151 Farmington Avenue
Hartford, CT 06156-3124

November 1, 2024

Via Email: HPC-Testimony@mass.gov

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

Re: HPC 2024 Cost Trends Hearing, Pre-Filed Testimony

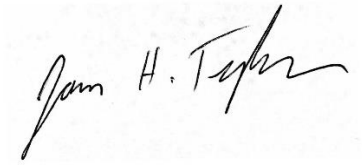
Dear Ms. Johnson:

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

2024 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 2024 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, November 4, 2024**, 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 2023, 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.

THE 2024 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2024 Health Care Cost Trends Hearing will take place in a period of significant upheaval and reflection for the Commonwealth's health care system. The bankruptcy and dissolution of Steward Health Care, previously the third largest hospital system in Massachusetts, led to substantial disruptions to the state's health care market and has taken a significant toll on communities, patients, provider organizations, and health care workers across the region. This market instability is occurring while many providers across the health care continuum are still struggling to adapt to a post-pandemic "new normal" state, wrestling with capacity constraints, financial volatility, administrative burdens, and workforce recruitment and retention challenges.

At the same time, an increasing number of Massachusetts residents are struggling with health care affordability and medical debt. Massachusetts has the second highest family health insurance premiums in the country. The average annual cost of health care for a family exceeds $29,000 (including out of pocket spending). Recently, more than half of residents surveyed cited the cost of health care as the most important health care issue, far surpassing those that identified access or quality. Due to high costs, 40 percent of survey respondents said they are putting off seeing a doctor or going to a hospital. These affordability challenges are disproportionally borne by populations of color, and those in Massachusetts with less resources, contributing to widening disparities in access to care and health outcomes. The annual cost of inequities experienced by populations of color in Massachusetts is estimated to exceed $5.9 billion and is growing every year. These challenges require bold action to move the health care system from the status quo to a new trajectory.

This year, in the wake of the considerable harm caused by the bankruptcy of Steward Health Care and other recent market disruptions, the HPC is focusing the 2024 Cost Trends Hearing on moving forward, from crisis to stability, and building a health care system that is more affordable, accessible, and equitable for all residents of Massachusetts.

Since 2012, pre-filed written testimony has afforded the HPC an opportunity to engage more deeply with Massachusetts health care market participants. In addition to pre-filed written testimony, the annual public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the Health Care Cost Growth Benchmark and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Reflecting on the health care market disruptions in Massachusetts in recent years, including the bankruptcy of Steward Health Care and related closures, what have been the most significant impacts of these disruptions on your members, your network(s), and your organization?

The Steward Health Care news created anticipatory challenges and taxed resources while preparing to mitigate any disruptions to patient care. Given the Division of Insurance's proactive and collaborative approach, it appears the stakeholders are working together to reduce any member, provider, and payor disruption. It is unclear whether the collaboration will be short-lived when new negotiations occur with new entities and/or the rate demands will continue to escalate. The health care market in Massachusetts continues to face numerous pressures post-Covid, along with the inflationary disruption. It is anticipated that financial pressures will occur, whether through new contracting processes, where reimbursement rate demands are untenable, or new infrastructure is required given new mergers and acquisitions. Future challenges include determining who will bear these costs and what the impact will be to the Massachusetts residents, all of which are anticipated to disrupt the Massachusetts health care market.

2. Please identify and briefly describe any policy, payment, or health care market reforms your organization would recommend to better protect the Massachusetts health care system from predatory actors, strengthen market oversight and transparency, and ensure greater stability moving forward.

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Public policy and health care reform efforts should always start from the patient's perspective. By keeping the patient experience at the center of the policy evaluation process, predatory behavior and destabilizing efforts become more readily apparent. Thus, while we don't have a specific policy or reform recommendation, we encourage the state to establish a baseline standard, such as: Does a proposal improve the patient experience and affordability? Or does a potential proposal exacerbate legacy fragmentation in the system, which will allow for things like maximizing fee-for-service and out of network reimbursement. For example, if two provider entities are looking to merge, will the merger lead to greater market concentration for services typically tied to fee-for-service, where contracting strength will ultimately drive prices up with no discernable difference in quality? Alternatively, a merger may allow a smaller group of providers to join a larger system with a history of effective value-

based contracting. There is no one-size-fits-all solution; however, policy and market reforms should continually move toward patient improvements and away from legacy fragmentation.

3. Reflecting on consistent HPC findings showing increasing health care affordability challenges, growing difficulties accessing needed care, and widening health disparities based on race, ethnicity, and income among Massachusetts residents, what are your organization's top two to three strategies for addressing these trends? What are the most significant challenges to implementing these strategies?

- Advancing Health Equity: One of our cornerstone initiatives is our Foundational Program on Culturally Respectful Care and Addressing Healthcare Disparities. This program focuses on identifying the various root causes of health disparities and promotes the integration of cultural humility into clinical interactions. By encouraging regular self-assessment for bias among our providers, we strive to enhance patient care, improve outcomes, and address disparities that often lead to increased healthcare costs.

- 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 potential options 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. 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 $58.5M in affordable housing in Massachusetts. In July 2024, CVS celebrated the grand opening of Grace Apartments, a $6.4M investment in East Boston, MA. This property is home to 42 units for low-income seniors. In August 2024, CVS Health closed a $10M investment for the historic adaptive re-use of the former Worcester Boys Club in Worcester, MA. This project will also include a new five-story

construction building adjacent and connected to the existing structure. Once complete, the property will be home to 80 affordable units for seniors (age 55+).

4. Please identify and briefly describe any policy, payment, or health care system reforms your organization would recommend to achieve a health care system that is more affordable, accessible, and equitable in Massachusetts.

Any policy, payment or healthcare reform should not impose further administrative restraints and reporting requirements that will not fundamentally change the outcomes of patient care. Overly complex regulations divert resources from patient care and create inefficiencies without impacting patient outcomes. An outcome-based approach will enhance delivery of care as opposed to focusing on process. Things that will benefit patient well-being are allowing health plans to focus on innovation and collaboration with members, providers, and plan sponsors with a transformative approach. Any reform that restricts or limits a payor the ability to reduce cost or introduces costly and ineffective administrative burdens will not advance patient centered goals of improving health outcomes.

2024 has brought considerable focus on the importance of Utilization Management which is an effective process to create more affordable, accessible, and appropriate care. Utilization Management is a fundamental commitment we make to our members to make sure they receive the right care at the right time for the right reason. Utilization Management has its place in patient safety and the integrity of the care that is delivered. We believe that complete removal of this process will put patients at risk. We want to protect patient safety and clinical integrity and eliminate hassles.

To support providers and reduce administrative burdens, we have invested in technology to streamline the experience as best we can for providers. Additionally, we have looked at services that are consistently approved, and we have made those eligible for automation.

We have a fleet of board-certified medical directors who may render a denial based on medical necessity for a service. Having board-certified medical directors make these decisions is extremely important because we're trying to find the right balance between patient safety, fiscal responsibility, and member and provider experience.

We also have spent reviewing the services our providers have historically requested, and we have enabled certain providers with consistent approval track records to receive auto approvals through our provider differentiation program.

Prior authorization is a member centric tool, and through this lens we can focus on the impact on patient safety, cost, and the potential for fraud, waste and abuse.

TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2020 to 2023 according to the format and parameters provided and attached as HPC Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2020 to 2023, 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 also impact Unit Cost trends because members are incented to see 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 similar to and difficult to differentiate from changes in demographics. As health status for the population changes, so will all categories of trend. In a block of declining health status, Costs and Utilization increase and drive increases in Provider Mix and Service Mix.

2. Reflecting on current medical expenditure trends your organization is observing in 2024 to date, which trend or contributing factor is most concerning or challenging?

   The most challenging trend factors Aetna is currently facing are increased utilization seen in almost all service categories, as well as the continued 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. Many providers are requesting double-digit increases to contracted rates, which is elevated from historical contract negotiations in the market. Overall recent trends have been 2-3% above historical levels, and our outlook remains consistent with that recent experience.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. 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.

Aetna has transitioned to a new website reporting tool allowing greater precision on price inquiries and has rerun 2022-2024 updating our search results.

Health Care Service Price Inquiries Calendar Years (CY) 2022-2024			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2022	Q1	14,642	116
	Q2	14,645	137
	Q3	12,906	94
	Q4	12,778	97
CY2023	Q1	10,654	148
	Q2	7,679	435
	Q3	7,721	269
	Q4	8,785	279
CY2024	Q1	12,062	427
	Q2	7,548	355
	TOTAL:	109,420	2,257

2. When developing benefit plan options for employer groups, do you consider point-of-service cost-sharing affordability separately from premium affordability? If so, how do you do this and what metrics and data sources do you use?

Aetna's fully insured portfolio for our Massachusetts market segments covers plans with 101 or more lives and consists of a broad range of medical plan design options at

varying price points. We aim to strike the right balance between member cost and overall health plan affordability. Aetna's portfolio includes different combinations of products and cost-sharing strategies – all of which are a starting point for medical plan strategy discussions that Aetna has with brokers and employers. First and foremost, Aetna collaborates with brokers and employers who are the decision makers and drivers behind the products Aetna offers. Most importantly is that the Aetna plans all have flex cost sharing options, and we provide the support tools so brokers and employers can model a plan design to benefit their specific needs. For example, the Aetna Upfront Advantage plan provides allocated reimbursement at dollar one for everyday care for selected services before the deductible. Another option is our Aetna Flexible Five which provides each member with up to 5 in-network services at no cost for selected services. These cost-sharing affordability focused plans are just some of the options that Aetna offers employers in building their employee benefit plans. Optimality and flexibility are Aetna's goals in providing a multitude of plan options that employers choose from. The stratified benefits we continually see requested by brokers are HSA plans with rich contributions or plans at a higher price point with more flexibility and lower out of pocket costs. Despite these options focused on balancing a price point and cost control, Aetna finds that overall, Massachusetts plan sponsors prefer very rich benefits at different tiers, compared to our other markets.

3. Are there any accommodations you offer to providers in consideration of point-of service cost sharing bad debt under your global risk arrangements? For instance, is the full allowable amount (i.e., both the insurer and the member portions) charged against the global budget even if the provider was never able to collect the member portion? Please provide details.

Aetna does not contact with Providers under any global risk arrangements. Policies or programs that shift bad debt to the insurers as risk bearing organizations will create greater instability in healthcare. Healthcare entities have access to a multitude of governmental resources that add stability into the healthcare delivery system and help providers maintain operations. Aetna's best practices include consistently reviewing the cost sharing and affordability of our products with our plan sponsors. As an alternative to global risk arrangements, Aetna offers a continuum of alternative payment methodologies as part of our Value Based programs to support the success of our provider partners. These programs are collaborative, member centric and focus on quality and affordability of care which may contain risk arrangements. These programs allow providers to better manage resources and invest in innovative care models to improve the health outcomes of their patients.

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

- Includes both fully-insured and self-insured Commercial product lines

Time Period	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2020	3.5%	-10.4%	-2.6%	-0.1%	-9.7%
CY 2021	4.8%	24.9%	-3.7%	-4.1%	20.9%
CY 2022	4.0%	-5.3%	-2.8%	8.0%	3.4%
CY 2023	5.3%	0.3%	0.5%	0.7%	7.0%

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 incented to see 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 similar to and difficult to differentiate from changes in demographics. 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 Mix and Service Mix