MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 Pre-Filed Testimony
PAYERS

As part of the
Annual Health Care
Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2022 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, October 24, 2021**, please electronically submit testimony to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2021, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

You are receiving questions from both the HPC and the Attorney General's Office (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC CONTACT INFORMATION

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

AGO CONTACT INFORMATION

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.

INTRODUCTION

This year marks a milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and unwarranted variation,
- Increased market consolidation and expansion of high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the state's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the past ten years of the Massachusetts health care cost containment effort, and the additional context of ongoing COVID-19 impacts, please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth, promoting affordability, and advancing health equity in future years.

Since 2010, more than 30 state reports, including those by the Health Policy Commission (HPC), have examined health care costs and the key drivers of cost growth in the Commonwealth. All have found that the prices charged by providers remain the most significant factor driving health care costs, accounting for somewhere between 50 and 75% of the total growth in health care spending. Moreover, price variation among providers has a disproportionate impact on health care spending in Massachusetts. As has been documented by state reports, provider prices are not tied to quality of care nor to the health status of the population served. In 2010, the Massachusetts Attorney General summarized her findings on health care cost drivers, saying prices paid to providers are "correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers." We remain concerned that, more than a decade later, the same market leverage dynamics remain or have worsened, putting greater pressure on unit costs. We are further concerned that policy proposals to address price variation have not focused on promoting health care affordability but rather on increasing payment levels for certain hospitals.

The Covid-19 pandemic has put tremendous pressure and strain on the healthcare delivery system. We have seen the impacts of inflation, higher labor costs, staffing shortages, and additional costs relative to the pandemic itself, such as personal protective equipment, Covid treatment and vaccinations. We cannot ignore these challenges; however, we must recognize that they continue to put pressure on unit costs during contract negotiations and will exacerbate the unit cost trends described above.

Our second concern is pharmacy trend, which continues to significantly outpace the state's cost growth benchmark, growing 7.7% net of rebates in 2020, according to CHIA. Inflationary pressures have touched every part of the pharmaceutical industry. For specialty drugs, we have seen the increased utilization of new drugs used to treat conditions where previous treatment was unavailable or ineffective, and the increased utilization of existing drugs that have received additional FDA approval(s) for expanded conditions. As the FDA approval of drugs with orphan drug and breakthrough status has increased, we have seen more specialty drugs with very high launch prices, ranging from $300,000 to $500,000 (e.g., Spinrazza and Exondys-51). For brand-name and generic drugs, manufacturer price increases continue to be a significant driver of trend, particularly given the magnitude and frequency of these changes. In January 2022, during the Covid-19 pandemic, drug manufacturers increased prices for over 800 everyday medications by an average of 5%.

Since 2014, prescription drug prices have risen 33 percent, 20 times faster than the rate of inflation and outpacing price increases for every other health care service. We are deeply concerned about the inflationary pressure that will result from the commercialization of the Covid-19 vaccinations, which is expected to happen early next year. Lastly, we have seen increased and new utilization of drug regimens for chronic disease management such as diabetes, inflammatory disease, and autoimmune diseases. For example, members with diabetes now utilize a cocktail of newly launched brand drugs instead of insulin, which results in increased costs to treat these conditions.

b. Please identify and briefly describe the top strategies your organization is pursuing to address those concerns.

Point32Health has many strategies and programs meant to address unit cost trend, including innovative contracting strategies, improving our analytical and care management capacity, strengthening our payment integrity programs, and guiding care to high-quality, lower cost settings of care. Our primary strategy for addressing unit cost trend remains promoting payment for value and alternative payment methods (APMs), rather than fee-for-service arrangements. Progress has been slowed in this area recently, as the HPC has noted, due to providers seeking greater revenue certainty and lowering their appetite to assume risk. The pandemic has certainly contributed to these conditions. We also must recognize that there are tangible differences among providers, both in the amount of risk assumed through payment arrangements and the ability to manage risk collaboratively, which have had varying results on performance. Moving forward, payers and providers must work to understand, replicate, and expand upon payment models that promote the most effective and efficient means of delivering care. Contracting Strategy: Point32Health always tries to negotiate contract renewals below the annual growth benchmark set by the state. We have value-based models that include more refined care improvement mechanisms, including enhanced contract performance models and menu-based quality (pay-for-performance) programs that give providers the flexibility and support in targeting care improvement that is most meaningful for their patients. In addition, we are focusing efforts on pricing rationality with providers to ensure our contracts are not only competitive in aggregate but also at the service category level. • Analytics & Care Improvement: We use provider analytics and engagement strategies to help providers better identify and capitalize on opportunities to close gaps in care, apply best practices, monitor drug compliance, and more. Specific areas of focus include reducing avoidable emergency room utilization and hospital readmission rates, as well as identifying practice pattern variations among providers. We have also enhanced our strategic insight and decision support tools so that we can work more closely with providers to develop goals based on their individualized data, execute a strategic plan, and monitor success. • Payment Integrity Programs: Point32Health maintains a portfolio of payment integrity programs for providers that reduce waste and support accurate coding and compliance with payment and medical policies. Areas of focus include correct coding initiatives and more robust expectations on appropriate medical record documentation. We also have established a claim-based predictive scoring program that examines claims in real-time, using a variety of analytics to detect and flag coding outliers (for things such as unusual repeat visits, upcoding, incorrect modifier use, unusual

frequency of services, etc.). Our coding analysis and education program analyzes provider coding and conducts outreach to outlying providers, providing education and follow up at regular intervals to track progress. • Lower Cost Settings & Patient Convenience: Point32Health wants to ensure patients receive the right care, in the right setting at the right time. Our tiered and limited network products offer members access to high-quality, lower cost providers and come with both lower member cost sharing at the advantaged tiers and significant premium discounts to our full-network products. We also offer members price-transparency tools so that they can shop for scheduled services and make informed decisions about their care based on cost and quality.

We have pursued many strategies to mitigate pharmacy trend, which are described in more detail below.

• PBM contract strategy: Point32Health will consolidate its PBM for all lines of business under one vendor, effective 1/1/23. With our increased membership and scale, we have been able to negotiate aggressive PBM and specialty pharmacy discounts as part of the agreement. • Lowest Net Cost Preferred: Point32Health selects the lowest net cost strategy for therapeutic classes, inclusive of those with biosimilar availability. Preferred products may be available on a lower tier and may not require clinical prior authorization in some cases. Non-preferred products are generally subject to step therapy requirements, sometimes in conjunction with clinical PA, or may be non-covered. Exceptions for non-preferred products are available for documented previous failure, contraindication, or clinical inappropriateness with a preferred product. • Biosimilar Utilization: Increased adoption of biosimilar products provides additional options and competition where brand manufacturers have little competition. As early as January 2023, we anticipate the launch of biosimilars to compete with Humira, a high-cost highly utilized drug to treat inflammatory conditions. Pending biosimilar launch, pricing will be evaluated against rebated brand Humira to determine which strategy will be more effective in mitigating drug trend in this category. • Utilization Management, Dose optimization, and Reducing Drug Wastage: We employ utilization management programs that ensure use is appropriate. For inflammatory disease conditions, we are moving toward indications-based preferred product and coverage criteria strategies. This will help manage trend for the various drugs used to treat the multiple diseases within the inflammatory disease category. • Channel management: We make efforts to steer utilization to the most cost-effective setting as appropriate. This includes the use of limited retail pharmacy networks where steeper discounts are leveraged through increased market share • Care coordination: Strong clinical management, including prescription adherence and side effect management, are highly effective in managing total cost of care. • Risk arrangements: Providers who bear pharmacy risk are very aware of preferred formulary options and have a higher rate of formulary adherence and compliance when prescribing. We ensure provider contracts contain pharmacy risk provisions that promote high quality, cost effective and rationale prescribing.

c. Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including

specific metrics and results. Please also describe other specific activities your organization has undertaken to advance health equity.

Point32Health regularly collects member race, ethnicity, and language (REL) data. REL data is collected through several systems ranging from self-disclosed member portals to enrollment. Point32Health uses standardized methods to collect REL data, and electronic systems can receive, store, and retrieve member-level data on race, ethnicity, and language. Point32Health has continued efforts over the past year to collect demographic data intended to support measurement and goal setting to identify disparities, address social risk factors, and work toward dismantling systemic and structural barriers that generate bias or discrimination. We seek to advance work done during the last four years by each of our heritage organizations (Tufts Health Plan and Harvard Pilgrim Health Care) to incorporate data on social determinants of health (SDOH), REL, behavioral health, and burden of disease into our population health analytics, care management identification algorithms, and analytic support for provider partners and our own care management programs. The analytics team has constructed an Enterprise Segmentation and Stratification (ESS) process that includes a monthly snapshot of every active member. The profile includes a comprehensive view of the needs of the member across medical, behavioral health, demographic information, provider, utilization metrics, and SDOH. SDOH data is aggregated from Heath Needs Assessments (HNAs), Z-codes documented by health care providers, as well information from care management and utilization management interactions. SDOH data is included in the ESS algorithms that support the prioritization of members for outreach from care management teams. SDOH information from these sources are bucketed into categories of: Economic and Housing instability, Health Literacy, and Access Limitations. Most recently, Point32Health expanded efforts to use member REL data to complete an analysis of the capacity of the network to meet the language needs of members as well as an analysis of the capacity of the network to meet the needs of members for culturally-appropriate care. The analysis reports on practitioner capabilities and whether the language and cultural needs of our membership are sufficiently met. Furthermore, Point32Health has a documented process for determining gaps that exist between the network's capacity and member needs, and is actively implementing and planning actions to address the identified cultural and linguistic gaps. This analysis has increased our understanding of the communities we serve, allowing for more personalized solutions that empower healthier living by meeting members' cultural needs. The expansion of data usage has initiated early development of health equity programs which will augment existing programs and allow Point32Health to inform culturally oriented health interventions and address social services needs that are necessary to achieve equitable outcomes for the diverse communities we serve.

Currently, several key initiatives are underway focused on health equity to improve the understanding of our membership and our ability to support them. These efforts are focused in three core areas. First, census-based geospatial data has been incorporated to augment self-reported and provider-reported SDOH data. The Area Deprivation Index has been included to provide census block level data to understand the neighborhood characteristics of members and provide a geospatial view of members at a more granular level than zip

code alone. Concurrently, Point32Health is working to create a Social Inequality Index to incorporate all the SDOH information available to better understand the characteristics of the population, and specific needs of each member. Second, a Member Care Dashboard is in the deployment phase to provide an organization-wide view of member information at-a-glance. The dashboard provides information on recent utilization, demographics, provider information, ESS stratification, SDOH, REL, care management and utilization management activities, and appeals and grievances data. The dashboard is designed to make REL and SDOH more readily available, and thus more actionable. Finally, improved criteria to identify members for care management outreach are being developed to improve the identification of members with SDOH needs. In January 2022, Point32Health embarked on the process of seeking NCQA Health Equity accreditation, and a comprehensive IT assessment was initiated. The assessment analyzed the collection, storage and reporting of member race/ethnicity, language, gender identity and sexual orientation data, as well as provider race/ethnicity and language data. Understanding the collection of this information about our members and providers will not only facilitate the accreditation but also serve as a foundation to support the development of targeted clinical programs and offerings for our members. The IT assessment revealed that although most of the collection systems have a sex field, additional work was needed to meet NCQA Health Equity standards. The following fields are being added and/or revised: • Birth Sex/Sex Assigned at Birth • Gender Identity • Sexual Orientation • Preferred Pronouns. Following the assessment, we have: 1. Identified and documented any data gaps that are required for the accreditation and beyond 2. Identified and recommended any system updates that need to be completed to remedy gaps in collection/storage/analysis of data 3. Created the needed measurements and documents to submit during the accreditation survey. We are actively working on implementation of the collection, storage, and reporting on member Sexual Orientation and Gender Identity (SOGI) data as well as increased standardization on provider race/ethnicity data. Point32Health's goal is to collect comprehensive data about race/ethnicity, preferred language, gender identity and sexual orientation, which will ultimately help us provide healthcare services that align with members identity and preferences. The goal is to use the information to design programs that will decrease health inequities and provide culturally sensitive materials and services. Additional health equity efforts have been underway across the organization from an operational perspective. We have developed a Health Equity Steering Committee to guide and steer the health equity areas of focus. Over 70 health equity initiatives have been identified and span areas such as Maternal Health, Vaccine Access, Food Insecurity and Health Literacy.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

In its 2022 Cost Trends Report, the Health Policy Commission has outlined a series of recommendations to address the cost drivers in the Commonwealth. Point32Health shares the HPC's vision of creating a more affordable health care system for the residents of the Commonwealth and our members. Critical in this context is the fact that more 90 percent of every health insurance premium dollar collected in Massachusetts is spent on direct medical care for members. A series of existing regulatory requirements ensure that any future

reduction in health care costs is passed on to individuals and employers who purchase insurance. These include both federal and state medical loss ratio requirements; rigorous annual rate review and approval by the Division of Insurance; and statutory limits on health plan contributions to reserves. No other part of the health care system has similar checks. We recognize that greater accountability on health plans for controlling costs is among the HPC recommendations. We stand ready to meet this challenge not only because we are required to do so but also because it is the right thing to do for our members and customers. However, to achieve these goals, it is paramount that the HPC recommendations are taken in their totality and work together. Only by addressing the underlying costs of care that are driving health care spending will we achieve greater affordability. To that end, the HPC's recommendations to target above benchmark spending and constrain excessive provider and pharmaceutical pricing are critically important. We support expanding the Performance Improvement Plan (PIP) process to give the HPC more authority to review spending above the cost growth benchmark and, moreover, to examine new areas of the delivery system. Specifically, CHIA should be able to report on, and the HPC should be able to monitor, total medical expense trends at hospitals and how they impact overall health care spending in the Commonwealth. We believe that, in order to make investments in behavioral health, health equity and community care while promoting affordability, the Commonwealth should consider policy solutions that meaningfully address provider price variation and limit facility fees. Nearly any state action to bring additional transparency to the pharmacy value chain and limit pharmacy trend would be welcomed. We believe a foundational start is including pharmaceutical manufacturers and PBMs in the existing Cost Trends Hearings process and requiring actors in this space to testify at the hearing. The state should monitor and report on drug prices, drug rebates and drug price increases, particularly for some subset of drugs that are most contributing to overall spending or that are seeing the largest price increases. We supported Governor Baker's proposal to hold manufacturers accountable for price increases above a certain benchmark (like the Consumer Price Increase). We also support concepts that rationalize drug pricing to some concept of value rather than market power exclusivity that predominates now.

We have further outlined a series of recommendation below that could improve health equity. We believe standardization of data collection and data sharing is foundational to any efforts in this area. Specifically, the state should consider: standardization of REL, SOGI and disability inquires across government entities, allowing for consistency and ease of sharing of data; the standardization of sharing of the REL, SOGI and disability data from governmental agencies to payers and providers; the standardization of sharing of REL, SOGI and disability data from providers and all facility types to payers. For example, the state could develop a standardized demographic fact sheet that could be submitted with claims and prior authorization requests. Payers and providers should also work to develop incentives for providers to submit Z-codes (SDOH codes) with claims. With respect to maternal health, recommendations regarding data collection would include: providing incentives for acute care inpatient facilities to submit Z-codes from emergency department visits and admissions of any female in the reproductive age range (ages 11-45). Improved pre-conception health will improve maternal outcomes. Facilities should also submit medical and psychiatric diagnostic codes that may identify the members/patients at risk of

developing maternal complications in any female in the reproductive age range. Medical and psychiatric conditions could identify the member as being at risk of having higher risk pregnancy in the future (e.g. tobacco use, obesity, hypertension). Payers and providers should work toward creating incentives for primary care providers and specialty providers to create outpatient workflows to submit Z-codes and medical and psychiatric diagnostic codes that may identify the members/patients at risk of developing maternal complications in any female in the reproductive age range. The submission of the Z-codes, medical and psychiatric diagnostic codes and discharge claims can help identify members who are at risk and/or who would benefit from acute and other long-term interventions, pre-pregnancy, antepartum, post-partum and the interval to the subsequent pregnancy. These might include outreach to members and providers based on SDOH needs of the member, care management to provide support for members with high-risk medical conditions and/or SDOH needs (e.g. glucose tolerance testing six weeks postpartum for member with gestational diabetes, post-partum depression screens and support) and other opportunities for pre-pregnancy programs (e.g. weight management, smoking cessation).

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

a. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2018 to 2021 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2018 to 2021, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., unit cost, utilization, provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

On average, the aging of the population adds about 1% to 2% to trend annually, while the health status of the population increased by 3% to 6% per year (including demographics changes), depending upon the line of business (e.g., Medicare, Medicaid, commercial). Please note that for 2020, the risk coding has been suppressed due to the pandemic. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. Point32Health has observed a similar rate of benefit buy down in each year over this time period.

b. Reflecting on current medical expenditure trends your organization is observing in 2022 to date, which trend or contributing factor is most concerning or challenging?

Of most concern are pharmacy cost trends, the impact of inflation on medical costs and the unknown and ongoing costs related to the COVID-19 pandemic. Many of these are discussed in testimony above.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available "price transparency tool." In the table below, please provide available data regarding the number of individuals that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2020-2022			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2020	Q1	3110	122
	Q2	1736	40
	Q3	3570	39
	Q4	4260	84
CY2021	Q1	4254	96
	Q2	4006	83
	Q3	3740	63
	Q4	3690	89
CY2022	Q1	4690	74
	Q2	3944	71
	TOTAL:	37,000	761

- Data is aggregated across Point32Health entities

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Service Mix	Total
CY 2018	1.7%	1.3%	0.9%	3.9%
CY 2019	3.0%	2.2%	1.7%	7.0%
CY 2020	0.9%	-7.7%	0.5%	-6.3%
CY 2021	0.3%	21.2%	-4.2%	16.6%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed Total Allowed Medical Expenditure Trend by Year

THP Commercial fully insured and self-insured product lines [6]

Year	Unit Cost	Utilization	Mix	Total
CY 2018	2.6%	1.9%	-0.9%	3.7%
CY 2019	0.8%	3.5%	-0.2%	4.1%
CY 2020	3.0%	-6.3%	0.0%	-3.4%
CY 2021	1.8%	19.0%	-4.7%	15.5%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees,
5. The impact from non-claims items are in unit cost. Rx rebates are inlcuded in the pharmacy trend
6. All years submitted above include both fully insured and self-insured business.

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines, Tufts Helath Public Plans Direct only

Year	Unit Cost	Utilization	Service Mix	Total
CY 2018	1.6%	5.0%	0.5%	7.2%
CY 2019	0.6%	2.4%	3.5%	6.7%
CY 2020	4.6%	-3.2%	-0.9%	0.3%
CY 2021	3.6%	14.5%	2.0%	21.0%

Note: Provider and Service mix trends are all included in the Service mix column

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.