MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

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 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses 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 2013, 2014, 2015, 2016, and/or 2017 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony 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.

If you have any difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

Pre-Filed Testimony Questions

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

Aetna's top areas of concern are (1) prescription drug spending, and (2) over-utilization and unnecessary utilization of health care services.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?

I. Prescription Drug Spending

Specialty drugs present the greatest barrier to reducing the growth of such spending. Where applicable and allowed, Aetna applies the solutions listed below to advance the priority of a reduction in the expenditures on specialty drugs:

- **Maximize biosimilar and generic specialty opportunities** – The United States is expecting a $31.8 billion biosimilar savings opportunity through 2020. Aetna is constantly monitoring the specialty drug pipeline and developing strategies for ways to maximize savings while ensuring therapy appropriateness. We anticipate that many of the tools that we have available today to encourage the use of cost effective agents will be useful with biosimilars. These tools include step therapy, precertification and copay differentials.

- **Ensure appropriate use through specialty precertification** – Aetna's standard is to require precertification for certain specialty drugs to ensure appropriate therapy. We do so using our Clinical Policy Bulletins (CPBs) to determine appropriate therapy.

- **Site of Care Optimization** –Through our site of care policy applied during precertification and claims analysis, Aetna engages identified members receiving care at high cost delivery sites and mandates or recommends alternate delivery options for the specialty infused drug. An Aetna staff member contacts the member and recommends the most cost effective and clinically appropriate site of care for the member (e.g., home infusion). We offer this program at no additional cost and it is either mandatory or voluntary (depending on the drug) for both the member and the customer. Once a member transitions to the new site of care, we then continue to monitor them closely to ensure a successful transition. This program saves an average of $83,000 per successful conversion.

II. Utilization

Aetna is committed to the pursuit of new and innovative strategies to manage utilization and reduce costs. We continually monitor expenses by working with our partners to identify efficiencies to help Aetna meet cost reduction goals. Like the industry as a whole, our networks have traditionally emphasized network discounts and medical management services. However, through value-based contracting initiatives, we have shifted our emphasis to strategic relationships with the provider community to deliver comprehensive health care management that includes, and goes beyond, traditional discount improvement programs. In doing so, we strengthen provider performance through collaboration, technology, analytics and data-sharing.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

I. Prescription Drug Spending

Aetna uses a number of strategies to address the rising trend in pharmacy plan costs and utilization. Aetna's plan design options and total member management programs take advantage of our integrated pharmacy and medical data which helps balance cost savings with member satisfaction and choice. Specifically, Aetna helps control costs through:

Formulary selection – We offer a variety of formulary options that balance member choice with plan savings. We have been leading with the Value and Value Plus formularies for many fully-insured customers because these include better plan cost controls by covering generic drugs with one or two preferred brands per class. The Value formulary offers up to 15% savings compared to our broadest formulary.

Plan design selection – Customer plan preferences can vary widely, which is why we offer a variety of benefit plan designs to support cost management strategies. This includes number of tiers, copay spread between tiers, percentage copays, pharmacy plan deductibles, home delivery, and generic options.

Generic promotion – We increase awareness of generics as safe, effective alternatives to brands through several programs. Examples of our generic promotion strategy include step therapy and generic substitution at home delivery. We also recommend our Choose Generics cost-sharing program which on average can save an estimated 2.5-3.5% on total pharmacy claim costs, depending on plan design and copays.

Specialty trend management – Specialty drug management challenges are unique and critical as drug spend on this category often exceeds 20% of plan totals, annually. We offer a focused approach to management of this category, through programs designed to encourage members to use our specialty management program, which includes comprehensive member management, counseling and support, as well as cost effective dispensing. The result is improved adherence and outcomes, along with plan and member savings.

Another program that specifically targets savings while achieving optimal health outcomes is Aetna's Site of Care Optimization program. There, we identify members who could select a more

cost effective solution for infusion. We work with each of the identified members and their providers to find ways of reducing the cost of care and, often, to make the infusion more convenient for the member. Depending on the drug, we work with members either prospectively or retrospectively.

Finally, with respect to lowering drug costs for our members, Aetna has announced that it plans to implement a program in 2019 to share rebates with individual members at the point of service. Aetna has plans to begin automatically applying pharmacy rebates it receives on rebatable brand drugs to all commercial fully insured members, including its members in Massachusetts, at their point of service beginning in 2019, so that members will realize certain savings at the point of service. For self-insured commercial policies, Aetna may share some or all of the rebate with self-insured plan sponsors. For federal Medicare Advantage and Medicare Part D prescription drug plans, Aetna passes rebates to beneficiaries through lower premiums.

II. Utilization

Spending more for care does not guarantee the quality of that care. Aetna is continually evaluating programs to address inefficient utilization and/or over-utilization by patients and directing our efforts toward the most effective solutions. We continually seek health care management solutions that address both total costs and quality.

Utilization Management and Review

One way Aetna helps contain costs is through thoughtful utilization management processes and reviews. These reviews help make sure our members get the care they need at a reasonable cost.

Precertification

By focusing on high-cost or over/under-utilized procedures, our precertification process is an important step in finding members in need of special services. It's where we learn who needs acute care management or referrals to special programs. From this entry point, we can work with the member to help save costs and improve health. For example, we can refer them to our Institutes of Excellence™ facilities for transplants and highly specialized services or we can refer them to our Institutes of Quality® facilities that offer quality care for certain bariatric, orthopedic and cardiac procedures. These facilities will have met a number of industry-recognized standards for cost efficiency and clinical quality.

We engage both our members and our network doctors in this cost-saving process since doctors don't always realize the cost differences among facilities when referring their patients for tests and other care. Our precertification program helps doctors give members more care options, steering them to lower-cost facilities that give quality care.

Concurrent review and discharge planning

Our clinical staff reviews inpatient admissions (except routine maternity care) while the member is in the hospital. We use proven standards of care as guidelines to help make sure care given is covered and medically necessary.

We also help members get the care they need after they get out of the hospital. Our proactive discharge planning begins during the hospital stay. We work with doctors and members to develop a transition plan from one level of care to the next.

Case management referrals boost engagement

During our utilization reviews, we look for members who can benefit from a nurse case manager to help prevent more significant health events. We effectively engage more than 95 percent of those members reached. And, our 30-day readmission rate is 5.4 percent.

Network solutions

Aetna offers a variety of network solutions, such as our Aetna Institutes™, that let our members find facilities that offer high levels of clinical care and cost efficiency. When combined with our strong plan design strategies, our networks help control overall costs. Our Aetna Institutes consist of:

Institutes of Excellence™ (IOE) facilities

Aetna's IOEs offer the highest quality, most cost-effective care available for complex cases. This includes care for organ transplants and infertility services. Because of the complex nature of this care, Aetna coordinates services to achieve better health and cost outcomes.

Institutes of Quality® (IOQ) facilities

Aetna's IOQs offer clinical services for common health procedures – morbid obesity, heart disease, spine surgery and hip and knee replacement. We measure many factors when selecting our IOQs – everything from the level of care to how often patients return to the hospital after surgery.

Plan design strategy

Aetna is continually evaluating ways to improve our plan designs. Adapting to and predicting market changes lets Aetna help members get the right care at the right time. For example, we were the first national insurer to launch a consumer-directed health plan: Aetna HealthFund® (AHF). AHF products are an attractive alternative to traditional plans. They provide coverage by combining a deductible-based medical plan with an employer sponsored health reimbursement arrangement or a high-deductible health plan with a tax-preferred health savings account. Experience shows that AHF products keep health care costs in check by encouraging members to get preventive care, obtain care for chronic illnesses, and use wellness and education tools to make good health care decisions. By educating members about their health care and involving them financially, they are motivated to use health care services in a more health- and cost-conscious way. In addition, our research tells us that employers who offered AHF plans had an average annual trend that was 1.8 percentage points lower than a comparison group's trend over a five-year period.

Customers that combine medical with pharmacy, dental, behavioral health and/or disability plans potentially save even more. In our most integrated model, Aetna One® Premier, 71% of referrals to disease management remained active after the referral and 65% had greater participation in case management. We have found that the longer members stay engaged with our programs, the

more effectively we can work with them and their providers to help manage acute illness and chronic conditions.

Finally, Aetna believes it could have more success encouraging members to receive care from lower cost, quality providers if it were allowed to offer plan designs in Massachusetts where the coinsurance differential between in and out of network providers could vary by more than 20%.

Engagement strategies - We also engage our members with proven results. Our 24-hour Informed Health® Line/nurseline service helps reduce unneeded doctor and emergency room visits by educating the member on their health topic of choice. In addition, our Healthy Lifestyle Coaching program showed an impressive reduction in indirect costs. Participants had the following results (per 2013 Aetna Informatics®):

- 57% improved weight
- 90% reduced or maintained stress
- 86% improved exercise levels
- 73% improved diet
- 58% quit tobacco usage

2. INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s), as applicable.

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

b) 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
☒Other: Customer Care and Prior Authorization Review

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).

Commercial (fully-insured and self-insured) and Medicare

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the

covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe this policy.

CVS's adjudication system uses a "lower of" logic, which charges a patient the lower of the copayment or the cost of the drug. CVS does not restrict a pharmacy from disclosing information on the cost or efficacy of a drug.

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe this policy.

No

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment? If yes, briefly describe this policy.

Yes. The CVS Caremark Provider Manual requires a pharmacist to disclose to a covered person the Usual and Customary Price if that price is less than the person's applicable copayment amount.

3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? [check all that apply, and describe your primary incentive related to the care delivery innovation in the fields below]

☒Readmissions
Payment Penalty or Non-Payment

☒Avoidable emergency department (ED) visits
Payment Penalty or Non-Payment

☒Behavioral health integration into primary care (e.g., collaborative care model)
Other (please describe in a text box)
Coordination and integration of behavioral health and primary care leads to better mental and physical health outcomes for our members.

☒Pharmacologic or other evidence-base therapies for substance use disorder
Other (please describe in a text box)
Increase access to and the affordability of evidenced-based treatment for substance use disorder

☐Peers and/or community health workers Required Answer: Click Here

☒Telehealth/telemedicine

Other (please describe in a text box)

Aetna wants to help members reach their health goals by increasing access to care and improving on the member experience by providing convenient telemedicine services, including through coverage of physician e-visits through arrangements with Teladoc, Inc.

☐Non-medical transportation Required Answer: Click Here

☐Supportive temporary or permanent housing Required Answer: Click Here

☐Other: Click here to enter text. Required Answer: Click Here

4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

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."

a) In the table below, please provide available data regarding the number of individuals that sought this information:

Health Care Service Price Inquiries CY2017-2018			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	16,585	219
	Q2	52,894	208
	Q3	17,306	153
	Q4	27,345	155
CY2018	**Q1**	39,169	173
	Q2	32,550	159
	TOTAL:	185,849	1,067

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

No significant barriers identified

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

No significant barriers identified

5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2015 to 2017, 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., utilization trend, payer 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.

Please see the attached HPC Exhibit 1 for Aetna's Response

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN APMS

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 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.)
   i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)
      1. HMO/POS 2.4% (in Massachusetts)
      2. PPO/Indemnity Business 97.6% (in Massachusetts)
   ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's PPO/indemnity lives is under a risk contract?
      1. HMO/POS 0% (in Massachusetts)
      2. PPO/Indemnity Business 0% (in Massachusetts)
   iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?
      1. HMO/POS 0% (in Massachusetts)
      2. PPO/Indemnity Business 0% (in Massachusetts)

b) Please answer the following questions regarding quality measurement in APMs.
   i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care

Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?

(a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

As a national carrier, Aetna engages providers where they are in their value-based contracting ("VBC") development and offer ongoing, collaborative support to enable progression further up the VBC continuum. The ultimate goal for our accountable care collaborations is to partner with provider organizations that can increase their level of clinical, quality and financial accountability. While we strive for consistency, we also recognize the unique capabilities of health systems and physician groups. As such, the clinical and financial performance targets used in our ACOs may vary depending on the provider organization's unique service attributes as well as the member/patient population. Our contracts are developed in conjunction with the provider after a capabilities assessment and agreement on the business model.

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

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 VBC initiatives include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and pay-for-performance (P4P) agreements.

Accountable care organizations

Aetna's contracted ACOs include some of the most advanced and efficient systems in the country. We currently have more than 500 ACOs and joint ventures (JVs). We are engaged in discussions with health systems across the country to identify additional ACOs that focus on delivering high quality, efficient care. Nationally, 56 percent of our claim payments go to providers who deliver value-based care, with 60 percent of those payments aligned with our commercial ACOs and joint ventures. In addition, 9 percent of VBC spend is aligned with our PCMH models and 13 percent is aligned with P4P arrangements. Our target for 2018 is to have 60 percent of claims aligned with providers in VBC models, with the expectation that VBC spend will hit 64 percent in 2019. We are committed to having 75 percent of all medical spend in VBC arrangements by 2020.

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 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:

- 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.

Patient-centered medical homes

PCMHs 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 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 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.

Pay for performance

The goal of our P4P model is to reduce unnecessary treatments and services, improve quality, and make care more affordable. We have P4P arrangements with physicians and hospitals. A cross-functional team of clinicians, quality improvement specialists, informatics, and reimbursement experts collaborate to identify measures that are clinically appropriate for inclusion in P4P arrangements. We reward providers that meet or exceed performance targets with a value-based payment. The payment methods are a one-time lump sum or an increase in rates. When an incentive payment is calculated and made, each customer pays a proportionate share of the payout based on their share of claims during the period that the value-based payment was earned.

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. Our VBC initiatives currently include physician P4P and PCMH arrangements. We offer two P4P arrangements with Lowell PHO and Atrius Health, the largest independent physician group in Massachusetts. 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.

***

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.

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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 2015	2.2%	-0.5%	-0.4%	-0.9%	-0.3%
CY 2016	1.7%	1.5%	2.3%	0.8%	5.6%
CY 2017	3.9%	-0.8%	1.4%	0.2%	4.8%

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.