American Hospital Association™
Advancing Health in America

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September 15, 2025

Mr. Steve Nelson
President
Aetna
151 Farmington Avenue
Hartford, CT 06156

Dear Steve:

America's hospitals and health systems are deeply concerned about Aetna's recently announced "level of severity inpatient payment" policy. This policy could erode the transparency consumers rely on to make informed decisions about their care, undermine important regulatory protections that safeguard patients' coverage, and jeopardize the ability of hospitals to provide high-quality, accessible care to all who need it. The American Hospital Association urges Aetna to rescind this policy.

Effective Nov. 15, 2025, Aetna will create a new type of inpatient reimbursement for so-called "low severity" inpatient stays that it has said will be "comparable" to observation rates. This policy will take the place of Aetna's (and essentially every other insurer's) long-standing approach of denying inpatient stays it deems medically unnecessary and then, in most instances, downgrading them to outpatient observation status. Instead, Aetna will approve these inpatient stays but reimburse hospitals at a lower rate it determined unilaterally outside of the good faith contract and rate negotiation process. This policy only will apply to Aetna's Medicare Advantage and dual eligible lines of business.

One of the most worrying consequences of this policy is the impact it could have on beneficiaries' and regulators' ability to assess the quality of Aetna's coverage. Specifically, this policy could distort data that have direct bearing on Aetna's performance on several measures that make up the Medicare Advantage Star Ratings Program. We are especially concerned about the impact on ratings related to the health plan's handling of appeals since Aetna's policy will reduce the opportunity for patients and providers to file appeals. Fewer appeals could impact the calculations for these measures, and, as a result, this policy could give the impression that Aetna's performance has improved. That, in turn, could influence whether Aetna qualifies for a performance bonus and for how much, potentially redirecting millions in taxpayer dollars to the health plan for reasons entirely unrelated to the goals of the Star Ratings Program.

Moreover, the policy appears to circumvent established regulatory standards regarding coverage for Medicare Advantage beneficiaries. Under current practice, the decision by Aetna to deny an inpatient claim and cover it as observation is subject to federal regulations that, among other requirements, require plans to use Centers for Medicare & Medicaid Services coverage rules and disallows use of proprietary criteria to determine whether care is medically necessary and should therefore be covered. By treating this as solely an issue of payment, Aetna avoids these rules and explicitly indicates it will use the proprietary MCG guidelines to determine the level of payment, not whether the care is medically necessary. The federal government adopted these regulations to safeguard beneficiaries against inappropriate denials and downgrades of care, but Aetna's policy will now shield the company from critical oversight.

Finally, this policy will further stress an already financially unstable health care system at a time when hospital costs for caring for patients continue to rise. Without an official denial, it is unclear how hospitals will know that an underpayment has occurred, something that is done today through established standard denial codes. Hospitals likely will need to invest in staff and financial resources to identify these claims and then adjudicate any disputes not through the standard appeals process, but rather through the dispute resolution mechanisms under their contracts. In most cases, this will be arbitration, a more costly and burdensome endeavor than traditional appeals and the outcomes of which almost always go undisclosed. This will further obscure regulators' oversight of Aetna's performance in delivering on the coverage consumers expected.

During this year's second quarter earnings calls, Aetna and its parent company CVS Health committed to shareholders to implement a margin recovery strategy in light of emerging cost trends. But shareholder returns cannot come at the expense of the quality of coverage for Medicare beneficiaries or otherwise compromise the integrity of the Medicare program and the health care system at large. **The AHA calls on Aetna to put patients first by rescinding this payment policy, which could artificially improve Aetna's performance metrics, restrict government oversight, and jeopardize the ability of hospitals to provide accessible care to all who need it.**

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer