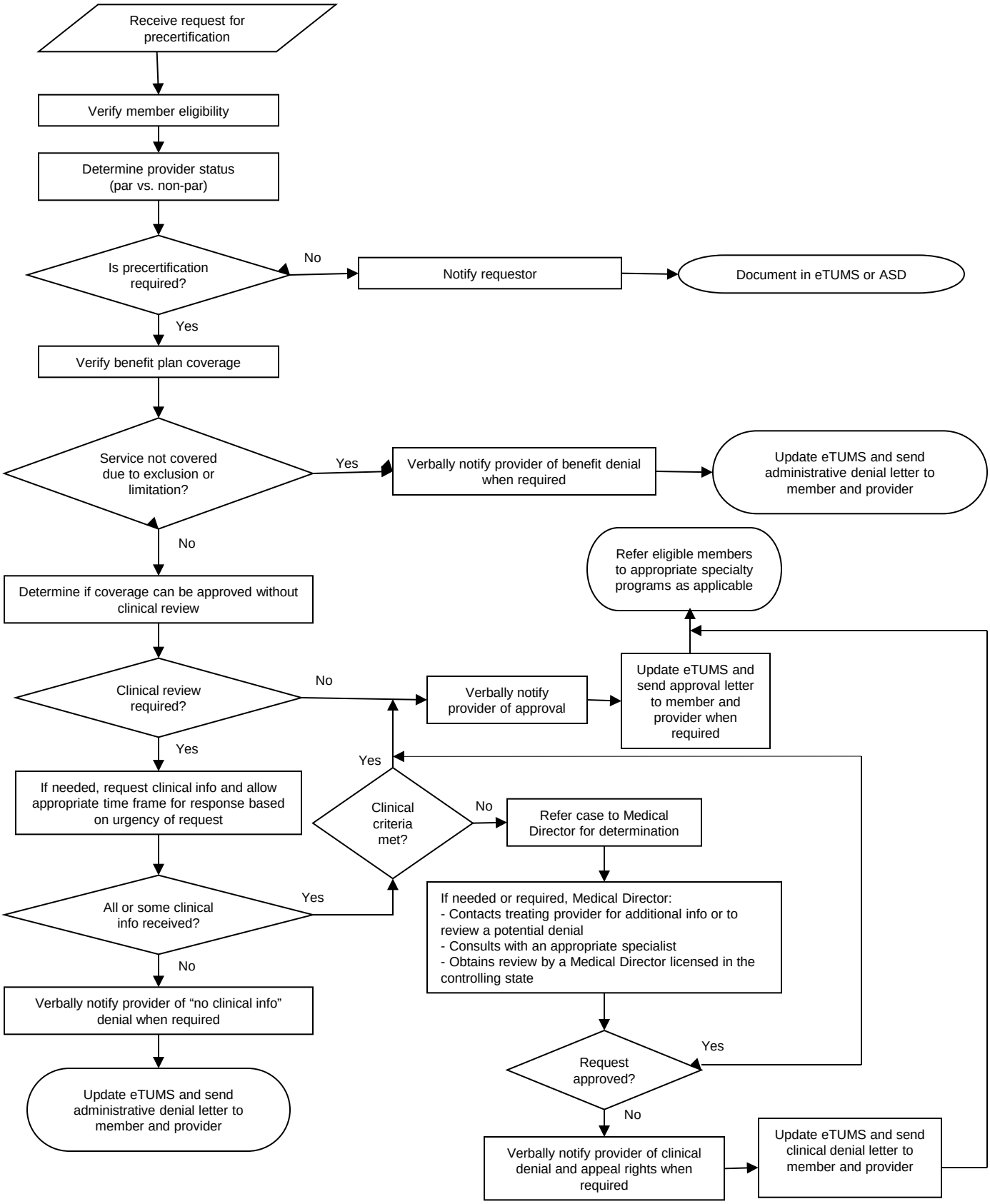
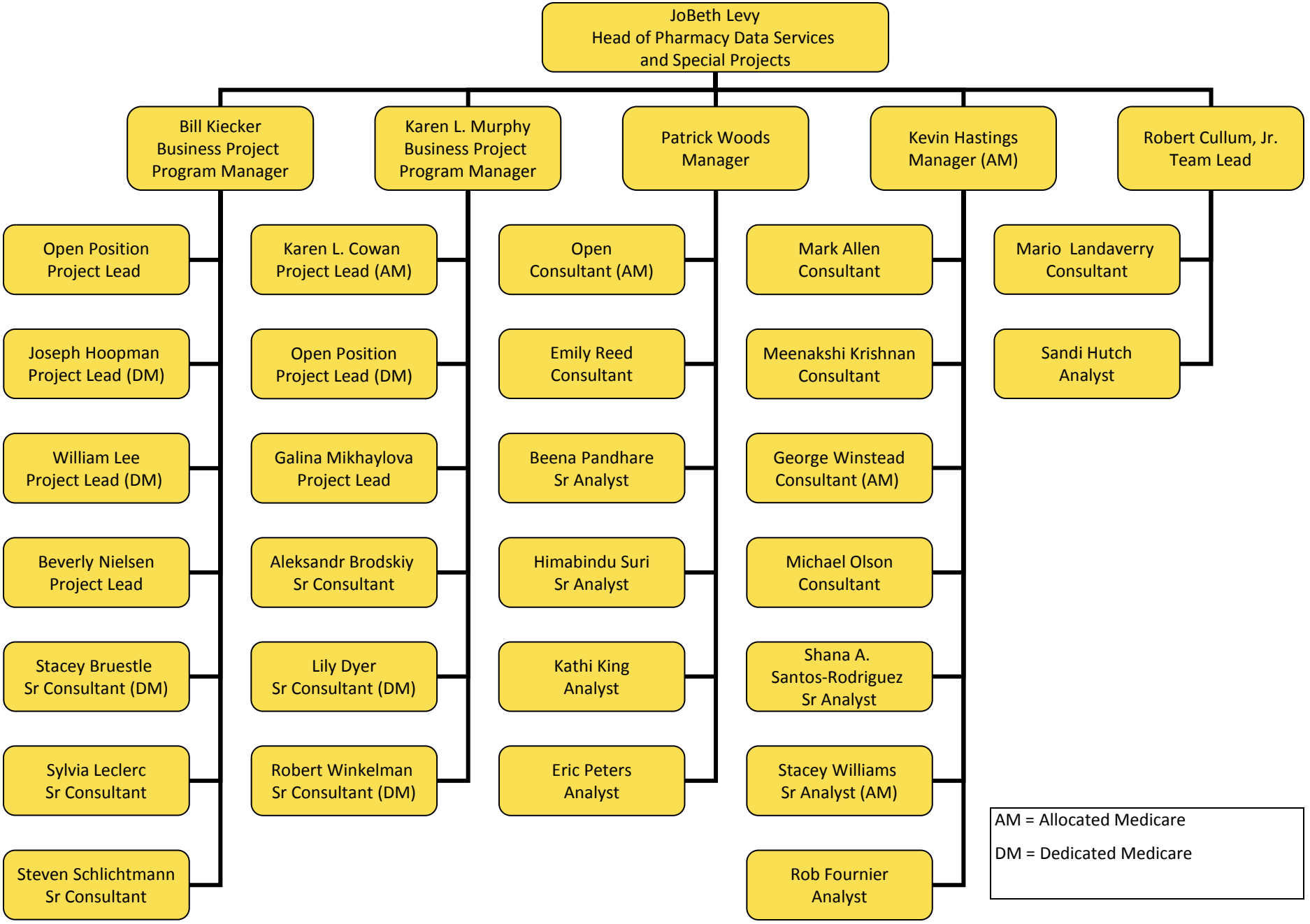
Precertification Workflow



SPB PBM Operations
Data Services and Special Projects



Retrospective Review Workflow

Receive verbal/electronic coverage request for services already provided

Verify member eligibility

Is precertification required ?

No

Notify requestor

Document call in eTums or ASD

Yes

Are services ongoing?

Yes

Go to Concurrent Review Workflow

No

Inpatient services?

No

Are services eligible for review through precertification process?

Yes

Go to Precertification Workflow

No

Yes

Notification within 2 business days of admission?

No

Notify requestor to submit claim

Yes

Receive claim referral for services already provided that require precert and have not been previously reviewed

Verify member eligibility

Verify benefit plan coverage

Notify Claims of decision

Service not covered due to exclusion or limitation or failure to follow precertification requirements?

Yes

Verbally notify provider of benefit denial if requested

Update eTums and send administrative denial letter to member and provider

No

Apply Focused Intervention Tool (FIT) to determine level of clinical review (when applicable)

Clinical review required?

No

Verbally notify provider of approval if requested

Update eTUMS and send approval letter to member and provider when required (EOB/EPP otherwise serves as notice)

• Refer eligible members to appropriate specialty programs (as applicable)
• Refer reportable and potential quality issues for quality review if indicated

Yes

If needed, request clinical info and allow appropriate time frame for response

Clinical criteria met?

Yes

No

Request approved?

Yes

No

All or some clinical info received?

Yes

No

Refer case to Medical Director for determination

Verbally notify provider of clinical denial and appeal rights if requested

Verbally notify provider of "no clinical info" denial if requested

If needed or required, Medical Director:
- Contacts treating provider for additional info or to review a potential denial
- Consults with an appropriate specialist
- Obtains review by a Medical Director licensed in the controlling state

Update eTUMS and send clinical denial letter to member and provider

Update eTUMS and send administrative denial letter to member and provider

Notify Claims of decision as applicable

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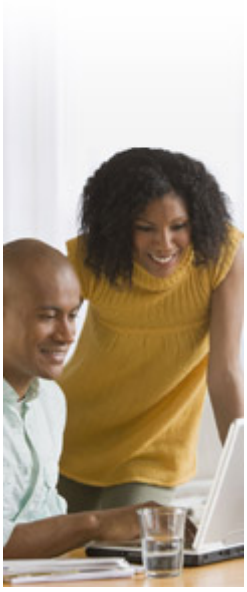

Have a burning question about dental health? Your search for an answer may begin here. Visit http://www.simplestepsdental.com/. You will find great online tools and facts to help you improve your dental health.

- Explore our Ask the Dentist feature. You'll get answers from the Columbia University College of Dental Medicine.
- Learn the Eight Steps to Dental Health that can help you keep your teeth for life.
- Access Solution Sleuth™ to find treatment options for certain dental health conditions.
- View our news-packed video on oral cancer — one of the most deadly forms of cancer.

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Get the right information

- Sign up for weekly dental health news updates.
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Log on to http://www.simplestepsdental.com/. See your dentist regularly. When it comes to dental health, the right information can mean everything.

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Quality health plans & benefits
Healthier living
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Intelligent solutions

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Aetna Resources For Living

Seminar Catalog 2012

www.aetna.com

XX.XX.XXX.X (X/12)

Welcome to Aetna Resources For Living

We are here for you

Aetna Resources For Living is a series of confidential services that help employees and household members balance the demands of work, life and personal issues.

Resources For Living onsite seminars bring our experts to you

Resources For Living offers many seminars that can fit your organization's needs. Our Nationwide Affiliate Educator Network of experienced trainers and educators can deliver your seminars. In this catalog, you will find sections for Workplace, Life and Wellness, Personal Growth, Legal and Financial. Each seminar is listed with:

- A brief description of what we will review in the seminar
- A listing of the seminar objectives
  - **The length of the seminar, if more than one hour**

Setting up a seminar is easy

We ask that our customers designate an appropriate staff person within your company, such as a human resources representative, supervisor or manager, who will then contact Resources For Living directly to schedule seminars. Seminars can be setup by submitting a completed request form to EAPseminarrequest@rfl.com.

They can also be requested by contacting your Account Executive directly. Be prepared to share any relevant worksite or company information that will be helpful to the trainer, such as new policies; changes in the worksite. EAP account executives will work with you to identify your specific needs and review the goals you wish to meet with your seminar. Account executives can recommend the seminar(s) that will help you reach your training goals. When you request a seminar, please have this information on hand:

- Topic requested
- Number of seminars
- Date(s) and time(s) preferred
- Site contact person's name, phone and email address
- Delivery site address
- Anticipated number of participants and group demographics
- Any special security/safety requirements

Lead time for seminar requests

We ask for sufficient lead time to schedule your trainers and appreciate your understanding of the need for sufficient scheduling time.

- **30 days notice for all standard seminars**
- **Six weeks notice for Financial and Legal seminars**

Cancelation policy

We understand that unexpected events occur. If you need to cancel a seminar, please contact the Training Department directly at EAPseminarrequest@rfl.com at least **three business days** in advance of the seminar. Cancelations within this window may result in a fee, please consult with EAP Account Executive if you have any questions regarding the cancelation fee. The Training Department will work with you to reschedule the seminar.

Seminar communication

These seminars work best with a group of 15-25 participants, as most seminars tend to be interactive, and participation is encouraged. Often, employers select topics they believe employees would find most useful. We suggest that you publicize the seminars to all employees.

Table of Contents

EAP & work/life orientation

EAP & work/life orientation (employee)

EAP1103

Come hear what your Employee Assistance Program is all about and what benefits it offers to you. In today's times we find ourselves having to do more with less, and time is a scarce commodity. Let us help you juggle those work and life issues. Our services are totally confidential.

- What is an EAP?
- Items we can help with
- No hassles with forms, easy access
- Benefits of your EAP
- Web access

EAP & work/life orientation (supervisor)

EAP1105

This training for supervisors discusses the EAP benefits provided by their employer. It provides details about who is eligible, how the process works, confidentiality, what types of problems are often addressed, and how to access benefits. It also provides information for supervisors on how to identify a troubled employee and walks them through the company's process of referring an employee to the EAP.

- Help give you guidance on how to focus on managing an employee's performance issues instead of their personal issues
- Assist managers with management consultation
- Provide support for traumatic workplace events
- Assist employees with work/life balance

Adult care

Caring for aging loved ones

AAC4005

More and more of us find ourselves caring for our parents or elderly loved ones. Join us to learn some of the basics: Learn how to assess your parent's or loved one's needs; hear about alternatives to single-handedly making all the choices for your loved one; get tips on when and how to discuss your loved one's needs as the ability to remain independent declines.

- Evaluating your loved one's needs
- Resources for care in the home and community
- Communicating with other family members
- Evaluating your own level of responsibility
- Involving your parent/loved one in decision making
- Tips for long-distance caregiving

Planning ahead for retirement

AAC4006

This seminar will help you list out things to consider for your retirement. We will walk you through questions to personalize your retirement decisions and give you some assessment tools.

- Explore attitudes and beliefs about retirement
- Discuss components of a "psychological portfolio"
- Review self-assessment tools
- Learn about resources for "whole person" retirement planning

Preparing for retirement — elder care

AAC4004

This training is for employees preparing for retirement and wishing to plan ahead for their own care. This program reviews things to consider for a comprehensive life plan.

- What constitutes healthy aging?
- Understanding pre- and post-retirement needs
- Health, housing, financial and legal issues to consider

Reframing the empty nest

AAC4002

Is this a time of joy or sadness? It can be both! Let's discuss how to transition into this new relationship with your child.

- What is happening
- Redefining parenting
- Tasks of the middle years
- If the nest fills up again

The sandwich generation

AAC4003

Feeling pulled at both ends? Caring for your children while at the same time caring for your aging parents? Tired? Stressed? This seminar explores the challenges and complexities of multigenerational living.

- Understanding developmental tasks of the middle years
- Understanding your own aging process
- Rules for multigenerational living
- Launching children into adulthood
- Taking care of yourself

Child care & parenting

Parenting skills development — the toddler years (12-24 months)

ACC1002

One of the major dilemmas facing parents of toddlers is that they perceive only two approaches to handling conflicts — some choose the "I win — You lose" approach, some the "You win — I lose" approach, while others seemingly cannot decide between the two. This session reviews the "no-lose" method of resolving conflicts.

- Developmental issues
- Behavioral interventions
- Toddler jealously
- Parent/toddler activities

Parenting your teen

ACC1003

It is the adolescent's task to begin separating from you. This can't occur without some friction and challenge to your authority. In order to be successful through this time, the adolescent must begin to sever some of the ties that bind him/her to you. Come join us to explore how to help rather than impede this process.

- Identity vs. role confusion
- Survival skills
- What makes a healthy family
- How to recognize when it's time to get help

Preparing your child for college

ACC1004

This seminar is intended for both parents and their children who are just entering college. Ultimately, the goal is to help the new college student have as successful a transition as possible, while offering tips to make that happen. Also, some awareness tips are given to help the family left behind.

- Changes in personality
- Discuss and share the financial picture
- Preparing for the report card
- Dealing with room mates and orientation day

Supporting school-age children

ACC1005

Teachers, classmates, friends ... where do you step in and where do you let your child negotiate these relationships? Learn ways to support your child through elementary school and intermediate school years while keeping your ultimate goal in mind — a healthy, well-adjusted adult.

- Review basic parenting assumptions
- Erikson's developmental stage
- Explore survival skills
- Parent/teacher conference tips
- How to recognize when it's time to get help

Daily life

Domestic violence — abuse

ADL6001

What is domestic violence and who is affected by it? What do you do if the victim decides to stay — or leave? Learn more about this issue and who it affects by attending this seminar.

- What is domestic violence?
- Cycle of violence
- Lenore walker's theory of violence
- Self-help
- Helping a coworker
- Helping a family member or friend

Managing in times of personal crisis

ADL6002

A crisis is a turning point for better or worse. Because it is unexpected, people tend to experience a period of psychological disequilibrium. This seminar will help you understand and manage this process.

- Defining crisis
- Considering stages of a crisis
- Preparing an action plan

War fatigue or PTSD

ADL6002

What is war fatigue? Is it similar to or the same as PTSD? How is it treated? What helps and what can family members do? This seminar helps us to explore these topics.

- Define war fatigue and PTSD
- Identifying the signs of each
- Identifying the differences
- Identify what helps
- Become familiar with resources

Health & wellness

Adopting a healthy lifestyle

AHW8013C

You can live a healthy life by adopting healthy habits and thoughts! This is an achievable goal in anyone's life. In this seminar, we'll review behaviors and beliefs that make up a healthy life, including:

- An overview of a healthy lifestyle
- Understanding the basics of healthy eating
- The role of exercise
- The power of sleep
- How setting and reaching goals empowers us to live well

Childhood and adolescent obesity

AHW8010

Childhood obesity is a common problem in our country. This seminar provides information, tips, and strategies on how to help your children obtain and maintain health.

- Obesity defined
- Calculating BMI
- Problems associated with obesity
- What can you do

Coping with anxiety

AHW8016

How do we tell the difference between normal feelings of stress and symptoms of anxiety? This workshop helps participants understand different types of anxiety and provides tools to notice signs in your own life or the life of someone close to you.

- Define anxiety disorders
- Identify anxiety symptoms
- Understand how thoughts and actions contribute to anxiety
- Overview of treatment and care of anxiety disorders

Coping with personal loss

AHW8002

Grief is caused by many types of losses — the loss of a loved one, a pet, a job, a lifestyle, a function. This seminar helps you to understand the grief process as well as help you to find healthy ways of coping.

- What to expect
- Healthy coping skills
- Warning signs
- Resources

Dealing with anger

AHW8012C

Anger is a powerful human emotion that has physical, psychological and interpersonal consequences. This program explores those areas and provides tips to manage angry responses.

- Defining anger
- Physiological responses to anger
- Identifying anger
- Proactive approaches to dealing with anger
- Managing anger

Dealing with burnout

AHW8005

A very real phenomenon that needs attention, this seminar will provide basic information on how to recognize and cope with burnout.

- Definition of burnout
- Signs to recognize burnout
- Symptoms of burnout
- Personal assessment
- Next steps to take

Depression in families

AHW8006

What is depression? Come learn the basics of what causes depression and how depression impacts a family. What can you do if a family member is depressed? Come and find out at this interactive seminar.

- What is depression?
- What are the symptoms of depression?
- How does depression impact families?
- Why families are important?
- How to care for a depressed family member
- Taking care of you

Emotional eating

AHW8001

Sometimes it is hard to know whether you are truly hungry or if you are filling another need. This seminar helps you to learn the difference between hunger of the body and hunger of emotions. You will learn:

- The definition of emotional eating
- Factors that trigger emotional eating
- Ways to identify your triggers
- How to distinguish between physical and emotional hunger
- How to eat in response to hunger rather than emotions

How to manage after quitting smoking

AHW8020

This seminar provides an understanding of what to expect and provides tips to manage the cravings.

- Learn about the healing process
- Making it through the first few days
- Tips to reduce weight gain
- Manage stress and irritability
- Learn some healthy practices

It's holiday time already?

AHW8007

The holidays are painted as cheerful and relaxing. So, why do we get so stressed? Let's look at what contributes to our stress and learn ways to reduce this level and truly enjoy those special occasions.

- Learn to address the stress of the holidays
- Find ways to make your holiday more enjoyable
- Learn tips to manage the holiday stress
- The EAP and its role in helping you fight stress

New Year's resolutions — how to make them and how to keep them!

AHW8008

This seminar reviews why we make New Year's resolutions and the most common ones. Can you guess? We will unveil "resolution pitfalls" and offer a recipe for resolution success.

- Why make New Year's resolutions?
- Common resolutions
- Resolution pitfalls
- Resolution success tips
- Recipe for success

Nutrition basics

AHW8018

Do you want to have a healthier diet? This seminar can help. You will come away with an understanding of the nutritional needs we all have. You will also receive information on:

- Ways to maintain healthy and balanced eating habits
- Developing an understanding of the different elements of nutrition
- The purpose of vitamins
- Healthy food choices

Quitting smoking

AHW8011

This seminar provides the smoker with an understanding of tobacco addiction. In addition, it helps the smoker to determine where he or she falls on the quitting smoking readiness scale. Several smoking cessation techniques will be discussed and include consideration of the pros and cons of each choice.

- Learn the facts about smoking and tobacco usage
- Understand what motivates you to consider quitting
- Clarify how ready you are to make these changes
- Identify how addicted you are to nicotine
- Learn how to customize a program that has the best chances of success
- Know what resources are available to help you

Seminar Length: 2 hours

Suicide awareness

AHW8014C

This seminar is designed to enhance understanding of behaviors and emotions experienced by the suicidal person. It debunks common myths and provides suggestions on what to look for and how to intervene when someone is suicidal.

- Learn about situations that increase suicide risk
- Become aware of feelings and actions associated with suicide
- Review common myths about suicide
- Learn ways to help and intervene
- Dealing with grief reactions
- Resources

Taking sleep seriously

AHW8019

How important is sleep? Without it you wouldn't survive. Sleep is an essential part of daily life. It helps us to stay focused, remember things, and keeps us energized and able to face the tasks of the day. This program looks at:

- What is considered "normal" sleep
- Things that might indicate a sleeping disorder
- Lifestyle influences on sleep
- Ways to increase your chances of getting a good night's sleep
- Where to go for more information

Thinking about quitting smoking

AHW8021

This seminar provides information about quitting tobacco use. The attendee will learn the many benefits of quitting and will also be:

- Provided state-of-the art, credible information about tobacco use
- Helped to assess readiness to quit smoking
- Given an overview of cessation techniques and approaches
- Helped to determine which approach might work best

Weight management

AHW8009

So, what is obesity? Join us and we'll tell you. Come learn how to calculate your BMI (body mass index). Identify those at risk for obesity. Receive some answers and hear more questions regarding obesity. Learn what we can do about the obesity epidemic.

- What is obesity?
- How to calculate BMI
- Identifying those at risk
- Some answers, more questions

Personal & professional development

Alcohol and drug-free workplace (employee)

APD9001

Best for employers that have a drug-free workplace policy or companies considering implementing such a policy. At the end of the training, employees will be familiar with the policy and aware of the dangers of alcohol and drug abuse.

- The requirements of the drug-free workplace policy
- The prevalence of alcohol and drug abuse and its impact on the workplace
- How to recognize the link between poor performance and alcohol and/or drug abuse
- The progression of the disease of alcohol and drug addiction
- What types of assistance may be available

Approaches to decision making

API11005

Staffing resources are limited, time is short, and you must do more with less — so how do you get that job done? Look for simple answers first before searching for complicated ones. But, will the simple answers work the next time? Join us as we review problem-solving techniques that give meaning to “thinking outside of the box.”

- Review of decision levels
- Planning for decision making
- Defining consensus
- Developing a team approach
- Overview of decision-making steps
- Requirements for creative thinking
- Stages of creative problem solving

The art of small talk

API11007

Find yourself at business meetings with little to say? How about social gatherings? Are you the one standing in the corner with the plant? This seminar will help you to develop the art of small talk so that you can increase your comfort level.

- Learning conversation builders
- Recognizing conversation stoppers
- Increasing comfort levels in social situations

Assertiveness

API11001

Assertiveness does not come naturally. Many people avoid potentially confrontational situations. In any situation, the aim should not be just to gain a win; the aim should be to solve the problem and get the best result. This presentation can help identify the assertiveness skills needed and situations where assertiveness should be applied.

- Review the differences between assertiveness, aggressiveness and passiveness
- Assertiveness bill of rights
- Steps to take toward gaining assertiveness
- Assertiveness conflicts

Building skills to handle life's pressures

API11003

Self-regulation is a valuable tool that can be utilized to improve our responses in both our personal and work lives. This seminar will provide information on the concept of self-regulation while introducing the physical and emotional effects of being under pressure. Participants will be provided tools to communicate more effectively under pressure and implement a personal plan to relieve pressures.

- Understand the definition for self- regulation
- Understand effects of being pressured
- Learn to communicate effectively when under pressure
- Implement a plan to relieve pressure
- Find balance within your life

Building successful teams

APD9021C

This one hour seminar focuses on the 4 stages of team development. Also considered is the key ingredients that make up a successful team. The story of the geese will be used to consider ways to enhance team unity and support.

- Understand team development issues
- Consider where your team is at in terms of development and its chance of success
- Increase understanding and use of team building techniques

Bullying in the workplace

APD9004

Workplace bullying can create poor morale, physical illness and splitting of teams. Let's be aware of this issue so it is not tolerated on our work teams.

- Definition of bullying
- Statistics
- Types of bullying
- Signs you are being bullied
- What can bullied targets do
- What can coworkers do

Communication skills

API11002

Do you know your communication style? Are you a blend? This seminar will help you to overcome barriers to effective communication and will provide many tips to improve your communication skills.

- Communication styles
- Communication process
- Guidelines for effective communication
- Barriers to effective communication
- Overcoming barriers to effective communication
- Communication tips

Coping with job loss

APD9007

For companies who are downsizing, this program provides practical tips for employees adjusting to changes in the workplace and coping with job loss.

- Adjusting to changes in your job
- Communicating with your family
- Stress management techniques
- Career counseling and job searches
- Helpful resources

Coping with organizational change

APD9029

In today's organizations, change is the rule rather than the exception. Reorganization, downsizing, mergers, takeovers, rapid growth, and new technology are among the major changes. The purpose of this workshop is to highlight practical and proven methods for coping with organizational change.

- The impact of organizational change
- The seven stages of change
- The key features of resiliency
- How to cope with high-magnitude change

Seminar Length: 1.5 hours

Coping with shift work

APD9030

The unique demands of shift work affect employees personally and professionally by creating conflicts between balancing work and family, as well as impacting their productivity on the job. This workshop will focus on identifying resources to help create successful strategies to effectively respond to the demands of shift work.

- Types of shift work stress
- Identify shift work stress and the impact on your life
- Personal strategies for managing shift work stress

Change mastery

API11004

This program explores the impact of change and our response to it. Take a brief personal inventory to see how change may affect you in the next year. Do you tend to be proactive or reactive? Do your beliefs limit or empower you? Come and learn positive strategies to cope with change. Discover how one can change his/her beliefs about change from limiting to empowering, and define your resilience to change.

- Phases of transition (the transition curve)
- The impact of change — (personal inventory exercise)
- Personal strategies when facing change
- Proactive vs. reactive response to change
- Procrastination
- Perfectionism
- Limiting beliefs vs. empowering beliefs about change
- Change hardiness (resilience)

Diversity

APD9009

Join us as we define culture and diversity. Answer our quiz to see how savvy you are in diversity issues. Do you know the ethnic and cultural stumbling blocks? Learn why companies are celebrating diversity!

- Culture
- Diversity defined
- Ethnic and cultural stumbling blocks
- Why diversity

Effective collaboration

APD9010

Join us as we look at the challenges of collaboration, one of which is communication both with the individual and the corporation. We'll look at how to effectively communicate and learn how to manage the collaborative process.

- Manage the collaborative process
- Identify barriers to collaboration and communication
- Overcome barriers

Effective communication at work

APD9027C

This presentation reviews the different types of communication used in the workplace and suggests how to be effective in each form. It includes: face-to-face communication, meetings, written, electronic (email), and telephone (voicemail). It will cover the benefits and challenges for each type and offer practical do's and don'ts to communicating at work.

- Methods of communication used in the workplace
- Do's and don'ts of workplace communication
- Effectiveness of workplace communication

Etiquette in the Workplace

APD9024C

Do you ever wonder how your workplace behaviors affect others? Are you ever concerned that you may be presenting yourself in a way that you do not intend? Understanding workplace etiquette is a must. It can affect your work relationships as well as how managers perceive you and your abilities. In this seminar, you will learn:

- The basics of workplace etiquette
- Etiquette tips for different areas of the work environment
- The little things that impact your image in the workplace

Goal setting for life and work

API11006

Achieve more in all areas of your life! You can improve your performance, enhance motivation and increase your self-confidence all by setting and achieving your goals! This seminar will increase your pride and satisfaction by:

- Teaching you effective goal setting skills
- Helping you to recognize barriers to goal achievement
- Having you establish appropriate and realistic goals in the context of you life roles

Learning about your conflict management style

APD9006

When confronted with a conflict in the workplace there are several ways a person might handle the situation. One might "take the bull by the horns" and meet others head-on with the facts; one could "wait it out" and see if the problem resolves itself or is resolved by others; one might focus on "short-term gains" in an effort to appease the conflicting parties or attempt to split the difference. Or, one could "take the time" to engineer a "win-win" scenario that would balance the needs of all interested parties. Learning more about the personal styles used to deal with conflict situations can help you handle conflict more effectively.

- Identify their personal approach to conflict
- Learn to identify the conflict management style of others
- Discuss how to use this information to improve conflict management skills

Length of seminar: 1.5 hours

Managing the difficult interaction

API11008

This seminar discusses ways to manage a difficult interaction whether this is at your workplace or at home.

- How does perception influence our behavior
- What are our options for handling a difficult encounter
- Skill-building techniques and roles plays.

Seminar length: 1.5 Hours

Managing a difficult customer

APD9013

This lesson covers techniques for handling customers who may be challenging to work with. We consider how perception influences the customer's presentation and what you can do about this.

- Identify three basic behavioral/personality styles
- Develop techniques for enhancing customer interactions
- Demonstrate how to handle difficult customers appropriately

Seminar length: 1.5 hours

Managing violence in the workplace (employee)

APD9015

In this session, the employee's role and responsibility in managing workplace violence will be examined. Additionally, this session explores how violence in the workplace is defined, what workplace violence costs your company and its employees, what contributes to workplace violence, and how to detect the potential for violence and prevent it. The seminar also gives employees the resources to assist them in dealing with a troubled coworker or situation.

- Your role and responsibility in avoiding workplace violence
- How violence in the workplace is defined
- What workplace violence costs your company and its employees
- What contributes to workplace violence, how to detect the potential for it
- Resources to report a troubled employee or situation

Seminar length: 1.5 hours

Negativity in the workplace (employee)

APD9031

Negativity can have a significant impact on a workplace's performance and productivity. This seminar will look at the two types of negativity found in the workplace: state and trait negativity as well as some common causes. Participants will also walk away from this seminar with practical solutions to help promote a more positive work environment.

- Identify the two types of negativity
- Review the causes/reasons negativity occurs in the workplace
- Identify ways negativity impacts the workplace
- Discuss solutions for creating a more positive workplace

Providing excellent customer service

APD9032

Difficult people make our jobs more challenging. We tend to feel frustrated, angry, and uncomfortable when we encounter someone who is a challenge. It helps to focus on what we can do rather than wishing it would all go away or that the other person will change. Difficult interactions tend to be the exception rather than the norm. But they usually create a majority of our job stress. This seminar will help you to learn:

- How to control your own response
- Essential components of communication
- Appropriate customer service etiquette
- Good habits to promote successful interactions
- Strategies to deal with situations and people when they do escalate

Seminar length: 1.5 hours

Resolving conflict

API11009

Whether you need to resolve conflict in your personal life or in your work capacity, it helps to understand the different personality types as described by the Myers Briggs Type Indicator (MBTI). For more than 60 years, the MBTI tool has helped millions of people throughout the world gain a deeper understanding of themselves and how they interact with others, helping them improve how they communicate, work and learn.

- Why it's important to know ones personality type
- Implications to your work environment
- Communicating with different personality types

Respectful communication in the workplace

APD9033

The workplace is focused on getting tasks done. It also is a place where work and personal relationships are formed. Thus, it's important to understand your own workplace culture so you know how to navigate these relationships successfully. This seminar helps you to:

- Distinguish different kinds of boundaries
- Develop skills to maintain healthy boundaries
- Understand successful communication
- Understand the wide range of factors in dealing with different personalities and situations
- Learn helpful strategies when dealing with different personalities

Seminar length: 1.5 hours

Sexual harassment prevention (employee)

APD9035

Sexual harassment complaints are on the rise and co-workers were named as alleged harassers 72% of the time. The most common complaint from victims involved offensive remarks, offensive jokes or teasing, or unwelcome touching. It is important to become aware of the types of behavior that others consider offensive. This seminar will outline the federal laws prohibiting discrimination in the workplace, define harassment and discrimination, and give examples of the different types. Suggestions for responding to harassment will also be reviewed.

- Recognize behavior that could be considered sexual harassment
- Avoid behaving in a way that could be interpreted as sexual harassment
- Describe employee's responsibilities in creating a work environment free of sexual harassment
- State the actions to take when any behavior considered to be sexual harassment, or having the potential to lead to a sexual harassment claim, occurs
- Understand and describe the policies and procedures related to sexual harassment

Seminar length: 2 hours

Strengthening work relationships — team building

APD9017

This seminar stresses the importance of workplace satisfaction and positive team engagement. We help you understand your contribution and the contribution of each team member is of vital importance to team success. We refer to the "Remember the Titans" effect — when you appreciate each other's differences, your team wins! And, other teams will want to work with you! This seminar works best with a group of around 25 participants, as the seminar tends to be interactive, and participation is encouraged.

- Workplace satisfaction
- Good rapport and trust create positive energy
- Knowledge that your contribution is important
- Knowledge that each team member is important
- "The Titans" effect — when you appreciate each other's differences, your team wins!
- Other teams will want to work with you!

Seminar length: 1.5 hours

Stress management

API11011

This one-hour introduction to stress management is for those interested in learning more about managing stress in daily life. The presentation includes a brief, 10-second stress reliever exercise. Areas discussed include:

- Defining stress and the stress response
- Improving ability to recognize and identify your personal stress symptoms
- Understand how thoughts and actions contribute to the stress response
- How to manage stress more effectively through improved evaluation and self-care

Stress management and achieving balance at work and home

API11012

This workshop is divided into two parts. Part one focuses on stress and distress. The focus is on recognizing and reducing life stress. Part two focuses on life balance. Handouts will be used to help attendees consider where their time and energy is focused. Suggestions will be given on how to create a healthy, life balance.

- Redefine stress
- Recognize your personal stress responses
- Identify priorities in your life
- Determine if priorities are in balance
- Create more balance in your life
- Manage stress more effectively

Seminar length: 2 hours

Stress management at work

APD9019

This seminar picks up where stress management — "the basics" leaves off. If you choose to focus on things that are not in your control (other people's behaviors, thoughts, actions or events that you cannot change) you will be growing your frustration; if you choose to focus on things that are in your control (your thoughts, behaviors, actions that you take), you are growing personal responsibility for your life and enhancing your happiness.

- Identifying what we can control
- Review balancing of demands
- How to prioritize and organize
- Effective meeting management and attendance

Time management

APD9020

This seminar looks at the two factors that drive our choice of how we use our time: Urgency and Importance. It helps participants identify their personal time management style and offers tips and tools to support their style.

- Why time management is important
- Common barriers to effective time management
- Helpful tools
- Identify what is in your control

The work and home balancing act

APD9003

This seminar helps you to consider the multiple roles you play in life. You will consider how much time you spend on these varied roles. Does this work for you? Do you wish you had more time for other pursuits? The information contained in the seminar will help you to answer these questions. It will focus on helping you to:

- Identify the important priorities in your life.
- Determine if your life gives you the balance you seek.
- Learn strategies to create more balance and harmony in your life.
- Create a plan for change.

Working with the terminally ill

APD9023

This one-hour seminar discusses the challenges of working with the terminally ill. It is hoped that by the end of the seminar, participants will gain a greater understanding of ways to get and give support while providing an invaluable service to those they serve.
It includes consideration of the following:

- Assumptions about what the job requires
- What makes the job difficult
- Beliefs about death
- Grief and adult reactions to grief
- Compassion fatigue
- Cognitive distortions
- Ways to build resiliency
- Self-care suggestions

Professional development for managers

Addressing negativity in the workplace (supervisor)

APDM10016

Negativity is bound to happen in a workplace and eliminating it completely is an unrealistic expectation. This presentation will help you focus your energy on the negativity that you can impact and will provide tools to create positive change.

- Identify the two types of negativity
- Review the causes/reasons negativity occurs in the workplace
- Identify ways negativity impacts the workplace
- Discuss solutions for creating a more positive workplace

Alcohol and drug-free workplace (supervisor)

APDM10001

This training is geared towards helping supervisors understand the different components of the drug-free workplace policy and their role in implementing the policy. This training does NOT meet Department of Transportation standards.

- The different components of the drug-free workplace policy
- Your role in implementing the drug-free workplace policy
- Identify and investigate crisis situations
- Recognize workplace problems that may be related to alcohol and other drugs
- Intervene in problem situations
- Refer employees who have problems with alcohol and other drugs
- Protect employee confidentiality
- Continue to supervise employees who have been referred to assistance
- Avoid enabling and common supervisor traps

Seminar length: 2 hours

Department of transportation: alcohol and drug-free workplace (supervisor) *

APDM10017

This course is designed to meet the training requirements for supervisors of employees in Department of Transportation (DOT) safety sensitive positions. The training maintains a focus on DOT related scenarios, cases and examples that individuals working under DOT mandates will be able to identify. The training provides 60 minutes of awareness training on controlled substance use and 60 minutes of awareness training regarding alcohol misuse.

- Understand how substance abuse impacts DOT safety sensitive roles
- Identify indicators of substance misuse
- Provide skills for responding to substance abuse problems
- Review of DOT regulations regarding testing procedures and duty process

Seminar length: 2 hours

* Additional Charges for this seminar may apply. Please contact your Account Executive for details.

Diversity in the workplace for supervisors

APDM10011

What makes us different? This workshop will look at several areas of diversity including age, sexual orientation, gender, race, religion, physical ability, family situation, class, and ethnicity. It offers a sensitivity-raising training about the do's and don'ts of appropriate respect of coworker differences.

- Define discrimination, harassment, protected class
- How to respect the rights of others
- How to truly embrace diversity

Seminar Length: 1.5 hours

Generational differences in the workplace

APDM10006

Understanding the influences and expectations that four generations bring to the workplace is very important in developing and maintaining harmonious, workplace relationships. This one-hour seminar will discuss generational influences and styles of the four generations currently in the workplace. You will learn about:

- Historical influences of each generation
- Personal and lifestyle influences
- Workplace characteristics
- Commonalities among the generations

Helping the distressed person

APDM10005

In some workplaces, one will encounter others who have experienced severe distress through life traumas such as bank robberies or weather-related disasters. In these times, it is helpful to be able to recognize distress and learn how to best manage the encounter. In this one-hour seminar, you will learn the following:

- How do you recognize distress in others
- How to manage critical behaviors and encounters
- Best practices and protocols
- Resources available to help
- Ways to take care of yourself in a stressful environment

Leadership

APDM10012

To manage or to lead? The first critical question to ask yourself when you become a supervisor is whether you are going to manage the people who report to you or lead them. Since leadership can be learned, this workshop presents values and behaviors that help develop good leadership skills. It also debunks some myths concerning leadership.

- Leadership Competencies
- Compare Traditional vs. Contemporary Leadership
- Common "De-railers" for Leaders
- Four Areas for Effective Leadership

Leading in difficult times

APDM10007

The changes that have occurred in today's workplace present a challenging environment for managers. This workshop will explore how managers can respond to this challenge by increasing the effectiveness of their communication and addressing employee disengagement.

- Discuss the impact of organizational change
- Review the 7 stages of change
- Learn key management skills for each stage
- Create a vision for the future
- Maintain awareness of employee's struggles
- Action steps to help with the transition

Seminar Length: 1.5 hours

Manager's guide to coping with downsizing

APDM10008

This half-hour presentation was developed to help managers address the needs of the downsized employee. It provides an action plan as well as discusses the stages of acceptance an employee may go through upon hearing he/she has been downsized. You will learn:

- How to be prepared with appropriate information
- To understand the stages of acceptance
- Increase awareness of risks and potential effects on employees
- How to recognize signs of distress or violence
- Available resources
- How to work with the remaining employees

Seminar Length: 2 hours

Managing critical behavior issues in the work place (supervisor)

APDM10002

So what are critical behaviors? What is your role as supervisor? We learn strategies to manage critical behaviors in the workplace.

- Critical behaviors to observe in the work place
- Your role and responsibilities
- Strategies to manage critical behaviors
- Supervisor pitfalls
- Case examples and role plays

Managing violence in the workplace (supervisor)

APDM10003

In this session, the supervisor's role and responsibility in managing workplace violence will be examined. Additionally, this session explores how violence in the workplace costs your company and its employees, what contributes to workplace violence and how to detect the potential for violence, and prevent it. The seminar also gives supervisors the resources to assist them in dealing with a troubled employee or situation.

- Your role and responsibility in managing workplace violence
- How violence in the workplace is defined
- What workplace violence costs your company and its employees
- What contributes to workplace violence, how to detect the potential for it, and how to prevent it

Seminar length: 2 hours

Meeting management

APDM10014

Poorly run meetings are time wasters and can decrease employees' confidence in management. This class discusses ways to analyze the flaws in your approach to meetings, the components of successful meetings, key roles to assign, using the "parking lot" tactic, and evaluating meeting outcomes.

- Different types of meetings
- What causes meetings to be ineffective
- Key roles needed in meetings
- Tools to make meetings more productive

Mentoring through coaching

APDM10015

A mentor's role is to match the interest and talents of the person he or she is mentoring with the organization's needs and development opportunities. This presentation will help you identify the principles that have made you successful and help the person you are mentoring put those principles to use in the context of his or her skills, personality, and goals.

- Four-step coaching method
- Apply the four-step method during a role play
- Develop a plan to coach on the job

Motivating your staff and improving morale

APDM10004

Staff who are motivated are more productive, less likely to leave a company, and happier. This seminar aids you in evaluating your ability to positively motivate your staff.

- What is motivation
- The benefits of focusing on staff motivation
- Common de-motivators
- Contributors to staff morale
- Are you a motivator
- Four Powerful questions

Sexual harassment prevention (supervisor)

APDM10018

"What you don't know can hurt you." This 2-hour workshop for supervisors will outline the federal laws prohibiting discrimination and harassment in the workplace. It includes various current scenarios of harassment to encourage discussion of what does and does not constitute harassment. It will review how to respond to a complaint and support employees who are being harassed and how to protect themselves and their organizations from lawsuits.

- Recognize behavior that could be considered sexual harassment
- Avoid behaving in a way that could be interpreted as sexual harassment
- Describe the responsibilities of both employees and managers in creating a work environment free of sexual harassment
- State the employee and supervisor actions to take when any behavior considered to be sexual harassment, or having the potential to lead to a sexual harassment claim, occurs
- Understand and describe the policies and procedures related to sexual harassment

Seminar length: 2 hours

Financial seminars

Adjusting to your adjustable mortgage

CF7001

Concerned you will not be able to afford future payments? This seminar presents helpful strategies to fix your broker ARM.

- Is your mortgage ARMed and dangerous?
- Understanding how and when payments adjust
- Knowing when to refinance
- Getting help when payments become unaffordable

Getting and keeping good credit

CF7002

Gain the knowledge to use credit to your advantage and learn the steps to get back on top of credit issues.

- The best time to use credit
- You have to manage your credit
- Why your credit score is so important
- Techniques for maintaining good credit

Home buying strategies

CF7003

You may have felt that home ownership is out of reach, but with the tips and strategies provided, you could be well on your way to becoming a homeowner.

- Is home ownership right for you?
- How much can you afford?
- Today's creative loan programs
- Understanding fees and closing costs

Identity theft: prevention & resolution

CF7004

This seminar highlights helpful information and key strategies people can use to reduce the chance of having their identity stolen.

- The I.D. theft crisis
- I.D. theft prevention
- The need for I.D. theft assistance
- What to do if you are a victim

Life stages retirement planning

CF7005

In this seminar you will review the things to do now to optimize retirement, whatever your age.

- Getting started: 20s and 30s
- Prime time: 40s and 50s
- Head for the finish line: 55 to 65
- At retirement

Money basics: spending, borrowing & savings

CF7006

Money is what makes your financial world go around. Learn how to make it work for you!

- Creating a workable monthly budget
- Techniques for building savings
- Setting financial goals
- Managing debt

Roadmap to retirement

CF7007

Get ahead of the curve or get a plan together to catch up. It's not too late to get started on a solid plan for retirement.

- Defining the retirement challenge
- Finding money to invest
- Paying yourself first
- Types and advantages of different retirement accounts
- How much should you save
- The risk versus return connection

Tips for a tax smart future

CF7008

The less money you send Uncle Sam, the more goes into your pocket. This seminar gives you some great tips on tax savings.

- Income tax overview
- How to check your withholding
- How an FSA or 401(k) contribution can save you money
- Tax credit vs. tax deduction

Understanding health savings accounts (hsa's)

CF7009

A Health Savings Account can help individuals save for qualified medical and retiree health expenses on a tax-free basis, but is it right for you?

- What is a Health Savings Account (HSA)
- Who is eligible for an HSA
- Benefits of an HSA
- Contribution and distribution provisions

Understanding investment basics

CF7010

Even as a small investor, you can make some very smart decisions by understanding how Wall Street works

- Stock investments, bond investments and mutual funds
- Key considerations (ex. Inflation, risk tolerance, asset allocation)
- The investment pyramid

Legal seminars

Estate planning/wills/trusts

CL12001

Estate Planning, Wills, and Trusts go hand in hand. This one hour presentation covers the fundamentals of each topic below:

- Identify reasons for the importance of Estate Planning
- Identify assets to consider for Estate Planning
- Define key Estate Planning tools (Wills/Trusts, and their differences)
- Learn the process of Estate Planning
- Develop strategies for communicating about Estate Planning with older relatives and other family members

Family law

CL12002

Family law can involve relationships of married couples; unmarried couples, or couples undergoing divorce. Additional family relationships that may involve lawyers include parent and child. Unmarried parents, neglected children, foster care, and adoption.

- Divorce: All states require a spouse to identify a legal reason for requesting a divorce when that spouse files the divorce papers with the court. These reasons are referred to as grounds for a divorce
  - Overview of community property law in your State if applicable
  - How marital property is divided, including residences and pensions
- Child Custody issues
  - How disputed custody cases are handled by the courts
- Child and Spousal Support
  - How is determined
  - How long it is payable

Legal issues for older relatives (or disabled family members)

CL12003

The key Estate Planning decisions people need to make for their future

- Describe the legal tools that assist older people and disabled family members when others must make decisions for them
- Identify how and when to utilize various tools to serve the needs of your older relatives
- Create a list of items for preparing for a meeting with your older relatives' attorney

Powers of attorney/advanced directives ("living-wills")

CL12004

Strategies for communicating with older relatives about the need for "Advance Directives"

- The definition of "Advanced Directives" and their benefits
- The difference between a "Living Will" and a "Durable Power of Attorney"
- The history of "Advanced Directives"
- Tips for preparing an "Advance Directives"

ATTACHMENT B – OFFEROR INFORMATION AND CERTIFICATION

OFFEROR INFORMATION AND CERTIFICATION

Proposals must confirm that the Offeror will comply with all provisions in this RFP; and, if applicable, provide notice that the firm qualifies as an Alaskan bidder. Proposals must be signed by a company officer empowered to bind the company. An Offeror's failure to include these items in their proposal may cause their proposal to be determined to be non-responsive and the proposal may be rejected.

This form shall be the cover page for the Offeror's proposal. In the space provided, enter the requested Offeror identification information. Use this form to indicate your acknowledgement of the response conditions.

RFP Number:	**RFP 2013-0200-1396**
RFP Name:	Medical Claims Administration and Managed Network, Pharmacy Benefit Management Services, Healthcare Management and Dental Claims Administration and Managed Network RFP

Offeror Name:	Aetna Life Insurance Company
Mailing Address:	151 Farmington Avenue
Telephone Number:	860-273-0123
Fax Number:	860-273-3382
Federal Tax ID #:	06-6033492
Alaska Business License Number:	431075

Contact Name:	Timothy J. Lieb
Title:	Sales Vice President
E-Mail Address:	LiebT@aetna.com
Alternate Phone Number:	425-747-7154

PROPOSAL CERTIFICATION:

BY SIGNATURE ON THIS PAGE, THE OFFEROR HEREBY CERTIFIES THAT ALL INFORMATION PROVIDED IS TRUE AND SERVES TO BIND THE OFFEROR TO THE PROVISIONS OF THE RFP.

Michael S. Copeck — 2/21/2013

SIGNATURE **DATE**

MICHAEL S. COPECK, ASSISTANT VICE PRESIDENT AND ACTUARY
PRINT NAME AND TITLE

OFFEROR'S CERTIFICATION

Acknowledge, under the penalty of perjury, the following Statements, conditions, and information by clearly marking the space provided. Failure to comply with these items may cause the proposal to be determined nonresponsive and the proposal may be rejected or the state may terminate the contract or consider the contractor in default.

#	CONDITION/CERTIFICATION	RESPONSE
1	Offeror certifies that 100% of all services provided under the resulting contract by the Offeror, joint venture partners, and all subcontractors shall be performed in the United States. (RFP 1.05)	☒ YES
2	Offeror has reviewed the RFP for defects and objectionable material and has provided comments to the Procurement Officer. By signature on the cover page, the Offeror waives any rights to file a protest as it relates to the contents of the RFP. (RFP 2.21)	☒ YES
3	Offeror agrees to comply with all of the terms of the RFP and not to restrict the rights of the state. (RFP 1.10)	☒ YES
4	Offeror acknowledges that this engagement with the state is subject to the Alaska Public Records Act, AS Title 40, Chapter 25 and that the state may be required to disclose certain information in response to requests for public information made under the Act. (RFP 1.12)	☒ YES
5	Offeror complies with the laws of the State of Alaska. (RFP 1.14)	☒ YES
6	Offeror complies with the applicable portion of the Federal Civil Rights Act of 1964. (RFP 1.14)	☒ YES
7	Offeror complies with the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government. (RFP 1.14)	☒ YES
8	Offeror complies with the American with Disabilities Act of 1990 and the regulations issued thereunder by the federal government. (RFP 1.14)	☒ YES

9	Offeror confirms that programs, services, and activities provided to the general public under the resulting contract conform to the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government. (RFP 1.14)	☒ YES
10	Offeror complies with all terms and conditions set out in this RFP. (RFP 1.14)	☒ YES*
11	This Proposal is not made in connection with any competing Offeror submitting a separate response to the RFP, and is in all respects fair and without collusion or fraud. The Offeror did not participate in the RFP development process, had no knowledge of the specific contents of the RFP prior to its public posting for comment, and that no employee of the agency or State participated directly or indirectly in the Offeror's proposal preparation. (RFP 1.14)	☒ YES
12	Offeror response and cost schedule shall be valid and binding for 120 days following the response due date. (RFP 1.14)	☒ YES
13	Offeror satisfies the minimum prior requirements (RFP 2.8) Additional confirmation/information requested in questionnaire.	☒ YES
14	Offeror certifies that Offeror has a valid Alaska business license. (RFP 2.12)	☒ YES
15	Offeror agrees to the state's Standard Agreement Form. **If the answer is NO, per Section 3.4, any objections to the agreements must be identified in a document attached to the Offeror's proposal. (RFP 3.4)**	☐ YES ☒ NO
16	Offeror understands and agrees to comply with all statutes, regulations, and policies regarding nondisclosure and confidentiality. (RFP 3.14)	☒ YES

*Yes, subject to the clarifications/deviations identified in our response.

CONFLICT OF INTEREST STATEMENT (MARK ONE)

One of the boxes below must be checked (by marking an "X"). If the second box is marked, indicating a possible conflict of interest, disclose the nature and full details of the conflict in the space provided. Please refer to RFP 1.16 for conflict of interest guidelines.

X	Neither the firm nor any individual proposed (including subcontractors or joint venture partners) has a possible conflict of interest. (RFP 1.15)
	The firm and/or an individual proposed have a possible conflict of interest. **Describe the nature of the conflict in the space below.**
n/a	

LOCATION-OF-WORK / HEADQUARTERS IN TIER 3 COUNTRIES

Certify the following statements by marking "X" in the space provided. Please refer to RFP 1.05 for guidelines. By signature on their proposal, the Offeror certifies that:

X	The Offeror and all subcontractors and joint venture partners are not established and headquartered or incorporated and headquartered in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report.

The most recent United States Department of State's Trafficking in Persons Report can be found at the following website: http://www.state.gov/g/tip/. Failure to comply with this requirement will cause the State to reject the proposal as nonresponsive, or cancel the contract.

SUBCONTRACTORS

For each proposed subcontractor, describe the relationship between the Offeror and any proposed subcontractor(s). Add more text boxes as necessary.

Each proposed subcontractor also must submit in a separate attachment a written statement, signed by a duly authorized representative that clearly verifies that the subcontractor is committed to render the services required by the contract.

Subcontractor #1:

Per Section 1.13, we are providing commitment letters from our member facing subcontractors. We define "member facing" as subcontractors provide member constituent services directly related to the administration of a customer contract and for whom a portion of the services provided may include direct member contact or significant access to member identifiable data. If the State would like additional information on non-member facing subcontractors/ suppliers/vendors, we would be happy to provide.

We maintain stringent requirements and standards for all subcontractors. We define a subcontractor as an entity that we have engaged to provide goods or perform services for Aetna. In addition, we can have an-house corporate purchasing department, which manages our subcontractor relationships, and aids in maintaining our stringent subcontractor requirements. We can facilitate a discussion between the State and this area, if the State

would like a better understanding of our subcontracting process.

We are utilizing the following sub-contractors specifically for this RFP. Please find a commitment letter from each included with this form:

1. Aftermath Claim Science, Inc.
2. Connolly Consulting
3. CVS Caremark
4. DiversiMed, Inc.
5. End-Game Strategy, Inc.
6. EOS
7. EquiClaim, Inc. (Viant/Concentra Preferred Systems)
8. OmniClaim, Inc.
9. Quest Labs
10. Rawlings Company, LLC
11. Sirona
12. Source One Direct, Inc.
13. Summit Labs
14. VSP

JOINT VENTURES

If submitting a proposal as a joint venture, the Offeror must submit a copy of the joint venture agreement which identifies the principles involved, prime Offeror, their rights and responsibilities regarding performance and payment, and provide proof of Alaska business license for each principle.

Not Applicable.

ALASKA BIDDER'S & VETERAN PREFERENCE

Please answer the following questions regarding the State of Alaska preference.

Are you claiming the State of Alaska preferences? (If "Yes", please answer the questions below). (RFP 2.13)	☒ YES

#	Questions	RESPONSE
1	Do you currently hold an Alaska business license?	☒ YES ☐ NO
2	Is the company name submitted on this proposal the same name that appears on the current Alaska Business License?	☒ YES ☐ NO
3	Has your company maintained a place of business within the State of Alaska staffed by the Offeror or an employee of the Offeror for a period of six months immediately preceding the date of the proposal?	☒ YES ☐ NO
4	Is your company incorporated or qualified to do business under the laws of the State, is a sole proprietorship and the proprietor is a resident of the State, is a limited liability company organized under AS 10.50 and all members are residents of the State, or is a partnership under former AS 32.05, AS 32.06, or AS 32.11 and all partners are residents of the State?	☒ YES ☐ NO
5	If your company a joint venture, is it composed entirely of ventures that qualify under (1-4) of this table?	☐ YES ☒ NO
6	Do you qualify for the Alaska Veteran Preference?	☐ YES ☒ NO

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RFP Number:	**RFP 2013-0200-1396**
RFP Name:	Medical Claims Administration and Managed Network, Pharmacy Benefit Management Services, Healthcare Management and Dental Claims Administration and Managed Network RFP

Offeror Name:	Aetna Life Insurance Company
Mailing Address:	151 Farmington Avenue
Telephone Number:	860-273-0123
Fax Number:	860-273-3382
Federal Tax ID #:	06-6033492
Alaska Business License Number:	431075

Contact Name:	Timothy J. Lieb
Title:	Sales Vice President
E-Mail Address:	LiebT@aetna.com
Alternate Phone Number:	425-747-7154

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SIGNATURE **DATE**

MICHAEL S. COPECK, ASSISTANT VICE PRESIDENT AND ACTUARY
PRINT NAME AND TITLE

OFFEROR'S CERTIFICATION

Acknowledge, under the penalty of perjury, the following Statements, conditions, and information by clearly marking the space provided. Failure to comply with these items may cause the proposal to be determined nonresponsive and the proposal may be rejected or the state may terminate the contract or consider the contractor in default.

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1	Offeror certifies that 100% of all services provided under the resulting contract by the Offeror, joint venture partners, and all subcontractors shall be performed in the United States. (RFP 1.05)	☒ YES
2	Offeror has reviewed the RFP for defects and objectionable material and has provided comments to the Procurement Officer. By signature on the cover page, the Offeror waives any rights to file a protest as it relates to the contents of the RFP. (RFP 2.21)	☒ YES
3	Offeror agrees to comply with all of the terms of the RFP and not to restrict the rights of the state. (RFP 1.10)	☒ YES
4	Offeror acknowledges that this engagement with the state is subject to the Alaska Public Records Act, AS Title 40, Chapter 25 and that the state may be required to disclose certain information in response to requests for public information made under the Act. (RFP 1.12)	☒ YES
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9	Offeror confirms that programs, services, and activities provided to the general public under the resulting contract conform to the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government. (RFP 1.14)	☒ YES
10	Offeror complies with all terms and conditions set out in this RFP. (RFP 1.14)	☒ YES*
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12	Offeror response and cost schedule shall be valid and binding for 120 days following the response due date. (RFP 1.14)	☒ YES
13	Offeror satisfies the minimum prior requirements (RFP 2.8) Additional confirmation/information requested in questionnaire.	☒ YES
14	Offeror certifies that Offeror has a valid Alaska business license. (RFP 2.12)	☒ YES
15	Offeror agrees to the state's Standard Agreement Form. **If the answer is NO, per Section 3.4, any objections to the agreements must be identified in a document attached to the Offeror's proposal. (RFP 3.4)**	☐ YES ☒ NO
16	Offeror understands and agrees to comply with all statutes, regulations, and policies regarding nondisclosure and confidentiality. (RFP 3.14)	☒ YES

*Yes, subject to the clarifications/deviations identified in our response.

CONFLICT OF INTEREST STATEMENT (MARK ONE)

One of the boxes below must be checked (by marking an "X"). If the second box is marked, indicating a possible conflict of interest, disclose the nature and full details of the conflict in the space provided. Please refer to RFP 1.16 for conflict of interest guidelines.

X	Neither the firm nor any individual proposed (including subcontractors or joint venture partners) has a possible conflict of interest. (RFP 1.15)
	The firm and/or an individual proposed have a possible conflict of interest. **Describe the nature of the conflict in the space below.**
n/a	

LOCATION-OF-WORK / HEADQUARTERS IN TIER 3 COUNTRIES

Certify the following statements by marking "X" in the space provided. Please refer to RFP 1.05 for guidelines. By signature on their proposal, the Offeror certifies that:

X	The Offeror and all subcontractors and joint venture partners are not established and headquartered or incorporated and headquartered in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report.

The most recent United States Department of State's Trafficking in Persons Report can be found at the following website: http://www.state.gov/g/tip/. Failure to comply with this requirement will cause the State to reject the proposal as nonresponsive, or cancel the contract.

SUBCONTRACTORS

For each proposed subcontractor, describe the relationship between the Offeror and any proposed subcontractor(s). Add more text boxes as necessary.

Each proposed subcontractor also must submit in a separate attachment a written statement, signed by a duly authorized representative that clearly verifies that the subcontractor is committed to render the services required by the contract.

Subcontractor #1:

Per Section 1.13, we are providing commitment letters from our member facing subcontractors. We define "member facing" as subcontractors provide member constituent services directly related to the administration of a customer contract and for whom a portion of the services provided may include direct member contact or significant access to member identifiable data. If the State would like additional information on non-member facing subcontractors/ suppliers/vendors, we would be happy to provide.

We maintain stringent requirements and standards for all subcontractors. We define a subcontractor as an entity that we have engaged to provide goods or perform services for Aetna. In addition, we can have an-house corporate purchasing department, which manages our subcontractor relationships, and aids in maintaining our stringent subcontractor requirements. We can facilitate a discussion between the State and this area, if the State

would like a better understanding of our subcontracting process.

We are utilizing the following sub-contractors specifically for this RFP. Please find a commitment letter from each included with this form:

1. Aftermath Claim Science, Inc.
2. Connolly Consulting
3. CVS Caremark
4. DiversiMed, Inc.
5. End-Game Strategy, Inc.
6. EOS
7. EquiClaim, Inc. (Viant/Concentra Preferred Systems)
8. OmniClaim, Inc.
9. Quest Labs
10. Rawlings Company, LLC
11. Sirona
12. Source One Direct, Inc.
13. Summit Labs
14. VSP

JOINT VENTURES

If submitting a proposal as a joint venture, the Offeror must submit a copy of the joint venture agreement which identifies the principles involved, prime Offeror, their rights and responsibilities regarding performance and payment, and provide proof of Alaska business license for each principle.

Not Applicable.

ALASKA BIDDER'S & VETERAN PREFERENCE

Please answer the following questions regarding the State of Alaska preference.

Are you claiming the State of Alaska preferences? (If "Yes", please answer the questions below). (RFP 2.13)	☒ YES

#	Questions	RESPONSE
1	Do you currently hold an Alaska business license?	☒ YES ☐ NO
2	Is the company name submitted on this proposal the same name that appears on the current Alaska Business License?	☒ YES ☐ NO
3	Has your company maintained a place of business within the State of Alaska staffed by the Offeror or an employee of the Offeror for a period of six months immediately preceding the date of the proposal?	☒ YES ☐ NO
4	Is your company incorporated or qualified to do business under the laws of the State, is a sole proprietorship and the proprietor is a resident of the State, is a limited liability company organized under AS 10.50 and all members are residents of the State, or is a partnership under former AS 32.05, AS 32.06, or AS 32.11 and all partners are residents of the State?	☒ YES ☐ NO
5	If your company a joint venture, is it composed entirely of ventures that qualify under (1-4) of this table?	☐ YES ☒ NO
6	Do you qualify for the Alaska Veteran Preference?	☐ YES ☒ NO

Minimum Qualification Question 2.1.1.2 Response

A. For the purpose of the document, Aetna refers to Aetna Life Insurance Company, Aetna Pharmacy Management, Active Health Management, PayFlex, Aetna Behavioral Health, LLC, Meritain and all other Aetna affiliates

B. Aetna meets the minimum requirements in Section 2.8 as follows:

(a) Medical Claims Administration and Managed Network – Offeror must have:

i. provided claim administration for medical, vision and FSA services and managed network services for at least one employer of 6,000 or more employees for at least 5 years

ii. provided claim administration for medical services and managed network services for at least one group of 20,000 or more retirees for at least 5 years

iii. at least 5 years of experience in processing over 125,000 claims per month for one group

iv. provided claim administration for a government employer or public retirement plan for medical services and managed network services for at least 3 years

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RESPONSE REDACTED

(b) Pharmacy Benefit Management Services– Offeror must have:

i. provided claim administration for pharmacy services and managed pharmacy network services for at least one employer of 6,000 or more employees for at least 5 years

ii. provided claim administration for pharmacy services and managed pharmacy network services for at least one group of 20,000 or more retirees for at least 5 years

iii. at least 5 years of experience in processing over 100,000 pharmacy point of sale claims per month for one group

Minimum Qualification Question 2.1.1.2 Response

iv. at least 5 years of experience in processing over 75,000 pharmacy mail order claims per month for one group

v. provided claim administration for pharmacy services and managed pharmacy network services for a government employer or public retirement plan for at least 3 years

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RESPONSE REDACTED

(c) Healthcare Management – Offeror must have:

i. provided healthcare management services for at least one employer of 6,000 or more employees for at least 5 years

ii. provided healthcare management services for at least one group of 20,000 or more retirees for at least 5 years

iii. provided healthcare management services for a government employer or public retirement plan for at least 3 years

---

RESPONSE REDACTED

(d) Dental Claims Administration and Managed Network – Offeror must have:

i. provided dental claim administration and managed network services for at least one employer of 6,000 or more employees for at least 5 years

ii. provided dental claim administration and managed network services for at least one group of 20,000 or more retirees for at least 5 years

iii. at least 5 years of experience in processing over 5,000 dental claims per month for one group

Minimum Qualification Question 2.1.1.2 Response

iv. provided dental claim administration and managed network services for a government employer or public pension plan for at least 3 years

RESPONSE REDACTED

Minimum Qualification Question 2.1.1.2 Response

C. Aetna meets the State of Alaska bidders preference, found in section 2.14, as follows:

An Alaska Bidder Preference of a five percent reduction in a qualified Offeror's cost proposal will be applied during evaluation. To qualify, an Offeror must:

(a) hold a current Alaska business license;

Confirmed- Our Alaska Business License is attached.

(b) submit a proposal for goods or services under the name on the Alaska business license;

Confirmed- This proposal is submitted under the name or our Alaska Business License.

(c) have maintained a place of business within the state staffed by the Offeror, or an employee of the Offeror, for a period of six months immediately preceding the date of the proposal;

Confirmed

Our Current Alaska Address (effective 12/3/2012) is:

4341 B Street, Suite 403
Anchorage, AK

Please note our former Alaska address (effective June 28, 2011) is:

510 L Street, Suite 650
Anchorage, AK 99501

Minimum Qualification Question 2.1.1.2 Response

(d) be incorporated or qualified to do business under the laws of the state, is a sole proprietorship and the proprietor is a resident of the state, is a limited liability company organized under AS 10.50 and all members are residents of the state, or is a partnership under AS 32.05 or AS 32.11 and all partners are residents of the state; and

Confirmed. Aetna is a corporation qualified to do business in the State of Alaska.

The Alaska Corporations Code (AS 10.60) generally requires foreign corporations to obtain a Certificate of Authority to transact business in Alaska. Aetna is exempt from that requirement pursuant to AS 21.03.010(b) as a foreign and alien insurer doing business as authorized insurer. Aetna's Certificate of Authority is attached as proof that it is an authorized foreign insurer.

(e) if a joint venture, be composed entirely of entities that qualify under (a)-(d) of this subsection.

Aetna is not a joint venture

(f) include a statement in Attachment B, appended hereto, certifying that the Offeror is eligible to receive the Alaska Bidder Preference.

Confirmed. We have provided a statement in Attachment, certifying that we are eligible to receive the Alaska Bidder Preference.

D. Aetna meets the State of Alaska licensing requirements, found in Section 2.12) as follows:

Minimum Qualification Question 2.1.1.2 Response

2.12 Alaska Business License and Other Required Licenses

At the time the proposals are opened, all Offerors must hold a valid Alaska business license and any necessary applicable professional licenses required by Alaska Statute. Without the business license, you will be declared non-responsive and your proposal will be rejected. (Registering as a foreign corporation does not meet the Alaska business license requirement.)

Aetna has both a current Business License from the Alaska Department of Commerce, Community, and Economic Development and a Certificate of Authority from the Alaska Department of Commerce. Both are included with our proposal.

Minimum Qualification Question 2.1.1.2 Response

Proposals must be submitted under the name as appearing on the Offeror's current Alaska business license in order to be considered responsive. Offerors should contact the Department of Commerce, Community and Economic Development, Division of Corporations, Business, and Professional Licensing, P. O. Box 110806, Juneau, Alaska 99811-0806 (www.commerce.alaska.gov/occ/home_bus_licensing.html), for information on these licenses.

Our proposal is submitted under Aetna Life Insurance Company, the name on our Business License and Certificate of Insurance.

Offerors must submit evidence of a valid Alaska business license with the proposal. An Offeror's failure to submit this evidence with the proposal will cause its proposal to be determined non-responsive. Acceptable evidence that the Offeror possesses a valid Alaska business license may consist of any one of the following:

i. Copy of an Alaska business license;

Our Alaska Business License has been included with our proposal response.

ii. Certification on the proposal that the Offeror has a valid Alaska business license and has included the license number in the proposal;

Our Alaska Business License has been included with our proposal response.

iii. A canceled check for the Alaska business license fee;

Our Alaska Business License has been included with our proposal response.

Minimum Qualification Question 2.1.1.2 Response

iv. A copy of the Alaska business license application with a receipt stamp from the state's occupational licensing office; or

Our Alaska Business License has been included with our proposal response.

v. A sworn and notarized affidavit that the Offeror has applied and paid for the Alaska business license.

Our Alaska Business License has been included with our proposal response.

Offerors are not required to hold a valid Alaska business license at the time proposals are opened if the Offeror possesses one of the following licenses and are offering services or supplies under that specific line of business:

i. Fisheries business licenses issued by Alaska Department of Revenue or Alaska Department of Fish and Game;

Not Applicable.

ii. Liquor licenses issued by Alaska Department of Revenue for alcohol sales only;

Not Applicable.

iii. Insurance licenses issued by Alaska Department of Commerce, Community and Economic Development, Division of Insurance; or

Our Certification of Authority has been included with our proposal response.

Minimum Qualification Question 2.1.1.2 Response

iv. Mining licenses issued by Alaska Department of Revenue.

Not Applicable.

"2.1.1.4 Harris County Case Study" is considered Confidential, and has been REDACTED.

QUESTION 2.1.3.2

Company Profile

HIPAA Compliance

Description:
We are in full compliance with HIPAA requirements that have been issued to date. Following is a brief summary:

Privacy
We have taken all steps necessary to comply with the Privacy Rule requirements, including:

- Naming a chief privacy officer and establishing a Privacy Office.
- Implementing new and/or revised company-wide privacy policies and procedures.
- Training impacted personnel.
- Implementing system changes and workflows to provide members with (i) access to their health information, (ii) an accounting of many types of disclosures, (iii) a process for requesting amendments to their health information, and (iv) the ability to request restrictions or have confidential information mailed to an alternative address.
- Delivering a Privacy Notice to full risk subscribers.
- Adopting specific disciplinary procedures and sanctions for employees who violate our Privacy Policies.

Transactions and Code Sets
We are positioned to support HIPAA compliant electronic transactions and code sets. We have the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare and Medicaid Services (CMS).

Security
To prepare for the HIPAA Security Rule, we performed a thorough risk assessment of our systems and operations and developed and executed a remediation plan.

Unique Identifiers
Aetna is compliant with the unique Employer Identifier Number (EIN) requirement.

QUESTION 2.1.3.2

We also can accept and process HIPAA standard electronic transactions that comply with the National Provider Identifier (NPI) regulations. Effective March 16, 2009, to comply with HIPAA regulations, we began rejecting electronic claims and encounters submitted without a billing provider NPI. If a "pay to" provider is identified on a claim, the NPI for that provider must also be included. We continue to work diligently with providers to educate them and bring them into compliance according to the HIPAA regulation.

Org Chart:
Diane F. McCammon is Aetna's Chief Privacy and Security Officer and is responsible for our compliance with the HIPAA Privacy and Security Rules.

Sean Hart, Head of Security Services, partners with the chief privacy and security officer to provide an overall improvement in the information security posture of Aetna as well as monitoring progress toward that objective. Exercising the chairman's retained authority, Sean and her unit perform the following functions:

- Protect Aetna information and information technology resources through a framework of timely, efficient and business driven Aetna Information System (AIS) security policies, standards and procedures.

- Recommend, maintain, communicate and manage adherence to integrated cross-functional AIS security and business continuity architectures, direction, policies, processes and standards that foster and serve as a basis for management planning, control and evaluation of information security activities.

- Establish individual employee responsibility for information security by setting simple, practical security requirements.

- Provide information security knowledge through the development and use of innovative, effective educational material.

- Interpret security policies, or provide input on direction of Information Security for Aetna.

- Establish and coordinate simple, business-related procedures for information security incident management, compliance monitoring and reporting. Provide AIS investigative support to management and investigative services, as required.

QUESTION 2.1.3.2

- Monitor pending legislation affecting AIS policies and practices and engages in effecting position (State and Federal) of health care/insurance information access, control and protection. Coordinate Aetna plan for required implementation or compliance.

- Assist in identification of appropriate, cost-effective sources of information to establish best practices and determine appropriate recommendation for a secure environment.

Subcontractor:
Aetna provides HIPAA compliance internally.

Location/Hours of Operation/Point of Contact/Onsite Support:
HIPAA compliance is followed and supported throughout our organization. Our privacy and security office is located in our headquarters in Hartford, CT.

The State's account executive, Lynda Gable, will serve as your single point of contact for any HIPAA related needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Communications

Description:
We offer extensive member communications to educate members, promote our programs and support our services. These communications include pre-enrollment materials, post enrollment materials, and extensive web tools.

Pre-enrollment communications
Some of the pre-enrollment communication materials include enrollment forms, provider directories, plan brochures, discount program flyers, special program flyers, wellness program brochures, flyers and html e-mails promoting our online tools and resources. In addition, we provide communication materials on other plans and programs available to the member, such as pharmacy and dental flyers, where appropriate.

Post enrollment communications
Post-enrollment materials may include eligibility change forms, ID cards, plan documents, wellness educational information and reminders, and html e-mails and electronic newsletters on educational, quality and patient safety topics.

QUESTION 2.1.3.2

Web tools
Members are looking for convenient, round-the-clock online tools and information to help them make educated health care decisions and manage their benefits online. Aetna Navigator®, our secure member website at www.aetna.com, offers several online resources which include benefits information, health education, health assessment tools, cost and quality tools and health care decision support.

Aetna Navigator offers secure functionality allowing members to:

- View eligibility and PCP selections for themselves or covered dependents.
- Change primary care physician and dentist selections.
- View eligibility information available on ID cards, such as member ID, group number, coverage effective date, etc.
- Inquire about the status of a medical, dental and pharmacy claim for themselves or a covered dependent.
- View details about medical, dental or pharmacy claims such as the amount paid by the plan and the members' responsibility.
- View benefit balances such as deductible and coinsurance maximums.
- View their Health History Record, a centralized summary of health information based on claims data for members and covered family members.
- Access a Health Plan Guide. Members can learn more about their health benefits by accessing the Health Plan Guide which helps explain how the plan works as well as the different tools and resources available with the plan. The plan guide is available as both flash presentation and PDF file.
- Download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.
- Check flexible spending account (FSA) status and detailed payment information.
- View EOB statements.
- Print out Aetna standard forms.

QUESTION 2.1.3.2

- Contact Member Services through secure messaging in both English and Spanish.

- Aetna Navigator member ID information, registration, claim search and Contact Us features is available on a mobile version of the website, allowing for the functionalities to be available in a more user-friendly format, specific to the mobile device being used.

- Aetna Navigator assists members in using their health plan and in making informed health choices by providing access to:

- Healthwise® Knowledgebase, a user-friendly decision-support tool designed to encourage informed health decision-making and allow users to better understand their treatment options.

- Aetna SmartSource℠, an intelligent online search tool available through Aetna Navigator, Simple Steps To A Healthier Life® and our Personal Health Record (PHR). A read-only version of the PHR is available for mobile devices.

- DocFind®, our newly redesigned, online directory of participating providers that includes details about providers and facilities as well as links to quality and patient safety information. Public DocFind is available for mobile devices.

- Simple Steps To A Healthier Life, a program that offers disease prevention, health education and behavior modification programs aimed at improving the health of our members.

- Aetna Pharmacy's website that offers interactive content and tools to help manage both health and pharmacy costs. Members can also sign up for mail order drug and check their order status.

- Women's Health Online, our women's health website that provides age-specific health care resources and interactive tools on a variety of health concerns for women.

- Plan For Your Health℠, a website that provides consumers with easy-to-understand information about health benefits and guidance on choices that will affect their financial futures.

- Credible health information through Aetna InteliHealth, our online health information subsidiary that provides members with online tools and resources to help them better understand health and wellness.

QUESTION 2.1.3.2

- All About the Benefits, an educational program designed to make health benefits a priority and provide young workers with the knowledge and confidence they need to make informed health benefits decisions as they enter the workforce.

- Aetna Navigator Hospital Comparison Tool, a tool that allows users access to evidence-based hospital outcome data and quality and safety information on hospitals in their area.

- Estimate the Cost of Care (ECC), a suite of interactive web-based cost tools designed to provide members with cost information they can use to make more informed decisions. Cost information is provided for the most common medical and dental procedures, prescription drugs, office visits, diagnostic test and vaccines and diseases and conditions. The Price-A-Drug tool is available for mobile devices.

Custom communications
Aetna Customized Communications Group℠ (CCG), our strategic communications consulting group, is available to partner with the State to develop and deliver customized materials. This talented, award-winning team has more than 25 years of experience in developing customized benefit communications and offers a broad range of products and services to meet your needs.

Offering a unique combination of benefits knowledge and communication expertise, CCG develops open enrollment campaigns, launches and sustains wellness initiatives, and educates employees about appropriate utilization of the programs and services that encompass their overall benefits program. CCG will prepare detailed proposals outlining recommendations, specifications and associated costs. All materials are developed according to your plan design, style, tone, philosophy and employee audience.

Backed by an experienced staff of project managers, writers, graphic designers, print production managers, web developers and distribution specialists, CCG has the expertise and technical resources to produce a broad range of materials and manage benefit communications of any size and level of complexity from start to finish.

Support of health literacy
Nearly 9 out of 10 adults have trouble understanding and using the health information they are given in health care settings.[1] This leads to poorer health and increased costs. To address this problem, we created the Health Literacy Workgroup. At the start, the main goal of the group was to raise awareness about the challenges of poor health literacy. Later, we began to propose solutions to address the challenges.

QUESTION 2.1.3.2

Our mission is to have a positive impact on health outcomes by using and promoting universal health literacy strategies. Our goals are to:

- Research the effect of health literacy on consumer understanding of health information and its impact on health outcomes.
- Increase awareness about health literacy among health care professionals, members and Aetna employees.
- Provide stakeholders with the tools and resources they need to address challenges to health literacy.
- Promote language simplification so that we communicate health information in a manner that is understood by all audiences.

Our cross-functional group contains representatives from:

- Health care management
- Quality management
- Pharmacy and dental operations
- Product and program development
- Marketing and communications
- Claims and customer service
- Sales

Health literacy initiatives

Since 2005, we've worked hard to:

Spread the word

We speak about the cause to Aetna employees, industry trade groups, professional associations and other health literacy groups. We've invited experts in the field to speak to our employees. These experts include Drs. Darren Dewalt, Bob Like and Barry Weiss, as well as plain language and cross-cultural communications expert Janet Ohene-Frempong.

QUESTION 2.1.3.2

Engage employees

Employee "champions" weave the concepts of health literacy and plain language into the fabric of the organization. This increases the value of our brand, reputation and business success. Every Aetna employee receives annual awareness training about health literacy and plain language. We also have an online health literacy awareness course for all employees.

Permanent features of our employee intranet include *Jargon Alerts* and *Because You Asked*, which both help employees figure out better ways to convey information. During national Health Literacy Month, we sponsor contests to engage employees. One asked entrants to rewrite a paragraph to reduce its reading grade level and enhance its clarity.

Reach out to clinicians

We talk to doctors and nurses about their role in helping patients better understand their health and health care. We have created awareness activities for doctors, including:

Health literacy messaging to physicians via educational and clinical apps
Features about health literacy in our physician newsletter
A health literacy reference tool on our provider education website
A cultural competency course for clinicians

Conduct research

We research and analyze the effect of health literacy on consumer understanding of health information and its impact on health outcomes.

Improve communications

We have used plain language to simplify more than 200 codes for our explanations of benefits and simplified more than 70 member letters. In addition, we produce *Navigating Your Health Benefits for Dummies*, a book that breaks down the complex health benefits system into easily digestible pieces and helps consumers navigate their way.

QUESTION 2.1.3.2

Collaborate with others

One of our medical directors serves on the programs committee of the American College of Physicians Foundation. An Aetna vice president is an active member of the Institute of Medicine's Round Table on Health Literacy, as well as chair of AHIP's Health Literacy Taskforce. We also collaborate with the American Medical Association Foundation to distribute their continuing medical education course on health literacy to clinicians.

We work with the Financial Planning Association to sponsor *Plan for Your Health,* a public education website that gives consumers the tools and information they need to make smart health benefit decisions to protect their health and financial future. The site focuses on life stages such as changing jobs, getting married, starting a family and planning for retirement. It is also available in Spanish.

[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Washington, D.C.

Workflow:
All standard pre-enrollment distribution activities are centralized. This helps to ensure the accurate fulfillment and timely delivery of enrollment materials regardless of where we send them. Our standard process is to bulk-ship enrollment materials from our fulfillment center to your locations for distribution to employees. There are no additional costs associated with this standard delivery process.

We will work with the State to determine whether pre-enrollment materials will be sent to the employees' homes or made available at employee meetings. There would be an additional cost to mail these materials to the members' homes.

Member ID cards are mailed to members' homes at no additional charge. Post-enrollment materials such as wellness messages and quality/patient safety e.messages, are available to you to send to members. Our monthly e-mail newsletter, Member Essentials℠, is sent to registered subscribers that have elected to receive e-mails on their Personal Profile page in Aetna Navigator®, unless you elect to opt out of this service.

Org Chart:
As of December 31, 2011, we had 198 employees in our Communications division.

Aetna Customized Communications Group℠ (CCG) has 25 full-time employees, including project managers, writers, graphic designers, print production managers and distribution specialists.

QUESTION 2.1.3.2

Subcontractor:
We primarily provide communication services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Production and fulfillment of most communications, including our CCG team, are located in Hartford, CT.

The State's account executive, Lynda Gable, will serve as your single point of contact for any communication needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Information Technology

Description:
Aetna Information Services (AIS), the Information Technology (IT) function of Aetna Inc., supports the core Aetna Group values by leveraging technological solutions that provide more information and more choices to policyholders, members and internal business partners.

Aetna's Information Security Policy was created based on the following supporting national standards:

- **HIPAA** (Health Insurance Portability and Accountability Act of 1996)
- **ISO/IEC 17799**, Information Technology - Code of Practice for Information Security Management, First Edition, Reference Number ISO/IEC 17799:2000(E), 2000-12-1
- **NIST Special Publication 800-12**, National Institute of Standards and Technology: An Introduction to Computer Security: The NIST Handbook, October 1995
- **NIST Special Publication (SP) 800-14**: Generally Accepted Principles and Practices for Securing Information Technology Systems, September 1996

The Company has placed into operation an Enterprise Risk Management Process to identify and prioritize the significant enterprise risks that could affect the Aetna Group and the Company, including its ability to provide reliable service to customers of the Company and, specifically, for purposes of this Report, to users of the Company's Self-Funded Products. The goal of this process is to assist management in identifying significant risks inherent in the processing of various types of transactions for users and implementing appropriate measures to monitor and manage these risks.

QUESTION 2.1.3.2

The Company's management of risks is primarily achieved through the various control environment items discussed above. The Chairman, CEO and President of the Company, along with the Chief Enterprise Risk Officer and other members of senior management, are responsible for identifying and managing the risks that might impact the Company through predefined organizational reporting structures. The Board of Directors of Aetna Inc., along with Aetna Inc.'s Audit Committee and other Aetna Inc. Board committees, oversees the Aetna Group's enterprise risk management processes, including risk identification and prioritization.

Information Security Awareness
New employees are introduced to Aetna's Information Security Program via a web-based New Employee Orientation Program. Each new employee and contingent worker must complete Aetna's Code of Conduct training program called Business Conduct & Integrity (BCI), which includes an Information Security module.

All employees and contingent workers must complete BCI annually thereafter. Audience specific (managers, application developers, etc.) security training is routinely provided. Aetna's training program is robust and well documented.

Continued reinforcement via emails, web articles, newsletters, and face-to-face activities is provided to the Aetna workforce regarding each individual's role in ensuring the confidentiality, integrity, and availability of Aetna information.

Background checks on all personnel
A comprehensive background investigation is conducted on all candidates for Aetna regular and Aetna temporary employment. Employment offers are contingent upon the candidate's successful completion of this investigation.

For additional information about our Information Technology, please refer to the attached Information Security High Level Overview document.

Flow Chart:
Please refer to the Information Technology Flow Chart and Network Diagram attachments.

Org Chart:
To design and deliver these technology solutions, AIS has nearly 3,000 IT professionals and over 2,000 contractors working collaboratively, in dozens of teams, in every area of IT. AIS and its service and solution orientation stretch from e-commerce to mainframe operations utilizing top technical and business talent. Project planners, network engineers, database analysts, architects, developers and quality assurance engineers are all key members of AIS.

QUESTION 2.1.3.2

These IT professionals are currently organized into eight functional departments. The eight main departments are Integrated Infrastructure Services (IIS); Enterprise Architecture (EA); Program Delivery (PD); Application Delivery (AD); AIS Delivery Operations (ADO); Enterprise Testing & Quality Assurance (ETQA); Production & Enhancement (P&E); and International IT.

Each department is accountable for a key element of practical and strategic IT solutions delivery.

Subcontractor:
We primarily provide Information Technology services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our IT staff is spread out across many offices throughout the country. The State's account executive, Lynda Gable, will serve as your single point of contact for any information technology needs.

Integration with Other Vendors

Description:
We have extensive experience integrating with other vendors.

We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Aetna Informatics® has more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

We typically disclose processed claim transaction data in our standard Universal File formats, one for Medical/Dental and a separate format for Aetna Pharmacy Management.

These electronic claims data extracts are available through CD-ROM or electronically on a fee-for-service basis. If the standard format does not meet the State's needs, customized reporting is available.

QUESTION 2.1.3.2

We also have the capability to import external pharmacy, medical and behavioral health claims data from third-party vendors into selected clinical and reporting applications. The external data that we bring into our organization is used for a wide variety of purposes including but not limited to:

- Disease identification
- Disease severity identification
- Decision support
- Case management
- Predictive modeling
- Personal health record input
- Patient safety programs such as MedQuery®
- Input into selected HEDIS measures

Subcontractor:
We perform integration services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
The State's account executive, Lynda Gable, will serve as your single point of contact for any integration needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Patient Value Chain

Network

Description:
Network services are led by a team of individuals based out of the Northwest Region which includes Alaska, Washington, Oregon and Idaho. The anchor of the NW team is Lori O'Banion, based in our Anchorage office. Lori has over ten years in network management within the state of Alaska.

The NW team has access to Aetna Network Employees based in our Western Region Office in Walnut Creek, California and our National Network Contracting team. The latter two departments support any regional or national providers such as Quest Diagnostic Services.

QUESTION 2.1.3.2

The Aetna advantage relates to our ability to use a local market resource to manage the network and contracting while calling on national organization for contracting support including best in industry analytics to support the contracting process.

Aetna is also an industry leader in engaging with delivery system on accountable care solutions where the market defines the opportunities and calls on the broader organization for assets and capabilities to support care delivery and financing reform.

Org Chart:
We have attached a Northwest Network Org Chart.

Subcontractor:
Network management services are provided in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Lori O'Banion will be the single point of contact for the State for all network needs. Lori is located in Anchorage, AK. She is available from 8 am to 6 pm, Alaska Time, and is available to offer onsite support as needed.

Indemnity Vision and Managed Care Network

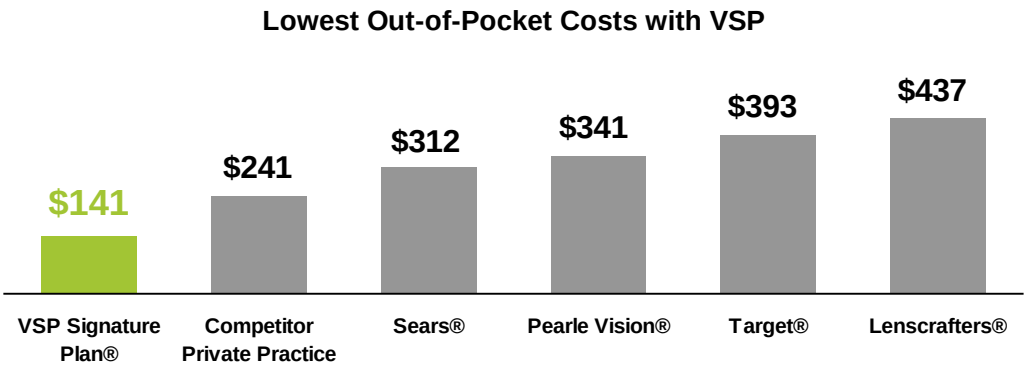
Description:
You can count on us to provide seamless vision benefit administration, personalized for the unique needs of State of Alaska. With more than half a century dedicated to vision care, we have significant experience implementing plans for clients similar to State of Alaska in size, complexity, and industry. We currently cover over 43,000 clients representing 58 million members, including the State of Alaska for over 20 years. We are proud to be doing business in the State of Alaska for 47 years and currently cover over a third of the population.

Unbeatable savings with a focus on health, more provider choices, and exceptional service are what make VSP the smart choice for State of Alaska's eyecare partner for the managed vision program.

Unbeatable Savings
After careful consideration of State of Alaska's unique needs, we are proposing our popular VSP's Signature Plan, which offers competitive premiums and provides the best overall value when you consider the total cost of a vision care plan—premiums plus employee out-of-pocket costs.

QUESTION 2.1.3.2

An independent, national pricing study shows that VSP members pay lower out-of-pocket costs.



Focus on Health
State of Alaska will receive our complimentary Eye Health Management Program®, which turns routine eyecare into preventive healthcare leading to healthier, more productive employees and significant cost avoidance.

Through our program we:

- Identify chronic conditions early. VSP providers have identified signs of chronic conditions in 2.4 million members since 2005.
- Share HIPAA-compliant patient condition data with PCPs, health plans, and disease management vendors. This enables you to proactively enroll your employees in programs to manage their health, helping you reduce healthcare costs.
- Engage more employees in preventive care. At no extra cost, we send VSP members identified as having diabetes a reminder letter – we see 22% more of these members return for an eye exam.

More Provider Choices
Your employees can choose any provider. For the best value, our program includes 49,000 **preferred provider** access points nationwide – including 1,967 privately-owned chain locations and 92 preferred providers in Alaska. All of our preferred providers offer full service (exams and eyewear) and 88% offer evening, weekend, or early morning hours.

In addition, we've contracted with Costco Optical and others as **affiliate providers**. Costco Optical includes over 400 locations across the country. Whether your employees choose a preferred or affiliate provider, they will receive a covered-in-full benefit experience. Your employees are only responsible for any plan copayments and/or non-covered options they select.

QUESTION 2.1.3.2

Through **VSP Open Access**[SM] your employees and their families always have the freedom to choose any provider, including local or national chains. All providers can contact us directly to check eligibility and submit claims to us on behalf of your employees. In fact, we have a national arrangement with Walmart® Vision Center and Sam's Club® Optical Center, which makes using our benefits easy.

Exceptional Service

We're passionate about delivering great service and have won many awards to back that up. In fact, Service Quality Measurement (SQM), the leading benchmarking authority for the call center industry, has recognized VSP with their **Call Center World Class Call Certification** for the tenth year in a row. SQM has also recognized us with the "Highest Customer Satisfaction in the Insurance Industry" award every year since 2003 and the "Highest Customer Satisfaction in the Business to Business Industry" award. We ensure that our clients, members, and preferred providers will speak to a knowledgeable VSP employee, not an independent phone rep that works for multiple companies. Our call center representatives are friendly, experienced, and empowered to make the right decisions on the spot for our customers who call in needing help. We also offer extended customer service hours that accommodate our clients' and members' needs in all U.S. time zones.

You and your employees will enjoy world-class care and easy-to-use tools:

- Award-winning customer service
- Consultative account management
- Personalized employee communication plan
- Robust suite of online tools
- Implementation plan that covers every detail
- Customizable reporting

Communications and Support

Our member communication materials focus on two important things: understanding plan coverage and educating members on eye health. We provide these materials free of charge, with you taking care of distribution to your employees.

Our member communication materials:

- Promote the importance of eye health and wellness
- Explain how to use the plan
- Include our toll-free number and website address
- May be cobranded with your company logo

QUESTION 2.1.3.2

We can also give you:

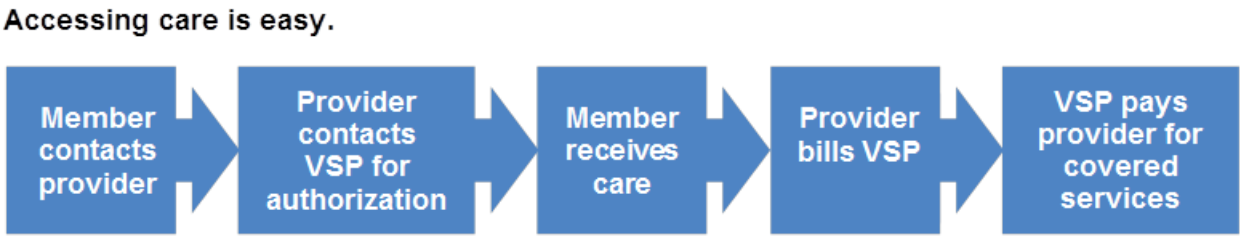
- Suggested wording for your own employee communications
- Ready-to-use articles and facts about vision and eyecare
- Help creating hotlinks from your website to ours

If needed, we can also provide you with useful materials for open enrollment meetings, including:

- Member benefit summary customized with your plan coverage and explanation on how to use the benefit,
- Collateral that informs on the importance of annual eye exams and how eyecare can affect your overall wellness,
- Promotional giveaway items for attendees,
- Special activities to educate your employees about eye health and protection.

VSP partners with many organizations who utilize VSP products to support the vision portion of their program. Clearly defined expectations help set the stage for a successful ongoing partnership. The State of Alaska can rest assured that our relationship with Aetna will translate into the successful administration of its vision plan.

Flow Chart:
Members just contact one of our providers and make an appointment. VSP and the preferred provider take care of the rest. Our providers contact us to check the patient's eligibility, plan coverage, and get authorization to provide services.



After the appointment, the provider submits the claim electronically to us and we pay the provider directly for covered services. No claim forms or paperwork for our members.
Members can easily find a provider or find out more about their benefits by:

- Visiting our website at vsp.com
- Calling our toll-free customer service number at 800.877.7195

QUESTION 2.1.3.2

With VSP Open Access[SM] your employees have the freedom to choose any provider, including any national or local chain. For the best coverage and value, most members choose one of our preferred providers. We also offer a schedule of allowances members can use at all other provider locations. Plus, we keep it simple by allowing other providers to contact us directly to check eligibility as well as submit claims directly to us under an assignment of benefits. That way, your employees don't need to pay the entire bill up front; they simply pay any overage above the schedule of allowances and we'll reimburse the scheduled amounts to the provider directly.

Org Chart:
VSP is a not-for-profit company with no owners or shareholders. We have attached a VSP Executive Organizational Chart for your reference.

Subcontractor:
We are partnering with VSP to provide the Vision services for this State of Alaska bid.

Location/Hours of Operation/Point of Contact/Onsite Support:
VSP is headquartered in California and have an Eastern Operations Center in Ohio. The following are our addresses:

Corporate Headquarters
3333 Quality Drive
Rancho Cordova, CA 95670
916.851.5000 or 800.852.7600

Eastern Operations Center
3400 Morse Crossing
Columbus, OH 43219
614.471.7511 or 800.462.7009

Extended hours give your employees the ability to talk to a U.S.-based VSP employee at their convenience. Our customer service representatives are available toll free:

- Monday through Friday, 5 a.m. to 8 p.m. PT
- Saturday, 6 a.m. to 5 p.m. PT

You will also have 24/7 access to our toll-free Interactive Voice Response (IVR) system and website. They both deliver personalized information including eligibility, plan coverage, and detailed provider information (including maps and driving directions on vsp.com).

In addition, we have 25 regional sales offices across the country to provide local service, including our local office in Seattle, Washington that will service the State of Alaska.

QUESTION 2.1.3.2

You can count on us to provide an experienced, responsive account team known for delivering exceptional service. Account Executive Deborah Levy and will partner with Aetna and provide ongoing service once the plan is in effect. Account Manager Jennifer Aberg will be your VSP contact for everyday needs. You can reach Deborah and Jennifer at:

Deborah Levy
600 University Street, Suite 2004
One Union Square Building
Seattle, Washington 98101
Phone: 800.228.1018 or 206.623.5178
Fax: 206.621.7515
E-mail: Deborah.Levy@vsp.com

Jennifer Aberg
121 S.W. Morrison, Suite 1050
Portland, Oregon 97204
Phone: 800.334.9201 or 503.232.8187
Fax: 503.234.8942
Jennifer.Aberg@vsp.com

Eligibility & Enrollment

Description:
You will have an assigned enrollment analyst who will be responsible for maintaining high quality in the eligibility data system.

We accept and process enrollment and change data in any of the following methods:

- Internet-based Eligibility Transfer Solutions – The State can submit eligibility using our web-based transfer solution called SecureTransport™. The State uses the software to transmit eligibility files to us during open enrollment and as needed for updates. SecureTransport is a trademark Axway® used under license.

- Electronic Transport Method – The State can submit enrollment through SecureTransport using an electronic transport method.

QUESTION 2.1.3.2

- e.Listing – An e.Listing is an Excel spreadsheet populated with eligibility data. We scan the spreadsheet into our systems and it mirrors an electronic file, eliminating manual intervention. The e.Listing functionality increases the timeliness of eligibility updates so that members can access care quickly. e.Listings received by us prior to 3 p.m. ET in the appropriate format are processed same day.

- Enrollment Forms – The State can submit paper enrollment forms that will be input manually.

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

We integrated the enrollment aspect with our policy entry, claims and pharmacy management systems.

Your enrollment analyst will monitor the eligibility file updates and will know immediately about any errors. The State and your assigned analyst will work together to decide how to best correct the errors. If we detect an error, we will modify or replace the file typically within 48 to 72 hours.

Open enrollment support
Our representatives are available to help employees with questions during the annual open enrollment meeting. We offer the following materials:

- Enrollment application and change forms
- Plan descriptions and benefits comparisons
- Provider directories
- Other program information

We will work with the State to coordinate open enrollment needs and communication support.

Flow Chart:
Please refer to the Enrollment Flow Chart attachment.

QUESTION 2.1.3.2

Org Chart:
The Enrollment/Eligibility department is managed by the National Accounts Plan Sponsor Services (NA PSS) organization within Aetna Service Operations. The NA PSS department manage plan set up, eligibility, billing and accounts receivable, and drafting for group customer accounts.

Eligibility, as with all PSS functions, is managed in two geographic regions within Aetna National Accounts (Northeast/West). The State will be managed by our West region. There is an overall PSS lead that oversees all aspects of PSS operations. Each region has a manager that oversees the servicing of their book of business. Teams in each region are dedicated to eligibility processing with eligibility managers, consultants, and technical staff. You are assigned a dedicated eligibility consultant that works with your appropriate contacts to ensure the account is handled timely and accurately.

Subcontractor:
We provide our eligibility and enrollment services in-house. We contract with Source One Direct, Inc. of Atlanta, GA and Kingston, RI for ID card production.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our enrollment/eligibility staff is spread out across several offices throughout the country. The State will be handled by our West region, which has eligibility consultants located in our California, Walnut Creek, CA Office.

In addition to an assigned eligibility analyst, who will be named upon award of business, the State can discuss eligibility and enrollment questions or needs with their onsite resources as well as Lynda Gable, the account executive.

Customer/Member Services

Description:
Our member services help take the guesswork out of health care. Members can solve a problem with a single phone call, get answers to their health questions in the middle of the night, and find a doctor online, at their convenience.

QUESTION 2.1.3.2

We offer our members a variety of tools that allow them to use the services they need when they need them. We have options for our most tech-savvy members, as well as those who prefer to conduct business in a more traditional way. Members benefit from services that include:

- A concierge to access information and connect members with clinicians and product specialists
- Cost look-ups for services and pharmacy products
- Easy to contact member service professionals who can solve a problem on the first call
- Multi-language and hearing impaired phone options
- 24-hour service with the Aetna Voice Advantage®
- Ratings for doctors and hospitals
- Ask Ann, an interactive tool that lets users ask questions and get personalized answers
- Mobile technology and apps for smartphones

Putting members first with the Aetna health concierge
For the State of Alaska, we are proposing a more personal one-to-one member advocate, called the My AlaskaCare Single Point of Contact, who will focus on providing a simplified, seamless member experience to help your members maximize all their available benefits and navigate their individual health care journey. Just as many hotel guests depend on the services of a concierge; our members depend on our concierge. J.D. Power and Associates has recognized our informed customer helper as “an outstanding customer service experience” for three years in a row. More than three-quarters of a million members rely on the health concierge, a single point of contact that provides personalized help. The concierge also connects members to additional resources to help them get the most from their benefits.

QUESTION 2.1.3.2

The My AlaskaCare Single Point of Contact service model provides custom-tailored service based on the unique aspects of your health benefits and program offerings. Think of the My AlaskaCare Single Point of Contact as a health resource consultant with in-depth benefits knowledge and consultative soft-skills that empower them to deliver high-satisfaction service that is personalized within the context of individual member needs for education, guidance, and support. They will help you make the most of your benefits strategy by empowering your members to make better-informed decisions that support program participation and engagement.

The State will have 16 concierge members dedicated to the State of Alaska. They will partner with all State members' connecting you to the right resources across your entire portfolio.

Checking the cost of care
Our members can become educated on the cost of their care by using our payment estimator tools. These tools can check estimated costs for:

- Surgical and scope procedures
- Office visits
- Diagnostic tests
- Vaccines
- Treatment of diseases and conditions
- Prescription drugs

Knowing these costs before scheduling an appointment allows members to make better decisions concerning their care and the care of loved ones.

Reaching a trained, caring member service professional
Many members still prefer person-to-person phone contact. We train our representatives to answer a question or solve a problem on the first call, and give them the tools they need to find answers and access to areas that can help when they can't.

In 2011, we resolved 94.3 percent of about 39 million calls on the first call in an average of 24.5 seconds. That resulted in an overall member satisfaction rate of 92 percent.

QUESTION 2.1.3.2

Member service professionals are available, toll-free, 10 hours a day. They can help with:

- Filing a claim
- Determining what members will pay
- Getting a referral, when required
- Finding doctors and other providers
- Finding care outside of the service area
- Understanding how the plan works

Providing specialized services for a diverse membership
Member services professionals can connect members to someone who speaks the same language through our Language Hotline. Interpreters for 140 languages are available to members who request this service.

Members who are hearing impaired can call Aetna's TDD line for specialized service.

Getting answers when you need them
The Aetna Voice Advantage® interactive telephone system is available 24 hours a day, 7 days a week to provide information for members when they need it. The easy-to-use tool determines the reason for the call as members talk and finds the information they need. This makes it easy to make better health care decisions.

A member who wishes during the call to be shifted over to a representative simply says so or presses "0." This transfers the call and all information already gathered to someone who is trained to help.

Finding a doctor or hospital
Members can quickly narrow their search for a doctor by using our DocFind® directory to find network providers. The online search tool provides information including:

- Plans accepted
- Office locations
- Handicap access
- Maps and driving directions
- Medical schools attended
- Board certification status
- Languages spoken

QUESTION 2.1.3.2

Aetna members can also get a personalized version of DocFind through Aetna Navigator. It automatically fills in the plan name and zip code, making their search even easier. Members can compare hospitals in their area with the hospital comparison tool. Comparisons are based on:

- Procedure
- Condition
- Diagnosis

They also can see which facilities specialize in certain procedures and check other information. We update DocFind six times a week so members always have the latest on doctors and facilities.

Interacting with Ann provides personal assistance for members
Ann is Aetna members' personalized, virtual assistant, offering 24-hour support about how to navigate our secure member website. When members visit the site, they can click on Ann to open a chat window and enter a question. Ann is programmed to understand the intent of the question by recognizing the natural language members use to ask it. She provides an immediate written and spoken response in a friendly voice to create a personal and interactive experience.

Ann's vocabulary and response capabilities are continually expanding. We also gather feedback from users and monitor it through a built-in feedback mechanism. Feedback has been extremely positive. Ann helps members get the information they need to make the right health care decisions and get the most from their benefits.

Helping members get information on the go

One out of five Americans accesses the mobile web on a typical day. We engage our members with mobile web, smartphone applications (apps) and text messaging to meet their needs on the go.

QUESTION 2.1.3.2

Aetna consumer research found that the best liked health-related mobile apps help users save money and easily access health information. Our apps help members to:

- Search for a doctor, dentist, hospital or pharmacy
- Register for our secure member site, where you can:
    - View your claims
    - View your coverage and benefits
    - View your Personal Health Record
    - View your ID card information
    - Check drug prices
    - Contact us by phone or e-mail

Texting for good health
We have been using text messaging in some programs since 2006 to remind patients about appointments or tests, encourage them to reschedule missed appointments and get messages with important health information. The programs showed that text messaging helps to engage members in their health. In fact, compliance with blood testing rose from 52 to 70 percent in members with diabetes in the initial pilot program, and we are working to expand our text messaging abilities to include even more members.

Meeting our members where they are
We meet our members where they are with resources that engage them in making well-informed health care decisions. Whether it's a phone call from home to member services or a text message from a smartphone, we have the resources in place to help our members get the most from their health care.

Flow Chart:
For the My AlaskaCare Single Point of Contact model, members call in to their assigned toll free member services number. They are then greeted by the Aetna Voice Advantage automated telephone service, which requests member identification information and can provide personalized self-service information. Members may opt out of Aetna Voice Advantage at any time by asking to speak with an operator, or CSR. By selecting this option the member will be routed directly to a My AlaskaCare Single Point of Contact concierge. If needed the concierge can warm transfer members to additional Aetna departments, or initiate a three-way call with the member and additional parties.

QUESTION 2.1.3.2

My AlaskaCare will eliminate the standard transactional view of health care. It will provide your employees, retirees and their families with a personalized member experience that is customized to their needs, not ours.

Org Chart:
We have attached our Fresno Service Center Organizational Chart.

Subcontractor:
Member services will be performed in-house by our Aetna employees.

Location/Hours of Operation/Point of Contact/Onsite Support:

Member services for the State will be provided by our Fresno, CA service center. You will also have onsite resources located in Anchorage and Juneau.

QUESTION 2.1.3.2

The My AlaskaCare Single Point of Contact team will be available from 8 am to 6 pm local time. We also offer automated member service support 24 hours a day, 7 days a week through Aetna Navigator, our secure member website, and Aetna Voice Advantage, our telephone self-service system.

Utilization Management

- Concurrent Review
- Outpatient Review
- Discharge Planning
- Approvals/Denials
- Travel Management

Description:
We want our members to enjoy their best level of health. Whether it's transitioning a member from the hospital to home health care or setting up a case management plan, our nurses work together to get members the care they need. We do this by using our care team approach and applying clinical expertise, technology, and evidence-based guidelines throughout our care management program.

Concurrent review
With the exception of normal maternity admissions, we register all inpatient admissions in our medical management system for review in accordance with the member's benefit plan. Our clinical staff uses evidence based clinical guidelines from nationally recognized authorities and the terms of the member's benefit plan to guide utilization management decisions for inpatient utilization, continued stay review and discharge planning, as well as for precertification and retrospective review.

We use on-line guidelines from the following sources:

- Milliman Care Guidelines® (Seattle, WA: Milliman USA)
- Our internally developed Clinical Policy Bulletins (CPBs)
- National and local Medicare coverage policies
- Other Aetna recognized criteria
- Applicable state and federal guidelines

QUESTION 2.1.3.2

Not all of the inpatient admissions require a clinical review for medical necessity (for example routine admissions with a short length of stay). We review outpatient procedures using the same criteria or guidelines as inpatient procedures. Licensed and experienced clinicians and professionals make decisions based on the above criteria as well as the individual needs of the member.

Discharge planning
Assessment for discharge planning begins at the time of notification. Once we identify post discharge needs, we begin to coordinate them during the hospital stay. It involves a proactive approach to work with providers and members to develop a transition plan from one level of care to the next. The discharge plan considers:

- The member's age
- Prior level of functioning
- Significant past medical history
- Anticipated discharge location
- Current medical condition and level of functioning
- Family/community support
- Psychosocial issues
- Barriers to discharge planning

Discharge planning may include internal and external referrals. Examples of internal referrals are:

- Case management
- Disease management
- Behavioral health
- The National Medical Excellence program®

Examples of external referrals are:

- Skilled nursing facilities
- Rehabilitation facilities
- Home health care agencies
- Community support groups
- Durable medical equipment and supplies
- Social work services

QUESTION 2.1.3.2

Approvals/Denials
The precertification staff confirms eligibility and collects information before inpatient admissions and selected ambulatory procedures and services.

Two components of precertification are:

- Notification – This process is the registration of a request for services or supplies included on a precertification list.

- Coverage determination – This process reviews plan documents and may include a review of clinical information to determine whether clinical guidelines/criteria for coverage are met. The coverage determination process takes into account:

  - Individual needs of the member

  - Characteristics of the local delivery system

  - The member's benefit plan

By focusing on high cost or over/under-used procedures, precertification provides an entry point for acute care utilization management. It also provides a referral point for complex case management and special programs. These help reduce medical expenses and improve the member's quality of life.

The precertification process helps communicate a coverage decision to the treating practitioner and/or member in advance of the procedure, service or supply. We can receive precertification requests:

- Electronically through an electronic data interchange (EDI) or Internet solution
- By telephone
- In writing by fax or mail

QUESTION 2.1.3.2

Our Precertification department also reviews the use of providers who do not participate in our networks. This includes:

- Members in certain plans who must initiate precertification themselves when seeking out-of-network care
- Members who are referred to out-of-network providers for covered medical services that are not available within our network

Travel Management

The My AlaskaCare Single Point of Contact team will be trained on the details of the travel program included with the State of Alaska's medical plan. The training will include a detailed review of the conditions for which travel may be reimbursed, as well as what specific expenses are eligible for reimbursement. The concierge team will serve as the initial contact for a member who is requesting pre-authorization of travel.

We will utilize our representatives located in Alaska to complete the review, make a determination and send a written communication to the member as to the approval or denial of the travel request.

In addition, we will set up a dedicated fax number for travel requests for State of Alaska employees, retirees and their family members. Travel requests received via fax will be handled by the representatives located in Alaska just as if the request was initiated through the concierge team.

Flow Chart:
We have attached a flow chart for our precertification, concurrent review, and retrospective review processes. A workflow of the travel management process is included below.

QUESTION 2.1.3.2

Travel Management

Pre-Authorization

Member could initiate request for travel pre-authorization via phone call to concierge service team or fax submission of Travel Preauthorization Form to dedicated fax number.

- Phone call to concierge service team
  - Representative will obtain the following information from member for requested travel
    - Name
    - Aetna ID#
    - Phone number for follow-up
    - Appointment date for consultation or treatment
    - Name and location of the doctor for consultation or treatment
    - Name and phone number of your local doctor
  - Representative will submit request for travel preauthorization to Alaska representative team for review and determination.
  - Alaska representative will make determination as to reimbursement for travel request.
  - Alaska representative will send written correspondence to member as to approval or denial of travel request.

- Submission of Travel Preauthorization Form to dedicated fax number for travel preauthorization
  - Alaska representative will review request for completeness.
  - Alaska representative will outreach to member for any missing information for review and determination.
  - Once request is complete – initially or after obtaining any additional information needed from member – Alaska representative will make determination as to reimbursement for travel request.
  - Alaska representative will send written correspondence to member as to approval or denial of travel expense.

Reimbursement Processing

- When travel reimbursement request is received, a review of the member's file is performed to confirm the following:
  - Travel was preauthorized
  - Medical consultation or treatment claims have been received for the date and location for which travel was approved.
- Reimbursement of airfare is processed and sent to the member if conditions from review of member's file is met.

QUESTION 2.1.3.2

- Reimbursement request is pended if travel preauthorization was approved, but no associated medical claims have yet been received.
- Reimbursement request is denied if there was no preauthorization for travel.

Org Chart:
We have attached a UM Organizational Chart for the West region with this response. Our travel management services would be handled by the customer service concierge team. We have attached a Fresno Service Center Organizational Chart.

Subcontractor:
We will provide these utilization management services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Utilization management for the State will be handled by our West Care Management teams. Locations and hours of operation for each West Care Management office are listed below. The following office will provide all utilization review functions – precertification, concurrent review, discharge planning, retrospective review and case management:

2625 Shadelands Drive
Walnut Creek, CA 94598
8 a.m. to 5 p.m. PT Monday through Friday

The following offices will provide concurrent review, discharge planning, retrospective review and case management (no precertification):

6303 Owensmouth Avenue
Woodland Hills, CA 91367
8 a.m. to 5 p.m. PT Monday through Friday

4645 E Cotton Center Blvd, Bldg 1
Phoenix, AZ 85040
8 a.m. to 5 p.m. MT Monday through Friday

601 Union, 2 Union Square
Suite 810
Seattle, WA 98101
8:00 AM to 5:00 PM PR Monday through Friday

QUESTION 2.1.3.2

Callers for all our care management programs receive a message after hours advising them to call back during regular business hours. The after-hours message also gives information on how to handle emergencies. In states that mandate round-the-clock operating hours, a recording gives members an option to speak with a representative. If the mandate is chosen, we forward the call to our team in Blue Bell, PA, which is operational 24-hours a day, 7 days a week.

Travel management services will be provided by your My AlaskaCare Single Point of Contact team, and will also be supported by our onsite resources in Anchorage and Juneau. Karri Priddy, the State's plan sponsor liaison, will be the contact for the State as it relates to the travel reimbursement program. Dr. Lydia Bartholomew will provide medical director support should it be needed as it relates to the travel program.

Case Management

Description:
We are proposing the Aetna Flexible Medical Model[SM] (Flex) for the State. Flex combines the benefits of our standard regional patient management model with some of the advantages of our more customized or dedicated models.

We designed the Flex model for customers who want an additional level of outreach to members along with customization of case management triggers and a higher degree of integration with external vendors. Our model casts a broader net to identify and engage members sooner so we can have a greater impact on their health care. We strongly believe that better engagement results in increased satisfaction, improved health, and lower medical costs over time.

The Flex model provides:

- A customer-specific focus on preference and company culture that supports some customized scripting (such as the ability to use the term "associate" rather than "employee")
- Options to purchase expanded outreach by the same team of nurses managing a member's complex care
- Options for a higher nurse-to-member ratio which enables more outreach to drive engagement

QUESTION 2.1.3.2

- A single-point-of-contact nurse who serves as the conduit to case management and referral sources

- A greater degree of third-party program integration

- A greater level of customization of case management features

We are proposing the Flex model option 2 for the State. Option 2 includes:

- A designated team to provide centralized case management services for all case management activities. Precertification, concurrent review and discharge planning remain a regional function.

- A designated single-point-of-contact (SPOC) nurse assigned to each customer that provides a high level of program oversight and vendor integration. The ratio of SPOC nurses to customers is 1:3.

- Some customization to the case management trigger list. For example, high dollar claims reviewed at $50,000, a lower threshold than our standard $75,000.

- Outreach to members with a predictive modeling (PULSE) score of 13 or greater and 2 or more action flags that indicate a potential health problem.

- Staffing is consistent with our standard regional model at 1 nurse to every 45,000 members.

- Integration with vendors. We will discuss the level and degree of integration available with the customer prior to implementation.

- Pre-admission for all elective admissions and post-discharge calls for all members discharged to home, except maternity and behavioral health.

- Outreach to members with a predictive modeling (PULSE) score of 10 or greater and 1 or more action flags. This lower threshold means we identify and engage members sooner when we can have a greater impact on their health and health care.

- Additional staffing of 1 nurse for every 20,000 members.

Flow Chart:
We have attached a case management workflow document.

QUESTION 2.1.3.2

Org Chart:
We have attached a UM Organizational Chart for the West region with this response. This includes our medical management staff.

Subcontractor:
We will provide case management services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
The Aetna Flexible Medical Model℠ (Flex) includes a single-point-of-contact (SPOC) nurse. The nurse provides:

- A single contact for you to clarify questions regarding our care management programs
- A contact for vendor integration arrangements, providing a high level of program oversight that reduces member calls and questions to you
- A participant at your quarterly meetings to review reports and provide insight into utilization trends

The SPOC nurse makes sure the daily operations of the model run smoothly and are successful. Working in partnership with you and our account team, the nurse provides a gateway to case management and vendor referral sources.

Hours of operation for our Aetna Flexible Medical Model℠ (Flex) teams are Monday through Friday 8 a.m. to 5 p.m. local time.

Our Flex staff members are located in regional offices throughout the country. We are proposing a Flex team in California for the State.

QUESTION 2.1.3.2

Claims Processing

- UCR Management
- Explanation of Benefits (EOB)
- Coordination of Benefits (COB)
- Health Flexible Spending Account (FSA)
- Dependent Care Assistance Program (DCAP)

Description:
When it comes to paying claims, we strive to get it right the first time. For you and your employees and their families, this means fewer pended claims, and faster, accurate payments.

Our First Claim Resolution program helps us avoid pended claims, extra paperwork and delays. Claims processors attempt to contact the provider for any missing information, such as accident details or a diagnosis.

We process claims on a customized version of the Dun & Bradstreet system, ClaimFacts®, that we call Automatic Claim Adjudication System (ACAS). It is a fully computerized, interactive, online, real-time claims payment and accounting system. ACAS is rule-based and allows for improved online availability, increased automatic adjudication and scalability to handle projected claim volume increases.

Our system supports both automated and manual claims processing and contains components for electronic claim intake, workflow management and imaging systems; as well as our plan, member, provider, quality management and utilization management databases.

ACAS processes a full range of health care plans executing a wide range of system controls and edits designed to:

- Confirm the eligibility of claimants
- Confirm adherence to plan provisions
- Validate the necessity of treatment
- Flag providers rendering inappropriate care

The system supports automatic adjudication for standard plan designs. While the vast majority of functions within ACAS are fully automated, there are times when claim benefit specialists must make decisions to properly adjudicate a claim. Non-standard plan designs may require the need for additional processor intervention.

QUESTION 2.1.3.2

UCR Management
For Reasonable and Customary (R&C) based benefit determinations we consult an external database. We use the FAIR Health Benchmarks database produced by the non-profit entity FAIR Health.

The standard value for the recognized amount is the 80th percentile of the R&C database with a $10 liberalization corridor for professional medical and surgical benefits. You may opt for the following recognized amount level alternatives: 50th, 60th, 70th, 75th, 85th, 90th or 95th percentile. These alternate recognized amount level percentiles will not affect automatic system calculation.

We also subject certain inpatient and outpatient facility claims to a reasonable charge review, using our Facility Charge Review Program (part of our National Advantage Program). Our Global Claim Services department uses extensive data on charges and inpatient costs/markups.

For outpatient facility services, we determine the reasonable charge level for the service using the MarketScan data licensed from the MedStat division of Thomson Reuters, which is updated annually. This data consists of charges submitted by outpatient facilities to commercial payers and sorted into geographic areas. We typically use the 80th percentile for the applicable geographic area of this database, unless the plan defines an alternative percentile.

For inpatient facility services, we determine the reasonable charge using the cost report information submitted by hospitals to government agencies. Financial cost to charge ratios specific to each hospital are developed using this information and applied to hospital charges to determine costs for the confinement. If the specific hospital cost information is not available, the state average inpatient hospital costing information is utilized. A state markup, representing the average profit margin for hospitals in the state, is then added to this amount.

Explanation of Benefits
We have an automated EOB process that is generated by our sophisticated claims system. We mail member EOBs for the same family, in the same envelope, whenever possible. We mail the EOBs on a consistent day of the week based on the state of residence of the member. We use an every 21-day mailing schedule; however, we may send EOBs out at 7 days or 14 days to comply with any state regulations. EOBs will go out daily, and not age, when there is a member payment or request for additional information from the member. We produce EOBs in Erlanger, KY by an off-site print vendor.

QUESTION 2.1.3.2

Our claims system will suppress EOB production in the following situations:

- Benefits are assigned and member's liability is zero
- Benefits are assigned and member's liability consists of a copayment only

Members can also view EOBs on Aetna Navigator®, our secure member website at www.aetnanavigator.com.

Coordination of Benefits
Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.

Our COB administration starts with the collection and maintenance of accurate information about other coverage. We have a variety of methods for gathering the information including:

- During enrollment, many of our customers collect information about other coverage and share it with us.

- During the precertification process, our nurses ask about other coverage.

- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.

- In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.

- We send mailers to members with more than one dependent and members who turn 65.

- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator®, our secure member website, at www.aetnanavigator.com.

- As required by law, we exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.

QUESTION 2.1.3.2

We consider the following as potential indicators of other coverage:

- Hospital bills submitted as paid
- Large physician bills submitted as paid
- Photocopied bills
- Hospital bills or large physician bills submitted late
- Indication of other party payment on the bill
- Auto accidents (i.e., potential no-fault insurance)
- Workers' compensation

Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer requesting the additional information. If we still do not obtain a response we pay, pend or deny the claim based on state regulation. If the information we receive does not seem plausible, we contact the provider or member to inquire about other coverage.

When we receive other coverage information, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes:

- Details about the other coverage
- Family members the other plan covers
- Carrier
- Type of coverage (e.g., medical only, medical-dental, etc.)
- Date of the last update

If we are secondary and the primary carrier's EOB is not attached to the claim, the claim is pended for receipt of the primary carrier's EOB.

QUESTION 2.1.3.2

Upon receipt of the primary carrier's EOB, claims are processed as follows:

- For maintenance of benefits (MOB) or non-duplication plans, the COB allowance is our normal benefit (i.e., our negotiated rate reduced by copays, coinsurance or other applicable plan provisions).

- For plans utilizing standard 100% allowable, the COB allowance expense varies based on the 100% allowable model chosen/required by state regulations.

Once we determine the allowable expense, we subtract the primary carrier's payment from it and pay the balance, if any, as long as the balance does not exceed our normal benefit.

2011 national COB savings for all PPO-based and Indemnity products for COB with commercial coverages were 1.04 percent. 2011 national COB savings for all PPO-based and Indemnity products for coordination with Medicare were 12.91 percent.

2012 YTD (as of 8/31/2012) national COB savings for all PPO-based and Indemnity products for COB with commercial coverages were 1.02 percent. 2012 YTD (as of 8/31/2012) national COB savings for all PPO-based and Indemnity products for coordination with Medicare were 11.99 percent.

FSA & DCAP :

Our Standard FSA administration includes:

- Healthcare FSA administration
- Dependent Care FSA administration
- Grace period of 2 and ½ months and run-out administration
- Communications materials support
- Account balance management
- Reimbursement schedules client defined as often as daily Monday - Friday
- Reimbursement to participant via direct deposit or check payment
- Reimbursement direct to provider via portal
- Participant IVR and Call Center Customer Service
- Manual claims processing
- Web-based participant service and online claims submission
- Participant communication options via email with *eNotify™*
- Employer web portal
- Comprehensive client reporting package with On-Demand feature
- Client management support
- 5500 reporting for reimbursement accounts administered

QUESTION 2.1.3.2

- Plan Document preparation
- Summary Plan Description preparation
- Compliance resources for legislative updates
- PayFlex Mobile™ Application

Optional services and features include:

- Debit card
- Optional participant statements
- Open enrollment support – Available onsite or Webinar
- Election Confirmation Statement
- Takeover of Previous Plan Year

Flow Chart:
We have attached a claims process, EOB, FSA, and COBRA flow chart.

Org Chart:
We have attached our Fresno Service Center Organizational Chart. We have also included a PayFlex Organizational Chart which is applicable for the FSA, COBRA and DCAP services.

PayFlex's account management philosophy is to work together with clients in partnership to create a stellar client and participant experience. We stress open communication and going the extra mile to ensure that client and participant needs are met. To that end, you will be assigned a specific Client Services Manager (CSM) who will act as your operational point of contact into PayFlex for your reimbursement administration. Your CSM will be responsible for the daily, operational aspects of your program and will facilitate your implementation activities. For COBRA and Direct Billing administration, a separate Implementation Manager will be assigned.

Your CSM will also be tasked with marshaling resources throughout the PayFlex organization to meet your ongoing strategic business requirements. As necessary, other team members will be available to assist your CSM. This includes IT resources, file transmission experts and operational management team members. Your assigned CSM will bring in the appropriate resources as needed to ensure a successful client relationship.

CSMs are organized into teams. Your assigned CSM's team will consist of 2 or more CSMs who report to a Director. Directors report to our Client Service organizational leaders. This structure facilitates team work, ensures adequate back up and provides a logical escalation path that ends with our General Manager. This team structure is depicted in the diagram below.

QUESTION 2.1.3.2

Subcontractor:

The majority of our claims processing functions are performed in-house. We use the following subcontractors for claims review:

Subcontractor	**Scope of Services**	**Location**	**Doing Business with Aetna Since**
Aftermath Claim Science, Inc.	Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment..	Newington, CT	2004
Connolly Consulting	Overpayment recovery for data mining, duplicate payments, provider credit balance.	Wilton, CT; Conshohocken, PA; Philadelphia, PA	2000
DiversiMed, Inc.	Overpayment recovery for hospital bill audit.	Tampa, FL	2006
End-Game Strategy, Inc.	Overpayment recovery - data mining - HMO (second pass)	Berlin, CT	2010
EquiClaim, Inc. (Viant/Concentra Preferred Systems)	Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit)	Naperville, IL; Chattanooga, TN; Lake Forest, CA	2000
OmniClaim, Inc.	Overpayment recovery for Implant and DRG services.	Woburn, MA	2009
Rawlings Company, LLC	Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.)	La Grange, KY; Van Nuys, CA	1996

QUESTION 2.1.3.2

As part of our efforts to ensure quality in each and every transaction that our constituents have with us, we subject potential subcontractors/vendors to a lengthy and involved process employing rigorous review of each subcontractor from a number of different perspectives (i.e., scrutinizing management, corporate history, financial performance and pro forma statements, references, site reviews, diversity and human resource policies and privacy and security practices) to determine each subcontractor's ability to meet our expectations of performance and scope. Once they become one of our subcontractors, we regularly re-review these factors.

We conduct business with subcontractors through a standard contracting methodology that outlines the relationship from a number of critical aspects, including, but not limited to, service levels, certain representations, covenants, warranties, audit rights, indemnities, confidentiality, compliance with laws, insurance, financial terms, security of information and termination. This also includes a contractual obligation to disclose any adverse legal actions related to the services performed for Aetna. We have relationship managers who are responsible for the overall relationship with our subcontractors.

FSA & DCAP
PayFlex does not outsource any of our administration services. With the exception of data services, which are provided through First National Technology Solutions and CenturyLink, and debit card processing which is provided by First Data Corporation, PayFlex provides all administration services in house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our Fresno, CA service center will provide claims processing services to the State. Lynda Gable, your account executive will act as a single point of contact for any claims related issues. Karri Priddy, the State's plan sponsor liaison, will also support the claims administration services for the State.

FSA & DCAP
PayFlex is headquartered in Omaha, Nebraska with additional offices in Denver, Colorado, Chicago, Illinois and Hagerstown, Maryland. Operations are provided primarily out of the Omaha headquarters location which includes: Reimbursement Account Services, COBRA Services, Call Center, Distribution Center, Claims Processing, IT support and Aetna headquarters in Hartford, CT. Client Service Managers are located in Omaha, Denver, Hagerstown and Hartford. A secondary call center site is also located in Maryland. A "virtual" call center environment approach ensures that call volume can be switched between call centers, as needed, to meet specific requirements. Our Chicago office provides additional technology support.

QUESTION 2.1.3.2

Kevin Hitzemann (PayFlex Senior Sales Executive) for FSA / COBRA and Direct Bill Proposal information and products. Telephone # (402) 758-8000 / Email: khitzemann@payflex.com

PayFlex provides call center customer service support via a toll-free number. Customer Service Representatives (CSRs) are available from 7 a.m. to 7 p.m. CTZ Monday through Friday and on Saturdays from 9 a.m. to 2 p.m. CTZ. CSRs are available to answer participant questions, assist with claim processing and to educate participants about spending account usage.

PayFlex provides participants with a 24 X 7 IVR through a toll-free number. Participants can call the IVR to receive updated account information.

Participants have access to a self-service web portal that is available 24 x 7. Through the portal, participants can view account status, account activity and claims status. They can also submit a claim, request an additional card, view and download correspondence and forms, sign up to receive e-mail correspondence and sign up for direct deposit.

Quality Control

- Performance Guarantees

Please refer to our response to question 2.5.2 and the requested Attachment I1 – Medical Claims Administration and Managed Network Implementation and Performance Guarantees for the complete list of performance guarantees we are proposing for the State.

We have also included a description of our Quality Management program below.

Quality Management program goals

Our Quality Management (QM) program is designed to promote and maintain quality assessment and improvement; effective, efficient and comprehensive provider/practitioner selection and retention processes through credentialing and recredentialing; achievement, maintenance, and compliance with external accreditation and regulatory standards; a complaint and appeal process for members and practitioners/providers; and review activities involving quality of care events. Specific goals include:

- Promote the principles and spirit of continuous quality improvement (CQI)

- Measure, monitor and improve performance in key aspects of quality and safety of clinical care, including behavioral health, and quality of service for all of our constituents (e.g., members, customers, and participating providers/practitioners)

QUESTION 2.1.3.2

- Address racial and ethnic disparities in health care that could negatively impact quality health care
- Implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population across the continuum of care
- Develop a comprehensive, meaningful and soundly executed QM strategy
- Facilitate communication and integration among key functional areas relative to implementing a sound and effective QM program
- Operate the QM program in compliance with and responsive to applicable requirements of customers, federal and state regulators, and appropriate accrediting bodies
- Increase the knowledge/skill base of staff across all functional areas
- Maintain effective, efficient and comprehensive provider/practitioner selection and retention processes through credentialing and recredentialing activities

Quality Management process

We use CQI techniques and tools to improve the quality and safety of clinical care and service delivered to members. Quality improvement is implemented through a cross-functional team approach, as evidenced by multidisciplinary committees.

We use reports to monitor, communicate and compare key quality indicators. In addition, we develop relationships with various professional entities and provider organizations and may include feedback on structure and implementation of their QM program activities or work collaboratively on quality improvement projects.

QUESTION 2.1.3.2

Quality Management program scope

The scope and content of the QM Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members. Specifically, the QM Program includes, but is not limited to, the following:

- Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high volume and high-risk services; and continuity and coordination of care
- Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines
- Monitoring of medical behavioral health, case and disease management programs
- Achievement and maintenance of regulatory and accreditation compliance
- Evaluation of accessibility and availability of network practitioners and providers
- Establishing standards for and auditing medical record documentation
- Monitoring for over and underutilization of services (Medicare)
- Performing credentialing and recredentialing activities
- Oversight of delegated activities
- Evaluation of member and practitioner satisfaction
- Supporting initiatives to address racial and ethnic disparities in health care
- Following these guidelines in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost, or quality only, but never cost data alone

Study selection and design are prioritized based on an ongoing evaluation of the enrolled population in terms of age and gender characteristics, disease incidence and prevalence, and risk status. Quality improvement activities that support the goals and objectives of the QM program are coordinated on an annual basis.

QUESTION 2.1.3.2

Quality Management program resources

We have dedicated computer/data and human resources at the national, regional and local levels sufficient to meet QM plan objectives and to complete annual and ongoing activities. National and regional QM staff work in close partnership to coordinate completion of the required activities.

Aetna Informatics® works closely with National Quality Management and Measurement (NQMM) to provide support for quality management projects, and it is part of the Innovation, Technology and Service Operations (ITSO) organization. This team combines our industry leading information technology, health information technology, and service operations capabilities in one area, allowing us to better anticipate and adapt to the needs of our customers. Aetna Informatics supports data retrieval from our data warehouse and provides analysis, performance measurement and statistical review of study results. Aetna's Data Warehouse incorporates data and information from multiple sources that is used to stratify member population by risk in order to derive patient outcomes and assess effectiveness of QM initiatives.

Medical Directors, QM, and other medical and professional staff from across the organization monitor, facilitate and support the QM program and initiatives focused on improving quality of care and service. National and regional QM staff work collaboratively to implement QM program activities. This includes facilitating quality improvement efforts through HEDIS® improvement workgroups, development of QM tools and templates and the development of national service and clinical indicators. NQMM coordinates development and review of national QM policies with input from regional QM and other departmental representatives as needed. They provide support for and monitoring of activities for consistent implementation of processes affecting QM program goals and provide support relative to accreditation strategies. NQMM coordinates administration of the Physician Practice Site Survey and CAHPS® (registered trademark of the Agency for Healthcare Research and Quality (AHRQ)). The regional QM staff conducts review of survey results, analysis and the development of improvement plans.

National, regional and behavioral health QM staffs are involved in the implementation of the QM program. QM and Aetna BH staff work collaboratively to ensure that QM program goals are met. Joint participation in regularly scheduled work groups and the Behavioral Health QOC results in the sharing of information and is a critical component of this collaborative strategy.

QUESTION 2.1.3.2

Other Aetna functional areas, including but not limited to the following, also support the QM program at all levels:

- Network and Provider Services
- Patient, Case and Disease Management
- Medical Policy and Operations Policy and Program Administration
- Complaints, Grievances and Appeals
- Member Communications and Customer Service
- Pharmacy
- Compliance
- Legal

Additional national committees and work groups support the QM program, and some exchange information and reports with the regional committees.

Appeals

Description:
We established a national process for handling complaints and appeals from members, providers and customers across all regions and products. The national process provides for administrative consistency, centralized data collection, business accountability, a consistent workflow process and standardized reports.

Aetna developed the Complaints and Appeals Tracking System (CATS) to support this national process. CATS stores the necessary data relating to a complaint or appeal for tracking, resolution and reporting purposes. This centralized data collection enables us to increase customer service, customer satisfaction and promotes regulatory compliance.

CATS provides a single system to capture, track, route and resolve all member and provider complaints and appeals. CATS interfaces with the customer service documentation system to capture verbal complaints and appeals. The application is web-based and allows for routing the complaint or appeal and relevant documents between the Customer Resolution Team and the accountable business units for processing.

QUESTION 2.1.3.2

Flow Chart:
We have attached a flow chart of our appeals process.

Org Chart:
Customer service representatives (CSRs) attempt to resolve all member complaints at the point of contact. If a CSR is unable to resolve a complaint, they forward it to a Customer Resolution Team (CRT) for handling and, if needed, to the appropriate business area for investigation and response.

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals. Medical directors make appeal decisions with a clinical element.

We have attached our Fresno Service Center Organizational Chart.

Subcontractor:
We have contracted with the following URAC accredited independent review organizations: IMEDECS and MCMC, LLC and AMR.

Location/Hours of Operation/Point of Contact/Onsite Support:
Lynda Gable, the State's account executive will be the point person for all appeal related issues.

Data Analysis

- Data Collection
- Reporting

Description:
Data Warehouse
One of our most differentiating assets, our vast data warehouse, consists of 18 terabytes of integrated claim, membership, product and provider information.

The data warehouse is larger and more sophisticated than standard database management systems available in the marketplace. It is sourced by numerous operational systems such as:

- Enrollment/eligibility
- Claims administration
- Provider applications
- Patient management applications

QUESTION 2.1.3.2

The data warehouse encompasses the following product lines:

- Medical
- Pharmacy
- Dental
- Vision
- Disability
- Behavioral Health

From this data warehouse we execute numerous data analytic, reporting, trending, predictive modeling and data mining processes and activities.

Data Quality
Aetna Informatics® is committed to ensuring the quality of our data assets and analytical tools. Over the past several years, we have completed multiple initiatives, which focus on improving the quality of the data stored in the warehouse. Aetna Informatics, in conjunction with our IT partners, has developed a rigorous monitoring process to screen the data added to the warehouse during our monthly load cycle. Designated Aetna Informatics support staff is dedicated to researching and resolving data issues, proactively communicating suspected and known data issues and ensuring our end-users understand the nuances of our information systems.

Reporting
We provide a variety of comprehensive reporting packages that allow the State to evaluate plan and program performance, monitor cash flows, and identify cost and utilization trends. Availability of certain reports is dependent upon your plan of benefits. We have outlined the type of reports that will be available to you and the frequency in the chart below.

Report Name	**Frequency**
Annual Accounting Reports	Annually
Claim Reports	Monthly
Banking Reports	Monthly
Utilization Reports	Monthly
Medical Management Activity Report	Quarterly
Flex Model Report	Quarterly

QUESTION 2.1.3.2

Competitive Difference
Aetna Health Information Advantage™ reporting tool produces the information you need when you need it. Our reporting system is fast, flexible and customizable. It can help you make benefits and plan decisions quickly and confidently. Aetna Health Information Advantage will take your benefits and plan performance to the next level.

Industry leading analytical tools

Aetna Informatics® combines data, systems and people to give you answers to questions you did not know to ask. Our seasoned experts use our world-class data warehouse and cutting-edge technologies to pull together reports for you. You get information that is easy to understand and recommended actions to help you craft a better benefits package for your unique population.

Flexible reporting options

We can provide you with all the data and information needed, in the way you need it, to effectively monitor your programs, address your issues, and help you make benefits strategy decisions. As a start, you receive immediate access to Aetna Health Information Advantage, a rapid and flexible Web-based decision support tool that houses your health benefits data. It includes standard and ad hoc reports, giving you all the fundamental information you need when you need it. You can also choose other levels of reporting and services for a fee.

Integrated data for a holistic view

Our experts take different data types from various sources and organize them on a member-centric basis. This means we can link an individual member's data across many different sources. This total information content is then available for analysis. It is a holistic view of an individual person. This approach to data allows for a clear understanding of problems. It helps us pinpoint actions to recommend for your group. Aggregating data, on the other hand, stops short of this level detail. It limits your ability to have even a basic understanding of any problem or issue.

Our tool can help you see:

- Total cost of your health benefits
- How well your medical and other programs work together
- Impact of your benefit design

QUESTION 2.1.3.2

It can also help you:

- Draw stronger conclusions about member choices and incentives
- Isolate cause and effect of activities on overall health care costs
- Achieve insights into outcomes of programs across a variety of measures
- Increase your ability to conduct offset analyses

With our tools you can better analyze your current situation and customize the perfect health benefits solution — based on actual experience — for your workforce, taking into account your budget and benefits strategy.

Subcontractor:
We provide our reporting in-house.

Location/Hours of Operation/Point of Contact/Onsite Support: Our reporting tools are available to the State 24 hours a day, 7 days a week. Your account team will also be available as needed to assist with reporting analysis.

Financial

- Subrogation
- Banking
- Direct Bill
- COBRA

Description:
Subrogation
We use The Rawlings Company, an experienced, national vendor of third-party recovery services headquartered in Louisville, KY, as our subrogation vendor.

The following provides an overview of The Rawlings Company's file identification, investigation and recovery processes:

Identification

Rawlings mines paid claims data using a proprietary set of diagnostic codes to identify trauma-related treatments.

Members are mailed up to five inquiry letters that include a brief questionnaire asking about their treatment. Rawlings begins their inquiry once accumulated medical claim payments reach a threshold of $300.

QUESTION 2.1.3.2

Members have three ways to respond to Rawlings' questionnaire:

1. Member can call a toll-free number answered by experienced analysts.

2. They can return their completed questionnaire in a postage-paid reply envelope.

3. They can visit www.TRGClaimsInfo.com and complete the questionnaire online.

Rawlings' also utilizes a subscription-based data warehouse of property and casualty claims to research whether an accident occurred.

Rawlings' Non-Cooperation Unit investigates high-dollar claims when members are not responding to inquiry letters.

Subrogation opportunities may also be brought to our attention when Aetna is asked to respond to a subpoena in a member's tort lawsuit requesting records of payment.

Investigation

Investigations are assigned to analysts organized by client-specific teams supported by team attorneys.

Analysts define a strategy based on every possible source of recovery and place all parties on notice of your claim.

Analysts manage files on their proprietary software. Some of the many features include:

An automated diary system that allows analysts to record the details of all file activity and share these with other team members collaborating on the file.

A tickler system that automatically prompts analysts to plan effective follow-up for each file.

Automated special handling notifications (e.g., group restrictions).

A library of letters and notices approved by Rawlings' legal team.

QUESTION 2.1.3.2

Recovery

Subrogation recoveries are remitted from Rawlings to Aetna via a bulk wire and recoveries are credited to an individual customer at the claim level through their wireline account. The customer will see a credit for the gross recovery, a charge for Rawlings fee and a separate charge for any administrative fee charged by Aetna on their claim detail report.

Banking
We use a joint benefit payment clearing account (i.e., a Single Account Multiple Participant or SAMP account) with Bank of America or Citibank Delaware. The State subscribes to this account by signing a banking agreement that we forward to our bank.

The State is identified as payer to show that benefit payments go directly from the customer to employees. We are shown as the State's agent. No minimum balance is required.

If plan benefit disbursements are issued electronically (via Electronic Funds Transfer), then we prepare disbursement files for the bank, similar to how we batch and prepare checks for providers/members. As the files are generated to the bank, you are charged for the disbursements which will be included with the plan benefit disbursement reconciled check payments.

Due to your funding being on a checks-issued basis, we request funds from your designated bank on the first day of each month and again if recorded claims total at least $20,000. We anticipate funding for the State to be daily.

Our claims accounting systems and our bank’s benefit payment clearing systems have been carefully designed to maintain tight item and dollar controls and to provide extensive edits for consistency and completeness. These systems serve large numbers of customers each day and are regularly audited by both internal and external auditors.

QUESTION 2.1.3.2

COBRA

Our Standard COBRA/HIPAA administration includes:

- Takeover of pending and enrolled participants
- Qualifying Event Notices
- COBRA elections and terminations
- Premium collection and distribution
- Eligibility updates to carriers
- Disability extensions
- Conversion Rights Notices
- Notices of Unavailability
- Medicare Notice
- Notice delivery via First Class mail (including Proof of Mailing for Initial Rights Notices and Qualifying Event Notices)
- Severance package management
  Participant IVR and Call Center Customer Service
- Web-based participant service for current account status, payments, mailed documents
  Participant communication options via email with *eNotify™*
- Employer web portal for reports, documents, participant information
- Comprehensive client reporting package with On-Demand feature
- Client management support
- Updates on legislative changes pertaining to COBRA administration

Optional services and features include:

- Initial Rights Notices and HIPAA Special Enrollment Rights
  - New plan members
  - Re-notification to currently eligible population
- HIPAA Certificates of Creditable Coverage/HIPAA Portability Statements
- HIPAA Notices of Privacy Practices statement sent on behalf of client. The notice will be drafted by and provided by the client
- Late payment reminder notices for participants sent 15 calendar days before the grace period ends if the current month's premium payment has not been received
- Termination of COBRA continuation rights sent to Qualified Beneficiaries who do not elect coverage within the 60 day election period – Noncommence Letter
- Medicare Part D: Creditable Coverage Notices and Non-Creditable Coverage Notices.
- Audit COBRA participant status with carriers

QUESTION 2.1.3.2

- Custom reporting
- Dedicated #800 capabilities
- Changes in Scope of Services
- Annual Open Enrollment Services (Available after PayFlex has been providing administration for a minimum of 90 days.)
- Optional Government Mandated Notices
- Premium Disbursement to Carriers

Direct Bill

Our Standard Direct Billing administration includes:

- Billing services for
  - Retirees
  - Leave of Absence
  - Layoffs
  - LTD Participants
  - Special Populations

  Takeover of existing participants
- Premium collection and distribution
- Flexible grace period time periods based on client requirements
- Eligibility updates to carriers
- Severance package management
- Participant IVR and Call Center Customer Service
- Web-based participant service for current account status, payments, mailed documents
- Participant communication options via email with *eNotify™*
- Employer web portal for reports, documents, participant information
- Comprehensive client reporting package with On-Demand feature
- Client management support

Optional services and features include:

- HIPAA Certificates of Creditable Coverage/HIPAA Portability Statements
- HIPAA Notices of Privacy Practices statement sent on behalf of client. The notice will be drafted by and provided by the client
- Late payment reminder notices for participants sent 15 calendar days before the grace period ends if the current month's premium payment has not been received

QUESTION 2.1.3.2

- Medicare Part D: Creditable Coverage Notices and Non-Creditable Coverage Notices.
- Custom reporting
- Dedicated #800 capabilities
- Changes in Scope of Services
- Annual Open Enrollment Services (Available after PayFlex has been providing administration for a minimum of 90 days.)
- Premium Disbursement to Carriers

Strengths & Differentiators:

1. State of the Art Proprietary Technology
   - Proprietary platform developed in-house
   - Unique web portal integrating all services
   - Multi-account Proprietary Debit Card

2. World Class Customer Service
   - 98% client retention rate
   - 20.3 sec average speed to answer
   - 1.51% average abandonment rate

3. Efficient and Reliable Processing
   - 99.77% financial precision
   - 99.38% adjudication proficiency
   - 90.50% debit card auto substantiation rate

4. Security and Compliance Focused
   - FNTS & Qwest Cybercenter data centers
   - SSAE 16 – reporting on controls of service org
   - PCI Level I compliant

5. PayFlex - Sole focus is Reimbursement Account and COBRA administration.
   - Enables us to provide the best possible service to our clients
   - Cultivate a thorough understanding of the flexible benefits market
   - Remain abreast of the financial services, banking, and IRS

Flow Chart:

We have attached flow charts for our subrogation, banking, FSA and COBRA processes.

QUESTION 2.1.3.2

Org Chart:
Rawlings is based in Louisville, KY. They have a satellite office in CA. Their staff is trained to handle subrogation matters in all states. Additionally, they have a staff of approximately 50 in-house attorneys that are available to provide guidance to their analysts and/or handle sensitive cases.

If the State would like to participate in a call on Subrogation, we would be happy to discuss and engage Rawlings.

We have attached an organizational chart for COBRA. This org chart is also included in the FSA Proposal that we prepared for the State.

PayFlex's account management philosophy is to work together with clients in partnership to create a stellar client and participant experience. We stress open communication and going the extra mile to ensure that client and participant needs are met. To that end, you will be assigned a specific Client Services Manager (CSM) who will act as your operational point of contact into PayFlex for your reimbursement administration. Your CSM will be responsible for the daily, operational aspects of your program and will facilitate your implementation activities. For COBRA and Direct Billing administration, a separate Implementation Manager will be assigned.

Your CSM will also be tasked with marshaling resources throughout the PayFlex organization to meet your ongoing strategic business requirements. As necessary, other team members will be available to assist your CSM. This includes IT resources, file transmission experts and operational management team members. Your assigned CSM will bring in the appropriate resources as needed to ensure a successful client relationship.

CSMs are organized into teams. Your assigned CSM's team will consist of 2 or more CSMs who report to a Director. Directors report to our Client Service organizational leaders. This structure facilitates team work, ensures adequate back up and provides a logical escalation path that ends with our General Manager. This team structure is depicted in the diagram below.

Subcontractor:
Subrogation
We use The Rawlings Company, an experienced, national vendor of third party recovery services headquartered in Louisville, KY, as our subrogation vendor. We have used the services of Rawlings since 1996.

QUESTION 2.1.3.2

For over 25 years, The Rawlings Company has pioneered the innovations in subrogation and recovery services.

We selected The Rawlings Company to provide subrogation and reimbursement services based on their experience and expertise in the field:

- Rawlings developed the first subrogation outsourcing program for the healthcare industry and pioneered subrogation processes that have since become industry standards.

- Rawlings publishes a comprehensive national treatise on health subrogation, the *Rawlings & Associates National Subrogation Law Manual*.

- Rawlings continuously monitors legislative changes at both the federal and state levels that may affect a plan's right to seek recovery. They apprise their clients of significant changes and offer strategic recommendations as appropriate.

- Rawlings' Partnership Program offers several valuable services to self-funded groups desiring to be a more active participant in their recovery program. Rawlings' attorneys will review a group's Summary Plan Description (SPD), making recommendations to strengthen recovery language as appropriate, and Rawlings will provide monthly reports listing unresponsive employees so groups can take steps that encourage cooperation.

- Rawlings offers members who speak a language other than English several ways to respond to their inquiry letters. Spanish-speaking members may call a dedicated toll-free line answered by Spanish-speaking recovery analysts, or they may elect to answer Rawlings' online questionnaire using the Spanish language option. Rawlings also uses AT&T's Language Line to communicate with members who speak a language other than English or Spanish.

- Rawlings provides excellent customer service to self-funded groups. For example, when a member calls The Rawlings Company, they speak directly to an experienced recovery analyst, not to a call center representative.

COBRA
PayFlex does not outsource any of our administration services. With the exception of data services, which are provided through First National Technology Solutions and CenturyLink, and debit card processing which is provided by First Data Corporation, PayFlex provides all administration services in house.

QUESTION 2.1.3.2

Location/Hours of Operation/Point of Contact/Onsite Support:

Subrogation

Rawlings is based in Louisville, KY. They have a satellite office in CA. Their staff is trained to handle subrogation matters in all states. Additionally, they have a staff of approximately 50 in-house attorneys that are available to provide guidance to their analysts and/or handle sensitive cases.

COBRA

PayFlex is headquartered in Omaha, Nebraska with additional offices in Denver, Colorado, Chicago, Illinois and Hagerstown, Maryland. Operations are provided primarily out of the Omaha headquarters location which includes: Reimbursement Account Services, COBRA Services, Call Center, Distribution Center, Claims Processing, IT support and Aetna headquarters in Hartford, CT. Client Service Managers are located in Omaha, Denver, Hagerstown and Hartford. A secondary call center site is also located in Maryland. A "virtual" call center environment approach ensures that call volume can be switched between call centers, as needed, to meet specific requirements. Our Chicago office provides additional technology support.

PayFlex provides call center customer service support via a toll-free number. Customer Service Representatives (CSRs) are available from 7 a.m. to 7 p.m. CTZ Monday through Friday and on Saturdays from 9 a.m. to 2 p.m. CTZ. CSRs are available to answer participant questions, assist with claim processing and to educate participants about spending account usage.

PayFlex provides participants with a 24 X 7 IVR through a toll-free number. Participants can call the IVR to receive updated account information.

Participants have access to a self-service web portal that is available 24 x 7. Through the portal, participants can view account status, account activity and claims status. They can also submit a claim, request an additional card, view and download correspondence and forms, sign up to receive e-mail correspondence and sign up for direct deposit.

QUESTION 2.1.3.2

State Objectives

Plan Design
Policy Development
Innovation
Performance Incentives

The State of Alaska has clearly articulated a vision and objectives that will transform health care delivery in the State. While not necessarily unique, they do require the State to partner with an organization that is innovating and evolving at a rapid rate to fully support the short and long term objectives. Aetna is an organization that can support the objectives and continue to bring forth approaches and solutions critical to the State of Alaska's future success through four key pillars:

INNOVATION, DESIGN AND PERFORMANCE EXCELLENCE– Aetna is the administrator for 643 national account customers, 318 public and labor organizations, 197,467 Medicare customers, 1,257,110 Medicaid members, and 17,818,931 commercial members. This portfolio of customers is the result of continuously innovating and supporting our customers. Our insured book of business is also important as we also require all of the innovation and support, the same as our self-funded customers.

We have a culture of innovation at Aetna and have developed multiple areas of the organization to support organizational improvements from all of our employees. This ranges from innovation at every level of the organization to our Emerging Business Unit focused on developing critical customer solutions. This innovation has resulted in on-going enhancements in how we are improving our operations to both streamline the administrative processes and enable design solutions to support our customers. This begins with the simple measures of having our clinical policies be included in our network contracts and our claim system tied to those same policies. Our network and any custom network solutions are fully integrated into our claim system to streamline the payment process. Our leadership has empowered all Aetna employees to identify methods to improve our operations to deliver the highest quality program to our plan sponsors and members.

QUESTION 2.1.3.2

Our innovation, design and performance excellence enables us to support the following State of Alaska objectives:

- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions
- High accuracy in claims processing
- Quality customer service

CONSUMER ENGAGEMENT – The age of the consumer is here and Aetna fully recognizes this as a key area to cost management. We are creating the critical support for the member with the personnel and technology to provide information and advocacy through the method sought by the member. We truly believe that the support the State of Alaska requires to transform health care is through One Member at a Time. Our Health Concierge Service model is the My AlaskaCare Single Point of Contact. The My AlaskaCare SPOCs are specially trained personnel with the tools to be the member advocate and truly the "Concierge" role across the full benefit program continuum. Our technology is the other mechanism that puts the power of transparency, clinical decision support and provider directories (in and out of network) at the member's fingertips via web and mobile phones. For the State of Alaska, the My AlaskaCare SPOC and web and mobile tools are a key cornerstone to supporting your members both in and out of Alaska. It supports the advocacy and member experience across Aetna and all of the State of Alaska benefit programs essential to delivering upon State of Alaska objectives.

Our consumer engagement enables us to support the following State of Alaska objectives:

- Encouraging patients to engage in the management of their own health
- Providing them with resources and skills to obtain appropriate health care services
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance

EVIDENCE-BASED MEDICINE – Aetna has not wavered from using evidence-based medicine to manage our customers' benefit programs on both a self-funded and fully insured basis. This begins with our disciplined approach to developing clinical policies based on evidence-based medicine. Our Clinical Policies are often used by TPAs and other insurance carriers, because of the disciplined approach and rigor around the on-going review process. Our Care Engine technology is the Clinical Decision Support the State of Alaska is seeking by ensuring evidence-based medicine is applied to all medical and pharmacy claims. The application of evidence-based medicine includes our dental program that leverages our Dental Medical Integration grounded on dental care that drives medical costs.

QUESTION 2.1.3.2

Our evidence-based medicine enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

PROVIDER COLLABORATION – Our network management is built on sound principles beginning with evidence-based medicine approach to our clinical policies to our reimbursement approach in Alaska. Our experience in core network management and breadth of our book of business will further support the necessary network development in the State.

More importantly, we are in a material shift in health care delivery through the evolution of Patient Centered Medical Homes and Accountable Care Organizations. Aetna has been a leader in national quality networks through Aexcel and the on-going evolution of high performance networks. This experience and our supporting technology have enabled us to be a market leader in the development of Accountable Care Organizations and the infrastructure to support other Patient Centered Medical Home models. Our collaboration includes the early stage evaluation of an Accountable Care Organization in Alaska, which would benefit the State of Alaska.

Our provider collaboration enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

QUESTION 2.1.3.2

Our experience across these four cornerstones in Alaska and the lower 48 will allow us to support the State of Alaska's objectives across each of the RFP components. When integrating each of the RFP components, we can deliver a fully integrated comprehensive solution that will support the goals and objectives, which includes delivering the cost controls so critical to the future of the State of Alaska benefit program.

Plan Enhancement Support

The identification of the plan enhancements is a key area that Aetna will support the State of Alaska. There are several elements to identification of plan design enhancements that we bring to the table:

Data Analytics – We have robust reporting tools that will enable us to effectively evaluate the State of Alaska's data. We have the ability to report across all of the critical facets and will structure the State of Alaska account to fully support reporting needs. Our reporting addresses all of the key areas and supports break downs by plan, group, location, etc. to effectively evaluate drivers. We have data analytics resources and subject matter experts to support the full assessment process. We leverage core reporting through our ePSM tool that provides key metrics and our more robust reporting tool AHIA. AHIA is a comprehensive reporting tool built on our data warehouse and enables robust data mining to fully identify cost drivers and issues. For State of Alaska, we will deploy all of our reporting tools to support the identification of cost drivers.

Solution Identification – While data analytics is essential, we feel the more fundamental need for our plan sponsors is the solution identification. We have made material investments in our processes to determine issues and the solutions. This begins with the use of our experts in analytics, clinical, operations, network management, Accountable Care Solutions and wellness to name a few. We also have reports exclusively focused on a detailed program review that identify issues and customer opportunities that we call Actionable Information Report. The report identifies key solutions and opportunities for the State that align to the State of Alaska's goals for policy and design, consumer engagement and provider delivery. For the State of Alaska, we commit to using our Actionable Information reporting approach as well as the full complement of our experts to develop recommendations for the State of Alaska.

Another fundamental element is the strategy and solution development process. As the State of Alaska is seeking significant change to transform health care in the State, we recommend a multi-faceted strategy and solution development process. We will facilitate the session with the State of Alaska and if appropriate, other State of Alaska vendor partners.

QUESTION 2.1.3.2

The Phase 1 of the strategy process is an annual review of the objective and short and long term goals. We will support the annual review and development of goals based on the market dynamics and leading edge approaches. We envision the goal development and strategy session will include our Account Team, Clinical Advisory Team and Alaska Advisory and Support Team to map out the strategy, barriers to success and general solutions. Through this framework, solutions begin to be framed addressing each of the areas of consideration in alignment with the State of Alaska's goals. Aetna will support the facilitation of the session and vetting national and Alaska specific solutions to support the goals. These solutions will be grounded in the tools and resources we bring to the table and specifically the level of advocacy Aetna can support through My AlaskaCare Singe Point of Contact and technology to speed the deployment of solutions.

Upon completion of the session, we will take the goals and objectives along with the potential solutions to evaluate against the State's data. We will mine the State of Alaska's data to determine the impact of solutions and begin to address necessary change management to deploy the solutions. Through this analysis, we will develop a discussion guide along with an outline of multiple paths and expected outcomes and impact to discuss with the State.

The last phase of the strategy process is a comprehensive ideation process with the State of Alaska. The ideation session will be based on sound practices used by our Emerging Business area to align to similar practices used to finalize decisions on proceeding with a business. We will assess solutions and convergence of solutions to use a brainsteering approach to develop the "product" for deployment. The ideation process uses the facets on issues, solution and overall adoption. The goal is to refine or reject solutions to arrive at an overall package for the State. We will leverage experts from our Emerging Business area to help support this process and arrive at solutions that fully understand the behavioral components and member experience so essential for long term sustainability.

QUESTION 2.1.3.2

Our expectation is to arrive at comprehensive solutions that are specific to the State's issues and extend beyond basic plan design or programmatic changes. We believe the real value we bring is the evaluation of more aggressive changes and the timing for deployment. As the State of Alaska will see, there are many solutions as we define in question 2.3.2.1. As we assess the most pivotal areas of how we can support the State of Alaska it is grounded in several key areas:

- Consumer Engagement – We have conducted significant research in consumer engagement from our Health Fund Study results, Consumer Engagement Metrics to our experiences with product development. Our focused studies in behavioral health and overall brain health are also informing us on the impact and handling of stressors. We have the ability to support solutions through all forms of designs and consumerism inclusive of leveraging our expertise on successful Health Savings Accounts and Health Reimbursement Accounts plans as well as consumer solutions for traditional PPO plans. The transformation will require overall consumer engagement and aligns with our commitment to support this one member at a time.

- Network Solutions – A core area of change necessary in the State of Alaska is the overall approach to network. While Aetna brings a highly effective and broad Alaska network that balances cost and quality, there are areas of Alaska that have boycotted networks. To a certain extent, our unwavering requirement for clinical and claim payment provisions has been a deterrent for some providers to contract. As we work with the State, we will focus solutions very specific to each borough in the State including the use of alternative arrangements as appropriate. Our expertise in Accountable Care Solutions, Patient Centered Medical Homes, Institutes of Quality for Bariatric and Cardiology, and High Performance Networks will inform solutions. A critical consumer facing tool for network solutions is our transparency tools.

- Tele-medicine – Another area of exploration is alternative providers and the role they can play for the State. Teledoc is an alternative provider option that can be leveraged for care delivery for members in rural locations as well as reduce emergency room utilization. Medical Home Exchange is another solution. These solutions reinforce an overall need to define a full strategy and align to an overall local provider base. Our expertise in these solutions and impact on networks will be evaluated with the overall network solutions for the State.

- Technology – The area of technology is rapidly expanding for us and will offer tremendous solutions for the State. iTriage is one of our solutions that is expanding over the next year and is a key tool for every State of Alaska member. Our technology and ability to integrate third party tracking (EOS Health for diabetes) for all areas will support the evolution of the State of Alaska's program.

QUESTION 2.1.3.2

While the active plan enables immediate solution deployment opportunities, we will also support the State in Pre-Medicare and Medicare design alternatives. We fully recognize the protected nature of the retiree medical program, but also recognize the plan lacks critical features to both manage costs and more importantly support retirees in health maintenance. We have extensive expertise with retiree populations to develop programs that fully balance preventive care, cost sharing and condition management to support retirees and their dependents in achieving their optimal health. We view our role as additional expertise and analytics to support the State in developing an optimal program for retirees that can be offered as a replacement or along-side the current plan.

We will support the State with the necessary solution development and analytics. The approach outlined and our support also materially changes the focus of quarterly meetings from a review of data to change measurement and solution refinement. The power of refinement is supported by the My AlaskaCare Single Point of Contact and ability to change their messaging to your members as they deliver the necessary advocacy to achieve your goals. Each year is a building block on achieving critical changes for your members and the provider network that is fully empowered by our people and solutions.

Once solutions are defined, we will use our implementation processes to deploy these solutions. The process will leverage our tools and capabilities as well as the communication budget for roll out. A critical element of any change will be the My AlaskaCare Single Point of Contact and the support the team will provide with both education and overall advocacy for the members. Leveraging our Alaska knowledge and experience along with Government and National Account experience will deliver effective design solutions to achieve the State's objectives.

Aetna has both experience as well as the underlying infrastructure to support the State in policy development. Our geographic footprint and the fact that we provide insurance coverage in Alaska and the lower 48 are benefits to the State in policy development. This experience and our disciplined approach with evidence-based medicine provide us with a unique position to support the State in policy development.

On a national basis, we remain focused on fostering compliance with the Affordable Care Act (ACA). We will continue to help our customers with the implementation of ACA. We will continue to advocate for workable regulations and needed legislative changes to avoid the unintended consequences of higher costs and needlessly complicated requirements on our customers. We will work with public policy leaders and legislators to fix the serious issues that continue to plague our health care system.

QUESTION 2.1.3.2

A significant element of policy development is the understanding of health care delivery and the variation by geography. The Account Team and advisory teams covering clinical and Alaska care delivery are a critical element to the policy development process. This team will leverage national and regional resources in the areas of clinical policy development, government affairs, Accountable Care Solutions, Primary Care Medical Home Enablement, Medicaid and Medicare program administration, health care reform, transparency and alternative payment approaches (e.g., reference based pricing and case rates) to name a few. Overall, we have the infrastructure and resources to support the State's policy development as well as a determination of pilot opportunities.

Our process will be to work with the State on developing the areas of policy development including the goals in specific areas. The team will leverage our national resources to identify best practices and approaches to impact the State's goals. Our sessions with the State will leverage the clinical and Alaska specific expertise to uncover opportunities. In addition, we will have participation by our subject matter experts to address emerging solutions in the market and address policies to support deployment of those solutions.

Once areas are identified we will work with our internal resources for the analysis of the data available. We will leverage our resources that handle our internal evaluation processes including data analytics, review of evidence, and understanding of provider and member impact. In addition, our data is made more robust by expertise we have in the establishment of Accountable Care Organizations and Patient Centered Medical Home enabled delivery systems.

We have supported organizations in the review and development of policies for their own organization as well as State legislation. While we do not provide legal advice, we have resources to support review and make recommendations on the type of changes that can change care delivery. Our role in health care reform emphasizes our desire to impact cost and quality in the health care delivery. The State of Alaska is in a unique position to drive health care delivery through policies that support the change. Our Alaska experience combined with the national resources can support the development of policy for the State of Alaska program only as well as for the State.

We envision a key component of the policies to be a potential demonstration of projects that explore changes to care delivery in the State. Our robust experience with Accountable Care Organizations and Patient Centered Medical Homes will be valuable in not only developing solutions, but guiding set up of changes in the delivery system.

QUESTION 2.1.3.2

Medical Director Support

Role of Medical Director

The role of the medical director is to:

- Support the nursing staff
- Make medical necessity determinations
- Conduct peer to peer reviews
- Be available for questions
- Solve and problems for the medical issues that arise

Medical directors also provide education on various topics and develop and assist in quality improvement efforts in the region.

Support for the State

Dr. Lydia Bartholomew will be the designated medical director for the State. Dr. Bartholomew meets twice weekly with the Utilization Management team to discuss hospitalized members and their care and discharge plans, and once weekly with the case managers. She also meets with long term care nursing staff on a regular basis and is available on an ad hoc basis for any questions that arise, and for peer to peer conversations as needed. Dr. Bartholomew also interacts with staff as needed from other areas to support patient management in the region. Dr. Bartholomew sits on several national committees that support clinical guidelines and quality improvement efforts.

Location

Dr. Bartholomew is located in Seattle, Washington and will be available to travel to Alaska on a quarterly basis to meet with the State and our staff as needed.

Credentials

Dr. Bartholomew currently has licenses in Washington, Oregon, Arizona and South Carolina. She does not currently have a license in the State of Alaska.

QUESTION 2.1.3.2

Dr. Bartholomew has substantial experience in the state of Alaska as she was the Senior Medical Director for Qualis Health from 2004-2007. Additionally she has been a guest speaker at the Providence Family Medicine Residency Program on several occasions, and has taught for the Alaska Academy of Family Physicians CME programs on multiple occasions, most recently at the 2012 Winter Update in Girdwood.

Dr. Bartholomew was just recently appointed to the American Academy of Family Physicians National Commission on Quality and Practice. It is a four year appointment.

Company Awards

As one of the nation's leading providers of health and related benefits, we are pleased that national organizations and publications recognize us for our:

- Commitment to diversity
- Innovative products
- Technology innovations
- Employment-related achievements
- World-class customer service

The following list represents some of the achievements of which we are most proud.

2012

- We have received national recognition from Bloomberg BusinessWeek magazine as one of America's most community-minded companies in The Civic 50" survey. The Civic 50 survey recognizes organizations that use their time, talent, and resources to help improve the quality of life in the communities where they do business. We have placed an impressive 4th on the list. Last year, along with the Aetna Foundation, our employees, retirees and directors we collectively gave nearly $25 million to improve people's health, particularly those from underserved populations, and to increase their access to high-quality health care. In addition, our employees volunteered over 340,000 hours of their time in support of charitable efforts. The Civic 50 survey was conducted by the National Conference on Citizenship (NCoC) and Points of Light, national experts on civic engagement, in partnership with Bloomberg L.P. Companies were evaluated on seven specific metrics: leadership, measurement/strategy, design, employee civic growth, community partnerships, cause alignment and transparency.

QUESTION 2.1.3.2

- We have been named 'Top Company' For Veterans. U.S. Veterans Magazine has named us a 2012 "Best of the Best: Top 100 Companies Recruiting Veterans**.**" The honor was based on numerous evaluations, including the company's outreach and accessibility to veterans.

- We have earned the top rating of "Excellent" in DALBAR's 2012 Trends and Best Practices in Explanation of Benefits Statements (EOBs). The DALBAR award is a sign of distinction earned by print and electronic communications that achieve excellence in clarity, content and design. We introduced a newly designed member EOB last year. The DALBAR award confirms the value of these improvements.

    - Our EOB ranked 4th out of 23 submissions

    - Only 6 companies received the rating of "Excellent"

    - Our statement was recognized as "Industry Best" for clarity – achieving the highest score in this category

- We have received top honors for our dedication to helping our employees achieve and maintain healthy, active lifestyles. The National Business Group on Health, a non-profit association of large U.S. employers, recognized Aetna with the highest Platinum honor for the 2012 Best Employers for Healthy Lifestyles awards plus a distinction for the Best Stress Management Intervention program.

    - We offer employees a variety of wellness programs and resources including:

    - Get Active Aetna, a popular 16-week wellness program that offers prizes to motivate employees to eat healthy and exercise;

    - Healthy Lifestyles Incentive program, which offers financial incentives for exercising and eating healthy;

    - Metabolic Syndrome program, which measures employees' risk for certain conditions, such as cardiovascular disease and diabetes; and

    - Virtual Wellness Center, a computer-based resource that offers a virtual kitchen and a virtual fitness center, where animated instructors lead workouts that vary by intensity.

QUESTION 2.1.3.2

- We also received the stress management recognition for our Mind-Body Stress Reduction programs which include Mindfulness at Work™ and Viniyoga™ Stress Management. These programs have shown significant results in a recent study with Duke Integrative Medicine, proving their effectiveness on perceived stress, productivity, pain, sleep and cardiac health.

- The 2012 Best Employers for Healthy Lifestyles awards were announced at the Leadership Summit sponsored by the National Business Group on Health's Institute on Innovation in Workforce Well-being. The top Platinum award is given to companies with established "healthy weight, healthy lifestyles" programs with measurable success and documented outcomes.

- For the second year in a row, we have received the top award from the Center for Plan Language in the category "Web/Multimedia" for our virtual benefits advisor, known as "David". We also received an award of distinction in the "before" and "after" private sector/corporation for improvements to e-mails sent to people who started an online application for an Aetna individual health insurance plan but did not finish.

- Aetna earned the top rating of 100 percent in the 2012 Corporate Equality Index, an annual Human Rights Campaign survey. It's the 10th year Aetna has received a perfect score for service to lesbian, gay, bisexual and transgender employees and consumers.

- DiversityInc named Aetna to its 2012 list of Top 50 Companies for Diversity® for the fourth straight year. In addition, DiversityInc ranked Aetna as a Top 10 company for lesbian, gay, bisexual and transsexual (LGBT) employees and employees with disabilities.

- Black Enterprise magazine has named Aetna to its 2012 list of the "40 Best Companies for Diversity".

- For the fourth year in a row, Aetna's concierge customer service call center has been recognized by J.D. Power and Associates for providing "An Outstanding Customer Service Experience."*

QUESTION 2.1.3.2

2011

- The National Business Coalition on Health honored us with an eValue8™Innovations Awards for Aetna One Premier, our integrated care management and service model that connects people, processes and technology for a simpler, smoother pathway through the health care delivery system.

- We won multiple leadership awards for our Aetna Navigator® website at the annual eHealthcare Leadership Awards. Our secure member website was honored with:

    - A Gold Award for Best Site Design
    - A Silver Award for Best Overall Internet Site
    - A Silver Award for Best Care/Disease Management Site

- The International Data Group (IDG) recognized us for removing paper from the contracting process. Each year, IDG's InfoWorld Green 15 Awards honor the 15 most innovative IT initiatives that embrace sustainability.

  We are the first health insurer to offer electronic contract processing to doctors, hospitals and other health care facilities. Using an e-signature solution, we:

    - Complete contracts faster and more reliably
    - Reduce fax and mail expenses
    - Reduce our carbon footprint

  We have sent more than 20,000 agreements electronically since 2010.

- Aetna finished first among national health plans in the 2011 PayerView Rankings. According to athenahealth and Physicians Practice®, our business transactions are among the most simple to use, efficient and transparent when compared to other national health plans. Aetna has placed either first or second in these rankings for five consecutive years.

- The National Business Group on Health recognized Aetna with their inaugural Innovation in Reducing Health Care Disparities award. We were one of six organizations honored for our commitment to racial and ethnic equality in health care and outstanding support for a culturally diverse workforce.

QUESTION 2.1.3.2

- Aetna won a national ClearMark Award from the Center for Plain Language in the Best Web/Dynamic Media category for Aetna Benefits Advisor. The interactive, online tool asks members questions in easy-to-understand language and helps members choose the benefits that are right for them based on their responses.

- The National Business Group on Health awarded us a Platinum Award as *2011 Best Employer for Healthy Lifestyles*. We are one of four dozen U.S. employers honored for our ongoing commitment to promoting healthy work environments and encouraging workers to live healthier lifestyles.

- For the third year in a row, Aetna's concierge customer service call center has been recognized by J.D. Power and Associates for providing "An Outstanding Customer Service Experience."*

- *Training* magazine ranked us 22 out of the top 125 companies with the best employee training. This is the 7th year in a row we have placed in the top 125.

- Diversity Employers magazine has named Aetna to its list of Top 100 Employers for the Class of 2011.

- Aetna's Hispanic Employee Resource Group was recognized by Latina Style as one of the Top Five Employee Resource Groups of 2011.

2010

- Aetna was named *International Benefits Provider of the Year* as part of the Forum for Expatriate Management's 2010 Expatriate Management and Mobility Awards. The awards recognize excellence in global mobility in 14 categories of distinction.

- We were awarded two ClearMark Awards from the Center for Plain Language for clear, reader-friendly communications. The only health insurer to earn a ClearMark Award in 2010, Aetna also was the only recipient to capture two top awards. We received the national honors for a section of our website on health and wellness, as well as for our employee newsletter on health literacy.

QUESTION 2.1.3.2

- Aetna landed the top industry ranking for FORTUNE's Most Admired List for the third consecutive year. The annual survey asks executives, board directors and analysts to rate companies in their own industry on nine attributes of reputation, including quality of products, social responsibility and global competitiveness. Aetna topped the Health Care: Insurance, Managed Care industry list overall and was ranked first in:

    - Use of corporate assets
    - Social responsibility
    - Quality of management
    - Quality of products and services

- Aetna received *New York Urban League's Champions of Diversity Award* in February 2010. The Champions of Diversity Award salutes companies that understand the need for diversity in the job market.

2009

- Aetna was named DiversityInc's *Top Company for Community Development* in 2009 for our support of nonprofits that share our focus on building strong communities, ending racial and ethnic disparities in health care, improving health literacy and promoting disease prevention.

- We were awarded a 2009 *Connecticut Climate Change Leadership Award* by the state of Connecticut for our efforts to reduce our environmental impact.

- The Davies Public Affairs 2009 national payer survey identified Aetna as the preferred partner for hospitals and health systems across the U.S. The survey revealed a "strong preference from hospitals based on trust, honesty, business practices and good faith negotiations."

  *For J.D. Power and Associates 2011 Call Center Certification Program℠ information, visit www.jdpower.com.

FCR Reasonable Charge Detailed Outline

Inpatient FCR:

- Use Hospital Specific Cost Charge Ratio (CCR) multiplied by Average State Mark Up (Standard Methodology)
- Apply to all eligible charges in the claim, excludes not covered expenses (example is cosmetic)
- If hospital is new or hospital does not participate with CMS, there is no CCR and the state average CCR is used times the state average mark up
- Alaska uses the 80th percentile of available individual hospital markups (regulatory requirement)
- Other non-hospital facilities are excluded from this R&C review; the financial data as collected by CMS would not apply (i.e. skilled nursing facilities, nursing homes, non-hospital rehabilitation centers, inpatient hospice services).
- Updated annually as hospitals update their annual data to CMS

Outpatient FCR:

- Use Truven Health Analytics Profile data (previously MedStat from Thomson Reuters) specific to the provider's geography (CBSA) at the HCPCS/CPT code level for eligible charges (standard methodology)
    - Data contributors include, approximately 100 payers, including commercial carriers, Blue Cross/Blue Shield and third party administrators (TPA's)
    - Data quality is ensured by edits for reasonableness of data (i.e. diagnosis vs. age) and validity of data (i.e. data fields for zip codes, date of service, etc.)
    - Raw data, collected form the appropriate payer consist of service-level adjudicated and paid claims
    - Only single Current Procedural Terminology (CPT) code procedures are profiled
- Utilizes 80th percentile, unless plan sponsor has higher alternate percentile on plan
- The code must have 19 occurrences in the geographic area in order for the data to be valid.
    - If there are not 19 occurrences, the national data is utilized
    - The national data is adjusted by the wage index to add geographic specificity to the allowance
    - If there are not 19 occurrences in the nation data then default logic will apply
- Default Logic:
    - Hospital specific CCR multiplied by Average State Mark up (Alaska use the 80th percentile of available individual hospital markups)
    - If no hospital specific CCR then state average CCR multiplied by average state mark up
- NCCI coding rules apply
- Multiple surgical/procedural rules apply
- Updated annually

Flexible Spending Account (FSA) / Limited Purpose Flexible Spending Account (LPFSA) Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
Fax: (888) 238-3539

For the hearing impaired, call 1-877-703-5572

To avoid claim payment delay, you must sign, date and complete this form. You must also include supporting documentation.

WAIT! Did you know that you can file a claim online? Log in to www.PayFlexDirect.com or accessible via Aetna Navigator®, select *File a Claim* under Quick Links. You can also find instructions online for completing this form.

Member Identification Number: (*Employer assigned number or W ID*)	**Member Full Name:** (*Last Name, First, MI*)
Member Address: (*Street, City, State, Zip Code*)	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name:

Health Care Expenses (For you, your spouse and your dependents)

Coordination of Benefits: Do you, your spouse or dependent have coverage under another plan? This includes any medical, dental, prescription or vision plan other than your primary coverage? ☐**Yes** – you **must** include a copy of the EOB for each date of service ☐**No**

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

Patient Name	**Type of Service** (deductible, dental, medical, orthodontia, OTC, RX, vision)	**From Date of Service** (not payment date) MM/DD/YYYY	**To/Thru Date of Service** (not payment date) MM/DD/YYYY	**Amount Requested**	Limited Purpose FSA Post deductible **Have you met your health plan deductible?** If yes, EOB must be provided.
				$	☐Yes ☐No
				$	☐Yes ☐No
				$	☐Yes ☐No
				$	☐Yes ☐No
			Total	**$**	

****If more lines are needed, please complete another form.** You can get claim forms at www.PayFlexDirect.com or accessible via Aetna Navigator under MyPayFlexDirect Resources and select Administrative Forms. Attach the appropriate documentation for each claim.

Dependent Care Expenses (Child or Adult) - If your caregiver completes and signs below, you do not need to include an itemized statement.

If requesting for multiple dependents, each dependent must be listed on a separate line.

Exact Dates of Service		**Amount Requested** (Required)	**Qualifying Person's First and Last Name** (Please Print)	Age On Service Date (Required)	Qualifying person is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12.**Please check, if yes.
From MM/DD/YYYY	**To** MM/DD/YYYY				
		$			☐Yes
		$			☐Yes
		$			☐Yes
		$			☐Yes
Total		**$**	**You do not need to submit evidence of diagnosed medical condition.**		

Caregiver Information/Certification: My signature certifies that I have provided the services for these expenses for _____(Qualifying Person's First Name)

Name *(Must be printed)*_____

Relative: ☐Yes ☐No

Provider Signature _____

Caregiver Information/Certification: My signature certifies that I have provided the services for these expenses for _____(Qualifying Person's First Name).
Note: This is for a second caregiver, if you have more than one.

Name *(Must be printed)*_____

Relative: ☐Yes ☐No

Provider Signature _____

For Health Care FSA: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

For Dependent Day Care FSA: I certify that I have incurred the Dependent Care expenses for me and, if married, my spouse to work. These expenses are for my Qualifying Person. These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. These are regardless of when I am billed or charged for, or pay for the service. I acknowledge that I will have to report the caregiver's name, address and Tax Identification Number on Form 2441.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed material for the FSA or Limited FSA plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

✍ **Employee Signature** _____ **Date** _____

If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents. *REV. 08/2012*

From: eNotify@payflex.com

Sent: <Day>, <Month> <Date>, <Year> <Time>

To: <email address>

Subject: Claim Payment from PayFlex – Action May Be Required

Attachments: Explanation of Payment – Reimbursement via Check

Dear <Name of Participant>:

Thank you for submitting your claims(s) to PayFlex. We have processed your claim(s) and your reimbursement check will be mailed to you. Remember, you can enroll in direct deposit by logging into <URL> and selecting **My Accounts and Services** on the left-navigation bar, then select **Enroll in Direct Deposit**. Simply enter your bank account information and click **Next** to receive your next reimbursement via direct deposit. If a claim has been denied, you may be required to take action. If action is required, please provide the requested documentation or payment, as the case may be, to PayFlex via fax or mail.

Thank you,
PayFlex Systems USA, Inc.
<URL>
XXX.XXX.XXXX (customer service)
XXX.XXX.XXXX (fax)

DO NOT REPLY TO THIS EMAIL. This was sent by an automated system. "Reply" messages are automatically deleted and will not receive a response.

LAST NAME, FIRST NAME
Employer Name

Explanation of Payment
(Reimbursement)

Thank you for submitting your claims(s) to PayFlex. We have processed your claim(s) and your reimbursement notification is attached. Below is a summary of the claims being paid. If a claim has been denied, you may be required to take action. If action is required, please provide the requested documentation or payment, as the case may be, to PayFlex via fax or mail.

Check #: XXXXXXXXX Check Date: 07/05/2012 Total Check Amount: **** $200.00

Your Account Balance After This Payment

Account Name	Annual Election	Deposits	Total Paid	Election Remaining	Amt This Payment
(2012) Healthcare (FSA)	$2,000.00	$1,992.92	$2,000.00	$0.00	$200.00

This Payment Includes

Account Name	Expense Type	Service Dates Begin	Service Dates End	Amt Requested	Amt Paid	Amt Denied	Claim #	Amt This Payment
(2012) Healthcare (FSA)	Dental	07/01/12	07/01/12	$215.26	$200.00	$15.26	XXXXXX	$200.00
Denied Reason: Plan year election has been met								
							Total:	$200.00

Access your account information online at <URL>
PayFlex Systems USA, Inc. I P.O. Box 3039 I Omaha, NE 68103-3039
Toll Free: (XXX) XXX-XXXX I Fax: (XXX) XXX-XXXX

You have the right to request upon appeal, a review and a copy of any internal procedures or guidelines used during the processing of your claim. Your request must be in writing within 180 days of receiving this explanation of payment. A review will be conducted and you will be notified by the plan administrator (or designated claims fiduciary) of the decision within 60 days (30 days if your plan has 2 levels of appeal). Please refer to your Summary Plan Description for additional information regarding any second level appeal that may be available to you under the plan (such as your time period for filing an appeal (which may be less than 180 days)) and where to file the appeal. After you have exhausted the plan's required appeal procedures, you have the right to bring civil action if you file a request for review and your request for benefits is denied. Note: Plans such as Dependent Care, Tuition Reimbursement and Transportation are not subject to ERISA or subject to this process.

Employer Reporting Guide

Updated August, 2012

00.05.100.1

Table of Contents

Standard Report Types

We offer a number of reports for employers to manage the accounting of their plans administered by PayFlex. Following is an overview of these reports as well as examples of these reports.

Scheduled Reports

These reports run on a regularly scheduled basis. You set the schedule.

Once these are set up, we will create and delivers the reports to the designated contact (see page 5 for details). Usually, we deliver them by e-mail. However, we may be able to deliver by fax or through the Website.

Here is a list of the available reports.

- **Ledger Summary Report** – For each participant, provides year to date deposits; amounts paid out; current cash balance; and the annual election. This is a monthly report.

  Please review this report for discrepancies. If you find any please notify us immediately. You should give special attention to the "Status" column, which identifies termed employees. In addition, review the "YTD Deposits" column, as this should agree with payroll deductions. You are responsible for reporting and reconciling any discrepancies.

- **Debit Card Transaction Register Report** – For each participant, shows all debit card activity on each participant's debit card for a specified period. You set the frequency.
- **Employer Funding Summary Report** – Shows a summary of the funding requests for a specified period. You set the frequency.
- **Employer Funding Detail Report** – For each participant, shows funding requests for a specified period. You set the frequency.
- **Production Deposit Register Report** – Shows the deposits posted to participant accounts for a specified period. You set the frequency.

Automated Reports

We send these reports as claims and debit card settlement occur. We send the HSA Deposit Register report daily as we post funds every day.

- **Production Payment Register Report** – Shows the payments made to participants for paper or web claims.
- **Settlement Payment Register Report** – Shows the settlement activity on participants' card accounts.
- **HSA Deposit Register Report** – Shows the deposits made to each employee's HSA.

On Demand Reports

You can request reports through the Employer Portal. Once logged into the portal click on the "On Demand Reports" link on the left side of the web page. You can request most of these reports in PDF, CSV or both.

The following reports are available via On Demand.

- Election Report
- Ledger Summary Report
- Employer Funding Summary Report
- Employer Funding Detail Report

When you request an "On Demand Report", you will receive an e-mail stating the report is available for download. This e-mail will go to the requester's email address (the email address used to log in to the Employer Portal). Once available, you can get to the report by clicking the "Plan Reporting Archive" link on the left side of the web page.

Sample Email Notification:

From: reporting@payflex.com
Subject: Requested PayFlex Report is Available

The report you have requested (Ledger Summary) is available to download on the Employer Portal.

To retrieve your report:
1. Go to our Employer Portal at PayFlexDirect.com/employer
2. Log in and go to the Plan Reporting Archive

Thank you,
PayFlex Systems USA, Inc.

Reports Distribution

Reports by Role

You have assigned roles to members of your organization. These roles determine who can get which report. The following is a list of the scheduled and automated reports by Roles. These roles defined in the Employer Contacts on the New Client Checklist.

Role	Report Distribution
Billing	▪ Combined Invoice Reports for Distribution ▪ Invoice Roster Report
Funding	▪ Funding Notification Report ▪ Production Payment Register Report ▪ Settlement Payment Register Report ▪ HSA Deposit Register Report (if applicable) ▪ Employer Funding Summary Report (if requested) ▪ Employer Funding Detail Report (if requested) ▪ Debit Card Transaction Register Report
Eligibility	▪ Election Report* ▪ Payroll Schedule Report*
Reporting	▪ Ledger Summary Report ▪ Debit Card Transaction Report

* Not a scheduled report

Scheduled Report Samples

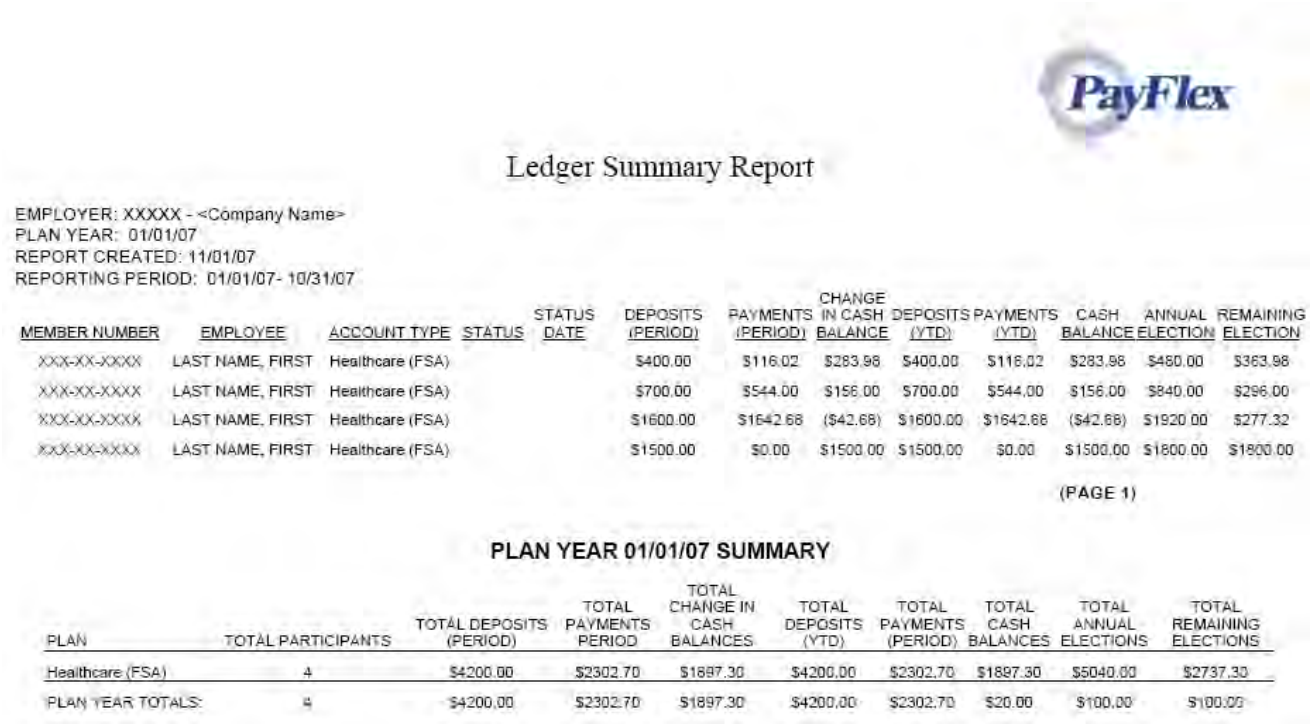
Ledger Summary Report

This report displays employee account balances. You can have these separated by division if needed. It summarizes by reporting period, year to date (YTD), and account type. For each of your employees in the FSA plan, it shows deposits, payments and balances.

Format: CSV and PDF

Note: For larger clients with multiple divisions, you will have to download the CSV format from the "Plan Reporting Archive" link on the Employer Portal.

Sample report (PDF Format)



PayFlex

Ledger Summary Report

EMPLOYER: XXXXX - <Company Name>
PLAN YEAR: 01/01/07
REPORT CREATED: 11/01/07
REPORTING PERIOD: 01/01/07- 10/31/07

MEMBER NUMBER	EMPLOYEE	ACCOUNT TYPE	STATUS	STATUS DATE	DEPOSITS (PERIOD)	PAYMENTS (PERIOD)	CHANGE IN CASH BALANCE	DEPOSITS (YTD)	PAYMENTS (YTD)	CASH BALANCE	ANNUAL ELECTION	REMAINING ELECTION
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$400.00	$116.02	$283.98	$400.00	$116.02	$283.98	$480.00	$363.98
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$700.00	$544.00	$156.00	$700.00	$544.00	$156.00	$840.00	$296.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$1600.00	$1642.68	($42.68)	$1600.00	$1642.68	($42.68)	$1920.00	$277.32
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$1500.00	$0.00	$1500.00	$1500.00	$0.00	$1500.00	$1800.00	$1800.00

(PAGE 1)

PLAN YEAR 01/01/07 SUMMARY

PLAN	TOTAL PARTICIPANTS	TOTAL DEPOSITS (PERIOD)	TOTAL PAYMENTS PERIOD	TOTAL CHANGE IN CASH BALANCES	TOTAL DEPOSITS (YTD)	TOTAL PAYMENTS (PERIOD)	TOTAL CASH BALANCES	TOTAL ANNUAL ELECTIONS	TOTAL REMAINING ELECTIONS
Healthcare (FSA)	4	$4200.00	$2302.70	$1897.30	$4200.00	$2302.70	$1897.30	$5040.00	$2737.30
PLAN YEAR TOTALS:	4	$4200.00	$2302.70	$1897.30	$4200.00	$2302.70	$20.00	$100.00	$100.00

Fields

Member Number	Employee	Account Type	Status	Status Date	Deposits (Period)	Payments (Period)	Change in Cash Balance	Deposits (YTD)	Payments (YTD)	*Cash Balance	Annual Election	Remaining Election
Internal code for the employee or SSN	Participant last and first name	Account in which activity occurred	Participant Status if termed, COBRA or LOA	Effective date of participant status	Deposits total for reporting period	Participant payments for reporting period	Change in account balance for reporting period	Year to date deposits amount	Year to date payments	Year to date deposits minus payments	Total annual election amount for the plan year	Total annual election minus YTD payments

* You can use the **Cash Balance** field to determine account forfeitures at the end of the plan year run out.

Debit Card Transaction Register Report

This report shows the debit card transactions and settlement activity for a specified period. The items will display in date order by effective date of the transaction.

Format: CSV

Effective	Settled	Authorized	Member Number	Last Name	First Name	Amount	Account Type	Merchant
3/29/2007	4/1/2007	3/29/2007	XXXXX8500	BRANNIG	TERRY	$50.00	Healthcare (FSA)	CVS PHARMACY #123456
3/30/2007	4/1/2007	3/30/2007	XXXXX8503	CHERON	TOM	$10.00	Healthcare (FSA)	WALGREEN #456789
3/30/2007	4/1/2007	3/30/2007	XXXXX8585	FLEMING	MARTHA	$55.29	Healthcare (FSA)	WALGREEN #987321
3/30/2007	4/1/2007	3/30/2007	XXXXX8599	MONROE	CHARLES	$9.00	Healthcare (FSA)	WALGREEN #123456
3/30/2007	4/3/2007	3/30/2007	XXXXX8588	SHERLING	JENNIFER	$5.76	Healthcare (FSA)	WAL MART #123456
3/30/2007	4/1/2007	3/30/2007	XXXXX8550	VOGT	GRACE	$7.37	Healthcare (FSA)	WAL MART #7778899
3/30/2007	4/1/2007	3/30/2007	XXXXX8586	WAGONER	HOWARD	$20.00	Healthcare (FSA)	WAL MART #123456
4/26/2007	4/28/2007	4/26/2007	XXXXX8598	BRANNIG	TERRY	$50.00	Healthcare (FSA)	WALGREEN #123456
4/26/2007	4/30/2007	4/26/2007	XXXXX8522	CHERON	TOM	$53.00	Healthcare (FSA)	TOTAL DENTAL CENTRE
4/26/2007	4/28/2007	4/26/2007	XXXXX8542	FLEMING	MARTHA	$7.75	Healthcare (FSA)	TOTAL DENTAL CENTRE
4/26/2007	4/28/2007	4/26/2007	XXXXX8599	MONROE	CHARLES	$10.00	Healthcare (FSA)	PRESTONS FOOD&DRUG
4/26/2007	4/28/2007	4/26/2007	XXXXX8503	SHERLING	JENNIFER	$5.00	Healthcare (FSA)	PRESTONS FOOD&DRUG

Fields

Effective	Settled	Authorized	Member Number	Last Name	First Name	Amount	Account Type	Merchant
Date of card swipe	Date of settlement	Date of merchant authorization	Internal code for the employee or SSN	Participant last name	Participant first name	Dollar amt. of transaction	Account in which activity occurred	Merchant and store number (if applicable)

Employer Funding Summary Report

This report summarizes the total employee account transactions by date, account type and funding type.

Format: CSV

Date Created	Reporting Period	Employer ID	Funding Date	Funding Type	Plan Year	Account Type	Amount
10/7/2008	[09/01/08-09/07/08]	10002	9/4/2008	Settlement	1/1/2008	Healthcare (FSA)	$513.24
10/7/2008	[09/01/08-09/07/08]	10002	9/5/2008	Settlement	1/1/2008	Healthcare (FSA)	$21.63
10/7/2008	[09/01/08-09/07/08]	10002	9/1/2008	Settlement	1/1/2008	Healthcare (FSA)	$78.54
10/7/2008	[09/01/08-09/07/08]	10002	9/4/2008	Production	1/1/2008	Healthcare (FSA)	$100.00
10/7/2008	[09/01/08-09/07/08]	10002	9/2/2008	Settlement	1/1/2008	Healthcare (FSA)	$84.30
10/7/2008	[09/01/08-09/07/08]	10002	9/6/2008	Settlement	1/1/2008	Healthcare (FSA)	$267.39
10/7/2008	[09/01/08-09/07/08]	10002	9/4/2008	Production	1/1/2008	Dependent Care	$335.63

Fields

Date Created	Reporting Period	Employer ID	Funding Date	Funding Type	Plan Year	Account Type	Amount
Date of the report	Date range covered in report	Internal number to identify employer	Date of funding request	**"Settlement"**- Debit card transactions or **"Production"** - paper claims	Plan year in which the activity occurred	Account in which activity occurred	Amount of the transaction

Employer Funding Detail Report

This is a detailed report of all the employee account transactions for a specified period.

Format: CSV

Date Created	Reporting Period	Employer ID	Division	Funding Date	Funding Type	Member Number	Last Name	First Name	Plan Year	Account Type	Transaction Type	Amount
10/7/2008	[09/01/08-09/08/08]	10002	100	9/1/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$25.00
10/7/2008	[09/01/08-09/08/08]	10002	700	9/1/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$8.54
10/7/2008	[09/01/08-09/08/08]	10002	900	9/1/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$45.00
10/7/2008	[09/01/08-09/08/08]	10002	100	9/2/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$15.00
10/7/2008	[09/01/08-09/08/08]	10002	100	9/2/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$50.95
10/7/2008	[09/01/08-09/08/08]	10002	700	9/2/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$18.35
10/7/2008	[09/01/08-09/08/08]	10002	100	9/4/2008	Production	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Dependent Care	Employee Account Payment	$38.46
10/7/2008	[09/01/08-09/08/08]	10002	100	9/4/2008	Production	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$25.00
10/7/2008	[09/01/08-09/08/08]	10002	100	9/4/2008	Production	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$75.00

Fields

Date Created	Reporting Period	Employer ID	Division	Funding Date	Funding Type	Member Number	Last Name	First Name	Plan Year	Account Type	Transaction Type	Amount
Date of the report	Date range covered in report	Internal number to identify employer	Participant division or location if provided by employer	Date funding requested from employer	"Settlement"- Debit card transactions or "Production" - paper claims	Internal code for the employee or SSN	Participant last name	Participant first name	Plan year in which the activity occurred	Account in which activity occurred	This will always be **Employee account Payment**	Amount of the transaction

Deposit Summary Report

This report shows the deposit history for all employees in the plan, during the specified period.

Format: CSV

Created	Reporting Period	Employer ID	Employer	Division Code	Member Number	Last Name	First Name	MI	Plan Year	Account Type	Type	Date	Amount
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	10/31/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	1/31/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	2/15/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	2/28/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	3/7/07	$20.00

Fields

Date Created	**Reporting Period**	**Employer ID**	**Employer**	**Division**	**Member Number**	**Last Name**	**First Name**	**MI**	**Plan Year**	**Account Type**	**Type**	**Date**	**Amount**
Date of the report	Date range covered in report	Internal number to identify employer	Employer Name	Participant division or location if provided by employer	Internal code for the employee or SSN	Participant last name	Participant first name	Participant Middle Initial	Plan year in which the activity occurred	Account in which activity occurred	Either **Payroll Deduction** or **Employer Contribution**	Deposit effective date	Amount of the transaction

Automated Report Samples

Production Payment Register Report

This report shows a detailed listing of all claims that PayFlex has processed and paid. This report provides the detail for the amount that we will ask you to fund for a specified period. This includes claims submitted by fax, mail and web (Express Claims).

Format: CSV and PDF

Sample report (CSV Format)

Plan Year	Account T	Division	Transactio	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	BRANNIG	TERRY		8793019	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	CHERON	TOM		8793025	7/26/2007	$24.50
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	FLEMING	MARTHA	M	8793033	7/26/2007	$162.40
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	MONROE	CHARLES		8793037	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		8793035	7/26/2007	$85.00
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	VOGT	GRACE		8793031	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	WAGONER	HOWARD		8793017	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	BRANNIG	TERRY		8793021	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	CHERON	TOM		8793015	7/26/2007	$76.92
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	FLEMING	MARTHA		8793023	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	MONROE	CHARLES		1.7E+07	7/26/2007	$75.00
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		8793027	7/26/2007	$192.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	VOGT	GRACE		8793039	7/26/2007	$100.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	WAGONER	HOWARD		8793027	7/26/2007	$418.36

Fields

Plan year	Account Type	Division	Transaction Type	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
Plan year in which the activity occurred	Account in which activity occurred	Participant division or location if provided by employer	**Employee account payment** or **adjustment**	Internal code for the employee or SSN	Participant last name	Participant first name	Participant middle initial	Internal code for payment	Date of payment	Payment amount

Production Payment Register Report

Sample report (PDF Format)

11/02/2007

<Company Name>
Production Payment Register Report

Plan Year: 01/01/06	MEMBER #	LAST NAME	FIRST NAME	MI	PMT #	PMT DATE	PMT AMT	TOTALS
Dependent Care								
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	2082236	01/12/07	$223.92	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	2082228	01/12/07	$90.00	
							EAP Total:	$313.92
Healthcare (FSA)							Dependent Care Total:	$313.92
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	2082234	01/12/07	$143.80	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16799701	01/12/07	$128.39	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16799700	01/12/07	$210.07	
							EAP Total:	$481.86
							Healthcare (FSA) Total:	$481.86
							Plan Year Total:	$795.78
Plan Year: 01/01/07								
Healthcare (FSA)								
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16888733	3/15/2007	$116.02	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16828268	2/7/2007	$126.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16836903	2/13/2007	$84.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16856836	2/23/2007	$214.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16856836	4/25/2007	$90.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16888732	3/15/2007	$30.00	
							EAP Total:	$660.02
							Healthcare (FSA) Total:	$660.02
							Plan Year Total:	$660.02
NET AMOUNT FOR <Company Name>:								$1455.80

EMPLOYER SUMMARY

Plan Year: 01/01/06	Checks	Direct Deps	Payments	Voids	Adjustments	Net Amount
Dependent Care	$0.00	313.92	313.92	0.00	0.00	313.92
Healthcare (FSA)	$338.46	143.40	481.86	0.00	0.00	481.86
	338.46	457.32	795.78	0.00	0.00	795.78
Plan Year: 01/01/07						
Healthcare (FSA)	501.62	158.40	660.02	0.00	0.00	660.02
	501.62	158.40	660.02	0.00	0.00	660.02
Plan Year: ALL						
Dependent Care	$0.00	313.92	313.92	0.00	0.00	313.92
Healthcare (FSA)	840.08	301.80	1141.88	0.00	0.00	1141.88
	840.08	615.72	1455.80	0.00	0.00	1455.80

Settlement Payment Register Report

This report shows the debit card settlement activity by employee. It provides the detail for the amount that we will ask you to fund for a specified period.

Format: CSV and PDF

Sample report (CSV Format)

Plan Year	Account T	Division	Transactio	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	BRANNIG	TERRY		7624150	7/2/2007	$13.80
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	CHERON	TOM		7689332	7/6/2007	$439.92
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	FLEMING	MARTHA		7648434	7/3/2007	$12.14
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	MONROE	CHARLES		7674952	7/5/2007	$140.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		7675256	7/5/2007	$977.37
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	VOGT	GRACE	A	8136718	7/9/2007	$67.42
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	WAGONER	HOWARD		7622764	7/2/2007	$28.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	BRANNIG	TERRY		7696886	7/7/2007	$28.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	CHERON	TOM		7675798	7/5/2007	$28.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	FLEMING	MARTHA		7689636	7/6/2007	$10.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	MONROE	CHARLES		7618372	7/2/2007	$25.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		7666516	7/5/2007	$297.62
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	VOGT	GRACE		8116992	7/8/2007	$34.34
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	WAGONER	HOWARD	M	7665266	7/5/2007	$75.00

Fields

Plan Year	Account Type	Division	Transaction	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
Plan year in which the activity occurred	Account in which activity occurred	Participant division or location if provided by employer	**Employee Account Payment**	Internal code for the employee or SSN	Participant last name	Participant first name	Participant middle initial	Internal code for payment	Date of card swipe	Payment amount

Settlement Payment Register Report

This is the same report on the previous page in PDF format.

Sample report (PDF Format)

10/25/2007

<Company Name>
Settlement Payment Register Report

Plan Year: 01/01/07	MEMBER #	LAST NAME	FIRST NAME	MI	PMT #	PMT DATE	PMT AMT	TOTALS
Healthcare (FSA)								
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919196	10/25/07	$3.67	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919186	10/25/07	$5.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919188	10/25/07	$10.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919190	10/25/07	$74.84	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919192	10/25/07	$57.86	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919194	10/25/07	$40.00	
							EAP Total:	$191.37
							Healthcare (FSA) Total:	$191.37
							Plan Year Total:	$191.37
NET AMOUNT for <Company Name>								$191.37

HSA Deposit Register Report

This report shows the HSA deposits, by employee, for the specified time period.

Format: CSV and PDF

Sample report (CSV Format)

Plan Year	Account Type	Division	Transaction Type	SSN	Last Name	First Name	Mi	Dep Date	Dep Amt
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$60.00
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$110.00
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	10/3/2008	$9.23
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	10/3/2008	$9.23
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	10/3/2008	$9.83
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$146.36
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$51.66
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$72.50

Fields

Plan year	Account Type	Division	Transaction Type	SSN	Last Name	First Name	MI	Dep Date	Dep Amt
Plan year in which the activity occurred	Account in which activity occurred	Participant division or location if provided by employer	**Employee account deposit** or **adjustment**	Internal code for the employee or SSN	Participant last name	Participant first name	Participant middle initial	Deposit effective date	Amount of deposit

Sample report (PDF Format)

<Company Name>
HSA Deposit Register Report

Plan Year: 01/01/08 / Health Savings Account / Employee Account Deposit	MEMBER #	LAST NAME	FIRST NAME	MI	DEP DATE	DEP AMT	TOTALS
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$76.93	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$145.46	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$192.31	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$115.39	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$192.31	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$69.24	
						EAD Total:	791.64
						Health Savings Account Total:	791.64
						Plan Year Total:	791.64

EMPLOYER SUMMARY

Plan Year: 01/01/08	Deductions	Contributions	Deposits	Adjustments	Net Amount
Health Savings Account	$791.64	$0.00	$791.64	0.00	$791.64
	$791.64	$0.00	$791.64	0.00	$791.64
Plan Year: ALL					
Health Savings Account	$791.64	$0.00	$791.64	0.00	$791.64
	$791.64	$0.00	$791.64	0.00	$791.64

Other Report Samples

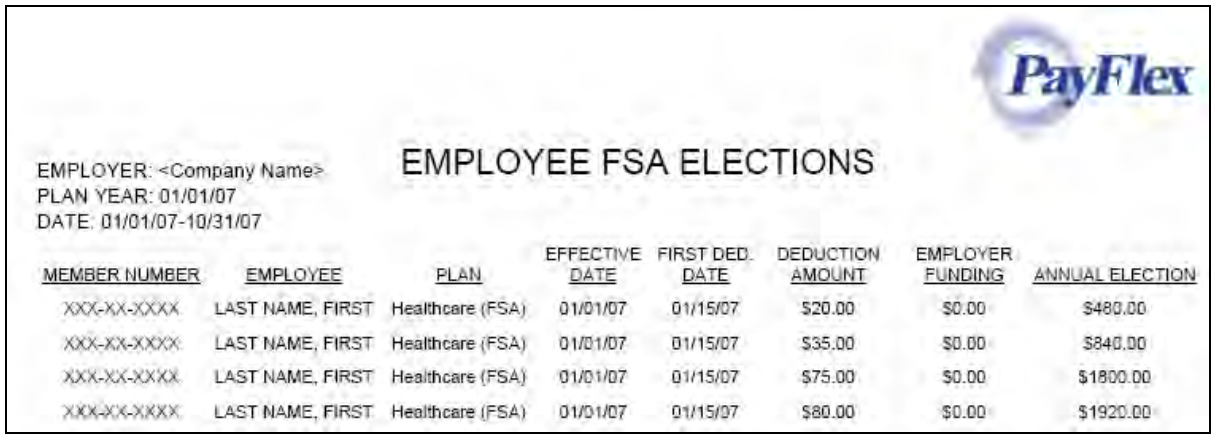
Election Report

This report shows employee elections for a given account. It also shows the scheduled payroll deduction amounts. The report also gives a summary of all elections for each account type in the plan.

Format: CSV and PDF

Report Body

This portion of the report shows election information for each employee in the plan.



EMPLOYER: <Company Name>
PLAN YEAR: 01/01/07
DATE: 01/01/07-10/31/07

EMPLOYEE FSA ELECTIONS

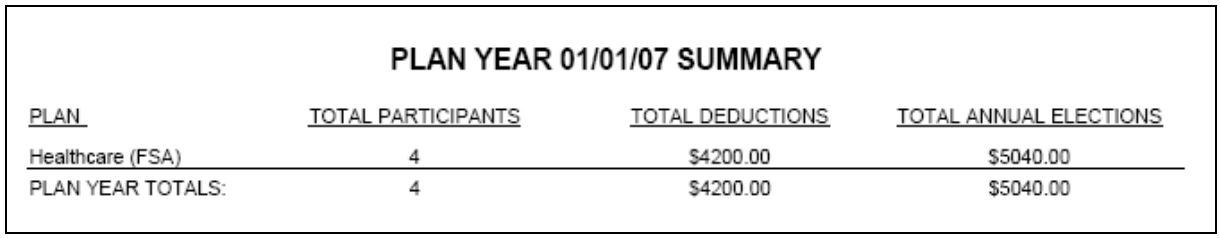
MEMBER NUMBER	EMPLOYEE	PLAN	EFFECTIVE DATE	FIRST DED. DATE	DEDUCTION AMOUNT	EMPLOYER FUNDING	ANNUAL ELECTION
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$20.00	$0.00	$480.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$35.00	$0.00	$840.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$75.00	$0.00	$1800.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$80.00	$0.00	$1920.00

Fields

Member Number	Employee	Plan	Effective Date	First Ded. Date	Deduction Amount	Employer Funding	Annual Election
Internal code for the employee or SSN	Participant last and first name	Account type	Date election begins	Date first deduction is scheduled to be taken	Amount of participant payroll deduction	Amount the employer adds, if any	Total annual election amount for the plan year

Report Summary

This section gives a summary of the election information for each account type.



PLAN YEAR 01/01/07 SUMMARY

PLAN	TOTAL PARTICIPANTS	TOTAL DEDUCTIONS	TOTAL ANNUAL ELECTIONS
Healthcare (FSA)	4	$4200.00	$5040.00
PLAN YEAR TOTALS:	4	$4200.00	$5040.00

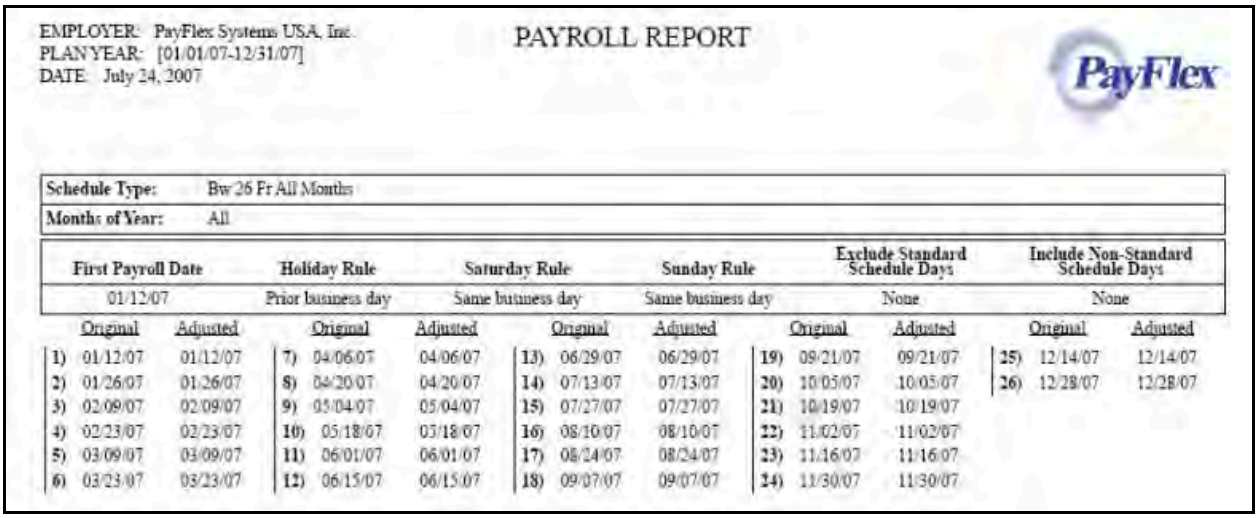
Fields

Plan	Total Participants	Total Deductions	Total Annual Elections
Account type	Number of participants in each plan type and the cumulative total in all plans	Total dollar amount of deductions for each plan type and cumulative total for all plans	Total dollar amount of annual elections for each plan type and cumulative total for all plans

Payroll Schedule Report

This report shows the payroll schedules by date for a specified plan year. This is based on the information that you provide.

Format: PDF



EMPLOYER: PayFlex Systems USA, Inc.
PLAN YEAR: [01/01/07-12/31/07]
DATE: July 24, 2007

PAYROLL REPORT

PayFlex

Schedule Type:	Bw 26 Fr All Months
Months of Year:	All

First Payroll Date	Holiday Rule	Saturday Rule	Sunday Rule	Exclude Standard Schedule Days	Include Non-Standard Schedule Days
01/12/07	Prior business day	Same business day	Same business day	None	None

	Original	Adjusted		Original	Adjusted		Original	Adjusted		Original	Adjusted		Original	Adjusted
1)	01/12/07	01/12/07	7)	04/06/07	04/06/07	13)	06/29/07	06/29/07	19)	09/21/07	09/21/07	25)	12/14/07	12/14/07
2)	01/26/07	01/26/07	8)	04/20/07	04/20/07	14)	07/13/07	07/13/07	20)	10/05/07	10/05/07	26)	12/28/07	12/28/07
3)	02/09/07	02/09/07	9)	05/04/07	05/04/07	15)	07/27/07	07/27/07	21)	10/19/07	10/19/07			
4)	02/23/07	02/23/07	10)	05/18/07	05/18/07	16)	08/10/07	08/10/07	22)	11/02/07	11/02/07			
5)	03/09/07	03/09/07	11)	06/01/07	06/01/07	17)	08/24/07	08/24/07	23)	11/16/07	11/16/07			
6)	03/23/07	03/23/07	12)	06/15/07	06/15/07	18)	09/07/07	09/07/07	24)	11/30/07	11/30/07			

Fields

Fields	Description
Original	Original payroll date before adjustment
Adjusted	Payroll date following adjustments such as Holiday Rule

Combined Invoice Report

This is a monthly report. It shows administrative fees for employee in the plan as well as run out employees. You can have it separated by division if needed.

Format: PDF

10802 Farnam Drive #100
Omaha, NE 68154
(P) (800) 284-4885
(F) (402) 231-4310
www.mypayflex.com

TO: Company Name
Attn: Billing Contact
Address 1
Address 2
City, State Zip

Date: mm/dd/yy
Invoice No: xxxxxx-xxxxx

RE: Month yyyy Administrative Service Fees

Administration Fees:		
Division Code - Division Description	(#particpants @ $Participant Rate)	$00.00
Division Code - Division Description	(#participants @ $Particpant Rate)	$00.00
Account Fee	#Total Participants @ $Participant Rate	$TOTAL DUE

Payment Terms: Net 10 Days

Please pay as invoiced. Any adjustments you wish to make must be supported by the appropriate documentation and adjustments will be reflected on a subsequent invoice.

PLEASE DETACH AND RETURN THE BELOW COUPON WITH PAYMENT

Remit to:

PayFlex Systems USA, Inc.
10802 Farnam Dr, Suite 100
Omaha, NE 68154

Client:	Client Name
Reference:	Month YYYY Administrative Service Fees
Invoice No:	xxxxxx-xxxxx
Total Due:	$00.00

Total Paid: _____

Client Name
Participant Roster
Invoice : xxxxxx-xxxxx

Description	Status	SSN	Name	Months	Rate	Total
Division Code- Division Description						
--- Account Fee (DepCare, HcFSA)					$0.00	
	PARTICIPATING	XXX-XX-XXXX	Last Name, First Name	1		$0.00

Total for Division Code – Division Description	Total	
Account Fee (DepCare- HcFSA)		
Add/Active Participants	1	$0.00
Retroactive Participants	0	$0.00
Runout Participants	0	$0.00
Termed Participants	1	N/A
Totals	1	$0.00

Account Statement

PayFlex Systems USA, Inc
10802 Farnam Drive, Suite 100
Omaha, NE 68154

(800) 284-4885

JULIE SMITH
1234 WEST MAIN STREET
CITY, STATE ZIP CODE

Member Number: 000-00-000
Employer ID: 12345
Employer Name: Any Name Company
Statement Date: 02/01/YY

Balance Summary

Account	Annual Election	Deposits	Total Paid	Election Remaining	Cash Balance
FSA 20XX	$800.00	$200.00	$300.00	$500.00	($100.00)
Transit 20XX	$0.00	$45.00	$45.00	$0.00	$0.00
Dependent Care 20XX	$1,000.00	$250.00	$250.00	$750.00	$0.00

Transaction Details

FSA 20XX

Tran Date	Post Date	Description	Amount
01/01/YY		BEGINNING AVAILABLE BALANCE	$800.00
01/10/YY	01/11/YY	NEIGHBORHOOD OPTICAL STORE	($100.00)
01/12/YY	01/14/YY	ABC COMMUNITY HOSPITAL	($125.00)
01/23/YY	01/25/YY	XYZ PHARMACY	($75.00)
01/31/YY		ENDING AVAILABLE BALANCE	$300.00

Transit 20XX

Tran Date	Post Date	Description	Amount
01/01/YY		BEGINNING AVAILABLE BALANCE	$0.00
01/31/YY	01/31/YY	PAYROLL DEPOSIT	$45.00
01/31/YY	01/31/YY	THE TRANSIT AUTHORITY	($45.00)
01/31/YY		ENDING AVAILABLE BALANCE	$0.00

Dependent Care 20XX

Tran Date	Post Date	Description	Amount
01/01/YY		BEGINNING AVAILABLE BALANCE	$0.00
01/15/YY	01/15/YY	PAYROLL DEPOSIT	$250.00
01/31/YY	01/31/YY	REIMBURSEMENT	($250.00)
01/31/YY		ENDING AVAILABLE BALANCE	$0.00

Important Messages About Your Account

Do you have questions about your account? Please visit us at www.payflex.com or phone (800) 284-4485

Did you know that you can receive your account statement electronically? For more information visit us at www.payflex.com

Your PayFlex Debit Card can now be used at many grocery and discount stores for Over The Counter purchases! A listing of participating merchants can be found at www.payflex.com

Remember to always save your receipts in case they are needed to verify your purchases!

PayFlex Systems USA, Inc.

Report Guide

COBRA & Direct Billing

Table of Contents

Reporting Overview

PayFlex has several reports to help you reconcile the premium payments that we have sent. You can also use these reports to track activity for your participants' benefits. When a report is available in the Employer Portal, we'll send an e-mail to your report contact.

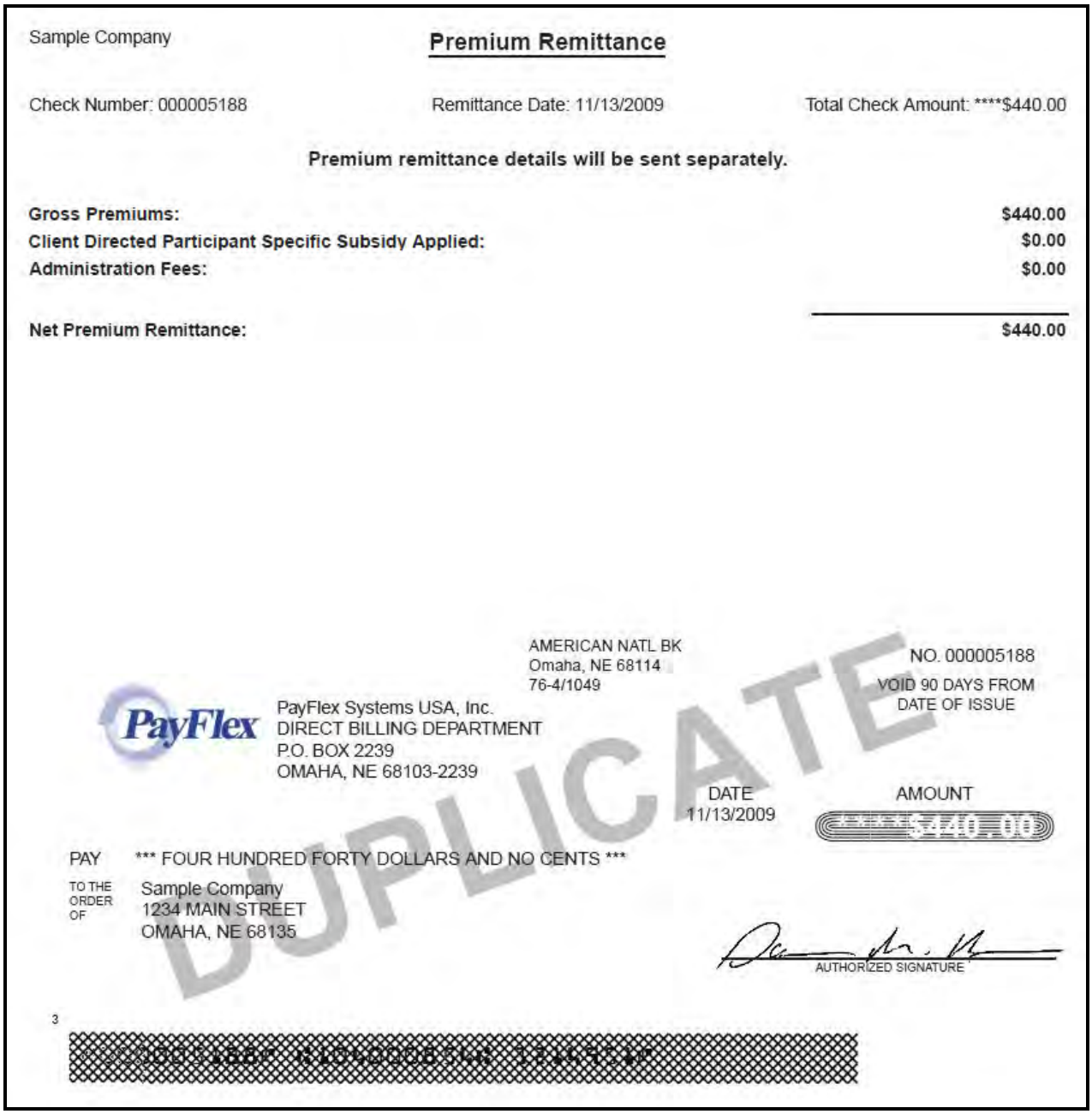
This guide will tell you about these reports. It will explain the purpose of each report and the type of information that each report provides.

Remittance Reporting

We have several reports for the premiums that we collect from your participants. Generally, we send these premiums monthly.

Employer Remittance Check

Though not a report, per se, this does give you some information for the premium remittance. If we mail a check for the premiums that we have collected, we will do so in a pressure-sealed document. The top portion of the summary will tell you if we withheld any subsidy payments and administration fees. You can also get an electronic copy of this on the Employer Portal.



Sample Company

Premium Remittance

Check Number: 000005188 | Remittance Date: 11/13/2009 | Total Check Amount: ****$440.00

Premium remittance details will be sent separately.

Gross Premiums:	**$440.00**
Client Directed Participant Specific Subsidy Applied:	**$0.00**
Administration Fees:	**$0.00**
Net Premium Remittance:	**$440.00**

AMERICAN NATL BK
Omaha, NE 68114
76-4/1049

NO. 000005188
VOID 90 DAYS FROM
DATE OF ISSUE

PayFlex Systems USA, Inc.
DIRECT BILLING DEPARTMENT
P.O. BOX 2239
OMAHA, NE 68103-2239

DATE
11/13/2009

AMOUNT
$440.00

PAY *** FOUR HUNDRED FORTY DOLLARS AND NO CENTS ***

TO THE ORDER OF
Sample Company
1234 MAIN STREET
OMAHA, NE 68135

AUTHORIZED SIGNATURE

DUPLICATE

Employer Remittance Summary

This is a summary of the premiums we have remitted via ACH. Similar to the remittance check, this will show how much we have withheld for subsidy payments and administration fees. The Net Premium Remittance is the amount that we have deposited.

Note: This Net Premium Remittance can be a negative amount. This could happen if we have to refund previously remitted premium dollars and administration fees (for ex., a participant's check doesn't clear due to insufficient funds). If the total refunds exceed the premium due for the month, then this will net to a negative amount. If the Transfer Destination is set up for ACH, this amount will be withdrawn from the bank account of record.

Premium Remittance Summary

PayFlex

PayFlex Systems USA, Inc.
DIRECT BILLING DEPARTMENT
P.O. BOX 2239
OMAHA, NE 68103-2239

Employer: 116128 - Sample Company **Remittance Date:** 12/15/2009

Premium remittance details will be sent separately.

Gross Premiums:	**$145.00**
Client Directed Participant Specific Subsidy Applied:	**$0.00**
Administration Fees:	**$0.00**
Net Premium Remittance:	**$145.00**

IMPORTANT: The amount shown as the Net Premium Remittance will be deposited into your bank account of record within 2 business days.

Premium Remittance Register Report

The Premium Remittance Register Report gives you the detail for the premiums that we have sent.

The Coverage Information gives you the detail by Carrier. For each carrier, the report provides detail for Plan Code, level of coverage and the payment period. If we're remitting premiums to multiple Transfer Destinations, the Consolidated Premium Remittance Register Report is created to consolidate all remittance activity for the collection cycle.

Employer Information:

Date Created	Transfer Destination	Employer Id	Employer
12/15/2009	Sample Company	116128	Sample Company
12/15/2009	Sample Company	116128	Sample Company

Participant Information:

Division	Member Number	Last Name	First Name	Middle Initial
West	987654320	SMITH	MATT	
West	987654320	SMITH	MATT	

Coverage Information:

Carrier	Plan Code	Coverage	Interval Paid	Premium Amount	...
ML	ML1	Employee Only	[01/01/2010-01/31/2010]	$45.00	...
UHC	UHC1	Employee Only	[01/01/2010-01/31/2010]	$100.00	...

...	Fee Amount	Subsidy Withheld	Transfer Amount	Fee Description
...	$0.00	$0.00	$45.00	
...	$0.00	$0.00	$100.00	

ARRA Report

The ARRA Report gives you the supporting detail for all ARRA-funded subsidies. For Specific Coverage Information, the report provides the detail by carrier (Ins Code). For each carrier, the report provides detail for Plan Code, level of coverage and the payment period. **Note**: This report is only for COBRA.

Employer Information:

Employer Name
Sample Company
Sample Company

Participant Information:

Division	Code 941	PQB SSN	Employee ID	Last Name	First Name
West	ABC	000000000	000000000	SMITH	JOHN
West	ABC	000000000	000000000	SMITH	JOHN

Event Information:

Event Type	ARRA Start Date
Reduced Hours	1/1/2010
Reduced Hours	1/1/2010

Coverage Information:

Ins Code	Plan Code	Description	Coverage Level	...
HUMANA: HUMANA	HUMANA:DENPREM	Humana Dental Premier	SINGLE ONLY	...
HUMANA: HUMANA	HUMANA:PREMIER	Humana Medical Premier	SINGLE ONLY	...

...	Paid Date	Voided Payment	Void Date	Coverage Period Begin	Coverage Period End	Participant Premium Amt
...	2/3/2010			1/1/2010	1/31/2010	$10.95
...	2/3/2010			1/1/2010	1/31/2010	$198.44

Subsidy Information:

Company Paid Subsidy Amt	Admin Fee	Stimulus Amt For 941 Filing	Total Premium WO 2 Percent
$0.00	$0.61	$20.33	$30.67
$0.00	$11.12	$368.52	$555.84

Periodic Status Reports

PayFlex has a number of other standard reports. You can receive these on a periodic basis of your choosing. You can also run these reports on demand. The periodic frequencies you can choose from are:

- **Daily** – Delivered daily
- **Weekly** – Delivered on Sunday for the previous seven day period (Sunday – Saturday)
- **Monthly** – Delivered on the first day of the month for the previous calendar month
- **Quarterly** – Delivered on the first day of each quarter for the previous calendar quarter
- **Annually** – Delivered on the first day of the year based on the employer's service effective date

As with all of PayFlex's reports, we'll send an e-mail to your Reporting contacts and deliver the reports to the Employer Portal.

E-mailed reports come from reporting@payflex.com.

Age Attainment Report

The Age Attainment Report will list all participants and dependents, enrolled in a benefit, which are near the age limit for that benefit. You or the enrolled member will have to take appropriate action.

Each Age Attainment Report covers a period of approximately five weeks. The member will first appear on this report 60 days prior to when he or she will reach the age limit. That person will stay on the report for 90 days.

Employer Information:

Employer Id	Employer	Created
116128	Sample Company	10/01/2009
116128	Sample Company	10/01/2009

Participant Information:

Division	Member Number	Participant First Name	Participant Last Name	Participant Age Today	Participant DOB
Nebraska	987654320	MATT	SMITH	65	09/30/1944
Maryland	987654321	JOE	JONES		

Coverage Information:

Benefit
Medical Pre 65 PPO
Medical Pre 65 PPO

Dependent Information:

Dependent First Name	Dependent Last Name	Dependent Age Today	Dependent DOB
JOYCE	JONES	64	10/27/1944

Census Report

The Census Report details the coverage for each participant and dependent that we are billing.

Employer & Service Information:

Employer Id	Employer Name	Service Type
111111	Sample Company	Direct Billing
111111	Sample Company	Direct Billing
111111	Sample Company	Direct Billing
111111	Sample Company	Direct Billing
111111	Sample Company	Direct Billing
111111	Sample Company	Direct Billing

Participant Information:

Participant Id	Member Number	SSN	Last Name	First Name	Middle Initial	...
12345	000000000	000000000	SMITH	JOHN		...
12345	000000000	000000000	SMITH	JOHN		...
12345	000000000	000000000	SMITH	JOHN		...
12345	000000000	000000000	SMITH	JOHN		...
12345	000000000	000000000	SMITH	JOHN		...
12345	000000000	000000000	SMITH	JOHN		...

...	Category	Division	DOB	Gender	Status	Term Date	...
...	Default		06/14/1943		ENROLLED		...
...	Default		06/14/1943		ENROLLED		...
...	Default		06/14/1943		ENROLLED		...
...	Default		06/14/1943		ENROLLED		...
...	Default		06/14/1943		ENROLLED		...
...	Default		06/14/1943		ENROLLED		...

...	Address 1	Address 2	City	State	Zip	...
...	123 MAIN ST		OMAHA	NE	68105	...
...	124 MAIN ST		OMAHA	NE	68105	...
...	125 MAIN ST		OMAHA	NE	68105	...
...	126 MAIN ST		OMAHA	NE	68105	...
...	127 MAIN ST		OMAHA	NE	68105	...
...	128 MAIN ST		OMAHA	NE	68105	...

...	Country	Phone	Enrolled Date	Hire Date	Last Paid Date	Paid Through Date
...	US		09/01/2009		02/08/2010	02/28/2010
...	US		09/01/2009		02/08/2010	02/28/2010
...	US		09/01/2009		02/08/2010	02/28/2010
...	US		09/01/2009		02/08/2010	02/28/2010
...	US		09/01/2009		02/08/2010	02/28/2010
...	US		09/01/2009		02/08/2010	02/28/2010

Employee Information if the Participant is/was not the Employee:

Employee Member Number	Employee First Name	Employee Middle Initial	Employee Last Name

Coverage Information:

Participant Benefit Id	Carrier	Benefit Type	Original Benefit Start Date	Benefit Code	Carrier Plan Code	Policy Number	...
560266	BCBSOK	MED		483100-0014	483100-0014		...
560266	BCBSOK	MED		483100-0014	483100-0014		...
560268	BCBSOK	RX		483103-3002	483103-3002		...
560268	BCBSOK	RX		483103-3002	483103-3002		...
560270	DELTA	DEN		5900-3301	5900-3301		...
560270	DELTA	DEN		5900-3301	5900-3301		...

...	Benefit Description	Coverage Level Code	Coverage Level Description
...	HSC Main BCBS Medicare Supplement	2	Retiree + Spouse
...	HSC Main BCBS Medicare Supplement	2	Retiree + Spouse
...	HSC Medicare Part D	5	Retiree + Spouse
...	HSC Medicare Part D	5	Retiree + Spouse
...	Basic Dental HSC	2	Retiree + Spouse
...	Basic Dental HSC	2	Retiree + Spouse

...	Coverage Start Date	Coverage End Date	Billing Start Date	Coverage Amount	Coverage Premium	...
...	09/01/2009		09/01/2009		$600.07	...
...	09/01/2009		09/01/2009		$600.07	...
...	09/01/2009		09/01/2009		$260.40	...
...	09/01/2009		09/01/2009		$260.40	...
...	09/01/2009		09/01/2009		$55.32	...
...	09/01/2009		09/01/2009		$55.32	...

...	General Subsidy Amount	General Subsidy Amount Interval	...
...	$300.04	[01/01/2010-12/31/2010]	...
...	$300.04	[01/01/2010-12/31/2010]	...
...	$130.20	[01/01/2010-12/31/2010]	...
...	$130.20	[01/01/2010-12/31/2010]	...
...	$16.82	[01/01/2010-12/31/2010]	...
...	$16.82	[01/01/2010-12/31/2010]	...

...	Participant Amount	Next Premium Due Date	Payments Remitted To Date
...	$0.00	03/01/2010	$1,697.54
...	$0.00	03/01/2010	$1,697.54
...	$0.00	03/01/2010	$781.20
...	$0.00	03/01/2010	$781.20
...	$18.18	03/01/2010	$217.00
...	$18.18	03/01/2010	$217.00

Dependent Information:

Dependent Id	Dependent Member Number	Relation	Relation Description	Dependent Last Name	Dependent First Name	...
						...
123	000000000	SPOUSE	Spouse	SMITH	MARY	...
						...
123	000000000	SPOUSE	Spouse	SMITH	MARY	...
						...
123	000000000	SPOUSE	Spouse	SMITH	MARY	...

...	Dependent Middle Initial	Dependent SSN	Dependent DOB	Dependent Gender	Full Time Student	Handicapped
...						
...		000000000	1/1/1970	F	false	false
...						
...		000000000	1/1/1970	F	false	false
...						
...		000000000	1/1/1970	F	false	false

Dependent Coverage Information:

Dependent Benefit Id	Dependent Coverage Start Date	Dependent Coverage End Date
1370	09/01/2009	
1366	09/01/2009	
1368	09/01/2009	

Deficient Payment Report

Sometimes, members send in partial payments. The Deficient Payment Report identifies those partial payments for the reporting period. This report will show the premium amount due; how much the member paid; and the balance still due.

Employer Information:

Employer Id	Employer Name	Date Created
116128	Sample Company	11/01/2009
116128	Sample Company	11/01/2009

Participant Information:

Level (Sub Group-Benefit Group)	Member Number	Last Name, First Name	Paid Through Date	Premium Amount Due	Amount Paid	Amount Owed
Maryland	987654321	JONES, JOE		$1,398.26	$459.20	$939.06
Nebraska	987654320	SMITH, MATT	09/30/2008	$1,398.26	$28.08	$1,370.18

Participant Amount Billed Report

The Participant Amount Billed Report is for our clients who use statements instead of coupon. The report will list all the benefits that we have billed for the reporting period.

Employer Information:

Created	Employer Id	Employer
11/08/2009	116128	Sample Company
11/08/2009	116128	Sample Company
11/08/2009	116128	Sample Company
11/08/2009	116128	Sample Company

Participant Information:

Division	Participant Id	Member Number	Last Name	First Name	Birthdate
Nebraska	82228	987654320	SMITH	MATT	09/30/1944
Nebraska	82228	987654320	SMITH	MATT	09/30/1944
Maryland	103562	987654321	JONES	JOE	09/09/1938
Maryland	103562	987654321	JONES	JOE	09/09/1938

Coverage Information:

Carrier	Plan Code	Benefit Type	Description	Coverage Level	...
Humana	HUMDEN	DEN	Humana Dental Standard Plan	Retiree+Family	...
Blue Cross Blue Shield	BCBSMED	MED	BCBS Medical Plan	Retiree+Family	...
Humana	HUMDEN	DEN	Humana Dental Standard Plan	Retiree Only	...
Humana	HUMMED	MED	Humana Medical Plan	Retiree Only	...

...	Effective	Expiration	Entered	Amount	Transaction Type
...	07/01/2009	07/31/2009	11/02/2009	$10.07	Premium
...	07/01/2009	07/31/2009	11/02/2009	$96.27	Premium
...	10/01/2009	10/31/2009	11/02/2009	$22.84	Premium
...	11/01/2009	11/30/2009	11/02/2009	$101.16	Premium

Participant Paid Thru Report

The Participant Paid Thru Report details the paid through dates for all participants.

Employer Information:

Date Created	Employer Id	Employer Name
11/08/2009	116128	Sample Company
11/08/2009	116128	Sample Company

Participant Information:

Division Code	Member Number	First Name	Last Name	Status	Status Effective	Paid Thru Date
Nebraska	987654320	SMITH	MATT	Enrolled	10/01/2009	12/31/2009
Maryland	987654321	JONES	JOE	Enrolled	10/12/2009	

Coverage Information:

Earliest Unsatisfied Premium Interval	Grace Period End Date of Earliest Unsatisfied Premium	Billing Start Date	Last Payment Received	Last Payment Postmark
		10/01/2009	10/27/2009	10/25/2009
[12/01/2009-12/31/2009]	12/13/2009	10/12/2009		

Participant Payments and Refunds Report

The Participant Payments and Refunds Report details all cash activity on participants' accounts. The report will show payments made for coverage, any refunds, and returns for insufficient funds.

Employer Information:

Employer Id	Employer Name	Date Created
116128	Sample Company	11/01/2009
116128	Sample Company	11/01/2009
116128	Sample Company	11/01/2009
116128	Sample Company	11/01/2009

Participant Information:

Level/Division Code	Member Number	Last Name	First Name
Nebraska	987654320	SMITH	MATT
Maryland	987654321	JONES	JOE
Maryland	987654322	MILLER	JOHN
Maryland	987654323	JOHNSON	PETER

Transaction Information:

Received	Entered	Postmark	Transaction Type	Payment Type	Amount	Void Reason
10/31/2009	10/31/2009	10/28/2009	Payment	EFT	$159.15	
10/31/2009	10/31/2009	10/28/2009	Payment	Check	$220.00	
	10/31/2009		Refund	Check	($220.00)	
	10/31/2009		Void	EFT	($129.00)	Insufficient Funds

Plan and Rate Report

When we enter rates into our benefits administration system, we'll ask you to confirm them. This report will show you those rates. A member of the PayFlex Implementation Team or your Account Manager will ask you to sign off on this report. **Note**: The Surcharge Percent and Surcharge Amount columns are only for COBRA.

Employer & Carrier Information:

Date Created	Employer Id	Employer Name	As of	Carrier Code	Carrier Description
10/16/2009	116128	Sample Company	10/16/2009	HUM	Humana
10/16/2009	116128	Sample Company	10/16/2009	HUM	Humana
10/16/2009	116128	Sample Company	10/16/2009	BCBS	Blue Cross Blue Shield
10/16/2009	116128	Sample Company	10/16/2009	BCBS	Blue Cross Blue Shield
10/16/2009	116128	Sample Company	10/16/2009	HUM	Humana
10/16/2009	116128	Sample Company	10/16/2009	HUM	Humana

Plan Information:

Benefit Effective Date	Benefit Expiration Date	Benefit Type	Benefit Code	Carrier Benefit Code	Description
10/01/2009		Medical	MED_HUM	MED_HUM	Humana Medical Plan
10/01/2009		Medical	MED_HUM	MED_HUM	Humana Medical Plan
10/01/2009		Medical	MED_BCBS	MED_BCBS	BCBS Medical Plan
10/01/2009		Medical	MED_BCBS	MED_BCBS	BCBS Medical Plan
10/01/2009		Dental	DEN_HUM_ST	DEN_HUM_ST	Humana Dental Standard Plan
10/01/2009		Dental	DEN_HUM_ST	DEN_HUM_ST	Humana Dental Standard Plan

Coverage Level Information:

Coverage Code	Coverage	Coverage Enrollment Eligible	Coverage Hierarchy
1	Retiree Only	Participant Only	1
2	Retiree+Family	Participant and Dependent(s)	2
1	Retiree Only	Participant Only	1
2	Retiree+Family	Participant and Dependent(s)	2
1	Retiree Only	Participant Only	1
2	Retiree+Family	Participant and Dependent(s)	2

Rate Table Parameters:

Rate Table Effective Date	Rate Table Expiration Date	Participant Gender	Participant Starting Age	Spouse/Domestic Partner Starting Age
01/01/2010				
01/01/2010				
01/01/2010				
01/01/2010				
01/01/2010				
01/01/2010				

Rate & Fee Information:

Rate Format	Rate	Fee Percent	Fee Amount	Surcharge Percent	Surcharge Amount	Total
DOLLAR_AMOUNT	$296.02					$296.02
DOLLAR_AMOUNT	$858.43					$858.43
DOLLAR_AMOUNT	$274.69					$274.69
DOLLAR_AMOUNT	$796.62					$796.62
DOLLAR_AMOUNT	$26.88					$26.88
DOLLAR_AMOUNT	$76.81					$76.81

Address Update Report

When we update a participant's address, that information will appear in the Address Update Report.

Employer & Service Information:

Employer ID	Employer Name	Service Type
116128	Sample Company	COBRA
116128	Sample Company	COBRA

Participant Information:

Participant ID	Member Number	First Name	Last Name	Division	...
927440	987654320	MATT	SMITH		...
1087184	987654321	JOE	JONES		...

...	Residential Address 1	Residential Address 2	Residential City	Residential State	Residential Country	Residential Zip Code	...
...	123 MAIN STREET		OMAHA	NEBRASKA	UNITED STATES	68105	...
...	987 DODGE STREET		OMAHA	NEBRASKA	UNITED STATES	68105	...

...	Mailing Address 1	Mailing Address 2	Mailing City	Mailing State	Mailing Country	Mailing Zip Code
...						
...						

COBRA Audit Report

The COBRA Audit Report tells you who has become eligible for, and who has enrolled in, COBRA. Participants in the following statuses for the reporting period will be on this report. **Note**: This report is only for COBRA.

- New Add Pending Enrollment
- Pending Enrollment
- Enrolled
- SSD
- State Extension
- Runout

Employer Information:

Date Created	Employer ID	Employer Name
7/2/2012	116128	Sample Company
7/2/2012	116128	Sample Company

Participant Information:

Participant ID	Member Number	SSN	Last Name	First Name	Middle Initial	Division	Status
927440	987654320	987654320	SMITH	MATT			COBRA Enrolled
1087184	987654321	987654321	JONES	JOE			COBRA Enrolled

Event Information:

Qualifying Event Code	Qualifying Event Description	Qualifying Event Date	Qualifying Event Received	Qualifying Event Notification	Election Form Received
Termination of Employment	Termination	2/10/2011	5/2/2011		4/14/2011
Termination of Employment	Termination	2/17/2011	5/2/2011		4/4/2011

Coverage Information:

Carrier	Benefit Type	Benefit Code	Carrier Plan Code	Policy Number	Benefit Description	...
DELTA	DEN	DELPPO	DELPPO	005508	Delta Dental PPO Dental Plan	...
EYEMED	VIS	STPVS2	STPVS2		EyeMed Enhanced Vision Plan	...

...	Coverage Level Code	Coverage Level Description	Coverage Start Date	Billing Start Date	Coverage End Date	...
...	A	Single	7/1/2011	7/1/2011	8/10/2012	...
...	C	Single plus Spouse	7/1/2011	7/1/2011	8/17/2012	...

...	Coverage Amount	Coverage Premium	General Subsidy Amount	General Subsidy Amount Interval	...
...		$30.00			...
...		$15.00			...

...	ARRA Subsidy	ARRA Subsidy	ARRA Subsidy	Participant	...

	Amount	Amount Effective	Amount Expiration	Amount	
...				$30.00	...
...				$15.00	...

...	COBRA Effective	COBRA Expiration	COBRA Months	HCTC	ARRA Eligible	ARRA Awarded	ARRA Denied
...	2/11/2011	8/10/2012	18	FALSE	FALSE	FALSE	
...	2/18/2011	8/17/2012	18	FALSE	FALSE	FALSE	

Employer Census Summary Report

The Employer Census Summary Report shows total counts by status. Statuses are summarized into Pending, Enrolled and Terminated. The report will give you this information for each plan, at the level of coverage.

Employer Information:

Date Created	Employer ID	Employer Name	Division
7/2/2012	116128	Sample Company	
7/2/2012	116128	Sample Company	

Coverage Information:

Carrier Name	Plan Code	Plan Description	Status	Coverage Level	Count
DELTA	DELPPO	Delta Dental PPO Dental Plan	Enrolled	Single	1
EYEMED	STPVS2	EyeMed Enhanced Vision Plan	Enrolled	Single plus Spouse	1

Termination Detail Report

The Termination Detail Report shows who has terminated COBRA coverage. **Note**: This report is only for COBRA.

Employer Information:

Date Created	Reporting Period	Employer ID	Employer Name
7/2/2012	[05/01/2012-05/31/2012]	116128	Sample Company
7/2/2012	[05/01/2012-05/31/2012]	116128	Sample Company

Participant Information:

Division	Member Number	Last Name	First Name	Termination Date	Paid Through Date
	987654320	SMITH	MATT	5/1/2012	4/30/2012
	987654321	JONES	JOE	5/17/2012	5/16/2012

Detailed PTD Report

The Detailed PTD Report gives you information on the Paid through Date (PTD) for each participant.

Employer Information:

Date Created	Employer ID	Employer Name
7/2/2012	116128	Sample Company
7/2/2012	116128	Sample Company

Participant Information:

Category	Member Number	SSN	First Name	Last Name	Division	Status	Status Effective Date
LOA	987654320	987654320	SMITH	MATT	Nebraska	Enrolled	10/1/2009
LOA	987654321	987654321	JONES	JOE	Maryland	Enrolled	10/1/2009

Coverage Information:

Benefit Code	Carrier Plan Code	Benefit Description	Coverage Level Code	Coverage Level Description	…
HUMDEN	HUMDEN	Humana Dental Standard Plan	1	Single	…
BCBSMED	BCBSMED	BCBC Medical Plan	4	Family	…

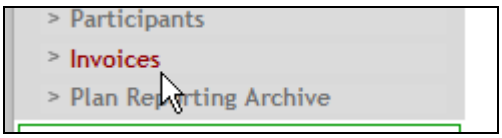
…	Coverage Start Date	Coverage End Date	Billing Start Date	Coverage Amount	Coverage Premium	…
…	10/1/2009		10/1/2009		$23.00	…
…	10/1/2009		10/1/2009		$97.00	…

…	Next Premium Due Date	Paid Thru Date	Earliest Unsatisfied Premium Interval	Grace Period End Date of Earliest Unsatisfied Premium Interval	…
…		12/31/2009			…
…	12/1/2009	11/30/2009	[12/01/2009-12/31/2009]	12/31/2009	…

…	Last Payment Received	Last Payment Postmark	Payment Amount	Payments Received To Date
…	10/27/2009	10/25/2009	$69.00	$69.00
…	11/1/2009	10/28/2009	$97.00	$194.00

Administration Invoices

We bill for services in arrears. For example, December's invoice will be for November activity. We calculate invoices on the first of the month and make them available on the Employer Portal around the fifth of the month. You can download the invoice, along with any supporting detail, under the Invoices tab.



You'll receive notifications regarding your invoices from accounting@payflex.com.

Invoice

The Invoice has a line item for each of the Administration Fees that we charge.

Invoice for Services 06/01/2012 To 06/30/2012

Description	Base Fee	Rate	Quantity	Total
Per Qualifying Event	$0.00	$15.50	512	$7,936.00
Per Termination Notice	$0.00	$3.50	55	$192.50
Per Initial Notice	$0.00	$3.50	208	$728.00
Subtotal				**$8,856.50**
Open Enrollment Packet (535 @ 15.00 a piece)				$8,025.00
Open Enrollment Postage (535 @ 1.50 a piece)				$802.50
Total Due				**$17,684.00**

The following reports all provide supporting detail for the invoice.

Active Participant Invoice Detail Report

This report is the supporting detail for the Per Participant Rate on the invoice.

Employer Information:

Date Created	Billing Period	Employer ID	Employer Name
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company

Participant Information:

Division	Participant Category	Member Number	Last Name	First Name	Birth Day
Nebraska	Retiree	987654320	SMITH	MATT	09/28/1946
Maryland	Retiree	987654321	JONES	JOE	02/28/1920

Document Billing Detail Report

This report is the supporting detail for the Per Document Type Rate on the invoice.

Employer Information:

Date Created	Billing Period	Employer ID	Employer Name
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company

Participant Information:

Division	Member Number	Last Name	First Name	Document Type	Created
Nebraska	987654320	SMITH	MATT	Participant Medicare Letter	11/16/2009
Maryland	987654321	JONES	JOE	Participant Medicare Letter	11/12/2009

Initial Notice Billing Detail

This report is the supporting detail for the Per Initial Notice Rate on the invoice. **Note**: This report is only for COBRA.

Employer Information:

Date Created	Billing Period	Employer ID	Employer Name
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company

Participant Information:

Division	Member Number	Last Name	First Name	Print Date
Nebraska	987654320	SMITH	MATT	11/05/2009
Maryland	987654321	JONES	JOE	11/01/2009

Qualifying Event Billing Detail

This report is the supporting detail for the Per Qualifying Event Rate on the invoice. **Note**: This report is only for COBRA.

Employer Information:

Date Created	Billing Period	Employer ID	Employer Name
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company
12/10/2009	[11/01/2009-11/30/2009]	116128	Sample Company

Participant Information:

Division	Member Number	Last Name	First Name
Nebraska	987654320	SMITH	MATT
Maryland	987654321	JONES	JOE

Event Information:

Event Type	Event Date	Date Notified	Election Ends	Days to Elect	COBRA Months
Termination	10/25/2009	11/15/2009	01/14/2010	35	18
Reduction in Hours	11/20/2009	11/17/2009	01/19/2010	40	3

Termination Invoice Detail Report

This report is the supporting detail for the Per Termination Notice Rate on the invoice.

Employer Information:

Date Created	Billing Period	Employer ID	Employer Name
12/01/2009	[11/01/2009-11/30/2009]	116128	Sample Company
12/01/2009	[11/01/2009-11/30/2009]	116128	Sample Company

Participant Information:

Division	Member Number	Last Name	First Name
Nebraska	987654320	SMITH	MATT
Maryland	987654321	JONES	JOE

Event Information:

Termination Date	Paid Through Date
10/16/2009	10/15/2009
10/21/2009	10/20/2009

Employer Reporting Guide

Updated August, 2012

00.05.100.1

Table of Contents

Standard Report Types

We offer a number of reports for employers to manage the accounting of their plans administered by PayFlex. Following is an overview of these reports as well as examples of these reports.

Scheduled Reports

These reports run on a regularly scheduled basis. You set the schedule.

Once these are set up, we will create and delivers the reports to the designated contact (see page 5 for details). Usually, we deliver them by e-mail. However, we may be able to deliver by fax or through the Website.

Here is a list of the available reports.

- **Ledger Summary Report** – For each participant, provides year to date deposits; amounts paid out; current cash balance; and the annual election. This is a monthly report.

  Please review this report for discrepancies. If you find any please notify us immediately. You should give special attention to the "Status" column, which identifies termed employees. In addition, review the "YTD Deposits" column, as this should agree with payroll deductions. You are responsible for reporting and reconciling any discrepancies.

- **Debit Card Transaction Register Report** – For each participant, shows all debit card activity on each participant's debit card for a specified period. You set the frequency.
- **Employer Funding Summary Report** – Shows a summary of the funding requests for a specified period. You set the frequency.
- **Employer Funding Detail Report** – For each participant, shows funding requests for a specified period. You set the frequency.
- **Production Deposit Register Report** – Shows the deposits posted to participant accounts for a specified period. You set the frequency.

Automated Reports

We send these reports as claims and debit card settlement occur. We send the HSA Deposit Register report daily as we post funds every day.

- **Production Payment Register Report** – Shows the payments made to participants for paper or web claims.
- **Settlement Payment Register Report** – Shows the settlement activity on participants' card accounts.
- **HSA Deposit Register Report** – Shows the deposits made to each employee's HSA.

On Demand Reports

You can request reports through the Employer Portal. Once logged into the portal click on the "On Demand Reports" link on the left side of the web page. You can request most of these reports in PDF, CSV or both.

The following reports are available via On Demand.

- Election Report
- Ledger Summary Report
- Employer Funding Summary Report
- Employer Funding Detail Report

When you request an "On Demand Report", you will receive an e-mail stating the report is available for download. This e-mail will go to the requester's email address (the email address used to log in to the Employer Portal). Once available, you can get to the report by clicking the "Plan Reporting Archive" link on the left side of the web page.

Sample Email Notification:

From: reporting@payflex.com
Subject: Requested PayFlex Report is Available

The report you have requested (Ledger Summary) is available to download on the Employer Portal.

To retrieve your report:
1. Go to our Employer Portal at PayFlexDirect.com/employer
2. Log in and go to the Plan Reporting Archive

Thank you,
PayFlex Systems USA, Inc.

Reports Distribution

Reports by Role

You have assigned roles to members of your organization. These roles determine who can get which report. The following is a list of the scheduled and automated reports by Roles. These roles defined in the Employer Contacts on the New Client Checklist.

Role	Report Distribution
Billing	▪ Combined Invoice Reports for Distribution ▪ Invoice Roster Report
Funding	▪ Funding Notification Report ▪ Production Payment Register Report ▪ Settlement Payment Register Report ▪ HSA Deposit Register Report (if applicable) ▪ Employer Funding Summary Report (if requested) ▪ Employer Funding Detail Report (if requested) ▪ Debit Card Transaction Register Report
Eligibility	▪ Election Report* ▪ Payroll Schedule Report*
Reporting	▪ Ledger Summary Report ▪ Debit Card Transaction Report

* Not a scheduled report

Scheduled Report Samples

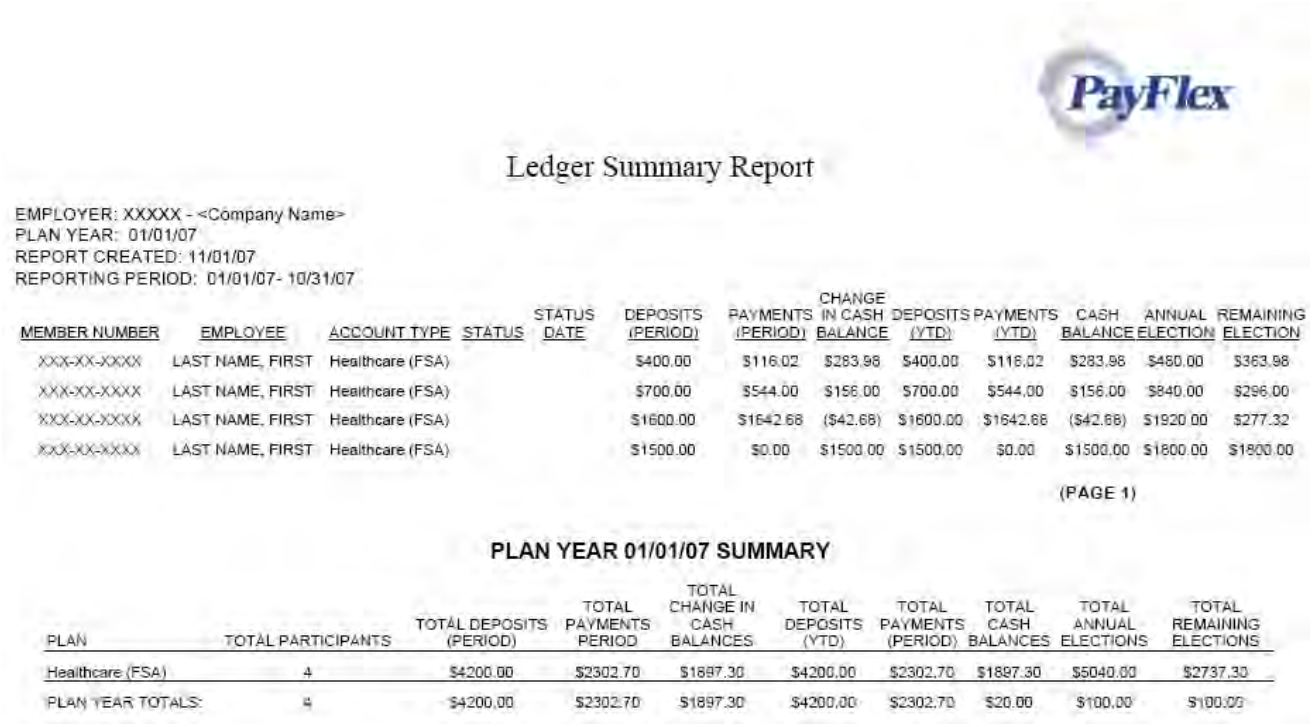
Ledger Summary Report

This report displays employee account balances. You can have these separated by division if needed. It summarizes by reporting period, year to date (YTD), and account type. For each of your employees in the FSA plan, it shows deposits, payments and balances.

Format: CSV and PDF

Note: For larger clients with multiple divisions, you will have to download the CSV format from the "Plan Reporting Archive" link on the Employer Portal.

Sample report (PDF Format)



PayFlex

Ledger Summary Report

EMPLOYER: XXXXX - <Company Name>
PLAN YEAR: 01/01/07
REPORT CREATED: 11/01/07
REPORTING PERIOD: 01/01/07- 10/31/07

MEMBER NUMBER	EMPLOYEE	ACCOUNT TYPE	STATUS	STATUS DATE	DEPOSITS (PERIOD)	PAYMENTS (PERIOD)	CHANGE IN CASH BALANCE	DEPOSITS (YTD)	PAYMENTS (YTD)	CASH BALANCE	ANNUAL ELECTION	REMAINING ELECTION
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$400.00	$116.02	$283.98	$400.00	$116.02	$283.98	$480.00	$363.98
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$700.00	$544.00	$156.00	$700.00	$544.00	$156.00	$840.00	$296.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$1600.00	$1642.68	($42.68)	$1600.00	$1642.68	($42.68)	$1920.00	$277.32
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)			$1500.00	$0.00	$1500.00	$1500.00	$0.00	$1500.00	$1800.00	$1800.00

(PAGE 1)

PLAN YEAR 01/01/07 SUMMARY

PLAN	TOTAL PARTICIPANTS	TOTAL DEPOSITS (PERIOD)	TOTAL PAYMENTS PERIOD	TOTAL CHANGE IN CASH BALANCES	TOTAL DEPOSITS (YTD)	TOTAL PAYMENTS (PERIOD)	TOTAL CASH BALANCES	TOTAL ANNUAL ELECTIONS	TOTAL REMAINING ELECTIONS
Healthcare (FSA)	4	$4200.00	$2302.70	$1897.30	$4200.00	$2302.70	$1897.30	$5040.00	$2737.30
PLAN YEAR TOTALS:	4	$4200.00	$2302.70	$1897.30	$4200.00	$2302.70	$20.00	$100.00	$100.00

Fields

Member Number	Employee	Account Type	Status	Status Date	Deposits (Period)	Payments (Period)	Change in Cash Balance	Deposits (YTD)	Payments (YTD)	*Cash Balance	Annual Election	Remaining Election
Internal code for the employee or SSN	Participant last and first name	Account in which activity occurred	Participant Status if termed, COBRA or LOA	Effective date of participant status	Deposits total for reporting period	Participant payments for reporting period	Change in account balance for reporting period	Year to date deposits amount	Year to date payments	Year to date deposits minus payments	Total annual election amount for the plan year	Total annual election minus YTD payments

* You can use the **Cash Balance** field to determine account forfeitures at the end of the plan year run out.

Debit Card Transaction Register Report

This report shows the debit card transactions and settlement activity for a specified period. The items will display in date order by effective date of the transaction.

Format: CSV

Effective	Settled	Authorized	Member Number	Last Name	First Name	Amount	Account Type	Merchant
3/29/2007	4/1/2007	3/29/2007	XXXXX8500	BRANNIG	TERRY	$50.00	Healthcare (FSA)	CVS PHARMACY #123456
3/30/2007	4/1/2007	3/30/2007	XXXXX8503	CHERON	TOM	$10.00	Healthcare (FSA)	WALGREEN #456789
3/30/2007	4/1/2007	3/30/2007	XXXXX8585	FLEMING	MARTHA	$55.29	Healthcare (FSA)	WALGREEN #987321
3/30/2007	4/1/2007	3/30/2007	XXXXX8599	MONROE	CHARLES	$9.00	Healthcare (FSA)	WALGREEN #123456
3/30/2007	4/3/2007	3/30/2007	XXXXX8588	SHERLING	JENNIFER	$5.76	Healthcare (FSA)	WAL MART #123456
3/30/2007	4/1/2007	3/30/2007	XXXXX8550	VOGT	GRACE	$7.37	Healthcare (FSA)	WAL MART #7778899
3/30/2007	4/1/2007	3/30/2007	XXXXX8586	WAGONER	HOWARD	$20.00	Healthcare (FSA)	WAL MART #123456
4/26/2007	4/28/2007	4/26/2007	XXXXX8598	BRANNIG	TERRY	$50.00	Healthcare (FSA)	WALGREEN #123456
4/26/2007	4/30/2007	4/26/2007	XXXXX8522	CHERON	TOM	$53.00	Healthcare (FSA)	TOTAL DENTAL CENTRE
4/26/2007	4/28/2007	4/26/2007	XXXXX8542	FLEMING	MARTHA	$7.75	Healthcare (FSA)	TOTAL DENTAL CENTRE
4/26/2007	4/28/2007	4/26/2007	XXXXX8599	MONROE	CHARLES	$10.00	Healthcare (FSA)	PRESTONS FOOD&DRUG
4/26/2007	4/28/2007	4/26/2007	XXXXX8503	SHERLING	JENNIFER	$5.00	Healthcare (FSA)	PRESTONS FOOD&DRUG

Fields

Effective	Settled	Authorized	Member Number	Last Name	First Name	Amount	Account Type	Merchant
Date of card swipe	Date of settlement	Date of merchant authorization	Internal code for the employee or SSN	Participant last name	Participant first name	Dollar amt. of transaction	Account in which activity occurred	Merchant and store number (if applicable)

Employer Funding Summary Report

This report summarizes the total employee account transactions by date, account type and funding type.

Format: CSV

Date Created	Reporting Period	Employer ID	Funding Date	Funding Type	Plan Year	Account Type	Amount
10/7/2008	[09/01/08-09/07/08]	10002	9/4/2008	Settlement	1/1/2008	Healthcare (FSA)	$513.24
10/7/2008	[09/01/08-09/07/08]	10002	9/5/2008	Settlement	1/1/2008	Healthcare (FSA)	$21.63
10/7/2008	[09/01/08-09/07/08]	10002	9/1/2008	Settlement	1/1/2008	Healthcare (FSA)	$78.54
10/7/2008	[09/01/08-09/07/08]	10002	9/4/2008	Production	1/1/2008	Healthcare (FSA)	$100.00
10/7/2008	[09/01/08-09/07/08]	10002	9/2/2008	Settlement	1/1/2008	Healthcare (FSA)	$84.30
10/7/2008	[09/01/08-09/07/08]	10002	9/6/2008	Settlement	1/1/2008	Healthcare (FSA)	$267.39
10/7/2008	[09/01/08-09/07/08]	10002	9/4/2008	Production	1/1/2008	Dependent Care	$335.63

Fields

Date Created	Reporting Period	Employer ID	Funding Date	Funding Type	Plan Year	Account Type	Amount
Date of the report	Date range covered in report	Internal number to identify employer	Date of funding request	**"Settlement"**- Debit card transactions or **"Production"** - paper claims	Plan year in which the activity occurred	Account in which activity occurred	Amount of the transaction

Employer Funding Detail Report

This is a detailed report of all the employee account transactions for a specified period.

Format: CSV

Date Created	Reporting Period	Employer ID	Division	Funding Date	Funding Type	Member Number	Last Name	First Name	Plan Year	Account Type	Transaction Type	Amount
10/7/2008	[09/01/08-09/08/08]	10002	100	9/1/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$25.00
10/7/2008	[09/01/08-09/08/08]	10002	700	9/1/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$8.54
10/7/2008	[09/01/08-09/08/08]	10002	900	9/1/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$45.00
10/7/2008	[09/01/08-09/08/08]	10002	100	9/2/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$15.00
10/7/2008	[09/01/08-09/08/08]	10002	100	9/2/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$50.95
10/7/2008	[09/01/08-09/08/08]	10002	700	9/2/2008	Settlement	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$18.35
10/7/2008	[09/01/08-09/08/08]	10002	100	9/4/2008	Production	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Dependent Care	Employee Account Payment	$38.46
10/7/2008	[09/01/08-09/08/08]	10002	100	9/4/2008	Production	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$25.00
10/7/2008	[09/01/08-09/08/08]	10002	100	9/4/2008	Production	XXX-XX-XXXX	LAST	FIRST	1/1/2008	Healthcare (FSA)	Employee Account Payment	$75.00

Fields

Date Created	Reporting Period	Employer ID	Division	Funding Date	Funding Type	Member Number	Last Name	First Name	Plan Year	Account Type	Transaction Type	Amount
Date of the report	Date range covered in report	Internal number to identify employer	Participant division or location if provided by employer	Date funding requested from employer	"Settlement"- Debit card transactions or "Production" - paper claims	Internal code for the employee or SSN	Participant last name	Participant first name	Plan year in which the activity occurred	Account in which activity occurred	This will always be **Employee account Payment**	Amount of the transaction

Deposit Summary Report

This report shows the deposit history for all employees in the plan, during the specified period.

Format: CSV

Created	Reporting Period	Employer ID	Employer	Division Code	Member Number	Last Name	First Name	MI	Plan Year	Account Type	Type	Date	Amount
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	10/31/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	1/31/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	2/15/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	2/28/07	$20.00
11/2/2007	[01/01/07-10/31/07	XXXXX	Company Name		XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	1/1/07	Healthcare (FSA)	Payroll Deduction	3/7/07	$20.00

Fields

Date Created	**Reporting Period**	**Employer ID**	**Employer**	**Division**	**Member Number**	**Last Name**	**First Name**	**MI**	**Plan Year**	**Account Type**	**Type**	**Date**	**Amount**
Date of the report	Date range covered in report	Internal number to identify employer	Employer Name	Participant division or location if provided by employer	Internal code for the employee or SSN	Participant last name	Participant first name	Participant Middle Initial	Plan year in which the activity occurred	Account in which activity occurred	Either **Payroll Deduction** or **Employer Contribution**	Deposit effective date	Amount of the transaction

Automated Report Samples

Production Payment Register Report

This report shows a detailed listing of all claims that PayFlex has processed and paid. This report provides the detail for the amount that we will ask you to fund for a specified period. This includes claims submitted by fax, mail and web (Express Claims).

Format: CSV and PDF

Sample report (CSV Format)

Plan Year	Account T	Division	Transactio	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	BRANNIG	TERRY		8793019	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	CHERON	TOM		8793025	7/26/2007	$24.50
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	FLEMING	MARTHA	M	8793033	7/26/2007	$162.40
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	MONROE	CHARLES		8793037	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		8793035	7/26/2007	$85.00
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	VOGT	GRACE		8793031	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	WAGONER	HOWARD		8793017	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	BRANNIG	TERRY		8793021	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	CHERON	TOM		8793015	7/26/2007	$76.92
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	FLEMING	MARTHA		8793023	7/26/2007	$192.30
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	MONROE	CHARLES		1.7E+07	7/26/2007	$75.00
1/1/2007	Dependent Care		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		8793027	7/26/2007	$192.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	VOGT	GRACE		8793039	7/26/2007	$100.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	WAGONER	HOWARD		8793027	7/26/2007	$418.36

Fields

Plan year	Account Type	Division	Transaction Type	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
Plan year in which the activity occurred	Account in which activity occurred	Participant division or location if provided by employer	**Employee account payment** or **adjustment**	Internal code for the employee or SSN	Participant last name	Participant first name	Participant middle initial	Internal code for payment	Date of payment	Payment amount

Production Payment Register Report

Sample report (PDF Format)

11/02/2007

<Company Name>
Production Payment Register Report

Plan Year: 01/01/06	MEMBER #	LAST NAME	FIRST NAME	MI	PMT #	PMT DATE	PMT AMT	TOTALS
Dependent Care								
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	2082236	01/12/07	$223.92	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	2082228	01/12/07	$90.00	
							EAP Total:	$313.92
Healthcare (FSA)							Dependent Care Total:	$313.92
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	2082234	01/12/07	$143.80	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16799701	01/12/07	$128.39	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16799700	01/12/07	$210.07	
							EAP Total:	$481.86
							Healthcare (FSA) Total:	$481.86
							Plan Year Total:	$795.78
Plan Year: 01/01/07								
Healthcare (FSA)								
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16888733	3/15/2007	$116.02	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16828268	2/7/2007	$126.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16836903	2/13/2007	$84.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16856836	2/23/2007	$214.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16856836	4/25/2007	$90.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	16888732	3/15/2007	$30.00	
							EAP Total:	$660.02
							Healthcare (FSA) Total:	$660.02
							Plan Year Total:	$660.02
NET AMOUNT FOR <Company Name>:								$1455.80

EMPLOYER SUMMARY

Plan Year: 01/01/06	Checks	Direct Deps	Payments	Voids	Adjustments	Net Amount
Dependent Care	$0.00	313.92	313.92	0.00	0.00	313.92
Healthcare (FSA)	$338.46	143.40	481.86	0.00	0.00	481.86
	338.46	457.32	795.78	0.00	0.00	795.78
Plan Year: 01/01/07						
Healthcare (FSA)	501.62	158.40	660.02	0.00	0.00	660.02
	501.62	158.40	660.02	0.00	0.00	660.02
Plan Year: ALL						
Dependent Care	$0.00	313.92	313.92	0.00	0.00	313.92
Healthcare (FSA)	840.08	301.80	1141.88	0.00	0.00	1141.88
	840.08	615.72	1455.80	0.00	0.00	1455.80

Settlement Payment Register Report

This report shows the debit card settlement activity by employee. It provides the detail for the amount that we will ask you to fund for a specified period.

Format: CSV and PDF

Sample report (CSV Format)

Plan Year	Account T	Division	Transactio	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	BRANNIG	TERRY		7624150	7/2/2007	$13.80
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	CHERON	TOM		7689332	7/6/2007	$439.92
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	FLEMING	MARTHA		7648434	7/3/2007	$12.14
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	MONROE	CHARLES		7674952	7/5/2007	$140.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		7675256	7/5/2007	$977.37
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	VOGT	GRACE	A	8136718	7/9/2007	$67.42
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	WAGONER	HOWARD		7622764	7/2/2007	$28.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	BRANNIG	TERRY		7696886	7/7/2007	$28.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	CHERON	TOM		7675798	7/5/2007	$28.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	FLEMING	MARTHA		7689636	7/6/2007	$10.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	MONROE	CHARLES		7618372	7/2/2007	$25.00
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	SHERLING	JENNIFER		7666516	7/5/2007	$297.62
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	VOGT	GRACE		8116992	7/8/2007	$34.34
1/1/2007	Healthcare (FSA)		Employee	XXX-XX-XXXX	WAGONER	HOWARD	M	7665266	7/5/2007	$75.00

Fields

Plan Year	Account Type	Division	Transaction	SSN	Last Name	First Name	Mi	Pmt #	Pmt Date	Pmt Amt
Plan year in which the activity occurred	Account in which activity occurred	Participant division or location if provided by employer	**Employee Account Payment**	Internal code for the employee or SSN	Participant last name	Participant first name	Participant middle initial	Internal code for payment	Date of card swipe	Payment amount

Settlement Payment Register Report

This is the same report on the previous page in PDF format.

Sample report (PDF Format)

10/25/2007

<Company Name>
Settlement Payment Register Report

Plan Year: 01/01/07	MEMBER #	LAST NAME	FIRST NAME	MI	PMT #	PMT DATE	PMT AMT	TOTALS
Healthcare (FSA)								
Employee Account Payment								
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919196	10/25/07	$3.67	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919186	10/25/07	$5.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919188	10/25/07	$10.00	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919190	10/25/07	$74.84	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919192	10/25/07	$57.86	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	13919194	10/25/07	$40.00	
							EAP Total:	$191.37
							Healthcare (FSA) Total:	$191.37
							Plan Year Total:	$191.37
NET AMOUNT for <Company Name>								$191.37

HSA Deposit Register Report

This report shows the HSA deposits, by employee, for the specified time period.

Format: CSV and PDF

Sample report (CSV Format)

Plan Year	Account Type	Division	Transaction Type	SSN	Last Name	First Name	Mi	Dep Date	Dep Amt
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$60.00
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$110.00
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	10/3/2008	$9.23
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	10/3/2008	$9.23
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	10/3/2008	$9.83
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$146.36
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$51.66
1/1/2008	Health Savings Account	<Name of Division>	Employee Account Deposit	XXX-XX-XXXX	LAST	FIRST	M	9/30/2008	$72.50

Fields

Plan year	Account Type	Division	Transaction Type	SSN	Last Name	First Name	MI	Dep Date	Dep Amt
Plan year in which the activity occurred	Account in which activity occurred	Participant division or location if provided by employer	**Employee account deposit** or **adjustment**	Internal code for the employee or SSN	Participant last name	Participant first name	Participant middle initial	Deposit effective date	Amount of deposit

Sample report (PDF Format)

<Company Name>
HSA Deposit Register Report

Plan Year: 01/01/08 / Health Savings Account / Employee Account Deposit	MEMBER #	LAST NAME	FIRST NAME	MI	DEP DATE	DEP AMT	TOTALS
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$76.93	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$145.46	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$192.31	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$115.39	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$192.31	
	XXX-XX-XXXX	LAST NAME	FIRST NAME	MI	9/30/2008	$69.24	
						EAD Total:	791.64
						Health Savings Account Total:	791.64
						Plan Year Total:	791.64

EMPLOYER SUMMARY

Plan Year: 01/01/08	Deductions	Contributions	Deposits	Adjustments	Net Amount
Health Savings Account	$791.64	$0.00	$791.64	0.00	$791.64
	$791.64	$0.00	$791.64	0.00	$791.64
Plan Year: ALL					
Health Savings Account	$791.64	$0.00	$791.64	0.00	$791.64
	$791.64	$0.00	$791.64	0.00	$791.64

Other Report Samples

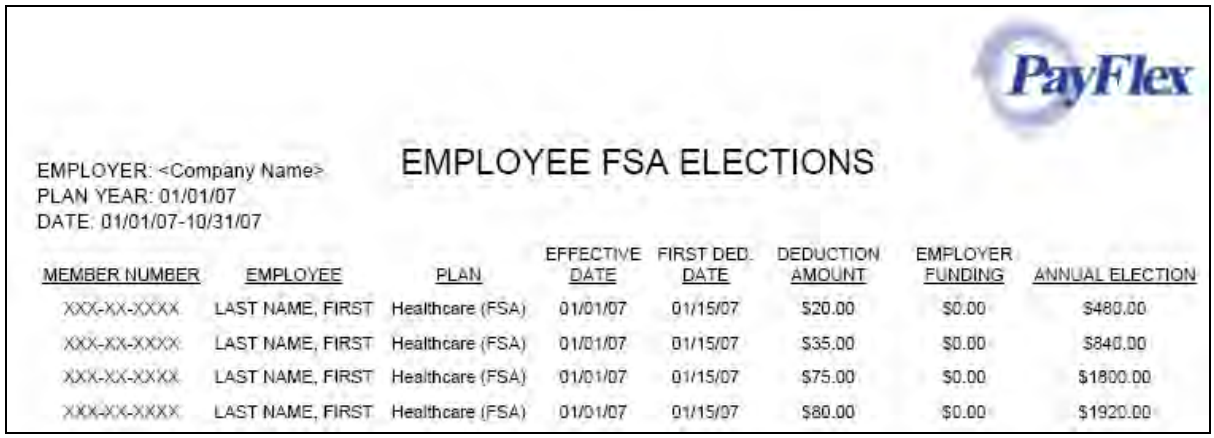
Election Report

This report shows employee elections for a given account. It also shows the scheduled payroll deduction amounts. The report also gives a summary of all elections for each account type in the plan.

Format: CSV and PDF

Report Body

This portion of the report shows election information for each employee in the plan.



EMPLOYER: <Company Name>
PLAN YEAR: 01/01/07
DATE: 01/01/07-10/31/07

EMPLOYEE FSA ELECTIONS

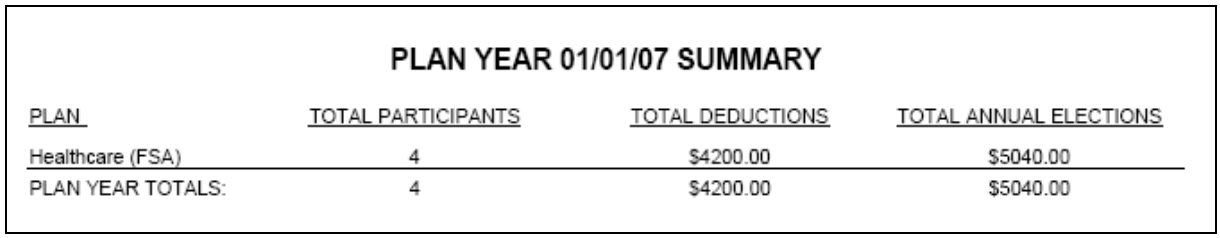
MEMBER NUMBER	EMPLOYEE	PLAN	EFFECTIVE DATE	FIRST DED. DATE	DEDUCTION AMOUNT	EMPLOYER FUNDING	ANNUAL ELECTION
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$20.00	$0.00	$480.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$35.00	$0.00	$840.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$75.00	$0.00	$1800.00
XXX-XX-XXXX	LAST NAME, FIRST	Healthcare (FSA)	01/01/07	01/15/07	$80.00	$0.00	$1920.00

Fields

Member Number	Employee	Plan	Effective Date	First Ded. Date	Deduction Amount	Employer Funding	Annual Election
Internal code for the employee or SSN	Participant last and first name	Account type	Date election begins	Date first deduction is scheduled to be taken	Amount of participant payroll deduction	Amount the employer adds, if any	Total annual election amount for the plan year

Report Summary

This section gives a summary of the election information for each account type.



PLAN YEAR 01/01/07 SUMMARY

PLAN	TOTAL PARTICIPANTS	TOTAL DEDUCTIONS	TOTAL ANNUAL ELECTIONS
Healthcare (FSA)	4	$4200.00	$5040.00
PLAN YEAR TOTALS:	4	$4200.00	$5040.00

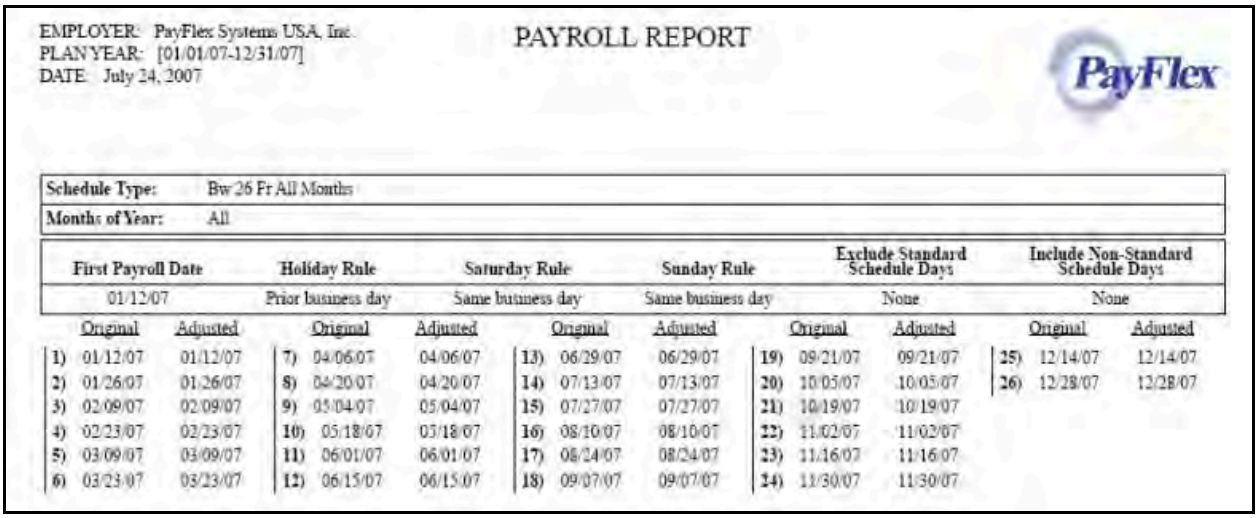
Fields

Plan	Total Participants	Total Deductions	Total Annual Elections
Account type	Number of participants in each plan type and the cumulative total in all plans	Total dollar amount of deductions for each plan type and cumulative total for all plans	Total dollar amount of annual elections for each plan type and cumulative total for all plans

Payroll Schedule Report

This report shows the payroll schedules by date for a specified plan year. This is based on the information that you provide.

Format: PDF



EMPLOYER: PayFlex Systems USA, Inc.
PLAN YEAR: [01/01/07-12/31/07]
DATE: July 24, 2007

PAYROLL REPORT

PayFlex

Schedule Type:	Bw 26 Fr All Months
Months of Year:	All

First Payroll Date	Holiday Rule	Saturday Rule	Sunday Rule	Exclude Standard Schedule Days	Include Non-Standard Schedule Days
01/12/07	Prior business day	Same business day	Same business day	None	None

	Original	Adjusted		Original	Adjusted		Original	Adjusted		Original	Adjusted		Original	Adjusted
1)	01/12/07	01/12/07	7)	04/06/07	04/06/07	13)	06/29/07	06/29/07	19)	09/21/07	09/21/07	25)	12/14/07	12/14/07
2)	01/26/07	01/26/07	8)	04/20/07	04/20/07	14)	07/13/07	07/13/07	20)	10/05/07	10/05/07	26)	12/28/07	12/28/07
3)	02/09/07	02/09/07	9)	05/04/07	05/04/07	15)	07/27/07	07/27/07	21)	10/19/07	10/19/07			
4)	02/23/07	02/23/07	10)	05/18/07	05/18/07	16)	08/10/07	08/10/07	22)	11/02/07	11/02/07			
5)	03/09/07	03/09/07	11)	06/01/07	06/01/07	17)	08/24/07	08/24/07	23)	11/16/07	11/16/07			
6)	03/23/07	03/23/07	12)	06/15/07	06/15/07	18)	09/07/07	09/07/07	24)	11/30/07	11/30/07			

Fields

Fields	Description
Original	Original payroll date before adjustment
Adjusted	Payroll date following adjustments such as Holiday Rule

Combined Invoice Report

This is a monthly report. It shows administrative fees for employee in the plan as well as run out employees. You can have it separated by division if needed.

Format: PDF

10802 Farnam Drive #100
Omaha, NE 68154
(P) (800) 284-4885
(F) (402) 231-4310
www.mypayflex.com

TO: Company Name
Attn: Billing Contact
Address 1
Address 2
City, State Zip

Date: mm/dd/yy
Invoice No: xxxxxx-xxxxx

RE: Month yyyy Administrative Service Fees

Administration Fees:		
Division Code - Division Description	(#particpants @ $Participant Rate)	$00.00
Division Code - Division Description	(#participants @ $Particpant Rate)	$00.00
Account Fee	#Total Participants @ $Participant Rate	$TOTAL DUE

Payment Terms: Net 10 Days

Please pay as invoiced. Any adjustments you wish to make must be supported by the appropriate documentation and adjustments will be reflected on a subsequent invoice.

PLEASE DETACH AND RETURN THE BELOW COUPON WITH PAYMENT

Remit to:

PayFlex Systems USA, Inc.
10802 Farnam Dr, Suite 100
Omaha, NE 68154

Client:	Client Name
Reference:	Month YYYY Administrative Service Fees
Invoice No:	xxxxxx-xxxxx
Total Due:	$00.00

Total Paid: _____

Client Name
Participant Roster
Invoice : xxxxxx-xxxxx

Description	Status	SSN	Name	Months	Rate	Total
Division Code- Division Description						
--- Account Fee (DepCare, HcFSA)					$0.00	
	PARTICIPATING	XXX-XX-XXXX	Last Name, First Name	1		$0.00

Total for Division Code – Division Description	Total	
Account Fee (DepCare- HcFSA)		
Add/Active Participants	1	$0.00
Retroactive Participants	0	$0.00
Runout Participants	0	$0.00
Termed Participants	1	N/A
Totals	1	$0.00

9th Annual Aetna HealthFund Study

Stephen Wyszomierski, Aetna Health Fund

Nancy Lusignan, Benefits Manager, Aetna

Dr. Greg Steinberg, Innovation Lab, Aetna

Aetna HealthFund Study Results

It's a fact: Consumer Directed Health Plans have proven to be much more than simply a way to control health care costs.

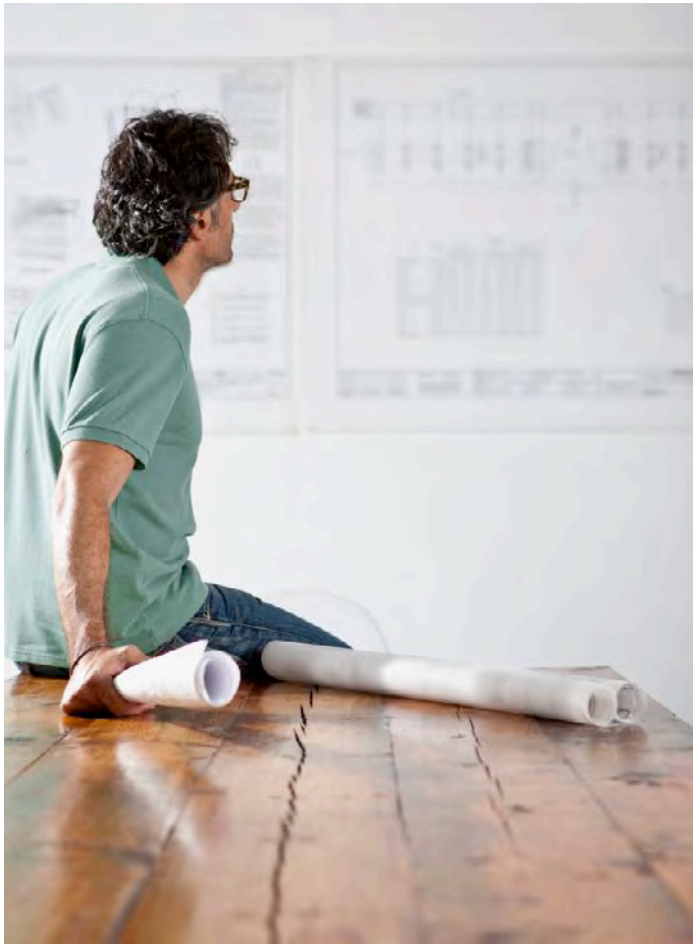
Discover how these plans can encourage your employees to:

- Make better use of preventive care services
- Become savvy health care consumers who comparison shop for high volume services like radiology and lab services
- See physicians and physician-specialists appropriately, and get recommended follow-up care
- Take steps to better manage their chronic illnesses

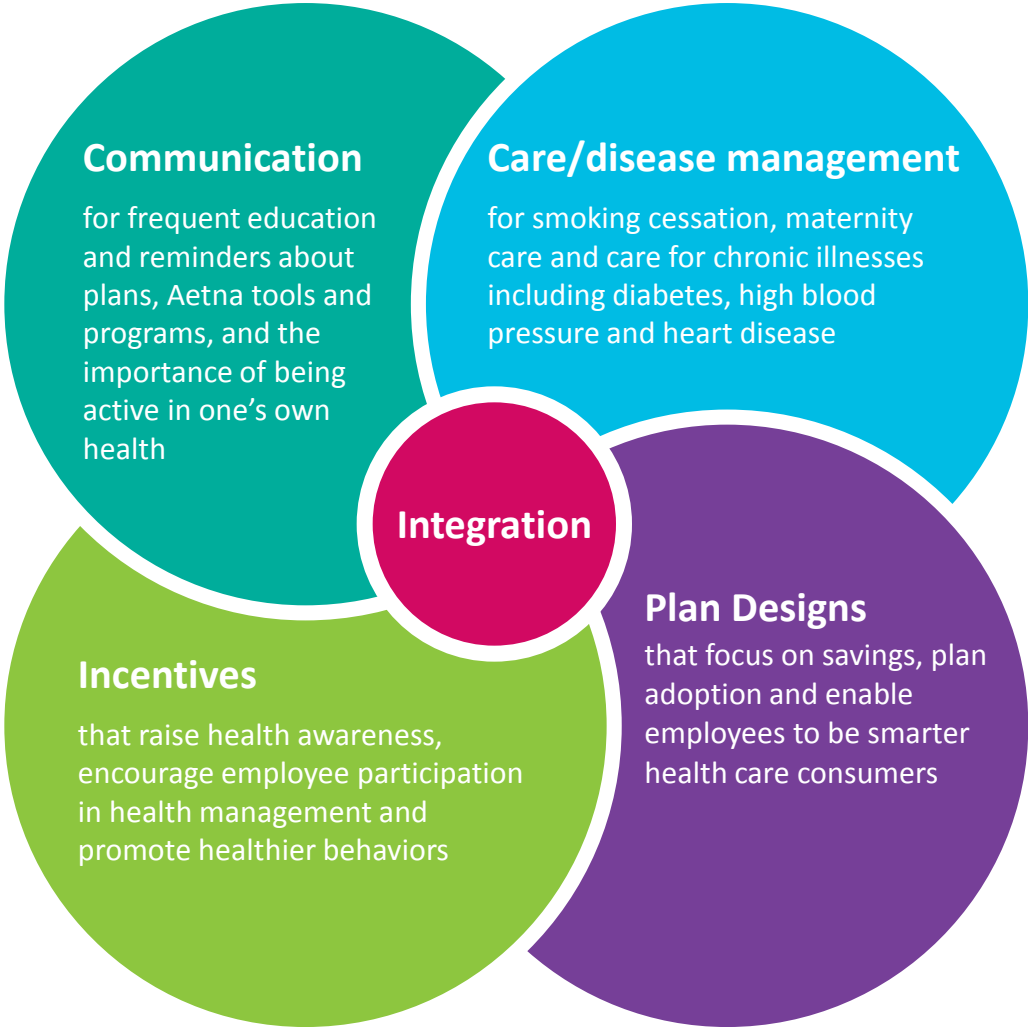
Draw on Aetna's experience to change the future of health care at your organization

As the first national insurer to offer CDHPs, Aetna continues to lead the way with:

- Programs to help control benefits costs *and* improve care quality, such as case management, disease management and patient education programs
- Convenient online tools and easy-to-understand information to enable employees make better-informed decisions about their health and financial wellbeing



Aetna's integrated approach to comprehensive plan management makes all the difference



Headline news

This year's "breaking news" headlines:

Plan sponsors **who implement comprehensive plan management strategies achieved savings through 40% lower trend,** compared to those who have not

AHF Members are up to 10% more likely to seek preventive care services, even with the Affordable Care Act mandates for all insured members

AHF Members use Aetna Tools to shop for lab, **choosing lower price providers and savings up to 3%**

Prior years' findings continue to be supported by this year's results

Full Replacement employers continue to save over $20M through 28% reduced trends

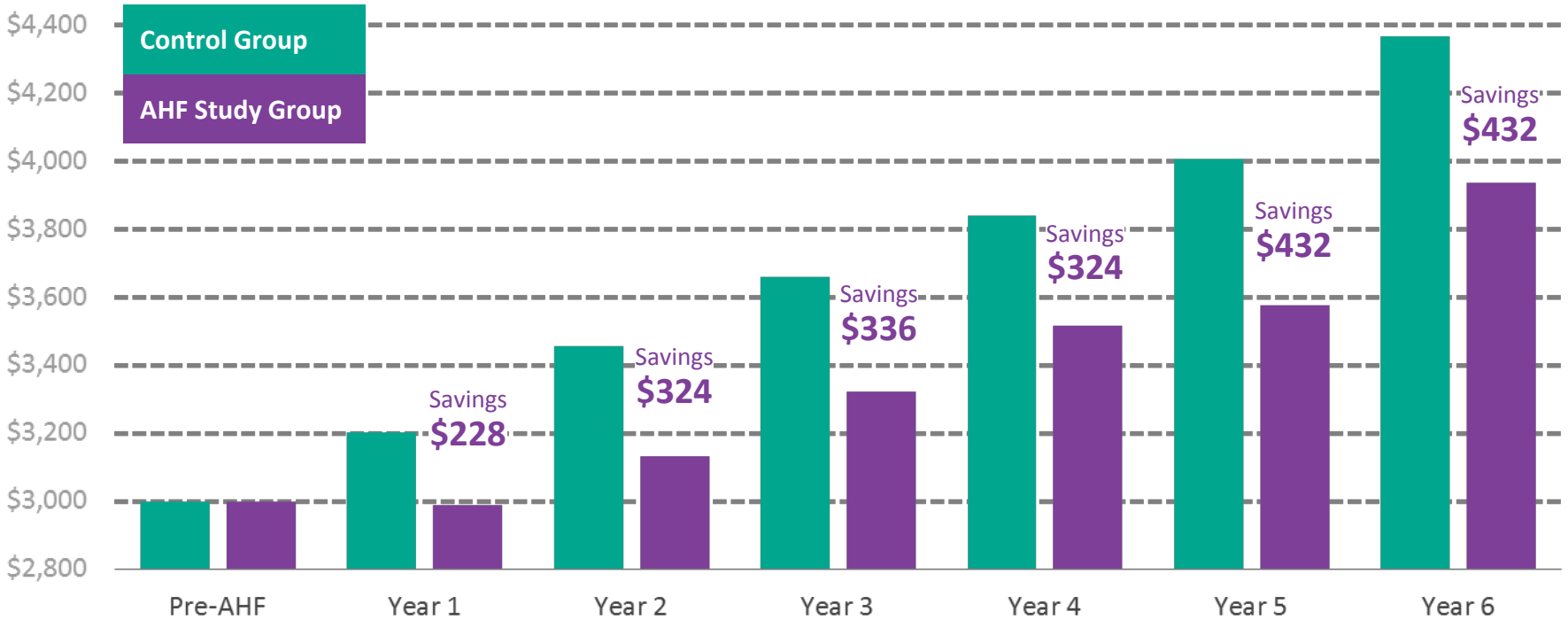
Members control costs through smarter choices, such as 11% more routine PCP visits

Members exhibit more engagement and two times more use of consumer tools, such as Member Payment Estimator

Trend and Savings

Full Replacement AHF HRA/HSA

$20.8M in savings per 10,000 members over 6 years



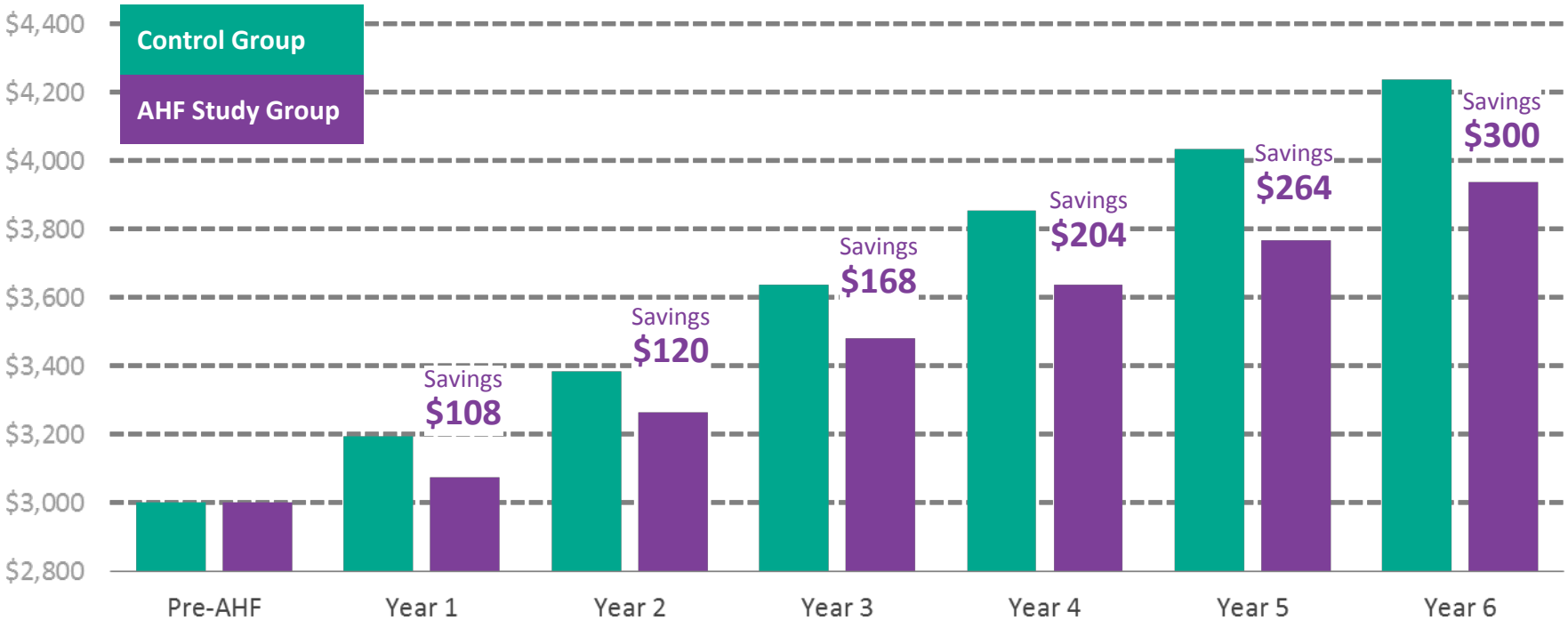
Average annual trend savings over the 6 year period is 1.8%, based on both plan and member spending

- Based on normalized allowed claim PMPM trends averaged over 6 years

Savings/10,000 = sum of PMPY savings over 6 years * 10,000

Option AHF HRA/HSA

$11.6M in savings per 10,000 members over 6 years

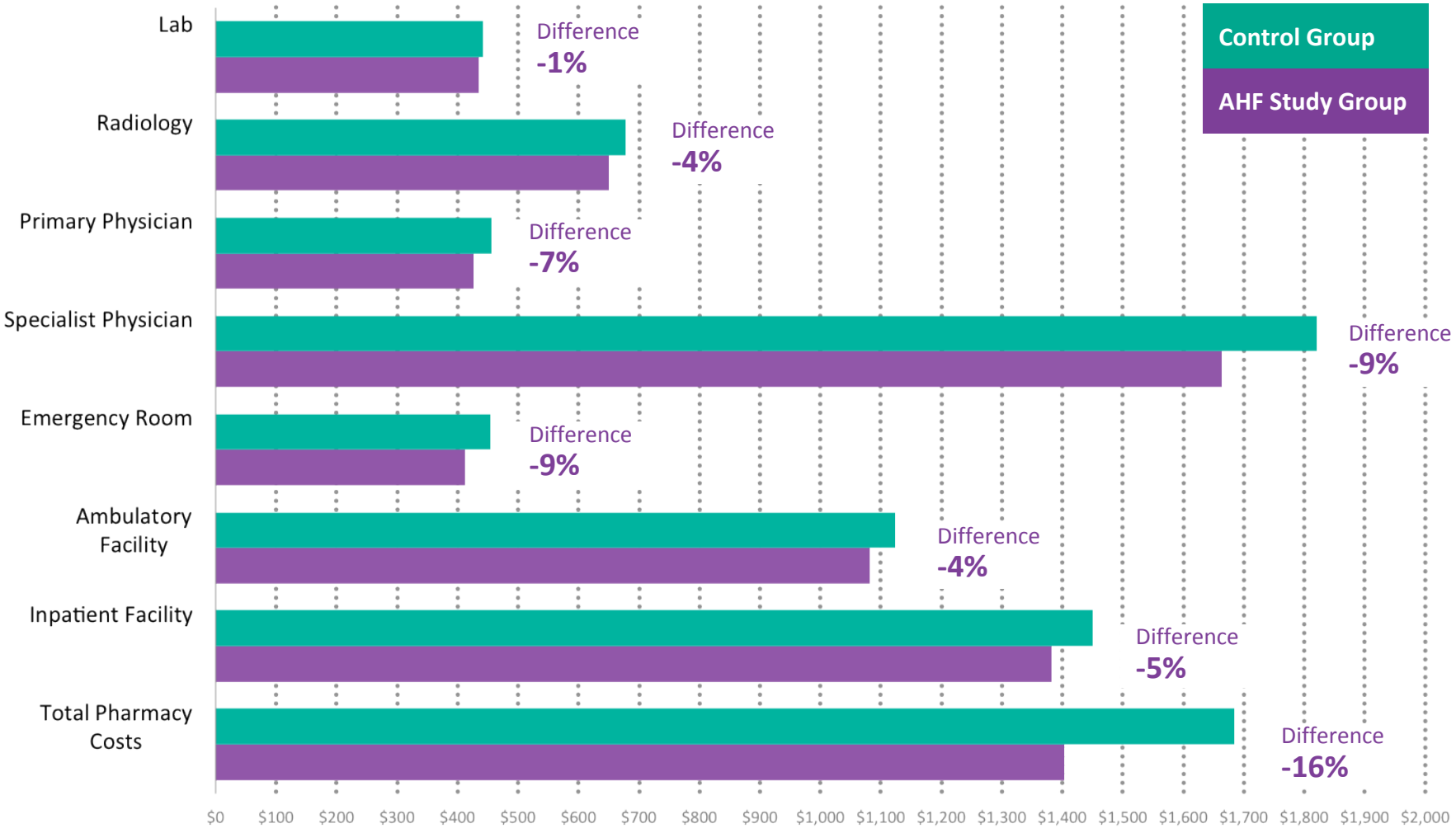


Average annual trend savings over the 6 year period is 1.3%, based on both plan and member spending

- Based on normalized allowed claim PMPM trends averaged over 6 years

Savings/10,000 = sum of PMPM savings over 6 years * 10,000

AHF households spend less for all types of health costs versus a matched population



Comprehensive Plan Management Strategies are an avenue to additional savings for option business

Calendar Year 2011

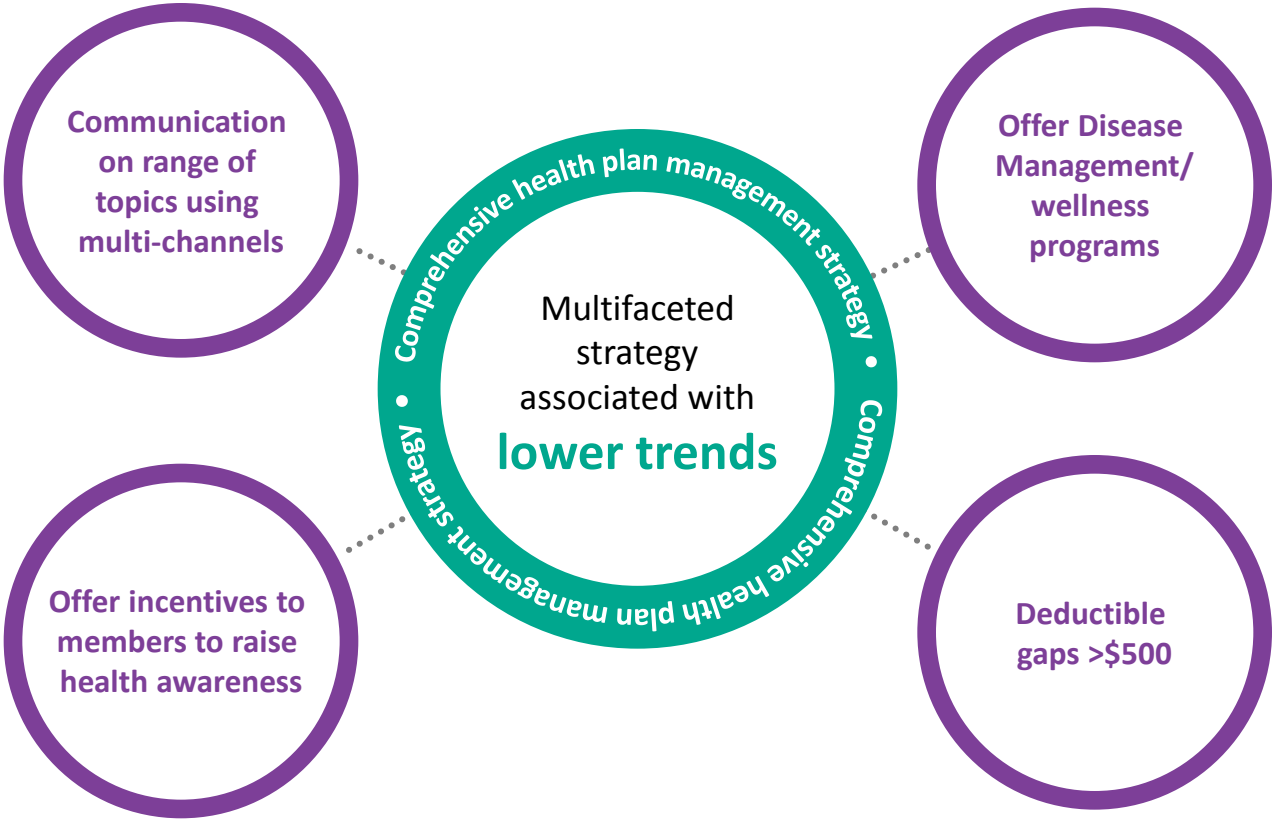
Favorable trend implies that $11.6M of savings could be even greater over the same time period by implementing Comprehensive Plan Management Strategies

*The forty-two plan sponsors in the Plan Sponsor Strategy Study (16: comprehensive strategy; 26 partial strategy) are a representative subset of the Trend and Savings Study.

Actual results and savings will vary based on a variety of factors including, temporal, geographic, demographic and plan factors.

Use a strategy that works to control cost

AHF employers with comprehensive strategies implemented at least three of the following components:



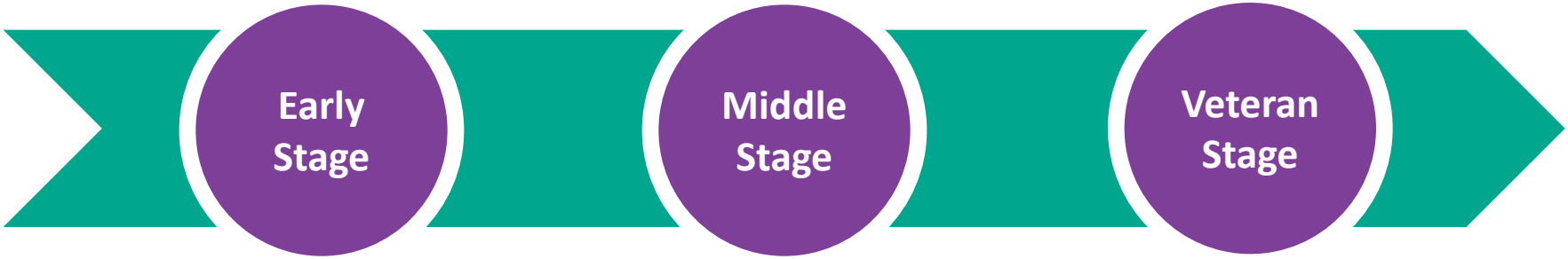
Implement a comprehensive strategy to achieve optimal results

The implementation of a comprehensive strategy leads to **lower trend** and **penetration rates** that are almost **twice as high** as partial strategy sponsors

	Comprehensive Strategies	vs:	Partial Strategies
Communication	**50% have an active communication approach.** C-level executives are twice as likely to personally communicate.		**Only 11%** actively communicate.
Incentives	**Offer incentives** regardless of variance between fund and deductibles.		**More likely to forego incentives** if the fund/deductible variance is small.
Deductibles	Success a result of integrated approach and not just high deductibles. **Comprehensive groups average only $140 higher deductible gaps.**		**Approach savings by deductible gap only.** Gaps tend to be very low or very high, but lack integration with communication and incentives.

Comprehensive strategies in action

Examples of actual strategies at various durations show the road to maturity for plan sponsors at any stage in AHF adoption



	Early Stage	Middle Stage	Veteran Stage
Deductible Gap	**Simple plan design:** with Deductible gap about $500	**Expand offerings to two plans:** one with individual deductible gap of about $1000 and $1500 for other	**More incentive-driven plan design:** reduction in deductible gap available **primarily** through earned incentives
Care Management	**Disease Management (DM), and Smoking Cessation**	**Increased focus on behavior change:** DM, Wellness with Active Health, PHR, Health Assessment (HA), MedQuery, and Biometric Screening	**Add Plan Sponsor specific management:** DM, HA, wellness, maternity management, MedQuery, biometric screening; other care management programs; and Care Advocate Team
Incentives	**Encourage participation:** Small premium credit for completion of Health Assessment; waived copays for smoking cessation drugs	**Increased incentives aligned with Care Management focus:** $300–$600 premium credit payment for wellness/disease management participation by self or family	**Fund dollars primarily earned by behavior change:** Principal form of employer contribution into the fund based on participation in care management programs. Incentive levels align appropriately with intensities of activity: Health Awareness, versus Participation versus Outcome-based
Communication	**Reach wide audience:** Variety of communication channels, highlighting wide range of health related topics	**Increase education component:** Very active communication on a variety of topics through all available channels; includes home mailing	**Drive home consumer mindset:** Continuous communication through a variety of channels, about all topics including programs, cost of care and reminders. Executive level testimonials and letters describing impact to company's bottom line

Aetna
Our Own Employees

Nancy Lusignan, Benefits Manager, Aetna

What is Metabolic Syndrome?

- **Metabolic syndrome is a cluster of five interrelated risk factors that occur together, increasing your risk of cardiovascular disease and diabetes**
    1. **Elevated blood pressure** *higher than 130/85*
    2. **Raised glucose levels** *higher than 110*
    3. **Elevated triglycerides** *higher than 150*
    4. **Larger waist circumference** *>40" (men), >35" (women)*
    5. **Low levels of "good" (HDL) cholesterol** *<40 (men), <50 (women)*
- **The more of these risk factors you have, the greater your risk. If you have metabolic syndrome, healthy lifestyle changes can delay or even prevent the development of these serious conditions**

Healthy weight and lifestyle matters

Obesity is likely the greatest risk factor

Metabolic Syndrome is present in:

- **5% of people with normal body weight**
- **22% of those who are overweight**
- **60% of those considered to be obese**

Source: WebMD Medical Reference from MedicineNet

Solution: Increased physical activity | Better eating habits | Weight loss | Stress reduction

Cost & Clinical Implications

Clinical implications:

- Diabetes
- Heart Attack
- Stroke
- Renal compromise

- **Cost Implications:**
  - Average annual cost is 1.6 times greater than those without the syndrome

  ($5,732 v. $3,581 per subject)

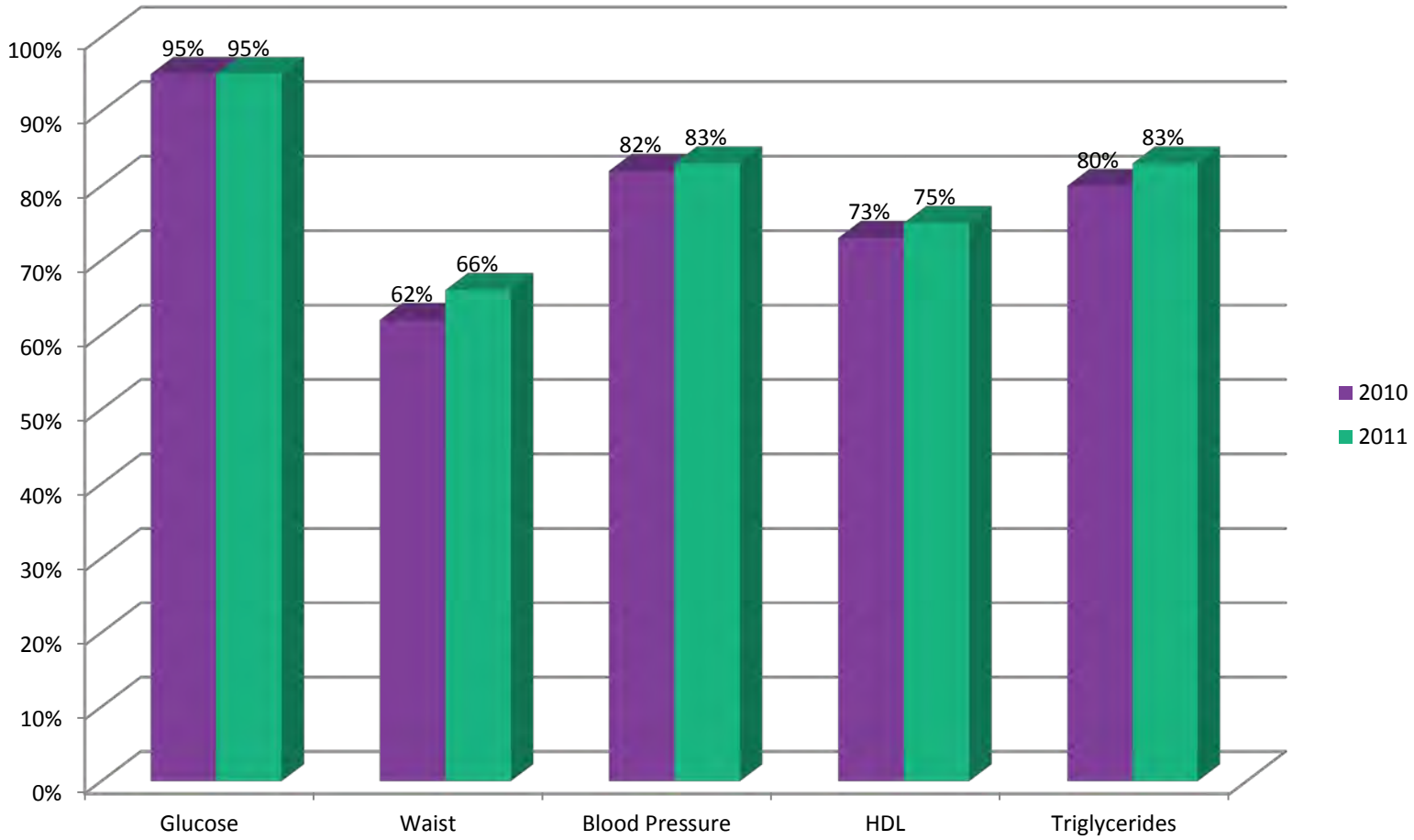
  - 24% total cost increase per additional risk factor

Source: Boudreau DM, Malone DC, Raebel MA, Fishman PA, Nichols GA, Feldstein AC, Boscoe AN, Ben Joseph RH, Magid DJ, Okamoto LJ, Health Care Utilization and Costs by Metabolic Syndrome Risk Factors, Metabolic Syndrome and Related Disorders, 7 (4), 2009.

What's Aetna Doing?
Metabolic Syndrome Testing Program

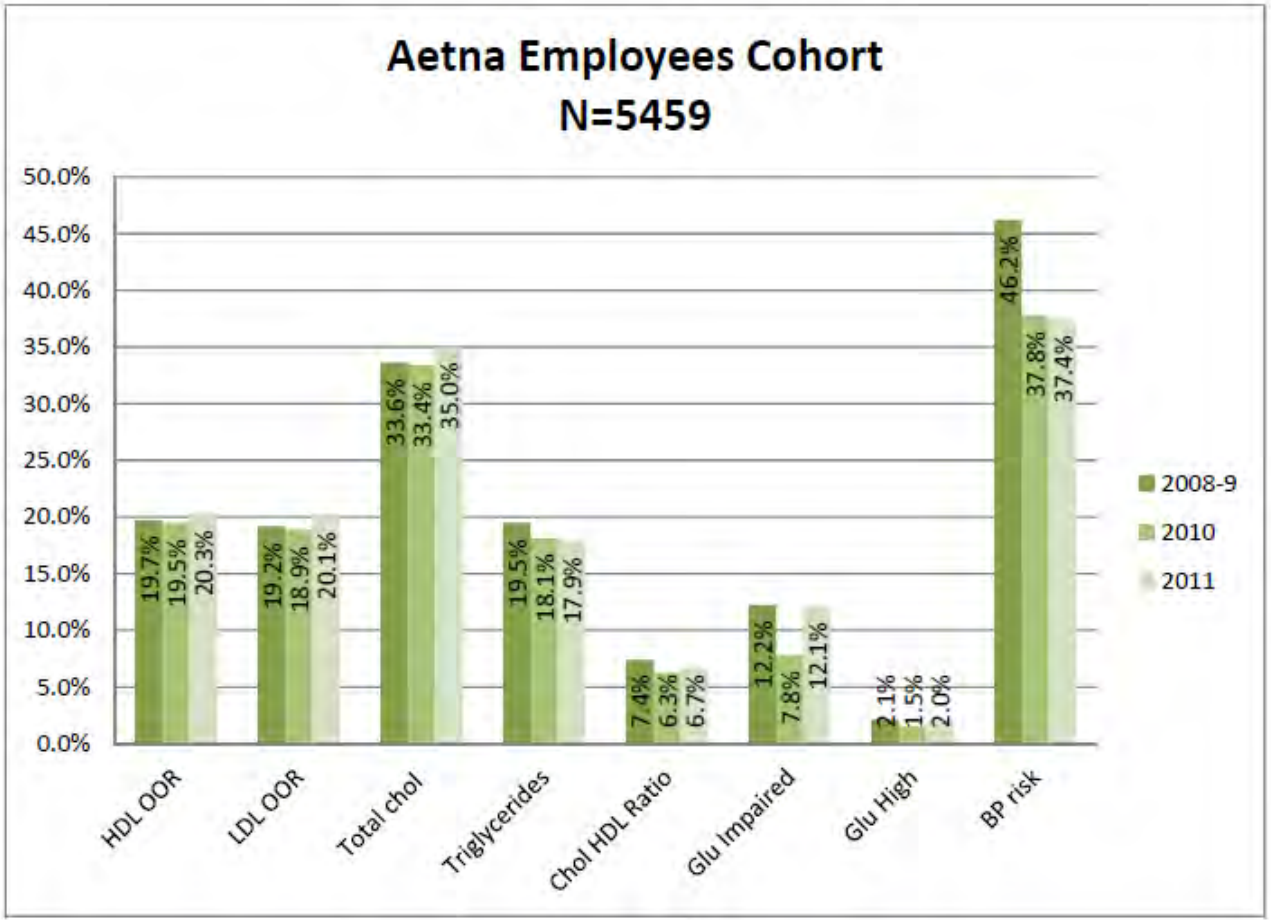
- **Voluntary program through which employees & spouses/partners can be screened for metabolic syndrome at no cost**
- **Employees and spouses/partners who test and are in range for 3 of 5 metabolic syndrome risk factors EACH receive a $300 annual medical plan premium credit.**
- **Participants have the opportunity to test once per calendar year.**
- **Medical affidavit is available for participants whose doctor feels it is medically inadvisable or unreasonably difficult to achieve one or more of the risk factors.**
- **Results from screenings done through Quest Diagnostics goes into the ActiveHealth CareEngine so employees can be referred into programs such as Disease Management and Healthy Lifestyle Coaching to help them manage their condition and reduce risk factors**
- **Specific metabolic syndrome intervention program being developed**

Comparison of 2010 to 2011 results by risk factor – Percent in range (all participants)*



*Percent in range is based on the metabolic syndrome guidelines for the risk ranges..

Cohort Results – 2008-2011



Risk Ranges:

- HDL: <50 (female) <40 (male)
- LDL: >100
- TC: >239
- Trig: >149
- Chol HDL Ratio: >5
- Glucose (imp): 100-125
- Glucose (High)>125)
- BP: >139/89

- Percentages shown reflect the percent of employees who are in the risk ranges shown above for each risk factor.
- Total cholesterol, LDL, and Chol HDL Ratio are not part of metabolic syndrome but are included as part of the test panel done by Quest Diagnostics.
- Waist circumference is not displayed because it was not measured in 2008/2009.

Aetna Innovation Labs

Dr. Greg Steinberg, Innovation Lab, Aetna

Aetna Innovation Labs mission: quickly develop concepts from ideas through data-proven pilot

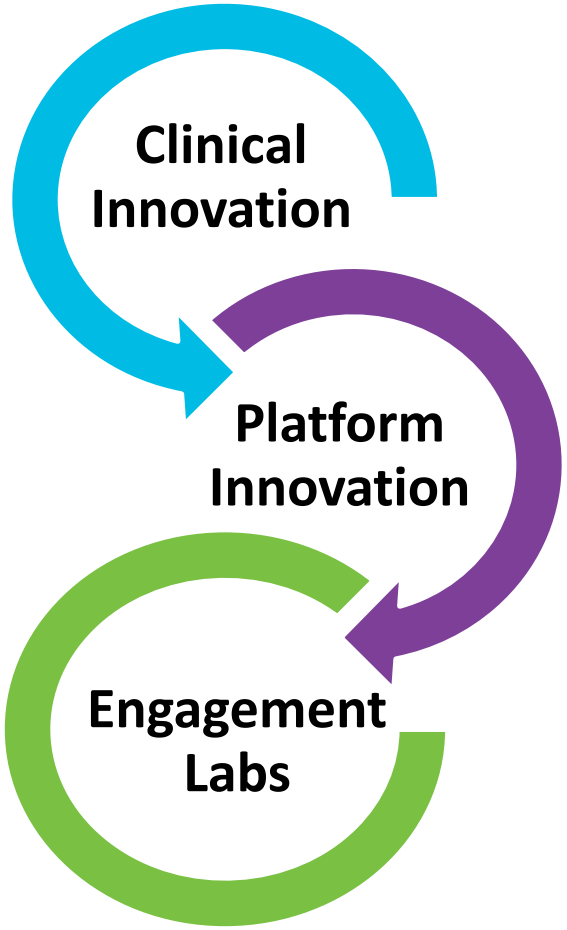
- Identify **impactful ideas two to three years ahead** of the market

- **Pilot the concepts rapidly and rigorously** to gather evidence that they work

- **Demonstrate measurable value** to consumers, employers, and providers *(and involve them in pilots)*

- **Deliver proven solutions** to Aetna business partners to bring to market

Aetna Innovation Labs has three focus areas: clinical, platform and engagement innovations



- Conceptualizing products and services that better **predict illness, enable evidence-based care and lengthen *healthy* lives**
- **Optimizing features, adaptability and compatibility of enterprise platforms** (products, processes and technology) and leveraging them in new and different ways
- **Improving member and provider engagement** by developing a better understanding of traditional and non-traditional barriers and motivators, and new interventions

Where appropriate, initiatives will focus on our **Top 5 Conditions:**
Cancer Cardiovascular Musculoskeletal Maternity Gastrointestinal

Example: Metabolic Syndrome Initiative

1 **Identify Causal Relationships of Benefit / Harm through Data Analysis** → **2** **Develop Programmatic Hypotheses Based on the Data Analytics** → **3** **Implement, Iterate, and Analyze Effectiveness of Program Modifications**

Plan Sponsor

Sample:85k members x 2 years of claims data; demographic data

Extract predictors of:

Metabolic Syndrome, Cardiovascular Disease, Diabetes, Heart Attack, Stroke, End Organ Damage, etc.

Identify predictors that are causally related to outcomes, not just correlated

***ALSO:** What makes one more likely to engage with a nurse/coach?*

vs.

vs.

- Programs to address risk factors
- Programs to address engagement strategies
- Programs to address treatment strategies

- Screen for Novel Risk Factors

- Vary engagement strategy according to the hypotheses

- Adjust treatment strategies based on hypotheses

- **Project future cost & utilization with more accuracy**

- **Examine alternative program enhancements, e.g.:**
  - Outcomes-based payment model(s)
  - Value-based formulary design

Feedback Loop

Models have shown the ability to predict the annual change in Metabolic Syndrome at the individual level

Individual Profile

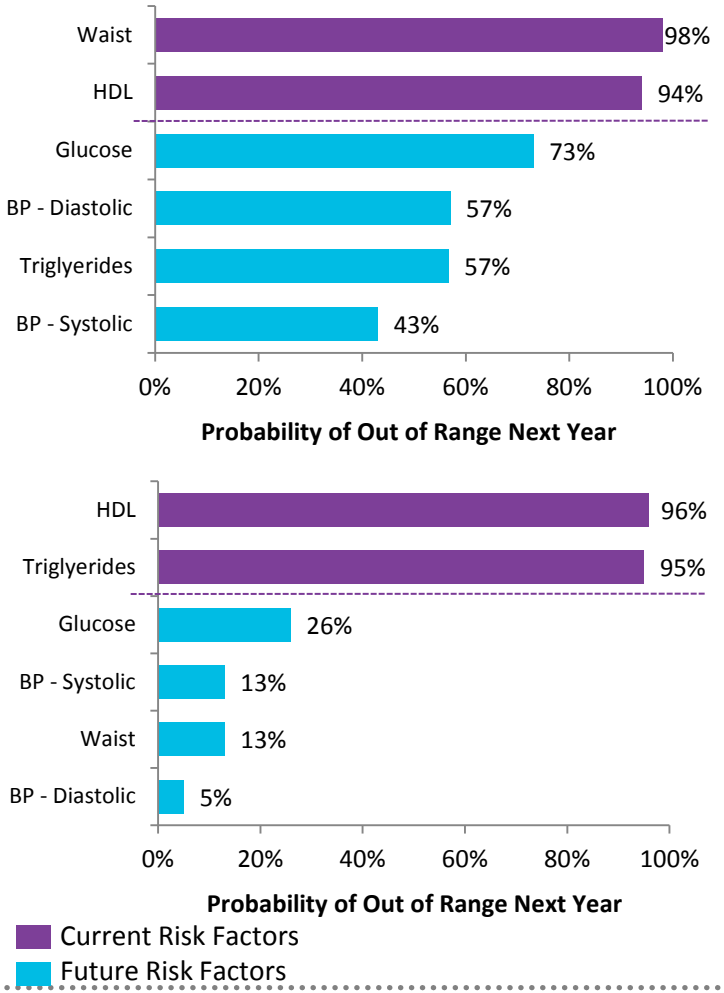
Subject ID 423262

- Male aged 46
- Current Risk Factors: HDL & waist
- Predicted Probability of MetS* next year: 92%
- Next Adds: glucose (73%), triglycerides (57%)

Subject ID 107975

- Male aged 37
- Current Risk Factors: HDL & triglycerides
- Predicted Probability of MetS* next year: 40%
- Next Adds: glucose (26%), waist (14%)

Personalized Prediction



Engagement Applications

Personalized Risk Report

Provide individuals with information on the next Metabolic Syndrome risk factor they are likely to acquire in the next year and things they can do to avoid onset.

Personalized Interventions

Tailor an individual's Metabolic Syndrome engagement & intervention program to current risk factors and risk factor they are likely to acquire in the next year.

- Illustrative -

Metabolic Syndrome Initiative Key Conclusions

Impact of Incremental Changes – It's About Waist & Glucose

Effect of Factor Improvement	**Factor with *Largest Positive Effect on Cost & Risk* if Improved by Probability & Population** Waist Circumference and Glucose	**Factor with *Smallest Positive Effect* if Improved by Probability & Population** Blood Pressure
Effect of Factor Worsening	**Factor with *Largest Negative Effect* if Worsened by Probability & Population** Waist Circumference and Glucose	**Factor with *Smallest Negative Effect* if Worsened by Probability & Population** Blood Pressure and HDL
Effect of Factor Improvement on Medical Costs	**Factor with *Largest Positive Effect* on Medical Cost by % Change & Population** Waist Circumference and Glucose	**Factor with *Smallest Positive Effect* on Medical Cost by % Change & Population** HDL and Triglycerides

Metabolic Syndrome Initiative Key Conclusions

Impact of Surrogates of Adherence

Impact of Medication Adherence[1]

Improving Medication Adherence Reduces Risk

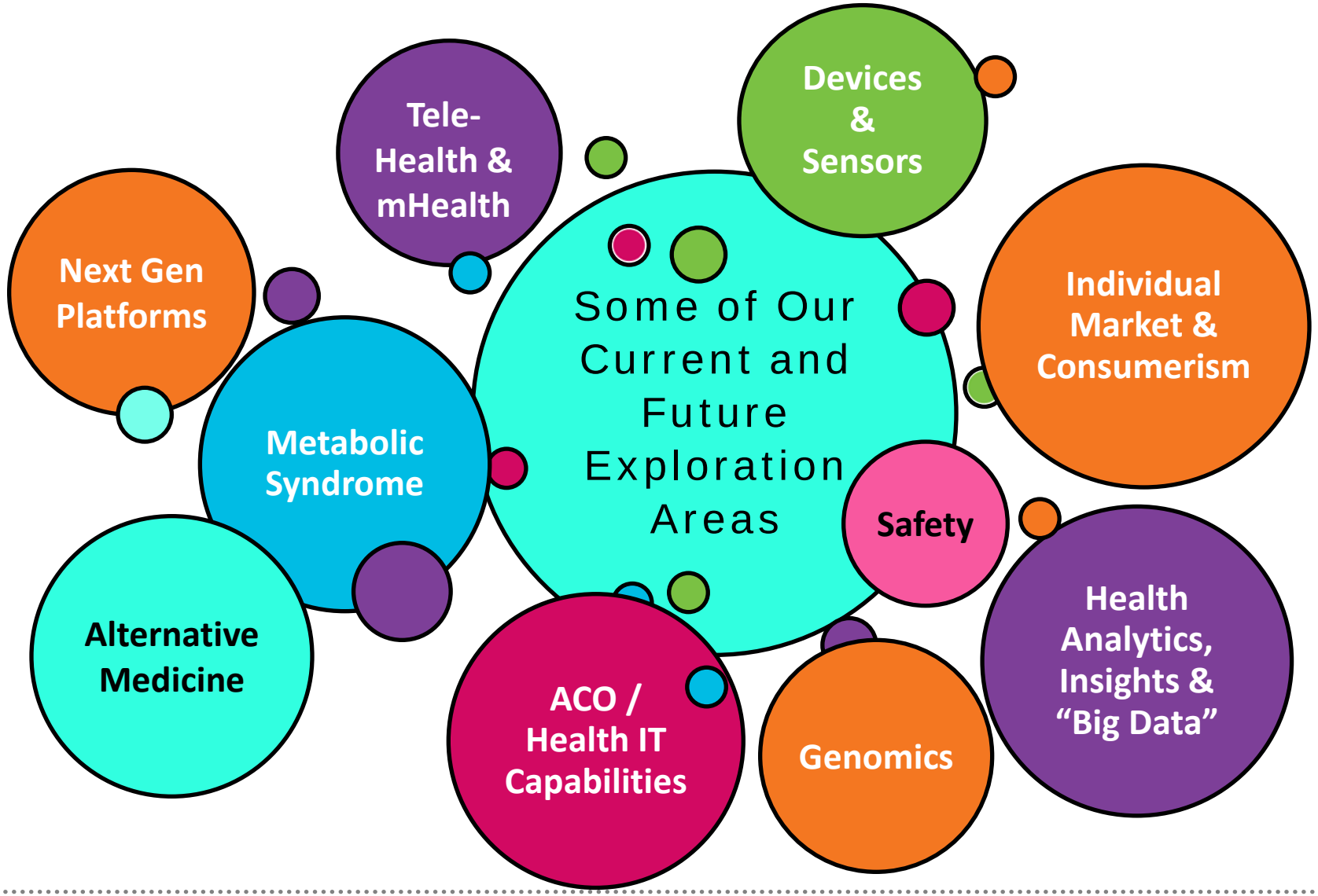
Almost 60% of non-adherent members taking any of three classes of medications (anti-hyperlipidemics, anti-hypertensives & anti-diabetics) reduce Metabolic Syndrome risk by becoming adherent

Impact of Preventative Visit Adherence[2]

Improving Preventative Visit Adherence Reduces Risk

Almost 90% of non-adherent members reduce their Metabolic Syndrome risk next year if they had at least one recommended annual preventative visit

Aetna Innovation Labs will continue exploring a number of areas in 2013 that will drive value to the marketplace



Questions

Stephen Wyszomierski,
Aetna Health Fund

Nancy Lusignan,
Benefits Manager, Aetna

Dr. Greg Steinberg,
Innovation Lab, Aetna

2.3.3.2

The State of Alaska is in a very unique situation based on its covered membership, location and provider delivery system for the Alaska residents. These challenges have limited the State of Alaska from successfully managing health care costs without a wholesale change in the system. The State of Alaska has developed a comprehensive health care vision and objectives that will support the transformation of health care in Alaska, improve health of the population and manage costs. Aetna's offering is based on our ability to fully support that transformation of health care one member at a time to achieve your goals in the areas of consumer engagement, evidence based medicine, operational excellence and cost management.

Our position surrounding one member at a time is not minimizing the nature of design and delivery, but emphasizing the magnitude of engaging the member for long term sustainable change. Human behavior research shows there are modifiable human risks and behaviors that account for 80% of all health care costs. The transformation of the delivery system will take many steps and investments by the State of Alaska and Aetna, but will not be successful without engagement by your members.

Engagement is further challenged by the breadth of the membership. As an employer, you must offer benefits that are going to attract and retain the necessary workforce, but the health care program only covers approximately 1/3 of the employees directly with 2/3 covered by Trusts. The retiree coverage provided by the State provides additional complexities as the State takes on retiree coverage for members it did not cover while they were employees. In addition, retirees are covered by a plan that is protected by the Alaska constitution, thereby limiting efforts tied to plan re-design without the shift to the State of Alaska's planned alternative retiree medical plan.

The underlying dynamics of the benefit program further reinforce the need for a vendor partner that has the resources to support the State's objectives now and in the future. Based on the current programs in place for the State of Alaska, there are opportunities for both basic changes as well as highly innovative approaches.

We have extensive experience working to enhance member accountability and their relationship with their provider through meaningful data exchange and clear calls to action. A partnership with Aetna will provide the State with an organization that brings solutions and capabilities to support the change, along with an understanding of the state, regional and local culture adaptation required of the solutions. We will personalize the health care experience and tear down the frequent barriers, transforming a members' health plan experience from something that must be worked through to something that works with and for them.

2.3.3.2

Aetna has an entire segment dedicated to the public and labor marketplace. We are aware of the multiple challenges that public sector employers face as a result of the rising cost of health care coverage. To help you achieve your goal of bringing healthier living to the State of Alaska, your employees and retirees, and their families — while maximizing your benefits spend – we have proposed an infrastructure to support the change.

The change the State of Alaska is seeking in its health care program will not take place over night and requires a full service organization that understands every facet of health care delivery and leverages the resources and capabilities to support the change. In order to achieve the State's objectives, we are fully prepared to deploy solutions utilized by our most innovative customers, and more importantly, jointly develop customized solutions for the State of Alaska. The process begins with strategy.

I. Strategy

The State has clearly articulated a vision and objectives for your health care program. Due to the degree of change to achieve health care transformation in the State, we are proposing a multi-phased strategy. The solutions for the State of Alaska must be specific to your culture, goals and objectives and more importantly tolerance for change. As a result, we will support the state in the development of a multi-year strategy.

This strategy, design and deployment mapping that we are proposing is our most innovative approach that optimizes data and the full breath of the Aetna and State's resources including the State of Alaska's other vendor partners. This approach enables us to build a plan together through a multi-phase approach

- Phase 1 – Clear understanding of State of Alaska objectives and parameters; knowledge session on market and market leading solutions
- Phase 2 – Analytics and solution review
- Phase 3 – Ideation session focused on final design, deployment and change management

The overview of each phase is as follows:

Phase 1 of the strategy process is detailed review of the State's objectives, and defining short and long term goals. We will support the State in developing the key strategies and desired timing for changing health care delivery in Alaska. We believe this step is essential as the level of change required in Alaska is both extensive and more importantly will require significant year over year effort. One of the most pivotal aspects of this session will be to define the desired change and the tolerance for disruption as the network delivery in Alaska is addressed and member behavior is changed.

2.3.3.2

This first phase of the strategy will include our Account Team, Clinical Advisory Team and Alaska Advisory and Support Team to map out the strategy, barriers to success and solution. Through this framework, strategies begin to be framed addressing each of the areas of consideration in alignment with the State of Alaska's goals. We recognize the State of Alaska has put considerable thought into the solutions and Aetna has also solutions specific to Alaska and lower 48.

We have extensive experience working with other vendor partners and suggest the inclusion of other vendor partners in the initial phase to ensure every organization is grounded on strategies, solutions and timing. Based on the final selected State of Alaska partners, we would map out the critical parties and the framework of the meeting. We would take the lead to ensure all parties are prepared for the session.

In **Phase 2,** we will document the strategies and solutions, and evaluate them against the State's data. In this phase, we will mine the State of Alaska's data to determine impact of solutions and begin to address necessary change management to deploy the solutions. Through this analysis, we will develop a discussion guide along with an outline of multiple paths and expected outcomes and impact to discuss with the State.

Phase 3 of the strategy process is a comprehensive ideation process with the State of Alaska and its vendor partners. The Ideation session is based on sound practices used by our Emerging Business area to define new products & services. We will assess solutions and convergence of solutions to define the "product" for deployment through a comprehensive "brainsteering" process. The ideation process will fully address the issues, solution and overall adoption. The goal is to refine or reject solutions to arrive at an overall package for the State to deploy. We will leverage the process from our Emerging Business area to help support this process and arrive at solutions that fully understand the behavioral components and member experience so essential for long term sustainability.

Our expectation is that through our innovative ideation process, we will arrive at comprehensive solutions that are specific to the State of Alaska and extend beyond basic plan design or programmatic changes. We believe the real value we bring is the evaluation of more aggressive changes and the timing for deployment to truly transform health care in the State.

II. Infrastructure – Having the Right Tools for the Job!

The support of the State of Alaska solutions and ability to achieve results is based on the infrastructure and resources we bring. The best solutions must be adequately supported to enable achievement of results. There are a few critical facets to our infrastructure that differentiate our organization and will enable the achievement of the State's objectives.

2.3.3.2

Personalized for You

First is our Health Concierge customer service model that is the "My AlaskaCare Single Point of Contact." The level of change management that will be required for the State to achieve its objectives requires a level of Customer Service that fully extends beyond a transactional delivery and provides the level of advocacy and support that the member needs to navigate the delivery system. This service model is in place on our most progressive and innovative customers. The genesis of this model was for our Aetna One customers and has supported these customers in achieving lower cost trends and true integration of vendor partners.

The value of the Health Concierge model is that it fosters a connection with the individual member through a more personalized experience. In doing so, the member is guided to a greater understanding of how the AlaskaCare program can support them specifically, and how they can make more informed and effective choices. The My AlaskaCare Single Point of Contact will support the following indirect elements of cost savings:

- Advocacy and support to enable member to achieve optimal health
- Support of new designs and steerage solutions including the necessary "hand holding" of members in appointment scheduling and provider and vendor partner discussions
- Optimization of all the State of Alaska vendor partner programs including non-Aetna programs
- First Impression messaging to address State's key messages on an annual basis
- Quarterly messages that can be delivered to all members

The importance of the My AlaskaCare Single Point of Contact is the influence they can have on both perception as well as behavior. Members are influenced by positive interfaces and will engage with resources that provide both meaningful information as well as support they are seeking. The My AlaskaCare Single Point of Contact will be instrumental in the future success of program changes and the transformation of health care delivery and member behavior change.

Meeting You Where You Are

Another key component of the infrastructure is our web and mobile technology. We recognize every member is different and their desired method to interface will vary. As the State transforms healthcare and puts in more innovative solutions, it will be essential to have the information at the members' fingertips via our mobile technology. iTriage is a highly intuitive mobile solution that is rapidly expanding and will power many of the consumer engagement tools necessary for the member. We will continue to evolve this tool and ensure it contains all of our mobile solutions. On July 1, 2013, iTriage will support:

- Condition and procedure code information

2.3.3.2

- Provider look up based on condition or procedure
- Custom plan sponsor steerage - Network providers, alternative providers (e.g., telemedicine), etc.
- Price transparency based on procedure at provider level to enable comparison across multiple providers
- ID card and Plan Sponsor specific information site link

iTriage will be available on stand-alone basis or on CarePass. CarePass is our innovate platform that supports mobile innovators the opportunity to build tools that will share personal information. Aetna members will be able to use CarePass to synchronize their data between mobile health applications. Members will be able to better understand their health by looking at the intersection of their fitness and nutrition data alongside their medical data. By using CarePass, a member will be able to manage their whole health & live healthier lives. Aetna members will have single sign on from Navigator to CarePass and we will prominently feature partner applications on the Navigator welcome screen once a user logs in. As part of the welcome screen there will be a section for mobile apps to be highlighted. In addition, Navigator will enable the easy push of the apps to users' smartphones.

We are partnering with the U.S. Department of Health and Human Services (HHS) to open up their data sets for CarePass in a developer friendly way. We are working with the HHS on interesting developer opportunities based on the combination of our data sets with their data sets. The Health Data Initiative (HDI) and the HHS as the Community Health Data Initiative, is a public-private collaboration that encourages innovators to utilize health data to develop applications to raise awareness of health and health system performance and spark community action to improve health.

This technology will enable the State of Alaska and Aetna to develop overall needs assessments and seek mobile innovators to develop solutions. Upon our initial roll out, we have seen great interest and the CarePass technology will enable innovation across solutions.

Our mobile solutions will empower State of Alaska members and deliver savings for the State of Alaska. We have proposed both the custom iTriage solution for the State and our free CarePass solution. Our commitment is to bring forth and define methods to deploy innovative mobile offerings through CarePass. In addition, we will work with the State to define needs to present to mobile developers for solutions.

2.3.3.2

Caring and Supporting You as a Patient

The last element of infrastructure is our Care Management model. Our Flex Medical Management model is built on key elements of member interface and outreach. This team is both a direct resource for your members, but also receives warm transfers from the My AlaskaCare Single Point of Contacts when clinical support is needed. The integration and alignment of these teams further supports the change management and support members will need under a new program. The underlying systems and rigor placed on evidence based medicine will have direct savings to the State.

The Flex Medical Management team will be fully connected to the Active Health Disease Management Nurses for the population that Health Care Management is deployed. The nurses will work together based on prioritization of the member needs and ensure consistent messaging and member goals are achieved.

III. Provider Network Delivery

Network is both the biggest immediate opportunity for the State and the biggest challenge. The immediate opportunity is the savings the State of Alaska will experience from the discount improvement both in Alaska and in the lower 48 with Aetna. The savings Aetna will deliver is generated from improvement with the same network providers as well as the breadth of our network compared to the incumbent's current rental network solution. We have seen these savings on other customers where we have replaced administrators using the Beechstreet network. Our discount performance incentive reflects the savings associated with the discount improvement through Aetna. In addition, our claim based performance incentive guarantee reflects the overall trend management Aetna can achieve through network as well as all proposed programs.

The area that will challenge the State of Alaska is the next level of solutions for your network delivery and the decisions surrounding deployment approach and timing. This is a key area that we will partner with the State of Alaska to define the optimal network delivery specific to each borough and the use of alternative solutions. During the strategy phase, we will work with the State to explore multiple design options that we are prepared to deploy for the State. Solution options will be focused on the degree to which the State of Alaska wants to influence the market, implement plan designs and tackle changes for member requirements surrounding network provider steerage.

The value of Aetna owning and operating the Alaska network and having network resources in and out of Alaska is our ability to support network solutions. Our strategy sessions will cover the full spectrum of solutions for the State and the projected impact and change management required. We envision an in-depth process in defining the solutions by borough that will first commence with an overall decision on network steerage.

2.3.3.2

Currently, the State limits network steerage to the active plan's hospital network in Anchorage. This lack of steerage outside of the hospital arrangement for actives is one of the reasons providers have not been eager to participate in network arrangements outside of Anchorage and Fairbanks. It is very clear that the State of Alaska is now prepared to challenge the status quo and use its purchasing power to change the current landscape.

We are fully prepared to support the State with the evaluation and deployment of alternative network options and steerage options in the State. We recognize the State has made decisions based on the options available via the rental network and it has a smaller base network to take advantage of today. Our network resources including experts in alternative arrangements will provide the State with the critical resources you need to change health care delivery in the State.

We believe a holistic view of all solutions in the boroughs and addressing how the State can incent network selection for both the actives and retirees is critical. We will work with you to develop creative solutions for the retirees to use network providers that can range from the development of a quality network for exclusive use to incentives via a retiree contribution or preventive care benefit. We are prepared to support the State in reviewing the preferred relationship arrangement including the expansion of the preferred relationship to other markets, expanding beyond hospital arrangement to include physician network and applying the network to the retiree population. The inclusion of the retiree membership will be pivotal in materially moving the needle on health care delivery.

As the State is clearly aware, many of our customers have network steerage options in place in the lower 48. The advantages of network steerage are both the financial savings of the discounts as well as the assurance of evidence based medicine embedded in the contracts. For the State, we are able to bring other Aetna customers with Alaska membership to help support the change in network delivery to a full steerage option. We will not only explore contracts ensuring quality, but seek financial terms more consistent with the lower 48 (e.g., case rates, DRG and bundled payments) or support solutions that compete or complement the existing delivery system.

- **Medical Tourism** – As we have heard the Commissioner communicate in public forums, medical tourism is something the State of Alaska will consider. The State of Alaska has a travel benefit in place that provides members with the necessary benefit for care at nearest location. Since the travel benefit is in already in place, Aetna can support the assessment of expanding the benefit to medical tourism. Our cost data and the on-line transparency tools can be used to pre-define high cost conditions in Alaska that would benefit if delivered in the lower 48 or enable members to further optimize the option to receive care in a lower cost setting.

2.3.3.2

We will support the financial assessment of medical tourism and determine the impact on the local delivery system in Alaska. The process will address the cost of care as well as all additional expenditures associated with receiving care in an alternative setting, such as air travel for member and companion, meals, lodging, etc. to determine full cost of tourism and the appropriate design. In addition, we will work with the State surrounding handling of follow-up care and any recidivism. This will support the development of the exact procedures that could benefit from medical tourism as well as directing care from the nearest facility to the optimal facility.

The deployment of medical tourism is a strategy one of our customers in Maine deployed with material success in impacting costs at a local level. As they were prepared to fully operationalize medical tourism, local providers addressed their costs. Aetna supported the customer in the overall assessment of medical tourism and the operational process.

- **Telemedicine** – Aetna has deployed Teladoc and other telemedicine solutions. We are prepared to deploy Teladoc for the State on either a statewide basis or select boroughs. Teladoc will generate savings for the State in locations with non-urgent emergency room utilization. In addition, it provides the member with alternatives for care delivery in locations with limited provider resources. For this very reason, we will work with the State to ensure the use of Teladoc is aligned to overall network delivery and member care goals.

  Teladoc has proven savings results for our customers and is currently operating in Alaska. We will work with the State and Teladoc to estimate the expected savings based on the deployment strategy.

- **Patient Centered Medical Home** – We are able to support the establishment of Patient Centered Medical homes through Practice iQ. Practice iQ is an Aetna company focused on the healthcare services and technology solution for independent primary care practices. This group is able to support the primary care practices in establishment of end to end solution to improve population health, patient engagement and care coordination for patients within a practice. The Practice iQ solution leverages technology, care management and coordination and operations to support practices. This is a solution that can be supported by the State or directly available to providers based on the State's goals and overall integration into the network delivery model. Under this model, the provider is revamping their model for all patient interactions.

2.3.3.2

Patient Centered Medical Homes are a key element of our offering in the lower 48. We have approximately 26,000 par providers in our network who are recognized by NCQA as medical homes. We have 2,500 physicians in our network contracted as PCMHs, with 400,000 attributed commercial members. We expect trend-mitigation of up to 5% and medical cost savings of approximately $3-$9 PMPM for attributed members to contracted PCMHs.

- **Medical Home Exchange** – Medical Home Exchange is a vendor partner of Aetna's that can support the deployment of a Medical Home Exchange with guaranteed return on investment. Medical Home Exchange is a Patient Centered Medical Home model that was developed to enable a partnership between the employer, employee and provider. Medical Home Exchange is designed to support the employer's management of the population and fully connecting real time data for physicians, coaches and your members. The Medical Home Exchange is a plan sponsor solution that we are prepared to support for the State of Alaska.

  Medical Home Exchange will support the assessment of the delivery system and the return on investment through the model. The return on investment will be guaranteed.

- **Accountable Care Organization** – Accountable Care Organization is a delivery system solution that Aetna can support via our Accountable Care Solutions practice. Our team is able to work directly with the delivery system in the evaluation and development of the Accountable Care Organization. The State of Alaska would need to evaluate its role in supporting any investments in the development of Accountable Care Organizations in Alaska, which in large part are geared to overall use and acceptance. It is expected to see cost reductions from an Accountable Care Organization that are both year 1 savings and on-going through the population health approach.

  We currently have 17 Accountable Care Organizations and anticipate 30 at the end of the year. We have an attribution model that will enable the State of Alaska to leverage Accountable Care Organizations as they are rolled out in Alaska and the lower 49. We are currently working with an organization with operations in both Alaska and lower 48 for preliminary evaluation of Accountable Care Organization in Alaska. This is in the preliminary phase, but emphasizes the ability to deploy an Accountable Care Organization is not limited to the lower 49.

2.3.3.2

Overall, Aetna is best positioned to support the State in network delivery that ranges from simply taking advantage of our existing networks and alternatives such as telemedicine to material changes in the network composition and delivery. With the State of Alaska backing, the overall network delivery and general payment reform can take place over a 2-3 year period. This will be driven by Aetna, but require support and overall State of Alaska membership to change provider delivery in the State. We estimate the minimum savings in excess of 10% for the non-Medicare membership, but want to work with the State on the optimal network solutions to align with all design changes to materially impact the future trend line.

The Aetna technology will enable all of the network providers to connect via our Health Information Technology. Our systems will support providers to access our eligibility, clinical policies and payment estimator for providers. In addition, they are connected to our evidence based medicine tools.

IV. Evidence Based Medicine

Our proposal reflects the use of our clinical policies to ensure the application of evidence based medicine. Our clinical policies are a cornerstone of our network management, care management and claims payment for the network. We are fully committed to evidence based medicine and the overall impact on quality for both the member and the bottom line. We will apply the clinical policies for our network providers and payment is made as appropriate. Our clinical policies and linkage to all aspects of our operation will have a financial impact for the State generating savings in the range of 3-5% for non-Medicare members.

As our clinical policies are evidence based, it aligns to the State of Alaska objectives for policy development. We are annually reviewing clinically policies and emerging evidence. We must clearly address that clinical policies are based on evidence and are not intended to pay for the lowest cost treatment, but the appropriate treatment. For example, we have clinical policies that will not pay for lower cost services that show no clinical evidence as this is waste in the system.

In addition to clinical policies, we have proposed our Care Engine for the members covered under the Health Care Management component of our proposal. The value of the Care Engine is a guaranteed ROI driven by the Health Information Technology that integrates all member claims to identify care considerations. The value of the care engine is the full connection of a disparate health care system via technology that is grounded in evidence based algorithms for clinical decision support. The care engine is mining all data for identification of gaps in care and issues with treatment or medication. We have attached a study that demonstrates the effectiveness of the Care Engine.

2.3.3.2

We are able to have the care engine in place for Non-Medicare and Medicare members. While the savings for Medicare members is diminished, due to Medicare is incurring the majority of the savings, the savings and objectives surrounding member health are achieved. The Care Engine is a key component of the condition management of our Health Care Management solution, but could be selected on a stand alone basis as well. We are prepared to turn on the Care Engine for all members and guarantee the return on investment. Many of our customers have the Care Engine even if they are not using our Condition Management program.

V. Plan Designs

Our experience in working with National Account and Government customers has enabled us to implement numerous creative designs. Many of the most innovative approaches that we can deploy will depend on the integration of medical, pharmacy and health care management to support behavior change and appropriate cost sharing across all facets of the health care experience. The goals are to ensure the design. As stated previously, modifiable risks and behaviors are key drivers of health care costs and plan design is a necessary tool to support change.

As stated previously, network delivery and the solutions deployed in that area will be a critical decision point and drive decisions on plan design. We will work with the State to define the full complement of design changes to drive appropriate provider utilization and align to quality associated with what our network providers. This will include the overarching design structure.

Consumer Driven Health Plans is one of the key design structures that we will support the State in evaluating. Consumerism is a pivotal component of any plan design to support consumer engagement. While Consumer Driven Health Plans are not the only design promoting consumerism, it is known and understandable by many people and designs that Aetna has extensive experience in designing and administering. Aetna was one of the first carriers to implement consumer driven health plans. We have detailed experience with both Health Reimbursement Account and Health Savings Account designs in Alaska and the lower 48. Our Aetna HealthFund (AHF) Study results demonstrate the effectiveness of Consumer Driven Health Plans in managing costs. The results show that:

- AHF members used preventive care services more often, prior to the Affordable Care Act mandates for all insured, and still do today
- AHF members become more price sensitive consumers, using Aetna price information tools more often to look up prices on certain tests and services
- Plan sponsors achieved trend savings in 2011 when they implemented a comprehensive plan management strategy

2.3.3.2

The 9th annual study shows that plan sponsors who adopt an AHF product, either exclusively or as an option to traditional plans, are continuing to achieve significant savings, largely because their members are more astute health care consumers. They are more likely to use preventive and primary care services and obtain more generic prescription drugs. They also use online education tools, indicating greater motivation and involvement in their care.

We will support the State in determining the appropriateness of the Consumer Driven Health Plan design, as well as other consumer driven designs and implementation timing in light of all of the other changes taking place. The advantage of working with Aetna is the resources we have that can support design, pricing and communication support necessary to accomplish goals. Many of the designs are cost sharing in nature and all within our capabilities via owned and operated claim system.

We have many examples of designs and how those impact customers and solutions to provide technology to connect your members and achieve health goals. Our goal is to support the necessary incentives to engage members in the process. While our infrastructure is critical in fully enabling all aspects of the material changes to the delivery system and supporting and providing critical advocacy for members, the plan design must align. We have extensive experience in incentive strategies that reward via behavior. These are material shifts from the current design features of the State's plan for the actives and especially so for the retirees. The results can be achieved through core steerage plans (traditional Preferred Provider Organization models), Consumer Driven Health Plans, and High/Low plan designs based on previous years behavior for earning entry into High plan.

We have detailed experience in supporting the design and implementation of the designs. However, program success is dependent on effective communication and incentives. As the State of Alaska determines the optimal plan design for your culture, we will leverage our expertise with other customers to design incentives to reward behavior. Our support on incentives is an annual process to continue to both raise the bar as well as expand the program to see on-going improvement. Incentives that we are prepared to support and provide tracking information for the State of Alaska either through our health care management solution or the State of Alaska's selected vendor:

- Web and mobile utilization
- Case Management utilization
- Managed Behavioral Health utilization

2.3.3.2

Aetna is one employer that has experienced significant cost reductions as a direct result of a multi-year approach building incentives and disincentives on Consumer Driven Health Plans. The Aetna story is a good example of the year over year change necessary to deliver on-going cost management and maintain changes that arrive at true behavior change. We have proven results of integrating with third party pharmacies and health care management companies in the delivery of these plan designs.

As defined in our health care management proposal, we are prepared to implement unique technology solutions for the State. EOS Health is one of the vendors that we have put in place in Alaska and the lower 48 as part of our condition management program. For the State, we are prepared to put EOS Health in place under the medical or health care management program. The program has demonstrated results with the cost of the program fully offset with the financial savings of supplies and the cost of care.

Remote monitoring is another area that we will want to explore with the State of Alaska. We are currently running a pilot program focused on remote biometric monitoring to evaluate improvements in member engagement and health from use of specific devices – (i.e., blood glucose). We will want to work with the State on additional pilots and determine optimal resource for supporting this based on the State's selected vendors.

Abilto is another offering that can support the State's goals and remote nature of the membership. Abilto is a structured fixed-duration (8-week) behavior health programs to help members manage addressable life transition issues. Abilto delivers support using web-based videoconferencing, enabling members to meet "face-to-face" with a dedicated team via proven protocols.

Specific to the retirees, we are able to support plan designs specific to the current protected plan or establishment of alternative retiree plan. We have extensive retiree medical experience and the designs and solutions that achieve cost savings. We would suggest the State of Alaska develop a plan that is based on Medicare Advantage principles to effectively support the members in achieving their optimal health, obtain preventive care and effectively manage costs. These solutions have worked for many customers in the lower 48.

Summary

Aetna has extensive experience designing solutions to meet our customer's goals. As the State of Alaska explores unique designs and network delivery, our fully owned and operated provider network and claim system will enable us to support unique designs and features for the State of Alaska. We envision the State of Alaska deploying a multi-year strategy that will rely upon steerage and incentives to both drive the market and achieve the necessary behavior change.

2.3.3.2

We will work with the State of Alaska to advance your program and have designs commensurate with the change. While a future state, we envision the State of Alaska taking advantage of concentric and 3-Tier designs that optimize custom network solutions and Accountable Care Organizations. These are the next evolution of Institutes of Quality and take the concepts used in our Aetna Performance Network. These designs will take time to deploy in Alaska, but are not out of reach if the State is willing to drive.

The connections across the full health care program will be critical. Aetna is a full service organization delivering the full complement of services the State of Alaska is seeking. We can support the design and deployment of programs, incentives and wellness solutions to achieve your goals. Through the Aetna companies, we can deliver these on a fully integrated basis or can partner with third party organizations. We have demonstrated results of integrating with third party organizations on many of our sophisticated customers.

The change the State of Alaska is seeking will not happen overnight. We have the resources and tools to support the State of Alaska in achieving its goals, but more importantly the commitment to support the change. Our commitment extends beyond your administrator, but to the impact of overall change for our other customers with Alaska membership and our own insured business. We have a vested interest in the State of Alaska achieving its goals and supporting the on-going changes to continue to move the program forward. We will continue to innovate and evolve our solutions to meet your needs today and in the future.

Michael Petryna, R.Ph, MBA, CEBS
Pharmacy Vice President, Client Management
Blue Bell, PA

Michael Petryna, R.Ph, MBA, CEBS, is a Pharmacy Vice President, Client Management with Aetna Pharmacy Management. He supports Aetna Public and Labor segment sales and account teams in the pharmacy sales process and the unique needs of this market segment. He provides strategic pharmacy oversight to the segment and supports specific cases in the unique operational, financial, and clinical analysis involved in selecting, implementing, and optimizing pharmacy benefits.

Michael has extensive managed care experience, most recently as a managed markets strategic marketer for a large pharmaceutical manufacturer. He has served in a clinical role with a large blues plan interfacing with organized medical groups and other functions supporting pay for performance and other quality initiatives. He also has extensive retail pharmacy operational and leadership experience with a national chain. Finally, he has served over 27 years with the United States Navy, both in the active and reserve components, where he currently holds the rank of Commander. Serving in numerous leadership capacities he has extensive ambulatory and specialty pharmacy experience in supporting healthcare delivery throughout the military healthcare system. Furthermore, he has operational pharmacy experience in multinational humanitarian operations, the advising & training of foreign military medical leadership, and post-disaster response.

Michael has worked in the pharmacy industry since 1994 and has been with Aetna since 2007.

A registered pharmacist, Michael earned his Bachelor of Science, Pharmacy, and his Master of Business Administration (with a focus in marketing and strategy) from the University of Colorado.

Kristi Coulter, R.Ph, MHA
Clinical Pharmacy Director
Seattle, WA

Kristi is part of the Customer Relationship Management group for APM serving as the Clinical Pharmacy Director for the West Region.

She is available to provide pharmacy plan analysis, recommendations and address drug utilization issues. She also aids internal constituents through drug information, clinical support, and reporting. She is a licensed pharmacist in Washington State.

Kristi came to Aetna in 2005 after being employed most recently by county and state government agencies. At Washington State Labor and Industries, she was the Consulting Pharmacist assisting with pharmacy benefit design and implementation. Prior to that time, she worked at Public Health – Seattle and King County as the Senior Pharmacist where she oversaw drug procurement, distribution and pharmacy software management. She has experience with clinical, administrative and information technology.

Kristi received her Pharmacy degree from the School of Pharmacy and a Masters in Health Administration from the School of Public Health and Community Medicine both at the University of Washington. She is a member of the Academy of the Managed Care Pharmacy and the Washington State Pharmacy Association.

Michelle Gutierrez
Sr. Account Manager
West Region – National Accounts

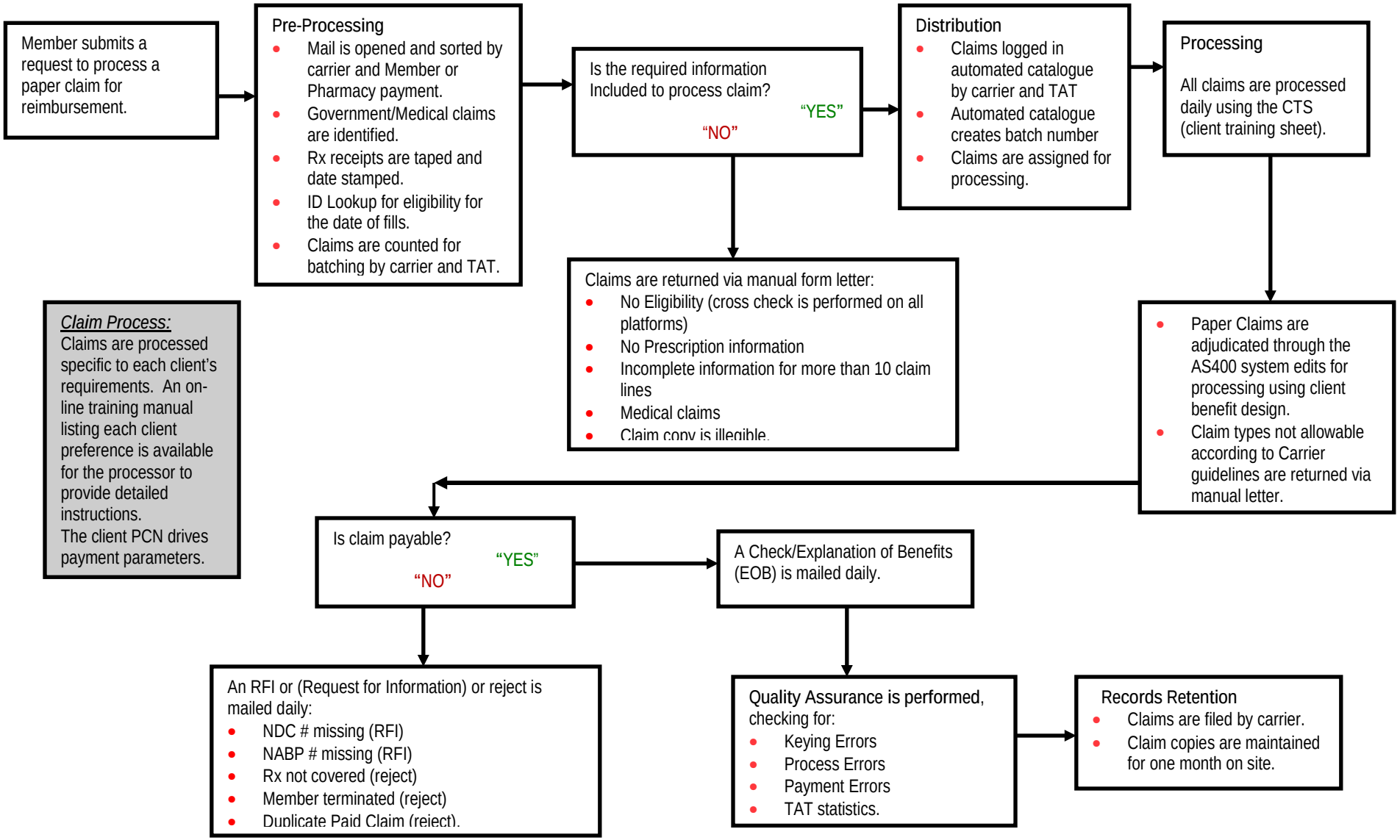
Joined Aetna in: October 2007	**Aetna:**	**3 years**
Began working at APM in: October 2007	**APM:**	**3 years**
Year began working in healthcare/PBM industry: 1997	**Experience:**	**13 years**
Began current position in: October 2007	**Current:**	**3 years**

Michelle is a Sr. Pharmacy Account Manager for the West region, accountable for quality pharmacy account services and customer satisfaction. Michelle manages pharmacy programs for the National Accounts business segment across the region. She plays a major role in supporting plan implementation, plan analysis, ad hoc reports and issue resolution. She is also responsible for retention of existing business by providing quality pharmacy account service and customer satisfaction.

Michelle joined Aetna in October of 2007. Michelle brings over 13 years of pharmacy industry experience to the Sr. Account Manager role. Prior to joining Aetna, Michelle spent several years in pharmacy recruiting with a national recruiting company and several years in account management with Caremark/PCS Health Systems.

Michelle holds a National PTCB Pharmacy Technician Certification, and an Arizona Pharmacy Technician License.

PAPER CLAIM PROCESSING FLOW CHART



QUESTION 3.1.3.2

Company Profile

HIPAA Compliance

Description:
We are in full compliance with HIPAA requirements that have been issued to date. Following is a brief summary:

Privacy
We have taken all steps necessary to comply with the Privacy Rule requirements, including:

- Naming a chief privacy officer and establishing a Privacy Office.
- Implementing new and/or revised company-wide privacy policies and procedures.
- Training impacted personnel.
- Implementing system changes and workflows to provide members with (i) access to their health information, (ii) an accounting of many types of disclosures, (iii) a process for requesting amendments to their health information, and (iv) the ability to request restrictions or have confidential information mailed to an alternative address.
- Delivering a Privacy Notice to full risk subscribers.
- Adopting specific disciplinary procedures and sanctions for employees who violate our Privacy Policies.

Transactions and Code Sets
We are positioned to support HIPAA compliant electronic transactions and code sets. We have the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare and Medicaid Services (CMS).

Security
To prepare for the HIPAA Security Rule, we performed a thorough risk assessment of our systems and operations and developed and executed a remediation plan.

Unique Identifiers
Aetna is compliant with the unique Employer Identifier Number (EIN) requirement.

QUESTION 3.1.3.2

We also can accept and process HIPAA standard electronic transactions that comply with the National Provider Identifier (NPI) regulations. Effective March 16, 2009, to comply with HIPAA regulations, we began rejecting electronic claims and encounters submitted without a billing provider NPI. If a "pay to" provider is identified on a claim, the NPI for that provider must also be included. We continue to work diligently with providers to educate them and bring them into compliance according to the HIPAA regulation.

Org Chart:
Diane F. McCammon is Aetna's Chief Privacy and Security Officer and is responsible for our compliance with the HIPAA Privacy and Security Rules.

Sean Hart, Head of Security Services, partners with the chief privacy and security officer to provide an overall improvement in the information security posture of Aetna as well as monitoring progress toward that objective. Exercising the chairman's retained authority, Sean and her unit perform the following functions:

- Protect Aetna information and information technology resources through a framework of timely, efficient and business driven Aetna Information System (AIS) security policies, standards and procedures.

- Recommend, maintain, communicate and manage adherence to integrated cross-functional AIS security and business continuity architectures, direction, policies, processes and standards that foster and serve as a basis for management planning, control and evaluation of information security activities.

- Establish individual employee responsibility for information security by setting simple, practical security requirements.

- Provide information security knowledge through the development and use of innovative, effective educational material.

- Interpret security policies, or provide input on direction of Information Security for Aetna.

- Establish and coordinate simple, business-related procedures for information security incident management, compliance monitoring and reporting. Provide AIS investigative support to management and investigative services, as required.

QUESTION 3.1.3.2

- Monitor pending legislation affecting AIS policies and practices and engages in effecting position (State and Federal) of health care/insurance information access, control and protection. Coordinate Aetna plan for required implementation or compliance.

- Assist in identification of appropriate, cost-effective sources of information to establish best practices and determine appropriate recommendation for a secure environment.

Subcontractor:
Aetna provides HIPAA compliance internally.

Location/Hours of Operation/Point of Contact/Onsite Support:
HIPAA compliance is followed and supported throughout our organization. Our privacy and security office is located in our headquarters in Hartford, CT.

The State's account executive, Lynda Gable, will serve as your single point of contact for any HIPAA related needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Communications

Description:
We offer extensive member communications to educate members, promote our programs and support our services. These communications include pre-enrollment materials, post enrollment materials, and extensive web tools.

Pre-enrollment communications
Some of the pre-enrollment communication materials include enrollment forms, provider directories, plan brochures, discount program flyers, special program flyers, wellness program brochures, flyers and html e-mails promoting our online tools and resources. In addition, we provide communication materials on other plans and programs available to the member, such as pharmacy and dental flyers, where appropriate.

Post enrollment communications
Post-enrollment materials may include eligibility change forms, ID cards, plan documents, wellness educational information and reminders, and html e-mails and electronic newsletters on educational, quality and patient safety topics.

QUESTION 3.1.3.2

Web tools
Members are looking for convenient, round-the-clock online tools and information to help them make educated health care decisions and manage their benefits online. Aetna Navigator®, our secure member website at www.aetna.com, offers several online resources which include benefits information, health education, health assessment tools, cost and quality tools and health care decision support.

Aetna Navigator offers secure functionality allowing members to:

- View eligibility and PCP selections for themselves or covered dependents.
- Change primary care physician and dentist selections.
- View eligibility information available on ID cards, such as member ID, group number, coverage effective date, etc.
- Inquire about the status of a medical, dental and pharmacy claim for themselves or a covered dependent.
- View details about medical, dental or pharmacy claims such as the amount paid by the plan and the members' responsibility.
- View benefit balances such as deductible and coinsurance maximums.
- View their Health History Record, a centralized summary of health information based on claims data for members and covered family members.
- Access a Health Plan Guide. Members can learn more about their health benefits by accessing the Health Plan Guide which helps explain how the plan works as well as the different tools and resources available with the plan. The plan guide is available as both flash presentation and PDF file.
- Download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.
- Check flexible spending account (FSA) status and detailed payment information.
- View EOB statements.
- Print out Aetna standard forms.

QUESTION 3.1.3.2

- Contact Member Services through secure messaging in both English and Spanish.

- Aetna Navigator member ID information, registration, claim search and Contact Us features is available on a mobile version of the website, allowing for the functionalities to be available in a more user-friendly format, specific to the mobile device being used.

- Aetna Navigator assists members in using their health plan and in making informed health choices by providing access to:

- Healthwise® Knowledgebase, a user-friendly decision-support tool designed to encourage informed health decision-making and allow users to better understand their treatment options.

- Aetna SmartSource℠, an intelligent online search tool available through Aetna Navigator, Simple Steps To A Healthier Life® and our Personal Health Record (PHR). A read-only version of the PHR is available for mobile devices.

- DocFind®, our newly redesigned, online directory of participating providers that includes details about providers and facilities as well as links to quality and patient safety information. Public DocFind is available for mobile devices.

- Simple Steps To A Healthier Life, a program that offers disease prevention, health education and behavior modification programs aimed at improving the health of our members.

- Aetna Pharmacy's website that offers interactive content and tools to help manage both health and pharmacy costs. Members can also sign up for mail order drug and check their order status.

- Women's Health Online, our women's health website that provides age-specific health care resources and interactive tools on a variety of health concerns for women.

- Plan For Your Health℠, a website that provides consumers with easy-to-understand information about health benefits and guidance on choices that will affect their financial futures.

QUESTION 3.1.3.2

- Credible health information through Aetna InteliHealth, our online health information subsidiary that provides members with online tools and resources to help them better understand health and wellness.

- All About the Benefits, an educational program designed to make health benefits a priority and provide young workers with the knowledge and confidence they need to make informed health benefits decisions as they enter the workforce.

- Aetna Navigator Hospital Comparison Tool, a tool that allows users access to evidence-based hospital outcome data and quality and safety information on hospitals in their area.

- Estimate the Cost of Care (ECC), a suite of interactive web-based cost tools designed to provide members with cost information they can use to make more informed decisions. Cost information is provided for the most common medical and dental procedures, prescription drugs, office visits, diagnostic test and vaccines and diseases and conditions. The Price-A-Drug tool is available for mobile devices.

Custom communications
Aetna Customized Communications Group℠ (CCG), our strategic communications consulting group, is available to partner with the State to develop and deliver customized materials. This talented, award-winning team has more than 25 years of experience in developing customized benefit communications and offers a broad range of products and services to meet your needs.

Offering a unique combination of benefits knowledge and communication expertise, CCG develops open enrollment campaigns, launches and sustains wellness initiatives, and educates employees about appropriate utilization of the programs and services that encompass their overall benefits program. CCG will prepare detailed proposals outlining recommendations, specifications and associated costs. All materials are developed according to your plan design, style, tone, philosophy and employee audience.

Backed by an experienced staff of project managers, writers, graphic designers, print production managers, web developers and distribution specialists, CCG has the expertise and technical resources to produce a broad range of materials and manage benefit communications of any size and level of complexity from start to finish.

QUESTION 3.1.3.2

Support of health literacy
Nearly 9 out of 10 adults have trouble understanding and using the health information they are given in health care settings.[1] This leads to poorer health and increased costs. To address this problem, we created the Health Literacy Workgroup. At the start, the main goal of the group was to raise awareness about the challenges of poor health literacy. Later, we began to propose solutions to address the challenges.

Our mission is to have a positive impact on health outcomes by using and promoting universal health literacy strategies. Our goals are to:

- Research the effect of health literacy on consumer understanding of health information and its impact on health outcomes.

- Increase awareness about health literacy among health care professionals, members and Aetna employees.

- Provide stakeholders with the tools and resources they need to address challenges to health literacy.

- Promote language simplification so that we communicate health information in a manner that is understood by all audiences.

Our cross-functional group contains representatives from:

- Health care management
- Quality management
- Pharmacy and dental operations
- Product and program development
- Marketing and communications
- Claims and customer service
- Sales

QUESTION 3.1.3.2

Health literacy initiatives

Since 2005, we've worked hard to:

Spread the word

We speak about the cause to Aetna employees, industry trade groups, professional associations and other health literacy groups. We've invited experts in the field to speak to our employees. These experts include Drs. Darren Dewalt, Bob Like and Barry Weiss, as well as plain language and cross-cultural communications expert Janet Ohene-Frempong.

Engage employees

Employee "champions" weave the concepts of health literacy and plain language into the fabric of the organization. This increases the value of our brand, reputation and business success. Every Aetna employee receives annual awareness training about health literacy and plain language. We also have an online health literacy awareness course for all employees.

Permanent features of our employee intranet include *Jargon Alerts* and *Because You Asked*, which both help employees figure out better ways to convey information. During national Health Literacy Month, we sponsor contests to engage employees. One asked entrants to rewrite a paragraph to reduce its reading grade level and enhance its clarity.

Reach out to clinicians

We talk to doctors and nurses about their role in helping patients better understand their health and health care. We have created awareness activities for doctors, including:

- Health literacy messaging to physicians via educational and clinical apps
- Features about health literacy in our physician newsletter
- A health literacy reference tool on our provider education website
- A cultural competency course for clinicians

Conduct research

We research and analyze the effect of health literacy on consumer understanding of health information and its impact on health outcomes.

QUESTION 3.1.3.2

Improve communications

We have used plain language to simplify more than 200 codes for our explanations of benefits and simplified more than 70 member letters. In addition, we produce *Navigating Your Health Benefits for Dummies*, a book that breaks down the complex health benefits system into easily digestible pieces and helps consumers navigate their way.

Collaborate with others

One of our medical directors serves on the programs committee of the American College of Physicians Foundation. An Aetna vice president is an active member of the Institute of Medicine's Round Table on Health Literacy, as well as chair of AHIP's Health Literacy Taskforce. We also collaborate with the American Medical Association Foundation to distribute their continuing medical education course on health literacy to clinicians.

We work with the Financial Planning Association to sponsor *Plan for Your Health,* a public education website that gives consumers the tools and information they need to make smart health benefit decisions to protect their health and financial future. The site focuses on life stages such as changing jobs, getting married, starting a family and planning for retirement. It is also available in Spanish.

[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Washington, D.C.

Workflow:
All standard pre-enrollment distribution activities are centralized. This helps to ensure the accurate fulfillment and timely delivery of enrollment materials regardless of where we send them. Our standard process is to bulk-ship enrollment materials from our fulfillment center to your locations for distribution to employees. There are no additional costs associated with this standard delivery process.

We will work with the State to determine whether pre-enrollment materials will be sent to the employees' homes or made available at employee meetings. There would be an additional cost to mail these materials to the members' homes.

Member ID cards are mailed to members' homes at no additional charge. Post-enrollment materials such as wellness messages and quality/patient safety e.messages, are available to you to send to members. Our monthly e-mail newsletter, Member Essentials℠, is sent to registered subscribers that have elected to receive e-mails on their Personal Profile page in Aetna Navigator®, unless you elect to opt out of this service.

QUESTION 3.1.3.2

Org Chart:
As of December 31, 2011, we had 198 employees in our Communications division.

Aetna Customized Communications Group℠ (CCG) has 25 full-time employees, including project managers, writers, graphic designers, print production managers and distribution specialists.

Subcontractor:
We primarily provide communication services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Production and fulfillment of most communications, including our CCG team, are located in Hartford, CT.

The State's account executive, Lynda Gable, will serve as your single point of contact for any communication needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Information Technology

Description:
Aetna Information Services (AIS), the Information Technology (IT) function of Aetna Inc., supports the core Aetna Group values by leveraging technological solutions that provide more information and more choices to policyholders, members and internal business partners.

Aetna's Information Security Policy was created based on the following supporting national standards:

- **HIPAA** (Health Insurance Portability and Accountability Act of 1996)
- **ISO/IEC 17799**, Information Technology - Code of Practice for Information Security Management, First Edition, Reference Number ISO/IEC 17799:2000(E), 2000-12-1
- **NIST Special Publication 800-12**, National Institute of Standards and Technology: An Introduction to Computer Security: The NIST Handbook, October 1995
- **NIST Special Publication (SP) 800-14**: Generally Accepted Principles and Practices for Securing Information Technology Systems, September 1996

QUESTION 3.1.3.2

The Company has placed into operation an Enterprise Risk Management Process to identify and prioritize the significant enterprise risks that could affect the Aetna Group and the Company, including its ability to provide reliable service to customers of the Company and, specifically, for purposes of this Report, to users of the Company's Self-Funded Products. The goal of this process is to assist management in identifying significant risks inherent in the processing of various types of transactions for users and implementing appropriate measures to monitor and manage these risks.

The Company's management of risks is primarily achieved through the various control environment items discussed above. The Chairman, CEO and President of the Company, along with the Chief Enterprise Risk Officer and other members of senior management, are responsible for identifying and managing the risks that might impact the Company through predefined organizational reporting structures. The Board of Directors of Aetna Inc., along with Aetna Inc.'s Audit Committee and other Aetna Inc. Board committees, oversees the Aetna Group's enterprise risk management processes, including risk identification and prioritization.

Information Security Awareness
New employees are introduced to Aetna's Information Security Program via a web-based New Employee Orientation Program. Each new employee and contingent worker must complete Aetna's Code of Conduct training program called Business Conduct & Integrity (BCI), which includes an Information Security module.

All employees and contingent workers must complete BCI annually thereafter. Audience specific (managers, application developers, etc.) security training is routinely provided. Aetna's training program is robust and well documented.

Continued reinforcement via emails, web articles, newsletters, and face-to-face activities is provided to the Aetna workforce regarding each individual's role in ensuring the confidentiality, integrity, and availability of Aetna information.

Background checks on all personnel
A comprehensive background investigation is conducted on all candidates for Aetna regular and Aetna temporary employment. Employment offers are contingent upon the candidate's successful completion of this investigation.

For additional information about our Information Technology, please refer to the attached Information Security High Level Overview document.

QUESTION 3.1.3.2

Flow Chart:
Please refer to the Information Technology Flow Chart and Network Diagram attachments.

Org Chart:
To design and deliver these technology solutions, AIS has nearly 3,000 IT professionals and over 2,000 contractors working collaboratively, in dozens of teams, in every area of IT. AIS and its service and solution orientation stretch from e-commerce to mainframe operations utilizing top technical and business talent. Project planners, network engineers, database analysts, architects, developers and quality assurance engineers are all key members of AIS.

These IT professionals are currently organized into eight functional departments. The eight main departments are Integrated Infrastructure Services (IIS); Enterprise Architecture (EA); Program Delivery (PD); Application Delivery (AD); AIS Delivery Operations (ADO); Enterprise Testing & Quality Assurance (ETQA); Production & Enhancement (P&E); and International IT.

Each department is accountable for a key element of practical and strategic IT solutions delivery.

Subcontractor:
We primarily provide Information Technology services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our IT staff is spread out across many offices throughout the country. The State's account executive, Lynda Gable, will serve as your single point of contact for any information technology needs.

Integration with Other Vendors

Description:
We have extensive experience integrating with other vendors.

We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Aetna Informatics® has more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

We typically disclose processed claim transaction data in our standard Universal File formats, one for Medical/Dental and a separate format for Aetna Pharmacy Management.

QUESTION 3.1.3.2

These electronic claims data extracts are available through CD-ROM or electronically on a fee-for-service basis. If the standard format does not meet the State's needs, customized reporting is available.

We also have the capability to import external pharmacy, medical and behavioral health claims data from third-party vendors into selected clinical and reporting applications. The external data that we bring into our organization is used for a wide variety of purposes including but not limited to:

- Disease identification
- Disease severity identification
- Decision support
- Case management
- Predictive modeling
- Personal health record input
- Patient safety programs such as MedQuery®
- Input into selected HEDIS measures

Subcontractor:
We perform integration services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
The State's account executive, Lynda Gable, will serve as your single point of contact for any integration needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Patient Value Chain

Retail Networks

- Broad National Retail Networks
- Retail-90 Networks
- Price Sources for Retail Networks

Description:
APM offers the following pharmacy networks to our self-funded customers. We use the Medi-Span® Prescription Pricing Guide (with supplements), as our pricing source for AWP discounts. Claims are adjudicated using Medi-Span drug prices as of the date of service. We receive and load AWP updates on a daily basis, Monday through Friday.

QUESTION 3.1.3.2

APM National Retail Pharmacy Network

Our broadest retail pharmacy network provides members with access to approximately 67,000 pharmacies throughout all 50 states, the District of Columbia, Puerto Rico, Guam, Northern Mariana Islands and the U.S. Virgin Islands.

Extended Day Supply (EDS) Network

Through this network, members can fill prescriptions for 35 to 90 days at a participating retail pharmacy, providing deeper discounts for you. The network currently consists of over 57,000 retail pharmacies, which includes chain and independent pharmacies.

Aetna Rx Value Network

This network offers a narrow retail pharmacy network, consisting of more than 42,000 pharmacies. Members can fill a maintenance prescription with a days' supply between 1 and 90 days at any of our network pharmacies. We include drug store chains, large retail merchandisers, grocery chains and independent pharmacies in the network.

The network helps to improve savings for you while maintaining superior access and convenience for members. Working with a smaller number of retail pharmacies provides the opportunity to negotiate better rates with the contracted pharmacies and deliver increased savings to you. Potential customer savings of 0.5% to 1.5% of gross retail drug spend, depending on your specific utilization experience.

The benefit of this network is the convenient access for members and the cost savings you should achieve. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

Aetna Rx Preferred Network

This retail network includes CVS/pharmacy and Wal-Mart and provides access to approximately 11,700 retail pharmacies. Members can fill a 1-90 day supply of drugs at any of the in-network pharmacies. We exclude all other pharmacies from this network. In order to maximize the savings potential and offer your members a choice of pharmacy, certain requirements apply. This limited network offering can provide up to 2.5% to 3.5% savings on your gross retail pharmacy spend, depending on your specific experience.

The benefit of this network is the convenient access for members and the cost savings for customers. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

QUESTION 3.1.3.2

Aetna Rx Choice Network

This retail network provides access to our entire national network of pharmacies with financial incentives to use the Aetna Rx Preferred Network. Members receive the lowest out of pocket costs when they fill drugs through CVS/pharmacy and Wal-Mart. Members can choose to use other pharmacies within our large national network and incur higher out of pocket costs. Members can fill a 1-90 day supply of drugs at any of the pharmacies in the first tier and a 30-day supply of drugs at any of the pharmacies in the second tier. In order to maximize the savings potential of this retail network offering, certain requirements apply. This offering can provide up to 2% to 3% savings on your gross retail pharmacy spend, depending on your specific experience.

The benefit of this network is the convenient access for members and the cost savings for you. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

APM Customized Pharmacy Network

By analyzing your actual pharmacy claim data, we can develop a customized network option for the State of Alaska. This may include excluding certain chains.

Subcontractor:
CVS Caremark provides the administration for Aetna's retail pharmacy network contracting and claim administration.

Location/Hours of Operation/Point of Contact/Onsite Support:
The State of Alaska or their members may also request that we have an out-of-network retail pharmacy contacted and asked to join our network. We may include retail pharmacies that meet qualification standards, agree to pharmacy contract requirements and agree to the financial terms of the network. Members may contact Member Services 24 hours a day, 7 days a week. The State of Alaska may contact their account management team during working hours.

QUESTION 3.1.3.2

Mail Order

- Shipping and Handling
- Member Payments

Description:
We have provided a complete description of the mail-order dispensing process under the headers below.

Order submission

Members can submit new prescriptions through mail, physician-submitted fax or e-prescribing. They can submit refills through mail, online, telephone or interactive voice response (IVR). Members can submit physician-authorized refills for up to one year for non-controlled substances and up to six months for most controlled substances, before having to renew their prescriptions.

Member registration/order entry

We have the order entry process automated with menu driven screens to optimize accuracy and efficiency. Order entry technicians key information from the order forms to the pharmacy system and match it with the member's pharmacy plan benefit data.

Order imaging

We have each prescription scanned so that a readable, high-resolution image of the actual prescription is maintained for reference and tracking throughout the dispensing process.

Order review

During the order review process, a pharmacist examines new prescriptions for details such as:

- Member and physician ID
- Drug name
- Drug strength
- Instructions for use
- Quantity
- Refill status

QUESTION 3.1.3.2

The pharmacist compares these to the corresponding image in the system. The pharmacist examines the printed label, and after confirming order accuracy, the pharmacist releases the order for eligibility and payment confirmation.

Clinical review

We have the clinical review conducted with an electronic support system responsible for DUR activities and other clinical exception processes within each order. Examples include informational or consultative physician and member calls concerning therapeutic duplication, medical diagnosis, dosage confirmation, member counseling and generic substitution.

Prescription dispensing

Once forwarded to the dispensing area, orders enter a streamlined routing system that promptly sends them to the correct location. We have the following systems used to dispense drugs:

- *Automated prescription selector* – We have this system used for unit-of-use packages. Orders fill through a time-paced conveyor system. Computerized scanning confirms that we had the correct drug selected and directed to the right prescription order.

- *OptiFill® system* – We have this system used for solid-dose drugs. The process begins when a series of electromechanical functions select, label, fill, check and cap a bottle. The system photographs the prescription content and verifies the count.

- *Semi-automated dispensing* – We use this approach for less frequently prescribed drugs. This approach includes pharmacy filling stations equipped with laser counting machines. These orders account for approximately 10 percent of all mail-order prescriptions.

The dispensing pharmacies operate in accordance with strict standard operating procedures. An independent quality department regulates and routinely audits the pharmacies.

Pharmacist quality assurance

Computerized systems and imaging technology enhance the final pharmacist check. The automated conveyor system delivers the completed order to the pharmacist check station. We have the tote scanned and the order displays on a computer screen. The pharmacist compares the actual drug to the reference picture.

QUESTION 3.1.3.2

If the pharmacist is not satisfied that the order is correct, we have a dedicated pharmacist assigned to research the order. Once resolved, we have the order placed back on the line for forwarding to the shipping area.

At least two pharmacists check every new order. If an order requires prescriber clarification or modification, a third pharmacist may become involved.

Packing

We have orders packed using a tamper-resistant special shipping mailer or a corrugated box sealed with tamper-evident brown stitch tape depending on the number of ordered drugs. We have special packaging used for refrigerated products as well as for those requiring pressure-sensitive handling.

We have environmentally sound packaging materials continually incorporated into the shipping process:

- White prescription bottles are recyclable
- Amber prescription bottles carry a recycling code of five
- Corrugated shipping containers are recycled
- Shipping envelopes are either polyethylene mailing bags or 100 percent recycled Kraft mailing bags
- Bubble liner is 85 percent recycled (35 percent is post-consumer).

Shipping and metering

When the package reaches the metering area, we have the order number bar code scanned. The member's address and the number of prescriptions ordered will appear on a computer screen only when the order is complete. The system then determines the best available method for sending the prescription, taking into consideration:

- Medicine type
- Speed of delivery
- Destination
- Package weight

QUESTION 3.1.3.2

The shipping label includes the member's address, the return address and method of shipment (U.S. Mail, Priority Mail, UPS, Fed-Ex, etc. or if an adult signature required is applicable). To prevent tampering, we have the shipping label placed over the package seal. To maintain further security and confidentiality, the shipping label indicates only the return address. Neither the word "prescription" nor the word "drug" appear anywhere on the outside of the shipping container.

Member payment

We collect copayments when members place their order. Payment options include:

- Check
- Money order
- Debit and credit cards (Visa, MasterCard, American Express and Discover)
- FSA
- Bill Me Later

For members paying by credit card and FSA, we have their credit information stored in our system. For security reasons, we make only the last four digits of the member's credit card number viewable.

If we receive a mail service prescription with an overpayment, we credit it to the member's next order. If requested, we issue a check for the amount overpaid.

Flow Chart:
Please refer to the attachment labeled Mail Order Workflow.

Org Chart:
Please refer to the attachment labeled Mail Order Organizational Chart.

Subcontractor:
We provide core mail order services internally. CVS Caremark manages purchasing, inventory management and order fulfillment for mail order operations.

Location/Hours of Operation/Point of Contact/Onsite Support:
We own and operate two front-end mail service pharmacies. Your account management team will be the primary point of contact for mail order questions. This team will provide onsite support, as necessary.

QUESTION 3.1.3.2

The addresses and hours of operation for the front-end pharmacies are:

10991 NW Airworld Dr.
Kansas City, MO 64153
Monday - Friday: 8 a.m. to 1 a.m. ET
Saturday: 8 a.m. to 4:30 p.m. ET

1600 SW 80th Terrace
Plantation, FL 33324
Monday - Friday: 7 a.m. to 10 p.m. ET

To support our front-end pharmacies, we dispense orders through one of the following dispensing pharmacies. Please note that the Plantation, FL pharmacy also dispenses all controlled substance prescriptions.

Location	Monday – Thursday**	Friday*	Saturday*	Sunday*
800 Biermann Ct. Mt. Prospect, IL 60056	6:00 a.m. - 1:45 a.m.	6:00 a.m. - 1:45 a.m.	6:00 a.m. – 3:30 p.m.	Closed
1 Great Valley Blvd. Wilkes-Barre, PA 18702	6:00 a.m. – 1:30 a.m.	6:00 a.m. - 1:30 a.m.	3:00 p.m. – 1:30 a.m.	3:00 p.m. – 1:30 a.m.
1600 SW 80th Terrace Plantation, FL 33324	7:00 a.m. – 10:00 p.m.	7:00 a.m. - 10:00 p.m.	Closed	Closed

* All times are local

Specialty Pharmacy

- Definition of Specialty Drugs
- Distribution Alternatives and Operations

Description:
We define specialty drugs as medications that include, but are not limited to, pharmaceutical products that are very expensive, typically have no less costly equivalents, are often biologicals, may or may not be infusible or injectable, require a greater amount of pharmaceutical oversight and clinical monitoring, and/or are addressed to serious conditions like cancer, rheumatoid arthritis and multiple sclerosis.

QUESTION 3.1.3.2

In addition, we also understand that these medications:

- Frequently cost over $500 per prescription
- Sometimes have harsh side effects
- Are most commonly infused or injected
- Require special handling or temperature control
- Need therapy management including:
  - Side effect management
  - Patient adherence and compliance
  - Training and support for administration
  - Are subject to wastage
  - Should be dispensed as a 30 day supply to account for potential changes in therapy
  - Are more effectively managed in a high touch, low volume delivery mode

Our specialty pharmacy dispensing process promotes proper dispensing and member satisfaction. We employ 268 individuals dedicated solely to specialty pharmacy services.

We carefully monitor and control the processes, procedures and outcomes through a clinically oriented team of pharmacists, nurses and technicians. We have provided a complete description of the dispensing process below:

Member registration/initial order entry

We use menu driven screens during the order entry process to optimize accuracy and efficiency. Aetna Specialty Pharmacy® representatives verify that prescriptions and order forms contain all necessary information.

If an order is missing necessary information, the representative reaches out to the prescribing physician to get an acceptable prescription order. Once obtained, the representative creates an electronic record by scanning an electronic prescription image and entering the information into our computer system. The representative keys in the member's contact information, and then categorizes the order into the proper tier:

- Tier 1 – Applies to standard specialty orders that we consider ready for processing
- Tier 2 – Applies to therapies that require precertification
- Tier 3 – Applies to orders for STAT drugs, including infertility and oncology therapies

Depending on the order tier, we create tasks in our clinical informatics system, COMPASS, for patient care coordinators (PCCs) to follow so that they can proceed with each order.

QUESTION 3.1.3.2

Member intake

We divide PCCs into the three order tiers. They interact with members and sometimes with prescribing physicians. They verify member information including gender, height, weight, age, therapy, dosage, allergies and shipping address. They also find out if members have any special needs, such as help understanding their therapy. The PCC enters all of this information into the member's electronic medical record (EMR).

PCCs also receive insurance information and any other information necessary to verify benefits. They run test claims to find out if orders will process under the pharmacy or medical benefit. They also confirm the member's method of payment.

Clinical assessment/nurse support

Members and physicians have 24/7 access to nurses and pharmacists. We record all nurse interactions with members in the member's EMR. If at any time the member reports side effects or trouble staying on track with their therapy, we offer the member coping advice. We then contact the prescribing physician to discuss:

- The member's concerns
- The suggested intervention
- Whether the member might benefit from a change in their medication, dose or therapy schedule

Screening for depression/anxiety

Another important function of the nursing team is that they can screen members for signs of depression or anxiety. If we discover that the member may be at risk, we work with them to offer extra emotional support.

Encouraging therapy compliance

For select therapies, nurses use an automated telephone scripting process that prompts them to ask certain questions to encourage therapy compliance. We then record the response data. This helps manage any side effects or injection issues, as well as monitor dose to see if we need to intervene.

Every time our nurses talk with members, they discuss any adherence issues. They leverage motivational interviewing techniques to uncover therapy concerns. This helps determine if members need extra emotional support or if we can do something else to improve compliance.

QUESTION 3.1.3.2

Our nurses support members throughout treatment, helping them stay compliant to achieve the best health outcome possible.

Order setup

Processing technicians (PTs) set up the components of each order and prepare the order for pharmacist review. They verify that the shipping address, date, method and signature requirement are correct. They also review the member's prescribing history to verify when they last filled their medication and if they are currently taking any other medications.

PTs enter specific diagnosis codes and follow all pharmacy regulatory laws. If there is any question about the prescription, we alert a pharmacist. If any information is missing or inaccurate, a pharmacist contacts the prescribing physician to clarify.

Next, PTs add all necessary supplies to the order. They then adjudicate the claim and work any rejections, if necessary. If the rejection is not resolvable at a PT level, they route the order to an insurance specialist. If the claim pays, the PT will complete the order and enter processing notes.

Insurance verification

Insurance specialists verify the member's plan benefits. They communicate with the member and their prescribing physician to keep them informed of the status. Once approved, the insurance specialist routes the order forward.

Claims specialist review

Once we adjudicate the prescription and verify insurance, the claims specialist helps members to stay on top of their payments for any out-of-pocket costs. If an outstanding balance persists, they contact the member and re-confirm their payment method. They may also help the member pursue a member assistance program. They provide information about available manufacturer copay assistance programs. For qualified members, they can also work with them to set up a payment plan.

QUESTION 3.1.3.2

First pharmacist review

Pharmacists perform two thorough quality reviews before approving order delivery. The first review takes place after the PT approves the order for fulfillment. The pharmacist reviews the prescription image and contacts the prescribing physician if there are any concerns. During this conversation, the pharmacist and physician discuss the member's prescription and determine if any intervention is necessary. The pharmacist may also contact the member to discuss any concerns.

Pharmacists also review the member's past medical history. They check the member's past medication compliance and their past dosage. Pharmacists look at the written prescription and compare it with the processed order to ensure accuracy. They ensure that we have noted the correct supplies, ship date and shipping address.

Pharmacists are on-call to assist members and physicians, 24 hours a day, 7 days a week. We record pharmacist interactions with members in the member's EMR. We report details of these interactions to the prescribing physician, as necessary.

Order confirmation

During order confirmation, a pharmacy service representative will call members, as well as their prescribing physicians, to confirm delivery. They also confirm the shipping address and whether or not a signature release is required. They will also review with the member any copay or coinsurance amount due and obtain a payment method.

Order filling

The Specialty Pharmacy Fulfillment System is a tote system for dispensing:

- Unit of use
- Unit dose
- Bulk
- Refrigerated drugs
- Supplies
- Various other materials

We have A-frame technology used to dispense unit of use, unit dose refrigerated and non-refrigerated items automatically. One frame is responsible for refrigerated dispensing while two frames dispense the non-refrigerated items.

QUESTION 3.1.3.2

The system requires all users to log in and perform scans as well as following the on-screen prompts, ensuring accuracy and accountability. Additionally, pharmacist verification stations check and verify the labeled prescription orders. Using this system, we have experienced minimal unscheduled downtime of a few hours in the past year.

Pharmacist review/quality control

For all prescriptions, a pharmacist completes a prospective use review for appropriateness, safety and therapeutic effectiveness.

Pharmacist initially assesses:

- Indications for use
- Dosing
- Route of administration
- Delivery system
- Point of care

Pharmacist monitors therapy problems:

- Drug allergies
- Co-morbidities
- Drug Interactions
- Therapeutic duplication
- Side-effect management

The dispensing system contains a number of checks and balances to minimize prescription entry errors. A pharmacist reviews the prescription entry to ensure accuracy of:

- Drug selection
- Dose
- Dosage form
- Frequency
- Route of administration
- Quantity prescribed
- Directions for use
- Number of refills

In the fulfillment area, a pharmacist performs a final check to ensure that the order is accurate and ready for shipping. This includes:

- Drug selection
- Strength
- Dosage form
- Quantity
- Label

QUESTION 3.1.3.2

Packaging

Many specialty drugs we have dispensed require special handling. To ensure product integrity during shipping, there are established packaging and shipping guidelines for each of the dispensed products. Guidelines indicate special handling requirements for certain medications and products, which may include using insulated containers and frozen gel packs. When we anticipate the package may travel through extreme weather conditions, we have special precautions used to prevent products from freezing or overheating during transit.

Delivery

Because of the high-cost and stability requirements for the specialty drugs dispensed, our primary method of product delivery is UPS. Our Aetna Specialty Pharmacy Logistics team assures all medication shipments arrive safe and quickly to the final destination and avoids waste. We use secure, online shipment tracking to monitor the whereabouts of every package throughout delivery.

All shipping packages are unmarked as to contents or other confidential information. The outside package is marked only with a shipping label, with the member's name and address and instructions for handling (e.g., "Refrigerate immediately upon arrival").

Special handling

Because most specialty drugs require special handling, we work closely with manufacturers to determine the most cost-effective method of shipping product. We use the ambient temperature of the shipping and receiving destinations, along with the manufacturer's recommendation, to determine the method and supplies for special handling.

Active refill

Through our active refill service, we proactively contact members seven days before their refill is due. During active refill, we monitor compliance and confirm delivery. We verify the member is still taking their medication, confirm their medication dosage and ask if they are experiencing any unmanageable side effects. At time of refill, we offer the member the opportunity to speak with a nurse or pharmacist to address any therapy-related questions or concerns.

QUESTION 3.1.3.2

Flow Chart:
New patients to Aetna Specialty Pharmacy

- Prescription is received by indexer via fax.
- Patient care coordinator verifies benefits and makes an outreach welcome call to all new members.
- Processing technician performs data entry and the prescription is reviewed by a pharmacist.
- Claim is adjusted. Prescriptions with paid claims are sent to a pharmacy service representative for delivery confirmation.

Existing Patients to Aetna Specialty Pharmacy

- Prescription is received by indexer via fax.
- Patient care coordinator verifies benefits and pushes order to processing technician.
- Processing technician performs data entry and the prescription is reviewed by the pharmacist.
- Claim is adjudicated. Prescriptions with paid claims are sent to a pharmacy service representative for delivery confirmation.

Org Chart:
Please refer to the attachment labeled Aetna Specialty Pharmacy Leadership Org Chart.

Subcontractor:
We provide core mail order services internally. CVS Caremark manages purchasing, inventory management and order fulfillment for specialty pharmacy operations.

Location/Hours of Operation/Point of Contact/Onsite Support:
Aetna Specialty Pharmacy® has a centralized pharmacy and customer service center in Orlando, FL. From this facility, we provide high-touch, therapy-specific support services to members living with complex conditions. Your account team will be the primary point of contact for specialty-related questions. They can provide onsite support, as needed.

Our dedicated team of pharmacists, nurses and pharmacy CSRs can address all therapy support needs through our toll-free number. Regular business hours are Monday through Friday, 8 a.m. to 7 p.m. ET. Our clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

Aetna Specialty Pharmacy
503 Sunport Lane
Orlando, FL 32809

QUESTION 3.1.3.2

Required Attachments

We have completed the Geo Access and Network Analysis Request.

Pricing

- Maximum Allowable Cost (MAC)
- Average Wholesale Price (AWP)
- Drug Classification
- Retail Pricing
- Mail Order
- Specialty Pharmacy Pricing
- Rebates

Description:
Maximum Allowable Cost

We manage our MAC list to help contain costs and promote effective and safe use of generic drugs. Through our MAC program, we encourage participating pharmacies to dispense certain therapeutically equivalent generic drugs (if appropriate) when a brand drug is prescribed. We are offering the State of Alaska our MAC program at both mail and retail.

We establish the MAC price for each drug by reviewing information from several sources, including Medi-Span®, drug wholesalers and the Centers for Medicare and Medicaid Services (CMS) and applying various formulas to develop an appropriate MAC reimbursement amount. We regularly review our MAC pricing and make adjustments as appropriate. We perform on-going evaluations based on marketplace dynamics and utilization to ensure a fair and equitable level of reimbursement.

We may exclude products from our MAC list if they do not meet our MAC criteria. This includes, but is not limited to, generics that are not A-rated drugs, generics with low claim volume or single-source generic drugs.

QUESTION 3.1.3.2

We use stringent criteria to promote quality generics under our pharmacy program. To be included on our MAC list, generics must:

- Contain the same active ingredients as the brand; non-active ingredients, fillers and colors may vary
- Be identical in dose, dosage form and method of administration
- Be absorbed to nearly the same extent and in a similar timeframe, as the brand drug
- Meet the same batch consistency requirements for identifying strength, purity and quality
- Be manufactured under the same standards as the FDA's Good Manufacturing Practice regulations as the brand drug
- Be available from a nationally reliable source and have an adequate supply of the drug available

Average Wholesale Price – Retail, mail and specialty pricing

We use the Medi-Span® Prescription Pricing Guide (with supplements), as our pricing source for AWP discounts. Claims are adjudicated using Medi-Span drug prices as of the date of service. We receive and load AWP updates on a daily basis, Monday through Friday. This applies to retail, mail order and specialty claims.

Drug classification

Our Pharmacy and Therapeutics (P&T) committee conducts an extensive clinical therapeutic class review to determine each drug's safety and effectiveness. The committee uses clinical information from literature and database searches from a number of sources including, but not limited to:

- Clinical Pharmacology, a Gold Standard product
- American Hospital Formulary Service Drug Information (AHFS-DI)
- MicroMedex's DRUGDEX®
- Medline

QUESTION 3.1.3.2

- Other databases, including relevant findings of Federal government agencies (e.g., National Institutes of Health, guidelines developed by federal government agencies, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention)

- Medical professional associations (e.g., American Medical Association, American Academy of Pediatrics, American College of Cardiology), national commissions (e.g., Institute of Medicine, Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults)

- Peer-reviewed journals (e.g., Journal of the American Medical Association, New England Journal of Medicine, Annals of Internal Medicine, Drugs, Annals of Pharmacotherapy)

We use an Academy of Managed Care Pharmacy (AMCP) Format for Formulary Submission dossier, if available, with new and currently available drugs.

We also include utilization data for drugs within the class in the review. Cost and manufacturer rebates are among the factors we consider for drugs that are clinically and therapeutically similar to other available products. We conduct additional reviews of such drugs before deciding whether to include these drugs on our formulary.

Regardless of cost factors, we include products that demonstrate important therapeutic advances. Precertification may apply to such products. We may exclude products that demonstrate significant disadvantages in safety or effectiveness in comparison to other similar products, or we may cover them at the higher copay level.

Rebates

To collect the rebates, we provide the manufacturer with an invoice documenting utilization of formulary or preferred specialty rebateable drugs. The manufacturer audits and approves the data, then pays us according to the term of our rebate contract. A report indicating the customer's rebate payments, broken down by calendar quarter, is included with each remittance received under the program and is available upon request.

We allocate collected rebates to each eligible customer based on the administrative services agreement and on the formulary rebateable drugs members used.

QUESTION 3.1.3.2

Subcontractor:
CVS Caremark provides the administration of selected functions for Aetna's retail pharmacy network contracting and claims administration, as well as mail order dispensing and customer service, specialty pharmacy order dispensing and inventory purchasing and management.

Eligibility and Enrollment

Description:
You will have an assigned enrollment analyst who will be responsible for maintaining high quality in the eligibility data system.

We accept and process enrollment and change data in any of the following methods:

- Internet-based Eligibility Transfer Solutions – The State can submit eligibility using our web-based transfer solution called SecureTransport™. The State uses the software to transmit eligibility files to us during open enrollment and as needed for updates. SecureTransport is a trademark Axway® used under license.

- Electronic Transport Method – The State can submit enrollment through SecureTransport using an electronic transport method.

- e.Listing – An e.Listing is an Excel spreadsheet populated with eligibility data. We scan the spreadsheet into our systems and it mirrors an electronic file, eliminating manual intervention. The e.Listing functionality increases the timeliness of eligibility updates so that members can access care quickly. e.Listings received by us prior to 3 p.m. ET in the appropriate format are processed same day.

- Enrollment Forms – The State can submit paper enrollment forms that will be input manually.

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

We integrated the enrollment aspect with our policy entry, claims and pharmacy management systems.

QUESTION 3.1.3.2

Your enrollment analyst will monitor the eligibility file updates and will know immediately about any errors. The State and your assigned analyst will work together to decide how to best correct the errors. If we detect an error, we will modify or replace the file typically within 48 to 72 hours.

Open enrollment support
Our representatives are available to help employees with questions during the annual open enrollment meeting. We offer the following materials:

- Enrollment application and change forms
- Plan descriptions and benefits comparisons
- Provider directories
- Other program information

We will work with the State to coordinate open enrollment needs and communication support.

Flow Chart:
Please refer to the Enrollment Flow Chart attachment.

Org Chart:
The Enrollment/Eligibility department is managed by the National Accounts Plan Sponsor Services (NA PSS) organization within Aetna Service Operations. The NA PSS department manage plan set up, eligibility, billing and accounts receivable, and drafting for group customer accounts.

Eligibility, as with all PSS functions, is managed in two geographic regions within Aetna National Accounts (Northeast/West). The State will be managed by our West region. There is an overall PSS lead that oversees all aspects of PSS operations. Each region has a manager that oversees the servicing of their book of business. Teams in each region are dedicated to eligibility processing with eligibility managers, consultants, and technical staff. You are assigned a dedicated eligibility consultant that works with your appropriate contacts to ensure the account is handled timely and accurately.

Subcontractor:
We provide our eligibility and enrollment services in-house. We contract with Source One Direct, Inc. of Atlanta, GA and Kingston, RI for ID card production.

QUESTION 3.1.3.2

Location/Hours of Operation/Point of Contact/Onsite Support:
Our enrollment/eligibility staff is spread out across several offices throughout the country. The State will be handled by our West region, which has eligibility consultants located in our California, Walnut Creek, CA Office.

In addition to an assigned eligibility analyst, who will be named upon award of business, the State can discuss eligibility and enrollment questions or needs with their onsite resources as well as Lynda Gable, the account executive.

Customer/Member Service

- Pharmacist Availability
- Specialty Drugs

Description:
When the State of Alaska's members call Member Services, they will first be greeted by your My AlaskaCare Single Point of Contact team. We have trained these concierges to handle issues across multiple lines of coverage, including pharmacy. Our pharmacy-specific Member Services unit consists of:

- 65 pharmacists dedicated to our pharmacy call center
- 560 CSRs who answer APM member calls
- 102 CSRs dedicated to specialty pharmacy Member Services

Pharmacists are available to talk to members:

- Monday through Friday – 6:30 a.m. to 9:00 p.m. CT
- Saturday – 6:30 a.m. to 3:00 p.m. CT
- We will page a pharmacists for emergency inquiries 24 hours a day, 7 days a week

Pharmacy-specific CSRs are empowered to function as member advocates by engaging members and educating them on how to maximize their prescription benefit. We provide the CSR teams and supervisors with customer-specific training, which enables CSRs to:

QUESTION 3.1.3.2

Inform members

- Provide members with detailed prescription benefit and plan information
- Provide pricing estimates on drug cost
- Verify a mail claim's status at any point in the dispensing process
- Verify order information
- Provide eligibility status

Educate members

- Teach members how to submit a claim
- Instruct members on how to use the mail order pharmacy and turnaround times for processing orders

Serve members

- Research claim inquiries regarding how a claim paid
- Maintain account information
- Create, view and resolve requests online, which allows for improved tracking of member requests
- View communications that have been sent to members
- Order ID cards and forms
- Find a retail pharmacy location that is convenient for the member

Flow Chart:

Members calling our toll-free APM Member Services call center using a touch-tone telephone can select from the following automated menu options:

- *Spanish Option:* When the caller selects the Spanish option, we will transfer the call to a Spanish-speaking representative.

- *Caller Type:* When the call selects "member," we will transfer the call to the Main Menu of our Interactive Voice Recognition (IVR) system. When the call selects "pharmacy," we will send the call to the Pharmacy Help Desk. When the call selects "physician," we will route the call to our precertification department for processing.

- *Main Menu:* Callers have the option of stating the area they would like to have their call directed to. Options include Refill, Order Status, Forms, Pharmacy Locator or they can ask to speak to a representative. The caller can also state that they would like the options repeated, at any time.

QUESTION 3.1.3.2

For those members who call us using a rotary dial phone, the system will recognize that the caller did not make a selection. At that time, we will transfer the call directly to the next available customer service representative.

Customer service representatives (CSRs) have access to all retail and mail claims data and use the same online system as our network pharmacies. The following information is available online:

- Member and dependent eligibility
- Plan design information for member-specific pharmacy benefits
- Member profile
- Covered drugs
- Utilization history, including all past prescriptions dispensed
- Notes from the pharmacist recorded at time of fill
- Brand and generic copays or co-insurance
- Convenient pharmacy access by ZIP Code
- Claims status and procedures (retail and mail)
- Location of a mail order prescription in the dispensing process
- Explanation of Benefits (EOBs) for paper claims
- Status of precertification
- Status of claims appeals
- Explanations of precertification and clinical programs
- Aetna Navigator registration status Targeted member communications
- Accumulator balances

CSRs also have access to a member-specific comment history screen. We include all notes taken during each time a member contacts us. The information remains in the member's record, so that CSRs can reference the previous information. Included in the system is customer-specific plan information, which we update any time something changes in the benefit plan.

Org Chart:
Please refer to the attachments labeled Fresno Service Center Organizational Chart, APM Member Services Org Chart and Specialty CSR and Pharmacist Org Chart.

Subcontractor:
We provide Health Concierge services and specialty Member Services internally. CVS Caremark provides additional APM Member Services.

QUESTION 3.1.3.2

Location/Hours of Operation/Point of Contact/Onsite Support:
The My AlaskaCare Single Point of Contact team is located in Fresno. We also offer the following pharmacy-specific customer service teams that will support Health Concierge:

- **APM Member Services** – The pharmacy Member Services center is located in San Antonio, TX. Members can reach a live representative 24 hours a day, 7 days a week.

- **Specialty** – Our specialty CSRs work in our specialty pharmacy in Orlando, FL. Regular business hours are Monday through Friday, 8 a.m. to 7 p.m. ET. Our clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

- **APM Provider Help Line** – The Provider Help Line is located in Plantation, FL and is available 24 hours a day, 7 days week.

Claims Processing

Description:
Our new, more robust claim platform is called RxClaim. We have spent the past year testing all scenarios to ensure that the new claim system is processing claims accurately. This system provides advanced programming abilities that we have not had in the past. RxClaim gives us more flexibility in our plan designs, benefit set-ups and clinical programs so that we can offer additional solutions that meet your pharmacy needs.

Pharmacies in the APM National Retail Pharmacy Network are required to have online access to the claim system. Member eligibility flows from the mainframe to the claim system, where it becomes available for online processing within 24 to 48 hours.

Once a claim is processed, we have it automatically edited against a single member profile. The system provides the dispensing pharmacists with eligibility and plan coverage, including copayment or coinsurance amounts, usually within three seconds. Prospective and concurrent drug utilization review (DUR) are also performed on each claim to help the pharmacist identify potential problems.

In the event of any issue, we instruct pharmacists to call our toll-free Pharmacy Help Desk, where CSRs are available 24 hours a day, 7 days a week, 365 days a year.

QUESTION 3.1.3.2

Flow Chart:
Please refer to the attachments labeled Network Claims Flow Chart and Paper Claims Flow Chart.

Org Chart:
Our highly knowledgeable claims processing department is composed of more than 60 employees who ensure that all claims generated by our customers are processed accurately. This unit maintains an experienced staff of individuals, consisting of the following positions:

- Vice President
- Director
- Managers
- Supervisors
- Trainer
- Advisors
- Claims analysts
- Processors
- Specialists

The management and staff of the unit are highly tenured. Our claims processors have an average of 5 years of experience, and our claims processing department supervisors have an average of 7.5 years of experience. We have staffing levels adjusted as required based on forecasted claim volume. The supervisor to processor ratio is 1:15 or lower. We have claims forecasted based on historical trends, adjusted for anticipated new customer activity.

Subcontractor:
CVS Caremark provides the claim platform used by Aetna which provides a robust operating platform which creates efficiency and improvements in reporting and the member experience.

Location/Hours of Operation/Point of Contact/Onsite Support:
We have over 99 percent of pharmacy claims automatically and virtually adjudicated at the point of care. When members fill prescriptions through non-network pharmacies, they pay the full cost at the point of care and submit paper claims to our Direct Member Reimbursement (DMR) unit. The DMR unit is located in Minnesota and the hours of operation are 8:00 a.m. to 4:30 p.m. CT.

QUESTION 3.1.3.2

Coordination of Benefits

Description:
Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.

Our COB administration starts with the collection and maintenance of accurate information about other coverage. We have a variety of methods for gathering the information including:

- During enrollment, many of our customers collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator®, our secure member website, at www.aetnanavigator.com.
- As required by law, we exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.

QUESTION 3.1.3.2

We consider the following as potential indicators of other coverage:

- Hospital bills submitted as paid
- Large physician bills submitted as paid
- Photocopied bills
- Hospital bills or large physician bills submitted late
- Indication of other party payment on the bill
- Auto accidents (i.e., potential no-fault insurance)
- Workers' compensation

2011 national COB savings for all PPO-based and Indemnity products for COB with commercial coverages were 1.04 percent. 2011 national COB savings for all PPO-based and Indemnity products for coordination with Medicare were 12.91 percent.

2012 YTD (as of 8/31/2012) national COB savings for all PPO-based and Indemnity products for COB with commercial coverages were 1.02 percent. 2012 YTD (as of 8/31/2012) national COB savings for all PPO-based and Indemnity products for coordination with Medicare were 11.99 percent.

Flow Chart:
Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer requesting the additional information. If we still do not obtain a response we pay, pend or deny the claim based on state regulation. If the information we receive does not seem plausible, we contact the provider or member to inquire about other coverage.

When we receive other coverage information, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes:

- Details about the other coverage
- Family members the other plan covers
- Carrier
- Type of coverage (e.g., medical only, medical-dental, etc.)
- Date of the last update

QUESTION 3.1.3.2

If we are secondary and the primary carrier's EOB is not attached to the claim, the claim is pended for receipt of the primary carrier's EOB.

Upon receipt of the primary carrier's EOB, claims are processed as follows:

- For maintenance of benefits (MOB) or non-duplication plans, the COB allowance is our normal benefit (i.e., our negotiated rate reduced by copays, coinsurance or other applicable plan provisions).

- For plans utilizing standard 100% allowable, the COB allowance expense varies based on the 100% allowable model chosen/required by state regulations.

Once we determine the allowable expense, we subtract the primary carrier's payment from it and pay the balance, if any, as long as the balance does not exceed our normal benefit.

Org Chart:
We have attached our Fresno Service Center Organizational Chart.

Subcontractor:
COB is imbedded in our claims process. The majority of our claims processing functions are performed in-house. We use the following subcontractors for claims review:

Subcontractor	**Scope of Services**	**Location**	**Doing Business with Aetna Since**
Aftermath Claim Science, Inc.	Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment..	Newington, CT	2004
Connolly Consulting	Overpayment recovery for data mining, duplicate payments, provider credit balance.	Wilton, CT; Conshohocken, PA; Philadelphia, PA	2000
DiversiMed, Inc.	Overpayment recovery for hospital bill audit.	Tampa, FL	2006
End-Game Strategy, Inc.	Overpayment recovery - data mining - HMO (second pass)	Berlin, CT	2010
EquiClaim, Inc. (Viant/Concentra Preferred	Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and	Naperville, IL; Chattanooga, TN; Lake Forest, CA	2000

QUESTION 3.1.3.2

Systems)	inpatient contract compliance audit)		
OmniClaim, Inc.	Overpayment recovery for Implant and DRG services.	Woburn, MA	2009
Rawlings Company, LLC	Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.)	La Grange, KY; Van Nuys, CA	1996

As part of our efforts to ensure quality in each and every transaction that our constituents have with us, we subject potential subcontractors/vendors to a lengthy and involved process employing rigorous review of each subcontractor from a number of different perspectives (i.e., scrutinizing management, corporate history, financial performance and pro forma statements, references, site reviews, diversity and human resource policies and privacy and security practices) to determine each subcontractor's ability to meet our expectations of performance and scope. Once they become one of our subcontractors, we regularly re-review these factors.

We conduct business with subcontractors through a standard contracting methodology that outlines the relationship from a number of critical aspects, including, but not limited to, service levels, certain representations, covenants, warranties, audit rights, indemnities, confidentiality, compliance with laws, insurance, financial terms, security of information and termination. This also includes a contractual obligation to disclose any adverse legal actions related to the services performed for Aetna. We have relationship managers who are responsible for the overall relationship with our subcontractors.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our Fresno, CA service center will provide claims processing services to the State. Lynda Gable, your account executive will act as a single point of contact for any claims related issues. Karri Priddy, the State's plan sponsor liaison, will also support the claims administration services for the State.

QUESTION 3.1.3.2

Clinical Programs

- Drug Utilization Review (DUR) Programs
- Formulary

Description:
We offer prospective, concurrent and retrospective DUR programs to promote appropriate prescribing, dispensing and use in accordance with FDA guidelines, manufacturer labeling and peer-reviewed literature.

Prospective utilization management

Our prospective programs evaluate the member's planned drug therapy before the drug adjudicates at the point of care. This process allows the pharmacist to identify and resolve issues before the member actually receives the drug.

- *Precertification program* – We offer our standard precertification program which is optional for you. We do require precertification for specialty drugs that are included on the Aetna National Precertification List. Precertification promotes appropriate and cost-effective use of drugs by providing coverage when certain generally accepted medical criteria are met.

- *Step Therapy program* – Members must try one or more prerequisite drugs before the step therapy medication can be covered. With our Aetna Rx Step program, you have the option of customizing step therapy around your population's needs. You can tailor the program by drug class. We will look to work with you to determine the right step therapy approach for your members.

Concurrent utilization management

Through concurrent DUR process, we use edits to identify any issues when a drug is being adjudicated. All relevant member history is reviewed, including medical claims information to make a determination.

QUESTION 3.1.3.2

When we detect a potential problem, we send either an informational or hard-coded edit message to the participating pharmacy.

Informational Edit	Notifies the dispensing pharmacist to take appropriate action but does not stop the claim from paying
Hard-coded Edit	Automatically reject the claim and provide an explanation and direction if appropriate

We have listed many of our DUR edits below. The most current listings and requirements, along with related program information, are available on our website at www.aetna.com.

Administrative DUR Informational Edits

- Additive Toxicity
- Alcohol Precaution
- Drug-Disease Inferred Precaution
- Drug-Age Precaution
- Drug-Allergy Alert
- Drug-Disease Inferred Precaution
- Drug-Disease Reported Precaution
- Drug-to-Drug Interaction
- Drug-Food Interaction
- Drug-Gender Alert
- Drug Incompatibility
- Drug-Lab Conflict
- Drug-to-Pregnancy/Lactation
- Duplicate Therapy
- Excessive Duration Alert
- High Dose Alert
- Iatrogenic Condition Alert
- Insufficient Duration Alert
- Ingredient Duplication
- Low Dose Alert
- Maximum dosing (geriatric and pediatric)
- Overuse Precaution
- Prior Adverse Drug Reaction
- Side Effect Alert
- Tobacco Use Precaution
- Underuse Precaution

Concurrent DUR Hard-Coded Edits

- Age Edit
- Cumulative Refill-to-Soon
- Dose Efficiency
- Drug to Avoid in the Elderly
- Drug-to-Disease Interaction
- Drug-to-Drug Interaction (Severe)
- Drug-to-Gender
- Duplicate Therapy
- Exact Duplicate
- High Dose Edit
- Maximum Daily Dose
- Maximum Pay Edit
- Refill-too-Soon

QUESTION 3.1.3.2

Participating pharmacists can call our 24/7 toll-free Pharmacy Help Desk with questions. Customer service representatives (CSRs) can assist with claim adjudication, program questions and eligibility verification.

Retrospective utilization management

Our retrospective DUR programs examine drug therapy after the member receives the medication. We have developed tools and outreach programs that use claims data to identify members who may benefit from quality improvement initiatives. These tools use pharmacy, or a combination of pharmacy and medical data. All of the following retrospective DUR programs are available to you at no additional cost.

- *Controlled Substance Use Program (CSUP)* – We identify those members who have filled prescriptions for eight, or more controlled substances; have prescriptions written by three, or more physicians; or have had prescriptions filled at three, or more pharmacies. Typically, this behavior is an indicator of substance abuse, in these cases we notify the member's physician and reach out to the member with the intent to restore members to a healthy and responsible way of life, before serious adverse events may happen.

- *Retail to Mail* – We identify members who are filling maintenance medications through a retail pharmacy, rather than through mail order. Within 30 days after the member fill a maintenance prescription at a retail pharmacy, we mail an educational letter educating them about the benefits of mail order, as well as the potential savings they may receive. The member only receives a letter if cost savings is attainable. We typically set the threshold for a minimum savings of $1.00; however, you can define the necessary cost sharing.

- *Migraine Management* – The goal of this program is to reduce the number of annual brain scans, emergency room visits and inpatient visits related to migraines. We target members between the ages of 15 and 64 who have a history of migraine headaches. Members are selected because of disease severity and are contacted by mail during the months of February and August with information explaining the causes and appropriate treatment of migraine headaches which will better prepare them to discuss their headache patterns and treatment with their physician.

- *Heart Care for Life (HCFL)* – This program is designed to improve the quality of care and to reduce overall medical costs for members with ischemic heart disease and a history of acute myocardial infarction (heart attack).

QUESTION 3.1.3.2

The goal of the program is to encourage members who have suffered a heart attack to follow proven methods for improving their health, and to specifically encourage long-term compliance with prescribed drug therapy. Among the most important drugs frequently prescribed for members who have recovered from a heart attack beta-blockers. Beta-blockers can reduce the risk of another heart attack and increase the probability of survival by up to 40 percent. However, only 45 percent of members who have survived a heart attack continue to take their prescribed medication once they start to feel better, usually within the first 12 months after the attack.

- *Selected Members' Clinical Information List* – By using integrated medical and pharmacy benefit information, we profile members with asthma, diabetes and cardiac disease to ensure there are no gaps in their medical and drug treatment. When we identify members who may benefit from an adjustment in the therapy or see that the member is not adhering to their treatment plan, the information is included on the clinical information list which can be accessed by participating physicians on the Aetna secure provider website via NaviNet®.

- *Prescription Savings Program (PSP)* – This educational program identifies members using specific non-preferred drugs and sends them a letter detailing the potential savings of switching to a therapeutically equivalent alternative. In these letters, we advise members to discuss alternatives with their physician. Because switching is optional, members can continue receiving coverage for the non-preferred drug under the terms of their benefit plan.

Our prospective, concurrent and retrospective programs described above are designed to meet the unique needs of every member in your population. Our innovative, total health benefits approach, along with our ability to use integrated medical, pharmacy and laboratory data, sets us apart from all other PBMs.

Formulary

Depending on your needs, you may choose among the tier copayment plan designs for in-network benefits:

- *A closed formulary single-tier plan* – Members pay a single copayment for each covered generic or brand prescription. Drugs on the Formulary Exclusion List are not covered unless a medical exception is obtained.

QUESTION 3.1.3.2

- *A closed formulary two-tier plan* – Members pay a lower copayment for each covered generic drug prescription and a higher copayment for each covered brand prescription. Drugs on the Formulary Exclusion List are not covered unless a medical exception is obtained.

- *An open formulary single-tier plan* – Members pay a single copayment for each covered generic or brand prescription.

- *An open formulary two-tier plan* – Members pay a lower copayment per prescription for covered generic drugs and a higher copayment for covered brands.

- *An open formulary three-tier plan* – Members pay a lower copayment for each covered generic drug on our formulary, a middle copayment for each covered brand drug on our formulary, or the highest copayment for each covered generic or brand drug not listed on our formulary.

- *An optional fourth and fifth tier plan for Aetna Specialty CareRx^{SM} drugs* – Members pay copayments ranging from 10 percent to 50 percent with a 10 percent spread between tiers as follows:

    - *Fourth Tier* – Copayment covers all preferred and non-preferred Aetna Specialty CareRx drugs.

    - *Fourth/Fifth Tier* – Copayment for Aetna Specialty CareRx drugs on the formulary (fourth tier) and Aetna Specialty CareRx drugs not on the formulary (fifth tier).

Additional Aetna Specialty CareRx copayment options include flat dollar ranging from $10 to $100 and minimum/maximums per script ranging from $10 to $200.

Subcontractor:
We internally control all clinical and formulary programs.

QUESTION 3.1.3.2

Medicare Part D

- Medicare Part D Administration
- Retail Network
- Formulary

Description:
Aetna has been serving Medicare beneficiaries for decades, paying the very first Medicare claim in 1966. We began offering Medicare Prescription Drug Plans (PDP) at the onset of the program in 2006. Today, our plans are available in all 50 states and the District of Columbia. Aetna's Medicare PDPs provide access to over 65,000 pharmacies nationwide, and include major chains and independent retail pharmacies. Our experience with Medicare and Medicare PDPs allows us to offer comprehensive benefits that will help to simplify the administration of retiree prescription coverage for the State of Alaska.

Customized Plan Designs
All Aetna's custom group plan designs meet actuarial equivalence tests that ensure our coverage satisfies the Centers for Medicare & Medicare Services (CMS) Part D plan requirements.

CMS' defined standard Part D benefit includes four phases of coverage for Medicare PDP plans; all carriers must utilize these plan parameters in creating their PDP plans. The phases include:

- *Phase One* – Deductible Amount, not to exceed $325
- *Phase Two* – Initial Coverage Period (ICP), which begins after the deductible has been reached, and ends at the defined Initial Coverage Limit (ICL) of $2,970
- *Phase Three* – Coverage Gap, which begins at the defined ICL ($2,970), and ends at $4,750 of True Out-of-Pocket (TrOOP) costs threshold
- *Phase Four* – Catastrophic Coverage begins at $4,750 of TrOOP costs, ending on the last day of the plan's policy period

QUESTION 3.1.3.2

All plans must offer these minimum benefits, but we can enhance plans to include non-Medicare benefits that provide richer coverage through lower member cost sharing. Additional enhanced benefits can include:

- Deductible level reduced or eliminated
- Reduced coinsurance, or more favorable copays
- Coverage gap partially or completely filled by coinsurance or copays
- Addition of a Non-Part D drug rider to cover the cost of certain non-Part D drugs

Coverage Gap

The Patient Protection and Affordable Care Act (PPACA) legislation requires a phased-in increase in the coverage provided during the coverage gap phase of Part D plans. This change will eventually reduce the coverage gap to no more than 25 percent member responsibility for both generics and brand name drugs by 2020. We will adjust our plan designs and rates accordingly to meet these requirements of health care reform.

Coordination of Benefits

We are able to perform coordination of benefit (COB) services as identified for Part B, Part D and/or other commercial payers. Part D coordination is available at the point of sale (POS) or manually. There is no charge for performing COB services.

When a Medicare Part D enrollee has other prescription drug coverage, COB allows the plans that provide coverage for the same beneficiary to determine each of their payment responsibilities. This process is necessary to avoid duplication of payment and to prevent Medicare from paying as a primary payer when it is the secondary payer. While this is the principal purpose of COB within the contexts of Medicare Parts A and B, COB also serves an additional function within the Part D context: it provides the mechanism for support of the tracking and calculating of beneficiaries' TrOOP expenditures, or "incurred costs."

QUESTION 3.1.3.2

Communication

We provide various member communication initiatives. Aetna Medicare Advantage Plans and standalone Aetna Medicare Prescription Drug Plans engage, support and empower beneficiaries to make choices that are best suited for their unique needs. We know that clear communication is critical, which is why we provide the following services:

Aetna Medicare Plan Announcement Mailing – The Medicare plan announcement mailing highlights plan information and encourages retirees to call our plan specialists to learn more. The State of Alaska can choose from the following three mailing options:

- Use our standard materials
- Customize our standard materials with your name
- Create a completely customized communication campaign

Aetna Medicare Enrollment Kits – Enrollment kits provide detailed plan information and forms.

Open-Enrollment Meetings – We work directly with beneficiaries in a comfortable environment that is ideal for asking and answering questions. We discuss key components and resolve any concerns or questions they may have about our Aetna Medicare Advantage Plans and/or standalone Aetna Medicare Prescription Drug Plans. Meeting announcement flyers are also available.

Commercial Age-In Program – We proactively communicate with employees/retirees who will soon be Medicare eligible to identify the advantages of changing from their current Aetna plan to an Aetna Medicare plan.

Post-Enrollment Member Communications – We provide extensive communication materials to help members make well-informed health and prescription drug plan decision. Post-enrollment materials may include the following:

- Member ID cards
- Member kits, which can include provider or pharmacy directory
- Maintenance change forms
- Plan documents
- Wellness reminders
- Safety mailers and newsletters

QUESTION 3.1.3.2

We distribute the Annual Notification of Change (ANOC) during the plan renewal period. Each October, CMS requires Medicare Advantage organizations to provide written notification to each member detailing all mandated benefits changes or enhancements, as well as any service area changes that affect all Medicare Advantage members. We send the ANOC to individual and group members.

Members also have access to online communications and interactive tools through Aetna Navigator, our secure member website. Our Aetna InteliHealth website provides current, trusted health information that is easy to understand.

Ultimately, our communications help to ensure member satisfaction and minimize the ongoing administrative burden for you. While we provide most of the communications described above without cost to you, services for group-specific customized materials and mailings may be provided for an additional fee based on the scope of the service provided.

Online Resources

We have leveraged our existing technologies from our commercial business to build technologies specifically designed for Medicare Part D. We adhere to all CMS requirements for web-based content, including:

- A publicly-accessed website to support pre-enrollment efforts
- A beneficiary-accessed website to support post-enrollment retention efforts
- Extensions based on additional audience-specific needs and business opportunities

We provide an online decision support tool that integrates our pharmacy network, formulary and benefit design data. It also helps your beneficiaries and human resources staff understand and maximize pharmacy benefits in each plan phase. This tool is exclusively available through Aetna for employer-sponsored Medicare plans. Your beneficiaries will have access to the tools available through Aetna Navigator that will allow them to do the following:

- Find drug pricing information and generic drug look up through Price-A-Drug
- Locate a pharmacy through DocFind
- Order new ID cards, print benefit-specific forms and more

We also include other value-added content for beneficiaries, including a link to the Aetna Rx Home Delivery site, online pharmacy directories, pharmaceutical industry news and a drug spend analysis tool.

QUESTION 3.1.3.2

We offer three (3) types of standard formularies for our group PDPs. All formularies comply with the Centers for Medicare & Medicaid (CMS) requirements.

Our Base Closed formulary covers a subset of Part D drugs prescribed for a medically-accepted indication for which a member meets medical necessity and follows plan rules. When new drugs come to market and are classified as "Part D", they are considered for inclusion in the formulary. Non-preferred copayment levels may apply to some drugs on the formulary.

Our Managed Standard formulary also covers a subset of Part D drugs prescribed for a medically accepted indication for which a member meets medical necessity and follows plan rules, but the list is broader that the base closed formulary described above. When new drugs come to market and are classified as "Part D", they are considered for inclusion in the formulary. Non-preferred copayment levels may apply to some drugs on the formulary.

Our Open formulary covers any Part D drug prescribed for a medically accepted indication for which a member meets medical necessity and follows plan rules. When new drugs come to market and are classified as "Part D" they are generally given immediate formulary status. Non-preferred copayment levels may apply to some drugs on the formulary.

The Base Closed and Managed Standard formularies provide cost-savings to the member and the State by offering at least one drug in each therapeutic drug class. By offering the less expensive drug, this will result in lower cost-shares for retirees and lower premiums for the State.

Org Chart:
Please see the attached Aetna Medicare Part D Org Chart.

Subcontractor:
Aetna Pharmacy Management (APM) subcontracts certain benefit plan and program administration support services which include:

- We began contracting with CVS Caremark in 2011. Services they provide include:
  - The pharmacy claim adjudication system we use to pay claims
  - Contracting and auditing services for our retail network
  - Member services for our retail and mail programs
  - Dispensing services and inventory management for our retail and mail benefits
- *Appeals Processing* – We have contracted with IMEDECS for appeals processing services since 1999. We have contracted with MCMC, LLC since 1999. In 2010, we began contracting with Advanced Medical Reviews (AMR).

QUESTION 3.1.3.2

- *ID Card Production and Distribution* – We have contracted with Source One Direct since 2000.
- *Subrogation* – We have had a contact in place with The Rawlings Group as our subrogation vendor since 1996.

Location/Hours of Operation/Point of Contact/Onsite Support:
Recognizing that the retiree population brings unique challenges to member services and claims, we provide Medicare-dedicated member service teams for our Prescription Drug Plans.

We provide dedicated member service units in our Fresno, CA; New Albany, OH; Pittsburgh, PA; Princeton, NJ service center locations. A beneficiary may contact member services for our Prescription Drug Plans Monday through Friday, between 8 a.m. and 8 p.m., in all time zones.

Quality Control

Description:
We check the accuracy of our claim processing system as follows:

Routine

Each week, our audit technicians review numerous pharmacy claims to verify our system is adjudicating the claims properly.

After program/system changes

When we make hardware or software changes, our technical staff and business subject matter experts perform stringent testing on the claim processing system. Testing includes change-specific scenarios followed by a full system regression test. All areas must sign-off on the new functionality before it goes into production to promote a smooth implementation.

QUESTION 3.1.3.2

Customer audits

We welcome independent audits of relevant records and documentation by our customers or their representatives, provided no audit interferes with our business operations or the confidential interests of our company or another party. We have assumed for the purpose of this proposal that an "audit" is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations and shall be subject to mutual agreement as to nature, scope, format, structure and cost.

Audits must be commenced within two years following the period being audited.

The size of the audit sample may not exceed 250 claim transactions for an onsite audit, without Aetna's written consent and the payment of fees as assessed by Aetna.

Aetna is not responsible for paying the State of Alaska's audit fees or the costs associated with the audit. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.

In order to successfully support an onsite audit, APM needs a minimum of four weeks to prepare and pull supporting documentation for the audit. Aetna supports hundreds of audits annually and needs to ensure that there is minimal disruption to the operation.

Aetna will share information with a qualified auditor under a strict confidentiality agreement that prohibits disclosure of the information to any third party and will not use this information for any purposes other than the audit. In addition, the qualified auditor must have no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent:

(i) Is employed by an entity, or any affiliate of such entity, which is a competitor to Aetna's benefits or claims administration business or Aetna's mail order or specialty pharmacy businesses

(ii) Is affiliated with a vendor subcontracted by Aetna to adjudicate claims or provide services in connection with Aetna's administration of benefits or provision of mail order or specialty pharmacy services. Auditors must enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any audit.

QUESTION 3.1.3.2

Claim audits are subject to the above referenced audit standards in the case of a physical, onsite, claim-based audit. In the case of electronic claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of claims is requested and processed offsite, you may elect to audit 100 percent of claims. You are entitled to one annual claim audit.

Flow Chart:
Please refer to the attachment labeled Internal Claim Audit Flow Chart.

Org Chart:
Please refer to the attachment labeled Internal Claim Audit Org Chart.

Subcontractor:
CVS Caremark supports our claim auditing services.

Location/Hours of Operation/Point of Contact/Onsite Support:
The internal audit team dedicated to Aetna is located in San Antonio, TX. The hours of operation are Monday through Friday from 6 am to 4 pm Central Time.

Appeals

Description:
We established a national process for handling complaints and appeals from members, providers and customers across all regions and products. The national process provides for administrative consistency, centralized data collection, business accountability, a consistent workflow process and standardized reports.

Aetna developed the Complaints and Appeals Tracking System (CATS) to support this national process. CATS stores the necessary data relating to a complaint or appeal for tracking, resolution and reporting purposes. This centralized data collection enables us to increase customer service, customer satisfaction and promotes regulatory compliance.

QUESTION 3.1.3.2

CATS provides a single system to capture, track, route and resolve all member and provider complaints and appeals. CATS interfaces with the customer service documentation system to capture verbal complaints and appeals. The application is web-based and allows for routing the complaint or appeal and relevant documents between the Customer Resolution Team and the accountable business units for processing.

Flow Chart:
We have attached a flow chart of our appeals process.

Org Chart:
Customer service representatives (CSRs) attempt to resolve all member complaints at the point of contact. If a CSR is unable to resolve a complaint, they forward it to a Customer Resolution Team (CRT) for handling and, if needed, to the appropriate business area for investigation and response.

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals. Medical directors make appeal decisions with a clinical element.

We have attached our Fresno Service Center Organizational Chart.

Subcontractor:
We have contracted with the following URAC accredited independent review organizations: IMEDECS and MCMC, LLC and AMR.

Location/Hours of Operation/Point of Contact/Onsite Support:
Lynda Gable, the State's account executive will be the point person for all appeal related issues.

Data Analysis

- Data Collection
- Reporting

Description:
Aetna Rx Tools, our online report tool and decision support system, accommodates the differentiation of clinical, financial and utilization data analysis. Secure online access will enable you to query large volumes of adjudicated retail, mail and specialty prescription claims without the frustrations of software updates.

QUESTION 3.1.3.2

Product functionality

You can define the way you manage pharmaceutical costs with use of an extensive portfolio of preformatted management reports and the freedom to create and customize reports.

Preformatted reports

You can easily generate preformatted reports in Aetna Rx Tools by selecting the desired preformatted report, identifying the search criteria from preselected dimensions and then retrieving your results.

Customized reports

Customized reporting options are virtually unlimited with this tool. You have the ability to design and format custom reports, beginning with hundreds of variables from the following industry dimensions:

- Standard Dimensions
- Beneficiary
- Cardholder
- Pharmacy
- Prescriber
- Claims
- Drug
- Metrics

Advanced Features

The following user-friendly features are available with every report you generate.

Drilling

The drill function enables you to analyze any underlined variable or metric on an active report with greater detail. Aetna Rx Tools generates a new report each time you drill, and houses the original report in the “History List” within the project.

Graphs

The system allows you to set the display and format styles for reports. This feature provides an easy switch from grid mode (rows and columns) to graph mode or vice versa.

QUESTION 3.1.3.2

Additional features

Advanced features allow you to

- Display totals
- Edit standard reports
- Export reports to Excel, a text file, HTML or PDF
- Print, save and format

Training and support

Your account team will provide you with the training and ongoing support to you so you are able to take full advantage of the many benefits of the tool.

We typically provide training for one to four users over the telephone. We can provide training for five or more users at your location, or at one of our Aetna offices.

Our technical and clinical teams offer consultative services to assist you and your users with any additional reporting issues or requirements.

Org Chart:
Please refer to the attachment labeled Reporting Organization Chart.

Subcontractor:
CVS Caremark supports some of our reporting capabilities.

Financial

- Subrogation
- Banking

Description:
Subrogation
We use The Rawlings Company, an experienced, national vendor of third-party recovery services headquartered in Louisville, KY, as our subrogation vendor.

The following provides an overview of The Rawlings Company's file identification, investigation and recovery processes:

QUESTION 3.1.3.2

Identification

Rawlings mines paid claims data using a proprietary set of diagnostic codes to identify trauma-related treatments.

Members are mailed up to five inquiry letters that include a brief questionnaire asking about their treatment. Rawlings begins their inquiry once accumulated medical claim payments reach a threshold of $300.

Members have three ways to respond to Rawlings' questionnaire:

1. Member can call a toll-free number answered by experienced analysts.

2. They can return their completed questionnaire in a postage-paid reply envelope.

3. They can visit www.TRGClaimsInfo.com and complete the questionnaire online.

Rawlings' also utilizes a subscription-based data warehouse of property and casualty claims to research whether an accident occurred.

Rawlings' Non-Cooperation Unit investigates high-dollar claims when members are not responding to inquiry letters.

Subrogation opportunities may also be brought to our attention when Aetna is asked to respond to a subpoena in a member's tort lawsuit requesting records of payment.

Investigation

Investigations are assigned to analysts organized by client-specific teams supported by team attorneys.

Analysts define a strategy based on every possible source of recovery and place all parties on notice of your claim.

Analysts manage files on their proprietary software. Some of the many features include:

An automated diary system that allows analysts to record the details of all file activity and share these with other team members collaborating on the file.

QUESTION 3.1.3.2

A tickler system that automatically prompts analysts to plan effective follow-up for each file.

Automated special handling notifications (e.g., group restrictions).

A library of letters and notices approved by Rawlings' legal team.

Recovery

Subrogation recoveries are remitted from Rawlings to Aetna via a bulk wire and recoveries are credited to an individual customer at the claim level through their wireline account. The customer will see a credit for the gross recovery, a charge for Rawlings fee and a separate charge for any administrative fee charged by Aetna on their claim detail report.

Banking
We use a joint benefit payment clearing account (i.e., a Single Account Multiple Participant or SAMP account) with Bank of America or Citibank Delaware. The State subscribes to this account by signing a banking agreement that we forward to our bank.

The State is identified as payer to show that benefit payments go directly from the State to employees. We are shown as the State's agent. No minimum balance is required.

If plan benefit disbursements are issued electronically (via Electronic Funds Transfer), then we prepare disbursement files for the bank, similar to how we batch and prepare checks for providers/members. As the files are generated to the bank, you are charged for the disbursements which will be included with the plan benefit disbursement reconciled check payments.

Due to your funding being on a checks-issued basis, we request funds from your designated bank on the first day of each month and again if recorded claims total at least $20,000. We anticipate funding for the State to be daily.

Our claims accounting systems and our bank's benefit payment clearing systems have been carefully designed to maintain tight item and dollar controls and to provide extensive edits for consistency and completeness. These systems serve large numbers of customers each day and are regularly audited by both internal and external auditors.

Flow Chart:
We have attached flow charts for our subrogation and banking processes.

Org Chart:

QUESTION 3.1.3.2

Rawlings is based in Louisville, KY. They have a satellite office in CA. Their staff is trained to handle subrogation matters in all states. Additionally, they have a staff of approximately 50 in-house attorneys that are available to provide guidance to their analysts and/or handle sensitive cases.

If the State would like to participate in a call on Subrogation, we would be happy to discuss and engage Rawlings.

Subcontractor:
Subrogation
We use The Rawlings Company, an experienced, national vendor of third party recovery services headquartered in Louisville, KY, as our subrogation vendor. We have used the services of Rawlings since 1996.

For over 25 years, The Rawlings Company has pioneered the innovations in subrogation and recovery services.

We selected The Rawlings Company to provide subrogation and reimbursement services based on their experience and expertise in the field:

- Rawlings developed the first subrogation outsourcing program for the healthcare industry and pioneered subrogation processes that have since become industry standards.

- Rawlings publishes a comprehensive national treatise on health subrogation, the *Rawlings & Associates National Subrogation Law Manual*.

- Rawlings continuously monitors legislative changes at both the federal and state levels that may affect a plan's right to seek recovery. They apprise their clients of significant changes and offer strategic recommendations as appropriate.

- Rawlings' Partnership Program offers several valuable services to self-funded groups desiring to be a more active participant in their recovery program. Rawlings' attorneys will review a group's Summary Plan Description (SPD), making recommendations to strengthen recovery language as appropriate, and Rawlings will provide monthly reports listing unresponsive employees so groups can take steps that encourage cooperation.

QUESTION 3.1.3.2

- Rawlings offers members who speak a language other than English several ways to respond to their inquiry letters. Spanish-speaking members may call a dedicated toll-free line answered by Spanish-speaking recovery analysts, or they may elect to answer Rawlings' online questionnaire using the Spanish language option. Rawlings also uses AT&T's Language Line to communicate with members who speak a language other than English or Spanish.

- Rawlings provides excellent customer service to self-funded groups. For example, when a member calls The Rawlings Company, they speak directly to an experienced recovery analyst, not to a call center representative.

Location/Hours of Operation/Point of Contact/Onsite Support:
Rawlings is based in Louisville, KY. They have a satellite office in CA. Their staff is trained to handle subrogation matters in all states. Additionally, they have a staff of approximately 50 in-house attorneys that are available to provide guidance to their analysts and/or handle sensitive cases.

State Objectives

Plan Design

Description:
We provide the capabilities and focus of our pharmacy experience with the benefit of an integrated approach to patient management. Under the headers below, we have described some of the ways we can achieve significant and lasting cost reductions for the State while improving health care quality for members. These include:

- Reducing costs through formulary management and steerage
- Improving medication adherence and lifestyle choices
- Managing care to meet member and provider needs

Reducing costs through a value-based formulary

We manage our formulary under the lowest net cost approach. Under this approach:

- Tier 1 - Generics are covered
- Tier 2 - Preferred brands are covered
- Tier 3 - Non-preferred drugs are covered

QUESTION 3.1.3.2

It is our intent to negotiate competitive prices for formulary medications and preferred products.

Working to reduce overall trend

Occasionally, a more expensive product is clinically more effective at treating disease states than others in the same therapeutic class. While many of our competitors may simply offer the lowest cost drugs, we take a holistic approach.

Because we provide both medical and pharmacy benefits, we are concerned with your overall trend. Therefore, we include the drug that is clinically more effective at treating disease states to help reduce overall trend through reduced physician office visits, hospitalizations and ER visits.

We not only manage pharmacy trend, but we also account for the impact on medical trend. This unique style helps to differentiate us from other PBMs in the industry.

Improving medication adherence and lifestyle choices

We also offer adherence programs to reduce overall costs, improve medication adherence and close gaps in care. We are committed to you and your employees on the issue of adherence. We will work diligently with you to explore the complexities surrounding each to improve the experience of your members, helping them achieve optimal health and ultimate savings to you and their plan.

We have described the programs we currently offer. Unless otherwise noted, our adherence programs are available at no additional cost.

- *Adherence to Drug Therapy* – We engage members through education and reminder communications. This solution monitors over 34 different drug classes used to treat nine conditions.

- *MedQuery* – Through this program, we analyze and integrate the full range of the member data, including medical, pharmacy and laboratory data. We use this data to identify opportunities for improved care and deliver member specific, evidence-based treatment guidelines to physicians. Additional data elements include 24 months of historical medical and pharmacy claims, member eligibility (demographics) and lab data. We offer this program to self-funded customers for an additional fee.

QUESTION 3.1.3.2

- *Specialty Pharmacy Adherence Support* – Our nurses identify members not filling their prescriptions. They then call these members to encourage compliance and provide any necessary support. The nurse tracks the conversation with the member, and if appropriate will contact the prescribing physician to discuss the members' lack of compliance.

- *Chronic Medication List Report* – This online report allows physicians to see how we scored them on a variety of factors including drug-to-drug interactions. The physician can see which specific members had drug-to-drug interactions. With this information, the physician can intervene and discontinue one of the interacting medications, or change it to a different drug.

- *Aetna Healthy Actions - Rx Savings*^{SM} – This program encourages members living with chronic conditions to continue taking their drugs. The conditions/drug classes include diabetes, asthma, heart failure, high cholesterol and high blood pressure. Members receive reduced copays for generic and preferred brand drugs when taking drugs within the specific therapeutic classes. This program is available for an additional fee.

- *Aetna Rx Healthy Outcomes* – This program promotes drug adherence and sustained positive health outcomes for members who survive a heart attack or other heart-related issues. The program begins after the member meets criteria and we generate and mail a letter within two weeks or less of the incident. Other types of outreach, such as pharmacist outreach, occur shortly thereafter.

Care management that meets member and provider needs

We employ a retrospective DUR approach for our condition management programs. By reviewing adjudicated pharmacy claims, or pharmacy and medical claims, we can identify and reach out to providers for the following programs:

- *Controlled Substance Use* - We improve member safety and quality of care related to chronic inappropriate use of controlled substances. We mail letters to physicians with a report of members who we have identified with chronic, long-term controlled substance use. We also mail letters to members asking them to speak with their physician and referring them for behavioral health support.

- *Migraine Management* - This program's goal is to reduce the number of annual brain scans, ER visits and inpatient visits related to migraines. We identify members by reviewing claims. Once identified, we mail letters explaining the program, a brochure and a diary/action plan. We emphasize discussing the condition with their physician.

QUESTION 3.1.3.2

- *Heart Care for Life (HCFL)* - This program encourages long-term compliance with drug therapy following a heart attack. We reinforce adherence and provide comprehensive education for members recovering from a heart attack. We also reach out to the physician with a program letter, actionable materials, brochures and a member roster containing compliance data.

Specialty Health Care Management℠

Specialty Health Care Management is an enhanced specialty care management solution that applies to select specialty drugs. Although we identify members for specialty care management in many ways, we primarily identify them when we see that they are:

- Newly diagnosed and/or new to a therapy
- Having issues with adherence
- Referred by another area within Aetna

Once identified, one of our nurses conducts an assessment call. The nurses who complete initial member assessments have experience in specialty therapies and medications. During the assessment call, the nurse will:

- Confirm treatment is appropriate
- Verify the member is able and motivated to succeed
- Understand the member's risk for non-compliance
- Review the member's medical history (including co-morbidities)
- Provide clinical support resources to resolve identified knowledge gaps

Based on the first assessment, we risk stratify members to determine the level of follow up needed and develop a customized care plan. The nurse will coordinate with the physician's office and provide additional education and support to the member, as needed, to implement an effective care management strategy.

- *Developing a call schedule* - The nurse will establish a call schedule with the member. We tailor the frequency of these calls to how much support the member needs.

- *Developing a care plan* - Every care plan is specific to the individual's needs but all identify long-term goals and actions. The nurse will continually adjust the care plan based on changing member needs. For instance, if the member begins struggling with new side effects, we may adjust the care plan to increase intervention.

QUESTION 3.1.3.2

- *Integrated, cross-functional support* - Our specialty care management program offers integrated coordination with Aetna's medical and behavioral health solutions. This means we can increase member engagement in Aetna's disease management, case management, behavioral health and wellness programs.

Subcontractor:
We provide these services internally.

Policy Development

Description:
We have a number of modeling tools available to support your pharmacy benefits plan. On a quarterly basis, our RxPerspectives Report supports our consultative approach to account management and enables you to construct a plan design and make new program decisions based on facts. Through the RxPerspectives Report, the team will provide recommendations that we align with your goals. We provide all modeling services described below at no additional cost.

Personalized Opportunity Analysis – identifying big picture opportunities

Using the Personalized Opportunity Analysis (POA), we will provide you with the tools and ongoing analyses of your results to clearly explain and optimize your spend. The POA, based on your actual data, will provide actionable channel, therapy and identify the opportunities for savings and performance improvement. We will then use the POA to deliver recommendations based on your needs and goals.

Plan design

The pharmacy team will use our consultative tools to measure the financial impact of various plan design changes and assess your plan performance.

For example, we can work with you to determine the savings associated with:

- Changing copays
- Adding Choose Generics cost-sharing options
- Implementing Aetna Rx Home Delivery® mail order options
- Comparing coinsurance versus copayment plan designs

QUESTION 3.1.3.2

Program-specific modeling

Your pharmacy account team can analyze how specific programs or initiatives (e.g., Save a Copay®, Aetna Rx Check® programs) will affect your pharmacy plan. We can present how these programs will influence spending while improving member health.

We will provide clinical guidance to ensure any program changes work to meet your goals. The team has access to clinical modeling and savings tools, which they use to determine any associated savings.

Subcontractor:
We provide these services internally.

Location/Hours of Operation/Point of Contact/Onsite Support:
Your contacts for this information will be Kristi Coulter, your clinical account executive (CAE), and Michael Petryna, your pharmacy vice president of client management (VPCM). Kristi is located in Seattle, Washington and Michael is located in Pennsylvania. Both Kristi and Michael will fly out to Alaska to attend in-person meetings as frequently as needed.

Innovation

Description:
The four most important ways we will help the State of Alaska control health costs now and in the future are:

1. Controlling overall trend through formulary management
2. Improving adherence through innovative programs
3. Managing chronically ill members
4. Reporting data and providing in-depth analysis

Under the headers below, we have briefly described how we can help the State control health care costs now and in the future.

1. Controlling overall trend through formulary management

We manage our formulary under the lowest net cost approach. We cover generics in the first tier, preferred brands in the second tier and non-preferred drugs in the third tier. We negotiate competitive prices for formulary drugs and preferred products.

QUESTION 3.1.3.2

Occasionally, a more expensive product is better at treating disease states than others in the same therapeutic class. While many of our competitors may simply offer the lowest cost drugs, we take a holistic approach. Because we provide both medical and pharmacy benefits, we are concerned with your overall trend.

Therefore, we include the drug that is clinically more effective at treating disease states to help reduce overall trend through reduced physician office visits, hospitalizations and ER visits. We not only manage pharmacy trend, but we also account for the impact on medical trend. This differentiates us from other PBMs.

2. Improving adherence through innovative programs

Our adherence programs reduce overall costs, improve medication adherence and close gaps in care. We have described the programs we currently offer. Unless otherwise noted, our adherence programs are available at no additional cost.

- *Adherence to Drug Therapy* - We engage members through education and reminder communications for over 34 different drug classes used to treat 9 conditions.

- *MedQuery* - This program is different because we analyze and integrate the full range of the member data, including medical, pharmacy and laboratory data. We use this integrated data to identify opportunities for improved care and deliver member specific, evidence-based treatment guidelines to physicians. Additional data elements include 24 months of historical medical and pharmacy claims, member eligibility (demographics) and lab data. We offer this program to self-funded customers for an additional fee.

- *Specialty Pharmacy Adherence Support* - Our nurses receive monthly reports for members taking specialty drugs and identify members not filling their prescriptions. They call these members and provide any needed support. The nurse tracks the conversation with the member, and if appropriate will contact the prescribing physician to discuss the members' lack of compliance.

- *Aetna Healthy Actions - Rx Savings*^{SM} - We offer Aetna Healthy Actions Rx Savings, to encourage members living with chronic conditions to continue taking their drugs. Compliance may lead to improved health outcomes and a healthier lifestyle. The conditions/drug classes include diabetes, asthma, heart failure, high cholesterol and high blood pressure. Members receive reduced copays for generic and preferred brand drugs when taking drugs within the specific therapeutic classes. This program is available for an additional fee.

QUESTION 3.1.3.2

- *Aetna Rx Healthy Outcomes* - This high-touch member outreach program targets post heart attack members often before the even leave the hospital. It offers member drug cost share reduction and member outreach to promote adherence.

3. Managing chronically ill members

Specialty Health Care Management is an enhanced specialty care management solution that applies to select specialty drugs. Once identified, one of our nurses will conduct an assessment call. The nurses who complete initial member assessments have experience in specialty therapies and medications. During the assessment call, the nurse will:

- Confirm treatment is appropriate
- Verify the member is able and motivated to succeed
- Understand the member's risk for non-compliance
- Review the member's medical history (including co-morbidities)
- Provide clinical support resources to resolve identified knowledge gaps

Based on the first assessment, we risk stratify members to determine the level of follow up needed and develop a customized care plan. The nurse will coordinate with the physician's office and provide additional education and support to the member, as needed, to implement an effective care management strategy.

- Developing a call schedule
- Developing a care plan
- Integrated, cross-functional support

4. Reporting data and providing in-depth analysis

Our standard quarterly reporting package will place valuable information right at your fingertips. You can perform interactive data analysis on topics such as key measures, utilization and membership. We produce these topics, called modules, at the customer level by funding arrangement and product type on an incurred basis. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, pharmacy detail, geographic and provider specific detail. Reports can be saved or downloaded into Microsoft® Excel for review, analysis and electronic communication.

QUESTION 3.1.3.2

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available quarterly, within 45 days following the end of the reporting period.

The standard preformatted report package provides data on the following:

- Key Statistics Pharmacy
- Key Statistics by Generic, Brand Single-Source and Brand Multi-Source
- Formulary Analysis
- Retail, Mail Order and Specialty Comparison Analysis
- Top 30 Drugs by Number of Claims
- Top 30 Drugs by Number of Paid Amount

In addition, your assigned Clinical Account Executive (CAE), Kristi Coulter, will help you make critical decisions for your pharmacy benefit plans. She will regularly meet with you on the phone and will fly to Alaska to meet with you in person. On an annual basis, Kristi will also provide RxPerspectives, an in-depth annual executive summary that will outline your cost and utilization metrics, key performance metrics and financial results. RxPerspectives includes the following:

- Estimates of potential savings based on your utilization
- Specialty pharmacy trend, cost and utilization metrics
- Forecasting Trends - Therapeutic categories to watch based on your population
- High Cost Claimant Analysis - Identifies members with greater than $12,000 in spend
- A year-to-year comparison of your drug spend by retail, mail and specialty
- Benchmark comparisons of your data against key metrics of our best-in-class customers, as well as benchmark results compared to our book-of-business

Subcontractor:
We provide these services internally.

Performance Incentives

Description:
Please refer to our response to question 3.5.2 and the requested Attachment I2 – Pharmacy Benefit Management Services Implementation and Performance Guarantees for the complete list of performance guarantees we are proposing for the State.

QUESTION 3.1.3.2

Subcontractor:
We provide these services internally.

Pharmacy Director Support

Role of Medical Director:
Michael Petryna will serve as your Pharmacy Director. Mike will develop and execute pharmacy growth strategies for the State of Alaska and will work in concert with the product and segment leadership.

Support for the State:
Michael will work support the State of Alaska by:

- Presenting consultative benefit design and program strategy to address ways to decrease drug spend and increase pharmacy plan value
- Supporting the Aetna sales and account teams in developing a pharmacy business plan
- Serving as the unique operational, financial and clinical analysis involved in selecting, implementing and optimizing pharmacy benefits

Location:
Michael lives and works in Pennsylvania. However, he will travel to Alaska quarterly or more frequently if necessary.

Credentials:
Michael Petryna, R.Ph, MBA, CEBS, is a Pharmacy Vice President, Client Management with Aetna Pharmacy Management. He supports Aetna Public and Labor segment sales and account teams in the pharmacy sales process and the unique needs of this market segment. He provides strategic pharmacy oversight to the segment and supports specific cases in the unique operational, financial, and clinical analysis involved in selecting, implementing, and optimizing pharmacy benefits.

QUESTION 3.1.3.2

Michael has extensive managed care experience, most recently as a managed markets strategic marketer for a large pharmaceutical manufacturer. He has served in a clinical role with a large blues plan interfacing with organized medical groups and other functions supporting pay for performance and other quality initiatives. He also has extensive retail pharmacy operational and leadership experience with a national chain. Finally, he has served over 27 years with the United States Navy, both in the active and reserve components, where he currently holds the rank of Commander. Serving in numerous leadership capacities he has extensive ambulatory and specialty pharmacy experience in supporting healthcare delivery throughout the military healthcare system. Furthermore, he has operational pharmacy experience in multinational humanitarian operations, the advising and training of foreign military medical leadership, and post-disaster response.

Michael has worked in the pharmacy industry since 1994 and has been with Aetna since 2007.

A registered pharmacist, Michael earned his Bachelor of Science, Pharmacy, and his Master of Business Administration (with a focus in marketing and strategy) from the University of Colorado.

SELF FUNDED PRESCRIPTION DRUG BENEFITS PLAN
STATEMENT OF AVAILABLE SERVICES
EFFECTIVE XXXX X, XXX

Prior to the Effective Date, Customer, or Contractholder, as applicable (hereinafter "Customer") and Aetna entered into a Master Services Agreement, Administrative Services Agreement or other similar agreement which enabled Customer to make available to Plan Participants one or more products offered by Aetna under certain general terms and conditions (the "Agreement"). Customer now wishes to make available to Plan Participants the products described as Services in this Statement of Available Services (or "SAS") and accompanying Service and Fee Schedule. Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as may be modified by Aetna from time to time pursuant to this Statement of Available Services) and the Agreement will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of this Statement of Available Services and the Agreement. This SAS and the Service and Fee Schedule which is incorporated by reference herein shall supersede any previous SAS or other document describing the Services herein. In the event of a conflict between the terms of this SAS and the Agreement or between the terms of this SAS and any other agreement previously entered into by Customer and Aetna, the terms of this SAS shall control.

I. Excluded and/or Superseded Provisions of Agreement:

A. Term

Unless one party informs the other of its intent to allow this SAS to terminate in accordance with the Agreement, the initial term of this SAS shall be 3 Years beginning on the Effective Date as first written above (referred to as an "Agreement Period"). This SAS will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to the Agreement. If the Agreement does not provide a termination clause, either party may terminate this SAS by giving the other party at least thirty-one (31) days written notice stating when, after the date of such notice, such termination shall become effective.

B. Benefit Funding

The "Benefit Funding" or "Funding of Plan Benefits" section of the Agreement is superseded by Section IV.B.1.of this SAS.

C. Audit Rights

The "Audit Rights" section of the Agreement is superseded by Section VII of this SAS.

II. Claim Fiduciary

Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974 or state law, as applicable, as amended, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under ERISA or state law, as applicable, necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

III. Definitions:

When used in this Statement of Available Services and/or the Self Funded Prescription Drug Benefits Plan Service and Fee Schedule, all capitalized terms shall have the following meanings:

"**Administrative Fees**" or "**Services Fees**" means an amount agreed to by Customer and Aetna in consideration of the Services.

"**Aetna**" shall include a subsidiary, affiliate or subcontractor of its choosing for the purposes of services to be performed under this Statement of Available Services and/or Service and Fee Schedule.

"**Aetna Mail Order Pharmacy**" means a licensed pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants and shall include a subcontractor of its choosing for the purposes of services to be performed under this Statement of Available Services and/or Service and Fee Schedule.

"**Aetna Specialty Pharmacy**" means a licensed pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants and shall include a subcontractor of its choosing for the purposes of services to be performed under this Statement of Available Services and/or Service and Fee Schedule.

"**Average Wholesale Price**" or "**AWP**" means the average wholesale price of a Prescription Drug as identified by Medispan (or other drug pricing service determined by Aetna). The applicable AWP for Prescription Drugs filled in (a) any Participating Pharmacy other than a mail service pharmacy will be the AWP on the date the drug was dispensed for the NDC for the package size from which the drug was actually dispensed, and (b) any mail service Participating Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed.

"**Bank**" means the bank selected by Aetna on which benefit payment costs are paid.

"**Benefit Cost(s)**" means the cost of providing Covered Services to Plan Participants and includes amounts paid to Participating Pharmacies and other providers. Benefit Costs do not include Cost Share amounts paid by Plan Participants. Benefit Costs do not include Service Fees. The Benefit Cost includes any Dispensing Fee paid to a Participating Pharmacy or other provider for dispensing covered medications to Plan Participants.

"**Benefit Plan Design**" means the terms, scope and conditions for Prescription Drug or device benefits under a Plan, including Formularies, exclusions, days or supply limitations, prior authorization or similar requirements, applicable Cost Share, benefit maximums and any other features or specifications as may be included in Plan documents, as communicated by Customer to Aetna in accordance with any implementation procedures described herein. Customer shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design.

"**Brand Drug**" means a Prescription Drug with a proprietary name assigned to it by the manufacturer and distributor. Brand Drug does not include those drugs classified as a Generic Drug hereunder.

"**Calculated Ingredient Cost**" means the lesser of:

a) AWP less the applicable percentage Discount;
b) MAC; or
c) U&C Price.

The Calculated Ingredient Cost does not include the Dispensing Fee, the Cost Share or sales tax, if any.

"**Claim**" or "**Claims**" means any electronic or paper request for payment or reimbursement arising from a Participating Pharmacy providing Covered Services to a Plan Participant.

"**Compound Prescription**" means a Prescription Drug which would require the dispensing pharmacist to produce an extemporaneously produced mixture containing at least one Federal Legend drug, the end product of which is not available in an equivalent commercial form. For purposes of this Agreement, a prescription will not

be considered a Compound Drug if it is reconstituted or if the only ingredient added to the prescription is water, alcohol, a sodium chloride solution or other common dilatants.

"**Concurrent Drug Utilization Review**" or "**Concurrent DUR**" means the review of drug utilization when an On-Line Claim is processed by Aetna at the point of sale.

"**Cost Share**" means that portion of the charge for a Prescription Drug or device dispensed to a Plan Participant that is the responsibility of the Plan Participant as provided in the applicable Plan, including coinsurance, copayments, deductibles and penalties, and may be a fixed amount or a percentage of an applicable amount. Cost Share will be calculated on the basis of the rates charged to Customer by Aetna for Covered Services except as required by law to be otherwise.

"**Covered Services**" means Prescription Drugs, Specialty Products, over-the-counter medications or other services or supplies that are covered under the terms and conditions set forth in the description of the Plan.

"**Discount**" means the Calculated Ingredient Cost rate or MAC to be charged by Aetna to Customer for Prescription Drugs. The Discount excludes the Dispensing Fee, Cost Share and sales tax, if any.

"**Dispensing Fee**" means an amount agreed by Customer and Aetna in consideration of the costs associated with a Participating Pharmacy dispensing medication to a Plan Participant.

"**DMR Claim**" means a direct member (Plan Participant) reimbursement claim.

"**Effective Date**" means the Effective Date set forth above in the heading of the SAS.

"**Formulary**" or "**Formularies**" means the list(s) of Prescription Drugs and supplies approved by the U.S. Food and Drug Administration ("FDA") developed by Aetna which classifies drugs and supplies for purposes of benefit design and coverage decisions.

"**Generic Drug**" means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed by Aetna to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

"**Implementation Credit**" if applicable, is a credit provided to Customer to cover specific costs related to the transition from another vendor to Aetna and further described in the Service and Fee Schedule

"**Law**" means any law, statute, rule, regulation, ordinance and other pronouncement having the effect of law of the United States of America, any foreign country or any domestic or foreign state, county, city or other political subdivision, or of any governmental or regulatory body, including without limitation, any court, tribunal, arbitrator, or any agency, authority, official or instrumentality of any governmental or political subdivision.

"**Maximum Allowable Cost**" or "**MAC**" means the cost basis for reimbursement established by Aetna, as modified from time to time, for the same dose and form of Generic Drugs which are included on Aetna's applicable MAC List.

"**MAC List(s)**" means the lists of MAC payment schedules for Prescription Drugs, devices and supplies identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case the Brand Drug may also be on the MAC List) and developed and maintained or selected by Aetna and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of drug manufacturers, utilization and/or pricing volatility.

"Mail Order Exception List" means the list of Prescription Drugs established by Aetna that includes Brand Drugs adjudicating as Generic Drugs, trademark Generic Drugs, any Generic Drug that is manufactured by one (1) manufacturer (or multiple manufacturers, for example, in the case of "authorized" Generic Drugs), and any Generic Drug that has an AWP within twenty-five percent (25%) of the AWP of the equivalent Brand Drug. The Mail Order Exception List is subject to change.

"**National Drug Code**" or "**NDC**" means a universal product identifier for human drugs. The National Drug Code Query (NDCQ) content is limited to Prescription Drugs and a few selected OTC products. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

"**On-Line Claim**" means a claim that (i) meets all applicable requirements, is submitted in the proper timeframe and format, and contains all necessary information, and (ii) is submitted electronically for payment to Aetna by a Participating Pharmacy as a result of provision of Covered Services to a Plan Participant.

"**Participating Pharmacy**" means a Participating Retail Pharmacy, Aetna Mail Order Pharmacy or Aetna Specialty Pharmacy.

"**Participating Retail Pharmacy**" means any licensed retail pharmacy that has entered into an arrangement with Aetna to provide Covered Services to Plan Participants.

"**Pharmacy Audits**" shall have the meaning set forth in Section VII.A.1.

"**Plan**" shall mean the self-funded employee health benefits plan for certain eligible Plan Participants pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA").

"**Plan Participants**" shall mean employees, dependents, beneficiaries, retirees, or members as referenced in the Plan documents, or any term used by Customer to designate participants in the Plan.

"**Precertification**" means a process under which certain drugs require prior authorization (prior approval) before Plan Participants can obtain them as a covered benefit. The Aetna Pharmacy Management Precertification Unit must receive prior notification from physicians or their authorized agents requesting coverage for medications on the Precertification List.

"**Prescriber**" means an individual who is appropriately licensed and permitted by law to order drugs that legally require a prescription.

"**Prescription Drug**" means a legend drug that, by Law, cannot be sold without a written prescription from an authorized Prescriber. For purposes of this Agreement, insulin, certain supplies, and devices shall be considered a Prescription Drug.

"**Prospective Drug Utilization Review**" or "**Prospective DUR**" means a review of drug utilization that is performed before a prescribed medication is covered under a Plan.

"**Rebates**" shall mean certain monetary distributions made to Customer by Aetna under the pharmacy benefit and funded from retrospective amounts paid to Aetna (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s) on Aetna's Formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain Prescription Drugs by Plan Participants.

"**Rebate Contract Excerpts**", if any, shall have the meaning set forth in Section VII.

"**Rebate Guarantee**" means the Rebate amount that Aetna guarantees Customer will receive as set forth in the Service and Fee Schedule.

"**Retrospective Drug Utilization Review**" or "**Retrospective DUR**" means a review of drug utilization that is performed after a Claim for Covered Services is processed.

"**Service and Fee Schedule**" means a document entitled same and incorporated herein by reference setting forth certain guarantees (if applicable), underlying conditions and other financial information relevant to Customer.

"**Services**" shall have the meaning set forth in Section IV.A.1.

"**Specialty Products**" means those injectable and non-injectable Prescription Drugs, other medicines, agents, substances and other therapeutic products that are designated in the Service and Fee Schedule and modified by Aetna from time to time in its sole discretion as Specialty Products on account of their having particular characteristics, including one or more of the following: (a) they address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis), (b) they require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste, (c) they have limited pharmaceutical supply chain distribution as determined by the drug's manufacturer and/or (d) their relative expense.

"**Step-Therapy**" means a type of Precertification under which certain medications will be excluded from coverage unless the Plan Participant tries one or more "prerequisite" drug(s) first, or unless a medical exception for coverage is obtained.

"**Termination Notice Date**", if applicable, shall have the meaning set forth in Section VI.

"**Usual and Customary Retail Price**" or "**U&C Price**" means the cash price less all applicable customer discounts which Participating Pharmacy usually charges customers for providing pharmaceutical services.

"**Wholesale Acquisition Cost**" or "**WAC**" means the wholesale acquisition cost of a prescription drug as listed in the Medispan weekly price updates (or any other similar publication designated by Aetna) received by Aetna.

IV. Administration Services:

Subject to the terms and conditions of this Statement of Available Services, the Services to be provided by Aetna, as well as certain Customer obligations in connection thereto, are described below.

A. General Responsibilities and Obligations

1. Services

Customer will purchase and Aetna will provide to Customer the services designated in this Statement of Available Services, if selected in the Service and Fee Schedule, and such other services Customer requests of Aetna and Aetna agrees in writing to perform, as further described herein (the "**Services**"). Customer acknowledges that Aetna may utilize the services of external reviewers or contractors in performing these Services. The Services to be provided by Aetna and the Service Fees may be adjusted by Aetna effective on the commencement of any Agreement Period, or at other times as indicated in the Service and Fee Schedule.

2. Customer's Responsibilities

Customer shall perform the obligations set forth in the Agreement and in this Statement of Available Services, including without limitation, the Service and Fee Schedule.

3. Exclusivity

During the term of this Statement of Available Services, Customer shall use Aetna as the exclusive provider of the Benefit Plan Design, including without limitation, pharmacy claims processing, pharmacy network management, clinical programs, formulary management and rebate management. All terms under this Statement of Available Services and on the attached Service and Fee Schedule are conditioned on Aetna's status as the exclusive provider of the Benefit Plan Design. Any failure by Customer to comply with this Section shall constitute a material breach of this Statement of Available Services and the Agreement. Without limiting Aetna's other rights or remedies, in the event Customer fails to comply with this Section, Aetna shall have the right to modify the terms and conditions of this Statement of Available Services, including without limitation, the financial terms set forth in the Service and Fee Schedule and any Performance Guarantees attached hereto.

B. Pharmacy Benefit Management Services

1. Pharmacy Claims Processing

a. On-Line Claims Processing. Using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the description of Plan benefits and this Statement of Available Services, Aetna will perform claims processing services for Covered Services that are provided by a Participating Pharmacy after the Effective Date, and submitted electronically to Aetna's on-line claims processing system. On-Line Claim processing services shall include confirmation of coverage, performance of drug utilization review activities pursuant to this Statement of Available Services, determination of Covered Services, and adjudication of the On-Line Claims. Aetna or Customer, as applicable, shall have ultimate and final responsibility for all decisions with respect to coverage of an On-Line Claim and the benefits allowed under the Plan as set forth in the Agreement.

b. DMR Claims Processing. If specified on the description of Plan benefits, Aetna will process DMR Claims using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the description of Plan benefits. The Plan Participant or Medicaid agency where applicable, shall be responsible for submitting DMR Claims directly to Aetna on such form(s) provided by Aetna within the timeframe specified on the description of Plan benefits. Aetna will process DMR Claims and, where appropriate, will reimburse such Plan Participant or Medicaid agency on behalf of Customer the lesser of: (i) the amount invoiced and indicated on such DMR Claim; or (ii) the amount the Plan Participant is entitled to be reimbursed for such claim pursuant to the description of Plan benefits. With respect to any Plan Participant who submits a DMR Claim which is denied on behalf of Customer, Aetna will notify said Plan Participant of the denial and of said Plan Participant's right of review of the denial in accordance with ERISA. Aetna or Customer, as applicable, shall have ultimate and final responsibility for all decisions with respect to coverage of a DMR Claim and the benefits allowed under the Plan as set forth in the Agreement.

c. Additional Services Related to Claims Processing. Whenever Aetna determines that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of Customer. Plan benefit payments and related charges of any amount payable under the Plan shall be made by check drawn by Aetna payable through the Bank or by electronic funds transfer or other reasonable transfer method. Customer, by execution of the Agreement, expressly authorizes Aetna to issue and accept such checks on behalf of Customer for the purpose of payment of Plan benefits and other related charges. Customer agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits (and which also may include Service Fees and any late charges under the Agreement) and related charges upon notice from Aetna or the Bank of the amount of payments made by Aetna. Customer agrees to instruct its bank to forward an amount in Federal funds on the day of the request equal to such liability by wire transfer or such other transfer method agreed upon between Customer and Aetna. As used herein "Plan benefits" means

payments under the Plan, excluding any copayments, coinsurance or deductibles required by the Plan.

Aetna reserves the right to place stop payments on all outstanding benefit checks (i.e., checks which have not been presented for payment) on the sooner of:

(A) one (1) year following the date Aetna completes its runoff processing obligations; or
(B) five (5) days following Customer's failure to provide requested funds or pay Service Fees due in accordance with the Termination section of the Agreement.

d. Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna will administer all Claims consistent with such provisions and any information concurrently in its possession as to duplicate or primary coverage. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the Claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights.

2. Pharmacy Network Management

a. Participating Retail Pharmacies. Aetna shall provide Plan Participants access to Participating Retail Pharmacies. Aetna shall make available an updated listing of Participating Retail Pharmacies on its internet website and via its member services call center. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to Customer of any deletions that have a material adverse impact on Plan Participants' access to Participating Retail Pharmacies. Aetna shall direct each Participating Retail Pharmacy to (a) verify the Plan Participant's eligibility using Aetna's on-line claims system, and (b) charge and collect the applicable Cost Share from Plan Participants for each Covered Service. Aetna will adjudicate On-Claims for Covered Services from Participating Retail Pharmacies using the negotiated rates that Aetna has in place with the applicable Participating Retail Pharmacy.

i. Aetna shall require each Participating Retail Pharmacy to comply with Aetna's applicable network participation requirements. Aetna does not direct or otherwise exercise any control over the professional judgment exercised by any pharmacist dispensing prescriptions or providing pharmacy services. Participating Retail Pharmacies are independent contractors of Aetna and Aetna shall have no liability to Customer, any Plan Participant or any other person or entity for any act or omission of a Participating Retail Pharmacy or its agents, employees or representatives.

ii. Aetna shall establish and maintain policies and procedures which it may revise from time to time specifying how and when a Participating Retail Pharmacy will be audited to review compliance with such pharmacy's agreement with Aetna. The audit may be conducted by Aetna's internal auditors and/or outside auditors, and may consist of a "desktop" audit of Claims submitted by the Participating Retail Pharmacy and/or a review of prescription and other records located onsite at such pharmacy. Any overpaid or erroneously paid amounts recovered by Aetna from a Participating Retail Pharmacy pursuant to an audit shall be credited to Customer net of any fees charged by Aetna in accordance with the Service and Fee Schedule or by Aetna's designated outside auditors, as applicable. Aetna shall attempt recovery of overpayments or payments made in error through offsets or demand of amounts due. In no event will Aetna be required to initiate litigation to recover any overpayments or payments made in error.

iii. Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee negotiated between Aetna and Participating Retail Pharmacy. For the avoidance of doubt, the Benefit Cost paid by Customer in connection with On-Line Claims for services rendered by Participating Retail Pharmacies will be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacies.

b. Aetna Mail Order Pharmacy. Aetna shall provide Plan Participants with access to the Aetna Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Mail Order Pharmacy on its internet website and via its member services call center. The Aetna Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Aetna Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable Law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Aetna Mail Order Pharmacy obtains consent of the Prescriber, the Aetna Mail Order Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Drugs, some acute drug products or certain compounds cannot be ordered through the Aetna Mail Order Pharmacy. The Aetna Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Aetna Mail Order Pharmacy may promote the use of the Aetna Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and Customer.

c. Aetna Specialty Pharmacy. Aetna shall provide Plan Participants with access to the Aetna Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Specialty Pharmacy on its internet website and via its member services call center. The Aetna Specialty Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Aetna Specialty Pharmacy generally will require that Specialty Drug medications and supplies be dispensed in quantities not to exceed a 30-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable Law do not prohibit substitution of a Generic Drug equivalent, if any, to the prescribed drug, or if the Aetna Specialty Pharmacy obtains consent of the Prescriber, the Aetna Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Aetna Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Aetna Specialty Pharmacy may promote the use of the Aetna Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Specialty Pharmacy's cost, unless otherwise agreed upon by Aetna and Customer. Further information regarding Specialty Product pricing and limitations is provided in the Service and Fee Schedule.

3. Clinical Programs

a. Formulary Management. Aetna shall implement the Formulary and Aetna's formulary management programs, which may include cost containment initiatives and formulary education programs. Customer hereby elects to adopt the Formulary for use with the Plan. Subject to the terms and conditions set forth in this Statement of Available Services, Aetna grants Customer the right to use the Formulary during the term of this Statement of Available Services solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary for the Plan. Customer further acknowledges and agrees that the Formulary is subject to change at Aetna's sole discretion as a result of a variety of factors, including without limitation, market conditions, clinical information, cost, rebates and other factors. Customer also acknowledges and agrees that the Formulary is the Confidential Information of Aetna and is subject to the requirements set forth in this Statement of Available Services and the Agreement.

b. Prospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan Benefits the Prospective DUR program, which may include Precertification and Step-Therapy programs and other Aetna standard Prospective DUR programs, with respect to

On-Line Claims. Under these programs, Plan Participants must meet standard Aetna clinical criteria before coverage of the Prescription Drugs included in the program will be authorized; provided, however, that Customer authorizes Aetna to approve coverage of drugs for uses that do not meet applicable clinical criteria in the event of complications, co-morbidities and other factors that are not specifically addressed in such criteria. Aetna shall perform exception reviews and authorize coverage overrides when appropriate for such programs, and other benefit exclusions and limitations. In performing such reviews, Aetna may rely solely on diagnosis and other information concerning the Plan Participant deemed credible and supplied to Aetna by the requesting provider, applicable clinical criteria and other information relevant or necessary to perform the review.

c. Concurrent Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan Benefits its standard Concurrent DUR programs with respect to On-Line Claims. Aetna's Concurrent DUR programs help Participating Pharmacies to identify potential drug interactions, duplicate drug therapy and other circumstances where prescriptions may be clinically inappropriate for Members. Aetna's Concurrent DUR programs are educational programs that are based on available clinical literature. Aetna's Concurrent DUR programs are administered using information submitted to and available in Aetna's on-line claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

d. Retrospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan Benefits its standard Retrospective DUR programs with respect to On-Line Claims. Aetna's Retrospective DUR programs are designed to help providers and Plan Participants identify circumstances where prescription drug therapy may be clinically inappropriate or other cost-effective drug alternatives may be available. Aetna's Retrospective DUR programs are educational programs and program results may be communicated to Plan Participants, providers and plan sponsors. Aetna's Retrospective DUR programs are administered using information submitted to and available in Aetna's on-line claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

e. Aetna Rx Check Program. If purchased by Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Aetna Rx Check Program. Aetna Rx Check programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, often within 24 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians and Plan Participants.

Aetna Rx Check will analyze Claims on a daily basis, identify potential opportunities for quality and cost improvements, and will notify physicians or Plan Participants of those opportunities. The physician-based Aetna Rx Check programs will identify:

- Certain medications that may duplicate each other's effect;
- Certain drug to drug interactions;
- Multiple prescriptions and/or Prescribers for certain medications with the potential for misuse;
- Prescriptions for a multiple daily dose of a targeted Prescription Drug when symptoms might be controlled with a once-daily dosing; and
- Plan Participants who have filled prescriptions for brand-new medications that have an A-rated generic equivalent available that could save members money.

Another Aetna Rx Check program will notify Plan Participants in selected plans with mail-order drug benefits when they can save money by filling maintenance prescriptions at Aetna Rx Home Delivery versus filling prescriptions at a Participating Retail Pharmacy.

f. Save-A-Copay℠: If purchased by Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Save-A-Copay program. Aetna's Save-A-Copay program is designed to encourage Plan Participants to use Generic Drugs, where appropriate and with the approval of their physician. If Plan Participants switch to a generic alternative from a brand-name product, the Plan Participant Cost Share is reduced for a six month period. In such circumstances, the Customer incurs an additional cost for such Claim equal to the amount the Cost Share is reduced.

g. Disease Management Educational Program. If purchased by Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Disease Management Educational Program. The Disease Management Educational Program is available to Customers who purchase Aetna managed prescription drug benefit management services, but not Aetna medical benefit plan services. The program consists of Plan Participant identification and outreach based on active Claims analysis for targeted risk conditions, such as asthma and diabetes. Upon identification, Plan Participants will receive a welcome kit introducing the program, complete with important information including educational materials and resources. Customer may choose either the Asthma or Diabetes program or a combination of the two programs.

h. Disclaimer Regarding Clinical Programs. Aetna's clinical programs do not dictate or control providers' decisions regarding the treatment of care of Plan Participants. Aetna assumes no liability from Customer or any other person in connection with these programs, including the failure of a program to identify or prevent the use of drugs that result in injury to a Plan Participant.

4. Plan Participant Services and Programs

Internet services including Aetna Navigator and Aetna Pharmacy Website.

Through Aetna Navigator, Plan Participants have access to the following:

- Estimating the cost of Prescription Drugs.
- Prescription Comparison Tool – Compares the estimated cost of filling prescriptions at a Participating Retail Pharmacy to Aetna's Rx Home Delivery mail-order prescription service.
- Preferred Drug List – Available for Plan Participants who wish to review prescribed medications to verify if any additional coverage requirements apply.
- View drug alternatives for medications not on the Preferred Drug List.
- Claim information and EOBs.

Through the Aetna Pharmacy website, Plan Participants have access to the following:

- Find-A-Pharmacy – This service helps locate an Aetna participating chain or independent pharmacy on hundreds of medications and herbal remedies.
- Tips on drug safety and prevention of drug interactions.
- Answers to commonly asked questions about prescription drug benefits and access to educational videos.
- Preferred Drug List and Generic Substitution List.
- Step Therapy List.

5. Rebate Administration

a. Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Rebates attributable to the utilization of certain prescription products by Plan Participants who receive benefits from Customers for whom Aetna provides pharmacy benefit management

services. Subject to the terms and conditions set forth in this Statement of Available Services, including without limitation, Aetna may pay to Customer Rebates based on the utilization by Plan Participants of rebateable Prescription Drugs administered and paid through the Plan Participant's pharmacy benefits.

b. If Customer is eligible to receive Rebates under this Statement of Available Services, Customer acknowledges and agrees that Aetna shall retain the interest (if any) on, or the time value of, any Rebates received by Aetna prior to Aetna's payment of such Rebates to Customer in accordance with this Statement of Available Services. Aetna may delay payment of Rebates to Customer to allow for final adjustments or reconciliation of Service Fees or other amounts owed by Customer upon termination of this Statement of Available Services.

c. If Customer is eligible to receive a portion of Rebates under this Statement of Available Services, Customer acknowledges and agrees that such eligibility under paragraphs a. and b. above shall be subject to Customer's and its affiliates', representatives' and agents' compliance with the terms of this Statement of Available Services, including without limitation, the following requirements:

   i. Election of, and compliance with, Aetna's Formulary;

   ii. Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Service and Fee Schedule;

   iii. Distribution of the Formulary (or a summary thereof) to Plan Participants and/or physicians, as applicable; and

   iv. Compliance with other generally applicable requirements for participation in Aetna's rebate program, as communicated by Aetna to Customer from time to time.

   Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Statement of Available Services, such eligibility shall be subject to the condition that Customer, its affiliates, representatives and agents do not contract directly or indirectly with any other person or entity for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Aetna pursuant to this Agreement, without the prior written consent of Aetna. Without limiting Aetna's right to other remedies, failure by Customer to obtain Aetna's prior written consent in accordance with the immediately preceding sentence shall constitute a material breach of the Agreement, entitling Aetna to (a) suspend payment of Rebates hereunder and to renegotiate the terms and conditions of this Agreement, and/or (b) immediately withhold any Rebates earned by, but not yet paid to, Customer as necessary to prevent duplicative Rebates on such drugs.

C. General Administration Services

1. Eligibility Transmission

The Service Fees set forth under the Service and Fee Schedule assume that Customer will provide eligibility information monthly, or more frequently, from one (1) location by electronic connectivity. Submission of eligibility information by more than one location or via multiple methods will result in additional charges to Customer as determined by Aetna. Costs associated with any custom programming necessary to accept eligibility information from Customer are excluded from the Service Fees set forth in the Service and Fee Schedule.

Customer has the sole and complete authority to determine eligibility of persons to participate in the Plan.

2. Customer Services

a. Aetna will assign an Account Executive to Customer's account. The Account Executive will be available to assist Customer in connection with the general administration of the Services, ongoing communications with Customer and assistance in claims administration and record-keeping systems for Customer's ongoing operation of the Plan.

b. Upon request by Customer and consent by Aetna, Aetna will implement changes in Claims administration consistent with Customer's modifications of its Plan. A charge may be assessed for implementing such changes. Customer's Services Fees, as set forth in the Service and Fee Schedule, will be revised if the foregoing amendments or modifications increase Aetna's costs.

c. Aetna will provide the following reports to Customer for no additional charge:

i. Monthly/Quarterly/Annual Accounting Reports - Aetna shall prepare the following accounting reports in accordance with the benefit-account structure for use by Customer in the financial management and administrative control of the Plan benefits:

- a monthly listing of funds requested and received for payment of Plan benefits;
- a monthly reconciliation of funds requested to Claims paid within the benefit-account structure;
- a monthly or quarterly or annual listing of paid benefits; and
- quarterly or annual standard claim analysis reports.

ii. Annual Accounting Reports - Aetna shall prepare standard annual accounting reports for each major benefit line under the Plan for the Agreement Period that include the following:

- forecast of Claim costs;
- accounting of experience; and
- calculation of Customer reserve.

Any additional reporting formats and the price for any such reports shall be mutually agreed upon by Customer and Aetna.

d. Customer shall adopt Aetna's administrative and record keeping systems, including the production of Plan Participant identification cards.

e. Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification reasonably desired by Customer.

f. Aetna shall provide plan design and underwriting services in connection with benefit revisions, additions of new benefits and extensions of coverage to new Plan Participants.

g. Aetna shall provide cost estimates and actuarial advice for benefit revisions, new benefits and extensions of coverage being considered by Customer.

h. Upon request of Customer, Aetna will provide Customer with information reasonably available to Aetna which is reasonably necessary for Customer to prepare reports for the United States Internal Revenue Service and Department of Labor.

i. Upon request, Aetna shall provide the following Plan description services:

(i). Upon request of Customer, Aetna shall prepare an Aetna standard Plan description, including benefit revisions, additions of new benefits, and extension of coverage under the Plan. If the Customer elects to have an Aetna non-standard Plan description, Aetna will provide a custom Plan description with all costs borne by Customer; or

(ii) Upon request of Customer, Aetna will review Customer-prepared employee Plan descriptions, subject to the Customer's final and sole authority regarding benefits and provisions in the self-insured portion of the Plan. Customer acknowledges its responsibility to review and approve all Plan descriptions and any revisions thereto and to consult Customer's legal counsel, at its discretion, with said review and approval.

Aetna shall have no responsibility or liability for the content of any of Customer's Plan documents, regardless of the role Aetna may have played in the preparation of such documents.

If Customer requires both preparation (a) and review (b), there may be an additional charge.

j. Upon request by Customer, Aetna will arrange for the printing of Plan descriptions, with all costs borne by Customer.

k. Upon request by Customer, Aetna will arrange for the custom printing of forms and identification cards, with all costs borne by Customer.

V. Important Information about the Pharmacy Benefit Management Services

A. Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Prescription Drug Formulary Rebates directly attributable to the utilization of certain Prescription Drugs by Plan Participants who receive Covered Services. The Rebate amounts negotiated by Aetna with pharmaceutical manufacturers vary based on several factors, including the volume of utilization, benefit plan design, and Formulary or preferred coverage terms. Aetna may offer Customer an amount of Rebates on Prescription Drugs that are administered and paid through the Plan Participant's pharmacy benefit. These Rebates are earned when members use drugs listed on Aetna's Formulary and preferred Specialty Products. Aetna determines each customer's Rebates based on actual Plan Participant utilization of those Formulary and preferred Specialty Products for which Aetna also has manufacturer Rebate contracts. The amount of Rebates will be determined in accordance with the terms set forth in Customer's Pharmacy Service and Fee Schedule.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Pharmaceutical rebates earned on Prescription Drugs and Specialty Products administered and paid through the Plan Participant's pharmacy benefits represent the great majority of Rebates.

A report indicating the Plan's Rebate payments, broken down by calendar quarter, is included with each remittance received under the program, and is also available upon request. Remittances are distributed as outlined in the Pharmacy Service and Fee Schedule. Interest (if any) received by Aetna prior to allocation to eligible self-funded customers is retained by Aetna.

Any material plan changes impacting administration, utilization or demographics may impact Rebate projections and actual Rebates received. Aetna reserves the right to terminate or change this program prior to the end of any Agreement Period for which it is offered if: (a) there is any legal, legislative or regulatory action that materially affects or could affect the manner in which Aetna conducts its Rebate program; (b) any material manufacturer Rebate contracts with Aetna are terminated or modified in whole or in part; or (c) the Rebates actually received **under** any material manufacturer Rebate contract are less than the level of Rebates assumed by Aetna for the applicable Agreement Period. If there is any legal action, law or regulation that

prohibits, or could prohibit, the continuance of the Rebate program, or an existing law is interpreted to prohibit the program, the program shall terminate automatically as to the state or jurisdiction of such law or regulation on the effective date of such law, regulation or interpretation.

B. Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates as compensation for bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs.

These other payments are unrelated to the Prescription Drug Formulary Rebate arrangements, and serve educational as well as other functions. Consequently, these payments are not considered Rebates, and are not included in the Rebates provided to Customer, if any.

C. Customer acknowledges that in evaluating clinically and therapeutically similar Prescription Drugs for selection for the Formulary, Aetna reviews the costs of Prescription Drugs and takes into account Rebates negotiated between Aetna and Prescription Drug manufacturers. Consequently, a Prescription Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from a Prescription Drug manufacturer are taken into account. In addition, certain Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to Customer for Covered Services will vary based on: (i) the terms of Aetna's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share obligation under the terms of the Plan; and (iii) the amount, if any, of Rebates to which Customer is entitled under this Statement of Available Services and Service and Fee Schedule. As a result, Customer's actual claim expense per prescription for a particular Formulary Prescription Drug may in some circumstances be higher than for a non-Formulary alternative.

In Plans with Cost Share tiers, use of Formulary Prescription Drugs generally will result in lower costs to Plan Participants. However, where the Plan utilizes a Cost Share calculated on a percentage basis, there could be some circumstances in which a Formulary Prescription Drug would cost the Plan Participant more than a non-Formulary Prescription Drug because: (i) the negotiated Participating Pharmacy payment rate for the Formulary Prescription Drug may be more than the negotiated Participating Pharmacy payment rate for the non-Formulary Prescription Drug; and (ii) Rebates received by Aetna from Prescription Drug manufacturers are not reflected in the cost of a Prescription Drug obtained by a Plan Participant.

D. Customer acknowledges that Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("PBM") subcontract to provide Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another. Customer pays the actual prices paid by Aetna to Participating Retail Pharmacies.

Under this Statement of Available Service and Service and Fee Schedule, Customer and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by Customer for all claims for Covered Services dispensed by Participating Retail Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services. Where the uniform price exceeds the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a positive margin. In

cases where the uniform price is lower than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a negative margin. Overall, lock-in pricing arrangements result in a positive margin for Aetna. Such margin is retained by Aetna in addition to any other fees, charges or other amounts agreed upon by Aetna and Customer, as compensation for the pharmacy benefit management services Aetna provides to Customer. Also, when Aetna receives payment from Customer before payment to a Participating Pharmacy or PBM, Aetna retains the benefit of the use of the funds between these payments.

E. Customer acknowledges that Covered Services under a Plan may be provided by Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy. In such circumstances, Aetna Mail Order Pharmacy refers to Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, both of which are subsidiaries of Aetna that are licensed Participating Pharmacies. Aetna's negotiated reimbursement rates with Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy, which are the rates made available to Customer, generally are higher than the pharmacies' cost of fulfilling orders of Prescription Drugs and Specialty Products and providing Covered Services and therefore these pharmacies realize an overall positive margin for the Covered Services they provide. To the extent Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy purchase Prescription Drugs and Specialty Products for their own account, the cost therefor takes into account both up-front and retrospective purchase discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors. Such purchase discounts, credits and other amounts are negotiated by Aetna Mail Order Pharmacy, Aetna Specialty Pharmacy or their affiliates for their own account and are not considered Rebates paid to Aetna by manufacturers in connection with Aetna's Rebate program.

F. Customer acknowledges that Aetna generally pays Participating Pharmacies (either directly or through PBM) for Brand Drugs whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay Participating Pharmacies (or PBM) based on MAC or continue to pay Participating Pharmacies (or PBM) on a discounted fee-for-service basis, typically a percentage discount off of the listed Average Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from Prescription Drug manufacturers in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay Participating Pharmacies (or PBM) according to an AWP Discount.

In some circumstances, a decision not to establish a MAC price for a Brand Drug and its generic equivalents dispensed by Participating Pharmacies could mean that the cost of such Prescription Drugs for Customer is not reduced. In addition, there may be some circumstances where Customer could incur higher costs for a specific Generic Drug ordered through Aetna Mail Order Pharmacy than if such Generic Drug were dispensed by a Participating Retail Pharmacy. These situations may result from: (i) the terms of Aetna's arrangements with Participating Pharmacies (or PBM); (ii) the amount of the Cost Share; (iii) reduced retail prices and/or discounts offered by Participating Pharmacies to patients; and (iv) the amount, if any, of Rebates to which Customer is entitled under the Statement of Available Services and the Service and Fee Schedule.

Claims for certain Generic Drugs ordered through Aetna Mail Order Delivery that cannot be purchased from manufacturers, wholesalers and other suppliers at reduced prices typical of multi-source generic drugs are paid by Aetna at the negotiated prices applicable to Brand Drugs ordered through Aetna Mail Order Pharmacy. Examples of these Generic Drugs include Brand Drugs that are incorrectly coded as generic by the

drug pricing publication used by Aetna, trademarked Generic Drugs, any Generic Drug that is manufactured by one (1) manufacturer (or multiple manufacturers in the case of "authorized" Generic Drugs), and any Generic Drug that has an AWP price within twenty-five percent (25%) of the equivalent Brand Drug. Aetna excludes Aetna Mail Order Pharmacy claims for such Generic Drugs from the reconciliation of its standard pharmacy Discount and Dispensing Fee financial guarantees.

VI. Early Termination

Consequences of Early Termination

Without limiting Aetna's other rights or remedies, the following shall apply in the event this Statement of Available Services is terminated (i) by Customer without cause or (ii) by Aetna for cause pursuant to the Agreement:

Customer acknowledges and agrees that Aetna shall retain any Rebates earned by, but not yet paid to, Customer as of the effective date of the termination of the Statement of Available Services.

VII. Audit Rights

A. General Pharmacy Audit Terms and Conditions

1. Subject to the terms and conditions set forth in this Statement of Available Services, the Agreement and the Service and Fee Schedule, Customer shall be entitled to have audits performed on its behalf (hereinafter "**Pharmacy Audits**") to verify that Aetna has processed Claims submitted by Participating Pharmacies or a Pharmacy benefits manager under contract with Aetna, in accordance with this Agreement. Pharmacy Audits must be performed at Aetna's Minnetonka, MN location. For purposes of this Section VII, the term "Aetna" as defined in Section III shall not include subcontractor.

2. Additional Terms and Conditions

In addition to the audit terms and conditions set forth in this Statement of Available Services, the Agreement and the Service and Fee Schedule, the following general terms and conditions shall apply with respect to Pharmacy Audits.

a. Auditor Qualifications and Requirements specific to Pharmacy Audits

All Pharmacy Audits shall be performed solely by third party auditors meeting the qualifications and requirements of this Statement of Available Services, the Agreement and the Service and Fee Schedule. Customer will ensure that third party auditors conduct Pharmacy Audits on its behalf in accordance with published administrative safeguards or procedures that shall prevent the unauthorized use or disclosure to Customer or any other third party (in the Pharmacy Audit report or otherwise) of any individually identifiable information (including health care information) or financial information contained in the information to be audited. Customer and such individuals will not make or retain any record of provider negotiated rates or financial information included in the audited transactions, or payment identifying information concerning treatment of drug or alcohol abuse, mental/nervous or HIV/AIDS or genetic markers, in connection with any Pharmacy Audit. There must be no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent (i) is employed by an entity, or any affiliate of such entity, which is a competitor to Aetna's benefits or claims administration business or Aetna Mail Order Pharmacy or Aetna Specialty Pharmacy; (ii) has terminated from Aetna within the past 12 months; (iii) is affiliated with a vendor subcontracted by Aetna to adjudicate claims or provide services in connection with Aetna's administration of benefits or provision

of mail order or specialty pharmacy services; or (iv) is compensated in a manner which could financially incent the agent to overstate or misconstrue data. Determination of the nature of a conflict of interest shall be at the discretion of Aetna and, in any event, shall be communicated to Customer within ten (10) business days of notice of intent to audit. The auditor chosen by Customer must be mutually agreeable to both Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 8.207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics For Professional Accountants (Revised 2004). Auditors shall enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any Audit hereunder

b. Closing Meeting

In the event that Aetna and Customer's auditors are unable to resolve any such disagreement regarding draft Pharmacy Audit findings, either Aetna or Customer shall have the right to refer such dispute to an independent third-party auditor meeting the requirements of the Agreement, this Section VII, and the Service and Fee Schedule and selected by mutual agreement of Aetna and Customer. The parties shall bear equally the fees and charges of any such independent third-party auditor, provided however that if such auditor determines that Aetna or Customer's auditor is correct, the non-prevailing party shall bear all fees and charges of such auditor. The determination by any such independent third-party auditor shall be final and binding upon the parties, absent manifest error, and shall be reflected in the final Pharmacy Audit report.

B. **Additional Pharmacy Claim Audit Terms and Conditions**

Claim audits are subject to the above referenced audit standards in the case of a physical, on-site, Claim-based audit. In the case of electronic Claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of Claims is requested and processed off-site, Customer may elect to audit 100% of claims. Customer is entitled to only one annual Claim audit.

VIII. Fees

Administrative Fees are provided in conjunction with Aetna's Services relating to the Benefit Plan Design and summarized in the Service and Fee Schedule.

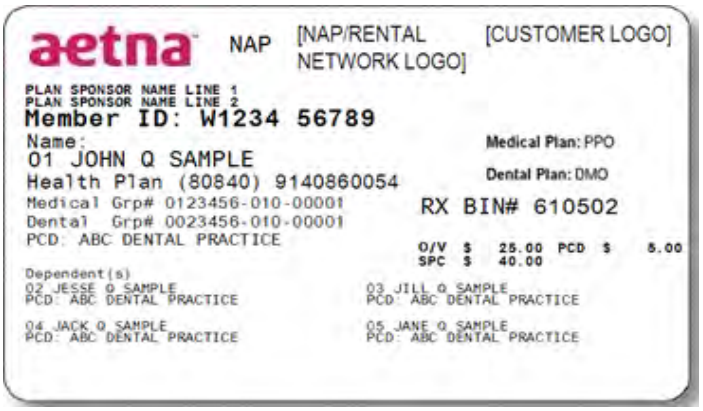
IX. Financial Guarantees

In conjunction with the Services provided by Aetna under this Statement of Available Services, Aetna shall provide any financial guarantees set forth in the Service and Fee Schedule.

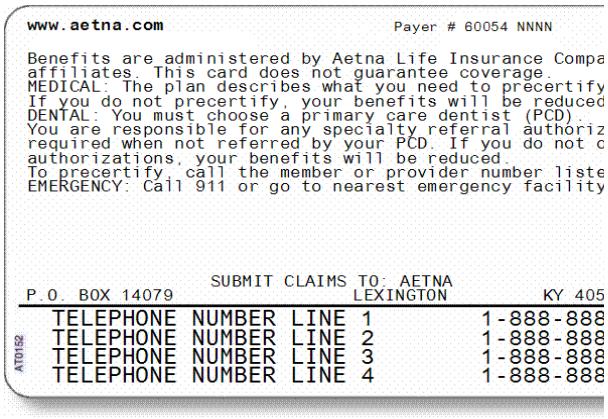
X. Performance Guarantees

Any Performance Guarantees applicable to this Statement of Available Services are attached in the Performance Guarantee Appendix as referenced in the Agreement.

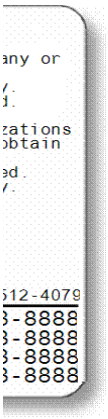
Front



Back



Please note: when applicable, the bottom section of the card will display data for state ID card mandates. The data varies depending on the state. For example, the State Compliance Wording for TX is "DOI."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3-8888

Pharmacy Management
151 Farmington Avenue
Hartford, CT 06156-3475

January 2009

Re: Important Information About Your New Aetna Pharmacy Benefits

Dear Member:

Welcome to Aetna! Enclosed is your ***Pharmacy Benefits Guide*.** Use it to get the most out of your prescription drug benefits and to make informed decisions.

Also enclosed is a copy of the Preferred Drug List (formulary). Your *Pharmacy Benefits Guide* explains why this list is important and how to use it.

You are enrolled in a three-tier/open formulary plan.*

- **Open formulary** means your pharmacy benefit covers medications that are on the Preferred Drug List, as well as many that are not.
- **Three-tier** means there are three copay tiers, or levels, for covered prescription medications. The lowest tier means you pay the lowest copay amount for this level.

Copay Tier**	Type of Drug
Tier One (Low Copay)	Covered generic medications on the Preferred Drug List
Tier Two (Middle Copay)	Covered brand-name medications on the Preferred Drug List
Tier Three (High Copay)	Covered generic or brand-name medications that are not on the Preferred Drug List

Your plan includes these program requirements:

- Precertification
- Step-Therapy
- Quantity Limits
- Therapeutic Duplication

That means some of your prescriptions may be subject to certain requirements before they will be covered. Your *Pharmacy Benefits Guide* explains more about these requirements.

Your guide also describes other pharmacy-related programs. To find out which programs apply to you or to look up your copay amounts, visit your secure Aetna Navigator® website at **www.aetna.com** or call the Member Services number on your ID card. We are glad to have you as a member.

Sincerely,

Robert C. Gallé
Chief Operating Officer, Aetna Pharmacy Management

*Based on information at time of mailing. If your pharmacy benefits plan changes, copays and coverages may no longer apply.

** Copays are either a flat fee or a percentage of the rate that Aetna negotiates with the Pharmacy. You pay the flat fee even if the cost of the drug is less. Some drugs on the Preferred Drug List are subject to manufacturer rebates. Percent copays are calculated before any rebates are subtracted. That means it may be possible for your cost of a preferred drug to be higher than your cost of a non-preferred drug. Our online cost estimator tools can help you decide which drug will cost you less.

Aetna Preferred Drug List *(All generically available covered prescription oral products are on Aetna's Preferred Drug List, unless otherwise noted on the non-Preferred Drug List.)*

ACTONEL
ACTONEL w/CALCIUM
ACTOPLUS MET
ACTOS
ADDERALL XR
ADVAIR DISKUS
ADVAIR HFA
ADVICOR
AGGRENOX
ALDARA
ALKERAN
ALPHAGAN P
ALREX
AMBIEN CR
AMERGE
ANDRODERM
ANDROGEL
ANTARA
ARIMIDEX
AROMASIN
ASACOL
ASMANEX
ASTELIN NASAL
AVANDAMET
AVANDARYL
AVANDIA
AVELOX
AVINZA
AVODART
AVONEX
AZILECT
AZOPT
BD insulin syringes
BENZACLIN
BRAVELLE
BYETTA
BYSTOLIC
CANASA
CARDIZEM LA
CEENU
CELLCEPT
CENESTIN
CIPRODEX
CLOBEX
COMBIVENT
COMBIVIR
COMTAN
COPAXONE
COREG CR
COZAAR
CREON
CRESTOR
CRIXIVAN
CYMBALTA
DAYTRANA
DIBENZYLINE
DIFFERIN gel/cream
DIOVAN
DIOVAN HCT
DIVIGEL
DUAC
DUETACT
EFFEXOR XR
ELIDEL
ELMIRON
EMCYT
EMEND
EMTRIVA
ENABLEX
ENBREL
ENJUVIA
EPIPEN
EPIPEN-JR
EPIVIR
ETHMOZINE
EVAMIST
EVISTA
EVOXAC
EXELON
EXFORGE
FEMARA
FEMRING
FLOMAX
FLOVENT HFA
FLOVENT ROTADISC
FOLLISTIM
FOLLISTIM AQ
FORADIL
FORTEO
FOSAMAX
FOSRENOL
FREESTYLE test strips
GLEEVEC
GONAL-F
HEPSERA
HEXALEN
HUMALOG
HUMALOG MIX 75/25
HUMATROPE
HUMIRA
HUMULIN 50/50
HUMULIN 70/30
HUMULIN N
HUMULIN R
HYZAAR
IMITREX
INVIRASE
JANUMET
JANUVIA
KADIAN
KALETRA
KEPPRA
KEPPRA XR
LAMICTAL
LANTUS
LESCOL
LESCOL XL
LEUKERAN
LEVEMIR
LEXIVA
LIALDA
LIDODERM
LOPROX gel/shampoo
LORABID
LOTEMAX
LOVAZA
LUMIGAN
LUPRON
LUXIQ
LYBREL
MATULANE
MAXAIR AUTOHALER
MAXALT
MAXALT-MLT
MENEST
MENOPUR
MEPRON
MESTINON
METROGEL 1%
MIRAPEX
MYAMBUTOL
MYLERAN
NAMENDA
NASONEX
NEBUPENT
NEXAVAR
NEXIUM
NIASPAN
NILANDRON
NITROSTAT
NORVIR
NOVOLOG
NOVOLOG MIX 70/30
NUTROPIN
NUTROPIN AQ
OLUX
OLUX-E
ONE TOUCH BASIC/ PROFILE/ONE TOUCH II test strips
ONE TOUCH FAST TAKE test strips
ONE TOUCH SURE STEP test strips
ONE TOUCH ULTRA test strips
OPANA ER
OPTIVAR
ORFADIN
OXYTROL
PANRETIN
PATADAY
PATANOL
PEGASYS
PEG-INTRON
PERFOROMIST
PHOSLO
PLAVIX
PRANDIN
PRECISION Q-I-D test strips
PRECISION SOF-TACT test strips
PRECISION XTRA KETONE test strips
PRECISION XTRA test strips
PREVACID
PREVACID SOLUTAB
PREVPAC
PROAIR HFA
PROGLYCEM
PROGRAF
PROMETRIUM
PROTOPIC
PROVENTIL HFA
PULMICORT RESPULES
RENAGEL
RETIN-A MICRO
REVATIO
REYATAZ
RILUTEK
SEASONIQUE
SEREVENT DISKUS
SEROQUEL
SEROQUEL XR
SIMCOR
SINGULAIR
SKELAXIN
SORIATANE
SPIRIVA
STARLIX
SUSTIVA
SUTENT
SYMBICORT
SYMLIN
TABLOID
TARCEVA
TARGRETIN
TAZORAC
TEKTURNA
TEMODAR
TEV-TROPIN
TRACLEER
TRAVATAN
TRICOR
TRINSICON
TRUVADA
TUSSIONEX
TYZEKA
ULTRASE
ULTRASE MT
UROXATRAL
URSO 250
URSO FORTE
VALCYTE
VALTREX
VANOS
VENTAVIS
VERAMYST
VESANOID
VESICARE
VIDEX
VIGAMOX
VIOKASE
VIRACEPT
VIRAMUNE
VIREAD
VOLTAREN GEL
VYTORIN
VYVANSE
WELCHOL
WELLBUTRIN XL
XELODA
XENAZINE
ZANTAC syrup
ZEMPLAR
ZETIA
ZIAGEN
ZIANA
ZOFRAN
ZOFRAN ODT
ZYPREXA
ZYPREXA ZYDIS
ZYVOX

Aetna Non-Preferred Drug List *(These are some of the medications that may be covered at the applicable non-preferred copay. Any brand-name drug not on the Preferred Drug List may be subject to the applicable non-preferred copay.)*

ABILIFY
ABILIFY DISC
ACCOLATE
ACCUNEB
ACCUPRIL
ACCURETIC
ACEON
ACIPHEX
ACTIQ
ACULAR
ACULAR LS
ACULAR PF
ACZONE
ADOXA
AEROBID
AEROBID-M
AGENERASE
AGRYLIN
AKNE-MYCIN
ALAMAST
ALCET
ALESSE
ALLEGRA
ALLEGRA D
ALOCRIL
ALOMIDE
ALORA
ALTABAX
ALTACE
ALTOPREV
ALUPENT
ALVESCO
AMARYL
AMBIEN
AMITIZA
ANCOBON
ANZEMET
APIDRA
ARAVA
ARICEPT
ARICEPT ODT
ARMOUR THYROID
ARTHROTEC
ATACAND
ATACAND HCT
ATROVENT
ATROVENT HFA
AUGMENTIN
AUGMENTIN ES
AUGMENTIN XR
AURALGAN
AVALIDE
AVAPRO
AVAR
AVAR GREEN
AXERT
AZASAN
AZASITE
AZELEX
AZMACORT
AZOR
BACTROBAN
BACTROBAN NASAL
BARACLUDE
BECONASE AQ
BENICAR
BENICAR HCT
BENZAMYCIN
BENZIQ
BENZIQ LS
BENZIQ WASH
BETIMOL
BETOPTIC-S
BIAXIN
BIAXIN XL
BINORA
BIO-THROID
BLEPHAMIDE S.O.P.
BONIVA
BREVICON
BREVOXYL kit
BREZE
BRONCAP
BROVANA
CADUET
CAMPRAL
CAPITROL
CAPOTEN
CAPOZIDE
CARDENE SR
CARDURA XL
CARTROL
CASODEX
CEDAX
CEFZIL
CELEBREX
CELESTONE
CELEXA
CENTANY KIT
CIPRO
CIPRO HC
CIPRO XR
CLARINEX
CLARINEX D
CLARINEX REDITAB
CLEANSE AND TREAT
CLEOCIN VAGINAL
CLIMARA
CLIMARA PRO
CLINDESSE
CLODERM
COGNEX
COLAZAL
COLESTID
COLY-MYCIN-S
COLYTE
COMBIGAN
COMBIPATCH
COMBUNOX
CONCERTA
COPEGUS
CORAZ
COREG
CORDRAN
CORTIFOAM
CORZIDE
COSOPT
COUMADIN
COVERA-HS
CUPRIMINE
CYCLESSA
DANTRIUM
DAYPRO
DDAVP
DEMULEN 1/35
DEMULEN 1/50
DENAVIR
DEPAKOTE
DEPAKOTE sprinkle
DEPAKOTE ER
DESOGEN
DESONATE
DESOXYN
DETROL
DETROL LA
DHE-45
diabetic strips- all except Lifescan or Medisense
diclofenac sodium XR
DIDRONEL
DIGEX
DILATRATE SR
DIPENTUM
DIPROLENE AF
DITROPAN XL
DORAL
DOVONEX
DUONEB
DURAGESIC
DURICEF
DUREZOL
DYNABAC
DYNACIRC
DYNACIRC CR
EDECRIN
EFFEXOR
ELESTAT
ELESTRIN
ELMIRON
EMADINE
EMSAM
ENTOCORT EC
EPIVIR HBV
EQUAGESIC
EQUETRO
ERTACZO
ESCLIM
ESTRADERM
ESTROGEL
ESTRASORB
ESTROSTEP FE
etodolac ER
EURAX
EVOCLIN
EXELDERM
EXTINA
FACTIVE
FAMVIR
FAZACLO
FENOGLIDE
FEXMID
fexofenadine
FINACEA
FIRST-TESTOSTERONE
FLECTOR
FLONASE
FLOXIN OTIC
FML-S
FOCALIN
FOCALIN XR
FORTAMET
FOSAMAX
FOSAMAX plus D
FROVA
GEOCILLIN
GEODON
GLUCOVANCE
GLYSET
GOLYTELY
GYNAZOLE-1
HALFLYTELY
HALOG
HALOTIN CREAM
HELIDAC
HIVID
HMS
IBUDONE
IMDUR
INOVA
INSPRA
insulin syringes (all syringes other than BD brand)
INTAL
IOPIDINE
IQUIX
ISO CARBACHOL
ISTALOL
KERLONE
KETEK
ketoprofen ER
KLARON
KLONOPIN WAFER
KRISTALOSE
KU-ZYME
KU-ZYME-HP
KYTRIL
LAMISIL
lancets- all brands except BD
LAVOCLEN
LETAIRIS
LEVAQUIN
LEVATOL
LEVLEN
LEVLITE
LEXAPRO
LEXXEL
LIPEX
LIPITOR
LIPOFEN
LIQUADD
LO/OVRAL
LODINE XL
LOESTRIN 1.5/30
LOESTRIN 1/20
LOESTRIN FE
LOESTRIN FE 1.5/30
LOESTRIN-24
LOFIBRA
LOPID
LOPRESS HCT
LOPRESSOR
LOPROX crm/lot/susp
LOTENSIN
LOTENSIN HCT
LOTREL
LOTRISONE
LOTRONEX
LUNESTA
LYNOX
LYRICA
LYTENSOPRIL
MACROBID
MAVIK
MAXIDONE
MENOSTAR
METADATE CD
METADATE ER
METAGLIP
metaproterenol
metipranolol
metoprolol SR
METROCREAM
METROGEL VAGINAL
METROLOTION
METYHLIN chew/soln
MEVACOR
MIACALCIN NASAL
MICARDIS
MICARDIS HCT
MIGRANAL
MILLIPRED
MIRALAX
MIRCETTE
MOBIC
MODICON 0.5/35
MONOPRIL
MONOPRIL HCT
MONUROL
MOVIPREP
MOXATAG
MYFORTIC
nabumetone
NAFTIN
NAPRELAN
NAPROXEN KIT
NASACORT AQ
nefazodone
NEOBENZ MICRO
NEOTIC
NEUPRO
NEVANAC
NIMITOP
NIRAVAM
NITROBID
NITRO-DUR
NORDETTE
NORINYL 1+35
NORINYL 1+50
NORITATE
NOROXIN
NOR-QD
NORVASC
NOVOLIN 70/30

Aetna Non-Preferred Drug List (continued)

NOVOLIN N
NOVOLIN R
NOXAFIL
NULYTELY
NUOX
NUVARING
NUZON
ocella
OMNARIS
OMNICEF
OPANA
OPTIPRANOLOL
ORACEA
ORAPRED
ORAXYL
ORTHO EVRA
ORTHO TRI-CYCLEN
ORTHO TRI-CYCLEN LO
ORTHO-CEPT
ORTHO-CYCLEN
ORTHO-NOVUM 1/35
ORTHO-NOVUM 1/50
ORTHO- NOVUM 10/11
ORTHO-NOVUM 7/7/7
ORUVAIL ER
OSMOPREP
OVACE
OVCON 50
OVCON FE
OVCON-35
oxaprozin
OXISTAT
PALCAPS
PALGIC
PANIXINE
PANOCAPS
pantoprazole
PARCOPA
PATANASE
PAXIL
PAXIL CR
PCE
PENLAC
PENTASA
PERCOCET
PEXEVA
PHOSPHOLINE
PILOPINE HS
PLENDIL
PLETAL
PLEXION EMULSION
PLEXION SCT
PLEXION TS
POLY-PRED
PONSTEL
PRAVACHOL
PRAZOLAMINE
PRECOSE
PRED-G
PRED-G S.O.P.
PREFEST
PREVACID NAPRAPAC
PRILOSEC
PRIMALEV
PRINIVIL
PRINZIDE
PRISTIQ
PROAMATINE
PROQUIN XR
PROSCAR
PROTONIX
PROVIGIL
PROZAC
PROZAC WEEKLY
PULMICORT INHALATION
PULMICORT TURBUHALER
PYLERA
QUESTRAN
QUIXIN
QVAR
RANEXA
RANICLOR
RAPIFLUX
RAZADYNE
RAZADYNE ER
RELAFEN
RELION 70/30
RELION N
RELION R
RELPAX
REQUIP
RETROVIR
RHINOCORT AQ
RIDAURA
RISPERDAL
RISPERDAL M
RITALIN LA
ROSAC
ROSANIL
ROSULA
ROSULA NS
ROWASA ENEMA
ROXICET
ROZEREM
ROZEX
SANCTURA
SANCUSO
SEASONALE
SEBIZON
SEMPREX D
SENOPHYLLINE
SKELID
SONATA
SPECTRACEF
SPORANOX
STAFLEX
STALEVO
STRATTERA
STRAZEPAM
STRIANT
SULAR
SULFACET-R
SULFOXYL
SUPRAX
SYMBYAX
SYNERA
TACLONEX
TAPAZOLE
TARKA
TASIGNA
TASMAR
TEQUIN
TERAZOL
TESTIM
TEVETEN
TEVETEN HCT
THEO-24
THERAPROXEN
THYROLAR
TILADE
TIMOLIDE
TINDAMAX
TOBRADEX
TOLECTIN
tolmetin sodium
TOPAMAX
TOPROL XL
TRANSDERM SCOPOLAMINE
TRAZAMINE
TREXALL
TREXIMET
TRI-LEVLEN
TRIAZ
TRIGLIDE
TRILEPTAL
TRINALIN
TRI-NORINYL
TRIPHASIL
TRUSOPT
TRYCET
ULTRACAPS
ULTRACET
ULTRAM
ULTRAM ER
ULTRAVATE
UNIPHYL
UNIRETIC
UNIVASC
URELLE
UREX
URISPAS
UTA
VANACHOL
VANOXIDE HC
VANTIN
VASERETIC
VASOTEC
VENLAFAXINE
VENLAFAXINE ER
VENTOLIN HFA
VEREGEN
VERIPRED
VEXOL
VFEND
VIDEX EC
VISICOL
VIVELLE
VIVELLE-DOT
VOLTAREN
VOLTAREN ophthalmic
VOLTAREN XR
WELLBUTRIN
WELLBUTRIN SR
XALATAN
XANAX XR
XIBROM
XIFAXAN
XOLEGEL
XOLEGEL DUO
XOPENEX
XOPENEX HFA
XYRALID RC
XYZAL
YASMIN
YAZ
ZACARE
ZANAFLEX
ZAZOLE
Z-CLINZ
ZEBETA
ZEGERID
ZERIT
ZESTORETIC
ZESTRIL
ZITHROMAX
ZMAX
ZOCOR
ZODERM
ZOLOFT
ZOMIG
ZOMIG ZMT
ZOVIRAX
ZYDONE
ZYFLO
ZYLET
ZYMAR
ZYTOPI

Precertification List

ACCUTANE
ACIPHEX
ACTIQ
All **Factor IX** products
All **Factor VIIa** products
All **Factor VIII** products
All **Fluoroquinolone** antibiotics **PR < 10 yr old**
All ***promethazine*** containing products **PR 2 yr old**
All **Tetracycline** antibiotics **PR 8 yr old**
ALLEGRA
ALLEGRA-D
AMITIZA
amnesteem
ARALEN
ATRALIN **PR ≥ 36 yr old**
AVITA **PR ≥ 36 yr old**
CASODEX
CELEBREX **PR < 60 yr old**
chloroquine
ciclopirox nail lacquer
claravis
CLARINEX
CLARINEX-D
DARAPRIM
DDAVP nasal ***PR 17 yr old***
desmopressin nasal ***PR 17 yr old***
DIFLUCAN
FANSIDAR
fentanyl lozenges
FENTORA
fexofenadine
FLOMAX
fluconazole
GENOTROPIN
HUMATROPE
hydroxychloroquine
INCRELEX
INFERGEN
INTRON-A
isotretinoin
itraconazole
IV IMMUNE GLOBULIN-IVIG
LAMISIL
LARIAM
LIQUADD
LOTRONEX
MALARONE
mefloquine
minirin nasal ***PR 17 yr old***
NEXIUM
NORDITROPIN
NOXAFIL
NUTROPIN
NUTROPIN AQ
ocella
omeprazole
OMNITROPE
ORACEA
patoprazole
PEGASYS
PEG-INTRON
PENLAC nail lacquer
PLAQUENIL
PREVACID
PREVACID NAPRAPAC **PR < 60 yr old**
PRILOSEC
PROSCAR **PR ≤ 50 yr old**
PROTONIX
PROVIGIL
ramipril
REBETRON
RETIN-A **PR ≥ 36 yr old**

Precertification List (continued)

RETIN-A MICRO gel
PR ≥ 36 yr old
REVATIO
RILUTEK
ROFERON-A
SAIZEN
SEMPREX-D
SEROSTIM
sotret
SPORANOX
SPRYCEL
STIMATE nasal
PR 17 yr old
SUTENT
SYMLIN
SYNAGIS
TASIGNA
terbinafine
TEV-TROPIN
tretinoin **PR ≥ 36 yr old**
TRETIN-X **PR ≥ 36 yr old**
UROXATRAL
VFEND
VIBRATAB
VIVOTIF BERNA EC
XIFAXAN
XOLAIR
XYREM
XYZAL
ZAVESCA
ZEGERID
ZETIA
ZIANA **PR ≥ 36 yr old**
ZORBTIVE
ZYVOX

Quantity Limits List

ABILIFY
ACCOLATE
ACIPHEX
ACTIQ
ACTONEL
ACTONEL with CALCIUM
ADDERALL
ADDERALL XR
ADVICOR
alendronate
ALLEGRA
ALLEGRA-D
ALORA
ALTOPREV
AMBIEN
AMBIEN CR
AMERGE
amphetamine/dextroamphetamine
ANZAMET
ARALEN
ASACOL
ATACAND
ATACAND HCT
AVALIDE
AVAPRO
AXERT
AZOR
AZULFIDINE
AZULFIDINE ENTABS
balsalazide
BENICAR
BENICAR HCT
BONIVA
budeprion
budeprion ER/SR
budeprion XL
buproprion
butorphanol nasal
BYETTA
CADUET
CANASA
CELEBREX
CELEXA
CESAMET
chloroquine
citalopram
CLARINEX
CLARINEX-D
CLIMARA
CLIMARA PRO WEEKLY
clozapine
CLOZARIL
COLAZAL
COMBIPATCH
COMBUNOX
CONCERTA
COZAAR
CRESTOR
CYMBALTA
DAYTRANA
DESOXYN
DESOXYN CR
DEXEDRINE
DEXEDRINE CR
dexmethylphenidate
dextroamphetamine
dextroamphetamine CR
dextrostat
DIFLUCAN
DIOVAN
DIOVAN HCT
DIPENTUM
DURAGESIC
EFFEXOR
EFFEXOR XR
EMEND
EMSAM
ESCLIM
ESTRADERM
estradiol patch
EXFORGE
FAZACLO
fentanyl lozenges
fentanyl patch
FENTORA
fexofenadine
FLECTOR
fluconazole
fluoxetine
fluvoxamine
FOCALIN
FOCALIN XR
FOSAMAX
FOSAMAX PLUS D
FROVA
gabapentin
GABARONE
GEODON
GLEEVEC
granisetron
HELIDAC
HYCAMTIN
hydroxychloroquine
HYZAAR
IMITREX
INVEGA
ketorolac
KYTRIL
LESCOL
LESCOL XL
LEXAPRO
LIALDA
LIQUADD
LIPITOR
lovastatin
LUNESTA
LUVOX CR
LYRICA
maprotiline
MAXALT
MAXALT MLT
MENOSTAR
METADATE CD
METADATE ER
methamphetamine
METHYLIN
METHYLIN chew/soln
METHYLIN ER
methylphenidate
methylphenidate CR/ER/SR
MEVACOR
MICARDIS
MICARDIS HCT
MIGRANAL
mirtazapine
mirtazapine ODT
NEURONTIN
NEXAVAR
NEXIUM
omeprazole
ondansetron
ondansetron ODT
ORACEA
oxycodone SR
oxycodone/ibuprofen
OXYCONTIN CR
oxycodone hcl ER
pantoprazole
paroxetine
paroxetine CR
PAXIL
PAXIL CR
PENTASA
PEXEVA
PLAQUENIL
PRAVACHOL
pravastatin
PREVACID
PREVACID SOLUTAB
PREVPAC
PRILOSEC
PRISTIQ
PROTONIX
PROVIGIL
PROZAC
PYLERA
RANEXA
RAPIFLUX
RELENZA
RELPAX
REMERON
REMERON SLTB
RISPERDAL
RISPERDAL M
risperidone
RITALIN
RITALIN LA
RITALIN SR
ROWASA
ROZEREM
SANCUSO
SARAFEM
selfemra
SEMPREX-D
SEROQUEL
SEROQUEL XR
sertraline
SIMCOR
simvastatin
SINGULAIR
SONATA
SPRYCEL
STADOL NS
STRATTERA
SULAR
sulfasalazine
sulfasalazine EC
sulfazine
sulfazine EC
SUTENT
SYMBYAX
TAMIFLU
TARCEVA
TASIGNA
TEKTURNA
TEKTURNA HCT
TEMODAR
TEVETEN
TORADOL
tretinoin capsules
TREXIMET
TYKERB
venlafaxine
VENLAFAXINE ER
VESANOID
VIVELLE
VIVELLE DOT
VYTORIN
VYVANSE
WELLBUTRIN
WELLBUTRIN SR
WELLBUTRIN XL
XELODA
XIFAXAN
XYZAL
zaleplon
ZEGERID
ZETIA
ZOCOR
ZOFRAN
ZOFRAN ODT
ZOLINZA
ZOLOFT
ZOMIG
ZOMIG ZMT
ZYFLO
ZYFLO CR
ZYPREXA
ZYPREXA ZYDIS

Step-Therapy List

ACCUTANE
ACIPHEX
ALTACE
ALTOPREV
AMBIEN
AMBIEN CR
ATACAND
ATACAND HCT
AXERT
AVALIDE
AVAPRO
BONIVA
BROVANA
CADUET
CELEXA
COMBUNOX
CONCERTA
COSOPT
CRESTOR 5 mg only
CYMBALTA
DDAVP (all forms)
DEPAKOTE
DEPAKOTE sprinkle
DEPAKOTE ER
DESOXYN
DESYREL
DETROL
DETROL LA
Diabetic test strips (all but those made by Abbott Diabetes Care or Lifescan)
DITROPAN XL
DURAGESIC
EFFEXOR
EFFEXOR XR
ELIDEL
FIRST TESTOSTERONE
FOCALIN
FOCALIN XR
FORADIL
FOSAMAX
FOSAMAX plus D
IMITREX
INVEGA
KYTRIL
LAMICTAL
LAMISIL granules
LEXAPRO
LIPITOR
LIQUADD
LOTREL
LUNESTA
LUVOX CR
LYRICA
METADATE CD
METHYLIN chew/soln
MIGRANAL
NASACORT AQ
nefaxodone
NOVOLIN 70/30
NOVOLIN N
NOVOLIN R
OMNARIS
PAXIL
PAXIL CR
PEXEVA
PRILOSEC
PRISTIQ
PROTONIX
PROTOPIC
PROZAC
PROZAC WEEKLY
RANEXA
RAPIFLUX
RELION 70/30
RELION N
RELION R
RELPAX
REMERON
REMERON SOLTAB
REQUIP XL
RHINOCORT AQ
RITALIN
RITALIN LA
RITALIN SR
ROZEREM
SANCTURA
SANCTURA XR
SANCUSO
SEREVENT
SONATA
STRATTERA
STRIANT
TACLONEX
TACLONEX SCALP
TESTIM
TOPAMAX
TREXIMET
TRUSOPT
TRYCET
ULTRAM
ULTRAM ER
VENLAFAXINE ER
VOLTAREN GEL
VYTORIN 10 mg/10 mg only
WELLBUTRIN
WELLBUTRIN SR
WELLBUTRIN XL
XOPENEX soln/conc.
ZEGERID
ZOLOFT
ZOMIG
ZOMIG ZMT

UPPER CASE = brand name medication *lower case italics* = generic medication

In accordance with state law, full-risk members in Texas who are receiving coverage for medications that are removed from the Preferred Drug List during the plan year will continue to have those medications covered at the same benefit level until their plan's renewal date.

The term precertification means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.

In accordance with state law, California HMO members who are receiving coverage for medications that are added to the Precertification or Step-Therapy lists will continue to have those medications covered, for as long as the treating physician continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

Some programs, such as step-therapy, precertification and quantity limits are not available in all service areas. Precertification programs do not apply in Indiana. Step-therapy does not apply to fully insured members in Indiana and New Jersey. Please refer to your plan documents or call the Member Services number on your ID card.

Our Aetna Specialty Pharmacy clinical programs are embedded in our clinical informatics system.

Step Therapy

We may perform step therapy for several disease states where response to therapy is monitored and measured, and where members who do not respond to therapy are referred to their physician for follow-up activities.

Our step therapy program is an optional program for you available at no additional cost. Through our step therapy program, members must try one or more prerequisite drugs before the step therapy medication can be covered.

With our Aetna Rx Step program, you have the option of customizing step therapy around your population's needs. You can tailor the program by drug class.

The following groups of drugs can be included in our Aetna Rx Step Therapy program. We will work with you to customize drugs in these classes based on your goals and member population.

- Acne
- Angina
- ACE inhibitor/ACE inhibitor combination
- Analgesics
- Angiotensin II antagonists/and combination
- Anti-Parkinson's Disease
- Asthma
- Bisphosphonates
- BPH
- Calcium Channel Blockers combination
- Antidepressants
- Diabetes-Insulin (not applicable in Texas) and oral
- Diabetes test strips
- Eye-Glaucoma
- Emetic
- Fibric Acid
- Fungal infection
- Gout
- HMG
- Immunomodulators-topical, oral and injectable
- Migraine
- Miscellaneous Endocrine

- Muscle Relaxants
- NSAID
- Oncology-oral
- Platelet inhibitors
- PPI
- Psoriasis-combo
- Psychotropics
- Sedative-hypnotics
- Seizure
- Steroid-nasal and topical
- Stimulants
- Testosterone replacement
- Urinary antispasmodic

Dose Monitoring

We include dose monitoring as a part of our regular, concurrent drug utilization review (DUR) edits. Pharmacists can review data regarding dose, administration or efficacy in the member's electronic medical record (EMR).

Precertification

Precertification promotes appropriate and cost-effective use of drugs by providing coverage when certain generally accepted medical criteria are met.

Prescriptions requiring precertification go through an intensive review process by nursing and case management. Botox, for example, may be prescribed for diverse uses. This process prevents improper payment of a claim for cosmetic use.

We require precertification for the following specialty drugs on the Aetna National Precertification list:

- Acthar Gel
- Adcirca
- Aldurazyme
- Aloxi IV (palonosetron)
- Anzemet IV (dolasetron)
- Aranesp (Darbepoietin alpha)*
- Aredia
- Avonex (interferon beta>1a)
- Benlysta (Belimumab)
- Berinert

- Betaseron (interferon beta>1b)
- Boniva injection
- Ceredase
- Cerezyme
- Cinryze
- Copaxone (glatiramer acetate injection)
- Elaprase
- Emend IV (fosaprepitant)
- Epogen (epoetin alpha)*
- Erbitux (Cetuximab)
- Euflexxa (1 percent sodium hyaluronate)
- Extavia (interferon beta>1b)
- Fabrazyme
- Firazyr
- Flolan (epoprostenol)
- Forteo (teriparatide)
- Genzyme
- Gilenya (fingolimod)
- Hyalgan (sodium hyaluronate)
- Kalbitor
- Krystexxa (Pegloticase)
- Letairis
- Lumizyme
- Makena
- Miacalcin
- Myozyme
- Naglazyme
- Orthovisc (High Molecular Weight Hyaluronan)
- Prolia
- Rebif (interferon beta>1a)
- Reclast
- Remodulin
- Revatio
- Rituxan (Rituximab)*
- Soliris (eculizumab)
- Supartz (sodium hyaluronate)
- Synagis (Palivizumab)*
- Synvisc (hylan G-F 20)
- Synvisc One (hylan G-F 20)
- Tracleer
- Tysabri (natalizumab)

- Tyvaso
- Vectibix (panitumumab)*
- Veletri
- Ventavis
- VPRIV
- Xgeva
- Xolair (Omalizumab)*
- Yervoy (Ipilimumab)
- Zavesca
- Zometa for ICD-9 diagnosis codes 733.0 – 733.09 only

Hard Edits

We prevent excessive refills, over dosage and quantity limits through hard edits built into the system.

*Note: Depending on the type of plan, there are exceptions to how the precertification of these medications are handled.

Smart Edits – Faster Claim Adjudication

Our Smart Edits are part of our concurrent drug utilization review (DUR) program. Smart edits use integrated claim data to automate the claim adjudication process to bypass a precertification, step therapy or quantity limits edit without disruption to the member and physician.

The claim system reviews the following information in real-time to override an edit:

Smart Edit	Description	Example
Diagnosis Code	Using actual diagnosis codes, we do not assume a member's condition based only on pharmacy claims.	If we see that a member has cancer, the member will be exempt from the Duragesic quantity limit.
Laboratory Information	We use laboratory data to confirm the member requires the medication based on test results.	If a member's lab result confirms a positive result for a certain toenail fungus, the system will override the precertification requirement for the antifungal drug.

Smart Edit	Description	Example
Provider Identification and Specialty	We use National Provider Identifier (NPI) or DEA numbers submitted with the pharmacy claim to identify the prescribing physician. With this information, the system can bypass an edit based on the physician's specialty.	If an oncology drug requiring precertification is prescribed and the system identifies that the physician is an oncologist, the system will let the prescription adjudicate so the physician will not need to seek coverage for the member.

Identifying Appropriate Generic Alternatives

Though few generic specialty drugs are currently dispensed, we identify any available generic equivalents during pharmacist review of each prescription. If the prescribing physician indicated "dispense as written" on the prescription, the pharmacist processes the order as required. If during member intake the member affirms they would prefer a generic equivalent, then we will substitute the available generic equivalent. The pharmacist may contact the prescribing physician to advise him or her of the change, if necessary.

Verifying Appropriate Therapy

Our highly-trained clinicians maintain an Interventions and Outcomes form. Pharmacists use this form to monitor medication orders and verify that drugs are prescribed appropriately. This process is performed during the pharmacist review of the prescription, to ensure that:

- If a comparable generic is available, it is appropriately dispensed.
- If dosage is too high, outreach is performed to alert the physician.
- If the drug is not on our formulary, the physician is consulted to see if a medication change is appropriate.

Our delivery turnaround is 24 to 48 hours. A team of nurses and pharmacists is available to assist members and physicians as needed.

We have included a complete listing of drugs that are in our precertification and step therapy program with this proposal for your review.

Additional Clinical Program Advantages through Aetna Specialty Pharmacy

Through Aetna Specialty Pharmacy, we offer you an integrated approach to managing your members' specialty therapies. Because our specialty pharmacy services are a part of our full-service network, we can monitor specialty medication needs by accessing the member's medical and pharmacy claim data and reviewing their medical history. By leveraging this approach, we provide information to

physicians and members that improve health outcomes while managing health care and pharmacy costs.

Integrated Plan Design and Development

We also integrate specialty pharmacy and medical management for the design and development of disease management protocols. Our specialty pharmacy services partner with our internal medical disease management company, Active Health.

We use Aetna's internally developed clinical policy bulletins (CPBs) to guide treatment protocols. These CPBs reference guidelines from:

- The Food and Drug Administration (FDA)
- Drug manufacturers and centers of policy
- Guidelines surrounding individual disease states

Our multi-disciplinary condition analysis team reviews the CPBs. This team has expertise within set disease states to research new literature and make suggestions for appropriate policy changes. We engage a strict committee review process to consider any changes suggested for the CPBs. You can review the most current CPBs that we adhere to online at www.aetna.com/formulary.

Integrated Services Provide a Holistic Approach

Members who use Aetna Specialty Pharmacy to obtain their specialty medications benefit from our integrated capabilities. Based on the plan design selected, members may be able to benefit from the integrated offerings listed below.

Case and Disease Management

Members living with chronic conditions often struggle with their dependence on specialty medications to prevent disease progression or allow for disease stabilization. To meet the needs of your members, we have a team of specially educated nurses working out of our specialty pharmacy in Orlando, FL. This nurse team acts as a liaison to our other clinical business areas, including case and disease management.

These nurses identify high-risk members taking specialty medications through various avenues, including direct transfer from nurses/pharmacists within the pharmacy. For example, a member may be transferred when they ask a nurse if it is acceptable to split medication doses so it will last longer and cost less.

We review weekly reports on members that are new to certain medications because many members that are starting on new medications have a hard time committing to it. We also receive another weekly report that outlines members who are not adhering to their medications.

Our disease management program receives automated referrals that contain standard information about the member and the reason for referral. Later this year, we will offer a completely integrated system where our assessments will be synonymous, and education provided will be consistent.

At Aetna Specialty Pharmacy, we offer disease management for each of the complex disease states we care for. We assess the member at the start of therapy to determine individual needs and offer therapy-specific, individualized support throughout the treatment. Aetna Specialty Pharmacy's team of nurses and pharmacists confirm dose and medical necessity, offer additional education, perform injection training, coordinate home health care, offer extra emotional support if needed, perform ongoing side effect and compliance monitoring, address questions or concerns with prescribing physicians, and proactively coordinate drug refills and supplies. Clinicians are available 24 hours a day, 7 days a week to offer support and answer questions.

Aetna Behavioral Health Services

We also work closely with our internal Behavioral Health Services area to identify and refer members who may benefit from additional emotional support. Upon therapy initiation, a specialty pharmacy nurse will reach out to the member to perform a depression/anxiety screening. The nurse will ask targeted questions that may vary depending upon whether the screening is completed by the member or caregiver, as in the case of adolescent or pediatric patients.

We include these questions as part of an electronic scripting tool. With this tool, specialty pharmacy nurses are guided through a series of screens. The nurse is prompted to ask the member pointed questions in order to advance to the next screen. When we collect the results of the depression/anxiety screenings, we engage our behavioral health team to reach out to those members who screen positive.

We use this integrated approach to act as a catalyst in helping members use their behavioral health benefit and stay compliant with their medication. Although the depression/anxiety screening is not mandatory for members, most are pleased by the simple screening and follow through that connects them with services they may not have been aware of.

Aetna's National Medical Excellence Program

We make Aetna's National Medical Excellence program available to members requiring transplant and hemophilia therapies. The program supplies medications and related educational services to members receiving transplants or have diagnosed with the blood disorder.

Members receiving transplant medication through Aetna Specialty Pharmacy automatically benefit from our Aetna Transplant Life Management[SM] program. Through this program, members receive a 90-day drug supply, as per their individual benefits plan. New transplant recipients will also receive a backpack starter kit containing:

- Blood pressure cuff
- Thermometer
- Pill crusher
- Pill cutter
- List of transplant medications and potential side effects
- An educational book

By coordinating our specialty pharmacy services with this program, members also benefit from an Aetna National Medical Excellence nurse case manager. This is a nurse who specializes in case management of transplant recipients. The nurse will work with the member and their transplant center to meet the member's health care needs within the guidelines of their health care benefits.

Our specialty pharmacy nursing team works with each participant's nurse case manager to ensure the member's transplant medication and administration needs are appropriately met. This program also performs precertification for Hemophilia members and most importantly monitors doses on hand to avoid stockpiling. Our nurses complete hemophilia clinical assessments to:

- Gain knowledge around the members' condition
- Provide education around preventing bleeds/joint injuries
- Monitor adherence to prophylactic therapies

They coordinate shipments and arrange for home health care. In cases where a hemophilia patient develops an acute bleed, the nurses are able to facilitate shipment expeditiously.

Select therapies require precertification, depending on the drug and/or disease state. Aetna Specialty Pharmacy triggers the precertification process, and follows through until all requirements have been met and approved.

All of these programs are important elements in helping manage the members' care and ultimately results in keeping the member compliant with their treatment regimen, especially within disease states where adherence is critical to therapy success, e.g. Hepatitis C and Multiple Sclerosis. This often avoids care that may occur in settings that are more expensive.

Utilization Management Programs

We also have a number of utilization management programs in place for specialty drugs, which include, but are not limited to:

- *Medically Incredible Dosing Edit* – Dosing checks on 100 J-codes for medical drug claims exceeding daily unit threshold for 95th percentile based upon product labeling, FDA dosing guidelines and peer-reviewed published medical literature.

- *Limits on oral J-code Drugs* - Quantity limits on oral drugs given by oncologists from their office practices and billed to Aetna medical under J-codes.

- *J-code Drug Dose Frequency Edits* – Frequency checks on 11 J-codes for medical drug claims that are submitted too soon after a prior claim for the same drug for the same patient based upon product labeling and FDA dosing guidelines for frequency

Medical Necessity Checks

All medical claims are processed through a diagnosis validation algorithm. These edits compare the ICD-10 code submitted with the claim against the ICD-10 codes listed in the Clinical Policy Bulletin (CPB). Claims will deny for diagnosis ICD-10 codes considered Experimental and Investigational.

Non-Participating Provider Claim Review

All J code claims over $600 by non-participating providers are reviewed by a claims examiner.

Miscellaneous J code Pricing

All claims that are submitted with a "miscellaneous" J code (i.e., J3490, J3590, J7599, J7799, J8999 and J9999) are required to have an NDC code submitted with the claim. These claims then go to the pharmacy claim system for proper pricing based upon current AWP rates.

Clinical Programs Through Retail Network

For specialty medication dispensed through our retail pharmacy network, we offer the same clinical programs as mentioned above, except we do not offer care management and disease state management services.

Care management and disease state management services are offered specific to members utilizing Aetna Specialty Pharmacy for their specialty medications needs. There is no additional cost to you or the member for these services.

APT Pharmacy Report Card
2011 Year-end Results

I. Loyalty Measures		2011 Results
a.	Overall Satisfaction	90%
b.	Likelihood to Recommend	82%
c.	Likelihood to Renew	91%

II. Coverage		
a.	Overall satisfaction with coverage and benefits	92%
b.	Satisfaction with out-of-pocket prescription costs	85%

III. Value		
a.	Overall satisfaction with the value of the prescription drug plan	91%
b.	Provides value for the money	83%
c.	Covers everything you expect with no surprises	83%
d.	Good value - Coverage of medication	91%
e.	Good value - Access to the best prescription drugs	91%
f.	Good value - Customer service experience	90%

VI. Image		
a.	Is an easy, hassle-free company to deal with	90%

Results are based on a telephone survey of Aetna Pharmacy members conducted from conducted from April through June and October through November 2011 by DSS Research, a third-party market research vendor.

Methodology for Calculating DUR Savings

Our DUR programs focus on preventive services, behavior modification and physician education. As a result, the programs can provide many benefits, such as increased on-the-job productivity and quality of life.

The financials associated with our DUR savings are captured using a macro approach. This entails comparing costs of members with an edit versus members without an edit using a linear regression. It is also important to note that there is no double counting; however, if a claim hits against two programs, it will result in savings for each program. For example, if a claim hits a quantity limit edit as well as a step therapy edit; the savings associated with the quantity limit program will be measured separately from the savings associated with the step therapy program. To avoid double counting, multiple regressions are used to divide the total savings between the programs.

Our prospective DUR edits have resulted in savings per member per month (PMPM).The following are the PMPM savings for our fully insured commercial plans for precertification, quantity limit, step therapy and Aetna Rx Check edits:

Program	2011 Savings	2012 YTD Savings
Precertification	$0.12 PMPM	$0.04 PMPM
Quantity Limits	$0.25 PMPM	$0.03 PMPM
Step Therapy	$0.09 PMPM	$0.02 PMPM
Aetna Rx Check*	$0.97 PMPM	$1.25 PMPM

* Because Aetna Rx Check is a retrospective program, actuals are not yet available $1.00 PMPM from existing programs and $0.27 PMPM for new Aetna Rx Check programs.

Aetna Rx Check Program Calculation Methodologies

- For each program, only claims that fit criteria are included for analysis
- Some claims are always excluded from analysis. These would include incidents where the physician letter is not delivered; the claim was reversed the same day of fill or within 8 days for the Brand to Generic and Retail to Mail programs; or, the member is no longer eligible.
- Once a case has been identified, we will determine expected refill range and identify all claims within the refill range within the drug category being analyzed.
- Savings calculations are based off of the difference in plan costs pre-outreach and post out-reach for cases identified.
- For the High Utilization and Therapeutic Duplication programs, the post-outreach period is defined as ending on the last day of the 5th month after the outreach month.
- For all other programs, the post-outreach period is defined as ending on the last day of the 12th month after the Outreach month.

We will provide cost savings reports to you, which display Aetna Rx Check pre- and post-intervention data along with a savings analysis for all Aetna Rx Check programs, with the exception of the Drug Interaction program. Aetna Rx Check programs may be purchased bundled or individually.

For fully insured plans in 2011, our Save A Copay® program resulted in an average ROI of 9:1 for available drug classes. Savings are based on differences in drug cost (targeted brand - generic drug cost) - copay waiver amount - letter cost.

We provide modeling tools to show individual customer impact, as program experience may vary. Save a Copay is available for an additional cost.

National Precert List	
Drug Class	**Restricted Drug**
Antiasthmatic-Monoclonal Antibodies	Xolair
Antiemetics-5HT3 Receptor Antagonists	Aloxi IV
	Anzemet IV
	Emend IV
Antihemophilic Products	all Hemophilia products Factor VII, VIII and IX
Antineoplastics	Rituxan
Antibodies	Vectibix
	Yervoy
	Erbitux
Antineoplastics-Miscellaneous	Jevtana inj 60mg/1.5ml
	Provenge
	Intron-A Roferon-A
Antivirals-Hepatitis Agents	Infergen
	Peg-Intron
	Pegasys
Bone Density Regulators	Aredia
	Boniva inj
	Forteo
	Miacalcin inj
	Pamidronate
	Reclast
	Xgeva
	Zometa
	Prolia
Corticotropin	H.P. Acthar gel
Endocrine	Bravelle inj 75 IU
Fertility Regulators	Follistim inj 75 IU Follistim AQ inj
	Gonal-F RFF Inj Gonal-F Inj
	Luveris Inj 75UNIT
	Menopur Inj 75UNIT Repronex Inj 75UNIT
	novarel inj 10,000UNIT *pregnyl inj 10,000UNIT* *chorionic gonadotropin for inj 10000 Unit*
	Ovidrel Inj 250MCG
GnRH/LHRH Antagonists	Cetrotide Kit
	Ganirelix AC Inj 250MCG/0.5ML
Gout Agents	Krystexxa
Growth Factor-Insulin like	Increlex
Growth Hormones	All Growth Hormone Products
Hemotologic Agents-	Berinert
Complement Inhibitors	Cinryze
	Soliris

Bradykinin B2 Receptor Antagonists	Firazyr
Plasma Kallikrein Inhibitors	Kalbitor
Hematopoetic Growth Factors	Aranesp
	Epogen Procrit
	Omontys
Immune Serums	all IVIG Products
Immunologics **IL-6 inhibitor**	Actemra
Antipsoriatic	Amevive Stelara
TNF-α Blockers	Cimzia Enbrel Humira Remicade Simponi
Costimulation Modulator	Orencia IV Orencia subQ
Metabolic Modifiers	Aldurazyme
	Ceredase
	Cerezyme
	Elaprase
	Elelyso
	Fabrazyme
	Lumizyme Myozyme
	Naglazyme
	Vpriv
	Zavesca
Monoclonal Antibodies	Synagis
Multiple Sclerosis Agents	Avonex
	Betaseron Extavia
	Copaxone
	Gilenya
	Rebif
	Tysabri
Neuromuscular Blocking Agents- **Botulinium toxin-A**	Botox
	Dysport
	Xeomin
Botulinum toxin-B	Myobloc
Progestins	Makena
Proteinase Inhibitor	Aralast
	Glassia
	Prolastin
	Zemaira
Pulmonary Arterial Hypertension Agents (PAH)	Adcirca
	Flolan *epoprostenol*
	Veletri

	Letairis
	Remodulin
	Revatio
	Tracleer
	Tyvaso
	Ventavis
Systemic Lupus Erythematosus (SLE) Agents	Benlysta
Viscosupplement	Euflexxa
	Hyalgan
	Supartz
	Orthovisc
	Synvisc
	Synvisc One

Precertification Edits

Drug Class	Restricted Drug
Acne Products	*all isotretinoin products*
ALS Agents	Rilutek 50mg tab
Antibiotics **Tetracyclines**	Adoxa
	Monodox
	Dynacin
	Minocin
	Doryx
Macrolides	Dificid
Oxazolidinones	Zyvox 600mg tab Zyvox 100mg/5ml susp
Anticataplectic Agents	Xyrem
Anticoagulant-Factor Xa Inhibitor	Xarelto
Anticoagulants-Thrombin Inhibitors	Pradaxa
Anticonvulsants	Banzel tablet Banzel Suspension Gabitril Onfi Potiga Sabril tablet Vimpat
Antidiabetics	Avandia Avandamet Avandaryl Korlym Symlin
Antiemetics-Miscellaneous	Marinol *dronabinol*
Antifungals	Sporanox/*itraconazole*
	Diflucan/*fluconazole*
	Lamisil/*terbinafine* Lamisil Granules
	Penlac *ciclopirox nail laquer*
Antiinfectives-Misc.	Xifaxan 200mg Xifaxan 550mg
Antimalaria	Coartem Lariam/*mefloquine* Malarone/*atovaquone/proguanil* Qualaquin/*quinine sulfate*
Antineoplastic-GnRH Antagonist	Firmagon *(degarelix)*
Antineoplastic-Enzyme Inhibitors	Afinitor Bosulif Gleevec Inlyta

	Jakafi Nexavar Oforta Sprycel Stivarga Sutent Tarceva Tasigna Tykerb Caprelsa (*vandetanib)* Votrient Xalkori Xtandi Zelboraf Zolinza
Antineoplastic-Hedgehog Pathway	Erivedge
Antineoplastic-Hormonal	Zytiga
Aromatase Inhibitors	Arimidex *anastrazole* Femara/*letrozole* Aromasin *exemestane*
Antineoplastic-Immunomodulator	Revlimid
Antineoplastic-Misc.	Sylatron
Antiretrovirals	Stribild
Antivirals-Hepatitis Agents	Incivek
	Victrelis
Asthma/COPD-Sympathomimetics	Arcapta Brovana Performist Foradil Serevent
PDE-4 Inhibitor	Daliresp
Anticholinergics	Tudorza
Bacterial Vaccines-Typhoid	Vivotif Berna EC
Bone Density Regulators	Prolia Xgeva
Cough/Cold/Allergy-NSA's	Clarinex D 24 hr Clarinex D 12 hr 2.5-120 Semprex-D 8-60mg
Antihistamines	Clarinex 5 mg reditab Clarinex 2.5mg reditabs Clarinex 5mg/*desloratadine tab* Clarinex syrup Xyzal 5mg tabs/*levocetirizine* Xyzal 2.5mg/5ml Oral Solution *levocetirizine 2.5mg/5ml*

Cystic Fibrosis Agents	Pulmozyme 1mg/ml Kalydeco
Dermatology-Immunomodulating Agents	Aldara 5% *imiquimod 5%* Zyclara cream 3.75%
	Zyclara cream 2.5%
	Picato gel
Dermatological Agents-Rosacea	Oracea
Endocrine- Growth Hormone Releasing Factor	Egrifta
Gaucher Agents	Zavesca
GI Agents Misc.-Peripheral Opioid Receptor Antagonist	Relistor
Chloride Channel Activators	Amitiza
Gout Agents	Krystexxa
Hemotological Agents-Platelet Aggregation Inhibitors	Brilinta
HMG-Intestinal Absorption Inhibitor	Zetia
Immunosuppressive Agents-topical	Elidel Protopic
Interleukin-1ß Blockers	Arcalyst injection Ilaris injection
Interstitial Cystitis Agents	Elmiron 100 mg
Irritable Bowel Syndrome Agents	Lotronex
Miscellaneous CNS-PBA Agents	Nuedexta
Movement Disorder-Huntington's Disease	Xenazine
Multiple Sclerosis	Ampyra Tysabri Aubagio
NSAID-Pyrimidine Synthesis	Arava, *leflunomide*
Opioid Agonists	Abstral Actiq/*fentanyl lozenges* Fentora Lazanda Onsolis Subsys
Opioid Partial Agonists	Butrans patch Suboxone Subutex *buprenorphine sublingual*
Platelet Aggregaton Inhibitor	Effient
Postherpetic Neuralgia Agents	Gralise, Gralise Starter Pack
Proton Pump Inhibitors	AcipHex

	Nexium Prevacid/*lansoprazole* capsule and ODT Dexilant (formerly Kapidex) Prilosec/*omeprazole* Prilosec powder Protonix/*pantoprazole* Zegerid/*omeprazole-sodium bicarbonate*
Pulmonary Artery Hypertension	Adcirca Revatio tablet Revatio injection
Restless Leg Syndrome Agents	Horizant
Stimulants-Misc.	Nuvigil Provigil

Age and Gender Precert Edits

PR/AGE	Drug Class	Restricted Drug	Limitations
Age	**Acne Products**	*avita* Atralin Retin-A Tretin-X *tretinoin*	PR-AGE ≥ 36 yrs; max age 35
		Ziana Veltin	
		Differin *adapalene*	
		Epiduo 0.1-2.5%	
	Antipsoriatics	Tazorac	PR-AGE ≥ 36 yrs; max age 35
Age	**Antibiotic**	Avelox	precert < 10 years old
	fluoroquinolones	Cipro Cipro XR	
		Factive	
		Floxin	
		Levaquin oral solution	
		Levaquin tablet	
		Noroxin	
		Proquin XR	
		Tequin	
Age	***tetracyclines***	*doxycycline monohydrate tablet*	precert < 8 yrs old
		doxycycline monohydrate capsule	
		Declomycin *demeclocycline*	
		Doryx *doxycycline hyclate* *doxycycline hyclate delayed-release* Oraxyl Vibramycin cap, tab	
		minocycline cap	
		minocycline tab	
		Oracea	
		oxytetracycline	
		Solodyn *minocycline SR*	
		tetracycline	
		Vibramycin suspension *doxycycline suspension* Vibramycin syrup	
Age	**Antihistamines**	*promethazine*	PR < 2 yrs old
		promethazine DM	minimum age = 2
		promethazine/VC	
		meperidine/promethazine	
		promethazine bulk powder	
		promethazine/codeine	PR < 6 yrs old
		promethazine/phenylephrine/codeine	minimum age = 6
Age	**NSAID's COX-II**	Celebrex 50mg	PR for < 60 yrs old

		Celebrex 100 mg Celebrex 200 mg Celebrex 400 mg	
Age	**Posterior Pituitary Hormones**	Stimate solution	PR ≤ 17 minimum age = 18
		DDAVP soln *desmopressin soln*	
		Minirin/desmopressin spray	
		DDAVP spray *desmopressin spray*	
Age/Gender	**Prostatic Hypertrophy Agents**	Proscar 5mg *finasteride 5mg*	PR for males < 50 yrs old and all females
Gender	**Prostatic Hypertrophy Agents**	Avodart *alfuzosin*	PR for females only
		Casodex *bicalutamide*	
		Flomax *tamsulosin*	
		Jalyn	
		Uroxatral	
		Rapaflo 4mg Rapaflo 8mg	
Gender	**Antineoplastic-GnRH Antagonist**	Firmagon *(degarelix)* injection	PR for females only

Quantity Limit Edits

Drug Class	Restricted Drug	Limitations
Angiotensin-II Receptor Blockers	Atacand 4 mg tab	Limit = 2 tablets/day
	Atacand 8 mg tab	Limit = 2 tablets/day
	Atacand 16 mg tab	Limit = 2 tablets/day
	Avapro 75 mg/*irbesartan 75mg*	Limit = 1 tablet/day
	Avapro 150 mg/*irbesartan 150mg*	Limit = 1 tablet/day
	Benicar 5 mg	Limit = 1 tablet/day
	Benicar 20 mg	Limit = 1 tablet/day
	Cozaar 25 mg/*losartan 25mg*	Limit = 2 tablets/day
	Cozaar 50 mg/*losartan 50mg*	Limit = 2 tablets/day
	Diovan 40 mg/*valsartan 40mg*	limit = 2 tablets/day
	Diovan 80 mg/*valsartan 80mg*	limit = 2 tablets/day
	Diovan 160 mg/*valsartan 160mg*	limit = 2 tablets/day
	Diovan HCT 80-12.5/*valsartan HCT*	limit = 1 tablet/day
	Diovan HCT 160-12.5/*valsartan HCT*	limit = 1 tablet/day
	Diovan HCT 160-25/*valsartan HCT*	Limit = 1 tablet/day
	Edarbi all strengths	All strengths = 1 tablet/day
	Micardis 40 mg tab	limit = 1 tablet/day
	Micardis 20 mg tab	limit = 1 tablet/day
	Teveten 400 mg tab	limit = 2 tablets/day
Antianginals-Other	Ranexa 500mg	Limit = 3 tabs/day
	Ranexa 1000mg	Limit = 2 tabs/day
Antibiotics-Macrolides	Dificid 200 mg	Limit = 20 tablets every 30 days QOT; 100% utilization
Anticataplectic Agents	Xyrem 500mg/ml	Limit = 18ml per day; 540ml/30ds
Anticoagulant-Factor Xa Inhibitor	Xarelto 10 mg	Limit = up to 35 tab every 365 days (100% used)
	Xarelto 15 mg	Limit = 1 tab/day
	Xarelto 20 mg	Limit = 1 tab/day
Anticoagulants-Thrombin Inhibitors	Pradaxa all strengths	Limit = 2 capsules / day
Anticonvulsants	Neurontin *gabapentin*	Limit all strengths = 6/day
	Lyrica 25mg	Limit = 3 caps/day
	Lyrica 50mg	Limit = 3 caps/day
	Lyrica 75mg	Limit = 3 caps/day
	Lyrica 100mg	Limit = 3 caps/day
	Lyrica 150mg	Limit = 3 caps/day
	Lyrica 200mg	Limit = 3 caps/day
	Lyrica 225mg	Limit = 2 caps/day
	Lyrica 300mg	Limit = 2 caps/day
	Lyrica Solution 20mg/ml	Limit = 900ml/30 days QOT
	Potiga 200mg	Limit = 3 tablets/day
	Potiga 300mg	Limit = 3 tablets/day
	Potiga 400mg	Limit = 3 tablets/day
	Vimpat 10mg/ml solution	Limit = 40ml/day
	Vimpat 50mg	Limit = 6 tab/day
	Vimpat 100mg	Limit = 2 tab/day
	Vimpat 150mg	Limit = 2 tab/day
	Vimpat 200mg	Limit = 2 tab/day
Antidepressants- **SSRI's and SNRI's**	Aplenzin 174mg tab	Limit = 1 tab/day
	Aplenzin 348mg tab	Limit = 1 tab/day
	Aplenzin 522mg tab	Limit = 1 tab/day
	Celexa/*citalopram* all strengths	Limit = 1 tab/day
	Cymbalta 20mg	Limit = 2 caps/day
	Cymbalta 30mg	Limit = 2 caps/day
	Cymbalta 60mg	Limit = 1 cap/day
	venlafaxine 25mg tab	Limit = 3 tab/day
	venlafaxine 37.5mg tab	Limit = 4 tab/day
	venlafaxine 50mg tab	Limit = 6 tab/day
	venlafaxine 75mg tab	Limit = 5 tab/day
	venlafaxine 100mg tab	Limit = 3 tab/day
	Effexor XR 37.5mg/*venlafaxine SR 37.5mg*	Limit = 1 capsule / day
	Effexor XR 75mg/*venlafaxine XR 75mg*	Limit = 1 capsule / day
	Effexor XR 150mg/*venlafaxine XR 150mg*	Limit = 2 capsules / day
	Emsam TD patch	Limit = 1 patch/day
	Lexapro /*escitalopram* all strengths tablets	Limit = 1 tab/day
	Lexapro 5 mg/5 ml *escitalopram 5mg/5ml*	Limit = 20 ml/day
	Luvox CR 100mg	Limit = 2 caps/day
	Luvox CR 150mg	Limit = 2 caps/day
	fluvoxamine 25mg tab	Limit = 1 tab/day
	fluvoxamine 50mg tab	Limit = 1 tab/day
	fluvoxamine 100mg tab	Limit = 3 tab/day
	Oleptro 150mg	Limit = 1.5 tab/day

	Oleptro 300mg	Limit = 1 tab/day
	Paxil 10mg tab/*paroxetine 10mg tab*	Limit = 1 tab/day
	Paxil 20mg tab/*paroxetine 20mg tab*	Limit = 1 tab/day
	Paxil 30mg tab/*paroxetine 30mg tab*	Limit = 2 tab/day
	Paxil 40mg tab/*paroxetine 40mg tab*	Limit = 2 tab/day
	Paxil 10mg/5ml susp/*paroxetine 10mg/5ml*	Limit = 30 ml/day
	Paxil CR /*paroxetine CR tablets* all strength	Limit = 2 tab/day
	Pexeva 10mg tab	Limit = 1 tab/day
	Pexeva 20mg tab	Limit = 1 tab/day
	Pexeva 30mg tab	Limit = 2 tab/day
	Pexeva 40mg tab	Limit = 2 tab/day
	Pristiq 50mg tab	Limit = 1 tab/day
	Pristiq 100mg tab	Limit = 1 tab/day
	Prozac 10mg cap/*fluoxetine 10mg non-PMDD*	Limit = 1 cap /day
	Prozac 20mg cap/*fluoxetine 20mg non-PMDD*	Limit = 4 cap/day
	Prozac 40mg cap/*fluoxetine 40mg cap*	Limit = 2 caps/day
	fluoxetine 10mg tab	Limit = 1 tab/day
	fluoxetine 20mg tab	Limit = 4 tabs/day
	fluoxetine 60mg tab	Limit = 1 tab/day
	fluoxetine liquid 20mg/5ml	Limit = 10 ml/day
	Prozac Weekly/*fluoxetine weekly*	Limit = 0.15/day
	Remeron and Remeron ODT All strengths	Limit = 1 tablet / day
	Wellbutrin 75mg tab/*bupropion 75mg tab*	Limit = 6 tab/day
	Wellbutrin 100mg tab/*bupropion 100mg tab*	Limit = 6 tab/day
	Wellbutrin SR 100mg tab	Limit = 2 tab/day
	bupropion SR 100mg tab	Limit = 2 tab/day
	Budeprion SR 100mg tab	Limit = 2 tab/day
	bupropion ER 100mg tab	Limit = 2 tab/day
	Wellbutrin SR 150mg tab	Limit = 2 tab/day
	bupropion SR 150mg tab	Limit = 2 tab/day
	Budeprion SR 150mg tab	Limit = 2 tab/day
	bupropion ER 150mg tab	Limit = 2 tab/day
	Wellbutrin SR 200mg tab/*bupropion SR 200mg*	Limit = 2 tab/day
	Wellbutrin XL 150mg	Limit = 1 tablet / day
	Budeprion XL 150mg	Limit = 1 tablet / day
	bupropion XL 150mg	Limit = 1 tablet / day
	Wellbutrin XL 300mg	Limit = 1 tablet / day
	Budeprion XL 300mg	Limit = 1 tablet / day
	bupropion XL 300mg	Limit = 1 tablet / day
	Forvivo XL 450mg	Limit = 1 tablet / day
	Venlafaxine 37.5mg tab ER	Limit = 1 tablet / day
	Venlafaxine 75mg tab ER	Limit = 1 tablet / day
	Venlafaxine 150mg tab ER	Limit = 2 tablets/day
	Venlafaxine 225mg tab ER	Limit = 1 tablet / day
	Viibryd all strengths	Limit = 1 tablet / day
	Viibryd Starter Kit	Limit = 1 tablet / day
	Zoloft 25mg tab/*sertraline 25mg tab*	Limit = 1 tab/day
	Zoloft 50mg tab/*sertraline 50mg tab*	Limit = 1 .5 tab/day
	Zoloft 100mg tab/*sertraline 100mg tab*	Limit = 2 tab/day
	Zoloft 20mg/ml conc/*sertraline 20mg/ml*	Limit = 10 ml/day
PMDD Agents	Sarafem 10mg tab	Limit = 14 tab per 30 days (0.5/day)
	Sarafem 20mg tab	Limit = 14 tab per 30 days (0.5/day)
	selfemra 10mg cap/fluoxetine 10mg cap PMDD	Limit = 14 tab per 30 days (0.5/day)
	selfemra 20mg cap/fluoxetine 20mg cap PMDD	Limit = 14 tab per 30 days (0.5/day)
Miscellaneous	*maprotiline 25mg tab*	Limit = 1 tab/day
	maprotiline 50mg tab	Limit = 2 tab/day
	maprotiline 75mg tab	Limit = 3 tab/day
Antidiabetic-Incretin Mimetic Agents	Byetta Pen 5mcg/0.02ml	Limit = 0.05/day (1.4ml/30d)
	Byetta Pen 10mcg/0.02ml	Limit = 0.08/day (2.4ml/30ds)
	Byetta Pen****old GPI****	Limit = 1 pen/30 days
	Victoza injection	Limit = 9ml/30days
	Korlym	Limit = 4 tab/day
Antiemetics-5HT3 Receptor Antagonists	Anzemet	any strength = 5 tablets/30 day
	Cesamet	Limit = 20 caps/30 days
	Emend tablets all strengths	Limit all strenghts= 5 tabs/30 day
	Emend 125mg/80mg	Limit = 2 pkgs (6 tab)/30 day
	granisetron 1mg tab	Limit = 10 tablets/30 days
	Granisol soln (2 mg /10ml)	Limit = 60ml/30ds
	Sancuso 3.1mg Patch	limit = 1 patch/21 days
	Zofran/*ondansetron* all strengths	Limit all strengths= 12 tab/30 day
	Zofran soln 4mg/5ml *ondansetron soln*	limit = 1 bottle (50 ml)/ 30 day
	Zofran ODT/*ondansetron ODT all strengths*	limit all strengths= 12 tab/30 day
	Zuplenz soluble film all strengths	Limit all strenghts=12 pack/30 day

Antifungals	Diflucan 150mg	PR > 1 tab/month
	Oravig 50mg	Limit = 14 tab per 30 days (0.47/day)
Antihypertensive Combinations	Amturnide all strengths	Limit = 1 tablet / day
	Atacand HCT 16-12.5 mg tab	limit = 2 tablets/day
	Avalide 150-12.5 mg tab	Limit = 1 tablet/day
	Azor all strengths	All strengths = 1 tablet/day
	Benicar HCT 20-12.5 mg	Limit = 1 tablet/day
	Edarbyclor all strengths	All strengths = 1 tablet/day
	Exforge all strengths	All strengths = 1 tablet/day
	Exforge HCT 5-160-12.5	Limit = 1 tablet/day
	Exforge HCT 5-160-25	Limit = 1 tablet/day
	Exforge HCT 10-160-12.5	Limit = 1 tablet/day
	Exforge HCT 10-160-25	Limit = 1 tablet/day
	Exforge HCT 10-320-25	Limit = 1 tablet/day
	Hyzaar 50-12.5/*losartan-hctz 50-12.5*	Limit = 1 tablet/day
	Micardis HCT 40-12.5 mg tab	Limit = 1 tablet/day
	Tekamlo all strengths	all strengths = 1 tablet/day
	Tekturna/HCT 150-12.5 mg	Limit = 1 tablet/day
	Tekturna/HCT 150-25 mg	Limit = 1 tablet/day
	Tribenzor all strengths	Limit all strengths = 1 tablet/day
	Twynsta all strengths	All strengths = 1 tablet/day
	Valturna all strengths	All strengths = 1 tablet/day
Antiinfectives-Misc.	Xifaxan 200mg	Limit = 9 tabs/30 days
	Xifaxan 550mg	Limit = 2 tabs/day
Antimalarials	Aralen *chloroquine*	PR qty < 30 tabs/30 days
	Daraprim	PR qty < 14 tabs/30 days
	Plaquenil *hydroxychloroquine*	PR qty < 30 tabs/30 days
	Qualaquin 324 mg/*quinine sulfate*	Limit = 42 capsules every 365 days
Antineoplastic Enzyme Inhibitors	Afinitor	
Max Days Supply = 30 on all Antineoplastics	Bosulif	
	Erivedge	Limit = 1 cap/day and max 30 day supply
	Inlyta	Limit = 2 tab/day and max 30 day supply
	Jakafi	Limit = 2 tab/day and max 30 day supply
	Gleevec	
	Nexavar	
	Oforta	
	Sprycel	
	Sutent	
	Stivarga	Limit= 84 per month & max 30 days
	Sylatron	
	Tarceva	
	Tasigna	
	Temodar	
	Tykerb	
	tretinoin capsules	
	Caprelsa (*vandetanib)*	
	Votrient	
	Xeloda	
	Zolinza	
	Hycamtin capsules	
	Xalkori 200mg	Limit = 2 tab/day and max 30 day supply
	Xalkori 250mg	
	Xtandi	Limit = 4/day and max 30 day supply
	Zelboraf 240mg	Limit = 8 tab/day and max 30 day supply
	Zytiga	Limit = 4 tab/day and max 30 day supply
Antipsychotics	Abilify 2mg	Limit = 1 tablet/day
	Abilify 5 mg	Limit = 1 tablet/day
	Abilify 10 mg	Limit = 1 tablet/day
	Abilify 15 mg	Limit = 1 tablet/day
	Abilify 20 mg	Limit = 1 tablet/day
	Abilify 30 mg	Limit = 1 tablet/day
	Abilify 10mg Disc	Limit = 1 tablet/day
	Abilify 15mg Disc	Limit = 1 tablet/day
	Abilify Solution	Limit = 30ml/day
	Clozaril 25mg/*clozapine 25mg*	Limit = 3 tablets/day
	clozapine 50mg	Limit = 3 tablets/day
	Clozaril 100mg/*clozapine 100mg*	Limit = 9 tablets/day
	Fanapt 1mg	Limit = 2 tablets/day
	Fanapt 2mg	Limit = 2 tablets/day
	Fanapt 4mg	Limit = 2 tablets/day
	Fanapt 6mg	Limit = 2 tablets/day

	Fanapt 8mg	Limit = 2 tablets/day
	Fanapt 10mg	Limit = 2 tablets/day
	Fanapt 12mg	Limit = 2 tablets/day
	Fanapt Titration pak	Limit = 1 pak/30 day supply
	Fazaclo 12.5mg	Limit = 12.5mg = 1 tablet/day
	Fazaclo 25mg	Limit = 25 mg = 3 tablets/day
	Fazaclo 100mg	Limit = 100 mg = 9 tablets/day
	Fazaclo 150mg	Limit = 150 mg = 6 tablets/day
	Fazaclo 200mg	Limit = 4 tablets/day
	Geodon/*ziprasidone*	all strengths = 2 capsules/day
	Invega 1.5mg	Limit = 2 tablets/day
	Invega 3mg	Limit = 2 tablets/day
	Invega 6mg	Limit = 2 tablets/day
	Invega 9mg	Limit = 1 tablet/day
	Latuda 20 mg	Limit = 1 tablet/day
	Latuda 40 mg	Limit = 1 tablet/day
	Latuda 80 mg	Limit = 2 tablets/day
	Latuda 120mg	Limit = 1 tablet/day
	Risperdal 0.25 mg/*risperidone 0.25 mg*	Limit = 2 tablets/day
	Risperdal 0.5 mg/*risperidone 0.5 mg*	Limit = 2 tablets/day
	Risperdal 1 mg/*risperidone 1 mg*	Limit = 2 tablets/day
	Risperdal 2 mg/*risperidone 2 mg*	Limit = 2 tablets/day
	Risperdal 3 mg/*risperidone 3 mg*	Limt = 2 tablets/day
	Risperdal 4 mg/*risperidone 4 mg*	Limit = 4 tablets/day
	Risperdal M-tab 0.25mg/*risperidone 0.25 mg ODT*	Limit = 2 tablets/day
	Risperdal M-tab 0.5 mg/*risperidone 0.5 mg ODT*	Limit = 2 tablets/day
	Risperdal M-tab 1 mg/*risperidone 1 mg ODT*	Limit = 2 tablets/day
	Risperdal M-tab 2 mg/*risperidone 2 mg ODT*	Limit = 2 tablets/day
	Risperdal M-tab 3 mg/*risperidone 3 mg ODT*	Limit = 2 tablets/day
	Risperdal M-tab 4 mg/*risperidone 4 mg ODT*	Limit = 4 tablets/day
	Saphris 5 mg	limit = 2 tablets/day
	Saphris 10 mg	Limit = 2 tablets/day
	Seroquel 25 mg/*quetiapine 25mg*	Limit = 6 tablets/day
	Seroquel 50 mg/*quetiapine 50mg*	Limit = 3 tablets/day
	Seroquel 100 mg/*quetiaprine 100mg*	Limit = 3 tablets/day
	Seroquel 200 mg/*quetiapine 200mg*	Limit = 4 tablets/day
	Seroquel 300 mg/*quetiapine 300mg*	Limit = 2 tablets/day
	Seroquel 400 mg/quetiapine 400mg	Limit = 2 tablets/day
	Seroquel XR 50 mg	Limit = 6 tablets/day
	Seroquel XR 150 mg	Limit = 1 tablet/day
	Seroquel XR 200 mg	Limit = 1 tablet/day
	Seroquel XR 300 mg	Limit = 2 tablets/day
	Seroquel XR 400 mg	Limit = 2 tablets/day
	Symbyax/*olanzapine-fluoxetine* all strengths	all strengths = 1/day
	Zyprexa 2.5 mg/*olanzapine 2.5mg*	Limit = 2 tablets/day
	Zyprexa 5 mg/*olanzapine 5mg*	Limit = 1 tablet/day
	Zyprexa 7.5 mg/*olanzapine 7.5mg*	Limit = 1 tablet/day
	Zyprexa 10 mg/*olanzapine 10mg*	Limit = 1 tablet/day
	Zyprexa 15 mg/*olanzapine 15mg*	Limit = 1 tablet/day
	Zyprexa 20 mg/*olanzapine 20mg*	Limit = 1 tablet/day
	Zyprexa Zydis 5 mg/*olanzapine ODT 5mg*	Limit = 1 tablet/day
	Zyprexa Zydis 10 mg/*olanzapine ODT 10mg*	Limit = 1 tablet/day
	Zyprexa Zydis 15 mg/*olanzapine ODT 15mg*	Limit = 1 tablet/day
	Zyprexa Zydis 20 mg/*olanzapine ODT 20mg*	Limit = 1 tablet/day
Antiviral-CMV Agents	Valcyte 450 mg	QOT 102 per 30 days
	Valcyte 1000 mg	QOT 1000 per 30 days
Antiviral-Herpes Agents	Famvir 125 mg *famciclovir 125 mg*	QOT 60 every 30 days
	Famvir 250 mg *famciclovir 250 mg*	QOT 60 every 30 days
	Famvir 500 mg *famciclovir 500 mg*	QOT 21 every 30 days
Antivirals-Hepatitis Agents	Incivek 375 mg	Limit = 6 tabs/day
	Victrelis 200 mg	Limit = 12 caps/day
Attention Deficit Hyperactivity Disorder (ADHD)/Narcolepsy	Adderall 5mg tab/*amphetamine-dexamphetamine*	Limit = 2 tab/day
	Adderall 7.5mg tab/*amphetamine-dexamphetamine*	Limit = 2 tab/day
	Adderall 10mg tab/*amphetamine-dexamphetamine*	Limit = 2 tab/day
	Adderall 12.5mg tab/*amphetamine-dexamphetamine*	Limit = 2 tab/day
	Adderall 15mg tab/*amphetamine-dexamphetamine*	Limit = 2 tab/day
	Adderall 20mg tab/*amphetamine-dexamphetamine*	Limit = 3 tab/day
	Adderall 30mg tab/*amphetamine-dexamphetamine*	Limit = 2 tab/day
	Adderall XR/*amphetamine-dexamphetamine SR*	All strengths= 1 cap/day
	Concerta 18mg tab	Limit = 1 tab/day

	Concerta 27mg tab	Limit = 1 tab/day
	Concerta 36mg tab	Limit = 2 tab/day
	Concerta 54mg tab	Limit = 1 tab/day
	Daytrana all strengths	Limit = 1 patch/day
	Desoxyn 5mg tab/*methamphetamine 5mg tab*	Limit = 4 tab/day
	dextroamphetamine 5mg tab *dextroamphetamine 10mg tab*	Limit = 4 tab/day
	Dexedrine CR */dextroamphetamine CR* all strengths	Limit = 3 cap/day
	Focalin tab/*dexmethylphenidate tabs* all strengths	All strengths = 2 tab/day
	Focalin XR all strengths	All strengths = 1 cap/day
	Intuniv all strengths	All stregths = 1/day
	Kapvay 0.1mg	Limit = 4 tab/day
	Kapvay Dose Pack	Limit = 1 pack per month (60 tabs)
	Metadate CD 10mg cap	Limit = 1 cap/day
	Metadate CD 20mg cap	Limit = 1 cap/day
	Metadate CD 30mg cap	Limit = 1 cap/day
	Metadate CD 40mg cap	Limit = 1 cap/day
	Metadate CD 50mg cap	Limit = 1 cap/day
	Metadate CD 60mg cap	Limit = 1 cap/day
	Methylin ER 10mg tab	Limit = 3 tab/day
	Methylin/Ritalin/*methylphenidate tab*	Limit = 3 tab/day
	Methylin chew 2.5 mg	Limit = 6/day
	Methylin chew 5 mg	Limit = 6/day
	Methylin chew 10 mg	Limit = 6/day
	Methylin soln 5mg/5ml *methylphenidate soln*	Limit = 60 ml/day
	Methylin soln 10mg/5ml *methylphenidate soln*	Limit = 30 ml/day
	Metadate ER/Methylin ER/Ritalin SR/ *methylphenidate CR/SR/ER 20mg*	Limit = 3 tab/day
	Ritalin LA 10mg cap	Limit = 1 cap/day
	Ritalin LA 20mg cap	Limit = 1 cap/day
	Ritalin LA 30mg cap	Limit = 2 cap/day
	Ritalin LA 40mg cap	Limit = 1 cap/day
	Nuvigil 50mg	Limit = 2 tab/day
	Nuvigil 150mg	Limit = 1 tab/day
	Nuvigil 250mg	Limit = 1 tab/day
	Procentra 5mg/5ml solution	Limit = 40ml/day
	Provigil 100mg tab Provigil 200mg tab	Limit = 2 tab/day
	Strattera 10mg cap	Limit = 2 cap/day
	Strattera 18mg cap	Limit = 2 cap/day
	Strattera 25mg cap	Limit = 2 cap/day
	Strattera 40mg cap	Limit = 2 cap/day
	Strattera 60mg cap	Limit = 2 cap/day
	Strattera 80mg cap	Limit = 1 cap/day
	Strattera 100mg cap	Limit = 1 cap/day
	Vyvanse all strengths	Limit = 1 cap/day
Bone Density Regulators	Actonel 35 mg tablet	Limit = 1 tablet per week
	Actonel 150mg tablet	Limit = 3 tabs/90days
	Atelvia 35 mg tablet	Limit = 1 tablet per week
	Binosto 70mg	Limit = 1 tablet per week
	Boniva 150 mg *ibandronate 150 mg*	Limit 3 tabs/90days
	Fosamax 35 mg *alendronate 35mg*	Limit = 1 tablet per week
	Fosamax 70 mg *alendronate 70mg*	Limit = 1 tablet per week
	Fosamax solution 70 mg/75 ml	Limit = 10ml/day
	Fosamax Plus Tab D 2600	Limit = 1 tablet per week
	Fosamax Plus Tab D 5600	Limit = 1 tablet per week
Cough/Cold/Allergy-NSA's	Clarinex D 24 hr	Limit = 1 tab/day
	Clarinex D 12 hr 2.5-120	Limit = 2 tab/day
	Semprex-D 8-60mg	Limit = 4 cap/day
Antihistamines	Clarinex 2.5 mg reditab	Limit = 1 tab/day
	Clarinex 5mg reditabs	Limit = 1 tab/day
	Clarinex 5mg tab	Limit = 1 tab/day
	Clarinex syrup	Limit= 10ml/day
	Xyzal 5mg tabs *levocetirizine 5mg tabs*	Limit = 1 tab/day
	Xyzal 2.5mg/5ml oral solution *levocetirizine 2.5mg/5ml*	Limit = 10ml/day
Cystic Fibrosis Agents	Kalydeco 150 mg tab	Limit = 2 tab/day; max 30 day supply per fill
Dermatology-Immunomodulating Agents	Aldara/*imiquimod 5% cream*	Limit = 120 days/365 days
	Zyclara cream 3.75% packet	Limit = 56 packets/365 days

	Zyclara cream 3.75% pump	2 pumps (15gm)/365 days
	Zyclara cream 2.5% pump	2 pumps (15gm)/365 days
	Picato gel 0.015%	Limit = 1 box (3 tubes)/60 days
	Picato gel 0.05%	Limit = 1 box (2 tubes)/60 days
Dermatologicals-Rosacea	Oracea 40mg capsules	Limit = 1 cap/day
Diagnostic Tests- Blood Glucose Strips	Blood Glucose Test Strips	QOT = 300 strips per 30 days
Direct Renin Inhibitors	Tekturna all strengths	all strengths = 1 tablet/day
Endocrine- Growth Hormone Releasing Factor	Egrifta 1mg injection 1 ml vial	Limit = 2 injections/day
	Egrifta 1mg injection 2ml vial	Limit = 1 vial per day
Estrogen Replacement	Alora 0.025 mg	Limit = 8 patches per month
	Alora 0.05 mg	
	Alora 0.075 mg	
	Alora 0.1 mg	
	Climara 0.025 mg	Limit = 4 patches per month
	Climara 0.0375 mg	
	Climara 0.05 mg	
	Climara 0.06 mg	
	Climara 0.075 mg	
	Climara 0.1 mg	
	Estraderm 0.05mg	Limit = 8 patches per month
	Estraderm 0.1 mg	
	Estradiol patch 0.05 mg/24hr	Limit = 4 patches per month
	Estradiol patch 0.075mg/24hr	
	Estradiol patch 0.1 mg/24hr	
	Menostar 14 mcg/24h	Limit = 4 patches per month
	Vivelle DOT 0.01 mg	Limit = 8 patches per month
	Vivelle DOT 0.025 mg	
	Vivelle DOT 0.0375 mg	
	Vivelle DOT 0.05 mg	
	Vivelle DOT 0.075 mg	
Estrogen Combinations Patches	Climara Pro Weekly	Limit = 4 patches per month
	Combipatch 0.05/0.14	Limit = 8 patches per month
	Combipatch 0.05/0.25	
Fibromyalgia Agents	Savella Titration Pak	Limit = 1 kit/30ds
	Savella 12.5mg	Limit = 2 tablets/day
	Savella 25mg	
	Savella 50mg	
	Savella 100mg	
GI Agents Misc.-	Relistor injection 12mg/0.6ml	Limit = QOT 10 inj/month
Peripheral Opioid Receptor	Relistor injection 12mg/0.6ml kit	Limit = QOT 1 kit /month
Antagonists	Relistor injection 8mg/0.4ml	Limit = 10 syringes per month
Inflammatory Bowel Agents	Apriso 0.375 gm cap	Limit = 4 cap/day
	Asacol 400mg EC tab	Limit = 12 tab/day
	Asacol HD 800mg tab	Limit = 6 tab/day
	Azulfidine 500mg tab *sulfasalazine 500mg tab* *Sulfazine 500mg tab*	Limit = 8 tab/day
	Azulfidine 500mg Entab *Sulfazine 500mg Entab*	Limit = 8 tab/day
	Canasa 1000mg supp	Limit = 1 sup/day
	Colazal 750mg cap *balsalaside 750mg cap*	Limit = 9 cap/day
	Dipentum 250mg cap	Limit = 4 cap/day
	Lialda 1.2gm tab	Limit = 4 tabs/day
	Pentasa 250mg CR cap	Limit = 16 cap/day
	Pentasa 500mg CR cap	Limit = 8 cap/day
Glucocorticosteroids	Entocort EC 3mg *budesonide SR 3 mg*	Limit = 3 cap/day
Hemostatics	Lysteda	30 tablets/30 day supply
Hemotological Agents-Platelet Aggregation Inhibitors	Brilinta	Limit = 2 tabs/day
HMG CoA Reductase Inhibitors	Advicor	all strengths = 2 tabs/day
	Altoprev 20mg	Limit = 1 tablet/day
	Altoprev 40mg	limit = 2 tablets/day
	Altoprev 60mg	limit = 1 tablet/day
	Crestor	all strengths = 1 tablet/day
	Lescol 20 mg tab	Limit = 2 tablets/day
	Lescol 40 mg tab	Limit = 2 tablets/day
	Lescol XL 80mg	Limit = 1 tablet/day
	Lipitor 10 mg/*atorvastatin 10 mg*	Limit = 1 tablet/day
	Lipitor 20 mg/atorvastatin 20 mg	Limit = 1 tablet/day

	Lipitor 40 mg/atorvastatin 40 mg	Limit = 1 tablet/day
	Lipitor 80mg/*atorvastatin 80 mg*	Limit = 1 tablet/day
	Livalo all strengths	all strengths = 1 tablet/day
	Mevacor 10mg/*lovastatin 10mg*	limit = 2 tablets/day
	Mevacor 20mg/*lovastatin 20mg*	limit = 2 tablets/day
	Mevacor 40mg/*lovastatin 40mg*	limit = 2 tablets/day
	Pravachol 10 mg/*pravastatin 10mg*	limit = 1 tablet/day
	Pravachol 20 mg/*pravastatin 20mg*	limit = 1 tablet/day
	Pravachol 40 mg/*pravastatin 40mg*	limit = 1 tablet/day
	Pravachol 80mg/*pravastatin 80mg*	limit = 1 tablet/day
	Simcor 500-20	limit = 2 tablets/day
	Simcor 500-40	limit = 1 tablet/day
	Simcor 750-20	limit = 2 tablets/day
	Simcor 1000-20	limit = 2 tablets/day
	Simcor 1000-40	limit = 1 tablet/day
	Zetia 10mg tab	Limit = 1 tablet/day
	Zocor 5 mg tab/*simvastatin 5mg*	Limit = 1 tablet/day
	Zocor 10 mg tab/*simvastatin 10mg*	Limit = 1 tablet/day
	Zocor 20 mg tab/*simvastatin 20mg*	Limit = 1 tablet/day
	Zocor 40 mg tab/*simvastatin 40mg*	Limit = 1 tablet/day
	Zocor 80mg tab/simvastatin 80mg tab	Limit = 1 tablet/day
HMG-Intestinal Absorption Inhibitor Combination	Vytorin	all strengths = 1 tablet/day
HMG Calcium Channel Blocker Combinations	Caduet/*amlodipine-atorvastatin*	All strengths = 1 tab/day
Huntington's Chorea	Xenazine 12.5 mg	4 tab/day (120/30ds)
	Xenazine 25 mg	2 tab/day (60/30ds)
Hypnotics	Ambien 5mg tab	Limit = 2 tab/day
	Ambien 10mg tab	Limit = 1 tab/day
	Ambien CR 6.25mg/*zolpidem ER 6.25mg*	Limit = 1 tab/day
	Ambien CR 12.5mg/*zolpidem ER 12.5mg*	Limit = 1 tab/day
	Edluar 5mg	Limit = 1 tab/day
	Edluar 10mg	Limit = 1 tab/day
	Intermezzo 1.75mg	Limit = 1 tab/day
	Intermezzo 3.5mg	Limit = 1 tab/day (males only; females excluded)
	Lunesta 1mg	Limit = 1 tab/day
	Lunesta 2mg	Limit = 1 tab/day
	Lunesta 3mg	Limit = 1 tab/day
	Rozerem 8mg	Limit = 1 tab/day
	Silenor 3mg Silenor 6mg	Limit = 1 tab/day
	Sonata 5mg cap	Limit = 4 cap/day
	Sonata 10mg cap	Limit = 2 cap/day
	Zolpimist spray 5 mg	Limit = 1 bottle/30 day supply
Impotence Agents *plan specific*	Caverject	Limit = 6/30 day supply
	Edex	
	Cialis	
	Levitra	
	Muse	
	Viagra	
	Staxyn	
Influenza Agents	Relenza	2 unit (= 40)/calendar yr
	Tamiflu 12mg/ml	Limit = 150ml/calendar yr
	Tamiflu 6mg/ml	Limit = 480ml/calendar yr
	Tamiflu 75mg	Limit = 20 cap/calendar yr
	Tamiflu 45mg	Limit = 20 cap/calendar yr
	Tamiflu 30mg	Limit = 20 cap/calendar yr
Interstitial Cystitis	ELMIRON 100 mg	Limit = 3 caps/day
Leukotriene	Accolate 10mg *zafirlukast 10mg*	Limit = 2 tabs/day
	Accolate 20mg *zafirlukast 20mg*	Limit = 2 tabs/day
	Singulair 4mg granules	Limit = 1 granule pack/day
	Singulair 4mg chewable	Limit = 1 tab/day
	Singulair 5mg chewable	Limit = 1 tab/day
	Singulair 10mg	Limit = 1 tab/day
	Zyflo 600mg tab	Limit = 4 tabs/day
	Zyflo 600mg CR tab	Limit = 4 tabs/day
Miscellaneous CNS-PBA Agents	Nuedexta 20 mg-10 mg	Limit = 2 capsules / day
Multiple Sclerosis Agents	Ampyra 10mg	Limit = 2 tablets/day
	Gilenya 0.5mg	1 cap/day
	Aubagio	1 cap/day
NSAID	Duexis 800 mg-26.6 mg	3 tablets/day

	PONSTEL 250 mg *mefenamic acid 250 mg*	Limit = 30 capsules every 30 days
	Toradol 10mg tab *ketorolac 10mg*	20 tab/28 day
	Sprix	5 UD sprays/30 days
	Vimovo 375-20mg	2 tablets/day
	Vimovo 500-20mg	
topical	Flector Patch 1.3%	2 patches/day
	Pennsaid solution 1.5%	300 ml/30ds; 10ml/day
	Voltaren 1% gel	Limit = QOT 500gm/month
NSAID-COX II	Celebrex 50mg	2 caps/day
	Celebrex 100 mg	2 caps/day
	Celebrex 200 mg	1 cap/day
	Celebrex 400 mg	2 caps/day
Opioid Agonists	Abstral 100 mcg	Limit = QOT 15 lozenges/30 day
	Abstral 200 mcg	
	Abstral 300 mcg	
	Abstral 400 mcg	
	Abstral 600 mcg	
	Abstral 800 mcg	
	Actiq Loz 200mcg/*fentanyl loz*	
	Actiq Loz 400mcg/*fentanyl loz*	
	Actiq Loz 600mcg/*fentanyl loz*	
	Actiq Loz 800mcg/*fentanyl loz*	
	Actiq Loz 1200mcg/*fentanyl loz*	
	Actiq Loz 1600mcg/*fentanyl loz*	
	Avinza	QOT = 60 capsules per 30 days
	oxycodone/ibuprofen 4-500	Limit = 28/30 day
	Conzip *tramadol ER Capsule*	QOT = 60 capsules per 30 days
	Duragesic 12mcg/hr *fentanyl patch 12mcg/hr*	20 patches/30 day
	Duragesic 25mcg/hr *fentanyl patch 25mcg/hr*	
	Duragesic 50mcg/hr *fentanyl patch 50mcg/hr*	
	Duragesic 75mcg/hr *fentanyl patch 75mcg/hr*	
	Duragesic 100mcg/hr *fentanyl patch 100mcg/hr*	
	Embeda 20-0.8mg	Limit = 2 capsules / day
	Embeda 30-1.2mg	
	Embeda 50-2mg	
	Embeda 60-2.4mg	
	Embeda 80-3.2mg	
	Embeda 100-4mg	
	Exalgo 8mg	Limit = 2 capsules / day
	Exalgo 12mg	Limit = 2 capsules / day
	Exalgo 16mg	Limit = 4 capsules/day
	Exalgo 32mg	Limit = 2 capsules /day
	Fentora Buccal 100mcg	Limit = QOT 15 tablets/ 30 day
	Fentora Buccal 200mcg	
	Fentora Buccal 400mcg	
	Fentora Buccal 600mcg	
	Fentora Buccal 800mcg	
	Kadian Morphine CR capsule	QOT = 60 capsules per 30 days
	Morphine CR tablet MS Contin tablet	QOT = 120 tablets per 30 days
	Methadone tablet	QOT = 180 tablets per 30 days
	Methadone tab for oral susp	
	Nucynta ER 50mg	Limit = QOT 60 units/30 day supply
	Nucynta ER 100mg	
	Nucynta ER 150mg	
	Nucynta ER 200mg	
	Nucynta ER 250mg	
	Nucynta 50mg	Limit = QOT 180 units/30 day supply
	Nucynta 75mg	
	Nucynta 100mg	
	Onsolis 200mcg	QOT Limit = 15/30ds
	Onsolis 400mcg	
	Onsolis 600mcg	
	Onsolis 800mcg	

	Onsolis 1200mcg	
	Opana ER tablet Oxymorphone ER tablet	QOT = 120 tablets per 30 days
	Oxycontin 10mg	Limit = 4 tab/day
	Oxycontin 15mg	Maximum daily dose = 320mg
	Oxycontin 20mg	
	Oxycontin 30mg	
	Oxycontin 40mg	
	Oxycontin 60mg	
	Oxycontin 80mg	
	butorphanol NS	2 units/mo (= 5 ml)
	Subsys 100mcg	QOT Limit = 15/30ds
	Subsys 200mcg	
	Subsys 400mcg	
	Subsys 600mcg	
	Subsys 800mcg	
	Subsys 1200mcg	
	Subsys 1600mcg	
	Tramadol ER Tablet	QOT = 60 capsules per 30 days
	Ultram ER Tablets	
Opioid Partial Agonists	Butrans 5mcg/hr	Limit = 4 per 30 days
	Butrans 10mcg/hr	
	Butrans 20mcg/hr	
	Suboxone 2-0.5mg tab	Limit = 3 per day
	Suboxone 8-2mg tab	
	Suboxone 2-0.5mg film	
	Suboxone 8-2mg film	
	Subutex 2 mg *buprenorphine 2 mg*	*Max 24 per month*
	Subutex 8 mg *buprenorphine 8 mg*	*Max 8 per month*
Platelet Aggregaton Inhibitor	Effient 5mg	limit = 1 tablet/day
	Effient 10mg	limit = 1 tablet/day
Postherpetic Neuralgia Agents	Gralise 300mg	Limit = 5 tab/day
	Gralise 600mg	Limit = 3 tab/day
	Gralise Starter Pack	Limit = 1 pack (78 tab)/365 days
	Qutenza patch 8%	4 patches every 90 days
Progestins	Makena	5 x 5 ml vials per 365 days
Proton Pump Inhibitors	AcipHex	All strengths = 1 tablet/day
	Dexliant	All strengths = 1 capsule/day
	Nexium	All strengths = 1 cap or packet/day
	Prevacid 30mg/*lansoprazole 30mg* Prevacid SoluTab/*lansoprazole ODT*	All strengths = 1 cap or tab/day
	Prilosec/*omeprazole*	All strengths = 1 cap or tab or powder/day
	Prilosec powder	Limit = 2 packets/day
	Protonix/*pantoprazole*	All strengths = 1 tablet/day
	Protonix Pak	All strengths = 1 packet/day
	Zegerid packet Zegerid capsule/*omeprazole-sodium bicarbonate*	All strengths = 1 packet/day All strengths = 1 capsule/day
Restless Leg Syndrome Agents	Horizant	Limit = 1 tablet / day
Serotonin Agonists	Amerge/*naratriptan* all strengths	Limit = 9 tabs/30 day
(Migraine)	Axert	Limit = 6 tabs/30 day
	Cambia	Limit = 9 tabs/30 day
	Frova 2.5 mg	Limit = 9 tabs/30 day
	Imitrex nasal/*sumatriptan nasal* all strength	Limit = 6 vials/30 day
	Imitrex tabs all strengths	Limit all strengths= 9 tabs/30 day
	Imitrex 6mg vial/*sumatriptan 6mg vial* Alsuma 6mg injection	Limit = 10 vials/30 day
	sumatriptan 4mg/0.5ml vial	Limit = 10 vials/30 days
	Maxalt/*rizatriptan* all strengths Maxalt MLT/*rizatriptan MLT* all strengths	Limit = 12 tabs/30 day all forms and strengths
	Migranal	Limit = 8 doses/30 days
	Relpax all strengths	Limit all strengths = 6 tab/30 day
	Sumavel 6mg/0.5ml Inj	Limit = 6 prefilled syringes/30 day
	Treximet 85/500mg	Limit = 9 tabs/30 day
	Zomig/Zomig ZMT/Zomig nasal all strength	limit all strengths= 6 tabs/30 days
Ulcer Therapy Combinations	Prevpac MIS	Limit = 14 (1 pack)/14 days
	Omeclamox	Limit = 80 (1 pack)/8 days

Added 01/01/2007; Old GPI = 27170020002020

Step-Therapy Edits

Drug Class	Restricted Drug
ACE Inhbitor and Calcium Channel Blocker Combinations	Lotrel 2.5-10 Lotrel 5-10mg Lotrel 5-20mg Lotrel 10-20mg
Acne Products	Tretin-X
	Veltin
	Atralin
	Retin-A
	Benzefoam Ultra 9.8%
	Acanya 1.2-2.5% Benzaclin 1-5%
	Benzamycin 5-3% Benzamycin pak 5-3%
	Duac 1-5%
Androgens	Striant
	Testim TD gel 1%
	Axiron 30mg/act
Anesthetics-topical	Lidoderm 5% patch
ARB and Renin Inhibitors	Atacand Avapro Benicar Diovan Diovan HCT Edarbi Teveten Atacand HCT Avalide Benicar HCT Edarbyclor Teveten HCT Tribenzor Twynsta
Antiadrenergic Antihypertensives	Nexiclon XR susp 0.09 mg/ml Nexiclon XR tablet 0.17 mg
Antianginals-Other	Ranexa 500mg Ranexa 1000mg

Anticonvulsants	Depakote
	Lamictal XR Kit
	Lamictal XR
	Keppra/XL
	Topamax
Antidementia Agents	Aricept 5mg Aricept 10mg Aricept ODT 5mg Aricept ODT 10mg Aricept 23mg
Antidepressants- **SSRI's and SNRI's**	Celexa
	Desyrel
	Effexor XR
	Cymbalta *nefazodone* Pexeva Rapiflux Wellbutrin XL/Forvivo Luvox CR Pristiq Venlafaxine ER tablets Aplenzin Viibryd Fluoxetine 60mg tab
	Lexapro
	Oleptro
	Paxil
	Paxil CR
	Prozac Caps Prozac Tabs Prozac Weekly
	Remeron Remeron Solutab
	Wellbutrin
	Wellbutrin SR
	Zoloft
	Celexa solution
	Paxil liquid
	Prozac liquid
	Zoloft concentrate
	Lexapro solution
Antidiabetic Combinations	Actoplus Met XR
Antineoplastic-Hormonal **(Aromatase Inhibitors)**	Arimidex Femara
Antiparkinson-Dopaminergics	Mirapex ER
	Requip XL

Antipsoriatics	Sorilux Foam
Antipsychotics	Fanapt Geodon Latuda Saphris Seroquel
	Invega
	Risperdal Risperdal-M Risperdal solution
Antiretrovirals	Viramune
	Ziagen
Asthma-Sympathomimetics	Maxair Autohaler 200 mcg/act
	Xopenex Neb 0.31mg Xopenex Neb 0.63mg Xopenex Neb 1.25mg / 3ml Xopenex Neb 1.25mg Xopenex Conc Neb 1.25mg / 0.5
Bone Density Regulators	Boniva
	Binosto
	Fosamax + D 70-2800 Fosamax + D 70-5600
Calcium Channel Blocker	Norvasc
Central Muscle Relaxant	Amrix
	Fexmid
Corticosteroids-topical	Clobex Shampoo
	Clobex Lotion
	Cloderm cr/pump
	Differin Cream
	Differin Lotion
	Differin 0.1% gel
	Luxiq
	Olux Olux-E Olux/Olux-E complete pack

	Vanos Cr. 1%
	Cutivate cr/lot/oint Locoid cr/lot/oint/sol Locoid Lipocream
	Desonate gel Verdeso aerosol
Diagnostic Tests- **Blood Glucose Strips**	All non-preferred blood glucose
Digestive Enzymes	Pertzye Ultresa Viokace
Fibric Acid Derivatives	Fenoglide tab mfr: 52725-0490 mfr: 52725-0495 mfr: 68012-0495
	Fibricor
	Lipofen
	Lofibra cap Lofibra tab
	Lopid
	Triglide
Glucocorticosteroids	Entocort EC
	Rayos
Gout Agents	Uloric
Heperinoid-Like Agents	Lovenox
Herpes Agents	Valtrex
HMG CoA Reductase Inhibitors	Altoprev 10 mg Altoprev 20 mg Altoprev 40mg Altoprev 60 mg
	Lipitor all strengths
HMG and Calcium Channel Blocker Combinations	Caduet
Hypnotics	Ambien Ambien CR Rozarem Sonata Zolpimist spray
	Intermezzo

	Edluar
	Silenor
Impotence Agents *plan specific*	Viagra Levitra Staxyn
Insulin *(Edits not implemented in the state of Texas)*	Novolin 70/30
	Relion 70/30
	Novolin R
	Relion R
	Novolin N
	Relion N
Leukotriene Modulators	Singulair
Nasal Agent Combination	Dymista
Nasal Steroids	Rhinocort Nasacort Qnasl Zetonna
NSAID	Duexis Vimovo
topical	Pennsaid solution 1.5% Voltaren gel 1% **any one preferred generic NSAID*
Ophthalmics-miscellaneous	Patanol
Opioid Agonists	Abstral
	Avinza
	Duragesic 12.5mcg Duragesic 25mcg Duragesic 50mcg Duragesic 75mcg Duragesic 100mcg
	Exalgo

	Kadian
	Lazanda
	Subsys
	Nucynta IR Opana tablet
Opioid Partial Agonists	Subutex
Platelet Aggregation Inhibitors	Plavix
Phosphate Binder Agents	PhosLo
	Renagel
Posterior Pituitary Hormones	DDAVP inj 4mcg/ml DDAVP tablets DDAVP solution 0.01%
Prostaglandins-Opthalmic	Xalatan Zioptan
Prostatic Hypertrophy Agents	Flomax
	Uroxatral
Proton Pump Inhibitors	Prilosec 10mg
	Prilosec 20mg capsule Prilosec 40mg
	Prilosec powder 10mg Prilosec powder 2.5mg
	Zegerid
	AcipHex
	Protonix 20mg tablet Protonix 40mg
	Protonix pack
	Prevacid 30mg
	Prevacid SoluTab
Serotonin Agonists (Migraine)	Axert Frova Imitrex Alsuma 6mg injection Migranal Relpax Sumavel Zomig/Zomig ZMT
	Amerge
	Maxalt/MLT
Migraine Combinations	Treximet *mandatory flag sumatriptan*
Urinary Antispasmodics	Oxytrol 3.9mg/24hr patch
	Detrol
	Detrol LA

	Sanctura Sanctura XR Ditropan XL Myrbetriq Toviaz

Pre-requisite Drugs
amlodipine/benazepril
topical tretinoin- mandatory *adapalene* (Differin) Benzaclin Duac Retin-A Micro Ziana *benzoyl peroxide* *topical clindamycin* *topical erythromycin* *erythromycin/benzoyl peroxide* *sulfacetamide* *sulfacetamide/sulfur*
benzoyl peroxide foam 9.8%
clindamycin/benzoyl peroxide *erythromycin/benzoyl peroxide* *clindamycin/benzoyl peroxide gel*
AndroGel Androderm
gabapentin
losartan *candesartan* *eprosartan* *irbesartan* *valsartan* *candesartan-hctz* *irbesartan-hctz* *losartan-hctz* *valsartan-hctz* Exforge Exforge HCT Micardis Micardis HCT
clonidine tablet *clonidine TTS patch*
nitro class *amlodipine* *beta blocker class (except*

sotalol)
divalproex sodium
lamotrigine
levetiracetam
topiramate
donepezil 5 mg *donepezil 10 mg* *donepezil ODT 5mg* *donepezil ODT 10mg*
citalopram
trazodone
venlafaxine SR capsule (generic Effexor XR)
Any one of: *budeprion, bupropion SR* *bupropion XL, bupropion* *citalopram* *escitalopram* *fluvoxamine* *fluoxetine* *nefazodone* *mirtazapine* *paroxetine/CR* *sertraline* *venlafaxine* *fluoxetine (PMDD)* *venlafaxine SR capsule (generic Effexor XR)*
escitalopram
trazodone
paroxetine
paroxetine SR
fluoxetine, fluoxetine weekly
mirtazapine
bupropion
Budeprion SR, bupropion SR
sertraline
citalopram solution
paroxetine liquid
fluoxetine liquid
sertraline concentrate
escitalopram solution
Actoplus Met
anastrozole *letrozole*
pramipexole
ropinirole ER

calcipotriene Tazorac
risperidone *quetiapine* *olanzapine* *ziprasidone*
risperidone *risperidone ODT*
nevirapine
abacavir
ProAir HFA Proventil HFA
levoalbuterol nebules/concentrate
alendronate, ibandronate ***AND*** Actonel, Atelvia
amlodipine
cyclobenzaprine or cyclobenzaprine ER (mandatory)
baclofen *carisoprodol* *carisoprodol w/asa* *carisoprodol w/asa, codeine* *chlorzoxazone* *methocarbamol* *orphenadrine SR* *orphenadrine compound (ASA/caffeine)* *tizanidine* Skelaxin
clobetasol shampoo
clobetasol lotion
mometasone furoate *triamcinolone acetonide* *hydrocortisone valerate*
adapalene cream/gel
adapalene cream/gel
adapalene cream/gel
betamethasone valerate
clobetasol propionate

betamethasone dipropionate *betamethasone valerate* *desoximetasone* *hydrocortisone butyrate* *hydrocortisone valerate* *mometasone furoate* *triamcinolone acetonide* *fluticasone propionate* *fluocinonide 0.05% cream* *desonide lotion* *prednicarbate*
desonide
preferred blood glucose test *strip by Johnson & Johnson* *OR Abbott Laboratories*
Creon Zenpep
Antara **mfr: 27437**** *fenofibrate capsule* *fenofibrate tablet* *gemfibrozil* Trilipix *fenofibric acid*
budesonide SR
prednisone
allopurinol
enoxaparin
valacyclovir
lovastatin
atorvastatin- ***mandatory*** Vytorin Crestor
amlodipine/atorvastatin
zolpidem *zolpidem ER*
zolpidem/zolpidem ER

doxepin- mandatory *zolpidem* *zolpidem ER*
Cialis
Humulin 70/30
Humulin R
Humulin N
montelukast
Flonase/*fluticasone* Astepro *azalastine* Veramyst Nasonex
Flonase *(fluticasone)* Nasonex Veramyst
choline mg trisalicylate *flurbiprofen* *fenoprofen* *ibuprofen* *indomethacin* *meloxicam* *meclofenamate* *naproxen/sodium* *piroxicam* *salsalate* *sulindac* *diflunisal* *diclofenac sodium* *diclofenac pot* *etodolac cap* *etodolac tab* *ketorolac* *ketoprofen*
Pataday
fentanyl transmucosal lozenge
morphine SO_4 SR
fentanyl TD patch
morphine sulfate CR

morphine SO_4 SR
fentanyl transmucosal lozenge
oxycodone IR cap *oxycodone IR tab* *oxycodone solution* *oxycodone concentrated solution* *morphine solution* *morphine IR*
buprenorphine SL
clopidogrel
calcium acetate
Renvela
desmopressin inj *desmopressin tablets* *desmopressin nasal*
latanoprost
tamsulosin
alfuzosin
Dexilant (formerly Kapidex) Nexium *lansoprazole 30mg*
sumatriptan (any dosage form)
naratriptan
rizatriptan
naproxen 500mg Naprelan 500mg *sumatriptan tablet*
Gelnique 10% gel Gelnique 3% gel
tolterodine
Enablex

Gelnique 10% gel
oxybutynin
Vesicare
tolterodine

We offer adherence programs to reduce overall costs, improve medication adherence and close gaps in care. We are committed to you and your members on the issue of adherence. We will work diligently with you to explore the complexities surrounding each to improve the experience of your members, helping them achieve optimal health and ultimate savings to you and their plan.

We have described the programs we currently offer under the headers below. Unless otherwise noted, our adherence programs are available to you, your employees and their families at no additional cost.

Adherence to Drug Therapy

We engage members through targeted education and reminder communications. This solution monitors over 34 different drug classes used to treat nine conditions. We identify members using one of these drugs, when they fill a prescription. We will then engage the member in the following ways:

- *Adherence Education Letter* – Approximately 10 days after the first fill
- *Refill Reminder Message* – Approximately 14 days before the next refill
- *Missed Refill Communication* – Approximately 10 days after a missed refill

Pharmacy Advisor Counseling

We proactively alert mail-order pharmacists to counsel members regarding diabetes and cardiovascular conditions. So that the pharmacist is aware of the member's condition, our claims system pulls all relevant member information and medication history. The mail-order pharmacist can see if there are any applicable gaps in care or refill-related issues, and address those with the member.

MedQuery

We differentiate ourselves from many competitors through an integrated solution that analyzes more than just active prescriptions. A PBM standard is to provide drug-interaction alerts that result from analyzing a member's active prescriptions. While we too can offer this service, our MedQuery program surpasses this ability. Our approach is different because we will analyze and integrate the full range of the member data, including:

- Medical data
- Pharmacy data
- Laboratory data

We use this integrated data to identify opportunities for improved care and deliver member specific, evidence-based treatment guidelines to physicians. Additional data elements include 24 months of historical medical and pharmacy claims, member eligibility (demographics) and lab data.

The MedQuery program applies more than 1,100 clinical algorithms to match the integrated data to current evidence-based medical research and, if an opportunity for improved care is identified, a communication is generated on member-specific treatment guidelines and faxed to their physicians' office. Because we have the medical, pharmacy and lab data available in real-time, we know right away that the member's health may be in jeopardy and will call the physician within hours, versus weeks

Specialty pharmacy adherence support

Our specialty care management nurses receive monthly adherence reports for members taking specialty drugs. They review these reports to identify abnormal or non-adherent filling practices. They call non-adherent members to perform an assessment and encourage them to continue their prescribed medication regiment and assist the member with any support they may need.

Chronic Medication List Report

Our Chronic Medication List Report is an online report that allows the physician to see how we scored them on a variety of factors including drug-to-drug interactions. The physician can see which specific members had drug-to-drug interactions. With this information, the physician can intervene and discontinue one of the interacting medications, or change it to a different drug. This ensures that the member does not continue taking drugs that can have a negative impact on their health.

Aetna Healthy Actions – Rx Savings℠

We also offer an incentive program, Aetna Healthy Actions Rx Savings, to encourage members living with chronic conditions to stay compliant with drug therapy. The conditions/drug classes include diabetes, asthma, heart failure, hyperlipidemia and hypertension. Members receive reduced copays for generic and preferred brand drugs when taking drugs within the specific therapeutic classes. Aetna Healthy Actions Rx Savings is available for an additional fee.

Aetna RX Healthy Outcomes

Our new Aetna RX Healthy Outcomes value-based program not only waives medication copays, but also identifies and engages members shortly after certain

cardiovascular events. Aetna RX Healthy Outcomes also includes pharmacist outreach and support which is enormously valuable in supporting members after a difficult medical experience. We highly recommend this innovative program for the State as it drives meaningful improvements in adherence, cost and outcomes for post-heart attack patients.

2012 Preventive Medications List

Aetna

TIER ONE Preferred generic medications	TIER TWO Preferred brand-name medications	TIER THREE Non-preferred medications
ACE INHIBITORS (hypertension, diabetes)		
amlodipine/benazepril		ACCUPRIL
benazepril		ACCURETIC
benazepril/hctz		ACEON
captopril		ALTACE
captopril/hctz		LOTENSIN
enalapril		LOTENSIN HCT
enalapril/hctz		LOTREL
fosinopril		MAVIK
fosinopril/hctz		PRINIVIL
lisinopril		PRINZIDE
lisinopril/hctz		TARKA
moexipril		UNIRETIC
moexipril/hctz		UNIVASC
perindopril		VASERETIC
quinapril		VASOTEC
quinapril/hctz		ZESTORETIC
ramipril		ZESTRIL
trandolapril		
ANGIOTENSIN II RECEPTOR ANTAGONISTS (hypertension)		
losartan	DIOVAN	ATACAND
losartan/hctz	DIOVAN HCT	ATACAND HCT
	EXFORGE	AVALIDE
	EXFORGE HCT	AVAPRO
	VALTURNA	AZOR
		BENICAR
		BENICAR HCT
		COZAAR
		EDARBI
		HYZAAR
		MICARDIS
		MICARDIS HCT
		TEVETEN
		TEVETEN HCT
		TRIBENZOR
		TWYNSTA
ANTIADRENERGIC ANTIHYPERTENSIVES (hypertension)		
clonidine		CARDURA
doxazosin		CATAPRES
guanabenz		CATAPRES-TTS
guanfacine		CLORPRES
methyldopa		MINIPRESS
methyldopa/hctz		NEXICLON
prazosin		TENEX
reserpine		
terazosin		
MISCELLANEOUS ANTIHYPERTENSIVES (hypertension)		
hydralazine	DIBENZYLINE	DEMSER
hydralazine/hctz		
minoxidil		

TIER ONE Preferred generic medications	TIER TWO Preferred brand-name medications	TIER THREE Non-preferred medications
ANTIHYPERLIPIDEMICS (high cholesterol)		
cholestyramine	ANTARA	ADVICOR
cholestyramine light	CRESTOR	ALTOPREV
colestipol	LESCOL	CADUET
fenofibrate	LESCOL XL	COLESTID
fenofibrate micronized	LOVAZA	FENOGLIDE
fenofibric acid	NIASPAN	FIBRICOR
gemfibrozil	SIMCOR	LIPITOR
lovastatin	TRILIPIX	LIPOFEN
pravastatin	VYTORIN	LIVALO
prevalite	WELCHOL	LOFIBRA
simvastatin	ZETIA	LOPID
		MEVACOR
		PRAVACHOL
		QUESTRAN
		QUESTRAN LITE
		TRICOR
		TRIGLIDE
		ZOCOR
BETA-BLOCKERS (hypertension)		
acebutolol	BYSTOLIC	BETAPACE
atenolol	COREG CR	BETAPACE AF
atenolol/chlorthalidone		COREG
betaxolol		CORGARD
bisoprolol		CORZIDE
bisoprolol/hctz		INDERAL LA
carvedilol		INNOPRAN XL
labetalol		KERLONE
metoprolol		LEVATOL
metoprolol/hctz		LOPRESSOR
nadolol		LOPRESSOR HCT
nadolol/bendroflumethazine		*metoprolol SR*
pindolol		SECTRAL
propranolol		TENORETIC
propranolol SR		TENORMIN
propranolol/hctz		TOPROL XL
sorin		TRANDATE
sotalol, sotalol AF		ZEBETA
timolol		ZIAC
BLOOD THINNING AGENTS (stroke prevention)		
anagrelinde	AGGRENOX	AGRYLIN
cilostazol	PLAVIX	ARIXTRA
dipyridamole	PRADAXA	BRILINTA
enoxaparin		COUMADIN
jantoven		EFFIENT
ticlopidine		FRAGMIN
warfarin		INNOHEP
		IPRIVASK
		LOVENOX
		PERSANTINE
		PLETAL
		XARELTO

TIER ONE Preferred generic medications	TIER TWO Preferred brand-name medications	TIER THREE Non-preferred medications
CALCIUM CHANNEL BLOCKERS (heart disease, hypertension)		
afeditab		ADALAT CC
amlodipine		CADUET
amlodipine/benazepril		CALAN
cartia XT		CALAN SR
dilt-CD		CARDENE
dilt-XR		CARDENE SR
diltiazem		CARDIZEM
diltiazem CD		CARDIZEM CD
diltiazem ER		CARDIZEM LA
diltiazem SR		COVERA-HS
felodipine		DILACOR XR
isradapine		DYNACIRC CR
matzim LA		ISOPTIN SR
nicardapine		LOTREL
nifediac CC		NIMOTOP
nifedical XL		NORVASC
nifedipine		PROCARDIA
nifedipine CR		PROCARDIA XL
nifedipine ER		SULAR
nifedipine SR		TARKA
nimodipine		TIAZAC
nisoldipine		VERELAN
taztia XT		VERELAN PM
verapamil		VERELAN SR
verapamil ER		
verapamil SR		
DIRECT RENIN INHIBITOR (hypertension)		
	AMTURNIDE	TEKAMLO
	TEKTURNA	
	TEKTURNA HCT	
DIURETICS (hypertension)		
acetazolamide		ALDACTAZIDE
amiloride		ALDACTONE
amiloride/hctz		DEMADEX
bumetanide		DIAMOX
chlorothiazide		DIURIL
chlorthalidone		DYAZIDE
eplerenone		DYRENIUM
furosemide		EDECRIN
hydrochlorothiazide		INSPRA
indapamide		INTROL
methazolamide		LASIX
methyclothiazide		MAXZIDE
metolazone		MICROZIDE
spironolactone		MIDAMOR
spironolactone/hctz		THALITONE
torsemide		ZAROXOLYN
triamterine/hctz		

Please remember that this is not a complete list of medications covered under your plan. Because there are thousands of medications included in your pharmacy benefit, we only list the most common ones. Certain drugs such as those for smoking cessation or vitamins may not be covered by your particular pharmacy plan. Diabetic supplies may be covered under your medical plan. If you have any questions about your pharmacy benefit, please visit Aetna's secure website at www.aetna.com. If you don't have access to our website, call the Member Services number on your ID card.

2012 Preventive Medications List

Aetna

TIER ONE Preferred generic medications	TIER TWO Preferred brand-name medications	TIER THREE Non-preferred medications
ANTIDIABETIC DRUGS (diabetes)		
acarbose	ACTOPLUS MET	ACTOPLUS MET XR
chlorpropamide	ACTOS	AMARYL
glimepiride	BYETTA	APIDRA
glipizide	CYCLOSET	AVANDAMET
glipizide ER	DUETACT	AVANDARYL
glipizide XL	HUMALOG products	AVANDIA
glipizide/metformin	HUMULIN products	DIABETA
glucose tab	JANUMET	FORTAMET
glyburide	JANUVIA	GLUCAGEN
glyburide micronized	KOMBIGLYZE	GLUCAGON
glyburide/metformin	LANTUS	GLUCOPHAGE
metformin	LANTUS SOLOSTAR	GLUCOPHAGE XR
metformin ER	LEVEMIR	GLUCOTROL
nateglinide	LEVEMIR FLEXPEN	GLUCOTROL XL
tolazamide	NOVOLOG products	GLUCOVANCE
tolbutamide	ONGLYZA	GLUMETZA
	PRANDIN	GLYCRON
	PROGLYCEM	GLYNASE
	SYMLIN	GLYSET
	SYMLINPEN	METAGLIP
	VICTOZA	NOVOLIN products
		PRANDIMET
		PRECOSE
		RELION products
		RIOMET
		STARLIX
		TRADJENTA
DIABETIC SUPPLIES (diabetes)		
insulin syringes (any generic)	BD insulin syringes	glucose test strips (all other brands)
	BD lancets	
lancets (any generic)	BD pen needles	insulin syringes (all other brands)
	FREESTYLE glucose test strips	
pen needles (any generic)	FREESTYLE LITE glucose test strips	lancets (all other brands)
	ONE TOUCH FAST TAKE glucose test strips	pen needles (all other brands)
	ONE TOUCH ULTRA glucose test strips	
	PRECISION Q-I-D glucose test strips	
	PRECISION SOF-TACT glucose test strips	
	PRECISION XTRA glucose test strips	
	PRECISION XTRA ketone test strips	
	SURESTEP glucose test strips	

TIER ONE Preferred generic medications	TIER TWO Preferred brand-name medications	TIER THREE Non-preferred medications
ANTIASTHMATICS (asthma)		
albuterol	ADVAIR DISKUS	ACCOLATE
albuterol/ipratropium	ADVAIR HFA	ACCUNEB
aminophylline	ASMANEX	ADRENALIN
budesonide inhalation suspension	DULERA	ALVESCO
	FLOVENT DISKUS	ATROVENT HFA
copd	FLOVENT HFA	BRONCOMAR-1
cromolyn	FORADIL	BRONDIL
dg 200	PERFOROMIST	BROVANA
difil-G (forte, 400 tab)	PROAIR HFA	COMBIVENT
dilex-G (200-200 tab)	PROVENTIL HFA	DILEX-G (200 syp, 400 tab)
dyflex-G	QVAR	DUONEB
ipratropium inhaler	SEREVENT DISKUS	DYLIX
terbutaline	SINGULAIR	ED-BRON G
theochron	SPIRIVA	ELIXOPHYLLIN
theophylline ER	SYMBICORT	LUFYLLIN
zafirlukast	XOLAIR	LUFYLLIN-GG
		MAXAIR AUTOHALER
		metaproterenol
		PULMICORT FLEXHALER
		PULMICORT RESPULES
		THEO-24
		VENTOLIN HFA
		VOSPIRE ER
		XOPENEX
		XOPENEX HFA
		ZYFLO
		ZYFLO CR
OSTEOPOROSIS DRUGS (osteoporosis)		
alendronate	ACTONEL	AREDIA
calcitonin	ATELVIA	BONIVA
etidronate	EVISTA	DIDRONEL
fortical	FORTEO	FORTEO
pamidronate		FOSAMAX
		FOSAMAX + D
		GANITE
		MIACALCIN
		PROLIA
		RECLAST
		SKELID
		XGEVA
		ZOMETA
PEDIATRIC VITAMINS with FLUORIDE		
chewable multivit/fluoride		
multiple vitamins/fluoride		
poly-vitamin/fluoride		
tri-vitamin/fluoride		
vitamins A/D/C/fluoride		
PRENATAL MULTIVITAMIN with IRON and FOLIC ACID		
vita-natal		MYNATAL

TIER ONE Preferred generic medications	TIER TWO Preferred brand-name medications	TIER THREE Non-preferred medications
SMOKING CESSATION MEDICATIONS (Tobacco Cessation)		
buproban		CHANTIX
buproban SR		NICOTROL INHALER
bupropion		NICOTROL NS
bupropion SR		ZYBAN

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The charges for RDS reporting is as follows:

Frequency [1]	Claim/Eligibility Reporting	Claim Reporting Only
Monthly	$11,000/year	$7,800/year
Quarterly	$6,700/year	$3,400/year
Annually	$5,200/year	$1,700/year

[1] Claim reporting frequency

The above Claim/Eligibility Reporting prices include an initial eligibility file and monthly eligibility files.

In addition to the reporting shown above, Aetna can submit cost reports and monthly retiree lists directly to CMS on State of Alaska's behalf

The annual fees for these services are as follows:

- $500 for direct cost report submission (claims and rebates)
- $500 for monthly retiree list submission (eligibility)

XYZ Company

Plan Sponsor ID 0000000000099999

Standard Report For Self Insured Pharmacy Products

Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Self Insured Pharmacy HMO

XYZ Company - Plan Sponsor ID 0000000000099999
Report Parameters
Self Insured Pharmacy HMO

Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Book of Business Data Incurred End Date March 31, 2007

Standard Report Template: Self Insured Pharmacy

Large Claimant Threshold: $50,000

Funding Arrangement and Product:	**Account Structure:**	**Network Service Area:**
Self Insured Pharmacy HMO	Plan Sponsor Level	All

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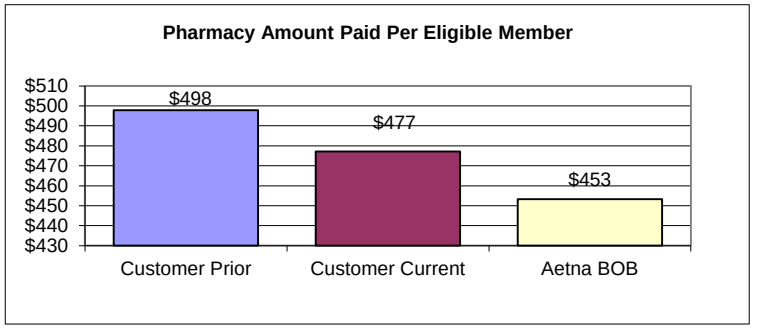
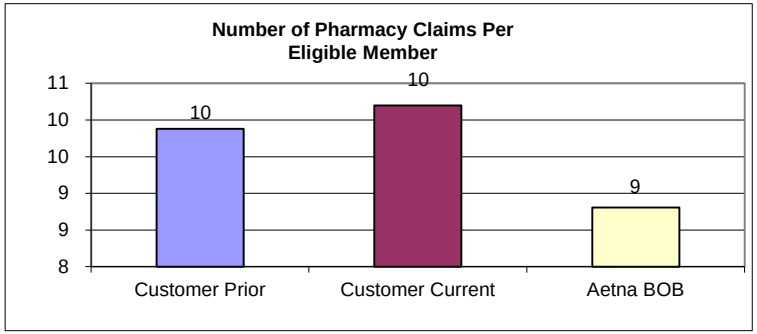
XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

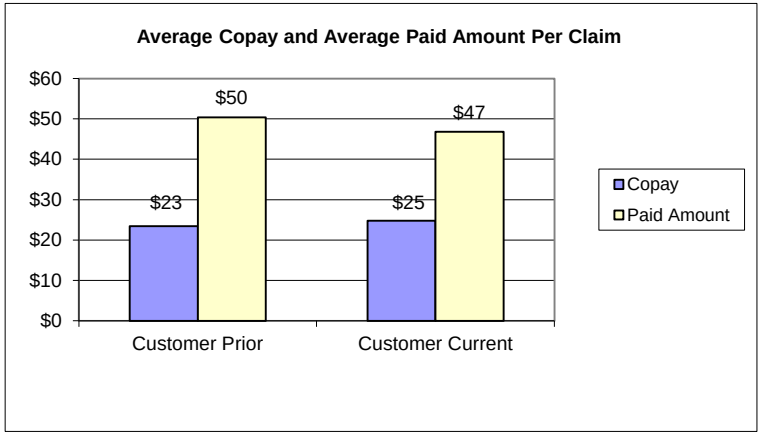
Key Statistics - Pharmacy

Demographics Summary	Customer Prior	Customer Current	% Change from Prior	Aetna BOB[1]
Number of Employees	7,940	7,639	-3.8%	N/A
Number of Members	21,383	20,478	-4.2%	N/A
Ratio of Members to Employees	2.7	2.7	-0.5%	1.9
Percent Male Members	49.8%	49.7%	-0.1%	48.7%
Percent Female Members	50.2%	50.3%	0.1%	51.3%
Average Age of Membership	32.1	32.6	1.6%	33.3
Number of Utilizing Members	17,441	16,767	-3.9%	N/A

Key Statistics				
Total Pharmacy Paid Amount	$10,645,909	$9,771,251	-8.2%	N/A
Pharmacy Paid Amount per Eligible Member	$498	$477	-4.2%	$453
Pharmacy Paid Amount per Utilizing Member	$610	$583	-4.5%	$518
Average Paid Amount per Claim	$50.40	$46.79	-7.2%	$51.47
Number of Pharmacy Claims	211,238	208,839	-1.1%	N/A
Number of Pharmacy Claims Per Eligible Member	9.9	10.2	3.2%	8.8
Number of Pharmacy Claims Per Utilizing Member	12.1	12.5	2.8%	N/A
Calculated Ingredient Cost	$15,268,383	$14,619,509	-4.2%	N/A
Total Copay Amount	$4,954,650	$5,178,050	4.5%	N/A
Average Copay Amount per Claim	$23.46	$24.79	5.7%	N/A
Generic Utilization	47.9%	53.8%	6.0%	58.0%
Generic Substitution	91.5%	93.9%	2.4%	95.3%
Brand Utilization	52.1%	46.2%	-6.0%	42.0%
Formulary Utilization	75.6%	76.8%	1.2%	79.8%





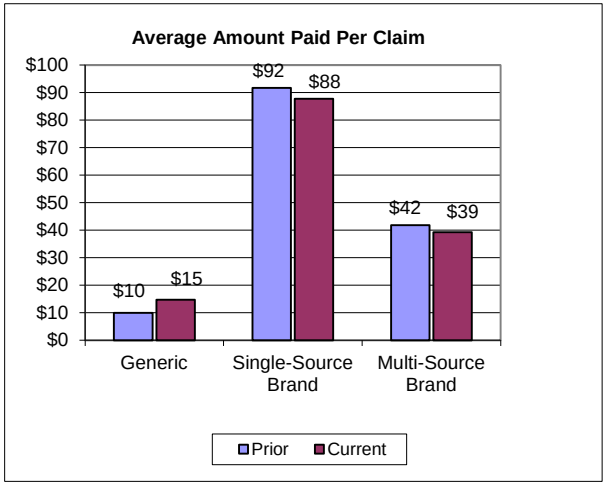


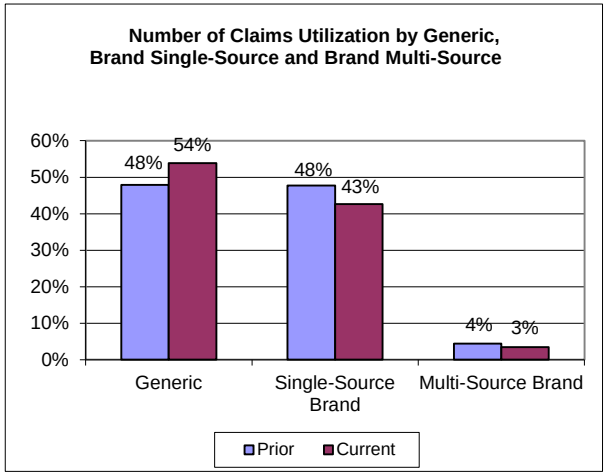
[1]Aetna BOB demographic metrics are specific to the product and to the plan sponsor's region(s). Aetna BOB financial and utilization metrics are further adjusted for the plan sponsor's age and gender mix. All BOB metrics are based on a 12 month incurred time period.

XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Key Statistics by Generic, Brand Single-Source & Brand Multi-Source

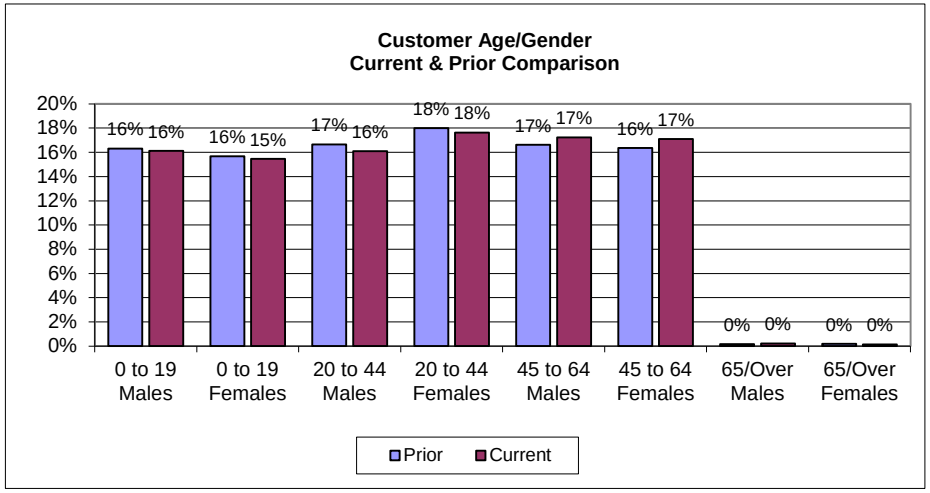
Generic	Customer Prior	Customer Current	% Change from Prior	Aetna BOB
Generic Pharmacy Paid Amount	$1,011,934	$1,662,368	64.3%	N/A
Generic Pharmacy Paid Amount per Eligible Member	$47	$81	71.5%	$72
Generic Pharmacy Paid Amount per Utilizing Member	$58	$99	70.9%	$82
Average Paid Amount Per Claim	$10.01	$14.79	47.7%	$14.05
Number of Generic Pharmacy Claims Per Eligible Member	4.7	5.5	16.1%	5.1
Calculated Ingredient Cost	$2,386,232	$3,159,800	32.4%	N/A
Total Copay Amount	$1,549,526	$1,689,735	9.0%	N/A
Generic Utilization	47.9%	53.8%	6.0%	58.0%
Brand Single-Source				
Brand Single-Source Pharmacy Paid Amount	$9,242,125	$7,822,744	-15.4%	N/A
Brand Single-Source Pharmacy Paid Amount per Eligible Member	$432	$382	-11.6%	$367
Brand Single-Source Pharmacy Paid Amount per Utilizing Member	$530	$467	-12.0%	$419
Average Paid Amount Per Claim	$91.71	$87.78	-4.3%	$106.40
Number of Brand Single-Source Pharmacy Claims Per Eligible Member	4.7	4.4	-7.7%	3.4
Calculated Ingredient Cost	$12,272,446	$11,034,594	-10.1%	N/A
Total Copay Amount	$3,173,395	$3,338,688	5.2%	N/A
Brand Single-Source Utilization	47.7%	42.7%	-5.0%	39.1%
Brand Multi-Source				
Brand Multi-Source Pharmacy Paid Amount	$391,851	$286,139	-27.0%	N/A
Brand Multi-Source Pharmacy Paid Amount per Eligible Member	$18	$14	-23.8%	$15
Brand Multi-Source Pharmacy Paid Amount per Utilizing Member	$22	$17	-24.0%	$17
Average Paid Amount Per Claim	$41.86	$39.23	-6.3%	$58.64
Number of Brand Multi-Source Pharmacy Claims Per Eligible Member	0.4	0.4	-18.6%	0.3
Calculated Ingredient Cost	$609,705	$425,115	-30.3%	N/A
Total Copay Amount	$231,729	$149,628	-35.4%	N/A
Brand Multi-Source Utilization	4.4%	3.5%	-0.9%	2.9%

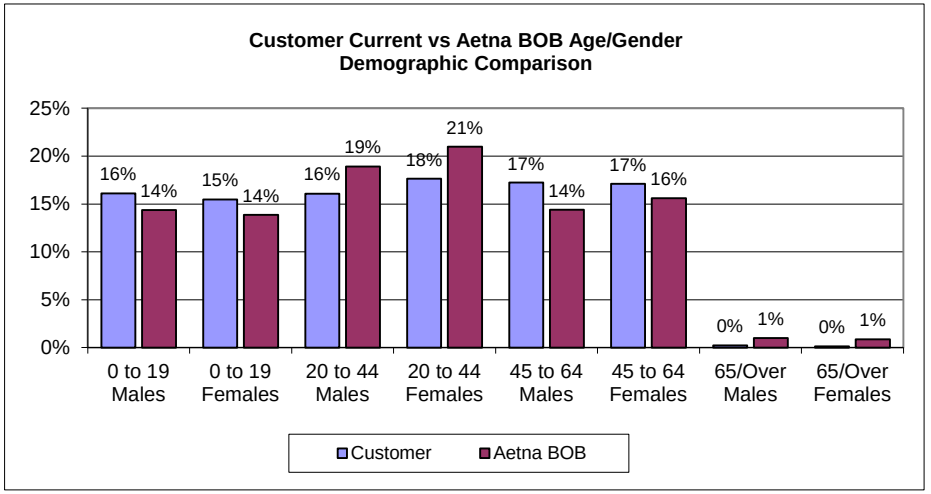


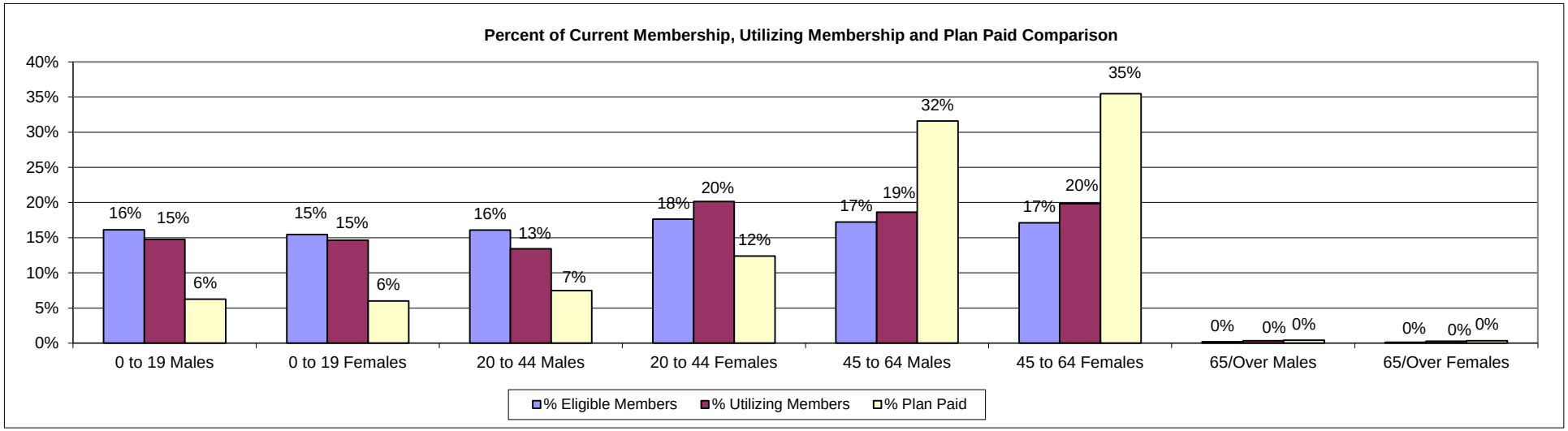


XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Demographics For Pharmacy Membership



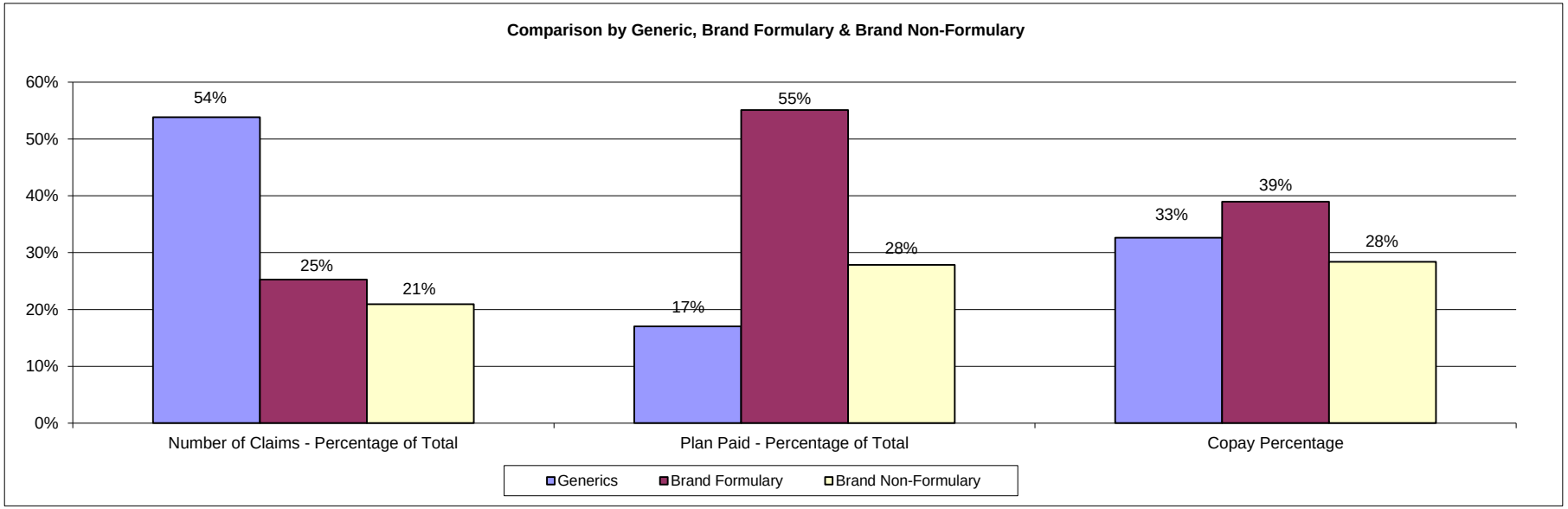




XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007

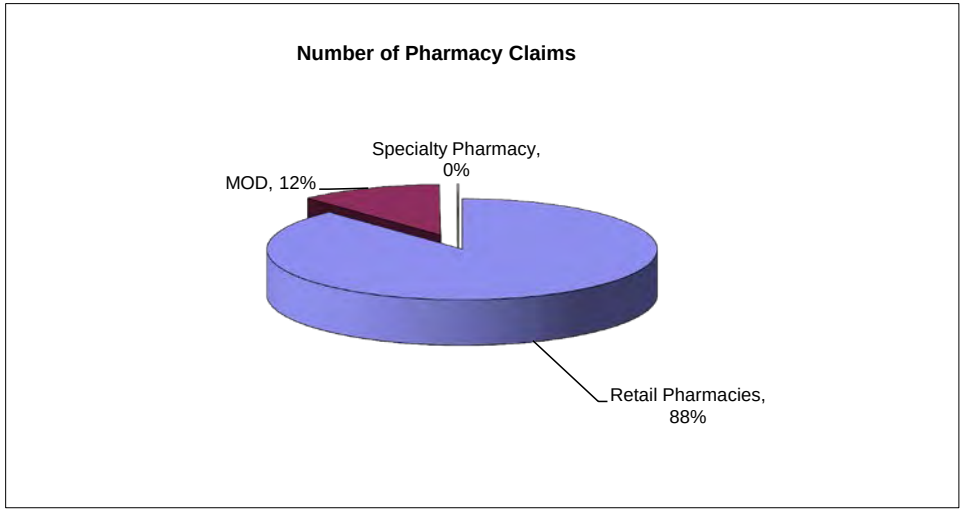
Formulary Analysis

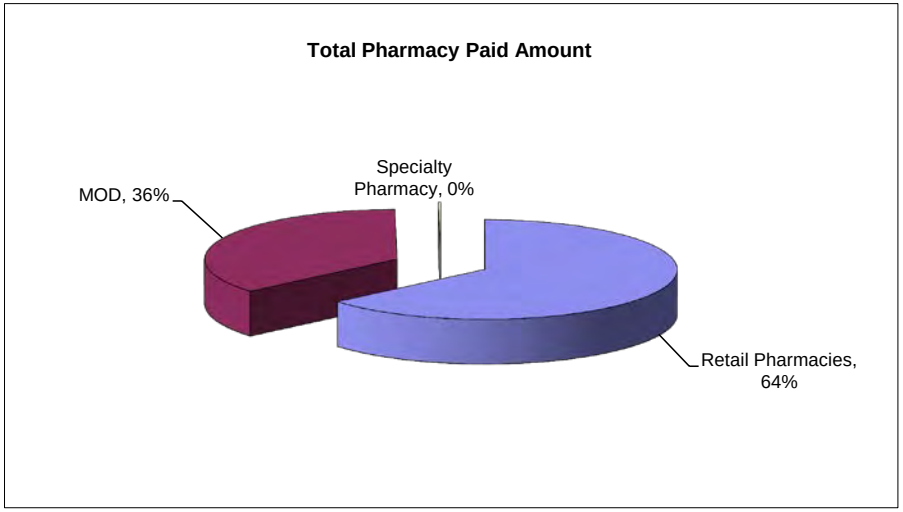
		Retail Pharmacies	Mail Order Drug Pharmacy	Specialty Pharmacy	Total
Generics	Number of Claims	101,661	10,569	200	112,430
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$2,535,193	$805,853	$11,058	$3,352,103
	- Total Copay Amount	$1,422,588	$264,298	$2,849	$1,689,735
	= Plan Paid	$1,112,605	$541,555	$8,208	$1,662,368
Brand Formulary	Number of Claims	43,940	8,761	24	52,725
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$4,647,888	$2,747,351	$10,761	$7,406,000
	- Total Copay Amount	$1,327,079	$690,446	$1,407	$2,018,933
	= Plan Paid	$3,320,810	$2,056,905	$9,353	$5,387,068
Brand Non-Formulary	Number of Claims	38,315	5,358	11	43,684
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$2,873,537	$1,314,571	$3,090	$4,191,197
	- Total Copay Amount	$1,074,066	$394,592	$724	$1,469,383
	= Plan Paid	$1,799,471	$919,979	$2,365	$2,721,815
Total	Number of Claims	183,916	24,688	235	208,839
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$10,056,618	$4,867,775	$24,908	$14,949,301
	- Total Copay Amount	$3,823,733	$1,349,336	$4,981	$5,178,050
	= Plan Paid	$6,232,885	$3,518,438	$19,927	$9,771,251



XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Retail Versus Mail Order Versus Specialty Analysis

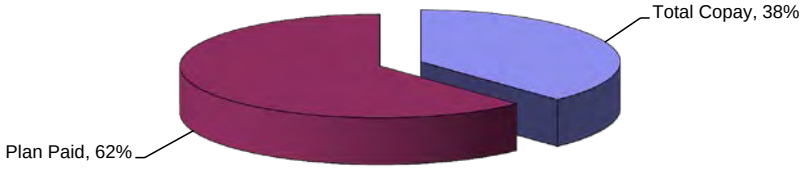




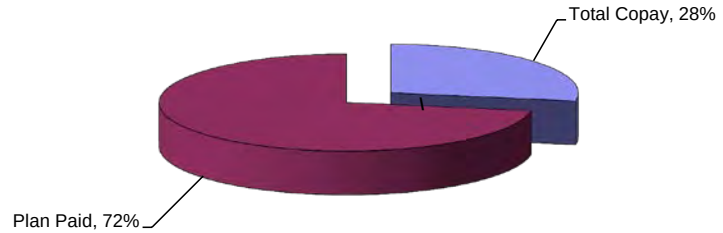
XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Retail Versus Mail Order Versus Specialty Analysis

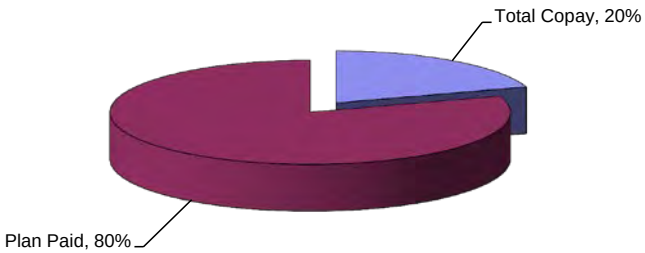
Retail Pharmacies
Employer/Employee Cost Sharing Comparison



Mail Order Drug
Employer/Employee Cost Sharing Comparison



Specialty Pharmacy
Employer/Employee Cost Sharing Comparison



XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Network Analysis and Savings

		Retail Pharmacies			Mail Order Drug Pharmacy		
Generics (MAC)		**Prior**	**Current**	**% Change**	**Prior**	**Current**	**% Change**
Number of Claims		21,923	32,484	48.2%	0	0	N/A
	Average Wholesale Price (AWP)	$1,739,158	$2,771,846	59.4%	$0	$0	N/A
-	Calculated Ingredient Cost	$777,383	$1,223,646	57.4%	$0	$0	N/A
=	AWP Savings	$961,775	$1,548,200	61.0%	$0	$0	N/A
	Percent Savings[1]	55.3%	55.9%	1.0%	N/A	N/A	N/A
	Calculated Ingredient Cost	$777,383	$1,223,646	57.4%	$0	$0	N/A
+	Dispensing Fee	$42,997	$64,221	49.4%	$0	$0	N/A
+	Sales Tax	$38	$44	15.9%	$0	$0	N/A
-	Copay	$335,381	$480,443	43.3%	$0	$0	N/A
=	Paid Amount[2]	$485,037	$807,468	66.5%	$0	$0	N/A
Generics (Non-MAC)							
Number of Claims		6,488	7,086	9.2%	4,997	6,887	37.8%
	Average Wholesale Price (AWP)	$376,201	$416,783	10.8%	$984,631	$1,662,717	68.9%
-	Calculated Ingredient Cost	$295,673	$330,976	11.9%	$367,887	$751,930	104.4%
=	AWP Savings	$80,528	$85,807	6.6%	$616,744	$910,788	47.7%
	Percent Savings[1]	21.4%	20.6%	-3.8%	62.6%	54.8%	-12.5%
	Calculated Ingredient Cost	$295,673	$330,976	11.9%	$367,887	$751,930	104.4%
+	Dispensing Fee	$12,282	$13,526	10.1%	$0	$0	N/A
+	Sales Tax	$2	$28	1204.7%	$0	$0	N/A
-	Copay	$99,375	$104,791	5.5%	$153,496	$211,409	37.7%
=	Paid Amount[2]	$208,582	$239,739	14.9%	$214,392	$540,520	152.1%
Brand							
Number of Claims		86,445	80,928	-6.4%	15,599	14,119	-9.5%
	Average Wholesale Price (AWP)	$9,771,480	$8,690,470	-11.1%	$5,408,163	$5,077,411	-6.1%
-	Calculated Ingredient Cost	$8,191,677	$7,284,045	-11.1%	$4,326,521	$4,061,922	-6.1%
=	AWP Savings	$1,579,803	$1,406,425	-11.0%	$1,081,642	$1,015,489	-6.1%
	Percent Savings[1]	16.2%	16.2%	0.1%	20.0%	20.0%	0.0%
	Calculated Ingredient Cost	$8,191,677	$7,284,045	-11.1%	$4,326,521	$4,061,922	-6.1%
+	Dispensing Fee	$146,431	$136,685	-6.7%	$0	$0	N/A
+	Sales Tax	$259	$202	-21.8%	$0	$0	N/A
-	Copay	$2,281,842	$2,366,513	3.7%	$893,261	$1,085,039	21.5%
=	Paid Amount[2]	$6,056,525	$5,054,419	-16.5%	$3,433,260	$2,976,883	-13.3%

[1] AWP Savings / Average Wholesale Price (AWP) = Percent Savings

[2] Calculated Ingredient Cost + Dispensing Fee + Sales Tax - Copay = Paid Amount

XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Network Analysis and Savings

	Specialty Pharmacy			Total		
Generics (MAC)	**Prior**	**Current**	**% Change**	**Prior**	**Current**	**% Change**
Number of Claims	21	14	-33.3%	$21,944	$32,498	48.1%
Average Wholesale Price (AWP)	$26,848	$8,720	-67.5%	$1,766,006	$2,780,566	57.4%
- Calculated Ingredient Cost	$12,960	$4,229	-67.4%	$790,343	$1,227,875	55.4%
= AWP Savings	$13,887	$4,491	-67.7%	$975,662	$1,552,691	59.1%
Percent Savings[1]	51.7%	51.5%	-0.4%	55.2%	55.8%	1.1%
Calculated Ingredient Cost	$12,960	$4,229	-67.4%	$790,343	$1,227,875	55.4%
+ Dispensing Fee	$37	$25	-33.3%	$43,033	$64,246	49.3%
+ Sales Tax	$0	$0	N/A	$38	$44	15.9%
- Copay	$460	$210	-54.3%	$335,841	$480,653	43.1%
= Paid Amount[2]	$12,537	$4,044	-67.7%	$497,574	$811,511	63.1%
Generics (Non-MAC)						
Number of Claims	31	7	-77.4%	11,516	13,980	21.4%
Average Wholesale Price (AWP)	$23,491	$461	-98.0%	$1,384,322	$2,079,962	50.3%
- Calculated Ingredient Cost	$19,249	$385	-98.0%	$682,809	$1,083,291	58.7%
= AWP Savings	$4,241	$76	-98.2%	$701,513	$996,671	42.1%
Percent Savings[1]	18.1%	16.5%	-8.6%	50.7%	47.9%	-5.4%
Calculated Ingredient Cost	$19,249	$385	-98.0%	$682,809	$1,083,291	58.7%
+ Dispensing Fee	$0	$7	N/A	$12,282	$13,533	10.2%
+ Sales Tax	$0	$0	N/A	$2	$28	1204.7%
- Copay	$535	$60	-88.8%	$253,405	$316,261	24.8%
= Paid Amount[2]	$18,714	$332	-98.2%	$441,688	$780,591	76.7%
Brand						
Number of Claims	27	33	22.2%	$102,071	$95,080	-6.8%
Average Wholesale Price (AWP)	$37,084	$16,420	-55.7%	$15,216,728	$13,784,301	-9.4%
- Calculated Ingredient Cost	$30,966	$13,516	-56.4%	$12,549,164	$11,359,483	-9.5%
= AWP Savings	$6,118	$2,904	-52.5%	$2,667,563	$2,424,818	-9.1%
Percent Savings[1]	16.5%	17.7%	7.2%	17.5%	17.6%	0.3%
Calculated Ingredient Cost	$30,966	$13,516	-56.4%	$12,549,164	$11,359,483	-9.5%
+ Dispensing Fee	$16	$11	-33.3%	$146,447	$136,696	-6.7%
+ Sales Tax	$0	$0	N/A	$259	$202	-21.8%
- Copay	$1,194	$2,035	70.4%	$3,176,297	$3,453,587	8.7%
= Paid Amount[2]	$29,788	$11,492	-61.4%	$9,519,573	$8,042,794	-15.5%

[1] AWP Savings / Average Wholesale Price (AWP) = Percent Savings

[2] Calculated Ingredient Cost + Dispensing Fee + Sales Tax - Copay = Paid Amount

XYZ Company - Plan Sponsor ID 0000000000099999

Self Insured Pharmacy HMO

Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Top 30 Drugs by Total Paid Amount

Drug Label	Number of Utilizing Members	Number of Claims	Calculated Ingredient Cost	Total Amount Paid	Average Paid Amount per Claim	Pharmacy Paid Amount per Utilizing Member	Average Days Supply
PREVACID	647	2,724	$530,199	$382,713	$140.50	$592	41.6
SIMVASTATIN	988	3,975	$398,381	$330,688	$83.19	$335	44.6
VYTORIN	626	3,028	$346,520	$246,187	$81.30	$393	42.3
SINGULAIR	740	2,465	$274,378	$195,608	$79.35	$264	36.8
ZOCOR	723	1,256	$241,990	$170,544	$135.78	$236	45.0
ACTOS	191	993	$218,092	$159,165	$160.29	$833	43.6
NEXIUM	291	1,053	$205,763	$140,113	$133.06	$481	42.0
ADVAIR DISKU	391	972	$186,440	$134,882	$138.77	$345	36.6
EFFEXOR XR	208	1,125	$181,941	$134,754	$119.78	$648	39.5
ACIPHEX	287	1,018	$188,910	$134,517	$132.14	$469	40.6
TRICOR	273	1,449	$183,635	$130,544	$90.09	$478	42.7
IMITREX	153	509	$152,140	$124,339	$244.28	$813	32.7
LOTREL	243	1,471	$165,322	$117,702	$80.02	$484	38.9
LIPITOR	283	1,272	$184,245	$112,335	$88.31	$397	48.0
WELLBUTRIN	205	848	$152,526	$110,591	$130.41	$539	40.2
DIOVAN HCT	289	1,625	$149,102	$105,924	$65.18	$367	42.4
AVANDIA	134	663	$140,577	$103,138	$155.56	$770	46.1
VALTREX	345	741	$134,487	$98,458	$132.87	$285	23.1
ADDERALL XR	230	970	$136,877	$98,322	$101.36	$427	36.0
AMBIEN	464	1,389	$158,686	$97,963	$70.53	$211	31.4
NASONEX	787	1,535	$126,974	$90,675	$59.07	$115	32.6
TOPAMAX	103	394	$119,789	$90,121	$228.73	$875	44.3
LEVAQUIN	1,106	1,398	$142,323	$87,554	$62.63	$79	8.5
DIOVAN	271	1,466	$118,096	$84,804	$57.85	$313	41.4
LEXAPRO	299	1,439	$136,098	$84,649	$58.82	$283	37.8
NORVASC	333	1,791	$135,448	$83,261	$46.49	$250	41.9
OMNICEF	1,005	1,294	$113,945	$81,352	$62.87	$81	10.0
LAMICTAL	85	416	$105,975	$80,473	$193.44	$947	38.2
ZYRTEC	555	1,862	$129,961	$80,396	$43.18	$145	36.1
CYMBALTA	164	707	$117,613	$80,204	$113.44	$489	39.1
Top 30 Drugs Total	N/A	41,848	$5,576,432.95	$3,971,976.84	$94.91	N/A	38.1
Total All Claims	**16,767**	**208,839**	**$14,619,508.66**	**$9,771,250.59**	**$46.79**	**$582.77**	**31.0**

XYZ Company - Plan Sponsor ID 0000000000099999

Self Insured Pharmacy HMO

Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Top 30 Drugs by Number of Claims

Drug Label	Number of Utilizing Members	Number of Claims	Calculated Ingredient Cost	Total Amount Paid	Average Paid Amount per Claim	Pharmacy Paid Amount per Utilizing Member	Average Days Supply
HYDROCO/APAP	2,540	5,452	$88,220	$22,489	$4.12	$9	9.7
SIMVASTATIN	988	3,975	$398,381	$330,688	$83.19	$335	44.6
AMOXICILLIN	2,878	3,768	$43,739	$874	$0.23	$0	8.8
AZITHROMYCIN	2,740	3,426	$86,013	$41,400	$12.08	$15	5.1
VYTORIN	626	3,028	$346,520	$246,187	$81.30	$393	42.3
LEVOTHYROXIN	586	2,991	$34,409	$305	$0.10	$1	45.0
LISINOPRIL	527	2,843	$51,894	$6,869	$2.42	$13	42.2
PREVACID	647	2,724	$530,199	$382,713	$140.50	$592	41.6
METFORMIN	527	2,576	$63,573	$23,780	$9.23	$45	41.1
SINGULAIR	740	2,465	$274,378	$195,608	$79.35	$264	36.8
TOPROL XL	427	2,251	$95,237	$59,262	$26.33	$139	41.0
HYDROCHLOROT	415	2,034	$17,806	$127	$0.06	$0	40.5
SYNTHROID	307	2,027	$36,032	$23,359	$11.52	$76	37.9
AMOX/K CLAV	1,542	1,915	$62,069	$37,053	$19.35	$24	10.1
ATENOLOL	316	1,894	$25,220	$1,369	$0.72	$4	41.1
ZYRTEC	555	1,862	$129,961	$80,396	$43.18	$145	36.1
NORVASC	333	1,791	$135,448	$83,261	$46.49	$250	41.9
FLUTICASONE	889	1,746	$95,168	$69,229	$39.65	$78	34.6
ALPRAZOLAM	484	1,680	$30,502	$10,421	$6.20	$22	25.5
ALBUTEROL	978	1,629	$26,079	$4,300	$2.64	$4	22.6
DIOVAN HCT	289	1,625	$149,102	$105,924	$65.18	$367	42.4
NASONEX	787	1,535	$126,974	$90,675	$59.07	$115	32.6
LOTREL	243	1,471	$165,322	$117,702	$80.02	$484	38.9
DIOVAN	271	1,466	$118,096	$84,804	$57.85	$313	41.4
TRICOR	273	1,449	$183,635	$130,544	$90.09	$478	42.7
FLUOXETINE	278	1,445	$43,653	$23,427	$16.21	$84	34.6
LEXAPRO	299	1,439	$136,098	$84,649	$58.82	$283	37.8
LEVAQUIN	1,106	1,398	$142,323	$87,554	$62.63	$79	8.5
AMBIEN	464	1,389	$158,686	$97,963	$70.53	$211	31.4
YASMIN 28	226	1,373	$63,869	$39,622	$28.86	$175	30.8
Top 30 Drugs Total	N/A	66,667	$3,858,605.57	$2,482,553.33	$37.24	N/A	31.6
Total All Claims	**16,767**	**208,839**	**$14,619,508.66**	**$9,771,250.59**	**$46.79**	**$582.77**	**31.0**

Drug Name	Common Use(s)
Accutane *(isotretinoin)*	Acne
Advair Discus	Asthma
albuterol	Asthma
Ambien	Sedative/hypnotic
amoxicillin	Bacterial infection
Augmentin *(amoxicillin/potassium clavulanate)*	Bacterial infection
Avonex; also, Copaxone	Multiple Sclerosis
Celebrex; also, Vioxx	Pain, inflammation, arthritis
cephalexin	Bacterial infection
Cipro,Levaquin	Bacterial infection
Combivir	HIV infection
Effexor	Depression
Enbrel	Rheumatoid arthritis
Epogen, Procrit	Red blood cell defiency
Flonase, Nasonex	Allergy
Fosamax	Osteoporosis
Glucophage/xr	Diabetes
Humatrope, Serostim, Protropin	Growth hormone; AIDS wasting

Drug Name	Common Use(s)
hydrochlorothiazide	High blood pressure
hydrocodone/apap	Pain
Imitrex	Migraine
Lamisil	Fungal infection
Neurontin	Seizures and pain
Norvasc	High blood pressure; heart problems
Ortho-Tri-Cyclen,Ortho-Cyclen	Contraception
Oxycontin	Pain
Paxil, Zoloft, Celexa, *fluoxetine*	Depression
Premarin	Estrogen replacement
Prempro	Estrogen replacement
Prevacid, Prilosec, Aciphex, Nexium	Gastrointestinal disorders
Rebetol	Hepatitis C
Singulair	Asthma
tamoxifen , Xeloda	Breast cancer
Toprol XL	High blood pressure; heart problems
Valtrex	Herpes infection, shigles
Wellbutrin	Depression
Zithromax	Bacterial infection
Zocor, Lipitor, Pravachol	Elevate Cholesterol
Zyrtec, Allegra, Clarinex	Allergy

XYZ Company

Plan Sponsor ID 0000000000099999

Standard Report For Self Insured Pharmacy Products

Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Self Insured Pharmacy HMO

XYZ Company - Plan Sponsor ID 0000000000099999
Report Parameters
Self Insured Pharmacy HMO

Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Book of Business Data Incurred End Date March 31, 2007

Standard Report Template: Self Insured Pharmacy

Large Claimant Threshold: $50,000

Funding Arrangement and Product:	**Account Structure:**	**Network Service Area:**
Self Insured Pharmacy HMO	Plan Sponsor Level	All

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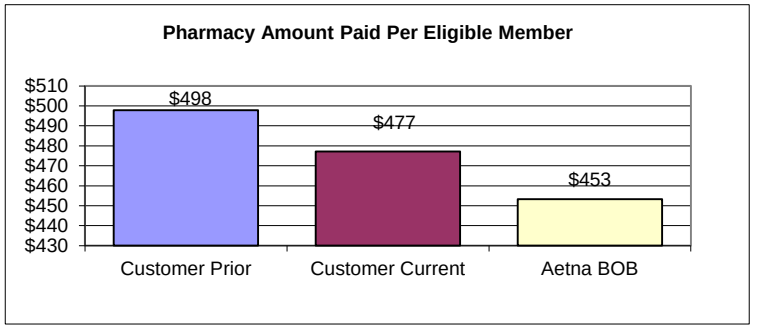
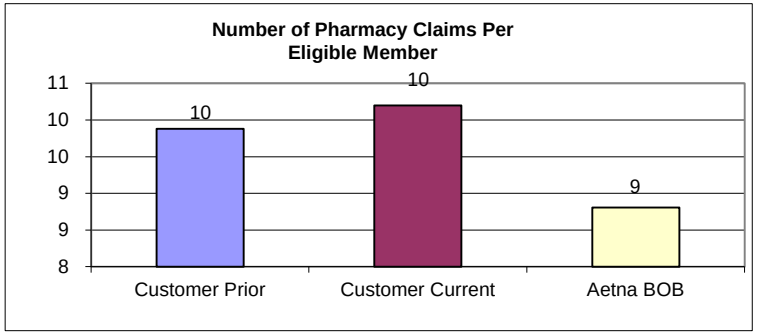
XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

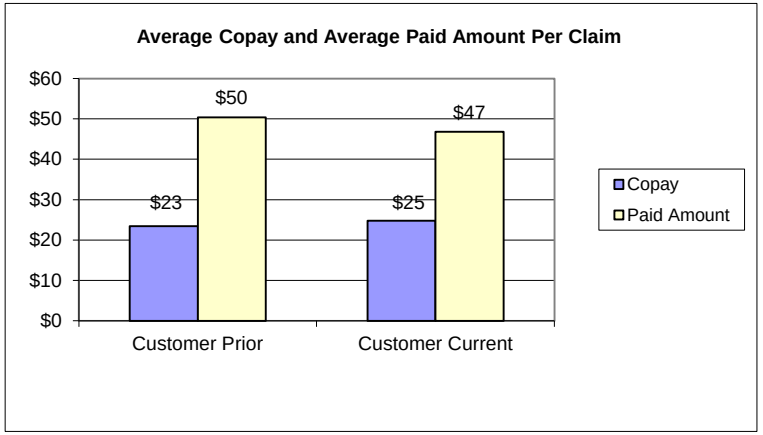
Key Statistics - Pharmacy

Demographics Summary	Customer Prior	Customer Current	% Change from Prior	Aetna BOB[1]
Number of Employees	7,940	7,639	-3.8%	N/A
Number of Members	21,383	20,478	-4.2%	N/A
Ratio of Members to Employees	2.7	2.7	-0.5%	1.9
Percent Male Members	49.8%	49.7%	-0.1%	48.7%
Percent Female Members	50.2%	50.3%	0.1%	51.3%
Average Age of Membership	32.1	32.6	1.6%	33.3
Number of Utilizing Members	17,441	16,767	-3.9%	N/A

Key Statistics				
Total Pharmacy Paid Amount	$10,645,909	$9,771,251	-8.2%	N/A
Pharmacy Paid Amount per Eligible Member	$498	$477	-4.2%	$453
Pharmacy Paid Amount per Utilizing Member	$610	$583	-4.5%	$518
Average Paid Amount per Claim	$50.40	$46.79	-7.2%	$51.47
Number of Pharmacy Claims	211,238	208,839	-1.1%	N/A
Number of Pharmacy Claims Per Eligible Member	9.9	10.2	3.2%	8.8
Number of Pharmacy Claims Per Utilizing Member	12.1	12.5	2.8%	N/A
Calculated Ingredient Cost	$15,268,383	$14,619,509	-4.2%	N/A
Total Copay Amount	$4,954,650	$5,178,050	4.5%	N/A
Average Copay Amount per Claim	$23.46	$24.79	5.7%	N/A
Generic Utilization	47.9%	53.8%	6.0%	58.0%
Generic Substitution	91.5%	93.9%	2.4%	95.3%
Brand Utilization	52.1%	46.2%	-6.0%	42.0%
Formulary Utilization	75.6%	76.8%	1.2%	79.8%





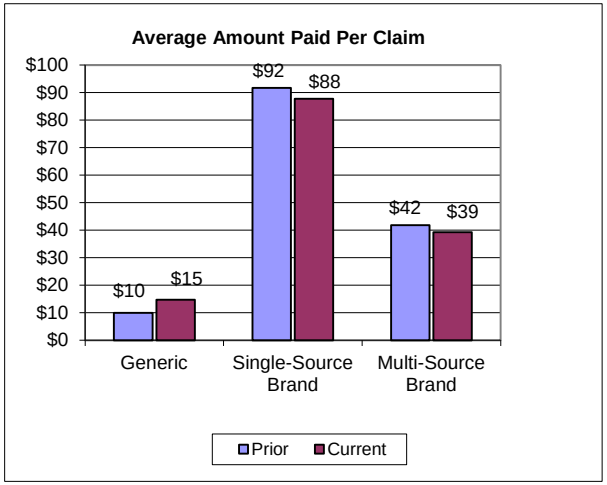


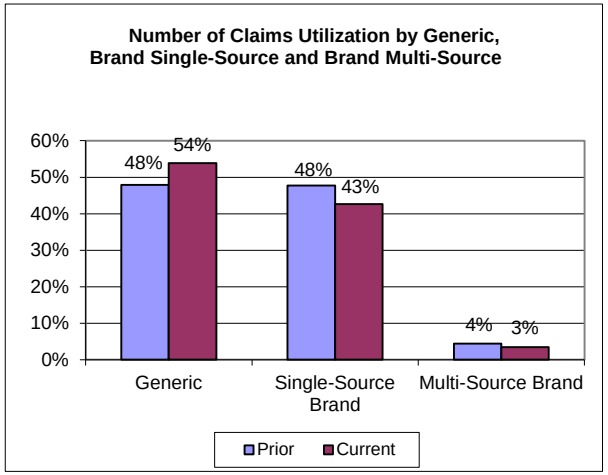
[1]Aetna BOB demographic metrics are specific to the product and to the plan sponsor's region(s). Aetna BOB financial and utilization metrics are further adjusted for the plan sponsor's age and gender mix. All BOB metrics are based on a 12 month incurred time period.

XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Key Statistics by Generic, Brand Single-Source & Brand Multi-Source

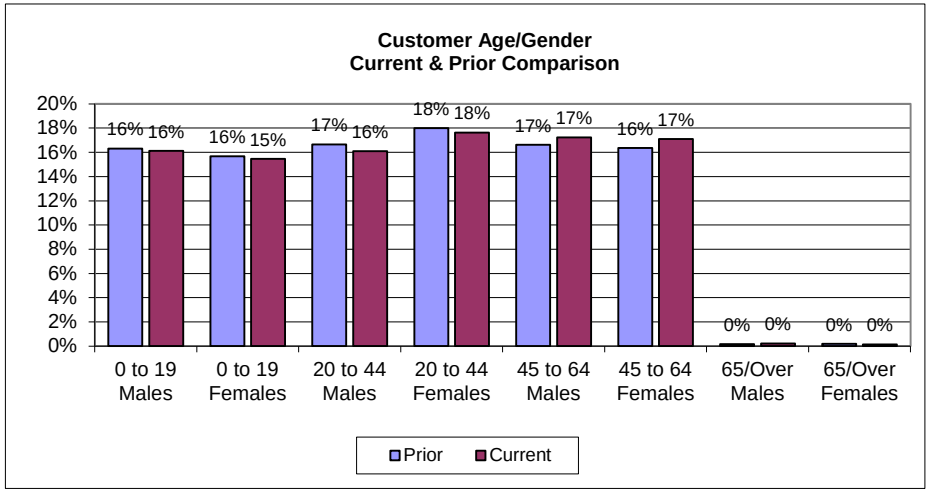
Generic	Customer Prior	Customer Current	% Change from Prior	Aetna BOB
Generic Pharmacy Paid Amount	$1,011,934	$1,662,368	64.3%	N/A
Generic Pharmacy Paid Amount per Eligible Member	$47	$81	71.5%	$72
Generic Pharmacy Paid Amount per Utilizing Member	$58	$99	70.9%	$82
Average Paid Amount Per Claim	$10.01	$14.79	47.7%	$14.05
Number of Generic Pharmacy Claims Per Eligible Member	4.7	5.5	16.1%	5.1
Calculated Ingredient Cost	$2,386,232	$3,159,800	32.4%	N/A
Total Copay Amount	$1,549,526	$1,689,735	9.0%	N/A
Generic Utilization	47.9%	53.8%	6.0%	58.0%
Brand Single-Source				
Brand Single-Source Pharmacy Paid Amount	$9,242,125	$7,822,744	-15.4%	N/A
Brand Single-Source Pharmacy Paid Amount per Eligible Member	$432	$382	-11.6%	$367
Brand Single-Source Pharmacy Paid Amount per Utilizing Member	$530	$467	-12.0%	$419
Average Paid Amount Per Claim	$91.71	$87.78	-4.3%	$106.40
Number of Brand Single-Source Pharmacy Claims Per Eligible Member	4.7	4.4	-7.7%	3.4
Calculated Ingredient Cost	$12,272,446	$11,034,594	-10.1%	N/A
Total Copay Amount	$3,173,395	$3,338,688	5.2%	N/A
Brand Single-Source Utilization	47.7%	42.7%	-5.0%	39.1%
Brand Multi-Source				
Brand Multi-Source Pharmacy Paid Amount	$391,851	$286,139	-27.0%	N/A
Brand Multi-Source Pharmacy Paid Amount per Eligible Member	$18	$14	-23.8%	$15
Brand Multi-Source Pharmacy Paid Amount per Utilizing Member	$22	$17	-24.0%	$17
Average Paid Amount Per Claim	$41.86	$39.23	-6.3%	$58.64
Number of Brand Multi-Source Pharmacy Claims Per Eligible Member	0.4	0.4	-18.6%	0.3
Calculated Ingredient Cost	$609,705	$425,115	-30.3%	N/A
Total Copay Amount	$231,729	$149,628	-35.4%	N/A
Brand Multi-Source Utilization	4.4%	3.5%	-0.9%	2.9%

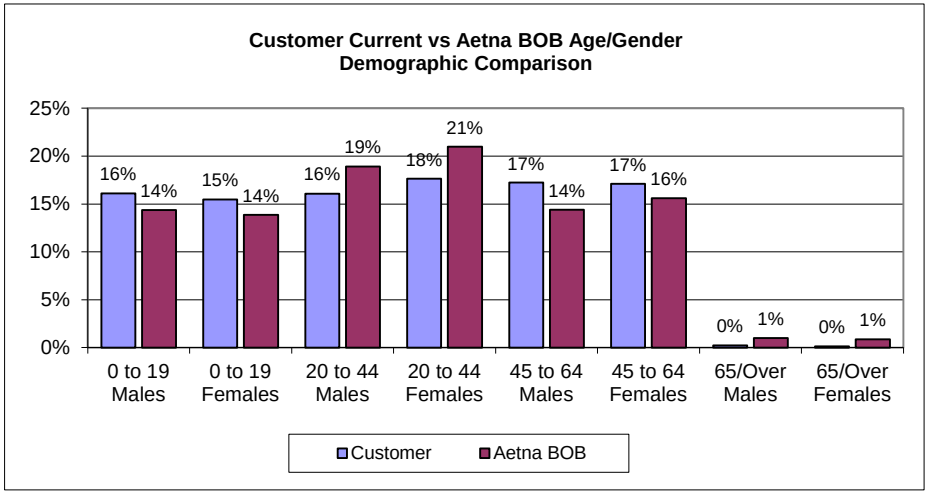


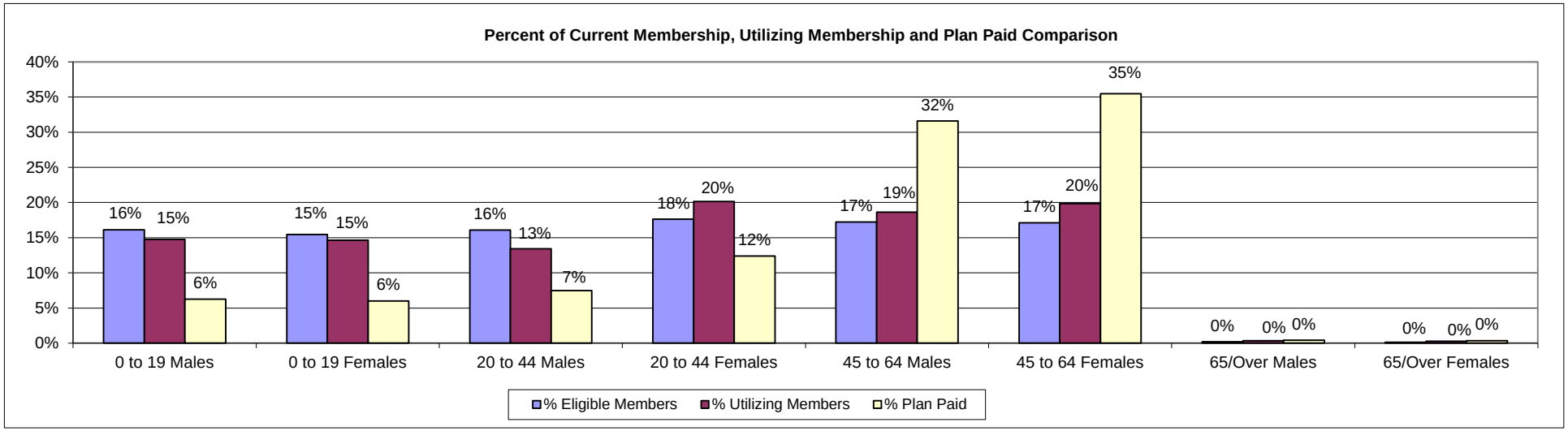


XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Demographics For Pharmacy Membership



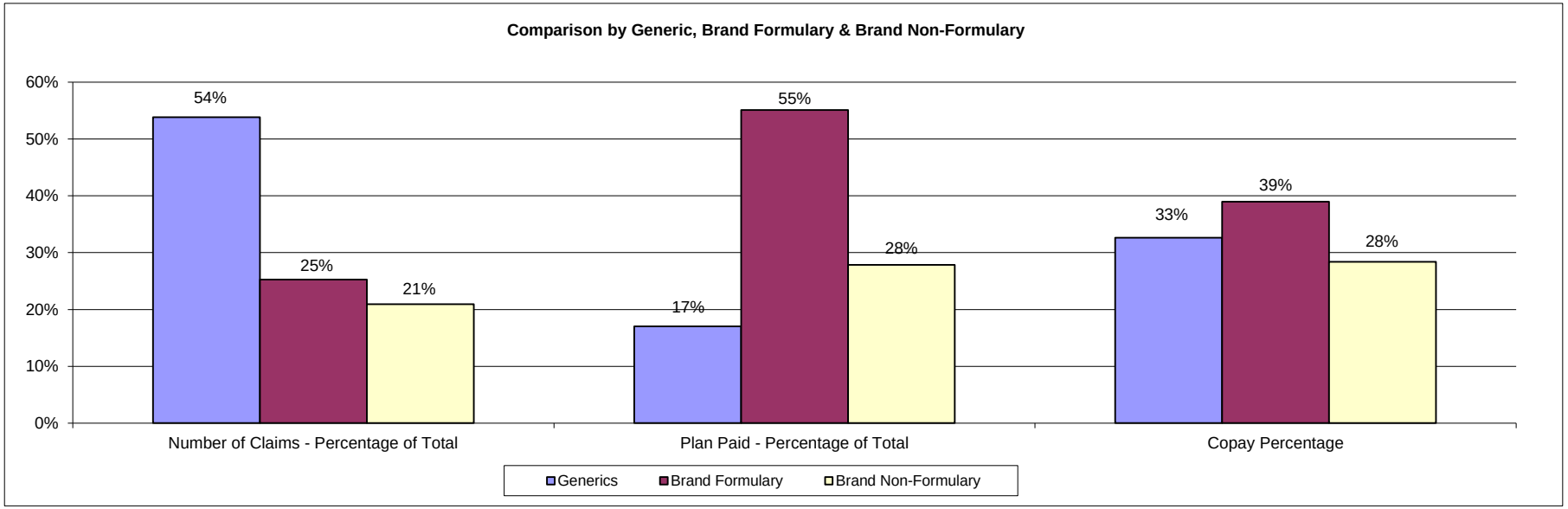




XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007

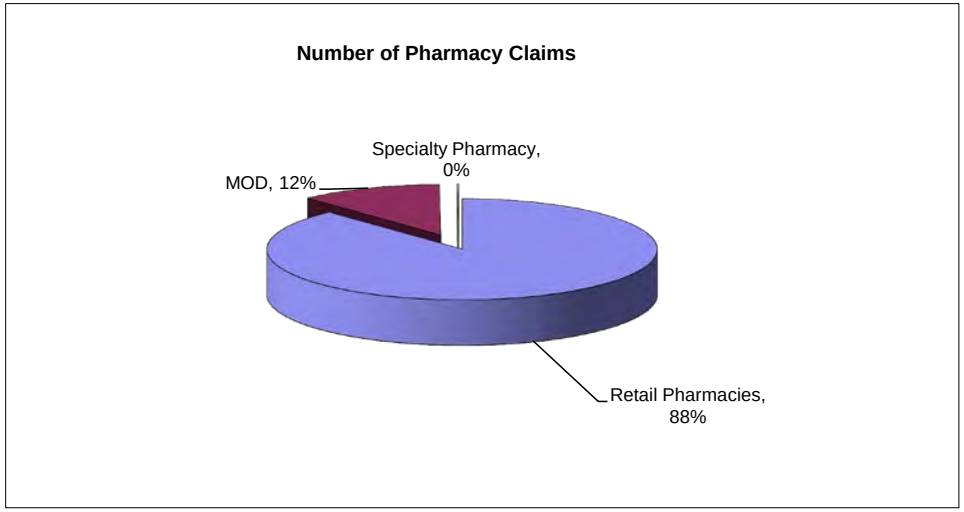
Formulary Analysis

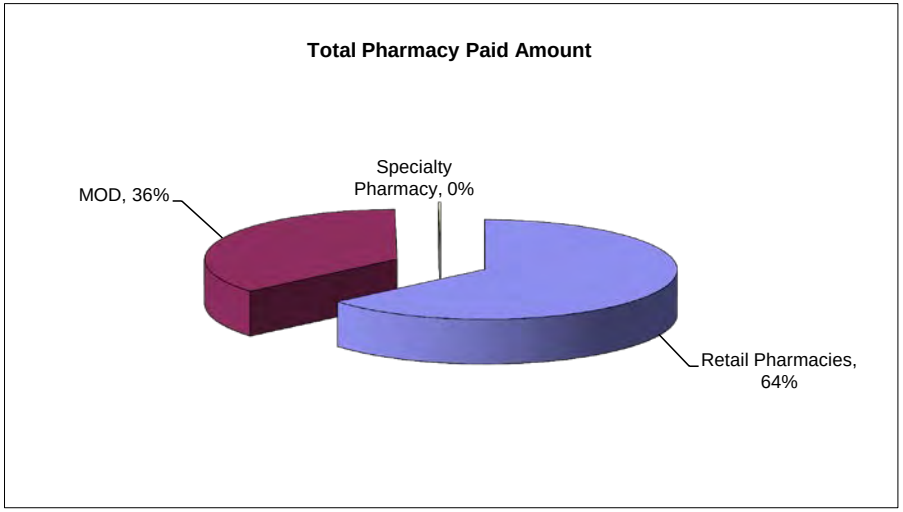
		Retail Pharmacies	Mail Order Drug Pharmacy	Specialty Pharmacy	Total
Generics	Number of Claims	101,661	10,569	200	112,430
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$2,535,193	$805,853	$11,058	$3,352,103
	- Total Copay Amount	$1,422,588	$264,298	$2,849	$1,689,735
	= Plan Paid	$1,112,605	$541,555	$8,208	$1,662,368
Brand Formulary	Number of Claims	43,940	8,761	24	52,725
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$4,647,888	$2,747,351	$10,761	$7,406,000
	- Total Copay Amount	$1,327,079	$690,446	$1,407	$2,018,933
	= Plan Paid	$3,320,810	$2,056,905	$9,353	$5,387,068
Brand Non-Formulary	Number of Claims	38,315	5,358	11	43,684
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$2,873,537	$1,314,571	$3,090	$4,191,197
	- Total Copay Amount	$1,074,066	$394,592	$724	$1,469,383
	= Plan Paid	$1,799,471	$919,979	$2,365	$2,721,815
Total	Number of Claims	183,916	24,688	235	208,839
	Calculated Ingredient Cost + Dispensing Fee + Sales Tax	$10,056,618	$4,867,775	$24,908	$14,949,301
	- Total Copay Amount	$3,823,733	$1,349,336	$4,981	$5,178,050
	= Plan Paid	$6,232,885	$3,518,438	$19,927	$9,771,251



XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Retail Versus Mail Order Versus Specialty Analysis

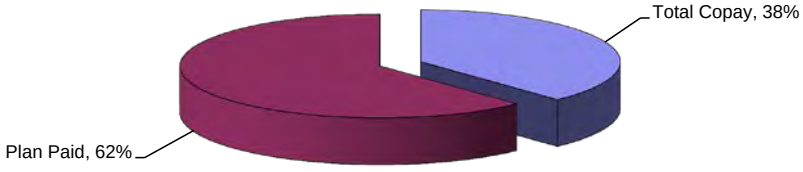




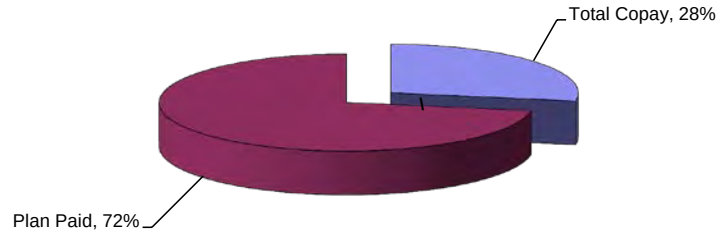
XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Retail Versus Mail Order Versus Specialty Analysis

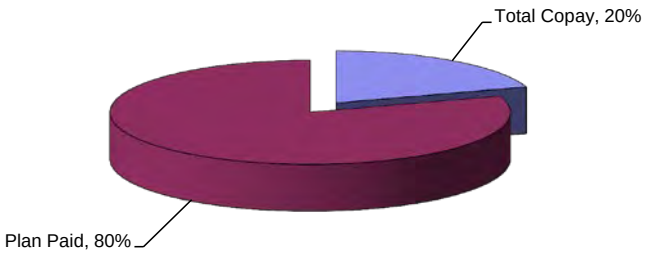
Retail Pharmacies
Employer/Employee Cost Sharing Comparison



Mail Order Drug
Employer/Employee Cost Sharing Comparison



Specialty Pharmacy
Employer/Employee Cost Sharing Comparison



XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Network Analysis and Savings

		Retail Pharmacies			Mail Order Drug Pharmacy		
Generics (MAC)		**Prior**	**Current**	**% Change**	**Prior**	**Current**	**% Change**
Number of Claims		21,923	32,484	48.2%	0	0	N/A
	Average Wholesale Price (AWP)	$1,739,158	$2,771,846	59.4%	$0	$0	N/A
-	Calculated Ingredient Cost	$777,383	$1,223,646	57.4%	$0	$0	N/A
=	AWP Savings	$961,775	$1,548,200	61.0%	$0	$0	N/A
	Percent Savings[1]	55.3%	55.9%	1.0%	N/A	N/A	N/A
	Calculated Ingredient Cost	$777,383	$1,223,646	57.4%	$0	$0	N/A
+	Dispensing Fee	$42,997	$64,221	49.4%	$0	$0	N/A
+	Sales Tax	$38	$44	15.9%	$0	$0	N/A
-	Copay	$335,381	$480,443	43.3%	$0	$0	N/A
=	Paid Amount[2]	$485,037	$807,468	66.5%	$0	$0	N/A
Generics (Non-MAC)							
Number of Claims		6,488	7,086	9.2%	4,997	6,887	37.8%
	Average Wholesale Price (AWP)	$376,201	$416,783	10.8%	$984,631	$1,662,717	68.9%
-	Calculated Ingredient Cost	$295,673	$330,976	11.9%	$367,887	$751,930	104.4%
=	AWP Savings	$80,528	$85,807	6.6%	$616,744	$910,788	47.7%
	Percent Savings[1]	21.4%	20.6%	-3.8%	62.6%	54.8%	-12.5%
	Calculated Ingredient Cost	$295,673	$330,976	11.9%	$367,887	$751,930	104.4%
+	Dispensing Fee	$12,282	$13,526	10.1%	$0	$0	N/A
+	Sales Tax	$2	$28	1204.7%	$0	$0	N/A
-	Copay	$99,375	$104,791	5.5%	$153,496	$211,409	37.7%
=	Paid Amount[2]	$208,582	$239,739	14.9%	$214,392	$540,520	152.1%
Brand							
Number of Claims		86,445	80,928	-6.4%	15,599	14,119	-9.5%
	Average Wholesale Price (AWP)	$9,771,480	$8,690,470	-11.1%	$5,408,163	$5,077,411	-6.1%
-	Calculated Ingredient Cost	$8,191,677	$7,284,045	-11.1%	$4,326,521	$4,061,922	-6.1%
=	AWP Savings	$1,579,803	$1,406,425	-11.0%	$1,081,642	$1,015,489	-6.1%
	Percent Savings[1]	16.2%	16.2%	0.1%	20.0%	20.0%	0.0%
	Calculated Ingredient Cost	$8,191,677	$7,284,045	-11.1%	$4,326,521	$4,061,922	-6.1%
+	Dispensing Fee	$146,431	$136,685	-6.7%	$0	$0	N/A
+	Sales Tax	$259	$202	-21.8%	$0	$0	N/A
-	Copay	$2,281,842	$2,366,513	3.7%	$893,261	$1,085,039	21.5%
=	Paid Amount[2]	$6,056,525	$5,054,419	-16.5%	$3,433,260	$2,976,883	-13.3%

[1] AWP Savings / Average Wholesale Price (AWP) = Percent Savings

[2] Calculated Ingredient Cost + Dispensing Fee + Sales Tax - Copay = Paid Amount

XYZ Company - Plan Sponsor ID 0000000000099999
Self Insured Pharmacy HMO
Current Data For Claims Incurred April 01, 2006 - March 31, 2007
Prior Data For Claims Incurred April 01, 2005 - March 31, 2006

Network Analysis and Savings

	Specialty Pharmacy			Total		
Generics (MAC)	**Prior**	**Current**	**% Change**	**Prior**	**Current**	**% Change**
Number of Claims	21	14	-33.3%	$21,944	$32,498	48.1%
Average Wholesale Price (AWP)	$26,848	$8,720	-67.5%	$1,766,006	$2,780,566	57.4%
- Calculated Ingredient Cost	$12,960	$4,229	-67.4%	$790,343	$1,227,875	55.4%
= AWP Savings	$13,887	$4,491	-67.7%	$975,662	$1,552,691	59.1%
Percent Savings[1]	51.7%	51.5%	-0.4%	55.2%	55.8%	1.1%
Calculated Ingredient Cost	$12,960	$4,229	-67.4%	$790,343	$1,227,875	55.4%
+ Dispensing Fee	$37	$25	-33.3%	$43,033	$64,246	49.3%
+ Sales Tax	$0	$0	N/A	$38	$44	15.9%
- Copay	$460	$210	-54.3%	$335,841	$480,653	43.1%
= Paid Amount[2]	$12,537	$4,044	-67.7%	$497,574	$811,511	63.1%
Generics (Non-MAC)						
Number of Claims	31	7	-77.4%	11,516	13,980	21.4%
Average Wholesale Price (AWP)	$23,491	$461	-98.0%	$1,384,322	$2,079,962	50.3%
- Calculated Ingredient Cost	$19,249	$385	-98.0%	$682,809	$1,083,291	58.7%
= AWP Savings	$4,241	$76	-98.2%	$701,513	$996,671	42.1%
Percent Savings[1]	18.1%	16.5%	-8.6%	50.7%	47.9%	-5.4%
Calculated Ingredient Cost	$19,249	$385	-98.0%	$682,809	$1,083,291	58.7%
+ Dispensing Fee	$0	$7	N/A	$12,282	$13,533	10.2%
+ Sales Tax	$0	$0	N/A	$2	$28	1204.7%
- Copay	$535	$60	-88.8%	$253,405	$316,261	24.8%
= Paid Amount[2]	$18,714	$332	-98.2%	$441,688	$780,591	76.7%
Brand						
Number of Claims	27	33	22.2%	$102,071	$95,080	-6.8%
Average Wholesale Price (AWP)	$37,084	$16,420	-55.7%	$15,216,728	$13,784,301	-9.4%
- Calculated Ingredient Cost	$30,966	$13,516	-56.4%	$12,549,164	$11,359,483	-9.5%
= AWP Savings	$6,118	$2,904	-52.5%	$2,667,563	$2,424,818	-9.1%
Percent Savings[1]	16.5%	17.7%	7.2%	17.5%	17.6%	0.3%
Calculated Ingredient Cost	$30,966	$13,516	-56.4%	$12,549,164	$11,359,483	-9.5%
+ Dispensing Fee	$16	$11	-33.3%	$146,447	$136,696	-6.7%
+ Sales Tax	$0	$0	N/A	$259	$202	-21.8%
- Copay	$1,194	$2,035	70.4%	$3,176,297	$3,453,587	8.7%
= Paid Amount[2]	$29,788	$11,492	-61.4%	$9,519,573	$8,042,794	-15.5%

[1] AWP Savings / Average Wholesale Price (AWP) = Percent Savings

[2] Calculated Ingredient Cost + Dispensing Fee + Sales Tax - Copay = Paid Amount

XYZ Company - Plan Sponsor ID 0000000000099999

Self Insured Pharmacy HMO

Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Top 30 Drugs by Total Paid Amount

Drug Label	Number of Utilizing Members	Number of Claims	Calculated Ingredient Cost	Total Amount Paid	Average Paid Amount per Claim	Pharmacy Paid Amount per Utilizing Member	Average Days Supply
PREVACID	647	2,724	$530,199	$382,713	$140.50	$592	41.6
SIMVASTATIN	988	3,975	$398,381	$330,688	$83.19	$335	44.6
VYTORIN	626	3,028	$346,520	$246,187	$81.30	$393	42.3
SINGULAIR	740	2,465	$274,378	$195,608	$79.35	$264	36.8
ZOCOR	723	1,256	$241,990	$170,544	$135.78	$236	45.0
ACTOS	191	993	$218,092	$159,165	$160.29	$833	43.6
NEXIUM	291	1,053	$205,763	$140,113	$133.06	$481	42.0
ADVAIR DISKU	391	972	$186,440	$134,882	$138.77	$345	36.6
EFFEXOR XR	208	1,125	$181,941	$134,754	$119.78	$648	39.5
ACIPHEX	287	1,018	$188,910	$134,517	$132.14	$469	40.6
TRICOR	273	1,449	$183,635	$130,544	$90.09	$478	42.7
IMITREX	153	509	$152,140	$124,339	$244.28	$813	32.7
LOTREL	243	1,471	$165,322	$117,702	$80.02	$484	38.9
LIPITOR	283	1,272	$184,245	$112,335	$88.31	$397	48.0
WELLBUTRIN	205	848	$152,526	$110,591	$130.41	$539	40.2
DIOVAN HCT	289	1,625	$149,102	$105,924	$65.18	$367	42.4
AVANDIA	134	663	$140,577	$103,138	$155.56	$770	46.1
VALTREX	345	741	$134,487	$98,458	$132.87	$285	23.1
ADDERALL XR	230	970	$136,877	$98,322	$101.36	$427	36.0
AMBIEN	464	1,389	$158,686	$97,963	$70.53	$211	31.4
NASONEX	787	1,535	$126,974	$90,675	$59.07	$115	32.6
TOPAMAX	103	394	$119,789	$90,121	$228.73	$875	44.3
LEVAQUIN	1,106	1,398	$142,323	$87,554	$62.63	$79	8.5
DIOVAN	271	1,466	$118,096	$84,804	$57.85	$313	41.4
LEXAPRO	299	1,439	$136,098	$84,649	$58.82	$283	37.8
NORVASC	333	1,791	$135,448	$83,261	$46.49	$250	41.9
OMNICEF	1,005	1,294	$113,945	$81,352	$62.87	$81	10.0
LAMICTAL	85	416	$105,975	$80,473	$193.44	$947	38.2
ZYRTEC	555	1,862	$129,961	$80,396	$43.18	$145	36.1
CYMBALTA	164	707	$117,613	$80,204	$113.44	$489	39.1
Top 30 Drugs Total	N/A	41,848	$5,576,432.95	$3,971,976.84	$94.91	N/A	38.1
Total All Claims	**16,767**	**208,839**	**$14,619,508.66**	**$9,771,250.59**	**$46.79**	**$582.77**	**31.0**

XYZ Company - Plan Sponsor ID 0000000000099999

Self Insured Pharmacy HMO

Current Data For Claims Incurred April 01, 2006 - March 31, 2007

Top 30 Drugs by Number of Claims

Drug Label	Number of Utilizing Members	Number of Claims	Calculated Ingredient Cost	Total Amount Paid	Average Paid Amount per Claim	Pharmacy Paid Amount per Utilizing Member	Average Days Supply
HYDROCO/APAP	2,540	5,452	$88,220	$22,489	$4.12	$9	9.7
SIMVASTATIN	988	3,975	$398,381	$330,688	$83.19	$335	44.6
AMOXICILLIN	2,878	3,768	$43,739	$874	$0.23	$0	8.8
AZITHROMYCIN	2,740	3,426	$86,013	$41,400	$12.08	$15	5.1
VYTORIN	626	3,028	$346,520	$246,187	$81.30	$393	42.3
LEVOTHYROXIN	586	2,991	$34,409	$305	$0.10	$1	45.0
LISINOPRIL	527	2,843	$51,894	$6,869	$2.42	$13	42.2
PREVACID	647	2,724	$530,199	$382,713	$140.50	$592	41.6
METFORMIN	527	2,576	$63,573	$23,780	$9.23	$45	41.1
SINGULAIR	740	2,465	$274,378	$195,608	$79.35	$264	36.8
TOPROL XL	427	2,251	$95,237	$59,262	$26.33	$139	41.0
HYDROCHLOROT	415	2,034	$17,806	$127	$0.06	$0	40.5
SYNTHROID	307	2,027	$36,032	$23,359	$11.52	$76	37.9
AMOX/K CLAV	1,542	1,915	$62,069	$37,053	$19.35	$24	10.1
ATENOLOL	316	1,894	$25,220	$1,369	$0.72	$4	41.1
ZYRTEC	555	1,862	$129,961	$80,396	$43.18	$145	36.1
NORVASC	333	1,791	$135,448	$83,261	$46.49	$250	41.9
FLUTICASONE	889	1,746	$95,168	$69,229	$39.65	$78	34.6
ALPRAZOLAM	484	1,680	$30,502	$10,421	$6.20	$22	25.5
ALBUTEROL	978	1,629	$26,079	$4,300	$2.64	$4	22.6
DIOVAN HCT	289	1,625	$149,102	$105,924	$65.18	$367	42.4
NASONEX	787	1,535	$126,974	$90,675	$59.07	$115	32.6
LOTREL	243	1,471	$165,322	$117,702	$80.02	$484	38.9
DIOVAN	271	1,466	$118,096	$84,804	$57.85	$313	41.4
TRICOR	273	1,449	$183,635	$130,544	$90.09	$478	42.7
FLUOXETINE	278	1,445	$43,653	$23,427	$16.21	$84	34.6
LEXAPRO	299	1,439	$136,098	$84,649	$58.82	$283	37.8
LEVAQUIN	1,106	1,398	$142,323	$87,554	$62.63	$79	8.5
AMBIEN	464	1,389	$158,686	$97,963	$70.53	$211	31.4
YASMIN 28	226	1,373	$63,869	$39,622	$28.86	$175	30.8
Top 30 Drugs Total	N/A	66,667	$3,858,605.57	$2,482,553.33	$37.24	N/A	31.6
Total All Claims	**16,767**	**208,839**	**$14,619,508.66**	**$9,771,250.59**	**$46.79**	**$582.77**	**31.0**

Drug Name	Common Use(s)
Accutane *(isotretinoin)*	Acne
Advair Discus	Asthma
albuterol	Asthma
Ambien	Sedative/hypnotic
amoxicillin	Bacterial infection
Augmentin *(amoxicillin/potassium clavulanate)*	Bacterial infection
Avonex; also, Copaxone	Multiple Sclerosis
Celebrex; also, Vioxx	Pain, inflammation, arthritis
cephalexin	Bacterial infection
Cipro,Levaquin	Bacterial infection
Combivir	HIV infection
Effexor	Depression
Enbrel	Rheumatoid arthritis
Epogen, Procrit	Red blood cell defiency
Flonase, Nasonex	Allergy
Fosamax	Osteoporosis
Glucophage/xr	Diabetes
Humatrope, Serostim, Protropin	Growth hormone; AIDS wasting

Drug Name	Common Use(s)
hydrochlorothiazide	High blood pressure
hydrocodone/apap	Pain
Imitrex	Migraine
Lamisil	Fungal infection
Neurontin	Seizures and pain
Norvasc	High blood pressure; heart problems
Ortho-Tri-Cyclen,Ortho-Cyclen	Contraception
Oxycontin	Pain
Paxil, Zoloft, Celexa, *fluoxetine*	Depression
Premarin	Estrogen replacement
Prempro	Estrogen replacement
Prevacid, Prilosec, Aciphex, Nexium	Gastrointestinal disorders
Rebetol	Hepatitis C
Singulair	Asthma
tamoxifen , Xeloda	Breast cancer
Toprol XL	High blood pressure; heart problems
Valtrex	Herpes infection, shigles
Wellbutrin	Depression
Zithromax	Bacterial infection
Zocor, Lipitor, Pravachol	Elevate Cholesterol
Zyrtec, Allegra, Clarinex	Allergy

Aetna - Pharmacy Finance
Pharmaceutical Manufacturers Rebate Program - Supplemental Invoicing
Self Funded Plan Sponsor Rebate Payment History

Customer Data:

PS Name	XYZ Company
PS Number	SI012345
Product	HMO
Market Segment	NAT
Wireline claim offset CSA	123456-10-001

Payment Detail:

Quarter	Receipts as of 05/31/04	Share Percentage (1)	Gross Payable	Paid in Prior Distributions	Net Payable Amount
1Q2002	$0.00	0%	$0.00	$0.00	$0.00
2Q2002	$2,425.97	90%	$2,183.37	$0.00	$2,183.37
3Q2002	$3,617.67	90%	$3,255.90	$0.00	$3,255.90
4Q2002	$4,170.96	90%	$3,753.86	$0.00	$3,753.86
1Q2003	$3,234.62	90%	$2,911.16	$0.00	$2,911.16
Prior Periods (2)	not applicable	not applicable	not applicable	not applicable	not applicable
Totals	$13,449.22		$12,104.29	$0.00	**$12,104.29**

Footnotes:

(1) "Share Percentage" is based on employee count level for the respective quarter of activity.

(2) If applicable, reflect activity for 1Q2000 through 4Q2001. The rebate amounts payable to customer are subject to change as additional funds are received from pharmaceutical manufacturers.

Carve-out PBMs will tell you that "integration" can occur with timely sharing of pharmacy claims. As a truly integrated carrier, we find that successful benefit integration goes beyond sharing pharmacy data, toward a holistic approach to care. This is particularly true for members who have complex conditions, have multiple conditions or are taking expensive specialty drugs. We will manage your members holistically through the My AlaskaCare Single Point of Contact, and not just those attributes of care specific to pharmacy claims.

Our integrated Aetna account and clinical team will provide ongoing support to identify key issues early and to provide solutions. We will work with you as disease acuity and usage patterns can change over time. We will continue to look for opportunities to refine not only your pharmacy benefit, but also your medical benefit to support and optimize your overall benefits strategy and member health.

We have provided examples of innovative steps we are prepared to implement for the State that will deliver superior member experience, improve member health and create the greatest reduction in cost. While we offer many more solutions than what we listed below, these are the ones that we believe will be the most impactful to the State.

Single point of contact through Health Concierge

We deliver an outstanding member experience through the health concierge, a single point of contact that helps members understand and maximize not only their medical benefits, but also their pharmacy benefits.

The health concierge pairs up with a clinical team and organizes clinical support and care for members to help them achieve better health. The concierge also will contact a nurse care advocate to share information with a member on health programs such as medical disease management. According to an internal study through Aetna Informatics, the program resulted in 65 percent greater case management participation than in a standard case management model, as well as very positive member experience.

In addition to answering pharmacy-related questions, the concierge can also:

- Update member preferences
- Respond to system alerts
- Transfer live calls to product specialists
- Work with clinicians who coordinate care across all clinical programs
- Schedule appointments
- Return phone calls through expanded support of outbound call activity

Smart Edits – How integrated claim adjudication works better for you

Our Smart Edits demonstrate how integrating pharmacy and medical data in real time manages care better than a carve-out solution.

Smart Edits are a unique feature programmed into our claim system to identify situations where we can bypass precertification, quantity limits and step therapy. While carve-out PBMs may infer diagnosis to assume a medical condition, we use actual medical claims to pinpoint a diagnosis and provide a seamless, simplified experience at the point of care. We use the following information to verify the criteria has been met:

- Diagnosis data
- Laboratory data
- Physician specialty designation

Why Smart Edits Matter – When we know a member's condition, we can speed up the adjudication process at the point of care.

Improving medication adherence

Improved member medication adherence is a significant need for many plan sponsors. We recognized this many years ago and designed value-based benefit designs that have successfully improved medication adherence for several of our plan sponsors.

Moreover, we have developed our programs beyond simply reducing copays for certain drug classes. Our Care Engine-driven Aetna Healthy Actions program has algorithms that can target member copay reductions based on disease acuity, rather than just drug class.

Taking our value-based designs a step further, our new Aetna RX Healthy Outcomes value-based program not only waives medication copays, but also identifies and engages members shortly after certain cardiovascular events. Aetna RX Healthy Outcomes also includes pharmacist outreach and support which is enormously valuable in supporting members after a difficult medical experience. The program's details are spurred by our collaboration with Brigham and Women's Hospital and Harvard Medical School and a prospective, randomized study. The Post-Myocardial Infarction Free Rx Event and Economic Evaluation (Post-MI FREEE) Trial was Published in New England Journal of Medicine[1] in November 2011 and showed how Aetna Rx Healthy Outcomes:

- Reduced the occurrence of heart events by 11% when copays were eliminated[4]
- Prevented avoidable medical costs, which offsets the pharmacy cost increase
- Plan sponsors and members get better care and better outcomes at no added net cost

We highly recommend this innovative program for the State as it drives meaningful improvements in adherence, cost and outcomes for post-heart attack patients.

Increasing safety and savings through Aetna Rx Check®

Another highly successful program is our rapid retrospective DUR program, Aetna Rx Check. This program promotes improved care and controls costs by analyzing pharmacy claims to identify opportunities for increased safety and possible savings. When we identify an issue, we reach out to targeted physicians to help:

- Bring to light potential misuse
- Spur direct and rapid physician involvement to improve member care
- Reduce medication errors

Improved drug safety and use equals savings - more than $268 million since our Aetna Rx Check program was launched[5].

Some issues that Aetna Rx Check identifies include:

- Simultaneous use of two drugs that serve the same purpose
- Severe drug-to-drug interactions
- Multiple prescriptions and/or prescribers for certain drugs with the potential for misuse
- Money-saving opportunities when generic equivalent drugs are available
- Prescriptions for a multiple daily dose of a proton pump inhibitor (PPI)

We highly recommend Aetna Rx Check for the State as it affords the opportunity to improve safety and medication use, while helping to control costs.

A better approach to managing specialty drugs

Although conventional, small molecule pharmaceuticals constitute the majority of pharmacy costs, the use of specialty drugs is rapidly becoming an increasing share of pharmacy costs. Significant growth in specialty drug spending has also rapidly increased the importance of specialty medical cost management.

Some industry experts predict that specialty spend could rise to encompass 40-50 percent of all pharmacy spend in this decade. We recognized this trend and created a holistic solution to improve outcomes and reduce costs.

The programs that we have in place deliver over $200 million in savings each year, while maximizing quality[1].

Clinical management systems ensure coordination of support

- *One holistic view* provides clinicians with available information about the member, providing the best opportunity to identify and act on the most important member needs

- *Seamless referrals, documentation and coordination* make coordination of care simpler for the member and provider; improving efficiencies

Enhanced support for members taking certain specialty drugs

Our Specialty Health Care Management[SM] nurse team leverages medical and pharmacy benefits to:

- Understand a member's total health picture and identify underlying issues in order to take meaningful next steps

- Use Aetna's resources to drive coordinated, optimal care for members

- Identify members who need assistance based on claim data or referral from our care management teams

- Educate members and ensure appropriate use and adherence for specialty drugs

- 100% of our specialty pharmacy members are screened for Behavioral Health issues. An additional 4% are identified for intervention by a behavioral specialist[2].

Our Specialty Health Care Management team provides extra support for members who need specialty drugs:

- Covers a total of 12 complex conditions, accounting for more than 80% of specialty drug spend, driven by 2.4% of our overall membership[2]

- 45% of patients offered the service participate

- Members with Multiple Sclerosis increased their medication possession ratio from 85% to 93%[1]

This nurse team also acts as an extension of the previously described Health Concierge model.

Personalized care drives better member outcomes

As an example, our high-touch support keeps members with Multiple Sclerosis healthier and reduces medical costs by increasing adherence to specialty drugs. For members engaged in our Specialty Health Care Management nurse team[3]:

- 47% fewer neurologist visits
- 19% fewer MRI's
- 29% lower related medical costs in one year

Holistic management of specialty pharmaceuticals would greatly support the State in achieving its vision, and will be particularly impactful moving forward as more and more of your members begin using specialty drugs. We have a tremendous focus on specialty solutions, and our solutions would be enormously valuable to the State.

Pharmacy Ambassador

Our Pharmacy Ambassador program serves as an extension of the Health Concierge single point of contact. Pharmacy Ambassador is another example of where we leverage our integrated medical and pharmacy data in our direct patient interactions. In this program, a clinical pharmacist collaborates with Health Concierge team to interact directly with members and providers to impact member care related to drug therapy.

The Pharmacy Ambassador improves health outcomes by:

- Optimizing drug therapy
- Increasing adherence to drug therapy
- Reduce medication expenses where appropriate
- Improve member health literacy

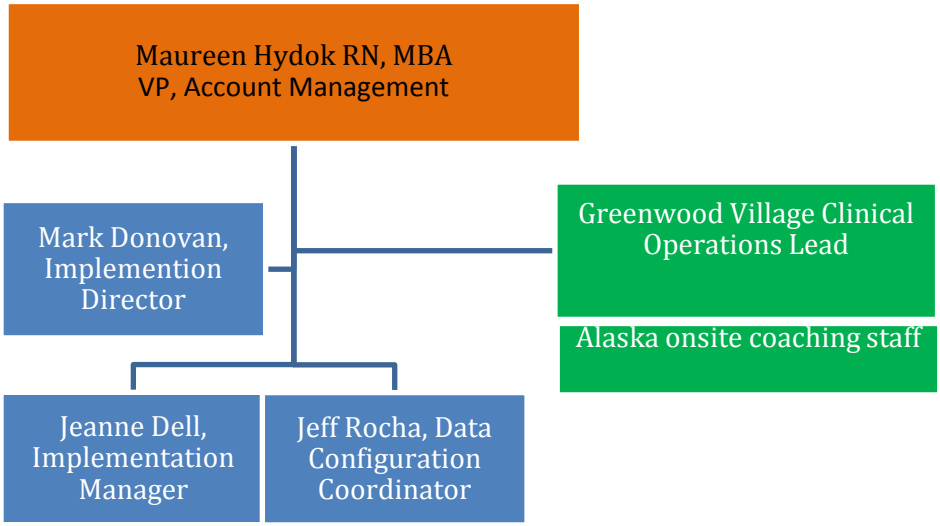
While not all plan sponsors have such a program in place, it is an example of cutting-edge, holistic support that helps control costs and manage care.

While the aforementioned programs are not an exhaustive presentation of all our solutions, these are the most impactful and address many of the issues preventing plans from achieving optimal value from their pharmacy benefits.

1 Aetna program analysis. January through September 2011.
2. Aetna Specialty Health Care Management team analysis. May 2011
3. Results based on Aetna internal study, Aetna Comparative Effectiveness Analysis, August 2012
4. *New England Journal of Medicine* and a press release from Brigham and Women's Hospital (BWH) .November 2011. Reduced the occurrence of a heart event after intervention that involved more than one event (e.g. stroke and heart attack) and/or revascularization procedure (coronary bypass, stenting, angioplasty) by 11%.
5. Aetna Rx Check internal analysis. October 2010

“4.1.1.4_North_Carolina_Case_Studies” is considered Confidential, and has been REDACTED.

State of Alaska
Account Management Team



QUESTION 4.1.3.2

Company Profile

HIPAA Compliance

Description:

ActiveHealth is compliant with HIPAA security, privacy, and transaction standards. Our servers are located in a secure datacenter within our facilities. Access to the server is controlled and granted on a need basis. Customer data is protected by access control to the database and physical servers. Access to these is audited at regular intervals to ensure compliance with company and regulatory policies.

Network connections are secured using industry standard network security technology including firewalls, intrusion detection systems, Virtual Private Networks, ongoing vulnerability scanning.

Applications are reviewed by the technical architecture team to ensure adherence to identified best practices. This includes (a) Guarding against malicious user input (b) Ensuring access to the database is through stored procedures guarding against SQL injection (c) Ensuring all traffic to the application is over encrypted protocols such as HTTPS and Secure FTP.

All customer data is transmitted using Secure FTP or Secure HTTP (HTTPS). Customer data is protected in the database by securing it against unauthorized access. Backup Media are encrypted using HP Backup and Recovery solutions before they are sent offsite.

ActiveHealth's Information Security Policy is based on standards, laws and regulations for the protection of Personal Health Information and Personally-Identifiable Information:

- HIPAA (Health Insurance Portability and Accountability Act of 1996)
- Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009
- ISO/IEC 17799, Information Technology - Code of Practice for Information Security Management, First Edition, Reference Number ISO/IEC 17799:2000(E), 2000-12-1
- NIST Special Publication 800-12, National Institute of Standards and Technology: An Introduction to Computer Security: The NIST Handbook, October 1995
- NIST Special Publication (SP) 800-14: Generally Accepted Principles and Practices for Securing Information Technology Systems, September 1996

The Controls Framework also provides for compliance with Trust Service Principles for Security and Confidentiality of proprietary information, personal health information, and personally-identifiable information.

QUESTION 4.1.3.2

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

Security and information technology are managed in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:

Security and information technology are managed at each of our clinical operations centers, including our Greenwood Village location, and managed out of our New York City Headquarters.

ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

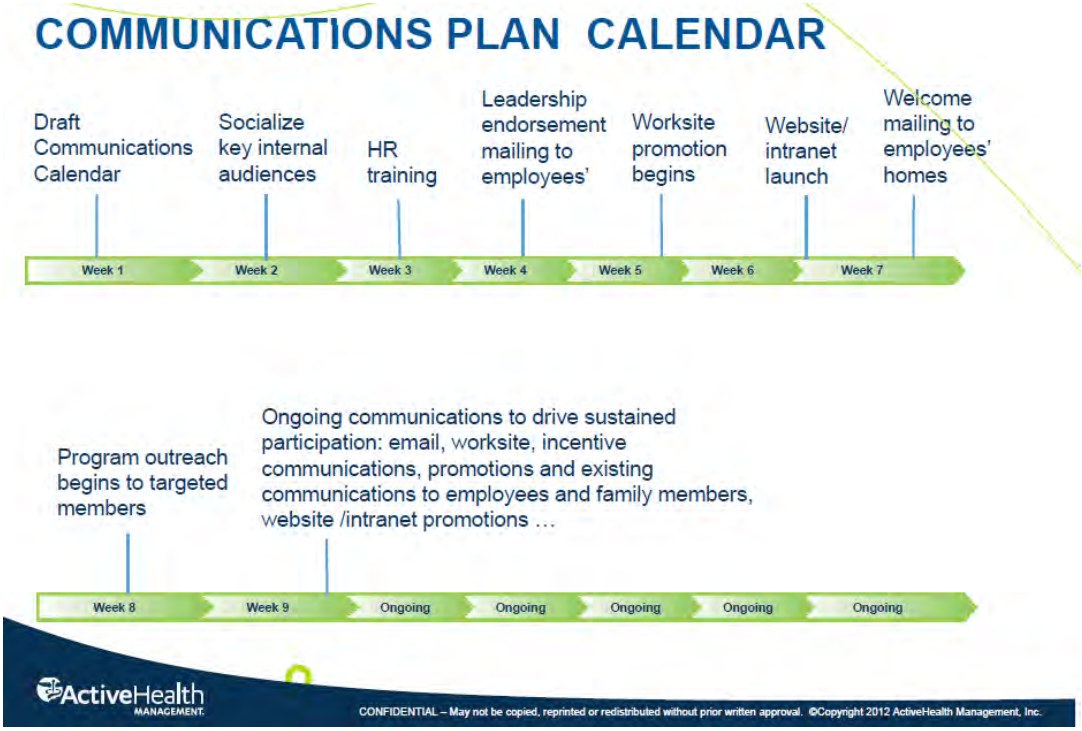
Communications

Description:

ActiveHealth prepared a comprehensive communications strategy overview document. Please refer to exhibit 4.1.6.1

QUESTION 4.1.3.2

Flow Chart:



Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

ActiveHealth manages communications for our large book of business through a dedicated in-house marketing team that designs campaigns and relies upon vendors for fulfillment and customized materials. We work with the Aetna Customized Communications Group to develop specialty communications campaigns.

Location/Hours of Operation/Point of Contact/Onsite Support:

The communications team works out of our New York City headquarters, located at 1333 Broadway in Manhattan.

QUESTION 4.1.3.2

Information Technology

Description:

ActiveHealth programs are powered by three proprietary systems working off of a single database: the CareEngine clinical decision support system, ActiveAdvice nurse workflow software, and our online member web portal MyActiveHealth.

High availability of our internal care management applications is achieved through redundancy at all levels. Load balancers front end all requests through the network into a bank of multiple web servers hosting the care management applications. The databases are highly available through a cluster of Active-Passive Nodes.

1. The CareEngine(R) System

Member identification follows the clinical predictive model continuously developed by the ActiveHealth Clinical Programs & Product Management team for the past 13 years. The validity of the CareEngine predictive model was validated against chart review for disease identification and found to be >98% valid relative to clinician-documented conditions. The validity and reliability of the predictive model have further been reviewed by the NCQA for accreditation (currently accredited for Disease Management programs).

Real-time CareEngine analytics analyze HRA, diagnostic, procedure, pharmacy, laboratory, HIE, patient-reported (from telephonic and online coaching sessions) and physician-reported data to generate an internal "Member Health Profile". The member health profile is incorporated into what is known as a "Member Health State", which is composed from thousands of "Monitored Events" representing both gaps in care as well as care patterns (e.g. multiple ER visits, hospital discharge without outpatient follow-up, complicated hospital courses) along with "Markers" of disease and pre-disease risk (e.g., at risk for diabetes, at risk for CAD). Additional "marker" algorithms also look for patterns of care indicative of other types of future risk, such as care patterns indicating the need for Preference-Sensitive Decision Support (e.g. for low back pain, knee or hip replacement, which can often see highly variable practice patterns among local orthopedic surgeons). Other care patterns are programmed into the rule sets to identify the imminent need for care coordination (e.g., cancer workups, where sequential symptom, imaging, and biopsy is detected that suggests a patient may need additional care coordination as well as psychosocial support in an Enhanced Case Management capability). Note that this identification, rather than triggering from a hospitalization event, tries to identify a pattern prior to the actual hospitalization, so that care patterns can still be influenced to improve the health and economic outcome for the member.

QUESTION 4.1.3.2

Particular emphasis is placed upon "impactible" items identified during the course of stratification. Members are identified and then hierarchically assigned to the best-matching set of wellness & disease management interventions using the predictive model, the output of which is made available to the nurses. It is important to note that the output of the CareEngine predictive model is clinically-driven, rather than identification strictly based on predicted future cost. There is both a summary numeric score as well as a narrative output that describes the member's conditions, co-morbidities, at-risk conditions, and specific actions they must take to mitigate future risk. This profile is made user-friendly and presented to the member themselves on our MyActiveHealth member portal so that they, too, can act upon it immediately.

The CareEngine Predictive Model (CSID) has historically been developed, and continues to be developed, with attention to directly integrate with nurse workflow and the ActiveHealth nurse workflow platform, ActiveAdvice. This means that output, in the form of validated conditions/disease, comorbidities, at-risk states, and care considerations, are electronically loaded into the ActiveAdvice nurse/coach workflow system on a regular basis, along with numeric scores indicating the overall opportunity for disease modification and health outcomes improvement. Nurse Managers are thereby able to select and prioritize sub-groups of members for outreach and engagement, often performing an additional layer to try to reach the highest-of-the-highest-risk members first, and then continuing along with the rest of the population. Incremental updates are also electronically delivered, such as if new data is found that changes a member's risk or opportunity, this, too is reflected in the Predictive Model output to ActiveAdvice. This is often most apparent in members who take the Health Risk Assessment, which can probe and uncover many more risks that are not always discovered through claims analyses (e.g. tobacco use pattern, dietary habits, weight / body mass index, exercise habits, and psychosocial stress level).

In addition, the nurses are able to see a uniquely detailed and actionable summary view of the predictive model. Rather than simply present raw numeric data (as is common with many cost-driven models), the CareEngine predictive model is clinically driven. Therefore, we are able to deliver a more detailed clinical view in the form of a "scoring note" and also a "justification" view. The "scoring note" is named from to the weighted scoring methodology contained in the algorithms, and reveals the specific risk level for each condition, and the modifiability or "impactibility" of each. Thus, the nurse or coach can view a quick summary, e.g. "Diabetes - High - Impactible; Hypertension - Moderate - Impactible; At-Risk for Breast Cancer; Tobacco Use" and proceed quickly from a running start, knowing the data at hand. This scoring note also contains a summary of the Care Considerations - the specific modifiable gaps in care and actions to be taken - which make the nurse-member interaction far more targeted impactful than would otherwise occur, even with a predictive model in place.

QUESTION 4.1.3.2

Lastly, work is in progress to develop next-generation capabilities to perform regression analyses on existing data sets in order to refine prediction capabilities for hospitalization as well as re-admission, in order to identify members who may require outreach, engagement and intervention; if these modeling exercises yield satisfactory performance (i.e. R-squared), then there is a possibility they may be incorporated into the identification rules for certain tracks or programs.

2. ActiveAdvice Nurse Workflow Technology

ActiveAdvice, the system utilized by our disease management nurses, maternity program and lifestyle health coaches, is currently Web-enabled and provides sophisticated workflow functionality including tracking of all medical management activity with members, documenting notes and scheduling tasks. The coach documents goal achievement in ActiveAdvice, such as weight loss, tobacco use status, nutritional and exercise activity as well as levels of stress which supports our reporting processes. ActiveAdvice technology is completely integrated with our reporting suite as well as the CareEngine, and is also utilized to support integration with external medical management programs.

Vendors involved with the State's program can access ActiveAdvice View, a portal with a window to summary information about a member's entitlement to and participation status in ActiveHealth Care Management programs. External vendors can use ActiveAdvice View to make referrals to ActiveHealth programs.

Data processing and integration from other programs would be managed by our data analytics division, which specializes in obtaining data from virtually any platform and format. We can integrate external data feeds as often as daily to ensure optimization of program effectiveness. ActiveHealth is able to provide multi-faceted data reporting on program performance. ActiveHealth develops fully integrated, seamless member experience processes with other health plans, PBMs, and lab vendors as well as HRA, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility. We do this using both data feeds and work processes, which ensure information is shared when it is needed.

QUESTION 4.1.3.2

3. MyActiveHealth Member Web Portal

MyActiveHealth serves as the gateway for members to all online ActiveHealth programs. Built with flexibility in mind, the programs available to members can be configured to best meet the customer's needs. The available options include:

- A full featured, claims-populated and member-reported electronic Personal Health Record
- A comprehensive, proprietary Health Risk Assessment, that includes Health Actions, a prioritized and personalized health 'to do' list
- Online components to our NCQA-accredited Disease Management program
- Online components to our Lifestyle Coaching (wellness) program
- ActiveChallenge, powered by a partnership with Shape-Up, is a year-round wellness offering for employees.
- The Rewards Center, which is designed to accommodate various client incentive program configurations
- The MyActiveHealth website is currently accessible by smart phones, including the iPhone and Android, and supports SMS text message delivery and calendar reminders.

MyActiveHealth utilizes a variety of interconnection technologies to communicate with other systems. XML based Web Services are used extensively to provide communication with related applications and external trading partners. Additionally, MyActiveHealth is connected to the ActiveHealth Service Oriented Architecture (SOA) that provides the ability for sophisticated process orchestrations.

MyActiveHealth also possesses the ability to establish Single Sign On (SSO) capability with external systems to enable users to easily access the system from secure application environments that may be provided by their employer or other sponsoring organization.

Embedded in the MyActiveHealth website, the electronic Personal Health Record (PHR) provides a view for members into their health information. Features of the PHR include:

- Pre-population of health information from medical and pharmacy claims, and lab results feeds
- Pre-printed forms, including emergency wallet card and immunization record
- Ability to upload and store health-related documentation
- Spanish translation of the Personal Health Record
- Ability for member to grant access to physicians and others
- Organization of personal health records 'topically' (i.e., conditions, tests & procedures, immunizations, insurance information, health care team, health summary page)

QUESTION 4.1.3.2

- Suppression from display of specific ‘sensitive diagnoses'
- Bi-directional persistency of data between PHR and HRA, if purchased (a member only have to input information in one place and it will pre-fill in other applicable areas)

Ongoing investment in IT infrastructure

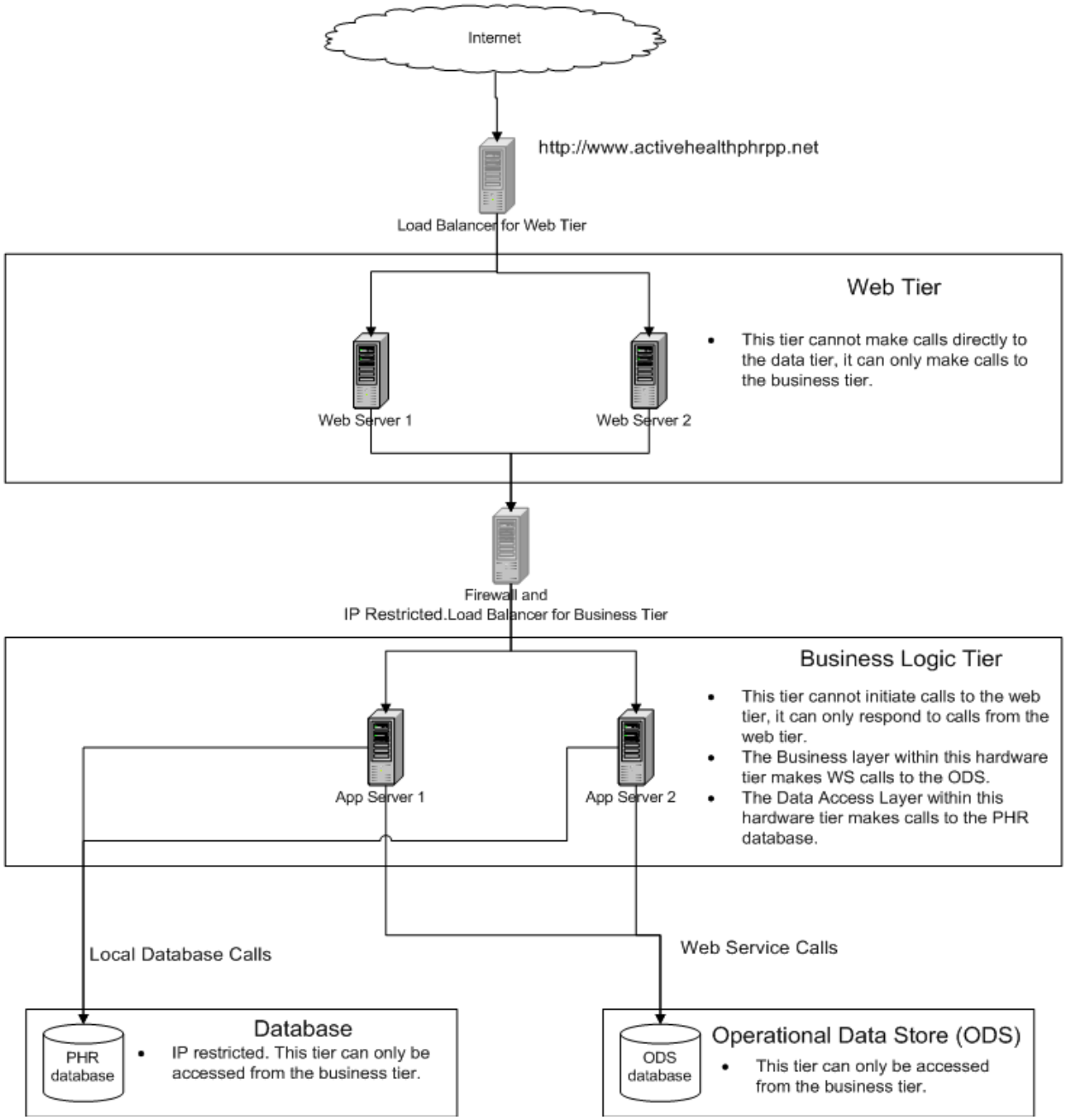
Across the Aetna umbrella of organizations, our corporate-wide 2012 plan currently calls for a total information technology spend of approximately $1.1 billion, with $403 million or 38 percent allocated to projects. Those projects include new applications development and significant enhancements as outlined below:

- Approximately $101 million or 25 percent to be invested in regulatory activities (Health Care Reform and ICD-10)
- Approximately $69 million or 17 percent to be invested in Integrated Front-End and application simplification
- Approximately $73 million or 18 percent to drive medical cost management
- Approximately $161 million or 40 percent to various investments in mobile applications, new system applications, etc.

QUESTION 4.1.3.2

Flow Chart:

Enterprise Architecture Overview



QUESTION 4.1.3.2

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

Security and information technology are managed in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:

Security and information technology are managed at each of our clinical operations centers, including our Greenwood Village location, and managed out of our New York City Headquarters.

ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

Integration with Other Vendors

Description:

ActiveHealth will set up completely integrated workflows, referral processes, and data feeds for our clients' third-party vendors, easing the referral and transfer processes thereby creating a seamless, best in class, member experience. During the implementation process we define the criteria and processes for integration with the plan sponsor's other vendors including the medical carrier, EAP, wellness, and disability. We use warm transfers as well as secure email and fax to support referral processes. We establish a case conference / grand rounds process with other vendors as well as establish ad-hoc processes for connecting with other vendors should issues arise outside of the grand round conference schedule. We also can share a summary level view into our care management workflow platform using our application ActiveAdvice View. This allows external entities who meet the requirements for access to member data to view eligibility for and participation status in various care management programs, as well as utilization and authorization details.

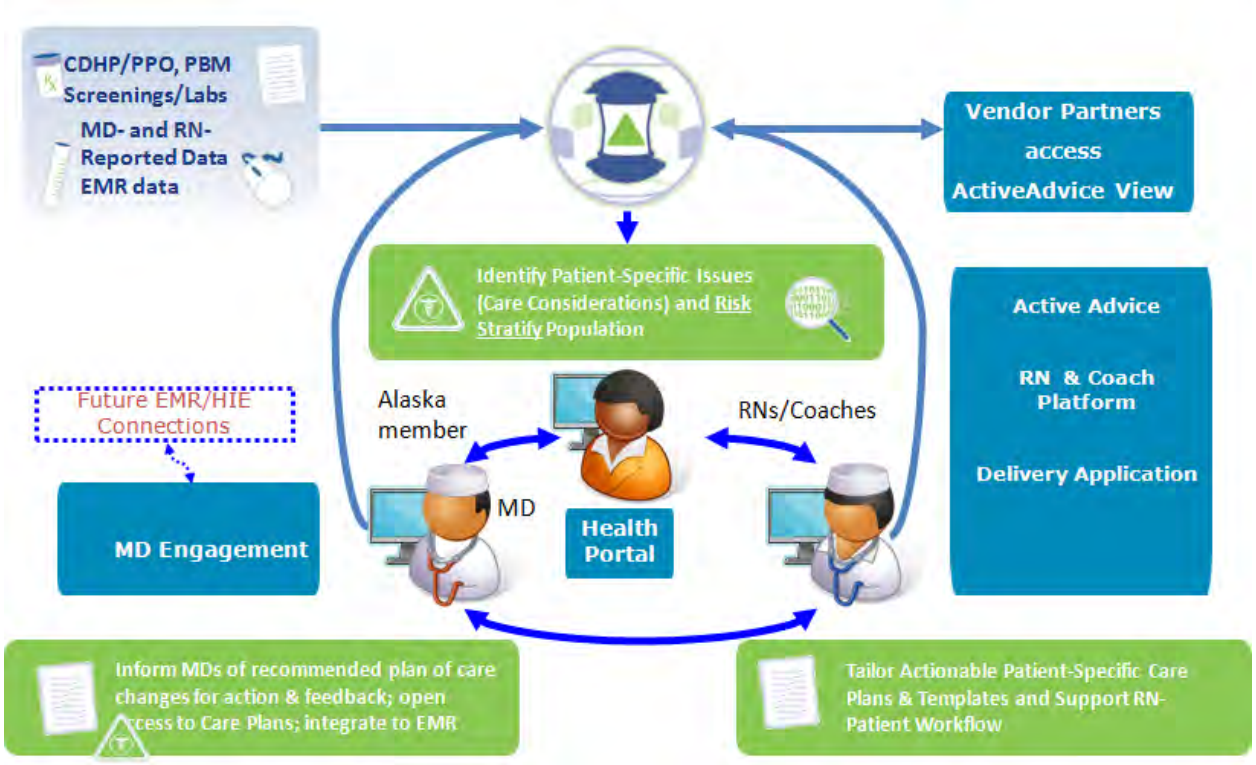
As an example of our ability to seamlessly integrate data, we note that ActiveHealth collects data from twelve health plans and other vendors for one of our clients. The key to the success of the project has been the consistent coordination of data transfer schedules across the various vendors. Ensuring that data are received according to a mutually agreed upon schedule enables us to meet the data update times per our agreements. For many of our clients, we've customized our technology platform and designed workflows to match their specific business models and to tie in directly to their required reporting and confidentiality requirements.

QUESTION 4.1.3.2

Data quality checks are performed throughout the data import processes. These data quality checks include, but are not limited to NDC Code validation, identification of meaningful/valid service dates, and completeness of clinical information. Patient identification is executed using key patient demographic fields, which are matched to Eligibility datasets through a standardized process for accurate patient assignment. Provider identification uses NPI and DEA master look-up tables for accurate provider assignment. If vendor specific issues arise, the starting point in the data integrity process is to review the initial reconciliation reports that were agreed to between HDMS and the vendors to uncover any potential issues. If the control balancing and reconciliation reports do not balance, then HDMS resources contact the appropriate vendor to validate internal totals.

Flow Chart:

Data integration and overall flow



Org Chart:

Please refer to our attached organizational chart exhibit.

QUESTION 4.1.3.2

Subcontractor:

ActiveHealth manages integration in-house through our data analytics division, HDMS, which imports, aggregates, cleanses, and formats all input data feeds. ActiveHealth applies a rigorous quality assurance process prior to transfer into the operational data store that powers all of our applications. ActiveHealth is a leader in designing, developing and processing very large, complex datasets.

Location/Hours of Operation/Point of Contact/Onsite Support:

Data integration is managed at each of our clinical operations centers, including our Greenwood Village location, and managed out of our New York City Headquarters.

ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

Patient Value Chain

Customer Service

Description:

ActiveHealth will provide staffing for the State's wellness program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by clinical and operational staff in our Greenwood Village, Colorado office. Greenwood Village is approximately a 20 minute drive from Denver and the Denver airport.

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

Not applicable unless the State purchases 24X7 Nurseline services from ActiveHealth, which would be subcontracted to our partner SironaHealth.

Location/Hours of Operation/Point of Contact/Onsite Support:

ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

QUESTION 4.1.3.2

Establishing Population Needs

Description:

i. Identification

ActiveHealth collects a diverse set of member data and runs it through a clinical predictive mode to identify candidates for lifestyle coaching, disease management and maternity. HRA and biometric screening results are combined with claims, pharmacy, laboratory, patient-reported (from telephonic and online coaching sessions) and physician-reported data to generate an internal "Member Health State". The member health state is comprised of hundreds of "Monitored Events" representing gaps-in-care as well as care patterns and markers of disease and pre-disease risks.

Before we can enroll, we identify members for Lifestyle, Maternity and Disease Management interventions by applying our CareEngine-powered identification and stratification rules (clinical predictive model) for the entire spectrum of health care services. Members are identified using all available data for the population, including Health Risk Assessment responses, biometric data, claims data (medical, procedural, pharmacy and lab) and member supplied data entered in the online personal health record or documented by one our coaches in our coaching sessions. The result of the scoring process is a clinical profile for each member that identifies issues across the continuum - ranging from lifestyle, at risk, to chronic and acute. Because members may have multiple issues and issues across the continuum, they are encouraged to participate and receive outreach for one program only, based on the following program hierarchy from highest to lowest priority: Maternity Management, Disease Management and Lifestyle Management.

All members of the population are stratified by risk level. ActiveHealth develops an Overall Opportunity Score which represents the degree to which lifestyle coaching or disease management has the opportunity to impact patients' clinical outcomes. The Overall Opportunity Score is the accumulation of Stratification Scores for each clinical stratification and identification matrix (Condition and Utilization) and points that are assigned to CareEngine Care Considerations. Selected Care Considerations are assigned points dependent on the clinical issue and contributes to the Overall Opportunity Score.

QUESTION 4.1.3.2

ActiveHealth also accepts members into the program based on self or other referral, such as from their treating provider, as well as other vendor program referrals, such as utilization management or EAP. In addition, we ask for daily utilization management files that are loaded into the CareEngine system. We will also integrate our program with external vendor programs and do so by adding vendor programs to our program hierarchy process. We recommend receiving daily data files from the vendors so we will know which members are participating in each vendor program. In addition, we are able to send ActiveHealth program participation data to the external vendors.

During the implementation process ActiveHealth will work with State and associated vendors to establish the hierarchy and "rules of the road" that determine which organization will provide outreach and engagement for various issues.

ii. Health Risk Assessment

The HRA is accessible through our online, phone or mail. Real time analytics power branching logic within the questions, leading to a personalized, unique assessment. After the member completes the online or telephonic HRA, immediate feedback and a Health Report is presented to the member. The report summarizes the results of the HRA and provides information to educate and spur action. If the biometric screening has already taken place prior to the member completing the HRA, the biometric screening results will have already been pre-populated into their PHR and will be reflected within the member's electronic Health Report. Conversely, if the member's biometric screening results are fed into our data vault subsequent to their HRA completion, they will update the member's electronic Health Report. The member would need to log into the web portal to access their updated Health Report.

A differentiator of our MyActiveHealth portal is the ability to provide members with a personalized and actionable list of action items, referred to as Health Actions. The Health Actions are derived via the complex clinical algorithms in ActiveHealth's CareEngine system. The list may include discussing Care Consideration alerts with their physician, participating in other programs such as health coaching, making lifestyle changes or other actions. Members see a completion score of their progress toward completing the Health Actions, along with an image of a 'running person' which signifies action and health. If an incentive is offered for the completion of the Health Assessment, a message may be shown on the member's home page that provides details about the incentive. ActiveHealth will pre-load external websites based on a member s clinical profile. Members also have the ability to add links to their favorite health websites.

QUESTION 4.1.3.2

Our HRA assesses the following risks:

- Biometrics
- BMI
- Waist circumference
- Blood pressure
- Lifestyle
- Safety (e.g. seatbelt use, home environment and fall risk)
- Tobacco use
- Alcohol (potential misuse/abuse/alcoholism)
- Physical activity
- Unhealthy diet (includes condition-specific diet)
- Mental Health
- Depression screen
- Stress level
- Routine healthcare needs
- Routine health evaluations (medical, dental, blood pressure, eye exams, etc.)
- Routine screening tests
- Future health conditions
- Obesity (based on biometrics above)
- Heart disease
- Diabetes
- Breast cancer
- Lung cancer

QUESTION 4.1.3.2

- Colon cancer
- Prostate cancer
- Skin cancer
- Current health conditions
- Exacerbations / complications of conditions
- Condition specific monitoring needs (e.g. lab or other evaluation for conditions like diabetes, cholesterol, anemia or bone disease)
- Medication Use
- Condition-specific adverse effects
- Polypharmacy
- Medication interactions (e.g. herbal / prescription)

iii. Biometrics

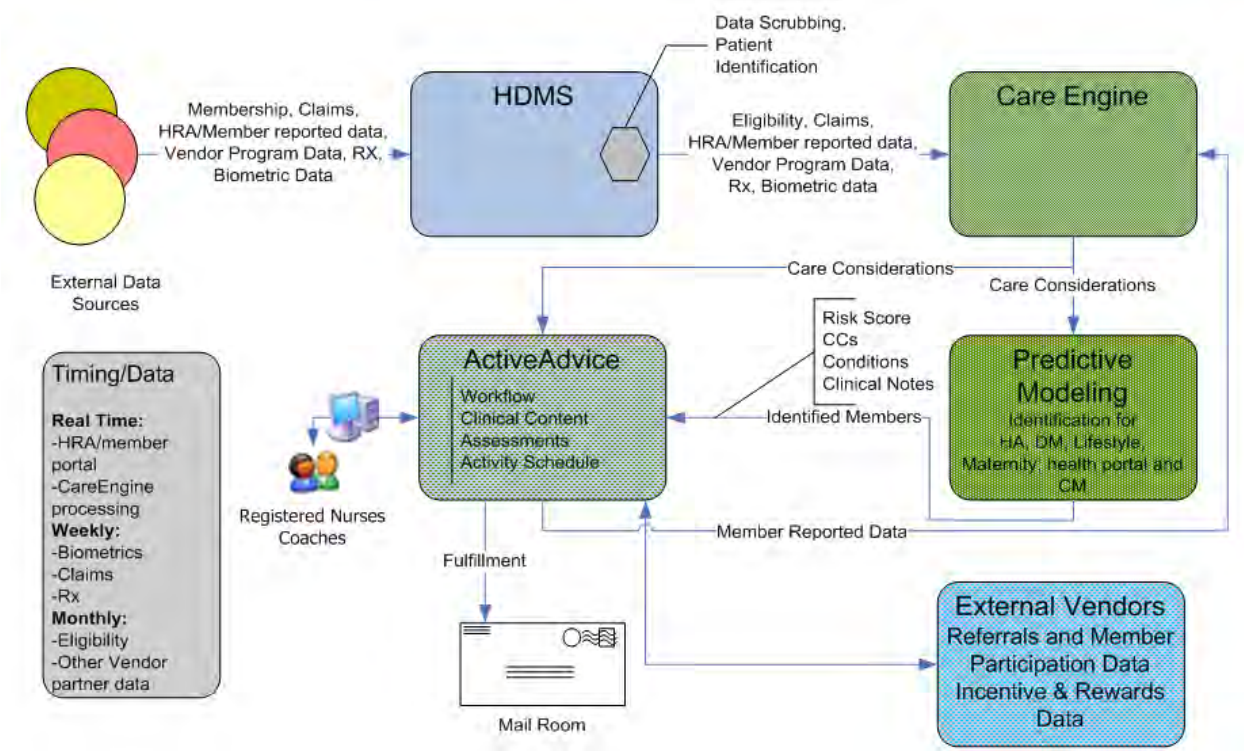
ActiveHealth will partner with our existing long term partner Summit Health because of their market expertise and extensive experience providing biometric screenings across the State of Alaska. Summit Health completed 200 health screening and flu shot clinics in Alaska during 2012 across the state including Anchorage, Fairbanks, Juneau, Ketchikan, Sitka, Kodiak, and the Kenai Peninsula. Summit Health also supplies home test kits, which will be important to reach all of the State's members while maintaining a cost effective solution. In 2012, Summit Health processed approximately 2,000 home test kits from Alaska residents.

ActiveHealth collects weekly batch files from Summit Health.

QUESTION 4.1.3.2

Flow Chart:

Clinical predictive model: timing & data flow



Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

ActiveHealth manages integration in-house through our data analytics division, HDMS, which imports, aggregates, cleanses, and formats all input data feeds. ActiveHealth applies a rigorous quality assurance process prior to transfer into the operational data store that powers all of our applications. ActiveHealth is a leader in designing, developing and processing very large, complex datasets.

Location/Hours of Operation/Point of Contact/Onsite Support:

Data integration is managed at each of our clinical operations centers, including our Greenwood Village location, and managed out of our New York City Headquarters.

QUESTION 4.1.3.2

ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

Outreach

Description:

The process for enrolling members in the various programs would focus on addressing a need within the continuum. First and foremost, this requires avoiding characterization of any of the health management and wellness activities in a way that would lead a participant to consider himself/herself identified or enrolled in a particular program (e.g., lifestyle management, disease or maternity management) rather than having a need to address within the continuum. The enrollment strategy will ensure the members experience these as a seamless continuum of health services, ranging in intensity from lifestyle management (least intensive), disease management (more intensive), and maternity management or referral to Case Management Vendor (most intensive).

Outreach Across the Entire Continuum of Care

Members are encouraged to participate and receive outreach for one program only, based on the following program hierarchy from highest to lowest priority: third party Case Management, Maternity Management, Disease Management and Lifestyle Management. Using our primary nurse coaching model, once the member is engaged for any issue, the same nurse or health coach will address other issues or will offer to co-manage with another specialty coach according to criteria (based on member status) and the member preference. If there are other issues to be addressed across the continuum, the primary nurse or health coach will address all of them or bring in other members of the care team to support the engagement process as described above. Using this approach, engagement is simplified and the concept of separate programs is transparent to the member as they navigate the health care continuum.

Maternity Management

Members identified by our predictive model rules or referrals from other programs receive outreach calls in an attempt to engage the member in the maternity program. ActiveHealth's maternity management program has the most impact when participants engage early - within the first 16-20 weeks of pregnancy. However, members may enroll at any point during their pregnancy.

QUESTION 4.1.3.2

Disease Management

Member identified for Disease Management are stratified across low, moderate and high risk opportunity levels. Members stratified as low opportunity are targeted for online engagement and can opt into telephonic coaching by self referring via calling our toll free line. Low opportunity members receive messaging in the member portal, MyActiveHealth, as well as an outreach letter promoting online and telephonic engagement.

Members identified as moderate and high opportunity are targeted for telephonic engagement and are supported by various online tools. Moderate and high opportunity members receive messaging in the online member portal, MyActiveHealth, as well as up to five outreach phone calls and four outreach letters. The outreach process includes the following elements:

* Introductory call and letter: The objective of the first automated introductory call and introductory letter are to introduce the program, build program awareness and encourage coach engagement.

* Invitation call and letter: Moderate and high risk members are then selected for additional outreach with the objective of promoting coach to member engagement. These members receive a second automated invitation telephone call followed by an invitation letter.

* Reminder calls and letter: Moderate and high risk members who have not yet engaged then receive up to two additional outreach telephone calls made by Customer Service Agents interspersed with one additional outreach letter.

* Unable to reach call and letter: If the member has not engaged after the outreach campaign, they receive one additional automated phone call and an "unable to reach" letter.

At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

Lifestyle Management

Member identified for Lifestyle Management are stratified across low, moderate and high risk opportunity levels. Members stratified as low opportunity are targeted for online engagement and can opt into telephonic coaching by self referring via calling out toll free line. Low opportunity members receive messaging in the online member portal, MyActiveHealth, as well as an outreach phone call and letter promoting online and telephonic engagement.

QUESTION 4.1.3.2

Members identified as moderate and high opportunity are targeted for telephonic engagement supported by the online program. Moderate and high opportunity members receive messaging in the member portal, MyActiveHealth, as well as up to five outreach phone calls and three outreach letters. The outreach process includes the following elements:

* Invitation call and letter: The objective of the first automated introductory call and introductory letter are to introduce the program, build program awareness and encourage coach engagement.

* Reminder calls and letter: Moderate and high risk members who have not yet engaged then receive a second automated phone call, followed by up to two additional outreach telephone calls made by Customer Service Agents interspersed with one additional outreach letter.

* Unable to reach call and letter: If the member has not engaged after the outreach campaign, they receive one additional automated phone call and an "unable to reach" letter.

At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

We also promote our programs from our member portal, MyActiveHealth, through messages posted to the portal as well as messaging generated from the member portal to the member's email. For example, MyActiveHealth provides members with a personalized list of action items, referred to as Health Actions. The Health Actions are derived via the clinical algorithms in ActiveHealth's CareEngine system. This ensures that a member is presented with appropriate, member-specific and actionable tasks to improve his or her health and to maximize savings. For example, Health Actions include recommendations to participate in one of our coaching programs, if the member has been identified as someone who will benefit from the program.

Flow Chart:

Please refer to exhibit 4.2.3.1 for Outreach & Engagement flow charts.

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

Not applicable; all outreach functions are performed by in-house staff.

QUESTION 4.1.3.2

Location/Hours of Operation/Point of Contact/Onsite Support:

ActiveHealth will provide staffing for the State's wellness program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by clinical and operational staff in our Greenwood Village, Colorado office. Greenwood Village is approximately a 20 minute drive from Denver and the Denver airport. ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

Incentives

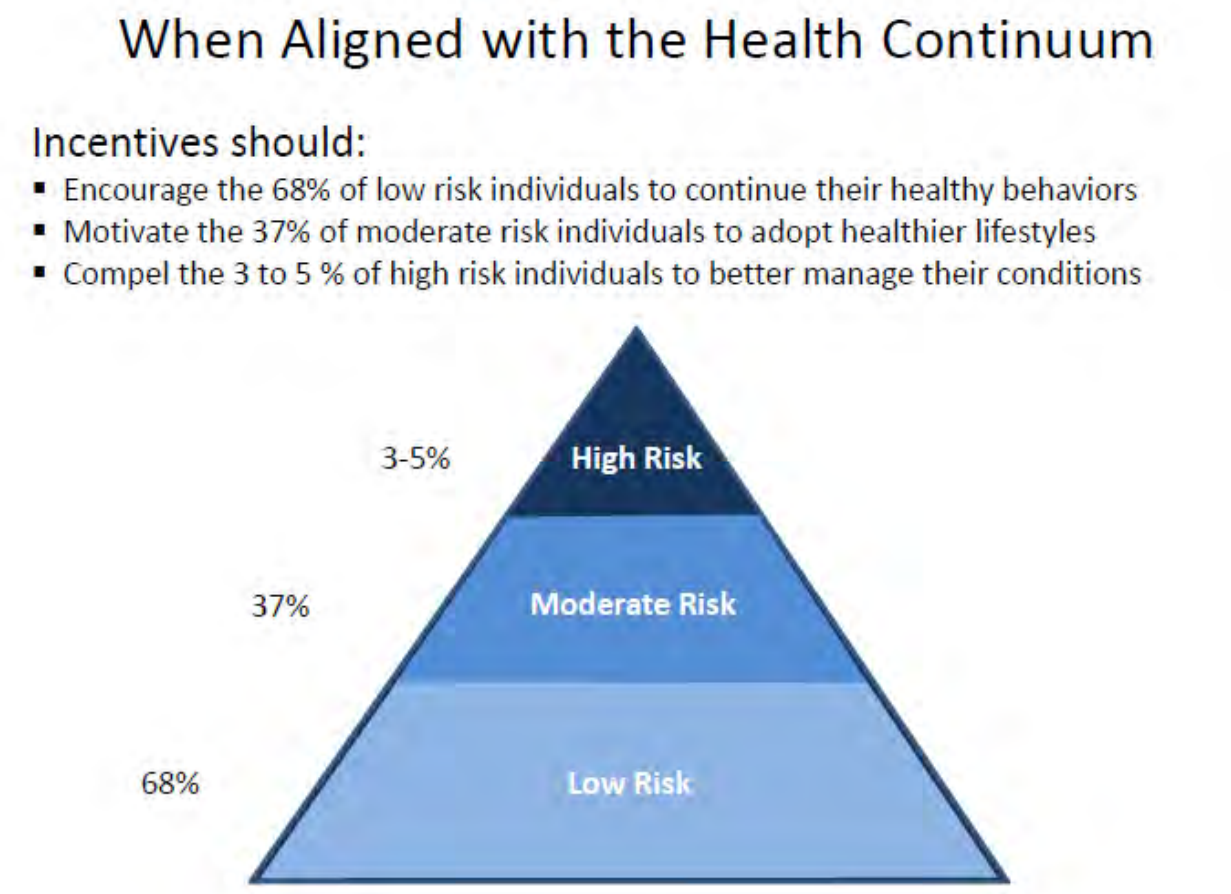
Description:

Each activity or program participation requirement can be tracked and incentivized on various levels, which the member can view as they progress through their program. Points, dollars and other ways to incent the member for each activity can be tracked and displayed on the tool to ensure each member is aware of their goals and their progress on a daily basis. Members will also be notified when they complete all their required activities and meet their goals to receive the full incentive.

Within the MyActiveHealth portal is a My Reward Center area. My Reward Center is a member facing incentive tracking tool that supports a number of various types of programs including a points-based one. The set up for the incentive program allows for various incentivized activities around the ActiveHealth products. Members are able to track their progress on a daily basis and see the actual dates they completed activities and the points earned for each activity. They are also notified on the tool when they reach their incentive goals and meet all their eligible incentive points.

QUESTION 4.1.3.2

Flow Chart:



Source: Janet L.Bruno M.D., M.A. Optum Health Solution, Incentive Strategy Design Best Practices. Culture of Health Institute, 2010

QUESTION 4.1.3.2

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

ActiveHealth will track whether the member meets the criteria for the incentive and coordinate with the organization fulfilling the incentive for no additional fee. We recently introduced an in-house Incentive Tracking tool, which allows participants to track their completed activities and progress and for clients to create a custom member level program.

Location/Hours of Operation/Point of Contact/Onsite Support:

ActiveHealth will provide staffing for the State's wellness program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by clinical and operational staff in our Greenwood Village, Colorado office. Greenwood Village is approximately a 20 minute drive from Denver and the Denver airport. ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

QUESTION 4.1.3.2

Participation

Description:

Using our primary nurse coaching model, once the member is engaged for any issue, the same nurse or health coach will address other issues or will offer to co-manage with another specialty coach according to criteria (based on member status) and the member preference. By applying our program hierarchy logic to the results of our clinical predictive model we are able to manage outreach and engagement so that members receive outreach for one program only. If there are other issues to be addressed across the continuum, the primary nurse or health coach will address all of them or bring in other members of the care team to support the engagement process as described above. Using this approach, engagement is simplified and the concept of separate programs is transparent to the member as they navigate the health care continuum.

Maternity Management

An expectant mother is enrolled in the program when she agrees to participate and completes a telephonic engagement session with one of our maternity nurses. Using the ActiveAdvice application and embedded maternity assessment tools, the nurse evaluates the member's current health status, obstetrical history, and medical history including the presence of any co-morbid conditions such as diabetes, hypertension, asthma, or HIV. Our assessment process evaluates members for complications of previous pregnancies or deliveries that may place expecting mothers at a higher risk, or require increased surveillance during this pregnancy.

Additionally, the initial interaction facilitates member education regarding regular pre-natal care. Nurses identify any gaps in pre-natal care and encourage adherence to the member's medical treatment plan. Examples of information collected and reviewed include:

* Estimated date of confinement (EDC).

* Pre-natal visits with their physician to date.

* Nutritional needs of a pregnant woman (e.g., a balanced diet).

* Member's current medications and supplements.

* Vaccinations, genetic testing and appropriate trimester screenings.

QUESTION 4.1.3.2

* Promoting a healthy pregnancy and lifestyle including educating member on the potential harm of smoking, drugs and alcohol use during pregnancy.

* Plan for follow-up visits.

* Diagnostic studies to date.

* Social and family issues or concerns, etc.

While our predictive model does assign an initial risk level based on analysis of available claims data, the initial assessment provides key information that might otherwise not be available via claims. Based on the results of the initial screening, our tool recalculates and updates the member's risk level assignment.

Once a risk level is determined, follow-up calls are scheduled at appropriate intervals. If the member is determined to be high-risk, the interactions with the member will occur monthly unless the member circumstances warrant more frequent contact. High risk members also receive a post partum call 2- 4 weeks following delivery. Moderate risk members received calls every 6-8 weeks and post partum. Low risk members receive follow-up calls at 28 weeks, 36 weeks, and post partum. After each interaction, a follow up letter including nurse coach contact information and educational materials are sent to the member.

Disease Management

The frequency of contact for engaged members is guided by their opportunity level as well as results of the assessment. Nurses use clinical judgment along with a flexible care plan development process, so they are able to schedule coaching sessions as often as needed. ActiveHealth encourages members to make unscheduled inbound calls, in between scheduled appointments, should the member have a new concern or question they would like to discuss with their assigned nurse. In addition, we will outreach to the member in between scheduled appointments, should we learn a new issue about the member that requires communication earlier than the next scheduled appointment. The average high opportunity member schedules nine to twelve engagement sessions per year. The average moderate opportunity member schedules six to nine engagement sessions each year. The average low opportunity member schedules four to six engagement sessions per year.

QUESTION 4.1.3.2

Lifestyle Management

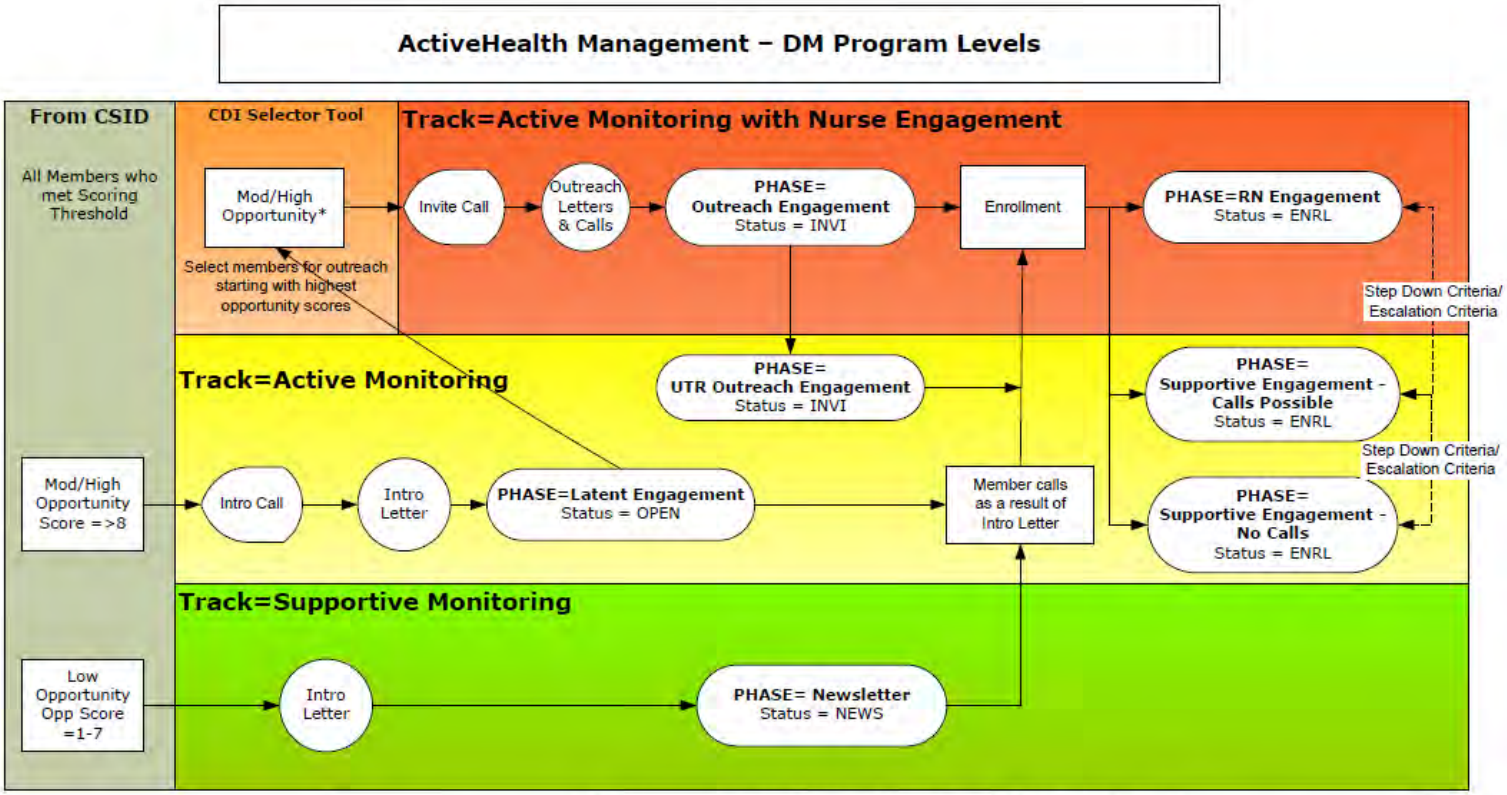
The frequency of contact for members engaged in the lifestyle management and coaching program is guided by their opportunity level, as well as the results of the assessment. Similar to the disease management program, lifestyle management coaches use clinical judgment along with a flexible care plan development process, so they are able to schedule coaching sessions as often as needed.

ActiveHealth encourages members to make unscheduled inbound calls, in between scheduled appointments, should the member have a new concern or question they would like to discuss with their assigned nurse.

In addition, ActiveHealth will outreach to the member in between scheduled appointments, should we learn a new issue about the member that requires communication earlier than the next scheduled appointment. Low, moderate and high opportunity members may schedule coaching sessions as frequently as weekly. Moderate and high opportunity members are offered unlimited weekly coaching sessions with the expected average number of sessions for moderate opportunity members at six and for high opportunity members at eight. Low opportunity members who self refer may engage in up to four sessions.

QUESTION 4.1.3.2

Flow Chart:



Notes:
Ongoing Re-scoring: If a member re-scores high enough to move from "Supportive Monitoring" to "Active Monitoring", the member would already appear in the Selector Tool. A member can never be downgraded to a lower engagement level via re-scoring.

CC Communication Methodology for All Program Levels

Track Type	Track Phase	Track Status	CC Severity & Level	CC Delivery Method
Active Monitoring Nurse Engagement	RN Engagement	Enrolled	Critical Level 1 & 2 Non-Critical Level 2 & 3	Phone Letter
Active Monitoring	Supportive Engagement- Calls Possible	Enrolled	Critical Level 1 & 2 Non-Critical Level 2 & 3	Phone Letter
Active Monitoring	Supportive Engagement- No Calls	Enrolled	All CC Severities & Levels	Letter
Active Monitoring Nurse Engagement	Outreach Engagement	Invited	Critical Level 1 & 2 Non-Critical Level 2 & 3	Phone Letter
Active Monitoring	UTR Outreach Engagement	Invited	All CC Severities & Levels	Letter
Active Monitoring	Latent Engagement	Open	Critical Level 1 & 2 Non-Critical Level 2 & 3	Phone Letter
Supportive Monitoring	Newsletter	News	All CC Severities & Levels	Letter

Org Chart:

Please refer to our attached organizational chart exhibit.

QUESTION 4.1.3.2

Subcontractor:

ActiveHealth will staff perform all aspects of the participation/engagement phase of the program.

Location/Hours of Operation/Point of Contact/Onsite Support:

ActiveHealth will provide staffing for the State's wellness program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by clinical and operational staff in our Greenwood Village, Colorado office. Greenwood Village is approximately a 20 minute drive from Denver and the Denver airport. ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

Effectiveness

Description:

We measure program utilization, clinical, operational, and financial performance using the following ActiveHealth Outcome Metrics:

* Utilization (assuming appropriate data are received) - hospitalizations for CAD, Diabetes, Asthma, COPD, CHF, Stroke; ER visits for Asthma, COPD, CHF

* Financial (assuming appropriate data are received) - CareEngine (resolved care considerations)

* Return on investment calculation information

* Clinical Indicators: Across 42 (36 adult and 6 pediatric) chronic conditions, the clinical indicators we select are those shown by evidence-based medical literature to have a compelling relationship to significant morbidity or mortality for the relevant conditions, representing modifiable risk.

* Functional status - e.g., asthma score, NYHA coronary artery disease functional status; GERD quality of life; MIDAS functional status for migraine.

* Behavioral - smoking cessation rates; changes in body-mass index.

QUESTION 4.1.3.2

Clinical outcomes for the CareEngine program are primarily measured in terms of the number of Care Considerations successfully resolved. We only report success when we actually receive claims evidence of compliance, e.g., that a recommended prescription was not only written by the physician, but was filled by the member. The quarterly reports show Care Consideration success rates by:

* Severity level

* Specific type of CC

* Major diagnostic category

Clinical outcomes for the program are specific to each clinical condition in disease management. Many are based on medical or pharmacy claims evidence (e.g., use of recommended medications for high cholesterol or cardiovascular risk factors, etc.) and some are based on self-reported information given to nurses such as achieving blood pressure or cholesterol target levels, stopping smoking, etc.

Behavior Change

Active Lifestyle Coaching captures behavior change associated with the following lifestyle topics: Tobacco use, elevated BMI, and nutrition, exercise and stress issues. Across all programs, behavior change outcome metrics include improvement in risk profile.

QUESTION 4.1.3.2

For all programs, including disease management, lifestyle coaching and maternity management, ActiveHealth effects, tracks and reports behavior change. Highly customized assessments embedded in our ActiveAdvice care management workflow platform measure behavior change, SMART goals, and are based on a member's individual clinical profile created by the CareEngine clinical stratification and identification algorithms. By generating very specific questions relative to identified conditions, the assessments support the acquisition of additional clinical information for use by the CareEngine System. Based on the answers to questions and utilizing branching logic, the assessments generate customized care plans which support individual SMART goal setting, interventions, and ongoing follow-up. The assessment tools also enable the primary nurse to provide member education and communication specific to the member's condition(s) and potential opportunities to improve their care. Communicating Care Considerations that have been converted from medical jargon to language easily understood by patients fully leverages our ability to achieve greater levels of compliance in correcting issues we identify for the specific member, as well as fostering behavior change. Additionally, the customized tools support the assessment of readiness to change, individualized educational opportunities and behavioral modification support so efforts can be directed at those issues most relevant to the patient. Members are coached on how to effectively interact with their physicians in a highly specific manner, further enhancing the information exchange between patient and physician. The overall result is a comprehensive patient-centric holistic approach to care management not limited to individual disease states.

Member-derived clinical data from the targeted assessments, such as blood pressure, weight, medications (including over-the-counter and herbal preparations), are quickly integrated into the CareEngine, providing an important source of new information. As new patient data enters the system, new clinical interventions can be defined instantaneously and communicated immediately if needed to physicians and patients that will inform and support the care plan as well as ensure the safety and optimal health of covered members.

Reduced risk

Please refer to the attached exhibits (4.2.6.1 Clinical Outcomes overview & 4.2.8.3 Savings Methodology) for detailed overviews describing ways in which our programs have reduced risks across populations similar to the State's.

Appropriate utilization

* Utilization (assuming appropriate data are received) - hospitalizations for CAD, Diabetes, Asthma, COPD, CHF, Stroke; ER visits for Asthma, COPD, CHF

QUESTION 4.1.3.2

Member satisfaction

We conduct a satisfaction survey for all members who enrolled in our program and who have been enrolled for 50 days and have conducted at least one follow-up assessment. Members are surveyed through an automated telephonic survey conducted by an independent third party vendor. A survey is administered after a member has been enrolled for 50 days with their Nurse Care Manager or wellness coach. The member satisfaction survey methodology is based on a five point Likert scale, which is the most widely used scale in survey research. When responding to a Likert questionnaire, members specify their level of agreement to a given statement. The objective of the survey is to measure member satisfaction with the disease management program, measure member's benefit from the disease management program, rate member satisfaction with their Nurse Care Manager, and identify any areas of concern or opportunities for improvement based on member satisfaction survey results. Survey results include response rate and percentage of respondents' answers for each possible response. A sample survey, including survey results is included with our proposal.

Return on investment

Please refer to our savings methodology overview (4.2.8.3 Savings Methodology).

QUESTION 4.1.3.2

Flow Chart:

Most-Impactible Hospitalizations are Reduced for Many Clients

Client	Products in Place During Study **	Approx # Members in Study Period	Baseline Period	Study Period	Relative Decrease in Hospital Admits	PMPM Savings*
Commercial Clients						
Retail Sales Network	CE, MM, WM, DM	16,000	1/06 –12/06	1/07-12/07	15.3%	$5.74
Financial Company	CE, MM, WM DM, LM, PHR	250,000	7/06 – 12/07	2009	14.3%	$3.77
Manufacturing Company	CE, MM, WM, DM, LM, PHR, RN	75,000	3/07 – 2/08	3/08-2/09	4.9%	$2.02
Service Company	CE, MM, WM, DM, PHR	225,000	10/06 – 9/07	10/07-9/08	3.5%	$1.16
State Employees	CE, MM, DM (CAD-DM-HF)	150,000	8/07 – 7/08	8/08 – 7/09 8/09 – 7/10	26.5% 28.1%	$4.00
Medicare Client						
Medicare Hi Risk	CE, MM, ADM	21,000	6/04 – 5/05	9/05-8/06	10.8%	$61.00

* Monetized; stated in 2009 dollars.
** CE: CareEngine; MM: Member Messaging; WM: Wellness Messages; LM; Lifestyle Management

QUESTION 4.1.3.2

Clinical Outcomes Improve

	Baseline CY 2010			12 MO END Q3 2011			
Metric	Denom	Numerator	Outcome	Denom	Numerator	Outcome	Change
Asthma: B-agonist overuse	2945	251	8.5%	2829	256	9.0%	0.5%
Asthma: ED Use per K mbrs with asthma per year	2873	187	65.1	2876	181	62.9	-2.15
Asthma: Hospital Use per K mbrs with asthma per year	2873	27	9.4	2876	23	8.0	-1.40
Asthma: Use of Appropriate Medications	2945	2593	88.0%	2814	2459	87.4%	-0.7%
Diabetes: HbA1c Rate	39449	32585	82.6%	38468	34201	88.9%	6.3%
Diabetes: Eye Exam	37841	10806	28.6%	38451	11330	29.5%	0.9%
Diabetes: LDL Monitoring	39449	29412	74.6%	38468	31206	81.1%	6.6%
Diabetes: Nephropathy Monitoring or Treatment	38000	32686	86.0%	38468	33937	88.2%	2.2%
Heart Failure: LVEF evaluation (ever)	1470	1363	92.7%	1631	1542	94.5%	1.8%
Heart Failure: Hospitalizations per K mbrs with CHF/yr	2326	593	254.9	2235	495	221.5	-33.47
Heart Failure: Readmission Rates (denom is admissions)	360	83	23.1%	297	64	21.5%	-1.5%
Adult Prevention: Breast CA Screening	173178	123455	71.3%	175324	122418	69.8%	-1.5%
Adult Prevention:Cervical CA Screening	241008	166782	69.2%	241459	173967	72.0%	2.8%
Adult Prevention: Colorectal CA Screening	173601	63138	36.4%	172329	71977	41.8%	5.4%

The population **improved** on 11 of 14 clinical outcomes metrics for the 12 months ending Q3 2011 compared to baseline 2010.

QUESTION 4.1.3.2

We reduce Lifestyle-related health risk factors

Risk Factor	Non Participants					All Participants				
	number of participants	Baseline Risk (# of risks per 100 participants)	Reduction in # of risks per 100 participants	% Change	p value for change	number of participants	Baseline Risk (# of risks per 100 participants)	Reduction in # of risks per 100 participants	% Change	p value for change
Alcohol	143	19	8.2	44%	0.00	87	21	7.1	34%	0.02
Blood pressure ☆	2,400	9	1.3	14%	0.00	3,142	13	3.9	30%	0.00
Body weight	4,465	39	1.1	3%	0.01	4,020	54	1.4	3%	0.00
Cholesterol ☆	352	5	-0.3	-6%	0.10	912	8	2.3	29%	0.00
Existing medical problem	1,183	12	-8.5	-71%	0.00	1,408	86	0.4	0%	0.03
HDL cholesterol	356	12	-7.5	-65%	0.00	779	16	-1.7	-11%	0.02
Perception of health ☆	2,876	5	-1.8	-33%	0.00	3,957	14	4.0	29%	0.00
Physical activity ☆	4,014	47	7.4	16%	0.00	2,812	47	12.2	26%	0.00
Smoking (tobacco) ☆	2,351	36	5.0	14%	0.00	1,227	47	15.5	33%	0.00
Stress	2,818	14	4.2	29%	0.00	1,390	18	4.4	24%	0.00
Sub Total		198	9*	5%			322	49*	15%	
Safety belt usage	475	49	31.7	64%	0.00	215	44	27.5	62%	0.00
Illness days in past year	2,118	14	-0.1	-1%	0.02	666	19	1.0	5%	0.03
Life satisfaction	253	56	6.5	12%	0.01	142	59	7.4	13%	0.01
Total	*6,578*	*318*	*48**	*15%*		*10,367*	*445*	*85**	*19%*	

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractor:

Not applicable

Location/Hours of Operation/Point of Contact/Onsite Support:

Reporting and outcomes analysis is performed out of our New York City based informatics group.

QUESTION 4.1.3.2

Healthcare Management Services

Description:

i. Wellness Services

Active Lifestyle Coaching is our dedicated lifestyle coaching program, emphasizing wellness components that are integral to all of our solutions. The purpose of the program is to identify the at-risk members in a population and impact them before they develop costly chronic conditions or other health issues. The program empowers individuals to quit tobacco, achieve their target weight, adopt healthier diets, develop healthy exercise habits and cope with stress. Health coaches establish an ongoing, telephonic relationship with each member and use various methods to encourage members to incorporate healthy behaviors and to achieve their lifestyle goals.

Our Active Lifestyle Coaching program fully integrates with other ActiveHealth programs to deliver a refined member experience. Active Lifestyle Coaching focuses on the following lifestyle issues:

- Weight Management
- Tobacco Cessation
- Healthy Nutritional Choices
- Physical Activity
- Stress Management

Identification

All member data including claims, health assessment, lab/test results, biometric data, etc., is analyzed by our predictive model to identify and stratify members who will benefit from Lifestyle Coaching. Similar to Disease Management, members are stratified as low, moderate or high risk based on their Clinical Risk Assessment (CRA) score.

Factors that drive the CRA score and assignment to various risk categories include at-risk elements such as at-risk for diabetes, pre-diabetes or cardiovascular disease; negative lifestyle behaviors such as tobacco use or elevated BMI; and presence of chronic conditions and co-morbidities. The combination and weighting of these factors drive the CRA score, which is mapped to the three risk categories.

QUESTION 4.1.3.2

Outreach and Engagement

Once the member has been identified, our outreach process starts. Moderate and high risk members are targeted for telephonic engagement with one of our Lifestyle Coaches. Low risk members receive mailed materials and can opt into telephonic engagement by calling the program. ActiveHealth introduced an online Wellness/Lifestyle module in our member portal, which is available for all risk groups. Our plan includes targeting low risk members for web based engagement while moderate and high risk members are targeted for coach engagement supported by the online program. At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

Engaged members are individuals who have been identified for the lifestyle management program, have been invited to engage with a coach due to being moderate or high risk, and have elected to work with a dedicated coach on an ongoing basis. Low risk members may also self refer for telephonic engagement with a coach. The engagement process includes targeted member assessment and supportive coaching to assist the member in establishing goals and a personalized plan of care to achieve the goals.

Care plan development through a primary coach model

Active Lifestyle Coaching applies motivational interviewing and other coaching techniques to facilitate healthy behavior changes across the continuum of health related life choices including weight, tobacco use, stress mitigation, nutrition and activity. Active Lifestyle Coaching uses a primary coach model where the same coach supports the member throughout the course of their engagement in the program. Member interaction with the coach may include discussion of Care Considerations, identification of base motivation, goal setting using SMART goals, and review of and support of strategies to achieve goals. Members also receive personalized follow up letters along with topic-specific brochures from their coach to reinforce information discussed during the telephone call. The coach will also suggest the member participate in various online educational follow-up activities at MyActiveHealth, such as picking up brochures, reading articles, documenting biometrics such as weight and blood pressure, and participating in other interactive programs.

At the end of each call, the coach will set up the next appointment. We make appointment reminder calls, and if the appointment is missed, we make another outreach attempt to reschedule the missed appointment. All members in the program are continuously monitored by the CareEngine regardless of level of engagement. Once members are identified for the program, member stratification may change based on new administrative data, member-derived information, and member progress.

QUESTION 4.1.3.2

The core philosophy of our lifestyle management program is to use motivational coaching and education tools to facilitate and integrate healthy behavior changes across the continuum of health-related life choices, including relaxation and stress mitigation, healthy nutrition choices, and maintenance of consistent activity levels. Coaches are trained to understand how to incorporate the Transtheoretical Model as developed by James Prochaska and Motivational Interviewing as developed Stephen Rollnick, Ph.D., & William R. Miller, Ph.D. The training takes place over a five week period with role plays, home work, and case reviews as some of the tools to help participants take these theories from the abstract to everyday practical application.

Regardless of whether we are coaching the member about chronic conditions or lifestyle issues, we utilize a personalized goal oriented approach to address where the member is on the health continuum. We incorporate cultural competency in our coaching, in order to make our discussions and recommendation more relevant and meaningful to the member. Our materials are in English and Spanish and we incorporate health literacy standards to make our materials more effective tools for our members.

Online lifestyle coaching features

Online components that members access through the MyActiveHealth web portal are a standard component of Active Lifestyle Coaching. Available by smart phone or web browser, the online program serves as both a supplement to a member who is working with a health coach as well as an additional engagement avenue for members who are low risk, who have not responded to our outreach efforts, or who prefer to work at their own pace rather than telephonically with a coach.

The online features include:

- Condition- and topic-specific pages that present general and member-specific health education information.
- Access to an incentives reward center
- Ability for the member to insert notes and provide other feedback and information
- Display of assigned Nurse Coach's name, toll-free number and direct extension
- The ability to email with your Nurse Coach (if currently working with a nurse)
- The ability to chat in real-time with a Nurse Coach
- Nurse Coach-recommended activities (i.e., homework assignments) in the member's website, including health-related articles, podcasts, videos and other online tools.

QUESTION 4.1.3.2

- Appointments scheduled with your Nurse Coach will display on the website
- Access to a robust online “Digital Coaching” program that provides members with support and information to make necessary lifestyle and behavioral changes
- “Call Me” form on specific Health Actions and Health Report
- Data persistency between MyActiveHealth and ActiveAdvice applications
- Ability to complete form and self-refer into program

Additionally, system integration points exist between the MyActiveHealth website and ActiveAdvice, the system platform ActiveHealth coaches use when working telephonically with members. Although this system integration is not visible to members, it is important in terms of overall care management. It prevents a member from having to provide the same information twice (one in MyActiveHealth and then a second time to the nurse) and ensure that the nurse is current on all important information. For example, if a member enters over the counter medications in the Personal Health Record within MyActiveHealth, that data is exported to ActiveAdvice so the nurse is aware. Another example is when a member provides information in order to complete a nurse-assigned homework item, that information is displayed to the nurse in ActiveAdvice.

An ActiveHealth nurse can, with a single click, open a member's MyActiveHealth site through the ActiveAdvice system. With the member's permission, the nurse will have a read-only view to assist the member with any questions.

ii. Nurse Call Line

By empowering employees to make informed healthcare decisions, your organization can improve appropriate utilization of healthcare resources while lowering your healthcare costs. Providing 24x7 Nurseline and health information services encourages employees to understand available healthcare resources and provides easy access to the most appropriate services and programs.

The telephone triage component of the Nurseline empowers members with symptomatic issues to obtain health information and advice and increases the appropriate use of healthcare resources. Callers with serious problems are encouraged to seek help immediately, avoiding dangerous and costly delays in initiating necessary care, and callers who do not require medical care are able to avoid unnecessary trips to emergency rooms and physician offices.

QUESTION 4.1.3.2

RNs educate members about their medical situation so they feel more confident about asking questions and pursuing appropriate healthcare options including choosing a doctor that is right for them or asking their doctor questions about their particular condition or treatment options. Members who call into the 24/7 nurse support line after hours will receive follow up from their regular nurse coaches within 24 to 48 hours of their call. Members also have access to an audio library on a wide range of health topics through this service.

Effective ongoing promotion is essential to the success of any Nurseline program. As part of the Nurseline service, employers receive a communications toolkit that includes print-ready electronic files of standard communications materials. These include a general service description, posters, seasonal reminders, and copy for the company's website.

Employers receive quarterly utilization reports that include call summary and management statistics, referral detail, employee satisfaction, and redirection analysis. In addition, clients receive standard call management reports on a monthly basis.

iii. Disease Management Programs

ActiveHealth provides an NCQA accredited disease management program to clients who understand that population-wide health improvement initiatives will lead to a cascade of benefits. Our clients are more productive and profitable; employees feel better and work better; health plans save money; and physicians are empowered to make better decisions.

Active Disease Management earnestly engages all parties in the decision making process. Targeted, member-specific information is communicated to both the member and the physician to help make smarter, more informed decisions about clinical care – one member at a time. Our unique approach and clinical technology foundation allows for better healthcare at lower costs. Active Disease Management:

- Focuses equally on physicians and patients in effecting behavior changes leading to improved clinical and financial outcomes;

- Identifies and targets impactable clinical issues that are communicated to physicians and patients with specific actions that can be taken to improve patient care;

- Customizes member engagement and education activities and intensity according to the member's specific clinical issues and medical needs;

- Targets resources to those members most likely to benefit from disease management interventions;

QUESTION 4.1.3.2

- Designs interventions and a plan of care around the member's complete set of conditions and co-morbidities;

- Maximizes multiple condition care by anticipating potentially harmful interactions between disease states;

- Integrates seamlessly with other internal and external care management programs, such as ActiveHealth's online web portal, HRA, lifestyle coaching, case management, UM, maternity, and incentive/reward programs;

- Savings over the first year of implementation exceed $3.10 per member per month, based upon a study involving a large-scale commercial population of 200,000 members.

Pinpointing members that need help managing their conditions

Our disease management program is "powered" by our proprietary CareEngine, which applies thousands of evidence-based clinical rules to aggregated member medical, pharmacy, and lab results along with self-reported data to uncover potential errors and instances of sub-optimal care.

The clinical predictive modeling rules are applied on a continuous basis to all members of a covered population, not just those with chronic illness, to find clinical improvement opportunities. The CareEngine also provides clinical decision support. For each opportunity identified, a "Care Consideration" is generated that identifies the clinical issue(s) found, and suggests a change in treatment that evidence-based literature and treatment guidelines indicate would improve the patient's care. These Care Considerations are communicated to treating physicians, our disease management nurses and members, each time a care improvement opportunity is identified by the CareEngine System®.

iv. Maternity Management

One of the primary tools of successful high-risk maternity management is patient education. Our High-Risk Maternity Program, supported by our ActiveAdvice Care Management System, contains an extensive assessment and educational information portfolio. As our high-risk maternity case manager interacts with the expectant mother, the system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG).

QUESTION 4.1.3.2

Plan design typically addresses identification by providing incentives for the mother-to-be that will motivate her to enroll and participate in the program. Identification of pregnant members may also occur through the utilization review process or referral by client, provider or member. To assure optimal impact of the program, members need to be identified and enrolled in the program by the 20th week of pregnancy.

The goals of the program include management of pregnant members to reduce the risks and costs associated with complications of pregnancy and premature birth. The program accomplishes this by continually assessing the member's risk status, then developing a personalized plan of care with interventions geared towards the member's risk, whether low, moderate or high.

The plan of care provides:

- Educational interventions geared towards maintaining a healthy pregnancy,
- focuses on appropriate care and monitoring during pregnancy,
- promotes self management through education and behavioral change techniques
- Identifies and manages risk through education and care management interventions.

v. Employee Assistance Program (EAP)

Our growth in EAP services has been a testament to our reputation for quality in customer service and clinical practice. We have over 20.5 million EAP covered members and are currently the third largest EAP in the industry with more than 2,400 clients. We also cover over 14.5 million behavioral health lives, making us the fifth largest behavioral health company in the country.

We are able to offer services that are not hindered by traditional processes, legacy systems, and over-burdened resources and personnel, realizing significant cost and process efficiencies for our clients and increasing employee satisfaction with our services. In short, we bring strengths to a client organization that is unparalleled within the industry.

We believe that a successful EAP is, first and foremost, the result of a vendor's ability to provide:

- A comprehensive continuum of care that works for your members
- **A fully-integrated EAP** that will provide access to timely and personalized services

QUESTION 4.1.3.2

- **Customized** services and ancillary products to meet member needs
- **24/7 access** to clinically-focused EAP and worklife services
- An **integrated approach** to physical, behavioral health management and EAP services
- **Industry leading website technology** and utilization reporting capability
- A single point of contact and client-focused account executive
- Crisis Response Specialists ready to assist the State of Alaska, its employees and supervisors
- A **partnership** where we understand the State's culture and anticipate your strategic vision and future direction

Custom Vision for State of Alaska

Our vision for the State of Alaska's EAP program is based on our unique understanding of government programs and needs. We provide EAP services to more than 120 state, county and municipal agencies with over 328,000 covered employees.

We coordinate care in many of those programs to raise the visibility of the EAP by connecting it with already recognizable and well communicated program elements such as ActiveHealth without creating another level or vendor in the employee benefits matrix. We are uniquely positioned to support an onsite EAP provider to serve at key State health service locations should the State choose this option. [1] The on-site EAP provider, trained by Aetna and ActiveHealth Management, will cross promote programs and medical plan resources, provide in-person counseling sessions and assist with coordination of training and other services.

Summary of Key Elements of Proposal

You will find our proposal unique and compelling in many respects. The following are among the important highlights of our proposed program for State of Alaska:

- A team of Management Consultants available telephonically 24 hours a day to assist with Crisis Response, Substance Abuse and Management Referrals
- On-site **Crisis Response Service Services**
- Onsite or web-based training
- **Performance guarantees** offering up to **20 percent of our fees at risk**
- A **three-year rate guarantee** to the State of Alaska to demonstrate our focus on partnering with you to achieve long term goals

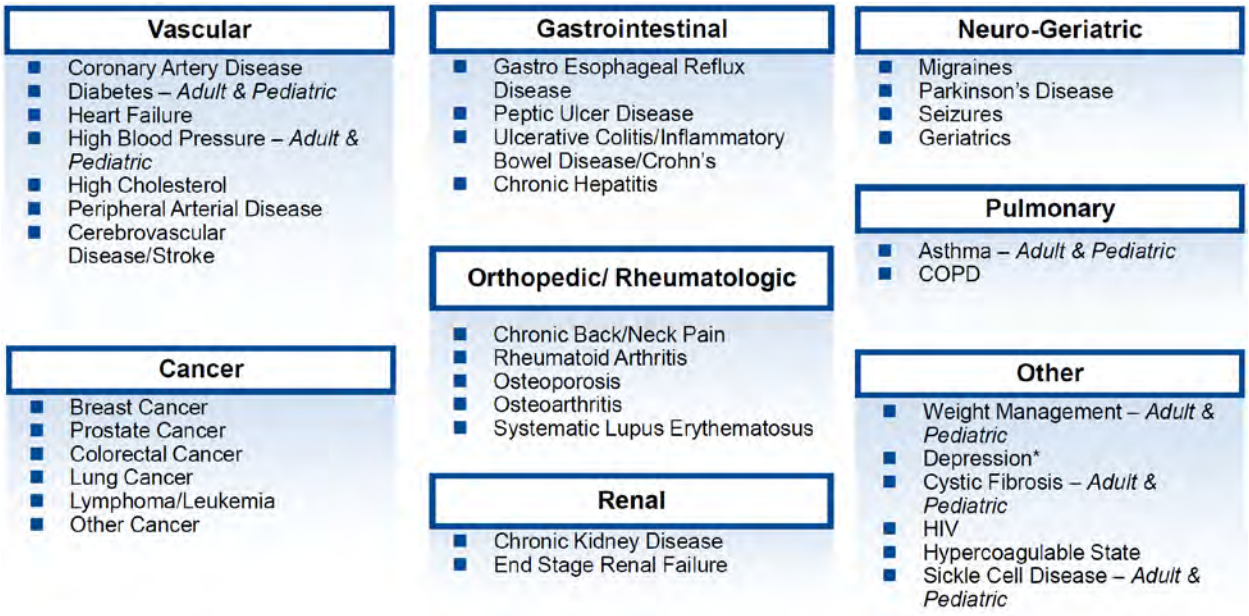
[1] On-site providers are subject to availability.

QUESTION 4.1.3.2

- A **designated account executive**
- The option of an onsite EAP provider for State employees who will provide:
  - Onsite short-term counseling
  - Lunch & Learn trainings
  - Management consultation
  - Onsite promotion at trainings and health services events
  - Assistance with making arrangements with our service center for continued counseling
- Our unparalleled **ability to identify members** through medical, pharmacy and other data sources, proactively engage those at risk, and facilitate the full integration of services[2]
- Standard and customized promotional and educational materials

Flow Chart:

Chronic conditions identified and managed by Active Disease Management



*Managed as a co-morbid condition

[2] Information and application will vary based on the benefits package purchased by the State.

QUESTION 4.1.3.2

EAP Flow Chart:

We propose a program that raises the visibility of the EAP by connecting it to recognizable and well communicated programs without creating another level or vendor in the employee benefits matrix. We are uniquely positioned to support this. We also have provided for the option of an on-site EAP provider, trained by Aetna and ActiveHealth Management, who can cross promote programs and medical plan resources during in-person counseling sessions and to larger audiences at lunch and learn trainings.

Org Chart:

Please refer to our attached organizational chart exhibit.

Subcontractors:

Disease management, maternity, lifestyle coaching and EAP is delivered completely in-house by ActiveHealth. Our 24x7 Nurseline service is subcontracted to SironaHealth.

We partner with other organizations to provide EAP related services to our clients. We base vendor selection on our comprehensive due diligence assessment of their ability to administer the required services.

QUESTION 4.1.3.2

Legal/Financial Benefits - We use a seamless warm-transfer process to provide legal and financial services through the same toll-free number used for EAP benefits. Our partner, CLC Inc. provides legal and financial services. Its national office is located in Granite Bay, CA.

The national network of more than 20,000 attorneys includes members of medium-sized law firms with a minimum of five years' experience in family law, real estate, probate, contract, consumer, and criminal legal matters. Attorneys must be fully licensed and qualified and cover the US, Canada, Puerto Rico and Virgin Islands.

The initial financial consultation is provided by one of 17 in-house specialists. Additional resources may include Consumer Credit Counseling, United Way, Catholic Charities, etc.

Backup Crisis Response Services - We provide Crisis response services through our national network and, where necessary, in partnership with Crisis Care Network (CCN). This ensures our members that these important services will be available when and where needed.

CCN is a distinguished provider of comprehensive crisis response services located in Grand Rapids, Michigan. This relationship became effective with the implementation of our program on July 1, 2004. We have aligned with this industry leader in this specialized field in order to allow our participants to have access to the most professional, contemporary and geographically diverse services available. CCN has ample national network coverage, with clinicians fully trained in the crisis response field.

We contract nationally with American Substance Abuse Professionals (ASAP) to enhance our substance abuse training network and provide Substance Abuse Professional (SAP) referrals. ASAP is continuously locating and recruiting qualified substance abuse professionals, as well as identifying areas that are in need of expanded coverage. ASAP has 1,575 counselors available nationwide (as of June 2012).

<u>Care Management Location/Hours of Operation/Point of Contact/Onsite Support:</u>

ActiveHealth will provide staffing for the State's wellness program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by clinical and operational staff in our Greenwood Village, Colorado office. Greenwood Village is approximately a 20 minute drive from Denver and the Denver airport. ActiveHealth's customer service program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

SironaHealth, our subcontractor for Nurseline services, is located in Maine and is open 24x7.

QUESTION 4.1.3.2

EAP Location/Hours of Operation/Point of Contact/Onsite Support:

Our operational service strategy uses a virtual call center model which allows us to have full access to all of our counselors in all time zones. Call Center locations include San Diego, Denver, Dallas, Austin and Hartford. This model increases operational efficiencies and enhances overall member experience by providing the right call routing based on customer preferences and needs.

For our service model, we take a service/skill approach rather than a geographical approach. Our virtual call center allows us to take full advantage of the efficiencies we have to offer our customers. Instead of limiting calls to one specific location, we have counselors located across time zones that are linked through a consistent platform and technology and are available for call routing based on skill sets and functions.

Quality Control

Calls are constantly monitored for quality using a variety of methods to meet the developing needs of the staff. ActiveHealth Management has the ability to record and retrieve calls through its Centricity Product, provided by Envision Telephony, Inc. Centricity allows our calls to be recorded and saved 24/7 through a web-based product platform called Envision Centricity. This system also allows recording of the data entry by the staff into our medical management tool and standardized templates used to evaluate the quality of the call. Centricity provides: workforce optimization, including analytics, performance management, workforce management, quality monitoring and e-learning.

Centricity allows supervisors to listen to calls, save calls and send coaching packages to staff for learning purposes. Supervisors meet with their staff to review opportunities for development. In addition, we have one way silent monitoring for telephone calls, preceptor programs that utilize side by side reviews and management side by side reviews of the staff.

Quality Assurance overview:

ActiveHealth's Quality Management (QM) program is driven by a Quality Improvement (QI) committee chaired by the Vice President of Operations and staffed by the Executive Vice President of Operations, the Medical Director, the manager of Quality Assurance and Regulatory Compliance, the Manager of Customer Service, and clinical managers. The committee meets on a quarterly basis.

QUESTION 4.1.3.2

Our Medical Director has primary authority and responsibility for the overall operation of our Quality Management program and, in this capacity, reviews and provides oversight of our company's Medical Management activities. Our Quality Assurance program has several primary objectives that include:

* Evaluate staff compliance with policies and procedures and assure consistency in Medical Management processes and procedures.

* Assure that ActiveHealth satisfies industry, federal and state standards and regulations regarding utilization review and case management services.

* Evaluate the effectiveness of ActiveHealth's medical management processes.

* Identify instances where medical care appears to be non-standard.

* Identify quality of care and outcomes issues based on industry directives.

* Identify opportunities for improvement and make recommendations to improve our overall processes and procedures.

Responsibilities of the QI committee include review of the following:

* QM program effectiveness (annually)

* Results of case audits (quarterly)

* Program statistics (quarterly)

* Findings of satisfaction surveys (annually)

* Disease management outcome measures (quarterly)

* Incidents and complaints to identify trends of poor quality of care or service (annually)

* Telephone access standards (quarterly)

* Review oversight of delegated services (annually)

The committee recommends corrective actions for adverse findings of quality monitoring activities.

QUESTION 4.1.3.2

Our CareEngine rules and related clinical content are reviewed and updated by ActiveHealth's Clinical Development Center in an ongoing quality improvement process. The Clinical Development Center staff includes 25 clinicians who are board certified physicians, pharmacists, and nurses. The primary role of the clinicians is to review the medical literature for evidenced-based clinical information that may enhance the CareEngine and its related services. The medical literature reviewed includes, practice guidelines, position statements of major medical organizations, standard medical journals, publications of clinical trials, and medical textbooks among other sources. In addition, a panel of academically-affiliated sub-specialty medical practitioners is consulted to clarify any ambiguities, potential controversies, or conflicting information identified.

As part of our quality improvement program, we review each of our over 1,000 existing Care considerations on a 12 to 24 month basis. The quality improvement process may occur earlier depending on the particular Care Consideration and the impact of new or emerging medical literature.

The QI committee additionally conducts regular case audits on randomly selected cases for all Nurse Care Managers. Additionally, for our utilization and care management programs, QI conducts audits on 100 percent of denials and appeals. Audit tools are designed to evaluate compliance with URAC standards.

Performance Guarantees

Please refer to our response to question 4.5.2 and the requested Attachment I3 –Healthcare Management Implementation and Performance Guarantees for the complete list of performance guarantees we are proposing for the State.

Data Analysis

i. Data Collection

ii. Reporting

Data Collection Description:

To facilitate ongoing flow of participation data, we have set up completely integrated workflows, web portal access and data feeds for our clients' third-party vendors, easing the referral and transfer processes thereby creating a seamless, best in class, member experience.

QUESTION 4.1.3.2

During the implementation process we define the criteria and processes for integration with the plan sponsor's other vendors including the medical carrier, UM/CM, EAP, wellness/disease management, disability, etc. We use warm transfers as well as secure email and fax to support referral processes. We establish a case conference / grand rounds process with other vendors as well as establish ad-hoc processes for connecting with other vendors should issues arise outside of the grand round conference schedule. We also can share a summary level view into our care management workflow platform using our application ActiveAdvice View. This allows external entities who meet the requirements for access to member data to view eligibility for and participation status in various care management programs, as well as utilization and authorization details.

As an example of our ability to seamlessly integrate data, we note that ActiveHealth collects data from twelve health plans and other vendors for one of our clients. The key to the success of the project has been the consistent coordination of data transfer schedules across the various vendors. Ensuring that data are received according to a mutually agreed upon schedule enables us to meet the data update times per our agreements. For many of our clients, we've customized our technology platform and designed workflows to match their specific business models and to tie in directly to their required reporting and confidentiality requirements.

ActiveHealth develops fully integrated, seamless member experience processes with other health plans, PBMs, and lab vendors as well as HRA, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility.

<u>Reporting Description:</u>

ActiveHealth will provide ongoing evaluation (quarterly and annual) of program activity, and of clinical, utilization and financial outcomes to measure program success - with the goal of improving the overall health of the State's population while reducing costs. During and after implementation we can utilize multiple communication paths and reports including:

Communication Activities:

- Status and delegation reporting.
- Bi-weekly conference calls.
- Quarterly, semi-annual and annual reports.
- Face-to-face visits to provide progress-to-date reports.

QUESTION 4.1.3.2

• Ongoing consultation with the State's designated staff on data findings, provisions of program recommendations and joint efforts to target potential performance improvement.

• Work with the State to refine ROI reports, conduct analyses and program satisfaction surveys, including data collection and coordination of resources and logistics.

Program Activities:

ActiveHealth's quarterly reports will include operational statistics for the CareEngine and disease management, such as;

• Number of Care Considerations (CC) issued to providers and to the State's members, by severity level, type of CC (perform a test, discontinue a drug, etc.) major diagnostic category, and specific clinical subject.

• Number of the State's members participating in disease management at each level of engagement.

• Number of the State's members identified with each clinical condition.

• Volume of outreach letters and telephone calls of each type.

• Types and volumes of clinical issues addressed by disease management nurses.

• Number of medication reviews by type.

• Health education activities by topic.

• Number of other interventions by type of intervention.

• Comparison of the State's statistics to benchmark levels.

Clinical Outcomes:

Clinical outcomes for the disease management program are specific to each clinical condition in disease management.

• Some are based on medical or pharmacy claims evidence, e.g., use of recommended medications for high cholesterol or cardiovascular risk factors, etc.

• Some are based on self-reported information given to our nurses, e.g., achieving blood pressure or cholesterol target levels, stopping smoking, etc.

QUESTION 4.1.3.2

Clinical outcomes for the CareEngine program are primarily measured in terms of the number of Care Considerations successfully resolved. We only report success when we actually receive claims evidence of compliance, e.g., that a recommended prescription was not only written by the physician, but was filled by the member. The quarterly reports show Care Consideration success rates by;

- Severity level.
- Specific type of Care Consideration.
- Major diagnostic category.

Utilization and Financial Outcomes:

ActiveHealth will deliver quarterly and annual ROI/Savings reporting. We can also report upon a list of hospitalizations that are impacted by our disease management programs.

Org Chart:

Our account management strategy includes a health data analyst that is dedicated to a new client during implementation and designated thereafter for ad hoc report generation and ongoing data quality analysis. The data analyst plays a much larger role when we provide data warehouse services that assimilate program information, as well as other health and financial data sources into a powerful and central resource to facilitate more informed, strategic decisions.

Please refer to our attached organizational chart exhibit for more information.

Subcontractor:

Not applicable; data analytics and reporting will be provided by ActiveHealth.

Location/Hours of Operation/Point of Contact/Onsite Support:

Reporting and data analytics will be driven from our Colorado clinical operations center, supported by our New York City-based clinical analytics team.

Financial

Please refer to the response to 2.1.3.2 for our organization's response.

QUESTION 4.1.3.2

State Objectives

Strong partnerships with healthcare providers starts with even stronger ties to healthcare innovators. Each member of the Aetna Accountable Care Solutions network is widely recognized as a market leader in its respective field. Combined, they create the end-to-end intelligent solution set that allows healthcare providers to deliver better care and better value at every touch point in the care delivery journey.

To support ACOs, the Active CareTeam Suite includes the following capabilities:

- **Population view and reporting:** Being able to quickly identify the population that requires attention, and drill down to the individual needing support or follow up is a key function in the new PCMH (Patient-Centered Medical Home), pay for performance and ACO (Accountable Care Organization) models of healthcare. Without access to physician and population-specific reports and tables, an organization will not be able to ensure systemic improvements and change in their patient population.
- **Financial analysis:** As more practices and organizations are taking on financial risk, the only way to succeed is to have a firm understanding of your patient population from clinical quality, outcomes, and financial perspectives. Using our Data Analytics and Reporting Tool (DART), Active CareTeam can identify and report trends and risk factors to drive financial viability.
- **Clinician-directed dashboard:** Powered by a clinical engine that analyzes all patient data in real time to identify gaps in care and care improvement opportunities. The Dashboard is designed to prioritize the most relevant clinical items with opportunities for intervention, allowing delegation and immediate follow-up actions.
- **Workflow management functions:** Allows timely patient follow up, proactive identification of patient “to dos” prior to visit, and messaging and communication between the entire care team.
- **Clinically relevant summaries:** Current EMRs provide access to data, but not in a format that is actionable and focused. Active CareTeam was designed by physicians for physicians to display relevant data, allowing quick clinical decision making and access to the full data set and history.
- **Patient education and management tools:** The patient is a key player in better managing clinical outcomes. Their education on clinical issues and compliance has a large impact on clinical results. ActiveCare Team has a patient portal and personal health record that provides access to patient education information and tools that drive compliance and facilitate communication between the care team and patient.
- **Seamless Integration & Scalability:** Active CareTeam has cloud-hosted options to decrease maintenance costs, and it is scalable to meet the needs of a growing health

QUESTION 4.1.3.2

system or ACO. The Active CareTeam is able to connect via any HIE to a vast majority of EMRs, lab, pharmacy, and payer systems. Active CareTeam also comes with human support to train your staff to get the most out of the product.

- **Care Management and Coordination:** Provides tools that identify both population and patient-specific gaps in care, and facilitate patient follow up and management in a coordinated fashion by the team of caregivers. Disease management services are currently offered through a disease registry platform. The system helps drive patient assessments, care plans and overall care management, allowing the entire care team to focus on the critical elements of patient care and follow up.

Case Study: North Carolina Patient Centered Medical Home Model

ActiveHealth launched a robust healthcare management program with the North Carolina State Health Plan (NCSHP) in 2011, providing Disease Management, Maternity, Nurseline, Lifestyle coaching, Portal and Mobile services. Since the program launch ActiveHealth has engaged 81 percent of eligible members in our healthcare management programs, delivering $163 Million in savings and an ROI of 6:1 across our combined programs.

North Carolina is one of the first states where the state health plan is instituting a broad-based strategy to move members toward a community-based Patient-Centered Medical Home (**PCMH)** model of care. In January of 2012, ActiveHealth began to identify and transition high-risk members -- those most in need of intensive management -- to participating primary care providers.

To enable an effective PCMH our provider based population health management tool, **Active CareTeam**, provides practitioners access to valuable, integrated and actionable patient data in the form of a condition registry stratified by risk level, dashboard. CMS and other customized quality metrics at the point of care.

<u>Outcomes to date:</u>

ActiveHealth has already enrolled over 135,000 members in our new provider based ACO solution with NCSHP, and will have PCMH models in 61 out of 100 counties by the end of 2013.

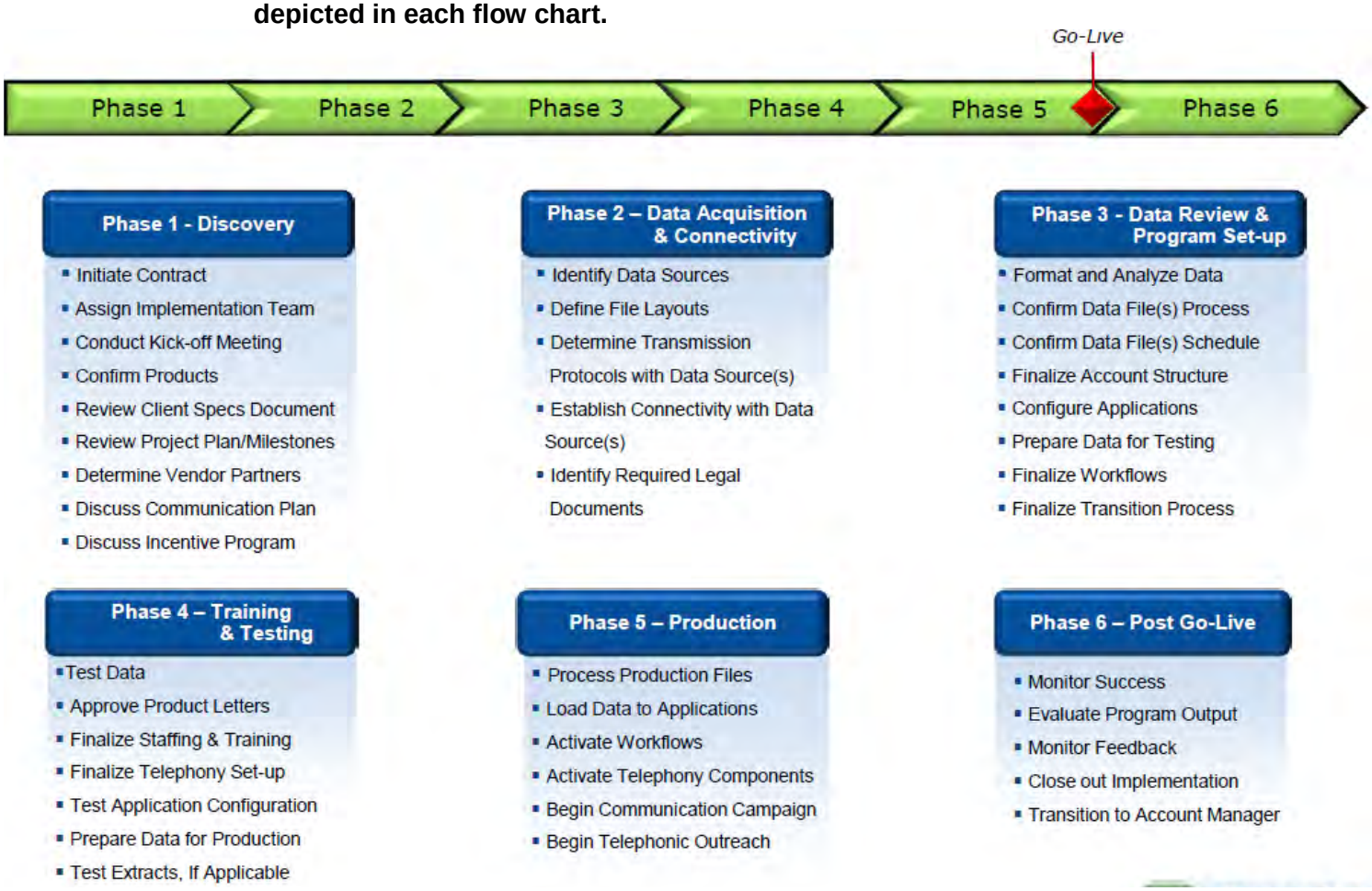
QUESTION 4.1.3.2

After just one year of providing disease, case management, maternity and lifestyle coaching services for members of the North Carolina State Health Plan for Teachers and State Employees (Plan), ActiveHealth Management (ActiveHealth®) has engaged 81 percent of eligible members in care management programs. Member engagement in these programs can help lead to better health outcomes through enhanced management of existing health conditions as well as members taking steps to address health risks identified through the program. ActiveHealth began providing disease management, case management and wellness coaching services for the Plan on January 1, 2011. Members are considered "engaged" after they have been contacted by ActiveHealth, and have agreed to participate and scheduled a follow-up appointment for the care management program. Now ActiveHealth is working with Community Care of North Carolina (CCNC) to implement local assistance for the highest-risk members and deploying its Active CareTeamSM technology to support the effort.

Please refer to the response to section 4.3 for more information**.**

4.1.4.1 Identify and describe, by function, how you will execute a successful implementation for each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Healthcare Management component. For each function, please provide:

1. **A work flow chart depicting how the implementation work associated with each function will be performed and a narrative describing the processes depicted in each flow chart.**



2. **Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.**

Our implementation plan exhibit shows each function and managing party. Across all aspects of implementation and ongoing account management, the ActiveHealth and Aetna team will serve as the primary account managers. ActiveHealth will lead Summit Health (biometric screenings) and SironaHealth (24x7 nurse advice line) programs.

3. **If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.**

ActiveHealth will lead Summit Health (biometric screenings) and SironaHealth (24x7 nurse advice line) programs.

Summit Health Biometric Screenings Vendor:
ActiveHealth will partner with our existing long term partner Summit Health (over six years with ActiveHealth & Aetna) because of their market expertise and extensive experience providing biometric screenings across the State of Alaska. Summit Health completed 200 health screening and flu shot clinics in Alaska during 2012 across the state including Anchorage, Fairbanks, Juneau, Ketchikan, Sitka, Kodiak, and the Kenai Peninsula. Summit Health also supplies home test kits, which will be important to reach all of the State's members while maintaining a cost effective solution. In 2012, Summit Health processed approximately 2,000 home test kits from Alaska residents.

SironaHealth Nurse Advice Line:
ActiveHealth has partnered with SironaHealth/IntelliCare for over six years. The SironaHealth management and operation teams have provided Nurse Advice Line services since 1997 under the brand names of SironaHealth and IntelliCare.

4. **If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.**

The ActiveHealth account management team leads all communication and coordinates reporting and flow of all functional services. Typically during implementation, we conduct daily status update calls to gauge progress on all tasks.

5. **Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.**

For all of our vendor partners and subcontractors, ActiveHealth establishes a set of quality metrics, Service Level Agreements (SLAs) and audit requirements - set in place and adhered to with financial penalty at risk. The contracts with our subcontractors specify those terms. We require Business Associate Agreements and security and confidentiality provisions in all our agreements. As PHI data is exchanged, a HIPAA agreement must be in place.

Summit Health Biometric Screenings Vendor:
Summit Health implements a continuous improvement program using the following steps:

1. Receive feedback from:
    a) Customer site coordinator
    b) Customer Account Executive
    c) Summit Health Local Staffing Managers
    d) Summit Health Account Executive & Program Manager
2. Identify areas for program improvements
3. Discuss and share feedback in daily conference calls over the course of a program.
4. Incorporate action items into future events
5. Update Procedure Manual (Customized)
6. Communicate target action items to Customer

Summit Health has an on-line Client Satisfaction survey that will be sent out to each site coordinator at the completion of their health screening.

SironaHealth Nurse Advice Line:
SironaHealth's purpose is to ensure all patients are directed to the next level of appropriate care with speed and compassion. We achieve this through our accreditation programs and robust quality architecture, which we refer to as "QCare".

The graphic below illustrates our approach to quality. The goal of the QCare program is to improve patient safety and satisfaction. Like most clinical organizations, we rely on metrics, standards, and call auditing to ensure quality. We incorporate the patient's perspective by closely monitoring and analyzing what they consider excellent service

Most organizations have the top three layers of the quality pyramid – in some form. However at SironaHealth, the foundation for all quality management activities is built upon a process control and statistical analysis system. Our commitment to quality and our unique application of statistical analysis to human intensive processes are significant differentiators for Nurse Advice Line services.

QCare, our quality architecture, defines Nurse and Medical Service Representative performance. Incentives are based on call quality and patient experience not on throughput. Data analysis and process auditing has taught us that one size does not fit all patients. Thus, we focus on providing timely, compassionate, and sound clinical advice rather than managing how much time is spent on the call. 100% of all inbound and outbound calls are digitally recorded and are available for review and audit on demand.

The QCare program consists of:

- Call monitoring and auditing programs employing inter-rater reliability.
- Daily, weekly, monthly, quarterly and annual reviews of all Call Center operations.
- Performance, tracking, trending, and identification of process improvement opportunities.

- Process Improvement Projects sponsored by senior management employing statistical process analysis techniques and Lean methodologies such as value stream mapping.
- 'Call Clarification' process for reporting, tracking and remediating all concerns or complaints raised by internal audits or customer feedback.
- Continuous customer satisfaction surveys.
- Predictive statistical methodology for identifying emerging areas of risk.
- Maintenance of URAC accreditation standards, for average speed to answer, average abandonment rate, average call back time, and average blocked call rate.
- Extensive education and training curriculums.
- Interdisciplinary senior management oversight from SironaHealth's Quality Improvement Review Committee.
- SironaHealth's Clinical Leadership and Quality Department's auditing process ensures:
- Complete documentation by clinical and non-clinical staff.
- Appropriate clinical dispositions.
- Appropriate clinical judgment.
- Superior customer service skills.

A component of QCare, the Q60 program, focuses our management team on service availability from the caller's perspective. Extensive use of control charts and member surveys gives us a clear picture of the "caller experience". Call center service metrics are analyzed and remediated by supervisors and managers daily. Weekly results are reviewed every Tuesday afternoon by the senior management team. This meeting examines the previous week's performance and corrective action plans.

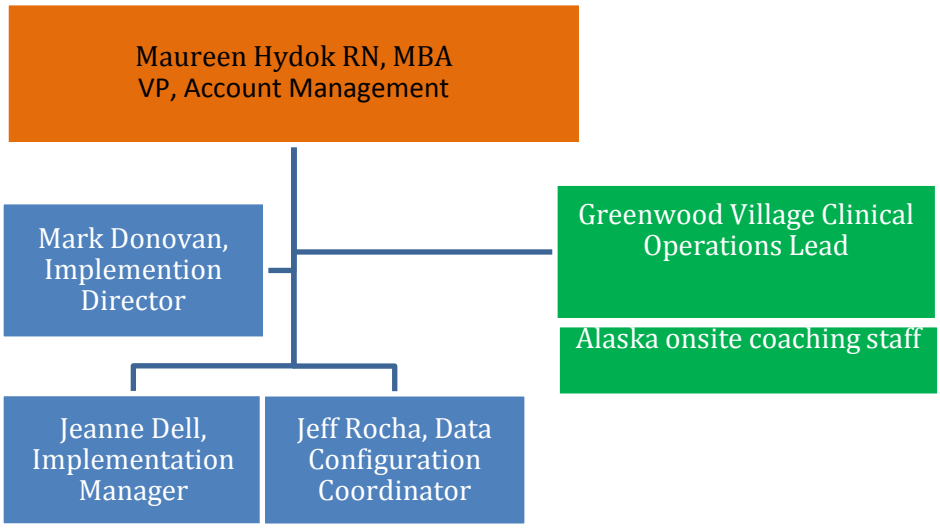
SironaHealth has also pioneered Statistical Process Control techniques (Human Intensive Process Control – HIPC) to gain a deeper understanding of the company's operations. In order to manage quality in a high volume clinical environment, a statistical model is needed to identify issues as they emerge.

For example, we use our statistical model to:

- Risk rate Nurses in training.
- Determine appropriate guideline adoption.
- Rate process adherence.

We believe trust and performance is achieved through a relentless focus on patients, processes, innovative mathematics, and employing a great group of Nurses and Medical Service Representatives.

6. **An organizational chart depicting the implementation management team structure.**



7. **Whether you will provide an Alaska-based implementation project manager during the term of the implementation.**

The implementation manager will be based out of our Greenwood Village, CO office and will travel to Alaska for key moments (implementation kick off and key meetings) throughout the implementation and during ongoing operations project set up that require onsite attention.

8. **The individuals who will comprise the implementation management team.**

ActiveHealth will assign a senior implementation manager, Jeanne Dell, based in Greenwood Village, Colorado. Jeff Rocha will be the Data/Configuration Coordinator, also based out of Greenwood Colorado.

9. **For each individual on the proposed implementation management team:**
    1. **name**
    2. **title**
    3. **physical work location where normally based**
    4. **years of industry experience**
    5. **years with organization**
    6. **level of educational attainment**
    7. **resume**
    8. **years in current position**
    9. **level and scope of decision making authority**
    10. **whether the individual management team member will be exclusively assigned to the implementation until completion. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the implementation.**

The State will be supported by a Maureen Hydok, VP of Account Management, responsible for:
-Coordinating day-to-day services
-Addressing questions from the State as single point of contact
-Managing an Implementation Manager & Data Configuration Coordinator
-The Implementation Manager and Data Configuration Coordinator are both supported by the Implementation Director for issue escalation or performance issues.

The VP of Account Management is able to alter scope from an operational perspective and has complete decision making authority over the program.

<u>Jeanne Dell – Implementation Manager</u>
Greenwood Village, CO

Jeanne has over 20 years of experience in group healthcare, holding key positions for some of the largest group insurance carriers in the country. Most recently, Jeanne worked for CIGNA Healthcare as a Client Wellness Strategist, driving consistent wellness program support, development, guidelines, product consultation, and client program implementations. Jeanne was also Product Manager for CIGNA Healthcare's wellness programs, where she was the product owner and subject matter expert. Additionally, Jeanne worked for Great-West Healthcare, serving as Senior Events Manager for Client Relations and Training Consultant for Plan Services. All of these roles have had a major emphasis on meeting and exceeding client needs.

Jeanne's role as Implementation Manager is to provide overall project management of the implementation. This includes developing and maintaining customized project plans, defining milestones and updating key stakeholders of the progress of the implementation and any associated risks. The Implementation Manager works with the Aetna and ActiveHealth teams (Account Manager, Operations Lead, Data Analyst and Data/Configuration Coordinator) to ensure the implementation is handled in an efficient and timely manner.

Jeffrey Rocha-Data/Configuration Coordinator
Greenwood Village, CO

As a data configuration coordinator for ActiveHealth, Jeff is responsible for managing data for various different implementations, as well as configuring internal requests for letter and plan note updates. Jeff started with ActiveHealth Management in 2008 in the Utilization Management department as a Customer Service Advocate, and with his exemplary performance was quickly promoted to a Customer Service Supervisor, managing a team of over 20 employees. In this role, Jeff was instrumental to assuring the measurement, performance and delivery of client performance guarantees, as well as training staff on new implementations including a major state health plan. During this time, Jeff was a silver award winner for the Aetna Way Excellence Awards for Constituent Focus and Service Excellence.
Prior to ActiveHealth, Jeff has 13 years of combined healthcare and call center experience, including working in data ingest and training on complex treatment planning software for multiple radiation oncology and cancer centers. In addition to this, Jeff has also had prior experience as a team leader for companies like Quest Imaging and T-Mobile.
Jeff is currently working on his Bachelor's Degree in Health Care Management from Metropolitan State University in Denver, CO with an expected graduation year of 2013.

Mark Donovan – Director, Implementation
Greenwood Village, CO

Mark Donovan is the Director of the Implementation Department for ActiveHealth Management. Mark has been with ActiveHealth for 4 years, beginning as an Implementation Manager. In this time Mark has managed over 40 client implementations, ranging from large complex municipal clients to major corporations wellness plans. Since taking over the team as Director, Mark has overseen several provider implementations, managing the complexities of the challenges presented.

Mark has 25 years of experience in group healthcare, and previously held several key management positions with MetLife, Great-West Healthcare and Guardian Life. Each of his roles has had a major emphasis on meeting and exceeding client needs.

10. **The geographic location where the work associated with each identified implementation function will be performed, including which implementation functions will be performed exclusively in Alaska.**

All implementation activities will be led from our Greenwood Village, CO office.

11. **For any implementation function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each implementation function.**

All implementation activities will be led from our Greenwood Village, CO office.

12. **The proposed point-of-contact for each implementation function.**

The State will be supported by a Senior Account Manager responsible for addressing questions from the State as the single point of contact.

13. **Timeline for implementation**

Please refer to the attached implementation plan exhibit.

14. **How often the implementation team will meet with the Project Director and/or his designee(s) and whether the implementation team leader will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the State.**

The implementation team will meet with the Senior Account Manager on a weekly basis or more often as needed. The implementation director will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the State.

Implementation Plan for ActiveHealth Products and Services

Developed for: State of Alaska

Products: CareEngine Physician and Member Messaging, Disease Management, Maternity Management, MyActiveHealth, Active Lifestyle Coaching, Biometric Program, Program Incentives and 24 Hour Nurseline

Go-Live Date 7/1/2013 **Start Date** 4/1/2013 **End Date** 8/15/2013

Phase	WBS	Tasks and Deliverables	Owner	Start	Finish	Status
Phase One	**1**	**Discovery/Kick-Off**	**Acct Manager; Imp Manager**	**4/1/2013**	**6/7/2013**	**Open**
	1.1	**Communicate State of Alaska Components and Products to Stakeholders at ActiveHealth**	**Sales Lead**	**4/1/2013**	**4/8/2013**	**Open**
	1.1.1	Complete Pre-Implementation Form and Submit to Implementation	Sales Lead	4/1/2013	4/8/2013	Open
	1.1.2	Internal Discussion in Preparation for Implementation	Account Team	4/1/2013	4/8/2013	Open
	1.2	**Letter of Intent/Contract**	**Sales Lead**	**4/1/2013**	**5/20/2013**	**Open**
	1.2.1	Initiate Letter of Intent	Sales Lead	4/1/2013	4/8/2013	Open
	1.2.2	Begin Contract Discussion/Review	Acct Manager; Sales Lead; State of Alaska	4/8/2013	4/22/2013	Open
	1.2.3	Finalize Contract/Contract Addendum	Acct Manager; Sales Lead; State of Alaska	4/22/2013	5/6/2013	Open
	1.2.4	Distributes Contract Internally to Stakeholders at ActiveHealth	Sales Lead	5/6/2013	5/20/2013	Open
	1.3	**Conduct Kick Off Meeting with State of Alaska**	**Acct Manager; Imp Manager; State of Alaska**	**4/8/2013**	**4/8/2013**	**Open**
	1.3.1	Obtain Cultural Overview from the State of Alaska for the Implementation Team	State of Alaska	4/8/2013	4/8/2013	Open
	1.3.2	Confirm ActiveHealth Purchased Product(s)	Imp Manager; Sales Lead; State of Alaska	4/8/2013	4/8/2013	Open
	1.3.3	Provide Product Letters for Review	Imp Manager	4/8/2013	4/8/2013	Open
	1.3.4	Provide Logo Requirements for Branding of Specific Letters and Envelopes	Imp Manager	4/8/2013	4/8/2013	Open
	1.3.5	Provide ActiveHealth Toll-Free Number(s) based on Products and Services	Imp Manager	4/8/2013	4/8/2013	Open
	1.3.6	Provide Hours of Operations based on Products and Services	Imp Manager	4/8/2013	4/8/2013	Open
	1.3.7	Identify External and Internal Team Members	Imp Manager; Sales Lead; State of Alaska	4/8/2013	4/8/2013	Open
	1.3.8	Determine Update Protocols	Acct Manager; Imp Manager; State of Alaska	4/8/2013	4/8/2013	Open
	1.4	**CareEngine Program**	**Imp Manager; Data Coordinator**	**4/8/2013**	**4/15/2013**	**Open**
	1.4.1	Provide/Discuss Data Specifications with State of Alaska	Imp Manager; Data Coordinator	4/8/2013	4/15/2013	Open
	1.4.2	Discuss Historical Claims Requirements for Products and Services	Imp Manager; Data Coordinator; AHDI Analyst	4/8/2013	4/15/2013	Open
	1.5	**ActiveAdvice Components**	**Imp Manager**	**4/8/2013**	**4/22/2013**	**Open**
	1.5.1	Provide Vendor Contact List for Completion	Imp Manager	4/8/2013	4/22/2013	Open
	1.5.2	Confirm eligible members (Spouses, Dependents, Pre-65 Retirees, Post-65 Retirees, COBRA)	Imp Manager	4/8/2013	4/8/2013	Open
	1.5.3	**Transitioning Members**	**Imp Manager; State of Alaska**	**4/8/2013**	**4/22/2013**	**Open**
	1.5.3.1	Determine if Transition Cases/Transitioning Vendor(s) is a Requirement	Imp Manager; State of Alaska	4/8/2013	4/8/2013	Open
	1.5.3.2	Provide Overview of Transition Process	Imp Manager; Operations; State of Alaska	4/8/2013	4/22/2013	Open
	1.5.3.3	Discuss Transition of Care Expectations	Imp Manager; State of Alaska	4/8/2013	4/8/2013	Open
	1.5.3.4	Identify Transitioning Vendors	Imp Manager; State of Alaska	4/8/2013	4/8/2013	Open
	1.5.3.5	Provide Requested Transition Data Elements	Imp Manager	4/8/2013	4/22/2013	Open
	1.5.4	Request Specific Plan Documents (SPDs) from State of Alaska	Imp Manager	4/8/2013	4/8/2013	Open
	1.6	**Disease Management Program**	**Imp Manager; State of Alaska**	**4/8/2013**	**4/22/2013**	**Open**
	1.6.1	Provide List of Conditions that are Implemented	Imp Manager; State of Alaska	4/8/2013	4/8/2013	Open
	1.6.2	Review Outreach Process with State of Alaska to Include Outreach Letters, Outreach Calls & Automated	Imp Manager; Operations	4/8/2013	4/22/2013	Open
	1.10	**Maternity Management Program**	**Imp Manager; State of Alaska**	**4/8/2013**	**4/8/2013**	**Open**
	1.10.1	Provide high-level product overview	Sales Lead; Operations	4/8/2013	4/8/2013	Open
	1.11	**MyActiveHealth (PHR) Program**	**Imp Manager**	**4/8/2013**	**4/29/2013**	**Open**
	1.11.1	Review registration elements (last name, first name , DOB, zip, gender, last 4 digits SSN)	Imp Manager	4/8/2013	4/29/2013	Open
	1.11.2	Inform State of Alaska that Health Risk Assessment is contained within MyActiveHealth	Imp Manager; State of Alaska	4/8/2013	4/29/2013	Open
	1.11.3	Review minor dependent access (through subscriber account only)	Imp Manager; State of Alaska	4/8/2013	4/29/2013	Open
	1.11.4	Review State of Alaska Options	Imp Manager; State of Alaska	4/8/2013	4/29/2013	Open
	1.11.5	Review Customer Support Process with State of Alaska	Imp Manager; State of Alaska	4/8/2013	4/29/2013	Open
	1.11.6	Review MyActiveHealth Member Communication Strategy with State of Alaska	Acct Manager; Imp Manager; State of Alaska	4/8/2013	4/29/2013	Open
	1.13	**Active Lifestyle Coaching Program**	**Imp Manager; Sales Lead; State of Alaska**	**4/8/2013**	**4/29/2013**	**Open**
	1.13.1	Confirm Active Lifestyle Coaching Components to be Implemented	Imp Manager; Sales Lead; State of Alaska	4/8/2013	4/29/2013	Open
	1.13.2	Determine Member Interaction with Program	Imp Manager; Sales Lead; State of Alaska	4/8/2013	4/29/2013	Open
	1.14	**ActiveHealth 24 Hour Nurse Line**	**Imp Manager**	**4/8/2013**	**5/6/2013**	**Open**
	1.14.1	Determine Phone Routing Requirements for 24 Hour Nurse Line	Imp Manager; Operations; State of Alaska	4/8/2013	4/29/2013	Open
	1.14.2	Complete and Submit ActiveHealth 24 Hour Nurse Line Implementation Form	Imp Manager; Operations	4/29/2013	5/6/2013	Open
	1.15	**ActiveHealth Reporting**	**Acct Manager**	**4/8/2013**	**5/13/2013**	**Open**
	1.15.1	Discuss Reporting Package With State of Alaska Based on Products Purchased	Acct Manager; Reporting Analyst	4/8/2013	4/29/2013	Open
	1.15.2	Finalize Applicable Performance Guarantees with State of Alaska	Sales Lead	4/29/2013	5/13/2013	Open
	1.15.3	Communicate Applicable Performance Guarantees to the ActiveHealth Team	Sales Lead	5/13/2013	5/13/2013	Open

Developed for: State of Alaska

Products: CareEngine Physician and Member Messaging, Disease Management, Maternity Management, MyActiveHealth, Active Lifestyle Coaching, Biometric Program, Program Incentives and 24 Hour Nurseline

Go-Live Date 7/1/2013 | **Start Date** 4/1/2013 | **End Date** 8/15/2013

Phase	WBS	Tasks and Deliverables	Owner	Start	Finish	Status
	1.16	**State of Alaska Communication Strategy**	**Imp Manager; Marketing; State of Alaska**	**4/8/2013**	**4/8/2013**	**Open**
	1.16.1	Discuss Communication Options for Communicating ActiveHealth Programs	Imp Manager; Marketing; State of Alaska	4/8/2013	4/8/2013	Open
	1.16.2	Develop Communication Plan based on Requirements and Budget	Marketing; State of Alaska	4/8/2013	5/23/2013	Open
	1.17	**Program Incentive**	**Imp Manager; Marketing; State of Alaska**	**4/8/2013**	**6/7/2013**	**Open**
	1.17.1	Determine if Program Incentives Exist	Imp Manager; State of Alaska	4/8/2013	4/8/2013	Open
	1.17.2	Discuss Process for Receiving Incentive	State of Alaska; Operations	4/8/2013	5/8/2013	Open
	1.17.3	Determine Process for Communicating Incentive and Required Support	Imp Manager; Marketing; State of Alaska	4/8/2013	6/7/2013	Open
	1.18	**Biometric Program**	**Acct Manager, Imp Manager, Biometric Rep**	**4/8/2013**	**5/8/2013**	**Open**
	1.18.1	Review Preferred Biometric Screening Approach	Acct Manager, Imp Manager, Biometric Rep	4/8/2013	4/8/2013	Open
	1.18.2	Review Planned Locations of Biometric Screenings	Acct Manager, Imp Manager, Biometric Rep	4/8/2013	4/22/2013	Open
	1.18.3	Discuss State of Alaska Culture and Communication Needs Related to the Screenings.	Acct Manager, Imp Manager, Biometric Rep	4/8/2013	5/8/2013	Open
Phase Two	**2**	**Data Acquisition and Connectivity**	**Imp Manager; Data Coordinator**	**4/8/2013**	**6/19/2013**	**Open**
	2.1	**Data Procurement**	**Imp Manager; Data Coordinator; State of Alaska**	**4/8/2013**	**4/22/2013**	**Open**
	2.1.1	**Determine Source/Contact for each CareEngine Data Component**	**Imp Manager; Data Coordinator; State of Alaska**	**4/8/2013**	**4/18/2013**	**Open**
	2.1.1.1	Initiate Discussions to Procure Each Required Data Type (Eligibility, Medical/Provider, Pharmacy)	Data Coordinator; AHDI Analyst; Source	4/8/2013	4/18/2013	Open
	2.1.1.2	Initiate Discussions to Procure Additional Data Types (Lab)	Data Coordinator; AHDI Analyst; Source	4/8/2013	4/18/2013	Open
	2.1.2	**Acquire Historical (Up to 24 Months) and Ongoing Data from Sources**	**Imp Manager; Data Coordinator; Source**	**4/8/2013**	**6/1/2013**	**Open**
	2.1.2.1	Provide Requested Data Fields to Sources for each Data Type	Data Coordinator; AHDI Analyst; Source	4/8/2013	4/22/2013	Open
	2.1.2.2	Request Data Release Agreements (DRAs) from Each Data Source	Imp Manager; Data Coordinator; Source	4/22/2013	4/29/2013	Open
	2.1.2.3	Review DRAs and Process for Signature	Data Coordinator; Source	4/29/2013	5/9/2013	Open
	2.1.2.4	Determine Transmission Protocols with Each Data Source	Data Coordinator; AHDI Analyst; Source	4/22/2013	4/29/2013	**Open**
	2.1.2.5	Complete Paperwork for the Secure File Transfer Protocol Setup	Data Coordinator; AHDI Analyst; Source	4/29/2013	5/9/2013	Open
	2.1.2.6	Establish Connectivity with each Data Source	Data Coordinator; AHDI Analyst; Source	5/9/2013	5/16/2013	Open
	2.1.2.7	Receive Test (Production) File from each Data Source	Data Coordinator; AHDI Analyst; Source	5/16/2013	5/23/2013	Open
	2.1.2.8	Receive Historical Files from each Data Source	Data Coordinator; AHDI Analyst; Source	5/27/2013	5/30/2013	Open
	2.1.2.9	Start Receiving Ongoing Production Files from each Data Source	Data Coordinator; AHDI Analyst; Source	5/27/2013	6/1/2013	**Open**
	2.6	**Disease Management Program**	**Imp Manager**	**4/22/2013**	**5/13/2013**	**Open**
	2.6.1	Coordinate with Transitioning Vendor(s)	Imp Manager; State of Alaska	4/22/2013	4/29/2013	Open
	2.6.2	Finalize File Transfer Process	Imp Manager; Data Coordinator; Source	4/29/2013	5/13/2013	Open
	2.10	**Maternity Management Program**	**Imp Manager**	**4/22/2013**	**5/13/2013**	**Open**
	2.10.1	Coordinate with Transitioning Vendor(s)	Imp Manager; ABD Prod Mgr; State of Alaska; PBM	4/22/2013	4/29/2013	Open
	2.10.3	Finalize File Transfer Process	Imp Manager; Data Coordinator; Source	4/29/2013	5/13/2013	Open
	2.11	**MyActiveHealth (PHR) Program**	**Acct Manager; Imp Manager**	**4/8/2013**	**5/13/2013**	**Open**
	2.11.1	Confirm Groups Eligible for MyActiveHealth	Acct Manager; Imp Manager	4/8/2013	4/29/2013	Open
	2.11.2	Assign URL	PHR IT Imp Mgr	4/29/2013	5/13/2013	Open
	2.13	**Active Lifestyle Coaching Program**	**Imp Manager; AHDI Analyst**	**4/29/2013**	**5/20/2013**	**Open**
	2.13.1	Confirm Eligibility File Components for Active Lifestyle Coaching Program	Imp Manager; AHDI Analyst	4/29/2013	5/20/2013	Open
	2.14	**ActiveHealth 24 Hour Nurse Line**	**Imp Manager; Operations**	**5/6/2013**	**5/27/2013**	**Open**
	2.14.1	Establish Connectivity with 24 Hour Nurse Line Team based on Telephony Requirements	Imp Manager; Operations; Telecom Tech	5/6/2013	5/27/2013	Open
	2.14.2	Confirm Eligibility File Components for 24 Hour Nurse Line Program	Imp Manager; Operations	5/6/2013	5/27/2013	Open
	2.17	**Program Incentive**	**Imp Manager; State of Alaska; Vendor Partners**	**5/8/2013**	**6/19/2013**	**Open**
	2.17.1	Coordinate Data Elements Needed to Report on Program Incentive	Acct Manager; Imp Manager; State of Alaska	5/8/2013	5/22/2013	Open
	2.17.2	Finalize File Format for Program Incentive Data Elements	Imp Manager; State of Alaska; Vendor Partners	5/22/2013	6/5/2013	Open
	2.17.3	Finalize File Transfer Process	Imp Manager; State of Alaska; Vendor Partners	6/5/2013	6/19/2013	Open
	2.18	**Biometric Program**	**Biometric Rep**	**4/22/2013**	**5/20/2013**	**Open**
	2.18.1	Determine Biometric Screening Availability Based on Geographic Locations	Biometric Rep	4/22/2013	5/6/2013	Open
	2.18.2	Deploy Draft Timeline and Plan for Each Location	Biometric Rep	5/6/2013	5/20/2013	Open

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Go-Live Date 7/1/2013 | **Start Date** 4/1/2013 | **End Date** 8/15/2013

Phase	WBS	Tasks and Deliverables	Owner	Start	Finish	Status
Phase Three	**3**	**Data Review and Program Set-Up**	**Imp Manager; AHDI Analyst**	**4/8/2013**	**7/1/2013**	**Open**
	3.1	**Determine Account Structure Based on Application Requirements**	**Imp Manager; AHDI Analyst**	**4/8/2013**	**6/3/2013**	**Open**
	3.1.1	Develop Account Structure for Set-Up	Imp Manager; Config Coordinator; Reporting Analyst	4/8/2013	4/29/2013	Open
	3.1.2	Approve Account Structure based on Breakout	Acct Manager; State of Alaska	4/29/2013	5/13/2013	Open
	3.1.3	Approve Account Structure based on Eligibility Data Elements	AHDI Analyst	5/13/2013	5/13/2013	Open
	3.2	**AHDI Data Review**	**AHDI Analyst**	**5/20/2013**	**6/3/2013**	**Open**
	3.2.1	Analyze Data	AHDI Analyst	5/20/2013	5/27/2013	Open
	3.2.2	Troubleshoot Data Issues	Data Coordinator; AHDI Analyst	5/27/2013	6/3/2013	Open
	3.2.3	Sign-Off on Data for Each Data Type	AHDI Analyst	6/3/2013	6/3/2013	Open
	3.2.4	Process Data based on Program Requirements	AHDI Analyst	5/27/2013	6/3/2013	Open
	3.4	**CareEngine Program**	**Imp Manager; AHDI Analyst**	**4/29/2013**	**6/7/2013**	**Open**
	3.4.1	Finalize Workflows with Service Center	Imp Manager; Operations	4/29/2013	5/6/2013	Open
	3.4.2	Request Supplier IDs	AHDI Analyst	5/6/2013	5/13/2013	Open
	3.4.3	Complete ActiveHealth Setup in Admin Tool	Config Coordinator	5/13/2013	5/27/2013	Open
	3.4.4	Verify Appropriate Set-Up in Admin Tool	ABD Prod Mgr; ABD IT	5/27/2013	6/3/2013	Open
	3.4.5	Set Up Supplier Care Considerations	Acct Manager; State of Alaska	6/3/2013	6/7/2013	Open
	3.5	**ActiveAdvice Components**	**Imp Manager**	**4/22/2013**	**6/3/2013**	**Open**
	3.5.1	Confirm Vendor Partner Information based on the Vendor Contact List	Imp Manager	4/22/2013	5/6/2013	Open
	3.5.2	Confirm Process for Each Vendor Partner	Imp Manager; Operations	5/6/2013	5/20/2013	Open
	3.5.3	Finalize Workflows with Service Center	Imp Manager; Operations	5/20/2013	6/3/2013	Open
	3.5.4	Confirm Completion of Application Configuration for Workflow Components	Imp Manager	6/3/2013	6/17/2013	Open
	3.13	**Active Lifestyle Coaching Program**	**Imp Manager**	**5/20/2013**	**6/3/2013**	**Open**
	3.13.1	Confirm Program Set-Up in Progress based on State of Alaska Requirements	Imp Manager	5/20/2013	6/3/2013	Open
	3.14	**ActiveHealth 24 Hour Nurse Line**	**Imp Manager; Operations**	**5/27/2013**	**6/17/2013**	**Open**
	3.14.1	Build Account within IntelliView	SironaHealth	5/27/2013	6/10/2013	Open
	3.14.2	Confirm Program Set-Up in Progress based on State of Alaska Requirements	SironaHealth	6/10/2013	6/17/2013	Open
	3.15	**ActiveHealth Reporting**	**Acct Manager**	**5/13/2013**	**6/24/2013**	**Open**
	3.15.1	Confirm Account Structure Meets Reporting Requirements	Acct Manager	5/13/2013	6/3/2013	Open
	3.15.2	Perform Billing Setup with Accounting and State of Alaska	Acct Manager	6/3/2013	6/17/2013	Open
	3.15.3	Set-Up Reporting in Parameter Tool	Acct Manager	6/17/2013	6/24/2013	Open
	3.17	**Program Incentive**	**Acct Manager; Imp Manager; State of Alaska**	**5/8/2013**	**6/5/2013**	**Open**
	3.17.1	Document Program Incentive Requirements	Acct Manager; Imp Manager; State of Alaska	5/8/2013	5/22/2013	Open
	3.17.2	Document Program Incentive Selection Criteria	Acct Manager; Imp Manager; State of Alaska	5/22/2013	6/5/2013	Open
	3.18	**Biometric Program**	**Biometric Rep**	**5/20/2013**	**7/1/2013**	**Open**
	3.18.1	Finalize Biometric Screening Schedule Based on State of Alaska Input	Biometric Rep	5/20/2013	6/1/2013	Open
	3.18.2	Initiate Location Coordination	Biometric Rep	6/1/2013	7/1/2013	Open
	3.18.3	Coordinate Communication Efforts Based on Schedules and Locations	Biometric Rep	6/1/2013	7/1/2013	Open
Phase Four	**4**	**Training and Testing**	**Imp Manager; Operations**	**4/8/2013**	**7/1/2013**	**Open**
	4.1	**Telephony Components**	**Imp Manager**	**6/3/2013**	**7/1/2013**	**Open**
	4.1.1	Confirm Initial Call Scripting to be Implemented	Imp Manager	6/3/2013	6/10/2013	Open
	4.1.2	Program Phone Based on Requirements	Telecom Tech	6/10/2013	6/24/2013	Open
	4.1.3	Test Telephony Components	Operations	6/24/2013	7/1/2013	Open
	4.2	**Staffing, Space and Equipment, Training**	**Operations**	**4/8/2013**	**5/8/2013**	**Open**
	4.2.1	**Staffing**	**Operations**	**4/8/2013**	**5/13/2013**	**Open**
	4.2.1.1	Determine Staffing Requirements	Operations	4/8/2013	4/22/2013	Open
	4.2.1.2	Recruit/Hire Staff	Operations	4/22/2013	5/13/2013	Open
	4.2.2	**Space and Equipment**	**Operations**	**4/22/2013**	**6/3/2013**	**Open**
	4.2.2.1	Determine Space and Equipment Needs	Operations	4/22/2013	5/13/2013	Open
	4.2.2.2	Coordinate Space and Equipment Set-Up	Operations	5/13/2013	6/3/2013	Open
	4.2.3	**Training**	**Operations**	**5/13/2013**	**5/22/2013**	**Open**
	4.2.3.1	Develop Training Materials	Operations	5/13/2013	6/3/2013	Open
	4.2.3.2	Train Staff on Process Flows and Systems	Operations	6/3/2013	6/13/2013	Open

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Go-Live Date 7/1/2013 | **Start Date** 4/1/2013 | **End Date** 8/15/2013

Phase	WBS	Tasks and Deliverables	Owner	Start	Finish	Status
	4.3	**Product Letters**	**Imp Manager**	**6/3/2013**	**6/3/2013**	**Open**
	4.3.1	Receive Approval From State of Alaska on Product Letters	State of Alaska	4/8/2013	5/8/2013	Open
	4.3.2	Submit Approved Letters for Setup	Imp Manager	5/8/2013	5/22/2013	Open
	4.3.3	Confirm Completion of Letter Configuration	Data Coordinator	5/22/2013	6/5/2013	Open
	4.3.4	Test Letter Templates in the System	Imp Manager; Data Coordinator	6/5/2013	6/19/2013	Open
	4.3.5	Coordinate Ordering of Preprinted Materials for the Program(s)	Imp Manager	6/19/2013	6/29/2013	Open
	4.4	**CareEngine Program**	**Imp Manager; Operations**	**6/7/2013**	**6/14/2013**	**Open**
	4.4.1	Test Set-Up and Data	Imp Manager; Operations	6/7/2013	6/14/2013	Open
	4.5	**ActiveAdvice Components**	**Imp Manager; Config Coordinator**	**6/17/2013**	**6/27/2013**	**Open**
	4.5.1	Test Set-Up and Data	Imp Manager; Config Coordinator	6/17/2013	6/27/2013	Open
	4.6	**Disease Management Program**	**Acct Manager; Imp Manager**	**6/16/2013**	**6/27/2013**	**Open**
	4.6.1	Provide Automated Call Information for Set-Up	Imp Manager; Operations	6/16/2013	6/16/2013	Open
	4.6.2	Obtain File(s) of Transition Cases	Acct Manager; Imp Manager	6/13/2013	6/20/2013	Open
	4.6.3	Prepare File for Loading into ActiveAdvice	AHDI Analyst	6/20/2013	6/27/2013	Open
	4.10	**Maternity Management Program**	**Imp Manager**	**6/13/2013**	**6/27/2013**	**Open**
	4.10.1	Obtain File of Transition Cases	Imp Manager; Operations; State of Alaska	6/13/2013	6/20/2013	Open
	4.10.2	Prepare File(s) for Loading into ActiveAdvice	Int Manager	6/20/2013	6/27/2013	Open
	4.11	**MyActiveHealth (PHR) Program**	**Acct Manager; Imp Manager; State of Alaska**	**5/13/2013**	**5/31/2013**	**Open**
	4.11.1	Obtain Home Page Welcome Text from State of Alaska	Acct Manager; Imp Manager; State of Alaska	5/13/2013	5/13/2013	Open
	4.11.2	Obtain Customer Logo (If co-branding desired)	Imp Manager	5/13/2013	5/13/2013	Open
	4.11.3	Submit MyActiveHealth Set-Up spreadsheet	Imp Manager	5/13/2013	5/15/2013	Open
	4.11.4	Review and Sign Off on MyActiveHealth URL Assignment, Logo and Welcome Message	PHR IT Imp Mgr; Acct Mgr; PHR Prod Mgr; State of Alaska	5/29/2013	5/31/2013	Open
	4.13	**Active Lifestyle Coaching Program**	**Imp Manager**	**5/23/2013**	**6/20/2013**	**Open**
	4.13.1	Submit Eligibility Test File for Active Lifestyle Coaching Program	AHDI Analyst	5/23/2013	5/30/2013	Open
	4.13.2	Confirm Integration of Active Lifestyle Coaching Program with ActiveHealth's Programs	Imp Manager	6/13/2013	6/20/2013	Open
	4.14	**ActiveHealth 24 Hour Nurse Line**	**Operations**	**5/23/2013**	**7/1/2013**	**Open**
	4.14.1	Submit Eligibility Test File for 24 Hour Nurse Line Program	AHDI Analyst	5/23/2013	5/30/2013	Open
	4.14.2	Test Inbound Calls and Call Routing	Operations	6/17/2013	6/24/2013	Open
	4.14.3	Test Front-End Greetings	Operations	6/17/2013	6/24/2013	Open
	4.14.4	Test Outbound Communications	Operations	6/24/2013	7/1/2013	Open
	4.16	**State of Alaska Communication Strategy**	**Marketing; State of Alaska**	**4/8/2013**	**6/6/2013**	**Open**
	4.16.1	Coordinate Communication Strategy with State of Alaska	Marketing; State of Alaska	5/23/2013	6/6/2013	Open
	4.16.2	Finalize State of Alaska Communication Materials	Marketing; State of Alaska	6/6/2013	7/21/2013	Open
	5.16.1	Begin Communication Campaign based on the Communication Plan	Marketing; State of Alaska	7/21/2013	8/24/2013	Open
	4.17	**Program Incentive**	**Acct Manager; Imp Manager**	**6/3/2013**	**7/1/2013**	**Open**
	4.17.1	Train Staff on the Incentive	Operations	6/3/2013	6/24/2013	Open
	4.17.2	Document Incentive Requirements in the Application	Config Coordinator	6/10/2013	6/24/2013	Open
	4.17.3	Test the Incentive Extract	Acct Manager; Reporting Analyst	6/24/2013	7/1/2013	Open
Phase Five	**5**	**Production**	**Imp Manager; Operations**	**6/3/2013**	**7/31/2013**	**Open**
	5.1	**Initiate Production**	**AHDI Analyst**	**6/3/2013**	**7/1/2013**	**Open**
	5.1.2	Process Production Files for Programs	AHDI Analyst	6/3/2013	6/13/2013	Open
	5.1.3	Launch Telephony Components	Telecom Tech	7/1/2013	7/1/2013	Open
	5.4	**CareEngine Program**	**NY IT; Operations**	**7/1/2013**	**7/8/2013**	**Open**
	5.4.1	Notify CareEngine Project Manager that Data is Available for the CareEngine Run	Imp Manager	7/1/2013	7/3/2013	Open
	5.4.2	Load Files into ODS	IT Ops	7/3/2013	7/3/2013	Open
	5.4.3	Select Account to Run in ODS	Operator	7/3/2013	7/4/2013	Open
	5.4.4	CareEngine Run Occurs	Operator	7/4/2013	7/5/2013	Open
	5.4.5	Load CRS Production	Operator	7/5/2013	7/6/2013	Open
	5.4.6	Confirm Portal Access	Imp Manager; Operations	7/6/2013	7/6/2013	Open
	5.4.7	Deliver 1st Care Considerations to Physicians	Operations	7/6/2013	7/8/2013	Open
	5.4.8	Deliver 1st Care Considerations to Members	Operations	7/8/2013	7/8/2013	Open

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Go-Live Date 7/1/2013 **Start Date** 4/1/2013 **End Date** 8/15/2013

Phase	WBS	Tasks and Deliverables	Owner	Start	Finish	Status
	5.5	**ActiveAdvice Components**	**Imp Manager; Int Manager**	**6/3/2013**	**6/14/2013**	**Open**
	5.5.1	Load Eligibility into ActiveAdvice	Int Manager	6/3/2013	6/13/2013	Open
	5.5.2	Load Transition Files into ActiveAdvice, if applicable	Int Manager	6/9/2013	6/14/2013	Open
	5.6	**Disease Management Program**	**Imp Manager; Operations**	**6/3/2013**	**7/7/2013**	**Open**
	5.6.1	Confirm Portal Access for DM Program	Imp Manager; Operations	7/6/2013	7/6/2013	Open
	5.6.2	Notify Operator that Data is Available for Initial Run	Operations	6/3/2013	6/13/2013	Open
	5.6.3	Initiate Outreach to Members that were Transitioned	Int Manager	7/1/2013	7/29/2013	Open
	5.6.4	Run Care Consideration Logic, Clinical Stratification and Identification and Scoring	Operator	7/5/2013	7/7/2013	Open
	5.6.5	Identify members through Common Data Interchange (CDI) for Introductory Notification	Operator	7/5/2013	7/7/2013	Open
	5.6.6	Initiate Automated Disease Management Calls	Vendor	7/7/2013	7/9/2013	Open
	5.6.7	Generate Disease Management Introductory Letter to Members	Mail Management	7/7/2013	7/9/2013	Open
	5.6.8	Identify members through Common Data Interchange (CDI) for Outreach Notification	Operator	7/9/2013	7/16/2013	Open
	5.6.9	Initiate Telephonic DM Outreach Calls to Members	Operations	7/16/2013	7/17/2013	Open
	5.6.10	Initiate All DM Workflows	Operations	7/17/2013	7/17/2013	Open
	5.10	**Maternity Management Program**	**Operations**	**7/1/2013**	**7/5/2013**	**Open**
	5.10.1	Initiate Outreach to Members that were Transitioned	Operations	7/1/2013	7/5/2013	Open
	5.10.2	Initiate All Maternity Workflows	Operations	7/1/2013	7/5/2013	Open
	5.11	**MyActiveHealth (PHR) Program**	**PHR IT Imp Mgr**	**5/31/2013**	**7/1/2013**	**Open**
	5.11.1	Ensure data loaded into ODS for MyActiveHealth display	PHR IT Imp Mgr	5/31/2013	6/7/2013	Open
	5.11.2	Notify ODS to ensure registration export file is sent to CRS/Portal	PHR IT Imp Mgr	5/31/2013	6/7/2013	Open
	5.11.3	Schedule Clinical Stratification & Identification run prior to MyActiveHealth go-live	PHR IT Imp Mgr	5/31/2013	6/3/2013	Open
	5.11.4	Confirm Set-up	PHR IT Imp Mgr	5/31/2013	6/7/2013	Open
	5.11.5	Activate MyActiveHealth	PHR IT Imp Mgr	6/30/2013	7/1/2013	Open
	5.11.6	**MyActiveHealth Flyer**	**Imp Manager**	**5/29/2013**	**6/8/2013**	**Open**
	5.11.6.1	Order MyActiveHealth Flyer for Inclusion in Disease Management Follow-Up Letter	Imp Manager	5/29/2013	6/8/2013	Open
	5.11.6.2	Notify QA1 Team for Content Inclusion	Imp Manager; Clinical Content Coordinator	5/29/2013	6/8/2013	Open
	5.13	**Active Lifestyle Coaching Program**	**Imp Manager; Operations**	**6/3/2013**	**7/1/2013**	**Open**
	5.13.1	Submit eligibility production file	AHDI Analyst	6/3/2013	6/8/2013	Open
	5.13.2	Activate Active Lifestyle Coaching Team	Operations	6/8/2013	7/1/2013	Open
	5.13.3	Activate Active Lifestyle Coaching Tools	Operations	6/8/2013	7/1/2013	Open
	5.14	**ActiveHealth 24 Hour Nurse Line**	**Imp Manager; Operations**	**6/3/2013**	**7/1/2013**	**Open**
	5.14.1	Submit eligibility production file	AHDI Analyst	6/3/2013	6/28/2013	Open
	5.14.2	Activate 24 Hour Nurse Line Team	Operations	6/28/2013	7/1/2013	Open
	5.14.3	Activate 24 Hour Nurse Line Feedback Extract	Operations	6/28/2013	7/1/2013	Open
	5.15	**ActiveHealth Reporting**	**Acct Manager**	**6/24/2013**	**7/1/2013**	**Open**
	5.15.1	Distribute Reporting Schedule	Acct Manager	7/1/2013	7/1/2013	Open
	5.16	**State of Alaska Communication Strategy**	**Acct Manager; State of Alaska**	**7/1/2013**	**7/31/2013**	**Open**
	5.16.1	Begin Communication Campaign based on the Communication Plan	Marketing; State of Alaska	7/1/2013	7/31/2013	Open
	5.17	**Program Incentive**	**Acct Manager; Imp Manager**	**7/1/2013**	**7/1/2013**	**Open**
	5.17.1	Activate Incentive and Extract	Acct Manager; Imp Manager	7/1/2013	7/1/2013	Open
	5.18	**Biometric Program**	**Biometric Rep**	**7/1/2013**	**7/31/2013**	**Open**
	5.18.1	Launch Biometric Screening Based on Schedule	Biometric Rep	7/1/2013	7/31/2013	Open
	5.18.2	Launch Communication Approach Based on Locations/Schedule	Marketing; State of Alaska	7/1/2013	7/31/2013	Open

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Go-Live Date 7/1/2013 **Start Date** 4/1/2013 **End Date** 8/15/2013

Phase	WBS	Tasks and Deliverables	Owner	Start	Finish	Status
Phase Six	**6**	**Post Implementation**	**Acct Manager; Imp Manager**	**7/1/2013**	**8/15/2013**	**Open**
	6.1	**Monitor Success of Implementation**	**Acct Manager; Imp Manager**	**7/1/2013**	**7/31/2013**	**Open**
	6.1.1	Evaluate Program Output	Acct Manager; Imp Manager	7/1/2013	7/31/2013	Open
	6.1.2	Monitor Member and Provider Feedback to the Program	Acct Manager; Imp Manager	7/22/2013	7/29/2013	Open
	6.1.3	Identify/Define Additional Needs	Acct Manager; Imp Manager	7/22/2013	7/29/2013	Open
	6.1.4	Re-Define Roles and Responsibilities	Acct Manager	7/22/2013	7/29/2013	Open
	6.2	Close Out Implementation and Transition to Account Manager	Imp Manager	7/29/2013	7/31/2013	Open
	6.15	**ActiveHealth Reporting**	**Acct Manager**	**7/1/2013**	**7/22/2013**	**Open**
	6.15.1	Productionalize Reporting	Acct Manager	7/1/2013	7/22/2013	Open
	6.16	**State of Alaska Communication Strategy**	**Imp Manager; AHDI Analyst**	**7/1/2013**	**8/15/2013**	**Open**
	6.16.1	Monitor Effectiveness of Communication Campaign	Imp Manager; AHDI Analyst	7/1/2013	8/15/2013	Open
	6.17	**Program Incentive**	**Acct Manager; Imp Manager**	**7/1/2013**	**8/15/2013**	**Open**
	6.17.1	Monitor Effectiveness of Program Incentive	Acct Manager; Imp Manager	7/1/2013	8/15/2013	Open
	6.18	**Biometric Program**	**Biometric Rep**	**7/1/2013**	**8/15/2013**	**Open**
	6.18.1	Monitor/Coordinate Biometric Screenings Based on Schedule	Biometric Rep; Acct Manager	7/1/2013	8/15/2013	Open

Implementation Milestones

Products: CareEngine Physician and Member Messaging, Disease Management, Maternity Management, MyActiveHealth, Active Lifestyle Coaching, Biometric Program, Program Incentives and 24 Hour Nurseline

Project Milestones	Target Date
Conduct Kick Off Meeting with State of Alaska	4/8/2013
Initiate Discussions to Procure Each Required Data Type (Eligibility, Medical/Provider, Pharmacy)	4/18/2013
Determine Transmission Protocols with Each Data Source	4/29/2013
Confirm Groups Eligible for MyActiveHealth	4/29/2013
Finalize Contract/Contract Addendum	5/6/2013
Receive Test (Production) File from each Data Source	5/23/2013
Review and Sign Off on MyActiveHealth URL Assignment, Logo and Welcome Message	5/31/2013
Start Receiving Ongoing Production Files from each Data Source	6/1/2013
Finalize Biometric Screening Schedule Based on State of Alaska Input	6/1/2013
Train Staff on Process Flows and Systems	6/13/2013
Go-Live Date	7/1/2013
Activate 24 Hour Nurse Line Team	7/1/2013
Activate MyActiveHealth	7/1/2013
Activate Active Lifestyle Coaching Team	7/1/2013
Launch Biometric Screening Based on Schedule	7/1/2013
Initiate Outreach to Members that were Transitioned	7/5/2013
CareEngine Run Occurs	7/5/2013
Run Care Consideration Logic, Clinical Stratification and Identification and Scoring	7/5/2013
Deliver 1st Care Considerations to Physicians	7/8/2013
Deliver 1st Care Considerations to Members	7/8/2013
Initiate Automated Disease Management Calls	7/9/2013
Generate Disease Management Introductory Letter to Members	7/9/2013

DM Newly Identified Member Outreach Letters

Week 1 - Low Risk

Outreach	Description	Inserts	Frequency	Content Customization & Branding Allowed?	Template
Letter 1a: DM Introductory Package **Low Risk**	This letter is sent to all low risk members on behalf of the entity sponsoring the program. Low risk members are targeted for online engagement. It provides information about the program, how to access the online programs, and offers the opportunity to participate in telephonic coaching sessions via self referral.	• Low Risk FAQ	Mailed within 1 week of identification for disease management services.	Yes	Letter 1A_Low Risk-Adult DM Intro Letter
Low Risk Frequently Asked Questions (FAQ)	This FAQ is included in letter package 1a- DM Low Risk.		Same as above.	Yes	Low Risk_Adult FAQ 072712.doc

Week 1 - Mod/High Risk

Outreach	Description	Inserts	Frequency	Content Customization & Branding Allowed?	Template
Outreach Call 1 to **Mod/High Risk**	This automated call is a precursor to Letter 1b.- High/Mod risk only. It notifies all moderate and high risk members about the program and allows the member to speak to a program representative.	• N/A	Initiated prior to letter 1b- Mod/High being mailed.	No	Outreach 1-2011.doc
Letter 1b: DM Introductory Package to **Mod/High Risk**	This letter is sent to all moderate and high risk members on behalf of the entity sponsoring the program. Moderate & high risk members are targeted for telephonic engagement. It provides information about the program, how to access the nurse coach to participate in the telephonic program, and provides information about the on line program including how to access it.	• Mod/High Risk FAQ • Reply Card with Return Envelope	Mailed to members within 1 week of identification for disease management services.	Yes	Letter 1B_Mod-High Risk_Adult DM Intro L
Mod/High Risk Frequently Asked Questions (FAQ)	FAQs are included in all mod/high letter packages.		Same as above.	Yes	Mod_High Risk_Adult FAQ 072712.doc

Week 2- Mod/High Risk

Outreach	Description	Additional Inserts	Frequency	Content Customization & Branding Allowed?	Template
Outreach Call 2- Mod/High Risk	This automated call notifies the member that he/she will be receiving an invitation letter in the mail.	• N/A	Initiated prior to letter 2 being mailed.	No	Outreach 2-2011.doc
Letter 2: DM Invitation Package -Mod/High Risk	This letter invites members to enroll in the program and includes their rights and responsibilities. This mailing is not sent to members that enrolled or opted out.	• Mod/High Risk FAQs • Reply Card with Return Envelope	Mailed to members 1 week after letter 1.	Yes	Letter 2_Mod-High Risk_Adult DM Invite

Week 3- Mod/High Risk

Outreach Call 3 to Mod/High Risk	Call made by a customer service advocate promoting the program.	• N/A	Initiated after letter 2 is mailed.	No	

Week 4- Mod/High Risk

Letter 3: Reminder Package -Mod/High Risk	This package is sent to members reminding them about the program. This mailing is not sent to members that enrolled or opted out.	• Mod/High Risk FAQs • Reply Card with Return Envelope	Mailed to members 2 weeks after letter 2.	Yes	Letter 3_Mod-High Risk_Adult DM Remin
Outreach Call 4- Mod/High Risk	Call made by a customer service advocate promoting the program.	• N/A	Initiated 7 days after outreach call 3.	No	

Week 5- Mod/High Risk

Letter 4: Unable to Reach Package-Mod/High Risk	This package notifies members that contact has been unsuccessful. This mailing is not sent to members that enrolled or opted out.	• Mod/High Risk FAQs • Reply Card with Return Envelope	Mailed to members 1 week after letter 3.	Yes	Letter 4_Mod-High Risk_Adult DM UTR Le

Week 6- Mod/High Risk

Outreach Call 5 to Mod/High Risk	This automated call notifies the member that we have been unable to reach him/her, promotes the program, and reminds the member to call to engage in the DM program. This call is not sent to members that enrolled or opted out.	• N/A	Initiated 7 days after outreach call 4.	No	Outreach Call 3-2011.doc

DM Transition Letters

Week 1 – DM Transition Cases

Outreach	Description	Inserts	Frequency	Content Customization & Branding Allowed?	Template
Letter 1: DM Transition Case Intro Letter	This letter is sent to transition members who were actively working with a nurse in the previous vendor's DM program. It includes information about the ActiveHealth programs that are replacing the previous vendor's services.	• N/A	Mailed within 1 week of transition case file load.	Yes	DM Transition Letter 1
Transition Call 1	This automated call notifies all DM transition members about the new program and allows the member to speak to a program representative.	• N/A	Initiated 5 days after Letter 1.	No	Transition Call-2011.doc

Week 2

Transition Call 2	Call made by a DM staff promoting the program.	• N/A	Initiated 3 days after Transition Call 1.	No	N/A

Week 3

Transition Call 3	Call made by a DM staff promoting the program.	• N/A	Initiated 7 days after Transition Call 2.	No	N/A
Letter 2: DM Transition Case UTR Letter	This package notifies members that contact has been unsuccessful. This mailing is not sent to members that enrolled or opted out.	• N/A	Mailed to members 2 weeks after Letter 1 (if Transition Call 3 contact unsuccessful)	Yes	DM UTR Transition Letter 2

ACTIVEHEALTH MANAGEMENT
PO Box 221138
Chantilly, VA 20153-1138

<CUR DATE FULL>

<PRIMARY PROV>
<PROV PHONE>
<PROV FAX>
<PROV ADDR 1>
<PROV ADDR 2>
<PROV CITY>, <PROV STATE> <PROV ZIP>

RE: <PT FIRST NAME> <PT LAST NAME>, <PT DOB>

Dear <PRIMARY PROV>:

Your Patient Is Working With Me
I'm writing to let you know that your patient, <PT FIRST NAME> <PT LAST NAME>, is working with me in a telephonic Disease Management health coaching program. This program is sponsored by your patient's health plan or employer, and is administered by ActiveHealth Management.

The program is designed to:

- Help the patient comply with your treatment plan
- Educate the patient about his or her condition, including warning signs to watch for
- Support the patient in making positive lifestyle changes if needed
- Help patients access healthcare resources available through their health plan

Following each call, I send your patient a letter that recaps the information we discussed and outlines follow up items. I encourage your patient to share this information with you.

As part of the program, you may receive clinical alerts, called Care Considerations. We identify the alerts from evidence-based guidelines and patients' medical, Rx and lab data. The alerts may provide information not otherwise available to you, such as treatment by other physicians or patient non-compliance.

Tell Me How I Can Help You
I want to work with you and your office to improve your patient's health. Let me know if there are specific things I should be talking to your patient about. My direct line is <CONTACT PROG PHONE>< ASSIGNED USER PHONE EXT>.
.

Sincerely

<Assigned User>
ActiveHealth Management
<CONTACT PROG PHONE>< ASSIGNED USER PHONE EXT>

ACTIVEHEALTH MANAGEMENT
PO Box 221138
Chantilly, VA 20153-1138

Practitioner Rights

As a practitioner treating a patient participating in the disease management program, you have the following **rights**:

1. To have information about ActiveHealth Management, including the Disease Management program and services provided in conjunction with the sponsoring organization, Disease Management staff and staff qualifications, and any contractual relationships with the sponsoring organization or health plan
2. To decline to participate in or work with the Disease Management program for your patients, if contractually possible
3. To be informed of how the Disease Management program coordinates its interventions with treatment plans for individual patients
4. To know how to contact the person responsible for managing and communicating with your patient
5. To be supported by the Disease Management program to make decisions interactively with your patient regarding their healthcare
6. To receive courteous and respectful treatment from the Disease Management program staff
7. To communicate complaints about the Disease Management program.

For more information on the Disease Management program, please visit our website at www.activehealth.net. To request additional program information or printed materials including clinical guidelines, plan of care and detailed program content, or to provide feedback or file a complaint, please contact us toll-free at <CONTACT PROG PHONE><CONTACT PROG HOURS>.

10885

ACTIVEHEALTH MANAGEMENT

Pediatric Disease Management Program Communication Index

Week 1

Outreach	Description	Inserts	Frequency	Customization Allowed?	Template
Outreach Call 1 to **Mod/High Risk only**	This automated call is a precursor to Letter 1b.- High/Mod risk only. It notifies all moderate and high risk members about the program and allows the member to speak to a program representative.	• N/A	Initiated prior to Letter 1 mailing.	Program Name & Phone Number Only	Outreach Call 1
Letter 1: DM Introductory Package **All Risk Levels**	This letter is sent to all pediatric members on behalf of the entity sponsoring the program. It provides information about the program including rights and responsibilities and offers the parent/guardian the opportunity to work with a nurse coach to impact the child's health.	• FAQs	Mailed within 1 week of identification for disease management services.	Content & Branding	Pedatric Letter 1
Pediatric Frequently Asked Questions (FAQ)	This FAQ is included in Letter 1: DM Introductory Package	• N/A	Same as above.	Content Only	Pediatric FAQ

Week 2- Mod/High Risk Only

Outreach Call 2	This automated call notifies the member that he/she will be receiving an invitation letter in the mail.	• N/A	Initiated prior to letter 2 being mailed.	Program Name & Phone Number Only	Outreach Call 2
Letter 2: DM Invitation Package	This letter invites members to enroll in the program. This mailing is not sent to members that enrolled or opted out.	• FAQs • Reply Card with Return Envl	Mailed to members 1 week after letter 1.	Content Only	Pediatric Letter 2

Week 3- Mod/High Risk Only

Outreach Call 3	Call made by a customer service advocate promoting the program.	• N/A	Initiated after letter 2 is mailed.	N/A	

Week 4- Mod/High Risk Only

Letter 3: Reminder Package	This package is sent to members reminding them about the program. This mailing is not sent to members that enrolled or opted out.	• FAQs • Reply Card with Return Envl	Mailed to members 2 weeks after letter 2.	Content Only	Pediatric Letter 3
Outreach Call 4	Call made by a customer service advocate promoting the program.	• N/A	Initiated 7 days after outreach call 3.	N/A	

Week 5- Mod/High Risk Only

Letter 4: Unable to Reach Package	This package notifies members that contact has been unsuccessful. This mailing is not sent to members that enrolled or opted out.	• FAQs • Reply Card with Return Envl	Mailed to members 1 week after letter 3.	Content Only	Pediatric Letter 4

Week 6- Mod/High Risk Only

Outreach Call 5	This automated call notifies the member that we have been unable to reach him/her, promotes the program, and reminds the member to call to engage in the DM program. This call is not sent to members that enrolled or opted out.	• N/A	Initiated 7 days after outreach call 4.	Program Name & Phone Number Only	Outreach Call 3

ActiveHealth Management
PO Box 221168
Chantilly, VA 20153-1168

ProviderName
ProviderAddress
ProviderAddress2
ProviderCity, ProviderState ProviderZip

Date: June 16, 2009

No. of Pages (including cover): NUMPAGES

From: ActiveHealth Management

Fax Number: 1-866-681-3980

NOTES: ***Please see the attached Care Consideration.***

If you have any questions or comments, please do not hesitate to call:
1-800-319-4454

THANK YOU

VERIFICATION OF RECEIPT IS REQUESTED BY PROPER RECIPIENT.

Patient: John Doe

DOB: 06/05/40
Physician: Dr. Jane Noone
Tracking Number: 123455678
Date: July 8, 2008

ACTIVEHEALTH MANAGEMENT

►1. REVIEW THIS CARE CONSIDERATION for Patient John Doe

Tracking Number: 12345678 Date: 7/8/2008

Care Consideration: Bisphosphonates - Avoid Use in Renal Insufficiency - #99121C
Your patient is 55 years of age or older, has claims evidence for hypertension, another cardiovascular risk factor (MI, stroke, type 2 diabetes, atherosclerotic cardiovascular disease, HDL less than 35 mg/dL, smoking) and an alpha blocker. In the ALLHAT study, high risk patients treated with doxazosin monotherapy had a greater risk of developing CHF than those treated with chlorthalidone alone, and the addition of other antihypertensives attenuated, but did not eliminate, this risk. If your patient fits this clinical profile, and if not already done, consider reassessing the risks/benefits of continuing the alpha blocker.

JACC AHA/ACC; Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult: Executive Summary 2001; 38:2102-2113
Circulation; Comparative Effects of Low and High Doses of the Angiotensin-Converting Enzyme Inhibitor, Lisinopril, on Morbidity and Mortality in Chronic Heart Failure (Atlas Study) 1999; 100:2312-2318

See next page for answers to Frequently Asked Questions

Code	Description	Occurs	Starting	Ending
250.02	DIAB W/O MENTION COMP TYPE II/UNS TYPE UNCNTRL	15	06/21/2005	10/20/2008
00029315900	AVANDIA	11	02/13/2008	12/23/2008
68382003010	METFORMIN HCL	6	06/21/2008	12/23/2008
250.02	DIAB W/O MENTION COMP TYPE II/UNS TYPE UNCNTRL	15	06/21/2005	10/20/2008
00029315900	AVANDIA	11	02/13/2008	12/23/2008
68382003010	METFORMIN HCL	6	06/21/2008	12/23/2008
250.02	DIAB W/O MENTION COMP TYPE II/UNS TYPE UNCNTRL	15	06/21/2005	10/20/2008
00029315900	AVANDIA	11	02/13/2008	12/23/2008

► 2. CHECK ONE OF THE FOLLOWING AND FAX TO 1-166-681-3980

☐ I **HAVE** already implemented this Care Consideration

☐ I **PLAN** to implement this Care Consideration

I will not implement this Care Consideration because…

☐ Patient does not have diagnosis/condition mentioned

☐ Patient is NOT known to me or any other clinician in my practice

☐ Patient stable on current regimen

☐ I am not treating the patient for the diagnosis/condition mentioned

☐ Patient is allergic/intolerant to the drug

☐ Patient is no longer treated in this practice

☐ Patient is noncompliant

☐ Patient is terminally ill or expired

To speak with a Clinician call 1-800-319-4454

► FREQUENTLY ASKED QUESTIONS

We respect your important role in this patient's care and we truly value your insight and professional opinion. Thank you for your time and for helping to ensure the best possible care.

The following are answers to some of the most common questions about Care Considerations. If you have any further questions or comments, please give us a call at 1-800-319-4454 between 9 am and 5:30 pm Eastern time.

Who are we and where do we get this patient information?

We are contracted by [CLIENT/HEALTH PLAN NAME] to aggregate and analyze patient medical, lab and pharmacy data, with the sole purpose of improving quality of care. We handle this information in complete accordance with HIPAA privacy guidelines.

Does this affect physician performance or compensation in any way?

No. This is not a utilization review, pre-certification program or a professional medical consultation. The only purpose is to share information that might help you care for your patient.

What is the accuracy of this information?

We base our Care Considerations on the most complete patient data we can collect. Our Care Considerations have an accuracy rate of up to 90 percent based on a review of actual patient medical records from two major academic medical centers.

What's the compelling reason for returning the form on Page 1?

Your feedback provides information that we could not get from claims (e.g., drug intolerance or allergy). Your feedback is incorporated into our system to increase the accuracy of future messages to you and your patients. We know your time is valuable, but the extra minute you spend completing the form can be a huge value to the health of your patient. Thank you.

Does this Care Consideration program really help patients?

Yes. A study population of 39,462 members of a Midwestern managed care plan showed the following impact on quality of care:

- A potentially serious gap in care was detected in about one out of 20 members.
- It resulted in 8.4 percent fewer hospitalizations across the study population.

Who has reviewed our Care Considerations?

Physicians on the Harvard Medical School faculty have reviewed and approved the clinical content of ActiveHealth's Care Considerations and application of the evidence in the medical literature. Harvard Medical School faculty do not have access to any information about the medical conditions of this or any other patient or about the care rendered by this or any other physician.

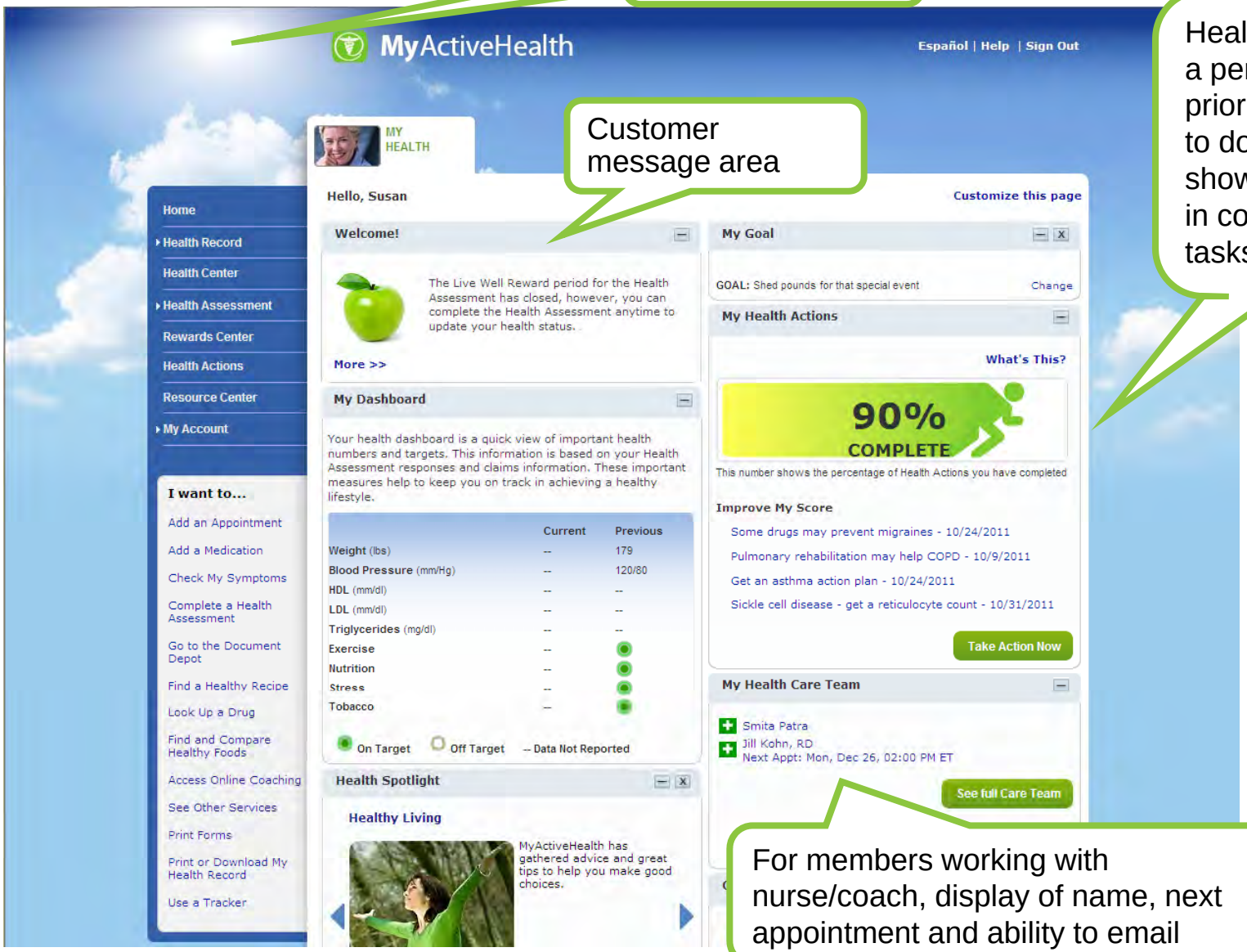
Home Page

Ability to co-brand the site

Customer message area

Health Actions, a personalized, prioritized health to do list; score shows progress in completing tasks

For members working with nurse/coach, display of name, next appointment and ability to email securely.



Home Page

"Give me easy access to tasks frequently updated."

Easy Health Assessment access

"Remind me of what is important and let me communicate with my care provider

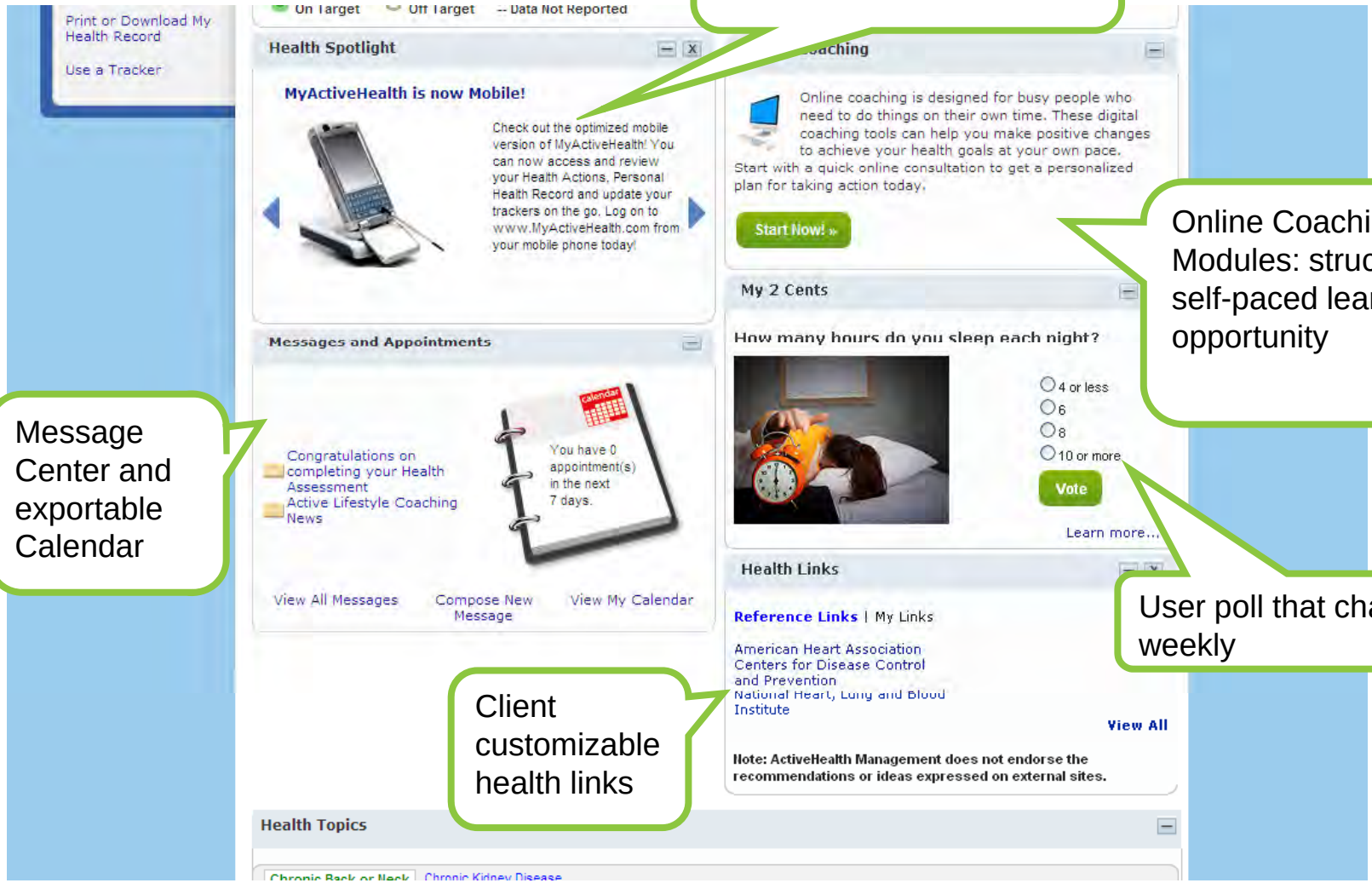
"I know what's important to me"

Track my Rewards

Powered by CareEngine

Home Page (Continued)

Featured videos, articles and games appear in our monthly spotlight!



Online Coaching Modules: structured, self-paced learning opportunity

Message Center and exportable Calendar

User poll that changes weekly

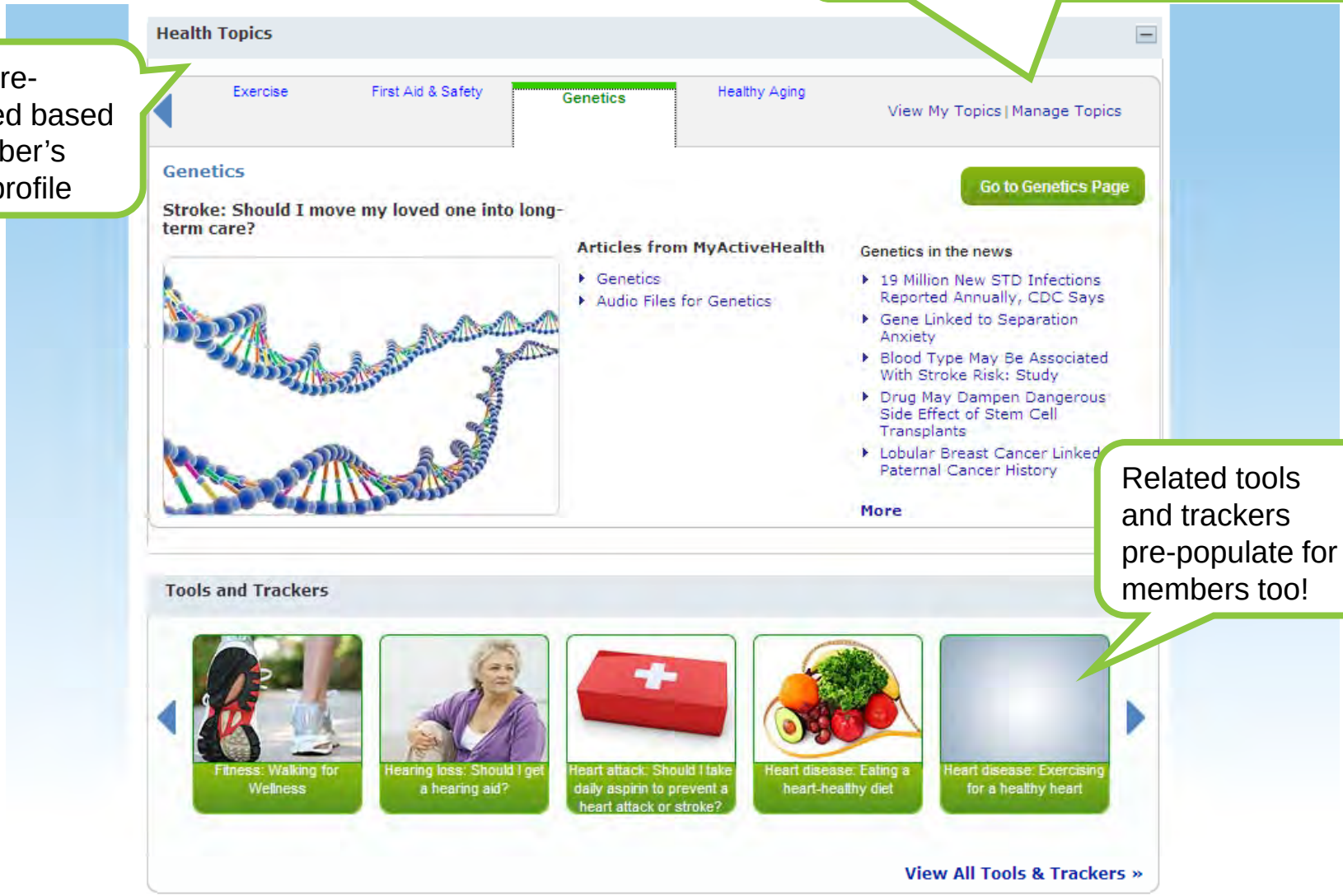
Client customizable health links

Powered by CareEngine

Home Page (Continued)

Members can personalize site by clicking "Manage Topics" and adding their personal areas of interest

Topics pre-populated based on member's clinical profile



Related tools and trackers pre-populate for members too!

Powered by CareEngine

4.2.2.1.5 In the most recent calendar year and of those eligible for the program at each risk level (high, moderate, low) indicate the percent of members in each category for your book of business (with an incentive and without an incentive). (

The following tables show results for Disease Management and Lifestyle Coaching:

Disease Management	High Risk (with incentive)	Medium Risk (with incentive)	Low Risk (with incentive)	High risk (No incentive)	Medium Risk (No Incentive)	Low Risk (No Incentive)
* Identified %	1.4%	2.4%	3.9%	2.9%	4.4%	9.5%
** Outreached To %	98.1%	91.7%	79.6%	73.4%	73.4%	32.6%
*** Reached %	46.5%	40.9%	46.8%	27.0%	21.1%	21.6%
**** Opted Out %	6.3%	10.7%	22.0%	21.3%	22.8%	27.0%
***** Enrolled %	41.4%	34.9%	33.5%	18.2%	14.3%	13.3%
****** Dropped Out % (includes autostepped down)	21.9%	16.3%	20.4%	33.0%	25.7%	34.6%
Dropped Out – excludes autostepped down	1.8%	1.9%	2.5%	5.3%	4.0%.	5.5%
*******Completed program – goals met %	8.7%	9.2%	5.8%	4.5%	5.4%	5.5%

***** % of members identified with specific risk level of entire incentive or no incentive population
** % of members outreached of those identified with specific risk level
*** % of members reached of those outreached with specific risk level
**** % of members opted out of those reached with specific risk level
***** % of members enrolled out of those outreached with specific risk level
****** % of members dropped out of those enrolled with specific risk level
******* % of members completing program of those enrolled with specific risk level

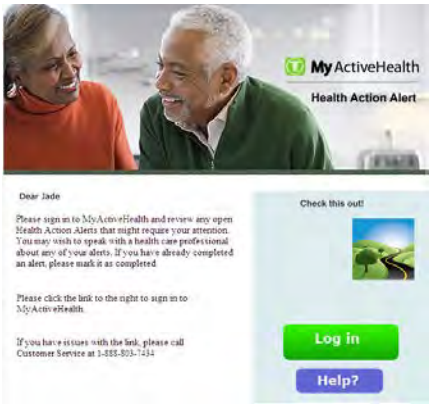
Active Lifestyle Coaching	High Risk (with incentive)	Medium Risk (with incentive)	Low Risk (with incentive)	High risk (No incentive)	Medium Risk (No Incentive)	Low Risk (No Incentive)
*Identified %	12.9%	3.2%	17.2%	11.6%	2.0%	11.6%
**Outreached To %	40.6%	17.9%	5.0%	24.1%	21.9%	4.8%
***Reached %	55.6%	36.5%	71.3%	22.4%	17.4%	27.4%
****Opted Out %	10.1%	24.1%	9.2%	17.4%	39.6%	18.9%
*****Enrolled %	88.8%	72.5%	86.4%	76.2%	50.9%	63.5%
******Dropped Out %	3.2%	4.2%	4.9%	3.6%	1.8%	4.3%
*******Completed program – goals met %	33.8%	42.8%	32.1%	13.2%	36.1%	39.1%

***** % of members identified with specific risk level of entire incentive or no incentive population
** % of members outreached of those identified with specific risk level
*** % of members reached of those outreached with specific risk level
**** % of members opted out of those reached with specific risk level
***** % of members enrolled out of those outreached with specific risk level
****** % of members dropped out of those enrolled with specific risk level
******* % of members completing program of those enrolled with specific risk level

MyActiveHealth Email Overview

The MyActiveHealth member website sends periodic email notifications to members when certain events occur. Please note that the below describes today's current state; as new functionality is built, additional email notifications may be added to MyActiveHealth.

Health Action Alert Emails



MyActiveHealth displays Health Action Alerts to members in the MyActiveHealth website. These Alerts include the Care Considerations that are sent to physicians, as well as other wellness-focused messages, and represent potential opportunities to improve a member's health care.

Monthly Summary

Sent to all registered members, the Monthly Summary can consist of up to seven bullet points and serves as a communication and reminder device. This email is only sent if at least one of the following conditions is true. It contains a standard intro and closing, along with the applicable bullet points described below:

1) *New Conditions were validated.* A new condition was validated by ActiveHealth's CareEngine® System and will display on the Health Center page within MyActiveHealth.

2) *Open Messages in MyActiveHealth.* This bullet is included in the Summary email if there are any open messages in the Message Center.

3) *Health Tracker not updated during the last 90 days.* If an active Tracker has not been updated within the last 90 days, by either the member or systematically through a laboratory results feed, a reminder bullet is included in the Monthly Summary.

4) *New Claims.* PHR purchased required. If new claims were added in the past 30 days to the Personal Health Record section of the website this bullet is included.

5) Take HRA Again (after initial completion). HRA purchase required. If the HRA has not been completed within the past 12 months, a reminder bullet is included in the Monthly Summary.

6) *Open Health Actions.* HRA purchase required. This bullet item displays if there are any open Health Actions in the member's website.

7) *New Assignments from Health Coach.* Disease Management and/or Active Lifestyle Coaching program(s) purchase required. If the member has open assignments from his/her previous telephonic interaction, a reminder is included in the Monthly Summary email.

Other MyActiveHealth email

- *Log In Reminder.* An email sent once every 90 days, if the member has not logged on during that time period. The email encourages members to take advantage of the features and benefits of MyActiveHealth.

- *Forgotten User Name.* A security email sent to members who have recovered their user name using the "Forgot user name" functionality.

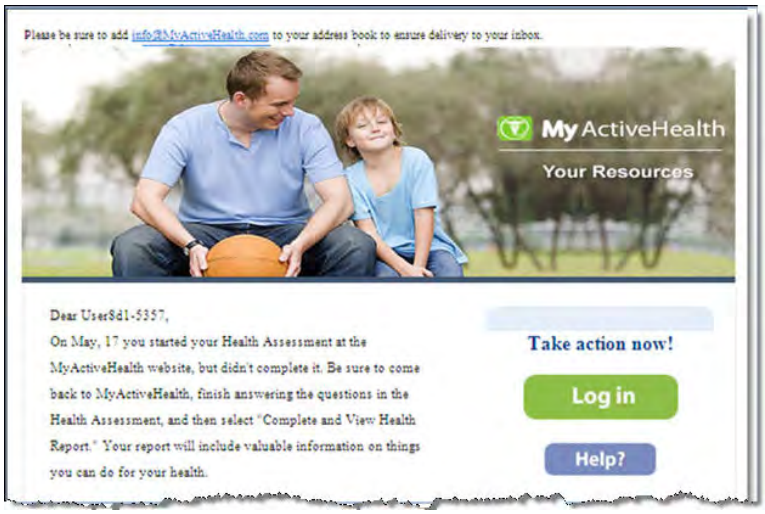
- *Forgotten Password.* A security email sent to members who have recovered their password using the "Forgot password" functionality.

- *Minor dependent access expiration.* 90 days before a minor dependent turns 18, a message is sent to inform the subscriber that access to that particular minor dependent's website will be removed on his/her18th birthday. A follow-up email is sent on the minor's actual 18th birthday.

- *Terminated Members.* PHR purchase required. An email is sent to members who are no longer eligible for the Personal Health Record within MyActiveHealth. The email encourages members to log in to view options available to them. Options may include printing, downloading, sharing data with Microsoft HealthVault and/or converting their Health Record to the consumer version of MyActiveHealth.

- *Calendar Reminders.* When a member sets up an appointment on the calendar in MyActiveHealth, he/she may also request to receive an email reminder on a specified day (up to 7 days) prior to the appointment. If a recurring appointment is set up, the email reminders will also recur.

- *HRA Completion Reminder.* This email is sent to members who started – and saved, but did not complete - the Health Risk Assessment. The email encourages members to return to MyActiveHealth and complete the HRA.

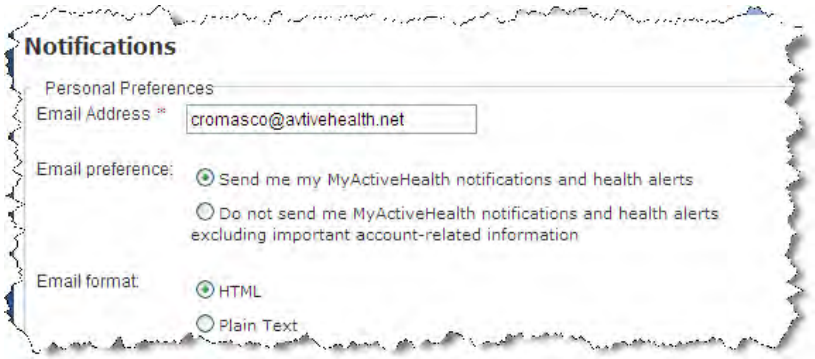


Email Options

On the Notifications page within the My Account section, members can select from a few options related to emails.

Opt-out

Users of the MyActiveHealth website have the ability to opt-out of receiving emails. The options currently available are:



- Send me MyActiveHealth notifications and health alerts
- Do not send me my MyActiveHealth notifications and health alerts

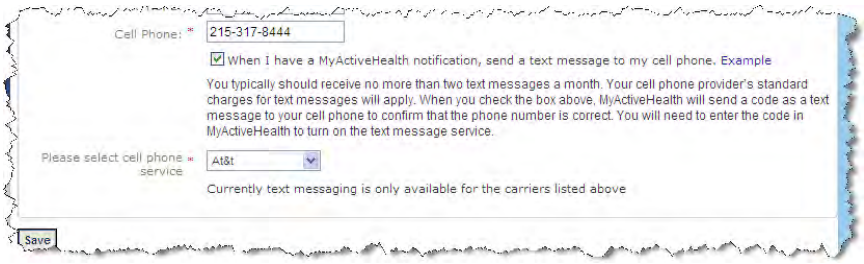
Note that the "Do not send" option excludes account-related information. The account-related emails include items important to security such as password and user name resets.

Format

Members may elect to receive email in either an HTML or Plain Text format. HTML is the default setting.

Text (SMS)

Members may elect to receive certain email notifications from MyActiveHealth on their cell phone, or other mobile device.



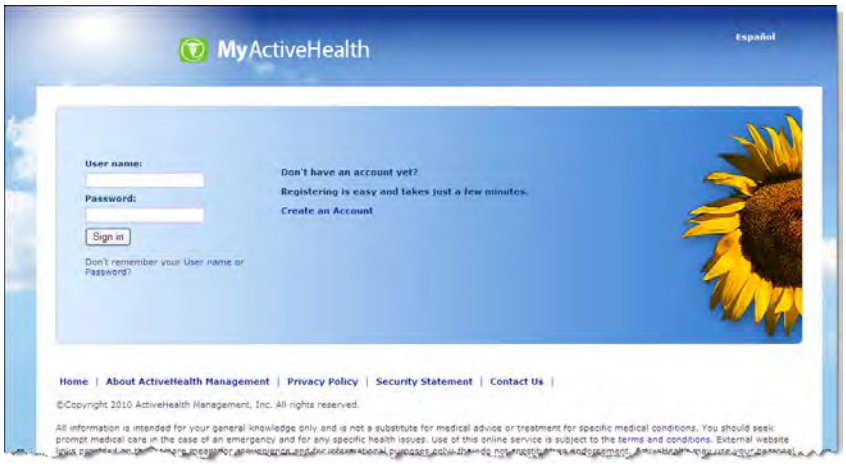
Security Considerations

It is important to note that no Personal Health Information (PHI) is sent in any email from MyActiveHealth. The emails always encourage members to log into the website to view their health information.

Special Single Sign On (SSO) Considerations

Customers who elect to implement Single Sign On from an internal website into MyActiveHealth (additional development and costs apply), have an additional option relative to emails from MyActiveHealth.

Each of the emails contains a Log In button that standardly directs members to the Sign In page of MyActiveHealth. If the member has only ever accessed MyActiveHealth via SSO, he/she will not be familiar with this page and will not have a User name and Password for the site.

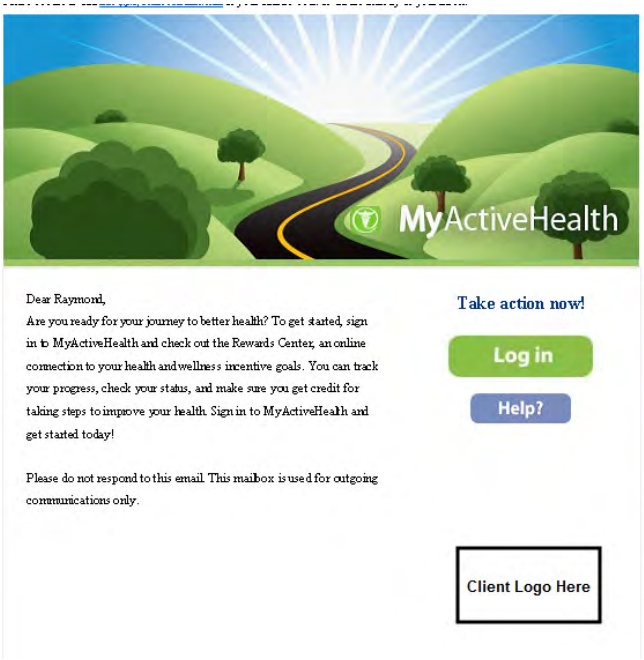


To minimize confusion, ActiveHealth can set the 'target' of the Log In button in the email to our customer's internal, or originating SSO site.

Additionally, because the SSO may only be available to employees, and not dependents, ActiveHealth can continue to direct dependents to our Sign In page where they can access the site directly. Employees, on the other hand, will log in to the internal (originating SSO) site and then, by clicking on a link, have direct access into the MyActiveHealth website.

Rewards Center Email

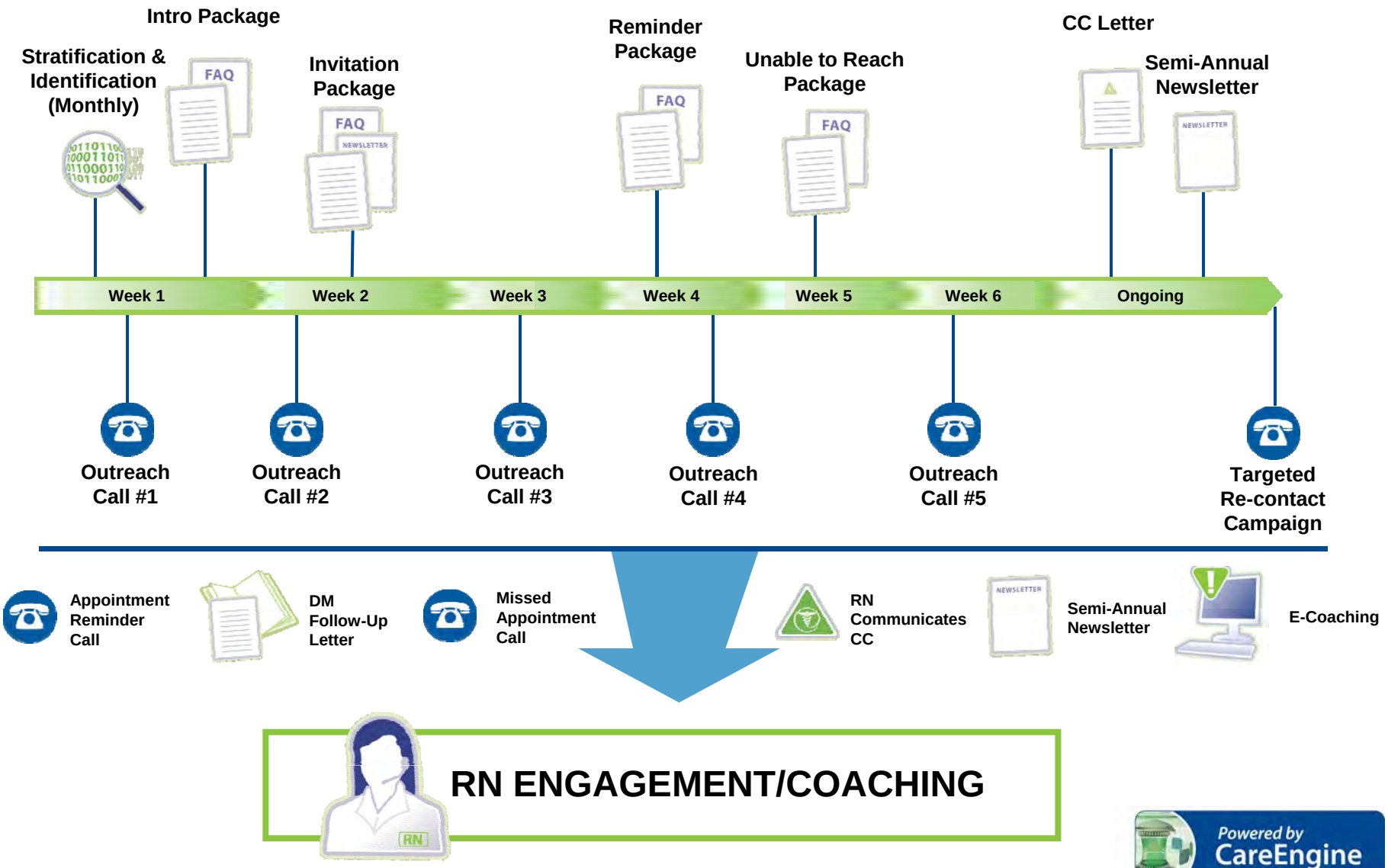
Clients who have purchased the Rewards Center also have the option of customizing a set of emails which are automated and sent to their members according to their specific program requirements.



Configuration Options for Emails

Email	Date to be sent	Subject Line	Content
Email # 1	On day of Program Go live	Ready to start your journey in the Rewards Center?	Are you ready for your journey to better health? To get started, sign in to MyActiveHealth and check out the Rewards Center, an online connection to your health and wellness incentive goals. You can track your progress, check your status, and make sure you get credit for taking steps to improve your health. Sign in to MyActiveHealth and get started today!
Email # 2	30 days after program go live	Have you checked your Rewards Center status?	There is still time to start using the Rewards Center on MyActiveHealth and get moving towards your incentive health and wellness goals. The Rewards Center allows you to see your status and track progress towards your upcoming incentive deadline.
Email # 3	30 days before program end date	Time is running out! Check your status in the Rewards Center today	The deadline is quickly approaching for your health and wellness incentive. Visit the Rewards Center on MyActiveHealth today to check your status and make sure you get credit for taking action to improve your health.

DM Outreach & Engagement: High and Moderate Risk



DM Outreach & Engagement: Low Risk

Intro Package

Stratification & Identification (Monthly)

Intro mailing:

- Builds awareness
- Introduces MyActiveHealth
- Offers self-referral for nurse coaching

CC Letter

Semi-Annual Newsletter

Week 1 → **Ongoing**

 **Health Actions**

 **Care Considerations**

 **Health Trackers**

 **Online Coaching**

 **Education**

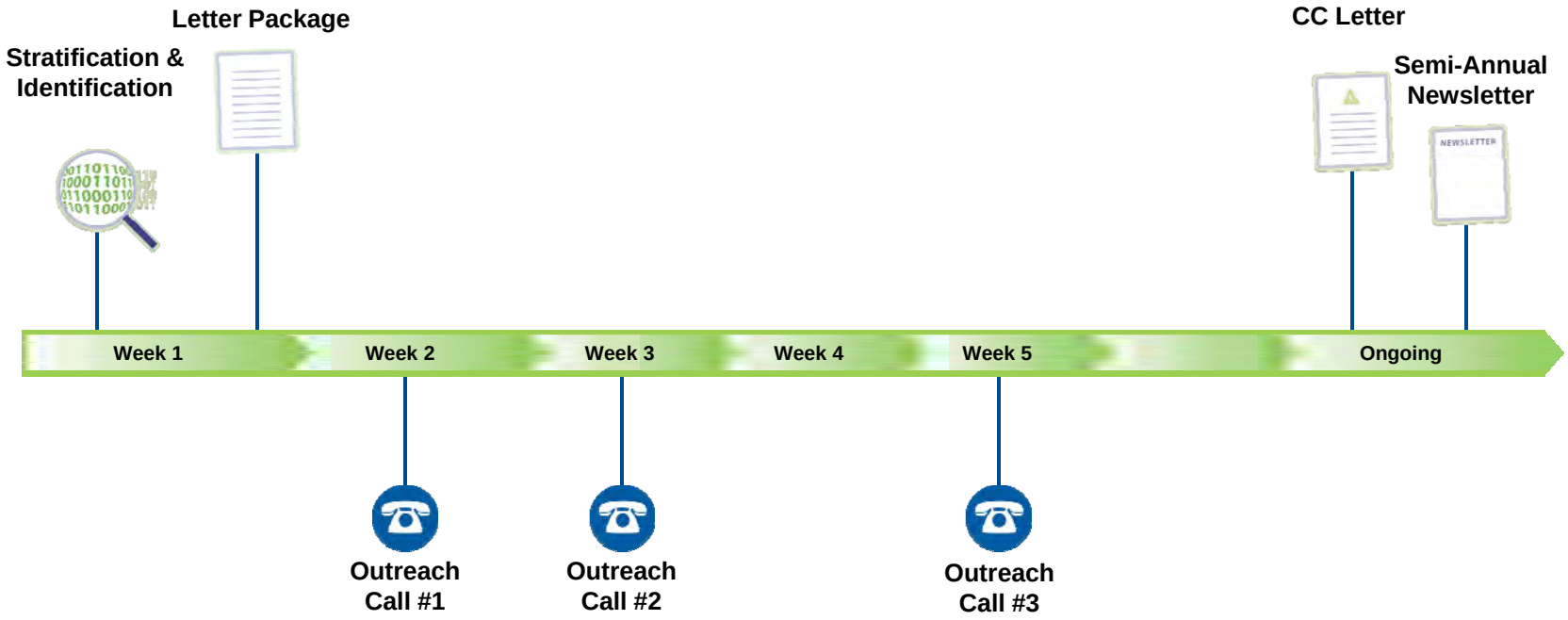
 **RN Engagement**

MyActiveHealth e-Engagement/e-Coaching

Powered by CareEngine

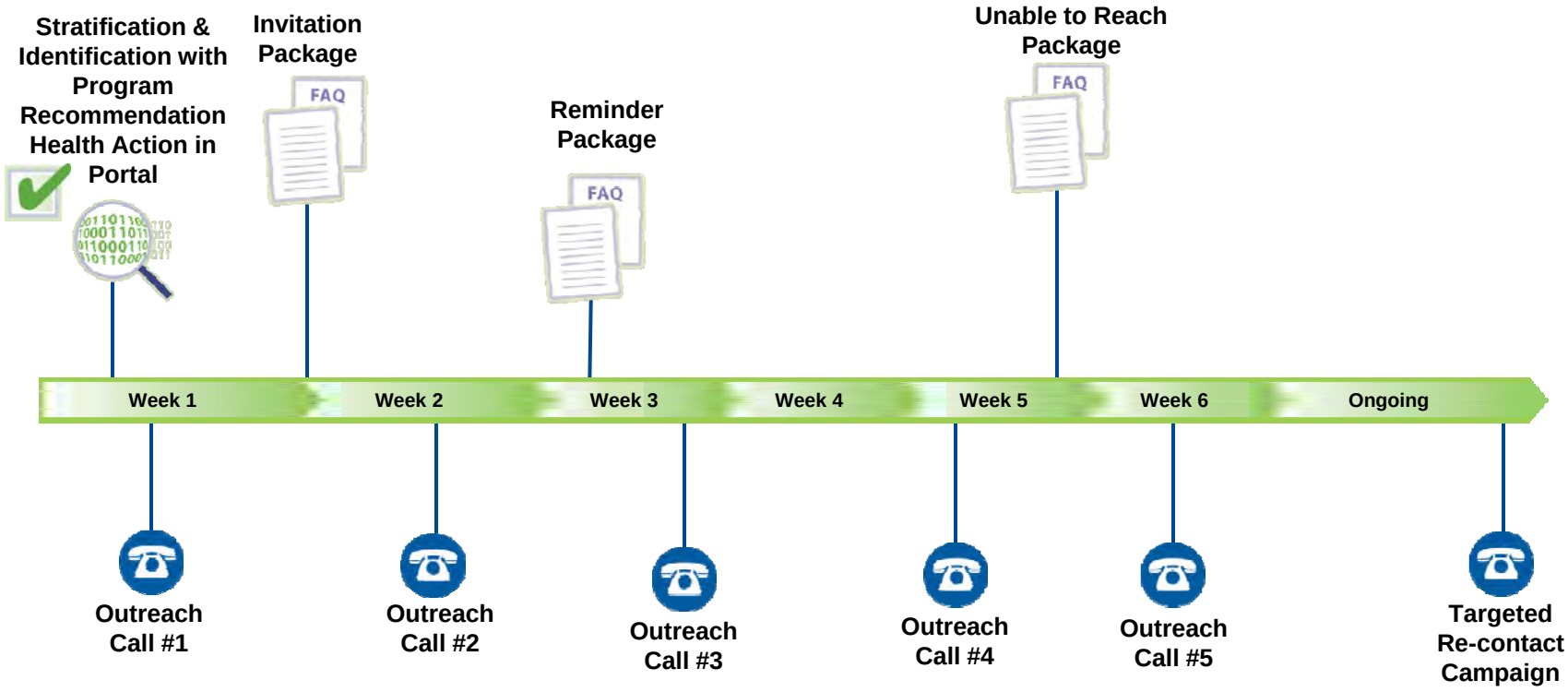
DM Targeted Re-Contact Campaign

Members Identified for Nurse Engagement Who Couldn't Be Reached



Powered by CareEngine

ALC Outreach & Engagement: Moderate and High Risk



ALC Outreach & Engagement: Low Risk

Stratification & Identification with Program Recommendation Health Action in Portal

Invitation Package

Invitation mailing:

- Builds awareness
- Introduces MyActiveHealth
- Offers self-referral for lifestyle coaching

Week 1 | **Week 2** | **Ongoing**

Outreach Call #1

Health Actions

Health Trackers

Online Coaching

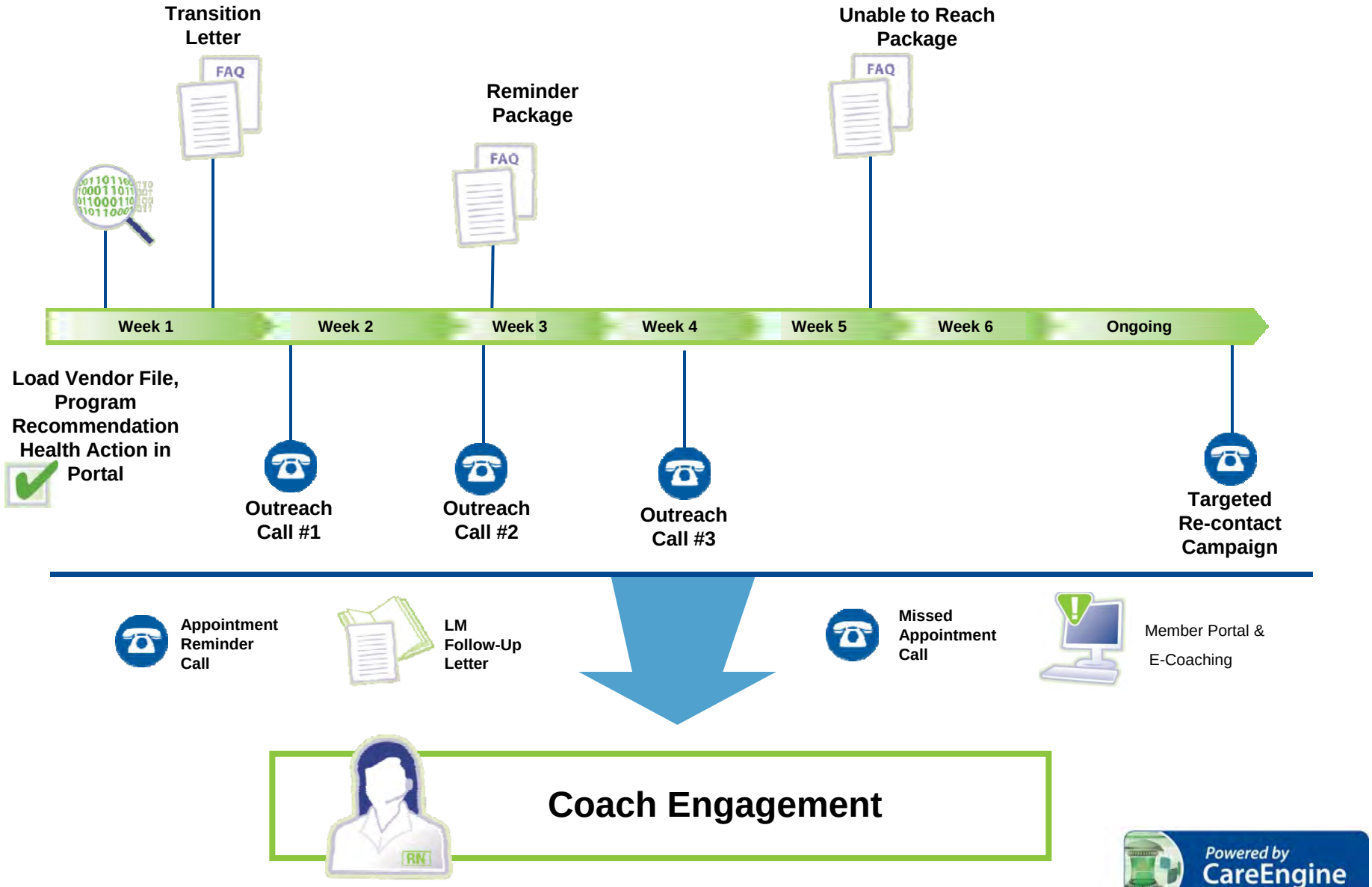
Education

Coach Engagement

MyActiveHealth
e-Engagement / e-Coaching

Powered by CareEngine

ALC Transition: Members Engaged by Previous Vendor



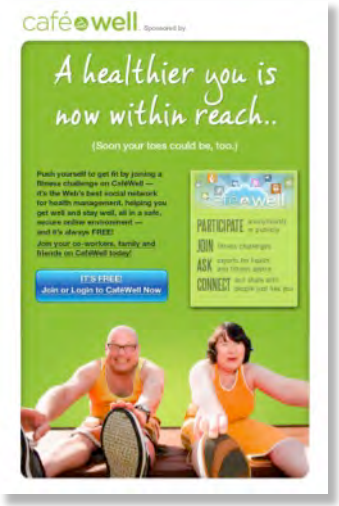
Communications Personality

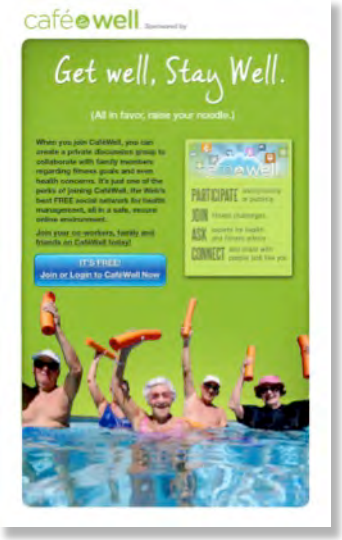
Creative Expression:
Standing Apart & Cutting Through the Clutter to Increase Adoption and Engagement

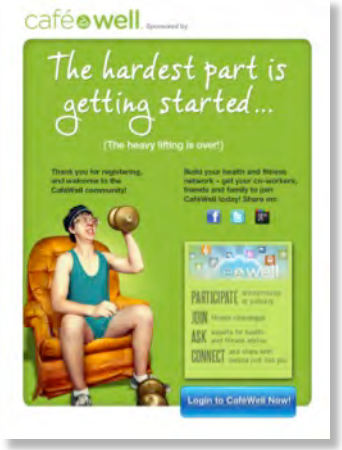
- **Inclusive**
- **Empathetic**
- **Humorous**
- **Positively disruptive**

café well

Adoption Email Campaign Tactics







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Get on board with CaféWell!

(No helmet required)

Add more value with new and existing clients — get on board with CaféWell, the Web's best social network for health management. Help your employer groups create a physically, mentally and financially healthier company. Now you can sharpen your competitive edge by offering CaféWell, a new program added to the plan options you offer, that helps members get well and stay well in a safe, secure online environment – and it's always FREE! Members can:

- **PARTICIPATE** anonymously or publicly
- **JOIN** fitness challenges
- **ASK** experts for health advice
- **CONNECT** and share with other members

HELP YOUR CLIENTS TO GET WELL AND STAY WELL!

If you haven't already, join CaféWell today!

Contact Tori Woods, your CaféWell Channel Specialist, today!

XXX.XXX.XXXX

Tori.Woods@WellTok.com

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Stay ahead of the competition with CaféWell!

There's no question your customers are looking for the best value they can get out of a health plan, and you need to set yourself apart from other brokers. Increase your value to clients with CaféWell, the Web's best social network for health management. It's a new program added to the plan options you offer that helps members get well and stay well in a safe, secure online environment – and it's always FREE!

- **PARTICIPATE** anonymously or publicly
- **JOIN** fitness challenges
- **ASK** experts for health advice
- **CONNECT** and share with other members

SHARPEN YOUR COMPETITIVE EDGE!

If you haven't already, join CaféWell today!

Contact Tori Woods, your CaféWell Channel Specialist, today!

XXX.XXX.XXXX

Tori.Woods@WellTok.com

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THE SOCIAL NETWORK TO GET WELL AND STAY WELL

JOIN THE FIGHT

Against Obesity

CAFÉWELL GIVES YOU EASY STEPS, HELPFUL INFORMATION AND SUPPORT, PRIZES TO WIN, AND YOU CAN BE ANONYMOUS.

CaféWell is here to help, it's free, and you can participate anonymously. Register now at CaféWell.com, and you'll have access to fun health activities, support from others, and monthly incentives* awarded to activity participants. Together, we can improve our health – in small, easy steps – register for CafeWell now!

1 VISIT
CafeWell.com

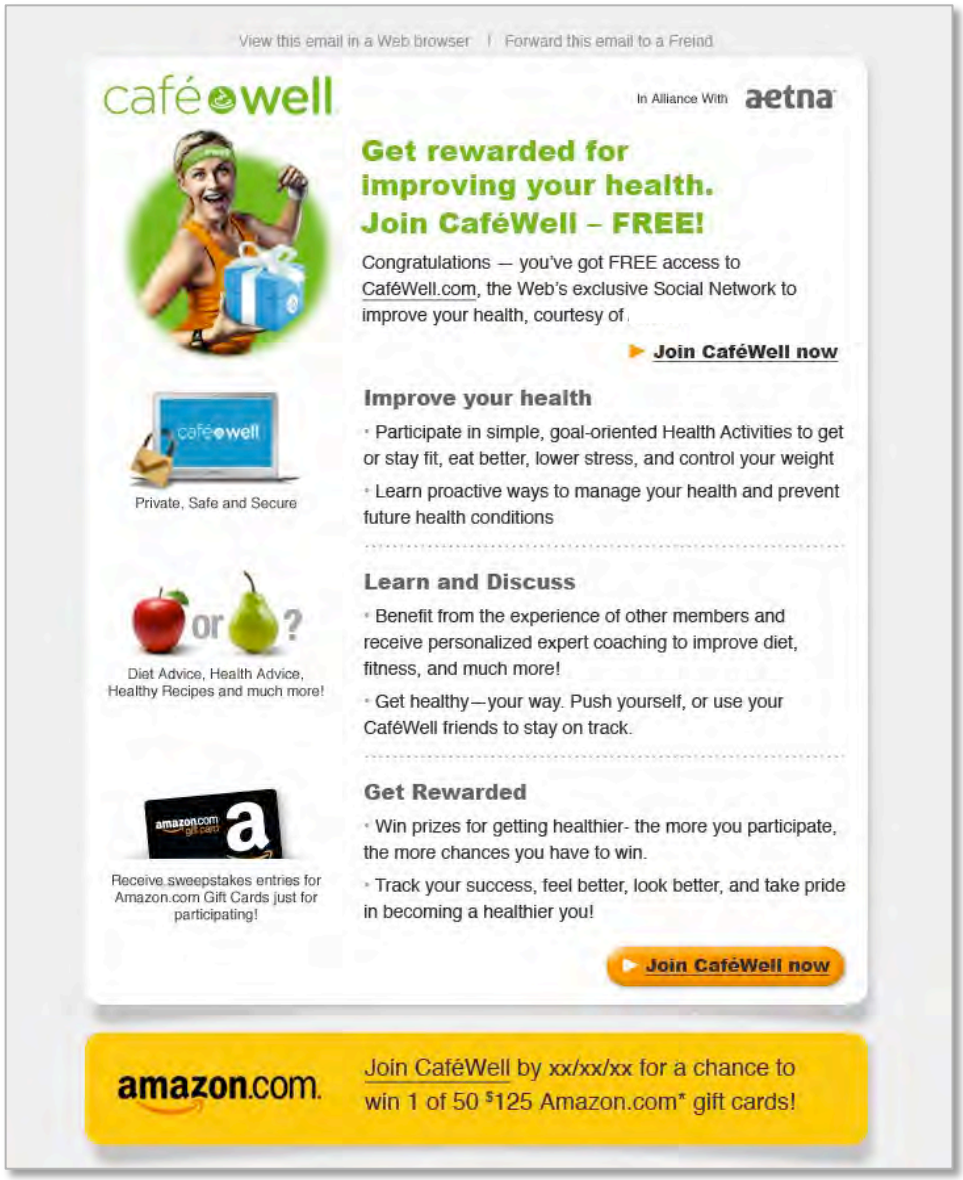
2 JOIN
Create your User Name and Password

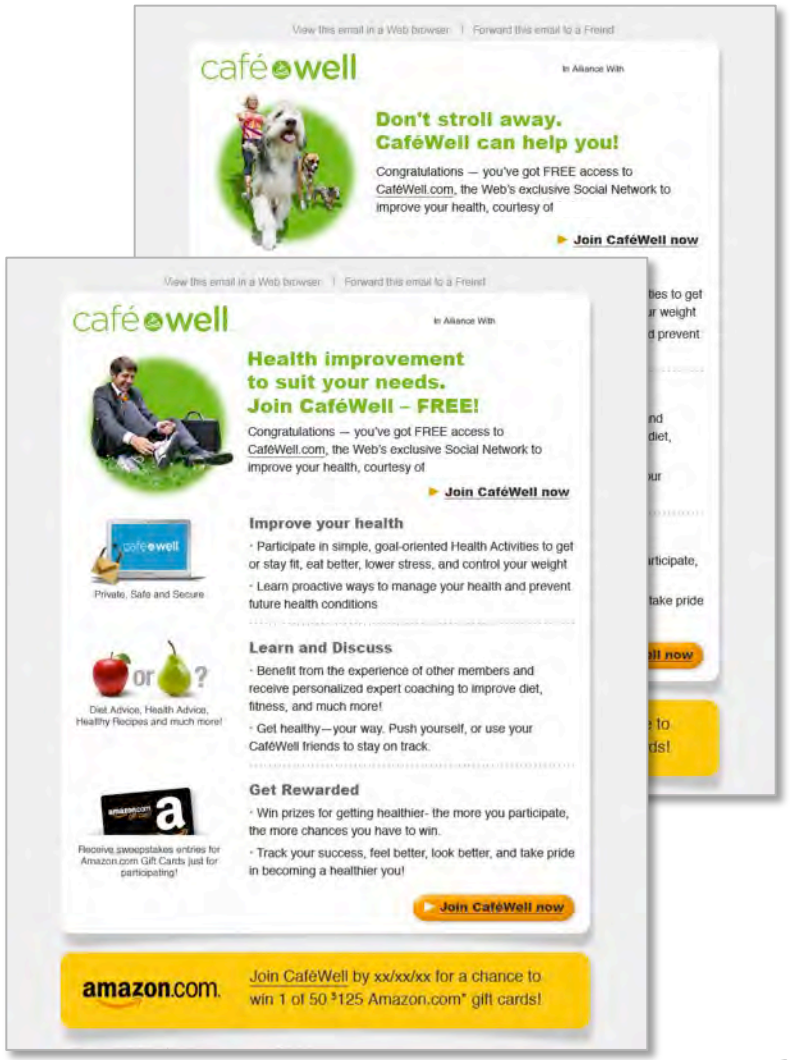
3 LEARN & EARN
Join a health activity to Get Well and Stay Well!

* No purchase necessary. Sweepstakes starts 7/1/12 and ends 5/31/13. Open only to legal residents of the United States or D.C., who participate in approved CafeWell activities listed in the Official Rules during the Sweepstakes and are eighteen (18) years of age or older. Void where prohibited. Subject to full Official Rules at rules.cafewell.com/rules/monthly. Sponsor: WellTok, Inc., 1530 15th Street, Denver, Colorado 80202.

Enhanced Master Email Templates

Enhanced Master Email Templates (In Progress)





DRAFT

ActiveHealth Clinical Quality Measures

ActiveHealth has an extensive library of clinical quality measures that encompass many relevant conditions, e.g., diabetes mellitus, asthma, cancer, preventive health. Using our patented technology we have the ability to measure the clinical care of populations, networks, and individual providers. Our expectation is that, as a part of a quality program, physicians, quality managers, and care managers will have access to reporting dashboards. Useful dashboards show quality measures, a list of patients in both the denominator and numerator of each measure, and the measured compliance. It is our vision that quality managers, care managers, etc., will have the ability to influence patient outcomes if they are provided with tools to monitor and increase compliance with specific measures.

ActiveHealth invests vast amounts of time and resources into developing and maintaining a library of quality measures that support a wide array of nationally recognized measure, including those developed by the Healthcare Effectiveness Data and Information Set (HEDIS), measures endorsed by the National Quality Forum (NQF), the Physician Quality Reporting Initiative (PQRI), and measures to support "meaningful use." These measures can be used in a number of settings, whether for a health plan to monitor standard of care for a population, or physician groups that want to monitor clinical outcomes for their patient panels.

In addition, ActiveHealth has a subset of clinical outcomes measure specifically designed to support and monitor compliance of patients who enroll in our disease management programs. These clinical outcomes measures for the most part are also aligned with our health actions that are sent to patients. By aligning quality measures with gaps in care (Health Actions), we can drive patient compliance.

The ActiveHealth quality library currently consists of three groups of measures described below, but it is important to note that we are continually adding additional measures as indicated by the medical literature and in collaboration with the needs of our clients, i.e. client-specific measures.

A) NQF-endorsed, ActiveHealth Measures (see list below).

In 2009, the NQF endorsed 69 total measures and 26 are ActiveHealth measures. Of the ActiveHealth Quality Measures there are 14 "level three" measures, which consist of clinically enriched laboratory, patient, or provider derived data and is the ultimate goal in measurement development. ActiveHealth's measures cover 10 conditions (e.g., cardiovascular disease, respiratory illness, diabetes) and have the broadest distribution across medical conditions providing a more holistic view of the patient's care.

The majority of ActiveHealth's measures are complex and clinically sophisticated measurements supporting evidence-based treatment for high-risk individuals.

Condition	ActiveHealth NQF-Endorsed Measure Title
Cancer Monitoring	Breast Cancer-Cancer Surveillance (c) ActiveHealth
Cancer Monitoring	Prostate Cancer - Cancer Surveillance (c) ActiveHealth
Cardiovascular	Atherosclerotic Disease and LDL Greater than 100-Use of a Lipid Lowering Agent (c) ActiveHealth
Cardiovascular	Atherosclerotic Disease- Lipid Panel Monitoring (c) ActiveHealth
Cardiovascular	Atrial Fibrillation -Warfarin Therapy(c) ActiveHealth
Cardiovascular	Congestive Heart Failure-Use of a Beta Blocker (c) ActiveHealth
Cardiovascular	Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy (c) ActiveHealth
Cardiovascular	MI-Use of Beta Blocker Therapy (c) ActiveHealth
Cardiovascular	Secondary Prevention of Cardiovascular Events- Use of Aspirin or anti-platelet therapy (c) Active Health
Cardiovascular	Warfarin - INR Monitoring (c) ActiveHealth
Diabetes	Diabetes and elevated HbA1c - Use of diabetes medications (c) ActiveHealth
Diabetes	Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB (c) ActiveHealth
Diabetes	Diabetes with LDL greater than 100 - Use of a lipid lowering agent (c) ActiveHealth
Gastrointestinal	GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms (c) ActiveHealth
Hepatic	Chronic Liver Disease - Hepatitis A Vaccination (c) Active Health
Osteoporosis	Osteopenia and Chronic Steroid Use - Treatment to prevent Osteoporosis (c) ActiveHealth
Osteoporosis	Osteoporosis-Use of Pharmacologic Treatment (c) Active Health

Osteoporosis
Steroid Use Osteoporosis Screening (c) ActiveHealth
Preventive
High Risk for Pneumococcal Disease - Pneumococcal Vaccination (c) ActiveHealth
Preventive
Hyperlipidemia (Primary Prevention)- Lifestyle Changes and/or Lipid Lowering Therapy (c) ActiveHealth
Preventive
Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) Screening for AAA (c) ActiveHealth
Preventive
Primary prevention of cardiovascular events in diabetics older than 40 years - Use of aspirin or antiplatelet therapy (c) ActiveHealth
Renal
Chronic Kidney Disease - Lipid Profile Monitoring (c) ActiveHealth
Renal
Chronic Kidney Disease with LDL Greater than or equal to 130 - consider adding a lipid lowering agent (c) ActiveHealth
Renal
Non-Diabetic Nephropathy - consider adding and ACEI or ARB (c) ActiveHealth
Respiratory
Asthma - Use of Short-Acting Beta Agonist Inhaler for Rescue Therapy (c) ActiveHealth

B) NQF Nationally Endorsed Measures (see list below for examples).

In addition to ActiveHealth's NQF-endorsed quality measures, our library contains a number of measures developed by other organizations, e.g., the National Committee on Quality Assurance (NCQA), American Medical Association's Physician Consortium for Performance Improvement (PCPI). Our library of nationally recognized measures is growing and the table below shows measures that cover many high-risk conditions.

Condition
Endorsing Body Measure Title
Cardiovascular
Cholesterol Management for Patients With Cardiovascular Conditions (CMC) LDL Screening and Control (LDL Screening)
Cardiovascular
Cholesterol Management for Patients With Cardiovascular Conditions (CMC) LDL Screening and Control (LDL <100 mg/dL)
Diabetes
Comprehensive Diabetes Care: HbA1c control (<7.0%) for a selected population*

Diabetes
Comprehensive Diabetes Care: HbA1c control (<8.0%)
Diabetes
Comprehensive Diabetes Care: HbA1c poor control (>9.0%)
Diabetes
Comprehensive Diabetes Care: HbA1c Testing
Diabetes
Comprehensive Diabetes care: LDL Screening
Diabetes
Comprehensive Diabetes Care: Nephropathy Monitoring
Diabetes
Comprehensive Diabetes Care: LDL-C Control <100 mg/dL
Diabetes
Comprehensive Diabetes Care: Blood Pressure Control (<130/80 mm Hg)
Diabetes
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
Medication Management
Annual Monitoring for Patients on Persistent Medications (MPM) - ACE or ARB
Medication Management
Annual Monitoring for Patients on Persistent Medications (MPM) - Digoxin
Medication Management
Annual Monitoring for Patients on Persistent Medications (MPM) - Diuretics
Preventive
Chlamydia Screening in Women: 16 - 20 Years of Age
Preventive
Chlamydia Screening in Women: 21 - 24 Years of Age
Preventive
Colorectal Cancer Screening
Preventive
Cervical Cancer Screening
Preventive
Breast Cancer Screening
Preventive
Childhood Immunization Status - DTaP
Preventive
Childhood Immunization Status - IPV
Preventive
Childhood Immunization Status - MMR
Preventive
Childhood Immunization Status - HiB
Preventive
Childhood Immunization Status - Hep B
Preventive

Childhood Immunization Status - VZV
Preventive
Childhood Immunization Status - PCV
Preventive
Childhood Immunization Status - Hep A
Preventive
Childhood Immunization Status - RV
Preventive
Immunizations for Adolescents - Meningococcal
Preventive
Immunizations for Adolescents - Tdap-Td
Respiratory
Appropriate Testing for Children with Pharyngitis
Respiratory
Appropriate Treatment for Children With Upper Respiratory Infection (URI)
Respiratory
Use of Appropriate Medications for Asthma
Respiratory
Avoidance of antibiotic treatment for adults with acute bronchitis

B) Clinical Outcome Measures to Support Disease Management Programs (see table below for examples).

These clinical outcomes measures for the most part are also aligned with our health actions that are sent to patients. By aligning quality measures with gaps in care (Health Actions), we can drive patient compliance. These clinical outcomes measure are driven by data collected directly from the patient when they engage with a nurse in a disease management program and therefore better reflect the patient's compliance with specific quality initiatives. These measures often look for compliance in important aspects of a patient's condition which we typically can not capture with administrative data, e.g., blood pressure control. The table below shows examples of measures used to support the disease management program by condition.

Condition
Measure Title
Respiratory
Asthma - Action Plan
Respiratory
COPD - Non Smoker
Respiratory
COPD - Pneumococcal Vaccination
Cardiovascular Disease

CAD - Use of Lipid Lowering Agents
Cardiovascular Disease
CAD - Lipid Panel Monitoring
Cardiovascular Disease
CAD - Blood Pressure At Target
Diabetes
Diabetes - Nephropathy Monitoring
Diabetes
Diabetes - Blood Pressure At Target
Diabetes
Diabetes - HbA1C < 7

In summary, quality measures could be the strategic cornerstone for any program.

4.2.6.2 ROI

Product	**Pop demog requirements**	**ROI offered**	**Methodology**
CareEngine+Disease Management	minimum avg age of members >=30, measured at the end of the measurement year	**Yr 1: 2:1** **Yr 2: 2.25:1** **Yr 3: 2.5:1**	FIF + HEM/DM fee (including CE fee component)
Active Lifestyle Coaching	minimum avg age of members >=30, measured at the end of the measurement year	**Yr 1: none** **Yr 2: 1:1** **Yr 3: 1.5:1**	LC savings/LC fees HEM based on improvement in lifestyle risks

ACTIVEHEALTH MANAGEMENT

Active Lifestyle Coaching Program Communication Index

Week 1 - Invitation

Outreach	Description	Additional Inserts	Frequency	Template
Outreach Call 1 Low	This automated call notifies the member of the program and allows the member to speak to a program representative.	• No Inserts	Initiated prior to letter 1 being mailed.	ALC Automated C 1 Intro.doc
Outreach Call 1 to Mod /High	This automated call notifies the member of the program and allows the member to speak to a program representative.	• No Inserts	Initiated prior to letter 1 being mailed.	ALC Automated C 1 Into Mod-high 9.
Letter 1a: ALC Invitation Package to Low Risk	This letter is sent to all low risk members on behalf of the entity sponsoring the program that are targeted for on line engagement. It provides information on the program, how to access the on line programs, and offers the opportunity to participate in up to four telephonic coaching sessions via self referral.	• Frequently Asked Questions (FAQs)	Mailed to members within 1 week of identification for Active Lifestyle Coaching.	STD ALC 1a Low R Invite 9.21.doc
Letter 1b: ALC Invitation Package to Mod / High Risk	This letter is sent to all moderate and high risk members on behalf of the entity sponsoring the program that are targeted for telephonic engagement. It provides information on the program, how to access the coach with the telephonic program, and provides information about the on line program including how to access it.	• Frequently Asked Questions (FAQs) • Reply Card with Return Envelope	Mailed to members within 1 week of identification for Active Lifestyle Coaching.	STD ALC 1b mod.high risk Invit

Week 2 – Reminder

Outreach Call 2 to Mod / High risk	This automated call reminds the moderate and high risk members of the program and allows the member to speak to a program representative.	• No Inserts	Initiated prior to letter 2 being mailed.	ALC Automated C 2 OTR Mod-high 9.

Week 3 - Reminder

Letter 2: ALC Reminder Package to Mod / High risk	This package is sent to moderate and high risk members reminding them about the program. This mailing is not sent to members that enrolled or opted out.	• Reply Card with Return Envelope	Mailed to members 1 week after letter 1.	STD ALC 2 high.m reminder letter 922

ACTIVEHEALTH MANAGEMENT

Active Lifestyle Coaching Program Communication Index

Outreach Call 3a to Mod / High risk	This call is made by a customer service advocate promoting the program. (when member is reached)	• No Inserts	Initiated after letter 2 is mailed.	 CSA call when rea member 9.24.201(
Outreach Call 3b to Mod / High risk	This call is made by a customer service advocate promoting the program. (when member is not reached)	• No Inserts	Initiated after letter 2 is mailed	 Current CSA call L 9.24.2010.doc

Week 5 – Reminder and Unable to Reach

Outreach Call 4a to Mod / High risk	This call is made by a customer service advocate promoting the program. (when member is reached)	• No Inserts	Initiated a week to 10 days after call 3	 CSA call when rea member 9.24.201(
Outreach Call 4b to Mod / High risk	This call is made by a customer service advocate promoting the program. (when member is not reached)	• No Inserts	Initiated a week to 10 days after call 3	 Current CSA call L 9.24.2010.doc
Letter 3: ALC Unable to Reach Package to Mod / High risk	This package notifies moderate and high members that contact has been unsuccessful. This mailing is not sent to members that enrolled or opted out.	• FAQs • Reply Card with Return Envelope	Mailed to members 2 weeks after letter 2	 STD ALC 3 high.m UTR letter 9.22.20

Week 6 – Unable to Reach

Outreach Call 5 to Mod / High risk	This automated call notifies the member that we have been unable to reach him/her, promotes the program, and reminds the member to call to engage in the ALC program.	• No Inserts	Initiated a week after call 4	 ALC Automated C 3 UTR Mod-high 9.

ALC Reply Card

Active Lifestyle Coaching Program Communication Index


reply card.doc

ALC Frequently Asked Questions

Low Risk	Mod – High Risk
 ALC Std FAQ Low.doc	 ALC Std FAQ Mod-High.doc

4.2.7.3.21 In the most recent calendar year and of those eligible for the program at each risk level (high, moderate, low) indicate the percent of members in each category for your book of business (with an incentive and without an incentive).

Disease Management	High Risk (with incentive)	Medium Risk (with incentive)	Low Risk (with incentive)	High risk (No incentive)	Medium Risk (No Incentive)	Low Risk (No Incentive)
* Identified %	1.4%	2.4%	3.9%	2.9%	4.4%	9.5%
** Outreached To %	98.1%	91.7%	79.6%	73.4%	73.4%	32.6%
*** Reached %	46.5%	40.9%	46.8%	27.0%	21.1%	21.6%
**** Opted Out %	6.3%	10.7%	22.0%	21.3%	22.8%	27.0%
***** Enrolled %	41.4%	34.9%	33.5%	18.2%	14.3%	13.3%
****** Dropped Out % (includes autostepped down)	21.9%	16.3%	20.4%	33.0%	25.7%	34.6%
Dropped Out – excludes autostepped down	1.8%	1.9%	2.5%	5.3%	4.0%.	5.5%
*******Completed program – goals met %	8.7%	9.2%	5.8%	4.5%	5.4%	5.5%

***** % of members identified with specific risk level of entire incentive or no incentive population
** % of members outreached of those identified with specific risk level
*** % of members reached of those outreached with specific risk level
**** % of members opted out of those reached with specific risk level
***** % of members enrolled out of those outreached with specific risk level
****** % of members dropped out of those enrolled with specific risk level
******* % of members completing program of those enrolled with specific risk level

Harvard Medical School Faculty Approve the Clinical Content of ActiveHealth's Maternity Management Program

NEW YORK — April 18, 2012 — ActiveHealth Management (ActiveHealth®) announced today that physicians on the Harvard Medical School (HMS) faculty have reviewed and approved the clinical content in Active Maternity Management℠, a personal health management program that helps reduce the risks and costs associated with the complications of pregnancy.

This clinical review supports ActiveHealth's rigorous application of evidence-based medicine throughout program assessments and educational content used to protect and improve the health of expecting mothers. The review process is a collaboration between a committee of HMS physicians and the ActiveHealth Clinical Development Center.

The content is used by experienced Maternity Nurse Coaches to support women during and after their pregnancy to help reduce the complications of pregnancy.

The Maternity Management review is in addition to the ongoing HMS faculty review of ActiveHealth's library of more than 1,400 Care Considerations. In keeping with ActiveHealth privacy standards, the Harvard Medical School faculty does not have access to any information about specific patients or about the care being rendered by physicians.

About ActiveHealth Management

ActiveHealth Management is a leading provider of health management services, including disease management, clinical decision support and personal health records. The company's solutions, all based on its patented CareEngine® System, help individuals receive quality care and help organizations like health plans, employers, providers and health systems and government payers reduce medical costs. More than 22 million people nationwide benefit from ActiveHealth programs. Founded in 1998 and headquartered in New York City, ActiveHealth is

an independent subsidiary of Aetna (NYSE: AET). For more information, please visit http://www.activehealth.com.

About Harvard Medical School

Harvard Medical School has more than 10,000 faculty working in eight academic departments based at the School's Boston quadrangle or in one of 47 academic departments at 18 Harvard teaching hospitals and research institutes. Those Harvard hospitals and research institutions include Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Cambridge Health Alliance, The CBR Institute for Biomedical Research, Children's Hospital Boston, Dana-Farber Cancer Institute, Forsyth Institute, Harvard Pilgrim Health Care, Joslin Diabetes Center, Judge Baker Children's Center, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, Massachusetts Mental Health Center, McLean Hospital, Mount Auburn Hospital, Schepens Eye Research Institute, Spaulding Rehabilitation Hospital, and the VA Boston Healthcare System.

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Contact:

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Aetna
904.351.4592
sanderfords@aetna.com

Disease Management Savings Methodology

ActiveHealth uses a two-part method to calculate cost savings - a Health Economic Model (HEM) to estimate savings from the CareEngine (which underlies all of our health management programs) and one of two methods to measure or estimate the additional value of disease management itself, depending on the size of the population being served.

1) Care Considerations—The Health Economic Model (HEM) Method

This methodology projects savings from avoided adverse events due to successfully resolved Care Considerations (CCs) identified by the CareEngine system and used to engage physicians and members as part of our health management programs. This model applies to the use of the CareEngine across a population and the impact of Care Considerations which are successfully resolved (representing closure in a gap in care). The incremental impact from further member support as part of a health management program, such as a disease management program, is additional to the HEM impact from Care Considerations.

For a given resolved Care Consideration, HEM savings are derived from:

- Reduction in the probability of an adverse event(s) due to implementing the service specified in the Care Consideration.

- Multiplied by the one-year cost of the adverse event(s)

- Minus the cost of implementing the Care Consideration (giving the drug, performing a test or procedure, adverse events related to implementation such as bleeding from starting an anticoagulant for a patient with atrial fibrillation, etc). In some Stop Drug Care Considerations where no replacement drug is given, this cost is negative.

Total HEM savings are obtained by summing the allocated value of all implemented Care Considerations (during the reporting period), divided by the number of member-months in the reporting period, and expressed as PMPM.

2a) Disease Management—Claims-based Savings Study Method (For populations of 50,000 members or more)

Outside of a randomized control trial, it is challenging to answer the question "how much would the intervention (disease managed) group have cost absent the intervention?" When a randomized study is not feasible, ActiveHealth uses two methods – both of which are consistent with Disease Management Association of America (DMAA) recommendations – for assigning an appropriate control group. In both cases, the question is addressed by predicting that, in the absence of the intervention, the year-over-year cost trend for the intervention group would have been the same as the trend of a non-intervened group. If pre-baseline year data are available, this assumption can be examined and adjustments made accordingly.

The two study designs for constructing a pre/post control group are:

- **Quasi-experimental design (external comparison group):** If the client has a non-intervened, concurrent group that is (or can, by statistical adjustment, be made to be) similar to the intervention group, then the trend of this external group is taken as the predicted trend of the intervention (disease managed) group. To the extent that the intervention group has a lower PMPM trend than the comparison group, the latter is assigned savings. That is, the baseline year PMPM for the intervention group is multiplied by (1 + predicted trend) to get *predicted PMPM*; then, predicted PMPM – actual PMPM = savings PMPM.

- **Non-suitables index group:** ActiveHealth defines the "suitables" group as those who are identified (using our clinical stratification and identification algorithms) as having one or more conditions managed by our disease management program. The non-suitables (sometimes referred to as the "index group") trend is used as the predicted trend for the suitables, as above.

In both pre/post study designs, the "pre" or baseline period is the year prior to the implementation date. The "post" period is the year following the implementation date. ActiveHealth lags the start of the "after" period by one month to allow for program ramp-up and affect lag. The "suitables" group is regenerated in each period to ensure comparability and avoid regression to the mean. This treatment of the "suitables" group is consistent with the approach defined in outcomes methodology endorsed by the DMAA. This means that ActiveHealth does not measure financial impact on only those who participate in the program because this approach invites regression to the mean, and there is no way to designate a valid comparison "would have participated" control group. This is also why they use calendar time, rather than individuals' participation time, as savings start date.

Third-party validation

ActiveHealth uses industry-standard methodologies, which have been examined by third parties. As part of client projects, Hewitt and Lotter Actuarial Partners have audited the methodology for "Claims-Based Savings Studies" for evaluation of savings in disease management programs.

The credibility and ROI of our programs is demonstrated by the clinical trials we conduct to validate the effectiveness of our programs. Several studies of the impact of our programs have been published in peer-reviewed journals, several in conjunction with third party collaboration. A randomized controlled trial of the utilization and economic impact of CareEngine in a commercial health plan was published in The American Journal of Managed Care in 2005, co-authored with the medical director of a client health plan, and a follow-up study was published in The Journal of Health Economics in 2008, with two external authors including the Chairman of Economics of Case Western University. A study of the impact of our disease management programs appeared in Disease Management in 2005, and a study of the member messaging component of the CareEngine was in The American Journal of Managed Care in 2008, featuring a Columbia University faculty member as lead author.

In addition, a study conducted jointly by ActiveHealth and Cornell Medical College confirmed the high level of validity of the alerts issued by the CareEngine, and was presented at the annual American Medical Informatics Association (AMIA) meeting in 2008. The patients' medical records confirmed that Care Considerations were clinically valid 98 percent of the time, with correct diagnoses/clinical situations, correctly-identified gaps in care, and correct presence/absence of contraindications, and administratively valid 91 percent of the time; i.e., they were sent to the correct physicians at a time when corrective actions had not yet been taken.

The randomized trial findings referenced below were validated by Professor James Rebitzer, department of economics, Case Western Reserve University.

Outcomes Results

The two Commercial health plan studies referenced above showed the following summary results:

Controlled clinical trial of the CareEngine System: Approximately 35,447 members age 12 and above (and who had at least one encounter or pharmacy claim in the preceding year) were randomized to control and study groups. Study group physicians received Care Considerations; control group data was sequestered and run at the completion of the study to determine which Care Considerations would have been issued. Successful Care Consideration resolution rate was significantly greater in the study group, as were "most impactible" hospitalizations (neurologic, respiratory, and cardiovascular). Paid claims were $8.07 PMPM lower in the control group after adjustment for trend (as determined by the control group). In the group who generated Care Considerations, hospitalizations were 19 percent lower for the study group compared to the control group and paid claims were $68.08 PMPM lower for the study group compared with control group.

Disease management Program Economic Impact, 2003:

ActiveHealth conducted a pre/post study of the incremental (compared with CareEngine alone) economic impact of a multi-condition disease management program on 200,000 members of five commercial employer-based health plans, with six months' claims run-out in both baseline and intervention years.

As defined in the "Claims-Based Savings Study" methodology, the trend of the "non-suitables" was used to predict the trend of the "suitables," those who scored as qualifying for invitation to at least one disease management program. Using allowed (covered) charges, the following was found:

- The pre-implementation trends (pre-baseline year to baseline year) were comparable at 10.7 percent for non-suitables and 10.4 percent for suitables.

- The baseline-to-implementation year trends diverged: 8.9 percent for non-suitables (the predicted trend) and 6.7 percent for suitables (220 basis points lower than predicted). The calculated PMPM savings across the suitables population (those with qualifying conditions) was $12.58 (in allowable charges). Spreading the savings over the entire population results in allowable charges savings of $2.46 PMPM ($3.10 in 2007 dollars).

2b) HEM-Based Incremental Savings Method (for populations of fewer than 50,000 members)

The above methods do not produce reliable forecasts on populations of fewer than 50,000 members, and are therefore not endorsed by the DMAA for use in these smaller groups. In these situations, we use the following method:

This model measures incremental savings due to the disease management program using a multi-component HEM:

- Savings for nurse-engaged (NE) ICM participants.
- Savings for non-nurse-engaged (NNE) ICM participants.
- Savings due to interventions (specific clinical actions) for NE participants
    - Interventions that prevent the occurrence of a gap in care ("Care Consideration prevention").
    - High-impact interventions not related to a Care Consideration (CC), but which have clinical and economic value.

In addition, we project presenteeism savings for participating employees.

Methodology by savings component- Medical

COMPONENT	DESCRIPTION
Patient-derived CC savings: Nurse-Engaged members	Due to nurse engagement: 100% credit
Claims-derived CC savings: Nurses-Engaged members	Due to nurse engagement: 21% credit "bump"
CC savings: Non Nurse-Engaged members (all claims-derived)	During non nurse engagement: ½ of nurse engagement credit
Interventions: Nurse-Engaged members	Condition-specific, actionable interventions: CC prevention, lifestyle modification, specific actions with physician, warning signs

The rationale for this model derives from the recognition that the savings (measured in our book of business clients with sufficient sample size) arises from the above specific

sources. The model was constructed iteratively to plausibly account for the actually-measured savings.

Lifestyle Coaching Savings Methodology

Lifestyle Coaching engagement reduces behaviorally-impactible health risks ("lifestyle-related risk factors"). While there are many more health related risks than appear in our savings model, we use the widely-accepted 13 risk factors promoted by Dee Edington and the University of Michigan Research Center (Edington D. Am J Health Promotion 2001, 15(5):341-349).
We value savings for lifestyle coaching with these metrics:

- Engagement (HRA use, AHLC participation coach or online) – covered elsewhere
- Risk factor reduction
- Absenteeism (for employees)
- Savings by monetized risk factor reduction

The 13 lifestyle-related risk factors in our model are as follows:

RISK FACTOR	HIGH RISK CRITERIA
Alcohol (excessive)	Men: > 14 drinks or Women: > 7 drinks per week
Blood pressure	Systolic > 139 OR Diastolic > 89
Body weight	BMI ≥ 27.5
Cholesterol	Total > 239 or LDL > 160
Existing medical problem	Heart, cancer, diabetes, stroke
HDL cholesterol	Men: < 35 or Women: < 45
Illness days in past year	> 5
Life satisfaction	Partly or not satisfied
Perception of health	Fair or poor (on a five point scale)
Physical activity	Less than one time/week
Safety belt usage	Less than 100% of the time
Smoking (tobacco)	Current smoker (user)
Stress	High (3-level scale)

There is a large body of observational research that relates future healthcare costs when each of these risk factors are present or absent. There is less research relating to savings achieved *from reducing an already-present risk.* As of December, 2011, we consider the U. Michigan statements on savings per risk reduced to be current, but (like most of the industry) we plan to review the findings of the next Health Enhancement

Research Organization (HERO) study, expected to be published in mid-2012, and we will reevaluate and may redesign our savings model based on this study.

Absenteeism savings are derived from a recent comprehensive survey of health promotion programs, which found a ratio of absenteeism to medical claims savings of 0.8/1. (Katherine Baicker, David Cutler and Zirui Song, Workplace Wellness Programs Can Generate Savings, *Health Affairs*, 29, no.2 (2010):304-311).

With either model, the savings modeling approach remains the same:

1. Status of the lifestyle-related risk factors is assessed (by claims, self-report, HRA, PHR and biometrics) for the measured population in two consecutive years
2. The number of risks reduced is calculated
3. Savings per risk reduced is applied
4. Absenteeism factor is applied to savings for employees
5. Total savings are summed
6. Savings is divided by member-months to express as population PMPM

Unless modified by the HERO study, the 2012 savings per risk reduced = $343.44.
A sample savings and ROI calculation is presented below:

ALC Savings and ROI Calculation

1	Risks reduced/100 LC participants	11.30	
2	% of members that are employees	60%	
3	Savings/risk reduced	$343.44	from Edington
4	Savings/risk reduced for employees (includes absenteeism)	$617.99	[3] * 1.8
5	Savings from employees	$418,997	[1]*[2]*[4]*100
6	Savings from non-employees	$155,235	[1]*(1-[2])*[3]*100
7	Total savings	$574,232	[5]+[6]
8	Covered pop (12-mo average)	12,250	
9	**Savings PMPM**	$3.91	[7]/ ([8] x 12)
10	Program fees PMPM	$2.00	

11	**ROI**	1.95 : 1	[9] / [10]

Maternity Management Savings Methodology

Return on Investment can be calculated based upon reduced preterm births compared to statewide rates (published by the CDC). Depending on the type of financial data available to ActiveHealth, we could develop a methodology that is more targeted to a specific population based on demographic, group size and costs; and could potentially include NICU avoidance.

For our entire book of business of maternity management program ROI exceeds 2:1.

4.2.9.1.6 Data model and reporting highlights

HDMS DART Data Model and Reporting Highlights

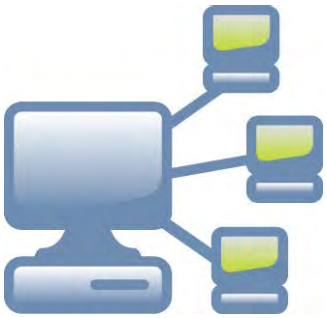
EMPLOYER SOURCE DATA

Medical
Pharmacy
Eligibility
Behavioral Health
Dental
Vision
Disability LTD
Disability STD
Lab/Biometric
Absence
Workers' Comp
HRA
Disease Management

BEST IN CLASS META DATA

DRG / MDC Groupers
ERG Risk Adjustment
High Cost Claimant Markers
Age / Gender Adjustment
Benchmarks
Episode Treatment Groupers

HDMS ETL PROCESSING



ARROW℠

A consultative set of reports built on a sophisticated set of smart text rules that update verbiage automatically with each database update

CARESHIELD™

Applies evidence-based quality rules to healthcare data to identify gaps between observed patient care and compliance with treatment guidelines

FORECAST™

A benefit modeling tool that utilizes the client's actual claims experience to measure the impact of proposed plan design changes

EXECUTIVE BRIEFCASE™

Provides easy access to key information in a question and answer format via a user friendly interface

CATAPULT™

Provides the capability to schedule and automatically deliver parameter driven reports on both a one-time and recurring basis

Exhibit 4.2.9.2.1 – Reporting Overview

ActiveHealth's portfolio will provide reporting which will reflect transactional elements as well as the overall success of the program (quarterly and annual) elements. The report list and frequency will be as follows:

DELIVERABLE	ONGOING FREQUENCY	DESCRIPTION
Monthly Dashboard Report	Monthly – by the 20th of the month following the previous month	A one page report containing counts of identified members and participants for each program, stratified by risk category.
CareEngine/Disease Management Quarterly Executive Summary Report	Quarterly – 45 days after the quarter end	Detailed report showing activity volume in each of the Programs. Metrics include but are not limited to: Care Consideration volume, program referrals, disease prevalence member engagement by risk stratification. Modeled savings for CareEngine and DM are available after third quarter.
DM Clinical Outcomes Report	Quarterly – 18 Months after go live	Detailed report showing clinical outcomes measurements in the DM Program. Metrics including but not limited to measures for Asthma, Vascular Diseases, Diabetes, etc.
UM Executive Summary Report	Quarterly – 45 days after the quarter end	Detailed report showing activity volume in the UM Program. Metrics including but not limited to: Denials, Appeals, Reviews, Days Approved, Estimated Cost Savings

CM EXECUTIVE SUMMARY REPORT	QUARTERLY – 45 DAYS AFTER THE QUARTER END	DETAILED REPORT SHOWING ACTIVITY VOLUME IN THE CM PROGRAM. METRICS INCLUDING BUT NOT LIMITED TO: ENROLLMENTS, CONDITIONS, OUTREACH, AND INTERVENTIONS
CM Participation Report	Daily; Monthly – by the 20th of the month following the previous month	Detailed report showing member level activity in the CM Program
Pre-Certification within X Business Days	Quarterly – 45 days after the quarter end	Detailed report showing Pre-Certifications made within X timeframe.
Maternity Management Report	Quarterly – 45 days after the quarter end	Comprehensive report showing activity volume in the Maternity Program. Metrics including but not limited to: Identification, Outreach, Outcomes, Risk
Provider Survey Reporting	Quarterly – 45 days after the quarter end	Detailed report showing provider responses to Care Consideration notifications mailed to providers
RN Coaching Sessions Report	Quarterly – 45 days after the quarter end	Report showing nurse outreach rates to members engaged in the Disease Management Program
Transplant Report	Monthly – by the 20th of the month following the previous month	Detailed report showing activity volume in the Transplant Program

Active Health Management
Attn: Elizabeth Copeland
95 Madison Avenue
New York, NY 10016
(212) 448-1882 Fax (212) 448-0096

Invoice No. ASAMPLE

INVOICE

Customer
ABC Company
123 Main Street
Anytown, NY 12345

ATTN: Accounts Payable

Customer #	1010-ABC001
Date	11/18/2005
Terms	Due Upon Receipt

Invoice Description SAMPLE INVOICE

Quantity	Description	Rate	Total
18,000.00	1010ABC001 ABC Company	1.0000	18,000.00
	INFORMED CARE MANAGEMENT SERVICES		
18,000.00	1010ABC001 ABC Company	1.0000	18,000.00
	UTILIZATION MANAGEMENT SERVICES		
18,000.00	1010ABC001 ABC Company	1.0000	18,000.00
	CASE MANAGEMENT SERVICES		

Total Due $54,000.00

Please Remit To:

Active Health Management
P.O. Box 75174
Baltimore, MD 21275-5174

Payment Details

Due Upon Receipt
Federal Tax ID # 52-2182411

Performance Guarantees for Clients with 10,000-24,999 Members

Max Fees at Risk 30% across all products, percentage may be divided as the client chooses

Active Lifestyle Coaching—HRA Takers

Outcome Type	Outcome	Population Requirements	Minimum conditions for PG to apply	Payback Schedule	X	% at risk
Population: HRA Takers	Change in number of risks per 100 members age 18+ who take the HRA +/- 3 months of the first day of the measurement year, and who report data on at least 10 of the 13 risk factors	client must have AHM's HRA and ALC with at least 4 core conditions*	At least 50% of the pop over age 18 who are eligible to take the HRA (but not necessarily the same members) must take HRA in <u>each</u> of the performance and prior years	Risks reduced/100 mbrs / Payback % of pool: 15 or more — 0%; 7.5 to 14.9 — 50%; Fewer than 7.5 — 100%. Members as defined in outcome column	☐	____ %
Cohort: HRA Takers	Change in number of risks per 100 members age 18+ who take the HRA +/- 3 months of the first day, and last of the measurement year, and who report data on at least 10 of the 13 risk factors	client must have AHM's HRA and ALC with at least 4 core conditions*	At least 20% of the pop over age 18 who are eligible to take the HRA must take HRA in ***<u>both</u>*** years (same people in both years)	Risks reduced/100 mbrs / Payback % of pool: 20 or more — 0%; 10 to 19.9 — 50%; Fewer than 10 — 100%. Members as defined in outcome column	☐	____ %

***Tobacco Cessation, Weight Management, Physical Activity and Stress Management**

Active Lifestyle Coaching—Program Participants

Measure Type	Program/Measure	Min Sessions	PG Goal	Minimum conditions for PG to apply Population Requirements	X	% at

						risk
Cohort	Tobacco cessation: 2 mo quit rate	4	25%	At least 20 participants who meet minimum time/# of sessions criteria for the metric's program	☐	☐ %
Cohort	Tobacco cessation: 6 mo quit rate	6	15%	At least 20 participants who meet minimum time/# of sessions criteria for the metric's program	☐	☐ %
Cohort	Physical activity: Increase exercise by at least 1 level reported at 1-3 months	4	50%	At least 20 participants who meet minimum time/# of sessions criteria for the metric's program	☐	☐ %
Cohort	Weight management: Lose at least 1 point of BMI reported at 3-6 mo	4	50%	At least 20 participants who meet minimum time/# of sessions criteria for the metric's program	☐	☐ %
Cohort	Stress management: Reduce stress by at least 1 level reported at 1-3 mo	4	50%	At least 20 participants who meet minimum time/# of sessions criteria for the metric's program	☐	☐ %

My ActiveHealth Member Website

Metric	Eligibility Criteria	X	% at risk
The MyActiveHealth website will be available 24 hours a day, 7 days a week with the exception of periodic scheduled infrastructure and application maintenance windows.	1. CareEngine Customer 2. MyActiveHealth customer (customer has MyActiveHealth website and at least one online product accessed through MAH: HRA, PHR, DM Online, ALC Online)	☐	☐ %
MyActiveHealth will be available 95% during the hours of operation specified above from a production implementation	1. CareEngine Customer 2. MyActiveHealth customer (customer has	☐	☐ %

date to six weeks following the implementation.	MyActiveHealth website and at least one online product accessed through MAH: HRA, PHR, DM Online, ALC Online)		
MyActiveHealth will be available 98% during the hours of operation specified above **six** weeks following any production implementation.	1. CareEngine Customer 2. MyActiveHealth customer (customer has MyActiveHealth website and at least one online product accessed through MAH: HRA, PHR, DM Online, ALC Online)	☐	%

Reporting

Product	Measure	Report Period	X	% at risk
Maternity	Total participation, outcomes and risk type reports will be delivered within 20 days from the end of the month	Monthly	☐	%
Maternity	C-section rate **(must also have UM product)** and maternity assessment reports will be delivered within 45 days from the end of the reporting period.	Quarterly	☐	%
Disease Management	All reports, excluding clinical outcomes and special studies (ROI) will be delivered within 45 days	Quarterly	☐	%
CareEngine	All reports, excluding ROI, will be delivered within 45 days	Quarterly	☐	%
Member Satisfaction	All reports will be delivered 45 days after the end of the year	Annually	☐	%
Call Center	All reports will be delivered within 45 days	Quarterly, guarantee settled annually	☐	%
Clinical Metrics—Disease Management	All reports will be delivered 6 months after the close of the reporting period	Annually	☐	%
ROI	8 months after close of performance period if the calculation includes CE savings, 6 months if the calculation is DM only	Annually	☐	%

Operational

PG Type	Standard Response	X	% at risk
Implementation Satisfaction	85% satisfaction	☐	____%
Account Management Satisfaction	As measured by either: (A) 85% satisfaction on client's proprietary 0-100% satisfaction scale or (B) Overall average of at least 4 on all answered questions on the AHM survey	☐	____%
Member Satisfaction	**A minimum of 85%** of members who complete survey will show responses of satisfied or very satisfied on 5 point scale **(BOB results will be reported)** (not offered for MyActiveHealth member website or CE)	☐	____%

Call Center (DM, LC)

PG Type	Standard Response	X	% at risk
Phone Performance	Call Abandonment rate will be **≤ 5%** **For accounts without a dedicated line, overall BOB rate will be reported**	☐	____%
Phone Performance Average Speed of Answer	**80% or more of all in-bound calls (member and provider) will be answered within 30 seconds (URAC standard)** **For accounts without a dedicated line, overall BOB rate will be reported**	☐	____%

ROI

Product	Pop demog requirements	ROI offered	Methodology	X	% at risk
CareEngine	minimum avg age of members >=30, measured at the end of the measurement year	Yr 1: 2:1 Yr 2: 2.25:1 Yr 3: 2.5:1	HEM	☐	____%
CareEngine+Disease Management	minimum avg age of members >=30, measured at the end of the measurement year	Yr 1: 2:1 Yr 2: 2.25:1 Yr 3: 2.5:1	FIF + HEM/DM fee (including CE fee component)	☐	____%
Active Lifestyle Coaching	minimum avg age of members >=30, measured at the end of the measurement year	Yr 1: none Yr 2: 1:1 Yr 3: 1.5:1	LC savings/LC fees HEM based on improvement in lifestyle risks	☐	____%

Disease Management –Clinical

An **Outcomes Index** allows us to report clinical metrics on smaller populations by combining metrics to increase the size of their denominators. (These are all cohort metrics)

	X	% at risk
Check here if requesting index clinical performance guarantees, all metrics outlined below will be reported	☐	____%
Index 1: "Clinical targets" (measurement pool is nurse-engaged only)		
Component 1: Diabetes HbA1c target of 7% (met or improved by 10% from baseline) Component 2: Vascular conditions LDL target of 100 mg/dL (met or improved by 10% from baseline) Component 3: Vascular conditions BP target (130/80 for members with diabetes or chronic kidney disease, otherwise 140/90) (met or improved by 10% from baseline)		
Index 2: "Clinical process metrics" (measurement pool is all-engaged except for Component 4)		

Component 1: Diabetes HbA1c monitoring Component 2: Vascular conditions appropriate use of lipid-lowering drugs Component 3: Diabetes nephropathy screening Component 4: Diabetes annual foot exam (nurse-engaged only)
Index 3: "Asthma-specific metrics" (measurement pools shown below)
Component 1: Asthma action plan (nurse-engaged only) Component 2: Asthma use of controller medications all-engaged)

Dollars at-risk in the clinical outcomes guarantee pool are divided as follows:

- Miss 1 of the 3 Indices: Forfeit 10% of the outcomes at-risk pool
- Miss 2 of the 3 Indices: Forfeit 50% of the outcomes at-risk pool
- Miss 3 or the 3 Indices: Forfeit 100% of the outcomes at-risk pool

Clients with membership over 20K:

Outcomes indices are preferred; however, individual metrics are acceptable but metrics with fewer than 10 members in the denominator cannot be counted for a performance guarantee

Cohort Measures: tracking the same individuals over time; the same members are in the baseline and performance year

Population Measures: tracking the same type of people over time; members validating for diabetes in the baseline compared to members validating for diabetes in the performance year

Data requirement for population metrics: AHM must receive complete eligibility and claims for all measurement years, including the pre-implementation year, this includes members who terminate during the measurement year

METRIC	PG MET IF:	X	% at risk
Check here if requesting individual clinical performance guarantees, all metrics outlined below will be reported		☐	____ %
Cohort: Vascular cluster nurse-engaged participants who met LDL target for condition,	% who met target increased by 2%, or 75% met target or improved by 10% relative to		

or decreased by ≥ 10%	their baseline
Cohort: Diabetes nurse-engaged participants who met HbA1c of < 7%, or decreased by ≥ 10%	% who met target increased by 2%, or 75% met target or improved by 10% relative to their baseline
Cohort: Vascular cluster nurse-engaged participants who met blood pressure target for condition, or decreased by ≥ 10% (systolic)	% who met target increased by 2%, or 75% met target or improved by 10% relative to their baseline
Cohort: Vascular cluster all-engaged participants: appropriate use of lipid-lowering agents (LLA)	Up to 65% compliance: improve by 2% <65% to <75% compliance: improve by 1% 75%+ compliance: PG met
Cohort: Diabetes all-engaged participants with HbA1c monitoring in prior 12 months	Up to 65% compliance: improve by 2% <65% to <80% compliance: improve by 1% 80%+ compliance: PG met
Cohort: Diabetes all-engaged participants with nephropathy screening in prior 12 months	Up to 65% compliance: improve by 2% <65% to <75% compliance: improve by 1% 75%+ compliance: PG met
Cohort: Asthma nurse-engaged participants with a physician-supervised asthma action plan	Up to 65% compliance: improve by 2% <65% to <75% compliance: improve by 1% 75%+ compliance: PG met
Population: Vascular cluster population (CAD or PAD or Cerebrovascular or Diabetes): appropriate use of lipid-lowering agent(LLA) (ALTERNATE): Separate into two metrics: CAD population appropriate use of lipid-lowering agent (LLA); and Diabetic population appropriate use of lipid-lowering agent (LLA)	Up to 65% compliance: improve by 2% <65% to <75% compliance: improve by 1% 75%+ compliance: PG met
Population: Diabetes population with HbA1c monitoring in prior 12 months	Up to 65% compliance: improve by 2% <65% to <80% compliance: improve by 1% 80%+ compliance: PG met

Population: Use of controller medication in people with evidence of persistent asthma	Up to 75% compliance: improve by 2% <65% to <90% compliance: improve by 1% 90%+ compliance: PG met

Clinical Metrics Payback Schedule	
Missed Metrics	**Penalty**
0-2	**0%**
3	**1/9 of at risk pool**
4	**2/9 of at risk pool**
5	**3/9 of at risk pool**
6	**4/9 of at risk pool**
7	**5/9 of at risk pool**
8	**6/9 of at risk pool**
9	**7/9 of at risk pool**
10	**8/9 of at risk pool**
11	**9/9 of at risk pool**

% Total Fees at Risk (not to exceed 30%) **%**

ADD

Maximum % at Risk for this Account _____%

Use of Administrative Data to Identify Health Plan Members With Unrecognized Bipolar Disorder: A Retrospective Cohort Study

Iver A. Juster, MD; Michael Stensland, PhD; Lisa Brauer, PhD; and Paul Thuras, PhD

Objective: This retrospective cohort study used an algorithmic case-finding system on claims data from nationwide commercial health plans to validate previously identified predictors of unrecognized bipolar disorder among adults.

Study Design: Retrospective cohort design.

Methods: Using logistic regression, 2 claims data sets were evaluated to explore potential predictors; the first included claims for all healthcare encounters (all-encounters data set); the second excluded mental health provider claims (carve-out data set). A total of 280 244 members aged 18 to 64 years were included from 2 commercial health plans.

Results: Claims related to attention deficit-hyperactivity disorder, depression, depression treated with antipsychotics, use of 3 (of 5) classes of psychotherapeutic drugs, younger age, and sex were all significant predictors of a subsequent diagnosis of bipolar disorder. In the all-encounters data set, a predicted value of 5% or greater yielded a sensitivity of 9.8% and a specificity of 99.9%; a predicted threshold of 3% increased sensitivity to 20.7%; area under the receiver operating characteristic curve (AUC) was 0.82. Performance of the model was acceptable in the carve-out data set, with AUC 0.69.

Conclusions: The case-finding system described here, which compares favorably with other screening tests used in primary care, may have significant value in helping physicians to identify patients with unrecognized bipolar disorder.

(Am J Manag Care. 2005;11:578-584)

Bipolar disorder is a chronic, disabling mental illness that can have devastating consequences for the patient and poses a substantial burden to the healthcare system. Although bipolar disorder is relatively uncommon, patients with the disorder utilize disproportionate medical and psychiatric healthcare resources.[1,2] Proper treatment of bipolar disorder can prevent psychosocial morbidity and relapses, although patients must be followed closely and treatment regimens may require ongoing adjustment.[3-5]

The prevalence of bipolar disorder is difficult to determine, in large part because of controversy and lack of clarity regarding diagnostic criteria. The diagnosis of bipolar I, characterized by a frank manic episode, is less ambiguous than the diagnosis of bipolar II, which depends on accurate characterization of a hypomanic episode. Whereas estimates of the lifetime prevalence of bipolar disorder range from 1%[6] to 11%[7] across studies, prevalence estimates for clearly defined bipolar disorder I and II generally fall in the range of 1% to 4%, with bipolar I clustering around 1%.

Bipolar illness is frequently misdiagnosed or unrecognized. In 1 survey, 70% of patients with bipolar disorder reported being misdiagnosed at some point,[8] often with major depression. Another study found that on average 8 years elapsed between initial presentation and diagnosis.[9] Such diagnostic and treatment delays can lead to poor outcomes.[10] Inappropriate treatment for (misdiagnosed) unipolar depression may exacerbate symptoms and induce cycling to mania or hypomania.[7,11] Furthermore, retrospective analyses indicate that healthcare costs may be higher for bipolar patients whose diagnosis is delayed.[12,13]

Because earlier identification of bipolar disorder could lead to improved outcomes and lower costs, innovative methods to facilitate its early identification are needed. One recently developed tactic is case-finding systems using standardized claims, prescription fills, and laboratory results data with clinical algorithms to identify patients whose medical care appears to deviate from accepted standards. Such a system can be used to screen large numbers of claims for various treatment patterns that may indicate a missed bipolar disorder diagnosis, prompting contact with the healthcare provider for secondary screening with a brief questionnaire. Several such questionnaires have been validated to screen for bipolar disorder in primary care settings, including the Mood Disorders Questionnaire[14] and the Hypomanic Personality Scale.[15] These instruments have proven useful for identifying patients who may have

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bipolar disorder, but first the physician must consider the diagnosis. A reasonably effective claims-based screening tool could help primary care physicians identify the up to 30% of patients with affective disorders who may have bipolar disorder.[16]

In a previous exploratory case-control study (unpublished), we tested the ability of several claims-codable characteristics (developed by a panel of bipolar disorder experts) to discriminate healthplan members with bipolar disorder from members with unipolar depression or neither diagnosis. We found that diagnoses or medications for unipolar depression, psychotic depression, attention deficit-hyperactivity disorder (ADHD), conduct or impulse control disorders, and prescriptions for multiple classes of psychotropic medications were significant discriminators.

The purpose of this study was to replicate our previous findings using a retrospective cohort design on 2 nationwide commercial health plan claims data sets: 1 including all encounters and 1 with a mental health "carve-out" (missing encounters with the identified mental healthcare system, but not prescriptions). These 2 databases reflected 2 common managed care scenarios and allowed us to replicate the predictive accuracy with mental health services "carved in" and extend the findings to the mental health "carved out" scenario. This study assessed the accuracy of a predictive model of bipolar disorder based on claims clues.

METHODS

To construct and validate the predictive model, we utilized "claims clues" developed by a bipolar disorder expert consensus panel and tested in the previous case-control study. The current study extended the previous findings in additional data sets, using a retrospective cohort design.

Data

The present study utilized the variables from the development study in 2 different data sets representing 2 common mental health payment scenarios: an *all-encounters data set* and a *mental health carve-out data set.* The carve-out data set excluded claims from mental health providers; both included all filled prescriptions. Both data sets contained only members of commercially insured nationwide health maintenance organizations or preferred provider organizations aged 18 to 64 years as of January 1, 2001, who were continuously enrolled from January 1, 2000, through September 30, 2003. The all-encounters set contained all claims for 40 244 members who met the age and enrollment criteria. The carve-out set, representing a different health plan, contained all noncarved-out claims and all prescription fills for 240 000 members who met the age and enrollment criteria.

Procedures

For each data set, we defined an *antecedents period* as containing claims with dates of service in 2000, and a *recognition period* as containing claims with dates of service from January 1, 2001, through September 30, 2003. The algorithmic case-finding system was designed to search for "bipolar clues" in claims from the year 2000, from the standpoint of January 1, 2001.

For the all-encounters set, which included mental health providers' claims, we defined the term "bipolar disorder" based on the presence of at least 2 claims for bipolar disorder (*International Classification of Diseases, 9th Revision, Clinical Modification [ICD-9-CM]* codes 296.1, 296.4-296.8). For the carve-out set, we defined bipolar disorder as the presence of at least 2 claims for bipolar disorder, at least 2 claims for lithium, or at least 2 claims for valproic acid derivatives unless the patient had a claim for any of the following diagnoses: migraine (346.xx); epilepsy (345.xx); convulsions (not otherwise specified) (780.39); undersocialized conduct disorder, aggressive type (312.34); or isolated explosive disorder (312.35). This medication-inclusive definition of bipolar disorder was used to capture individuals with bipolar disorder in the carve-out set who might not have claims with a bipolar disorder diagnosis from providers outside the mental health carve-out.

To increase the diagnostic specificity, several types of individuals were excluded from the analysis: individuals with preexisting bipolar disorder, a single bipolar diagnosis during the antecedents period, or only a single bipolar diagnosis during the recognition period. **Figures 1** and **2** describe the categorization based on these restrictions. In the all-encounters data set we considered individuals to have bipolar disorder only when their diagnoses were made by a mental health provider, based on the following criteria: (1) at least 1 hospitalization with a diagnosis in the mental health ICD cluster or (2) at least 2 claims with a CPT code between 90801 and 90899.

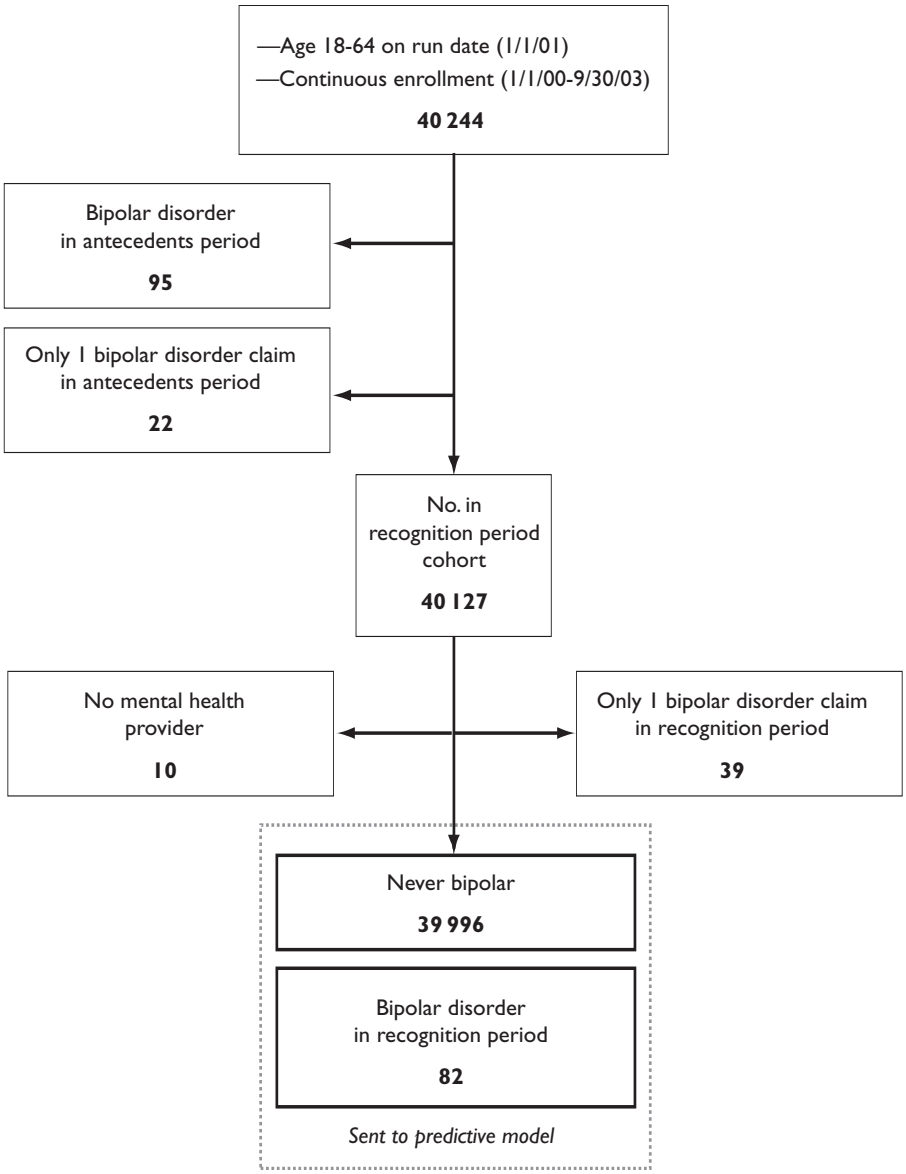
In both data sets the base-rates of newly diagnosed bipolar disorder were low. For the all-encounters data set 82 (0.20%) members were identified as having bipolar disorder during the recognition period. For the carve-out set, 1081 (0.45%) members were identified as having bipolar disorder during the recognition period.

Construction of the Predictive Model

A production algorithmic case-finding system (the CareEngine[SM] System, Active Health Management, Inc,

METHODS

Figure 1. Allocation of Members—All-encounters Data Set



New York) was used to identify possibly unrecognized cases of bipolar disorder. The system applied clinical rules to healthcare encounter claims (*ICD-9-CM* codes), prescription fills (National Drug Codes), age, and sex. All members in each data set who did not have a bipolar disorder diagnosis during the antecedents period were loaded into the case-finding system and evaluated from the standpoint of January 1, 2001. The system evaluated each member using claims with dates of service from January 1, 2000, through December 31, 2000 (the antecedents period), searching for the presence of predictor variables.

For each data set, we also used logistic regression[17] (SPSS V.11, Chicago, Ill) to predict new bipolar diagnosis during the recognition period using all the predictor variables as well as age and sex. For the all-encounters data set 2 variables (impulse control and conduct control disorders) were removed because they were not positive for any of the 82 individuals with a new diagnosis of bipolar disorder; therefore the equation could not be fit with them. Because all of the predictors had been selected based on expert opinion and previously substantiated, we constructed an all-predictors model (regardless of statistical significance). In each data set the model performance was further characterized as area under the curve (AUC) of the receiver operating characteristic (ROC) curve.[18]

RESULTS

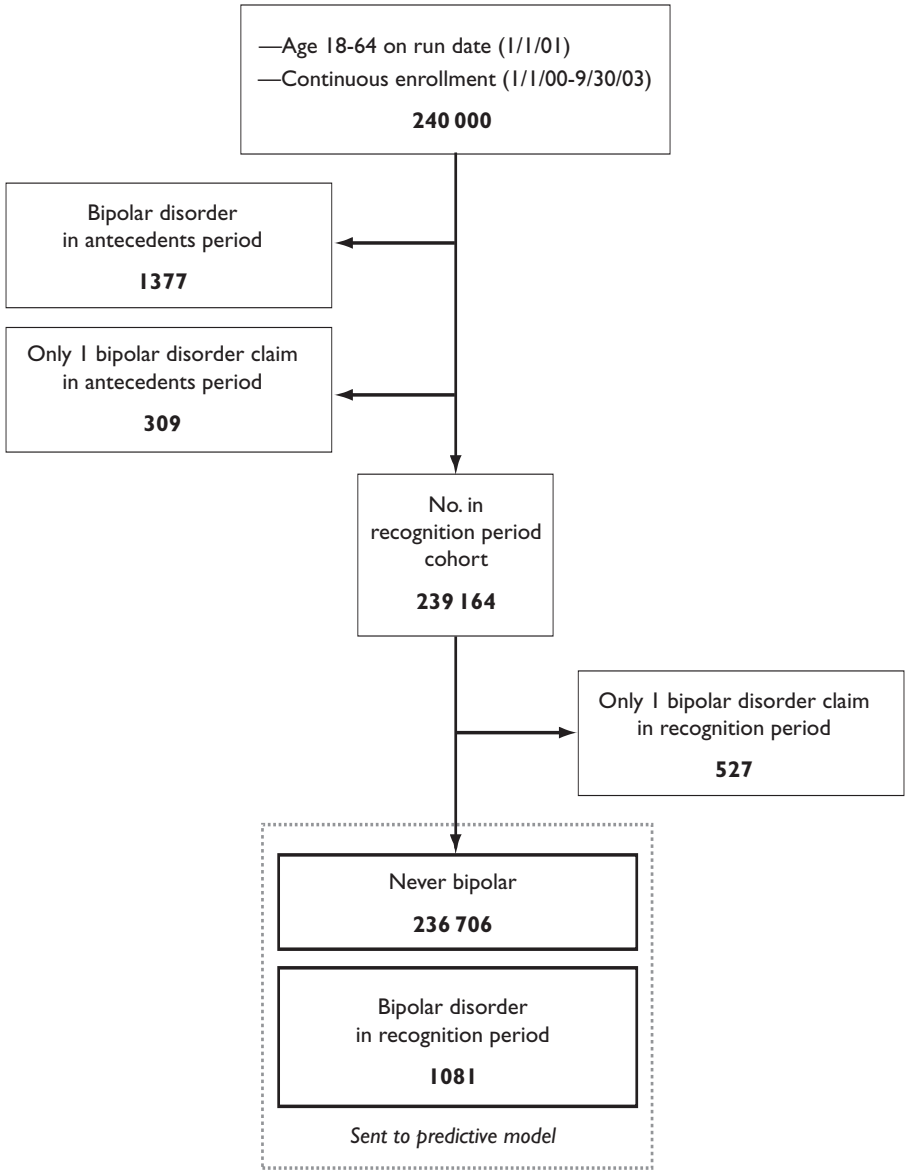
The predictor variables entered into the case-finding system are listed in **Table 1.** In the *all-encounters data set,* no individuals with bipolar disorder diagnosed during the recognition period exhibited the impulse control, conduct disorder, or substance abuse variables. In multivariate logistic regression entering all remaining variables, sex, age, use of 3 (of 5) psychotherapeutic medications, and depression were found to be independently predictive of subsequent recognition of bipolar disorder. Gender was found to have opposite associations in the data sets with subsequent recognition of bipolar disorder, as shown in **Table 2:** negative for the "carve-out" but positive in the "all encounters." The other significant associations appeared in the same direction in both data sets.

Table 2 shows the regression equation fitted from the variables representing those triggered by any patient with bipolar disorder in the all-encounters set, plus sex and age. The overall performance of the model on the all-encounters set can be expressed by the AUC of the

ROC curve. The AUC for the model on the all-encounters set was 0.82 (95% confidence interval [CI], 0.76-0.87). In the larger *carve-out data set,* recognition period patients with bipolar disorder triggered all candidate variables. Although this model did not fit as well to the carve-out set, performance was significantly better than chance, with an AUC of 0.69 (95% CI, 0.67-0.70).

For the all-encounters data set, a threshold of 5% predicted probability of bipolar disorder found 8 of the 82 individuals with bipolar disorder (ie, a sensitivity of 9.8%) and correctly identified 39 940 of the 39 996 individuals without bipolar disorder (for a specificity of 99.9%). Reducing the detection threshold to 3% increased the sensitivity to 20.7%, with 99.4% specificity; however, the number of positive tests needed to identify a case increased from 8 using the 5% threshold to 15.6 with the 3% threshold.

Figure 2. Allocation of Members—Carve-out Data Set



DISCUSSION

The purpose of this study was to create a practical predictive model to support identification of unrecognized bipolar disorder using claims data from commercially insured adults and an algorithmic case-finding system. Using claims for adult members (continuously enrolled for 3.75 years) of 2 commercial health plans, we developed and validated a predictive model based on claims-coded rules for identification of unrecognized bipolar disorder developed by a bipolar expert panel and substantiated in a previous case-control study. The goal of the model was to predict subsequent recognition of bipolar disorder in individuals with no evidence of the disorder during the first year. We validated the model in 2 common scenarios relating to how health plans pay for mental health services. An *all-encounters data set* contained claims for all encounters; a *carve-out data set* excluded claims from mental health providers; both included all prescriptions.

The model demonstrated that in both data sets, sex, age, history of ADHD, psychotic depression, history of use of multiple categories of psychotherapeutic medication, and depression were significantly associated with the subsequent recognition of bipolar disorder. An unexpected finding was that sex was a negative association for "carve-out" but positive for "all-encounters." We postulate that this perplexing finding may relate to the differences in our operational definitions for bipo-

Table 1. Predictor Variables Used by the Case-finding System

Predictor Variable	Operational Definition
ADHD by medications or diagnostic codes	At least 2 claims for ADHD *or* at least 2 claims for an ADHD medication*
Poor response of ADHD to treatment	ADHD (above) and use of 2 or more categories of ADHD medications*
Psychotic depression by medications or diagnostic codes	At least 2 claims for depression or at least 2 claims for medication predominantly used in depression,* plus antipsychotic medication
Prescription of 3 of 5 classes of psychotherapeutic medication	Classes—anticonvulsants, anxiolytics, antidepressants, lithium, antipyschotics (at least 2 claims for each qualifying medication)
Conduct disorder	At least 2 claims (312, 312.0x-312.2x, 312.4x, 312.8x, 312.9x, 313.81)
Impulse control disorder	At least 2 claims (312.3, 312.31, 312,32, 312.34, 312.35)
Significant anxiety disorder	At least 2 claims for excitative-type psychoses (298.1x) or anxiety states (300.0x)
Substance abuse disorder	At least 2 claims (304.xx, 305.xx except 305.1x)
Depression	At least 2 claims for depression (296.2x, 296.3x, 298.0x, 300.4x, 311.xx) or at least 2 claims for medication predominantly used in depression*
Depression and variable: depression and any other single-condition predictor variable	Depression by ICD or meds

Numbers in parentheses indicate *ICD-9-CM* codes. The presence of "x"in an ICD code indicates that any digit, or none, may occupy that place.
*Medication classes used to define "ADHD" included amphetamines, dexmethylphenidate, dextroamphetamine, methylphenidate, and pemoline. Antipsychotic medications included chlorpromazine, clozapine, haloperidol, loxapine, mesoridazine, thioridizine, thiothixene, trifluoperazine molindone, perphenazine, pimozide, olanzapine, quetiapine, risperidone, and ziprasidone. Medications used to define depression included selective serotonin reuptake inhibitors (SSRI); monamine oxidase inhibitors (MAOI), Wellbutrin (only this brand of bupropion), mirtazapine, venlafaxine.
ADHD indicates attention deficit-hyperactivity disorder; *ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification.*

lar disorder, the sequestration of claims in the carved-out mental health networks, or differences in the populations. In the carve-out data set we used a less stringent definition (based on any bipolar diagnoses or specific patterns medication use; see Methods section) that yielded a newly diagnosed bipolar disorder base-rate of 0.45%, whereas in the all-encounters data set we used a more stringent definition of 2 bipolar claims by mental health providers that yielded a base-rate of only 0.20%.

Performance of the algorithmic case-finding system was acceptable for a primary screening tool with low risk of misidentification of false positives, as shown by a sensitivity of 9.8% and a specificity of 99.9% using a predicted diagnosis threshold of 5%, and a sensitivity and specificity of 20.7% and 99.4%, respectively, using a 3% threshold in the carve-out set. Sensitivities in the all-encounters set were slightly higher. A lower sensitivity was expected in the carve-out set, in which some cases of bipolar disorder were identified by relatively (but not completely) specific mood stabilizer therapy. Nevertheless the area under the ROC curve, a test performance measure relating the calculated probability to each individual's actual state, was highly significantly better than chance. The AUC indicated that 82% of the time the model would accurately discriminate a randomly selected individual with bipolar disorder from a randomly selected individual without bipolar disorder. Although individuals in clinical practice who screen positive for bipolar disorder based on this predictive model will in fact have it much less frequently (because of the condition's low prevalence), the positive predictive values at the 5% and 3% prediction thresholds in our study compare favorably with those of many commonly advised primary care screening tests.[19-21] Further improvement of the model's performance with a prospective study could reduce the number needed to secondary screen and capture more individuals with bipolar disorder.

This study looked for subsequent recognition of bipolar disorder during a relatively short prediction interval, 2.75 years. Although this strategy was practical given the turnover commonly observed in health plans, this amount of time may be less than is commonly needed to make an accurate diagnosis,[9] and therefore the possibility exists that more diagnoses of bipolar disorder might have been made with a longer recognition period. Nevertheless, the prevalence of bipolar diagnosis in the mental health carve-out data set was approximately 1%, similar to the preva-

Table 2. Logistic Regression for the 2 Data Sets: All-variables Model

	All-encounters Data Set		Carve-out Data Set	
Indicators	**Coefficient**	**Odds Ratio (95% CI)**	**Coefficient**	**Odds Ratio (95% CI)**
ADHD by *ICD* or medications	0.36	1.43 (0.24, 8.41)	1.198	3.31 (2.30, 4.77)
Poor response of ADHD to treatment	0.50	1.64 (0.10, 27.65)	–0.490	0.61 (0.08, 4.60)
Psychotic depression	0.22	1.247 (0.30, 5.20)	1.630	5.11 (3.52, 7.40)
Use of 3 (of 5) categories of psychotherapeutic medications	2.70	14.90 (3.86, 57.54)	0.31	1.37 (0.59, 3.17)
Conduct disorder	None among patients with BD		–0.41	0.66 (0.09, 4.71)
Impulse control disorder	None among patients with BD		1.58	4.84 (0.56, 41.97)
Anxiety	0.70	2.02 (0.78, 5.20)	0.37	1.45 (1.04, 2.03)
Substance abuse	None among patients with BD		1.25	3.47 (2.26, 5.33)
Depression by *ICD* or medications	2.75	15.58 (9.62, 25.23)	2.04	7.70 (6.72, 8.83)
Age category (Nine 5-year categories: 60-64 years = 0; 18-24 years = 8)	0.22	1.251 (1.13, 1.37)	0.06	1.06 (1.03, 1.09)
Sex (female = 1)	0.68	1.972 (1.19, 3.26)	–0.25	0.78 (0.69, 0.88)
Constant	–8.40		–5.91	

ADHD indicates attention deficit-hyperactivity disorder; BD, bipolar disorder; CI, confidence interval; *ICD, International Classification of Diseases* ; No bipolars, the all-encounters data set contained no bipolar individuals who triggered indicators for conduct disorder, impulse control disorder, or substance abuse). Statistically significant at $P < .05$.

lence cited in epidemiological studies for bipolar I.[6] Furthermore, the time during which claims were examined was sufficient to yield impressive sensitivity and specificity estimates in identifying people who were later recognized as having bipolar disorder.

It may be impractical to execute a claims-based study on a longer-term continuous health plan enrollment data set. A prospective study would address the often-cited diagnostic delay associated with bipolar disorder, as well as the issue of error in ICD coding by physicians.[22-24] Discrepancies across claims-based studies may also be related to differences in criteria for determining who had bipolar disorder. For example, in some claims-based studies, bipolar disorder is defined as a single ICD code and sometimes as a single prescription for a mood stabilizer, without exclusionary diagnoses in the case of valproic acid derivatives. In this study, more rigorous criteria were used to define bipolar disorder, including the absence of exclusionary diagnoses.

Determining a "diagnosis" of ADHD or depression during the antecedents period using medications commonly prescribed for these conditions might yield false-positive ADHD or depression "diagnoses," as these medications may be used to treat other conditions (eg, bupropion for smoking cessation). However, the accuracy of the claims-based ADHD and depression diagnoses is not of primary importance for the predictive model; it is the ability of these claims-based ADHD and depression "diagnoses" to accurately predict missed bipolar disorder that is crucial.

With any screening test, it is important to consider the potential burden of screening results on the physician and the healthcare system. At a predictive threshold of 5% probability (from the regression equation), of 1000 patients identified from the predictive model, 125 would have bipolar disorder; of 1000 patients with bipolar disorder, 98 would be found and 902 missed; the number needed to subject to secondary screening (NNS) to identify 1 case of bipolar disorder would be 8. At the 3% threshold, of 1000 identified from the predictive model, 64 would have bipolar disorder; 207 of 1000 with bipolar disorder would be accurately identified; and NNS would be 15.6. Thus the predictive "score" or threshold could be set to find a reasonable proportion of cases without undue burden, with the knowledge of the likely proportion of missed cases.

METHODS

Early identification and proper treatment of bipolar disorder can reduce healthcare cost and work-loss, and improve psychosocial function. A shorter diagnostic delay means less opportunity for inappropriate treatment (eg, antidepressant monotherapy, which can hasten the switch to mania). Further, delayed treatment is associated with worse outcome.[10] Early identification is also important from the health plan perspective. In the United States alone, the total lifetime cost of care for individuals with bipolar disorder with onset of illness in 1998 was $24 billion.[25] During a 1-year period, patients with bipolar disorder were found to cost nearly 4 times more than age- and sex-matched individuals without the illness ($7663 vs $19 622). The situation is exacerbated for patients with unrecognized bipolar disorder, who have been shown to have higher rates of hospital use and attempted suicide compared with patients with recognized bipolar disorder. Thus, it is reasonable to expect that care providers and health plans could substantially benefit from the use of a predictive model or case-finding algorithm.

Given the routine underrecognition of bipolar disorder, its devastating consequences for patients, and its significant cost to health plans, a case-finding algorithm that could be used to identify patients with risk factors early in the disease course would be expected to contribute substantially to the management of bipolar disorder. Such a system, based on readily available administrative data, has real-world practicality and can be used to screen millions of claims in a day. Indeed, such systems are beginning to see widespread implementation for other conditions.

We propose that such a system could be used to sort individuals identified into 2 levels of intervention based on their predicted likelihood of having bipolar disorder. For example, physicians of patients predicted at greater than 5% risk by regression equation could receive a validated brief screening tool (such as the Mood Disorders Questionnaire); physicians of individuals who triggered a 3% risk by regression equation might receive a recommendation to consider the diagnosis and might be urged to use the screening tool if the physician considers the diagnosis a possibility. We hypothesize that such a system could considerably reduce the biopsychosocial and financial costs of unrecognized bipolar disorder. Prospective studies with a large number of claims and clinical follow-up of identified patients will be needed to determine the actual effect of a case-finding system.

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Using a Claims Data–Based Sentinel System to Improve Compliance With Clinical Guidelines: Results of a Randomized Prospective Study

Jonathan C. Javitt, MD, MPH; Gregory Steinberg, MD; Todd Locke, MD; James B. Couch, MD, JD; Jeffrey Jacques, MD; Iver Juster, MD; and Lonny Reisman, MD

Objective: To demonstrate the potential effect of deploying a sentinel system that scans administrative claims information and clinical data to detect and mitigate errors in care and deviations from best medical practices.

Methods: Members (n = 39 462; age range, 12-64 years) of a midwestern managed care plan were randomly assigned to an intervention or a control group. The sentinel system was programmed with more than 1000 decision rules that were capable of generating clinical recommendations. Clinical recommendations triggered for subjects in the intervention group were relayed to treating physicians, and those for the control group were deferred to study end.

Results: Nine hundred eight clinical recommendations were issued to the intervention group. Among those in both groups who triggered recommendations, there were 19% fewer hospital admissions in the intervention group compared with the control group ($P < .001$). Charges among those whose recommendations were communicated were $77.91 per member per month (pmpm) lower and paid claims were $68.08 pmpm lower than among controls compared with the baseline values ($P = .003$ for both). Paid claims for the entire intervention group (with or without recommendations) were $8.07 pmpm lower than those for the entire control group. In contrast, the intervention cost $1.00 pmpm, suggesting an 8-fold return on investment.

Conclusion: Ongoing use of a sentinel system to prompt clinically actionable, patient-specific alerts generated from administratively derived clinical data was associated with a reduction in hospitalization, medical costs, and morbidity.

(Am J Manag Care. 2005;11:93-102)

Governmental and private initiatives in the United Kingdom and the United States[1,2] have called for expanded use of information technology in healthcare and for the incorporation of clinical decision support systems[3] to detect and alert physicians to potential medical errors and deviations from best medical practices. Previous authors have demonstrated the value of decision support systems in guiding the choice of antibiotic therapy[4] and in monitoring the use of potentially nephrotoxic drugs.[5] A review of 65 such systems demonstrated improved physician compliance with treatment guidelines in two thirds of studies.[6] However, all previously reported decision support systems have been deployed within a hospital setting or within an integrated delivery system in which electronic health record systems provide the backbone of clinical information.

We developed a clinical decision support system that uses the clinical information contained in administrative claims data from physicians, hospitals, pharmacies, and clinical laboratories to identify common errors in care and departures from widely accepted clinical guidelines. Therefore, the system can operate in any fee-for-service clinical environment or other environment in which encounter data are reported without requiring any cooperation from the caregiver community beyond responding to clinical recommendations as they are issued. Because of its ongoing vigilance in monitoring patient information and spontaneously contacting treating physicians, we applied the term *sentinel system* to distinguish its function from point-of-care decision support.

The claims-based system we developed is deployed in the care of approximately 4 million Americans who are enrolled in health plans funded by large employers, managed care organizations, federal employee programs, Medicare managed care programs, and Medicaid programs. In this report, we describe the results of a 12-month randomized prospective study to test the hypothesis that a claims-driven decision support system could increase compliance with evidence-based prac-

From Active Health Management, Inc, New York, NY (JCJ, GS, JJ, IJ, LR); Potomac Institute for Policy Studies, Arlington, Va (JCJ); Qualchoice, Inc, and Case Western Reserve University School of Medicine, Cleveland, Ohio (TL); and American Re-Insurance Company, Princeton, NJ (JBC).

This study was funded by American Re-Insurance Company, which provides services to Qualchoice, Inc. The role of American Re-Insurance Company was limited to review of the study protocol before study inception. The company had no contact with those implementing the clinical interventions or with the physicians who received the intervention recommendations.

Dr Javitt is a shareholder of Active Health Management, Inc, and remains a consultant to the company. Drs Steinberg, Juster, and Reisman are employees and shareholders of Active Health Management, Inc. Although not at the time of the study, Dr Couch independently contracts with Active Health Management, Inc. He is now with New World Healthcare Solutions, Princeton, NJ.

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tices and effect improvements in patient outcomes as measured by decreased hospitalization and attendant cost. As subgroup analyses, we examined the causes of hospitalization for any recommendation issued with sufficient frequency to yield adequate study power.

METHODS

Sentinel System Intervention

The sentinel system was designed as a rule-based artificial intelligence engine combined with an automatic message generator that conveys clinical recommendations and supporting literature to treating physicians. Software coding was programmed in a combination of C++ and Visual Basic (Microsoft Corporation, Redmond, Wash) that draws data from an Oracle 8i–based data warehouse (Oracle Corporation, Redwood City, Calif). Daily data inputs include physician-generated insurance claims, hospital discharge and outpatient claims, laboratory claims and laboratory test results, and pharmacy claims. Information is coded in *International Classification of Diseases, Ninth Revision*, Clinical Modification codes, *Current Procedural Terminology* codes, Logical Observation Identifier Names and Codes, and National Drug Code identifiers.

Candidate clinical issues for inclusion in the clinical rules engine were identified from national multicenter clinical trials, guidelines published by the federal government or medical specialty societies, and Food and Drug Administration–approved pharmaceutical labeling by an in-house committee of physicians, working in consultation with health plan medical directors and a panel of medical consultants. Typical issues targeted by the rules engine include the following: (1) absence of angiotensin-converting enzyme inhibitor therapy in patients with congestive heart failure[7-9] and in those who meet the Heart Outcomes Prevention Evaluation (HOPE) trial criteria,[10] (2) absence of β-blocker use in patients who have had myocardial infarction,[11,12] (3) absence of anticoagulation in patients with atrial fibrillation and structural heart disease,[13,14] and (4) absence of documented laboratory monitoring in patients taking warfarin sodium, glitazones,[15] and other medications that require specific laboratory tests. Depending on the clinical urgency of the issue, notification may be by physician-to-physician telephone contact, fax, or letter.

The criteria that trigger the engine to issue a specific recommendation are multidimensional decision matrices that take into account all available information on each patient. For instance, the criteria surrounding the use of β-blockers after myocardial infarction attempt to identify known contraindications for β-blocker therapy, such as severe bronchospasm and advanced heart block in the absence of a pacemaker. Should any of those contraindications be identified, the recommendation is not issued.

The system contains more than 1000 decision matrices that, when triggered, result in the transmission of a communication to the treating physician, recommending that he or she consider a particular avenue of care. Because a claims-based system such as this will never have as much information about the patient as the treating physician, all recommendations make clear that the communication is merely for the physician's consideration and that there may be mitigating circumstances that might render the recommendation inappropriate. For this reason, such communications are interchangeably referred to as care considerations.

Patients and Setting

The study was performed among the commercially insured population of a university-affiliated managed care plan, in which patients were free to choose their primary care physician and to move their care from one primary care physician to another. The protocol was approved by the human subjects committee of the health plan before inception and was in accord with the Declaration of Helsinki with regard to protection of human subjects. In the annual enrollment form, all plan members provided written informed consent to the analysis of their healthcare data and to the medical management and quality improvement activities of the health plan. Eligible subjects were notified by letter that the health plan was undertaking a quality improvement study and that they might be randomly allocated to a program in which their physicians might receive information relevant to their care and were given a telephone number to call if they wished not to be included in such a study. To maximize the study power, intervention and control group members consisted of all health plan enrollees who were between the ages of 12 and 64 years and had incurred at least 1 physician claim or 1 pharmacy claim in the 12 months before enrollment. Patients were assigned to an intervention or a control group, using an individually assigned random number. Assignment occurred on a single date at study inception. Neither patients nor treating physicians were informed of the allocation, although it is likely that those physicians who received communications about specific patients surmised that those patients were part of the intervention group.

Study Power and Sample Size

The study was designed to measure potential differences in cost of care and to measure the extent to which

physicians comply with clinical prompts issued in this manner. The sample size required was calculated to have a power of greater than 80% ($\beta = .2$) to detect a 5% difference in claims cost and compliance with recommendations between the 2 groups at a type I error rate of .01 (2-sided). We determined that subgroup analysis (with the same study power) was feasible for any recommendation issued to at least 100 intervention and control group subjects in which the adverse event rate in controls exceeded 40%.

Data Analysis

All analyses were performed on an intention-to-treat basis. For each group, individual members' claims were measured monthly during the study and expressed in terms of dollars per member per month (pmpm). All claims were also broken down into type of service, including inpatient, outpatient, professional services, and pharmacy. For each group, the totals and means were calculated for total claims and claims by type of service. We also compared the costs for the intervention group participants who triggered care considerations vs controls who triggered but were not issued care considerations.

To compare differences in total admissions and total days in the hospital, 2×2 tables were created containing the numbers admitted and the numbers not admitted in the intervention and control groups (as well as for days in the hospital and days not in the hospital) and were tested by χ^2 test. Differences in the rates of hospital admissions per 1000 subjects were tested by z test. Differences in mean charges and paid amounts in the intervention and control groups were tested by t test, weighted for the number of months under observation. $P < .02$ was required for rejection of the null hypothesis. As a safety measure, a masked analysis was conducted at 6 months to assess whether there was any difference ($P < .05$) in the number of deaths between the 2 groups.

RESULTS

A total of 39 462 subjects were initially enrolled in the study (**Figure 1**). At baseline, no significant differences were observed in age or sex between the intervention and control group subjects (**Table 1**). Eighty-four percent of control group members and 85% of intervention group members remained in the study for the entire 12 months (Figure 1). Approximately half of the early withdrawals occurred in the first month, comprising individuals enrolled and randomized in December who chose another health plan for the study year. Therefore, 90% of control and intervention group members who began the study remained under observation for the entire study. During the study year, no difference in mortality was observed between the intervention group and the control group. The data available to us identified hospital mortality, including death

Figure 1. Flowchart of Study Progress

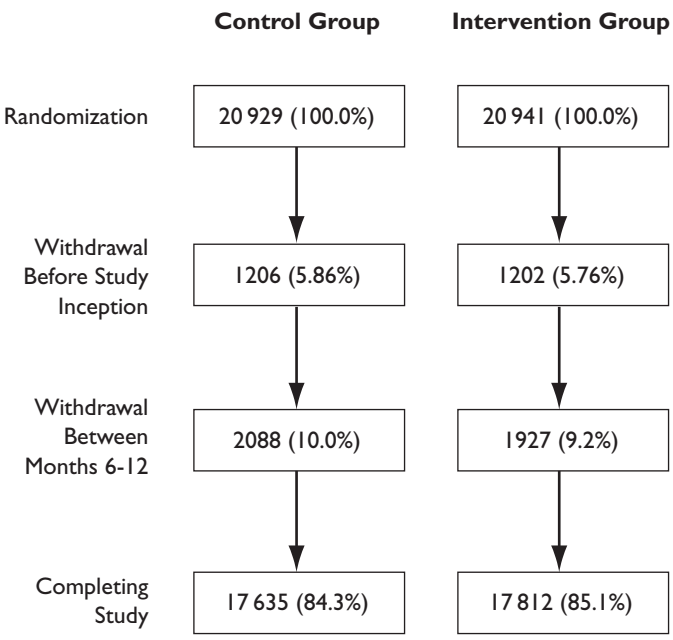


Table 1. Demographic Characteristics of the Intervention and Control Group Subjects

Variable	Intervention Group	Control Group	Relative Difference
All subjects, No.	19 739	19 723	—
Mean age ± SD, y	38.5 ± 14.9	38.3 ± 14.8	NS
% Female	58.6	58.2	NS
Subjects triggering recommendations, No.	968	1165	—
Mean age ± SD, y	52.6 ± 12.3	51.2 ± 12.8	$P < .01$
% Female	53.0	52.7	NS

NS indicates not significant.

Table 2. Most Frequently Issued Recommendations

Purpose	Recommendation Description	No. of Recommendations Issued	
		Intervention Group	Control Group
Prevention	Monitor liver function in statin use[16]	193	197
Clinical	Start ACE inhibitor in HOPE trial qualifier[10]	156	155
Clinical	Stop proton pump inhibitors or perform reflux studies	100	101
Prevention	Perform yearly eye examination in patients with diabetes mellitus[17]	74	101
Clinical	Monitor renal function with metformin use[18]	78	64
Prevention	Monitor liver function in patients taking glitazones[15]	58	62
Clinical	Perform biannual hemoglobin A_{1c} monitoring in patients with diabetes mellitus[19]	35	60
Clinical	Screen for microalbuminuria in diabetes mellitus[19]	64	49
Clinical	Monitor coagulation factors in Coumadin use[19]	26	40
Clinical	Evaluate for renal artery stenosis[20,21]	54	38
Clinical	Stop Ultram in patients at increased risk for seizure[15]	67	37
Clinical	Add anti-inflammatory agent to improve asthma control[22]	45	37
Clinical	Treat or test for osteoporosis in patients taking systemic corticosteroid[23,24]	51	34
Clinical	Stop drugs that may contribute to depression[25]	34	33
Clinical	Perform complete lipid panel in vascular disease[26,27]	49	27
Clinical	Stop nonsteroidal anti-inflammatory medication in hypertension[15]	25	18
Prevention	Hepatitis B screening in pregnancy[28]	56	17
Clinical	Start clopidogrel bisulfate in patients with acute coronary syndromes[29]	11	12
Prevention	Perform eye examination in patients taking hydroxychloroquine sulfate	17	11
Clinical	Stop a β-blocker that may exacerbate asthma[15]	12	10
Clinical	Monitor digoxin levels in patients at risk for toxicity[15]	8	9
Clinical	Look for underlying cause of thrombotic disease[30]	8	8
Clinical	Stop nonsteroidal anti-inflammatory medication or alendronate sodium[15]	17	7
Clinical	Add β-blocker in heart failure[31]	11	7
Clinical	Anticoagulate patients with atrial fibrillation at risk for stroke[32,33]	8	7
Clinical	Stop metformin in patients with renal insufficiency[19]	10	6
Clinical	Start β-blocker following myocardial infarction[11,12]	18	5
Prevention	Perform complete lipid panel if indicated[32]	11	4
Clinical	Add inhaled corticosteroid to reduce oral corticosteroid[27]	7	4
Clinical	Add ACE inhibitor in congestive heart failure[7]	14	3
	Total	**1317**	**1163**
	Total prevention recommendations	409	388
	Total clinical recommendations	908	775

ACE indicates angiotensin-converting enzyme; HOPE, Heart Outcomes Prevention Evaluation.

on arrival to the hospital, and mortality documented by the health plan.

Compliance With Recommendations

Nine hundred eight clinical recommendations were issued to the intervention group: 395 of those involved the recommendation to start a medication, 150 entailed the suggestion to stop a medication, and 790 suggested a test or procedure (**Table 2**). Compliance with care considerations that entailed starting a new drug was measured by ascertaining the date the drug was dispensed at the pharmacy. Physicians complied

with 24% of these "add-a-drug" recommendations in the intervention group. In the control group, physicians spontaneously instituted the treatment that would have been recommended in 17% of instances in which the recommendation was triggered but not issued. This 42% relative difference in compliance was statistically significant (P = .007). The same clinical triggers that generated add-a-drug recommendations were measured at baseline, and identical rates of spontaneous resolution of those clinical situations in the absence of intervention were noted in those subjects ultimately assigned to the intervention group and to the control group (18% for both).

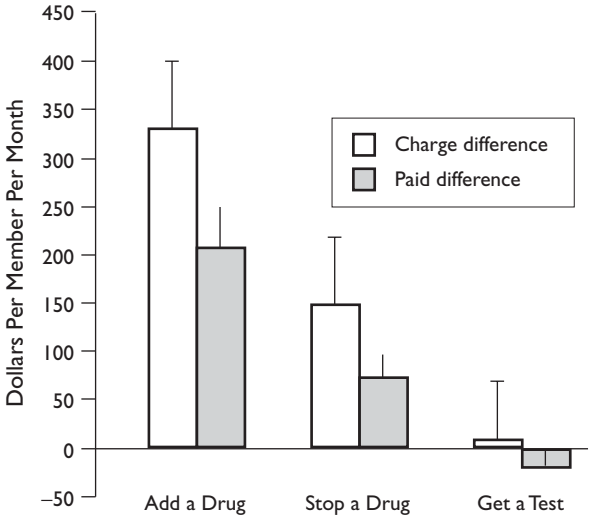
As seen in Table 2, more recommendations were triggered for the intervention group than for the control group. Although this difference was statistically significant (P < .01), it was associated with recommendations to obtain laboratory tests. This recommendation category is unrelated to differences in cost or hospital utilization (**Figure 2**). We believe that the most likely explanation for this is that the care consideration engine was run weekly on the intervention group patients, whereas it was run at the end of the study on the control group patients. This was to avoid the potential ethical problem of withholding actionable clinical information from control group participants.

Compliance with recommendations could not accurately be assessed in the case of recommendations to discontinue a medication, because discontinuance does not result in a medical order. Compliance with recommendations for laboratory testing was not ascertainable, in part because approximately one third of laboratory testing, including all inpatient laboratory testing, in this care system did not generate a discrete claim.

Observed Differences in Hospital Utilization

Overall, there were 115 more hospital admissions in the control group than in the intervention group (**Table 3**). Most of this difference (96 admissions) occurred in the 5% of subjects who triggered recommendations. No meaningful differences were observed in the 95% of the population that did not trigger recommendations. Among all those triggering recommendations in the intervention and control groups, 19% fewer hospital admissions per 1000 subjects were observed in the intervention group (P < .001). Because intervention group members who were admitted experienced a slightly longer stay, the overall difference in hospital bed days per 1000 subjects was only 8% (P = .004).

Figure 2. The Difference Between the Intervention and Control Groups for Those Issued Care Considerations, Grouped by Type of Intervention Recommended



A positive value indicates higher costs in the control group. The largest difference between the intervention and control groups is in those for whom the addition of a drug was recommended.

Observed Differences in Charges and Paid Claims

For total charges and paid claims, differences between the intervention and control groups were not significant at baseline but became highly significant during the study (**Figure 3**). Although charges in the study year compared to the baseline were higher in both groups, charges in the intervention group were $18.62 pmpm (95% confidence limits, $12.00-$25.00 pmpm) lower and paid claims were $8.07 pmpm (95% confidence limits, $5.00-$11.00 pmpm) lower. The difference in charges was observed for all categories of care except pharmacy claims, in which a small difference was observed in favor of the control group (pharmacy claims increased slightly for both groups from baseline to the study year because of changes in reporting across the health plan). This increase in observed pharmacy related charges is attributable to implementation of the add-a-drug recommendations. Multivariate analyses that included baseline utilization as an independent variable did not attenuate this effect.

Subgroup Analyses of Evidence for Mechanism of Action

Examination of Those Who Triggered Care Considerations. Examination of the subgroup that triggered care considerations reveals a more striking difference between the intervention group and controls. **Figure 4**

demonstrates that a far greater financial difference between the intervention group and controls is observable in the subpopulation of those who triggered care considerations. Comparing the study year results with baseline values, the intervention group patients incurred $77.91 pmpm (95% confidence limits, $26.00-$130.00 pmpm) less in charges and $68.08 pmpm (95% confidence limits, $39.00-$98.00 pmpm) less in paid claims than controls (P = .003 for both). There was no statistically significant difference between intervention and control group subjects who did not trigger care considerations.

Examination by Type of Care Consideration Issued. When differences in utilization are analyzed by type of care consideration issued (Figure 2), the most pronounced difference is associated with those patients who triggered recommendations to add a specific medication. A smaller but meaningful difference was identifiable in patients who triggered recommendations to stop specific medications. No significant difference was identified in cost or utilization among patients who triggered recommendations for laboratory or diagnostic procedures.

Analysis of Heart Outcomes Prevention Evaluation Trial–Related Hospitalizations. The only clinical recommendation that was issued with sufficient frequency to enable subgroup analysis of outcomes was the recommendation to prescribe angiotensin-converting enzyme inhibitors in patients meeting the HOPE trial criteria.[10] In these 311 patients (156 intervention and 155 control group subjects), a $510.00 pmpm difference in total charges was observed between the control and intervention groups (date not shown), as well as a difference of 12 hospital admissions per 100 patients (**Table 4**).

The frequency with which this HOPE recommendation was issued afforded the ability to examine the clinical details associated with the hospital admissions to determine whether the difference in hospitalization was related to the intervention. We considered hospital admissions for stroke, cardiac disease (except for dysrhythmia), and vascular complications of diabetes mellitus to be consistent with the clinical outcomes studied in the HOPE trial. Hospital admissions for other disease entities were not considered to be plausibly prevented by the addition of angiotensin-converting enzyme inhibitors.

There were 152 admissions during the study year among the 155 controls who triggered the recommendation to prescribe angiotensin-converting enzyme inhibitors, compared with 133 admissions among the intervention group members who triggered this recommendation (Table 4). Of those, 69 control group admissions, compared with 49 intervention group admissions, were for cerebrovascular or cardiovascular disease. This difference of 20 admissions (45% vs 37%, P = .02) was statistically significant by χ test. In contrast, there was no difference in the rate of hospital admission for diagnoses unrelated to the HOPE trial end points. This reduction

Table 3. Hospital Utilization During 12 Months in All Subjects and in Those Who Triggered Recommendations*

Variable	Intervention Group	Control Group	Difference
All subjects, No.	19 739	19 723	—
Total admissions	1251	1366	115
Admissions per 1000 persons, mean ± SD	63.5 ± 3.4	69.3 ± 3.4	–9.1% (P = .03)
Inpatient days per 1000 persons, mean ± SD	247.7 ± 6.0	273.0 ± 6.2	–9.3% (P = .001)
Length of stay, mean, d	4.1	4.1	—
Total inpatient charges PMPM, $	58.95	68.36	–9.41 (P = .001)
Total inpatient paid claims PMPM, $	26.06	28.20	–2.14 (P = .008)
Subjects triggering recommendations, No.	961	982	—
Total admissions	206	302	96
Admissions per 1000 persons, mean ± SD	213.8 ± 5.7	264.6 ± 5.7	–19.2% (P < .001)
Inpatient days per 1000 persons, mean ± SD	1152.0 ± 45.0	1252.3 ± 47.0	–8.0% (P = .004)
Length of stay, mean, d	5.4	4.7	13.8%
Total inpatient charges PMPM, $	242.30	296.30	–54.00 (P = .007)
Total inpatient paid claims PMPM, $	93.50	127.50	–34.00 (P = .006)

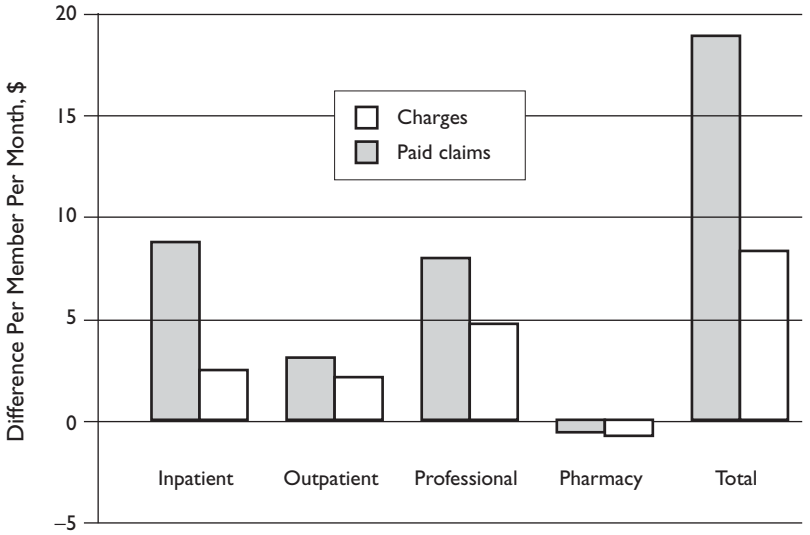
PMPM indicates per member per month.
*Inpatient charges reflect mean charges or paid amounts per person hospitalized who were issued at least 1 care consideration.

in the risk of hospitalization was consistent with the reduction in the risk observed in the HOPE trial.[10]

Return on Investment

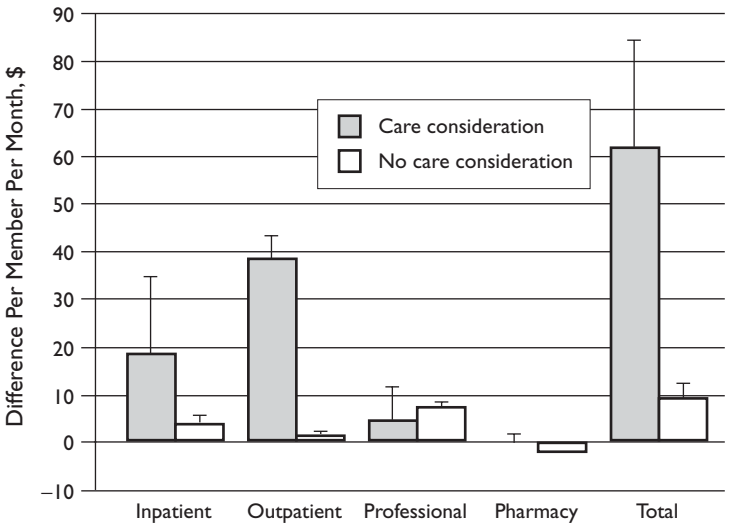
The study was not intended as a formal cost-effectiveness or cost savings analysis in that we did not directly measure costs at the patient or caregiver level, nor did we consider noneconomic costs or benefits. Our study can, however, speak to the return on investment associated with the intervention from the perspective of the payer. The intervention cost ranged from $1.00 to $1.50 pmpm, depending on the demographics of the covered population, with older populations generating higher charges because of greater severity of illness. In the case of the intervention population, the intervention cost was $1.00 pmpm and the overall return was $8.07 pmpm, indicating an 8-fold return on investment in the first year of the intervention. For many of the interventions triggered, one would expect ongoing benefits to accrue, suggesting that over time the return on investment may be even greater.

Figure 3. The Overall Difference in Charges and Paid Claims Between the Intervention and Control Groups



A positive number indicates lower costs in the intervention group.

Figure 4. The Difference in Charges and Paid Claims Between the Intervention and Control Groups for Those Individuals Issued Care Considerations.



A positive number indicates lower costs in the intervention group.

DISCUSSION

Our findings suggest that deployment of a sentinel system that issues clinical prompts based on administratively derived clinical data has the potential to positively influence physician practice and may be associated with decreases in morbidity and healthcare cost among patients with targeted conditions. The use of physician prompts, delivered primarily by written communication, was associated with a moderate degree (42%) of increased compliance with widely accepted standards of care, compared with that observed in a randomly allocated control group. The intervention cost $1.00 pmpm to deploy and was associated with lower charges of $18.62 pmpm and lower paid claims of $8.07 pmpm in the intervention group compared with controls.

The difference in compliance with standards of care associated with our intervention was clinically and statistically significant and was associated with a substantial difference in hospitalization and cost of care. However, the compliance, even in the intervention group (24%), leaves significant room for improvement.

Table 4. Hospital Utilization During 12 Months in Subjects Who Triggered the HOPE Trial Recommendation To Prescribe Angiotensin-Converting Enzyme Inhibitors

Variable	Intervention Group (n = 156)	Control Group (n = 155)	*P*
Total admissions	133	152	—
HOPE related			
Admissions, No. (%)	49 (36.8)	69 (45.4)	.02
Inpatient days per person, mean	1.4	2.2	.003
Inpatient charges per person, mean, $	5835	8746	.05
Non–HOPE related			
Admissions, No. (%)	84 (53.8)	83 (53.5)	.55
Inpatient days per person, mean	3.3	3.8	.34
Inpatient charges per person, mean, $	6704	8416	.30

HOPE indicates Heart Outcomes Prevention Evaluation.

More potent interventions are needed that may involve further engaging the physician via electronic means and point-of-care systems, in addition to engaging the patient directly.

Two factors argue in favor of a causal relationship between the intervention and the observed outcome and, hence, its clinical plausibility. First, the observed difference is almost completely attributable to those members of the intervention and control groups who triggered recommendations. Second, the subgroup analysis of patients who triggered the recommendation to prescribe angiotensin-converting enzyme inhibitors for subjects meeting the HOPE criteria demonstrated that the entire difference in hospitalization was attributable to admission for cardiac and peripheral vascular disease.

It may seem counterintuitive that intervening 5% of the population can have such a broad effect. However, one must remember that most commercially insured persons have no major illnesses. Most hospital utilization is attributable to the few with chronic disease. By drawing on the existing stream of administrative data, we constructed an approach that does not depend on underlying health information infrastructure (other than ubiquitous claims submission systems) and that draws data from a broad array of otherwise unconnected caregivers.

Although this study addressed the potential benefit of deploying a sentinel system in a commercial population, the disease entities most affected by the intervention—neurological, respiratory, and cardiovascular conditions—are the major drivers of health cost in older populations. Therefore, we expect that sentinel systems such as this would have an even greater effect when deployed in populations with greater morbidity, such as populations covered by Medicaid and Medicare.

Limitations of the Intervention

In an ideal world, clinical decision support systems would be embedded within comprehensive electronic health information environments that include medical records and order entry. The best moment to intervene and prompt a caregiver to comply with evidence-based guidelines is at the point of care, using detailed clinical information about the patient. Physicians are likely to be more responsive to prompts generated at the point of care, provided that those prompts are clinically on target and patient specific. Unfortunately, few Americans (except for active-duty military and veterans) are cared for in an electronic healthcare environment that enables point-of-care systems, and those systems may not yet have developed the instantaneous decision analytic capabilities necessary to address the broad range of issues affecting the ill.[34]

Today, most Americans are cared for in a community provider–based environment. Although point-of-care systems are available for installation in some tightly integrated healthcare delivery systems, the exchange of health information among nonrelated medical providers requires currently unavailable solutions to technical and legal barriers. Outside of an integrated delivery system, only a claims-based system has the potential to integrate clinical data from the patient's entire network of providers, pharmacies, and laboratories. We, like much of the readership, dream of a future in which electronic medical records flow seamlessly from one point of care to another. In that future, we believe that sentinel systems will be integral to comprehensive point-of-care systems and will draw on much richer sources of data.

The intervention that we implemented lags days to weeks behind the moment of care and is restricted to summary information contained in diagnosis and procedure codes, along with pharmacy data and laborato-

ry values. This lag may reduce compliance with care considerations and limits the type of issues that may be addressed to clinical issues involving the prescription of medications for chronic illness, monitoring of those medications, and management of the underlying illness. Medication issues that are likely to have an immediately harmful effect, for instance, cannot usefully be addressed in a system of this type. However, as is evident from our data, there are many such issues that can be addressed, even in a healthy working-age population.

Our system relies on the diagnosis and procedure codes contained in administrative claims data, the accuracy of which is far from perfect. The logic algorithms within the sentinel system attempt to maximize the specificity of the inferences gained from claims data by requiring multiple pieces of corroborating information (eg, diagnosis codes indicative of diabetes mellitus, evidence of pharmacotherapy for diabetes mellitus, and laboratory tests indicative of hyperglycemia) before classifying a patient as having a particular condition. Nevertheless, as the specificity of the data stream improves, particularly through the widespread implementation of electronic health records, sentinel systems will become more clinically useful.

Limitations of the Study

Our study is subject to at least 3 sources of bias, including selection bias, treatment bias, and ascertainment bias. We designed this study as a community-based trial, in which the study cohort was as representative as possible of the underlying community. The only potential selection bias is the extent to which the membership of the health plan studied is or is not representative of the commercially insured population of the Cleveland metropolitan area. Given that enrollment is employer based, there is little reason to believe that this represents a significant bias.

A second potential source of bias is treatment bias. Once a physician received a clinical recommendation, the physician was then alerted to the fact that the patient in question was under scrutiny. If this prompted physicians to rethink other aspects of the patient's care, there may have been an effect larger than the simple effect of implementing that specific recommendation. Because the objective of this study was to demonstrate the potential value of sentinel systems in improving overall care, not the effect of any specific clinical recommendation, this bias (if it was a factor) does not diminish the overall value of the findings of the study. One alternative design would have been to attempt a nonspecific notification of control group physicians to try to attenuate this bias.

The study is also subject to ascertainment bias in that it is based on surrogate outcome measures, namely, hospitalization and other provision of medical care, rather than ultimate outcomes, such as quality of life or survival. That limitation is inherent in nearly every study that attempts to measure health system effects rather than the traditional end points associated with clinical trials.

CONCLUSIONS

Our study demonstrates that decision support systems can be applied across a system of care to improve compliance with evidence-based medicine. The results suggest that such compliance improves outcomes of care as suggested by the clinical trials that underlie the individual clinical recommendations. The study was performed using the summary data available in an administrative claims stream. As richer electronic health records become available across the medical enterprise, sentinel systems such as this will have increased clinical accuracy and deliver patient-specific recommendations in an increasingly timely manner.

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QualChoice Study

GROUNDBREAKING LARGE-SCALE CLINICAL TRIAL CONDUCTED IN AN OUTPATIENT HEALTH PLAN ENVIRONMENT.

This randomized, prospective study was conducted by ActiveHealth® Management at QualChoice, a Midwestern managed care plan, and published as a peer-reviewed article in *The American Journal of Managed Care*.

OVERVIEW

ActiveHealth's core technology, the CareEngine® System, compares the most current clinical guidelines to an individual member's data. The CareEngine identifies and generates clinical opportunities to the treating physician and, when appropriate, the member. These clinical alerts, called Care Considerations, are communicated by fax, phone or letter.

"This study shows that clinical support systems like the CareEngine improve care, potentially save lives AND reduce costs. In addition, physicians find the clinical information in the Care Considerations timely, accurate and actionable."

— Todd Locke, MD
Former Chief Medical Officer
QualChoice

The Proof.

"The QualChoice study validates what we already knew — that the CareEngine is a cost-saver and a life-saver. Health plans. Physicians. Members. TPAs. They all can benefit from this active technology just as 12 million of our members are benefiting today."

— Lonny Reisman, MD
CEO, ActiveHealth Management

ACTIVEHEALTH MANAGEMENT®

METHODOLOGY

The study population was 39,462* members of a Midwestern managed care plan.

CONTROL GROUP:	INTERVENTION GROUP:
Approximately half were randomly assigned to the control group.	Approximately half were randomly assigned to the intervention group.
PROCESS:	PROCESS:
No Care Considerations were communicated during study.	Care Considerations were identified and communicated during study.

IMPACT ACROSS THE STUDY POPULATION

RESULTS:	RESULTS:
MEDICAL ERRORS	
– –	**46** potentially serious medical errors identified per 1000 people – nearly 1 for every 20 members.
HOSPITALIZATIONS	
– –	**8.4%** fewer hospitalizations.
PAID CLAIMS	
– –	**$8.07** per member per month saved.

PROOF

Life-threatening medical errors diminished. Better care achieved.

- Members in the intervention group were hospitalized less.
- CareEngine findings significantly improved communication between members and physicians – reducing life-threatening events.

Significantly lower costs for health plans.

- Health plans saw substantial cuts in medical costs. Paid claims per member were substantially lower.

The CareEngine System Saves Lives, Reduces Medical Errors and Substantially Lowers Costs.

*Study population consisted of 39,462 members age 12-64 and with at least 1 claim in the prior year. Source: Javitt, et al. "Using a Claims Data-based, Sentinel System to Improve Compliance with Clinical Guidelines: Results of a Randomized Prospective Study," American Journal of Managed Care Feb. 2005: 93-102.

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Information technology and medical missteps: Evidence from a randomized trial

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Abstract

We analyze the effect of a decision support tool designed to help physicians detect and correct medical "missteps". The data comes from a randomized trial of the technology on a population of commercial HMO patients. The key findings are that the new information technology lowers average charges by 6% relative to the control group. This reduction in resource utilization was the result of reduced in-patient charges (and associated professional charges) for the most costly patients. The rate at which identified issues were resolved was generally higher in the study group than in the control group, suggesting the possibility of improvements in care quality along measured dimensions and enhanced diffusion of new protocols based on new clinical evidence.

Keywords: Information technology; Medical errors; Medical charges; Care quality

1. Introduction

In 1987, Nobel Laureate Robert Solow famously remarked, "you can see the computer age everywhere but in the productivity statistics." (Solow, 1987, p. 36). Solow's aphorism neatly summarized the state of knowledge in the late 1980s and early 1990s. Since that time, however, economists have been able to identify measurable economic effects of the revolution in information technology (IT). The emerging consensus from this research is that the effect of IT varies depending on the design of organizations and the nature of production processes. IT *complements* the work of people engaged in non-routine problem solving and communication while it *substitutes* for lower-skill tasks involving the sorts of explicit rules that are relatively easy to program into computers.[1]

Studying the effect of IT on work processes involving non-routine problem solving and communication is hard—in large part because the inherent complexity of these processes make it difficult to identify meaningful performance

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[1] For discussions of this perspective see Autor et al. (2003), Brynjolfsson and Hitt (2000), Bresnahan et al. (2002), and Levy and Murnane (2004).

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measures that are also directly related to specific IT innovations. The search for good performance indicators and cleanly demarcated innovations has moved economists away from the analysis of aggregate productivity and technology data towards more narrowly focused studies.[2] The added institutional knowledge made possible by the limited scope of these studies also helps analysts address the selection problems created by the non-random distribution of new innovations across organizations and work places.[3]

In this paper, we also analyze the effects of an IT enabled innovation in a narrowly defined production process characterized by non-routine problem solving and communication. The information technology we study is a decision support tool designed to notify physicians about potential medical "errors" as well as deviations from evidence-based clinical practice guidelines. Our approach is closest in spirit to Athey and Stern's (2002) study of emergency medical services. Like Athey and Stern, we focus on the introduction of a discrete innovation that altered the handling of information in a health care setting and we assess the efficacy of the innovation by tracking health-related outcomes. Our econometric approach, however, differs from theirs in that we use a randomized controlled trial to identify the effect of the new technology.[4]

Although we focus on a specific production process, the results we report have broad implications for management and economic issues in health care. A large and influential body of research suggests that preventable medical errors have a substantial effect on the cost and quality of medical care.[5] In response to these findings, a number of high-profile public and private initiatives have called for major new investments in information technology and decision support tools to reduce the incidence of errors and increase compliance with evidence-based treatment guidelines (President's Information Technology Advisory Committee, 2004; Institute of Medicine Committee on Quality of Health Care in America, 2001).[6] Economists who have examined these issues generally agree that new information technologies and decision support tools – perhaps combined with novel incentive arrangements – will likely have a substantial influence on both errors and efficiency in the delivery of health care, yet economic studies concerning the efficacy these interventions have been scarce (Newhouse, 2002).[7]

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[2] See for example Athey and Stern (2002) on IT and the delivery of emergency medical services; Autor et al. (2002) on banking; Bartel et al. (2005) on computer controlled machines in manufacturing and Hubbard (2003) on capacity utilization in the trucking industry.

[3] The econometric challenges involved in studying the effect of IT innovations closely parallel the issues involved in the study of innovations in human resource practices. For an illuminating discussion and review see Ichniowski and Shaw (2003) and for an application to the health care setting see Gaynor et al. (2004).

[4] Athey and Stern (2002) identify the effect of the technology in their study by comparing early and late adopters in a differences-in-differences framework. An obvious issue with this approach is that participants who choose to adopt early might be those for whom the benefits of the innovation are especially large. A randomized controlled trial eliminates this source of bias because the participants receiving the treatment are a random sample of the subject pool. Randomized trials have other limitations, however. The subject pools are often small and may not be representative of the underlying population. This can bias estimates of the effect of the intervention on a population. For a practical example of this sort of bias in a health care setting see Duggan (2005).

[5] Evidence on the incidence of medical errors was recently reviewed by the Institute of Medicine of the National Academy of Sciences (Institute of Medicine Committee on Quality of Health Care in America, 2000). This report concluded that tens of thousands of Americans die each year as a result of medical errors during hospitalization. To date, very little is known about the incidence of errors in outpatient settings, but the incidence may be high (Lapetina and Armstrong, 2002). A recent study of errors in intensive care units is Landrigan et al. (2004). A discussion of the literature on the use of IT to reduce errors and increase compliance with evidence-based guidelines can be found in Institute of Medicine Committee on Quality of Health Care in America (2001).

[6] As an indicator of the high level of public policy interest in these issues it is worth noting that reference to the use of IT to reduce errors appeared in President Bush's *Economic Report of the President* in 2004 (President's Council of Economic Advisors, 2004) and in his State of the Union Address. "By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care." (cited in President's Information Technology Advisory Committee, 2004, p. 3). Private sector initiatives concerned with preventing medical errors have also been formed. The most prominent of these may be the Leapfrog Group, a coalition of more than 150 large public and private organizations that provide health care benefits. The purpose of this organization is to use employer purchasing power to speed the adoption of processes that improve patient safety (The Leap Frog Group For Patient Safety, 2004).

[7] There is a growing literature on disease management programs that often rely on information technology similar to that which we evaluate in this study. Disease management programs typically analyze billing records and other clinical information to identify patients whose care deviates from accepted clinical practice guidelines. Although disease management programs have become a ubiquitous part of health care and there is some evidence that they can be effective in reducing costs and improving quality (Shojania and Grimshaw, 2005; Gertler and Simcoe, 2004; Beaulieu et al., 2007), many of the studies are poorly designed and few of them use evidence from randomized controlled trials of interventions (Shojania and Grimshaw, 2005).

The data in this study comes from a randomized trial of a physician decision support technology introduced to a population of commercial HMO patients. We find that the intervention reduced resource utilization: average charges were 6% *lower* in the study group than in the control group. These savings were the result of reduced in-patient charges (and associated professional charges) for the most costly patients.

The importance of IT-based decision support systems for physicians extends beyond resource utilization: patients, providers, payers and policy-makers want to know whether this type of technology improves care quality. Decision support might improve quality if the system reminded physicians to do something beneficial for their patients that they had already intended to do but somehow forgot. Alternatively, decision support might improve quality if it provided useful new information to physicians in a form that was easy to incorporate into their daily practice and routines. This latter avenue of action is especially important because of the problem of physician information overload. In medicine, the number and variety of diseases and treatments and the rapid growth of new knowledge threaten to overwhelm the information processing capacities of individual doctors. Failure to keep abreast of this flood of information can cause physicians to overlook important new treatments or protocols that may improve care quality (Frank, 2004; Phelps, 2000; IMCQHCA, 2000, 2001).

Although the experiment was not designed to analyze the source of missteps or the mechanisms by which the technology influenced physicians, we can learn something about quality by comparing the rate at which identified issues were resolved in study and control groups.[8] Under plausible assumptions, a higher rate of resolution in the study relative to the control group can be interpreted as an improvement in care quality—at least along measured dimensions. Our findings generally point towards higher resolution rates in the study group, although measurement issues discussed below require that we present this conclusion cautiously. The increase in resolution rates was especially large for a new treatment protocol that emerged from the results of a widely publicized clinical trial in the year 2000, the year before our study began. Computer generated messages suggesting that a patient appeared to be a good candidate for the new protocol were triggered quite frequently in our study, suggesting that it takes some time for physicians to incorporate even widely promoted new protocols into their treatment of patients. More importantly we found that the resolution rates in the study group were double those in the control group. This result suggests that the IT system may have been more effective than conventional communication channels in disseminating new knowledge to physicians. We discuss the economic and behavioral implications of these results below.

The plan of the paper is as follows: Section 2 describes the setting of the trial and the decision support technology. Section 3 presents the data analysis. Section 4 concludes and discusses new research questions raised by the study.

2. The setting

2.1. Physician mistakes

Physicians make mistakes—and these mistakes are increasingly believed to have a substantial effect on the cost and quality of medical care. The causes of errors are not entirely clear, but a leading suspect is the volume and complexity of the information that physicians must process about their patients' medical conditions and the rapidly changing state of medical knowledge (Bohmer, 1998; Institute of Medicine Committee on Quality of Health Care in America, 2001; Landrigan et al., 2004).

If errors result from "too much information", then it makes sense to look to information technology to help manage this burden. Ideally one would like to use IT to collect and analyze patient information and to communicate likely missteps to physicians. In order for these messages to be influential it is important that they be delivered in a timely fashion, be targeted to specific patients, and that they reliably inform physicians of overlooked issues or issues about which he or she lacked adequate knowledge. Generating these timely, targeted and informative messages is hard—especially because most physician practices are not linked by a common IT system. In the absence of such linkages, it is difficult for most managed care organizations to construct usable electronic medical records for patients treated within their physician networks.[9] Since managed care organizations are the predominant form of private sector health insurance, the

[8] In the control group physicians did not receive messages about identified issues, but these issues were tracked and often successfully resolved without outside intervention.

[9] "...to be effective, CDSS [clinical decision support systems] diagnostic systems require detailed, patient-specific clinical information (history, physical results, medications, laboratory test results), which in most health care settings resides in a variety of paper and automated datasets that

problems posed by balkanized IT systems can be a significant barrier to bringing computer-assisted decision-making to medical care.

The decision support software evaluated in this trial was designed to overcome the problems posed by fragmented IT systems.[10] It collects information about patients from billing records, lab feeds and pharmacies to assemble a virtual electronic medical record. It then passes this information through a set of decision rules culled from the medical literature. When the software uncovers an issue it produces a message, called a care consideration, that includes the patient's name, the issue discovered, a suggested course of corrective action and a cite to the relevant medical literature. The care considerations (CCs) fall into three distinct, but not entirely mutually exclusive, categories: stop a drug; do a test; and add a drug. The CCs are also coded into three severity levels. A level one message (the most severe) includes potentially life-threatening situations: for example that a patient's blood potassium levels are dangerously off. A level two (moderate) CC refers to issues that might have an important effect on clinical outcomes. An example might be that the patient is a good candidate for an ACE inhibitor, a drug that is useful in treating many cardiovascular conditions. A level three (least severe) CC refers to preventative care issues such as being sure that diabetics have regular eye exams.

Contrary to most other studies of medical errors, issues tracked by the software are not limited to events occurring during hospitalizations. This is important because, most of the evidence regarding medical errors comes from studying the treatment of hospitalized patients, but in-patient treatments are a declining share of medical treatment.

2.2. Study design

The participants selected for the study came from an HMO located in a Midwestern city. All were all under age 65 and all had some medical charges in the year prior to the experiment. Once selected, the participants were randomly allocated into study and control groups. The software was turned on for patients in the study group. This means that their physicians received CCs during the year-long course of the experiment. The software was *not* turned on for patients in the control group until the experiment was over, but the billing, pharmacy and lab data from these patients was collected and saved. At the end of the year, the control group's medical data was analyzed to find CCs that *would* have appeared if the software had been running. An important feature of the study design was that randomization occurred at the level of the patient. This means that some physicians had patients in both the study and the control group.[11] Thus lessons that physicians learned from receiving a CC for a study group patient might spillover to their control group patients. These spillovers could therefore have the effect of biasing the estimated impact of the decision support software downwards.

2.3. Computer-generated messages

When the software generated a CC, doctors employed by the software company manually checked it. If the CC passed this scrutiny and was coded a level one (most severe) the HMOs medical director was called and he, in turn, called the appropriate physician. If the CC was at level two (moderate) or level three (least severe), a nurse employed by the HMO received the error message and decided whether to fax the CC on to the enrollee's physician. The HMOs nurse passed on most (but not all) level two CCs and some of the level three CCs. Unfortunately there are no records documenting the nurse's decisions concerning which messages to pass on. From informal discussions, however, it appears that some types of CCs were not sent because they duplicated advice in disease management programs already in place at the HMO. These were mostly level three CCs focused on preventative care. In addition, the nurse decided that some other CCs did not make clinical sense.

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cannot easily be integrated. Past efforts to develop automated medical record systems have not been very successful because of the lack of common standards for coding data, the absence of a data network connecting the many health care organizations and clinicians involved in patient care, and a number of other factors." (Institute of Medicine Committee on Quality of Health Care in America, 2001).

[10] The technology we analyze is the property of ActiveHealth Management, Inc., which was acquired by Aetna in 2005 but continues to operate as a standalone business. It is important to note that two of the authors had a proprietary interest in the company at the time of the study. Dr. Reisman was, and continues to be, the CEO of ActiveHealth. Dr. Javitt was a shareholder and had a consulting relationship with the company. Rebitzer, who conducted the econometric analysis upon which this paper is based, has never worked for ActiveHealth and has no financial relationship with or proprietary interest in the company.

[11] The initial randomization included 49,988 members with at least 1378 distinct primary care providers (for 567 individuals, no PCP was identified at the time of the randomization). The vast majority of members were treated by physicians having patients in both the study and control groups. Of the patients with identifiable PCPs, only 424 patients (0.8% of the total) were treated by PCPs having only study or control group members.

2.4. Outcomes

The data collected in this study yields two natural performance measures: the rate at which problems identified by CCs are resolved; and the average costs of medical care. We discuss each of these in turn.

2.4.1. Resolution rates

Physicians often have better information about their patients than does the error detecting software. Actions that look like a misstep to the computer may in fact be the result of informed physician choice, informed patient choice and/or patient non-compliance. For this reason, the HMO and the software company viewed CCs as recommendations that physicians were free to ignore if they disagreed.[12] In addition, some issues identified by the software would have been resolved even if no messages had been sent to physicians. Given these ambiguities, how should we interpret differences in resolution rates between study and control groups?

In answering this question it is helpful to consider a simple example. Imagine there is a clinical action recommended by the computer that a physician can either take or not take and that this action can have an effect on the patient that is either positive or not. The probability that a physician in the study group takes an action that benefits a patient is $P(A=1|B=1,S=1)P(B=1)$ where $A=1$ if the action is taken and zero otherwise; $B=1$ if the recommendation in the CC is indeed beneficial to the patient and 0 otherwise; $S=1$ if the individual is in the study group and 0 if in the control; and $P(\ )$ represents probabilities. With this notation we write the probability that the physician will take the action and the patient will *not* benefit as $P(A=1|B=0,S=1)(1-P(B=1))$. The corresponding probabilities for the control group are $P(A=1|B=1,S=0)P(B=1)$ and $P(A=1|B=0,S=0)(1-P(B=1))$, respectively. Resolution rates will appear higher in the study than the control group when

$$P(A=1|B=1,S=1)P(B=1)+P(A=1|B=0,S=1)(1-P(B=1)) > P(A=1|B=1,S=0)P(B=1)+P(A=1|B=0,S=0)(1-P(B=1)) \quad (1)$$

Regrouping we can rewrite (1) as

$$[P(A=1|B=1,S=1)-P(A=1|B=1,S=0)]P(B=1) > [P(A=1|B=0,S=0)-P(A=1|B=0,S=1)](1-P(B=1)) \quad (2)$$

From expression (2) it is clear that if the care considerations are always right so that $P(B=1)=1$, then if more resolutions to care considerations are observed in the study than the control group the quality of care in the study group must be higher than the control group. Conversely if the care considerations do not benefit patients at all, $P(B=0)=1$, then we can make no inferences about quality from differences in rates of resolution. Given the state of the software (and the state of medical science) it is reasonable to assume that $0<P(B=1)<1$. In this case it is possible, but not certain, that the messages delivered contain useful medical information. It follows that quality improves in the study group when:

$$[P(A=1|B=1,S=1)-P(A=1|B=1,S=0)]P(B=1) > [P(A=0|B=0,S=0)-P(A=0|B=0,S=1)](1-P(B=1)) \quad (3)$$

Subtracting (3) from (2) it is easy to derive sufficient conditions under which resolution rates and quality can both increase in the study group when $0<P(B=1)<1$:

$$[P(A=1|B=1,S=1)-P(A=1|B=1,S=0)]P(B=1)>0; \quad \text{and} \quad P(A=0|B=0,S=1)-P(A=0|B=0,S=0)>0 \quad (4)$$

The two conditions in (4) are intuitive. The first states that CCs contain enough useful information to persuade physicians to take actions that offer benefit to their patients. The second states that physician judgment is sufficiently good that computer messages will not persuade doctors to take actions when no action is in the best interest of their

[12] Informal conversations with physicians who attended a discussion group about the software indicated that they also viewed the care considerations as suggestions that they could disregard.

patient.[13] If these conditions hold, then higher resolution rates in the study group are an indicator of improved care quality–at least along the dimensions measured by the computer system.

2.4.2. Average charges

The CCs issued by the system recommended roughly three types of actions: "add a drug", "stop a drug" and "do a test". The first and the third of these entail a direct increase in the utilization of medical resources. If, however, these actions prevent subsequent costly complications, the net effect might be to reduce charges relative to the control group.

Administrative data from the HMO was collected on average charges per member per month in the year prior to the study and also during the year of the study. Charges are "list prices". They are the prices that providers bill for services, but that are rarely used in actual transactions because most purchasers negotiate discounts. For this reason charges should not be interpreted as a price in the usual economic sense of the word. Rather we use average charges to track movements in aggregate resource utilization. Assuming that similar charges are applied to similar services in the study and control group, charges can be a useful dollar index of resource utilization. In the context of our study, the assumption of a common charge schedule in study and control groups is reasonable. The participants in our study were taken from a single HMO and more than 99% of them have primary care providers with patients in both the study and control group. While individual PCPs and medical practices may have a different schedule of charges for different HMOs, they use the same schedule when charging a single HMO. Thus differences in physician charges between study and control groups should be largely eliminated by the random assignment of patients to study and control groups. This is especially true in fixed effects specifications because, if patients remained with their PCP over the course of the study, the effect of cross PCPs variation in the charge schedule will be largely absorbed in the "fixed effect". Most of the hospital admissions in this HMO were to a single hospital, so it is also unlikely that differentials in average charges for in-patient services and for hospital-related professional services were the result of differences in the schedule of charges between the study and the control group.

In addition to charges, we also have data on reimbursements. Reimbursements are the amount insurers actually pay to providers for specific services and they typically are below charges. Data from the *Medical Expenditures Survey* indicates that reimbursements differ from charges and that these differences vary by service and also have been increasing over time (Slesnick and Wendling, 2006). This would suggest that charges may be a poor proxy for reimbursements—especially if studying variation over long periods of time and diverse geographic settings. Reimbursements might be preferred to charges as a measure of resource utilization because they are used to settle actual transactions. In our setting, however, reimbursements are less informative about resource use than charges. The reason for this has to do with the accounting practices used in the HMO we study. Specifically the hospital that accounted for the bulk of in-patient activity *charged* the HMO for resources used during a stay, but the HMO *reimbursed* the hospital a set amount per-diem. This means that a high daily use of in-patient resources would be reflected in high in-patient charges but not in in-patient reimbursements. This per-diem arrangement did not apply to in-patient-related professional services.[14]

It is also worth noting that the study is designed to assess only the short-run effects of the intervention on resource utilization. Many of the benefits of avoiding missteps may appear years after the error occurred. Given the high rate

[13] Of course these conditions are not relevant if physicians simply viewed the CCs as "orders" that they had to follow or as messages with an inherent legitimacy. As noted above, conversations with physicians involved in the study indicate that participating doctors viewed CCs as suggestions that they were free to ignore. In the long-run, if the decision support technology proved to be sufficiently reliable, physicians may substitute its advice for their own reading or discussion with peers. This will have interesting effects on the diffusion of new knowledge. See Rebitzer et al. (2007) for an analysis.

[14] More information about the design as well as a preliminary analysis of results can be found in Javitt et al. (2005). This study differs from the earlier one in a number of important respects. First, we use an additional 2 years of data to analyze the effect of the intervention on resource utilization. This allows us to run a "reverse experiment" that corroborates and extends the findings of the initial experiment. Our analysis of resource utilization also includes a discussion of the ways that the billing practices of the HMO influence measures of resource utilization based on average charges and average reimbursements. Second, we investigate the effect of the intervention on different quantiles of the cost distribution as well as on sub-populations whose pre-experiment characteristics give them a high-propensity to generate care considerations. Third, we offer a much more extensive and detailed analysis of the effect of the intervention on resolution rates including: a discussion of potential measurement error in the identification of CCs in the control group; a clear statement of the relationship of resolution rates to care quality; and a consideration of the behavioral implications of the observed pattern of resolution rates.

Table 1
Descriptive statistics

	Study	Control
Number of members in 2001 >12 years old	19,716	19,792
Fraction of members in study for all 12 months 2001	0.730	0.724
Average charges in 2001 (pmpm)		
Total charges	327.54	352.31
In-patient charges	58.15	72.06
Out-patient charges	71.69	74.11
Rx charges	65.21	65.27
Professional charges	132.48	140.87
Average charges in 2000 (pmpm)		
Total charges	280.45	283.39
In-patient charges	58.23	59.43
Out-patient charges	57.39	57.97
Rx charges	47.13	47.88
Professional charges	117.71	118.11

of turnover among HMO patients, however, much of the benefits to individual insurers of reduced resource utilization may be best captured by short-run savings identified in this study.[15]

3. Data and results

3.1. Descriptive statistics

Table 1 presents descriptive statistics. The analysis excludes enrollees younger than age 11 because the decision support software had very few pediatric treatment guidelines in place at the time of the study. The number of individuals in the study and control groups older than age 12 in the year 2001 was 19,716 and 19,792, respectively. There is some attrition from the study in the year 2001, mostly because of the change of insurers that takes place at the beginning of each calendar/contract year. In both the study and control groups, roughly 72% of respondents stayed in the sample for all 12 months.

3.2. Who gets CCs?

Table 2 examines who in the study group gets CCs, how many they get, and of what severity. Column (1) is a probit with a dependent variable equal to one if the member received any CCs at all. It is estimated for members of the study group because actual CCs were generated only in the study group. The first set of right-hand side variables code for age. The omitted group consists of those between age 12 and 20 and the coefficients are expressed as derivatives. Thus a participant aged 20–30 is 1.1 percentage points more likely to receive a CC than a participant in the omitted group. The likelihood of generating a CC increases with each subsequent decade and peaks for the oldest group. HMO members aged 60–65 are 31 percentage points more likely to generate a CC than those in the omitted group. Women are 0.6 percentage points less likely to generate a CC than are men, a difference of roughly 12% from the mean. This gender differential probably is due to two factors: first, the software program did not have codes for many obstetric and gynecological issues and secondly, cardiac and other issues that were well represented in the software often manifest themselves a decade later in life for women than for men. Since this study focused on a commercial insurance population less than 65 years old, this decade delay in onset would reduce the number of CCs generated for women. Finally, participants with higher levels of charges in the year 2000 are more likely to generate CCs in the year

[15] Cebul et al. (2007) find insurance turnover rates in excess of 30% per year. In their study, Gertler and Simcoe (2004) report that a disease management program for diabetes reduced costs by about 8% in the first 12 months and larger cost savings were realized in subsequent quarters.

Table 2
Who received care considerations in the study group?

	Probit receive any CC?	Negative binomial number CCs received	Ordered probit severity of CCs
20 < AGE ≤ 30	0.011 (1.31)	1.446 (1.26)	−0.134 (1.26)
30 ≤ AGE < 40	0.041 (5.03)**	3.742 (5.26)**	−0.447 (4.93)**
40 ≤ AGE < 50	0.092 (9.83)**	8.825 (9.14)**	−0.823 (9.56)**
50 ≤ AGE < 60	0.175 (13.57)**	16.251 (11.76)**	−1.136 (13.10)**
60 ≤ AGE	0.314 (16.45)**	27.828 (13.75)**	−1.4860 (16.06)**
Female	−0.00600 (2.29)*	0.83151 (2.63)**	0.0620 -(1.92)
Charges (pmpm) in 2000	0.000011 (5.67)**	1.0005 (10.00)**	−0.00014 (6.25)**
Constant		−7.290 (31.42)**	
Observations	19,693	19,693	19,693
Log pseudolikelihood	−3389.5289	−4077.0834	−4077.0834

Column (1) is a probit with coefficients expressed as derivatives. For dummy variables this is a discrete change from 0 to 1. For continuous variables the derivative is evaluated at the mean. Column (2) is a negative binomial count model of the number of CCs received. Parameter $\alpha = 4.02$. The coefficients are expressed as incident rate ratios so that the number of CCs for those 20–30 is 3.742 times that of the omitted age group. Column (3) is an ordered probit of an indicator of CC severity. CCs were ranked from least (3) to most (1) dangerous. Those with no CCs were given a 4. Members were assigned the level of the most dangerous CC they received. The omitted age category is teenagers between 12 and 20. Numbers in parenthesis are z scores.*Means significant at 5% level; **means significant at 1% level.

2001. The effect, while statistically significant, is also small. Moving from zero charges in 2000 to the mean level of $280 increases the odds of generating a CC by 0.003, an increase of 6% above the mean incidence of CCs.

Taken together, the results in column (1) of Table 2 indicate that older, male patients with high medical charges in the previous year are more likely to have errors. The findings are consistent with the notion that care complexity is an important determinant of physician missteps. As bodies age, more things are likely to go wrong—leading to more treatment and also more opportunities for lapses. Similarly, the more charges a patient generates, the greater the medical activity undertaken on their behalf. Managing these activities creates additional opportunities for missteps.

The models estimated in columns (2) and (3) of Table 2 redo the analysis focusing respectively on the number of CCs received (a negative binomial model) and the severity of the most severe CC received (an ordered probit model). In both cases we find that older patients, male patients and patients with more charges prior to the experiment are likely to generate more, and more severe, CCs. These results are both statistically significant and large in magnitude. They further underscore the likely role that complexity of care plays in generating errors.

3.3. Charge differentials

Table 3 analyzes the effect of the intervention on average charges per member per month. We adopt an "intention to treat" approach and compare the average charges in the study group and the treatment group. There are many possible treatment mechanisms in this study and it is hard to appropriately identify them all. As discussed above, we observe

Table 3
The average effect of the intervention on utilization as measured by dollar charges per member per month and hospitalization

	(1) Total charges (pmpm)	(2) In-patient charges (pmpm)	(3) Out-patient charges (pmpm)	(4) Rx charges (pmpm)	(5) Professional charges (pmpm)	(6) In hospital
Year = 2001	69.099 (8.88)**	12.692 (2.51)*	16.172 (7.47)**	17.399 (31.53)**	22.837 (8.92)**	0.002 (0.83)
Study × Year = 2001	−21.92 (1.99)*	−12.833 (1.8)#	−1.823 (0.60)	0.7 (0.90)	−7.963 (2.20)*	0.000 (0.10)
Constant	281.856 (72.37)**	58.829 (23.29)**	57.661 (53.23)**	47.499 (171.96)**	117.867 (92.01)**	0.05 (47.34)**
Individual fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Observations	78,976	78,976	78,976	78,976	78,976	78,976
Individuals	39,508	39,508	39,508	39,508	39,508	39,508

Absolute value of t statistics in parentheses. #Significant at 10% *significant at 5%; **significant at 1%. The absolute value of bootstrapped z-scores for Study × Year in columns (1)–(6) are respectively: (−1.85), (−1.83), (−0.58), (0.84), (−2.42), (−0.10). These were calculated by sampling, with replacement, 100 times for each equation. Similar results were found if we estimated the model using only study year data. For columns 1–5 the coefficients (t-statistics) for Study × Year are −24.777 (2.44), −13.906 (2.38), −2.423 (0.82), −.057 (0.04), −8.390 (−2.24). Bootstrapped standard errors were very close to OLS in these models. F tests that individual fixed effects are jointly zero can be rejected at 1% significance levels.

CCs generated by the software and approved by MDs working for the software company, but the HMO's nurse passed only a subset of these along to the treating physician. Similarly it is hard to know if the effect of the intervention was due to the information content of the particular CC or simply the fact that a physician received a CC at all. The "intention to treat" approach allows us to be agnostic about the mechanisms of action.

Column (1) in Table 3 estimates a fixed effects model of the determinants of total charges (pmpm) between the study group and the control group. The variable Year = 2001 is an indicator variable that is equal to 1 in 2001 and 0 in the year 2000. The coefficient 69.099 means that average charges rose from the pre-study year to the study year by $69.10 pmpm. This increase is driven by two factors: the growth in charges from 1 year to the next and also the increase in medical services delivered as individuals become 1 year older. The key variable that identifies the average treatment effect is Study × Year = 2001. The coefficient reported implies that the increase in average charges from the pre-study year to the study year was $21.92 less in the study group than in the control group. Thus the intervention reduced the average of total charges in the study group by 6.1% of the average $352 pmpm control group charges. This difference is both economically significant and statistically significant at the 5% level.

Columns (2)–(5) of Table 3 present estimates of the average treatment effect for the components of total charges. These are in-patient charges (charges incurred during hospitalization); out-patient charges, prescription (Rx) charges, and professional charges (charges resulting from professional services such as radiology). Focusing attention on the key variable, Study × Year = 2001, in-patient charges are reduced by $12.83 ($t = 1.8$) in the study group relative to the control. This accounts for 58% of the total cost differential. In contrast, out-patient and Rx charge differentials are quite small and statistically insignificant, −$1.82 ($t = 0.60$) and $0.70 ($t = 0.90$), respectively. Professional charges, however, are $7.96 ($t = 2.21$) smaller in the study group. The final column of Table 3 estimates a linear probability model of the determinants of hospitalization. The dependent variable is equal to one if the participant had ever been hospitalized and is 0 otherwise. The coefficient on Study × Year = 2001 is very small and statistically insignificant, −0.002 ($t = 0.83$). Since hospitalization is expensive, this suggests that the reduction in in-patient costs observed in column (2) is likely due to reduced resource use when hospitalized or due to a reduction in the number of hospitalizations in the year. This makes sense, as the likely effect of some of the CCs is to prevent re-hospitalization or to reduce resource utilization per hospital visit—perhaps by improving the health of individuals who might become hospitalized.[16]

Further support for this interpretation of Table 3 emerges from an analysis of average reimbursement differentials between study and control groups. In fixed effects estimates identical to those presented in Table 3, we find that the coefficient on Study × Year = 1 is −$8.96 ($t = 1.60$). This is a 6% drop in charges. Fifty-one percent of this difference is due to the $4.62 ($t = 2.39$) differential in professional reimbursements while 43% is due to the $3.88 ($t = 1.15$) differential in average in-patient charges. Comparing these results to Table 3 we see that in-patient savings account for less of the total treatment effect and are more imprecisely measured when we use average reimbursements rather than average charges to measure resources used. The fact that the effect on in-patient reimbursements was smaller and much more imprecisely measured is not surprising given what we know about the HMOs accounting practices (discussed in Section 2). The hospital that the HMO relied on for the bulk of in-patient services *charged* the HMO for all services provided but was *reimbursed* on a fixed per-diem basis. If patients in the study group used on average fewer resources per day than the control group counterparts, they would appear to have lower average charges but not lower average reimbursements. In contrast, professional charges and reimbursements were both based on services provided and we find that the intervention reduced these significantly, regardless of whether reimbursements or charges were used as the measure of resource utilization.

The results in Table 3 imply that in-patient and professional charges account for 95% of the average charge differential between study and control groups. In-patient charges arise from the use of hospital resources, but professional charges include services that can be delivered in either an inpatient or outpatient setting. Our findings suggest that the experiment did not reduce all professional charges, but only those associated with hospitalization. Taking the coefficient on Study × Year = 2001 in column (2) and dividing it by the analogous coefficient in column (5) we get 1.62. Thus every dollar decrease in professional charges that is due to being in the study group is associated with a $1.66 reduction in in-patient charges. Similar calculations using results from column (3) of Table 3 suggest that a dollar reduction in

[16] Examples of issues reported as CCs that were likely to prevent re-hospitalization include inadequate use of ACE inhibitors or beta-blockers for patients with myocardial infarctions or congestive heart failure.

Table 4
Exposure to technology reduces costs at the far-right tail of the distribution of costs

	(1)	(2)	(13)
	Quantile regressions (total charges, pmpm)		
	Median	90th percentile	99th percentile
Study	−0.541 (0.36)	−20.942 (1.31)	158.436 (0.74)
Year = 2001	13.910 (7.16)**	166.308 (9.07)**	962.548 (3.49)**
Study × Year = 2001	0.561 (0.20)	−26.512 (1.06)	−658.612 (1.85)#
Constant	86.47083 (77.92)	636.9142 (54.00)	3189.613 (19.50)
Observations	78,976	78,976	78,976
Individuals	39,508	39,508	39,508
R^2	0.0005	0.0032	0.0037

Quantile regressions estimated for the median, 90th and 99th percentiles, respectively. The standard errors for these regressions were bootstrapped with 1000 repetitions. The R^2 for the quantile regressions are pseudo-R^2. #Means significant at 10% level; * means significant at 5% level; ** means significant at 1% level.

professional charges resulting from the experimental intervention is associated with a drop in outpatient charges of only $0.23.

The results in Table 3 indicate that the reduction in total charges is largely driven by inpatient costs and associated professional charges. Since hospitalization is expensive, this suggests that savings generated in the experiment are the result of reduced resource use for high-cost participants. Table 4 examines this directly through the use of quantile regressions. Column (1) of Table 4 is a median regression. The variable of interest is once again Study × Year = 2001. The coefficient of 0.541 ($t = 0.20$) suggests that the median participants in the study and control groups had virtually identical total charges (pmpm). The corresponding coefficients in Column (2) suggest charge differentials are $26.51 ($t = 1.06$) at the 90th percentile and $658.61 ($t = 1.85$) at the 99th percentile. Clearly the intervention is having its effect at the far right tail of the distribution of costs.

The finding that the "action" generated by the intervention primarily affects high-use patients raises concerns about the appropriate way to calculate the *t*-statistics reported in Table 3. Specifically one might be concerned about the assumption that the error term in our cost equations is normally distributed. For this reason we recalculated the *t*-statistics in Table 3 using a bootstrap technique that makes no assumptions about the functional form of the errors. As reported in the notes to Table 3, we find that bootstrapped standard errors are quite close to the conventional standard errors generated by fixed effect estimators.

If the experimental intervention is the primary cause of the differences between study and control groups, one might expect the cost savings to be greatest for individuals with the highest propensity to generate CCs. Table 5 examines this issue by restricting our estimates to those individuals whose pre-study characteristics put them most at risk for producing an error message. Columns (1)–(5) of Table 5 examine charges for individuals who were over age 50 in the year prior to the experiment. This sample is of particular interest because the results in Table 2 indicate that this age group is most likely to generate error messages. In this table we use only data from the study year, so the key variable of interest is Study.[17] We find that the average total charges are $72.17 less in the study group than the control and this difference is rather precisely measured. As we observed in Table 3, much of this differential is the result of differences in in-patient charges (study group members had in-patient charges that are nearly $50.00 lower than the control group with a *t*-statistic of 2.12). Out-patient charges and Rx charges are not significantly different between the study and control group although the point estimate of magnitude of the out-patient differential ($9.59) is sizeable. Professional charges are, as before, estimated to be the second leading contributor to the differential between the study and control group differential, but the size of the professional charges differential was imprecisely measured and we cannot reject the hypothesis that the true effect was zero.

Restricting our sample to individuals over age 50 causes us to discard much of our data. An alternative approach, which we present in columns (6)–(10) is to use the "CC" equation in Table 2 to estimate each individual's propensity

[17] As we observe in the notes to Table 3, point estimates of the average treatment effect were very close whether we used a fixed effects model or restricted our attention to the study year differentials.

Table 5
The effect of the intervention on individuals likely to receive a CC

	Sample in study year over age 50 in base year					Weighting observations using the propensity score entire sample in study year				
	OLS (1) total charges (pmpm)	OLS (2) in-patient charges (pmpm)	OLS (3) out-patient charges (pmpm)	OLS (4) Rx charges (pmpm)	OLS (5) professional charges (pmpm)	(6) Total charges (pmpm)	(7) In-patient charges (pmpm)	(8) Out-patient charges (pmpm)	(9) Rx charges (pmpm)	(10) Professional charges (pmpm)
Study	−72.171 (2.04)*	−49.633 (2.12)*	−9.59 (1.10)	0.447 (0.13)	−13.395 (1.18)	−66.363 (3.44)**	−38.067 (3.5)**	−2.913 (−0.57)	−0.821 (0.46)	−24.562 (2.86)**
AGE ≥ 60	234.697 (5.82)**	114.847 (4.30)**	24.101 (2.42)*	18.271 (4.54)**	77.478 (5.97)**					
Female	−29.64 (0.83)	−56.477 (2.39)*	9.918 (1.12)	13.444 (3.78)**	3.475 (0.3)					
Charges (pmpm) in 2000	0.383 (26.60)**	0.105 (11.05)**	0.08 (22.35)**	0.034 (23.41)**	0.165 (35.54)**					
Constant	422.06 (12.13)**	121.917 (5.29)**	75.666 (8.81)**	92.749 (26.76)**	131.729 (11.78)**	706.486 (51.76)**	181.492 (23.54)**	137.071 (37.73)**	111.2238 (87.94)**	276.7003 (45.55)**
Observations	8291	8291	8291	8291	8291	39,468	39,468	39,468	39,468	39,468
R^2	0.09	0.02	0.06	0.07	0.14	0.0003	0.0003	0.000	0.000	0.0002

Absolute value of *t* statistics in parentheses. *Significant at 5%; **significant at 1%. In columns (1)–(5), the absolute value of the bootstrapped *z* scores for variable Study are respectively (2.14), (2.17), (1.06), (0.13), (1.07). The standard errors for all bootstrapped estimates involved sampling, with replacement, 100 times. For the weighted regressions in (6)–(10), we set the analytical weight in STATAs regression command equal to the observation's propensity score, i.e. the predicted probability from Eq. (1) in Table 2 that an individual will generate a CC. This weighting scheme assumes that observations with high propensities to generate CCs are measured more accurately than observations with low propensities. Specifically, analytical weights are assumed to be inversely proportional to the variance of an observation; i.e., the variance of the *j*th observation is assumed to be s/w_j where the weights, w_j, are rescaled to sum to the number of observations in the data.

for receiving a CC based on pre-study characteristics. We can then weight each observation by its propensity score and, in this way, observe how our estimates change when greater weight is given to individuals likely – on the basis of pre-experiment characteristics – to be exposed to a care consideration.[18]

In column (6) of Table 5 the coefficient on Study is −66.36, a cost differential in between study and control groups that is roughly three times the estimate in Table 3. Interestingly this number is not too far from the coefficient on Study in column (1).[19] This result confirms the impression from column (1) that cost savings from the study are greatest for individuals with a high propensity to receive a computer-generated message. The weighted estimates for in-patient charges (column (7)) and professional charges (column (10)) follow a similar pattern. The coefficients on the variable Study in each of these cases is negative, statistically significant, and roughly three times the size of the effect observed in the un-weighted regressions in Table 3. The results on out-patient and Rx charges follow the now familiar pattern: the coefficient on variable Study is small in magnitude and imprecisely measured. One cannot reject the hypothesis that the true effect of the intervention on outpatient and Rx charges is zero.

The overall impression from Table 5 is that the magnitude of the reductions in resource utilization in the study group are largest for those participants whose pre-study characteristics mark them as likely to be directly effected by the intervention.

3.4. Reverse experiments

The experiment was concluded at the end of December 2001, but the system was kept in place for study group members until the end of February 2002. At that time the entire software system was turned off. In June 2002 the software was started up again and CCs were sent to all HMO enrollees, including those in the original study and control groups. The general rollout of the system makes possible an additional test of the system's effects on costs. If the reduction in charges observed in the study group was indeed the result of the intervention, one should expect charges in the two groups to converge when the controls began receiving CCs.

Table 6 compares charges in the study and control groups in the 2 years following the end of the experiment. Panel A of Table 6 analyzes cost data from calendar 2002. The coefficient on Study in column (1) indicates that average total charges in the study group were about $8.58 lower in the study than the control group. This difference is about 40% of that observed in the year of the experiment and it is imprecisely measured ($t = 0.78$) and not statistically distinct from zero at conventional significance levels. The corresponding coefficients for inpatient, outpatient, prescriptions and professional charges are presented in columns (2)–(4), respectively. They are similarly small, imprecisely measured, and not different from zero at conventional significance levels. Column (6) is a probit where the dependent variable is 1 if a patient was ever hospitalized in the year and 0 otherwise. The probability of any hospitalization in 2002 was 0.5 percentage points lower in the study group than the control group ($z = 2.27$). Column (7) is a quantile regression comparing the study and control groups at the 99th percentile. The coefficient on Study is −238.91, slightly more than a third of the analogous coefficient in Table 4 and imprecisely measured ($t = 1.07$). Panel B compares the remaining members of the study and control groups in the year 2003, two full years after the experiment. We find no statistically significant difference in charges between the two groups in any component of costs. Taken together, the absence of cost differentials in years when the intervention was rolled out to both treatment and control groups supports the conclusion that the cost differentials observed during the study year were the result of the intervention. These findings also suggest that the effect that the intervention had on our dollar index of utilization was fast-acting (appearing in the first year of the study) and also quickly dissipated.

3.5. Resolution rates

In the decision support system we study, messages are aimed at physicians. The charges data we analyzed above are a useful index of utilization, but charges are far removed from the actions physicians may take in response to messages.

[18] We set the analytical weight in STATAs regression command equal to the observation's propensity score. This weighting scheme assumes that observations with high propensities to generate CCs are measured more accurately than observations with low propensities. Specifically, analytical weights are assumed to be inversely proportional to the variance of an observation; i.e., the variance of the jth observation is assumed to be σ^2/w_j where the weights, w_j, are rescaled to sum to the number of observations in the data.

[19] The 95% confidence interval is between −104.14 and −28.58.

Table 6
Charges in the study and control groups after the care engine was rolled out to both groups

	(1) OLS total charges (pmpm)	(2) OLS in-patient charges (pmpm)	(3) OLS out-patient charges (pmpm)	(4) OLS Rx charges (pmpm)	(5) OLS professional charges (pmpm)	(6) Probit in hospital	(7) Quantile regression 99th percentile total charges (pmpm)
Utilization measures in 2001							
Study	−24.777 (2.44)*	−13.906 (2.38)*	−2.423 (0.82)	−0.057 (0.04)	−8.39 (2.24)*	−0.031 (1.50)	−500.176 (1.58)
Constant	352.313 (44.04)**	72.057 (14.63)**	74.112 (32.62)**	65.27 (71.12)**	140.874 (49.78)**	−1.611 (109.67)**	4,152.16 (16.36)**
Observations	39,508	39,508	39,508	39,508	39,508	39,508	39,508
Utilization measures in 2002							
Study	−8.528 (0.78)	−5.796 (0.86)	2.416 (0.89)	−1.783 (1.29)	−3.365 (0.90)	−0.005 (2.27)*	−238.91 (1.07)
Constant	338.544 (41.94)**	70.051 (13.89)**	65.342 (33.61)**	65.258 (62.98)**	137.891 (49.50)**		3948.585 (25.23)**
Observations	38,056	38,056	38,056	38,056	38,056	38,056	38,056
Utilization measures in 2003							
Study	15.574 (0.94)	14.072 (1.45)	0.589 (0.12)	2.273 (1.17)	−1.36 (0.24)	0.001 (0.22)	−184.170 (0.39)
Constant	379.225 (37.25)**	78.716 (14.55)**	88.1 (25.85)**	50.632 (39.57)**	161.776 (43.77)**		5214.387 (16.03)**
Observations	27,288	27,288	27,288	27,288	27,288	27,288	27,288

Robust *t* statistics in parentheses in columns (1)–(5) and (7). Column (6) presents *z* statistics. The standard errors for the quantile regressions were calculated by bootstrapping 100 times with replacement. *Significant at 5%; **significant at 1%. The experiment concluded at the end of December 2001, but the "care engine" remained on for 2 months. At the end of February, the entire system was "turned off" and in June the system was rolled out to all members. Panel A compares charges in the study and control group during the study year, 2001. Panels B and C compare study and control groups in 2002 and 2003, after the experiment was rolled out to all members.

Table 7
Descriptive statistics regarding care considerations

	Study	Control
Number of CCs issued	1299	1519
Fraction of members with at least 1 CC in 2001	0.050	0.061
Distribution of CCs among members who have any CCs		
Percent of members having any CC who have 1 CC	76.87	80.96
Percent of members having any CC who have 2 CCs	16.46	14.56
Percent of members having any CC who have 3 CCs	4.55	3.17
Percent of members having any CC who have 4 CCs	2.12	1.14
Percent of members having any CC who have 5 CCs	0	0.16
Mean CCs for members with CCs	1.321	1.253
Number of distinct types of CCs issued	90	83
Severity of CCs		
Fraction of members with at least 1 level 1 CC in 2001 (most serious)	0.001	0.002
Fraction of members with at least 1 level 2 CC in 2001 (less serious)	0.036	0.042
Fraction of members with at least 1 Level 3 CC in 2001 (least serious)	0.019	0.024

We can move closer to observing physician behavior by examining the rate of resolution of issues identified by the computer in the study and the control group.

The recommendations issued by the software fell into three, not-quite mutually exclusive, categories: “add a drug”, “do a test”, and “stop a drug”. To identify compliance with an “add a drug” recommendation, the computer scanned pharmacy records following the recommendation. If a prescription for the indicated drug was filled, the issue was declared resolved. Similarly, billing records were scanned following a “do a test” recommendation. If bills for the suggested test were sent, the recommendation was also declared to be resolved. Calculating resolution rates for the “stop a drug” recommendations was more problematic than for the other two categories of suggestions. Individuals might have month-long supplies of the drug at home and the records only tell us that no new prescriptions for the drugs were filled. To identify compliance with “stop a drug” recommendations, pharmacy records were scanned for 60–150 days after the CC was transmitted, and the issue was declared resolved if no new scripts for the indicated medication were filled in that time.

Table 7 presents descriptive statistics regarding care considerations. The number of CCs issued was 1299 in the study group and 1519 in the control group. The CC differential between the study and the control group is statistically significant and therefore unlikely to be a purely statistical artifact.[20] If random chance is unlikely to generate this differential, we need to consider what other causes might be and the consequences these might have for estimating resolution rate differentials.[21]

3.6. Why were extra CCs triggered in the control group?

We have identified four potential causes for excess CCs in the control group. First, it is possible that the randomization did not “work” in the sense that a larger proportion of expensive patients with characteristics that trigger CCs ended up in the control group than the study group. In Table 3, however, we report that the average cost differential between study and control groups is almost completely unchanged by the presence or absence of fixed, participant effects. This suggests that inherently expensive patients were evenly distributed between the study and control groups.

A second possible cause of excess CCs in the control group might be that the decision support tool was triggering extra scrutiny of patient files and therefore preventing subsequent CCs for patients who received any CCs. The evidence is, however, inconsistent with this hypothesis. In Table 7 we see that 80.96% of the control group CCs were issued to participants with only one CC compared to 76.87% in the study group.

[20] The fraction of individuals receiving a CC is 20% higher in the control than the study group. A probit regressing the variable any CC generated against the variable Study finds that the difference between the study and control group is statistically significant at the 1% level.

[21] The estimates of the propensity to generate CCs that we used in Table 5 used only the actual CCs issued to the study group and hence were not influenced by the process of CC generation in the control group.

Table 8
The effect of the experiment on resolution rates and the probability of receiving any care consideration

	(1) Probit successful resolution any "add a drug" CC [0.18]	(2) Probit successful resolution any "do a test" CC [0.31]	(3) Probit successful resolution any "stop a drug" CC [0.34]
Study	0.086 (2.51)*	0.058 (2.24)*	−0.060 (1.53)
Observations (only for 2001)	601	1354	592
Observations in control group	322	724	355

Robust z statistics in parentheses. [ ] is mean of dependent variable in the control group in 2001. *Significant at 5%; **significant at 1%. Probits in column (1) are estimated for all members who received at least one "add a drug" CC in 2001. Probits in columns (2) and (3) are for "do a test" CCs and "receive any CC", respectively. Coefficients are expressed as "derivatives". Thus 0.18 of the control group who received an "add a drug" CC in 2001, had a successful resolution of an "add a drug" CC. The resolution rate in the study group was 8.6% points higher or 0.266.

A third explanation for excess CCs arises from the way that the CCs were identified in the control group after the end of the experiment. The software company saved all the data generated by the controls and ran this data through their software in early 2002. As was true in the study group, a committee of three physicians examined the resulting CCs and sent along those that made sense to them. The clinical thinking of the committee likely evolved over the year 2001, thus the real-time decisions they made over the course the experiment might have been different than the ones they made when evaluating the control group data after the experiment ended in early 2002. If the committee of physicians approved a larger number of CCs over time as they gained confidence in the computer system, then it would be reasonable to expect that more CCs would have been approved for the control group.[22]

The fourth possibility is one that we believe to be the most important. During the course of the study, the computer system generated messages based on information available at the time the program was run—roughly every week. In contrast, the control group CCs were generated using information accumulated over the entire year of the experiment. This subtle difference in the handling of information appears to be sufficient to generate significant differences in the number of CCs in the study relative to the control group.[23]

Of the 101 distinct care considerations that the software could generate, we observe 90 types issued in the study group and 83 issued in the control group. Our resolution rate estimates will be biased if the mix of CCs in the control group was more or less likely to resolve spontaneously than the mix of CCs in the study group. Unfortunately we have no way of assessing the spontaneous resolution rates of different CCs and hence we have no way of assessing the sign or magnitude of potential biases. One might suppose that very serious errors are more likely to be picked up by care providers because of other pre-existing safety measures and this might provide some hint about the direction of biases. The breakdown of CCs by severity level in Table 7 suggest that there are more severe CCs in the study than in the control group, but the number of such serious issues are very small and are therefore unlikely to be driving the results.

We can control for some of the potential differences in the mix of CCs between study and control groups by examining resolution rate differentials by type of CC. The results of this comparison can be found in the probits presented in Table 8. In Eq. (1) we observe that resolution rate for "add a drug" CCs is 8.6 percentage points higher in the study group than the control group. This is a 48% improvement over the control group. In column (2) we observe that resolution rates for "do a test" CCs are 5.8% higher in the study group, an improvement of 19% over the control group. We do *not*, however, observe higher resolution rates in the study group for "stop a drug" CCs. The coefficient on Study in column (3) has the wrong sign, but is also imprecisely measured.[24]

[22] We have some reason to believe, however, that increasing confidence in the system by the committee is not the cause of the differential we observe. In analysis of a subsequent randomized trial on Medicare patients, we found excess CCs in the study group rather than the controls—not the pattern one would expect if the differential was driven by a continued rise in confidence in the software.

[23] In the second randomized trial mentioned in the preceding footnote, we were able to eliminate the CC differential between study and control groups by forcing the computer system to conduct an evaluation of patients using data generated at the same moment in time. It appears that the triggering of some CCs is quite sensitive to small changes in the window of data available to the computer. For technical reasons, it is not possible to construct such simulated CCs for this experiment. The analysis of this second randomized trial is currently in process.

[24] In evaluating these resolution rate differentials, it is important to observe that it is hardly automatic that physicians respond to interventions in a positive way. Shojania and Grimshaw (2005) report in their assessment of quality improvement studies that interventions targeting provider behavior typically produce only modest improvements in compliance with care guidelines and the variation in results across studies is often large.

We do not know why there appears to be no effect of CCs on "stop a drug" resolution rates and substantial effects on "add a drug" and "take a test" resolution rates. One plausible explanation is that many of the drug–drug interactions that trigger "stop a drug" CCs are also caught by pharmaceutical databases used by major pharmacies. If this were true, the computer system would not be providing much additional information about "stop a drug" issues to the study group.

Looking more closely at Table 8, we observe that 83% of excess CCs are "stop a drug" and "do a test" CCs. These CCs also had relatively high resolution rates in the control group, suggesting that excess CCs tended to appear where there was a high likelihood that issues would resolve spontaneously and without intervention. This would tend to bias downwards our estimate of resolution rate differentials between study and control groups.

"Add a drug" messages accounted for only 17% of excess CCs and the most common CC in this class appears to have been relatively unaffected by differences in the handling of data in the study and control groups. This CC was sent out if a patient was a good candidate for taking ACE inhibitors on the basis of protocols emerging from the Heart Outcomes Prevention Evaluation (HOPE) trials. The HOPE trial results were published in 2000, shortly before our experiment began in 2001 and the resulting treatment protocols were widely publicized—so much so that they were even included in the disease management guidelines of the HMO.[25] Of the 601 individuals with an "add a drug CC" in Table 1, 311 received the recommendation to use an ACE inhibitor on the basis of the HOPE trial. The distribution of these individuals was nearly perfectly balanced between study (155) and control (156) group members. We found that the resolution rate (the rate at which patients identified as good candidates on the basis of the HOPE trial began using ACE inhibitors) was 0.27 in the study group compared to 0.14 in the control group.[26] The resolution rates for the remaining individuals with "add a drug" CCs was 0.26 with no significant difference between the study and the control group. In short, the experimental treatment improved the rate of resolution of this issue roughly twofold and brought resolution rates in line with those prevailing for other, "add a drug" CCs.

Models of physician learning in complex environments have typically assumed that physicians give disproportionate weight to easy-to-access "local" sources of information such as peers, teachers or even accumulated observations from the physician's own experience (Frank, 2004; Phelps, 2000; Rebitzer et al., 2007). This assumption implies that the diffusion of new information that is not "local" will be relatively slow and that inefficient, geographically specific, practice styles are likely to emerge (Phelps, 2000; Rebitzer et al., 2007). From the perspective of learning models, it is perhaps not surprising that a CC based on a newly implemented protocol would be a commonly issued CC—it takes time for information distributed in medical journals and conferences to be incorporated into "local information" and hence practice styles. Our results, however, suggest something more: the messages in the CCs seem to have had a bigger effect on physicians than the conventional medical channels used to promote the HOPE trial findings. It seems plausible that the CCs were influential because they linked a general recommendation ("take ACE inhibitors") to a specific patient and a specific cite to the medical literature. If this explanation proves to be correct, then computer-based decision support may be a way to make new knowledge as easy-to-access as "local knowledge" (Rebitzer et al., 2007). The wide-spread implementation of computer-based IT systems might plausibly enhance the diffusion of new knowledge and also break down the small area practice variations that stubbornly persist in the face of new evidence-based medical findings (Skinner and Staiger, 2005; Skinner et al., 2001).[27]

4. Conclusions

This paper analyses the effect of a decision support tool designed to help physicians detect and correct medical "errors". Prior research suggests that physician missteps have a substantial effect on the cost and quality of medical care, and a number of high-profile public and private initiatives are premised on the notion that new information technologies can reduce the incidence of errors. Economic studies of the efficacy of these technological fixes have, however, been scarce.

[25] "The HOPE trial, published in 2000, looked specifically at high risk patients. These patients were defined as being either: diabetics with one additional risk factor (i.e. smoking, high blood pressure, high cholesterol) or patients with known CAD as demonstrated by remote MI, need for cardiac surgery or cardiac stenting, or angiographic evidence of narrowed coronary arteries. ACE inhibitors were shown to reduce the rate of cardiovascular death, MI, stroke, and new cases of diabetes. The results were so striking that the study was terminated early" (Shepherd, p. 6).

[26] This difference in resolution rates was statistically significant with a z score of 2.82.

[27] While it is plausible that the program we analyze ameliorates some of the effects of information overload, our experiment was not designed to test this hypothesis.

The data in this study comes from a randomized trial of the new technology in a population of commercial HMO patients. We find that average charges were 6% *lower* in the study group than in the control group. These reductions in resource utilization were the result of reduced in-patient charges (and associated professional charges) for the most costly patients. Patients with the greatest propensity to trigger the computer messages were the most expensive and also the most likely to experience a reduction in charges over the course of the experiment. Consistent with these results, we also observed that when the experiment was ended and the computer system was rolled out to all HMO members, the cost differential between the study and control group rapidly disappeared. This reverse experiment also suggests that the effect of the intervention on resource utilization is quite rapid.

We also found that the rate at which identified issues were resolved was generally higher in the study group than in the control group—especially so for a set of messages promoting a new ACE inhibitor protocol resulting from a high profile clinical trial completed shortly before our study began. These resolution rate differentials must be interpreted cautiously because of a number of difficult measurement issues. They do offer suggestive evidence that the intervention may have improved care quality along measured dimensions. To the extent that the intervention stimulated physicians in the study group to adopt protocols that, like the ACE inhibitor protocol, were also being widely promoted through more conventional channels, our results suggest that IT-based decision support software may offer new and more effective ways of communicating new clinical knowledge to physicians.

We conclude by assessing the limitations of the experiment and suggesting avenues for future research. One important limitation is the study's short duration. To the extent that some of the benefits of correcting missteps spill over into future years, our analysis *understates* the saving due to the physician decision support system. A similar bias may result from physicians having patients in both the treatment and control groups. If lessons learned from patients in the study group spill over to the treatment of patients in the control group, our estimates of the intervention's effect will be further understated.

A second limitation is that the study was conducted on a commercial insurance population where everyone was less than 65 years old. Since the likelihood of errors increases dramatically with age, much of the impact of this new technology will be found in older age groups not included in this study. In future work we will analyze a similar trial conducted for Medicare populations aged 65 and older.

A final issue left unresolved by this study is the mechanism by which care considerations influence outcomes. Specifically, the analysis does not identify the lessons physicians learned from the messages they received. It is possible that physicians learned only that the patient named in the care consideration required additional attention. Alternatively, it may be that the specificity of the messages provided by the system enabled physicians to more easily incorporate evidence-based clinical protocols to the care of particular patients. This latter possibility suggests that investments in IT-based decision support in medicine may have quite a different long-term effect than IT investments in other settings. If IT systems can be used to increase the rate of diffusion of evidence-based clinical knowledge, this may have the salutary effects of breaking down inefficient geographic variations in physician practice style and increasing the dynamic efficiency of the health care system. Understanding the effect of IT-based decision support tools on the diffusion of new medical knowledge will be the subject of future investigations.

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Supporting the Patient's Role in Guideline Compliance: A Controlled Study

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Objective: Clinical messages alerting physicians to gaps in the care of specific patients have been shown to increase compliance with evidence-based guidelines. This study sought to measure any additional impact on compliance when alerting messages also were sent to patients.

Study Design: For alerts that were generated by computerized clinical rules applied to claims, compliance was determined by subsequent claims evidence (eg, that recommended tests were performed). Compliance was measured in the baseline year and the study year for 4 study group employers (combined membership >100,000) that chose to add patient messaging in the study year, and 28 similar control group employers (combined membership >700,000) that maintained physician messaging but did not add patient messaging.

Methods: The impact of patient messaging was assessed by comparing changes in compliance from baseline to study year in the 2 groups. Multiple logistic regression was used to control for differences between the groups. Because a given member or physician could receive multiple alerts, generalized estimating equations with clustering by patient and physician were used.

Results: Controlling for differences in age, sex, and the severity and types of clinical alerts between the study and control groups, the addition of patient messaging increased compliance by 12.5% (P <.001). This increase was primarily because of improved responses to alerts regarding the need for screening, diagnostic, and monitoring tests.

Conclusion: Supplementing clinical alerts to physicians with messages directly to their patients produced a statistically significant increase in compliance with the evidence-based guidelines underlying the alerts.

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For author information and disclosures, see end of text.

Numerous studies have documented the slow dissemination of new medical knowledge[1,2] and the failure of many patients to receive important evidence-based clinical services.[3,4] Clinical alerts can accelerate the dissemination of new knowledge and increase the use of evidence-based services by providing information on important drugs, tests, or other services that appear to be missing from a patient's treatment.[5-7] However, when alerts are sent only to physicians, these improvements often do not reach optimal levels.[8,9] Busy physicians are inundated with messages from health plans and care management programs. Because of this, and the fact that messages from some sources may be perceived as unreliable, physicians may pay little attention to any clinical alerts. If physicians do take action based on alerts, their patients may not understand the recommendations or their importance, or may fail to fill the prescriptions or obtain the recommended tests.

These problems suggest that supplementing alerts to physicians with notices to their patients might be beneficial—encouraging patients to follow their physicians' advice or to remind their physicians about overlooked guidelines. Patients and health plan members increasingly want to play an active part in their own care.[10] Yet few consumer decision support programs are designed to empower the consumer at a point in time when a potential problem of clinical quality or safety has been detected, and fewer still are integrated with systems of physician alerts. As Glasziou and Haynes pointed out, full implementation of improvements in medical care requires not just dissemination of abstract knowledge, but also application of that knowledge by physicians to individual patients and, in most cases, actions by the patients themselves.[11] It is not enough that a physician knows that medication X is now the drug of choice for condition Y. The physician must recognize that medication X is appropriate for patient Z and must write a prescription, and patient Z must fill and adhere to that prescription. Clearly, enhanced knowledge diffusion in the medical community alone is not enough. Clinical alerts to physicians concerning gaps in the care of specific patients can provide a useful reinforcement by directly addressing the applicability of new knowledge to individual patients. However, getting all the way to our goal may require including the patient in the system.

We studied the impact of a patient-messaging program designed to address these needs. Several previ-

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ous studies documented the value of clinical alerts to physcians,[5-7,12] and this study did not reexamine that issue. Our focus was on the incremental impact of supplementing a physician clinical alert system with information sent directly to patients concerning possible gaps in evidence-based care for their condition, with the 2 messages coordinated to enable the patient and physician to collaborate in closing those gaps.

STUDY DESIGN

The alerting program we studied was built around a rule-based artificial intelligence expert system combined with a message generator that conveys clinical recommendations and supporting literature citations to treating physicians. More recently, as an option available to health plan sponsors (insurers and employers), messages also can be sent to patients. Health plans began to implement patient messaging in January 2006, providing the opportunity to conduct a controlled study of its incremental value.

The system develops an integrated patient record (reflecting a patient's care history across multiple providers) through frequently updated data that include physician, hospital, outpatient facility, laboratory, pharmacy, and medical equipment claims; laboratory test results; information reported by patients on health risk assessments and to disease management nurses; and physician responses to alerts they have received. The records are evaluated for potential gaps in care through identification of medical conditions, the presence or absence of appropriate diagnostic and therapeutic interventions, and clinical situations under which a specific alert should not be generated (eg, the presence of a contraindication).

Clinical issues for inclusion in the rules engine are identified by an in-house committee of clinicians and a multispecialty consultant panel of medical school faculty physicians, based on multicenter clinical trials, federal government and specialty society guidelines, and US Food and Drug Administration–approved pharmaceutical labeling.

The system's output—currently approximately 900 types of clinical alerts—represents patient-specific discrepancies between the care that is actually being received (as reflected in claims and lab data) and the care that patients should be receiving according to the evidence-based literature. These discrepancies fall into a variety of clinical categories, addressing various aspects of patient safety and the quality of care. These are listed, with examples, in Table 1.

Alerts vary in their clinical and temporal urgency. Level 1 alerts address potentially life-threatening situations and are communicated to treating physicians via telephone, followed up by fax. Level 2 alerts concern serious but not immediately life-threatening situations and are faxed to physicians. Level

Table 1. Categories of Clinical Alerts

Category	Examples
Add or intensify therapy	Consider adding ACE inhibitor therapy for a patient with congestive heart failure or a patient with cardiovascular risks who meets the criteria of the Heart Outcomes Prevention Evaluation (HOPE) trial
Condition or drug monitoring	Consider monitoring A1C in diabetic patients, or the level of anticoagulation in patients taking warfarin when monitoring appears to be absent or insufficiently frequent
Condition screening	Consider age- and sex-specific screening, and ongoing surveillance of those who have been treated in the past for Hodgkin's disease and cervical, prostate, bladder, or testicular cancers
Drug–drug interaction	Warnings about the interaction between seizure medications and other drugs that can increase or decrease their blood levels (as well as more basic drug interactions that often slip by pharmacy drug safety systems)
Interactions between prescription drugs and alternative medicine, products or foods	Cautions concerning the interactions between St. John's wart, ginkgo biloba, or grapefruit juice and a number of medications
Other reasons to stop or modify medication	Consider stopping or lowering the dosage of various medications that may be unsafe for the elderly or for pregnant women, or that can be toxic for those with abnormal liver function or kidney function tests
Diagnostic workup	Consider a workup for the presence of *Helicobacter pylori* in a patient with evidence of peptic ulcer disease
Vaccination	Consider pneumococcal vaccine for patients with sickle cell disease, and hepatitis vaccine for those on hemodialysis

A1C indicates glycosylated hemoglobin; ACE, angiotensin-converting enzyme.

3 alerts apply to routine monitoring and issues of a preventive/wellness nature and are distributed by mail.

At the option of the health plan, copies of the alerts, in lay language, also are mailed to their members—with a delay of 10 working days to allow physicians to contact their patients first, if they choose, or to indicate via fax or phone that there are clinical reasons why alerts do not apply (eg, an allergy not revealed by claims data). In such cases, the patient version of the message is not sent out and the new information is entered into the rules engine, so that that patient will never again trigger an alert suggesting the use of that medication. Examples of the physician and patient versions of an alert are shown in the **Figure**.

Figure. Example of the Text in the Physician Version of a Clinical Alert

Your patient is at least 55 years old, has claims evidence for diabetes, has an additional cardiovascular disease risk factor (eg, history of cardiovascular disease, dyslipidemia, microalbuminuria), and has no claims evidence for an angiotensin-converting enzyme (ACE) inhibitor. The American Diabetes Association recommends that, in these patients, with or without hypertension, an ACE inhibitor be considered to reduce the risk of cardiovascular events. If your patient fits this clinical profile, and if not already done or contraindicated, consider starting an ACE inhibitor and titrating the dosage as tolerated.

Example of the text in the patient version of the same clinical alert:

- Our data show that you may have diabetes.
- If you have diabetes, it may help you to take a type of drug called an ACE inhibitor.
- You may not be taking this drug.
- Ask your doctor if you should take an ACE inhibitor.

The study group consisted of 4 large employers that had physician alert messaging throughout 2005, implemented patient messaging on January 1, 2006, and maintained both physician and patient messaging throughout 2006. The control group comprised 28 employers that were matched as closely as possible to the study group employers. The control group employers also participated in physician messaging throughout 2005 and 2006, but did not choose to add patient messaging in 2006. This study is based on the secondary analysis of data from claims processed on behalf of these 32 employers, after removal of all data elements identifying individuals and employers. Therefore, the study was not submitted to an institutional review board.

The primary goals of the program are enhanced compliance with evidence-based clinical guidelines, a decrease in adverse events (eg, strokes, asthma attacks) that should follow from compliance with guidelines, a reduction in related healthcare utilization (especially emergency room visits and admissions), and a decrease in healthcare cost as a consequence. The magnitude of these sequential effects for alerts sent to *physicians* has been measured in a number of studies, including randomized controlled trials.[9,12,13] The purpose of the current study was to measure any additional effects resulting from patient messages being added to this system of physician messages.

Given the study time frame, we used change in successful resolution of clinical gaps as a reasonable predictor of fewer clinical adverse events. There is strong support in the medical literature for a link between adherence to the guidelines underlying the system's alerts and reductions in adverse event rates, utilization, and cost.[3,12,13] The impact of patient messaging was assessed by comparing the changes in compliance from the baseline period to the study period in the group that added patient messaging versus the group that did not.

METHODS

Compliance with clinical alerts was based on claims evidence that the recommended actions (eg, to perform needed tests, to discontinue contraindicated medications) were actually carried out (eg, receipt of pharmacy claims documenting that patients filled prescriptions). For alerts suggesting the addition of a drug, test, vaccination, or other service, success was defined as claims evidence with a service date within 270 days after the alert was generated. For alerts recommending discontinuance of a drug, success was defined as the absence of a refill prescription between 60 and 150 days after generation of the alert.

The study was necessarily limited to "measurable" alerts, for which successful resolution could be determined from claims data. This excluded alerts recommending the avoidance of ginkgo biloba, or other outcomes knowable only from patient self-reports. Also eliminated from the study were newly implemented or discontinued alerts that were not in place during both the baseline and study years, and a small number of alert types that are never messaged to patients (eg, those that concern very sensitive topics such as HIV) or never messaged to physicians (eg, influenza immunizations that often are obtained from alternative sources).

A strenuous attempt was made to select similar employer groups for inclusion in the study and control groups, matching their membership as of January 2006 (the first month of the study period) in terms of average age, percent female, average risk score, and prevalence of 4 chronic conditions: diabetes, asthma, heart disease, and cancer. All employers in both groups had the same health insurer, health benefit design, and disease management program, and the 2 groups were matched for mix of industry types, using Standard Industrial Classification codes. Despite these efforts, significant differences in demographic characteristics, distribution of alerts, and compliance did exist between the study and control groups during the baseline year (Table 2). Therefore, in analyzing the impact of member messaging, we used multiple logistic regression to control for these variables. Compliance rates varied widely among types of alerts. To control for any differential impacts that year-to-year shifts in the mix of alerts might have on compliance rates in our study and control groups, compliance rates for each type of alert were included as independent variables in the regression. For the most stable estimates, we used the aggregate compliance rates for our entire client book of business, rather than rates for just the study and control group employers.

Members of the study and control groups who triggered alerts in the baseline year generated an average of 1.6 alerts each. Compliance with several alerts sent to the same patient (or the same physician) could not be considered independent. Therefore, our analyses used generalized estimating equations—the preferred method when analyzing correlated binary data—with clustering by both patient and physician.

RESULTS

During the study year (2006), more than 13,000 measurable alerts were issued to members of the study group, which added patient messaging, and almost 64,000 were issued to

Table 2. Characteristics of the Study Group (Physician and Patient Messaging) and Control Group (Physician Messaging Only) in the Baseline Year

Characteristic	Physician and Patient Messaging	Physician Messaging Only	*P* Value for Absolute Difference[a]
Membership	110,120	775,191	
Average age, y	34.4	33.4	<.001
Percent female	53.7	51.5	<.001
Percent receiving 1 or more measurable clinical alerts	6.1	5.1	<.001
Average number of measurable alerts per person receiving any	1.6	1.6	.023
Five most frequent alerts issued, in descending order	1. Heart protection study: add a statin	1. Diabetes: do eye exam	
	2. Women age ≥65 y: screen or treat for osteoporosis	2. Heart protection study: add a statin	
	3. Diabetes: do eye exam	3. Diabetes: test for microalbuminuria	
	4. High-risk diabetes: add an ACE inhibitor	4. Women age ≥65 y: screen or treat for osteoporosis	
	5. Diabetes: test for microalbuminuria	5. Diabetes: monitor A1C	
Compliance with clinical alerts			
• All measurable alerts	29.0%	30.0%	.045
• Add-a-drug alerts	26.7%	23.8%	<.001
• Stop-a-drug alerts	47.7%	43.0%	.004
• Do-a-test alerts	26.5%	30.0%	<.001
• Either/or alerts[b]	27.8%	38.2%	<.001

A1C indicates glycosylated hemoglobin; ACE, angiotensin-converting enzyme.
[a]Significance levels are based on 2-tailed *t* tests for comparisons of means and on χ^2 tests for all other comparisons.
[b]Either/or alerts suggest that 1 of 2 things should be done (eg, *either* a potentially toxic medication should be discontinued *or* a test should be performed periodically to monitor for toxicity).

Table 3. Characteristics of the Study Group (Physician and Patient Messaging) and Control Group (Physician Messaging Only) in the Study Year

Characteristic	Physician and Patient Messaging	Physician Messaging Only
Membership	167,120	836,322
Total alerts issued	14,760	69,537
Measurable alerts issued (rate per 1000 members)	13,364 (80.0/1000)	63,940 (76.5/1000)
By severity level		
• Level 1	298 (2.2%)	1427 (2.2%)
• Level 2	9439 (70.6%)	44,323 (69.3%)
• Level 3	3627 (27.1%)	18,190 (28.4%)
By outcome type		
• Add a medication	5823 (43.6%)	23,691 (37.1%)
• Discontinue a medication	1344 (10.1%)	6201 (9.7%)
• Do a test	5122 (38.3%)	26,751 (41.8%)
• Either/or[a]	1075 (8.0%)	7297 (11.4%)
Five most frequent alerts issued, in descending order	1. Diabetes: do eye exam 2. Heart protection study: add a statin 3. High cholesterol: work on lifestyle changes 4. Diabetes: test for microalbuminuria 5. Diabetes: monitor A1C	1. Diabetes: do eye exam 2. Heart protection study: add a statin 3. Diabetes: test for microalbuminuria 4. High cholesterol: work on lifestyle changes 5. Diabetes: monitor A1C

A1C indicates glycosylated hemoglobin.
[a]Either/or alerts suggest that 1 of 2 things should be done (eg, *either* a potentially toxic medication should be discontinued *or* a test should be performed periodically to monitor for toxicity).

members of the control group, which continued to have only physician messaging. The distribution of measurable alerts by severity level and outcome type is shown in Table 3. These outcome types are aggregations of the clinical alert types listed in Table 1, based on the types of evidence needed to determine compliance.

Overall, compliance with alerts in the study group increased from 29.0% in the baseline year to 31.0% in the study year, while decreasing from 30.0% to 29.0% in the control group. Controlling for age, sex, and the mix of alert severity levels and alert types, the addition of patient messaging increased compliance by 12.5% (P <.001). Spreading the impact over all the alerts that were issued for the study group employers—including alerts that were messaged only to physicians or only to patients—yielded an 11.4% increase in overall compliance.

The program's impact on compliance with each of the alert severity levels and outcome types is shown in Table 4. Statistically significant impact was limited to alerts of severity 2 (serious but not immediately life threatening) and 3 (routine monitoring and screening), and to those alerts recommending performance of a test. Changes in the mix of clinical alerts were seen to play a role; before the book-of-business compliance rate for each type of alert was entered into the regression analysis, the increase in compliance rates from baseline to study year for either/or alerts (which recommend that either 1 of 2 actions be taken) was larger (25.0%) and was also significant (P = .023). However, after these book-of-business compliance rates were added to the analysis, the increase in compliance for either/or alerts was reduced to 11.7% and was not statistically significant (P = .309).

We also examined the relationships among compliance, program impact, and patient demographics. In the study and control groups combined, men were 1.34% more likely than women to comply with alerts, but the addition of patient messaging did not have significantly different impacts on men and women. In the study and control groups combined, patients more than 50 years of age were 33.2% more likely than younger patients to comply with alerts, but again the impact of patient messaging did not differ significantly for patients of different ages.

DISCUSSION AND CONCLUSION

Supplementing clinical alerts to physicians with messages directly to their patients produced a statistically significant increase in compliance with the evidence-based guidelines underlying the alerts. The overall increase seems to be due

Table 4. Impact of Patient Messaging on Compliance With Clinical Alerts

Type of Alert	Compliance Rate, %		Absolute Year-to-Year Change, %	Relative Impact of Patient Messaging (95% CI), %[a]
	Baseline Year	Study Year		
All measurable alerts				**+12.5 (+5.0, +20.4) *P* <.001**
Physician and patient messaging	29.0	31.0	+2.0	
Physician messaging only	30.0	28.9	–1.0	
Severity level 1 alerts				**+14.2 (–33.1, +94.9) *P* = .627**
Physician and patient messaging	54.6	62.8	8.1	
Physician messaging only	61.6	61.2	–0.3	
Severity level 2 alerts				**+11.9 (+1.4, +21.2) *P* = .006**
Physician and patient messaging	29.5	32.8	+3.3	
Physician messaging only	29.6	29.9	+0.3	
Severity level 3 alerts				**+14.8 (+0.9, +30.5) *P* = .036**
Physician and patient messaging	25.6	23.8	–1.8	
Physician messaging only	28.6	24.2	–4.4	
Add-a-drug alerts				**+5.9 (–4.9, +17.9) *P* = .294**
Physician and patient messaging	26.7	27.4	+0.7	
Physician messaging only	23.8	24.1	+0.3	
Stop-a-drug alerts				**–6.5 (–22.9, +13.5) *P* = .499**
Physician and patient messaging	47.7	51.3	+3.5	
Physician messaging only	43.0	47.5	+4.5	
Do-a-test alerts				**+26.4 (+12.5, +42.0) *P* <.001**
Physician and patient messaging	26.5	29.5	+3.0	
Physician messaging only	30.0	28.2	–1.8	
Either/or alerts				**+11.7 (–9.8, +38.3) *P* = .309**
Physician and patient messaging	27.8	32.7	+5.0	
Physician messaging only	38.2	31.7	–6.5	

CI indicates confidence interval.
[a]These are the results of multiple logistic regression; the relative increase in compliance in the group with physician and patient messaging was compared with that in the group that had only physician messaging. Significance was based on 2-tailed *t* tests.

primarily to improved responses to advice regarding screening, diagnostic, and monitoring tests—advice that often is important but not temporally urgent. The improvement in compliance did not vary by patient age or sex.

Compliance with alerts is not the same as overall compliance with clinical guidelines. Alerts are issued only in those cases where evidence-based guidelines have not already been followed "spontaneously." Apparent noncompliance can occur for clinically valid reasons, such as allergy to the recommended medication and other contraindications, which may be known to the treating physician but not recorded in claims data. A clinical guideline recommending anticoagulation therapy, for instance, is likely to be correctly ignored by a physician who knows that the patient falls frequently. However, noncompliance also may occur because of physician or patient lack of knowledge, understanding, or motivation. Alerts should not produce compliance in situations where it is not clinically advisable, and it is probably not reasonable to expect even an ideal system of alerts to totally overcome the inappropriate barriers to compliance. It should be stressed that our study measured only apparent noncompliance because patients may receive therapies not recorded in claims data (eg, medication samples).

Many factors can affect rates of compliance with evidence-based medical guidelines. Chief among them is the influence of medical journals, direct-to-consumer advertising, and other media that disseminate information to physicians and the general public. The use of a large control group, in which patients and their physicians would presumably be exposed to the same information environment as those in the study group, is the most basic form of control for this influence. Matching study and control employers in terms of their

health insurance plan designs and the type of disease management program in which they participated (telephonic nurse counseling for chronic conditions) controlled for another group of factors known to affect compliance.

Take-away Points

To maximize the impact on clinical quality and patient safety when clinical alerts are sent to physicians, they should be accompanied by similar messages to their patients.

- The results of a controlled study demonstrate that the addition of patient messages increased compliance with evidence-based guidelines by 12.5%.
- The overall increase was because of significantly improved compliance with guidelines recommending screening, diagnostic, and monitoring tests.

Compliance rates for some clinical alert outcome types were observed to decrease from the baseline year to the study year, mostly in the control group and markedly for either/or alerts. Compliance rates for specific alerts vary widely, especially within a heterogeneous category like either/or alerts. If an alert with a low compliance rate begins to be issued more frequently—or an alert with a high compliance rate begins to be issued less frequently—it can depress the average level of compliance for an entire alert category. The latter appears to have occurred in the control group in 2006 for alerts that recommended either screening women more than 65 years of age for low bone density or treating them to prevent osteoporosis.

There are at least 3 possible mechanisms behind the increase in compliance with evidence-based guidelines when patient messages were added. It may be that patient messages served to remind patients and to reinforce the instructions that their physicians have given them, so that they were more likely to follow these instructions. It is also possible that patients, armed with the messages they receive from the system, reinforced the clinical alerts that their physicians received, thereby making it more likely that the physicians would write the prescriptions and order the tests in question. A third explanation is that a physician alert was directed to the incorrect physician for that patient or for that aspect of the patient's care. The alerted patient, however, took the message to the correct caregiver. Our finding that the addition of patient messaging appeared to have its greatest impact on compliance with do-a-test alerts suggests that patient messages exerted most of their influence on the behavior of patients themselves, increasing the number who complied with physicians' orders that involved time-consuming or unpleasant actions (eg, going to radiologists or laboratories for the performance of tests). Lack of a similar effect for patient alerts related to adding or stopping medications suggests that significant effort by patients was less of a barrier to compliance with these types of recommendations, which are largely under the control of their physicians, and that patients urging their physicians to follow guidelines may not be an important factor.

Interestingly, a previous study of this same program measured the impact of physician messaging and found 24% compliance with clinical alerts advising physicians to add a drug.[12] The current study found remarkably similar levels of compliance with add-a-drug alerts in both the baseline and study years, in both the control and study groups, ranging from 23.8% to 27.4%. This finding would seem to lend support to the findings of the earlier study.

A clinically sound, evidence-based system for detecting possible gaps in care and bringing them to the attention of *both* patients and their physicians in a timely and constructive manner would benefit all segments of the population.[14] As stated in *Crossing the Quality Chasm*,[1] "tens of thousands of Americans die each year from errors in their care, and hundreds of thousands suffer or barely escape from nonfatal injuries that a truly high-quality care system would largely prevent…."[1,pg2] "In the area of effectiveness, there is considerable evidence that automated reminder systems improve compliance with clinical practice guidelines."[1,pg164]

Such a system can be developed by adding patient messaging to an existing program of clinically advanced physician alerts, as demonstrated in this study, or by adding physician alerts to a system that began with patient reminders. Whichever approach is taken, the result should be one in which the 2 sets of messages are coordinated to reinforce each other and to strengthen the patient–physician relationship.

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A COMPARATIVE ANALYSIS OF CHRONIC AND NON-CHRONIC INSURED COMMERCIAL MEMBER COST TRENDS

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Abstract

Background

Disease management (DM) is increasingly encountered in health plans and employer groups as a health care intervention targeted to individuals with chronic diseases ("Chronics"). To justify the investment by payers in DM, it is important to demonstrate beneficial clinical and financial outcomes. In the absence of randomized control studies, financial results are often estimated in a pre/post study in which the cost of Chronics in the absence of DM can be predicted by their pre-DM year cost (on a per member per month basis) adjusted for the Non-chronic population's cost trend. The assumption made, not previously tested, is that absent DM, the Chronic and Non-chronic trends are identical.

Methods

We calculated Chronic and Non-chronic trends over 1999-2002 and compared them under different assumptions regarding identification of chronic disease and medical services. Qualification for the Chronic group was defined as having coronary artery disease, heart failure, diabetes, asthma or chronic obstructive lung disease. Our base case used an algorithm that identified a member as Chronic prospectively, (that is, from the point of identification forward), with one or more of the chronic conditions.

Data

We used a data set of 1.5 million commercially insured members.

Results

When Chronic and Non-chronic members are identified and included in the population prospectively, the average 3-year trend over the study period for chronic and non-chronic members adjusted for high cost outliers were 4.9% and 13.9% respectively. Adjusting the population experience for differences in service mix had little impact on the divergence in trends. However, altering the Chronic selection algorithm to eliminate migration between groups (thus classifying a member as always Chronic if identified as Chronic at any point in the four years) caused the trends to converge (Chronics, 16.3%; Non-chronics 17.2%; Total 16.0%). Using the original selection algorithm but risk-adjusting

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the populations annually also caused their trends to converge (Chronics, 12.5%; Non-chronics 11.9%).

Conclusions

Estimating DM program financial outcomes based on the assumption that, absent the program, the Chronic population would have had the same trend as the Non-chronic population can lead to erroneous conclusions. Identification of a chronic member and the point at which that member is re-classified from one sub-population to another can significantly impact the observed trends in both sub-populations, implying that great care must be taken over classification and interpretation of the resulting trends, and their use in DM savings calculations. Trends calculated using a prospective identification methodology introduce a bias into estimates of outcomes. We refer to this effect, which has not previously been described or discussed in the literature, as "migration bias". It is critical to understand how trends in a reference population can vary according to selection criteria for disease in the chronic population, service mix, and changes in risk over time.

Disease Management

Disease Management (DM) is "a system of coordinated healthcare interventions and communications for populations with (chronic) conditions in which patient self-care efforts are significant.[4]" DM includes identification of healthplan members with chronic diseases, prioritization of members for interventions (often called stratification) by current or predicted risk for worsening illness, and coordination of care between care providers and patients. An important function in DM is measuring the clinical and economic outcomes of DM programs. It is believed that improving clinical outcomes reduces healthcare costs (demonstrated in claims) by reducing the probability of clinical adverse events such as heart attacks, strokes, episodes of heart failure, or complications of diabetes.

Early DM outcomes studies generally compared a cohort, pre- and post-intervention, in which the actually-managed cohort's cost was compared with those eligible for disease management, but not actually managed. This measurement methodology is susceptible to selection bias, in which the experience of the population electing to enroll is different to that of the non-enrolling population, absent intervention (see discussion in Paper 2). Clearly, selection bias distorts and invalidates any DM savings calculations determined using this methodology. Over time, this pre-post methodology has tended to be replaced by a population methodology in which the experience of the entire chronic population in the historic period is compared with that of the chronic population in the intervention period, thereby eliminating the potentially distorting effect of selection.

[4] As defined by the Disease Management Association of America, (DMAA). See www.dmaa.org.

A commonly used population method for estimating Disease Management financial outcomes is the Actuarially-adjusted Historical Control methodology[5], in which a healthcare cost trend factor is applied to historic chronic member costs (pre-program) to predict the cost of the chronic population in the absence of the program. These costs include all claims costs related to the care of members with specified chronic diseases, not just the costs related to care for the chronic diseases.

Cost trend factors are increasingly used in population studies. Because the chronic population is subject to medical management, an estimate of healthcare trend from a source external to the chronic condition (Chronic) population is an essential component of this method. One source of this estimator of trend is the Non-chronic population.

Although the Actuarially-adjusted Historical Cost method has been used extensively, the relationship between Chronic and Non-chronic trends is not well understood by those who apply them or by users of the studies. In particular it is often assumed that the Chronic and Non-chronic trends are equal in the absence of intervention, allowing the latter to be a valid estimator of the former. Because many DM savings studies make the assumption that Chronic and Non-chronic trends are identical, this study seeks to examine these trends in a large data set of commercially insured members. We are not aware of the specific disease management programs (if any) that cover the employer groups included in the database.

Previous Studies

Existing healthcare cost trend literature is limited to the cost trends for populations (Strunk and Ginsburg, 2003), sub-populations (such as the obese) (Thorpe, Florence, Howard and Joski, 2004), or to costs related to specific diseases (Thorpe, Florence and Joski, 2004) rather than to that of all payers' costs related to care for populations with specific diseases. The absence of prior studies of healthcare cost trends in chronic populations makes it difficult to benchmark the actual observations in DM studies. We include the Thorpe data because of the paucity of published data in this area. The study by Thorpe, Florence and Joski compares data on chronic disease prevalence and spending from the National Medical Expenditure Survey (NMES) in 1987 and the 2000 Medical Expenditure Panel Survey, Household Component (MEPS-HC). This study does not calculate trends according to the actuarial definition, but the authors provide the data and we report the results of our analysis of the Thorpe et al data in Table 1 as these results deserve to be better known by health actuaries.

The 1987 NMES surveyed 34,459 people (both chronic and non-chronic) and the 2000 MEPS-HC surveyed 25,096. The data used in Exhibit 2 of the paper are self-reported data from the 1987 NMES and the 2000 MEPS-HC, and

[5] See "An Actuarial Methodology for Evaluating Disease Management Outcomes", Paper 6 of the series "An Introduction to Care Management Interventions and their Implications for Actuaries", (a study sponsored by the Society of Actuaries Health Section) by Henry Dove and Ian Duncan, Available at www.soa.org).

include health spending, demographics, use of services and self-reported conditions. The data should be treated with some caution because they are self-reported by patients, (rather than the more-usual Disease Management methods of either clinician reporting or claims data analysis). Over time, it is possible that the increased awareness of and testing for chronic diseases in the population may have contributed to the increased prevalence observed. The data are easily summarized in a traditional actuarial trend form (Table 1). We have extracted only the cost and prevalence data associated with the traditional conditions managed by chronic disease programs, and converted to an average annual trend over the thirteen year period, 1987 to 2000.

The raw data provided from these two studies allow us to calculate rates of total expenditure, prevalence of chronic disease, and costs per member per year for the chronic population. Having data at two points in time (1987 and 2000) allows us also to calculate an average trend in each of these metrics between 1987 and 2000. Annual trends in the chronic population range from 3.0% (diabetes) to 7.3% (hypertension), with an average annual trend of 4.6%.

Table 1

Total Healthcare Spending For Each Condition

Year	Pulmonary	Hypertension	Diabetes	Heart	TOTAL
1987	$ 11,685	$ 8,008	$ 8,661	$ 30,450	$ 58,804
2000	$ 36,477	$ 23,395	$ 18,288	$ 56,679	$ 134,839
Increase in Chronic Spending	212.2%	192.1%	111.2%	86.1%	129.3%
Annualized Cost Increase	9.2%	8.6%	5.9%	4.9%	6.6%

Number of Chronic Individuals Per 100,000 of the population

Year	Pulmonary	Hypertension	Diabetes	Heart	TOTAL
1987	10,389	9,734	2,961	6,189	29,273
2000	15,526	11,384	4,260	6,226	37,396
Increase in Chronic Prevalence	49.4%	17.0%	43.9%	0.6%	27.7%
Annualized Prevalence Increase	3.1%	1.2%	2.8%	0.0%	1.9%

Healthcare Cost Per Member Per Year

Year	Pulmonary	Hypertension	Diabetes	Heart	TOTAL
1987	$ 1,125	$ 823	$ 2,925	$ 4,920	$ 2,009
2000	$ 2,349	$ 2,055	$ 4,293	$ 9,104	$ 3,606
Increase in Chronic Cost	108.9%	149.8%	46.8%	85.0%	79.5%
Annualized PMPY Increase	5.8%	7.3%	3.0%	4.8%	4.6%

Other studies of chronic prevalence trends include a CDC study that predicts an annual growth in chronic prevalence between 1998 and 2020 of about 1% annually, somewhat lower than the 1.9% measured in the Thorpe, Florence and Joski study between 1987 and 2002. The CDC study does not project future cost growth. In addition, these studies measured disease-specific cost trends for the entire population, as opposed to trends (as defined by actuaries) at the individual level (see below).

Many of the published studies examine just one chronic condition. Because of the prevalence of co-morbidities in the chronic population, these studies can contribute to over-estimation of prevalence of chronic disease(s) unless double-counting is explicitly eliminated. Hoffman, Rice and Sung (1996) report that forty-four percent of all chronic patients have one or more chronic conditions. Hogan et al. (2003), writing for the American Diabetes

Association, estimate the total cost of care associated with diabetes to be $92 billion in 2002. The historic rate of increase in diabetes expenditures per member per year is estimated by Hogan et al as 5.9% over the period 1987-2000. The growth in prevalence of diabetes over this period is estimated as 2.8%. Hogan et al estimate growth of diabetes prevalence between 2000 and 2020 as 2% annually, somewhat lower than the historic experience. The estimated growth in expenditures is 50% (to $138 billion) by 2020 in constant 2002 dollars. The implied annual trend is only 2.3% annually, to which we must add an estimate of future cost of living increases (we estimate 3%) to estimate future trend (5.3%).

Definition of Healthcare trend

"Healthcare trend" is the term applied to the empirical observation that most healthcare measures (such as utilization, unit cost, and per member per month costs) tend to change over time. Generally, but not always, trend results in increases in cost-related healthcare measures.

"Trend" is the rate of increase in per member per month cost, or the difference between year two and year one costs per member per month, divided by year one cost per member per month. Trend may be defined on a calendar year or any twelve-month basis, and with appropriate adjustment, any non-12 month period. Trend from period t to period t+1 is defined as:

$$\text{Trend} = \frac{Pmpm_{t+1} - Pmpm_t}{Pmpm_t}$$

$$Pmpm_t = \frac{\sum_{J=1}^{12} \sum_{i=1}^{n_j} C_{ij}}{\sum_{j=1}^{12} n_j}$$

where: C_{ij} is the claims (or utilization, or other statistic being measured) of the i-th member in the j-th month; and
n_j is the number of members enrolled in the j-th month

Measurement of Trend

For the purpose of the "actuarially-adjusted historical control" design, it is important that trend be derived from a stable population (or from chronic and non-chronic populations that exhibit similar tendencies) that is not subject to changes in risk profile, such as age, gender, or morbidity. At the very least the effect of changes in the underlying population must be isolated and an appropriate correction must be applied when the observed trend is used in a

calculation. Otherwise, the effect of underlying population changes will contribute to the trend calculation. For example, if it is known that the average age of the population increased between year one and year two, the effect of this age increase could be calculated and deducted from the observed trend to estimate the underlying, or "stable population" trend. To the extent that equivalence with respect to risk factors is not achieved in the two periods over which trend is measured, their effect on trend will have to be estimated and an actuarial adjustment applied.

Factors that Affect Trend

As actuaries are aware, unit cost and per member per month cost trends are influenced by many factors: changes in the covered population's age, sex, geographic or employment mix; underlying cost pressures; increases in intensity of services; actions taken as a result of cost-shifting by some payers; provider contract changes; or leveraging due to the interaction between increasing charges and fixed plan design features such as co-pays or deductibles. Utilization trend, on the other hand, is influenced by intensity of services, the propensity of demand for services to be affected by supply, regulations and changes in medical practice (such as increased use of defensive medicine, or the introduction of a requirement for minimum length-of-stay for certain procedures) and the effect of aging or "maturing" of the diseased population, or introduction of new technologies and treatments.

When trends are calculated for a typical health plan, the overall experience of the population is tracked over time. Measurement of disease management outcomes, however, often introduces the need to analyze the experience of sub-populations. Three factors that have a potentially significant effect on trend are the migration of members between categories (such as non-chronic, chronic or excluded members), catastrophic claims and the mix of services used by members of different categories. We discuss each of these factors below.

Factors that Affect Selection of measured populations

While a health plan may apply its DM programs to all members identified as Chronic for the diseases of interest, members may choose not to participate. Measuring only the outcomes of volunteers introduces the possibility of selection bias. In order to avoid selection bias, studies now tend to be done including the entire chronic population, that is, considering all members that meet criteria for identification as Chronic, whether or not they choose to enroll in a DM program. The population methodology has the additional advantage of potentially avoiding bias due to regression to the mean, provided increases and decreases in costs in the population are random, that is, offset each other (Fetterolf, Wennberg and DeVries, 2004). How members are selected into the measured Chronic population varies. For example, selection can be broader (one or two claims with ICD codes for the diagnosis), or narrower (scoring systems in which claims for encounters, drugs, procedures, and lab results are taken into account). Broad selection algorithms tend to have high sensitivity (identify most or nearly all members

who have the disease) but lower specificity (some members are selected who do not actually have the disease). Narrow selection algorithms tend to have lower sensitivity but higher specificity.

In addition, the literature cites several methods of determining whether a member, once identified, *remains* in the Chronic pool in succeeding periods[6]. A member may be identified as chronic either prospectively, implying that the member is included in the chronic population from the month of first identification onward, or retrospectively, in which case the member is retrospectively classified to the chronic population from the beginning of the study (also referred to as "ever/never Chronic"). In addition, an investigator must decide whether chronic members must be re-qualified as chronic year-to-year under the same set of criteria used to identify the member initially ("Re-qualification") or not. A third method that is used in some studies is the cohort methodology, which measures outcomes only on a cohort of (Chronic) members over all measurement periods, with no continuing eligible members allowed in or out across all periods. We explore some of these ideas in this paper. However, we do not address the issue of re-qualification, which we will explore in Paper 8.

Population and Methods

The population used for this analysis consisted of a total of 1.5 million covered lives enrolled under employer health plans from January 1998 to February 2003[7]. No information about specific medical management or disease management programs was included in the dataset, although the incidence of disease management programs in the commercial population is believed to be minor for the years for which we have data. Retired members whose coverage is complementary to Medicare (Medicare Supplemental) were excluded, and the analysis focuses on the active employer-insured (Commercial) population. Risk-bearing payers (generally employer groups) without continuous enrollment over the study period were excluded (although members of continuously-eligible employer groups were allowed to enter and leave the study). Total membership for analysis was slightly lower than 1 million lives each year.

No minimum eligibility requirements were imposed on individual members within payer groups. Claims for members who did not appear in the eligibility file for the month incurred were eliminated from analysis. The population was divided annually into several groups resulting in each member being counted as either Chronic or Non-chronic for one of the five assessed chronic diseases (coronary artery disease, heart failure, diabetes mellitus, asthma, or chronic obstructive lung disease) for each year based on the following criteria: A

[6] It may seem intuitively wrong for a "chronic" member to be re-classified as "non-chronic" after initially being identified as chronic. However, identification that is performed based on administrative data and chronic disease algorithms are not 100% infallible, and a percentage of "false positives" is to be expected with any algorithm. (See discussion in Paper 6 and practical application in Paper 8.)

[7] The Ingenix data set is used with permission of Ingenix Inc., Minneapolis, MN.

single admission with primary diagnosis for one of the diseases; or at least 2 face-to-face encounter claims on separate days for one of the diseases; or in the case of diabetes or asthma a prescription fill for a drug specific for that disease could substitute for one or both of the encounter claims. The diagnostic (ICD-9-CM) and drug (NDC) codes used were consistent with disease codes recommended by the Disease Management Association of America (Duncan, ed. 2004).

Claims costs were analyzed as allowed charges, that is, billed charges for allowed health plan benefits before negotiated discounts and before cost sharing with the insured. The per capita claims experience of the Chronic and Non-chronic groups was tracked; incurred claims were associated with the corresponding membership and summed and expressed as per member per month (PMPM). Trends were calculated based on PMPM costs (allowed charges). We did not separate the prevalence, costs or trends of members with different conditions.

All members were identified as Chronic or Non-chronic using the prospective "once chronic/always chronic" criterion. As an alternative, we varied the identification to attribute chronic conditions retrospectively as well.

Results

Table 2 shows costs and trends using the prospective identification methodology and illustrates the contribution of Chronic individuals to total cost over the four years 1999-2002. In 1999, although Chronic individuals accounted for 4.1% of all covered members, they accounted for 14.5% of all costs. By 2002, Chronic individuals had increased to 8.6% of the population and accounted for 23.1% of costs. This increase in Chronic prevalence arises in part because we analyze prevalence using the "Once chronic always chronic" methodology. It also points out an issue with commercial studies of chronic disease: in order for chronic identification to be consistent year-to-year, we would require as many historic years of claim data for the first year of the study (in this case, 1999) as we have for the last (2002)[8].

[8] Members identified in 1999 are identified through claims incurred in one year of historic claims data. When the population is not re-qualified annually, members identified in subsequent years could have incurred their identifying claims several years previously. For example a member counted as chronic in 2002 could have been identified through claims incurred in 1998, and have had no subsequent claims. Symmetry in claims-based identification would require that the 1999 chronic population be identified by claims back to 1995.

Chronic and Non-chronic members and costs

Table 2. Costs and trends using the "Prospective Identification" methodology.

Year	Chronic Member Months	Chronic Prevalence	Chronic Cost PMPM	Chronic Cost Trend	Total Chronic Cost ($'000)	Chronic Cost as % of Total
1999	463,196	4.1%	$ 745.87	-	$ 345,483	14.5%
2000	701,398	6.0%	$ 746.42	0.1%	$ 523,538	18.3%
2001	845,883	7.0%	$ 820.27	9.9%	$ 693,856	20.3%
2002	990,646	8.6%	$ 879.71	7.2%	$ 871,485	23.1%
3-Year Annualized				5.6%		

Year	Non-Chronic Member Months	Non-Chronic Cost PMPM	Non-Chronic Cost Trend	Total Non-Chronic Cost ($'000)	Non- Chronic Cost as % of Total
1999	10,956,779	$ 186.26	-	$2,040,836	85.5%
2000	11,067,274	$ 211.41	13.5%	$2,339,693	81.7%
2001	11,241,633	$ 242.83	14.9%	$2,729,790	79.7%
2002	10,591,169	$ 274.44	13.0%	$2,906,654	76.9%
3-Year Annualized			13.8%		

Year	Total Member Months	Total Cost PMPM	Total Cost Trend	Total Cost ($'000)
1999	11,419,975	$ 208.96	-	$2,386,319
2000	11,768,672	$ 243.29	16.4%	$2,863,231
2001	12,087,516	$ 283.24	16.4%	$3,423,646
2002	11,581,815	$ 326.21	15.2%	$3,778,138
3-Year Annualized			16.0%	

Effectively, the combination of "once chronic always chronic" and four historical years of data (in the case of 2002) means that the Chronic population is identified based on a total of five years of claims data. To replicate this identification protocol in each year would require that data be available from 1995 to 1998 to identify 1999 chronic members with the same number of historical years of claims. To analyze trends we need as many years of PMPM costs as we can assemble, which requires us to use all available years of claims. The consequence of this constraint, however, is that by 2002, more years of historic data exist to identify chronic members than were available for 1999.

For the entire population, per member per month (PMPM) cost increased at an annualized rate of 16.0% over this period. If Chronic prevalence remained at 4.1% throughout the study period, the average annualized increase would have been only 12.7%; implying that approximately 3.3% of the annual increase was due to the increase in chronic prevalence. This observation is derived from Table 3:

Table 3: Average Cost PMPM without the effect of Prevalence Creep

Year	Chronic Member Months	Non-chronic Member Months	Total Member Months	Chronic Prevalence	Cost PMPM
1999	463,196	10,956,779	11,419,975	4.1%	$208.96
2002	990,646	10,591,169	11,581,815	8.6%	$326.21
2002 (re-stated)	469,760	11,112,055	11,581,815	4.1%	$298.99

The chronic and non-chronic trend results may at first appear counter-intuitive. First, the chronic trend is lower than either the total or Non-chronic trend, which appears anomalous, given that Chronic members are high cost (their cost PMPM is between 3 and 4 times that of Non-chronic members). Second, the overall population trend is higher than that of either sub-population. These apparent anomalies, however, are accounted for by migration in membership between the relatively low-cost Non-chronic population, as newly-identified Chronic members transfer to the relatively high-cost Chronic population. The members who leave the Non-chronic are relatively high-cost, while they are relatively low-cost members of the chronic population. In each case the trend of the respective populations is reduced below the underlying rate. Finally, we note that the observed chronic trend (5.6%) is reasonably consistent with the trend observed for similar chronic conditions (4.6%) between 1987 and 2002 by Thorpe et al (2004).

The growth in the Chronic member population (more than doubling between 1999 and 2002) results from increasing identification of chronic members, or increased measured prevalence. Because the overall population is almost constant, the increase in chronic membership is matched by a decrease in the Non-chronic pool. Newly-identified Chronic members tend to be lower-cost than the remainder of the Chronic pool, but higher cost than the Non-chronic pool, effectively reducing the trends observed in each sub-population. Some more-recently introduced savings methodologies attempt to adjust for duration since chronic diagnosis, but this method is hampered by the availability of data. However, the lack of a long series of historical data makes it difficult to apply methods that introduce a true duration adjustment.

Decomposition by Service Sector

To further explore the gap between Chronic and Non-chronic trends, we explored whether this divergence could be accounted for by differences in service mix between the populations. Certain applications of the actuarially adjusted methodology apply a single trend to baseline costs. As actuaries are aware, trend is particularly susceptible to factors such as leveraging of plan design, change in mix of services, covered population. If this is a concern, a refinement to the simple single composite trend approach may be applied that decomposes the calculation into service categories and further decomposing

trend into its utilization and unit cost components. An example of such service category decomposition is shown in Figure 1.

Figure 1 Service Categories for decomposition of savings calculation

An advantage of this decomposition by service line category is the ability to calculate a weighted average of the individual service line trends (derived from the non-chronic population) using weights appropriate for the chronic population.

Table 4 compares the composition of overall (Total) PMPM claims of each of the Chronic, Non-chronic and all member populations by major service category. For example, over the three-year period, Inpatient Hospital claims amount to $67.32 PMPM for the Non-chronic population, compared with $294.02 for the chronic population, and $81.84 for the population as a whole. Data are annualized averages over the 4-year period 1999-2002. As one would expect, the composition of the claims dollar is different for each population, with Non-chronic members using relatively fewer inpatient hospitalization services (29.5% of their total expense) and relatively more physician office services (17.9%) than Chronic members (36.2% and 12.2%, respectively). The differences in service sector trends (hospital expenses growing relatively more slowly than certain outpatient expenses) when combined with these utilization differentials could result in different overall trends in each sub-population. While some trends were discernible within each service category (Inpatient services generally fell over the 4-year period, while outpatient services generally increased) there was relatively little variation in the service category percentages over time.

Table 4. Comparison of Chronic and Non-Chronic Service Cost PMPM and Service mix.

	ALL YEARS	Claims PMPM								ALL SERVICES
	Mem Mons	Inpatient	Outpatient	Presc Drug	Emerg Rm	Laboratory	Phys Ofc	Rehab	Other	TOTAL
NON-CHRONIC	10,964,214	$ 67.32	$ 68.53	$ 33.47	$ 5.24	$ 4.46	$ 40.90	$ 0.91	$ 7.58	$ 228.40
CHRONIC	750,281	$ 294.02	$ 197.69	$ 158.37	$ 9.69	$ 10.64	$ 99.34	$ 6.29	$ 35.10	$ 811.15
ALL	11,714,495	$ 81.84	$ 76.80	$ 41.47	$ 5.52	$ 4.86	$ 44.64	$ 1.25	$ 9.34	$ 265.72

	ALL YEARS	Service Category Weights								ALL SERVICES
	Mem Mons	Inpatient	Outpatient	Presc Drug	Emerg Rm	Laboratory	Phys Ofc	Rehab	Other	TOTAL
NON-CHRONIC	10,964,214	29.5%	30.0%	14.7%	2.3%	2.0%	17.9%	0.4%	3.3%	100.0%
CHRONIC	750,281	36.2%	24.4%	19.5%	1.2%	1.3%	12.2%	0.8%	4.3%	100.0%
ALL	11,714,495	30.8%	28.9%	15.6%	2.1%	1.8%	16.8%	0.5%	3.5%	100.0%

Table 4 above shows that the PMPM cost and relative service category utilization of Chronic and Non-chronic members is different, with chronic members being heavier utilizers of inpatient hospital, prescription drug, and rehabilitation services. These are all service categories that, for chronic members, have relatively low trends.

Table 5 compares the trends in Chronic and Non-chronic populations, by major service category. Trends are 3-year average annualized rates, calculated over the 4-year period. Different trends by service are observed in each sub-population and in the population as a whole, with non-chronic member trends generally higher than those of chronic members.

Table 5. Comparison of Chronic and Non-Chronic Trends by service category

	3- Year Annualized	Service Category Trends								ALL SERVICES
	Mem Mons	Inpatient	Outpatient	Presc Drug	Emerg Rm	Laboratory	Phys Ofc	Rehab	Other	TOTAL
NON-CHRONIC	10,964,214	12.3%	15.4%	11.0%	19.4%	10.8%	16.5%	12.8%	9.0%	13.8%
CHRONIC	750,281	6.6%	8.3%	1.1%	12.1%	0.6%	8.9%	-9.5%	-1.7%	5.7%
ALL	11,714,495	15.8%	17.2%	13.7%	20.0%	11.4%	17.7%	12.6%	11.3%	16.0%

To test the effect of service category mix on trend, we applied the chronic service category utilization percentages to the Non-chronic service category trends. Table 6 shows unadjusted non-chronic trend, compared with Non-chronic trend adjusted for the chronic population service distribution. The difference in service utilization accounts for relatively little of the difference in trends between sub-populations (between 0.3% and 0.8%, depending on the year, and 0.6% on average over the three-year period).

Table 6. Effect of Chronic Service mix on Non-Chronic trends (There was confusion by some of the POG members as to where the difference came from.

Year	Non-chronic Trend	Adjusted Non-Chronic Trend	Difference
2000	13.5%	12.7%	0.8%
2001	14.9%	14.6%	0.3%
2002	13.0%	12.4%	0.6%
Three-year average	13.8%	13.2%	0.6%

Effect of exclusions on Trend

In Disease Management applications, exclusions (both from the measured population and from the claims associated with the population) are often made to reduce potential confounding. Examples of exclusions of members are members with HIV/AIDS, and members who have a diagnosis of End-stage renal disease. Examples of exclusions of claims are claims above a catastrophic limit (outliers) or claims for certain diagnoses (such as maternity or mental health). More detail on this issue may be found in Paper 6.

We tested the effect of applying both member and claim exclusions on the Chronic and Non-chronic trends. Sample results are provided in Table 7.

Table 7. Effect of excluding high-cost outliers on Trend.

Year	Non-chronic cost PMPM	Non-chronic Trend	Chronic cost PMPM	Chronic Trend	Total cost PMPM	Total Trend
1999	$ 148.08	-	$ 650.87	-	$ 168.47	-
2000	162.89	10.0%	625.12	-4.0%	190.44	13.0%
2001	192.47	18.2%	706.81	13.1%	228.46	20.0%
2002	218.61	13.6%	751.95	6.4%	264.23	15.7%
3-year Annualized		13.9%		4.9%		16.2%

Excluding members and claims does not change the average 3-year trend for the Non-chronic or total population (16.2% vs. 16.0%; 13.9% vs. 13.8%). However, the Chronic trend is reduced (5.6% vs. 4.9%), and at the same time is more subject to variation year-to-year. This result suggests that the large claims in the Chronic population have been growing at a faster rate than corresponding large claims in the Non-chronic population. One important objective in commercial DM evaluations is to avoid incorrect conlusions due to random variation. This analysis suggests that including the full amount of high dollar claims makes the PMPM claims and trend of the Chronic population more variable. If the objective of a study is to avoid potential confounding due to variability, exclusion of large claims in excess of a stop-loss limit (also called "top-coding") appears to be justified.

Effect of migration between Chronic and Non-chronic populations

Migration from the Non-chronic to the Chronic population causes divergence between the trends of each group. We tested this effect by assigning members to a group (Chronic or Non-chronic) retrospectively to the beginning of the first measurement period, irrespective of the period in which they met the chronic condition identification criteria. Thus, for example, in the results reported in Table 2 above a member who is Non-chronic in 1999 and 2000, but meets the chronic test at January 1, 2001 will be classified in the Non-chronic group in 1999 and 2000 and re-classified to the Chronic group in 2001 and 2002. For the comparison below, this same member will be classified as Chronic for all 4 years of analysis. The analysis uses the member exclusion and claims exclusions, as in the previous section.

Table 8. Effect of applying retrospective ("ever/never chronic") identification methodology.

TRENDS	3-year annualized Chronic Member Months	RETROSPECTIVE IDENTIFICATION Chronic Trend	Non-Chronic Member Months	Non-Chronic Trend	Total Member Months	Total Trend
Year						
1999	1,410,116	0.0%	10,009,859	0.0%	11,419,975	0.0%
2000	1,440,371	15.5%	10,328,301	17.8%	11,768,672	16.7%
2001	1,437,872	17.2%	10,649,644	17.0%	12,087,516	16.2%
2002	1,317,536	16.3%	10,264,279	16.8%	11,581,815	15.3%
Three year	annualized	16.3%	annualized	17.2%	annualized	16.0%
		PROSPECTIVE IDENTIFICATION				
Three year	annualized	5.6%	annualized	13.8%	annualized	16.0%

When trend is measured on members assigned retrospectively from the beginning of the period, Chronic, Non-chronic and total trends are much closer: the Non-chronic group trend is at a slightly higher rate using the retrospective method (17.2%) vs. prospective (13.8%). The chronic trend is 16.3% using the retrospective method, considerably higher than the trend using the prospective method (5.6%). More important for commercial applications, either the Non-chronic or Total trend appears to be useable as a proxy for the Chronic trend measured on the retrospective basis.

The fact that both chronic and non-chronic trends are higher than overall trend in the case of the retrospectively identified population may appear to be anomalous. However, the lower trend in the overall population results from the relative growth rates of non-chronic members (0.8% per year) and chronic members (-2.2% per year) over the 4 years. During the four-year period, non-chronic members increase from 63.0% of the total population to 65.6% of the total population. The lower PMPM cost of the non-chronic population, combined with their relatively faster growth, depresses the overall trend in the population.

Effect of changes in the Population Risk Profiles

One possible source of difference between Chronic and Non-chronic trends is diffential changes in population risk over time. One commonly-used method for estimating member (and population) risk is the use of groupers or predictive models, which provide a single numerical value, at the individual member level. Each member is assigned a numerical "score" (which may also be aggregated to assess the risk of a population) based on risk factors in the individual member's risk profile. We applied a commonly-used and

commercially-available grouper[9] to the Chronic and Non-chronic populations defined above. The DxCG model was applied prospectively, that is, a risk score was predicted, based on the prior year's claims history, for each individual member for the following year. Results are shown in Table 9 for the populations identified by the "Prospective" methodology. Results are shown in Table 9 for the Chronic and Non-chronic populations identified by the "once Chronic/always Chronic" methodology.

Table 9. Effect on Trend of applying risk adjustment to the prospective methodology.

	Prospective Chronic Identification							
	CHRONIC				NON-CHRONIC			
Year	Risk-Score	Risk-score Trend	Pmpm Trend	Risk-Adjusted Pmpm Trend	Risk-Score	Risk-score Trend	Pmpm Trend	Risk-Adjusted Pmpm Trend
1999	3.162				0.878			
2000	2.814	-11.0%	0.1%	12.5%	0.870	-0.9%	13.5%	14.6%
2001	2.686	-4.5%	9.9%	15.1%	0.894	2.8%	14.9%	11.7%
2002	2.622	-2.4%	7.2%	9.9%	0.922	3.1%	13.0%	9.6%
3-Year annualized		-6.1%	5.6%	12.5%		1.7%	13.8%	11.9%

A risk score of 1.0 is the prediction that an individual or group will have the same PMPM cost as the mean of the entire insured population used for validating the risk adjustment model.

The trend in risk score of the Chronic population indicates that the Chronic population becomes less risky over time. Conversely, the Non-chronic population becomes slightly more risky over time. Making a simple adjustment to the PMPM Trend observed in each population, (by dividing PMPM trend by the effect of population risk-score change), the Adjusted Trends become closer. The adjusted trends are not significantly different.

The implication of this analysis may not be immediately obvious, so we remind the reader that unadjusted Non-chronic trend is often used as an estimator for chronic trend, in the absence of a program. This analysis indicates that the lower trend in the chronic population (when compared with the Non-chronic population) is associated with a differential change in risk score. The practical application of this technique is illustrated below.

Table 10 contains some basic (hypothetical) data and a typical Disease Management program savings estimate. The baseline cost Per Member Per Month represents the average cost during a period prior to the initiation of a program for all included services per chronic member per month for members who meet the inclusion criteria (for typical inclusion and exclusion criteria, see Paper 6). As is the case in many calculations, the baseline cost PMPM is

[9] The DxCG grouper, used with permission of DxCG Inc., Boston. More information about groupers and alternative products may be found in Cumming et al (2002).

trended forward using the Non-chronic population experience as an estimate of that which would have been experienced by the chronic population, absent the intervention program. The difference between the projected baseline cost and actual cost of the chronic population is our estimate of program savings PMPM. The remainder of the calculation applies a Risk-adjuster to these numbers to determine a more accurate estimate, firstly of Non-chronic trend, and then the effect of change in the Chronic population risk-profile, allowing the (adjusted) Non-Chronic trend to be used as a potentially unbiased estimate.

Table 10: Application of a Risk-adjusted Trend model

Basic Data

The standard adjusted historical control savings calculation uses the unadjusted trends and cost pmpm, as follows:

Population	Baseline Period	Intervention Period	Trend
Non-chronic Cost PMPM	$100	$110	10.0%
Non-chronic Risk Score	1.0	1.02	2.0%
Non-chronic Cost PMPM, adjusted for Risk trend		$110/1.02 = $107.84	
Risk-adjusted Non-Chronic Cost Trend, PMPM	$100	$107.84	7.84%
Chronic Cost PMPM	$300	$305	1.67%
Chronic Risk Score	3.0	2.90	(3.33%)

Baseline Chronic cost PMPM	$300
Trend (non-chronic)	1.10
Trended Baseline Chronic cost	$330
Actual cost	$305
Estimated Savings	$ 25 PMPM

Risk Adjusted historical control savings calculation uses the adjusted trends and cost pmpm, as follows:

Baseline Chronic cost PMPM	$300
Risk-adjusted Trend (non-chronic)	1.0784
Trended Baseline Chronic cost	$323.52
Actual cost	$305
Risk-adjusted Actual cost	$305/.967 = $315.41
Estimated Savings	$8.11 PMPM

Using the risk-adjusted trend as our estimate of chronic trend gives a lower but more credible estimate of savings.

Discussion

Those who pay for disease management programs want to understand whether they are receiving value for their money. Answering the value question means comparing the actual results to what would have been predicted absent the intervention. However, apart from a randomized controlled clinical trial (in which it can be assumed that the control or comparison group's actual costs would answer the "in the absence of" question), the healthcare cost for the intervened group must be predicted from its cost in the "pre" year adjusted by a suitable trend. While it is commonly assumed that the cost trend for the Chronic group (who receive the intervention) would be identical to the Non-chronic trend in the absence of intervention, this assumption has not been proven.

This study showed that at least if Chronics are identified using a "once Chronic/always Chronic" methodology, this assumption may not be true. We found that in a large commercially insured population over four years the Chronic trend was far lower than the Non-chronic trend. This conclusion was unaffected by readjusting the Non-chronic trend to the Chronic population's service mix. Because this divergence in trends may be due to the prospective method of classifying Chronics, we applied a second (retrospective) methodology, which assumed that over the four-year span all members were either Chronic or Non-Chronic. While this methodology resulted in convergence of the trends, it may not be clinically defensible because people are first identified with chronic diseases at a specific point in time, when either qualifying tests (or the claims proxy used in DM analyses) are satisfied. The "once Chronic/always Chronic" methodology has greater clinical appeal—people do not become cured of their chronic diseases.

Because migration of members from the Non-chronic to the Chronic pool may change the case (risk) mix in the pools, we applied a commonly-used and validated risk adjustment methodology. This resulted in the trends becoming almost identical.

Limitations

Because we used a commercially-available data-set, we had no information about the specific medical interventions, if any, present in the population. We expect that DM programs were limited during the time-period represented by the data, given the relative recent development of large-scale DM programs.

The results that we reproduce above represent a single specific sample and may not be reproduced in other data. We encourage actuaries to follow our methods, however, to publish detailed trend analyses in other populations.

We did not explore a third frequently used Chronic selection methodology, that of annual reselection. This method has been promoted as avoiding some of the effects of migration (because members can migrate both into and out of the Chronic pool). It is possible that the risk-adjusted "once/always" and "reselect annually" methods accomplish the same end—adjusting the Chronic populations' risk to avoid a decline in its trend due to dilution from lower-risk cases. This is an area where further data analysis is warranted.

Conclusions and Implications for Disease Management Purchasers

1. When Chronics are identified using a prospective "once Chronic/always Chronic" algorithm, unadjusted Non-chronic (or total population) trend is a poor proxy for chronic trend in DM evaluations.
2. Using trends calculated in this way introduces a bias into estimates of savings outcomes. Based on our analysis, the bias is upward (i.e. savings are over-stated as a result of the bias). This effect, which has not previously been described or discussed in the literature, may be called a "migration bias".
3. As an example of the effect of "migration bias", consider a DM evaluation in which the baseline cost of the chronic population is $100 PMPM. Projecting this cost to the next period using a non-chronic trend as calculated in this article (13.8%) would result in a projected cost of $113.80 PMPM. Savings would be estimated as the difference between the observed cost PMPM and the actual cost PMPM. However, our results show that the actual chronic trend that should have been used, in this example, is 5.6%, giving a projected cost PMPM of $105.60. The difference in projected baseline costs PMPM ($8.20) would be included in savings by a study that uses the trend projection and prospective chronic identification methodology.
4. While using Chronic population identification algorithms that retrospectively classify members as never or always Chronic (or Non-chronic), the Chronic and Non-chronic trends are closer to convergence. However, this methodology is difficult to justify on clinical grounds.
5. Adjusting the Non-chronic trend for service mix has little effect on trend.
6. Adjusting both the Non-chronic and Chronic populations for the effect of change in population risk results in an adjusted Non-chronic trend that closely approximates adjusted Chronic trend.
7. When using a prospective "once Chronic/always Chronic" selection algorithm, the bias in trends can be corrected by using a risk adjuster to account for risk-change in each population over time.
8. The above conclusions about trend relativities hold when several years of trend are averaged. However, the results for individual years are less consistent, because trend (particularly within the Chronic population) is volatile. In a particular savings calculation, Non-chronic trend may be more or less close to the true underlying Chronic trend.

Operationally, the Non-chronic trend as estimated using a retrospective (ever/never Chronic) method may be used to assess the effect of DM interventions without adjustment. However, the methodology may be rejected by some analysts on clinical grounds. As an alternative, a risk-adjustment methodology may be applied to a prospective analysis. To do so, the Non-chronic trend would first be adjusted by dividing the Non-chronic PMPM trend by the trend in Non-chronic risk-score trend. An estimate would have to be made of the trend in Chronic risk-score, which will require sufficient data series to estimate the risk-score. There is also a potential for confounding because the risk-score post-implementation of DM will be affected (reduced) by the intervention. However, this effect is expected to be relatively small in a Chronic population, which is permanently subject to its conditions, making this a potentially practical method for trend correction in applications.

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"Dial-an-ROI?" Changing Basic Variables Impacts Cost Trends in Single-Population Pre-Post ("DMAA Type") Savings Analysis

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Abstract

Disease management (DM) programs claim to achieve cost savings by reducing clinical adverse events. While measuring changes in adverse events is straightforward, plausibly demonstrating savings has been contentious, especially absent an external comparison population. In this situation, a single-population methodology is often used, in which the cost trend for those with no program conditions ("non-chronics"–NC) forms the expected trend for those who have at least 1 program condition ("chronics"–C). The methodology's fundamental assumption is that—absent DM—C and NC trends would be identical (or bear a constant relationship over time). We assessed this assumption by altering the values of key variables used to identify C and NC, and to calculate trend.

We compared C and NC baseline trends for a 23-condition telephonic DM multiemployer program representing nearly 300,000 members. Trends were calculated for 16 combinations of values for 4 key variables: identification look-back frame (12 vs. 24 months); identification threshold (high vs. lower specificity); claims runout (3 vs. 6 months); and minimum required insurance eligibility (any 6 months vs. 12 months continuous eligibility in the measurement year). Identification was performed by annual qualification.

Changes in values for the 4 key variables markedly impacted baseline C and NC trends. C trends varied between 10.1% and 13.1%; NC trends between 5.2% and 12.8%. C-NC trend differences ranged between −1.9% and +7.0%. The combination of 24 months identification look-back, high identification threshold, 6 months runout, and any-6-months eligibility gave the most convergent C and NC trends (10.4% and 10.7%).

Seemingly minor changes in key variables impact C and NC trends in single-population pre-post DM savings methodologies. When a suitable comparison population is not available, at least 1 year of baseline C and NC trends should be reported–as recommended by the DMAA—and values of key variables used should be specified. Plausibility metrics (eg, hospitalizations) should be reported. (*Population Health Management* 2009; 12:17–24)

Background

For over 15 years, disease management (DM) programs have proliferated rapidly; annual revenues for 2008 are projected at $1.8 billion, compared with $78 million in 1997.[1] DM's spread and penetration has occurred in response to concerns about the prevalence and cost of chronic conditions, persistently low rates of clinical practice guideline adherence,[2,3] and discontinuities in care coordination. Yet, health care spending in the United States continues to rise faster than inflation and is projected to continue to increase more quickly than the gross domestic product (GDP)—from 16.3% of GDP in 2006 to 19.5% in 2017.[4] It is well documented that a large fraction of health care costs are preventable, in theory, due to modifiable behavioral risk factors.[5]

DM's expansion and commercialization—functioning largely outside of the arena of direct clinical care—has raised concerns about value, particularly about whether the cost of DM is offset by savings from improved health status (avoided clinical adverse events).[6] Early programs claimed returns on investment of several times costs; however, these claims were unsupported by plausibility indicators such as

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Divide population into 3 compartments:

Chronics (C): Have a DM-managed condition
Non-chronics (NC): Don't have a DM-managed condition
Not measured (don't meet minimum eligibility, excluded)

Assume: absent DM: **Trend (C) = Trend (NC)***

Then, *expected* 1st program Year C PMPM =

$$C_{\text{baseline PMPM}} \times (1 + \text{Trend}_{NC})$$

FIG. 1. Single-population trends-comparison methodology. *Unless pre-program data are available, in which case assumption is that trends bear a constant relationship absent DM.

improvements in population health or reduced emergency or inpatient hospital use.[7]

Early DM financial outcomes methodologies contained built-in biases that resulted in overestimating savings based on the cost of the DM-managed group compared to that of an unmanaged group. While these biases would have been absent if the unmanaged group was part of a prospective randomized controlled study, this type of study has rarely been available in DM. (One such study of fee-for-service Medicare recipients in the Medicare Health Support initiative was found by the Centers for Medicare and Medicaid Services to save less than its costs.[8]) These biases—particularly active when there is no comparison group external to the DM-eligible population—include regression of costs following identification, and prospective qualification of the chronic population, in which individuals once identified by administrative data as having chronic conditions remain in the "chronics" pool in subsequent evaluation periods. The nature of financial evaluation biases and recommendations for addressing them have been reviewed by several authors.[9,10,11] While many published studies have found clinical improvements and some found cost savings, rigorous evaluation is hampered by the variety of program types and methodologies used to evaluate financial program impact.[12]

All financial outcomes methodologies have in common a comparison of cost observed during the program period to cost expected without the program. Estimation of expected cost depends on program and study design, and may include the same population (or segment with specified diseases) in the baseline period, a concurrent group in the same population, or a comparison unexposed population; this comparison population may consist of individuals with matching characteristics or may be an entire unexposed population.[13,14]

Methodologies that use randomized or well-matched comparison populations are considered to have the greatest validity in demonstrating savings. But use of comparison populations is often inappropriate in a business setting. In this common situation—in which anyone in the entire covered population is eligible for the program if they are identified to have a program condition—a single-population evaluation methodology (SPEM) must be used.

In one kind of SPEM, the question "What would expected cost have been without the program?" is answered by comparing the cost trend for those with no program conditions ("non-chronics") with the cost trend of those with at least one program condition ("chronics").[15] The non-chronic (NC) trend is applied to the baseline period[a] chronic (C) cost to derive the expected C cost; and program period savings is calculated as the C expected minus observed cost (Fig. 1 and Table 1).

The SPEM's fundamental assumption—that C and NC trends would be equal or bear a constant relationship absent DM—may not be provable because of its dependence on chronic population selection criteria. A recent study comparing C and NC trends in a generally non-DM-exposed large data set over 4 years found these trends to be convergent using prospective qualification selection criteria with risk adjustment, or using annual qualification selection criteria without risk adjustment.[16] However, only 5 common conditions and high-sensitivity claims diagnosis-based selection criteria were used to distinguish C and NC.

There has been little published work on how C and NC trends vary with changes in selection criteria and other important variables, such as the number of chronic conditions, algorithms used to select chronics, claims runouts, and minimum months' (insurance) eligibility. Because it is not known whether or how varying these criteria affects the relationship between C and NC trends, it has been suggested that the assumption of their equivalence or constant relationship be tested with a "dummy" or preimplementation period analysis in which C and NC are selected using the same criteria used for creating these groups for analysis in the program periods.[11] Such an analysis would be most reassuring if it covered at least 2 preprogram years, but data may not be available to do so.

We tested the SPEM's fundamental assumption of baseline period trends equivalence by altering the values of 4 key variables used as trend calculation inputs: identification look-back frame, identification (qualification) threshold to

[a]We use the term "baseline period trend" to mean the relative change in pre-baseline year to baseline year costs. Similarly, "program period trend" means the relative change in baseline year to first program year costs.

Table 1. Single-Population Trends-Comparison Methodology

Non-chronics (NC) (comparison group: trend to beat)	
Baseline year cost	$120.15
Program year cost	$130.88
Trend	8.93%
Chronics (C)	
Baseline year cost	$570.11
Predicted program year cost	$621.02
Observed program year cost	$608.45
Savings per C per month	$12.57
Savings over whole population	
C member months as % of whole population member months	19.59%
Savings over whole population (PMPM)	$2.46

PMPM, per member per month.

distinguish C from NC, claims runout, and minimum eligibility.[a]

Methods

We compared trends in medical allowed (covered) charges for health plan members who have 1 or more of 23 chronic conditions ("chronics"–C) with trends for members who have none of these conditions ("non-chronics"–NC) in a multi-employer population representing nearly 300,000 unique employees and dependents. This population had access to a 23-condition DM program delivered telephonically by nurses. The chronic conditions studied are listed in Table 2.

Baseline trends were calculated for all combinations of values for 4 key variables: the look-back period used for identification of the chronic conditions (12 months vs. 24 months); the stringency of the validation criteria applied in confirming the existence of the conditions (high vs. lower specificity[b]); the length of the claims runout period (3 vs. 6 months); and the minimum number of months of insurance enrollment required for inclusion in the study (any 6 months vs. 12 months of continuous eligibility in the measurement year). In each of the resulting 16 scenarios, identification of the chronic conditions was performed by annual qualification, with identical criteria applied in each year.

To test the central hypothesis of this study—that variations in these values cause substantial changes in the cost trends that emerge from the analysis, and will determine whether trends for C and NC are equal in the absence of DM—we compared trends for C and NC during the "baseline period," (ie, from 2 years prior to 1 year prior to implementation). To demonstrate the importance of baseline trend calculations, we also compared trends for C and NC during the "program year," from the baseline year to the first year after implementation. To *illustrate* the magnitude of precision around which trends can be estimated for this size population, we calculated simple (assuming normal cost distribution for purposes of illustration) 80% and 95% confidence intervals (CI) for all trends. This was done by first calculating the CI for C and NC baseline year (BY) and program year (PY) costs, and then computing confidence limits (CL) as follows:

$$\text{Lower } CL_{trend} = \{(\text{lower } CL_{cost} \text{ PY})/\text{upper } CL_{cost} \text{ BY}\} - 1$$

$$\text{Upper } CL_{trend} = \{(\text{upper } CL_{cost} \text{ PY})/\text{lower } CL_{cost} \text{ BY}\} - 1$$

Results

The entire population included 298,613 unique members in the baseline year and 292,283 unique members in the pro-

Table 2. Conditions Covered by the Disease Management Program

Asthma
Asthma—pediatric
Coronary artery disease
Congestive heart failure
Cholesterol (elevated)
Chronic hepatitis (types B and C)
Chronic renal failure
Chronic obstructive pulmonary disease
Cerebrovascular disease
Diabetes
Gastroesophogeal reflux disease
Geriatrics (with at least 1 chronic condition)
Hypercoagulable state
Hypertension
Inflammatory bowel disease
Migraine
Osteoporosis (primary & secondary)
Parkinson's disease
Peptic ulcer disease
Rheumatoid arthritis
Seizure
Sickle cell disease
Sickle cell disease—pediatric

All programs enrolled only members aged at least 18, unless specified as pediatric.

[a]SPEM's fundamental assumption is that the C and NC trends are equal or bear a constant relationship over time, but we state the assumption this way for simplicity.

[b]Condition validation in this program was based on a system that assigned points for medical claims with relevant diagnoses and procedures, for abnormal relevant test values, and for prescription drug claims with relevant medications. For this study, we defined "high specificity" as validation based on a minimum of 6 or 7 points and "low specificity" as validation based on a minimum of 3 points.

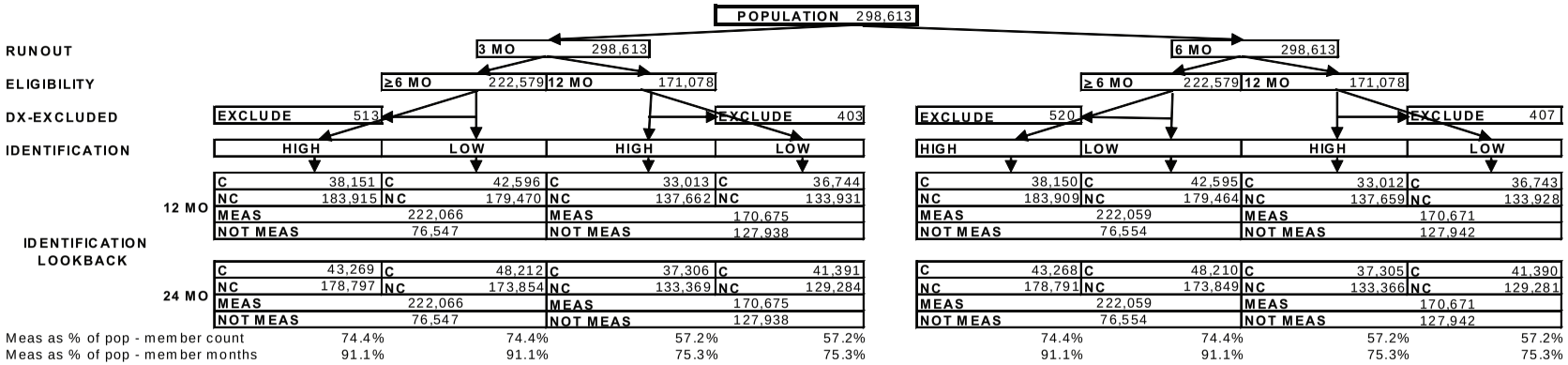

FIG. 2. Population partition cascades under all combinations of selection criteria. DX, diagnosis; MO, month; C, chronics; NC, non-chronics; MEAS, measured population; NOT MEAS, non-measured population.

Table 3. Representative Member Counts and Costs for 4 Scenarios (12 vs 24 Months' Identification Look-Back; High vs Low Identification Threshold; 3 Months Runout and Any-6-Months' Minimum Eligibility)

	Member count	*Member months*	*Total allowed*	*PMPM*
12-month identification look-back				
Baseline year	298,613	2,718,136	$569,677,430	$209.58
Program year	292,283	2,607,369	$600,776,442	$230.41
Baseline year				
After eligibility rule applied	222,579	2,481,823	$530,352,750	$213.69
After diagnostic exclusions	222,066	2,476,088	$512,197,862	$206.86
C HIGH	38,151	440,135	$260,181,666	$591.14
NC HIGH	183,915	2,035,953	$252,016,196	$123.78
TOT HIGH	222,066	2,476,088	$512,197,862	$206.86
C LOW	42,596	490,978	$282,724,735	$575.84
NC LOW	179,470	1,985,110	$229,473,127	$115.60
TOT LOW	222,066	2,476,088	$512,197,862	$206.86
24-month identification look-back				
Baseline year				
After eligibility rule applied	222,579	2,481,823	$530,352,750	$213.69
After diagnostic exclusions	222,066	2,476,088	$512,197,862	$206.86
C HIGH	43,269	498,597	$278,106,204	$557.78
NC HIGH	178,797	1,977,491	$234,091,658	$118.38
TOT HIGH	222,066	2,476,088	$512,197,862	$206.86
C LOW	48,212	554,803	$300,944,456	$542.43
NC LOW	173,854	1,921,285	$211,253,406	$109.95
TOT LOW	222,066	2,476,088	$512,197,862	$206.86

PMPM, per member per month; C, chronic; NC, non-chronic

gram year. The mean age of the baseline population was 34.1; 50.8% were females. Figure 2 shows the cascade of members excluded for eligibility and diagnoses and in the 12- and 24-month look-back qualification scenarios, and resulting numbers (and member-months) for the various pairs of C vs. NC qualification scenarios.

As expected, more members entered the measurement (C plus NC) pool in the any-6-month (74.4%) than in the all-12-month (57.2%) eligibility scenario. Expressed as percent of total population member-months, the measurement pools formed a much greater proportion of the total population (91.1% vs. 75.3%), but the difference due to eligibility requirements remained substantial. For the 16 selection scenarios, mean age varied from 53.0 to 54.5 for C, and from 30.5 to 32.6 for NC; percent female varied from 53.5% to 54.4% for C, and from 50.2% to 50.6% for NC.

A representative partitioning of baseline costs for 4 of the 16 variable-combination scenarios is shown in Table 3.

Baseline and program year cost trends with 80% and 95% CIs for the 16 measurement scenarios are shown in Fig. 3. In the baseline year (comparing the pre-baseline year to the baseline year), shorter identification look-back period tended to yield higher cost trends for both C and NC—and a lower trend difference between C and NC. Trends for C tended to be greater, and for NC lower, with longer claims runout. The trends difference, however, varied greatly depending on which scenario was selected. Only one scenario—24 months' identification look-back, 6 months runout, any-6-months' minimum eligibility, and a high identification threshold—yielded nearly-convergent C and NC baseline period trends.

In all scenarios, trends demonstrated wide CIs, approximately ±3% for 80% CI and ±4.5% for 95% CI. Confidence intervals tended to be slightly narrower for NC than for C.

To demonstrate the importance of measuring—and reporting—preimplementation trends, we show the results of program year measurements (comparing the baseline year to the program year) under the 16 scenarios. Again, C and NC trends and trend differences vary widely depending on which scenario is chosen. In this particular example, selection of the scenario yielding baseline-convergent trends shows a program year favoring the Cs (6.7% C vs. 8.9% NC). While all scenarios show program year C trend less than NC, the trend difference-in-difference between baseline and program years for some scenarios may be implausibly high (eg, 24 months' identification look-back, 6 months runout, 12 months' minimum eligibility, low identification threshold).

Discussion

In the DM program that we studied, the choices made regarding 4 key C and NC methodology-implementation variables (ie, identification look-back period, specificity of validation criteria, length of claims runout, and months of enrollment required for inclusion) had a significant impact on C and NC trends, both statistically and in a practical sense, because the intervention period trends reported by the DM program would surely influence the perception of the program's success and might determine its continuation.

A major limitation of the study was its focus on only these 4 variables and only 2 choices of values for each variable—

	Identification Threshold	Months of Eligibility	BASELINE PERIOD Identification Look-Back 12 months	BASELINE PERIOD Identification Look-Back 24 months	PROGRAM PERIOD Identification Look-Back 12 months	PROGRAM PERIOD Identification Look-Back 24 months
3 Months of Claims Runout	HIGH	Any 6+	C: 10.9% (±3.2%, ±4.9%) NC: 12.8% (±2.7%, ±4.1%) Diff: -1.9%	C: 10.1% (±3.1%, ±4.7%) NC: 11.2% (±2.7%, ±4.1%) Diff: -1.1%	C: 6.2% (±3.0%, ±4.6%) NC: 8.6% (±2.6%, ±3.9%) Diff: -2.4%	C: 6.3% (±3.0%, ±4.6%) NC: 7.6% (±2.5%, ±3.8%) Diff: -1.3%
		All 12	C: 11.2% (±3.2%, ±4.9%) NC: 9.5% (±3.0%, ±4.5%) Diff: +1.7%	C: 10.5% (±3.1%, ±4.8%) NC: 7.9% (±2.8%, ±4.4%) Diff: +2.7%	C: 5.4% (±3.0%, ±4.5%) NC: 9.5% (±2.8%, ±4.3%) Diff: -4.1%	C: 5.1% (±2.9%, ±4.5%) NC: 9.1% (±2.8%, ±4.2%) Diff: -4.0%
	LOW	Any 6+	C: 12.2% (±3.1, ±4.8%) NC: 11.3% (±2.7%, ±4.1%) Diff: +0.9%	C: 11.3% (±3.1%, ±4.7%) NC: 9.7% (±2.7%, ±4.1%) Diff: +1.6%	C: 6.0% (±2.9%, ±4.5%) NC: 9.1% (±2.6%, ±3.9%) Diff: -3.1%	C: 5.7% (±2.9%, ±4.4%) NC: 8.4% (±2.5%, ±3.8%) Diff: -2.7%
		All 12	C: 12.7% (±3.1%, ±4.8%) NC: 7.5% (±3.0%, ±4.5%) Diff: +5.2%	C: 11.9% (±3.1%, ±4.7%) NC: 5.8% (±2.8%, ±4.4%) Diff: +6.1%	C: 5.2% (±2.9%, ±4.4%) NC: 10.2% (±2.8%, ±4.3%) Diff: -4.9%	C: 4.6% (±2.8%, ±4.3%) NC: 10.4% (±2.8%, ±4.2%) Diff: -5.8%
6 Months of Claims Runout	HIGH	Any 6+	C: 11.3% (±3.3%, ±5.0%) NC: 12.3% (±2.7%, ±4.1%) Diff: -1.0%	C: 10.4% NC: 10.7% (±2.7%, ±4.1%) Diff: -0.2%	C: 6.7% (±3.1%, ±4.8%) NC: 10.0% (±2.6%, ±4.0%) Diff: -3.3%	C: 6.7% (±3.1%, ±4.7%) NC: 8.9% (±2.5%, ±3.9%) Diff: -2.2%
		All 12	C: 11.7% (±3.3%, ±5.1%) NC: 9.0% (±3.0%, ±4.5%) Diff: +2.7%	C: 11.0% (±3.2%, ±5.0%) NC: 7.3% (±2.8%, ±4.4%) Diff: +3.6%	C: 5.8% (±3.1%, ±4.8%) NC: 10.9% (±2.9%, ±4.4%) Diff: -5.1%	C: 5.5% (±3.0%, ±4.7%) NC: 10.6% (±2.9%, ±4.4%) Diff: -5.1%
		Any 6+	C: 12.5% (±3.2%, ±4.9%) NC: 10.7% (±2.7%, ±4.1%) Diff: +1.8%	C: 11.6% (±3.1%, ±4.8%) NC: 9.2% (±2.7%, ±4.1%) Diff: +2.5%	C: 6.6% (±3.0%, ±4.6%) NC: 10.4% (±2.6%, ±4.0%) Diff: -3.8%	C: 6.3% (±3.0%, ±4.6%) NC: 9.7% (±2.5%, ±3.9%) Diff: -3.4%
		All 12	C: 13.1% (±3.2%, ±5.0%) NC: 6.9% (±3.0%, ±4.5%) Diff: +6.3%	C: 12.3% (±3.2%, ±4.9%) NC: 5.2% (±2.8%, ±4.4%) Diff: +7.0%	C: 5.8% (±3.0%, ±4.6%) NC: 11.5% (±2.9%, ±4.4%) Diff: -5.8%	C: 5.1% (±3.0%, ±4.5%) NC: 11.8% (±2.9%, ±4.4%) Diff: -6.7%

FIG. 3. Baseline (pre-baseline to baseline year) and program period (baseline to program year) chronic and non-chronic trends, 80% and 95% confidence intervals, and mean trend differences, under the 16 selection criteria scenarios.

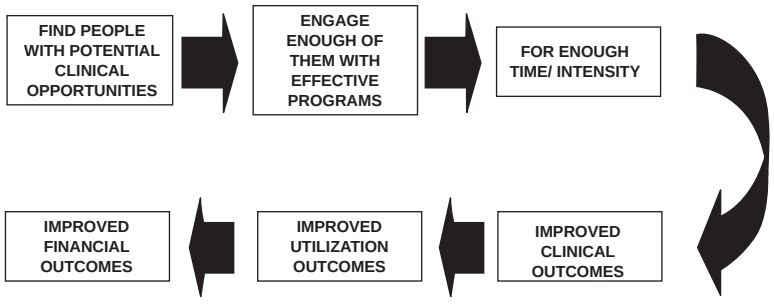

FIG. 4. The outcomes value ("plausibility") chain.

yielding 16 combinations of selection criteria scenarios. We could have expanded our comparison almost endlessly by testing other values of the 4 variables or including additional variables, such as different sets of chronic conditions, alternative methods of condition validation (eg, methods based on rules instead of on point scores), or alternative methods of condition qualification (eg, prospective instead of annual qualification). This may present opportunities for informative future analyses.

Another possible limitation of the study was defining the chronic population according to 23 conditions; it is unknown how the number (and type) of conditions chosen to define the chronic population affects trend. Currently, the DMAA guidelines focus on 5 conditions (coronary artery disease, heart failure, diabetes, asthma, and chronic obstructive pulmonary disease).[14] It is unknown whether using any set of conditions to divide a population into C and NC would yield the same relationship between these groups' trends.

Another limitation is that this is a single study. It would be useful to conduct additional studies of the same 4 variables that we tested using different populations and DM programs. It would be worth learning how frequently the particular combination of values that produced equal baseline period trends in this study lead to equal C and NC trends.

We were limited by not having data earlier than 2 years prior to implementation, and could therefore not test whether C and NC trends were equal in the year prior to the pre-baseline. We therefore cannot propose as a general case that if the trends are found to converge in the baseline in one case, they will do so in other cases. Nor could we test the hypothesis that the baseline trends relationship—whether it is 1-to-1 or some other ratio—would have remained stable during the program period, were it not for the existence of the program. To this point, the actuarial study cited in the introduction[11] is reassuring.

Regarding interpreting CIs, it could be argued that because we compared costs based on *all* qualified-for-measurement members in the population, we were dealing with population measures, not samples, and therefore did not need to calculate CIs or other indicators of statistical significance. On the other hand, one could take the position that cost trends over any given 2-year period represent samples taken from longer trends, or that trends for a population of 300,000 represent samples from a much larger universe of insured individuals. In any case, we presented simply-calculated CIs to highlight the scope of uncertainty in the precision of trend calculation.

One way of interpreting the results of our analysis is to conclude that there is no true answer to the question, "Are cost trends for chronics and non-chronics identical (or do they bear a constant relationship) in the absence of DM?" In fact, one might argue that *there are no "real" trends for Cs and NCs*, because the trends in a SPEM are—to a very great extent—*created* by the selection criteria values chosen in the methodology. While this may be an extreme way of interpreting our results, it emphasizes the need to be transparent about the methods used to measure trends. DM programs should utilize at least 2 and preferably more years of baseline data, so that preintervention trends can be measured.

Notwithstanding the above, we do not consider that the results of this study call into question the actuarial practice of determining and adjusting actual and expected trends *in a whole population*; rather we focus on the impact of dividing a population into C and NC subpopulations.

Transparency in selection criteria for Cs and NCs should be a given. Importantly, "plausibility metrics" such as program participation (volume and intensity) and clinical and utilization outcomes should supplement (and perhaps replace) statements of program savings or "return on investment" ratios (Fig. 4). Ultimately, the value of the single-population evaluation methodology will be best demonstrated by studies that compare this methodology–using clinically realistic variations of selection criteria scenarios–with valid comparison-group outcomes, and with the support of plausibility outcomes. Otherwise, the vendor has the opportunity to "dial-an-ROI" with a SPEM in the most self-serving way.

Disclosures

Drs. Juster and Rosenberg and Ms. Senapati are currently employed at ActiveHealth Management, a firm that provides population health services and clinical decision support. Mr. Shah was employed at ActiveHealth Management at the time of the study.

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Disease Management Study

TECHNOLOGY-DRIVEN INTERACTIVE CARE MANAGEMENT IDENTIFIES AND RESOLVES MORE CLINICAL ISSUES THAN A CLAIMS-BASED ALERTING SYSTEM.

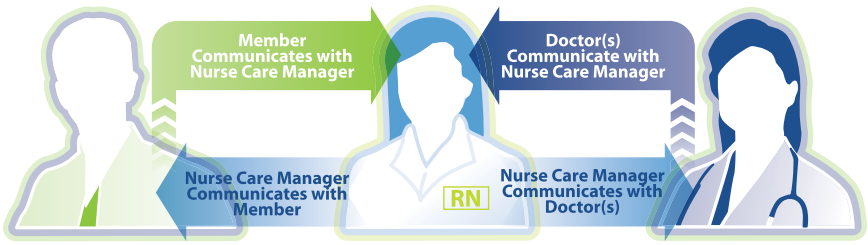
More Proof.

Interactive Care Management Study with members of self-insured health plans proves incremental benefit.

This opt-in program study was conducted by ActiveHealth Management over the first year of the care management program, which covered management of 20 conditions for over 200,000 members of 5 employer-sponsored health-plans. The study was published in ***Disease Management*** in June 2005. The study's focus was the incremental clinical value of a nurse-directed interactive program known as ActiveHealth's Informed Care Management program.

OVERVIEW

While program participants accounted for .65% of the total, they generated 4.82% of the population's claims-based clinical alerts through the CareEngine Clinical Decision Support program. This means program participants had a very high opportunity for clinical, and therefore financial, impact. An ActiveHealth Nurse Care Manager then engaged these participants. An important part of this engagement was to address potential gaps in clinical care uncovered by the alerts, and empower participants' discussions with their physicians.



Member Engagement
Using a customized, clinically driven plan of care, our Nurse Care Managers arm members with information about their conditions to discuss with their physicians.

Physician(s) Engagement
Through communication of useful, clinically-driven Care Considerations, our Nurse Care Managers arm physicians with information that can change their patients' treatment plans.

"This study shows the benefits of adding a nurse-directed interactive program to communicate with both patients and physicians. Most importantly, keeping patients healthy by increasing their rates of resolution."

— Iver A. Juster, M.D.

"Our beliefs were confirmed in this study – Increased nurse/patient interaction leads to proactive behavior by members and increases our rate of clinical issue identification."

— Lonny Reisman, M.D.
CEO, ActiveHealth

METHODOLOGY

The opt-in nurse managed pilot program, including identification and resolution of specific clinical issues, was implemented for 205,463 members of self-insured health plans that utilize the claims-based physician alerting system.

IMPACT ON ENTIRE POPULATION	204,128 Non-Participants	1,335 Participants
CLAIMS-BASED ALERTS	12,714	644
CLAIMS-BASED ALERTS RESOLVED	3,380 (26.6% resolved)	207 (32.14% resolved)
ALERTS BASED IN PARTICIPANT SUPPLIED DATA	None	514
STUDY FINDINGS	Participants and non-participants had same rate of alert resolution in the year prior to ICM implementation.	ICM participants generated an additonal **80%** more alerts per member, based on data they supplied. **20.9%** increase in the rate of successful resolution of claims-based alerts.
RESULTS	**The addition of a nurse-directed Interactive Care Management Program:** • Communicated specific issues to both patients and physicians. • Substantially increased the rate of identification of specific clinical issues compared to those generated by a claims system alone. • Increased the rate of claims-based alert resolution.	

3 WAYS NURSE-INTERACTION CONTRIBUTES TO BETTER RESULTS

1. Better informed and actively participating patients can better accept and adhere to the physician's recommendation.
2. Patients who understand key clinical practice guidelines related to their health conditions, feel empowered to discuss these guidelines with their physician(s). This also serves as a physician reminder.
3. Patients are an important data source, as seen by an 80% increase in alerts in program participants.

Source: Juster, I. "Technology-Driven Interactive Care Management Identifies and Resolves More Clinical Issues than a Claims-Based Alerting System," Disease Management June 2005: 188-197 Volume 8, Number 3, 2005.

ACTIVEHEALTH MANAGEMENT®

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DISEASE MANAGEMENT
Volume 8, Number 3, 2005

Technology-Driven Interactive Care Management Identifies and Resolves More Clinical Issues than a Claims-Based Alerting System

IVER A. JUSTER, M.D.

ABSTRACT

Due to patient or physician factors, people with chronic diseases frequently do not receive evidence-based care. While a physician-directed claims-based alerting system targeting gaps in care was previously shown to increase resolution of specific clinical issues, many apparently relevant issues remained unresolved. The purpose of this research was to demonstrate that adding member interaction with a nurse to a physician alerting system can uncover additional care gaps beyond those identified by a claims, prescription, and lab results-based alerting system, and increase successful resolution of alerts by communicating care gaps to members. An opt-in nurse-managed pilot program focusing on identification and resolution of specific clinical issues was implemented for 205,463 members of self-insured health plans that had been utilizing the claims-based physician alerting system. Specific clinical issues identified by the claims-based system were communicated to both program enrollees and physicians, and new clinical issues were identified based on nurse-directed participant feedback. Participants were encouraged to discuss issues with their physicians. Issue resolution rates were tracked using subsequent claims, pharmacy, and lab data. At 1 year, we studied the rate of new clinical issue identification and compared the program's resolution rate of claims-identifable issues to that of non-enrollees. While program participants accounted for 0.65% of total member-months in the pilot year, they triggered 4.82% (644) of the population's claims-based clinical alerts, and an additional 514 alerts from data based on participant-supplied data—80.8% more than claims/pharmacy/lab-generated alerts. Of the participants' claims-based alerts, 207 (32.1%) showed claims/lab evidence of successful resolution, compared with 3,380 of 12,714 (26.6%) for non-participants, a 20.9% increase in resolutions ($\chi^2 = 9.8$, $p < 0.01$). Care management technology complemented by a nurse-directed interactive program increased the rate of identification of clinical issues compared to claims alerts alone. Use of this program to communicate specific issues to both patients and physicians significantly increased the rate of issue resolution. (Disease Management 2005;8:188–197)

INTRODUCTION

As morbidity and mortality from acute infectious and traumatic diseases declined throughout the 20th century, the industrialized world experienced a rise in the prevalence of many chronic diseases, such as diabetes, coronary artery disease, heart failure, and chronic obstructive pulmonary disease. Much of this increasing prevalence was due to the ageing of

Active Health Management, Inc., New York, New York.

the population, and the influence of multiple lifestyle-associated factors, such as smoking, obesity, and a sedentary lifestyle. In concert with this prevalence rise, the past two decades have seen a multitude of advances in our evidence base for optimum management of many chronic diseases. This management includes primary and secondary prevention as well as optimizing function and the quality of life for individuals with chronic conditions.

Ideally, dissemination of the findings of evidence-based medicine should bring about greater uniformity in clinical practice of performance of these findings. The past 20 years of medical research is replete with well-conducted studies demonstrating meaningful reductions in adverse events related to chronic diseases. For example, beta-blockers[1–6] and angiotensin converting enzyme (ACE) inhibitors[7,8] reduce exacerbations for people with systolic heart failure; screening for diabetic nephropathy (urine albumin) and use of ACE inhibitors in those showing early nephropathy prevents deterioration to overt nephropathy and end-stage renal disease[9–11]; and use of ACE inhibitors in patients with established coronary heart disease or diabetics with risk factors prevents several cardiovascular adverse events.[12]

Despite the wide dissemination of evidence showing how physicians can order specific tests or prescribe (or avoid prescribing) specific medications in their patients with chronic disease, substantial evidence indicates the presence of substantial gaps between what should happen and what does happen.[13,14]

Studies show that it takes many years to adopt clinical practice guidelines into practice. The studies quoted are several years old. Contemporary studies, especially on patients with health insurance, give somewhat better results, but perhaps only because public agencies such as the National Committee on Quality Assurance (NCQA) has been measuring these items annually for a decade—and publicly posting the results.[15] Longitudinal studies of adoption of clinical practice guidelines show the many-year course of innovation diffusion.[16–18]

Studies of the use of medications, other treatments, and monitoring in the ongoing world of the outpatient setting serve as better indicators of the quality of care for chronic diseases than do the rates of such services performed during hospitalizations. Physicians forget to prescribe indicated tests and therapies; patients receive care from multiple sources (and therefore contraindicated therapies can be prescribed, as with calcium channel blockers in heart failure),[19] and patients are sometimes non-adherent to their treatment. A RAND study of 439 indicators of the quality of health care demonstrated that nearly half of services important to optimal outcomes in quality care were not being delivered.[20] Because of the diffuse nature of outpatient care, alert and reminder systems that may be effective in a hospital setting are often unsuited to the outpatient world.

Multiple strategies have been attempted to increase physician and patient adherence to established clinical practice guidelines. Many of these strategies have recognized that people adopt innovations at varying rates. Adopting an innovation (ie, a behavior associated with a practice guideline) is different from acquiring new knowledge. The classic work of Everett Rogers on innovation diffusion theory (showing an S-shape adoption curve from innovators and early adopters through the early majority, late majority, and late adopters or resisters)[21] suggests that physicians will adopt an innovation (such as the findings of a major clinical study or a clinical practice guideline) if the potential adopter judges that the benefits of the innovation outweigh its risks, if it can be tried without disrupting usual workflows, if the physician can watch others using it, if respected "opinion leaders" are using the innovation, and if the innovation can be tried out without involving great commitment.

However, the method of innovation diffusion plays a key role in physicians' adoption as well. Passive information dissemination (brochures, mailings, and continuing education courses) that does not provide patient-specific, clinical scenario-specific feedback has little influence on physician performance, while active participation (eg, workshop groups), use of opinion leaders, and patient-specific guideline alerts showed improvement in measured performance and sometimes in outcomes.[13,22–25] Studies of use of computer-supported decision support systems (such as alerts and reminders at the point of care or shortly thereafter), which

do provide patient- and scenario-specific feedback, showed significant improvements in physician adherence to guidelines.[25,26] Further, systems that alert or remind both physician and patient might be even more effective.[24] While studies show that patient education can be an effective method of implementing practice guidelines,[25,27] the strategy was more likely to be effective if the service specified in the guideline was straightforward and intended to be delivered once (such as a mammogram or glyosylated hemoglobin test) rather than complex, involving individualized decision-making and adherence to a possibly changing treatment regimen over time.[28]

The question remains as to whether for a relatively complex practice guideline, such as use of ACE inhibitors in patients with established cardiovascular disease or diabetes with certain risk factors[12]—especially those where clinical judgment is required and dose adjustment over time may be required—adding patient to already-existing physician engagement improves guideline adherence for specified chronic diseases.

We therefore undertook to study the addition of patient engagement in specific clinical circumstances to an established physician-directed alerting system that had previously shown (in a randomized study) improved adherence to practice guidelines.[29]

MATERIALS AND METHODS

In January 2003, an interactive, patient-focused chronic disease care management program was added to an existing care management program of five large corporations' employees and their dependents. The health care of these approximately 200,000 insured had been under surveillance of an alerting system (The CareEngine System[SM], Active Health Management, Inc., New York) for the previous three years. This system consisted of evaluation of medical, surgical, and pharmacy claims, as well as laboratory test results, by algorithmic case-finding software.

Examples of alerts included recommendations to start a beta-blocker in patients with heart failure; to stop Viagra in patients taking nitrates; to start a statin in patients age 40–80 with cardiovascular diseases; or to perform urinary screening for diabetic nephropathy. An alert would not be issued in the presence of a clinically compelling exception (such as COPD for beta-blockers).

The operation of this algorithmic system for an alert based on the Heart Protection Study (which showed that patients with cardiovascular disease age 40–80 benefit from statin therapy regardless of LDL-cholesterol level) is illustrated in Figure 1. New claims for health care services trigger the system to look over historical claims against a set of clinical rules that include clinically important exceptions, and to issue a provisional recommendation that is then subjected to human or automated clinician review. Cases that pass review become alerts ("care considerations") sent to the treating physician telephonically, by fax, or by mail. The alerts are worded in such a way as to recognize that the claims system may not have all relevant information about a patient, and include key supporting literature citations such as major clinical trials, national-level clinical practice guideline statements, or FDA "black box" warnings.

A previous randomized study[29] showed that issuing care considerations only to physicians in this manner significantly increased the likelihood of subsequent resolution (eg, that an ACE inhibitor would be prescribed, or that a calcium channel blocker would be discontinued, for a heart failure patient). Such alerts could be considered active interventions because they were specific to a single patient and clinical scenario, and by their nature invited interaction (such as pulling the chart or talking with the patient).

In 2003, the patient-engagement process was added under the theory that discussing the alert and it's meaning with the patient, as well as advising the patient (after determining that the alert remained valid) to discuss its subject with their physician, would improve the likelihood of successful resolution. In addition, we recognized that talking with the patient would trigger additional alerts due to more complete collection and surfacing of disease-related issues.

Accordingly, after allowing 2 weeks following notification of the physician of the poten-

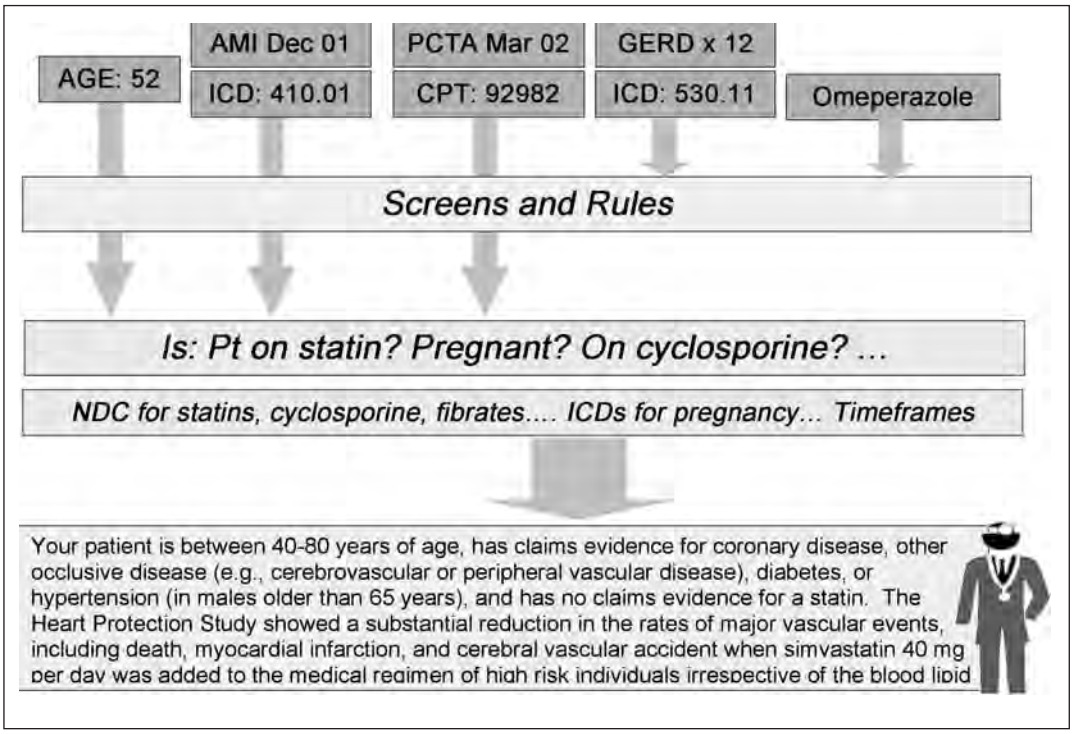

FIG. 1. How the alerting system works (physician communication portion). Example of the alerting system taken from the Heart Protection Study, which recommends statins in patients age 40–80 with a history of coronary artery disease. Data from claims (or enrollee report) are fed into a clinical rules-based algorithmic software engine. If the member's data indicates a fit to the pattern for the clinical practice guideline, the indicated treatment (a statin) is checked for. If the treatment is not present, the system checks for contraindications. If no contraindications are found, an alert (bottom box) is issued to the physician and after an appropriate interval (and in patient-friendly language), to the member as well. Since the presence of GERD is not material to this alert, claims for GERD are ignored. ICD, International Classification of Diseases (version 9); PCTA, percutaneous transluminal (coronary artery) angioplasty; CPT, Common Procedural Terminology (verison 4); NDC, National Drug Code; GERD, gastroesophageal reflux disease.

tial gap in care, the patient was contacted and the care consideration discussed. (The physician alert mentioned the possibility that their patient might be contacted and the physician could request that we not contact their patient.) Claims were reviewed prior to patient contact to determine whether (from the claims perspective) the alert remained current. We later examined claims to determine whether the care consideration had successfully resolved.

Discussing an already generated care alert with a participant in "patient-friendly language" is straightforward, but how the care management program generated additional alerts may be understood through an example; see Appendix.

Care considerations recommending doing a test or starting a drug were counted as successful if the claims and test results system showed the presence of the specified test or drug 0–270 days following the delivery of the care consideration. Care considerations recommending that a drug be stopped were counted as successful if the claims and test results system showed the absence of a filled prescription for a drug in that class 60–150 days following delivery of the care consideration.

Following the first year of the program, we studied the extent to which the program identified new clinical issues and also compared the program's resolution rate of claims-identified issues to that of non-enrollees, and to the pre-program results.

RESULTS

The Informed Care Management program began inviting health plan members to opt-in in mid-January and enrollees first interacted

with nurses in late January. Because the five participating health plans had staggered start points through April, results are calculated using member-years of active participation during 2003. For each month, each health plan member was designated as being a program enrollee or non-enrollee.

In the first 12 program months, there were 205,463 health plan member-years and 1336 member-years of active participation (enrollee-years)—0.7 enrollee-years per 100 member-years overall. However, because of rapid ramp-up during the second half of the year, the program had enrolled 2,936 members by year's end. Enrollees were older (57.9 versus 34.8 years) and more likely to be female (57.0% versus 51.4%) compared to non-enrollees.

Evaluating the urgent clinical alerts, enrollees accounted for 644 of the 13,358 (4.82%) claims/lab-based alerts issued during the year. The claims/lab-based alert rate was 48.2 per 100 enrollee-years and 6.23 for non-enrollees, reflecting enrollees having been drawn from a group considered to have significant (and often multiple) chronic conditions. Table 1 summarizes the demographics, and Table 2 the alert status for enrollees and non-enrollees.

For claims/lab-based urgent alerts, the resolution rate (as of December 31, 2003) was 3,380 of 12,714 (26.6%) for non-enrollees and 205 of 636 (32.3%) for enrollees, representing a 21.2% increase for enrollees ($\chi^2 = 9.836, p < 0.01$). The non-enrollee resolution rate is in line with rates for the same clients in years prior to the Informed Care Management program.

There were 514 enrollee report-based urgent alerts during the program year, of which 136 (26.5%) were noted as resolved by December 31, 2003. Thus, enrollee report-based alerts represented an increase of 80.8% in the volume of alerts for this group.

The distribution of alerts by clinical severity/urgency level, and examples, is shown in Table 3. Approximately 81% of alerts involved important, but not highly urgent, clinical issues such as lack of secondary screening in chronic disease, moderate drug/disease contraindications, or omissions of probably appropriate care for people with specific chronic diseases. Two percent involved extremely urgent potential gaps in care, and 17% involved lack of primary prevention, early detection, or disease or drug monitoring activities.

DISCUSSION

Many studies—and popular media—have documented disturbing deviations from evidence-based health care. Despite an explosion of nationally-promoted clinical practice guidelines based on well-conducted clinical trials and meta-analyses, physician adherence to these guidelines remains low, and diffusion of clinical evidence and best practices can take years.[30,31]

Studies of physician awareness, adoption, and adherence to clinical practice guidelines have shown that simple knowledge dissemination may increase awareness but fails to improve adherence to guidelines and evidence-based medicine in clinical practice.[25,32] Yet a course in evidence-based medicine, in which physicians learned to actively participate in evaluating clinical evidence and its meaning for their practices, improved both knowledge

Table 1. Distribution of Enrollees and Non-Enrollees by Demographics

Group	*Member-years (% of total)*	*Mean age (years)*	*Percent female*
All plan members	205,463 (100%)	35.1	51.5%
Non-enrollees	204,127 (99.3%)	34.8	51.4%
Enrollees	1,336 (0.7%)	57.9	57.0%

Member-years indicates the number of member-months (divided by 12) spent by health plan members in enrollee or non-enrollee status. A health plan member may occupy either (or both) status during the year.

Table 2. Urgent Clinical Alerts Issued to, and Resolved, for Enrollees and Non-Enrollees

	Claims-based alerts		*Enrollee report-based alerts*	
Group	n *(% of total)*	*Resolved (%)*	n	*Resolved (rate)*
All plan members	13,358 (100)	3,587 (26.85)		
Non-enrollees	12,714 (95.18)	3,380 (26.58)		
Enrollees	644 (4.76)	207 (32.14)	514	136 (26.5)

Chi-square = 9.836 ($p < 0.01$).

and outcomes, possibly because it stimulated greater "evidence vigilance."[33] Many studies have shown that active participation by the physician, as well as use of decision support systems (especially if computerized), can meaningfully increase the likelihood that a physician will take the action (when appropriate) in the guideline. This points up the difference between knowledge and innovation diffusion; the latter is required to step from awareness to practice.

Even with effective use of methods of knowledge and innovation diffusion, our state of clinical knowledge is constantly shifting. A study performed by the Agency for Healthcare Research and Quality showed that three quarters of guidelines currently promoted at the national (federal or medical society) level already were out of date.[34] By the time new knowledge has diffused and been incorporated into clinical practice, it is likely to have been superceded by knowledge that could lead to better outcomes. This highlights the urgent need for effective clinical knowledge diffusion systems.

Some studies have highlighted the importance of the patient in adherence to best clinical practices. This patient contribution can occur in three ways. First, the informed and actively participating patient can better accept and adhere to the physician's recommendation. Second, the patient who understands key clinical practice guidelines relevant to his or her

Table 3. Distribution of Alerts by Type among Program Enrollees

	Examples	n *(% of total)*	*Percent resolved*
Extremely urgent	Metformin/heart failure	31 (2.2)	60.0%
	Overlapping sildenafil + nitrates		
	Class 1 C antiarrhythmic in structural heart disease		
	Cilostazol/heart failure		
Clinically important, urgent, such as secondary prevention	Cardiovascular candidate for ACEI	1127 (80.9)	31.6%
	Cardiovascular disease or diabetic/no statin		
	Diabetic with microalbuminaria/no ACEI		
	CAD or diabetes/no ASA (enrollee)		
Prevention, early detection, and monitoring	Monitor LFTs in statin use	235 (16.9)	19.7%
	Monitor CBCs with azulfidine		
	Diabetic/no retinal exam		
	No mammographic screening		

All alerts may be triggered by claims and/or enrollee-supplied information.
ACEI, Angiotensin converting enzyme inhibitor; CAD, coronary artery disease; ASA, aspirin; CBC, complete blood count; LFT, liver function tests.

condition and who feels empowered to discuss these guidelines with his or her physician can serve as a sort of physician reminder. Third, as shown by the 80% increase in alerts in program participants, the patient serves as an important data source.

It is not enough for disease management systems to promote carrying out the physician's directives. It is even more important to help ensure that the physician's recommendation is based on current best evidence. Previous studies also have demonstrated that adding patient education about specific, guideline-based disease treatment components increased the likelihood that a practice guideline would be implemented.[13,24,35,36]

Disease management programs, which engage the patient as an active participant in achieving important process and outcomes goals, have shown improvement in clinical processes and outcomes,[37,38] and some have demonstrated improvements in disease-related utilization and cost outcomes.[39] However, disease management programs have usually been studied as a whole—involving not only patient education about clinical practice guideline components, but behavior change, coordination of care, and general disease education. The contribution of each of these components to outcomes improvement is not known.

We hypothesized that much of disease management's potential to improve disease management processes and outcomes could be related to the implementation of specific, evidence-based clinical practice guidelines for individuals whose care appeared to fall short of the guideline. These guidelines are based on medical evidence demonstrating reduction in adverse events related to specific clinical activities, such as using beta-blockers in heart failure when not contraindicated. However, even though in a previous randomized study we had shown statistically significant improvement in adherence to specific guidelines with a physician-engagement alerting system, we believed that engaging the patient, via communicating the alert and discussing its meaning, and recommending discussion with the physician, would further improve resolution of the alerts as shown in claims data, and thus expand the value of disease management. In addition, we regarded the patient-engagement portion of the system as supporting the adoption of innovation (behavior)—helping bring physician awareness of new knowledge into daily practice.

In the first year of an opt-in pilot patient-engagement program called Informed Care Management, we engaged 1,336 of 205,463 members member-years and approximately 3,000 members overall by the year's end. Alerts for which all triggering information was derived from claims showed a 20.9% relative increase in likelihood of successful resolution among enrollees compared with non-enrollees. In addition, talking directly with the enrollee generated an increase of 80.8% in alert volume over claims/lab-based alerts.

The major limitation of the study was a potential for volunteer bias, in which those who "opted-in" (enrolled) may have a different propensity to resolve clinical issues than those who do not enroll. To explore this possibility, we compared the baseline year alert resolution rate in the study year enrollee cohort versus that in the study year non-enrollee cohort. A significant difference in resolution between these groups would suggest a greater propensity for one group to resolve clinical issues. As shown in Table 4, the baseline year resolution rate of the non-enrollee cohort was 30.2% versus 31.6% in the enrollee cohort—a nonsignificant difference. This suggests that volunteer bias did not play a role in the resolution rate difference observed during the study year.

We conclude that the program's first year strongly suggested that communicating directly with patients about gaps in specific services impacting their care increases the likelihood that the gaps will be resolved, and that gathering condition-related information from

Table 4. Comparison of Alerts Resolutions of Enrollees in the Study and Baseline Year

	Enrollees	*Non-enrollees*	*Difference*	*Significance*
2003	32.1%	26.6%	20.7%	<0.01
2002	31.6%	30.2%	4.4%	NS

The study year was 2003; the baseline year was 2002. NS, non-significant ($p > 0.05$).

program enrollees dramatically increases the generation of clinical alerts.

Consistent with the program's nature as a pilot effort, the current study needs to be extended and certain potential biases addressed. Because the program was opt-in, the increased resolution rate of claims-based alerts in the enrollee group may be due to volunteer bias. A control group would be needed to determine whether this was the case. The 32.1% overall alert resolution has room for improvement. In 2003, alerts were communicated only once; in 2004, alerts will be followed up to check for resolution or to discuss further action with enrollees. This would be expected to further increase resolutions or weed out false-positive alerts. In 2004, the Informed Care Management program will be extended to a greater proportion of health plan members and alert issuance and resolution rates will be evaluated in the population segmented by degree of engagement.

Finally, while the medical literature says that successful resolution of clinical alerts should lead to a reduction in adverse events, this study focused only on the rates of alert resolution and the generation of new alerts arising from talking with enrollees. To evaluate the effect of a program of patient engagement on adverse event outcomes awaits a study with larger enrollment and adequate study power.

CONCLUSION

The addition of a nurse-directed interactive care management program substantially increased the rate of identification of specific clinical issues (alerts) compared to those generated by a claims system alone. In addition, the use of the program to communicate specific issues to both patients and physicians increased the rate of alert resolution. Adding patient engagement increases the likelihood of adherence to clinical practice guidelines.

APPENDIX: PATIENT ENGAGEMENT CASE SCENARIO

X is a 60-year-old male smoker whose claims show diabetes, but no history of hypertension or coronary, cerebral, or peripheral vascular disease. His medications (claims) include Metformin and a diuretic but with no explanatory ICD codes. His claims show a HbA1C, eye exam, and urine for albumin performed in the appropriate timeframe. Under the physician alerting system, X would not have received any alerts related to his diabetes. However, he also had claims for COPD and was found to have had ER visits for COPD but was not taking a long-acting beta agonist or other controller medication.

Due to scoring on the case-finding system, X was invited to the care management program and accepted. He told the nurse that he didn't know why the diuretic had been prescribed, and that he was a smoker. In addition to interactions related to lifestyle factors and his COPD, as well as reminders to continue to have periodic monitoring for his conditions, an alert was generated recommending consideration be given to treatment with an ACE inhibitor, as the diabetic arm of the HOPE Trial demonstrated that diabetics with additional risk factors—including smoking—benefited from treatment.

In addition, X was not taking aspirin, as recommended by the U.S. Preventive Services Task Force, and had no contra-indications; thus an alert was generated recommending consideration of low-dose preventive aspirin therapy.[40]

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Impact Of Decreasing Copayments On Medication Adherence Within A Disease Management Environment

Value-based cost sharing can increase patients' adherence to important medications.

by Michael E. Chernew, Mayur R. Shah, Arnold Wegh, Stephen N. Rosenberg, Iver A. Juster, Allison B. Rosen, Michael C. Sokol, Kristina Yu-Isenberg, and A. Mark Fendrick

ABSTRACT: This paper estimates the effects of a large employer's value-based insurance initiative designed to improve adherence to recommended treatment regimens. The intervention reduced copayments for five chronic medication classes in the context of a disease management (DM) program. Compared to a control employer that used the same DM program, adherence to medications in the value-based intervention increased for four of five medication classes, reducing nonadherence by 7–14 percent. The results demonstrate the potential for copayment reductions for highly valued services to increase medication adherence above the effects of existing DM programs. [*Health Affairs* 27, no. 1 (2008): 103–112; 10.1377/hlthaff.27.1.103]

In 2002 Pitney Bowes reduced copayment rates for several classes of prescription drugs that are important in the treatment of chronic disease. This intervention represents an early example of a Value-Based Insurance Design (VBID) because it connects patients' cost sharing to the value of health care services.[1] This initiative received considerable attention in the employer and policy communities.[2] Although Pitney Bowes reported favorable clinical results and cost

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savings, the analysis was conducted without an external control, and it is unclear whether or not the experience is replicable in other settings.[3]

In this paper we evaluate a similar VBID initiative undertaken by a different employer. In addition to providing insight regarding the generalizability of the Pitney Bowes results, we make two contributions to the literature on the effects of copayments on utilization. First, the body of evidence on the effects of raising copays does not take into account other concurrently implemented interventions that could have either a direct or an indirect effect on medication adherence. For example, many employers and health plans have adopted disease management (DM) programs designed to improve patients' compliance with recommended treatments.[4] The presence of these programs, which are typically unobserved in copay studies, may confound existing studies if adoption of DM is related to copay changes. Relative to other literature that examines copay rate changes, the presence of a common DM program across treatment and control firms in this study allows us to better control the information environment.

We cannot predict how DM will affect the impact of copay changes because DM programs influence which patients are not complying with treatment regimens at baseline and because DM programs change patients' awareness, which could influence their response to copays. Moreover, because we do not observe the prevalence of DM in other studies of copay effects, we cannot ascertain how controlling for DM will influence findings. Nevertheless, given the popularity of these programs and their potential to confound the results from other copay studies, it is important to assess the responsiveness of adherence to copay changes, controlling for the presence of DM programs.

A second contribution of this work is to examine the effects of copayment rates in a setting in which copays are reduced, as opposed to increased. The literature examining the effects of copay changes on utilization is very large and has been summarized elsewhere.[5] Most of the literature either compares adherence across firms with different copay rates or examines the effects of copay increases. However, because of concerns about the adverse clinical effects of high copayment rates, several large employers have reduced these rates for selected high-value services, and there has been limited evaluation of these copay declines.[6]

There are several reasons why we might expect the impact of copay-lowering schemes to differ from copay-raising initiatives. Specifically, with the latter, employees are losing something by being forced to pay more. With the former, they are being given something (lower copays). Although neoclassical economics might suggest similar but opposite effects associated with increases versus decreases in copay rates, considerable research in behavioral economics suggests that the results might not be symmetrical because of employee anchor points and, perhaps, endowment effects.[7]

Study Data And Methods

■ **The intervention.** In January 2005, a large employer reduced copayment rates for five classes of medication: angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), beta-blockers, diabetes medications (including oral therapies and insulin), HMG-CoA reductase inhibitors (statins), and inhaled corticosteroids (steroids).[8] Copayment rates for generic medications were reduced from $5 to zero. Copays for brand-name drugs were lowered 50 percent (from $25 to $12.50 for preferred drugs and from $45 to $22.50 for nonpreferred drugs).

The intervention was implemented by ActiveHealth Management (AHM), an integrated care management company. The program was added to an already existing accredited DM program used by both the treatment and control firms. The DM program was a comprehensive, telephonic, and nurse-staffed program. This is a fairly typical telephonic DM program, except for its broad scope—covering thirty-two clinical conditions—and its linkage to a system of clinical alerts, in which medical, drug, and lab claims; lab results; and a large electronic database of clinical recommendations from the medical literature are used to identify opportunities to improve clinical care. Although all eligible employees and dependents have access to the program, participation is voluntary. Participation rates in the DM program were similar in both the treatment and control firms, both before and after the intervention. All employees and dependents were covered by the clinical alert system, without an option to "opt out."

When the clinical data provided an indication (or contraindication) for (or against) the use of a specific test or medication, the physician and patient were notified. This "clinical alerting" program was run for the employer's entire insured population several times a month. Physicians were notified of potential clinical improvement opportunities via telephone, fax, or mail as appropriate to the urgency of the clinical alert; members were notified by telephone and mail if enrolled in the DM program or by mail alone if not enrolled. To permit physicians to respond first to any clinical alerts, member notification was lagged by two weeks.

All patients in the treatment firm who were already taking any of the intervention medications without a contraindication were eligible for the copay reduction, beginning with their next prescription fill. Copay relief was also available for those who were not taking the medication if they were identified by the clinical alert system as patients who would benefit from the medication. The list of eligible patients was compiled by AHM and transmitted to the pharmacy benefit manager (PBM), which facilitated the reduced copayments at the point of service. Eligible people received a letter explaining the importance of taking the recommended drug therapy class and an appended intervention letter notifying them of the copay reduction program.

■ **Analytic strategy.** We used a quasi-experimental, pre-post study design with a control group (difference-in-difference design), using data for a year before and a year after the copayment change for the intervention employer and for a second large

employer that used the same DM program but did not adjust copayments.[9]

For each eligible employee and dependent, adherence to the relevant medication for each quarter was ascertained. Thus, our unit of observation was the patient-quarter, yielding a maximum of eight observations per patient over the two-year study period. The results were not sensitive to the different specifications, so we present results using linear regression models, estimated separately by drug class.

■ **Sample.** Employees and dependents ages 18–64 who were continuously enrolled for the relevant quarter and the entire previous quarter were eligible for the study. The control group was determined using these same selection criteria. People age sixty-five or older were excluded because their medical claims data from Medicare were incomplete.

The study was divided into two periods (pre- and postintervention). People were entered into the sample each year using an identical sampling process. Specifically, for each drug class, people were selected for the sample in a given year if they used a medication within three months of the start of the study year and did not have a contraindication to its use, or if they were identified by AHM as having a clinical indication for the medication's use but did not receive it in the previous six months. People could be included in multiple drug class samples and could enter the study at any point during either study year (pre or post), as long as they qualified for a drug class sample as described above.

This approach maintains comparability between the pre and post samples because the exact same rules were used to construct both samples. Because we did not have a full year of data for 2003 (the year before the "pre" year), we did not use the full year of data in 2004 to construct the "post" (2005) sample.

Because of the comparability of sample construction between the pre and post years and between the control and treatment firms, any flaws in sample construction should be controlled for by our difference-in-difference study design, minimizing selection bias. Results are robust to the use of a sample limited to continuously enrolled beneficiaries.[10]

■ **Variables.** *Adherence.* Our measure of adherence is based on the Medication Possession Ratio (MPR), defined as the number of eligible days in the quarter the person was in possession of the medication divided by the number of days in the quarter.[11] If patients were on multiple medications in different categories within the same class (for example, an ACE inhibitor and an ARB, or two different medications to treat hyperglycemia), the patient was assumed to be taking the medications concurrently. We made the conservative assumption that a patient was noncompliant only if he or she had no medication available in the category (neither an ACE inhibitor nor an ARB). We also estimated separate logistic regression models that used MPR 80 percent or MPR Î percent as dependent variables, which are commonly used thresholds to distinguish between adherent and nonadherent groups.[12]

Explanatory variables. The primary explanatory variables were binary variables

denoting the following: employment in the treatment firm, observation post-implementation, and an interaction of these two variables. The estimated effects are based on the coefficient on the interaction term.

We used a range of demographic variables to adjust for population differences, but, given the research design, we would not expect inclusion of these covariates to affect the results. They included age; sex; previous use of the medication (if the drug in the class was filled within six months prior to the first quarter of the year); duration, defined as the number of quarters that the subject was eligible for the study (reset to 1 at the first quarter of the post period); and comorbidities, measured by a series of indicator variables measuring whether the subject had one of several diseases related to the class of medications (as identified in the claims data).[13]

Models that included interactions between duration and the binary variables measuring coverage by the treatment firm and observation in the post year were also estimated to test whether the effects changed over the year. All analyses were adjusted for multiple observations on the same person using generalized estimating equations.

Study Results

■ **Subjects.** There were several statistically significant differences between the employees at the intervention and control firms. Intervention-firm employees were, on average, about six years younger and slightly more likely to be female (Exhibit 1). Moreover, the subjects insured by the intervention firm were more likely to be employees than dependents.

■ **Impact of copayments on medication adherence.** In 2004, before the intervention, both the control and treatment firms had similar copayment rates for brand-name drugs ($29.72 versus $28.55). For generic medications, copayment rates were higher in the control firm than in the treatment firm in 2004 ($16.22 versus $5). Between 2004 and 2005, copays for targeted drugs in the control employer rose about $1 per prescription for brand-name drugs (about 4 percent), while copays

EXHIBIT 1
Demographic Comparison Of Intervention And Control Employers In Study Of A Disease Management Intervention, 2004 And 2005

	Year	No. of members[a]	Age (years)	Percent female	Percent employee	Percent spouse	Percent child
Intervention firm	2004	35,807	37.4	53.5	73.0	21.4	5.6
Control firm	2004	74,345	43.9	51.2	65.6	29.4	5.0
Intervention firm	2005	37,867	38.0	53.5	72.2	21.5	6.3
Control firm	2005	70,259	44.7	51.2	65.7	29.1	5.2

SOURCE: Authors' tabulations of administrative data.

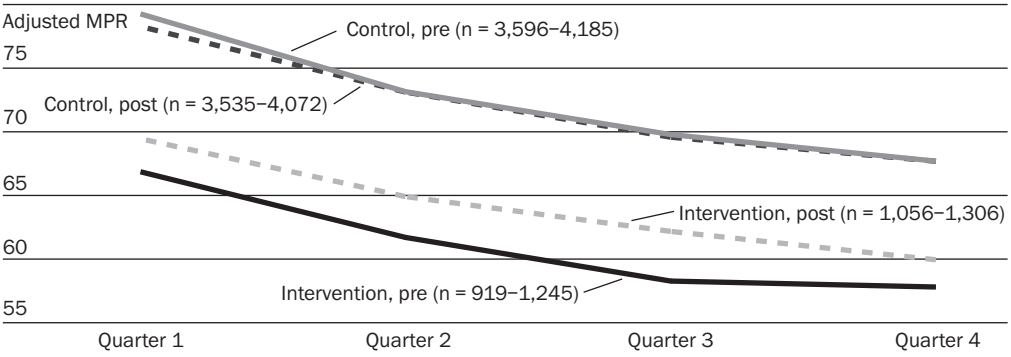
[a] Average per quarter, adjusted for enrollment or disenrollment.

in the intervention firm fell 29.9 percent over this period. This is less than the full 50 percent reduction for several reasons. First, initial prescriptions were filled at the higher copay rate for patients not yet identified as needing the medication. Second, any delay in transferring information to the pharmacy could result in prescriptions' being filled at the higher copay rate. Finally, in cases in which the prescription cost was lower than the copay rate, the reduction might not be 50 percent. The effects for generic drugs were similar in magnitude. In particular, copayments for targeted generic drugs in the control firm dropped about twenty-one cents per prescription (less than 1 percent), while they dropped about 70 percent (more than $3) for the intervention firm. Weighted average copay rates (brand and generic) fell in the intervention firm by 33.9 percent compared to a 2 percent increase in the control firm.

The unadjusted data on adherence for diabetes medications illustrate the effect of the intervention on adherence (Exhibit 2). The declining slope within the year reflects the system of qualifying subjects for the sample, which included everyone taking the medication within three months prior to the beginning of the year. However, because the sample selection criteria were identical for the intervention and control firms, this pattern is common to both firms. Relative to adherence patterns in control firms, there was a clear increase in adherence in the intervention firm. Results were similar for beta-blockers and ACE inhibitors/ARBs (data not shown). The unadjusted data are more difficult to interpret for statins and suggest no effect for inhaled corticosteroids.

The econometric models based on these data support the conclusions from the raw data (Exhibit 3). Specifically, there is a clear positive effect of the intervention on adherence to diabetic agents, beta-blockers, and ACE inhibitors/ARBs. The effect for statins is also positive and statistically significant. Multivariate analyses suggest a small positive result for inhaled corticosteroids, but this is not statistically significant.

EXHIBIT 2
Adjusted Medication Possession Ratio (MPR) For Diabetic Therapy, In The Pre And Post Periods, For Intervention And Control Groups, Calendar Years 2004 And 2005



SOURCE: Authors' multivariate analysis of administrative data.
NOTE: Pre period is calendar year 2004; post period is calendar year 2005.

EXHIBIT 3
Effect Size For Medication Possession Ratio (MPR)

Drug category	Effect size (percent MPR points)	Baseline MPR	Percent increase	Take-up percentage	Elasticity
ACE inhibitors/ARBs	2.59****	68.37	3.79	8.20	−0.118
Beta-blockers	3.02****	68.30	4.43	9.54	−0.112
Diabetes drugs	4.02****	69.46	5.79	13.16	−0.136
Statins	3.39****	52.99	6.28	7.08	−0.182
Steroids	1.86[a]	31.56	5.88	2.71	−0.202

SOURCE: Authors' multivariate analysis of administrative data.

NOTES: Percent increase is the percentage-point increase divided by base adherence. Take-up percentage is the percentage-point increase divided by nonadherence percentage (for example, 1 − base adherence). Elasticity is the percentage increase/percentage change in copays for each drug class. ACE is angiotensin-converting enzyme. ARB is angiotensin-receptor blocker.

[a] $p = 0.134$

****$p < 0.001$

The magnitude of the findings (Exhibit 3) demonstrates an increase in adherence ranging from 1.86 percentage points ($p = 0.134$) for inhaled corticosteroids to approximately four percentage points for diabetes medications ($p < 0.001$). This represents a 7–14 percent reduction in nonadherence for the four classes where a statistically significant effect was found. The implied elasticities for the drug classes that yielded statistically significant results were −0.11 to −0.20. These elasticities are comparable to those reported in the literature, which suggests an elasticity of demand for chronic disease medications ranging from −0.1 to −0.4, with recent studies reporting results in the range of about −0.1 to −0.25.[14]

It is difficult to assess whether the effects of copay reduction changed over time. To examine this issue, we estimated an expanded model, which allowed the effect to change over time by adding a quarter variable that captures the trend over the year, and an interaction between this variable and the postvariable to allow the trend over the year to vary in the post period. This was interacted with a dummy for the treatment firm, thereby allowing the change in trend between the pre and post periods to vary for the treatment and control firms. The models suggest that these adherence effects of the intervention were increasing over time for ACE inhibitors/ARBs ($p < 0.001$) and diabetes medications ($p < 0.10$). The slope result for statins was consistent with this finding but not statistically significant. The analogous results for beta-blockers and steroids were sensitive to the specification of a linear or logarithmic time trend but were never statistically significant. The logistic models estimating adherence and nonadherence, using MPR thresholds of 80 percent and 20 percent, respectively, confirmed our findings of improved adherence as a result of the intervention.

Discussion

Given the widespread use of DM programs, it is important to understand how copayment changes affect adherence within a DM environment. This is the first study on copay changes that holds access to DM constant for both treatment and control firms. Moreover, in contrast to much of the existing literature on copayment effects, our methods control for secular trends and for employer fixed effects. This study is also among the first to address the effects of a value-based copay reduction, such as that implemented by Pitney Bowes, and thus adds to our understanding of the impact of copayment reductions.

We found that reductions in drug copayments increased medication adherence. The magnitude of the adherence-improving effect with copay reduction is similar to those estimated in the existing literature for increases in copayment rates.[15] The similarity between our results and the literature could indicate that DM does not affect price responsiveness much, or it could reflect widespread use of DM in the firms whose data were used in other studies. Our analysis suggests that the adherence effects may increase over time for some clinical areas, but with only one year of postintervention data, this conclusion is tentative.

Consistent with the published literature, we observed differences in effect across medication classes.[16] Most notably, we did not observe a statistically significant effect for inhaled corticosteroids. We believe that this reflects the difficulty in measuring adherence for these medications, since there are multiple doses in a single inhaler as opposed to the other medications that allow individual doses to be counted.

This analysis has several other limitations. Most notably, the control group, although facing similar copayments, had higher adherence throughout the study period. This could be attributable in part to demographic differences, but we believe that those differences were not large enough to explain the difference in baseline adherence. We consider it more likely that the difference reflects differences in the attributes of the physicians or preferences of the two patient groups. To the extent that those differences are time invariant, our analysis controls for them. Although this limitation is important, it is shared by much of the literature in this area. For example, studies that rely only on cross-sectional variation in copayment rates do not control for any employer-specific unobservables that may affect adherence. Moreover, some studies that use longitudinal data do not control for unobserved differences across employers. Others that do control for unobserved traits use employer fixed effects, which is analogous to our approach in that the fixed effects control for time-invariant differences across employers, but not differences in trends across employers.

Our results would be biased if existing trends, as opposed to the intervention, could account for the increase in adherence in the treatment firm. We were not able to recreate the exactly analogous database for the entire year prior to the pre period; however, analysis of available data for the period 2003–04 (prior to the in-

"Reform proposals must include safeguards against unwanted clinical effects resulting from misaligned financial incentives."

tervention) did not reveal any consistent trend in adherence in the treatment firm, which suggests that the bias associated with existing trends was likely small.

Another limitation is that the implementation lag partially dampened the reduction in copays. However, this would tend to bias our findings against an effect on adherence, which suggests that the magnitude of our elasticity estimates could be conservative.

Finally, the full clinical and financial consequences are difficult to assess because health gains and financial offsets associated with better adherence may accrue over time. Because clinical evidence supports adherence to these medications, we expect health improvements, although we do not quantify them in this study. Moreover, although existing reports in the press suggest substantial short-term savings associated with this type of value-based insurance program, we have not assessed the financial effects of this initiative. We expect that there will be some savings in nondrug spending associated with improved adherence, and there might be gains in worker productivity or reduced absenteeism or disability. Although a detailed examination of these issues was beyond the scope of this study, estimates based on crude assumptions about effectiveness of these medications on adverse events suggests that adherence results of the magnitude reported here could generate offsets equal to the costs of the additional prescriptions filled.

As health care cost pressures mount, the prevailing cost containment approaches increasingly shift costs to patients. The evidence is strong, however, that increased cost sharing leads to decreased adherence to potentially life-saving medications, with likely serious deleterious health effects. These adverse health outcomes can be mitigated if cost-sharing provisions are explicitly designed with value in mind. This analysis demonstrates that such value-based insurance design programs can effectively increase adherence to important medications and complement existing DM programs. As policymakers consider future quality and cost containment initiatives, it is important that health benefit reform proposals include safeguards against unwanted clinical effects resulting from misaligned financial incentives.

Earlier versions of this paper were presented at the Value-Based Insurance Design Conference in Ann Arbor, Michigan, 1 May 2007; and at the American Economic Association conference in Chicago, 8 January 2007. Michael Chernew and Mark Fendrick provide consulting services to Hewitt Associates LLC related to Value-Based Insurance Design. Allison Rosen is clinical director, Center for Value-Based Insurance Design. This study was funded by support from GlaxoSmithKline and Pfizer Inc. The authors thank David Ridley for his helpful comments.

NOTES

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8. We used four classes of diabetes medications: biguanides, insulin, sulfonylureas, and thiazolidinediones.
9. J. Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84, no. 3 (1994): 622–641.
10. For complete details, see Appendix 1, online at http://content.healthaffairs.org/cgi/content/full/27/1/103/DC1.
11. Days' supplies for all medication classes were based on the data on the prescription. Several adjustments/assumptions were made: Days in the hospital were treated as fully compliant and not assumed to reduce medication possession. Days' supply covered by refill prescriptions were added to the existing days' supply if the refill was for the same product or dose. It was assumed that patients who were filling a prescription for a substitute product would discard their existing supply.
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13. The set of disease controls varied by drug class. They include the following: for angiotensin-converting enzyme (ACE) inhibitors/angiotensin-receptor blockers (ARBs), coronary artery disease (CAD), congestive heart failure (CHF), chronic kidney disease (CKD), hypertension (HTN), and DM; for beta-blockers, CAD and CHF; for statins, CAD, CHF, cardiovascular disease (CVD), and diabetes mellitus; for steroids, asthma; and for diabetic agents, diabetes.
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16. Goldman et al., "Pharmacy Benefits."

Disease Management NEWS
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January 28, 2008

Noncompliance reduced by 7%–14%

Study: Copayment decrease improves adherence

Decreasing medication copayments improves adherence to treatment regimens within a disease management (DM) environment and therefore can complement DM, a study published this month shows.

The study, from New York City–based ActiveHealth Management, showed a significant reduction in noncompliance—between 7% and 14%—with four of the five drug classes studied—ACE inhibitors/angiotensin receptor blockers (ARB), beta-blockers, diabetes medications (including oral therapies and insulin), and statins.

"This finding is significant, since cost containment approaches that increasingly shift costs to patients can cause decreased compliance with potentially lifesaving medications," says **Stephen Rosenberg,** study coauthor and senior vice president for outcomes research at ActiveHealth.

The study, jointly designed by researchers from ActiveHealth, Harvard Medical School, and the University of Michigan, tracked two large employers from 2004 through 2006. In January 2005, one of the large employers selectively reduced copays for five classes of medications—ACE inhibitors/ARBs, beta-blockers, diabetes medications, statins, and inhaled corticosteroids. These five classes of drugs were chosen because of the large body of evidence-based literature documenting their cost-effectiveness in the treatment of common chronic conditions, such as hypertension, heart disease, kidney disease, elevated cholesterol, diabetes, and asthma.

Copayments for generic medications, which had been $5, were eliminated. Copayments for branded drugs were lowered by 50%, from $25 to $12.50 for preferred drugs and from $45 to $22.50 for nonpreferred drugs. At the other large employer, copayment requirements remained stable.

> **"This finding is significant, since cost containment approaches that increasingly shift costs to patients can cause decreased compliance with potentially lifesaving medications."**
>
> *—Stephen Rosenberg*

Meanwhile, ActiveHealth used its clinical decision support technology, CareEngine System, to identify the most clinically appropriate individuals to benefit from copayment reductions. Using available claims data, including diagnoses, procedures, medications, and labs, along with data obtained directly from members involved in ActiveHealth's DM program and/or via their personal health record, CareEngine compiles continually refreshed, membercentric electronic medical histories. It then compares this information with a large and expanding set of evidence-based medical algorithms.

In addition to identifying individuals who already were taking one or more of the five medication classes in the study, the system identified individuals who were not taking these medications but who should have been taking them. In addition, patients who already were taking the medications but in whom use of the drugs was contraindicated were identified, notified, and excluded from the study.

Employees and dependents aged 18–64 who were continuously enrolled for the relevant quarter and the

entire previous quarter were eligible for the study. All patients in the treatment group who were already taking any of the intervention medications without a contraindication were eligible for the copayment reduction, beginning with their next prescription fill. Copayment relief also was available for those who were not taking the medication if they were identified by the clinical alert system as patients who would benefit from the medication.

This is the first study on copayment changes that holds access to DM constant for both treatment and control groups, the authors say, and also is among the first to address the effects of a value-based copayment reduction.

"We found that reductions in drug copayments increased medication adherence," the authors wrote. "Our analysis suggests that the adherence effects may increase over time for some clinical areas."

The authors did not observe a statistically significant effect for inhaled corticosteroids, but said that this may reflect "the difficulty in measuring adherence for these medications, since there are multiple doses in a single inhaler as opposed to the other medications that allow individual doses to be counted."

The study does have several other limitations, largely linked to differences between the control group and the intervention group. However, the authors concluded that properly aligning financial incentives can help improve outcomes.

"This analysis demonstrates that such value-based insurance design programs can effectively increase adherence to important medications and complement existing DM programs," the authors wrote.

The study was published in the January/February edition of *Health Affairs*. ■

Partnering for Success in the Medicare Shared Savings Program

Health systems throughout the nation are gearing up to take advantage of the Medicare Shared Savings Program. With providers now able to participate without downside risk – receiving bonus payments on top of traditional reimbursement – the benefits of becoming a Medicare ACO are even more compelling.

But the challenge of creating and executing a plan to participate in the Shared Savings Program may seem daunting.

Aetna Accountable Care Solutions can help.

For more than three years, Aetna has established Medicare Advantage ACO collaborations – demonstrating up to 25 percent savings in medical costs exclusive of denials compared to unmanaged Medicare.

Aetna Accountable Care Solutions offers an all-payer solution to help our health system partners manage financial risk and produce rewards from the Medicare Shared Savings Program. Our suite of capabilities and expertise include:

A 2010 study revealed the following results for Aetna's Medicare Advantage ACO collaborations:

- *31% fewer hospital acute care days*
- *24% fewer ER visits*
- *34% fewer hospital/rehabilitation sub-acute care days*
- *39% fewer long hospital stays (greater than 15 days)*

Application drafting and review

To participate in the Shared Savings Program, you must complete a formal application that delineates how your ACO will deliver evidence-based medicine, patient engagement in care, care coordination, effective quality measurement and more.

Aetna Accountable Care Solutions can partner with you in the application process – from drafting the application from the ground up to providing legal review and expert Medicare counsel for your completed application. We also provide access to consulting services and legal counsel to help you stand up your ACO or ensure that it meets requirements for the Shared Savings Program. Our subject matter experts can guide you around a wide range of issues, from governance to antitrust and care management program design.

Together, we can present a plan that effectively outlines how you will realize the specific goals of the Shared Savings Program.

Care management and technology assessment

Aetna's accountable care team can assess your readiness for the Medicare Shared Savings program. Based on the successes we have achieved in more than 60 pilots, our team specifically assesses your readiness for:

- Establishing evidence-based care plans
- Coordinating care for attributed populations
- Using health information technology to identify and close care gaps
- Managing your Medicare population under financial risk arrangements
- Reporting on quality, cost and satisfaction
- Staffing care managers
- Engaging patients
- Engaging physicians

We can identify any gaps that might prevent effective management of your Medicare population and help you develop a plan for overcoming those gaps.

Technology designed for the world of accountable care

Aetna brings together a suite of best-of-breed technologies designed to enable accountable care strategies – integrating technology directly to business and clinical improvements. This suite of solutions delivers:

- Clinical interoperability for every provider in your ACO
- Clinical ontology
- Stratification of your population for specific risk factors and conditions
- Analysis for gaps in care
- Quality and efficiency reporting dashboards
- Intelligent clinical decision support
- Analytics and reporting
- Tools to drive patient engagement

Our solutions fit into your workflow and complement existing technology investments, filling gaps where needed. As a result, you can achieve fast, low-risk deployments to successfully manage your Medicare population.

Care management support

You may have the information technology in place for intelligent population health management, but do you have the personnel on the ground to manage the care of your Medicare beneficiaries?

Aetna's accountable care expertise extends beyond technology and business modeling to encompass the personalized coordination and support a patient needs to optimize health. Our services include:

- Embedded and remote care manager services and training
- Community health worker support for high-risk beneficiaries
- Programs for care transitions and compassionate end-of-life care
- Health literacy outreach
- PCMH care navigator and health-coaching programs
- Payment and incentive models to drive physician engagement

With this care management expertise, we can partner with you to meaningfully engage patients and create significant impact for your Medicare population.

Medicare beneficiary data analysis

Once you are accepted to participate in the Medicare Shared Savings Program, you will receive copious data concerning the Medicare beneficiaries likely to receive care from your ACO based on primary care utilization. Aetna has the tools to analyze this data and identify opportunities quickly. By turning this raw data into actionable information, we can optimize care management strategies for your ACO's success.

You may not be ready for a full ACO across all of your populations. Start with the Medicare Shared Savings Program. Any investments you make in this program become building blocks for the transition to a broader model in the future.

We want to collaborate with you. Contact us today to determine how we can work together for your success in the new era of accountable care.

accountablecaresolutions@aetna.com

aetna℠

HealthAffairs Blog

Cost And Quality Concerns, Policy Changes Lead To Innovation, Collaboration — And Accountable Care

Posted on August 24th, 2012

by Charles Kennedy

Health care in the United States is changing at a pace not seen since the launch of Medicare. The changes are largely a response to runaway medical costs in our health care delivery system.

Our nation spends nearly twice as much per person on health care services than most industrialized countries. Yet, by almost any recognized standard, quality is lacking. The U.S. scored lowest overall in quality, access, efficiency, equity, and healthy lives when compared with six other nations, according to a 2010 Commonwealth Fund report. We also lagged behind in chronic care management, care coordination and safety, and the use of information technology.

The Supreme Court's decision in June to largely uphold the constitutionality of the Patient Protection and Affordable Care Act (ACA) will mean that health reform implementation will proceed at a rapid pace. The Congressional Budget Office projects that as many as 23 million more people will have insurance by 2022. Coverage expansion, along with multiple other ACA-funded initiatives, is intensifying hospital systems' interest in meaningful reforms. Further, new Federal financial opportunities — including the Medicare Shared Savings Program, dual-eligible demonstrations, Pioneer Accountable Care Organizations, Bundled Payments, and numerous primary care initiatives — are setting the stage to reward health care providers for patient care that is higher quality, more efficient, and more effective overall.

Five years from now, the health care landscape will likely look radically different than it does today. Today, we have fee-for-service payment models that reward physicians and hospitals based on the volume of services rather than the quality and overall value of the care. Physicians struggle with fragmented and limited information about the patient. Many health care teams are disconnected and not incented to work together. Patients have limited information about health care cost and quality, and aren't

actively engaged in their health. Many efforts are taking shape to address these problems so that everyone has the information, tools, and financial incentive to make health care better.

Health care providers and insurers understand that doing business as usual is not an option. New strategies are underway in boardrooms and around conference tables, answering the call for significant and fundamental changes to the way we provide care and coverage. A world dominated by pilot programs seems to have changed almost overnight into one in which major decisions must be made immediately. Should health care providers jump in — or risk waiting to see what succeeds and what fails?

To Be Or Not To Be An ACO

An Accountable Care Organization (ACO) is a collection of health care providers and care management professionals working together to manage and coordinate care for a defined population. The goal is to reduce overall costs and improve quality and outcomes. If the ACO is successful, providers are rewarded with a percentage of shared savings or bonus payments based on savings benchmarks and quality measures.

One major decision is whether to participate in the various ACO or shared savings programs with CMS. Last year, CMS announced partnerships with 32 Pioneer ACOs — health care organizations and providers experienced in care coordination across health care settings. These ACOs will move quickly from a shared-savings model to a population-based payment model. In a shared-savings model, the ACOs are paid on a fee-for-service basis and share savings or losses on a set of patients. When they move to a population-based model, they receive payments in advance each month for each beneficiary they serve rather than fee-for-service payments. This type of arrangement gives the participating ACO the flexibility to offer services not normally reimbursable under Medicare (such as phone consultations.)

CMS is currently accepting applications for the Medicare Shared Savings Program, which is open to health care providers and networks that have established or could establish an accountable care organization (ACO). The ACO would enter into a contract to share savings (and potential losses) with Medicare. To participate in the three-year program, an ACO must serve at least 5,000 Medicare fee-for-service beneficiaries. Applicants must demonstrate compliance with governance, leadership and legal requirements, as well as document their care management resources and adequate health IT support.

In April 2012, CMS announced the first 27 Medicare Shared Savings Program ACOs, and in July, approved another 89 ACOs. The next opportunity to apply is August 1 through September 6 for operations to begin January 1, 2013.

The ACO Investment: The Right Steps And Resources

Addressing the care management, payment reform and IT components to become an ACO can be a massive undertaking. Many health care providers and hospitals do not have the risk management experience, expertise in care management and total population health management, or the necessary health IT in place that will be needed. Conversely, health plans and disease management companies have limited knowledge of the clinical workflows that occur within care delivery settings, yet have knowledge that is essential in setting up an ACO. Success will require creating new partnerships to collectively share knowledge and capabilities.

In this quickly evolving environment, providers are faced with the imperative to commit to a course and invest to ensure relevance and viability in the market. What does an organization need to do now to thrive? Some early steps to consider are:

- Frankly assess whether your organization has or can develop a culture open to innovation in its service, processes and technologies.
- Conduct an honest evaluation of current capabilities and any gaps that may exist in managing the health of a defined population. Can your organization meet the requirements for accountable care programs? What effort or expense will be required? How do you stack up against local, regional, or national best-in-class benchmarks?
- Identify and reach out to organizations that offer complementary services and share your mutual vision of improved patient care and value.
- Align public and commercial care delivery efforts, including contracting, services, and measurement.
- Integrate care across the entire network or continuum. Why invest in a dramatic change to only realize value in a siloed program or with a segment of the population?

The Bigger Picture

From technologies to payment programs, the ingredients necessary to transform health care are available now. Programs such as the Medicare Shared Savings Program can now be combined with private

insurance contracts offering similar rewards and incentives. The day of transformed care delivery and quality, reduced costs, and improved care through broader multi-payer programs has never been closer.

Many in the private market have already begun adopting the tenets of accountable care. Collaboration between payers and health care providers is replacing the tension and contention of the past. New partnerships are forming, reflecting the market's willingness to explore more integrated solutions.

Alternatively, some are choosing a slower, wait-and-see type of approach. Their leaders may decide that being a fast follower—learning from others' mistakes—might offer superior results. This strategy could pose risks. For example, as competing delivery systems become more efficient, the market's need for hospital beds may be reduced. So in markets where there are multiple competing delivery systems, the organizations that start earlier may enjoy a first-mover advantage by establishing their reputation for quality and value.

Regardless of where an organization is in its readiness, striving for better quality and better outcomes at lower cost is the right thing to do. We all deserve a better (and more accountable) health care system. Now is the time to make it a reality.

Charles Kennedy, Cost And Quality Concerns, Policy Changes Lead To Innovation, Collaboration — And Accountable Care, *Health Affairs* Blog, August 24, 2012 http://healthaffairs.org/blog/2012/08/24/cost-and-quality-concerns-policy-changes-lead-to-innovation-collaboration-and-accountable-care/.

Healthcare Informatics
Healthcare IT Leadership, Vision & Strategy

A Health Plan Executive Helps Lead Provider-Payer Collaboration Forward on ACO Development

Aetna's Charles Kennedy, M.D. heads up a company division focused on private-sector accountable care organization development

By Mark Hagland

Posted on August 10, 2012

The Hartford, Conn.-based Aetna has been moving forward assertively to collaborate with hospitals and physicians to develop private-market accountable care organizations (ACOs), which generally match the ACO concept evolving forward under the Medicare Shared Savings Program. As of July 14, the Aetna Accountable Care Solutions office had created 14 accountable care programs in 10 states. What's more, supported by a staff of more than 80 people, the health plan is actively working with more than 160 health systems to develop additional programs, says Charles Kennedy, M.D., CEO of Aetna Accountable Care Solutions. The Los Angeles-based Kennedy spoke recently with *HCI* Editor-in-Chief Mark Hagland regarding his organization's current work and plans for the future. Below are excerpts from that interview.

Healthcare Informatics: How long has your office existed?

Charles Kennedy, M.D.: Aetna has been working on ACO-like entities for several years now. I joined the company about a year ago (I'm an internist by clinical background); but we already had several ACO-like relationships in place. So we've been working on ACO-like agreements for about five years; and the ACO division has been in place now for about a year and a half.

A FOCUS ON CULTIVATING RELATIONSHIPS

HCI: How would you define your organization's mission?

Kennedy: Our mission is to create collaborative relationships between Aetna and various delivery systems that result in health plan products and services that are market-leading in terms of costs; that offer measurable high-quality care; and that offer clinical innovations that enhance patient satisfaction. So we're all about the Triple Aim [the concept promoted by Maureen Bisognano, president and CEO of the Cambridge, Mass.-based Institute for Healthcare Improvement, and coauthor, with Charles Kenney, of the 2012 book *Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs*]. And we believe through our clinical innovations that we'll be able to transform healthcare.


Charles Kennedy, M.D.

We believe that when a health plan and a provider organization work together collaboratively, we can create things like care coordination and health information technology, to improve care. And when I say health information technology, I don't mean electronic health records or health information exchanges, though those are very helpful; instead, I'm speaking at the broadest level of innovation in IT. If you're going to move from a traditional way of operating to an ACO way of operating, the fundamental tenet is that we're moving away from a focus on volume of healthcare, and moving towards high-value healthcare. And that means a series of things.

First, we're providing incentives for providers to efficiently deliver care, whereas in the old world, they were punished for being efficient. Second, we help them really work as a healthcare system, working on behalf of

their community. In the old world, you had fragmentation, where the physicians weren't necessarily aligned, whereas in the new world, there's now structural alignment. And finally, there's technology alignment. And why is that important? In today's world, it's up to the patient to seek care. In the ACO world, you may need to see patients who are ticking time bombs, because they're not compliant, and have chronic diseases that need to be proactively approached. And technology allows you to go out and find those people who need proactive care management.

HCI: You have 14 clients across 10 states. Are they all integrated delivery systems?

Kennedy: Some are integrated delivery systems; others are standalone hospitals, to whose leaders we've reached out. Others are various types of medical groups. So it's really a potpourri of different types of organizations. What we try to do is to meet them where they are and help them to align the elements in their communities.

HCI: How are you picking these partners?

Kennedy: We are very diligent about whom we work with. We've profiled all the hospitals and medical groups in the United States, and have identified the ones whose financial, operational, or competitive characteristics give them a good chance at success in the ACO environment; and then we meet with them and look out for elements that will give us a higher level of confidence in them. For instance, we look at their organizational leadership. If they're not at the point where they want to build their own ACO, we can't do business with them. So making sure that strong clinical and administrative leadership is in place is key.

HCI: What will happen in the next few years in this general area?

Kennedy: We expect to experience rapid growth; and, much as we saw HMOs grow past a tipping point in the 1990s, we expect to see a paradigm shift taking place for ACOs in the next few years. And so we expect to see rapid growth, driven by the private-market innovations, as well as the changes in federal policy. We also have over 60 collaborations in Medicare Advantage programs.

BUSINESS IMPERATIVE: MAKE SENSE OF DATA

HCI: So obviously, the affirmation of the constitutionality of the Affordable Care Act by the Supreme Court earlier this summer was important?

Kennedy: It definitely was powerful. We would have been doing this anyway, because it was the right thing to do in the industry. What the ACA added was the power of the Medicare program, and to an extent, the power of the Medicaid program.

HCI: What should our audience of healthcare IT leaders be doing right now?

Kennedy: The business imperative that most CIOs and CMIOs will face is the need to improve their collection and analysis of clinical data. And they should not assume that electronic medical records necessarily give them a major leg up in this area. Electronic medical records are important as records, but you need complementary technology that converts the data into information and the information into actionable information that clinicians can actually use. Second, CIOs and CMIOs should look very closely at technologies that help convert free-text or unstructured data into structured data. We use a variety of technologies associated with Medicity and other affiliates that help accomplish that conversion.

And you can't apply a computer very effectively to the art of medicine and have it create the benefits that computerization has created in so many other parts of society. But as you begin to move down this path, you'll see those sorts of benefits start to apply; and those patient care organizations that first begin to move down this path will see a pretty dramatic competitive advantage.

HCI: What are your perspectives on the health information exchange [HIE] element in payer-provider collaboration?

Kennedy: There are various levels of sophistication in an HIE. The basic level is where the HIE allows you to exchange EMR-based documents, where they can be read by another human being, generally a clinician. Now you're starting to see the industry become more sophisticated, and they're adding, beyond a viewing component, a data component to this, and I think you're going to see a step-wise advancement in that area. For instance, one of our customers had five electronic medical records [EMRs] , and they said, oh, this will be easy for you, because all of our EMRs produce a continuity of care document (CCD), and you can take in a CCD, so this will be easy. But their CCDs failed the federal HIT standard, so that actually made our work almost as difficult as if they didn't have CCDs.

HCI: It's an area that providers really need to work on?

Kennedy: It's an area that technology vendors really need to work on, and providers really need to partner carefully with vendors to get the full value out of that element.

HCI: Do you have any other advice for our audience?

Kennedy: Even though there's been significant uptake of the meaningful use funds, still, only about 20 percent of providers have availed themselves of that program. So I think an ongoing emphasis on that program is important; and providers really need to move forward to more tightly bind their clinicians to them, their physicians to them; there are still significant opportunities in that area. ◆

BANNER HEALTH NETWORK
PIONEER ACO
CLINICAL INTELLIGENCE & BUSINESS INTELLIGENCE
APPROACHES

November, 2012

Accountable Care Solutions from aetna℠

HIMSS ANALYTICS®
It's How You Know What's Next.

Introduction

pi·o·neer noun \ˌpī-ə-ˈnir\

> *A person or group that originates or helps open up a new line of thought or activity or a new method or technical development.*[1]

The growth of the United States as a nation is indebted to "pioneers." In American culture, pioneers are best represented by those who went into the unexplored territories of the West in search of a new life, looking to establish a permanent settlement. But the role of the pioneer in our nation's life is not relegated to a bygone era. Pioneers are present in our healthcare system today, blazing paths toward sustainable models of care delivery. For example, the Centers for Medicare & Medicaid Services (CMS) Innovation Center (Innovation Center), has created the Pioneer Accountable Care Organization (ACO) program with the intent of enlisting pioneers to explore a new frontier of healthcare. In December 2011, the Centers for Medicare & Medicaid Innovation (CMMI) awarded 32 organizations the title of "Pioneer ACO."

"Pioneer ACOs are leaders in our work to provide better care and reduce healthcare costs. We are excited that so many innovative systems are participating in this exciting initiative."[2]

Kathleen Sebelius, US Secretary of Health and Human Services (HHS)

What does the path look like so far for those leading the way? With roughly half of the first year of a three-year journey behind the Pioneer ACOs, HIMSS Analytics has developed a series of white papers to report from the pioneer frontier.

Background and Purpose

HIMSS and its research arm, HIMSS Analytics, have seen a tremendous interest of late in the use of Clinical and Business Intelligence (C&BI) tools and processes to improve clinical outcomes, enhance and monitor healthcare business operations and manage patient populations. This interest appears to stem from multiple forces converging to elevate the importance of healthcare intelligence in response to healthcare reform drivers. Forces range from the expansive adoption of evidence-based medicine to new payment methodologies such as accountable care and patient-centered medical homes. These new models of care require both clinical intelligence and business intelligence at levels not previously seen in healthcare. Implementing C&BI tools for predictive modeling, population management, care coordination and electronic health information exchange requires a trailblazing spirit in today's shifting healthcare landscape.

Thirty-two Pioneer ACOs were chosen through an open and competitive process from a large applicant pool that included diverse organizations. These 32 organizations brought experience

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[1] http://www.merriam-webster.com/dictionary/pioneer , 7/12
[2] News Release, http://www.hhs.gov/news/press/2011pres/12/20111219a.html , HHS Press Office, December 19, 2011

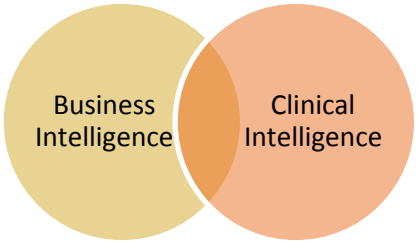
in coordinating patient-centered care and in operating in ACO-like arrangements.[3] The Pioneer ACO Model will test the impact of different payment arrangements as these Pioneer organizations seek to provide better care to patients while reducing Medicare costs.[4]

Extensive information about the Pioneer ACO program can be found on the Innovation Center's website at http://innovations.cms.gov/initiatives/aco/pioneer/.

The Pioneer ACOs are unique in organizational structure, technical infrastructure, size and approach to care. As such, each has a unique history as well as a story to share about its planning, success and progress towards reinventing healthcare in the accountable care model. In this Pioneer ACO white paper HIMSS Analytics worked with Banner Health Network (BHN), one of the larger of the 32 Pioneer ACOs, to present its unique perspective on how it approached management and delivery of care to BHN assigned beneficiaries. This whitepaper provides a benchmark of the approach BHN has taken to manage two critical components of its Pioneer ACO -- clinical intelligence and business intelligence.

Study Population and Approach

This white paper is based upon research and in-depth interviews with BHN executive staff, including Bill Harris, Senior Director Operations, Dr. Tricia Nguyen, Chief Medical Officer, Chuck Lehn, SVP and CEO of Banner Health Network, Jennifer Jackson, Sr. Director Information Technology, and Linda Stutz, Sr. Director of Care Coordination. The interviews were parceled into roughly three sections. The first set of interviews focused on an overview of the organization, the second focused on the organization's approach to clinical intelligence, and the third addressed the organization's approach to business intelligence. Our intent is to orient readers to the organization in general and then specifically narrow the focus into the clinical and business intelligence approaches used to facilitate ACO efforts. In the future, we may re-interview BHN executives to see which approaches and methodologies have evolved and matured, been abandoned, or remain unchanged.



Although the interviews were structured to address business intelligence (BI) and clinical intelligence (CI) separately, we recognize that distinguishing between the two in a healthcare organization can be a challenge. Sometimes decisions in healthcare, such as contract negotiations or facility management, clearly relate to business alone and stand out as demonstrations of the use of BI. At other times, decisions are entirely clinical in nature and clearly within the realm of the use of CI. For example, using lab results to confirm a diagnosis or mapping patient population demographics for analyzing and managing ER utilization in a region are examples of using clinical intelligence. On other occasions, BI and CI overlap. For example, in making a staffing call schedule, there is a financial component that translates into business intelligence as well as

[3] http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf , CMS, 7/12
[4] http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf , CMS, 7/12

a clinical intelligence component that translates into having the right resources to deliver the quality and quantity of care needed. BI and CI in healthcare exist in an overlapping Venn diagram that fluctuates based on the decision at hand, point of view, and the availability and sophistication of the data and tools leveraged to support those decisions.

Banner Health Network, due to its size and design, has significant overlap in the way it manages clinical and business intelligence.

Banner Health

Organizational Background

The Banner Health, named by Thomson Reuters as one of the top five large health systems in the country for clinical performance[5], is a part of the Banner Health Network (BHN), a patient care and financial accountability partnership between Arizona Integrated Physicians (AIP), Banner Medical Group (BMG) and the Banner Physician Hospital Organization (BPHO). The partnership includes more than 2,600 primary care and specialty physicians with approximately 500 as direct employees and includes Banner hospitals and other related healthcare services. The network serves a population base of more than 4 million people[6] in Maricopa and Pinal counties, Arizona.

BHN has a long history of providing managed care and at-risk contracting. BHN not only owns a Medicare Advantage plan that has been in place for 20 years, but also has managed care/accountable care product relationships in the commercial sector with Aetna, Blue Cross Blue Shield, and CIGNA. BHN is also involved[7] in a CMS Shared Savings Program ACO[8].

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[5] http://thomsonreuters.com/news_ideas/press_releases/?itemId=537037 Thomson Reuters press release, January 16th, 2012

[6] http://www.bannerhealth.com/Locations/Arizona/Banner+Gateway+Medical+Center/For+Physicians/News+for+Physicians/_Banner+Health+Network+to+participate+as+Medicare+Pioneer+Accountable+Care+Organization.htm Banner Health press release

[7] http://www.aetna.com/news/newsReleases/2012/0510-Aetna-And-Banner-Health-Expand-Accountable-Care-Relationship.html Shared Savings Program ACO press release from Aetna

[8] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/ CMS Website for Shared Savings Program

BHN has strongly embraced the concept of population health management and the accountable care oriented model, with over 200,000 at risk covered lives. The Pioneer ACO program has approximately 50,000 beneficiaries. William Harris, Chief Operations Officer, and Chuck Lehn, SVP and CEO of BHN, have a long history with healthcare products in this space. Not only have they managed the risk of their own employee plan, but they have worked with Medicare Advantage and other full-risk contracting products for many years. As a result, BHN had existing infrastructure to support claims payment, medical management, customer service and other health-plan-like activities.

"For us to go into the Pioneer [ACO program] we did not have to make massive investments, we only had to make incremental investments."

Chuck Lehn, SVP and CEO of BHN

The decision to pursue an ACO model was motivated by senior leadership's belief that existing healthcare fee-for-service payment models are unsustainable. Recognizing that the Banner organization as a whole would be facing declining revenues and efficiency without transformative change – especially during times of recession and with the expectation of future Medicaid payment cuts – leadership saw the ACO model as a viable solution.

Senior leadership considers their ACO efforts as well as their efforts to coordinate the patient experience to be an extension of their mission to provide excellent patient care. They expect that developing the skills, relationships and infrastructure to be a Pioneer ACO will secure BHN's future success.

"We are moving from an acute care system to a more comprehensive delivery system that is more viable and stable."

Dr. Tricia Nguyen, Chief Medical Officer

Banner Health defines its vision, values and mission as follows[9]:

VISION

> *"We will be a national leader recognized for clinical excellence and innovation, preferred for a highly coordinated patient experience, and distinguished by the quality of our people."*
>
> BHN's vision statement paints a picture of what its goals are for the future. The statement clearly defines the work BHN must do and connects to the desired behaviors it must demonstrate to achieve the following five year goals:

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9 http://www.bannerhealth.com/Locations/Arizona/Banner+Gateway+Medical+Center/About+Us/Mission+Vision+Values.htm Banner Health website

- Be recognized for clinical excellence and innovation
- Develop a highly coordinated patient experience
- Be distinguished by the quality of its people

MISSION

"We exist to make a difference in people's lives through excellent patient care."

VALUES

Banner's values define the culture of Banner Health and how these values are demonstrated through actions and behaviors.

People Above All *… by treating those we serve with compassion, dignity and respect.*

Excellence *… by acting with integrity and striving for the highest quality care and service.*

Results *… by exceeding the expectations of those we serve and those we set for ourselves.*

Key Drivers

The Triple Aim

The ultimate goal for BHN is to achieve the "triple aim" as noted by the Institute for Healthcare Improvement[10].

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

By decreasing the cost of an acute care episode they propose to reduce the overall cost of care. BHN in general is striving to keep the population healthy so less care is needed for a given population. Delivering care proactively – working reduce acute care procedure volume for a population while at the same time making up reduced volume by expanding coverage to a broader population – is BHN's approach for delivering enhanced population healthcare and growth.

Communication

Pioneer ACO beneficiaries have the freedom to select a physician of their own choosing; they are not required to seek care from within the ACO network. Attracting and retaining these patients requires a commitment to improving their healthcare experience, as well as strong communications to increase awareness of BHN's strengths and differentiators. BHN has made

[10] http://www.ihi.org/offerings/initiatives/tripleaim/pages/default.aspx IHI Website

communication a key focus area. Prolific communication in many forms ensures staff are aligned and informed to provide the best care possible and that beneficiaries appreciate the value proposition BHN offers.

"The fundamental underpinning in this effort is the critical need for patient engagement to support all our endeavors."

Bill Harris, Sr. Director of Operations

One example of opening communication channels for beneficiaries is the presentation of a smartphone application called iTriage. This Apple iOS and Android[11] app allows patients to evaluate their medical condition, make appointments, pre-register and perform other tasks[12]. By empowering beneficiaries with this smartphone app, BHN has created a communication channel that empowers the user and reduces the occurrence of visits (expenses and delivery of care) outside the Banner Health Network. BHN is also considering leveraging other non-traditional, technology-based communication channels such as e-mail and electronic chat. Mindful of the diverse population they serve, BHN has a broad spectrum of communication channels that use both high- and low-tech mediums. Traditional outreach by care managers using POTS (plain old telephone service) and letters complement more sophisticated electronic discharge coordination activities between acute care facilities and primary care providers. The overall goal is a coordinated communication plan that reaches out to a broad cross-section of beneficiaries and encourages them to seek care within the BHN network.

Many of the communication efforts have been inspired by the two patient advocates placed on the BHN Board as part of a Pioneer ACO requirement. These advocates have presented a compelling patient perspective for the board to consider, bringing insights that have supported unique programs and opportunities. One such example includes leveraging "expos" that focus on the specific interests of the Pioneer patient population. An expo is a small set of conferences or presentations that target a specific geographic area or consumer segment in a given market. They might be held at a community center or regional office or at an Area Agency on Aging office. They cover a variety of topics that are relevant to the given population. For example, BHN supports caregiver forums and seminars such as "Making Sense of Memory Loss"[13], which demonstrate low-tech outreach to enhance the patient care experience. Banner also supports outreach programs and expos around diabetes, fall prevention, cancer and other topics in a similar manner.

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[11] https://play.google.com/store/apps/details?id=com.healthagen.iTriage.tablet&feature=nav_other#?t=W10. Google Play store

[12] http://mobihealthnews.com/17306/aetna-equips-arizona-aco-with-mobile-tools-hie/ Mobile Health News Website, May 10, 2012

[13] http://www.aaaphx.org/FAMILY+CAREGIVERS+FORUMS Area Agency on Aging website

"We need to recreate the relationship between the member or the patient and the organization… we have been talking about physician and patient relationship, but it's really the relationship with the organization."

Dr. Tricia Nguyen, Chief Medical Officer

From coordinating with the local Area Agency on Aging and seniors to facilitating outreach through sophisticated smartphone applications, BHN has strived to balance traditional and non-traditional patient engagement and communication approaches. While BHN feels they can't achieve their goals without technology, it's clearly not all about technology.

"We can't get there without the technology to manage the care and the initiatives...but really the technology is just a powerful tool to help us reach our objectives."

Bill Harris, Sr. Director of Operations

Advice to Those Starting an ACO

BHN executives have some simple advice for those developing and working in the ACO environment. First make sure there is a good balance between acquiring the ACO business and investing in the infrastructure to support it. Having the core infrastructure in place to support the services you are contracting for is very important to success. Second, they suggest you can't over-communicate what you are trying to achieve. Their experience is that it takes time for the message or change to sink in. Restating the reasons for change again and again is critical to ensure staff – from those on the front lines to those in the back office – are realigning their perspectives to align with the new cultural norms.

"You just can't over-communicate what you are trying to achieve….The ongoing communication, not just the printed stuff, but the conversations and dialogue, are where it happens."

Chuck Lehn, SVP and CEO of BHN

BHN feels it is critical not to underestimate the need to look at the true cultural transformation needed to change from traditional fee-for-service oriented care and billing to accountable care. BHN works to constantly refresh the cultural change message while ensuring it is has clarity and is efficient, both internally and externally with independent partner physicians. BHN put this into action by creating a "Pioneer ACO – Physician Toolkit", a 22-page document for physicians, physician office staff and beneficiaries that answers a variety of questions like:

"What is an ACO?"
"What is the Pioneer ACO Model initiative?"
"What is my financial risk?"
"Where do I submit claims?"
"How can you expect to build accountability in the patient population?"
"How are physicians paid?"
"Why Banner Health network?"

By clearly answering the basic questions and those that are most relevant and pressing to its key audiences, BHN is educating and changing its culture and approach to delivering quality care.

"To be successful, this cannot be seen as one initiative or a separate program.… It is not just about creating a new model…It really is a transformation in the culture of the organization."

Bill Harris, Sr. Director of Operations

Clinical and Business Intelligence Approach

For Banner Health Network, the distinction between clinical intelligence and business intelligence is often merged. Most efforts and activities have a dual role of both impacting business performance and optimizing population and patient care. Their efforts are noted together here for the reader to appreciate the impact the programs have on both business and clinical operations.

"It is the right thing to do, and we clearly know the current predominately volume-based model we have functioned under for years is not sustainable."

Bill Harris, Sr. Director of Operations

Collaborating with Aetna for a Technology Solution

A cornerstone part of enabling this vision is collaboration with Aetna, which brings to the table an integrated suite of health management solutions[14]. In May of 2012[15] Aetna announced an expansion of its relationship with Banner Health Network to include full technology support for population health management and patient services for more than 200,000 patients. The agreement includes support for the 50,000 Medicare fee-for-service patients covered under the Pioneer ACO shared savings program and members in Aetna's ACO relationship with Banner Health Network.

Aetna and BHN are in the process of fully implementing a broad technology suite and care management services to support greater care quality, coordination and convenience for Banner Health doctors and their patients. The agreement includes implementation of the following capabilities from Aetna companies:

- Health information exchange technology from Medicity to enable the secure, two-way exchange of health information across a patient's entire care team, including hospitals, physicians, labs, pharmacies and other ambulatory services

[14] http://activehealthmanagement.com/index.php ActiveHealth website information.
[15] http://www.aetna.com/news/newsReleases/2012/0510-Aetna-And-Banner-Health-Expand-Accountable-Care-Relationship.html Aetna press release from May 10, 2012

- Active CareTeam[SM] from ActiveHealth Management to give physicians access to CareEngine®-powered, point-of-care clinical decision support services and a desktop-based workflow tool to track, monitor, coordinate and report on patient health outcomes
- Smartphone and online appointment setting and pre-registration services for patients through iTriage, one of the most downloaded health and fitness apps in both the iTunes® App store and Android™ Market.

This technology suite brings a multi-layer approach to building a platform that supports beneficiary health management, physician (office) interaction, and healthcare business management. These functional layers are demonstrated in the graphic…

BHN calls this their "wedding cake" design which shows not only how the systems, applications and technology work together, but demonstrates Banner Health's commitment to the relationship with Aetna.

"The fact that we have invested so much as an organization…into the build of our data warehouse, which is a combination of business, clinical and operational data integrated into a 360-degree view of the patient, has enabled us to move faster with understanding our patient population and to work with ActiveHealth…and CMS data."

Jennifer Jackson, Sr. Director Information Technology

Payment Model and Delivery Model Alignment

BHN is transitioning from fee-for-service payment and incentive methodology to a value-based methodology. The key to supporting this transformation is getting information to the physician at the right time and focusing on delivering the information the physician needs to create care value. Particular focus is paid to spurring the primary care network to deliver more care value by performing the following:

- Looking for patients that have haven't had a recent preventative care visit, and arranging one for them
- Ensuring proper follow-up through the primary care physician after an inpatient stay
- Generating care plans for patients and interacting with the care manager to ensure those care plans are followed through

These efforts require physicians to not only spend extra time with the patient but to review relevant patient risk scores and profiles. These profiles and scores are computed and reported from the information systems BHN uses to inform physicians about the status of their patients, thus allowing physicians and their office staff to manage care and risks associated with their patients more accurately and effectively. In doing so, physicians are in a better position to manage and control patient population risk as opposed to focusing on fee-for-service billing volume or immediate singular health concerns. BHN has implemented payment codes that reward and incentivize physicians to perform these new tasks around patient and population management.

"The payment has to align with the functions we want them to do….There has to be a re-balancing of where the dollars are spent."

Chuck Lehn, SVP and CEO of BHN

While approximately 500 of the roughly 2,600 physicians in the Banner Health network are employed by Banner, the remaining BHN primary care physicians had to choose to participate in the BHN Pioneer ACO. This voluntary participation implies Banner has less specific control over how these physicians manage their office processes, including the referral process, care coordination and beneficiary risk management. In order to manage and minimize uncoordinated

care and expense related to lack of patient engagement or the use of physicians and facilities outside the Banner Health network, Banner Health uses historical patient data to identify gaps in care and the utilization of external network care. Using both clinical and business intelligence, BHN was able to identify that some specialists were serving as primary care physicians in addition to acting as specialists. While BHN does not want to disrupt the patient – physician relationship, this has created a challenge for the network. As a result BHN works to manage and refine communications with these specialists.

Motivating these physicians to follow processes that align and coordinate patient care with BHN standards requires re-assessment of the incentive system, specifically the payment system. Scalability of the payment incentive system as a whole was important to encourage non-employed BHN physicians to manage their patients in a way that aligned with the goals of the Pioneer ACO program. There is no clear and defined algorithm to address these issues. Ensuring sufficient technological support – that there are proper ties working back to the payer community and that all partners are aware and involved – is critical to shifting the payment model.

"The first time you do it [re-align incentives] you might stumble a little bit, the second time you get better, and the third time you get a whole lot better. It's been a good lesson learned and we are better prepared for the future."

Bill Harris, Sr. Director of Operations

As a result of the above noted changes, physicians are being asked to venture into territories that support more holistic care for the patient, including behavioral health and social health. Since some physicians were lacking experience and expertise in these areas, BHN stepped in to support physicians by offering training and education in support of the cultural change and direction they were asking physicians to take.

BHN provides physicians a comprehensive care management model supporting Pioneer ACO efforts. This model allows patient engagement to happen in a more meaningful way, and BHN is supporting physicians using this engagement with newly aligned incentives. BHN leverages business intelligence to track gaps in care, healthcare risks, communication plan effectiveness, and to benchmark progress achieved towards the desired change in physician and patient engagement.

Physician Tools

To assist physicians' success with participation in the network, BHN offers a number of solutions and tools to support them. BHN contracted with Accountable Care Solutions (ACS) from Aetna for an integrated suite of technology that enables physicians to see their patient population and panel broken out by disease cohort such as diabetes and asthma. The technology suite – specifically, tools offered by ActiveHealth Management®, an Aetna subsidiary – stratifies the disease cohorts and empowers physicians with additional data points in making a diagnosis and treatment planning.

Using this technology suite, BHN is establishing connections into the most common ambulatory EHR systems so that up-to-date health information is beginning to flow into and through the system. These bi-directional connections between EHRs and Banner Health systems will allow physicians deeper insights into specific patient information.

Getting the data into ActiveHealth is creating a lot of variable processes and a significant amount of manual effort. This hurdle is a real challenge to BHN given their large participating physician population, but they are committed to resolving this challenge.

"ACOs need to be prepared for the investment that's going to be necessary to put them in a position to not only get access to the data, but to use the data in a way that's going to be beneficial to population health management."

Bill Harris, Sr. Director of Operations

BHN is constantly looking at ways to fine-tune and refine its data collection methods that feed the BHN data warehouse, physician tools and clinical and business intelligence efforts. Since many physicians are not employed by Banner Health Network, they have their own methods for collecting patient and encounter information. Some offices may even use paper records (superbills) and may not be familiar with the latest Meaningful Use-compliant technologies. In addition the variety of different EHR solutions in place adds to the difficulty of creating and maintaining interfaces with all the different systems. Some of the EHR vendors used by affiliated physicians are not allowing third-party integration or make it difficult by requiring custom interfaces (this may be resolved with some of the recent requirements for Meaningful Use Stage 2).

On top of these technical issues, there is a cultural challenge from physicians' offices. Many physicians and office managers are apprehensive about releasing their records into BHN to facilitate and meet the goals of accountable care and the 33 quality measures required by CMS for participation in the Pioneer ACO program. Patient records have traditionally been segregated and secured by the practicing physician and associated staff. In the new world of coordinated care, patient records and physicians' notes are more accessible and available to a variety of caregivers. Personal patient comments that previously were private and localized to a specific physician's practice could be exposed. Contributions to a patient's EMR are now shown as a standardized presentation of findings in a structured format from a community of caregivers which in some cases represents a significant shift from the way medical records have been used in the past by some physicians and their offices. Banner Health is tackling these issues head on, empowering their clinical and business intelligence tools with high quality standardized information. BHN can't manage their business or ensure quality patient care where and when healthcare information is isolated or undocumented. Their efforts are emblematic of a shift from individualized care to coordinated care, from fee-for-service to bundled payments, from the past to the future of healthcare.

Patient Registry Solution

Technology and care management come together for Banner Health with the "Care Team approach." Active CareTeam℠ – a desktop tool and registry from ActiveHealth – is used by a clinical practice or a physician to see and manage their chronic disease patients. They can see gaps in care, send alerts to the staff, and track and report on patient quality measures, including the 33 Pioneer ACO mandated measurements.

The following illustrates the benefits of the CareTeam approach. If a diabetic patient hasn't had an A1C, a standard test for that diagnosis, in six months, CareTeam prompts staff to contact the patient and deliver that preventative care. This care coordination allows everyone in the office to function at the top of their license and be efficient and informed when handling their patient load. The application is web-based. When the staff log in, they see a number of different screens for their risk-stratified cohort. These screens allow drill down to the individual patient level and provide alerts for rule-based notifications and care standards.

"ActiveHealth provides a 360° view, a presentation of information to the physician in a holistic view of their entire patient population and what different disease cohorts people fall into so they can be proactive in their care."

Jennifer Jackson, Sr. Director Information Technology

Banner Health's approach to engage the physician in an effective way is multi-fold, but first on the list is to maximize the engagement of the office staff. CareTeam can be used by the management assistant on a regular basis throughout the day, prompting questions like "Have you had your flu shot?" so that this information can be recorded as part of the patient's electronic medical record. BHN envisions that case management staff will use the tool to develop a comprehensive action plan for the patient on an ongoing basis and that everyone involved in the patient's care will be able to see progress against the action plan and work from the same page. Case managers are now allowed to enter some documentation into the patient's record to enable the 360–degree view of the patient and minimize faxing between offices.

The current focus for these registry capabilities is around COPD, asthma, diabetes, heart failure and pneumonia. These are the kinds of diagnoses that, if cared for well in the physician's office, will present themselves less often in the hospital. The outpatient case managers follow up with patients to minimize the risk of admission initially or, after an inpatient stay and discharge, work to prevent re-admissions (e.g., by watching patient weight and adjusting medications and care as appropriate).

"We suffer from the high cost of un-coordinated care."

Linda Stutz, Sr. Director of Care Coordination

Banner Health works closely with key partner nursing homes to ensure care is coordinated. Active CareTeam℠, enabling both clinical and business intelligence functions, is a critical part of managing the Pioneer ACO population health at a high level, engaging healthcare staff in the most effective way to address critical risks and to see specific health issues and risks at the patient level.

Palliative Care

Banner Health has a keen focus on the top 3-5 percent of patients, or roughly 1,500 Pioneer ACO beneficiaries, that have the highest opportunity to improve quality and service. BHN recognizes that even within that group some patients will improve, some will stay the same, and others will benefit by end-of-life or advanced illness planning. BHN has experienced that most people don't want to keep coming back to the hospital in these situations and are looking for alternatives to caring for themselves in their own home or care system. Banner Health has a specialized team that focuses on palliative care, which is an area of healthcare that focuses on relieving and preventing the suffering of patients[16]. This team's work and programs are appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life. Palliative medicine utilizes a multidisciplinary approach to patient care, relying on input from physicians, pharmacists, nurses, chaplains, social workers, psychologists and other allied health professionals in formulating a plan of care to relieve suffering in all areas of a patient's life.

BHN also has their own hospice and is developing a bridge program for Palliative care and the hospice. Aetna offers a "Compassionate Care Program" supporting telephonic outreach. The initial program concept is leveraging the Compassionate Care Program to expand the reach of the BHN Palliative Care program, leveraging the ActiveHealth technology, to more effectively reach and support coordinated care and patient outreach. While these programs are in the early stages, they represent the leading edge of building and designing true population-based health management tools, identifying population health risks and engaging to manage those risks in a priority-based manner. This is the essence of leveraging healthcare data for clinical and business intelligence in support of high quality, disease-state and stage-appropriate coordinated care.

"What are the care goals, what does the patient expect, what do they want, what is important to them…those are the things we are trying to help them identify as we reach out to them."

Linda Stutz, Sr. Director of Care Coordination

Technology

Banner Health has made a concerted effort to ensure its technology enables its corporate vision and mission. In fact, the organization has developed a vision for business intelligence.

"To further develop the integrated Enterprise Data Warehouse framework to improve data quality and consistency that will provide actionable and practice based information for enhanced decision making and expedite deployment to support Banner's strategic vision."

Business Intelligence Vision, Banner Health

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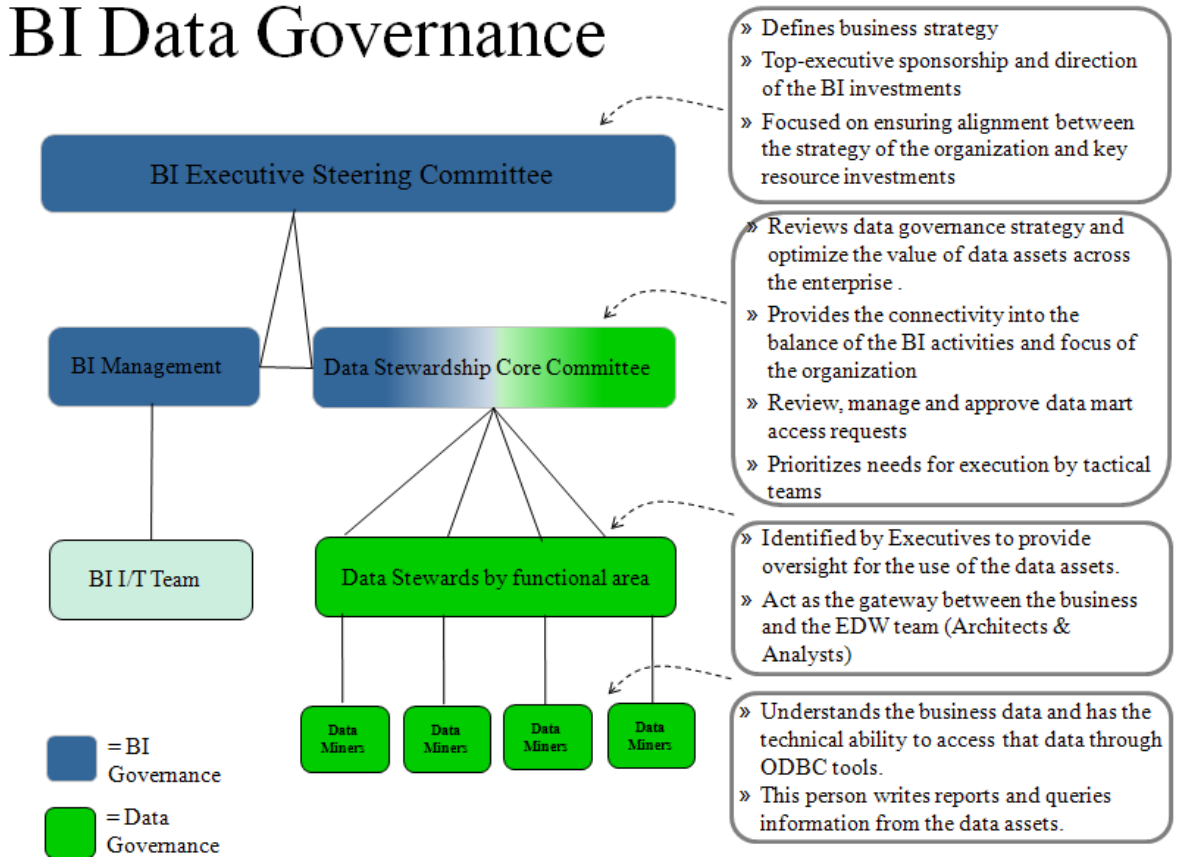
[16] http://en.wikipedia.org/wiki/Palliative_care Definition from Wikipedia, the online free encyclopedia.

From Data to Information

The “wedding cake” layers and applications are only helpful if you have information moving into and through them. The cornerstone of these solutions is data, and BHN is a demonstration of a leading-edge approach to data warehousing in healthcare. The BHN enterprise data warehouse (see appendix “A” for graphic) collects and assimilates data from many internal and external sources. To ensure the effort of collecting and managing all this data is not wasted, BHN has put in place, with executive level support and leadership, a strong BI Data Governance program. Data governance embodies a convergence of data quality, data management, data policies, business process management and risk management surrounding the handling of data in an organization[17].



Clearly demonstrated are how BI Data Governance starts with the Executive Steering Committee. IT has strong advocates within the executive suite. Each level of data governance has clearly defined roles and responsibilities and supports managing information effectively and efficiently within the enterprise design and not as silos. This level of governance is an indicator of a more mature, experienced business intelligence and clinical intelligence enabled

[17] http://en.wikipedia.org/wiki/Data_governance Definition from Wikipedia, the online free encyclopedia.

environment, one where using CI and BI are encouraged and often integrated into standard business processes.

"Early on we focused on the build of the enterprise data warehouse, the loading and the integration of the data. We quickly moved into how do we utilize this information…What is the source of truth for the Average Length of Stay (ALOS), and how are we sure everyone is defining it the same way."

Jennifer Jackson, Sr. Director Information Technology

Banner Health is now setting ambitious goals for its information management. Currently, they are using evidence-based practice around clinical intelligence to enable physicians and clinicians to make better decisions at the bedside. Today that revolves primarily around internal data and tools. BHN is working to expand that to external data sources such as pharmacy, lab, social behaviors, external claims data and other sources to better understand their population and create opportunities for better care coordination.

"The goal is to get the broader picture of our members and patients so we can better understand how to provide quality care"

Jennifer Jackson, Sr. Director Information Technology

Conclusion

Banner Health is a large organization serving a large population of beneficiaries. It needed a comprehensive solution to effectively engage in the Pioneer ACO and population health management approach. By seeking out and selecting a suite of tools, provided by and implemented in cooperation with Aetna, BHN is able to bring the pioneer spirit to population management and patient-level care coordination. The progress made with this collaboration will demonstrate for many followers the new frontier of quality health information aggregation, palliative care and population management, and in general for healthcare, what's next.

About HIMSS Analytics

HIMSS Analytics is a wholly owned not-for-profit subsidiary of the Healthcare Information and Management Systems Society (HIMSS). The company collects and analyzes healthcare information related to IT processes and environments, products, IS department composition and costs, IS department management metrics, healthcare trends and purchase-related decisions. HIMSS Analytics delivers high quality products, services and analytical expertise to healthcare delivery organizations, healthcare IT companies, state governments, financial companies, pharmaceutical companies, and consulting firms. Visit www.himssanalytics.org for more information.

About Sponsor Corporation

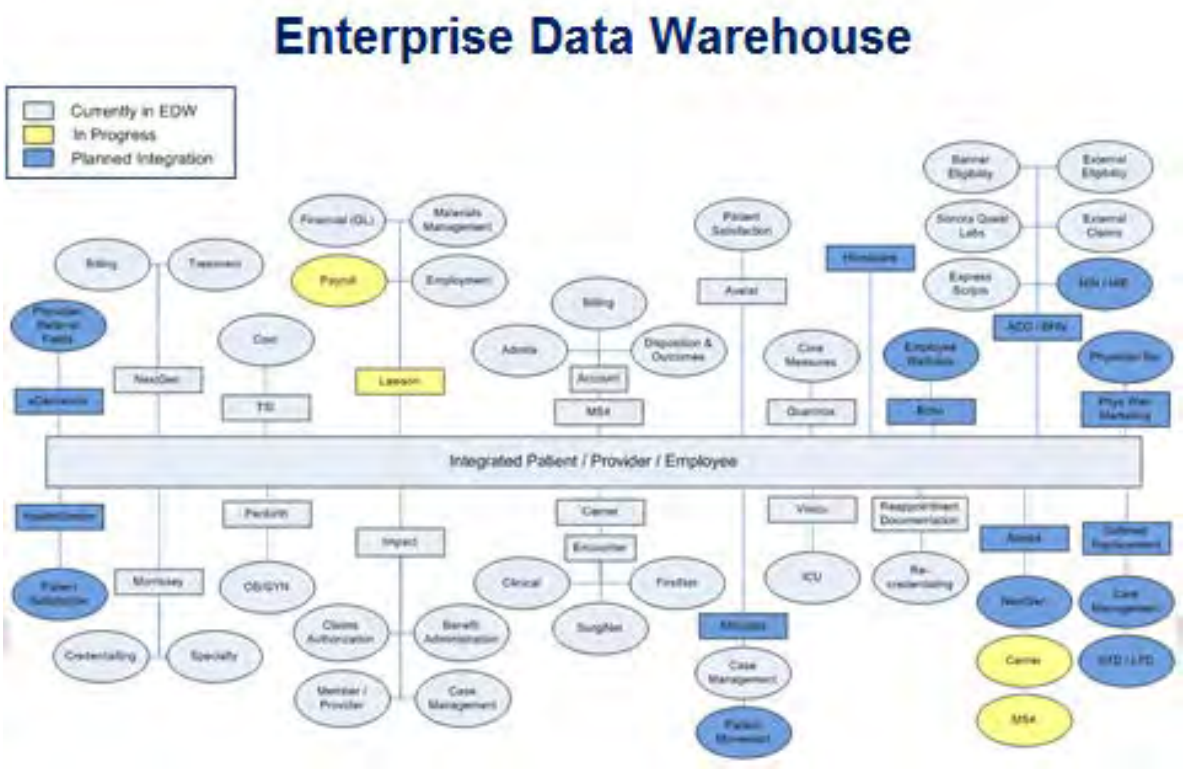
Accountable Care Solutions from Aetna empowers each provider organization to realize its unique strategic vision of value-based care through patient-centered health solutions, an

advanced technology suite and flexible health plan services. We work closely with our clients to deliver the strategic insight and market intelligence needed to jointly design and build more sustainable business models that allow providers to reduce costs, improve care quality and deliver a better experience for patients.

About The Author

Mr. James E. Gaston has 22+ years of healthcare information technology experience which started at Arkansas Children's Hospital in medical research and hospital administration, progressed with Arkansas Blue Cross Blue Shield where he served as the Enterprise EDI Architect and as a business intelligence leader. Currently, Mr. Gaston is Senior Director of Clinical and Business Intelligence for HIMSS and HIMSS Analytics, where he facilitates healthcare clinical and business intelligence related research along with providing expertise in mobile health and healthcare related information technology.

Appendix A


Enterprise Data Warehouse
Currently in EDW
In Progress
Planned Integration
Integrated Patient / Provider / Employee

QUESTION 5.1.3.2

Company Profile

HIPAA Compliance

Description:
We are in full compliance with HIPAA requirements that have been issued to date. Following is a brief summary:

Privacy
We have taken all steps necessary to comply with the Privacy Rule requirements, including:

- Naming a chief privacy officer and establishing a Privacy Office.
- Implementing new and/or revised company-wide privacy policies and procedures.
- Training impacted personnel.
- Implementing system changes and workflows to provide members with (i) access to their health information, (ii) an accounting of many types of disclosures, (iii) a process for requesting amendments to their health information, and (iv) the ability to request restrictions or have confidential information mailed to an alternative address.
- Delivering a Privacy Notice to full risk subscribers.
- Adopting specific disciplinary procedures and sanctions for employees who violate our Privacy Policies.

Transactions and Code Sets
We are positioned to support HIPAA compliant electronic transactions and code sets. We have the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare and Medicaid Services (CMS).

Security
To prepare for the HIPAA Security Rule, we performed a thorough risk assessment of our systems and operations and developed and executed a remediation plan.

Unique Identifiers
Aetna is compliant with the unique Employer Identifier Number (EIN) requirement.

QUESTION 5.1.3.2

We also can accept and process HIPAA standard electronic transactions that comply with the National Provider Identifier (NPI) regulations. Effective March 16, 2009, to comply with HIPAA regulations, we began rejecting electronic claims and encounters submitted without a billing provider NPI. If a "pay to" provider is identified on a claim, the NPI for that provider must also be included. We continue to work diligently with providers to educate them and bring them into compliance according to the HIPAA regulation.

Org Chart:
Diane F. McCammon is Aetna's Chief Privacy and Security Officer and is responsible for our compliance with the HIPAA Privacy and Security Rules.

Sean Hart, Head of Security Services, partners with the chief privacy and security officer to provide an overall improvement in the information security posture of Aetna as well as monitoring progress toward that objective. Exercising the chairman's retained authority, Sean and her unit perform the following functions:

- Protect Aetna information and information technology resources through a framework of timely, efficient and business driven Aetna Information System (AIS) security policies, standards and procedures.

- Recommend, maintain, communicate and manage adherence to integrated cross-functional AIS security and business continuity architectures, direction, policies, processes and standards that foster and serve as a basis for management planning, control and evaluation of information security activities.

- Establish individual employee responsibility for information security by setting simple, practical security requirements.

- Provide information security knowledge through the development and use of innovative, effective educational material.

- Interpret security policies, or provide input on direction of Information Security for Aetna.

- Establish and coordinate simple, business-related procedures for information security incident management, compliance monitoring and reporting. Provide AIS investigative support to management and investigative services, as required.

QUESTION 5.1.3.2

- Monitor pending legislation affecting AIS policies and practices and engages in effecting position (State and Federal) of health care/insurance information access, control and protection. Coordinate Aetna plan for required implementation or compliance.

- Assist in identification of appropriate, cost-effective sources of information to establish best practices and determine appropriate recommendation for a secure environment.

Subcontractor:
Aetna provides HIPAA compliance internally.

Location/Hours of Operation/Point of Contact/Onsite Support:
HIPAA compliance is followed and supported throughout our organization. Our privacy and security office is located in our headquarters in Hartford, CT.

The State's account executive, Lynda Gable, will serve as your single point of contact for any HIPAA related needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Communications

Description:
We offer extensive member communications to educate members, promote our programs and support our services. These communications include pre-enrollment materials, post enrollment materials, and extensive web tools.

Pre-enrollment communications
Some of the pre-enrollment communication materials include enrollment forms, provider directories, plan brochures, discount program flyers, special program flyers, wellness program brochures, flyers and html e-mails promoting our online tools and resources. In addition, we provide communication materials on other plans and programs available to the member, such as pharmacy and dental flyers, where appropriate.

Post enrollment communications
Post-enrollment materials may include eligibility change forms, ID cards, plan documents, wellness educational information and reminders, and html e-mails and electronic newsletters on educational, quality and patient safety topics.

QUESTION 5.1.3.2

Web tools
Members are looking for convenient, round-the-clock online tools and information to help them make educated health care decisions and manage their benefits online. Aetna Navigator®, our secure member website at www.aetna.com, offers several online resources which include benefits information, health education, health assessment tools, cost and quality tools and health care decision support.

Aetna Navigator features secure functionality allowing members to:

- Check claim status and view claim details such as the amount paid by the plan and the member's responsibility
- View eligibility information for themselves or a covered dependent
- Request a replacement ID card, view ID card information and print a scaled-down wallet sized image, if needed
- View explanation of benefits statements
- Check plan contact information including our toll-free member services number and claim office address
- Contact member services through secure messaging in both English and Spanish
- Download personal claims safely and securely to a computer or disk for use in planning for dental care expenses, tax reporting and record keeping

Dental health information and resources

We offer user-friendly online tools to help members more effectively use their dental plan and make more informed care decisions. Resources include:

- DocFind® – Our online directory of participating providers is accessible from our public website and is available in English and Spanish. We update DocFind six times per week. DocFind includes details about participating dentists, such as location, dental school attended and year of graduation. Public DocFind is also available on mobile devices.

QUESTION 5.1.3.2

- Simple Steps to Better Dental Health® – Our educational website at www.simplestepsdental.com provides members with comprehensive dental health information in collaboration with The Columbia University College of Dental Medicine. The site includes 17 major topic areas, interactive tools, an "Ask the Dentist" feature, detailed information on over 50 conditions and procedures, and information on the effects that medical conditions such as diabetes and heart disease can have on oral health. The site also features resources for children to learn about dental terms and the importance of taking care of their teeth at an early age. For example, children can watch a video that shows the typical experiences of a young girl when she visits her dentist for a checkup. Children can also play interactive games such as "Connect the Dots" and explore the "What's In Your Mouth" tool. The site also provides important information to parents about children's dental health, from a baby's first dental visit to the teen years.

- Aetna SmartSource℠ – Our intelligent online search tool is available through Aetna Navigator, Simple Steps To Better Dental Health and our Personal Health Record (PHR). Users simply enter a dental term to find easy-to-understand information and articles about the search topic, estimated costs for dental care, dental discount program information, and dental clinical policy bulletins. Aetna SmartSource integrates information about the importance of good oral health into search results for related health conditions, such as diabetes or pregnancy. It also features this information for users who have identified relevant health conditions in their PHR. For example, users who list diabetes as a condition on their PHR will see featured articles about gum disease.

- Ask Ann – Our virtual assistant, "Ann", provides members with personalized guidance to find health and dental benefits information on our Aetna Navigator website. In her role as a subject matter expert, members can ask her questions in their own words. Ann translates a member's natural language and returns the appropriate responses and additional web links. Ann knows specific information about each member, so she can offer personalized support. Ann knows which page the member is on and supplies relevant page information specific to the member. With an average of over 20,000 chats per day, her fast and relevant responses range from simple transactional information to expansive knowledge that targets the two most important member topics - claims and benefits.

QUESTION 5.1.3.2

- Aetna InteliHealth – Our health information subsidiary at www.intelihealth.com is a leading source of online health information. We partner with Columbia University College of Dental Medicine to provide credible dental content to educate members and engage them in their dental health.

- Access Healthwise® Knowledgebase – Our user-friendly decision-support tool helps members make more informed health decisions, such as when to treat a health problem at home, when to call a doctor or dentist and what treatment options may be available. Available in both English and Spanish, we designed Healthwise Knowledgebase to encourage informed health decision-making, allowing users to better understand their treatment options.

- Estimate the Cost of Care (ECC) –This interactive tool provides members with cost information to help them plan for and better manage their dental care expenses. Members can compare the estimated average in-network and out-of-network costs in their area for selected dental services and see the potential cost savings by choosing a participating dentist. ECC also links to Aetna InteliHealth and Healthwise Knowledgebase.

- Dental Plan Selection & Cost Estimator Tool – Available upon request, we offer this decision support tool during open enrollment to help the State's employees select the dental plan that is right for them. We customize the tool to reflect the State's Aetna benefit offerings. The tool educates employees about their dental benefits and encourages them to select the most cost effective dental plan to meet their needs. It includes high-level in-network plan details, such as copay, coinsurance and deductible amounts, so employees can compare costs of dental plan options. We have found that this approach not only encourages employees to become better dental care consumers but also builds employee satisfaction with their dental benefits.

Custom communications

Aetna Customized Communications Group℠ (CCG), our strategic communications consulting group, is available to partner with the State to develop and deliver customized materials. This talented, award-winning team has more than 25 years of experience in developing customized benefit communications and offers a broad range of products and services to meet your needs.

QUESTION 5.1.3.2

Offering a unique combination of benefits knowledge and communication expertise, CCG develops open enrollment campaigns, launches and sustains wellness initiatives, and educates employees about appropriate utilization of the programs and services that encompass their overall benefits program. CCG will prepare detailed proposals outlining recommendations, specifications and associated costs. All materials are developed according to your plan design, style, tone, philosophy and employee audience.

Backed by an experienced staff of project managers, writers, graphic designers, print production managers, web developers and distribution specialists, CCG has the expertise and technical resources to produce a broad range of materials and manage benefit communications of any size and level of complexity from start to finish.

Support of health literacy
Nearly 9 out of 10 adults have trouble understanding and using the health information they are given in health care settings.[1] This leads to poorer health and increased costs. To address this problem, we created the Health Literacy Workgroup. At the start, the main goal of the group was to raise awareness about the challenges of poor health literacy. Later, we began to propose solutions to address the challenges.

Our mission is to have a positive impact on health outcomes by using and promoting universal health literacy strategies. Our goals are to:

- Research the effect of health literacy on consumer understanding of health information and its impact on health outcomes.
- Increase awareness about health literacy among health care professionals, members and Aetna employees.
- Provide stakeholders with the tools and resources they need to address challenges to health literacy.
- Promote language simplification so that we communicate health information in a manner that is understood by all audiences.

QUESTION 5.1.3.2

Our cross-functional group contains representatives from:

- Health care management
- Quality management
- Pharmacy and dental operations
- Product and program development
- Marketing and communications
- Claims and customer service
- Sales

Health literacy initiatives

Since 2005, we've worked hard to:

Spread the word

We speak about the cause to Aetna employees, industry trade groups, professional associations and other health literacy groups. We've invited experts in the field to speak to our employees. These experts include Drs. Darren Dewalt, Bob Like and Barry Weiss, as well as plain language and cross-cultural communications expert Janet Ohene-Frempong.

Engage employees

Employee "champions" weave the concepts of health literacy and plain language into the fabric of the organization. This increases the value of our brand, reputation and business success. Every Aetna employee receives annual awareness training about health literacy and plain language. We also have an online health literacy awareness course for all employees.

Permanent features of our employee intranet include *Jargon Alerts* and *Because You Asked*, which both help employees figure out better ways to convey information. During national Health Literacy Month, we sponsor contests to engage employees. One asked entrants to rewrite a paragraph to reduce its reading grade level and enhance its clarity.

QUESTION 5.1.3.2

Reach out to clinicians

We talk to doctors and nurses about their role in helping patients better understand their health and health care. We have created awareness activities for doctors, including:

- Health literacy messaging to physicians via educational and clinical apps
- Features about health literacy in our physician newsletter
- A health literacy reference tool on our provider education website
- A cultural competency course for clinicians

Conduct research

We research and analyze the effect of health literacy on consumer understanding of health information and its impact on health outcomes.

Improve communications

We have used plain language to simplify more than 200 codes for our explanations of benefits and simplified more than 70 member letters. In addition, we produce *Navigating Your Health Benefits for Dummies*, a book that breaks down the complex health benefits system into easily digestible pieces and helps consumers navigate their way.

Collaborate with others

One of our medical directors serves on the programs committee of the American College of Physicians Foundation. An Aetna vice president is an active member of the Institute of Medicine's Round Table on Health Literacy, as well as chair of AHIP's Health Literacy Taskforce. We also collaborate with the American Medical Association Foundation to distribute their continuing medical education course on health literacy to clinicians.

We work with the Financial Planning Association to sponsor *Plan for Your Health,* a public education website that gives consumers the tools and information they need to make smart health benefit decisions to protect their health and financial future. The site focuses on life stages such as changing jobs, getting married, starting a family and planning for retirement. It is also available in Spanish.

[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Washington, D.C.

QUESTION 5.1.3.2

Workflow:
All standard pre-enrollment distribution activities are centralized. This helps to ensure the accurate fulfillment and timely delivery of enrollment materials regardless of where we send them. Our standard process is to bulk-ship enrollment materials from our fulfillment center to your locations for distribution to employees. There are no additional costs associated with this standard delivery process.

We will work with the State to determine whether pre-enrollment materials will be sent to the employees' homes or made available at employee meetings. There would be an additional cost to mail these materials to the members' homes. Member ID cards are mailed to members' homes at no additional charge. Post-enrollment materials are available to you to send to members.

Org Chart:
As of December 31, 2011, we had 198 employees in our Communications division.

Aetna Customized Communications Group℠ (CCG) has 25 full-time employees, including project managers, writers, graphic designers, print production managers and distribution specialists.

Subcontractor:
We primarily provide communication services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Production and fulfillment of most communications, including our CCG team, are located in Hartford, CT.

The State's account executive, Lynda Gable, will serve as your single point of contact for any communication needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

Information Technology

Description:
Aetna Information Services (AIS), the Information Technology (IT) function of Aetna Inc., supports the core Aetna Group values by leveraging technological solutions that provide more information and more choices to policyholders, members and internal business partners.

QUESTION 5.1.3.2

Aetna's Information Security Policy was created based on the following supporting national standards:

- **HIPAA** (Health Insurance Portability and Accountability Act of 1996)
- **ISO/IEC 17799**, Information Technology - Code of Practice for Information Security Management, First Edition, Reference Number ISO/IEC 17799:2000(E), 2000-12-1
- **NIST Special Publication 800-12**, National Institute of Standards and Technology: An Introduction to Computer Security: The NIST Handbook, October 1995
- **NIST Special Publication (SP) 800-14**: Generally Accepted Principles and Practices for Securing Information Technology Systems, September 1996

The Company has placed into operation an Enterprise Risk Management Process to identify and prioritize the significant enterprise risks that could affect the Aetna Group and the Company, including its ability to provide reliable service to customers of the Company and, specifically, for purposes of this Report, to users of the Company's Self-Funded Products. The goal of this process is to assist management in identifying significant risks inherent in the processing of various types of transactions for users and implementing appropriate measures to monitor and manage these risks.

The Company's management of risks is primarily achieved through the various control environment items discussed above. The Chairman, CEO and President of the Company, along with the Chief Enterprise Risk Officer and other members of senior management, are responsible for identifying and managing the risks that might impact the Company through predefined organizational reporting structures. The Board of Directors of Aetna Inc., along with Aetna Inc.'s Audit Committee and other Aetna Inc. Board committees, oversees the Aetna Group's enterprise risk management processes, including risk identification and prioritization.

Information Security Awareness
New employees are introduced to Aetna's Information Security Program via a web-based New Employee Orientation Program. Each new employee and contingent worker must complete Aetna's Code of Conduct training program called Business Conduct & Integrity (BCI), which includes an Information Security module.

All employees and contingent workers must complete BCI annually thereafter. Audience specific (managers, application developers, etc.) security training is routinely provided. Aetna's training program is robust and well documented.

QUESTION 5.1.3.2

Continued reinforcement via emails, web articles, newsletters, and face-to-face activities is provided to the Aetna workforce regarding each individual's role in ensuring the confidentiality, integrity, and availability of Aetna information.

Background checks on all personnel
A comprehensive background investigation is conducted on all candidates for Aetna regular and Aetna temporary employment. Employment offers are contingent upon the candidate's successful completion of this investigation.

For additional information about our Information Technology, please refer to the attached Information Security High Level Overview document.

Flow Chart:
Please refer to the Information Technology Flow Chart and Network Diagram attachments.

Org Chart:
To design and deliver these technology solutions, AIS has nearly 3,000 IT professionals and over 2,000 contractors working collaboratively, in dozens of teams, in every area of IT. AIS and its service and solution orientation stretch from e-commerce to mainframe operations utilizing top technical and business talent. Project planners, network engineers, database analysts, architects, developers and quality assurance engineers are all key members of AIS.

These IT professionals are currently organized into eight functional departments. The eight main departments are Integrated Infrastructure Services (IIS); Enterprise Architecture (EA); Program Delivery (PD); Application Delivery (AD); AIS Delivery Operations (ADO); Enterprise Testing & Quality Assurance (ETQA); Production & Enhancement (P&E); and International IT.

Each department is accountable for a key element of practical and strategic IT solutions delivery.

Subcontractor:
We primarily provide Information Technology services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our IT staff is spread out across many offices throughout the country. The State's account executive, Lynda Gable, will serve as your single point of contact for any information technology needs.

QUESTION 5.1.3.2

Integration with Other Vendors

Description:
We have extensive experience integrating with other vendors.

We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Aetna Informatics® has more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

We typically disclose processed claim transaction data in our standard Universal File formats, one for Medical/Dental and a separate format for Aetna Pharmacy Management.

These electronic claims data extracts are available through CD-ROM or electronically on a fee-for-service basis. If the standard format does not meet the State's needs, customized reporting is available.

We also have the capability to import external pharmacy, medical and behavioral health claims data from third-party vendors into selected clinical and reporting applications. The external data that we bring into our organization is used for a wide variety of purposes including but not limited to:

- Disease identification
- Disease severity identification
- Decision support
- Case management
- Predictive modeling
- Personal health record input
- Patient safety programs such as MedQuery®
- Input into selected HEDIS measures

Subcontractor:
We perform integration services in-house.

Location/Hours of Operation/Point of Contact/Onsite Support:
The State's account executive, Lynda Gable, will serve as your single point of contact for any integration needs. Please refer to the attached document "State of Alaska Organizational Chart" for Aetna's complete team that will support the State of Alaska.

QUESTION 5.1.3.2

Patient Value Chain

Network

Description:
Aetna Dental® celebrated its 55th anniversary in 2012 and is one of the nation's leading providers of integrated and standalone dental products, serving over 13 million dental members. We offer some of the largest dental networks and discounts available in the industry today.

Offering our plan on a national basis attracts large customers who can provide the patient base participating providers are looking for. Our experience in offering dental benefits for over three decades encourages dental providers to apply for participation.

Our DPPO has networks in all 50 states as well as Washington, D.C., Mexico and Puerto Rico.

We value the relationships with participating providers. Our philosophy is to build long-term, positive working relationships across our networks. We accomplish this by providing equitable compensation as well as resources such as a local network management team, a national dedicated toll-free telephone number and a dedicated dentist website. In addition, we have a Value Plus Program where participating providers can access discounts on laboratory services, dental supplies, computer hardware and software, infection control services, record-keeping systems and continuing education.

We continually look for opportunities to grow our dental network. Working with customers to identify and target non-participating providers has proven to be effective and we will continue to take advantage of the leverage that this provides when negotiating with potential providers.

We identify the high claim volume, non-participating providers across our book-of-business on a quarterly basis and reach out to them with recruiting packages. These efforts involve thousands of dentists each year.

Annually, we go through a detailed national network fortification process at a county level. We review the population, number of available dentists, competitor's networks and market penetration.

We also reach out to our sales and account management teams to identify and prioritize areas that might be targeted for sales growth. We send out solicitation kits to these areas and follow-up in an attempt to add them to our networks.

QUESTION 5.1.3.2

We continue to reduce out of network use by increasing the size of our network. We work with our customers to focus on the recruitment of frequently used non-participating providers in addition to other national recruitment initiatives.

Our steerage plans (Active PPO) encourage in-network care by offering higher benefit levels when members receive services from participating dentists. Members and State of Alaska can save on the cost of dental care when participating dentists are used.

Members can see the price difference of visiting an in-network provider by visiting the "Estimate the Cost of Care" comparison tool on the secure website for members at www.aetnanavigator.com.

We will work with State of Alaska to create and communicate plan designs that encourage in-network usage and communicate to members the benefits of seeking in-network care.

Org Chart:
We have included a West Region Network Staff organizational chart attachment.

Subcontractor:
Network management services are provided in-house. We directly contract with approximately 85 percent of our participating dental providers. The remaining 15 percent come to us through network access arrangements with other network vendors.

Location/Hours of Operation/Point of Contact/Onsite Support:
The West Territory Dental network teams are located in California, Arizona, Michigan, Missouri and Illinois. We do not have any staff residing in Alaska.

We provide specific, designated toll-free telephone numbers for both members and providers. While the nature of member and provider calls is often different, we train our customer service representatives to handle both types of calls, regardless of what toll-free number is used. This is part of our effort to promote resolution of inquiries at the first point of contact.

Dental service center hours of operation, Monday through Friday (excluding holidays), are:

- Albany, NY: 8 a.m. to 6 p.m. ET
- Jacksonville, FL: 8 a.m. to 6 p.m. ET
- Woodland Hills, CA: 8 a.m. to 6 p.m. PT

Our dental service centers are strategically located so that we provide customer service access from 8 a.m. to 6 p.m., regardless of the caller's time zone.

QUESTION 5.1.3.2

Aetna Voice Advantage and Aetna Navigator are both available 24 hours a day, 7 days a week. These self-service options allow members to obtain information without speaking with a customer service representative.

The State's account executive, Lynda Gable, will serve as your single point of contact for any network needs.

Plan Design

Our Dental PPO (DPPO) plan is designed to work well for all customers. Our versatile claims system allows us to accommodate the deductibles, coinsurance levels and plan maximums that you select. Member cost sharing is based on negotiated provider fees.

Please refer to our dental plan design and deviation documents included with this proposal response.

The State's account executive, Lynda Gable, will serve as your single point of contact for any plan design needs.

Eligibility & Enrollment

Description:
You will have an assigned enrollment analyst who will be responsible for maintaining high quality in the eligibility data system.

We accept and process enrollment and change data in any of the following methods:

- Internet-based Eligibility Transfer Solutions – The State can submit eligibility using our web-based transfer solution called SecureTransport™. The State uses the software to transmit eligibility files to us during open enrollment and as needed for updates. SecureTransport is a trademark Axway® used under license.

- Electronic Transport Method – The State can submit enrollment through SecureTransport using an electronic transport method.

QUESTION 5.1.3.2

- e.Listing – An e.Listing is an Excel spreadsheet populated with eligibility data. We scan the spreadsheet into our systems and it mirrors an electronic file, eliminating manual intervention. The e.Listing functionality increases the timeliness of eligibility updates so that members can access care quickly. e.Listings received by us prior to 3 p.m. ET in the appropriate format are processed same day.

- Enrollment Forms – The State can submit paper enrollment forms that will be input manually.

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

We integrated the enrollment aspect with our policy entry, claims and pharmacy management systems.

Your enrollment analyst will monitor the eligibility file updates and will know immediately about any errors. The State and your assigned analyst will work together to decide how to best correct the errors. If we detect an error, we will modify or replace the file typically within 48 to 72 hours.

Open enrollment support
Our representatives are available to help employees with questions during the annual open enrollment meeting. We offer the following materials:

- Enrollment application and change forms
- Plan descriptions and benefits comparisons
- Provider directories
- Other program information

We will work with the State to coordinate open enrollment needs and communication support.

Flow Chart:
Please refer to the Enrollment Flow Chart attachment.

QUESTION 5.1.3.2

Org Chart:
The Enrollment/Eligibility department is managed by the National Accounts Plan Sponsor Services (NA PSS) organization within Aetna Service Operations. The NA PSS department manage plan set up, eligibility, billing and accounts receivable, and drafting for group customer accounts.

Eligibility, as with all PSS functions, is managed in two geographic regions within Aetna National Accounts (Northeast/West). The State will be managed by our West region. There is an overall PSS lead that oversees all aspects of PSS operations. Each region has a manager that oversees the servicing of their book of business. Teams in each region are dedicated to eligibility processing with eligibility managers, consultants, and technical staff. You are assigned a dedicated eligibility consultant that works with your appropriate contacts to ensure the account is handled timely and accurately.

Subcontractor:
We provide our eligibility and enrollment services in-house. We contract with Source One Direct, Inc. of Atlanta, GA and Kingston, RI for ID card production.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our enrollment/eligibility staff is spread out across several offices throughout the country. The State will be handled by our West region, which has eligibility consultants located in our California, Walnut Creek, CA Office.

In addition to an assigned eligibility analyst, who will be named upon award of business, the State can discuss eligibility and enrollment questions or needs with their onsite resources as well as Lynda Gable, the account executive.

Customer/Member Services

Description:
Our member services help take the guesswork out of health care. Members can solve a problem with a single phone call, get answers to their health questions in the middle of the night, and find a doctor online, at their convenience.

QUESTION 5.1.3.2

We offer our members a variety of tools that allow them to use the services they need when they need them. We have options for our most tech-savvy members, as well as those who prefer to conduct business in a more traditional way. Members benefit from services that include:

- A concierge to access information and connect members with clinicians and product specialists
- Cost look-ups for services and pharmacy products
- Easy to contact member service professionals who can solve a problem on the first call
- Multi-language and hearing impaired phone options
- 24-hour service with the Aetna Voice Advantage®
- Ratings for doctors and hospitals
- Ask Ann, an interactive tool that lets users ask questions and get personalized answers
- Mobile technology and apps for smartphones

Putting members first with the Aetna health concierge
For the State of Alaska, we are proposing a more personal one-to-one member advocate, called the My AlaskaCare Single Point of Contact, who will focus on providing a simplified, seamless member experience to help your members maximize all their available benefits and navigate their individual health care journey. Just as many hotel guests depend on the services of a concierge; our members depend on our concierge. J.D. Power and Associates has recognized our informed customer helper as “an outstanding customer service experience” for three years in a row. More than three-quarters of a million members rely on the health concierge, a single point of contact that provides personalized help. The concierge also connects members to additional resources to help them get the most from their benefits.

QUESTION 5.1.3.2

The My AlaskaCare Single Point of Contact service model provides custom-tailored service based on the unique aspects of your health benefits and program offerings. Think of the My AlaskaCare Single Point of Contact as a health resource consultant with in-depth benefits knowledge and consultative soft-skills that empower them to deliver high-satisfaction service that is personalized within the context of individual member needs for education, guidance, and support. They will help you make the most of your benefits strategy by empowering your members to make better-informed decisions that support program participation and engagement.

The State will have 16 concierge members dedicated to the State of Alaska. They will partner with all State members' connecting you to the right resources across your entire portfolio.

Reaching a trained, caring member service professional
Many members still prefer person-to-person phone contact. We train our representatives to answer a question or solve a problem on the first call, and give them the tools they need to find answers and access to areas that can help when they can't.

In 2011, we resolved 94.3 percent of about 39 million calls on the first call in an average of 24.5 seconds. That resulted in an overall member satisfaction rate of 92 percent.

Member service professionals are available, toll-free, 10 hours a day. They can help with:

- Filing a claim
- Determining what members will pay
- Getting a referral, when required
- Finding dentists and other providers
- Finding care outside of the service area
- Understanding how the plan works

Providing specialized services for a diverse membership
Member services professionals can connect members to someone who speaks the same language through our Language Hotline. Interpreters for 140 languages are available to members who request this service.

Members who are hearing impaired can call Aetna's TDD line for specialized service.

QUESTION 5.1.3.2

Getting answers when you need them
The Aetna Voice Advantage® interactive telephone system is available 24 hours a day, 7 days a week to provide information for members when they need it. The easy-to-use tool determines the reason for the call as members talk and finds the information they need. This makes it easy to make better health care decisions.

A member who wishes during the call to be shifted over to a representative simply says so or presses "0." This transfers the call and all information already gathered to someone who is trained to help.

Helping members get information on the go

One out of five Americans accesses the mobile web on a typical day. We engage our members with mobile web, smartphone applications (apps) and text messaging to meet their needs on the go.

Aetna consumer research found that the best liked health-related mobile apps help users save money and easily access health information. Our apps help members to:

- Search for a doctor, dentist, hospital or pharmacy

- Register for our secure member site, where you can:

    - View your claims
    - View your coverage and benefits
    - View your Personal Health Record
    - View your ID card information
    - Check drug prices
    - Contact us by phone or e-mail

Meeting our members where they are
We meet our members where they are with resources that engage them in making well-informed health care decisions. Whether it's a phone call from home to member services or a text message from a smartphone, we have the resources in place to help our members get the most from their health care.

QUESTION 5.1.3.2

Flow Chart:

For the My AlaskaCare Single Point of Contact model, members call in to their assigned toll free member services number. They are then greeted by the Aetna Voice Advantage automated telephone service, which requests member identification information and can provide personalized self-service information. Members may opt out of Aetna Voice Advantage at any time by asking to speak with an operator, or CSR. By selecting this option the member will be routed directly to a My AlaskaCare Single Point of Contact concierge. If needed the concierge can warm transfer members to additional Aetna departments, or initiate a three-way call with the member and additional parties.

My AlaskaCare will eliminate the standard transactional view of health care. It will provide your employees, retirees and their families with a personalized member experience that is customized to their needs, not ours.

QUESTION 5.1.3.2

Org Chart:
We have attached our Fresno Service Center Organizational Chart, as well as a Western Dental Service Center Organizational Chart.

Subcontractor:
Member services will be performed in-house by our Aetna employees.

Location/Hours of Operation/Point of Contact/Onsite Support:

The My AlaskaCare Single Point of Contact team will be located in our Fresno Service Center. The State will also receive additional dental claims and member service support from our Western Dental Service Center.

You will also have onsite resources located in Anchorage and Juneau.

The My AlaskaCare Single Point of Contact team will be available from 8 am to 6 pm local time. We also offer automated member service support 24 hours a day, 7 days a week through Aetna Navigator, our secure member website, and Aetna Voice Advantage, our telephone self-service system.

Utilization Management

- Approvals/Denials

Description:
We do not require predetermination of benefits; however, when a dentist expects the charge for a proposed course of treatment to exceed a specific dollar amount, we do recommend a predetermination of benefits.

Flow Chart:
The dentist sends the proposed treatment plan, which details the condition of the patient's mouth, the proposed services and the charges for those services, to the appropriate claim office prior to the start of treatment. The claim office estimates the benefits payable for the covered dental course of treatment.

We base the benefits for covered dental services on widely accepted national standards of dental practice for the treatment of the dental condition, taking into account the current oral condition of the patient.

Our claim personnel determine the necessity of treatment and, if applicable, apply the alternate benefit provision. They may refer the case to a consulting dentist for professional evaluation and opinion for situations that require it.

QUESTION 5.1.3.2

We do not deny benefits solely because the dentist does not submit a predetermination, unless the terms of the plan specify otherwise. The State may choose to require a predetermination for services over a specific dollar amount. Predeterminations are not required for emergency treatment.

The intent of predetermination is to inform the patient and dentist of the estimated benefits payable for the proposed course of treatment and of expenses for noncovered procedures.

Subcontractor:
We perform predetermination of benefits in-house.

Claims Processing

- UCR Management
- Explanation of Benefits (EOB)
- Coordination of Benefits (COB)

Description:
We process claims through our dental claim payment system, which is capable of handling a wide variety of plans and includes features that promote a streamlined workflow in the dental service centers. The system automatically applies:

- Plan deductibles,
- Coinsurance,
- Benefit maximums,
- Age/frequency limitations,
- Exclusions, and
- UCR and/or scheduled limits.

If we cannot process a claim to completion, we pend it in the system. Claim benefit specialists can retrieve them online and process to completion when we receive the required information. Our system provides an immediate update to claim history.

UCR Management
For R&C based benefit determinations Aetna consults the FAIR Health Benchmarks database produced by a new, not-for-profit entity, FAIR Health.

QUESTION 5.1.3.2

The standard value for the recognized amount is the 80th percentile of the R&C database. The State may opt for the following recognized amount level alternatives: 50th, 60th, 70th, 75th, 85th, 90th or 95th percentile. These alternate recognized amount level percentiles will not affect automatic system calculation. Additionally, we can accommodate a $5 or $10 corridor within which we would not reduce charges.

UCR is updated semi-annually.

Explanation of Benefits
Member EOBs
We consolidate member EOBs for the same family on one EOB whenever possible and mail on a consistent day of the week, which we base on the member's state of residence. We use a 21-day mailing schedule; however, if state regulations require an earlier issue date, the system will back up the mail date to the 14th or the 7th, to the same day issue.

We mail EOBs daily when there is a member payment or request for additional information from the member.

Members can view EOBs on our secure Aetna Navigator website, www.aetnanavigator.com.

Provider EOBs
We bulk print and mail provider EOBs and checks with delivery within 24 days of the date we receive the claim. We mail the majority on a weekly or biweekly schedule, and on a consistent day of the week, depending on the provider's state of residence. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Coordination of Benefits
Our coordination of benefits (COB) approach is "pursue, and then pay." We investigate the availability of other primary benefits before paying a claim. We screen all claims for COB, including those where the member's current eligibility file does not indicate other coverage.

Identifying other coverage

Effective COB administration starts with the collection and maintenance of accurate information about other coverage. We gather this information in many ways including:

- During enrollment, many of our customers collect information about other coverage and share it with us.

QUESTION 5.1.3.2

- Due to the cooperative nature of our relationship with network providers, dentists routinely obtain other coverage information and submit it with the claim.

- In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and request specific details.

- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of our Aetna Navigator website.

Updating COB information

When we receive other coverage information, we update the employee and family's online eligibility record. Our claims system then automatically flags claims with a COB notice during claim processing. This notice includes details about:

- Other coverage
- Names of family members the other plan covers
- Carrier name
- Type of coverage
- Date of the last update

COB process

If we are the secondary payer and the claim does not include the primary carrier's explanation of benefits (EOB), we pend the claim and request the information from the member.

When we receive the EOB, we process the claim according to the plan design.

For maintenance of benefits or non-duplication plans, the COB allowable expense is our normal benefit. This is our negotiated rate reduced by copays, coinsurance or other applicable plan provisions.

For standard plans, the COB allowable expense is the lesser of the primary plan's negotiated fee (if the primary plan is also a network plan) or the amount submitted to the primary carrier, subject to usual and customary reimbursement limitations.

Once we determine the allowable expense, we subtract the primary carrier's payment and pay any balance that does not exceed our normal benefit.

QUESTION 5.1.3.2

Flow Chart:
We have attached a claims process and EOB flow chart.

Org Chart:
We have attached our Western Dental Service Center Organizational Chart.

Subcontractor:
The majority of our claims processing functions are performed in-house. We use the following subcontractors for claims review:

Subcontractor	**Scope of Services**	**Location**	**Doing Business with Aetna Since**
Aftermath Claim Science, Inc.	Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment..	Newington, CT	2004
Connolly Consulting	Overpayment recovery for data mining, duplicate payments, provider credit balance.	Wilton, CT; Conshohocken, PA; Philadelphia, PA	2000
DiversiMed, Inc.	Overpayment recovery for hospital bill audit.	Tampa, FL	2006
End-Game Strategy, Inc.	Overpayment recovery - data mining - HMO (second pass)	Berlin, CT	2010
EquiClaim, Inc. (Viant/Concentra Preferred Systems)	Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit)	Naperville, IL; Chattanooga, TN; Lake Forest, CA	2000
OmniClaim, Inc.	Overpayment recovery for Implant and DRG services.	Woburn, MA	2009
Rawlings Company, LLC	Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.)	La Grange, KY; Van Nuys, CA	1996

QUESTION 5.1.3.2

As part of our efforts to ensure quality in each and every transaction that our constituents have with us, we subject potential subcontractors/vendors to a lengthy and involved process employing rigorous review of each subcontractor from a number of different perspectives (i.e., scrutinizing management, corporate history, financial performance and pro forma statements, references, site reviews, diversity and human resource policies and privacy and security practices) to determine each subcontractor's ability to meet our expectations of performance and scope. Once they become one of our subcontractors, we regularly re-review these factors.

We conduct business with subcontractors through a standard contracting methodology that outlines the relationship from a number of critical aspects, including, but not limited to, service levels, certain representations, covenants, warranties, audit rights, indemnities, confidentiality, compliance with laws, insurance, financial terms, security of information and termination. This also includes a contractual obligation to disclose any adverse legal actions related to the services performed for Aetna. We have relationship managers who are responsible for the overall relationship with our subcontractors.

Location/Hours of Operation/Point of Contact/Onsite Support:
Our Western Dental Service Center will provide dental claims processing services to the State. Lynda Gable, your account executive will act as a single point of contact for any claims related issues.

Quality Control

- Performance Guarantees

Please refer to our response to question 5.5.2 and the requested Attachment I4 – Dental Claims Administration and Managed Network Implementation and Performance Guarantees for the complete list of performance guarantees we are proposing for the State.

We have also included a description of our Quality Management program below.

Dental Quality Management
Quality management is provided through our Dental Quality Management (QM) program, which focuses on the ongoing assessment and promotion of appropriate dental care and support services for dental members.

QUESTION 5.1.3.2

The goals of the QM program are:

- To implement a comprehensive, multidisciplinary program that addresses and responds to the dental needs of the member population
- To measure, monitor and help improve performance in key aspects of dental service quality for members, providers and customers
- To promote the provision of affordable and timely dental services to members
- To facilitate communication among key functional areas
- To promote compliance with applicable law

The National Dental Quality Oversight Committee (QOC) has accountability for and oversees our QM program, including:

- Establishing priorities for the QM program
- Evaluating clinical and operational quality
- Integrating quality management activities among departments
- Reviewing and evaluating services rendered by participating dental providers
- Identifying and evaluating systemic issues and corrective action steps

The QOC includes the following individuals:

- Dental regional managers
- Chief dental officer
- Head of Dental Networks, Administration & Clinical Services (chair)

As appropriate, quality management information gathered and evaluated by the QOC is forwarded to and referenced by the National Dental Credentialing and Provider Performance committee (CPPC) in the credentialing/recredentialing and evaluation of participating providers. The QOC meets at least quarterly.

The National Dental Quality Advisory Committee (QAC) is responsible for reviewing clinical issues and assisting in the establishment of national clinical policies, subject to the oversight and authority of the QOC. The QAC meets and reports on its activities to the QOC, and discusses and makes recommendations to the QOC on clinical issues, quality programs, work plans, policies and procedures. The QAC also reports to the QOC on any delegated activities.

QUESTION 5.1.3.2

The QAC includes the following individuals:

- Chief Dental Officer (chair)
- Regional Dental Directors
- National Dental Director of Utilization Management

The National Dental Credentialing and Provider Performance Committee (CPPC) is a national committee responsible (subject to state law) for the credentialing and recredentialing of individual dental providers.

The CPPC and its delegated subcommittees have decision-making authority with respect to network providers. The CPPC conducts and/or oversees review activities involving the professional competence and conduct of dental providers.

CPPC membership is appointed by the QOC and includes:

- One Regional Dental Director (chair, appointed by the Chief Dental Officer)
- One additional Regional Dental Director (appointed by the chair of the CPPC)
- Four participating network dentists (including at least one specialist dentist)

This QM Program is maintained in written format by the national QOC and made available to the QAC and QOC members, applicable regulatory authorities, and other individuals and/or committees designated by the QOC.

We monitor and evaluate important aspects of care and service delivered to members in various ways, including but not limited to:

- Credentialing/recredentialing of dental providers
- Review and evaluation of:

    - Utilization
    - Quality-related member complaints and appeals
    - Peer review of applicable professional competence and conduct issues
    - Any activities delegated to an outside entity

- Development, implementation and monitoring of clinical practice guidelines

QUESTION 5.1.3.2

We also evaluate individual instances of alleged or apparent poor quality. Local plan staff is responsible for the investigation and evaluation of the facts surrounding the applicable event, and the facilitation of review and follow-up action by the appropriate committee(s) or individual(s). Examples of situations that may be considered for review include, but are not limited to:

- Member-expressed concerns regarding administrative and/or quality of care issues
- Practitioner-expressed concerns regarding previous dental management
- Evidence of inappropriate dental management identified during routine review of claims or other clinical assessments
- Inappropriate conduct on the part of a dentist

Additional mechanisms used to monitor and evaluate significant aspects of dental care and the delivery of dental services include:

- Member services data
- Member disenrollment
- Fraud detection

Appeals

Description:
We established a national process for handling complaints and appeals from members, providers and customers across all regions and products. The national process provides for administrative consistency, centralized data collection, business accountability, a consistent workflow process and standardized reports.

Aetna developed the Complaints and Appeals Tracking System (CATS) to support this national process. CATS stores the necessary data relating to a complaint or appeal for tracking, resolution and reporting purposes. This centralized data collection enables us to increase customer service, customer satisfaction and promotes regulatory compliance.

QUESTION 5.1.3.2

CATS provides a single system to capture, track, route and resolve all member and provider complaints and appeals. CATS interfaces with the customer service documentation system to capture verbal complaints and appeals. The application is web-based and allows for routing the complaint or appeal and relevant documents between the Customer Resolution Team and the accountable business units for processing.

Flow Chart:
We have attached a flow chart of our appeals process.

Org Chart:
Customer service representatives (CSRs) attempt to resolve all member complaints at the point of contact. If a CSR is unable to resolve a complaint, they forward it to a Customer Resolution Team (CRT) for handling and, if needed, to the appropriate business area for investigation and response.

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals. Medical directors make appeal decisions with a clinical element.

We have attached our Western Dental Service Center Organizational Chart.

Subcontractor:
We have contracted with the following URAC accredited independent review organizations: IMEDECS and MCMC, LLC and AMR.

Location/Hours of Operation/Point of Contact/Onsite Support:
Lynda Gable, the State's account executive will be the point person for all appeal related issues.

Data Analysis

- Data Collection
- Reporting

Description:
Data Warehouse
One of our most differentiating assets, our vast data warehouse, consists of 18 terabytes of integrated claim, membership, product and provider information.

QUESTION 5.1.3.2

The data warehouse is larger and more sophisticated than standard database management systems available in the marketplace. It is sourced by numerous operational systems such as:

- Enrollment/eligibility
- Claims administration
- Provider applications
- Patient management applications

The data warehouse encompasses the following product lines:

- Medical
- Pharmacy
- Dental
- Vision
- Disability
- Behavioral Health

From this data warehouse we execute numerous data analytic, reporting, trending, predictive modeling and data mining processes and activities.

Data Quality
Aetna Informatics® is committed to ensuring the quality of our data assets and analytical tools. Over the past several years, we have completed multiple initiatives, which focus on improving the quality of the data stored in the warehouse. Aetna Informatics, in conjunction with our IT partners, has developed a rigorous monitoring process to screen the data added to the warehouse during our monthly load cycle. Designated Aetna Informatics support staff is dedicated to researching and resolving data issues, proactively communicating suspected and known data issues and ensuring our end-users understand the nuances of our information systems.

Reporting
Aetna Health Information Advantage™ is the ideal tool for benefits managers, placing valuable information right at their fingertips. Aetna Health Information Advantage, an information application software tool created by Aetna Informatics, makes performance experience data available through the Internet. We encrypt the information so it remains secure.

Aetna Health Information Advantage is comprised of interactive data analysis capabilities and preformatted reporting.

QUESTION 5.1.3.2

Interactive data analysis can be performed on topics such as Key Measures, Dental Trend, and Membership. These topics are called "Modules" and are produced at the customer level by funding arrangement and product type on an incurred basis with a 2-month claim lag. These modules offer a high level view of the current data as well as book of business and prior year comparisons. Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, etc. as well as geographic and provider related options.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis, rolling 12 months with a 2-month claim lag. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format.

The preformatted Dental Standard Report package includes the following exhibits:

- Key Statistics - Dental
- Trend Analysis by Dental Cost Category
- Dental Provider Network Experience (applies to PPO product only)
- Dental - Costs Sharing Analysis
- Demographics for Dental Membership
- Top 25 Services by Dollar
- Savings and Benefit Payment Distribution
- Utilization by Procedure Group

The standard report package can also be run by various time periods, account structure, product combinations and incurred versus processed.

In addition to the product-specific standard reports, we offer a Summary by Product package which provides key information for all dental product lines in one package.

We will also provide the following reports at no additional cost to the State:

Renewal Accounting Package
This package includes a complete, detailed accounting of the policy period. We provide this after the policy period is complete. It includes an analysis of actual paid fees, claims and employees. It also details any charges incurred throughout the policy period, and if applicable performance guarantee results.

QUESTION 5.1.3.2

Banking Reports
These reports perform monthly bank reconciliation and track appropriate funding liability limits. A monthly funds request and receipt report provides a summary of the funds requested as well as a record of the funds received for paid claims in a one-month period. The funds summary report provides a control/suffix breakdown of the recorded claim dollars included in the wire transfers. Additional reports allow the customer to check the monthly status of paid claims charged against a plan's liability limits, depending on the funding arrangement.

Subcontractor:
We provide our reporting in-house.

Location/Hours of Operation/Point of Contact/Onsite Support: Our reporting tools are available to the State 24 hours a day, 7 days a week. Your account team will also be available as needed to assist with reporting analysis.

Financial

- Subrogation
- Banking
- Direct Bill
- COBRA

Description:
Subrogation
We use The Rawlings Company, an experienced, national vendor of third-party recovery services headquartered in Louisville, KY, as our subrogation vendor.

The following provides an overview of The Rawlings Company's file identification, investigation and recovery processes:

Identification

Rawlings mines paid claims data using a proprietary set of diagnostic codes to identify trauma-related treatments.

Members are mailed up to five inquiry letters that include a brief questionnaire asking about their treatment. Rawlings begins their inquiry once accumulated medical claim payments reach a threshold of $300.

QUESTION 5.1.3.2

Members have three ways to respond to Rawlings' questionnaire:

1. Member can call a toll-free number answered by experienced analysts.

2. They can return their completed questionnaire in a postage-paid reply envelope.

3. They can visit www.TRGClaimsInfo.com and complete the questionnaire online.

Rawlings' also utilizes a subscription-based data warehouse of property and casualty claims to research whether an accident occurred.

Rawlings' Non-Cooperation Unit investigates high-dollar claims when members are not responding to inquiry letters.

Subrogation opportunities may also be brought to our attention when Aetna is asked to respond to a subpoena in a member's tort lawsuit requesting records of payment.

Investigation

Investigations are assigned to analysts organized by client-specific teams supported by team attorneys.

Analysts define a strategy based on every possible source of recovery and place all parties on notice of your claim.

Analysts manage files on their proprietary software. Some of the many features include:

An automated diary system that allows analysts to record the details of all file activity and share these with other team members collaborating on the file.

A tickler system that automatically prompts analysts to plan effective follow-up for each file.

Automated special handling notifications (e.g., group restrictions).

A library of letters and notices approved by Rawlings' legal team.

QUESTION 5.1.3.2

Recovery

Subrogation recoveries are remitted from Rawlings to Aetna via a bulk wire and recoveries are credited to an individual customer at the claim level through their wireline account. The customer will see a credit for the gross recovery, a charge for Rawlings fee and a separate charge for any administrative fee charged by Aetna on their claim detail report.

Banking
We use a joint benefit payment clearing account (i.e., a Single Account Multiple Participant or SAMP account) with Bank of America or Citibank Delaware. The State subscribes to this account by signing a banking agreement that we forward to our bank.

The State is identified as payer to show that benefit payments go directly from the customer to employees. We are shown as the State's agent. No minimum balance is required.

If plan benefit disbursements are issued electronically (via Electronic Funds Transfer), then we prepare disbursement files for the bank, similar to how we batch and prepare checks for providers/members. As the files are generated to the bank, you are charged for the disbursements which will be included with the plan benefit disbursement reconciled check payments.

Due to your funding being on a checks-issued basis, we request funds from your designated bank on the first day of each month and again if recorded claims total at least $20,000. We anticipate funding for the State to be daily.

Our claims accounting systems and our bank’s benefit payment clearing systems have been carefully designed to maintain tight item and dollar controls and to provide extensive edits for consistency and completeness. These systems serve large numbers of customers each day and are regularly audited by both internal and external auditors.

QUESTION 5.1.3.2

COBRA

Our Standard COBRA/HIPAA administration includes:

- Takeover of pending and enrolled participants
- Qualifying Event Notices
- COBRA elections and terminations
- Premium collection and distribution
- Eligibility updates to carriers
- Disability extensions
- Conversion Rights Notices
- Notices of Unavailability
- Medicare Notice
- Notice delivery via First Class mail (including Proof of Mailing for Initial Rights Notices and Qualifying Event Notices)
- Severance package management
  Participant IVR and Call Center Customer Service
- Web-based participant service for current account status, payments, mailed documents
  Participant communication options via email with *eNotify™*
- Employer web portal for reports, documents, participant information
- Comprehensive client reporting package with On-Demand feature
- Client management support
- Updates on legislative changes pertaining to COBRA administration

Optional services and features include:

- Initial Rights Notices and HIPAA Special Enrollment Rights
  - New plan members
  - Re-notification to currently eligible population
- HIPAA Certificates of Creditable Coverage/HIPAA Portability Statements
- HIPAA Notices of Privacy Practices statement sent on behalf of client. The notice will be drafted by and provided by the client
- Late payment reminder notices for participants sent 15 calendar days before the grace period ends if the current month's premium payment has not been received
- Termination of COBRA continuation rights sent to Qualified Beneficiaries who do not elect coverage within the 60 day election period – Noncommence Letter
- Medicare Part D: Creditable Coverage Notices and Non-Creditable Coverage Notices.
- Audit COBRA participant status with carriers

QUESTION 5.1.3.2

- Custom reporting
- Dedicated #800 capabilities
- Changes in Scope of Services
- Annual Open Enrollment Services (Available after PayFlex has been providing administration for a minimum of 90 days.)
- Optional Government Mandated Notices
- Premium Disbursement to Carriers

Direct Bill

Our Standard Direct Billing administration includes:

- Billing services for
  - Retirees
  - Leave of Absence
  - Layoffs
  - LTD Participants
  - Special Populations

  Takeover of existing participants
- Premium collection and distribution
- Flexible grace period time periods based on client requirements
- Eligibility updates to carriers
- Severance package management
- Participant IVR and Call Center Customer Service
- Web-based participant service for current account status, payments, mailed documents
- Participant communication options via email with *eNotify™*
- Employer web portal for reports, documents, participant information
- Comprehensive client reporting package with On-Demand feature
- Client management support

Optional services and features include:

- HIPAA Certificates of Creditable Coverage/HIPAA Portability Statements
- HIPAA Notices of Privacy Practices statement sent on behalf of client. The notice will be drafted by and provided by the client
- Late payment reminder notices for participants sent 15 calendar days before the grace period ends if the current month's premium payment has not been received

QUESTION 5.1.3.2

- Medicare Part D: Creditable Coverage Notices and Non-Creditable Coverage Notices.
- Custom reporting
- Dedicated #800 capabilities
- Changes in Scope of Services
- Annual Open Enrollment Services (Available after PayFlex has been providing administration for a minimum of 90 days.)
- Premium Disbursement to Carriers

Strengths & Differentiators:

1. State of the Art Proprietary Technology
   - Proprietary platform developed in-house
   - Unique web portal integrating all services
   - Multi-account Proprietary Debit Card

2. World Class Customer Service
   - 98% client retention rate
   - 20.3 sec average speed to answer
   - 1.51% average abandonment rate

3. Efficient and Reliable Processing
   - 99.77% financial precision
   - 99.38% adjudication proficiency
   - 90.50% debit card auto substantiation rate

4. Security and Compliance Focused
   - FNTS & Qwest Cybercenter data centers
   - SSAE 16 – reporting on controls of service org
   - PCI Level I compliant

5. PayFlex - Sole focus is Reimbursement Account and COBRA administration.
   - Enables us to provide the best possible service to our clients
   - Cultivate a thorough understanding of the flexible benefits market
   - Remain abreast of the financial services, banking, and IRS

Flow Chart:

We have attached flow charts for our subrogation, banking, and COBRA processes.

QUESTION 5.1.3.2

Org Chart:
Rawlings is based in Louisville, KY. They have a satellite office in CA. Their staff is trained to handle subrogation matters in all states. Additionally, they have a staff of approximately 50 in-house attorneys that are available to provide guidance to their analysts and/or handle sensitive cases.

If the State would like to participate in a call on Subrogation, we would be happy to discuss and engage Rawlings.

We have attached an organizational chart for COBRA.

PayFlex's account management philosophy is to work together with clients in partnership to create a stellar client and participant experience. We stress open communication and going the extra mile to ensure that client and participant needs are met. To that end, you will be assigned a specific Client Services Manager (CSM) who will act as your operational point of contact into PayFlex for your reimbursement administration. Your CSM will be responsible for the daily, operational aspects of your program and will facilitate your implementation activities. For COBRA and Direct Billing administration, a separate Implementation Manager will be assigned.

Your CSM will also be tasked with marshaling resources throughout the PayFlex organization to meet your ongoing strategic business requirements. As necessary, other team members will be available to assist your CSM. This includes IT resources, file transmission experts and operational management team members. Your assigned CSM will bring in the appropriate resources as needed to ensure a successful client relationship.

CSMs are organized into teams. Your assigned CSM's team will consist of 2 or more CSMs who report to a Director. Directors report to our Client Service organizational leaders. This structure facilitates team work, ensures adequate back up and provides a logical escalation path that ends with our General Manager. This team structure is depicted in the diagram below.

Subcontractor:
Subrogation
We use The Rawlings Company, an experienced, national vendor of third party recovery services headquartered in Louisville, KY, as our subrogation vendor. We have used the services of Rawlings since 1996.

For over 25 years, The Rawlings Company has pioneered the innovations in subrogation and recovery services.

QUESTION 5.1.3.2

We selected The Rawlings Company to provide subrogation and reimbursement services based on their experience and expertise in the field:

- Rawlings developed the first subrogation outsourcing program for the healthcare industry and pioneered subrogation processes that have since become industry standards.

- Rawlings publishes a comprehensive national treatise on health subrogation, the *Rawlings & Associates National Subrogation Law Manual*.

- Rawlings continuously monitors legislative changes at both the federal and state levels that may affect a plan's right to seek recovery. They apprise their clients of significant changes and offer strategic recommendations as appropriate.

- Rawlings' Partnership Program offers several valuable services to self-funded groups desiring to be a more active participant in their recovery program. Rawlings' attorneys will review a group's Summary Plan Description (SPD), making recommendations to strengthen recovery language as appropriate, and Rawlings will provide monthly reports listing unresponsive employees so groups can take steps that encourage cooperation.

- Rawlings offers members who speak a language other than English several ways to respond to their inquiry letters. Spanish-speaking members may call a dedicated toll-free line answered by Spanish-speaking recovery analysts, or they may elect to answer Rawlings' online questionnaire using the Spanish language option. Rawlings also uses AT&T's Language Line to communicate with members who speak a language other than English or Spanish.

- Rawlings provides excellent customer service to self-funded groups. For example, when a member calls The Rawlings Company, they speak directly to an experienced recovery analyst, not to a call center representative.

COBRA
PayFlex does not outsource any of our administration services. With the exception of data services, which are provided through First National Technology Solutions and CenturyLink, and debit card processing which is provided by First Data Corporation, PayFlex provides all administration services in house.

QUESTION 5.1.3.2

Location/Hours of Operation/Point of Contact/Onsite Support:

Subrogation

Rawlings is based in Louisville, KY. They have a satellite office in CA. Their staff is trained to handle subrogation matters in all states. Additionally, they have a staff of approximately 50 in-house attorneys that are available to provide guidance to their analysts and/or handle sensitive cases.

COBRA

PayFlex is headquartered in Omaha, Nebraska with additional offices in Denver, Colorado, Chicago, Illinois and Hagerstown, Maryland. Operations are provided primarily out of the Omaha headquarters location which includes: Reimbursement Account Services, COBRA Services, Call Center, Distribution Center, Claims Processing, IT support and Aetna headquarters in Hartford, CT. Client Service Managers are located in Omaha, Denver, Hagerstown and Hartford. A secondary call center site is also located in Maryland. A "virtual" call center environment approach ensures that call volume can be switched between call centers, as needed, to meet specific requirements. Our Chicago office provides additional technology support.

PayFlex provides call center customer service support via a toll-free number. Customer Service Representatives (CSRs) are available from 7 a.m. to 7 p.m. CTZ Monday through Friday and on Saturdays from 9 a.m. to 2 p.m. CTZ. CSRs are available to answer participant questions, assist with claim processing and to educate participants about spending account usage.

PayFlex provides participants with a 24 X 7 IVR through a toll-free number. Participants can call the IVR to receive updated account information.

Participants have access to a self-service web portal that is available 24 x 7. Through the portal, participants can view account status, account activity and claims status. They can also submit a claim, request an additional card, view and download correspondence and forms, sign up to receive e-mail correspondence and sign up for direct deposit.

QUESTION 5.1.3.2

State Objectives

Plan Design
Policy Development
Innovation
Performance Incentives

The State of Alaska has clearly articulated a vision and objectives that will transform health care delivery in the State. While not necessarily unique, they do require the State to partner with an organization that is innovating and evolving at a rapid rate to fully support the short and long term objectives. Aetna is an organization that can support the objectives and continue to bring forth approaches and solutions critical to the State of Alaska's future success through four key pillars:

INNOVATION, DESIGN AND PERFORMANCE EXCELLENCE– Aetna is the administrator for 643 national account customers, 318 public and labor organizations, 197,467 Medicare customers, 1,257,110 Medicaid members, and 17,818,931 commercial members. This portfolio of customers is the result of continuously innovating and supporting our customers. Our insured book of business is also important as we also require all of the innovation and support, the same as our self-funded customers.

We have a culture of innovation at Aetna and have developed multiple areas of the organization to support organizational improvements from all of our employees. This ranges from innovation at every level of the organization to our Emerging Business Unit focused on developing critical customer solutions. This innovation has resulted in on-going enhancements in how we are improving our operations to both streamline the administrative processes and enable design solutions to support our customers. This begins with the simple measures of having our clinical policies be included in our network contracts and our claim system tied to those same policies. Our network and any custom network solutions are fully integrated into our claim system to streamline the payment process. Our leadership has empowered all Aetna employees to identify methods to improve our operations to deliver the highest quality program to our plan sponsors and members.

QUESTION 5.1.3.2

Our innovation, design and performance excellence enables us to support the following State of Alaska objectives:

- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions
- High accuracy in claims processing
- Quality customer service

CONSUMER ENGAGEMENT – The age of the consumer is here and Aetna fully recognizes this as a key area to cost management. We are creating the critical support for the member with the personnel and technology to provide information and advocacy through the method sought by the member. We truly believe that the support the State of Alaska requires to transform health care is through One Member at a Time. Our Health Concierge Service model is the My AlaskaCare Single Point of Contact. The My AlaskaCare SPOCs are specially trained personnel with the tools to be the member advocate and truly the "Concierge" role across the full benefit program continuum. Our technology is the other mechanism that puts the power of transparency, clinical decision support and provider directories (in and out of network) at the member's fingertips via web and mobile phones. For the State of Alaska, the My AlaskaCare SPOC and web and mobile tools are a key cornerstone to supporting your members both in and out of Alaska. It supports the advocacy and member experience across Aetna and all of the State of Alaska benefit programs essential to delivering upon State of Alaska objectives.

Our consumer engagement enables us to support the following State of Alaska objectives:

- Encouraging patients to engage in the management of their own health
- Providing them with resources and skills to obtain appropriate health care services
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance

EVIDENCE-BASED MEDICINE – Aetna has not wavered from using evidence-based medicine to manage our customers' benefit programs on both a self-funded and fully insured basis. This begins with our disciplined approach to developing clinical policies based on evidence-based medicine. Our Clinical Policies are often used by TPAs and other insurance carriers, because of the disciplined approach and rigor around the on-going review process. Our Care Engine technology is the Clinical Decision Support the State of Alaska is seeking by ensuring evidence-based medicine is applied to all medical and pharmacy claims. The application of evidence-based medicine includes our dental program that leverages our Dental Medical Integration grounded on dental care that drives medical costs.

QUESTION 5.1.3.2

Our evidence-based medicine enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

PROVIDER COLLABORATION – Our network management is built on sound principles beginning with evidence-based medicine approach to our clinical policies to our reimbursement approach in Alaska. Our experience in core network management and breadth of our book of business will further support the necessary network development in the State.

More importantly, we are in a material shift in health care delivery through the evolution of Patient Centered Medical Homes and Accountable Care Organizations. Aetna has been a leader in national quality networks through Aexcel and the on-going evolution of high performance networks. This experience and our supporting technology have enabled us to be a market leader in the development of Accountable Care Organizations and the infrastructure to support other Patient Centered Medical Home models. Our collaboration includes the early stage evaluation of an Accountable Care Organization in Alaska, which would benefit the State of Alaska.

Our provider collaboration enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

QUESTION 5.1.3.2

Our experience across these four cornerstones in Alaska and the lower 48 will allow us to support the State of Alaska's objectives across each of the RFP components. When integrating each of the RFP components, we can deliver a fully integrated comprehensive solution that will support the goals and objectives, which includes delivering the cost controls so critical to the future of the State of Alaska benefit program.

Plan Enhancement Support

The identification of the plan enhancements is a key area that Aetna will support the State of Alaska. There are several elements to identification of plan design enhancements that we bring to the table:

Data Analytics – We have robust reporting tools that will enable us to effectively evaluate the State of Alaska's data. We have the ability to report across all of the critical facets and will structure the State of Alaska account to fully support reporting needs. Our reporting addresses all of the key areas and supports break downs by plan, group, location, etc. to effectively evaluate drivers. We have data analytics resources and subject matter experts to support the full assessment process. We leverage core reporting through our ePSM tool that provides key metrics and our more robust reporting tool AHIA. AHIA is a comprehensive reporting tool built on our data warehouse and enables robust data mining to fully identify cost drivers and issues. For State of Alaska, we will deploy all of our reporting tools to support the identification of cost drivers.

Solution Identification – While data analytics is essential, we feel the more fundamental need for our plan sponsors is the solution identification. We have made material investments in our processes to determine issues and the solutions. This begins with the use of our experts in analytics, clinical, operations, network management, Accountable Care Solutions and wellness to name a few. We also have reports exclusively focused on a detailed program review that identify issues and customer opportunities that we call Actionable Information Report. The report identifies key solutions and opportunities for the State that align to the State of Alaska's goals for policy and design, consumer engagement and provider delivery. For the State of Alaska, we commit to using our Actionable Information reporting approach as well as the full complement of our experts to develop recommendations for the State of Alaska.

Another fundamental element is the strategy and solution development process. As the State of Alaska is seeking significant change to transform health care in the State, we recommend a multi-faceted strategy and solution development process. We will facilitate the session with the State of Alaska and if appropriate, other State of Alaska vendor partners.

QUESTION 5.1.3.2

The Phase 1 of the strategy process is an annual review of the objective and short and long term goals. We will support the annual review and development of goals based on the market dynamics and leading edge approaches. We envision the goal development and strategy session will include our Account Team, Clinical Advisory Team and Alaska Advisory and Support Team to map out the strategy, barriers to success and general solutions. Through this framework, solutions begin to be framed addressing each of the areas of consideration in alignment with the State of Alaska's goals. Aetna will support the facilitation of the session and vetting national and Alaska specific solutions to support the goals. These solutions will be grounded in the tools and resources we bring to the table and specifically the level of advocacy Aetna can support through My AlaskaCare Singe Point of Contact and technology to speed the deployment of solutions.

Upon completion of the session, we will take the goals and objectives along with the potential solutions to evaluate against the State's data. We will mine the State of Alaska's data to determine the impact of solutions and begin to address necessary change management to deploy the solutions. Through this analysis, we will develop a discussion guide along with an outline of multiple paths and expected outcomes and impact to discuss with the State.

The last phase of the strategy process is a comprehensive ideation process with the State of Alaska. The ideation session will be based on sound practices used by our Emerging Business area to align to similar practices used to finalize decisions on proceeding with a business. We will assess solutions and convergence of solutions to use a brainsteering approach to develop the "product" for deployment. The ideation process uses the facets on issues, solution and overall adoption. The goal is to refine or reject solutions to arrive at an overall package for the State. We will leverage experts from our Emerging Business area to help support this process and arrive at solutions that fully understand the behavioral components and member experience so essential for long term sustainability.

QUESTION 5.1.3.2

Our expectation is to arrive at comprehensive solutions that are specific to the State's issues and extend beyond basic plan design or programmatic changes. We believe the real value we bring is the evaluation of more aggressive changes and the timing for deployment. As the State of Alaska will see, there are many solutions as we define in question 2.3.2.1. As we assess the most pivotal areas of how we can support the State of Alaska it is grounded in several key areas:

- Consumer Engagement – We have conducted significant research in consumer engagement from our Health Fund Study results, Consumer Engagement Metrics to our experiences with product development. Our focused studies in behavioral health and overall brain health are also informing us on the impact and handling of stressors. We have the ability to support solutions through all forms of designs and consumerism inclusive of leveraging our expertise on successful Health Savings Accounts and Health Reimbursement Accounts plans as well as consumer solutions for traditional PPO plans. The transformation will require overall consumer engagement and aligns with our commitment to support this one member at a time.

- Network Solutions – A core area of change necessary in the State of Alaska is the overall approach to network. While Aetna brings a highly effective and broad Alaska network that balances cost and quality, there are areas of Alaska that have boycotted networks. To a certain extent, our unwavering requirement for clinical and claim payment provisions has been a deterrent for some providers to contract. As we work with the State, we will focus solutions very specific to each borough in the State including the use of alternative arrangements as appropriate. Our expertise in Accountable Care Solutions, Patient Centered Medical Homes, Institutes of Quality for Bariatric and Cardiology, and High Performance Networks will inform solutions. A critical consumer facing tool for network solutions is our transparency tools.

- Tele-medicine – Another area of exploration is alternative providers and the role they can play for the State. Teledoc is an alternative provider option that can be leveraged for care delivery for members in rural locations as well as reduce emergency room utilization. Medical Home Exchange is another solution. These solutions reinforce an overall need to define a full strategy and align to an overall local provider base. Our expertise in these solutions and impact on networks will be evaluated with the overall network solutions for the State.

QUESTION 5.1.3.2

- Technology – The area of technology is rapidly expanding for us and will offer tremendous solutions for the State. iTriage is one of our solutions that is expanding over the next year and is a key tool for every State of Alaska member. Our technology and ability to integrate third party tracking (EOS Health for diabetes) for all areas will support the evolution of the State of Alaska's program.

While the active plan enables immediate solution deployment opportunities, we will also support the State in Pre-Medicare and Medicare design alternatives. We fully recognize the protected nature of the retiree medical program, but also recognize the plan lacks critical features to both manage costs and more importantly support retirees in health maintenance. We have extensive expertise with retiree populations to develop programs that fully balance preventive care, cost sharing and condition management to support retirees and their dependents in achieving their optimal health. We view our role as additional expertise and analytics to support the State in developing an optimal program for retirees that can be offered as a replacement or along-side the current plan.

We will support the State with the necessary solution development and analytics. The approach outlined and our support also materially changes the focus of quarterly meetings from a review of data to change measurement and solution refinement. The power of refinement is supported by the My AlaskaCare Single Point of Contact and ability to change their messaging to your members as they deliver the necessary advocacy to achieve your goals. Each year is a building block on achieving critical changes for your members and the provider network that is fully empowered by our people and solutions.

Once solutions are defined, we will use our implementation processes to deploy these solutions. The process will leverage our tools and capabilities as well as the communication budget for roll out. A critical element of any change will be the My AlaskaCare Single Point of Contact and the support the team will provide with both education and overall advocacy for the members. Leveraging our Alaska knowledge and experience along with Government and National Account experience will deliver effective design solutions to achieve the State's objectives.

Aetna has both experience as well as the underlying infrastructure to support the State in policy development. Our geographic footprint and the fact that we provide insurance coverage in Alaska and the lower 48 are benefits to the State in policy development. This experience and our disciplined approach with evidence-based medicine provide us with a unique position to support the State in policy development.

QUESTION 5.1.3.2

On a national basis, we remain focused on fostering compliance with the Affordable Care Act (ACA). We will continue to help our customers with the implementation of ACA. We will continue to advocate for workable regulations and needed legislative changes to avoid the unintended consequences of higher costs and needlessly complicated requirements on our customers. We will work with public policy leaders and legislators to fix the serious issues that continue to plague our health care system.

A significant element of policy development is the understanding of health care delivery and the variation by geography. The Account Team and advisory teams covering clinical and Alaska care delivery are a critical element to the policy development process. This team will leverage national and regional resources in the areas of clinical policy development, government affairs, Accountable Care Solutions, Primary Care Medical Home Enablement, Medicaid and Medicare program administration, health care reform, transparency and alternative payment approaches (e.g., reference based pricing and case rates) to name a few. Overall, we have the infrastructure and resources to support the State's policy development as well as a determination of pilot opportunities.

Our process will be to work with the State on developing the areas of policy development including the goals in specific areas. The team will leverage our national resources to identify best practices and approaches to impact the State's goals. Our sessions with the State will leverage the clinical and Alaska specific expertise to uncover opportunities. In addition, we will have participation by our subject matter experts to address emerging solutions in the market and address policies to support deployment of those solutions.

Once areas are identified we will work with our internal resources for the analysis of the data available. We will leverage our resources that handle our internal evaluation processes including data analytics, review of evidence, and understanding of provider and member impact. In addition, our data is made more robust by expertise we have in the establishment of Accountable Care Organizations and Patient Centered Medical Home enabled delivery systems.

We have supported organizations in the review and development of policies for their own organization as well as State legislation. While we do not provide legal advice, we have resources to support review and make recommendations on the type of changes that can change care delivery. Our role in health care reform emphasizes our desire to impact cost and quality in the health care delivery. The State of Alaska is in a unique position to drive health care delivery through policies that support the change. Our Alaska experience combined with the national resources can support the development of policy for the State of Alaska program only as well as for the State.

QUESTION 5.1.3.2

We envision a key component of the policies to be a potential demonstration of projects that explore changes to care delivery in the State. Our robust experience with Accountable Care Organizations and Patient Centered Medical Homes will be valuable in not only developing solutions, but guiding set up of changes in the delivery system.

Medical Director Support

Our professional dental consultants review requests for services and specialty care referrals. Based on their dental knowledge and experience, along with documentation submitted by the provider, the consultants review requests for appropriateness and eligibility according to the plan provisions.

Our dental consultants hold active dental licenses, many in multiple states. We have general dentists, oral surgeons and periodontists on staff. They provide clinical review for all utilization management review sites.

Support for the State

Dr. Lydia Bartholomew will be the designated medical director for the State. Dr. Bartholomew meets twice weekly with the Utilization Management team to discuss hospitalized members and their care and discharge plans, and once weekly with the case managers. She also meets with long term care nursing staff on a regular basis and is available on an ad hoc basis for any questions that arise, and for peer to peer conversations as needed. Dr. Bartholomew also interacts with staff as needed from other areas to support patient management in the region. Dr. Bartholomew sits on several national committees that support clinical guidelines and quality improvement efforts.

Location

Dr. Bartholomew is located in Seattle, Washington and will be available to travel to Alaska on a quarterly basis to meet with the State and our staff as needed.

Credentials

Dr. Bartholomew currently has licenses in Washington, Oregon, Arizona and South Carolina. She does not currently have a license in the State of Alaska.

QUESTION 5.1.3.2

Dr. Bartholomew has substantial experience in the state of Alaska as she was the Senior Medical Director for Qualis Health from 2004-2007. Additionally she has been a guest speaker at the Providence Family Medicine Residency Program on several occasions, and has taught for the Alaska Academy of Family Physicians CME programs on multiple occasions, most recently at the 2012 Winter Update in Girdwood.

Dr. Bartholomew was just recently appointed to the American Academy of Family Physicians National Commission on Quality and Practice. It is a four year appointment.

Company Awards

As one of the nation's leading providers of health and related benefits, we are pleased that national organizations and publications recognize us for our:

- Commitment to diversity
- Innovative products
- Technology innovations
- Employment-related achievements
- World-class customer service

The following list represents some of the achievements of which we are most proud.

2012

- We have received national recognition from Bloomberg BusinessWeek magazine as one of America's most community-minded companies in The Civic 50" survey. The Civic 50 survey recognizes organizations that use their time, talent, and resources to help improve the quality of life in the communities where they do business. We have placed an impressive 4th on the list. Last year, along with the Aetna Foundation, our employees, retirees and directors we collectively gave nearly $25 million to improve people's health, particularly those from underserved populations, and to increase their access to high-quality health care. In addition, our employees volunteered over 340,000 hours of their time in support of charitable efforts. The Civic 50 survey was conducted by the National Conference on Citizenship (NCoC) and Points of Light, national experts on civic engagement, in partnership with Bloomberg L.P. Companies were evaluated on seven specific metrics: leadership, measurement/strategy, design, employee civic growth, community partnerships, cause alignment and transparency.

QUESTION 5.1.3.2

- We have been named 'Top Company' For Veterans. U.S. Veterans Magazine has named us a 2012 "Best of the Best: Top 100 Companies Recruiting Veterans**.**" The honor was based on numerous evaluations, including the company's outreach and accessibility to veterans.

- We have earned the top rating of "Excellent" in DALBAR's 2012 Trends and Best Practices in Explanation of Benefits Statements (EOBs). The DALBAR award is a sign of distinction earned by print and electronic communications that achieve excellence in clarity, content and design. We introduced a newly designed member EOB last year. The DALBAR award confirms the value of these improvements.

    - Our EOB ranked 4th out of 23 submissions

    - Only 6 companies received the rating of "Excellent"

    - Our statement was recognized as "Industry Best" for clarity – achieving the highest score in this category

- We have received top honors for our dedication to helping our employees achieve and maintain healthy, active lifestyles. The National Business Group on Health, a non-profit association of large U.S. employers, recognized Aetna with the highest Platinum honor for the 2012 Best Employers for Healthy Lifestyles awards plus a distinction for the Best Stress Management Intervention program.

    - We offer employees a variety of wellness programs and resources including:

    - Get Active Aetna, a popular 16-week wellness program that offers prizes to motivate employees to eat healthy and exercise;

    - Healthy Lifestyles Incentive program, which offers financial incentives for exercising and eating healthy;

    - Metabolic Syndrome program, which measures employees' risk for certain conditions, such as cardiovascular disease and diabetes; and

    - Virtual Wellness Center, a computer-based resource that offers a virtual kitchen and a virtual fitness center, where animated instructors lead workouts that vary by intensity.

QUESTION 5.1.3.2

- We also received the stress management recognition for our Mind-Body Stress Reduction programs which include Mindfulness at Work™ and Viniyoga™ Stress Management. These programs have shown significant results in a recent study with Duke Integrative Medicine, proving their effectiveness on perceived stress, productivity, pain, sleep and cardiac health.

- The 2012 Best Employers for Healthy Lifestyles awards were announced at the Leadership Summit sponsored by the National Business Group on Health's Institute on Innovation in Workforce Well-being. The top Platinum award is given to companies with established "healthy weight, healthy lifestyles" programs with measurable success and documented outcomes.

- For the second year in a row, we have received the top award from the Center for Plan Language in the category "Web/Multimedia" for our virtual benefits advisor, known as "David". We also received an award of distinction in the "before" and "after" private sector/corporation for improvements to e-mails sent to people who started an online application for an Aetna individual health insurance plan but did not finish.

- Aetna earned the top rating of 100 percent in the 2012 Corporate Equality Index, an annual Human Rights Campaign survey. It's the 10th year Aetna has received a perfect score for service to lesbian, gay, bisexual and transgender employees and consumers.

- DiversityInc named Aetna to its 2012 list of Top 50 Companies for Diversity® for the fourth straight year. In addition, DiversityInc ranked Aetna as a Top 10 company for lesbian, gay, bisexual and transsexual (LGBT) employees and employees with disabilities.

- Black Enterprise magazine has named Aetna to its 2012 list of the "40 Best Companies for Diversity".

- For the fourth year in a row, Aetna's concierge customer service call center has been recognized by J.D. Power and Associates for providing "An Outstanding Customer Service Experience."*

QUESTION 5.1.3.2

2011

- The National Business Coalition on Health honored us with an eValue8™Innovations Awards for Aetna One Premier, our integrated care management and service model that connects people, processes and technology for a simpler, smoother pathway through the health care delivery system.

- We won multiple leadership awards for our Aetna Navigator® website at the annual eHealthcare Leadership Awards. Our secure member website was honored with:

    - A Gold Award for Best Site Design
    - A Silver Award for Best Overall Internet Site
    - A Silver Award for Best Care/Disease Management Site

- The International Data Group (IDG) recognized us for removing paper from the contracting process. Each year, IDG's InfoWorld Green 15 Awards honor the 15 most innovative IT initiatives that embrace sustainability.

  We are the first health insurer to offer electronic contract processing to doctors, hospitals and other health care facilities. Using an e-signature solution, we:

    - Complete contracts faster and more reliably
    - Reduce fax and mail expenses
    - Reduce our carbon footprint

  We have sent more than 20,000 agreements electronically since 2010.

- Aetna finished first among national health plans in the 2011 PayerView Rankings. According to athenahealth and Physicians Practice®, our business transactions are among the most simple to use, efficient and transparent when compared to other national health plans. Aetna has placed either first or second in these rankings for five consecutive years.

- The National Business Group on Health recognized Aetna with their inaugural Innovation in Reducing Health Care Disparities award. We were one of six organizations honored for our commitment to racial and ethnic equality in health care and outstanding support for a culturally diverse workforce.

- Aetna won a national ClearMark Award from the Center for Plain Language in the Best Web/Dynamic Media category for Aetna Benefits Advisor. The interactive,

QUESTION 5.1.3.2

online tool asks members questions in easy-to-understand language and helps members choose the benefits that are right for them based on their responses.

- The National Business Group on Health awarded us a Platinum Award as *2011 Best Employer for Healthy Lifestyles*. We are one of four dozen U.S. employers honored for our ongoing commitment to promoting healthy work environments and encouraging workers to live healthier lifestyles.

- For the third year in a row, Aetna's concierge customer service call center has been recognized by J.D. Power and Associates for providing "An Outstanding Customer Service Experience."*

- *Training* magazine ranked us 22 out of the top 125 companies with the best employee training. This is the 7th year in a row we have placed in the top 125.

- Diversity Employers magazine has named Aetna to its list of Top 100 Employers for the Class of 2011.

- Aetna's Hispanic Employee Resource Group was recognized by Latina Style as one of the Top Five Employee Resource Groups of 2011.

2010

- Aetna was named *International Benefits Provider of the Year* as part of the Forum for Expatriate Management's 2010 Expatriate Management and Mobility Awards. The awards recognize excellence in global mobility in 14 categories of distinction.

- We were awarded two ClearMark Awards from the Center for Plain Language for clear, reader-friendly communications. The only health insurer to earn a ClearMark Award in 2010, Aetna also was the only recipient to capture two top awards. We received the national honors for a section of our website on health and wellness, as well as for our employee newsletter on health literacy.

QUESTION 5.1.3.2

- Aetna landed the top industry ranking for FORTUNE's Most Admired List for the third consecutive year. The annual survey asks executives, board directors and analysts to rate companies in their own industry on nine attributes of reputation, including quality of products, social responsibility and global competitiveness. Aetna topped the Health Care: Insurance, Managed Care industry list overall and was ranked first in:

    - Use of corporate assets
    - Social responsibility
    - Quality of management
    - Quality of products and services

- Aetna received *New York Urban League's Champions of Diversity Award* in February 2010. The Champions of Diversity Award salutes companies that understand the need for diversity in the job market.

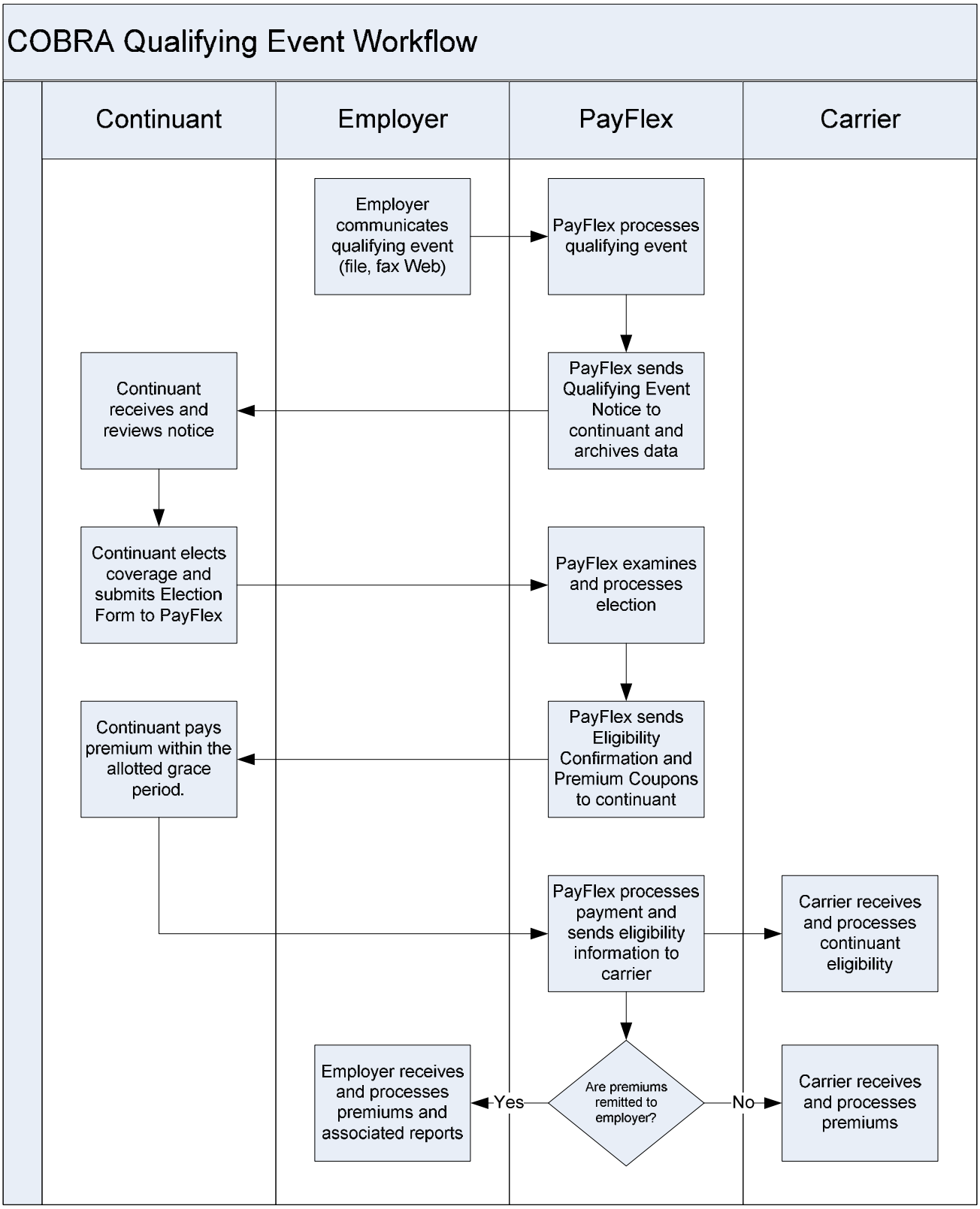
2009

- Aetna was named DiversityInc's *Top Company for Community Development* in 2009 for our support of nonprofits that share our focus on building strong communities, ending racial and ethnic disparities in health care, improving health literacy and promoting disease prevention.

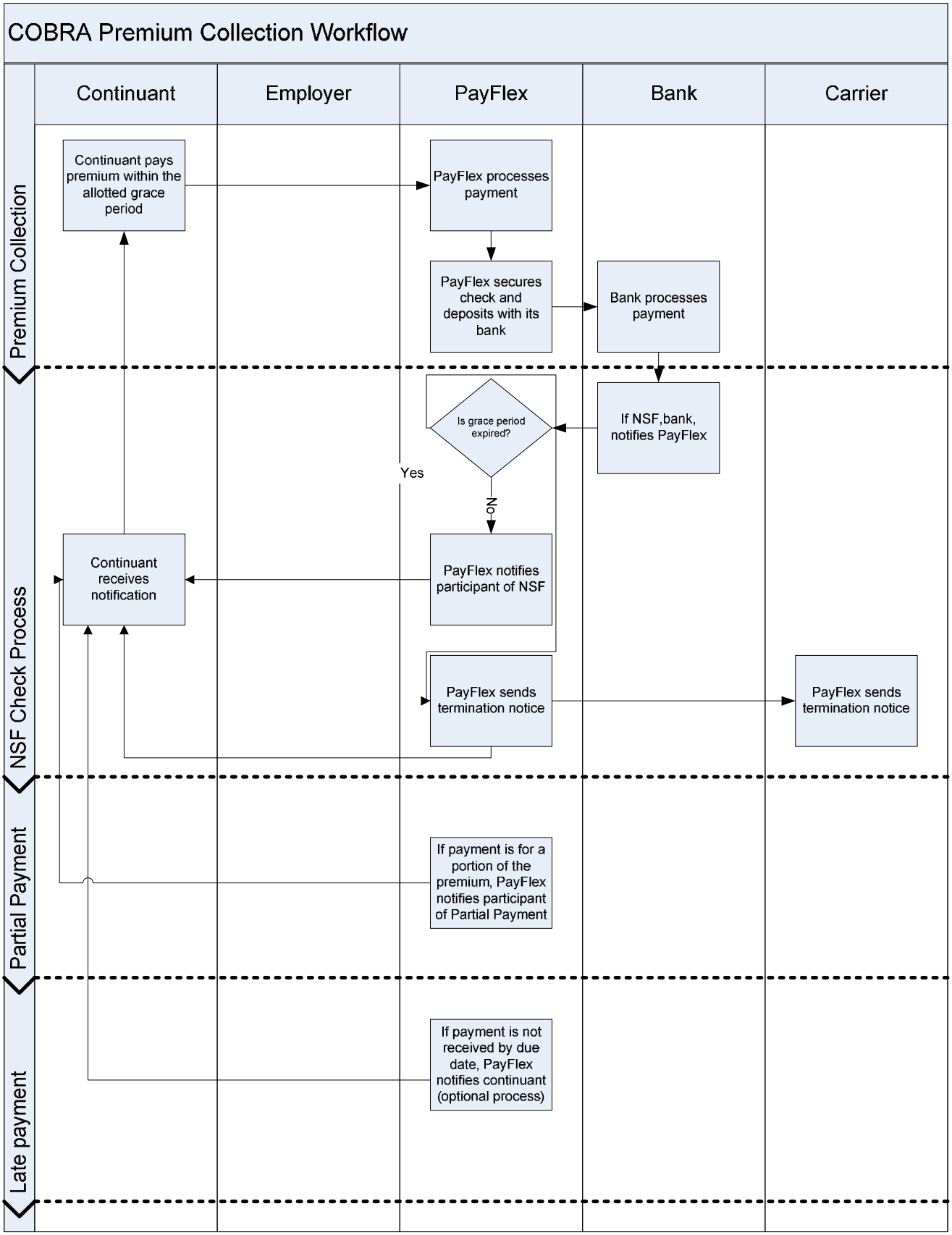
- We were awarded a 2009 *Connecticut Climate Change Leadership Award* by the state of Connecticut for our efforts to reduce our environmental impact.

- The Davies Public Affairs 2009 national payer survey identified Aetna as the preferred partner for hospitals and health systems across the U.S. The survey revealed a "strong preference from hospitals based on trust, honesty, business practices and good faith negotiations."

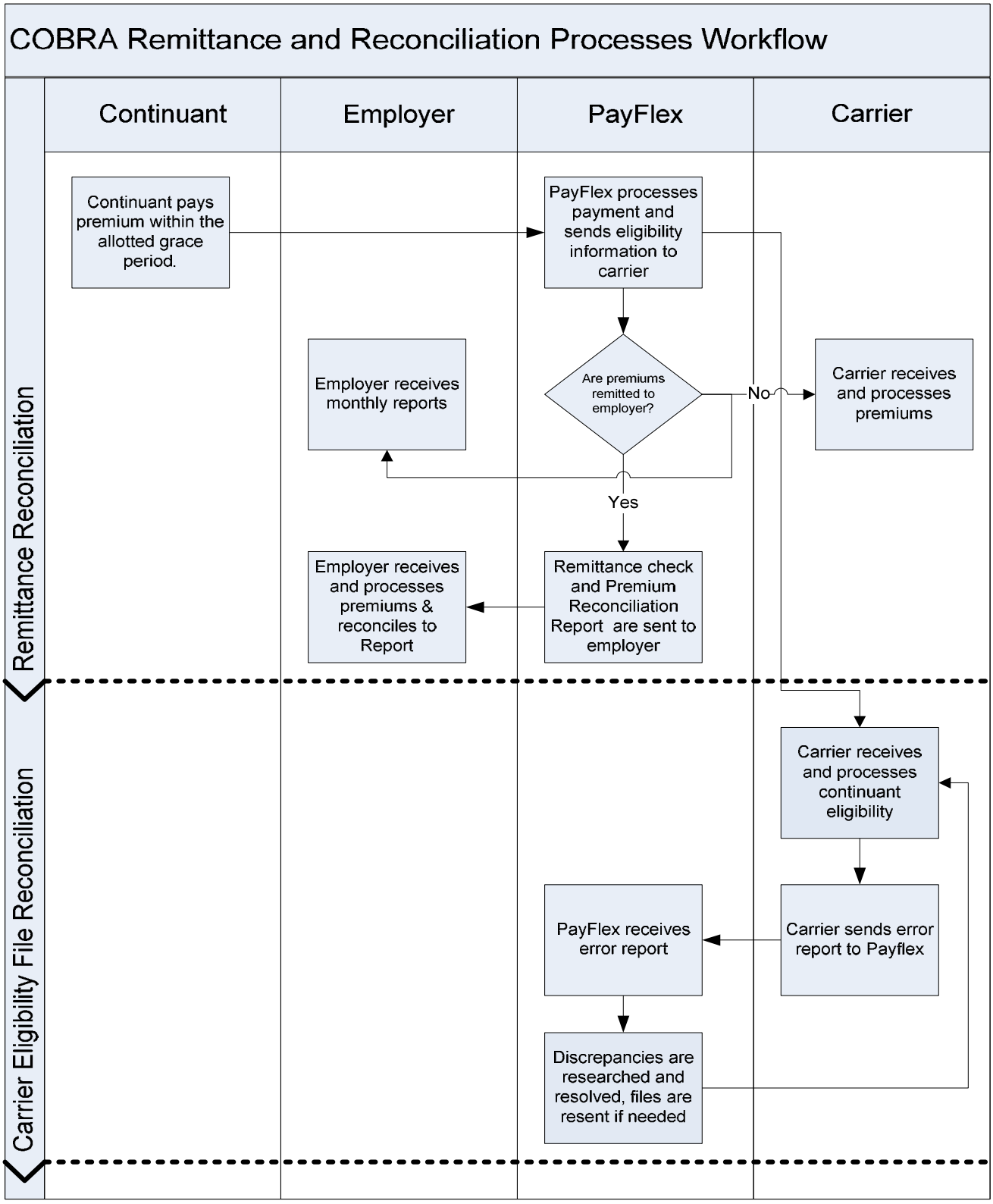
  *For J.D. Power and Associates 2011 Call Center Certification Program℠ information, visit www.jdpower.com.



COBRA Qualifying Event



COBRA Premium Collection Process



COBRA Remittance & Reconciliation

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1.

DMI

Our Dental/Medical Integration (DMI)[SM] program identifies and engages at-risk members who need dental care the most.

Our claim system identifies Dental/Medical Integration[SM] (DMI) members and automatically applies the enhanced benefits available under the program. The process is seamless. Providers do not need to call us if they treat a DMI member.

Our Dental/Medical Integration[SM] (DMI) program focuses on improving member quality of life, and ultimately, reducing costs and increasing productivity. We do this by:

- Targeting those who are at-risk and not receiving dental care
- Increasing member awareness of good dental health
- Motivating members to seek appropriate care through enhanced benefits
- Supporting members' healthy decisions through outreach

A strong scientific foundation

There is a strong connection between oral health and overall well-being. Our research shows that individuals with certain conditions, such as diabetes, coronary artery disease, cerebrovascular disease, and pregnant women, may benefit the most from the earlier dental and periodontal care that is more likely in an integrated program.

Our DMI program was founded on this scientific evidence to provide a coordinated care approach and enhanced benefits for members who need it the most.

Positively impacting costs

Our DMI program aims to avoid future costs, risks and adverse outcomes that can negatively impact a member's well-being. As we target members with certain chronic conditions, we can produce both dental and medical cost savings.

5.3.3.2

Studies have shown:

- Individuals with diabetes, coronary artery disease, and cerebrovascular disease, who received dental care earlier, lowered the risk or severity of their respective conditions, which reduced their overall medical costs.[1]
- Women who received preventive dental care had fewer birth complications than those who did not. [2]

In addition, you may save administrative costs when you use one carrier for both medical and dental coverage.

Increasing productivity

Employees miss millions of hours of work each year for dental-related illnesses or dental visits, and that number increases for parents who miss time for their children's dental appointments. Our DMI program helps lower absenteeism rates by making it more likely for an employee to receive care earlier.

We also know that better overall health leads to increased productivity. Our proactive approach to care decreases "presenteeism" and helps employees perform to their fullest when on the job.

Moving forward

While offering an integrated program is an important first step, we know it is also critical to consistently educate and motivate at-risk members to get the dental care they need. We will continue to look for ways to leverage an integrated approach to positively impact member health and ultimately lower the bottom line for our customers.

For customers with our medical and dental plans, we offer the program at no additional cost and automatically identify members using medical claim data.

Identifying Aetna medical and dental members

We offer the DMI program at no additional cost to customers who have both Aetna medical and dental plans. We automatically identify eligible members using medical data and target those who are not receiving dental care. Eligible members include those who are pregnant or who have diabetes, heart disease and/or cerebrovascular

5.3.3.2

disease, and have not visited a dentist in the past 12 months. Members may contact us directly to enroll in the enhanced benefits which are part of the program.

Identifying Aetna dental members with other medical plans

We also offer the DMI program to customers who have another medical carrier. This includes customers who have all of their medical coverage through another carrier or have some of their employees covered through another medical carrier. Aetna dental-only customers who elect the program may choose to send us their medical carrier's claim data or have members self-report their at-risk condition, for an additional cost. Your assigned account team works with you to coordinate this process.

Member engagement

When members contact us directly to enroll in the program and enhanced benefits, our Dental Care Coordinators use the interaction as an opportunity for engagement. Along with registering members for the program, they educate them about good oral health, help them select a dentist, and send them an informational postcard.

Regardless of how members are identified for the program, we automatically apply DMI enhanced benefits to applicable dental claims. We require no further outreach or action by the member.

Since the DMI program started, we show the following book of business data:

- Up to 20 percent of employees are likely to be automatically identified by our DMI program as having an 'at-risk' medical condition
- Our DMI program proves that over 50 percent of medically at-risk members, who were not getting care, did seek dental care
- At least 35 percent of these at-risk members saw a dentist within 90 days after receiving our DMI outreach mailer
- The majority of the members using the enhanced benefits visit their dentist for scaling and root planing and periodontal maintenance (the most common treatment to help control gum disease)

5.3.3.2

We measure the number of members we provide outreach to and the claims paid under our enhanced benefits program. We can separate results by condition (chronic conditions or pregnancy). In addition, we can determine if members had a dental visit following the initial outreach or if they required a follow-up outreach event.

When our members receive their enhanced dental benefits available with our DMI program, they are getting the care they need.

[1]*An examination of periodontal treatment and Per Member Per Month medical costs in an insured population*, BMC Health Services Research, August 16, 2006. Continued analysis of retrospective study proves sustained results, Aetna Health Analytics, August 2008.)

[2] *An Examination of Periodontal Treatment, Dental Care, and Pregnancy Outcomes in an Insured Population in the United States*, AM J Public Health. Published online ahead of print November 15, 2010: e1-e6. doi: 10.2105/AJPH.2009.185884).

Legal Clarifications (Deviations)

RFP Provision	Aetna's Clarifications/Deviations
1. Section One Introduction and Instructions: 1.16 Right to Inspect Place of Business 6. Section Six Attachments: Attachment C General Provisions - Article 2. Inspections and Reports Attachment N Proposed Terms and Conditions - Audit Proposal Tech Response to State of Alaska RFP 2013-0200-1396: 2. Medical Claims Administration and Managed Network - 2.2.8.8 - 2.2.8.9 - 2.2.8.11 You will allow auditing of your operations as they relate to the administration and servicing of this account. - 2.2.8.11 Your organization will not charge for services rendered in conjunction with the audit. 5. Dental Claims Administration and Managed Network - 5.2.7.8 - 5.2.7.9 - 5.2.7.11 You will allow auditing of your operations as they relate to the administration and servicing of this account. - 5.2.7.11 Your organization will not charge for services rendered in conjunction with the audit.	We agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder.
2. Section Two Standard Proposal Information 2.5 Supplemental Terms and Conditions 6. Section Six Attachments: Attachment C General Provisions - Article 12. Conflicting Provisions. Attachment A Standard Agreement Form for Professional Services - Article 2. Performance of Service - 2.1 Attachment N Proposed Terms and Conditions - Entirety of Contract	Aetna can agree to this provision with regard to the general language of our proposal. We have specifically identified our deviations to the proposal in this document and our financial proposal. The final contract will include the terms in the RFP subject to the specific deviations provided in this document and our financial proposal.

Legal Clarifications (Deviations)

6. Section Six Attachments: Attachment N Proposed Terms and Conditions - Force Majeure	Confirmed. Aetna can agree to this language. We would note, however, that if the Customer fails to reimburse Aetna for benefit payments for a period of at least five (5) business days as a result of a Force Majeure event, Aetna may suspend claims payment to protect against the credit risk.
Proposal Tech Response to State of Alaska RFP 2013-0200-1396: 2. Medical Claims Administration and Managed Network - 2.2.8.11 If problems are discovered, follow-up audits will be paid by your organization. 5. Dental Claims Administration and Managed Network - 5.2.7.11 If problems are discovered, follow-up audits will be paid by your organization.	Aetna can agree to bear the expense of reasonably tailored follow-up audits.

Benefit Review Document

We have reviewed State of Alaska's requested Active Premium, Standard and Economy and Retiree medical plan designs and Premium, Standard and Preventive Dental plan designs and matched them as closely as possible to Aetna's Passive Open Choice PPO medical and Dental PPO dental plan designs.

We have listed here those benefit design features that we cannot administer exactly as requested, and any recommendations or clarifications to the current plan benefit design. Where benefits are not specified, we assume Aetna's standard benefit provisions will apply. Aetna's standard claim policies, schedule frequencies, definitions, limitations and exclusions will also apply unless otherwise noted.

All plans and benefits are subject to and governed by applicable contracts, policies and government regulations. The information herein is believed to be accurate as of the date of submission and is subject to change without notice. All benefits of the plan are subject to coordination of benefits and the terms (including exclusions) of the Agreement.

This plan review is based on a self-insured contract. Plan features and product availability are subject to federal requirements as applicable.

Benefit Review Document

Plan Design	RFP/SPD Ref	Benefit Category	Requested Benefit	Comments
Dental PPO / ASC w/Aetna Stop Loss	Premium Plan Page 74; Standard Plan Page 74	Predetermination of Benefits -In and Out Of Network	$1,000 threshold for advance claim review.	**Recommendation:** We can apply the $1,000, however, we recommend our standard $350 threshold for pre-determination of benefits. A larger threshold amount can carry too great a risk that the service may not be covered in full or in part and the member will bear the full financial burden.
Dental PPO / ASC w/Aetna Stop Loss	Premium Plan Page 69; Standard Plan Page 69; Preventive Plan Page 69	Class I - Type A/Diagnostic & Preventive -In and Out Of Network	A frequency is not stated for Class I routine oral exams, prophylaxis or most preventive x-rays.	**Clarification is requested:** Is the absence of any stated frequency an indicator for no limits? Or should we apply our standard of: Routine exams & prophylaxis - twice per plan year, and bitewing x-rays = 1 set per plan year. Please clarify what limits, if any, need to be applied here so we may match according to the State's needs.
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Active Premium Page 30; Active Standard Page 30; Active Economy Page 30; Retiree Page 21	Continuation Provision -In and Out of Network	If the claims administrator changes during the time you are hospitalized, benefits for the entire period of confinement are paid by the previous claims administrator. The new claims administrator is effective the day after you are discharged.	**Compliance:** Federal HIPAA legislation requires the subsequent carrier to enroll a confined active member. Aetna will work with the new carrier to determine when coverage ends for Aetna and begins for the new carrier.
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Active Premium Page 32; Active Standard Page 32; Active Economy Page 32; Retiree Page 23	Home Health Care – In and Out of Network	Visiting R.N or L.P.N. visits may not last more than 2 hours.	**Clarification:** No specific number of hours limit is placed on nursing care visits. Time would be based on member's medical need /service being provided.

Benefit Review Document

Plan Design	RFP/SPD Ref	Benefit Category	Requested Benefit	Comments
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Active Standard Page 45; Active Economy Page 45	Immunizations -In Network	Charges for office visits in connection with routine, preventive immunizations are not covered.	**Compliance:** Per PPACA requirements in-network preventive care will be covered at 100%, no copays, nor deductible. Out of network, the regular plan coinsurance after deductible will apply.
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Retiree Page 12 & 15	Maximum – Lifetime – In and Out of Network	$2,000,000 lifetime maximum per person. At the end of each benefit year, up to $5,000 of medical benefits used is automatically restored regardless of your physical condition. If you have received more than $5,000 of covered medical benefits, your full annual spend maximum may be restored with proof of good health.	**Compliance:** Per PPACA, an unlimited lifetime maximum will apply. PPACA prohibits applying plan dollar lifetime maximums. Evidence of good health is prohibited by federal HIPAA. We will administer the provision as written if the State of Alaska has received an exception for compliance with this provision due to nature of plan.
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Active Standard Page 44; Active Premium Page 44; Active Economy Page 44; Retiree page 36	Prescription Drugs -In and Out Of Network	Pharmacy plan exclusions include contraceptive drugs prescribed for contraceptive purposes.	**Compliance**: Per PPACA, no deductible or copay can apply. We will include formulary generic contraception at 100%, to comply with PPACA requirements.
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Retiree Page 37-38	Routine Mammogram – In and Out of Network	One baseline mammogram between the ages of 35 and 40; one mammogram every two years between age 40 and 50; annual mammogram at age 50 and above with personal or family history of breast cancer.	**Compliance:** Per PPACA, annual coverage starts at age 40. We do cover the baseline mammogram between 35 & 40, but will provide annual mammograms starting at age 40 for all covered females in accordance with PPACA guidance. No limiting stipulation related to family or personal history can be applied.
Open Choice® (PPO) / ASC w/Aetna Stop Loss	Active Premium Page 14; Active Standard Page 14; Active Economy Page 14	Spinal Manipulation Therapy – Outpatient – In and Out of Network	$750 per person per year limit.	**Compliance:** Per PPACA requirements, no dollar maximums may apply to essential benefits. We recommend a 60 visit limit per year instead.

Clarifications:

Aetna will comply with federal requirements to pay claims submitted by an Indian tribe or tribal organization for providing care through the IHS, the tribe or the tribal organization to any individual who is otherwise covered by the carrier.

External link to Aetna's Clinical Policy Bulletins: http://www.aetna.com/about/cov_det_policies.html

Aetna will achieve full compliance with Patient Protection and Affordable Care Act. This review may not reflect the impact of all of the newly passed federal PPACA legislation, nor the regulations that will be issued to clarify and implement the law. Certain provisions of the law and forthcoming regulations may have a material impact on this review.

Aetna will include the following preventive services for benefit counseling in accordance with PPACA requirements which include:
Obesity Preventive Counseling: - Age 0 - 22 unlimited visits; Ages 22 and over, 26 visits per 12 months, of which up to 10 visits may be used for Healthy Diet Counseling; Tobacco Preventive Counseling - Smoking/Tobacco cessation preventive counseling limited to 8 visits per 12 months & Alcohol Preventive Counseling - Alcohol/Drug Abuse preventive counseling limited to 5 visits per 12 months

Dental PPO -- 90-day extension of benefits for prosthetic devices fitted and ordered while you were covered. -- We do support a 90-day extension of benefits (ordered but not delivered) following termination, but we will apply Aetna's standard list which also includes root canal when the pulp chamber was opened, inlays, onlays, crowns, bridges, cast of processed restorations, etc.

A frequency or age limit for topical application of fluoride is not stated. -- In lieu of a stated frequency or age limit, we will assume our standard of one application per plan year for children under age 16 to apply.

A frequency limit is not stated for sealants. -- In lieu of a stated limitation, we will assume our standard to apply: Sealants per tooth limited to one application per 3 plan years.

Precertification is required in-network. -- Our standard precertification requirements will apply. In-network precertification is the responsibility of the contracted provider. The member is not subject to any penalty if the provider fails to precertify in-network treatment. Precertification applies to all inpatient admissions, treatment facilities hospice care, home health care, skilled nursing facilities, and private duty nursing.

The mail order program is limited to maintenance medications.-- almost all prescription medications are available through Aetna Rx Home Delivery. A specific list of maintenance drugs does not apply.

100% no deductible for second surgical opinions. -- These will need to be reported as second opinions at the time of claim submission so the 100% may be applied, and the deductible waived.

Online Wellness Programs

Report Prepared for

Simple Steps To A Healthier Life

Report Prepared on August 17, 2009

HealthMedia®
Revolutionizing Behavior Change

We want you to know®
Aetna®

Table of Contents

Glossary

Online Wellness Programs:
The following programs are part of the online wellness programs suite:

- •HealthMedia® Balance™ -- a weight management program
- •HealthMedia® Breathe™ -- a smoking cessation program
- •HealthMedia® Nourish™ -- a nutrition improvement program
- •HealthMedia® Relax™ -- a stress management program
- •HealthMedia® Overcoming™ Depression -- a depression program
- •HealthMedia® Overcoming™ Insomnia -- an insomnia program

Enrollments or Enrolled Users: A participant has submitted the baseline questionnaire for one of the online wellness programs. Also referred to as participation in the program.

Completions or Completors: A participant has submitted the 30-day evaluation (also known as "Evaluation 1") for one of the online wellness programs.

Session Activity: A session occurs when a user enters their online wellness program by clicking on the program link in their action plan.

Tools: The online wellness programs have a variety of interactive tools to help participants reach their goals. The tools included in this report only include those which are accessible for any online wellness program participant regardless which individual program they are enrolled in.

Baseline and Evaluation Assessments: Each online wellness program begins with a baseline assessment which asks basic information about their current health status and factors that contribute to behavior change regarding the topic of the program. Each program also has three evaluation assessments which are administered at 30-days, 90-days, and 180-days after submission of the baseline assessment. Only baseline and evaluation 1 data are included in this report.

Body Mass Index (BMI): Body Mass Index (BMI) is a ratio of weight to height squared. There are five weight categories of BMI as defined by the National Heart, Lung and Blood Institute -- underweight (<18.5), healthy (18.5-24.9), overweight (25-29.9), and obese (>=30).

Work Productivity and Activity Impairment (WPAI): The WPAI instrument is used to quantify overall productivity impairment, which is a combination of presenteeism and absenteeism and represents the percentage of employees' time that is not productive because of health conditions or behavior. Higher scores indicate more productivity impairment.

Overall Productivity Impairment: Based on answers to the WPAI, overall productivity impairment is calculated. It is a combination of presenteeism and absenteeism and represents the percentage of employees' time that is not productive because of health conditions or behavior.

Center for Epidemiologic Studies Depression Rating Scale (CES-D): The CES-D is a rating of a participant's level of depression. Higher scores indicate more severe depression.

Nicotine Addiction Level: Nicotine addiction level is calculated based on the Fagerstrom Tolerance Test for Nicotine Dependency.

Section 1: Executive Summary

Purpose of the Report:

This report provides an overview of your population's experience in the online wellness programs. It also provides a comparative view of your organization's experience to other Aetna customers for the same time period.

What is Included in the Report:

The key elements of the data include: demographics, session activity, program completion, engagement in tools, e-mail statistics, and behavior change. All of the behavior change data included are self-reported and have been culled from pre- and post-program assessments.

The charts below illustrate the behavior changes and program outcomes for the participants in your population.

Nutrition

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
36.4%	Motivated to either improve or maintain their nutrition habits			X			
36.4%	Improved their eating habits			X			
45.4%	Improved or met their nutrition goals	X					

Physical Activity

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
63.6%	Increased their level of physical activity	X					

Weight Management

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
54.6%	Increased their level of motivation	X					
63.6%	With a BMI of 25+ have dropped an entire BMI Stratification Level	X					
63.6%	With a BMI of 25+ have dropped at least 1 BMI point	X					
72.7%	Lost Weight	X					

Smoking Cessation

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
30.0%	Have not smoked at all in the past 28 days		X				
60.0%	Are confident that they can continue to not smoke cigarettes		X				
60.0%	Are motivated to stay smoke-free		X				
60.0%	Quit smoking		X				

Stress Management

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
62.5%	Increased their level of motivation to manage stress				X		
50.0%	Have fewer symptoms of stress				X		
68.8%	Improved their ability to handle stress				X		

Overcoming Depression

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
25.0%	Decrease in days of work missed due to health					X	
42.9%	Increased their level of motivation to manage depression					X	
46.4%	Increased their level of confidence to manage depression					X	
78.6%	Decrease in average depression score (CES-D)					X	

Overcoming Insomnia

		Balance	Breathe	Nourish	Relax	Depression	Insomnia
25.0%	Decrease in level of anxiety about falling asleep						X
33.3%	Increased their level of confidence to manage insomnia						X
41.7%	Increased their level of motivation to manage insomnia						X
45.8%	Decrease in difficulty of falling asleep ratings						X
45.8%	Increase in quality of sleep ratings						X
54.2%	Decrease in difficulty of staying asleep ratings						X

Productivity

	Balance	Breathe	Nourish	Relax	Depression	Insomnia
Point reduction in productivity impairment	18.18%			18.75%	7.14%	12.50%

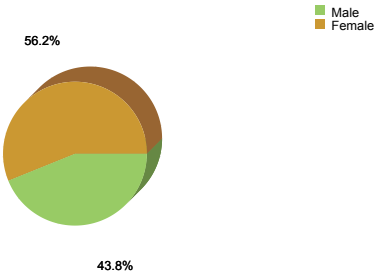
Site Activity

	Balance	Breathe	Nourish	Relax	Depression	Insomnia
Total enrollments	19	12	11	19	35	38
Total unique users	19	12	11	19	18	21
Total completions	11	10	11	16	28	24

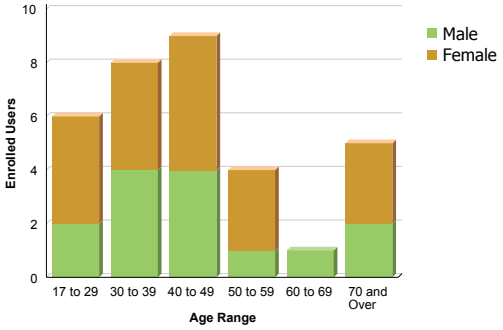
Total Enrolled Users

Below is an overview of the key demographics of enrolled users. The current total enrolled user population of Simple Steps To A Healthier Lifer from this quarter is broken up below by gender, age range, BMI risk category, and online wellness program.

	DMT-AETNA INC	Aetna
Female	56.2%	30.0%
Male	43.8%	70.0%



	DMT-AETNA INC			Aetna		
	Male	Female	Total	Male	Female	Total
17 to 29	2	4	6	10	20	30
30 to 39	4	4	8	264	38	302
40 to 49	4	5	9	14	22	36
50 to 59	1	3	4	8	8	16
60 to 69	1		1	2		2
70 and Over	2	3	5	16	14	30
Total	**14**	**19**	**33**	**314**	**102**	**416**



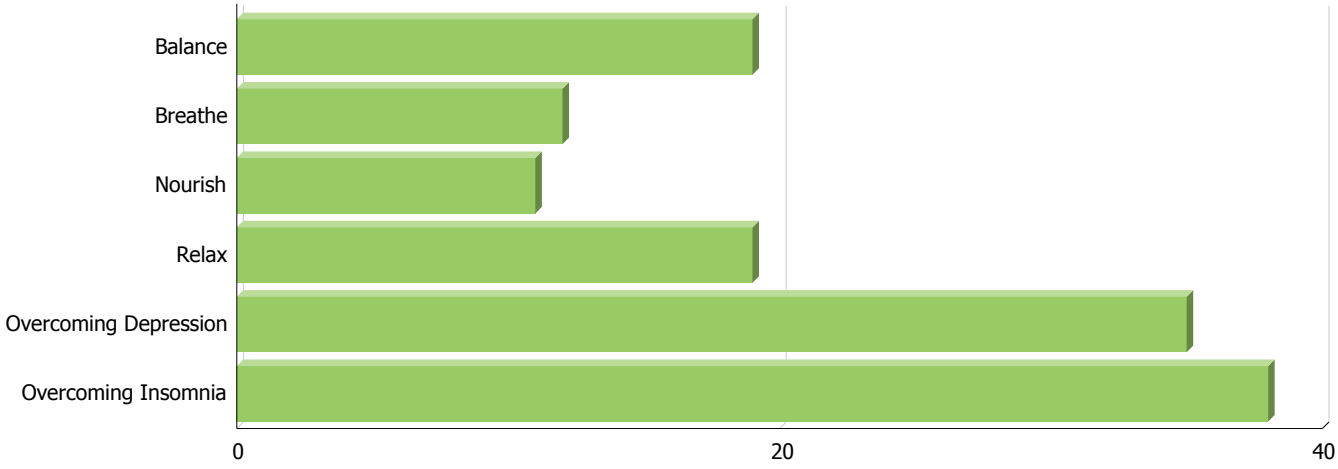
Current Online Wellness Program Participation

The charts below provide a snapshot of enrolled users' current participation in the online wellness program as of the end of this reporting period. This information does not reflect any prior online wellness program participation.

Online Wellness Program	DMT-AETNA INC	Aetna
Balance	19	85
Breathe	12	73
Nourish	11	70
Relax	19	80
Overcoming Depression	35	123
Overcoming Insomnia	38	105
Total	**134**	**536**

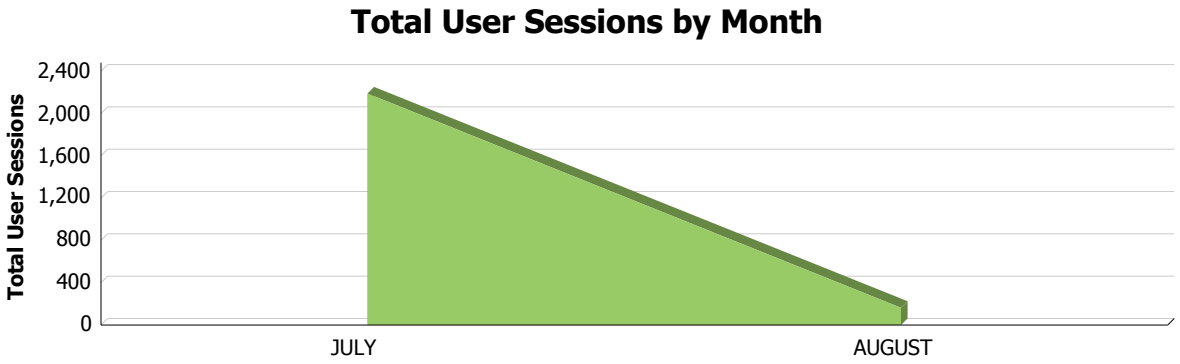
Online Wellness Program

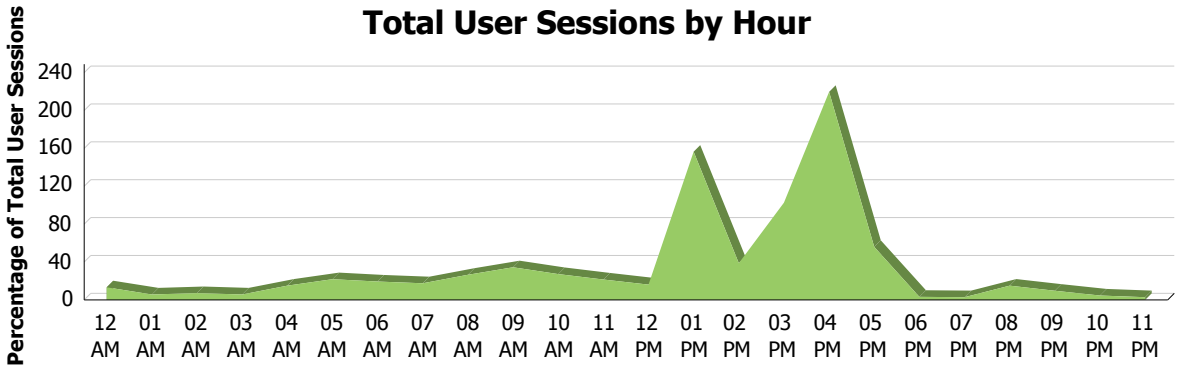
By Enrolled Users per Program for Plan Sponsor

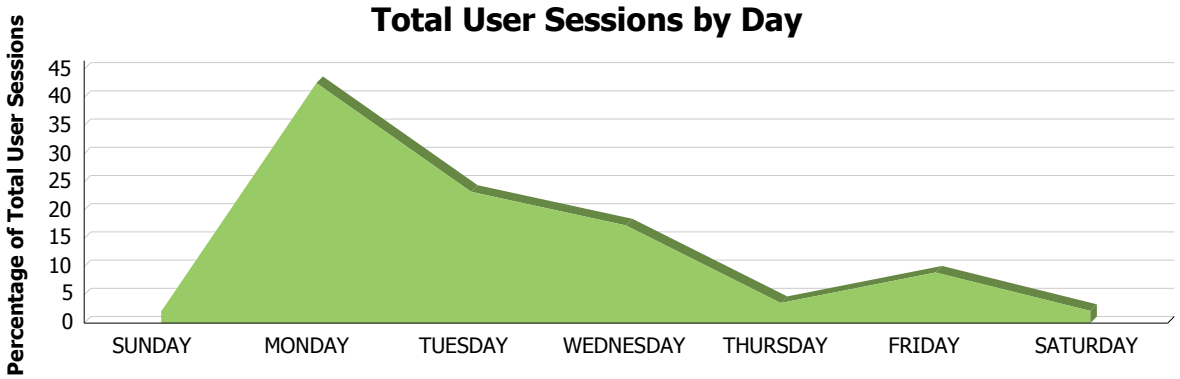


Section 2: Session Activity

Below is an overview of year-to-date session activity for enrolled users, broken out by month, day of week and hour of day. A total of 2,351 sessions were created during this period, with an average of 1,175.50 sessions recorded per user, per month.



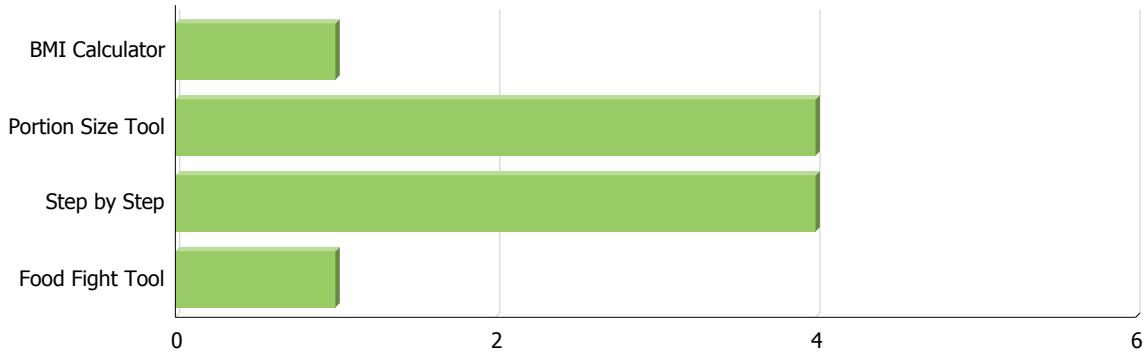




Section 3: Tool Usage

Usage of the tools provided in the online wellness programs is outlined below. Note that these tools are available to all users regardless of their current online wellness program.

	DMT-AETNA INC Total Users	Aetna Total Users
BMI Calculator	1	8
Portion Size Tool	4	39
Step by Step	4	38
Food Fight Tool	1	33



Section 4: Program E-mail Statistics

Users who are enrolled in a online wellness program receive e-mails to highlight when new program features become available and to encourage usage. The "click-through" rate indicates the percentage of users that click on links within the body of any program e-mail throughout a given period.

Balance

	DMT-AETNA INC	Aetna
Period	**Click-Through Rate**	**Click-Through Rate**
Q3 2009	5.93%	10.11%

Breathe

	DMT-AETNA INC	Aetna
Period	**Click-Through Rate**	**Click-Through Rate**
Q3 2009	12.01%	20.46%

Nourish

	DMT-AETNA INC	Aetna
Period	**Click-Through Rate**	**Click-Through Rate**
Q3 2009	8.58%	8.58%

Relax

	DMT-AETNA INC	Aetna
Period	**Click-Through Rate**	**Click-Through Rate**
Q3 2009	6.85%	11.76%

Overcoming Depression

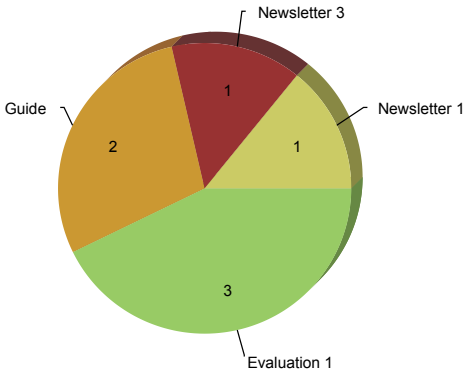
	DMT-AETNA INC	Aetna
Period	**Click-Through Rate**	**Click-Through Rate**
Q3 2009	9.92%	8.08%

Overcoming Insomnia

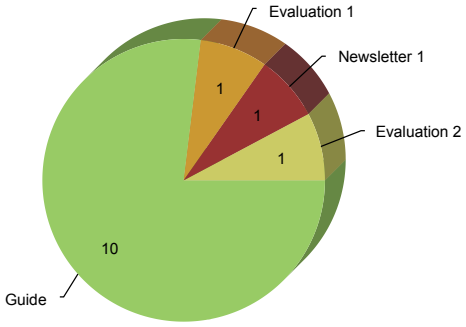
	DMT-AETNA INC	Aetna
Period	**Click-Through Rate**	**Click-Through Rate**
Q3 2009	5.23%	18.09%

Click-Throughs by Link Type:

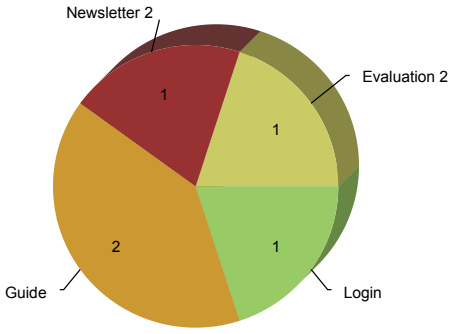
Program e-mail messages may contain one or more different links, directing users to various areas of interest on the site. "Link Type" indicates the type of content associated with the e-mail link. The chart below compares the relative frequency that users click on each type of link.



Balance
- Evaluation 1
- Guide
- Newsletter 3
- Newsletter 1

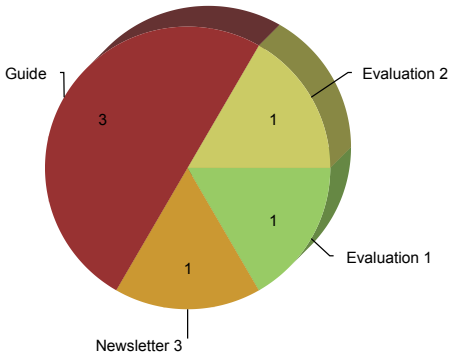


Breathe
- Guide
- Evaluation 1
- Newsletter 1
- Evaluation 2



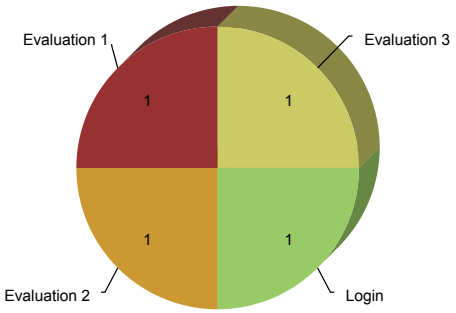
Nourish
- Login
- Guide
- Newsletter 2
- Evaluation 2

Click-Throughs by Link Type:



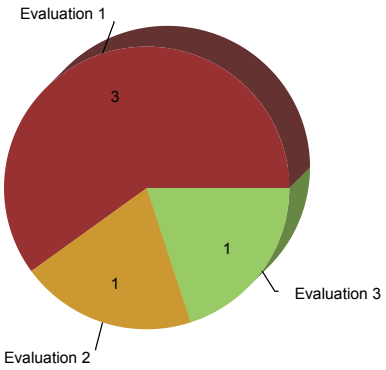
Relax

- Evaluation 1
- Newsletter 3
- Guide
- Evaluation 2



Overcoming Depression

- Login
- Evaluation 2
- Evaluation 1
- Evaluation 3



Overcoming Insomnia

- Evaluation 3
- Evaluation 2
- Evaluation 1

Section 5: Online Wellness Programs

Below is an overview of online wellness program user activity and completion by year, quarter and total overall. A program is considered complete when a user has completed the 30-day evaluation. Users will also receive 90-day and 180-day evaluations. The program life cycle is 210 days.

The table below shows the total number of programs completed (note that one user may complete multiple programs).

	Q2 2009	Q3 2009	DMT-AETNA INC 2009	Aetna 2009
Balance	3	8	11	32
Breathe		10	10	28
Nourish	1	10	11	30
Relax		16	16	34
Overcoming Depression		28	28	53
Overcoming Insomnia		24	24	46

Section 6: Balance

Section 6.1: Participation and Demographics

This report will provide details of your population enrolled in the Balance program. It will also provide a comparative view for your organization compared to the Aetna book-of-business participants for the same time period.

Balance participants have taken a program focused on a multi-faceted approach to weight loss that focuses on the mind, body, and food connection. The gender, age, and ethnic distribution of your population is represented in the tables and charts that follow.

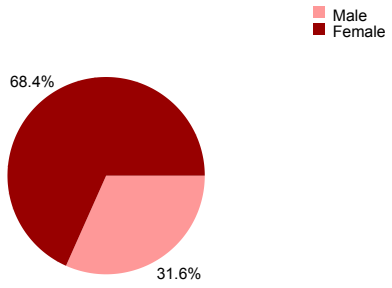
Participation

	DMT-AETNA INC	Aetna
Total	19	85

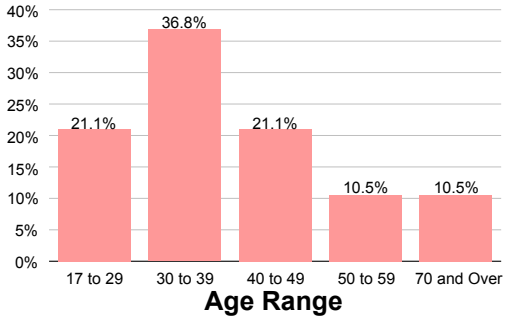
Demographics

	DMT-AETNA INC	Aetna
Male	31.6%	72.9%
Female	68.4%	27.1%
Age Range		
17 to 29	21.1%	9.4%
30 to 39	36.8%	70.6%
40 to 49	21.1%	7.1%
50 to 59	10.5%	5.9%
70 and Over	10.5%	7.1%
Ethnicity		
Caucasian	21.1%	52.9%
African American	21.1%	7.1%
Hispanic	0.0%	2.4%
Asian	15.8%	14.1%
Pacific Islander	0.0%	2.4%
Native American	21.1%	7.1%
Hawaiian	15.8%	4.7%
Other	5.3%	1.2%

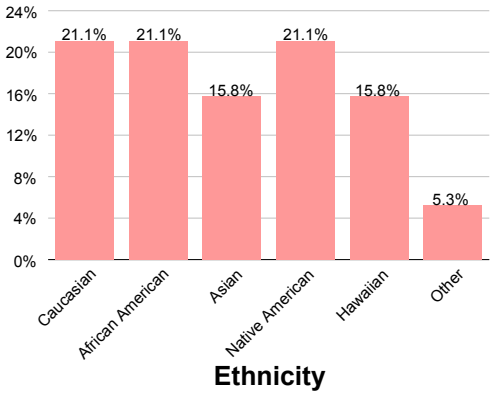
Gender



Age Range



Ethnicity

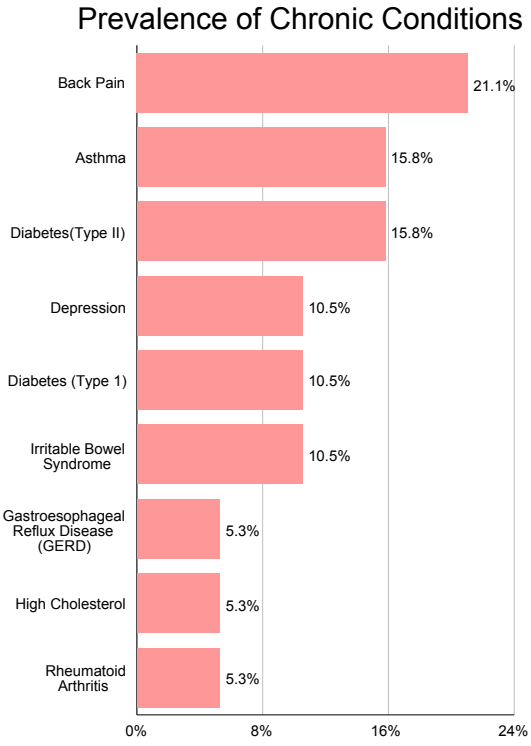


Section 6.2: Disease & Health History

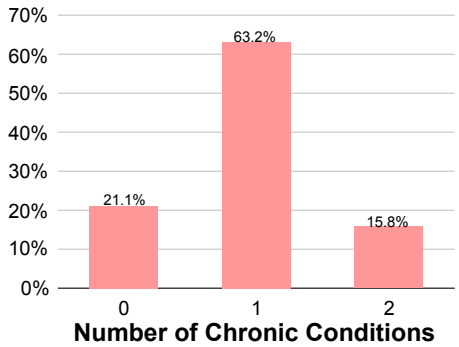
Diagnosed Conditions

The prevalence of medical conditions is an indication of disease burden in your population. Individuals who are overweight or obese are already at increased risk for many diseases and health problems including: hypertension, osteoarthritis, high cholesterol, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, sleep apnea and respiratory problems, and some cancers (endometrial, breast, and colon). The following table shows that many of these health problems already exist within your population.

Condition	DMT-AETNA INC	Aetna
Back Pain	21.1%	5.9%
Asthma	15.8%	8.2%
Diabetes(Type II)	15.8%	3.5%
Depression	10.5%	2.4%
Diabetes (Type 1)	10.5%	5.9%
Irritable Bowel Syndrome	10.5%	2.4%
Gastroesophageal Reflux Disease (GERD)	5.3%	3.5%
High Cholesterol	5.3%	2.4%
Rheumatoid Arthritis	5.3%	1.2%



Number of Chronic Conditions		
0	21.1%	22.4%
1	63.2%	24.7%
2	15.8%	52.9%

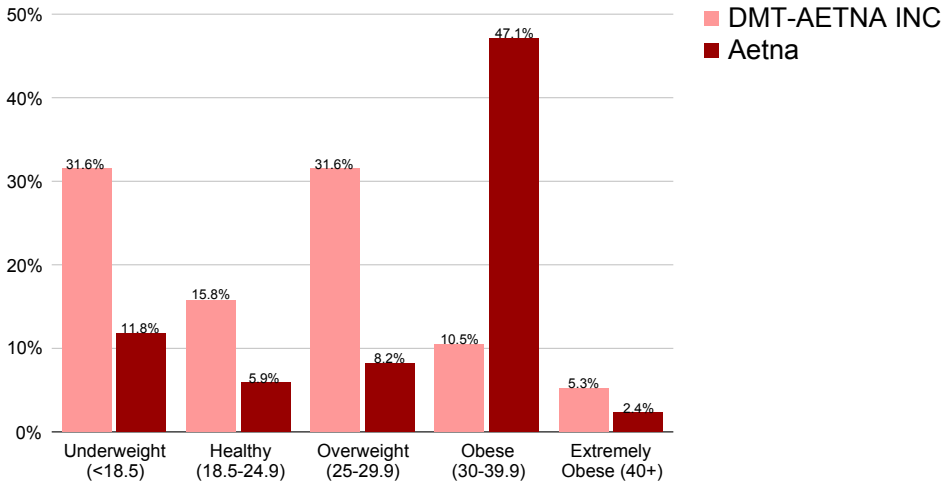


Section 6.3: Obesity Prevalence & BMI Distribution

Your Population & Body Mass Index (BMI)

Body Mass Index (BMI) is a ratio of weight to height squared. The following chart and tables show the distribution of participants who fall into the five weight categories of BMI as defined by the National Heart, Lung and Blood Institute.

BMI Distribution



Average Weight

The average weight of your population at baseline is:

Female	**142**
Male	**197**

Body Mass Index (BMI)	DMT-AETNA INC	Aetna
Underweight (<18.5)	31.6%	11.8%
Healthy (18.5-24.9)	15.8%	5.9%
Overweight (25-29.9)	31.6%	8.2%
Obese (30-39.9)	10.5%	47.1%
Extremely Obese (40+)	5.3%	2.4%

Body Mass Index (BMI) by Gender	Male	Female	Male	Female
Underweight (<18.5)	15.8%	15.8%	5.9%	5.9%
Healthy (18.5-24.9)		15.8%		5.9%
Overweight (25-29.9)	10.5%	21.1%	3.5%	4.7%
Obese (30-39.9)		10.5%	44.7%	2.4%
Extremely Obese (40+)		5.3%	1.2%	1.2%

BMI Explained

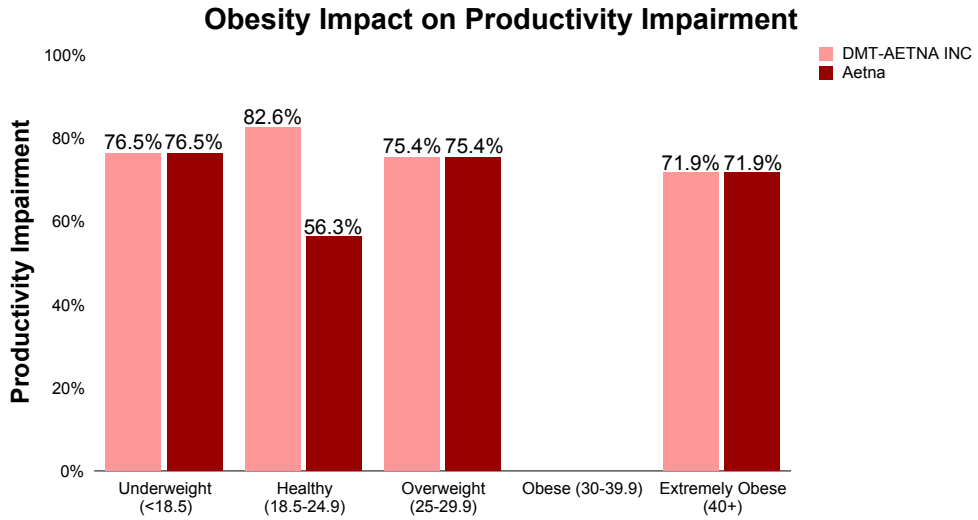
One of the Healthy people 2010 targets is to reduce the proportion of adults who are obese (defined as a BMI of 30 or more) to less than 15% and to increase the proportion of adults who are maintaining their weight within a healthy range (defined as a BMI between 18.5-24.9) to 60%. These goals have remained but the task is becoming even more difficult as the proportion of adults who are obese continues to increase. Having your population take Balance was a step in the right direction.

In general, weight loss focusses on reducing food intake and increasing Physical Activity. Balance takes this one step further by including the importance of the mind in behavior chnage as a whole. Balance is a three-element comprehensive approach to successful weight loss and maintenance. It adresses the mind, body, and food connection. Among findings from the National Weight Control Registry, programs that included these three elements were more succesful than others.

Section 6.4: Productivity

Obesity and Productivity in the Workplace

The overweight and obese population within the United States has a significant impact on the healthcare system both through direct and indirect costs, one of which is productivity in the workplace. The chart below shows the Overall Productivity Impairment for each of the five BMI ranges.



DMT-AETNA INC	Work Missed Due to Health	Impairment at Work Due to Health	Sick Days Last 12 Months	Productivity Impairment
Underweight (<18.5)	57.7%	43.3%	0.0	76.5%
Healthy (18.5-24.9)	42.0%	70.0%	0.0	82.6%
Overweight (25-29.9)	45.5%	60.0%	0.0	75.4%
Obese (30-39.9)	0.0%	0.0%	0.0	0.0%
Extremely Obese (40+)	6.2%	70.0%	0.0	71.9%

Aetna				
Underweight (<18.5)	57.7%	43.3%	0.0	76.5%
Healthy (18.5-24.9)	21.0%	50.0%	0.0	56.3%
Overweight (25-29.9)	45.5%	60.0%	0.0	75.4%
Obese (30-39.9)	0.0%	0.0%	0.0	0.0%
Extremely Obese (40+)	6.2%	70.0%	0.0	71.9%

What Productivity Impairment Means

HealthMedia Utilizes the Work Productivity and Activity Impairment (WPAI) instrument to quantify overall productivity impairment for your population. Overall Productivity impairment, a combination of absenteeism and presenteeism, represents the percentage of the employees' time that is not productive because of health conditions or behavior.

The tables on the left show the percentage work missed due to health, percentage productivity impairment at work due to health and the overall productivity impairment percentage for each BMI range. These results are for individuals working at least 20 hours per week. Multiplying the percentages by the average salary and applying the prevalence rate within the employee population for each BMI range allows the impairment percentage to be expressed as salary dollars lost.

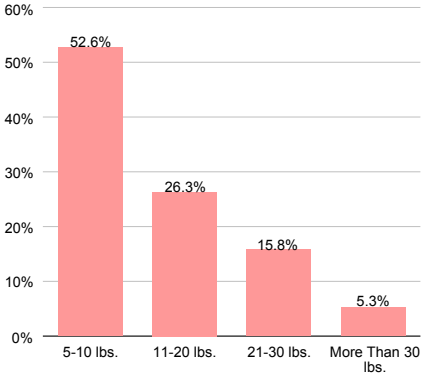
Section 6.5: Weight Goals, Barriers, & Self Image

Weight Goals

Some individuals may be using this program to lose weight or maintain a recent weight loss. Additionally, some may be using it to remain within their ideal weight range. The table below shows the goals participants have reported they would like to achieve.

Goal	DMT-AETNA INC	Aetna
Maintain Current Weight		3.5%
5-10 lbs.	52.6%	18.8%
11-20 lbs.	26.3%	17.6%
21-30 lbs.	15.8%	7.1%
More Than 30 lbs.	5.3%	48.2%

Weight Goal

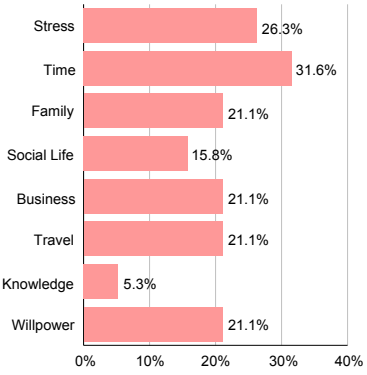


Weight Loss Barriers

There is a long list of barriers to eating right and exercising. Societal pressures, family obligations and work commitments are just a few of the things that keep people from making healthy choices on a day to day basis. In the table below, participants have reported what makes it difficult for them to manage their weight. Participants could report more than one barrier.

Barrier	DMT-AETNA INC	Aetna
Stress	26.3%	8.2%
Time	31.6%	7.1%
Family	21.1%	7.1%
Social Life	15.8%	5.9%
Business	21.1%	51.8%
Travel	21.1%	8.2%
Knowledge	5.3%	1.2%
Willpower	21.1%	7.1%

Weight Loss Barriers

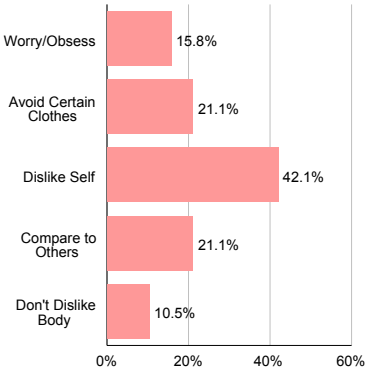


Self-Image

Low self-esteem and/or a negative self-image can be a factor in poor food choices, a sedentary lifestyle, and a lack of motivation to change. Individuals need support mentally and emotionally in order to take active steps at healthy changes. The table below shows the prevalence of your population struggling with various self-image and self-esteem issues.

Self Image	DMT-AETNA INC	Aetna
Worry/Obsess	15.8%	5.9%
Avoid Certain Clothes	21.1%	52.9%
Dislike Self	42.1%	56.5%
Compare to Others	21.1%	54.1%
Don't Dislike Body	10.5%	5.9%

Self Image



Section 6.6: Eating Habits & Physical Activity

Eating Habits & Food Choices

Developing healthy eating behaviors is an important component of achieving and maintaining a healthy body weight. Choosing a diet that includes the consumption of high calorie and high fat items is often the result of unhealthy eating habits, such as eating on the run or snacking and can contribute to weight gain. The Balance program provides strategies for developing healthy eating behaviors. The following tables and charts show the prevalence of your population that is engaging in unhealthy eating habits and poor food choices.

Eating Habits	DMT-AETNA INC	Aetna
Eat at Night	5.3%	1.2%
Eat large portions	31.6%	54.1%
Eat Fast	36.8%	11.8%
Eat Out	21.1%	51.8%
Snack too much		3.5%
TV/Computer/Car	5.3%	3.5%

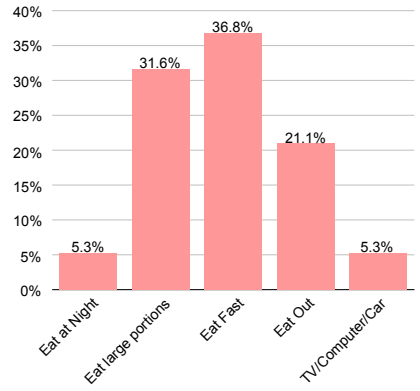
Daily Food Choices	DMT-AETNA INC	Aetna
Sweet Drinks	10.5%	3.5%
Alcoholic Beverages	15.8%	4.7%
Dessert or Treat	21.1%	10.6%
Deep Fried Foods	26.3%	52.9%
Fast Food	5.3%	47.1%
High Fat Meat	21.1%	10.6%
High Fat Dairy	15.8%	3.5%

Physical Activity

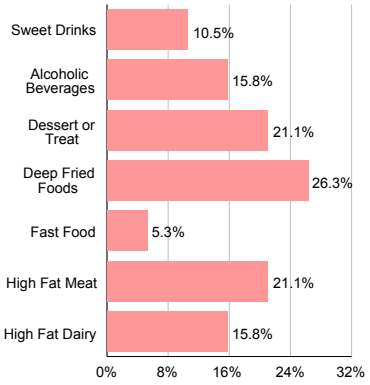
Another key component to weight loss success is physical activity. Just as it is easy to make poor food choices, there are a number of excuses to not getting enough physical activity on a daily basis. However, making time is essential, especially for people that need to lose weight or want to maintain their current weight. People who lead physically active lifestyles tend to live longer, healthier, and happier lives. The Balance program includes suggestions for leading a more active lifestyle. The table below shows how much cardiovascular exercise your population is getting.

Cardiovascular Exercise	DMT-AETNA INC	Aetna
I dont exercise at all		1.2%
I get less than this amount of exercise every week	42.1%	56.5%
I get about this much exercise every week	21.1%	8.2%
I get more exercise than this every week	5.3%	1.2%

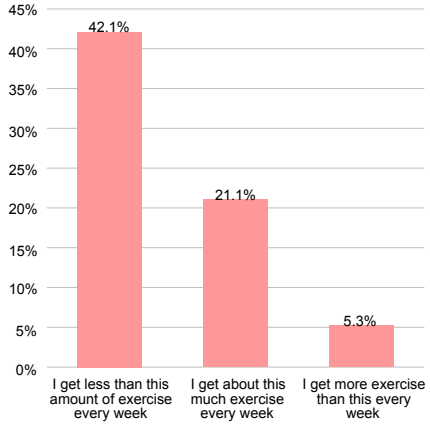
Eating Habits



Food Choices



Physical Activity



Section 6.7: Weight Management and Productivity Outcomes

Being overweight or obese is linked with poor outcomes, and poor health often adversely affects workplace productivity. The graph and charts below illustrate your population's vulnerability to productivity impairment, as well as weight management outcomes.

Comparisons of Weight & BMI from Enrollments to Completions

	DMT-AETNA INC	Aetna
% of Weight Lost	18.2%	10.5%
% of BMI(25+) who dropped atleast one BMI point	63.6%	36.8%

% of Weight Loss Population that Dropped an Entire BMI Stratification Level

	DMT-AETNA INC	Aetna
Overweight (25-29.9) - Healthy (18.5-24.9)	0.0%	0.0%
Obese (30-39.9) - Overweight (25-29.9)	0.0%	0.0%
Extremely Obese (40+) - Obese (30-39.9)	0.0%	0.0%

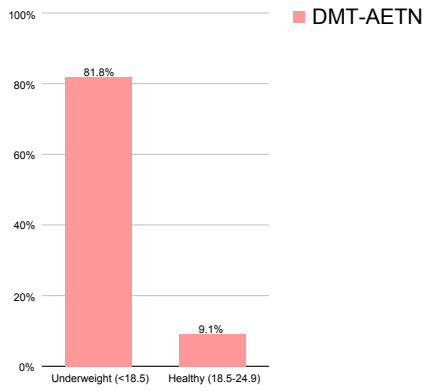
Motivation Improvement from Enrollment to Completion

	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Average Motivation (0-10)	5.4	5.9	7.1	6.8

Comparison of WPAI Measures from Enrollments to Completion

	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Work Missed Due to Health	44.9%	22.5%	40.8%	22.5%
Impairment at Work Due to Health	57.0%	12.5%	54.5%	12.5%
Overall Impairment	76.1%	32.0%	71.9%	32.0%
Sick Days Last 12 Months	0.0	0.0	0.0	0.0

Body Mass Index (BMI) of Completors



Section 7: Breathe

Section 7.1: Participation and Demographics

This report represents key information about the health and smoking history of your population. It addresses your population's motivations and barriers in relation to quitting, as well as how your population's productivity and wellness are impacted by smoking. It will also provide a comparative view for your organization compared to the Aetna book-of-business participants for the same time period. To begin, here is a snapshot of your population's demographics.

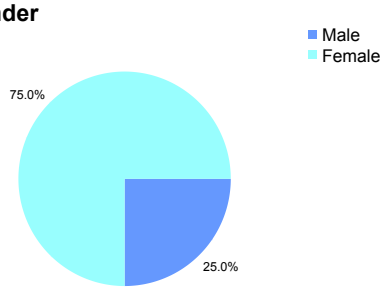
Participation

	DMT-AETNA INC	Aetna
Totals	12	73

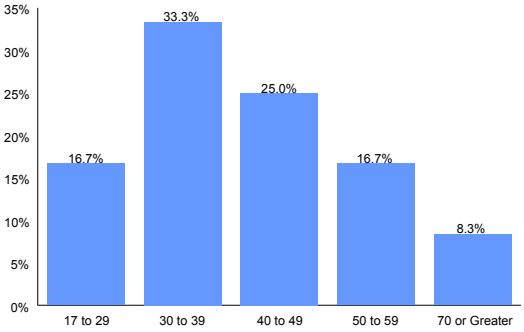
Demographics

Gender	DMT-AETNA INC	Aetna
Male	25.0%	76.7%
Female	75.0%	23.3%
Age Range		
17 to 29	16.7%	8.2%
30 to 39	33.3%	74.0%
40 to 49	25.0%	5.5%
50 to 59	16.7%	6.8%
70 or Greater	8.3%	5.5%
Average Age		
Average Age	42	37
Ethnicity		
Caucasian	8.3%	60.3%
African American	8.3%	4.1%
Hispanic	8.3%	6.8%
Asian	16.7%	6.8%
Native American	25.0%	6.8%
Hawaiian	8.3%	1.4%

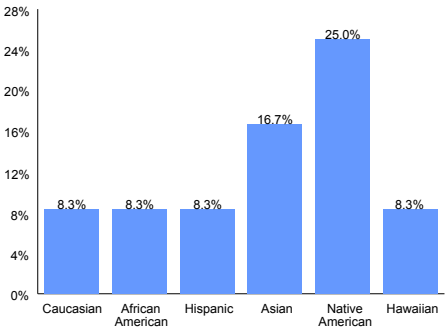
Gender



Age Range



Ethnicity

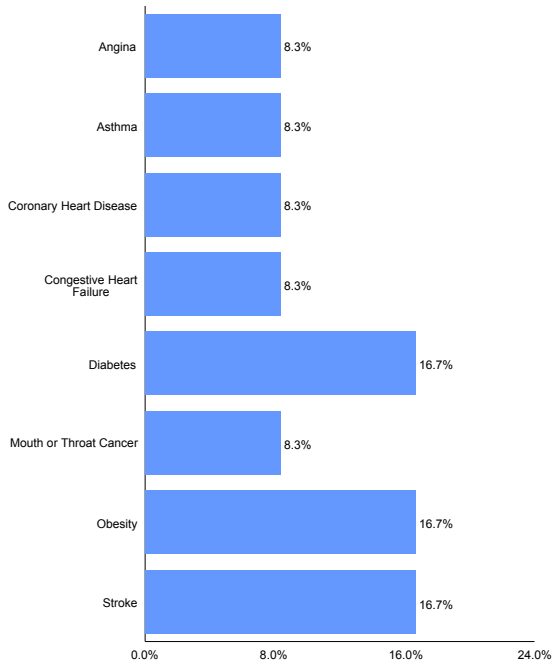


Section 7.2: Disease and Health History

The Breathe program captures data about a wide range of conditions your population has been diagnosed with, as well as the number of diagnoses they have. This data provides insight into other health issues your population is dealing with.

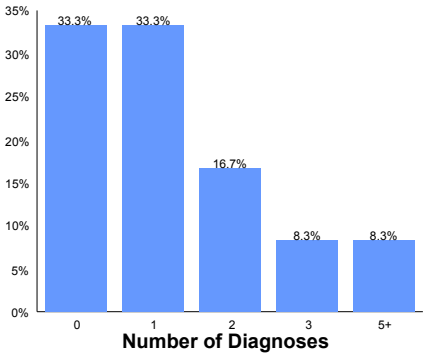
Prevalence of Diagnoses	DMT-AETNA INC	Aetna
Angina	8.3%	2.7%
Asthma	8.3%	1.4%
Coronary Heart Disease	8.3%	4.1%
Congestive Heart Failure	8.3%	2.7%
Chronic Bronchitis	0.0%	2.7%
Depression	0.0%	2.7%
Diabetes	16.7%	57.5%
Emphysema	0.0%	54.8%
Heart Attack	0.0%	1.4%
High Blood Pressure	0.0%	1.4%
Mouth or Throat Cancer	8.3%	1.4%
Obesity	16.7%	4.1%
Peripheral Vascular Disease	0.0%	2.7%
Stroke	16.7%	4.1%
TIA	0.0%	1.4%

Disease & Health History
Prevalence of Diagnoses



No. of Diagnoses		
0	33.3%	11.0%
1	33.3%	12.3%
2	16.7%	61.6%
3	8.3%	1.4%
4	0.0%	1.4%
5+	8.3%	12.3%

No. of Diagnoses



Avg. No. of Diagnoses		
Avg. No. of Diagnoses	1.0	1.7

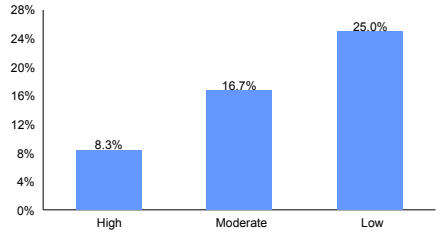
Section 7.3: Smoking Addiction and History

The Fagerstrom Tolerance Test for Nicotine Dependency was used to assess nicotine addiction levels for your population. Scores have been grouped into high, moderate, and low. Number of cigarettes smoked per day (1 pack = 20 cigarettes) and number of years smoking are also shown below, as well as the methods of quitting your population has tried in the past.

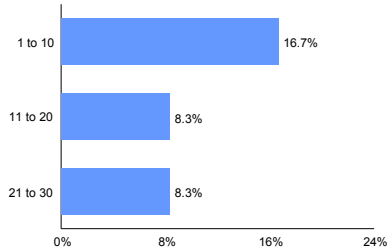
Nicotine Addiction Level	DMT-AETNA INC	Aetna
High	8.3%	1.4%
Moderate	16.7%	5.5%
Low	25.0%	68.5%
Cigarettes Per Day		
1 to 10	16.7%	11.0%
11 to 20	8.3%	1.4%
21 to 30	8.3%	57.5%
Smoke Years		
Less than 4	33.3%	12.3%
16 - 20	0.0%	2.7%
Greater than 25	0.0%	54.8%
Past Quit Methods		
Acupuncture	8.3%	56.2%
Cold Turkey	0.0%	2.7%
Nicotine Gum	8.3%	2.7%
Nicotine Oral Inhaler	8.3%	57.5%
Nicotine Patch	0.0%	2.7%
Nicotine Lozenge	0.0%	54.8%
Zyban	0.0%	1.4%

Smoking Addiction and History

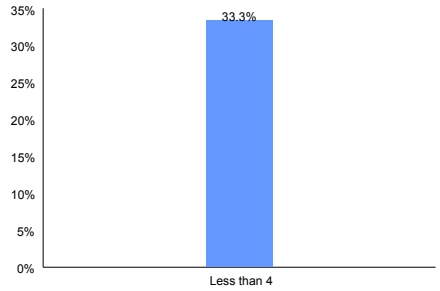
Nicotine Addiction Level



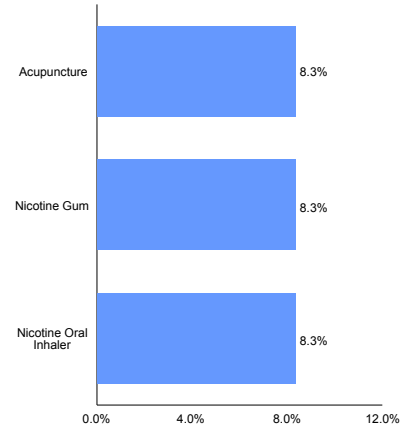
Cigarettes Per Day



Smoke Years



Past Quit Methods

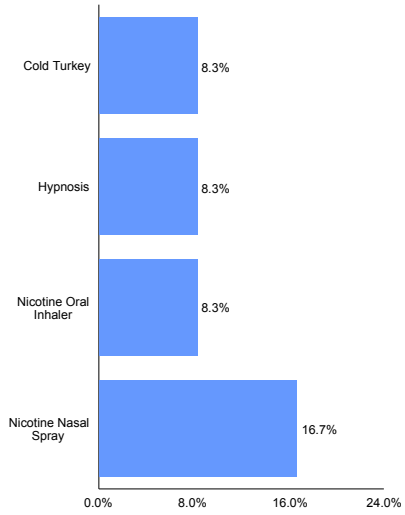


Section 7.4: Quitting Motivation and Preferred Methods

Smokers who decide to quit do so for a wide range of reasons. In Breathe, participants are asked to rank four common reasons for quitting in order of importance. Just as reasons for quitting vary among smokers, so do preferred methods of quitting. Find out about your populations reasons for quitting, their motivation levels for quitting, and how they plan to do it below.

No.1 Quit Reason	DMT-AETNA INC	Aetna
Personal health	33.3%	12.3%
Pressure of Influence from family or friends	0.0%	4.1%
Financial Concerns	0.0%	54.8%
Desire to gain control over my life	0.0%	0.0%
Avg. Quit Motivation (0-10)		
Quit Motivation	5.8	5.7
Preferred Quit Methods		
Cold Turkey	8.3%	2.7%
Nicotine Gum	0.0%	57.5%
Hypnosis	8.3%	2.7%
Nicotine Oral Inhaler	8.3%	57.5%
Nicotine Nasal Spray	16.7%	4.1%
Nicotine Lozenge	0.0%	1.4%

Preferred Quit Methods



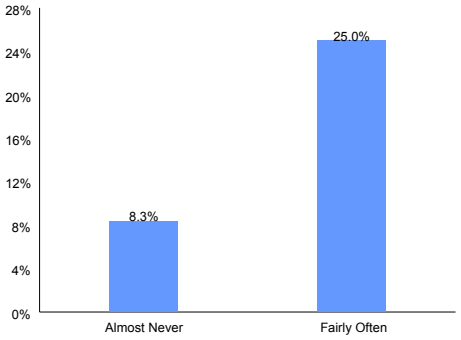
Section 7.5: Barriers to Quitting

Often, smokers have worries about how becoming non-smokers will impact other aspects of their lives. These can be health-related, such as increases in stress, depression, and weight. Another concern smokers often have is being confident they can resist cigarettes in situations where they are accustomed to smoking. It's important to understand these barriers, as your population may need help with these behaviors as well. The impact of these barriers on your population is shown below.

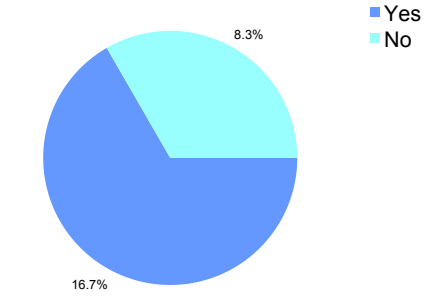
Stress Experience	DMT-AETNA INC	Aetna
Never	0.0%	2.7%
Almost Never	8.3%	4.1%
Sometimes	0.0%	1.4%
Fairly Often	25.0%	58.9%
Experienced Depression When Quitting		
Yes	16.7%	6.8%
No	8.3%	60.3%
Concerned About Weight Gain		
Not Concerned	8.3%	8.2%
Some Concerned	16.7%	5.5%
Very Concerned	16.7%	57.5%
Avg. Confidence in Situations (1-5)		
After I have just finished a meal	2.0	2.8
When I feel angry or frustrated	3.2	3.0
When I am at a bar or party	3.5	2.2
When I am bored	2.8	2.1
When I am happy and feel like celebrating	2.8	2.1
While driving or riding in a car	2.5	2.1
When I feel nervous or anxious	3.0	2.9
While talking on the telephone	4.0	2.3
When I feel sad or lonely	3.5	3.0
When I feel stressed	2.0	3.6
While drinking coffee and talking with friends	3.0	2.1
When I am around people who are smoking	3.2	2.2

Barriers to Quitting

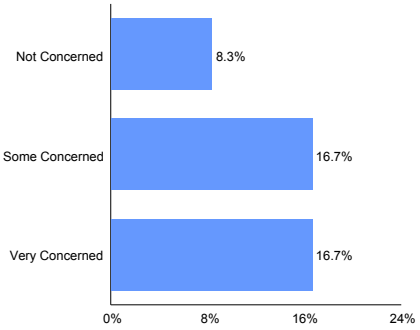
Stress Experience



Experienced Depression When Quitting

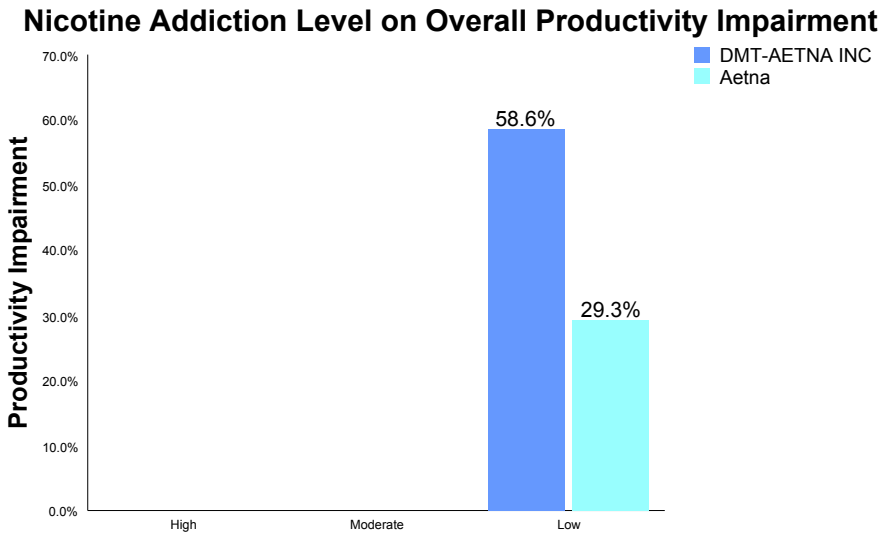


Concerned About Weight Gain



Section 7.6: Productivity Impairment

Smoking is linked to poor health outcomes, and poor health often adversely affects workplace productivity. The graph and charts below illustrate your population's vulnerability to productivity impairment related to smoking, as well as how smoking impacts productivity, attendance, and impairment on the job.



The average Productiviry Impairment of your Population is: **58.6%**

HealthMedia utilizes the Work Productivity and Activity Impairment (WPAI) instrument to quantify overall productivity Impairment for your population. Overall Productivity impairment, a combination of absenteeism and presenteeism, represents the percentage of the employees' time that is not productive because of health conditions or behavior.

DMT-AETNA INC	Sick Days Last 12 Months	Work Missed Due to Health	Impairment at Work Due to Health	Overall Productivity Impairment
High	23.0	0.0%	0.0%	0.0%
Moderate	9.5	0.0%	0.0%	0.0%
Low	12.3	31.0%	40.0%	58.6%
Aetna				
High	23.0	0.0%	0.0%	0.0%
Moderate	7.0	0.0%	0.0%	0.0%
Low	7.1	15.5%	20.0%	29.3%

The table on the left shows the percentage work missed due to health, percentage productivity impairment at work due to health and the overall productivity impairment percentage for each nicotine addiction level. These results are for individuals working at least 20 hours per week. Multiplying the percentages by the average salary and applying the prevalence rate within the employee population for each nicotine addiction level allows the impairment percentage to be expressed as salary dollars lost.

Section 7.7:

Below are the outcomes of Breathe program users related to smoking status, motivation and confidence to stay smoke-free, and productivity.

Smoking Status at 30 Day Evaluation

	DMT-AETNA INC	Aetna
Quit Smoking	50%	10%
Not Smoked in Past 28 Days	25%	5%
Not Smoked in Past 7 Days	17%	3%

Motivation & Confidence to Stay Smoke Free

	DMT-AETNA INC	Aetna
Avg. motivation (0-10)	5	5
Avg. confidence (0-10)	6	7

Comparison of WPAI Measures from Enrollment to Completion

Productivity Impairment	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Sick days in last 12 months	13.2	3.2	8.4	3.6
Work missed due to health	31.0%	17.8%	15.5%	14.8%
Impairment at work due to health	40.0%	8.0%	20.0%	6.7%
Overall impairment	58.6%	24.0%	29.3%	20.0%

Section 8: Nourish

Section 8.1: Participation and Demographics

This report represents key information about the nutritional health of your population. It also addresses your population's motivations and barriers in relation to eating healthy. The following pages also provide a comparative view for your organization compared to the Aetna book-of-business Nourish participants for the same time period. To begin, here is a snapshot of your population's demographics.

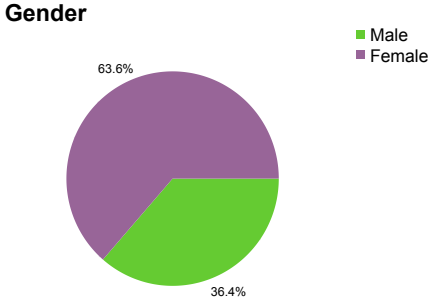
Participation

	DMT-AETNA INC	Aetna
Totals	11	70

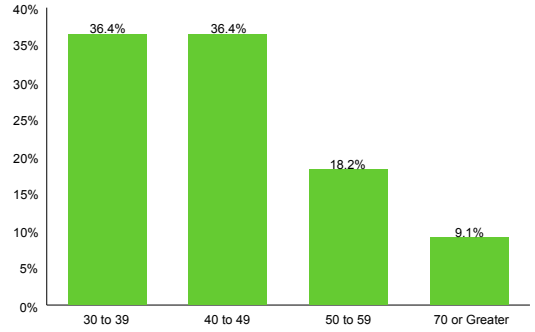
Demographics

Gender	DMT-AETNA INC	Aetna
Male	36.4%	77.1%
Female	63.6%	22.9%
Age Range		
17 to 29	0.0%	4.3%
30 to 39	36.4%	75.7%
40 to 49	36.4%	8.6%
50 to 59	18.2%	4.3%
70 or Greater	9.1%	7.1%
Average Age		
Average Age	45	38
Ethnicity		
Caucasian	9.1%	61.4%
African American	18.2%	5.7%
Hispanic	9.1%	7.1%
Asian	0.0%	5.7%
Native American	18.2%	4.3%
Hawaiian	9.1%	1.4%
Other	18.2%	4.3%

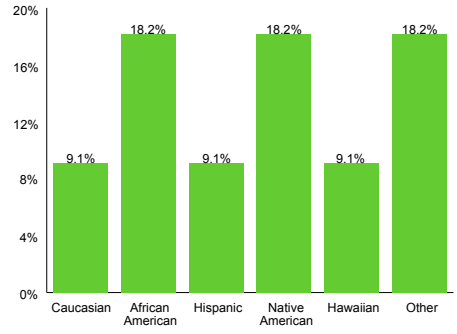
Gender



Age Range



Ethnicity

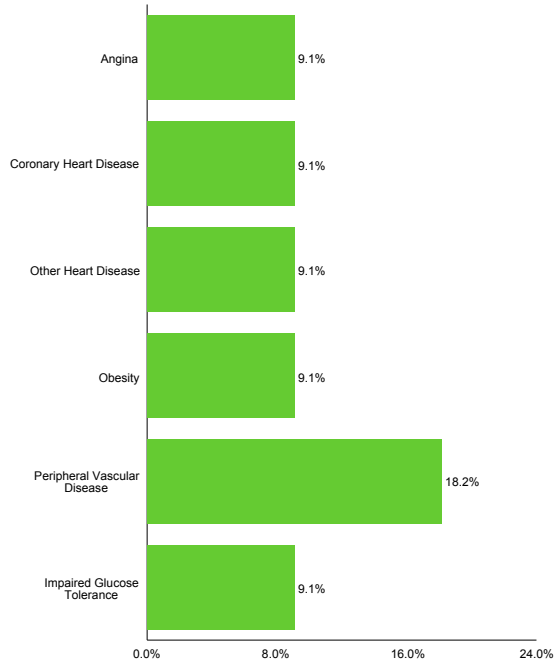


Section 8.2: Disease and Health History

The Nourish program captures data about a wide range of conditions your population has been diagnosed with, as well as the number of diagnoses they have. This data provides insight into other health issues your population is dealing with.

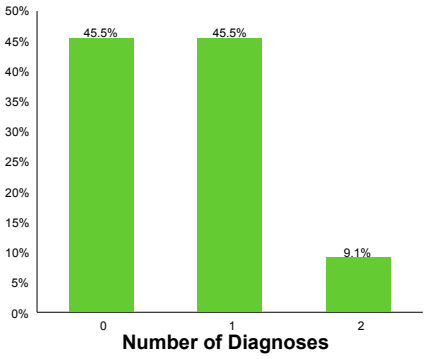
Disease History	DMT-AETNA INC	Aetna
Angina	9.1%	2.9%
Breast Cancer	0.0%	1.4%
Coronary Heart Disease	9.1%	58.6%
Congestive Heart Failure	0.0%	1.4%
Colorectal Cancer	0.0%	1.4%
Diabetes type 2	0.0%	1.4%
Heart Attack	0.0%	1.4%
High Blood Pressure	0.0%	2.9%
High Cholesterol	0.0%	2.9%
Other Heart Disease	9.1%	55.7%
Obesity	9.1%	1.4%
Peripheral Vascular Disease	18.2%	5.7%
Prostate Cancer	0.0%	1.4%
Stroke	0.0%	1.4%
Impaired Glucose Tolerance	9.1%	1.4%

Prevalence of Chronic Conditions



No. of Diagnoses		
0	45.5%	20.0%
1	45.5%	18.6%
2	9.1%	61.4%

No. of Diagnoses



Avg. No. of Conditions		
Avg. No. of Conditions	0.6	1.4

Section 8.3: BMI Distribution

Issues with weight could be an indicator of poor nutritional health. Body Mass Index (BMI) is a ratio of weight to height squared. The following chart and tables show the distribution of participants who fell into the five weight categories of BMI as defined by the National Heart, Lung, and Blood Institute. For more information on BMI, see the sidebar below.

BMI Range	DMT-AETNA INC	Aetna
Underweight (<18.5)	18.2%	7.1%
Healthy (18.5 - 24.9)	18.2%	7.1%
Overweight (25 - 29.9)	18.2%	2.9%
Obese (30 - 39.9)	9.1%	4.3%

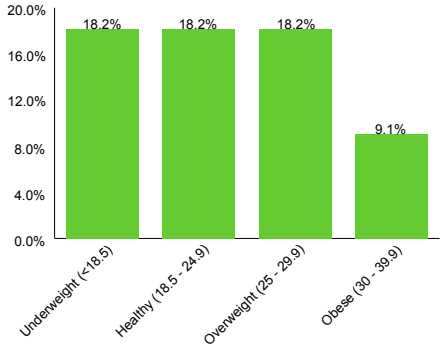
Average BMI		
Average BMI	12.5	3.6

Choosing a diet that is high in calories and fat is often the result of unhealthy eating habits, such as eating on the run or snacking. Often people make unhealthy choices due to time constraints or other factors, and might not even be aware of the impact on their nutritional health. Your population's ratings of their eating habits, along with the special diets they follow, are shown below. Participants could report more than one special diet.

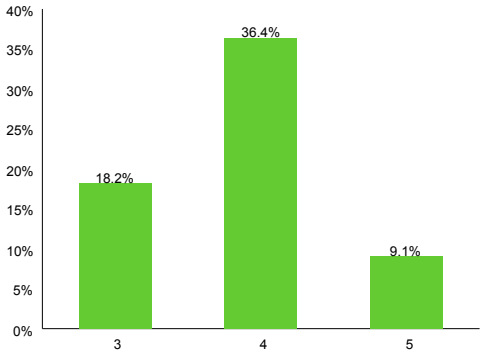
Eating Habits (Self Rating)	DMT-AETNA INC	Aetna
Excellent	0.0%	4.3%
Very Good	0.0%	2.9%
Good	18.2%	7.1%
Fair	36.4%	7.1%
Poor	9.1%	2.9%

Following Special Diet		
Diabetic	0.0%	1.4%
Low Fat	0.0%	2.9%
Low Cholesterol	9.1%	4.3%
Low Salt	0.0%	57.1%
Weight Reducing	27.3%	5.7%
Vegetarian	9.1%	61.4%
Vegan	18.2%	2.9%

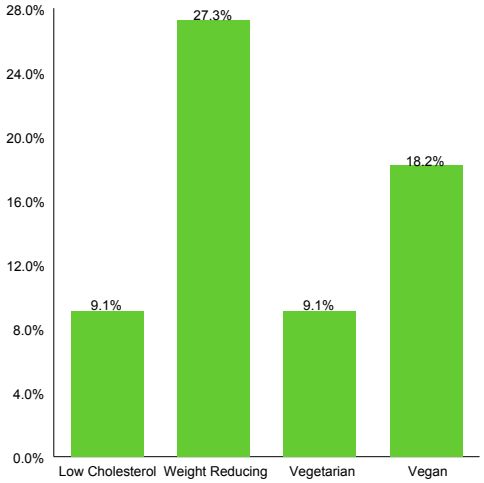
BMI Range



Eating Habits (Self Rating)



Following Special Diet

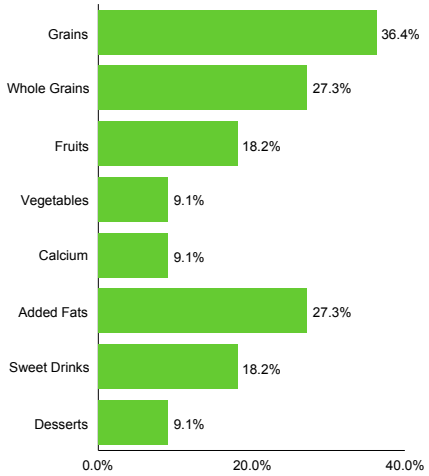


Section 8.4: Recommended Guidelines

The food intake guidelines below are based on the U.S. Dietary Guidelines for Americans (2005), U.S. Department of Agriculture (USDA), and the USDA's Food Guide Pyramid. Below, see how successful your population is at meeting these requirements.

Meet US Dietary Guidelines	DMT-AETNA INC	Aetna
Grains	36.4%	11.4%
Whole Grains	27.3%	8.6%
Fruits	18.2%	58.6%
Vegetables	9.1%	1.4%
Calcium	9.1%	5.7%
Protein	0.0%	1.4%
Added Fats	27.3%	7.1%
Sweet Drinks	18.2%	60.0%
Desserts	9.1%	57.1%
Breakfast	0.0%	1.4%

Meet US Dietary Guidelines



Avg. Confidence(1-5) about following a Healthful Diet in Situations		
Around tempting desserts or fast foods	12.5	3.6
Eat out frequently	2.8	2.9
Feel the need to reward yourself with food	3.2	2.2
No time to shop for groceries	2.2	2.1
Around others who don't follow healthful diets	1.8	4.3
Tired and don't feel like preparing a healthful meal.	2.6	2.2

Avg. Motivation(0-10) to include Recommended Amount of Servings in Diet		
Whole Grains	0.0	0.0
Fruits & Vegetables	0.0	0.0
Limit Amount of Fat	4.0	6.1

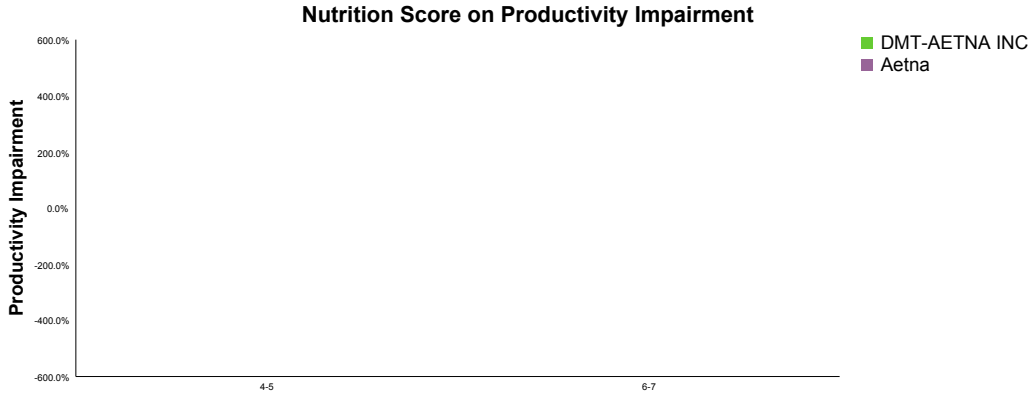
Avg. Confidence(1-5) to include Recommended Amount of Servings in Diet		
Whole Grains	2.4	3.6
Fruits & Vegetables	0.0	0.0
Limit Amount of Fat	2.8	3.7

Section 8.5: Productivity Impairment

Nutrition and Workplace Productivity

Nutritional health is linked to poor health outcomes, and poor health often adversely affects workplace productivity. The graph and charts below illustrate your population's vulnerability to productivity impairment related to poor nutrition, as well as how nutrition impacts productivity, attendance, and impairment on the job.

The average Impairment Productiviry of your Population is:



DMT-AETNA INC	Sick Days Last 12 Months	Work Missed Due to Health	Impairment at Work Due to Health	Overall Productivity Impairment
4-5	0.0	0.0%	0.0%	0.0%
6-7	0.0	0.0%	0.0%	0.0%

Aetna				
4-5	0.0	0.0%	0.0%	0.0%
6-7	0.0	0.0%	0.0%	0.0%

What Productivity Impairment Means

HealthMedia Utilizes the Work Productivity and Activity Impairment (WPAI) instrument to quantify overall productivity impairment for your population. Overall Productivity Impairment, a combination of absenteeism and presenteeism, represents the percentage of the employees' time that is not productive because of health conditions or behavior.

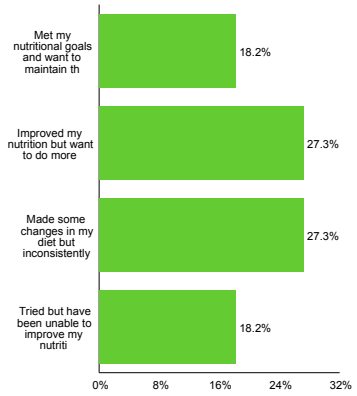
The tables on the left show the percentage work missed due to health, percentage productivity impairment at work due to health and the overall productivity impairment percentage for each nutrition score range. These results are for individuals working at least 20 hours per week. Multiplying the percentages by the average salary and applying the prevalence rate within the employee population for each nutrition score range allows the impairment percentage to be expressed as salary dollars lost.

Section 8.6: Program Results

Below are the outcomes of Nourish users related to nutrition habits, motivation and confidence, and productivity impairment.

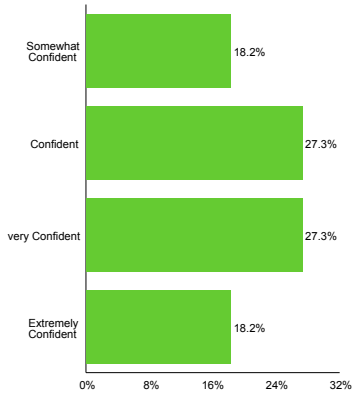
Nutrition Habits Since Participating in Program	DMT-AETNA INC	Aetna
Met my nutritional goals and want to maintain them	18.2%	12.5%
Improved my nutrition but want to do more	27.3%	31.2%
Made some changes in my diet but inconsistently	27.3%	18.8%
Tried but have been unable to improve my nutrition	18.2%	12.5%
Not tried to improve my nutrition	0.0%	25.0%

Nutrition Habits Since Participating in Program



Confidence on Healthful Diet	DMT-AETNA INC	Aetna
Somewhat Confident	18.2%	16.7%
Confident	27.3%	41.7%
very Confident	27.3%	25.0%
Extremely Confident	18.2%	16.7%

Confidence on Healthful Diet



Motivation Levels		
Motivation to improve nutrition (0-10)	6.0	6.6
Motivation to maintain nutrition habits(0-10)	9.0	9.0

Productivity Impairment	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Work Missed Due to Health	0.0%	22.4%	0.0%	22.4%
Impairment at Work Due to Health	0.0%	7.5%	0.0%	7.5%
Overall Impairment	0.0%	27.6%	0.0%	27.6%
Sick Days Last 12 Months	0.0	7.7	0.0	8.1

Section 9: Relax

Section 9.1: Participation and Demographics

This report represents key information about the stress levels of your population. It also addresses your population's sources of stress, symptoms, and coping behaviors. The following pages also provide a comparative view for your organization compared to the Aetna book-of-business Relax participants for the same time period. To begin, here is a snapshot of your population's demographics.

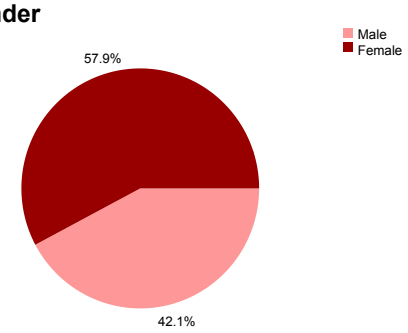
Participation

	DMT-AETNA INC	Aetna
Totals	19	80

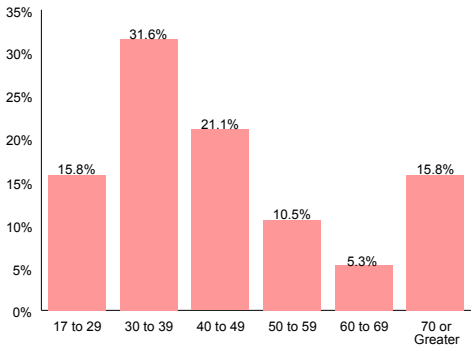
Demographics

Gender	DMT-AETNA INC	Aetna
Male	42.1%	76.2%
Female	57.9%	23.8%
Age Range		
17 to 29	15.8%	3.8%
30 to 39	31.6%	75.0%
40 to 49	21.1%	5.0%
50 to 59	10.5%	5.0%
60 to 69	5.3%	1.2%
70 or Greater	15.8%	10.0%
Average Age		
Average Age	46	39
Ethnicity		
Caucasian	26.3%	61.2%
African American	10.5%	5.0%
Hispanic	5.3%	3.8%
Asian	10.5%	7.5%
Pacific Islander	0.0%	1.2%
Native American	21.1%	7.5%
Hawaiian	10.5%	2.5%
Multi-racial	5.3%	2.5%
Other	5.3%	1.2%

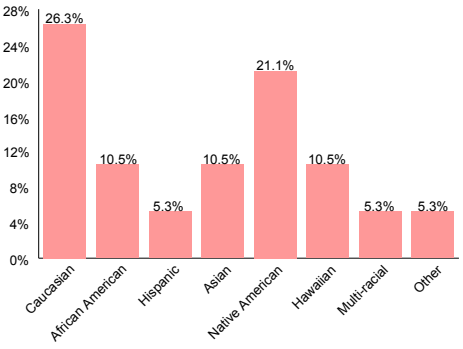
Gender



Age Range



Ethnicity

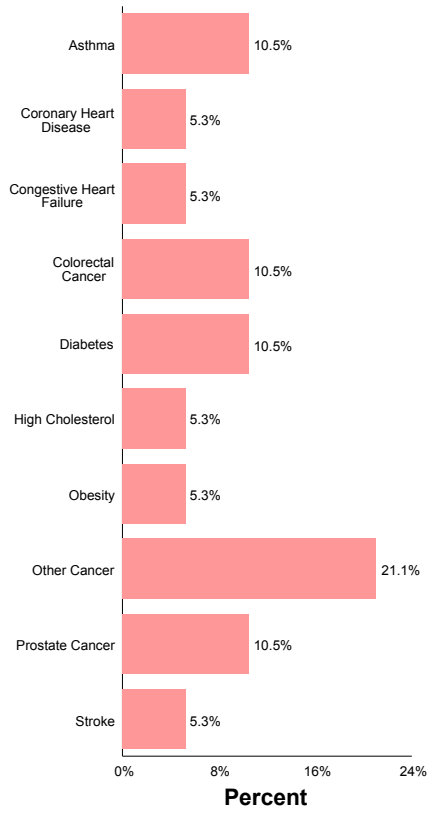


Section 9.2: Disease and Health History

The Relax program captures data about a wide range of conditions your population has been diagnosed with, as well as the number of diagnoses they have. This data provides insight into other health issues your population is dealing with.

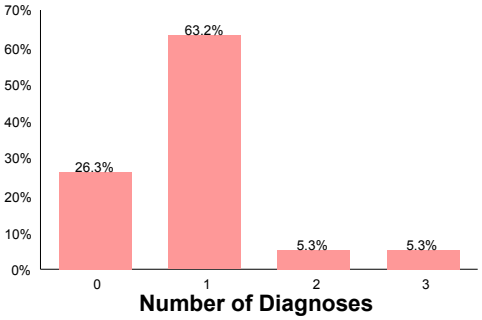
Health Conditions	DMT-AETNA INC	Aetna
Angina	0.0%	2.5%
Asthma	10.5%	3.8%
Breast Cancer	0.0%	1.2%
Coronary Heart Disease	5.3%	2.5%
Congestive Heart Failure	5.3%	1.2%
Colorectal Cancer	10.5%	5.0%
Diabetes	10.5%	56.2%
Heart Attack	0.0%	1.2%
High Blood Pressure	0.0%	1.2%
High Cholesterol	5.3%	2.5%
Lung Cancer	0.0%	55.0%
Obesity	5.3%	2.5%
Osteoarthritis	0.0%	52.5%
Osteoporosis	0.0%	1.2%
Other Cancer	21.1%	5.0%
Other Heart Disease	0.0%	1.2%
Prostate Cancer	10.5%	3.8%
Stroke	5.3%	2.5%

Prevalence of Chronic Conditions



No. of Conditions		
0	26.3%	17.5%
1	63.2%	21.2%
2	5.3%	5.0%
3	5.3%	55.0%
4	0.0%	1.2%

No. of Conditions



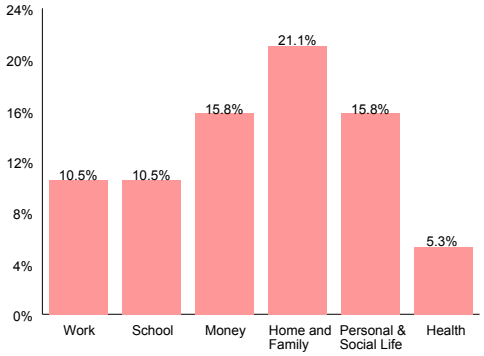
Avg. No. of Conditions		
Avg. No. of Conditions	0.9	2.0

Section 9.3: Primary Source of Stress

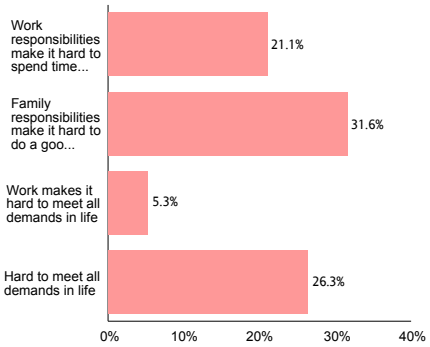
Understanding how to help your population manage stress begins with identifying stressors. Your population's greatest sources of stress are shown below.

Primary Source of Stress	DMT-AETNA INC	Aetna
Work	10.5%	3.8%
School	10.5%	2.5%
Money	15.8%	5.0%
Home & Family	21.1%	61.2%
Personal & Social Life	15.8%	3.8%
Health	5.3%	2.5%
Stressful Situations		
Work responsibilities make it hard to spend time with family	21.1%	6.2%
Family responsibilities make it hard to do a good job at work	31.6%	62.5%
Work makes it hard to meet all demands in life	5.3%	3.8%
Hard to meet all demands in life	26.3%	7.5%
Perception of Stress (0-4)		
Unable to control the important things in life	1.9	3.3
Nervous and stressed	2.5	1.4
Confident to handle personal problems	2.2	1.3
Things were going your way	2.2	2.0
On top of things	1.8	1.3
Angered by things out of control	1.8	1.3
Difficulties were piling up	2.4	2.1

Primary Source of Stress



Stressful Situations

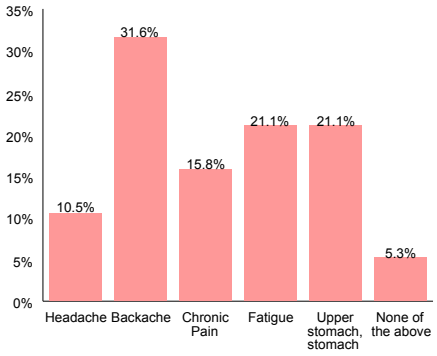


Section 9.4: Stress Symptoms

In addition to understanding causes of stress, it's also important to identify how your population experiences stress. Stress can manifest as physical symptoms, emotional reactions, or changes in behavior. The ways population experiences stress are shown below. Participants could report more than one symptom.

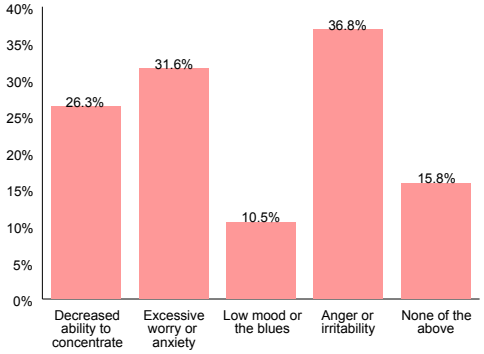
Physical Symptoms	DMT-AETNA INC	Aetna
Headache	10.5%	6.2%
Backache	31.6%	10.0%
Chronic Pain	15.8%	60.0%
Fatigue	21.1%	6.2%
Upper stomach, stomachache or intestinal Problems	21.1%	6.2%
None of the above	5.3%	1.2%

Physical Symptoms



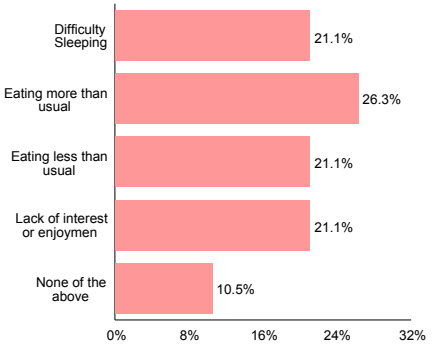
Emotional Symptoms	DMT-AETNA INC	Aetna
Decreased ability to concentrate	26.3%	7.5%
Excessive worry or anxiety	31.6%	11.2%
Low mood or the blues	10.5%	6.2%
Anger or irritability	36.8%	63.8%
None of the above	15.8%	5.0%

Emotional Symptoms



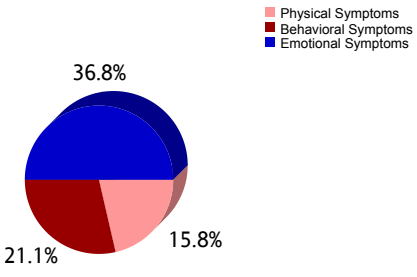
Behavior Symptoms	DMT-AETNA INC	Aetna
Difficulty sleeping	21.1%	58.8%
Eating more than usual	26.3%	8.8%
Eating less than usual	21.1%	7.5%
Lack of interest or enjoyment from usual activities	21.1%	7.5%
None of the above	10.5%	3.8%

Behavior Symptoms



Symptoms of Greater Concern	DMT-AETNA INC	Aetna
Physical Symptoms	15.8%	57.5%
Behavioral Symptoms	21.1%	5.0%
Emotional Symptoms	36.8%	13.8%

Symptoms of Greater Concern

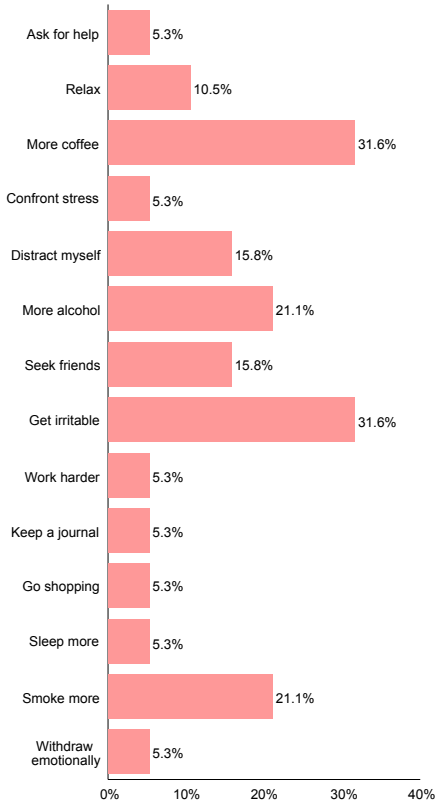


Section 9.5: Coping Behaviors

How does your population cope with stress? Some methods help people deal with stress effectively, such as engaging in physical activity or taking time to relax or unwind. Other ways are less effective, such as consuming more caffeine or alcohol, or withdrawing emotionally. Find out how your population copes with stress below. Participants could report more than one coping style.

Coping Styles	DMT-AETNA INC	Aetna
Ask for help	5.3%	3.8%
Take a little time to relax, breathe, or unwind	10.5%	3.8%
Drink more coffee, tea, or other caffeinated beverages than usual	31.6%	8.8%
Confront my source of stress and work to change it	5.3%	2.5%
Distract myself	15.8%	3.8%
Drink more alcohol than usual	21.1%	6.2%
Seek out friends for conversation and support	15.8%	5.0%
Get irritable and take it out on those around me	31.6%	10.0%
Ignore my own needs and just work harder and faster	5.3%	1.2%
Keep a journal	5.3%	53.8%
Engage in some type of physical activity	0.0%	2.5%
Pray, meditate or enhance my spiritual life	0.0%	2.5%
Go shopping and buy something to make myself feel good	5.3%	2.5%
Sleep more than I need	5.3%	55.0%
Smoke more cigarettes than usual	21.1%	6.2%
Withdraw emotionally	5.3%	1.2%

Coping Styles



Stress Prevention	DMT-AETNA INC	Aetna
Maintain a balance between work and leisure	10.5%	3.8%
Good at recognizing and dealing with stressful situations	5.3%	5.0%
Include planned periods of relaxation in my day	21.1%	8.8%
Practice stress management techniques	10.5%	56.2%
Good at effectively managing my time	5.3%	5.0%
Often engage in activities that I really enjoy	5.3%	2.5%
None of the above	21.1%	5.0%

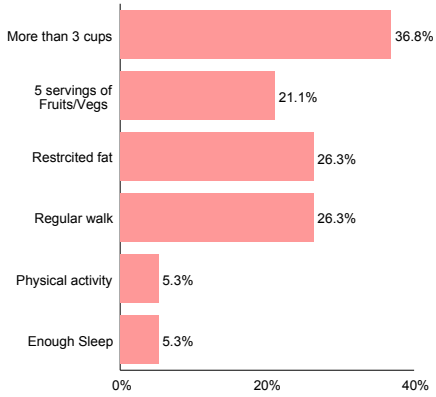
Stress Prevention

Section 9.6: Health Behaviors

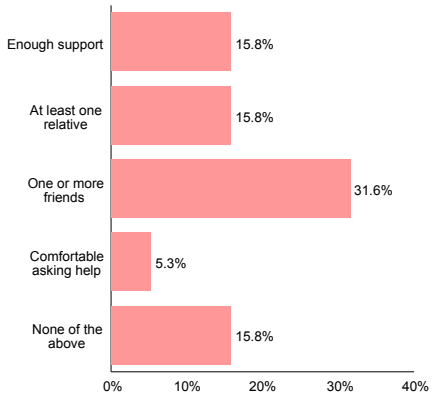
Engaging in healthy behaviors such as eating well, getting adequate rest, and exercising can help your population manage stress. Below are some behaviors related to stress management, and the percentage of people in your population who are engaging in them. Participants could report more than one health habit, social support characteristic, and stress management technique.

Health Habits	DMT-AETNA INC	Aetna
Drink more than 3 cups of coffee/tea on a typical day	36.8%	11.2%
Eat 5 or more servings of fruits & vegetables on a typical day	21.1%	0.0%
Eat 5 or more servings of fruits and vegetables on a typical day	0.0%	60.0%
Restrict amount of fat in my diet	26.3%	10.0%
Regularly take walks, do homework, etc. on a regular day	26.3%	11.2%
I engage in at least 30 minutes of physical activity	5.3%	1.2%
Enough sleep to feel satisfied when I wake up	5.3%	53.8%
Social Support		
Enough support from friends and family	15.8%	57.5%
At least one relative or close friend	15.8%	6.2%
One or more friends to confide on personal matters	31.6%	65.0%
Comfortable asking for help when needed	5.3%	2.5%
None of the above	15.8%	3.8%
Stress Management Techniques		
Relax muscles and reduce tension	10.5%	2.5%
Manage time better	21.1%	6.2%
Say no without feeling guilty	15.8%	7.5%
Control worries	21.1%	7.5%
Meditate	15.8%	58.8%
Set managable goals	10.5%	2.5%
Create and use visualization	5.3%	53.8%
Get a good nights sleep	10.5%	3.8%

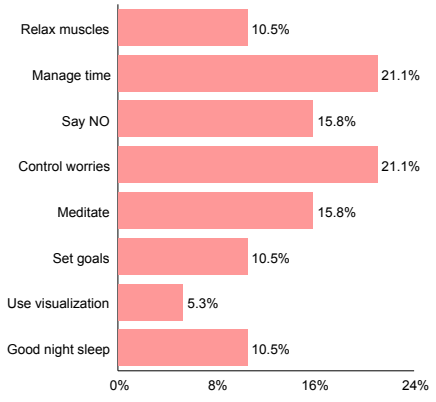
Health Habits



Social Support



Stress Management Techniques

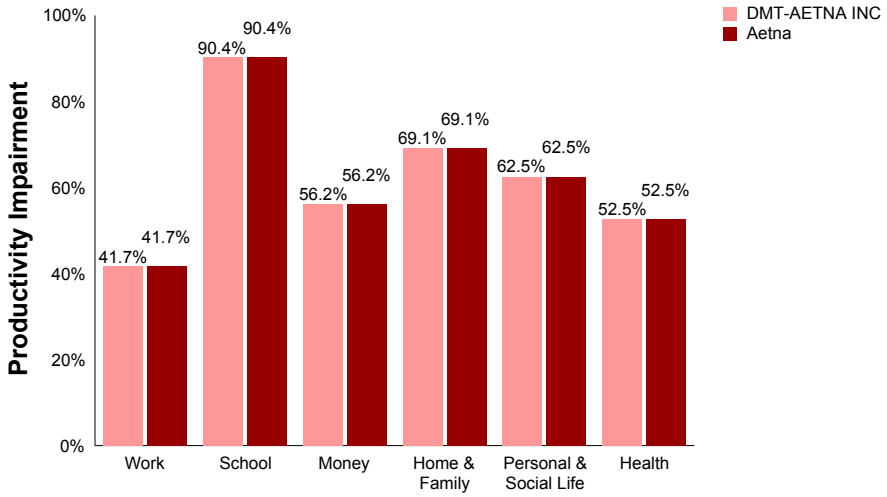


Section 9.7: Productivity

Source of Stress and Workplace Productivity

Stress is linked to poor health outcomes, and poor health often adversely affects workplace productivity. The graph and charts below illustrate your population's vulnerability to productivity impairment related to stress, as well as how stress impacts productivity, attendance, and impairment on the job.

Primary Source of Stress on Productivity Impairment



The average Impairment Productivity of your Population is: **60.4%**

DMT-AETNA INC	Sick Days Last 12 Months	Work Missed Due to Health	Impairment at Work Due to Health	Overall Impairment
Work	6.0	13.3%	35.0%	41.7%
School	97.0	51.8%	80.0%	90.4%
Money	3.7	27.0%	40.0%	56.2%
Home & Family	13.8	22.3%	65.0%	69.1%
Personal & Social Life	9.3	6.2%	60.0%	62.5%
Health	6.0	32.2%	30.0%	52.5%

Aetna				
Work	8.0	13.3%	35.0%	41.7%
School	97.0	51.8%	80.0%	90.4%
Money	5.8	27.0%	40.0%	56.2%
Home & Family	10.1	22.3%	65.0%	69.1%
Personal & Social Life	9.3	6.2%	60.0%	62.5%
Health	6.0	32.2%	30.0%	52.5%

What Productivity Impairment Means

HealthMedia utilizes the Work Productivity and Activity Impairment (WPAI) instrument to quantify overall productivity impairment for your population. Overall Productivity Impairment, a combination of absenteeism and presenteeism, represents the percentage of the employees' time that is not productive because of health conditions or behavior.

The tables on the left show the percentage of work missed due to health, percentage of productivity impairment at work due to health, and the overall productivity impairment percentage for each primary source of stress. These results are for individuals working at least 20 hours per week. Multiplying the percentages by the average salary and applying the prevalence rate within the employee population for each primary source of stress allows the impairment percentage to be expressed as salary dollars lost.

Section 9.8: Stress Management

Below are the outcomes of Relax users related to stress symptoms, motivation and confidence to manage stress, and productivity impairment.

Stress Symptoms for Completors	DMT-AETNA INC	Aetna
Decreased Symptoms	42.1%	13.8%

Managing Stress	DMT-AETNA INC	Aetna
Avg. Motivation (0-10)	7.6	6.7
Avg. Confidence (0-5)	3.6	3.2

Productivity Impairment	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Work missed due to health	23.6%	17.1%	23.6%	17.1%
Impairment at work due to health	51.2%	13.8%	51.2%	13.8%
Overall impairment	60.4%	28.0%	60.4%	28.0%
Sick days in last 12 months	20.4	22.2	16.1	21.3

Section 10: Overcoming Depression

Section 10.1: Participation and Demographics

This report presents key information about your population enrolled in the Depression program. The Depression program captures a wide range of data points in order to depict a population's composition, exposure to various depression risk factors, and ability to cope with depression. This report also addresses how your population's productivity and wellness are impaired by stress factors and depression. The following pages also provide a comparative view for your organization compared to the Aetna book-of-business Depression participants for the same time period.

Participation

	DMT-AETNA INC	Aetna
Totals	35	123

Demographics

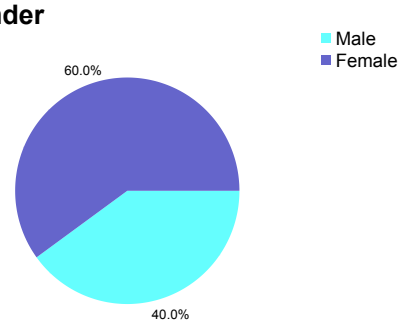
Gender	DMT-AETNA INC	Aetna
Male	40.0%	70.7%
Female	60.0%	29.3%

Age Range		
17 to 29	20.0%	11.4%
30 to 39	45.7%	69.9%
40 to 49	22.9%	8.1%
50 to 59	5.7%	4.1%
70 and Over	5.7%	6.5%

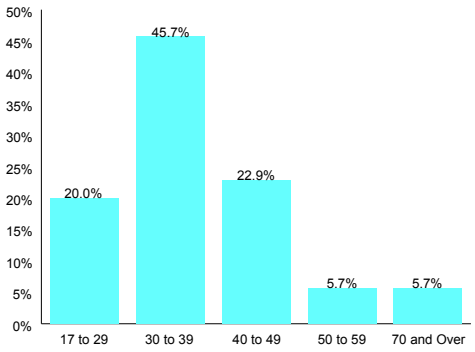
Average Age		
Average Age	39	37

Ethnicity		
Caucasian	14.3%	35.8%
African American	17.1%	6.5%
Hispanic	5.7%	3.3%
Asian	17.1%	11.4%
Pacific Islander	0.0%	2.4%
Native American	22.9%	11.4%
Hawaiian	17.1%	6.5%
Multi-racial	0.0%	1.6%
Other	5.7%	1.6%

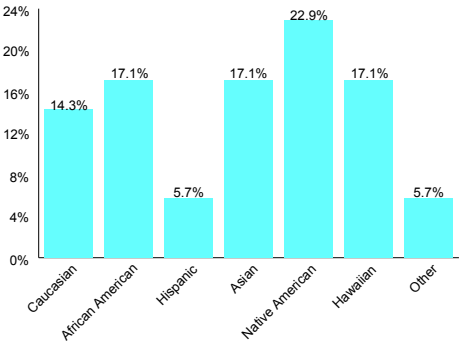
Gender



Age Range



Ethnicity



Section 10.1: Participation and Demographics

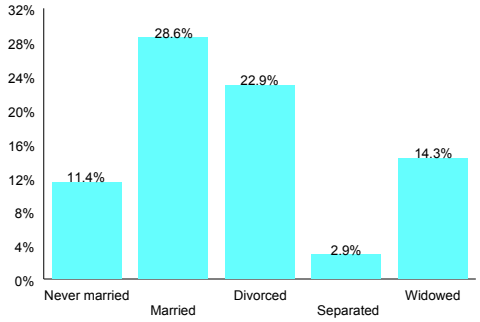
Those dealing with depression may struggle to negotiate close relationships, though the lack of a committed relationship can also contribute to depression. Partners of those dealing with depression are often stressed and find it challenging to assist their loved ones.

Studies also indicate that depression rates are often higher for those with lower levels of education. Your population's marital status and education levels are shown below.

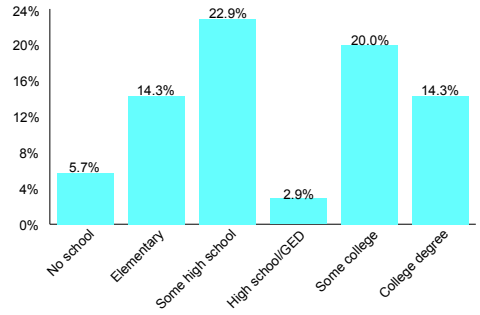
Marital Status	DMT-AETNA INC	Aetna
Never married	11.4%	8.1%
Married	28.6%	10.6%
Divorced	22.9%	8.1%
Separated	2.9%	49.6%
Widowed	14.3%	8.1%

Education		
No school	5.7%	4.9%
Elementary	14.3%	6.5%
Some high school	22.9%	10.6%
High school/GED	2.9%	3.3%
Some college	20.0%	52.8%
College degree	14.3%	6.5%

Marital Status



Education

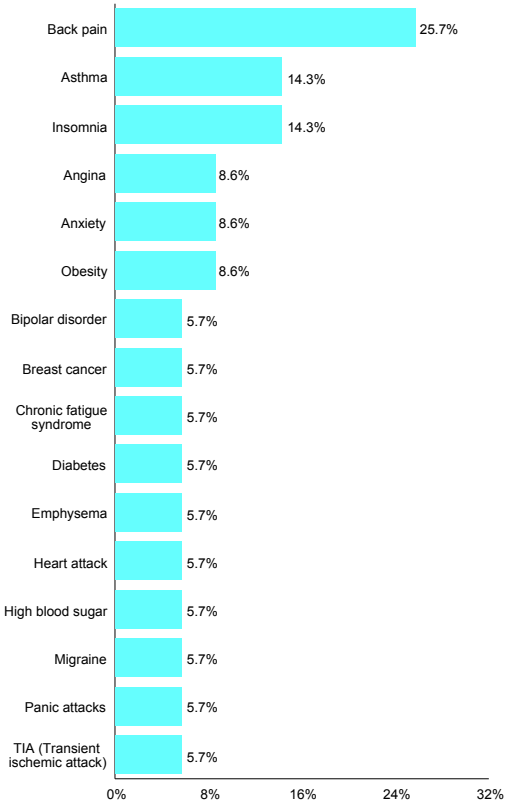


Section 10.2: Disease & Health History

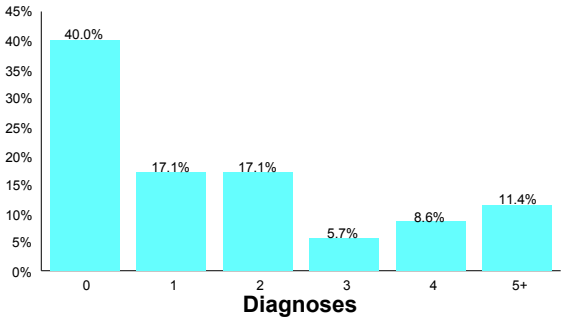
Studies in progress indicate that other diseases often accompany depression, and that these diseases can deepen a individual's depression, while the depression can worsen the health outcomes of these diseases. Your population's comorbidity is shown below.

Disease History	DMT-AETNA INC	Aetna
Back pain	25.7%	55.3%
Asthma	14.3%	8.1%
Insomnia	14.3%	5.7%
Angina	8.6%	4.9%
Anxiety	8.6%	4.1%
Obesity	8.6%	4.9%
Bipolar disorder	5.7%	3.3%
Breast cancer	5.7%	3.3%
Chronic fatigue syndrome	5.7%	2.4%
Diabetes	5.7%	4.1%
Emphysema	5.7%	2.4%
Heart attack	5.7%	3.3%
High blood sugar	5.7%	4.9%
Migraine	5.7%	3.3%
Panic attacks	5.7%	2.4%
TIA (Transient ischemic attack)	5.7%	2.4%

Prevalence of Chronic Conditions



No. of Diagnoses		
0	40.0%	23.6%
1	17.1%	13.0%
2	17.1%	48.8%
3	5.7%	4.9%
4	8.6%	4.9%
5+	11.4%	4.9%



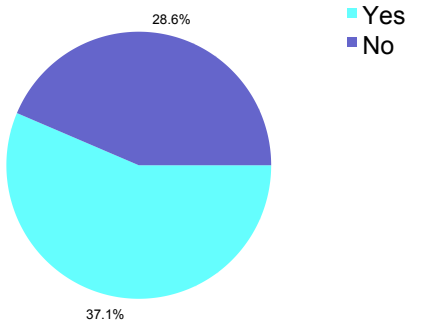
Avg. No. of Conditions		
Avg. No. of Conditions	1.7	2.0

Section 10.3: Prevalence of Pain, Insomnia & Stress

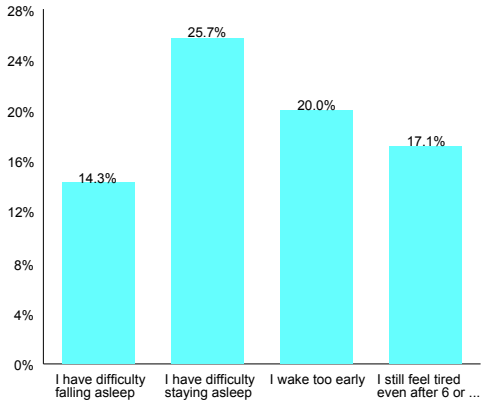
Factors influencing depression are shown below. Chronic pain has been linked to depression, as has insomnia and other sleep challenges. Participants could report more than one sleep challenge.

Chronic Pain	DMT-AETNA INC	Aetna
Yes	37.1%	18.7%
No	28.6%	59.3%
Pain Rating		
Average pain level (0-10)	7.1	5.9
Difficulty Sleeping		
I have difficulty falling asleep	14.3%	8.1%
I have difficulty staying asleep	25.7%	9.8%
I wake too early	20.0%	12.2%
I still feel tired even after 6 or more hours of sleep	17.1%	11.4%
Degree of Stress		
Never	5.7%	1.6%
Almost never	5.7%	4.9%
Sometimes	17.1%	54.5%
Fairly often	25.7%	11.4%
Very often	17.1%	6.5%

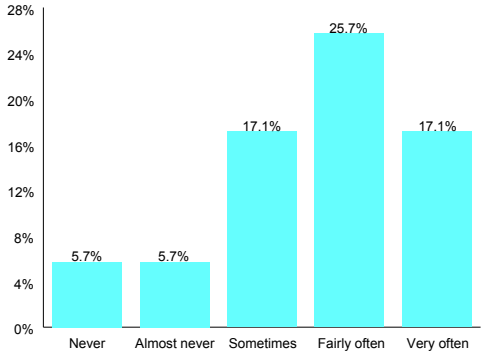
Chronic Pain



Difficulty Sleeping



Degree of Stress

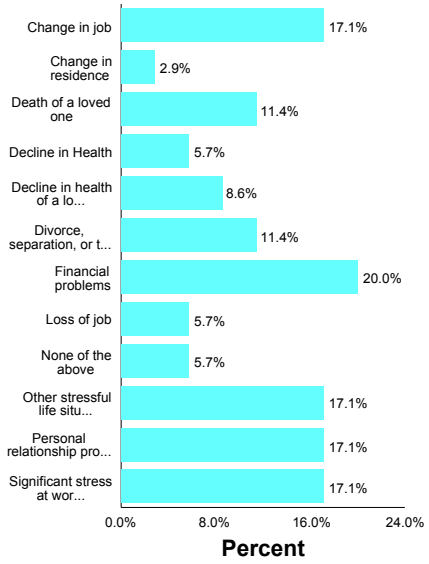


Section 10.4: Quality of Health & Life

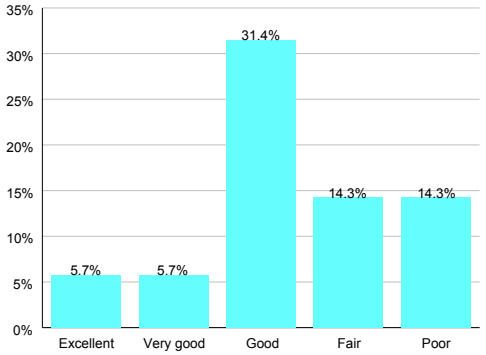
Stressful life events raise the risk of depression. Your population has been polled regarding their specific stressors, and the results are shown below. Participants could report more than one life event.

Stressful Life Events	DMT-AETNA INC	Aetna
Change in job	17.1%	8.9%
Change in residence	2.9%	3.3%
Death of a loved one	11.4%	4.9%
Decline in Health	5.7%	4.1%
Decline in health of a loved one	8.6%	5.7%
Divorce, separation, or termination of long-term relationship	11.4%	4.1%
Financial problems	20.0%	52.0%
Loss of job	5.7%	4.9%
None of the above	5.7%	2.4%
Other stressful life situation	17.1%	50.4%
Personal relationship problems	17.1%	7.3%
Significant stress at work	17.1%	9.8%
Quality of Health		
Excellent	5.7%	3.3%
Very good	5.7%	1.6%
Good	31.4%	59.3%
Fair	14.3%	9.8%
Poor	14.3%	6.5%
Quality of Life		
Excellent	2.9%	0.8%
Very good	14.3%	49.6%
Good	22.9%	11.4%
Fair	11.4%	4.9%
Poor	20.0%	10.6%
CES-D Score		
Avg. CES - D* score (0-10)	6.5	5.5

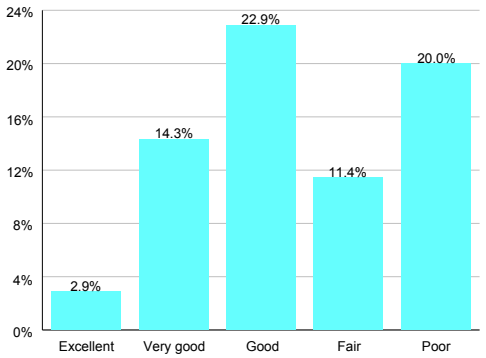
Stressful Life Events



Quality of Health



Quality of Life



*Center for Epidemiologic Studies Depression Rating Scale (CES-D) is a rating of a participant's depression level. Scores range from 0 (low level of depression) to 10 (high level of depression).

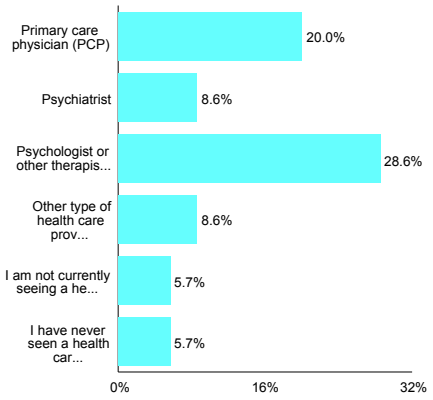
Section 10.5: Health Care Utilization

Those struggling with depression are likely to seek medical attention, both for depression itself, and for related conditions such as exhaustion, anxiety, and ill health. Check below to see your population's treatment methods and use of medical resources.

Current HCP Provider	DMT-AETNA INC	Aetna
Primary care physician (PCP)	20.0%	8.9%
Psychiatrist	8.6%	7.3%
Psychologist or other therapist	28.6%	13.0%
Other type of health care provider	8.6%	3.3%
I am not currently seeing a health care provider for my depression, but have in the past	5.7%	4.9%
I have never seen a health care provider for my depression	5.7%	51.2%

HealthCare Utilization Rates		
Avg. physician visits last 3 months	13.9	5.2
Avg. ER visits last 3 months	9.0	3.3
Avg. hospital nights last 3 months	2.0	0.9

Current HCP Provider

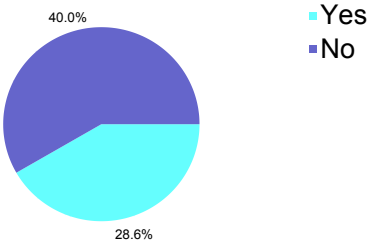


Section 10.6: Medication Adherence

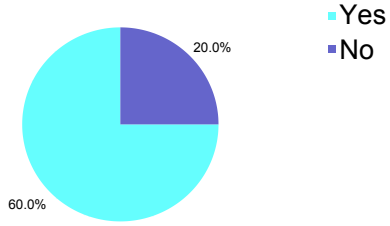
Those who become convinced that they can deal with their depression are more likely to find success, both with therapy and with medical treatment. But faulty compliance in taking medications can make the treatment of depression more difficult. Look below to discover your population's use of depression medication.

Taking Depression Medication	DMT-AETNA INC	Aetna
Yes	28.6%	16.3%
No	40.0%	65.0%
Confidence & Motivation		
Confidence on prescription medication adherence (0-10)	3.7	4.2
Motivation on prescription medication adherence (0-10)	5.8	5.4
Find Medications Helpful		
Yes	60.0%	60.0%
No	20.0%	20.0%
Frequency of Taking Medication as Prescribed		
Never	0.0%	5.0%
Rarely	20.0%	35.0%
Sometimes	60.0%	40.0%
Mostly	10.0%	10.0%
Always	10.0%	5.0%
Length of Time Taking Medication		
Less than 6 months	10.0%	10.0%
6 months to less than 1 year	20.0%	30.0%
1 year to less than 5 years	30.0%	30.0%
5 years to less than 10 years	40.0%	30.0%

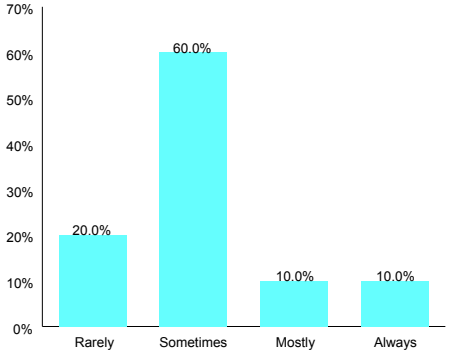
Taking Depression Medication



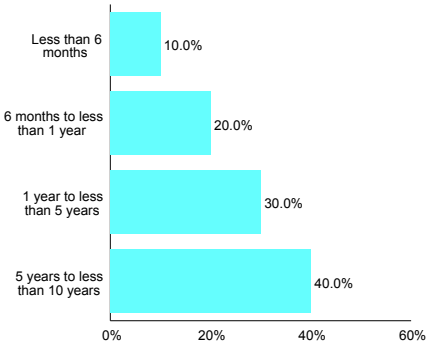
Find Medications Helpful



Medication Frequency



Time Taking Medication



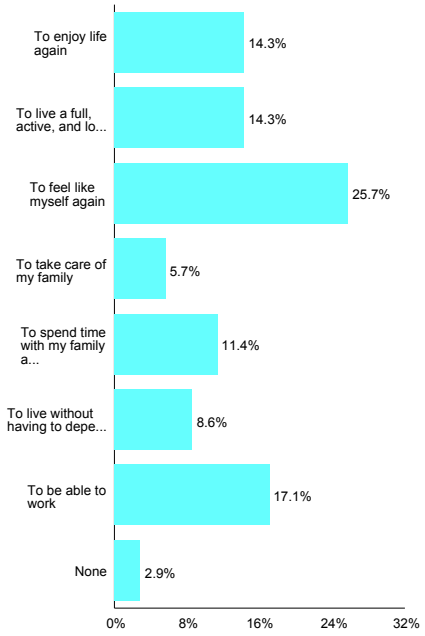
Section 10.7: Confidence, Motivation, and Reasons

Once a participant recognizes his or her coping strategies, he or she is in a much better position to draw up a workable game plan against depression. Lack of education about depression, and negative coping strategies often cripple those seeking to manage depression. Once positive coping strategies become habitual, participants have higher chances of succeeding. Participants could report more than one reason for managing depression.

Confidence & Motivation	DMT-AETNA INC	Aetna
Confidence on managing depression (0-10)	5.8	6.9
Motivation on managing depression (0-10)	6.1	6.8

Reasons for Managing Depression		
To enjoy life again	14.3%	8.9%
To live a full, active, and long life	14.3%	6.5%
To feel like myself again	25.7%	58.5%
To take care of my family	5.7%	4.9%
To spend time with my family and friends	11.4%	6.5%
To live without having to depend on someone else	8.6%	4.9%
To be able to work	17.1%	8.9%
None	2.9%	0.8%

Reasons for Managing Depression

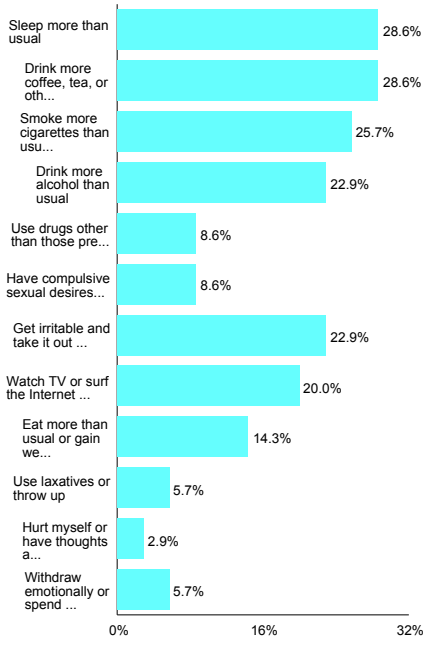


Section 10.8: Coping Strategies

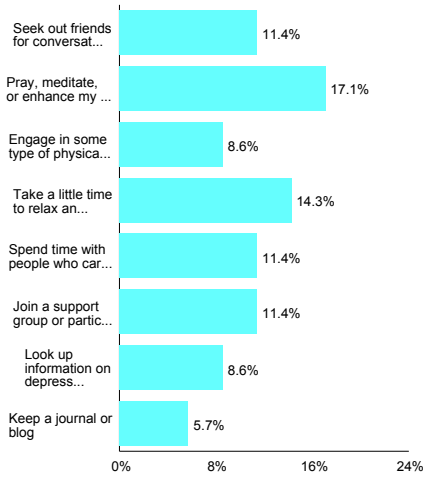
It's natural for those depressed to try a wide range of coping strategies. The goal is to move participants away from negative coping strategies, and towards healthier means of managing depression. The distribution of typical coping strategies is shown below. Participants could report more than one coping strategy.

Negative Coping Strategies	DMT-AETNA INC	Aetna
Sleep more than usual	28.6%	11.4%
Drink more coffee, tea, or other caffeinated beverages than usual	28.6%	10.6%
Smoke more cigarettes than usual	25.7%	52.0%
Drink more alcohol than usual	22.9%	9.8%
Use drugs other than those prescribed to me	8.6%	6.5%
Have compulsive sexual desires, fantasies, or behaviors	8.6%	4.1%
Get irritable and take it out on those around me	22.9%	10.6%
Watch TV or surf the Internet for long hours	20.0%	8.1%
Eat more than usual or gain weight	14.3%	6.5%
Use laxatives or throw up	5.7%	2.4%
Hurt myself or have thoughts about hurting myself or others	2.9%	2.4%
Withdraw emotionally or spend time alone	5.7%	4.1%
Positive Coping Strategies		
Seek out friends for conversation and support	11.4%	6.5%
Pray, meditate, or enhance my spiritual life	17.1%	6.5%
Engage in some type of physical activity	8.6%	4.9%
Take a little time to relax and do activities that make me feel better	14.3%	7.3%
Spend time with people who care about me	11.4%	4.1%
Join a support group or participate in online bulletin boards or chats	11.4%	3.3%
Look up information on depression	8.6%	2.4%
Keep a journal or blog	5.7%	1.6%

Negative Coping Strategies



Positive Coping Strategies

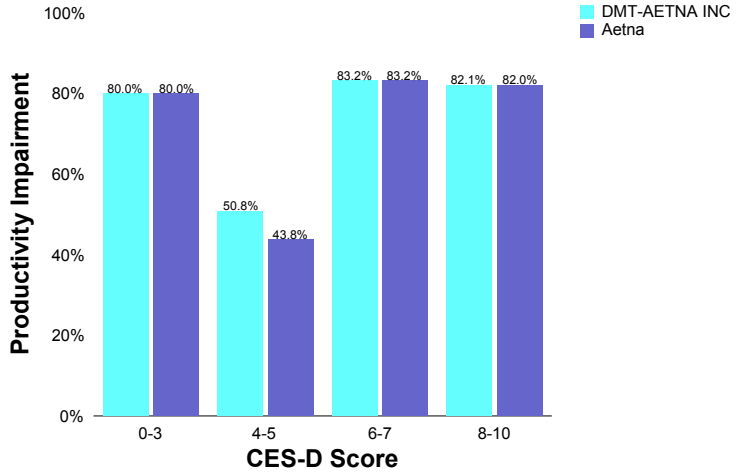


Section 10.9: Productivity Impairment

Depression and Productivity in Work Place

Depression and stress is linked to poor health outcomes when comorbid with other diseases. Poor health often adversely affects workplace productivity. The graph and charts below illustrate your population's vulnerability to Depression and productivity impairment

CES-D Score and Productivity Impairment



* Scores range from 0 (low level of depression) to 10 (high level of depression).

DMT-AETNA INC	Work Missed Due to Health	Impairment at Work Due to Health	Sick Days Last 12 Months	Productivity Impairment
0-3	33.3%	70.0%	90.0	80.0%
4-5	35.0%	20.0%	34.9	50.8%
6-7	43.8%	78.0%	67.8	83.2%
8-10	31.3%	76.0%	40.0	82.1%
Aetna				
0-3	33.3%	70.0%	31.3	80.0%
4-5	23.3%	23.3%	4.6	43.8%
6-7	43.8%	78.0%	56.8	83.2%
8-10	30.8%	77.1%	67.3	82.0%

Average Productivity Impairment

The average Productivity Impairment of your population at baseline is: **77.5%**

What Productivity Impairment Means

HealthMedia Utilizes the Work Productivity and Activity Impairment (WPAI) instrument to quantify overall productivity impairment for your population. Overall productivity impairment, a combination of absenteeism and presenteeism, represents the percentage of the employees' time that is not productive because of health conditions or behavior.

The tables on the left show the percentage work missed due to health, percentage productivity impairment at work due to health and the overall productivity impairment percentage for each depression score range. These results are for individuals working at least 20 hours per week. Multiplying the percentages by the average salary and applying the prevalence rate within the employee population for degree of stress allows the impairment percentage to be expressed as salary dollars lost.

Section 10.10: Depression Outcomes

Below are the outcomes of Overcoming Depression users related to CES-D Score, motivation and confidence to manage depression, and productivity impairment.

Confidence & Motivation to Manage Depression	DMT-AETNA INC	Aetna
Average Confidence (0-10)	6.8	7.1
Average Motivation (0-10)	6.7	7.3

CES-D Score	CES-D Scores* DMT-AETNA INC		CES-D Scores* Aetna	
	Enrollments	Completions	Enrollments	Completions
CES-D Score	6.5	2.8	5.5	1.0

*CES-D Scores range from 0-10. Scores range from 0 (low level of depression) to 10 (high level of depression).

Productivity Impairment	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Work Missed Due to Health	36.8%	12.3%	33.6%	10.6%
Impairment at Work Due to Health	67.7%	10.0%	66.9%	8.6%
Overall Impairment	77.5%	20.8%	75.1%	17.8%
Sick Days Last 12 Months	51.7	0.6	19.7	1.2

Section 11: Overcoming Insomnia

Section 11.1: Participation and Demographics

This report presents key information about your population enrolled in the Insomnia program. The Insomnia program captures a wide range of data points in order to depict a population's composition, exposure to various insomnia risk factors, and ability to manage sleeplessness. This report also addresses how your population's productivity and wellness are impaired by insomnia. The following pages also provide a comparative view for your organization compared to the Aetna book-of-business Insomnia participants for the same time period.

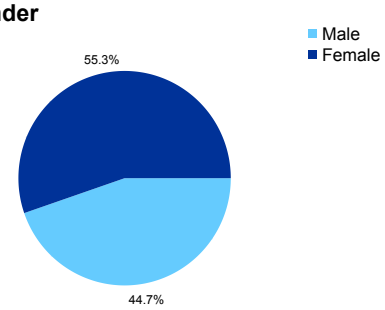
Participation

	DMT-AETNA INC	Aetna
Totals	38	105

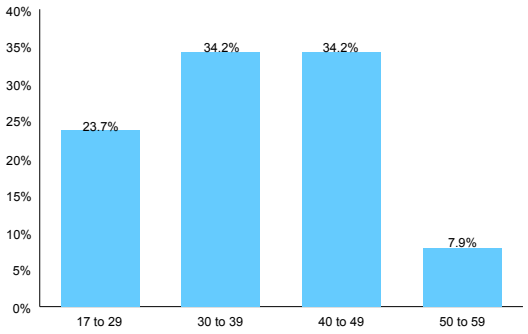
Demographics

Gender	DMT-AETNA INC	Aetna
Male	44.7%	71.4%
Female	55.3%	28.6%
Age Range		
17 to 29	23.7%	14.3%
30 to 39	34.2%	62.9%
40 to 49	34.2%	13.3%
50 to 59	7.9%	4.8%
70 and Over	0.0%	4.8%
Average Age		
Average Age	38	37
Ethnicity		
Caucasian	13.2%	41.9%
African American	21.1%	10.5%
Hispanic	5.3%	3.8%
Asian	15.8%	12.4%
Pacific Islander	0.0%	1.9%
Native American	23.7%	14.3%
Hawaiian	15.8%	5.7%
Multi-racial	0.0%	1.0%
Other	5.3%	1.9%

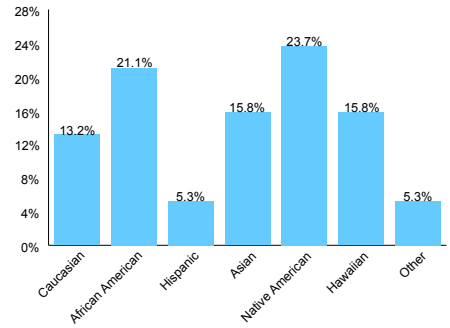
Gender



Age Range



Ethnicity



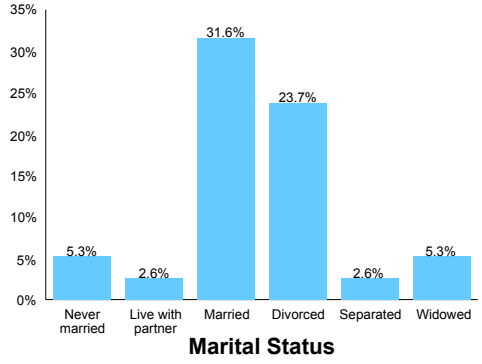
Section 11.1: Participation and Demographics

Studies indicate that stresses within a relationship can contribute to insomnia, just as a supportive relationship can help ward off sleeplessness. Additionally, higher insomnia rates are often linked to lower education levels. Your population's marital status and education levels are shown below.

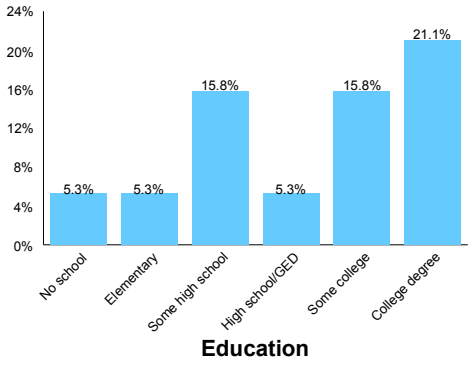
Marital Status	DMT-AETNA INC	Aetna
Never married	5.3%	4.8%
Live with partner	2.6%	1.0%
Married	31.6%	16.2%
Divorced	23.7%	9.5%
Separated	2.6%	43.8%
Widowed	5.3%	2.9%

Education		
No school	5.3%	4.8%
Elementary	5.3%	3.8%
Some high school	15.8%	48.6%
High school/GED	5.3%	2.9%
Some college	15.8%	6.7%
College degree	21.1%	11.4%

Marital Status



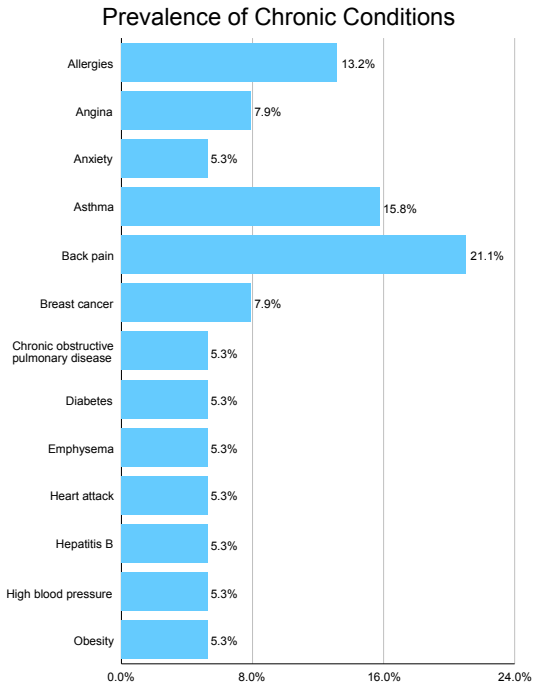
Education

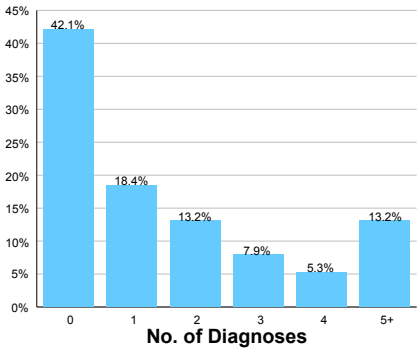


Section 11.2: Disease & Health History

Insomnia is strongly linked to other chronic disease, as well as to the likelihood of depression and other psychiatric disorders. Your population's disease comorbidity is shown below.

Disease History	DMT-AETNA INC	Aetna
Allergies	13.2%	5.7%
Angina	7.9%	6.7%
Anxiety	5.3%	1.9%
Asthma	15.8%	49.5%
Back pain	21.1%	45.7%
Breast cancer	7.9%	4.8%
Chronic obstructive pulmonary disease	5.3%	2.9%
Diabetes	5.3%	4.8%
Emphysema	5.3%	2.9%
Heart attack	5.3%	3.8%
Hepatitis B	5.3%	1.9%
High blood pressure	5.3%	3.8%
Obesity	5.3%	3.8%
No. of Diagnoses		
0	42.1%	25.7%
1	18.4%	8.6%
2	13.2%	9.5%
3	7.9%	5.7%
4	5.3%	9.5%
5+	13.2%	41.0%
Avg. No. of Conditions		
Avg. Conditions	1.7	3.4





Section 11.3: Stress Treatment & Medication

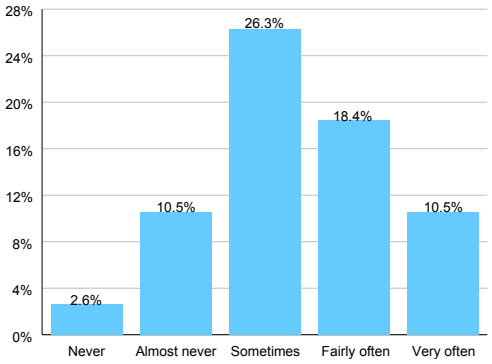
Your population's stress level assessment categories are shown below. Generally, the more stressors a participant experiences, the higher risk he or she runs for insomnia.

Degree of Stress	DMT-AETNA INC	Aetna
Never	2.6%	1.0%
Almost never	10.5%	6.7%
Sometimes	26.3%	14.3%
Fairly often	18.4%	9.5%
Very often	10.5%	4.8%

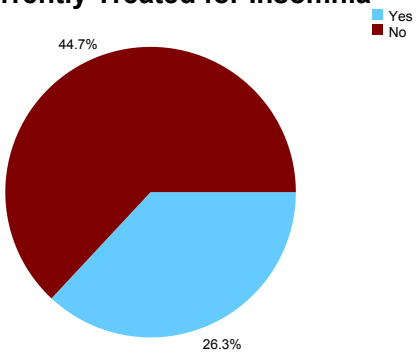
Development of sleep aids and medication for sleeplessness has grown rapidly in the last decade, though many viable nonmedical means of dealing with insomnia still exist. Look below to discover your population's use of medication to treat insomnia.

Currently Treated for Insomnia	DMT-AETNA INC	Aetna
Yes	26.3%	58.1%
No	44.7%	21.9%
Medication Type		
Taking prescription sleep medication	18.4%	8.6%
Taking over-the-counter sleep aids	23.7%	17.1%
No medications or sleep aids	34.2%	54.3%
Medication Frequency		
Every night	7.9%	4.8%
3 or more nights a week	18.4%	13.3%
1-2 nights a week	10.5%	6.7%
Less than once a month	2.6%	1.9%

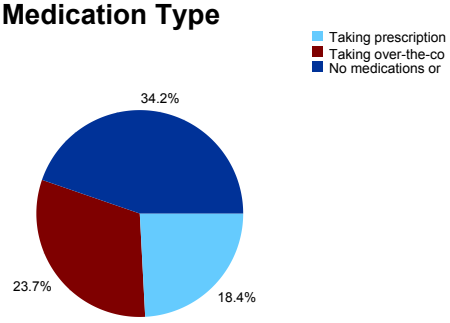
Degree of Stress



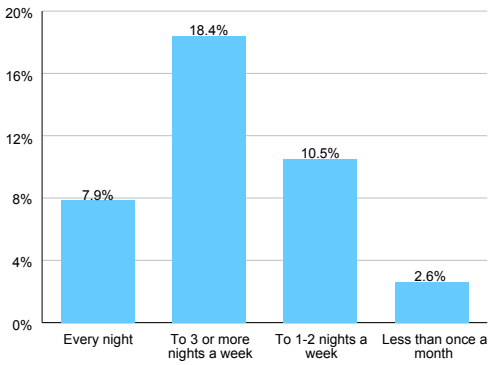
Currently Treated for Insomnia



Medication Type



Medication Frequency

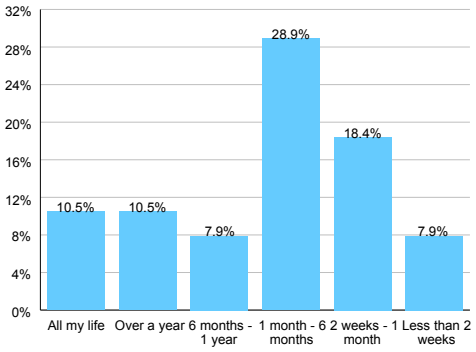


Section 11.4: Quality of Sleep, Health & Life

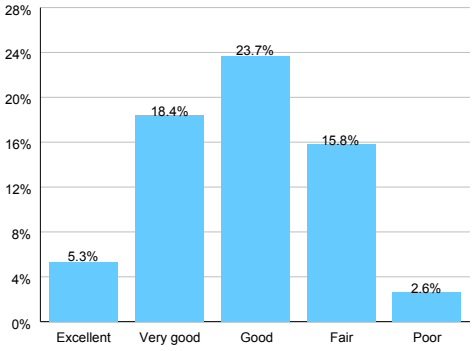
Please refer to the data below for a snapshot of how your population members assess their quality of life and sleep experiences.

Duration of the Problem	DMT-AETNA INC	Aetna
All my life	10.5%	4.8%
Over a year	10.5%	3.8%
6 months - 1 year	7.9%	5.7%
1 month - 6 months	28.9%	14.3%
2 weeks - 1 month	18.4%	50.5%
Less than 2 weeks	7.9%	3.8%
Average Sleep Hours		
Avg. hours of sleep	5.1	5.1
Quality of Sleep (0-10)		
Difficulty falling asleep	5.7	3.6
Difficulty staying asleep	6.2	3.4
Waking early	5.6	3.0
Overall sleep quality	4.2	5.1
Fatigue level	5.7	5.5
Quality of Health		
Excellent	5.3%	1.9%
Very good	18.4%	48.6%
Good	23.7%	13.3%
Fair	15.8%	8.6%
Poor	2.6%	1.9%
Quality of Life		
Excellent	7.9%	2.9%
Very good	23.7%	10.5%
Good	18.4%	55.2%
Fair	13.2%	4.8%
Poor	2.6%	1.0%

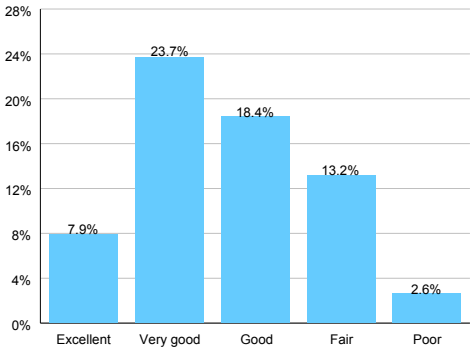
Duration of the Problem



Quality of Health



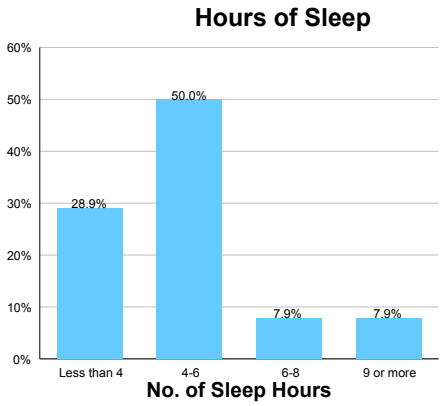
Quality of Life



Section 11.5: Sleep History

Factors influencing sleep and the duration of insomnia for participants are shown below. For some, insomnia is a rare and seemingly random intruder, while others struggle with it daily. Participants could report more than one factor.

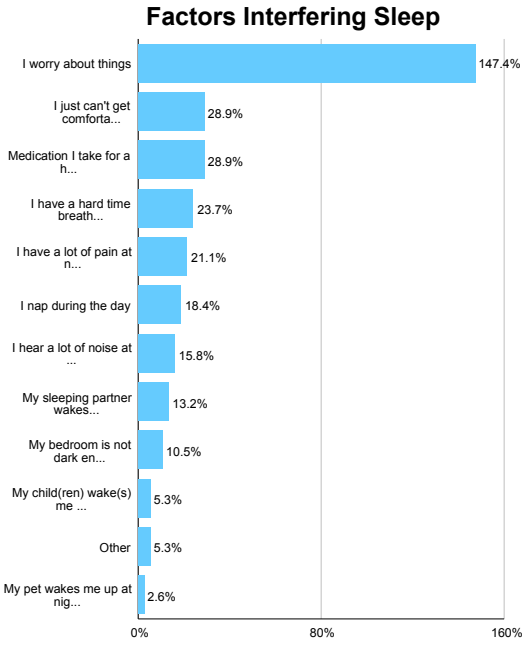
Hours of Sleep	DMT-AETNA INC	Aetna
Less than 4	28.9%	19.0%
4-6	50.0%	65.7%
6-8	7.9%	7.6%
9 or more	7.9%	5.7%
Avg. No. of Days with Sleep Problems		
Took an hour to fall asleep	3.2	2.1



Factors Interfering with Sleep

Here you can view a break-down of specific issues that influence and interfere with quality of sleep. Factors are often extrinsic, but intrinsic factors, such as worrying, can also play large and complicated roles in causing insomnia.

Factors Interfering with Sleep	DMT-AETNA INC	Aetna
I worry about things	31.6%	53.3%
I just can't get comfortable	28.9%	10.5%
I hear a lot of noise at night	15.8%	5.7%
I have a hard time breathing	15.8%	8.6%
I nap during the day	13.2%	6.7%
I have a lot of pain at night	13.2%	7.6%
Medication I take for a health condition makes it hard to sleep	13.2%	10.5%
My sleeping partner wakes me up at night	10.5%	4.8%
My bedroom is not dark enough	7.9%	3.8%
My child(ren) wake(s) me up at night	5.3%	1.9%
Other	5.3%	1.9%
My pet wakes me up at night	2.6%	1.0%



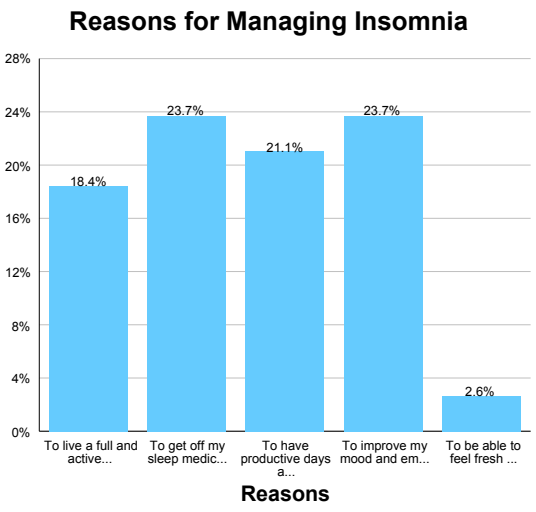
Section 11.6: Managing Insomnia

In order to effectively treat insomnia, participants typically need to reach high levels of confidence in their ability to establish healthy behaviors. Your population's confidence scores and motivations for managing insomnia are shown below. Participants could report more than one reason for managing insomnia.

Reasons for Managing Insomnia	DMT-AETNA INC	Aetna
To live a full and active life	18.4%	7.6%
To get off my sleep medication(s)	23.7%	17.1%
To have productive days at work and home	21.1%	51.4%
To improve my mood and emotions	23.7%	10.5%
To be able to feel fresh and energetic	2.6%	1.0%

Managing Insomnia		
Avg. confidence to manage Insomnia (0-10)	5.8	4.4
Avg. motivation to manage Insomnia (0-10)	6.0	3.8

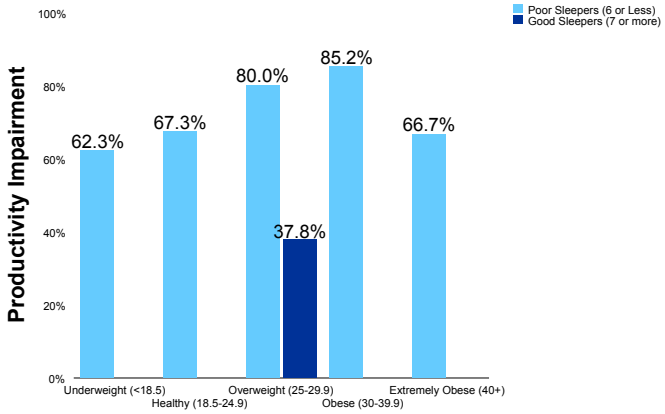
Avg. Confidence in Ability to Make Specific Changes (0-5):		
Avg. confidence to manage Insomnia (0-10)	3.3	2.6
Exercise about 30 minutes on most days	3.4	2.6
Wake up at the same time everyday no matter when you slept	2.7	2.8
Take steps to overcome insomnia when you are stressed	3.0	2.9
Have exposure to bright sunlight for 10 or more minutes during the day	3.4	2.6
Avoid sleeping in on weekends	3.3	3.0



Section 11.7: Productivity

Insomnia and obesity appear to be correlated in a vicious cycle. Studies seem to indicate that obese people experience more sleep problems on average than fit people, and also that those dealing with insomnia and other sleep issues run higher risks of gaining weight than those who sleep well. The effects of obesity on productivity are shown below.

Impact of Obesity and Hours of Sleep on Productivity Impairment



The average Impairment Productivity of your Population is: **66.5%**

DMT-AETNA INC	No. of Sleep Hours	Work Missed Due to Health	Impairment at Work Due to Health	Sick Days Last 12 Months	Productivity Impairment
Underweight (<18.5)	Poor Sleepers (6 or Less)	37.2%	40.0%	8.0	62.3%
Healthy (18.5-24.9)	Poor Sleepers (6 or Less)	27.8%	55.0%	32.7	67.3%
	Good Sleepers (7 or more)	0.0%	0.0%	5.0	0.0%
Overweight (25-29.9)	Poor Sleepers (6 or Less)	50.0%	60.0%	10.0	80.0%
	Good Sleepers (7 or more)	27.7%	15.0%	17.0	37.8%
Obese (30-39.9)	Poor Sleepers (6 or Less)	29.7%	80.0%	12.5	85.2%
	Good Sleepers (7 or more)	0.0%	0.0%	0.0	0.0%
Extremely Obese (40+)	Poor Sleepers (6 or Less)	33.3%	50.0%	90.0	66.7%

Aetna	No. of Sleep Hours	Work Missed Due to Health	Impairment at Work Due to Health	Sick Days Last 12 Months	Productivity Impairment
Underweight (<18.5)	Poor Sleepers (6 or Less)	37.2%	40.0%	4.2	62.3%
Healthy (18.5-24.9)	Poor Sleepers (6 or Less)	27.8%	55.0%	32.7	67.3%
	Good Sleepers (7 or more)	0.0%	0.0%	2.5	0.0%
Overweight (25-29.9)	Poor Sleepers (6 or Less)	50.0%	60.0%	10.0	80.0%
	Good Sleepers (7 or more)	27.7%	15.0%	17.0	37.8%
Obese (30-39.9)	Poor Sleepers (6 or Less)	29.7%	80.0%	12.5	85.2%
	Good Sleepers (7 or more)	0.0%	0.0%	0.0	0.0%
Extremely Obese (40+)	Poor Sleepers (6 or Less)	33.3%	50.0%	48.0	66.7%
	Good Sleepers (7 or more)	0.0%	0.0%	4.0	0.0%

What Productivity Impairment Means

Aetna utilizes the Work Productivity and Activity Impairment (WPAI) instrument to quantify overall productivity impairment for your population. Overall productivity impairment, a combination of absenteeism and presenteeism, represents the percentage of the employees' time that is not productive because of health conditions or behavior.

The tables on the left show the percentage work missed due to health, percentage productivity impairment at work due to health and the overall productivity impairment percentage for each BMI range for good sleepers and poor sleepers. These results are for individuals working at least 20 hours per week. Multiplying the percentages by the average salary and applying the prevalence rate within the employee population for degree of stress allows the impairment percentage to be expressed as salary dollars lost.

Section 11.8:

Below are the outcomes of Overcoming Insomnia users related to average number of hours of sleep, quality of sleep, motivation and confidence to manage insomnia, and productivity impairment.

Average Sleep Hours	DMT-AETNA INC	Aetna
Avg. hours of sleep	5.1	5.1
Quality of Sleep (0-10)		
Difficulty falling asleep	2.8	3.2
Difficulty staying asleep	3.1	3.6
Waking early	3.3	4.1
Overall sleep quality	5.4	6.0
Fatigue level	3.3	3.9
Managing Insomnia		
Avg. confidence to manage Insomnia (0-10)	6.9	6.9
Avg. motivation to manage Insomnia (0-10)	7.0	6.6

Comparison of WPAI Measures from Enrollment to Completion

Productivity Impairment	DMT-AETNA INC		Aetna	
	Enrollments	Completions	Enrollments	Completions
Sick days in last 12 months	28.2	1.0	22.4	1.6
Work missed due to health	30.0%	12.8%	30.0%	12.8%
Impairment at work due to health	52.6%	22.5%	52.6%	22.5%
Overall impairment	66.5%	33.2%	66.5%	33.2%

Account management team

Organizational chart for the State of Alaska

Leadership

- Norman Seabrooks
  President Pacific Northwest Market
- Matt McCormick
  Vice President Client Management
- Beth Andersen
  Executive Sponsor
  President West Region
- Tom Finn
  Public and Labor Market Head West Region

Service

- Linda Machado
  Service Center Lead & My AlaskaCare Single Point of Contact Team
- Trisha Karjalainen
  Claims Team Lead

Plan management

- Lynda Gable
  Account Team Lead
- Account Executive
  Located in Juneau
- Catie Lynch
  Account Manager
- Allison Johnson
  Clinical Program Consultant
- Dr. Lydia Bartholomew
  Medical Director
- Sales Support Consultants
  Located in Juneau and Anchorage
- Matt McCormick
  Vice President Client Management
- Karri Priddy
  Plan Sponsor Liaison

Alaska advisory and support team

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  Care Delivery
- Shelley Nordlinger
  Customer Service
- Lori O'Banion
  Network
- Dana Lewis
  Clinical

Health care transformation advisory team

- Dr. Andrew Oliveira
  Clinical Strategy and Delivery
- Maureen Hydok
  Wellness Strategy, Active Health Management
- John Wagner
  Network Strategy and Delivery
- Daniel Brostek
  Technology Strategy and Solutions

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Account Management Team

Meeting with the State

During the implementation phase, your account team will participate in all weekly meetings and all other meetings as necessary. In person meetings are generally monthly during implementation. Ongoing, we will meet with the State in person in Alaska on a quarterly basis, at a minimum. We have no limits on the number of meetings your account team will have with you. Our goal is to provide optimal service and support, and to meet your needs. Because the State is looking to transform healthcare and make material changes, we anticipate additional meetings will be necessary.

Responsibility for other accounts

Your account executive, Lynda Gable, and account manager, Catie Lynch, have limited responsibility for other customers. Their portfolio will be balanced to assure the ability to support and focus on the State of Alaska. They both currently work on the State of Alaska Political Subdivision Group Health and Life Plan and would continue to support those accounts. The sales support consultants who will be located in Alaska (2 in Juneau and 2 in Anchorage) will be fully dedicated to the State of Alaska.

The leadership team has responsibility for the customers within their market. Although they will have other account responsibility, the leadership team and all individuals identified to support you recognize the importance of the State of Alaska and your goals to transform health care.

Other anticipated implementations

There are no known implementations that will impact any team member for the 7/1 effective date. The team will have the ability to focus on the State's 7/1 implementation and provide support.

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Account Management Team

Leadership

Name: Norman Seabrooks

Title: President Pacific Northwest Market

Location: Seattle, WA

Years of industry experience: 40 years

Years with Aetna: 40 years

Level of educational attainment: Bachelor's of Arts

Resume: Norman Seabrooks is 1973 graduate of The Citadel with a Bachelor of Arts Degree in History. He was the first African American Scholar athlete in the Citadel's history. He joined Aetna as a member of the 1973 summer Group School. Upon graduation, he was assigned to the Washington, D.C. field office as a sales executive. In 1980, Norm was named the first African American manager of an Aetna Group office when he was selected to head the Albany N.Y. field office. In 1985, he was named manager of the Garden City Long Island office. Upon closure of the Long Island office in 1988, he was transferred to New York City as a Senior Account Sales Executive. In 1991, he was transferred to Los Angeles where he subsequently assumed the role of Sales Manager in 1994 and District Manager in 1996. In 2001, he accepted a transfer to Seattle as Middle Market Head of Sales. In 2004 Norm was promoted to Vice President, Market Head of Sales and Service. In 2010 he was named President of the Northwest Market with responsibility for Sales, Service and Network Development for Washington, Oregon, Alaska and Idaho.

Years in current position: 3 years

Level and scope of decision making authority: Has decision making authority for the Pacific Northwest Market

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Account Management Team

Leadership

Name: Matt McCormick

Title: Regional Vice President Client Development

Location: Walnut Creek, CA

Years of industry experience: 28 years

Years with Aetna: 28 years

Level of educational attainment: Bachelor of Arts

Resume: Matt is responsible for Aetna's Public Sector and Labor clients in the West Region, and the Account Management and Service Teams for these clients. Matt is in his 29th year of service with Aetna. His career began as a part-time mail clerk in the San Antonio service center. As a high school co-op student, he became a claims processor, and continued this work on a part-time basis while attending college. In 1987, he joined Aetna full-time in the Pathways employee development program, performing 18-month rotations in COBRA Direct Billing, IRC Section 89 Consulting and Custom Report Development & Analysis. Matt was selected for Aetna's Group School sales program in 1992. During his tenure, he has held additional positions of increasing responsibility in benefit plan administration, Customer Implementation Management Services, account management, sales, sales & service management. Matt received his B.A. degree in psychology from Creighton University.

Years in current position: 3 years

Level and scope of decision making authority: As a member of the West Region Leadership team, Matt has responsibility for the services and associated costs Aetna provides to the State.

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Account Management Team

Leadership

Name: Beth Andersen

Title: President West Region

Location: Walnut Creek, CA

Years of industry experience: 27 years

Years with Aetna: 27 years

Level of educational attainment: Master's Degree

Resume: Beth Andersen is President of Aetna's West Region and is responsible for the management of a $4 billion regional P&L across multiple product lines and business segments in the eleven region states, including provider network, sales and distribution. Prior to taking this role in January 2010, Ms. Andersen was the President of the Small and Middle Market business segments for the West Region and served in this role since 2001. Her experience in health care spans over twenty seven years of service with Aetna in various management positions in Sales, Customer operations and Underwriting. Beth also worked as a benefit analyst for the Office of the President of the University of California. In addition to Ms. Andersen's roles at Aetna, she currently serves on the Board of Directors for California Association of Health Plans and on the Advisory Board for Mobiquity, Inc. Ms. Andersen has a BA in Economics and an MBA from University of California Berkeley.

Years in current position: 3 years

Level and scope of decision making authority: As the Executive Sponsor, has full decision making authority for the market and resources for the State of Alaska.

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Account Management Team

Leadership

Name: Tom Finn

Title: Public and Labor Market Head, West Region

Location: Orange County, CA

Years of industry experience: 10 years

Years with Aetna: New to Aetna January 2013

Level of educational attainment: Bachelor of Science in Business Administration, Minor in Political Science

Resume: Tom brings tremendous energy to our Public and Labor segment. As the Market Head for the West Region he is responsible for all customer interaction including onboarding of customers to ongoing plan sponsor and member needs. Tom recently joined Aetna, but has already begun to make a positive impact for customers and members reaching out to customers and making service improvements. He is known for always being readily available and leads with the customers best interest at heart. Tom earned his Bachelor of Science in Business Administration and Minor in Political Science from the University of Arizona.

Years in current position: New to Aetna January 2013

Level and scope of decision making authority: Tom has the ultimate decision making authority on all pricing and renewal discussions for the State of Alaska.

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Account Management Team

Service

Name: Linda Machado

Title: Customer Service Director – National Accounts and Public & Labor Call Operations

Location: Fresno, CA

Years of industry experience: Over 20 years

Years with Aetna: 11 years

Level of educational attainment: Bachelors in Business Administration

Resume: Linda currently leads the National Accounts and Public & Labor Call Operations for the Aetna Customer Service Center in Fresno, California. Linda joined Aetna in March 2001 as service center director for National Accounts, and Key & Select Accounts operations. Prior to joining Aetna, Linda held the position of Customer Service Director for PacifiCare's Western Region Operations, responsible service center operations in Northern and Southern California. As company acquisitions and consolidations occurred in the health care industry in the past twenty years, she has successfully driven change management, facilitating transitions of process and function, while directing ongoing operations. Key leadership responsibilities have included leading and motivating staff to be responsive to performance expectations in rapidly changing work environments while maintaining customer focus and satisfaction. Linda's background includes management of customer service, claims, enrollment and billing, and provider capitation management, and oversight of multiple service center sites and is experienced in all product lines. While at PacifiCare, she earned top honors for leadership with the President's Circle Award and within Aetna was the recipient of the National Accounts Customer Operations Spirit Award for Innovation and Creative Thinking.

Years in current position: 11 years

Level and scope of decision making authority: Has decision making authority for the member services team in our Fresno Service Center, including the My AlaskaCare Single Point of Contact team.

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Account Management Team

Plan Management

Name: Lynda Gable

Title: Account Team Lead

Location: Seattle, WA

Years of industry experience: 32 years

Years with Aetna: 32 years

Level of educational attainment: High School diploma

Resume: Lynda joined Aetna's Seattle Marketing Department in May of 1980, and has provided service to Northwest customers for 32 years. In 1989, Lynda was promoted to the position of Service Representative after serving nine years as a Senior Administrative Assistant and Marketing Support Assistant. She was again promoted in 1991 and 1995, and was an Account Consultant until late 1997. She then joined the national account management team in Seattle as an Account Executive. Most recently in 2010, she became part of the team that is focused and dedicated to public sector and labor customers. During her 32 year career, Lynda has worked with a broad array of benefits, and developed strong expertise in other areas of account administration.

Years in current position: 15 years

Level and scope of decision making authority: Lynda is the account owner and would have responsibility for the State's account.

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Account Management Team

Plan Management

Name: Catie Lynch

Title: Account Manager

Location: Seattle, WA

Years of industry experience: 5 years

Years with Aetna: 5 years

Level of educational attainment: Bachelor of Arts

Resume: Catie Lynch serves as an Account Manager within Aetna's Public and Labor segment in Seattle, WA. Catie has significant Aetna work experience with other current and former Aetna public sector entities such as the City of Seattle, City of Santa Monica, State of Alaska and State of Washington. She has been recognized by her customers as a top performer in her annual customer survey, and currently works on 5 accounts within the labor and public sector. Catie joined the Aetna team in June of 2007 serving as a Marketing Coordinator, after working a collective 2 years within the arena of Radio and Children's Theatre. She is a 2004 graduate of the College of the Holy Cross in Worcester, MA with a BA in Theatre Arts and a concentration in Peace and Conflict Studies.

Years in current position: 2 ½ years

Level and scope of decision making authority: Catie has day to day deliverable decision making authority for the State of Alaska.

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Account Management Team

Plan Management

Name: Allison Johnson

Title: Sr. Clinical Business Consultant

Location: Sacramento, CA

Years of industry experience: 30 years

Years with Aetna: 4 years

Level of educational attainment: Bachelor's of Arts in Nursing

Resume: Allison Johnson is an RN and has been a Clinical Consultant in National Accounts' West Region reporting into the Clinical Consulting, Strategy, and Analysis Department since she joined Aetna in April 2009. Allison was promoted to Sr. Clinical Business Consultant November 2012 with an emphasis on National Accounts' reporting. Prior to joining Aetna, Allison worked in Employee Benefits for 10 years, two years at a local insurance brokerage firm in the San Francisco area and 8 years at SHPS's serving as Director of Client Consulting for national, self-funded clients. Prior to that, Allison held Care Management and Utilization Review leadership positions for a six year period at King County Medical Blue Shield in Seattle, WA (now Regence Blue Shield) and at United Healthcare in Golden Valley, MN. Allison's career started in clinical nursing first at Scott and White Hospital in Temple, TX followed by a move to Hennepin County Medical Center (HCMC) in Minneapolis, MN. She held multiple nursing positions at HCMC over a 9 year period including her final position as Unit Supervisor of a 21 bed End Stage Renal Disease unit managing a team of 60 delivering inpatient care and dialysis therapies to stable and critically ill patients.

Years in current position: Two months in senior role

Level and scope of decision making authority: Allison works in a support capacity to the client Account Team.

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Account Management Team

Plan Management

Name: Dr. Lydia Bartholomew MD MHA FAAFP FACPE

Title: Senior Medical Director

Location: Seattle, WA

Years of industry experience: 7 years

Years with Aetna: 18 months

Level of educational attainment: MD – MHA – FACPE (fellow of the American College of Physician Executives, which requires a CPE – certified physician executive credential)

Resume: Dr. Bartholomew is a physician executive with significant experience in clinic leadership and quality improvement. Before joining Aetna in 2011 as the Senior Medical Director for Care Management in the Pacific Northwest, Lydia was a consultant for the Washington Academy of Family Physicians, and the Medical and Administrative Director for Evergreen Medical Group in Washington. She has also served as the Senior Medical Director for Qualis Health from 2004-2007. Dr. Bartholomew serves on several hospital committees for Evergreen Medical Center and Valley Medical Center, and was recently named a member of the Commission on Quality and Practice for the American Academy of Family Physicians. She is also currently the Secretary/Treasurer for the Washington Academy of Family Physicians. Her professional memberships include the American Academy of Family Physicians, Washington State Medical Association, and American College of Physician Executives. She has current medical staff privileges at the University of Washington Academic Medical Center, Harborview Medical Center, and Evergreen Hospital. Dr. Bartholomew earned her Executive Masters in Health Administration from the University of Washington, completed her residency at the University of Colorado, and earned her Doctor of Medicine from the University of California.

Years in current position: 18 months

Level and scope of decision making authority: Responsible for medical management for the Pacific Northwest, including Alaska, Washington, Idaho and Oregon

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Account Management Team

Plan Management

Name: Karri Priddy

Title: Plan Sponsor Liaison

Location: Fresno, CA

Years of industry experience: 13 years

Years with Aetna: 13 years

Level of educational attainment: High school

Resume: Karri began her career with Aetna in December 1999 as a Customer Service Professional. In 2002, she participated in training for claim processing and utilized the skills obtained to analyze adjudication processes. In 2003 Karri was selected for the role of Single Point of Contact for a large National Account customer, in which she worked on a one-on-one basis with both the Plan Sponsor and account management team. Karri's expertise, leadership and team work skills allowed her to be well-positioned to move into the role of Plan Sponsor Liaison in 2005. In 2012, Karri was selected to join the Government Services organization, focused exclusively on Public Sector and Labor customers and their unique needs.

Years in current position: 8 years

Level and scope of decision making authority: Has member issue decision making authority.

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Account Management Team

Alaska advisory and support team

Name: Jennifer Lind

Title: Client Relationship Manager, Meritain Health

Location: Anchorage, AK

Years of industry experience: 12 years

Years with Aetna: 9 years

Level of educational attainment: Bachelor of Arts

Resume: Jennifer worked three years in a multi-provider clinic billing and coding various insurance providers including predeterminations and pre-certifications. Secured and managed network contracts between various insurance companies including Medicaid and Tricare. She was hired in 2004 at RBMS, LLC an Alaskan owned TPA as Supervisor of Group Administration. I was responsible for overseeing the operations of the COBRA/Eligibility Department, Reinsurance filing/submissions , Client Accounting and Ancillary Providers (Utilization Review, Prescription Benefit Managers and Life/LTD/STD). Jennifer was in this position for 5 years at which time RBMS, LLC was purchased by Meritain Health in 2009. She was then was hired under Meritain Health as a Client Relationship Coordinator. Jennifer currently oversees benefits for 11 Rural Alaskan School Districts, 4 Tribal Corporations including I.H.S facilities and 30 other Alaskan businesses spread from Barrow to Ketchikan. Jennifer earned a B.A. in Business Management from the University of Alaska Anchorage.

Years in current position: 3 years

Level and scope of decision making authority: Is serving in an advisory and support role only for the State of Alaska.

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Account Management Team

Alaska advisory and support team

Name: Shelley Nordlinger

Title: Account Manager for Alaska Groups

Location: Alaska

Years of industry experience: 25 years

Years with Aetna: 16 years

Resume: Shelley has been in the medical arena for over 30 years. She started as a scrub tech in an operating room and proceeded from there to venture into Medical administration for multiple physicians/surgeons. Shelley then relocated from Arizona to Alaska and was fortunate enough to work again in the medical community. Her first 13 years with Aetna was in Operations. She oversaw an office dedicated to assist customers under the State of Alaska. Several years ago, Shelley became an account manager located in Anchorage. She currently interacts with brokers and customers as well as hundreds of employees, to insure our customers receive the high standards of service Aetna is committed to provide for a long relationship.

Years in current position: 2 ½ years

Level and scope of decision making authority: Is serving in an advisory and support role only for the State of Alaska.

Account Management Team

Alaska advisory and support team

Name: Lori O'Banion

Title: Network Manager Alaska

Location: Anchorage, AK

Years of industry experience: 28 years

Years with Aetna: 21 years

Level of educational attainment: College and professional courses

Resume: Lori began working for Aetna in 1984 in the Operations department. In 1995 she transitioned into a network management position, with focus on Aetna's Tennessee, Kentucky, and Georgia networks. In 2001 Lori transferred to Aetna's Anchorage office and began her focus on our Alaska networks.

Years in current position: 8 years

Level and scope of decision making authority: Responsible for the Aetna Health provider network and contracting in Alaska. Will serve in an advisory and support role for the State of Alaska.

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Account Management Team

Alaska advisory and support team

Name: Dana Lewis

Title: RN, Supervisor Care Management Team

Location: Homer, AK

Years of industry experience: 24 years as an RN, 16 years in Utilization Management and Case Management

Years with Aetna: 9 years

Level of educational attainment: Registered Nurse

Resume: Dana has worked for Aetna for nine years in our clinical department. For the past eight months Dana has been the supervisor for our Care Management team. Prior to joining Aetna, Dana was a registered nurse for 15 years.

Years in current position: 8 months

Level and scope of decision making authority: Supervisor for Care Management team. Will serve in an advisory and support role only for the State of Alaska.

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Account Management Team

Health care transformation advisory team

Name: Dr. Andrew Oliveira

Title: Senior Medical Director, National Accounts

Location: Seattle, WA

Years of industry experience: 8 years

Years with Aetna: 8 years

Level of educational attainment: MD, MHA

Resume: Prior to being named Aetna's Senior Medical Director for the West Region for National Accounts in 2011, Dr. Oliveira served as Aetna's Senior Medical Director for the Northwest Market from 2005 to 2011. In this role, he was responsible for the Alaska, Idaho, Washington and Oregon medical management programs including case management, pre-certification and quality measurement. Contributed to managing high performance networks, measuring physician performance and pay for performance programs. In his current position he is responsible for customer interfacing for clinical consulting, strategy and analysis for large customers across the Western US markets. The position is external facing and includes strategic positioning for new business opportunities. Core components include clinical presentations, data analysis and providing recommendations to our plan sponsors to optimize there member health and wellness. Close relationships with our internal sales and support teams and external consultants. Prior to joining Aetna, Dr. Oliveira worked for the Valley Medical Center in Renton, WA as the chair of the Professional Performance Committee and as the Residency Program Director. Dr. Oliveira earned his Medical Doctorate from the University of California and a Masters in Health Care Administration from the University of Washington. He is also certified by the American Board of Family Medicine. He is a member of several professional organizations including the American Academy of Family Physicians, the Oregon Medical Association, Washington State Medical Association and Washington Academy of Family Physicians.

Years in current position: 1 ½ years

Level and scope of decision making authority: Clinical strategy and analysis, with decision making authority on clinical programs.

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Account Management Team

Health care transformation advisory team

Name: Maureen Hydok

Title: Wellness Strategy, ActiveHealth Management

Location: Park City, Utah

Years of industry experience: 25 years

Years with Aetna/ActiveHealth: 5 years

Level of educational attainment: RN, BSW and an MBA

Resume: Maureen Hydok has over 25 years in the healthcare industry where she has worked in leadership positions in the health plan and provider space. Maureen joined ActiveHealth Management in 2008 and is currently servicing a large state account. Additionally, Maureen has lead clinical teams in developing new technology and business processes to improve quality, performance and control costs. Maureen earned her nursing and social work degrees at the University of Vermont and her master's in business with a focus in healthcare management from the University of Phoenix.

Years in current position: 5 years

Level and scope of decision making authority: Has decision-making authority for health care management services within the scope of the State of Alaska’s contract.

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Account Management Team

Health care transformation advisory team

Name: John Wagner

Title: Network Market Head, Northwest Markets

Location: Portland, OR

Years of industry experience: 18 years

Years with Aetna: 1 year

Level of educational attainment: MBA

Resume: John Wagner is the Network Market Head for Aetna's Northwest markets. He has ultimate responsibility for all provider contracting in Alaska, Washington, Oregon, and Idaho. Prior to joining Aetna in 2012, John was Vice President of Payer Strategy and Contracting for Providence Health and Services in Renton, WA beginning in 2010. From 2004 – 2010, John was Vice President of Network Strategy and Provider Operations for The Regence Group in Portland, OR. He has also served as an Assistant Vice President of Risk Sharing of Regence BlueShield and RegenceCare, Seattle, Washington and Director of Network Management for PacifiCare of Texas. John has a Masters in Business Administration from the University of Portland, Oregon, and a Bachelor's of Science degree in Accounting from Oregon State University.

Years in current position: 1 year

Level and scope of decision making authority: Responsible for all provider contracting decisions in AK, WA, OR, ID. He will own all provider solutions for the State of Alaska.

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Account Management Team

Health care transformation advisory team

Name: Daniel Brostek

Title: Head of Member and Consumer Engagement

Location: Hartford, CT

Years of industry experience: 12 Years (in May 2012)

Years with Aetna: 12 Years (in May 2012)

Level of educational attainment: BS Systems Engineering, West Point

Resume: Dan joined Aetna in 2001 as a procurement senior manager. Dan has been the Head of Member and Consumer Engagement for Aetna since 2010. In this role he is responsible for Aetna's enterprise social media, community, mobile solutions and gaming strategies. Prior to this position Dan was the Head of Product Strategy for Aetna, where he was responsible for the product and program management of Aetna's suite of integrated Health and Productivity solutions. Prior to joining Aetna, Dan was a Captain of Field Artillery for the United States Army from June 1996 to May 2001. He earned a Bachelors of Science in Systems Engineering from the United States Military Academy at West Point.

Years in current position: 3 years

Level and scope of decision making authority: Leads Aetna's strategy for mobile solutions and social media across the enterprise.

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- Daniel Brostek
  Technology Strategy and Solutions

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“State of Alaska Concierge Incentive” has been REDACTED

State of Alaska EAP Program Description RFP# 2013-0200-1396




Jody Dean, PhD
Vice President, Sales, National Accounts
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Aetna's Brand Promise
At Aetna, we work every day to ensure the power of health is in your hands. We strive to see the world from your perspective and provide convenient tools and resources that fit your life. We give you the support you need, when you need it, to make confident choices and live a healthier life.

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Why Aetna Resources For Living?

Aetna Behavioral Health (Aetna) is pleased to offer a comprehensive and innovative program that others simply cannot provide with the staff, systems and clinical expertise we offer. We believe that a successful EAP is, first and foremost, the result of a vendor's ability to provide:

- A comprehensive continuum of care that works for your members
- **A fully-integrated EAP** that will provide access to timely and personalized services
- **Customized** services and ancillary products to meet member needs
- **24/7 access** to clinically-focused EAP and worklife services
- An **integrated approach** to physical, behavioral health management and EAP services
- **Industry leading website technology** and utilization reporting capability
- A single point of contact and client-focused account executive
- Crisis Response Specialists ready to assist the State of Alaska, its employees and supervisors
- A **partnership** where we understand the State's culture and anticipate your strategic vision and future direction

Custom Vision for State of Alaska

Aetna's ability to customize our services to meet the State's current and future needs is unmatched.

Our vision for the State of Alaska's EAP program is based on our unique understanding of government programs and needs. We provide EAP services to more than 120 state, county and municipal agencies with over 328,000 covered employees.

We coordinate care in many of those programs to raise the visibility of the EAP by connecting it with already recognizable and well communicated program elements such as ActiveHealth without creating another level or vendor in the employee benefits matrix. We are uniquely positioned to support an onsite EAP provider to serve at key State health service locations should the State choose this option. [1] The on-site EAP provider, trained by Aetna and ActiveHealth Management, will cross promote programs and medical plan resources, provide in-person counseling sessions and assist with coordination of training and other services.

[1] On-site providers are subject to availability.

Summary of Key Elements of Proposal

You will find our proposal unique and compelling in many respects. The following are among the important highlights of our proposed program for State of Alaska:

- A team of Management Consultants available telephonically 24 hours a day to assist with Crisis Response, Substance Abuse and Management Referrals
- On-site **Crisis Response Service Services**
- Onsite or web-based training
- **Performance guarantees** offering up to **20 percent of our fees at risk**
- A **three-year rate guarantee** to the State of Alaska to demonstrate our focus on partnering with you to achieve long term goals
- A **designated account executive**
- The option of an onsite EAP provider for State employees who will provide:
    - Onsite short-term counseling
    - Lunch & Learn trainings
    - Management consultation
    - Onsite promotion at trainings and health services events
    - Assistance with making arrangements with our service center for continued counseling
- Our unparalleled **ability to identify members** through medical, pharmacy and other data sources, proactively engage those at risk, and facilitate the full integration of services[2]
- Standard and customized promotional and educational materials

[2] Information and application will vary based on the benefits package purchased by the State.

Numbers Count – 2012 Outcomes

RFL tracks service outcomes using the SIGNAL[3] System, which measures an individual's level of distress and, when repeated, can be used to measure improvement. Sixty percent of the members who spoke with a RFL clinician reported being in moderate to severe distress upon initial assessment.

Among callers who have multiple clinical contacts with RFL, **81% report improvement** in overall well-being. Thirty-eight percent said that improvement would likely continue without further clinical support.

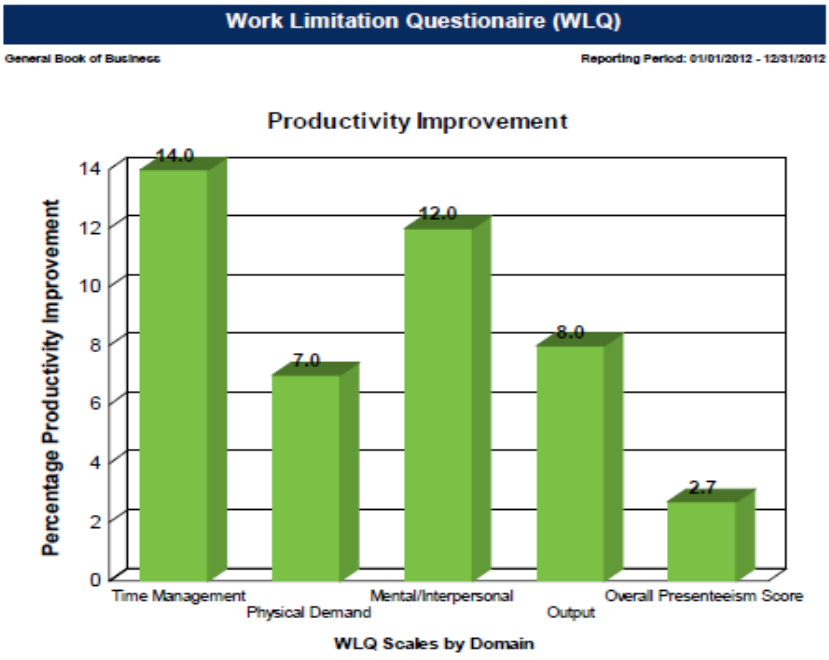
Those associates or family members who called RFL for help in severe or moderate distress achieved a **14% of overall improvement** in emotional wellbeing.

Members involved in ongoing counseling sessions with one of our staff receive an additional Signal measure that tracks the member's engagement with the counselor, the Work Limitations Questionnaire (WLQ).

Work Limitations Questionnaire 2012

WLQ is a tool designed to measure the impact and related costs associated with presenteeism. This eight-item questionnaire measures the level of on-the-job ability/disability, distress and resulting presenteeism. When repeated, it measures improvement.

We use the WLQ with members in distress to measure the impact of that distress on their productivity in the workplace. By taking two measurements, the second 45 days after the first session, we can measure improvements in productivity as a result of interventions offered by our staff.



[3] Statistical Indicators of Growth, Navigation, Alignment and Learning System

Results

For those members who reported emotional distress and had multiple contacts with RFL, the following results were reported:

- 2.7% overall productivity increase for EAP members
  - 14% reported improvement in time management
  - 7% reported improvement in physical demand
  - 12% reported improvement in mental/interpersonal wellbeing
  - 9% reported improvement in output
- Resulting in an average productivity savings of **$875 per member**

On-site Services

While no one can prepare fully for the damage and mayhem created by a storm like Sandy, the first step was to work with those who deliver when things are at their worst.

"It involves an enormous effort," said Management Consultant Michael Nash. Our Management Consultants (MCs) are full-time licensed clinicians dedicated to crisis response, substance abuse and management issues. "When you are there working with your customer, you understand." Michael and other Management Consultants were working in New York, New Jersey and Long Island before power returned.

MC Specialist Benita Rabinovich leads the Crisis Response team. Benita is Critical Incident Stress Debriefing certified and a Licensed Professional Counselor (LPC).

While some companies were in the early stages of planning for behavioral health counseling sessions in New York and New Jersey, others were already scheduling sessions. MCs routinely met with HR and administrative staff to review EAP benefits, consult on risk management advice related to EAP and recommend additional local, state and federal organization/agency resources. Our worklife and marketing team assisted by vetting those resources on an ongoing basis with local, county, state and federal authorities. Materials were then sent electronically to those who distributed them in hard copy and other formats (please see **Hurricane Sandy Communications**).

> *"Often, with Critical Incidents, we are the first point of psychological first aid. We will come up with a plan and it is very calming to go from a state of crisis to feeling like you have a link to help and will be taken care of."*
>
> *Critical Incident Specialist Benita Rabinovich*

When it snowed in Brooklyn in November following a hurricane, an EAP that cared was a valuable commodity.

Comprehensive Benefit Platform

Training, communication and services will flow through a continuum of care designed to enhance the full benefit platform. We are positioned to support on-site services in Fairbanks, Juneau and Anchorage should you choose this additional cost option. The on-site EAP provider[4], trained by Aetna and Active Health, will cross promote ActiveHealth programs. Twenty (20) hours per week are proposed at your choice of sites.

[4] On-site providers are subject to availability.

Coordinating EAP and Behavioral Health services will be Account Executive Shelly Duhamell. She will direct EAP and Behavioral Health services during implementation, ongoing promotion and customer service activities, strategic planning and reporting. She will work in coordination with your on-site licensed Master's-level clinician(s) to promote the full range of Aetna services and resources available to State employees and dependents, bridging resources to complete the continuum of care. This will increase the effectiveness of on-site consultation, management referrals, crisis services and training along with ActiveHealth, health fairs and other wellness resources.

We bring more than a quarter century of clinical experience, our growing provider network and superior account management support to your chosen sites.

Around the Clock Support

From the first call, a member is connected to the resources needed for their individual need. Our members can engage immediately in confidential telephone consultation and referral for emotional, family, personal, work or any issues limiting the member's personal and professional effectiveness. Licensed Master's-level clinicians are available 24 hours per day, 365 days a year should a face-to-face referral be appropriate or preferred by the member. If a member requests a clinical consultation, or it is determined that there is risk, we refer the member to a clinician who provides immediate support, additional assessment and any needed referrals. If a risk is identified, we take steps to ensure that the member is safe and provide appropriate follow-up and referrals.

The initial assessment includes basic demographics, assessment of presenting request/issue, assessment of imminent risk and referrals. If we identify the need for further intervention, requiring face-to-face counseling service, the clinician will arrange referrals to an affiliate EAP network provider.

Face-To-Face Counseling

For those situations when face-to-face counseling is appropriate, Aetna Resources For Living provides access to face-to-face counseling with a Master's-level clinician. All network providers are licensed and credentialed at the highest industry standards and are monitored regularly to maintain that credentialing. After an initial assessment, the EAP specialist determines whether the issue can be resolved within the scope of EAP services or if a behavioral health benefit referral is clinically indicated. Should face-to-face services be deemed appropriate, a local provider is identified to meet the specific need and any other specifications, such as location, gender or language.

Our EAP network includes providers with specific expertise in home and work-related issues. We offer the member a choice of several providers. If requested, the EAP clinician will schedule the appointment on behalf of the member.

Account Management

Shelly Duhamell is a senior account executive for Aetna Behavioral Health. Using her more than eight years of account management experience in managing behavioral healthcare and EAP, she is responsible for overseeing Employee Assistance Program and Managed Behavioral Health services for Aetna plan sponsors. She works with large national commercial accounts, health plans, and Employee Assistance Programs, both integrated and standalone.

Additional responsibilities include implementation of new programs, interfacing and consulting with other benefits and Human Resources representatives, analysis of utilization reports and trends, program promotional plans, needs assessment analysis, product enhancement, and renewals.

In addition to her account management expertise, Shelly has a strong background in relationship development, consultation, and collaboration from previous employment as a National Sales Consultant for Mayo Clinic. She also has extensive experience in employee benefit operations as a result of over eleven years as an Employee Benefit Manager for a large school district in Arizona. In both roles, Shelly was responsible for the supervision of employees.

Shelly's degrees include a Master of Business Administration, Bachelor of Science in Business Management, and an Associate of Applied Science in Accounting. She also holds an Arizona Insurance License. She has completed courses in school accounting, budget and finance, COBRA, FMLA, workers compensation, marketing, and sales.

EAP Provider Network

Aetna EAP has demonstrated the ability to grow our network where our members live and work. We currently contract with 108,000 behavioral health providers and 46,000 EAP providers throughout the United States. These providers were recruited, selected, and credentialed based on their ability to offer quality services to our employees and their ability to provide the specialized services that are required by some of our unique members. In addition to being able to address basic home and work-related issues, our providers have experience in crisis and emergency situations, workplace issues, adolescent and elder care services, dysfunctional families, and health and wellness issues, including eating disorders and substance abuse. All network providers are required to be able to provide individual therapy sessions and those with cultural competency must demonstrate their ability to address specific cultural and language issues.

Though we lead many other EAP providers in the number of providers in our network, we realize that there are numerous clinicians throughout the country who can offer a variety of EAP and behavioral health services to our clients and their members. Ideally, we would like to be able to say that we have EVERY competent and appropriately credentialed provider in the nation in our network. As we strive towards that ideal, we work hard to ensure that our clients are well served by the providers we currently have in our network.

At a minimum, all Aetna EAP network providers, with whom members may schedule face-to-face counseling sessions, must have:

- A current, active, valid, unencumbered license to practice independently in a behavioral health field from the state(s) in which services will be provided to Aetna members
- A Master's or Doctoral degree in a behavioral health field, which includes, but is not limited to, psychologists, clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse practitioners/advanced practice nurses/clinical nurse specialists
- 3,000 hours post-license behavioral health work experience
- 3,000 additional hours post-license chemical dependency work experience for substance abuse providers

Crisis Resources and Support

Aetna Resources For Living's Organizational Risk Management Center (ORMC) is a unique service offered to those at the administrative, supervisory and executive level. With the ORMC, your workers and supervisors are never alone. This unique center dedicated to management issues offers your supervisors and managers immediate access to Management Consultants (MCs) — experienced, licensed, Master's-level clinicians who are available to consult on such issues as performance concerns, inappropriate behavior, alcohol or drug violations and emotional instability.

Please see Hurricane Sandy Communications for the range of communication materials we provided during the aftermath of Hurricane Sandy.

Crisis Resources and Support

The ORMC provides expert crisis response services and support. A crisis is any occurrence in which a person or group experiences a trauma — an **unexpected** and **unnatural** event where employees feel overwhelmed by a sense of personal vulnerability and/or lack of control. Examples of crisis situations include natural disasters, serious workplace accidents, a hostage situation or violence in the workplace. Performed properly, Crisis Response Management can prevent personal trauma, reduce disability claims and quickly return an organization to a normal level of functioning.

From our Customers:

When your Human Resources Staff needs help:

"I am so grateful for our partnership. You spoke with (employee) and got her scheduled for an appointment the same day."

When Crisis strikes the workplace:

"You could feel the mood of the entire workforce change for the better after the on-site sessions were over. Those who were apprehensive about attending said later that they got a lot out of it. Your coordinator and counselor were prompt, professional and caring. They worked around our schedule and changed sessions to fit our needs. My hat is off to your group. Many thanks for what you do."

Our Organizational Risk Management Center ultimately provides you with the tools to increase employee productivity, retain and develop top talent and decrease workplace inefficiencies.

Comprehensive Work and Life Services

Seamless Benefits and Technology

Our program is integrated through sophisticated technology, seamless transfer protocols, and stringent network and quality assurance standards that ensure members receive consistent, high quality, integrated support. We deliver on the promise of integration in every facet of our program:

- **Universal Case Records** – We have the ability to seamlessly share case information. We ensure that there is a single case record that offers a 360 degree view of each member (and their family members). This results in smooth call transfers and consistent follow-up procedures for all services provided, and members never have to repeat their information to different consultants.
- **Integrated Marketing Campaign** – Aetna's holistic marketing campaign focuses on life events that touch on multiple benefits and resources. This approach ensures that all *components* of the program are promoted effectively, and that members understand exactly how we can assist them, whether they are facing an emotional crisis or they are simply looking to find affordable child care in their area.
- **Integrated QA Processes** - Our superior case management technology enables us to track the customer experience through every phase of the case. The simple fact is that every single case is important to us.
- **Comprehensive Reporting** - Our reports give an accurate snapshot of the entire program, and we break out the details you need to easily review trends and utilization associated with each component.

- Legal Services
  - 30 minute telephonic or face-to-face attorney consultations for an unlimited number of issues. There is a 25 percent discount with attorney or mediator beyond the initial 30 minutes. Issues include domestic/family, civil, landlord/tenant, criminal, incarceration, DUI, estate planning, immigration, motor vehicle, harassment, discrimination and other work related disputes and other similar issues.
  - Mediation services - access to "do it yourself" legal forms and document preparation in addition to a comprehensive website which provides over 5,000 legal and financial forms and other tools.
- Financial Services
  - 30 minute telephonic financial consultations for an unlimited number of issues. Consultations are provided by staff financial counselors for budgeting, credit, debt, retirement, college funding, buying vs. leasing, mortgages/refinancing, financial planning, and similar issues.

- Tax Assistance - Tax return assistance and consultations are also included in the initial 30-minute session at no cost. If the associate desires to have his or her tax return prepared by a CPA, the CPA's normal hourly rate is discounted by 25 percent for the work.
    - ➢ Identity Theft Consultation services Telephonic Fraud Resolution Consultation is provided by staff Certified Fraud Resolution Specialists for up to 60 minutes per each new issue, with an unlimited number of issues
    - ➢ Assistance with ID theft breaches and assists associates with identity restoration
    - ➢ Emergency Response Kit - sent by e-mail, mail or fax

<u>Online Worklife Services</u>

Our website offers associates and family members online access to a proprietary database of over one million worklife providers, useful and compelling research and information on health and wellness, robust concierge resources, and discounts at a network of national vendors. Using the site, employees and family members can gather information and make important decisions about family, health, leisure time and how to get "the most for their money" — all through one web tool that they can use at their pace and when their schedule permits.

- My Family
    - My Family provides links to dependent care resources to assist individuals with family caregiving responsibilities for family members of all ages.
- My Health
    - The My Health portal for health and wellness content helps people make better health decisions by providing high quality health and lifestyle information when needed.
- My Time
    - My Time provides you with direct, informative recommendations and answers to questions on specific topics in the areas of Household & Home, Dining, Travel, Tourist & City, Entertainment, and Sports & Recreation.
- My Money
    - Everyone wants to make sound purchasing decisions and spend wisely. My Money helps your associates do both. My Money capitalizes on e-commerce to broaden benefit offerings.
- Child Care Resources
    - A searchable network of over a million providers, including: attorneys, babysitters and child care providers, schools and fitness centers. Topics include adoption, child care, health and safety, grandparents, infancy, parenting, school-age children, starting a family, summer care and toddlers and preschoolers.

- College and Education Searches
    - Find out information on financial aid, saving money, preparation tips for parents and students. Learn about the school selection and tips for school-age children.
- Emergency Preparedness
    - Download a Disaster Supply Kit Checklist, and find links to several organizations that can help
- Military Life
    - Deployment
    - Returning home
    - Additional resources
- Pets
    - Information on adopting pets and pet care
- Worklife Library - View a full list of links for all of the My Family topics Worklife notes. Our experienced communications staff of Master's-level, Licensed Clinical Social Workers and Therapists write all Worklife notes.
- Online Concierge
    - Dining
    - Air conditioning and cooling
    - Cleaning services
    - Electrical
    - Flooring
    - Fencing
    - Painting
    - Plumbing
    - Event tickets planning and much, much more
- LifeMart
    - Top-3 online shopping platform
    - 4,000,000+ SKUs
    - 25-40% average off retail savings
    - Wide range of products and services
- Customization of website - Customization is a standard feature of Aetna Resources For Living's EAP/Worklife website, My Life Values[SM]. General areas of customization include:
    - Username/password
    - State of Alaska's name in "Welcome" message
    - Banner: The entire banner space can be customized; at a minimum, we can add your logo and toll-free number
    - Features: Any menu features under the tabs can be suppressed, if desired. Any of the full main tabs can be suppressed, if desired
- Free educational materials on life needs topics
    - Associate Resource Library which includes articles on life needs topics
    - Monthly newsletters
    - Monthly calendar
- Free weekly online webinars

- Variety of topics, from coping methods during our current economic state to healthy living and much more
- Monthly 1-hour webinar and shorter 30 minute webinars throughout the month

<u>Optional Telephonic Master's-level response 24 hours a day with a 24-72 hour turnaround time for:</u>

- Child Care services, including:
  - Licensed/certified centers/family homes
  - Nanny agencies
  - Summer camps
  - Specialty camps (children with special needs)
- Adult Care including:
  - Support groups (smoking cessation, substance abuse related, grief/loss, eating disorder, caregiver related, mental health related)
  - Relocation (schools, libraries, parks/recreation, gyms, hospitals, places of worship, Chamber of Commerce information)
  - Substance abuse treatment (local sliding scale assessment/evaluation and treatment programs)
  - Local mental services (community sliding scale/low cost)
  - Personal development (job search, resume writing, language classes)
  - Services for disabled adults (supportive housing, vocational rehabilitation)
  - Medical services (community clinics for uninsured/underinsured, immunizations)
  - Medicare, Medicaid and Social Security
  - Respite Care
  - Senior Health and Safety
  - Geriatric Care Management
  - Caregiver issues and concerns
  - Home Meal Delivery
  - Hospice Services
  - Transportation
- Basic Needs, including:
  - Rent/mortgage assistance
  - Utility bill assistance
  - Food
  - Emergency shelter/housing
- Autism Spectrum Disorder (ASD) Support
  - Support groups
  - Advocacy resources and assistance with locating supportive services including speech, occupational and physical therapy
  - Child care services
  - Early childhood intervention programs
  - Non-profit programs
  - Health professionals

    - Educational information including local, state and federal agencies
- Funeral and Estate Planning
    - Assist associates with identifying steps to take after losing a loved one
    - Provide information for free or low-cost services where appropriate
    - Provide information on local funeral homes and resources when needed
- Personal Concierge Services, includes referrals for:
    - Home cleaning
    - Lawn and landscape
    - Appliance and electrical
    - Home security
    - Roofing and siding
    - Gyms
    - Yoga classes
    - Restaurants
    - Taxi services
    - Veterinarians

  Our services also enhance travel and entertaining with over 10,000 online recommendations in over 75 destinations worldwide in the categories of:
    - Dining
    - Entertainment
    - Tourist and city
    - Sports and recreation
    - Shopping
    - Travel
- Military Re-entry Support
- Verified College and Education Referrals
- Emergency Preparedness
- Pet adoption and care

<u>Worklife Kits</u>

We include active adult, elder caregiving, pregnancy, new baby, and child safety care kits in our Worklife services benefit.

<u>Follow Up Services</u>

- Worklife staff will follow up with employees or dependents approximately two weeks after the resource information was provided
- All associates and family members who agree to an electronic survey will be emailed three weeks after the initial contact with the worklife team

Pricing

6,670 active employees	PEPM
1–5-Session—Consultation and resource services with up to five face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included with a live Master's-level response.	**$1.94**
1–8-Session—Consultation and resource services with up to eight face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included with a live Master's-level response.	**$2.27**
1-12-Session—Consultation and resource services with up to twelve face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included with a live Master's-level response.	**$3.03**
On-site EAP provider (20 Hours Per Week)—A Master's-level clinician familiar with Aetna and Active Health will cross promote programs and resources, providing in-person counseling sessions, training and program integration.**	**$1.40**
A pool of twenty (20) hours of Crisis Response Services. Customized and designed to meet organizational and individual needs to minimize damage and return people to previous levels of productivity as soon as possible.*	**$0.07**
A pool of twenty (20) hours of on-site or web-based training. *	**$0.06**
36,532 retirees	
1–5-Session—Consultation and resource services with up to five face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included with a live Master's-level response.	**$1.46**
1–8-Session—Consultation and resource services with up to eight face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included with a live Master's-level response.	**$1.78**
1-12-Session—Consultation and resource services with up to twelve face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included with a live Master's-level response.	**$2.33**
A pool of twenty (20) hours of Crisis Response Services. Customized and designed to meet organizational and individual needs to minimize damage and return people to previous levels of productivity as soon as possible.*	**$0.01**
A pool of twenty (20) hours of on-site or web-based training. *	**$0.01**
* Travel costs are $50 per hour within Anchorage, Fairbanks and Juneau or at cost elsewhere within the state. Costs apply per clinician or trainer. Hours apply per clinician or trainer. Additional travel costs may apply where overnight, extended travel or a specialist not otherwise available is required.	
** On-site providers and services are subject to availability. Onsite counselor will be available to Actives population only. On-site counselor only available as an additional option to face-to-face session model.	

Optional benefits	
Telephonic Worklife—Comprehensive telephonic worklife consultation and referral services, specializing in child care, elder care, care for persons with disabilities, convenience services, pet care and those challenges faced by members at home and work. Members receive access to worklife specialists around the clock, seven days a week. The specialist will do the legwork, or a member can search using the web and our proprietary database to find immediate information on child care, home health, assisted living, schools, colleges, health clubs, pet services and more.	**$0.25**
EAP Models Include	
Website— Round-the-clock, self-service website that includes fully integrated EAP and worklife resources so employees have all the information and resources they need at their fingertips.	
Unlimited Legal Consultation—Members receive 30-minute telephonic or face-to-face attorney consultations for an *unlimited* number of issues. There is an additional 25% discount off the attorney or mediator fees beyond the initial 30 minutes. Issues include domestic/family, civil, landlord/tenant, criminal, estate planning, immigration, motor vehicle, and other similar issues. Work related matters are not covered. Also included are telephonic or face-to-face mediation consultations; after-hour telephonic attorney consultations for criminal, incarceration and DUI; HR Mediation Consultations – Available to HR only; Free online will for all eligible members (available in all 50 States, except Louisiana); a 10% discount for do-it-yourself/assisted document preparation for divorce forms, estate planning forms and immigration forms, and other similar issues.	
Unlimited Financial Consultation—Members receive 30-minute telephonic financial consultations for an *unlimited* number of issues. Telephonic financial consultations are provided by staff financial counselors for budgeting, credit, debt, retirement, college funding, buying vs. leasing, mortgages/refinancing, financial planning, and similar issues. Telephonic tax consultations are provided by staff CPA and enrolled agents for tax questions, tax preparation and IRS matters. Telephonic tax levy/garnishment resolution consultation is provided as well.	
ID Theft Consultation—Telephonic fraud resolution consultation is provided by staff Certified Fraud Resolution Specialist for up to 60 minutes per each new issue, with an unlimited number of issues. This includes assistance with ID theft breaches and identity restoration.	
Unlimited Management Referral—Our Organizational Risk Management Center is staffed by licensed clinicians who are specially trained in resolving workplace issues. When an employee's situation mandates a formal management referral, we can help your managers and supervisors through every step of the referral process.	
Unlimited Supervisor Consultation—Our Account Managers, Management Consultants, and training consultants maintain a broad base of knowledge to help formulate and update corporate policies.	

Communication and Promotional Materials—Information provided to Employees and management about EAP Services, including, in part, how EAP Services can be accessed for consultation and assistance. The communications and promotional resources may include template e-mails, letters, flyers, wallet cards, and posters for employees and management. Certain of these materials can be customized by the customer. We will provide reasonable quantities of printed materials in support of implementation and/or on an annual basis at customer's request at no cost. Reasonable quantities are defined as up to 120% of the number of eligible employees for items such as flyers or brochures; a quantity up to 5% of the number of eligible employees for items such as posters; and a quantity of up to 20% of anticipated attendees at health fairs for other promotional items. Requests exceeding these quantities may incur an additional fee.	
Reporting—We provide quarterly utilization reports at no additional fee. With our specialized EAP system, all identified data elements entered into our system are tracked and analyzed. EAP management reports include overall utilization numbers, rates and patterns, percent of conversion into benefits plans, and results from satisfaction surveys. Reports give you a comprehensive overview of your EAP program and its impact.	
A dedicated toll-free line for State of Alaska employees providing exclusive access to resources and services.	
Fee For Service Options	Price
Crisis Response Services—(after 20 hours per benefit year) - Customized and designed to meet organizational and individual needs to minimize damage and return people to previous levels of productivity as soon as possible. Travel: $50.00 per hour of travel to and from the Customer's location. Failure to provide Company with 24 hour notice of cancellation of Workplace Crisis Response Services will result in a charge of $325.00 per incident.	**$325 Per Hour**
RIF Groups are provided for companies that request on-site support due to having to reduce their workforce.	**$325 Per Hour plus travel costs**
Workplace Seminars/Brown Bag Training—(after 20 hours per benefit year) - A full slate of workshops and seminars to meet your organization's training needs. Travel: $50.00 per hour of travel to and from the Customer's location. Cancellation: Failure to provide Company three (3) business days' notice of cancellation of a previously scheduled training program may result in a charge equivalent to the duration of the training and travel at the contracted rate.	**$275 Per Hour**

Substance Abuse Professional (SAP) Services—The EAP shall provide initial and ongoing management consultation and referral for drug and alcohol cases that fall under the Department of Transportation (DOT) guidelines. We will refer the employee to a qualified SAP to conduct initial assessment and provide additional services as required. Services can include treatment recommendations, referral to an education/treatment program, compliance monitoring, SAP re-evaluation, and follow-up testing recommendations once the employee has been cleared to return to work.	**$750 Per Case plus travel costs where they apply**
Awareness Training is available for substance abuse prevention, maintaining a drug-free workplace and other topics promoted through the DOT and other professional organizations. Should Compliance training be required, we will refer you to a licensed provider. ▪ DOT Supervisor Training - 2 hours at $800 plus travel ▪ DOT Employee Training - 1 hour at $400 plus travel	

EAP Pricing Assumptions

- All employees, dependents and immediate household members are eligible for services
- Sessions counted on a per issue basis rather than a per year basis
- Rates are good until case effective date of this proposal.
- 3 Year Rate Guarantee from case effective date
- Rates are dependent on employee population within 20% (+/-) of that quoted
- Fee for Service Rates are per clinician
- Cancellation fees apply to crisis services, training and other on-site benefits per contract terms
- Pooled hours and unlimited benefits apply to an individual clinician or trainer
- Travel costs are $50 per hour within Anchorage, Fairbanks and Juneau or at cost elsewhere within the state. Costs apply per clinician or trainer. On-site providers and services are subject to availability. Hours apply per clinician or trainer. Additional travel costs may apply where overnight, extended travel or a specialist not otherwise available is required.

Implementation Solutions

Open Choice PPO, Dental PPO, Pharmacy
Plan Effective date July 1, 2013

Submitted to
State of Alaska

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Seamless Transitions and Complete Support — Your Aetna Implementation Team's Proactive Approach

We understand that implementing new health benefits packages can present many challenges. That's why we provide you with a whole team of experts to help guide you through a smooth transition.

You will have many questions along the way, including:

- How and when to communicate benefit changes to employees
- Timing of the open enrollment period
- How to facilitate the exchange of key information
- How to ensure a positive interaction between your employees and the plan administrator

We will help you address these questions by combining a team of experts supported by effective project management tools. This approach, developed over 30 years ago and refined annually through our Continuous Quality Initiatives, provides us the opportunity to develop the foundation for a long lasting relationship with you.

Collaboration and Accountability

Our implementation team approach is designed to establish a collaborative environment through the partnership we create with you and your business partners. The team is a blend of Aetna subject matter experts and State of Alaska's representatives. While each member of the implementation team contributes his or her unique talents to ensure a seamless transition, the Implementation Manager has overall accountability to you.

The Aetna team includes an Implementation Manager, your Aetna Account Management Team, representatives responsible for the set up and administration of the products and services you selected, as well as specialized subject matter experts.

We recommend that your own implementation team be comprised of members representing employee benefits, eligibility, finance, human resources and communications. Additional team members may be included to meet your specific needs.

The Implementation Manager will develop an Implementation Management Plan that outlines tasks and target completion dates specific to each team member. The Implementation Manager carefully monitors the progress using this plan along with complementary project management tools. Through regularly scheduled meetings and conference calls, the team provides updates and the status and resolution of issues raised during the transition.

Continuous Commitment

We remain committed in our service to you. Several members of the implementation team will remain actively involved with the ongoing service of your account.

The Implementation Team

The implementation team members work together throughout the duration of the project toward a seamless transition of your benefits program. This team includes the following representatives:

The Customer's Team	State of Alaska's representatives
The Aetna Team	Tim Lieb, Sales Executive, Seattle, WA

Account Manager
- Primary Aetna contact throughout implementation
- Coordinates open enrollment activities
- Provides ongoing account management after the plan effective date

Tami Polsonetti, Sales Support Manager, Hartford, CT
Craig Baker, Strategic Proposal Consultant, Hartford, CT
- Provides initial details of sale, rates, special procedures
- Prepares and documents the Letter of Understanding

Frenso Member Service Center
Thousand Oaks Dental Service Center
- Provides Member Services support
- Processes claims
- Coordinates audits

Laura Ocegueda, Implementation Manager, Walnut Creek, CA
- Directs implementation activities
- Oversees activities of all Aetna areas

Teresita Go, Plan Benefit Set-Up, Walnut Creek, CA
- Reviews benefits plans
- Codes benefits and structure into Aetna systems

Distributes documents to appropriate departments

Sandra Lloyd, Contracts/Agreements, Walnut Creek, CA
- Drafts contracts
- Prepares funding agreements
- Drafts employee Booklets and/or Certificates of Coverage, if applicable

Barri Frank, Eligibility, Walnut Creek, CA
- Maintains member eligibility data
- Coordinates production and ID card mailings

Billing
- Codes billing rates into Aetna systems
- Prepares billing statements

Assumptions

The Key Events and Implementation Management Plan are prepared based upon the information and assumptions provided.

The decision to implement the proposed benefits program will be made by March 29, 2013.

The effective date will be July 1, 2013.

Benefits will be those described in the proposal.

Eligibility certification:

- Aetna will certify eligibility for medical, pharmacy and dental claims.
- State of Alaska will report eligibility via electronic file.

Funding arrangements:

- The Open Choice PPO plan will be on an Administrative Services Agreement and/or insured basis.
- The Dental PPO and Pharmacy plans will be on an Administrative Services Agreement basis.

Billing methods:

- ASA Fee Billing
- List Billing
- Summary Billing
- Self-Billing

Aetna will pay claims incurred on and after the effective date of July 1, 2013.

Prior Carrier will pay claims runoff incurred prior to July 1, 2013.

The **Key Events** highlight the important milestones and dates the team will focus on during the implementation.

The **Implementation Management Plan** (IMP) provides an ongoing status report on the team's progress, and identifies tasks to be completed, the individual(s) responsible, a scheduled start and finish date. It is updated throughout the implementation and distributed to all implementation team members.

The **Gantt Chart** is a high-level timeline of the implementation.

All dates are approximate and will be modified as priorities are determined.


State of Alaska_AllProducts_K *Key Events*


State of Alaska_AllProducts_I *Implementation Management Plan*


State of Alaska_AllProducts_G *Gantt Chart*

Implementation Solutions

Open Choice PPO
Plan Effective date July 1, 2013

Submitted to
State of Alaska

Table of Contents

Seamless Transitions and Complete Support — Your Aetna Implementation Team's Proactive Approach

We understand that implementing new health benefits packages can present many challenges. That's why we provide you with a whole team of experts to help guide you through a smooth transition.

You will have many questions along the way, including:

- How and when to communicate benefit changes to employees
- Timing of the open enrollment period
- How to facilitate the exchange of key information
- How to ensure a positive interaction between your employees and the plan administrator

We will help you address these questions by combining a team of experts supported by effective project management tools. This approach, developed over 30 years ago and refined annually through our Continuous Quality Initiatives, provides us the opportunity to develop the foundation for a long lasting relationship with you.

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State of Alaska_Medical_KEY.p

Key Events


State of Alaska_Medical_IMP.p

Implementation Management Plan


State of Alaska_Medical_GANT

Gantt Chart

THE RAWLINGS COMPANY

Value

Experience

Flexibility

Service

An Overview of Subrogation Recovery Services

Information for Aetna's Self-Funded Plans

aetna

EXECUTIVE SUMMARY

Aetna selected The Rawlings Company to provide comprehensive subrogation and reimbursement services for our health benefit plans, because they are the proven industry leader. The Rawlings Company has the unmatched legal experience, advanced technology, and consistent track record to provide Aetna's clients with the largest possible net recoveries of any subrogation firm. You can be assured that The Rawlings Company will return outstanding financial results for you while providing the highest level of professionalism, integrity, and attentiveness that Aetna expects.

The Most Experienced

The Rawlings Company is the most experienced healthcare subrogation firm in the nation. They were the first company to offer complete national subrogation outsourcing to the health insurance industry, and they developed the identification and recovery techniques that have become standard practice in the market today.

Subrogation Legal Experts

The Rawlings Company is the leader in interpreting and developing subrogation law. They pioneered many of the legal arguments that are used today in subrogation recoveries. Listed here are a few examples that demonstrate the organization's expertise.

- In response to a Pennsylvania statute that barred healthcare subrogation in the state, Rawlings led the suit challenging the statute's application to HMO plans. The Supreme Court of Pennsylvania issued a decision in August 2006 that will have a dramatic positive effect on clients' recoveries for HMOs operating in Pennsylvania.
- Rawlings literally wrote the book on subrogation law. *The Rawlings & Associates National Subrogation Law Manual*, published annually, is the leading compendium of subrogation laws and regulations at both the state and federal level. It is used by health plans and competitors alike.
- Rawlings is actively involved in lobbying federal and state legislatures to press the concerns and rights of their clients.

Most Comprehensive

Rawlings provides the most comprehensive identification and recovery program in the industry. They have worked diligently to define and refine their internal procedures and technology to maximize both effectiveness and efficiency. From their advanced data mining technologies to their ability to match to proprietary databases; from their five-letter approach for gathering claims information to their special investigation units; as an organization, they've been able to refine and perfect the case management process. This persistent dedication to continual process improvement has resulted in a better, more effective identification and recovery process that recovers more dollars for clients.

The following is an overview of Rawlings' identification and recovery process.

Investigating Potential Claims

- Rawlings analyzes data using over 13,000 diagnostic, procedural, and billing codes to identify trauma-related injuries.
- Once a potential subrogation case is identified, Rawlings mails up to five inquiry letters to members, including a questionnaire asking about their treatment.
- Rawlings prints the first and fourth letters on Aetna letterhead to improve the response rate.
- Members can respond in several ways:
  - Toll-free phone lines are answered by experienced analysts
  - A postage-paid reply envelope is enclosed with letters
  - Members can complete the questionnaire online at ww.TRGClaimsInfo.com
- Rawlings also submits claims data to proprietary databases to determine if a property and casualty-related claim or work-related claim has been filed. When a match occurs, special teams immediately begin investigating these cases.

Working Subrogation Cases

- Subrogation analysts are organized by client-specific teams and supported by legal counsel.
- Analysts identify every potential source of recovery and place all parties on notice of your claim.
- Caseloads are managed on Rawlings' proprietary Subrogation Recovery System.
- Analysts negotiate, settle, and recover the largest lien amount possible.

Financial Results

Rawlings has consistently proven the superiority of their services by outperforming every competitor and internal unit after assuming their recovery responsibilities from common clients. Rawlings doesn't just increase your recoveries; they increase your bottom line.

Outstanding Customer Service

Virtually every subrogation recovery firm will claim to offer outstanding customer service. The problem is that many can't back up the claim with proof. Rawlings has compiled a long list of clients who have gone out of their way to articulate their satisfaction with Rawlings' superior customer service. For example, when your members call Rawlings, they don't speak with a call center generalist; they speak with an experienced subrogation analyst.

Expert Advice and Guidance

The Rawlings legal team will review the Summary Plan Description for Aetna's self-funded groups to ensure that it contains the strongest possible recovery language. The individuals who make up these legal teams are also available to answer questions and explain the benefits of a subrogation program.

Reporting

Rawlings offers a reporting Website that gives self-funded groups immediate access to information about their recovery program. Reports are posted by the end of the month following the quarter end. All reports can be viewed, downloaded, or printed. A full package of reports is available that include a description of recoveries, files currently being worked, and files closed without a recovery. Recovery reports from previous quarters are archived to allow users to compare current data with past results.

OVERVIEW OF SUBROGATION SERVICES

Subrogation and reimbursement services are effective ways to control and even reduce healthcare costs without cutting benefits to members.

> **Subrogation** allows a health plan to recover claims paid on behalf of a member that are the responsibility of another party.
>
> **Reimbursement** allows a health plan to recover funds from a member after the member has received compensation for an accident or injury.

Motor vehicle accidents, medical malpractice, and accidents on commercial premises are examples of situations where an at-fault party may be responsible for covering the injured person's medical expenses.

Stages of the Recovery Process

The Rawlings Company has defined and refined their recovery process through the years. This proven process is what allows Rawlings to maximize recoveries and provide the responsive service that self-funded groups expect. The recovery process is divided into three stages:

- Identifying potential subrogation claims
- Managing open files
- Recovering funds and reporting results

Stage 1: Identifying Potential Subrogation Claims

Data Mining/Data Matching – Identifying potential subrogation claims begins with a monthly electronic transfer of paid claims data. Rawlings screens data through a proprietary identification system. The system automatically identifies potential subrogation claims based on a variety of criteria, including over 13,000 diagnostic, procedural, and billing codes covering every category of traumatic injury claims. A subset of claims data is also submitted to proprietary databases to determine if a property and casualty-related claim or work-related claim has been filed.

Accumulating Claims – Rawlings bases decisions about whether to initiate an investigation on the level of accumulated paid claims. They typically begin investigation activities at a threshold of $300. Once they have begun an investigation, they continue to accumulate claims until the investigation is complete.

Inquiry Letters – When a potential subrogation opportunity is identified, the Rawlings system automatically generates inquiry letters. Rawlings mails up to five inquiry letters to members explaining why they are being contacted and requesting specific information about their treatment. This information helps determine the recovery potential. The first and fourth letters are mailed on Aetna letterhead. Through experience, this is an effective way to improve response rates.

If the member does not respond and the investigation meets certain criteria (e.g., significant paid claims), it is forwarded to the special identification teams for resolution.

Response Channels – Rawlings offers members a variety of ways they can respond to inquiry letters. Members can respond by**:**

- Calling a toll-free number answered by experienced recovery analysts
- Mailing back the completed questionnaire in a postage-paid reply envelope
- Visiting the Rawlings secure Web site and completing the questionnaire online

Special Identification Teams – Special teams immediately begin investigating cases that have resulted in a match to a proprietary database search. If a record does not match a claim contained in the proprietary database, it is forwarded to the Non-Cooperation Team. By using a variety of online and offline tools, associates locate and contact members to determine if an accident occurred. Tools include Web-based locator sites, Westlaw (an online docket for state public records, litigation, and court records), and the AT&T Language Line to communicate with members who do not speak English or Spanish.

Stage 2: Managing Open Subrogation Files

The recovery process takes places within complex legal and regulatory environments at both the state and federal levels. While the average life of a file is approximately six to nine months, some files take years to resolve. Rawlings analysts proactively manage open investigations throughout the life of the file.

Determining a Recovery Strategy – Rawlings works diligently to maximize recoveries for each client. They identify the best recovery strategy at the very outset of the investigation, taking every appropriate step to ensure that your recovery interests are protected. The analyst's first task is to gather all necessary information and place all parties on notice of your lien.

Analysts carefully research and weigh many factors when determining the best recovery strategy. Key drivers include the following:

- ***Plan Language*** – The strength of recovery language contained in a client's Summary Plan Description (SPD) is critical to recovery. At your request, the Rawlings legal team will review your SPD to ensure that strong recovery language is included.
- ***State and Federal Law*** – Subrogation law varies widely across all 50 states. For example, some states have strict limits on liability coverage, some limit first-party recoveries, and others prohibit subrogation for fully-insured plans altogether. In addition, various federal circuit courts have interpreted federal law differently, affecting if and how an analyst can handle a file.
- ***Plan Type*** – Different plan types (e.g., insured, self-funded ERISA qualified, Medicare Replacement, federal employee plans, etc.) determine the extent to which Rawlings can pursue recoveries.
- ***Available Funds*** – Sometimes medical claims far exceed settlement funds available.
- ***Litigation Status*** – If a member has filed suit, litigation can prolong the life of a file.

Sources of Recovery – Rawlings pursues the following types of cases and sources of recovery:

- Automobile Accidents – (First-Party and Third-Party Coverage)
  - Liability Coverage
  - "No Fault" Coverage/ Personal Injury Protection (PIP)
  - Uninsured and Underinsured Motorist Coverage
  - Medical Payments Coverage
- Premises Liability (i.e., "slips and falls")
- Homeowners Liability
- Medical Malpractice
- Product Liability (i.e., defective products)
- Workers' Compensation (when permitted)

Handling Large Dollar Claims and Sensitive Cases – Rawlings' analysts are motivated to recover 100% of all liens, because a significant portion of their pay is based on the amount of dollars recovered. When a reduction of lien is necessary to settle a file and it exceeds the analyst's authority, the analyst must obtain settlement authorization from a team manager, team attorney, the Director of Subrogation, or the Director of Workers' Compensation.

In addition, a settlement committee comprised of the Director of Subrogation, the Company's General Counsel, and a team attorney must approve all large dollar files. All recovered files are audited for appropriate settlement authority. In cases involving severe hardship on the member or cases involving litigation, Rawlings may contact the group for settlement considerations.

Litigation Management Strategy – Recognizing that litigation can have both beneficial and detrimental effects on the entire subrogation industry, Rawlings carefully reviews matters where litigation is contemplated or where a suit must be defended. The facts of each individual case, the applicable law, and chances of success are considered. In the event that Rawlings believes it is appropriate to initiate a suit, they will not do so until after the matter is discussed with the client and they receive approval to proceed. Rawlings only uses Aetna-approved counsel.

Compliance with Federal and State Regulations – Rawlings continually monitors federal and state court decisions, pending legislation, and administrative regulations in all states. Attorneys from Rawlings & Associates PLLC provide the primary effort. They annually update and publish *The Rawlings & Associates National Subrogation Law Manual*. This manual summarizes the law relevant to subrogation and reimbursement for each state, as well as federal court decisions and statutes.

Rawlings notifies clients of any new law or court decision that may significantly impact recoveries. Further, their subrogation analysts are immediately informed and trained regarding changes in law that affect the recovery process.

Subrogation Recovery System (SRS) – Analysts and team attorneys manage their files using Rawlings' Subrogation Recovery System (SRS), a powerful application developed in-house. SRS' robust design allows analysts to proactively manage each file and collaborate as needed. The following list highlights the most important features of the SRS application:

- Analysts can track and share information about file activity via the online diary system. Diary notes are either manually entered by the analyst or automatically written by the system when specific actions are taken on the file.
- The automated tickle system allows analysts to plan effective and timely follow-up.
- A library of templates approved by the legal team allow analysts and team attorneys to create over 200 types of correspondence and legal notices in a matter of seconds.
- Analysts can access a library of plan language or automatically request plan language that has not yet been scanned into the library.
- Team attorneys can track files they are managing on behalf of their team members, including those that have been referred to outside counsel.
- Managers can audit their team members' files and file-handling practices in real time.
- Onscreen messages alert analysts to special Aetna- or group-specific file handling issues.

Stage 3: Recovering Funds and Reporting Results

Processing Recoveries – Processing payments swiftly and accurately is a critical part of the overall recovery process. At Rawlings, defined processes ensure that all payments are processed under strict controls to ensure the security of the checks that are received.

Reporting Recoveries – Reporting is an integral part of the recovery process. Reports are provided quarterly and are made available either online, in hardcopy, or in electronic formats. Plans can choose to receive only summary reports. Plans that request the detailed reporting package receive the following:

- Detailed listing of recoveries
- Open file listing as of quarter-end
- Detailed listing of files closed without recovery
- Non-cooperation report providing information about unresponsive members

George Rawlings launched Rawlings & Associates in 1977 to offer legal services to insurance providers. Early on, Mr. Rawlings recognized the need for specialized recovery services. In response to this unmet market demand, he launched what would ultimately become the first subrogation outsourcing program for the healthcare industry.

Given the success of our subrogation business, Mr. Rawlings surveyed the market and realized there was demand for similar types of recovery services focusing on other segments of the health insurance industry. In response, The Rawlings Group was the first to launch outsourcing programs specifically dedicated to medical claims recovery, mass tort litigation, and pharmaceutical claims recovery.

Organizational Growth

As market demand for The Rawlings Group recovery services continued to grow, the organizational focus became more defined. Today, TRG is focused exclusively on health insurance recovery services for our health insurance plan clients. Due in part to this focus and in part to the tenacious commitment to servicing the needs of the clients, they've grown into the largest provider of these services in the industry.

TRG currently employs over 700 people, and processes significantly more claims than any other company in this industry. The Rawlings Group will mine over $300 billion in claims in 2011.

Industry Leadership

In addition to being the largest company in this field, The Rawlings Group is also widely recognized as the industry leader. Consider these examples.

Setting the Standard. The recovery methods and processes that The Rawlings Group has defined and implemented over the years have become standard procedure for the entire industry.

Legal Expertise. The Rawlings Group literally wrote the book on subrogation law. They publish *The Rawlings & Associates National Subrogation Law Manual*. This comprehensive legal compendium is the *only* reference book that compiles and analyzes subrogation related laws in all state and federal jurisdictions. It is the recognized authority for subrogation law, and it is used both by health plan providers as well as by competitive subrogation firms.

Market Innovation. The primary mission is to maximize your recoveries. In order to do this as effectively as possible, The Rawlings Group routinely monitors new legislation and regulations that impact your recovery rights. Where necessary, TRG also lobby's legislators and regulators to improve your recovery rights.

The Rawlings Group offers you the most experienced and most comprehensive healthcare recovery services in the country.

Comprehensive Service Offering

Today, The Rawlings Group offers a comprehensive line of recovery services that include COB audit, subrogation, and pharmacy claims.

SUBROGATION

The Rawlings Group was the first company to offer subrogation outsourcing services to the healthcare industry. Further, TRG pioneered many innovations in subrogation. As a result of these efforts, Rawlings is today the leading subrogation recovery company in the nation. This ranking is based on a number of criteria, including the size of our organization, the volume of claims processed, and the number of major insurance providers served.

MASS TORT LITIGATION

The Rawlings Group pioneered the use of mass tort litigation to represent the interests of health insurers in major product liability cases. We took the lead in the Silicone Gel Breast Implant Products case, the Factor VIII Concentrate Blood Products case, Acromed Bone Screw Litigation, and Synthroid Marketing Litigation. In addition, we represented health insurers in the Fen-Phen litigation. To date, we have negotiated hundreds of millions of dollars in settlements for our health plan clients.

COB

Rawlings is the nation's leading provider of COB recovery services for the healthcare industry. The Rawlings Group has an unbeaten record of recovering more money for health plans than any other vendor. This is an important fact. It proves that TRG staff, processes, and technology are the best in the industry at identifying and recovering COB overpayments.

PHARMACY

The Rawlings Group was not only the first to offer recovery services for pharmacy claims, they've also demonstrated that they are the largest and most effective at identifying and recovering pharmaceutical overpayments. Perhaps most notable, TRG recently introduced an innovative approach to pharmacy overpayment recovery that dramatically increases the percentage of identified overpayments they're able to recover.

Company Organization

What is informally referred to as The Rawlings Group of companies is comprised of three unique organizations. Though separate and distinct, each organization works cooperatively with the others.

THE RAWLINGS COMPANY LLC

The Rawlings Company LLC is focused on data mining and claims recovery services. This includes subrogation, medical claims recovery, and workers' compensation.

RAWLINGS & ASSOCIATES PLLC

Rawlings & Associates PLLC is focused primarily on providing legal advice and support to the other organizations within the Rawlings group of companies. They also focus on legal research and mass tort litigation.

RAWLINGS FINANCIAL SERVICES LLC

Rawlings Financial Services LLC is focused on providing collection services. Specifically, they provide collection services for our Pharmacy claims business. They also operate our Accelerated Recoveries Department (ARD). A department of the COB Audit group, ARD specializes in collecting overpayments from providers.

Please contact your Aetna Account Executive for more information about how subrogation and reimbursement services from The Rawlings Company can help you to minimize expenses and improve your bottom line.

Date

Name
Address
City, AK Zip

Member Name:
Member Number:
Employer Name:

This letter confirms coverage approval for one round-trip airfare for Patient from City, AK to Destination for treatment or consultation to be rendered on or about Date.
Travel does not include the cost of lodging, food or local ground transportation such as airport shuttles, cabs or car rental.

This predetermination does not constitute authorization or a benefit level for the services being received in Destination.

To submit a claim for travel reimbursement, the following information will be required:

- Boarding pass or passenger receipts *(Destination, origination and price paid for the ticket must be present on the documentation)*
- A completed medical benefit request claim form

Fax the information to **1-860-754-0363**

– or mail to –

Aetna Alaska Medical Travel Team
1385 E. Shaw Ave.
Fresno, CA 93710

Note: Travel reimbursement cannot be issued until the medical services claims have been received substantiating the need for the medical travel.

Processing/reimbursement will take between 17-24 days upon receipt of the complete claim.

Should you have any questions regarding this determination, please call the Member Services number on the back of your ID card.

Sincerely,

Aetna Alaska Medical Travel Team

DATE

MEMBER NAME
ADDRESS
CITY, AK ZIP CODE

Member Name:
Member Number: Employer Name: State of Alaska

This letter confirms Aetna's coverage denial for one round-trip airfare for PATIENT from CITY, AK for treatment or consultation to be rendered on or about DATE.

INSERT REASON FOR DENIAL OF TRAVEL

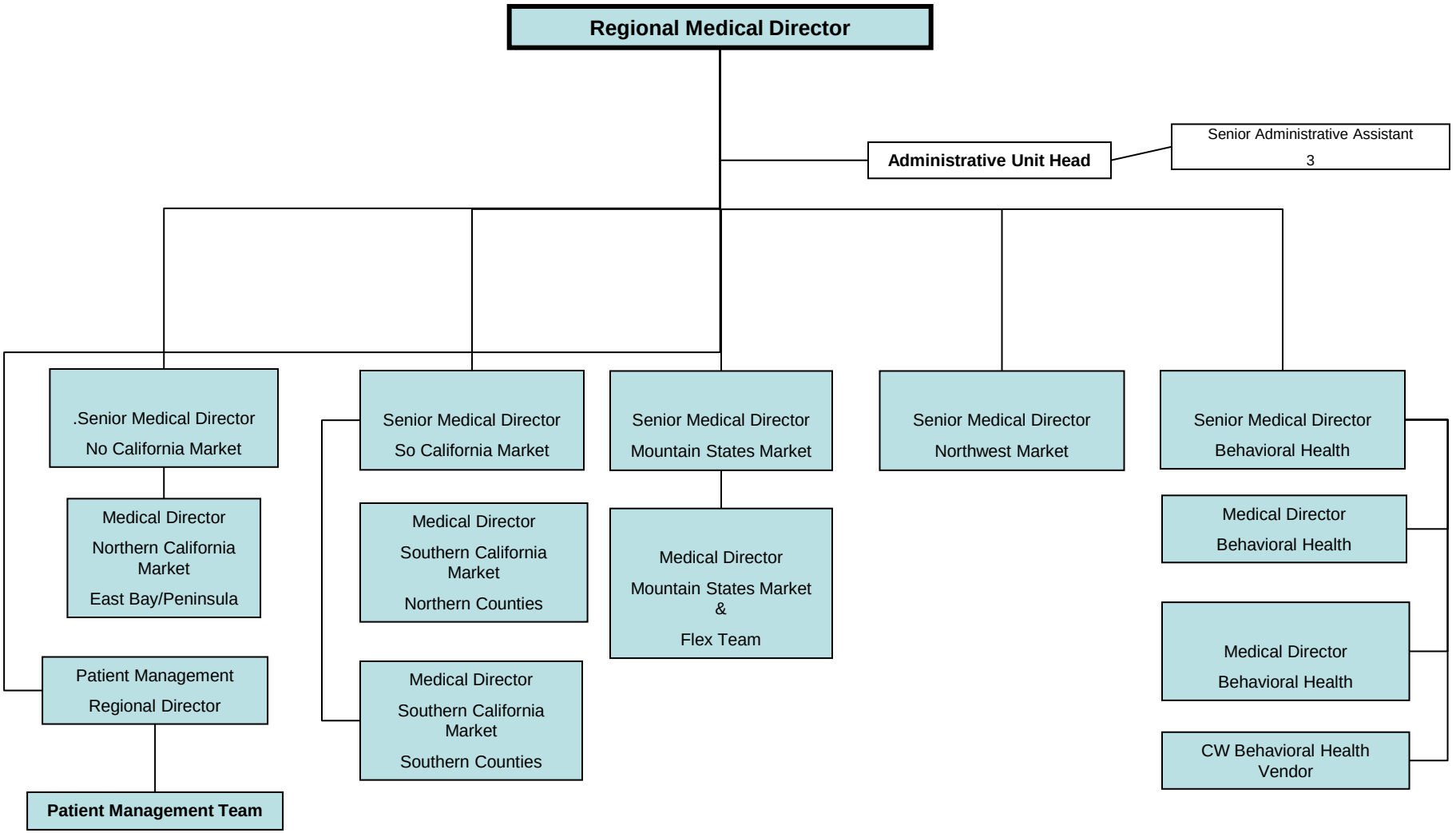
Should you have any questions regarding this determination, please call the Member Services number on the back of your ID card.

Sincerely,

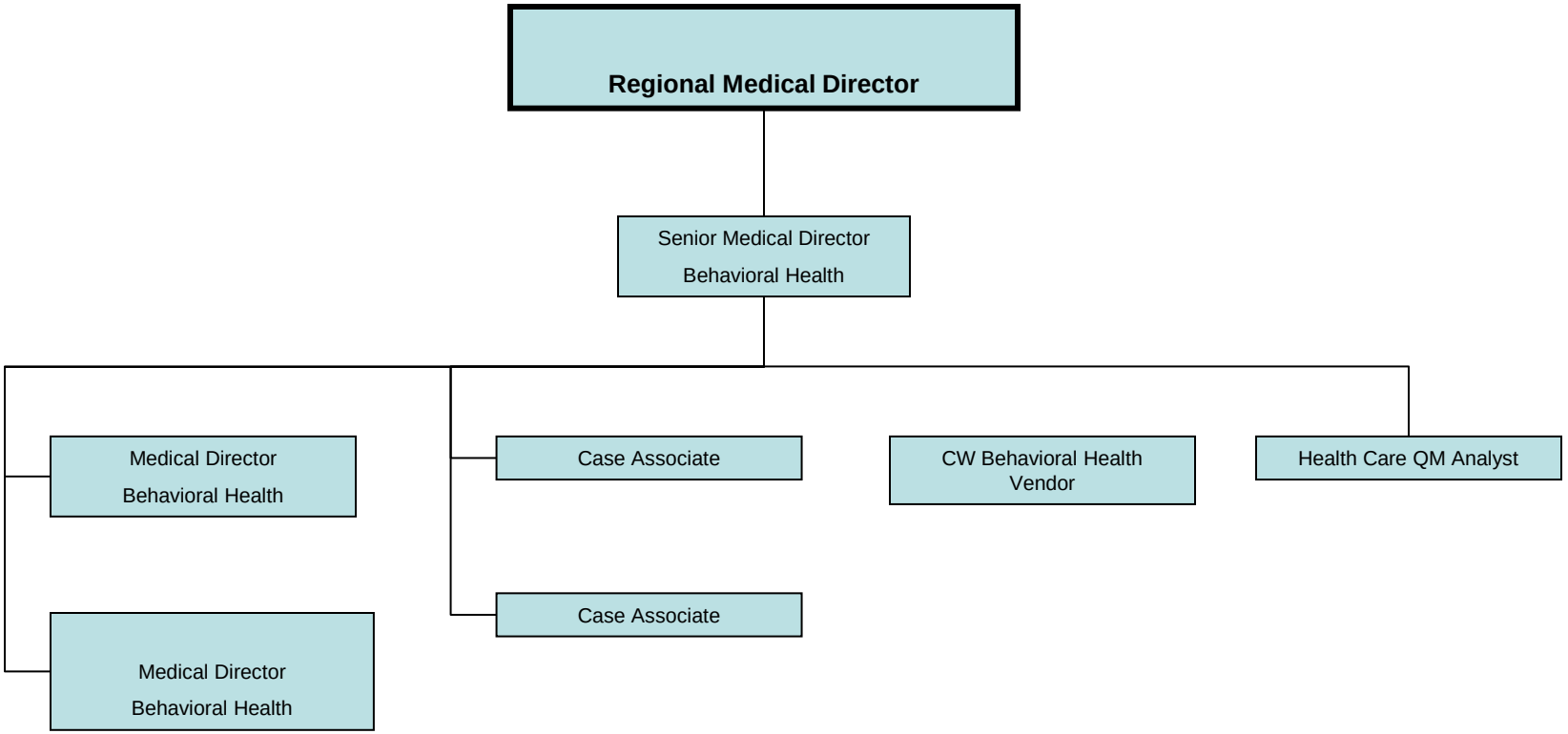
Aetna Alaska Medical Travel Team

Trend Based Earn Back Guarantee has been REDACTED

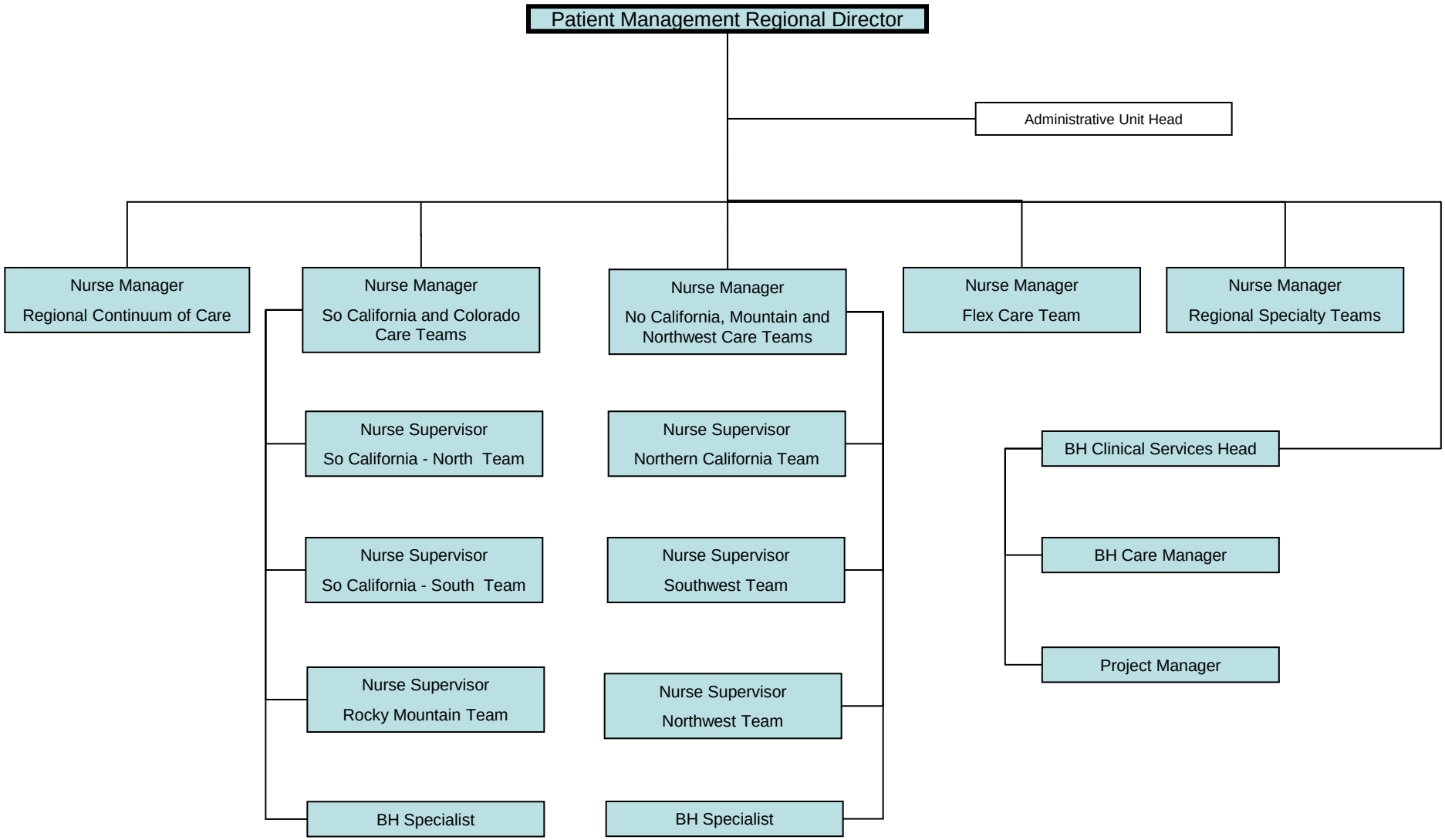
Regional Care Management - West



Regional Care Management - West



Patient Management Team - West



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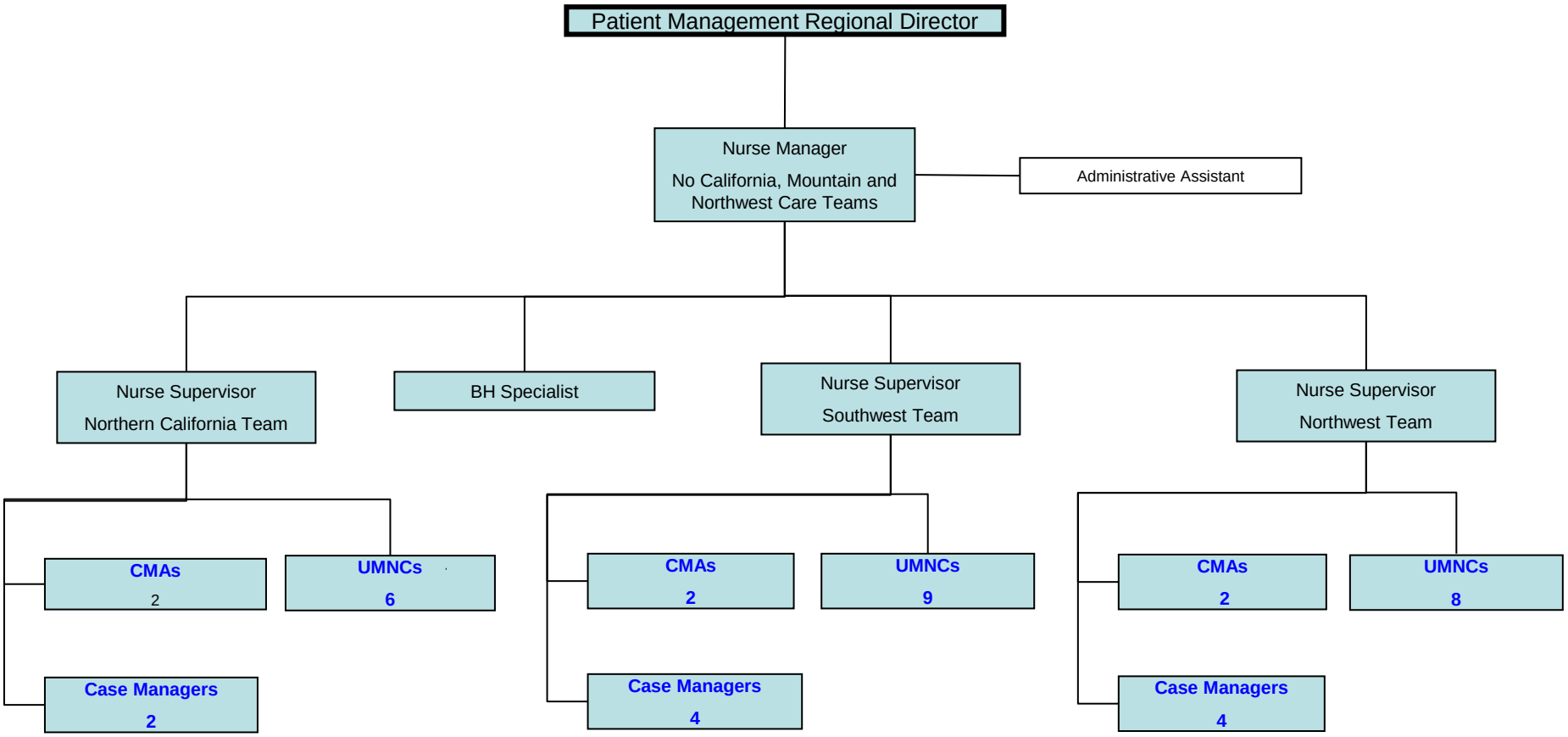

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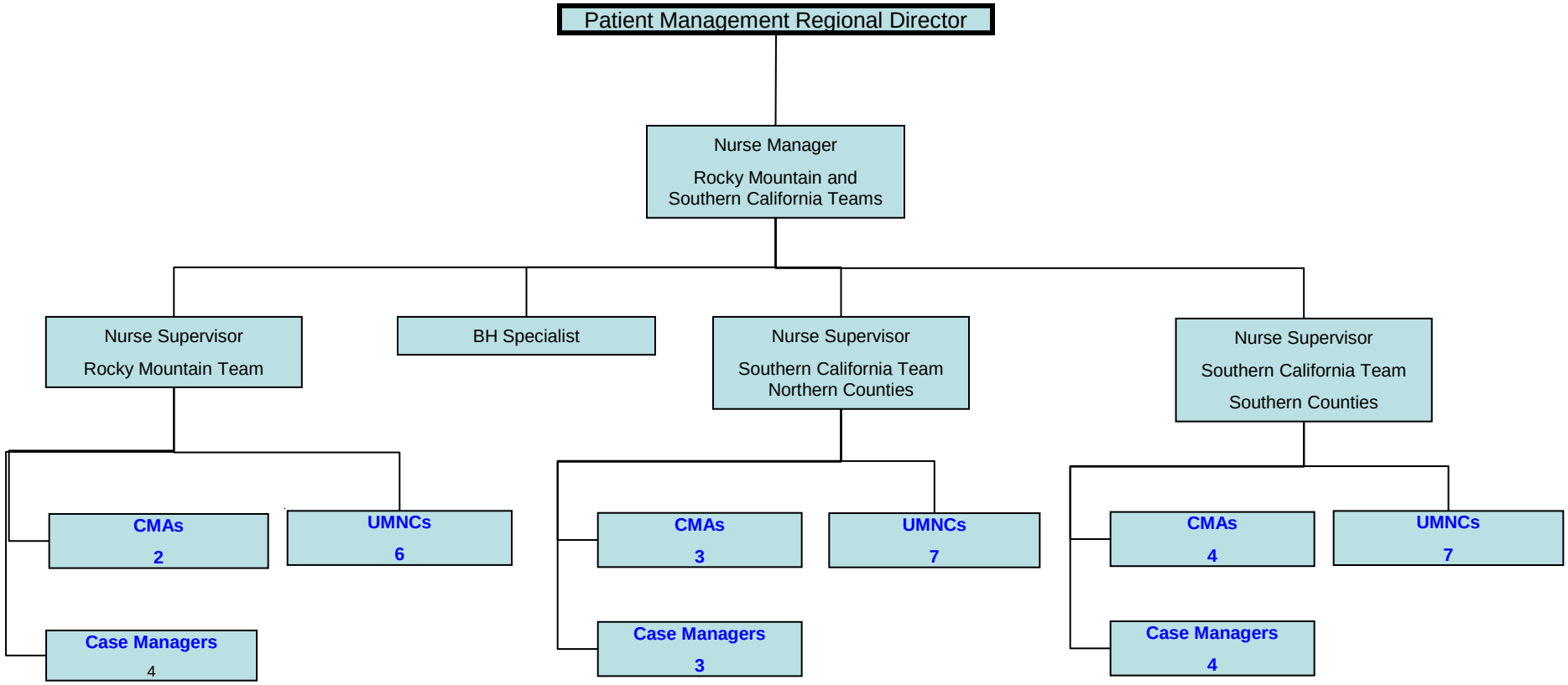

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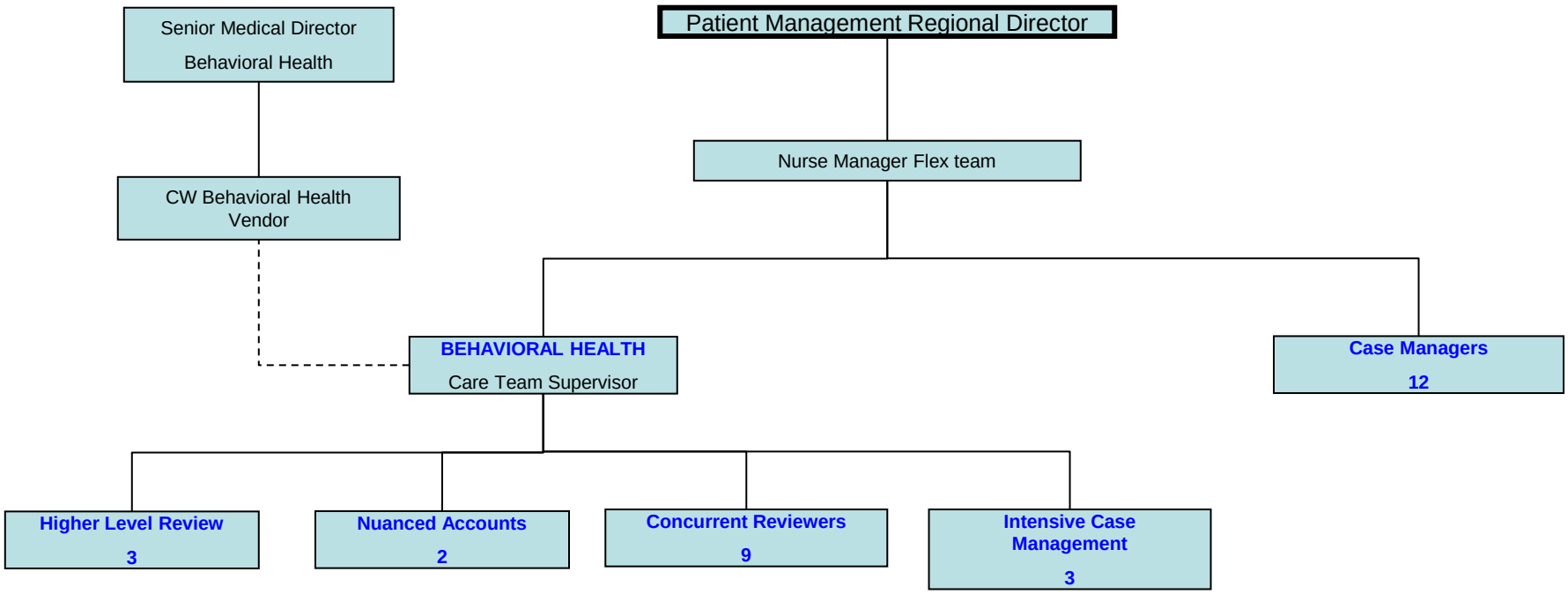
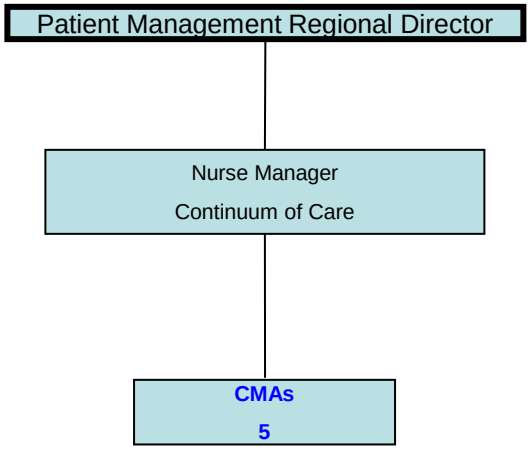
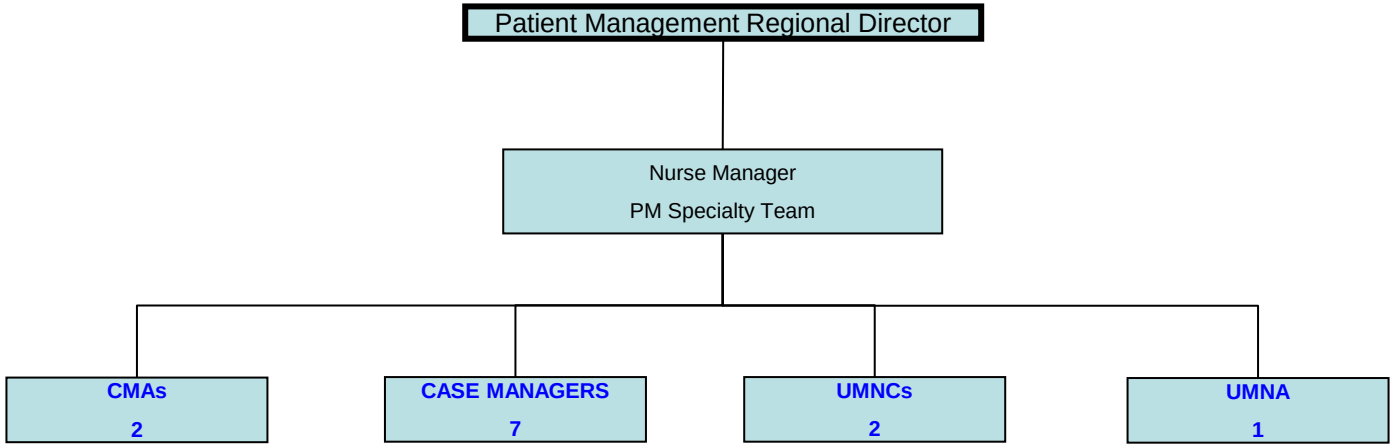


Patient Management Team - West



Patient Management Team - West



Patient Management Team - West