Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (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-CY2013 and CY2013-CY2014 is 3.6%.

    a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

    ANSWER:

    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. Accountable care arrangements can enhance patient experience, improve quality of care, and reduce costs to support market share growth and high quality care delivery to larger populations. When these arrangements focus on value-based care delivery, improved efficiency, and overall improved patient satisfaction, they can help to achieve health care cost growth benchmarks such as the one set forth in the Commonwealth.

    Exhibit Aetna1 contains additional information on Aetna's provider collaboration and accountable care arrangements.

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

    a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

b. What efforts does your organization plan between now and October I, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

ANSWER:

Aetna agrees that paying for value by way of accountable care arrangements and other provider collaboration arrangements can lead to lower health care costs, ultimately benefitting consumers and the health care system as a whole. Aetna has implemented numerous value based contracting arrangements across the country including accountable care arrangements, and hopes to introduce several of these agreements in Massachusetts in 2015.

Please see response to Exhibit B, Question 1, above, and corresponding Exhibit Aetna1 for additional information on Aetna's provider collaboration and accountable care arrangements across the country.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to 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 the provider, including contracts that subject the provider to limited or minimal "downside" risk.

Year	Number of Physicians in your Network Participating in Risk Contracts*	Percentage of Physicians in your Network Participating in Risk Contracts*
CY2012	0	0
CY2013	0	0

*The P4P and PCMH Recognition programs described in response to Exhibit B, Question 1 are incentive only programs and not considered risk-based contracts.

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.

    a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?

    b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

    c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?

    d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?

    ANSWER:

    As stated above, Aetna does not have any risk contracts in the Commonwealth, but has introduced two incentive-only provider models.

    Nationally, Aetna uses a broad and individualized set of criteria (e.g. infrastructure, solvency) to determine if a collaboration will improve cost, quality and overall member experience. We recognize that provider groups/systems have varying capabilities. Not every group is ready to participate in a risk based contract, and not every provider arrangement will be successful with the same metrics. 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.

5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.

    a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use different quality measures or performance targets tor different providers or provider organizations?

    b. What values and/or drawbacks docs your organization identity regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM
    contracts, both across providers and across payers? What arc the values and/or drawbacks of differentiation? Use different quality measures or performance targets for different providers or provider organizations?

ANSWER:

Aetna adopts national metrics endorsed by national entities (e.g. National Quality Forum), but has also developed specific measures when needed to help our Accountable Care Organizations (ACO) improve quality and costs.

We provide ongoing analytical and care management consulting to our ACO organizations (review of monthly results, metrics, and cost/quality trends) to support continuous improvement in quality and financial outcomes. We also conduct formal quarterly meetings with each ACO to review financial and quality results and trends and assist with action plans to improve outcomes across all facets of care delivery and cost.

Exhibit Aetna3 contains information on defining metrics for value based provider arrangements. Response to Exhibit B, Question 4 contains information on Aetna's evaluation of provider collaboration arrangements.

6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

    a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:

        I. provider types considered tor attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)
        II. units used in counting services (e.g., number of claims, share of allowed expenditures)

        III. services included in a claims-based methodology (e.g., E&M, Rx, OP)

IV. time period tor evaluation of attribution (e.g., 12 months, 18 months) and

V. whether patients are attributed retrospectively or prospectively.

b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization laced?

c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

ANSWER:

Aetna exited the fully insured small group and individual Massachusetts markets in 2010. For large group fully insured HMO products, we assign (based on geographic location) a primary care physician who do not select one. Aetna's Massachusetts PPO portfolio does not contain gatekeeper products, and our systems are not configured for attribution.

We believe that our Massachusetts Patient Centered Medical Homes (PCMH) accreditation program results in primary care provider selections. The coordination of care payments we make are based on members we attribute to each provider. These attributions make it easier for providers to engage their patients in their respective panels and encourage them to make a primary care provider selection.

Exhibit Aetna4 contains information on Aetna's ACO attribution method.

7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.

ANSWER:

Aetna offers several programs to its Massachusetts self-insured plan sponsors to promote high value providers. In addition to the PCMH and P4P programs described in response to Exhibit B, 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 network products are not available to Aetna's fully insured 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.

8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

ANSWER:

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

Aetna received 10,856 health care service price inquiries from Massachusetts members during the first three quarters of 2014.

Please see Exhibit Aetna6 for the top ten procedures requested per quarter and more information on Aetna's Member Payment Estimator. Please also see the response to Question 7 of Aetna's September 20, 2013 Pre-Filed Testimony, for historical background on Aetna's transparency efforts.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	Ql	4,126	252	15
	Q2	3,881	201	17
	Q3	2,319	77	15
	TOTAL:	10, 326	530	

* *Please indicate the unit of time reported.*

9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.

ANSWER:

Medical cost increases are part of the overall increase in health care costs. However, utilization increases generated by new technologies and the increased use of specialty pharmaceuticals also contribute to increased health care costs. Aetna manages future health care costs through negotiation of favorable provider contracts, medical management programs, product designs, and underwriting criteria.

Exhibit Aetna2 contains additional information on how Aetna addresses the impact of medical trend increases. Please also see response to Exhibit B, Question 1 for information on Aetna's provider collaboration programs, which aim to reduce overall medical utilization through the provision of appropriate care in appropriate settings. Aetna has not conducted any Massachusetts specific analyses on "outmigration" to lower cost community settings.

10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

    a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.

    b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided tor these high-cost, high-risk patients.

ANSWER:

Aetna understands that spending for patients with comorbid behavioral health and chronic medical conditions can be higher than spending for those patients with a chronic medical condition alone. To help achieve better outcomes and reduce costs, Aetna offers several different case management services and activities that address both behavioral health and medical conditions in an integrated way. Exhibit Aetna7 contains additional information on Aetna's integrated case management programs.

Aetna does not contract with or otherwise use a behavioral health managed care organization or "carve-out" for fully insured plans in Massachusetts. Some of our self-funded national account customers, which may have members residing in Massachusetts, do carve-out behavioral health services.

11. Please describe whether and how your organization provides financial support or incentives or a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.

ANSWER:

Please see response to Exhibit B, Question 1 for information on Aetna's provider collaboration programs.

12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

ANSWER:

Exhibit C: Instructions and AGO Questions for Written Testimony

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit I with all applicable fields completed. Please explain for each year 2011 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 ret1ected (e.g., utilization trend, payer mix trend).

   ANSWER:
   Completed in Attachment AGO Payer Exhibit C1

2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 20 I 0 to 2013, broken out by:

   a. Market segment (Hereafter "market segment" shall mean commercial individual,
   commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully- insured and self-insured.)

   b. Membership whose care is reimbursed through a risk contract by market segment
   (Hereafter "risk contracts" shall mean 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 subject the provider to limited or minimal "downside" risk.)

   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 hospital 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 cost sharing plan by market segment
(Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of$1,000 or more may apply to any in-network benefit at any tier level.)

ANSWER:

Completed in Attachment AGO Payer Exhibit C2

3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing)

ANSWER:

Nationally, membership totals change as groups enroll with, and terminate from Aetna. We don't track the specific reasons that drive enrollment and termination. However, we will focus future growth on the 100 to 3000 member market segments.

4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers.

Completed in Attachment AGO Payer Exhibit C4

Exhibit Aetna 1

Throughout the country, Aetna collaborates with providers to help them transition to value-based care delivery models and delivers technology and services that facilitate provider readiness for accountable care arrangements. The Aetna Accountable Care Organization works on two levels: providing strategic financial incentives for physicians to improve quality and control costs; and providing information to help doctors and patients make more informed health care decisions. Nationally, Aetna had 47 ACOs in place by the end of 2013, and we expect to have approximately 60 ACOs in place by the end of 2014. We hope to have accountable care networks in geographic regions representing about two-thirds of the total American population and we're investing, staffing and growing to be able to meet that objective, By the end of 2017, we anticipate that 47% of our contracts nationally will have some type of value based contracting component. Aetna further hopes to introduce an ACO arrangement in Massachusetts in 2015.

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 PCMH 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 PCMH 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. 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 implementing two provider collaborative models: PCMH Recognition and Pay for Performance (P4P) Agreements - both designed to improve the quality and efficiency of care. In 2013 Aetna introduced a PCMH Recognition program to Massachusetts NCQA certified physician practices, encouraging certain physicians to treat patients while maintaining NCQA PCMH accreditation status. We currently have 328 providers and 5,696 members participating in our Massachusetts PCMH recognition programs. As more providers become NCQA PCMH certified, we hope that these programs will serve as the foundation for future 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. Currently, we have 2096 providers and 17,882 members participating in our P4P programs.

In 2015 Aetna hopes to expand its value based contracting footprint in Massachusetts by introducing additional accountable care attribution and product based model arrangements to the market.

Exhibit Aetna 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 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, precertification, 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 Aetna 3

Since our accountable care arrangements are flexible in scope, there is no single approach to defining metrics. We work collaboratively with each organization to outline appropriate measurable and actionable metrics, some of which include, but are not limited to:

- Outpatient surgeries/procedures performed at preferred (ambulatory) facilities
- Hospital readmissions for medical and behavioral health
- Avoidable emergency room utilization
- Ambulatory sensitive condition admissions
- Non-trauma admissions
- 30 Day readmissions
- Outpatient laboratory tests/services
- Radiology services at preferred (freestanding) facilities
- Generic prescribing rate
- Breast cancer screening
- Colorectal screening
- Cervical cancer screening
- Diabetes Hba1c screening
- Flu vaccination
- Pneumonia vaccination
- Diabetes/Lipid screening
- Other preventive care measures

We can track utilization to allow each ACO to manage a specific population. In addition, we provide analytic capabilities that allow ACOs to view results and create actionable reports on a wide range of utilization, quality and financial metrics. These capabilities include both standard monthly/quarterly metrics/results reporting and data sets with user driven drill down capabilities at the physician and member level. We continue to build on our capability to transform raw claims and other administrative data into understandable, actionable and clinically meaningful information.

Exhibit Aetna 3 (continued)

Our reports include, but are not limited to the following metrics:

Quality of care measures:

- Breast cancer screening
- Colorectal screening
- Cervical cancer screening
- Diabetes Hba1c screening
- Flu vaccination
- Pneumonia vaccination
- Diabetes/Lipid screening
- Pharmacotherapy management of COPD exacerbation
- Use of spirometry testing to assess and diagnose COPD
- Use of appropriate medications for people with asthma
- Follow-up after hospitalization for mental illness
- Medication reconciliation post discharge
- Annual health risk assessment
- Routine medical exams
- Medication adherence (specific drug classes)

Outcomes-based measures:

- Diabetes Hba1c for patients with Type 1 or 2 diabetes
- Diabetes/cholesterol management for people with Type 1 or 2 diabetes and LDL greater than 100
- Cholesterol management for patients with cardiovascular conditions
- Beta blocker therapy for CAD patients with prior myocardial infarction
- Congestive heart failure screening/management
- Medication management for patients with asthma
- Medication adherence/management for newly diagnosed patients with depression; effective acute phase treatment and effective continuation phase treatment
- Adverse event: hospital acquired conditions

Infrastructure/care process measures:

- Outpatient surgeries/procedures performed at preferred/lower cost (ambulatory) facilities
- Hospital readmissions for medical and behavioral health

Care coordination measures:

- Avoidable emergency room utilization
- Ambulatory sensitive condition admissions

Exhibit Aetna 3 (continued)

Financial/efficiency measures:

- Non-trauma admissions
- 30 Day Readmissions
- Outpatient laboratory tests/services
- Radiology services at preferred (freestanding) facilities
- Generic prescribing rate
- Utilization: ER visits per 1,000
- Utilization: Total Acute hospital days
- Utilization: Total NICU days
- Utilization: Total skilled nursing facility/rehab days

Please see response to Exhibit B, Question 4, for additional information on the way in which Aetna evaluates provider collaboration arrangements generally.

Exhibit Aetna 4

Attribution for providers in ACO arrangements provides a way of identifying which doctors are considered accountable for which patients, in order to measure performance of the medical group. If claims activity is found, then that member is "attributed" to the ACO where the doctor practices.

Our basic member attribution algorithm for ACO arrangements uses two years of historical claims data to attribute members to primary care doctors. If there is no evidence of primary care doctor utilization during that period, then the member is attributed to certain medical specialists who are associated with the ACO. This process is typically performed annually.

The attribution criteria are outlined below:

Primary care attribution logic

- Primary care doctor visits
- Most recent visit, if history contains visits to multiple primary care doctors

Claims measurement period

1. First, we look at primary care outpatient visits in the prior 12 months, followed by an additional 12 months if necessary. Primary care doctors include Physician Assistants and Nurse Practitioners who are part of a primary care practice/Tax Identification Number (TIN).
2. If a member has claims from multiple primary care doctor TINs, we attribute them to the most recent primary care physician TIN, provided there were two or more visits at that TIN. Otherwise, we attribute them to the primary care physician TIN with the greatest number of visits. If there are an equal number of visits between doctors, we attribute the member to the most recently seen primary care physician TIN.
3. If there is no primary care doctor attribution in the last 24 months, an attribution loop is run for select specialties listed below:

- Primary care specialties include:
- Internal Medicine
- Family Medicine
- General Practice
- Pediatrics
- Specialty physician specialties included, if member not attributed to a primary care doctor:
- Cardiology
- Endocrinology
- Oncology
- Pulmonology
- Gastroenterology
- Rheumatology
- Nephrology
- OB/Gyn
- Code sets:
- Office visit evaluation & management (E&M)
- Preventive care visits
- Office consultations

Exhibit Aetna 4 (continued)

Patient/physician encounters are considered opportunities for quality and efficient care delivery. Due to data limitations, it is not always possible to have an algorithm to verify if a member was under a physician's care throughout the duration of a measure's time frame. For all measures where nationally recognized standards are not readily available, our team of clinical and technical experts have developed clinically appropriate measures to capture appropriate data.

Exhibit Aetna 5

Aetna's Member Payment Estimator (MPE) is an online interactive tool that members use to estimate and compare out-of-pocket costs for over 650 medical services for up to 10 in-network providers at once. MPE provides point-in-time estimates using Aetna's claim adjudication system and real-time data, provider's negotiated rates and the member's plan information such as deductible balances, benefit limits and coinsurance amounts. MPE is free of charge and available to over 96% of Aetna's commercial medical membership.

MPE is available via Aetna Navigator (Aetna's secure member website), but "Ask Ann," our online virtual assistant, is also available to walk members through the estimation process step by step, and to answer questions about MPE. Members of our non-major medical plans not supported by MPE (e.g. Student Health, Affordable Health Choices and Fixed Indemnity plans) can receive similar information by calling a dedicated customer service line.

To allow for advance planning for members, services included in the tool are those that are most commonly utilized by members and that are non-emergency in nature. For example, we include physician office visits, surgical procedures including maternity and cataract/lens surgeries, and diagnostic tests and procedures (including upper GI endoscopies and colonoscopies). The member can generate an estimate for themselves and their covered dependents. The tool displays the services appropriate for the member, based on age and gender. It provides both in-network (doctor and hospital) and out-of-network charges (doctor only). MPE displays icons to indicate high-performing doctors and hospitals that have met clinical performance and efficiency standards, so members can review quality along with costs. We've added direct links for 13 or the most frequently searched services on MPE, and hope to introduce MPE into the Aetna mobile app in first quarter 2015.

We also provide estimates in the form of service bundles where appropriate. Service bundles represent the most likely combination of services that may be performed together in a doctor's office or in a facility setting. Estimates will include all related costs from admission to discharge. For example, the number of units of anesthesia included with a particular procedure in addition to the physician and facility charges. There are approximately 450 physician service bundles and approximately 220 facility bundles included in MPE.

Because MPE uses real-time claim adjudicating logic, it consistently uses the most current provider rates and member benefit plan information to provide Aetna members with a point-in-time estimate. This is the same information that would be used to adjudicate a claim should one be incurred for that member with that particular provider.

In 2011, members that used MPE and had a claim for the same procedure experienced average savings of $612 on allowed expenses and $170 on their out of pocket costs for the 34 procedures included in our 2012 study.* Members who used MPE displayed increased use of lower cost providers and lower rates of using higher cost providers – 60% chose to receive care at a low or medium cost in-network provider after getting an estimate.

*Member Payment Estimator Study, Aetna Informatics and Product Strategy, August 2012.

Exhibit Aetna 5 (continued)

2014 Top 10 Requested Procedures/Services Information by Quarter

Q1	Top 10 Procedures via Website
1	New Patient Office Visit
2	Vaginal Delivery Uncomplicated
3	Colonoscopy - For Diagnosis or Follow-up
4	Colonoscopy - For Preventive Care
5	Cesarean Section Uncomplicated
6	MRI Abdomen without Dye
7	Upper GI Endoscopy
8	New Patient Office Visit
9	MRI of the Lower Extremity Joint without Contrast (Dye)
10	Initial Gynecologic Well Visit for New Patient Ages 18-39

Q1	Top 10 Procedures via Customer Service
1	Colonoscopy - For Diagnosis or Follow-up
2	MRI of the Lower Extremity Joint without Contrast (Dye)
3	CT Scan of the Abdomen/Pelvis without Contrast (Dye)
4	Cataract/Lens Procedures
4	Sleep Studies
4	MRI -General (1 Body Part) with Contrast (Dye)
5	Vaginal Delivery Uncomplicated
5	Shoulder x-ray; complete, minimum of two views
6	MRI of the Lower Extremity Joint without Contrast (Dye)
7	Upper GI Endoscopy
7	MRI of the Lower Back without Contrast (Dye)
8	MRI of the Brain with Contrast (Dye)
9	Knee x-rays; both knees, standing, anteroposterior
10	Uterine Ablation
10	CT Scan of the Face and Jaw without Contrast (Dye)
10	Mammogram (diagnostic)
10	MRI Chest without Dye
10	Vitamin D

Q2	Top 10 Procedures via Website
1	Colonoscopy - For Preventive Care
2	Vaginal Delivery Uncomplicated
3	Colonoscopy - For Diagnosis or Follow-up
4	New Patient Office Visit
5	Cesarean Section Uncomplicated
6	MRI of the Lower Extremity Joint without Contrast (Dye)
7	Typical Established Patient Office Visit
8	MRI Pelvis without Dye
9	MRI Brain without Dye
10	Established Patient Preventive Care Visit Ages 18 - 39 male

Exhibit Aetna 5 (continued)

Q2	Top 10 Procedures via Customer Service
1	Ultrasound (Transvaginal)
2	MRI of the Lower Back without Contrast (Dye)
3	MRI of the Lower Extremity Joint without Contrast (Dye)
4	MRI Brain without Dye
5	MRI of the Brain with Contrast (Dye)
5	Mammogram (diagnostic)
6	Colonoscopy - For Diagnosis or Follow-up
7	Upper GI Endoscopy
7	Sleep Studies
8	Total Knee Replacement (1 knee)
8	MRI Thoracic (spinal canal) without Dye
8	Office Consultation ONLY for new or established patients, no testing (Orthopedics)
9	Cataract/Lens Procedures
10	Fibroid Removal via Hysteroscopy
10	Vaginal Delivery Uncomplicated
10	CT Scan of the Chest with Contrast (Dye)

Q3	Top 10 Procedures via Website (as of 8/20/2014)
1	Colonoscopy - For Preventive Care
2	Vaginal Delivery Uncomplicated
3	Colonoscopy - For Diagnosis or Follow-up
4	Cesarean Section Uncomplicated
5	Mammogram (preventive)
6	Established Patient Preventive Care Visit Ages 18 - 39 male
7	Hernia repair (Inguinal Herniorrhaphy)
8	MRI of the Lower Back without Contrast (Dye)
9	Sleep Studies in a facility setting
10	MRI Chest without Dye

Exhibit Aetna 5 (continued)

Q3	Top 10 Procedures via Customer Service (as of 8/8/2014)
1	MRI of the Lower Extremity Joint without Contrast (Dye)
2	Colonoscopy - For Diagnosis or Follow-up
2	MRI of the Brain with Contrast (Dye)
2	Office Consultation ONLY for new or established patients, no testing (Orthopedics)
3	CT Scan of the Chest with Contrast (Dye)
3	Ultrasound (complete) during Pregnancy
4	Skin Biopsy - New Patient
4	Colonoscopy - For Preventive Care
4	CT Scan of the Chest without Contrast (Dye)
4	MRI Pelvis without Dye
4	MRI Upper Extremity Joint without Dye
5	New Patient Office Visit
5	Cataract/Lens Procedures
5	Sleep Studies
5	DEXA Scan (Dual-energy X-ray absorptiometry) bone density study, 1 or more sites; axial skeleton (eg
5	Hemoglobin
5	Ultrasound, Pelvic (Non-Obstetric)
6	Laparoscopically Assisted Vaginal Hysterectomy
6	Vaginal Delivery Uncomplicated
6	CT Scan of the Face and Jaw without Contrast (Dye)
6	MRI of the Lower Back without Contrast (Dye)
6	MRI -General (1 Body Part) with Contrast (Dye)
6	MRI of the Lower Extremity Joint without Contrast (Dye)
6	Vasectomy - in a Facility Setting
6	CT Scan of the Abdomen with Dye
6	MRI Abdomen without Dye
6	Chest x-ray, two views, frontal and lateral;
6	Thyroid Stimulating Hormone (TSH)
6	Ultrasound of the abdomen - complete
6	Ultrasound of Pregnancy, after 14 weeks pregnancy

Exhibit Aetna 6

In 2011, Aetna launched efforts to more fully integrate case management for its members with medical and behavioral health conditions. We provided additional training to Aetna care managers to allow them to better assess and manage routine behavioral health issues of members identified for Aetna Case Management and Disease Management Programs.

As part of this integration, members with serious behavioral health issues are referred to Aetna's behavioral health/medical psychiatric case management program – the Med-Psych Case Management Program (the "Med-Psych Program".) The Med-Psych Program addresses significant behavioral health issues that may impede treatment progress for medical conditions and facilitates communication and coordination of care between treating physicians and behavioral health professionals. The Med-Psych Program can help members improve/resolve behavioral issues before they have a serious effect on medical conditions, which in turn can help to reduce high-cost medical procedures. Through internal program development, we have found the Med-Psych program to have reduced emergency room visits by 5% and medical admissions by 37%.

In addition, Aetna created a program with AbilTo, LLC which assists members with chronic health conditions such as diabetes and cardiac conditions with video-based counseling and coaching services which address emotional challenges that may accompany medical diagnoses (e.g. depression, anxiety, and stress). The program has a 97% satisfaction rate and has resulted in significant health improvements, including a significant reduction in depression among participants. *

* Aetna Analytics AbilTo 2013 Study.

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

Martha Temple
President, New England Market
Aetna