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The CIGNA community continues to express its deepest sympathies to the Sarkisyan family. We also would like to clarify three issues with regard to the Sarkisyan case that have been reported on in the press. First is the nature of CIGNA's role in this matter, second is how we make coverage decisions, and third is why we ultimately offered to pay for the transplant ourselves.

While we are bound by federal and state privacy laws that prohibit us from sharing patient-specific information, we are confident that as the facts become available in this case, it will be clear that we conducted our decision-making based on the best medical evidence and guidelines established by the medical community, and we went above and beyond out of empathy for the Sarkisyan family.

CIGNA's role. In all instances, treating physicians—in consultation with their patients—make the decisions with respect to all aspects of patient care. This includes, in the case of a transplant, whether or not to proceed with a transplant or place a patient on a transplant list. Our role is to determine whether a procedure is covered under a specific patient's health benefit plan.

Also important is the fact that much of our business involves managing health benefits for self-insured entities, such as large employers. Under these Administrative Services Only (ASO) contracts, we provide administrative services and coordinate clinical procedures, including determining if a plan covers a specific proposed treatment. In an ASO contract, we are not financially responsible for, nor do we fund, the health care services that are covered and provided.

In this instance, as in similar ASO arrangements, it was the self-insured entity, the employer—not CIGNA—that pays for all clinical procedures and related care. Our responsibility is to administer the employer's policy and make coverage decisions in accordance with the plan based on the best clinical evidence.

How we make coverage decisions. We make determinations as to whether or not a plan provides coverage for a specific procedure based on the best medical evidence and guidelines established by the medical community. In this instance, that evidence included guidelines endorsed by the American Association for the Study of Liver Diseases and the American Society of Transplantation. (https://www.aasld.org/eweb/docs/practiceguidelines/evalu_patient_livertransplantation.pdf) The clinical determination included both internal and independent external review by physician transplant experts who concluded that this procedure would be unproven and ineffective in this situation and therefore experimental and not covered under the patient's health benefit plan. Coverage determinations are made without regard to any financial implication.

In this instance, CIGNA had three transplant experts review this case. The internal reviewer is an expert in critical care and the pre- and post-operative management of transplant patients. The two external reviewers have equally impressive credentials. One is an oncologist specializing in

hematologic malignancies including leukemia and bone marrow transplantation, and the other is a surgeon on an organ transplant team that performs nearly 100 liver transplants a year.

Why we offered to pay for the transplant ourselves. Given our empathy for this family and the unique circumstances of this situation, CIGNA volunteered, entirely independent of any plan or coverage decision and outside of the medical review process, to pay out of our pocket—not the employer's pocket—for a transplant should Ms Sarkisyan's doctors decide to proceed. This decision was made despite the fact that we had no obligation to do so, and despite concluding, based on the information available, that the treatment would be unproven and ineffective—and therefore experimental and not covered by the plan.

While the above clarifies CIGNA's role, how we make these coverage decisions, and why we ultimately offered to pay for the transplant ourselves, there is a broader societal question that this case raises. The fact is that experimental treatments are a complex societal issue for which there is no easy answer. Virtually no health plan—public or private—provides coverage for treatments that are considered unproven or ineffective, and therefore experimental, by the medical community. Transplants are especially complex given the scarcity of organs themselves. In fact, at this time there are more than 98,000 (<http://www.unos.org/>) people waiting for an organ transplant—nearly 17,000 (<http://www.optn.org/data/>) specifically for liver transplants.

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