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BETWEEN YOU AND YOUR DOCTOR: THE PRIVATE HEALTH INSURANCE BUREAUCRACY—DAY 2

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 17, 2009

Serial No. 111–128

Printed for the use of the Committee on Oversight and Government Reform



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BETWEEN YOU AND YOUR DOCTOR: THE PRIVATE HEALTH INSURANCE BUREAUCRACY—DAY 2

THURSDAY, SEPTEMBER 17, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:25 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Tierney, Kennedy, Foster, Towns (ex officio), Jordan, and Schock.

Also present: Representative Conyers.

Staff present: Jaron R. Bourke, staff director; Yonathan Zamir, counsel; Jean Gosa, clerk; Charisma Williams, staff assistant; Ron Stroman, chief of staff, full committee; Carla Hultberg, chief clerk, full committee; Leneal Scott, IT specialist, full committee; Adam Hodge, deputy press secretary, full committee; Rob Borden, minority general counsel; Dan Blankenburg, minority director of outreach and senior advisor; Adam Fromm, minority chief clerk and Member liaison; Ashley Callen, minority counsel; and Molly Boyl, minority professional staff member.

Mr. KUCINICH. The Domestic Policy Subcommittee of the Oversight and Government Reform Committee will now come to order.

Today is the second of this subcommittee's 2-day hearings examining how the bureaucracy of the private health insurance industry influences the relationship between physicians and their patients.

Yesterday, the subcommittee heard the testimony from individuals, doctors, whistleblowers, and policy analysts, all of whom related their experiences with, and opinions about, the private health insurance bureaucracy and its impact on health care in America.

Today, the subcommittee will hear testimony from top executives of the six largest health insurance companies in the United States, and I want to welcome the witnesses and thank them for their presence here, and we look forward to hearing from you.

Now, without objection, the Chair and ranking minority member will have 5 minutes to make opening statements, followed by opening statements not to exceed 3 minutes by any other Member who seeks recognition.

Without objection, Members and witnesses may have 5 legislative days to submit a written statement or extraneous materials for the record.

I want to add that the House has adjourned for the weekend, and while generally that means that there would be very few Members here, there are a number of Members who have expressed an interest, and you may see them come in throughout the course of the hearing. But good afternoon and thank you very much for your presence before this subcommittee.

Yesterday, we received testimony from the daughter of a man whose bone marrow transplant was delayed an agonizing 126 days while authorization from his insurer was denied and sustained on appeal. She asks, "Would there have been a different end to my dad's story if he had been given approval of the first transplant request in April 2006? Would he be alive today? We don't know. What we do know is that his chance for survival most assuredly did not increase because"—and she is talking about the insurer—"built the bureaucratic roadblocks that changed the course of my father's treatment and made him wait for his potentially life-saving bone marrow transplant."

We also heard from the father of a 2-year-old who was born with a severe cognitive disorder. He has had to struggle to get the coverage his premiums pay for. Recounting the toll on his family that the repeated delays and denials of care for his daughter caused by his health insurer, here is what he told us. He said, "The stress of constantly of having to hold the HMO and their agents to their agreed-upon obligations has relegated me to the role of my daughter's care manager and all too often robbed me of my role as Sidney's loving daddy."

The experiences of these individuals are the tip of an iceberg. Court and State regulatory records are replete with recent findings of wrongful denial and delay of health care by private health insurance bureaucrats. Hundreds of thousands of people have been wrongly denied health care coverage, hassled with unnecessary documentation requests, underpaid claims, ripped off by fixed data bases that underpaid claims. The actions of insurance company bureaucrats in causing needless delays and denials of coverage for prescribed treatment can be as detrimental as the disease itself.

Now, this was the conclusion of the Ohio Supreme Court when it upheld the largest jury award in Ohio's history against Anthem for denying life-saving treatment to Esther Dardinger. Here is what the Court said in that decision.

"Then came the bureaucracy. Anthem had worn"—talking about the Dardingers—"Anthem had worn the Dardingers down as surely as the cancer had. Like the cancer, Anthem relentlessly followed its own course, uncaring, oblivious to what it destroyed, seeking only to have its own way."

That is from the court decision.

Now, regulatory actions and jury awards do not, however, tell the whole story, since these measures consist only of instances in which insurers were caught and punished for a violation. There is no record of the silent suffering that our constituents endure without filing a complaint or a lawsuit.

Recently, however, the research arm of the California Nurses Association published results of its analysis of claims payment data maintained by the California Department of Managed Health Care. They found that claim denials by health insurers operating in Cali-

fornia averaged 21 percent in the period 2002 to June 2009. Unfortunately, we learned yesterday from another witness that there is no comprehensive national data source on all health care coverage that has been denied, substituted, or delayed.

In this absence of transparency, health insurance companies promote the public image that they encourage healthy living. All of the insurance companies here today wanted to be represented by their top doctors, known as chief medical officers. Had we allowed that, their preferred representatives would have been consistent with the public image that the companies like to project, but it would have denied the subcommittee the ability to probe how health insures really work. What is your business model?

Whether a health insurer follows a doctor's order or interferes with it by denying a pre-authorization is in large part a business decision. It is not a medical one. Financial analysts of the health insurance industry carefully chart the medical loss ratio, which you are all familiar with, the MLR, the amount of each dollar received in premiums that health insurers spend on medical expenses. Investors consider MLR to be a key indicator of an insurer's ability to control its spending on health care and thereby is a predictor of profitability.

Insurance company executives pay attention first to the concerns of Wall Street. We understand that. According to a former executive of one of the Nation's largest for-profit insurers, quote, investors want that MLR to keep shrinking. And if they see that an insurance company has not done what they think meets their expectations with the medical loss ratio, they'll punish them. I've seen a company stock price fall 20 percent in a single day, when it did not meet Wall Street's expectations with this medical loss ratio.

That's a quote.

Private health insurers have developed a sophisticated bureaucracy to find reasons to avoid paying for expensive treatment. They are developing new products, with high deductibles and copayments, so they don't have to pay the health care bills. Private health insurers refuse to abandon the practice of rescissions, in which they revoke a policy after receiving premium payments once large claims are filed. Over 60 percent of people who entered bankruptcy due to medical costs that caused them to become insolvent had private insurance at the start of the illness.

Finally, private health insurers are insuring fewer people and earning higher profits by avoiding providing coverage to people who get very sick and have very high medical bills. That is what Wall Street wants to see; and today, thankfully, we have before us senior executives from the six largest private insurers in the Nation who are here to explain to this committee and to Congress how you can reconcile the demands of Wall Street—which are quite significant and severe sometimes—the demands of Wall Street with the health care needs of your policyholders. That is what we are going to be exploring today.

So, with that, I am going to recognize the distinguished ranking member of the subcommittee, Mr. Jordan of Ohio.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Opening Statement of
Dennis J. Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee

Hearing entitled: "Between You and Your Doctor: the Private Health Insurance Bureaucracy" Part II

September 17, 2009

Yesterday, this Subcommittee received testimony from the daughter of a man whose bone marrow transplant was delayed by 126 agonizing days, while authorizations from his insurer were denied and sustained on appeal. She asks: "Would there have been a different end to my dad's story if he had been given approval of the first transplant request in April 2006? Would he be alive today? We don't know. What we do know is that his chance for survival most assuredly did not increase because…[his insurer] built the bureaucratic roadblocks that changed the course of my father's treatment and made him wait for his potentially life-saving bone marrow transplant."

We heard from the father of a two year old who was born with a severe cognitive disorder. He has had to struggle to get the coverage his premiums pay for. Recounting the toll on his family that the repeated delays and denials of care for his daughter caused by his health insurer, he stated: "The stress of constantly having to hold the HMO and their agents to their agreed upon obligations has relegated me to the role of my daughter's care manager, and all too often robbed me of my role as Sidney's loving daddy."

The experiences of these individuals are the tip of an iceberg. Court and state regulatory records are replete with recent findings of wrongful denial and delay of health care by private health insurance bureaucrats. Hundreds of thousands of people have been wrongly denied health care coverage, hassled with unnecessary documentation requests, underpaid claims, ripped-off by fixed databases that underpaid claims. The actions of insurance company bureaucrats in causing needless delays and denials of coverage for prescribed treatment can be as detrimental as disease itself. Such was the conclusion of the Ohio Supreme Court, when it upheld the largest jury award in Ohio's history against Anthem for denying life-saving treatment to Esther Dardinger: *"[T]hen came the bureaucracy…Anthem had worn [the Dardingers] down as surely as the cancer had. Like the cancer, Anthem relentlessly followed its own course, uncaring, oblivious to what it destroyed, seeking only to have its way."*

Regulatory actions and jury awards do not, however, tell the whole story, since these measures consist only of instances in which insurers were caught and punished for a violation. There is no record of the silent suffering that our constituents have endured

without filing a complaint or lawsuit. Recently, however, the research arm of the California Nurses Association published results of its analysis of claims payment data maintained by the California Department of Managed Health Care. They found that claims denials by health insurers operating in California averaged 21% in the period 2002 to June 2009. Unfortunately, we learned yesterday from another witness that there is no comprehensive national data source on all the health care coverage that has been denied, substituted, or delayed.

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Whether a health insurer follows a doctor's order, or interferes with it by denying a pre-authorization, is in large part a business decision, not a medical one. Financial analysts of the health insurance industry carefully chart the Medical Loss Ratio ("MLR"), the amount of each dollar received in premiums that health insurers spend on medical expenses. Investors consider MLR to be a key indicator of an insurer's ability to control its spending on health care, and thereby is a predictor of profitability. Insurance company executives pay attention first to the concerns of Wall Street. According to a former executive of one of the nation's largest for-profit insurers, "investors want that [MLR] to keep shrinking. And if they see that an insurance company has not done what they think meets their expectations with the medical loss ratio, they'll punish them. I've seen a company stock price fall 20 percent in a single day, when it did not meet Wall Street's expectations with this medical loss ratio."

Private health insurers have developed a sophisticated bureaucracy to find reasons to avoid paying for expensive treatment. They are developing new products, with high deductibles and co-payments, so they don't have to pay the health care bills. Private health insurers refuse to abandon the practice of rescissions, in which they revoke a policy after receiving premium payments, once large claims are filed. Over 60 percent of people who entered bankruptcy due to medical costs that caused them to become insolvent had private health insurance at the start of the illness.

Private health insurers are insuring fewer people and earning higher profits, by avoiding providing coverage to people who get very sick and who have very high medical bills. That's what Wall Street wants to see, and today, we have before us senior executives from the 6 largest private insurers in the nation, who are here to explain to us how they reconcile the demands of Wall Street with the health care needs of their policyholders.

Mr. JORDAN. Thank you, Mr. Chairman, for holding this hearing. I want to thank our witnesses for being here today.

Yesterday, we heard some heart-breaking stories of families dealing with severe illnesses and the mounds of paperwork they were forced to wade through when trying to get treatment. Bureaucracy, whether in government or private industry, should not be the final arbiter of health care decisions. In my opinion, those decisions should be between doctors, patients, and their families.

My constituents come into our office and say that their child got sick and their insurance got canceled. Practices like this are inexcusable. People purchase health insurance to guard against the day their child or spouse becomes gravely ill. It is precisely these instances when people most need coverage. Individuals who have acted in good faith, paid their premiums, and upheld their contractual responsibilities should, in fact, be covered and get coverage.

Last year, in the full committee, we held a hearing on improper health insurance rescissions. This was a problem in California and Connecticut. Rescissions should only occur when there is a material misrepresentation of fact or other breach of contract. It must be noted that any rescission, even when proper, leaves individuals uninsured. All stakeholders, regulators, insurers, and consumers should obviously try to prevent these occurrences.

So what can we do to make sure that all Americans have access to coverage? My friends on the other side believe that more and bigger government is the answer. I think most Americans instinctively realize that trading some challenges with private insurance for the bureaucracy of the Federal Government is certainly not the solution. Instead, we should keep what works best in the current system and try to reform what is not working.

The plan I support has four principles that I think need to be a part of any health care reform proposal: First, all Americans must have access; second, that coverage should be truly owned by the patient; third, we must improve the health care delivery structure; and, finally, any reform must attempt to rein in out-of-control costs.

As we address these challenges in our health care system, it is important that everyone has a seat at the table. I am glad that our witnesses can be here today, and I look forward to hearing their testimony.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Hon. Jim Jordan follows:]

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

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Opening Statement of Ranking Member Jim Jordan
Oversight and Government Reform Committee, Domestic Policy Subcommittee
Hearing:
"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Thursday, September 17, 2009

Mr. Chairman, thank you for holding this hearing today.

I would like to thank the witnesses for participating.

Yesterday, we heard some heart-breaking stories of families dealing with severe illnesses and the mounds of paperwork they were forced to wade through when trying to get treatment. Bureaucracy, whether in government or private industry, should not be the final arbiter of health care decisions. In my opinion, these decisions should be between doctors, patients, and their families.

I have had constituents come into my office and say that their child got sick and their insurance got cancelled. Practices like this are inexcusable. People purchase health insurance to guard against the day their child or spouse becomes gravely ill. It is precisely these instances when people most need the coverage. Individuals who have acted in good faith, paid their premiums, and upheld their contractual responsibilities should be covered.

These cancellations, as you know, are referred to as rescissions. Last year, in the full Committee we held a hearing on improper health insurance rescissions. This was a real problem in California and Connecticut. Rescissions should only occur when there is a material misrepresentation of fact or other breach of contract. It must be noted that any rescission, even when proper, leaves individuals uninsured. All stakeholders, regulators, insurers, and consumers should strive to prevent these occurrences.

So, what can we do to make sure that all Americans have access to coverage? My friends on the other side believe that more and bigger government is the answer. I think that most Americans, like me, instinctively realize that trading some challenges with insurance companies for the bureaucracy of the federal government is not the solution. Instead, we should keep what works best in the current system and reform what is broken.

The plan I support has four principles that I think need to be part of any health care reform proposal. First, all Americans must have access to health care coverage. Second, that coverage should be truly owned by the patient. Third, we must improve the health care delivery structure. Finally, any reform must rein in out-of-control costs.

As we address the challenges in our health care system, it is important that everyone has a seat at the table. I am glad that our witnesses can be here today and I look forward to hearing your testimony.

Mr. KUCINICH. I want to thank my colleague from Ohio. We have a bipartisan effort here on these committee hearings; and I have always appreciated his perspective and also the fact that you sometimes offer a contrary point of view, which is needed to get to the truth. So thank you.

We have the privilege of having the chairman of the full committee here, and I am sure all Members would agree that it is our responsibility when the chairman of the full committee shows up to provide the chairman of the full committee with an opportunity to be recognized. So at this time I want to thank Mr. Towns for the support that he has given this subcommittee in our effort to get to the bottom of some of these serious health care issues and thank you for your support on the whole range of concerns that the American people have.

The Chair recognizes the chairman of the full committee, Mr. Towns of New York.

Mr. TOWNS. Thank you very much. I would like to thank you, Chairman Kucinich and Ranking Member Jordan, for holding this important hearing on unfair practices engaged in by private health insurance carriers.

And let me begin by saying I agree with President Obama's statement last week to the joint session that private, for-profit health insurance companies perform valuable services to their subscribers and our Nation. However, President Obama rightly called for health care reform legislation that, No. 1, ends discrimination against people with pre-existing conditions; limits discrimination because of age and gender, so that seniors and women will pay the same coverage as others; prevents insurance companies from dropping coverage when people are sick and need it most; caps out-of-pocket expenses so people do not become broke when they become sick; and eliminates additional charges for preventative care such as mammograms.

In many States, insurance companies can simply cancel a person's insurance if any existing medical condition is not listed on the application, and this can happen whether the person is even aware of the condition or not. We hear repeated reports that insurance companies limit benefits, simply drop or deny coverage for high-risk patients whose claims eat into the carrier's profits, and purge small businesses with high claims. Carriers are doing this at the same time that their executives are receiving millions and millions of dollars compensation packages.

Businesses cannot provide their employees with coverage due to their own eagerness to make a profit. On the other hand, patients are afraid to disclose health conditions and might even be forced to lie in order to receive medical treatment. Some patients suffer greatly as their health declines without necessary medical treatment. These insurance carriers' practices are unacceptable and must be reformed.

I believe insurance carriers must be held accountable. If a company sells insurance, it must provide insurance coverage. When claims are made in that regard, it is essential that Congress enact health care legislation that includes provisions designed to ensure accountability and strong enforcement.

Mr. Chairman, I applaud you and Mr. Jordan for the work that you are doing and the members of the committee, but I want you to know that we have a lot of work to do because as we look and we see in terms of what people are going through, that we must reform it and we must reform it in a positive way.

On that note, I yield back the balance of my time.

Mr. KUCINICH. I thank Chairman Towns.

The Chair recognizes Mr. Foster, who was here even before anybody else.

Mr. FOSTER. I yield back.

Mr. KUCINICH. OK. We will go to Mr. Cummings then.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. And, Mr. Chairman, thank you again for holding this hearing; and I want to thank our panelists for being here this afternoon.

Yesterday, we heard chilling testimony, shocking to the conscience—and, to be frank with you, after hearing that testimony, it was very difficult for me to sleep—about what insurance companies do to regular, everyday people like the people that I represent.

We heard from a Mr. Potter, Wendell Potter, and let me just give you some of the words that he said.

He said, "For weeks now we've been hearing industry executives saying the same things and making the same assurances; and I am sure you will hear the same refrain tomorrow. This time, though, the industry is bigger, richer, and stronger; and it has a much tighter grip on our health care system than ever before."

"In the 15 years since the insurance companies killed the Clinton plan, the industry has consolidated to the point that it is now dominated by a cartel of large, for-profit insurers. The average family doesn't even understand how Wall Street dictates determine whether they will be offered coverage and whether they can keep it and how much they will be charged for it. But in fact Wall Street plays a powerful role. The top priority of for-profit companies is to drive up the value of their stock. Stocks fluctuate based on companies' quarterly reports, which are discussed every 3 months in conference calls with investors and analysts."

"On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical loss ratio, or medical benefit ratio as some companies now call it. That is a ratio between what the company actually pays out in claims and what is left over to cover sales, marketing, underwriting, and other administrative expenses and, of course, profits."

And I will end it there.

Basically, what they were telling us is that too many people are paying loyally, year after year after year, but when they want the insurance company to pay, the insurance companies quite often slap them in the face and say, no, we are going to give you a rescission. We are going to find a pre-existing condition so we can save money.

But one of the things that was most chilling was the testimony that came when they told us that, quite often, these panels in the insurance companies get together and they wait out people while they are sick. They wait out while they are trying to get a decision; and, quite often, they wait so they can die. That is what we heard in here yesterday.

And I said to them at that time that if that is the case then that is fraud, and it is criminal, and we as a country can do better than that.

So I look forward to the testimony, Mr. Chairman; and, with that, I yield back.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes Mr. Tierney of Massachusetts.

Mr. TIERNEY. Thank you, Mr. Chairman.

I don't intend to take my full 5 minutes except to note that you have all heard a little bit about the testimony we have been hearing from individuals, and I hope you take a moment rather than to read any pro forma statements that you may have made to address the particular issues like the medical loss ratio.

Can you explain how it is as medical costs rise faster than inflation companies still manage to keep the same ratio—medical loss ratio? Meaning they are putting less money into actual medical care and more money into profits, into salaries for executives, and into underwriting?

And when it gets to underwriting, I think we would like to hear a little bit about why it is that other executives from firms like yours came before Congress and said that they would not do away with such practices like rescission, where somebody is ill and getting treatment only to find out the company then reaches back and tells them they are disqualified for some reason or why it is that you won't stop the practice of pre-existing conditions unless you are regulated to do it or why it is you continue to put caps on coverage.

It is all those reasons and things that lead this Congress to think that the only protection we can have for consumers is to put up a viable competitor against your companies to make them behave, make them come back and do more for consumers and less for their own self-interests and Wall Street's self-interest.

I see and we heard testimony yesterday about all sorts of new plans that you have coming out, voluntary benefits, limited medical benefits. And the voluntary usually means that employees are going to pay 100 percent of the premiums and that really the employers pay nothing, while limited benefit plans mean that they are providing limited coverage, maybe prescription drugs or maybe some lab work and X-rays, maybe through doctors' visits, but essentially the premiums are again paid entirely for by the employees. Those monthly premiums are usually 30 to 50 percent less than major medical plans, and the employees get left holding the bag because they are not really covered at the end.

I know some of your companies are sponsoring a medical conference in Los Angeles next month promoting those types of plans. I want you to address for us how you think that is that will help small businesses. You say that they are doing it because you can't afford it, when in fact you are the ones who set the rates. You determine how high you are going to raise the premiums on other policies, driving them into policies like this for the small business employees.

My small businesses aren't impressed with it, and they don't want to go in that direction. They want their employees to have good, solid coverage.

So I hope you answer all of those questions, and I look forward to your testimony and maybe discussion afterwards of I think the sorry direction that we are going in the private health care industry, and maybe you can convince us why it is not essential that we do something in terms of regulation and competition to put a stop to those practices which really haven't shown or reflected well on your industry.

I yield back. Thank you, Mr. Chairman.

Mr. KUCINICH. If there are no further opening statements, we will proceed to receive testimony from the witnesses before us today.

I want to start by introducing our first panel:

Mr. Richard Collins, welcome, Mr. Collins.

Mr. Collins is the senior vice president of Underwriting, Pricing, and Healthcare Economics at UnitedHealthcare Group. He also serves as CEO of Golden Rule Insurance Co. and president of UnitedHealthOne, UnitedHealthcare's individual line of business. He has served in this capacity since July 2005. Mr. Collins also manages the individual business of American Medical Security Life Insurance Co. and PacifiCare.

Next, Mr. Brian Sassi, welcome. Thank you for being here.

Mr. Sassi is president and CEO of the Consumer Business unit for WellPoint, Inc. Mr. Sassi is responsible for the company's seniors, State-sponsored, and individual under 65 businesses. Previously, Mr. Sassi was president of Blue Cross of California and chief executive officer of its life and health affiliate. He also served as vice president of Operations and Strategic Initiatives for Blue Cross of California and general manager of Small Group Accounts for the west region for WellPoint, Inc., the parent company of Blue Cross of California. Thank you.

Ms. Patricia A. Farrell. Welcome, Ms. Farrell.

Ms. Farrell is senior vice president of National and International Business Solutions for Aetna, Inc., leading divisions which provide health insurance for the Federal Government, TRICARE and State Medicaid programs and other businesses in the United States and abroad. Previously, she was the senior vice president of Aetna Specialty Products and Medicaid. This included Aetna dental, life, disability, long-term care, and voluntary products, and Aetna's Medicaid and children health insurance program business. Ms. Farrell has also served as senior vice president for Strategic Planning.

Mr. James H. Bloem—is that correct? The pronunciation?

Mr. BLOEM. Bloem.

Mr. KUCINICH. Mr. James H. Bloem.

Mr. Bloem is senior vice president, chief financial officer and treasurer for Humana, Inc. He has primary responsibility to supervise all accounting, actuarial, analytical, financial, tax, risk management, treasury, and investor relations activities for that company. Thank you for being here.

Mr. Thomas Richards. Appreciate your attendance here, Mr. Richards.

Mr. Richards is senior vice president for Product Management and New Product Development for CIGNA Healthcare and CIGNA's Choice Link subsidiary, which provides customer benefits and online enrollment. Previously, Mr. Richards ran CIGNA's stop

loss business, which provides reinsurance to middle market and national segment customers. During his career, Mr. Richards has held a variety of product positions in CIGNA Healthcare, including in CIGNA Healthcare's marketing department, where he helped design and bring to market preferred provider organization products and networks.

And, finally, Ms. Colleen Reitan.

Ms. REITAN. Reitan.

Mr. KUCINICH. Reitan. Ms. Reitan is executive vice president and chief operating officer of Health Care Service Corp., where she is responsible for its internal operations, as well as numerous divisions of the company, including subscriber services, government services, enterprise information, strategy and management financial services, among others. Previously, Ms. Reitan was president and chief operating office of Blue Cross Blue Shield of Minnesota, 20 years of experience in the health insurance field. She was also the co-creator of the Minnesota Health Information Exchange, a national model for sharing electronic health information.

I want to thank you, Ms. Reitan, for appearing, and I want to a thank all the witnesses for appearing before our subcommittee today.

I have to say, in just these first few minutes, in looking out at you and looking at your accomplishments in the insurance industry, this hearing is not and any of the questions that are asked, this isn't about anything personal. We respect who you are. But the institutions that you represent are here to be questioned today and challenged today, and we are going to need your cooperation in understanding your business model.

With that, I will proceed to the swearing in. It is the policy of the Committee on Oversight and Government Reform to swear in all witnesses before they testify. I would ask that you please rise, each of the witnesses, and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that each of the witnesses stood, raised their right hand and answered in the affirmative.

You may be seated.

Mr. CUMMINGS. Mr. Chairman.

Mr. KUCINICH. Yes, Mr. Cummings.

Mr. CUMMINGS. Mr. Chairman, just a point of information. Mr. Chairman, you just swore in the witnesses. Should a witness fail to be truthful with this committee, is there a penalty connected with that?

Mr. KUCINICH. Staff attorneys have just handed this to me. This is pretty pro forma for any congressional hearing where witnesses testify and swear under oath. There are two sections covered.

One is 18 U.S.C., section 1001, which relates to knowingly and willfully falsifying any statement. There are provisions in this for penalties that include fine and imprisonment.

There is another section that I was given, 2 U.S.C., section 194, that relates to congressional and committee procedure. If anyone fails to answer any pertinent question, we would have to, according to this, certify through the House of Representatives the facts as we see them to the U.S. attorney's office.

So, you know, it is a standard operating procedure in this committee, Mr. Cummings, that you know we expect witnesses to tell the truth, but, if they don't, there are penalties under law.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. KUCINICH. Let's go to opening statements.

Mr. Collins, you may begin with your opening statement. Thank you. And make sure that mic is close so we can hear what you have to say.

STATEMENTS OF RICHARD A. COLLINS, SENIOR VICE PRESIDENT OF UNDERWRITING, PRICING, AND HEALTHCARE ECONOMICS, UNITEDHEALTHCARE GROUP, CEO, GOLDEN RULE INSURANCE CO., PRESIDENT, UNITEDHEALTHONE; BRIAN A. SASSI, PRESIDENT AND CEO, CONSUMER BUSINESS, WELLPOINT, INC.; PATRICIA FARRELL, SENIOR VICE PRESIDENT, NATIONAL AND INTERNATIONAL BUSINESS SOLUTIONS, AETNA, INC.; JAMES H. BLOEM, SENIOR VICE PRESIDENT, CHIEF FINANCIAL OFFICER, AND TREASURER, HUMANA, INC.; THOMAS RICHARDS, SENIOR VICE PRESIDENT OF PRODUCT, CIGNA HEALTHCARE; AND COLLEEN REITAN, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, HEALTH CARE SERVICE CORP.

STATEMENT OF RICHARD A. COLLINS

Mr. COLLINS. Thank you.

Chairman Kucinich, Ranking Member Jordan and members of the subcommittee, my name is Richard Collins. I'm the head of underwriting, pricing, and health care economics for UnitedHealthcare. I am also the CEO of Golden Rule Insurance Co., a UnitedHealth Group company that provides individual health insurance to individuals and their families.

Today, I will start with some relevant facts about UnitedHealth Group, our industry, and try to demonstrate how we are improving the quality of health care while reducing costs and streamlining administration.

First, UnitedHealth Group provides high-quality health services and products for more than 70 million people in partnership with 5,000 doctors—5,000 hospitals and 600,000 doctors across all 50 States.

Second, we employ 75,000 committed and dedicated men and women. These people work hard to improve the health care and well-being of our health plan members.

Third, we have prudently managed our finances during these challenging economic times and can back the promises that we make to our stakeholders.

Fourth, our industry is already one of the most highly regulated in the United States. UnitedHealth Group has long advocated for comprehensive, bipartisan health care reform. We have proposed constructive changes that would ensure rates do not vary because of health status and gender and will guarantee coverage regardless of pre-existing conditions for those that maintain continuous coverage. These reforms would also require that individuals obtain and maintain health insurance coverage so that everyone participates in both the benefits and the costs of the system.

Discussions of administration processes and health begin with benefits of a strong provider network. Our members receive great value from our extensive network, which includes more than 85 percent of the physicians and hospitals in the United States.

We perform periodic credential reviews to make sure that network physicians and hospitals continue to meet standards of quality. Our members receive negotiated savings and discounts when they are cared for by one of our contracted providers. A key element to the success of this network is health information technology that we use to increase the speed and accuracy of claim processing.

We pay more than 250 million claims annually, and more than 95 percent are processed on our primary commercial platforms within 10 days. In fact, over 80 percent are processed automatically.

Across our entire business, we have identified 100,000 physicians through our premium designation program that consistently deliver quality in accordance with evidence-based standards, and they do so at costs 10 to 20 percent below their peers. These physicians use data, efficient practice management, and evidence-based medicine to guide and consistently improve patient care.

This network system extends to doctors and hospitals that are best at managing complex medical conditions such as organ transplants, cancer, and congenital heart disease. This helps the sickest patients receive the best possible care, often resulting in better outcomes and often at prices with savings as much as 60 percent.

Partnerships with physicians and hospitals are critical to streamlining administrative processes and providing greater value to our members. To that end, we have established two national and numerous local physician advisory committees. They provide us with feedback and help us ensure that we maximize the health care quality and minimize the administrative burden.

We're also introducing innovative and practical tools that allow doctors and nurses and other health care providers to spend more time with their patients and less on paperwork. For instance, our eSync program synchronizes a person's medical history to help identify gaps in care that they should be receiving. Electronic medical records and e-prescribing technology help physicians practice better medicine through clinical decision support and reduce administrative costs through automation and Web-based transactions.

In conclusion, UnitedHealth Group provides critical services and support at every point in the health care delivery system. We are privileged to serve our members and take seriously our responsibilities to serve Americans in this socially sensitive area of health care. Through innovative technology and programs, as well as close collaboration with the provider community, we are successfully improving quality, reducing costs, and making the administration of health care more efficient.

Thank you, Mr. Chairman.

Mr. KUCINICH. Thank you, Mr. Collins.

[The prepared statement of Mr. Collins follows:]



UnitedHealth Group

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Tel 202 654 9900

Testimony of

Richard A. Collins

SVP Pricing, Underwriting, and Healthcare Economics for United Healthcare and CEO Golden Rule Insurance Company

Before the

House Oversight and Government Reform Committee

Domestic Policy Subcommittee

On

September 17, 2009

TESTIMONY OF RICHARD A. COLLINS
BEFORE THE DOMESTIC POLICY SUBCOMMITTEE OF THE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 17, 2009

Chairman Kucinich, Ranking Member Jordan and members of the subcommittee, my name is Richard Collins and I am the head of underwriting, pricing and health care economics for UnitedHealthcare, a UnitedHealth Group business that provides a full spectrum of commercial consumer-oriented health benefit plans and services to individuals, public sector employers and businesses of all sizes. I am also the CEO of Golden Rule Insurance Company, a UnitedHealth Group business that provides health insurance policies to individuals and their families.

In my remarks today, I will reaffirm UnitedHealth Group's commitment to achieving comprehensive, bipartisan health reform that carefully balances the needs of all our stakeholders. In addition, I will describe for you how we are working – in partnership with physicians and hospitals – to streamline administrative processes, improve efficiency, reduce costs and enhance care.

Let me open my statement by providing the subcommittee with key facts about UnitedHealth Group and our industry. This information is important because it sometimes gets lost amidst the heated rhetoric of the health care policy debate.

- First, UnitedHealth Group provides high-quality health services and products to more than 70 million people each year in partnership with 5,000 hospitals and 600,000 doctors and thousands of other care providers across all 50 states.

- Second, we employ approximately 75,000 good, hard-working Americans. These people care about and work hard to improve the health and well-being of our

health plan members. So, too, do the employees of health insurance companies across America.

- Third, we are a financially stable company that has carefully managed our balance sheet during challenging economic times. We satisfy solvency, liquidity and capital requirements imposed by our regulators.

- Fourth, our industry is one of the most highly regulated in the United States.

Our company has long advocated that our country needs comprehensive health reform. To us, true reform includes modernizing the delivery system, tackling the fundamental drivers of health care cost growth, strengthening employer-based coverage, and providing support for low-income families. We are committed to health care reform that builds on what is working in the current health care system and fixes what is broken.

These fundamental elements of reform should be pursued alongside the constructive changes to the individual insurance market that we and our industry partners have proposed. These changes would ensure rates would not vary because of health status or gender, and would guarantee coverage regardless of preexisting conditions for those who maintain continuous coverage. They would also require that individuals obtain and maintain health coverage so that everyone participates in both the benefits and the costs of the system.

Discussion of administrative processes in health care begins with the benefits of a strong provider network. UnitedHealth Group has built the largest network of physicians, hospitals and caregivers in the country, providing broad access to cost-effective, quality health care for our members. We contract with more than 85 percent of the physicians in the U.S. and more than 85 percent of the hospitals.

Our members receive great value from our extensive network. We perform periodic credential reviews to make sure our network physicians and hospitals continue to meet

our standards for quality. Members receive negotiated savings when they are cared for by one of our contracted providers. Our members are not balance billed for in-network services after satisfaction of any co-payment obligations. In summary, we improve access to care by providing a broad, quality network and substantial savings over typical billed charges.

A key element to the success of this network is the health information technology we use to increase the speed and accuracy of claims adjudication. We pay more than 250 million claims annually. Over 80 percent are processed automatically and more than 95 percent are processed within 10 days on our primary commercial platform.

Across our entire business, we have identified 100,000 physicians in 132 cities and 21 medical specialties who consistently deliver quality in accordance with industry evidence-based standards, while doing so at costs 10 to 20 percent below their peers. This is our Premium designation program. These physicians use data, efficient practice management, and evidence-based medicine to guide and consistently improve patient care – and these physicians see more patient volume as consumers begin to compare quality and cost. We make it easy for our members to find and access these physicians. In fact, some of our plans reward members for using Premium designated physicians. And certain medical practices and physicians who qualify are rewarded with enhanced fees.

This system extends to facilities in our network for managing complex medical conditions, such as organ transplants, cancer and congenital heart disease. These Centers of Excellence deliver better treatment outcomes for complex courses of care and at the same time produce significant savings, sometimes as high as 60 percent.

Partnerships with physicians and hospitals are critical to streamlining administrative processes and providing greater value to our members. To that end, we have convened a national Physician Advisory Committee and a Physician Administrative Advisory Committee comprised of physician and practice manager representatives from across our

network. The committees provide us with in-depth feedback about our programs and help ensure that we maximize health care quality and minimize administrative burden on a physician's practice. In addition, we have established local Physician Advisory Committees across the country.

We also are introducing innovative and practical tools that allow doctors, nurses and other health care providers to spend more time with their patients and less on paperwork. For instance, UnitedHealth's proprietary technology platform, called eSync, synchronizes a person's medical history, medical and pharmacy claims, self-reported data and life-stage demographics in order to help identify gaps in the care they should be receiving. With a patient's permission, the program is shared with physicians to give them a more comprehensive view of an individual's health, and therefore more personalized health care. Other examples include our provision of electronic medical records and e-prescribing technology that help physicians practice better medicine through clinical decision support, and reduce administrative costs through automation and web-based transactions.

We also create innovative products, services and technology that provide consumers with the information, choices and incentives to actively participate in their own care and that encourage them to comply with routine preventive measures recommended by their physicians. For example, our Diabetes Health Plan guides people with diabetes to physicians with documented success in treatment, educates patients on the importance of routine care, and offers incentives for compliance with preventive care guidelines. The direct and indirect costs of diabetes in health care and lost productivity are more than $170 billion annually.

In conclusion, UnitedHealth Group provides critical services and support at every point of the health care delivery system. Our advanced technology is making administration of health care simpler, easier and more cost-effective for patients, providers and the entire health care community. We are working to improve the quality of care as we reduce health care costs, making health care more affordable for more people. We are focused

on serving the needs of patients, consumers, physicians and other health care providers, employers, and government programs – everyone in the health care community we touch and who touch us.

Thank you.

Mr. KUCINICH. Mr. Sassi, you're recognized for 5 minutes. You may proceed. Make sure you bring that mic close enough.

STATEMENT OF BRIAN A. SASSI

Mr. SASSI. Thank you, Chairman Kucinich, Ranking Member Jordan, and members of the subcommittee for allowing me to testify before you today. I'm Brian Sassi, president and CEO of the consumer division of WellPoint.

WellPoint provides insurance and health benefits to 35 million people across the country, representing almost one in nine Americans. We recognize we have the ability to help change health care for the better; and with this ability comes a responsibility to our members and to all Americans to advance health care quality, safety, and affordability.

I look forward to discussing how WellPoint helps create health care value for our customers. At WellPoint, we develop evidence-based medical policy based on the latest clinical research. Our nurses and other health care professionals support our members to ensure that care is safe, necessary, and timely. And looking to the future, we continue to explore new ways to reward value over volume and stress safety, efficiency, and patient satisfaction.

One of the areas under discussion in the current health care reform debate is health plan administrative costs. Last year, PricewaterhouseCoopers conducted an analysis of how the typical health insurance premium dollar is spent. My written testimony includes a chart that shows that 87 cents of every premium dollar is paid out to cover the cost of health care claims. Of the remaining 13 cents, 6 cents goes toward taxes, other government payments, claims processing, and other administrative costs. Four cents go to consumer services such as care coordination, disease prevention, chronic care management, provider support, and marketing. And only three cents of premium dollars remains for profit or surplus.

I understand the subcommittee is interested in knowing how we determine medical policy and how our medical policy relates to how we process our members' health care claims. Our medical policies reflect input from premier academic institutions and experts within the medical profession, as well as considering the standards of care within our local communities. These medical policies are available online to all providers and to the public at large.

Last year, WellPoint received 380 million claims; and we processed 97 percent of those in 30 days.

The subcommittee's letter asked for some information on deferral of claims. I should note that we do not defer claims. What happens sometime is that claims are pending as we await additional information or conduct additional reviews. Some common reasons for pending claims are that premiums have not been paid; the claim is incomplete, such as missing diagnosis codes; or when members have health coverage—other health coverage that may be primary.

The subcommittee's letter also asked about administrative costs. Our administrative costs include a variety of initiatives designed to promote the health and well-being of our members. For instance, WellPoint employs thousands of health professionals, including nurses, dieticians, social workers, and pharmacists, among others. These professionals speak with thousands of members each day,

encouraging them to learn more about their conditions and how they can better manage their care. Our health professionals help members schedule the necessary followup care and specialist care, remind them to pick up important prescriptions, and serve as a valuable resource to our members, 24 hours a day, 7 days a week.

Another example of our clinical—is our clinical research subsidiary, HealthCore, which has produced noteworthy studies on best practices for treating low back pain, high cholesterol, asthma, to name just a few. We take these recommendations and share them with physicians to help them improve our members' health. HealthCore also works with the FDA and the CDC to improve drug and vaccine safety and has created a sentinel system that helps these agencies monitor emerging drug safety issues in real time.

My written testimony includes more detail of these types of initiatives, which are typically not included in government-run programs. Efforts like these, funded out of our administrative expenses, are critical to our ability to follow through on our primary commitment, which is to improve the lives of the people we serve and the health of our communities.

In closing, I would like to assure the subcommittee that WellPoint supports responsible health care reform, but reform must go beyond the insurance marketplace to address system-wide challenges and associated costs. Changing how we finance health care without changing how we deliver health care would be incomplete reform at best.

I appreciate the opportunity to testify before you today and to respond to your questions.

Mr. KUCINICH. Thank you, Mr. Sassi.

[The prepared statement of Mr. Sassi follows:]

TESTIMONY

Enabling Health Care Quality, Safety and Affordability

Brian Sassi
Executive Vice President and Chief Executive Officer, Consumer Business Unit
WellPoint, Inc.

Testimony presented before
the Domestic Policy Subcommittee of the Committee for Oversight and Government Reform

September 17, 2009

WELLPOINT

INTRODUCTION

Thank you, Chairman Kucinich and members of the subcommittee for inviting me to testify today. I am Brian Sassi, president and CEO of the Consumer Business Unit for WellPoint, Inc., and it is an honor to appear before you to discuss how WellPoint is advancing health care quality and safety in the United States. WellPoint provides health benefits to nearly 35 million members across the country, representing nearly one in every nine Americans. Our subsidiary companies serve an additional 30 million individuals in the United States through programs and services including life and disability insurance benefits; pharmacy benefit management; dental, vision, and behavioral health benefit services; long-term care insurance; and flexible spending accounts. We also serve 22 million Medicare beneficiaries in 26 states as a Medicare administrative contractor through our National Government Services subsidiary.

We recognize that with the largest membership of any private insurer, we have the ability to change health care for the better. We also recognize that, with this ability, we have a responsibility to our members and to all Americans to advance health care quality, safety, and affordability, and to invest in innovative solutions to address the persistent health problems our country faces today and anticipate the challenges of the future. As a family of primarily Blue Cross or Blue Cross Blue Shield plans, WellPoint has decades of experience in our local markets and communities from California to Maine. We believe this blend of national scope and local depth is a unique and powerful combination that contributes greatly to our ability to improve the quality and value of our members' health coverage.

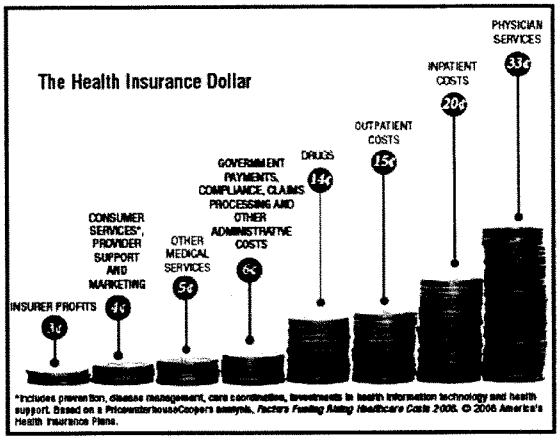
I look forward to discussing how WellPoint helps create the best health care value for our customers. The renewed debate over health care reform has provided us today with an opportunity to discuss how managed care has evolved over the past decade. At WellPoint, we are proud of how we develop medical policy to try to help physicians keep current on what works in health care. We are proud of how our nurses and other health professionals support our members to ensure their care is safe, necessary, and timely. And looking to the future, we continue to explore new payment models that reward value over volume and that stress safety, efficiency, and patient satisfaction.

Where Premium Dollars Go

The operating expenses of health plans have received much attention over the past several months. To help inform the debate, America's Health Insurance Plans (AHIP) commissioned PricewaterhouseCoopers (PwC) to conduct an analysis last year, breaking down how a dollar of health insurance premiums is spent. PwC's study shows that 87 cents of every premium dollar is paid out to cover the costs of health care services and products.

Of the remaining 13 cents of the premium dollar:

- 6 cents go toward taxes, other government payments, claims processing and other administrative costs;
- 4 cents go to consumer services (including prevention, disease management, care coordination, and investments in health information technology and health support), provider support and marketing; and
- 3 cents go to profits.



How We Develop Medical Policy

At WellPoint, our technology assessment and clinical reviews are the foundation for clinical decision making and address all medical procedures, devices, genetic testing, and specialty pharmaceuticals. Our medical policy development process involves input from premier academic institutions, expert physician representation from 33 medical specialty societies, and consideration of the standards of care in our communities. We follow guidelines set forth in federal publications such as "The Guide to Clinical Preventive Services," as published by HHS and the Agency for Healthcare Research and Quality; the Advisory Committee on Immunization Practices (ACIP) and those established by groups such as the American Heart Association, the National Comprehensive Cancer Network; and the American College of Cardiology. The Medical Policy and Technology Assessment Committee and its subcommittees in behavioral health and hematology and oncology meet at least quarterly, and more often as necessary, to review emerging clinical research that is published or presented at national meetings. Our medical policy decisions are extensively researched, and vetted externally to ensure the most comprehensive and clinically informed policies possible.

Our medical policies are available online to all network physicians. The policies include background and coding guidelines, as well extensive discussion on the rationale upon which they are based. The policies contain detailed references to the peer-reviewed journals and other authoritative publications used in making the medical policy determination, as well as a complete chronological revision history, so that physicians may view the progression of how and why the policy became what it is today.

How We Process Claims

Last year, WellPoint received 380 million claims and processed 97 percent of them within 30 days. We do not "defer" the remaining 3 percent of those claims, but sometimes we "pend" claims as we await additional information from the provider or patient or as we determine whether our coverage determination is consistent with the member's policy. Once we receive the necessary information, the claim will either be approved or denied – again, consistent with the member's policy.

Earlier this month, a nurses' organization in California issued a report suggesting that managed-care companies in California, such as our Anthem Blue Cross subsidiary, rejected more than 20 percent of the claims we received in the first half of 2009. However, the data that organization relied upon for its report came from a regulatory filing that requires a count of all claims that may not initially be paid by a health plan for *any* reason. Some common examples of these claims are:

- claims for people who are not our members;
- claims within the member's policy deductible;
- claims that have already been paid by other health plans;
- claims not paid because the same claim was submitted multiple times; and
- claims returned to a provider because necessary information was missing or incorrect.

Once we received the necessary information to resolve the claims in question, our Anthem Blue Cross subsidiary in California ultimately denied less than 3 percent of the claims received during the first half of 2009. To provide further context, we denied less than than one-half of one percent (<0.5%) of the total number of claims received on the basis that our medical personnel determined the services were not medically necessary for the member.

How Our Operating Expenses Improve the Quality, Safety and Efficiency of Care

We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which in turn can help manage costs. There are many opportunities to improve health care in this country, as we are far from having a system that provides the right care at the right place at the right time. Building on the following four principles, WellPoint has identified solutions that will help deliver better health care while helping to reduce costs:

- Promote evidence-based medicine and determine real-world outcomes
- Align payment incentives for improved health outcomes
- Focus on prevention and managing of chronic illness
- Promote safety and efficiency through the adoption of health information technology

I'd like to offer examples of how we follow through on each of these principles:

- ***Promote Evidence Based Medicine & Determine Real-World Outcomes***

  At WellPoint, we believe it is important that we continuously monitor and evaluate the effectiveness of treatments, procedures, therapies and pharmaceuticals to identify, minimize, and/or eliminate quality gaps. WellPoint's clinical research subsidiary, HealthCore, Inc., performs clinical outcomes and comparative effectiveness research to determine what works in health care and advance high-quality, cost-effective care. HealthCore studies use clinical, laboratory, and drug information to determine how therapies, treatments, and pharmaceuticals work in the real world, outside of the compliance-guaranteed clinical trial environment.

  For instance, nine of ten Americans experience back pain at least once in their lifetime, and $90 billion is spent nationally on back pain treatment annually. Additionally, low back pain is the number-one cause of lost productivity among our employer groups. Although clinical studies have shown that most back pain resolves within six weeks without invasive treatment, our analysis revealed more than 20 percent of those studied underwent unnecessary imaging tests and nearly 1,000 of our members underwent inappropriate and expensive back surgery less than six weeks after diagnosis. We recognize some back pain sufferers may indeed require imaging or surgery, and as a result, we implemented a program to educate members and physicians on clinically comparable and appropriate alternative treatment options, including pharmaceutical pain management, physical therapy, or rest during the first six weeks of experiencing back pain.

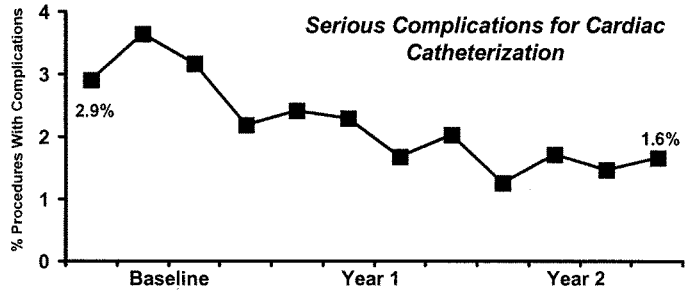
- ***Align Payment Incentives for Improved Health Outcomes***

  The current health care system is designed to reward quantity over quality, and volume over value. Although we know some care is unnecessary and potentially harmful, we also recognize that sometimes, the "right care" is more care or different care. We have implemented clinical programs to enable better-informed physician-patient decision-making that reflects evidence-based medicine and the unique health and financial characteristics of each member treated.

  For example, we work hand-in-hand with medical specialty societies to develop consistent, meaningful performance metrics and reward physicians and hospitals for improved patient outcomes, compliance with recommended care guidelines, use of health information technology, and patient satisfaction. These incentives represent true, tangible health improvement results, as demonstrated by a five percent improvement over the national average for door-to-balloon time for heart attacks[1] and

[1] Internal analysis; validated by actuary. Note: Hospital performance payment program as applied to American College of Cardiology National Cardiovascular Data Registry (NCDR)® outcomes

a reduction in serious complications for cardiac catheterizations in our Virginia hospital quality program.[2]



- ***Focus on Prevention and Managing Chronic Illness***

Chronic illness, such as diabetes, asthma, and heart disease is our country's number one public health issue, affecting nearly half of all Americans. Staggering cost estimates of the hundreds of billions of dollars associated with chronic illness do not even include the indirect costs due to lost productivity in American industry.

Yet, we also know, through research by RAND and others, that existing, proven, and established guidelines are only followed 55 percent of the time[3]. Recent studies of our most vulnerable populations suggest that 35 percent of recommended screenings and preventive care are not delivered to our elderly Medicare and Medicaid population,[4] and only 41 percent of recommended preventive care is delivered to children. [5] Variation even exists among our country's leading academic institutions, where Wennberg demonstrated a 300 percent variation in hospital days and use of clinical procedures during the last six months of life. [6] Finally, we know that there is often no correlation between cost and quality and that actually an inverse relationship may exist,

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[2] See Note 12 above

[3] McGlynn, E.A, S.M. Asch, J. Adams et. al. 2003. *The Quality of Health Care Delivered to Adults in the United States*. NEJM 348 (26): 2635-45

[4] Zingmond, D. S.; Wilber, K.H.; MacLean, C.H.; Wenger, N.S. 2007 *Measuring the Quality of Care Provided to Community Dwelling Vulnerable Elders Dually Enrolled in Medicare and Medicaid. Medical Care*. 45(10):931-938, October 2007;

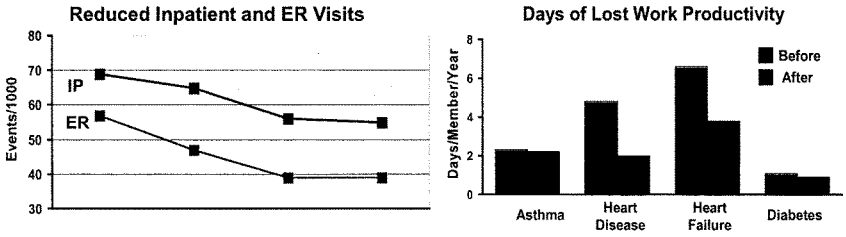
[5] Yu, S.M., Bellamy, H.A, Kogan, M.D., Dunbar J.L., Schwalberg, R.H., Schuster, M.A. 2002. *Factors that Influence Receipt of Recommended Pediatric health and Dental Care*, Pediatrics Vol. 110 (6) December 2002, pp. e73; Mangione-Smith R, DeCristofaro AH, Setodji CM, Keesey J, Klein DJ, Adams JL, Schuster MA, McGlynn EA. *The Quality of Ambulatory Care Delivered to Children in the United States* The New England Journal of Medicine, Vol. 26, No. 5, Sept 2007, pp. 644-649

[6] John E Wennberg, Elliott S Fisher, Thérèse A Stukel, Jonathan S Skinner, Sandra M Sharp, and Kristen K Bronner; *Use of hospitals, physician visits, and hospice care during last six months of life among cohorts loyal to highly respected hospitals in the United States* BMJ 2004 328: 607; *See also*; Dartmouth Atlas

such as where the most expensive care for Medicare beneficiaries is also of the poorest quality.

At WellPoint, we know that one percent of our membership drives 25 percent of our medical costs, and five percent of our membership drives 50 percent of costs. The majority of these members are the severely chronically ill, typically those with multiple chronic conditions. Our goal is to help these members manage their conditions and prevent their illnesses from progressing to a more advanced stage.

WellPoint's 4,000 nurses, dieticians, social workers, pharmacists, exercise physiologists and respiratory therapists speak with thousands of members each day encouraging them to learn about their conditions and how they can manage them. We help members schedule necessary follow-up and specialist care, remind them to pick up important prescriptions, and serve as a real-life resource when they have questions or concerns 24 hours a day, 7 days a week.



This direct person-to-person contact has demonstrated an increase in preventive screening, improved compliance with evidence-based care and improved health outcomes for our members. For example, these programs demonstrated a 20 percent decrease in chronic condition-specific inpatient admissions and a 32 percent decrease in condition-specific emergency room visits. Additionally, employers saw a 25 percent to 50 percent reduction in days of lost work productivity[7].

- ***Promote Safety and Efficiency Through The Adoption of Health Information Technology***

Health information technology is the future of the health care system and WellPoint's administrative costs are invested in programs that create system-wide efficiency, as well as improved national public health safety, monitoring, coordination, and response.

[7] Internal analysis; validated by actuary. This example is a Health Management Corporation analysis of WLP contract accounts that would contain the average employee make-up for an employer group.

The Institute of Medicine Report "To Err is Human" estimated that at least 44,000 Americans die every year in hospitals as a result of medical errors.[8] For Medicare alone, $8.6 billion dollars can be attributed to patient safety events.[9] Adverse drugs events lead to more than 7,000 deaths, 1.5 million injuries, and 700,000 emergency room visits annually, translating to loss of life, decreased quality of life, and $77 billion in avoidable health care costs.[10] Patients who had potentially preventable adverse medical events were twice as likely to die during a readmission within 30 days following discharge and 32 percent more likely to be discharged to a long-term care facility.[11]

To respond to public demand for increased safety, WellPoint has developed the Healthcare Safety Sentinel System℠ to monitor more effectively and rapidly the safety of pharmaceuticals and other medical therapies. WellPoint's Healthcare Safety Sentinel System℠ was developed in close collaboration with leading government and academic institutions, including the FDA, and faculty from key academic institutions, including Harvard University, the University of North Carolina, and the University of Pennsylvania. The Safety Sentinel System, which will ultimately be able to monitor safety risks associated with drugs and other clinical care decisions in real-time, will also assist physicians and other health care professionals to make more informed decisions about how to treat their patients.

The Healthcare Safety Sentinel System℠ is already operational and performing work for the CDC on biologic, vaccine and human tissue product safety. It has also been selected as one of four potential technologies to serve as the foundation for the FDA Sentinel Initiative, the nation's drug safety surveillance system. The Healthcare Safety Sentinel System℠ will make it possible to examine whether particular combinations of treatments could cause serious medical problems, especially in patients with certain diseases. This critical information will allow health care decision-makers including federal agencies, physicians, consumers and manufacturers to move far more quickly than in the past in addressing potential drug risks.

CONCLUSION

In closing, I want to assure the Subcommittee that WellPoint supports responsible health care reform, but reform must go beyond the insurance marketplace to address system-wide challenges and associated costs. Changing how we finance health care without changing how we deliver health care would be incomplete reform, at best.

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[8] Institute of Medicine; Too Err Is Human: Building a Safer Health System (http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf)

[9] The Fourth Annual HealthGrades Patient Safety in American Hospitals Study (2007)

[10] See Classen DC, Pestotnik SL, Evans RS, et al. Adverse drug events in hospitalized patients. JAMA 1997;277(4):301-6.

[11] Adverse Patient Safety Events: Costs of Readmissions and Patient Outcomes Following Discharge. Bernard D, Encinosa W; AcademyHealth. Meeting (2004 : San Diego, Calif.). Abstract AcademyHealth Meet. 2004; 21: abstract no. 1908

Health plans have provided significant ideas for reform, many of which are incorporated in the legislation being considered in the House and Senate. We look forward to continuing to play a constructive role by providing members of this subcommittee and your fellow legislators with assessments of how proposals for reform would impact your constituents. We have decades of real-world experience with different reforms in various local markets that we are sharing with Congress and the Administration, so that our policymakers can make decisions the same way we make medical policy – using the best available evidence on what works best.

But as the health reform debate continues, our main focus will remain on improving the lives of the people we serve and the health of our communities. We do this every day by:

- providing clear, actionable, evidence-based messages to our members and their physicians, and by connecting our health care system through health information technology;
- encouraging an informed physician-patient dialogue regarding the risks and benefits of available treatment options and what is best for each patient;
- deploying thousands of nurses, physicians, and other health professionals to support and empower members in their own care; and
- promoting innovation through an unbiased, transparent scientific analysis of clinical research and real-world outcomes.

I appreciate the opportunity to testify before you today and to respond to your questions.

Mr. KUCINICH. The Chair recognizes Ms. Farrell. You may proceed for 5 minutes.

STATEMENT OF PATRICIA FARRELL

Ms. FARRELL. Good afternoon. My name is Pat Farrell, and I am the senior vice president at Aetna.

Aetna's one of the Nation's leading insurance companies providing medical, dental, pharmacy, disability, life insurance, and other health benefits. We provide those products and services in all 50 States, and we provide those products and services to 37 million Americans.

I'm proud to have worked at Aetna for over 20 years in a variety of capacities. On behalf of the thousands of employees at Aetna, I look forward to talking to you today about the value we bring to the health care system and in discussing Aetna's commitment to reforming the health care system.

Aetna today is a health care solutions company that helps Americans manage their health care and get the most out of their health care dollar. Since 2005, Aetna has called for major fundamental reform of the insurance market so that all Americans have guaranteed access to affordable coverage with no exclusions for pre-existing conditions. This, combined with the requirement that everyone have insurance coverage and financial assistance for those who can't afford it and who need it, will get and keep everyone covered in our system.

I expect that many of the issues we will discuss today will illustrate the need for reform. Aetna is committed to health reform that addresses access, affordability, and quality. We operate in a dynamic and highly competitive marketplace. Our business can only be successful when health care consumers are confident that we can provide the greatest value for their health care dollar and helping them improve or maintain their health care status.

Our employees come to work every day—doctors, nurses, and customer service professionals—with the same commitment, to make sure our members get the best health care coverage possible.

Much of our focus during the health care reform debate has been on building what works well in the employer- sponsored market today while addressing the problems in the small group market and in the individual marketplace. These solutions, which now seem to be broadly accepted, should go a long way to addressing the problem of access to health insurance.

What we strongly believe is that for health care reform to be enduring and affordable in the Nation we must address the underlying problem of rising health care costs. Health care costs drive insurance premiums, not the other way around. Over the last decade, health care costs have risen about 7½ percent, and premiums have risen that very same amount.

It's fundamental to our discussion today to understand the value that Aetna brings to the health care system and how our business practices are focused on empowering consumers and health care providers to make the best decisions possible.

We process hundreds of millions of claims every year, and getting them right every single time is our goal. We recognize even a small percentage of problems represent real issues for our customers and

for our providers. When we do get it wrong, we have processes in place to help get it back on track quickly.

Aetna's driving innovation is to improve the lives and the health of our members. In just the past 4 years, we've invested over $1.8 billion in health information technology. For example, some of that investment went to having personal health records that can empower consumers' decisions around their health.

Finally, we're also leaders in promoting wellness and prevention and the management of chronic diseases. Refocusing our system to prevent disease and promote wellness can lead to better health for all Americans and positively impact costs system-wide.

I believe the competitive marketplace has played, and should continue to play, an important role in fostering the innovation that's necessary for our country to achieve true and widespread quality and affordability in our health care system.

Thank you, and I look forward to continuing to work with Congress to pass health care reform this year.

Mr. KUCINICH. Thank you, Ms. Farrell.

[The prepared statement of Ms. Farrell follows:]

Testimony of

Patricia Farrell

Senior Vice President, National and International Business Solutions

Aetna Inc.

before the

U.S. House of Representatives

House Committee on Oversight and Government Reform

Subcommittee on Domestic Policy

September 17, 2009

(Written Submission)

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

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

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

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

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

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

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

I. Aetna Innovations – Connecting a Fragmented Health Care System

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

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

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

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

[1] CMS, National Health Expenditures Data, 2009

Building Strong Partnerships with Physicians

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

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

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

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

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

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

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

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

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

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

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

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

Harnessing technology to improve quality of care

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

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

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

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

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

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

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

Promoting Health and Wellness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Specific Committee Requests

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

Governance:

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

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

Coverage Decisions:

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

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

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

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

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

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

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

Appeals:

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

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

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

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

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

Rescissions:

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

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

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

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

III. Health Care Reform

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

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

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

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

Mr. KUCINICH. The Chair recognizes Mr. Bloem.

STATEMENT OF JAMES H. BLOEM

Mr. BLOEM. Thank you, Mr. Chairman.

Mr. KUCINICH. Make sure that mic is close. We want to hear you. Go ahead.

Mr. BLOEM. Mr. Chairman, Ranking Member Jordan, members of the subcommittee, I'm James H. Bloem. I am a senior vice president and I'm the chief financial officer and treasurer of Humana, Inc.

Humana's a health benefits company headquartered in Louisville, Kentucky, offering health benefit plans for employer groups, government programs, and individuals. We have 10.3 million medical members and 6.8 million specialty members in all 50 States and Washington, DC, and in Puerto Rico. Humana employs 28,600 employees and contracts with nearly 400,000 physicians around the country.

We've provided extensive written testimony on today's subject matter, and I will briefly summarize a few key points here.

Every aspect of Humana's operations is governed by Federal and/or State laws and regulations, and Humana continues to both support and advocate for responsible health system reform. We believe that doing nothing is—doing nothing is not an option. We believe that all Americans should have affordable, quality health coverage. It's essential that everyone participate in the health system, with subsidies for those who can't afford coverage; and, in return, coverage should be guaranteed and not based on pre-existing conditions or health status.

To ensure affordability, reform must focus on improving health outcomes, reducing variations in care, and reducing costs.

Humana also supports America's Health Insurance Plans' comprehensive reform plan which provides for universal coverage with insurance rating reforms. These reforms, voluntarily offered, will obviate the need for business practices that were put into place because there currently is no requirement that individuals have health insurance coverage.

The subcommittee has specifically requested that we comment on our processes for both coverage determination and processing claims, as well as the physician feedback on these processes.

For 2009, Humana ranked No. 1 among national payers as the easiest to do business for both doctors and hospitals. Specifically, Athena Health found Humana to have the lowest denial rate among all major payers. In contrast, the Medicare Part B program ranked fifth. Humana also ranked as the fastest payer to physicians, with the Medicare Part B program again ranking in fifth place.

The subcommittee also asked that we address how Humana makes coverage decisions. Let me summarize.

Coverage decisions are based on evidence-based medical criteria, developed and approved by physicians. Under our policy, a nurse or a non-clinician can authorize any service that's under review. However, only a licensed, board-certified physician medical director can issue a denial based on a medical criterion. To the extent that a practicing physician disagrees with a decision, there are timely

internal appeal processes allowing peer-to-peer input. These grievance and appeals processes are governed by State and Federal regulations. Internal appeal decisions can be further appealed to an independent external review entity, whose decision is binding on Humana.

Humana's worked effectively over the past few years to streamline and simplify our administrative practices. We've partnered closely with the hospitals and physicians who care for our members and our members themselves. Here's one example.

Availity is an industry leading multipayer, multiuse electronic medical provider information exchange. Humana cofounded Availity with the Blues of Florida. It fulfills the President's and Congress' call for a workable health care information technology superhighway. It has standardization, speed, accuracy, transparency; and it results in significant cost savings.

Today, across the country, 50,000 physicians, 1,000 hospitals, 100 million members, and 1,000 payers, including public payers, access or connect with Availity every year. This will result this year in approximately 600 million transactions. Availity, what it does is provides seamless provider interactions and improves patient safety, saving money. It has digitized most of the nonstandard administrative processes that providers have complained about for years. And for those who use e-prescribing, preventable adverse drug events have been reduced by 61 percent; and, most importantly, there are no charges to providers for using Availity.

In closing, Mr. Chairman, let me say that Humana's committed to continue to work closely with the administration and Congress to increase the likelihood that measures designed to solve the most significant problems in our health care system become the focal points of responsible and real health reform efforts.

I look forward to your questions. Thank you very much.

Mr. KUCINICH. Thank you, Mr. Bloem.

[The prepared statement of Mr. Bloem follows:]

Testimony
Of
James H. Bloem

Senior Vice President, Chief Financial Officer and Treasurer
Humana Inc.

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, September 17, 2009
2154 Rayburn HOB
2:00 p.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Mr. Chairman, Congressman Jordan, and other members of the Committee, I am James H. Bloem, Senior Vice President, Chief Financial Officer and Treasurer for Humana Inc., as well as a member of the company's corporate executive committee that determines the company's strategic direction. Humana is a health benefits company headquartered in Louisville, Kentucky offering a wide array of health and supplementary benefit plans for employer groups, government programs, and individuals. We have 10.3 million medical members and 6.8 million specialty-benefit members in 50 states, Washington, D.C., and Puerto Rico.

My testimony today will address: 1) our support for health system reform; 2) how we develop clinical policies and make coverage determinations; 3) our interactions with both physicians and members to ensure collaboration; 4) government oversight of plan activities; and 5) plan innovations designed to simplify administrative processes and provide members with actionable information.

Support For Health System Reform

We appreciate the fact that the Subcommittee's work is intended to complement the effort by Congress and the Administration to provide health coverage for all Americans, while simultaneously lowering costs and improving quality. Humana supports and advocates for reform of our health care system and believes that doing nothing is not an option. We further believe that all Americans should have affordable, quality health care coverage. It is essential that all Americans participate in the system with subsidies for those who cannot afford coverage, and in return, coverage should be guaranteed and not based on pre-existing conditions or health status. To ensure affordability, reform must focus on reducing costs, increasing efficiencies, reducing geographic variations in care and improving health outcomes. Americans deserve a

system that eliminates fraud and abuse, promotes health and wellness and incentivizes the most effective and efficient patient care.

Finally, as a member of America's Health Insurance Plans (AHIP), our industry trade association, we and they began offering such reform plans as early as November, 2006. AHIP's comprehensive reform plan provides for universal coverage with insurance rating reforms. These reforms, voluntarily offered, will obviate the need for business practices that were put into place primarily because there is no requirement that individuals have health insurance coverage. Every aspect of our operations is governed by federal and/or state laws and regulations.

Coverage And Related Claims And Administrative Processes

The Subcommittee has requested that we comment on Humana's processes for making coverage determinations and processing claims as well as physicians' responses to those processes. In responding to the Subcommittee's request, let me start with findings from the most recent PayerView rankings, conducted each year by athenahealth (a physician revenue management company). These findings are based on that organization's independent statistical analysis derived from more than 17,000 physicians representing $7 billion in billed charges, sent to 172 payers in over 40 states. In addition to ranking Humana and our peer companies, athenahealth also ranks Medicare Part B, providing an important point of comparison between private health plans and the government-run Medicare Fee-for-Service program.

For 2009, Humana ranked first among national payers as "easiest to do business with" for doctors and hospitals. Specifically, athenahealth found Humana to have the lowest "denial rate" among all major payers. In contrast, the government's Medicare Part

B ranked fifth. Humana also was ranked as the fastest payer to physicians. Medicare Part B again ranked fifth.

Turning now to our coverage determination process, Humana's process is based on the benefits and provisions defined in a member's certificate of coverage. In that certificate is a list of services or requests that must meet certain evidence-based clinical protocols. In most cases, we have a specific coverage policy that determines Humana's threshold or criteria to cover a particular service. Our coverage policies are posted on our website. Services for which we require prior authorization are also posted on our website. Providers receive a minimum of 90 days' notice of any changes.

Development Of Clinical Policies

In developing clinical policies, our clinical team researches and analyzes new and emerging technologies. Our **Medical Pipeline** infrastructure at Humana ensures that clinical, financial and other non-clinical considerations are forecast for new and emerging medical technologies and procedures. We rely on a number of scientific publications, governmental information and other relevant, independent information in evaluating our clinical protocols. Our medical and clinical teams compile all relevant information to respond to changes in innovation that may require coverage decisions to change.

Through the systematic collection of data, analysis of the information and tracking of future health technologies, Medical Pipeline builds a robust foundation to forecast changes in new products, therapy and treatment regimes. Humana's Technology Assessment Forum (TAF), composed of board-certified Humana physicians, uses this data to evaluate new products coming to the marketplace and to evaluate those products that have a safety profile warning.

We strongly support the development and dissemination of more information on evidence-based medicine to providers, consumers and plans. Because medical technology becomes more complex each day, having the right evidence-based medical information is critical to defining, disseminating, and operationalizing decisions on best-known methods in healthcare. Humana utilizes independent evidence-based technology assessment organizations to help formulate its policy decisions. We incorporate that information into Humana's processes for medical coverage policy (MCP) development. Providing consumer-centric medical information to Humana's members and their physicians allows members to choose medically appropriate procedures that will improve their health and healthcare outcomes.

Clinical evidence must permit conclusions to be made concerning the effect of certain procedures and treatments on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed medical journals in the English language. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Technologies and procedures under review must ultimately have a beneficial effect on patients' outcomes and that beneficial effect should outweigh any known harmful effects on health outcomes. The improvement must be attainable outside investigational settings. Additional information is also sought, as necessary, from external experts and participating providers in an attempt to reach a final conclusion.

A Clinical Advisor (physician) within the Clinical Policy Department oversees this process of conducting an evidence-based review of emerging technologies as well as reviews and rates the overall peer-reviewed available literature. After final approval, the MCPs are posted on Humana's website for easy and immediate access for providers, members, employers and associates.

Making Coverage Determinations

As previously discussed, a member's benefit plan document (certificate of coverage) is the primary document that delineates what services are covered as well as the member's personal financial obligation. There are select services that are covered if they meet specific, evidence-based medical criteria developed and approved by physicians. These medical criteria are entered into our clinical system such that a non-physician at Humana can authorize a service requiring a medical criteria review based the system-generated response. However, only a licensed, board-certified physician medical director can issue a medical criterion denial. Medical directors also have authority to determine that the issues in a case are unique such that exceptions to medical policy are warranted. To the extent that a member disagrees with a decision, there are internal and external processes to receive peer-to-peer input and manage grievances and appeals according to state and federal regulations. Decisions can be appealed to an independent, external review entity whose decision is binding on the plan.

In the end, our goal is to ensure that our benefits are being offered in compliance with state and federal laws and regulations, and that the related MCPs are consistently being applied.

Feedback From Physicians On Our Administrative Processes

The Subcommittee has also asked for comment on physician response to our administrative and clinical processes. Humana highly values its relationships with physicians and hospitals. Positive relations with the provider community are essential for Humana to create provider networks and meet its essential role in the health care system of providing financial protection for our members, assuring access to employer-specific and individual plan benefits, and providing guidance to our members as they access the health care system.

First, Humana has endeavored to simplify and speed the process by which providers' claims are processed. As previously noted, Humana has been recognized by athenahealth, and we have also been recognized by the Medical Group Management Association (MGMA) as the easiest national health plan for providers to work with. We are a leader in administrative simplification, including claims payment and verification of benefits which can be performed on-line. Humana is the first health plan to have real-time claims adjudication (RTA) originating from the physician's practice management system, so that physician practices can know and process Humana's payment and the member responsibility at the time the member receives medical services in the physician's office.

We are driving efficiencies to reduce administrative work that we believe can have a dramatically favorable impact in the industry. For example, with RTA, providers have the opportunity to submit claims in real time and receive the completed response within seconds. Along with RTA, innovative Humana tools and services include Availity, a multi-use, multi-payor electronic data exchange which I will discuss later, and the Humana*Access* Visa Debit Card.

Humana is working on these and similar standardization efforts with national provider organizations like the Medical Group Management Association (MGMA), the Healthcare Financing Management Association (HFMA), the American Medical Association (AMA) and the American Medical Group Association (AMGA). Our goal is to be a collaborative partner in advancing administrative simplification and multi-payer solutions in the industry. Examples of initiatives Humana supports include:

- **Project SwipeIT**: Humana is a leading supporter of this important MGMA initiative with the goal of industry-wide standardized patient identification card acceptance by the 2010 plan year. We were the first plan to publicly pledge support of Project SwipeIT.
- **Healthcare Administrative Simplification Coalition (HASC):** Humana is an active member of HASC and supports its goal of making healthcare operate more efficiently and effectively through the implementation of administrative simplification strategies that reduce unnecessary healthcare costs.
- **CAQH:** We fully support the Council for Affordable Quality Healthcare (CAQH), a catalyst for industry collaboration on initiatives that simplify healthcare administration. Examples of CAQH initiatives Humana supports (also supported by the HASC) include:
    - The requirement of Universal Provider Datasource™ (UPD) credentialing for contracted providers, as well as the use of the UPD for primary data collection.
    - Encouragement of health plans and PBMs to provide real-time, patient-specific formulary access into e-prescribing functionality.
    - Encouragement of EHR vendors to support SureSripts-RxHub capabilities in their products.
    - Humana is a founding and certified member of the Committee on Operating Rules for Information Exchange (CORE) launched by CAQH to create an all-payer solution that enables provider access to patient insurance information before or at the time of service, with providers using the electronic system of their choice.
- **AMA "Cure the Claims" Campaign**: Humana is an active supporter of the AMA campaign to make claims processing more cost-effective and transparent. Humana is working with the AMA to understand how we can improve our claims performance in relation to their new National Health Insurer Report Card that provides objective information on claim payment timeliness, transparency and accuracy of claims processing by health insurance companies. Based on a random-sample pulled from more than 5 million electronically-billed services, the report card provides an in-depth look at the claims processing performance of Medicare and seven national commercial health insurers. In the 2009 Cure the Claims results, Humana

had the highest contracted fee schedule match rate and the lowest percentage of edited claim lines reduced to $0 of all major payers. Humana also had a significantly lower rate of claim lines denied than Medicare.

Engaging Physician Groups In Clinical Policy Development

In developing Humana's medical policies, including assessment of new technologies, Humana works closely with many leading medical professional societies. For example, Humana worked recently with the American Academy of Pediatrics on the development and dissemination of immunization protocols. As effective medical practice evolves at an ever-increasing pace, the professional societies are best positioned to assist us with the implementation of these types of medical policies.

Supporting Members with Actionable Information

We also have been at the forefront of the development of tools to assist members to obtain vital information as they access care. We have worked closely with the medical community to ensure that the information we provide to our members is accurate and consistent with medical standards—whether it is through web-based tools, telephonic reminders to secure preventive services, or telephone interactions with a member of one of Humana's teams of nurses that interact with members. Humana includes on its website the consumer tool from the American Academy of Family Physicians, FamilyDoctor.org, including the "questions to ask your doctor" that the Academy developed.

Humana's comprehensive tools to help members in the selection of their physicians have been developed with the valuable input of many local, state and national medical organizations. We have used physician focus group meetings to assess the value of these tools at localities in Texas, Wisconsin, Ohio, Kentucky and Kansas as examples. We also have incorporated the input of the American College of Physicians, the

American Academy of Family Physicians, the American College of Surgeons, and the American Academy of Pediatrics in developing these tools. In addition, for the past four years, Humana has convened a Physician Advisory Committee, appointed jointly by Humana and by counsel for physicians, which meets semi-annually to discuss issues of joint interest between physicians and Humana.

Care Coordination

Humana actively has pursued methods to coordinate delivery of services for the five percent of Humana's commercial membership who consume almost half of health care costs because of the existence of complex or chronic medical conditions. This mirrors the experience reported by the federal Agency for Healthcare Research and Quality (AHRQ). Due to these conditions, most of these individuals have multiple physicians. Humana's case managers and personal nurses work to coordinate patients' care. At the conclusion of a time of hospitalization of members with serious conditions, a Humana nurse meets with the member to make sure that the individual knows about discharge medications, appointments, and therapies so that continuity of care takes place smoothly after discharge. These steps lead to significantly improved health outcomes, and also can help avoid an unplanned readmission to the hospital.

Support Services For Physician Offices

Because Humana recognizes the wide variation in clinical practice, we know we must develop clinical support programs that meet individual physician office needs. More than fifty percent of Americans receive health care services from clinical practices with five or fewer doctors. Smaller practices tend to have limited technology availability and have needs that differ from a large multi-specialty practice. We are working with

input from physicians and MGMA in developing systems approaches to further support the variety of clinical practices.

Humana has "learning labs" programs in Florida and Kentucky for small practices to help them learn about the value, accuracy, and speed that e-tools, such as the aforementioned e-prescribing and payer-based electronic health records, can bring to patient care.

For medium-sized practices, Humana has developed a Model Practice program designed to help physicians become comfortable with reporting quality measures for their patients.

With larger, more sophisticated, group practices, Humana has assisted with the formation of Medical Homes, which enhances coordination of care. Currently some 17,000 Humana members receive care coordinated through medical homes located in Atlanta, Cincinnati, Florida and Denver. Within a year we expect over 50,000 Humana members to receive care in a Medical Home.

Humana is also working on a project with Dartmouth and The Brookings Institution involving a large, integrated health system to pilot an Accountable Care Organization (ACO) that we expect to be operational in 2010. This pilot is among the first such projects on a commercial health insurance platform. The goal of the ACO is to improve quality while lowering costs for a population of patients.

Quality Improvement Efforts

Our activities also have focused on quality improvement. Humana has been an active participant in the development of standardized, national quality measures through its involvement with the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI) and with the Ambulatory Quality Alliance

(AQA). Humana has focused on 19 current quality measures developed by these organizations that involve common conditions for which physician organizations have recognized that there is a wide variation in adherence. These measures, which are all AQA and National Quality Forum-endorsed, represent the clinical areas of diabetes, asthma, cardiac conditions and preventive health. In fact, the AMA has sought Humana's assistance with its own quality improvement programs.

Nationally, one of the leading causes of hospitalization and illness relates to inappropriate medication use. Many factors cause this, ranging from drug interactions to patients' misunderstandings of their medications, to multiple prescribers unaware of other drugs the patient may be taking. Humana is working with local medical societies on many of these fronts. In Harris County (Houston) Texas, Humana is part of the Medical Society's efforts to help physicians with their prescribing to diverse cultures. In Louisville, Kentucky, Humana has provided information on prescribing patterns to the Jefferson County Medical Society for its patient safety program. Additionally, Humana's pharmacy programs provide point-of-sale alerts to patients and to doctors where prescriptions may be likely to cause drug interactions.

Government Oversight Of Administrative Processes

The Subcommittee also requested that we attempt to put into context anecdotes that purport to represent claim denials, deferrals and policy rescissions by insurers and the adequacy of government oversight of these activities.

With respect to denials, there are a number of reasons why a claim may be denied. The most common reason is that it is a duplicate or miscoded claim. Other reasons include a service or device which is not covered under the policy purchased by or on behalf of the member, for example, experimental treatment or treatment for cosmetic,

rather than therapeutic purposes. A denial may also occur because it appears not to have been medically necessary. Our decisions are subject to an internal, government-prescribed grievance and appeal process. If a member is not satisfied with the decision, the member has access to an independent, external review organization whose decision is binding on our plan.

As for rescissions, we would note, as I discussed earlier, that Humana has strongly supported guaranteed-issue of health plans with no pre-existing condition requirements or health status rating in concert with a personal requirement for coverage. With these requirements, coverage becomes more affordable and the issue of rescissions will no longer exist. Humana has both an internal appeal process for rescission decisions and has contracted with an external review organization to provide a final level of independent, outside review. The decision of this entity is binding on our plan.

Finally, with respect to government oversight of plan practices, we would invite you to review the "Summary of Health Insurance Plan Regulation" developed by America's Health Insurance Plans (AHIP) (*Exhibit 1*). It summarizes the scope and scale of state and federal regulations governing every aspect of our business, from the methods by which we price our products to what benefits are offered, to grievance and appeal processes and other consumer protections, to the substantial reserves that must be set aside to protect policyholders against insurer insolvency. These requirements set standards for claims processing, including denials and pended claims, and for processing coverage requests. We are dedicated to compliance with these laws and regulations and expend substantial resources each year on compliance, including funds expended for training, compliance programs and internal audits.

Plan Innovations In Administrative Simplification And Transparency

As I stated at the beginning of this testimony, Humana has worked diligently over the past few years not only in advocating for health insurance reform, but also in working actively to make it happen. In so doing we've partnered closely with the hospitals and physicians who care for our members, and with our members themselves. For the sake of brevity, I'll offer just two among many examples – the first involving medical providers, and the second involving transparency and actionable information for our members.

First, through **Availity** which I mentioned earlier, the industry-leading, multi-payer, multiuse electronic medical provider information exchange that we co-founded in 2001 with Blue Cross Blue Shield of Florida, we've shown the way to fulfill the President's call for a workable healthcare IT superhighway, with attendant standardization, speed, accuracy, transparency, and significant cost savings. Today, across the country, over 50,000 physicians, 1,000 hospitals, 100 million members, 100,000 employers, 150 direct public/private health plans, 1,150 indirect public/private plans connect and/or access Availity, resulting in 600 million transactions projected this year. There are no charges to providers to use Availity's services.

Availity has digitized most of the frustrating, hassle-riddled and non-standardized administrative processes that providers have endured from payers over the years. It serves as a claims clearinghouse with real-time transactions in the areas of eligibility and benefits, claims submission and status, remittances, authorizations and referral submission and inquiry. Its CardRead function allows for member ID card processing and its financial solutions include CareCostEstimator, allowing for real-time patient responsibility estimation and CareCollect, which uses a combination of ID card, debit/credit card and check processing. Availity's clinical solutions include the

CareProfile, a real-time electronic health record, and CarePrescribe for new, refill and renewal prescriptions.

In terms of streamlined, cost-saving interactions with health plans as well as improved patient safety, a study of doctors who use the Availity CareProfile electronic payer-based health record show a three- to six-minute reduction in patient intake and assessment time, adding critical efficiency to the system while giving physicians critical clinical information about their patients. Providers who use Availity regularly have reduced their phone call interactions with plans by more than ten (10) percent in the first ten (10) months. At a cost of $1.38-$2.70 per call, industry-wide savings can be exponential. And, Availity's CarePrescribe has been shown to reduce preventable adverse drug events by sixty-one (61) percent.

Finally, the State of Florida's Agency for Health Care Administration uses Availity as a health information exchange and health record with its Medicaid program. In addition, the Commonwealth of Virginia has contracted with Availity for its Virginia Health Exchange Network to develop a public/private portal for the state. And, America's Health Insurance Plans selected Availity for a multi-payer portal proof-of-concept in Ohio.

Second, through our **SmartSummary member benefits statements** *(Exhibit #2)*, we have brought to our members cost transparency, clinical information and innovative ways our members can maximize their benefits. Launched in 2004, these personalized statements reach 10 million Humana members every quarter, helping them save money, better understand how to use their benefits, and find ways to improve their health.

Conclusion

Mr. Chairman, in closing, let me say that at Humana, we continue to work closely with the Administration and with Congress to increase the likelihood that measures designed to solve the most significant problems in our nation's healthcare system – the rising costs of care associated with obesity and other chronic conditions, the lack of interconnected electronic systems and coordinated care, and the unsustainability of greater-than-CPI annual increases in health care costs – become the focal points for national health reform efforts.

Humana continually strives to operate our company honorably, in conformance with best practices, statutory and regulatory requirements, and through innovations designed to improve the health of Americans. We are proud of our leadership role in calling for comprehensive health care reform which results in coverage for all of our citizens. We remain committed to reform that brings everyone into the system, guarantees access, and provides help to those who cannot afford coverage.

Thank you.

Mr. KUCINICH. The Chair recognizes Mr. Richards. You may proceed for 5 minutes. Thank you.

STATEMENT OF THOMAS RICHARDS

Mr. RICHARDS. Chairman Kucinich, Ranking Member Jordan, and members of the subcommittee, I appreciate the opportunity to address the subcommittee and to discuss the issues raised in your letter to Mr. Hamm on August 26th.

My name is Tom Richards. I am the senior vice president of Product for CIGNA Corp., which is based in Philadelphia.

At the outset, I want to emphasize, on behalf of the 26,000 CIGNA employees, that we support health care reform that provides security, affordability, and stability for all Americans. We believe such a goal is achievable by strengthening the current system to include both a personal coverage requirement and a helping hand for those who can't afford coverage.

We support guaranteed coverage for everyone and no exclusion for any pre-existing condition. We support reforms in the way premiums are calculated, without taking into consideration health status or gender. We support providing subsidies to individuals who have difficulty affording health insurance, including subsidies to small businesses. We support administrative standardization and simplification. We support a focus on health and wellness. Further, we support the establishment of exchanges to provide a choice of plan options for all Americans. We also support reimbursement reforms to the current fee-for-service delivery system.

It's also important to understand CIGNA's role in health care. While we have some insurance business, nearly 80 percent of CIGNA's health care business is administrative services only. This means we administer the programs for employers in accordance with their policies and pay claims for them. It is not risk-based, as would be traditional insurance. These employers are self-insuring, and the claim payments come out of their employer funds. There is no financial incentive for our employees to accept or deny claims.

At CIGNA, in 2008, 89 cents of each premium dollar was spent on medical care. Our support for reform is aligned with what we stand for as a company. Our mission is to improve the health, well-being, and sense of security of the customers we serve.

Our results demonstrate our focus on health improvement. Competitive data from NCQA's 2008 State of Health Care Quality Report shows this difference. Against a baseline of standard care provided by doctors and hospitals in a fee-for-service unmanaged situation, we have better results. If you turn to figure 1 on page 4 of my written testimony, you will see a chart that reflects these results.

All of our coverage policies follow best practices and are evidence-based, which means they're based on the most recently published scientific evidence. We consider safety and effectiveness. It's important to note that cost is not a factor unless there are multiple items or services with equivalent safety and effectiveness.

We are very proud to employ over 3,000 clinicians. These doctors and nurses make decisions about clinical policy, review medical necessity, and advocate for individuals. They make the system easier to understand. They help our customers navigate the health care

system when they need help, and they literally save lives. We've included the words of several of these individuals in our written testimony telling you how we have helped them.

In 2008, CIGNA processed approximately 91 million claims for payment. More than 90 million of these claims were paid without question. I call your attention to figure 2 on page 10 of the written testimony. Of the approximately 1 million claims that did require prior authorization, all but 0.80 percent were approved on initial review. What that means is at CIGNA more than 99.9 percent of the time the person received the care that the doctor recommended and the services were covered.

At CIGNA, all medical coverage decisions are made by doctors and nurses; and, ultimately, the chief medical officer is responsible for all coverage decisions. We recognize the doctor-patient relationship is critical and do everything we can to enhance it. Let me cite just a few examples.

First, CIGNA is simplifying and reducing administrative complexities from payment methodologies and claim process to problem resolution and education.

Second, CIGNA's further innovating our payment methodologies. An example of this is CIGNA's patient-centered medical home initiative, such as the one we have with Dartmouth-Hitchcock, New Hampshire. Our joint goal is to improve patient access, continuity, and coordination of care, quality of care for patients, and lower medical costs for everyone.

At CIGNA, we focus on helping people improve their health. We believe the health care is a shared responsibility of the individual, the private sector, the medical community, and the Government. Such a shared responsibility is right for individuals, families, and the country as a whole. We look forward to how we can work together to improve the health and wellness and quality of care for all Americans.

Mr. Chairman, this concludes my remarks.

Mr. KUCINICH. Thank you very much, Mr. Richards.

[The prepared statement of Mr. Richards follows:]

Written Testimony
Of

Tom Richards
Senior Vice President, Product Delivery

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Thursday, September 17, 2009
2154 Rayburn HOB
2:00 p.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy."

Chairman Kucinich, Ranking Member Jordan, and all Members of the Domestic Policy Subcommittee of the Oversight and Government Reform Committee, I ask that the following written testimony be submitted for the record.

Health Care Reform Background

Before I begin, Mr. Chairman, let me be clear, CIGNA supports health care reform that provides security and stability for all Americans and we believe such a goal is achievable by strengthening the current system to include both a personal coverage requirement and a helping hand for those who can't afford coverage. We support and joined with others in our industry nearly a year ago to recommend insurance market reforms. Among other things, we support guaranteed coverage for everyone and no exclusion for any pre-existing condition. We support reforms in the way premiums are calculated, without taking into consideration health status or gender. We support providing subsidies to individuals who have difficulty affording health insurance, including subsidies to small businesses. We support standardization of applications, forms, and administrative simplification of the process. We support the focus on health and wellness. Further, while the details are difficult, we support the establishment of exchanges to provide a

choice of plan options for all Americans. We also support reforms to the way health care professionals and facilities are reimbursed under the current fee for service delivery system.

While these and other changes are critical to reducing the cost of health care in this country, at CIGNA we focus not just on paying claims but, most important, on what we believe the ultimate goal of health care reform should be – improving the health and wellness of our customers.

CIGNA's Business

CIGNA is a global company. Our business provides an integrated suite of medical, dental, behavioral health, pharmacy and vision care benefits, as well as group life, accident and disability insurance, to more than 46 million people throughout the United States and around the world.

Most people do not appreciate CIGNA's valuable role in the process of health care. While we have some insurance business, nearly 80% of CIGNA's health care business is an administrative service only (ASO) business. This means it is not a risk-based business, as would be a traditional insurance business. Employers pay us to administer the programs in accordance with their plan policies and pay claims for the employer from an employer bank account. The Employer holds the risk. There is NO financial incentive to our employees to accept or deny claims.

As such, CIGNA strives every day to lower our administrative costs and our operating expenses – it is simply good business. We have taken action to become more efficient and have a strong record in this respect. In 2008, $.89 of each premium dollar (or

premium equivalent for ASO business) was spent on medical care – and this figure has increased every year since 2005.

Focus on Health Improvement

CIGNA embarked on a new mission three years ago – one that focuses on helping individuals improve their health, well being, and sense of security. While we pay for sick care, we also help people recover from illness faster, and more importantly, we help people stay healthy in the first place. We do this through analysis, collaboration, and advocacy. We use predictive models to identify when people are at risk and then provide valuable information to both the individual and his or her health care professional to facilitate better quality care. This helps individuals improve their quality of life, and it has the added benefit of reducing their out-of-pocket expenses and reducing their employers' health care cost.

Our efforts are reflected in every aspect of our business – policies, products, our clinical staff, case workers, service representatives, and how we serve our customers and clients. Our mission guides our actions and decisions, but what really matters is the outcome.

Our own results support the focus on health improvement. As a result of helping individuals, comparative data from the National Committee for Quality Assurance's (NCQA's) 2008 State of Health Care Quality Report shows the difference. The baseline is the standard care by doctors and hospitals in a fee-for-service unmanaged situation. As a health service company, we have better results.

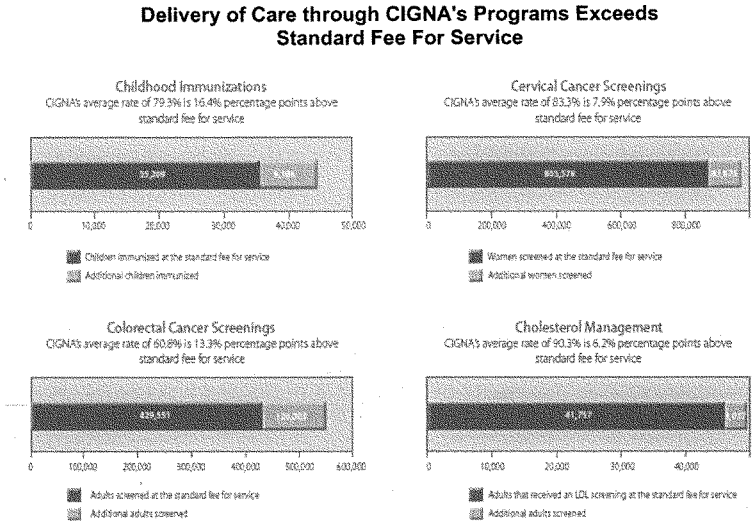

Figure 1

For example, CIGNA's rate of screening for colorectal cancer is 13.3% higher than in the typical fee-for-service situation – which translates to 120,002 more individuals who received colorectal cancer screening. And, as we know, colorectal cancer is the third most common cancer and the second leading cause of cancer-related deaths among men and women in the United States. Screening and early detection is critical to survival.

CIGNA has a rate of 83.3% for cervical cancer screening, 7.9% higher than in the typical situation. This means 83,874 more people received the screening than would have without CIGNA's emphasis on wellness. Cervical cancer is the second most common cancer worldwide and the third leading cause of cancer-related death. It is preventable and treatable. We have made such prevention and treatment a priority.

Childhood immunizations are the safest, most effective way to protect children from a whole variety of serious – and deadly – diseases. CIGNA's rate of 79.3% for children receiving all recommended vaccines is 16.4 percentage points higher than non-NCQA Accredited Plans. This means 9,186 more children are immunized against serious childhood diseases than would be without our program.

Heart disease is the number one killer in the United States. Our LDL cholesterol screening is 6.2% higher, which translates to 3,077 more of our customers being screened than would be without our work. Screening is the first step to preventing this killer from striking.

Screening for these and many more deadly conditions is a first step. Then our chronic care team comes in to help people manage their conditions, lowering future risk or maintaining acceptable levels to improve their health and quality of life – such as with diabetes or cardiovascular condition care.

Collaboration with Physicians is Critical

We cannot accomplish our mission alone. To be effective, a critical linkage is the relationship between doctors and their patients – our customers. At CIGNA, we recognize this relationship and recognize the physician is most often the most trusted expert and, thus, has significant influence on the individual. To influence individuals to participate in improving their own health is imperative to improving health in this country. Enhancing the doctor-patient relationship is fundamental and we not only look for but create opportunities to do just that. We recognize that success will be maximized

through collaboration with health care professionals. That is one reason we work hard to try to help physicians reduce their administrative costs.

To understand how to best work with health care professionals, we listen. We do this through our annual physician survey. We hold face-to-face interviews with over 50 hospitals and physician practices each year. CIGNA also established a National Healthcare Advisory Council earlier this year. As a result, we have rich data from thousands of physicians on how we can lower administrative costs and how we can work together more effectively to improve the quality of care.

First, we are simplifying and reducing administrative costs and complexities so doctors can focus on their patients instead of paperwork. We have initiatives for everything from payment methodologies, to claim processing, problem resolution, communication, and education. Since 2006, CIGNA has invested over $25 million to create new and enhanced solutions for health care professionals' needs.

Second, CIGNA is starting to pay for quality not quantity and we provide actionable information that helps physicians determine the best course of treatment.

CIGNA believes this investment is critical because the relationship between our customer and his or her doctor is critical. As already stated, at CIGNA we understand the physician is often our customer's most trusted expert. To increase our customers' quality of health, it is imperative that we enhance the doctor-patient relationship.

An example is our Patient-Centered Medical Home pilot program. CIGNA is conducting pilots in Colorado, Connecticut, New Hampshire, Pennsylvania, Texas and Vermont.

Specifically, in New Hampshire, the Patient-Centered Medical Home initiative we are conducting is with Dartmouth-Hitchcock – the hospital, clinical and research facilities for Dartmouth Medical School. Our joint goal is to pay for and improve coordination of care through a comprehensive, accountable, and collaborative approach. The result is to improve patient access, continuity and coordination of care, quality of care for patients, and lower medical costs for everyone. In a patient-centered medical home model of care, the **primary care physician** is responsible for monitoring and coordinating all aspects of an individual's medical care. In the Dartmouth program, patients – especially those with chronic illness or ongoing medical needs – have access to enhanced care coordination, communications, appointment availability and education to help them navigate the health care system. Individuals simply keep or select one of the primary care physicians participating in the program – they do not have to change their primary care doctor and there is no change in any benefit plans or authorization requirements. Ultimately, this collaboration will strengthen the doctor-patient relationship.

But rather than talk about what we are doing, let me share a quote from Dr. Barbara Walters, Senior Medical Director with Dartmouth-Hitchcock:

> "In our clinical collaboration with CIGNA, we get information from CIGNA that our physicians do not have. This information helps us work more effectively with people who are living real lives, and doing real things. We do this in urban communities, small communities and large communities and we think this is what advanced primary-care practice is all about. The doctors love it; it takes away the burden of the paperwork and they get a patient who is ready to talk to them. The nurses love it; they're being able to practice nursing the way they want to practice it and what they went to nursing school for. And patients love it; they say 'oh, my gosh,

you called me, I didn't have to call you.' I have seen how this program is making a difference for people by improving care. Our partnership with CIGNA to pilot the patient-centered medical home program is an example of our ongoing mission at work – to achieve the healthiest population by providing each person with the best care, at the right time, every time. Our organizations are working together to set the standard for this new model of patient care."

Our program to alert doctors of patient gaps in care is another way we try to enhance the doctor-patient relationship and medical outcomes by averting problems before they arise.

We also believe that safety and quality will greatly increase with universal adoption of electronic health records. To that end, we look forward to working with the Department of Health and Human Services in the implementation of the information technology provisions of the American Recovery and Reinvestment Act.

Coverage Policy and Action

One thing should be crystal clear – we do NOT consider costs in establishing coverage policy or in our decisions to provide access to care. CIGNA's coverage policies and determinations are all made by clinicians and are all based on the most recently published scientific evidence. We consider both the safety and the effectiveness of health care procedures, treatments, devices, drugs, and diagnostic tests. The only time cost even arises in coverage policy determinations is when there are multiple items or services with equivalent safety and effectiveness. For example, if there are two drugs that are equivalent in terms of safety and effectiveness, the patient has the same access

to both, but the specific benefit plan may give the patient a choice to pay a higher out of pocket payment (coinsurance) for the higher cost drug. Our 580 medical and pharmacy coverage policies are targeted to health care professionals (and often specialists), and they are transparent and readily available to everyone through our public web site.

CIGNA employs over 3,000 clinicians. It is these clinicians – no one else – who make decisions about clinical policy, review medical necessity, and advocate for individuals. These highly trained doctors, nurses, behavioral specialists, and health coaches spend their days listening, advising, helping people make behavioral and lifestyle changes, helping our customers manage acute and chronic diseases, making coverage determinations, and maximizing their health benefits. They make the system easier to understand, they navigate when our customers need the help, they find resources, they make the decisions and lives easier for thousands of people each year, and they literally save lives.

The question of who makes coverage decisions is important. At CIGNA, only clinicians write coverage policies and only clinicians make individual determinations. The physicians and specialists are all board-certified and they make coverage determinations and review all appeals.

Furthermore, no clinicians receive financial incentives or are rewarded for denying claims, as is sometimes alleged. Ultimately, the authority for coverage decisions rests not with the CEO, COO, or CFO, but with the Chief Medical Officer. CIGNA's Chief Medical Officer is Jeffrey Kang, MD. Dr. Kang is an internist and geriatrician and practiced for 10 years in a not-for-profit group practice. His career began as the Executive Director of the Urban Medical Group, a non-profit, private group practice

specializing in the care of the frail elderly and disabled. From 1995-2002, he worked for the federal government as the Chief Medical Officer for the Centers for Medicare and Medicaid Services (CMS). In addition to his position at CIGNA, he is currently a Board member of the eHealth Initiative, based in Washington, D.C., and serves on the Institute of Medicine's Committee on National Health Care Quality and Disparities.

Finally, in 2008, CIGNA processed approximately 91 million claims for payment. More than 90 million of those claims did not require prior authorization. Of the 1% of claims on which CIGNA required prior authorization, all but 0.08% were approved upon our initial review. That means that, nationally, more than 99.9% of the time the person received the care the doctor recommended and the services were covered with no need for any kind of appeal.

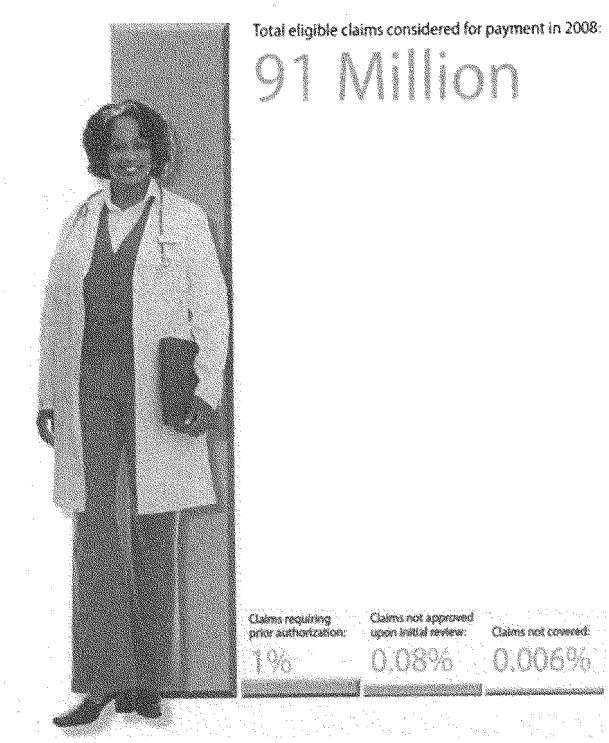

Figure 2: 99.9% of the time the person received the care the doctor recommended

Claims Policy

Once covered and after the person has already received the recommended care, CIGNA spends time and energy ensuring claims are reimbursed appropriately and accurately, while minimizing fraud and abuse. In fact, in 2008 CIGNA removed over $250 million in fraud and abuse claims from the system, which included items such as double billing, unbundling of services, correcting coding, and, in some cases, actual fraud.

To summarize:

- Our coverage policies are evidence-based, transparent, and do not consider costs except where there are two items or services which are equivalent in terms of safety and effectiveness.
- Over 99.9% of the claims are covered and people are receiving the services that the doctor recommended.
- Our vigilance in minimizing fraud and abuse helps ensure affordable care, consistent with our mission.

Deferral and Rescissions

Our business that serves the individual market is quite small, less than 1% of our health care customers. In fact, we have had no rescissions year-to-date for 2009. Year-to-date 2009 we have had 11.7% deferrals for individuals who did not meet current, commonly accepted medical underwriting assessment criteria.

CIGNA supports the aim for affordable quality health care coverage for all Americans. When everyone is required to have health coverage, as I said at the outset, we support a policy of no deferrals for pre-existing conditions, health status, or gender, and we commit to no rescission of coverage except in the case of fraud.

Improving Outcomes

Often our nurses are in a position to significantly help an individual through a crisis. Their ability to step into a difficult situation and help the individual understand his or her options and navigate the complexities of the health care system is invaluable. We take great pride and satisfaction in knowing that we have and will continue to help improve people's quality of life.

We currently have an innovative pilot running that is designed to provide advice to customers who need diagnostic testing. A proactive call from us not only can serve as a prior authorization, but becomes consultative as we help customers find the service they need. For example, a customer needing an MRI can be referred to a facility, as part of the prior authorization process, based on a location closer to work or home, business or off-business hour availability, or other factors important to him or her. As a result, we are also able to help find a location with high quality and lower cost, since prices and quality vary significantly depending on the facility delivering the diagnostic medical service.

Here is just one of the illustrative stories that come into our offices daily from customers who found the service they received to be exceptional. This comes from customer Stephanie Ellis, a mother in North Carolina:

> "Personal experiences can speak volumes regarding a situation. Our family's experience with case management has been tremendously positive and one that is worth sharing to promote the worth of such programming.

"We were afforded the opportunity to work with a quality case manager when our son Braxton was born. He was diagnosed at two days old with Citrullinemia, a Urea Cycle Disorder. It was then determined that to resolve Citrullinemia issues the appropriate medical treatment was a liver transplant. From the mention of such a need, Cigna resourced us to a specialty case management group and from that point on our needs were met to the utmost level of care and expertise. There was a trust-bond formed between our family and our case manager immediately, with us depending on her to handle medical requests and answer our questions. If the answer wasn't known when a question was asked, it would be found quickly and returned back to us personally. Cigna's case management group utilized numerous available resources to manage Braxton's medical needs superbly. There was obvious concern expressed for the patient's outcome, not the company's bottom line. The delicate balancing of patient needs, policy coverage, company responsibility, and ethical responsibility were managed impeccably. Time after time we experienced an expression of genuine concern for Braxton and our family that was well-evidenced through communication and actions. These memories, like the numerous health crises Braxton has survived, will last our lifetimes! We believe that case management had a direct link in the positive transplant outcome experienced by Braxton and our family.

"Case management can be provided at multiple levels. Yet, high quality case management is a vital link for patients to utilize available resources inaccessible otherwise. Such assistance fills gaps for individuals without the knowledge, access, time, and/or emotional strength to handle insurance details and claims. Furthermore, case managers function as outlets to answer questions that surface after the provider is not available to the patient and family. Communication and

> connections within the insurance company among case managers also enables best practices, management techniques and other pertinent information to be shared. This in turn improves care provided for those insured/covered. Case management takes the opportunity to improve patient care in specialty areas via analysis of data and action taken in critical situations to better serve clients in future situations/need. This information is then disseminated among case managers, who are experienced medical professionals, to ensure patients and families access and receive healthcare to manage complex health situations."

That is one mother's story. Other stories are included in the appendix at the end of this written testimony.

Summary

The bottom line is that at CIGNA we believe in meaningful, sustainable health care reform. We support many of the key principles of reform outlined by the President last week before your Joint Session. We believe in affordable, quality health care for all individuals. We look forward to and trust the debate will not lose focus on how we can all work together to improve the health and wellness of, and quality of care for all Americans. This can improve the lives of our citizens and sustainably lower costs for those individuals, the employers who provide them with access to health care, and the country as a whole.

At CIGNA we are continuously looking for ways to improve our own operations from an effectiveness, quality, and cost perspective, and that includes helping however we can to enhance the doctor-patient relationship. It makes sense for the outcomes we hope to affect and is a large part of how we are able to fulfill our promise to help individuals

improve their health, well being, and sense of security. This is our mission. It is at the heart of our actions and decisions and at the forefront of the thinking of our people and the health care professionals with whom we partner.

Appendix

Customer Letters

Cocoa, FL
July 10, 2009

Ms. Rebecca
4100 International Parkway
Suite 1010
Carrolton, TX 75007

Dear Ms.

This letter is to inform you what an invaluable source of support and comfort your nurse case manager, Ms. Iris was to my husband and I during his illness and subsequent death.

My husband was diagnosed with pancreatic cancer in September of 2008 and died on March . During this most difficult time Iris was always available to answer any questions or concerns that we had. She also was able to co-ordinate care between the insurance company and the doctors. The nurse at our physician's office said she wished all of her patients has someone like Iris.

My hope is that you will continue to provide this wonderful service and that all of your nurse case managers are as efficient and empathic as Iris.

Sincerely,

Barbara

July 6, 2009

Rebecca
Cigna
4100 International Parkway
Suite 1010
Carrollton, TX 75007

Dear Ms. ,

I would like to take this opportunity to request that Carla be recognized for her knowledgeable, caring and professional manner in dealing with patients during difficult times. She is willing and eager to step up and fight for the best treatments for the patient. In my case, this meant getting approval for a cancer drug that has been on the market for only a short time. I was able to start treatment in a timely manner, for which I am very thankful to Carla and her hard work which made this possible. She is always eager to help and I feel that she genuinely has the patient's best interests at heart. Because of her efforts, I have been able to focus on getting better and being an inspiration to others in similar situations.

I would like Carla to be considered for the Cigna Champion Award as I feel her compassion and dedication to patient care is an example for others to follow.

Sincerely,

Robert
ID: U
Corp.

Hi Liz:

I want to personally thank you from the bottom of my heart. For making me feel like more than a "case number" from the time I met you on the phone at 20 weeks pregnant, I new you were special. You fought for me, my patient rights, for 19 weeks! With the doctors, pharmacy and whoever threatened the well being of me and my unborn child. You enrolled me in the high risk program which would make sure I received progesterone shots, this helped me to make it to 39 weeks for the first time without contractions! You also saw to it that my gestational diabetes was under control AND when my AFP results were high you had me in such good hands that I did not panic. At 44 years old no one thought it was a good idea for me to get pregnant, and further that I could have healthy child.

Where there times when I wanted to give up? Absolutely! But you were so positive and caring that I didnt give up. Many times you called me and I was just about to give up but your phone call and caring voice gave me the courage to hang in there. It was like heaven sent me an Angel **named LIZ**. I will also let my daughter know about you, everytime she looks at the Mommie Files. (smile)

Well, before I start crying, let me give you a picture of our little angel. She was 7lbs 10 oz, and I named her " " which means "Purpose from God". Also there are two pictures of me, when I was 9 months pregnant and how I normally look without being pregnant. (smile)

CIGNA is so lucky to have RN case manager like you. In my heart I wish I could send you flowers or a gift, even though you wont let me! So I'll just say heartfelt THANK YOU A MILLION TIMES.

Take Care, Love always, WE Will always remember you!

Darlene

Please allow me to express my family's appreciation and praise for one of your employees. Connie , my daughter's Nurse Case manager, is the epitome of competence, efficiency, and conscientious perseverance.

Our daughter was born with a condition which has resulted in lifelong medical issues. From October 2008 through February 2009 she experienced the most serious medical crises of her life, the consequences of which are still with us.

Connie's constant availability to us has been instrumental to our very survival during this stressful time. She has and continues to insure that [our daughter] gets what she needs without unnecessary complications or delays.

With all the negative PR regarding health insurance companies and their reputed negative impact on health care, I personally feel very blessed and grateful to have CIGNA as my family's insurer.

If anyone has ever deserved special recognition for outstanding service, it is Connie . She definitely goes far above and beyond the call of duty for us as, I am sure, she does for all her clients.

Sincerely yours,

Elizabeth .

My husband, Mike , had a hemorrhagic infarct April , 2008 and the doctor told us to give him a couple of days and pull the plug. If he lived, he would be shipped off and be a vegetable the rest of his life. We chose to believe God for the impossible! Cigna made it possible to receive outstanding coverage and care for the impossible! Thanks Cigna for everything you covered during these past 15 months!!

I have received personal support from Maureen , Case Manager, for my husband over the past 15 months. Maureen has always been very personable, always available, an advocate for my husband concerning many difficult medical situations we have had to face. As a result, my husband has always been well taken care of; and he has always been at the right place at the right time! I don't know of anyone quite like Maureen...she has been such a source of help, support. She has always been very professional, and could identify with my husband's medical needs, and was also compassionate and supportive to me.

I don't think I would have made it without the support of Maureen this past year! I believe she played a big part in the progress of my husband's health! She was my husband's biggest advocate, and as a result he is now home and is continuing to progress.

I believe Maureen deserves to receive an award for Outstanding Employee of the Year! I will never forget how she went the extra mile to fight for my husband, to make a way when there seemed to be no way; in and out of hospitals for 5 months, in Assisted Living , then in a Nursing Home for 5 months, and finally, we both saw the impossible happen before our eyes....my husband came home, March , 2009! Thanks Maureen ! Never stop caring.....it really made the difference.....

We will miss Cigna, because of Maureen , and her personal support. Our coverage will end this month, we had an extension through Cobra.

Sincerely,
Marilyn and Mike

Phoenix, AZ
Cell

Health Care Provide Quotes

General feedback:

- "I think it's a good show of your resolve to come here and speak to us so that is well appreciated. Just the opportunity to share this is not something a lot of companies do in the industry so that is certainly a good sign of where you want to be." (Source: Provider Experience Interview - health system in VT)

Revenue cycle improvements:

- "We submit a claim and it's paid within ten days." (Source: Provider Experience Interview - cardiovascular surgery practice)

- "We've tested Estimator with patients, and found that it can help reduce confusion and the potential for late payment of medical bills and bad debt issues." (Source: hospital system in Chicago)

Electronic Services:

- "On eServices, I can't think of anyone who does better than CIGNA." (Source: Provider Experience interview - physician group in WA)

- "CIGNA's web site is excellent ... it's saved lots of phone calls. All our facilities are using it and are very happy." (Source: National Hospital System)

- "I have truly enjoyed the cost estimator. It saves me an enormous amount of time and I do not have to guess what the allowable charges are. I wish all of my insurance companies had the same option!!" (Source: Email from provider - podiatry practice in TX)

- "The rehab does use the precert process and they absolutely love it. They said it was so simple they couldn't believe it so they use that on a regular basis." (Source: Medical Center in Vermont)

Mr. KUCINICH. The Chair recognizes Ms. Reitan. Thank you. Please proceed for 5 minutes.

STATEMENT OF COLLEEN REITAN

Ms. REITAN. Good afternoon, Mr. Chairman, Ranking Member Jordan, and members of the subcommittee. I'm Colleen Reitan. I am the executive vice president and chief operating officer of Health Care Service Corp. We are a mutual legal reserve corporation that does business as the BlueCross BlueShield plans in Illinois, New Mexico, Oklahoma and Texas.

By way of background, HCSC is the largest customer-owned health insurance company in the Nation. We are not investor-owned. We are a customer-owned mutual. We have a work force of more than 16,000 employees serving 12.3 million members through our BlueCross plans in those four States. Our mission is to promote the health and wellness of health care for our members and the communities that we serve through accessible, cost-effective, high-quality care.

Prior to joining HCSC in 2008, I was the president and chief operating officer of BlueCross BlueShield in Minnesota, that State's largest health insurer. And they are a not-for-profit health plan. I have 28 years of experience in the BlueCross system. The areas of accountability I have with the HCSC is for management of our subscriber services division which processes member claims and handles health care inquiries. I'm also responsible for information technology, finance and actuarial functions.

We certainly recognize and share the public's concern with the current health care system. But fundamentally we believe in the strength and the value of the American health care system. We believe that insurers like HCSC are uniquely positioned to help foster and form improvements to the health care system. And we really welcome the opportunity to serve in that role.

HCSC has been an advocate of health care reform. To that end, we support the proposition that health insurance companies are required to offer coverage to all applicants regardless of their current health status, coupled with a personal responsibility for all Americans to obtain and maintain coverage.

Second, we support subsidies for those Americans who cannot afford health care coverage.

Third, we support health and wellness initiatives that focus on the prevention of chronic illness.

And finally, we support initiatives that promote effective care and treatment and for information technologies that improve quality and provide value for every health care dollar.

We are pleased to share with the subcommittee some examples of how HCSC has incorporated evidence-based approach into medical policy, into two key tenets that underpin the core values of our company, and that of access and quality.

My written statement outlines our approach in each of those areas in greater detail, but a few items are just worth noting before the discussion today.

First, our members need access to proven medical care. One of HCSC's four guiding principles is our belief that the interests of our members are of primary importance to our company. The mem-

bers we serve provide the reason for our existence and the rationale for the resources with which we operate.

Second, but equally important, is to continually improve the quality of care.

Another of our guiding principles is our belief that we as representatives of our members have an obligation to provide leadership in the health care field. We are promoting evidence-based medicine to increasingly focus our plans around proven health care services. We also work closely with our very broad network of doctors and hospitals to invest in data-sharing technology that works to improve clinical decisionmaking, and these efforts help improve quality and ensure that doctors and hospitals treat patients effectively and get paid efficiently.

HCSC is committed to working with the administration and Congress to achieve comprehensive health care reform, to expand access and improve quality of care for all Americans.

On behalf of our company and its members, I thank the subcommittee for the opportunity to discuss these important issues today.

Mr. KUCINICH. Thank you very much for your testimony.

[The prepared statement of Ms. Reitan follows:]

Written Testimony
Of
Colleen Reitan
Executive Vice President and Chief Operating Officer
Health Care Service Corporation
d/b/a/ Blue Cross and Blue Shield of Illinois, New Mexico, Oklahoma and Texas

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Thursday, September 17, 2009
2154 Rayburn House Office Building
2:00 p.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy."



BlueCross BlueShield
of Illinois, New Mexico, Oklahoma & Texas

Statement of Colleen Reitan, Executive Vice President & Chief Operating Officer
Health Care Service Corporation, d/b/a/ Blue Cross and Blue Shield of Illinois, New Mexico, Oklahoma and Texas
Hearing *"Between You and Your Doctor: The Bureaucracy of Private Health Insurance"*
United States House of Representatives, Domestic Policy Subcommittee of the Oversight & Government Reform Committee
2:00 p.m. Thursday, September 17, 2009
2154 Rayburn House Office Building

Introduction

Good afternoon Mr. Chairman and members of the Subcommittee. I am Colleen Reitan, Executive Vice President and Chief Operating Officer of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company which does business as Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of New Mexico, Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of Texas.

One of the areas within my responsibilities is management of our Subscriber Services Division, which is responsible for processing member health care claims and inquiries. I am also responsible for our Information Technology, Finance and Actuarial functions.

Prior to joining HCSC in 2008, I was President and Chief Operation Officer of Blue Cross and Blue Shield of Minnesota, that state's largest health insurer. I have more than 20 years experience in the Blue Cross Blue Shield system and am the co-creator of the Minnesota Health Information Exchange, a national model for sharing electronic information. I have a Master's degree in Health Care Administration from the University of Minnesota.

HCSC's mission is to "promote the health and wellness of our members and communities through accessible, cost effective quality health care." As the largest customer-owned health insurance company in the nation, we have a workforce of more than 16,000 employees serving

12.3 million members through our Blue Cross Blue Shield Plans in four states. Unlike a stockholder-owned company, the individuals and employers who are served by HCSC are also its owners, which, first and foremost, drive HCSC to structure its business practices to promote their health and wellness. To that end, we offer a full range of products that maximize access to needed care while making products as affordable as possible. We use our earnings to improve our administrative capabilities and other programs where they can further benefit our members and the physicians who serve them, and also to fund the reserves health insurers are required to hold.

We certainly recognize, and share, the public's concern with the current health care system. Fundamentally, we believe in the strength and value of the health care system as it exists. But we also know that every system must be on a path of continued improvement. We believe health insurers are uniquely positioned to help foster and inform the design and implementation of necessary improvements to the healthcare system. HCSC welcomes the opportunity to serve in this role.

To that end, HCSC has been an active advocate for health care reform, supporting:

(1) The proposition that health insurance companies be required to offer coverage to all applicants, coupled with a personal responsibility requirement to obtain and maintain health coverage;

(2) Subsidies for those Americans who cannot afford health care;

(3) Health and wellness initiatives that focus on prevention; and

(4) Initiatives that promote effective care, treatment, research and information technologies that improve quality and provide value for each health care dollar.

The issue of medical policy being explored by the Subcommittee today is a critical factor in any sustainable health care reform solution. We applaud Congress for including $1.1 billion for comparative effectiveness research in the *American Recovery and Reinvestment Act.* On behalf of HCSC, and its members, I thank the Subcommittee for the opportunity to discuss this important issue. I also thank the Subcommittee for its recognition and respect for the limitations under the Health Insurance Portability & Accountability Act and other patient privacy laws and regulations that govern my testimony.

HCSC's Approach to Medical Policy

HCSC's approach to medical policy is fully aligned with its member-focused structure and related philosophy of engaging with the providers who serve our members. HCSC medical policies are written statements that include benefit coverage positions for new or existing technology, products, devices, procedures and medications. By providing benefit coverage positions for specific treatments, medical policies help to ensure access to safe and effective care. All HCSC plans provide open access to the public to HCSC medical policies through their websites.

The development and maintenance of our medical policy involves a process that is built upon the bedrock of evidence-based medicine. This is consistent with the principles of comparative effectiveness research, which focuses on identifying care that is most likely to improve condition-specific health outcomes. To accomplish this, information from a variety of sources, including, but not limited to, the Agency for Health Care Research and Quality ("AHRQ"), the Blue Cross and Blue Shield Technical Evaluation Center, peer-reviewed medical

literature, statements from professional organizations, and recommendations from the practice community are all considered in the development of our medical policy coverage positions. The process is iterative. Findings and new data arising from unique claims and third-party review of cases brought to our attention through our appeals processes are used to further enhance the medical policy.

HCSC medical policies are routinely reviewed on a periodic basis. When a new or recently revised medical policy may limit the scope of coverage, HCSC provides at least a 90-day notice of this planned change on our websites. If during that period, new information is obtained that may impact this coverage position, HCSC will review it and, if appropriate, reassess its position.

The following are some examples of how HCSC has incorporated our evidence-based approach to medical policy into two key tenets that underpin our administrative activities: Access and Quality.

Access

Our medical policy positions seek to ensure that benefits are available for high quality care for our members in an efficient and consistent manner. A clear medical policy enables our claims payment system to be structured in a manner that allows the vast majority of the claims we receive to be efficiently processed without manual review.

One of HCSC's four Guiding Principles is our belief "that the interests of our members are of primary importance to [HCSC]. The members provide the reasons for our existence and the rationale for the resources with which we operate." Our corporate claims administration policy reflects that principle by striving to promptly and correctly process claims.

Claims payments, first and foremost, must be consistent with contractual benefits, corporate benefits policy and procedures, and any applicable state regulations. Our policy also provides, however, that, where there is latitude in interpreting how these authorities apply, we will "favor a benefit interpretation ***for the member*** that is as liberal as is administratively practical and financially prudent." This member-focused operating philosophy aligns naturally with our member-owned business structure.

Our philosophy is embraced by our employees. For example, we receive around 570,000 claims per day and approximately 97% of process-ready claims are paid within 14 days of processing. Both our claims item accuracy and financial accuracy are at approximately 99%. As demonstrated in a recent customer survey, 93% of our group business customers surveyed rated their overall customer experience "Excellent" or "Good."

HCSC's efforts to ensure that our benefit coverage positions are responsive at the level of the individual member also entail the efforts of medical professionals in each of our four plans. HCSC employs locally licensed physicians, pharmacists and nurses located in each of the states in which we operate. This means that local physicians can pick up the phone and speak with a local HCSC medical director. This process frequently serves to allow communication about previous interventions and possible changes to standard therapies. It further enables HCSC to glean important information about potential changes in standards of care. Lastly, this form of communication can also assist in ensuring that the practitioner is aware of the member's appeal rights. Information generated throughout this process is used to further hone our efforts to improve access to quality and affordable care.

Finally, we remain accessible to members in situations where members may question or disagree with a claims determination. In 2009, over 92% of member inquiries in our group business were resolved by our claims professionals on the first contact. If a claims issue remains unresolved, we have robust appeals processes which are governed by plan contracts and state insurance and labor regulations.

Quality

Another of our Guiding Principles is our belief that "we, as representatives of our members, have an obligation to provide leadership in the health care field." As such, we continually seek new ways with which to collaborate with our broad network of health care providers for the benefit of our members. For instance, we have taken a leadership role in publicly reporting on the performance of our providers, which has positively impacted both provider performance and the outcomes for our members. We also use data analytics to identify potential gaps in evidence based preventive care and chronic care management and use this information to inform members and providers about opportunities to improve the quality of care.

We have invested in technology that facilitates enhanced data sharing with physicians to improve both clinical decision making and operational efficiencies. HCSC recognizes the important role electronic medical records must play in any health care solution. We are dedicated to the continued development of tools to provide actionable information to our network physicians as well as the acceptance of electronic information from network practitioners.

As we explore long-term solutions, our benefit plans are increasingly designed around proven preventive care services. These are in accordance with nationally recognized clinical

guidelines. Prevention and wellness are critical factors in decreasing the rate of preventable chronic diseases such as Type 2 diabetes, high blood pressure, cardiovascular disease and some forms of cancer. In tandem with evidence-based medical policy, the design of benefits that encourage and engage members in preventive care can help to control health care costs and improve quality.

Rescission[1]

Rescission is an unfortunate, but necessary, part of fraud prevention. HCSC regrets any situation that requires us to rescind coverage for any of our members. Given the gravity of these situations, HCSC only rescinds insurance coverage when it is clear, after a thorough review and appeals process, that the applicant intended to deceive by either failing to disclose or misrepresenting relevant and material medical information. It is our goal in applying this strict standard to limit the numbers of rescissions, while at the same time ensuring that we identify and prevent insurance fraud. Both the Administration and Congress recognize that fraud places significant cost burdens on the healthcare system and, in turn, on other insured citizens.

When we learn that a misrepresentation may have been made on an insurance application, we assess the facts and circumstances carefully and with the degree of rigor and sensitivity they deserve. We have a multifaceted review process, which includes a thorough review of the facts that were not disclosed on an insurance application, review by an internal committee and an appeal process for the applicant.

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[1] The Subcommittee's August 26, 2009 invitation requested information on policy rescissions by insurers. As a point of clarification, the issue of policy rescission (i.e., revocation of insurance coverage) is a separate and distinct contractual issue that is not encompassed or impacted by HCSC's medical policy previously described.

We are also committed to "reforming" policies, rather than fully rescinding them, which means in many cases we are able to work to exclude coverage for the medical condition(s) related to the misrepresentation(s), rather than revoking an entire policy. In addition, over the past year we have committed to making our review even more robust, by adopting a plan which we are working to have implemented by early 2010 to require independent third-party review of all rescission recommendations. As a result of our processes, rescissions are not a frequent occurrence for HCSC.

Conclusion

HCSC is committed to working with the Administration and Congress to achieve comprehensive health care reform to expand access and improve the quality of care for all Americans. I thank you on behalf of HCSC for the opportunity to be part of this important discussion on that goal.

Mr. KUCINICH. Without objection, the Chair and the ranking member will proceed for 10 minutes each for questions, and then each member after that will have 5 minutes. So we may have several rounds. We will see how it goes.

The only thing I want to share with the members of the panel here is this: Members of Congress generally like to get answers. If you are able to give us a brief answer and it covers the territory, that's fine. If you start to go on and on on something—I don't want to appear confrontational, but I may have to encourage you to hurry up your answer or maybe have to cut you off. I don't want to do that. But I do want you to know that we are here to get answers and we need your help.

So without objection, I will begin. I just want to add one other thing. We may be joined by other Members of Congress who are not members of this committee. That's not unusual. And without objection, if other Members choose to come here from either side of the aisle, even though they are not on this committee, without objection, we will permit them to sit in, to participate and to ask questions.

So with that, I would like to start the questioning with Mr. Sassi of WellPoint. Sir, in your testimony you state, "Last year WellPoint received 380 million claims and processed 97 percent of them within 30 days." I'm looking at the arithmetic. And if the arithmetic is correct, it means that you did not pay within 30 days over 11 million claims.

Would you tell this subcommittee what is the value in dollars to WellPoint of the 11 million claims that were not paid in that time period?

Mr. SASSI. Chairman, I don't know the value of that.

Mr. KUCINICH. Can you provide this subcommittee with such information? There has to be a way to calculate it.

Mr. SASSI. I'm not sure, because that is at a point in time—the vast majority of those claims most likely were paid at a future point, either on the 31st day, or if we had requested additional information that was provided and then subsequently paid.

Mr. KUCINICH. Maybe you could then chart out 30 days, 60, 90. Businesses operate that way, of course, 120. And maybe if you could provide us information with what was the average cost of each claim that you did not immediately pay, it would be helpful. You could either look at it as a cost or a value. And we will follow-up with written questions so we can keep going. We are not going to belabor that.

Mr. Sassi, on a 2008 earnings conference call with Wall Street, your CEO said the following, "We will not sacrifice profitability for membership." As you know, WellPoint was forced to pay $1 million last year to settle claims or charges by the California Department of Insurance that you removed coverage from 2,330 members after they submitted claims for expensive medical care.

I am going to submit for the record the article on the settlement from the Los Angeles Times from February of this year.

[The information referred to follows:]

Los Angeles Times Business

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Anthem Blue Cross agrees to take back clients, pay $1-million fine

As part of a deal with California regulators, the state's largest health insurer will offer new coverage to 2,330 people it dropped after they submitted bills for expensive medical care.

By Lisa Girion
February 11, 2009

Anthem Blue Cross, the state's largest for-profit health insurer, has agreed to pay a $1-million fine and offer new coverage -- no questions asked -- to 2,330 people it dropped after they submitted bills for expensive medical care.

As part of a deal that the California Department of Insurance is set to announce today, Anthem also will offer to reimburse those people for medical expenses that they paid out of pocket after they were dropped. The company, a subsidiary of Indianapolis-based WellPoint Inc., estimated that those reimbursements could reach $14 million.

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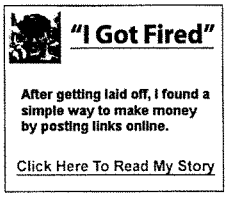

In exchange, the state agreed to drop its prosecution of its accusation that the company broke state laws in the way it rescinded members in preferred provider organization (PPO) policies between 2004 and 2008.

The settlement follows Anthem's agreement last year to pay a $10-million fine to settle similar charges involving 1,770 members in HMO-type policies overseen by the Department of Managed Health Care, another state regulator.

In both cases, Anthem agreed to make substantial changes in the way it sells and manages individual insurance coverage in California. Those changes, which include simplifying coverage applications, are expected to reduce the number of people who lose coverage through rescission.

The Anthem deal is the latest in a two-year effort by regulators to crack down on health insurers for dropping sick members on dubious grounds. It brings the last state rescission investigation to a close.

But insurers Anthem, Blue Shield of California and Health Net Inc. all remain targets of individual and class-action lawsuits alleging that they gamed insurance laws to dump sick people and avoid the costs of their care.

The only case to go to trial so far involved Health Net's rescission of a woman suffering from breast cancer. In that case, an arbitration judge awarded $9 million to Patsy Bates, a Gardena hair salon owner, after hearing her recount the fear she felt when she lost insurance and had to stop chemotherapy treatments.

"I am pleased that through this settlement, we have guaranteed reimbursement and restoration of coverage for the more than 2,300 people whose healthcare insurance was terminated without their consent," state Insurance Commissioner Steve Poizner said about the Anthem deal. "The settlement is a significant step towards ending rescission practices that can devastate consumers already weakened in their battle against illness."

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Mr. KUCINICH. WellPoint settled similar charges the previous year and paid a $10 million fine for removing coverage from 1,770 members of its HMOs in California.

Mr. Sassi, is dropping members just when they need health care what your CEO meant when she said that she wouldn't sacrifice profitability for membership?

Mr. SASSI. Absolutely not.

Mr. KUCINICH. What did she mean, then?

Mr. SASSI. I believe what was meant was that we would not reduce prices artificially to essentially buy membership in the open marketplace.

Mr. KUCINICH. And Mr. Sassi, what characteristics did those 2,330 individuals have in common that resulted in WellPoint's decision to drop members just as their medical bills threatened to reduce WellPoint's profitability?

Mr. SASSI. That settlement pertained to a settlement agreement that we reached with the Department of Managed Health Care and the Department of Insurance in California relative to recissions in the individual marketplace. I'm sure you're aware that companies agree to settle lawsuits or situations for a variety of reasons and——

Mr. KUCINICH. But you're in front of a congressional committee here. There is—unless your counsel is advising you that you can't answer that question, you should answer the question.

Mr. SASSI. I did answer the question, sir.

Mr. KUCINICH. You didn't really say what characteristics those individuals had in common that resulted in WellPoint's decision to drop members just as their medical bills threatened to reduce WellPoint's profitability. You did not answer the question. I would just ask you if you would answer the question.

Mr. SASSI. Those members were rescinded in the individual market because they materially misrepresented their medical history on their insurance application at the time that they applied for coverage.

Mr. KUCINICH. How did WellPoint discipline the executives who committed the practices that led to the enforcement action against you?

Mr. SASSI. We did not admit—we did not agree with the findings of the Department of Managed Health Care. That is on public record. They did issue a report. We did append a report to that. The settlement—we agreed to settle with the Department of Managed Health Care——

Mr. KUCINICH. I understand.

Mr. SASSI [continuing]. To put the issue behind us.

Mr. KUCINICH. Mr. Collins, in UnitedHealthcare Group's social responsibility report in 2008, your CEO writes, "The businesses of UnitedHealthcare Group are fundamentally organized around advancing our mission of helping people live healthier lives."

Now, if your business is fundamentally organized around that mission, will you explain UnitedHealthcare's settlement of charges last year that its PacifiCare subsidiary wrongfully denied 130,000 claims in California, paid claims incorrectly, lost documents that included medical records, failed to acknowledge claims in a timely

manner, and hassled its members with multiple requests for documentation that was previously provided?

Mr. COLLINS. Yes, sir. We are vigorously contesting the findings of the State. I do not contest that there is room for improvement in our California operations. We have put a lot of resources into improving our operations. And we regret inconvenience to our membership. But I don't see our aspirations provide products, services and financing of the health care of Americans as inconsistent with our behavior.

Mr. KUCINICH. Then that is fine. You have answered that question. But in 2007, what was the compensation of the top executives at PacifiCare?

Mr. COLLINS. In 2007, sir, PacifiCare was a wholly owned subsidiary of UnitedHealthcare. So the top executives would have been the top executives of United Health Group. And that is public record, sir.

Mr. KUCINICH. Was the compensation possibly in millions?

Mr. COLLINS. I don't have those numbers off the top of my head, Congressman.

Mr. KUCINICH. Would you provide them to this committee?

Mr. COLLINS. Absolutely. They are public record in our 10-K, sir.

Mr. KUCINICH. Other members may have this question. But I think it would be great if each of you could provide us that compensation information of officers and also information about bonuses and incentives received by PacifiCare executives and employees that would have rewarded the denial of claims in California in 2006 and 2007. We want to see if there is any connection there. And we need that information, if you can cooperate and provide it.

Mr. COLLINS. I'm confident, sir, that there was no bonuses awarded for denial of claims or other activity that was illegal. And as I said before, we are vigorously contesting the findings of the Department and the characterization of the actions there as denial of claims.

Mr. KUCINICH. Thank you, Mr. Collins.

Mr. Richards of CIGNA. On page 8 of your written testimony you state, "We do not consider costs in establishing coverage policy in our decisions to provide access to care."

But we heard from a former senior executive with CIGNA, who told us yesterday that CIGNA has meetings every quarter which are called "town hall meetings," internal town hall meetings, in which executives go over the past quarter's financial statements and talk about how they can tighten utilization to lower the share of CIGNA's premium income spent on medical expenses.

Isn't it true that CIGNA has held internal town hall meetings at which those topics are discussed?

Mr. RICHARDS. It is absolutely true that we hold town hall meetings to communicate with our employees, to reinforce our mission and to talk about our financial results.

Mr. KUCINICH. And those town hall meetings are videotaped, are they not, and audiotaped?

Mr. RICHARDS. I do not believe they are videotaped. We certainly audiotape them so that individual employees who are not able to attend are able to——

Mr. KUCINICH. Are there audiotapes available?

Mr. RICHARDS. Yeah.

Mr. KUCINICH. I would like you to provide this subcommittee with copies of those audiotapes and any videotapes that you have. Our staff will work with you to achieve the——

Mr. RICHARDS. Again, what I would like to emphasize, Mr. Chairman, is those internal meetings are to communicate to our employees——

Mr. KUCINICH. I understand. And we—I understand that they are. And we will be in touch with you regarding our request that we get those audiotapes.

I just would like to conclude with this question for each and every one of you. The premise of this hearing is that health insurers wield strong influence in the kind of care, whether there is care, for their policyholders who become very sick.

According to the American Cancer Society, "Cancer patients and survivors may delay or forego care, in the face of cost sharing, that they find difficult to afford."

A recent study found that 5 percent of non-elderly adults with private health insurance who have been diagnosed with a chronic condition such as cancer reported they went without needed care in 2006. This is the American Cancer Society saying this.

I want to give you a chance to express for the record what you think about this question, and really with a simple yes or no answer. And we are going to go down the line and I want you to answer this question. Do you believe that a health insurer's refusal to pay for a patient's cancer treatment can directly or indirectly cause harm or death to that patient?

I'm going to ask the question one more time. Do you believe that a health insurer's refusal to pay for a patient's cancer treatment can directly or indirectly cause harm or death to that person?

I would like to go right down the line, Mr. Collins, and just give me a simple answer go. All the way down the line and then my question time is completed. Mr. Collins.

Mr. COLLINS. Yes, sir.

Mr. KUCINICH. Pardon?

Mr. COLLINS. Yes, sir.

Mr. KUCINICH. Mr. Sassi.

Mr. SASSI. Yes, sir.

Mr. KUCINICH. Ms. Farrell.

Ms. FARRELL. Yes.

Mr. KUCINICH. Mr. Bloem.

Mr. BLOEM. Yes.

Mr. KUCINICH. Mr. Richards.

Mr. RICHARDS. Yes. But CIGNA only allows clinicians to make coverage decisions and those coverage decisions are only based on external scientific evidence.

Mr. KUCINICH. The answer is yes. OK. Ms. Reitan.

Ms. REITAN. Yes, sir.

Mr. KUCINICH. Thank you. I want to thank each and every one of you for your candor.

The Chair recognizes for 10 minutes Mr. Jordan of Ohio. You may proceed.

Mr. JORDAN. Thank you, Mr. Chairman. I appreciate the chairman's having this hearing. I appreciate the chairman's intensity

and passion that he brings to any debate, but I fundamentally disagree with sort of the underlying premise here, the idea that because there has been—as I stated in my opening statement, that there has been some problems with the way private insurance works; that somehow that should cause us to move to a government-run system. I just fundamentally disagree with that.

Frankly, I think the majority of Americans, as pointed out over the last several months in any poll you look at here of recent date, is—would say the same thing.

So I have really kind of two focuses here in the few minutes I have with you. And, again, I appreciate you being here. One, I want to get the facts. And then I want to get at this idea that I think is fundamental to real reform and what needs to happen in this country, and that is a health care system that empowers the patient.

There is a great—I think a great article in this month's Atlantic which talks about the idea that it is always somebody else who is paying. And when somebody else is paying, that is—I think Ms. Farrell said it well. She said insurance premiums don't drive health care costs; health care costs drive insurance premiums. We have to get at health care costs. And that only happens when the consumer, the patient, the family, the small business owner out there, has a better handle on what is happening, more transparency so they can figure this out and make some real market—real market-type decisions.

So let me start with this. One of the things we heard yesterday, again in an effort to get to the facts, one of the things we heard yesterday was from the panel we had; 57 percent of every dollar is all that goes toward health care of the premiums that you take in. And so we heard about the cartels and—I'm actually looking now at a piece the Journal ran this Monday. And they actually talk about an example in Alabama where it was 92 percent, according to what is happening in the State of Alabama, where one insurer, BlueCross BlueShield of Alabama, has 70 percent of the market share.

So I would like to know, do you agree with that 57 percent figure; and if not, what it is in each of your companies' situation? We'll just go down the list. Mr. Collins.

Mr. COLLINS. Thank you, Congressman Jordan. The statistics cited in Mr. Sassi's testimony come from a PriceWaterhouseCooper's study that cites 83 cents on the dollar. That is a credible study. It is a recent study. There is another study that just came out from Sherlock & Co., just in the last few weeks, which corroborates the PriceWaterhouse study.

Mr. JORDAN. What is United? What do you say? What do you pay? With every dollar you take in, how much goes for patient care?

Mr. COLLINS. That's not a real simple answer to——

Mr. JORDAN. Is it 57 percent? Is it less? Is it more?

Mr. COLLINS. No, sir. It's consistent with the findings in the Sherlock and the PriceWaterhouseCooper's studies.

Mr. JORDAN. Have you done an internal investigation? Do you know? Do you have a good idea what United would be?

Mr. COLLINS. Sir, a loss ratio for 2008 was approximately 83 percent, 83½ percent for the company. But that is across a wide spectrum of businesses.

Mr. JORDAN. Mr. Sassi, WellPoint?

Mr. SASSI. Same question?

Mr. JORDAN. Yeah.

Mr. SASSI. The loss ratio for WellPointplans overall is directionally similar to what I quoted as PriceWaterhouseCooper's. But as I also stated, loss ratio is just the calculation of premium less claims that are paid. And as I also indicated in my testimony, there are a fair amount of administrative costs that we pay to help manage chronic care, chronic conditions. We pay out of our administrative cost for disease management programs for asthma, heart disease, diabetes, COPD, to help those 50 percent of Americans that have chronic illness manage their costs. And that is typically not included in the loss ratio. That is included in administrative expense. So if you're looking for a holistic what-do-we-spend, it's north of that.

Mr. JORDAN. I understand. I understand.

Ms. FARRELL. Congressman, at Aetna, we spend 84 cents on the dollar directly on medical claims. We do spend a fair amount on administration relative to innovations in the health care industry, making sure that we are providing our members and our providers with the most recent tools and technologies and information in order to, as you said, give them the tools to make them understand what policies they purchased, what is in those policies, so that they can make better decisions on behalf of themselves and their families.

Mr. BLOEM. Ranking Member Jordan, we paid between 83 and 85 percent for the last 7 years. Last year was the upper end of the range. Around 84.6.

Mr. RICHARDS. Ranking Member Jordan, for CIGNA last year, the number was 89 cents. That number has gone up each of the last 5 years.

Ms. REITAN. Our medical care ratio at HCSC is approximately 84 percent.

Mr. JORDAN. OK. Let me move to another one.

According to the Congressional Research Service, each year 1 billion claims are submitted to Medicare and 10 percent of those claims are denied. So 10 percent—that is a lot of claims denied, if I got the numbers right when you went through your testimony—I just jotted these down.

United, you have 70 million that you insure; WellPoint 35; Aetna 37; Humana, I think had 2 different distinctions, but I totaled 16; CIGNA, 46 here and around the world; and HCSC, 12.3 million.

So how does your denial rate compare to what the Government currently does with the Medicare program?

Mr. COLLINS. Congressman, I'm not prepared to answer that question today. I really just don't have those numbers available, I would like to point out——

Mr. JORDAN. How many claims do you have a year? I'm interested in Medicare population, older populations who are probably going to be significantly more claims. But 70 million people com-

pared to 45 in Medicare—45 million in Medicare. How many claims do you get a year?

Mr. COLLINS. I don't know exactly. On our primary processing platform where the vast majority of our claims are processed, as I stated in my testimony, 250 million claims.

Mr. JORDAN. OK.

Mr. SASSI. Ranking Member Jordan, I don't have the percentage of claims that were denied, if that is the question. We processed 380 million—we received 380 million claims. The number I read was the amount that we processed in 30 days. We processed——

Mr. JORDAN. Ninety-seven percent in 30 days. I got that. But we heard stories yesterday, so there have to be some that are denied.

Mr. SASSI. Oh, absolutely.

Mr. JORDAN. Do you know what percentage are denied?

Mr. SASSI. I don't have that.

Mr. JORDAN. Is it more than 10 percent?

Mr. SASSI. I don't have that number. I'm sorry.

Mr. JORDAN. Ms. Farrell.

Ms. FARRELL. We process approximately 407 million claims annually at Aetna. And if you look at the reasons why claims are denied, I think what you are trying to get at is the reason something might be denied for medical necessity, and at Aetna less than one-half of 1 percent of claims are denied because of medical reasons.

Mr. JORDAN. Thank you.

Mr. BLOEM. Ranking Member Jordan, I cited the Athena Health Study which I commented that we ranked first in terms of the lowest denial rate. Our denial rate in that survey was 5.7 percent. The government, in the government—the Medicare Part B program, that had an 8.7 percent denial rate for fifth place.

Mr. RICHARDS. Ranking Member Jordan, at CIGNA, we have about 91 million claims we processed last year, and again 99.9 first of those were approved for the coverage. So it would have been point 1 percent that were not approved for coverage.

Mr. JORDAN. Good.

Ms. REITAN. HCSC processes 560,000 claims a day, and we deny for the medical necessity coverage three-tenths of a percent.

Mr. JORDAN. Wonderful.

Mr. Bloem, in your testimony you talked about some things you were doing to make it easier for the folks who you do business with, people you insure to deal with—that is one thing you hear from folks in our own lives. You get the statement of benefits, you try to figure out what the heck it says. I think if a lot of Americans are like me, they are looking—if it says it's not a bill, they kind of file it away and not worry about it too much.

But you talked about some things you're doing. I would like for you to elaborate on that a little bit. Because one of the things we hear from health care professionals is they don't like the reimbursement rate they get from Medicare and Medicaid. But in some ways it's not as cumbersome as some of the other things they have to deal with. So I'm curious what you are doing to make it easier for people to deal with and figure out what is going on, and again getting at this idea to empower the patient, which I believe will lower the cost.

Mr. BLOEM. OK. A couple of things I mentioned in my written testimony I would just like to quickly summarize. First of all, when we talk about the problems that have existed between the various constituencies, obviously we have three people involved: We have us as the payer, we have the member, and we have the provider.

So to make things simpler, to make things easier, what we've done, as in Florida but now throughout the country, is come up with a joint venture that we have with a number of companies that helps providers get instant adjudication, real-time adjudication in terms of what a member's responsibilities are, what ours are. We are trying to provide certainty against all—for all our constituencies.

Mr. JORDAN. So the providers are liking it and the patients are liking it?

Mr. BLOEM. Because it's electronic and it basically tells people when they go to the doctor, this is what is going to be expected of you, this is what Humana is going to pay, this is what you are going to pay, this is what the provider is going to charge.

We also—if I could be real brief—we also have a document called a "smart summary" that we mail to 10 million of the 10.3 million members that we have, every quarter. And it basically tells all the claims that they have had, what those claims are for, what doctors, what hospitals they went to, what pharmacy, what drugs they are taking. It gives them sort of a quick summary of what their situation was for that quarter, much like you get with maybe investment accounts you have. I would be happy to provide this.

Mr. JORDAN. A quarterly statement?

Mr. BLOEM. Yes. So that people understand that they can begin to have the knowledge you're talking about in order to take effective control of their health status and their insurance. Thank you.

Mr. JORDAN. Ten minutes goes fast, Mr. Chairman. Thank you.

Mr. KUCINICH. I thank my colleague from Ohio.

We've been joined by two other members. And before we go to Mr. Cummings, I will introduce Mr. Schock from Illinois, and also the distinguished chairman of the Judiciary, John Conyers, who is the author of—he is the author of H.R. 676. I'm always pleased to work with him on that. Mr. Conyers, we are honored by your presence here, as well as Mr. Schock's presence.

We are going to go to Mr. Cummings for your questions. Go ahead, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I just want to know, how many of you—which of you, if any—we will go down the line—give bonuses for folks who deny coverage? Straight down the line.

Mr. COLLINS. We don't issue bonuses for people that deny coverage.

Mr. CUMMINGS. Is it a part of their evaluation? I'm going to ask each one of you the same question. Is it part of their evaluation—is there any kind of incentives with regard to evaluations regarding denial of coverage; that is, claims?

Mr. COLLINS. I'm sorry, Congressman. Without going back and doing research on that topic, I really could not give you a responsive answer to that question.

Mr. CUMMINGS. You don't know the answer to that question? Is that what you are telling me?

Mr. COLLINS. Yes, sir.

Mr. SASSI. I can tell you that WellPoint does not have any policies in place to reward people for denying care.

Mr. CUMMINGS. So there's no policies and you do not do that; is that correct?

Mr. SASSI. My understanding is we do not.

Mr. CUMMINGS. Or physicians? How about physicians denying treatment?

Mr. SASSI. There are no metrics or anything surrounding denial of care.

Mr. CUMMINGS. Very well. Ms. Farrell.

Ms. FARRELL. Only physicians can deny a claim at Aetna, and we have absolutely no incentives, financial incentives, tied to that decisionmaking process.

Mr. CUMMINGS. So employees don't either; is that right? I know you said physicians, but what about employees?

Ms. FARRELL. Physicians are the only ones that can actually——

Mr. CUMMINGS. In other words, do they ever?

Ms. FARRELL. Physicians are the only ones who can actually——

Mr. CUMMINGS. Did you ever have that policy of giving incentives for denying claims?

Ms. FARRELL. You say "ever." I can't speak for ever.

Mr. CUMMINGS. To your knowledge, have you?

Ms. FARRELL. To my knowledge, no.

Mr. CUMMINGS. I see your lawyer is trying to advise you. You're welcome to do so because we are going to followup on this. Are you finished, Mr. Lawyer?

Ms. FARRELL. To my knowledge, no.

Mr. CUMMINGS. All right. Mr. Bloem.

Mr. BLOEM. To my knowledge, during my tenure of 8½ years, no.

Mr. RICHARDS. There are no financial incentives for our clinicians to deny coverage.

Ms. REITAN. At HCSC there are no financial incentives and no bonuses paid related to denial of care.

Mr. CUMMINGS. Then between today and yesterday, there are some—apparently there must be some other insurance companies, then, because the testimony we got yesterday was just the opposite to that. But we will go forward.

Very interestingly, when you all were answering Mr. Jordan's question, you were talking about this whole idea of claims. And, Mr. Richards, you in your oral testimony and your written testimony seemed—were very proud and I think you should be—I think, when you said that over 99 percent of the claims that are covered, people are receiving the services that the doctor recommended; is that correct?

Mr. RICHARDS. That's correct.

Mr. CUMMINGS. Mr. Richards, when you say "claim," what do you mean by that?

Mr. RICHARDS. When I refer to that, I'm talking about the determination of whether the particular procedure is covered.

Mr. CUMMINGS. In other words, those are services that were already done; is that right?

Mr. RICHARDS. Actually, a lot of times a physician, the individual's physician would check with us prior to the procedure being done under what is called a "prior authorization" to see if the procedure would be covered.

Mr. CUMMINGS. So you're including—when you look at this, when you're giving us this figure, you're telling us that in those cases before services were rendered, you include those, and you include those after services were rendered that you paid, "claims." Is that what you mean by claims? Because I want to make sure that we are going from the same page. Because the testimony we got yesterday is that, you know, the industry has a definition for claims. And claims means some services that have already been rendered. And then you're talking about denial. But a lot of the problems that we heard yesterday were things leading up to that, where the doctor calls—we had one doctor here yesterday that said he literally had to double his number of employees just to deal with getting authorization to do procedures.

So just answer my question. When you say 99.9 percent, what do you mean?

Mr. RICHARDS. I mean of the claims that we get, 99.9 percent of those are approved without any need for appeal. I think—first of all, I appreciate, Congressman, the chance to clarify this because I don't think it's well understood by the public. CIGNA—and I suspect other insurance companies—get submitted a lot of claims that are duplicates or are for people that are not insured by CIGNA.

Mr. CUMMINGS. Are those included in this definition?

Mr. RICHARDS. They are not included. So if, for instance, a doctor submitted us a duplicate claim, we had already received one——

Mr. CUMMINGS. OK. I got the duplicate. What else? I want to make sure—the definition is changing already.

Mr. RICHARDS. Well, I understand the committee is interested in both what insurance companies are doing relative to medical coverage—which is how I was answering the question—but I also understand you're very interested in the administrative procedures. I'm trying to clarify that.

Fraud and abuse would be another reason why a claim might be denied. And, for instance, I know that that is extremely important to Medicare and the Office of the Inspector General. So we, for instance, denied—or did not pay 215 million claims for fraud and abuse. Again, these would be situations where the individual has already received the care but that the doctor or provider is inappropriately billing for that.

Mr. CUMMINGS. When you say a "duplicate," do you mean a case where somebody may have been denied and then they try again?

Mr. RICHARDS. No, no. I mean due to a billing error; we would have already, for instance, paid the claim and it was submitted again. Sometimes things cross in the mail, Congressman.

Mr. CUMMINGS. So is that the only other thing that is—that may not be included in your denial rate?

Mr. RICHARDS. I think those are the major categories. The only other thing I might mention is in California, there's a fair number of doctors in California who operate under a prepayment mechanism where we pay them a certain amount per month to cover the care for our customers. So that prepaid—the way that prepayment

works, we pay them whether the individuals seek care from that doctor that month or not. We occasionally—we sometimes do get claims from those doctors, again erroneously, for care that we have already paid under the prepayment. In that case, those claims would also not be paid.

Mr. CUMMINGS. Thank you.

Mr. KUCINICH. The gentleman's time is expired.

The Chair recognizes the Congressman from Illinois, Mr. Schock. You may proceed for 5 minutes.

Mr. SCHOCK. Thank you, Mr. Chairman. Thank you to our distinguished panel for being here. Unfortunately I have half the time as the chairman and the ranking member. So I'm going to try to make this quick.

It seems as we discuss health care and the rising costs of health care, the focus seems to be on who is paying for it. And to me it doesn't matter whether you're a State government providing Medicaid or a Federal Government providing Medicare or a private business or an individual paying for it privately, the issue is the huge rise in costs.

My question to all of you in the private pay business is within your respective organizations—I'm assuming when you negotiate with rates to your preferred providers, you ask for some justification in costs. And what there seems to be very little discussion about is the rise in cost. Some of that is true operating costs; in other words, new X-ray, new MRIs, new technologies, staff. And some of the rise in cost is also a cost shift.

In other words, the great debate this year is whether or not we should cut Medicare rates by 16 percent, and we seem to pat ourselves on the back when we leave and we say we staved off cuts again this year. We may have staved off cuts, but we didn't adequately reimburse the providers for the true increase in their costs, therefore requiring them to shift that cost to those in the private pay industry.

So my question to each one of you is: Have any of you within your organization looked at the increase in reimbursement rates that you all are required to pay and thus raising your premium rates? What percent of that is a true cost increase in terms of costs to the recipient and what percent of that cost increase is because of cost shifting as a result of the State and Federal Government not adequately paying for their patients?

Mr. Collins.

Mr. COLLINS. Thank you for that question, Congressman. The trend in unit costs—so the negotiated rates we have with providers and doctors has been running in the range of 4½ to 6 percent for many years now. That is in excess of CPI. I don't know the exact percentage of what our costs are due to cost shifting. But according to a recent Milliman Study, Milliman & Robertson of the accounting firm or the actuarial firm, $88 billion a year are cost-shifted from Medicare and Medicaid programs to the private sector. The American Hospital Association and the AMA have both published statistics that show that Medicaid programs on average pay less than 90 percent of cost and that Medicare pays less than 100 percent of cost. So there is a cost shifting that has been a constant pressure on unit costs in the private sector, and it's an ongoing and

major driver of unit cost inflation in health care on the private side.

Mr. SCHOCK. You said your premiums went up on the average of 4 to 6 percent?

Mr. COLLINS. Unit cost trend over time in the industry has been running around 4 to 6 percent, and that's over a long period of time. Annual—just the unit cost. Other components of inflation are utilization increases, new technology, those sorts of things. But just straight unit costs has been running 4 to 6 percent.

Mr. SCHOCK. And have you looked at what percent of that is costs of doing business and what percent of it is a shift?

Mr. COLLINS. I'm sorry, sir. I couldn't answer that precise question. But 88 billion over the private sector is a significant amount of money.

Mr. SCHOCK. Yeah.

Mr. SASSI. Congressmen, I would agree with Mr. Collins' comments. Milliman did publish that study and it estimated that 88 billion is being cost-shifted to the private sector from Medicare and Medicaid, which equates to about an overall increase across the board for commercial members of about 10 percent, or, I believe the study says $1,600 per covered member. It would be very difficult for us to identify on a facility-by-facility, doctor-by-doctor understanding their entire cost structure, what goes into that, to identify at that level. But I believe that the Milliman study is credible.

Mr. SCHOCK. Because I'm tight on time, I'm not going to ask anyone to repeat the same thing. Has anyone done—I guess I understand provider by provider, it's not possible to do that. But I didn't know if you actually looked, did some independent study on a sampling pool of preferred providers on what their justification of increase in costs is?

Mr. RICHARDS. Congressman, first of all, I do agree that the underpayment by Medicare and Medicaid is absolutely a huge problem for hospitals and doctors and it's definitely increasing medical inflation. CIGNA has done some analysis of the disparity in the rates between Medicare and Medicaid and commercial rates. I don't have that with me, but we would be happy to provide that analysis of the average rates to the committee.

Mr. SCHOCK. I only have a couple—what is the yellow, 2 minutes, 1 minute?

Mr. KUCINICH. Go ahead and finish.

Mr. SCHOCK. OK. One other question, because I'm going to be cutoff here. I wish I had more time. It seems to me, again as we talk about controlling costs, I found it very interesting, I met with the Consulate General of Canada, and he is very much supportive of their Canadian health care system. But one thing I thought during the discussion was he said, Congressman Schock, he said, "It's still too easy in your country to sue doctors." And I kind of sat back in my chair and I said, "Excuse me?" He said, "Well, our health care system in Canada would not continue to function if comprehensive tort reform were not a part of the health care plan when we passed it in our country."

My question—obviously my view on this is we shouldn't wait for a single-payer system in our country to have comprehensive tort reform as a part of reducing not only the premiums that the health

care community pays but, more importantly, the unnecessary medicine that's ordered as a result.

My question to you, again, is whether or not within your respective companies you have looked at the amount of reimbursed care that you give through the insured folks, what percent of that's done through defensive medicine as a result of a fear of these physicians being sued?

Ms. REITAN. I actually don't have the data with me, but I know the BlueCross BlueShield association has done some work on this exact issue. So we would be happy to submit that in followup.

Mr. SCHOCK. Could you provide us a copy of that?

Ms. REITAN. Yes, we would be happy to do that.

Mr. SCHOCK. Anyone else?

Mr. BLOEM. Tort reform would be very helpful because the absence of tort reform increases the intensity of procedures that doctors perform, which is one key aspect of utilization which you talked about before.

If I may, I would just like to go back to your question about cost shifting with government programs. One of the things that happens with Medicare and Medicaid is that they lower reimbursement rates in an effort to get more efficiency out of the health care system. That, in part, does happen. But when it doesn't fully pay for the reimbursements, then what happens is there is a cost shift. And the commercial segment, the commercial products pay for that shortfall that's not made up by efficiency that comes from those reimbursement cuts. And that's estimated to be $1,500 for a family of four who has private health insurance. That—if you look at the total cost of private health insurance, that's a major component it of. Thank you.

Mr. SCHOCK. Thank you. And thank you, Chairman, for your generosity.

Mr. KUCINICH. We are glad that you're on this committee and we appreciate your participation. The Chair will recognize the distinguished chairman of the Judiciary Committee who has joined us, Mr. Conyers. You may proceed.

Mr. CONYERS. Thank you for this permission, Chairman Kucinich. And I want to thank you for the hearing. These are distinguished, experienced members of the health insurance industry, and I'm sure their testimony has been very important as we work toward a reform of health care.

And I also want to commend the ranking Republican member, Aaron Schock, who is carving out quite a record of distinction for himself. I'm glad he is here with us as well.

Ms. Farrell, what do you think—what is your feeling about the public option, and how do you think it fits into health care reform as you see it, ma'am?

Ms. FARRELL. My view of the public option is that I think we really need to focus our efforts on understanding what problems that we are trying to solve around access and quality and affordability, and then ask ourselves at the end of that whether or not a public plan would actually progress us further down the path than some of the bills that have already been put in place. I do believe——

Mr. CONYERS. Could you pull the mic just a little closer, please?

Ms. FARRELL. One of the things that's concerning about a public plan, which Congressman Schock was just referencing, is the cost shift. If a public plan were to reimburse at Medicaid or Medicare rates, there would be quite a cost shift to the commercial segment, which would in turn result in increased costs in the commercial sector, and therefore increased premiums, which is really antithetical to what we are trying to achieve in health care reform.

Now, Mr. Richards, it was my impression that the public option would be designed to save money, not cost more money, and that it would provide a choice between citizens as to whether they wanted a private insurance plan, of which there are literally hundreds, or would they want a public plan. Is that your impression?

Mr. RICHARDS. Congressman, CIGNA supports many of the reforms that are being debated in the debate in both the Senate and in the House, including personal coverage requirements, guaranteed coverage, the elimination of preexisting conditions, and the reform of payment mechanisms. We believe if those reforms are enacted, then a government-run plan is not necessary.

Mr. CONYERS. So, Mr. Sassi, if you agree with that last comment, then you don't want any competition in the insurance—health insurance field, right?

Mr. SASSI. I think it's our position that there is a lot of competition today in the health insurance industry. There are over 1,300 health insurers in this country that compete for business.

The challenge is that when the Government could come in and have the ability to set reimbursement rates, that it creates an unlevel playing field between private industry and the Government, and that certainly has the potential to exacerbate the cost shift that already occurs between Medicare and Medicaid and the private sector.

We also fear that as a result of that, since we don't have—we would not have a level playing field, since insurers are subject to taxes and other types of expenses, that lower reimbursements, coupled with taxes that we pay, create a dramatically unlevel playing field and that could reduce choice for the American public.

Mr. CONYERS. Well, Ms. Reitan, with this unanimity against the public option, we are putting in a provision that everybody has to get insurance, and if you can't afford it, guess who will pay for? The Government. And you're talking about the public option will cost—someone is talking about it, not you. How could one public option destabilize 1,300 private insurance companies?

Ms. REITAN. Our company agrees with the statement that was made earlier, that when you implement some of the reforms that are being discussed that require insurers to offer coverage to all individuals, regardless of their health status, as long as they have a requirement to access and carry coverage——

Mr. CONYERS. Could you pull your mic up a little closer?

Ms. REITAN. We do agree there are people who are lower income, often low-income working individuals, who will need some subsidy in order to be able to afford health care coverage. So we believe if you pass reform with all of those elements, we actually will have a more well functioning health care system today and have the ability to put in the market plans that can be affordable over time.

Mr. CONYERS. Couldn't a public option accomplish that?

Ms. REITAN. We don't think it's needed in order to accomplish that.

Mr. CONYERS. Why not? There are a lot of people advocating it.

Ms. REITAN. Because those reforms that I have described have never been in existence in the United States. And so by passing them, we think that can significantly improve the health insurance system and make coverage both more accessible and more affordable.

Mr. CONYERS. Well—surely.

Mr. KENNEDY. We have a public option in the VA. The Veterans Administration is essentially a public option. So we do have one here in this country.

Mr. CONYERS. What about Medicare? Who do you think runs that?

Mr. KENNEDY. Exactly.

Mr. CONYERS. Well, let me—I'm not doing too well on these question, Mr. Chairman. Nobody seems to——

Mr. KUCINICH. I would suggest that the Chair is doing very well with the questions. It may be the answers that we may be having difficulty dealing with here, but your questions are just fine.

Mr. CONYERS. Well, let me try Mr. Collins. Have you ever heard of a universal single-payer health care system?

Mr. COLLINS. Yes, sir, I have heard of the concept.

Mr. CONYERS. And have you developed some feelings about it?

Mr. COLLINS. Well, yes, sir, I have—clearly I'm a partisan for the—having a private health care, robust private health care sector. I believe that the private health care sector brings a lot of value to the overall system that we have here, and of course we have a robust public system with Medicare, Medicaid, VA system, TRICARE. Those are all components of the public system.

I believe the private system is important because it brings in innovation, it brings energy, it brings change, it brings ideas that are often used in the public sector system as well. And I think we can have both a private and public system. We can build on what is good in the public system—in the private system, and use those things to improve the private system as well, sir.

Mr. CONYERS. That's encouraging. Then why not let's try the single-payer system, H.R. 676? That's mostly a public system. What's wrong with it?

Mr. COLLINS. I'm not actually familiar with that bill. If it's a single-payer system it would be the end of the private system as we know, I believe.

Mr. CONYERS. Is that true, Mr. Bloem? Does that mean that the private system goes out if you have a single-payer system?

Mr. BLOEM. I think the primary concern, Congressman, is the fact that we mentioned before with respect to the cost shift. The Medicare and the government programs, the VA, all of those programs have lower rates of reimbursement. So that in the entire system, not all of the costs are being covered by—not the proportional costs of care that those programs—that those programs give are being borne by the Government. So there is a shift, as I mentioned to Congressman Schock, of about $1,500 for a family of four every year.

And so I think one valid concern would be that if all—there was a single payer and all of the costs were borne by the Government, then there would be none of the innovations that the others have discussed. It would be the end of the commercial. But then you would have to—the Government would then have to absorb all that other cost, and that would make it—that would make it more expensive for everyone. There is also, I want to remind everybody, what was said to—was said about the value of what the private sector provides.

Mr. CONYERS. But what about all the cost increases that the health industry is imposing upon people with health care, not only in their premiums but also in pharmacy prescriptions that are being raised? I mean, you talk about cost shifting; you ladies and gentlemen are representing companies that keep raising the costs of premiums every single year, and yet you're worried about somebody else shifting costs.

Mr. KUCINICH. Mr. Conyers, time has expired. But each one of you that wishes to respond to his question, please do so. And I would urge any or all of you to do it. Would someone care to respond?

Mr. CONYERS. Could we start—Ms. Farrell, could you help me understand how I can increase my sympathy for health insurance companies?

Mr. KUCINICH. Ms. Farrell.

Ms. FARRELL. Yeah. The way we look at premium increases every year and the way they are calculated is based on the underlying increase in medical costs. And so——

Mr. CONYERS. So you have to do it. But the profits are greater and help—the only people I can think of that make more profits than the industry that you six represent is oil and pharmacy.

Mr. KUCINICH. The gentleman's time is expired.

Mr. CONYERS. I'm sorry.

Mr. KUCINICH. We are grateful that you're here.

Mr. CONYERS. All right. Thank you very much.

Mr. KUCINICH. And the Chair recognizes Mr. Kennedy. And we are grateful that you're here, Mr. Kennedy. And we are grateful for your family's lifelong commitment to health care for all Americans.

Mr. KENNEDY. Thank you, Mr. Chairman.

To the panel, as my former colleague was just talking about the public option, and given the environment right now in Congress with respect to the political liability of a public option, I wanted to get to how we are going to implement savings in the event that a public option isn't passed. I am in strong favor of a public option and want that on the record, but I understand that the political reality of what is going on right now in Congress shows that that may or may not happen.

If that doesn't happen, I want to hear today what insurance companies are going to do to step up to the plate to make sure that we don't waste a lot of time before we get put into place what will be the alternative to a public option; that is, perhaps a trigger of the public option, which means that we are going to have to wait for us to show that insurance companies aren't doing their job before a public option then gets kicked into place. And, of course, that's an ugly kind of scenario because it's basically saying OK, we

are going to wait until things go wrong before we fix them. And that presupposes things are going to go wrong.

So obviously we don't want things to go wrong. And what I would like to hear from you is—we hear a lot of talk about different tools in health care that will save money and improve quality and efficiency, and we are all familiar with the inefficiencies in our current system that lead not only to wasted dollars and poor health outcomes for patients, but also huge administrative headaches and red tape for patients.

Health care information technology, as I know, is one of the tools we talk about in achieving efficiencies. But another area where we could generate savings and quality improvements is through a process called improvement tools, such as value stream mapping and flat mapping.

We talk about how to make clinical improvements to improve efficiency, so to save money. But what do you see for these as potential to save money through the process of administrative improvements? And what can be done to incentivize the use of these tools in not only making clinical improvements, but also making improvements in the whole process of administrative making and cutting out a lot of that red tape that everybody always acknowledges is a big cumbersome part of your business? Could you tell us how do we incentivize in government a way for you to do the right thing?

Mr. SASSI. Congressman, I think there are many things that the private sector can work with government on. I think you brought up an important element: health information technology. I think there—certainly my company, WellPoint, is very interested in implementing health insurance technology. Examples include e-prescribing and making sure that—making available to doctors the ability via a PDA to prescribe—to check for drug-to-drug interactions, to get personal health information——

Mr. KENNEDY. We know all—we don't have much time. We know all about IT and what it can do. But how do we ensure that, you know, when you have an IT system that's actually an IT system that's working to the maximum effect? We all know IT can work, but it doesn't do a lot of good to have IT and say all those great buzzwords about keep prescribing and, you know, Doctor, you know, supported protocols and all of that stuff. It's not going to do well if you don't have a way of monitoring whether the system is actually running efficiently.

And when the doctor says, oh, go out for these five referrals, and they go out to the front and the administrative clerk only gives them three of the five, who picks up that it was only three of the five? How do you measure whether your system is working up to speed?

How do you measure whether your system is working up to speed? Who's going to be testing to make sure that you're doing the job in terms of getting the most efficiency out of your IT system.

Mr. SASSI. I think each company owns that for their own IT areas, but I think it's a shared responsibility.

Mr. KENNEDY. See, that's the problem. See, that's the problem, because you can't have all these proprietary systems out there. Everybody thinks they've got this new age IT thing going, and then,

you know, they've all got different systems for, oh, we're going to try to do this process more efficiently here and this process here, when we don't have standards.

We have basic metrics for clinical care. Where are the metrics for making sure that you're going to do the best administratively? I mean, we can do all the protocols in the world, when you come into an ER and say, you know, wash your hands, get this glove, get that glove, cooperate this way, we want this person to be treated so that they don't get an infection.

What I want to know is what you are doing to standardize, so no matter what IT system there is and what health system, we know that you all are doing, you know, not your own proprietary thing, but whatever proprietary thing is doing, it's Good Housekeeping Seal of Approval proprietary system that is squeezing out every bit of waste and duplication and redundancy that there is out there; how do we know that it's really working to the best effect that it's supposed to be?

Mr. KUCINICH. The gentleman's time has expired, but the witness—one of the witnesses may respond if they care to. Anyone? I think that Mr. Kennedy raised some important points. In the followup discussions that staff has with the panel, we'll explore that. Thank you, Mr. Kennedy.

We're now going to go to round two of questions. Just a little bit of housekeeping here. On the last round of questions, I asked Mr. Richards for information about his town hall meetings. You know about all of our town hall meetings, we want to know about yours. And so you have internal town hall meetings. We want your audio tapes as well as copies of all minutes of those meetings and all memoranda that was discussed at those meetings or actions decided at those meetings. So you will be hearing from us in an even more formal way, but just to understand that we do want that information, and I just announced it from the Chair here.

Now, I want——

Mr. CUMMINGS. Will the gentleman yield?

Mr. KUCINICH. The gentleman will yield.

Mr. CUMMINGS. Just one quick question. We don't know whether the others have these types of materials. I just was wondering if the gentleman was——

Mr. KUCINICH. At Mr. Cummings request that we will ask, so we're not singling you out, Mr. Richards, we will ask everybody to produce the same information. You may not call them town hall meetings, but we will try to find out what it is you have there, try to organize your troops on the issue of cost reduction.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman.

Mr. KENNEDY. Mr. Chairman, in response to the questions I'd asked, if all of them could get back to me on actual, tangible recommendations as I pointed out to what we can do to standardize incentives for them to have widespread standard of option of IT to incentivize those savings.

Mr. KUCINICH. I thank Mr. Kennedy. This is not solely an investigative subcommittee. We also look for recommendations as to how the existing system can be improved. So, as long as we have this

system, I would imagine you ladies and gentlemen probably have some pretty good ideas. So thank you, Mr. Kennedy.

Now, Ms. Farrell, let's talk about Aetna. Aetna's the third largest private for-profit insurer, according to Fortune magazine, but your current management returned your company to profitability by shedding members. You made bigger profits with fewer premium payers; isn't that true?

Ms. FARRELL. Are you referring to back in the late nineties and early 2000's?

Mr. KUCINICH. That you have made—there is a point at which you shed some members, and the profits started to go up; isn't that right?

Ms. FARRELL. There was a point in our history where we were as an enterprise not profitable, and one of the reasons—the big reason why we were not profitable is we had underestimated medical costs.

Mr. KUCINICH. I'm sure. That's exactly the point. So how many customers did you have to lose in order to return to profitability?

Ms. FARRELL. I don't recall. It wasn't looked at in terms of how many members we had to lose. It was looked at in terms of how—what is the underlying weight of medical costs and how are we going to price appropriately for that in the marketplace.

Mr. KUCINICH. Forbes magazine said you had to lose about 8 million. We're going to put that article in the record.

[The information referred to follows:]

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OutFront

Aetna's Ron Williams on Health Reform

David Whelan, 08.24.09, 12:00 AM ET

On a June evening President Obama was hosting a *Nightline* special at the White House on health care. Diane Sawyer posed a question to an HMO executive in the audience, **Aetna** Chief Executive Ronald Williams. With premiums and profits always rising, she asked, is the President right that your industry needs a new government-run public plan to be "kept honest"? Williams smiled and said no. "It's difficult to compete against a player that's also refereeing the game," he said. The President then got his turn and muffed the name. "First of all I want to say that Mr. Walters has been very cooperative," he said, going on to explain why reform must include a public plan.

Not, until now, much of a public persona, Williams, 59, is taking a surprisingly visible role in arguing for change in the health care system. He has met with Obama a half-dozen times (he shrugs off the surname gaffe), has testified four times in front of Senate committees this year and participates in shindigs set up by the many trade groups for which he's a director.

Williams' position echoes that of the HMO industry generally: He's against a government-run plan but favors universal coverage and forcing insurers to take all comers. He advocates cutting costs by standardizing payments among insurers, doctors and hospitals. "I don't meet anyone who doesn't think we should get more people covered," he says.

But comments like that are drawing the criticism that, while he is now calling for expanding coverage, his company has profited in the past by deliberately covering fewer people.

Williams joined Aetna in 2001, recruited by his predecessor, John Rowe. During their run from 2001 to 2006, after which Williams took over, the company went from losing $266 million to earning $1.7 billion. The turnaround was mostly credited to the decision by Williams to dump millions of members who were deemed unprofitable. From 1999 to 2004 membership fell by 8 million. Aetna cost "thousands of workers their jobs and millions of other people their insurance coverage," says Wendell Potter, a former Cigna executive. Williams responds, "We wish we had kept every customer." He says that when Aetna raised its premiums to cover costs, customers left.

Williams, who has earned $54 million since he was promoted, says Aetna is "well positioned" for a shift in the insurance system. "It's a result of conscious strategic work on our part," he says.

While a public plan would likely damage all HMOs, Aetna might get hurt the least because such a plan would mostly scoop up small businesses and individuals, not Aetna's huge customers, like Bank of America and UPS. Aetna is only a bit player in the individual insurance market, covering 400,000 out of 18 million. If reformers create some kind of public marketplace in which people would buy coverage, Aetna could find new opportunities, by selling to these folks without going through expensive retail brokers, the modus operandi of Blue Cross and Blue Shield plans. Williams also never went deep into the Medicare HMO business, now threatened with 14% reimbursement cuts.

In the short term Aetna has bigger problems. The company reported a 28% fall in profit in the second quarter. Aetna's actuaries didn't see a rise in claims and priced coverage too low. Aetna now estimates it will pay out 85 cents in claims for every dollar it receives in premiums. That's 5% higher than last year. Williams says the company is fixing the problem. Barclays HMO analyst Joshua Raskin predicts that by next year Aetna will right the ship--by cutting 600,000 members.

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Mr. KUCINICH. Does Aetna have an estimate of how much expenses the company avoided by shedding those policyholders?

Ms. FARRELL. I don't believe it was looked at that way. It was looked at relative to——

Mr. KUCINICH. Can you determine for us, look at your internal memoranda, at your actuarials? You should be able to figure out how much money you actually saved by shedding 8 million policyholders?

Ms. FARRELL. I can look at that——

Mr. KUCINICH. I appreciate if you look at that. Also, almost all of those 8 million people received their health insurance through employers, and they lost their Aetna health insurance when Aetna raised prices of the group plans beyond what their employers could pay. I mean, isn't that true?

Ms. FARRELL. I say if they left us, it was beyond that which they felt was a reasonable premium——

Mr. KUCINICH. Thank you. Now, your CEO has spoken publicly about the significant investments in sophisticated information technology he authorized at the start of his leadership. I assume those IT investments helped Aetna identify employers for repricing. So I'm wondering, could you tell the subcommittee if Aetna picks employers to shed by, for example, the type of occupation, work is performed?

Ms. FARRELL. No, that's not the way we would do that.

Mr. KUCINICH. Age in the plan, the age of the workers?

Ms. FARRELL. You're asking about our underwriting practices?

Mr. KUCINICH. Does your IT system identify people by age, and do you pick employers to shed by the age of the workers in the plan?

Ms. FARRELL. Our IT system does not identify people by age. The way it works is that an employer will provide us with a list of their employees and, along with that list would be other requirements in order to underwrite, age being one of those.

Mr. KUCINICH. Can you identify how long someone has been in the system?

Ms. FARRELL. It would identify how long they have been a member at Aetna, yes.

Mr. KUCINICH. OK. Now, do you pick employers to shed by claims histories of the workers in the plan, such as frequency of emergency room visits or disease clusters, like cancer?

Ms. FARRELL. Could you repeat your question, I'm sorry?

Mr. KUCINICH. I'm just trying to explore how employers get shed. Do you look at claims histories of workers in the plan? For example, if somebody visits an emergency room frequently or there is a number of people with cancers, do you make decisions based on some of those principles? Are any of those programmed into your information technology?

Ms. FARRELL. No, we never drop a member because of an increase in their medical.

Mr. KUCINICH. Like some, there will be a report that will just be spit out that will say, uh oh, cluster of diseases here, cancer, high cost, out?

Ms. FARRELL. No.

Mr. KUCINICH. That does not happen?

Ms. FARRELL. That does not happen.

Mr. KUCINICH. And you don't screen by location or ZIP codes; or do you? Do you screen by location or ZIP codes?

Ms. FARRELL. One of the ways we price our business is to actually look at geography because there are significant cost variations by geography across the United States.

Mr. KUCINICH. Are those cost variations determined by, among other things, epidemiological factors?

Ms. FARRELL. They are determined by looking at the underlying costs by geography, and there can be significant variations just towns away from one another. So that's one of the things that we do take a look at.

Mr. KUCINICH. My time has expired on this round, but what I'd like to do, Ms. Farrell, is so that we can better understand the relationship between your information technology and how it serves as a tool for decisionmaking, if you could provide this subcommittee with a narrative so that we can come to an understanding of the relationship between the data that you gather and the way that's used as a tool for your decisionmaking with respect to your customers and whether they will continue to have policies. This would deal with shedding, rescissions, even, you know, any use of information technology that would use to shed any of those 8 million customers.

And since we're trying to be fair to each and every one of you, this subcommittee's going to ask each and every one of you by letter to provide that information, that with the information technology that you have, how does it—does it help you decide which customers to shed and how does it do that?

OK. My time has expired. We are going to go to Mr. Schock. You have 5 minutes. You may proceed.

Mr. SCHOCK. Thank you, Mr. Chairman. You know, I guess in response to some of the concerns raised, I would only say that, you know, I think most of us agree—at least I agree—with the comments that were made earlier that health care premium costs are a function of reimbursement rates. And so I think it's disingenuous to compare a government-run plan to a private plan when a private plan cannot control for costs and a government plan can.

In other words, in a truly static system where all reimbursement rates are set at a Medicare and Medicaid reimbursement level, the system then would be forced to control their costs either by reducing quality or reducing options.

And I think for those of us who share the concern of a movement toward a single-payer system, it is clearly focused on the quality of the care the patient will receive and continuing the progress that this country and its health care system has made over those countries with a different plan in terms of the innovation and the technology that we have here in our country.

I can only speak from my experience prior to being in Congress, which was in the State legislature in Illinois, and I witnessed firsthand what happened in Illinois under then Rob Blagojevich's health care proposal, which was All Kids, which did similar to what the Majority wants to do here, which was basically offer health care, a government plan, for all kids in the State of Illinois regardless of income.

I saw firsthand in my legislative office individuals who had children insured, individuals who were duly employed by an employer who offered a private health care plan and who opted for the savings of anywhere from $50 to $70 a month to take their child out of the private plan and enroll them in the All Kids Medicaid reimbursement level health care plan.

Now, it did two things. No. 1, I've got a very poor legislative district, 40,000 voters, 20,000 of them on food stamps. The people living in poverty who otherwise had access to care, their access dried up and went away. Today, there is not a dentist in the city of Peoria, Illinois that will take an All Kids patient.

Second, it ballooned the deficit within the State of Illinois' Medicaid program, All Kids program. We are now 9 months late in our reimbursement levels.

So I would just throw this out there as a case-in-point example, a microcosm in our country where we have tried a similar option, a competition if you will, against private insurers.

Second, and to that point I just don't—I don't buy the concept that the solution to greater quality, greater access, and lower costs is the Government.

To that point, though, I think we need to do a better job of providing—if we understand we're trying to control cost, if everyone accepts the fact that health care premiums rising are making it more difficult for businesses to provide health insurance, for individuals to provide health insurance, how do we lower the health care premium costs? Are we going to have to lower the request for services or the rates that we're paying back?

My question to you would be, how do we give those tools to the consumer? Because it's my view right now, as consumers, if I have a private-pay health care plan, whether it's provided to me as an individual or whether it's provided to me by my employer, I don't have the tools necessary—there's not a lot of competition. I'm digressing a little bit.

But there's a lot of talk about health insurance being compared to automobile insurance. The biggest difference I see in automobile insurance is that if my car gets in a wreck I'm going to do one of two things. I'm going to go around and I'm going to get probably two or three estimates, not because I'm going to pay for out of pocket, but because I know when I turn in my automobile expenses, my automobile insurance rates are going to go up. That connection doesn't seem to be there—while it's true, that connection doesn't seem to be in the mind of the patient as he or she accesses the health care system.

So what tools can you in the insurance industry give to consumers, how can we look at maybe reforming the way in which people buy their health care, not the premium, not the premium, but rather, the actual service, how they buy it—and I understand you can't do it in emergency care. But if I go in—I live in a relatively large city, 150,000 people. A lot of places offer MRIs and each one of those locations charge a different rate. Yet that information is not readily available to me as a consumer.

I think that is a part and parcel to us of doing a better job of controlling the costs that go and drive up health care premiums. So if you could answer that question I would appreciate it. What

are you doing now and what could we be doing to give those tools better to consumers?

Mr. KUCINICH. The gentleman's time has expired, but the witnesses can answer the question. Thank you.

Mr. SASSI. Congressman, I can answer that from my company, WellPoint. Several years ago, we embarked on a journey to increase the transparency so that consumers could more easily compare the prices of commonly used services within their geographic area; because you're right, there is a large disparity between an MRI in one part of the city and another part of the city, a cost for commonly—knee replacements in one part of the city versus others.

So we created Anthem Care Compare, which is a Web site that identifies the top 34 elective-type procedures and a member can go into that Web site, type in their ZIP code, and it will identify different providers within the area and the costs associated that would be charged by the different facilities for those areas. Plus, we try and tie in as much quality—publicly available quality information that is available to members, so that if you're considering having your knee replaced at a certain facility, how often do they do that procedure and what is the success rate, what is the readmission rate for that?

We have rolled that out in many of our markets across the country, and actually we're now providing that service to many BlueCross BlueShield plans across the country. So that's one example of how we can increase the transparency.

Mr. RICHARDS. Congressman, you mentioned MRIs, which is a great example. In some geographies the cost of an MRI can vary by 100 percent or more depending on where you go. At CIGNA, we've provided the cost of MRIs on our Web site so individuals can go and look it up. The vast majority of the health care providers that work with us allow us to do that. There are some that do not allow us to show the transparency, but the vast majority do, and it does help.

The other thing I would say is—along the lines of tools, you need to provide the incentives to individuals. One of CIGNA's customers is Safeway, and I think they're a marvelous example of a company that has worked with CIGNA to both increase the cost and quality transparency—because it's not cost of areas but quality of areas as well—among their employees so they can get the right care, get it at the most efficient price. They also incentivize people for appropriate behaviors, whether that's not using tobacco or exercising because, at the end of the day for Safeway, if you have a healthier employee, it's also going to be a lower-cost employee.

Mr. KUCINICH. I thank Mr. Schock for his presence here, and if you have followup questions, you want to put them in writing, we will make sure that they will go through the committee. We support your request.

You know you brought up that issue—I just want as Chair just take a little bit of your pointing out that, you know, when you brought up the issue about car insurance and compared to health insurance, I mean that's one of the debates right now. And just what occurs to me is that if you wrecked your car, you get a new car. If you wreck your health, you're dead, you know, unless you believe in reincarnation.

Mr. Schock, thank you.

Mr. SCHOCK. Thank you.

Mr. KUCINICH. The Chair recognizes Mr. Cummings.

Mr. CUMMINGS. As I was sitting here listening to you all, I was saying to myself, boy, they sound real nice, I mean it sounds like everything's rosy, and you know, when—it's amazing, the people who sat here yesterday made us—I mean said some things that were very, I thought, I felt, very damaging to the—to what you all do every day. I'm not talking about you all individually, of course.

And the thing I guess that I'm just sort of wondering about, they made a big deal of this whole denial of claims. And I specifically asked them the question about whether they felt that things were worse or better since the Clintons tried to get through health care reform, and they said that they were far worse with regard to denial of claims.

And so, Ms. Farrell, I'm going to go to you because I—for one reason because you had said something that interests me. You had talked a little bit earlier about claims, that there were no—there was no one—that only—maybe it was several of you who said only doctors deny claims; is that right? So you all were telling me that there are no other nonmedical people who make decisions that a person cannot get a certain treatment paid for; is that what you're telling me?

Ms. FARRELL. Just to clarify, what I said was that there are no medical decisions or no medical denials that are made by somebody who is not a physician. You can deny a claim for a nonmedical reason, and that decision can be made, obviously, by a nonclinician.

Mr. CUMMINGS. And I take it that those kinds of decisions are made every day, are they not, by nonmedical people?

Ms. FARRELL. Nonmedical decisions, yes, can be made by nonmedical people; but if it's medically related, it is made by a physician.

Mr. CUMMINGS. And so a claim is for services—I just want to make sure our definitions are right again—services already rendered; is that right? A claim is normally for something—I see you shaking your head, Mr. Bloem; is that right?

Mr. BLOEM. I think that we are as a group here struggling with what the definition of a denial of a claim is. To me, a claim, when I cited what the survey said about us, a claim—there are basically three kinds of claims, and the first kind has been really enunciated here quite well. That's when you get a duplicate claim. That's when you've rendered service, as you said, and then you get a claim that comes in, and then another claim comes in and you probably paid the first one.

In the denial rate, in the numbers I cited, the 5.7 that we have and the 5.4 that we have and the 8.7 that Medicare Part B has, in those claims, the biggest cause of that is duplicate claims.

The next kind of claim is for experimental or investigational where there wasn't any preauthorization, which was also discussed earlier.

And the last kind is where the employer has not—has through the policy terms decided we are not going to cover that kind of a claim, that kind of a process, that kind of a procedure.

Now, the other thing that we're struggling—when you are asking questions, I believe you're also talking about coverage determination; other people have coverage in advance of when services are covered.

Mr. CUMMINGS. Yes, OK. I've got to ask you this. I understand a person can have their treatment preauthorized and even get a preauthorization number, get treatment and still the payment for that same procedure may be denied; is that true?

Mr. BLOEM. In a coverage determination, there's an initial decision made about whether this procedure is covered, and that, in our company, like in the case of Ms. Farrell's company, that's done on a denial of coverage, is only for medical reasons, is only done by a licensed board-certified medical director.

Mr. CUMMINGS. And so none of you all, then, nobody up here has anyone who denies a person treatment, in other words that's—in other words, how many of you all deny folks, if any of you have people who you give bonuses to or give financial incentive for a denial of treatment? Nobody.

Mr. BLOEM. I answered before, neither, none.

Mr. CUMMINGS. No, OK. I just think that based upon the testimony that we got yesterday, the testimony was clear that there are many, many instances where insurance companies are basically intentionally—and you may call it coverage, you may call it claims, whatever—holding back decisions and literally waiting for certain things to happen and, sadly, in some instances, death, and then, you know, and the person is denied one way or the other. So as the chairman said, here—different with an automobile—a person dies, and that's a sad, sad situation.

Mr. KUCINICH. The Chair recognizes Mr. Conyers. You may proceed for 5 minutes.

Mr. CONYERS. Thank you for your generosity, Chairman Kucinich.

Ms. Farrell, are you aware of the report from Health Care for America Now, on July 15th, that reported that profits at the 10 largest publicly traded insurance companies was 428 percent from 2000 to 2007?

Ms. FARRELL. I am not aware of the specific report that you're referencing, but Aetna's profits—for every dollar we take in, we pay about—we make about 5 cents in profit, pay about 84 cents in medical claims.

Mr. CONYERS. Well, what about you, Mr. Richards, are you aware of this report?

Mr. RICHARDS. I'm not aware of that report. I do know that if you look at CIGNA's total profits globally, we make about $1.66 per customer per month.

Mr. CONYERS. I see. Mr. Sassi, have you ever heard of this statement?

Mr. SASSI. I am not aware of that report either.

Mr. CONYERS. OK. And Ms. Reitan, you must have heard about this.

Ms. REITAN. I have not heard of it, and we wouldn't be in there because we're a noninvestor-owned company.

Mr. CONYERS. Well, I know Mr. Collins has.

Mr. COLLINS. As a matter of fact, Chairman Conyers, I've seen that report in the newspaper and I believe it's just—it's somewhat deceptive in the way it's framed. There's been an enormous amount of growth among the top companies, and it's simply adding up the gross profits of companies as they've grown over time. So there's a larger share of profitability today in those top companies than there was 10 years ago, but that doesn't mean that profits have grown per member, per unit of business, per customer. It—one necessarily doesn't flow from the other. It's a function of the size.

Mr. CONYERS. Mr. Bloem, you know about this, don't you?

Mr. BLOEM. I'm not familiar with that study, but let me comment on my company.

Mr. CONYERS. Wait a minute, I don't want you to comment on your company. You're not familiar with the statement?

Mr. BLOEM. I'm not familiar with—I'm not familiar with the study or the statement.

Mr. CONYERS. OK. Well, how long have you been in the business?

Mr. BLOEM. I've been at my company since the beginning of 2001.

Mr. CONYERS. OK. Have you ever heard of Health Care for America Now?

Mr. BLOEM. No, I've not.

Mr. CONYERS. OK. Well, let me ask you this question. Are you familiar with a recent study of the American Medical Association that 94 percent of the insurance markets in the United States are highly concentrated?

Mr. BLOEM. I'm not. I would——

Mr. CONYERS. You're not familiar?

Mr. BLOEM. I'm not familiar generally with those statistics, but it's not an unfamiliar statistic that in terms of some markets don't have a lot of competition, but most markets have much competition. Excuse me.

Mr. CONYERS. Well, do you contest this finding of the AMA?

Mr. BLOEM. I don't know enough to contest or affirm.

Mr. CONYERS. OK. Well, let's go down the line again then. Ms. Farrell, you're a student of the—I know you subscribe to AMA journals; you've heard of it.

Ms. FARRELL. I'm not aware of that specific study.

Mr. CONYERS. You've never heard of it. Richards, you never heard of it?

Mr. RICHARDS. No, I have not, Congressman.

Mr. CONYERS. Well, let me just ask to save time: Has anybody ever heard of it? Has anybody ever heard of the AMA?

Mr. BLOEM. Yes.

Mr. RICHARDS. Yes.

Mr. SASSI. Yes.

Mr. CONYERS. All right. Well, let me—let me ask you about this. Have you ever heard of the statement that's been made public, and to my knowledge never contested, that the 10 largest companies in health insurance, the CEOs' compensations total $118.6 million, an average of $11.9 million per CEO?

Now, let's save some time. Anybody ever heard of that before? Nobody? Well, do you want a citation for it? Not particularly. OK.

All right. Let me ask you this, Ms. Farrell: What is your annual compensation per year?

Ms. FARRELL. My annual compensation is something that is very private to me and something that I would be happy to submit——

Mr. CONYERS. You don't want to tell me; is that what you're saying?

Ms. FARRELL. I'm saying that I consider my compensation to be very private and that I would be happy to submit it to the committee in writing.

Mr. CONYERS. But you don't want to say it publicly?

Ms. FARRELL. No, because I do consider it to be private.

Mr. KUCINICH. Mr. Conyers, before you came, we asked the witnesses to submit information about their compensation in writing, if they choose not to answer at this committee meeting, but they will present it to us in writing.

Mr. CONYERS. OK.

Mr. KUCINICH. We can still get that information with their agreement.

Mr. CONYERS. Last question. Does anybody here—I've never had a hearing with six executives of health insurance who were all on the same panel. This is a new experience for me. Do any of you want to tell me what your annual compensation is, just for the record, without having to submit it in writing?

Mr. KUCINICH. If the witnesses care to respond, you can do that. If you don't, we certainly want you to submit that in writing.

Mr. CONYERS. What do you want to tell me, Ms. Reitan?

Ms. REITAN. I'll tell you I make $728,000 a year in salary.

Mr. CONYERS. OK. I thank you for that. And what did you want to tell me, Mr. Bloem?

Mr. BLOEM. My compensation is $545,000 a year. It's a matter of public record.

Mr. CONYERS. Sure, and I thank you for that. And what do you want to tell me, Mr. Sassi?

Mr. SASSI. I'd be happy to provide it in writing but it's a privacy issue.

Mr. CONYERS. It's what?

Mr. SASSI. I consider it a privacy issue, and I'd be happy to submit it in writing.

Mr. CONYERS. OK.

Mr. KENNEDY. Would you yield?

Mr. KUCINICH. Before we go to Mr. Kennedy, I just want it understood that you have agreed to submit this information to the committee. As long as we have that agreement, that's fine. You can choose to answer the question now or you can choose to answer it in writing. It's really your choice.

Mr. KUCINICH. So, Mr. Conyers. Mr. Kennedy,

Mr. KENNEDY. I just to yield, just to be happy, John was bringing up a point. I think folks here just are obviously just working in a field that's perfectly legal and set up by our society to earn what they're doing and there's nothing wrong with that.

I think what is wrong, as the gentleman's trying to point out, is that last year the head of CIGNA earned $11 million. Now, if you're going to talk about where that money's coming from, it's

clearly coming from denied claims. The head of the UnitedHealth Group earned $9.4 million. Now, these are public records.

So you don't have to ask. They're nice to—I'm sure they love to be called senior executives; but frankly, John, I think they hope to be senior executives at those kinds of pay scales, but they're I'm sure not at that level yet.

But the point is, we are trying to make the point that the industry is allowing for these kinds of exorbitant pay at the very top, which just begs the question, it's an allowable industry in our country. But we need to know, you know, kind of what is this a matter of where these dollars are coming from when people are paying these premiums and people are getting rejected for health care, how are these compensations so exorbitant?

So I appreciate the questions you're asking. I also understand the fact that these individuals here have every right to say or do what they're, you know, doing because they're in an industry——

Mr. KUCINICH. If I may, Mr. Conyers' time has expired. However, we will now go to you, Mr. Kennedy, if you want to yield any time back to Mr. Conyers. You can proceed for 5 minutes, and we're going to go one more round after that, and then we will be done, because I know everyone here is trying to catch your planes.

Mr. KENNEDY. Well, I would like, Mr. Chairman, to go back to this whole idea of how we're—if insurance has thus far not gotten around to figuring out ways to help the government or the society change reimbursement reform, if we've known for years that our system is upside down, that all we pay is for sick care rather than health care, if there are simple ways for us to keep people from being frequent flyers in our emergency rooms, if we just did X, Y and Z, and that that would lessen the pressure on you as insurers to charge your customers exorbitant premiums, then why haven't you in your industry taken upon yourself to be the biggest advocates for insurance reform over the last 20 years?

And furthermore, what I don't get is that back home, like most of my businesses for the most part are passive when it comes to their insurance premiums. They let their insurer—insurance carriers kind of dictate to them. They said, oh, here's your premium this year. And in fact, it's the insurance companies that work for the company that they are, you know, subscribing for and they've been hired to do their policies for.

And so I just don't for the life of me understand why, if it's in the interest of their client to reduce premium costs and so forth and health—why insurers in this country haven't been at the forefront of this health care debate saying, listen, we've got—here are the ways we can restructure the health care market based upon a capitalist system whereby it pays to have better care at reduced costs.

That's what I can't figure out, Mr. Chairman. If this is really about making money, we know there's plenty of money to be made. Why can't they build a better mousetrap to make money and also save—save money and give us the answers? You know, we're just trying to do what I think is consistent with what they're trying to do, and that is lower costs and build quality. They're the experts. They keep saying they've got all the innovation because they're in the private sector. Then why aren't they giving it to us?

Why do I have to sit up here and ask about things that I frankly am not all that educated about, because my staff person puts it in front of me, and they're going to promise to get back to me on value-based streamlining and engineering. That cannot apply to health care.

You know, all of these kinds of things that we're going to have to try to put in law so as to enforce insurance companies to bring their costs down, why do we have to put that into law? I'm sure they don't want to be regulated anymore than they are being regulated.

So tell us why—because we're being pressured to bring our deficit down. We've got this enormous deficit. It's going to swallow all our future dollars, our taxpayer dollars. Our taxpayers are going crazy because they're getting on our tail for having a big deficit, and what we are trying to do is respond to them and say health care is one of the biggest financial nuts our country has going forward.

So we're asking you to help us because one way or the other, money's going to get—have to be streamlined, and it's a question of whether it's going to be done at the expense of our consumers, which we don't want, or it's going to be done efficiently and with quality in mind so that people don't get their health care cut just because we haven't been on the forefront of making the right decisions policy-wise that allows them to continue their health care in the most efficient way possible.

Maybe you could comment on why you don't think—you guys have been ahead of the game in terms of getting better reimbursement reform prior to this year—why does the Government have to do all this incentivizing for health rather than sick care? Why are we the ones that have to do this? Why haven't you been out there for years doing this stuff?

Mr. RICHARDS. Congressman, I'd love to respond to your question. First of all, I think there are some things that we can do individually. Certainly, at CIGNA we do several things to improve the health of our customers.

For instance, we have a gaps-in-care program where we monitor for evidence-based care to identify if our customers aren't getting the care they need. For instance, somebody who has recently had a heart attack, who is not on the proper medication, a beta blocker. By mining that data, we can then outreach to that individual's doctor and to the individual and say, shouldn't this person be on a beta blocker because medical evidence would say that for most people that's appropriate and if they don't take that drug they're much more likely to have an heart attack. So that's an instance where we are using technology and our people to actually increase pharmaceutical claims for the better health of the individual. That's something we can do and do do today.

Relative to your payment reform question, again, CIGNA is working with a variety of health care professionals. I referenced Dartmouth-Hitchcock in New Hampshire. We're actually working with five other entities around the country for payment reform where we have a patient-centered medical home, where a primary care doctor can coordinate the care because it is a complex system. If somebody is very sick, they tend to need a lot of different doctors,

and having that primary care person look after the care is very important. A lot of primary care doctors can't afford to do that today because the reimbursement rates that Medicare and private insurance pay them, it's very tough for them to be able to do that.

So medical home is a promising pilot that we're trying where we're paying extra money to those primary care physicians to allow them the time to help coordinate the care. So I think there are things we can do individually. There are thing we can do in partnership with health care professionals, the doctors and hospitals, and then I think there are things that the government needs to help on as well. And CIGNA and the industry have definitely supported reforms for a variety of things that we mentioned at the committee today.

We really need government to work with us to help enact some reform as well. We look forward to working with you on this debate, Congressman Kennedy.

Mr. KENNEDY. My point is that medical home we've known for a long time works. Why are we piloting it? I know it's what we're piloting in the legislation, but we're only doing it because we're slow-walking something that we know works. It's been demonstrated over and over again. It makes so much common sense. It's like this whole trigger thing. We're doing what is inevitable, but it's going to take us an extra 4 or 5 years before we take the whole medical home thing to scale, because we're just—too many financial interests that we're going to have to tiptoe around in order to get this thing implemented.

But if you guys stood up and said, hey, we all know medical homes are about making more efficient, giving the primary care doc and gatekeeper more time to help coordinate care because 80 percent of the dollars are spent on 20 percent of the people. They're the chronic users. They're the highest users of health care. That's where we can get the most money. Let's do it, boom, let's go. What are we slowing down for?

The reason we're slowing down is because there is this inertia out there because everybody is trying to protect their piece of the turf, and we wouldn't have that if insurance was more proactive. It's in your interest to be more proactive because at the end of the day we're going to hit the wall, and when we hit the wall, everyone else who is well off is going to be fine. It's the people in the middle and the bottom who are going to be hurt.

Mr. KUCINICH. The gentleman's time expired quite a while ago. But I tell you, I think everyone in this room and everyone watching knows how important what you just said is. And they're wondering if there's any response to—does industry care to respond to what Mr. Kennedy said? Anyway, what he's providing is a wake-up call here. Does anyone care to respond? We're going to have one more—Mr. Kennedy, we're going to have one more round after this and we'll wrap it up. But does anyone want to respond to Mr. Kennedy?

Mr. COLLINS. Chairman Kucinich, we've submitted—and we'll send it for the record—proposals that we circulated with the administration and Capitol Hill of $500 billion of potential savings. I won't——

Mr. KUCINICH. Over what period of time?

Mr. COLLINS. Over a period of time from 2010 to 2019, and we'll submit this report to the committee as part of the record.

Mr. KUCINICH. How much was that again?

Mr. COLLINS. It was $540 billion, sir.

Mr. KUCINICH. OK. That would be helpful, and anyone who wants to submit similar information, so ordered, and we appreciate you doing that.

I just want to say that as we go to the final round of questions here, I'm sure that the insurance company executives who are here recognize that everything's changed with respect to health care in America. You are facing a totally new environment than when you started your careers in health care: 47 million people uninsured, another 50 million underinsured.

As you know, many people are losing everything they have because they can't afford to pay their hospital bills, and many of those people had insurance. And so today we're talking about this business model, but we also have to understand—you get respect for your being here, but we also have a great understanding of your position and your political power.

Let me give you an example. The insurance companies are so powerful that you were able to take H.R. 676, Medicare for All, well off the table right at the beginning of the discussion, for either party, not just one party or another. Both parties took it off the table. There's 85 Members of Congress that have signed on to it. It's a bill that Mr. Conyers and I drafted—86, thank you.

But the point is that you are able to exert your influence, and some of the reasons you're here today, I mean very clearly clashes with your business model. We understand that you're very influential here.

Based on your influence, we're seeing the so-called public option which will provide some competition—we understand you feel it wouldn't be productive. But based on your influence, the public option looks like it is going to be very difficult to get into a final bill. And of course, the industry has had an influence in shaping issues such as triggers and co-ops.

What Mr. Kennedy had to say I think is so important, and where Mr. Kennedy's comments lead to is that you should be thinking about the fact that the business model that you have could end up being—could end up killing the goose that laid your golden egg. You may be reaching an end point as to how much medical loss ratio you can go before people start to say, what's going on here? How far can your executives go, making millions of dollars a year, while claims are being denied—you may say there's no connection, but the public does make a connection.

And look at where we're headed toward. This is where your presence here is not a small matter. We could very well be headed toward a condition where health care reform in America is really a form of a continuation of what I call insurance care, whereby the food and well-being of people, according to CBO, will potentially be covered by H.R. 3200.

Without a public option, 32 million people will be pushed into private plans. They have to choose among private plans, and if they don't do that and they don't choose and they don't pay, they could be penalized. Extraordinary. But with that kind of power, I would

hope you start to think about a different model of business and social responsibility. I'm not lecturing you. I'm just sharing some thoughts.

The insurance industry, because of changes in the global climate, is due to take enormous hits, particularly in coastal areas over the next 40 years. We should all be working together, but on health care, you may eventually want to think about what it's going to be like when you wind down your health care products because, frankly, Mr. Chairman, I think sooner or later, whether it's this decade or another decade, you're moving toward a condition where more people are going to be uninsured, more people will be underinsured. Premiums, copays, and deductibles are going to be out of the reach of more and more Americans, and they're going to put it on you, and you know that.

And so you know, I didn't call you in front of this committee today to embarrass you. That's not my intention at all. We need to get information about how your business model works, because people really need to understand that. We understand you're not charitable organizations. That's not why you were formed. You're responsible to shareholders; we understand that. If your medical loss ratio changes too significantly, Wall Street will punish you; we understand that too.

The question is, is this business model sufficient to provide health care to American people at costs that's affordable? There's a collision here, and you happen to be at that time and place where this collision is happening.

I'm going to ask one final question as I wrap up my time here. Yesterday we received testimony from Erinn Ackley of Montana. Erinn's father, William Ackley—and his obituary is part of the record—had a request for bone marrow transplant and that request was denied coverage on four separate occasions, causing a delay of 126 days in his cancer treatment. He ended up dying from the cancer.

Now, Erinn Ackley told this committee that had he been enrolled in Medicare he would have received his bone marrow transplant right away. And Government-run Medicare provides primary health insurance to most senior citizens, has developed standardized forms, and standardized fits, with administrative costs that are a fraction of yours as percentage of revenues.

Now, I'd just like to go down the line and answer this question. Isn't it true that your reason for not adopting Medicare's coverage standards as your own is that you could not deny payment for expensive treatments such as the one I just referred to? Mr. Collins.

Mr. COLLINS. Chairman Kucinich, I can't answer that question. I'm not familiar with the Medicare guidelines. That would have been something appropriate for our chief medical officer to discuss.

Mr. KUCINICH. Mr. Sassi.

Mr. SASSI. Like Mr. Collins, I am not familiar with it.

Mr. KUCINICH. Ms. Farrell.

Ms. FARRELL. Same, Mr. Chairman, I'm not familiar either.

Mr. KUCINICH. Mr. Bloem.

Mr. BLOEM. Nor myself.

MR. KUCINICH. Mr. Richards, can you answer that?

Mr. RICHARDS. No. Our chief medical officer actually used to be the chief medical officer for CMS, Dr. Jeffrey Kang. Had he been here today, I'm sure he could have answered it.

Mr. KUCINICH. Thank you. But I'm glad that you're here because I got a chance to ask you about your town hall meetings, and I'm really interested in that. So thanks for being here, Mr. Richards.

Ms. Reitan.

Ms. REITAN. I've got the same problem that everyone else mentioned. One of our chief medical officers could have answered that question.

Mr. KUCINICH. See, I mean, you know, you may not be as familiar with the Medicare standards—and I'll accept that answer—but I think you understand why I asked the question; and that is, we're trying to get to the genesis of the business model here: How do you make money?

Many Americans believe that insurance companies make money not providing health care; that your first obligation is to the stockholders or shareholders, and then you have an obligation somewhere down the road to the people who are your policyholders. You have to have some obligation. You do pay, you said you have. You have a pretty good batting average on a lot of that. And when you get into the mechanics of analyzing it, it will raise some questions which is what we did today.

Mr. Conyers, you have 5 more minutes for questions, or do you wish to——

Mr. CONYERS. I'm so nearly exhausted, Mr. Chairman, I hardly have anything else to say, but to thank you for this meeting and to thank our witnesses for holding up.

But you know, it's been made public, but the American Medical Association has sort of come out for the Obama approach. You all have heard about that, have you? No? Yes, no? OK. You don't know if the AMA is with Obama or not?

What about your companies? Have your companies said anything one way or the other about Obama's strategy of health reform? Anybody? You don't know? Yes, sir.

Mr. RICHARDS. Congressman, CIGNA has come out, as have many others in the industry, in support of many aspects of the President's plan.

Mr. CONYERS. OK. Let me put it more delicately. Are there parts of the Obama H.R. 3200 approach that your company is for and there are other parts you may not be in full accord with? Is that about fair? Everybody shakes their head. There are parts you can go along with and some parts—obviously public option is not one of your favorite parts of the bill, however it may appear, but there may be some other things. But there are things you like.

Mr. RICHARDS. Congressman, there are many things we like, yes.

Mr. CONYERS. Pardon?

Mr. RICHARDS. There are many things we like, yes.

Mr. CONYERS. Well, thank you. Let me just ask you about the Baucus bill. You've got a reaction. Did he make a little impression on you, or somewhat favorable? How does that resonate with your companies?

Mr. RICHARDS. Congressman, just from CIGNA's standpoint, I know that Senator Baucus just came out with it, and we're still reviewing the details of that bill.

Mr. CONYERS. Yeah, but so am I. I mean, we all got the news at the same time. It's been on television, newspapers, commentators, doctors, come on. I mean, how long do you have to—how much study——

Mr. RICHARDS. Congressman, my understanding is there's no legislative language actually that's been shared yet; but again, we are studying what has been released.

Mr. CONYERS. Really?

Mr. RICHARDS. That's my understanding, yes.

Mr. CONYERS. He's been preaching about his bill and copying headlines all over the place. You say there's been nothing specific. There's a bill out that's got the chairman of the Finance Committee of the Senate.

Well, I tell you what, could you—I know you've got a lot of assignments coming here today. Could you let me know when you—when your companies have examined it sufficiently to let me know what you think of it?

Mr. COLLINS. Absolutely.

Mr. CONYERS. OK. All right. Thank you very much.

Now, finally, we had testimony in the Judiciary Committee, under subcommittee Chairwoman Linda Sanchez, from doctors that there were 1 million medical bankruptcies in the United States; that is, personal bankruptcies caused by medical bills. Ever heard of that? Nobody's heard of that. OK. Well, I can't—I can't ask you to comment on that.

Let's do it hypothetically. If you heard it and learned about that, would that cast some concern on you about the problems that individuals are going through when the largest cause of individual bankruptcies in the United States are due to medical bills that people couldn't afford? You'd be concerned? Well, may I send you some things? You're sending us a lot of things; can I send you some more information about that subject? OK.

Thank you, Mr. Chairman, for your generosity.

Mr. KUCINICH. I thank the gentleman. Finally, Congressman Kennedy, you may proceed for 5 minutes.

Mr. KENNEDY. Thank you, Mr. Chairman. Thank you for holding this hearing, Mr. Chairman, appreciate it.

Thank you all for your patience this afternoon during our questions, and looking forward to getting responses to the ones I asked earlier.

I would ask all of you if you would just give me affirmative in terms of working with my office in closing a loophole that appeared in last year's Wellstone-Domenici Mental Health Parity and Addiction Equity Act bill. We applied it to all insurers for mental benefits. It seems as though college students' health insurance plans do not have—it's not applicable to college students' health care plans because students are not technically employees of the university. So the bill talks about this as covering employee-based health insurance plans. So you see the wrinkle there.

And as a result, since students aren't considered employees, they're not subject to the requirement—although the insurance

companies who insure students aren't subject to the requirement for parity and because suicide amongst kids is the third largest cause of death, I would ask all of you now, would you be willing to work with me to close that loophole in this health bill with language that ensures that the spirit of the law that's applying to all of you for every other health insurance plan is—ensures that kids who need it the most get that coverage as mandated under the Wellstone-Domenici parity bill.

Mr. COLLINS. Yes, sir.

Mr. SASSI. Yes, sir.

Ms. FARRELL. Yes, sir.

Mr. RICHARDS. Yes. CIGNA strongly supported the Domenici-Kennedy bill, and we'd be glad to work with you to close the loophole.

Mr. KENNEDY. OK. That would be great. William Gardner in my office, if you could be in touch with him. We're just trying to make sure we get that facilitated in this bill so that the kids don't get, you know, disrupted in their health insurance coverage.

Obviously, I have a lot of other things but want to make sure we tidied that up. Thank you, Mr. Chairman.

Mr. KUCINICH. Thank you very much, Mr. Kennedy and Mr. Conyers, for remaining.

This has been a hearing of the Domestic Policy Subcommittee of the Oversight and Government Reform Committee. We have gone over 3 hours now, and the witnesses have been much appreciated and your presence here.

The title of today's hearing, Between You and Your Doctor: The Private Health Insurance Bureaucracy: I feel, as Mr. Kennedy just implied, that we barely scratched the surface here, but I hope that the witnesses understand and hope that you feel that this committee has treated you fairly. There's no brow-beating here, there's no trick questions, there's no attempt to try to force you to give an answer over something that you're not ready to do at this moment, and that's the way we're going to continue to proceed.

We are a fact-finding investigative subcommittee. We're going to continue to try to get information from the industry so that we can understand your business model a little bit better.

And while I have tried to conduct these hearings in an impartial way, away from these hearings I'm a very strong advocate of the bill that I wrote with John Conyers, but I don't let that interfere with the conduct of this meeting. I want to make sure that you're given a chance to put your point of view on the record. And so while you're treated fairly here, we're hopeful that you're going to treat—treat the American people fairly.

And I think as we move forward this issue of awareness, Mr. Conyers is going to send you some information. I think this is a time we can become more aware of your business model and you can become more aware of why we have such great concerns and why there is a national movement right now to really move away from the model that you have spent your life building.

So it's a great time for this debate in the country. Health care ends up being a flashpoint, you know this: people losing their jobs, their homes, their retirement security, their investments. And we're right at the point where it's a flashpoint. So let's see if there

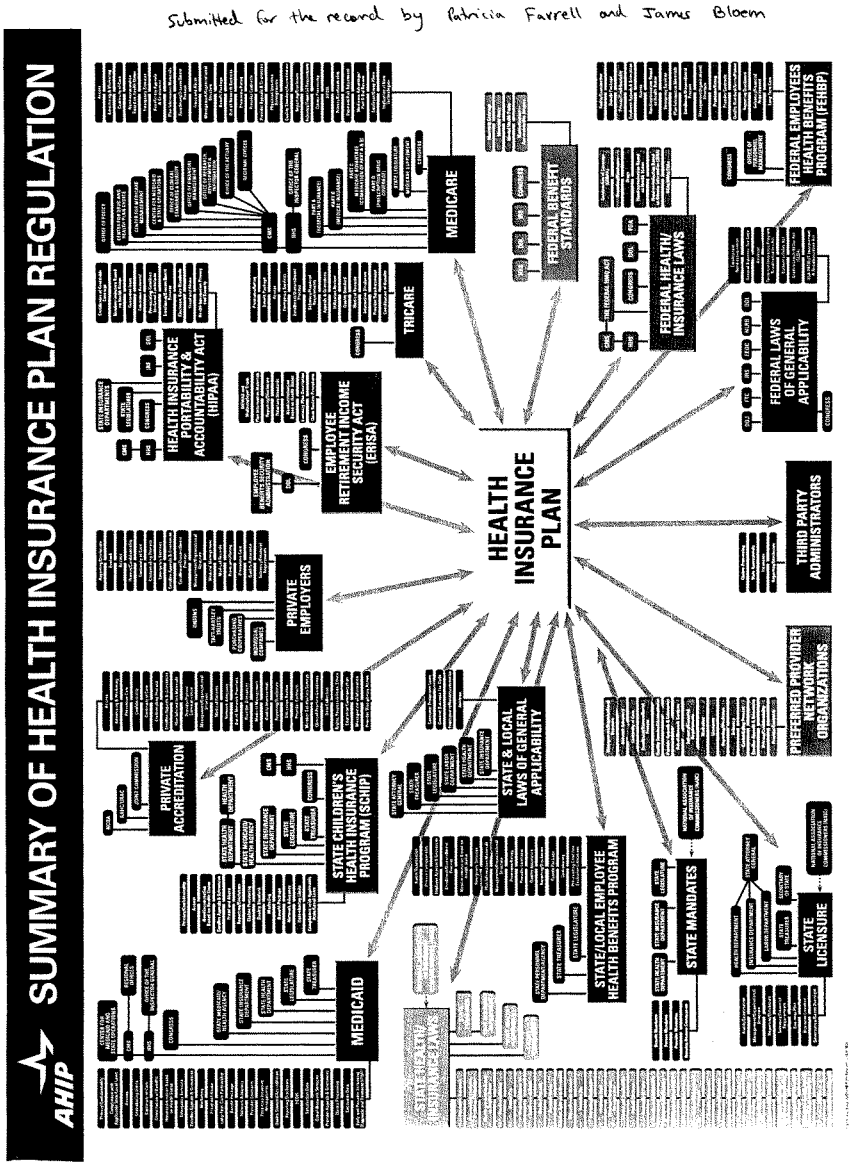
is a way that we can find to best serve the American people. That's why we're in Congress, and I hope that's what you'll conclude is a good purpose to be in business.

I'm Congressman Dennis Kucinich, Chairman of the subcommittee. This committee stands adjourned.

[Whereupon, at 5:26 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Submitted for the record by Patricia Farrell and James Bloom



submitted for the record by James Bloem

Fictional Example

HUMANA
Guidance when you need it most

SmartSummary℠

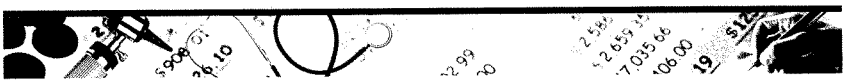
Your personal health
finance and benefits statement

Statement period
September 1, 2006 to November 30, 2006 - 1st Qtr

Member ID
987654321 01

Member Name
Jane Doe

Group ID
123456



Welcome to your personal health finance and benefits statement.

Your new SmartSummary statement helps you better understand how your health plan works, how to get the most value from your plan, and plan for future healthcare spending. This statement includes:

- Your medical and prescription claims
- Savings opportunities
- Health resources
- Available wellness programs
- Personalized health news

Your SmartSummary will be updated every three months and available online at *My*Humana on **www.humana.com**.

To maintain privacy, each dependent on your health plan is receiving a personalized SmartSummary. Individual statements also allow each member of your family to receive the most personalized and relevant information based on his or her medical and prescription claims.

What's inside...

Your personal profile....2
Numbers to watch....2
Claims we received....3
Communications with Humana....4
Your health care accounts....5
What's new in health care....6
Your portable health care record....9

Look for these icons

- Savings alerts - see pg 3
- Health alerts - see pg 3, 10
- How your plan works - see pg 2, 3, 5
- Plan coverage changes - see pg 5, 11
- Personalization - see pg 2, 11
- Online Resources - see pg 4, 10, 11
- Phone Resources

070720072047070720072047000000 1
JANE DOE
500 W MAIN ST
HUM10
LOUSVILLE KY 40202-1234

© 2007 Humana Inc., Patent Pending
Questions about your plan or this statement call 1-866-4-ASSIST or visit www.humana.com

PPO 9/17

Fictional Example

SmartSummary℠

HUMANA.
Guidance when you need it most

Your personal health finance and benefits statement

Your personal profile

Member name:	Jane Doe
Member ID:	987654321 01
Your medical plan:	Traditional PPO, Single
Your prescription plan:	Rx4

Partnership opportunities

- ☐ Email your SmartSummary
- ☑ Register at www.humana.com
- ☐ Electronic EOBs

Programs you are enrolled in

- ☐ Humana*Beginnings*
- ☐ Health Risk Assessment

Your accounts

- ☐ Health Savings Account
- ☑ Flexible Spending Account
- ☐ Dependent Care Account

Remember, your next statement will not be sent in the mail. To view your statement, log on to *My*Humana through www.humana.com.

The items checked here are accounts, programs and opportunities in which you are enrolled. The unchecked items are available to you, but you are not enrolled.

See page 5 for more information about your health care accounts.

Numbers to watch

"Humana discounts" shown here are for costs and charges that have been negotiated for you by Humana with doctors, pharmacists and hospitals. "Excluded costs" represent the items or partial amounts that are not covered by your plan, which you may be responsible for paying to the doctor or hospital.

What you've spent this year

Medical Costs	
– Copays	$0.00
– Other medical costs	$92.00
Prescription costs	$170.00
Excluded costs	$0.00
What you paid	**$262.00**



What you paid	**$262.00**
What your plan paid	$1,086.06
Humana discounts	$621.88
Total billed charges	$1,969.94

What's remaining in your accounts

Health Flexible Spending Account	$690.00

Your privacy is important to us

At Humana, your personal, health and financial information is confidential. Humana protects your information and only uses or discloses your information in accordance with federal and state privacy laws and Humana's privacy policy. For additional information on Humana's privacy policy, please access Humana's Notice of Privacy Practices on the Web at www.humana.com.

Fictional Example

SmartSummary℠

HUMANA.
Guidance when you need it most

Your personal health finance and benefits statement

Medical claims we received

This section lists new medical claims that were processed this quarter or previously processed claims that have been adjusted this quarter.

As a Humana member, you pay a reduced price that has been negotiated by Humana with participating doctors and hospitals. The "Humana discounts" column represents these savings. The "Humana exclusions" column represents the items or partial amounts that are not covered by your plan, or amounts from a non participating provider which you may be responsible for paying to the doctor or hospital.

If you have a question about information listed in this section, you can call the customer service number listed at the bottom of the first page of this statement. If you believe a claim was processed incorrectly, you will need to submit a written grievance and appeal.

			What you pay with this plan				
Date of service, Provider name	**Total charge**	**Humana discounts**	**Humana exclusions**	**Copay**	**Deductible**	**Coinsurance**	**Humana paid**
(Processed on: Sep 29/06)							
Sep 18/06, Claim 999999999999999 **Smith MD**							
- Level IV - Surgical Pathology, (In-Network)	145.00	29.00	-	-	-	-	116.00
(Processed on: Oct 11/06)							
Sep 25/06, Claim 999999999999999 **Jones MD**							
- Exc Mal Les Marg Sclp Nck Hnd, (In-Network)	500.00	300.00	-	-	-	20.00	180.00
- Adj Tiss Trans Forehead Nck Ax, (In-Network)	700.00	140.00	-	-	-	56.00	504.00
(Processed on: Oct 18/06)							
Sep 28/06, Claim 999999999999999 **Jones MD**							
- Exc Ben Les Marg Fce Ers Eyeld, (In-Network)	200.00	40.00	-	-	-	16.00	144.00

See page 6 for your personalized health news.

The *My*Humana Health & Wellness Savings Center, available at www.humana.com, includes valuable discounts and coupons for:

- Exercise and fitness- Monthly discounts on membership fees to local gyms.
- Oral care - $7 discount on Crest Whitestrips Renewal.
- Personal care and beauty - 15 percent discount on Conair's spa products and more.
- Skin care - Free samples of Olay.
- Weight management - Weight Watchers discounts.

Nutrition Tip-Steam your vegetables to preserve their nutrients. Boiling pulls the nutrients out of the food.

Fictional Example

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HUMANA.
Guidance when you need it most

Your personal health finance and benefits statement

Prescription claims we received

This list shows all of your submitted prescription claims and total costs covered by Humana for the past quarter. Adjusted claims may not be reflected in this list or may show an amount that is different than what was listed prior to the adjustment.

As a Humana member, you have the advantage of a reduced price negotiated by Humana with the pharmacy. The cost of the prescription displayed is the average retail price at the pharmacy at the time of purchase and does not take into account other reimbursements, including rebates. Retail prices on prescription drugs can vary by pharmacy, quantity, strength and/or dosage of the drug. You should always discuss your medications with your doctor to determine appropriateness or clinical effectiveness.

If you have a question about information listed in this section, you can call the customer service number listed at the bottom of the first page of this statement. If you believe a claim was processed incorrectly, you will need to submit a written grievance and appeal.

Drug name	Cost of prescription	Drug tier	Copay	What Humana paid
Oct 15/06 ABC Pharmacy **Paxil Cr, 12.5 Mg, 30.0 Tablet Ext**	99.89	2	30.00	55.61
Oct 15/06 ABC Pharmacy **Lisinopril, 20.0 Mg, 30.0 Tablet**	16.10	1	10.00	-
Oct 16/06 ABC Pharmacy **Clonazepam, 0.5 Mg, 30.0 Tablet**	16.19	1	10.00	-
Oct 19/06 ABC Pharmacy **Azithromycin, 250.0 Mg, 6.0 Tablet**	49.13	2	30.00	-
Oct 19/06 ABC Pharmacy **Ibuprofen, 800.0 Mg, 90.0 Tablet**	21.86	1	10.00	-
Nov 25/06 ABC Pharmacy **Clonazepam, 0.5 Mg, 30.0 Tablet**	16.19	1	10.00	-
Nov 25/06 ABC Pharmacy **Lisinopril, 20.0 Mg, 30.0 Tablet**	16.10	1	10.00	-
Nov 25/06 ABC Pharmacy **Paxil Cr, 12.5 Mg, 30.0 Tablet Ext**	99.89	2	30.00	55.61
Nov 28/06 ABC Pharmacy **Malarone, 12.0 Tablet**	89.59	2	30.00	30.84

Communication with Humana

This list of inquiries is provided to help you manage service interactions, and may include inquiries made on your behalf. As inquiries can be directed to different areas within Humana, this list may not include all of your communications with Humana.

Date	Reference Number	Type	Reason for contact
Sep 26/06	00000000000 - 0000001	Inbound Call	Issue OR Request About Your Humana Access Card
Sep 26/06	00000000000 - 0000001	Inbound Call	Issue OR Request About Your Humana Access Card

Remember to visit *My*Humana, your password-protected personal home page on www.humana.com. You can see your claims, benefit and prescription coverage information anytime.

Fictional Example

SmartSummary℠

HUMANA.
Guidance when you need it most

Your personal health finance and benefits statement

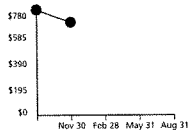
Your health care accounts

The IRS may request that you submit receipts to confirm that FSA, HSA and PCA funds were used for appropriate medical expenses. Please keep all receipts from these accounts for IRS substantiation. For questions regarding your FSA, HSA or PCA account please call 1-800-604-6228.

Your Health Flexible Spending Account summary (this year)

Amount you chose for FSA		$780.00
Amount spent to date		
First quarter	$90.00	
Total spent		$90.00
Remaining Balance		**$690.00**

Your FSA balance



Please save all receipts for end of year tax purposes.

You can use your FSA to pay for...

- Deductibles
- Doctor visits
- Hospital charges
- Urgent care and emergency room visits
- Medical supplies such as braces and walkers
- Physical therapy, speech therapy, podiatrist and chiropractic expenses
- Prescription drugs and over the counter medications

Be sure to check with your employer for a complete list.

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Your personal health finance and benefits statement

What's new in health care

We strive to personalize your health news by selecting articles about new research and studies that are relevant to your life. The information contained in these articles does not reflect endorsement or coverage by Humana. Consult your doctor before making any changes that could possibly affect your health.

Shortness of breath a potential sign of heart trouble

Dyspnea, or difficulty breathing, is another in the growing list of risk factors that could signal heart trouble.

A study, published in the *New England Journal of Medicine*, of nearly 18,000 people who had standard stress tests found that those with dyspnea but no other signs of heart problems were at more than twice the risk of death from cardiac causes than those with angina.

Patients should be sure to mention any shortness of breath to their doctors, said senior researcher Dr. Daniel S. Berman, director of cardiac imaging at Cedars-Sinai Medical Center in Los Angeles.

"The patient often doesn't think of it as a symptom," Berman noted. But when signs of a heart problem are discovered, "we ask whether there is shortness of breath, they say 'yes.'"

Dyspnea has many causes, and physicians routinely ask people if they have trouble breathing, said Dr. Alan Rozanski, director of nuclear cardiology at St. Luke's-Roosevelt Hospital in New York City, and another member of the research team. He said trouble breathing is often a rip-off to the physician that a patient may have some underlying lung disease, maybe even heart failure. But until now, only a few studies, most with a limited number of participants, have looked at whether dyspnea is a predictor of cardiac events, Rozanski said.

The New York team divided their 17,991 patients into five groups based on the number and type of symptoms: no symptoms, two different forms of angina, chest pain not caused by angina, and dyspnea alone.

After an average follow-up of nearly three years, the death rate among patients with dyspnea was significantly higher than for those with any other symptom or no symptoms -- even in patients with no known history of coronary artery disease.

The risk of sudden death was also four times higher for patients with dyspnea and coronary artery disease than for people with no symptoms, the researchers noted.

SOURCES: Alan Rozanski, M.D., director, nuclear cardiology, St. Luke's-Roosevelt Hospital, New York; Daniel S. Berman, director, cardiac imaging, Cedars-Sinai Medical Center, Los Angeles; Nov. 3, 2005 New England Journal of Medicine

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Recurring melanoma more prevalent than thought

Nearly 15 percent of people diagnosed with the potentially fatal skin cancer melanoma are at risk of a second diagnosis within two years, a new study has found.

About 6 percent of patients will develop a second melanoma within one year of the initial diagnosis, while 8 percent will be diagnosed with a second malignancy within two years, according to the researchers from Dartmouth Medical School in Hanover, N.H. This rate is more frequent than previously thought and points to the importance of surveillance and skin screenings, according to the study in the Archives of Dermatology.

"This is not surprising, but it gives us another stimulus to be very vigilant about picking up second and third melanomas," said Dr. Vijay Trisal, assistant professor of surgical oncology at City of Hope Cancer Center, in Duarte, Calif.

The current study included 354 New Hampshire residents who'd had a previous diagnosis of melanoma. Six percent of the participants developed an additional melanoma within one year of the first diagnosis, while 8 percent developed an additional melanoma within two years.

Roughly two-thirds of those who developed additional malignancies and 37 percent of those who did not had at least one atypical mole, which is a risk factor for additional melanomas. Someone with three or more atypical moles had four times the risk of developing an additional tumor. Atypical moles have at least three of the following features -- a diameter larger than 5 millimeters; redness; an irregular or ill-defined border; a variety of colors or a portion that is flat, the researchers said.

SOURCES: Vijay Trisal, M.D., assistant professor of surgical oncology, City of Hope Cancer Center, Duarte, Calif.; Keyvan Nouri, M.D., director of Mohs and dermatologic surgery and associate professor of dermatology, University of Miami Miller School of Medicine; April 2006, Archives of Dermatology

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Your personal health finance and benefits statement

Trends in health care costs

Experts predict costly hip-fracture epidemic

The world faces an epidemic of hip fractures over the next few decades as more and more people's bones weaken from osteoporosis as they age.

So conclude researchers, reporting their findings in *The Lancet*, who estimate that at least 6.3 million people worldwide will suffer a hip fracture in the year 2050 -- more than triple the 1.7 million cases recorded in 1990.

Already, "fracture rates seem to be rising in many parts of the world," wrote researchers Drs. Philip Sambrook of Royal North Shore Hospital in Sydney, Australia, and Cyrus Cooper of the University of Southampton in England. "On the assumption that age-adjusted rates will rise by only 1 percent per year, the number of hip fractures worldwide could be as high as 8.2 million by 2050."

The trend toward more fractures could be turned around, however, with a little prevention.

"We should be looking at the younger population to maximize calcium," said Dr. Joseph Fetto, associate professor of orthopedics at the New York University Hospital for Joint Diseases.

"The maximum amount of calcium early in life is determined by intake in the diet," he said. Young people should try to get adequate amounts of calcium, magnesium, zinc and vitamin D in their diets, even taking supplements if necessary, Fetto said.

The annual costs of all osteoporotic fractures have been estimated to be $20 billion in the U.S.A. and about $30 billion in the European Union, the researchers wrote.

SOURCES: Joseph Fetto, M.D., associate professor of orthopedics, New York University Hospital for Joint Diseases, New York City; June 17, 2006, The Lancet

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Fictional Example

Your Portable Health Record

HUMANA.
Guidance when you need it most

For December 1, 2005 to November 30, 2006 **Jane Doe**

This list is compiled from claims information submitted to your insurance plan. If this list does not include information you received from your doctor concerning a surgery or procedure, for example, please check with your doctor for the correct information. This list is not intended to be a substitute for a medical record.

This list is provided as a courtesy to help you manage your interactions with your doctors and pharmacists. It may be helpful to take this with you to your next visit to your doctor, hospital or pharmacist to give them a broader view of your health care interactions.

Date	Name of provider, specialty	Procedure	Name of drug, dosage, quantity
Dec 11/05	ABC Pharmacy		-Lisinopril, 20.0 Mg, 30 Tablet
Dec 13/05	ABC Pharmacy		-Paxil Cr, 12.5 Mg, 30 Tablet Ext
Dec 14/05	Jones MD	-Clinic-General	
Dec 14/05	Jones MD	-Ofc/Outpt Visit E&M Estab Mod-	
Dec 21/05	Jones MD	-Inf Agt-Dna/Rna; Papillomaviru -Cytopath Cerv/Vag Thin Lay Pre	
Dec 21/05	ABC Pharmacy	-Init Preventative Med E&M New	
Dec 28/05	ABC Pharmacy		-Amoxicillin/Potassium Cla, 20 Tablet
Jan 7/06	Smith MD	-Other Imaging Services-Screeni	
Jan 7/06	Smith MD	-Screening Mammography Bilatera -Cmpt Aided Detect Phys Rev For	
Jan 13/06	Smith MD	-Ofc/Outpt Visit E&M Est Low-MO -ECG Routine ECG W/At Least 12	
Jan 18/06	Smith MD	-Bld Count; Cmpl Auto & Auto Di -UA Dip Stick/Tablet Reagent; W -Basic Metabolic Panel -Lipid Panel	
Jan 19/06	ABC Pharmacy		-Lisinopril, 20.0 Mg, 30 Tablet -Clonazepam, 0.5 Mg, 30 Tablet -Paxil Cr, 12.5 Mg, 30 Tablet Ext
Jan 30/06	ABC Pharmacy	-Anes-Integ Syst Musc&Nerv Head	
Jan 30/06	ABC Pharmacy		-Cefadroxil, 500.0 Mg, 14 Capsule -Hydrocodone/Acetaminophen, 30 Tablet
Feb 2/06	ABC Pharmacy		-Propoxyphene-N/Acetaminop, 30 Tablet
Mar 2/06	ABC Pharmacy		-Paxil Cr, 12.5 Mg, 30 Tablet Ext -Prevacid, 30.0 Mg, 30 Capsule DE -Lisinopril, 20.0 Mg, 30 Tablet
Mar 3/06	ABC Pharmacy		-Neo/Poly/Bac/Hc, 4 Ointment -Oxycodone/Acetaminophen, 20 Tablet
Apr 7/06	Smith MD	-Bx Skin Subq Tissue &/ Mucous	
Apr 7/06	Smith MD	-Ofc/Outpt Visit E&M Est Low-MO	
Apr 8/06	ABC Pharmacy		-Clonazepam, 0.5 Mg, 30 Tablet -Lisinopril, 20.0 Mg, 30 Tablet -Prevacid, 30.0 Mg, 30 Capsule DE
Apr 11/06	ABC Pharmacy		
Apr 12/06	Jones MD	-Level IV - Surgical Pathology	

Fictional Example

Your Portable Health Record

HUMANA.
Guidance when you need it most

Jane Doe

May 5/06	Jones MD	-Level IV - Surgical Pathology	
May 6/06	ABC Pharmacy		-Paxil Cr, 12.5 Mg, 30 Tablet Ext -Clonazepam, 0.5 Mg, 30 Tablet
May 8/06	ABC Pharmacy		-Lisinopril, 20.0 Mg, 30 Tablet
Jun 12/06	ABC Pharmacy		-Olux, 0.05 %, 100 Foam
Jun 22/06	ABC Pharmacy		-Lisinopril, 20.0 Mg, 30 Tablet
Jun 23/06	ABC Pharmacy		-Paxil Cr, 12.5 Mg, 30 Tablet Ext
Jul 2/06	ABC Pharmacy		-Clonazepam, 0.5 Mg, 30 Tablet
Jul 14/06	ABC Pharmacy		-Levaquin, 500.0 Mg, 10 Tablet
Jul 25/06	ABC Pharmacy		-Lisinopril, 20.0 Mg, 30 Tablet
Jul 29/06	ABC Pharmacy		-Paxil Cr, 12.5 Mg, 30 Tablet Ext -Clonazepam, 0.5 Mg, 30 Tablet
Aug 29/06	ABC Pharmacy		-Clonazepam, 0.5 Mg, 30 Tablet -Paxil Cr, 12.5 Mg, 30 Tablet Ext -Lisinopril, 20.0 Mg, 30 Tablet
Sep 19/06	Jones MD	-Level IV - Surgical Pathology	
Sep 26/06	Smith MD	-Exc Mal Les Marg Scln Nck Hnd -Adj Tiss Trans Forehead Nck Ax	
Sep 29/06	Smith MD	-Exc Ben Les Marg Fce Ers Eyelid	
Oct 17/06	ABC Pharmacy		-Paxil Cr, 12.5 Mg, 30 Tablet Ext -Lisinopril, 20.0 Mg, 30 Tablet
Oct 18/06	ABC Pharmacy		-Clonazepam, 0.5 Mg, 30 Tablet
Oct 19/06	ABC Pharmacy		-Azithromycin, 250.0 Mg, 6 Tablet -Ibuprofen, 800.0 Mg, 90 Tablet
Nov 25/06	ABC Pharmacy		-Clonazepam, 0.5 Mg, 30 Tablet -Lisinopril, 20.0 Mg, 30 Tablet -Paxil Cr, 12.5 Mg, 30 Tablet Ext
Nov 28/06	ABC Pharmacy		-Malarone, 12 Tablet

To help estimate what you're likely to spend on health care by the end of the current plan year, use the Estimate My Health Care Costs tool available through www.humana.com.

October-April is cold and cough season. Visit the medications savings page on *My*Humana, your password-protected personal home page on www.humana.com, for coupons on over-the-counter cold and cough medications.

Water is a key part of any diet, so drink 6-8 glasses a day and eat foods with high water content such as melons, grapes, cucumbers, onions, apples, cabbage and soup. Staying properly hydrated helps flush toxins from your body, relieves constipation and helps keep your joints flexible and your mind clear.

Your prescriptions at a glance

Prescription Refill Information	2005	2006										
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Lisinopril 20.0 MG 30 Tablet, 30 days supply Smith MD	●	●		●	●	●	●	●				
Paxil Cr 12.5 MG 30 Tablet Ext, 30 days supply Smith MD	●	●		●		●	●	●	●		●	●
Amoxicillin/Potassium Cla 20 Tablet, 10 days supply Smith MD	●											

Fictional Example

Your Portable Health Record

HUMANA.
Guidance when you need it most

Jane Doe

Prescription Refill Information	2005	2006										
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Clonazepam 0.5 MG 30 Tablet, 30 days supply Jones MD		●			●	●		●	●		●	●
Cefadroxil 500.0 MG 14 Capsule, 7 days supply Smith MD		●										
Hydrocodone/Acetaminophen 30 Tablet, 3 days supply Smith MD		●										
Propoxyphene-N/Acetamin op 30 Tablet, 5 days supply Smith MD			●									
Prevacid 30.0 MG 30 Capsule De, 30 days supply Jones MD				●	●							
Neo/Poly/Bac/Hc 4 Ointment, 7 days supply Smith MD				●								
Oxycodone/Acetaminophen 20 Tablet, 3 days supply Smith MD				●								
Olux 0.05 % 100 Foam, 15 days supply Smith MD							●					
Levaquin 500.0 MG 10 Tablet, 10 days supply Jones MD								●				
Lisinopril 20.0 MG 30 Tablet, 30 days supply Smith MD									●		●	●
Azithromycin 250.0 MG 6 Tablet, 5 days supply Jones MD											●	
Ibuprofen 800.0 MG 90 Tablet, 22 days supply Jones MD											●	
Malarone 12 Tablet, 23 days supply Smith MD												●

To choose another way for us to communicate with you, register or log on to *My*Humana, your password-protected personal home page on www.humana.com.

You can visit www.humana.com and use the Drug Coverage Search to determine whether a specific prescription drug is covered by your Humana plan. You can also check for quantity, dosage strength, side effects, and other drug-specific information. Humana's drug list is the most up-to-date list of prescription medications approved for coverage.

Help stop healthcare fraud. If you know or suspect fraudulent activities involving your doctor, pharmacy, or an acquaintance, please call the Humana Customer Service number on the back of your ID card or visit www.humana.com.

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

October 22, 2009

Mr. Thomas Richards
Senior Vice President of Product
CIGNA Healthcare
2 Liberty Place
Philadelphia, Pennsylvania 19192

Dear Mr. Richards:

To complete the record of your testimony before the Domestic Policy Subcommittee on September 17, 2009, the Subcommittee requests the following information in writing:

1) In 2004, CIGNA settled claims for delaying and/or denying claims for patients of self-refunded plans. And in 2009, CIGNA settled with the New York State Attorney General concerning its use of the Ingenix database.

   a) What did CIGNA agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by CIGNA and its subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.

   b) Has CIGNA settled other claims or state regulatory actions relating to the wrongful delay or denial of claims since 2004? If so, please include all relevant details of the settlement. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that included the alleged activities that were the subject of settlement.

2) In your testimony, you stated "In 2008, CIGNA processed approximately 91 million claims for payment. More than 90 million of these claims were paid without question… Of the approximately one million claims that did require prior authorization, all but 0.08 percent were approved on initial review." What is the value in dollars to CIGNA of the claims that CIGNA did not pay within 30 days, 60 days, 90 days, 120 days?

3) Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

5) Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

6) Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Thursday, November 5, 2009**.

If you have any questions regarding this request, please contact Jaron Bourke, Staff Director, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 Rayburn House Office Building
Washington, DC 20515–6143

Majority (202) 225-5051
Minority (202) 225-5074

Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

STEPTOE & JOHNSON LLP
ATTORNEYS AT LAW

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steptoe.com

November 19, 2009

The Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Kucinich:

We represent CIGNA Corporation ("CIGNA" or the "Corporation") and are writing in response to your October 22, 2009 letter to Mr. Thomas Richards. By agreement with your staff, our deadline for a response to your letter was extended to November 19, 2009. Please find below responses to your questions and document requests.

Some of the information contained herein may be business sensitive and would cause commercial harm to CIGNA if it were to be publicly disclosed. To the extent that the Subcommittee is considering such disclosure, we request that you provide us notice and an opportunity to be heard on whether the publication of our responses or the release of the audio tapes would be appropriate under the circumstances. We understand that your inquiry is for the public record in the context of an official Subcommittee hearing, but we do not view anything in either the House or Committee Rules that would prevent you from redacting our responses from public disclosure. We appreciate your discretion in this respect.

Request #1:

In 2004, CIGNA settled claims for delaying and/or denying claims for patients of self-refunded plans. And in 2009, CIGNA settled with the New York State Attorney General concerning its use of the Ingenix database.

(a) What did CIGNA agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by CIGNA and its

subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.

(b) Has CIGNA settled other claims or state regulatory actions relating to the wrongful delay or denial of claims since 2004? If so, please include all relevant details of the settlement. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that included the alleged activities that were the subject of settlement.

CIGNA does not as a business strategy or practice delay claims processing or inappropriately deny claims. One of our principal imperatives as a provider of health and wellness benefits is to help health care providers achieve the best possible medical outcomes for our members. CIGNA does not consider costs of service in establishing coverage policy or in our decisions to provide access to care other than infrequent circumstances. Those infrequent occurrences arise when there are multiple items or services with equivalent safety and effectiveness. CIGNA's medical necessity policies and determinations are made by clinicians and are based on the most recently published scientific evidence. We consider both the safety and the effectiveness of health care procedures, treatments, devices, drugs, and diagnostic tests.

Attachment A contains copies of two settlement agreements with respect to the multi-district litigation settled in 2004 referred to above. In addition, please find attached a copy of the settlement with the New York Attorney General relating to the Ingenix litigation. These documents reflect the monetary components as well as substantive changes implemented by CIGNA.

With respect to individual settlement claims, please find below a chart reflecting (1) the total amount of claims CIGNA has paid since 2004, (2) the aggregate settlement amounts for each of those years, and (3) the number of settled lawsuits for each of those years. The first column is included as context for claim payment history, that is, the total settlement amounts over this period represent less than 0.01 percent of the total amount that CIGNA paid in claims.

Year	Total Value of Medical and Pharmacy Benefits Paid (Rounded)	Aggregate Settlement Amounts	Number of Settled Member Lawsuits
2004	$26,396,000,000	$1,475,655.71	69
2005	$25,392,000,000	$ 553,791.55	59
2006	$26,444,000,000	$1,549,295.81	50
2007	$29,217,000,000	$ 611,512.12	47
2008	$34,913,000,000	$ 310,189.59	33

Additionally, Attachment B contains settlement agreements in two multi-party actions. CIGNA is prepared to discuss with you and your staff any additional information that we can provide pursuant to this request.

With respect to state regulatory actions, it is important for the Subcommittee to realize that the health insurance industry, including CIGNA, is subject to regular reviews from state insurance commissioners and other regulators. In particular, the states conduct "market conduct exams" ("MCEs")" on a regular basis. The MCEs cover the full scope of CIGNA's business. The following is a summary of actions over the last five years.

Year	Regulatory Actions	Aggregate Settlement Amounts
2004	14	$ 809,726.00
2005	11	$ 310,609.48
2006	7	$ 106,300.00
2007	9	$ 975,900.00
2008	5	$ 280,991.57

Finally, in response to the last part of your inquiry, as stated above, CIGNA's medical necessity policies and determinations are made by clinicians and are based on the most recently published scientific evidence. The income and "incentives" of CIGNA executives or employees are not dependent on the approval or denial of claims. Therefore, we have no responsive data with respect to the third sentence of this inquiry.

Request #2:

> **In your testimony, you stated "In 2008, CIGNA processed approximately 91 million claims for payment. More than 90 million of these claims were paid without question ... Of the approximately one million claims that did require prior authorization, all but 0.08 percent were approved on initial review." What is the value in dollars to CIGNA of the claims that CIGNA did not pay within 30 days, 60 days, 90 days, 120 days?**

CIGNA holds itself to a high standard on the payment of claims. Our commitment to continuous improvement includes paying doctors, facilities, and other health care professionals on a timely basis. In 2008, 98.87 percent of claims were paid within 30 days, and 95.88 percent of claims were paid within 14 days. We track payment in 14-day and 30-day categories based on when we receive a "complete" claim. Please note that we do not track claims payment based on dollar amount and, as such, do not manage our claims payment inventory based on dollar amount. We work to pay claims as timely as possible regardless of the dollar value of the claim.

Request #3:

> **Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in**

some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

Included in this transmittal are recordings of CIGNA "town hall meetings" conducted in 2009. Attachment C contains copies of slides referenced in the audios for the specific meetings.

Request #4:

Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

CIGNA itself does not maintain any specific data on the amount of "defensive medicine" that physicians may perform out of concerns about medical malpractice liability. We look at the safety and the effectiveness of health care procedures, treatments, devices, drugs, and diagnostic tests requested for our customers when making access to care determinations.

Provided below are citations for four publicly available studies that document and quantify the impact of "defensive medicine."

1. A May 1996 study in the *Quarterly Review of Economics and Finance,* by Daniel P. Kessler and Mark B. McClellan, estimated that 5-9 percent of total medical spending is due to defensive medicine

2. A June 2005 study in the *Journal of America Medical Association* concluded that 93 percent of Pennsylvania physicians surveyed reported practicing defensive medicine.

3. A 2006 PriceWaterhouseCoopers study estimated that overall, approximately 10 percent of the costs of medical services are attributed to the cost of litigation and defensive medicine.

4. A November 2008 study done by the Massachusetts Medical Society found that 13 percent of all hospital admissions and 30 percent of MRI/CT studies and specialty consultations were ordered due to malpractice concerns.

Request #5:

Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

CIGNA works closely with doctors and hospitals to reduce waste, duplication and redundancy. We are committed to addressing the needs of practicing physicians for administrative simplicity, and in that way contributing to improvements in patients' experience. We propose that the following industry metrics will help to improve quality, outcomes and ultimately have a positive affect on health care costs.

Metric 1: Percent of Electronic Administrative Transactions

With respect to administrative interaction between providers and health plans, there are five primary touch points that benefit from the application of information technology: (1) eligibility verification, (2) claim submission, (3) claim status inquiry, (4) claim payment and (5) claim remittance. Electronic versions of these interactions, based on existing HIPAA standards, currently support 43 percent of all such activity across the industry. Conversion of the remaining activity to electronic means would yield $29.7 billion in savings across the industry (source: US Healthcare Efficiency Index, www.ushealthcareindex.com). We suggest metrics around these touch points.

Relatedly, CIGNA is one of many major healthcare companies participating in a task force led by America's Health Insurance Plans ("AHIP") to identify opportunities to simplify administrative interaction between health care professionals and healthcare companies. The goal of the task force is to reduce the administrative complexity that health care professionals experience when interacting with multiple healthcare companies. On October 5, 2009, CIGNA and other AHIP representatives joined health care professionals to announce the kickoff of a technology test phase in Ohio. This will give doctors access to a new multi-payer web portal (i.e., a single website) designed to simplify their interactions with CIGNA and other health plans. The web portal will offer 15 administrative and clinical capabilities in real-time for eligibility and benefits inquiry, claim submission, claim status inquiry, referrals, and prior authorization.

Metric 2: CORE Certification

The Committee on Operating Rules for Information Exchange ("CORE"), established by the Council for Affordable Quality Healthcare ("CAQH"), was created to build consensus among health care industry stakeholders on a set of operating rules that enhance HIPAA transaction standards to further streamline electronic healthcare data exchange. The widespread adoption of CORE rules will help health care professionals receive more consistent and predictable data across multiple health plans. CAQH reports that 75 percent of commercially insured members are covered by health plans that are either CORE-certified or are in the process of achieving certification. CIGNA suggests adding CORE certification as a metric for each phase of CORE rules.

Metric 3: Electronic Prescriptions

Electronic prescriptions improve patient safety by allowing medication history and allergies to be evaluated at the point of care. We suggest a metric around the percentage of prescriptions enabled electronically for transmission.

Metric 4: Electronic Lab Results

There is significant value in making lab test results available electronically. It can reduce duplicative testing (reducing costs) and improve quality as well (providing a more complete

and accurate clinical picture to track health issues). We suggest a metric around the percentage of lab results available electronically.

Metric 5: "Gaps in Care" Electronic Alerts

"Gaps in Care" alerts are evidence-based care guidelines that shape appropriate interventions and medication adherence for a variety of chronic and acute conditions. Health plans often maintain the most comprehensive set of clinical data available for individuals today, and as such, programs to "alert" physicians to potential compliance issues with these care guidelines are common.

Metric 6: Electronic Personal Health Records

Consumer access to information has been accepted as a means of creating well-informed patients that have the ability to make better decisions working with their family and physicians. Personal Health Records ("PHRs") are a comprehensive solution to providing records with information automatically populated with medical and pharmacy claim details, and often lab results. PHRs often present patient-specific educational resources driven by diagnosis/procedure codes in claim detail, benefits/coverage, family history, etc.

CIGNA believes any suggestions to improve health plan performance must also focus on individual quality of care and health outcomes. Through these types of administrative simplification initiatives, we hope to reduce the time, effort, and expense related to the paperwork that burdens much of today's health care system – while making it easier for health care professionals to interact with health plans.

Request #6:

Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

Mr. Richards will provide the Subcommittee with his CIGNA compensation over the past 5 years under a separate and confidential transmittal. On behalf of Mr. Richards, we ask that he be notified in advance of any public release of the information he is providing.

Please contact me if CIGNA may provide any additional information or otherwise be of assistance to the Subcommittee.

Sincerely,

James D. Barnette

James D. Barnette

cc: The Honorable Jim Jordan
Attachments

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO.: 1334

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

CHARLES B. SHANE, M.D., et al.

Plaintiffs,

v.

HUMANA, INC.; AETNA, INC.; AETNA-US1IC, INC.; CIGNA; COVENTRY HEALTH CARE, INC.; HEALTHNET, INC.; HUMANA HEALTH PLAN, INC.; PACIFICARE HEALTH SYSTEMS, INC.; PRUDENTIAL INSURANCE COMPANY OF AMERICA; UNITED HEALTH GROUP; UNITED HEALTH CARE; WELLPOINT HEALTH NETWORKS, INC.; AND ANTHEM, INC.

Defendants.

TIMOTHY N. KAISER, M.D., and SUZANNE LeBEL CORRIGAN, M.D., on behalf of a class of others similarly situated,

Plaintiffs,

v.

CIGNA CORPORATION; CIGNA HEALTHCARE OF ST. LOUIS, INC.; and CIGNA HEALTHCARE OF TEXAS, INC.,

Defendants.

SETTLEMENT AGREEMENT AMONG
CIGNA HEALTHCARE AND PHYSICIANS

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LIST OF EXHIBITS

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Exhibit 15 Form of Additional Medical Society Agreement

PREAMBLE:

This Settlement Agreement, dated as of September 4, 2003 (the "Agreement") is made and entered into by the Class Representative Plaintiffs (as defined below) (on behalf of themselves and each of the Class Members as hereafter defined), by and through their counsel of record in these actions, those medical societies identified on the signature pages hereto (such medical societies are herein collectively referred to as the "Signatory Medical Societies") and CIGNA Corporation (on behalf of those persons that are included in the definition of CIGNA HealthCare, including those Subsidiaries that are named as defendants in these actions) (CIGNA Corporation and CIGNA HealthCare being collectively referred to herein as "CIGNA HealthCare") (all of the above being collectively referred to as the "Settling Parties"). This Agreement is intended by the Settling Parties to resolve, discharge and settle the Released Claims, according to the terms and conditions set forth hereafter.

WHEREAS:

A. On December 7, 1999, certain of MDL Class Counsel filed *Eugene Mangieri, M.D., on behalf of himself and all others similarly situated, v. CIGNA Corporation, et al.*, CV 99-C-3254-W (N.D. Ala.). *In re Managed Care Litigation*, MDL 1334 was created by order of the Judicial Panel on Multidistrict Litigation ("MDL Panel") on April 17, 2000. On October 23, 2000, *Mangieri* was transferred by the MDL Panel to the United States District for the Southern District of Florida (the "Court"). The above captioned *Shane, et al. v. Humana, Inc., et al.* ("*Shane*") became the lead case in the Provider Track of MDL 1334 ("Provider Track"). The operative complaint in *Shane*, the Second Amended Consolidated Class Action Complaint, was filed on July 11, 2002, and includes Mangieri and the claims made in his original complaint. On September 26, 2002, the Court conditionally certified a class and two subclasses defined as:

> The Global Class: All medical doctors who provided services to any person insured by any Defendant from August 4, 1990 to September 30, 2002.

CIGNA 000009

> National Subclass: Medical doctors who provided services to any person insured by a Defendant, when the doctor has a claim against such Defendant and is not bound to arbitrate the claim.
>
> California Subclass: Medical doctors who provided services to any person insured in California by any Defendant when the doctor was bound to arbitrate the claim being asserted.

The named plaintiffs in *Shane* were named as class representatives, and the following attorneys have been designated as Class Counsel:

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Waterbury, CT 06708

("MDL Class Counsel"). An appeal of the class certification order in *Shane* was allowed by the United States Court of Appeals for the Eleventh Circuit and this appeal remains pending. MDL Class Counsel have conducted discovery and an investigation related to the claims and defenses in *Shane*.

B. On May 26, 2000, Timothy N. Kaiser, M.D. and Suzanne LeBel Corrigan, M.D. filed a class action lawsuit styled *Kaiser, et al. v. CIGNA Corporation, CIGNA HealthCare of St. Louis, Inc., and CIGNA HealthCare of Texas, Inc.* (Case No. 00-L-480), in the Circuit Court of Madison County, Illinois ("*Kaiser*"). Kaiser Counsel are:

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("Kaiser Counsel"). The named plaintiffs were subsequently designated as class representatives.

C. On November 22, 2002, a third amended complaint was filed in *Kaiser* and on November 25, 2002, defendants removed the action to the United States District Court for the

CIGNA 00005

Southern District of Illinois. On November 25, 2002, Kaiser Counsel and counsel for the defendants in *Kaiser* reached agreement on a settlement and on November 26, 2002, Chief Judge G. Patrick Murphy of the United States District Court for the Southern District of Illinois entered an order preliminarily approving the settlement, conditionally certifying a settlement class and directing notice and a hearing on the settlement. The settlement class conditionally certified was defined as:

> All physicians, physician groups, hospitals, facilities, ancillary providers, and other health care practitioners, entities, or providers, who at any time from January 1, 1996 through the present:
>
> A. Provided health care services or supplies to participants in or beneficiaries of health plans (including Medicare HMO plans) whose benefits were insured or administered by CIGNA HealthCare; and
>
> B. Submitted claims to CIGNA HealthCare for such services or supplies on a fee-for-service basis either:
>
> 1. as a participating provider pursuant to a "Managed Care Agreement" or another contract; or,
>
> 2. on the basis of an assignment of health plan benefits, *i.e.*, as a non-participating provider.

This class is hereafter referred to as the "Kaiser Class."

D. On December 23, 2002, Chief Judge Murphy issued a minute order suspending proceedings with respect to the settlement pending a decision by the MDL Panel as to whether the *Kaiser* case should be transferred to the United States District Court for the Southern District of Florida. That Court, on December 12, 2002, had issued an injunction against further proceedings with respect to the settlement.

E. On February 21, 2003, the MDL Panel issued an order transferring the *Kaiser* case to the United States District Court for the Southern District of Florida, to become part of *In re Managed Care Litigation*, MDL 1334. As a result, and since said transfer, settlement discussions and proceedings as to Physicians, Physician Groups and Physician Organizations that

were part of the Kaiser Class and the state court class certified in *Kaiser* have been subsumed by discussions and proceedings in the *Shane* case.

F. Beginning on April 10, 2003, under the supervision of the Mediator appointed by the Court, further settlement discussions were held by and among MDL Class Counsel, Kaiser Counsel and counsel for CIGNA HealthCare. The results of those discussions are reflected in this Agreement.

G. The Class Representative Plaintiffs, on behalf of themselves and as representatives of and on behalf of the Class Members as defined below, after considering the benefits of the Settlement and the risks of litigation, have concluded that it is in the best interests of the Class Members to enter into this Agreement. The Signatory Medical Societies agree with this conclusion. CIGNA HealthCare is willing to settle this Litigation by agreeing to the terms and conditions of this Agreement. This Agreement takes into consideration the risks of litigation, including trials and possible appeals, the strengths and weaknesses of the case against CIGNA HealthCare, and such other factors as are appropriate in evaluating the matter.

H. CIGNA HealthCare denies each and all of the material factual allegations and legal claims asserted in this Litigation, including any and all charges of wrongdoing or liability arising out of any of the conduct, statements, acts or omissions alleged in this Litigation. CIGNA HealthCare denies any liability to members of a class certified by the Madison County Circuit Court in *Kaiser*, the members of the Kaiser Class and the members of the classes certified in *Shane*, and is prepared to defend these lawsuits vigorously at trial. Additionally, CIGNA HealthCare maintains its contentions that the claims of thousands of Class Members may not be advanced in this Litigation through trial by reason of valid and enforceable arbitration provisions. Neither this Agreement nor any act taken in furtherance of it shall constitute an admission of any fact, fault, liability or wrongdoing by any party or their respective counsel as more fully set forth hereafter.

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I. The Class Representative Plaintiffs and Class Counsel believe that the claims asserted against CIGNA HealthCare in this Litigation have merit. However, Class Representative Plaintiffs and Class Counsel recognize and acknowledge the length of continued proceedings that would be necessary to prosecute the Litigation against CIGNA HealthCare through trial and through appeals. Class Representative Plaintiffs and Class Counsel have also taken into account the uncertain outcome and risks of any litigation, especially in complex actions such as this Litigation, as well as the difficulties and delays inherent in such litigation. Class Representative Plaintiffs and Class Counsel are mindful of the inherent problems of proof under the various theories asserted in the Litigation and are further aware of, but disagree with, CIGNA HealthCare's claims in this Litigation regarding the need for individualized proof of injury and damages. Further, Class Representative Plaintiffs and Class Counsel are aware that CIGNA HealthCare has sought to enforce arbitration clauses that could prohibit large numbers of Class Members from participating in the Litigation. Therefore, Class Representative Plaintiffs and Class Counsel believe that the Settlement set forth in this Agreement confers substantial benefits upon the Class Members. Based upon their evaluation of all of these factors, Class Representative Plaintiffs and Class Counsel have determined that this Settlement is in the best interests of the Class Representative Plaintiffs and the Class Members, despite any disagreements Class Representative Plaintiffs and Class Counsel may have with the averments made by CIGNA HealthCare.

NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED by the Settling Parties that, in consideration of the covenants, agreements and releases set forth herein, and subject to the approval of the Court and entry of the Final Order and Judgment after a Fairness Hearing, the Litigation as to CIGNA HealthCare shall be finally and fully compromised and settled as to Class Representative Plaintiffs and Class Members, and the Litigation as to CIGNA HealthCare shall be dismissed with prejudice as to Class Representative Plaintiffs and all Class Members, upon and subject to the following terms and conditions:

Healthsource Corporate Services, Inc., Healthsource Innovative Medical Management, Inc., Healthsource Health Plans, Inc., CIGNA HealthCare of North Carolina, Inc., Healthsource North Carolina, Inc., Healthsource Indiana, Inc., Healthsource Indiana Insurance Company, Healthsource Indiana Managed Care Plan, Inc., Healthsource Insurance Group, Inc., Healthsource Kentucky, Inc., Healthsource Maine, Inc., Healthsource Maine Preferred, Inc., Healthsource Management, Inc., Healthsource Syracuse, Inc., Healthsource HMO of New York, Inc., Healthsource Preferred of New York, Inc., CIGNA HealthCare of Tennessee, Inc., Healthsource Tennessee Preferred, Inc., CIGNA HealthCare of Massachusetts, Inc., Healthsource Metropolitan New York Holding Company, Inc., Healthsource New York/New Jersey, Inc., Healthsource New Hampshire, Inc., Healthsource Ohio Preferred, Inc., Healthsource Preferred, Inc., Healthsource Rhode Island, Inc., Healthsource South Inc., CIGNA HealthCare of Georgia, Inc., Healthsource Arkansas Ventures, Inc., Healthsource Arkansas, Inc., Healthsource Arkansas Preferred, Inc., Healthsource Insurance Company, Physicians' Health Systems, Healthsource Insurance Services, Inc., Healthsource South Carolina, Inc., Arizona Health Plan, Inc., CIGNA HealthCare Mid-Atlantic, Inc., CIGNA HealthCare of Arizona, Inc., CIGNA Community Choice, Inc., CIGNA HealthCare of California, Inc., CIGNA HealthCare of Colorado, Inc., CIGNA HealthCare of Connecticut, Inc., CIGNA HealthCare of Delaware, Inc., CIGNA HealthCare of Florida, Inc., CIGNA HealthCare of Illinois, Inc., CIGNA Healthplan of Louisiana, Inc., CIGNA HealthCare of New Jersey, Inc., CIGNA HealthCare of New York, Inc., CIGNA HealthCare of Ohio, Inc., CIGNA HealthCare of Oklahoma, Inc., CIGNA HealthCare of Pennsylvania, Inc., CIGNA HealthCare of Puerto Rico, Inc., CIGNA HealthCare of Utah, Inc., CIGNA HealthCare of Virginia, Inc., Lovelace Health Systems, Inc., Ross Loos Hospital, Inc., International Rehabilitation Associates, Inc., and CIGNA Behavioral Health, Inc.

1.19 "CIGNA HealthCare Member" means any individual who receives health care benefits that are insured and/or administered by CIGNA HealthCare.

1.20 "Claim Coding and Bundling Edits" means adjustments to CPT® Codes or HCPCS Level II Codes included in claims in which (a) CIGNA HealthCare's payment is or was based on some, but not all, of the CPT® Codes or HCPCS Level II Codes included in the claim; (b) CIGNA HealthCare's payment was based on different billing codes than those billed to CIGNA HealthCare; (c) CIGNA HealthCare's payment for one or more CPT® Codes is or was reduced by application of Multiple Procedure Logic; or (d) any combination of the above.

1.21 "Claim Distribution Fund" means the account into which monies sufficient to pay all Category One Compensation and certain Category Two Compensation and Medical Necessity Denial Compensation shall be deposited periodically by CIGNA HealthCare pursuant to Section 8.3.a of this Agreement, together with any interest or earnings thereon following the deposit of such monies by CIGNA HealthCare.

1.22 "Claims Period" means the one hundred eighty (180) day period after Final Approval during which Class Members can make requests for compensation under the terms of this Settlement. The one hundred eighty (180) day Claims Period commences forty-five (45) days after Final Approval.

1.23 "Class" means any and all Physicians, Physician Groups and Physician Organizations (and all Persons claiming by or through them, such as Physicians' Assistants and Advanced Practice Registered Nurses), who or which provided Covered Services to any CIGNA HealthCare member or any individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in the *Shane* complaint or by any of their respective current or former Subsidiaries from August 4, 1990 through the date of the entry of the Preliminary Approval Order; provided, however, that the Class shall not include any Physician who is or was an employee of a CIGNA HealthCare staff-model HMO at the time of providing such Covered Services.

1.24 "Class Counsel" means MDL Class Counsel.

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1.25 "Class List" means the list of putative Class Members used for purposes of distributing notice of this Litigation and Settlement pursuant to the Plan of Notice.

1.26 "Class Members" means all Physicians, Physician Groups and Physician Organizations who or which fall within the definition of the Class, who or which have not timely and validly exercised their right to Opt Out of this Litigation and Settlement pursuant to the Initial Notice, and who or which are therefore bound by the terms of this Agreement, including all of those claiming by or through them.

1.27 "Class Period" means the period from August 4, 1990 through the date of Final Approval.

1.28 "Class Representative Plaintiffs" or "Class Representatives" means collectively, to the extent each executes this Agreement, Susan McIntosh, M.D., J. Kevin Lynch, M.D., F. Scott Gray, M.D., Stephen Levinson, M.D., Karen Laugel, M.D., Edgar Borrero, M.D., Malcolm Gottesman, M.D., Michael Hellstrom, M.D., Lawrence Weiner, M.D., Zachary Rosenberg, M.D., Kevin Molk, M.D., Manuel Porth, M.D, Michael C. Burgess, M.D., Eugene Mangieri, M.D., Glenn Kelly, M.D., Leonard Klay, M.D., Charles B. Shane, M.D., Jeffrey Book, M.D., Andres Taleisnik, M.D., Julio Taleisnik, M.D., David Boxstein, M.D., Roger Wilson, M.D., Susan R. Hansen, M.D., Edward Davis, M.D., Thomas Backer, M.D., Martin Moron, M.D., H. Robert Harrison, Ph.D., M.D., Lance R. Goodman, M.D., Timothy M. Kaiser, M.D., and Suzanne LeBel Corrigan, M.D.

1.29 "Clinical Information" means clinical, operative or other medical records and reports kept in the ordinary course of a Physician's business, and, where applicable, requested statements of medical necessity.

1.30 "Clinical Information Officer" shall have the meaning assigned to that term in Section 7.12 of this Agreement.

1.31 "CMS" means the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration).

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1.32 "CMS 1500" means the health care provider claim form number 1500 created by CMS (and taking the place of HCFA 1500 forms), and as it may be amended, modified or superseded thereafter during the term of this Agreement.

1.33 "Complaints" means the Third Amended Class Action Complaint filed in *Kaiser* on November 22, 2002 in the Madison County Circuit Court and subsequently removed to the United States District Court for the Southern District of Illinois, and the Second Amended Consolidated Class Action Complaint filed on July 11, 2002 in *Shane*, which subsumed the *Mangieri* complaint that had been filed on December 7, 1999.

1.34 "Compliance Dispute" means (i) any claim that CIGNA HealthCare has failed to carry out any of its obligations under Section 7 of this Agreement (with the exception of Section 7.28.f); provided, however, that none of the following shall be deemed a Compliance Dispute: (A) a Released Claim; (B) a Retained Claim; (C) a claim eligible to be a Billing Dispute under Section 7.10 (except for a claim that a CIGNA HealthCare Claim Coding and Bundling Edit is inconsistent with Section 7.20 of this Agreement); (D) a claim subject to Section 7.12 of this Agreement; (E) a claim for which the Medical Necessity External Review Process is available; or (F) a claim challenging a Medical Necessity determination arising out of administration of benefits for a Self-Funded Plan as to which the plan sponsor has not elected to participate in CIGNA HealthCare's Medical Necessity External Review Process.

1.35 "Compliance Dispute Claim Form" means a document in substantially the same form as Exhibit 14, attached hereto.

1.36 "Compliance Dispute Facilitator" means the person chosen, pursuant to Section 15.2.a(1) of this Agreement, who shall first hear Compliance Disputes.

1.37 "Compliance Dispute Review Officer" means the person chosen pursuant to Section 15.2.a(2) of this Agreement and charged with the administration of Certifications and Compliance Disputes under this Agreement.

1.38 "Conclusion Date" shall have the meaning assigned to that term in the Preamble to Section 7 of this Agreement.

1.39 "Correct Coding Initiative" or "CCI" means the Centers for Medicare and Medicaid Services' (formerly known as Health Care Financing Administration) published list of edits and adjustments that are made to health care providers' claims submitted for services or supplies provided to patients insured under the federal Medicare program and under other federal insurance programs.

1.40 "Counsels' Award" shall have the meaning assigned to that term in Section 14.1 of this Agreement.

1.41 "Court" shall have the meaning assigned to that term in WHEREAS Clause A of this Agreement.

1.42 "Covered Service" means a health care benefit that is within the coverage described in the Plan Documents applicable to an eligible CIGNA HealthCare Member.

1.43 "Current Procedural Terminology" ("CPT®" or "CPT® Codes") means medical nomenclature published by the American Medical Association containing a systematic listing and coding of procedures and services provided to patients by Physicians and non-physician health professionals. When used herein, "CPT®" and "CPT® Codes" refer to such medical nomenclature as it exists as of the date of this Agreement and as it may be amended, modified or superseded thereafter during the term of this Agreement.

1.44 "Deductible" means the amount a CIGNA HealthCare Member must pay for Covered Services during a specified coverage period in accordance with the CIGNA HealthCare Member's Plan Documents before benefits are payable by the CIGNA HealthCare Member's Plan.

1.45 "Defendants" means CIGNA Corporation, CIGNA HealthCare of St. Louis, Inc., and CIGNA HealthCare of Texas, Inc.

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1.46 "Defendants' Counsel" means: John G. Harkins, Jr. and Eleanor Morris Hloway (Harkins Cunningham); and Marty L. Steinberg (Hunton & Williams).

1.47 "Delegated Entity" means an entity that is not a Subsidiary of CIGNA HealthCare to the extent that such entity (i) maintains its own contracts with Physicians separate from any contracts between CIGNA HealthCare and Physicians, and, by agreement with CIGNA HealthCare, (ii) (A) agrees to provide CIGNA HealthCare Members with access to such Physicians pursuant to the terms of such agreements; and (B) performs some or all of the functions with respect to Plans which otherwise would be performed by CIGNA HealthCare, including without limitation claims adjudication, utilization review, utilization management and credentialing.

1.48 "Downcoding" shall have the meaning assigned to that term in Section 7.19 of this Agreement.

1.49 "Effective Period" shall have the meaning assigned to that term in the Preamble to Section 7 of this Agreement.

1.50 "ERA/EFT" means the capability to facilitate electronic remittance advice and electronic funds transfer.

1.51 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.

1.52 "Execution Date" means the date on which this Agreement is signed by counsel and CIGNA HealthCare.

1.53 "Explanation of Benefits Form" or "EOB" means an explanation of benefits sent to a CIGNA HealthCare Member.

1.54 "External Review" means review of any Proof of Claim by the Settlement Administrator or the Independent Review Entity, as required under Section 8 of this Agreement.

1.55 "Facilitation List" means, on a best efforts basis, an electronic file, organized by tax identification number (and, within tax identification number, by Class Member name),

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containing a list of (i) Evaluation and Management Codes submitted by each Class Member during the Class Period that were denied payment by CIGNA HealthCare; (ii) claims paid on the basis of code 90769 (CIGNA HealthCare's so-called "well woman" benefit code); (iii) Fee for Service Claims in which Evaluation and Management Codes were billed with a procedure code and either code was denied payment; and (iv) Fee for Service Claims in which Evaluation and Management Codes were billed with add-on codes and either code was denied payment. The Facilitation List shall include the corresponding patient name and date of service.

1.56 "Fairness Hearing" means a hearing to be held by the Court to determine whether to certify the Class, to approve the notice given under the Plan of Notice, to approve the Agreement and the Settlement it embodies as fair, reasonable and adequate, and to determine whether the Final Order and Judgment should be entered, including Counsels' Award.

1.57 "Fairness Hearing Date" shall have the meaning assigned to that term in Section 6.2 of this Agreement.

1.58 "Fee for Service Claim" means any submission by a Class Member to CIGNA HealthCare using CPT® Codes or HCPCS Level II Codes or codes specially created by CIGNA HealthCare (such as its "well woman" code, code 90769) and seeking payment on a fee for service basis for the provision of one or more services and/or supplies to a CIGNA HealthCare Member on a single date of service (inpatient or outpatient) or for a single period of inpatient care on or after August 4, 1990, through the date of Final Approval.

1.59 "Final Approval" means the first Business Day after all of the following events shall have occurred:

a. The Court has entered the Order of Preliminary Approval and Conditional Class Certification substantially in the form set forth in Exhibit 2;

b. The Court has entered the Final Order and Judgment substantially in the form of Exhibits 3 and 4; and,

c. One of the following has occurred:

(1) if no appeal is filed or if an appeal is filed only as to the amount of any Counsels' Award ordered by the Court, the expiration of the time for the filing or noticing of any appeal from the Court's Judgment, *i.e.*, thirty days after the date of the entry of the Judgment; or

(2) the date of final dismissal of any appeal from the Judgment or the final dismissal of any proceeding or denial of *certiorari* to review the Judgment; or

(3) the date of final affirmance on appeal, the expiration of the time for a petition for a writ of *certiorari* and, if *certiorari* is granted, the date of final affirmance following review pursuant to that grant.

1.60 "Final Order and Judgment" means the order and form of judgment approving this Agreement and dismissing claims by Class Members against CIGNA HealthCare with prejudice, but with the Court maintaining jurisdiction to enforce the Agreement, in each case in the form attached hereto as Exhibits 3 and 4.

1.61 "Foundation" shall have the meaning assigned to that term in Section 8.1 of this Agreement.

1.62 "Healthcare Common Procedure Coding System Level II Codes" or "HCPCS Level II Codes" means alphanumeric codes used to identify those codes not included in the American Medical Association's Current Procedural Terminology (*e.g.*, supplies, durable medical equipment, etc.).

1.63 "Independent Review Entity" means an organization or other entity that will be selected by mutual agreement between Notice Counsel and Defendants' Counsel to conduct External Review of certain requests for Category Two Compensation and Medical Necessity Denial Compensation under this Agreement.

1.64 "Individually Negotiated Contract" means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to substantial modifications to the terms of CIGNA HealthCare's standard form agreement to individually suit the needs of a Participating Physician, Physician Group or Physician Organization.

1.65 "Initial Notice" means the first notices to putative Class Members, attached as Exhibits 6 and 7 to this Agreement, advising such putative Class Members of the Preliminary

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Approval Order and of the right to seek exclusion from the settlement class or object to the terms of the Settlement, in accordance with the Plan of Notice.

1.66 "Insured Plan" means a Plan as to which CIGNA HealthCare assumes all or a majority of health care costs and/or utilization risk, depending on the product.

1.67 "Judgment" means the final judgment of dismissal of CIGNA HealthCare with prejudice, but with the Court maintaining jurisdiction to enforce this Agreement, to be rendered by the Court substantially in the form attached hereto as Exhibit 4.

1.68 "*Kaiser*" shall have the meaning assigned to that term in WHEREAS Clause B of this Agreement.

1.69 "Kaiser Class" shall have the meaning assigned to that term in WHEREAS Clause C of this Agreement.

1.70 "Kaiser Counsel" shall have the meaning assigned to that term in WHEREAS Clause B of this Agreement.

1.71 "Lead Counsel" means Archie C. Lamb, Jr. and Harley S. Tropin.

1.72 "Litigation" means the above-captioned actions.

1.73 "MDL Class Counsel" shall have the meaning assigned to that term in WHEREAS Clause A.

1.74 "Medically Necessary" or "Medical Necessity" shall have the meaning assigned to those terms in Section 7.16.a(1) of this Agreement for purposes of the Prospective Relief provided under Section 7; and shall have the following meaning for purposes of the Retrospective Relief procedures relating to Medical Necessity Denial Compensation under Section 8.3.d hereof: services or supplies that, at the time they were delivered to a CIGNA HealthCare Member, were (a) appropriate and necessary for the diagnosis or treatment of the CIGNA HealthCare Member's illness, injury, disease or its symptoms; (b) provided for diagnosis or direct care and treatment of the illness, injury, disease or its symptoms; (c) within generally

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accepted standards of medical practice; and (d) not primarily for the convenience of the CIGNA HealthCare Member, the Class Member or another provider.

1.75 "Medical Necessity Denial Compensation" means compensation paid to Class Members who submit Valid Proofs of Claim for same pursuant to Section 8.3.d of this Agreement for allegedly improper denials of payment on Medical Necessity grounds.

1.76 "Medical Necessity Denial Compensation Proof of Claim Form" means a Proof of Claim Form submitted by a Class Member seeking Medical Necessity Denial Compensation, using the form attached to this Agreement as Exhibit 13.

1.77 "Medical Necessity External Review Process" shall have the meaning assigned to that term in Section 7.11.c of this Agreement.

1.78 "Medical Necessity External Review Organization" means an organization, as described more fully in Section 7.11.c of this Agreement, that provides independent medical reviews of CIGNA HealthCare's denials of coverage which are based on the lack of Medical Necessity or experimental or investigational nature of the proposed or rendered service or supply.

1.79 "Multiple Procedure Logic" means the payment methodology used by CIGNA HealthCare, when processing claims, that makes adjustment(s) to payment(s) for one or more procedures or other services, in each case constituting Covered Services (excluding CPT® Evaluation and Management Codes), when multiple such procedures or services are performed on the same patient on the same date of service.

1.80 "National Medicare Fee Schedule" means the National Medicare Fee Schedule in effect on June 1, 2001 for CPT® Codes and HCPCS Level II Codes, without geographic conversion factors. For those CPT® Codes or HCPCS Level II Codes not included or without an assigned relative value in the National Medicare Fee Schedule in effect on June 1, 2001, National Medicare Fee Schedule shall mean the National Medicare Fee Schedule in effect during the Class Period that is closest in time to the National Medicare Fee Schedule in effect on June 1, 2001 that contains fee schedule amounts for those codes. For those CPT® Codes or

HCPCS Level II Codes for which there is no National Medicare Fee Schedule during the Class Period with an assigned relative value for the code, the Settlement Administrator shall use the default preferred provider organization ("PPO") fee schedule in effect on June 1, 2001 for CIGNA HealthCare of Illinois, Inc.

1.81 "Non-Participating Physician" means any Physician other than a Participating Physician and includes, when appropriate, Physician Groups and Physician Organizations.

1.82 "Notice Costs" means the costs of complying with the Plan of Notice approved by the Court

1.83 "Notice Counsel" means those Counsel listed in Section 19.8.

1.84 "Notice Date" shall have the meaning assigned to that term in Section 5.1 of this Agreement and "Notice of Commencement of the Claims Period" means those notices to be submitted by the Settling Parties and approved by the Court which will be mailed within fourteen (14) days of Final Approval according to the Plan of Notice, informing Class Members of the date they may begin submitting Proofs of Claim.

1.85 "Objection Date" shall have the meaning assigned to that term in the Preamble to Section 6 of this Agreement.

1.86 "Opt Out" shall have the meaning assigned to that term in Section 6.1 of this Agreement.

1.87 "Opt Out Deadline" shall have the meaning assigned to that term in Section 6.1 of this Agreement.

1.88 "Overpayment" means, with respect to a claim submitted by or on behalf of a Physician, Physician Group or Physician Organization, any erroneous or excess payment that CIGNA HealthCare makes because of payment of an incorrect rate, duplicate payment for the same service or supplies, payment with respect to an individual who was not a CIGNA HealthCare Member as of the date the Physician provided the service(s) or supplies that are the

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subject of such payment, or payment for any non-Covered Service; provided that "Overpayment" shall not mean any erroneous or excess payment arising out of inappropriate coding or other error in the claim submission to which such payment relates and shall not mean any adjustment to a prior payment when CIGNA HealthCare makes such adjustment in whole or part on the basis of information contained in a separate claim submitted by a Physician for services rendered on the same date to which the original payment relates (other than duplicate bills).

1.89 "Participating Physician" means any Physician who has entered into a valid written contract with CIGNA HealthCare (directly or indirectly through a Physician Organization, Physician Group or other entity authorized by the Physician) to provide Covered Services to CIGNA HealthCare Members, during the period the contract is in force.

1.90 "Person" or "Persons" means all persons and entities (including without limitation natural persons, firms, corporations, limited liability companies, joint ventures, joint stock companies, unincorporated organizations, agencies, bodies, governments, political subdivisions, governmental agencies and authorities, associations, partnerships, limited liability partnerships, trusts, and labor unions, and their predecessors, successors, administrators, executors, heirs and assigns).

1.91 "Petitioner" shall have the meaning assigned to that term in Section 15.2.b of this Agreement.

1.92 "Physician" means an individual duly licensed by a state licensing board as a Medical Doctor or as a Doctor of Osteopathy and shall include without limitation both Participating Physicians and Non-Participating Physicians.

1.93 "Physician Advisory Committee" shall have the meaning assigned to that term in Section 7.9.a of this Agreement.

1.94 "Physician Group" means two or more Physicians, and those claiming by or through them, who practice under a single taxpayer identification number.

1.95 "Physician Organization" means any association, partnership, corporation or

other form of organization (including without limitation independent practice associations and physician hospital organizations), and those claiming by or through them, that arranges for care to be provided by Physicians to CIGNA HealthCare Members and that may be organized under multiple taxpayer identification numbers.

1.96 "Physician Specialty Society" means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

1.97 "Plaintiffs" means the named Plaintiffs in the above-captioned actions.

1.98 "Plan" means a benefit plan through which a CIGNA HealthCare Member obtains health care benefits set forth in pertinent Plan Documents.

1.99 "Plan Documents" means the documents defining the health care benefits available to a CIGNA HealthCare Member, and the terms and conditions under which such benefits are available, under the Plan sponsored by the CIGNA HealthCare Member's employer or other third party.

1.100 "Plan of Notice" means the Plan of Notice attached as Exhibit 5.

1.101 "Preliminary Approval Hearing" shall have the meaning assigned to that term in Section 4 of this Agreement.

1.102 "Preliminary Approval Order" shall have the meaning assigned to that term in Section 4 of this Agreement.

1.103 "Proof of Claim" means an application by a Class Member for compensation under the terms of this Agreement with respect to a single Category A Claim or Fee for Service Claim, whether submitted in paper form or electronic form in the manner to be described in the Notice of Commencement of the Claims Period, which application satisfies all applicable requirements set forth in Sections 8.2 and 8.3 of this Agreement.

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1.104 "Proof of Claim Form" means the forms, substantially in the form of Exhibits 10-13 to this Agreement, to be used by Class Members in seeking compensation under this Agreement.

1.105 "Prospective Relief" means the prospective undertakings by CIGNA HealthCare described in Section 7 of this Agreement.

1.106 "Provider Track" shall have the meaning assigned to that term in WHEREAS Clause A of this Agreement.

1.107 "Qualified Settlement Fund" means the Category A Settlement Fund, together with all interest and earnings thereon. The parties intend the fund to be a qualified settlement fund under Section 468B of the Internal Revenue Code of 1986, as amended, and Treas. Reg. Section 1.468B-1.

1.108 "Released Claims" means and includes any and all claims that have been or could have been asserted by or on behalf of any or all Class Members against the Released Persons, or any of them, and which arise prior to Final Approval by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Litigation, except as otherwise provided for by this Agreement. This includes, without limitation and as to Released Persons only, any aspect of any Fee for Service Claim submitted by any Class Member to CIGNA HealthCare, and claims based upon a capitation agreement with CIGNA HealthCare, and any allegation that Defendants and/or CIGNA HealthCare have conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Litigation or with regard to CIGNA HealthCare's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, and/or other third parties. Notwithstanding this definition, Released

Claims do not include any and all claims of any kind whatever arising out of the alleged nonpayment or payment at inappropriate rates or amounts of fee for service claims submitted to CIGNA HealthCare for services or supplies not represented by CPT® Codes or HCPCS Level II Codes or codes specially created by CIGNA HealthCare (such as its "well woman" code, code 90769).

1.109 "Releasing Parties" (each a "Releasing Party") means Class Members and, to the extent they have claims against CIGNA HealthCare derived by contract or operation of law from the claims of Class Members, any and all Subsidiaries, affiliates, shareholders, parents, directors, officers, employees, professional corporations, agents, administrators, executors, legal representatives, partners and partnerships, heirs, predecessors, successors and assigns of Class Members.

1.110 "Released Persons" means:

a. CIGNA HealthCare and CIGNA HealthCare's insurers and counsel, including Defendants' Counsel as defined herein.

b. Persons who provided claim processing services, software, proprietary guidelines or technology to CIGNA HealthCare, those contracted agents processing claims on CIGNA HealthCare's behalf, together with each such Person's predecessors or successors, but only to the extent of such Person's services and work done pursuant to contract with CIGNA HealthCare. Such Persons are expressly not "Released Persons" as to services provided to any Person other than CIGNA HealthCare. Nothing herein is intended to release Delegated Entities.

c. "Released Persons" shall not include any defendant in MDL No. 1334 other than CIGNA HealthCare or any Subsidiary of CIGNA Corporation.

1.111 "Remittance Form" means the form sent by CIGNA HealthCare to health care providers explaining CIGNA HealthCare's computation of benefits and payment amounts on a claim. The Remittance Form is sometimes referred to as an "Explanation of Payment" form or "EOP".

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1.112 "Resolved Claims" means any submissions to CIGNA HealthCare for payment made by Class Members for or on account of services provided to CIGNA HealthCare Members within the Class Period that, prior to the date of Final Approval, were finally adjudicated and determined in a court of law or in an arbitrable forum, or resolved by a final and binding settlement.

1.113 "Retained Claim" shall have the meaning assigned to that term in Section 13.4 of this Agreement.

1.114 "Retrospective Relief" means the monetary relief to be provided by CIGNA HealthCare under Section 8 of this Agreement.

1.115 "Review File" means the documentation assembled by CIGNA HealthCare to facilitate External Review as required under the terms of Sections 8.3.c(2)(i)(i) and 8.3.d(7)(a) of this Agreement.

1.116 "Reviewer" shall have the meaning assigned to that term in Section 7.10.c of this Agreement.

1.117 "Self-Insured Plan" and "Self-Funded Plan" mean any Plan other than an Insured Plan.

1.118 "Settlement" means the agreed-upon compromise of the Litigation as approved by the Court.

1.119 "Settlement Administrator" means Poorman-Douglas Corporation.

1.120 "Settlement Consideration" means the benefits which Class Counsel believe have been conferred, and will be conferred, on Class Members through this Litigation and through performance of this Agreement. These benefits include: (i) CIGNA HealthCare's agreement to implement the Prospective Relief described in Section 7 hereof; (ii) CIGNA HealthCare's agreement to fund Retrospective Relief as described in Section 8 hereof, including its uncapped obligations to pay all Valid Category One Proofs of Claim, all Valid Category Two Proofs of Claim and all Valid Medical Necessity Denial Proofs of Claim, all in the manner set forth in

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Section 8; (iii) CIGNA HealthCare's agreement, as part of this Agreement, to waive any right it may have to enforce arbitration agreements with Class Members in connection with the Retrospective Relief available under this Settlement; (iv) CIGNA HealthCare's agreement to waive any available defense it may have of "no private right of action" under state prompt pay statutes and CIGNA HealthCare's agreement to pay simple interest on certain claims under Section 7.18 in those states and in states without a specific prompt pay statute; (v) CIGNA HealthCare's agreement to relieve Class Members of the burden of having to pay attorneys' fees, costs and expenses out of the monetary relief made available under this Agreement by making separate payment of attorneys' fees, costs and expenses to Class Counsel and Kaiser Counsel, requested in an amount up to Fifty-Five Million Dollars ($55,000,000); (vi) the funding of the Foundation provided in Section 8 of this Agreement; (vii) the Compliance Dispute Resolution Procedure provided in Section 15 of this Agreement; and (viii) CIGNA HealthCare's agreement to pay Administration Costs and the costs of two separate notices.

1.121 "Settling Parties" shall have the meaning assigned to that term in the Preamble to this Agreement.

1.122 "*Shane*" shall have the meaning assigned to that term in WHEREAS Clause A of this Agreement.

1.123 "Signatory Medical Societies" shall have the meaning assigned to that term in the Preamble to this Agreement.

1.124 "Subsidiary" means any entity of which securities or other ownership interests having ordinary voting power to elect a majority of the board of directors or other persons performing similar functions are, as of Final Approval, or were prior thereto, directly or indirectly owned by CIGNA Corporation.

1.125 "Tag-Along Action" shall have the meaning assigned to that term in Section 17.1 of this Agreement.

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1.126 "Termination Date" shall have the meaning assigned to that term in Section 16.4 of this Agreement.

1.127 "Valid Proof of Claim" means a Proof of Claim that entitles a Class Member to receive payment pursuant to the terms of the Settlement.

1.128 "Website" means the online resource for the public and health care providers to obtain information about CIGNA HealthCare, its products and policies and other information and which is currently located at www.cigna.com. Some portion of this Website may be password protected at CIGNA HealthCare's discretion.

2. EFFECT OF SETTLEMENT

The claims made against CIGNA HealthCare by Class Representatives and Class Members in the Litigation and all Released Claims shall be fully compromised and settled by performance of this Agreement according to its terms.

3. COMMITMENT TO SUPPORT AND COMMUNICATIONS WITH CLASS MEMBERS

The Settling Parties agree that it is in their best interests to consummate this Agreement and all the terms and conditions contained herein and to cooperate with each other and to take all actions reasonably necessary to obtain Court approval of this Agreement and entry of the orders of the Court that are required to implement its provisions. They also agree to support this Agreement in accordance with and subject to the provisions of this Agreement.

CIGNA HealthCare hereby agrees, upon execution of this Agreement, to withdraw its pending appeal of the Court's September 26, 2002 Order Granting Provider Track Class Certification before the United States Court of Appeals for the Eleventh Circuit. Notwithstanding the foregoing, if this Agreement is terminated or does not become effective for any reason, Settling Parties agree that, in addition to otherwise restoring the Settling Parties to their status prior to entering into this Agreement, any further ruling on the propriety of the Court's September 26, 2002 Order Granting Provider Track Class Certification certifying

classes in *Shane* shall apply to the Released Persons as if the Released Persons had participated in further proceedings with respect to that Order.

Class Counsel and Plaintiffs shall make every reasonable effort to encourage putative Class Members to participate and not to Opt Out. In addition, Class Counsel shall make all reasonable efforts to enforce the Compliance Dispute resolution provisions of this Agreement set forth in Section 15.

Plaintiffs, Class Counsel and CIGNA HealthCare agree that CIGNA HealthCare may communicate with putative Class Members regarding the provisions of this Agreement, so long as such communications are not inconsistent with the Initial Notice, the Notice of Commencement of the Claims Period or other agreed upon communications concerning the Agreement. CIGNA HealthCare will not discourage the filing of any claims allowed under this Agreement or advise Class Members with respect to the category or categories of claims that the Class Members should or should not file under this Agreement. CIGNA HealthCare will refer to the Settlement Administrator or to Class Counsel any inquiries from Class Members about claims to be filed under this Agreement.

4. PRELIMINARY APPROVAL ORDER AND SCHEDULING OF FAIRNESS HEARING

Pursuant to Rule 23(e), the Settling Parties shall submit this Agreement, together with the exhibits attached hereto, to the Court at a hearing (the "Preliminary Approval Hearing") for, among other things, its conditional certification of a settlement class, preliminary approval of the Agreement and Plan of Notice and scheduling of a Fairness Hearing, and shall apply to the Court for an Order of Preliminary Approval and Conditional Class Certification, substantially in the form of Exhibit 2 ("Preliminary Approval Order").

5. NOTICE

5.1 *Initial Notice.*

On a date to be fixed by the Court that is within thirty (30) days of the date of the entry by the Court of the Preliminary Approval Order (the "Notice Date"), and subject to approval by

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the Court, Initial Notice according to the Plan of Notice, substantially in the form of Exhibits 6 and 7, shall be given by the Settling Parties in cooperation with the Settlement Administrator in accordance with the Plan of Notice attached hereto as Exhibit 5.

5.2 *Notice of Commencement of the Claims Period.*

Upon Final Approval, and subject to approval by the Court, Notice of Commencement of the Claims Period shall be given by the Settling Parties in cooperation with the Settlement Administrator in accordance with the Plan of Notice.

5.3 *Responsibility for Costs of Notice.*

Notice Costs shall be paid by CIGNA HealthCare.

6. PROCEDURE FOR FINAL APPROVAL; LIMITED WAIVER

Following the dissemination of the Initial Notice as described in Section 5, the Settling Parties shall seek the Court's final approval of this Agreement. Class Members shall have until the Objection Date to file, in the manner specified in the Initial Notice, any objection or other response to this Agreement. The Settling Parties agree to urge the Court to set the Objection Date on the date that is sixty (60) days after the Notice Date (the "Objection Date").

6.1 *Opt Out Timing and Rights.*

The Initial Notice shall provide that putative Class Members may request exclusion from the Class by providing notice, in the manner specified in such Initial Notice, on or before a date set by the Court as the Opt Out Deadline. The Settling Parties agree to urge the Court to set the Opt Out Deadline on the date that is sixty (60) days after the Notice Date (the "Opt Out Deadline").

Putative Class Members have the right to exclude themselves ("Opt Out") from this Agreement and from the Class by timely submitting to the Settlement Administrator a request to Opt Out and otherwise complying with the agreed-upon Opt Out procedure approved by the Court. Putative Class Members who or which so timely request to Opt Out shall be excluded from this Agreement and from the Class. Any putative Class Member who or which does not

submit a request to Opt Out by the Opt Out Deadline or who or which does not otherwise comply with the agreed upon Opt Out procedure approved by the Court shall become a Class Member and shall be bound by the terms of this Agreement and the Final Order and Judgment. Any putative Class Member who or which does not Opt Out of this Agreement shall be deemed to have taken all actions necessary to withdraw and revoke the assignment to any Person of any claim against CIGNA HealthCare.

Any putative Class Member who or which timely submits a request to Opt Out shall have until the Fairness Hearing to deliver to Class Counsel and the Settlement Administrator a written revocation of such putative Class Member's request to Opt Out and shall thereby become a Class Member. Class Counsel shall apprise the Court of such revocations.

Within ten (10) days after the Opt Out Deadline, the Settlement Administrator shall furnish CIGNA HealthCare and Class Counsel with a complete list in machine-readable form of all Opt Out requests filed by the Opt Out Deadline and not then revoked. CIGNA HealthCare shall pay the costs of obtaining a copy of the Opt Out requests. A final list of those filing Opt Out requests and not revoking them shall be prepared by the Settlement Administrator and filed with the Court at the Fairness Hearing.

6.2 *Setting the Fairness Hearing Date and Fairness Hearing Proceedings.*

The Settling Parties agree to urge the Court to hold the Fairness Hearing on a date that is approximately one hundred five (105) days after the Notice Date (the "Fairness Hearing Date") and to work together to identify and submit any evidence that may be required by the Court to satisfy the burden of proof for obtaining approval of this Agreement and the orders of the Court that are necessary to effectuate the provisions of this Agreement, including without limitation the Final Order and Judgment and the orders contained therein. At the Fairness Hearing, the Settling Parties shall present evidence necessary and appropriate to obtain the Court's approval of this Agreement, the Final Order and Judgment and the orders contained therein and shall meet and

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confer prior to the Fairness Hearing to coordinate their presentation to the Court in support of Court approval thereof.

7. PROSPECTIVE RELIEF; ADDITIONAL DISCLOSURES; CHANGES IN BUSINESS PRACTICES

The settlement consideration to the Class Members includes, among other things, initiatives and other commitments with respect to CIGNA HealthCare's disclosures and business practices. The Settling Parties agree that the initiatives and other commitments set forth below, which absent this agreement CIGNA HealthCare would generally be under no obligation to undertake, constitute substantial value and will enhance and facilitate the delivery of health care services by Class Members. CIGNA HealthCare investigated and began to implement certain of the initiatives described in this Section 7 while engaged in discussions to resolve the Litigation. Such initial and partial implementation, which shows CIGNA HealthCare's good faith desire to resolve the Litigation, was undertaken to, and does, form part of the consideration of the Settlement. CIGNA HealthCare shall have the unilateral and unrestricted right to block access to and/or not apply any or all of the business practice initiatives set forth below to Physicians who Opt Out of the Class, except as otherwise required by contract or law.

CIGNA HealthCare shall be obligated to commence implementing each commitment set forth in this Section 7 from and after the date set forth on Exhibit 8 attached hereto across from the relevant section number on such Exhibit and shall continue implementing each such commitment until the Termination Date, except as otherwise expressly provided in this Agreement (any earlier date provided for herein being a "Conclusion Date"). With respect to each commitment set forth in this Section 7, the "Effective Period" for such commitment shall be the period of time beginning on the start date set forth for such commitment on Exhibit 8 attached hereto and continuing through the Termination Date.

7.1 *Increased Automated Adjudication of Claims.*

CIGNA HealthCare, recognizing the desirability of making investments to improve its business relationships with Physicians providing health care services and supplies to CIGNA

HealthCare Members through, *inter alia*, efficiency in the processing of claims, has made substantial investments and will continue to make investments in two new claims platforms that are already receiving newly written business and to which CIGNA HealthCare will migrate substantially all the claims handling now being performed on its existing claims platforms; and by the use of its new claims platforms, has increased and will continue to increase the percentage of claims that are autoadjudicated, in an effort to shorten the period for payment of claims, and to improve the overall efficiency of the claim adjudication process.

7.2 *Internet Disclosures and Functionality.*

CIGNA HealthCare is making substantial investments, and will continue to make investments, to enhance the ability of Physicians to register referrals, pre-certify procedures, submit claims for Covered Services, check CIGNA HealthCare Member eligibility for Covered Services (based upon current information supplied by or relating to Plan sponsors), and check the status of claims for Covered Services, in each case via the Internet and clearinghouses.

a. *Addition of Disclosures to CIGNA HealthCare's Website.*

(1) *In General.*

CIGNA HealthCare will place additional information about CIGNA HealthCare's claim administration policies and procedures on CIGNA HealthCare's Website at www.cigna.com, and shall periodically update this additional information pursuant to Section 7.2.b of this Agreement. An index or table of contents shall be included with the additional information posted, and the additional information shall be word-searchable. If prior to the Termination Date, any portion is made password protected and passwords are provided to Class Members, a password will also be provided to Notice Counsel for the benefit of Class Members and for use in monitoring performance under the terms of this Agreement.

(2) *Specifications for Additional Disclosures.*

The additional information that CIGNA HealthCare shall post and periodically update on its Website shall include disclosures on the topics identified below.

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(a) *Forms to be Used for Submitting Claims.*

The forms to be used for submitting claims, both in paper and electronic format, shall be identified.

(b) *Software or Programs Used to Review Relationships Among Billing Codes.*

The computer claims processing software or programs used by CIGNA HealthCare to review the relationships among billing codes (e.g., ClaimCheck®) shall be identified by name and version, including any software used to audit the relationship between CPT® or HCPCS Level II Codes, or other billing codes, and diagnosis codes.

(c) *Requirements with Respect to Fee for Service Claims.*

The items of information that CIGNA HealthCare requires on a claim form, whether paper or electronic, and the information (if any) that CIGNA HealthCare requires to accompany that claim form in order to permit CIGNA HealthCare to process the claim for payment shall be described. The disclosure shall include a description of those limited categories of claims for which the submission of Clinical Information by Class Members may be required (*e.g.*, claims for multiple procedures in the same anatomical region where one of the submitted procedures is coded with modifier 59, claims for unlisted procedures, etc.) in order to obtain payment of the claim as submitted. This disclosure shall be consistent with Section 7.17.b.

(d) *Timing of Claim Submission.*

Class Members shall have one hundred eighty (180) days from the date of service to submit claims to CIGNA HealthCare. With respect to claims submitted more than one hundred eighty (180) days after the date of service, CIGNA HealthCare shall specify on its Website those circumstances under which such claims shall be accepted for processing and, if appropriate, for payment. CIGNA HealthCare shall waive the one hundred eighty (180) day limit for a reasonable period in the event that a Class Member gives notice to CIGNA HealthCare along with appropriate evidence of extraordinary circumstances that resulted in the delayed submission.

CIGNA HealthCare shall determine "extraordinary circumstances" and the reasonableness of the submission date.

(e) *Procedures for Appealing Partial or Total Claim Denials or Reductions.*

The procedures for appealing a partial or total claim denial or reduction, including the documentation that must accompany the appeal and the address to which appeals must be directed, shall be described.

(f) *Certain Claim Bundling Logic.*

CIGNA HealthCare shall use its best efforts to describe with particularity any single Claim Coding and Bundling Edit that it reasonably judges, based on its experience with submitted claims, will cause, on the initial review of submitted claims, the denial of or reduction in payment for a CPT® Code or HCPCS Level II Code more than five hundred (500) times per year. To the extent CIGNA HealthCare intends, following Final Approval of this Agreement, to apply any Claim Coding and Bundling Edits that are identified for Category One Compensation in this Agreement, those Claim Coding and Bundling Edits shall be identified.

(g) *Policies Respecting the Reimbursement of Supplies.*

CIGNA HealthCare's policies regarding the reimbursement of supplies and materials utilized in the provision of Covered Services by Class Members, including those instances where the submission of Clinical Information may be required in order for Class Members to obtain payment of the claim as submitted, shall be described.

(h) *Policies Respecting Multiple Procedures Performed on the Same Date of Service.*

Consistent with this Agreement, CIGNA HealthCare's policies and procedures for reducing the indicated payments for the second and subsequent procedures performed on the same patient on the same date of service shall be described.

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(i) *Postings with Regard to Definitions of "Medical Necessity" and "Medically Necessary."*

CIGNA HealthCare shall post the definitions of "Medical Necessity" and "Medically Necessary," as set forth in Section 7.16.a(1) hereof.

(j) *Postings with Regard to Medical Necessity Clinical Guidelines.*

CIGNA HealthCare shall post those internally developed clinical guidelines, consistent with Section 7.16.b, used by CIGNA HealthCare to assist in making Medical Necessity determinations, along with a list of the resources used to develop such guidelines. To the extent CIGNA HealthCare uses any guidelines licensed from third parties or derived from peer-review journals or similar sources to assist in making Medical Necessity determinations, CIGNA HealthCare shall post, as applicable, the title, author/source, volume, and publication date of such guidelines. CIGNA HealthCare shall provide, upon request by the Class Member, a complete copy of the relevant guideline applicable to a specific service and clinical indication through the electronic mail provider inquiry facility identified in Section 7.3 of this Agreement or through existing CIGNA HealthCare provider relations communication channels.

(k) *Procedures for Obtaining Fee Schedule Information and Claim Bundling Logic Information Via Electronic Mail.*

CIGNA HealthCare shall describe the procedures available to Class Members to obtain fee schedule information and information regarding CIGNA HealthCare's Claim Coding and Bundling Edits via electronic mail, pursuant to Section 7.3 of this Agreement.

(l) *Databases Used to Determine "Reasonable and Customary" Charges.*

If CIGNA HealthCare uses databases licensed from one or more third parties in order to determine "reasonable and customary" billed charges in the medical community, those databases shall be identified.

(m) *Drug Formularies.*

CIGNA HealthCare shall identify its drug formularies applicable to Plans, inclusive of tiers (if any) applicable to said formularies.

(n) *External Review Entities.*

CIGNA HealthCare shall post the names, addresses, phone numbers and web addresses of all external review entities CIGNA HealthCare uses to conduct its Medical Necessity External Review Process.

(o) *ERA/EFT Capabilities.*

CIGNA HealthCare shall post ERA/EFT capabilities.

(p) *Services or Supplies for Which Precertification is Required.*

In a manner consistent with Section 7.5 hereof, CIGNA HealthCare shall identify those services or supplies for which precertification is routinely required for its products. If a Self-Insured Plan specifies services or supplies that are different from or in addition to the services or supplies for which CIGNA HealthCare routinely requires precertification, that information will be identified on the Website if the Self-Insured Plan sponsor consents. CIGNA HealthCare will recommend to its Self-Insured Plan customers that they allow such Website identification. CIGNA HealthCare will recommend to its Self-Insured Plan customers that they utilize CIGNA HealthCare's standard list of services or supplies for which precertification is required.

(q) *Online Eligibility and Other Information.*

CIGNA HealthCare Members' eligibility and benefits shall be disclosed through a secure, online provider self-service tool that allows Physicians or their staffs to access the most current information available to CIGNA HealthCare about CIGNA HealthCare Members' general benefits, coverage dates, copay and deductible information. Physicians may access CIGNA HealthCare's standard referral requirements and lists of services or supplies for which precertification is routinely required through CIGNA HealthCare's Website.

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(r) *Electronic Mail Address for Fee Schedule, Billing Edits, and Other Information.*

CIGNA HealthCare shall place on its Website a "hot link" with the address where Physicians can submit inquiries to obtain information available under Section 7.3.

(s) *Savings Clause.*

Nothing in this Section 7.2.a(2) shall be applied in a manner inconsistent with another provision of this Agreement. Such other provision shall govern.

(3) *Form of Initial Disclosure Content.*

The form of initial disclosures required to be posted pursuant to this Agreement shall be presented to Notice Counsel and a limited number of the Plaintiffs for their review and approval at least forty-five (45) days prior to the Fairness Hearing. Notice Counsel shall respond promptly to this presentation.

b. *Periodic Updates of Disclosures.*

During the term of this Agreement, CIGNA HealthCare shall make appropriate revisions to the disclosures posted on CIGNA HealthCare's Website pursuant to this Agreement if any of the following circumstances occur.

(1) *Changes to Policies and Procedures.*

If the policies, procedures, or limitations that are included in the initial disclosures are materially changed by CIGNA HealthCare, such that continued posting of the initial disclosures as to those policies, procedures, and/or limitations would be materially misleading, CIGNA HealthCare shall revise the posted disclosures so that they remain accurate.

(2) *Introduction of New or Revised Claim Review Software or Programs.*

If CIGNA HealthCare intends to begin use of a new or revised computer claims processing software or program to review the relationships among billing codes (including updates to ClaimCheck®), CIGNA HealthCare shall post a disclosure of CIGNA HealthCare's intention to do so on its Website at least sixty (60) days in advance of applying the new or revised computer software or program to any Class Member's claims, to enable Class Members

to make electronic mail requests for information about how the new or revised computer software or program will affect their specific combinations of billing codes, as generally described in Section 7.3.

(3) *Introduction of New Claim Coding and Bundling Edits.*

CIGNA HealthCare shall use its best efforts to post on its Website a disclosure of CIGNA HealthCare's intention to begin applying any new Claim Coding and Bundling Edit not previously applied where CIGNA HealthCare reasonably judges, based on its experience with submitted claims, that the new Claim Coding and Bundling Edit will cause, on the initial review of submitted claims, the denial of or reduction in payment for a CPT® Code or HCPCS Level II Code more than five hundred (500) times per year. CIGNA HealthCare shall use its best efforts to post such disclosures on the Website at least thirty (30) days in advance of applying the new Claim Coding and Bundling Edit to submitted claims.

(4) *Changes to CIGNA HealthCare's Maximum Default Fee Schedules.*

CIGNA HealthCare shall dedicate a page on CIGNA HealthCare's Website for use in alerting Class Members to anticipated changes in the maximum default fee schedules used in CIGNA HealthCare's various geographic markets. If CIGNA HealthCare intends, in any such geographic market, to make a change to any applicable maximum default fee schedule, CIGNA HealthCare shall disclose its intention to make such a change, the effective date of such change, and the general nature of the change (*e.g.*, that the change involves moving from 2002 Medicare RVUs to 2003 RVUs, if the underlying fee schedule is based on a Medicare fee schedule) on the dedicated fee schedule Website page no less than ninety (90) days prior to such effective date. The fee schedule change disclosures shall be organized geographically to facilitate consultation and inquiry by Class Members. This page shall be linked to the electronic mail address created in accordance with Section 7.3 of this Agreement. While CIGNA HealthCare shall be required to respond to Class Members' electronic mail inquiries seeking applicable fee schedule amounts, pursuant to Section 7.3, and consistent with 7.8.b of this Agreement, CIGNA HealthCare shall

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have no obligation under this Agreement to post an entire fee schedule, with amounts, on the dedicated fee schedule page.

c. *Prohibition on Certain Representations.*

CIGNA HealthCare shall not, under any circumstances, represent in its Website disclosures, in any other disclosure materials, or orally that CIGNA HealthCare's Claim Coding and Bundling Edits are endorsed by the American Medical Association or that the American Medical Association has participated in the development of CIGNA HealthCare's Claim Coding and Bundling Edits.

7.3 *Availability of Fee Schedule, Claims Coding Edits and Other Information Through Establishment of Electronic Mail Provider Inquiry Facility.*

CIGNA HealthCare shall establish and designate an electronic mail address on its Website to receive and respond to Class Members' inquiries concerning CIGNA HealthCare's claim administration policies, procedures and limitations, and issues related to coverage. A Class Member shall be entitled to use this electronic mail address to: (a) inquire of CIGNA HealthCare concerning the Claim Coding and Bundling Edits applicable to specific combinations of billing codes; (b) make reasonable requests for applicable fee schedule amounts for all CPT® or other billing codes related to a Class Member's practice; (c) inquire of CIGNA HealthCare concerning whether certain medical services, procedures or supplies are Covered Services within the meaning of a CIGNA HealthCare Member's benefit plan; and (d) request a copy of a specific clinical guideline as applied to a specific procedure or specific episode of care used by CIGNA HealthCare to assist in making Medical Necessity determinations. CIGNA HealthCare shall use its best efforts to prepare and provide responsive information to Class Members' electronic mail inquiries under this Section within ten (10) days of receiving such inquiries. There will be no charge for such inquiries, regardless of the number of such inquiries made. CIGNA HealthCare shall make this procedure available to Participating Physicians and other Physicians who are considering becoming Participating Physicians.

7.4 *Investments in Initiatives to Improve Provider Relations.*

Since the inception of this Litigation, and through the Termination Date, CIGNA HealthCare has and will expend significant amounts of money and other resources to improve its relations with those providing health care services and supplies to CIGNA HealthCare Members, and in particular to carry out the initiatives described in Sections 7.1, 7.2, 7.3, 7.7, 7.23 and 7.24 of this Agreement.

7.5 *Reduced Number of Services or Supplies Requiring Precertification.*

CIGNA HealthCare has reduced the number of services or supplies requiring precertification and will undertake efforts to standardize the services and supplies for which precertification is required across all CIGNA HealthCare Insured Plans and Self-Insured Plans. CIGNA HealthCare's Self-Insured Plan customers may, however, specify services or supplies for which precertification is required that differ from or are in addition to the services or supplies for which CIGNA HealthCare routinely requires precertification. A list of services or supplies for which precertification is required shall be posted by CIGNA HealthCare as set forth in Section 7.2.n(2)(p) hereof. CIGNA HealthCare shall permit Class Members to seek precertification through electronic means.

7.6 *Greater Notice of Policy and Procedure Changes.*

CIGNA HealthCare shall, if it intends to make a material adverse change in the terms of contracts with Participating Physicians, give ninety (90) days written notice to each Participating Physician affected thereby (except to the extent that a shorter notice period is required to comply with changes in applicable law) and the change shall become effective at the conclusion of the ninety (90) day notice period. If a Participating Physician objects to the change that is subject to the notice, the Participating Physician must, within thirty (30) days of the date of the notice, give written notice to terminate his, her or its contract with CIGNA HealthCare, which termination shall be effective at the end of the ninety (90) day notice period of the material adverse change.

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The continuation of care provisions in Section 7.13.c hereof shall apply to any such contract termination.

7.7 *Initiatives to Reduce Claims Resubmissions.*

CIGNA HealthCare has developed, will implement and will maintain at least until the Termination Date processes to send next-Business Day written communications to Physicians when it is determined that additional information is necessary to process a claim, explaining the information needed, and to send two written reminders at thirty (30) days and sixty (60) days if the necessary information has not been received in response to the initial communication. If the necessary information has not been received at ninety (90) days, then the claim will be denied at that time, and the Physician may appeal pursuant to 7.10 or 7.11. If CIGNA HealthCare obtains information prior to that time showing that the claim should be denied, CIGNA HealthCare will promptly deny the claim, so that the Physician may pursue any other remedies the Physician may have. If the denial is based on eligibility of the patient, the Physician may directly bill the patient.

7.8 *Disclosure of and Commitments Concerning Claim Payment Practices.*

a. *Consistency Across Ongoing Claims Systems and Products.*

CIGNA HealthCare shall cause its automated "bundling" and other claims payment rules to conform to this Agreement and to be consistent in all material respects across its ongoing claims systems and products; and it will continue to maintain such consistency at least until the Termination Date.

b. *Availability of Web-Based Pre-Adjudication Tool.*

If a software vendor makes commercially available a web-based pre-adjudication tool that would allow Participating Physicians to obtain information regarding the manner in which CIGNA HealthCare's claims systems adjudicate claims for specific CPT® Codes or combinations of such Codes, consistent with the provisions of this Agreement, CIGNA HealthCare shall make such tool available on its Website as soon as practical after it becomes available on commercially reasonable terms. CIGNA HealthCare shall make good faith efforts to

obtain any such tool on commercially reasonable terms. If CIGNA HealthCare makes available such tool, it may cease to provide the information that is made available through the tool pursuant to any other provisions of this Agreement.

c. *Requirement for Submission of Clinical Information.*

CIGNA HealthCare shall not routinely require submission of Clinical Information before or after payment of claims. Notwithstanding the foregoing, (i) CIGNA HealthCare may require submission of Clinical Information before or after payment of certain categories of claims and shall promptly disclose on the Website any such claim category or categories pursuant to Section 7.2.a(2)(c); and (ii) CIGNA HealthCare may require submission of Clinical Information before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, CIGNA HealthCare has a reasonable basis for believing that such investigation is warranted and Physicians may contest such requirement pursuant to Section 7.12. Nothing contained in this Section 7.8.c is intended, or shall be construed, to limit CIGNA HealthCare's right to require submission of Clinical Information for precertification purposes consistent with Section 7.5 herein.

7.9 *Physician Advisory Committee.*

a. CIGNA HealthCare shall take all actions necessary on its part to establish an advisory committee ("Physician Advisory Committee") to discuss agenda items of nationwide scope. CIGNA HealthCare shall thereafter continue to maintain the Physician Advisory Committee at least through the Termination Date. The Physician Advisory Committee shall meet at least once every six (6) months. The meetings shall be conducted in Bloomfield, Connecticut, but attendance may be in person or by teleconference or by video-conference.

b. The Physician Advisory Committee shall include nine (9) members, one of whom shall be CIGNA HealthCare's Chief Medical Officer or his or her designee, who shall serve as chairperson of the Physician Advisory Committee. Except as provided in this Section

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7.9.b, the remaining members shall be Physicians who are not employees of CIGNA HealthCare. CIGNA HealthCare shall select two (2) members in addition to its Chief Medical Officer not later than thirty (30) days after the date of the entry of the Preliminary Approval Order; Notice Counsel, on behalf of and after consultation with the Plaintiffs, shall select three (3) members not later than thirty (30) days after the date of the entry of the Preliminary Approval Order, and those six shall select the remaining three (3) members not later than ninety (90) days after the date of the entry of the Preliminary Approval Order. The Settling Parties shall use reasonable efforts to cause one of such three (3) remaining members to be a Non-Participating Physician. The members selected by Notice Counsel shall include at least one board-certified primary care Participating Physician and at least one board-certified specialist Participating Physician. The names of the members of the Physician Advisory Committee and the dates of the Physician Advisory Committee meetings shall be posted on CIGNA HealthCare's Website. If any member discontinues serving on the Physician Advisory Committee, that member's position shall be filled in the same manner as the member was originally selected.

c. Subject to such procedures as the Physician Advisory Committee may adopt, it may consider any issue at a meeting at which a quorum is present, including proposals for discussion submitted by Class Members through an address to be maintained on CIGNA HealthCare's Website. A quorum shall consist of at least two (2) of the appointees of Notice Counsel, two (2) of the representatives of CIGNA HealthCare and two (2) of the representatives selected by the representatives appointed by CIGNA HealthCare and Notice Counsel. The Physician Advisory Committee, by a majority vote of a quorum, shall have authority to recommend changes to CIGNA HealthCare's business practices. CIGNA HealthCare shall consider whether the implementation of any recommendation of the Physician Advisory Committee is commercially feasible and consistent with the best interests of Class Members, CIGNA HealthCare Members, customers, shareholders and other constituencies. If CIGNA HealthCare decides not to accept a recommendation of the Physician Advisory Committee,

CIGNA HealthCare shall communicate that decision in writing to the Physician Advisory Committee with an explanation of CIGNA HealthCare's reasons. The Committee's recommendations and CIGNA HealthCare's responses will be published on CIGNA HealthCare's Website. CIGNA HealthCare agrees to include in the Certification filed annually and at the end of the Effective Period a listing of all Physician Advisory Committee recommendations made to CIGNA HealthCare and CIGNA HealthCare's responses to such recommendations.

d. Each member of the Physician Advisory Committee will agree to maintain and treat as confidential any proprietary information reasonably designated as such by CIGNA HealthCare. No member of the Physician Advisory Committee shall serve as a member of an advisory or similar committee established by any other managed care company or health insurer, but this provision is not meant to exclude Physicians who serve on credentialing or similar committees for other companies.

e. CIGNA HealthCare shall pay the reasonable expenses of each Physician Advisory Committee member in attending meetings of the Physician Advisory Committee and shall pay a reasonable honorarium to each member other than the chairperson for attendance at a meeting.

7.10 *Dispute Resolution Process for Physician Billing Disputes.*

a. CIGNA HealthCare shall implement an independent, external billing dispute review process (the "Billing Dispute External Review Process") for resolving disputes with Class Members concerning the application of CIGNA HealthCare's coding and payment rules and methodologies to (i) patient specific factual situations, including without limitation the appropriate payment amount when two or more CPT® Codes are billed together, or whether the Class Member's use of modifiers is appropriate, or (ii) any Retained Claims, so long as such Retained Claims are submitted by the Physician to the Billing Dispute External Review Process prior to the later to occur of either ninety (90) days after Final Approval or thirty (30) days after

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exhaustion of CIGNA HealthCare's internal appeals process. Each such matter shall be a "Billing Dispute." The Reviewer (as defined below) shall not have jurisdiction over any disputes that are not patient specific application of Claim Coding and Bundling Edits, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in Section 7.11 of this Agreement, disputes about the submission of Clinical Information that fall within the scope of Section 7.12, Compliance Disputes and disputes concerning the scope of Covered Services. Nothing contained in this Section 7.10 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures of § 503 of ERISA.

b. Any Class Member may submit Billing Disputes through the Billing Dispute External Review Process upon payment of a filing fee calculated as set forth in Section 7.10.j and in accordance with the provisions of this Section 7.10, after the Class Member exhausts CIGNA HealthCare's internal appeals process, when the amount in dispute (either a single claim for Covered Services or multiple claims involving the same or similar issues) exceeds Five Hundred Dollars ($500). Whether a claim is "similar" to another claim shall be determined by the Reviewer (defined below). CIGNA HealthCare shall post a description of its health care provider internal appeals process on its Website. Each Billing Dispute shall be submitted on a form (the "Billing Dispute Form") and shall include any Clinical Information the Class Member believes is relevant to the Billing Dispute. The Billing Dispute Form and a description of the procedure to be followed in submitting a Billing Dispute shall be set forth on the Website.

c. The Billing Dispute External Review Process shall be conducted by an organization acceptable to CIGNA HealthCare and Notice Counsel (the "Billing Dispute Administrator"), which Billing Dispute Administrator shall designate independent certified procedure coding specialists to resolve Billing Disputes ("Reviewers"). A Billing Dispute shall

be resolved on a written record, consisting of documents submitted by the Class Member and CIGNA HealthCare, without oral argument. The procedures for submission of Billing Disputes and the identity of the Reviewers will be posted on CIGNA HealthCare's Website. CIGNA HealthCare and the appealing Class Member shall supply appropriate documentation to the designated Reviewer not later than thirty (30) days after request by such Reviewer.

d. Notwithstanding the foregoing, a Class Member may submit a Billing Dispute if less than Five Hundred Dollars ($500) is at issue and if such Class Member intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute which involve issues that are the same as or similar to those of the original Billing Dispute, in which event the Billing Dispute External Review Process will, at the request of such Class Member, be deferred while the Class Member accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Termination Date, the Class Member has not accumulated the requisite amount of Billing Disputes and CIGNA HealthCare has chosen not to continue the Billing Dispute External Review Process following the Termination Date, then any rights the Class Member had as to such Billing Disputes, including rights to arbitration, shall be tolled from the date the Billing Dispute was submitted to the Billing Dispute External Review Process through and including the Termination Date.

e. In any event, a Class Member will have one (1) year from the date he, she or it submits the original Billing Dispute and requests that consideration of such Billing Dispute should be deferred to allow submission of additional Billing Disputes involving issues that are the same as or similar to those of the original Billing Dispute and amounts in dispute that in aggregate exceed Five Hundred Dollars ($500). In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute Administrator shall dismiss the original Billing Dispute and any such additional Billing Disputes and, in that event, the filing fee will be refunded by CIGNA HealthCare to the Class Member.

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f. The filing fee shall be payable upon the submission of the original Billing Dispute and shall apply to all subsequent Billing Disputes submitted pursuant to the first sentence of Section 7.10.d until the aggregate amount at issue exceeds One Thousand Dollars ($1,000) at which time additional filing fees will be payable in accordance with Section 7.10.j. The Class Member may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches Five Hundred Dollars ($500) and, in that event, the filing fee will be refunded by CIGNA HealthCare to the Class Member.

g. The Class Member must exhaust CIGNA HealthCare's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Process; provided that a Class Member shall be deemed to have satisfied this requirement if CIGNA HealthCare does not communicate notice of a final decision resulting from such internal appeals process within forty-five (45) days of receipt of all documentation required to decide the internal appeal. In the event CIGNA HealthCare and a Class Member disagree as to whether the requirements of the preceding sentence have been satisfied, such disagreement shall be resolved through the Billing Dispute External Review Process. Except as otherwise provided in this Section 7.10, all Billing Disputes must be submitted to the Billing Dispute External Review Process no more than ninety (90) days after a Class Member exhausts CIGNA HealthCare's internal appeals process and the Billing Dispute External Review Process shall not be used to hear or decide any Billing Dispute submitted more than ninety (90) days after CIGNA HealthCare's internal appeals process has been exhausted. The Billing Dispute Administrator shall resolve any question as to whether a Billing Dispute has been timely submitted and such decision shall be final and not reviewable. The Billing Dispute Administrator shall also resolve any question as to whether a submitted dispute is properly cognizable as a Billing Dispute and such decision shall be final and non-reviewable. CIGNA HealthCare shall supply appropriate documentation to the Billing Dispute External Review Process not later than thirty (30) days after request by the Reviewer, which request shall not be made if Billing Disputes are submitted

pursuant to Section 7.10.d until Billing Disputes have been submitted involving amounts in dispute that in aggregate exceed Five Hundred Dollars ($500).

h. Except to the extent otherwise specified in this Section 7.10, procedures for review through the Billing Dispute External Review Process, including without limitation the documentation to be supplied to the Reviewer and a prohibition on *ex parte* communications between any party and the Reviewer, shall be set by agreement between CIGNA HealthCare and Notice Counsel, and shall be set forth in the Certification filed annually and at the end of the Effective Period. Such procedures shall provide that (i) a Class Member submitting a Billing Dispute to the Billing Dispute External Review Process shall state in the documents submitted to the Billing Dispute External Review Process the amount in dispute, and (ii) the Reviewer shall not be permitted to issue an award based on an amount that exceeds the amount stated by such Class Member in the documents submitted to the Billing Dispute External Review Process to be in dispute.

i. If CIGNA HealthCare and Notice Counsel cannot agree on the Billing Dispute Administrator within sixty (60) days of the date of the entry of the Preliminary Approval Order, the matter shall be deemed a Compliance Dispute and referred to the Compliance Dispute Review Officer. Billing Disputes shall be stayed and any time limitations shall be tolled pending resolution of such Compliance Dispute.

j. For any Billing Dispute that a Class Member submits to the Billing Dispute External Review Process, the Class Member submitting such Billing Dispute shall pay to CIGNA HealthCare a filing fee calculated as follows: (i) if the amount in dispute is One Thousand Dollars ($1,000) or less, the filing fee shall be Fifty Dollars ($50) or (ii) if the amount in dispute exceeds One Thousand Dollars ($1,000), the filing fee shall be equal to Fifty Dollars ($50), *plus* five percent (5%) of the amount by which the amount in dispute exceeds One Thousand Dollars ($1,000), but in no event shall the fee be greater than fifty percent (50%) of the cost of the review.

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k. CIGNA HealthCare's contract(s) with the Billing Dispute Administrator shall require decisions to be rendered not later than thirty (30) days after receipt of the documents necessary for the review and to provide notice of such decision to the parties promptly thereafter.

l. In the event that a decision is rendered as a result of the Billing Dispute External Review Process requiring payment by CIGNA HealthCare, CIGNA HealthCare shall make such payment after CIGNA HealthCare receives notice of such decision, less any portion of such amount that is payable by the CIGNA HealthCare Member under his or her Plan Documents; provided that the interest described in Section 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Billing Dispute External Review Process that was not provided to CIGNA HealthCare during the internal appeals process.

m. CIGNA HealthCare agrees to record in writing a summary of the results of the review proceedings conducted through the Billing Dispute External Review Process, including without limitation the issues presented. CIGNA HealthCare agrees to include a summary of the dispositions of such proceedings in the Certification to be filed annually and at the end of the Effective Period. If the same issue is the subject of not fewer than twenty (20) Billing Dispute External Review Process proceedings during the effective period of this Agreement, and CIGNA HealthCare's position is overturned in at least fifty percent (50%) of such matters, CIGNA HealthCare shall bring the matter to the attention of the Physician Advisory Committee.

n. The Billing Dispute External Review Process shall be available at the option of the Class Member. If such Class Member elects to utilize this process, then any decision rendered through the Billing Dispute External Review Process shall be binding on CIGNA HealthCare and the Class Member. For Retained Claims, all Billing Disputes shall be directed not to the Court nor to any other federal court or state court, arbitration panel (except as

hereinafter provided) or any other binding or non-binding dispute-resolution mechanism, but instead shall be submitted for final and binding resolution to the Billing Dispute External Review Process so long as such Billing Dispute arises after the establishment of the Billing Dispute External Review Process.

7.11 *Appeals of Determinations Related to Medical Necessity or the Experimental or Investigational Nature of Any Proposed Health Care Service or Supplies.*

CIGNA HealthCare shall maintain the following appeal process with respect to determinations that a health care service or supply is not Medically Necessary or is of an experimental or investigational nature.

a. *Initial Determinations.*

A Physician designated by CIGNA HealthCare shall be responsible for making the initial determination for CIGNA HealthCare whether proposed health care services or supplies are Medically Necessary or experimental or investigational (hereinafter in this Section 7.11 only, Medically Necessary and experimental or investigational shall collectively be referred to as Medically Necessary except where otherwise noted). A nurse or other health care professional, acting for a medical director, may approve any health care service or supply as being Medically Necessary, but only a Physician designated by CIGNA HealthCare may deny any such service or supply as being not Medically Necessary.

b. *Two Level Internal Appeals of Medical Necessity Denials.*

(1) *Level One.*

With respect to an appeal of a determination that a health care service or supply is not Medically Necessary, CIGNA HealthCare shall adopt a two step internal appeal process which allows CIGNA HealthCare Members, or a Class Member when authorized in writing by a CIGNA HealthCare Member, or without written authorization if the service has already been provided, to pursue appeals of Medical Necessity denials, including appeal by External Review. That process shall insure that only a Physician may deny the appeal of any CIGNA HealthCare Member or Class Member. A nurse or other health care professional employed by CIGNA

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HealthCare shall review the internal appeal and may grant but not deny the appeal. If the nurse or other health care professional does not grant the appeal, then a Physician designated by CIGNA HealthCare, other than the one that made the initial determination of Medical Necessity, shall review and decide the Level One internal appeal in accordance with applicable CIGNA HealthCare clinical guidelines, which shall be consistent with Section 7.16.b.

(2) *Level Two.*

If the Physician conducting the Level One review determines that the requested health care service or supply is not Medically Necessary, and if that Physician is not a specialist in the same specialty as the appealing Physician, a second Physician employed or contracted by CIGNA HealthCare who is a specialist in the same specialty (but not necessarily the same sub-specialty) as the appealing CIGNA HealthCare Member's Physician or the Class Member shall review the appeal and shall decide the appeal in accordance with applicable CIGNA HealthCare clinical guidelines, which shall be consistent with Section 7.16.b. If the CIGNA HealthCare Member does not pursue an appeal and the Physician employed or contracted to perform the Level One review is of the same specialty as the appealing Class Member, such that no Level Two review is required, then the appealing Class Member shall be notified that the appealing Class Member may proceed to external review.

(3) *Time Limits for Completing Internal Appeals.*

All internal appeals shall be completed within the time limits required by regulations issued by the Department of Labor, even those internal appeals for which ERISA is not applicable.

c. *Establishment of External Review Program and Scope.*

Following exhaustion of its internal appeal process, CIGNA HealthCare shall make available to CIGNA HealthCare Members whose health care benefits are provided through an Insured Plan, and to CIGNA HealthCare Members whose health care benefits are provided through a Self-Insured Plan and whose Plan sponsors have elected to participate in the program

established by this Section (or in each case, by a Class Member when authorized in writing by the CIGNA HealthCare Member) the option to appeal directly an adverse determination based upon lack of Medical Necessity or the characterization of the relevant service or procedure as experimental or investigational, to an independent external review organization identified by CIGNA HealthCare (the "Medical Necessity External Review Organization"); provided that, where there has been a denial based upon Medical Necessity of services already provided, no authorization from the CIGNA HealthCare Member shall be required. The cost of the external appeal (the "Medical Necessity External Review Process") will be borne by CIGNA HealthCare and the decision of the Medical Necessity External Review Organization shall be binding upon CIGNA HealthCare and the Class Member. Election to pursue review under this Section is at the option of the Class Member, who may instead choose any other remedy available as a matter of law or contract. CIGNA HealthCare shall require that the Medical Necessity External Review Organization issue its decision within thirty (30) days of the request for External Review. The external reviewer designated by the Medical Necessity External Review Organization to conduct the review shall be of the same specialty (but not necessarily the same sub-specialty) as the appealing Class Member. The Medical Necessity External Review Process offered by CIGNA HealthCare shall not supersede any state-required program for external review inconsistent with CIGNA HealthCare's external review process. In the case of state-required external review process that is different than the process herein set forth, only the state-required program shall be utilized where applicable.

(1) The Medical Necessity External Review Organization must meet the standards for external review entities under applicable federal and state law. The External Review entity will be contracted to conduct a *de novo* review of the case consistent with Section 7.16.a(1) of this Agreement, subject to the CIGNA HealthCare Member's Plan Documents. The External Review entity shall have the authority to review any adverse determination related to the Medical Necessity of a particular health care service or supply after the CIGNA HealthCare

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Member or his or her Class Member Physician, where appropriate, has exhausted the internal appeal process or after CIGNA HealthCare and the CIGNA HealthCare Member or his or her Class Member Physician, where appropriate, agree to forego any level of internal appeal and proceed directly to external review. The CIGNA HealthCare Member or his or her Class Member Physician, where appropriate, shall have the option to elect this review within one hundred eighty (180) days from the date of the final denial decision by CIGNA HealthCare. The Medical Necessity External Review Organization's compensation shall not be tied to the outcome of the reviews performed. Likewise, the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make decisions in a biased manner.

(2) Notwithstanding the provisions of this Section 7.11, Class Members may not seek review of any claim for which the CIGNA HealthCare Member (or his or her representative) seeks review through the external review program. In the event that both a CIGNA HealthCare Member (or his or her representative) and a Physician seek review before a service is rendered, the CIGNA HealthCare Member's claim shall go forward and the Physician's claim shall be dismissed and may not be brought by or on behalf of the Physician in any forum.

(3) Notwithstanding the provisions of this Section 7.11, Class Members may not seek review of any claim for which the CIGNA HealthCare Member (or his or her representative) has filed suit under § 502(a) of ERISA or other suit for the denial of health care services or supplies on Medical Necessity grounds. In that event, or if such a suit is subsequently initiated, the CIGNA HealthCare Member's lawsuit shall go forward and the Class Member's claims shall be dismissed and may not be brought by or on behalf of the Class Member in any forum; provided that such dismissal shall be without prejudice to any Class Member seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Class Member and not to such CIGNA HealthCare Member.

(4) Nothing contained in this Section 7.11 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA.

(5) In the event the Medical Necessity External Review Process is initiated, the Medical Necessity External Review Organization shall request documentation from CIGNA HealthCare promptly but in any event no later than five (5) Business Days after the CIGNA HealthCare Member or Class Member initiates the Medical Necessity External Review Process, and CIGNA HealthCare shall provide such requested documentation within ten (10) Business Days. The Medical Necessity External Review Organization shall provide a decision within thirty (30) days of CIGNA HealthCare's submission of all necessary information. In the event that a decision in favor of the Class Member is rendered as a result of appeal of a Medical Necessity External Review for denial of services already provided, CIGNA HealthCare shall make payment to the Class Member, consistent with Section 7.18 of this Agreement, less any portion of allowed charges that is payable by the CIGNA HealthCare Member under his or her Plan Documents; provided that the interest described in Section 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Medical Necessity External Review Process that was not provided to CIGNA HealthCare during the internal appeal process.

(6) CIGNA HealthCare shall cause its contract with the Medical Necessity External Review Organization to be consistent with the terms of this Section 7.11.c.

7.12 *Disputes Regarding Compliance With Section 7.8.c.*

Notice Counsel and Defendants' Counsel will jointly select two persons, one of whom is experienced in issues of fraud in the health care field, such as a former state or federal government employee who has been involved in health care fraud investigations, and the other of whom is experienced in clinical practice (each a "Clinical Information Officer"). The Clinical

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Information Officers shall resolve any disputes that arise under Section 7.8.c of this Agreement with respect to any requirement of CIGNA HealthCare for the submission of Clinical Information. Such disputes shall not be the subject of review either as a Billing Dispute under Section 7.10 or as a Compliance Dispute under Section 15 (except in the case of alleged systemic violation of Section 7.8.c(i)). A Class Member may initiate the process by filing a request for review (which may involve multiple claims of non-conformity with Section 7.8.c) in the manner and with the information to be identified on CIGNA HealthCare's Website, which request shall be accompanied by a filing fee of Fifty Dollars ($50.00) payable to CIGNA HealthCare.

a. *Disputes Involving Section 7.8.c(i).*

If CIGNA HealthCare is not invoking its right to obtain Clinical Information for the purpose of investigating possible fraudulent, abusive or other inappropriate billing practices under Section 7.8.c(ii), then CIGNA HealthCare shall promptly (but in any event within ten (10) Business Days) so notify the appropriate Clinical Information Officer, and both CIGNA HealthCare and the Class Member shall, upon request by the Clinical Information Officer, supply within twenty (20) Business Days such information to the Clinical Information Officer and to the other party as they deem relevant to the issue of compliance with Section 7.8.c(i). The Clinical Information Officer shall then make a determination, binding on both parties, of the issue of compliance with Section 7.8.c(i).

b. *Disputes Involving Section 7.8.c(ii).*

If CIGNA HealthCare is invoking its right to obtain Clinical Information under Section 7.8.c(ii), then it shall promptly (but in any event within ten (10) Business Days) so notify the appropriate Clinical Information Officer and shall submit *ex parte* and *in camera* within twenty (20) Business Days to him or her its reasons for believing that it has reasonable grounds for proceeding under Section 7.8.c(ii). The Clinical Information Officer, without revealing the information or material received from CIGNA HealthCare, shall allow the Class Member to submit, within twenty (20) Business Days of notice from the Clinical Information Officer, any

information supporting his, her or its request beyond that submitted with the initial request. The sole responsibility of the Clinical Information Officer in these circumstances shall be to make a binding determination as to whether CIGNA HealthCare has reasonable grounds for its action. If the Clinical Information Officer determines that reasonable grounds exist, the Clinical Information Officer shall notify the parties that the matter has been closed pursuant to Section 7.8.c(ii). If the Clinical Information Officer determines that reasonable grounds under Section 7.8.c(ii) do not exist, he or she shall notify the parties that the requirement for submission of Clinical Information is to cease. Under no circumstances shall the Clinical Information Officer reveal to the Physician or any other Person the evidence submitted to him or her by CIGNA HealthCare, and all material submitted to the Clinical Information Officer by CIGNA HealthCare shall be immediately returned to CIGNA HealthCare, without the retention by the Clinical Information Officer of any copies or extracts therefrom.

c. *Miscellaneous*

The authority of a Clinical Information Officer is limited to issues of compliance with Section 7.8.c and does not extend to issues of payment or otherwise. A Clinical Information Officer shall attempt to reach a conclusion within twenty (20) days after receipt of requested documentation from the parties.

7.13 *Participating in CIGNA HealthCare's Network.*

a. *Advance Credentialing.*

CIGNA HealthCare will allow Physicians to submit credentialing applications (including, as relevant, licensure and hospital privileges or other required information) and will begin to process such applications prior to the time that the Physician formally changes or commences employment or changes location, provided that the Physician must represent that he or she has new employment or intends to move to a new location. CIGNA HealthCare shall process completed applications and notify the Physician within ninety (90) days. If a Physician is already credentialed by CIGNA HealthCare but changes employment or changes location,

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CIGNA HealthCare will only require the submission of such additional information, if any, as is necessary to continue the Physician's credentials based upon the changed employment or location.

b. *"All Products" or "All Affiliates" Clauses.*

CIGNA HealthCare does not include provisions in its contracts with Class Members that require, or purport to require, Class Members to participate in one or more of CIGNA HealthCare's products (e.g., HMO, PPO, POS, indemnity) as a condition of participating in any other product, and shall not include such provisions in its contracts with Class Members at least through the Termination Date. With respect to CIGNA Behavioral Health, unless a psychiatrist, psychiatric group practice or psychiatric facility and CIGNA Behavioral Health, Inc. agree otherwise concerning Covered Services to be provided by that psychiatrist or psychiatric facility, psychiatrists who provide Covered Services to patients for whom CIGNA Behavioral Health, Inc. provides managed behavioral benefit and/or employee assistance program services and network services (both CIGNA HealthCare patients and patients covered under other health benefit arrangements) are expected to provide such Covered Services to all such patients, subject to Section 7.13.d.

c. *Termination Without Cause.*

Unless an Individually Negotiated Contract between CIGNA HealthCare and a Participating Physician specifies a longer period of notice, or specifies that the contract may not be terminated except for cause during a defined period of time, either party shall have the right to terminate the contract without cause upon at least sixty (60) days written notice to the other party. In the event of a contract termination by either party, the following obligations shall apply with respect to the continuation of care for those patients of the Participating Physician who are CIGNA HealthCare Members who suffer from a chronic condition requiring continuity of care and who are unable, prior to the date of termination, to arrange for an alternative means of receiving the necessary care. In the case of a continuity of care situation as defined in the

preceding sentence, the Participating Physician shall continue to render necessary care to the CIGNA HealthCare Member until CIGNA HealthCare, in conjunction with the CIGNA HealthCare Member, has arranged an alternative means for the provision of such care, provided that, if after the date of termination the Class Member determines that CIGNA HealthCare has not used due diligence to arrange alternative care the Class Member may take such action as is necessary to terminate the Physician-patient relationship. CIGNA HealthCare shall pay claims by such terminating Participating Physician for such services or supplies at rates provided by the contract to be terminated through the date of termination and thereafter at the reasonable and customary rates then prevailing for that geographical area, until such time as an alternative means for the provision of such care is arranged.

d. *Rights of Class Members to Refuse to Accept Additional Patients.*

CIGNA HealthCare will not prohibit Class Members from declining to accept CIGNA HealthCare Members as new patients while remaining open to members of plans insured or administered by other managed care companies once the number of CIGNA HealthCare Members who are patients of the Class Member reaches a certain numerical or percentage threshold established by the Class Member provided that (a) the number of CIGNA HealthCare Members who are patients of the Class Member exceeds the number of patients who are members of plans insured or administered by any other single managed care organization at the time the Class Member closes his practice to CIGNA HealthCare Members; (b) if the acceptance of new patients causes the number of patients who are members of plans insured or administered by any other managed care organization to exceed the number of CIGNA HealthCare members, the Class Member must begin accepting new patients who are CIGNA HealthCare members; and (c) if a patient of the Class Member becomes a CIGNA HealthCare Member by switching from a plan insured or administered by another managed care organization to one insured or administered by CIGNA HealthCare, the Class Member must continue as the patient's Physician.

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Furthermore, CIGNA HealthCare will not prevent Class Members from closing their practices to all new patients.

7.14 Fee Schedule Changes.

a. *Notices Regarding Fee Schedules.*

CIGNA HealthCare agrees not to reduce its fee schedule for a Participating Physician more than once a calendar year (except as provided below in this Section 7.14.a) and shall give notice of any such change as a material adverse change subject to the provisions of Section 7.6 hereof. Notwithstanding the foregoing, in between such annual changes, CIGNA HealthCare may increase or decrease the fee schedule payment rates for vaccines, pharmaceuticals, durable medical supplies or other goods or non-Physician services to reflect changes in market prices, and CIGNA HealthCare may update fee schedules to add payment rates for newly-adopted CPT® Codes and for new technologies, and new uses of established technologies, that CIGNA HealthCare concludes are eligible for payment, and to update such fee schedules to reflect any applicable interim revisions made by CMS. In the first year of a Physician's contract, a change in fee schedule may be made before December 31st of the year in which the contract became effective. Nothing contained herein shall prevent CIGNA HealthCare from maintaining, altering or expanding the use of capitation or other compensation methodologies. The requirements in this Section may be altered pursuant to the terms in Individually Negotiated Contracts.

b. *Payment Rules for Injectibles, Durable Medical Equipment, Administration of Vaccines, and Review of New Technologies.*

CIGNA HealthCare agrees to pay a fee (per the applicable fee schedule for a Participating Physician and a reasonable fee for Non-Participating Physicians) for the administration of vaccines and injectibles in addition to paying for such vaccines and injectibles. CIGNA HealthCare agrees to pay Participating Physicians for the cost of injectibles and vaccines at the rate set forth in the applicable fee schedule in each market, as in effect from time to time. With respect to capitated primary care Participating Physicians, CIGNA HealthCare agrees to continue to pay fees (in addition to contractually agreed-upon capitation payments) for vaccines

administered pursuant to the schedules recommended by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices, as applicable; provided that if the primary care Participating Physician so requests, CIGNA HealthCare may include such fees within the scope of capitated services. As of the effective date of such recommendation, CIGNA HealthCare shall pay for vaccines newly recommended by the institutions identified above. Other than as specified in the preceding sentence with respect to vaccines, if a Physician Specialty Society recommends a new technology or treatment or a new use for an established technology or treatment as an appropriate standard of care, CIGNA HealthCare shall evaluate such recommendation and issue a coverage statement not later than one hundred twenty (120) days after CIGNA HealthCare learns of such Physician Specialty Society recommendation. CIGNA HealthCare agrees to list in the Certification to be filed annually and at the end of the Effective Period the dates on which such updates are completed and to include in such Certification any written policies and procedures it has developed regarding payments for the administration of vaccines and injectibles.

c. *Appeals of Reasonable and Customary Determinations.*

If a Non-Participating Class Member initiates a dispute using CIGNA HealthCare's internal dispute resolution procedures over how CIGNA HealthCare has determined the "reasonable and customary" charge for a given health care service or supply and, consequently, over how CIGNA HealthCare has computed the benefits payable for that health care service or supply, CIGNA HealthCare shall disclose to the Class Member initiating the dispute the data used by CIGNA HealthCare to determine the "reasonable and customary" charge for that given health care service or supply.

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7.15 *Recognition of Assignments of Benefits of Plan Member.*

When billed by a Non-Participating Physician Class Member for health care services or supplies provided to a CIGNA HealthCare Member, CIGNA HealthCare will require that the Non-Participating Physician Class Member shall have received a valid Assignment of Benefits from the CIGNA HealthCare Member and shall have so evidenced the Assignment to CIGNA HealthCare. CIGNA HealthCare shall recognize all valid Assignments by CIGNA HealthCare Members of Plan benefits to Physicians.

7.16 *Application of Clinical Judgment to Patient-Specific and Policy Issues.*

a. *Medically Necessary/Medical Necessity Definition.*

(1) *Medically Necessary/Medical Necessity Definition.*

Except where state law or regulation requires a different definition, CIGNA HealthCare shall apply the following definition of "Medically Necessary" or comparable term in each agreement with Physicians, Physician Groups, and Physician Organizations: "Medically Necessary" or "Medical Necessity" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas

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and any other relevant factors. Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents.

(2) *External Review Statistics.*

Within not more than ninety (90) days after the end of each calendar year and at least through the Termination Date, CIGNA HealthCare shall post on its Website the number of Medical Necessity appeals sent to the Medical Necessity External Review Organization for final determination for the preceding calendar year and the percentage of such appeals that are upheld or reversed.

b. *Policy Issues Involving Clinical Judgment.*

In adopting clinical policies with respect to Covered Services, CIGNA HealthCare shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the medical community, and shall take into account Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors. CIGNA HealthCare shall continue to make such policies readily available to CIGNA HealthCare Members and Physicians via the Website or by other electronic means. Promptly after adoption, CIGNA HealthCare shall file a copy of each new policy or guideline with the Physician Advisory Committee.

c. *Future Consideration by CIGNA HealthCare of an Administrative Exemption Program.*

CIGNA HealthCare shall consider the feasibility and desirability of exempting certain Participating Physicians from certain administrative requirements based on criteria such as a Participating Physician's delivery of quality and cost effective medical care and accuracy and appropriateness of claims submissions. CIGNA HealthCare shall not be obliged to implement any such exemption process during the term hereof, and this Section 7.16.c is not intended and shall not be construed to limit CIGNA HealthCare's ability to implement any such program on a pilot or experimental basis, to base exemptions on any grounds determined by CIGNA HealthCare, or otherwise to implement one or more programs in only some markets.

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7.17 *Billing and Payment.*

a. *Timing of Claim Submission.*

Except where CIGNA HealthCare and a Class Member have entered into an Individually Negotiated Contract that provides for a different submission period, CIGNA HealthCare shall treat all claims submitted within one hundred eighty (180) days of the date of service as timely. With respect to claims submitted more than one hundred eighty (180) days after the date of service, CIGNA HealthCare shall specify on its Website those circumstances under which such claims shall be accepted for processing and, if appropriate, for payment, pursuant to Section 7.2.a(2)(d) hereof.

b. *Claim Submission.*

CIGNA HealthCare agrees to accept both properly and timely completed paper claims submitted on Form CMS 1500, UB-92 or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format or fields. CIGNA HealthCare may continue to require submission of Clinical Information in connection with review of specific claims and as contemplated elsewhere in this Agreement, including without limitation Sections 7.8, 7.19 and 7.20; provided that nothing in this sentence is intended or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning CIGNA HealthCare's ability to make requests for Clinical Information in connection with adjudication of claims. CIGNA HealthCare shall disclose on its Website its policies and procedures regarding the appropriate format for claims submissions and requests for Clinical Information. Nothing herein is intended to or shall alter CIGNA HealthCare's right to obtain eligibility information that it needs to process a claim from the CIGNA HealthCare Member or the CIGNA HealthCare customer for which CIGNA HealthCare insures or administers the CIGNA HealthCare Member's Plan.

7.18 *Payment of Simple Interest on Certain Claims.*

a. Through the use of two new claims platforms described in Section 7.1 of

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this Agreement; CIGNA HealthCare has increased its ability to autoadjudicate claims and to receive claims electronically. The level of claims submitted electronically has also increased. At present, approximately 60% of the claims handled on one new system are submitted electronically and approximately 70% are submitted electronically on the other. The new systems are presently processing for payment approximately 90% of the number of fee for service claims that include the information set forth in Section 7.17.b within fourteen (14) calendar days of receipt. Every claim received by CIGNA HealthCare is and at least until the Termination Date will be logged with a receipt date whether the claim is received on paper or electronically. CIGNA HealthCare will continue to pursue initiatives designed to improve the timeliness of claim processing and shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to CIGNA HealthCare within twenty four (24) hours after such clearinghouse's receipt thereof.

b. CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted by Class Members that are processed and finalized for payment more than thirty (30) calendar days following the submission of all information necessary to make the claim consistent with Section 7.17.b of this Agreement. Beginning one year following Final Approval, for claims processed on either of the new systems referenced above, CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted electronically by Class Members that are processed and finalized for payment more than fifteen (15) Business Days following the submission of all information necessary to make the claim consistent with Section 7.17.b of this Agreement. Notwithstanding the foregoing, if CIGNA HealthCare determines that an applicable state law or regulation requires interest to be computed and paid at a different interest rate, CIGNA HealthCare shall observe the requirements of that state law or regulation. Under this provision, simple interest shall be computed from the sixteenth (16th) or the thirty-first (31st) day (as appropriate based on the circumstances described above) after CIGNA HealthCare receives the

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information necessary to make the claim consistent with Section 7.17.b to the date on which the claim is processed by CIGNA HealthCare and placed in line for payment. Interest so computed shall, at CIGNA HealthCare's election, either be included in the claim payment check or wire transfer or be remitted in a separate check or wire transfer. Notwithstanding the terms of this subparagraph, CIGNA HealthCare shall have no obligation to make any interest payment on any such claim as to which (i) the Class Member , within thirty (30) days of the submission of an original claim, submits a duplicate claim while the original claim is still being processed; or (ii) the Class Member violates the terms of his, her or its contract with CIGNA HealthCare by inappropriately billing a CIGNA HealthCare Member for the balance due from CIGNA HealthCare. In addition, with respect to interest payments that total less than One Dollar ($1.00) on any single claim ("de minimis interest"), CIGNA HealthCare may, at its sole option, either (i) pay such amounts in the same manner as any other interest payment under this paragraph, or (ii) if it determines that it cannot practically pay using option (i), calculate the total dollar amount of de minimis interest for each year during the period for which this section 7.18 applies, and pay such amount to the Foundation. If CIGNA HealthCare elects the approach described in subsection (ii) in the preceding sentence, the calculation of de minimis interest will be determined by a claim audit based on statistically valid claim audit procedures and will include interest on the de minimis interest for the preceding year, which interest of six percent (6%) per annum will be calculated on a reasonable basis. CIGNA HealthCare will provide the audits to Notice Counsel.

7.19 *No Automatic Downcoding of Evaluation and Management Claims.*

CIGNA HealthCare shall not automatically reduce the code level of CPT® Evaluation and Management Codes billed for Covered Services. Notwithstanding the foregoing sentence, CIGNA HealthCare shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by a selected Class Member) based

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on a review of Clinical Information at the time the service was rendered for particular claims, a review of information derived from CIGNA HealthCare's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of Evaluation and Management services; provided that the decision to reduce is based at least in part on a review of the Clinical Information.

7.20 *Modifications to Payment Policies.*

CIGNA HealthCare shall modify its claim processing and claim payment policies as follows and will insure that its automated claims handling will be consistent with the requirements of this Agreement. If there are legislative or regulatory efforts to bring about uniform coding and editing standards, CIGNA HealthCare will not oppose such efforts. Nothing in this Section is intended or shall be construed to require CIGNA HealthCare to pay for anything other than Covered Services for CIGNA HealthCare Members, to make payment at any particular rates, to limit CIGNA HealthCare's right to deny or adjust claims based on reasonable belief of fraudulent, abusive or other inappropriate billing practices (so long as the Class Member has had the opportunity to invoke the provisions of Section 7.12) or to supersede Individually Negotiated Contracts that specifically provide for alternative payment logic.

a. *Moratorium on Requirement that Providers Submit Clinical Information in Order to Obtain Payment for Surgical Procedures and for Evaluation and Management Services on the Same Date of Service.*

CIGNA HealthCare shall not require Class Members to submit Clinical Information of their patient encounters in order to receive payment for both surgical procedures and CPT® Evaluation and Management services for the same patient on the same date of service. CIGNA HealthCare shall pay for both CPT® Evaluation and Management Codes and surgical codes or other procedure codes when submitted for the same patient on the same date of service with appropriate modifiers (e.g., modifiers 25 and 57), unless a Claim Coding and/Bundling Edit (which edit will be disclosed on the Website and shall be consistent with this section 7.20)

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precludes payment of the specific combination of billing codes involved. Additionally, CIGNA HealthCare will remove from its claim review and payment systems those Claim Coding and Bundling Edits that generally deny payment for CPT® Evaluation and Management Codes when submitted with surgical or other procedure codes for the same patient on the same date of service except for a discrete number of exceptions which will be disclosed on CIGNA HealthCare's Website. Nothing in this Agreement shall prohibit CIGNA HealthCare from requiring use of the appropriate CPT® Code modifiers for Evaluation and Management billing codes (e.g., modifiers 25 and 57) on their original claim forms. Moreover, nothing in this Agreement shall preclude CIGNA HealthCare from requiring Participating Physicians and Non-Participating Physicians (to the extent the audit is limited to claims submitted under an Assignment of Benefits) to submit to an audit of their submitted claims (including claims for surgical procedures and Evaluation and Management services on the same date of service), and to produce copies of their Clinical Information in connection with such an audit.

b. *Termination of Use of "Well Woman" Billing Code for Obstetrical and Gynecological Examinations.*

After October 14, 2003, CIGNA HealthCare shall process claims for obstetrical and gynecological examinations using standard CPT® Codes denoting Evaluation and Management services, eliminating use of the CIGNA HealthCare "well woman" code (i.e., code 90769).

c. *Processing of Add-On and Modifier 51 Exempt Billing Codes.*

CIGNA HealthCare will process and separately reimburse add-on billing codes and modifier 51 exempt billing codes without reducing payment under CIGNA HealthCare's Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to the guidelines and protocols set forth in CPT®.

d. *Recognition of CPT® Codes and HCPCS Level II Codes.*

CIGNA HealthCare shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its

claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, CIGNA HealthCare shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require CIGNA HealthCare to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

e. *CPT® Code That Includes Supervision and Interpretation.*

A CPT® Code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided, that for each such procedure (e.g., review of x-ray or biopsy analysis), CIGNA HealthCare shall not be required to pay for supervision or interpretation by more than one physician; and provided further that, consistent with Section 7.8.c of this Agreement, nothing in this Section 7.20.e shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements of the billed CPT® Code have been satisfied.

f. *Indented Codes.*

Other than codes specifically identified as modifier 51-exempt or "add-on," a CPT® Code that is considered an indented code within CPT® shall not be reassigned into the primary (*i.e.*, non-indented) code, from the same CPT® Code series, unless more than one indented code under the same indentation is submitted with respect to the same service, in which event only one such code shall be eligible for payment; provided that for indented code series contemplating that multiple codes in such series properly may be reported and billed concurrently, all such codes properly billed shall be recognized and eligible for payment.

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g. *Modifier 59.*

CPT® Codes submitted with a modifier 59 attached will be recognized and eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) although such procedures or services are not normally reported together they are appropriately reported together under the particular presenting circumstances; (2) it would not be more appropriate to append any other CPT® recognized modifier to such codes; and (3) to the extent that the CPT® Code submitted for payment with a modifier 59 attached is otherwise subject to a Claim Coding and Bundling edit, substantiating Clinical Information indicates that the use of modifier 59 was appropriate (which requirement shall be posted on the Website consistent with Section 7.8.c of this Agreement).

h. *Global Periods.*

No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict CIGNA HealthCare from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).

i. *Code Changes.*

CIGNA HealthCare shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® Code is one among a series that differentiates among simple, intermediate and complex; provided that, consistent with Section 7.8.c of this Agreement, nothing in this Section 7.20.i shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements for intermediate and complex versions of the service have been satisfied.

j. *Other Modifiers.*

Nothing contained in this Section 7.20 shall be construed to limit CIGNA HealthCare's recognition of modifiers to those modifiers specifically addressed in this section 7.20.

7.21 *Modifications of Language Included in Remittance Forms Provided to Class Members.*

a. *Remittance Forms.*

CIGNA HealthCare shall use its best efforts to identify on those Remittance Forms issued to Class Members the following information: the name of and a number identifying the CIGNA HealthCare Member, the date of service, the amount of payment per line item, any adjustment to the invoice submitted and generic explanation therefor in compliance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requirements, all billing codes submitted by the Class Members and the distinct charges therefor, and, whether such codes were paid or denied, and, if denied, the reasons therefor, and an address and telephone number for questions regarding the claim described in the Remittance Form. Such Remittance Forms shall also contain a printed disclosure advising Class Members that reconsideration of the application of any denied billing codes, regardless of the reason for the denial, is available through CIGNA HealthCare's appeal procedures, which procedures may require the submission of relevant Clinical Information. The Settling Parties recognize that certain claim processing systems currently in use at CIGNA HealthCare cannot immediately meet this requirement and that implementation of this specification will require the migration of claim processing activity to other claim processing systems that already meet this specification. The Settling Parties recognize that this migration effort, which is already underway, is a complex effort that will occur over time. Accordingly, CIGNA HealthCare shall provide quarterly status reports to Notice Counsel regarding its efforts to meet this specification, and shall report to Notice Counsel when the efforts are complete. Once this process of migration has been completed and Notice Counsel have been so advised, Remittance Forms shall continue to identify all distinct billing codes submitted by Class Members at least through the Termination Date.

b. *Balance Billing by Non-Participating Physicians.*

Nothing in this Agreement is intended to, and shall not, alter or change the rights of Non-Participating Physicians to balance bill or to bill a CIGNA HealthCare Member at rates and on

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terms that are agreed between the Non-Participating Physician and the CIGNA HealthCare Member.

7.22 *Overpayment Recovery Procedures.*

CIGNA HealthCare shall initiate or continue to take actions reasonably designed to reduce Overpayments, and it shall publish on its Website an address and procedures for Class Members to return Overpayments. In addition, other than for recovery of duplicate payments, CIGNA HealthCare shall provide Class Members with thirty (30) days written notice before seeking Overpayment recovery, whether or not the Overpayment occurred during the Class Period or afterward. The notice shall state the patient name, service date, payment amount, proposed adjustment, and explanation or other information (including without limitation procedure code, where appropriate) giving Class Members reasonably specific notice of the proposed adjustment. CIGNA HealthCare shall not initiate Overpayment recovery efforts more than twelve (12) months after the original payment; provided that no time limit shall apply to initiation of Overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Self-Insured Plan; and in the event that a Class Member asserts a claim of underpayment, CIGNA HealthCare may defend or set off such claim or it may counterclaim based on Overpayments going back in time as far as the claimed underpayment.

7.23 *Efforts to Improve Accuracy of Information About Eligibility of CIGNA HealthCare Members.*

CIGNA HealthCare has sought to increase the accuracy of eligibility data in its systems, and will continue to do so, by devoting resources to improving each step in the timeliness and accuracy of transmission of information from CIGNA HealthCare Members to their employers and from employers to CIGNA HealthCare, through, *inter alia*, 1) an internal end-to-end review of the eligibility process from the perspective of both the employer and CIGNA HealthCare; 2) the application of "Six Sigma" process improvement techniques, a rigorous statistical approach designed to reduce variation from targeted accuracy standards; 3) the formation of so-called Six

Sigma teams to examine each important step in the chain of eligibility information registration and to develop procedures or other means to reduce inaccuracy or delays through process improvement projects; 4) measurement of the results of process improvement projects; 5) encouragement of employers to submit eligibility data in electronic form, to reduce errors and mishandling that can impact paper-based processes, and by developing a web-based process for employers who cannot use other forms of electronic submission; and 6) regular comparison of CIGNA HealthCare's eligibility data with employers' data to improve the accuracy of the data in CIGNA HealthCare's systems.

7.24 *Provider Service Centers.*

Since the commencement of this Litigation, CIGNA HealthCare has consolidated its provider services centers so as to have a center located at each of its five principal claims handling centers, plus four satellite provider relations centers; and it has established a provider resolution unit responsible for consolidating and coordinating the identification of problems being encountered in claims submissions and processing, researching the causes of such problems and the means for their solutions, and performing certain appeal-related functions. CIGNA HealthCare shall continue these or other efforts to improve provider services.

7.25 *Effect of CIGNA HealthCare Confirmation of Medical Necessity.*

CIGNA HealthCare agrees that if CIGNA HealthCare certifies that a proposed treatment is Medically Necessary for a particular CIGNA HealthCare Member, CIGNA HealthCare shall not subsequently revoke that Medical Necessity determination absent evidence of fraud, evidence that the information submitted was materially erroneous or incomplete, or evidence of material change in the CIGNA HealthCare Member's health condition between the date that the certification was provided and the date of the treatment that makes the proposed treatment not Medically Necessary for such CIGNA HealthCare Member. In the event that CIGNA HealthCare certifies the Medical Necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be

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deemed to be a new request and CIGNA HealthCare's denial of such request shall not be deemed to be inconsistent with the preceding sentence. Any policies and procedures promulgated to effectuate this commitment and in effect at the end of the Effective Period shall be included in the Certification to be filed annually and at the end of the Effective Period.

7.26 *Electronic Connectivity.*

The Website shall operate with a reasonable degree of reliability. If for any thirty (30) day period during the Effective Period, the Website is inoperable or lacks reliability, CIGNA HealthCare shall take commercially reasonable measures to enhance the operability and reliability of the Website. The Certification to be filed annually and at the end of the Effective Period shall include the dates during the Effective Period on which the Website has been substantially inoperable.

7.27 *Information About Physicians Posted on CIGNA HealthCare's Website.*

Information currently posted on CIGNA HealthCare's Website about individual Physicians is derived from data supplied by those Physicians and from applicable agreements between CIGNA HealthCare and a Participating Physician. Upon notice of an inaccuracy sent to CIGNA HealthCare (pursuant to the direction as to how to give such notice that will be posted on the Website), CIGNA HealthCare shall take steps reasonably necessary to ensure that the Website is updated within twenty (20) Business Days after receipt of such notice to reflect any corrections in the Physician information necessary to make it accurate. Similarly, when CIGNA HealthCare is notified by a Physician in the manner set forth in the preceding sentence that such Physician is incorrectly listed on CIGNA HealthCare's Website as a Participating Physician, CIGNA HealthCare shall delete any such erroneous reference within twenty (20) Business Days after receipt of such notice and shall make corresponding changes in systems affecting the level of payments and generation of EOBs.

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7.28 *Capitation and Physician Organization Specific Issues.*

a. *Capitation Reporting.*

CIGNA HealthCare shall provide Class Members who are capitated with monthly reports within ten (10) Business Days after the beginning of each month. These monthly reports will include membership information to allow reconciliation by Class Members of capitation payments, such information to include CIGNA HealthCare Member identification number or the equivalent, name, age, address, gender, health plan, Physician Group/Physician Organization number, copayment, deductible, monthly capitation amount, primary care Physician, provider effective date, type of coverage, enrollment date, and, in the monthly report following an applicable change (e.g., selection of new primary care Physician), a report of such change.

b. *Assignment to Primary Care Physician Where CIGNA HealthCare Member Does Not Make Selection Initially.*

If a CIGNA HealthCare Member does not choose a primary care Physician upon enrollment, CIGNA HealthCare shall, unless prohibited from doing so by the employer sponsor of a Self-Insured Plan, assign the CIGNA HealthCare Member to a primary care Physician that is a Participating Physician randomly selected based upon the CIGNA HealthCare Member's home address zip code or on the basis of another reasonable method developed by CIGNA HealthCare. CIGNA HealthCare will recommend to all Plan sponsors that if a CIGNA HealthCare Member in the Plan of that sponsor does not select a primary care Physician upon enrollment, then CIGNA HealthCare will assign the CIGNA HealthCare Member to a primary care Physician that is a Participating Physician randomly selected based upon the CIGNA HealthCare Member's home address zip code or on the basis of another reasonable method developed by CIGNA HealthCare, pending the CIGNA HealthCare Member's selection of a primary care Physician. CIGNA HealthCare shall pay the initially assigned primary care Physician, from the date of the CIGNA HealthCare Member's enrollment, any capitation rates under such primary care Physician's contract with CIGNA HealthCare, and the assigned primary care Physician shall become responsible for the care of the CIGNA HealthCare Member in accordance with the applicable

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terms of such Participating Physician's agreement with CIGNA HealthCare, from the date of notice of the enrollment. The CIGNA HealthCare Member has the right to select a new primary care Physician at any time in accordance with the Plan in which the CIGNA HealthCare Member is enrolled, which newly selected primary care Physician (if a capitated Physician) shall from the date of selection begin receiving capitation at such capitation rate specified in such primary care Physician's contract with CIGNA HealthCare. At such point in time, the initially assigned primary care Physician, if a capitated Physician, shall cease receiving any capitation payments.

7.29 *Miscellaneous.*

a. *No Introduction of "Gag Clauses."*

CIGNA HealthCare does not include in its contracts with Class Members, and, at least through the Termination Date, will not include in its contracts, any provision restricting the free, open and unrestricted exchange of information between Class Members and CIGNA HealthCare Members regarding 1) the nature of the CIGNA HealthCare Member's medical conditions or treatment; 2) treatment options and the relative risks and benefits of such options; 3) whether or not such treatment is covered under the CIGNA HealthCare Member's Plan; and 4) any right to appeal any adverse decision by CIGNA HealthCare regarding coverage of treatment that has been recommended or rendered. CIGNA HealthCare agrees not to penalize or sanction Class Members in any way for engaging in any free, open and unrestricted communication with a CIGNA HealthCare Member with respect to the foregoing subjects or for advocating for any service on behalf of a CIGNA HealthCare Member.

b. *Ownership of Medical Records.*

CIGNA HealthCare agrees that it does not own medical records kept by Class Members; provided, however, that CIGNA HealthCare, as reasonably needed or as required by law, has the right with respect to a Participating Physician, and a Non-Participating Physician submitting a claim for payment based on an Assignment by the CIGNA HealthCare Member to such Non-Participating Physician of his or her benefits, to ask for and receive copies of such records or, at

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CIGNA HealthCare's election, to review them for treatment, payment, or health care operations purposes, for purposes required by law, and for other customary purposes such as disease management, patient management, utilization management, quality assurance, quality review, quality management, and audit (including without limitation any audit activities undertaken by CIGNA HealthCare to comply with NCQA accreditation rules); and provided further, that nothing herein is intended to or should be construed to convey to a Physician any property interest in (i) CIGNA HealthCare's data or intellectual property, (ii) products or services offered or provided now or in the future, or (iii) any business, systems or information management process that incorporates any medical records or related data obtained by CIGNA HealthCare from such Physician or any reports or data resulting from any such data or processes. Notwithstanding the foregoing or any other provisions of this Agreement, any right of CIGNA HealthCare to demand information or cooperation from a Non-Participating Physician shall be limited to whatever rights to such information or cooperation CIGNA HealthCare would be able to assert for purposes required by law or through the terms of the agreement between CIGNA HealthCare and the CIGNA HealthCare Member upon whose Assignment of Benefits the Non-Participating Physician has submitted a claim for payment.

c. *Limitations on Costs of Non-Judicial Dispute Resolution for Individual Physicians and Small Physician Groups.*

In any non-judicial dispute resolution proceeding (other than under Sections 7.10, 7.11, 7.12, and 15 of this Agreement) commenced by a Class Member who has an individual contract with a CIGNA HealthCare entity or who has contracted with a CIGNA HealthCare entity through a Physician Group contract in which the Physician Group includes no more than six (6) individual Class Members, the Class Member's maximum share of the costs of the dispute resolution entity shall be limited to one half of those costs or One Thousand Dollars ($1,000.00), whichever is less. CIGNA HealthCare shall be responsible for one hundred percent (100%) of those costs that exceed Two Thousand Dollars ($2,000.00). This provision applies notwithstanding the requirements of any contract between CIGNA HealthCare and any Class

Member requiring the Class Member to share evenly the fees of a dispute resolution procedure, including arbitration. This Section 7.29.c shall not apply to dispute resolution proceedings in which the Class Member involved purports to represent other Physicians outside of his or her Physician Group of no more than six (6) individual Class Members. Subject to the above and except as otherwise addressed in a Physician contract or by law, each party will bear its own costs.

d. *Impact of this Agreement on Standard Agreements and Individually Negotiated Contracts.*

CIGNA HealthCare's standard Physician agreements and/or ancillary documents (*e.g.*, criteria schedule) shall incorporate or be consistent with the commitments and undertakings CIGNA HealthCare makes in this Agreement. To the extent that CIGNA HealthCare's existing agreements with Participating Physician Class Members contain provisions inconsistent with the terms hereof, CIGNA HealthCare shall administer such agreements consistent with the terms set forth in this Agreement; provided that where CIGNA HealthCare and a Class Member have an Individually Negotiated Contract, this Agreement shall not modify or nullify the individually negotiated terms of such Individually Negotiated Contracts unless the Class Member notifies CIGNA HealthCare in writing, specifically setting forth the negotiated terms it seeks to have modified or nullified by this Agreement. Upon such notification, either party to the Individually Negotiated Contract may then elect to renegotiate the Individually Negotiated Contract or terminate it. Furthermore, CIGNA HealthCare, upon request, may separately agree with individual Participating Physicians, Physician Groups or Physician Organizations on customized rates and/or payment methodologies that deviate from the terms of its standard agreements.

e. *Impact of Agreement on Covered Services.*

Notwithstanding anything to the contrary contained in this Agreement, nothing contained herein shall supersede or otherwise alter the scope of Covered Services under a CIGNA HealthCare Member's Plan Documents or require payment by CIGNA HealthCare or a Plan for services that are not Covered Services.

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f. *Privacy of Records and Right of Class Member to Elect Exemption From Use of Electronic Transactions.*

CIGNA HealthCare shall safeguard the confidentiality of CIGNA HealthCare Member medical records in accordance with HIPAA, state and other federal law and any other applicable legal requirements; provided, however, that this undertaking shall not be the subject of a Compliance Dispute, and that Physicians may resort to any other remedial measures that they may have outside this Agreement to protect their interests. If a Physician elects not to be compliant with the portions of HIPAA relating to the electronic submission of claims, CIGNA HealthCare shall not require such Physician to use electronic transactions or otherwise require such Physician to become compliant with HIPAA. Instead, it will maintain reasonable non-electronic systems to serve the information needs of such Physicians.

g. *Pharmacy Risk Pools.*

CIGNA HealthCare agrees that it will not utilize pharmacy risk pools except when expressly requested in writing to do so by a Class Member.

h. *No Requirement to Purchase Stop-Loss Insurance.*

CIGNA HealthCare agrees that it shall not require Physicians to purchase stop-loss insurance from it.

i. *Pharmacy Provisions.*

CIGNA HealthCare shall disclose to CIGNA HealthCare Members whether that Member's Plan uses a formulary and, if so, explain what a formulary is, how CIGNA HealthCare determines which prescription medications are included in the formulary, and how often CIGNA HealthCare reviews the formulary list; and CIGNA HealthCare shall provide CIGNA HealthCare Members with formulary lists upon request. CIGNA HealthCare shall maintain the exception process that is in place on the date of Final Approval (as such process may be reasonably amended by CIGNA HealthCare) by which coverage for medications not included on the formulary may be requested. CIGNA HealthCare will continue to provide coverage for off-label uses of pharmaceuticals that have been approved by the FDA (but not approved for the

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prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by supporting documentation in any one of the following: (1) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (2) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals.

j. *Restrictive Endorsements.*

Where reimbursement for services is a partial payment of allowable charges, a Class Member may negotiate a check with a "Payment in Full" or other restrictive endorsement without waiving the right to pursue a remedy available under this Agreement.

k. *Physician Specialty Society Guidelines.*

Notwithstanding anything to the contrary in this Section 7, no claims adjudication policy or practice adhered to by CIGNA HealthCare shall be deemed to violate the terms of this Agreement to the extent such policy or practice is consistent with the then current billing or claims adjudication guidelines issued by a Physician Specialty Society.

l. *Scope of CIGNA HealthCare's Responsibilities.*

The obligations undertaken by CIGNA HealthCare under Section 7 of this Agreement shall be applicable only to those functions or activities performed directly by CIGNA HealthCare and its employees, or third parties (other than Delegated Entities) performing functions on CIGNA HealthCare's behalf. To the extent it deems practical, CIGNA HealthCare shall endeavor to include in contracts entered into with Delegated Entities subsequent to Final Approval terms that are substantially equivalent to the terms of this Agreement; provided that CIGNA HealthCare shall not be liable hereunder in the event any Delegated Entity acts in a manner inconsistent with this Agreement.

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m. *Provision of Contract Copies.*

CIGNA HealthCare will continue its practice of providing copies to Class Members of their contracts, along with all attachments, within thirty (30) days or as soon as practical, upon request of the Class Member. In addition, subject to the permission of a Participating Physician Group or Physician Organization with which CIGNA HealthCare has a contract, CIGNA HealthCare will provide a copy of that contract to a Class Member participant in such Physician Group or Physician Organization upon request of the Class Member. In its agreements with Physician Groups or Physician Organizations, CIGNA HealthCare will not require that a restriction on distribution of the Physician Group or Physician Organization agreement to a Physician in such Group or Organization be included.

n. *State and Federal Laws and Regulations.*

Nothing contained in Section 7 of this Agreement is intended to, or shall in any way waive, reduce, eliminate or supersede any Settling Party's obligation to comply with applicable provisions of relevant state and federal law and regulations and to the extent federal or state law or regulation imposes obligations greater than those set forth in this Agreement, CIGNA HealthCare shall comply with said law or regulation; and provided that nothing in this Section 7.29.n is intended to give rise to or should be construed as giving rise to any private right of action (other than through the Compliance Dispute procedure in Section 15) for any violation of any federal or state law (whether under a breach of contract theory or any other theory) where federal or state law does not allow a private right of action for such violation.

o. *Ability of CIGNA HealthCare to Modify Means of Disclosure.*

CIGNA HealthCare may alter the method or means by which it makes any disclosure or otherwise transmits information as described in, and required by, this Agreement, so long as CIGNA HealthCare reasonably believes, expects and intends that the newly-adopted means or method of disclosure or transmission is as effective or more effective than the means or method set forth in this Agreement.

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p. *Participating Physician Status Dependent Upon Existence of Contracts; Limitations on Obligations of Non-Participating Physician.*

CIGNA HealthCare agrees that it will treat a Class Member as a Participating Physician only in those circumstances in which the Class Member is a party to a written contract with CIGNA HealthCare or with an intermediary with which CIGNA HealthCare has a written contract. CIGNA HealthCare further agrees that at least through the Termination Date, it will not rent its networks to any other managed care company or health insurer for the purpose of providing health care services or supplies to any person who is not a CIGNA HealthCare Member; provided that nothing in this sentence shall prevent CIGNA HealthCare from making its networks available among the various current and future Subsidiaries of CIGNA Corporation; and provided, further, that nothing in this sentence shall be held to apply to a situation in which a CIGNA HealthCare customer elects to make payments on claims in respect to provisions of health care services or supplies to a CIGNA HealthCare Member through a third party administrator or where CIGNA Behavioral Health provides mental health services for another health insurance company or other entity. No affirmative obligation that this Section 7 imposes on a Participating Physician shall apply to Non-Participating Physicians unless and until, and then only to the extent that, with regard to each individual claim, such Non-Participating Physician submits or transmits to CIGNA HealthCare a claim for payment which designates therein that the Non-Participating Physician has accepted an Assignment of the CIGNA HealthCare Member's benefits as payment for that individual claim.

q. *Effect of Assignment of Benefits.*

The existence of an Assignment of Benefits authorization, whether or not submitted by the Non-Participating Physician to CIGNA HealthCare, does not constitute in and of itself full or partial payment of the Non-Participating Physician's fee (unless so agreed between the Non-Participating Physician and the CIGNA HealthCare Member), does not create an implied contract between the Non-Participating Physician and CIGNA HealthCare, and does not limit the Non-Participating Physician's fee to any fee schedule. The Non-Participating Physician retains

the right to elect either to collect the Non-Participating Physician's full fee from the CIGNA HealthCare Member or collect partial payment from CIGNA HealthCare and the balance from the CIGNA HealthCare Member ("balance bill").

r. Nondisparagement.

When CIGNA HealthCare sends an Explanation of Benefits to a CIGNA HealthCare Member for whom health care services or supplies were provided by a Non-Participating Physician Class Member, it shall not indicate that the amount unpaid by CIGNA HealthCare cannot be balance billed. Consistent with the desire that CIGNA HealthCare Members receive accurate communications that do not disparage Physicians, and subject to the last section of this Section 7.29.r, each such EOB shall state "Physician may balance bill you," or contain language to substantially similar effect. CIGNA HealthCare shall not use any language in its correspondence with CIGNA HealthCare Members that disparages the services or charges of Non-Participating Physicians; provided, however, that (i) language that CIGNA HealthCare reasonably determines to be required by applicable law to be included in such correspondence shall not be deemed disparagement, and (ii) the citation by CIGNA HealthCare of language from applicable Plan provisions, reasonably determined by CIGNA HealthCare to be required by ERISA, state law, or federal or state regulation (including, without limitation, language stating that billings exceed reasonable and customary charges) shall not be deemed disparagement; and provided further that CIGNA HealthCare shall take such steps as are necessary as promptly as possible to eliminate the reference to "reasonable and customary charges" in Insured Plan Documents and to substitute therefor the words "claim exceeds maximum allowable amount" (or words to that effect), and shall encourage the sponsors of Self-Funded Plans to eliminate the reference to "reasonable and customary charges" in their Plan Documents and to substitute therefor the words "claim exceeds maximum allowable amount" (or words to that effect). It is understood that changes in Plan Documents will require state regulatory approval as well as changes in CIGNA HealthCare's customers' Plan Documents.

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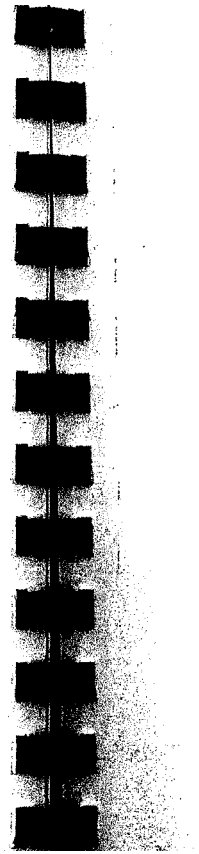

7.30 *Compliance With Applicable Law and Requirements of Government Contracts.*

The obligations undertaken in Section 7 herein shall be fulfilled by CIGNA HealthCare to the extent permissible under applicable laws and current or future government contracts. If, and during such time as, CIGNA HealthCare is unable to fulfill its obligations under this Agreement to the extent contemplated by this Agreement because to do so would require state or federal regulatory approval or action, CIGNA HealthCare shall perform the obligation to the extent permissible by applicable law or by the terms of a government contract and shall continue to fulfill its other obligations under this Agreement, to the extent permitted by applicable law or by government contract. To the extent that any state or federal regulatory approval is required for any Settling Party to implement any part of this Agreement, such Settling Party shall make all reasonable efforts to obtain any necessary approvals of state or federal regulators as needed for the implementation of this Agreement. For any act required by Section 7 of this Agreement that cannot be undertaken without regulatory approval, the Effective Date as to that act shall be delayed until such approval is granted.

7.31 *Estimated Value of Section 7 Initiatives.*

Since the inception of this Litigation and through the Termination Date, CIGNA HealthCare will have spent over Four Hundred Million Dollars ($400,000,000) in order to carry out the initiatives described in Sections 7.1, 7.2, 7.3, 7.7, 7.23 and 7.24 of this Agreement. The Settling Parties estimate that, taking into account these expenditures by CIGNA HealthCare and other commitments with respect to CIGNA HealthCare's business practices set forth in Section 7, the approximate value of the initiatives in Section 7 is in excess of the amount stated above.

7.32 *Force Majeure.*

CIGNA HealthCare shall not be liable for any delay or non-performance of its obligations under this Agreement arising from any act of God, governmental act, act of terrorism, war, fire, flood, explosion or civil commotion. The performance of CIGNA HealthCare's

obligations under this Agreement, to the extent affected by the delay, shall be suspended for the period during which the cause persists.

7.33 *Mental Health Provisions.*

The following provisions shall apply where CIGNA HealthCare is responsible for insuring or administering mental health services under a Plan.

a. CIGNA HealthCare agrees that it will reimburse Physicians for appropriately coded Medically Necessary Covered Services for mental health care, including treatment for psychiatric illness and substance abuse, in the same manner in which it applies the definition of Medical Necessity to all clinical conditions, and in accordance with the definition of Medical Necessity set forth in Section 7.16 of this Agreement and subject to the terms of Plan Documents; provided that considering the appropriateness of any level of care, the following standards relevant to mental health care must be met:

(i) A diagnosis as defined by standard diagnostic nomenclatures (DSM IV or its equivalent in ICD-9-CM) and an individualized treatment plan appropriate for the patient's illness or condition; and

(ii) A reasonable expectation that the patient's illness, condition, or level of functioning will be stabilized, improved, or maintained through ambulatory care, through treatment known to be effective for the patient's illness; custodial care is not typically a Covered Service; and

(iii) Is not primarily for the avoidance of incarceration of the patient;

(iv) Is not primarily for convenience of the patient or his/her family or his/her treating Physician or other Physician.

b. CIGNA HealthCare agrees that participating psychiatrists will be listed in CIGNA HealthCare's provider directory via a "hot link" or otherwise. CIGNA HealthCare will allow its primary care Physicians to make direct referrals to CIGNA HealthCare's in-network psychiatrists, provided that any such referral is subject to the same precertification provisions as

for other Participating Physicians. CIGNA Behavioral Health will permit Class Members to seek precertification electronically for routine outpatient care.

c. CIGNA HealthCare agrees that, where a Physician has not entered into a different agreement with CIGNA HealthCare, CIGNA Behavioral Health, or the hospital or other mental health care facility where the services are rendered, CIGNA HealthCare will reimburse the psychiatrist in accordance with his or her patient's Plan terms based on his or her appropriately billed charges.

d. CIGNA Behavioral Health adheres to state "prudent layperson" laws which require payment of benefits for medical or psychiatric services in the event of an emergency under prudent layperson standards. An emergency department Physician can make a decision regarding admission or physical or chemical restraints. In the event of an emergency, the Physician shall be reimbursed for Medically Necessary Covered Services resulting from the admission in accordance with prudent layperson standards and the definition of Medical Necessity in Section 7.16.

e. CIGNA Behavioral Health will post on its website (www.cignabehavioral.com) a record release form that Physicians may print or download to obtain patient consent for release of Clinical Information to CIGNA HealthCare or CIGNA Behavioral Health, if needed for processing of claims for payment.

8. <u>OTHER SETTLEMENT CONSIDERATION</u>

In addition to the initiatives and other commitments set forth in Section 7 of this Agreement, the consideration supporting this Settlement shall include the establishment by CIGNA HealthCare of a Foundation, as described in more detail in Section 8.1, and two funds for payment of claims to Class Members, that will be established and operated in accordance with the provisions of Sections 8.2 and 8.3.

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8.1 *Foundation.*

The Foundation shall mean the Foundation described in Exhibit 9. No more than five (5) Business Days after Final Approval, CIGNA HealthCare shall create the fund for the Foundation by making a deposit in the amount of Fifteen Million Dollars ($15,000,000) by wire transfer into a separate interest bearing account with an escrow agent acceptable to both Notice Counsel and CIGNA HealthCare and held pursuant to an order of the Court. In addition, any amounts directed to the Foundation or reverting to the Foundation from the Category A Settlement Fund or reverting from the Claim Distribution Fund shall be transferred through the Settlement Administrator to the Foundation. Notice of this transfer to the Foundation shall be given to Notice Counsel and Defendants' Counsel. The Settlement Administrator shall, on the one hundred fiftieth (150th) day following the date on which the last check was issued to a Class Member for payment of a Category A amount or an amount under the Claim Distribution Fund, transfer to the Foundation any portion remaining in the Category A Settlement Fund and such amount of the Claim Distribution Fund as, pursuant to Section 8.3.b, shall revert to the Foundation and shall notify Notice Counsel and Defendants' Counsel of the amounts thus transferred. The Foundation's purposes and activities shall be subject to the supervision of the Court.

8.2 *Category A Settlement Fund.*

a. *Establishment of the Category A Settlement Fund.*

No more than ninety (90) days after Final Approval, CIGNA HealthCare shall create the Category A Settlement Fund by making a deposit in the amount of Thirty Million Dollars ($30,000,000) by wire transfer into a separate interest bearing account with an escrow agent acceptable to both Notice Counsel and CIGNA HealthCare and held pursuant to an order of the Court.

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b. *Method of Distribution of the Category A Settlement Fund; Contributions to the Foundation.*

The Settlement Administrator shall determine the total number of Class Members filing Valid Proofs of Claim against the Category A Settlement Fund ("Category A Claims") for (i) retired and deceased Physicians and (ii) actively practicing Physicians. The number of retired and deceased Physicians will be doubled to reflect that each of them will receive double the amount to be received by actively practicing Physicians and added to the number of actively practicing Physicians, and the Settlement Administrator shall divide that number into Thirty Million Dollars ($30,000,000). The result shall be the amount to be distributed to each Class Member submitting a Category A Claim. Physician Groups and Physician Organizations shall be allowed to file claims on behalf of Physicians employed by or otherwise working with them at the time that the claims are made, without the necessity of individual signatures from the individual Physicians.

c. *Distribution.*

Each Class Member desiring to file a Category A Claim may elect either to receive the payment from the Category A Settlement Fund or to direct that such amount be contributed to the Foundation or to a foundation established by any Signatory Medical Society on his, her or its behalf. Any Class Member filing a Category A Claim Form shall not be eligible to seek Category One Compensation, Category Two Compensation, or Medical Necessity Denial Compensation.

d. *Encouragement to Contribute to Foundation.*

The Settling Parties and any Signatory Medical Societies shall make every reasonable effort to encourage Class Members to elect to contribute their portions of the Category A Settlement Fund to the Foundation or to a foundation established by a Signatory Medical Society.

e. *Submission of Category A Settlement Fund Claim Forms and Payment.*

Each Class Member must submit a claim form (the "Category A Claim Form") to the Settlement Administrator using the Proof of Claim Form attached as Exhibit 10 hereto and in accordance with the instructions included in the Notice of Commencement of the Claim Period in order for such Class Member to have a valid right to receive payment from the Category A Settlement Fund. Promptly after receipt of all timely Category A Claim Forms, the Settlement Administrator shall calculate the amount that is payable to, or on behalf of, each Class Member (or to the Foundation or to a foundation established by a Signatory Medical Society) pursuant to the provisions of Sections 8.2.b and 8.2.c of this Agreement. Promptly upon completion by the Settlement Administrator of the calculations of the amounts that are payable, the Settlement Administrator shall cause the Category A Settlement Fund to issue payment to Class Members who or which submitted Valid Category A Claims in accordance with this Section 8.2 or to the Foundation or a foundation, as directed by such Class Members.

f. *Payment to Foundation of Unclaimed Amounts.*

After all amounts have been paid to Class Members or to the Foundation or a foundation, at the direction of Class Members, in each case pursuant to Section 8.2.e of this Agreement, the Settlement Administrator shall determine the amount of funds remaining in the Category A Settlement Fund, including interest earned on such funds but excluding taxes owed. The Settlement Administrator shall provide written notice of this amount to CIGNA HealthCare and Class Counsel and, no later than twenty (20) Business Days after providing such written notice, the Settlement Administrator shall cause the Settlement Fund to remit the amount to the Foundation by wire transfer.

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8.3 *Claim Distribution Fund.*

a. *Establishment of Fund.*

CIGNA HealthCare shall create the Claim Distribution Fund to be held pursuant to an order of the Court by an escrow agent acceptable to both Notice Counsel and Defendants' Counsel for the purpose of paying Class Members' claims submitted pursuant to Sections 8.3.c and 8.3.d of this Agreement. Within forty-five (45) days of Final Approval, CIGNA HealthCare shall make an initial deposit of Two Million Five Hundred Thousand Dollars ($2,500,000) and shall replenish the Claim Distribution Fund as necessary to pay Valid Proofs of Claim. There shall be no limit on CIGNA HealthCare's responsibility to make replenishment deposits to the Claim Distribution Fund pursuant to this provision. The Claim Distribution Fund shall be deemed to be in *custodia legis* of the Court and shall remain subject to orders of the Court until such time as all funds are distributed to Class Members, or are paid to the Foundation, or revert to CIGNA HealthCare pursuant to the terms of this Agreement. No Class Member who or which files a Category A Settlement Fund Claim Form may make any claim against the Claim Distribution Fund.

b. *Minimum Amount and Reversion.*

If less than a total of Forty Million Dollars ($40,000,000) is paid under this Section 8.3, then CIGNA HealthCare will pay to the Foundation the difference between $40,000,000 and the amount paid under this Section 8.3; provided, however, that CIGNA HealthCare shall be entitled to deduct from this amount due to the Foundation the Administration Costs expended in administering the Claim Distribution Fund up to a limit of Seven Million Five Hundred Thousand Dollars ($7,500,000). Any amounts paid into the Claim Distribution Fund by CIGNA HealthCare not paid to Class Members or to the Foundation shall revert to CIGNA HealthCare without further order of the Court one hundred fifty (150) days after the date on which the last check was issued to a Class Member from the Claim Distribution Fund.

c. *Relief Respecting Claim Coding and Bundling Edits.*

CIGNA HealthCare agrees to pay two categories of compensation to Class Members affected by Claim Coding and Bundling Edits: Category One Compensation and Category Two Compensation. Category One Compensation shall be available to Class Members based on the Claim Coding and Bundling Edits that qualify for Category One Compensation pursuant to Section 8.3.c(1) and the table attached hereto as Exhibit 1. To obtain Category One Compensation, a Class Member shall submit a Category One Compensation Proof of Claim to the Settlement Administrator. Category Two Compensation shall be available to Class Members affected by Claim Coding and Bundling Edits, other than in circumstances for which Category One Compensation is available, upon submission of a Category Two Compensation Proof of Claim in accordance with Section 8.3.c(2) of this Agreement. No compensation of any kind shall be available under this Section with respect to Resolved Claims.

(1) *Category One Compensation.*

(a) *In General.*

The Settlement Administrator shall make distributions from the Claim Distribution Fund to Class Members who submit Valid Proofs of Claim for Category One Compensation during the Claims Period. Category One Compensation shall be available under this Agreement only for those denials of payment for Category One Codes in the specific circumstances and within the date of service limitations (if any) set forth in Exhibit 1 hereto. Denials of Category One Codes resulting from the application of other payment and benefit limitations (*e.g.*, coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the Proof of Claim or with other health care providers) shall not be eligible for Category One Compensation. The Category One Codes for which compensation will be paid under this Agreement, and the specific compensation that shall be paid by the Settlement Administrator on a Valid Proof of Claim for such Category One Codes, are set forth in the table

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attached hereto as Exhibit 1. Class Members seeking Category One Compensation must make a timely and proper application for payment by submitting a Proof of Claim Form according to the procedures described in Section 8.3.c(1)(c) of this Agreement. There shall be no limit on CIGNA HealthCare's responsibility to make or fund payments under this provision to all Class Members who submit Valid Proofs of Claim for Category One Compensation.

(b) *Timing of Category One Distributions.*

Subject to other provisions of this Agreement, the Settlement Administrator shall make payments from the Claim Distribution Fund on Category One Proofs of Claim within fourteen (14) days of the date that the Settlement Administrator judges such Proofs of Claim to be Valid Proofs of Claim.

(c) *Form of Application; Time Period for Submission; Documentation Required.*

(i) Class Members may submit Proofs of Claim for Category One Compensation to the Settlement Administrator using the Proof of Claim Form attached hereto as Exhibit 11. A single Proof of Claim Form may be used to submit multiple requests for Category One Compensation under this Agreement, provided adequate documentation concerning each of the affected Fee for Service Claims is included. Physician Groups and Physician Organizations may submit Proofs of Claim on behalf of Physicians employed by or otherwise working with them at the time that the claims are made, without the necessity of individual signatures from the individual Physicians; provided, however, the Class Member who or which submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization who or which originally submitted the claim and must use the same tax identification number as was used on the original claim when submitting the Proof of Claim. Any Proof of Claim Form originally postmarked more than one hundred eighty (180) days after commencement of the Claims Period shall not be a Valid Proof of Claim, and shall be denied by the Settlement Administrator. The Settlement Administrator shall mail notification to all Class Members whose Proofs of Claim are denied as untimely under this Section 8.3.c(1)(c)(i).

(ii) Class Members submitting Proof of Claim Forms for Category One Compensation shall include documentation with each Proof of Claim evidencing that they were denied payment for one or more Category One Codes pursuant to the table attached as Exhibit 1 hereto under the circumstances and within the date of service limitations (if any) set forth in Exhibit 1 hereto. A copy of the relevant CIGNA HealthCare's Remittance Form showing that payment was denied by CIGNA HealthCare for one or more Category One Codes under the circumstances and within the date of service limitations (if any) set forth in Exhibit 1 hereto shall constitute adequate documentation unless the Settlement Administrator determines that the records are false or fraudulent. Alternatively, for those items not asterisked on Exhibit 1, a copy of the Class Member's HCFA 1500 form (now known as the CMS 1500) or other claim form showing that Category One Codes were originally submitted to CIGNA HealthCare for payment under the circumstances and within the date of service limitations (if any) set forth in Exhibit 1 hereto shall also be accepted by the Settlement Administrator as constituting adequate documentation, unless the Settlement Administrator determines that the records are false or fraudulent. If a Class Member making application for payment certifies, in accordance with Section 8.3.c(1)(g), that the CIGNA HealthCare Remittance Form and the HCFA 1500 or other claim form cannot be located and are not available for submission, the Class Member may submit copies of internal accounting records (such as a printout of accounts receivable records or paid account records) with the Proof of Claim Form. Those records shall be accepted by the Settlement Administrator as constituting adequate documentation if those records show, as to the underlying Fee for Service Claim and specific date of service concerned, that Category One Codes were originally submitted to CIGNA HealthCare for payment under the circumstances (*e.g.*, in the specific combination(s) set forth in Exhibit 1 hereto) and within the date of service limitations (if any) set forth in Exhibit 1 hereto), and payment was denied as submitted, unless the Settlement Administrator determines that the records are false or fraudulent.

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(d) *Claims Supported by Inadequate Documentation; Resubmission to Settlement Administrator.*

If, in the judgment of the Settlement Administrator, a Class Member's Proof of Claim Form for Category One Compensation does not include adequate documentation under Section 8.3.c(1)(c), the Settlement Administrator shall notify the Class Member by mail that the Proof of Claim has been rejected (with identification of the reasons therefor). Said notice shall also state that the Class Member has the right to resubmit the Proof of Claim Form within thirty (30) days from the date the notice was mailed. The Class Member may thereafter resubmit the Proof of Claim Form in an effort to correct the deficiencies noted by the Settlement Administrator, provided that the Class Member's resubmission must be postmarked no later than thirty (30) days from the date on which the Settlement Administrator's notice of the deficiencies was mailed to the Class Member. If the Settlement Administrator still concludes that the Proof of Claim Form does not contain adequate documentation, then the Class Member's Proof of Claim shall not be deemed a Valid Proof of Claim, and no Category One Compensation shall be paid with respect to that Fee for Service Claim. The Settlement Administrator shall mail notification of this final determination to the Class Member submitting the Proof of Claim. If the Settlement Administrator determines that a Class Member's Proof of Claim Form for Category One Compensation is not a Valid Proof of Claim because the Class Member is seeking compensation for CPT® Codes or HCPCS Level II Codes which were provided outside the circumstances and/or date of service limitations specified in Exhibit 1 hereto, the notification of denial shall so state and shall indicate that the Class Member has the right to submit a Category Two Proof of Claim Form with regard to that Fee for Service Claim within thirty (30) days from the date the notification of denial was mailed.

(e) *Special Review Procedure for Certain Category One Compensation Requests.*

The Settlement Administrator shall provide copies to CIGNA HealthCare of all Proof of Claim Forms for Category One Compensation which, as to any single Category One Code, seek in excess of One Hundred Dollars ($100.00), within fourteen (14) days after receiving said Proof

of Claim Forms. Such a Proof of Claim shall not be accepted by the Settlement Administrator as a Valid Proof of Claim until thirty (30) days have elapsed from the date on which the Settlement Administrator provided a copy of that Proof of Claim Form to CIGNA HealthCare. Within the thirty (30) day notice period, CIGNA HealthCare shall have the right to provide the Settlement Administrator with a written objection to payment based on the Proof of Claim if CIGNA HealthCare's payment records indicate that the Fee for Service Claim to which the Proof of Claim relates has already been adjusted and fully paid on appeal or is a Resolved Claim; or that the Category One Codes in the Fee for Service Claim were denied for reasons other than the application of Claim Coding and Bundling Edits. CIGNA HealthCare shall include, with its written objection, copies of all payment records and/or litigation or settlement records or other records relied on for this purpose. Upon receipt of the written objection, the Settlement Administrator shall notify the Class Member by mail that the Category One Proof of Claim has been challenged by CIGNA HealthCare and the reasons therefor. The Settlement Administrator shall include, with the notification, copies of all documentation relied on by CIGNA HealthCare. Said notice shall also state that the Class Member has the right to submit additional documentation within thirty (30) days from the date the notice from the Settlement Administrator was mailed. The Class Member who submitted the Proof of Claim Form may, thereafter, submit additional information in order to rebut CIGNA HealthCare's objections concerning the Proof of Claim, provided that the Class Member's submission must be postmarked no later than thirty (30) days from the date of the Settlement Administrator's mailed notice regarding such Proof of Claim. The Settlement Administrator shall not accept any Proof of Claim that is the subject of an objection by CIGNA HealthCare pursuant to this Section as a Valid Proof of Claim if the Settlement Administrator determines that the Claim has already been adjusted and fully paid on appeal or is a Resolved Claim, or that the Claim to which the Proof of Claim relates was denied for reasons other than the application of Claim Coding and Bundling Edits. The Settlement Administrator shall determine whether the Class Member has submitted a Valid Proof of Claim

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based upon the Class Member's Proof of Claim Form, the payment records provided by CIGNA HealthCare, and any supplemental materials submitted by the Class Member after receiving a copy of CIGNA HealthCare's notice of objection under this provision. A Class Member whose Proof of Claim is denied after an objection by CIGNA HealthCare under this Section is entitled to notice of the denial and an opportunity for reconsideration in accordance with Section 8.3.c(1)(h). A Class Member whose Proof of Claim is determined to be a Valid Proof of Claim after an objection by CIGNA HealthCare under this Section shall receive payment on the Proof of Claim in accordance with Section 8.3.c(1)(h). If CIGNA HealthCare does not serve an objection within the time period permitted in this Agreement, the Settlement Administrator shall assume that the Fee for Service Claim has not been adjusted or fully paid on appeal and is not a Resolved Claim or a Fee for Service Claim denied for reasons other than the application of Claims Coding and Bundling Edits in determining whether the Proof of Claim shall be accepted as a Valid Proof of Claim.

(f) *Establishment of Controls by Settlement Administrator; Motion to Impose Additional Controls.*

The Settlement Administrator shall establish controls to ensure that payment of Category One Compensation is denied for Proof of Claim Forms that are duplicative of Proofs of Claim already submitted by Class Members and paid pursuant to this Agreement. A Proof of Claim Form that is duplicative of a Proof of Claim submitted by the same Class Member earlier shall not be deemed a Valid Proof of Claim and shall be denied by the Settlement Administrator. If, at any time, CIGNA HealthCare believes that the controls established by the Settlement Administrator to ensure against duplicative payments of Category One Compensation are inadequate, it shall have the right to move the Compliance Dispute Review Officer on an expedited basis for an order imposing additional controls. Any such motion shall be served on Notice Counsel as well as on the Settlement Administrator.

(g) *Certification Required by Class Members Making Category One Compensation Claims.*

No Proof of Claim for Category One Compensation may be accepted by the Settlement Administrator as a Valid Proof of Claim unless the Class Member signs the certification on the Proof of Claim Form indicating that: (i) the Category One Code(s) for which the Class Member is requesting payment describe services that were actually provided to a CIGNA HealthCare Member; (ii) the additional payment requested has not already been made by CIGNA HealthCare on resubmission of the Fee for Service Claim or on an appeal; and (iii) the Fee for Service Claim to which the Proof of Claim relates is not a Resolved Claim. If the Class Member billed the CIGNA HealthCare Member to whom services or supplies were provided for the amount not originally paid by CIGNA HealthCare, and if the CIGNA HealthCare Member reimbursed the Class Member for such amount, it is expected that the Class Member shall reimburse the CIGNA HealthCare Member with any amount paid pursuant to this Agreement. If a Class Member submits internal accounting records in support of a Category One Proof of Claim, the Class Member must also certify that the CIGNA HealthCare Remittance Form and the claim form originally submitted to CIGNA HealthCare cannot be located and are not available for submission.

(h) *Timing of Settlement Administrator's Decisions; No Further Review of Decisions By Settlement Administrator; Requests for Reconsideration.*

The Settlement Administrator shall use its best efforts to determine the validity of Proofs of Claim for Category One Compensation within thirty (30) days of their submission by Class Members, and shall make payments to a Class Member within fourteen (14) days of determining that his, her or its Proof of Claim is a Valid Proof of Claim. If the Settlement Administrator denies a Proof of Claim for Category One Compensation, the Settlement Administrator shall notify the Class Member by mail that the Proof of Claim has been rejected (with identification of the reasons therefore). Said notice shall also state that the Class Member has the right to have the Proof of Claim reconsidered within thirty (30) days from the date the notice was mailed. Decisions by the Settlement Administrator regarding Fee for Service Claims for Category One

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Compensation shall not be subject to External Review under this Agreement, and shall not be subject to review by the Court or by any other court or tribunal. Notwithstanding this provision, a Class Member shall have the right to have an adverse decision by the Settlement Administrator reconsidered, provided the request for reconsideration is postmarked within thirty (30) days of the date on which the Settlement Administrator mailed notification of its original denial decision to the Class Member. The Settlement Administrator's notices of rejection under this Section shall advise Class Members of this right of reconsideration. Upon reconsideration, if the Settlement Administrator maintains its denial of the Proof of Claim, the Settlement Administrator shall notify the Class Member of the denial and of the reasons for rejection of the Proof of Claim. An adverse decision by the Settlement Administrator upon reconsideration shall not be subject to further reconsideration by the Settlement Administrator or other form of review.

(2) *Category Two Compensation.*

(a) *In General.*

Except as provided below, upon the submission of timely and proper Proof of Claim Forms by affected Class Members, CIGNA HealthCare shall reconsider and, where appropriate or where they are directed to do so under this Agreement, make or fund additional payments to Class Members for denials of or reductions in payment resulting from the application of Claim Coding and Bundling Edits. Category Two Compensation shall not be available on any Proof of Claim for which Category One Compensation is available, and Category One Compensation shall be the exclusive remedy in such circumstances. However, Category Two Compensation shall be permissible, subject to the standards set forth in this Agreement, for any denials of Category One Codes that occurred outside the circumstances and/or date of service limitations (if any) identified on Exhibit 1. Denials of or reductions in payment for such CPT® Codes or HCPCS Level II Codes resulting from the application of payment and benefit limitations other than Claim Coding and Bundling Edits (*e.g.*, coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, limitations stemming from

capitation or other risk-bearing agreements with the Class Member submitting the Proof of Claim or with other health care providers) shall not be eligible for Category Two Compensation. Class Members seeking Category Two Compensation must make a timely and proper application for payment by submitting a Proof of Claim Form according to the procedures described in Section 8.3.e(2)(d) of this Agreement. There shall be no limit on CIGNA HealthCare's responsibility to make or fund payments under this provision to all Class Members who submit Valid Proofs of Claim for Category Two Compensation.

(b) *Computation of Payment Amounts.*

For Category Two Proofs of Claim deemed Valid Proofs of Claim relating to services or supplies delivered to CIGNA HealthCare Members less than one year before the commencement of the Claims Period, payment shall be made directly by CIGNA HealthCare at the CIGNA HealthCare Member's benefit amount (*i.e.*, the applicable fee schedule amount or reasonable and customary charge less the CIGNA HealthCare Member's required coinsurance payments, copayments, and deductible contributions, if applicable), and the Class Member shall be free to collect any applicable coinsurance payments, copayments, and deductible contributions directly from the CIGNA HealthCare Member to whom the services were provided. For Category Two Proofs of Claim deemed Valid Proofs of Claim relating to services or supplies delivered to CIGNA HealthCare Members more than one year before the commencement of the Claims Period, payment shall be made from the Claim Distribution Fund by the Settlement Administrator on the basis of the National Medicare Fee Schedule, without any deductions for the CIGNA HealthCare Member's coinsurance payments, copayments, and deductible contributions, and Class Members shall be prohibited from seeking further compensation from the CIGNA HealthCare Member or the CIGNA HealthCare Member's employer or employer plan on that Fee for Service Claim. With respect to the latter Proofs of Claim, where CIGNA HealthCare based its payment on a CPT® Code or HCPCS Level II Code other than the code(s) submitted by the Class Member, the Class Member's payment under this Agreement shall be the

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difference between the fee assigned to the paid code(s) according to the National Medicare Fee Schedule and the fee assigned to the submitted code(s) according to the National Medicare Fee Schedule.

(c) *Facilitation List for Category Two Compensation.*

In order to assist Class Members (i) in identifying Fee for Service Claims as to which CIGNA HealthCare denied payment for CPT® Codes 99201-99499 (CPT® Evaluation and Management Codes) due to the application of Claim Coding and Bundling Edits; (ii) in identifying Fee for Service Claims in which CIGNA HealthCare made payment on the basis of code 90769 (CIGNA HealthCare's so-called "well woman" benefit code); (iii) in identifying Fee for Service Claims in which Evaluation and Management Codes were billed with a procedure code and either code was denied payment; and (iv) in identifying Fee for Service Claims in which Evaluation and Management Codes were billed with add-on codes and either code was denied payment, CIGNA HealthCare shall use its best efforts to create an electronic Facilitation List. Depending on the nature of the Fee for Service Claim involved, the Facilitation List may be limited as to the time period covered, claims platforms or platforms from which payment was made or level of detail that can be provided. Subject to the foregoing, CIGNA HealthCare shall make the Facilitation List available to the Settlement Administrator within fourteen (14) days following Final Approval. The Settlement Administrator shall, within fourteen (14) days of the request of any Class Member, provide that Class Member with a printout or download of that portion of the Facilitation List, if any, pertaining to such Class Member's Fee for Service Claims for use in identifying candidate Fee for Service Claims for Category Two Compensation. The Settling Parties understand and agree that CIGNA HealthCare's obligation under this provision is limited to the use of its best efforts. CIGNA HealthCare shall not be required to warrant, and does not warrant, the completeness of the Facilitation List provided to the Settlement Administrator under this provision. The absence of any code from the Facilitation List shall not excuse any Class Member's noncompliance with the claims procedures in this Agreement or

afford any Class Member any right of action. Moreover, Class Members are not limited to the Facilitation List compiled by CIGNA HealthCare and are permitted to submit Proof of Claim Forms with respect to Fee for Service Claims that are not reflected in the Facilitation List generated by CIGNA HealthCare under this provision. The Settling Parties understand and agree that the Facilitation List created by CIGNA HealthCare under this provision will contain patient-identifiable medical privacy data; therefore, the Settlement Administrator is authorized to take, and shall take, whatever steps it deems necessary (including, but not limited to, requiring tax identification numbers, social security numbers or requiring other detailed identification from Class Members seeking a printout or download from the Facilitation List) in order to protect patient-identifiable medical privacy data from being made available to unauthorized recipients, including whatever steps are necessary to comply with all applicable laws and regulations.

(d) *Form of Application; Time Period for Submission; Documentation Required.*

(i) Class Members may submit Proofs of Claim for Category Two Compensation to the Settlement Administrator using the Proof of Claim Form attached hereto as Exhibit 12. A single Proof of Claim Form may be used to submit multiple requests for Category Two Compensation under this Agreement, provided adequate documentation concerning each of the affected Fee for Service Claims is included. Physician Groups and Physician Organizations may submit Proofs of Claim on behalf of Physicians employed by or otherwise working with them at the time that the claims are made, without the necessity of individual signatures from the individual Physicians; provided, however, the Class Member who or which submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization who or which originally submitted the claim and must use the same tax identification number as was used on the original claim when submitting the Proof of Claim. Any Proof of Claim Form originally postmarked more than one hundred eighty (180) days after the commencement of the Claims Period shall not be a Valid Proof of Claim and shall be denied

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by the Settlement Administrator. The Settlement Administrator shall send notification by mail to all Class Members whose Proofs of Claim are denied as untimely under this paragraph.

(ii) Except for those Proof of Claim Forms subject to Sections 8.3.c(2)(d)(iii) and 8.3.c(2)(d)(iv), Class Members submitting Proof of Claim Forms for Category Two Compensation shall include with each Proof of Claim Form: (a) documentation evidencing that, with respect to the underlying Fee for Service Claim concerned, (i) they were denied payment, in whole or in part; (ii) they received reduced payment, including payment for a different billing code than the one(s) billed, for one or more CPT® Code(s) or HCPCS Level II Code(s); or (iii) they received a reduced payment based upon the application of Multiple Procedure Logic; and (b) a complete copy of the Clinical Information generated in connection with the Class Members' services on the specific date of service concerned. A copy of the relevant CIGNA HealthCare Remittance Form showing that payment was denied on the CPT® Codes or HCPCS Level II Codes in question, in whole or in part, shall constitute adequate documentation for purposes of requirement (a) above unless the Settlement Administrator determines that the records are false or fraudulent. In the event that the Class Member cannot locate the CIGNA HealthCare Remittance Form applicable to a given Fee for Service Claim, the Class Member may submit copies of internal accounting records (such as printouts of accounts receivable records or paid account records) provided those records show, as to the underlying Fee for Service Claim and specific date of service concerned, all CPT® Codes or HCPCS Level II Codes which were submitted to CIGNA HealthCare for payment and those that remain unpaid, in whole or in part. If the Class Member's internal accounting records do not show all CPT® Codes or HCPCS Level II Codes which were submitted to CIGNA HealthCare for payment on the Fee for Service Claim in question, then the Class Member may supplement the internal accounting records with additional documentation for that Fee for Service Claim, such as the HCFA 1500 form (now known as CMS 1500).

(iii) A Class Member shall not be required to include

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Clinical Information with the documentation accompanying his, her or its Proof of Claim Forms if the Class Member is seeking reimbursement based on the contention that CIGNA HealthCare (a) failed to recognize modifiers 50, RT, LT, FA-F9, or TA-T9, and thus denied payment for one or more CPT® Codes as duplicative of other CPT® Codes reported; and/or (b) a HCPCS Level II "J" Code was translated into an incorrect or overbroad CPT® Code and, based on that incorrect translation, denied. However, for these Fee for Service Claims, the Class Member shall be required to submit a copy of the HCFA-1500 or other claim form used to submit the original Fee for Service Claim to CIGNA HealthCare showing the precise manner in which all services or supplies included in the Fee for Service Claim were originally billed to CIGNA HealthCare. Additionally, the Class Member must submit documentation showing that payment was denied, in whole or in part, for the CPT® Codes or HCPCS Level II Codes concerned. Such documentation may include a copy of the relevant CIGNA HealthCare Remittance Form or the Class Member's internal accounting records. If the Class Member is unable to show, through the above documentation, how the services or supplies were originally billed to CIGNA HealthCare (inclusive of the modifiers submitted with each CPT® Code or HCPCS Level II Code billed), then the Class Member may not submit the Proof of Claim under these special documentation exceptions, but instead shall be required to submit the Proof of Claim with the documentation required by Section 8.3.c(2)(d)(ii).

(iv) A Class Member shall not be required to include Clinical Information with the documentation accompanying his, her or its Proof of Claim Form when the Class Member is seeking reimbursement based on the contention that CIGNA HealthCare incorrectly processed one or more modifier 51 exempt CPT® Codes and/or add-on CPT® Codes using Multiple Procedure Logic when those codes were exempt from multiple procedure reduction. However, for these Fee for Service Claims, the Class Member shall be required to submit a copy of the documentation showing that payment was denied, in whole or in part, for the CPT® Codes concerned. Such documentation may include a copy of the relevant

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CIGNA HealthCare Remittance Form or the Class Member's internal accounting records. CIGNA HealthCare agrees to use reasonable efforts to determine whether it can compile a list of those modifier 51 exempt codes and add-on codes for which CIGNA HealthCare may have systematically applied Multiple Procedure Logic during the Class Period. To the extent such a list can be compiled, CIGNA HealthCare shall compile this list and make it available to the Settlement Administrator, with a copy to Notice Counsel. The Settlement Administrator shall make the list available to a Class Member within fourteen (14) days of a request for same.

(e) *Adequacy of Documentation.*

The Settlement Administrator shall use its best efforts to determine the adequacy of the documentation accompanying Proof of Claim Forms for Category Two Compensation within fourteen (14) days of the date of submission by the Class Member. If the Settlement Administrator determines that a Class Member's Proof of Claim Form for Category Two Compensation does not include adequate documentation, the Settlement Administrator shall notify the Class Member by mail that the Proof of Claim has been rejected (with identification of the reasons therefor). Said notice shall also state that the Class Member has the right to resubmit the Proof of Claim Form within thirty (30) days from the date the notice was mailed. The Class Member may thereafter resubmit the Proof of Claim Form in an effort to correct the deficiencies noted by the Settlement Administrator, provided that the Class Member's resubmission must be postmarked no later than thirty (30) days from the date on which the Settlement Administrator's notice of the deficiencies was mailed to the Class Member. If the Settlement Administrator still concludes that the Proof of Claim Form does not contain adequate documentation, then the Class Member's Proof of Claim shall not be a Valid Proof of Claim, and no Category Two Compensation shall be paid with respect to that Fee for Service Claim. The Settlement Administrator shall provide mailed notification of this determination, including the reasons therefor, to the Class Member submitting the Proof of Claim.

(f) *Certification Required by Class Members Making Category Two Compensation Claims.*

No Proof of Claim Form for Category Two Compensation shall be accepted by the Settlement Administrator for processing unless the Proof of Claim Form includes a certification by the submitting Class Member that: (i) the CPT® Code(s) or HCPCS Level II Code(s) for which the Class Member is requesting payment (or additional payment) describe services or supplies that were actually provided to a CIGNA HealthCare Member; (ii) the additional payment requested has not already been made by CIGNA HealthCare on resubmission of the Fee for Service Claim or on an appeal; and (iii) the Fee for Service Claim to which the Proof of Claim relates is not a Resolved Claim. If the Class Member billed the CIGNA HealthCare Member to whom services or supplies were provided for the amount not originally paid by CIGNA HealthCare, and if the CIGNA HealthCare Member reimbursed the Class Member for such amount, it is expected that the Class Member shall reimburse the CIGNA HealthCare Member with any amount paid pursuant to this Agreement. If a Class Member submits internal accounting records in support of a Category Two Proof of Claim, the Class Member must also certify that the CIGNA HealthCare Remittance Form and the claim form originally submitted to CIGNA HealthCare cannot be located and are not available for submission.

(g) *Submission to CIGNA HealthCare for Processing: Payment.*

Upon determining that a Class Member has made a timely Proof of Claim for Category Two Compensation, that the Proof of Claim Form contains all required information and documentation, and has been properly certified by the Class Member, the Settlement Administrator shall forward the Proof of Claim Form, within fourteen (14) days, to CIGNA HealthCare for processing. CIGNA HealthCare shall have thirty (30) days from the date that the Settlement Administrator transmits a Proof of Claim Form to CIGNA HealthCare to make a determination whether to approve or deny, in whole or in part, the Proof of Claim and to notify the Settlement Administrator of that determination.

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(i) *Approval of Category Two Claim by CIGNA HealthCare.*

In the event CIGNA HealthCare decides to approve a Category Two Proof of Claim relating to services or supplies delivered to CIGNA HealthCare Members less than one year before the commencement of the Claims Period, the Proof of Claim shall be deemed a Valid Proof of Claim and CIGNA HealthCare shall mail the additional payment required by Section 8.3.c(2)(b) to the Class Member within thirty (30) days of notifying the Settlement Administrator of its determination. In the event that CIGNA HealthCare decides to approve a Category Two Proof of Claim relating to services or supplies delivered to CIGNA HealthCare Members more than a year before the commencement of the Claims Period, the Proof of Claim shall be deemed a Valid Proof of Claim and the Settlement Administrator shall mail the additional payment required by Section 8.3.c(2)(b) within fourteen (14) days of receiving notice of CIGNA HealthCare's determination.

(ii) *Denial of Category Two Claim by CIGNA HealthCare.*

In the event CIGNA HealthCare decides to deny a Category Two Proof of Claim, it shall mail notification of that decision (with identification of the reasons therefor) to the Class Member at the same time it notifies the Settlement Administrator of the denial. Said notice shall state that the Class Member's Proof of Claim will automatically be forwarded for External Review. Where CIGNA HealthCare's denial is based on its judgment that the services or supplies denoted by the denied CPT® Codes or HCPCS Level II Codes were included in the CPT® Codes or HCPCS Level II Codes for which CIGNA HealthCare already made payment, or otherwise should not have been reported and paid separately according to reasonable and customary practice in the medical community, the Settlement Administrator shall automatically forward the denied Proof of Claim to the Independent Review Entity for External Review. Where CIGNA HealthCare's denial is based on any other determination (*e.g.*, that the Fee for Service Claim to which the Proof of Claim relates is a Resolved Claim, that the individual to

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whom the services or supplies were provided was not a CIGNA HealthCare Member at the time, etc.), the denied Proof of Claim shall be subject to automatic External Review by the Settlement Administrator.

(iii) *Category Two Claims Deemed Approved by CIGNA HealthCare.*

In the event CIGNA HealthCare does not provide notice to the Settlement Administrator of its determination with respect to a Class Member's Category Two Proof of Claim within thirty (30) days of transmission of such Proof of Claim to CIGNA HealthCare by the Settlement Administrator, the Settlement Administrator shall deem the Proof of Claim approved by CIGNA HealthCare such that it is a Valid Proof of Claim. The Settlement Administrator shall notify CIGNA HealthCare of its failure to act by mailing notice of the deemed approval to CIGNA HealthCare. Within fourteen (14) days of the deemed approval, payment shall be made to the Class Member pursuant to the terms set forth in Section 8.3.c(2)(b).

(h) *Procedure for External Review.*

(i) *Assembly of Review File.*

Upon denial of a Proof of Claim Form for Category Two Compensation, CIGNA HealthCare shall assemble documentation related to the Class Member's denied Proof of Claim (the "Review File"). CIGNA HealthCare shall forward the Review File to the Settlement Administrator within thirty (30) days of CIGNA HealthCare's denial. The Review File assembled shall consist, at minimum, of (i) copies of all records documenting prior CIGNA HealthCare payments on the Fee for Service Claim(s) for which the Class Member submitted a Proof of Claim; (ii) copies of all other documents prepared or obtained by CIGNA HealthCare in its initial review of the Proof of Claim Form; and (iii) if the Fee for Service Claim relates to services or supplies provided to a CIGNA HealthCare Member within the twelve (12) months preceding the date of commencement of the Claims Period, a computation of the CIGNA HealthCare Member's co-insurance and deductible responsibility, and how that CIGNA HealthCare Member responsibility would affect the Class Member's payment were the Proof of

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Claim approved as a Valid Proof of Claim. Upon receiving the Review File, the Settlement Administrator shall mail a copy of the same to the Class Member submitting the Proof of Claim and, where appropriate, the Settlement Administrator shall immediately transmit the Review File to the Independent Review Entity.

(ii) *Effect of CIGNA HealthCare's Failure to Assemble Review File.*

If CIGNA HealthCare fails to assemble and forward to the Settlement Administrator the Review File for a denied Proof of Claim within the time limits specified in this Agreement, the denied Proof of Claim shall be deemed approved and shall constitute a Valid Proof of Claim. The Settlement Administrator shall notify CIGNA HealthCare of its failure to act by mailing notice of the deemed approval to CIGNA HealthCare. Within fourteen (14) days of the deemed approval, payment shall be made to the Class Member pursuant to the terms set forth in Section 8.3.c(2)(b).

(iii) *Timing of Determinations.*

The Settlement Administrator or the Independent Review Entity, as appropriate, shall use its best efforts to complete External Review as to a Proof of Claim within thirty (30) days of receiving the Review File as to such Proof of Claim.

(iv) *Adjudication Standards for the Independent Review Entity.*

The Settlement Administrator shall automatically forward the Proof of Claim and Review File to the Independent Review Entity for all denials based upon Claim Coding and Bundling Edits.

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(A) *Proof of Claim Forms Respecting Alleged Non-Recognition of Certain Modifiers.*

A Class Member requesting review of CIGNA HealthCare's denial of a Proof of Claim regarding a Fee for Service Claim in which the Class Member asserts that CIGNA HealthCare failed to recognize modifier(s) 50, RT, LT, FA-F9, and TA-T9 and thus denied payment for one or more CPT® Codes shall be entitled to payment for such denied codes when, in the judgment of the Independent Review Entity, the Fee for Service Claim and/or Review File establish that (a) the CPT® Code(s) for which payment was denied were, at the time the services were delivered by the Class Member, appropriately performed and reported; (b) the Class Member originally submitted the Fee for Service Claim to CIGNA HealthCare with modifier 50, RT, LT, FA-F9, or TA-T9 appropriately appended to the denied CPT® Code(s); and (c) CIGNA HealthCare did not make payment on the denied CPT® Code(s) when the Class Member originally submitted the Fee for Service Claim, and has not, on resubmission of the Fee for Service Claim or on appeal, made appropriate payment on the CPT® Code(s) at issue.

(B) *Proofs of Claim Alleging Inappropriate Application of Multiple Procedure Logic.*

A Class Member requesting review of CIGNA HealthCare's denial of a Proof of Claim in which the Class Member asserts that CIGNA HealthCare inappropriately applied Multiple Procedure Logic to so-called modifier 51 exempt CPT® Codes and add-on CPT® Codes shall be entitled to an additional payment when, in the judgment of the Independent Review Entity, the Proof of Claim and/or Review File establish that (a) the CPT® Code(s) for which payment was reduced were, at the time the services were delivered by the Class Member, listed as exempt from modifier 51 or as add-on codes in CPT®; (b) CIGNA HealthCare made a reduced payment on such CPT® Code(s) through the application of Multiple Procedure Logic when it processed the Class Member's Fee for Service Claim originally; and (c) CIGNA HealthCare has not made additional payments on resubmission of the Fee for Service Claim or on appeal bringing the total amount paid on such CPT® Code(s) to the full fee schedule or benefit amount since the Fee for Service Claim was originally processed.

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(C) *Proofs of Claim Alleging Misinterpretation of HCPCS Level II J-Codes.*

A Class Member requesting review of CIGNA HealthCare's denial of a Proof of Claim in which the Class Member asserts that CIGNA HealthCare misclassified HCPCS Level II J-codes and therefore denied payment on such codes shall be entitled to payment for such denied codes when, in the judgment of the Independent Review Entity, the Proof of Claim and/or Review File establish that (a) the Fee for Service Claim originally submitted by the Class Member identified the specific HCPCS Level II J-code(s) for which the Class Member seeks Category Two Compensation; (b) CIGNA HealthCare made no payment on such HCPCS Level II J-code(s) when it processed the Class Member's Fee for Service Claim originally; and (c) CIGNA HealthCare has not, on resubmission of the Fee for Service Claim or on appeal, made appropriate payment on the HCPCS Level II J-codes at issue.

(D) *Claims Alleging Non-Payment of Separately Identifiable Services or Supplies.*

A Class Member shall be entitled to payment on a Proof of Claim regarding a Fee for Service Claim in which the Class Member asserts that CPT® Codes or HCPCS Level II Codes were billed to CIGNA HealthCare for services or supplies provided to a CIGNA HealthCare Member, that CIGNA HealthCare denied or reduced payment for such codes (including payment for a different billing code than the one(s) billed), and that such codes described services or supplies that were separately identifiable from services or supplies represented by CPT® Codes or HCPCS Level II Codes for which CIGNA HealthCare already provided reimbursement when, in the judgment of the Independent Review Entity, the Proof of Claim and/or Review File establish that (a) the Fee for Service Claim when originally submitted by the Class Member identified the specific CPT® Code(s) or HCPCS Level II Code(s) for which the Class Member seeks Category Two Compensation; (b) the CPT® Code(s) or HCPCS Level II Code(s) for which payment was denied and/or reduced described services or supplies that, at the time the services or supplies were delivered by the Class Member, were not, according to reasonable and

customary practice in the medical community, included in the services or supplies denoted by CPT® Code(s) or HCPCS Level II Code(s) for which payment was already made by CIGNA HealthCare; (c) CIGNA HealthCare made no payment or reduced payment on such CPT® Code(s) or HCPCS Level II Code(s) when it processed the Class Member's Fee for Service Claim originally; and (d) CIGNA HealthCare has not, on resubmission of the Fee for Service Claim or on appeal, made appropriate payment on the CPT® Code(s) or HCPCS Level II Code(s) at issue. For purposes of this section, any CPT® Code(s) or HCPCS Level II Code(s) that were, under the Correct Coding Initiative published and in effect at the time the services or supplies were provided by the Class Member, deemed not payable when billed in conjunction with the CPT® Code(s) for which CIGNA HealthCare already made payment to the Class Member, shall be deemed by the Independent Review Entity to fail to qualify for additional payment under this section, and the Class Member's Proof of Claim for Category Two Compensation shall be denied; provided, however, that if the specific edit included in the Correct Coding Initiative at the time the services or supplies were provided was removed from the Correct Coding Initiative within one year of the date of service, then the Independent Review Entity shall not consider that Correct Coding Initiative edit in adjudicating the Proof of Claim. Proofs of Claim for Category Two Compensation in which the Class Member seeks payment for a denied CPT® Evaluation and Management Code shall not be denied on the basis that the Class Member failed to submit the denied CPT® Evaluation and Management Code with a modifier.

(E) *External Review by Settlement Administrator.*

All Category Two Compensation Proofs of Claim denied for reasons other than Claim Coding and Bundling Edits shall be subject to External Review by the Settlement Administrator. When a Proof of Claim for Category Two Compensation that has been denied by CIGNA HealthCare on the ground that the Fee for Service Claim to which the Proof of Claim Form relates is a Resolved Claim is presented to the Settlement Administrator for External Review, the Settlement Administrator shall determine whether the Proof of Claim and Review File establish

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this ground for denial. A Class Member shall be entitled to payment on the Proof of Claim if the Settlement Administrator determines that the Fee for Service Claim to which the Proof of Claim relates is not a Resolved Claim. When a Proof of Claim for Category Two Compensation that has been denied by CIGNA HealthCare on any other ground is presented to the Settlement Administrator for External Review, the Settlement Administrator's sole undertaking shall be to determine, based on the Proof of Claim and Review File, whether CIGNA HealthCare's denial of the Fee for Service Claim to which the Proof of Claim relates was based on Medical Necessity grounds or experimental or investigational grounds or the result of the application of a Claim Coding and Bundling Edit. If the Settlement Administrator determines that CIGNA HealthCare's denial of the Claim to which the Proof of Claim relates was based on Medical Necessity grounds or experimental or investigational grounds or the result of the application of a Claim Coding and Bundling Edit, the Settlement Administrator shall forward the Proof of Claim and Review File to the Independent Review Entity, which shall thereupon conduct External Review as if the Proof of Claim had been presented to the Independent Review Entity originally. If the Settlement Administrator determines that CIGNA HealthCare's denial of the Fee for Service Claim to which the Proof of Claim relates was based on grounds other than Medical Necessity grounds or experimental or investigational grounds or a Claim Coding and Bundling Edit, the Proof of Claim shall be denied. The Settlement Administrator's denial of the Proof of Claim in these circumstances shall be without prejudice to the Class Member's rights, if any, to seek further payment on the Fee for Service Claim under the CIGNA HealthCare Member's Plan Documents.

(F) *Computation of Payment Amounts; Payment Procedure.*

If the Settlement Administrator decides on External Review that a Proof of Claim denied by CIGNA HealthCare is a Valid Proof of Claim, it shall so notify CIGNA HealthCare by mail and payment shall be made to the Class Member at the amount and in the manner required by Section 8.3.c(2)(b) within fourteen (14) days thereafter. If the Independent Review Entity

decides on External Review that a Proof of Claim denied by CIGNA HealthCare is a Valid Proof of Claim, it shall so notify the Settlement Administrator and CIGNA HealthCare by mail, and payment shall be made to the Class Member at the amount and in the manner required by Section 8.3.c(2)(b) within fourteen (14) days thereafter.

(G) *Finality of Decisions by Settlement Administrator and Independent Review Entity.*

When Proofs of Claim are denied on External Review, the Settlement Administrator shall notify the Class Members submitting such Proof of Claim by mail of the denials and of the reasons therefor. Decisions of the Settlement Administrator or Independent Review Entity, as appropriate, shall be final and not subject to review by the Court or any other court or tribunal. Neither the Settlement Administrator nor the Independent Review Entity shall entertain any requests for reconsideration of their decisions regarding Proofs of Claim for Category Two Compensation.

d. *Compensation for Erroneous Denials of Claims on Medical Necessity Grounds.*

(1) *In General.*

Upon the submission of timely and proper Proof of Claim Forms by affected Class Members, CIGNA HealthCare shall reconsider and, where appropriate or where it is directed to do so under this Agreement, make or fund additional payments to Class Members for Claims that were submitted to CIGNA HealthCare and denied, in whole or in part, on the grounds that the services or supplies delivered to the CIGNA HealthCare Members concerned were determined by CIGNA HealthCare to be either experimental or investigational or not Medically Necessary. (For purposes of this Section 8.3.d, "experimental or investigational" means services or supplies that, at the time they were delivered to a CIGNA HealthCare member were (a) neither approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the use to which they were put nor recognized for the treatment of the particular indication involved in one of the

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standard reference compendia (the United States Pharmacopoeia Drug Information or the American Hospital Formulary Service Drug Information) or in scientific studies published in peer-reviewed national professional medical journals; or (b) under review for the use to which they were put by an Institutional Review Board or similar entity at the licensed and accredited inpatient facility at which such services or supplies were or were intended to be delivered; or (c) the subject of an ongoing clinical trial that meets the definition of a Phase I, Phase II or Phase III Clinical Trial as set forth in FDA regulations, regardless of whether the trial is subject to FDA oversight; or (d) not demonstrated, through then-existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which they were used). In particular, except as provided below, CIGNA HealthCare shall make or fund additional payments to Class Members for Claims denied, in whole or in part, on Medical Necessity grounds or experimental or investigational grounds where (a) the Class Member's Clinical Information and/or the Class Member's notes of the patient's history and physical examination demonstrate to CIGNA HealthCare or the Independent Review Entity that services or supplies provided to a CIGNA HealthCare Member were, at the time the services or supplies were provided, Medically Necessary. Medical Necessity Denial Compensation shall be available under this Agreement only for those denials of payment for services or supplies represented by CPT® Codes or HCPCS Level II Codes based on CIGNA HealthCare's judgment that the services or supplies were not Medically Necessary or were experimental or investigational. Denials of such CPT® Codes or HCPCS Level II Codes resulting from the application of other payment and benefit limitations (e.g., coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the Proof of Claim or with other health care providers) shall not be eligible for Medical Necessity Denial Compensation. In addition, no Medical Necessity Denial Compensation shall be available where the services or supplies were excluded from coverage (other than under a general exclusion for cosmetic

services or supplies) under the CIGNA HealthCare Member's Plan Documents. Class Members seeking Medical Necessity Denial Compensation must make a timely and proper application for payment by submitting a Proof of Claim Form according to the procedures described in Section 8.3.d(3) of this Agreement. To assist Class Members in determining what types of Clinical Information to include with their Medical Necessity Denial Proofs of Claim, no later than fourteen (14) days after Final Approval, CIGNA HealthCare shall provide the Settlement Administrator and Class Counsel with information about the types of Clinical Information, by billing code, CIGNA HealthCare has traditionally required to be submitted for review in order to make Medical Necessity determinations. This information shall be made available to a Class Member by the Settlement Administrator within fourteen (14) days of the Class Member's request for same. There shall be no limit on CIGNA HealthCare's responsibility to make or fund payments to Class Members who submit a Valid Proof of Claim for Medical Necessity Denial Compensation. No compensation of any kind shall be available under this Section with respect to Resolved Claims.

(2) *Computation of Payment Amounts.*

For Medical Necessity Denial Proofs of Claim deemed Valid Proofs of Claim and relating to services or supplies delivered to CIGNA HealthCare Members less than one year before the commencement of the Claims Period, payment shall be made directly by CIGNA HealthCare at the CIGNA HealthCare Member's benefit amount (i.e., the applicable fee schedule amount or reasonable and customary charge less the CIGNA HealthCare Member's required coinsurance payments, copayments, and deductible contributions, if applicable), and the Class Member shall be free to collect any applicable coinsurance payments, copayments, and deductible contributions directly from the CIGNA HealthCare Member to whom the services were provided. For all other Medical Necessity Denial Proofs of Claim deemed Valid Proofs of Claim, payment shall be made from the Claim Distribution Fund by the Settlement Administrator on the basis of the National Medicare Fee Schedule, without any deductions for the CIGNA

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HealthCare Member's coinsurance payments, copayments, and deductible contributions, and Class Members shall be prohibited from seeking further compensation from the CIGNA HealthCare Member on that Fee for Service Claim.

(3) *Form of Application; Time Period for Submission; Documentation Required.*

(a) Class Members may submit Proofs of Claim for Medical Necessity Denial Compensation to the Settlement Administrator using the Proof of Claim Form attached hereto as Exhibit 13. A single Proof of Claim Form may be used to seek multiple requests for Medical Necessity Denial Compensation under this Agreement provided adequate documentation concerning each of the affected Fee for Service Claims is included. Physician Groups and Physician Organizations may submit Proof of Claims on behalf of Physicians employed by or otherwise working with them at the time that the claims are made, without the necessity of individual signatures from the individual Physicians; provided, however, the Class Member who or which submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization who or which originally submitted the claim and must use the same tax identification number as was used on the original claim when submitting the Proof of Claim. Any Proof of Claim originally postmarked more than one hundred eighty (180) days after commencement of the Claims Period shall not qualify as a Valid Proof of Claim and shall be denied by the Settlement Administrator. The Settlement Administrator shall send mailed notification to all Class Members whose Proofs of Claim are denied as untimely under this Section.

(b) Class Members filing Proofs of Claim for Medical Necessity Denial Compensation shall include with their Proof of Claim Forms: (a) documentation evidencing that they submitted Fee for Service Claims for payment to CIGNA HealthCare for services or supplies provided to a CIGNA HealthCare Member, and were thereafter denied payment for one or more CPT® Codes or HCPCS Level II Codes due to CIGNA HealthCare's determination that the medical services, procedures or supplies

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corresponding to such codes were either not Medically Necessary or were experimental or investigational; and (b) a complete copy of the Clinical Information generated in connection with the Class Member's services. A copy of the relevant CIGNA HealthCare Remittance Form showing that payment was denied for one or more CPT® Codes or HCPCS Level II Codes shall constitute adequate documentation for purposes of requirement (a) above unless the Settlement Administrator determines that the records are false or fraudulent. For purposes of the requirement set forth in (a) above, in the event that the Class Member cannot locate the CIGNA HealthCare Remittance Form applicable to a given Fee for Service Claim, the Class Member may submit copies of internal accounting records (such as printouts of accounts receivable records or paid account records) if those records show that the CPT® Codes or HCPCS Level II Codes in question were submitted to CIGNA HealthCare for payment and remain unpaid. For purposes of the requirement set forth in (b) above, the Class Member shall not be required to submit Clinical Information that relates to dates of service occurring more than ninety (90) days before the date of service at issue in the Proof of Claim. A Proof of Claim Form for Medical Necessity Denial Compensation that does not include the documentation required by (a) and (b) above does not contain adequate documentation and is subject to resubmission pursuant to Section 8.3.d(4).

(4) *Adequacy of Documentation.*

The Settlement Administrator shall use its best efforts to determine the adequacy of the documentation accompanying Proof of Claim Forms for Medical Necessity Denial Compensation within fourteen (14) days of the date of submission by the Class Member. If, in the judgment of the Settlement Administrator, a Class Member's Proof of Claim Form for Medical Necessity Denial Compensation does not include adequate documentation under this provision, the Settlement Administrator shall notify the Class Member by mail that the Proof of Claim has been rejected (with identification of the reasons therefor). Said notice shall also state that the Class Member has the right to resubmit the Proof of Claim Form within thirty (30) days

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from the date the notice was mailed. The Class Member may, thereafter, resubmit the Proof of Claim Form in an effort to correct the deficiencies noted by the Settlement Administrator, provided that the Class Member's resubmission must be postmarked no later than thirty (30) days from the date on which the Settlement Administrator's notice of the deficiencies was mailed to the Class Member. If the Settlement Administrator still concludes that the Proof of Claim Form does not contain adequate documentation, then the Class Member's Proof of Claim shall not be deemed a Valid Proof of Claim, and no Medical Necessity Denial Compensation shall be paid with respect to that Claim. The Settlement Administrator shall provide mailed notification of this determination to the Class Member submitting the Proof of Claim.

(5) *Certification Required by Class Members Filing Proof of Claim Forms for Medical Necessity Denial Compensation.*

No Proof of Claim for Medical Necessity Denial Compensation shall be accepted by the Settlement Administrator for processing unless the Proof of Claim Form includes a certification by the submitting Class Member that: (i) the CPT® or HCPCS Level II Code(s) for which the Class Member is requesting payment (or additional payment) describes services or supplies that were actually provided to a CIGNA HealthCare Member; (ii) the additional payment requested has not already been made by CIGNA HealthCare on resubmission of the Claim or on an appeal; and (iii) the Claim to which the Proof of Claim relates is not a Resolved Claim. If the Class Member billed the CIGNA HealthCare Member to whom services or supplies were provided for the amount not originally paid by CIGNA HealthCare, and if the CIGNA HealthCare Member reimbursed the Class Member for such amount, it is expected that the Class Member shall reimburse the CIGNA HealthCare Member with any amount paid pursuant to this Agreement. If a Class Member submits internal accounting records in support of a Medical Necessity Denial Proof of Claim, the Class Member must also certify that the CIGNA HealthCare Remittance Form and the claim form originally submitted to CIGNA HealthCare cannot be located and are not available for submission.

(6) *Submission to CIGNA HealthCare for Processing.*

Within fourteen (14) days after determining that a Proof of Claim for Medical Necessity Denial Compensation is timely, contains all required information and documentation, and includes the proper certification by the Class Member, the Settlement Administrator shall forward the Proof of Claim Form to CIGNA HealthCare for processing. CIGNA HealthCare shall have thirty (30) days from the date that the Settlement Administrator transmits a Proof of Claim Form to CIGNA HealthCare to make a determination whether to (a) approve the Proof of Claim; or (b) deny the Proof of Claim, in whole or in part, based on its judgment that the services or supplies addressed in the Proof of Claim were not Medically Necessary or were experimental or investigational; or (c) deny the Proof of Claim, in whole or in part, because the Fee for Service Claim to which the Proof of Claim relates was paid by CIGNA HealthCare on resubmission or on appeal; or (d) deny the Proof of Claim, in whole or in part, for any other reason (e.g., because the services or supplies addressed in the Proof of Claim were excluded from coverage under the CIGNA HealthCare Member's Plan Documents, because the Fee for Service Claim to which the Proof of Claim relates is a Resolved Claim, because the services or supplies addressed in the Proof of Claim were not supplied to a CIGNA HealthCare Member, because the services or supplies were delivered in violation of the CIGNA HealthCare Member's Plan Documents due to the CIGNA HealthCare Member's failure to obtain a referral or due to the Class Member's failure to obtain required preauthorization for a procedure, etc.). A judgment by CIGNA HealthCare that the services or supplies addressed in the Proof of Claim were excluded from coverage under the CIGNA HealthCare Member's Plan Documents because they were of a cosmetic nature shall, for purposes of this provision, be deemed a judgment that the services or supplies were not Medically Necessary.

(a) *Approval of Claim by CIGNA HealthCare.*

In the event that CIGNA HealthCare decides to approve a Proof of Claim for Medical Necessity Denial Compensation relating to services or supplies delivered to a CIGNA

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HealthCare Member less than one year before the commencement of the Claims Period, the Proof of Claim shall be deemed a Valid Proof of Claim and CIGNA HealthCare shall mail the additional payment required by Section 8.3.d(2) to the Class Member within thirty (30) days of notifying the Settlement Administrator of its determination. In the event that CIGNA HealthCare decides to approve a Proof of Claim for Medical Necessity Denial Compensation relating to services or supplies delivered to a CIGNA HealthCare Member more than one year before the commencement of the Claims Period, the Proof of Claim shall be deemed a Valid Proof of Claim and the Settlement Administrator shall mail the additional payment required by Section 8.3.d(1) within fourteen (14) days of receiving notice of CIGNA HealthCare's determination.

(b) *Denial of Claim by CIGNA HealthCare.*

In the event that CIGNA HealthCare decides to deny a Proof of Claim, it shall mail notification of that denial to the Settlement Administrator and to the Class Member submitting the Proof of Claim, with identification of the reasons for the denial. Said notice shall state that the Class Member's Proof of Claim will automatically be forwarded for External Review.

(c) *Deemed Approval of Claim by CIGNA HealthCare.*

In the event that CIGNA HealthCare does not provide notice to the Settlement Administrator of its determination with respect to a Class Member's Proof of Claim within thirty (30) days of the Settlement Administrator's transmission of such Proof of Claim to CIGNA HealthCare, the Settlement Administrator shall deem the Proof of Claim approved as a Valid Proof of Claim by CIGNA HealthCare. The Settlement Administrator shall notify CIGNA HealthCare of its failure to act by mailing notice of the deemed approval to CIGNA HealthCare. Within fourteen (14) days of the deemed approval, payment shall be made to the Class Member pursuant to the terms set forth in Section 8.3.d(1).

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(7) *Procedure for External Review.*

(a) *Assembly of Review File.*

If CIGNA HealthCare denies a Proof of Claim for Medical Necessity Compensation, CIGNA HealthCare shall assemble a Review File consisting, at minimum, of (i) a complete copy of the Class Member's Proof of Claim Form as submitted; (ii) copies of all records documenting prior CIGNA HealthCare payments on the Fee for Service Claim(s) with respect to which the Class Member submitted a Proof of Claim; (iii) copies of all other documents prepared or obtained by CIGNA HealthCare in its initial review of the Proof of Claim, including Plan Documents, if relevant; and (iv) if the Fee for Service Claim relates to services or supplies provided to a CIGNA HealthCare Member within the twelve (12) months preceding the date of commencement of the Claims Period, a computation of the CIGNA HealthCare Member's co-insurance and deductible responsibility and how that CIGNA HealthCare Member's responsibility would affect the Class Member's payment were the Proof of Claim approved. CIGNA HealthCare shall provide the Review File to the Settlement Administrator within thirty (30) days of CIGNA HealthCare's denial. Upon receiving the Review File, the Settlement Administrator shall mail a copy of the same to the Class Member submitting the Proof of Claim and, where appropriate, the Settlement Administrator shall immediately transmit the Review File to the Independent Review Entity.

(b) *Effect of CIGNA HealthCare's Failure to Assemble Review File.*

If CIGNA HealthCare fails to assemble and forward to the Settlement Administrator the Review File for a denied Proof of Claim within the time limits specified in this Agreement, the denied Proof of Claim shall be deemed approved as a Valid Proof of Claim. The Settlement Administrator shall notify CIGNA HealthCare of its failure to act by mailing notice of the deemed approval to CIGNA HealthCare. Within fourteen (14) days of the deemed approval, payment shall be made to the Class Member pursuant to the terms set forth in Section 8.3.d(1).

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(8) *Roles of Settlement Administrator and Independent Review Entity in External Review Process.*

Where CIGNA HealthCare's denial of a Proof of Claim for Medical Necessity Denial Compensation is based on its judgment that the services or supplies addressed in the Proof of Claim were not Medically Necessary or were experimental or investigational or that the Claim to which the Proof of Claim relates was fully paid by CIGNA HealthCare on resubmission or on appeal, External Review shall be performed by the Independent Review Entity. All other denials shall be subject to External Review by the Settlement Administrator, as hereinafter provided.

(a) *Timing of Determinations.*

The Settlement Administrator or the Independent Review Entity, as appropriate, shall use its best efforts to complete External Review as to a Proof of Claim within thirty (30) days of receiving the Review File as to such Proof of Claim.

(b) *Adjudication Standards.*

(i) *External Review by Independent Review Entity.*

A Class Member shall be entitled to payment on a Proof of Claim for Medical Necessity Denial Compensation when, in the judgment of the Independent Review Entity, the services or supplies were not experimental or investigational and the Proof of Claim and/or Review File establishes that (a) the CPT® Code(s) or HCPCS Level II Code(s) for which payment was denied described services or supplies that were Medically Necessary at the time the services or supplies were delivered by the Class Member; (b) the CPT® Code(s) or HCPCS Level II Code(s) for which payment was denied described services or supplies that, at the time the services or supplies were delivered by the Class Member, were not, according to reasonable and customary practice in the medical community, included in the services or supplies denoted by CPT® Code(s) or HCPCS Level II Code(s) for which payment was already made by CIGNA HealthCare; and (c) CIGNA HealthCare has not, on resubmission of the Fee for Service Claim or on appeal, already made appropriate payment on the denied CPT® Code(s) or HCPCS Level II Code(s).

(ii) *External Review by Settlement Administrator.*

When a Proof of Claim for Medical Necessity Denial Compensation that has been denied, in whole or in part, by CIGNA HealthCare on the ground that the Claim to which the Proof of Claim relates is a Resolved Claim is presented to the Settlement Administrator for External Review, the Settlement Administrator shall determine whether the Proof of Claim and Review File establish this ground for denial. A Class Member shall be entitled to payment on the Proof of Claim if the Settlement Administrator determines that the Fee for Service Claim to which the Proof of Claim relates is not a Resolved Claim. When a Proof of Claim for Medical Necessity Denial Compensation that has been denied by CIGNA HealthCare on any other ground is presented to the Settlement Administrator for External Review, the Settlement Administrator's sole undertaking shall be to determine, based on the Proof of Claim and Review File, whether CIGNA HealthCare's denial of the Fee for Service Claim to which the Proof of Claim relates was based on Medical Necessity grounds or experimental or investigational grounds or the result of the application of a Claim Coding and Bundling Edit. If the Settlement Administrator determines that CIGNA HealthCare's denial of the Fee for Service Claim to which the Proof of Claim relates was based on Medical Necessity grounds or experimental or investigational grounds or was the result of the application of a Claim Coding and Bundling Edit, the Settlement Administrator shall forward the Proof of Claim and Review File to the Independent Review Entity, which shall thereupon conduct External Review as if the Proof of Claim had been presented to the Independent Review Entity originally. If the Settlement Administrator determines that CIGNA HealthCare's denial of the Fee for Service Claim to which the Proof of Claim relates was based on grounds other than Medical Necessity grounds or experimental or investigational grounds or Claim Coding and Bundling Edit, the Proof of Claim shall be denied. The Settlement Administrator's denial of the Proof of Claim in these circumstances shall be without prejudice to the Class Member's rights, if any, to seek further payment on the Claim under the CIGNA HealthCare Member's Plan Documents.

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(9) *Computation of Payment Amounts.*

If the Settlement Administrator decides on External Review that a Proof of Claim denied by CIGNA HealthCare is a Valid Proof of Claim, it shall so notify CIGNA HealthCare by mail and payment shall be made to the Class Member at the amount and in the manner required by Section 8.3.d(2) within fourteen (14) days thereafter. If the Independent Review Entity decides on External Review that a Proof of Claim denied by CIGNA HealthCare is a Valid Proof of Claim, it shall so notify the Settlement Administrator and CIGNA HealthCare by mail, and payment shall be made to the Class Member at the amount and in the manner required by Section 8.3.d(2) within fourteen (14) days thereafter.

(10) *Finality of Decisions by Settlement Administrator and Independent Review Entity; Payment Procedure.*

When Proofs of Claim are denied on External Review, the Settlement Administrator shall notify the Class Members submitting such Proofs of Claim by mail of the denials and of the reasons therefor. Decisions of the Settlement Administrator or Independent Review Entity, as appropriate, shall be final and not subject to review by the Court or any other court or tribunal. Neither the Settlement Administrator nor the Independent Review Entity shall entertain any further requests for reconsideration of its decisions under this section.

8.4 *Procedure for Inquiry About Status of Proofs of Claim; Procedure for Requesting Facilitation List; Procedure for Requesting Medical Necessity Information.*

The Settlement Administrator shall establish procedures, to be described in the Notice of Commencement of the Claims Period, that (a) allow Class Members to inquire about the status of their Proofs of Claim; (b) allow Class Members to make requests, via telephone and/or e-mail, for copies of the Facilitation List available under Section 8.3.c(2)(c); and (c) allow Class Members to make requests, via telephone and/or e-mail, for copies of the information about the types of medical records, by billing code, CIGNA HealthCare has traditionally required to be submitted for review in order to make Medical Necessity determinations, available under Section 8.3.d(1).

8.5 *Submission to Jurisdiction of Court.*

Any Class Member submitting a Category A Claim or Proof of Claim Form for Category One Compensation, Category Two Compensation or Medical Necessity Denial Compensation shall, through the act of submitting that Proof of Claim Form, agrees to be subject to the jurisdiction of the Court for any related proceedings.

9. SETTLEMENT ADMINISTRATION

9.1 Notice Counsel and Defendants' Counsel have jointly selected Poorman-Douglas Corporation as the Settlement Administrator to carry out the terms of the Agreement and orders of the Court. The Settlement Administrator shall have the duties and responsibilities set forth elsewhere in this Agreement including without limitation Sections 5, 6.1 and 8 hereof and this Section 9.

9.2 Within sixty (60) days following the date of the entry of the Preliminary Approval Order, Notice Counsel and Defendants' Counsel shall jointly select the Independent Review Entity to carry out the terms of the Agreement and orders of the Court. The Independent Review Entity shall have the duties and responsibilities set forth in Section 8 hereof.

9.3 The Settling Parties, Class Counsel, Kaiser Counsel, and Defendants' Counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the investment of or distribution of the Category A Settlement Fund and the Claim Distribution Fund. Settling Parties, Class Counsel, Kaiser Counsel, and Defendants' Counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the determination, administration, calculation, or payment of Proofs of Claim from the Category A Settlement Fund or the Claim Distribution Fund (except as specifically described in this Agreement) or any losses incurred in connection therewith. Nothing in this section, however, shall prevent CIGNA HealthCare from receiving the reversion provided for in Section 8.3.b or enforcing the terms of the Agreement in order to protect its right to such reversion. The Billing Dispute Administrator (and its members and agents, if any), the Compliance Dispute Facilitator (and his agents, if any),

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the Internal Compliance Officer (and his agents, if any), the Clinical Information Officers, and the Compliance Dispute Review Officer (and his agents, if any) do not owe a fiduciary duty to the Class Members, the Plaintiffs, or CIGNA HealthCare. The Settling Parties shall ask the Court to grant the Billing Dispute Administrator, the Compliance Dispute Facilitator (and his agents, if any), the Internal Compliance Officer (and his agents, if any), the Clinical Information Officers, and the Compliance Dispute Review Officer (and his agents, if any) limited immunity from liability to the effect that the above-mentioned (and their members and agents, if any) shall be liable only for willful misconduct and gross negligence.

9.4 Administration Costs shall be paid by CIGNA HealthCare.

9.5 The escrow agent(s) with whom the Category A Settlement Fund and the Claim Distribution Fund are deposited shall invest the monies in those funds solely in interest bearing investments which the escrow agent(s) consider(s) to involve no substantial risk of payment of principal at maturity.

9.6 No Person shall have any cause of action against the Plaintiffs, Class Counsel, Kaiser Counsel, the Settlement Administrator, the Independent Review Entity, CIGNA HealthCare, the Released Persons, or Defendants' Counsel, including any counsel representing CIGNA HealthCare in connection with this Litigation, Compliance Dispute Review Officer, Compliance Dispute Facilitator, Clinical Information Officers, Medical Necessity External Review Organization, or Billing Dispute Administrator based on the administration or implementation of the Agreement or orders of the Court or based on the distribution of monies under the Agreement. In such circumstances, the sole remedy (other than those provided pursuant to the terms of the Agreement) is application to this Court for enforcement of the Agreement or order.

9.7 The Settlement Administrator shall make appropriate reports under Internal Revenue Code § 1099 with respect to all payments it makes to Class Members under this Agreement. CIGNA HealthCare shall make appropriate reports under Internal Revenue Code

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§ 1099 as to all payments of Category Two Compensation and Medical Necessity Denial Compensation it makes directly to Class Members. The Settlement Administrator shall file any tax returns necessary with respect to any income earned by the Foundation, the Category A Settlement Fund and the Claim Distribution Fund and shall pay, as and when legally required to do so, any tax payments (including interest and penalties) due on income earned by such Funds, and shall request refunds, when and if appropriate, and shall apply any such refunds that are issued to the appropriate Fund to become a part thereof.

9.8 When this Agreement requires mailed notification, other than notification undertaken pursuant to the Plan of Notice, the notification may be accomplished by transmitting the communication either by first-class mail or by electronic mail if an electronic mail address is available (for instance, if the Class Member has included an electronic mail address on a Proof of Claim Form), unless otherwise specifically set forth in this Agreement. Unless otherwise specified in this Agreement, the Settlement Administrator shall use its best efforts to send notification within fourteen (14) days of the event that requires notification.

9.9 At the conclusion of the settlement process, the Settlement Administrator shall provide a final accounting to Defendants' Counsel and Notice Counsel.

9.10 If a Class Member submits a Proof of Claim requesting compensation under the wrong compensation category (e.g., a request for Category Two Compensation which should have been submitted as a request for Category One Compensation), the Settlement Administrator shall automatically review the Proof of Claim under the provisions set forth herein for the correct compensation category unless the documentation submitted with said Proof of Claim is insufficient under those provisions.

10. THE JUDGMENT

If at or after the Fairness Hearing, the Agreement is approved by the Court, the Settling Parties shall jointly request that the Court enter the Final Order and Judgment attached as Exhibits 3 and 4.

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11. CLASS MEMBERS WITH ARBITRATION AGREEMENTS

For purposes of this Settlement only, CIGNA HealthCare waives its right as to Fee for Service Claims subject to Section 8 of this Agreement to require those Class Members with valid, enforceable arbitration provisions to arbitrate their claims against CIGNA HealthCare. Nothing in this Agreement shall preclude Class Members from challenging the enforceability of arbitration provisions in connection with disputes or claims not resolved by this Agreement, provided, however, that no Class Member may assert that by entering into this Agreement, CIGNA HealthCare has waived its right to compel arbitration of such disputes or claims.

12. CONDITION OF SETTLEMENT, EFFECT OF DISAPPROVAL, CANCELLATION, OR TERMINATION

12.1 If Final Approval does not occur, the terms and provisions of this Agreement shall have no further force and effect with respect to the Settling Parties and shall not be used for any other purpose. In that event, any Judgment or other order entered by the Court in accordance with the terms of this Agreement shall be treated as vacated *nunc pro tunc*. Both Notice Counsel and Defendants' Counsel agree that no further notice to the Class Members would be necessary under these circumstances. If, however, the Court finds it is in the best interests of Class Members to receive additional notice, then the Settling Parties agree that CIGNA HealthCare will pay for said notice. In the event of any termination pursuant to the terms hereof, the Settling Parties shall be restored to their original positions, except as expressly provided herein.

12.2 Either CIGNA HealthCare or Notice Counsel on behalf of Class Members may withdraw from this Agreement if the Court does not within a reasonable period of time after the Preliminary Approval Hearing enter a Preliminary Approval Order as to the Settlement that includes substantially all of the terms and conditions of this Agreement. Should either CIGNA HealthCare or Notice Counsel elect to withdraw from the Settlement pursuant to this Section 12.2, the terms of Section 12.1 shall take effect.

12.3 CIGNA HealthCare may, in its sole discretion, withdraw from the

Settlement if more than seven and one-half percent (7.5%) of the putative members of the Class, as identified on the Class List, elect to exclude themselves (Opt Out) of the Settlement. The percentage of the putative members of the Class requesting exclusion shall be determined by dividing the number of names on the Class List who have submitted a valid Opt Out request by the total number of names included on the Class List. Should CIGNA HealthCare elect to withdraw from the Settlement pursuant to this section, the terms of Section 12.1 shall take effect.

12.4 If the Court has not entered the Final Order and Judgment substantially in the form attached hereto as Exhibits 3 and 4 by the date that is one hundred eighty (180) calendar days after the date of the entry of the Preliminary Approval Order, Notice Counsel and CIGNA HealthCare may, in the sole and absolute discretion of each, terminate this Agreement by delivering a notice of termination to the other. Should either CIGNA HealthCare or Notice Counsel elect to withdraw from the Settlement pursuant to this Section 12.4, the terms of Section 12.1 shall take effect.

12.5 If Notice Counsel and Defendants' Counsel are unable to agree on the selection of the Independent Review Entity within the time constraints imposed by this Agreement, then Notice Counsel and Defendants' Counsel shall resolve the disagreement as a Compliance Dispute, or if the Compliance Dispute mechanism is not in place, they shall submit the disagreement to the Court for resolution.

12.6 If Notice Counsel object to the form of the initial disclosures prepared by CIGNA HealthCare pursuant to Section 7.2.a(3) and Notice Counsel and CIGNA HealthCare cannot resolve Notice Counsel's objections by negotiation, then Notice Counsel (on behalf of Class Members) or CIGNA HealthCare may elect to withdraw from the Settlement. If Notice Counsel or CIGNA HealthCare elects to withdraw from the Settlement pursuant to this section, then this Settlement shall become null and void and the terms of Section 12.1 shall take effect.

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13. RELEASE AND COVENANT NOT TO SUE

13.1 Upon Final Approval, the Releasing Parties and each of them shall hereby be deemed to have, and by operation of the Judgment shall have, fully, finally, and forever, remised, released, relinquished, compromised and discharged all Released Claims against each Released Person, whether or not any such Releasing Party submits any Proofs of Claim or otherwise seeks any payment under the terms of this Agreement.

13.2 The Releasing Parties and each of them agree and covenant not to sue or prosecute, institute or cooperate in the institution, commencement, filing, or prosecution of any suit on the basis of any Released Claim against any Released Person.

13.3 With respect to all Released Claims, the Releasing Parties and each of them agree that they are expressly waiving and relinquishing to the fullest extent permitted by law (a) the provisions, rights, and benefits conferred by Section 1542 of the California Civil Code, which provides:

> A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him must have materially affected his settlement with the debtor.

and (b) any law of any state or territory of the United States, federal law or principle of common law, or of international or foreign law, which is similar, comparable or equivalent to Section 1542 of the California Civil Code.

13.4 Notwithstanding the foregoing, the Releasing Parties are not releasing claims for payment (each a "Retained Claim" and, collectively, the "Retained Claims") for Covered Services provided to CIGNA HealthCare Members prior to or on the date of Final Approval as to which, as of Final Approval, (i) no claim with respect to such Covered Services has been filed with CIGNA HealthCare; provided that the contractual period for filing such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been filed with CIGNA HealthCare but such claim has not been finally adjudicated by CIGNA HealthCare. For purposes of clause (ii), above, final adjudication shall include completion of CIGNA

HealthCare's internal appeals process. In the event that a claim referred to in clause (ii) is finally adjudicated less than thirty (30) days prior to Final Approval, such claim shall constitute a Retained Claim if a Physician seeks relief under Section 7.10 not later than ninety (90) days after notice of such final adjudication, but otherwise such claim shall constitute a Released Claim. Retained Claims shall be resolved pursuant to the provisions of Section 7.10 of this Agreement.

13.5 Upon Final Approval and until the Termination Date, each Releasing Party shall be deemed to have covenanted and agreed not to sue with respect to, or assert, against any Released Person, in any other forum (i) any Retained Claim, (ii) any dispute subject to Section 7.12, or (iii) any Compliance Dispute, which respectively shall be asserted and pursued only pursuant to the provisions of Section 7.10, Section 7.12 and Section 15.2 of this Agreement (it being understood that this Section 13.5 shall not apply to any claims that arise within twenty (20) days before the Termination Date that could not reasonably be presented or resolved pursuant to the procedures set forth in Section 15; provided that any such claim shall be prosecuted on an individual basis only and not otherwise).

13.6 Nothing in this Agreement is intended to relieve any Person that is not a Released Person from responsibility for its own conduct or conduct of other Persons who are not Released Persons, or to preclude any Plaintiff from introducing any competent and admissible evidence to the extent consistent with this Agreement. Moreover, nothing in this Agreement prevents the Plaintiffs and the Class from pursuing claims to hold any person or party that is not a Released Person liable for damages caused by any Released Person.

13.7 Notwithstanding the foregoing, Releasing Parties shall retain the rights: (i) to enforce CIGNA HealthCare's obligations under Section 7.29.n pursuant to the procedures set forth in Section 15 of this Agreement; and (ii) to bring an action asserting claims against CIGNA HealthCare by or on behalf of Physicians to recover amounts alleged to be owed to such Physicians by any Physician Organization that has become insolvent, provided that no such action may be commenced or maintained against CIGNA HealthCare unless substantially all

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health plans or insurers who contracted with such Physician Organization and have not paid all amounts allegedly owed to health care providers with respect to such insolvent Physician Organization are named as defendants in addition to CIGNA HealthCare and further provided that in any such action CIGNA HealthCare may assert all available legal claims and defenses, including without limitation defenses based on the fraudulent conduct of such Physician Organization.

13.8 The Settling Parties agree that CIGNA HealthCare shall suffer irreparable harm if a Releasing Party takes action inconsistent with either Section 13.1, Section 13.2, or Section 13.5, and that in that event CIGNA HealthCare may seek an injunction from the Court as to such action without further showing of irreparable harm.

13.9 Nothing contained in this Agreement is intended, or shall be construed, to preclude any Settling Party from seeking legislative or regulatory changes as to matters addressed herein or from seeking to enforce any such changes using any available legal remedy.

14. ATTORNEYS' FEES, COSTS AND EXPENSES

14.1 Class Counsel shall petition the Court for attorneys' fees, costs and expenses not to exceed Fifty-Five Million Dollars ($55,000,000), including any attorneys' fees, costs and expenses of Kaiser Counsel for their representation of Physicians (collectively referred to hereafter as "Counsels' Award"). CIGNA HealthCare shall not oppose such petition. CIGNA HealthCare shall pay Counsels' Award as ordered by the Court, which shall be in addition to the other benefits conferred upon Class Members under the Settlement. If the Court were to order a Counsels' Award in excess of Fifty-Five Million Dollars ($55,000,000), Class Counsel and Kaiser Counsel, on behalf of themselves and the Class, hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The Counsels' Award agreed to be paid pursuant to this provision are in addition to and separate from all other consideration and remedies paid to and available to the Class Members. CIGNA HealthCare shall not be obligated to pay any attorneys'

fees or expenses incurred by or on behalf of any Releasing Party in connection with the Litigation, other than the payment of Counsels' Award in accordance with this Section.

14.2 At the Fairness Hearing, Class Counsel shall petition the Court for incentive awards in the amount of Seven Thousand Five Hundred Dollars ($7,500) for each Plaintiff for their services as Class Representatives Plaintiffs. CIGNA HealthCare shall not oppose this petition. If approved by the Court, CIGNA HealthCare shall pay these amounts over and above any other compensation contained in this Agreement.

14.3 If there is no appeal of the award of Counsels' Award, then within five (5) Business Days after Final Approval, CIGNA HealthCare shall pay Counsels' Award, plus any interest accrued thereon. The amount of fees, costs and expenses awarded by the Court shall be increased at the rate of six percent (6%) per annum (without compounding) during the period between (i) the thirtieth (30th) day following entry of the Judgment and (ii) the date of Final Approval. If there is an appeal of the Judgment and Settlement, CIGNA HealthCare agrees that, subject to the Court's approval, the amount of Counsels' Award ultimately awarded by the Court shall be increased at the rate of six percent (6%) per annum (without compounding) during the period of delay caused by the appeal, with that period being defined as the period between (i) the thirtieth (30th) day following entry of the Judgment, and (ii) the date of Final Approval. Payment shall be made by wire transfer to the Trust Account of the Law Office of Archie C. Lamb, L.L.C., for the benefit of Class Counsel and Kaiser Counsel. Reporting pursuant to Internal Revenue Code § 1099 shall identify Class Counsel and Kaiser Counsel as payees; each Class Counsel and Kaiser Counsel shall advise CIGNA HealthCare of the correct § 1099 reporting amounts applicable to her or his law firm.

14.4 If there is an appeal of the Judgment and Settlement, and this appeal delays Final Approval, CIGNA HealthCare agrees that (i) payments on all Valid Proofs of Claim for Category One Compensation, (ii) payments on all Valid Proofs of Claim for Category Two Compensation and (iii) payments on all Valid Proofs of Claim for Medical Necessity

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Compensation shall be increased by CIGNA HealthCare at the rate of six percent (6%) per annum (without compounding) during the period between (i) the thirtieth (30th) day following entry of the Judgment and (ii) the date of Final Approval.

14.5 If there is an appeal related solely to the Counsels' Award, CIGNA HealthCare agrees that, subject to the Court's approval, the amount of Class Counsel fees, costs and expenses ultimately awarded by the Court to Class Counsel, if any, shall be increased at the rate of six percent per annum (without compounding) during the period of delay caused by the appeal, with that period being defined as the period between (i) the thirtieth (30th) day following entry of the Judgment, and (ii) five (5) Business Days before payment of such fees, costs and expenses. Payment of such fees, costs and expenses shall occur within five (5) Business Days after the date of final dismissal of any appeal taken under Section 1.59.a(1), or the final dismissal of any proceeding or denial of *certiorari* to review such appeal.

14.6 As set forth in Section 1.59, an appeal related solely to the Counsels' Award shall not delay Final Approval, and in such event the Settling Parties shall proceed with implementation of this Agreement.

14.7 Any and all disputes related to the issue of the Counsels' Award, including but not limited to the allocation of that Award, or the incentive awards shall be resolved by the Court, and all parties agree that no other forum shall have jurisdiction over any such dispute.

15. COMPLIANCE PROVISIONS

15.1 *Internal Compliance Officer.*

CIGNA HealthCare will appoint a compliance officer (the "Compliance Officer"), responsible directly to its President, and any successor thereto, to monitor and report quarterly to the President on CIGNA HealthCare's compliance with this Agreement. CIGNA HealthCare may, at its sole discretion, select the Compliance Officer from among individuals currently or previously employed by CIGNA Corporation or any of its Subsidiaries, and the Compliance

Officer may bear other responsibilities to CIGNA Corporation or any of its Subsidiaries while discharging his or her responsibilities under this Agreement.

a. *Quarterly Report.*

The Compliance Officer shall establish effective mechanisms for monitoring compliance with this Agreement and correcting violations thereof, and shall issue a quarterly report to CIGNA HealthCare's President and to Notice Counsel covering the following areas:

(1) The Compliance Officer will examine a random sample of Physician contracts issued or modified in the prior quarter, which sample shall be drawn in such a way as to provide confidence that it is representative of the universe of such Physician contracts, and certify that they are compliant with the terms of this Agreement.

(2) The Compliance Officer will report the percentage of claims received in the quarter that have been processed within the time frames specified in this Agreement, and the quarter-to-quarter trend in such percentage.

(3) The Compliance Officer will examine a random sample of claims that were processed outside the time frames specified in this Agreement to ensure that the interest payable under the terms of this Agreement has been paid to the Class Members submitting such claims, and shall report on the results of this random sample.

(4) The Compliance Officer will report, in summary form, on all complaints by Class Members that CIGNA HealthCare has failed to comply with the terms of this Agreement, and on the resolution of such complaints.

(5) The Compliance Officer report will address the status of CIGNA HealthCare's best efforts to modify its claim processing systems and practices in accordance with this Agreement.

(6) The Compliance Officer report will address any other issues referred to the Compliance Officer by CIGNA HealthCare or Notice Counsel.

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b. *Annual Report.*

The Compliance Officer will render to CIGNA HealthCare's President and to Notice Counsel an annual report on the status of CIGNA HealthCare's compliance with the terms of this Agreement, including, with respect to instances of non-compliance, a statement of any corrective action being taken. The report shall address, at least, the following subjects with respect to the preceding year:

(1) Compliance with the processing timeliness requirements of this Agreement, including whether CIGNA HealthCare has failed to process at least ninety percent (90%) of claims within the timeframes specified by this Agreement during any continuous six (6) month period, and whether CIGNA HealthCare has failed to pay the interest required by this Agreement on the claims processed outside those timeliness requirements;

(2) Compliance with the terms of this Agreement regarding information to be included on Remittance Forms with respect to denials of claims, including any systematic noncompliance with such terms by any single CIGNA HealthCare claim processing facility.

(3) Compliance with the terms of this Agreement regarding disclosure of CIGNA HealthCare's Claim Coding and Bundling Edits and changes thereto, changes in fee schedules, CIGNA HealthCare's procedures for determining reasonable and customary provider charges, and other claim processing practices and procedures on CIGNA HealthCare's Website.

c. *Internal Monitoring Mechanisms.*

CIGNA HealthCare shall create such internal mechanisms for monitoring compliance and appoint such persons to assist the Compliance Officer as may be necessary to enable the Compliance Officer to carry out the tasks heretofore described. CIGNA HealthCare's President shall approve the compliance processes outlined in this Section and a description thereof shall be furnished to Notice Counsel.

d. *Term of Internal Compliance Mechanism.*

The Compliance Officer requirements set forth herein shall continue in place until the Termination Date.

15.2 *Compliance Disputes Arising Under This Agreement.*

a. *Jurisdiction.*

(1) *Compliance Dispute Facilitator.*

All Compliance Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel or any other binding or non-binding dispute resolution mechanism but to the Compliance Dispute Facilitator to be designated by Notice Counsel. CIGNA HealthCare shall publish on the Website the name and address of the Compliance Dispute Facilitator. The proposed Final Order and Judgment shall provide that no state or federal court or dispute resolution body of any kind shall have jurisdiction over any enforcement of Section 7 of this Agreement at any time, including without limitation through any form of review or appeal, except to the extent otherwise provided in this Agreement.

(2) *Compliance Dispute Review Officer.*

Pursuant to Sections 15.2.c(2) and 15.2.f and subject to Sections 15.2.d and 15.2.e, the Compliance Dispute Facilitator shall refer Compliance Disputes that satisfy the requirements of Section 15.2.c to the Compliance Dispute Review Officer for resolution. The Compliance Dispute Review Officer shall be agreed upon by Notice Counsel and Defendants' Counsel within thirty (30) days of the date of the entry of the Preliminary Approval Order. If the Compliance Dispute Review Officer is no longer able to serve in such role for any reason, then a replacement shall be chosen by mutual agreement of Notice Counsel and Defendants' Counsel.

(3) *Fees and Costs*

CIGNA HealthCare shall pay the reasonable hourly fees and costs of the Compliance Dispute Facilitator and the Compliance Dispute Review Officer.

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b. *Who May Petition the Compliance Dispute Facilitator.*

The following may petition the Compliance Dispute Facilitator (each a "Petitioner"):

(1) any Class Member who or which, based on particularized facts, contends that CIGNA HealthCare has materially failed to perform specific obligations under Section 7 of this Agreement, and that such Class Member is adversely affected by CIGNA HealthCare's failure to comply with such specific obligations under Section 7; and

(2) any Signatory Medical Society, so long as such Signatory Medical Society identifies in its petition to the Compliance Dispute Facilitator a Class Member who or which satisfies the requirements of Section 15.2.b(1) and brings the Compliance Dispute solely on behalf of such Class Member.

(3) Nothing in subsections (1) and (2) of this Section 15.2.b is intended or shall be construed to limit the remedies that the Compliance Dispute Review Officer may order pursuant to Section 15.2.f(4) hereof.

c. *Procedure for Submission, and Requirements, of Compliance Disputes.*

(1) *Compliance Dispute Claim Form.*

Before the Compliance Dispute Facilitator may consider a Compliance Dispute, a Petitioner must submit a properly completed Compliance Dispute Claim Form, attached hereto as Exhibit 14 and approved by the Court, to the Compliance Dispute Facilitator. The Compliance Dispute Claim Form may include supporting documentation or affidavit testimony. The Compliance Dispute Claim Form shall be made available by the Compliance Dispute Facilitator to Class Members upon request.

(2) *Qualifying Submissions.*

When the Compliance Dispute Facilitator is petitioned pursuant to Section 15.2.c(1) of this Agreement, in order for the Compliance Dispute Facilitator to refer the Compliance Dispute to the Compliance Dispute Review Officer, the Compliance Dispute Facilitator must determine that:

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(a) the Petitioner has satisfied the requirements of Section 15.2.b;

(b) the Petitioner has submitted a properly completed Petition not later than thirty (30) days after such Compliance Dispute arose;

(c) in the Compliance Dispute Facilitator's judgment, the Petitioner's Compliance Dispute is not frivolous;

(d) the Petitioner sufficiently alleges adverse impact to the Petitioner or, in the case of a Petitioner that is a Signatory Medical Society, the Class Member identified in the Submission and on whose behalf the Compliance Dispute is brought, in each case resulting from the alleged material failure by CIGNA HealthCare to comply with an obligation under Section 7 of this Agreement to the Petitioner;

(e) the Compliance Dispute cannot be easily resolved by the Compliance Dispute Facilitator without the intervention of the Compliance Dispute Review Officer; and

(f) the Compliance Dispute is not properly the subject of a proceeding pursuant to Section 7.10 or Section 7.11 or Section 7.12 of this Agreement.

If the Compliance Dispute Facilitator determines that the Petitioner's Compliance Dispute is properly the subject of an External Review proceeding pursuant to Section 7.10 or Section 7.11 or subject to a proceeding under Section 7.12 of this Agreement, the Compliance Dispute Facilitator shall expressly inform the Petitioner of the external review procedures available to such Petitioner.

d. *Rejection of Frivolous Claims.*

The Compliance Dispute Facilitator may reject as frivolous, and the Compliance Dispute Review Officer shall not hear, any Compliance Dispute that the Compliance Dispute Facilitator determines in his or her sole and absolute discretion to be frivolous, filed for nuisance purposes, or otherwise without merit on its face. The Compliance Dispute Facilitator may issue a written

explanation or a written order of the grounds for denial of Petitioner's Compliance Dispute. Petitioner shall have no right to appeal the Compliance Dispute Facilitator's decision.

e. *Dispute Resolution Without Referral to Compliance Dispute Review Officer.*

If in the Compliance Dispute Facilitator's judgment a Petitioner's Compliance Dispute can be resolved using available resources without the invocation of the Compliance Dispute Review Officer's authority, the Compliance Dispute Facilitator shall refer the Petitioner to the appropriate resources or otherwise assist in the resolution of the Petitioner's Dispute. All Settling Parties agree that dispute resolution without invocation of the Compliance Dispute Review Officer's authority is preferable, and all Settling Parties further agree to assist the Compliance Dispute Facilitator in these efforts.

f. *Procedure for Compliance Dispute Review Officer Determination of Compliance Disputes.*

(1) *Initial Negotiation.*

In the event the Compliance Dispute Facilitator has determined that the Compliance Dispute Review Officer should resolve a particular Compliance Dispute, the Compliance Dispute Facilitator shall notify the Compliance Dispute Review Officer, Petitioner and CIGNA HealthCare of such determination and the basis therefor. Unless the Petitioner specifies otherwise, the Compliance Dispute Facilitator shall serve as the Petitioner's representative in the Compliance Dispute process thereafter with respect to such Compliance Dispute. The Compliance Dispute Review Officer shall then direct the Petitioner and CIGNA HealthCare to convene negotiations at a time and place agreeable to both so that they may reach agreement on whether a breach of CIGNA HealthCare's obligations under Section 7 of this Agreement has occurred and, if so, what remedy, if any, should be implemented. At these negotiations, the Compliance Dispute Review Officer shall, if requested by both the Petitioner and CIGNA HealthCare, serve as a non-binding mediator. If the Petitioner and CIGNA HealthCare cannot resolve the Compliance Dispute within ninety (90) days of the date of the determination and

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notification by the Compliance Dispute Facilitator that the Compliance Dispute Review Officer should resolve the Compliance Dispute, then they shall so inform the Compliance Dispute Review Officer.

(2) *Memoranda to Compliance Dispute Review Officer.*

If the Compliance Dispute Review Officer has been notified pursuant to Section 15.2.f(1) that no agreement has been reached through negotiation, the Compliance Dispute Review Officer shall request written memoranda from the Petitioner and CIGNA HealthCare as to the merits of the Compliance Dispute and appropriate remedies for such Compliance Dispute. The Petitioner shall have fifteen (15) days from the date of the Compliance Dispute Review Officer's request to submit its memorandum and appropriate supporting exhibits, and CIGNA HealthCare shall respond within fifteen (15) days after CIGNA HealthCare's receipt of the Petitioner's memorandum and accompanying exhibits. Requests for extensions of time for the submission of such materials must be submitted to the Compliance Dispute Review Officer no less than five (5) days before the date the memoranda and supporting exhibits in question are due.

(3) *Oral Argument Concerning Compliance Dispute.*

The Petitioner or CIGNA HealthCare may, at the time of submission of the memoranda described in Section 15.2.f(2), request oral argument before the Compliance Dispute Review Officer on the subject of the Compliance Dispute and appropriate remedies, if any. If either so requests, the Compliance Dispute Review Officer shall hear such argument at a time and place convenient to the Compliance Dispute Review Officer, the Petitioner, and CIGNA HealthCare.

(4) *Decisions by the Compliance Dispute Review Officer.*

In resolving a Compliance Dispute, the Compliance Dispute Review Officer shall decide, based on the written submissions, oral argument and any other information that the Compliance Dispute Review Officer in his or her sole discretion deems necessary, whether CIGNA HealthCare has failed to comply with its obligations under Section 7 of this Agreement, and if so, direct what actions are to be taken by CIGNA HealthCare. In no event shall the Compliance

Dispute Review Officer direct that CIGNA HealthCare take actions above or beyond CIGNA HealthCare's obligations under Section 7 of this Agreement. The Compliance Dispute Review Officer must, at the time he or she announces his or her decision, issue a written opinion setting forth the basis of the decision.

(5) *Rehearing by the Compliance Dispute Review Officer.*

After the Compliance Dispute Review Officer has issued a written opinion in accordance with Section 15.2.f(4), the Petitioner or CIGNA HealthCare, or both; may petition the Compliance Dispute Review Officer within ten (10) days from receipt of the decision, in writing, for rehearing on the question of whether a Section 7 violation has occurred and whether the remedies (if any) required by the Compliance Dispute Review Officer are appropriate. The Compliance Dispute Review Officer may deny the petition for rehearing or issue a new written opinion after considering such a petition.

(6) *Systemic Violations.*

If the Compliance Dispute Review Officer determines that CIGNA HealthCare is engaged in a systemic violation of its obligations under Section 7 of this Agreement, then the Compliance Dispute Review Officer may order appropriate remedies to address such systemic violation.

(7) *Finality of the Compliance Dispute Review Officer's Decision.*

Upon the issuance of the Compliance Dispute Review Officer's decision after a rehearing, if any, the decision of the Compliance Dispute Review Officer shall be final unless appealed to the Court, and such decision shall not be appealed by the Petitioner or CIGNA HealthCare to any other federal court, any state court, any State Medical Society, any arbitration panel or any other binding or non-binding dispute resolution mechanism. In the event that the Petitioner or CIGNA HealthCare seeks review by the Court of a final decision of the Compliance Dispute Review Officer, the Court shall consider only whether the Compliance Dispute Review Officer's final decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with

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law," as defined by 5 U.S.C. § 706(2)(A), and whether the decision was contrary to or inconsistent with the second sentence of Section 15.2.f(4) of this Agreement. If and only if the Court finds the final decision was "arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law," or that the decision was contrary to or inconsistent with the second sentence of Section 15.2.f(4) of this Agreement, the Court may remand the Compliance Dispute to the Compliance Dispute Review Officer for further proceedings.

(8) *Enforcement by the Court.*

If the Compliance Dispute Review Officer certifies that either CIGNA HealthCare or the Petitioner is not in compliance with any decision issued or remedy ordered by the Compliance Dispute Review Officer, such Person shall have thirty (30) days from the date of such certification to cure the non-compliance. If after such thirty (30) day period, the Person is not in compliance and the Compliance Dispute Review Officer certifies that the Person has failed to cure the non-compliance during such thirty (30) day period, the other Person (CIGNA HealthCare or Petitioner, as the case may be) may petition the Court for enforcement.

16. STAY OF DISCOVERY AND TERMINATION

16.1 Until the Preliminary Approval Order has been entered, including the stay of discovery as to the Released Persons in the form contained therein, the Releasing Parties and Class Counsel covenant and agree that Class Counsel shall not pursue discovery against the Released Persons and shall not in any way subsequently argue that the Released Persons have failed to comply with their discovery obligations in any respect by reason of the Released Persons' suspension of discovery efforts following the Execution Date, except for authentication of CIGNA HealthCare's claims data bases and documents, with the understanding that Class Counsel will first seek to resolve any authentication issue through stipulation. There shall not be any stay of discovery from third parties because it may relate to CIGNA HealthCare or from Released Persons who are former employees of CIGNA HealthCare. However, CIGNA

HealthCare shall have the right to object to any discovery of third parties that relates solely to CIGNA HealthCare.

16.2 From and after Final Approval, the Releasing Parties and Class Counsel covenant and agree that the Releasing Parties and Class Counsel shall not pursue discovery against the Released Persons, except as stated above. Nothing contained herein shall preclude the Releasing Parties or Class Counsel from introducing and relying on otherwise admissible evidence as to other defendants.

16.3 Notwithstanding the definition of Final Approval set forth in Section 1.59 of this Agreement, if one or more notices of appeal are filed from the Final Order and Judgment, CIGNA HealthCare shall have the right, in its sole and absolute discretion, to provide notice that it shall thereafter be bound by this Agreement and the Settling Parties shall perform their respective obligations as if Final Approval had occurred. If the Final Order and Judgment are not affirmed in their entirety on any such appeal or discretionary review, CIGNA HealthCare may terminate this Agreement by delivering a notice of termination to Notice Counsel. If CIGNA HealthCare does not elect to so terminate this Agreement, CIGNA HealthCare shall be entitled, in its sole and absolute discretion, to provide notice to Notice Counsel that it shall be bound by the terms of this Agreement (if CIGNA HealthCare has not already done so pursuant to the first sentence of this Section) and the Settling Parties shall continue to be bound by this Agreement and shall perform their respective obligations hereunder as if the Final Order and Judgment had been affirmed in its entirety on such appeal or discretionary review.

16.4 This Agreement shall terminate (the "Termination Date") upon the earlier to occur of (i) termination of this Agreement by any Party pursuant to the terms hereof, and (ii) the four year anniversary of the date of the entry of the Preliminary Approval Order. Effective on the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability on the part of any of the Settling Parties, except for willful or knowing breaches of this Agreement prior to the time of such termination;

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provided that in the event of a termination of this Agreement as contemplated by clause (ii) of this Section 16.4, (A) the provisions of Sections 9.6, 13.1, 13.2, 13.4, 13.6, 13.7, 17.2, 17.3, 18 and 19.14 shall survive such termination indefinitely, (B) the provisions of Section 7.10 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Billing Disputes that are in the process of being resolved in the Billing Dispute External Review Process as of the date of such termination and any disputes described in Section 7.11 that are being resolved pursuant to the Medical Necessity External Review Process as of the date of such termination, (C) the provisions of Section 7.12 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Disputes that are in the process of being resolved in that process as of the date of such termination and (D) the provisions of Section 15.2.f shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Compliance Disputes that are in the process of being resolved by the Compliance Dispute Review Officer as of the date of such termination. In the event of termination of this Agreement as contemplated by clause (ii) of this Section 16.4, CIGNA HealthCare agrees to file as of the Termination Date a document (the "Certification") with the Compliance Dispute Review Officer enumerating the items described elsewhere in this Agreement as required elements of such Certification. CIGNA HealthCare shall provide a copy of such Certification to the members of the Physicians Advisory Committee. Upon the filing of the duly completed Certification by CIGNA HealthCare on the Termination Date, all of CIGNA HealthCare's obligations under this Agreement shall be satisfied. No decision or ruling of the Compliance Dispute Review Officer shall (except with respect to Clause "(D)" above) have any force on the Settling Parties after the Termination Date and CIGNA HealthCare shall be under no obligation to continue performance of any kind under this Agreement. CIGNA HealthCare may, in its sole and absolute discretion, elect to continue after the Termination Date the implementation of various business practices described in this Agreement.

17. RELATED PROVIDER TRACK ACTIONS

17.1 *Ordered Stays and Dismissals in Tag-Along Actions.*

As to any action brought by or on behalf of putative Class Members that asserts any claim that as of Final Approval would constitute a Released Claim against CIGNA HealthCare, other than the *Kaiser* or *Shane* actions, that has been, or will in the future, be consolidated with the Provider Track Actions under MDL Docket No. 1334 (the "Tag-Along Actions"), Plaintiffs, Class Counsel and CIGNA HealthCare shall cooperate to obtain an order of the Court, to be included in the Preliminary Approval Order, providing for the interim stay of all proceedings as to CIGNA HealthCare in each such action pending entry of the Final Order and Judgment, with respect to the claims that are Released Claims under this Agreement. In addition, no later than ten (10) Business Days after Final Approval, Plaintiffs, Class Counsel and CIGNA HealthCare shall jointly apply for orders from the Court dismissing each of the Tag-Along Actions with prejudice as to Released Claims against CIGNA HealthCare; provided that no such dismissal order shall be sought with respect to any Tag-Along Action with respect to any named plaintiff that has timely submitted an Opt Out request.

17.2 *Certain Related State Court Actions.*

As to any action in which at least one Class Counsel is counsel of record that is now pending, hereafter may be filed in or remanded to any state court that asserts any of the Released Claims against CIGNA HealthCare on behalf of any Class Member, Plaintiffs and Class Counsel agree that they will cooperate with CIGNA HealthCare, and file all documents necessary (a) to obtain an interim stay of all proceedings against CIGNA HealthCare in any such state court action and (b) on or promptly after Final Approval, to obtain the dismissal with prejudice of any such action to the extent that it asserts Released Claims as to CIGNA HealthCare, other than with respect to any named plaintiff that has timely submitted an Opt Out request.

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17.3 *Other Related Actions.*

As to any action not referred to in Sections 17.1 and 17.2 that is now pending or hereafter may be filed in any court that asserts any of the Released Claims against CIGNA HealthCare on behalf of any Class Member, Plaintiffs and Class Counsel agree that they will cooperate with CIGNA HealthCare, to the extent reasonably practicable, in CIGNA HealthCare's effort to seek relief from the Court or the forum court to obtain the interim stay and dismissal with prejudice of such action as to CIGNA HealthCare to the extent necessary to effectuate the other provisions of this Agreement.

18. NOT EVIDENCE; NO ADMISSION OF LIABILITY

The Settling Parties agree that in no event shall this Agreement, in whole or in part, whether effective, terminated, or otherwise, or any of its provisions or any negotiations, statements, or proceedings relating to it in any way be construed as, offered as, received as, used as or deemed to be evidence of any kind in *Kaiser* or *Shane* or in any other action, or in any judicial, administrative, regulatory or other proceeding, except in a proceeding to enforce this Agreement. Without limiting the foregoing, neither this Agreement nor any related negotiations, statements or proceedings shall be construed as, offered as, received as, used as or deemed to be evidence or an admission or concession of liability or wrongdoing whatsoever or breach of any duty on the part of CIGNA HealthCare, the Defendants or the Plaintiffs, or as a waiver by CIGNA HealthCare, the Defendants or the Plaintiffs of any applicable defense, including without limitation any applicable statute of limitations. None of the Settling Parties waives or intends to waive any applicable attorney-client privilege or work product protection or mediation privilege for any negotiations, statements or proceedings relating to this Agreement. The Settling Parties agree that this provision shall survive the termination of this Agreement pursuant to the terms hereof.

19. MISCELLANEOUS PROVISIONS

19.1 *Obligations Under Federal or State Law.*

Except as provided in this Agreement, nothing in this Agreement is intended to waive or supersede any rights that Physicians or Signatory Medical Societies may have under state or federal law or regulations.

19.2 *Application to Insured Plans and Self-Funded Plans.*

This Agreement applies to CIGNA HealthCare's conduct with respect to both Insured Plans and Self-Funded Plans, except where otherwise specified or as provided by applicable law.

19.3 *No Obligation to Facilitate Submission of Proofs of Claim.*

CIGNA HealthCare has no obligation under this Agreement to provide information to facilitate the submission of any Proof of Claim except as specifically set forth in this Agreement.

19.4 *Amendment or Modification of Agreement.*

This Agreement may be amended or modified only by a written instrument signed by or on behalf of all signatories to this Agreement (or their successors in interest) and approved by the Court. Beginning eighteen (18) months after Final Approval, in the event CIGNA HealthCare encounters a change in circumstances that will cause performance or maintenance of one or more provisions of this Agreement to become impractical, it will provide notice thereof to Lead Counsel with an explanation of the changed circumstances and the proposed change in the Agreement. For this purpose, "impractical" shall mean a change in circumstances that would place CIGNA HealthCare at a meaningful competitive disadvantage, or would make performance or maintenance unduly burdensome, or would, on account of new technology, make continued performance or maintenance inefficient or less cost-effective relative to use of the new technology. Within thirty (30) days of the date of such notice, counsel for CIGNA HealthCare and Notice Counsel will meet and confer regarding the proposed change and will attempt in good faith to reach an agreement thereon. In this process, CIGNA HealthCare and Notice Counsel

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will consider whether there is a more efficient way in which to fulfill the intent of the applicable aspect of the Agreement. If agreement is reached, CIGNA HealthCare and Notice Counsel will jointly apply to the Court for a modification of this Settlement Agreement. If within thirty (30) days after the date of the initial meeting of CIGNA HealthCare and Lead Counsel, agreement has not been reached, then CIGNA HealthCare may apply to the Court for a modification of this Settlement Agreement.

19.5 *Additional Signatory Medical Societies.*

Those additional medical societies desiring to become Signatory Medical Societies may do so by signing an agreement in the form attached hereto as Exhibit 15.

19.6 *Counterparts.*

This Agreement may be executed in one or more counterparts. All executed counterparts and each of them shall be deemed to be one and the same instrument. Class Counsel and Defendants' Counsel shall exchange among themselves original signed counterparts and a complete set of original executed counterparts shall be filed with the Court. If one or more Class Counsel or Kaiser Counsel, and/or one or more Class Representative Plaintiffs do not execute this Agreement, the Agreement shall be binding upon all signatories and shall nevertheless be presented to the Court for preliminary and final approval.

19.7 *Retention by Court of Jurisdiction.*

Without affecting the finality of the Final Order and Judgment entered in accordance with this Agreement, the Court shall retain exclusive jurisdiction with respect to the implementation and enforcement of the terms of this Agreement and all orders issued with respect to this Agreement. All Settling Parties submit to the jurisdiction of the Court for purposes of implementing and enforcing the Settlement embodied in this Agreement.

19.8 *Notices, Notice Counsel, and Implementation of Agreement.*

Any notice to the parties required to be given under the terms of this Agreement shall be given in writing to Notice Counsel (the persons listed below) and Defendants' Counsel. Notice Counsel are:

Archie C. Lamb, Jr.

Harley S. Tropin

Edith M. Kallas

These Class Counsel agree that they will promptly respond to any notice from CIGNA HealthCare, and they shall be responsible for informing CIGNA HealthCare of any decision by Class Counsel.

CIGNA HealthCare also agrees to provide all notices due under this Agreement to Debra Brewer Hayes.

Notices to Defendants' Counsel shall be submitted to:

John G. Harkins, Jr. Eleanor Morris Illoway Harkins Cunningham LLP 2800 One Commerce Square 2005 Market Street Philadelphia, PA 19103-7042	Marty L. Steinberg Hunton & Williams Mellon Financial Center 1111 Brickell Avenue, Suite 2500 Miami, FL 33131-3136

On behalf of CIGNA HealthCare, said counsel agree to respond promptly to any notice from Notice Counsel and shall be responsible for informing Notice Counsel of any decision by CIGNA HealthCare.

19.9 *Headings.*

The descriptive headings contained in this Agreement are for convenience of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

19.10 *Governing Law.*

This Agreement and all agreements, exhibits, and documents relating to this Agreement shall be construed under the laws of the State of Florida, excluding its choice of law rules.



19.11 *Entire Agreement.*

This Agreement, including its Exhibits, contains an entire, complete, and integrated statement of each and every term and provision agreed to by and among the Settling Parties; it is not subject to any condition not provided for herein. This Agreement supersedes any prior agreements or understandings, whether written or oral, between and among Plaintiffs, Class Members, Class Counsel, Kaiser Counsel, and CIGNA HealthCare regarding the subject matter of the Litigation or this Agreement. This Agreement shall not be modified in any respect except by a writing executed by all the Settling Parties or as provided in Section 19.4.

19.12 *No Presumption Against Drafter.*

None of the Settling Parties shall be considered to be the drafter of this Agreement or any provision hereof for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Agreement was drafted with substantial input by all Settling Parties and their counsel, and no reliance was placed on any representations other than those contained herein.

19.13 *Cooperation.*

Plaintiffs, Class Counsel and CIGNA HealthCare agree to move that the Court enter an order to the effect that should any Person desire any discovery incident to (or which the Person contends is necessary to) the approval of this Agreement, the Person must first obtain an order from the Court that permits such discovery.

19.14 *Successors and Assigns.*

The provisions of this Agreement shall be binding upon and inure to the benefit of the successors of the Settling Parties and shall be binding upon the assigns of the Class Members; provided that CIGNA HealthCare may not assign, delegate or otherwise transfer any of its rights or obligations under this Agreement without the consent of Notice Counsel.

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO. 1334
Master File No. 00-1334-MD-MORENO

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

THIS DOCUMENT RELATES ONLY TO:

KATHY TISKO, P.T.; DR. SCOTT J. ASHTON;
DR. C. PHILLIP BARNWELL; and DR. MICK MAHAN, on
behalf of a class of others similarly situated,

Plaintiffs,

v.

CIGNA CORPORATION and
CIGNA HEALTHCARE OF TEXAS, INC.,

Defendants.

Formerly Kaiser, et al. v. CIGNA Corporation, et al.

DR. ALLEN KNECHT; DR. LAVERNE A. SABOE, JR.; DR. DAVID MILROY; DR. AMY HOFFMAN; DR. ROBIN O'NEAL; HUBBARD HEALTH CLINIC, INC.; and INDEPENDENT CHIROPRACTIC PHYSICIANS, on behalf of a class of others similarly situated,

Plaintiffs,

v.

CIGNA; ANTHEM, INC.; HEALTH NET, INC.; HUMANA, INC.; HUMANA HEALTH PLAN, INC.; PACIFICARE HEALTH SYSTEMS, INC.; PRUDENTIAL INSURANCE COMPANY OF AMERICA; UNITED HEALTH GROUP; UNITED HEALTH CARE; COVENTRY HEALTH CARE, INC.; WELLPOINT HEALTH NETWORKS, INC.; AETNA, INC.; and AETNA-USHC, INC.,

Defendants.

DR. JEFFREY SOLOMON; DR. ORLAND ARMSTRONG; DR. ROBERT VRANES; AMERICAN PODIATRIC MEDICAL ASSOCIATION; FLORIDA CHIROPRACTIC ASSOCIATION; CALIFORNIA PODIATRIC MEDICAL ASSOCIATION; FLORIDA PODIATRIC MEDICAL ASSOCIATION; TEXAS PODIATRIC MEDICAL ASSOCIATION, for the individuals on behalf of themselves and on behalf of all others similarly situated, and for the associations in a representational capacity,

Plaintiffs,

v.

CIGNA; ANTHEM, INC.; HEALTH NET, INC.; HUMANA, INC.; HUMANA HEALTH PLAN, INC.; PACIFICARE HEALTH SYSTEMS, INC.; PRUDENTIAL INSURANCE COMPANY OF AMERICA; UNITED HEALTH GROUP; UNITED HEALTH CARE; COVENTRY HEALTH CARE, INC.; WELLPOINT HEALTH NETWORKS, INC.; AETNA, INC.; and AETNA-USHC, INC.,

Defendants.

SETTLEMENT AGREEMENT
AMONG CIGNA HEALTHCARE
AND HEALTHCARE PROVIDERS

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PREAMBLE:

This Settlement Agreement, dated this 9th day of December, 2004 (the "Agreement") is made and entered into by each of the Class Representative Plaintiffs in the above captioned actions (on behalf of themselves and each of the Class Members as hereafter defined), by and through their counsel of record in these actions, the Plaintiff Healthcare Provider Associations identified on the signature pages hereto and CIGNA Corporation (on behalf of those persons that are included in the definition of CIGNA HealthCare, including those Subsidiaries that are named as defendants in these actions) (all of the above being collectively referred to as the "Settling Parties"). This Agreement is intended by the Settling Parties to resolve, discharge and settle the Released Claims, fully, finally and forever according to the terms and conditions set forth hereafter.

WHEREAS:

A. On May 26, 2000, Timothy N. Kaiser, M.D. and Suzanne LeBel Corrigan, M.D. filed a class action lawsuit styled *Kaiser, et al. v. CIGNA Corporation, CIGNA HealthCare of St. Louis, Inc., and CIGNA HealthCare of Texas, Inc.* (Case No. 00-L-480), in the Circuit Court of Madison County, Illinois ("*Kaiser*").

B. On March 29, 2001, the Madison County Circuit Court certified a class consisting of:

> All physicians or health care Providers who, from May 26, 1990, to the present (1) executed a Preferred Provider Organization (PPO) fee-for-service agreement with CIGNA; (2) submitted claims for covered services and/or supplies pursuant to said agreement; and (3) whose claims were audited by CIGNA's ClaimCheck® computer software program prior to any payment. . . .

The Madison County Circuit Court appointed Timothy N. Kaiser, M.D. and Suzanne LeBel Corrigan, M.D. as class representatives and named, *inter alia*, Michael C. Dodge, David Dodge, Debra Brewer Hayes and Dennis Reich as Class Counsel.

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C. Pursuant to Orders of the Madison County Circuit Court, individual notice was sent, via first class U.S. mail, to potential members of the certified class. The opt-out period expired and the Madison County Circuit Court assumed jurisdiction over the members of the class certified on March 29, 2001 (excluding opt-outs).

D. Extensive discovery on the merits was conducted in *Kaiser*, including service of hundreds of requests for production of documents and interrogatories, review of hundreds of thousands of pages of documents, creation of a document depository consisting of tens of thousands of provider contract files, depositions of numerous employees of CIGNA HealthCare, and review and analysis of millions of computer claim files. In addition, experts were retained and consulted.

E. On April 22, 2002, in the Madison County Circuit Court, plaintiffs in the *Kaiser* action filed a "Motion For Leave To File Second Amended Class Action Complaint," proposing to make broader allegations against the defendants. On November 22, 2002, those plaintiffs filed their Third Amended Class Action Complaint in the Madison County Circuit Court alleging both state and federal causes of action. On November 25, 2002, the case was removed to the United States District Court for the Southern District of Illinois.

F. On November 25, 2002, the parties in the *Kaiser* action reached agreement on a settlement and on November 26, 2002, Chief Judge G. Patrick Murphy of the United States District Court for the Southern District of Illinois entered an order preliminarily approving the settlement, conditionally certifying a settlement class and directing notice and a hearing on the settlement.

G. On December 23, 2002, Chief Judge Murphy issued an order suspending proceedings with respect to the settlement pending a decision by the Judicial Panel on Multidistrict Litigation (the "Panel") as to whether the case should be transferred to the United States District Court for the Southern District of Florida. The Panel issued an order on February 21, 2003, transferring the *Kaiser* case to the United States District Court for the Southern District of Florida ("the Court"), to be consolidated with *In re Managed Care Litigation*, MDL No. 1334.

H. On May 8, 2003, plaintiffs in *Knecht, et al. v. Cigna, et al.*, Case No. 03-22138-CIV-Moreno filed a complaint in the United States District Court for the District of Oregon, originally Case No. 03-6109-AA (the "*Knecht* Action"), alleging claims by chiropractors against CIGNA and other defendants. The Panel issued an order on July 23, 2003 transferring the *Knecht* Action to the Court, to be consolidated with MDL 1334. Before transfer was effected, the *Knecht* plaintiffs filed their First Amended Complaint on May 27, 2003.

I. On October 17, 2003, plaintiffs in *Solomon, et al. v. CIGNA, et al.*, filed their class action complaint in the United States District Court for the Southern District of Florida, 03-22804, CIV-Jordon (the "*Solomon* Action"), alleging claims by all Healthcare Providers (as defined herein) against, among other defendants, CIGNA Corporation, setting forth claims similar to those alleged in the *Knecht* Action. The *Solomon* Action was transferred to Judge Federico A. Moreno on December 17, 2003 to be consolidated with *In re Managed Care Litigation*, MDL No. 1334.

J. Beginning in April, 2003, under supervision of the mediator appointed by the Court, settlement discussions were held by and among counsel in *Shane, et al. v. Humana Inc., et al.* ("*Shane*"), the lead case in the Provider Track of MDL 1334, counsel in *Kaiser* and counsel for CIGNA HealthCare. Those discussions resulted in the Settlement Agreement Among CIGNA HealthCare and Physicians (the "Physician Settlement"). That settlement applies to claims asserted by Physicians, Physician Groups and Physician Organizations (and all Persons claiming by or through them, such as Physicians' Assistants and Advanced Practice Registered Nurses) but does not include claims asserted by Healthcare Providers. Counsel in *Kaiser*, along with counsel in the *Knecht* Action and *Solomon* Action, continued separately to negotiate a settlement with respect to claims brought on behalf of the Class described herein.

K. On September 5, 2003, following a hearing to consider the proposed settlement among CIGNA HealthCare and Physicians, the Court preliminarily approved the settlement and certified a physician settlement class ("Physician Class") as follows:

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any and all Physicians, Physician Groups and Physician Organizations (and all Persons claiming by or through them, such as Physicians' Assistants and Advanced Practice Registered Nurses), who or which provided Covered Services to any CIGNA HealthCare member or any individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in the *Shane* complaint or by any of their respective current or former Subsidiaries from August 4, 1990 through the date of the entry of the Preliminary Approval Order; provided, however, that the Class shall not include any Physician who is or was an employee of a CIGNA HealthCare staff-model HMO at the time of providing such Covered Services.

The Court also vacated so much of Judge Murphy's Order of Preliminary Approval as applied to the class members under the proposed Physician Settlement.

L. A fairness hearing was held on December 18, 2003 with respect to the Settlement Agreement Among CIGNA HealthCare and Physicians and the Court subsequently approved the settlement and directed entry of a final judgment.

M. On December 13, 2004, the Third Amended Complaint in *Kaiser* was amended to clarify that the remaining claims in that action pertain to Healthcare Providers, to add additional plaintiffs and to change the caption to *Tisko, et al. v. CIGNA Corporation, et al.* Michael C. Dodge, David Dodge, Debra Brewer Hayes and Dennis Reich are counsel for plaintiffs in *Tisko*.

N. Following the fairness hearing regarding the Physician Settlement, counsel in *Tisko, Knecht* and *Solomon* have continued to negotiate a Healthcare Provider settlement with CIGNA HealthCare.

O. CIGNA HealthCare denies each and all of the material factual allegations and legal claims asserted by the members of the class certified by the Madison County Circuit Court, the members of the class in *Kaiser* and the putative members of the classes alleged in *Knecht* and *Solomon*, including any and all charges of wrongdoing or liability arising out of any of the conduct, statements, acts or omissions alleged in this Litigation. CIGNA HealthCare denies any liability to members of the class certified by the Madison County Circuit Court, the members of the class in *Kaiser* and the putative members of the classes alleged in *Knecht* and *Solomon* and is prepared to defend these lawsuits vigorously at trial. Additionally, CIGNA HealthCare

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maintains its contentions that the claims of many of the Class Members may not be advanced in this Litigation through trial by reason of valid and enforceable arbitration provisions. Neither this Agreement nor any act taken in furtherance of it shall constitute an admission of any fact, fault, liability or wrongdoing by any party or their respective counsel as more fully set forth hereafter.

P. The Plaintiffs and Class Counsel believe that the claims asserted against CIGNA HealthCare in this Litigation have merit and have considered the full value of these claims, including any interest that might be due. However, Plaintiffs and Class Counsel recognize and acknowledge the expense and length of continued proceedings that would be necessary to prosecute the Litigation against CIGNA HealthCare through trial and through appeals. Plaintiffs and Class Counsel have also taken into account the uncertain outcome and risks of any litigation, especially in complex actions such as this Litigation, as well as the difficulties and delays inherent in such litigation. Plaintiffs and Class Counsel are mindful of the inherent problems of proof under the various theories asserted in the Litigation and are further aware of, but disagree with, CIGNA HealthCare's claims in this Litigation regarding the need for individualized proof of injury and damages. Further, Plaintiffs and Class Counsel are aware that CIGNA HealthCare has sought to enforce arbitration clauses that could prohibit large numbers of Class Members from participating in the Litigation. Therefore, Plaintiffs and Class Counsel believe that the Settlement set forth in this Agreement confers substantial benefits upon the Class Members. Based upon their evaluation of all of these factors, Plaintiffs and Class Counsel have determined that this Settlement is in the best interests of the Plaintiffs and the Class Members, despite any disagreements Plaintiffs and Class Counsel may have with the averments made by CIGNA HealthCare.

NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED by the Settling Parties that, in consideration of the covenants, agreements and releases set forth herein, and subject to the approval of the Court and entry of the Order and Final Judgment after a Fairness Hearing, the Litigation as to CIGNA HealthCare shall be finally and fully compromised

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and settled, and the Litigation as to CIGNA HealthCare shall be dismissed with prejudice as to Plaintiffs and all Class Members, upon and subject to the following terms and conditions:

1. **DEFINITIONS**

As used in this Agreement and all exhibits to the Agreement, the following terms have the meanings specified.

1.01 "Administration Costs" means all fees and charges of the Settlement Administrator and other retained Persons incurred in connection with the administration of the Settlement, including the costs of processing and administering Claim Forms submitted by Class Members and the costs of establishing, processing and administering the Settlement Fund.

1.02 "Agreement" means this Settlement Agreement, inclusive of all exhibits hereto.

1.03 "Assignment of Benefits" or "Assignment" means an authorization by a CIGNA HealthCare Member provided to a Non-Participating Healthcare Provider who has rendered Covered Services to said CIGNA HealthCare Member allowing at the discretion of, but not requiring, said Non-Participating Healthcare Provider to seek payment for such services directly from CIGNA HealthCare to the extent allowed under the terms of the CIGNA HealthCare Member's Plan Documents.

1.04 "Base Amount" means the minimum amount of compensation from the Settlement Fund to which a Class Member may be entitled to be determined in accordance with Section 8.1.

1.05 "Billing Dispute" shall have the meaning assigned to that term in Section 7.10.a of this Agreement.

1.06 "Billing Dispute Administrator" shall have the meaning assigned to that term in Section 7.10.c of this Agreement.

1.07 "Billing Dispute External Review Process" shall have the meaning assigned to that term in Section 7.10.a of this Agreement.

1.08 "Billing Dispute Form" shall have the meaning assigned to that term in Section 7.10.b of this Agreement. The Billing Dispute Form is attached hereto as Exhibit 12.

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[redacted]

1.09 "Business Day" means any day on which commercial banks are open for business in New York City. Any other reference to "day" shall mean a calendar day.

1.10 "Certification" shall have the meaning assigned to that term in Section 16.4 of this Agreement.

1.11 "CIGNA HealthCare" means Defendants CIGNA Corporation and CIGNA HealthCare of Texas, Inc., and any and all of their divisions, Subsidiaries (whether direct or indirect), directors, officers, employees, administrators, representatives, or parents, together with each such individual's or entity's predecessors and successors, that are involved in the health insurance or health benefits administration business, including, but not limited to, CIGNA Holdings, Inc., Connecticut General Corporation, Connecticut General Life Insurance Company, CIGNA Health Corporation, Healthsource, Inc., Healthsource Corporate Services, Inc., Healthsource Innovative Medical Management, Inc., Healthsource Health Plans, Inc., CIGNA HealthCare of North Carolina, Inc., Healthsource North Carolina, Inc., Healthsource Indiana, Inc., Healthsource Indiana Insurance Company, Healthsource Indiana Managed Care Plan, Inc., Healthsource Insurance Group, Inc., Healthsource Kentucky, Inc., Healthsource Maine, Inc., Healthsource Maine Preferred, Inc., Healthsource Management, Inc., Healthsource Syracuse, Inc., Healthsource HMO of New York, Inc., Healthsource Preferred of New York, Inc., CIGNA HealthCare of Tennessee, Inc., Healthsource Tennessee Preferred, Inc., CIGNA HealthCare of Massachusetts, Inc., Healthsource Metropolitan New York Holding Company, Inc., Healthsource New York/New Jersey, Inc., Healthsource New Hampshire, Inc., Healthsource Ohio Preferred, Inc., Healthsource Preferred, Inc., Healthsource Rhode Island, Inc., Healthsource South Inc., CIGNA HealthCare of Georgia, Inc., Healthsource Arkansas Ventures, Inc., Healthsource Arkansas, Inc., Healthsource Arkansas Preferred, Inc., Healthsource Insurance Company, Physicians' Health Systems, Healthsource Insurance Services, Inc., Healthsource South Carolina, Inc., Arizona Health Plan, Inc., CIGNA HealthCare Mid-Atlantic, Inc., CIGNA HealthCare of Arizona, Inc., CIGNA Community Choice, Inc., CIGNA HealthCare of California, Inc., CIGNA HealthCare of Colorado, Inc., CIGNA HealthCare of Connecticut, Inc., CIGNA HealthCare of

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Delaware, Inc., CIGNA HealthCare of Florida, Inc., CIGNA HealthCare of Illinois, Inc., CIGNA HealthCare of St. Louis, Inc., CIGNA Healthplan of Louisiana, Inc., CIGNA HealthCare of New Jersey, Inc., CIGNA HealthCare of New York, Inc., CIGNA HealthCare of Ohio, Inc., CIGNA HealthCare of Oklahoma, Inc., CIGNA HealthCare of Pennsylvania, Inc., CIGNA HealthCare of Puerto Rico, Inc., CIGNA HealthCare of Utah, Inc., CIGNA HealthCare of Virginia, Inc., Lovelace Health Systems, Inc., Ross Loos Hospital, Inc., International Rehabilitation Associates, Inc., and CIGNA Behavioral Health, Inc.

1.12 "CIGNA HealthCare Member" means any individual who receives health care benefits that are insured and/or administered by CIGNA HealthCare.

1.13 "Claim" means an application by a Class Member for compensation under the terms of this Agreement, submitted in the manner described in the Notice, which application satisfies all applicable requirements set forth in Section 8.1 of this Agreement.

1.14 "Claim Form" means the form, substantially in the form of Exhibit 8 to this Agreement, to be used by Class Members in seeking compensation under this Agreement.

1.15 "Claim Coding and Bundling Edits" means adjustments to CPT® Codes or HCPCS Level II Codes included in claims in which (a) CIGNA HealthCare's payment is or was based on some, but not all, of the CPT® Codes or HCPCS Level II Codes included in the claim; (b) CIGNA HealthCare's payment was based on different billing codes than those billed to CIGNA HealthCare; (c) CIGNA HealthCare's payment for one or more CPT® Codes is or was reduced by application of Multiple Procedure Logic; or (d) any combination of the above.

1.16 "Claims Period" means the one hundred twenty (120) day period during which Class Members may make requests for payment under the terms of Section 8 of this Agreement. The Claims Period commences five (5) Business Days after the Notice Date.

1.17 "Class" means any and all Healthcare Providers, Healthcare Provider Groups and Healthcare Provider Organizations (and all Persons claiming by or through them) who or which provided Covered Services to any CIGNA HealthCare Member or any individual enrolled in or covered by a plan offered or administered by any Persons named as defendants in the *Knecht*

Action and *Solomon* Action or by any of their respective current or former Subsidiaries from January 1, 1990 through the date of the entry of the Preliminary Approval Order; provided, however, that the Class shall not include a) hospitals or facilities; b) laboratories; c) any member of the Physician Class and any Person who or which opted out of the Physician Class; d) suppliers of medical equipment who or which do not provide health care services along with their provision of medical equipment or do not bill separately for health care services with their provision of medical supplies; and e) any Healthcare Provider who is or was an employee of a CIGNA HealthCare staff-model HMO at the time of providing such Covered Services.

1.18 "Class Counsel" means Michael C. Dodge, David Dodge, Debra Brewer Hayes and Dennis Reich on behalf of plaintiffs in *Tisko* and JoBeth Halper and Andrew S. Friedman on behalf of plaintiffs in *Knecht* and *Solomon*.

1.19 "Class List" means the list of putative Class Members used for purposes of distributing notice of this Litigation and Settlement pursuant to the Plan of Notice.

1.20 "Class Members" means all Healthcare Providers, Healthcare Provider Groups and Healthcare Provider Organizations who or which fall within the definition of the Class, who or which have not timely and validly exercised their right to Opt Out pursuant to the Notice, and who or which are therefore bound by the terms of this Agreement and the Final Judgment.

1.21 "Class Period" means the period from January 1, 1990 through the date of the Final Approval.

1.22 "Class Representatives" or "Class Representative Plaintiffs" means collectively, to the extent each executes this Agreement, Kathy Tisko, P.T., Scott J. Ashton, D.P.M., C. Phillip Barnwell, D.C., Mick Maban, D.C., Dr. Allen Knecht, Dr. LaVerne A. Saboe, Jr., Dr. David Milroy, Dr. Amy Hoffman, Dr. Robin O'Neal, Hubbard Health Clinic, Inc., Dr. Jeffrey Solomon, Dr. Orland Armstrong, and Dr. Robert Vranes.

1.23 "Clinical Information" means clinical, operative or other medical records and reports kept in the ordinary course of a Healthcare Provider's business, and, where applicable, requested statements of medical necessity.

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1.24 "Clinical Information Dispute Review Form" means a document in the form attached hereto as Exhibit 11.

1.25 "Clinical Information Officer" shall have the meaning assigned to that term in Section 7.12 of this Agreement.

1.26 "CMS" means the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration).

1.27 "CMS 1500" means the health care provider claim form number 1500 created by CMS (and taking the place of HCFA 1500 forms), and as it may be amended, modified or superseded thereafter during the term of this Agreement.

1.28 "Complaints" means the Fourth Amended Class Action Complaint in *Tisko* filed contemporaneously with this Settlement Agreement, the Amended Complaint filed in *Knecht* and the Complaint filed in *Solomon*.

1.29 "Compliance Dispute" means (i) any claim that CIGNA HealthCare has failed to carry out any of its obligations under Section 7 of this Agreement (with the exception of Section 7.29.f); provided, however, that none of the following shall be deemed a Compliance Dispute: (A) a Released Claim; (B) a Retained Claim; (C) a claim eligible to be a Billing Dispute under Section 7.10 (except for a claim that a CIGNA HealthCare Claim Coding and Bundling Edit is inconsistent with Section 7.20 of this Agreement); (D) a claim subject to Section 7.12 of this Agreement; (E) a claim for which the Medical Necessity External Review Process is available; or (F) a claim challenging a Medical Necessity determination arising out of administration of benefits for a Self-Funded Plan as to which the plan sponsor has not elected to participate in CIGNA HealthCare's Medical Necessity External Review Process.

1.30 "Compliance Dispute Claim Form" means a document in the form attached hereto as Exhibit 13.

1.31 "Compliance Dispute Facilitator" means the person chosen pursuant to Section 15.2.a(1) of this Agreement who shall first hear Compliance Disputes.

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1.32 "Compliance Dispute Review Officer" means the person chosen pursuant to Section 15.2.a(2) of this Agreement and charged with the resolution of Compliance Disputes under this Agreement.

1.33 "Counsels' Award" shall have the meaning assigned to that term in Section 14.1 of this Agreement.

1.34 "Court" shall have the meaning assigned to that term in WHEREAS Clause G of this Agreement.

1.35 "Covered Service" means a health care benefit that is within the coverage described in the Plan Documents applicable to an eligible CIGNA HealthCare Member.

1.36 "Current Procedural Terminology" ("CPT®" or "CPT® Codes") means medical nomenclature published by the American Medical Association containing a systematic listing and coding of procedures and services provided to patients by Physicians and Healthcare Providers. When used herein, "CPT®" and "CPT® Codes" refer to such medical nomenclature as it exists as of the date of this Agreement and as it may be amended, modified or superseded thereafter during the term of this Agreement.

1.37 "Defendants" means CIGNA Corporation and CIGNA HealthCare of Texas, Inc.

1.38 "Defendants' Counsel" means: John G. Harkins, Jr. and Eleanor Morris Hilloway (Harkins Cunningham); and Marty L. Steinberg (Hunton & Williams).

1.39 "Delegated Entity" means an entity that is not a Subsidiary of CIGNA HealthCare to the extent that such entity (i) maintains its own contracts with Healthcare Providers separate from any contracts between CIGNA HealthCare and Healthcare Providers, and, by agreement with CIGNA HealthCare, (ii) (A) agrees to provide CIGNA HealthCare Members with access to such Healthcare Providers pursuant to the terms of such agreements; and (B) performs some or all of the functions with respect to Plans which otherwise would be performed by CIGNA HealthCare, including without limitation claims adjudication, utilization review, utilization management and credentialing.

1.40 "ERA/EFT" means the capability to facilitate electronic remittance advice

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and electronic funds transfer.

1.41 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.

1.42 "Execution Date" means the date on which this Agreement is signed by Class Counsel and CIGNA HealthCare.

1.43 "Explanation of Benefits Form" or "EOB" means an explanation of benefits sent to a CIGNA HealthCare Member.

1.44 "Fairness Hearing" means a hearing to be held by the Court to determine whether finally to certify the Class, to approve the notice that was given under the Plan of Notice, to approve the Agreement and the Settlement it embodies as fair, reasonable and adequate, and to determine whether the Order and Final Judgment should be entered, including Counsels' Award.

1.45 "Fairness Hearing Date" shall have the meaning assigned to that term in Section 6.3 of this Agreement.

1.46 "Fee for Service Claim" means any submission by a Class Member to CIGNA HealthCare using CPT® Codes or HCPCS Level II Codes seeking payment on a fee for service basis for the provision of one or more services to a CIGNA HealthCare Member on a single date of service (inpatient or outpatient) or for a single period of inpatient care on or after January 1, 1990, through the date of Final Approval.

1.47 "Final Approval" means the first Business Day after all of the following events shall have occurred:

a. The Court has entered the Order and the Final Judgment substantially in the forms of Exhibits 2 and 3 (or any Amended Order or Amended Final Judgment); and,

b. One of the following has occurred:

(1) thirty (30) days have passed from the later of entry of the Order or the Final Judgment (or any Amended Order or Amended Final Judgment) and no appeal is filed or, if an appeal is filed, it is only as to the amount of any Counsels' Award ordered by the Court;

(2) ten (10) Business Days have passed from final dismissal of any appeal from the Order and the Final Judgment (or any Amended Order or Amended Final Judgment) or the final dismissal of any proceeding or denial of *certiorari* to review the Order and the Final Judgment (or any Amended Order or Amended Final Judgment); or

(3) ten (10) Business Days have passed from final affirmance on appeal, the expiration of the time for a petition for a writ of *certiorari* and, if *certiorari* is granted, the date of final affirmance following review pursuant to that grant.

1.48 "Final Judgment" shall have the meaning assigned to that term in Section 1.73 of this Agreement.

1.49 "Healthcare Provider" means any Person who has provided Covered Services to any CIGNA HealthCare Member or any individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in the Complaints or by any of their respective current or former subsidiaries from January 1, 1990 through the date of the entry of the Preliminary Approval Order, including but not limited to chiropractors, psychologists, counselors, podiatrists, acupuncturists, optometrists, physical and occupational therapists, nurse midwives, nurse practitioners, nurse anesthetists, nutritionists, orthotists, prosthetists, audiologists and speech and hearing therapists; provided, however, Healthcare Provider does not include those Persons or entities excluded from the Class as set forth in Section 1.17.

1.50 "Healthcare Provider Advisory Committee" shall have the meaning assigned to that term in Section 7.9.a of this Agreement.

1.51 "Healthcare Provider Group" means two or more Healthcare Providers, and those claiming by or through them, who practice under a single taxpayer identification number.

1.52 "Healthcare Provider Organization" means any association, partnership, corporation or other form of organization of Healthcare Providers (including without limitation independent practice associations), and those claiming by or through them, that is organized under multiple taxpayer identification numbers.

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1.53 "Healthcare Provider Specialty Society" means the following health care specialty societies: American Chiropractic Association, American Podiatric Medical Association, American Physical Therapist Association, American Psychological Association, American Optometric Association, American Academy of Nurse Practitioners, American College of Nurse-Midwives, National Association of Social Workers, American Association of Oriental Medicine, American Speech-Language-Hearing Association, and American Occupational Therapy Association.

1.54 "Healthcare Common Procedure Coding System Level II Codes" or "HCPCS Level II Codes" means alphanumeric codes used to identify those codes not included in the American Medical Association's Current Procedural Terminology.

1.55 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

1.56 "Individually Negotiated Contract" means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to substantial modifications to the terms of CIGNA HealthCare's standard form agreement to individually suit the needs of a Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization.

1.57 "Insured Plan" means a Plan as to which CIGNA HealthCare assumes all or a majority of health care costs and/or utilization risk, depending on the product.

1.58 "*Kaiser*" shall have the meaning assigned to that term in WHEREAS Clause A of this Agreement.

1.59 "*Knecht*" means the Amended Complaint in *Knecht, et al. v. Cigna, et al.*, as described more fully in WHEREAS Clause H of the Agreement.

1.60 "Lead Counsel" means Debra Brewer Hayes and Michael C. Dodge.

1.61 "Litigation" means the above-captioned actions: *Tisko* (formerly styled *Kaiser*), *Knecht* and *Solomon*.

1.62 "Medical Necessity External Review Process" shall have the meaning assigned to that term in Section 7.11.c of this Agreement.

1.63 "Medical Necessity External Review Organization" means an organization, as described more fully in Section 7.11.c of this Agreement, that provides independent medical reviews of CIGNA HealthCare's denials of coverage which are based on the lack of Medical Necessity or experimental or investigational nature of the proposed or rendered service or supply.

1.64 "Multiple Procedure Logic" means the payment methodology used by CIGNA HealthCare, when processing claims, that makes adjustment(s) to payment(s) for one or more procedures or other services, in each case constituting Covered Services (excluding CPT® Evaluation and Management Codes), when multiple such procedures or services are performed on the same patient on the same date of service.

1.65 "Non-Participating Healthcare Provider" means any Healthcare Provider other than a Participating Healthcare Provider and includes, where appropriate, Healthcare Provider Groups and Healthcare Provider Organizations.

1.66 "Notice" means the notice to putative members of the Class, substantially in the form attached as Exhibit 5 to this Agreement, advising such putative members of the Preliminary Approval Order and of the right to seek exclusion from the settlement class or object to the terms of the Settlement, in accordance with the Plan of Notice.

1.67 "Notice Costs" means the costs of complying with the Plan of Notice approved by the Court.

1.68 "Notice Date" shall have the meaning assigned to that term in Section 5.1 of this Agreement.

1.69 "Objection Date" shall have the meaning assigned to that term in Section 6.2 of this Agreement.

1.70 "Opt Out" shall have the meaning assigned to that term in Section 6.1 of this Agreement.

1.71 "Opt Out Deadline" shall have the meaning assigned to that term in Section 6.1 of this Agreement.

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1.72 "Opt Out Form" means a document substantially in the form attached as Exhibit 7 to this Agreement.

1.73 "Order" and "Final Judgment" mean the order and form of judgment approving this Agreement and dismissing claims by Class Members against CIGNA HealthCare with prejudice, but with the Court maintaining jurisdiction to enforce the Agreement, in each case substantially in the forms attached hereto as Exhibits 2 and 3.

1.74 "Overpayment" means, with respect to a claim submitted by or on behalf of a Healthcare Provider, including a Healthcare Provider Group or Healthcare Provider Organization, any erroneous or excess payment that CIGNA HealthCare makes because of payment of an incorrect rate, duplicate payment for the same service or supplies, payment with respect to an individual who was not a CIGNA HealthCare Member as of the date the Healthcare Provider provided the service(s) or supplies that are the subject of such payment, or payment for any non-Covered Service; provided that "Overpayment" shall not mean any erroneous or excess payment arising out of inappropriate coding or other error in the claim submission to which such payment relates and shall not mean any adjustment to a prior payment when CIGNA HealthCare makes such adjustment in whole or part on the basis of information contained in a separate claim submitted by a Healthcare Provider for services rendered on the same date to which the original payment relates (other than duplicate bills).

1.75 "Participating Healthcare Provider" means any Healthcare Provider who has entered into a valid written contract with CIGNA HealthCare (directly or indirectly through a Healthcare Provider Organization, Healthcare Provider Group or other entity authorized by the Healthcare Provider at the time the claim arose) to provide Covered Services to CIGNA HealthCare Members, during the period the contract is in force.

1.76 "Person" or "Persons" means all persons and entities (including without limitation natural persons, firms, corporations, limited liability companies, joint ventures, joint stock companies, unincorporated organizations, agencies, bodies, governments, political subdivisions, governmental agencies and authorities, associations, partnerships, limited liability partnerships,

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trusts, and labor unions, and their predecessors, successors, administrators, executors, heirs and assigns).

1.77 "Petitioner" shall have the meaning assigned to that term in Section 15.2.b of this Agreement.

1.78 "Physician" means an individual duly licensed by a state licensing board as a Medical Doctor or as a Doctor of Osteopathy.

1.79 "Physician Settlement" means the settlement among CIGNA HealthCare and Physicians in *Shane*.

1.80 "Plaintiffs" means the named Plaintiffs in *Tisko, Knecht* and *Solomon*.

1.81 "Plan" means a benefit plan through which a CIGNA HealthCare Member obtains health care benefits set forth in pertinent Plan Documents.

1.82 "Plan Documents" means the documents defining the health care benefits available to a CIGNA HealthCare Member, and the terms and conditions under which such benefits are available, under the Plan sponsored by the CIGNA HealthCare Member's employer, or other third party.

1.83 "Plan of Notice" means the Plan of Notice attached as Exhibit 4.

1.84 "Preliminary Approval Hearing" shall have the meaning assigned to that term in Section 4 of this Agreement.

1.85 "Preliminary Approval Order" shall have the meaning assigned to that term in Section 4 of this Agreement.

1.86 "Prospective Relief" means the prospective undertakings by CIGNA HealthCare described in Section 7 of this Agreement.

1.87 "Released Claims" means and includes any and all claims that have been or could have been asserted by or on behalf of any or all Class Members against the Released Persons, or any of them, and which arise prior to Final Approval by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Litigation, except as

otherwise provided for by this Agreement. This includes, without limitation and as to Released Persons only, any aspect of any Fee for Service Claim submitted by any Class Member to CIGNA HealthCare, and claims based upon a capitation agreement with CIGNA HealthCare, and any allegation that Defendants and/or CIGNA HealthCare have conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Litigation or with regard to CIGNA HealthCare's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, and/or other third parties. Notwithstanding this definition, Released Claims do not include any and all claims of any kind whatever arising out of the alleged nonpayment or payment at inappropriate rates or amounts of fee for service claims submitted to CIGNA HealthCare for services or supplies not represented by CPT® Codes or HCPCS Level II Codes or codes specially created by CIGNA HealthCare.

1.88 "Releasing Parties" (each a "Releasing Party") means Class Members and, to the extent they have claims against CIGNA HealthCare derived by contract or operation of law from the claims of Class Members, any and all Subsidiaries, affiliates, shareholders, parents, directors, officers, employees, professional corporations, agents, administrators, executors, legal representatives, partners and partnerships, heirs, predecessors, successors and assigns of Class Members.

1.89 "Released Persons" means:

a. CIGNA HealthCare and CIGNA HealthCare's insurers and counsel, including Defendants' Counsel as defined herein.

b. Persons who provided claim processing services, software, proprietary guidelines or technology to CIGNA HealthCare, those contracted agents processing claims on CIGNA HealthCare's behalf, together with each such Person's predecessors or successors, but only to the extent of such Person's services and work done pursuant to contract with CIGNA

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HealthCare. Such Persons are expressly not "Released Persons" as to services provided to any Person other than CIGNA HealthCare. Nothing herein is intended to release Delegated Entities.

c. "Released Persons" shall not include any defendant in MDL No. 1334 other than CIGNA HealthCare or any Subsidiary of CIGNA Corporation.

1.90 "Remittance Form" means the form sent by CIGNA HealthCare to health care providers explaining CIGNA HealthCare's computation of benefits and payment amounts on a claim. The Remittance Form is sometimes referred to as an "Explanation of Payment" form or "EOP".

1.91 "Retained Claim" shall have the meaning assigned to that term in Section 13.4 of this Agreement.

1.92 "Reviewer" shall have the meaning assigned to that term in Section 7.10.c of this Agreement.

1.93 "Self-Insured Plan" and "Self-Funded Plan" mean any Plan other than an Insured Plan.

1.94 "Settlement" means the agreed-upon compromise of the Litigation as approved by the Court.

1.95 "Settlement Administrator" means Poorman-Douglas Corporation.

1.96 "Settlement Consideration" means the benefits which Class Counsel believe have been conferred, and will be conferred, on Class Members through this Settlement and as a result of the Litigation, including the *Kaiser* litigation and original Settlement of that action to the extent it benefited any member of the Healthcare Provider Class, and through performance of this Agreement.

1.97 "Settlement Fund" shall mean the fund established under Section 8.1.a of this Agreement, together with all interest and earnings thereon. The parties intend the Settlement Fund to be a qualified settlement fund under Section 468B of the Internal Revenue Code of 1986, as amended, and Treas. Reg. Section 1.468B-1.

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1.98 "Settling Parties" shall have the meaning assigned to that term in the Preamble to this Agreement.

1.99 "Signatory Healthcare Provider Societies" means American Podiatric Medical Association, Florida Chiropractic Association, California Podiatric Medical Association, Florida Podiatric Medical Association, Texas Podiatric Medical Association and those Healthcare Provider societies that have executed and delivered to Class Counsel the Healthcare Provider Society Agreement referred to in Section 19.5 of this Agreement and attached hereto as Exhibit 10.

1.100 "*Solomon*" shall have the meaning assigned to that term in WHEREAS Clause I of this Agreement.

1.101 "Subsidiary" means any entity of which securities or other ownership interests having ordinary voting power to elect a majority of the board of directors or other persons performing similar functions are, as of Final Approval, or were prior thereto, directly or indirectly owned by CIGNA Corporation.

1.102 "Termination Date" shall have the meaning assigned to that term in Section 16.4 of this Agreement.

1.103 "*Tisko*" means the case formerly styled *Kaiser v. CIGNA Corporation, et al.* as it applies to Healthcare Providers only.

1.104 "Valid Claim" means a Claim that entitles a Class Member to receive payment pursuant to the terms of the Settlement.

1.105 "Website" means the online resource for the public and health care providers to obtain information about CIGNA HealthCare, its products and policies and other information and which is currently located at www.cigna.com. Some portion of this Website may be password protected at CIGNA HealthCare's discretion.

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2. EFFECT OF SETTLEMENT

The claims made against CIGNA HealthCare by Plaintiffs and Class Members in the Litigation and all Released Claims shall be fully compromised and settled by performance of this Agreement according to its terms.

3. COMMITMENT TO SUPPORT AND COMMUNICATIONS WITH CLASS MEMBERS

The Settling Parties agree that it is in their best interests to consummate this Agreement and all the terms and conditions contained herein and to cooperate with each other and to take all actions reasonably necessary to obtain Court approval of this Agreement and entry of the orders of the Court that are required to implement its provisions. They also agree to support this Agreement in accordance with and subject to the provisions of this Agreement.

Class Counsel shall make all reasonable efforts to enforce the Compliance Dispute resolution provisions set forth in Section 15 of this Agreement.

Plaintiffs, Class Counsel and CIGNA HealthCare agree that CIGNA HealthCare may communicate with putative Class Members regarding the provisions of this Agreement, so long as such communications are not inconsistent with the terms of this Agreement, the Notice or other agreed upon communications concerning the Agreement. CIGNA HealthCare will not discourage the submission of any claims allowed under this Agreement. CIGNA HealthCare will refer to the Settlement Administrator any inquiries from Class Members about Claims to be submitted under this Agreement.

4. PRELIMINARY APPROVAL ORDER AND SCHEDULING OF FAIRNESS HEARING

Pursuant to Rule 23(e), the Settling Parties shall submit this Agreement, together with the exhibits attached hereto, to the Court for, among other things, its conditional certification of a settlement class, preliminary approval of the Agreement and Plan of Notice and scheduling of a Fairness Hearing, and shall apply to the Court for an Order Preliminarily Approving Proposed

Settlement Among CIGNA HealthCare and Healthcare Providers, substantially in the form attached as Exhibit 1 to this Agreement (the "Preliminary Approval Order").

5. **NOTICE**

5.1 *Notice.*

On or before a date to be fixed by the Court that is within thirty (30) days of the date of the entry by the Court of the Preliminary Approval Order (the "Notice Date"), and subject to approval by the Court, Notice, substantially in the form attached as Exhibit 5 to this Agreement, shall be given by the Settling Parties in cooperation with the Settlement Administrator in accordance with the Plan of Notice attached hereto as Exhibit 4. The Signatory Healthcare Provider Societies and Class Counsel are permitted, but not required, to post the Notice on their websites, along with a "hot link" to the website of the Settlement Administrator.

5.2 *Responsibility for Costs of Notice.*

Notice Costs shall be paid by CIGNA HealthCare.

6. **PROCEDURE FOR FINAL APPROVAL; LIMITED WAIVER**

Following the dissemination of the Notice as described in Section 5, the Settling Parties shall seek the Court's final approval of this Agreement.

6.1 *Opt Out Timing and Rights.*

The Notice shall provide that putative Class Members may request exclusion from the Class by submitting an Opt Out Form in the form attached hereto as Exhibit 7, in the manner specified in the Notice, on or before a date set by the Court (the "Opt Out Deadline"). The Settling Parties agree to urge the Court to set the Opt Out Deadline on the date that is sixty (60) days after the Notice Date.

Putative Class Members have the right to exclude themselves ("Opt Out") from this Agreement and from the Class by timely submitting to the Settlement Administrator a completed Opt Out Form, and otherwise complying with the agreed-upon Opt Out procedure approved by the Court. Putative Class Members who or which timely submit a completed Opt Out Form shall be excluded from this Agreement and from the Class. Any putative Class Member who or which



does not submit an Opt Out Form by the Opt Out Deadline or who or which does not otherwise comply with the Opt Out procedure approved by the Court shall be a Class Member and shall be bound by the terms of this Agreement and the Order and the Final Judgment. Any putative Class Member who or which does not Opt Out of this Agreement shall be deemed to have taken all actions necessary to withdraw and revoke the assignment to any Person of any claim against CIGNA HealthCare.

If a Healthcare Provider Group or Healthcare Provider Organization submits an Opt Out Form in compliance with the Opt Out procedure approved by the Court and elects to Opt Out on behalf of all of its current members, then each of the Group's or Organization's members identified in the Opt Out Form shall be excluded from this Agreement and from the Class with respect to those claims billed through the Healthcare Provider Group or the Healthcare Provider Organization. If a Healthcare Provider Group or Healthcare Provider Organization does not timely file an Opt Out Form electing to Opt Out all of its members, then the individual members of such Group or Organization may submit Opt Out Forms.

Any putative Class Member who or which timely submits an Opt Out Form shall have until ten (10) days prior to the Fairness Hearing to deliver to the Settlement Administrator a written revocation of such Class Member's request to Opt Out in the manner specified in the Notice, and shall thereby become a Class Member.

Within ten (10) days after the Opt Out Deadline, the Settlement Administrator shall furnish CIGNA HealthCare and Lead Counsel with a complete list in machine-readable form of all those who submitted Opt Out Forms by the Opt Out Deadline and did not revoke those forms. CIGNA HealthCare shall pay the costs of obtaining the list. A final list of those submitting Opt Out Forms and not revoking them shall be prepared by the Settlement Administrator and filed with the Court at the Fairness Hearing.

If a putative Class Member submits both an Opt Out Form and a Claim Form, the Opt Out Form shall control and the putative Class Member shall not be a Class Member; provided, however, that the Settlement Administrator shall notify the putative Class Member in writing of

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the conflicting requests and, if the deadline for revoking Opt Outs has not yet passed, shall inform the putative Class Member that he, she or it may still participate in the Settlement by revoking the Opt Out. If, before the deadline for revoking Opt Outs, the putative Class Member informs the Settlement Administrator in writing in the manner specified in the Notice that he, she or it intends to participate in the Settlement, the Opt Out Form shall be deemed revoked and the Claim Form shall be processed. Nothing in this paragraph shall supercede or interfere with the Settlement Administrator's obligation to prepare a list of those opting out of the Settlement to be filed with the Court at the time of the Fairness Hearing. No revocations of Opt Outs will be accepted after ten (10) days prior to the Fairness Hearing. If a putative Class Member Opts Out of the Settlement, has not revoked the Opt Out within ten (10) ten or more days before the Fairness Hearing and subsequently submits a Claim Form, the Claim Form shall be invalid.

6.2 *Objection Timing and Rights*

Any putative Class Member who or which has not submitted an Opt Out Form and who or which wishes to object to the fairness, reasonableness or adequacy of the Settlement or the award of attorneys' fees and expenses, must serve on Lead Counsel and Defendants' Counsel and file with the Court, postmarked no later than the Objection Date, a statement of his, her or its objection, as well as the specific reason(s) for each objection, including any legal support the Class Member wishes to bring to the Court's attention and any evidence the Class Member wishes to introduce in support of the objection. The Settling Parties agree to urge the Court to set the Objection Date on the date that is sixty (60) days after the Notice Date (the "Objection Date"). Class Members, at their own expense, may retain attorneys to present objections but are not required to do so. Fees or expenses incurred by Class Members or their attorneys will not be paid by Defendants or Class Counsel. Class Members, or their attorneys, who wish to appear at the Fairness Hearing and present argument must file with the Court and serve on Lead Counsel and Defendants' Counsel written notification of an intention to appear at the hearing not less than fourteen (14) days before the Fairness Hearing. Class Members who fail to comply with this Section 6 forfeit any right they may have to appear, object and/or appeal any term of the

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Settlement. Any Class Member who takes an appeal from the denial of a validly made objection pursuant to the terms set forth herein must post an appropriate bond as set forth in the Court's Order approving the Settlement.

6.3 *Setting the Fairness Hearing Date and Fairness Hearing Proceedings.*

The Settling Parties agree to urge the Court to hold the Fairness Hearing on a date that is approximately ninety (90) days after the Notice Date (the "Fairness Hearing Date") and to work together to identify and submit any evidence that may be required by the Court to satisfy the burden of proof for obtaining approval of this Agreement and the orders of the Court that are necessary to effectuate the provisions of this Agreement, including without limitation the Order and the Final Judgment and the orders contained therein. At or before the Fairness Hearing, the Settling Parties shall present evidence necessary and appropriate to obtain the Court's approval of this Agreement, the Order and the Final Judgment and the orders contained therein and shall meet and confer prior to the Fairness Hearing to coordinate their presentation to the Court in support of Court approval thereof.

7. PROSPECTIVE RELIEF: ADDITIONAL DISCLOSURES; CHANGES IN BUSINESS PRACTICES

The Settlement consideration to the Class Members includes, among other things, initiatives and other commitments with respect to CIGNA HealthCare's disclosures and business practices. The Settling Parties agree that the initiatives and other commitments set forth below, which absent the Physician Settlement and this Agreement CIGNA HealthCare generally would be under no obligation to undertake, constitute substantial value and will enhance and facilitate the delivery of health care services by Class Members. CIGNA HealthCare investigated and began to implement certain of the initiatives described in this Section 7 while engaged in discussions to resolve the Litigation brought by Physicians and Healthcare Providers. Such initial and partial implementation, which shows CIGNA HealthCare's good faith desire to resolve the Litigation, was undertaken to, and does, form part of the Settlement Consideration. CIGNA HealthCare shall have the unilateral and unrestricted right to block access to and/or not

apply any or all of the business practice initiatives set forth below to Healthcare Providers who Opt Out of the Class, except as otherwise required by contract or law.

CIGNA HealthCare shall be obligated to commence implementing each commitment set forth in this Section 7 from and after the date set forth on Exhibit 9 attached hereto across from the relevant section number on such Exhibit and shall have no obligation to continue the commitment after the conclusion date set forth on Exhibit 9. To the extent a particular Section 7 provision is not listed on Exhibit 9, CIGNA HealthCare shall not be obligated to continue the commitment made in that provision after the Termination Date. With respect to the Section 7 commitments that have conclusion dates of September 4, 2007, if CIGNA HealthCare determines, at its sole discretion, to keep those commitments in place after September 4, 2007 for the Physician class members, those obligations will also be maintained for Class Members in this Litigation.

7.1 *Increased Automated Adjudication of Claims.*

CIGNA HealthCare, recognizing the desirability of making investments to improve its business relationships with those providing health care services and supplies to CIGNA HealthCare Members through, *inter alia*, efficiency in the processing of claims, has made substantial investments and will continue to make investments in two new claims platforms that are already receiving newly written business and to which CIGNA HealthCare will migrate substantially all of the claims handling now being performed on its existing claims platforms; and by the use of its new claims platforms, has increased and will continue to increase the percentage of claims that are autoadjudicated, in an effort to shorten the period for payment of claims, and to improve the overall efficiency of the claim adjudication process.

7.2 *Internet Disclosures and Functionality.*

CIGNA HealthCare is making substantial investments, and will continue to make investments, to enhance the ability of Healthcare Providers to register referrals, pre-certify services or supplies, submit claims for Covered Services, check CIGNA HealthCare Member eligibility for Covered Services (based upon current information supplied by or relating to Plan

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sponsors), and check the status of claims for Covered Services, in each case via the Internet and clearinghouses.

a. *Addition of Disclosures to CIGNA HealthCare's Website.*

(1) *In General.*

CIGNA HealthCare will place additional information about CIGNA HealthCare's claim administration policies and procedures on CIGNA HealthCare's Website at www.cigna.com, and shall periodically update this additional information pursuant to Section 7.2.b of this Agreement. An index or table of contents shall be included with the additional information posted, and the additional information shall be word-searchable. Passwords will be provided to Class Members to access any portions of the Website that are password protected. Upon request, passwords will also be provided to Lead Counsel for use in monitoring performance under the terms of this Agreement; provided, however, that Lead Counsel will not have access to patient specific information or be able to request or transmit information through the Website.

(2) *Specifications for Additional Disclosures.*

The additional information that CIGNA HealthCare shall post and periodically update on its Website shall include disclosures on the topics identified below.

(a) *Forms to be Used for Submitting Claims.*

The forms to be used for submitting claims, both in paper and electronic format, shall be identified and made available for downloading on the Website.

(b) *Software or Programs Used to Review Relationships Among Billing Codes.*

The computer claims processing software or programs used by CIGNA HealthCare to review the relationships among billing codes (*e.g.*, ClaimCheck®) shall be identified by name and version, including any software used to audit the relationship between CPT® or HCPCS Level II Codes, or other billing codes, and diagnosis codes.

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(c) *Requirements with Respect to Fee for Service Claims.*

The items of information that CIGNA HealthCare requires on a claim form, whether paper or electronic, and the information (if any) that CIGNA HealthCare requires to accompany that claim form in order to permit CIGNA HealthCare to process the claim for payment shall be described. The disclosure shall include a description of those limited categories of claims for which the submission of Clinical Information by Class Members may be required (*e.g.*, claims for multiple procedures in the same anatomical region where one of the submitted procedures is coded with modifier 59, claims for unlisted procedures, etc.) in order to obtain payment of the claim as submitted. This disclosure shall be consistent with Section 7.17.b.

(d) *Timing of Claim Submission.*

Class Members shall have one hundred eighty (180) days from the date of service to submit claims to CIGNA HealthCare. With respect to claims submitted more than one hundred eighty (180) days after the date of service, CIGNA HealthCare shall specify on its Website those circumstances under which such claims shall be accepted for processing and, if appropriate, for payment. CIGNA HealthCare shall waive the one hundred eighty (180) day limit for a reasonable period in the event that a Class Member gives notice to CIGNA HealthCare along with appropriate evidence of extraordinary circumstances that resulted in the delayed submission. CIGNA HealthCare shall determine "extraordinary circumstances" and the reasonableness of the submission date.

(e) *Procedures for Appealing Partial or Total Claim Denials or Reductions.*

The procedures for appealing a partial or total claim denial or reduction, including the documentation that must accompany the appeal and the address to which appeals must be directed, shall be described.

(f) *Certain Claim Bundling Logic.*

CIGNA HealthCare shall use its best efforts to describe with particularity any single Claim Coding and Bundling Edit that it reasonably judges, based on its experience with

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submitted claims, will cause, on the initial review of submitted claims, the denial of or reduction in payment for a CPT® Code or HCPCS Level II Code more than five hundred (500) times per year.

(g) *Policies Respecting the Reimbursement of Supplies.*

CIGNA HealthCare's policies regarding the reimbursement of supplies and materials utilized in the provision of Covered Services by Class Members, including those instances where the submission of Clinical Information may be required in order for Class Members to obtain payment of the claim as submitted, shall be described.

(h) *Policies Respecting Multiple Procedures Performed on the Same Date of Service.*

Consistent with this Agreement, CIGNA HealthCare's policies and procedures for reducing the indicated payments for the second and subsequent procedures performed on the same patient on the same date of service shall be described.

(i) *Postings with Regard to Definitions of "Medical Necessity" and "Medically Necessary."*

CIGNA HealthCare shall post the definitions of "Medical Necessity" and "Medically Necessary," as set forth in Section 7.16.a(1) hereof.

(j) *Postings with Regard to Medical Necessity Clinical Guidelines.*

CIGNA HealthCare shall post those internally developed clinical guidelines, consistent with Section 7.16.b, used by CIGNA HealthCare to assist in making Medical Necessity determinations, along with a list of the resources used to develop such guidelines. To the extent CIGNA HealthCare uses any guidelines licensed from third parties or derived from peer-reviewed journals or similar sources to assist in making Medical Necessity determinations, CIGNA HealthCare shall post, as applicable, the title, author/source, volume, and publication date of such guidelines. CIGNA HealthCare shall provide, upon request by the Class Member, a complete copy of the relevant guideline applicable to a specific service and clinical indication

through the electronic mail provider inquiry facility identified in Section 7.3 of this Agreement or through existing CIGNA HealthCare relations communication channels.

(k) *Procedures for Obtaining Fee Schedule Information and Claim Bundling Logic Information Via Electronic Mail.*

CIGNA HealthCare shall describe the procedures available to Class Members to obtain fee schedule information and information regarding CIGNA HealthCare's Claim Coding and Bundling Edits via electronic mail, pursuant to Section 7.3 of this Agreement.

(l) *Databases Used to Determine "Reasonable and Customary" Charges.*

If CIGNA HealthCare uses databases licensed from one or more third parties in order to determine "reasonable and customary" billed charges in the medical community, those databases shall be identified.

(m) *Drug Formularies.*

CIGNA HealthCare shall identify its drug formularies applicable to Plans, inclusive of tiers (if any) applicable to said formularies.

(n). *External Review Entities.*

CIGNA HealthCare shall post the names, addresses, phone numbers and web addresses of all external review entities CIGNA HealthCare uses to conduct its Medical Necessity External Review Process.

(o) *ERA/EFT Capabilities.*

CIGNA HealthCare shall post ERA/EFT capabilities.

(p) *Services or Supplies for Which Precertification is Required.*

In a manner consistent with Section 7.5 hereof, CIGNA HealthCare shall identify those services or supplies for which precertification is routinely required for its products. If a Self-Insured Plan specifies services or supplies that are different from or in addition to the services or supplies for which CIGNA HealthCare routinely requires precertification, that information will be identified on the Website if the Self-Insured Plan sponsor consents. CIGNA HealthCare will

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recommend to its Self-Insured Plan customers that they allow such Website identification. CIGNA HealthCare will recommend to its Self-Insured Plan customers that they utilize CIGNA HealthCare's standard list of services or supplies for which precertification is required.

(q) *Online Eligibility and Other Information.*

CIGNA HealthCare Members' eligibility and benefits shall be disclosed through a secure, online self-service tool that allows Healthcare Providers or their staffs to access the most current information available to CIGNA HealthCare about CIGNA HealthCare Members' general benefits, coverage dates, copay and deductible information. Healthcare Providers may access CIGNA HealthCare's standard referral requirements and lists of services or supplies for which precertification is routinely required through CIGNA HealthCare's Website.

(r) *Electronic Mail Address for Fee Schedule, Billing Edits, and Other Information.*

CIGNA HealthCare shall place on its Website a "hot link" with the address where Healthcare Providers can submit inquiries to obtain information available under Section 7.3.

(s) *Savings Clause.*

Nothing in this Section 7.2.a(2) shall be applied in a manner inconsistent with another provision of this Agreement. Such other provision shall govern.

b. *Periodic Updates of Disclosures.*

CIGNA HealthCare shall make appropriate revisions to the disclosures posted on CIGNA HealthCare's Website pursuant to this Agreement if any of the following circumstances occur.

(1) *Changes to Policies and Procedures.*

If the policies, procedures, or limitations that are included in the initial disclosures are materially changed by CIGNA HealthCare, such that continued posting of the initial disclosures as to those policies, procedures, and/or limitations would be materially misleading, CIGNA HealthCare shall revise the posted disclosures so that they remain accurate.

(2) *Introduction of New or Revised Claim Review Software or Programs.*

If CIGNA HealthCare intends to begin use of a new or revised computer claims processing software or program to review the relationships among billing codes (including updates to ClaimCheck®), CIGNA HealthCare shall post a disclosure of CIGNA HealthCare's intention to do so on its Website at least sixty (60) days in advance of applying the new or revised computer software or program to any Class Member's claims, to enable Class Members to make electronic mail requests for information about how the new or revised computer software or program will affect their specific combinations of billing codes, as generally described in Section 7.3.

(3) *Introduction of New Claim Coding and Bundling Edits.*

CIGNA HealthCare shall use its best efforts to post on its Website a disclosure of CIGNA HealthCare's intention to begin applying any new Claim Coding and Bundling Edit not previously applied where CIGNA HealthCare reasonably judges, based on its experience with submitted claims, that the new Claim Coding and Bundling Edit will cause, on the initial review of submitted claims, the denial of or reduction in payment for a CPT® Code or HCPCS Level II Code more than five hundred (500) times per year. CIGNA HealthCare shall use its best efforts to post such disclosures on the Website at least thirty (30) days in advance of applying the new Claim Coding and Bundling Edit to submitted claims.

(4) *Changes to CIGNA HealthCare's Maximum Default Fee Schedules.*

CIGNA HealthCare shall dedicate a page on CIGNA HealthCare's Website for use in alerting Class Members to anticipated changes in the maximum default fee schedules used in CIGNA HealthCare's various geographic markets. If CIGNA HealthCare intends, in any such geographic market, to make a change to any applicable maximum default fee schedule, CIGNA HealthCare shall disclose its intention to make such a change, the effective date of such change, and the general nature of the change (*e.g.*, that the change involves moving from 2002 Medicare RVUs to 2003 RVUs, if the underlying fee schedule is based on a Medicare fee schedule) on the

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dedicated fee schedule Website page no less than ninety (90) days prior to such effective date. The fee schedule change disclosures shall be organized geographically to facilitate consultation and inquiry by Class Members. This page shall be linked to the electronic mail address created in accordance with Section 7.3 of this Agreement, and consistent with 7.8.b of this Agreement. While CIGNA HealthCare shall be required to respond to Class Members' electronic mail inquiries seeking applicable fee schedule amounts, pursuant to Section 7.3, CIGNA HealthCare shall have no obligation under this Agreement to post an entire fee schedule, with amounts, on the dedicated fee schedule page.

c. *Prohibition on Certain Representations.*

CIGNA HealthCare shall not, under any circumstances, represent in its Website disclosures, in any other disclosure materials, or orally that CIGNA HealthCare's Claim Coding and Bundling Edits are endorsed by any Healthcare Provider society or the American Medical Association or that the American Medical Association has participated in the development of CIGNA HealthCare's Claim Coding and Bundling Edits.

7.3 *Availability of Fee Schedule, Claims Coding Edits and Other Information Through Establishment of Electronic Mail Provider Inquiry Facility.*

CIGNA HealthCare shall establish and designate an electronic mail address on its Website to receive and respond to Class Members' inquiries concerning CIGNA HealthCare's claim administration policies, procedures and limitations, and issues related to coverage. A Class Member shall be entitled to use this electronic mail address to: (a) inquire of CIGNA HealthCare concerning the Claim Coding and Bundling Edits applicable to specific combinations of billing codes; (b) make reasonable requests for applicable fee schedule amounts for all CPT® or other billing codes related to a Class Member's practice; (c) inquire of CIGNA HealthCare concerning whether certain medical services, procedures or supplies are Covered Services within the meaning of a CIGNA HealthCare Member's benefit plan; and (d) request a copy of a specific clinical guideline as applied to a specific procedure or specific episode of care used by CIGNA HealthCare to assist in making Medical Necessity determinations. CIGNA HealthCare shall use

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its best efforts to prepare and provide responsive information to Class Members' electronic mail inquiries under this Section 7.3 within ten (10) days of receiving such inquiries. There will be no charge for such inquiries, regardless of the number of such inquiries made. CIGNA HealthCare shall make this procedure available to Participating Healthcare Providers and other Healthcare Providers who are considering becoming Participating Healthcare Providers.

7.4 *Investments in Initiatives to Improve Provider Relations.*

Since the inception of this Litigation, and through the Termination Date, CIGNA HealthCare has and will expend significant amounts of money and other resources to improve its relations with those providing health care services and supplies to CIGNA HealthCare Members, and in particular to carry out the initiatives described in Sections 7.1, 7.2, 7.3, 7.7, 7.23 and 7.24 of this Agreement.

7.5 *Reduced Number of Services or Supplies Requiring Precertification.*

CIGNA HealthCare has reduced the number of services or supplies requiring precertification and will undertake efforts to standardize the services and supplies for which precertification is required across all CIGNA HealthCare Insured Plans and Self-Insured Plans. CIGNA HealthCare's Self-Insured Plan customers may, however, specify services or supplies for which precertification is required that differ from or are in addition to the services or supplies for which CIGNA HealthCare routinely requires precertification. A list of services or supplies for which precertification is required shall be posted by CIGNA HealthCare as set forth in Section 7.2.a(2)(p) hereof. CIGNA HealthCare shall permit Class Members to seek precertification through electronic means.

7.6 *Greater Notice of Policy and Procedure Changes.*

CIGNA HealthCare shall, if it intends to make a material adverse change in the terms of contracts with Participating Healthcare Providers, give ninety (90) days written notice to each Participating Healthcare Provider affected thereby (except to the extent that a shorter notice period is required to comply with changes in applicable law) and the change shall become effective at the conclusion of the ninety (90) day notice period. If a Healthcare Provider objects

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to the change that is subject to the notice, the Healthcare Provider must, within thirty (30) days of the date of the notice, give written notice to terminate his, her or its contract with CIGNA HealthCare, which termination shall be effective at the end of the ninety (90) day notice period of the material adverse change. The continuation of care provisions in Section 7.13.c hereof shall apply to any such contract termination.

7.7 *Initiatives to Reduce Claims Resubmissions.*

CIGNA HealthCare has developed, will implement and will maintain at least until the conclusion date on Exhibit 9 processes to send next-Business Day written communications to Healthcare Providers when it is determined that additional information is necessary to process a claim, explaining the information needed, and to send two written reminders at thirty (30) days and sixty (60) days if the necessary information has not been received in response to the initial communication. If the necessary information has not been received at ninety (90) days, then the claim will be denied at that time, and the Healthcare Provider may appeal pursuant to 7.10 or 7.11. If CIGNA HealthCare obtains information prior to that time showing that the claim should be denied, CIGNA HealthCare will promptly deny the claim, so that the Healthcare Provider may pursue any other remedies the Healthcare Provider may have. If the denial is based on eligibility of the patient, the Healthcare Provider may directly bill the patient. The obligations set forth in this Section 7.7 are limited to claims processed on the two new claims platforms described in Section 7.1.

7.8 *Disclosure of and Commitments Concerning Claim Payment Practices.*

a. *Consistency Across Ongoing Claims Systems and Products.*

CIGNA HealthCare shall cause its automated "bundling" and other claims payment rules to conform to this Agreement and to be consistent in all material respects across its ongoing claims systems and products; and it will continue to maintain such consistency at least until the conclusion date on Exhibit 9.

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b. *Availability of Web-Based Pre-Adjudication Tool.*

If a software vendor makes commercially available a web-based pre-adjudication tool that would allow Healthcare Providers to obtain information regarding the manner in which CIGNA HealthCare's claims systems adjudicate claims for specific CPT® Codes or combinations of such Codes, consistent with the provisions of this Agreement, CIGNA HealthCare shall make such tool available on its Website as soon as practical after it becomes available on commercially reasonable terms. CIGNA HealthCare shall make good faith efforts to obtain any such tool on commercially reasonable terms. If CIGNA HealthCare makes available such tool, it may cease to provide the information that is made available through the tool pursuant to any other provisions of this Agreement.

c. *Requirement for Submission of Clinical Information.*

CIGNA HealthCare shall not routinely require submission of Clinical Information before or after payment of claims. Notwithstanding the foregoing, (i) CIGNA HealthCare may require submission of Clinical Information before or after payment of certain categories of claims and shall promptly disclose on the Website any such claim category or categories pursuant to Section 7.2.a(2)(c); and (ii) CIGNA HealthCare may require submission of Clinical Information before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, CIGNA HealthCare has a reasonable basis for believing that such investigation is warranted, and the Healthcare Provider may contest such requirement pursuant to Section 7.12. Nothing contained in this Section 7.8.c is intended, or shall be construed, to limit CIGNA HealthCare's right to require submission of Clinical Information for precertification purposes consistent with Section 7.5 herein.

7.9 *Healthcare Provider Advisory Committee.*

a. CIGNA HealthCare shall take all actions necessary on its part to establish an advisory committee ("Healthcare Provider Advisory Committee") to discuss agenda items of nationwide scope. CIGNA HealthCare shall thereafter continue to maintain the Healthcare

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Provider Advisory Committee at least through the Termination Date. The Healthcare Provider Advisory Committee shall meet at least once per year. The meetings shall be conducted in Bloomfield, Connecticut, but attendance may be in person or by teleconference or by video-conference.

b. The Healthcare Provider Advisory Committee shall include five (5) members, one of whom shall be CIGNA HealthCare's Chief Medical Officer or his or her designee, who shall serve as chairperson of the Healthcare Provider Advisory Committee. Except as provided in this Section 7.9.b, the remaining members shall be Healthcare Providers in active clinical practice who are not employees of CIGNA HealthCare. The other four (4) members shall be selected as follows: CIGNA HealthCare shall select one (1) member, who shall be a chiropractor, not later than thirty (30) days after the date of the entry of the Preliminary Approval Order; Lead Counsel, on behalf of and after consultation with the Plaintiffs, shall select two (2) members, one of whom shall be a psychologist and one who shall be a podiatrist, not later than thirty (30) days after the date of the entry of the Preliminary Approval Order; and those four shall select the remaining member not later than ninety (90) days after the date of the entry of the Preliminary Approval Order. That member shall be a representative of a different health care specialty or discipline. There shall be no more than one representative of any Healthcare Provider discipline appointed to the Healthcare Provider Advisory Committee at any one time. The names of the members of the Healthcare Provider Advisory Committee and the dates of the Healthcare Provider Advisory Committee meetings shall be posted on CIGNA HealthCare's Website. If any member discontinues serving on the Healthcare Provider Advisory Committee, that member's position shall be filled in the same manner as the member was originally selected.

c. Subject to such procedures as the Healthcare Provider Advisory Committee may adopt, it may consider any issue at a meeting at which a quorum is present, including proposals for discussion submitted by Class Members through an address to be maintained on CIGNA HealthCare's Website. A quorum shall consist of at least three (3) of the members. The Healthcare Provider Advisory Committee, by a majority vote of a quorum, shall

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have authority to recommend changes to CIGNA HealthCare's business practices. CIGNA HealthCare shall consider whether the implementation of any recommendation of the Healthcare Provider Advisory Committee is commercially feasible and consistent with the best interests of Class Members, CIGNA HealthCare Members, customers, shareholders and other constituencies. If CIGNA HealthCare decides not to accept a recommendation of the Healthcare Provider Advisory Committee, CIGNA HealthCare shall communicate that decision in writing to the Healthcare Provider Advisory Committee with an explanation of CIGNA HealthCare's reasons. The Committee's recommendations and CIGNA HealthCare's responses will be published on CIGNA HealthCare's Website. CIGNA HealthCare agrees to include in the annual report referenced in Section 15.1.b. of this Agreement and in the Certification submitted as of the Termination Date a listing of all Healthcare Provider Advisory Committee recommendations made to CIGNA HealthCare and CIGNA HealthCare's responses to such recommendations.

d. Each member of the Healthcare Provider Advisory Committee will agree to maintain and treat as confidential any proprietary information reasonably designated as such by CIGNA HealthCare. No member of the Healthcare Provider Advisory Committee shall serve as a member of an advisory or similar committee established by any other managed care company or health insurer.

e. CIGNA HealthCare shall pay the reasonable expenses of each Healthcare Provider Advisory Committee member in attending meetings of the Healthcare Provider Advisory Committee and shall pay a reasonable honorarium to each member other than the chairperson for attendance at a meeting.

7.10 *Dispute Resolution Process for Healthcare Provider Billing Disputes.*

a. For the Physician Settlement, CIGNA HealthCare has implemented an independent, external billing dispute review process (the "Billing Dispute External Review Process") for resolving disputes concerning the application of CIGNA HealthCare's coding and payment rules and methodologies to (i) patient specific factual situations, including without limitation the appropriate payment amount when two or more CPT® Codes are billed together,

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or whether modifiers have been used appropriately, or (ii) any Retained Claims (each such matter deemed a "Billing Dispute"). The Billing Dispute External Review Process, as implemented for the Physician Settlement, will be made available to Healthcare Providers, Healthcare Provider Groups and Healthcare Provider Organizations as set forth in this Section 7.10. The Reviewer (as defined below) shall not have jurisdiction over any disputes that are not patient specific application of Claim Coding and Bundling Edits, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in Section 7.11 of this Agreement, disputes about the submission of Clinical Information that fall within the scope of Section 7.12, Compliance Disputes and disputes concerning the scope of Covered Services. Nothing contained in this Section 7.10 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures of § 503 of ERISA.

b. Any Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization may submit Billing Disputes through the Billing Dispute External Review Process upon payment of a filing fee calculated as set forth in Section 7.10.i and in accordance with the provisions of this Section 7.10, after the Healthcare Provider exhausts CIGNA HealthCare's internal appeals process, when the amount in dispute (either a single claim for Covered Services or multiple claims involving the same or similar issues) exceeds Five Hundred Dollars ($500). Whether a claim is "similar" to another claim shall be determined by the Reviewer (defined below). CIGNA HealthCare shall post a description of its Healthcare Provider internal appeals process on its Website. Each Billing Dispute shall be submitted on a form (the "Billing Dispute Form") and shall include any Clinical Information the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization believes is relevant to the Billing Dispute. The Billing Dispute Form and a description of the procedure to be followed in submitting a Billing Dispute are posted on the Website.

c. The Billing Dispute External Review Process shall be conducted

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by Hayes, Plus (the "Billing Dispute Administrator"), which Billing Dispute Administrator shall designate independent certified procedure coding specialists to resolve Billing Disputes ("Reviewers"). A Billing Dispute shall be resolved on a written record, consisting of documents submitted by the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization and CIGNA HealthCare, without oral argument. The procedures for submission of Billing Disputes and the identity of the Reviewers are posted on CIGNA HealthCare's Website. CIGNA HealthCare and the appealing Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization shall supply appropriate documentation to the designated Reviewer not later than thirty (30) days after request by such Reviewer.

d. Notwithstanding the foregoing, a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization may submit a Billing Dispute if less than Five Hundred Dollars ($500) is at issue and if such Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute which involve issues that are the same as or similar to those of the original Billing Dispute, in which event the Billing Dispute External Review Process will, at the request of such Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization, be deferred while the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the conclusion date on Exhibit 9, the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization has not accumulated the requisite amount of Billing Disputes and CIGNA HealthCare has chosen not to continue the Billing Dispute External Review Process following the conclusion date on Exhibit 9, then any rights the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization had as to such Billing Disputes, including rights to arbitration, shall be tolled from the date the Billing Dispute was submitted to the Billing Dispute External Review Process through and including the conclusion date on Exhibit 9.

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e. In any event, a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization will have one (1) year from the date he, she or it submits the original Billing Dispute and requests that consideration of such Billing Dispute should be deferred to allow submission of additional Billing Disputes involving issues that are the same as or similar to those of the original Billing Dispute and amounts in dispute that in aggregate exceed Five Hundred Dollars ($500). In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute Administrator shall dismiss the original Billing Dispute and any such additional Billing Disputes and, in that event, the filing fee will be refunded by CIGNA HealthCare to the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization.

f. The filing fee shall be payable upon the submission of the original Billing Dispute and shall apply to all subsequent Billing Disputes submitted pursuant to the first sentence of Section 7.10.d until the aggregate amount at issue exceeds One Thousand Dollars ($1,000) at which time additional filing fees will be payable in accordance with Section 7.10.i. The Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches Five Hundred Dollars ($500) and, in that event, the filing fee will be refunded by CIGNA HealthCare to the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization.

g. The Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization must exhaust CIGNA HealthCare's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Process; provided that a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization shall be deemed to have satisfied this requirement if CIGNA HealthCare does not communicate notice of a final decision resulting from such internal appeals process within forty-five (45) days of receipt of all documentation required to decide the internal appeal. In the event CIGNA HealthCare and a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization disagree as to whether the requirements of the preceding sentence have been satisfied, such disagreement

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shall be resolved through the Billing Dispute External Review Process. Except as otherwise provided in this Section 7.10, all Billing Disputes must be submitted to the Billing Dispute External Review Process no more than ninety (90) days after a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization exhausts CIGNA HealthCare's internal appeals process and the Billing Dispute External Review Process shall not be used to hear or decide any Billing Dispute submitted more than ninety (90) days after CIGNA HealthCare's internal appeals process has been exhausted. The Billing Dispute Administrator shall resolve any question as to whether a Billing Dispute has been timely submitted and such decision shall be final and not reviewable. The Billing Dispute Administrator shall also resolve any question as to whether a submitted dispute is properly cognizable as a Billing Dispute and such decision shall be final and non-reviewable. CIGNA HealthCare shall supply appropriate documentation to the Billing Dispute External Review Process not later than thirty (30) days after request by the Reviewer, which request shall not be made if Billing Disputes are submitted pursuant to Section 7.10.d until Billing Disputes have been submitted involving amounts in dispute that in aggregate exceed Five Hundred Dollars ($500).

h. Except to the extent otherwise specified in this Section 7.10, procedures for review through the Billing Dispute External Review Process, including without limitation the documentation to be supplied to the Reviewer and a prohibition on *ex parte* communications between any party and the Reviewer, shall be set by agreement between CIGNA HealthCare and Lead Counsel, and shall be set forth in the annual report referenced in Section 15.1.b. of this Agreement. Such procedures shall provide that (i) a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization submitting a Billing Dispute to the Billing Dispute External Review Process shall state in the documents submitted to the Billing Dispute External Review Process the amount in dispute, and (ii) the Reviewer shall not be permitted to issue an award based on an amount that exceeds the amount stated by such Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization in the documents submitted to the Billing Dispute External Review Process to be in dispute.

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i. For any Billing Dispute that a Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization submits to the Billing Dispute External Review Process, the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization submitting such Billing Dispute shall pay to CIGNA HealthCare a filing fee calculated as follows: (i) if the amount in dispute is One Thousand Dollars ($1,000) or less, the filing fee shall be Fifty Dollars ($50) or (ii) if the amount in dispute exceeds One Thousand Dollars ($1,000), the filing fee shall be equal to Fifty Dollars ($50), *plus* five percent (5%) of the amount by which the amount in dispute exceeds One Thousand Dollars ($1,000), but in no event shall the fee be greater than fifty percent (50%) of the cost of the review.

j. CIGNA HealthCare's contract(s) with the Billing Dispute Administrator shall require decisions to be rendered not later than thirty (30) days after receipt of all the documents necessary for the review and to provide notice of such decision to the parties promptly thereafter.

k. In the event that a decision is rendered as a result of the Billing Dispute External Review Process requiring payment by CIGNA HealthCare, CIGNA HealthCare shall make such payment after CIGNA HealthCare receives notice of such decision, less any portion of such amount that is payable by the CIGNA HealthCare Member under his or her Plan Documents, provided that the interest described in Section 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Billing Dispute External Review Process that was not provided to CIGNA HealthCare during the internal appeals process.

l. CIGNA HealthCare agrees to record in writing a summary of the results of the review proceedings conducted through the Billing Dispute External Review Process, including without limitation the issues presented. CIGNA HealthCare agrees to include a summary of the dispositions of such proceedings in the annual report referenced in Section 15.1.b. of this Agreement. If the same issue is the subject of not fewer than twenty (20) Billing Dispute External Review Process proceedings during the time this Section 7.10 is in effect and

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CIGNA HealthCare's position is overturned in at least fifty percent (50%) of such matters, CIGNA HealthCare shall bring the matter to the attention to the Healthcare Provider Advisory Committee.

m. The Billing Dispute External Review Process shall be available at the option of the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization. If such Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization elects to utilize this process, then any decision rendered through the Billing Dispute External Review Process shall be binding on CIGNA HealthCare and the Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization. For Retained Claims, all Billing Disputes shall be directed not to the Court nor to any other federal court or state court, arbitration panel (except as hereinafter provided) or any other binding or non-binding dispute resolution mechanism, but instead shall be submitted for final and binding resolution to the Billing Dispute External Review Process using the form (the "Retained Claims Form") posted on the Website and attached hereto as Exhibit 14.

n. The Billing Dispute External Review Process shall be kept in place beyond the conclusion date on Exhibit 9 and up to the Termination Date if before the conclusion date on Exhibit 9 fifty (50) Billing Disputes have been filed in each calendar year and an aggregate amount of One Hundred Thousand Dollars ($100,000) has been paid to Class Members for Billing Disputes in each calendar year.

7.11 *Appeals of Determinations Related to Medical Necessity or the Experimental or Investigational Nature of Any Proposed Health Care Service or Supplies.*

CIGNA HealthCare shall maintain the following appeal process with respect to determinations that a health care service or supply is not Medically Necessary or is of an experimental or investigational nature.

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a. *Initial Determinations.*

A Physician or other Healthcare Provider designated by CIGNA HealthCare shall be responsible for making the initial determination for CIGNA HealthCare whether proposed health care services or supplies are Medically Necessary or experimental or investigational (hereinafter in this Section 7.11 only, Medically Necessary and experimental or investigational shall collectively be referred to as Medically Necessary except where otherwise noted). A nurse or other health care professional acting for a medical director may approve any health care service or supply as being Medically Necessary, but only a Physician or other Healthcare Provider designated by CIGNA HealthCare may deny any such service or supply as being not Medically Necessary.

b. *Two Level Internal Appeals of Medical Necessity Denials.*

(1) *Level One.*

With respect to an appeal of a determination that a health care service or supply is not Medically Necessary, CIGNA HealthCare shall adopt a two level internal appeal process which allows CIGNA HealthCare Members, or a Class Member when authorized in writing by a CIGNA HealthCare Member, or without written authorization if the service has already been performed, to pursue appeals of Medical Necessity denials, as well as a separate External Review. That process shall insure that only a Physician or a Healthcare Provider (but only a Healthcare Provider practicing in the same or similar discipline) may deny the appeal of any CIGNA HealthCare Member or Class Member. A nurse or other health care professional employed by CIGNA HealthCare shall review the internal appeal and may grant but not deny the appeal. If the nurse or other health care professional does not grant the appeal, then a Physician or a Healthcare Provider (but only a Healthcare Provider practicing in the same or similar discipline) designated by CIGNA HealthCare, other than the one that made the initial determination of

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Medical Necessity, shall review and decide the Level One internal appeal in accordance with applicable CIGNA HealthCare clinical guidelines, which shall be consistent with Section 7.16.b.

(2) *Level Two.*

If the Level One review is conducted by a Physician or other Healthcare Provider who determines that the requested health care service or supply is not Medically Necessary, then the appeal shall be reviewed by and shall be decided in accordance with applicable CIGNA HealthCare guidelines, which shall be consistent with Section 7.16.b, by one of the following, provided that such person has sufficient knowledge, experience or information about the condition or treatment under review: (a) a second Physician employed or contracted by CIGNA HealthCare who is a specialist in the same specialty (but not necessarily the same sub-specialty) as the referring or prescribing Physician, or (b) a second Physician employed or contracted by CIGNA HealthCare who typically treats the same conditions as the appealing Healthcare Provider, or (c) a Healthcare Provider employed or contracted by CIGNA HealthCare who practices in the same or similar discipline as the appealing Healthcare Provider. If the CIGNA HealthCare Member does not pursue an appeal and the Physician employed or contracted to perform the Level One review is of the same specialty as the referring or prescribing Physician, or if the Physician employed or contracted to perform the Level One review typically treats the same conditions as the appealing Healthcare Provider, or if the Level One review was conducted by a Healthcare Provider practicing in the same or similar discipline as the appealing Healthcare Provider, such that no Level Two review is required, then the appealing Class Member shall be notified that the appealing Class Member may proceed to external review.

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(3) *Time Limits for Completing Internal Appeals.*

All internal appeals shall be completed within the time limits required by regulations issued by the Department of Labor, even those internal appeals for which ERISA is not applicable.

c. *Establishment of External Review Program and Scope.*

Following exhaustion of its internal appeal process, CIGNA HealthCare shall make available to CIGNA HealthCare Members whose health care benefits are provided through an Insured Plan, and to CIGNA HealthCare Members whose health care benefits are provided through a Self-Insured Plan and whose Plan sponsors have elected to participate in the program established by this Section (or in each case, by a Class Member when authorized in writing by the CIGNA HealthCare Member) the option to appeal directly an adverse determination based upon lack of Medical Necessity or the characterization of the relevant service or procedure as experimental or investigational, to an independent external review organization identified by CIGNA HealthCare (the "Medical Necessity External Review Organization"); provided that, where there has been a denial based upon Medical Necessity of services already provided, no authorization from the CIGNA HealthCare Member shall be required. The cost of the external appeal (the "Medical Necessity External Review Process") will be borne by CIGNA HealthCare, and the decision of the Medical Necessity External Review Organization shall be binding upon CIGNA HealthCare and the Class Member. Election to pursue review under this Section 7.11.c is at the option of the Class Member, who may instead choose any other remedy available as a matter of law or contract. CIGNA HealthCare shall require that the Medical Necessity External Review Organization issue its decision within thirty (30) days of the request for External Review. The external reviewer designated by the Medical Necessity External Review Organization to conduct the review shall be one of the following, provided that such person has sufficient

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knowledge, experience or information about the condition or treatment under review: (1) a Physician who is a specialist in the same specialty (but not necessarily the same sub-specialty) as the referring or prescribing Physician, or (2) a Physician who typically treats the same conditions as the appealing Healthcare Provider, or (3) a Healthcare Provider who practices in the same or similar discipline as the appealing Healthcare Provider. The Medical Necessity External Review Process offered by CIGNA HealthCare shall not supersede any state-required program for external review inconsistent with CIGNA HealthCare's external review process. In the case of a state-required external review process that is different than the process herein set forth, only the state-required program shall be utilized where applicable.

(1) The Medical Necessity External Review Organization must meet the standards for external review entities under applicable federal and state law. The External Review entity will be contracted to conduct a *de novo* review of the case consistent with Section 7.16.a(1) of this Agreement, subject to the CIGNA HealthCare Member's Plan Documents. The External Review entity shall have the authority to review any adverse determination related to the Medical Necessity of a particular health care service or supply after the CIGNA HealthCare Member or his or her Healthcare Provider, where appropriate, has exhausted the internal appeal process or after CIGNA HealthCare and the CIGNA HealthCare Member or his or her Healthcare Provider, where appropriate, agree to forego any level of internal appeal and proceed directly to external review. The CIGNA HealthCare Member or his or her Healthcare Provider, where appropriate, shall have the option to elect this review within one hundred eighty (180) days from the date of the final denial decision by CIGNA HealthCare. The Medical Necessity External Review Organization's compensation shall not be tied to the outcome of the reviews performed. Likewise, the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make decisions in a biased manner.

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(2) Notwithstanding the provisions of this Section 7.11, Class Members may not seek review of any claim for which the CIGNA HealthCare Member (or his or her representative) seeks review through the external review program. In the event that both a CIGNA HealthCare Member (or his or her representative) and a Healthcare Provider seek review before a service is rendered, the CIGNA HealthCare Member's claim shall go forward and the Healthcare Provider's claim shall be dismissed and may not be brought by or on behalf of the Healthcare Provider in any forum.

(3) Notwithstanding the provisions of this Section 7.11, Class Members may not seek review of any claim for which the CIGNA HealthCare Member (or his or her representative) has filed suit under § 502(a) of ERISA or other suit for the denial of health care services or supplies on Medical Necessity grounds. In that event, or if such a suit is subsequently initiated, the CIGNA HealthCare Member's lawsuit shall go forward and the Class Member's claims shall be dismissed and may not be brought by or on behalf of the Class Member in any forum; provided that such dismissal shall be without prejudice to any Class Member seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Class Member and not to such CIGNA HealthCare Member.

(4) Nothing contained in this Section 7.11 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA.

(5) In the event the Medical Necessity External Review Process is initiated, the Medical Necessity External Review Organization shall request documentation from CIGNA HealthCare promptly but in any event no later than five (5) Business Days after the CIGNA HealthCare Member or Class Member initiates the Medical Necessity External Review

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Process, and CIGNA HealthCare shall provide such requested documentation within ten (10) Business Days of receiving the request. The Medical Necessity External Review Organization shall provide a decision within thirty (30) days of CIGNA HealthCare's submission of all necessary information. In the event that a decision in favor of the Class Member is rendered as a result of an appeal of a Medical Necessity External Review for denial of services already provided, CIGNA HealthCare shall make payment to the Class Member, consistent with Section 7.18 of this Agreement, less any portion of allowed charges that is payable by the CIGNA HealthCare Member under his or her Plan Documents; provided that the interest described in Section 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Medical Necessity External Review Process that was not provided to CIGNA HealthCare during the internal appeal process.

(6) CIGNA HealthCare shall cause its contract with the Medical Necessity External Review Organization to be consistent with the terms of this Section 7.11.c.

7.12 *Disputes Regarding Compliance With Section 7.8.c.*

For the Physician Settlement, CIGNA HealthCare has implemented procedures for resolving disputes relating to requests for Clinical Information and has selected two persons, one of whom is experienced in issues of fraud in the health care field, and the other of whom is experienced in clinical practice (each a "Clinical Information Officer"). The procedures implemented for the Physician Settlement shall be made available to Healthcare Providers, Healthcare Provider Groups and Healthcare Provider Organizations. The Clinical Information Officers shall resolve any disputes that arise under Section 7.8.c of this Agreement with respect to any requirement of CIGNA HealthCare for the submission of Clinical Information. Such disputes shall not be the subject of review either as a Billing Dispute under Section 7.10 or as a Compliance Dispute under Section 15 (except in the case of alleged systemic violation of Section 7.8.c(i)). A Class Member may initiate the process by submitting a request for review (which may involve multiple claims of non-conformity with Section 7.8.c) using the form (the "Clinical Information Dispute Review Form") attached hereto as Exhibit 11. The request shall be

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accompanied by a filing fee of Fifty Dollars ($50) payable to CIGNA HealthCare. The Clinical Information Dispute Review Form and a description of the procedure to be followed in submitting a Clinical Information dispute are posted on the Website.

a. *Disputes Involving Section 7.8.c(i).*

If CIGNA HealthCare is not invoking its right to obtain Clinical Information for the purpose of investigating possible fraudulent, abusive or other inappropriate billing practices under Section 7.8.c(ii), then CIGNA HealthCare shall promptly (but in any event within ten (10) Business Days of receipt of the request for review) so notify the appropriate Clinical Information Officer, and both CIGNA HealthCare and the Class Member shall, upon request by the Clinical Information Officer, supply within twenty (20) Business Days of receipt of the request for review such information to the Clinical Information Officer and to the other party as they deem relevant to the issue of compliance with Section 7.8.c(i). The Clinical Information Officer shall then make a determination, binding on both parties, of the issue of compliance with Section 7.8.c(i).

b. *Disputes Involving Section 7.8.c(ii).*

If CIGNA HealthCare is invoking its right to obtain Clinical Information under Section 7.8.c(ii), then it shall promptly (but in any event within ten (10) Business Days of receipt of the request for review) so notify the appropriate Clinical Information Officer and shall submit *ex parte* and *in camera* within twenty (20) Business Days of notification to him or her its reasons for believing that it has reasonable grounds for proceeding under Section 7.8.c(ii). The Clinical Information Officer, without revealing the information or material received from CIGNA HealthCare, shall allow the Class Member to submit within twenty (20) Business Days of notice from the Clinical Information Officer, any information supporting his, her or its request beyond that submitted with the initial request. The sole responsibility of the Clinical Information Officer in these circumstances shall be to make a binding determination as to whether CIGNA HealthCare has reasonable grounds for its action. If the Clinical Information Officer determines that reasonable grounds exist, the Clinical Information Officer shall notify the parties that the

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matter has been closed pursuant to Section 7.8.c(ii). If the Clinical Information Officer determines that reasonable grounds under Section 7.8.c(ii) do not exist, he or she shall notify the parties that the requirement for submission of Clinical Information is to cease. Under no circumstances shall the Clinical Information Officer reveal to the Healthcare Provider or any other Person the evidence submitted to him or her by CIGNA HealthCare, and all material submitted to the Clinical Information Officer by CIGNA HealthCare shall be immediately returned to CIGNA HealthCare, without the retention by the Clinical Information Officer of any copies or extracts therefrom.

c. *Miscellaneous.*

The authority of a Clinical Information Officer is limited to issues of compliance with Section 7.8.c and does not extend to issues of payment or otherwise. A Clinical Information Officer shall attempt to reach a conclusion within twenty (20) days after receipt of requested documentation from the parties.

d. *Duration.*

The obligations of this Section 7.12 shall be extended beyond the conclusion date on Exhibit 9 up to the Termination Date if twenty-five (25) disputes are submitted in each calendar year up to the conclusion date.

7.13 *Participating in CIGNA HealthCare's Network.*

a. *Advance Credentialing.*

CIGNA HealthCare will allow Healthcare Providers to submit credentialing applications (including, as relevant, licensure and hospital privileges or other required information) and will begin to process such applications prior to the time that the Healthcare Provider formally changes or commences employment or changes location, provided that the Healthcare Provider must represent that he or she has new employment or intends to move to a new location. CIGNA HealthCare shall process completed applications and notify the Healthcare Provider within ninety (90) days. If a Healthcare Provider is already credentialed by CIGNA HealthCare but changes employment or changes location, CIGNA HealthCare will only require the submission

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of such additional information, if any, as is necessary to continue the Healthcare Provider's credentials based upon the changed employment or location.

b. *"All Products" or "All Affiliates" Clauses.*

CIGNA HealthCare does not include provisions in its contracts with Class Members that require, or purport to require, Class Members to participate in one or more of CIGNA HealthCare's products (*e.g.*, HMO, PPO, POS, indemnity) as a condition of participating in any other product, and shall not include such provisions in its contracts with Class Members at least through the Termination Date. With respect to CIGNA Behavioral Health, unless a Healthcare Provider or a group practice or facility rendering mental health services and CIGNA Behavioral Health agree otherwise concerning Covered Services to be provided by that Healthcare Provider, group practice or facility, those who provide Covered Services to patients for whom CIGNA Behavioral Health provides managed behavioral benefit and/or employee assistance program services and network services (both CIGNA HealthCare Members and patients covered under other health benefit arrangements) are expected to provide such Covered Services to all such patients, subject to Section 7.13.d.

c. *Termination Without Cause.*

Unless an Individually Negotiated Contract between CIGNA HealthCare and a Participating Healthcare Provider specifies a longer period of notice, or specifies that the contract may not be terminated except for cause during a defined period of time, either party shall have the right to terminate the contract without cause upon at least sixty (60) days written notice to the other party. In the event of a contract termination by either party, the following obligations shall apply with respect to the continuation of care for those patients of the Participating Healthcare Provider who are CIGNA HealthCare Members who suffer from a chronic condition requiring continuity of care and who are unable, prior to the date of termination, to arrange for an alternative means of receiving the necessary care. In the case of a continuity of care situation as defined in the preceding sentence, the Participating Healthcare Provider shall continue to render necessary care to the CIGNA HealthCare Member until CIGNA HealthCare, in conjunction with

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the CIGNA HealthCare Member, has arranged an alternative means for the provision of such care, provided that, if after the date of termination the Class Member determines that CIGNA HealthCare has not used due diligence to arrange alternative care the Class Member may take such action as is necessary to terminate the Healthcare Provider-patient relationship. CIGNA HealthCare shall pay claims by such terminating Participating Healthcare Provider for such services or supplies at rates provided by the contract to be terminated through the date of termination and thereafter at the reasonable and customary rates then prevailing for that geographical area, until such time as an alternative means for the provision of such care is arranged.

d. *Rights of Class Members to Refuse to Accept Additional Patients.*

CIGNA HealthCare will not prohibit Class Members from declining to accept CIGNA HealthCare Members as new patients while remaining open to members of plans insured or administered by other managed care companies once the number of CIGNA HealthCare Members who are patients of the Class Member reaches a certain numerical or percentage threshold established by the Class Member provided that (a) the number of CIGNA HealthCare Members who are patients of the Class Member exceeds the number of patients who are members of plans insured or administered by any other single managed care organization at the time the Class Member closes his practice to CIGNA HealthCare Members; (b) if the acceptance of new patients causes the number of patients who are members of plans insured or administered by any other managed care organization to exceed the number of CIGNA HealthCare Members, the Class Member must begin accepting new patients who are CIGNA HealthCare Members; and (c) if a patient of the Class Member becomes a CIGNA HealthCare Member by switching from a plan insured or administered by another managed care organization to one insured or administered by CIGNA HealthCare, the Class Member must continue as the patient's Healthcare Provider. Furthermore, CIGNA HealthCare will not prevent Class Members from closing their practices to all new patients.

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7.14 *Fee Schedule Changes.*

a. *Notices Regarding Fee Schedules.*

CIGNA HealthCare agrees not to reduce its fee schedule for a Participating Healthcare Provider more than once a calendar year (except as provided below in this Section 7.14.a) and shall give notice of any such change as a material adverse change subject to the provisions of Section 7.6 hereof. Notwithstanding the foregoing, in between such annual changes, CIGNA HealthCare may increase or decrease the fee schedule payment rates for vaccines, pharmaceuticals, durable medical supplies or other goods or non-professional services to reflect changes in market prices, and CIGNA HealthCare may update fee schedules to add payment rates for newly-adopted CPT® Codes and for new technologies, and new uses of established technologies, that CIGNA HealthCare concludes are eligible for payment, and to update such fee schedules to reflect any applicable interim revisions made by CMS. A change in the Healthcare Provider's contract and fee schedule may be made before December 31st of the year in which the contract became effective. Nothing contained herein shall prevent CIGNA HealthCare from maintaining, altering or expanding the use of capitation or other compensation methodologies. The requirements in this Section 7.14.a may be altered pursuant to the terms in Individually Negotiated Contracts.

b. *Payment Rules for Injectibles, Administration of Vaccines, and Review of New Technologies.*

CIGNA HealthCare agrees to pay a fee (per the applicable fee schedule for a Participating Healthcare Provider and a reasonable fee for Non-Participating Healthcare Providers) for the administration of vaccines and injectibles in addition to paying for such vaccines and injectibles. CIGNA HealthCare agrees to pay Participating Healthcare Providers for the cost of injectibles and vaccines at the rate set forth in the applicable fee schedule in each market, as in effect from time to time.

c. *Appeals of Reasonable and Customary Determinations.*

If a Non-Participating Class Member initiates a dispute using CIGNA HealthCare's internal dispute resolution procedures over how CIGNA HealthCare has determined the "reasonable and customary" charge for a given health care service or supply and, consequently, over how CIGNA HealthCare has computed the benefits payable for that health care service or supply, CIGNA HealthCare shall disclose to the Class Member initiating the dispute the data used by CIGNA HealthCare to determine the "reasonable and customary" charge for that given health care service or supply.

7.15 *Recognition of Assignments of Benefits of Plan Member.*

When billed by a Non-Participating Healthcare Provider for health care services or supplies provided to a CIGNA HealthCare Member, CIGNA HealthCare will require that the Non-Participating Healthcare Provider shall have received a valid Assignment of Benefits from the CIGNA HealthCare Member and shall have so evidenced the Assignment to CIGNA HealthCare. CIGNA HealthCare shall recognize all valid Assignments by CIGNA HealthCare Members of Plan benefits to Healthcare Providers.

7.16 *Application of Clinical Judgment to Patient-Specific and Policy Issues.*

a. *Medically Necessary/Medical Necessity Definition.*

(1) *Medically Necessary/Medical Necessity Definition.*

Except where state law or regulation requires a different definition, CIGNA HealthCare shall apply the following definition of "Medically Necessary" or comparable term in each agreement with Healthcare Providers, Healthcare Provider Groups and Healthcare Provider Organizations: "Medically Necessary" or "Medical Necessity" shall mean health care services that a Healthcare Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient or

Healthcare Provider, a Physician or any other Healthcare Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician and Healthcare Provider Specialty Society recommendations, the views of Physicians and Healthcare Providers practicing in relevant clinical areas and any other relevant factors. Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents.

(2) *External Review Statistics.*

Within not more than ninety (90) days after the end of each calendar year and at least through the Termination Date, CIGNA HealthCare shall post on its Website the number of Medical Necessity appeals sent to the Medical Necessity External Review Organization for final determination for the preceding calendar year and the percentage of such appeals that are upheld or reversed.

b. *Policy Issues Involving Clinical Judgment.*

In adopting clinical policies with respect to Covered Services, CIGNA HealthCare shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the medical community, and shall take into account Physician and Healthcare Provider Specialty Society recommendations and the views of Physicians and Healthcare Providers practicing in relevant clinical areas and any other relevant factors. CIGNA HealthCare shall continue to make such policies readily available to CIGNA HealthCare Members and Physicians via the Website or by other electronic means. Promptly after adoption, CIGNA HealthCare shall distribute a copy of each new policy or guideline to the Healthcare Provider Advisory Committee.

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c. *Future Consideration by CIGNA HealthCare of an Administrative Exemption Program.*

CIGNA HealthCare shall consider the feasibility and desirability of exempting certain Participating Healthcare Providers from certain administrative requirements based on criteria such as a Participating Healthcare Provider's delivery of quality and cost effective medical care and accuracy and appropriateness of claim submissions. CIGNA HealthCare shall not be obliged to implement any such exemption process during the time this Section 7.16.c is in effect, and Section 7.16.c is not intended and shall not be construed to limit CIGNA HealthCare's ability to implement any such program on a pilot or experimental basis, to base exemptions on any grounds determined by CIGNA HealthCare, or otherwise to implement one or more programs in only some markets.

7.17 *Billing and Payment.*

a. *Timing of Claim Submission.*

Except where CIGNA HealthCare and a Class Member have entered into an Individually Negotiated Contract that provides for a different submission period, CIGNA HealthCare shall treat all claims submitted within one hundred eighty (180) days of the date of service as timely. With respect to claims submitted more than one hundred eighty (180) days after the date of service, CIGNA HealthCare shall specify on its Website those circumstances under which such claims shall be accepted for processing and, if appropriate, for payment, pursuant to Section 7.2.a(2)(d) hereof.

b. *Claim Submission.*

CIGNA HealthCare agrees to accept both properly and timely completed paper claims submitted on Form CMS 1500, UB-92 or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format or fields. CIGNA HealthCare may continue to require submission of Clinical Information in connection with review of specific claims and as contemplated elsewhere in this Agreement, including without limitation Sections 7.8, 7.19 and 7.20; provided that nothing in this sentence is intended or shall be construed to alter

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or limit any restrictions set forth elsewhere in this Agreement concerning CIGNA HealthCare's ability to make requests for Clinical Information in connection with adjudication of claims. CIGNA HealthCare shall disclose on its Website its policies and procedures regarding the appropriate format for claim submissions and requests for Clinical Information. Nothing herein is intended to or shall alter CIGNA HealthCare's right to obtain eligibility information that it needs to process a claim from the CIGNA HealthCare Member or the CIGNA HealthCare customer for which CIGNA HealthCare insures or administers the CIGNA HealthCare Member's Plan.

7.18 *Payment of Simple Interest on Certain Claims.*

a. Through the use of two new claims platforms described in Section 7.1 of this Agreement, CIGNA HealthCare has increased its ability to autoadjudicate claims and to receive claims electronically. The level of claims submitted electronically has also increased. The new systems are presently processing for payment more than 95% of the number of fee for service claims that include the information set forth in Section 7.17.b within thirty (30) calendar days of receipt. Every claim received by CIGNA HealthCare is and at least until the conclusion date on Exhibit 9 to this Agreement will be logged with a receipt date whether the claim is received on paper or electronically. CIGNA HealthCare will continue to pursue initiatives designed to improve the timeliness of claim processing and shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to CIGNA HealthCare within twenty four (24) hours after such clearinghouse's receipt thereof.

b. CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted by Class Members that are processed and finalized for payment more than thirty (30) calendar days following the submission of all information necessary to make the claim consistent with Section 7.17.b of this Agreement. Notwithstanding the foregoing, if CIGNA HealthCare determines that an applicable state law or regulation requires interest to be computed and paid at a different interest rate, CIGNA HealthCare shall observe the requirements of that state law or regulation. Under this provision,

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simple interest shall be computed from the thirty-first (31st) day after CIGNA HealthCare receives the information necessary to make the claim consistent with Section 7.17.b to the date on which the claim is processed by CIGNA HealthCare and placed in line for payment. Interest so computed shall, at CIGNA HealthCare's election, either be included in the claim payment check or wire transfer or be remitted in a separate check or wire transfer. Notwithstanding the terms of this subparagraph, CIGNA HealthCare shall have no obligation to make any interest payment on any such claim as to which (i) the Class Member, within thirty (30) days of the submission of an original claim, submits a duplicate claim while the original claim is still being processed; or (ii) the Class Member violates the terms of his, her or its contract with CIGNA HealthCare by inappropriately billing a CIGNA HealthCare Member for the balance due from CIGNA HealthCare. In addition, with respect to interest payments that total less than One Dollar ($1.00) on any single claim ("*de minimis* interest"), CIGNA HealthCare may, at its sole option, either (i) pay such amounts in the same manner as any other interest payment under this paragraph, or (ii) if it determines that it cannot practically pay using option (i), calculate the total dollar amount of *de minimis* interest for each year during the period for which this Section 7.18 applies, and pay such amount to the National Hospice and Palliative Care Organization. If CIGNA HealthCare elects the approach described in subsection (ii) in the preceding sentence, the calculation of *de minimis* interest will be determined by a claim audit based on statistically valid claim audit procedures and will include interest on the *de minimis* interest for the preceding year, which interest of six percent (6%) per annum will be calculated on a reasonable basis. CIGNA HealthCare will provide the audits to Lead Counsel.

c. The obligations set forth in this Section 7.18 are limited to claims processed on the two new claims platforms described in Section 7.1.

7.19 *No Automatic Downcoding of Evaluation and Management Claims.*

CIGNA HealthCare shall not automatically reduce the code level of CPT® Evaluation and Management Codes billed for Covered Services. Notwithstanding the foregoing sentence, CIGNA HealthCare shall continue to have the right to deny or adjust such claims for Covered

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Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by a selected Class Member) based on a review of Clinical Information at the time the service was rendered for particular claims, a review of information derived from CIGNA HealthCare's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of Evaluation and Management services; provided that the decision to reduce is based at least in part on a review of the Clinical Information.

7.20 *Modifications to and Commitments Regarding Payment Policies.*

CIGNA HealthCare shall modify certain of its claim processing and claim payment policies as follows and will insure that its automated claims handling will be consistent with the requirements of this Agreement. If there are legislative or regulatory efforts to bring about uniform coding and editing standards, CIGNA HealthCare will not oppose such efforts. Nothing in this Section 7.20 is intended or shall be construed to require CIGNA HealthCare to pay for anything other than Covered Services for CIGNA HealthCare Members, to make payment at any particular rates, to limit CIGNA HealthCare's right to deny or adjust claims based on reasonable belief of fraudulent, abusive or other inappropriate billing practices (so long as the Class Member has had the opportunity to invoke the provisions of Section 7.12) or to supersede Individually Negotiated Contracts that specifically provide for alternative payment logic.

a. *Moratorium on Requirement that Healthcare Providers Submit Clinical Information in Order to Obtain Payment for Surgical Procedures and for Evaluation and Management Services on the Same Date of Service.*

CIGNA HealthCare shall not require Class Members to submit Clinical Information of their patient encounters in order to receive payment for both surgical procedures and CPT® Evaluation and Management services for the same patient on the same date of service. CIGNA HealthCare shall pay for both CPT® Evaluation and Management Codes and surgical codes or other procedure codes when submitted for the same patient on the same date of service with

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appropriate modifiers (*e.g.*, modifiers 25 and 57), unless a Claim Coding and Bundling Edit (which edit will be disclosed on the Website and shall be consistent with this section 7.20) precludes payment of the specific combination of billing codes involved. Additionally, CIGNA HealthCare will remove from its claim review and payment systems those Claim Coding and Bundling Edits that generally deny payment for CPT® Evaluation and Management Codes when submitted with surgical or other procedure codes for the same patient on the same date of service except for a discrete number of exceptions which will be disclosed on CIGNA HealthCare's Website. Nothing in this Agreement shall prohibit CIGNA HealthCare from requiring use of the appropriate CPT® Code modifiers for Evaluation and Management billing codes (*e.g.*, modifiers 25 and 57) on their original claim forms. Moreover, nothing in this Agreement shall preclude CIGNA HealthCare from requiring Participating Healthcare Providers and Non-Participating Healthcare Providers (to the extent the audit is limited to claims submitted under an Assignment of Benefits) to submit to an audit of their submitted claims (including claims for surgical procedures and Evaluation and Management services on the same date of service), and to produce copies of their Clinical Information in connection with such an audit.

b. *Termination of Use of "Well Woman" Billing Code for Obstetrical and Gynecological Examinations.*

Since October 14, 2003, CIGNA HealthCare has processed claims for obstetrical and gynecological examinations using standard CPT® Codes denoting Evaluation and Management services, eliminating use of the CIGNA HealthCare "well woman" code (*i.e.*, code 90769).

c. *Processing of Add-On and Modifier 51 Exempt Billing Codes.*

CIGNA HealthCare will process and separately reimburse add-on billing codes and modifier 51 exempt billing codes without reducing payment under CIGNA HealthCare's Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to the guidelines and protocols set forth in CPT®.

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d. *Recognition of CPT® Codes and HCPCS Level II Codes.*

CIGNA HealthCare shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, CIGNA HealthCare shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require CIGNA HealthCare to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any CIGNA HealthCare Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

e. *CPT® Code That Includes Supervision and Interpretation.*

A CPT® Code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided, that for each such procedure (*e.g.*, review of x-ray or biopsy analysis), CIGNA HealthCare shall not be required to pay for supervision or interpretation by more than one physician or Healthcare Provider; and provided further that, consistent with Section 7.8.c of this Agreement, nothing in this Section 7.20.e shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements of the billed CPT® Code have been satisfied.

f. *Indented Codes.*

Other than codes specifically identified as modifier 51-exempt or "add-on," a CPT® Code that is considered an indented code within CPT® shall not be reassigned into the primary (*i.e.*, non-indented) code, from the same CPT® Code series, unless more than one indented code under the same indentation is submitted with respect to the same service, in which event only one such code shall be eligible for payment; provided that for indented code series contemplating

that multiple codes in such series properly may be reported and billed concurrently, all such codes properly billed shall be recognized and eligible for payment.

g. *Modifier 59.*

CPT® Codes submitted with a modifier 59 attached will be recognized and eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Healthcare Provider, but only to the extent that (1) although such procedures or services are not normally reported together they are appropriately reported together under the particular presenting circumstances; (2) it would not be more appropriate to append any other CPT® recognized modifier to such codes; and (3) to the extent that the CPT® Code submitted for payment with a modifier 59 attached is otherwise subject to a Claim Coding and Bundling edit, substantiating Clinical Information indicates that the use of modifier 59 was appropriate (which requirement shall be posted on the Website consistent with Section 7.8.c of this Agreement).

h. *Global Periods.*

No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict CIGNA HealthCare from establishing global periods for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).

i. *Code Changes.*

CIGNA HealthCare shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® Code is one among a series that differentiates among simple, intermediate and complex; provided that, consistent with Section 7.8.c of this Agreement, nothing in this Section 7.20.i shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements for intermediate and complex versions of the service have been satisfied.

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j. *Other Modifiers.*

Nothing contained in this Section 7.20 shall be construed to limit CIGNA HealthCare's recognition of modifiers to those modifiers specifically addressed in this Section 7.20.

k. *No Differentiation Among Provider Specialties.*

CIGNA HealthCare's claim processing and claim payment policies do not distinguish among provider types or specialties with respect to the application of CPT® codes or edits. CIGNA HealthCare will not change its current practice during the term of this Agreement.

7.21 *Modifications of Language Included in Remittance Forms Provided to Class Members.*

a. *Remittance Forms.*

CIGNA HealthCare shall use its best efforts to identify on those Remittance Forms issued to Class Members the following information: the name of and a number identifying the CIGNA HealthCare Member, the date of service, the amount of payment per line item, any adjustment to the invoice submitted and generic explanation therefor in compliance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requirements, all billing codes submitted by the Class Members and the distinct charges therefor, and whether such codes were paid or denied, and, if denied, the reasons therefor, and an address and telephone number for questions regarding the claim described in the Remittance Form. Such Remittance Forms shall also contain a printed disclosure advising Class Members that reconsideration of the application of any denied billing codes, regardless of the reason for the denial, is available through CIGNA HealthCare's appeal procedures, which procedures may require the submission of relevant Clinical Information. The Settling Parties recognize that certain claim processing systems currently in use at CIGNA HealthCare cannot immediately meet this requirement and that implementation of this specification will require the migration of claim processing activity to the two new claim processing systems described in Section 7.1 that already meet this specification. The Settling Parties recognize that this migration effort, which is already underway, is a complex effort that will occur over time. Accordingly, until the conclusion date set forth on Exhibit 9,

CIGNA HealthCare shall provide quarterly status reports to Lead Counsel regarding its efforts to meet this specification, and shall report to Lead Counsel when the efforts are complete. Once this process of migration has been completed and Lead Counsel have been so advised, Remittance Forms shall continue to identify all distinct billing codes submitted by Class Members at least through the conclusion date listed on Exhibit 9.

b. *Balance Billing by Non-Participating Healthcare Providers.*

Nothing in this Agreement is intended to, and shall not, alter or change the rights of Non-Participating Healthcare Providers to balance bill or to bill a CIGNA HealthCare Member at rates and on terms that are agreed between the Non-Participating Healthcare Providers and the CIGNA HealthCare Member.

7.22 *Overpayment Recovery Procedures.*

CIGNA HealthCare shall initiate or continue to take actions reasonably designed to reduce Overpayments, and it shall publish on its Website an address and procedures for Healthcare Providers to return Overpayments. In addition, other than for recovery of duplicate payments, CIGNA HealthCare shall provide Healthcare Providers with thirty (30) days written notice before seeking Overpayment recovery, whether or not the Overpayment occurred during the Class Period or afterward. The notice shall state the patient name, service date, payment amount, proposed adjustment, and explanation or other information (including without limitation procedure code, where appropriate) giving Healthcare Providers reasonably specific notice of the proposed adjustment. CIGNA HealthCare shall not initiate Overpayment recovery efforts more than twelve (12) months after the original payment; provided that no time limit shall apply to initiation of Overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Self-Insured Plan; and in the event that a Healthcare Provider asserts a claim of underpayment, CIGNA HealthCare may defend or set off such claim or it may counterclaim based on Overpayments going back in time as far as the claimed underpayment.

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7.23 *Efforts to Improve Accuracy of Information About Eligibility of CIGNA HealthCare Members.*

CIGNA HealthCare has sought to increase the accuracy of eligibility data in its systems, and will continue to do so, by devoting resources to improving each step in the timeliness and accuracy of transmission of information from CIGNA HealthCare Members to their employers and from employers to CIGNA HealthCare, through, *inter alia*, 1) an internal end-to-end review of the eligibility process from the perspective of both the employer and CIGNA HealthCare; 2) the application of "Six Sigma" process improvement techniques, a rigorous statistical approach designed to reduce variation from targeted accuracy standards; 3) the formation of so-called Six Sigma teams to examine each important step in the chain of eligibility information registration and to develop procedures or other means to reduce inaccuracy or delays through process improvement projects; 4) measurement of the results of process improvement projects; 5) encouragement of employers to submit eligibility data in electronic form, to reduce errors and mishandling that can impact paper-based processes, and by developing a web-based process for employers who cannot use other forms of electronic submission; and 6) regular comparison of CIGNA HealthCare's eligibility data with employers' data to improve the accuracy of the data in CIGNA HealthCare's systems. The obligations set forth in this Section 7.23 are limited to the two new claims processing systems described in Section 7.1.

7.24 *Provider Service Centers.*

Since the commencement of this Litigation, CIGNA HealthCare has consolidated its provider services centers so as to have a center located at each of its five principal claims handling centers, plus four satellite provider relations centers; and it has established a provider resolution unit responsible for consolidating and coordinating the identification of problems being encountered in claim submissions and processing, researching the causes of such problems and the means for their solutions, and performing certain appeal-related functions. CIGNA HealthCare shall continue these or other efforts to improve provider services at least through the conclusion date for this commitment set forth on Exhibit 9.

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7.25 *Effect of CIGNA HealthCare Confirmation of Medical Necessity.*

CIGNA HealthCare agrees that if CIGNA HealthCare certifies that a proposed service or supply is Medically Necessary for a particular CIGNA HealthCare Member, CIGNA HealthCare shall not subsequently revoke that Medical Necessity determination absent evidence of fraud, evidence that the information submitted was materially erroneous or incomplete, or evidence of material change in the CIGNA HealthCare Member's health condition between the date that the certification was provided and the date of the service or supply that makes the proposed treatment not Medically Necessary for such CIGNA HealthCare Member. In the event that CIGNA HealthCare certifies the Medical Necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be deemed to be a new request and CIGNA HealthCare's denial of such request shall not be deemed to be inconsistent with the preceding sentence. Any policies and procedures promulgated to effectuate this commitment and in effect as of the conclusion date set forth on Exhibit 9 shall be included in the annual report referenced in Section 15.1.b. of this Agreement.

7.26 *Electronic Connectivity.*

The Website shall operate with a reasonable degree of reliability comparable to that of CIGNA HealthCare's other websites. If for any thirty (30) day period during the time this Section 7.26 is in effect, the Website is inoperable or lacks reliability comparable to that of CIGNA HealthCare's other websites, CIGNA HealthCare shall take commercially reasonable measures to enhance the operability and reliability of the Website. The report referenced in Section 15.1.b to be prepared annually shall include the dates, if any, on which the Website has been substantially inoperable.

7.27 *Information About Healthcare Providers Posted on CIGNA HealthCare's Website.*

Information currently posted on CIGNA HealthCare's Website about individual Healthcare Providers is derived from data supplied by those Healthcare Providers and from applicable agreements between CIGNA HealthCare and a Participating Healthcare Provider.

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Upon notice of an inaccuracy sent to CIGNA HealthCare (pursuant to the direction as to how to give such notice that will be posted on the Website), CIGNA HealthCare shall take steps reasonably necessary to ensure that the Website is updated within twenty (20) Business Days after receipt of such notice to reflect any corrections in the Healthcare Provider's information necessary to make it accurate. Similarly, when CIGNA HealthCare is notified by a Healthcare Provider in the manner set forth in the preceding sentence that such Healthcare Provider is incorrectly listed on CIGNA HealthCare's Website as a Participating Healthcare Provider, CIGNA HealthCare shall delete any such erroneous reference within twenty (20) Business Days after receipt of such notice and shall make corresponding changes in systems affecting the level of payments and generation of EOBs.

7.28 *Capitation Reporting.*

CIGNA HealthCare shall provide Class Members who are capitated with monthly reports within ten (10) Business Days after the beginning of each month. These monthly reports will include membership information to allow reconciliation by Class Members of capitation payments, such information to include CIGNA HealthCare Member identification number or the equivalent, name, age, address, gender, health plan, Healthcare Provider Group/Healthcare Provider Organization number, copayment, deductible, monthly capitation amount, provider effective date, type of coverage, enrollment date, and, in the monthly report following an applicable change, a report of such change. The obligations set forth in this Section 7.28 are limited to the two new claims processing systems described in Section 7.1.

7.29 *Miscellaneous.*

a. *No Introduction of "Gag Clauses."*

CIGNA HealthCare does not include in its contracts with Class Members, and, at least through the conclusion date set forth on Exhibit 9, will not include in its contracts, any provision restricting the free, open and unrestricted exchange of information between Class Members and CIGNA HealthCare Members regarding 1) the nature of the CIGNA HealthCare Member's medical conditions or treatment; 2) treatment options and the relative risks and benefits of such

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options; 3) whether or not such treatment is covered under the CIGNA HealthCare Member's Plan; and 4) any right to appeal any adverse decision by CIGNA HealthCare regarding coverage of treatment that has been recommended or rendered. CIGNA HealthCare agrees not to penalize or sanction Class Members in any way for engaging in any free, open and unrestricted communication with a CIGNA HealthCare Member with respect to the foregoing subjects or for advocating for any service on behalf of a CIGNA HealthCare Member.

b. *Ownership of Medical Records.*

CIGNA HealthCare agrees that it does not own medical records kept by Class Members; provided, however, that CIGNA HealthCare, as reasonably needed or as required by law, has the right with respect to a Participating Healthcare Provider, and Non-Participating Healthcare Provider submitting a claim for payment based on an Assignment by the CIGNA HealthCare Member to such Non-Participating Healthcare Provider of his or her benefits, to ask for and receive copies of such records or, at CIGNA HealthCare's election, to review them for treatment, payment, or health care operations purposes, for purposes required by law, and for other customary purposes such as disease management, patient management, utilization management, quality assurance, quality review, quality management, and audit (including without limitation any audit activities undertaken by CIGNA HealthCare to comply with NCQA accreditation rules); and provided further, that nothing herein is intended to or should be construed to convey to a Healthcare Provider any property interest in (i) CIGNA HealthCare's data or intellectual property, (ii) products or services offered or provided now or in the future, or (iii) any business, systems or information management process that incorporates any medical records or related data obtained by CIGNA HealthCare from such Healthcare Provider or any reports or data resulting from any such data or processes. Notwithstanding the foregoing or any other provisions of this Agreement, any right of CIGNA HealthCare to demand information or cooperation from a Non-Participating Healthcare Provider shall be limited to whatever rights to such information or cooperation CIGNA HealthCare would be able to assert for purposes required by law or through the terms of the agreement between CIGNA HealthCare and the

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CIGNA HealthCare Member upon whose Assignment of Benefits the Non-Participating Healthcare Provider has submitted a claim for payment.

c. *Limitations on Costs of Non-Judicial Dispute Resolution for Individual Healthcare Providers and Small Healthcare Provider Groups.*

In any non-judicial dispute resolution proceeding (other than under Sections 7.10, 7.11, 7.12, and 15 of this Agreement) commenced by a Class Member who has an individual contract with a CIGNA HealthCare entity or who has contracted with a CIGNA HealthCare entity through a Healthcare Provider Group contract in which the Healthcare Provider Group includes no more than six (6) individual Class Members, the Class Member's maximum share of the costs of the dispute resolution entity shall be limited to one half of those costs or One Thousand Dollars ($1,000), whichever is less. CIGNA HealthCare shall be responsible for one hundred percent (100%) of those costs that exceed Two Thousand Dollars ($2,000). This provision applies notwithstanding the requirements of any contract between CIGNA HealthCare and any Class Member requiring the Class Member to share evenly the fees of a dispute resolution procedure, including arbitration. This Section 7.29.c shall not apply to dispute resolution proceedings in which the Class Member involved purports to represent other Healthcare Providers outside of his or her Healthcare Provider Group of no more than six (6) individual Class Members. Subject to the above and except as otherwise addressed in a Healthcare Provider's contract or by law, each party will bear its own costs.

d. *Impact of this Agreement on Standard Agreements and Individually Negotiated Contracts.*

CIGNA HealthCare's standard agreements and/or ancillary documents (*e.g.*, criteria schedule) shall incorporate or be consistent with the commitments and undertakings CIGNA HealthCare makes in this Agreement. To the extent that CIGNA HealthCare's existing agreements with Participating Healthcare Providers contain provisions inconsistent with the terms hereof, CIGNA HealthCare shall administer such agreements consistent with the terms set

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forth in this Agreement; provided that where CIGNA HealthCare and a Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization have an Individually Negotiated Contract, this Agreement shall not modify or nullify the individually negotiated terms of such Individually Negotiated Contracts unless the Participating Healthcare Provider, Healthcare Provider Group or Healthcare Provider Organization notifies CIGNA HealthCare in writing, specifically setting forth the negotiated terms it seeks to have modified or nullified by this Agreement. Upon such notification, either party to the Individually Negotiated Contract may then elect to renegotiate the Individually Negotiated Contract or terminate it. Furthermore, CIGNA HealthCare, upon request, may separately agree with individual Participating Healthcare Providers, Healthcare Provider Groups or Healthcare Provider Organizations on customized rates and/or payment methodologies that deviate from the terms of its standard agreements.

e. *Impact of Agreement on Covered Services.*

Notwithstanding anything to the contrary contained in this Agreement, nothing contained herein shall supersede or otherwise alter the scope of Covered Services under a CIGNA HealthCare Member's Plan Documents or require payment by CIGNA HealthCare or a Plan for services that are not Covered Services.

f. *Privacy of Records and Right of Class Member to Elect Exemption From Use of Electronic Transactions.*

CIGNA HealthCare shall safeguard the confidentiality of CIGNA HealthCare Member medical records in accordance with HIPAA, state and other federal law and any other applicable legal requirements; provided, however, that this undertaking shall not be the subject of a Compliance Dispute, and that Healthcare Providers may resort to any other remedial measures that they may have outside this Agreement to protect their interests. If a Healthcare Provider elects not to be compliant with the portions of HIPAA relating to the electronic submission of claims, CIGNA HealthCare shall not require such Healthcare Provider to use electronic transactions or otherwise require such Healthcare Provider to become compliant with HIPAA.

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Instead, it will maintain reasonable non-electronic systems to serve the information needs of such Healthcare Providers.

g. *No Requirement to Purchase Stop-Loss Insurance.*

CIGNA HealthCare agrees that it shall not require Healthcare Providers to purchase stop-loss insurance from it.

h. *Pharmacy Provisions.*

CIGNA HealthCare shall disclose to CIGNA HealthCare Members whether that Member's Plan uses a formulary and, if so, explain what a formulary is, how CIGNA HealthCare determines which prescription medications are included in the formulary, and how often CIGNA HealthCare reviews the formulary list; and CIGNA HealthCare shall provide CIGNA HealthCare Members with formulary lists upon request. CIGNA HealthCare shall maintain the exception process that is in place on the date of Final Approval (as such process may be reasonably amended by CIGNA HealthCare) by which coverage for medications not included on the formulary may be requested. CIGNA HealthCare will continue to provide coverage for off-label uses of pharmaceuticals that have been approved by the FDA (but not approved for the prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by supporting documentation in any one of the following: (1) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (2) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals.

i. *Restrictive Endorsements.*

Where reimbursement for services is a partial payment of allowable charges, a Class Member may negotiate a check with a "Payment in Full" or other restrictive endorsement without waiving the right to pursue a remedy available under this Agreement.

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j. *Healthcare Provider Society Guidelines.*

Notwithstanding anything to the contrary in this Section 7, no claims adjudication policy or practice adhered to by CIGNA HealthCare shall be deemed to violate the terms of this Agreement to the extent such policy or practice is consistent with the then current billing or claims adjudication guidelines issued by a Healthcare Provider Specialty Society.

k. *Scope of CIGNA HealthCare's Responsibilities.*

The obligations undertaken by CIGNA HealthCare under Section 7 of this Agreement shall be applicable only to those functions or activities performed directly by CIGNA HealthCare and its employees, or third parties (other than Delegated Entities) performing functions on CIGNA HealthCare's behalf. To the extent it deems practical, CIGNA HealthCare shall endeavor to include in contracts entered into with Delegated Entities subsequent to Final Approval terms that are substantially equivalent to the terms of this Agreement; provided that CIGNA HealthCare shall not be liable hereunder in the event any Delegated Entity acts in a manner inconsistent with this Agreement.

l. *Provision of Contract Copies.*

CIGNA HealthCare will continue its practice of providing copies to Class Members of their contracts, along with all attachments, within thirty (30) days or as soon as practical, upon request of the Class Member. In addition, subject to the permission of a Participating Healthcare Provider Group or Healthcare Provider Organization with which CIGNA HealthCare has a contract, CIGNA HealthCare will provide a copy of that contract to a Class Member participant in such Healthcare Provider Group or Healthcare Provider Organization upon request of the Class Member. In its agreements with Healthcare Provider Groups or Healthcare Provider Organizations, CIGNA HealthCare will not require that a restriction on distribution of the Healthcare Provider Group or Healthcare Provider Organization agreement to a Healthcare Provider in such Group or Organization be included.

m. *State and Federal Laws and Regulations.*

Nothing contained in Section 7 of this Agreement is intended to, or shall in any

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[redacted]

way waive, reduce, eliminate or supersede any Settling Party's obligation to comply with applicable provisions of relevant state and federal law and regulations and to the extent federal or state law or regulation imposes obligations greater than those set forth in this Agreement, CIGNA HealthCare shall comply with said law or regulation; and provided that nothing in this Section 7.29.m is intended to give rise to or should be construed as giving rise to any private right of action (other than through the Compliance Dispute procedure in Section 15) for any violation of any federal or state law (whether under a breach of contract theory or any other theory) where federal or state law does not allow a private right of action for such violation.

n. *Ability of CIGNA HealthCare to Modify Means of Disclosure.*

CIGNA HealthCare may alter the method or means by which it makes any disclosure or otherwise transmits information as described in, and required by, this Agreement, so long as CIGNA HealthCare reasonably believes, expects and intends that the newly-adopted means or method of disclosure or transmission is as effective or more effective than the means or method set forth in this Agreement.

o. *Participating Healthcare Provider Status Dependent Upon Existence of Contracts; Limitations on Obligations of Non-Participating Healthcare Providers.*

CIGNA HealthCare agrees that it will treat a Class Member as a Participating Healthcare Provider only in those circumstances in which the Class Member is a party to a written contract with CIGNA HealthCare or with an intermediary with which CIGNA HealthCare has a written contract. CIGNA HealthCare further agrees that at least through the conclusion date set forth on Exhibit 9, it will not rent its networks to any other managed care company or health insurer for the purpose of providing health care services or supplies to any person who is not a CIGNA HealthCare Member; provided that nothing in this sentence shall prevent CIGNA HealthCare from making its networks available among the various current and future Subsidiaries of CIGNA Corporation; and provided, further, that nothing in this sentence shall be held to apply to a situation in which a CIGNA HealthCare customer elects to make payments on claims in respect

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the implementation of this Agreement. For any act required by Section 7 of this Agreement that cannot be undertaken without regulatory approval, the start date as to that act shall be delayed until such approval is granted.

7.31 *Estimated Value of Section 7 Initiatives.*

Since the inception of this Litigation and the Litigation resolved by the Physician Settlement and through the Termination Date, CIGNA HealthCare will have spent over Four Hundred Million Dollars ($400,000,000) in order to carry out the initiatives described in Sections 7.1, 7.2, 7.3, 7.7, 7.23 and 7.24 of this Agreement. The Settling Parties estimate that, taking into account these expenditures by CIGNA HealthCare and other commitments with respect to CIGNA HealthCare's business practices set forth in Section 7, the approximate value of the initiatives in Section 7 is in excess of the amount stated above.

7.32 *Force Majeure.*

CIGNA HealthCare shall not be liable for any delay or non-performance of its obligations under this Agreement arising from any act of God, governmental act, act of terrorism, war, fire, flood, explosion or civil commotion. The performance of CIGNA HealthCare's obligations under this Agreement, to the extent affected by the delay, shall be suspended for the period during which the cause persists.

7.33 *Mental Health Provisions.*

The following provisions shall apply when CIGNA HealthCare is responsible for insuring or administering mental health services under a Plan.

a. CIGNA HealthCare agrees that it will reimburse Healthcare Providers for appropriately coded Medically Necessary Covered Services for mental health care, including treatment for psychiatric illness and substance abuse, in the same manner in which it applies the definition of Medical Necessity to all clinical conditions, and in accordance with the definition of Medical Necessity set forth in Section 7.16 of this Agreement and subject to the terms of Plan Documents; provided that considering the appropriateness of any level of care, the following standards relevant to mental health care must be met:

(i) A diagnosis as defined by standard diagnostic nomenclatures (DSM IV or its equivalent in ICD-9-CM) and an individualized treatment plan appropriate for the patient's illness or condition;

(ii) A reasonable expectation that the patient's illness, condition, or level of functioning will be stabilized, improved, or maintained through ambulatory care, through treatment known to be effective for the patient's illness; custodial care is not typically a Covered Service;

(iii) Is not primarily for the avoidance of incarceration of the patient; and

(iv) Is not primarily for convenience of the patient or his/her family or his/her treating Healthcare Provider or Physician, or other provider.

b. CIGNA HealthCare agrees that participating psychologists, therapists with master's degrees and nurse practitioners will be listed in CIGNA Behavioral Health's provider directory. CIGNA HealthCare will allow its primary care Physicians to make direct referrals to CIGNA Behavioral Health's in-network Healthcare Providers, provided that any such referral is subject to the same precertification provisions as for other participating CIGNA Behavioral Health's Healthcare Providers. CIGNA Behavioral Health will permit Class Members to seek precertification electronically for routine outpatient care.

c. CIGNA HealthCare agrees that, where a Healthcare Provider has not entered into a different agreement with CIGNA HealthCare, CIGNA Behavioral Health, or the hospital or other mental health care facility where the services are rendered, CIGNA HealthCare will reimburse the Healthcare Provider in accordance with his or her patient's Plan terms based on his or her appropriately billed charges.

d. CIGNA Behavioral Health will post on its website (www.cignabehavioral.com) a record release form that a Healthcare Provider may print or download to obtain patient consent for release of Clinical Information to CIGNA HealthCare or CIGNA Behavioral Health, if needed for processing of claims for payment.

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and has not opted out of the Class; (2) stating that he, she or it submitted to CIGNA HealthCare the estimated dollar amount of claims set forth on the Claim Form; and (3) where applicable, the Claim Form is submitted by a Healthcare Provider Group or Healthcare Provider Organization on behalf of the Class Members listed in the Claim Form. Class Members are expected to make a reasonable good faith effort to determine that the estimated dollar amount of claims set forth in the Claim Form is accurate.

e. *Inadequate Claim Forms.*

If the Settlement Administrator finds, upon review of a timely submitted Claim Form, that required information is missing (*i.e.*, the estimated dollar amount of claims submitted to CIGNA HealthCare between January 1, 1990 and the Notice Date is not indicated, the Claim Form is not signed, etc.) or is otherwise not valid, the Settlement Administrator shall notify the Class Member by mail that the Claim Form has been rejected, with identification of the reason(s) for such rejection. The notification shall state that the Class Member has the right to resubmit the Claim Form within thirty (30) days of the date the notification was postmarked. The Settlement Administrator shall be obligated to send only one notification of deficiency to a Class Member. If a revised Claim Form is not timely resubmitted by the Class Member, or if a resubmitted Claim Form is still deficient, the Claim will not be a Valid Claim and no payment will be made by the Settlement Administrator. Decisions by the Settlement Administrator as to the validity of Claim Forms shall be final and shall not be subject to review by the Court or any other court or tribunal.

f. *Payment; Election of Payment to a Healthcare Provider Association.*

Each Class Member entitled to payment from the Settlement Fund may elect, by indicating on the Claim Form, either to receive such payment or to direct that such amount be contributed on his, her or its behalf to one of the following organizations: American Academy of Nurse Practitioners, American Chiropractic Association, American Optometric Association, American Physical Therapist Association, American Podiatric Medical Association, American Psychological Association or National Hospice and Palliative Care Organization.

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g. *Processing of Claim Forms.*

Upon determining that a Class Member has submitted a Claim Form in a timely manner, and that the Claim Form contains all required information and has been properly certified by the Class Member, the Settlement Administrator shall deem the Claim Form a Valid Claim. The Settlement Administrator shall direct that payment be made from the Settlement Fund to the Class Member, or to the organization designated by the Class Member, in accordance with Sections 8.1.h through j.

h. *Calculation of Base Payment.*

In accordance with the chart in Section 8.1.b., the Settlement Administrator shall determine the number of points to be assigned to each Valid Claim submitted by an individual Class Member or a Healthcare Provider Group or Healthcare Provider Organization.

For each Valid Claim submitted by an individual Class Member, the Settlement Administrator shall assign a number of points based on the estimated total dollar amount of claims submitted to CIGNA HealthCare as set forth in the Claim Form and the number of points corresponding to that total amount as set forth in the chart set forth in Section 8.1.b.

For each Valid Claim submitted by a Healthcare Provider Group or Healthcare Provider Organization, the Settlement Administrator shall assign a number of points as follows. The Settlement Administrator will determine the average amount billed per member by dividing the total dollar amount set forth in the Claim Form by the number of Healthcare Providers identified in the Claim Form. The Settlement Administrator will determine the total number of points assigned to the claim of the Group or Organization by multiplying the number of points assigned to the average amount in accordance with the chart set forth in Section 8.1.b by the number of such Healthcare Providers identified in the list attached to the Claim Form. No Group or Organization Claim may be assigned more than 10% of the total points assigned to all Valid Claims.

On the first Business Day following sixty (60) days after the last day of the Claims Period, the Settlement Administrator shall determine the Base Amount by (1) aggregating the total

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number of points assigned to all Valid Claims submitted by individual Class Members and the total number of points assigned to all Valid Claims submitted by Healthcare Provider Groups and Healthcare Provider Organizations and (2) dividing that number into the amount of the Settlement Fund on the date of the calculation, less any amount the Settlement Administrator estimates will be owed for the payment of taxes. The quotient resulting from that calculation shall represent the Base Amount.

i. *Calculation of Payment to Each Class Member Submitting Valid Claim.*

The Settlement Administrator shall determine the amount payable to each Class Member who or which submits a Valid Claim according to the estimated total claims the Class Member submitted to CIGNA HealthCare as set forth in Section 8.1.b and as certified on the Claim Form and, where applicable, the number of Class Members on whose behalf the Claim Form was submitted. The Settlement Administrator shall multiply the Base Amount by the number of points assigned to the Class Member's Claim, according to the chart set forth in Section 8.1.b as multiplied by the number of Class Members on whose behalf the Claim Form was submitted. The result of that calculation shall be the amount payable to the Class Member.

j. *Payment from the Settlement Fund.*

Upon completion by the Settlement Administrator of the calculations of the amounts that are payable, the Settlement Administrator shall issue payment to Class Members who or which submitted Valid Claims in accordance with this Section 8.1, or to the organizations listed in Section 8.1.f, as directed by such Class Members. Payments shall be made within twenty (20) days of the time the Settlement Administrator calculates the Base Amount pursuant to Section 8.1.h. Each check issued by the Settlement Administrator shall bear an expiration date of ninety (90) days from the date of the check, after which the check is no longer valid and may not be cashed.

k. *Distribution of Remaining Funds.*

Any funds remaining in the Settlement Fund (*e.g.*, as a result of checks not being cashed or resulting from additional accrued interest) one hundred and twenty (120) days after the

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distribution made in accordance with Section 8.1.j shall be paid in equal amounts to the organizations listed in Section 8.1.f.

8.2 *Submission to Jurisdiction of Court.*

Any Class Member submitting a Claim shall, through the act of submitting a Claim Form, agree to be subject to the jurisdiction of the Court for any related proceedings.

9. SETTLEMENT ADMINISTRATION

9.1 Lead Counsel and Defendants' Counsel have jointly selected Poorman-Douglas Corporation as the Settlement Administrator to carry out the terms of the Agreement and orders of the Court. The Settlement Administrator shall have the duties and responsibilities set forth in this Agreement including without limitation Sections 5.1, 6.1, 8 and this Section 9.

9.2 The Settling Parties, Class Counsel, and Defendants' Counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the investment of or distribution of the Settlement Fund. Settling Parties, Class Counsel, and Defendants' Counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to the determination, administration, calculation, or payment of Claims from the Settlement Fund (except as specifically described in this Agreement) or any losses incurred in connection therewith. The Billing Dispute Administrator (and its members and agents, if any), the Compliance Dispute Facilitator (and his or her agents, if any), the Compliance Dispute Review Officer (and his or her agents, if any), the Internal Compliance Officer (and his or her agents, if any), and the Clinical Information Officers do not owe a fiduciary duty to the Class Members, the Plaintiffs, or CIGNA HealthCare. The Settling Parties shall ask the Court to grant the Billing Dispute Administrator (and its members and agents, if any), the Compliance Dispute Facilitator (and his or her agents, if any), the Compliance Dispute Review Officer (and his or her agents, if any), the Internal Compliance Officer (and his or her agents, if any), and the Clinical Information Officers limited immunity from liability to the effect that the above-mentioned (and their members and agents, if any) shall be liable only for willful misconduct and gross negligence.

9.3 Administration Costs shall be paid by CIGNA HealthCare.

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9.4 No Person shall have any cause of action against the Plaintiffs, Class Counsel, the Settlement Administrator, CIGNA HealthCare, the Released Persons, or Defendants' Counsel, including any counsel representing CIGNA HealthCare in connection with this Litigation, the Compliance Dispute Review Officer, the Compliance Dispute Facilitator, the Internal Compliance Officer, the Clinical Information Officers, the Medical Necessity External Review Organization, or the Billing Dispute Administrator based on the administration or implementation of the Agreement or orders of the Court or based on the distribution of monies under the Agreement. In such circumstances, the sole remedy (other than those provided pursuant to the terms of the Agreement) is application to this Court for enforcement of the Agreement or order.

9.5 The Settlement Administrator shall make appropriate reports under Internal Revenue Code § 1099 with respect to all payments it makes to Class Members under this Agreement. The Settlement Administrator shall file any tax returns necessary with respect to any income earned by the Settlement Fund and shall pay, as and when legally required to do so, any tax payments (including interest and penalties) due on income earned by the Settlement Fund, and shall request refunds, when and if appropriate, and shall apply any such refunds that are issued to the Settlement Fund to become a part thereof.

9.6 When this Agreement requires mailed notification, other than notification undertaken pursuant to the Plan of Notice, the notification may be accomplished by transmitting the communication either by first-class mail or by electronic mail if an electronic mail address is available (for instance, if the Class Member has included an electronic mail address on a Claim Form), unless otherwise specifically set forth in this Agreement. Unless otherwise specified in this Agreement, the Settlement Administrator shall use its best efforts to send notification within fourteen (14) days of the event that requires notification.

9.7 At the conclusion of the settlement process, the Settlement Administrator shall provide a final accounting to Defendants' Counsel and Lead Counsel.



10. **THE FINAL JUDGMENT**

If at or after the Fairness Hearing, the Agreement is approved by the Court, the Settling Parties shall jointly request that the Court enter the Order and the Final Judgment in substantially the forms attached as Exhibits 2 and 3.

11. **CLASS MEMBERS WITH ARBITRATION AGREEMENTS**

For purposes of this Settlement only, CIGNA HealthCare waives its right as to Fee for Service Claims that are being released as a result of this Agreement to require those Class Members with valid, enforceable arbitration provisions to arbitrate their claims against CIGNA HealthCare. Nothing in this Agreement shall preclude Class Members from challenging the enforceability of arbitration provisions in connection with disputes or claims not resolved by this Agreement, provided, however, that no Class Member may assert that by entering into this Agreement, CIGNA HealthCare has waived its right to compel arbitration of such disputes or claims.

12. **CONDITION OF SETTLEMENT, EFFECT OF DISAPPROVAL, CANCELLATION, OR TERMINATION**

12.1 If Final Approval does not occur, the terms and provisions of this Agreement shall have no further force and effect with respect to the Settling Parties and shall not be used for any other purpose. In that event, any Final Judgment or other order entered by the Court in accordance with the terms of this Agreement shall be treated as vacated *nunc pro tunc*. Both Class Counsel and Defendants' Counsel agree that no further notice to the Class Members would be necessary under these circumstances. If, however, the Court finds it is in the best interests of Class Members to receive additional notice, then the Settling Parties agree that CIGNA HealthCare will pay for said notice. In the event of any termination pursuant to the terms hereof, the Settling Parties shall be restored to their original positions, except as expressly provided herein.

12.2 Either CIGNA HealthCare or Class Counsel on behalf of Class Members may withdraw from this Agreement if the Court does not within a reasonable period of time after the

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Preliminary Approval Hearing enter a Preliminary Approval Order as to the Settlement that includes substantially all of the terms and conditions of this Agreement. Should either CIGNA HealthCare or Lead Counsel elect to withdraw from the Settlement pursuant to this Section 12.2, the terms of Section 12.1 shall take effect.

12.3 CIGNA HealthCare may, in its sole discretion, withdraw from the Settlement if more than seven and one-half percent (7.5%) of the putative members of the Class, as identified on the Class List, elect to exclude themselves (Opt Out) from the Settlement. The percentage of the Healthcare Providers requesting exclusion shall be determined by dividing the number of names on the Class List who have submitted a valid Opt Out request by the total number of names included on the Class List. Should CIGNA HealthCare elect to withdraw from the Settlement pursuant to this Section 12.3, the terms of Section 12.1 shall take effect.

12.4 If the Court has not entered the Order and the Final Judgment substantially in the form attached hereto as Exhibits 2 and 3 by the date that is one hundred eighty (180) calendar days after the date of the entry of the Preliminary Approval Order, Class Counsel and CIGNA HealthCare may, in the sole and absolute discretion of each, terminate this Agreement by delivering a notice of termination to the other. Should either CIGNA HealthCare or Class Counsel elect to withdraw from the Settlement pursuant to this Section 12.4, the terms of Section 12.1 shall take effect.

13. RELEASE AND COVENANT NOT TO SUE

13.1 Upon Final Approval, the Releasing Parties and each of them shall hereby be deemed to have, and by operation of the Final Judgment shall have, fully, finally, and forever, remised, released, relinquished, compromised and discharged all Released Claims against each Released Person, whether or not any such Releasing Party submits any Claims or otherwise seeks any payment under the terms of this Agreement.

13.2 The Releasing Parties and each of them agree and covenant not to sue or

prosecute, institute or cooperate in the institution, commencement, filing, or prosecution of any suit on the basis of any Released Claim against any Released Person.

13.3 With respect to all Released Claims, the Releasing Parties and each of them agree that they are expressly waiving and relinquishing to the fullest extent permitted by law (a) the provisions, rights, and benefits conferred by Section 1542 of the California Civil Code, which provides:

> A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor.

and (b) any law of any state or territory of the United States, federal law or principle of common law, or of international or foreign law, which is similar, comparable or equivalent to Section 1542 of the California Civil Code.

13.4 Notwithstanding the foregoing, the Releasing Parties are not releasing claims for payment (each a "Retained Claim" and, collectively, the "Retained Claims") for Covered Services provided to CIGNA HealthCare Members prior to or on the date of Final Approval as to which, as of Final Approval, (i) no claim with respect to such Covered Services has been submitted to CIGNA HealthCare, provided that the contractual period for submitting such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been submitted to CIGNA HealthCare but such claim has not been finally adjudicated by CIGNA HealthCare. For purposes of clause (ii), above, final adjudication shall include completion of CIGNA HealthCare's internal appeals process. In the event that a claim referred to in clause (ii) is finally adjudicated less than thirty (30) days prior to Final Approval, such claim shall constitute a Retained Claim if a Healthcare Provider seeks relief under Section 7.10 not later than ninety (90) days after notice of such final adjudication, but otherwise such claim shall constitute a Released Claim. Retained Claims shall be resolved pursuant to the provisions of Section 7.10 of this Agreement.

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13.5 Upon Final Approval and until the Termination Date, each Releasing Party shall be deemed to have covenanted and agreed not to sue with respect to, or assert against, any Released Person, in any other forum (i) any Retained Claim, (ii) any dispute subject to Section 7.12, or (iii) any Compliance Dispute, which respectively shall be asserted and pursued only pursuant to the provisions of Section 7.10, Section 7.12 and Section 15.2 of this Agreement (it being understood that this Section 13.5 shall not apply to any claims that arise within twenty (20) days before the Termination Date that could not reasonably be presented or resolved pursuant to the procedures set forth in Section 15; provided that any such claim shall be prosecuted on an individual basis only and not otherwise).

13.6 Nothing in this Agreement is intended to relieve any Person that is not a Released Person from responsibility for its own conduct or conduct of other Persons who are not Released Persons, or to preclude any Plaintiff from introducing any competent and admissible evidence to the extent consistent with this Agreement. Moreover, nothing in this Agreement prevents the Plaintiffs and the Class from pursuing claims to hold any person or party that is not a Released Person liable for damages caused by any Released Person.

13.7 Notwithstanding the foregoing, Releasing Parties shall retain the rights: (i) to enforce CIGNA HealthCare's obligations under Section 7.29.m pursuant to the procedures set forth in Section 15 of this Agreement; and (ii) to bring an action asserting claims against CIGNA HealthCare by or on behalf of Healthcare Providers to recover amounts alleged to be owed to such Healthcare Providers by any Healthcare Provider Organization that has become insolvent, provided that no such action may be commenced or maintained against CIGNA HealthCare unless substantially all health plans or insurers who contracted with such Healthcare Provider Organization and have not paid all amounts allegedly owed to Healthcare Providers with respect to such insolvent Healthcare Provider Organization are named as defendants in addition to CIGNA HealthCare and further provided that in any such action CIGNA HealthCare may assert all available legal claims and defenses, including without limitation defenses based on the fraudulent conduct of such Healthcare Provider Organization.

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13.8 The Settling Parties agree that CIGNA HealthCare shall suffer irreparable harm if a Releasing Party takes action inconsistent with either Section 13.1, Section 13.2, or Section 13.5, and that in that event CIGNA HealthCare may seek an injunction from the Court as to such action without further showing of irreparable harm.

13.9 Nothing contained in this Agreement is intended, or shall be construed, to preclude any Settling Party from seeking legislative or regulatory changes as to matters addressed herein or from seeking to enforce any such changes using any available legal remedy.

14. ATTORNEYS' FEES, COSTS AND EXPENSES

14.1 Class Counsel shall petition the Court for attorneys' fees, costs and expenses not to exceed Seven Million Five Hundred Thousand Dollars ($7,500,000) (collectively referred to hereafter as "Counsels' Award"). CIGNA HealthCare shall not oppose such petition. CIGNA HealthCare shall pay Counsels' Award as ordered by the Court, which shall be in addition to the other benefits conferred upon Class Members under the Settlement. If the Court were to order a Counsels' Award in excess of Seven Million Five Hundred Thousand Dollars ($7,500,000), Class Counsel, on behalf of themselves and the Class, hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The Counsels' Award agreed to be paid pursuant to this provision is in addition to and separate from all other consideration and remedies paid to and available to the Class Members. CIGNA HealthCare shall not be obligated to pay any attorneys' fees or expenses incurred by or on behalf of any Releasing Party in connection with the Litigation, other than the payment of Counsels' Award in accordance with this Section.

14.2 At the Fairness Hearing, Class Counsel shall petition the Court for incentive awards not to exceed six thousand five hundred dollars ($6,500) for each Plaintiff, the exact amount to be determined at the Fairness Hearing. CIGNA HealthCare shall not oppose this petition. If approved by the Court, CIGNA HealthCare shall pay the amounts awarded over and above any other compensation contained in this Agreement.

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(4) The Compliance Officer will report, in summary form, on all complaints by Class Members that CIGNA HealthCare has failed to comply with the terms of this Agreement, and on the resolution of such complaints.

(5) The Compliance Officer's quarterly report will address the status of CIGNA HealthCare's best efforts to modify its claim processing systems and practices in accordance with this Agreement.

(6) The Compliance Officer's quarterly report will address any other issues referred to the Compliance Officer by CIGNA HealthCare or Lead Counsel.

b. *Annual Report.*

For calendar years 2005 and 2006, the Compliance Officer will render to CIGNA HealthCare's President and to Lead Counsel an annual report on the status of CIGNA HealthCare's compliance with the terms of this Agreement, including, with respect to instances of non-compliance, a statement of any corrective action being taken. The report shall address, at least, the following subjects with respect to the preceding year:

(1) Compliance with the processing timeliness requirements of this Agreement, including whether CIGNA HealthCare has failed to process at least ninety percent (90%) of claims within the timeframes specified by this Agreement during any continuous six (6) month period, and whether CIGNA HealthCare has failed to pay the interest required by this Agreement on the claims processed outside those timeliness requirements.

(2) Compliance with the terms of this Agreement regarding information to be included on Remittance Forms with respect to denials of claims, including any systematic noncompliance with such terms by any single CIGNA HealthCare claim processing facility.

(3) Compliance with the terms of this Agreement regarding disclosure of CIGNA HealthCare's Claim Coding and Bundling Edits and changes thereto, changes in fee schedules, CIGNA HealthCare's procedures for determining reasonable and customary

Healthcare Providers charges, and other claim processing practices and procedures on CIGNA HealthCare's Website.

c. *Internal Monitoring Mechanisms.*

CIGNA HealthCare shall create such internal mechanisms for monitoring compliance and appoint such persons to assist the Compliance Officer as may be necessary to enable the Compliance Officer to carry out the tasks heretofore described. CIGNA HealthCare's President shall approve the compliance processes outlined in this Section and a description thereof shall be furnished to Lead Counsel.

d. *Term of Internal Compliance Mechanism.*

The Compliance Officer requirements set forth in Section 15.1 shall continue in place until September 4, 2007.

15.2 *Compliance Disputes Arising Under This Agreement.*

a. *Jurisdiction.*

(1) *Compliance Dispute Facilitator.*

All Compliance Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel or any other binding or non-binding dispute resolution mechanism but to the Compliance Dispute Facilitator to be designated by Lead Counsel with the agreement of Defendants' Counsel. CIGNA HealthCare shall publish on the Website the name and address of the Compliance Dispute Facilitator. The proposed Order and the Final Judgment shall provide that no state or federal court or dispute resolution body of any kind shall have jurisdiction over any enforcement of Section 7 of this Agreement at any time, including without limitation through any form of review or appeal, except to the extent otherwise provided in this Agreement.

(2) *Compliance Dispute Review Officer.*

Pursuant to Sections 15.2.c(2) and 15.2.f and subject to Sections 15.2.d and 15.2.e, the Compliance Dispute Facilitator shall refer Compliance Disputes that satisfy the requirements of Section 15.2.c to the Compliance Dispute Review Officer for resolution. The Compliance

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Dispute Review Officer shall be the person who serves as Compliance Dispute Review Officer for the Physician Settlement.

(3) *Fees and Costs.*

CIGNA HealthCare shall pay the reasonable hourly fees and costs of the Compliance Dispute Facilitator and the Compliance Dispute Review Officer.

b. *Who May Petition the Compliance Dispute Facilitator.*

The following may petition the Compliance Dispute Facilitator (each a "Petitioner"):

(1) any Class Member who or which, based on particularized facts, contends that CIGNA HealthCare has materially failed to perform specific obligations under Section 7 of this Agreement, and that such Class Member is adversely affected by CIGNA HealthCare's failure to comply with such specific obligations under Section 7; and

(2) any Signatory Healthcare Provider Society, so long as such Signatory Healthcare Provider Society identifies in its petition to the Compliance Dispute Facilitator a Class Member who or which satisfies the requirements of Section 15.2.b(1) and brings the Compliance Dispute solely on behalf of such Class Member.

(3) Nothing in subsections (1) and (2) of this Section 15.2.b is intended or shall be construed to limit the remedies that the Compliance Dispute Review Officer may order pursuant to Section 15.2.f(4) hereof.

c. *Procedure for Submission, and Requirements, of Compliance Disputes.*

(1) *Compliance Dispute Claim Form.*

Before the Compliance Dispute Facilitator may consider a Compliance Dispute, a Petitioner must submit a properly completed Compliance Dispute Claim Form, attached hereto as Exhibit 13 and approved by the Court, to the Compliance Dispute Facilitator. The Compliance Dispute Claim Form may include supporting documentation or affidavit testimony. The Compliance Dispute Claim Form shall be made available by the Compliance Dispute Facilitator to Class Members upon request and shall be posted on Class Counsels' website(s).

(2) *Qualifying Submissions.*

When the Compliance Dispute Facilitator is petitioned pursuant to Section 15.2.c(1) of this Agreement, in order for the Compliance Dispute Facilitator to refer the Compliance Dispute to the Compliance Dispute Review Officer, the Compliance Dispute Facilitator must determine that:

(a) the Petitioner has satisfied the requirements of Section 15.2.b;

(b) the Petitioner has submitted a properly completed Compliance Dispute Claim Form not later than thirty (30) days after such Compliance Dispute arose;

(c) in the Compliance Dispute Facilitator's judgment, the Petitioner's Compliance Dispute is not frivolous;

(d) the Petitioner sufficiently alleges adverse impact to the Petitioner or, in the case of a Petitioner that is a Signatory Healthcare Provider Society, the Class Member identified in the submission and on whose behalf the Compliance Dispute is brought, in each case resulting from the alleged material failure by CIGNA HealthCare to comply with an obligation under Section 7 of this Agreement to the Petitioner;

(e) the Compliance Dispute cannot be easily resolved by the Compliance Dispute Facilitator without the intervention of the Compliance Dispute Review Officer; and

(f) the Compliance Dispute is not properly the subject of a proceeding pursuant to Section 7.10 or Section 7.11 or Section 7.12 of this Agreement. If the Compliance Dispute Facilitator determines that the Petitioner's Compliance Dispute is properly the subject of an External Review proceeding pursuant to Section 7.10 or Section 7.11 or subject to a proceeding under Section 7.12 of this Agreement, the Compliance Dispute Facilitator shall expressly inform the Petitioner of the external review procedures available to such Petitioner.

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d. *Rejection of Frivolous Claims.*

The Compliance Dispute Facilitator may reject as frivolous, and the Compliance Dispute Review Officer shall not hear, any Compliance Dispute that the Compliance Dispute Facilitator determines in his or her sole and absolute discretion to be frivolous, submitted for nuisance purposes, or otherwise without merit on its face. The Compliance Dispute Facilitator may issue a written explanation or a written order of the grounds for denial of Petitioner's Compliance Dispute. Petitioner shall have no right to appeal the Compliance Dispute Facilitator's decision.

e. *Dispute Resolution Without Referral to Compliance Dispute Review Officer.*

If in the Compliance Dispute Facilitator's judgment a Petitioner's Compliance Dispute can be resolved using available resources without the invocation of the Compliance Dispute Review Officer's authority, the Compliance Dispute Facilitator shall refer the Petitioner to the appropriate resources or otherwise assist in the resolution of the Petitioner's Dispute. All Settling Parties agree that dispute resolution without invocation of the Compliance Dispute Review Officer's authority is preferable, and all Settling Parties further agree to assist the Compliance Dispute Facilitator in these efforts.

f. *Procedure for Compliance Dispute Review Officer Determination of Compliance Disputes.*

(1) *Initial Negotiation.*

In the event the Compliance Dispute Facilitator has determined that the Compliance Dispute Review Officer should resolve a particular Compliance Dispute, the Compliance Dispute Facilitator shall notify the Compliance Dispute Review Officer, Petitioner and CIGNA HealthCare of such determination and the basis therefor. Unless the Petitioner specifies otherwise, the Compliance Dispute Facilitator shall serve as the Petitioner's representative in the Compliance Dispute process thereafter with respect to such Compliance Dispute. The Compliance Dispute Review Officer shall then direct the Petitioner and CIGNA HealthCare to convene negotiations at a time and place agreeable to both so that they may reach agreement on

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whether a breach of CIGNA HealthCare's obligations under Section 7 of this Agreement has occurred and, if so, what remedy, if any, should be implemented. At these negotiations, the Compliance Dispute Review Officer shall, if requested by both the Petitioner and CIGNA HealthCare, serve as a non-binding mediator. If the Petitioner and CIGNA HealthCare cannot resolve the Compliance Dispute within ninety (90) days of the date of the determination and notification by the Compliance Dispute Facilitator that the Compliance Dispute Review Officer should resolve the Compliance Dispute, then they shall so inform the Compliance Dispute Review Officer.

(2) *Memoranda to Compliance Dispute Review Officer.*

If the Compliance Dispute Review Officer has been notified pursuant to Section 15.2.f(1) that no agreement has been reached through negotiation, the Compliance Dispute Review Officer shall request written memoranda from the Petitioner and CIGNA HealthCare as to the merits of the Compliance Dispute and appropriate remedies for such Compliance Dispute. The Petitioner shall have fifteen (15) days from the date of the Compliance Dispute Review Officer's request to submit its memorandum and appropriate supporting exhibits, and CIGNA HealthCare shall respond within fifteen (15) days after CIGNA HealthCare's receipt of the Petitioner's memorandum and accompanying exhibits. Requests for extensions of time for the submission of such materials must be submitted to the Compliance Dispute Review Officer no less than five (5) days before the date the memoranda and supporting exhibits in question are due.

(3) *Oral Argument Concerning Compliance Dispute.*

The Petitioner or CIGNA HealthCare may, at the time of submission of the memoranda described in Section 15.2.f(2), request oral argument before the Compliance Dispute Review Officer on the subject of the Compliance Dispute and appropriate remedies, if any. If either so requests, the Compliance Dispute Review Officer shall hear such argument at a time and place convenient to the Compliance Dispute Review Officer, the Petitioner, and CIGNA HealthCare.

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(4) *Decisions by the Compliance Dispute Review Officer.*

In resolving a Compliance Dispute, the Compliance Dispute Review Officer shall decide, based on the written submissions, oral argument and any other information that the Compliance Dispute Review Officer in his or her sole discretion deems necessary, whether CIGNA HealthCare has failed to comply with its obligations under Section 7 of this Agreement, and if so, direct what actions are to be taken by CIGNA HealthCare. In no event shall the Compliance Dispute Review Officer direct that CIGNA HealthCare take actions above or beyond CIGNA HealthCare's obligations under Section 7 of this Agreement. The Compliance Dispute Review Officer must, at the time he or she announces his or her decision, issue a written opinion setting forth the basis of the decision.

(5) *Rehearing by the Compliance Dispute Review Officer.*

After the Compliance Dispute Review Officer has issued a written opinion in accordance with Section 15.2.f(4), the Petitioner or CIGNA HealthCare, or both, may petition the Compliance Dispute Review Officer within ten (10) days from receipt of the decision, in writing, for rehearing on the question of whether a Section 7 violation has occurred and whether the remedies (if any) required by the Compliance Dispute Review Officer are appropriate. The Compliance Dispute Review Officer may deny the petition for rehearing or issue a new written opinion after considering such a petition.

(6) *Systemic Violations.*

If the Compliance Dispute Review Officer determines that CIGNA HealthCare is engaged in a systemic violation of its obligations under Section 7 of this Agreement, then the Compliance Dispute Review Officer may order appropriate remedies to address such systemic violation.

(7) *Finality of the Compliance Dispute Review Officer's Decision.*

Upon the issuance of the Compliance Dispute Review Officer's decision after a rehearing, if any, the decision of the Compliance Dispute Review Officer shall be final unless appealed to the Court, and such decision shall not be appealed by the Petitioner or CIGNA HealthCare to any

other federal court, any state court, any State Medical Society, any arbitration panel or any other binding or non-binding dispute resolution mechanism. In the event that the Petitioner or CIGNA HealthCare seeks review by the Court of a final decision of the Compliance Dispute Review Officer, the Court shall consider only whether the Compliance Dispute Review Officer's final decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," as defined by 5 U.S.C. § 706(2)(A), and whether the decision was contrary to or inconsistent with the second sentence of Section 15.2.f(4) of this Agreement. If and only if the Court finds the final decision was "arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law," or that the decision was contrary to or inconsistent with the second sentence of Section 15.2.f(4) of this Agreement, the Court may remand the Compliance Dispute to the Compliance Dispute Review Officer for further proceedings.

(8) *Enforcement by the Court.*

If the Compliance Dispute Review Officer certifies that either CIGNA HealthCare or the Petitioner is not in compliance with any decision issued or remedy ordered by the Compliance Dispute Review Officer, such Person shall have thirty (30) days from the date of such certification to cure the non-compliance. If after such thirty (30) day period, the Person is not in compliance and the Compliance Dispute Review Officer certifies that the Person has failed to cure the non-compliance during such thirty (30) day period, the other Person (CIGNA HealthCare or Petitioner, as the case may be) may petition the Court for enforcement.

16. STAY OF DISCOVERY AND TERMINATION

16.1 Until the Preliminary Approval Order has been entered, including the stay of discovery as to the Released Persons in the form contained therein, the Releasing Parties and Class Counsel covenant and agree that Class Counsel shall not pursue discovery against the Released Persons and shall not in any way subsequently argue that the Released Persons have failed to comply with their discovery obligations in any respect by reason of the Released Persons' suspension of discovery efforts following the Execution Date.

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16.2 From and after Final Approval, the Releasing Parties and Class Counsel covenant and agree that the Releasing Parties and Class Counsel shall not pursue discovery against the Released Persons. Nothing contained herein shall preclude the Releasing Parties or Class Counsel from introducing and relying on otherwise admissible evidence as to other defendants.

16.3 Notwithstanding the definition of Final Approval set forth in Section 1.47 of this Agreement, if one or more notices of appeal are filed from the Order and the Final Judgment, CIGNA HealthCare shall have the right, in its sole and absolute discretion, to provide notice that it shall thereafter be bound by this Agreement and the Settling Parties shall perform their respective obligations as if Final Approval had occurred. If the Order and the Final Judgment are not affirmed in their entirety on any such appeal or discretionary review, CIGNA HealthCare may terminate this Agreement by delivering a notice of termination to Class Counsel. If CIGNA HealthCare does not elect to so terminate this Agreement, CIGNA HealthCare shall be entitled, in its sole and absolute discretion, to provide notice to Class Counsel that it shall be bound by the terms of this Agreement (if CIGNA HealthCare has not already done so pursuant to the first sentence of this Section) and the Settling Parties shall continue to be bound by this Agreement and shall perform their respective obligations hereunder as if the Order and Final Judgment had been affirmed in its entirety on such appeal or discretionary review.

16.4 This Agreement shall terminate (the "Termination Date") upon the earlier to occur of (i) termination of this Agreement by any Party pursuant to the terms hereof, and (ii) the four year anniversary of the date of the entry of the Preliminary Approval Order. Effective on the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability on the part of any of the Settling Parties, except for willful or knowing breaches of this Agreement prior to the time of such termination; provided that in the event of a termination of this Agreement as contemplated by clause (ii) of this Section 16.4, (A) the provisions of Sections 9.6, 13.1, 13.2, 13.4, 13.6, 13.7, 17, 18 and 19.14 shall survive such termination indefinitely, (B) the provisions of Section 7.10 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Billing

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Disputes that are in the process of being resolved in the Billing Dispute External Review Process as of the date of such termination and any disputes described in Section 7.11 that are being resolved pursuant to the Medical Necessity External Review Process as of the date of such termination, (C) the provisions of Section 7.12 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Disputes that are in the process of being resolved in that process as of the date of such termination and (D) the provisions of Section 15.2.f shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Compliance Disputes that are in the process of being resolved by the Compliance Dispute Review Officer as of the date of such termination. In the event of termination of this Agreement as contemplated by clause (ii) of this Section 16.4, CIGNA HealthCare agrees to submit as of the Termination Date a document (the "Certification") to the Compliance Dispute Review Officer enumerating the items described elsewhere in this Agreement as required elements of such Certification. CIGNA HealthCare shall provide a copy of such Certification to the members of the Healthcare Provider Advisory Committee. Upon the submission of the duly completed Certification by CIGNA HealthCare as of the Termination Date, all of CIGNA HealthCare's obligations under this Agreement shall be satisfied. No decision or ruling of the Compliance Dispute Review Officer shall (except with respect to Clause "(D)" above) have any force on the Settling Parties after the Termination Date and CIGNA HealthCare shall be under no obligation to continue performance of any kind under this Agreement. CIGNA HealthCare may, in its sole and absolute discretion, elect to continue after the Termination Date the implementation of various business practices described in this Agreement.

17. OTHER RELATED ACTIONS

As to any action that is now pending or hereafter may be filed in any court that asserts any of the Released Claims against CIGNA HealthCare on behalf of any Class Member, Plaintiffs and Class Counsel agree that they will cooperate with CIGNA HealthCare, to the extent reasonably practicable, in CIGNA HealthCare's effort to seek relief from the Court or the

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forum court to obtain the interim stay and dismissal with prejudice of such action as to CIGNA HealthCare to the extent necessary to effectuate the other provisions of this Agreement.

18. NOT EVIDENCE; NO ADMISSION OF LIABILITY

The Settling Parties agree that in no event shall this Agreement, in whole or in part, whether effective, terminated, or otherwise, or any of its provisions or any negotiations, statements, or proceedings relating to it in any way be construed as, offered as, received as, used as or deemed to be evidence of any kind in *Tisko, Knecht or Solomon* or in any other action, or in any judicial, administrative, regulatory or other proceeding, except in a proceeding to enforce this Agreement. Without limiting the foregoing, neither this Agreement nor any related negotiations, statements or proceedings shall be construed as, offered as, received as, used as or deemed to be evidence or an admission or concession of liability or wrongdoing whatsoever or breach of any duty on the part of CIGNA HealthCare, the Defendants or the Plaintiffs, or as a waiver by CIGNA HealthCare, the Defendants or the Plaintiffs of any applicable defense, including without limitation any applicable statute of limitations. None of the Settling Parties waives or intends to waive any applicable attorney-client privilege or work product protection or mediation privilege for any negotiations, statements or proceedings relating to this Agreement. The Settling Parties agree that this provision shall survive the termination of this Agreement pursuant to the terms hereof.

19. MISCELLANEOUS PROVISIONS

19.1 *Obligations Under Federal or State Law.*

Except as provided in this Agreement, nothing in this Agreement is intended to waive or supersede any rights that Healthcare Providers may have under state or federal law or regulations.

19.2 *Application to Insured Plans and Self-Funded Plans.*

This Agreement applies to CIGNA HealthCare's conduct with respect to both Insured Plans and Self-Funded Plans, except where otherwise specified or as provided by applicable law.

CIGNA HealthCare has no obligation under this Agreement to provide information to facilitate the submission of any Claim except as specifically set forth in this Agreement.

19.4 *Amendment or Modification of Agreement.*

This Agreement may be amended or modified only by a written instrument signed by or on behalf of all signatories to this Agreement (or their successors in interest) and approved by the Court. Beginning six (6) months after Final Approval, in the event CIGNA HealthCare encounters a change in circumstances that will cause performance or maintenance of one or more provisions of this Agreement to become impractical, it will provide notice thereof to Lead Counsel with an explanation of the changed circumstances and the proposed change in the Agreement. For this purpose, "impractical" shall mean a change in circumstances that would place CIGNA HealthCare at a meaningful competitive disadvantage, or would make performance or maintenance unduly burdensome, or would, on account of new technology, make continued performance or maintenance inefficient or less cost-effective relative to use of the new technology. Within thirty (30) days of the date of such notice, counsel for CIGNA HealthCare and Lead Counsel will meet and confer regarding the proposed change and will attempt in good faith to reach an agreement thereon. In this process, CIGNA HealthCare and Lead Counsel will consider whether there is a more efficient way in which to fulfill the intent of the applicable aspect of the Agreement. If agreement is reached, CIGNA HealthCare and Lead Counsel will jointly apply to the Court for a modification of this Settlement Agreement. If within thirty (30) days after the date of the initial meeting of CIGNA HealthCare and Lead Counsel, agreement has not been reached, then CIGNA HealthCare may apply to the Court for a modification of this Settlement Agreement.

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19.5 *Additional Signatory Healthcare Provider Societies.*

Those Healthcare Provider societies desiring to become Signatory Healthcare Provider Societies may do so by signing an agreement in the form attached hereto as Exhibit 10 and delivering the form to Class Counsel. Lead Counsel shall file such forms with the Court.

19.6 *Counterparts.*

This Agreement may be executed in one or more counterparts. All executed counterparts and each of them shall be deemed to be one and the same instrument. Lead Counsel and Defendants' Counsel shall exchange among themselves original signed counterparts and a complete set of original executed counterparts shall be filed with the Court.

19.7 *Retention by Court of Jurisdiction.*

Without affecting the finality of the Order and the Final Judgment entered in accordance with this Agreement, the Court shall retain exclusive jurisdiction with respect to the implementation and enforcement of the terms of this Agreement and all orders issued with respect to this Agreement. All Settling Parties submit to the jurisdiction of the Court for purposes of implementing and enforcing the Settlement embodied in this Agreement.

19.8 *Dismissal of Certain Litigation.*

Upon Final Approval of the Settlement in this Litigation, CIGNA HealthCare shall move to dismiss the case of: *CIGNA HealthCare of St. Louis, Inc., CIGNA HealthCare of Texas, Inc. and CIGNA Corporation v. Timothy N. Kaiser, M.D., in his capacity as class representative in a class action filed in the Circuit Court, 3rd Judicial Circuit, Madison County, Illinois, and Northwestern Medical Faculty Foundation, Midwest Neoped Associates, Ltd., Northwestern Memorial Hospital, Evanston Northwestern Healthcare Corporation, Edward Hospital*, now pending in the United States District Court for the Northern District of Illinois, Case No. 1:01-CV-5130, with prejudice.

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19.9 *Notices, and Implementation of Agreement.*

Any notice to the parties required to be given under the terms of this Agreement shall be given in writing to Lead Counsel and Defendants' Counsel. Lead Counsel are:

Debra Brewer Hayes
Reich & Binstock
4265 San Felipe, Suite 1000
Houston, TX 77027

Michael C. Dodge
Dodge, Anderson, Jones, Bezrey & Gillman, P.C.
One Lincoln Centre
5400 LBJ Freeway, Suite 910
Dallas, TX 75240

These Lead Counsel agree that they will promptly respond to any notice from CIGNA HealthCare, and they shall be responsible for informing CIGNA HealthCare of any decision by Class Counsel.

Notices to Defendants' Counsel shall be submitted to:

John G. Harkins, Jr.
Eleanor Morris Illoway
Harkins Cunningham LLP
2800 One Commerce Square
2005 Market Street
Philadelphia, PA 19103-7042

Marty L. Steinberg
Hunton & Williams
Mellon Financial Center
1111 Brickell Avenue, Suite 2500
Miami, FL 33131-3136

On behalf of CIGNA HealthCare, said counsel agree to respond promptly to any notice from Lead Counsel and shall be responsible for informing Lead Counsel of any decision by CIGNA HealthCare.

19.10 *Headings.*

The descriptive headings contained in this Agreement are for convenience of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

19.11 *Governing Law.*

This Agreement and all agreements, exhibits, and documents relating to this Agreement shall be construed under the laws of the State of Florida, excluding its choice of law rules.

19.12 *Entire Agreement.*

This Agreement, including its Exhibits, contains an entire, complete, and integrated statement of each and every term and provision agreed to by and among the Settling Parties; it is

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not subject to any condition not provided for herein. This Agreement supersedes any prior agreements or understandings, whether written or oral, between and among Plaintiffs, Class Members, Class Counsel, and CIGNA HealthCare regarding the subject matter of the Litigation or this Agreement. This Agreement shall not be modified in any respect except by a writing executed by all the Settling Parties or as provided in Section 19.4.

19.13 *No Presumption Against Drafter.*

None of the Settling Parties shall be considered to be the drafter of this Agreement or any provision hereof for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Agreement was drafted with substantial input by all Settling Parties and their counsel, and no reliance was placed on any representations other than those contained herein.

19.14 *Cooperation.*

Plaintiffs, Class Counsel and CIGNA HealthCare agree to move that the Court enter an order to the effect that should any Person desire any discovery incident to (or which the Person contends is necessary to) the approval of this Agreement, the Person must first obtain an order from the Court that permits such discovery.

19.15 *Successors and Assigns.*

The provisions of this Agreement shall be binding upon and inure to the benefit of the successors of the Settling Parties and shall be binding upon the assigns of the Class Members; provided that CIGNA HealthCare may not assign, delegate or otherwise transfer any of its rights or obligations under this Agreement without the consent of Lead Counsel.

CIGNA 001411

IN WITNESS WHEREOF, the Settling Parties have caused this Agreement to be executed by their duly authorized attorneys or representative as of the date below.

Dated this 9 day of December, 2004.

By: _____
Michael W. Bell
On Behalf of CIGNA HealthCare

By: _____
Michael C. Dodge
David W. Dodge
Dodge, Anderson, Jones, Bezrey & Gillman, P.C.
One Lincoln Centre
5400 LBJ Freeway, Suite 910
Dallas, Texas 75240
Telephone: (972) 960-3200
Fax: (972) 341-5201

By: _____
Debra Brewer Hayes
Dennis Reich
Reich & Binstock
4265 San Felipe, Suite 1000
Houston, Texas 77027
Telephone: (713) 622-7271
Fax: (713) 623-8724

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

In the Matter of	Investigation No. 09-008
CIGNA CORPORATION	

ASSURANCE OF DISCONTINUANCE
UNDER EXECUTIVE LAW § 63(15)

As authorized by Article 22-A of the General Business Law and Section 63(12) of the Executive Law, Andrew M. Cuomo, Attorney General of the State of New York, initiated an industry-wide investigation into certain business practices of health insurers, including CIGNA Corporation ("CIGNA"). The investigation concerns the system that health insurers use to reimburse consumers who have seen doctors[1] outside of the insurer's network (commonly referred to as "out-of-network").

WHEREAS the Attorney General finds that health insurers typically promise to reimburse members[2] for out-of-network care based on the fair market rate of the billed services, which insurers describe as the "reasonable and customary," "usual, customary and reasonable," or "prevailing" rate;

WHEREAS the Attorney General finds that the largest health insurers in the country and the State of New York, including UnitedHealth, Aetna, CIGNA and Wellpoint;[3] use schedules

[1] "Doctors" and "physicians" refers to all nonfacility healthcare providers unless the context indicates otherwise.
[2] "Members" refers to participants and beneficiaries in the insurer's health care benefit plans unless the context indicates otherwise.
[3] Wellpoint's subsidiary, Empire BlueCross BlueShield, the largest insurer in the State of New York, uses the Ingenix schedules to determine reimbursement rates.

(the "Ingenix schedules") compiled by the same data company, namely, Ingenix, Inc. ("Ingenix"), in determining reimbursement rates[4] for out-of-network care;

WHEREAS the Attorney General finds that among Ingenix's sources of information are the largest health insurers in the country and the State, including UnitedHealth, Aetna, CIGNA and Wellpoint;

WHEREAS Ingenix is a wholly-owned subsidiary of UnitedHealth;

WHEREAS the Attorney General finds that Ingenix has a conflict of interest in creating the schedules used as a basis for reimbursement by UnitedHealth;

WHEREAS the Attorney General finds that health insurers have an incentive to manipulate the data they submit to Ingenix so as to depress reimbursement rates they determine using the Ingenix schedules, given their own reimbursement obligations toward consumers;

WHEREAS the Attorney General finds that the Ingenix databases are a "black box" to consumers, who are left in the dark as to what reimbursement rates to expect for their out-of-network care;

WHEREAS the Attorney General finds that consumers should not be required to write effectively a blank check for out-of-network services, but should instead be able to shop intelligently for those services before choosing their doctors;

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[4] "Reimbursement rates" refers to out-of-network reimbursement rates defined by reference to physicians' billed charges, currently referred to as the "reasonable and customary," "usual, customary and reasonable," "prevailing" rate, and "average, prevailing," or similar language.

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WHEREAS most insured Americans have insurance plans allowing them to choose their own doctor;[5]

WHEREAS the Attorney General finds that this is a national problem affecting millions of consumers who are generally responsible to pay out-of-network bills irrespective of how much their insurers decide to reimburse them;

WHEREAS the Attorney General finds that the system that is meant to reimburse consumers fairly as a reflection of the market is instead wholly owned and operated by the industry;

WHEREAS the Attorney General finds that a solution requires that the healthcare system be fundamentally reformed by creating a new, independent database, not controlled by any insurer, to be used for determining fair and accurate reimbursement rates;

WHEREAS the Attorney General finds that a website should be made available to the public to disclose reimbursement rate information and to educate consumers, bringing much needed transparency to the out-of-network system; and

WHEREAS the Company has agreed to comply with the provisions of this Assurance of Discontinuance (the "Assurance") in accordance with New York Executive Law Section 63(15).

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[5] These include managed care plans with out-of-network options as well as indemnity plans, which frequently reimburse members based on usual and customary rates.

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CIGNA CORPORATION

1. CIGNA is a Delaware corporation with executive offices located in Philadelphia, Pennsylvania.

2. "Company" or "CIGNA" means CIGNA Corporation and each and every one of its divisions, subsidiaries, and affiliates. An "affiliate" of the Company encompasses any entity that controls, is controlled by, or is under common control with the Company. For purposes of all terms and conditions of this Assurance that are to be performed or satisfied in the future, "Company" shall include future divisions, subsidiaries, and affiliates of the Company, including, but not limited to, any entities or operations that the Company may hereafter acquire, or merge with, or otherwise become affiliated.

THE ATTORNEY GENERAL'S INVESTIGATION

3. During 2007 and 2008, the Office of the Attorney General (the "OAG") received complaints that consumers did not understand how health insurers computed reimbursement rates or how to challenge those determinations. Consumers questioned the rates of reimbursement for out-of-network care. Accordingly, the OAG initiated an investigation of certain insurers' determination of reimbursement rates for out-of-network services.

4. During the course of the investigation, the OAG collected and reviewed documents, analyzed data, and consulted with representatives of insurers, consumer advocacy groups, medical societies and organizations, and experts in the fields of health care economics and statistics.

STATUTORY BASES

5. The OAG investigated whether certain of the Company's alleged acts, practices, and omissions above violated: (a) Section 349 of the New York General Business Law, which prohibits deceptive acts or practices in the conduct of any business, trade, or commerce in the State of New York; or (b) Section 2601(a) of the New York Insurance Law, which prohibits insurers from engaging in unfair claims settlement practices.

6. In addition, the OAG investigated whether the Company's alleged acts and practices constituted repeated or persistent fraudulent and illegal conduct in violation of New York Executive Law Section 63(12).

FINDINGS OF THE ATTORNEY GENERAL

7. Health insurance is a valuable employee benefit or consumer purchase. Clear and accurate information is critical to consumers making healthcare decisions, including the choice of physician.

8. Certain health insurers offer lower premiums in connection with health plans where members agree to confine themselves to preferred "networks" or lists of physicians or other healthcare providers. These providers, in turn, agree to provide services for negotiated lower rates. Certain insurers charge higher premiums in connection with health plans that afford members the right to select providers from outside these preferred networks. These "out-of-network" providers have not contracted with the health insurers to provide services to members. For members who wish to see these out-of-network providers, insurers frequently promise to reimburse a percentage of either the actual amount of the charge or of the usual and customary rate, whichever is less.

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9. UnitedHealth's wholly-owned subsidiary Ingenix maintains the Prevailing Healthcare Charges System ("PHCS") and Medical Data Research ("MDR") databases (collectively, the "Ingenix Databases") with data contributed by various insurers and other entities. The Ingenix Databases generate the Ingenix schedules that are widely used by health insurers as a benchmark in determining reimbursement rates.

10. The OAG investigated numerous issues concerning the Ingenix Databases, including, but not limited to: (a) whether UnitedHealth's ownership of Ingenix creates a potential conflict of interest in determining reimbursement rates; (b) whether Ingenix manipulates the Ingenix Databases by deleting valid "high" charges and deleting proportionately more "high" charges than "low" charges; (c) whether some data contributors themselves delete valid "high" charges from the data they submit; (d) whether the Ingenix Databases contain information about the out-of-network provider's training and qualifications, the type of facility where the comparative service was provided, and the patient's condition; (e) whether Ingenix pools data from dissimilar providers (such as nurses, physician assistants, and physicians) for use in the Ingenix Databases; and (f) whether Ingenix audits data from data contributors to ensure that they have not included, among other things, negotiated or discounted rates.

11. The Attorney General finds that UnitedHealth has a conflict of interest in owning and operating the Ingenix Databases in connection with determining reimbursement rates. "Usual and customary rate" is a form of market rate designed to reflect how much doctors typically charge for the healthcare service in question. UnitedHealth subsidiaries have an obligation to reimburse members a percentage of the "usual and customary rate," depending on

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the particular benefit plan of the insured. This gives UnitedHealth a financial incentive to understate the "usual and customary" rate so as to reduce the amount reimbursed to consumers.

12. The Attorney General finds for the same reason that other health insurers have a conflict of interest in using the Ingenix Databases in determining reimbursement rates. Furthermore, other health insurers have a financial incentive to manipulate the data they provide to the Ingenix Databases so that the pooled data will skew reimbursement rates downward. When combined with Ingenix's lack of incentive to audit the data it receives and pools, consumers are at risk of under-reimbursement.

13. The largest health insurers in the country and in New York have for years used the Ingenix schedules as a benchmark for determining reimbursement rates for out-of-network care, making Ingenix the industry leader in this area.

14. The "usual and customary rate" is designed to reflect the market and as such should be determined by an independent third party free of conflicts of interest. The Attorney General rejects the notion that a health insurer can fairly determine market rates which the insurer knows it will be obliged to use as a basis for reimbursing consumers.

15. The basis and process of determining reimbursement rates is a black box to the consumer. Health insurers do not explain how they arrive at these rates and do not disclose their conflicts of interest. The lack of pricing and reimbursement information available to healthcare consumers is striking. Given the cost of healthcare and health insurance, it should go without saying that consumers need clear and accurate information before choosing their health insurance and before deciding whether to see an out-of-network doctor or other healthcare provider. Yet consumers typically do not know what they will end up owing before they go out of network. In

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effect, they are asked to write a blank check for healthcare services without any meaningful information about the extent of reimbursement they should expect. Under these circumstances, consumers have practically no ability to shop intelligently for services in the out-of-network market and this problem must be remedied.

16. The structure of the out-of-network reimbursement system is broken. The system that is meant to reimburse consumers fairly as a reflection of the market is instead wholly owned and operated by the industry. The determination of out-of-network rates is an industry-wide problem and accordingly needs an industry-wide solution. Consumers require an independent database to reflect true market rate information, rather than a database owned and operated by a health insurance company. A viable alternative that provides rates fairly reflecting the market based on reliable data and unbiased standards should be created to solve this problem. Specifically, an independent database should be set up to determine rate information by receiving and analyzing millions of pieces of claims data or other relevant billing information for the full range of healthcare services across the United States.

17. Moreover, consumers should be able to find out the rate of reimbursement before they decide to go out of network, and they should be able to find out the purchase price before they shop for insurance policies or for out-of-network care.

18. The groundbreaking reforms established by this Assurance will revolutionize the antiquated, conflict-riddled system used by hundreds of insurers across the country and affecting millions of Americans. The new system will independently and rigorously determine the prevailing rate of healthcare services. And, for the first time, the public will be able to learn the prevailing rate of healthcare services *before* choosing their doctor.

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IT NOW APPEARING THAT the Company desires to resolve the conflict of interest questions and help provide transparent information for consumers in the out-of-network setting;

THEREFORE, the OAG and the Company hereby enter into this Assurance as follows:

REFORM OF THE INDUSTRY

19. This Assurance accomplishes the Attorney General's goals of reforming the out-of-network reimbursement system by creating an independent database for out-of-network rate purposes and increasing transparency for consumers by creating a website to inform and educate the public about reimbursement rates.

20. A qualified, independent, university-level school of public health or other appropriate school in New York (the "School") will be selected to establish and operate an independent database (the "New Database") for academic research and as a tool for determining reimbursement rates.

21. The School will perform the functions described herein through a New York not-for-profit corporation (the "Not-for-Profit Company"), which will have a representative board of directors approved by the OAG.

22. The Not-for-Profit Company, as determined by the OAG, will be the owner and operator of the New Database. The Not-for-Profit Company will collect the data from data contributors and convey rate information to the recipients for reimbursement rate purposes, and will publish rate information for industry users and the public in a transparent way.

23. The Not-for-Profit Company will make rate information from the New Database available for academic research and to health insurers to help determine reimbursement rates for a period of at least five years. The School and/or the Not-for-Profit Company will also seek to

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solicit data from other health insurers and contract with other health insurers to establish itself as the independent, credible source for reimbursement information nationwide.

24. The Not-for-Profit Company or other entities as determined by the OAG will create a website available to the public to disclose out-of-network reimbursement rates for healthcare services in relevant geographic locations, and provide consumer education services in the area of health care. The website is described in further detail in Paragraphs 32 and 33 of this Assurance.

25. The Company shall give the School and/or the Not-for-Profit Company all data for all available years and all methodologies, computer programs used to accept and analyze the data, and the code forensics (changes in the codes over time) relating to the Ingenix Databases reasonably necessary in the judgment of the OAG to establish and operate the New Database (the "Database Materials"). The Company shall cooperate fully with the School and the Not-for-Profit Company and render all requested information and assistance, technical and otherwise, including any requested measures with respect to existing data, reasonably necessary in the judgment of the OAG to establish expeditiously and operate the New Database and the Consumer Website.

26. The Company shall contribute the sum of $10 million (the "Sum") for the benefit of the Not-for-Profit Company or other entities as determined by the OAG to fund the establishment and operation of the New Database and the website described in this Assurance, related services, and consumer education efforts. The Company shall pay the Sum to the Not-for-Profit Company as directed by the OAG under such terms and conditions, and in such increments and on such dates, as the OAG directs.

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27. The School and the Not-for-Profit Company shall use their best efforts to ensure that the New Database is available for use as soon as possible after the signing of the Database Agreement described in Paragraph 31 of this Assurance.

28. The OAG will notify the Company when the New Database is available for use by the Company. Within sixty (60) days of such notification (the "Notification Date"), the Company shall cease using the Ingenix Databases to determine reimbursement rates, irrespective of any disclaimer by Ingenix. Also within sixty (60) days of the Notification Date, unless excused by the OAG, the Company shall use the New Database in determining reimbursement rates for a period of five years, and shall not own, operate, or fund any other database product that provides data pooled from more than one insurer to other health insurers for determining reimbursement rates.

29. The Company shall contribute all claims data requested by the OAG and/or the Not-for-Profit Company for a period of at least five (5) years from the Notification Date. The Company shall endeavor to provide data that is as accurate and reliable as possible, in the form and manner requested by the Not-for-Profit Company. During the five-year period, the Company shall not be required to pay a fee for the use of the New Database for determining reimbursement rates.

30. The School will nominate for the OAG's approval a qualified person or entity to monitor the progress of the School and/or the Not-for-Profit Company in performing

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the functions described in this Assurance (the "Contract Monitor"). The Contract Monitor will be paid from the Sum described in Paragraph 26 of this Assurance. The Contract Monitor will report periodically to the OAG on such terms and conditions as the OAG will direct.

31. The OAG will enter into a separate agreement (the "Database Agreement") with the School and/or the Not-for-Profit Company governing the functions described in this Assurance. The Company understands that the OAG will have total discretion to negotiate the terms and other contractual arrangements with the School and/or the Not-for-Profit Company, including duration, services, use of financial proceeds, budgets, deadlines, cancellation, publication, websites, data sharing and any other terms and conditions the OAG deems appropriate. In the event that the OAG cancels the agreement with the School and/or the Not-for-Profit Company, or selects a new school or not-for-profit company to perform the functions described herein, this Assurance shall remain in full force and effect, and the OAG shall notify the Company how to disburse any remaining portion of the Sum described in Paragraph 26 of this Assurance.

CONSUMER WEBSITE

32. The Not-for-Profit Company will create a website (the "Healthcare Information Transparency Website" or "HIT Website") accessible to the public. The HIT Website will include a search function that permits users to select medical services and the zip codes for the areas where the services are sought. The search result will indicate clearly the prevailing charge amount at a stated percentile in a given geographic area, or a range of charges, from the New Database. With the search result, the HIT Website will remind consumers who access the site that their insurers or third-party administrators determine reimbursement amounts by reference to

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the applicable benefit plan document, and that the plan's sponsor or claims fiduciary may administer such benefit plan by applying a predetermined percentile of the New Database, various reimbursement policies, co-insurance, and deductibles in determining the actual reimbursement amount, or may determine reimbursement amounts using a mechanism other than the New Database or other databases of provider charges. The HIT Website will advise consumers to refer to applicable benefit plan documents or the consumer's plan administrator or insurer for further information regarding the consumer's individual plan. With the search result, the HIT Website also will remind consumers that they may be financially responsible for the balance of their providers' charges that exceed the amounts paid by their insurance or health care benefit plans.

33. The HIT Website also will describe in a transparent manner the purpose of the website, the search function, and how a health care benefit plan's reimbursement rate standard or other benchmark for determining reimbursement for out-of-network health care services may impact consumers' out-of-pocket costs. The School and the Not-for-Profit Company will use commercially reasonable efforts to launch the HIT Website within ninety (90) days after the first release of the New Database is available for use.

MEMBER DISCLOSURES

34. Within ninety (90) days after the Effective Date defined in Paragraph 49 of this Assurance, the Company shall provide additional information to its members on the Company's internet website portal accessible to members (the "Website") concerning the New Database and explaining the Company's method of determining reimbursement rates. The Company shall disclose to its members on the Website any transitional use of any Ingenix Databases, including

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the fact that Ingenix is owned by UnitedHealth. The Company also shall revise as applicable its benefit plan documents and disclosures to members, or in a separate writing to members approved in advance by the OAG, to describe clearly and accurately its out-of-network reimbursement policies and to disclose any transitional use of any Ingenix Databases, including the fact that Ingenix is owned by UnitedHealth, within a commercially reasonable time after the Effective Date.

NOT EVIDENCE; NO ADMISSION OF LIABILITY

35. In no event shall this Assurance, in whole or in part, whether effective, terminated, or otherwise, or any of its provisions or any negotiations, statements, or proceedings relating to it be construed as, offered as, received as, used as, or deemed to be evidence of any kind in any action or proceeding, except in a proceeding to enforce this Assurance. Without limiting the foregoing, neither this Assurance nor any related negotiations, statements, or proceedings shall be construed as, offered as, received as, used as, or deemed to be evidence, or an admission or concession of liability of wrongdoing or breach of any duty on the part of any party, or as a waiver by any party of any applicable defense, including without limitation any applicable statute of limitations. None of the parties waives or intends to waive any applicable attorney-client privilege or work product protection for any negotiations, statements, or proceedings relating to this Assurance. This provision shall survive termination of this Assurance.

DISCONTINUANCE OF INVESTIGATION

36. The OAG shall discontinue its investigation of the Company with respect to the conflict of interest issues described in this Assurance. The Attorney General reserves the right to

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seek financial relief such as restitution.

COSTS

37. The Company shall pay the amount of $60,000 to the OAG for costs incurred by the OAG in its investigation of the Company. The Company shall make this payment within thirty (30) days following the Effective Date of this Assurance.

COMPANY TO BEAR COSTS

38. The Company shall not seek contribution or indemnity for the funding of the OAG costs or payments made to the Not-for-Profit Company in connection with the New Database from managed care or health insurance companies based on their operation of or submission of data to the Ingenix Databases, the State of New York, the New York State Department of Civil Service, or any other employer, agency, authority, and/or other entity that participates in the New York State Empire Plan (the "Empire Plan"), or any other plan offered through the New York State Health Insurance Program or any other employer, government agency, authority and/or other government entity.

MONITORING BY THE OAG

39. The OAG may request documents and information from the Company to confirm that the Company is in compliance with the terms of this Assurance, and the Company shall cooperate in responding to the OAG's requests.

40. This Assurance does not in any way limit the OAG's right to obtain, by subpoena or by any other means permitted by law, documents, testimony, or other information to determine whether the Company has complied fully with this Assurance.

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JURISDICTIONS THAT REQUIRE USE OF INGENIX DATABASES

41. To the extent that any jurisdiction currently requires the Company to use the Ingenix Databases as the basis for determining reimbursement for out-of-network health care services, the Company shall notify the appropriate regulatory authority of this Assurance within sixty (60) days of the Effective Date. To the extent that any regulatory authority informs the Company that the provisions of this Assurance are inconsistent with the pertinent requirements of law, regulation, contract under its purview, the Company promptly shall notify the OAG.

MEMBERS' RIGHTS; LEGAL CONFLICTS

42. To the extent any provisions of this Assurance provide greater benefits to members than that required under the laws or regulations of the State of New York, any other State or Territory of the United States, or the United States as of the Effective Date or later, then the terms of this Assurance shall prevail.

43. Nothing in this Assurance is to be construed as narrowing or limiting any member's rights or any of the Company's obligations under the laws of the State of New York or the United States, or any applicable regulations thereunder. In the event there is an unresolved conflict between the requirements of the AOD and the laws of another jurisdiction or the express language of an existing contractual obligation by the Company, the OAG will resolve the conflict so as not to impose additional liability on the Company for complying with this Assurance.

DEADLINES

44. In the event that the Company in the exercise of good faith is unable to comply with a deadline prescribed in this Assurance, the Company may request additional time from the

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OAG to comply with the relevant provision.

OAG'S AUTHORITY

45. Nothing in this Assurance in any way limits the OAG's ability to investigate or take other action with respect to any non-compliance at any time by the Company with respect to this Assurance, or the Company's noncompliance with any applicable law with respect to any matters.

VALID GROUNDS AND WAIVER

46. The Company hereby accepts the terms and conditions of this Assurance and waives any right to challenge it in a proceeding under Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

CORRESPONDENCE AND PAYMENT

47. All correspondence and payment that the Company submits to the OAG concerning this Assurance or any related issues is to be sent to the attention of the person identified below or his successor:

James E. Dering, Esq.
Deputy Chief, Health Care Bureau
Office of the New York Attorney General
The Capitol
Albany, NY 12224-0341

All checks issued pursuant to this Assurance as agreed payment of the OAG's costs shall be made out to "State of New York Department of Law" and reference "Investigation No. 09-008."

MISCELLANEOUS

48. The Company shall not take any action to make or permit to be made any public statement denying, directly or indirectly, any findings of the Assurance or creating the

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impression that this Assurance is without factual basis. Notwithstanding the above, nothing in this Assurance shall affect or limit the Company's rights or legal or factual defenses in any litigation not brought by the New York State Attorney General, including but not limited to the Company's right to take any legal or factual positions in defense of litigation related to its use of Ingenix schedules.

SUCCESSORS

49. This Assurance and all obligations imposed on or undertaken by the Company are binding upon and enforceable against any subsequent owner or operator (whether by merger, transfer of control, contractual arrangements, or other means) of the Company.

EFFECTIVE DATE

50. This Assurance is effective upon the date of its last signature (the "Effective Date"), and the document may be executed in counterparts, which shall all be deemed an original for all purposes.

GOVERNING LAW

51. This Assurance and all agreements, exhibits, appendices, and documents relating to this Assurance shall be construed under the laws of the State of New York, excluding its choice of law rules.

NO PRESUMPTION AGAINST DRAFTER

52. None of the parties shall be considered to be the drafter of this Assurance or any provision for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Assurance was drafted with substantial input by all parties and their counsel, and no reliance was placed on any representation other than those contained in this Assurance.

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DIVISIONS AND HEADINGS

53. The division of this Assurance into sections and subsections and the use of captions and headings in connection herewith are solely for convenience and shall have no legal effect in construing the provisions of this Assurance.

ENTIRE AGREEMENT; AMENDMENT

54. This Assurance, including its exhibits and appendices, contains an entire, complete, and integrated statement of each and every term and provision agreed to by and among the parties, and the Assurance is not subject to any condition not provided for herein. This Assurance supersedes any prior agreements or understandings, whether written or oral, between and among the OAG and the Company regarding the subject matter of this Assurance. This Assurance may be amended or modified only as provided in a written instrument signed by or on behalf of all signatories to this Assurance (or their successors in interest).

AUTHORITY

55. Each Person signing this Assurance on behalf of a party represents and warrants that he or she has all requisite power and authority to enter into this Assurance and to implement the transactions contemplated herein, and is duly authorized to execute this Assurance on behalf of that party.

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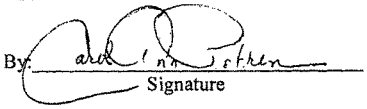
AGREED TO BY THE PARTIES:

Dated: January 21, 2009

CIGNA CORPORATION

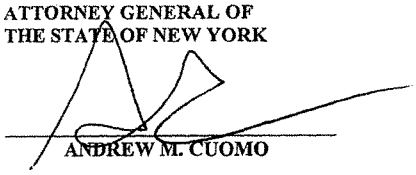
By: 
Signature

Carol Ann Petren
Name

Executive Vice President
and General Counsel
Title

Dated: February 17, 2009

ATTORNEY GENERAL OF THE STATE OF NEW YORK



ANDREW M. CUOMO

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CONFIDENTIAL SETTLEMENT AGREEMENT AND MUTUAL RELEASE

This Confidential Settlement Agreement and Mutual Release ("Agreement") is made and entered into by and among Connecticut General Life Insurance Company, including all members, directors, officers, agents, attorneys, stockholders, employees, contractors, parents, subsidiaries, affiliates, successors, assigns, servants, heirs, executors, administrators, and predecessors ("CGLIC"), on the one hand, and, on the other hand, Alexander Gross and Penni Alper, individually and as next friends of Samuel S. Gross, and Samuel Gross, through next friends Alexander Gross and Penni Alper ("Plaintiffs"). The parties to this Agreement may be referred to collectively herein as the "Parties."

WHEREAS, Plaintiffs brought certain litigation against CGLIC styled Alexander Gross et al. v. Connecticut General Life Ins. Co. d/b/a CIGNA, subsequently removed to the United States District Court for the Northern District of Georgia, pending under Civil Action File No. 1:04-cv-1000 (WSD) (the "Litigation"), arising from a policy of insurance issued by CGLIC to the Southern Medical Association that provided certain coverage to Plaintiffs.

WHEREAS, CGLIC and Plaintiffs now desire to enter into this Agreement to provide for certain payments and covenants in full settlement, compromise, and discharge of all claims that are or might have been asserted by Plaintiffs in the Litigation.

WHEREAS, CGLIC and Plaintiffs further desire to enter into this Agreement to govern the submission and coverage of certain insurance claims going forward, as specified herein, to avoid future similar disputes.

Now, therefore, in consideration of the payment, covenants, undertakings and representations described herein and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the Parties hereby agree as follows:

1. PAYMENT

Within 10 business days of Plaintiffs securing appropriate approval for the full compromise of the Litigation and to enter into this Agreement, as specified herein, and upon dismissal of the Litigation with prejudice, as specified herein, CGLIC will pay to Plaintiffs a total amount of $500,000 in consideration of full releases of all claims against CGLIC and the other agreements, covenants, and warranties contained herein.

2. RELEASES

(a) Plaintiffs, and each of them, hereby release and forever discharge CGLIC from all (i) past or present claims, actions, causes of action, rights, damages, and all other expenses or compensation of any nature whatsoever, whether known or unknown, that were asserted or could have been asserted in the Litigation and (ii) future claims, actions, causes of action, rights, damages, and all other expenses or compensation of any nature whatsoever, whether known or unknown, that accrue, arise or are otherwise acquired as a result of actions or events that occurred or transpired in whole or in part prior to the execution of this Agreement, for injuries, losses or damages, expenses, liability and obligations of every kind or character (including

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attorneys fees or expenses of litigation) that were asserted or could have been asserted in the Litigation.

(b) CGLIC hereby releases and forever discharges Plaintiffs from all (i) past or present claims, actions, causes of action, rights, damages, and all other expenses or compensation of any nature whatsoever, whether known or unknown, that were asserted or could have been asserted in the Litigation and (ii) future claims, actions, causes of action, rights, damages, and all other expenses or compensation of any nature whatsoever, whether known or unknown, that accrue, arise or are otherwise acquired as a result of actions or events that occurred or transpired in whole or in part prior to the execution of this Agreement, for injuries, losses or damages, expenses, liability and obligations of every kind or character (including attorneys fees or expenses of litigation) that were asserted or could have been asserted in the Litigation.

3. COVERAGE LIMITATIONS

(a) Plaintiffs agree that, in addition to all other applicable policy terms, conditions, and limitations, no further payment shall be made or coverage provided by CGLIC, including under the existing SMA policy, for expenses incurred by or for Samuel Gross for or in connection with speech therapy, occupational therapy, physical therapy, vocational rehabilitation, behavioral training, or training or educational therapy for, arising from, or in connection with learning disabilities, developmental delays, autism, or related conditions.

(b) Plaintiffs further: (i) agree that Plaintiffs shall not submit claims for payment or reimbursement for the services described in paragraph (a) above; (ii) agree that Plaintiffs shall inform any provider of the services described above that Plaintiffs are fully responsible for payment of all charges in connection with the services described above and that the providers should not submit claims for such services to CGLIC or any of its affiliates; (iii) agree to indemnify and hold harmless CGLIC and its affiliates from any claims for the payment for the services described in paragraph (a) above by or on behalf of any person or provider; and (iv) covenant not to sue for or in connection with such claims or the denial of such claims in the future.

4. CLAIMS OF SAMUEL GROSS

(a) Plaintiffs Alexander Gross and Penni Alper warrant that they have or shall expeditiously obtain any authority or approval necessary, including from any appropriate court, for the compromise of any claims asserted by Samuel Gross or otherwise to bind Samuel Gross to the terms of this Agreement.

(b) Plaintiffs Alexander Gross and Penni Alper agree to indemnify, defend, and hold harmless CGLIC from any claims that may be asserted by or on behalf of Samuel Gross that would have been released or compromised as part of this settlement had Samuel Gross had full capacity to agree to such terms.

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5. DISMISSAL OF THE LITIGATION

Upon execution of this Agreement by all Parties, Plaintiffs will dismiss the Litigation with prejudice.

6. CONFIDENTIALITY

The Parties may disclose the fact of their settlement but otherwise agree that they will not disclose any terms of this Agreement, including the amount of the settlement, or any non-public information related to disputes between the parties prior to execution of this Agreement except (i) as necessary to enforce the terms of this Agreement, (ii) as may be necessary to comply with any statute, regulation, or law or (iii) for financial reporting or tax purposes. In the event disclosure is made under any of the foregoing exceptions to this confidentiality provision, the disclosing party will take reasonable steps to protect the confidentiality of the information. Nothing herein shall limit the ability or right of the parties to disclose any information to related corporations or entities, accountants, auditors, attorneys, or others that may require such information in connection with the business of the parties.

7. ATTORNEYS' FEES AND COSTS

The Parties agree that each shall bear its own attorneys' fees and costs arising from the actions of its own counsel, any litigation between these parties, this Agreement, and the matters and documents referred to herein, and any and all other related matters.

8. ENTIRE AGREEMENT

This Agreement contains the entire and sole agreement between the Parties and shall be binding upon and inure to the benefit of their executors, administrators, personal representatives, heirs, successors, assigns, affiliates, subsidiaries and parent corporations. The Parties agree that there are and were no oral or written representations, warranties, understandings, stipulations, agreements or other promises pertaining to this Agreement that are not incorporated in writing in this Agreement. Neither this Agreement itself nor any terms or provisions hereof shall be amended, modified, or abrogated, except upon written agreement executed by the Parties.

9. GOVERNING LAW AND FORUM FOR DISPUTES

(a) The Parties agree and acknowledge that this Agreement shall be construed and interpreted in accordance with the substantive law of the State of Georgia, without regard to its choice of law rules, and in no event will it be construed in a manner inconsistent with Georgia law.

(b) The Parties hereby consent to the jurisdiction of any local, state, or federal court sitting in Fulton County, Georgia for adjudication of any dispute arising from, or related in any way to, the subject matter of this Agreement. Each of the Parties hereby waives any objection to the exercise of personal jurisdiction by any local, state, or federal court sitting in Fulton County, Georgia.

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10. SEVERABILITY

If any paragraph, subparagraph, sentence, or clause of this Agreement shall be adjudged illegal, invalid, or unenforceable, the balance and remainder of this Agreement shall remain in full force and effect.

11. EXECUTION IN COUNTERPARTS

This Agreement may be executed in counterparts, each of which shall be deemed an original and, together, shall constitute one and the same agreement.

12. NEGOTIATION AND COMPREHENSION OF DOCUMENT

(a) In entering into this Agreement each of the Parties represents to the others (i) that it has relied upon the advice of its respective attorney(s) and other advisor(s), who are of its own choosing, (ii) that it has not relied on any advice from the other or from any attorney or other advisor of the other, and (iii) that it has completely read and understands the terms of this Agreement and that those terms are fully understood and voluntarily accepted by it.

(b) The Parties acknowledge and agree that this Agreement is the result of negotiations between the Parties, each having its own legal counsel, and that no legal presumption will arise against either party as the drafter.

[Signatures on next page]

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WHEREFORE, the Parties have set their hands:

ALEXANDER GROSS, individually and as next friend of Samuel Gross

Date: 7/27/06

PENNI ALPER, individually and as next friend of Samuel Gross

Date: 7-27-06

SAMUEL GROSS, through next friends Alexander Gross and Penni Alper

Alexander Gross
Date: 7/27/06

Penni Alper
Date: 7-27-06

Approved as to form:

Stephen C. Andrews, Esq.
Georgia Bar No. 019650
John H. Killeen, Esq.
Georgia Bar No. 417557

BODKER, RAMSEY, ANDREWS, WINOGRAD & WILDSTEIN, P.C.
One Securities Centre
3490 Piedmont Road, N.E.
Suite 1400
Atlanta, Georgia 30305-4808
(404) 351-1615 (telephone)
(404) 352-1285 (facsimile)

Attorneys for Plaintiffs

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

By:_____
Its:_____

Date:_____

Approved as to form:

Matthew J. Calvert
Georgia Bar No. 105340
Benjamin F. Johnson IV
Georgia Bar No. 395405

HUNTON & WILLIAMS LLP
Bank of America Plaza, Suite 4100
600 Peachtree Street, N.E.
Atlanta, Georgia 30308-2216
(404) 888-4000 (telephone)
(404) 888-4190 (facsimile)

Attorneys for Connecticut General Life Insurance Company

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EXHIBIT 1 TO MOTION FOR PRELIMINARY APPROVAL OF REVISED SETTLEMENT AGREEMENT AND PROPOSED PLAN OF NOTICE AND FOR CONDITIONAL CLASS CERTIFICATION

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

Kimberly Sylvester, Lisa Steinbeiser-Maurer, Carolee Lindsey, Roger Cromwell, Jennifer Byrd, Janice Bayne, Robin Mitchum and Gladys Hall, as Personal Representative of the Estate of David Hall, on behalf of themselves and all other persons similarly situated,	)	
Plaintiffs,	)	
v.	)	
CIGNA Corporation d/b/a CIGNA Healthcare, CIGNA Holdings, Inc., Connecticut General Corporation, CIGNA Health Corporation, Healthsource, Inc., Healthsource Management, Inc., CIGNA Insurance Group, Inc., f/k/a Healthsource Insurance Group, Inc., Healthsource Corporate Services, Inc., Healthsource Employer Services, Inc., Healthsource South, Inc., Employee Benefit Plan Administration, Inc., Kilmoylar Corporation, CIGNA HealthCare of Maine, Inc., CIGNA HealthCare Preferred of Maine, Inc., Healthsource Maine Management, Inc., CIGNA HealthCare of New Hampshire, Inc., CIGNA HealthCare Preferred of New Hampshire, Inc., CIGNA HealthCare of South Carolina, Inc., CIGNA Insurance Services Company, Physicians' Health Systems, Inc., Provident Health Care Plan, Inc. of South Carolina, CIGNA HealthCare of Indiana, Inc., Healthsource Indiana, Inc., CIGNA Indiana Insurance Company, CIGNA HealthCare of Connecticut, Inc., Healthsource Connecticut Preferred, Inc., Healthsource Connecticut Ventures, Inc., CIGNA HealthCare of New York, Inc., CIGNA HealthCare Preferred of New York, Inc., Healthsource Syracuse, Inc., Healthsource Metropolitan New York Holding Company, Inc., CIGNA HealthCare of Ohio, Inc., CIGNA HealthCare Preferred of Ohio, Inc., Healthsource Ohio Ventures, Inc., CIGNA HealthCare of Kentucky, Inc., Healthsource Kentucky Ventures, Inc., Healthsource Kentucky Preferred, Inc., CIGNA HealthCare of Texas, Inc.,	)	**Civil Action No. 03-CV-176-P-S**

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Healthsource North Texas, Inc., CIGNA HealthCare of Arkansas, Inc., CIGNA HealthCare Preferred of Arkansas, Inc., Healthsource Arkansas Ventures, Inc., Spradley & Coker, Inc., CIGNA HealthCare of Georgia, Inc., Healthsource Georgia Preferred, Inc., CIGNA HealthCare of North Carolina, Inc., Provident Health Care Plan, Inc. of North Carolina, CIGNA HealthCare of North Carolina Administrators, Inc., Healthsource Health Plans, Inc., CIGNA HealthCare of Massachusetts, Inc., Healthsource Florida, Inc., CIGNA HealthCare of Tennessee, Inc., CIGNA HealthCare Preferred of Tennessee, Inc., Healthsource Insurance Company, Healthsource Provident Administrators, Inc., Provident Health Plans, Inc., Provident Health Care Plan, Inc. of Tennessee and Healthsource Rhode Island, Inc.,

Defendants.

REVISED SETTLEMENT AGREEMENT

This Revised Settlement Agreement (the "Agreement") is made by and among the Class Representatives, individually and on behalf of the Class and all Class Members, as defined in paragraph 1.7 below, and the Defendants, as defined in 1.8 below, by and through their attorneys in the above-captioned action and subject to the approval of the Court. This Agreement fully and finally compromises and settles the claims asserted by Plaintiffs, on behalf of themselves and all Class Members, in the above-captioned lawsuit *Sylvester, et al. v. CIGNA Corporation, et al.*, Docket No. 03-CV-176-P-S, filed on July 15, 2003 as a class action in the United States Court for the District of Maine ("the Class Action Litigation"). Subject to the following terms and conditions, the Class Action Litigation is hereby compromised and settled ("the Healthsource Class Action Settlement").

1.0 DEFINITIONS

As used in this Revised Settlement Agreement and the attached exhibits, in addition to any definitions set forth elsewhere in this Revised Settlement Agreement, the following terms shall be defined as set forth below:

1.1. "Agreement" or "Settlement Agreement" means this Revised Settlement Agreement, including all exhibits and attachments.

1.2. "Class Action Litigation" means the action captioned *Sylvester, et al. v. CIGNA Corporation, et al,* Docket No. 03-CV-176-P-S, filed on July 15, 2003 as a class action in the United States District Court for the District of Maine.

1.3. "Class" means the definition of the Plaintiff class as set forth in Article 4.0 of this Agreement.

1.4. "Class Counsel" means the Plaintiffs' counsel as set forth on the signature page of this Agreement.

1.5. "Class Member" or "Member" means a person included within the Class.

1.6. "Class Period" means the period of time between January 1, 1986 and December 31, 1997.

1.7. "Class Representatives" or "Plaintiffs" means Kimberly Sylvester, Lisa Steinbeiser-Maurer, Carolee Lindsey, Roger Cromwell, Jennifer Byrd, Janice Bayne, Robin Mitchum, and Gladys Hall as Personal Representative of the Estate of David Hall.

1.8. "Defendants" means all of the companies named as Defendants in Plaintiffs' Second Amended Class Action Complaint and Demand for Jury Trial ("the Second Amended Complaint"), as also listed in the above caption of this Settlement Agreement, and their successors, predecessors, parents, related organizations, subsidiaries, divisions, departments, or

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affiliates, past or present and any of their past or present officers, directors, stockholders, partners, agents, attorneys, servants, subrogees, insurers, employees, representatives, and assigns.

1.8.1. "Healthsource" means Healthsource, Inc. and its subsidiaries.

1.9. "Settlement Hearing" means the settlement approval hearing(s) to be conducted by the Court pursuant to Rule 23(e) of the Federal Rules of Civil Procedure to determine the fairness, reasonableness, and adequacy of this Agreement and the final settlement and adjudication of the Class Action Litigation in accordance with the terms thereof.

1.10. "Final Approval" means the later of (1) the day after the final day on which the Final Order and Judgment entered by the Court, in a form that is mutually agreeable to the Parties consistent with the terms of this Agreement and not materially different than the proposed Order attached as Exhibit C, approving this Agreement and the settlement of the Class Action Litigation pursuant to Rule 23(e) of the Federal Rules of Civil Procedure, can be appealed; or (2) if an appeal is filed, the date of final dismissal or other rejection of all appeals. Such Final Approval and Final Order and Judgment shall not be contingent on approval of Class Representative Compensation or attorneys' fees and/or costs payable to Class Counsel in any amount, the final amounts of such payments, if any, to be determined by the Court in its sole discretion, with all other provisions of this Settlement Agreement to remain fully effective and enforceable notwithstanding the amounts of such payments, if any, approved by the Court. Should any appeal be taken, however, from any ruling regarding the award of attorney fees or costs, or Class Representative Compensation, Final Approval shall not be deemed to have occurred until the date of final dismissal or other rejection of all such appeals — the intent of the parties being that no payments shall be made from the Settlement Trust until the amounts of all payments from the Settlement Trust shall have been finally determined.

1.11. "Health Plan Member" means any subscriber, member, dependent or other person covered and entitled to receive benefits under a Health Plan underwritten or administered by Healthsource.

1.11.1. "Health Plan" means any plan, program, or arrangement for the provision of medical, surgical, dental, mental health, or hospital care or other health benefits provided on account of injury, sickness, or disease that was underwritten or administered by Healthsource.

1.11.2. "Discounted Fee" means a reduction in the payment by Healthsource to a health care provider from the charge billed by that provider, whether determined by percentage, per diem, per capita, per case, DRG, or any other payment method.

1.12. "Parties" means Plaintiffs, Class Members, and Defendants.

1.13. "Person" means an individual or legal entity or their respective successors or assigns.

1.14. "Residual Corpus" or "Corpus" means any amount remaining in the Settlement Trust, together with accrued interest, after subtraction of the approved costs and fees of the Settlement Administrator, the approved attorney fees and costs of Class Counsel, and the approved award to the Class Representatives.

1.15. "Settled Claim" means any claim, liability, right, demand, suit, matter, obligation, damage, including consequential damages, losses or costs, punitive damages, multiple damages, attorney's fees and costs, actions or causes of action, of every kind or description that the Class and Class Members have, had, or may have against any Defendant, that arise out of or relate to the facts giving rise to the subject matter of the Class Action

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Litigation, whether known or unknown, suspected or unsuspected, asserted or unasserted, accrued or which may hereafter accrue, regardless of legal theory and the type of equitable relief or damages claimed, including, without limitation, those claims described in the Second Amended Complaint.

1.16. "Settlement Administrator" or "Administrator" means Tilghman & Co., P.C., P.O. Box 11250, Birmingham, AL, 35209.

1.17. "Share of the Settlement" means the total amount payable to each Class Member (not including awards to Class Representatives, if any) out of the Settlement Trust, as determined by the Court, whether such amount is the same for every Class Member or differs among Class Members. In no event shall the Shares of Settlement paid exceed the amount of the Residual Corpus.

2.0 SETTLEMENT PURPOSES ONLY

This Agreement is for settlement purposes only, and to the fullest extent permitted by law, neither the fact of, nor any provision contained in this Agreement or attached exhibits, nor any actions taken hereunder, shall constitute, be construed as, or used as, or be admissible in evidence as, an admission of the validity of any claim or any fact alleged by the Class and/or the Plaintiffs in this action or in any other pending or subsequently filed action, or of any wrongdoing, fault, violation of laws, or liability of any kind on the part of the Defendants or any of them, or admission by any of the Parties of the validity, or lack thereof, of any claim, allegation or defense asserted in this action or any other action. Nor shall this agreement constitute an admission, concession or indication by Plaintiffs or the Class that their alleged damages are limited to the settlement amount.

3.0 SUBMISSION FOR PRELIMINARY APPROVAL

3.1 Upon execution of this Agreement, on or before August 12, 2005, Plaintiffs shall submit this Agreement, through their attorneys, to the Court, and request that the Court enter an Order preliminarily approving the proposed settlement of the Class Action Litigation and approving the form and manner of notice to the Class ("Preliminary Approval Order"), substantially in the form attached hereto as Exhibit A.

3.2 No Party shall initiate any publicity relating to or making any public comment regarding this Agreement or settlement until the Court has issued the Preliminary Approval Order.

3.3 The Parties and their respective counsel shall limit their public comments regarding both the action and settlement to disclosure of such information as is necessary to implement this Agreement. Defendants may disclose information about the Settlement to their accountants and insurers and as deemed necessary to comply with federal and state securities law disclosure requirements or any other requirement by law.

3.4 Following entry of the Preliminary Approval Order, the Settlement Administrator shall, by first class mail, send the Notice of Pendency of Class Action, Proposed Revised Class Action Settlement, and Settlement Hearing, as approved by the Court in the Preliminary Approval Order, to the Class Members and shall make publication notice of the Notice of Pendency of Class Action and Change in Terms of Proposed Settlement, pursuant to the Notice and Settlement Distribution Plan, Exhibit B to this Agreement.

4.0 DESCRIPTION OF THE LITIGATION

The Class Action Litigation consists of the action captioned *Sylvester, et al. v. CIGNA Corporation, et al.*, Docket No. 03-CV-176-P-S, filed on July 15, 2003 as a class action in the

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United States Court for the District of Maine. For purposes of this settlement, the Class is defined as follows:

> All Health Plan Members who, at any time between January 1, 1986 and December 31, 1997, made payments to medical product or service providers under a percentage coinsurance plan, where an agreement existed between any of the Defendants and the provider to accept a Discounted Fee and where that Defendant did not use that Discounted Fee in calculating the Health Plan Member's coinsurance payment as required by the Health Plan (the "Class"). The Class does not include: (1) Health Plan Members whose claims have already been resolved in the Court-approved class action settlements in *Lecza v. Healthsource, Inc., et al., Civil* Action No. C-95-382-JRM, U.S. District Court, District of New Hampshire or *Garvin v. CIGNA Healthsource of South Carolina, Inc.*, Civil Action No. 94-CP-40-3472, South Carolina Court of Common Pleas, Richland County; and (2) those individuals who hold or have held any executive position at Healthsource, and their immediate families.

The Second Amended Complaint asserts the Defendants are liable for, inter alia, violations of ERISA and RICO, breach of contract and fraud, where Defendants allegedly failed to base calculations of Health Plan Members' percentage co-insurance charges on the discounted charges that the Defendants secured from certain providers. Defendants assert that Plaintiffs' claims are without merit, deny all allegations of wrongdoing, and deny any liability to Plaintiffs and other members of the Class.

5.0 PRE-TRIAL PROCEEDINGS

In response to Plaintiffs' Second Amended Complaint, Defendants filed an Answer denying liability and raising various defenses, including that the Plaintiffs' claims are barred by the applicable limitations periods. Plaintiffs have alleged fraudulent concealment. The Parties have exchanged written discovery responses and extensive production of documents. The Defendants have deposed three of the named Plaintiffs, Sylvester, Steinbeiser-Maurer, and Lindsey. The Plaintiffs have deposed Defendants Healthsource, Inc., through its designees Susan Cooper, Janis Kent and Diane Rivera; Healthsource of Maine, Inc., through

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its designee Richard White; and Defendants' actuarial consultant Clark Slipher of Milliman USA. Defendants have provided to Plaintiffs extensive claims data and expert analysis of that data indicating that the total amount of co-insurance payments at issue in this case is substantially less than alleged in the Second Amended Complaint. Class Counsel have conducted extensive investigation and discovery in this matter and researched, analyzed, and briefed the applicable law. Through expert health insurance actuaries and health insurance industry experts retained by Class Counsel, Plaintiffs have analyzed Defendants' data and conduct and the merits of the case as to liability and damages. On July 1, 2005, Plaintiffs moved for class certification.

6.0 THE BENEFITS OF SETTLEMENT TO THE CLASS

Plaintiffs' counsel recognize the substantial expense and time that would be necessary to continue litigation against Defendants through a contested motion to certify the putative class for trial, through trial, and through any appeals. The Plaintiffs' counsel have also taken into account the possibility of not prevailing on their motion to certify the putative class for trial, at trial, or on appeal, the uncertainty and risks associated with the outcome of further litigation, and the difficulties and delays inherent in such litigation. Plaintiffs' counsel are also aware of the burdens of proof necessary to establish liability for Plaintiffs' claims, the nature and scope of the defenses raised herein, and of the expense and amount of time necessary to prove the appropriate amount of relief. Plaintiffs' counsel have also considered the intensive, arms-length settlement negotiations conducted by the Parties. Based on the foregoing, as well as the substantial benefits to be provided to the Class by the settlement set forth in this Agreement, Class Counsel, with the concurrence of the named Class Representatives, have determined this settlement is fair, reasonable and in the best interests of the Class. The Agreement, if approved by the Court, will result in a Final Order and Judgment in the above-captioned action.

7.0 DEFENDANTS' REASONS FOR SETTLEMENT

Defendants have concluded that further defense of this litigation would be protracted and expensive. Substantial amounts of time, energy and resources of Defendants have been and will continue to be devoted to the defense of the Plaintiffs' claims. Defendants are also aware of the cost, uncertainty and risks associated with contesting Plaintiffs' motion to certify the putative class for trial and other pretrial motions, of trial, and of any appeals. Defendants, therefore, have agreed to settle this action in the manner and upon the terms set forth in this Agreement.

8.0 DEFENDANTS' DENIAL OF WRONGDOING

Defendants deny each of the claims and contentions alleged by the Plaintiffs and the Class in the Second Amended Complaint filed by Plaintiffs' counsel. Defendants have asserted defenses thereto and have expressly denied any wrongdoing or legal liability arising out of any fact or conduct alleged in these actions. Defendants contend that they complied with all applicable statutes, laws, rules, regulations, and requirements relating to calculation of member percentage co-insurance. Defendants further assert the benefits of provider discounts were passed on to members of any Plan underwritten or administered by the Defendants in the form, *inter alia*, of reduced premiums and enhanced benefits.

9.0 PLAINTIFFS' CLAIMS

Plaintiffs claim that each and every one of the contentions made in the Second Amended Complaint filed on their behalf has merit and gives rise to liability on the part of Defendants upon the claims asserted and entitlement to damages and/or declaratory, injunctive and/or other equitable relief.

10.0 SUBSTANTIVE TERMS OF SETTLEMENT

10.1 Creation of a Settlement Trust. Defendants have caused to be created at KeyBank (the "Escrow Agent") an Escrow Account to hold settlement funds related to this litigation ("the Settlement Trust").

10.1.1 Funding of the Trust. Within ten (10) business days after Preliminary Approval of the settlement, Defendants shall make a deposit sufficient to cause the balance of the Settlement Trust to equal two million three hundred thousand dollars ($2,300,000), and shall cause the Settlement Trust to be invested promptly in Victory Funds' Federal Money Market Fund.

10.1.2 Sole Recourse. All approved payments to Class Members, Class Representatives, Class Counsel, and the Settlement Administrator, and any other payments in connection with this Settlement shall be made exclusively from the Settlement Trust. In no event shall Defendants be liable for any payments other than the deposit referred to in this paragraph. The sole recourse of any person claiming any payment from the Settlement Trust, any right to payment under or in any way related to this Agreement or to any matter related in any way to the Settled Claims or to the Litigation — including, without limitation, Class Members, Class Counsel, the Settlement Administrator, KeyBank, state or federal taxing authorities, or any person claiming by, through, or on behalf of any of the foregoing — shall be against the Settlement Trust.

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10.1.3 Tax Treatment of the Settlement Trust. All costs of administering the Settlement Trust, including but not limited to notice, administering and distributing the Settlement Trust, and taxes and other expenses, are the sole responsibility of the Class and shall be paid out of the Settlement Trust, as provided herein.

The Parties and the Escrow Agent agree to treat the Settlement Fund as being at all times a "qualified settlement fund" within the meaning of Treas. Reg. § 1.468B-1. In addition, the Escrow Agent and, as required, the Parties shall jointly and timely make such elections as necessary or advisable to carry out the provisions of this paragraph 10.1.3, including the "relation-back election" (as defined in Treas. Reg. § 1.468B-1) back to the earliest permitted date. Such elections shall be made in compliance with the procedures and requirements contained in such regulations. The Settlement Administrator shall timely and properly file all informational and other tax returns necessary or advisable with respect to the Settlement Trust (including without limitation the returns described in Treas. Reg. § 1.468B-2(k and l)). Such returns (as well as the election described above) shall be consistent with this paragraph 10.1.3 and in all events shall reflect that all taxes (including any estimated taxes, interest or penalties) on the income earned by the Settlement Trust shall be paid out of the Settlement Trust as provided hereunder. All (i) taxes (including any estimated taxes, interest or penalties) arising with respect to the income earned

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by the Settlement Trust, including any taxes or tax detriments that may be imposed upon Defendants with respect to any income earned by the Settlement Trust for any period during which the Settlement Trust does not qualify as a "qualified settlement fund" for federal or state income tax purposes ("Taxes"), and (ii) expenses and costs incurred in connection with the operation and implementation of this paragraph 10.1.3 (including, without limitation, expenses of tax attorneys and/or accountants and mailing and distribution costs and expenses relating to filing (or failing to file) the returns described in this paragraph 10.1.3) ("Tax Expenses"), shall be paid out of the Settlement Trust; in all events Defendants and their insurers shall have no liability or responsibility for the Taxes or the Tax Expenses or the filing of any tax returns or other documents related thereto with respect to the Settlement Trust with the Internal Revenue Service or any other state or local taxing authority. Further, Taxes and Tax Expenses shall be treated as, and considered to be, a cost of administration of the Settlement and shall be timely paid out of the Settlement Trust without prior order from the Court, and the Escrow Agent shall be obligated (notwithstanding anything herein to the contrary) to withhold from distribution to Class Members, Class Counsel or the Settlement Administrator any funds necessary to pay such amounts including the establishment for adequate reserves for any Taxes and Tax Expenses (as well as any amounts that may be required to be withheld under Treas. Reg

§ 1.468B-2(1) (2)); Defendants and their insurers are not responsible and shall have no liability therefor or for any reporting requirements that may relate thereto. The parties hereto agree to cooperate with the Escrow Agent, the Settlement Administrator, each other, and their tax attorneys and accountants to the extent reasonably necessary to carry out the provisions of this paragraph 10.1.3. Defendants make no representation or warranty regarding the tax consequences of any aspect of the Settlement, and are not responsible for any tax liability of any Class Member, Class Counsel, the Settlement Trust, or any other person with any interest in this Settlement.

10.2 Effective Date of Settlement Agreement. This Settlement Agreement will be effective upon the date of the Final Approval.

10.3 Claim Form and Notice. Within ten business days after the Preliminary Approval Order a Notice of Pendency of Class Action, Proposed Revised Class Action Settlement, and Settlement Hearing, shall be mailed and publication Notice made, by the Settlement Administrator, pursuant to the Notice and Settlement Distribution Plan, Exhibit B to this Agreement.

10.4 Determination of Amount Payable to Class Members. Class Counsel shall seek Court approval of the method for determining each Class Member's Share of the Settlement, as set forth in the Notice and Settlement Distribution Plan, Exhibit B to this Agreement. Court approval of a method of determination different than the method proposed by Class Counsel shall be binding on the Class and shall not negate any other provisions of this Settlement Agreement, which shall remain fully effective and enforceable, and the Parties expressly

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agree that the determination of amounts payable to Class Members is committed to the sound discretion of the Court.

10.5 Class Representatives' Compensation. Subject to approval and modification by the Court, the Class Representatives shall be entitled to payment of $5,000 each out of the Corpus of the Settlement Trust for services as the Class Representatives, in addition to any amounts due to them as Class relief, to be paid by the Settlement Administrator from the Corpus of the Settlement Trust within fourteen (14) business days after Final Approval. Court approval of Class Representatives' Compensation in an amount less than stated herein shall not negate any other provisions of this Settlement Agreement, which shall remain fully effective and enforceable.

10.6 Administration. All fees and costs incurred by the Settlement Administrator and all distributions made by the Administrator shall first be approved by the Court and then paid from the Settlement Trust, provided, however, the Settlement Administrator shall be allowed to request advances for administration costs from the Settlement Fund with the consent of counsel for all Parties. The Settlement Administrator shall immediately prepare an estimate of costs and fees, including proposed advances, for preliminary approval by the Court and Parties' Counsel. The Administrator has entered a privacy, security, and confidentiality agreement consistent with the provisions of HIPAA and HCQIA of 1986, which agreement shall be binding upon the Administrator and any outside contractor or subcontractor used by the Administrator.

Attorney fees and costs, including those of Class Counsel, Class Representative Compensation, and any and all claim payments shall be made only and totally from the Corpus of the Settlement Trust and any interest earned on the Corpus, after payment of the costs of all aspects of notice, mailing, Administrator's fee, Escrow Agent's fee, Tax Expenses, if any, and any other costs or expenses of claim or settlement administration.

CIGNA:00181

No portion of the Corpus of the Settlement Trust or the interest thereon shall be returned to Defendants. The entire Settlement Trust and interest thereon shall be disbursed pursuant to the terms of this Agreement.

The Settlement Administrator shall, within 14 days after Final Approval ("the Payment Date"), send by first class mail a check for each Class Member's Share of the Settlement, calculated as described in this Agreement. The proceeds from any returned check or a check that remains uncashed for 60 days after the date of mailing shall be subject to the provisions of Paragraph 10.8.

10.7 Fees, Costs and Expenses. Any costs of suit or attorneys' fees approved by the Court shall, within fourteen (14) business days after Final Approval, be paid by the Settlement Administrator from the Corpus of the Settlement Trust. Court approval of an attorneys' fee and/or costs in an amount less than the amount requested by Class Counsel — or the Court's disallowance of any award of fees or expenses — shall not negate any other provisions of this Settlement Agreement, which shall remain fully effective and enforceable.

10.8 Unclaimed Funds and Interest. A record shall be kept by the Settlement Administrator of all Class Members whose checks are not cashed within 60 days of issuance. The proceeds represented by all returned or uncashed checks shall be referred to collectively herein as "unclaimed funds." On the 70th calendar day following the date of mailing of the last Class Member check, or as soon thereafter as is commercially reasonable, any and all unclaimed funds and any accrued, unapplied interest shall be distributed in accordance with the cy pres distribution provisions of the Notice and Settlement Distribution Plan, Exhibit B to this Agreement, or shall be distributed as otherwise directed by the Court, but in no event shall any monies be returned to Defendants.

CIGNA:00182

10.9 Preliminary Approval. The Parties shall mutually cooperate to request a hearing for Preliminary Approval of the Settlement Agreement as soon as is practical, and to seek from the Court an Order granting Preliminary Approval of the Settlement Agreement in an Order mutually agreeable to the Parties and not materially different from the Preliminary Approval Order attached as Exhibit A.

10.10 Walk-Away. Defendants have the right to walk away from this Settlement Agreement, at their sole discretion, if:

A. This Agreement is not approved by the Court as drafted by the Parties;

B. The Court does not certify the settlement class described in Article 4.0;

C. More than 3% of the Class Members opt-out of the settlement; and/or

D. Any material objections to the proposed Settlement Agreement are sustained by the Court.

10.11 Final Order and Judgment. After notice and hearing, the Court shall enter a Final Order and Judgment dismissing this action with prejudice, in a form not materially different from the Order attached as Exhibit C. Such Final Order and Judgment shall be final, binding and with prejudice against all Class Members and the Parties. Such Final Order and Judgment shall not be contingent on approval of Class Representative Compensation or attorneys' fees and/or costs payable to Class Counsel, the final amounts of such payments to be determined by the Court in its sole discretion, with all other provisions of this Settlement Agreement to remain fully effective and enforceable notwithstanding the amounts of such payments as are approved by the Court.

10.12 Effect of Non-Approval. If the Court does not enter an Order preliminarily approving this Settlement Agreement or does not enter the Final Judgment and Order of dismissal with prejudice of settled claims, all in forms materially consistent with those attached to this

CIGNA:00183

Agreement, or any such Order is reversed on appeal and not substantially reinstated, this Agreement shall be cancelled and terminated.

10.13 Restoration to Status Quo. In the event this Agreement is terminated or cancelled, or fails to become effective for any reason, then the Parties to this Agreement shall be deemed restored to their respective status as of the date and time immediately prior to the execution of this Agreement, and they shall proceed in all respects as if this Agreement and related Orders had not been executed, and shall file a stipulated motion to schedule further action in the ordinary course.

10.14 Integration. This Agreement and its exhibits and attachments constitute the entire agreement among the Parties and no representations, warranties or inducements have been made to any Party concerning this Settlement Agreement or its exhibits and attachments other than the representations, warranties and covenants contained and memorialized in such documents.

10.15 Drafting. Plaintiffs and Defendants agree that no single party shall be deemed to have drafted this Settlement Agreement, or any portion thereof, for purpose of the invocation of *contra proferentum*. This Settlement Agreement is a collaborative effort of the undersigned attorneys.

10.16 Successors. This Settlement Agreement shall be binding upon and inure to the benefit of the heirs, successors and assigns of the Parties thereto.

10.17 Interpretation and Governing Law. All terms and conditions of this Settlement Agreement and the exhibits and attachments shall be governed by and interpreted according to the laws of the State of Maine, without reference to its conflict of law provisions.

10.18 Fair & Reasonable. Class Counsel believe this Agreement is fair and reasonable, in the best interest of the Class Members, and have arrived at this Agreement as a result of

CIGNA:00184

extensive arms-length negotiations. Defendants and their counsel also believe this Agreement is a reasonable compromise of the disputed claims.

10.19 Continuing Jurisdiction. The United States District Court for the District of Maine shall retain continuing jurisdiction over this litigation until this Agreement and the settlement and all transactions contemplated herein are completed, and thereafter, for the enforcement, interpretation and construction of relief hereunder.

10.20 Counterparts. This Agreement may be executed in one or more counterparts. All executed counterparts and each of them shall be deemed to be one and the same instrument provided that counsel for the Parties to this Agreement shall exchange among themselves original signed counterparts.

10.21 Cooperation. Plaintiffs and Defendants shall cooperate in presenting papers, declarations, affidavits, and/or testimony to the Court as may be necessary to effectuate the purposes and intent of this Settlement Agreement.

Dated: August 12, 2005

/s/ Gregory P. Hansel
Gregory P. Hansel
Robert O. Newton
Randall B. Weill
Jonathan G. Mermin
PRETI, FLAHERTY, BELIVEAU, PACHIOS & HALEY, LLP
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/s/ W. Jones Andrews, Jr.
W. Jones Andrews, Jr.
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/s/ Joyce Leary Clark
Joyce Leary Clark
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Attorneys for Plaintiffs and the Proposed Class

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DELIVER TO:

NAME:	**The Honorable Dennis Kucinich**	TELECOPY PHONE NUMBER:	**(202) 225-2392**
COMPANY:	**House Oversight and Government Reform: Subcommittee on Domestic Policy**	VERIFICATION NUMBER:	
TOTAL PAGES & COVER SHEET:		DATE TRANSMITTED:	
S&J OPERATOR'S NAME:		TELEPHONE NUMBER:	
CLIENT/CASE NUMBER:	**16517.0001**		

FROM:

NAME: **Jim Barnette**

REQUEST MADE ON	DATE:	**11/20/09**	TIME:	**2:09 PM**
COMPLETION REQUIRED BY	DATE:	**11/20/09**	TIME:	**ASAP**

SPECIAL INSTRUCTIONS:

STEPTOE & JOHNSON LLP
ATTORNEYS AT LAW

James D. Barnette
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jbarnette@steptoe.com

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Washington, DC 20036-1795
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November 20, 2009

The Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Kucinich:

Further to CIGNA Corporations' response to your letter of October 22, 2009, please find below and attached the compensation information for Mr. Thomas Richards.

This information is not publicly available, and could cause CIGNA and Mr. Richards significant commercial harm were it to be made public. We therefore reiterate our request that CIGNA be consulted prior to any public disclosure of this information. Again, we appreciate your discretion in this regard.

Request #6:

Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

Year	Compensation
2004	$285,552
2005	$406,996
2006	$586,754
2007	$594,523
2008	$902,011

Attachment A sets forth two spreadsheets that more fully clarify Mr. Richards' compensation over the last five years.

Please contact me if CIGNA may provide any additional information or otherwise be of assistance to the Subcommittee.

Sincerely,

James D. Barnette

c: The Honorable Jim Jordan

BALANCE_YEAR	CATEGORY	ERNCD	DESCR	EARNINGS
2003	Non-equity incentive plan compensation	BE	MIP BONUS	$ 43,100.00
2003	All other compensation	DC	REST STK DIV	$ 3,020.82
2003	Salary	RG	Regular Earnings	$ 175,948.03
2003	Realized Value of Stock Sales	BK	RSTD STK VEST	$ 16,407.71
2003 Total				**$ 238,476.56**
2004	Non-equity incentive plan compensation	BE	MIP BONUS	$ 64,700.00
2004	All other compensation	DC	REST STK DIV	$ 2,706.08
2004	Salary	RG	Regular Earnings	$ 191,533.28
2004	Salary	BR	RETRO PAY	$ 5,179.44
2004	Realized Value of Stock Sales	BK	RSTD STK VEST	$ 21,433.15
2004 Total				**$ 285,551.95**
2005	Bonus	IE	EXEC BONUS	$ 141,693.00
2005	Salary	RG	Regular Earnings	$ 214,999.98
2005	Realized Value of Stock Sales	BK	RSTD STK VEST	$ 39,955.63
2005	All other compensation	DC	REST STK DIV	$ 372.10
2005	Bonus	IF	SPU AWARD	$ 9,975.00
2005 Total				**$ 406,995.71**
2006	All other compensation	DC1	Restricted Stock Dividends	$ 268.59
2006	Non-equity incentive plan compensation	IE1	Executive Bonus	$ 88,550.00
2006	Non-equity incentive plan compensation	IF1	SPU Award	$ 52,246.20
2006	Realized Value of Stock Sales	BK1	Restricted Stock Vested	$ 227,546.61
2006	Salary	REG	Regular Pay	$ 218,142.39
2006 Total				**$ 586,753.79**
2007	All other compensation	DC1	Restricted Stock Dividends	$ 110.36
2007	Non-equity incentive plan compensation	IE1	Executive Bonus	$ 145,200.00
2007	Non-equity incentive plan compensation	IF1	SPU Award	$ 94,180.65
2007	Realized Value of Stock Sales	BK1	Restricted Stock Vested	$ 130,836.04
2007	Salary	REG	Regular Pay	$ 224,196.23
2007 Total				**$ 594,523.28**
2008	All other compensation	DC1	Restricted Stock Dividends	$ 51.13
2008	Non-equity incentive plan compensation	IE1	Executive Bonus	$ 118,800.00
2008	Non-equity incentive plan compensation	IF1	SPU Award	$ 200,000.00
2008	Realized Value of Option Exercises	GL1	Non-Qualified Stock Earning	$ 270,615.89
2008	Realized Value of Stock Sales	BK1	Restricted Stock Vested	$ 80,770.71
2008	Salary	REG	Regular Pay	$ 231,773.02
2008 Total				**$ 902,010.75**

	year	doe_code	doe_desc	earnings	category	last_name	first_name	headcnt_stad	hire_date	term_date	job_no	job_title	job_grad
'3	2005	IE	EXEC BONUS	$ 141,693.00	Bonus	RICHARDS	THOMAS	ACT REG	6/21/1982		K00600	VP PRODUCT LEADER	70
'3	2005	RG	Regular Earnings	$ 214,999.98	Salary	RICHARDS	THOMAS	ACT REG	6/21/1982		K00600	VP PRODUCT LEADER	70
'3	2005	BK	RSTD STK VEST	$ 39,955.63	Realized Value of Stock Sales	RICHARDS	THOMAS	ACT REG	6/21/1982		K00600	VP PRODUCT LEADER	70
'3	2005	DC	REST STK DIV	$ 372.10	All other compensation	RICHARDS	THOMAS	ACT REG	6/21/1982		K00600	VP PRODUCT LEADER	70
'3	2005	IF	SPU AWARD	$ 9,975.00	Bonus	RICHARDS	THOMAS	ACT REG	6/21/1982		K00600	VP PRODUCT LEADER	70
	2005 Total			$ 406,995.71									

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRI

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

October 22, 2009

Ms. Patricia Farrell
Senior Vice President, National and International Business Solutions
Aetna Incorporated
151 Farmington Avenue
Hartford, Connecticut 06156

Dear Ms. Farrell:

To complete the record of your testimony before the Domestic Policy Subcommittee on September 17, 2009, the Subcommittee requests the following information in writing:

1) In 2003, Aetna settled claims that it had engaged in a conspiracy to improperly deny, delay and/or reduce payment to physicians by engaging in several types of allegedly improper conduct, including, but not limited to, misrepresenting and/or failing to disclose the use of edits to unilaterally "bundle, "downcode" and/or reject claims for medically necessary covered services, failing and/ or refusing to recognize CPTO modifiers, and concealing and/or misrepresenting the use of improper guidelines and criteria to deny, delay and/or reduce payment for medically necessary covered services.
    a. What did Aetna agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by Aetna and its subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.
    b. Has Aetna settled other claims or state regulatory actions relating to allegations of wrongful denial, delay or reduction of claims since 2003? If so, please include all relevant details. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that were challenged by state regulators as violations of state law.

2) Please provide the subcommittee with the following statistics for 2008: Number of claims Aetna received; number of claims paid within 30 days, and the value in dollars to Aetna of claims that Aetna did not pay within 30 days, 60 days, 90 days, 120 days.

3) Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

5) Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

6) Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

7) Can you provide an estimate of the value of medical expenses the company believed it was avoiding by shedding 8 million policyholders, as reported by Forbes Magazine? Additionally, provide a narrative "of the relationship between the data that you gather and the way that's used as a tool for your decision making with respect to your customers and whether they will continue to have policies. This would deal with shedding, rescissions, even, you know, any use of information technology that was used to shed any of those 8 million customers."
    a. What were the guidelines and/or criteria used to determine which policy holders to shed? Did you focus on any particular occupations, industries, medical conditions or geographic areas?
    b. What tactics were implemented to shed those policy holders or to cause them to discontinue their policies?

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Thursday, November 5, 2009.**

If you have any questions regarding this request, please contact Jaron Bourke, Staff Director, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

AKIN GUMP
STRAUSS HAUER & FELD LLP
Attorneys at Law

STEVEN R. ROSS
202.887.4343/fax: 202.887.4288
sross@akingump.com

November 18, 2009

The Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Kucinich:

On behalf of Aetna Inc. ("Aetna"), this letter and accompanying enclosures responds to your October 22, 2009 letter seeking further information in conjunction with your September 17, 2009 hearing.

Please be advised that the information contained in this response is confidential and proprietary in nature and has been marked as such. We ask that these documents and information be kept confidential by the Committee. The disclosure of this information could result in substantial injury to the economic and competitive position of Aetna. We therefore ask that the Committee staff provide us with notice and an opportunity to be heard before the Committee, notwithstanding our request that these documents be kept confidential, discloses any information from these documents to third parties.

Attached here are documents and information responsive to Questions One, Two, Four, Five, and Seven of your letter. For purposes of identification and reference, the documents attached here have been consecutively numbered from AETNA-OGR-00001 – AETNA-OGR-00016. Aetna's response to Question Six will be provided tomorrow under separate cover and its remaining responses will be provided shortly.

If you have any questions, please contact me at 202-887-4343.

Sincerely,

Steven R. Ross
Counsel for Aetna

Enclosures

cc: The Honorable Jim Jordan, Ranking Member (w/ Encls.)

1) In 2003, Aetna settled claims that it had engaged in a conspiracy to improperly deny, delay and/or reduce payment to physicians by engaging in several types of allegedly improper conduct, including, but not limited to, misrepresenting and/or failing to disclose the use of edits to unilaterally "bundle," "downcode" and/or reject claims for medically necessary covered services, failing and/or refusing to recognize CPTO modifiers, and concealing and/or misrepresenting the use of improper guidelines and criteria to deny, delay and/or reduce payment for medically necessary covered services.

   a. What did Aetna agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by Aetna and its subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.

Aetna's Response: See attached document at AETNA-OGR-00002 — AETNA-OGR-00005.

We want you to know®
Aetna

Physicians And Aetna Begin New Era Of Cooperation

Agreement focuses on streamlining communication, reducing administrative complexity and improving the quality of the health care system; upon court acceptance, agreement would conclude litigation for Aetna; establishment of independent foundation and Physicians' Advisory Board highlight agreement

NEW YORK, May 22, 2003 — Aetna (NYSE: AET) and representatives of over 700,000 physicians, state and other medical societies have settled a national class action pending in the federal court for the Southern District of Florida before U.S. District Judge Federico Moreno, as well as multiple state court actions filed against the company. The agreement includes industry-leading improvements to physician-related business practices that set new levels of transparency in paying claims, including a National Advisory Committee of Practicing Physicians to provide advice to Aetna on issues of importance to physicians. It also establishes an independent foundation dedicated to improving the quality of health care in America. The agreement will streamline communication between physicians and Aetna, reduce administrative complexity in the claims payment system and help improve the quality of the health care system.

These changes are expected to result in increased predictability and speed of claims payment, creating significant value for physicians by reducing time-consuming and costly administrative burdens and giving them and their office staffs more time to focus on their central mission – providing health care to patients. Aetna also expects to be able to operate more efficiently and serve its customers and members more effectively, with lower administrative costs over time.

If approved by the court, the agreement would conclude this lawsuit against Aetna involving issues dating back to 1990 and was part of on-going multi-district litigation currently pending against many of the nation's largest for-profit health insurers. This agreement will be filed with the court today.

The value to physicians of the business practice improvements over the course of the agreement is estimated at approximately $300 million. This represents, among other things, the value of prompt payment, lower administrative costs for physicians due to electronic claims submissions and reduced resubmissions resulting from increased levels of auto-adjudication. The cost to Aetna of implementing these changes already has been included in Aetna's financial plans, including guidance for 2003.

In addition to the significant business practice commitments that create a new a standard for the industry, Aetna has agreed to pay $100 million to physicians and $20 million to a foundation established by the agreement, as well as up to $50 million in legal fees to be determined by the court. In connection with the settlement, Aetna expects to take an after-tax charge of approximately $75 million in the second quarter of 2003, reflecting anticipated payments net of insurance. It will be recorded as an "other item" with no impact on operating earnings.

Openness and Cooperation

The physicians and Aetna have agreed to new levels of transparency and communication as well as a renewed commitment concerning business practices through a number of initiatives. Examples of these include:

- Establishing a National Advisory Committee of practicing physicians to provide advice to Aetna on issues of concern to physicians.
- An efficient independent mechanism for doctors to appeal payment decisions with which they disagree.
- Application of generally accepted medical standards in determining medical necessity.
- Agreement on a nationally recognized and physician-approved set of rules governing claims

coding and grouping procedures.
- A joint effort to develop a claims-editing software package that incorporates physician- and industry-accepted claims coding and grouping procedures.
- Increased electronic connectivity and direct, web-enabled access to Aetna systems to verify reimbursement information and track claims.
- Making a pharmacy discount card program available for physicians to offer their patients.

Agreement Establishes Foundation to Focus on Critical Health Care Issues

The Agreement establishes and provides initial funding for a newly created foundation, which will support initiatives that enhance physicians' ability to focus on the health care of their patients in critical areas such as:

- Elimination of racial and ethnic disparities in health care.
- Improvements in the way the health care system manages end-of-life care.
- Reduction and prevention of childhood obesity.
- Addressing the problem of the uninsured.

The foundation will be funded with an initial grant of $20 million from Aetna. In addition, physicians will have the option of directing their individual shares of the $100 million settlement to the foundation.

"This agreement represents a sea change in relations between physicians and Aetna that will lead to greater cooperation on critical aspects of quality, availability and affordability of care," said John W. Rowe, M.D., chairman and CEO of Aetna. "As a physician, I know the importance of strengthening our working relationship with the medical community and have made it a priority for the entire Aetna organization.

"These initiatives build on our ongoing efforts to increase efficiency and lower administrative costs in the health care system. Streamlining business processes will leverage great value for physicians in terms of reduced overhead and greater focus on patient care, as well as reduce Aetna's administrative costs.

"We do not anticipate that the agreement will affect Aetna's ability to effectively manage medical costs for its customers. In fact, the new climate of cooperation will further enhance Aetna's competitiveness by increasing our ability to work with physicians on case and disease management programs, which help control medical costs by ensuring that patients receive timely care. I am also pleased that this agreement removes the major and costly distraction of this litigation from our business environment and will allow us to concentrate further on achieving our objective of profitable growth."

"They have opened their doors and we see this as a turning point in modern medicine," agreed Jack Lewin, M.D., CEO of the California Medical Association. "Aetna is a leader in demonstrating real innovation in this agreement. In short, physicians will have more time to be physicians. This improved efficiency has enormous value to physicians as well as to the entire health care system, including Aetna. We also believe that the Foundation established by this agreement will make an important contribution in improving health quality for Americans."

"Today marks a new era in health care delivery and Aetna should be congratulated for their openness and support of physicians and their patients," said Tim Norbeck, executive director of the Connecticut State Medical Society. "From the very beginning, our primary goal has been to change the system and make it better for physicians and their patients. Our member physicians are pleased that many of their issues have been addressed fairly, and we believe that this new level of cooperation and transparency will benefit patients. Aetna's bold step in this class action settlement has set a new standard for the industry."

Medical Societies Endorse Agreement

The agreement has been endorsed by the following medical societies and professional organizations who will be actively encouraging their members to indicate their support for the proposal:

- Alaska State Medical Association
- California Medical Association
- Connecticut State Medical Society
- Denton County (TX) Medical Association
- El Paso County (CO) Medical Society
- Florida Medical Association
- Hawaii Medical Association
- Louisiana State Medical Society
- Medical Association of Georgia
- Medical Society of the State of New York
- Medical Society of New Jersey
- Nebraska Medical Association
- New Hampshire Medical Society
- North Carolina Medical Society
- North Virginia Medical Societies
- South Carolina Medical Association
- Tennessee Medical Association
- Texas Medical Association
- Washington State Medical Association

"The American Medical Association expects this settlement to raise the bar for the entire health insurance industry on fair and open business practices," said Donald J. Palmisano, M.D., AMA President-elect. "The AMA commends the many medical associations and individual physician plaintiffs, who fought for these improvements and persevered. Dr. Rowe, Aetna's CEO and a longtime AMA member, has succeeded in turning his understanding of physician concerns into action will benefit both patients and Aetna as well."

"The primary achievement of this agreement for physicians is found in the fundamental recognition by Aetna of the importance of America's physicians in the healthcare equation," said Archie Lamb, co-lead counsel of the national class action. "Aetna's promises memorialized in the agreement to commit to external review, transparency, clearly defined coding guidelines and a meaningful enforcement mechanism are truly landmark commitments."

"The commitments contained in this agreement are premised on achieving the highest quality delivery of health care and represent a new standard for the industry that is truly in the best interest of physicians and their patients," said Edith Kallas, a partner at Milberg Weiss Bershad Hynes & Lerach LLP.

"As an employer we applaud today's agreement between Aetna and physicians as an opportunity to leapfrog industry efforts to remove administrative costs by streamlining our complex health care system. We believe this will be a win for our employees, retirees and their families, as well as for doctors and employers," said David Kostelansky, Corporate Director, Human Resources & Benefits, FMC Technologies, which has been a customer of Aetna's for 14 years, and has worked in partnership with Aetna on efforts to improve relationships with physicians.

"We believe that this agreement has the potential to ultimately remove costs from the system by enhancing Aetna's substantial efforts to date to streamline processes and improve its relationships with doctors and care providers," added Kostelansky.

Aetna is one of the nation's leading providers of health care, dental, pharmacy, group life, disability and long-term care products, serving approximately 13.0 million medical members, 11.4 million

dental members and 11.8 million group insurance customers, as of March 31, 2003. The company has expansive nationwide networks of more than 562,000 health care services providers, including over 337,000 primary care and specialist physicians and 3,387 hospitals. For more information about Aetna, please visit the company's website at www.aetna.com.

The California Medical Association is the professional organization of 35,000 California physicians, representing all modes of practice and specialties.

The Connecticut State Medical Society (CSMS) is a federation of eight component county medical associations, with a total membership exceeding 7,000 physicians. CSMS itself is a constituent state entity of the American Medical Association. Founded by the physician-patriots of the American Revolution, the Society operates from a heritage of democratic principles embodied in its Charter and Bylaws.

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2) Please provide the subcommittee with the following statistics for 2008: Number of claims Aetna received; the number of claims paid within 30 days, and the value in dollars to Aetna of claims that Aetna did not pay within 30 days, 60 days, 90 days, and 120 days.

Aetna's Response: In 2008, Aetna processed approximately 223 million medical and dental claims. This figure includes claims processed both for insurance policies underwritten by Aetna and for self funded plans for which Aetna acts as third party administrator. For that total set, Aetna adjudicated 98.9% within 30 days of receipt.

In general, state laws require payment of interest to the extent payment occurs later than a period set by statute, typically 30 days after receipt of a clean claim. Interest rates are set by statute and vary among states, but under all such laws the statutory interest rate exceeded the interest Aetna could earn on short-term fixed rate investments in 2008. Any financial benefit from the use of funds associated with claims adjudicated for self funded plans inures to those plans. Therefore, Aetna did not obtain any net financial benefit from the use of funds associated with claims that Aetna adjudicated more than 30 days after receipt.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

Aetna's Response: See attached document at AETNA-OGR-00008 — AETNA-OGR-00014.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

October 9, 2009

Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to your request for an updated analysis of the effects of proposals to limit costs related to medical malpractice ("tort reform"). Tort reform could affect costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of diagnostic tests and other health care services when providers recommend those services principally to reduce their potential exposure to lawsuits. Because of mixed evidence about whether tort reform affects the utilization of health care services, past analyses by the Congressional Budget Office (CBO) have focused on the impact of tort reform on premiums for malpractice insurance. However, more recent research has provided additional evidence to suggest that lowering the cost of medical malpractice tends to reduce the use of health care services. CBO has updated its estimate of the budgetary effects of proposals for tort reform to reflect that new information.

Background on Tort Reform

Under current law, individuals may pursue civil claims against physicians and other health care providers for alleged torts—breaches of duty that result in personal injury. The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for losses they incur (including medical costs, lost wages, and pain and suffering) resulting from injuries that occur because of negligence.

Many observers have proposed nationwide curbs on medical malpractice torts. As CBO outlined in its 2008 report *Key Issues in Analyzing Major Health Insurance Proposals*, reforms to the tort system generally fall into one of two categories: caps on the payments that may be made and limits on who may be found liable. Broader reforms, such as the establishment of specialized courts or different standards of evidence, have also been discussed, but they have not featured as prominently in legislative proposals.

Caps on tort awards could take a number of forms. One common proposal would limit awards for noneconomic damages, such as pain and suffering. Other proposals would limit the amount awarded for punitive damages, or the situations in which a plaintiff could receive awards for punitive damages, or both. Still other proposals would cap the contingency fees that claimants' attorneys could collect as a percentage of the total

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damages recovered. Additionally, some proposals would allow compensation that plaintiffs received from other sources—including payments from health and life insurance, workers' compensation, and automobile insurance—to be introduced at trials (juries presumably would take that information into account in determining awards); some proposals would also prevent those other sources from receiving any portion of awards for damages.

The two most common ways of imposing limits on liability are to shorten the statute of limitations on malpractice claims and to change the rules regarding joint-and-several liability. The principle of joint-and-several liability allows a claimant to recover the entire amount of a damage award from any one of the parties found to be responsible for an injury, regardless of the party's degree of responsibility for that injury. Replacing joint-and-several liability with a "fair-share" rule would limit each defendant's financial liability to his or her percentage share of responsibility for the injury.

Several times over the past decade, CBO has estimated the effects of legislative tort reform proposals. Typical proposals have included:

- A cap of $250,000 on awards for noneconomic damages;
- A cap on awards for punitive damages of $500,000 or two times the award for economic damages, whichever is greater;
- Modification of the "collateral source" rule to allow evidence of income from such sources as health and life insurance, workers' compensation, and automobile insurance to be introduced at trials or to require that such income be subtracted from awards decided by juries;
- A statute of limitations—one year for adults and three years for children—from the date of discovery of an injury; and
- Replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.

The Effect of Tort Reform on Premiums for Medical Liability Insurance

National implementation of a package of proposals similar to the preceding list would reduce total national premiums for medical liability insurance by about 10 percent, CBO now estimates. That figure reflects the fact that many states have already enacted at least some of the proposed reforms. For example, about one-third of the states have implemented caps on noneconomic damages, and about two-thirds have reformed their rules regarding joint-and-several liability.

CBO estimates that the direct costs that providers will incur in 2009 for medical malpractice liability—which consist of malpractice insurance premiums together with settlements, awards, and administrative costs not covered by insurance—will total approximately $35 billion, or about 2 percent of total health care expenditures. Therefore,

lowering premiums for medical liability insurance by 10 percent would reduce total national health care expenditures by about 0.2 percent.

Recent Evidence on the Broader Effects of Tort Reform

On the basis of newly available research, CBO has updated its analysis of the effects of tort reform to include not only direct savings from lower premiums for medical liability insurance but also indirect savings from reduced utilization of health care services. Many analysts surmise that the current medical liability system encourages providers to increase the volume or intensity of the health care services they provide to protect themselves against possible lawsuits. (An example of increasing intensity would be ordering a computerized tomography scan rather than a simple x-ray.) In earlier analyses, CBO did not incorporate such effects in its estimates because research on the impact of tort reform on the use of health care services produced inconsistent results. For example, Kessler and McClellan (1996) and CBO (2006) both observed reductions in Medicare's hospital spending in states that had enacted a cap on noneconomic damages (for the full citations, see the attached list of references); however, those studies also reported *increases* in Medicare's spending for hospitals and for physicians' services in states that had changed their joint-and-several liability rules to fair-share rules.

More recent research has yielded additional evidence that tort reform reduces the use of health care services. Lakdawalla and Seabury (2009) and Baicker, Fisher, and Chandra (2007), using data on hospitals' total expenditures and Medicare's spending for Part A and Part B services, found that reductions in the cost of medical liability lowered health care expenditures.[1] In addition, Avraham, Dafny, and Schanzenbach (2009) found that several types of reform significantly lowered the costs of health plans offered by self-insured employers.

Other recent research seeks to reconcile some earlier results that appeared to be contradictory. Currie and MacLeod (2008) have suggested that certain components of tort reform, such as changes in the rules on joint-and-several liability, create different financial incentives for physicians than do other reform components, such as caps on noneconomic damages. Caps on damages unambiguously reduce financial liability for all providers. Reform of joint-and-several liability rules, however, is likely to increase the financial liability of the providers assigned the greatest share of responsibility in malpractice cases—typically, physicians. Therefore, physicians may reduce the volume and intensity of the services they provide in response to caps on damages, but they may increase volume and intensity in response to reform of joint-and-several liability rules. As a result, the inclusion or exclusion of specific components in a legislative tort reform proposal could affect the proposal's likely impact on health care spending.

The Effects of Tort Reform on Total Health Care Spending and the Federal Budget

CBO now estimates, on the basis of an analysis incorporating the results of recent research, that if a package of proposals such as those described above was enacted, it would reduce total national health care spending by about 0.5 percent (about $11 billion in 2009). That figure is the sum of the direct reduction in spending of 0.2 percent from

[1] Part A of Medicare pays for hospital care and related services; Part B pays for care by physicians and related services.

Table 1.
Effects of Tort Reform on Mandatory Spending and Tax Revenues

(Billions of dollars)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total 2010-2014	Total 2010-2019
Change in Mandatory Spending[a]	0	-0.7	-1.8	-3.2	-4.6	-5.4	-5.9	-6.0	-6.3	-7.0	-10.3	-41.0
Change in Revenues	0	0.2	0.6	1.0	1.5	1.7	1.8	1.9	2.1	2.2	3.2	13.0
Net Effect on the Deficit[b]	0	-0.9	-2.4	-4.2	-6.1	-7.1	-7.7	-7.9	-8.4	-9.2	-13.5	-54.0

Sources: Congressional Budget Office; Joint Committee on Taxation.

a. Includes Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program. Numbers do not include potential effects on payments made through the Federal Tort Claims Act and effects on other, small mandatory programs.

b. Negative numbers indicate a reduction in the deficit.

lower medical liability premiums, as discussed earlier, and an additional indirect reduction of 0.3 percent from slightly less utilization of health care services. (That reduction is the estimated net effect of the entire package listed earlier, although some components of that package might increase the utilization of physicians' services, as has already been noted.) CBO's estimate takes into account the fact that because many states have already implemented some of the changes in the package, a significant fraction of the potential cost savings has already been realized.

In the case of the federal budget, enactment of such a package of proposals would reduce mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program by roughly $41 billion over the next 10 years (see Table 1).[2] That figure includes a larger percentage decline in Medicare's spending than in the other programs' or in national health spending in general, a calculation based on empirical evidence showing that the impact of tort reform on the utilization of health care services is greater for Medicare than for the rest of the health care system. One possible explanation for that disparity is that the bulk of Medicare's spending is on a fee-for-service basis, whereas most private health care spending occurs through plans that manage care to some degree. Such plans limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as "defensive" medicine); in that way, plans control costs and keep premiums lower than they otherwise would be. In research reported in 2002, Kessler and McClellan found that when tort reform was introduced, health care spending in regions with relatively more enrollees in managed care plans did not fall as much as it did in regions with relatively fewer enrollees. Presumably, the managed care plans had already eliminated some of the defensive medicine that would otherwise have been diminished by tort reform.

[2] Spending in some discretionary federal programs could also be reduced, but funding for those programs is subject to future appropriation action and is not included in the estimates in Table 1. For example, some savings could be realized if the amounts appropriated to such federal agencies as the Department of Defense and the Department of Veterans Affairs were reduced because of lower health care costs as a result of tort reform. In CBO's estimation, that reduction would be less than $1 billion during the 2010–2019 period. The impact on federal agencies would be proportionally smaller than the impact on the overall health care system because medical malpractice costs are already lower than average for entities covered by the Federal Tort Claims Act.

By reducing spending on health care in the private sector, the package of proposals discussed here would also affect federal revenues. Much private-sector health care is provided through employment-based insurance that represents nontaxable compensation. Lower costs for health care arising from those proposals would lead to higher taxable wages and thereby increase federal tax revenues by an estimated $13 billion over the next 10 years, according to estimates by the staff of the Joint Committee on Taxation (JCT). Combining the effects on both mandatory spending and revenues, a tort reform package of the sort described earlier in this letter would reduce federal budget deficits by roughly $54 billion over the next 10 years. That estimate assumes that a change enacted in 2010 would have an impact that increased over time, achieving its full effect after four years, as providers gradually changed their practice patterns. Of course, the estimated effect of any specific legislative proposal would depend on the details of that proposal.

The Effects of Tort Reform on Health Outcomes

Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes. There is less evidence about the effects of tort reform on people's health, however, than about its effects on health care spending—because many studies of malpractice costs do not examine health outcomes. Some recent research has found that tort reform may adversely affect such outcomes, but other studies have concluded otherwise. Lakdawalla and Seabury (2009) found that a 10 percent reduction in costs related to medical malpractice liability would increase the nation's overall mortality rate by 0.2 percent. However, Kessler and McClellan (1996 and 2002) and Sloan and Shadle (2009) concluded that tort reform generated no significant adverse outcomes for patients' health.

I hope you find this information useful. If you have any further questions, please contact me or my staff. The primary staff contact is Stuart Hagen.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Patrick J. Leahy
Chairman
Senate Committee on the Judiciary

Honorable Jeff Sessions
Ranking Member
Senate Committee on the Judiciary

Honorable John Conyers Jr.
Chairman
House Committee on the Judiciary

Honorable Lamar Smith
Ranking Member
House Committee on the Judiciary

Attachment: References

References

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5) Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

Aetna's Response: Aetna is committed to reducing costs and improving quality in our health care system. Streamlined administrative functions, including the sharing of patient medical information at the point of service, will greatly improve the delivery of health care for patients and medical professionals. Aetna's efforts and those of the industry will increase provider efficiency and enhance cooperation among providers, patients and insurers. These initiatives have already led to demonstrated quality improvements and have tremendous potential both to raise quality and reduce administrative cost.

While Aetna participates in the national discussion regarding health information technology ("HIT") and its role in health care reform, Aetna, along with other carriers, has already committed to a comprehensive overhaul of administrative processes to standardize and automate five key functions: claims submissions, eligibility, claims status, payment, and remittance to providers. The industry, including America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA), have launched a pilot program in Ohio giving physicians access to multiple insurers through a single channel for the purpose of conducting key administrative functions. This initiative has strong support from local health plans (that represent more than 91% of state residents with private health insurance) and five major statewide physician organizations. In creating this cooperative system, the industry is responding to physicians' need for singular and streamlined service in electronic transactions. This is a critical first step in HIT reform and similar regional services should be developed and eventually expanded to cover the entire country. Similar efforts will be launched in New Jersey in the near future. This reform is a critically important component of our nation's overall strategy for containing costs and has the potential to create hundreds of billions of dollars in provider savings.

As a leader in the HIT movement, Aetna uses HIT to improve health care quality by giving consumers and their doctors tools to empower better decision-making with access to personal health information in real-time. Since 2005, Aetna has invested more than $1.8 billion in HIT, an investment that is already proving valuable. Our unique clinical decision-support technology, CareEngine® provided through ActiveHealth Management, has been used to analyze more than 18 million complete patient records against current standards of care to identify gaps in care and to alert physicians to "care considerations" for their review.

CareEngine® was tested in a random clinical trial, with the results published in 2005 and again in 2008. This technology and the subsequent physician actions produced a reduction in patient hospitalizations of 8% and a savings in charges of more than $8 per member, per month. In a 2008 study, the tool's impact was further validated by findings that showed the use of advanced clinical-decision support with care alerts reduced overall charges by 6%, with savings in excess of $21 per member per month. Aetna is dedicated to raising the bar of quality measurement by its ability to collect and integrate diverse data for clinicians.

7) Can you provide an estimate of the value of medical expenses the company believed it was avoiding by shedding 8 million policyholders, as reported by Forbes magazine? Additionally, provide a narrative "of the relationship between the data that you gather and the way that's used as a tool for your decision making with respect to your customers and whether they will continue to have policies. This would deal with shedding, rescissions, even, you know, any use of information technology that was used to shed any of those 8 million customers."

   a. What were the guidelines and/or criteria used to determine which policy holders to shed? Did you focus on any particular occupations, industries, medical conditions or geographic areas?
   b. What tactics were implemented to shed those policy holders or to cause them to discontinue their policies?

Aetna's Response: The referenced Forbes magazine article relates to a period during which Aetna's membership declined significantly. In 2001, Aetna suffered substantial operating losses, primarily because the company's previously calculated premium increases did not rise as quickly as did medical costs. During 2001, Aetna increased premiums to levels that it estimated would permit it to return to profitability. To determine requested premium levels, Aetna analyzed historic medical costs and trends, analyzed actuarial data and applied Aetna's underwriting policies, consistent with applicable state laws. Since 2001, Aetna has continued to determine its premium requests using the same types of data and actuarial and underwriting methodologies. Since the period referenced in the Forbes magazine article, Aetna has increased membership and has adjusted premiums in response to increasing medical costs. In light of competitive conditions and inherent uncertainty in the insurance pricing process, it is not certain whether Aetna's pricing actions in any given year will lead to increases or decreases in membership, premiums, medical costs or profits. In all instances, however, Aetna's pricing process is guided by medical costs and trends, actuarial data, underwriting policies, and applicable state laws and regulations.

AKIN GUMP
STRAUSS HAUER & FELD LLP
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November 19, 2009

The Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Kucinich:

On behalf of Aetna Inc. ("Aetna"), this letter and enclosure responds to your October 22, 2009 letter seeking further information in conjunction with your September 17, 2009 hearing.

Please be advised that the information contained in this response is highly confidential and proprietary in nature and has been marked as such. We ask that this document and information contained herein be kept confidential by the Committee. The disclosure of this information could result in substantial injury to Ms. Patricia Farrell in both a professional and personal capacity. We therefore ask that the Committee staff provide us with notice and an opportunity to be heard before the Committee, notwithstanding our request that this document be kept confidential, discloses any information from this document to third parties.

Attached here is a document that responds to Question Six of your letter. For purposes of identification and reference, this document has been numbered AETNA-OGR-00017. Aetna's remaining responses will be provided shortly. If you have any questions, please contact me at 202-887-4343.

Sincerely,

Steven R. Ross
Counsel for Aetna

Enclosure

cc: The Honorable Jim Jordan, Ranking Member (w/ Encl.)

At the September 17, 2009 hearing, Rep. John Conyers asked Patricia Farrell, Senior Vice President, National and International Business Solutions at Aetna Inc., what was "her annual compensation per year?" Ms. Farrell agreed to provide this confidential information in writing at a later date. For 2008, Ms. Farrell received from Aetna compensation payments, including her bonus, of $672,649.

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November 19, 2009

The Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Kucinich:

We represent CIGNA Corporation ("CIGNA" or the "Corporation") and are writing in response to your October 22, 2009 letter to Mr. Thomas Richards. By agreement with your staff, our deadline for a response to your letter was extended to November 19, 2009. Please find below responses to your questions and document requests.

Some of the information contained herein may be business sensitive and would cause commercial harm to CIGNA if it were to be publicly disclosed. To the extent that the Subcommittee is considering such disclosure, we request that you provide us notice and an opportunity to be heard on whether the publication of our responses or the release of the audio tapes would be appropriate under the circumstances. We understand that your inquiry is for the public record in the context of an official Subcommittee hearing, but we do not view anything in either the House or Committee Rules that would prevent you from redacting our responses from public disclosure. We appreciate your discretion in this respect.

Request #1:

In 2004, CIGNA settled claims for delaying and/or denying claims for patients of self-refunded plans. And in 2009, CIGNA settled with the New York State Attorney General concerning its use of the Ingenix database.

(a) What did CIGNA agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by CIGNA and its

subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.

(b) Has CIGNA settled other claims or state regulatory actions relating to the wrongful delay or denial of claims since 2004? If so, please include all relevant details of the settlement. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that included the alleged activities that were the subject of settlement.

CIGNA does not as a business strategy or practice delay claims processing or inappropriately deny claims. One of our principal imperatives as a provider of health and wellness benefits is to help health care providers achieve the best possible medical outcomes for our members. CIGNA does not consider costs of service in establishing coverage policy or in our decisions to provide access to care other than infrequent circumstances. Those infrequent occurrences arise when there are multiple items or services with equivalent safety and effectiveness. CIGNA's medical necessity policies and determinations are made by clinicians and are based on the most recently published scientific evidence. We consider both the safety and the effectiveness of health care procedures, treatments, devices, drugs, and diagnostic tests.

Attachment A contains copies of two settlement agreements with respect to the multi-district litigation settled in 2004 referred to above. In addition, please find attached a copy of the settlement with the New York Attorney General relating to the Ingenix litigation. These documents reflect the monetary components as well as substantive changes implemented by CIGNA.

With respect to individual settlement claims, please find below a chart reflecting (1) the total amount of claims CIGNA has paid since 2004, (2) the aggregate settlement amounts for each of those years, and (3) the number of settled lawsuits for each of those years. The first column is included as context for claim payment history, that is, the total settlement amounts over this period represent less than 0.01 percent of the total amount that CIGNA paid in claims.

Year	Total Value of Medical and Pharmacy Benefits Paid (Rounded)	Aggregate Settlement Amounts	Number of Settled Member Lawsuits
2004	$26,396,000,000	$1,475,655.71	69
2005	$25,392,000,000	$ 553,791.55	59
2006	$26,444,000,000	$1,549,295.81	50
2007	$29,217,000,000	$ 611,512.12	47
2008	$34,913,000,000	$ 310,189.59	33

Additionally, Attachment B contains settlement agreements in two multi-party actions. CIGNA is prepared to discuss with you and your staff any additional information that we can provide pursuant to this request.

With respect to state regulatory actions, it is important for the Subcommittee to realize that the health insurance industry, including CIGNA, is subject to regular reviews from state insurance commissioners and other regulators. In particular, the states conduct "market conduct exams" ("MCEs")" on a regular basis. The MCEs cover the full scope of CIGNA's business. The following is a summary of actions over the last five years.

Year	Regulatory Actions	Aggregate Settlement Amounts
2004	14	$ 809,726.00
2005	11	$ 310,609.48
2006	7	$ 106,300.00
2007	9	$ 975,900.00
2008	5	$ 280,991.57

Finally, in response to the last part of your inquiry, as stated above, CIGNA's medical necessity policies and determinations are made by clinicians and are based on the most recently published scientific evidence. The income and "incentives" of CIGNA executives or employees are not dependent on the approval or denial of claims. Therefore, we have no responsive data with respect to the third sentence of this inquiry.

Request #2:

> **In your testimony, you stated "In 2008, CIGNA processed approximately 91 million claims for payment. More than 90 million of these claims were paid without question ... Of the approximately one million claims that did require prior authorization, all but 0.08 percent were approved on initial review." What is the value in dollars to CIGNA of the claims that CIGNA did not pay within 30 days, 60 days, 90 days, 120 days?**

CIGNA holds itself to a high standard on the payment of claims. Our commitment to continuous improvement includes paying doctors, facilities, and other health care professionals on a timely basis. In 2008, 98.87 percent of claims were paid within 30 days, and 95.88 percent of claims were paid within 14 days. We track payment in 14-day and 30-day categories based on when we receive a "complete" claim. Please note that we do not track claims payment based on dollar amount and, as such, do not manage our claims payment inventory based on dollar amount. We work to pay claims as timely as possible regardless of the dollar value of the claim.

Request #3:

> **Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in**

some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

Included in this transmittal are recordings of CIGNA "town hall meetings" conducted in 2009. Attachment C contains copies of slides referenced in the audios for the specific meetings.

Request #4:

Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

CIGNA itself does not maintain any specific data on the amount of "defensive medicine" that physicians may perform out of concerns about medical malpractice liability. We look at the safety and the effectiveness of health care procedures, treatments, devices, drugs, and diagnostic tests requested for our customers when making access to care determinations.

Provided below are citations for four publicly available studies that document and quantify the impact of "defensive medicine."

1. A May 1996 study in the *Quarterly Review of Economics and Finance,* by Daniel P. Kessler and Mark B. McClellan, estimated that 5-9 percent of total medical spending is due to defensive medicine

2. A June 2005 study in the *Journal of America Medical Association* concluded that 93 percent of Pennsylvania physicians surveyed reported practicing defensive medicine.

3. A 2006 PriceWaterhouseCoopers study estimated that overall, approximately 10 percent of the costs of medical services are attributed to the cost of litigation and defensive medicine.

4. A November 2008 study done by the Massachusetts Medical Society found that 13 percent of all hospital admissions and 30 percent of MRI/CT studies and specialty consultations were ordered due to malpractice concerns.

Request #5:

Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

CIGNA works closely with doctors and hospitals to reduce waste, duplication and redundancy. We are committed to addressing the needs of practicing physicians for administrative simplicity, and in that way contributing to improvements in patients' experience. We propose that the following industry metrics will help to improve quality, outcomes and ultimately have a positive affect on health care costs.

Metric 1: Percent of Electronic Administrative Transactions

With respect to administrative interaction between providers and health plans, there are five primary touch points that benefit from the application of information technology: (1) eligibility verification, (2) claim submission, (3) claim status inquiry, (4) claim payment and (5) claim remittance. Electronic versions of these interactions, based on existing HIPAA standards, currently support 43 percent of all such activity across the industry. Conversion of the remaining activity to electronic means would yield $29.7 billion in savings across the industry (source: US Healthcare Efficiency Index, www.ushealthcareindex.com). We suggest metrics around these touch points.

Relatedly, CIGNA is one of many major healthcare companies participating in a task force led by America's Health Insurance Plans ("AHIP") to identify opportunities to simplify administrative interaction between health care professionals and healthcare companies. The goal of the task force is to reduce the administrative complexity that health care professionals experience when interacting with multiple healthcare companies. On October 5, 2009, CIGNA and other AHIP representatives joined health care professionals to announce the kickoff of a technology test phase in Ohio. This will give doctors access to a new multi-payer web portal (i.e., a single website) designed to simplify their interactions with CIGNA and other health plans. The web portal will offer 15 administrative and clinical capabilities in real-time for eligibility and benefits inquiry, claim submission, claim status inquiry, referrals, and prior authorization.

Metric 2: CORE Certification

The Committee on Operating Rules for Information Exchange ("CORE"), established by the Council for Affordable Quality Healthcare ("CAQH"), was created to build consensus among health care industry stakeholders on a set of operating rules that enhance HIPAA transaction standards to further streamline electronic healthcare data exchange. The widespread adoption of CORE rules will help health care professionals receive more consistent and predictable data across multiple health plans. CAQH reports that 75 percent of commercially insured members are covered by health plans that are either CORE-certified or are in the process of achieving certification. CIGNA suggests adding CORE certification as a metric for each phase of CORE rules.

Metric 3: Electronic Prescriptions

Electronic prescriptions improve patient safety by allowing medication history and allergies to be evaluated at the point of care. We suggest a metric around the percentage of prescriptions enabled electronically for transmission.

Metric 4: Electronic Lab Results

There is significant value in making lab test results available electronically. It can reduce duplicative testing (reducing costs) and improve quality as well (providing a more complete

and accurate clinical picture to track health issues). We suggest a metric around the percentage of lab results available electronically.

Metric 5: "Gaps in Care" Electronic Alerts

"Gaps in Care" alerts are evidence-based care guidelines that shape appropriate interventions and medication adherence for a variety of chronic and acute conditions. Health plans often maintain the most comprehensive set of clinical data available for individuals today, and as such, programs to "alert" physicians to potential compliance issues with these care guidelines are common.

Metric 6: Electronic Personal Health Records

Consumer access to information has been accepted as a means of creating well-informed patients that have the ability to make better decisions working with their family and physicians. Personal Health Records ("PHRs") are a comprehensive solution to providing records with information automatically populated with medical and pharmacy claim details, and often lab results. PHRs often present patient-specific educational resources driven by diagnosis/procedure codes in claim detail, benefits/coverage, family history, etc.

CIGNA believes any suggestions to improve health plan performance must also focus on individual quality of care and health outcomes. Through these types of administrative simplification initiatives, we hope to reduce the time, effort, and expense related to the paperwork that burdens much of today's health care system – while making it easier for health care professionals to interact with health plans.

Request #6:

Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

Mr. Richards will provide the Subcommittee with his CIGNA compensation over the past 5 years under a separate and confidential transmittal. On behalf of Mr. Richards, we ask that he be notified in advance of any public release of the information he is providing.

Please contact me if CIGNA may provide any additional information or otherwise be of assistance to the Subcommittee.

Sincerely,

James D. Barnette

James D. Barnette

cc: The Honorable Jim Jordan
Attachments

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

October 22, 2009

Ms. Colleen Reitan
Executive Vice President and Chief Operating Officer
Health Care Service Corporation
300 East Randolph Street
Chicago, Illinois 60601

Dear Ms. Reitan:

To complete the record of your testimony before the Domestic Policy Subcommittee on September 17, 2009, the Subcommittee requests the following information in writing:

1) In 2008, Blue Cross and Blue Shield of Texas, a subsidiary of Health Care Service Corporation, was charged for failing to make non-preferred benefits reasonably available to policyholders, and for failing to maintain an accurate listing of preferred providers.

    a) What did Health Care Service Corporation agree to do to remedy those violations? Please include dollar amounts as well as all substantive and procedural changes implemented by Health Care Service Corporation and its subsidiaries (by name) as part of the settlement or as a result of the claims being brought.

    b) Has Health Care Service Corporation settled other claims or state regulatory actions relating to the wrongful delay or denial of claims since 2004? Please include all relevant details of the settlement. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that included the alleged activities that were the subject of settlement.

2) Please provide the subcommittee with the following statistics for 2008: Number of claims HCSC and its subsidiaries received; number of claims paid within 30 days, and the value in dollars to HCSC and its subsidiaries of claims that they did not pay within 30 days, 60 days, 90 days, 120 days.

3) Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

5) Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

6) Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Thursday, November 5, 2009**.

If you have any questions regarding this request, please contact Jaron Bourke, Staff Director, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
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Domestic Policy Subcommittee Document Request Instruction Sheet

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2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.



BlueCross BlueShield
of Illinois, New Mexico, Oklahoma & Texas

Colleen Reitan
Executive Vice President and
Chief Operating Officer

Peter Fise 11/5/09
Sharon Ay 11-5-09

November 5, 2009

CONFIDENTIAL/VIA MESSENGER

The Honorable Dennis J. Kucinich
Chairman, Domestic Policy Subcommittee
United States House of Representatives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Re: Response to Subcommittee's October 22, 2009 Request for Information

Dear Chairman Kucinich:

On behalf of Health Care Service Corporation ("HCSC"), I am responding to the U.S. House Domestic Policy Subcommittee's (the "Subcommittee's") October 22, 2009 request (the "October 22 request") for additional information to supplement my testimony provided to the Subcommittee on September 17, 2009. The responses below correspond to the numbered requests (1)-(6) in the October 22 request.

Request (1)(a): In 2008, the Texas Department of Insurance ("TDI") alleged that amounts paid by Blue Cross and Blue Shield of Texas ("BCBSTX") for certain services provided by facility providers which were not part of BCBSTX's contracted network were too low and were not adequately defined in policies, allegedly making non-preferred benefits not reasonably available to BCBSTX policyholders. BCBSTX denied these allegations. To resolve this dispute, BCBSTX worked with the TDI to enter into Consent Order 08-0514 (the "Order") and made certain changes to its practices in response to the issues raised.

First, BCBSTX changed its payment methodology for non-contracted facilities. The methodology is now based on several factors, including identification of services consistent with the Centers for Medicare and Medicaid Services, reasonable reflection of the seriousness of the treatment or condition, and regional variations in the cost of care. BCBSTX had already adopted an updated, regionalized, non-contracting facility allowable amount reimbursement schedule prepared using this criteria in January, 2008, prior to the execution of the Order. BCBSTX also implemented more frequent updates to its online provider directory.

Second, BCBSTX reimbursed fully-insured members who previously received and paid for certain covered services provided by non-contracting facilities from Jan. 1, 2004 – Dec. 31, 2007, for the difference between the allowable amount applied by BCBSTX when the claim was

300 East Randolph Street • Chicago, Illinois 60601 • (312) 653-6635 • (312) 946-8407 Fax • Colleen_Reitan@hcsc.net

Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

originally processed and BCBSTX's updated allowable amount, resulting in payments of approximately $1.6 million.

Third, BCBSTX made a payment to TDI of $250,000.00 and a subsequent payment in October 2009 of approximately $2.2 million according to the terms of the Order. By making the agreed upon changes to out of network payment methodology and the requisite payments BCBSTX has fully complied with the Order.

Request (1)(b): To the best of my knowledge and belief, HCSC has not settled with any other state regulator since 2004 any other regulatory actions brought by the state relating to the wrongful delay or denial of claims. We have construed this request as not seeking information related to inquiries about individual claim or payment disputes in which a member or provider may engage a state regulator in some capacity and which arise as part of the routine regulatory process.

Request 2: To the best of my knowledge and belief, in 2008, HCSC received around 137 million claims for processing. Approximately 98.4% of those claims are paid within 30 days, 99.6% within 60 days, 99.89% within 90 days and 99.96% within 120 days. The vast majority of claims paid after 30 days are claims that involve other independent Blue Cross Blue Shield plans, which necessitate additional interplan processing and payment reconciliation. HCSC does not monitor the requested information on the "value in dollars" of claims not paid within these periods because nearly all of our claims are paid within 30 days.

Request 3: To the best of my knowledge and belief, HCSC does not hold the types of meetings described in Request 3, in which financial results, particularly Medical Loss Ratios, are discussed with employees.

Request 4: While this is an important topic in the discussion of health care costs, HCSC is not engaged in the medical treatment of patients. HCSC therefore cannot speculate as to whether physicians may choose treatment options "out of concerns about medical malpractice liability."

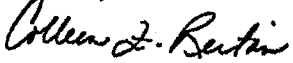
Request 5: As a member-owned organization, our goal is to simplify processes for the benefit of our members. One example of HCSC's use of Information Technology to better serve our members is a real-time electronic tool we are piloting whereby physicians, in their offices, can estimate what a plan will pay for a member's care. The physician's office staff can then provide an estimate of the amount of out-of-pocket expense that the member will owe. Members and physicians like the tool because it helps bring clarity to the cost for the given procedure and allows for payment arrangements to be made.

Request 6: I provided my current salary amount in my testimony on September 17, 2009 in response to a specific question. In response to this request, my total compensation for 2009 includes my salary $728,000, and an annual incentive bonus of $315,040. I joined HCSC in

October 2008, and for the period October 1to December 31 of that year my salary was $175,000. I was employed by another unrelated company prior to joining HCSC in October 2008.

We trust that this responds to the Subcommittee's inquiries.

Sincerely,



Colleen F. Reitan
Executive Vice President & Chief Operating Officer
Health Care Service Corporation,
a Mutual Legal Reserve Company

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

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Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

October 22, 2009

Mr. Brian Sassi
President and CEO, Consumer Business
WellPoint, Incorporated
120 Monument Circle
Indianapolis, Indiana 46204

Dear Mr. Sassi:

To complete the record of your testimony before the Domestic Policy Subcommittee on September 17, 2009, the Subcommittee requests the following information in writing:

1) Regarding Wellpoint's removal of 2330 members who were the subject of the settlement last year with the California Department of Insurance, and 1770 members the previous year,

a) What guidelines or criteria were used in the decisions to remove those members?

b) If those members were removed for misrepresenting their medical history, in what manner(s) did they do so? (You may aggregate by category in your response)

c) Was this situation unique to California, or did WellPoint apply a similar strategy in other states? If so, which states?

d) Did WellPoint face similar claims in other states? If so, which states? Please provide details about the claims, findings and/or settlements of claims, such as the nature of the alleged violation, the number of instances, the dollar amount of the fine and/or settlement. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that were fined by state regulators for any violations of state law.

2) In your testimony, you stated "Last year, WellPoint received 380 million claims and processed 97 percent of them within 30 days." What is the value in dollars of the claims that WellPoint did not pay in 2008 within 30 days, 60 days, 90 days, 120 days.

3) Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

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The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Thursday, November 5, 2009**.

If you have any questions regarding this request, please contact Jaron Bourke, Staff Director, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
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    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

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16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

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proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

HOGAN & HARTSON

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November 12, 2009

E. Desmond Hogan
Partner
202-637-5493
edhogan@hhlaw.com

BY HAND DELIVERY

The Honorable Dennis J. Kucinich
Chairman
Committee on Oversight and Government Reform
Domestic Policy Subcommittee
United States House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

RE: Request for Information

Dear Chairman Kucinich:

This letter, the attached responses to the questions posed, and the enclosed files are being sent on behalf of WellPoint, Inc. ("WellPoint") in response to your October 22, 2009 letter on behalf of the Committee on Oversight and Government Reform, Domestic Policy Subcommittee ("Committee") requesting that the company supplement the testimony it provided to the Committee on September 17, 2009.

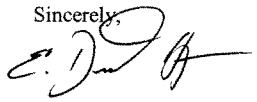
The submission of this information does not waive, nor is it intended to waive, any rights, privileges, or immunities of the company with respect to this matter, including any applicable attorney-client, work product, or other privilege or immunity. Moreover, to the extent that nonresponsive documents have inadvertently been produced, the company does not agree to any expansion in the scope of the request. The company expressly reserves any applicable privileges and immunities to which it is entitled under applicable law.

In addition, this letter, the attached responses to the questions posed, and the enclosed documents contain or constitute confidential or proprietary business information, records, and trade secrets of the company. The company has labeled the documents that it believes contain personal, trade secret or other competitively sensitive information as "CONFIDENTIAL." Because of the sensitive nature of this information, in the event that the Committee intends, during the investigation of this matter, to disclose any of the company's documents to an agent, employee, or other person affiliated with any competitor, the company requests that it be given *one week advance notice* in order to permit it to address the issue with you. Similarly, in the

event that the Committee intends to disclose any of this information in any public forum or to a third party who does not expressly agree to maintain the confidentiality of the information and to not effect transactions in WellPoint's common stock, the company requests that it be given *one week advance notice* in order to permit it to address the issue with you.

If you have any questions regarding this letter or the submitted documents, please contact me at (202) 637-5493.

Sincerely,



E. Desmond Hogan
Counsel for WellPoint, Inc.

Responses of WellPoint, Inc. ("WellPoint") to the Committee's Supplemental Requests

Request 1: *Regarding WellPoint's removal of 2330 members who were the subject of the settlement last year with the California Department of Insurance, and 1770 members the previous year:*

a. What guidelines or criteria were used in the decisions to remove those members?

Response to Request 1(a): WellPoint follows California statutes and applicable case law as its standard for rescission. See Exhibit A, WLP-DPS-00000001-00000003.

b. If those members were removed for misrepresenting their medical history, in what manner(s) did they do so? (You may aggregate by category in your response).

Response to Request 1(b): The members were rescinded because they made a material misrepresentation or omission at the time they were applying for individual insurance coverage. WellPoint follows California statutes and applicable case law as its standard for rescission. See Exhibit A

c. Was this situation unique to California, or did WellPoint apply a similar strategy in other states? If so, which states?

Response to Request 1(c): WellPoint follows each state's statutes and applicable case law as its standard for rescission, as outlined in Exhibit A. The following chart lists the WellPoint entities that sell major medical individual health insurance policies and the states in which these entities have sold policies:

Legal Name*	State(s) Issued Policies
Anthem Health Plans, Inc.	CT
Anthem Health Plans of Maine, Inc.	ME
Anthem Health Plans of New Hampshire, Inc.	NH
Empire HealthChoice Assurance, Inc.	NY
Empire HealthChoice HMO, Inc.	NY
Anthem Health Plans of Virginia, Inc.	VA
HealthKeepers, Inc.	VA
Peninsula Health Care, Inc.	VA
Priority Health Care, Inc.	VA
Blue Cross and Blue Shield of Georgia, Inc.	GA
Anthem Health Plans of Kentucky, Inc.	KY
Community Insurance Company	OH
Blue Cross Blue Shield of Wisconsin	WI
Compcare Health Services Insurance Corporation	WI
Healthy Alliance Life Insurance Company	MO
HMO Missouri, Inc.	MO
HealthLink HMO, Inc.	MO

UniCare Health Insurance Company of the Midwest	IL/IN
UniCare Health Plans of Texas, Inc.	TX
UniCare Life & Health Insurance Company	IL, IN, MI, NV, TX, VA
HMO Colorado, Inc.	CO/NV
Rocky Mountain Hospital and Medical Service, Inc.	CO/NV
Anthem Blue Cross of California	CA
Anthem BC Life & Health Insurance Company	CA
Anthem Life Insurance Company	IN
Anthem Insurance Companies, Inc.	IN

* These are the current legal names of the corporate entities.

d. Did WellPoint face similar claims in other states? If so, which states? Please provide details about the claims, findings and/or settlements of claims, such as the nature of the alleged violation, the number of instances, the dollar amount of the fine and/or settlement. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that were fined by state regulators for any violations of state law.

Response to Request 1(d): Because this question was not time limited, we investigated this issue and respond back to the date of the merger that created WellPoint, Inc. Since 2004, WellPoint has not been the subject of a regulatory fine related to rescissions in any other state.

***Request 2**: In your testimony, you stated "Last year, WellPoint received 380 million claims and processed 97 percent of them within 30 days." What is the value in dollars of the claims that WellPoint did not pay in 2008 within 30 days, 60 days, 90 days, 120 days.*

Response to Request 2: While WellPoint does not currently collect or maintain this information in this way, we developed system queries and were able to obtain data for systems that focus on CA, NV, CO, CT, NH, and ME that reflects over 160 million claims received in 2008. The following chart shows the number of claims processed in those states during the timeframes in question, the value of claims paid during each timeframe, and the amount of claims not paid by the end of the timeframe. Data reporting systems that include timeliness of claims for WellPoint's other markets do not track the dollars associated with those claims.

	Within 30 days	31-60 days	61-90 days	91-120 days	121+ days	Grand Total
Number of Claims Processed	155,848,565	3,886,095	821,308	192,132	104,548	**160,852,648**
Percent of Total	**96.9%**	**2.4%**	**0.5%**	**0.1%**	**0.1%**	**100%**
Paid Amounts	$ 24,570,983,496	$ 1,833,554,591	$ 384,910,068	$ 134,503,527	$ 73,333,710	**$ 26,997,285,391**
Percent of Total	**91.0%**	**6.8%**	**1.4%**	**0.5%**	**0.3%**	**100%**
Amount not Paid by End of Period	$ 2,426,301,896	$ 592,747,305	$ 207,837,237	$ 73,333,710	N/A	N/A
Percent of Total	**9.0%**	**2.2%**	**0.8%**	**0.3%**	N/A	N/A

Notes:

- *Claims processed includes all claims paid and rejected.*
- *Amount not paid by end of period is from the universe of claims paid and does not include rejected claims. Claims can be rejected for a variety of reasons, including claims from individuals who are not our members and for services that are not covered benefits.*

There are a number of reasons for claims not being processed within a 30-day timeframe. For example, a claim may not have complete information from the provider and requires additional information that must be completed prior to processing.

***Request 3**: Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly Medical Loss Ratio, are discussed with employees.*

Response to Request 3: Each quarter following an earnings release, WellPoint, Inc. conducts internal meetings with its employees holding the title of staff vice president and above (a group of approximately 600 people), to discuss the company's financial results. These meetings are known internally as Quarterly Update and Discussion (QUAD) meetings. Among the meetings with employees where financial performance is discussed, we believe the QUAD meetings are most responsive to the committee's request based on their timing (immediately following each earnings release) and their primary objective (to discuss the company's financial results). The QUAD meetings for the years 2008 and 2009 have covered other topics in addition to the financial results. WellPoint is providing those slides which contain company financial performance information, as requested by the Committee. Responsive portions of the QUAD meetings in 2008 and 2009 are attached and Bates Labeled WLP-DPS-00000004-00000072. WellPoint does not make recordings of these meetings.

***Request 4**: Mr. Shock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.*

Response to Request 4: Researchers and health policy experts have found it difficult to estimate what percentage of national health care expenditures is attributable to "defensive medicine."[1] However, there have been several studies that attempt to estimate the reduction in national health care expenditures, including a reduction in defensive medicine practices, which would result if tort reforms were enacted.

The first and now widely-cited study was conducted by Daniel Kessler and Mark McClellan in 1996, examining Medicare data of beneficiaries treated for serious heart

[1] "Defensive medicine" is defined as providing medical services that are not expected to benefit the patient, but that are undertaken to minimize the risk of a subsequent lawsuit against the provider. Defensive medicine may also result in providers limiting their practices, refusing to perform high-risk procedures, and avoiding patients with complex problems or patients perceived as litigious.

disease.[2] The authors found that liability reforms could reduce defensive medicine practices, leading to a 5%-9% reduction in medical expenditures.

In 2008, the Massachusetts Medical Society conducted a statewide survey of practicing physicians in 8 specialty areas.[3] The results showed that:

- 83% of physicians responding to the survey practiced defensive medicine;
- 22%-28% of diagnostic tests (X-ray, CT, MRI, ultrasound) were ordered for defensive reasons;
- 28% of specialty referrals were motivated by liability concerns;
- 18% of laboratory tests were done for defensive medicine purposes; and
- On average, 13% of hospital admissions were done for liability reasons.

Based on 2006 Medicare data for Massachusetts, the estimated annual cost to the Massachusetts health care system of defensive medicine totals almost $1.4 billion.

Nationwide, PricewaterhouseCoopers estimated that $210 billion in national health care expenditures is wasted due to defensive medicine practices.[4]

Finally, in October 2009, the Congressional Budget Office ("CBO"), at the request of Senator Orrin Hatch, updated its analysis of the effects of proposals to limit costs related to medical malpractice.[5] The CBO estimated that, if federal tort reforms similar to those set forth in the letter were enacted, total national health care spending could be reduced by about 0.5% (about $11 billion in 2009), which would include 0.3% reduction in health care expenditures ($6 billion) from slightly less utilization of health care services (due to a reduction in defensive medicine).

***Request 5**: Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.*

Response to Request 5: WellPoint is strongly committed to the full adoption and continuing evolution of electronic transactions between health care providers and health plans. Much work has already been done in this area through a variety of nationally recognized collaborative efforts and standards-making organizations, such as the Certification Commission for Health Information Technology (CCHT), Healthcare

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[2] Kessler, D. and McClellan, M., "Do Doctors Practice Defensive Medicine," The Quarterly Journal of Economics vol. 111, issue 2, at 353-390 (1996), available at: http://www.stanford.edu/~jay/health_class/Readings/Lecture08/kessler_mcclellan_qje_defensive_medicine.pdf

[3] Massachusetts Medical Society, "Investigation of Defensive Medicine in Massachusetts," November 2008, available at: http://www.massmed.org/AM/Template.cfm?Section=Research_Reports_and_Studies2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=27797

[4] PricewaterhouseCoopers Health Research Institute, "The Price of Excess: Identifying Waste in Healthcare Spending," April 2008, available at: http://pwchealth.com/cgi-local/hregister.cgi?link=reg/waste.pdf

[5] Congressional Budget Office, "Letter to Senator Orrin Hatch: Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ("Tort Reform")," October 9, 2009, available at: http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf

Information Technology Standards Panel (HITSP), the Workgroup for Electronic Data Interchange (WEDI), the Accredited Standards Committee (ASC) X12, and the Coalition for Affordable Quality Health Care (CAQH). WellPoint is actively engaged in each of these organizations, serving on work groups, boards and even as a founding member of CAQH. When considering how to measure the effect of technology on electronic transactions, it will be important to take into consideration the work these groups have done and are doing.

The work of the U.S. Healthcare Efficiency Index ("the Index"), a public-private sector collaborative effort involving payers, providers, vendors, banks and others, is also instructive. The Index is focused on increasing awareness of the health care dollars that could be saved through administrative simplification and creating a single national indicator that measures the progress of administrative health information technology adoption across the healthcare industry. Using trusted industry sources, the Index created a list of key business transaction measures to be monitored by an independent Advisory Council and outside auditor to track the industry's progress toward a goal of creating a healthcare delivery system whose administrative transactions are handled almost entirely through electronic means.

The Index offers a phased approach that initially takes a broad-based industry view and becomes more specific over time. Phase I of the effort focuses on electronic claim submissions; eligibility verification; claims status inquiries; claim payment; and claim remittance. According to information gathered by the Index, "Phase 1 of the Index estimates the total annual savings potential to be nearly $30 billion for medical claims-related transactions. Medical payment transactions alone could bring an estimated $11 billion in savings through direct deposit. Addressing this issue can bring immediate relief – within existing policy –for both payers and providers."[6]

***Request 6**: Mr. Conyers requested the compensation received by you, including deferred compensation, incentives, and bonuses, in the last 5 years.*

Response to Request 6: Mr. Sassi's compensation is private information that is not publicly reported. Nonetheless, in an effort to assist the committee, attached is information regarding Mr. Sassi's 2008 compensation, the first year he became a Section 16 officer of WellPoint. The attachment, Bates Labeled WLP-DPS-00000073, contains the amount reported on Box 5 of Mr. Sassi's 2008 IRS W-2 Form, which includes base salary, incentive bonus, other income, including taxable income from the vesting of restricted stock, deferred compensation matching contributions, and perquisites. Mr. Sassi provides this private compensation information in response to this question, but he specifically requests that it not be publicly distributed.

[6] U.S. Healthcare Efficiency Index, available at: http://www.ushealthcareindex.com/purpose.php 09/15/09.

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6143

Majority (202) 225-5051
Minority (202) 225-5074

October 22, 2009

Mr. Richard Collins
Senior Vice President of Underwriting, Pricing, and Healthcare Economics
United Healthcare Group
9900 Bren Road East
Minnetonka, Minnesota 55343

Dear Mr. Collins:

To complete the record of your testimony before the Domestic Policy Subcommittee on September 17, 2009, the Subcommittee requests the following information in writing:

1) Last year United Healthcare Group settled claims that its PacifiCare subsidiary wrongfully denied 130,000 claims in California, paid claims incorrectly, lost documents that included medical records, failed to acknowledge claims in a timely manner and hassled its members with multiple requests for documentation that was previously provided. In testimony, you asserted that UHC denies those charges.

a) Did UHC face similar claims in any other states? If so, which states? Please provide details about the claims, findings and/or settlements of claims, such as the nature of the alleged violation, the number of instances, the dollar amount of the fine and/or settlement. Please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that were fined by state regulators for any violations of state law.

b) UHC also settled claims relating to fraudulent manipulation of reimbursement rates through the use of the Ingenix database. Please include all relevant details of the settlement. .

2) In your testimony, you stated "We pay more than 250 million claims annually, and more than 95 percent are processed on our primary commercial platforms within 10 days." What is the value in dollars to UHC of the claims that UHC did <u>not</u> pay in 2008 within 30 days, 60 days, 90 days, 120 days?

3) Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

5) Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

6) Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Thursday, November 5, 2009**.

If you have any questions regarding this request, please contact Jaron Bourke, Staff Director, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
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Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

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4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

O'MELVENY & MYERS LLP

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November 20, 2009

VIA HAND DELIVERY

The Honorable Dennis Kucinich
Chairman, Subcommittee on Domestic Policy
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Re: *UnitedHealth Group Incorporated*

Dear Chairman Kucinich:

This letter responds to your letter to Richard Collins, Senior Vice President of Underwriting, Pricing, and Healthcare Economics for UnitedHealthcare, dated October 22, 2009. We represent UnitedHealth Group ("United" or "the Company") in connection with the inquiry by the Committee on Oversight and Government Reform and its Subcommittee on Domestic Policy ("Subcommittee"). We respond below to each of the questions set forth in your letter.

Question 1: California and New York Regulatory Matters

Beginning in 2007, the California Department of Insurance ("CDI") examined PacifiCare Life and Health Insurance Company ("PacifiCare"), a subsidiary of United, in California. The CDI's examination related primarily to claims processing, implementation of provider contracts, and provider dispute resolution. On January 25, 2008, the CDI issued an Order to Show Cause to PacifiCare alleging violations of certain insurance statutes and regulations in connection with, among other things, claims processing and implementation of provider contracts. On June 3, 2009, PacifiCare filed a Notice of Defense to the Order to Show Cause denying all material allegations and asserting numerous defenses. The dispute is now the subject of an administrative proceeding before an administrative law judge. As Mr. Collins testified to the Subcommittee, PacifiCare has not settled this matter and continues to vigorously contest the CDI's allegations.

The Subcommittee also asked for information about state insurance regulatory enforcement matters similar to the CDI's action involving PacifiCare. The CDI's action against PacifiCare alleges over 130,000 insurance code violations and seeks fines and penalties that

would be unprecedented in a CDI enforcement action. To our knowledge, the Company has not been involved in any state insurance regulatory enforcement matters similar to the CDI matter in terms of the number of alleged violations or the magnitude of the remedies sought by the insurance department. Of course, United's business segment that markets commercial medical plans, UnitedHealthcare – along with the rest of the industry – is routinely subject to market conduct examinations and other state regulatory reviews relating to the accuracy and timeliness of claims processing which may result in agreements with state regulators, some of which are publicly reported. But none of these matters has been similar in size or scope to the pending CDI action.

With respect to compensation received by United executives responsible for PacifiCare and other business units subject to regulatory oversight, all United subsidiaries and business units ultimately report to the senior management of UnitedHealth Group. United publicly discloses to the U.S. Securities & Exchange Commission ("SEC") the compensation information for its Chief Executive Officer, Chief Financial Officer, and each of the three other most highly compensated executive officers. United has enclosed its 2009 proxy statement, bearing control numbers UHG_DP_000001 - UHG_DP_000077, which contains the responsive compensation information.

On February 13, 2008, the Office of the Attorney General of the State of New York announced that it was conducting an industry-wide investigation into out-of-network provider reimbursement practices of health insurers, including United, and served the Company with a notice of intent to initiate litigation. On January 13, 2009, the Company announced that it had reached an agreement with the New York Attorney General resolving the matter. Under the terms of the settlement agreement with the New York Attorney General, the Company has paid $50 million to fund a not-for-profit entity to develop and operate a new, independent database to replace the Prevailing Health Charges System ("PHCS") and Medical Data Research ("MDR") database owned and licensed by Ingenix, Inc. Both databases are licensed by a number of health plans and employers to assist them in setting reimbursement rates for members who receive physician services outside of their managed care networks. When the new database is operational, the Company will cease licensing the PHCS and MDR databases and will rely on the new database for a period of at least five years in connection with out-of-network reimbursement rates for those benefit plans that employ a "reasonable and customary" standard for setting out-of-network reimbursement rates.

Contrary to the assertion in this question, the Company's agreement with the New York Attorney General did not relate to the manipulation of data and the Company did not admit to any fraud in connection with the settlement. Indeed, United continues to stand behind the integrity of its data. Moreover, Ingenix did not set the reimbursement rates of other health plans that licensed its charge database and was not involved in the decisions of other health plans regarding the setting of reimbursement rates for out of network services.

Question 2: Claims Processing

It is the policy of United to process all claims in a timely manner according to the requirements of the law and applicable insurance and/or provider contracts. The Company does not remit benefit payments for claims not payable because of incompleteness, benefit ineligibility, untimely filing, duplication, or other reasons of non-coverage. By their very nature, these types of claims are not payable under the insurance contract and, thus, there is no "savings" to the Company associated with the denial of these claims.

Question 3: Company Presentations

United does not have Company-wide meetings to discuss financial results with employees, nor does it maintain a centralized repository for recordings of or materials relating to all presentations that might be made pertaining to the financial results and medical loss ratios of the Company or its various business segments. However, United does publicly report the medical care ratios for its commercial, major medical business. Below, please find a table listing the annual medical care ratio for UnitedHealthcare's commercial major medical business since 2007.

Year	Commercial Medical Care Ratio
2008	83.5%
2007	82.6%

Question 4: Defensive Medicine

United has not conducted any studies to measure empirically the prevalence and financial impact of so called "defensive medicine." However, research by various medical societies shows that many health care practitioners seek to protect themselves from the increasing threat of liability suits by altering their methods of practicing medicine. Recent surveys indicate that the practice of defensive medicine is a significant and growing problem. According to a study published in the *Journal of the American Medical Association*, 93% of high-risk specialist physicians indicated that they practiced defensive medicine.[1] A poll conducted by Harris Interactive found that 79% of physician respondents practiced defensive medicine by ordering unnecessary tests and most doctors' fear of malpractice liability has harmed their ability to provide quality care.[2] Moreover, a 2008 survey by the Massachusetts Medical Society found that approximately 25 percent of surveyed medical procedures are defensive in nature.[3] While the total cost of defensive medical practices has been widely debated by experts, most agree that the cost to the health care system is substantial. The Congressional Budget Office ("CBO") has estimated that enacting medical liability reforms such as limiting noneconomic damages and

---

[1] David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609-2617 (2005).

[2] *Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care: Caused Them to Order Unnecessary Tests, Provide Unnecessary Treatment and Make Unnecessary Referrals*. The Harris Poll, No. 22, May 8, 2002.

[3] Massachusetts Medical Society, *Investigation of Defensive Medicine in Massachusetts* (November 2008).

tightening the statute of limitations for filing a suit would reduce the federal deficit by $54 billion over 10 years, largely by curbing defensive medicine.[4] However, other experts believe that CBO has underestimated the impact of defensive medicine. The Pacific Research Institute, for example, concluded that "[d]efensive medicine wastes patients' and doctors' time and costs $191 billion annually."[5]

Question 5: Value of Information technology

UnitedHealth's Center for Health Reform & Modernization published *Working Paper 2: Health Care Cost Containment – How Technology Can Cut Red Tape and Simplify Health Care Administration*, which identified practical ways in which technology can save health care dollars by modernizing the administrative and transactional aspects of health care delivery. The Working Paper focuses on potential savings across the health care system as a whole – savings that would accrue to physicians, hospitals and payers, and to consumers, employers, and taxpayers. We are enclosing for the Subcommittee's consideration a copy of the paper, bearing control numbers UHG_DP_000078 - UHG_DP_000098, which explains in detail United's recommendations for potential cost savings associated with improved health care technology.

Question 6: Mr. Collins' Compensation

Mr. Collins indicated during the hearing that he would voluntarily provide his current compensation to the Subcommittee. Accordingly, below please find a table reflecting the annual salary and bonus that United paid to Mr. Collins from 2008 to the present. Mr. Collins' bonus for 2009, if any, has not yet been determined.

Year	Salary	Bonus	Other Incentive	Total
2009	$400,000	-	-	$400,000
2008	$400,000	$225,000	-	$625,000

This compensation information is highly confidential to Mr. Collins and United. Disclosure of this information to the public or United's competitors would not only unfairly compromise Mr. Collins' personal privacy but it would also raise serious competitive concerns for United. We trust that the Subcommittee will treat this information as highly confidential, proprietary data.

* * *

As described above, the information that you have requested includes confidential and proprietary business information that United does not make available to the general public. Please be advised that United formally requests that these materials be afforded the full

[4] Letter from Douglas Elmendorf, Director of CBO, to Orrin G. Hatch, U.S. Senator (Oct. 9, 2009), *available at* http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.
[5] Lawrence McQuillan, *CBO Underestimates Benefits of Malpractice Reform*, Wall Street J., Oct. 23, 2009.

confidentiality protections provided by the Rules of the House of Representatives, including but not limited to Rule VII(3)(b)(2) & (4). Should you wish to publicly release any of these documents or information, United respectfully requests reasonable notice of your intent to do so and the opportunity to object to such a release.

Should you have any questions regarding this information or this matter generally, please contact me at your earliest convenience.

Very truly yours,

K. Lee Blalack, II
of O'MELVENY & MYERS LLP

KLB/uea

Enclosures

cc: The Honorable Jim Jordan (via hand delivery)
Ranking Member, Subcommittee on Domestic Policy
Jaron Bourke (via hand delivery)
Staff Director, Subcommittee on Domestic Policy
Mr. Jud C. Sommer (via electronic delivery)
Senior Vice President, UnitedHealth Group



UnitedHealth Group

April 23, 2009

9900 Bren Road East Minnetonka, Minnesota 55343

Dear Shareholder:

We cordially invite you to attend our 2009 Annual Meeting of Shareholders. We will hold our meeting on Tuesday, June 2, 2009 at 10:00 a.m. central time at UnitedHealth Group South, 9701 Data Park Drive, Minnetonka, Minnesota.

At this year's meeting, you will be asked to vote on the election of directors, ratification of Deloitte & Touche LLP's appointment as our independent registered public accounting firm and one shareholder proposal.

Attached you will find a notice of meeting and proxy statement that contain further information about these items and the meeting itself, including:

- How to obtain admission to the meeting if you plan to attend; and
- Different methods you can use to vote your proxy, including by Internet and telephone.

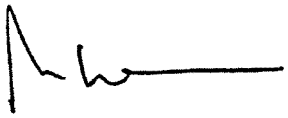
Whether or not you attend the meeting in person, we encourage you to vote by Internet or telephone or complete, sign and return your proxy prior to the meeting. If you cannot attend the meeting in person, you may listen to the meeting via webcast. Instructions on how to access the live webcast are included in the attached proxy statement.

Every shareholder vote is important. To ensure your vote is counted at the Annual Meeting, please vote as promptly as possible.

Sincerely,



Stephen J. Hemsley
President and Chief Executive Officer



Richard T. Burke
Chairman of the Board

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UnitedHealth Group

NOTICE OF ANNUAL MEETING OF SHAREHOLDERS

TO THE SHAREHOLDERS OF UNITEDHEALTH GROUP INCORPORATED:

UnitedHealth Group Incorporated (the "Company") will hold its Annual Meeting of Shareholders on Tuesday, June 2, 2009 at 10:00 a.m. central time at UnitedHealth Group South, 9701 Data Park Drive, Minnetonka, Minnesota. The purposes of the meeting are:

1. To elect the nine nominees that are set forth in the attached proxy statement to the Company's Board of Directors.
2. To ratify the appointment of Deloitte & Touche LLP as the independent registered public accounting firm for the Company for the fiscal year ending December 31, 2009.
3. To consider one shareholder proposal set forth in the proxy statement, if properly presented at the Annual Meeting.
4. To transact other business that properly may come before the Annual Meeting or any adjournment or postponement of the meeting.

Only shareholders of record of the Company's common stock at the close of business on April 3, 2009 are entitled to receive notice of and to vote at the meeting and any adjournment or postponement thereof.

BY ORDER OF THE BOARD OF DIRECTORS,

Dannette L. Smith

Dannette L. Smith
Secretary to the Board of Directors

April 23, 2009

We cordially invite you to attend our Annual Meeting. Whether or not you plan to be present at the meeting, please vote by Internet or telephone, or by completing, signing and returning a proxy prior to the meeting. If you later choose to revoke your proxy, you may do so at any time before it is exercised at the Annual Meeting by following the procedures described under Question 13 of the "Questions and Answers about the Annual Meeting and Voting" section in the attached proxy statement.

IMPORTANT NOTICE REGARDING AVAILABILITY OF PROXY MATERIALS FOR THE ANNUAL MEETING OF SHAREHOLDERS TO BE HELD ON JUNE 2, 2009:

The Notice of Internet Availability of Proxy Materials, Notice of Annual Meeting, Proxy Statement, Annual Report on Form 10-K, as amended, and the Summary Annual Report are available at www.unitedhealthgroup.com/proxymaterials.

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UnitedHealth Group

UnitedHealth Group Center
9900 Bren Road East
Minnetonka, Minnesota 55343

PROXY STATEMENT
FOR
ANNUAL MEETING OF SHAREHOLDERS
TO BE HELD JUNE 2, 2009

GENERAL MATTERS

General Information Regarding Proxy Materials and Annual Meeting of Shareholders

The Board of Directors of UnitedHealth Group Incorporated provides this Proxy Statement to you to solicit proxies to act upon the matters outlined in the Notice of Annual Meeting of Shareholders. These include the election of directors set forth in this Proxy Statement, ratification of the appointment of our independent registered public accounting firm and consideration of one shareholder proposal. The Board of Directors will use the proxies at the 2009 Annual Meeting of Shareholders. The Annual Meeting will take place on Tuesday, June 2, 2009 at 10:00 a.m. central time at UnitedHealth Group South, 9701 Data Park Drive, Minnetonka, Minnesota. The proxies also may be voted at any adjournment or postponement of the meeting.

This Proxy Statement, our Summary Annual Report to Shareholders and our Annual Report on Form 10-K, as amended, for the year ended December 31, 2008 are first being mailed to the Company's shareholders and made available on the Internet at *www.unitedhealthgroup.com/proxymaterials* on or about April 23, 2009.

Whether or not you plan to attend the Annual Meeting, please vote your proxy by Internet or telephone or by completing, signing and returning the proxy card in the accompanying envelope. All properly executed written proxies, and all properly completed proxies submitted by Internet or telephone that are delivered pursuant to this solicitation will be voted at the 2009 Annual Meeting of Shareholders (including any adjournment or postponement thereof) in accordance with the directions given in the proxy, unless the proxy is revoked prior to completion of voting at the Annual Meeting.

Only owners of record of shares of common stock of the Company at the close of business on April 3, 2009, the record date, are entitled to notice of and to vote at the Annual Meeting, or at any adjournments or postponements of the Annual Meeting. Each owner of record on the record date is entitled to one vote for each share of common stock held. On April 3, 2009, the record date, there were 1,181,338,477 shares of common stock issued, outstanding and entitled to vote.

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Information About the Notice of Internet Availability of Proxy Materials

This year, instead of mailing a printed copy of our proxy materials, including our Proxy Statement, Summary Annual Report to Shareholders and Annual Report on Form 10-K, as amended, to each shareholder, we have decided to provide access to these materials to our shareholders in a fast and efficient manner via the Internet. This reduces the amount of paper necessary to produce these materials, as well as the costs associated with mailing these materials to all shareholders. Accordingly, on April 23, 2009, we began mailing a Notice of Internet Availability of Proxy Materials (the "Notice") to some of our shareholders and posted our proxy materials on the website referenced in the Notice (*www.unitedhealthgroup.com/proxymaterials*). As more fully described in the Notice, shareholders may choose to access our proxy materials on the website referred to in the Notice or may request to receive a printed set of our proxy materials. In addition, the Notice and website provide information regarding how you may request to receive proxy materials in printed form by mail or electronically by e-mail on an ongoing basis.

QUESTIONS AND ANSWERS ABOUT THE ANNUAL MEETING AND VOTING

1. What is the purpose of the Annual Meeting?

At the Annual Meeting, shareholders will act upon the matters outlined in the Notice of Annual Meeting of Shareholders. These include the election of directors, ratification of the appointment of Deloitte & Touche LLP as our independent registered public accounting firm and consideration of one shareholder proposal. Also, once the business of the Annual Meeting is concluded, management of the Company will report on our performance. Management, Chairs of each standing Board committee and representatives of Deloitte & Touche LLP will be available to respond to questions from shareholders.

2. What is a proxy?

It is your legal designation of another person to vote the stock you own in the manner you direct. That other person is called a proxy. If you designate someone as your proxy in a written document, that document also is called a proxy or a proxy card. We have designated Christopher J. Walsh and Dannette L. Smith to serve as proxies for the 2009 Annual Meeting.

3. What is a proxy statement?

It is a document that Securities and Exchange Commission ("SEC") regulations require us to give you as a shareholder when we are soliciting your vote.

4. What is the difference between a shareholder of record and a shareholder who holds stock in street name?

Shareholders of Record. If your shares are registered in your name with our transfer agent, Wells Fargo Shareowner Services, you are a shareholder of record with respect to those shares, and the Notice or the proxy materials were sent directly to you by Wells Fargo.

Street Name Holders. If you hold your shares in an account at a bank or broker, then you are the beneficial owner of shares held in "street name." The Notice or proxy materials were forwarded to you by your bank or broker, who is considered the shareholder of record for purposes of voting at the Annual Meeting. As a beneficial owner, you have the right to direct your bank or broker on how to vote the shares held in your account.

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5. How many shares must be present to hold the Annual Meeting?

In order for us to conduct the Annual Meeting, holders of a majority of the shares entitled to vote as of the close of business on the record date must be present in person or by proxy. This is referred to as a quorum. Your shares are counted as present if you attend the Annual Meeting and vote in person, if you properly vote over the Internet or by telephone or if you properly return a proxy card or voting instruction form by mail. Abstentions and broker non-votes will be counted as present for purposes of establishing a quorum. If a quorum is not present, the Annual Meeting will be adjourned until a quorum is obtained.

6. How can I access the proxy materials for the Annual Meeting?

Shareholders may access the proxy materials, which include the Notice of Annual Meeting, Proxy Statement (including a form of proxy card), Summary Annual Report to Shareholders and Annual Report on Form 10-K, as amended, for the year ended December 31, 2008 on the Internet at *www.unitedhealthgroup.com/proxymaterials*. We will also provide a hard copy of any of these documents free of charge upon request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, Minnesota 55343, Attention: Secretary to the Board of Directors.

Instead of receiving future copies of our proxy materials by mail, you can elect to receive an e-mail that will provide electronic links to these documents. Opting to receive your proxy materials online will save the cost of producing and mailing documents to your home or business, will give you an electronic link to the proxy voting site and also will help preserve environmental resources.

Shareholders of Record. If you vote on the Internet at *www.eproxy.com/unh*, simply follow the prompts for enrolling in the electronic proxy delivery service. You also may enroll in the electronic proxy delivery service at any time by going directly to *www.unitedhealthgroup.com* and following the enrollment instructions.

Street Name Holders. If you hold your shares in a bank or brokerage account, you also may have the opportunity to receive the proxy materials electronically. Please check the information provided in the proxy materials you receive from your bank or broker regarding the availability of this service.

7. How do I attend the Annual Meeting? What do I need to bring?

To attend the Annual Meeting, you will need to bring an admission ticket and valid photo identification.

Shareholders of Record. If you are a shareholder of record and received a Notice, the Notice is your admission ticket. If you are a shareholder of record and received proxy materials by mail, your admission ticket is attached to your proxy card. You will need to bring the Notice or the admission ticket with you to the Annual Meeting in order to be admitted to the meeting.

Street Name Holders. If you hold your shares in street name, bring your most recent brokerage statement or a letter from your broker or other nominee with you to the Annual Meeting. We will use that statement or letter to verify your ownership of common stock and admit you to the Annual Meeting; *however, you will not be able to vote your shares at the Annual Meeting without a legal proxy, as described in question 8.*

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Please note that cameras, sound or video recording equipment or other similar electronic devices, large bags or packages will not be allowed in the meeting room.

8. How can I vote at the Annual Meeting if I own shares in street name?

If you are a street name holder, you will not be able to vote your shares at the Annual Meeting unless you obtain a legal proxy from your bank or broker. A legal proxy is a bank's or broker's authorization for you to vote the shares it holds in its name on your behalf.

9. What shares are included on the Notice, proxy card or voting instruction form?

If you are a shareholder of record, you will receive only one Notice or proxy card for all the shares of common stock you hold:

- in certificate form;
- in book-entry form; and
- in any Company benefit plan.

If you hold your shares in street name, you will receive one Notice or voting instruction form for each account you have with a bank or broker.

If you hold shares in our 401(k) savings plan and do not vote your shares or specify your voting instructions on your proxy card, the administrators of the 401(k) savings plan will vote your 401(k) plan shares in the same proportion as the shares for which voting instructions have been received. **To allow sufficient time for voting by the 401(k) administrators, your voting instructions must be received by 11:59 p.m. Central Time on Thursday, May 28, 2009.**

10. How can I listen to the live webcast of the Annual Meeting?

You can listen to the live webcast of the Annual Meeting by logging on to our website at *www.unitedhealthgroup.com* and clicking on "Investors" and then on the link to the webcast. An archived copy of the webcast also will be available on our website.

We have included the website address for reference only. The information contained on our website is not incorporated by reference into this proxy statement.

11. What different methods can I use to vote?

By Written Proxy. All shareholders of record who received proxy materials by mail can vote by written proxy card. If you received a Notice, you may request a proxy card at any time by following the instructions on the Notice. If you are a street name holder, you will receive instructions on how you may vote from your bank or broker, unless you previously enrolled in electronic delivery.

By Telephone or Internet. All shareholders of record who received proxy materials by mail also can vote by touchtone telephone from the U.S. and Canada, using the toll-free telephone number on the proxy card, or through the Internet using the procedures and instructions described on the proxy card. If you received a Notice, you may request a proxy card at any time by following the instructions on the Notice. Street name holders may vote by Internet or telephone if their bank or broker makes those methods available, in which case the bank or broker will enclose the instructions with the proxy materials. The Internet and telephone voting procedures are designed to authenticate shareholders' identities, to allow shareholders to vote their shares and to confirm that their instructions have been properly recorded.

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In Person. All shareholders of record may vote in person at the Annual Meeting. Street name holders may vote in person at the Annual Meeting if they have a legal proxy, as described in question 8.

The Notice is not a proxy card and it cannot be used to vote your shares.

12. What is the record date and what does it mean?

The record date for the 2009 Annual Meeting is April 3, 2009. The record date is established by our Board of Directors as required by the Minnesota Business Corporation Act. Owners of record of common stock at the close of business on the record date are entitled to:

- receive notice of the Annual Meeting; and
- vote at the Annual Meeting and any adjournments or postponements of the Annual Meeting.

13. If I submit a proxy, may I later revoke it and/or change my vote?

Shareholders can revoke a proxy and/or change their vote prior to the completion of voting at the Annual Meeting by:

- signing another proxy card or voting instruction form with a later date and delivering it to an officer of the Company before the Annual Meeting;
- voting again over the Internet or by telephone prior to 11:59 p.m., Central Time, on June 1, 2009 (or, if you are a street name holder, such earlier time as your bank or broker may direct);
- voting at the Annual Meeting if you are a shareholder of record or are a street name holder that has obtained a legal proxy from your bank or broker; or
- notifying the Secretary to the Board of Directors in writing before the Annual Meeting.

14. Are votes confidential? Who counts the votes?

We will continue our long-standing policy of holding the votes of all shareholders in confidence from directors, officers and employees except:

- as necessary to meet applicable legal requirements and to assert or defend claims for or against the Company;
- in case of a contested proxy solicitation;
- if a shareholder makes a written comment on the proxy card or otherwise communicates his or her vote to management; or
- to allow the independent inspectors of election to certify the results of the vote.

We will also continue, as we have for many years, to retain an independent inspector to receive and tabulate the proxies and to certify the results.

15. What are my choices when voting for director nominees, and what vote is needed to elect directors?

In the vote on the election of director nominees, shareholders may:

- vote in favor of a nominee;
- vote against a nominee; or
- abstain from voting with respect to a nominee.

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Directors will be elected by a majority of the votes cast by the holders of the shares of common stock present and entitled to vote in person or by proxy at the Annual Meeting. To address a holdover provision in Minnesota law that allows a director who has not been re-elected to remain in office until a successor is elected and qualified, we have a policy that requires any director who does not receive a greater number of votes "for" than "against" his or her election in an uncontested election to tender his or her resignation from the Board of Directors following certification of the shareholder vote. Under this policy, the Board of Directors will determine whether to accept or reject the offer to resign within 90 days of certification of the shareholder vote. The text of this policy appears in our Principles of Governance, which are available on our website.

The Board of Directors recommends a vote FOR each of the nominees.

16. What are my choices when voting on each of the other proposals considered at the Annual Meeting, and what vote is needed to approve each proposal?

For each of the other proposals, shareholders may:

- vote for the proposal;
- vote against the proposal; or
- abstain from voting on the proposal.

The vote required to approve each proposal, and the Board of Directors' recommendation, is included below:

- A proposal to ratify the appointment of Deloitte & Touche LLP as our independent registered public accounting firm requires approval by the holders of a majority of the shares of common stock present and entitled to vote in person or by proxy at the Annual Meeting.

The Board of Directors recommends a vote FOR ratification.

- A separate vote will be held on the shareholder proposal if it is properly presented at the Annual Meeting. In order to be approved, the shareholder proposal requires approval by the holders of a majority of the shares of common stock present and entitled to vote in person or by proxy at the Annual Meeting.

The Board of Directors recommends a vote AGAINST the shareholder proposal.

17. What if I do not specify a choice for a matter when returning a proxy?

Shareholders should specify their choice for each matter in the manner described in the Notice or on their proxy card. If no specific instructions are given, proxies which are signed and returned will be voted:

- FOR the election of all director nominees;
- FOR the proposal to ratify the appointment of Deloitte & Touche LLP as the Company's independent registered public accounting firm; and
- AGAINST the shareholder proposal if it is properly presented at the Annual Meeting.

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18. How are abstentions and broker non-votes counted?

Abstentions have no effect on the election of directors.

Abstentions have the effect of an "AGAINST" vote on the ratification of the appointment of the Company's independent registered public accounting firm and on the shareholder proposal. Broker non-votes have no effect on the shareholder proposal.

19. Are my shares voted if I do not provide a proxy?

If you are a shareholder of record and do not provide a proxy, you must attend the Annual Meeting in order to vote. If you hold shares through an account with a bank or broker, your shares may be voted by the bank or broker if you do not provide voting instructions. Banks and brokers have the authority under New York Stock Exchange rules to vote shares for which their customers do not provide voting instructions on routine matters. The election of directors and the ratification of Deloitte & Touche LLP as our independent registered public accounting firm are considered routine matters. The shareholder proposal is not considered routine and banks and brokers cannot vote shares without instruction on that proposal. Shares that banks and brokers are not authorized to vote are counted as "broker non-votes."

20. Does the Company have a policy about directors' attendance at the Annual Meeting of Shareholders?

The Company expects directors to attend the Annual Meeting. All of the incumbent directors attended the 2008 Annual Meeting (other than Dr. Shine who was not a director at the time of the 2008 Annual Meeting) and have indicated that they plan to attend the 2009 Annual Meeting.

21. What are the deadlines for submitting shareholder proposals for the 2010 Annual Meeting?

In order to be eligible for inclusion in our proxy statement for our 2010 Annual Meeting or to be considered at that meeting, shareholder proposals must be received, in writing, at our principal executive offices at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343, Attention: Secretary to the Board of Directors, not later than December 24, 2009. Shareholder proposals received after December 24, 2009 would be untimely. Shareholder proposals must be in the form provided in our Bylaws. If we do not receive a shareholder proposal by the deadline described above, the proposal may be excluded from the proxy statement and from consideration at the 2010 Annual Meeting. This advance notice requirement supersedes the notice period in SEC Rule 14a-4(c)(1) of the federal proxy rules regarding the discretionary proxy voting authority with respect to such shareholder business.

22. How are proxies solicited and what is the cost?

We bear all expenses incurred in connection with the solicitation of proxies. We have engaged D.F. King & Co. to assist with the solicitation of proxies for an estimated base fee of $17,000 plus expenses. We will reimburse brokers, fiduciaries and custodians for their costs in forwarding proxy materials to beneficial owners of common stock.

Our directors, officers and employees may also solicit proxies by mail, telephone and personal contact. They will not receive any additional compensation for these activities.

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SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The following table provides information about each shareholder known to us to beneficially own more than five percent of the outstanding shares of our common stock, based solely on the information filed by each such shareholder in 2009 for the year ended December 31, 2008 on Schedule 13G under the Securities Exchange Act of 1934, as amended (the "Exchange Act").

Name and Address of Beneficial Owner	Amount and Nature of Beneficial Ownership (1)	Percent of Class
Wellington Management Company, LLP 75 State Street Boston, MA 02109	102,161,679	8.46%

(1) This information, including percent of class, is based on the Schedule 13G filed with the SEC by Wellington Management Company, LLP on February 17, 2009, reporting beneficial ownership as of December 31, 2008. Wellington Management Company, LLP reported shared voting power for 56,498,279 shares of common stock and shared investment power for 102,161,679 shares of common stock as of December 31, 2008. Wellington Management Company, LLP reported having neither sole voting power nor sole investment power over any of the shares.

The following table provides information about the beneficial ownership of our common stock as of April 3, 2009 by each director and nominee for director, each executive officer named in the 2008 Summary Compensation Table in this proxy statement, and by all of our current directors, executive officers and director nominees as a group. As of April 3, 2009, there were 1,181,338,477 shares of our common stock issued, outstanding and entitled to vote.

Name of Beneficial Owner or Identity of Group	Ownership of Common Stock	Number of Shares Deemed Beneficially Owned as a Result of Equity Awards Exercisable Within 60 Days of April 3, 2009	Total (1)	Percent of Common Stock Outstanding
William C. Ballard, Jr.	39,200	338,000	377,200	*
Richard T. Burke	2,728,608 (2)	376,140	3,104,748	*
Robert J. Darretta	2,910 (3)	45,371	48,281	*
Michele J. Hooper	2,940 (3)	30,000	32,940	*
Douglas W. Leatherdale	946,215 (4)	342,220	1,288,435	*
Glenn M. Renwick	1,610	16,429	18,039	*
Kenneth I. Shine, M.D.	0	3,167	3,167	*
Gail R. Wilensky, Ph.D.	34,090	301,800	335,890	*
Stephen J. Hemsley	2,348,620 (5)	7,000,000	9,348,620	*
George L. Mikan III	9,633 (5)	910,000	919,633	*
Thomas L. Strickland	0	378,642	378,642	*
Anthony Welters	3,897	647,500	651,397	*
David S. Wichmann	17,897 (5)	2,144,250	2,162,147	*
All current directors, executive officers and director nominees as a group (18 individuals)	6,347,705 (6)	13,505,044	19,852,749	1.7%

* Less than 1%.

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(1) Unless otherwise noted, each person and group identified possesses sole voting and investment power with respect to the shares shown opposite such person's or group's name. Shares not outstanding but deemed beneficially owned by virtue of the right of an individual to acquire them within 60 days of April 3, 2009 are treated as outstanding only when determining the amount and percent owned by such individual or group.

(2) Includes 110,308 shares held directly by Mr. Burke's spouse. Mr. Burke does not have voting or investment power over these shares, and disclaims beneficial ownership of these shares.

(3) Does not include the following number of vested restricted stock units which are considered owned under the Company's stock ownership guidelines for directors: Mr. Darretta — 1,563 restricted stock units; and Ms. Hooper — 1,563 restricted stock units.

(4) Includes 885,615 shares pledged by Mr. Leatherdale as collateral for borrowings from certain financial institutions. Also includes 6,600 shares held in irrevocable trusts for the benefit of Mr. Leatherdale's grandchildren and for which Mr. Leatherdale disclaims beneficial ownership.

(5) Includes the following number of shares held in trust for the individuals pursuant to our 401(k) plan: Mr. Hemsley — 281 shares; Mr. Mikan — 139 shares; and Mr. Wichmann — 210 shares.

(6) Includes the indirect holdings included in footnotes (2) and (4), the shares held in our executive officers' 401(k) accounts which were previously held in such officers' accounts under the Company's former Employee Stock Ownership Plan, 163,739 shares of restricted stock held by certain of our executive officers, 2,880 shares held in a trust for the benefit of one of our executive officers and 40 shares held in custodial accounts for the benefit of one of our executive officer's children. Pursuant to the terms of the Company's 401(k) plan, a participant has sole voting power over his or her shares; however, the plan trustee votes all unvoted shares in the same proportions as the actual proxy votes submitted by plan participants.

SECTION 16(a) BENEFICIAL OWNERSHIP REPORTING COMPLIANCE

Section 16(a) of the Exchange Act requires our executive officers and directors, and persons who beneficially own more than 10% of our common stock, to file initial reports of ownership and reports of changes in ownership with the SEC and the New York Stock Exchange ("NYSE"). Executive officers, directors and greater-than-10% beneficial owners are required by SEC rules to furnish us with copies of all Section 16(a) reports they file.

Based solely on our review of these reports and written representations from our executive officers and directors, we believe that all of our executive officers and directors complied with all Section 16(a) filing requirements during 2008, with the exception of Ms. Hooper who made a late filing related to a purchase of stock on the open market.

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PROPOSAL 1 – ELECTION OF DIRECTORS

Under our Articles of Incorporation and Bylaws, each member of our Board of Directors is elected annually. On February 3, 2009, the Board of Directors, acting upon the recommendation of the Nominating and Corporate Governance Committee, appointed Kenneth I. Shine, M.D. to serve as a director of the Company. The Board of Directors has nominated nine directors for election: William C. Ballard, Jr., Richard T. Burke, Robert J. Darretta, Stephen J. Hemsley, Michele J. Hooper, Douglas W. Leatherdale, Glenn M. Renwick, Kenneth I. Shine, M.D. and Gail R. Wilensky, Ph.D.

All of the nominees have informed the Board of Directors that they are willing to serve as directors. If any nominee should decline or become unable to serve as a director for any reason, the persons named as proxies will elect a replacement.

The Board of Directors recommends that you vote FOR the election of each of the nominees. Proxies will be voted FOR the election of each nominee unless you specify otherwise.

Name	Age	Director Since
William C. Ballard, Jr.	68	1993
Richard T. Burke	65	1977
Robert J. Darretta	62	2007
Stephen J. Hemsley	56	2000
Michele J. Hooper	57	2007
Douglas W. Leatherdale	72	1983
Glenn M. Renwick	53	2008
Kenneth I. Shine, M.D.	74	2009
Gail R. Wilensky, Ph.D.	65	1993

The director nominees, if elected, will serve until the 2010 Annual Meeting and until their successors are elected and qualified.

Mr. Ballard served as Of Counsel to Greenebaum Doll & McDonald PLLC, a law firm in Louisville, Kentucky, from June 1992 until July 2008. In 1992, Mr. Ballard retired from Humana, Inc., a company operating managed health care facilities, after serving as the Chief Financial Officer and a director for 22 years. Mr. Ballard is also a director of Health Care REIT, Inc.

Mr. Burke is Chairman of the Board of UnitedHealth Group, has been a member of our Board of Directors since inception, and was Chief Executive Officer of UnitedHealthcare, Inc., our predecessor corporation, until February 1988. From 1995 until February 2001, Mr. Burke was the owner, Chief Executive Officer and Governor of the Phoenix Coyotes, a National Hockey League team. Mr. Burke is also a director of First Cash Financial Services, Inc. and Meritage Homes Corporation.

Mr. Darretta is the retired Vice Chairman, Board of Directors, Chief Financial Officer and member of the Executive Committee of Johnson & Johnson, a health care products company. Mr. Darretta served as Chief Financial Officer and a member of the Executive Committee of Johnson & Johnson from 1997 to March 2007. Mr. Darretta joined Johnson & Johnson in 1968. Mr. Darretta is also a trustee for certain Putnam mutual funds.

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Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group and has served in that capacity since November 2006. He has been a member of the Board of Directors since February 2000. Mr. Hemsley joined the Company in 1997 as Senior Executive Vice President. He became Chief Operating Officer in 1998, was named President in 1999, and served as President and Chief Operating Officer from 1999 to November 2006.

Ms. Hooper is Managing Director of The Directors' Council, a private company which she co-founded in 2003, that works with corporate boards to increase their independence, effectiveness and diversity. She was President and Chief Executive Officer of Voyager Expanded Learning, a developer and provider of learning programs and teacher training for public schools, from 1999 until 2000. Prior to that, she was President and Chief Executive Officer of Stadtlander Drug Company, Inc., a provider of disease-specific pharmaceutical care, from 1998 until Stadtlander was acquired in 1999. She is also a director of AstraZeneca plc., PPG Industries, Inc. and Warner Music Group Corp.

Mr. Leatherdale served as the Chairman and Chief Executive Officer of The St. Paul Companies, Inc. (currently known as Travelers Companies, Inc.), a property casualty insurance company, from 1990 until he retired in October 2001. Mr. Leatherdale is also a director of Xcel Energy, Inc.

Mr. Renwick is President and Chief Executive Officer of The Progressive Corporation, an auto insurance company. Before being named Chief Executive Officer in 2001, Mr. Renwick served as Chief Executive Officer-Insurance Operations and Business Technology Process Leader from 1998 through 2000. Prior to that, he led Progressive's Consumer Marketing group and served as President of various divisions within Progressive. Mr. Renwick joined Progressive in 1986 as Auto Product Manager for Florida. Mr. Renwick is also a director of The Progressive Corporation and Fiserv, Inc.

Dr. Shine has served as the executive vice chancellor for health affairs of the University of Texas System, which consists of nine academic campuses and six health institutions, since November 2003. Dr. Shine also served as the interim Chancellor of the University of Texas System from May 2008 until December 2008. Prior to November 2003, Dr. Shine served as President of the Institute of Medicine at the National Academy of Sciences from 1992 until 2002. From 1993 until 2003, Dr. Shine served as a Clinical Professor of Medicine at the Georgetown University School of Medicine. From 1971 until 1992, Dr. Shine served in several positions at the University of California School of Medicine, with his final position being Dean and Provost, Medical Sciences, and he continues to hold the position of Professor of Medicine Emeritus. Dr. Shine has also served as Chair of the Council of Deans of the Association of American Medical Colleges from 1991 until 1992 and as President of the American Heart Association from 1985 until 1986.

Dr. Wilensky has been a senior fellow at Project HOPE, an international health foundation, since 1993. From December 2006 to December 2007, Dr. Wilensky co-chaired the Department of Defense Task Force on the Future of Military Health Care. During 2007 she also served as a commissioner on the President's Commission on Care for America's Returning Wounded Warriors. From May 2001 to May 2003, she was the Co-Chair of the President's Task Force to Improve Health Care for our Nation's Veterans. From 1997 to 2001, she was also Chair of the Medicare Payment Advisory Commission. From 1992 to 1993, Dr. Wilensky served as the Deputy Assistant to President George H. W. Bush for policy development, and from 1990 to 1992, she was the Administrator of the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services) directing the Medicaid and Medicare programs for the United States. Dr. Wilensky is also a director of Cephalon, Inc., Gentiva Health Services, Inc., Quest Diagnostics Incorporated, and SRA International Inc.

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CORPORATE GOVERNANCE

Overview

UnitedHealth Group is committed to high standards of corporate governance and ethical business conduct, reporting results with accuracy and transparency, and maintaining full compliance with the laws and regulations that govern our businesses.

Important documents governing our corporate governance practices include our Articles of Incorporation, Bylaws, Principles of Governance, Board of Directors Committee Charters, Standards for Director Independence, Code of Business Conduct and Ethics, Related-Person Transactions Approval Policy, Board of Directors Communication Policy, Political Contributions Policy and Corporate Environmental Policy. You can access these documents at *www.unitedhealthgroup.com* to learn more about our corporate governance practices. We will also provide a copy of any of these documents published on our website, free of charge, upon request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, Minnesota 55343, Attention: Secretary to the Board of Directors.

Corporate Governance Practices

Some of our key corporate governance practices include:

Board Structure

- Our Board of Directors is declassified (all directors are elected annually by our shareholders).
- Our Articles of Incorporation provide that in an uncontested election, each director must be elected by a majority vote.
- We have a non-executive Chairman of the Board.

Board and Board Committees Composition and Performance

- We have committed to have five Board seats filled by new independent directors by the end of 2009 in order to bring new experiences, expertise and perspectives onto the Board of Directors. To that end, our Board of Directors has:
  - formed and convened a Nominating Advisory Committee comprised of representatives from the shareholder and medical communities to provide input into the composition of our Board of Directors; and
  - added four new independent directors as follows: Robert J. Darretta (April 2007), Michele J. Hooper (October 2007), Glenn M. Renwick (June 2008) and Kenneth I. Shine, M.D. (February 2009).
- All members of our Audit Committee are required to be financial experts as defined by the SEC.
- A director may not serve on more than four public company boards of directors (including the Company); any of our current directors serving in January 2007 (who are now limited to serving on six boards) will be subject to this four board limit commencing at our 2012 Annual Meeting of Shareholders.

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- Our directors are required to offer their resignations upon a change in their primary careers.
- Our Board of Directors conducts executive sessions at each regularly scheduled Board meeting. Our Chairman of the Board presides over each executive session. Our Board committees also conduct executive sessions that are presided over by the Committee Chairs of their respective committees.
- Our Board of Directors and Board committees have the authority to retain independent advisors.
- Our Board of Directors and individual directors conduct performance reviews annually.
- All directors are required to attend director education sessions accredited by RiskMetrics.

Shareholder Rights

- In 2007, we amended our Articles of Incorporation and Bylaws to:
  - remove supermajority approval requirements to approve certain business combinations; and
  - remove supermajority approval provisions for the removal of directors.

Guidelines and Policies

- Our Board of Directors reviews our chief executive officer ("CEO") succession plan annually. Our CEO succession plan was developed by our Board of Directors with input from our CEO and has two components: a succession plan that addresses emergency or unanticipated loss of our CEO and a longer term succession plan. Material features of this plan include identification of Board members to lead the succession process, identification and development of internal candidates, and identification of external resources necessary to ensure a successful transition.
- We have implemented stock ownership guidelines for directors and executive officers. See the discussions under the heading "Compensation Discussion and Analysis — Elements of Our Compensation Program — Other Compensation Practices — Executive Stock Ownership Guidelines" for a description of the stock ownership guidelines for the Company's executive officers, and under the heading "Director Compensation — Stock Ownership Guidelines" for a description of the stock ownership guidelines for the Company's non-employee directors.
- Our Board of Directors has adopted a related-person transactions approval policy regarding the review, approval and ratification of related-person transactions by our Audit Committee. See the discussion under the heading "Certain Relationships and Transactions" below.
- Our Board of Directors has adopted a clawback policy that allows the Company to recover cash incentive compensation and equity awards from senior executives in the event of fraud or misconduct resulting in a restatement of the Company's financial statements or in the event of a senior executive's violation of a restrictive covenant. See the discussion under the heading, "Compensation Discussion and Analysis — Elements of Our Compensation Program — Other Compensation Practices — Potential Impact on Compensation from Executive Misconduct" below.

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- Our Board of Directors has adopted an independent compensation consultant policy that requires the consultant engaged by the Compensation and Human Resources Committee to be independent of the Company or the Company will disclose the fees paid to the consultant in the Company's proxy statement. See the discussion under the heading, "Compensation Discussion and Analysis — Determination of Total Compensation — The Compensation Committee's Use of an Independent Compensation Consultant."
- Our Board of Directors believes that effective Board-shareholder communication strengthens the Board of Directors' role as an active, informed and engaged fiduciary and has adopted a communication policy which outlines how shareholders may communicate with the Board of Directors. See the discussion under the heading, "Corporate Governance – Communication with the Board of Directors."
- Our Board of Directors has adopted a political contributions policy pursuant to which it has committed to disclose semi-annually the political contributions of the Company and its federal and state political action committees.
- Our Board of Directors has adopted an environmental policy which outlines our focus on minimizing our impact on the environment and creating a Company culture that heightens our employees' awareness of the importance of preserving the environment and conserving energy and natural resources.

Independent Auditors

- Our independent registered public accounting firm is ratified by our shareholders annually.
- The 2008 non-audit fees paid to our independent registered public accounting firm were less than 10% of total fees paid to that firm by the Company in 2008.

Principles of Governance

Our Articles of Incorporation and Bylaws, together with Minnesota law and NYSE and SEC rules, govern the Company. Our Principles of Governance reflect the current views of our Board of Directors and set forth many of our long-standing practices, policies and procedures which provide the foundation of our commitment to best practices. The policies and practices covered in our Principles of Governance include shareholder rights and proxy voting; structure, composition and performance of the Board of Directors; use of an independent compensation consultant; Board of Directors operation; individual director responsibilities; and Board committees. Our Principles of Governance are reviewed at least annually by our Nominating and Corporate Governance Committee and are revised as necessary.

Code of Business Conduct and Ethics

The Code of Business Conduct and Ethics is published on the Company's website and covers our principles and policies related to business conduct, conflicts of interest, public disclosure, legal compliance, reporting and accountability, corporate opportunities, confidentiality, fair dealing and protection, and proper use of Company assets. Any waiver of the Code of Business Conduct and Ethics for the Company's executive officers, senior financial officers or directors of the Company may be made only by the Board of Directors or a committee of the Board. Any amendments to the Code of Business Conduct and Ethics and waivers of the Code of Business Conduct and Ethics for our CEO, CFO, Chief Accounting Officer or Controller will be published on the Company's website.

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Ethics & Compliance HelpCenter

We strongly encourage employees to raise ethics and compliance concerns. We offer several channels for employees and third parties to report ethics and compliance concerns or incidents, including concerns about accounting, internal controls or auditing matters. We provide an Ethics & Compliance HelpCenter that is available to employees 24 hours a day, 7 days a week with live operators who can connect to speakers in multiple languages. In addition to phone support, we also provide a website for employees to submit an online report to the HelpCenter. Whether reporting by phone or online, individuals may choose to remain anonymous. Employees may also raise their ethics and compliance concerns with our Ethics and Integrity Office, their manager, the Human Capital department or the Corporate Security department. We prohibit retaliatory action against any individual for raising concerns or questions regarding ethics and compliance matters or for reporting suspected violations. We conduct regular training of all employees to advise them of the means by which they may report possible ethics or compliance issues and their affirmative responsibility to report any possible issues.

Director Independence

Our Board of Directors has adopted the Company's Standards for Director Independence, which are attached as Appendix A. The Standards for Director Independence were strengthened in 2006 to exceed the standards set by the SEC and the NYSE.

Our Board of Directors has affirmatively determined that each of William C. Ballard, Jr., Richard T. Burke, Robert J. Darretta, Michele J. Hooper, Douglas W. Leatherdale, Glenn M. Renwick, Kenneth I. Shine, M.D. and Gail R. Wilensky, Ph.D. is "independent" under the NYSE rules and the Company's Standards for Director Independence and that these directors have no material relationships with the Company.

In determining independence, the Board of Directors considered, among other factors, all of the business relationships between the Company and our directors and nominees, their immediate family members (as defined by the NYSE) or their affiliated companies. In particular, the Board of Directors considered whether any director or any nominee was a partner, significant shareholder or executive officer of an organization that has a relationship with the Company, and charitable contributions that the Company or its affiliates made to organizations with which such directors or nominees are or have been associated. With respect to each of the most recent three fiscal years, the Board of Directors evaluated the following relationships and determined that such relationships did not impair the directors' exercise of independent judgment:

- for Mr. Burke and Dr. Shine, the annual amount of payments for goods or services between the Company and the organization where the director (and/or a member of the director's immediate family) is a significant shareholder or serves as an executive officer;
- for Mr. Leatherdale and Dr. Wilensky, the amount of the Company's charitable contributions to organizations where such director serves as an executive officer, director or trustee or with which the director had been associated; and
- relationships between the Company and organizations on which our outside directors serve as directors.

The Company's President and CEO, Stephen J. Hemsley, is not an independent director.

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In fiscal 2008, James A. Johnson, Thomas H. Kean, Mary O. Mundinger, Dr.P.H. and Robert L. Ryan also served as independent directors until their retirement from the Board of Directors on June 5, 2008. In determining their independence, the Board of Directors considered the relationships discussed in our 2008 proxy statement and determined that such relationships did not impair the directors' exercise of independent judgment.

Board Meetings and Annual Meeting Attendance

Directors are expected to attend Board meetings, meetings of committees on which they serve and the Annual Meeting of Shareholders. All of our incumbent directors attended the 2008 Annual Meeting (other than Dr. Shine who was not a director at the time of the 2008 Annual Meeting). During the year ended December 31, 2008, the Board of Directors held four regular meetings and eight special meetings. All incumbent directors attended at least 75% of the meetings of the Board and any Board committees of which they were members.

Board Committees

The Board of Directors has established four standing committees: the Audit Committee, the Compensation and Human Resources Committee (the "Compensation Committee"), the Nominating and Corporate Governance Committee (the "Nominating Committee") and the Public Policy Strategies and Responsibility Committee (the "Public Policy Strategies Committee"). These committees help the Board of Directors fulfill its responsibilities and assist the Board of Directors in making informed decisions. Each committee operates under its own written charter, and evaluates its charter and conducts a committee performance evaluation annually.

In addition, during 2006, the Board of Directors formed a Special Litigation Committee, consisting of two former Minnesota Supreme Court Justices with no prior affiliation with the Company, to investigate the claims raised in the shareholder derivative actions and demands related to the Company's historical option granting practices.

Director	Audit	Compensation and Human Resources	Nominating and Corporate Governance	Public Policy Strategies and Responsibility
William C. Ballard, Jr.	Chair		X	
Richard T. Burke*				
Robert J. Darretta	X	X		
Stephen J. Hemsley				
Michele J. Hooper			Chair	X
Douglas W. Leatherdale		Chair	X	
Glenn M. Renwick	X			
Kenneth I. Shine, M.D.				X
Gail R. Wilensky, Ph.D.		X		Chair

* Mr. Burke is the Chairman of the Board and ex-officio member of each Board committee.

Audit Committee

The Audit Committee consists of Messrs. Ballard (Chair), Darretta and Renwick, each of whom is an independent director under the NYSE listing standards and the SEC rules. The Board of Directors

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has determined that Messrs. Ballard, Darretta and Renwick are "audit committee financial experts" as defined by the SEC rules. The Audit Committee has responsibility for the selection and retention of the independent registered public accounting firm, and assists the Board of Directors by overseeing financial reporting, public disclosure and compliance activities. The Audit Committee operates as a direct line of communication between the Board of Directors and our independent registered public accounting firm, as well as our internal audit, compliance and legal personnel. The Audit Committee held eight regular meetings and two special meetings in 2008.

Compensation and Human Resources Committee

The Compensation Committee consists of Messrs. Leatherdale (Chair) and Darretta and Dr. Wilensky, each of whom is an independent director under the NYSE listing standards, a non-employee director under the SEC rules and an outside director under the Internal Revenue Code of 1986 (the "Internal Revenue Code"). The Compensation Committee is responsible for overseeing our policies and practices related to total compensation for executive officers and the administration of our incentive and equity-based plans. The Compensation Committee also negotiates and administers our employment arrangements with our CEO and other executive officers, conducts an annual performance review of the CEO, and reviews and monitors director compensation programs and the Company's stock ownership guidelines. The Compensation Committee held four regular meetings and four special meetings in 2008.

Nominating and Corporate Governance Committee

The Nominating Committee consists of Ms. Hooper (Chair) and Messrs. Ballard and Leatherdale, each of whom is an independent director under the NYSE rules. The Nominating Committee's duties include identifying and nominating individuals to be proposed for election as directors at each Annual Meeting or to fill board vacancies, conducting the director and Board evaluation process, evaluating the categorical standards which the Board of Directors uses to determine director independence, and monitoring and evaluating corporate governance. The Nominating Committee held four regular meetings and two special meetings in 2008.

Public Policy Strategies and Responsibility Committee

The Public Policy Strategies and Responsibility Committee consists of Dr. Wilensky (Chair), Ms. Hooper and Dr. Shine. The Public Policy Strategies and Responsibility Committee, formed in May 2006, is responsible for assisting the Board of Directors in fulfilling its responsibilities relating to the Company's public policy, government relations, community and charitable activities and social responsibilities. The Public Policy Strategies Committee held three regular meetings and one special meeting in 2008.

Special Litigation Committee

The Special Litigation Committee consisted of the Hon. Edward Stringer and the Hon. Kathleen Blatz, former Justice and former Chief Justice, respectively, of the Minnesota Supreme Court. They are not members of the Board of Directors. The Special Litigation Committee was responsible for investigating the claims raised in the shareholder derivative actions and demands related to the Company's historical option granting practices, and for determining whether any claims should be pursued. The Special Litigation Committee was completely independent of the Board of Directors and

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the Company. On December 6, 2007, the Special Litigation Committee concluded its review of claims relating to the Company's historical stock option practices and published a report which is described in "Note 15 to Consolidated Financial Statements" included in the Company's Annual Report on Form 10-K, as amended, for the year ended December 31, 2008.

Director Nomination

Criteria for Nomination to the Board

The Nominating Committee Charter, which is available on our website, provides that the Nominating Committee is responsible for analyzing, on an annual basis, important Board member skills and characteristics, and recommending to the Board of Directors appropriate individuals for nomination as Board members. The Nominating Committee considers the appropriate balance of experience, skills and characteristics required of a director. Nominees for director are selected on the basis of skills and characteristics described in the Company's Principles of Governance, which include diversity, age, skills (such as an understanding of health care issues, management of large public companies, and academic, political, financial or medical background), familiarity with ethical and corporate governance issues and other relevant factors. The Nominating Committee has also developed a skills matrix that reflects the qualities it believes the Board of Directors as a whole should possess. The Nominating Committee uses the skills matrix to analyze the strengths of each Board member and to determine whether a potential Board member's skills would complement the skills of the current Board members. A new director may not be a board member on more than four public company boards, including the Company.

Shareholder Proposals for Nominees

The Nominating Committee will consider candidates proposed by shareholders upon timely written notice to the Secretary to the Board of Directors. For the 2010 Annual Meeting, notice must be received at our principal executive offices, directed to the Secretary to the Board of Directors, on or before December 24, 2009, and must set forth the following information: (i) the name, age, business address, residence address and principal occupation or employment of each proposed nominee, (ii) the name and address of the shareholder giving notice is the same as it appears in the Company's stock register, (iii) the number of shares of the Company's common stock which are beneficially owned by the nominee and shareholder, and (iv) other information concerning the nominee as would be required in soliciting proxies for the election of that nominee. The notice must also include a signed consent of each nominee to serve as a director of the Company, if elected. Shareholder proposals for nominees received after December 24, 2009 would be untimely.

Nominating Advisory Committee

The Nominating Advisory Committee was formed by the Board of Directors in 2006 to provide the Nominating Committee with additional input from shareholders and others regarding desirable characteristics of director candidates and the composition of the Board of Directors. Input provided by the Nominating Advisory Committee is considered by, but is not binding on, the Nominating Committee. The Nominating Advisory Committee currently includes four individuals affiliated with long-term shareholders of the Company and one individual who is a member of the medical community. Nominating Advisory Committee meetings are convened by the Company. The Nominating Advisory

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Committee held two meetings in 2008. At these meetings, the Nominating Advisory Committee provided feedback on desired director characteristics to be represented on the Board of Directors as a whole, including the following factors: overall quality and experience of potential candidates, age, independence from the Company and management, ability to work collegially with other directors, diversity and expertise in clinical health care, accounting or audit, corporate governance/ethics, government/political relations, consumer/marketing, or technology. In addition, members of the Nominating Advisory Committee suggested potential candidates for consideration by the Nominating Committee and provided feedback on the characteristics of candidates under consideration by the Nominating Committee. A description of the Nominating Advisory Committee can be found on the Company's website at *www.unitedhealthgroup.com*. Members of the Nominating Advisory Committee do not receive any compensation from the Company for serving on the Nominating Advisory Committee.

Process for Identifying and Evaluating Nominees

The Nominating Committee's process for identifying and evaluating nominees to the Board of Directors is as follows: In the case of incumbent directors, in addition to the factors listed above under "Criteria for Nomination to the Board," the Nominating Committee reviews the directors' overall service to the Company and performance on the Board of Directors during their terms, including the number of meetings attended, level of participation, quality of performance, level of experience, subject matter expertise the director brings to the Company, familiarity with the Company and other relevant factors.

As announced in 2006, the Board of Directors has committed to having five Board seats filled by new independent directors by the end of 2009 in order to bring in new experiences, expertise and perspectives. To that end, the Board of Directors added four new independent directors as follows: Robert J. Darretta (April 2007), Michele J. Hooper (October 2007), Glenn M. Renwick (June 2008) and Kenneth I. Shine, M.D. (February 2009). Dr. Shine was identified after the Nominating Committee determined that, based upon a review of its skill matrix, it was useful for the Board of Directors to include a nationally recognized health care expert with provider experience. Dr. Shine was identified in a nationwide search by the Nominating and Corporate Governance Committee for a person with this skill set and appointed to the Board of Directors in February 2009 upon nomination by the Nominating and Corporate Governance Committee. All other director nominees were elected by shareholders at the 2008 Annual Meeting.

The Nominating Committee has also considered input from the Nominating Advisory Committee regarding appropriate Board composition characteristics. In considering potential candidates, including Messrs. Darretta and Renwick, Ms. Hooper and Dr. Shine, the Nominating Committee assessed that person's qualifications and how the qualifications fit with the desired composition of the Board of Directors as a whole, including the criteria set forth above under "Criteria for Nomination to the Board" and criteria discussed by the Nominating Advisory Committee. In evaluating a nominee's qualifications, among other things, the Nominating Committee reviewed biographical information and references, and received input from the full Board of Directors.

The Nominating Committee will consider director candidates put forth by shareholders provided the procedures outlined under the heading "Shareholder Proposals for Nominees" are followed by the shareholders in submitting recommendations. The Nominating Committee will evaluate new candidates according to the procedures outlined in the previous paragraph regardless of the source of the candidate recommendation.

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Communication with the Board of Directors

The Board of Directors values the input and insights of our shareholders and believes that effective Board-shareholder communication strengthens the Board of Directors' role as an active, informed and engaged fiduciary. To facilitate communication, the Board of Directors has adopted a Board of Directors Communication Policy. Under the policy, the Board of Directors has designated the Company's Secretary to the Board of Directors as its agent to receive and review communications addressed to any director, committee of the Board or the full Board of Directors.

The Company will not forward to the directors communications received which are of a personal nature or not related to the duties and responsibilities of the Board of Directors, including, without limitation, junk mail and mass mailings, business solicitations, routine customer service complaints, new product or service suggestions, and opinion survey polls. The Secretary to the Board of Directors will forward complaints and suggestions received to the appropriate members of the Company's management.

Appropriate Board communications include matters relating to:

- Board succession planning process;
- CEO succession planning process;
- Executive compensation;
- Corporate governance; and
- General Board oversight, including accounting, internal accounting controls, auditing and other related matters.

The policy, including information on how to contact the Board of Directors, may be found in the corporate governance section of the Company's website, *www.unitedhealthgroup.com*.

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EXECUTIVE COMPENSATION

Compensation Discussion and Analysis

Executive Summary

As described in this Compensation Discussion and Analysis, UnitedHealth Group designed an executive compensation program to attract and retain highly qualified executives and establish a strong relationship between executive pay and Company performance based on the achievement of the enterprise goals and benchmarks described below. The Compensation Committee believes that total compensation for our Chief Executive Officer, our Chief Financial Officer and each of our three other most highly compensated executive officers for fiscal 2008 (the "named executive officers") should be heavily weighted toward long-term performance-based compensation. In 2008, long-term compensation represented approximately 70% of the total mix of base salary, annual and long-term compensation granted to named executive officers other than the CEO. The program, however, does not target a specific mix of compensation between annual and long-term or between equity and cash compensation. Further, given that each executive officer has unique considerations, the program's flexibility allows the Board of Directors to devise a compensation mix that rewards each individual with the proper incentives.

UnitedHealth Group is committed to the notion that the structure of executive compensation drives growth, increases shareholder value, and spurs management to improve efficiency and market value for the Company. Therefore, in the past several years, extensive changes have been made to the executive compensation arrangements with the aim of aligning management's incentives with those of our shareholders. First, as described below, the Compensation Committee changed the structure of the annual bonus program to include appropriate incentives for management to achieve UnitedHealth Group's business strategy. Historically, the sole metric for the long-term incentive plan was earnings per share ("EPS"). In 2008, the Compensation Committee added average return on equity ("ROE") as a second component to its long-term cash incentive program for the 2008-2010 performance period. In 2008, the Compensation Committee, acting in accordance with current best practices, also included restricted stock units as a component of the equity awards. In 2009, performance-based restricted stock units were included.

These updates to UnitedHealth Group's executive compensation structure are in line with the Company's commitment to enhance shareholder value and align executive compensation with long-term performance.

Philosophy and Objectives of our Compensation Program

We seek to attract and retain highly qualified executives and establish a strong relationship between executive pay and Company performance based on the achievement of enterprise goals. We strive to pay competitively and sensibly based on individual and Company performance. We also believe that compensation is not the exclusive means to attract and retain highly qualified executive officers.

The primary objectives of our executive compensation program are to:

- Attract and retain highly qualified executive officers and motivate them to deliver a high level of performance consistently in the industries and markets in which we compete.

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- Align the economic interests of our executive officers with those of our shareholders by placing a substantial portion of pay at risk through performance goals that, if achieved, are expected to increase total shareholder return and contribute to the long-term health of the Company.
- Reward performance that emphasizes teamwork and close collaboration among executive officers, supports Company growth by leveraging enterprise capabilities, drives efficiencies and integrates products and services for the benefit of customers and other stakeholders.
- Reward performance that supports the Company's values by promoting and instilling a culture of integrity, business ethics, customer and provider service, community service and diversity.
- Reward performance that furthers our mission to help people live healthier lives.
- Foster an entrepreneurial spirit that reflects innovative thinking and action, and effective and accountable management to maximize shareholder value and leverage the ingenuity of our employees.

Compensation Program Principles

Our Compensation Committee uses the following principles to implement our compensation philosophy and realize our executive compensation program objectives:

1. *Pay for performance.* A substantial portion of the total compensation of our named executive officers is composed of annual and long-term incentive payments that are earned upon achievement of financial and non-financial outcomes that either influence or produce shareholder value creation.
2. *Enhancing long-term health of the business.* We base annual cash incentives on achievement of goals and objectives that reflect a balanced mix of quantitative and qualitative performance measures to avoid excessive weight on a single performance measure. We believe this balanced mix encourages named executive officers to weigh the longer-term health of the Company while avoiding excessive risk-taking in the short-term.
3. *Reward long-term growth and sustained profitability.* Compensation of our named executive officers is heavily weighted toward equity and cash awards that are earned upon achievement of long-term goals. These awards encourage our named executive officers to deliver continued growth over an extended period of time and aid us in the retention of executive officers who are vital to our long-term success. The equity awards, coupled with executive stock ownership guidelines, further assure the alignment of interests between our named executive officers and our shareholders.
4. *Modest benefits and limited perquisites.* We provide standard employee benefits and very limited perquisites or other forms of compensation to our named executive officers. We believe that the financial opportunities provided to our named executive officers through our compensation program minimize the need for extra benefits or perquisites and that the absence of such benefits or perquisites does not impact our ability to attract and retain such executives.

Determination of Total Compensation

The Compensation Committee's Use of an Independent Compensation Consultant

The Compensation Committee's practice has been to retain independent compensation consultants to advise the Compensation Committee on executive and director compensation matters, assess total compensation program levels and program elements for executive officers and evaluate

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competitive compensation trends. From mid-2006 through 2008, the Compensation Committee retained Semler Brossy Consulting Group, LLC ("Semler Brossy") as its compensation consultant. Semler Brossy took directions from, and reported directly to, the Compensation Committee and did not perform any work for management except at the direction of the Compensation Committee. In February 2009, the Compensation Committee retained Towers Perrin to act as its compensation consultant. Prior to retaining Towers Perrin, the Compensation Committee considered prior relationships that Towers Perrin had with the Company and the health benefits consulting services that Towers Perrin provides to certain customers of the Company. The Compensation Committee concluded that Towers Perrin is an independent compensation consultant under the Board of Directors' recently enacted policy regarding the use of an independent compensation consultant.

In 2009, the Board of Directors adopted a policy formalizing the Compensation Committee's practice of using an independent compensation consultant. The policy provides that if the Compensation Committee does not use an independent consultant, the Company will disclose the consultant's lack of independence in its proxy statement and disclose by appropriate category the aggregate payments made to the consultant. The consultant will not be considered independent if it or any member of its affiliated group is paid by the Company or its affiliates for any services or products not provided at the direction and under the supervision of the Compensation Committee in an amount that exceeds 2% of the affiliated group's consolidated gross revenues. In addition, the consultant will not be deemed independent if the individuals providing services to the Compensation Committee provide any services or products to the Company, its affiliates or management that are not provided at the direction and under the supervision of the Compensation Committee.

Competitive Positioning

The Compensation Committee determines the overall compensation for the named executive officers based on its own evaluation, including internal pay equity considerations, tenure and performance of various executive officers, input from its independent consultant and benchmark data. The Compensation Committee believes that total compensation for named executive officers should be heavily weighted toward long-term performance-based compensation, but it does not target a specific mix of compensation between annual and long-term compensation or between equity and cash compensation. In 2008, long-term (cash and equity) compensation represented approximately 70% of the total mix of base salary, annual and long-term compensation granted to named executive officers other than the CEO because our CEO did not receive any equity awards in 2008.

In general, the Compensation Committee's goal is to achieve total compensation for each named executive officer, as well as all executive officers as a group, that falls within a range of 50-75% of benchmark data if paid at target. In 2008, the Compensation Committee discontinued its previous practice of reviewing individual components of compensation against benchmark data because it felt this approach placed undue emphasis on the individual elements of compensation instead of its desired focus on the competitive positioning of total compensation.

In 2007, the Compensation Committee, with the advice of its independent compensation consultant, established the peer group below. In addition to reviewing data from peer group companies when considering annual cash incentive awards for 2008, long-term cash incentive awards for the 2006-2008 performance period and equity awards made in February 2009, the Compensation Committee also considered general industry data maintained by Towers Perrin, which includes approximately 800 companies, as well as a subset of the companies included in the general industry data, with revenues in excess of $50 billion.

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The Compensation Committee reviewed the general industry data because it contains more companies and is more robust than the peer group and allows for adjustments to ensure comparability based on size or scope. For example, the Compensation Committee believes that the data derived from the peer group companies does not contain comparable roles for two of the Company's executive officers. In 2009, the Compensation Committee intends to conduct a best practices review of our peer group. The peer group companies are:

3M Company
Abbott Laboratories
Aetna Inc.
American Express Company
Amgen Inc.
Anheuser-Busch Companies, Inc.*
Boeing Company
Caterpillar Inc.
CIGNA Corporation
Coventry Health Care, Inc.
Dow Chemical Company
DuPont (EI) De Nemours
Humana Inc.
Johnson & Johnson
Lowe's Companies, Inc.
McDonald's Corporation
Medtronic, Inc.
PepsiCo, Inc.
Procter & Gamble Company
Target Corporation
United Parcel Service, Inc.
United Technologies Corporation
Wachovia Corporation*
Walgreen Co.
Washington Mutual, Inc.*
WellPoint, Inc.
Wells Fargo & Company

Companies highlighted in italics are the five largest publicly traded managed care companies with which we compete. The Company does not feel, however, that it is appropriate to benchmark its compensation practices only against other managed care companies because we are larger, more complex and more diverse than those companies, and we compete for talent and capital with other successful large companies without regard to industry. Companies marked with an asterisk were acquired during 2008.

Role of Management and CEO in Determining Executive Compensation

While the Compensation Committee has the responsibility to approve and monitor all compensation for our named executive officers, management plays an important role in determining executive compensation. At the Compensation Committee's request, management recommends appropriate enterprise-wide financial and non-financial performance goals. Management works with the Compensation Committee to establish the agenda and prepare meeting information for each Compensation Committee meeting. Our CEO assists the Compensation Committee by providing his evaluation of the performance of the named executive officers who report directly to him and recommends compensation levels for such named executive officers. Our CEO does not, however, make recommendations regarding or participate in the determination of his own compensation.

Use of Tally Sheets and Wealth Accumulation Analysis

When making compensation decisions, the Compensation Committee reviews tally sheet information for each of our named executive officers. These tally sheets are prepared by management and quantify the elements of each named executive officer's total compensation, including base salary, annual cash incentive awards and long-term cash incentive awards, stock ownership levels, value of benefits provided, 401(k) and deferred compensation balances and three-year reported compensation

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on Form W-2. The tally sheets also include a summary of all equity awards previously granted to each named executive officer, the gain realized from past vesting or exercise of equity awards and the projected value of accumulated equity awards based upon various stock appreciation scenarios. This is done to more effectively analyze not only the amount of compensation each named executive officer has accumulated to date, but also to better understand the amount the named executive officer could accumulate in the future.

At the request of the Compensation Committee, in September 2008, Semler Brossy performed a review to determine how targeted compensation awards for named executive officers compared to realized compensation during the period from 2005 through 2008. This analysis showed that the then current intrinsic value of those awards were well below their original targeted value, demonstrating alignment with shareholders given the performance of the Company's stock during this period.

Elements of our Compensation Program

Overview

The compensation program for our named executive officers consists of the following elements:

Compensation Element	Objective	Form and Type of Compensation
Base salary	To provide a minimum, fixed level of cash compensation for the named executive officers	Annual cash compensation, not at risk
Annual cash incentive awards	To encourage and reward named executive officers for achieving annual corporate performance goals	At risk, annual performance compensation
Long-term cash incentive awards	To encourage and reward named executive officers for achieving three year corporate performance goals	At risk, long-term performance compensation
Equity awards	To retain named executive officers and align their interests with shareholders	At risk, long-term performance compensation
Employee benefits	To promote health, well-being and financial security of employees, including named executive officers	Annual indirect compensation, not at risk

Annual Compensation

Base Salary

The Compensation Committee generally determines base salary levels for our named executive officers early in the fiscal year, with changes becoming effective during the first quarter of the fiscal year. In 2008, the Compensation Committee approved increases to the base salaries of each of our named executive officers, other than Mr. Hemsley, to $700,000 annually, based upon the recommendation of our CEO. Our CEO believed that internal base pay parity was important to reinforce the importance of executive teamwork and success among all of the Company's business lines to meeting the goals set forth in the Company's 2008 strategic business plan. The Compensation Committee did not increase Mr. Hemsley's salary in 2008 ($1,300,000).

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Annual Cash Incentive Awards

Annual cash incentive awards are paid if our Company meets or exceeds annual performance goals as determined by the Compensation Committee for that year. These awards are considered qualified performance-based compensation under Section 162(m) of the Internal Revenue Code ("Section 162(m)"). Under the Company's 2008 Executive Incentive Plan, the material terms of which were approved by the Company's shareholders in 2008, the maximum potential annual bonus pool is equal to 2% of net income. For each participating named executive officer, the Compensation Committee established a maximum potential annual cash incentive award that was expressed as a percentage of the bonus pool and, under the terms of the 2008 Executive Incentive Plan, could not exceed 25% of the annual bonus pool. The actual annual cash incentive award for each named executive officer for 2008 was less than such percentage of the bonus pool established by the Compensation Committee, and was determined based on the performance criteria and target performance goals described below. This approach was designed to establish each named executive officer's annual cash incentive award in a manner that complied with the performance-based compensation requirements of Section 162(m), while preserving the Compensation Committee's flexibility to determine the actual annual cash incentive award for each named executive officer up to the maximum amount under the Company's 2008 Executive Incentive Plan. In February 2008, the Compensation Committee approved performance criteria and target performance goals to pay out an annual cash incentive award. These performance measures are based on enterprise wide measures because the Compensation Committee believes that the named executive officers share the responsibility to support the goals and performance of the Company as key members of the Company's leadership team. The following table sets forth these performance measures, as well as the actual performance in each of those categories:

2008 Performance Measure	Weight	Threshold Performance	Target Performance	Maximum Performance	Actual 2008 Performance
Revenue	1/3	$74.7 billion	$83.0 billion	$87.2 billion	$81.2 billion
Operating Income	1/3	$7.695 billion	$8.550 billion	$8.978 billion	$6.346 billion
Cash Flow		$6.3 billion	$7.0 billion	$7.4 billion	$4.8 billion
Customer and Physician Satisfaction	1/3	Establish enterprise-wide baseline of performance in 2007	2% above baseline	4% above baseline	1% above baseline
Employee Engagement		Establish enterprise-wide baseline of performance in 2007	2% above baseline	4% above baseline	4% above baseline
Employee Teamwork		Establish enterprise-wide baseline of performance in 2007	2% above baseline	4% above baseline	1% above baseline

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Consistent with the terms of the 2008 Executive Incentive Plan, the following adjustments to the Company's 2008 Operating Income and Cash Flow were made to exclude gains and losses relating to extraordinary, unusual or nonrecurring items:

- Operating Income was positively adjusted for pre-tax operating costs related to:
  - settlement of class action litigation related to reimbursement for out-of-network medical services ($350M);
  - settlement of two class action lawsuits and related legal costs ($882M); and
  - employee severance related to operating cost reduction initiatives and other items ($46M).
- Operating Income was negatively adjusted for pre-tax operating costs related to:
  - insurance recoveries and legal fees related to various matters ($10M); and
  - proceeds from the sale of certain assets and membership in the individual Medicare Advantage business in Nevada ($185M).
- Cash Flow was positively adjusted for net cash payments related to settlement of two class action lawsuits related to the Company's historical stock option practices ($600M).

In determining the actual amount of annual cash incentive compensation to be awarded to each named executive officer, the Compensation Committee considers overall Company performance against all approved goals as set forth in the table above, as well as performance by each individual, and retains discretion to pay an annual incentive award that is higher or lower based on this consideration. The Compensation Committee also has discretion to consider other factors, such as regulatory compliance, reputation advancement, brand identity and public and social responsibility, in determining annual cash incentive awards.

In approving the performance measures for annual cash incentive awards in 2008 set forth in the table above, the Compensation Committee sought to broadly align the compensation of our named executive officers to key elements of the Company's 2008 strategic business plan, which was developed in late 2007. Development of the Company's 2008 strategic business plan was a robust process that involved input from all of the Company's business units and was reviewed with the Company's Board of Directors in the fourth quarter of 2007.

The financial performance measures set forth in the table above represented meaningful growth in revenues, operating earnings and operating cash flow at the target performance level. These financial performance measures at target were consistent with the 2008 financial outlook presented in December 2007 at the Company's annual Investor Conference. The non-financial performance measures were intended to incent named executive officers to take actions necessary (and incur associated costs) to achieve improvements in customer and provider satisfaction and to encourage employee behaviors that contribute to the overall success of the enterprise. These measures were viewed to be important to obtaining longer-term financial successes that might not be immediately reflected in annual financial results.

The Compensation Committee believes that the breadth of financial and non-financial performance measures for the 2008 annual cash incentive award set forth in the table motivate the named executive officers to achieve results that should create value for our shareholders on both a short- and long-term basis. The breadth of financial and non-financial performance measures also serves to mitigate the possibility that named executive officers will take excessive risks to achieve their

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maximum annual bonus. At the beginning of 2008, the Company believed it was unlikely that the enterprise-wide revenue, operating income and cash flow goals for 2008 could be achieved without substantial performance on a broad range of material initiatives contained in the 2008 strategic business plan that were designed to drive growth, improve service, reduce medical costs while improving outcomes, and lower operating costs through increased productivity. These material initiatives included the following:

- significant growth in Medicare and Part D enrollment;
- expansion of Medicaid markets and programs;
- decreased year-over-year decline in commercial risk-based enrollment;
- the roll-out and expansion of new commercial products including EDGE, Total Choice and Vital Measures;
- revitalization of the commercial broker distribution channel;
- expansion of the provider Premium Designation program to increase the transparency, improve the quality and reduce the cost of health care for fully insured and self-funded customers;
- re-launch of a consumer health portal and the expansion of private health portals in OptumHealth;
- reduced operating cost ratio; and
- completion of the Sierra Health Services acquisition.

Because management did not fully realize its plans with respect to enrollment growth, medical cost ratios and reduced operating cost ratios, 2008 revenues were between the threshold and target levels of performance and 2008 operating income and cash flow did not achieve the threshold level of performance.

Determination of 2008 Annual Cash Incentive Award Amounts

At the beginning of each year, the Compensation Committee approves an "annual incentive target percentage" for each named executive officer as a percentage of the named executive officer's base salary. The maximum cash incentive award that each named executive officer may earn is equal to two times the applicable annual incentive target percentage. The amount of the annual cash incentive award to be paid to each named executive officer in a particular fiscal year is approved by the Compensation Committee in the first quarter of the following fiscal year.

The annual incentive target percentages for annual cash incentive awards to our named executive officers and the actual 2008 annual cash incentive award paid are set forth in the table below:

	Annual Cash Incentive Awards				
Name	Target Percentage (% of Salary)	Target Award Value ($)	Maximum Award Value ($)	Actual Award Paid ($)	Paid Award (% of Target)
S. Hemsley	125%	1,625,000	3,250,000	1,218,750	75%
G. Mikan	100%	700,000	1,400,000	1,400,000	200%
A. Welters	100%	700,000	1,400,000	525,000	75%
D. Wichmann	100%	700,000	1,400,000	525,000	75%

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The Compensation Committee believes that it was important to provide the same target opportunity to all of the named executive officers, other than Mr. Hemsley, to increase collaboration and teamwork across the enterprise, to recognize the skills and versatility of each of the named executive officers and to reflect internal parity of contributions. In recognition of his leadership role as Chief Executive Officer, Mr. Hemsley's annual incentive target percentage was approved at 125% of base salary.

The Company's 2008 Executive Incentive Plan requires an executive officer to be employed with the Company on the date that awards are paid in order to receive a payment of the award. As a result, because of the timing of Mr. Strickland's departure in mid-January 2009 to accept a senior level position in the U.S. Department of Interior, he was ineligible to receive an annual cash incentive award. The factors considered by the Compensation Committee in determining the 2008 annual cash incentive award amounts are discussed under "Rationale for Individual Incentive Compensation Decisions" below.

Long-Term Incentive Compensation

The long-term cash incentive program, together with equity awards, represents the largest portion of named executive officer compensation. This combination of long-term incentives provides a compelling performance-based compensation opportunity, aids in aligning and retaining the senior management team and accelerates the leveraging of business unit capabilities across the enterprise.

Long-Term Cash Incentive Awards

The long-term cash incentive awards program creates a strong financial incentive for achieving or exceeding three-year financial goals for the enterprise. These awards are considered qualified performance-based compensation under Section 162(m) of the Internal Revenue Code. Long-term cash incentive awards for the 2006-2008 performance period are paid under the Company's 2002 Executive Incentive Plan, the material terms of which were approved by the Company's shareholders in 2002. The maximum potential long-term cash incentive award for any participant is equal to 1% of the Company's earnings for the performance period. The actual long-term cash incentive award for each named executive officer for the 2006-2008 performance period was less than such percentage of the Company's earnings for the performance period and was determined based on the long-term incentive plan metrics described below. This approach was designed to establish each named executive officer's long-term cash incentive award in a manner that complied with the performance-based compensation requirements of Section 162(m), while preserving the Compensation Committee's flexibility to determine the actual long-term cash incentive award for each named executive officer up to the maximum amount under the Company's 2002 Executive Incentive Plan.

Historically, the Compensation Committee used EPS as the sole long-term incentive plan metric for awards under the long-term incentive program, as sustained earnings growth over a longer period should contribute to our market valuation and have a favorable impact on the future appreciation of our stock. Beginning in 2007, the Compensation Committee added average ROE as a second long-term cash incentive plan metric for awards for the three-year performance period beginning that year. The Compensation Committee believes the combination of these two metrics correlates closely to the creation of shareholder value over the long-term and measures management's effectiveness at reinvesting capital. Each performance metric is based on achievement of the Company's long-term strategic business plan and is not targeted to performance by the Company's peer group companies.

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The Company did not readjust performance measures for open performance periods to include an ROE component (including the 2006-2008 performance period) due to implications related to treatment as qualified performance-based compensation under Section 162(m).

The long-term cash incentive award for the 2006-2008 performance period was granted under the Company's 2002 Executive Incentive Plan. The following table shows the performance measure and targets for the 2006-2008 long-term cash incentive award, approved by the Compensation Committee in January 2006, as well as the actual performance achieved:

Performance Measure	Threshold Performance	Maximum Performance	Actual Performance 2006-2008
Cumulative EPS	$8.57	$10.08	$9.42

The first-year component of the cumulative three-year EPS required for maximum performance was based on the Company's business plan and external outlook for 2006. The annual targets used to build up to the cumulative three-year EPS required for maximum performance corresponded to a compound annual growth rate of 15.7% over the three-year period. This growth rate was consistent with the Company's then stated goal of achieving 15% long-term earnings growth. In approving the target, the Company was of the view that achieving performance at those levels would require significant revenue growth, effective medical and operating cost management and efficient use of capital. A threshold cumulative EPS requirement was approved at 85% of the three-year $10.08 target (which equaled $8.57).

Consistent with the terms of the 2002 Executive Incentive Plan, the Compensation Committee approved the following adjustments to the Company's reported EPS for the impact of changes in accounting principles, extraordinary items and unusual or non-recurring losses:

- in 2008, reported EPS was increased by a net amount of $0.55 to exclude pre-tax operating costs of $1.28 billion relating to the settlement of class-action lawsuits and related legal costs and employee severance related to operating cost reduction initiatives and other items, and to exclude a $195 million relating to the reduction in operating costs for the proceeds from the sale of assets and membership in the individual Medicare Advantage business in Nevada and insurance recoveries and legal fees related to various matters; and
- in 2007, reported EPS was increased by $0.08 to exclude expenses related to the Company's corrective actions under Section 409A of the Internal Revenue Code ("Section 409A").

Actual results for the 2006-2008 performance period were above the EPS threshold, but below the maximum cumulative EPS requirement. The Company had strong EPS growth in 2006 and 2007, with a compound annual growth rate of 23%, as adjusted. However, EPS declined in 2008 due to a number of factors, including the factors discussed under "Annual Cash Incentive Awards" above and the challenging economic environment, resulting in a three-year average compound annual growth rate of 8.5%, as adjusted.

Determination of Long-Term Cash Incentive Awards

The long-term incentive target percentage for each named executive officer was approved at 50% of average base salary over the three-year incentive period. The maximum long-term cash incentive award that may be earned by a named executive officer is equal to two times the long-term incentive target percentage.

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The amount of the long-term cash incentive award to be paid to the named executive officers is approved by the Compensation Committee in the first quarter of the fiscal year following the three-year performance period. The Compensation Committee may exercise discretion with respect to the amount of the long-term cash incentive which is payable, for either threshold or maximum financial performance results.

Long-Term Cash Incentive Awards — 2008

The long-term incentive target percentages for long-term cash incentive awards to our named executive officers and the actual long-term cash incentive awards paid based on 2006-2008 EPS results and the exercise of Compensation Committee discretion are set forth in the table below:

	Long-Term Cash Incentive Award				
Name	Target Percentage (% of 3-Yr. Avg. Base Salary)	Target Award Value ($)	Maximum Award Value ($)	Actual Award Paid ($)	Paid Award (% of Target Award)
S. Hemsley	50%	603,269	1,206,538	603,269	100%
G. Mikan	50%	276,705	553,410	350,000	126%
A. Welters	50%	293,750	587,500	350,000	119%
D. Wichmann	50%	311,292	622,584	350,000	112%

Mr. Mikan became a participant in the long-term cash incentive program in May 2006 in connection with his assumption of enterprise-wide responsibilities and, as a result, the target value of his long-term cash incentive award was prorated.

The factors considered by the Compensation Committee in the exercise of its discretion in the approval of the 2006-2008 long-term cash incentive award amounts are discussed under "Rationale for Individual Incentive Compensation Decisions" below. As discussed in "Determination of 2008 Annual Cash Incentive Award Amounts" above, due to the timing of Mr. Strickland's departure, he was ineligible to receive a long-term cash incentive award.

Equity Awards

Awards of equity-based compensation to our named executive officers complement long-term cash incentives and serve the purposes described above under "Long-Term Cash Incentive Awards." In addition, equity-based awards encourage a strong equity stake in our Company and align the interests of named executive officers and our shareholders. All outstanding equity-based compensation awards to the named executive officers have been awarded under one of three equity-based compensation plans. The most recent equity-based compensation plan, the 2002 Stock Incentive Plan, is the source of current awards.

While the Compensation Committee historically has emphasized stock options and/or stock-settled stock appreciation rights ("SAR"), it has begun using other forms of equity-based grants as general trends in equity-based compensation change. The Compensation Committee determined that equity-based compensation for 2008 should include both SAR grants and restricted stock unit ("RSU") grants to achieve better balance, effectiveness and decreased leverage of equity-based compensation.

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SAR grants were selected because they have a similar accounting treatment to stock options and result in a smaller number of shares being issued from our 2002 Stock Incentive Plan. This extends the life of the authorized pool of shares under the 2002 Stock Incentive Plan that are available for future equity awards. RSU grants were selected because they are full value shares with time vesting and, as such, provide added retention value. In February 2009, the Compensation Committee decided to include awards of performance-based restricted stock units ("performance shares") as a component of the total compensation awarded to named executive officers. The Compensation Committee believes that the use of performance shares further strengthens the pay-for-performance alignment of the Company's compensation program. The Compensation Committee's decision to grant performance shares was informed, in part, by discussions held between the Company and certain of its shareholders regarding the merits of performance shares in a pay-for-performance executive compensation program. The number of performance shares that each named executive officer will receive will be determined at the end of a three-year performance period and will be dependent upon the achievement of average EPS growth percentages and average ROE performance metrics approved by the Compensation Committee.

The Compensation Committee approves all equity awards, including those made to our named executive officers. SAR awards are made with an exercise price equal to or greater than fair market value on the date of grant, and typically have a term of ten years with 25% of the award vesting on each of the first four anniversaries of the date of grant. RSU awards are valued at the fair market value on the date of grant, and typically vest 25% annually on each of the first four anniversaries of the date of grant. The Company does not pay dividend equivalents on RSUs granted to employees.

Equity Awards — 2008

Stephen J. Hemsley. In light of the value of equity awards previously granted to Mr. Hemsley, and with the agreement of Mr. Hemsley, the Compensation Committee did not grant any equity-based awards to him in 2008.

Other Named Executive Officers. In June 2008, the Compensation Committee granted a mix of equity-based compensation awards to each of the Company's other named executive officers with a FAS 123R value at the time of grant of approximately $3 million set forth in the table below. The mix of equity-based compensation to be awarded to each executive officer was determined upon individual circumstances.

Name	SARs	RSUs
G. Mikan	60%	40%
A. Welters	25%	75%
D. Wichmann	60%	40%
T. Strickland	60%	40%

For further information regarding equity award grants in 2008, see "2008 Grants of Plan-Based Awards" below.

Thomas L. Strickland. In addition to the equity compensation granted to Mr. Strickland in June 2008, the Compensation Committee also granted Mr. Strickland an award of 65,000 shares of restricted stock in February of 2008 in light of strong performance as discussed in more detail below.

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Equity Award Practices

The Compensation Committee's equity award policy is designed to facilitate the establishment of appropriate processes, procedures and controls in connection with the administration of equity-based incentive plans. The Compensation Committee's equity award policy requires that all grants of equity awards be made at set times and at the sole discretion of the Compensation Committee. The Compensation Committee does not delegate authority to management to grant equity awards. As a result, we do not have a specific program, plan or practice to time equity compensation awards to named executive officers in coordination with our release of material information.

Since 2002, the Company has decreased the aggregate number of shares subject to equity awards made on an annual basis as a percentage of shares outstanding at year end. The aggregate number of shares subject to equity awards made in 2008 was less than 2% of the Company's shares outstanding at the end of 2008.

For grants in 2009, the Company reinstated provisions providing for continued vesting and exercise of equity awards after employee retirement for five years, subject to certain conditions. For this provision, retirement is generally defined as the attainment of age 55 or older with at least 10 continuous years of service with the Company. The Compensation Committee elected to provide such continued vesting and exercisability because such provisions are a common market practice and our other retirement benefits are limited to the Company's 401(k) Plan and non-qualified deferred compensation plans.

Rationale for Individual Incentive Compensation Decisions

Stephen J. Hemsley. Mr. Hemsley's 2008 annual and 2006-2008 long-term cash incentive awards were determined by the Compensation Committee after considering the results of a performance evaluation conducted by the Compensation Committee. The amount of these awards was based on:

- Achievement of some, but not all, of the additional performance measures for the 2008 annual cash incentive award, and three-year EPS performance that was between the threshold and maximum level payouts;
- Achievement of certain operational and financial goals and objectives of the Company in the face of challenging circumstances;
- Leadership in filling key positions in key corporate areas and obtaining positive results for the Company using the new team of employees;
- Leadership in positively enhancing the Company's culture, including furthering a strong governance culture and encouraging corporate social responsibility initiatives;
- General recognition for strong and effective leadership, including:
    - In January 2008, *Institutional Investor* magazine named Mr. Hemsley as one of the top CEOs in America and the Number 1 CEO in Managed Care;
    - *Institutional Investor* magazine ranked the Company's corporate governance practices as Number 5 of all large to mega-cap companies in the United States in April 2008; and
    - *Fortune* magazine's recognition of the Company in 2008 as being the most innovative health care company for the third year in a row;

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- An internal pay analysis of Mr. Hemsley's cash incentive compensation to cash incentive compensation awarded to other executive officers at the Company, which the Compensation Committee believes is appropriate because the senior leadership team, including the CEO, is most responsible for the Company's performance; and
- An external pay analysis and comparison of Mr. Hemsley's compensation to certain of the executive officers at the Company's competitors.

Based on Mr. Hemsley's performance evaluation and the competitive positioning of Mr. Hemsley's overall compensation for 2008, the Compensation Committee proposed to increase the amount of the 2008 annual and 2006-2008 long-term cash incentive awards paid to Mr. Hemsley above the payout at the performance levels that the Company met. Mr. Hemsley, however, voluntarily declined such proposed increase due to the challenges the Company faced in 2008 and the challenging economic circumstances facing the Company in 2009.

George L. Mikan III. Mr. Mikan's 2008 annual and 2006-2008 long-term cash incentive awards were determined by the Compensation Committee after considering recommendations made by and a performance evaluation conducted by Mr. Hemsley. Although certain performance measures for the 2008 annual cash incentive award were not met, the Compensation Committee awarded Mr. Mikan an annual cash incentive payment and long-term cash incentive award at a higher percentage of target than the awards made to other named executive officers. These awards were based on a number of factors, including the following:

- Unparalleled and widely recognized management of the Company's investment portfolio at a time of great market stress in 2008, resulting in a net unrealized loss of approximately two-tenths of 1% of the portfolio at December 31, 2008;
- Mr. Mikan's skill and leadership abilities, including his ability to take on additional enterprise-wide responsibilities and perform well;
- Achievement of some, but not all of the additional performance measures for the 2008 annual cash incentive award and three-year EPS performance that was between the target and maximum level payouts;
- Achievement of certain operational and financial goals and objectives of the Company in the face of challenging circumstances;
- Efforts and emphasis on enterprise-wide ethical values and leadership by example in community service initiatives; and
- An internal pay analysis and comparison of the cash incentive compensation of the named executive officers to each other and to certain of the other most senior managers at the Company. The Compensation Committee believes an internal pay analysis is appropriate because the executive officers, including the named executive officers, are most responsible for the Company's financial results.

David S. Wichmann and Anthony Welters. The 2008 annual and 2006-2008 long-term cash incentive awards for Messrs. Wichmann and Welters were determined by the Compensation Committee after considering recommendations made by and performance evaluations conducted by Mr. Hemsley. These awards were based on a number of factors, including the following:

- Achievement of some, but not all of the additional performance measures for the 2008 annual cash incentive award and three-year EPS performance that was between the target and maximum level payouts;

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- Achievement of certain operational and financial goals and objectives of the Company in the face of challenging circumstances;
- The responsibilities of each named executive officer;
- Cross enterprise teamwork and collaboration efforts of each named executive officer and emphasis on enterprise-wide ethical values;
- The skill and leadership abilities of each named executive officer, including the ability of each of them to take on additional enterprise-wide responsibilities and perform well; and
- An internal pay analysis and comparison of the cash incentive compensation of the named executive officers to each other and to certain of the other most senior managers at the Company. The Compensation Committee believes an internal pay analysis is appropriate because the executive officers, including the named executive officers, are most responsible for the Company's financial results.

Thomas L. Strickland. Subsequent to the end of the 2008 fiscal year, Mr. Strickland left the Company to accept a senior level position in the U.S. Department of the Interior. The Compensation Committee awarded Mr. Strickland a bonus of $2 million because his departure date made him ineligible to receive any awards under the terms of the Company's Executive Incentive Plan. The Compensation Committee further decided that the vesting of the SARs, RSUs and restricted stock previously granted to Mr. Strickland should be accelerated and the exercise period of such SARs should be extended due to Mr. Strickland's extraordinary service to the Company during 2008.

The Compensation Committee considered the circumstances under which Mr. Strickland joined the Company as well as a number of factors in determining these compensation awards, including the following:

- Mr. Strickland's leadership in reorganizing and rebuilding the Company's legal department, resulting in external recognition of the strength of the Company's corporate governance practices;
- Mr. Strickland's leadership in filling key positions in the Company's legal department;
- Mr. Strickland's leadership in modeling an appropriate commitment to ethical conduct and building a pro bono program across the Company;
- Mr. Strickland's success in pursuing and responding to the Company's legal and regulatory challenges, including the successful resolution of certain important matters;
- An external pay analysis of Mr. Strickland's compensation; and
- The implication of Mr. Strickland's departure date precluding him from being eligible to receive any cash incentive awards earned in 2008 under the Executive Incentive Plan.

The Compensation Committee did not make specific assessments of, quantify or otherwise assign relative weights to the factors considered in reaching its decisions with respect to any of the named executive officers. See the "2008 Summary Compensation Table" and other related compensation tables below for details regarding 2008 total compensation.

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Other Compensation

Benefits

Our named executive officers are generally eligible to participate in our broad-based employee health, welfare and retirement benefit programs. These benefits include a 401(k) savings plan, an employee stock purchase plan, short- and long-term disability plans, term life insurance coverage, medical, vision and dental plans, flexible spending account plan and an employee assistance plan.

In addition to these benefits, our named executive officers are eligible to receive supplemental long-term disability coverage equal to 60% of base salary (up to $420,000) and all of our named executive officers, other than Mr. Hemsley, are eligible to receive supplemental group term life insurance coverage of $2 million at Company expense. Named executive officers are also eligible to participate in our non-qualified Executive Savings Plan. See the "2008 Non-Qualified Deferred Compensation" table below for additional information regarding contributions, earnings and distributions for each named executive officer under the Executive Savings Plan. Our Executive Savings Plan does not provide for guaranteed or above-market interest.

As part of its continued focus on the community, the Company implemented an Executive Board Service Matching Program in March of 2008. This program is available to approximately 200 senior leaders of the Company, including the named executive officers. This program provides for Company matching contributions to certain charitable and nonprofit organizations up to a maximum amount of $10,000 per organization. In order to receive the matching contribution, the employee must serve on the board of the charitable or nonprofit institution and make a financial contribution of an equal amount.

Perquisites

We do not believe that providing generous executive perquisites is either necessary to attract and retain executive talent or consistent with our pay-for-performance philosophy. Therefore, we do not provide perquisites such as executive physicals, company automobiles, security services, private jet services, financial planning services, club memberships, apartments, vacation homes or drivers for personal travel to our executive officers. Our corporate aircraft use policy prohibits personal use of corporate aircraft by any executive officer, including our named executive officers. Because there is essentially no incremental cost to the Company, however, the policy does permit an executive officer's spouse to accompany the executive officer on a business flight on Company aircraft.

Employment Agreements and Post-Employment Payments and Benefits

In 2006 and 2007, the Company entered into new employment agreements with each of our named executive officers, as described in greater detail in "Executive Employment Agreements." None of these agreements provides for fixed minimum annual equity awards, fixed cash incentive awards or perquisites. The Company's policies related to post-employment payments and benefits do not provide for enhanced cash severance payments upon termination in connection with a change-in-control or for excise tax gross up payments payable in connection with a change in control. The Company also does not have supplemental executive retirement plan obligations for its named executive officers, other than Mr. Hemsley. In 2006, Mr. Hemsley and the Company agreed to freeze his supplemental executive retirement plan at $10.7 million.

The employment agreements with our named executive officers provide for certain severance payments in connection with their termination of employment under various circumstances, typically

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termination by the Company without "cause" or in some cases by the executive officer for a "good reason." See the "Executive Employment Agreements" and "Potential Payments Upon Termination or Change-in-Control" for additional information regarding potential severance payments that may be made to named executive officers. We have provided these post-employment payments and benefits and severance payment triggers because they have enabled us to obtain specific post-employment non-competition, non-solicitation and non-disclosure agreements with our executive officers that we believe are of value to the Company and our shareholders.

Our equity award agreements typically provide that the awards become fully vested and exercisable if the executive officer's employment ends due to death or disability, or if a change in control of the Company occurs. We adopted acceleration of the vesting of equity awards upon a change in control in 1994 to offer our executive officers greater protection in the context of a corporate restructuring. Our equity award agreements also generally provide for continued vesting and exercisability during any period in which an executive officer receives severance and for continued exercisability of an award for a limited period of time after termination of employment for other reasons. In addition, certain equity awards granted from 2002 to 2005 and in 2009 provide for continued vesting and exercisability for up to five years after retirement, subject to certain conditions.

Other Compensation Practices

Executive Stock Ownership Guidelines

The Compensation Committee believes that requiring significant stock ownership by our named executive officers further aligns their interests with those of long-term shareholders. Under the stock ownership guidelines established in 2006, each named executive officer must beneficially own a number of shares of the Company's common stock with a fair market value equal to or in excess of a specified multiple of the individual's base salary within three years of adoption of the policy or an executive officer's election or appointment as an executive officer for the first time, whichever is later, as follows:

- for the CEO, five times base salary; and
- for other executive officers, two times base salary.

Stock options and SARs do not count toward satisfaction of the ownership requirements under the guidelines, regardless of their vesting status. However, RSUs and restricted stock awards are counted toward the satisfaction of the ownership requirements. The Compensation Committee periodically reviews compliance with this requirement. As of the record date of this proxy statement, all of our named executive officers meet the ownership requirements.

Transactions in Company Securities

In general, SEC rules prohibit uncovered short sales of shares of our common stock by our executive officers, including the named executive officers. Accordingly, our insider trading policy prohibits short sales of shares of our common stock by our executive officers, including the named executive officers, and discourages all employees from engaging in any hedging transactions relating to our common stock. The policy also requires all employees to consult with our Office of the Chief Legal Officer if they intend to engage in any hedging transactions. In 2008, no executive officer consulted with the Office of the Chief Legal Officer regarding hedging transactions.

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Potential Impact on Compensation from Executive Misconduct

If the Board of Directors determines that an executive officer has engaged in fraud or misconduct, the Board of Directors may take a range of actions to remedy the misconduct, prevent its recurrence and impose such discipline as would be appropriate. Actions taken would vary depending on the facts and circumstances and may include, without limit: (1) a termination of employment and (2) initiating legal action against the executive officer. In addition, with respect to approximately 50 members of senior management, if the fraud or misconduct causes, in whole or in part, a material restatement of the Company's financial statements, action may include (a) seeking reimbursement of the entire amount of cash incentive compensation awarded to the executive officer, if the executive officer would have received a lower (or no) cash incentive awards if calculated based on the restated financial results and (b) canceling all outstanding vested and unvested equity awards subject to the clawback policy and requiring the executive officer to return to the Company all gains from equity awards realized during the twelve-month period following the filing of the incorrect financial statements.

Accounting and Tax Considerations

Section 162(m) imposes a $1 million limit on the amount that a company may annually deduct for compensation to its CEO and its three other highest-paid executive officers employed at the end of the year, unless, among other things, the compensation is "performance-based," as defined in Section 162(m), and provided under a plan that has been approved by the shareholders. The Compensation Committee seeks to structure most elements of our executive compensation program to meet this exception. However, to maintain flexibility to promote varying corporate goals, we have not adopted a policy requiring all compensation to be deductible. In particular, stock options granted under the Company's 1998 Broad-Based Stock Incentive Plan (the "1998 Plan") and exercised by named executive officers do not qualify as performance-based compensation, however no equity awards have been granted under the 1998 Plan since April 2002. Also, future exercises of stock options determined to have an exercise price less than the closing price of our common stock on the accounting measurement date as a result of the review of our historical stock option practices may not qualify as performance-based compensation under Section 162(m). In light of the Company's amendments to its compensation plans and actions related to certain outstanding equity awards during 2007 and 2008, the Company believes that its executive compensation plans and agreements are in compliance with Section 409A.

Compensation and Human Resources Committee Report

The Compensation and Human Resources Committee has reviewed and discussed the above Compensation Discussion and Analysis with management. Based on the review and discussions, the Compensation and Human Resources Committee recommended to the Board of Directors that the Compensation Discussion and Analysis be included in the proxy statement and incorporated by reference into the Company's Annual Report on Form 10-K, as amended, for the year ended December 31, 2008. This report was provided by the following independent directors who comprise the Compensation and Human Resources Committee:

Douglas W. Leatherdale (Chair)
Robert J. Darretta
Gail R. Wilensky, Ph.D.

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2008 Summary Compensation Table*

The following table provides certain summary information for the fiscal years ended December 31, 2008, 2007 and 2006 relating to compensation paid to, or accrued by us on behalf of, our named executive officers.

Name and Principal Position	Year	Salary ($) (1)	Bonus ($)	Stock Awards ($) (2)	Option/SAR Awards ($) (2)	Non-Equity Incentive Plan Compensation ($) (3)	Change in Pension Value and Non-Qualified Deferred Compensation Earnings ($) (4)	All Other Compensation ($) (5)	Total ($)
Stephen J. Hemsley . .	2008	1,300,000	—	—	— (6)	1,622,019	— (7)	119,023	3,241,042
President and Chief	2007	1,300,000	—	—	8,134,691	3,635,000	—	94,838	13,164,529
Executive Officer	2006	1,019,615	—	—	11,290,311	2,875,000	257,229	106,873	15,549,028
George L. Mikan III . .	2008	692,115	—	176,982	2,774,947	1,750,000	—	1,137,362	6,531,406
Executive Vice	2007	650,000	—	—	3,224,258	1,282,000	—	71,874	5,228,132
President and Chief Financial Officer	2006	445,809	—	—	2,123,277	748,000	—	22,192	3,339,278
Thomas L. Strickland . .	2008	692,115	2,000,000(8)	1,397,926	898,915	—	—	27,852	5,016,808
Former Executive Vice President and Chief Legal Officer (8)									
Anthony Welters	2008	692,115	—	331,844	2,438,557	875,000	—	1,297,661	5,635,177
Executive Vice	2007	634,616	—	—	3,170,328	1,282,000	—	298,632	5,385,576
President and President of Public and Senior Markets Group									
David S. Wichmann . .	2008	696,058	—	176,982	2,838,223	875,000	—	52,607	4,638,870
Executive Vice	2007	675,000	—	—	2,774,954	1,282,000	—	38,601	4,770,555
President and President of UnitedHealth Group Operations	2006	496,693	—	—	2,584,633	1,081,000	—	32,359	4,194,685

* Please see "Compensation Discussion and Analysis" above for a description of our executive compensation program necessary to an understanding of the information disclosed in this table. Please see "Executive Employment Agreements" below for a description of the material terms of each named executive officer's employment agreement.

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(1) Amounts reported include the following salary amounts deferred by the named executive officers under our Executive Savings Plan:

Name	Year	Amount deferred
Stephen J. Hemsley	2008	$64,200
George L. Mikan III	2008	$27,727
Thomas L. Strickland	2008	$27,727
Anthony Welters	2008	$53,712
David S. Wichmann	2008	$27,963

(2) The actual value to be realized by a named executive officer related to stock options/SARs depends upon the appreciation in value of the Company's stock and the length of time the stock options/SARs are held. No value will be realized with respect to any stock option/SAR if the Company's stock price does not increase following the award's grant date.

The amounts reported in this column are based on the dollar amount recognized for financial statement reporting purposes with respect to the Company's fiscal years ended December 31, 2008, December 31, 2007 and December 31, 2006 in accordance with FAS 123R, but disregarding the estimate of forfeitures related to service-based vesting conditions, for the fair value of stock options and SARs, as applicable, granted in 2008, as well as prior fiscal years (2004, 2005, 2006 and 2007). These amounts reflect the Company's accounting expense for these awards, including expenses relating to payments of cash to Messrs. Mikan and Welters made in connection with increasing the exercise price of certain Company stock options in 2007, and do not correspond to the actual value that will be recognized by the named executive officers.

For a description of the assumptions used in computing the dollar amount recognized for financial statement reporting purposes, see "Note 12 to Consolidated Financial Statements" included in the Company's Annual Report on Form 10-K, as amended, for the fiscal year ended December 31, 2008. These assumptions also have been used in computing the dollar amount recognized for financial statement reporting purposes since fiscal 2003.

See the "2008 Grants of Plan-Based Awards" table for information on SAR and stock awards made in 2008.

(3) Amounts reported include both annual and long-term cash incentive awards to our named executive officers under our Executive Incentive Plan. The annual incentive awards earned in 2008 and paid in 2009, including amounts deferred by the named executive officers, were the following:

Name	Year	Total amount of annual cash incentive award	Amount of annual cash incentive award deferred
Stephen J. Hemsley	2008	$1,218,750	$73,125
George L. Mikan III	2008	$1,400,000	$84,000
Anthony Welters	2008	$ 525,000	$31,500
David S. Wichmann	2008	$ 525,000	$31,500

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The long-term cash incentives earned for the 2006-2008 incentive period under our Executive Incentive Plan and paid in 2009 were the following:

Name	Period	Total amount of long-term cash incentive award
Stephen J. Hemsley	2006-2008	$603,269
George L. Mikan III	2006-2008	$350,000
Anthony Welters	2006-2008	$350,000
David S. Wichmann	2006-2008	$350,000

(4) Named executive officers participate in our Executive Savings Plan, which is a non-qualified deferred compensation plan. The Executive Savings Plan does not credit above-market earnings or preferential earnings to the amounts deferred, and accordingly, no non-qualified deferred compensation earnings have been reported. Under the Executive Savings Plan, there are no measuring investments tied to Company stock performance. The measuring investments are a collection of unaffiliated mutual funds identified by the Company.

(5) All other compensation includes the following:

Name	Year	Company Matching Contributions Under 401(k) Savings Plan	Company Matching Contributions Under Executive Savings Plan	Company Matching Contributions Under Executive Board Service Matching Program (a)	Insurance Premiums	Other (b)
Stephen J. Hemsley	2008	$8,050	$108,250	—	—	—
George L. Mikan III	2008	$8,050	$ 42,686	—	—	$1,081,533
Thomas L. Strickland	2008	$ —	$ 13,886	—	$10,320	—
Anthony Welters	2008	$5,513	$ 40,154	$30,000	—	$1,215,774
David S. Wichmann	2008	$8,050	$ 38,024	—	—	—

As permitted by SEC rules, we have omitted perquisites and other personal benefits that we provided to certain named executive officers in 2008 as the aggregate amount of such compensation to each of the named executive officer was less than $10,000. In addition, consistent with SEC rules, we have not separately quantified and identified those items of other compensation that have a value of less than $10,000.

(a) As part of its commitment to serve local communities, the Company encourages its executive officers to serve on the boards of charitable organizations and to financially contribute to those organizations. The Company has adopted a policy pursuant to which it will match certain charitable contributions made by an executive officer if the executive officer also serves on the board of the charitable organization. The amount included for Mr. Welters represents donations to charitable organizations made by the Company in 2008 to match the donations Mr. Welters made to charitable organizations on whose board he serves.

(b) As part of our review of the Company's historical stock option practices, the Company determined that certain historical stock options granted to individuals who were non-executive officer employees at the time of grant (including Messrs. Mikan and Welters) were granted with an exercise price that was lower than the closing price of our common stock on the

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applicable accounting measurement date, subjecting these individuals to additional tax under Section 409A. For any outstanding stock options subject to additional tax under Section 409A that were granted to non-executive officer employees, the Company increased the exercise price and committed to make cash payments to these holders following the vesting of the options based on the difference between the original stock option exercise price and the revised increased stock option exercise price. The payments will be made on a quarterly basis following vesting of the applicable awards. If the modified stock options are subsequently exercised, the Company will recover these cash payments at that time from exercise proceeds at the revised increased stock option exercise prices.

(6) Mr. Hemsley did not receive any equity awards in 2008. The Company recognized all compensation expense for Mr. Hemsley's outstanding equity awards in prior years.

(7) In May 2006, the amount of Mr. Hemsley's supplemental retirement benefit was frozen based on his current age and average base salary and converted into a lump sum of $10,703,229. As such, there was no increase in the benefit payable to Mr. Hemsley under his supplemental retirement benefit in fiscal 2008.

(8) Mr. Strickland resigned as Executive Vice President and Chief Legal Officer on January 21, 2009. Due to the timing of Mr. Strickland's departure, the Compensation Committee awarded Mr. Strickland a bonus in lieu of any amounts that would have otherwise been payable to him as an annual cash incentive or long-term cash incentive under the Company's Executive Incentive Plan.

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2008 Grants of Plan-Based Awards*

The following table presents information regarding each grant of an award under our compensation plans made during 2008 to our named executive officers for fiscal 2008.

Name	Grant Date (1)	Estimated Future Payouts Under Non-Equity Incentive Plan Awards			All Other Stock Awards: Number of Shares of Stock or Units (#)	All Other Option/ SAR Awards: Number of Securities Underlying Options/ SARs (#)	Exercise or Grant Price of Option/ SAR Awards ($/Sh) (1)	Grant Date Fair Value of Stock or Option/ SAR Awards ($) (2)
		Threshold ($)	Target ($)	Maximum ($)				
Stephen J. Hemsley (3)								
President and Chief Executive Officer								
Annual Cash Incentive Award (4)	—	1,462,500	1,625,000	3,250,000	—	—	—	—
Long-Term Cash Incentive Award (5)	—	494,687	659,583	1,319,166	—	—	—	—
George L. Mikan III								
Executive Vice President and Chief Financial Officer								
Annual Cash Incentive Award (4)	—	630,000	700,000	1,400,000	—	—	—	—
Long-Term Cash Incentive Award (5)	—	265,385	353,846	707,692	—	—	—	—
SAR Award (6)	6/5/2008	—	—	—	—	203,642	33.94	1,912,198
Restricted Stock Unit Award (7)	6/5/2008	—	—	—	36,452	—	—	1,237,181
Thomas L. Strickland								
Former Executive Vice President and Chief Legal Officer								
Annual Cash Incentive Award (4)	—	630,000	700,000	1,400,000	—	—	—	—
Long-Term Cash Incentive Award (5)	—	265,385	353,846	707,692	—	—	—	—
SAR Award (6)	6/5/2008	—	—	—	—	203,642(8)	33.94	1,912,198
Restricted Stock Unit Award (7)	6/5/2008	—	—	—	36,452(8)	—	—	1,237,181
Restricted Stock Award (7)	2/19/2008	—	—	—	65,000(8)	—	—	3,125,200
Anthony Welters								
Executive Vice President and President of Public and Senior Markets Group								
Annual Cash Incentive Award (4)	—	630,000	700,000	1,400,000	—	—	—	—
Long-Term Cash Incentive Award (5)	—	265,385	353,846	707,692	—	—	—	—
SAR Award (6)	6/5/2008	—	—	—	—	84,851	33.94	796,751
Restricted Stock Unit Award (7)	6/5/2008	—	—	—	66,348	—	—	2,319,731
David S. Wichmann								
Executive Vice President and President of UnitedHealth Group Operations								
Annual Cash Incentive Award (4)	—	630,000	700,000	1,400,000	—	—	—	—
Long-Term Cash Incentive Award (5)	—	265,877	354,503	709,006	—	—	—	—
SAR Award (6)	6/5/2008	—	—	—	—	203,642	33.94	1,912,198
Restricted Stock Unit Award (7)	6/5/2008	—	—	—	36,452	—	—	1,237,181

* Please see "Compensation Discussion and Analysis" above for a description of our executive compensation program necessary to an understanding of the information disclosed in this table.

(1) Each per share exercise price/grant price of the awards shown was the per share closing market price of our common stock on the NYSE on the grant date.

(2) The actual value to be realized by a named executive officer depends upon the appreciation in value of the Company's stock and the length of time the award is held. No value will be realized with respect to any SAR

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award if the Company's stock price does not increase following the grant date. The amount reported in the column is based on the grant date fair value of the awards computed in accordance with FAS 123R. For a description of the assumptions used in computing the grant date fair value for the SAR award pursuant to FAS 123R, see "Note 12 to Consolidated Financial Statements" included in the Company's Annual Report on Form 10-K, as amended, for the fiscal year ended December 31, 2008. The grant date fair value of each restricted stock and restricted stock unit award is computed in accordance with FAS 123R based on the closing stock price on the grant date.

(3) Mr. Hemsley did not receive any equity awards in 2008. On February 19, 2008, the exercise prices of Mr. Hemsley's following outstanding options were increased, consistent with his intentions previously disclosed in the Report of the Special Litigation Committee dated December 6, 2007. The increase in exercise prices lowered the fair value of the awards from the fair value calculated based on the original terms of the award and as a result the incremental fair value, computed in accordance with FAS 123R, is zero.

Grant Date	Option Shares Outstanding (#)	Original Exercise Price ($)	2008 Revised Exercise Price ($)
02/11/2004	300,000	29.7000	36.2382
02/11/2004	600,000	39.7783	58.3600
02/12/2003	300,000	20.0600	58.3600
02/12/2003	900,000	30.1383	58.3600

(4) Amounts represent estimated potential payouts of annual cash incentive awards granted under our Executive Incentive Plan in 2008. The Executive Incentive Plan permits a maximum annual bonus pool for executive officers equal to 2% of our Company's net income (as defined in the plan) and no executive officer may receive more than 25% of such annual bonus pool. The maximum amounts reported for each named executive officer equal two times each named executive officer's target amount because the Compensation Committee limited annual cash incentive payouts to not more than two times the target amount. In order for any amount to be paid, the Company must achieve approved performance metrics of (i) growth and innovation, (ii) operating income and cash flow and (iii) stewardship. The actual annual cash incentive amounts earned in connection with the 2008 awards were paid in 2009, and are reported in the "2008 Summary Compensation Table." See "Compensation Discussion and Analysis — Elements of our Compensation Program — Annual Compensation — Annual Cash Incentive Awards" for a description of the Company's annual cash incentive award program. Mr. Strickland did not participate in the payout of the 2008 annual cash incentive award due to his resignation on January 21, 2009.

(5) Amounts represent estimated future payouts of long-term cash incentive awards granted under our Executive Incentive Plan in 2008 for the 2008-2010 incentive period, to be paid in 2011. The Executive Incentive Plan permits a maximum long-term bonus pool for executive officers equal to 2% of our Company's average net income (as defined in the plan) during the performance period and no executive officer may receive more than 25% of such long-term bonus pool. The maximum amounts reported for each named executive officer equals two times each named executive officer's target amount because the Compensation Committee limited the long-term cash incentive payout maximum amount to not more than two times each named executive officer's target

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amount. In 2008, upon recommendation by management, the Compensation Committee approved a minimum cumulative EPS goal and an average ROE goal for the 2008-2010 incentive period that must be achieved before the target amount shown above becomes earned and payable. Each measure is weighted equally. In 2011, the Compensation Committee will determine whether or not the goals have been achieved. The estimated target and maximum awards listed in the table were computed assuming that participants' salaries are increased 5% effective February 1, 2010. See "Compensation Discussion and Analysis — Elements of our Compensation Program — Long-Term Incentive Compensation — Long-Term Cash Incentive Awards" for a description of the Company's long-term cash incentive award program. Mr. Strickland will not participate in the payout of the long-term cash incentive award due to his resignation on January 21, 2009.

(6) Amounts represent the number of SARs granted under our 2002 Stock Incentive Plan. These SARs expire ten years following the date of grant, vest and become proportionately exercisable on each of the first four anniversaries of the date of grant, and are subject to earlier termination upon certain events related to termination of employment. SARs not yet exercisable generally become exercisable upon a change-in-control of the Company, as this term is defined in each executive's equity-award agreement. See "Compensation Discussion and Analysis — Elements of our Compensation Program — Long-Term Incentive Compensation — Equity Awards" for a description of the Company's equity awards program. See also the "Outstanding Equity Awards at 2008 Fiscal Year-End" table for the vesting schedule of all outstanding equity awards for each named executive officer.

(7) Amounts represent the number of shares of restricted stock units or restricted stock awards granted under our 2002 Stock Incentive Plan. These shares of restricted stock units and restricted stock awards proportionately vest on each of the first four anniversaries of the date of grant, and are subject to earlier termination upon certain events related to termination of employment. Restricted stock units and restricted stock awards not yet vested generally become vested upon a change-in-control of the Company, as this term is defined in each executive's equity-award agreement. See "Compensation Discussion and Analysis — Elements of our Compensation Program — Long-Term Incentive Compensation — Equity Awards" for a description of the Company's equity awards program. See also the "Outstanding Equity Awards at 2008 Fiscal Year-End" table for the vesting schedule of all outstanding equity awards for each named executive officer.

(8) The vesting of these awards was accelerated upon Mr. Strickland's resignation on January 21, 2009 and the exercise period for the stock appreciation rights was extended to the original expiration date of each award.

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Outstanding Equity Awards at 2008 Fiscal Year-End

The following table presents information regarding outstanding equity awards held at the end of 2008 by our named executive officers for fiscal 2008.

	Option/SAR Awards					Stock Awards		
Name	Date of Option/SAR Grant	Number of Securities Underlying Unexercised Options/ SARs (#) Exercisable (1)	Number of Securities Underlying Unexercised Options/ SARs (#) Unexercisable	Option/ SAR Exercise/ Grant Price ($)	Option/ SAR Expiration Date (2)	Stock Award Grant Date	Number of Shares or Units of Stock That Have Not Vested (#)	Market Value of Shares or Units That Have Not Vested ($) (3)
Stephen J. Hemsley	1/31/2006	100,000	100,000 (4)	59.4200	1/31/2016	—	—	—
President and	5/2/2005	62,500	—	57.4183	5/2/2015			
Chief Executive Officer	5/2/2005	125,000	62,500 (5)	48.3550	5/2/2015			
	2/3/2005	300,000	150,000 (5)	45.2800	2/3/2015			
	2/3/2005	150,000	—	55.3583	2/3/2015			
	2/11/2004	300,000	—	29.7000	2/11/2014			
	2/11/2004	300,000	—	36.2382(6)	2/11/2014			
	2/11/2004	600,000	—	58.3600(6)	2/11/2014			
	2/12/2003	300,000	—	58.3600(6)	2/12/2013			
	2/12/2003	900,000	—	58.3600(6)	2/12/2013			
	1/7/2002	1,200,000	—	25.0925	1/7/2012			
	1/17/2001	1,200,000	—	18.0475	1/17/2011			
	3/8/2000	1,200,000	—	15.6250	3/8/2010			
	10/13/1999	1,995,000	—	8.7188	10/13/2009			
	10/13/1999	2,880,000	—	8.7188	10/13/2009			
George L. Mikan III	6/5/2008	—	203,642 (4)	33.9400	6/5/2018	6/5/2008	36,452 (4)	969,623
Executive Vice	5/28/2007	—	75,000 (7)	54.4100	5/28/2017			
President and	5/28/2007	43,750	131,250 (4)	54.4100	5/28/2017			
Chief Financial Officer	5/2/2006	62,500	62,500 (4)	48.5800	5/2/2016			
	10/31/2005	33,750	11,250 (4)	60.0700	10/31/2015			
	5/2/2005	75,000	25,000 (4)	48.5700	5/2/2015			
	11/4/2004	190,000	—	42.8650	11/4/2014			
	5/10/2004	150,000	—	30.7050	5/10/2014			
	10/28/2003	17,500	—	26.1750	10/28/2013			
	10/28/2003	52,500	—	28.1000	10/28/2013			
	2/12/2003	25,000	—	20.0600	2/12/2013			
	2/12/2003	75,000	—	20.7250	2/12/2013			
	8/5/2002	30,000	—	22.1100	8/5/2012			
	8/5/2002	30,000	—	20.5350	8/5/2012			
	1/7/2002	25,000	—	18.1225	1/7/2012			
Thomas L. Strickland	6/5/2008	—	203,642 (8)	33.9400	6/5/2018	6/5/2008	36,452 (8)	969,623
Former Executive Vice	5/28/2007	43,750	131,250 (8)	54.4100	5/28/2017	2/19/2008	65,000 (8)	1,729,000
President and Chief						5/28/2007	40,000 (8)	1,064,000
Legal Officer								
Anthony Welters	6/5/2008	—	84,851 (4)	33.9400	6/5/2018	6/5/2008	68,348 (4)	1,818,057
Executive Vice	5/28/2007	—	25,000 (7)	54.4100	5/28/2017			
President and	5/28/2007	37,500	112,500 (4)	54.4100	5/28/2017			
President of Public and	5/2/2006	50,000	50,000 (4)	48.5800	5/2/2016			
Senior Markets Group	10/31/2005	30,000	10,000 (4)	60.0700	10/31/2015			
	5/2/2005	75,000	25,000 (4)	48.5700	5/2/2015			
	11/4/2004	270,000	—	42.8650	11/4/2014			
	10/28/2003	97,500	—	28.1000	10/28/2013			

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	Option/SAR Awards					Stock Awards		
Name	Date of Option/SAR Grant	Number of Securities Underlying Unexercised Options/ SARs (#) Exercisable (1)	Number of Securities Underlying Unexercised Options/ SARs (#) Unexercisable	Option/ SAR Exercise/ Grant Price ($)	Option/ SAR Expiration Date (2)	Stock Award Grant Date	Number of Shares or Units of Stock That Have Not Vested (#)	Market Value of Shares or Units That Have Not Vested ($) (3)
David S. Wichmann . . .	6/5/2008	—	203,642 (4)	33.9400	6/5/2018	6/5/2008	36,452 (4)	969,823
Executive Vice	5/28/2007	—	25,000 (7)	54.4100	5/28/2017			
President and	5/28/2007	37,500	112,500 (4)	54.4100	5/28/2017			
President of	5/2/2006	75,000	75,000 (4)	48.5800	5/2/2016			
UnitedHealth Group	10/31/2005	48,750	16,250 (4)	59.0000	10/31/2015			
Operations	5/2/2005	25,000	—	49.7886	5/2/2015			
	5/2/2005	50,000	25,000 (5)	48.3550	5/2/2015			
	12/7/2004	154,000	—	39.8500	12/7/2014			
	12/7/2004	154,000	—	42.2986	12/7/2014			
	8/6/2004	75,000	—	33.1236	8/6/2014			
	8/6/2004	75,000	—	31.5350	8/6/2014			
	11/28/2003	112,500	—	29.3986	11/28/2013			
	11/28/2003	37,500	—	26.9500	11/28/2013			
	2/12/2003	200,000	—	22.5086	2/12/2013			
	8/5/2002	200,000	—	22.1100	8/5/2012			
	1/7/2002	300,000	—	18.2375	1/7/2012			
	1/17/2001	80,000	—	14.7000	1/17/2011			
	1/17/2001	240,000	—	14.5075	1/17/2011			
	7/26/2000	120,000	—	14.7891	7/26/2010			
	3/8/2000	60,000	—	8.0859	3/8/2010			

(1) All exercisable options/SARs are currently vested.

(2) The expiration date shown is the latest date that options/SARs may be exercised. Options/SARs may terminate earlier in certain circumstances, such as in connection with the named executive officer's termination of employment.

(3) Based on the per share closing market price of our common stock on December 31, 2008 of $26.60.

(4) Vest 25% annually over a four year period beginning on the first anniversary of the grant date.

(5) Vest 33% annually over a three year period beginning on the second anniversary of the grant date.

(6) The exercise prices of the stock options were increased on February 19, 2008 as further described in note 3 to the 2008 Grants of Plan-Based Awards table.

(7) Vest 100% on the 6th anniversary of the grant date.

(8) The vesting of these awards was accelerated upon Mr. Strickland's resignation on January 21, 2009. Mr. Strickland's stock appreciation rights will remain exercisable through their original expiration date.

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2008 Option Exercises and Stock Vested

The following table presents information regarding the exercise of stock options during 2008 by our named executive officers and vesting of restricted stock awards held by our named executive officers for fiscal 2008.

Name	Option Awards		Stock Awards	
	Number of Shares Acquired on Exercise (#)	Value Realized on Exercise ($) (1)	Number of Shares Acquired on Vesting (#)	Value Realized on Vesting ($)
Stephen J. Hemsley ..... President and Chief Executive Officer	365,000	6,233,838 (2)	—	—
George L. Mikan III ..... Executive Vice President and Chief Financial Officer	100,000	1,374,150 (3)	—	—
Thomas L. Strickland ..... Former Executive Vice President and Chief Legal Officer	—	—	10,000	342,300 (4)
Anthony Welters ..... Executive Vice President and President of Public and Senior Markets Group	—	—	—	—
David S. Wichmann ..... Executive Vice President and President of UnitedHealth Group Operations	—	—	—	—

(1) Computed by determining the market value per share of the shares acquired based on the difference between: (a) the per share market value of our common stock at exercise, defined as the closing price on the date of exercise, or the average selling price if a same-day sale, and (b) the exercise price of the options.

(2) Mr. Hemsley retained all shares he acquired upon the exercise of stock options. Mr. Hemsley's value is computed as described in note (1) above and was based on the following:

Date of Award	Exercise Date	Number of Options Exercised	Stock Splits Since Date of Award	Market Price at Exercise	Exercise Price
October 13, 1999	September 16, 2008	215,000	8:1	$26.7800	$8.7188
October 13, 1999	October 17, 2008	150,000	8:1	$24.3900	$8.7188

(3) Mr. Mikan's value is computed as described in note (1) above and was based on the following:

Date of Award	Exercise Date	Number of Options Exercised	Stock Splits Since Date of Award	Average Selling Price at Exercise	Exercise Price
January 7, 2002	August 22, 2008	25,000	4:1	$30.2500	$18.1225
January 7, 2002	August 22, 2008	35,000	4:1	$30.2500	$17.3875
June 1, 2001	August 22, 2008	10,000	4:1	$30.2500	$16.6250
June 1, 2001	August 22, 2008	30,000	4:1	$30.3258	$14.1750

(4) Mr. Strickland's restricted stock award was granted on May 28, 2007 and its value is computed based on a closing stock price of $34.23 on May 28, 2008.

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2008 Pension Benefits

The following table presents information regarding the present value of accumulated benefits payable under our non-qualified defined-benefit pension plans covering our named executive officers for fiscal 2008.

Name	Plan Name	Number of Years Credited Service (#)	Present Value of Accumulated Benefit ($)	Payments During Last Fiscal Year ($)
Stephen J. Hemsley ..... President and Chief Executive Officer	Individual Agreement for Supplemental Executive Retirement Pay	— (1)	10,703,229 (1)	—
George L. Mikan III ..... Executive Vice President and Chief Financial Officer	N/A	—	—	—
Thomas L. Strickland .... Former Executive Vice President and Chief Legal Officer	N/A	—	—	—
Anthony Welters ..... Executive Vice President and President of Public and Senior Markets Group	N/A	—	—	—
David S. Wichmann ..... Executive Vice President and President of UnitedHealth Group Operations	N/A	—	—	—

(1) Upon termination of Mr. Hemsley's employment for any reason, a lump-sum benefit of $10,703,229 will be paid six months and one day after his termination. In the event of Mr. Hemsley's death prior to payment of his entire supplemental retirement benefit, his surviving spouse will receive any unpaid benefit. The dollar amount of this lump sum benefit will not vary, regardless of Mr. Hemsley's age, years of service or average compensation at the time of his actual termination.

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2008 Non-Qualified Deferred Compensation

The following table presents information as of the end of 2008 regarding the non-qualified deferred compensation arrangements for our named executive officers for fiscal 2008.

Name (a)	Executive Contributions in Last FY ($) (1) (2) (b)	Registrant Contributions in Last FY ($) (1) (3) (c)	Aggregate Earnings in Last FY ($) (4) (d)	Aggregate Withdrawals/ Distributions ($) (5) (e)	Aggregate Balance at Last FYE ($) (1) (f)
Stephen J. Hemsley ..... President and Chief Executive Officer	216,300	108,250	(427,977)	—	5,871,960
George L. Mikan III ..... Executive Vice President and Chief Financial Officer	85,327	42,686	(53,434)	—	340,549
Thomas L. Strickland ..... Former Executive Vice President and Chief Legal Officer	27,727	13,886	(2,961)	—	38,652
Anthony Welters ..... Executive Vice President and President of Public and Senior Markets Group	101,712	40,154	(74,334)	—	462,711
David S. Wichmann ..... Executive Vice President and President of UnitedHealth Group Operations	75,963	38,024	(497,156)	—	875,329

(1) All amounts in columns (b) and (c) are reported as compensation in the "2008 Summary Compensation Table." In addition to the amounts shown in columns (b) and (c), column (f) includes the following amounts reported in the summary compensation table for prior years:

Name	Amount previously reported
Stephen J. Hemsley	$5,975,386
George L. Mikan III	$ 265,971
Thomas L. Strickland	—
Anthony Welters	$ 395,180
David S. Wichmann	$1,258,498

Because Mr. Strickland was not previously a named executive officer under SEC rules, his compensation has not previously been reported.

(2) Named executive officers participate in our Executive Savings Plan, which is a non-qualified deferred compensation plan. Under the plan, employees may generally defer up to 80% of their eligible annual base salary (100% prior to January 1, 2007) and up to 100% of their annual and long-term cash incentive awards. In addition, employee deferrals may be made to the plan when

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an employee's contributions to the Company's 401(k) plan reach certain limits imposed by the Internal Revenue Code (the "401(k) restoration option"). Amounts deferred, including Company credits, are credited to a bookkeeping account maintained for each participant, and are distributable pursuant to an election made by the participant as to time and form of payment that is made prior to the time of deferral. The Company maintains a Rabbi Trust for the plan. The Company's practice is to set aside amounts in the Rabbi Trust to be used to pay for all benefits under the plan, but the Company is under no obligation to do so except in the event of a change-in-control.

(3) For the first 6% of the employee's 401(k) restoration option and annual incentive award deferrals under our Executive Savings Plan, the Company provides a matching credit of up to 50% of amounts deferred at the time of each deferral. This matching credit does not apply to deferrals of base salary, long-term cash incentive awards, or other special incentive awards.

(4) Amounts deferred are credited with earnings from measuring investments selected by the employee from a collection of unaffiliated mutual funds identified by the Company. The Executive Savings Plan does not credit above-market earnings or preferential earnings to amounts deferred. The returns on those mutual funds for the year ended December 31, 2008 ranged from -43.31% to 2.93%, with a median return of -36.46%. Executives may change their selection of measuring investments on a daily basis.

(5) Under our Executive Savings Plan, unless a participant in the plan elects to receive distributions during the term of his or her employment with the Company, benefits will be paid no earlier than at the beginning of the year following the executive officer's termination. However, upon a showing of severe financial hardship, an executive officer may be allowed to access funds in his or her deferred compensation account earlier. Benefits can be received either as a lump sum payment, in five or ten annual installments, in pre-selected amounts and on pre-selected dates, or a combination thereof. A participant may change his or her election with respect to the timing and form of distribution for such deferrals under certain conditions. However, for deferrals relating to services performed on or after January 1, 2004, participants may not accelerate the timing of the distributions.

Executive Employment Agreements

We have entered into an employment agreement with each of the named executive officers.

Stephen J. Hemsley

On November 7, 2006, the Board of Directors entered into an employment agreement with Mr. Hemsley to serve as President and CEO. The employment agreement provides for a four-year term that will extend automatically for additional one-year periods unless sooner terminated in accordance with the terms of the employment agreement. During the period of his employment, the Board of Directors will nominate Mr. Hemsley for election to the Board of Directors by the shareholders of the Company.

Under the employment agreement, Mr. Hemsley receives a base salary of $1,300,000, with any increases at the sole discretion of the Compensation Committee and ultimately the independent members of the Board of Directors. The employment agreement does not set any minimum or target level for any bonus or other incentive compensation. All bonus and incentive compensation awards are solely at the discretion of the Compensation Committee. Mr. Hemsley is eligible to participate in the Company's generally available employee benefit programs.

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Upon termination of Mr. Hemsley's employment for any reason, he is entitled to a previously accrued and vested lump sum supplemental retirement benefit of $10,703,229 to be paid six months and one day after his termination.

If Mr. Hemsley's employment is terminated by the Company without Cause, other than upon expiration of the term of the employment agreement, or by Mr. Hemsley for Good Reason, the Company will pay Mr. Hemsley a lump sum in an amount equal to his annual base salary for the longer of the remainder of the term under the employment agreement or twelve months.

If Mr. Hemsley's employment is terminated because of his death or permanent disability, the Company will pay him or his beneficiaries a lump sum in an amount equal to two years' total compensation of base salary plus the last two calendar years' average bonus, excluding any special or one-time bonus or incentive compensation payments.

If Mr. Hemsley is terminated by the Company for Cause, by Mr. Hemsley without Good Reason or because of his retirement or upon expiration of the term of the employment agreement, he will not be entitled to any further compensation from the Company other than earned but unpaid salary and benefits.

As defined in the employment agreement, "Cause" generally means willful and continued failure to perform his duties after written notice and a failure to remedy the deficiency, a violation of the Company's Code of Conduct that is materially detrimental to the Company and is not remedied after written notice, engaging in fraud, material dishonesty or gross misconduct in connection with the Company's business or conviction of a felony. As defined in the employment agreement, "Good Reason" generally means an assignment of duties inconsistent with his position or duties, a relocation of the Company's principal place of business, failure by the Board of Directors to elect Mr. Hemsley as CEO, failure by the Board of Directors to nominate Mr. Hemsley to serve on the Board of Directors, the Company's failure to pay or provide Mr. Hemsley's base salary, incentive compensation or other benefits, or any other material breach of Mr. Hemsley's employment agreement that is not remedied.

Pursuant to the employment agreement, Mr. Hemsley is subject to provisions prohibiting his solicitation of the Company's employees and customers or competing with the Company during the term of the employment agreement and the longer of two years following termination or the period that severance payments are made to him under the employment agreement. In addition, he is prohibited at all times from disclosing confidential information related to the Company.

George L. Mikan III, Thomas L. Strickland, Anthony Welters and David S. Wichmann

Messrs. Mikan, Strickland, Welters and Wichmann each entered into an employment agreement with the Company, effective November 2006, May 2008, April 2007 and December 2006, respectively. The titles of these executive officers are specified in the "2008 Summary Compensation Table" above.

Under their respective employment agreements, Messrs. Mikan, Strickland, Welters and Wichmann report to the President and CEO of the Company and receive base salaries with any adjustments at the discretion of the Compensation Committee, including those adjustments described under "Compensation Discussion and Analysis – Elements of our Compensation Program – Annual Compensation." These executive officers are eligible to participate in the Company's incentive compensation plans. The target and maximum amount of any actual bonus payable to each executive officer is in the discretion of the Compensation Committee. These executive officers also are eligible to

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receive stock-based awards in the discretion of the Compensation Committee and to participate in the Company's generally available employee benefit programs. During the term of each executive officer's employment, in addition to the Company's generally available benefits, the Company will provide each executive officer, at the Company's expense, a $2 million face value term life insurance policy and a long-term disability policy which covers 60% of his base salary in the event of a qualifying long-term disability, subject to the terms of the policy.

Each employment agreement and each executive officer's employment may be terminated (a) at any time by mutual agreement or by the Company with or without Cause, (b) at any time by the executive officer with or without Good Reason and (c) upon the executive officer's death or disability that renders him incapable of performing the essential functions of his job, with or without reasonable accommodation. If an executive officer's employment is terminated by the Company without Cause or by the executive officer for Good Reason, the Company will provide the executive officer with outplacement services consistent with those provided to similarly situated executives and pay the executive officer severance compensation equal to the sum of (a) 200% of his annualized base salary as of his termination date, (b) 200% of the average of his last two calendar years' bonus, excluding any equity awards and any special or one-time bonus or incentive compensation payments (except that with respect to Mr. Strickland, if termination occurs within two years following the effective date of his employment agreement, the amount payable will be 200% of the greater of his target incentive or the most recent year's annual bonus after the first year anniversary of the effective date of the employment agreement), and (c) $12,000 to offset the costs of benefit continuation coverage. The severance compensation will be payable over a 24-month period.

For purposes of each applicable employment agreement, "Cause" generally means (a) material failure to follow the Company's reasonable direction or to perform any duties reasonably required on material matters, (b) a material violation of, or failure to act upon or report known or suspected violations of, the Company's Principles of Integrity and Compliance, (c) conviction of a felony, commission of any criminal or dishonest act or any conduct that is materially detrimental to the interests of the Company, or (d) material breach of the employment agreement. The employment agreement provides that the Company will, within 120 days of the discovery of the conduct constituting Cause, give the executive officer written notice specifying the conduct constituting Cause in reasonable detail and the executive officer will have 60 days to remedy the conduct, if the conduct is reasonably capable of being remedied. In any instance where the Company may have grounds for Cause, failure by the Company to provide written notice of the grounds for Cause within 120 days of discovery will be a waiver of its right to assert the subject conduct as a basis for termination for Cause.

For purposes of each applicable employment agreement, "Good Reason" will generally exist if the Company (a) reduces the executive officer's base salary or long- or short-term target bonus percentage other than in connection with a general reduction affecting a group of similarly situated employees, (b) moves the executive officer's primary work location more than 50 miles, (c) makes changes that substantially diminish the executive officer's duties or responsibilities, or (d) changes the executive officer's reporting relationship away from the President and CEO of the Company. The employment agreement provides that the executive officer must give the Company written notice specifying in reasonable detail the circumstances constituting Good Reason within 120 days of becoming aware of the circumstances, or those circumstances will not constitute Good Reason. If the circumstances constituting Good Reason are reasonably capable of being remedied, the Company will have 60 days to remedy the circumstances.

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Pursuant to their respective employment agreements, each executive officer is subject to provisions prohibiting his solicitation of the Company's employees or competing with the Company during the term of the employment agreement and two years following termination for any reason. In addition, each executive officer is prohibited at all times from disclosing confidential information related to the Company.

Potential Payments Upon Termination or Change-in-Control

The following table describes the potential payments to named executive officers upon termination of employment or a change-in-control of the Company as of December 31, 2008. Amounts are calculated based on the benefits available to the named executive officers under existing plans and arrangements, including each of their employment agreements described under "Executive Employment Agreements."

	For Good Reason or Not For Cause ($)	Death ($)	Disability ($)	Retirement ($)	Change-In-Control ($)
Stephen J. Hemsley					
Cash Payments	2,491,667	7,010,000	7,010,000	—	—
Annual Cash Incentive (1)	—	3,250,000	3,250,000	3,250,000	—
Long-Term Cash Incentive (2)	—	2,512,927	2,512,927	2,512,927	2,512,927
SERP	10,703,229	10,703,229	10,703,229	10,703,229	10,703,229
Insurance Benefits	—	—	420,000	—	—
Acceleration of Equity (3)	—	—	—	—	—
Total (4)	13,194,896	23,476,156	23,896,156	16,466,156	13,216,156
George L. Mikan III					
Cash Payments	3,024,000	—	—	—	—
Annual Cash Incentive (1)	—	1,400,000	1,400,000	1,400,000	—
Long-Term Cash Incentive (2)	—	1,243,111	1,243,111	1,243,111	1,243,111
Insurance Benefits	—	2,000,000	420,000	—	—
Acceleration of Equity (3)	—	969,623	969,623	—	969,623
Total (4)	3,024,000	5,612,734	4,032,734	2,643,111	2,212,734
Thomas L. Strickland					
Cash Payments	3,732,000	—	—	—	—
Annual Cash Incentive (1)	—	1,400,000	1,400,000	1,400,000	—
Long-Term Cash Incentive (2)	—	984,295	984,295	984,295	984,295
Insurance Benefits	—	2,000,000	420,000	—	—
Acceleration of Equity (3)	—	3,762,623	3,762,623	—	3,762,623
Total (4)	3,732,000	8,146,918	6,566,918	2,384,295	4,746,918
Anthony Welters					
Cash Payments	2,612,000	—	—	—	—
Annual Cash Incentive (1)	—	1,400,000	1,400,000	1,400,000	—
Long-Term Cash Incentive (2)	—	1,273,898	1,273,898	1,273,898	1,273,898
Insurance Benefits	—	2,000,000	420,000	—	—
Acceleration of Equity (3)	—	1,818,057	1,818,057	—	1,818,057
Total (4)	2,612,000	6,491,955	4,911,955	2,673,898	3,091,955
David S. Wichmann					
Cash Payments	2,812,000	—	—	—	—
Annual Cash Incentive (1)	—	1,400,000	1,400,000	1,400,000	—
Long-Term Cash Incentive (2)	—	1,319,154	1,319,154	1,319,154	1,319,154
Insurance Benefits	—	2,000,000	420,000	—	—
Acceleration of Equity (3)	—	969,623	969,623	—	969,623
Total (4)	2,812,000	5,688,777	4,108,777	2,719,154	2,288,777

(1) Represents the maximum amount the Compensation Committee may in its discretion determine, but is not required, to pay the executive officer (or the executive officer's estate, if applicable)

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based upon a pro-rated portion of the award that the executive officer would have received but for the death, disability or retirement, calculated at the achievement of the maximum performance target, as more fully described in note (4) to the "2008 Grants of Plan-Based Awards" table.

(2) With respect to "For Good Reason or Not for Cause," "Death," "Disability" and "Retirement," represents the maximum amount the Compensation Committee may in its discretion determine, but is not required, to pay the executive officer (or the executive officer's estate, if applicable) based upon the portion of the incentive periods prior to death, disability or retirement and measurement of Company and executive performance based on performance through the end of the fiscal year of the Company which ends closest to the executive officer's date of death, disability or retirement, calculated at the achievement of the maximum performance target, as more fully described in note (5) to the "2008 Grants of Plan-Based Awards" table. With respect to "Change-in-Control," represents the amount payable by the Company or its successor to each executive officer (or credit to the named executive officer's account in the Company's Executive Savings Plan if a timely deferral election is in effect), which is a pro-rated portion of the maximum long-term cash incentive award for which the executive officer is eligible for, for each incentive period within 90 days of the occurrence.

(3) Represents the (i) unvested restricted stock unit awards multiplied by the closing stock price on December 31, 2008 ($26.60) and (ii) intrinsic value of the unvested equity awards which is calculated based on the difference between the closing price of our stock on December 31, 2008 ($26.60) and the exercise or grant price of the unvested stock options and SARs as of that date. Excludes unvested equity awards held by the executive officer that will not immediately vest upon termination, but will continue to vest through any applicable severance period because the intrinsic values of such equity awards are not determinable. Upon termination in which a named executive officer is entitled to severance, vesting of equity awards will continue for the period of severance. If the named executive officer's employment is terminated by reason of retirement, certain unvested equity awards granted between 2002 and 2005 will continue to vest and be exercisable for a period of five years (but not after the award's expiration date). At December 31, 2008, only Mr. Hemsley had met the retirement eligibility provisions. On January 21, 2009, Mr. Strickland resigned as the Company's Executive Vice President and Chief Legal Officer. In connection with his resignation, the Compensation Committee accelerated the vesting of his outstanding stock appreciation rights and restricted stock awards. Mr. Strickland's stock appreciation rights will remain exercisable until their original expiration date. Mr. Strickland's stock appreciation rights had no intrinsic value on January 21, 2009 as the exercise price of such awards was greater than the closing stock price on such date. Based on a closing stock price of $25.05 on January 21, 2009, Mr. Strickland's restricted stock awards had an intrinsic value of $3,543,373.

(4) Does not include value of benefits, plans or arrangements that would be paid or available following termination of employment that do not discriminate in scope, terms or operation in favor of our executive officers and that are generally available to all salaried employees or accrued balances under any non-qualified deferred compensation plan that is described above on page 50.

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DIRECTOR COMPENSATION

Our compensation and benefit program is designed to compensate our non-employee directors fairly for work required for a company of our size and scope, and align their interests with the long-term interests of our shareholders. Director compensation reflects our desire to attract, retain and use the expertise of highly qualified people serving on the Company's Board of Directors. The Compensation Committee reviews the compensation level of our non-employee directors on an annual basis and makes recommendations to the Board of Directors.

The Company uses annual retainers, meeting and committee fees, equity-based compensation, expense reimbursement and other forms of compensation, as appropriate, to attract and retain non-employee directors.

Cash Compensation – Annual Retainers, Meeting Fees and Committee Meeting Fees

Directors who are not Company employees receive an annual retainer of $30,000. In addition, we pay the Chairman of the Board an additional annual retainer of $300,000, and the Chairs of the Audit Committee and the Compensation Committee additional annual retainers of $5,000. The retainers are compensation for general preparation for meetings and responsibilities as a director. Each director also receives a meeting attendance fee of $1,500 for attending each Board of Directors meeting in person ($750 for attending by telephone) and a meeting attendance fee of $1,000 for attending each committee meeting in person ($500 for attending by telephone). We pay our directors who are unable to attend a meeting the standard telephone attendance fee if they receive a briefing by telephone prior to or after the meeting.

Director annual retainers, Board meeting fees, committee Chair fees and committee meeting fees are payable in cash on a quarterly basis. Under our Directors' Compensation Deferral Plan ("Director Deferral Plan"), however, non-employee directors may elect annually to defer receipt of all or a percentage of their retainer, meeting fees and committee meeting fees. Amounts deferred are credited to a bookkeeping account maintained for each director participant and are distributable upon the termination of the director's directorship for any reason. Subject to certain additional rules set forth in the Director Deferral Plan, participating directors may elect whether distribution is made in either:

- an immediate lump sum;
- a series of five or ten annual installments;
- a delayed lump sum following either the fifth or tenth anniversary of the termination of the director's directorship; or
- pre-selected amounts and on pre-selected dates while the director remains a member of our Board of Directors.

The Director Deferral Plan does not provide for matching contributions by the Company, but our Board of Directors may determine, in its discretion, to supplement the accounts of participating directors with additional amounts. No accounts were supplemented in 2008. The Director Deferral Plan does not permit directors to defer stock options or other equity-based compensation.

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Equity-Based Compensation – Stock Options, Restricted Stock Units and Conversion of Cash Compensation into Stock Options or Common Stock

Non-employee directors receive grants of equity awards under our 2002 Stock Incentive Plan. Under the 2002 Stock Incentive Plan and terms approved by the Board of Directors with respect to non-employee director grants, our non-employee directors receive:

- a one-time grant of non-qualified stock options and/or restricted stock units for new directors;
- quarterly grants of non-qualified stock options; and
- grants of non-qualified stock options or shares of common stock to reflect a decision to convert certain cash compensation into equity.

The exercise price for all stock options granted under the 2002 Stock Incentive Plan is the closing sale price of our common stock on the NYSE on the date the option is granted.

A new director receives an initial one-time grant of non-qualified stock options to purchase 25,000 shares of our common stock. The new director may elect to take all or a portion of the initial one-time stock option award in restricted stock units, using a four-to-one conversion ratio (which would result in an award of 6,250 restricted stock units if all options were elected to be received in the form of restricted stock units). These stock options or restricted stock units, as the case may be, are granted on the date of the director's appointment to the Board of Directors. The options or restricted stock units vest at a rate of 25% per year for four years, subject to service on the Board of Directors on the vesting date. A director is required to retain the underlying shares of this equity award (net of any exercise price or taxes) until he or she completes his or her service on the Board of Directors.

Non-employee directors also receive quarterly grants of non-qualified stock options to purchase 5,000 shares of our common stock. The quarterly grants are made automatically on the first business day following the end of each fiscal quarter and are exercisable immediately upon grant. This grant is in consideration of general service and responsibilities and required meeting preparation.

Directors may also elect to convert certain retainers and fees into either non-qualified stock options or shares of common stock of the Company. These include cash Board retainers, cash retainers for service as Chair of the Audit Committee or Compensation Committee and cash meeting attendance fees for regularly scheduled quarterly Board and committee meetings. The cash retainer for service as Chairman of the Board and cash meeting attendance fees for special meetings are not eligible for conversion. The conversion grants are made on the day of each regularly scheduled quarterly Board meeting and become exercisable immediately upon grant. If a director elects to convert his or her eligible cash compensation into stock options, he or she will receive a non-qualified stock option to purchase the number of shares of our common stock equal to four times the amount of the cash compensation foregone, divided by the fair market value of one share of our common stock on the date of grant. If a director elects to convert his or her eligible cash compensation into shares of our common stock, he or she will receive the number of shares equal to the cash compensation foregone, divided by the fair market value of one share of our common stock on the date of grant.

Reimbursement of Director Expenses and Health Care Coverage

We reimburse directors for any out-of-pocket expenses incurred in connection with service as a director. We also provide health care coverage to incumbent directors who are not eligible for coverage

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under another group health care benefit program. Health care coverage is provided generally on the same terms and conditions as current employees. Upon retirement from the Board of Directors, current directors may continue to obtain health care coverage under benefit continuation and after lapse of the benefit continuation coverage, under the Company's post-employment medical plan for up to ninety-six months if they are otherwise eligible. Directors who were not serving on the Board of Directors as of February 2009 and who are not eligible for coverage under another group health care benefit program or Medicare may also receive health care coverage.

Stock Ownership Guidelines

Under our stock ownership guidelines, we require directors to achieve ownership of 10,000 shares of the Company's common stock (excluding stock options, but including restricted stock units after vesting) within five years upon appointment to the Board of Directors. Further, we require directors who were serving as of January 2007 to achieve ownership of 20,000 shares of the Company's common stock by April 26, 2009. Messrs. Ballard, Burke and Leatherdale and Dr. Wilensky have met the ownership requirement.

2008 Director Compensation Table

The following table provides summary information for the fiscal year ended December 31, 2008 relating to compensation paid to or accrued by us on behalf of any of our non-employee directors who served in this capacity during 2008.

Name	Fees Earned or Paid in Cash ($) (1)	Stock Awards ($)(2)	Option Awards ($) (3)	Change in Pension Value and Non-Qualified Deferred Compensation Earnings ($)(4)	All Other Compensation ($)	Total ($)
William C. Ballard, Jr.	67,500	—	189,206	—	—	256,706
Richard T. Burke	363,000	—	201,965	—	7,387 (5)	572,352
Robert J. Darretta	62,500	43,626	234,048	—	—	340,174
Michele J. Hooper	65,250	75,864	189,206	—	—	330,320
James A. Johnson (7)	20,450	—	139,114	—	50,000 (6)	209,564
Thomas H. Kean (7)	24,950	—	139,114	—	100,000 (6)	264,064
Douglas W. Leatherdale	64,610	—	203,271	—	—	267,881
Mary O. Mundinger, Dr.P.H. (7)	22,450	—	139,663	—	50,000 (6)	212,113
Glenn M. Renwick (7)	33,400	15,443	65,840	—	—	114,683
Robert L. Ryan (7)	26,700	—	139,401	—	50,000 (6)	216,101
Gail R. Wilensky, Ph.D.	59,660	—	194,018	—	—	253,678

(1) Amounts reported include the following annual retainer, committee Chair retainer and/or meeting attendance fees earned by the directors but elected by the directors to be converted into shares of common stock or into options to purchase shares of common stock: Mr. Burke – $51,000 (6,730 options); Mr. Darretta – $51,000 (1,700 shares); Ms. Hooper – $51,000 (1,700 shares); Mr. Johnson – $18,450 (1,740 options); Mr. Kean – $18,450 (1,740 options);

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Mr. Leatherdale – $52,360 (7,060 options); Dr. Mundinger – $15,950 (1,630 options); Mr. Renwick – $29,650 (1,170 shares); Mr. Ryan – $21,450 (2,090 options); and Dr. Wilensky – $24,205 (3,050 options). Mr. Renwick has elected to defer all cash compensation not converted into equity awards under the Director Deferral Plan.

(2) The amount reported for Messrs. Darretta and Renwick and Ms. Hooper includes (i) incremental value of shares of common stock of $867, $270 and $867, respectively, issued in lieu of annual retainer and/or cash meeting fees (incremental value refers to the FAS 123R value of the shares issued less the amount of annual retainer and/or cash meeting fees foregone) and (ii) FAS 123R expense recognized in 2008 in connection with the Company's initial grant in 2007 of 3,125 and 6,250 restricted stock units which vests over 4 years to Mr. Darretta and Ms. Hooper, respectively, and the Company's initial grant in 2008 of 3,125 restricted stock units which vests over 4 years to Mr. Renwick.

The grant date fair values of the stock awards expensed in fiscal 2008 computed in accordance with FAS 123R, based on the closing stock price on the grant date, are as follows:

	2/19/08 ($)	6/5/08 ($)	7/24/08 ($)	11/7/08 ($)	4/17/07 ($)	10/30/07 ($)
Robert J. Darretta	13,462	13,237	12,159	13,009	170,688	—
Michele J. Hooper	13,462	13,237	12,159	13,009	—	299,375
Glenn M. Renwick	—	110,815	12,159	13,009	—	—

As of December 31, 2008, our non-employee directors held outstanding restricted stock unit awards as follows: Mr. Darretta – 3,125; Ms. Hooper – 6,250; and Mr. Renwick – 3,125.

(3) The actual value to be realized by a director depends upon the appreciation in value of the Company's stock and the length of time the stock option is held. No value will be realized with respect to any stock option if the Company's stock price does not increase following the grant date. The amount reported in the column is based on the dollar amount recognized for financial statement reporting purposes with respect to the Company's fiscal year ended December 31, 2008 in accordance with FAS 123R, but disregarding the estimate of forfeitures related to service-based vesting conditions. For a description of the assumptions used in computing the dollar amount recognized for financial statement reporting purposes, see "Note 12 to Consolidated Financial Statements" included in the Company's Annual Report on Form 10-K, as amended, for the fiscal year ended December 31, 2008. Except as noted below for Messrs. Darretta and Renwick, all option awards were 100% vested on the grant date. Amounts reported include the following incremental values of options issued in lieu of annual retainer and/or cash meeting fees (incremental values refer to the FAS 123R values of the options issued less the amount of annual retainer and/or cash meeting fees foregone): Mr. Burke – $12,758; Mr. Johnson – $64; Mr. Kean – $64; Mr. Leatherdale – $14,065; Dr. Mundinger – $613; Mr. Ryan – $350; and Dr. Wilensky – $4,812. The amount reported for Mr. Darretta also includes the FAS 123R expense recognized in 2008 in connection with the Company's initial one-time grant in 2007 of 12,500 non-qualified stock options, which vests over 4 years. The amount reported for Mr. Renwick also includes the FAS 123R expense recognized in 2008 in connection with the Company's initial one-time grant in 2008 of 12,500 non-qualified stock options, which vests over 4 years.

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The grant date fair values of the option awards expensed in fiscal 2008, computed in accordance with FAS 123R, are as follows:

	1/2/08 ($)	2/19/08 ($)	4/1/08 ($)	6/5/08 ($)	7/1/08 ($)	7/24/08 ($)	10/1/08 ($)	11/7/08 ($)	4/17/07 ($)
William C. Ballard, Jr.	67,097	—	42,920	—	40,024	—	39,165	—	—
Richard T. Burke	67,097	12,410	42,920	14,461	40,024	15,021	39,165	21,866	—
Robert J. Darretta	67,097	—	42,920	—	40,024	—	39,165	—	179,000
Michele J. Hooper	67,097	—	42,920	—	40,024	—	39,165	—	—
James A. Johnson	67,097	12,410	42,920	6,104	29,033	—	—	—	—
Thomas H. Kean	67,097	12,410	42,920	6,104	29,033	—	—	—	—
Douglas W. Leatherdale	67,097	10,930	42,920	14,836	40,024	16,625	39,165	24,034	—
Mary O. Mundinger, Dr.P.H.	67,097	7,173	42,920	9,390	29,033	—	—	—	—
Glenn M. Renwick	—	—	—	117,375	11,439	—	39,165	—	—
Robert L. Ryan	67,097	12,410	42,920	9,390	29,033	—	—	—	—
Gail R. Wilensky, Ph.D.	67,097	6,831	42,920	7,700	40,024	7,511	39,165	6,975	—

As of December 31, 2008, our non-employee directors held outstanding (and unexercised) option awards as follows: Mr. Ballard – 328,000 options; Mr. Burke – 366,140 options; Mr. Darretta – 41,621 options; Ms. Hooper – 20,000 options; Mr. Johnson – 355,757 options; Mr. Kean –354,067 options; Mr. Leatherdale – 370,300 options; Dr. Mundinger – 330,317 options; Mr. Renwick – 18,929 options; Mr. Ryan – 143,467 options; and Dr. Wilensky – 290,920 options.

(4) The Director Deferral Plan does not credit above-market earnings or preferential earnings to the amounts deferred. There are no measuring investments tied to Company stock performance. The measuring investments are a collection of unaffiliated mutual funds identified by the Company.

(5) In 2008, we paid $7,387 in health care premiums on behalf of Mr. Burke.

(6) In honor of their service on the Board of Directors, we made contributions aggregating $50,000 to charitable organizations selected by each of Messrs. Johnson and Ryan and Dr. Mundinger. With respect to Mr. Kean, we made a donation of $100,000 to Drew University (where Mr. Kean was formerly President), which is being combined with donations from other companies to fund a visiting professorship in recognition of Mr. Kean's contributions as Chairman of The National Commission on Terrorist Attacks upon the United States (more commonly known as the 9/11 Commission). The Company made similar donations to Drew University in 2007 and 2006.

(7) On June 5, 2008, Messrs. Johnson, Kean and Ryan and Dr. Mundinger retired from the Board of Directors and Mr. Renwick was elected to the Board of Directors by the shareholders.

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CERTAIN RELATIONSHIPS AND TRANSACTIONS

Approval or Ratification of Related-Person Transactions

The Board of Directors has adopted a written Related-Person Transactions Approval Policy which is administered by the Audit Committee. A copy of the policy is available on our website at *www.unitedhealthgroup.com*. Under the policy, the following "related-person" transactions are prohibited unless approved or ratified by the Audit Committee:

- Any transaction or series of transactions directly or indirectly involving a director, executive officer or five-percent shareholder of the Company or any of their respective immediate family members, in which the Company or its subsidiaries is directly or indirectly a participant and the amount involved exceeds $1.00.
- Any amendment or modification to an existing related-person transaction.
- Any transaction or relationship involving a director that is not deemed to be immaterial under the Company's Standards for Director Independence as then in effect.

Related-person transactions under the policy do not include:

- Indemnification and advancement of expenses made pursuant to the Company's Articles of Incorporation or Bylaws or pursuant to any agreement or instrument.
- Any transaction that involves the providing of compensation to a director or executive officer in connection with his or her duties to the Company or any of its subsidiaries, including the reimbursement of business expenses incurred in the ordinary course.

Under the policy, Company management will determine whether a transaction falls under the definition of a related-person transaction, requiring review by the Audit Committee. Identifying possible related-person transactions involves a number of search and identification processes and procedures, including the following:

- The Company annually requests each director, director nominee and executive officer of the Company to verify and update certain information, including:
  - A list of the immediate family members of each executive officer of the Company. Under the policy, "immediate family member" means any child, stepchild, parent, stepparent, spouse, sibling, mothers- and fathers-in-law, sons- and daughters-in-law and any person (other than a tenant or employee) sharing the same household as the director, executive officer or five-percent shareholder.
  - A list of the entities (except the Company) where a director or executive officer of the Company (or an immediate family member) is a director, executive officer or employee.
  - A list of the entities where a director or executive officer of the Company (or an immediate family member) is a partner or principal or in a similar position or in which such person has a 10% or greater beneficial ownership interest.
  - Each charitable or non-profit organization where a director or executive officer of the Company (or an immediate family member) is an executive officer, director or trustee.
- The Company identifies five-percent shareholders of the Company by reviewing Schedules 13G and 13D filed with the SEC periodically.

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- The Company compiles a list of all above-referenced persons and entities provided by directors and executive officers, reviews the updated list, and expands the list if necessary, based on its review of SEC filings and Internet searches.
- The Company distributes the list within the Company, including applicable subsidiaries of the Company, and conducts periodic searches to identify any potential related-person transactions.
- The Company reviews search results and, with respect to any transactions that fall within the definition of related-person transactions under the policy, submits relevant information to the Audit Committee for approval, ratification or other action. The Nominating Committee also reviews the identified related-person transactions in connection with its recommendations to the Board of Directors on the independence determinations of each director of the Company.

In determining whether to approve or ratify a related-person transaction, the Audit Committee will consider, among others, the following factors to the extent deemed relevant by the Audit Committee:

- Whether the terms of the related-person transaction are fair to the Company and on terms at least as favorable as would apply if the other party was not or did not have an affiliation with a director, executive officer or five-percent shareholder of the Company.
- Whether there are demonstrable business reasons for the Company to enter into the related-person transaction.
- Whether the related-person transaction could impair the independence of a director under the Company's Standards for Director Independence.
- Whether the related-person transaction would present an improper conflict of interest for any director or executive officer of the Company, taking into account the size of the transaction, the overall financial position of the director or executive officer, the direct or indirect nature of the interest of the director or executive officer in the transaction, the ongoing nature of any proposed relationship, and any other factors the Audit Committee deems relevant.

Any member of the Audit Committee who has an interest in the transaction under discussion will abstain from voting on the approval of the related-person transaction, but may, if so requested by the Chair of the Audit Committee, participate in some or all of the Audit Committee's discussions of the related-person transaction. Any related-person transaction that is not approved or ratified, as the case may be, will be voided, terminated or amended, or other actions will be taken in each case as determined by the Audit Committee so as to avoid or otherwise address any resulting conflict of interest.

As required under SEC rules, transactions that are determined to be directly or indirectly material to the Company or a related person are disclosed in the Company's proxy statement.

Related-Person Transactions

Dr. Shine is the executive vice chancellor for health affairs of the University of Texas System (the "UT System"), which includes six health institutions. The health institutions are part of the Company's broad national network of hospitals and physicians and other care providers. During the UT System's 2008 fiscal year, we paid the UT System approximately $248 million for medical expenses on behalf of consumers who obtain health insurance from us and approximately $2.9 million for other network

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provider services. In addition, members of some of our self-funded customers paid approximately $150 million for health care services received through the UT System.

Dr. Shine had no interest in any of these transactions and was not involved in the negotiations of any of the contractual agreements. We believe the pricing terms were determined on an arm's length basis and were within the range of comparable contracts with similar facilities in the Texas market.

Advances of Defense Costs for Certain Litigation Matters

Certain current and former officers and directors of the Company have been named as defendants in lawsuits arising out of the issues relating to the dating of stock options. The current and former directors and officers who have been named as defendants in these actions have a legal right under the Minnesota Business Corporation Act and the Company's Bylaws to advancement of their costs of defense. Accordingly, in 2008, we have advanced defense costs on behalf of the current and former directors and officers of approximately $16.8 million.

COMPENSATION COMMITTEE INTERLOCKS AND INSIDER PARTICIPATION

During fiscal 2008, Messrs. Darretta and Leatherdale and Dr. Wilensky served on the Compensation Committee. None of these persons has ever been an officer or employee of the Company or any of our subsidiaries and has no interlocking relationships requiring disclosure under applicable SEC rules.

AUDIT COMMITTEE REPORT

The Audit Committee of our Board of Directors is comprised of three non-employee directors, all of whom are audit committee financial experts, as defined by the SEC. The Board of Directors has determined that all of the members of the Audit Committee are independent within the meaning of the listing standards of the NYSE, the rules of the SEC and the Company's Standards for Director Independence. The Audit Committee operates under a written charter adopted by the Board of Directors.

Management is responsible for the Company's internal controls and the financial reporting process. The Company's independent registered public accounting firm, Deloitte & Touche LLP, is responsible for performing an independent audit of the Company's consolidated financial statements in accordance with the standards of the Public Company Accounting Oversight Board (United States), expressing an opinion as to the conformity of the financial statements with generally accepted accounting principles, and auditing management's assessment of the effectiveness of internal control over financial reporting. The Audit Committee's responsibility is to monitor and oversee these processes. The Audit Committee has discussed and reviewed with both management and Deloitte & Touche LLP management's annual report on the Company's internal control over financial reporting and Deloitte & Touche LLP's attestation. The Audit Committee also discussed with management and Deloitte & Touche LLP the process used to support certifications by the Company's Chief Executive Officer and Chief Financial Officer that are required by the SEC and the Sarbanes-Oxley Act of 2002 to accompany the Company's periodic filings with the SEC and the process used to support management's annual report on the Company's internal controls over financial reporting.

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Management represented to the Audit Committee that the Company's consolidated financial statements were prepared in accordance with accounting principles generally accepted in the United States of America, and the Audit Committee has reviewed and discussed with management and the independent registered public accounting firm in separate sessions the Company's consolidated financial statements for the fiscal years ended December 31, 2008, December 31, 2007 and December 31, 2006.

The Audit Committee discussed with Deloitte & Touche LLP matters required to be discussed by Statement on Auditing Standards No. 61 (Communications with Audit Committees) and Rule 2-07 of Regulation S-X. The Company's independent registered public accounting firm also provided to the Audit Committee the written disclosures and the letter required by applicable requirements of the Public Company Accounting Oversight Board regarding the independent registered public accounting firm's communications with the Audit Committee concerning independence, and the Audit Committee discussed with the independent registered public accounting firm the accounting firm's independence. In considering the independence of the independent registered public accounting firm, the Audit Committee took into consideration whether the provision of non-audit services is compatible with maintaining the independence of the independent registered public accounting firm.

Based upon the Audit Committee's review of the financial statements, independent discussions with management and Deloitte & Touche LLP, and the Audit Committee's review of the representation of management and the report of the independent registered public accounting firm to the Audit Committee, the Audit Committee recommended to the Board of Directors that the audited consolidated financial statements for the years ended December 31, 2008, December 31, 2007 and December 31, 2006 be included in the Company's Annual Report on Form 10-K, as amended, for the fiscal year ended December 31, 2008 filed with the SEC.

Members of the Audit Committee
William C. Ballard, Jr., Chair
Robert J. Darretta
Glenn M. Renwick

INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Disclosure of Fees Paid to Independent Registered Public Accounting Firm

Aggregate fees billed to the Company for the fiscal year ended December 31, 2008 represent fees billed by the Company's principal independent registered public accounting firm, Deloitte & Touche LLP, the member firms of Deloitte Touche Tohmatsu, and their respective affiliates, which includes Deloitte Consulting (collectively, "Deloitte & Touche"). The Audit Committee pre-approved the audit and non-audit services provided in fiscal year 2008 by Deloitte & Touche, as reflected in the table below.

	Fiscal Year Ended	
Fee Category	2008	2007
Audit Fees	$23,765,000	$25,650,000
Audit-Related Fees (a)	1,398,000	1,800,000
Total Audit and Audit Related Fees	$25,163,000	$27,450,000
Tax Fees (b)	1,557,000	1,650,000
All Other Fees (c)	—	125,000
Total	$26,720,000	$29,225,000

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(a) Audit-Related Fees include benefit plan and other required audits, certain AICPA agreed-upon procedures, internal control assessments and due diligence services.

(b) Tax Fees include tax compliance, planning and support services.

(c) All Other Fees include certain actuarial reviews, security systems assistance, risk management support and contract analysis and review assistance services.

Audit Committee's Consideration of Independence of Independent Registered Public Accounting Firm

The Audit Committee has reviewed the nature of non-audit services provided by Deloitte & Touche and has concluded that these services are compatible with maintaining the firm's ability to serve as our independent registered public accounting firm.

Audit and Non-Audit Services Approval Policy

The Audit Committee has adopted an Audit and Non-Audit Services Approval Policy (the "Policy") outlining the scope of services that Deloitte & Touche may provide to the Company. The Policy sets forth guidelines and procedures the Company must follow when retaining Deloitte & Touche to perform audit, audit-related, tax and other services. In addition to providing detailed descriptions of the specific types of services which may be provided under these four categories, the Policy also specifies certain non-audit services that may not be performed by Deloitte & Touche under any circumstances.

Pursuant to the Policy, the Audit Committee pre-approved for each service sub-category a fee threshold under which all services are deemed pre-approved for 2008 and 2009. All fees reported above were approved pursuant to the Policy. Additional specific pre-approval is required from the Audit Committee to exceed these pre-approved dollar amounts for proposed new individual projects exceeding specified dollar thresholds, or to add new specific service sub-categories. The services provided by our independent registered public accounting firm and related fees are discussed with the Audit Committee at each regular meeting, and the Policy is evaluated and updated periodically by the Audit Committee.

PROPOSAL 2 – RATIFICATION OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Audit Committee has appointed Deloitte & Touche LLP as our independent registered public accounting firm for the fiscal year ending December 31, 2009. The Board of Directors has proposed that shareholders ratify this appointment at the Annual Meeting. If shareholders do not ratify the appointment of Deloitte & Touche LLP, the Audit Committee will reconsider the appointment but is not obligated to appoint another independent registered public accounting firm. The Audit Committee evaluates, at least every three years, whether to rotate our independent registered public accounting firm.

Representatives of Deloitte & Touche LLP are expected to be present at the meeting, will have an opportunity to make a statement and will be available to respond to questions from shareholders.

The Board of Directors recommends a vote FOR ratification of the selection of Deloitte & Touche LLP as our independent registered public accounting firm for the fiscal year ending December 31, 2009. Proxies will be voted FOR ratifying this selection unless you specify otherwise.

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SHAREHOLDER PROPOSAL

The following shareholder proposal will be voted on at the Annual Meeting only if properly presented by or on behalf of the shareholder proponent. The Board of Directors has recommended a vote against the proposal for the reasons set forth following the proposal.

Shareholder Proposal — Advisory Vote on Executive Compensation

We have been informed that The Nathan Cummings Foundation, 475 Tenth Avenue, 14th Floor, New York, New York 10018, a beneficial holder of 2,100 shares of common stock and in conjunction with Missionary Oblates of Mary Immaculate and Trillium Asset Management as co-sponsors, intends to introduce at the Annual Meeting the following resolution.

ADVISORY VOTE ON EXECUTIVE COMPENSATION

"RESOLVED, that shareholders of UnitedHealth Group request the board of directors to adopt a policy that provides shareholders the opportunity at each annual shareholder meeting to vote on an advisory resolution, proposed by management, to ratify the compensation of the named executive officers ("NEOs") set forth in the proxy statement's Summary Compensation Table (the "SCT") and the accompanying narrative disclosure of material factors provided to understand the SCT (but not the Compensation Discussion and Analysis). The proposal submitted to shareholders should make clear that the vote is non-binding and would not affect any compensation paid or awarded to any NEO."

SUPPORTING STATEMENT

Former UnitedHealth Group CEO William McGuire recently agreed to pay $30 million and forfeit 3.7 million stock options as part of what the *Wall Street Journal* has referred to as, "one of the largest executive-pay givebacks in history." The prominence of this and other high profile cases has led to increasing investor concern over ballooning executive compensation. It has also led to frustration over the current lack of any formal mechanism for investors to express opinions on the compensation of named executive officers.

Evidencing this concern, votes on "Say on Pay" resolutions in 2008 averaged 43% in favor, with ten resolutions receiving the support of a majority of shares voted. Nine leading public companies have now agreed to an advisory vote. Following Aflac's first advisory vote in 2008, the company's Chairman and CEO said, "An advisory vote on our compensation report is a helpful avenue for our shareholders to provide feedback on our pay-for-performance compensation philosophy and pay package."

The influential proxy voting advisory service RiskMetrics Group recommends voting in favor of "Say on Pay" resolutions, noting: "RiskMetrics encourages companies to allow shareholders to express their opinions of executive compensation practices by establishing an annual referendum process. An advisory vote on executive compensation is another step forward in enhancing board accountability."

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RiskMetrics is not alone in its support of allowing investors to have a say on pay. In April 2007, the U.S. House of Representatives passed a bill to allow annual advisory votes by a 2-to-1 margin. During the 2008 presidential campaign, Senators Obama and McCain both voiced support for say on pay. In Europe, the EU Commission has recommended that the directors' remuneration policy be submitted to a vote to increase accountability.

The Council of Institutional Investors, which has also endorsed advisory votes on pay, has stated that, "Executive compensation is the most critical and visible aspect of a company's governance." Shortly after the options-backdating scandal that led to the resignation of former Chair and CEO William McGuire, current CEO Stephen Hemsley offered assurances that UnitedHealth would, "be unrelenting in achieving the highest standards for governance and integrity." (BusinessWeek.com, 10/18/06, "The Ties UnitedHealth Failed to Disclose") We urge our board to uphold this promise by instituting this best-practice governance reform and allowing shareholders to have a say on pay.

The Board of Directors unanimously recommends a vote AGAINST the foregoing proposal for the following reasons:

The Board of Directors has carefully considered the proposal submitted by the Nathan Cummings Foundation and has concluded that the proposal would not be in the best interests of the Company and its shareholders at this time. Our Nominating and Corporate Governance Committee and the entire Board have studied the merits of advisory votes carefully and continue to believe it is not necessary to adopt this proposal.

Our Compensation Committee, which consists entirely of independent directors, is responsible for the careful design and implementation of our compensation policies and programs—as described in the section entitled "Compensation Disclosure and Analysis – Elements of our Compensation Program." We believe that these compensation policies and programs are fully serving the interests of the shareholders and the Company, as well as being appropriately balanced and competitive to accomplish the critical tasks of recruiting and retaining talented senior executives and motivating those executives to achieve superior value for our shareholders over the longer term.

The proponent of this proposal believes that a non-binding (yes or no) advisory vote by shareholders would provide an effective mechanism for investors to express opinions on the compensation of the named executive officers. In fact, executive compensation is a complex topic. A single yes or no vote does not effectively distinguish among the various elements of compensation and goals and thus does not offer a mechanism for constructive input by our shareholders into a matter of considerable complexity and great importance.

The Board of Directors of the Company believes that better alternatives exist to obtain shareholder input on our executive compensation practices. For instance, we have taken the following steps to promote greater engagement and accountability to shareholders with respect to our executive compensation practices:

- Our 2007 declassification of our board;
- Our 2008 actions to provide for majority voting for all directors;

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- The independence of our Compensation Committee, in compliance with SEC, NYSE and IRS independence requirements for Compensation Committee members;
- The regular extensive disclosures we provide on executive compensation, in compliance with SEC rules, including a thorough explanation of the Company's compensation philosophy and practices and the basis for particular pay decisions; and
- Regular discussions between UnitedHealth Group and our shareholders on executive pay, including direct outreach and engagement by the Company with a number of large, long-standing shareholders for purposes of listening to their insights and opinions about the Company's compensation practices and learning about executive compensation trends and developments.

We believe that these actions have had and will continue to have direct and observable effects on our executive compensation determinations.

Shareholder proposals similar to this proposal have been presented for a shareholder vote at each of our last two annual meetings and, in each instance, have received less than a majority support. In addition, the investment community is divided in its views about the usefulness of an advisory vote, when balanced against the resources required by the investment community to implement it. Because of the continuing interest of some shareholder groups, the Board of Directors continues to believe it is important for the Company to monitor developments in this area, but does not believe that it would be prudent to adopt an advisory vote policy at this time.

For the reasons described above, the Board recommends a vote AGAINST this proposal. Proxies will be voted AGAINST the proposal unless you specify otherwise.

SHAREHOLDER PROPOSALS FOR THE NEXT ANNUAL MEETING

In order to be eligible for inclusion in our proxy statement for our 2010 Annual Meeting or to be considered at that meeting, shareholder proposals must be received, in writing, at our principal executive offices at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343, Attention: Secretary to the Board of Directors, not later than December 24, 2009. Shareholder proposals received after December 24, 2009 would be untimely. Shareholder proposals must be in the form provided in our Bylaws. If we do not receive a shareholder proposal by the deadline described above, the proposal may be excluded from the proxy statement and from consideration at the 2010 Annual Meeting. This advance notice requirement supersedes the notice period in SEC Rule 14a-4(c)(1) of the federal proxy rules regarding the discretionary proxy voting authority with respect to such shareholder business.

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HOUSEHOLDING NOTICE

We have adopted "householding" procedures that allow us to deliver one Notice or a single copy of each of the annual report, proxy statement and other documents related to a shareholder meeting to any household at which two or more shareholders reside who share the same last name or whom we believe to be members of the same family. Each registered shareholder living in that household will receive a separate proxy card if the householded proxy materials are received by mail.

If you participate in householding but wish to receive a separate copy of this proxy statement or our annual report, we will deliver a separate copy of these documents to you promptly upon your written or oral request to the Secretary to the Board of Directors, UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343, telephone (800) 328-5979. You may opt-in or opt-out of householding at any time by contacting our transfer agent, Wells Fargo Shareowner Services at (877) 602-7615. Your householding election will apply to all materials mailed more than 30 days after your request is received.

Your participation in the householding program is encouraged. It will reduce the volume of duplicate information received at your household as well as the cost to us of printing and mailing duplicate materials. As an alternative to householding, you may choose to receive documents electronically. Instructions for electing electronic delivery are described in Question 6 of the "Questions and Answers about the Annual Meeting and Voting" above.

We have been notified that some banks and brokers will household proxy materials. If your shares are held in "street name" by a bank or broker, you may request information about householding from your bank or broker.

OTHER MATTERS AT MEETING

In accordance with the requirements of advance notice described in our Bylaws, no shareholder nominations or shareholder proposals other than those included in this proxy statement will be presented at the 2009 Annual Meeting. We know of no other matters that may come before the Annual Meeting. However, if any matters calling for a vote of the shareholders, other than those referred to in this proxy statement, should properly come before the meeting, the persons named in the enclosed proxy will vote such proxy according to their individual judgment.

BY ORDER OF THE BOARD OF DIRECTORS,

Dannette L. Smith

Dannette L. Smith
Secretary to the Board of Directors

Dated: April 23, 2009

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APPENDIX A

UNITEDHEALTH GROUP

STANDARDS FOR DIRECTOR INDEPENDENCE

The UnitedHealth Group Board of Directors (the "Board") will be composed of a majority of directors who are independent and its nominating, compensation and audit committees will be composed entirely of directors who are independent for purposes of the New York Stock Exchange ("NYSE") Corporate Governance Rules. For a director to be deemed "independent," the Board will affirmatively determine, based on all relevant facts and circumstances, that the director has no material relationship with UnitedHealth Group Incorporated (together with its subsidiaries, the "Company"), either directly or as a director, partner, shareholder and/or officer of an entity that has a relationship with the Company. The Company will identify which directors are independent and disclose the basis for that determination in its annual proxy statement for the election of directors. The Board, pursuant to the recommendation of its nominating committee, has adopted the following guidelines to assist in determining independence.

Material Relationships With The Company

A director will be deemed to have a material relationship with the Company and not be considered independent, if any of the following apply:

- The director or an immediate family member (as defined below) is, or has been within the last three years, employed by the Company or has received during any twelve-month period within the last three years any direct compensation from the Company, other than director and committee fees and pension or other forms of deferred compensation for prior service (provided that such compensation is not in any way contingent on continued service);
- The director is, or has been within the last three years, an "affiliated person" of the Company, as that term is used in Section 10A of the Securities Exchange Act of 1934;
- (A) The director or an immediate family member is a current partner of a firm that is the Company's internal or external auditor; (B) the director is a current employee of such a firm; (C) the director has an immediate family member who is a current employee of such a firm and who participates in the firm's audit, assurance or tax compliance (but not tax planning) practice; or (D) the director or an immediate family member was within the last three years (but is no longer) a partner or employee of such a firm and personally worked on the Company's audit within that time;
- The director or an immediate family member is, or has been within the last three years, employed as an executive officer of another company where any of the Company's present executive officers at the same time serves or served on that company's compensation committee;
- The director is a current employee, or an immediate family member is a current executive officer, of an entity that has made payments to, or received payments from, the Company for property or services in an amount which, in any of the last three fiscal years, exceeds the greater of $1 million or 2% of the other company's consolidated gross revenues; and
- The director or an immediate family member is a current executive officer of a tax-exempt organization that receives contributions from the Company or a Company-affiliated tax exempt organization, in an amount which, in any of the last three fiscal years, exceeds the greater of $1 million or 2% of the tax exempt organization's consolidated gross revenues.

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Material Relationships With An Executive Officer

Consistent with the expectation that non-employee directors will not have professional or financial relationships (including side-by-side investments) that could impair their independence, a director will be deemed to have a material relationship with the Company and not be considered independent, if any of the following apply:

- The director receives, or has an immediate family member who receives, any direct compensation from an executive officer or any immediate family member of an executive officer of the Company;
- An entity affiliated with the director or with an immediate family member receives any payment from any executive officer of the Company, other than in a routine, commercial or consumer transaction with terms no more favorable than those customarily offered to similarly-situated persons;
- The director or an immediate family member receives, or is affiliated with an entity that receives, any payment, whether direct or indirect, for legal, accounting, financial or other professional services provided to an executive officer of the Company or an immediate family member of an executive officer; and
- The director or an immediate family member is a current executive officer of a tax-exempt organization that receives contributions from an executive officer of the Company, in an amount which exceeds the lesser of $50,000 or 1% of the tax exempt organization's consolidated gross revenues in that fiscal year.

Relationships That Are Not Material

A director generally will not be deemed to have a material relationship with the Company and will be considered independent, if any of the following, when viewed singularly, apply:

- A transaction in which the director's interest arises solely from the director's position as a director or advisory director (or similar position) of another corporation or organization that is a party to the transaction, and the director did not participate in furtherance or approval of the transaction and the transaction was negotiated on an arms length basis;
- A transaction in which the director's interest arises solely from the director's ownership of an equity or limited partnership interest in the other party to the transaction, so long as the aggregate ownership of all directors, director nominees, executive officers and 5% shareholders of the Company (together with their immediate family members) does not exceed 5% of the equity or partnership interests in that other party;
- A relationship arising solely from the director's status as an employee or non-controlling equity owner of a company to which the Company was indebted at the end of the Company's last full fiscal year in an aggregate amount not in excess of 5% of the Company's total consolidated assets;
- The director, or an organization of which the director is an executive officer or in a similar position, purchasing health care services from the Company on terms no more favorable to the director or such organization than those customarily offered to similarly-situated persons who are not directors or executive officers of the Company;

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- Ownership by the director of equity or other securities of the Company, as long as the director is not the beneficial owner, directly or indirectly, of more than 10% of any class of the Company's equity securities;
- The receipt by the director of compensation for service as a member of the Board of Directors or any committee thereof, including regular benefits received by other outside directors;
- Any other relationship or transaction that is not listed above and in which the amount involved does not exceed $50,000;
- Any immediate family member of the director having any of the above relationships; and
- Any relationship between the Company and a non-immediate family member of the director.

Definitions

For purposes of these standards:

- "Executive officer" means an "officer" within the meaning of Rule 16a-1(f) under the Securities Exchange Act of 1934; and
- "Immediate family" means spouse, parents, children, siblings, mothers- and fathers-in-law, sons- and daughters-in-law, brothers- and sisters-in-law and anyone (other than employees) sharing a person's home. When applying the look-back provision in Section 303A.02(b) of the NYSE's Corporate Governance Rules, the Company need not consider any person who is no longer an immediate family member as a result of legal separation or divorce, or death or incapacitation.

The Board shall undertake an annual review of the independence of all non-employee directors. In advance of the meeting at which this review occurs, each non-employee director shall be asked to provide the Board with full information regarding the director's business and other relationships with the Company and its affiliates and with senior management and their affiliates to enable the Board to evaluate the director's independence.

Directors have an affirmative obligation to inform the Board of any material changes in their circumstances or relationships that may impact their designation by the Board as "independent." This obligation includes all business relationships between, on the one hand directors or members of their immediate family, and, on the other hand, the Company and its affiliates or members of senior management and their affiliates, whether or not such business relationships are subject to any other approval requirements of the Company.

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UnitedHealth Group®

Health Care Cost Containment – How Technology Can Cut Red Tape and Simplify Health Care Administration

UnitedHealth Center for Health Reform & Modernization

Working Paper 2
June 2009

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Health Care Cost Containment – How Technology Can Cut Red Tape

Introduction

America is not getting good value for the $2.6 trillion it spends on health care. Too few people have access to high quality care - and yet there is too much waste. Today the nation is once again grappling with how to respond.

UnitedHealth Group supports the goal of universal health care coverage, believing it is best achieved as part of fundamental modernization of how care is delivered. So we accept our responsibility to contribute innovative ideas and options that would enable this to become reality.

UnitedHealth's Center for Health Reform & Modernization therefore recently published *Working Paper 1: Federal Health care Cost Containment – How in Practice Can it be Done?* It identified $540 billion in potential medical cost savings to the Federal government over the next decade. These were based on applying to traditional Medicare some of the well-tested techniques we as a company use in funding and managing the care of over 70 million Americans. They were not an exhaustive list of the programs we run, or the ideas we have for how to reduce cost growth. They were intended as an initial, constructive, contribution to the debate - aiming to show that "it can be done."

What this new Working Paper adds

Where our first working paper focused on Federal savings in medical costs, this second working paper is a companion document that identifies practical ways in which technology can save money by modernizing the administrative and transactional aspects of health care. Its focus is on savings across the health care system as a whole – savings that will accrue to physicians, hospitals and payers, and to consumers, employers and taxpayers.

Through twelve building blocks we identify administrative savings opportunities of $332 billion in national health expenditure over the next decade. These savings would be likely to benefit families and employers through lower health care costs. As importantly, they would simplify the lives of patients, and eliminate much frustration on the part of doctors and hospitals.

Of these $332 billion in administrative savings, we estimate that approximately 50 percent would accrue to providers (physicians and hospitals), 20 percent directly to government in its role as a health care payer (through Medicare and Medicaid), and 30 percent to commercial payers. (In the options that follow, the combined government and health plan savings are identified as "payer" savings.)

However there are a variety of mechanisms by which the federal government could capture a larger share of the savings, should it so wish. It would first need to set a deadline by which many of the new system-wide standards and processes would take effect. For maximum effect, the new requirements would need to cover all hospitals, physician offices, health plans and all public payers. Once the new processes had taken effect, the resulting administrative savings could help offset the subsidy cost of health care coverage expansions for the newly insured, and the government might also take account of expected overall productivity gains in setting Medicare and Medicaid provider payments. There are also other possible mechanisms that government could use to capture more of the savings. But whether it does so or not, we believe these changes make sense, and need to be adopted comprehensively.

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Basis of savings estimates

These proposals derive from our experience - not just as a large payer and care management organization, but as one of the largest health care technology companies in the United States. UnitedHealth Group's 12,000 technology professionals oversee 30 terabytes of health care data and invest seven million hours annually in application development. In funding and arranging $115 billion of health care we interact with over 5000 hospitals and 650,000 physicians across the country. Each year our technology systems process 60 billion transactions and support 82 million calls, routed to 20,000 customer service agents.

The ideas in this document are supportive of industry-wide approaches to administrative simplification being advanced by AHIP. This working paper draws on the distinctive experience and insights of UnitedHealth Group particularly regarding likely savings impacts and "real world" implementation issues. While not intended as a comprehensive list of options, we believe the twelve approaches identified here are sufficiently detailed to permit reasonable savings estimates. Where individual options are interdependent or potentially overlap, we have sought to net-out possibly duplicative savings estimates.

In addition to these administrative savings, they would create substantial medical cost savings. Only a subset of them are identified in this paper, and none of them are included in the $332 billion figure. For example, the prospective approach to fraud reduction discussed in Options 9 and 10 could save an additional $362 billion in medical costs over the next decade. Some aspects of these medical savings were discussed in our first working paper, but most were not.

Two caveats

We recognize that while there are many opportunities to make savings in administrative costs, payers' costs represent a small share of total health spending. The Congressional Budget Office calculates that only 7 cents in every dollar of national health spending goes on "administration and the net cost of private insurance."[1] While administrative costs are certainly worth pursuing, they pale in significance compared with savings opportunities from medical costs.

That points to a second caveat: administrative programs can have important positive impacts on reducing wasteful medical costs. Fraud reduction programs are the most obvious example, where there is ample evidence that Medicare's administrative under-investment in fact costs taxpayers through avoidable fraud.[3] Health plans – and self insured employers - also spend administratively on a wide range of programs that provide patients information to support them make informed choices, and that identify and incentivize best practices on the part of physicians and hospitals.

However many of these approaches are absent from traditional fee-for-service government health programs. By under-investing in modern management techniques, government therefore over-spends on inefficient or wasteful medical services. The Congressional Budget Office estimates that health plans' use of these administrative initiatives can reduce medical

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costs by 5-10 percent.[4] It follows that minimizing administrative costs should not be a public policy goal in isolation, and reform options for new programs should be assessed against their ability to tackle the well-documented problems of fraud, waste and inappropriate utilization that affect US health care today.[5]

What needs to change

Our experiences suggest that even where the technology exists and efforts have been made to introduce it, its full potential is not being realized. For example, UnitedHealth Group now has 30 million magnetic swipe cards in circulation that would eliminate much red tape for patients, but full adoption will require greater uptake of matching technology by doctors' offices and hospitals across the nation.

We therefore believe that shared and consistent action is now needed across all payers – commercial and governmental – in partnership with physicians and hospitals, so as to unleash the savings identified in this Working Paper. We call for:

- tighter mandatory data and transaction standards
- the elimination of antiquated manual processes, unnecessary paperwork, and redundant intermediaries
- automated payment accuracy processes across the health care system
- a single credentialing and quality measurement process, and
- a sophisticated and consistent regulatory regime.

In this way we think it should be possible to better balance two objectives: innovation and continuous improvement from choice and competition between America's 1300 payers, while removing the cost of duplicative and inconsistent administrative processes.

In doing so, we believe it is possible to distinguish between value-added administrative programs, versus those that add little and simply exist for historical reasons. Making that distinction is what we set out to do in this Working Paper. The result, we hope, is a substantive contribution to the formulation of a "route map" to better care with less red tape and lower administrative overhead.

References

[1] Congressional Budget Office, December 2008: Key issues in analyzing major health insurance proposals. Page 19, Table 1-4

[2] CBO Op cit. Page 69, Table 3-1

[3] See for example recent reports from the US Government Accountability Office: Medicare: Improvements Needed to Address Improper Payments in Home Health, GAO-09-185 February 27, 2009; Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process, GAO-08-955 July 3, 2008; Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices, GAO-08-452 June 13, 2008

[4] CBO Op cit. Page 67

[5] It is for this reason that the CBO argues that 'medical cost ratios' (which measure the share of spending on medical costs versus administrative items) may not be good indicators of a plan's efficiency or value. CBO Op cit.

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Summary of proposed actions/recommendations

A. Required use of common technology and information standards, with enhanced interoperability and connectivity	2010-2019 Savings
Option 1: Rapidly develop and adopt system-wide data and transaction standards to simplify administration and improve patients' diagnosis, treatment and outcomes.	**Foundational**
Option 2: Use of automated cards to validate patient eligibility and benefits at the point of service.	**~$18 billion**
Option 3: Eliminate explanation of benefits for each transaction and replace with monthly personalized health statements, delivered through secure online portals where possible.	**~$14 billion**
Option 4: Eliminate paper checks and Paper Remittance Advice in favor of electronic funds transfer and electronic remittance advice.	**~$109 billion**
Option 5: Implement multi-payer transactional capability on Practice Management Information Systems.	**~$29 billion**
Option 6: Expand use of Electronic Data Interchange for claims, eligibility and coverage verification, notification/administration and claims status.	**~$31 billion**
Option 7: Integrate Practice Management Information Systems and payer administrative systems.	**~$11 billion**
Option 8: Integrate essential elements of electronic medical records and personal health records and promote information sharing and use of data to improve prevention and coordination of care.	**~$13 billion**
B. Use advanced system-wide techniques to improve payment speed and accuracy	
Option 9: Use predictive modeling to prescore claims for Coordination of Benefits, upcoding, subrogation, fraud and medical management prior to payment.	**~$47 billion**
Option 10: Create a national payment accuracy clearinghouse to settle under-payments and over-payments.	**~$41 billion**
C. Streamlined provider credentialing, privileging and quality designation processes	
Option 11: Eliminate multiple payer credentialing and separate hospital privileging. Develop industry utility for credentialing.	**~$18 billion**
Option 12: Adopt common quality designation standards and create single health information database for quality determination.	**~$1 billion**

Potential administrative savings to the health care system by applying these selected programs are estimated at approximately $332 billion during 2010-2019, assuming reasonable implementation phasing.

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Option 1 Rapidly develop and adopt health system-wide data and transaction standards to simplify administration and improve patients' diagnosis, treatment and outcomes.

Current system: The nation's health care system badly lags behind many other sectors of the U.S. economy in terms of its use of widely adopted data and transactional standards. The results include: frequent inability to properly coordinate patients' care; doctor and hospital frustration at the amount of administrative red tape; and excessive cost incurred on administrative activity that does not add value to health care. Paper-based processes are all too typical where technology could easily streamline care funding and delivery.

Progress made through HIPAA standards is a first step toward administrative simplification, helping facilitate electronic interactions between payers and care providers. But these standards still leave too much room for variation caused by payer-specific requirements and multiple "companion guides." If health care is to advance to the level of interoperability found in many other industries, there need to be new guidelines that eliminate variation in data and transaction standards, while meaningfully enhancing the value of the data exchanged. These standards should enable direct exchange among participants in the system, as opposed to using translation intermediaries or clearinghouses. Currently, the industry has embraced several standards-setting organizations, with specific recognition given to X12 and CORE as the two best situated to develop administrative exchange guidelines.

Proposed solution: We recommend and support much more rapid adoption of tighter data and transaction standards, starting with CORE Phase I and II eligibility and benefit rules, then moving quickly on to tightened standards for exchanging other HIPAA items, including claims submission, claims inquiry, electronic funds transfer, electronic remittance and auto posting, prior authorization/notification, and demographic updates. These new standards should also cover critical encounter data, such as care plan, lab results, conditions and Rx orders. We envision this information being shared with individuals through a Health Information Exchange in a fully secure, private environment. The information will then assist care providers and health plans in engaging patients and coordinating care.

Estimated cost savings: Wider and faster adoption of programs using these standardized types of clinical data would over time help reduce lifestyle-driven illnesses, improve patient safety, advance the adoption of "pay-for-performance" programs and support innovative benefit designs that reward people for adopting healthy behaviors. However, data and transaction standards on their own produce few savings, and should instead be regarded as "foundational." Because other sections of this Working Paper (Options 2, 4-8 and 12) require use of these standards to make further advances, the savings are not separately quantified under this option.

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Option 2 Use automated cards to validate patient eligibility and benefits at the point of service.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.4	0.7	1.1	1.1	3.3	9.9
Provider	0.0	0.3	0.6	0.9	1.0	2.8	8.3
Total	**0.0**	**0.7**	**1.3**	**2.0**	**2.1**	**6.1**	**18.2**

Current system: When a patient visits a doctor's office or hospital, the clerical staff often photocopy information from the patient's health plan identification card. To verify eligibility, about 60 percent of providers' offices access a health plan's call center. This process, and the subsequent claims submission and adjudication are typically performed after care has been provided. These manual methods cause delays in processing that are costly and confusing to patients. They also result in delayed billing and settlement, which can make it harder for physicians to be paid what they are owed by the patient. This contributes to an estimated $60 billion in bad debt write-offs annually across the health care system.

Proposed solution: Using secure swipe card technology – or an appropriate automated link to a doctor's or hospital's systems – the provider can view in real-time the patient's eligibility for benefits, and accurately ascertain what will be reimbursed by the insurer/employer. The doctor or hospital can then request payment for the visit in real time while submitting a claim electronically to the health plan or other payer. UnitedHealth Group currently has 30 million medical ID swipe cards in circulation that can achieve this solution. Besides the efficiency gains in eligibility and benefit verification, these cards also contribute to better care by providing doctors with access to a patient's personal health record and relevant health alerts. Barriers to higher adoption of this technology include lack of consistent data standards, provider reluctance to alter workflows and practices, and lack of development and use of multi-payer applications in PMIS systems.

To overcome these barriers to adoption we recommend that: 1) all health care payers adopt WEDI identification card standards and electronic eligibility capabilities; 2) payers agree to provide a single access point for eligibility information and electronic claims filing; 3) health care providers be incentivized from the future savings stream to acquire the relevant technology and broadly implement it in their practices; and 4) PMIS systems be extended to include basic multi-payer inquiry and claims submission capability.

Estimated cost savings: Incentivizing or mandating electronic eligibility adoption to 95 percent by 2019 results in an estimated $18.2 billion in savings over 10 years. It should also be noted that other benefits from this option have not been included in the savings estimates. These include the likelihood that for each 10 percent increase in electronic eligibility verification there is a 3 percent increase in total eligibility verifications; eligibility write-offs fall by 2.5 percent as a percent of net patient revenue; and there are other general reductions in administrative burdens in care providers' offices. These would be likely to offset the investments needed to implement these changes, which in the case of providers would include third track card readers (if they choose swipe technology), the ability to import benefits and payment information into their PMIS system, and related PMIS system upgrades.

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Option 3 Eliminate explanation of benefits (EOBs) for each transaction and replace with monthly personalized health statements, delivered through secure online portals where possible.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.5	0.7	1.2	1.5	3.9	14.4
Provider	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**0.0**	**0.5**	**0.7**	**1.2**	**1.5**	**3.9**	**14.4**

Current system: After a patient visits a health care provider, an explanation of benefits (EOB) is delivered, usually by mail. It describes the services provided, the payment sent to the doctor, and the amount the patient can expect to pay. Stamped on the document are the words, "This is not a bill." Most payer systems send EOBs for every claim and may be required by law to do so. This can lead to confusion, wasted resources and unpaid bills.

Proposed solution: Individual EOBs for each service should be universally replaced with a monthly health statement. The statement would combine all health care activity and explain clearly to patients which elements their employer/insurer was responsible for. Even better, a truly modern health system would have consumers receiving their statements electronically through a secure health plan portal, reducing the number of mailings to members – saving postage, processing, and paper – as well as time spent clarifying the meaning of mailed EOBs by customer service representatives. That is what UnitedHealth Group already does to the extent permitted by state law – and that is the approach that should be universally available across the health care system.

Estimated cost savings: Migrating individual paper EOBs to monthly paper statements would save $9.6 billion over the next 10 years. By moving to online statements, an additional $4.8 billion would be saved for a total savings of $14.4 billion. Further savings (which have not been quantified in these estimates) would result from reduced calls among patients, care providers and payers.

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Option 4 Eliminate paper checks and Paper Remittance Advice in favor of electronic funds transfer and electronic remittance advice.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	1.5	1.8	2.2	2.5	8.0	21.7
Provider	0.0	6.1	7.3	8.6	10.0	32.0	86.9
Total	**0.0**	**7.6**	**9.1**	**10.8**	**12.5**	**40.0**	**108.6**

Current system: When health care providers treat patients, they submit claims by manual and electronic means to health plans or other payers for payment. The plans then adjudicate the claims and send payments (usually checks), and remittance advices (printed and mailed) to the providers. Providers then reconcile payments, assess patient responsibility and bill patients. McKinsey estimates that doctors and other health care providers spend $100 billion or more on the laborious process of managing claims submissions. UnitedHealth Group's OptumHealth 2008 survey of physician practices found that 20 percent of physicians were submitting all claims electronically, 6 percent were receiving all remittance advices electronically and only 3 percent were receiving all payments electronically. Larger numbers of physicians were using a combination of paper-based and electronic systems: 68 percent for submitting claims, 57 percent for receiving remittance advices and 47 percent for receiving payments. When asked what prevented them from fuller adoption of electronic claims processing and payment, those surveyed cited physicians' preference and the lack of a reliable, easy-to-use system that encompassed all payers.

Proposed solution: Providers should be required to receive both claims payments and remittance advices electronically, eliminating millions of dollars in printing and postage costs and improving efficiency with bundled payments deposited directly into providers' bank accounts. Providers' administrative staff could then access Electronic Remittance Advice (ERAs) through an online system that lets them view, print and/or download ERAs into their own practice management system. The technology for this solution exists today. UnitedHealth Group's commercial business already delivers 55 percent of claims payments and remittances electronically to more than 400,000 health care professionals nationwide. The largest electronic claims payment systems include Emdeon, Payformance and OptumHealth Electronic Payments and Statements (EPS).

Estimated cost savings: Mandating electronic payment adoption so that it increases from 40 percent to 90 percent by 2019 could save the U.S. health care system an estimated $109 billion over the next 10 years.

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Option 5 Implement multi-payer transactional capability on PMIS systems.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.1	0.2	0.3	0.3	0.4	1.2	3.2
Provider	0.6	1.2	2.7	2.8	2.8	10.1	26.2
Total	**0.7**	**1.4**	**3.0**	**3.1**	**3.2**	**11.3**	**29.4**

Current system: Most Practice Management Information Systems already allow the creation of basic claims formats, and many have the ability to post what is known as a "standard 835 transaction." Some also have the ability to handle so-called 270/271, 276/277 and other standard HIPAA transactions. But most of these systems do not have the ability to handle the multitude of payer specific requirements ("companion guides"). Indeed, some older systems do not have the ability to generate a HIPAA-compliant version of these transactions. These limitations mean that providers often use an intermediary clearinghouse to gain access to all payers. These clearinghouses also provide varying degrees of format translation, HIPAA validation, and claims editing services to help providers with compliance and reimbursement. Since no single clearinghouse provides a full "all payer" connectivity, each clearinghouse "trades" connectivity with other clearinghouses to create a network that enables all payers to be reached. In this piecemeal system, a single claim may traverse three or more "hops" each with its own edits before reaching the payer. In addition to the direct cost associated with this process, a "claims failure" may happen at any point in this chain of custody, with limited visibility as to where denials may have occurred and the rationale for those denials. Likewise, the payer cannot be assured that the information received has not been inappropriately modified in some way by one of the intermediary steps.

Proposed solution: If all of the variation arising from individual payers' requirements were eliminated, direct provider PMIS to payer connectivity would be possible (although some form of intermediary clearinghouse might still be needed for production control, validation, customer services and updating of health plan and provider connectivity). The resulting system would have far fewer clearinghouses and would support a few super-regional hub gateways (potentially as part of the NHIN) that aggregate payer connectivity and that provide gateways to direct provider connectivity or local geographic aggregator exchanges (HIEs). These gateways would handle the full range of electronic connectivity for payers and could, in addition to providing administrative and financial functions, also provide clinical connectivity and analytics. Combining administrative and clinical functions would result in vibrant regional health information exchanges. In order to realize this potential, government should promote this approach by:

- Supporting national standards and specifications for regional gateways
- Setting a timetable for implementation of clinical, administrative, analytics, and financial modules
- Rolling-out and enforcing a single, non-variable format for all administrative transactions
- Providing the national regulatory infrastructure for privacy and security for the whole health care system.

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Option 5 (Cont.)

Regional Gateway Functions

- **Clinical transactions**
  - Electronic health records
  - Labs results
  - Pharmacy
  - Clinical summary
  - Personal health records
- **Administrative transactions**
  - Real time adjudication/integrated payer rules
  - Claims eligibility, coverage, status

Quality and analytics
- Integrated clinical and administrative data
- Common provider measurements & processes

Financial transactions
- Electronic funds transfers
- Statement remittances

Estimated cost savings: Implementing a technology gateway by 2012 results in an estimated $29 billion in savings by 2019. Using data from the California Office of Statewide Health Planning and Development (OSHPD) and the recent Casalino study, we estimate that the total internal administrative costs for provider interactions related to claims transaction and payment is around $60 billion per year. Full standardization and common exchange pathways would lower the cost of these interactions and associated technology, billing and clearinghouse costs, which total an additional $9 to $12 billion a year.

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Option 6 Expand use of Electronic Data Interchange for claims, eligibility and coverage verification, notification/administration and claims status.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.1	0.6	2.0	2.7	2.9	8.4	24.9
Provider	0.0	0.2	0.5	0.7	0.7	2.1	6.2
Total	**0.1**	**0.8**	**2.5**	**3.4**	**3.6**	**10.5**	**31.1**

Proposed solution: In addition to the use of smart cards (Option 2) and EFT and ERA (Option 4), providers could also adopt EDI for claims status checking (276/277) and other eligibility verification outside scheduling and registration processes for coverage verification.

Estimated cost savings: Advancing the use of EDI on a staged basis through 2012 results in $31 billion in savings over 10 years.

The savings rates associated with each transaction type vary, however, it is generally accepted that a blended savings rate of $2.20-$2.30 accrues to the system for the use of each electronic transaction. This ranges from about $1 per claim, $2.50 per eligibility check, more than $10 for some referrals and $50 or more for processing a denied, appealed claim. Net of the savings that have already been captured in Options 2 and 4, we estimate that 95 percent adoption for EDI for all eligibility checking and claims status checking would yield an additional savings of $31 billion over 10 years.

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Option 7 Integrate PMIS and payer administrative systems, minimizing the need for clearinghouses.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.1	0.1	0.1	0.1	0.5	1.3
Provider	0.3	0.5	0.9	1.0	1.0	3.7	9.4
Total	**0.3**	**0.5**	**1.1**	**1.1**	**1.2**	**4.2**	**10.7**

Current system: The majority of practice management information systems currently do not connect directly to payer adjudication systems, as a result of payer-specific variations. Instead, claims are usually transmitted through clearinghouses and other intermediaries and may traverse three or more "hops" prior to reaching their final destination.

Proposed solution: If all payer-specific variations were removed from the health care system, direct PMIS-payer connectivity could be achieved through a "pure technology" intermediary that correctly identifies appropriate counterparties for claims transmissions and which is continually updated to reflect new counterparty connections. Alternatively, both providers and payers could adopt ASP-based adjudication and POMIS systems. This solution reflects a stripped down version of Option 8 without the full benefits of the value-add that could exist within "technology gateways."

Estimated cost savings: The savings in this option are over and above those detailed in Option 5. Increasing integration between payer and care provider systems could result in an estimated $11 billion in savings over 10 years. Savings from reductions in manual transactions are mostly reflected in other sections of this Working Paper. However, the incremental impact of reducing the need for intermediaries is estimated at $0.75 billion to 1.25 billion annually, based on a $1.5 billion to $2 billion market spend on clearinghouses minus the impact of Option 5.

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Option 8 Integrate essential elements of electronic medical records and personal health records and promote information sharing and use of data to improve prevention and coordination of care.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.0	0.3	0.7	1.0	2.0	9.9
Provider	0.0	0.0	0.1	0.2	0.3	0.7	3.3
Total	**0.0**	**0.0**	**0.4**	**0.9**	**1.4**	**2.7**	**13.2**
Medical, non additive	*0.0*	*0.0*	*3.2*	*6.7*	*10.5*	*20.4*	*101.9*

Current system: The nation's health care system currently lacks critical information-sharing between patients, hospitals and doctors, and payers. Too often, even where they have been adopted, Electronic Medical Records (EMRs) do not integrate with Personal Health Records (PHRs). Arguably the most complete longitudinal and usable records of care reside within payer databases – particularly those capable of episode treatment aggregation, integrated PHR display and national population surveillance, like those found at UnitedHealth Group.

Proposed solution: To make health care truly interoperable, the capabilities of EMRs need to be integrated with the PHRs. The best source for these PHRs are those that validate the underlying activity through to claims payment, and which therefore reside with the payer. However, these PHRs do not currently contain the critical information to ensure proper follow-up by patients and their various care providers, that can only be supplied by the care provider, including Rx orders, lab values, care plans and referrals, all of which largely go unmonitored. UnitedHealth Group has developed a national system which is updated daily with individual patient data and then prioritizes the patient's health care needs each night, for outreach by over 12,500 of our clinicians and other support staff, who ensure any missing care is provided in a timely manner. This helps patients keep medications refilled, ensures that tests are administered at proper intervals, wellness routines and education are properly supported and evidence-based medicine guidelines are followed. These activities form a vital care coordination function that is not universally available across the health care delivery system.

Estimated cost savings: If implementation of this solution is phased-in between 2012 and 2014, administrative cost savings over the next decade are estimated at $13 billion. We expect an additional $102 billion in medical cost savings would be associated with this solution.Because this option relies in part on the adoption of EMRs, the full benefits of the program would take some time to achieve. However, we regard this as feasible given that UnitedHealth Group, for example, already has the capacity to administer a national surveillance system. It would need little time to fully aggregate all payer data and EMR outputs to achieve the full potential benefits of this option.

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Option 9 Use predictive modeling to pre-score claims for COB, upcoding, subrogation, fraud and medical management prior to payment.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	2.1	4.5	4.8	5.1	16.4	47.4
Provider	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**0.0**	**2.1**	**4.5**	**4.8**	**5.1**	**16.4**	**47.4**
Medical, non additive							
Commercial	*0.0*	*10.9*	*23.4*	*25.0*	*26.5*	*85.8*	*248.4*
Government	*0.0*	*6.2*	*10.0*	*10.8*	*11.6*	*38.6*	*113.3*

Current system: The FBI's financial crimes report in 2007 estimated that somewhere between 3 percent to 10 percent of total health care spend is attributable to fraud, overpayments, coordination of benefits and subrogation errors. This means that up to $260 billion a year in associated costs are due to health care fraud. According to the National Health Care Anti-Fraud Association, approximately 70 percent of payers currently employ some form of anti-fraud system mostly following a "pay and chase" methodology – that is, they attempt to correct the problem after it has occurred.

Proposed solution: A national predictive model pre-scoring service would actively monitor and flag claims prior to payment, leading to a more robust real time adjudication process for most payments. This service, coupled with the establishment of a national payment accuracy clearinghouse (Option 10), would reduce the instances of mispayment and administrative friction between payers and providers.

Estimated cost savings: UnitedHealth Group's experience suggests that savings are obtainable of between 2 percent and 7 percent (depending on the type of health service) for employer-sponsored and the Medicare and Medicaid programs, net of associated contingency and recovery costs. Applying these figures nationally, we estimate that implementing payment accuracy-related predictive modeling, in combination with the Payment Accuracy clearinghouse (discussed as Option 10), has the potential to reduce administrative costs associated with inappropriate medical payments over the next decade by $47 billion. In addition, as the health care system becomes better at detecting fraud, waste and abuse, the incidence of fraud is likely to decline.

We also anticipate that medical costs related to overpayments could be reduced by an estimated $362 billion over the same period.

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Option 10 Create a national payment accuracy clearinghouse to settle under-payments and over-payments.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	1.0	2.1	2.2	2.2	7.5	20.3
Provider	0.0	1.0	2.1	2.2	2.3	7.6	20.4
Total	**0.0**	**2.0**	**4.2**	**4.4**	**4.5**	**15.1**	**40.7**

Current system: Processing over/under payments is a costly and time consuming process marked by a high degree of manual intervention and investigation, but with varying degrees of effectiveness.

Proposed solution: Deploy a national, third party clearinghouse to audit and ensure correct payments. If combined with adoption of a single, non-variable format for all transactions, the added transparency would make contract compliance much easier for both providers and payers. This would mean payers and providers shared a common platform to address payment errors and settle credit balances, allowing for inventory management, electronic settlement and reporting and audit. This shared utility would still permit appropriate analysis of payment data and data mining – either by the clearinghouse itself or the individual payers.

Estimated cost savings: Implementation of a national payment accuracy clearinghouse could result in $41 billion in savings over 10 years. We estimate that a 20 percent to 30 percent reduction in spending by hospitals, physicians and payers on collections and claims management can be achieved through such a national payment accuracy clearinghouse, as a result of centralized credit resolution, reductions in the number of payer-provider interactions needed to resolve a claim, and pre-and post- tracking of outstanding credit resolution balances. This equates to potential savings on the provider side of $1.5 billion to $2 billion of administrative cost, and for payers, savings of $2 billion to $3 billion. (Note: the estimated value of reducing mis-payments has already been captured in Option 9.)

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Option 11 Eliminate multiple payer credentialing and separate hospital privileging. Develop industry utility for credentialing.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.6	0.6	0.7	0.7	2.6	7.1
Provider	0.0	1.0	1.1	1.1	1.1	4.3	10.5
Total	**0.0**	**1.6**	**1.7**	**1.8**	**1.8**	**6.9**	**17.6**

Current system: Health plans typically have their own unique credentialing requirements for participating physicians and hospitals. Providers often need to apply for accreditation from each insurer separately. For hospitals, this process can cost up to $60,000 per application. In addition, physicians are subjected to various hospital privileging processes using varied criteria.

Proposed solution: Using a single standardized process for accreditation and licensing nationwide would reduce costs for physicians and hospitals without compromising quality. The government could facilitate this process by creating an antitrust safe harbor allowing hospitals and health plans to agree on common rules and standards. An industry program would then be developed and deployed for provider credentialing.

Estimated cost savings: Implementing a single credentialing and hospital privileging process used by all payers could result in $18 billion in savings over 10 years. As part of that overall estimate, we estimate that standardizing credentialing and licensure requirements could reduce care provider administrative costs by about a billion dollars per year with savings of $10.5 billion over 10 years.

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Option 12 Adopt common quality designation standards and create single health information database for quality determination.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.1	0.1	0.1	0.1	0.1	0.5	1.1
Provider	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.5**	**1.1**

Current system: While progress has been made in standardizing physician performance measurement, significant variability in this activity remains across the health care system. Physicians are often measured by multiple parties using different measures and methodologies. In addition, the underlying data necessary for performing measurement is suboptimally coordinated across providers, facilities, and health plans, which often presents challenges for the data aggregation necessary for statistically significant analyses. The end result is suboptimal quality of care, which results in inefficient and wasteful use of health care assets.

Proposed solution: Accelerate the adoption of industry-wide rules and systems for data aggregation and measurement methodologies. Health plans and Medicare, working collaboratively with physicians, hospitals and other key stakeholders, would agree on the infrastructures and processes necessary to efficiently pool local data across health plans and settings of care. A new independent public/private partnership at the national level would lead and accelerate consistency in the processes necessary to achieve this and ensure uniformity across the country. As a result, physicians would be able to access, correct and utilize their local aggregated data for performance improvement. Researchers and others would have benefit of aggregated data for the purposes of tracking and developing quality improvement interventions.

Regarding performance measures themselves, and the methodologies underlying the process of performance measurement, there currently exists a useful infrastructure upon which to build. The recent infusion of federal dollars into the National Quality Forum provides the essential oversight and endorsement of proposed measures' scientific accuracy based upon best available evidence. The AMA's Performance Consortium for Performance Improvement provides a forum for expert physicians, and their specialty societies, to develop and test specialty-specific measures, but requires augmented financial support. Finally, specialty societies themselves require augmented support to accelerate closing the essential link in the translation of science into specific clinical guidance that serves as the foundation for performance measure development. Special attention needs to be devoted to advancing "episodes of care" and other analytic techniques for cost and utilization measurement.

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Some abbreviations used in this report

ASP – Average Sales Price.

COB – Coordination of Benefits.

CORE – Committee on Operating Rules for Information Exchange. The Council for Affordable Quality Healthcare (CAQH) launched CORE with the vision of giving providers access to eligibility and benefits information before or at the time of service, using the electronic system of their choice, for any patient or health plan.

EDI – Electronic Data Interchange refers to the structured transmission of data between organizations by electronic means.

EOP – Explanation of Payment.

ERA – Electronic Remittance Advice is the electronic equivalent of the Explanation of Payment. An ERA provides details on how claims were paid and/or why they were denied.

HIE – Health Information Exchange.

HIPPA – The Health Insurance Portability and Accountability Act. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, require the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers to help people keep their information private.

NHIN – Nationwide Health Information Network.

PHI – Personal Health Information.

PMIS – Practice Management Information System.

POMIS – Physicians Office Management and Medical Information Systems.

PRA – Paper Remittance Advice. Same as Explanation of Payment (EOP).

WEDI – Workgroup for Electronic Data Interchange.

X12 – The Accredited Standards Committee (ASC) X12 develops electronic data interchange (EDI) standards and related documents for national and global markets.

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About the UnitedHealth Center for Health Reform & Modernization

UnitedHealth's new Center serves as a focal point for work on health care modernization and national health reform. The Center assesses and develops innovative policies and practical solutions for the health care challenges facing the nation. Drawing on UnitedHealth Group's internal expertise and extensive external partnerships, our initial work program falls into six priority areas:

1. Practical cost containment strategies to slow the growth of U.S. health care costs
2. Payment reform strategies that better support physicians, hospitals and other providers in delivering high quality patient-centered care
3. Reducing health disparities, particularly in underserved communities
4. Innovative approaches to universal coverage and health benefits, grounded in evidence-based care and consumer engagement
5. Modernizing the care delivery system, including strengthening primary care
6. Modernizing Medicare, including chronic disease management and end-of-life care

For more information, see **www.unitedhealthgroup.com/reform**

About UnitedHealth Group

UnitedHealth Group serves 70 million Americans, funding and arranging health care on behalf of individuals, employers and government, in partnership with more than 5,000 hospitals and 650,000 physicians, nurses and other health professionals across the nation. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan – serving one in five seniors nationwide – and the largest Medicaid health plan, supporting underserved communities in 22 states and the District of Columbia.

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UnitedHealth Center for Health Reform & Modernization

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EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

Majority (202) 225-5051
Minority (202) 225-5074

October 22, 2009

Mr. James Bloem
Senior Vice President, Chief Financial Officer and Treasurer
Humana Incorporated
500 West Main Street
Louisville, Kentucky 40202

Dear Mr. Bloem:

To complete the record of your testimony before the Domestic Policy Subcommittee on September 17, 2009, a number of members make the following requests for information in writing:

1) In 2005, Humana settled claims for alleged improper conduct, including, but not limited to, misrepresenting and/or failing to disclose the use of edits to unilaterally "bundle," "downcode" and/or reject claims for medically necessary covered services, failing to recognize CPTO modifiers, and concealing and/or misrepresenting the use of improper guidelines and criteria to deny, delay, and/or reduce payment for medically necessary covered services.

    a) What did Humana agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by Humana and its subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.

    b) Has Humana settled other claims or state regulatory actions relating to the wrongful delay or denial of claims since 2004? Please include all relevant details. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that were charged by state regulators for any violations of state law.

2) Please provide the subcommittee with the following statistics for 2008: Number of claims Humana received; number of claims paid within 30 days, and the value in dollars to Humana of claims that Humana did not pay within 30 days, 60 days, 90 days, 120 days.

3) Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.

4) Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.

5) Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.

6) Mr. Conyers requested the compensation received by you, including deferred compensation, incentives and bonuses, in the last 5 years.

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Thursday, November 5, 2009.**

If you have any questions regarding this request, please contact Jaron Bourke, Staff Director, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

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Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

Heidi S. Margulis
Senior Vice President
Government Relations

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HUMANA.
Guidance when you need it most

Peter Fise 11/5/09
Stacy Cr 11-5-09

November 5, 2009

VIA HAND DELIVERY

The Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515-6143
Attn: Jason Bourke, Majority Staff Director (B-349B Rayburn House Office Building)
Jean Gosa, Clerk (jean.gosa@mail.house.gov)

Re: Humana Inc. Response to the Committee's October 22, 2009 Request for Supplemental Information

Dear Mr. Chairman:

On behalf of Humana Inc. ("Humana"), I am responding to the Subcommittee's written request of October 22, 2009 for supplemental information relating to the testimony of James H. Bloem, Senior Vice President, Chief Financial Officer and Treasurer of Humana, before the Subcommittee on September 17, 2009. Humana is submitting this information in its continuing spirit of cooperation. Pursuant to the Committee's instructions, the documents submitted in connection with this request for information are bates-stamped for tracking purposes (Bates Nos. HUM-OGR-000001 - HUM-OGR-000542).

Follow-up Question 1: *In 2005, Humana settled claims for alleged improper conduct, including, but not limited to, misrepresenting and/or failing to disclose the use of edits to unilaterally "bundle," "downcode" and/or reject claims for medically necessary covered services, failing to recognize CPTO modifiers, and concealing and/or misrepresenting the use of improper guidelines and criteria to deny, delay, and/or reduce payment for medically necessary covered services.*

a) What did Humana agree to do to settle those claims? Please include dollar amounts, if settlement included a monetary component, as well as all substantive and procedural changes implemented by Humana and its subsidiaries (by name) as part of the settlement or as a result of the claims having been brought.

In 1999, Humana was among the managed care companies involved in a lawsuit that was part of a wave of generally similar actions targeting the health care payer industry. These lawsuits included a lawsuit against us and originally nine of our competitors that was brought on behalf of physicians who treated our members since 1990. The plaintiffs asserted that we and other defendants paid providers incorrectly. These cases were consolidated in the United States District Court for the Southern District of Florida and styled *In re Managed Care Litigation.* In October, 2005, we agreed to settle the matter by payment of $40 million for the physicians and $18 million for the plaintiffs' attorneys. The settlement agreement (the "Agreement"), which included a disclaimer of any wrongdoing by Humana, recognized that Humana had undertaken numerous initiatives to facilitate relationships with, and payments to, physicians and provided for additional undertakings during its four-year term. Five of the other companies involved in the lawsuit entered into similar agreements. The Agreement expired on October 19, 2009. A copy of the Agreement, which has been widely available for several years, is attached hereto as Exhibit A. Section 7 of the Agreement contains a detailed description of the initiatives.

b) *Has Humana settled other claims or state regulatory actions relating to the wrongful delay or denial of claims since 2004? Please include all relevant details. If so, please also provide the Subcommittee with figures on the income and incentives received by executives responsible for operations that we charged by state regulators for any violations of state law.*

Our current and past business practices are subject to review by various state insurance and health care regulatory authorities and other state and federal regulatory authorities on a regular basis. These regulatory authorities regularly scrutinize the business practices of health insurance and benefits companies, focusing on numerous facets of our business, including claims payment practices, competitive practices, commission payments, privacy issues, utilization management practices, and sales practices. Attached as Exhibit B, please find a summary including all relevant details of fines and violations levied against Humana and its subsidiaries relating to any alleged wrongful delay or denial of claims since 2004.

In addition, we also are involved in various other lawsuits that arise in the ordinary course of our business operations, including claims relating to performance of contractual obligations to providers, members and others, including assertions of failure to properly pay claims. We have resolved matters involving state laws requiring interest payments for claims not paid within a limited period of time, and have also settled claims brought by members and providers relating to asserted claims payment issues. In addition, pursuant to the Agreement referenced in response to Question 1.a., we agreed for a four-year period to pay interest on all claims not paid within the time periods referenced in the Agreement. None of these settlements (other than the Agreement referenced above) has been material.

In addition, please note Mr. Bloem's written testimony submitted to the Subcommittee regarding findings from the most recent PayerView rankings, conducted each year by athenahealth (a physician revenue management company). These findings are based on that organization's independent statistical analysis derived from more than 17,000 physicians representing $7 billion in billed charges, sent to 172 payers in over 40 states. In addition to ranking Humana and our peer companies, athenahealth also ranks

Medicare Part B, providing an important point of comparison between private health plans and the government-run Medicare Fee-for-Service program. For 2009, Humana ranked first among national payers as "easiest to do business with" for doctors and hospitals. Specifically, athenahealth found Humana to have the lowest "denial rate" among all major payers. In contrast, the government's Medicare Part B ranked fifth. Humana also was ranked as the fastest payer to physicians. Medicare Part B again ranked fifth.

Humana's senior management is ultimately responsible for the operations that were charged by state regulators as detailed in Exhibit B. Please see Humana's Proxy Statements for the years 2006 through 2009, attached hereto as Exhibit C, which set forth the compensation for Humana's top five executive officers for the years 2004 through 2008. In addition, please refer to the section entitled, "*Compensation Discussion and Analysis – Annual Incentives – Management Incentive Plan*" in the Proxy Statements for the years 2007 through 2009, which provides a detailed description of Humana's compensation philosophy, compensation program objectives, and the performance targets used to determine incentive compensation for those years for each named executive officer.

Follow-up Question 2: *Please provide the Subcommittee with the following statistics for 2008: Number of claims Humana received; number of claims paid within 30 days, and the value in dollars to Humana of claims that Humana did not pay within 30 days, 60 days, 90 days, 120 days.*

Humana does not maintain statistics for the concept of claims "paid," because a single claim may include multiple itemized requests for payment, each of which is evaluated during processing for validity and appropriateness under the member's policy. Some of these itemized requests, after processing, may have been returned to the provider for additional information or found to not be within the coverage of the policy. The remaining claims, classified as claims "allowed," are either paid by Humana or applied to the member's deductible or other cost sharing arrangement. In 2008, Humana processed approximately 62.4 million medical claims (excluding pharmacy claims, health care encounters with providers under a capitation arrangement and the company's Puerto Rico operations, which represents a de minimus amount), of which 61.4 million, or 98.46% were processed within 30 days. Of the approximately $17.56 billion in claims processed and allowed in 2008, approximately $16.2 billion, or 92.25%, were processed and allowed within 30 days.

Certain claims information for Humana in 2008 was as follows[1]:

Claims allowed within 30 days.....	92.25%
Claims allowed between 30 and 60 days.....	4.79%
Claims allowed between 60 and 90 days.....	1.15%
Claims allowed between 90 and 120 days.....	0.59%
Claims allowed after 120 days	1.22%

[1] Represents the percentage of claims received in 2008, by dollar value, that were processed and allowed (paid or applied to the member's deductible or other cost sharing arrangement) within the specified number of days from receipt.

As mentioned above, in addition to being ranked first among national payers as "easiest to do business with" for doctors and hospitals in the most recent PayerView rankings conducted by athenahealth, Humana was also ranked as the fastest payer to physicians, with an average of 26.7 days for a practice to get paid by Humana from the date the charge was entered into athenahealth's system.

Humana is required by state "prompt pay" laws to process claims within a certain time frame, usually 30, 45, or 60 days. These laws impose a series of requirements and penalties intended to ensure that health care professionals are paid in a timely fashion. A typical prompt pay law applies to all "clean claims," meaning that the provider properly used our paper claim form or followed the specified electronic billing format, and has completed all the required fields with enough information to allow us to process the claim. Although there are generally exceptions for situations where we cannot make a determination on a claim without additional information (such as whether the member has other insurance), in such circumstances, we are required to request such additional information within a set time frame and process the claim within the required prompt pay period once the information has been provided. If we fail to process claims within the required time period, we are generally required to pay interest to the provider, and may be subject to fines if we routinely fail to pay claims in a timely manner and/or fail to pay interest.

During the September 17 hearing, members of the Subcommittee queried whether insurance companies delay payment of claims in order to take advantage by holding the "float" and earning investment income. Humana does not engage in this practice because it does not make sound business sense for two reasons:

(1) We believe that this practice would adversely impact our relationship with providers, whom we view as valued partners in our business model. Accordingly, we strive to be the fastest and most accurate payor in the industry, and, as mentioned above, have been recognized as such by athenahealth.

(2) Claim payment delays lead to more administrative costs in the form of handling provider inquiries (calls), duplicate claim submissions and rework.

We believe that both of these issues more than outweigh any potential financial gain from trying to take advantage of the "float" for purposes of earning additional investment income.

Follow-up Question 3: *Mr. Cummings asked that your company provide the Subcommittee with audiotapes of, and materials prepared for or about, internal meetings, known in some companies as "town hall meetings," in which financial results, particularly the Medical Loss Ratio, are discussed with employees.*

Although Humana does not hold "town hall meetings," Michael B. McCallister, the company's Chief Executive Officer, does hold semi-annual meetings to update employees on strategic and other matters. These meetings did not include a discussion of the company's medical loss ratio. However, for your information, we have enclosed as Exhibit D copies of the presentations for such meetings held on

December 3, 2008 and May 12, 2009. Please note that this portion of the submission has been marked "Confidential and Proprietary," as it includes sensitive, confidential and proprietary information, the public disclosure of which would be wrong and unethical and harmful to Humana's competitiveness in its markets. We urge you to ensure that such information is not disseminated.

Follow-up Question 4: *Mr. Schock asked what percent of reimbursed care is defensive medicine performed out of physician concerns about medical malpractice liability.*

Although Humana does not maintain statistics regarding the use of defensive medicine, or the practice of medicine designed to avert the future possibility of malpractice suit, primarily in order to avoid liability rather than to benefit the patient, it is a subject that we have been aware of for some time. For your information, we have attached two studies that addressed the subject of defensive medicine.

In 2008, the Massachusetts Medical Society conducted a study of Massachusetts physicians and the practice of defensive medicine, one of the first such studies to attempt to quantify defensive practices across a number of medical specialties and link defensive medicine to Medicare cost data. The study found that 83 percent of physicians reported practicing defensive medicine, and that an average of 18 to 28 percent of tests, procedures, referrals and consultations, and 13 percent of hospitalizations, were ordered for defensive reasons. In the study, the Massachusetts Medical Society estimated the cost of such practices to be a minimum of $1.4 billion, but noted that this estimate did not include tests and diagnostic procedures ordered by physicians in other specialties, observation admissions to hospitals, specialty referrals and consultations, or unnecessary prescriptions. Furthermore, the eight specialties surveyed represented only 46 percent of Massachusetts physicians. For your reference, a copy of this study is attached as Exhibit E.

In 2005, researchers from the Harvard School of Public Health and Columbia Law School conducted a joint study of physicians in Pennsylvania to determine the prevalence and characteristics of defensive medicine among physicians practicing in high-liability specialties during a period of substantial instability in the malpractice environment. Out of a total of 824 physicians that completed the survey, nearly all of the physicians (93%) reported practicing defensive medicine. The study found that "assurance behavior," such as ordering tests, performing diagnostic procedures, and referring patients for consultation, was very common (92%). The study also found that avoidance of procedures and patients that were perceived to elevate the probability of litigation was also widespread, and 42 percent of respondents reported taking steps to restrict their practice in the previous 3 years, including eliminating procedures prone to complications, such as trauma surgery, and avoiding patients who had complex medical problems or were perceived as litigious. The study concludes with an analysis of the effects of such defensive and avoidance measures on the cost of, and access to, health care. For your reference, a copy of this study is attached as Exhibit F.

HUMANA.
Guidance when you need it most

Follow-up Question 5: *Mr. Kennedy asked for tangible recommendations for creating metrics with which to evaluate the efficiency of the company's Information Technology with respect to its performance in reducing waste, duplication and redundancy.*

As mentioned in Mr. Bloem's written testimony submitted to the Subcommittee for the September 17, 2009 hearing, through **Availity,** an industry-leading, multi-payer, multiuse electronic medical provider information exchange that Humana co-founded in 2001 with Blue Cross Blue Shield of Florida, we've shown the way to fulfill the President's call for a workable healthcare IT superhighway, with attendant standardization, speed, accuracy, transparency, and significant cost savings. Today, across the country, over 50,000 physicians, 1,000 hospitals, 100 million members, 100,000 employers, 150 direct public/private health plans, 1,150 indirect public/private plans connect and/or access Availity, resulting in 600 million transactions projected this year.

Availity has digitized most of the non-standardized administrative processes. It serves as a claims clearinghouse with real-time transactions in the areas of eligibility and benefits, claims submission and status, remittances, authorizations and referral submission and inquiry. Its CardRead function allows for member ID card processing and its financial solutions include CareCostEstimator, allowing for real-time patient responsibility estimation and CareCollect, which uses a combination of ID card, debit/credit card and check processing. Availity's clinical solutions include the CareProfile, a real-time electronic health record, and CarePrescribe for new, refill and renewal prescriptions.

In terms of streamlined, cost-saving interactions with health plans as well as improved patient safety, a study of doctors who use the Availity CareProfile electronic payer-based health record show a three- to six-minute reduction in patient intake and assessment time, adding critical efficiency to the system while giving physicians critical clinical information about their patients. Providers who use Availity regularly have reduced their phone call interactions with plans by more than ten percent in the first ten months. At a cost of $1.38-$2.70 per call, industry-wide savings can be exponential. And, Availity's CarePrescribe has been shown to reduce preventable adverse drug events by 61 percent.

Finally, the State of Florida's Agency for Health Care Administration uses Availity as a health information exchange and health record with its Medicaid program. In addition, the Commonwealth of Virginia has contracted with Availity for its Virginia Health Exchange Network to develop a public/private portal for the state. America's Health Insurance Plans selected Availity for a multi-payer portal proof-of-concept in Ohio.

In addition to Availty, Humana has leveraged Information Technology to drive electronic transactions and self-service to reduce waste, duplication and redundancy. Today, we have 2 million members registered for MyHumana, our secure portal for member self-service, tools, and access to health and wellness content. These members access MyHumana 500,000 times each month, driving over 1.2

million inquiries and transactions that would otherwise generate phone calls. In addition, 450,000 members have opted to receive explanation of benefits and SmartSummary statements electronically instead of in paper form. Overall, members view over 4 million pages of information each month at no cost.

In addition to those registered through Availity, approximately 1.7 million providers, office administrators, and clinical support and billing professionals are registered on our secure provider portal. The web site complements transactions and information offered through Availity, and generates over 4 million transactions each month.

Our transparency tools engage consumers and facilitate informed healthcare decisions. Our Physician Finder helps members find in-network providers across a variety of specialties, and includes certifications, accreditations and recognition from organization such as the National Committee for Quality Assurance (NCQA), a not-for-profit organization dedicated to improving health care quality. Other tools provide pharmacy locations and drug comparisons, helping members understand potential savings between brand name and generic drugs.

Finally, our clinical alerts software identifies members who may benefit from clinical guidance. We deliver the alerts electronically to customer care specialists handling member phone calls as one way to engage members in clinical programs. Member participation in clinical programs can help reduce medical costs and improve health outcomes.

We believe that widespread adoption of Availty and Humana's other Information Technology initiatives would lead to lower cost across the health care system, and we are working toward that goal. For a detailed presentation of administrative, financial and clinical metrics that Humana has identified to evaluate the efficiency of the company's Information Technology, including Availty, please refer to the attached Exhibit G.

Follow-up Question 6: *Mr. Conyers requested the compensation received by [Mr. Bloem], including deferred compensation, incentives and bonuses, in the last 5 years.*

Please refer to Humana's Proxy Statements for the years 2006 through 2009, attached hereto as Exhibit C, which set forth the compensation received by Mr. Bloem, Humana's Senior Vice President, Chief Financial Officer and Treasurer, for the years 2004 through 2008, including deferred compensation, incentives and bonuses.

HUMANA.
Guidance when you need it most

Let me conclude by noting that Humana's voluntary response was prepared to the best of our abilities to comply with the Committee's requests and deadlines. We reserve the right to supplement and amend these responses as needed.

If you have any questions about the information we have provided in this letter or the enclosures, please let us know.

Sincerely,

Heidi S. Margulis

Enclosures

cc: The Honorable Jim Jordan, Ranking Minority Member (w/enclosure)
Michael B. McCallister, President and Chief Executive Officer, Humana Inc. (w/o encl.)
Christopher M. Todoroff, Senior Vice President and General Counsel, Humana Inc. (w/o encl.)