Testimony of

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(Written Submission)

Good morning Chairman Kucinich, Ranking Member Jordan and members of the committee. My name is Patricia Farrell, and I am the Senior Vice President of National and International Business Solutions at Aetna. Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, disability insurance and employee benefits. We provide products and services in all 50 states, serving over 36.8 million unique individuals. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

Thank you for the opportunity to participate in today's hearing to discuss the value we bring to the health care consumer and the health care provider. Our industry has evolved much in the last several decades. In fact, a health insurance executive from the 1970's would not recognize many of the functions that Aetna now performs. Today, more than twenty percent of our workforce are clinical practitioners or information technology experts. Aetna today is a health care solutions company that helps employers and individuals manage their health and get the most value out of their health care dollar.

Our business is successful when we 1) provide our customers with the greatest value for their health care dollar, and 2) help them improve or maintain their health status. Our 35,000 employees -- doctors, nurses and customer service personnel -- come to work every day with the commitment to make sure our members get the best, affordable health care possible. We have one of the highest employee satisfaction rates because our employees believe in the value we bring to our customers.

I also want to comment on the important health care reform proposals Congress is now considering. Aetna is committed to meaningful health care reform, and I think that the record shows that we are the most active in our industry in bringing thoughtful proposals based on our significant experience to the national discussion. Since 2005, we have called for insurers to guarantee coverage and make no exclusions for pre-existing conditions in the context of a universal coverage requirement coupled with appropriate subsidies to individuals.

We also believe it is critical that health reform must address the underlying affordability issue of rising health costs. Increases in insurance premiums are a direct result of increases in the underlying cost of care. To be clear, health care costs drive insurance premiums, not the other way around. Over the last decade, health care costs have risen about 7.7 percent a year on

average, and insurance premiums also have risen at 7.7 percent.[1] Insurance reform, without payment and cost reform, will not work to make health care more affordable for Americans.

In order to address the interest of the committee in these matters, it is important to understand the value we bring to the health care system and how our business practices are geared to empowering consumers and their health care providers to make the best decisions possible. Of the 407 million claims processed in 2008, virtually all were done correctly. However, we recognize that even a very small percentage of errors, translates into real concerns for our members and our provider networks. When we do get it wrong we have processes that are designed to help our customers and us get the issue back on track.

I. Aetna Innovations – Connecting a Fragmented Health Care System

Patients need a delivery system that helps them achieve optimal health by delivering the right care at the right time – *every* time. Today, we simply do not have such a system in place in this country. The statistics are familiar but startling. As many as 98,000 Americans die annually as a result of medical errors in hospitals and at least 1.5 million are injured every year because of medication errors. In fact, Rand estimates that only 55% of Americans get recommended care.

There is a thirty percent geographic variation in medical services that is unexplainable by patient health status or quality of care. For instance, there are 4.6 lumbar fusions per 1000 in Idaho Falls, Idaho but only 0.3 per 1000 in Grand Forks, ND. Vulnerable elders receive only about half of recommended care – with preventive care having the lowest adherence at 43 percent. And when new treatments are found to be effective, it takes almost 17 years to be fully introduced at the delivery level – a life threatening delay for many patients.

Aetna is committed to addressing the dangerous shortcomings of today's health system through:

- Building strong partnerships with doctors and health systems,
- Harnessing technology to improve quality and efficiency of care, and
- Promoting health and wellness for all Americans.

[1] CMS, National Health Expenditures Data, 2009

Building Strong Partnerships with Physicians

Aetna believes that physicians and health care professionals are the backbone of our delivery system and has developed partnerships and initiatives to maximize the important contributions of these providers. Aetna is a health care company comprised of a comprehensive medical team including many doctors and nurses. These medical professionals work side by side with the external medical community to give our members access to quality, evidence-based health care in a cost-effective manner.

Aetna's hard work on its provider relationships has been acknowledged by independent experts, who rank us number one in the insurance industry. Last year, we received the Verden Group's *Annual Award for Most Provider Friendly Network*. The Verden Group monitors managed care companies to determine how well provider networks are being managed. In addition, Aetna ranked second in 2009 PayerView[SM] Rankings. PayerView reflects the experience of specific providers with insurers. We believe these positive ratings are a direct result of our initiatives to (1) Dialogue with physicians and (2) Improve quality of care.

(1) *Dialogue with Physicians:* One of our pioneering initiatives in this regard occurred in 2004, when we established a formal Physician Advisory Board. The Advisory Board is composed of nine external physicians reflecting a diversity of medical specialties, geographies and ethnicities. Its mission is to recommend policies that encourage adherence to evidence based medicine and facilitate physician interaction with Aetna.

In 2008, Aetna voluntarily published Guiding Principles that govern our day-to-day interactions with providers. These Principles have been hailed by the medical community as an example of how a health insurer can do the right thing. We also have established a forum for state medical societies to have issues heard and resolved if there's any difficulty handling them through normal channels.

About six years ago, we established the Physician Liaison Program. This program matches each of our in-house medical directors with specialty and state medical societies across the country. Aetna's medical directors work with these external physicians and incorporate both the expertise and local perspective of medical societies into day to day issues like quality, safety and coding. Around this time frame, we also established a series of dedicated Provider Service Centers. These service centers focus on the specific needs of health care providers.

(2) *Improve Quality of Care:* We are now rolling out a Physician Collaboration Model which links up primary care physicians with Aetna care managers inside of a PCP's office to supplement the services of the PCP. The Aetna care managers facilitate care management with the patient outside of the office. This program, which benefits both doctors and patients, has resulted in 9% fewer acute hospital admissions.

Since 2008, our Pathways to Excellence program has aligned recognition, incentives and/or provider payments with the delivery of high quality and efficient care. Currently, nearly 80,000 physicians and 350 hospitals participate in *Pathways to Excellence*. To ensure that our provider partners are actively engaged in achieving successful outcomes, we work with them to select mutually agreed-upon measures for improvement assessment. In our High Performance Provider Initiatives, we work with hospital and health plan data to identify variations in care and implement targeted interventions to reduce these variations. Examples of successful impacts from individual participating hospitals or hospital systems include:

- Reduced 60 day re-admission rates by 19%
- Improved post discharge physician visits by 16%
- Increased generic prescriptions for statins (from 16 to 50%) and anti-depressants (from 50 to 60%)

These results reinforce the goal of having members get affordable, quality care by taking unnecessary costs out of the system.

We've established two high performance network programs called Aexcel Network and Aetna Institutes. In Aexcel, specialists who have met certain clinical quality and efficiency standards are recognized. This high performance network is associated with high-quality care that can save up to 4 percent in medical costs annually. Aetna is the only national carrier to earn Bridges to Excellence endorsement of our Aexcel Network.

Aetna Institutes™ facilities are publicly recognized, high-quality, high-value health care facilities. Our Institutes of Quality for Bariatric Surgery have achieved exceptional outcome results for our members, resulting in less complications and fewer readmission and medical costs in the year post surgery that are 15 percent lower than the year prior.

These are just a few examples of the outreach and partnering initiatives that Aetna has with the provider community. We've demonstrated a continued commitment to building strong provider relationships because we know this is central to ensuring Aetna members get the highest quality, affordable care possible.

Harnessing technology to improve quality of care

We also believe we need to leverage health information technology (HIT) significantly to enable providers and health care consumers to make much better use of health information, lab data, pharmacy data, claims data and the personal health record. HIT can facilitate vast improvements in individuals' health care experiences by offering them a clearer picture of their own health, a more coordinated interaction with multiple health care providers and better, safer health outcomes.

Aetna has numerous initiatives to harness technology and data to further the continuity and quality of care. Today I would like to highlight our "Care Engine" technology that helps physicians and patients detect and fix potential gaps in care.

The Care Engine is our unique clinical-decision support technology provided through ActiveHealth Management, an Aetna company founded by physicians. This technology is currently used to analyze more than 18 million individual, comprehensive electronic patient medical records against current standards of care to identify potential gaps in care. The Care Engine incorporates diagnosis and procedure claims data from health plans, pharmacy data from pharmacy benefit management companies, lab data, other patient data entered either directly by patients via their personal health record or indirectly by their disease management nurse coach, as well as clinical feedback from physicians.

This process creates continually refreshed patient-centric electronic medical records. These data are then applied against an ever expanding set of evidence-based clinical rules developed and maintained by a large team of board certified physicians, pharmacists, and nurses at ActiveHealth. The resulting output are patient specific 'care gaps' that represent the difference between the care that patients actually are receiving and the care that the established clinical literature would suggest they should be receiving. These gaps, called "Care Considerations" (CCs) are then sent to treating physicians and patients through a variety of electronic and non-electronic means. All CCs are reviewed and approved by medical faculty from Harvard Medical School.

More than 7 million care alerts were generated in 2008. Most importantly, these alerts are having a measurable impact on both the quality and value of patient care, especially in chronic disease patients where effective care coordination makes a tremendous difference. Some real world results include the following:

- A randomized, prospective clinical trial (the most scientifically rigorous trial design) of the Care Engine was published in 2005. This showed a statistically significant decrease in hospitalizations (8.4%).
- The Care Engine is associated with objectively measured improvement in compliance with national clinical guidelines:
    - Up to 30% improvement in compliance with general National Kidney Foundation (NKF) guidelines
    - Up to 47% improvement in compliance with NKF guidelines relating to bone disease in kidney patients
    - Up to 23 % improvement with National Osteoporosis Foundation guidelines.

In sum, advanced clinical decision support systems such as the Care Engine can effectively aggregate available clinical data sets to create comprehensive, longitudinal, patient-centric electronic medical records, and generate actionable clinical alerts to physicians and patients. This results in measurable improvement in clinical quality and outcomes, and decreases overall resource utilization and costs.

Promoting Health and Wellness

As Americans, we simply are not leading the healthy lifestyles that we should be, and this is costly, in terms of quality of life for those leading these lifestyles, and in terms of financial costs for all Americans who end up bearing the costs of bad health habits. Twenty-four percent of American males still smoke[2]; over one-third of adults in the country are obese[3] and 9 percent of

[2] Centers for Disease Control and Prevention. National Center for Health Statistics. "National Health Interview Survey." 2006.

[3] Centers for Disease Control and Prevention. National Center for Health Statistics. "Obesity Among Adults in the United States." 2007.

Americans age 12 and over misuse alcohol or drugs[4]. Compounding lifestyle issues is the aging of our population. By 2030, twenty percent of the American population will be over 65[5].

The end result of all of these factors is that today, more than half of Americans are living with a chronic disease. And yet, more than 50 percent of patients with diabetes, hypertension, hyper lipidemia, tobacco addiction, CHF, asthma, depression, and chronic atrial fibrillation are currently managed inadequately[6]. A startling 22% of patients don't take their medications properly.

All of this has a tremendous impact on underlying health care costs. Some estimates are that 10% of all health costs are due to obesity[7]. And two-thirds of the growth in health care costs is due to the rising growth of chronic disease[8].

Aetna is committed to helping members achieve better health and manage their chronic diseases. To accomplish this, Aetna has developed wellness initiatives such as (1) Aetna Health Connections Disease Management, (2) our Childhood Obesity Project and (3) Value Based Benefit Designs.

(1) *Aetna Health Connections Disease Management* helps people with chronic conditions obtain the treatment and preventive care they need by taking a wider view of an individual's health, rather than focusing solely on a single disease. Aetna's clinicians help members understand and follow their doctor's treatment plan and better manage ongoing conditions.

Through disease management, patients have had 26% fewer inpatient admissions for diabetes, coronary artery disease, congestive heart failure and stroke. In addition, participants are more likely to continue necessary medications after a heart attack, control

[4] Department of Health and Human Services. Substance Abuse and Mental Health Services Administration: Office of Applied Studies. "Results from the 2007 National Survey on Drug Use and Health: National Findings." 2007.

[5] U.S. Census Bureau Population Division. "Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050." 2008.

[6] RAND Corporation. "The quality of health care delivered to adults in the United States." 2003.

[7] Health Affairs 28, no. 5. "Annual Medical Spending Attributable To Obesity: Payer- And Service-Specific Estimates." 2009.

[8] Partnership to Fight Chronic Disease. "About the Crisis: Chronic diseases are creating a national health care crisis." 2009.

asthma through proper prescription adherence and maintain proper blood pressure and cholesterol levels.

(2) *Childhood Obesity Pilot.* In 2009, Aetna launched a childhood obesity pilot in cooperation with the Alliance for a Healthier Generation (partnership between William J. Clinton Foundation and American Heart Association), Aetna's employer clients and the medical community. The program is currently available to five large employer groups totaling 74,000 employees. It includes coverage for obesity and nutritional counseling provided by physicians, access to clinically-based community resources, educational materials distributed at the worksite and educational resources for physicians.

We believe the program is breaking new ground. Currently there is no evidence-based protocol for treating childhood obesity with counseling unless there is a co-morbid condition such as diabetes. By addressing childhood obesity *before* it leads to serious health complications, this program takes an important, proactive step in improving health and quality of life for children in need. Our program offers a uniquely comprehensive approach by combining proactive treatment of childhood obesity with collaboration among insurers, employers, the medical community and families.

(3) *Value-Based Insurance Design.* Based on evidence in the medical literature that co-payments and/or coinsurance can create barriers to care, value-based insurance design eliminates or reduces co-payments or coinsurance for certain medications or types of care that are demonstrated to be crucial in preventing or managing disease. In other words, insurance is designed so that costs are not a deterrent to individuals in seeking the right care. Prevention is often a core element of value based benefit design.

We believe so strongly in prevention that all of our comprehensive insurance products include a preventive benefits schedule that goes beyond those recommended by the United States Preventive Services Task Force (USPSTF). This schedule of preventive services is available to our fully insured members with no out-of-pocket cost.

Aetna and the Aetna Foundation are supporting two clinical studies to evaluate the efficacy of value-based insurance design with researchers at Brigham and Women's Hospital and the University of Pennsylvania. Our preliminary findings in a smaller review were positive – for instance, medical adherence increased in 80% of targeted drug categories.

These programs have been successful in achieving better health for our members and are possible because of our unique role in the health care system. As the steward of our members' personalized and complete patient health information, Aetna has the unique capability to help members manage their care. All of this results in better health for members and health care cost savings for the system.

II. Specific Committee Requests

The Committee specifically asked about several of the more technical aspects of health insurance procedures and processes. These include governance, the development of coverage policies, the claims process and administrative costs.

Governance:

The health insurance industry is one of the most heavily regulated industries in the country. Regulation includes an extensive overlay of state and federal laws, as well as compliance with a myriad of private accreditation organizations such as NCQA or URAC, and auditing performed by private employers.

State regulation and enforcement of insurance laws involve myriad state departments – from the insurance commissioner to the state Attorney General. States oversee a host of laws and regulation, including rules on claims payments, utilization review and complaints/appeals. For example, virtually every state has an Unfair Claims Practices Act governing insurer claims payment that impose fines, license suspension or revocation as penalty for noncompliance. In addition to its Complaints Units, a state's Insurance Department enforces this Act extensively through market conduct exams and data inquiries. Through June 2009, Aetna received 580 exam requests and data inquiries from different state insurance departments; in 2008, we received 978 for the full year. See attached chart demonstrating regulatory bodies involved in insurance regulation.

Coverage Decisions:

The vast majority of Aetna coverage decisions involve simple eligibility decisions such as whether a service is covered under the benefit contract. For example, cosmetic surgery usually is not a covered benefit. In the case of group insurance products, large employers often determine the benefit coverage provisions included in the contract.

This means the majority of coverage decisions don't involve clinical issues. However, for a relatively small number of claims, Aetna does determine whether a particular service is "medically necessary" under the insurance policy sold and meets the medical profession's current standard of care.

A very small percentage of claims are denied because the services are deemed not medically necessary or experimental and investigational. Most claim denials are because of non-clinical reasons such as duplicate claim submissions (e.g. Aetna previously paid the claim), members have coverage with another carrier that is primary to Aetna or because the member is no longer an Aetna plan member. Aetna maintains processes that allow members and their doctors to find out in advance whether or not certain services will be covered. For most procedures, this determination is provided within 48 hours and Aetna does not require prior review for emergency services.

There are controls and robust procedures in place designed to make sure that coverage denials are objective and rational and in accord with the terms of the insurance policy that was purchased. For example, clinical reviews of medical claims are performed by licensed physicians. Any denial resulting from the clinical review can only be made a physician and such decisions are based upon Aetna clinical policy. The purpose of Aetna's clinical policy is to ensure that we are making our decisions based upon peer reviewed literature and recommendations by the various physician specialty societies.

Aetna's Clinical Policy Unit is responsible for assessing medical technologies to evaluate their effectiveness and safety for patients. This extensive scientific and medical review by physicians culminates in a Clinical Policy Bulletin (CPB) – Aetna maintains 600 active CPBs. The development of a CPB begins with a review of the published medical literature and regulatory status (e.g., FDA approval) of the medical intervention. In addition, we actively consult the Agency for Healthcare Research and Quality's evidence based guidelines, the National Library of Medicine's technology assessments and outside medical experts.

All CPBs are published on-line for the broader provider community, members and the general public and an on-line feedback system also is maintained. At a minimum, each Clinical Policy Bulletin is reviewed annually to assure that it reflects the latest medical research and findings. In the case of transplant procedures, Aetna has established an internal committee of outside transplant experts to advise us on our policies. We meet with experts in the field quarterly to help us shape our transplant policies. In other words, we do not randomly or subjectively decide on our own what to cover and what not to cover.

In addition to providers, Aetna receives feedback on our CPBs from vendors (e.g., drug and medical device manufacturers), employer groups and even its members. In sum, Aetna's CPBs are medically sound, widely vetted and transparent.

Appeals:

Aetna members and their physicians who are dissatisfied with the dispensation of their claims or a pre-service determination have opportunities to receive further review by filing an appeal or a complaint. However, in 2008 only a small percentage of claims generated an appeal or a complaint.

Aetna provides members and physicians with two levels of appeal for all products and funding arrangements, although, state or plan sponsor requirements may differ. Aetna also has implemented a voluntary external review program for its commercial insured plans and most self-funded HMO based plans. Self-funded traditional plan sponsors have the option of adding external review as a feature to their plans.

Aetna maintains an internal grievance procedure in accordance with various state and federal regulatory requirements and consistent with independent accreditation organization requirements such as the National Committee for Quality Assurance.

In addition, there is an Aetna Appeals Committee that reviews all final level medical necessity appeals regarding solid organ or stem cell transplants, and also may be utilized for precedent setting cases, experimental/investigational treatment or cases involving life-threatening conditions. This Committee consists of the Chief Medical Officer, and 9 regional and national medical directors. Importantly, clinical records are sent for three independent external medical opinions and shared with the member and their physician prior to the Committee's review.

It is important to note, that at every step in the process, medical reviews are done by a physician, and only a physician can make the decision to deny a claim based upon the medical review. In addition, 46 states and DC have enacted independent medical review laws which we support, permitting an individual to appeal an adverse decision by the health insurance plan to an independent, external entity. These appeals involve the medical necessity or experimental nature of a treatment or service. Importantly, these reviews are handled expediently—virtually all of these state laws specify timeframes for review completion. In addition, at least 33 states require the plan to pay for the appeal.

Rescissions:

At Aetna we take the rescission of insurance coverage very seriously. As a result, Aetna has a low rate of rescissions. The majority of these rare policy rescissions are due to insurance fraud, in which an individual obtains a policy under false pretense, makes an initial premium payment, immediately receives a medical procedure and then allows the policy to lapse.

To address public policy concerns about rescissions, Aetna has voluntarily implemented an independent external review of proposed rescissions for enhanced consumer protection. Launched in September 2008, this industry-leading independent, external review process is designed to fairly address the concerns of health care consumers. This process allows Aetna members who face policy rescission to obtain, at no cost to them, an independent third-party review which is binding on Aetna.

The reviewers re-examine all information used by Aetna in its decision process. Reviewers have the ability to interact directly with the member to gather further information as needed. Upon completion of the review, the reviewers provide a "Rescission Review Report" directly to the member with a copy to Aetna. There is no contact between Aetna and the reviewers at any time until the report has been independently mailed to the member.

While we work on reforming our health care system overall, we continue to rely on this fair and impartial process to combat fraud and misrepresentation to keep health care more affordable for our customers. We understand that consumers want and need more peace of mind in all health care transactions, and this approach allows us to respond to consumer concerns with a fair and workable solution.

III. Health Care Reform

Aetna is committed to the enactment of comprehensive health reform. We support significant changes in the rules governing insurance coverage once all individuals have a personal responsibility to obtain coverage coupled with subsidies for individuals. We believe all individuals should be able to obtain coverage – both the sick and the healthy -- and that no one should be penalized through higher premiums because of their health status.

However, insurance reforms alone will not address the real underlying problems in today's health care system – spiraling costs. To improve affordability, we strongly support payment reform that would reward doctors and hospitals that provide value – not just volume. We also must harness technology to help providers accomplish these goals, assure the health system maximizes administrative efficiency and encourage patients to take control of their health.

Aetna has been at the fore front of bringing about innovations to improve the health and lives of our members and to enhance the functioning of the many parts and players in the health care system. I believe the competitive marketplace has played – and should continue to play – an important role in fostering the innovation necessary for our country to achieve true and widespread greatness in our health care system. I encourage Congress to accelerate the implementation of these innovations on a wider scale for the benefit of our entire population.

I want to thank the Committee for this opportunity, and we look forward to continuing to work with the Congress to pass Health Care reform this year.