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VIA Email (HPC-Testimony@state.ma.us)

David Seltz
Executive Director
Health Policy Commission

Thomas O'Brien
Chief, Health Care Division
Office of the Attorney General

Aron Boros
Executive Director
Center for Health Information and Analysis

Dear Sirs:

Attached please find Aetna's written testimony as requested by the Health Policy Commission, the Office of the Attorney General, and the Center for Health Information and Analysis.

Please let me know if you require any further information.

Sincerely,

B. Hennessy/end

Barbara Hennessy
Regional General Counsel

EXHIBIT B

1. C.224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012 – CY2103 and CY2013 – CY2014 is 3.6%.
   a. What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?
   b. What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?
   c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?
   d. What steps have your taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

The Fee-For-Service system rewards providers for the volume of services they provide rather than the value they deliver to health purchasers. When we pay for value, providers are incented to deliver better outcomes, which can lead to lower health care costs. Those cost savings ultimately benefits consumers and the health system as a whole.

We believe physicians and hospitals should manage the care process in a convenient, high-quality, low-cost way. Nationally, Aetna is enhancing the patient experience, improving quality of care, and reducing costs through new accountable care models that support market share growth and high quality care delivery to larger populations. These arrangements focus on value-based care delivery, improved efficiency, and overall improved patient satisfaction.

Exhibit 1 contains additional information on Aetna's provider collaboration arrangements.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?

Aetna believes that while medical cost increases are a component of the increase in health care costs, increases in utilization generated by new technologies for the treatment of existing conditions and increased use of specialty pharmaceuticals also contribute to the increased cost of health care.

With respect to medical care, Aetna manages future health care costs through negotiation of favorable provider contracts, medical management programs, product designs, and underwriting criteria.

Exhibit 2 contains additional information on how Aetna addresses the impact of growth in prices on medical trend.

3. C. 224 requires health plans, to the maximum extent feasible, to reduce the use of fee for service payment mechanisms in order to promote high quality, efficient care

delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?

Please see response to Question 1, above.

4. C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.

Aetna exited the small group and individual Massachusetts fully insured HMO market in 2010. For large group fully insured HMO products, we systematically assign a primary care physician to members who do not select one, based on the member's geographic location.

Aetna's Massachusetts PPO portfolio does not contain gatekeeper products. As such, we have not historically assigned Massachusetts members to a primary care provider, and our systems are not configured to make primary care physician assignments for these PPO products.

Exhibit 3 contains additional information on additional primary care provider selections.

5. Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?

Aetna offers several programs to its Massachusetts self-insured plans sponsors to promote high value providers. In addition to the PCMH and P4P programs described in response to Question 1, above, Aetna also offers these plan sponsors "Aexcel" (high performance tiered physician network) and the Aetna Performance Network (high performance tiered hospital network).

While tiered and network products are not available on a fully insured basis to Aetna customers in Massachusetts, we do offer the Institute of Excellence (transplants) and Institutes of Quality (bariatric surgery, cardiac surgery and orthopedic spine and joint replacement) on a fully insured and self-insured basis.

Exhibit 4 contains additional information on Aetna's high value programs.

6. Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response

Many of Aetna's provider partners have either merged or partnered with other groups/systems since 2006. As a result, we have worked to control the trend impact of these consolidations, largely through contracting efforts (reducing expected increases/capping future charge increases) and product designs. We also negotiate with providers both during and after a corporate merger

or acquisition, to ensure that members using the newly merged/acquired organization get the same or lower costs after a corporate transaction as they did prior to it.

7. Please describe the actions that your organization has undertaken to provide customers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.

Transparency empowers consumers to anticipate their health care costs, compare costs and/or quality between providers, and decide where to receive care. Aetna is committed to maintaining and enhancing our position as a leader in transparency and is proud of its efforts to provide customers with cost information on health care services.

Exhibit 5 contains additional information on Aetna's leading transparency tools.

EXHIBIT C

1. Please submit a summary table showing actual observed allowable medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g. utilization trend, payer mix trend).

AGO Exhibit C1 is attached as Exhibit 6.

Determining the impact of demographic changes on trend isn't always possible because demographic factors such as age and gender impact overall utilization.

Please see Exhibit 6A, attached for responses to subsections (a) through (c).

2. Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:
   a. Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial, large group, commercial small group, and commercial individual)
   b. Membership whose care is reimbursed through a risk contract, by market segment(contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that do not subject the provider to any "downside" risk; hereinafter "risk contracts")
   c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO indemnity)
   d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and

outpatient services (e.g. lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
e. Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
f. Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations)

Please see Exhibit 7, attached.

3. To the extent your membership in any of the categories reported in your response to the above. Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.

Nationally, membership totals change as groups enroll with, and terminate from, Aetna. We don't track the specific reasons that drive enrollment and termination.

4. Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g. HMO, PPO, self-insured, fully insured).

The majority of Aetna providers have been on a fee for service contract since 2009. We piloted a limited capitation payment model (covering both primary and specialty care physicians) for some self-insured and fully-insured HMO plans from January 1, 2009 through May 31, 2013, but are no longer offering that option and no longer have any risk based contracts in Massachusetts. The P4P and PCMH Recognition programs described in response to Exhibit B, Question 1 are incentive programs for attaining specified metrics. There is no downside risk to the providers in the program and thus are not categorized as risk based contracts.

5. Please explain and submit supporting documents that show how you quantify and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.

As stated above, we do not have any risk based provider contracts in Massachusetts.

6. Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.

We do not have any risk based provider contracts in Massachusetts. However, Aetna believes that value-based contracting will help control medical costs and will partner with providers using

a broad set of criteria to determine their ability to improve cost, quality and overall member experience. Provider groups and systems have varying capabilities, and not every provider group is ready to participate in a risk based contract. We evaluate multiple criteria (infrastructure, solvency, etc.) to ensure that we are partnering with providers that can drive results. If a provider group does not meet our criteria, we may consider a different type of arrangement in line with their current capabilities and help the group move toward a risk based contract.

7. Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited network and non-limited network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.

We do not offer a fully insured limited network product in Massachusetts. Our tiered network product is offered only on a self-insured basis, so there are no underwriting or customer-premium calculations involved. Only a third party administrative fee is charged which is not specific to such a product.

8. Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter "wellness programs"). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.

Wellness focuses on identifying, reducing and eliminating modifiable risk factors through lifestyle change and behavior modification. Aetna's wellness programs concentrate on holistic wellness, prevention, weight management, stress reduction, and tobacco cessation through a total population health approach. Wellness programs may demonstrate different types of results, such as improvement in body mass index, stress reduction, improvements in nutrition or physical activity, improved biometric results or other key indicators of modifiable health improvement. Employers are implementing wellness programs to help to increase participant awareness, increase engagement in health, improve productivity and drive better outcomes.

Exhibit 8 contains additional information on Aetna's wellness programs.

EXHIBIT D

1. Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?
    a. If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers

As described in our response to Exhibit B, Question 1, Aetna recently launched a PCMH recognition program in Massachusetts to reward NCQA certified physicians for maintaining their

NCQA PCMH accreditation status. Because the program is in its infancy, we have not yet analyzed spending trend or clinical performance information.

Exhibit 1

Provider collaboration arrangements reduce unnecessary utilization, provide for shared savings through aligned incentives for appropriate care delivered in the best setting, and allow for financially sustainable provider business models.

Throughout the country, Aetna is collaborating with providers to help them transition to these new value-based care delivery models and delivering technology and services that facilitate the move to provider readiness for accountable care. The Aetna ACO works on two levels: we provide strategic financial incentives for physicians to improve quality and control costs; and we deliver timely information that helps doctors and patients make more informed health care decisions. Nationally, Aetna expects to have more than 30 ACOs in place by the end of 2013 and 60 ACOs in place by the end of 2014. We hope to have ACO networks in geographic regions that represent about two-thirds of the total American population and we're investing and staffing and growing to be able to meet that objective.

Patient-Centered Medical Homes (PCMH) realign care to focus on maintaining health, and reducing high-intensity, duplicative or medically unnecessary services. Nationally, Aetna has three PCMH models. The Direct Contract Relationship model allows for care coordination and shared savings by way of a per member per month payment for patients attributed to the practice and a percentage of savings when clinical quality targets are met. The PCMH Recognition Model provides a care coordination fee by way of a per member per month payment for patients attributed to the practice. Aetna monitors providers' clinical performance and efficiency under both the Direct Contract Relationship and the PCMH Recognition models. The Multi-Payor Collaboratives, CMS, and Comprehensive Primary Care Initiative (CPCI) model focuses generally on fully insured commercial business, and allows for variation in clinical performance, efficiency, and data aggregation measures. Aetna is currently participating in CPCI arrangements in Maine, Maryland, New York, Ohio, Pennsylvania and Washington and New York. We are working to implement similar arrangements with multiple large provider groups in Massachusetts with a goal of covering the majority of the Commonwealth.

In Massachusetts, Aetna is beginning to implement two provider collaborative models – PCMH and Pay for Performance (P4P) Agreements – both designed to improve the quality and efficiency of care. Aetna recently introduced a PCMH recognition program to Massachusetts NCQA certified physician practices to encourage certain physicians to treat patients while maintaining NCQA PCMH accreditation status. - Aetna hopes that this program will serve as the foundation for future PCMH programs that will reward recognized PCMH providers for investment in infrastructure, training, health information technology and proactive case management. Aetna also has P4P arrangements in place to reward the continued achievement of specified quality benchmarks with multiple provider groups. Aetna is considering expanding other value-based contracting initiatives, such as ACOs, to Massachusetts.

As a general rule, any reductions in healthcare spending resulting from provider collaboration models are reflected in the historical experience used to develop current cost levels for premium rates for insured policies. Any anticipated future reductions in healthcare spending are reflected in the trend component of the rate development.

Exhibit 2

Aetna's ability to address the impact of growth in prices on medical trend is affected by the rates we pay providers for services rendered to our members (including financial incentives to deliver quality medical and/or other covered services in a cost-effective manner) and by our provider payment and other provider relations practices (including whether to include providers in the various provider network options we make available to our customers). In addition, there are factors not associated with us that impact these providers and their pricing decisions (merger and acquisition activity and other consolidations among providers), changes in Medicare and/or Medicaid reimbursement levels to health care providers, and increasing revenue and other pressures on providers.

Aetna strives to contract competitively while developing and maintaining favorable relationships with hospitals, physicians, pharmaceutical benefit service providers, pharmaceutical manufacturers and other health care benefits providers. We seek to enhance our health provider networks by entering into collaborative risk-sharing arrangements, including ACOs, with health care providers, and are keenly aware of the cost impact of out of network utilization both to us and our members. To reduce these costs, we offer products that incent members to use participating providers and have implemented a variety of programs (at both the member and provider level) to reduce the cost impact of out of network utilization.

Aetna also addresses the impact of healthcare spending through our national care management programs and underwriting criteria. Our national care management programs, supervised by medical directors, include: concurrent review, disease management, pre-certification, and clinical claims review. Our underwriting criteria account for industry standards and historical data, and allow us to reasonably project and adjust the factors in our underwriting and rating methodologies.

Exhibit 3

Aetna believes that our new Massachusetts PCMH accreditation program will result in additional primary care provider selections. The coordination of care payments we make under this accreditation program are based on members we attribute to each provider, and are designed to help cover the provider's cost of infrastructure, training, use of health information technology, and proactive case management for Aetna members. This information will make it easier for providers to engage the patients in their respective panels and encourage them to make a primary care provider selection.

Exhibit 4

Aetna currently has approximately 17,000 members who visit Massachusetts providers in our P4P programs and approximately 4,500 who visit Massachusetts providers in its PCMH.

Aetna currently has 10,171 self-insured enrollees who visit Aexcel Massachusetts providers. All of our Massachusetts members have access to the Institute of Excellence and Institute of Quality programs.

In addition, Aetna has been promoting its Aetna Health Fund suite of consumer directed health care products, which incent members to choose high quality, cost-effective providers.

Finally, Aetna encourages its members to use its online tools to find low cost providers and to estimate the cost of care. For further details on Aetna's transparency tools, please see response to Exhibit B, Question 7.

Exhibit 5

In 2004, Aetna began its transparency initiatives with a tool that provided members with the average cost of an in network service in a geographic area. In 2006, we introduced transparency at the physician level by providing members access to negotiated rate information for physician services. In 2007, we expanded transparency to facilities with our "Medical Procedure by Facility Cost" Tool. In April of 2010, Aetna launched its Member Payment Estimator (MPE).

Our MPE is an online healthcare transparency tool provided to Aetna's commercial medical members. We continue to invest in the MPE, recently adding over 100 additional procedures.

Members can use our MPE to obtain and compare out-of-pocket cost estimates for healthcare services for up to 10 in-network providers at once. Estimates are based on actual provider negotiated rates, and are real-time, personalized, and based on the member's health insurance and benefits plan using Aetna's claim adjudication process. The tool is available through our secure member website. [1]

Our MPE also allows members to generate out-of-pocket cost information for out-of -network physician services, physician services for Traditional Choice Indemnity plans and plans with out of network benefits. This capability helps members to make informed health care decisions and underscores the benefits of staying in-network.

The tool includes the non-emergency services most commonly used by members, such as physician office visits (routine exams and specialist visits), surgical procedures (maternity ear tube insertion and cataract/lens surgeries) and diagnostic tests and procedures (including upper GI endoscopies and colonoscopies). Members can call customer service to get an estimate for services not included in the MPE.

MPE can be accessed via DocFind (Aetna's online participating provider directory), through the center of Aetna Navigator's home screen (Aetna's online member portal), and on the new "What's Your Healthy" website. Members can also "Ask Ann" (Aetna's virtual online assistant) and our Aetna Customer Service and Consierge service representatives to get cost estimates or learn how to use MPE.

In addition to the MPE, members can also access our "Price-A-Drug" Tool. Launched in 2003, this tool allows members to determine whether a drug is covered under their particular pharmacy plan and calculates (based on the terms and conditions of the benefit plan) the total cost of the drug (what Aetna pays for the drug) and out-of-pocket costs (their pharmacy copay).

Aetna makes resources available for employers to promote and increase awareness for our MPE, including online videos, e.Cards (promotional email templates), and member education tools. Aetna staff is also available to conduct training upon request.

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[1] Members who prefer not to use the tool can get estimates through Ask Ann, our online virtual assistant, or through customer service.

Exhibit C1 AGO Questions to Payers Exhibit 6

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2010*	0.0%	0.7%	0.3%	0.6%	1.6%
CY 2011	1.8%	1.5%	-1.0%	-0.2%	2.1%
CY 2012	2.7%	4.4%	0.1%	-1.6%	5.6%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					1.8%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					6.6%

* Contains fully insured membership only

Exhibit 6a

Population Changes 2010 - 2012			
	Demographic Index Change	Benefit Index Changes*	Morbidity Index Changes
CY 2010	0.4%	-2.0%	2.9%
CY 2011	0.3%	-3.4%	0.3%
CY 2012	0.1%	-3.3%	3.7%
* Fully insured population only			

a. The effect of demographics on trend is contained within the changes due to Utilization and Service Mix as the age/gender and other demographic factors vary the utilization and intensity of services people receive as they age.
b. Benefit buy downs affect utilization as the impact of members paying increased cost share of the total spend lowers unnecessary utilization. Benefit buy downs also impact unit cost trends as members are incented to see lower cost providers and sites of service.
c. The change in health status is similar to, and measurement would be difficult to differentiate from, (a) above. As health status for the population changes, so will all of the categories of trend. In a block of declining health status, costs and utilization increase and drive increases in Provider and Service mix.

Response to Exhibit C, Question 2 a-f

			ye2009	ye2010	ye2011	ye2012
a	Large		182,685	190,368	183,871	175,831
	Small		1,622	1,415	1,179	1,226
	Individual		91	79	79	68
	Medicaid		0	0	0	0
	Medicare				1380	1574
	other govt		2,101	2,216	2,151	1,817
b	Large		0	0	0	0
	Small		0	0	0	0
	Individual		0	0	0	0
c						
	Large	HMO/POS FI	12,644	9,801	9,408	10,710
		HMO/POS SI	118,779	130,151	127,953	123,987
		PPO/INDEM FI	34,862	35,569	34,710	29,925
		PPO/INDEM SI	16,400	14,847	11,800	11,209
	Small	HMO/POS FI	1,013	802	612	604
		HMO/POS SI	0	0	0	0
		PPO/INDEM FI	609	613	567	622
		PPO/INDEM SI	0	0	0	0
	Individual	HMO/POS FI	20	22	32	21
		HMO/POS SI	0	0	0	0
		PPO/INDEM FI	71	57	47	47
		PPO/INDEM SI	0	0	0	0
	*Product available for SI Plans only					
d	Large				798	662
	Small				0	0
	Individual				0	0
e	Large		0	0	0	0

	Small	0	0	0	0
	Individual	0	0	0	0
f	Large	5,808	9,897	14,826	17,489
	Small	317	408	331	441
	Individual	0	0	3	1
	other govt	222	319	327	368

- The high deductible health plan information presented relates to plans for which Aetna is the administra
- Aetna does not separately track the business defined by the "other government" category. Therefore, tl

Exhibit 8

Aetna offers a variety of wellness programs to promote overall health and well-being. All of the programs below are offered to Aetna employees. Many of the offerings not included as part of our standard medical coverage (described immediately below) are available to both fully insured and self-insured plan sponsors. Some offerings, however, are limited to self-funded plan sponsors.

Programs offered by Aetna and included as part of our standard medical coverage

- **Aetna's Flu Care** program helps members prepare for the flu season with onsite flu clinics, a flu care card (a debit style card providing members with prepaid flu shot amounts at participating pharmacies), and/or promotion of flu shots covered under current medical plans.

- **Simple Steps to a Healthier Life (Simple Steps)** is a personalized, online health and wellness program that begins with a health assessment. Simple Steps encourages participants to identify and reduce health risks and improve and maintain healthy lifestyles. Our topics include: weight management, diet and nutrition, stress management, smoking cessation, sleep improvement, and depression management.

- **Informed Health Line**, a 24 hour toll-free nurse line, helps members make informed decisions about their health. Nurses teach them how to communicate more effectively with their doctors and save money by learning how to get the right care at the right time.

- **Aetna Surgery Decision Support (SDS) tool**, an online surgery decision support program provides surgery candidates with a helpful approach to deciding on, preparing for and recovering from surgery.

- **Aetna SmartSource,** an online search tool, is available through our secure member website, our Personal Health Record, and our online health and wellness program. Users simply enter a condition, symptom, medication, test, procedure or other health term into the tool. Based on the user's profile (where they live, selected health plan and more), the tool provides information on locally participating doctors and specialists, medications and treatment options, estimated health care costs, relevant programs and discounts, and Aetna clinical policy bulletins.

- **Aetna InteliHealth,** established in 1996, is our online health information program which helps people better understand health and wellness topics. It provides credible information through its relationship with Harvard Medical School and the Columbia University College of Dental Medicine.

- **Healthwise® Knowledgebase,** available in both English and Spanish, this user-friendly online tool features information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medications.

- **Mobile technology** gives our members access to mobile "apps" and a mobile website that provide information on health information, access to our DocFind online provider directory, the Aetna Personal Health Record, Price-a-Drug, claims search, and electronic ID cards.

Aetna also offers the following programs for purchase by employers:

- **Aetna Healthy Actions** program includes incentives to help members and their families take steps toward a healthier lifestyle. Eligible participants can view and track their incentives through the Healthy Actions page on our member website.

- **The Viniyoga Stress Reduction** program teaches stress management, improves sleep, and relieves muscle and tension headaches through Viniyoga postures, breathing and mental techniques, and guided relaxation.

- **Mindfulness at Work**, an online program delivered by an expert instructor in a virtual classroom, teaches evidence-based stress management skills, including mindfulness awareness, breathing techniques and emotion management.

- **Aetna Fitness Reimbursement Program** provides customers with reporting and expense reimbursement for employee fitness, reimburses employee fitness club/gym dues, fitness equipment purchases, personal training, weight management and nutrition counseling sessions.

- **Onsite Biometric and Metabolic Syndrome Screenings Programs** provide onsite health screenings, counseling, and workshops. Some programs also provide access to virtual metabolic health advisors. Results are integrated into our CareEngine and Personal Health Record technologies, which generate health alerts when gaps in care are detected and allow members access to personal results.

- **Simple Steps To A Healthier Life online disease management programs**

  We offer a suite of online disease management programs to help members and their families with chronic health conditions, including the following:

  - Intelligent recruitment e-mails and reminder e-mails to participants who have not yet taken action on the initial e-mail.
  - Tailored action plans
  - Newsletters
  - Online supplemental resources specifically designed to support progress toward health goals.

  We also offer an array of online disease management programs to help members and their families with chronic health conditions. Participants receive tailored action plans to address their unique needs, newsletters with additional tips and suggested action items, supplemental online resources, and program evaluations. Specific online disease management programs include:

- **Care for Your Back**, which assesses and addresses risk factors associated with back pain to provide individually-tailored prevention and management techniques for each participant.
- **Care for Pain**, delivers a tailored plan (patient self-care, pharmacological management, physical therapy, and cognitive behavioral therapy) for members suffering from chronic pain conditions, including rheumatoid arthritis, osteoarthritis, joint pain, disc pain, back pain, fibromyalgia, neuropathy and migraines. This program also addresses pain co-morbidities and co-behavioral issues, such as depression and insomnia.
- **Achieve** provides tailored actions plans (improved nutrition habits and weight loss, increased physical activity levels, improved medication adherence, and better communication with doctors) for those with high cholesterol and those who may be at risk for the condition.
- **Care for Diabetes** works to effectively change behaviors across all acuity levels by improving lifestyle issues, medication adherence, doctor-patient relationships, and diabetes education. The program combines what is known from research about living with and managing diabetes and personalizes it so individuals have a program plan to follow and can accept the responsibility of day-to-day management of their condition.
- **Control** helps participants with high blood pressure, and those at risk for the condition, by bringing them into recommended blood pressure ranges. The program generates tailored program plans for each participant that focus on improving medication adherence, working more effectively with their doctors, losing weight, improving nutrition habits, and increasing physical activity levels
- **Healthy Lifestyle Coaching (HLC)**, a program that allows members and their dependents (even those enrolled in a medical plan with another company) across all risk levels to interact with a health coach. HLC helps members identify, and focus on, their personal health and wellness priorities. Action plans are supported by a suite of online tools and educational materials.
- **Aetna Personal Health Record (PHR)** is a secure online tool (updated each time a claim is filed) that helps members keep track of doctor contact information, prescription drugs, immunizations and medical tests. Members can also add additional information about their health that is not reflected by claims data, such as family health history or the use of over-the-counter medications.
- **Member Health Engagement Plan**, an enhanced version of the PHR, allows members to track their progress as they complete recommended health activities.

Discounts We Offer

The Aetna Discount Program, available to all Aetna medical plan members, includes the following discounts:

- **At home products**

Members get discounts on products and services for their home and family that best fit their needs and their life, such as the Omron 7 Series™ Upper Arm Blood Pressure Monitor.

- **Books**
  Members save on books, DVDs, online videos and more through the American Cancer Society Bookstore, the Mayo Clinic Bookstore and Pranamaya.
- **Fitness**
  Members save on gym memberships[1] and name-brand home fitness and nutrition products that support a healthy lifestyle with services provided by GlobalFit®.
- **Hearing**
  Members get discounts on hearing exams, hearing aids, batteries, repairs and other hearing services from Hearing Care Solutions and Hear PO®.
- **Natural products and services**
  Members save on specialty health care products and services (e.g. acupuncture, chiropractic massage therapy, and nutrition), including online consultations and alternative remedies.
- **Oral health care**
  Members save on select dental health care products from Epic Dental and Waterpik®:
- **Vision**
  Members get discounts on eye exams, eyeglasses, prescription and nonprescription sunglasses, contact lenses and solutions at participating locations through EyeMed Vision Care, LLC. They also get discounts on LASIK surgery and replacement contact lenses.
- **Weight management**
  Members get discounts on the CalorieKing®Program and products, eDiets® diet plans; Jenny Craig® weight loss programs; and Nutrisystem® weight loss meal plans.

I, Martha Temple, President of the New England market for Aetna, am legally authorized and empowered to represent Aetna for the purposes of this testimony, which is signed under the pains and penalties of perjury.

Martha Temple
President, New England Market
Aetna