MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 Pre-Filed Testimony
PAYERS

As part of the
Annual Health Care
Cost Trends Hearing

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

INSTRUCTIONS FOR WRITTEN TESTIMONY

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

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

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

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

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

HPC CONTACT INFORMATION

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

AGO CONTACT INFORMATION

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

INTRODUCTION

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

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

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

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

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

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

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

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

The below answer represents Aetna's experience at the level of its corporate parent, CVS Health Corporation.

Economic conditions are top of mind for us, just as they are for our members and provider partners. The continued high rate of inflation, labor costs, and staffing shortages in the health care industry have exerted pressure on the cost of care and doing business across the board. We continue to monitor our members' access to care, including the number of providers needed to meet demand and the manner in which care is delivered (office, clinic, home visit, telehealth).

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

We are focused on expanding access to primary and preventive care, which includes building on existing resources and platforms for virtual care and existing programs on outreach to at-risk members. In addition, we are working on health equity initiatives related to access to care as detailed below.

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

We have focused on increasing member engagement by collecting data on race and ethnicity, language, gender identity, sexual orientation, and disability status at various touchpoints (enrollment, online Member Portal). We have also included messaging on collection and use of this data to improve member experience with us. More broadly, we use this data to address health disparities in heart health, mental health, and women's health and to develop and integrate programs and strategies on health equity.

Other health equity initiatives undertaken include investment in a team of behavioral data scientists to help us proactively identify members in need. This team uses a variety of data resources to collect social determinants of health on our members, including from public databases (e.g., census track level of social determinants of health indices) and from non-public databases (e.g., social isolation index (SII)). The data collected is then used to build our proprietary case management algorithm. In addition, staff social workers complete a

holistic psycho-social assessment that includes all domains of a member's life with particular focus on social determinants of health. Our staff social workers use care coordination, resource and referral, education, and crisis intervention techniques to remove barriers to appropriate care.

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

Increasing labor costs are in part responsible for the growing cost of care. We would recommend policy changes—such as the collection of additional provider data, if needed—that allow for a better understanding of the impact that periods of prolonged inflation have on the financial health and status of health care providers as they relate to or overlap with development of carrier rates and policy design.

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

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

There have been no changes to our risk scores year over year, as our population has remained consistent year over year. However, we have observed significant increase in utilization driven by rebounding behaviors or pent-up demand for health care services as result of eased COVID-19 restrictions.

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

The impact of elevated medical costs associated with inflation and the health care staffing shortage are most challenging in terms of setting cost growth benchmarks. We also expect continued high demand for care, including delayed care as a result of the COVID-19 public health crisis in addition to routine/standard non-COVID 19 related utilization.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

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

Health Care Service Price Inquiries Calendar Years (CY) 2020-2022			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2020	Q1	4,282	238
	Q2	2,645	77
	Q3	14,331	166
	Q4	39,492	149
CY2021	Q1	41,061	171
	Q2	46,986	175
	Q3	50,603	148
	Q4	43,575	88
CY2022	Q1	65,188	116
	Q2	41,250	137
	TOTAL:	349,413	1,465