U.R.N. Resources

NOVEMBER 2006 EDUCATION AND INFORMATION FOR UNITED RESOURCE NETWORKS' CLIENTS

IN THIS ISSUE

Guidelines on Recommended Timing for Transplant Consultation

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These guidelines for transplant consultation have been developed jointly by the NMDP and the American Society of Blood and Marrow Transplantation (ASBMT) and are based upon current clinical practice and the medical literature, including comprehensive evidence-based reviews. One critical factor in the outcome of hematopoietic cell transplantation is the appropriate planning and timing of the transplant. The intent of these guidelines is to indicate prognostic factors for patients at risk of disease progression and, therefore, determine which patients should be evaluated for transplantation.

While transplant may be immediately warranted for some patients with these factors, it may not be for all patients. The consultation helps ensure there are plans in place for the patient to move quickly to transplant, if needed, before the disease progresses or complications develop. If allogeneic transplant is a possibility, it helps provide adequate time for an unrelated donor or cord blood search, if needed.

Evidence-based Reviews, ASBMT, 2006. To download or order copies of the guidelines, visit the National Marrow Donor Program's Physicians' Resource Center at ***www.marrow.org/md****. The Physicians' Resource Center also has outcomes data; references for key publications; and a subscription offer to an e-newsletter to stay abreast of advances in transplantation, patient resources and available CME programs offered by NMDP.*

Adult Myelodysplasia and Leukemias

High-risk AML including:
- Antecedent hematological disease [e.g. myelodysplasia]
- Treatment-related leukemia
- Induction failure

CR1 with poor-risk cytogenetics
CR2 and beyond

Acute Lymphoblastic Leukemia (ALL)
High-risk ALL including:
- Poor-risk cytogenetics [e.g. Philadelphia chromosome positive, 11q23]
- High WBC (>30,000 - 50,000) at diagnosis
- CNS or testicular leukemia
- No CR within four weeks of initial treatment
- Induction failure

CR2 and beyond

Myelodysplastic Syndromes (MDS)
Intermediate-1 (INT-1), intermediate-2 (INT-2) or high IPSS score, which includes either:
- >5 percent marrow blasts
- Other than good risk cytogenetics [good risk includes 5q- or normal]
- >1 lineage cytopenia

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Chronic Myelogenous Leukemia (CML)
- No hematologic or minor cytogenetic response three months post-imatinib initiation
- No complete cytogenetic response six to 12 months post-imatinib initiation
- Disease progression

Accelerated phase
Blast crisis [myeloid or lymphoid]

Pediatric Acute Leukemias

Acute Myelogenous Leukemia (AML)
- Monosomy five or seven
- Age <two years at diagnosis
- Induction failure

CR1 with HLA-matched sibling donor
CR2 and beyond

High-Risk Acute Lymphoblastic Leukemia (ALL)
- Induction failure
- Philadelphia chromosome positive
- WBC >100,000 at diagnosis
- 11q23 rearrangement
- Mature B cell phenotype (Burkitt's lymphoma)
- Infant at diagnosis

CR1 duration <18 months
CR3 and beyond

Lymphomas

Non-Hodgkin's Lymphoma
Follicular
- Poor response to initial treatment
- Initial remission duration <12 months
- Second relapse
- Transformation to diffuse large B-cell lymphoma

Diffuse Large B-Cell
- At first or subsequent relapse
- CR1 for patients with high or high-intermediate IPI risk
- No CR with initial treatment

Mantle Cell
- Following initial therapy

Hodgkin's Lymphoma
- No initial CR
- First or subsequent relapse

Multiple Myeloma

Multiple Myeloma
- After initiation of therapy
- At first progression

*These guidelines have been published jointly by the National Marrow Donor Program (NMDP) (**www.marrow.org**) and the American Society of Blood and Marrow Transplantation (ASBMT) (**www.asbmt.org**).*

Employee Spotlight

Pat Ross, R.N.
account manager,
United Resource Networks

As an account manager for United Resource Networks (U.R.N.), Pat Ross, RN draws upon her 30 years of clinical experience to help clients understand U.R.N. contracts, processes and procedures, and the value of the U.R.N. Centers of Excellence networks. Ross, who began her medical career as an emergency room nurse, spent years working in cardiovascular intensive care, tending to heart transplant patients and other critically ill patients. Her experience has served her well since joining UnitedHealthcare 13 years ago, first as a case manager, working directly with patients, and then as a supervisor, mentoring other case managers.

Last year, Ross's expertise was tapped again when she was asked to become part of the United Resource Networks Account Management team where, today, she draws upon her deep clinical experience as well as her years of managing and educating other case mangers as she works with payer groups, insurers and reinsurers.

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"Many of the client case managers I work with are generalists," explains Ross. "I help them understand the value of procedures and interpret contracts to help make sure their patients receive the best care." Ross, who has always been driven to make sure patients receive the right care, finds the opportunities and challenges of her new job both demanding and rewarding.

To stay current with clinical developments and maintain her hands-on expertise, Ross takes advantage of free lectures on transplantation offered through U.R.N.'s online and Web-based educational events. She also continues her clinical work several weekends a month at a local county jail in the Chicago area. "It's different," explains Ross. "These are people in need. Many of them are off the street with substance abuse problems, STDs and multiple medical problems."

In her spare time, Ross, the mother of two grown children, looks after her miniature poodle, "Curly," reads and stays fit by swimming at the neighborhood pool.

Frontlines of Care

Anxious Patient Obtains Top Care and Peace of Mind from a Cancer Resources Services Nurse Consultant

"I felt like I was a ticking time bomb," recalls Eileen Liverani, 52, following her gynecologist's diagnosis of endometrial cancer and her immediate referral to a surgeon. Anxious, Liverani called for an appointment only to learn that the surgeon was out on medical leave. A call to a second specialist brought little immediate relief, with a three-week wait for an appointment.

A co-worker, with whom Liverani confided, suggested she explore a new service available through her employer called Cancer Resource Services (CRS). To access the service, Liverani called the 800 number and spoke with a CRS nurse consultant. "She was great," recalls Liverani. "She provided names of cancer centers that were in the U.R.N. Cancer Centers of Excellence network and information on their expertise."

Memorial Sloan-Kettering Cancer Center was selected for Liverani since it was convenient to her home and well qualified to treat her form of cancer. The CRS clinical consultant also found a physician for her to call for an appointment. Less than a week later, Liverani was traveling to New York City to meet with the chief of gynecology at Memorial Sloan-Kettering. Surgery was quickly scheduled, and to Liverani's relief, her utilization of the CRS Centers of Excellence network meant that her benefit plan paid travel expenses for her and her husband.

The CRS nurse consultant helped Liverani access housing close to Memorial Sloan-Kettering for her husband during the week she was hospitalized. "It was comforting to know that I didn't have to worry about this," she recalls. The surgery was performed and she recovered in the Women's Cancer ward. "The expertise of the doctors and the highly coordinated efforts of the hospital staff were impressive," says Liverani.

She has since made several trips back to Memorial Sloan-Kettering for radiation treatments, which she arranged to take place in the morning so she could enjoy New York's cultural offerings before boarding the train to go home at the end of the day. "Sometimes my husband came with me; other times I had a girlfriend come. We would go out to lunch or a Broadway matinee in the afternoon after the treatments," she said. "I tried to make the best of a difficult situation."

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One year later, doctors tell Liverani that there is a 98 percent chance that the cancer will not recur. After three years, her odds of contracting cancer again will be the same as the general population. "I credit my recovery to the excellent care I received right at the start," recalls Liverani. "Having access to an outstanding hospital like Memorial Sloan-Kettering and their wonderful physicians made all the difference in the world. CRS made this possible."

If you have questions about Cancer Resource Services or any of our U.R.N. products, call your U.R.N. account manager at (800) 847-2050.

TransAdvise—Transplant Clinical Consulting Services for U.R.N. Clients and Patients

United Resource Networks' TransAdvise clinical consultants provide information regarding transplant-related diagnoses and treatment options to client case managers and patients to help them make informed decisions about their transplant care.

A dedicated team of transplant nurse experts, each with extensive transplant management experience, work with more than 10,000 transplant patients each year. These nurses provide case managers and patients with transplant program performance information, as well as news on relevant clinical trials and treatment protocols based on a patient's diagnosis and underlying conditions. This information and the clinical consultant's guidance assist patients through their referral to the transplant Centers of Excellence network programs.

To access TransAdvise, simply call (800) 343-4305, (8 a.m. to 5 p.m. Central Standard Time, Monday through Friday) to speak directly with a TransAdvise clinical consultant. You may also provide this phone number directly to patients.

A TransAdvise clinical consultant will capture and document all calls with your patients. Weekly and monthly activity reports will be provided to clients accessing these services.

We look forward to working with you and your patients. Please direct any questions regarding TransAdvise to your U.R.N. account manager at (800) 847-2050.

U.R.N. Resources

U.R.N.'s Mother and Child Continuum Identifies and Manages Complex Conditions and Cases

Although infertility and neonatal care may seem like relatively uncommon occurrences, their costs can have dramatic impact on patients and payers alike and aren't as uncommon as one may think. Today, more than 10 percent of all couples experience infertility, more than 480,000 babies are born prematurely each year (one out of every eight live births), one in 10 newborns require neonatal care and the average cost of treatment for a child with congenital heart disease is $290,000. As a payer, managing these cases can be time-consuming, costly and difficult. Now U.R.N.'s Mother and Child Continuum program helps clients handle these complex conditions by identifying and managing patients in order to promote the delivery of healthy singleton babies, and reducing overall perinatal and neonatal costs for both patients and payer.

Reproductive Resource Services (RRS) combines a Centers of Excellence network of reproductive endocrinologists with specialized infertility consulting. The RRS program strives to provide the best outcomes for both the patient and the payer by increasing the probability of healthy singleton births.

The Healthy Pregnancy Program (HPP) enrolls, assesses and manages pregnant women; helps to identify high-risk pregnancies; and refers women to specialized OB/GYN case management and other clinical programs as appropriate. Approximately 50 percent of premature births can be predicted in-utero; HPP identifies high-risk pregnancies and refers them to Neonatal Resource Services.

Neonatal Resource Services (NRS) helps reduce Neonatal Intensive Care Unit (NICU) costs by guiding patients to Centers of Excellence network providers. Patient education and guidance is provided by dedicated nurse consultants, who closely follow NICU babies and help ensure the appropriate care plan is implemented. This, in turn, saves money for patients and payers by reducing length of stay and NICU readmissions.

In the News…

New Options Considered to Ease Donor Organ Shortage

With a five-year wait for a new organ in some parts of the U.S. and expectations that this waiting time could double to 10 in less than five years, the demand for donor organs increasingly outpaces the supply, despite decades of efforts to improve organ donation awareness, according to a June 26, 2006 *USA Today* opinion piece. Today, 18 people die each day waiting for a new organ.

This critical shortage of available donor organs is prompting the consideration of new, sometimes controversial, approaches that could ameliorate the situation. Among the possible solutions reported in the *USA Today* article:

- Contracting with families in advance of the loss of a loved one and establishing a "futures" contract that would indicate that the adult or family agrees to donate organs upon death in return for financial remuneration (usually less than $10,000) that would cover funeral and other related expenses. Donated organs would enter the donor system and not be sold to private individuals.

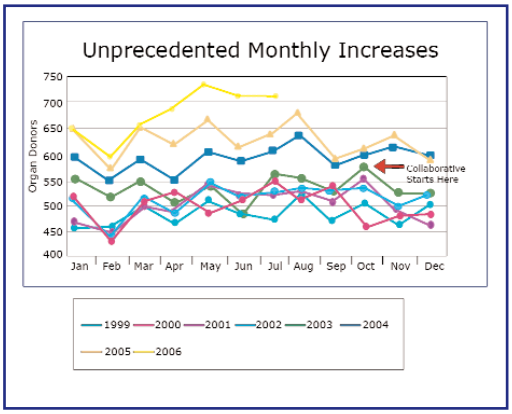
- The network, LifeSharers, made up of 4,500 donor members, is an organization of organ donors who agree that other members will receive their organs when they die.

- Today, Arkansas, Georgia, Iowa, Minnesota, New Mexico, North Dakota, Utah and Wisconsin all allow tax deductions of up to $10,000 to compensate living donors for travels expenses and lost income. Other states are considering similar legislation.

- Limited financial incentives could be provided for cadaver organ donations. Organs would be distributed through the existing donor system, which bases recipients on need and length of time on a waiting list—not on financial ability.

Another important initiative to increase the availability or organs from deceased donors was begun in April 2003 at the direction of Tommy Thompson, then the Secretary of Health and Human Services. Secretary Thompson challenged the 58 organ procurement organizations (OPOs) throughout the United States to increase the number of organ donors. From 1988 through 2003, organ donation rates had been flat at about 50 percent of eligible donors. His challenge was to increase the organ donation rate to 75 percent. This was to be accomplished through:

- Unrelenting focus on change, improvement and results
- Rapid, early referral and linkage
- Integrated donation process management
- Aggressive pursuit of every donation opportunity



Over the last few years, there has been a marked increase in organ donation as a

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result of the Organ Donation Breakthrough Collaborative efforts.

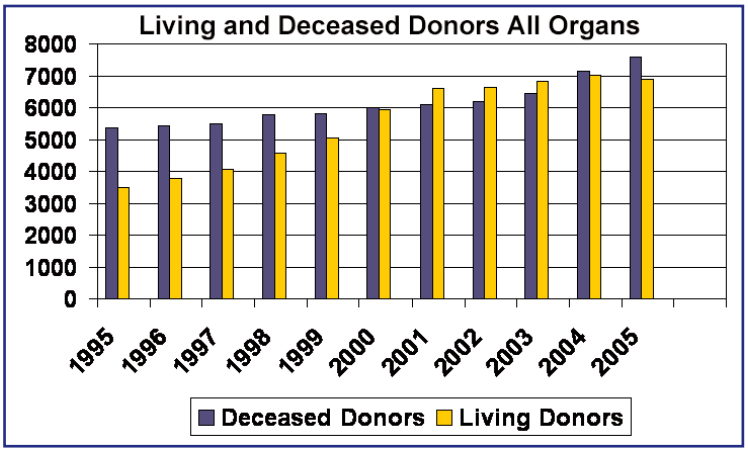
In 2004, Secretary Thompson issued another challenge: increase the number of organs recovered from every donor from 3.06 to 3.75. Secretary Thompson stated that we could "Save or enhance thousands of lives a year by maximizing the number of organs transplanted from each and every donor…with a goal to achieve an average of 3.75 organs transplanted per donor." If the donation rate could be increased to 75 percent of eligible donors and the number of organs harvested from each donor could be increased to 3.75, this would have the effect of increasing the number of patients who could receive an organ transplant from a deceased donor from about 18,000 per year to 36,000 per year. This would have a substantial effect on reducing deaths on the waiting list for patients who are so ill that they do not survive long enough under the current system to receive a donated organ.

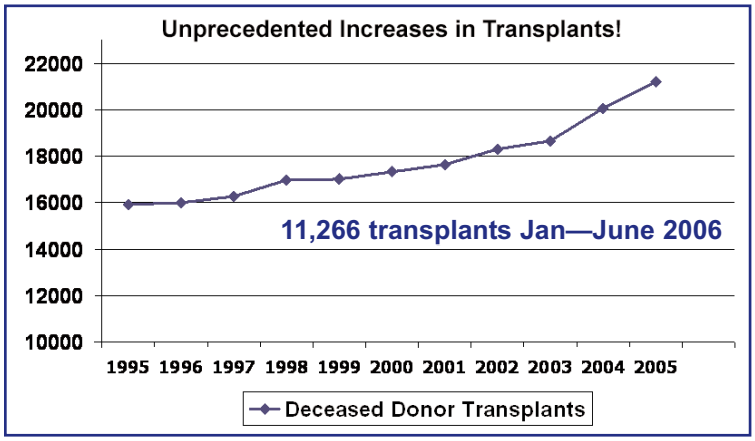
In fact, this effort has been very successful to date. In the last three years, while donations from living donors has been relatively flat, there has been an unprecedented increase in the number of organs obtained from deceased donors and a corresponding increase in the number of patients receiving organ transplants.

Sources: *Dr. Frank Irwin, national medical director, United Resource Networks.*

"Organ donations fall short; financial incentives can help," USA Today. 06/26/2006.

"State Tax Deductions and Donor Leave Laws," United Network for Organ Sharing. ***www.unos.org****.*





Ventricular Assist Devices

Ventricular Assist Devices, or VADs, are surgically implantable, mechanical devices that assist the heart in pumping blood to the body. Specifically, a VAD is used to pump the blood from a weakened heart ventricle to the body. Invented in the 1980s by legendary cardiologist Dr. Michael E. De Bakey[1], the VAD has improved health care and health care options for numerous cardiac patients over the years. There are three main uses for VADs: Bridge-to-Transplant, Destination Therapy and Bridge-to-Recovery.

Bridge-to-Transplant
VADs were originally intended to be used as a Bridge-to-Transplant. They were meant for short-term use to support failing hearts until a donor heart became available.

Approximately 75 percent of all VADs implanted are meant to be a Bridge-to-Transplant[2]. To qualify for a Bridge-to-Transplant VAD, a patient would have to be identified as a candidate for a heart transplant, present an imminent risk of dying before donor heart procurement and be dependent on vasopressor support.

Destination Therapy
VADs have become more commonly used as Destination Therapy (DT). DT is defined as a permanent support mechanism for patients who are in severe heart failure and do not qualify for a heart transplant.

Reasons that contribute to transplant ineligibility include advanced age, comorbidities, fixed pulmonary hypertension, contraindication to immunotherapy and/or patient refusal to transplant[3]. Nearly half of all ineligibilities are due to advanced age and over one-third of all ineligibilities are due to comorbidities[4].

Prior to VADs, transplant-ineligible patients were medically treated via ACE inhibitors, beta blockers and inotropic agents[5].

Bridge-to-Recovery
Recently, VADs have been used for Bridge-to-Recovery therapy. Bridge-to Recovery VADs account for 5 percent of VAD procedures[6]. Bridge-to-Recovery treatment is used for patients that present with an acute onset of heart failure. The VAD is used to allow the heart to rest and recover on its own. Once the heart's condition has improved, the VAD is removed.

Forty-five percent of patients who receive VADs for Bridge-to-Recovery have the VAD explanted within six months[7]. Data shows that six months after the implant of a VAD for Bridge-to-Recovery, 12 percent of patients receive transplants[8]. This suggests that their status switched from Bridge-to-Recovery to Bridge-to-Transplant due to increased acuity of their condition.

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United Resource Networks
VADs can significantly improve the longevity and quality of life for patients, and U.R.N. agreements support VAD utilization.

Bridge-to-Recovery and Destination Therapy procedures do not normally involve transplants and therefore are out of the scope of coverage of a transplant contract.

Please Note: United Resource Networks does not make benefit determinations for our clients. Our clients make determinations based on their specific benefit for transplantation. If requested, U.R.N. can provide medical appropriateness opinion services through Specialized Physician Review.

[1]*http://www.micromedtech.com/*
[2]*ISHLT/MCSD Analysis: Jan. 2002–Dec. 2004*
[3]*http://www.bcbs.com/tec/vol17/17_19.html*
[4]*ISHLT/MCSD Analysis: Jan. 2002–Dec. 2004*
[5]*LVAD as Destination Therapy for End Stage HF – BCBS Assoc. TEC – Dec. 2002.*
[6]*ISHLT/MCSD Analysis: Jan. 2002–Dec. 2004*
[7]*Ibid.*
[8]*Ibid.*

Contracting Corner

U.R.N. Adds New Centers to Its Networks

Kidney Resource Services (KRS)

Dialysis Clinic, Inc. (DCI)
United Resource Networks has entered into an agreement with DCI, a not-for-profit dialysis provider, with 202 dialysis centers in 27 states. The agreement is effective Dec. 1, 2006. The contract includes the KRS standard Dialysis Performance Standards and Guarantees, which is an all-inclusive rate for dialysis including drugs, labs and training.

Diversified Specialty Institutes (DSI)
United Resource Networks has entered into an agreement with DSI, a for-profit dialysis provider, with 108 dialysis centers, in 19 states. The agreement is effective for providers located in Arizona beginning Jan. 1, 2007. U.R.N. will continue to work on a state-by-state basis to achieve access for the KRS membership.

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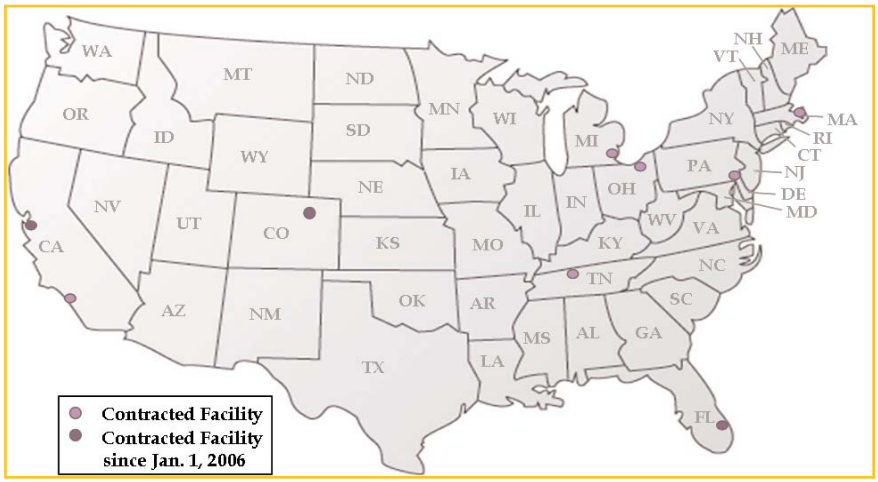
Facilities added to the U.R.N. CHD Centers of Excellence network since Jan. 1, 2006

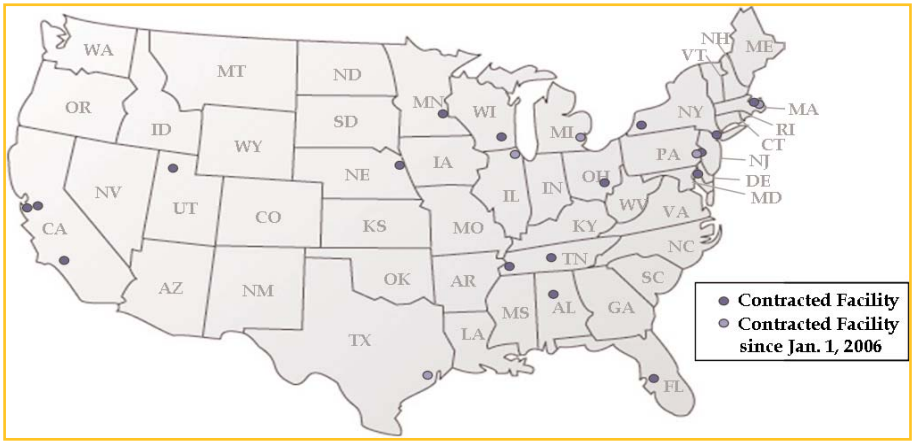


CALIFORNIA
Lucile Packard Children's Hospital at Stanford (Stanford)
COLORADO
Children's Hospital of Denver (Denver)
FLORIDA
Miami Children's Hospital (Miami)

Updated: Nov. 9, 2006

Please contact United Resource Networks at (800) 847-2050 to verify hospital participant status or for additional questions about this offering.

Facilities added to the U.R.N. Cancer Centers of Excellence network since Jan. 1, 2006



ILLINOIS
Children's Memorial Hospital (P) (Chicago)
MASSACHUSETTS
Children's Hospital Boston (P) (Boston)
MICHIGAN
Karmanos Cancer Institute (Detroit)
PENNSYLVANIA
Children's Hospital of Philadelphia (P) (Philadelphia)
TEXAS
****MD Anderson Cancer Center*** (P) (Houston)

* National Comprehensive Cancer Network® Member Institution (www.nccn.org)

(P) Pediatric oncology services are offered at these U.R.N. Cancer Centers of Excellence.
Updated Nov. 9, 2006

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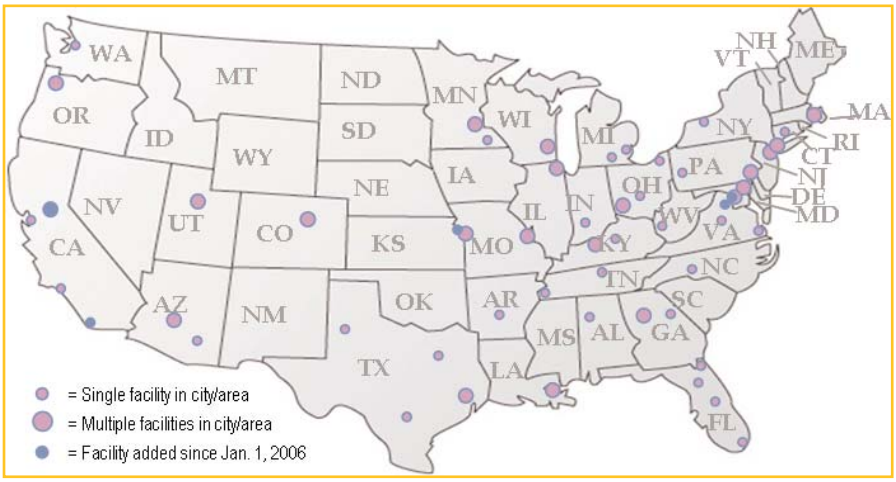
Facilities added to the Transplant Access Program since Jan. 1, 2006



* This program number reflects U.R.N.'s new methodology for counting transplant programs. Blood/Marrow programs are counted as three programs total (Auto, Allo-Rel and Allo-Unrel). Pediatric and adult programs are counted separately as well.

Note: Blood/Marrow programs include autologous (auto) and allogeneic (allo) transplants unless otherwise noted.
* PAK = Pancreas After Kidney

Five New Centers
Updated: Nov. 9, 2006

CALIFORNIA
University of California Davis Medical Center (Sacramento)
Blood/Marrow, Kidney, Kidney/Liver, Kidney/Pancreas, Liver, Pancreas

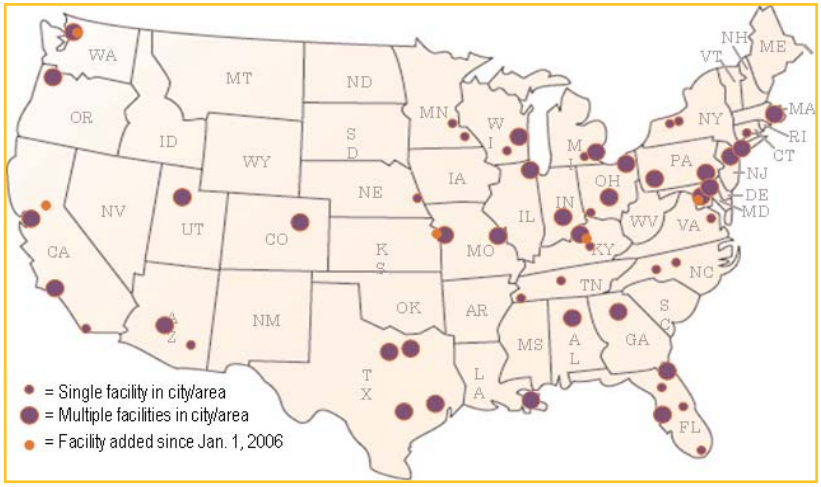
Sutter Medical Center (Sacramento)
Heart, Kidney/Pancreas, Pancreas

DISTRICT OF COLUMBIA
Children's National Medical Center (Washington)
Heart, Kidney

KANSAS
University of Kansas Hospital Authority (Kansas City)
Blood/Marrow, Kidney/Pancreas, Liver, Pancreas

VIRGINIA
Inova Fairfax Hospital (Fairfax)
Blood/Marrow, Heart, Kidney, Kidney/Liver, Kidney/Pancreas, Liver, Lung, Pancreas

Facilities added to the U.R.N. Transplant Centers of Excellence network since Jan. 1, 2006



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Note: Blood/Marrow programs include autologous (auto) and allogeneic (allo) transplants unless otherwise noted.
*CHD = Congenital Heart Disease. Contact your account manager for access to CHD programs.

Five New Centers
Updated: Nov. 9, 2006

CALIFORNIA
Sutter Medical Center (Sacramento)
Kidney

DISTRICT OF COLUMBIA
Children's National Medical Center (Washington)
Blood/Marrow

KANSAS
University of Kansas Hospital Authority (Kansas City)
Kidney

KENTUCKY
Kosair Children's Hospital (Louisville)
Blood/Marrow

WASHINGTON
Children's Hospital & Regional Medical Center (Seattle)
Heart, Kidney, Liver