151 Farmington Avenue
Hartford, CT 06156-3124

October 27, 2023

Via Email: HPC-Testimony@mass.gov

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

Re: HPC 2023 Cost Trends Hearing, Pre-Filed Testimony

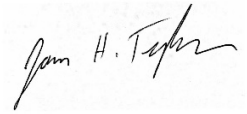
Dear Ms. Johnson:

Attached please find:

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

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

Sincerely,



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

MASSACHUSETTS
HEALTH POLICY COMMISSION

2023 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 2023 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 27, 2023**, 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 2022, 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.

INTRODUCTION

This year marks a critical inflection point in the Commonwealth's nation-leading journey of health care reform. As documented in the Health Policy Commission's 10th annual Cost Trends Report, there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses, including:

- Massachusetts residents have high health care costs that are consistently increasing faster than wages, exacerbating existing affordability challenges that can lead to avoidance of necessary care and medical debt, and widening disparities in health outcomes based on race, ethnicity, income, and other factors. These high and increasing costs are primarily driven by high and increasing prices for some health care providers and for pharmaceuticals, with administrative spending and use of high-cost settings of care also contributing to the trend.
- Massachusetts employers of all sizes, but particularly small businesses, are responding to ever-rising premiums by shifting costs to employees through high deductible health plans. As a result, many employees are increasingly at risk of medical debt, relying on state Medicaid coverage, or are becoming uninsured, an alarming signal of the challenges facing a core sector of the state's economy.
- Many Massachusetts health care providers across the care continuum continue to confront serious workforce challenges and financial instability, with some providers deciding to reduce services, close units (notably pediatric and maternity hospital care) or consolidate with larger systems. The financial pressures faced by some providers are driven, in part, by persistent, wide variation in prices among providers for the same types of services (with lower commercial prices paid to providers with higher public payer mix) without commensurate differences in quality or other measures of value.

The HPC report also contains nine policy recommendations that reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 and 2024 prioritize modernizing and evolving the state's policy framework, necessary to chart a path for the next decade.

This year's Cost Trends Hearing will focus these policy recommendations and on the efforts of all stakeholders to enhance our high-quality health care system in Massachusetts to ensure that it is also affordable, accessible, and equitable.

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

a. Reflecting on the findings of the HPC's 2023 Cost Trends Report showing concerning trends of high and increasing health care costs and widening health disparities based on race, ethnicity, and income, please identify and briefly describe your organization's top 2-3 strategies for reducing health care cost growth, promoting affordability, and advancing health equity for residents of the Commonwealth.

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

- Enhancing Provider Relationships: Aetna is committed to continue building its important relationships with providers. As part of this effort, Aetna has established Performance Improvement Programs, which provide direct payments as rewards for achieving quality outcomes, key components in mitigating rising health care cost trends.

- Providing Members with Information about Available Alternative Sites for Emergent Care: Aetna seeks to offset emergent care costs through product design that lowers health care costs for alternative sites of care. We have expanded access to care through telehealth programs, advancing PCP networks and offering alternative sites of low-cost, high-quality care as alternatives to expensive emergency departments. Our members have access to over 180 low-cost, in-network alternative healthcare options at sites throughout Massachusetts that save time and money.

- Prioritizing Social Determinants of Health: Recognizing that approximately 60% of a person's life expectancy is influenced by everyday activities not connected to care given by providers, Aetna's parent organization, CVS Health, has developed a series of programs throughout its many business areas and philanthropic activities that address social determinants of health. In particular, Aetna supports organizations that address food scarcity, promote education, and provide access to health care, affordable housing, and job opportunities. Since 1997, CVS Health, has invested $42.87 million in affordable housing in Massachusetts, including $950,000 in 2022 alone.

b. Please identify and briefly describe the top state health policy changes your organization would recommend to support efforts to advance health care cost containment, affordability, and health equity.

Aetna appreciates the opportunity to recommend state health policy changes to support health care cost containment, affordability, and health equity. Aetna therefore makes the following recommendations:

- Adopt a Default Out-of-Network Payment Rate: Given the legal uncertainty surrounding the implementation of the federal *No Surprises Act*, Aetna supports the adoption of a state-based default rate for out-of-network services performed at in-network facilities, as highlighted in the 2023 Massachusetts Health Care Cost Trends Report. Aetna submits that the default rate should be adopted for both out-of-network emergency and non-emergency services and it should be based on the carrier's average in-network rate for services in the same geographic area. The establishment of reasonable out-of-network reimbursement rates will increase patient access to health care services by reducing an insured's out-of-pocket costs for services from a provider that is unknowingly not contracted with their health plan and produce cost savings across the state health insurance system by encouraging out-of-network providers to charge more reasonable rates and to participate in health plan networks.

- Establish Site Neutral Reimbursement/Facility Fees: Over the years, the price of similar services performed in similar settings has increased dramatically because certain facilities (outpatient clinics and other facilities) have been purchased by hospital systems. In these instances, Aetna supports close monitoring and potential public policy solutions because the cost of health care at the facilities has risen significantly solely due to the facilities' ownership or affiliation with a larger hospital system.

- Recognize the Importance of Utilization Management: Utilization management, including care management and coordination, prior authorization, and fraud waste and abuse efforts are utilized by health plans to protect patients, reduce medical expenses, and prevent fraudulent care. Legislative efforts to restrict or reduce the use of utilization management could have the unintended consequence of increasing health care costs and reducing access to care.

c. Many Massachusetts health care providers continue to face serious workforce and financial challenges, resulting in the closure and reorganization of care across the Commonwealth. How are these challenges impacting your organization today? What steps is your organization taking to address these challenges?

The economic conditions which health care providers are facing throughout the Commonwealth, including workforce and inflationary challenges, have a direct impact on Aetna, but most importantly, its members and their employer-sponsored plans. Aetna has observed that health systems are seeking to account for these increasing costs at the conclusion of contractual lifecycles through significant demands to increase payments for the same services delivered to members seeking care. Historically, Aetna has considered reasonable rate increase requests, mostly single-digit percentage increases, which have not impeded contract negotiations. In recent years, however, double-digit percentage increases (as high as 71% in at least one case) are demanded regularly. If Aetna is unable to accommodate the rate increase demands, it will create the potential to lose network partners, which ultimately reduces member access to quality care. More directly, our biggest challenge is striking the right balance between recognizing the economic factors provider partners are facing without indirectly forcing employers and consumers to bear those costs through premium increases.

As it relates to addressing these challenges, Aetna is diligently working to negotiate fair and equitable rate reimbursements, utilizing HPC's cost growth benchmarks to drive these efforts. More broadly, in recognition that hospital-based care is far more costly than the preventive care which PCPs provide, we are pursuing value-based contracting and other alternative payment models to redirect those dollars and reward PCPs for quality care outcomes rather than quantity of services.

Furthermore, Aetna is enabling our members to receive the care they need, how they want it, and in an affordable way. To engage these members, we have contracted with providers who collaborate to provide lower-cost solutions, including those who are willing to provide care after hours, telehealth options, and Virtual Primary Care. To further meet the needs of our members, we have expanded mental health access. For example, our behavioral health network in Massachusetts has expanded more than fifty percent from 2022-2023.

d. Please identify and briefly describe the policy changes your organization recommends to promote the stability and equitable accessibility of health care resources in Massachusetts?

Aetna has two policy recommendations for consideration. First, Aetna supports a comprehensive review of scope of practice laws to ensure that all health care providers are practicing at the top of their license. In many states, including in the Commonwealth, the regulatory environment prevents certain providers from performing services in low-cost, high-value settings. For example, we have seen throughout the pandemic the role pharmacists can play in the health care delivery system, providing most of the COVID-19 vaccinations and tests in the Commonwealth. These providers are an example of a highly skilled and underutilized health care resource where state law could expand their scope of practice to perform additional services.

Second, Aetna supports initiatives to monitor public payor reimbursement rates on an ongoing basis to ensure rates are commensurate with services rendered. Doing so helps mitigate rate increases that providers may otherwise seek exclusively from commercial payors. Consistently evaluating public payor reimbursement rates will likely help to prevent any related cost-shifting, which would further impede a payor's ability to contain costs and adhere to established cost growth benchmarks.

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

a. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2019 to 2022 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2019 to 2022, 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.

(a) The effect of changes in demographics on trend is contained within Utilization and Service Mix. As members age, utilization and intensity of services vary according to gender, age, and other demographic factors.

(b) The effect of benefit buy downs on trend is contained within Unit Cost and Utilization. Benefit buy downs impact Unit Cost trends because members are incentivized to seek care from lower-cost providers and sites of service. Benefit buy downs also impact utilization because as members pay an increased share of total spend, unnecessary utilization decreases.

(c) The effect of changes in health status on trend is difficult to differentiate from the question posed in (a) above, changes in demographics. As health status for the population changes, so will all the categories of trend. In a block of declining health status, Costs and Utilization increase and drive increases in Provider Mix and Service Mix.

b. Reflecting on current medical expenditure trends your organization is observing in 2023 to date, which trend or contributing factor is most concerning or challenging?

The most challenging trend factor Aetna is currently facing is the impact of economic inflation on both our contracts with providers (facility & professional) and drug price inflation (pharmacy). We expect this impact to last several years on medical costs due to the length of provider contracts, averaging three years. In contrast, the impact is felt more immediately for pharmacy because prices/contracts are updated annually.

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) 2021-2023			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2021	Q1	41061	171
	Q2	46986	175
	Q3	50603	148
	Q4	43575	88
CY2022	Q1	65188	116
	Q2	41250	137
	Q3	39311	94
	Q4	43309	97
CY2023	Q1	6115	138
	Q2	4908	283
	TOTAL:	371,283	1,447

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 2019	3.50%	1.40%	-1.90%	0.30%	3.20%
CY 2020	3.50%	-10.40%	-2.60%	-0.10%	-9.70%
CY 2021	4.80%	24.90%	-3.70%	-4.10%	20.90%
CY 2022	4.00%	-5.30%	-2.80%	8.00%	3.40%

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.