

Aetna Settlement Fact Sheet
Prepared By The Massachusetts Medical Society Office Of The General Counsel

On May 21, 2003, a settlement was arrived at in the lawsuit brought by a class of physicians and several medical societies against Aetna, Inc. The suit alleges federal racketeering, conspiracy and various systemic reimbursement related violations. It is currently pending before Judge Moreno of the Multi District Litigation Panel in the United States District Court, Southern District of Florida. Judge Moreno entered an order on June 2, 2003, preliminarily approving the proposed Settlement.

The following outlines the proposed Settlement Agreement, which amounted to over 100 pages. Should you wish to read the Agreement in its entirety, you can access it at http://www.aetna.com/legal_issues/pdf_documents/settlement.pdf or www.milberg.com.

Parties to the Agreement

- Aetna, Inc.
- Representative Members of the Physician Class – (26 individual physicians)
- Signatory Medical Societies
 - Alaska State Medical Association
 - Connecticut State Medical Society
 - El Paso County Medical Society
 - Hawaii Medical Association
 - Nebraska Medical Association
 - New Hampshire Medical Society
 - Medical Society of New Jersey
 - Medical Society of the State of New York
 - North Carolina Medical Society
 - South Carolina Medical Association
 - Tennessee Medical Association
 - North Virginia Medical Societies
 - Washington State Medical Association
 - California Medical Association
 - Medical Association of Georgia
 - Florida Medical Association
 - Louisiana State Medical Society
 - Denton County Medical Association
- Class Counsel (14 firms)

Which Physicians are Included in the Class?

Any and all Physicians, Physicians Groups and Physician Organizations who provided Covered Services to any Plan Member or any individual enrolled in or covered by a plan offered or administered by Aetna (including subsidiaries and affiliates) from August 4, 1990 through Preliminary Approval Date of June 2, 2003.

How Will Physicians be Notified About the Settlement?

The Agreement states that published notice shall be issued in the legal notices section in the national editions of the Wall Street Journal and USA Today, Aetna's public website, and to the extent feasible – The Journal of the American Medical Association or The American Medical News.

The Agreement calls for the notice to be disseminated no later than 30 days after the Preliminary Approval Date, and said notice will identify the Opt-Out Deadline. Class Members wishing to opt out of the class will be excluded from the Agreement and Aetna does not need to apply any of the business practice initiatives contained in the Agreement to those individuals. Those who do not exercise their right to opt out will be bound by the terms of the Agreement and the Final Order and Judgment of the court.

The term of this Agreement is 4 years.

Aetna's Obligations under the Agreement

- NOTE:** The Agreement contains provisions which state that the Agreement is not intended to reduce, eliminate or supersede any Party's existing obligation to comply with applicable provisions of relevant state and federal law and regulations, and that Aetna shall comply with state and federal law and regulations (e.g. Chapter 141 – MA Managed Care Reform Act).
- **Automated Adjudication of Claims**
Aetna shall make investments designed to facilitate the automated adjudication of claims submitted by physicians, intended to reduce the average time taken to pay clean claims for covered services.
 - **Increased Internet and Clearinghouse Functionality**
Aetna shall make investments to enhance the ability of physicians to register referrals, pre-certify procedures, submit claims for covered services, check plan member eligibility for covered services, and check status of claims via the internet and clearinghouses.
 - **Availability of Fee Schedules and Scheduled Payment Dates**
Aetna shall develop and implement a plan to permit participating contracted physicians and physician groups to view, by December 31, 2004 on Aetna's provider website, on a confidential basis, the complete fee schedule applicable to such physician or group – stating dollar amount for each CPT code. Prior to that time Aetna shall, upon written request by a participating physician or group, provide the fee schedule for up to 50 CPT codes, as specified by said physician or group.
 - **Reduce Pre-Certification Requirements**
Aetna has reduced the number of procedures requiring pre-certification by physicians as well as the number of services requiring submission of clinical

information for pre-certification medical review. Pre-certification lists are now standardized across Aetna's products and pre-certification can be requested via electronic data interchange and the internet.

- **Greater Notice of Policy and Procedure Changes**
Aetna shall provide participating physicians with 90 days advance notice of all planned Material Adverse Changes (defined as “any change in Policies that could reasonably be expected to have a material adverse impact on (i) the aggregate level of payment by Aetna to participating physicians for covered services or (ii) participating physicians’ administration of their practices”) to its policies and procedures affecting performance under contracts with participating physicians.
- **Initiatives to Reduce Claims Resubmissions**
Aetna has begun to implement initiatives to increase the percentage of claim issues resolved on initial review and thereby reduce the percentage of resubmitted claims (e.g. make up to 3 inquiries for additional information upon receipt of incomplete claims before denying such claims).
- **Disclosure of and Commitments Concerning Claims Payment Practices**
By December 31, 2004 Aetna’s automated “bundling” and other claims payment rules shall be consistent across ongoing claims systems and products. By December 31, 2003, a web-based pre-adjudication tool shall be made available to provide information regarding the manner in which Aetna’s claim system adjudicates invoices for specific CPT codes or combinations of codes. By December 31, 2003, Aetna will disclose its payment rule or approach in each area in which CMS has promulgated a definitive rule or approach that is relevant to payment of physicians for covered services.
- **Physician Advisory Committee**
Aetna shall take all actions necessary to establish a Physician Advisory Committee (“PAC”) to discuss agenda items of nationwide scope, which will meet every 6 months for the duration of this Agreement. Aetna will establish an electronic mailbox on the provider website to enable participating physicians to communicate with the PAC. Composition of the 9 member PAC will include Aetna’s Chief Medical Officer or designee as Chair, and the remaining shall be participating physicians in active clinical practice to be chosen jointly by Aetna and the Plaintiffs. The PAC will have authority to recommend changes to Aetna’s business practices.
- **New Dispute Resolution Process for Physician Billing Disputes**
Aetna shall arrange for the establishment of an independent Billing Dispute External Review Board or Boards (“Billing Dispute Board”) - the organization of which is to be selected by Aetna and attorneys for the Class, for resolving disputes relating to: (i) the application of Aetna’s coding and payment rules and methodologies to patient-specific factual situations – including use of modifiers; (ii) whether Aetna has complied with the provisions of the Agreement; (iii)

Retained Claims (defined as claims for payment that have not been filed as of the Implementation Date of this Agreement or a claim which has been filed but has not been fully adjudicated)

Physicians may submit billing disputes which amount to \$500+ to the Billing Dispute Board only after exhausting Aetna's internal appeals process and upon payment of a filing fee (\$50 if dispute is \$1,000 or less; \$50 + 5% of the amount by which the amount in dispute exceeds \$1,000 – but never to exceed 50% of the cost of the review). These must be submitted within 90 days of exhausting the internal appeals process, and the Billing Dispute Board shall render a decision no later than 30 days after receipt of the documents necessary for the review. Any orders for payment must be satisfied by Aetna within 15 days.

If the same issue is in dispute at least 20 times, and Aetna's position is overturned in at least 50% of such matters, the PAC shall discuss the payment issue and consider recommending an appropriate policy or practice change.

- **Medical Necessity External Review Process**

Except as otherwise required by state law, Aetna currently maintains a nationwide process ("Medical Necessity Review") permitting plan members to seek independent external review of Aetna's determination that certain services or supplies are not covered services because they are not medically necessary or are experimental or investigational in nature. A filing fee is required for physicians seeking to access this process.

- **Electronic Remittance Advice and Electronic Fund Transfers**

As an inducement for increased electronic submission of claims, Aetna shall establish a mechanism to reimburse Qualifying Physicians Offices (defined as submitting in excess of 300 claims to Aetna electronically in the calendar quarter immediately preceding date of application for said reimbursement) for their actual cost toward acquisition of software to facilitate electronic remittance advice and electronic funds transfer transactions – not to exceed \$500 per Office and spending no more than \$5,000,000 in the aggregate.

If after the second anniversary of the implementation date of the Agreement Aetna has not paid up to \$5,000,000 in subsidy payments, it shall then offer reimbursement less than or equal to \$200.00 per physician office which submits in excess of 100 but less than 300 claims electronically in the preceding quarter.

Where multiple offices acquire a single software package, they will be treated as a single qualifying office.

Aetna will publicize this on its website and make reasonable investments to conduct educational seminars and other programs to educate participating physicians about electronic remittance advice and electronic fund transfer software capabilities and to promote the reimbursement program.

- **Credentialing of Physicians**
Primary source verification of a physician joining an existing group to be completed within 90 days of receiving the application.
- **All Products Clauses**
Aetna will not require physicians to participate in capitated fee arrangements in order to participate in products in which compensation is made on a fee for services basis.
- **Termination Without Cause**
Contracts with groups having fewer than 5 physicians will include a provision permitting either party to terminate such contract without cause with at least 90 days notice.
- **Standardization of Rates**
Aetna will establish and operate a fee schedule or schedules for fee for service payments for each geographic market in which it maintains a network. These will be updated annually, and with some noted exceptions, Aetna will not reduce any scheduled fees for physicians between such annual updates. Aetna will not be prevented from maintaining, altering or expanding the use of capitation or other compensation methodologies.
- **Recognition of Assignments of Benefits by Plan Members**
Aetna shall recognize all valid assignments by plan members of plan benefits to physicians.
- **Application of Clinical Judgment to Patient-Specific and Policy Issues**
 - Explicit definition of “medically necessary” is included in the Agreement.
 - Aetna shall make an annual, aggregate disclosure (on website) of the percentage of covered services recommended or provided by treating physicians that Aetna denies payment or authorization of on grounds of medical necessity.
 - In adopting clinical policies, Aetna shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the medical community, and take into account specialty society recommendations. These shall be readily available on the public website.
- **Time Period for Submission of Bills for Services Rendered**
Aetna shall not contest the timeliness of a bill if the bill is received within 120 days after (i) the date of service and (ii) the date of the physician’s receipt of an EOB from the primary payor if Aetna is the secondary payor.

Aetna agrees to accept paper and electronic claims.

- **Timelines for Processing Clean Claims**
15 days for electronic claims
30 days for paper claims
Interest shall be paid at rate specified by state law.
- **No Automatic Downcoding of Evaluation and Management Claims**
Aetna maintains the right, however, to deny or adjust such claims on other bases and to reduce the code level for selected claims.
- **Bundling and Other Computerized Claim Editing**
Aetna agrees to cooperate with and promote the establishment of one or more claim-editing software packages and a mutually acceptable process for modifying such software packages to accommodate future evolution of CPT and/or other billing rules or conventions.
- **EOB and Remittance Advice Content**
Aetna shall expend resources, not to exceed \$4,000,000 to revise by December 31, 2003, or soon thereafter, the EOB forms for its traditional products to include specific information as identified in the Agreement.
- **Overpayment Recovery Procedures**
Aetna shall initiate actions to reduce overpayments, including system enhancements to identify duplicate invoices prior to payment. Physicians shall be given 30 days written notice (detailed information identified in Agreement) before Aetna initiates overpayment recovery efforts. Aetna cannot recoup more than 24 months after the original payment, with limited exceptions (e.g. fraud).
- **Efforts to Improve Accuracy of Information About Eligibility of Plan Members**
Aetna shall take actions to reduce overpayments and claim denials resulting from inaccuracy of information about eligibility of plan members. Suggested actions are listed in the Agreement.
- **Provider Service Centers**
By December 31, 2004, Aetna shall establish a reasonable number of dedicated provider service centers to improve the speed, accuracy and efficiency of responses to physician inquiries and concerns.
- **Effect of Company Confirmation of Patient/Procedure Medical Necessity**
If Aetna has certified that a proposed treatment is medically necessary for a particular plan member, it shall not subsequently revoke that determination (absent fraud, etc.)
- **Electronic Connectivity**

Aetna agrees to maintain the provider website with a degree of reliability, and will ensure that physicians have the capacity to update their information on said website.

- **Capitation Reporting**

Aetna agrees to provide monthly reports to participating physicians, physician groups and physician organizations that receive capitation to allow for reconciliation of capitation payments.

If a plan member does not choose a primary care physician upon enrollment, Aetna will assign one at random.

- **“Gag” Clauses**

These will be omitted from all contracts.

- **Ownership of Medical Records**

Aetna’s standard agreements shall confirm that physicians own their medical records and that Aetna has a right to receive or review such records only as reasonably needed in the ordinary course for specific purposes.

- **Arbitration**

Limits fee required to be paid by physicians.

- **Impact of this Agreement on Standard Agreements and Individually Negotiated Contracts**

Aetna’s agreements shall incorporate and/or be consistent with this Agreement.

- **Pharmacy Risk Pools**

Aetna shall not require the use of pharmacy risk pools.

- **“Stop Loss” Coverage**

Aetna shall not restrict physicians from purchasing stop loss coverage from insurers other than it.

- **Pharmacy Provisions**

Aetna shall disclose to its members whether the plan uses a formulary, and if so, explain what a formulary is, how determinations are made as to what’s included and how often Aetna reviews the formulary list.

- **Mail Order Discount Card**

Aetna shall distribute forms to physicians permitting patients to enroll in a program enabling individuals to purchase prescription medications at discounted prices through a Company-affiliated mail order pharmacy.

- **Physician Specialty Society Guidelines**

No claims adjudication policy if practice adhered to by Aetna shall be deemed to violate the terms of this Agreement to the extent such policy or practice if consistent with the then current billing or claims adjudication guidelines issued by a physician specialty society.

- **Establishment of Foundation**

Aetna shall establish a 501(c)(3) charitable not-for-profit corporation (“Foundation”), to be governed by certain identified signatory medical societies. Aetna will pay all costs and expenses associated with establishing the Foundation, and contribute \$20 million to it. The Foundation will support initiatives that help physicians enhance the quality of care for their patients in areas such as:

- Patient safety and the reduction of medical errors
- Elimination of racial and ethnic disparities in health care
- Improvements in the way the health care system managed end-of-life care
- Reduction and prevention of childhood obesity
- Addressing the problem of the uninsured

- **Settlement Fund**

Aetna will establish an account for the administration of settlement payments to class members, governed by the terms of an escrow agreement. Aetna will contribute \$100 million to the fund and a settlement administrator will administrate the settlement fund.

The Agreement contains a detailed formula that the settlement administrator shall use to determine allocation of payment. Aetna and the Class Counsel are to work together to establish a basis of the estimates of the amounts that class members who submit the requisite claim form will be entitled to receive. Class members can either receive payment from the fund or direct the fund to contribute the amount on the individual’s behalf to the Foundation.

- **Attorneys Fees and Representative Plaintiffs’ Fees**

Class Counsel intends to apply to the Court for an award of attorneys’ fees in an amount not to exceed \$50 million, which Aetna agrees not to oppose. Class Counsel also intends to apply for an award of fees for each Representative Plaintiff in the amount of \$7,500, which Aetna agrees not to oppose.

- **Compliance Disputes Arising Under This Agreement**

All compliance disputes shall be directed to the Compliance Dispute Facilitator (“Facilitator”) to be designated by Class Counsel, and not to any state court, federal court, arbitration panel or other. The Facilitator will then refer the disputes to a Compliance Dispute Review Officer (“Officer”) for resolution. Aetna and Class Counsel shall agree upon the Officer. The Agreement provides for Alternates as replacements in certain circumstances.

Aetna will pay fees and costs of the Compliance Facilitator and Officer.

- **Who May Petition Compliance Dispute Facilitator**
 1. Any Class Member who has not properly requested to opt-out, and that based on the facts, contends that Aetna has materially failed to perform specific obligations contained in the Agreement and that he/she has been adversely affected; and
 2. Any Signatory Medical Society, so long as such society (i) identifies in its petition to the Facilitator a Class Member who has not properly requested to opt-out and (ii) brings the dispute solely on behalf of such Class Member.

- **Procedures for Submission, and Requirements, of Compliance Disputes**

Detailed procedures are contained in the Agreement, including that the Facilitator has the authority to reject claims deemed to be frivolous. Petitioner has no right to appeal the Facilitator's decision. If feasible, the Facilitator can resolve a dispute without invocation of the Officer's authority.

Detailed procedures are also contained in Agreement for the Officer's determination of compliance disputes. The Facilitator shall serve as the Petitioner's representative in the dispute process, unless otherwise specified by the Petitioner.

Memoranda are to be submitted to the Officer and oral argument is afforded. A written decision shall be issued by the Officer setting forth the basis of the Officer's decision. Petitions for rehearing are allowable. If the Officer determines that Aetna has engaged in systemic violations of its obligations, the Officer may order appropriate remedies.

Appeals from the Officer's final decision may only be made to the United States District Court for the Southern District of Florida. The court will have the authority only to determine whether the Officer's final decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law".

- **Internal Compliance Officer**

This is in addition to the Facilitator and Officer referenced above, and its role is to generally monitor and facilitate Aetna's compliance with the obligations set forth in the Agreement.

- **Settlement Commitments Modifiable to Prevent Substantial Impairment of Company's Competitive Position**

Aetna can alter or modify the agreements and undertakings in this Agreement, with limitations (e.g. not within 12 months of the preliminary approval date of this Agreement), as reasonably needed to compete in the applicable marketplace. Notice will be given and if Class Counsel determines, with the concurrence of the Facilitator, that such modification is not needed for competitive reasons, that

determination shall be deemed to create a compliance dispute and shall be referred to the Officer.

- **Release: Covenant Not to Sue**

Aetna and all of its present and former parents, wholly-owned subsidiaries, divisions Affiliates, officers, directors, employees and attorneys shall be released and forever discharged by the Signatory Medical Societies and all Class Members who have not properly requested to opt out of this Agreement, and by their respective heirs, executors, agents, legal representatives, professional corporations, partnerships, etc.

Aetna is released and discharged from any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities and demands of whatever kind or character, arising on or before the Preliminary Approval Date, that are, were or could have been asserted against Aetna based on or arising from the factual allegations of the Complaint, whether any such Claim was or could have been asserted by any releasing party on its own behalf or on behalf of other persons.

Aetna is also released from a claim of any kind which arises after the Preliminary Approval Date, that in any way relates to, arises from, is similar to, or is based on, the causes of action and/or factual allegations in the Complaint – but only to the extent that the claim is based on actions or omissions by Aetna that are consistent with its practices and procedures as of the Execution Date.

Similarly no claims can be brought against any other persons or entities, which arise from or are based on conduct by Aetna, etc.

Claims for payment for covered services which, as of the implementation date of this Agreement, no claim has been filed or has been finally adjudicated by Aetna are not being released. Releasing parties also retain the rights to bring an action asserting claims against Aetna by or on behalf of physicians to recover amounts alleged to be owed to such physicians by any physician organization that has become insolvent, with some limitations.

Judicial proceedings can be instituted to seek non-monetary, non-injunctive declaratory relief with respect solely to the meaning or interpretation of state and federal law or regulations. If the releasing parties believe that one or more actions of Aetna are inconsistent with any declaration, they may pursue a Compliance Dispute pursuant to the procedures in this Agreement.

- **Related Provider Track Actions**

Representative Plaintiffs, Signatory Medical Societies, Class Counsel and Aetna shall cooperate to obtain an order dismissing tag along actions.

- **Provisions Applicable to Other Proposed Settlements**

Counsel agree to use best efforts to ensure that the terms of a settlement agreement entered into with any of the other defendants in the Class Action within one year of the Preliminary Approval Date, include at least the same total cash amount as this Agreement with some adjustments, and that the value of the non-monetary relief be at least as valuable as that which is contained in this Agreement (estimated at \$300 million).