By Electronic Mail

November 4, 2024

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street
Boston, MA 02109

Re: WellSense Health Plan – Health Care Cost Trends Pre-Filed Testimony

Dear Mr. Seltz:

This is in response to your request for written testimony in connection with the upcoming health care cost trends hearing to be held by the Health Policy Commission.

On behalf of WellSense Health Plan, please find our written testimony responding to the questions set forth in the 2024 Pre-filed Testimony for payers. I am legally authorized and empowered to represent WellSense Health Plan, Inc. for purposes of the written testimony herein, and sign this testimony under the pains and penalties of perjury.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Heather Thiltgen

Heather Thiltgen

President, WellSense Health Plan

Enclosures

MASSACHUSETTS
HEALTH POLICY COMMISSION

2024 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 **Monday, November 4, 2024**, 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 2023, 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 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 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.

THE 2024 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 2024 Health Care Cost Trends Hearing will take place in a period of significant upheaval and reflection for the Commonwealth's health care system. The bankruptcy and dissolution of Steward Health Care, previously the third largest hospital system in Massachusetts, led to substantial disruptions to the state's health care market and has taken a significant toll on communities, patients, provider organizations, and health care workers across the region. This market instability is occurring while many providers across the health care continuum are still struggling to adapt to a post-pandemic "new normal" state, wrestling with capacity constraints, financial volatility, administrative burdens, and workforce recruitment and retention challenges.

At the same time, an increasing number of Massachusetts residents are struggling with health care affordability and medical debt. Massachusetts has the second highest family health insurance premiums in the country. The average annual cost of health care for a family exceeds $29,000 (including out of pocket spending). Recently, more than half of residents surveyed cited the cost of health care as the most important health care issue, far surpassing those that identified access or quality. Due to high costs, 40 percent of survey respondents said they are putting off seeing a doctor or going to a hospital. These affordability challenges are disproportionally borne by populations of color, and those in Massachusetts with less resources, contributing to widening disparities in access to care and health outcomes. The annual cost of inequities experienced by populations of color in Massachusetts is estimated to exceed $5.9 billion and is growing every year. These challenges require bold action to move the health care system from the status quo to a new trajectory.

This year, in the wake of the considerable harm caused by the bankruptcy of Steward Health Care and other recent market disruptions, the HPC is focusing the 2024 Cost Trends Hearing on moving forward, from crisis to stability, and building a health care system that is more affordable, accessible, and equitable for all residents of Massachusetts.

Since 2012, pre-filed written testimony has afforded the HPC an opportunity to engage more deeply with Massachusetts health care market participants. In addition to pre-filed written testimony, the annual 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. Reflecting on the health care market disruptions in Massachusetts in recent years, including the bankruptcy of Steward Health Care and related closures, what have been the most significant impacts of these disruptions on your members, your network(s), and your organization?

Members: Whenever there are market disruptions, such as redetermination or network changes, our primary concern is preserving member access to care. The most significant impacts on members include eligibility, provider access, and care coordination. WellSense partnered with MassHealth through the Health Plan Assister Program to outreach to Medicaid members to help them complete their redetermination applications directly in the MassHealth system. For instances in which WellSense needed to assign a member to a new primary care physician (PCP), WellSense used advanced algorithms and claims data to help preserve access to appropriate providers and ensure continuity of care. WellSense has established transition of care programs where our care managers work directly with high-risk members with complex needs to ensure they get the care they need without disruption. Communication and member support throughout this process is paramount and WellSense assists members in finding providers who are accepting new patients and directly assist members with scheduling timely appointments as needed. WellSense was able to utilize programs and methods established to assist with transitioning MassHealth members into our ACOs, and from dealing with the closure of Compass Medical last year, to minimize the disruption caused by the Steward bankruptcy transition and closures.

Network: Recent disruptions in the Massachusetts healthcare market have posed significant challenges, particularly from a network standpoint. With increased market consolidation, in which a few large systems dominate different regions, managing unit costs has become more difficult. One of the key challenges is the timing of these disruptions and their effect on maintaining network adequacy. While evaluating facility network adequacy is generally straightforward, changes in physician practices are much harder to navigate. The process of terminating, re-enrolling, and re-credentialing physicians is both labor-intensive and time-consuming. Additionally, ensuring timely communication about the new locations of providers and facilities is essential for reconfiguring systems and completing the re-credentialing process, adding further complexity to managing these changes. As enhanced provider directory requirements are implemented, future transitions will be even more administratively burdensome requiring solid partnership and timely information sharing with our provider partners and network members.

Organization: The market disruptions in recent years have given WellSense opportunities to stress test our processes and evaluate the efficiency of our workflows. These challenges have helped us identify strengths and assess our performance in responding to major network disruptions. The recent Steward bankruptcy and Change Healthcare incidents underscored the need for a centralized response team. The Steward bankruptcy created the need re-enroll a large number of providers and quickly reload them into our system. In addition, WellSense has needed to quickly transition authorizations from the Steward-related NPI to the new owner's NPI, ensuring uninterrupted member care and minimizing administrative burdens for facilities during the ownership change. Further, we relied on our Care Management teams to conduct significant

outreach ahead of the Carney and Nashoba Valley closures to avoid interruption of our members' care. All of this is a significant, unanticipated administrative burden on our staff as we try to accommodate the hospital transfers while avoiding disruption to normal operations.

While WellSense does not use Change Healthcare as a clearinghouse, the incident affected the printing of remittance advices and paper checks and required additional work from our IT and Provider Relations teams to mitigate impact to providers. We also offered cash advances to certain providers who relied on Change Healthcare for claims submission, upon request.
Our strategy has proven to be effective in managing past incidents and will continue to evolve to ensure WellSense can navigate future disruptions while minimizing the impact on our members and providers.

2. Please identify and briefly describe any policy, payment, or health care market reforms your organization would recommend to better protect the Massachusetts health care system from predatory actors, strengthen market oversight and transparency, and ensure greater stability moving forward.

Pharmacy: WellSense Health Plan has continued to observe significant growth in pharmacy spending, particularly in the areas of specialty drugs and GLP-1's. The specialty drug spending increase is a result of increased utilization, price increases, and drug mix changes, while the GLP-1 uptick is a result of members beginning to take a GLP-1 for weight loss. Unfortunately, we have not yet seen any offsetting medical expense reduction because we have also seen 70% of those members discontinue therapy within 6 months.

WellSense is addressing increases in pharmacy spending via several initiatives, including, but not limited to: continuing to opt for pass-through terms in our contract with our pharmacy benefit manager, managing our formulary, establishing a biosimilar drug strategy, promoting 90-day fills for chronic medications and positively impacting quality measure performance through medication adherence and other quality incentives.

Through re-procurement of our PBM partner, WellSense has reduced baseline pharmacy cost and continues to build upon the savings with appropriate utilization management strategies. Regarding specialty drugs, WellSense partners closely with a network of specialty pharmacies geared towards disease management activities to achieve optimal outcomes, given the cost and complexities of specialty drugs. We are also working closely with our PBM on a biosimilar strategy, which should yield significant savings over the next several years. WellSense remains committed to positively impacting patient care by focusing on health equity, key quality measures, and promoting medication adherence. Lastly, WellSense is committed to enhanced data transparency with regulators in order to facilitate continued communication and collaboration on pharmacy-related efforts around cost containment.

Despite the numerous actions WellSense has taken and initiatives we are engaged in implementing, we continue to see insufficient market oversight to truly ensure market stability. In order to promote greater stability, through pharmacy oversight and regulation, Massachusetts could ban spread pricing deals through PBMs.

Prior Authorization: WellSense continues to utilize prior authorization (PA) as one of a number of methods to effectively improve the health outcomes of our members and manage healthcare costs. This assists WellSense in effectively evaluating requested high-cost services or treatments, which may be subject to overutilization, by making medical necessity determinations based on evidence-based clinical review criteria. The WellSense PA process ensures that: services provided to members are medically necessary; we reduce unnecessary healthcare services and associated costs; we direct members to the most appropriate clinical setting; we ensure the utilization of first-line or conservative interventions with fewer risks of complication, whenever possible; and we identify members who may benefit from care management and care coordination.

WellSense would support appropriate oversight of insurers to weed out predatory actors. Such oversight would include ongoing monitoring of the financial stability of the payer, including average claims turnaround time, evaluation of financial records, and periodic evaluation of certain elements related to PA.

Oversight of prior authorization could include: evaluations of payer processing times and approval rates; provider ease to identify services which require PA and complete the appropriate the PA process; compliance with CMS and NCQA standards for the development and review of adopted medical necessity criteria used for PA; and timely appeals and grievances processes.

Additional Policy Suggestions:
Massachusetts seeks to limit fraud, waste and abuse ("FW&A") in a number of ways, including through contracts requiring carriers to engage in regular FW&A prevention activities. All payer and provider entities should be required to vigilantly guard against FW&A, but one way to deter against predatory activity would be to significantly enhance the penalties on actors who engage in FW&A activities.

For example, Massachusetts could invest in new and evolving technology and systems that can detect fraudulent billing practices and abuse within the healthcare system. Massachusetts could also encourage and support (financially and otherwise) collaborations between law enforcement agencies and healthcare regulatory bodies designed to address fraudulent activities more effectively.

Individuals seeking health care would benefit from greater transparency around member cost share for in network providers compared to out of network providers. Individuals are often faced with confusing or uncertain costs for medical visits, some of which are not apparent until long after the visit has occurred. Greater transparency would empower people to make fully informed decisions around health care.

Reliability, standardization and uniformity would also provide greater stability in provider reimbursement models, quality measurements and through funding impacted by risk adjustment. Provider reimbursement is wildly different across Medicaid, Commercial and Medicare. A more standardized level of compensation could help both the provider community and the health insurance industry. Quality measures vary from program to program and carrier to carrier. Standardizing quality benchmarks would simplify workflows for providers. Lastly, risk adjustment models are unnecessarily different for every insurance product. Streamlining risk adjustment models would simplify coding for providers and reimbursement for carriers.

Finally, patients have a role to play in helping create greater stability across health care too. But most patients lack all of the tools required to effectively provide impactful assistance. Education and awareness campaigns, combined with patient advocacy programs would help enhance the health care ecosystem. Massachusetts could create initiatives to educate patients about their rights, the importance of understanding healthcare costs, and how to report unethical practices. The Commonwealth could also require payers and providers to participate and assist with such initiatives.

Patient education programs should be combined with state-sponsored training programs for healthcare providers focused on ethical practices, patient-centered care, and compliance with regulations. Similarly, the state could create programs that provide resources and support for patients to navigate the healthcare system and report predatory practices.

3. Reflecting on consistent HPC findings showing increasing health care affordability challenges, growing difficulties accessing needed care, and widening health disparities based on race, ethnicity, and income among Massachusetts residents, what are your organization's top two to three strategies for addressing these trends? What are the most significant challenges to implementing these strategies?

WellSense Health Plan has a long history of providing equitable, high-quality care services to our culturally and linguistically diverse population. It is our health equity mission, to improve the health and wellness of the diverse communities we serve. Every member, regardless of race, ethnicity, age, gender, gender identity or expression, sexual orientation, disability, veteran status, religion, income, or other physical or social characteristic, is entitled to access to high quality, affordable health care.

We have initiated several member-focused actions focused on reducing disparities including: updating capture of member demographic (RELDSOGI) data; fielding a disability survey, capturing direct member feedback; providing training for providers and member services staff on cultural literacy and language access. We are using the output from these member-focused data to target areas of disparity reduction in partnership with our ACO partners and providers. Our goal is to reduce heath disparities by implementing interventions to eliminate bias and discrimination, for identified groups who are likely to experience or are experiencing obstacles to accessing health care services due to their race, ethnicity, income, language preference, gender identity, and/or sexual orientation. In addition, to further expand our commitment we have initiated the efforts to seek NCQA Health Equity Accreditation which will facilitate and align our operational commitment and strategies to improve equitable health outcomes for the members we serve.

As we continue to deliver our Health Equity mission, we are focusing on, among others, the following strategies:

Employee Focus
Building Diverse Workforce and Staff Training

Diversity, equity, and inclusion (DEI), along with Cultural Responsiveness, are crucial for the success of WellSense. A diverse workforce not only reflects the communities we serve but also enhances our ability to understand and address our members' unique needs, ultimately improving care and outcomes. Our focus is to continue to integrate DEI principles into our hiring and governance practices, to build a more compassionate and responsive healthcare system that benefits everyone. WellSense partners with Affirmative Action Program (AAP) to conduct an annual review of WellSense workforce, hiring, recruiting and promotions practices to assess the level of diversity, equity, and inclusion (DEI) within our staff, and leadership. We have also implemented a DEI committee and employee Business Resource Groups - Pride, BIPOC and Women, to provide guidance for and feedback on enterprise Health Equity, Diversity and Inclusion efforts.

Member Focus

WellSense is collecting and centralizing data on race, ethnicity, language, sexual orientation, gender identity, and health-related social needs. We collect stratified HEDIS data by race and ethnicity intended to further our identification and understanding of racial and ethnic disparities in care. This data informs opportunities within these populations and helps develop focused efforts to address disparities.

As a vital component of serving our members in a culturally responsive manner, WellSense has implemented a standardized approach to screen for and address enrollees' health-related social needs such as food insecurities, financial instabilities, transportation, health harming legal issues, and housing security. We have worked closely with our ACO partners to set up referral pathways to local community-based and culturally specific organizations that can help address the health-related social needs of our members.

WellSense regularly analyzes data related to disparities in quality measures and social determinants of health to identify inequalities, reduce medical cost, and improve diverse member service and quality.

Provider Focus

WellSense intentionally credentials and contracts with practitioners who speak languages that reflect our members' linguistic needs as well as recruiting practitioners whose cultural and ethnic backgrounds align with our member populations.

We also provide cultural competency trainings to our network of providers and organizations which include topics such as: cultural competence, understanding implicit bias and embracing multiculturalism, diversity and inclusion to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of members with the goal of reducing health disparity for disenfranchised populations.

Challenges

While we are implementing several member-focused avenues to collect demographic data – updating the Health Risk Assessment, configuring an option to provide information through the call center's Interactive Voice Response when a member calls in, the most challenging component is voluntary disclosure. Only members who want to provide WellSense with this data will do so, as disclosure is completely at the discretion of the member. Similarly, disclosure of information through providers is voluntary and remains challenging.

4. Please identify and briefly describe any policy, payment, or health care system reforms your organization would recommend to achieve a health care system that is more affordable, accessible, and equitable in Massachusetts.

Greater Pharmaceutical Oversight

The Health Policy Commission works diligently each year to establish and set a desired cost growth benchmark. However, the state currently lacks a strong and viable enforcement mechanism, which ensures that cost growth will remain within the benchmark, while allowing for appropriate and necessary flexibility from those constraints as necessary. WellSense Health Plan would support enhanced enforcement authority, especially for pharmaceutical manufacturers who have largely avoided any accountability to the benchmark.

Recent studies have shown that prescription drug costs account for between 18-22% of the premium dollar. In the CHIA 2024 annual report, we saw that pharmacy spending has exceeded spending growth in other areas. Given the outsized impact of prescription drug costs on health care spending and prices, drug manufacturers should be held accountable along with other health care entities. Therefore, WellSense would support requiring pharmaceutical manufacturers to be subject to the HPC's annual Cost Trends Hearing and associated data collection requirements of the HPC, CHIA and the AGO. In addition, we would support legislation requiring pharmaceutical manufacturers to report and justify price increases for drugs on the market.

Competition in the individual and small group markets

WellSense also supports policies that would foster more pure competition in the individual and small group markets, through the Connector. For example, policies preventing plans from creating unique and appropriate networks for non-Silver level offerings prevents plans from offering lower cost options, as appropriate. In addition, the Connector's policy of providing premium smoothing, which has a short-term impact of lowering the sticker price to consumers shopping for a plan, also has the long-term impact of increasing the underlying cost of health insurance as plans have less incentive to provide lowest cost options. We believe that eliminating these two cost-inflationary policies would result in a more affordable, accessible and equitable marketplace.

TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2020 to 2023 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2020 to 2023, 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.

The following supplemental chart shows our Health Status Adjusted (HSA) trends for Massachusetts in total:

Time Period	Unadjusted TME Trend	Risk Score Trend	HSA TME Trend
CY 2020	**-1.4%**	**2.4%**	**-3.5%**
CY 2021	**-0.5%**	**-4.0%**	**3.4%**
CY 2022	**1.9%**	**1.5%**	**0.4%**
CY 2023	**-4.2%**	**-14.4%**	**12.5%**

Trend from 2023 to 2022 is -4.2% on an unadjusted basis and 12.5% on a Health Status Adjusted basis. WellSense's member mix has significantly changed from CY2022 to CY2023 due to four additional ACOs, which began serving members on April 1, 2023. WellSense's membership increased by 110.7% from March to April 2023 in a way that significantly increased the percentage of children composing our enrolled membership. In March 2023, our business was 32.4% pediatrics compared to 47.5% pediatrics in April 2023. This change in member mix will significantly impact reported trend.

With the end of the Public Health Emergency (PHE) and the resumption of eligibility redeterminations in MassHealth, we have observed a population decrease from April 2023 to April 2024. Some of the members leaving MassHealth have joined our qualified health plan (QHP) during which time WellSense also became the lowest cost carrier in the market in several regions, resulting in significant growth of WellSense QHP membership between 2023 to 2024.

Trend from 2021 to 2022 is 1.9% on an unadjusted basis and .4% on a Health Status Adjusted basis. Membership increased 2.6% from 2021 to 2022, mostly due to the lack of eligibility redeterminations for MassHealth during the PHE.

In 2020, our risk scores increased less and our TME trend also decreased due to the COVID pandemic. Through 2022, our MassHealth membership continued to increase, while our TME and risk scores increased slightly. At the same time from 2020 to 2022, our QHP membership decreased as the market size of the Connector Exchange population shrunk and our premium was no longer the lowest option.

2. Reflecting on current medical expenditure trends your organization is observing in 2024 to date, which trend or contributing factor is most concerning or challenging?

Medical expenditures for 2024 are emerging higher than 2023 on both an unadjusted basis (7.7%) and after Health Status Adjustment (1.0%). Redeterminations and a higher acuity patient population are major contributors to the higher medical expenditures in 2024.

Another concerning trend is the increasing utilization of GLP-1 drugs. Spending is up significantly in Q2 and Q3 of 2024. GLP-1 spend across our MassHealth membership during CY23 was $12.72 PMPM. In calendar year 2024 through July, the WellSense MassHealth spend is $16.51 PMPM, with the month of July 2024 at $22.96 PMPM. For QHP, CY23 costs were $17.83 PMPM, and calendar year 2024 through July was $20.43 PMPM, with July costs coming in at $26.22.

Behavioral Health trend is also increasing in the emerging 2024 data and WellSense will continue to monitor BH trend in Q4 and RY25.

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 that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2022-2024			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2022	**Q1**	0	9
	Q2	1	15
	Q3	4	1
	Q4	2	2
CY2023	**Q1**	3	1
	Q2	4	1
	Q3	3	0
	Q4	5	1
CY2024	**Q1**	2	2
	Q2	3	4
	TOTAL:	27	36

2. When developing benefit plan options for employer groups, do you consider point-of-service cost-sharing affordability separately from premium affordability? If so, how do you do this and what metrics and data sources do you use?

The only employer group plans offered by WellSense Health Plan are standardized designs through the Connector and the point of service cost share is prescribed in the annual RFR.

3. Are there any accommodations you offer to providers in consideration of point-of service cost sharing bad debt under your global risk arrangements? For instance, is the full allowable amount (i.e., both the insurer and the member portions) charged against the global budget even if the provider was never able to collect the member portion? Please provide details.

WellSense is driving alternative payment models and creative value-based payment models as one of many levers of cost containment. We continue to be focused on whole person care with a commitment to looking at more integrative models of care appreciating that containing costs will require addressing comorbidity and approaching members' needs holistically.

For CY 2026 we will be insourcing our behavioral health network and exploring non-traditional models of reimbursement to support our commitment. In addition to increasing APM participation, we are also diligently managing foundational fee-for-service unit cost increases ensuring adherence to the HPC cost trend target.

Due to our limited participation in the non-connector based commercial market, our global risk arrangements have largely not considered point-of-service cost sharing regarding bad debt.

HPC Payer Exhibit 1

*****All cells shaded in BLUE should be completed by carrier*****

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2020	1.5%	-2.2%	0.0%	-0.6%	-1.4%
CY 2021	-2.6%	3.5%	1.0%	-2.4%	-0.5%
CY 2022	8.5%	-5.1%	0.4%	-1.4%	1.9%
CY 2023	12.0%	-12.7%	0.4%	-2.4%	-4.2%

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

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.