

NO. D-1-GV-09-000160

THE STATE OF TEXAS,  
Plaintiff

IN THE DISTRICT COURT OF

v.

TRAVIS COUNTY, TEXAS

AETNA LIFE INSURANCE COMPANY  
and CHICKERING CLAIMS  
ADMINISTRATORS, INC.  
Defendants

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419<sup>th</sup> JUDICIAL DISTRICT

**ASSURANCE OF VOLUNTARY COMPLIANCE**

This Assurance of Voluntary Compliance (the "Agreement") is made and entered into the 5<sup>th</sup> day of February, 2009, between the State of Texas, by and through its Attorney General, Greg Abbott, and Aetna Life Insurance Company and Chickering Claims Administrators, Inc. (Defendants).

Whereas, Chickering Claims Administrators, Inc. provides claims handling services for Aetna Life Insurance Company on its college student health insurance business in Texas; and

Whereas, the Consumer Protection & Public Health Division of the Office of the Attorney General is authorized to investigate and bring an action in the name of the State of Texas for possible violations of the Deceptive Trade Practices-Consumer Protection Act ("DTPA"), TEX. BUS. & COMM. CODE ANN. § 17.41 *et seq.*, and TEX. INS. CODE ANN. Chapter 541 and the rules and regulations promulgated thereunder ("Chapter 541"); and

Whereas, the State of Texas contends that Defendants violated the DTPA and Chapter 541 by failing to update data used to determine the reasonable charge for payment of out of network services provided by physicians and other providers on student health insurance claims; and

Whereas, Defendants deny that they have violated the DTPA or Chapter 541; and

Whereas, in order to avoid the time, expense and uncertainty of litigation, the State of Texas and Defendants are desirous of compromising and settling their mutual disputes and differences.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained, the State of Texas and Defendants agree as follows:

1. Defendants shall pay current and former plan members and their providers the difference between the amount that was allowed for claims using outdated Ingenix MDR charge data and the amount that should have been allowed had the then-current Ingenix MDR charge data been used ("the underpayment amount"), since January 1, 1998, plus interest, as provided in this Agreement. The total amount of payments to members and their providers in this Agreement is estimated to be approximately \$114,000 including interest.

2. Defendants have made all reasonable efforts to identify current and former plan members eligible for reimbursement under paragraph 1, through searches of their electronic records, and have identified approximately 1,209 plan members who may be entitled to payment under paragraph 1 above. Defendants will mail to each of these presently identified plan members a letter in the form of Exhibit A attached hereto within thirty (30) days of the effective date of this Agreement. The envelope for this letter shall have the statement "REPLY REQUESTED ABOUT POSSIBLE REFUND" on the front and, for letters mailed to addresses within the United States, shall also contain a self-addressed postage paid reply envelope. Current or former plan members who respond "yes" to the claim form contained in Exhibit A shall be paid by Defendants, within 150 calendar days after the effective date of this Agreement, a check for the underpayment amount plus 18% per annum simple interest from the date the claim was originally paid to the date the check is issued. Although Exhibit A requests a response within 45 days, an untimely response which

answers "yes" shall still be honored by Defendants and a check shall be duly issued as provided in this paragraph. Also, a signed and dated response is not required for the member to receive payment.

3. Each check to a current or former plan member shall be accompanied by a letter in the form attached hereto as Exhibit "C" in an envelope that contains the statement "IMPORTANT INFORMATION - DO NOT DISCARD." There shall be no release language in either the letter or the check.

4. All correspondence and payments shall be mailed to the most current address available of the current or former plan member or provider, with an address correction requested. All letters returned to any Defendant with a corrected address shall be forwarded to such address. Any payments that remain unnegotiated for 3 years from the issue date of the checks shall be subject to TEX. PROP. CODE § 72.001, *et seq.* and Defendants shall follow those provisions regarding such persons and such sums of money.

5. Defendants have made all reasonable efforts to identify providers eligible for reimbursement under paragraph 1, through searches of their electronic records, and have identified those providers who may be entitled to payment under paragraph 1 above. As to providers of current or former plan members who did not answer "yes" within 45 days of the mailing of Exhibit A, Defendants will mail to each of these presently identified providers a letter in the form of Exhibit B attached hereto no sooner than 60 days but not later than 150 days after the effective date of this Agreement. With such letter Defendants shall pay each such provider a check for the underpayment amount plus simple interest calculated at the rate of 5% per annum or the prime rate for each year, whichever is higher (but not to exceed 15% per annum), from the date the claim was originally paid to the date the check is issued. There shall be no release language in either the letter or the check.

6. Eight (8) months from the effective date of this Agreement, Defendants shall provide, the Consumer Protection & Public Health Division of the Office of the Texas Attorney General with a sworn verified accounting which shall reflect:

- a. the total number of plan members who were sent claim forms;
- b. the total number of plan members who responded to the claim forms;
- c. the total number of plan members who answered "yes" to the claim forms;
- d. the total number of plan members who were mailed checks;
- e. the total dollar amount of checks mailed to plan members;
- f. the total number of providers who were mailed checks;
- g. the total dollar amount of checks mailed to providers; and
- h. the total number and total dollar amount of checks not negotiated.

7. On or before the effective date of this Agreement, and continuing thereafter, Defendants shall cease and desist in Texas student health insurance plans from paying out of network claims based on outdated Ingenix MDR charge data.

8. Within 15 days of the effective date of this Agreement, Defendants shall pay \$30,000.00 to the Office of the Attorney General as its expenses and costs of investigation. Failure to pay within the designated time period shall be a material breach of this Agreement.

9. The parties agree that they will submit this Agreement to the court of competent jurisdiction in Travis County and request that the court approve and enter this Agreement pursuant to TEX. BUS. & COM. CODE § 17.58.

10. The parties hereto agree that this is a compromise of a disputed claim, and that this Agreement is entered into without admitting any liability, which liability is expressly denied, and

without agreement by any party to any of the allegations made by another party. Nothing contained herein shall be deemed an admission of liability or wrongdoing of any kind.

11. The parties represent and warrant, each to the other, that each has the authority to enter into and made this Agreement, and to bind themselves to this Agreement.

12. This Agreement shall be governed by TEX. BUS. & COM. CODE § 17.58.

13. Defendants shall bear all costs associated with this settlement. Any and all taxable costs of court are taxed against Defendants.

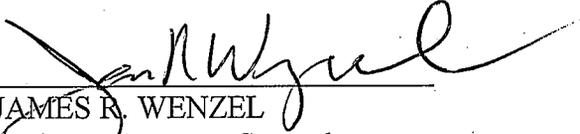
EXECUTED AND EFFECTIVE this 5<sup>th</sup> day of February, 2009.

GREG ABBOTT  
Attorney General of Texas

C. ANDREW WEBER  
First Assistant Attorney General

JEFF L. ROSE  
Deputy First Assistant Attorney General

PAUL CARMONA  
Chief, Consumer Protection & Public Health Division

By:   
JAMES R. WENZEL  
Assistant Attorney General  
Consumer Protection & Public Health Division  
Insurance Practices Section  
State Bar No. 21179370  
300 West 15th Street, 9th Floor  
Austin, Texas 78701  
(512) 463-1264/FAX (512) 463-1267

ATTORNEYS FOR THE STATE OF TEXAS

CHICKERING CLAIMS ADMINISTRATORS, INC.

By: Karen M. Bayley

Title: President Aetna Student Health

AETNA LIFE INSURANCE COMPANY

By: \_\_\_\_\_

Title: \_\_\_\_\_

CHICKERING CLAIMS ADMINISTRATORS, INC.

By: \_\_\_\_\_

Title: \_\_\_\_\_

AETNA LIFE INSURANCE COMPANY

By: Robert J. K.

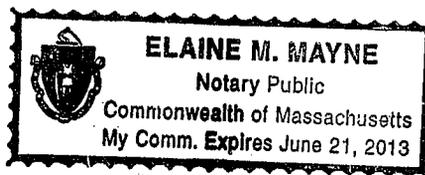
Title: V.P., FINANCE & TREASURER

THE STATE OF Massachusetts §  
COUNTY OF Middlesex §

On this 14th day of January, 2009, before me, the undersigned authority, personally appeared Katharine N. Begley, who is personally known to me and acknowledged himself/herself to be an agent for Chickering Claims Administrators, Inc. and he/she, as such an agent, being authorized to do so, executed the foregoing instrument for the purpose and consideration therein contained by signing for Chickering Claims Administrators, Inc. by himself/herself as an agent for such.

In witness whereof, I hereunto set my hand and official seal.

  
Notary Public, State of Massachusetts





**Member Letter**

[Date}

Dear [MEMBER'S NAME]:

Our records indicate that you are currently a member or have been a member in an Aetna Student Health\* student health plan. Our records also show that you received care from someone who was not in our network of participating health care providers.

We did not calculate your claim correctly and owe an additional payment for claims that were underpaid. We are asking for your help so we can determine whether we owe the additional payment to you or to the provider. When the claim is reprocessed, Aetna Student Health will send you an Explanation of Benefits that will provide additional detail about the payment. In addition to sending the underpaid amount, we will also pay you or the provider interest and penalties required by law. Please note that this notice is being sent for all claims affected by this issue, even those for which the amount of the underpayment does not exceed the cost of postage and handling.

Our records show the following:

<b>1) Date You Received Care</b>	<b>2) Health Care Provider</b>	<b>3) Your Deductible And Coinsurance On This Claim</b>	<b>4) Amount Plan Underpaid</b>
[prefill]	[prefill]	[prefill]	[prefill]

To help us determine who should receive the additional payment, please complete the attached form and mail it back to us in the enclosed return envelope. **In order to help us complete this process, please return this form to us by [insert date that is 45 days away from date of mailing.]** If you do not return the form by that date, the payment will automatically be sent to the provider.

We regret the inconvenience to you and thank you in advance for your cooperation. If you have any questions about this letter, please do not hesitate to call us toll-free at 866-805-7643. You can also get additional information at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

Sincerely,

Aetna Student Health

\*Aetna Student Health insured plans are underwritten by Aetna Life Insurance Company (ALIC), with administrative services provided by Chickering Claims Administrators, Inc. (CCA). Self-insured plans are funded by the educational institution, with administrative services provided by CCA. Aetna purchased CCA in 2003. In March of 2008, "Aetna Student Health" replaced "The Chickering Group" as the brand name for products and services provided for student health plans by ALIC and CCA.

[Member Name, Ref #]

Please complete the below, and return this form in the enclosed postage-prepaid return envelope. In column 5, for each claim listed, please indicate "Yes" if you paid your provider in excess of your deductible and coinsurance. Indicate "No" if you did not pay you're the provider in excess of your deductible and coinsurance. If you indicate "Yes," Aetna Student Health will send the additional payment to you. If you indicate "No," we will pay the provider.

<b>1) Date You Received Care</b>	<b>2) Health Care Provider</b>	<b>3) Your Deductible And Coinsurance On This Claim</b>	<b>4)Additional Amount Plan Will Pay</b>	<b>5) I paid My Provider In Excess of My Deductible and Coinsurance For This Claim (Indicate Yes or No)</b>
[prefill]	[prefill]	[prefill]	[prefill]	

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Note: If your address has changed from the address on this letter, please add your preferred mailing address to receive your explanation of benefits and payment:

\_\_\_\_\_

\*This amount does not include interest and penalties, which will also be paid as required by law.

**EXHIBIT A**

**Provider Letter [Non-personalized insert with EOB/payment to provider]**

Our records indicate that you have treated one or more patients covered under an Aetna Student Health\* student health plan. We paid an incorrect amount on one or more claims and believe we owe you additional payment.

The enclosed Explanation of Benefits provides additional detail about the patient, services rendered and additional amount paid on those services. The payment includes simple interest at the rate of 5% per annum or the prime rate for each year, whichever is higher.

If you have already been paid in full for these services, please post the payment and follow your office's normal process for issuing refunds to your patients. In addition, if this payment results in your receiving any amounts in excess of your full billed charges for the applicable services (e.g., due to prior partial payment by a patient), please forward any such excess amounts to your patients. Please do not return the check to Aetna.

We apologize for this inconvenience and thank you for your cooperation. If you have any questions, please call us at 1-866-805-7643. You can also get additional information at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

Sincerely,

Aetna Student Health

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**EXHIBIT B**

**Member Payment Letter [Non-personalized insert with EOB/payment to member]**

Dear Member,

Our records indicate that you are currently a member or have been a member in an Aetna Student Health\* student health plan. Our records also show that you received care from someone who was not in our network of participating health care providers.

We did not calculate your claim correctly and owe an additional payment for claims that were underpaid. The enclosed Explanation of Benefits provides additional detail about the additional payment. The payment includes interest of 18% per annum simple interest.

We regret the inconvenience to you and thank you for your cooperation. If you have any questions, please do not hesitate to call us toll-free at 1-866-805-7643. You can also get additional information at [www.aetna.studenthealth.com](http://www.aetna.studenthealth.com).

Sincerely,

Aetna Student Health

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**EXHIBIT C**