To Your Health!

Aetna's Proposal for Health Care System Transformation

We want you to know®

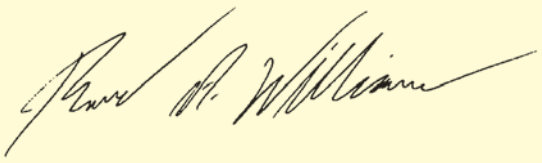
Aetna®

00.02.928.1 (12/08)

I am pleased to share with you ***To Your Health! Aetna's Proposal for Health Care System Transformation***. This proposal presents a framework for health care reform, addressing the interrelated issues of access, cost and quality.

We at Aetna believe that every American should have access to affordable health care that produces quality outcomes and facilitates prevention, wellness and care coordination. This goal is as ambitious as it is vital to the well-being of our nation's citizens. And it is an achievable goal if the private and public sectors work together to build upon the strengths of our current system. It is important that we ensure a vigorous marketplace and an effective public health system while empowering consumers with the information, tools and options necessary for achieving optimal health.

All of us have a stake in the future of our health care system. Aetna is committed to playing a leadership role in transforming the system into one that we and generations to come can be proud of. I encourage you to join us in being a positive force for change.



Ronald A. Williams
Chairman and Chief Executive Officer
Aetna Inc.

The U.S. health care system remains the world's pioneer in research and medical technology, leading treatment breakthroughs that benefit Americans and people across the globe. The presence of first-rate physicians, hospitals, drugs and treatments are due, in large measure, to the competition inherent in our market-based system. While an impressive 85 percent of people in America — over 250 million people — have some form of health insurance, there are also real and severe deficiencies within the U.S. health care system.

The crisis of the uninsured:

There are now nearly 46 million uninsured in the United States, which represents a staggering one in six adults under the age of 65. Over 8 million of these uninsured are children. The uninsured come from a variety of ages, household incomes and work statuses — but they share a common plight. A robust body of research concludes that the uninsured obtain less care, receive fewer preventive services and fail to adhere to recommended treatments. Additionally, tens of billions of dollars are spent each year treating those without health insurance, often in expensive emergency room settings for illnesses or chronic conditions that could have been prevented or treated earlier had they been part of a course of care associated with having health insurance.

Escalating health care costs and affordability problems:

There are many reasons why people are uninsured, but rising health care costs and their attendant effects on affordability of coverage are widely viewed as the fundamental problems. Indeed, the price the nation pays for these problems comes in the form of 46 million uninsured. Health care is expensive — and costs continue to rise at a rapid pace, which is reflected in the form of higher premiums for health insurance. Premium increases are driven primarily by three factors: general inflation, health care price increases in excess of inflation (for example, cost-shifting and higher-priced technologies) and increased utilization (for example, aging population, lifestyle changes and new treatments).[1] These rising premiums, in turn, have made it increasingly difficult for employers to offer coverage to their workers. Today, approximately 63 percent of firms offer health benefits — down from 69 percent as recently as 2000 — which is of concern given the vital role employers play in the health care system. Rising premiums also have made it increasingly difficult for people to purchase coverage. With the average premium for employer-sponsored family coverage now exceeding $12,000, participating in the health insurance marketplace is a financial strain for a growing number of Americans.[2] At the national level, health care now represents more than 16 percent of the gross domestic product, and the traditional funding sources and mechanisms used to support health care cannot keep pace with costs accelerating at approximately twice the rate of inflation.

Pervasive quality problems:

Quality problems in the U.S. health care system came into focus in the late 1990s when the Institute of Medicine documented persistent, systemic shortcomings in quality, including preventable medical errors and widespread overuse, underuse and misuse. Huge gaps exist between the levels of care delivered by health care organizations in different regions and settings. These quality gaps result in 35,000 to 75,000 avoidable deaths each year and between $2.7 billion and $3.7 billion in avoidable medical costs.[3] Numerous studies have found that, overall, American adults receive only about half of recommended care.[4]

What Aetna believes

As one of the oldest and largest insurers in America, we believe Aetna has both an opportunity and an obligation to be a key part of the solution. Our commitment to advancing the public good is engrained in the company's 155-year heritage and is reflected in Aetna's core values of integrity, quality service and value, excellence and accountability, and employee engagement. We believe that being a leader in health care means not only meeting business expectations, but also exercising ethical business principles and social responsibility in everything we do. We also believe that our considerable intellectual resources and experience can be leveraged to build a stronger and more effective health care system — a stance that is embodied by Aetna's leadership on a variety of public policy issues, including racial and ethnic disparities, end-of-life care, genetic testing, price transparency, and health and benefits literacy.

Aetna has been active in both developing and supporting proposals for change. For example, the company played an integral role in creating the comprehensive health care access proposal put forward by America's Health Insurance Plans (AHIP) in November 2006. Titled *A Vision for Reform*, the AHIP proposal articulates a set of policy recommendations aimed at achieving near-universal coverage for all children within three years and adults within ten years. In addition to endorsing this comprehensive access proposal, Aetna was the first national health insurer to publicly announce its support of President Bush's Executive Order on health care transparency and was one of the first Fortune 100 employers to sign the Statement of Support for the *Four Cornerstones of Value-Driven Health Care*.

Aetna's proposal for health care system transformation

Described in the following pages is Aetna's proposal to transform the U.S. health care system. It is intended to serve as a framework for sensible policy action, and reflects Aetna's commitment to being part of the solution and our willingness to serve as a resource in the health care discourse. The ten points highlighted are organized into four pillars, or tenets, for health care reform:

- **Get and keep everyone covered;**
- **Maintain the employer-based system and export its strengths to make the individual market function better;**
- **Reorient the system toward prevention, value and quality of care; and**
- **Use market incentives to improve coverage, drive down costs and make the system more consumer-oriented.**

When considering this proposal, it is important to recognize the considerable interplay between various policy interventions. Aetna believes that health care reform should identify and take advantage of companion solutions. Companion solutions refer to the pairing of complementary public policies. When implemented together, companion solutions result in an outcome that greatly exceeds the impact of any isolated reform component. A good example of a companion solution is the pairing of an individual coverage requirement with both strong enforcement mechanisms and broadly funded subsidies to increase the affordability of coverage for lower-income Americans. Another is coupling reasonable public program expansion with efforts to enroll individuals who are currently eligible but not participating in these programs, as well as implementing targeted tax credits for low- to moderate-income households, which controls against the risk of crowd-out (that is, individuals who would have purchased private coverage choosing to utilize public coverage instead).

Get and keep everyone covered

Point 1: Transform health insurance into a civic responsibility

A person's coverage status has system-wide implications. When individuals keep up their insurance coverage, regardless of their health status, they make insurance more affordable for everyone by contributing to the general pool. Transforming health insurance into a civic responsibility requires viewing insurance as a mechanism for mutual aid, and not just as a means for self-protection. Importantly, there is growing consensus that, without dismantling the entire system, an individual coverage requirement is the only way to achieve universal coverage.[5]

Require all Americans to possess health insurance coverage — an individual coverage requirement — as a common-sense approach for achieving universal coverage through universal participation.

Between 2000 and 2006, 165,000 people, including 27,000 in 2006, died simply because they lacked health insurance.[6] In 2005, the average family premium for employer-sponsored insurance included an extra $922 as a result of uncompensated care for the uninsured.[7] Under a system of shared responsibility, those who can afford coverage could no longer shift the risks and costs of remaining uninsured onto others. Moreover, the risk profile of the overall health insurance pool would be improved with the addition of young, healthy Americans who currently comprise a substantial proportion of the uninsured population (for example, 18 million of the 46 million uninsured are between the ages of 18 and 34).[8]

Aetna was the first national insurer to endorse the concept of an individual coverage requirement, recognizing that universal coverage is possible only when there is universal participation.[9] Qualifying coverage could, for example, take the form of a basic and essential product that includes preventive coverage. Enforcement of the requirement should be phased into the tax system; for instance, eligibility for the personal tax exemption and/or child tax credit could be conditioned upon proof of coverage.

Pair an individual coverage requirement with government assistance for low-income Americans who are ineligible for public programs to enter the health insurance marketplace.

Today, 28 million uninsured people — nearly two-thirds of the uninsured — come from households with incomes under $50,000 a year, and about 13 million of these individuals come from households with incomes under $25,000 per year. Many of these individuals (for example, childless adults) do not qualify for public coverage, yet they need a helping hand.

Aetna supports targeted public subsidies for certain low-income individuals and families in the form of advanceable, refundable tax credits to help finance the purchase of private health insurance coverage. Subsidies should be structured on a sliding scale, so that individuals and families with lower household incomes would receive proportionately greater assistance than those with higher incomes.

Create or improve broadly funded safety net programs, such as reinsurance mechanisms or state high-risk pools, to ensure that the most vulnerable Americans have health insurance. Public-private collaboration is critical to the success of these safety nets.

The distribution of the nation's health care spending is highly skewed, with the top 5 percent of the population with the highest expenditures accounting for about half of all health care spending.[10] The elevated risk of high-cost individuals yields high premiums *for them* in medically underwritten markets, while their high costs yield higher premiums *for all* in guaranteed issue markets.

Aetna believes a strong safety net is one of the most vital factors in increasing the affordability of insurance while still ensuring the health and financial security of the nation's least healthy citizens. Two risk-transfer mechanisms — high-risk pools and public reinsurance — operate by separating the costs of particularly high-cost enrollees from the rest of an insurance market. They aim to stabilize insurance markets and increase premium affordability; increase coverage availability for the uninsured; and provide affordable options for high-risk individuals who would otherwise be unable to secure coverage. The future success of either mechanism depends on sufficient public funding and the design of program incentives and structure.

Point 2: Strengthen public programs and the safety net for those most in need

Almost 68 percent of U.S. residents access their insurance through the private market. While large segments of the uninsured should be able to access coverage through this market (for example, those uninsured with household incomes above a reasonable threshold), there are also segments of the uninsured population for whom the private sector cannot respond adequately. For them, strengthened public programs and a robust safety net are critical features of health care reform.

Strengthen public programs to ensure certain populations have access to quality health care. The federal government should expand State Children's Health Insurance Program (SCHIP) funding to ensure all states can, at a minimum, fully cover children from low-income households. Medicaid eligibility should be expanded to cover all adults up to 100 percent of the Federal Poverty Level, including single adults. Public programs should not, however, displace those who would otherwise participate in the private health insurance marketplace.

About 83 million Americans receive government coverage for health care,[11] and Medicaid and SCHIP, in particular, provide a pathway to insurance for low-income Americans for whom affordability challenges make it difficult to obtain coverage in the private market. At present, however, Medicaid and SCHIP reach fewer people than needed, as many individuals who are unable to afford private coverage are also ineligible for public programs.

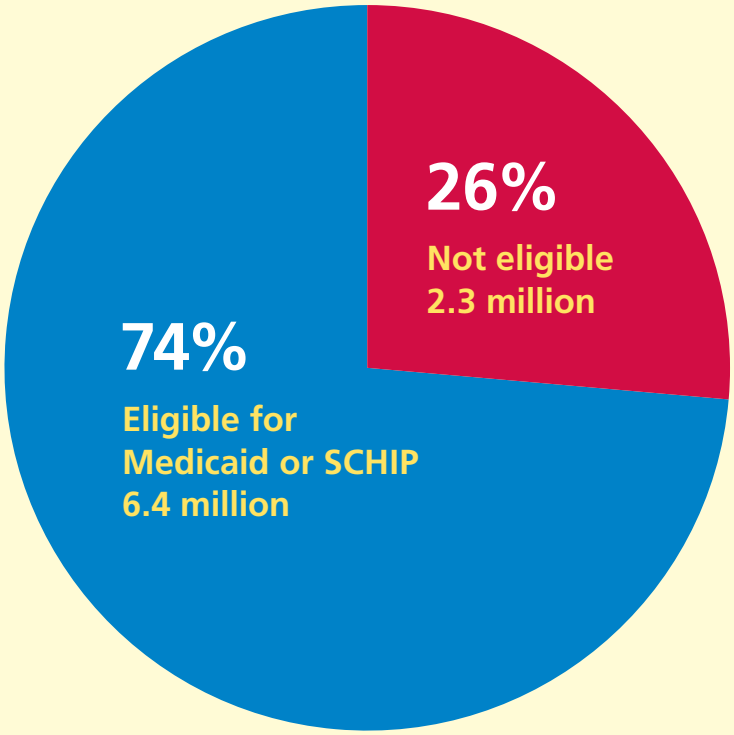
Aetna believes Medicaid should be expanded to cover all low-income adults up to a minimum of 100 percent of the Federal Poverty Level, regardless of parental status. SCHIP should also be expanded to cover, at a minimum, all children up to 200 percent of the Federal Poverty Level, while bearing in mind the importance of preventing crowd-out (that is, people who can afford private coverage avoid purchasing it because of public coverage availability). At the same time, it is critical to address the problem of the 11 million uninsured people who are eligible for public programs but not enrolled in them, by using outreach and auto-enrollment programs to facilitate continuous coverage.[12]

Health insurers, the federal and state governments, and employers should come together to explore new ways of working together to ensure no American lacks affordable health insurance options.

Many of the challenges associated with designing a strong safety net rest in funding, and various stakeholders need to come together to address this challenge. There are many creative possibilities that should be explored, including the potential creation of a Federal Catastrophic Health Cost Grants program to defray or cover the costs of extremely expensive cases.

Distribution of uninsured children by eligibility for Medicaid/SCHIP

Total uninsured children in 2006: 8.7 million



Source: John Holahan, Allison Cook, and Lisa Dubay. "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, February 2007; U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2006." Issued August 2007.

Maintain the employer-based system and export its strengths to make the individual market function better

Point 3: Leverage the strengths of the current health care system, which already covers nearly 85 percent of the U.S. population, to advance the goal of achieving universal coverage

Nearly 85 percent of people living in the United States have health insurance.[13] Among those with health insurance coverage, more than 177 million — or 60 percent of the entire U.S. population — receive coverage through an employer. While shortcomings in the current system have left 46 million people without health insurance,[14] Aetna believes the nation must build upon the current system's successes to fill this unacceptable gap and ensure universal coverage.

Encourage public-private coordination and collaboration. It is imperative that government and the private sector work together to expand access, increase affordability and improve quality. A competitive marketplace and a strong public health system are not mutually exclusive.

The country's uninsured population is heterogeneous, which means there is no single solution for getting them covered. For example, uninsured individuals from households above a moderate income threshold would likely be better served by a private solution, while those coming from lower-income households would undoubtedly benefit from enrollment in a public program.

Aetna believes that the public and private sectors must share responsibility for closing the coverage gap on both ends of the financial spectrum. On the public side, expansion of public programs to include a larger set of low-income individuals — for example, up to a standard of at least 200 percent of the Federal Poverty Level — would offer access to uninsured persons with limited financial means to purchase coverage on their own. At the same time, it is important to ensure those who can afford to purchase coverage take advantage of private sector solutions now available.

The private sector can also play a vital role in expanding access by developing affordable and diverse coverage options. Creating insurance products that appeal to the needs and financial capabilities of those with household incomes over 200 percent to 300 percent of the Federal Poverty Level would enable this segment to secure their own coverage, especially when coupled with an individual coverage requirement and targeted subsidies. Expanding public-private collaboration also involves private sector administration of government programs. Examples of such collaboration include Medicaid, Medicare Part D and Medicare Advantage — programs in which Aetna participates.

Continue to support the existing employer-based system, which is responsible for covering 60 percent of the non-elderly population in the United States (177 million people). At the same time, support policies that promote affordable health insurance options for individuals and small employers not participating in the employer-based system.

The employer-based system provides not only a medium for coverage of American workers and their families, but also added value in the form of diverse risk pools, administrative savings and actual dollars. Employers' premium contributions totaled $420 billion in 2005.[15] In 2008, employer contributions covered 84 percent and 73 percent of premium costs for singles and families, respectively.[16] Administrative overhead for group coverage rests at 10 percent, significantly lower than administrative costs in the individual market,[17] and these savings are passed on to consumers as well. Finally, because employee groups are diversified in terms of risk, no workers are declined coverage because of health status or age.[18]

Aetna also believes it is critical to expand opportunities for lower-wage workers and employees of small firms. Only 49 percent of the smallest firms offer their employees insurance options,[19] and of those employees not offered coverage, 45 percent are uninsured.[20] Enhanced opportunities for these workers could come in the form of pooling structures for small businesses, consumer-directed health plans, mandate-lite products and tax incentives.

Point 4: Use the tax system to expand access and increase affordability

The tax system in the United States offers incentives to stimulate various behaviors, including charitable giving, home ownership and even employer provision of health benefits. Although 26 million people purchase private insurance coverage directly — outside of the purview of the employer-based system — there are few incentives designed to give tax relief to these individuals, as well as to the many uninsured who could potentially purchase insurance in this market.[21] Aetna believes the tax system should play a vital role in advancing efforts to achieve universal health insurance coverage by making coverage affordable for more Americans.

Equalize the tax treatment of health insurance for those who obtain coverage through their employer and those who purchase it directly in the individual market by extending favorable tax treatment to both sets of individuals, without changing the favorable tax treatment employers currently receive for offering benefits.

Currently, health insurance-related tax benefits exist almost exclusively within the employer-based system, with both employees and employers paying premiums with pretax income.[22] Using these pretax dollars, many employees purchase benefits that are more generous than they need, distorting the system and raising overall costs.[23] Such tax benefits are not readily available for those who are limited to purchasing insurance on the individual market. This not only burdens individuals already within this market, but also produces a market that is smaller than it could be if tax incentives for purchasing insurance existed.

Aetna believes that individuals should be able to use pretax dollars to purchase coverage. Favorable tax treatment (for example, tax credits) for health insurance expenditures can serve as a strong incentive for insurance purchase. In fact, tax changes could result in a net increase of 3 million to 9.2 million insured individuals.[24] Such an increase would expand the size of the market and reduce the ranks of the uninsured, ultimately lowering premiums for everyone.

Create tax-based incentives for employers — especially small firms — to offer or continue offering health benefits to their employees in order to preserve and strengthen the employer-based system. Employers should be encouraged to offer, at a minimum, Section 125 cafeteria plans.

Relative to small employers, large employers enjoy various benefits by virtue of their size, including the ability to maintain a large risk pool, the option to self-insure (through ERISA), and the organizational capacity to research and select the best insurance options for their employees. The effective tax benefit for large employers providing health insurance is much greater than that enjoyed by small employers, making it unsurprising that only 62 percent of small firms (3–199 workers) and 49 percent of the nation's smallest firms (3–9 workers) offer health insurance coverage to their employees, as compared to 99 percent of large employers (200+ workers).[25]

Aetna believes the tax system should encourage small employers to offer health benefits to their workers by providing tax deductions to employers who offer such benefits. States could provide, for example, a tax credit to employers to help pay for a portion of their employees' premiums or give premium subsidies to employers offering

employer-sponsored coverage. At the very least, employers should be encouraged to provide Section 125 cafeteria plans so that employees of small firms may purchase health insurance on a pretax basis.

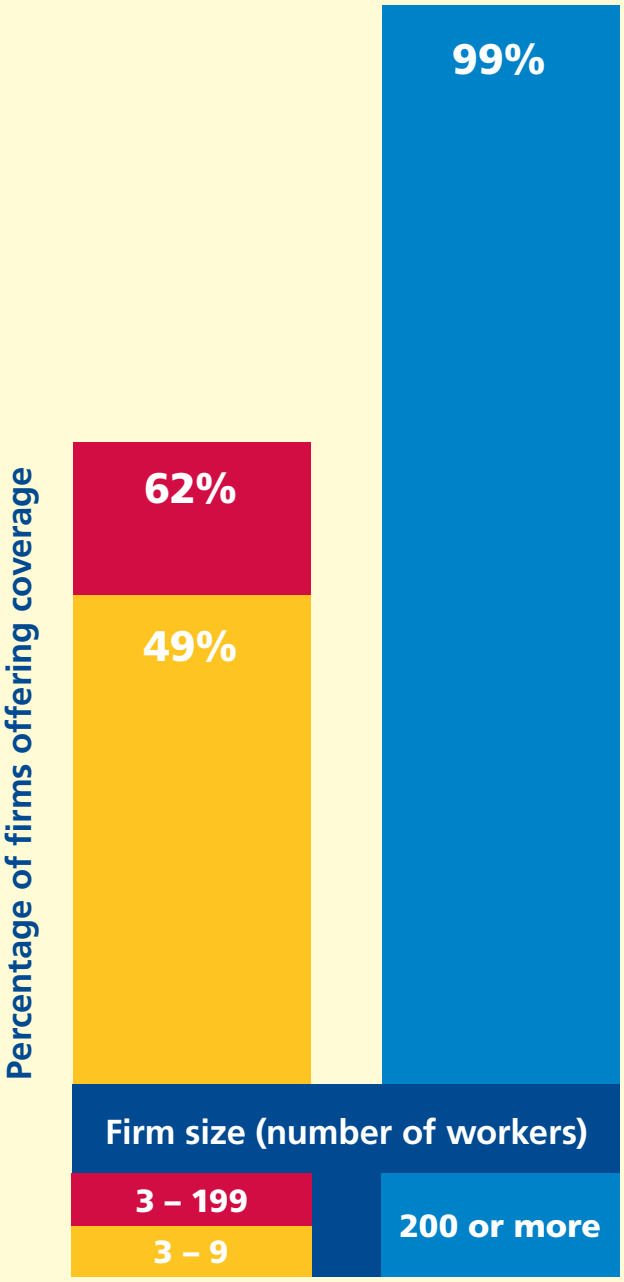
Use tax credits as a tool to encourage and enable target populations (e.g., lower-income adults and children) to enter the health insurance marketplace. Tax credits should be administered on a sliding scale according to income and should be broadly financed.

The tax system is an important vehicle for facilitating the entrance of individuals into the insurance marketplace. Targeted tax credits for individuals to purchase coverage could have a significant impact on the rate of uninsurance. Unlike tax deductions, which are increasingly beneficial as an individual's income increases, a tax credit can be administered in a progressive — as opposed to regressive — manner, using a sliding scale according to household income.

Aetna believes tax credits should be *advanceable* (that is, available before tax filing) so that individuals can actually use the credit to purchase insurance, and *refundable*, allowing individuals to receive the full amount of the credit, even if it is greater than what they owe in taxes. It is projected that tax credits, depending on their design, could reduce the number of uninsured children by 1.3 million, thereby covering half of the 2.7 million uninsured children currently eligible for but not enrolled in a public program.[26] Careful design of a tax credit program is vital, as both the size and administration of tax credits can have a substantial impact on their ability to reduce uninsurance.

Percentage of firms offering health benefits by firm size, 2008

Only 13 states offer tax credits or deductions for small employers.



Sources: Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employer Health Benefits: 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008. Accessed online: **http://ehbs.kff.org/images/abstract/7791.pdf**; Kaiser Family Foundation, **http://statehealthfacts.org**.

Point 5: Promote greater portability of health insurance

There is an important opportunity to enhance health insurance coverage through expanded portability. While 60 percent of Americans are insured through the employer-based system, the limited availability and affordability of portable insurance options makes it challenging for workers to maintain and finance insurance coverage in between jobs.[27] And yet, the average American worker will have 10 to 12 jobs over the course of a lifetime. Many of these workers are challenged to find new sources of coverage, which can be both costly and frustrating. College graduates and early retirees also experience similar challenges. Fears about losing insurance, being unable to pay for health care, and the inability to secure coverage for pre-existing conditions deter people from making necessary job changes and decrease confidence in the health care system.

Facilitate the growth of consumer-directed health plans with Health Savings Accounts, which allow people to save for future medical needs by investing in tax-favored accounts that are portable. Consumer-directed health plans should include first-dollar coverage for the most common chronic conditions to ensure people benefit from disease management and care coordination.

Health Savings Accounts (HSAs) offer people a unique opportunity to make a portable and long-term investment in their future health. HSA plans include three major components: a portable savings account, high-deductible medical coverage and access to information tools to help make informed decisions. Contributions to HSAs are tax-free and earn tax-free investment income. An HSA is owned by the employee, can be rolled over from year to year, and is portable from job to job. While the cost-sharing inherent in HSA plans encourages members to become more involved in their own health care decisions, most plans also provide 100 percent coverage of preventive care. HSAs have become increasingly popular, but they still represent a small proportion of the marketplace — about 6.1 million people as of January 2008.[28] About 11 percent of all employers offered HSA-qualified high-deductible health plans in 2008.[29]

Aetna believes Health Savings Accounts represent an important tool for expanding the portability of health insurance and the financing of health care. People covered by HSAs enjoy the unique benefit of having a growing fund of tax-free dollars from which to finance future health care needs, no matter where or whether they are employed. On a system-wide level, widespread adoption of high-deductible health plans is projected to result in a one-time cost reduction of 4 percent to 15 percent.[30]

Permit the purchase of health insurance across state borders (that is, rather than having to purchase in one's home state) so consumers can buy (over phone, mail, Internet, etc.) coverage in states with legislative and regulatory environments that facilitate the existence of affordable health insurance options.

Americans are becoming increasingly mobile: In 2007 alone, more than 1.4 million Americans moved to a new state.[31] The health insurance system has been slow to adapt to this trend, with no geographic portability in the purchase of health care. Premiums consumers pay for coverage depend, to a large extent, on where they live. In 2006, the average annual premium for employer-sponsored family coverage was $10,060 in North Dakota, while it was only $7,085 in neighboring South Dakota.[32]

Aetna supports policies that would make it easier for consumers to purchase affordable coverage. One proposal would allow health insurance companies based in one state to sell insurance products to consumers in any other state, under the regulatory rules of the primary state. In other words, people would be able to access the health insurance coverage that is best suited to their needs, without geographic limitations.

Cross-state selling of insurance would stimulate price competition among insurers to attract members, while stimulating competition among states to attract and keep insurers. Public policies addressing cross-state selling should be implemented carefully in order to prevent a "death spiral," wherein insurance markets in certain states become attractive to only the sickest individuals.[33] Aetna believes in leveraging the competitive benefits of the free market, but also recognizes the need for universal access to health care.

In order to uphold both of these principles, it is essential to expand the competitiveness of the market, thereby lowering prices for the public, while also ensuring that the sickest are not left without the mutual aid that rests as a central component of health insurance. Rather than simply raising costs across the board and limiting the efficiencies generated by a competitive marketplace, policymakers and others should promote the free market while maintaining a robust public health system that addresses any potential market failures.

Explore new mechanisms for portability, such as developing new pooling arrangements, reforming COBRA and creating new products designed for people in transition.

Putting forward sensible and affordable coverage solutions for Americans in transition will require partnership between the public and private sectors to ensure that changing jobs, entering the workforce upon graduation, retiring early or moving to another state does not result in disruptions of health insurance coverage. It is important that policymakers and the private sector work together to identify and develop new mechanisms for portability. Among the ideas that deserve consideration are creating new pooling arrangements for workers not participating in the employer-based system and the working uninsured; increasing the affordability of COBRA coverage for workers who leave their jobs; and giving the private sector greater leverage to create innovative transitional or short-term coverage options.

Reorient the system toward prevention, value and quality of care

Point 6: Promote preventive care and wellness

Disease prevention programs are the cornerstone of public health practice and have long served as effective tools for reducing the burden of disease on society. While the United States has continued to make substantial public health improvements over the past century, there is considerable room for growth. Today, more than half of Americans are living with at least one chronic disease.[34] Smoking alone accounts for 440,000 annual deaths,[35] and obesity is associated with more than 111,000 excess deaths each year.[36] These public health-related issues present severe economic consequences as well; according to a recent report, the nation spent $217.6 billion on direct costs in treating chronic disease while experiencing an added $905 billion in losses associated with a decline in worker productivity, presenteeism and overall reductions in the labor supply.[37] Aetna believes preventive care, early detection, wellness and chronic disease management must be featured prominently in any health care reform effort.

Create incentives for individuals to achieve optimal health status by making healthy choices, participating in wellness, chronic care and disease management programs and obtaining routine preventive care.

The most common causes of disease, disability and premature death in the United States are four voluntary behaviors: smoking, unhealthy diet, physical inactivity and risky alcohol use.[38] With well-structured incentives, individuals can improve their lifestyles, yielding benefits not only for themselves but also for the public at large.

Aetna is committed to helping people achieve their optimal health status — being as healthy as they can be, given their medical circumstances — and believes the use of incentives complements the trend of consumer engagement. Incentives can take various forms, ranging from discounts on the purchase of certain goods and services to rewards for engaging in healthy behaviors.

Preventive care should receive first-dollar coverage and public and private health insurers should promote wellness vigorously in member and provider services. All Americans should have access to wellness tools, such as health risk assessments, weight management and smoking cessation programs.

Historically, only about 5 percent of U.S. health care spending has been dedicated to population-wide approaches to health improvement. Yet investments in prevention can have large payoffs; for instance, flu vaccinations can prevent between 50 percent and 60 percent of flu-related hospitalizations.[39]

Aetna contends that a high-performance health system is one that not only exhibits leadership in the treatment of disease, but also one that emphasizes wellness, preventive health and early detection and intervention. In addition to supporting first-dollar coverage for preventive care, Aetna is encouraged by innovative reimbursement arrangements that promote preventive care. The company also believes wellness tools should be made available to all Americans. However, Aetna believes promoting preventive care and wellness should remain a health insurer responsibility rather than a new form of mandated coverage.

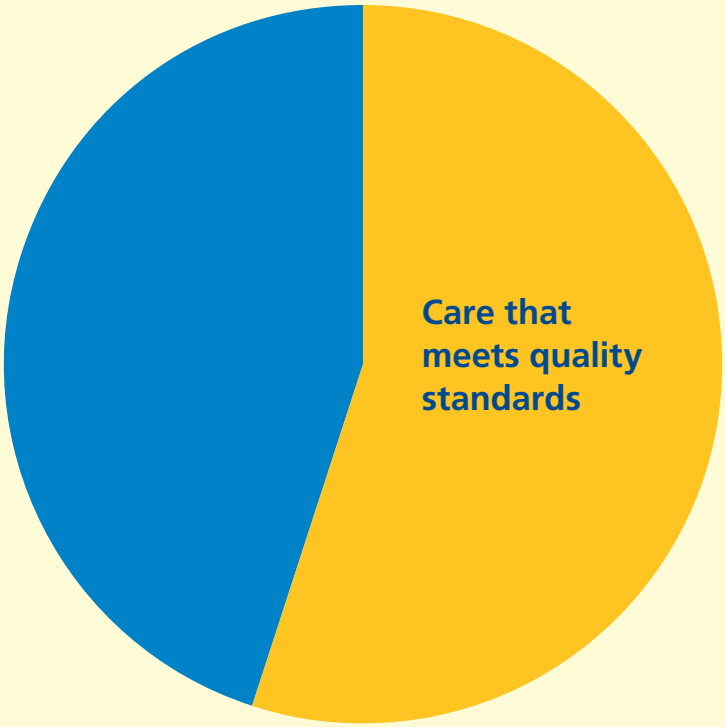
Achieve greater integration among medical, behavioral and dental health services to facilitate total wellness and improve patient outcomes.

Researchers have documented the strong connection among all aspects of an individual's health. For example, poor dental health can be an important indicator of poor physical health, with oral disease linked to multiple illnesses, including diabetes and heart and lung disease.[40] People with mental illness are five times more likely than the general population to experience a co-occurring medical condition.[41]

Consistent with the company's emphasis on holistic approaches to health care, Aetna was the first health insurer to support the 2007 Mental Health Parity Act. This measure requires equal coverage for mental and physical illnesses, which research has shown to be justified because of the attendant comprehensive health benefits.

Percentage of care in accordance with clinical quality standards

Overall, about one-half of recommended care is received.



Source: Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro, and Eve A. Kerr. "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26, June 26, 2003, 2635-2645.

Point 7: Improve health care quality and patient safety

Quality in health care means doing the right thing at the right time in the right setting for the right person, yielding the best results possible.[42] And yet, a 2003 RAND study found that adults receive only about half of recommended care.[43] Quality-related challenges include tremendous variation in how patients with the same conditions are treated, discrepancies between actual and evidence-based recommended clinical practices, preventable medical errors and inadequate transparency throughout the system. Aetna supports various initiatives to enhance health care quality and improve patient safety.

Support rigorous analysis and research about clinical best practices, including analysis of cost-effectiveness data to determine which medical technologies, protocols and drugs are most effective.

An estimated half of American adults do not receive care in accordance with clinical best practices.[44] There is also a large body of studies showing that higher health care spending does not equate to better health outcomes.[45]

Modernizing the U.S. health care system requires strengthening the use of scientific evidence to improve health care quality and safety.[46] In 2007, Aetna joined with our industry peers in AHIP to develop *Setting a Higher Bar,* a proposal to improve health care quality and safety. One of the key recommendations is the establishment of a new national, public-private entity to evaluate new and existing health care services and technologies. This entity would compare the clinical and cost-effectiveness of drugs, procedures and other services; assess alternative uses of treatments currently in practice; and distribute information so patients and clinicians can make informed health care decisions. Aetna also supports AHIP's recommendation to reinforce the FDA's capacity to assess the long-term safety and effectiveness of new drugs, as well as the recommendation to coordinate health services research across the Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC) and other federal agencies.

Reward health care providers who efficiently deliver evidence-based care through pay-for-performance (P4P) programs. Quality measures employed in P4P programs should be clinically important, credible to physicians, transparent to all stakeholders, consistent across health plans and other payers, understandable to consumers and useful to them in making choices. P4P programs should also equip providers with the information and tools necessary for improving practice outcomes and efficiencies.

Each year, 44,000 to 98,000 people die in hospitals as a result of preventable medical errors.[47] These errors correspond to estimated total costs of between $17 billion and $29 billion. Waste accounts for 34 percent to 50 percent of all health care spending.[48]

Aetna believes payment structures should reward physicians for quality and value, using a series of credible measures. Aetna joins various organizations, including the Leapfrog Group, the National Quality Forum, and the National Center for Quality Assurance (NCQA), in supporting P4P programs that promote and reward high-quality care.

Transform the medical liability system into one that focuses on the fair and timely resolution of medical disputes and promotes health care quality improvements. The medical liability system should encourage — not discourage — physicians to discuss and learn from mistakes and preventable errors. Patients experiencing medical injuries should be fairly compensated through an administrative system that draws upon independent medical expertise in the decision-making process.

The current medical liability system fails to foster quality improvement or transparency about errors. Medical malpractice tort costs totaled $30.4 billion in 2007,[49] and the cost of defensive medicine — ordering unnecessary tests and procedures to avoid accusations of malpractice — has been estimated to be between $38 billion and $100 billion per year.[50] The system also often fails to compensate legitimate victims of medical errors; in fact, one in six malpractice claims involved errors, yet no payment.[51]

Aetna supports fundamental medical liability reform that encourages transparency about medical errors and promotes fair compensation of victims of medical errors. Aetna endorses the establishment of a system of "health courts," specialized administrative courts designed to handle medical injury disputes. Health courts should engage neutral experts, expedite the claims resolution process, provide for equity in treatment of similar claims, promote an environment in which health care providers can learn from mistakes, and ultimately improve the quality of patient care and enhance patient safety.

Invest in initiatives to reduce racial and ethnic disparities in health care, including the analysis of treatment and outcomes data to ensure sustained progress in eliminating disparities.

Suboptimal quality associated with racial and ethnic disparities leads to approximately 84,000 U.S. deaths every year.[52] African American males are 1.4 times more likely, and African American females are 1.2 times more likely, to die of cancer than their white counterparts.[53] African American and Latina women who get breast cancer are more likely to be diagnosed at a later stage than white women.

Aetna has implemented and advocated for various efforts to combat racial and ethnic disparities. Aetna collects voluntarily provided race, ethnicity and language preference data from members to track trends in care; educates employees and providers on cultural competency issues; provides culturally appropriate disease management programs; and promotes regular mammograms for African American and Latina women. Aetna believes government and the private sector should partner in continued research on the prevalence of specific types of disparities and in developing programs to eliminate them.

Create public-private partnerships to ensure the availability of end-of-life care products that empower people facing end-of-life care decisions by offering access to curative care whether in a hospital, hospice or home.

Although 70 percent of Americans say it is their wish to die at home, only 24.9 percent do so.[54] In the advanced stages of illness, individuals and their families too often face the challenging all-or-nothing decision of choosing between curative care in a hospital setting and palliative care in a hospice or home setting.

Aetna believes people should be given the options and information they need to live out the end of their lives in dignity and comfort. The public and private segments of the health care community should work together to offer patients nearing the end of life the choice of receiving palliative care in a hospice or home setting while retaining the option to receive curative care. Aetna's Compassionate Care Program provides this option, while also offering members nurse case management, information resources and decision-making tools, respite care and bereavement care services.

Use market incentives to improve coverage, drive down costs and make the system more consumer-oriented

Point 8: Create a legislative and regulatory environment conducive to the development and availability of affordable health insurance options

With the right legislative and regulatory environment, health insurance companies can offer consumers a wide range of affordable product options that fit individual needs, preferences and pocketbooks. Creating such an environment requires policymakers to balance multiple interventions.

Create new pooling mechanisms that facilitate affordable access to health insurance for individuals and small employers.

People with employer-based coverage enjoy the benefits of a large risk pool — comparatively lower premiums based on group risk rather than individual risk and negotiated rates and discounts. Limited risk-pooling mechanisms in the individual and small-group markets put members at a comparative disadvantage. Association Health Groups and discretionary groups are examples of pooling mechanisms that eliminate this disadvantage by enabling individuals and small groups to create their own pools. Such groups benefit both individuals and insurance companies, spreading risk effectively and keeping costs down.

Permit private health insurers to use transparent and fairly devised medical underwriting techniques, while preserving a strong safety net for all Americans.

Aetna believes that all Americans should have access to affordable health care, regardless of their health status. However, individual insurance markets are particularly susceptible to adverse selection, wherein individuals acquire insurance only after they are sick. The resulting insurance pool yields higher premiums for all. Guaranteed issue exacerbates adverse selection, especially in the absence of an individual coverage requirement. In states that have implemented guaranteed issue in lieu of medical underwriting, premiums have increased 30 to 60 percent, and many insurers have abandoned the individual market.[55]

Medical underwriting helps to prevent adverse selection by giving individuals an incentive to purchase insurance even when they do not expect to have high health care costs. For those with extensive health problems accompanied by extensive costs, a safety net, including risk-transfer mechanisms (for example, state high-risk pools or public reinsurance programs), should be available. Aetna believes fair and transparent underwriting practices are critical for maintaining consumer confidence. Individuals must know that their continuous participation in the system assures them coverage if they do become sick.

Improve the affordability of prescription drugs by removing barriers to generic competition and creating a regulatory pathway for generic biopharmaceutical medicines.

Prescription drug spending in the United States represents 10 percent of total health care costs ($228 billion in 2007).[56] Generics comprise 65 percent of all prescriptions dispensed in the nation, but only 20.5 percent of all dollars spent on prescription drugs.[57] Savings associated with generics usage are extensive; for each 1 percent increase in the use of generic drugs, consumers save $4 billion annually.[58] Aetna supports legislation that paves the way for enhanced generic competition in both the traditional and biopharmaceutical markets, so that consumers can reap the benefits of this competition through equivalent medication and treatment at significantly lower costs.

Promote the development and availability of mandate-lite and mandate-free products. Control the proliferation of costly benefit mandates by establishing independent review commissions.

The accumulation of mandated benefits has a significant impact on the cost of health insurance. There are more than 1,900 mandated benefits and services among the states, each one raising the cost of premiums, on average, 1 percent to 2 percent.[59] Together, the cumulative effect of benefit mandates can be substantial. Increased costs translate into higher premiums for all consumers and a paucity of affordable insurance options.

Aetna supports the creation of mandate review laws that establish independent, thorough and scientifically sound processes for assessing the medical, financial and public health impact of existing and proposed benefit mandates. Aetna also believes that insurers should be permitted to offer mandate-lite or mandate-free product designs (that is, products that cover, at a minimum, preventive and catastrophic care) to ensure that individuals have access to affordable coverage options.

Encourage uniformity of state laws and regulations. Explore the development of an optional federal charter.

While states have long been the sole regulators of most insurance products, this decentralized system results in a tangled web of inconsistent insurance regulations regarding licensing, policy forms, rates and market conduct exams. Insurers with a multistate presence face costly administrative burdens to comply with divergent state laws and regulations, and these higher administrative costs are passed onto the market at large through higher insurance premiums.

Aetna believes it is critical to develop greater uniformity of state laws and regulations. One prime area for reform is prompt payment of claims, for which Aetna supports the adoption of a strong national standard, based on federal Medicare rules. Aetna also supports advancing the creation of an optional federal charter, which would give insurers the choice of being regulated at the state or federal level — similar to the way banks have the option of being state or federally chartered.

Point 9: Make the health care system more transparent and consumer-friendly

Transparency entails making clinical performance, efficiency and price information available to the public. With easily accessible quality and price information, consumers are better able to make decisions in support of their own health while maintaining up-front awareness about the costs of their treatment. Aetna has pioneered, and continues to promote, transparency in health care in order to ensure the proliferation of higher quality and lower costs throughout the health care system.

Provide consumers with meaningful information to allow them to make value-based health care decisions. Advance transparency in health care quality and pricing, giving consumers easy access to health care information, including cost and price information, and the ability to seek out hospitals and other health care providers that have a proven track record of high-quality care. Investments in transparency should be accompanied by rewards and other incentives for providers that efficiently deliver evidence-based care.

In most markets, consumers use a wealth of information to make decisions on the purchase of products and services, thereby encouraging providers to improve quality and decrease costs.[60] Health care consumers often lack quality and price information before they receive care, often leading them to pay too much for care without being assured of the standard of care they expect. Conventional wisdom might have suggested that more expensive health care is better care, but researchers have found that neither quality of care nor patient satisfaction is correlated with costs.[61] Advances in transparency, coupled with consumer-driven health plans that give people "skin in the game," will help stem the tide of rising costs and infuse a critical form of competition — among providers and among hospitals — into the health care system.[62,63]

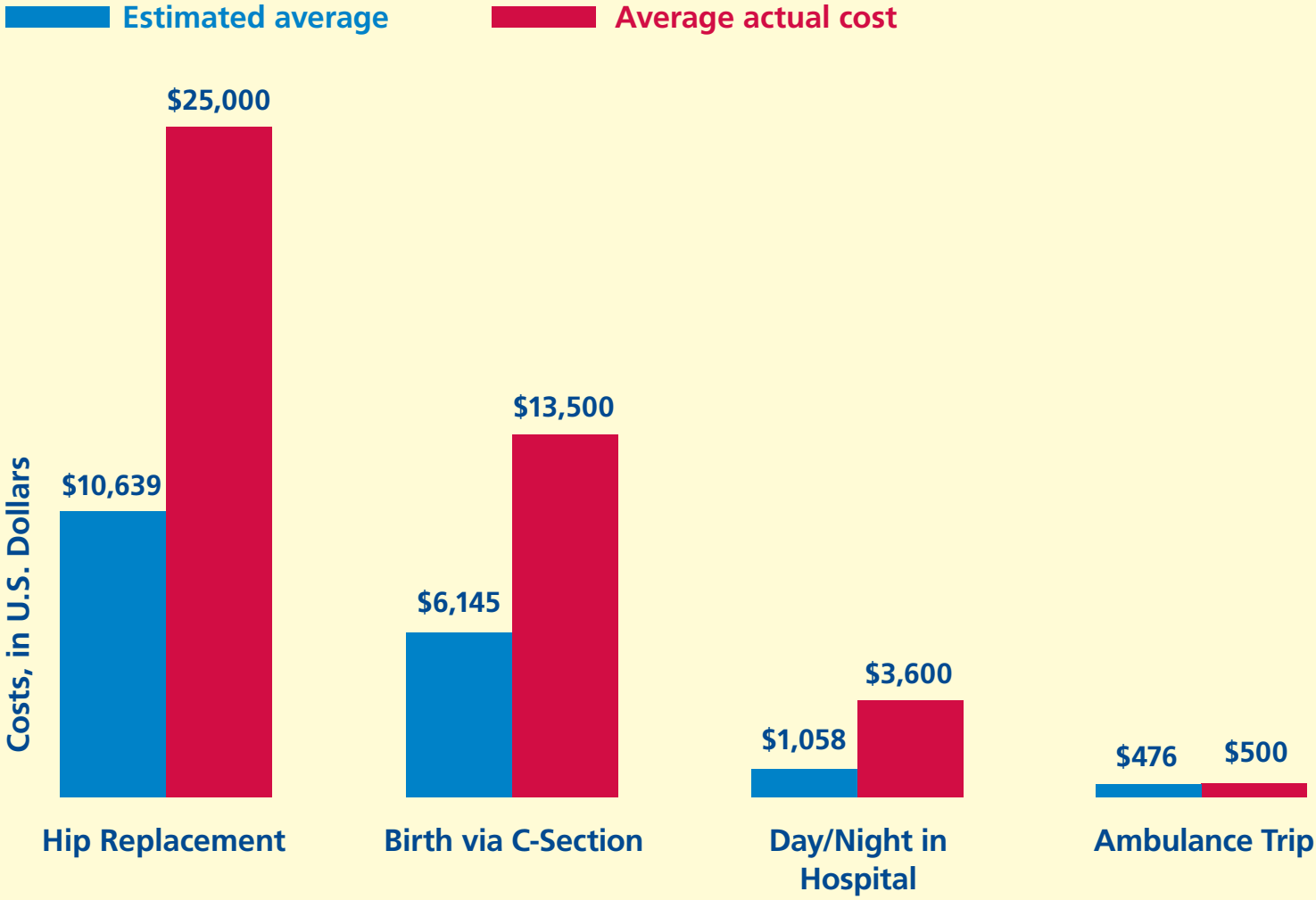
Aetna believes health insurers must play a critical role in providing consumers with the information they need to make the right decisions for their own health care, as they possess a wealth of data, develop provider networks and design incentive-based benefit structures. In an effort to disseminate these forms of valuable data, Aetna provides members online access to physician-specific cost, clinical quality and efficiency information. Ensuring transparency on all three levels makes certain that price information will not disproportionately drive health care decisions. In addition, providing price information for an "episode of care," rather than for unique services, will allow consumers to accurately assess projected costs.[64]

Invest in efforts to improve health and benefits literacy, especially for the nearly half of adults in the nation who have difficulty locating, matching and integrating written information. Government and industry should partner with providers to improve health literacy and ensure that health information is easy to understand.

Low health literacy is the single best predictor of poor health status, with patients who are marginally health literate being more likely to report poorer overall health and less likely to manage their health conditions effectively.[65] Low health literacy also appears to result in excessive health care utilization and higher per patient spending. Despite these well-known implications, most health information today exceeds the reading skills of an average high school graduate, even though the majority of U.S. adults read at the eighth- or ninth-grade level.

In order to improve health and benefits literacy, Aetna believes health plans and providers should make health information available at the fifth-grade level and use visual aids, short paragraphs, and terminology that is understandable to non-medical professionals, as recommended by the American Medical Association Foundation. Use of oral communication and development of plan materials in multiple languages is also critical in enhancing health literacy. Among other health literacy efforts, Aetna has published *Navigating Your Health Benefits for Dummies*, which includes easy-to-understand information about choosing the right coverage, making the most of plan "extras" and paying for benefits.

Consumer perceptions vs. reality of medical costs, 2006



Source: JR Raskin et al. "Health Insurance and Consumerism," Lehman Brothers, May 2006.

Point 10: Harness the power of health information technology and research to reduce costs and improve quality

The U.S. health care sector lags far behind other industries and countries in its investment in and use of information technology. Moreover, physicians do not always have easy access to the best information to choose treatments for their patients, evidenced in part by studies showing that an estimated half of American adults do not receive care in accordance with clinical best practices. Aetna believes it is essential for the nation to modernize the U.S. health care system in a way that promotes quality and improves patient safety while enhancing value and fostering innovation.

Advance public-private partnerships to develop and implement health information technology (HIT), including personal health records and the development of an interoperable health record system that allows for the seamless and secure transmission of health information.

Just over one-quarter of all physicians reported using an electronic health record (EHR) system as recently as 2006.[66] Yet widespread adoption of EHRs could save an estimated $80 billion annually by improving the coordination of care, eliminating duplication of services, and reducing paperwork and prescription errors. Through personal health records (PHRs), individuals can benefit from improved access to health information, improved portability of records and greater involvement in their own health care.

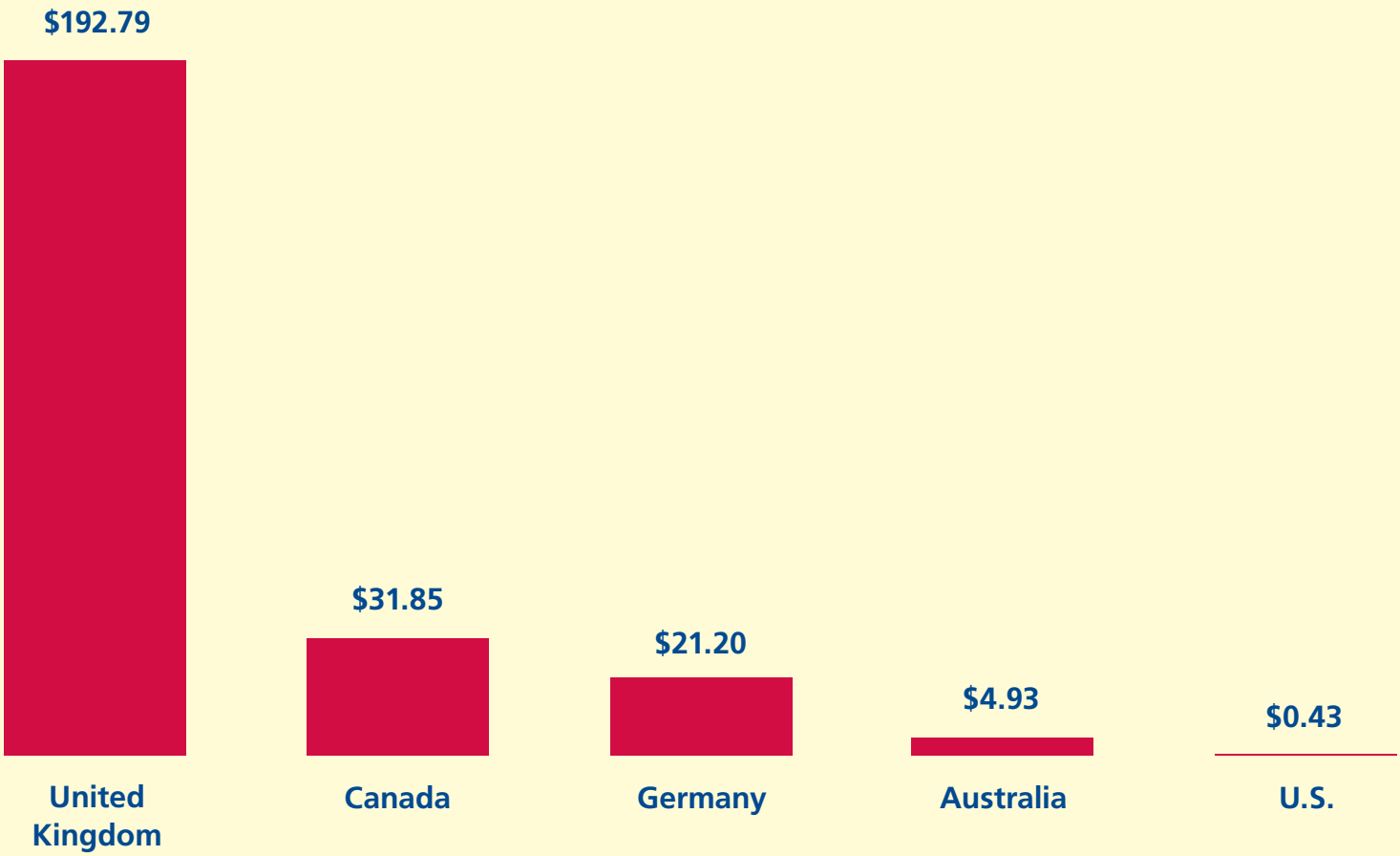
Aetna believes all Americans should have access to a secure, interoperable health system that provides administrative and confidential medical information. Health information technology, coupled with evidence-based medicine, translates into fewer errors, improved patient safety and better doctor-patient communication. Interoperability and health information privacy and security must be top priorities in any HIT initiative. Aetna contends that all entities participating in a health information exchange should be required to comply with the robust privacy and security rules established under the Health Insurance Portability and Accountability Act (HIPAA), and that steps should be taken to reconcile federal, state and local laws and regulations governing the collection and distribution of personal health information.

Create incentives for consumers, providers, employers and payers to adopt health information technology — accelerating the goal of replacing the outdated and costly paper-based medical records and billing systems.

Successful HIT implementation requires considerable public-private collaboration, and multiple sources of funding are needed to underwrite the costs of developing and building interoperable HIT.

Aetna believes that payers should fund the development of claims-based PHRs for their members. The development of interoperable EHRs, however, requires financial leadership from the federal government, and support could come in the form of interest-free loans, loan guarantees or Hill-Burton-type grants.[67] This support should be accompanied by incentives to encourage rapid and widespread adoption.

Public investment per capita in health information technology, 2005



Source: The Commonwealth Fund. "Healthcare Spending and Use of Information Technology in OECD Countries", *Health Affairs*, 2006.

Endnotes

[1]PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2008," Prepared for America's Health Insurance Plans, December 2008.

[2]Of this total premium cost, workers pay an average $3,354 from their paychecks, with employers covering the remaining premium costs. Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employer Health Benefits: 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008. Accessed online: **http://ehbs.kff.org/images/abstract/7791.pdf.**

[3]National Committee on Quality Assurance, "The State of Health Care Quality 2007." Accessed online: **www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf**.

[4]Rand Health, "The First National Report Card on Quality of Health Care in America," *Research Highlights*, 2006. Accessed online: **www.rand.org/pubs/research_briefs/2006/RAND_RB9053-2.pdf**.

[5]Linda J. Blumberg and John Holohan. "Do Individual Mandates Matter?" *Timely Analysis of Immediate Health Policy Issues*, Urban Institute, January 2008.

[6]Stan Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality," Urban Institute, January 2008. Accessed online: **www.urban.org/UploadedPDF/411588_uninsured_dying.pdf**.

[7]These extra costs account for one out of every $12 spent for employer-sponsored health insurance. Families USA. "Paying a Premium: The Added Cost of Care for the Uninsured," June 2005.

[8]Over one-quarter (28%) of residents between the ages of 18 and 24 — totaling 8 million people — were uninsured in 2007. This age group represented 17.5% of the total uninsured population. U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2007," August 2008.

[9]Aetna's former Chairman and CEO, Dr. John W. Rowe, first articulated Aetna's support for the concept of an individual coverage requirement at the company's annual meeting in April 2005. That summer, Ronald A. Williams, Aetna's current Chairman and CEO, co-authored an op-ed with Dr. Jack Lewin, President of the California Medical Association, titled "Cover Yourself!" that was published in *The Wall Street Journal* on August 19, 2005. In the fall of 2005, Aetna formalized a policy statement supporting an individual coverage requirement.

[10]Linda J. Blumberg and John Holahan. "Government as Reinsurer: Potential Impacts on Public and Private Spending," *Inquiry* 41: 130-143. (Summer 2004). Accessed online: **www.inquiryjournalonline.org/i0046-9580-041-02-0130.pdf**.

[11]U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Issued August 2008.

[12]John Holahan, Allison Cook and Lisa Dubay. "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, February 2007. Accessed online: **www.kff.org/uninsured/upload/7613.pdf**.

[13]U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Issued August 2008.

[14]The 47 million uninsured represent people who are uninsured at a given point in time during the year. The number of people uninsured for the entire year is much smaller, representing approximately 9-13% of the non-elderly population, or between 23.4 and 33.8 million people in 2006. See: Congressional Budget Office, "How Many People Lack Health Insurance and For How Long?" May 2003. Accessed online: **www.cbo.gov/ftpdoc.cfm?index=4210&type=0&sequence=2**.

[15]Sara Collins, Chapin White and Jennifer Kriss. "Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance," The Commonwealth Fund, September 2007. Accessed online: **www.commonwealthfund.org/usr_doc/Collins_whitheremployer-basedhltins_1059.pdf?section=4039**.

[16]Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employer Health Benefits: 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008. Accessed online: **http://ehbs.kff.org/images/abstract/7791.pdf**.

[17]Jon Gabel, Kelley Dhont and Jeremy Pickreign. *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund, May 2002).; Mark Hall. "The Geography of Health Insurance Regulation," Health Affairs, March/April 2000, 19(2):173-84.

[18]Collins, et al., 2.

[19]Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employer Health Benefits: 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008. Accessed online: **http://ehbs.kff.org/images/abstract/7791.pdf**

[20]Collins, et al., 4.

[21]U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Issued August 2008.

[22]President's Advisory Panel on Federal Tax Reform. "Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System," November 2005. Accessed online: **www.taxreformpanel.gov/final-report/TaxReform_Intro.pdf**.

[23]The tax treatment of employer-sponsored health benefits, in fact, accounts for one of the largest tax expenditures in the U.S. budget, and estimates for personal federal forgone tax revenue in 2006 ranged from $91 billion (Joint Committee on Taxation) to $133 billion (Office of Management and the Budget).Paul Fronstin, "The Tax Treatment of Health Insurance and Employment-Based Health Benefits," Employee Benefit Research Institute, *Issue Brief* No. 294, June 2006.

[24]Paul Fronstin and Dallas Salisbury. "Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?" Employee Benefit Research Institute, Issue Brief No. 309, September 2007.

[25]Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employer Health Benefits: 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008. Accessed online: **http://ehbs.kff.org/images/abstract/7791.pdf**

[26]Lisa Dubay, Jocelyn Guyer, Cindy Mann, and Michael Odeh. "Medicaid At The Ten-Year Anniversary Of SCHIP: Looking Back And Moving Forward," *Health Affairs*, March/April 2007; 26(2): 370-381; U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2006." Issued August 2007.

[27]Although COBRA and HIPAA provide an alternative to workers in between jobs, these options may be prohibitively expensive, and typically greatly exceed the costs incurred by workers receiving employer-based coverage.

[28]America's Health Insurance Plans. "January 2008 Census Shows 6.1 Million People Covered by HSA/High-Deductible Health Plans," April 2008. Accessed online: **www.ahipresearch.org/pdfs/2008_HSA_Census.pdf**.

[29]Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employee Health Benefits 2008 Summary of Findings." Kaiser Family Foundation and Health Research and Education Trust, September 2008. Accessed online: **http://ehbs.kff.org/images/abstract/7791.pdf**

[30]Cheryl Damberg. "Consumer-Directed Health Plans: Research on Implications for Health Care Quality and Cost," Testimony presented before the California Department of Insurance on September 20, 2005, RAND. Accessed online: **www.rand.org/pubs/testimonies/2005/RAND_CT249.pdf**.

[31]U.S. Census Bureau. "Geographical Mobility: 2006 to 2007 Detailed Tables," Table 1. General Mobility, By Region, Sex, and Age: 2006 to 2007, September 4, 2008. Accessed online: **www.census.gov/population/www/socdemo/migrate/cps2007.html**.

[32]Kaiser Family Foundation State Health Facts. "Average Family Premium per Enrolled Employee for Employer-Based Health Insurance, 2006."

[33]The term "death spiral" is used to explain a potential outcome of adverse selection. When a company's insurance pool becomes increasingly sicker, premiums are raised across the board. The healthier members of the pool then seek out less expensive alternatives (cheaper insurance, no insurance, or, in this case, out-of-state insurance), thereby leaving behind a progressively sicker risk pool that eventually becomes uninsurable.

[34]Ross DeVol, Armen Bedroussian, Anita Charuworn, Anusuya Chatterjee, In Kyu Kim, Soojung Kim, and Kevin Klowden. *An Unhealthy America: The Economic Burden of Chronic Disease Charting a New Course to Save Lives and Increase Productivity and Economic Growth*, Milken Institute, October 2007. Accessed online: **www.milkeninstitute.org/pdf/chronic_disease_report.pdf**.

[35]National Committee for Quality Assurance. State of Health Care Quality 2007, 48. Accessed online: **www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf**.

[36]Katherine M. Flegal, Barry I. Graubard, David F. Williamson, and Mitchell H. Gail. "Excess Deaths Associated With Underweight, Overweight, and Obesity," JAMA, April 20, 2005, Vol. 293, No. 15, 1861-1867.

[37]Ross DeVol, Armen Bedroussian, Anita Charuworm, Anusuya Chatterjee, In Kyu Kim, Soojung Kim, and Kevin Klowden. "An Unhealthy America: The Economic Burden of Chronic Disease Charting a New Course to Save Lives and Increase Productivity and Economic Growth," Milken Institute, October 2007.

[38]Maribel Cifuentes, Douglas Fernald, Larry Green, et. al., "Prescription for Health: Changing Primary Care Practice to Foster Healthy Behaviors," *Annals of Family Medicine*, Vol. 3, Supplement 2, July/August 2005.

[39]Estimated total direct hospitalization costs of a severe influenza epidemic exceed $3 billion. NCQA, *State of Health Care Quality*, 2007, 40, citing: National Foundation for Infectious Diseases. "Facts About Influenza for Adults." Last accessed July 25, 2007 from **www.nfid.org/pdf/factsheets/influadult.pdf**. Updated: August 2006.

[40]Kaiser Family Foundation. "Dental Coverage and Care for Low-Income Childre**n: The Role of Medicaid and SCHIP," August 2007. Accessed online: www.kff.org/medicaid/upload/7681.pdf**.

[41]Surgeon General's Office. "Mental Health: A Report of the Surgeon General," 1999. Accessed online: **www.surgeongeneral.gov/library/mentalhealth/home.html**.

[42]Agency for Healthcare Research and Quality. "National Healthcare Quality Report," U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, December 2003. Accessed online: **www.ahrq.gov/qual/nhqr03/nhqr2003.pdf**.

[43]Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro, and Eve A. Kerr. "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26, June 26, 2003, 2635-2645.

[44]RAND Research Highlights. "The First National Report Card on Quality of Health Care in America," 2007.

[45]Cathy Schoen, Stuart Guterman, Anthony Shih, Jennifer Lau, Sophie Kasimow, Anne Gauthier and Karen Davis. "Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Care Spending," The Commonwealth Fund Commission on a High-Performance Health System, December 2007.

[46]America's Health Insurance Plans. "Setting a Higher Bar: We believe there is more the nation can do to improve quality and safety in health care," April 2007. Accessed online: **www.ahipbelieves.com/media/Setting%20A%20Higher%20Bar%20-%20Improve%20Quality%20and%20Safety%20in%20Health%20Care.pdf**.

[47]Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson. "To Err is Human: Building a Safer Health System," Institute of Medicine, November 1999.

[48]Pricewaterhouse Coopers Health Research Institute. "The Price of Excess: Identifying Waste in Healthcare Spending," 2008.

[49]Towers-Perrin Tillinghast, "2008 Update on U.S. Tort Cost Trends," December 2008.

[50]David M. Studdert. "Testimony Before the Senate Committee on Health, Education, Labor, and Pensions at the Hearing Entitled 'Medical Liability: New Ideas for Making the System Work Better for Patients,'" June 22, 2006; Kessler, Daniel and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, Vol. 3, No. 2, May 1996.

[51]David M. Studdert, Michelle M. Mello, Atul A. Gawande, Tejal K. Gandhi, Allen Kachalia, Catherine Yoon, Ann Louise Puopolo and Troyen A. Brennan. "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, Vol. 354, May 11, 2006.

[52]David Satcher, George E. Fryer, Jr., Jessica McCann, et al. "Trends: What if We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000," *Health Affairs*, March/April 2005.

[53]African-American to White Cancer Mortality Rate Ratios, U.S., 1997-2001, National Center for Health Statistics, Centers for Disease Control and Prevention.

[54]Robert Wood Johnson Foundation. "Means to a Better End: A Report on Dying in America Today," November 2002. Accessed online: **www.rwjf.org/files/publications/other/meansbetterend.pdf**.

[55]Leigh Wachenheim and Hans Leida. "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman/AHIP, July 10, 2007.

[56]Kaiser Family Foundation, "Prescription Drug Trends," September 2008. Accessed online: **http://wworg/rxdrugs/upload/3057_07.pdfw.kff**.

[57]Generic Pharmaceutical Association Website. "Industry Statistics," 2007. **www.gphaonline.org/Content/NavigationMenu/AboutGenerics/Statistics/default.htm**.

[58]Generic Pharmaceutical Association Website. "Statement from GPhA President and CEO Kathleen Jaeger on the Growing Use of Generic Medicines," September 27, 2007. **www.gphaonline.org/AM/Template.cfm?Section=Press_Releases&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=3832**

[59]Juliette Cubanski and Helen H. Schauffler. "Mandated Health Insurance Benefits: Tradeoffs Among Benefits, Coverage, and Costs?" Center for Health and Public Policy Studies, University of California, Berkeley. Accessed online: **www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13995**.

[60]Paul B. Ginsburg. "Shopping for Price in Medical Care," *Health Affairs*, February 6, 2007, 208-216.

[61]Elliot S. Fisher. "More Medicine is Not Better Medicine," *The New York Times*, December 1, 2003.

[62]For information on consumer control and competition, see: Regina Herzlinger. "Let's Put Consumers in Charge of Health Care," Harvard Business Review, July 2002. See also: Michael E. Porter and Elizabeth Olmstead Teisberg. "Redefining Competition in Health Care," Harvard Business Review, June 2004.

[63]Researchers note the potential risk of transparency leading to collusion among hospitals and providers on prices, an eventuality which could lead to higher prices. It is important to exercise caution to prevent this. Aetna has created barriers to such price-setting by limiting the availability of price information to members and preventing its availability to providers. See: Margaret K. Kyle and David B. Ridley. "Would Greater Transparency and Uniformity of Health Care Prices Benefit Poor Patients?" *Health Affairs*, September/October 2007, 1384-1391.

[64]Alex M. Azar II, Thomas P. Miller, David B. Kendall, and Walton Francis. "Transparency in Health Care: What Consumers Need to Know," *Heritage Lectures*, No. 986, Published by the Heritage Foundation, January 22, 2007.

[65]Michael S. Wolf, Julie A. Gazmararian and David W. Baker. "Health Literacy and Functional Health Status Among Older Adults," *Archives of Internal Medicine*, Vol. 165 (Sept. 26, 2005), p. 1946-52.

[66]Catherine W. Burt, Esther Hing, and David Woodwell, "Electronic Medical Record Use by Office-based Physicians: United States, 2006," October 2007.

[67]In 1946, Congress passed P.L. 79-725, the Hospital Survey and Construction Act, sponsored by Senators Lister Hill and Harold Burton and widely known as the Hill-Burton Act. It was designed to provide Federal grants to modernize hospitals that had become obsolete due to lack of capital investment throughout the period of the Great Depression and World War II (1929 to 1945). Hill-Burton hospitals were required to provide uncompensated services for 20 years after receiving funds. In 1975, Congress enacted an amendment to the Hill-Burton Program, Title XVI of the Public Health Service Act, which established Federal grants, loan guarantees and interest subsidies for health facilities. Facilities assisted under Title XVI were required to provide uncompensated services in perpetuity.

Aetna's Proposal for Health Care System Transformation

- Get and keep everyone covered
- Maintain the employer-based system and export its strengths to make the individual market function better
- Reorient the system toward prevention, value and quality of care
- Use market incentives to improve coverage, drive down costs and make the system more consumer-oriented

We want you to know®

Aetna®

www.aetna.com

00.02.928.1 (12/08)