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Via Email: HPC-Testimony@state.ma.us

September 9, 2016

David Seltz
Executive Director
Health Policy Commission
2 Boylston Street
Boston, MA 02116

Re: Health Policy Commission Written Testimony and Exhibit

Dear Mr. Seltz:

Attached please find:

1. Completed Exhibit B, in response to the HPC Questions for Written Testimony;
2. Completed Exhibit C, in response to the AGO Questions for Written Testimony; and
3. Completed HPC Payer Exhibit 1, in response to Question 9 of Exhibit B.

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

Sincerely,

Melissa Munster

cc: Assistant Attorney General Emily Gabrault (Emily.Gabrault@state.ma.us)

Exhibit B: Aetna's Responses to HPC Questions for Written Testimony

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are the top areas of concern you would identify for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Higher unit prices charged by hospitals and physicians as well as increased utilization by patients continue to be major drivers of the rise in health care spending and put the most pressure on a payer's ability to meet the Health Care Cost Growth Benchmark. Another significant driver in the past year has been the dramatic increase in pharmaceutical spending. This is a result of increases in both utilization and the cost of prescription drugs. In particular, increased utilization of the more expensive specialty drugs have put significant pressure on Aetna's ability to meet the Benchmark for its commercial products.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

Aetna fully supports the mission of the Health Policy Commission to monitor health care spending growth in the Commonwealth and to provide data-driven policy recommendations. To that end, Aetna remains committed to the implementation of thoughtful changes in policy and law that foster a value-based marketplace, promote an efficient, high quality, healthcare delivery system, advance alternative payment methods, and support increased transparency. That being said, local players continue to account for the bulk of members in the Massachusetts marketplace. Aetna, which has focused on consumer-directed plan options and dynamic delivery systems across the country, has maintained a smaller presence in the Commonwealth. However, as the Massachusetts marketplace becomes more consumer-centric and embraces value-based delivery plan options, we believe that competition will increase. Being a national carrier with national standards and metrics presents some difficulty in supporting regional intricacies, such as the Commonwealth's merged individual and small group markets, product mandates, and very high medical loss ratio coupled with increasing state mandated administrative requirements.

2. Strategies to Address Pharmaceutical Spending Trends.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising pharmaceutical prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Do you contract with a pharmacy benefit manager (PBM)? Yes

i. If yes, please identify the name of your PBM.

Caremark PCS Health, L.L.C. ("CVS")

ii. If yes, please indicate the PBM's primary responsibilities below *(check all that apply)*

☒ Negotiating prices and discounts with drug manufacturers
☐ Negotiating rebates with drug manufacturers
☐ Developing and maintaining the drug formulary
☒ Pharmacy contracting
☒ Pharmacy claims processing
☐ Providing clinical/care management programs to members

b. In the table below, please quantify your projected per-member-per-year (PMPY) rate of growth in pharmaceutical spending for different lines of business and drug types from 2015 to 2016.

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	15.9%	4.9%	17.3%	20.6%
Medicaid	**N/A**	**N/A**	**N/A**	**N/A**
Medicare	-3.3%	-23.4%	11.4%	-0.6%

Please note that these numbers represent actual year-to-date trends for Massachusetts (i.e., YTD2016 over YTD2015, through July). Also, because Aetna has no Medicaid membership in Massachusetts, those fields have been left blank.

c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.

i. Risk-Based or Performance-Based Contracting

Currently Implementing

ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts

Currently Implementing

iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).

Currently Implementing

iv. Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends

Currently Implementing

v. Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs

Currently Implementing

vi. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vii. Pursuing exclusive contracting with pharmaceutical manufacturers

Currently Implementing

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending

Currently Implementing

ix. Strengthening utilization management or prior authorization protocols

Currently Implementing

x. Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers

Currently Implementing

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit

Currently Implementing

xii. Other: In an effort to curb the opioid epidemic, Aetna sent letters in the past year to almost 1,000 doctors across the country who refill opioid prescriptions at a considerably higher rate than their peers. Aetna's hope was that sharing this data with these doctors would help them realize how far out of the norm their prescribing habits are and cause them to reevaluate their prescribing patterns. Aetna also distributed new opioid guidelines from the Centers for Disease Control and Prevention to encourage these providers to consider other options to help their patients control pain.

xiii. Other: Insert Text Here

3. **Strategies to Increase the Adoption of Alternative Payment Methodologies.**

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

a. What are the top strategies your organization is pursuing to increase use of APMs, including efforts to expand APMs to other provider types including hospitals, specialists (including behavioral health providers), and new product types (e.g., PPO)? (Please limit your answer to no more than three strategies)

Throughout the country, Aetna continues its efforts to collaborate with providers to help them transition from fee-for-service models to value-based care delivery models. We give providers strategic financial incentives to improve quality and control costs and information to help them and their patients make more informed health care decisions. Aetna's efforts have focused on accountable care organizations (ACOs), Patient-Centered Medical Homes (PCMH), and other provider collaborative models known as PCMH Recognition and Pay for Performance (P4P) Agreements.

First, Aetna's contracted ACOs include some of the most advanced and efficient systems in the country. We currently have 78 signed ACO arrangements in place, and we expect that number to grow in 2017. We are engaged in discussions with health systems across the country to identify additional ACOs that focus on delivering high quality, efficient care. Today, 42.5% of our claim payments go to providers who deliver value-based care, with 44% of those payments aligned with our ACOs, 17% of those payments aligned with our PCMHs, and 13% of those payments aligned with our P4P models. We have developed a well-thought out, aggressive roadmap to increase value-based models in our contracts and are working systematically to achieve it. We are projecting 47% of spend in value-based models in 2017, and at least 50% by 2018. By 2020, we expect this number will be about 75%.

We provide ongoing analytical and care management consulting to our ACO organizations (review of monthly results, metrics, and cost/quality trends) to support continuous improvement in quality and financial outcomes.

Aetna adopts national metrics endorsed by national entities (e.g., National Quality Forum), but since our ACO arrangements are flexible in scope, there is no single approach to defining metrics. We work collaboratively with each organization to outline appropriate measurable and actionable metrics, some of which include the following:

- Outpatient surgeries/procedures performed at preferred (ambulatory) facilities
- Hospital readmissions for medical and behavioral health
- Avoidable emergency room utilizations
- Ambulatory sensitive condition admissions
- Non-trauma admissions
- 30 day readmissions
- Outpatient laboratory tests/services
- Radiology services at preferred (freestanding) facilities
- Generic prescribing rate
- Breast cancer screening
- Colorectal screening
- Cervical cancer screening
- Diabetes Hba1c screening
- Flu vaccination
- Pneumonia vaccination
- Diabetes/lipid screening
- Other preventive care measures

We track utilization to allow each ACO to manage a specific population. In addition, we provide analytic capabilities to allow ACOs to view results and create actionable reports on a wide range of utilization, quality and financial metrics. These capabilities include both standard monthly/quarterly metrics/results reporting and data sets with user driven drill-down capabilities at the physician and member level. We continue to build on our capability to transform raw claims and other administrative data into understandable, actionable and clinically meaningful information.

Second, Patient-Centered Medical Homes (PCMH) realign care to focus on maintaining health, and reducing high-intensity, duplicative or medically unnecessary services. Nationally, Aetna has three PCMH models. The PCMH Direct Contract Relationship model allows for care coordination and shared savings by way of a per member per month payment for patients attributed to the practice and a percentage of savings when clinical quality targets are met. The PCMH Recognition Model provides a

care coordination fee by way of a per member per month payment for patients attributed to the practice. Aetna monitors providers' clinical performance and efficiency under both the Direct Contract Relationship and the Recognition models. The PCMH Multi-Payor Collaboratives, CMS, and Comprehensive Primary Care Initiative (CPCI) model focuses generally on fully insured commercial business, and allows for variation in clinical performance, efficiency, and data aggregation measures. Aetna is currently participating in CPCI arrangements in Ohio, New York (Hudson Valley) and Colorado.

Finally, Aetna, which has focused on consumer-directed plan options and dynamic delivery systems across the country, has maintained a smaller presence in Massachusetts fully-insured products. However, as the Massachusetts marketplace becomes more consumer-centric and embraces value-based delivery plan options, we believe that competition will increase. To that end, Aetna is implementing two provider collaborative models in Massachusetts: PCMH Recognition and Pay for Performance (P4P) Agreements – both designed to improve the quality and efficiency of care. In 2013, Aetna introduced a PCMH Recognition program to Massachusetts NCQA certified physician practices, encouraging certain physicians to treat patients while maintaining NCQA PCMH accreditation status. As more providers become NCQA PCMH certified, we hope that these programs will serve as the foundation for future programs that will reward recognized PCMH providers for investment in infrastructure, training, health information technology and proactive case management. Aetna also has P4P arrangements in place to reward the continued achievement of specified quality benchmarks with multiple provider groups.

b. What are the top barriers to increased use of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

   Please refer to Aetna's response to Question 3a above, for information on Aetna's provider collaboration and ACO arrangements.

c. Please describe your organization’s specific efforts to support smaller providers, including ancillary and community providers, who seek alternatives to fee-for-service payment models.

   Please refer to Aetna's response to Question 3a above, for information on Aetna's provider collaboration and ACO arrangements.

4. Strategies to Align of Technical Aspects of APMs.

In the 2015 Cost Trends Report, the HPC called for an alignment and improvement of APMs in the Massachusetts market.

a. Please describe your organization’s efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).

   Alternative payment methods and value-based contracting continue to be critical components of Aetna's long-term strategy. We are continuously examining quality, efficiency and outcome metrics and benchmarks and applying them nationally across all of our lines of business. Aetna's use of risk scores is a major component of this strategy that is designed to accurately reflect the characteristics of an attributed population.

b. What are the top barriers to alignment on these technical aspects and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Aetna continues to work toward expanded Patient Centered Medical Homes and value-based payment methodologies. Being a national carrier with national standards and metrics presents some difficulty in supporting regional intricacies. However, Aetna expects to have continued success in implementing these programs as we grow.

5. **Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.**
Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.
    a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

    Aetna provides coverage of drugs to treat dependencies, such as Vivitrol for alcohol and opiate use disorder and Narcan (naloxone) nasal spray & Evzio (naloxone) self-injections at covered tier status, and does not place those drugs in the Specialty Drug higher cost-share tiers even if they qualify as a Specialty Drug. In addition, Aetna continues to make available and cover generic products (i.e. buprenorphine/naloxone SL tabs), which results in these drugs being available to members at the lowest cost-share. Aetna has also collaborated with providers to support dissemination of information concerning pharmacologic treatment for substance use disorder in collaboration with the Oregon Science Health University and the National Institute of Drug Abuse.

    b. What are the top barriers to increasing access to pharmacologic treatment for your members and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

    The increasing cost of medications is a barrier to access to pharmacologic treatment of substance use disorders. Aetna is working to address this issue by continuing to negotiate with pharmaceutical manufacturers to obtain better pricing and, where applicable and appropriate, rebate opportunities.

6. **Strategies to Support Telehealth.**
In its 2015 Cost Trends Report, the HPC recommended that the Commonwealth be a national leader in the use of enabling technologies to advance care delivery transformation.
    a. Does your organization offer or pay for telehealth services? Yes
        i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?

Aetna covers telemedicine in its fully insured products for medically necessary covered services that are provided by a physician acting within the scope of his or her license. Aetna also offers Teladoc to all fully insured members in Massachusetts and automatically includes it for most self-funded plan sponsors in Massachusetts. Teladoc is a program that provides members with access to quality, affordable care for non-emergency, routine illnesses via telephonic and video consultation, thereby helping prevent unnecessary use of the emergency room or urgent care centers. A mobile application is also available 24/7/365 for members to access their accounts, manage their health records, and request a phone or video consult. Some of the more common illnesses that Teladoc handles are:

- Allergies
- Basic Dermatological issues
- (Episodic) Behavioral Health needs (such as Anxiety, Panic Attacks and Depression)
- Bronchitis
- Cough
- Ear infection
- Flu
- Nasal congestion
- Pink eye
- Sinus problems
- Upper respiratory infection
- Urinary tract infection

ii. If yes, how do you pay for these services (e.g. equivalent FFS rates as office visits, partial FFS rates, as part of a global budget, etc.)?

Aetna reimburses providers for telemedicine 'visits' in the same manner/same rates as if the services were performed in-person. Aetna pays for services rendered by Teladoc on a per member per month/per employee per month basis.

iii. If no, why not?
36T

7. Strategies to Encourage High-Value Consumer Choices.

In the 2015 Cost Trends Report, the HPC recommended that payers continue to innovate and provide new mechanisms that reward consumers for making high-value choices. The HPC highlighted strategies such as providing cash-back incentives for choosing high-value providers and offering members incentives at the time of primary care provider selection.

a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? No
   i. If yes, please describe the types of cash-back incentives offered.
   36T

   ii. If no, why not?

   Aetna's plan designs encourage members to select high value providers and service settings by those choices resulting in a lower cost-sharing level. Aetna offers several such programs to its self-insured plan sponsors. In addition to the PCMH and P4P programs described above in Aetna's answer to Question 3, Aetna also offers these plan sponsors "Aexcel" (high performance tiered physician network) and the Aetna Performance Network (high performance tiered network).

   Aetna also intends to offer a tiered network product for its fully-insured Massachusetts customers effective January 1, 2017. This tiered network, known as Savings Plus, aims to reduce health care costs for employers and create cost savings opportunities for employees by directing members to a designated network of quality, cost-effective doctors and hospitals.

   In addition to the programs described above, Aetna also offers other programs that help members access high quality, low-cost services. We offer Institutes of Excellence (transplants) and Institutes of Quality (bariatric surgery, cardiac surgery, and orthopedic spine and joint

replacement) on a fully-insured and self-insured basis. We also offer Teladoc (the program offering members access to quality, affordable care for routine illnesses via telephonic and video consultation) to all fully insured members in Massachusetts. Teladoc is automatically included for most self-funded plan sponsors unless they opt out. Lastly, the iTriage app is also available to Aetna members in Massachusetts. In addition to the basic iTriage features, plan sponsors may purchase additional features that enable members to view membership, claim and network status.

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? No
   i. If yes, please describe the types of incentives offered.
   36T

   ii. If no, why not?
   There are premium differentials between Aetna's different plan offerings (i.e., the premium for Aetna's tiered plan, Savings Plus, is less than a standard PPO plan). However, Aetna does not offer premium differentials for members within the same plan offering based on PCP or any other selection at enrollment.

8. Strategies to Increase Health Care Transparency.

Chapter 224 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."

a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	Q1	19,780	259
	Q2	14,513	298
	Q3	8,138	200
	Q4	6,779	325
CY2016	Q1	10,545	252
	Q2	6,787	218
	TOTAL:	66,542	1,552

9. Information to Understand Medical Expenditure Trends.

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b)

benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

Please see the attached HPC Payer Exhibit 1 for Aetna's response.

10. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) increase the adoption of APMs; c.) support alignment of APMs; d.) increase access to pharmacologic treatment; e.) support the adoption of telehealth; f.) encourage high-value consumer choices; and, g.) enhance consumer price transparency and utilization of transparency tools.

    Aetna has no additional comments to provide.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please answer the following questions related to risk contracts and pharmaceutical spending for the 2015 calendar year, or, if not available for 2015, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

    a. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

HMO/POS	6%
PPO/Indemnity Business	94%

    b. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	0%
PPO/Indemnity Business	0%

    c. What percentage of your HMO/POS business that is under a risk contract has carved out the pharmaceutical benefit? What percentage of your PPO/indemnity business that is under a risk contract has carved out the pharmaceutical benefit?

HMO/POS	0%
PPO/Indemnity Business	0%

    d. For your risk contracts that include the pharmaceutical benefit, how is the provider's pharmacy budget set? How is the budget trended each year?

    N/A – Aetna does not currently have risk contracts with providers in Massachusetts.

    e. For your risk contracts that include the pharmaceutical benefit, how, if at all, are pharmaceutical discounts and/or rebates (e.g., from the manufacturer) incorporated into the provider's pharmacy budget?

    N/A – Aetna does not currently have risk contracts with providers in Massachusetts.

I, Mark Santos, President of the New England Market for Aetna, am legally authorized and empowered to represent Aetna for the purposes of this testimony, which is signed under the pains and penalties of perjury.

Mark Santos
President, New England Market
Aetna

HPC Payer Exhibit 1

Actual Observed Total Allowed Medical Expenditure Trend by Year

- Fully-insured and self-insured product lines

Time Period	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2013	1.6%	0.3%	-0.3%	0.1%	1.6%
CY 2014	1.6%	-0.9%	0.5%	0.8%	2.1%
CY 2015	2.2%	-0.5%	-0.4%	-0.9%	-0.3%

a. The effect of demographics on trend is contained within the changes due to Utilization and Service Mix as the age/gender and other demographic factors vary the utilization and intensity of services people receive as they age.

b. Benefit buy downs affect utilization as the impact of members paying increased cost share of the total spend lowers unnecessary utilization. Benefit buy downs also impact unit cost trends as members are incented to see lower cost providers and sites of service.

c. The change in health status is similar to, and measurement would be difficult to differentiate from, (a) above. 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 and Service mix.