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October 30, 2025

**Via Email:** HPC-Testimony@mass.gov

Lois Johnson, General Counsel  
Massachusetts Health Policy Commission  
50 Milk Street, 8th Floor  
Boston, MA 02109

Re: HPC 2025 Cost Trends Hearing, Pre-Filed Testimony

Dear Ms. Johnson:

Attached please find:

1. Responses to pre-filed testimony questions; and
2. Completed HPC Payer Exhibit.

Under the penalties of perjury, I verify to the best of my knowledge and belief that the submitted information is true and correct.

Sincerely,

A handwritten signature in black ink that reads "Jason H. Tompkins". The signature is written in a cursive style.

Jason Tompkins  
President, Northeast Region  
Aetna, a CVS Health Company

**2025 Pre-Filed Testimony  
PAYERS**



**As part of the  
*Annual Health Care  
Cost Trends Hearing***

Massachusetts Health Policy Commission  
50 Milk Street, 8<sup>th</sup> Floor  
Boston, MA 02109

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## INSTRUCTIONS FOR WRITTEN TESTIMONY

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If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the [2024 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document to: [HPC-Testimony@mass.gov](mailto: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 2024, 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. All submissions are public record and will be posted to the [HPC's website](#).

You may receive questions from both the HPC and the Office of the Attorney General (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 relevant 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](mailto:HPC-Testimony@mass.gov) or  
[lois.johnson@mass.gov](mailto: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](mailto:sandra.wolitzky@mass.gov)  
or (617) 963-2021.

## THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

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The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), and residents paying \$5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants.

In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark](#) and the status of public and industry-led health care policy reform efforts.

## QUESTIONS FROM THE HEALTH POLICY COMMISSION

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1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on members and purchasers, coverage and access to care, providers, in addition to premiums and out-of-pocket costs? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

Recent federal actions, whether legislative or regulatory, have little direct impact on commercial insurance products. However, the changes to publicly funded programs, and Medicaid in particular, may have significant secondary impacts on commercial insurers and employer-purchasers. Changes to Medicaid provider taxes and state-directed payments will significantly impact state budgets and Medicaid-related provider funding. We anticipate this will create new cost shifting pressures on commercial purchasers as providers look to make up reimbursement elsewhere, and states look to mitigate lost federal revenue. The changes to Medicaid eligibility may also decrease Medicaid enrollment and increase uncompensated care pressure on providers, thereby exacerbating the revenue issues already mentioned.

To mitigate the potential cost shift onto commercial purchasers, Aetna is already talking to providers about future reimbursement to ensure lost Medicaid-related revenue is not simply passed onto commercial insurers. Payers and providers will need to double down on value-based contracting to ensure aligned incentives. At the same time, payers recognize the pressures that providers are under, and we're exploring contracting and reimbursement levels that ensure continued affordable access for Aetna's members.

Regarding potential policy safeguards, we encourage the state to avoid steep one-time changes to Medicaid-related reimbursement policies and instead the state could consider long term strategies. These strategies could include full-risk value-based contracts with large hospital systems in managed care programs, a sliding scale of VBC options for Medicaid providers that meet them where they are, and thoughtful

technological regulations that ensure federal interoperability rules can be fully implemented across all insurance segments.

Finally, we recognize that there is pending debate about whether the enhanced Advanced Premium Tax Credits (eAPTC) will expire at the end of the year. While Aetna is not in the individual market in Massachusetts, we agree with the numerous reports that suggest individual market premiums will go up significantly if the eAPTC is not renewed or extended. This additional federal change will exacerbate the issues outlined above even further by reducing the number of commercially insured, reducing commercial-based provider reimbursement, and increasing uncompensated care for facilities.

2. Many Massachusetts health care providers continue to face significant workforce challenges. What policy, payment, or health care system reforms does your organization recommend to better sustain, strengthen, and diversify the health care workforce in Massachusetts?

Aetna recognizes the ongoing and significant workforce challenges facing health care providers across Massachusetts. We are committed to supporting policies and reforms that promote a sustainable, diverse, and resilient health care workforce, while allocating resources effectively to achieve those goals.

#### Scope of Practice

Massachusetts has an opportunity to modernize the scope of practice laws to better utilize nurse practitioners, physician assistants, and other advanced practice clinicians. These professionals are essential to delivering high-value, team-based care. By allowing qualified non-physician providers to practice to the full extent of their training, states can alleviate bottlenecks in care delivery and reduce wait times for patients. These changes also help mitigate provider burnout by distributing workload more effectively across the care team. Expanded scope of practice also enables health plans to implement payment models that recognize the efficiency and quality of care delivered by these clinicians.

#### Accelerate Growth Telehealth Models

Telehealth remains a strategic solution to workforce challenges and growing patient demand. Aetna supports embedding virtual-first care into primary, urgent, and behavioral health workflows. These models allow for timely screening, triage, and follow-up, while offering clinicians greater flexibility. Aligning these models with value-based arrangements ensures improved access and continuity for patients across diverse provider settings without compromising quality.

### Require Interoperable Electronic Health Records with Payer Integration

To reduce administrative burden and improve care coordination, Massachusetts should require interoperable EHR systems that allow seamless data exchange across providers and with health plans. Real-time access to standardized data supports efficient prior authorization, quality measurement, and care management — freeing up clinician time and improving patient outcomes. By investing in interoperable systems, stakeholders can enhance efficiency, reduce stress on providers, and improve overall healthcare delivery.

### Promote Payment and Equitable Provider Reimbursement Reform

Aetna is advancing payment reforms that promote long-term system sustainability. We maintain broad, accessible provider networks that ensure timely access to care for our members. Aetna's reimbursement models are fair, equitable, and consistent, allowing providers the flexibility to allocate resources in ways that sustain their practices and support workforce development.

### Support Right-Sized Resource Allocation

We advocate for reforms that ensure care is delivered in the most appropriate setting — particularly by strengthening primary care. Properly aligning resources with patient needs help reduce provider burnout, improves care coordination, and enables clinicians to practice at the top of their license.

Aetna is committed to engaging in dialogue that promotes a diverse, well-trained workforce. We support efforts to improve retention and ensure equitable opportunities across all communities, with mindful allocation of resources that reflect the needs of Massachusetts' evolving health care landscape.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What are the most meaningful steps you are taking to reduce administrative complexity that provides little value to patient care? What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs and the administrative costs of providing care borne by providers and others?

Aetna is at the forefront of changing utilization management, especially prior authorization, that will reduce administrative burden for providers and make care simpler for all Aetna members. Aetna has voluntarily agreed to six key changes to our prior authorization processes over the next two years, including:

- standardizing electronic prior authorization and fully implementing federal interoperability requirements for all segments
- reducing the number of services that require prior authorization.
- ensuring continuity of care by recognizing other payers' authorizations
- enhancing member and provider communications regarding authorization timelines and decisions
- expanding the number of approvals that will be provided in real-time upon submission, and
- ensuring human-led clinical decision making in all non-approval decisions.

In addition to the six commitments listed above, Aetna is also leading the industry in efforts to bundle authorization requirements for courses of treatment that previously required multiple prior authorization submissions. Collectively, and especially when interoperability standards are fully implemented, these changes will significantly reduce administrative complexity for providers, and we do not expect any of the changes to add costs to our own administrative systems after initial technological investments are made.

When considering public policy strategy, it is important that the state allows voluntary innovation to move forward without regulatory constraints, which will negate the positive impacts. For example, interoperability and streamlining the number of services needing prior authorization will significantly reduce administrative costs for providers and payers alike and lead to more real time approvals. However, if the state were to adopt prior authorization turnaround times that are exceedingly fast, it would force payers to either increase administrative costs by hiring significantly more staff to speed up internal processes or to increase overall costs by allowing for default approvals under unsustainable turnaround time standards.

This example is illustrative of legislation that many states have introduced, contributing to increased costs instead of innovation through interoperability and efficiency.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. What specific actions or investments is your organization pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your members? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms do your organization recommend to enhance equitable access to high-quality primary care services?

Aetna takes its role in controlling health care costs seriously, promoting affordability, and advancing health equity for its members and all residents of the Commonwealth. Aetna understands that preventative care and access to primary care is critical to the well-being of our members. We recognize the financial pressure that rising health care costs place on employers and employees, and the impact that such costs have on access to care. Driven by data, clinical insights, and a deep understanding of the health care environment, Aetna strives to create solutions to help our members improve health care outcomes and lower costs. As part of these solutions, Aetna employs strategies to address cost growth trends and to advance health equity. Aetna has committed to these ongoing efforts to further these initiatives:

Reducing Administrative Burdens: Aetna is committed to improving the member and provider experience with technological investments and operational advancements aimed at enhancing quality care and addressing areas of frustration and inefficiency experienced by providers and members. We are innovating to support and serve our members at every stage of their health. One example of this advancement is Aetna's bundled approach to select prior authorization processes.

Aetna is launching several actions to streamline prior authorization processes and approvals. The first action is that we are "bundling" prior authorization codes to help eliminate the need for multiple requests for individual services and create clinical value for patients. The bundles streamline the prior authorization request process by consolidating multiple requests into one, reducing administrative tasks for providers and creating a simplified experience for members. For example, a patient undergoing breast cancer treatment might require multiple high-tech imaging scans. With our bundled approach, they will receive a single authorization for a series of sequential imaging procedures.

AI Solutions to Decrease Administrative Tasks: Aetna is leading the way in reducing administrative burdens through strategic investments in AI automation and innovation. By leveraging advanced artificial intelligence, Aetna automates claims processing for approvals, streamlines prior authorization workflows, and enhances provider data management—freeing up valuable provider capacity to focus on patient care. Aetna never utilizes artificial intelligence to make clinical determinations in any denial, whether it be prior authorization or claims payments. Adverse decisions based on medical necessity are only made by licensed healthcare professionals. Generative AI tools support nurse care managers with case preparation and documentation, reducing time spent on administrative tasks driving greater member engagement and savings. Additionally, Aetna's AI-powered provider search tool, Smart Compare, utilizes predictive analytics to guide members to high-quality, cost-effective providers, supporting both self-service and clinical referrals. These initiatives

underscore Aetna's commitment to improving efficiency, accessibility, and quality of care for all members across Massachusetts.

Expanding Access and Alternative Sites of Care: To better meet the needs of our members, we have significantly expanded access to mental health services. For example, our behavioral health network in Massachusetts grew by more than fifty percent from 2022 to 2023, and we are already seeing the positive impact of this expansion in improved access and support for our members seeking behavioral health care. Through innovative product design, we lower costs for emergent care by promoting alternative sites such as telehealth, advanced primary care networks, and over 180 in-network, low-cost care options across Massachusetts. These alternatives offer members timely, affordable, and high-quality care outside of traditional emergency departments. CVS Health Virtual Care and MinuteClinic provide members with 24/7 access to virtual primary care and behavioral health services nationwide, offering \$0 cost-sharing for those who are eligible. Telehealth services are seamlessly integrated with in-person care, ensuring timely access to support, particularly for mental health needs and chronic condition management. For Aetna members, virtual care is available in all 50 states through CVS Virtual Care or CVS Virtual Primary Care, expanding the reach and convenience of high-quality, person-centered care.

Enhancing Provider Relationships: Aetna is committed to continuing to build its important relationships with providers. As part of this effort, Aetna has established Performance Improvement Programs, which provide payments based on achieving quality outcomes, key components in mitigating rising health care cost trends.

Tracking impacts of Initiatives: Aetna tracks its investments and innovations in healthcare improvement and reform for our enterprise, providers, and members by driving quality and efficiency through alternate payment models, using value-based arrangements and data-driven metrics to monitor outcomes, cost savings, and enhanced care delivery across our network. We assess a variety of performance indicators—including clinical quality measures, patient satisfaction scores, provider engagement, and financial impact—to ensure our initiatives are effectively advancing high-quality, and equitable care for all stakeholders.

Policy Reform: Our organization recommends reducing administrative and regulatory burdens on healthcare constituents and prioritizing regulatory efforts that directly improve care delivery. We advocate for primary care payment reform by supporting policies that expand value-based payment models, such as capitation and shared risk, to incentivize both quality and access. Additionally, we promote regulatory

flexibility for advanced practice providers (APPs), pharmacists, and other clinicians, enabling them to practice at the top of their license and thereby expanding care capacity and access. To further enhance equitable access, and cross-state licensure, ensuring sustained availability of virtual care. Finally, we encourage the adoption of AI and digital tools to streamline administrative processes, improve provider experience, and facilitate effective care navigation.

5. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state's health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents. Please describe the current and anticipated pharmaceutical trends (and detail the potential impact on health care spending) in the next three to five years, including but not limited to information about anticipated trends in utilization, new medications and therapies, and price increases for brand name and generic drugs. What specific actions is your organization taking to address these trends and to balance patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and members?

Aetna enjoys best-in-class drug trends thanks to the work of our integrated PBM, CVS Caremark ("Caremark"). However, current, and future pharmaceutical trends are still significant cost drivers. This will not change as new drugs come onto the market at record high prices and brand drug manufacturers continue to increase prices at a pace well above inflation. In partnership with Caremark, we are tackling pharmaceutical cost issues on all fronts, some of which include:

#### Innovation and Transparency

We are committed to transparency by adopting the industry-leading model, TrueCost, introduced by Caremark to reshape the future of drug pricing. TrueCost is a transparent, cost-based model showing clients how much we pay and reimburse for every drug. It is more transparent for clients, more predictable for members, and more reliable for pharmacies. We have seen increased prescription pickup rates and more stable pricing at the pharmacy counter. TrueCost not only improves transparency but also access and affordability.

Additionally, we are leveraging resources provided by Caremark to give employers the reports, dashboards, and insights they need to make the best decisions on how to spend their health care dollars, including regular, detailed updates on spend, utilization, and claims. We also recognize that members who understand how

their benefits work make more informed health care decisions. That's why we've promoted member-facing digital tools created to enhance their experience – promoting medication adherence, empowering them to take control of their health care, and providing transparency into costs.

### Biosimilars

Aetna has partnered with our PBM, Caremark, to drive the adoption of biosimilars, deliver lower costs at the pharmacy counter and get these drugs to the people who need them. Last year, we dropped Humira (brand) from our major template formularies, instead covering (and preferring) biosimilar versions, resulting in a thriving marketplace. Since making these changes, members are paying lower costs, in most cases \$0 out-of-pocket cost, and we are driving savings for our customers compared to the original brand product. The continued partnership with our PBM to increase the use of biosimilars that come to market will continue to be an important strategy in reducing prescription drug costs moving forward.

To this end, we urge regulators to maintain flexibility for insurers to work with their PBMs to determine the best path forward to achieving those goals. Flexibility in offerings is important to promote competition, innovation, and transparency, allowing the ability to design benefits that suit the needs of our clients and members.

6. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

We fully agree that underlying costs are driving insurance premiums higher, and Aetna is doing everything it can to mitigate and lower costs as discussed in multiple answers above. This includes pushing for more value-based contracting, heavily investing in technological solutions like interoperability, and relying on integrated partners like Caremark to mitigate drug costs. While those big-picture efforts will mitigate escalating costs, we also have more tactical approaches to help individuals access care affordably. As an insurer and benefits administrator, our biggest contribution will always be ensuring our members have access to the right care at the right cost. This includes emphasizing primary care and preventive services. Our plan

designs ensure low or no cost sharing for key primary care services, robust first dollar coverage for all recommended preventive services and vaccines, and no-cost virtual services to eliminate access hurdles. We are also embedding clinical staff with key network allies to help coordinate care for our most high-risk members, thereby improving outcomes and avoiding unnecessary costs.

## TRENDS IN MEDICAL EXPENDITURES

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1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2021 to 2024 according to the format and parameters provided as **HPC Payer Exhibit** (attached) with all applicable fields completed. Please explain the portion of actual observed allowed claims trends that are due to (a) changing demographics of your population; (b) benefit buy down; and/or (c) change in health status/risk scores of your population for each year. 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.

Please see HPC Payer Exhibit 1

2. Reflecting on current medical expenditure trends your organization has been observing in 2025 to date, which trend or contributing factor is most concerning or challenging?

In 2025, Aetna continues to navigate a challenging landscape of medical expenditure trends that are higher than historical averages. One contributing factor is rising hospital costs that get passed down to the health plan through provider contracting. Elevated healthcare and hospital expenditure indices, along with wage increases, indicate that hospital systems are still burdened by rising operational costs. Ongoing labor shortages and inflation in the costs of supplies and goods are expected to keep inflation high, offering little operational relief for hospitals in the foreseeable future. Complicating the picture are broader economic influences, including tariffs and the downstream impact of proposed changes to Medicare and Medicaid. The confluence of these key factors create uncertainty in financial planning and continue to keep our expectations of medical trend high into the near future.

**QUESTIONS 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 who sought this information.

<b>Health Care Service Price Inquiries                      Calendar Years (CY) 2023-2025</b>		
Year	Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2023	Q1	10,654
	Q2	7,677
	Q3	7,721
	Q4	8,785
CY2024	Q1	3,770
	Q2	2,802
	Q3	2,704
	Q4	2,971
CY2025	Q1	4,000
	Q2	3,619
<b>TOTAL:</b>	<b>54,705</b>	<b>3,548</b>

## HPC Payer Exhibit 1

*\*\*All cells should be completed by carrier\*\**

### Actual Observed Total Allowed Medical Expenditure Trend by Year

- Includes both fully-insured and self-insured Commercial product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2021	4.8%	24.9%	-3.7%	-4.1%	20.9%
CY 2022	4.0%	-5.3%	-2.8%	8.0%	3.4%
CY 2023	5.3%	0.3%	0.5%	0.7%	7.0%
CY 2024	5.5%	2.8%	1.2%	0.6%	10.5%

- a. The effect of changes in demographics on trend is contained within Utilization and Service Mix. As members age, utilization and intensity of services vary according to gender, age, and other demographic factors.
- b. The effect of benefit buy downs on trend is contained within Unit Cost and Utilization. Benefit buy downs impact Unit Cost trends because members are incented to see lower-cost providers and sites of service. Benefit buy downs also impact Utilization because as members pay an increased share of total spend, unnecessary utilization decreases.
- c. The effect of changes in health status on trend is similar to and difficult to differentiate from changes in demographics. As health status for the population changes, so will all of the categories of trend. In a block of declining health status, Costs and Utilization increase and drive increases in Provider Mix and Service Mix

#### 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.