MASSACHUSETTS
HEALTH POLICY COMMISSION

2025 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 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. 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 or lois.johnson@mass.gov.

AGO CONTACT INFORMATION

For any inquiries regarding AGO questions, please contact:
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THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

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

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?

The landscape of healthcare in Massachusetts is more disrupted right now than it has ever been. In addition to ongoing issues with affordability, the federal disruption is creating both policy, coverage, and funding uncertainty that are going to weigh heavily going forward. The affordability of both the Medicaid program and the Connector insurance is the top concern of HNE at this time. State efforts to shield members from costs and to maintain a rich benefits will continue to shift costs to commercial plans and drive up premiums. The risks of lower federal funding and its impact on the Commonwealth cannot be overstated. The Commonwealth needs to prioritize healthcare which has the highest value and the greatest impact across the population to truly improve the health of the population. Giving rich benefits to some individuals while expecting others to shoulder the increasingly impossible cost of care does not lead to an over-all healthier population or workforce. The western part of the Commonwealth continues to be challenged in a number of areas but we have provided high quality and high value care due to pricing differentials with the east as well a push to value across the region. We are working with our provider partner to continue to maximize value and to improve access, which remains a serious challenge. Despite this, we remain impacted by the income and wealth disparities of the western region. Also, the disproportionately expensive care from the eastern medical centers continues to drive our costs, as academic medical centers raise prices. Without a Commonwealth-wide effort, costs will continue to rise and the cost-shift will become even more unsustainable.
Mandated care within the Commonwealth is also already driving significant cost in the

marketplace, and this will continue, even as some of this care is neither best practice nor evidence based. The rich benefit of the Commonwealth will continue to impact affordability. We will adjust our benefits as possible for the highest value, but the Commonwealth mandates hamper our ability to drive to true value. Considering the option of a less-rich benefit for those who would prefer this will improve affordability. Specific Actions the Market, Policymakers, and the Public Should Consider•

Safeguard coverage continuity. With the imposition of federal work requirements and stricter eligibility parameters, policymakers should adopt a comprehensive, multi-prong strategy to ease the administrative burden of these new requirements. This approach should include: 1) establishing clearly defined, narrowly tailored work requirement parameters to limit unnecessary disenrollment; 2) developing a standardized suite of communication materials for use by payers, providers, advocacy organizations, and legislators to promote consistent messaging and reduce consumer confusion; 3) implementing uniform redetermination and navigation supports, such as multilingual outreach, structured 30/60/90 day follow-ups, presumptive eligibility for high-need populations where possible, and good-cause reinstatements to reduce avoidable coverage losses; and 4) Ensuring EOHHS and HPC monitor coverage continuity and churn over time, rather than relying solely on point-in-time measures of enrollment.

• Shore up Health Safety Net spending. MassHealth is revising the Health Safety Net Trust Fund (HSNTF) regulations to curb spending and ensure resources go to the hospitals and patients that need them most. By tightening the definition of Disproportionate Share Hospital (DSH), which currently allows even the state's wealthiest hospitals to qualify, the state can improve accountability and target funding more effectively. With more residents losing Medicaid or Connector coverage due to immigration status or affordability, it is essential that every HSNTF dollar is used efficiently to support true safety-net care and prevent further strain on the system.•

Advance affordability reforms by: a. Establishing a moratorium on new coverage mandates, legislation, and regulation that would increase health care premiums until the Commonwealth can demonstrate adherence to the cost growth benchmark. The continued passage of new legislative mandates is exacerbating affordability challenges. With seven new mandates adding nearly $1 billion in spending and hundreds more under consideration, the Commonwealth must first bring existing costs under control. Affordability cannot improve if new unfunded mandates continue to outpace the state's own benchmark goals. b. Promoting coding integrity and payment accuracy. Implement audits and offsets for unexplained growth in coding intensity and severity inflation, consistent with the HPC's findings and MedPAC methodology, to prevent budget leakage.

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?

Health New England recognizes the critical role that health care institutions—including health plans—play in sustaining and strengthening the health care workforce across the Commonwealth. Our approach is rooted in equity, innovation, and whole-person support, and we offer the following recommendations based on our organizational practices and strategic priorities. Educational Partnerships and Workforce Development: We recommend expanding partnerships between health care organizations, academic medical institutions, and local colleges and universities to create robust pipelines into health care careers. Health New England actively supports workforce development through educational reimbursement programs available to all associates, enabling continuous learning and career advancement. Provide equitable access to professional development programs, including mentorship, leadership training, and skill-building workshops, all essential competencies for today's healthcare workforce. Policy Review to Remove Barriers: We regularly review internal policies and procedures to identify and eliminate barriers to workforce participation. Whole-Person Well-Being Through Benefits: Health New England offers benefits that support physical, mental, social, and financial well-being. These programs are designed to help associates lead full and healthy lives while maintaining work/life balance – key to long-term workforce retention and satisfaction. Engagement and Collaboration: We foster a culture of collaboration through engagement programs that connect teams across departments. These initiatives strengthen organizational cohesion and support a shared commitment to health equity and community impact. Future-Ready Workforce Through Technology: Innovation is central to a future-ready workforce strategy. As health care organizations explore emerging tools and digital innovations, we recommend training the workforce in essential competencies in order to build a workforce that is equipped to serve our communities in a rapidly evolving health care environment. System-wide Transformation and Payvider Strategy: As a unified healthcare system evolving toward a payvider model, Health New England and Baystate Health are committed to building a workforce that is agile, data-driven, and aligned with system-wide goals for care delivery. Where possible, we recommend health systems collectively engage in cross-functional workforce planning models that allow for alignment across clinical, operational and financial goals and priorities. These initiatives not only address current workforce challenges but also lay the foundation for a sustainable and inclusive health care system in Massachusetts. Health New England remains committed to advancing policies and practices that support the well-being and professional growth of all health care workers

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?

Administrative burden remains an area of concern but reduction must also not drive up costs, as these are also unsustainable. Administrative complexity is a byproduct of attempts to reduce cost. To successfully reduce administrative complexity, we must address the underlying etiology of it's existence. Value-based contracts which allow the providers to take upside and down-side risk on the cost of care can negate the need for prior authorization. Providers have been reluctant to partner with payers on these contracts, but this is the best way to assure quality while not driving costs and still lowering administrative burden. Streamlining prior authorization is often discussed, but the IT costs of a truly automated system are significant both for payers and for providers. This is a very complicated process. Electronic portals have done some to help, and gold-carding programs are another initiative which we are working on with our provider partner, however, full scale reduction in administrative burden requires meaningful provider risk for the total cost of care. Like other payers, we have implemented a payer portal with an electronic prior authorization platform that automate approvals for routine services, reducing paperwork for providers and accelerating patient access to care. Like others in the Commonwealth, we have aligned documentation protocols with state and federal guidelines, minimizing redundant requests and clarifying expectations. Interoperable digital platforms remain a goal at the level of the Commonwealth, but the expense and variability of these platforms remains an inhibitor. A standardized prior authorization platform or hub for the Commonwealth may be a way to lower variability and to improve interoperability for automated PA.

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 does your organization recommend to enhance equitable access to high-quality primary care services?

The practice of primary care, is one of the most challenging fields in all of medicine. Hours are long, salaries are low, and high quality primary care cannot rely exclusively on allied health professionals. The Commonwealth needs a comprehensive approach to encouraging primary care, and to both the development of primary care providers, and the ongoing support of the same after entering practice. We are working with our provider partner to improve access to primary care for our members, while at the same time evaluating gold carding and other programs to reduce the administrative burden on primary care providers. However, the largest challenge is the supply. Massachusetts is an expensive state in which to live and primary care salaries have not kept up with this expense. Ultimately, Massachusetts will not solve its primary care problem, unless a concerted effort is made at the level of the Commonwealth to incentivize providers, including physicians, to go into primary care. The compensation gap between specialists and primary care physicians needs to be narrowed, tuition assistance, and other benefits would also help to incentivize a movement into primary care. New Primary Care Spending Must Not Increase Health Care Costs. Health care affordability remains a top concern for Massachusetts residents and employers. As such, increased investment in primary care must be coupled with offsets in other spending areas to avoid upward pressure on premiums and overall health care spending. • Any shift in spending toward primary care must be offset by reductions elsewhere preventing an unsustainable increase in total health care expenditures. • States like Rhode Island and Oregon have shown that increased investment in primary care, coupled with controls on spending growth in other service lines, can reduce avoidable emergency room visits, hospitalizations, and excessive specialty care, all while improving patient outcomes and system efficiency. • Health plans today do not have visibility into how systems fund primary care at the practice level. To ensure that increases to primary care spending flow to practices • Increases in expenditures for primary care should reflect existing contractual relationships and must impose requirements on both payers and providers to meet the expenditure targets and contain spending growth.

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?

Every year prescription drugs drive a larger and larger portion of our total medical spend. Pharmacy expenses currently account for approximately 30% of total medical costs, with projections indicating a likely increase over the next five years. We have a generic fill-rate of approximately 90%, and we are pushing biosimilar-first policies wherever we are able to do so. That being said, we continue to struggle with rising drug costs. Utilization management continues to be vital in controlling prescribing of unnecessary medication, but this is increasingly under pressure from provider groups. Redefining benefits, especially around GLP-1s has become essential. When possible, we are shifting sites of care to less expensive options. To really tackle pharmacy spending, we need Massachusetts to take a larger and broader role in health policy and planning. Prescription drugs are responsible for nearly one-fifth of total premium costs in Massachusetts. Continued price inflation, expanded use of GLP-1s and specialty drugs continue to drive premium growth above the state's cost growth benchmark absent targeted interventions. To date, policies focused on limiting patient out of pocket costs have had limited impact on overall costs, as these interventions (copay caps, cost-sharing elimination) do not address the underlying prices set by drug manufacturers. Health plans have limited leverage to constrain pricing. Despite formularies, utilization management, and promotion of generics, manufacturers continue to unilaterally set launch and list prices unconstrained by regulation or competition. Current and Anticipated Pharmaceutical Trends • Prescription drug spending is the single largest driver of health care cost growth in Massachusetts. According to CHIA, prescription drug spending reached $15.2 billion in 2023, a $1 billion increase over 2022, accounting for 18-22% of every premium dollar. As in prior years, brand-name and specialty drugs, though small in volume, represent the vast majority of total drug spending. Brand name drugs make up only 15% of commercial pharmacy volume, but account for the majority of prescription drug spending. Specialty drugs make up just 2-3% of prescriptions, but now represent 50-60% of all pharmacy spending statewide. Commercial spending per branded prescription rose 69% from 2019 to 2023, with 5% of prescriptions exceeding $8,500 in 2023. • GLP-1 medications have reshaped utilization and spending trends. The HPC reported that in 2023, GLP-1 drugs accounted for 5.5% of all commercial pharmacy spending and contributed 3 percentage points to pharmacy spending growth an 0.6 points to overall commercial spending growth. Nationally, utilization has surged more than 400% since 2019, and list prices remain between $950-$1,400 per month, with many patients being on these medications for life. With new obesity, cardiovascular, and metabolic indications anticipated in future years, costs will only continue to climb. As demand grows, new research finds covering GLP-1 medications will drive up premiums for employer-provided coverage by as much as 14 percent, even when access is limited to patients with the highest need. • High-cost specialty and gene therapies pose new affordability challenges. Emerging gene therapies have been priced between $630,000 and $4.3 million per treatment, often for single-dose administration, resulting in short-term budget shocks and sustainability concerns for employers and health plans. Novel financing approaches must be developed in order to shield the market from budget shocks while ensuring access for patients. • Branded price growth continues. Biosimilars and generics now represent 90% of filled prescriptions but only 13% of total spending. Brand list prices have grown by 8 to 10% annually, and many new, branded drugs launch at prices exceeding $100,000 per year. Recommendations for Policymakers and Market Participants • Create a Massachusetts Prescription Drug

Affordability Board (PDAB). Strong support for a PDAB with the authority to establish Upper Payment Limits on excessively priced drugs, ensuring prices reflect value rather than monopoly power. This aligns with recommendations from the National Academy for State Health Policy (NASHP) and actions taken by other states like Colorado and Maryland. UPLs would create a rational counterweight to unregulated manufacturer pricing and protect consumers from unsustainable increases. • Expand the HPC's Drug Pricing Review Authority. Strong support for expanding the HPC's statutory authority to review and publicly report on drugs with significant commercial market impact, complementing the existing MassHealth oversight and enhancing the HPC's newly launched Office of Pharmaceutical Policy and Analysis. • Preserve Utilization Management Flexibility for Health Plans. Policymakers should prohibit rebate or manufacturer contracting practices that limit payers' ability to step therapy or prior authorization when clinically appropriate. Support for legislation to ban agreements that condition payments on specific utilization management restrictions, ensuring clinical decisions remain evidence-based and not rebate-driven. This flexibility is essential to maintain quality, safety, and affordability while ensuring patient access to high-value treatments. • Strengthen Rx Transparency and Accountability. Require manufacturer-level reporting of launch prices, price increases, and Research and Development justification to the HPC of CHIA. Chapter 342 of the Acts of 2024 enhanced transparency into PBM and health plan reporting on prescription drugs but placed no requirements on pharmaceutical manufacturers. • Establish Penalties for Price Gouging. To address unwarranted price increases by pharmaceutical manufacturers, the Legislature should require pharmaceutical manufacturers to report and justify increases in drug prices and to face financial penalties for unjustified increases. Establishing a penalty on manufacturers for excessive price increases addresses affordability concerns due to higher prescription drug spending and prices.

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?

The increase in family health insurance premiums in Massachusetts highlights a critical challenge for families that already struggle with affordability, rising medical debt, and barriers to accessing necessary care. Our organization acknowledges the urgency of this issue and recognizes a need for collaborative, market-wide solutions to reverse these trends. As an integrated health system, committed to the well-being of Massachusetts families, our organization can contribute to this effort in the following ways: 1. Expanding provider partnerships to promote value-based care models that reward high-quality, efficient services focused on preventive care, chronic disease management, and reduced unnecessary utilization. 2. Consumer education and increased transparency,

that includes providing clear, accessible information about benefit design, coverage options, costs, and provider networks for families to avoid unexpected expenses. 3. Actively participating in initiatives aimed at payment reform, drug price negotiations, and administrative simplification. 4. Expanding access to affordable coverage through innovative plan designs that offer affordable options tailored to diverse family needs; this includes tiered networks and telehealth services that broaden access while controlling costs. 5. Supporting Community Health Initiatives that address social determinants of health, such as nutrition, housing, and behavioral health, which aid in reducing preventable health care utilization and improve long-term outcomes for families.

TRENDS IN MEDICAL EXPENDITURES

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.

HNE experienced significant membership growth from 2020-2022, associated with an expansion from Western Massachusetts to Central. HNE then experienced a significant decrease in membership from 2022-2024, associated with pulling out of Central Massachusetts. These geographic adjustments are the primary driver of the portion of trend attributed to provider mix across the reporting period. Demographic changes were not significant across 2020-2024, with changes of plus or minus 0.4% from year to year. Benefit buy-down has an impact of up to 1% per year on observed paid trend, but is not a significant factor in observed allowed trend. Membership contraction from 2022-2024 contributed to a significant increase in the concurrent risk score of the covered population, averaging +4.4% annually, which is reflected in the utilization and service mix trend observed.

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?

The most concerning contributing factor for our organizations 2025 medical trend is the significant increase in pharmacy costs, particularly related to GLP-1 (glucagon-like peptide-1 receptor agonists) and other specialty medications. The rapid adoption of GLP-1 medications such as semaglutide and tirzepatide is especially noteworthy. These drugs are increasingly being prescribed for diabetes management, weight loss and cardiovascular risk reduction. This surge in utilization, coupled with high price points, makes them a primary driver of overall healthcare spending for our Commercial, Medicaid and Medicare Advantage population. Specialty medications, in general, continue to represent a disproportionate share of pharmacy costs, given their complexity, limited competition, and high cost per prescription. The financial impact of these pharmacy trends is compounded by the lack of generic alternatives and the ongoing introduction of new specialty therapies placing pressure on plan sponsors to enhance utilization management strategies and formulary controls that will help to manage costs. In summary, pharmacy expenditures

represent the most pressing challenge in our current landscape for 2025 and addressing this trend is critical to ensuring the sustainability of our benefit offerings and maintaining affordability for our members.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. 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.

Health Care Service Price Inquiries Calendar Years (CY) 2023-2025			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2023	**Q1**	535	22
	Q2	615	27
	Q3	541	20
	Q4	602	24
CY2024	**Q1**	678	34
	Q2	557	25
	Q3	572	30
	Q4	544	24
CY2025	**Q1**	706	33
	Q2	576	37
	TOTAL:	5926	276

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	Provider Mix	Service Mix	Total
CY 2021	5.3%	9.3%	1.0%	0.5%	16.7%
CY 2022	6.5%	-5.4%	0.2%	0.2%	1.1%
CY 2023	7.8%	0.9%	-0.5%	0.0%	8.3%
CY 2024	8.9%	-2.4%	0.0%	0.3%	6.5%

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, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.