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.

The Cigna Group is focused on delivering health care that is affordable, predictable, and simple, so people can live healthier, more vibrant lives. Still, with affordability and access challenges, and crises of mental health and care disparities, there is so much more that can be done to strengthen the system so that it works for everyone. Patients, providers, and employers deserve an efficient and integrated delivery model that creates and rewards quality outcomes and supports private sector innovation to best serve the patient.

Building a well-functioning, sustainable, accessible, and equitable health care system requires understanding and addressing social determinants of health (SDOH) and improving medical quality and access, while lowering health risks, promoting preventive health interventions, and coordinating all aspects of care.

Strategies for reducing health care cost growth include:

- The Cigna Group identifies and outreach members at higher risks for social determinant of health (SDOH) as early as possible and connect them with the most appropriate clinical programs. The Cigna Group has been on a mission to ensure all people have the opportunity to achieve their full health potential regardless of social, economic, or environmental circumstances. The Cigna Group continue to lead industry efforts, including active engagement with key stakeholders and communities, to promote the identification of health disparities and initiatives to close gaps.
- The Cigna Group helps individuals navigate to the highest-quality, cost-effective providers and appropriate sites of care and connect to digital health tools to quickly get ahead of a disease and eliminate gaps in care.
- The Cigna Group promotes programs and resources that make care less expensive such as case management and virtual care. The increased interest in and use of telehealth services has modernized the health care system and helped address gaps in access to care – especially for patients

who live in rural and underserved communities. Virtual care can improve the patient experience and help break down barriers that may otherwise prevent people from seeking care.

- We believe all patients should have access to the medications they need at affordable prices. As leaders in health care affordability, the Cigna Group has taken on one of the toughest challenges in health care: negotiating with large pharmaceutical manufacturers to lower the cost of drugs for employers, health plans, federal and state governments, and most importantly, patients. Cigna's Pharmacy Benefit Manager, Express Scripts, continues to lead innovative solutions designed to drive meaningful consumer and client outcomes and performance. Programs such as SafeGuardRx®, Embarc Benefit Protection®, and the Patient Assurance Program℠, combined with effective negotiation and medical management, saved consumers and clients more than $56 billion in 2022.

The Cigna Group is committed to engaging on public policies that drive choice and affordability, foster innovation, demand quality, and improve access. Through our two divisions, Cigna Healthcare℠ and Evernorth Health Services®, we are committed to enhancing the lives of our clients, customers, and patients. In order to fulfill this goal, we continually challenge ourselves to strengthen and evolve our capabilities and take on some of the biggest challenges in health care, including rising costs, access to care, and personalized support for individuals with complex conditions. We do all this while also being committed to fostering innovative new products and platforms that build healthier communities.

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.

As policymakers continue to debate ways to improve health care, we believe it is imperative to provide legislative and regulatory solutions that allow health plans and PBMs to bring affordable, personalized, and simple health care offerings to patients and employers. We must address the underlying cost of health care buy focusing on key costs drivers as opposed to merely shifting who pays for it.

Employers, health plans, and the federal government have an aligned incentive to ensure patients are provided with the most affordable, highest quality health care. A fundamental principle for achieving a sustainable health care system is that better outcomes lead to lower costs. Through innovative benefit designs and evidence-based

negotiations, we challenge and propel drug manufacturers, providers, hospitals, and health systems to embrace reimbursements aligned to patient health outcomes rather than volume driven reimbursements to improve affordability, maximize the value of every health care dollar expended, and drive out inefficiencies. The Cigna Group supports legislative and regulatory flexibilities to further these efforts, including:

- Protecting the ability of health plans to advance delivery system reforms to maximize the use of high-value services at the lowest possible cost (e.g., home delivery of medications, use of specialty pharmacies, and innovative benefit designs).
- Prohibiting anticompetitive tactics used by dominant health systems, hospitals, and providers to limit health plans' and employers' ability to incentivize and/or direct patients to seek high-quality, cost-effective care.
- Ensuring health plans and pharmaceutical benefit managers (PBMs) retain their ability to use formularies and utilization management tools, including prior authorization, to guarantee access to safe and reliable treatments while keeping costs down for clients and patients. Medical management tools promote better health outcomes and improve affordability by 1) ensuring patient safety, 2) ensuring that patient treatment is in accordance with the latest clinical guidelines and evidence-based medicine and 3) ensuring that the right service is provided in the right place at the right time.
- Enabling additional action by regulatory agencies to curb anticompetitive tactics and close loopholes used by drug manufacturers to delay market availability of lower-cost biosimilars. As near-identical alternatives with no clinically meaningful differences from existing FDA-approved biologic drugs, biosimilars provide additional treatment options and create greater competition in the marketplace, which is essential to achieving both access and affordability. Policymakers should embrace the biosimilar market and work to speed approval and market entry of these life-saving drugs to boost competition, lower costs, and increase access to medications.
- Expanding site-neutral payment policies to eliminate cost variations based on care setting (i.e., cancer treatments should not be prohibitively more expensive in a hospital when compared to a physician's office).

Employers should have the ability to design tailored benefit plans that best balance cost, coverage, and patient experience for their employees while choosing a payment structure that works best for their business. To preserve employer choice, we support legislative and regulatory flexibilities around benefit and contract designs.

Successful public policies should foster innovation, demand quality, and drive choice and affordability for an equitable and more sustainable health care system.

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?

Health plans are faced with similar workforce challenges. In non-clinical areas that are facing staffing challenges, the Cigna Group is leveraging early career development programs for individuals directly out of college. Additionally, for employees who show significant potential within the medical and business side, we've added training programs to further develop their skillset. Prioritizing key resources to provide the best care to our customers allows us to partner more effectively with the provider community and ensure a focus on patient care. The Cigna Group looks to leverage our current talent by creatively aligning and restructuring the way we deliver services to be more effective in our markets.

The Cigna Group believes that value-based relationships with providers are key to continually improving sustainable affordability, quality care and experience. We work with providers to help ensure their success in value-based care. We do this through aligned incentives, peer-to-peer consultative support, actionable information, and alignment with our consumer health engagement programs.

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?

The Cigna Group has long been an industry leader in our commitment to ensuring that all people have the opportunity to achieve their full health potential regardless of social, economic, or environmental circumstances. To accomplish this goal and eliminate disparities, we must close gaps in care – including differences in disease prevalence and severity, access to care, quality of care, and health outcomes, among all segments of the population and increase access to behavioral health providers.

One recommendation is to promote the use of advanced analytics to help identify high risk customers and improve their clinical outcomes. The power of data, analytics, and predictive modeling has the potential to significantly improve member's health and address the affordability challenge. Knowing the conditions and types of care that consume health care spending is fundamental to identifying

and prioritizing opportunities to improve health by understanding and addressing localized and patient-level challenges, consistent with state and federal privacy laws. The new data can provide insights into many crucial questions. What conditions represent the most significant share of health spending in a particular community? What types of care (e.g., pharmacy, inpatient services) are driving spending related to a particular condition? What types of service have high variability in per-patient cost? Do particular providers or therapies represent a disproportionate share of costs? What is the utilization of low-value services that have poor clinical evidence? Are there proactive strategies that can be deployed to promote health and wellness? This approach holds incredible potential for improving the entire health system. We should all be thinking differently about data, allowing state and federal health programs to be more efficient and responsive to health trends.

The state should continue to support cost and quality transparency. Providing our customers with meaningful and actionable information about the cost and quality of health care services has long been one of our principal priorities, and we are continuously investing to expand and improve the information available. Our experience has shown us, however, that the challenge in enabling patients to become active consumers is not the availability of price data, but awareness and use of such information.

Additionally, the state should continue to promote policies that enable access to critical behavioral health services. Our data-informed approach to behavioral health provides personalized and customized care across the entire continuum for the populations we serve. These solutions predict emerging health needs, close gaps in care, and drive cost savings—all while empowering whole-person and whole family health.

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.

For 2019 – 2022, demographics have impacted Cigna's book of business observed medical trend by 0.4%, 0.4%, -0.1%, and 0.0% respectively. For 2019-2021, benefit buy-downs have impacted observed medical trends by 0.2%, 0.8%, -0.9%, and -0.9% respectively. *Cigna is evaluating the impact of the COVID-19 pandemic on risk scores and the resulting comparability of risk scores between calendar years in determining risk adjusted total medical expenditure trend.

Trends	Change in Risk	Adjusted TME Trend
2018-2019	0.5%	**4.3%**
2019-2020	n/a*	**-4.9%**
2020-2021	-0.1%	**15.2%**
2021-2022	0.0%	**3.4%**

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?

Nationally we are seeing a significant return of utilization in 2023, including elevated use of mental health/substance abuse services. Health spending continues to increase and is projected to rise 5.6% annually from 2025-2031; and in 2031, health spending is projected to comprise nearly 20% of the U.S. economy.

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	20,648,666	3,401
	Q2	16,824,070	1,580
	Q3	17,209,013	1,987
	Q4	17,991,420	2,110
CY2022	Q1	21,126,505	4,201
	Q2	17,659,811	3,659
	Q3	18,033,599	4,540
	Q4	19,801,174	4,270
CY2023	Q1	27,079,645	7,131
	Q2	21,483,170	5,147
	TOTAL:	197,857,073	38,026

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	3.1%	0.8%	N/A	0.8%	4.8%
CY 2020	2.8%	-10.3%	-0.2%	3.3%	-4.9%
CY 2021	2.7%	23.6%	0.2%	-9.4%	15.2%
CY 2022	3.3%	-6.3%	1.3%	5.5%	3.4%

*2018 Provider Mix was not readily available.

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 shouldnot 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