seventy-three percent of hospital health systems were operating in the red.



Unfortunately, this is a troubling trend that both predates 2023 and continues into 2024. As of CHIA's last report (though June of 2024), hospitals' median operating margin had dipped back into the negatives, at (-0.9%). Hospitals are now being forced to make difficult decisions that are affecting their workforce, provision of certain services, and ability to modernize.

Operating margins are the best measure of hospital financial performance, since they encapsulate only the on-the-ground, actualized expenses of hospital operations. While CHIA also details total margins, it is important to recognize these include unrealized gains, or "paper gains" related to investment markets. In fact, unrealized gains comprise the majority of non-operating revenues. Using unrealized gains to assess hospital financial performance masks the fragile operating state of Massachusetts hospitals.

Driving these losses are increased hospital cost pressures, which include investment in wages and salaries; treating older, sicker patients in need of longer stays; increased supply costs, including pharmaceuticals; and inefficiencies due to administrative burdens.

[5] https://masshpc.gov/sites/default/files/2024-03/20240314_Benchmark_Process_Presentation.pdf

Hospital Labor Expenses

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. Workforce expenses have been tremendously disruptive over the past three-plus years. The pandemic accelerated the challenges that hospitals were already facing in recruiting and retaining healthcare workers. Following the pandemic, hospitals were forced to rely heavily on temporary staffing, which reached $1.5 billion in 2023, similar to the spending height experienced in 2022.

Hospitals have worked to address their workforce challenges with competitive wages, extensive signing bonuses, and retention packages to keep employees – especially for those that work at the bedside. According to CHIA's hospital financial reporting,[6] hospital health system wages and salaries grew at 7.0% in 2023. This followed a 7.2% growth in 2022. This growth rate is in line with the state's economic growth rate and inflation rates consumers experienced during this timeframe.

Workforce vacancies and demand for talent remain key drivers of these expense increases. In March 2023, the HPC found that healthcare providers experienced high rates of vacancies and turnover, including registered nursing vacancies doubling from 6.4% in 2019 to 13.6% in 2022.[7] In long-term care, the share of hours worked by contracted registered nurses had quintupled, from 4% in 2019 to 19% in 2022.

Workforce shortages not only increase the cost of care; they also have serious effects on the quality of care, such as patients remaining longer in hospital beds awaiting discharge, boarding in emergency departments, and lacking access to timely and appropriate services. Unfortunately, given the magnitude of operating losses across the healthcare system, many hospitals health systems have been forced to make difficult decisions affecting services and employment.

Inflation

Healthcare does not happen in a vacuum; it is subject to the same economic pressures as every other sector – including inflation. In addition to workforce costs, all other cost components of operating a hospital continued to increase in 2023. According to the U.S. Bureau of Labor Statistics,[8] the consumer price index (CPI) grew by 2.9% in 2023 for the New England area. This followed a CPI growth of 7.1% growth in 2022.

Unlike other sectors, providers cannot simply pass along increases to their customers (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. Therefore, the effect of prior-year inflation can cross over into subsequent provider and health plan contracts.

Looking forward to 2026, tariffs and other negative circumstances in the economy are expected to have a significant effect on the cost of goods, including on prices of medical supplies and energy. This is another unknown that should be considered when setting the benchmark for 2026 and beyond.

[6] Hospital and Hospital System Quarterly and Annual Financial Data, CHIA
[7] https://masshpc.gov/news/press-release/hpc-presents-new-health-care-workforce-data-convenes-leaders-discuss-policy
[8] U.S. Bureau of Labor Statistics. (2025, February 12). *Consumer Price Index for All Urban Consumers (CPI-U), All items in New England, all urban consumers, not seasonally adjusted [Data file]*. https://www.bls.gov/data/home.htm

Pharmaceutical Cost Growth

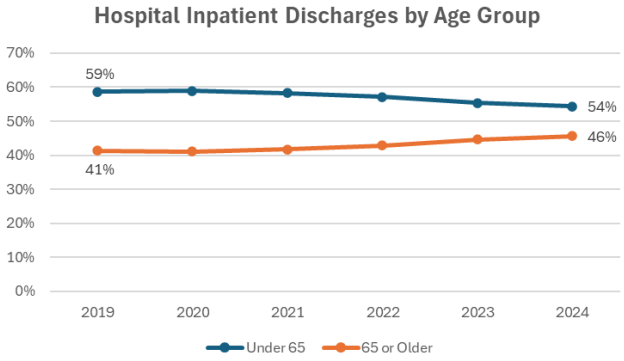
According to CHIA's 2025 Annual Report, pharmacy spending growth was the largest driver of the increase in total healthcare expenditures (THCE) from 2022 to 2023, growing by $1.6 billion. Without adjusting for rebates, pharmacy spending increased by 11.6%; 10% net of rebates.

It is important to note that pharmacy costs identified in the CHIA Annual Report are for prescription drugs largely purchased at retail pharmacies. The measure does *not* account for pharmacy expenses hospitals themselves incurred for drugs that were administered to patients in hospital settings. In outpatient settings, pharmacy expenses represent a major component of services delivered, including chemotherapy, antibiotics, and treatment for hemophilia. New, expensive, and growing treatments like cell and gene therapies are also administered in hospitals. MHA does not yet have data to determine what portion of hospital spending is pharmaceutical-driven, but we believe this is an important driver of hospital spending growth.

MHA recognizes that the HPC has made pharmaceutical spending a continuing focus. With the commission's new authorities granted through Chapter 343 of the Acts of 2024, we look forward to better understanding pharmaceutical spending growth and its effect on the healthcare system and consumers.

Caring for An Older, Sicker Population

When Chapter 224 was passed, one of the concerns identified with the year-over-year measurement of THCE was the inability to account for changes in the patient population. The per-capita spending comparisons assume the population is fixed and do not adjust for changing demographics. The "baby boom" population began turning 65 in 2011. Since then, an increasing number of people have become seniors and by 2030, all baby boomers will have reached 65.



Hospitals are feeling the effects of this changing demographic, as is evident in CHIA's hospital utilization statistics. Patients discharged from hospitals who are 65 years or older now make up 46% of all patients, a 10.5% increase compared to 2019. Elderly care is, of course, more complex and expensive than care for those under 65. According to data from the Centers for Medicare and Medicaid Services, total personal healthcare per-capita spending for those 65 years and older is 2.4 times greater than adults 19 to 64 years of age.[9]

The effect of the population becoming older, as well as other factors such as prioritizing inpatient care for more acute conditions and transitioning care to outpatient settings, has caused hospital stays to become longer. Patients are also staying longer due to challenges in the discharge process, including difficulties finding placements in post-hospital care settings. According to the most recent CHIA hospital utilization data, hospital inpatient average length of stay is now 5.54 days, which represents a 12% increase compared to 2019.[10] Because hospitals are essentially paid based on volume, rather than length of stay, this growing trend has become highly disruptive to hospitals' financial stability.

[9] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet
[10] https://www.chiamass.gov/massachusetts-acute-care-hospital-inpatient-discharge-reporting

MassHealth

This week, CHIA reported that one of the main drivers of THCE in 2023 was Medicaid supplemental payments. According to the report, MassHealth spending grew by 14.8%, primarily driven by non-claims, including hospital supplemental payments. **This spending was financed by a substantial annual assessment on acute care hospitals and federal revenue, with no impact on funding from state government. While this new funding increases THCE, the net source of the funding is paid by the federal government.** According to CHIA, excluding the new supplemental payments, MassHealth spending increased 7.2% (2.7% on a per-member-per-month basis.)

FY2023 marked the first year of this significant new funding from the MassHealth program to hospitals. The FY2023 budget incorporated a substantially revised hospital assessment and related Medicaid spending plan that was developed in strong collaboration with the state and hospital community. This nation-leading effort places special emphasis on health equity and care quality, with payments made available to hospitals only when they have made specific progress in those areas. The financing plan yielded more than $1.6 billion in new spending above FY2022 across hospitals, physician groups, ACOs, and Community Partners. MHA estimates more than $1.2 billion was realized by hospitals during FY2023, which includes the portion financed by hospitals themselves through the assessment.

As it relates to the healthcare cost benchmark, it is difficult to understand how the HPC will fairly account for this new spending and the assessment while setting the benchmark, as well as when evaluating potential PIPs. The hospital assessment and related spending provisions are advancing the priorities of the commonwealth on several important fronts, including health equity, improving clinical outcomes, supporting safety net providers, funding delivery system reforms, and reimbursing hospitals for the care they provide to MassHealth patients. It includes significant support for health-related social needs, including housing, nutrition, and care coordination in the community. These needed investments must be welcomed and not result in penalizing healthcare providers as part of the benchmark process.

Capacity Challenges

Across Massachusetts, many patients are experiencing longer wait times and other challenges as they seek the care they need. Hospitals and healthcare organizations are working tirelessly to deliver timely, high-quality care for everyone, but they are up against an unrelenting set of pressures that has made their mission more difficult than ever before.

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. Capacity challenges have been well documented in MHA's monthly Throughput Survey Report, which shows how delays in patient discharges to post-acute care settings have become a growing challenge for both acute care hospitals and post-acute care providers. As of the most recent report from January, there were 2,220 such patients awaiting discharge statewide. **MHA estimates that hospitals are spending more than $400 million each year for this extra, unpaid care.**

MHA also has been capturing behavioral health boarding metrics on a weekly basis, which show the number of patients waiting in an emergency department (ED) or medical surgical floor for a psychiatric evaluation or a bed in a psychiatric unit. The March 10 report showed that there were 309 behavioral health patients of all ages boarding in hospitals across the state.

Contributing factors to these capacity issues include insurance administrative barriers related to treatment authorization, delays for non-emergency transportation, and the lack of guardianships and conservatorships – all issues beyond a hospital's control. Psychiatric units and freestanding psychiatric facilities also face significant barriers in discharging patients to Department of Mental Health continuing care beds; some Massachusetts patients have been waiting more than two years for such a bed to become available.

Staffed medical surgical beds and ICU beds have also dropped significantly, by an average of 9% and 16%, respectively, over the past three years. Fewer beds means that average occupancy levels have risen to unprecedented heights at most hospitals. This leads to overcrowding and longer ED wait times.

Staffed Beds & Occupancy

Medical/Surgical Beds	2021	2024	% Change
Staffed Beds	11,541	10,542	-9%
Aggregate Occupancy %	77%	85%	
Intensive Care Unit Beds			
Staffed Beds	1,590	1,328	-16%
Aggregate Occupancy %	73%	78%	

Source: DPH COVID-19 hospital data; includes surge and post-acute beds

Providing safe, high-quality care is job number one. Moving patients efficiently through the healthcare system is a main component of that priority — and it is not being met. Each of the factors already outlined — fewer workers, fewer beds, and sicker patients – lead to the patient backups, longer wait times, and cost challenges that people are experiencing today.

MHA has recommended increased investment in the healthcare workforce to help address these challenges, including at hospitals, post-acute providers, and in the community. Continuing to financially support care that is delivered outside the walls of hospitals is also a priority, including through telehealth, hospital-at-home programs, and mobile integrated health. Many of these programs are still unsustainable without permanent, predictable policies and equitable reimbursement from insurers. More investment is needed to address capacity challenges and therefore must be factored into the healthcare cost benchmark's goals.

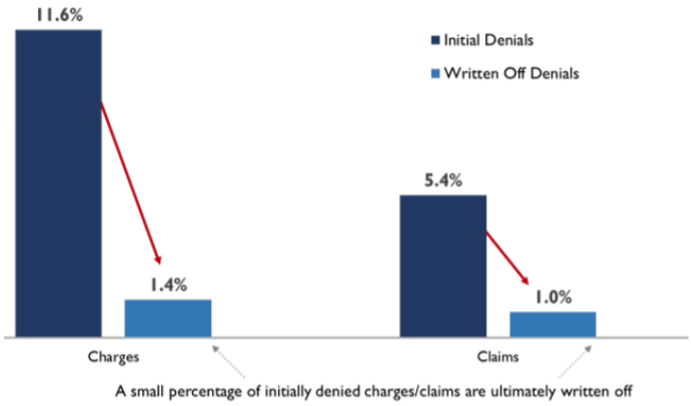
Administrative Burdens

Massachusetts hospitals and physician practices incur as much as $1.75 billion in unnecessary administrative costs from billing- and insurance-related practices each year. Addressing administrative complexity will remove unnecessary expenses in our healthcare system, bend the cost growth trend, and relieve healthcare providers of burdens that cause provider and staff burnout.

Administrative complexity, delays in obtaining prior authorizations, and insurer claims denials are a growing obstacle to timely patient care and the efficient use of healthcare dollars. Prior authorizations are often overturned – but only after they delay care and only after lengthy, time-intensive, and costly reviews. MHA began tracking hospital challenges with prior authorization and the effects of administrative burdens, and our analysis aligns with national findings. In our **November 2023 report** "Better Care, Lower Costs: How Massachusetts Can Lead on Sensible Insurance Reform," MHA found that 80% of initial denials are due to administrative reasons, including prior authorization. The

Percentage of Charges/Claims Initially Denied and Written Off

Hospitals spend significant time, effort, and resources to appeal initially denied charges/claims.



report found that the vast majority of the denials are eventually overturned.

In January, Kaiser Family Foundation (KFF) **published a study** showing a similar experience in the Medicare Advantage program. KFF reported, "Though a small share of prior authorization denials were appealed to Medicare Advantage insurers, most appeals (81.7%) were partially or fully overturned in 2023. That compares to less than one-third (29%) of appeals overturned in traditional Medicare in 2022. These requests represent medical care that was ordered by a healthcare provider and ultimately deemed necessary but was potentially delayed because of the additional step of appealing the initial prior authorization decision. Such delays may have negative effects on a person's health."[11]

MHA appreciates that the HPC has identified administrative complexity as an area of focus, especially in addressing primary care shortages and access challenges. At its February 2025 Advisory Council Meeting, HPC recommended the commonwealth "reduce sources of administrative burden and burnout for primary care clinicians, including actions from the legislature, public and private payers, and health care delivery organizations to reduce the sources of administrative burden and burnout for primary care clinicians."[12] And its 2024 Cost Trend recommendations stated "administrative complexity that does not add value permeates the U.S. health care system. These administrative and operational burdens on providers contribute to burnout, accelerate retirements, and influence provider decisions to pursue mergers, sales, or arrangements with management services organizations. Pursuing opportunities to reduce unnecessary administrative complexity for providers, such as in non-standardized prior authorization protocols, will further reduce the appeal of affiliation with potentially predatory actors."[13]

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. MHA strongly supports solutions to address these issues on behalf of healthcare providers and the people they serve – all while re-directing precious resources back to medical care and bending the cost growth trend.

Uncertainty Regarding Federal Policies

Looking forward, there are significant threats to our healthcare system at the federal level that will put into serious question the funding received from Medicare, Medicaid, and subsidized insurance programs. The House Republican budget resolution calls for $880 billion in spending cuts over the next decade from the Energy and Commerce Committee, where reductions are expected to fall heavily on Medicaid, Medicare, and nutrition programs that dominate the committee's spending jurisdiction. On the table are restrictions to Medicaid eligibility such as workforce requirements, which would result in increased uninsured residents and bad debt for hospitals; reductions in federal matching revenues; and limitations on provider tax spending that have helped states like Massachusetts finance their Medicaid program. And while Medicare beneficiary spending seems to be off the table, Congress is in fact looking at policy that could negatively affect provider reimbursement. This is a monumental unknown that has the potential to affect billions of dollars in healthcare spending in Massachusetts in 2026, posing significant consequences for health coverage, provider stability, and patient affordability – as well as the state's overall economy.

[11] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/
[12] https://masshpc.gov/sites/default/files/2025-02/20250213_AC-Presentation_vFinal.pdf
[13] https://masshpc.gov/sites/default/files/2024_Cost_Trends_Report.pdf

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 "potential gross state product" – 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.**

Each year, the state evaluates a past benchmark and projects forward without ever truly factoring the realities of today's healthcare system into the process. The lingering effects of a global pandemic, workforce shortages, extreme inflation, 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 2026, 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.

Thank you for the opportunity to offer testimony on this matter. If you have any questions or require further information, please do not hesitate to contact MHA's Executive Vice President & General Counsel Michael Sroczynski at (781) 262-6055 or msroczynski@mhalink.org.