

CAUSE NO. _____

THE STATE OF TEXAS,	:	IN THE DISTRICT COURT OF
Plaintiff,	:	
	:	
vs.	:	
	:	
AETNA U.S.	:	TRAVIS COUNTY, TEXAS
HEALTHCARE, INC.; AETNA	:	
U.S. HEALTHCARE OF NORTH	:	
TEXAS, INC.; and PRUDENTIAL	:	
HEALTH CARE PLAN, INC.,	:	
Defendants.	:	_____ DISTRICT COURT

ASSURANCE OF VOLUNTARY COMPLIANCE

TO THE HONORABLE JUDGE OF SAID COURT:

COME NOW, the State of Texas, by and through the Attorney General of Texas John Cornyn ("Attorney General"), Aetna U.S. Healthcare, Inc. (a Texas corporation), Aetna U.S. Healthcare of North Texas, Inc. and Prudential Health Care Plan, Inc. (collectively "Aetna"), and respectfully submit for the Court's approval and filing in accordance with the *Deceptive Trade Practices-Consumer Protection Act* ("DTPA"), TEX. BUS. & COM. Code § 17.58, this Assurance of Voluntary Compliance ("AVC").

**THE TEXAS ATTORNEY GENERAL AND AETNA’S AGREEMENT
AFFECTING AETNA’S TEXAS HMOS**

INTRODUCTION

Recognizing the importance of maintaining and improving the quality and integrity of benefits provided by health maintenance organizations (HMOs), the Texas Attorney General and Aetna have developed in this agreement a set of principles to guide managed care health plans to

better serve Texas consumers and strengthen the working relationships with physicians and other health care professionals. The Attorney General and Aetna endorse the principles of this agreement as a means of assuring that HMO members' health care needs will be considered first and foremost and as a means of educating consumers about managed health care.

The principles that the Attorney General and Aetna have agreed upon provide important new protections for consumers. In addition to these new protections, this agreement builds upon and improves Aetna's policies and provides a better set of principles for consumers' understanding of their HMO. The Attorney General and Aetna believe these principles respond to the needs of HMO members, physicians and providers, and demonstrate a commitment to improve the quality and integrity of HMO plans. In developing this set of principles, the Attorney General and Aetna have focused on four key areas.

First, this agreement seeks to improve the quality and integrity of determinations of medical necessity and covered benefits by HMOs by assuring that determinations of medical necessity are:(1) based solely on state of the art medical standards after reviewing all relevant medical information; (2) made by reference to a clearly stated and broad definition of medical necessity that is made available to members, physicians, providers and plan sponsors; (3) ultimately decided by qualified medical professionals licensed in Texas; and (4) not confused with determinations of covered health care services.

Second, this agreement seeks to improve the quality and integrity of member choices and access to health care services by: (1) prohibiting physicians from discriminating against any Aetna member based on the member's medical condition; (2) strengthening Aetna's ability to take steps

to detect and prevent underutilization of health care services, especially as underutilization affects women, minorities, and members with serious health conditions; (3) providing Aetna members increased protections for their choice of primary care physicians; (4) assuring Aetna members access, if medically necessary, on a standing basis to a specialist and, if medically necessary, to care outside the network of physicians and providers normally made available to the member; (5) making sure that Aetna gives advance notice of any changes in the prescription drugs Aetna will offer on its published formulary list in the next plan year; and (6) broadening Aetna member access to Aetna's external review process.

Third, this agreement seeks to improve the quality and integrity of the physician-patient relationship by ensuring that Aetna's contractual and financial arrangements with physicians and providers: (1) are disclosed; (2) include provisions that require physicians to provide the same standard of care for all Aetna members regardless of any financial incentive arrangement; (3) be designed to encourage and provide adequate compensation for all medically necessary covered services; (4) contain protections for Aetna members from financial inducements to limit medically necessary covered services; (5) permit physicians and providers more freedom in choosing the types of Aetna health care plans they accept; and (6) promote broad access for consumers to a large number of available physicians and providers.

Fourth, Aetna agrees to create an Office of Ombudsman within Aetna. The Office of Ombudsman will educate Aetna members, will act as an independent advocate on behalf of members, and will report to the Attorney General on Aetna's ability and efforts to comply with the terms of this agreement.

In addition to these four areas of protection, the Attorney General and Aetna have established broad oversight of this agreement by the Attorney General and the Ombudsman to ensure compliance with this agreement and Aetna agrees it will not raise any preemption defense based on *The Employee Retirement Income Security Act of 1974* (ERISA) against any action by the Attorney General to enforce this agreement.

ASSURANCES

I.

IMPROVING THE QUALITY AND INTEGRITY OF DETERMINATIONS OF MEDICAL NECESSITY AND COVERED BENEFITS

1. Aetna agrees that it will pay for all contractually covered medically necessary care to Aetna Members. Aetna agrees that the determination of medically necessary care is an analytical process that will be applied by Aetna on a case-by-case basis by qualified professionals who have the appropriate training, education, and experience and who possess the clinical judgment and case specific information necessary to make these decisions. Aetna agrees that the determination of whether proposed care is a contractually covered health care service is independent of the determination of whether proposed care is medically necessary. Aetna agrees that a determination of whether care is a contractually covered health care service will not be confused with a determination of whether the care is medically necessary. Aetna agrees that it will not use any decision-making process that operates to deny contractually covered, medically necessary care.
2. Aetna agrees that covered benefits are health care services paid for under the applicable certificate of coverage that are not otherwise excluded or limited. Aetna agrees that any exclusions

or limitations to covered benefits will be clearly and unambiguously disclosed in the certificate of coverage. The parties agree that Aetna is obligated to pay for only those covered benefits that are determined to be medically necessary.

3. Aetna agrees that medically necessary care shall be defined as health care services and supplies that under the applicable standard of care are appropriate:

- (a) to improve or preserve health, life, or function; or
- (b) to slow the deterioration of health, life, or function; or
- (c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness, or injury.

Determinations by Aetna of whether care is medically necessary under this definition shall also include determinations of whether the services and supplies are cost effective, timely, and sufficient in quality, quantity, and frequency, consistent with the applicable standard of care. Aetna agrees to include this definition of medically necessary care in all applicable certificates of coverage and otherwise disclose this definition to HMO enrollees and Network Providers. For purposes of this AVC, a treatment is cost effective if it is the least expensive medically necessary treatment selected from two or more treatments that are equally effective in achieving a desired health outcome for that particular patient. For purposes of this Section I.3. of this AVC, “effective” means that the care can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

4. Aetna agrees that, if it does not have enough information for a determination of whether proposed care is medically necessary, Aetna will, within the time appropriate to the circumstances relating to the delivery of the care and the condition of the patient, provide notice to the requestor

and Member that more information is needed to determine whether the proposed care is medically necessary. These notifications will identify the specific information needed to determine whether or not the proposed care is medically necessary. Aetna may initially deny authorization for payment of proposed care for lack of sufficient information regarding whether the proposed care is medically necessary only after three attempts to obtain the needed information have been made. Aetna agrees to evaluate the medical necessity of any proposed care within the time appropriate to the circumstances relating to the delivery of the benefits and condition of the patient as soon as the identified specific information is provided regardless of any previous denial based on lack of sufficient information.

5. Aetna agrees that the definition of medically necessary care in Section I. of this AVC in no way limits any more inclusive definition of medically necessary care enumerated elsewhere by applicable and binding judicial holding, statute, regulation, rule or determination by any Texas or federal regulating entity with jurisdiction.

6. Recognizing that medical necessity determinations should be made according to the appropriate medical standard of care, Aetna agrees that any non-case specific materials used by Aetna in Aetna's determinations of whether care is medically necessary will be based on recognized guidelines, if such guidelines exist, developed by licensed Physicians based upon scientific and medical evidence. For purposes of this Section I.6. of this AVC, scientific and medical evidence shall have the same meaning as at 28 TEX. ADMIN. CODE § 12.5.

7. Aetna agrees that Aetna's Coverage Policy Bulletins and any other similar non-case specific guidelines or policies prepared or developed and used by Aetna in Aetna's determination of covered

services or medical necessity will be made public over the Internet at Aetna's address: www.aetnaushc.com. Aetna agrees that any other non-case specific guidelines or policies used by Aetna in Aetna's determinations of covered services or medical necessity will be disclosed and made public and available for peer review to the extent permissible by applicable copyright, trademark or intellectual property law, contract, or relevant licensing agreement.

8. Aetna agrees that any determination that a proposed course of treatment, health care service, or supply is not a covered benefit will be communicated in writing or by telephone to the requestor and Member. The specific reasons and rationale for determining that the proposed course of treatment, health care service, or supply is not a covered benefit will be provided to the requestor and Member.

9. Aetna agrees to conduct audits or reviews every 180 days of utilization review personnel to determine the incidence of erroneous Adverse Determinations, if any, and to assure that the agreements in this AVC are implemented and followed. Aetna agrees to implement remedial action to prevent the occurrence of erroneous Adverse Determinations.

10. Aetna agrees that any Adverse Determination it makes will be ultimately decided only by a Physician with a license to practice medicine in Texas. Aetna agrees to disclose in Aetna's pre-enrollment marketing materials the fact that determinations of medically necessary care may be made by Physicians other than the Member's Specialist or primary care physician.

11. Aetna agrees that it will require all entities to which it delegates or assigns utilization review to comply with all of the agreements in Section I of this AVC and the TEX. INS. Code art. 21.58A and rules promulgated thereunder. Aetna agrees that it will contractually require all Network

Providers to agree to comply with the conditions agreed to by Aetna in this Section I.11 of this AVC.

12. Except to the extent otherwise required by law, plan or certificate of coverage, Aetna agrees to apply the same policies, procedures, and standards to all of Aetna's Members regardless of whether these Members participate through an ERISA or non-ERISA plan.

13. Aetna agrees to maintain or apply for National Committee for Quality Assurance accreditation for Aetna's commercial HMO operations in Texas. Aetna agrees to make the results of these applications public.

14. Aetna agrees that any Member, or Network Provider upon written consent of a Member, may appeal any of the following denials or reductions through Aetna's internal appeal process and if any part of that denial or reduction is upheld on appeal then Aetna shall permit the Member or Network Provider, upon written consent of a Member, to seek a timely external review of that denial or reduction provided at least \$500.00 is at issue. Aetna agrees that in complying with this Section I.14 of this AVC, it will meet all requirements and standards imposed by Texas law on the operation of, and provision of access to, an internal appeals process. The denials or reductions which are subject to this Section I.14 of this AVC are: (a) any denial or reduction of payment for emergency care based on failure to meet the prudent lay person standard; (b) any denial or reduction of payment because the health care services furnished or proposed are deemed to be experimental or investigational; (c) any denial of payment for drugs for covered health care services sought by a Member whose plan includes a prescription drug rider for any reason not subject to independent review pursuant to Art. 21.52J, TEX. INS. CODE ANN.; and, (d) any denial of a written request for a standing referral to a Specialist for reasons other than medical necessity. For purposes of this Section I.14 of this AVC,

a “reduction of payment” shall include a requirement of a higher co-payment. For the purposes of this AVC, “external review” is review arranged for and provided by Aetna to Aetna’s Members by a neutral and independent licensed Physician with appropriate expertise to consider the matter under review. Aetna shall not use any Independent Review Organization currently certified at the time of executing this AVC by the Texas Commissioner of Insurance under the authority of Art. 21.58C, TEX. INS. CODE ANN. to conduct external reviews, unless specifically authorized by the Texas Department of Insurance.

15. Aetna agrees that it will inform Members of their right to external review in Aetna’s Member handbook and disclosure form. Aetna agrees that when it makes determinations subject to external review it will clearly explain, to the Member and Network Provider, all steps necessary for the Member to appeal the determination and seek external review, including instructions for seeking help from Aetna’s Ombudsman.

16. Aetna agrees to make the following disclosures, or a mutually agreed upon substitute, in pre-enrollment marketing materials:

This plan does not pay for all health care expenses and includes exclusions and limitations. These exclusions will be clearly and unambiguously disclosed in your certificate of coverage. Read your certificate of coverage carefully to determine which health care services are covered benefits and to what extent. Services and supplies that are generally not covered benefits (depending on the specific benefits mandated in your state or offered by your employer) usually include, but are not necessarily limited to: cosmetic surgery, including breast reduction; special duty nursing unless medically necessary and preauthorized by Aetna; custodial care, dental care and dental x-rays (unless covered by a dental plan); experimental and investigational procedures; special equipment, including crutches and braces; immunizations for travel or work; hearing aids; orthotics; long-term rehabilitation therapy; orthoptic therapy (vision exercises); prescription drugs (unless covered by a prescription plan) and over-the-counter medications (except as provided in a hospital); oral or topical drugs used for sexual dysfunction or performance; lifestyle

enhancing drugs; substance abuse rehabilitation, and, in certain prescription plans, prescription drugs on the 'Formulary Exclusions' list available at www.aetnaushc.com.

Nothing in this Section I.16. of this AVC shall prevent Aetna from describing exclusions and limitations of coverage with more specificity than the disclosure above.

II.

IMPROVING THE QUALITY AND INTEGRITY OF THE PHYSICIAN-PATIENT RELATIONSHIP

A.

Capitation and Other Financial Incentive Arrangements

1. Aetna agrees that Network Providers are required to provide the same standard of care to all patients regardless of the Network Provider's Financial Incentive Arrangement or the patient's particular health care coverage or insurer. Aetna agrees to include such a requirement in Network Provider contracts.

2. (a) Aetna agrees in accordance with appropriate practices, consistent with applicable Texas law, Art. 20A.14(l), TEX. INS. CODE, not to use any Financial Incentive Arrangement in Aetna's contracts with Individual Physicians, Individual Health Care Providers, or Primary Care Physician Groups that provides additional compensation for not exceeding certain budgets or penalizes Individual Physicians, Individual Health Care Providers, or Primary Care Physician Groups for incurring expenses that are medically necessary or make additional compensation available for limiting medically necessary health care services. Further, Aetna agrees that Financial Incentive Arrangements in Aetna's contracts with Individual Physicians, Individual Health Care Providers, or Primary Care Physician Groups will not be affected by the actual (as opposed to projected) costs of

services incurred by Aetna or by the actual rate of utilization of services during that contract year, except as specifically otherwise provided within this AVC.

(b) Aetna agrees not to use any Financial Incentive Arrangement in contracts with all other Network Providers not identified in Section II.A.2(a) of this AVC, that provides additional compensation for not exceeding certain budgets or penalizes Individual Physicians, Individual Health Care Providers, or Primary Care Physician Groups for incurring expenses that are medically necessary or make additional compensation available for limiting medically necessary health care services. Further, Aetna agrees that Financial Incentive Arrangements in contracts with all other Network Providers will not be affected by the actual (as opposed to projected) costs of services incurred by Aetna or by the actual rate of utilization of services during that contract year, except as specifically otherwise provided within this AVC.

(c) Aetna agrees that it will contractually require all Network Providers to implement the conditions agreed to by Aetna in Section II.A.2 (a) and 2(b) of this AVC in the Network Providers' Downstream Contracts with other Network Providers.

(d) Aetna agrees that if a Network Provider refuses to contractually commit to implement the provisions in Section II.A.2(b) and 2(c) of this AVC within that Network Provider's contract with Aetna or within that Network Provider's Downstream Contracts with other Network Providers, then Aetna will contractually require the Network Provider to disclose any Financial Incentive Arrangements in that Network Provider's contracts to Aetna and Aetna's Members in a form acceptable to the Attorney General and shall report the identity of that Network Provider to the Attorney General. If any Network Provider refuses to provide this disclosure, then Aetna shall

identify to Aetna's Members which Network Providers have refused to disclose Financial Incentive Arrangements and Aetna will report to the Attorney General the identities of those Network Providers.

3. Aetna agrees that it will not use any Financial Incentive Arrangement that is not actuarially sound. Aetna agrees that a qualified actuary retained by Aetna must certify that the formula or method for calculating the actuarial soundness of a Financial Incentive Arrangement with a Network Provider is, based on reasonable assumptions, actuarially sufficient to compensate the Network Provider for the risk being assumed. The certification required by this Section II.A.3. of this AVC will not constitute or be part of the Network Provider's contract and will not be a guaranty, representation, or warranty to the Network Provider. Aetna further agrees that an actuary is qualified if that actuary is knowledgeable regarding Physician and Health Care Provider compensation and is either a member of the American Academy of Actuaries or is a fellow of the Society of Actuaries. Aetna agrees that it will contractually require all Network Providers to implement the conditions agreed to by Aetna in this Section II.A.3. of this AVC in the Network Provider's Downstream Contracts with other Network Providers.

4. Aetna agrees it will not enter into any Financial Incentive Arrangement with a Risk Bearing Network Provider unless the arrangement includes a means such as specific and aggregate stop loss insurance, reinsurance, or some other method that will, in case Member care imposes extraordinary costs upon the Risk Bearing Network Provider, reasonably protect Members from any inducement to limit medically necessary covered services resulting from those extraordinary costs. Aetna agrees that it will contractually require all Risk Bearing Network Providers to implement the conditions

agreed to by Aetna in this Section II.A.4. of this AVC in the Risk Bearing Network Providers' Downstream Contracts with other Risk Bearing Network Providers.

5. (a) Aetna agrees that directly contracted Individual primary care physicians and directly contracted Primary Care Physician Groups that are to be compensated on a capitated basis will be offered the option to be paid pursuant to a set amount per office visit as provided in this Section II.A.5. of this AVC. Aetna agrees that if, after at least six months of participating as a capitated provider, the directly contracted Individual primary care physician or directly contracted Primary Care Physician Group determines that, as of September 30 of a particular calendar year during which it was open to new members, it has less than 100 Aetna Members for which it received capitation, the directly contracted Individual primary care physician or directly contracted Primary Care Physician Group may determine whether additional funds would be owed if it were paid pursuant to the set amount per office visit for that calendar year. The directly contracted Individual primary care physician or directly contracted Primary Care Physician Group must exercise the option to be paid any additional funds that would be due under the set amount per office visit within 60 days of the end of the calendar year. The set amount per office visit shall be no less than the average fee paid for an intermediate office visit by a primary care physician under Aetna's usual and customary HMO fee for service schedule for the relevant geographic area. Aetna agrees that it will contractually require all Risk Bearing Network Providers to implement the conditions agreed to by Aetna in this Section II.A.5.(a) of this AVC in the Risk Bearing Network Provider's Downstream Contracts with other Network Providers.

(b) On June 1, 2000 Aetna agrees it will meet and report to the Attorney General, based

on Texas Commercial HMO patient encounter data for the most recent six months of data available, indicating whether the option in Section II.A.5.(a) of this AVC adequately assures sufficient compensation to primary care physicians for the provision of medically necessary covered services to Aetna Members, and agrees, if necessary to accomplish the goals and principles of this AVC, to negotiate with the Attorney General to increase the capitation rate or the maximum number of Members under capitation a primary care physician may have in order to exercise the option provided in Section II.A.5(a) of this AVC.

6. Aetna agrees that it will not compensate any Individual Physician through a Financial Incentive Arrangement for any services other than those directly provided by the Individual Physician, the Physician's staff, or if applicable, the Primary Care Physician Group. Aetna agrees that it will contractually require all Risk Bearing Network Providers to implement the conditions agreed to by Aetna in this Section II.A.6. of this AVC in the Risk Bearing Network Provider's Downstream Contracts with other Network Providers.

7. Aetna agrees that, in order to encourage participating Physicians to provide preventive care to Members, the Financial Incentive Arrangements for directly capitated primary care physicians and Primary Care Physician Groups may include additional compensation for: (a) prescribing ACE inhibitors for Members with congestive heart failure; (b) prescribing anti-inflammatory drugs for Members with asthma; (c) performing skin biopsies; (d) providing immunizations; (e) providing allergy desensitization injections; (f) seeing Members at least once every twelve months; (g) providing asthma treatment; (h) referring Members with complex asthma to Specialists; (j) providing Members with cardiac disease an influenza vaccine; (k) encouraging Members with hypertension

or congestive heart failure to take medications; (m) providing annual retinal eye examinations for Members with diabetes; and, (n) encouraging Members with diabetes to take medications. Aetna agrees to develop additional Financial Incentive Arrangements for directly capitated primary care physicians and directly capitated Primary Care Physician Groups to provide appropriate preventive care. Aetna agrees that it will contractually require all Network Providers to implement effective preventive care programs.

8. Aetna agrees that all services to be provided in exchange for a Financial Incentive Arrangement will be clearly and unambiguously disclosed in the contracts with Network Providers. Aetna agrees that Network Providers and prospective Network Providers will, at their option, be given no less than 30 days to evaluate all information necessary to determine whether or not they may assume the risks and obligations associated with entering a proposed contract without compromising patient care. Aetna agrees that it will contractually require all Network Providers to implement the conditions agreed to by Aetna in the first sentence of this Section II.A.8. of this AVC in the Network Provider's Downstream Contracts with other Network Providers.

9. Aetna agrees that it will disclose and describe the methods by which it compensates Network Providers in Aetna's Member Handbook. Aetna also agrees that it will include the following statement, or a mutually agreed upon substitute, in pre-enrollment marketing materials:

If you have any questions about how your physician or other health care providers are compensated, you should call Aetna's toll-free number for member services listed on your member identification card. Aetna encourages you to discuss this issue with your physician or other provider.

One of the purposes of managed care is to reduce and control the costs of health care. Financial incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to reduce and control the costs

of health care.

Appropriate financial incentives are intended to reduce waste in the application of medical resources. Appropriate financial incentives can be applied to eliminate inefficiencies which may lead to artificial inflation of health care costs. Appropriate financial incentives can be tailored to encourage physicians and health care providers to practice preventive medicine and focus on improving the long-term health of patients. Appropriate financial incentives can also be used to direct attention to patient satisfaction. Appropriate financial incentives can improve the efficient delivery of quality health care services without compromising the quality and integrity of the physician-patient relationship. Only appropriate financial incentives will be used to compensate physicians and providers treating Aetna members.

Capitation is an example of a financial incentive that, when used appropriately, can be an effective means of improving the delivery of health care services without compromising the physician-patient relationship. Under capitation, a physician, physician group, independent practice association, or other health care provider is paid a predetermined set amount to cover all costs of providing certain medically necessary covered benefits to members whether or not the actual costs of providing those medically necessary covered benefits is greater or lesser than the predetermined set amount. In its capitation arrangements with an individual physician or provider, Aetna provides capitation payments only for those services the physician or provider provides to you. However, in a capitation arrangement with a group of physicians or providers, Aetna may provide capitation payments for additional health care services such as hospitalization, use of specialists, tests, and prescription drugs. Under either capitation arrangement, your physician or provider has a financial incentive to reduce and control the costs of providing medical care.

Financial incentives should not be used improperly to encourage the denial of medically necessary covered benefits. An improperly used financial incentive may encourage a physician to provide a patient with a less effective treatment because it is less expensive.

Aetna will not improperly use financial incentives to compensate physicians and providers for treatments and services provided to Aetna members.

If you are considering enrolling in our plan, you are entitled to ask if the plan, or any provider group serving Aetna members, has compensation arrangements with participating physicians and providers that can create a financial incentive to reduce or control the costs of providing medically necessary covered services. A summary of the compensation arrangements known to Aetna relating to a particular physician or provider will be made available upon request by calling the member services

telephone number on your ID card. If you are not currently an Aetna Member, you may contact your employer's employee benefits manager for the same information. Alternatively, you may contact the provider group directly to find out about compensation arrangements between the provider group and any participating physician or provider. You may also wish to ask what arrangements your physician has made in case the costs of your medical care are extraordinary.

II.

B.

The Physician-Patient Relationship

1. Aetna agrees that it will not terminate or penalize a Network Provider because the Network Provider provides or proposes to provide medically necessary care that is more than that which is (a) projected; (b) the statistical norm; (c) provided or proposed to be provided by peers; or (d) established as a goal.
2. Aetna agrees that profiling of Network Providers will be the product of qualified and objective peer review, utilizing criteria directly related to the quality of patient care. Aetna agrees that it will not use economic profiling to discourage Network Providers from providing medically necessary care to Members.
3. Aetna agrees to provide any Individual Physician or other Individual Health Care Provider with 72 hours advanced written notice of which treatment requests and decisions of that Individual Physician or other Individual Health Care Provider will be evaluated and discussed at a utilization review committee meeting, if such meetings are held. Aetna also agrees to disclose all information that will be used in these utilization review committee meetings to the Individual Physician or other Individual Health Care Provider 72 hours prior to any such meeting. Aetna agrees to provide the

results, including all information used to reach such results, of any such committee's review to the Individual Physician or Individual Health Care Provider within ten days after such decision is reached.

4. Aetna agrees that it will not discriminate against a Member based on a Member's acute, chronic, disabling, or life threatening illness or condition. Aetna agrees it will develop and implement policies and procedures designed to detect and prevent patterns of discrimination against Aetna Members with acute, chronic, disabling, or life threatening illnesses or conditions by Network Providers. Aetna agrees that these policies and procedures will be submitted to and approved by unbiased professionals in the field, such as the National Committee for Quality Assurance, or any other group of qualified, unbiased professionals if approved by the Attorney General of Texas or the Texas Department of Insurance. Aetna agrees that the Ombudsman, provided for in Section IV of this AVC, will monitor the implementation of these policies and procedures and will assist Aetna Members who believe they may have been discriminated against because they have acute, chronic, disabling, or life threatening illnesses or conditions.

5. Aetna agrees that it will contractually require all Network Providers to implement the conditions agreed to by Aetna in Sections II.B.(1)-(4) of this AVC, in the Network Provider's Downstream Contracts with other Network Providers.

6. Aetna agrees that a copy of a contract, policy, guideline or criteria with which a Network Provider is obligated to comply pursuant to a contractual agreement with Aetna will be mailed or otherwise made available to any Network Provider within ten business days of receipt of a written request for a copy of such contract, policy, guideline or criteria, to the extent permissible by

applicable copyright, trademark, or intellectual property law, contract, or relevant licensing agreement.

7. Aetna agrees that any such policy, guideline or criteria relating to a Network Provider's performance of duties pursuant to a contractual agreement with Aetna will not be amended except upon 90 days prior written notice and opportunity to comment to all Network Providers unless a shorter notice period is necessary to protect patient safety. The notice shall allow the Network Provider to compare the proposed policies, guidelines, or criteria with the existing policies, guidelines, or criteria.

8. Aetna agrees to use Aetna's utilization review system to develop and implement policies designed to detect and prevent patterns of Clinically Inappropriate Underutilization of health care services by Network Providers or Members, particularly women Members, minority Members and Members with acute, chronic, disabling, or life-threatening illnesses or conditions.

II.

C.

Participation by Physicians in Aetna Health Care Products

1. Aetna agrees to offer all Individual Physicians, Individual Health Care Providers and Primary Care Physician Groups of 10 Physicians or fewer, and non-Primary Care Physician Groups of 25 Physicians or fewer, (hereafter in Section II.C. of this AVC "Small Groups") the option of participating in each Aetna health care product without accepting the All Products Provision as a condition of participation in a product. For purposes of Section II.C. of this AVC, a "Product Line" is defined as either: (a) all HMO and HMO-based products, or (b) all non-HMO and non-HMO-based products. For purposes of Section II.C. of this AVC, HMO and HMO-based plans or products shall have the same meaning as "health care plan" at Art. 20A.02(1), TEX. INS. CODE ANN.
2. Nothing in this AVC shall prevent Aetna from requiring an Individual Physician, Individual Health Care Provider or Small Group that elects to participate only in the HMO products, to participate in all Aetna HMO and HMO-based plans and products so long as the products are existing, enumerated, and explained in writing before execution of the contract with the Individual Physician, Individual Health Care Provider or Small Group, or with respect to a contract in effect as of the effective date of this AVC, plans and products existing at that time. For example, if an Individual Physician, Individual Health Care Provider or Small Group elects not to participate in all products but wants to participate only in the Aetna HMO product, this AVC shall not prohibit Aetna from requiring that Individual Physician, Individual Health Care Provider or Small Group to participate in all Aetna HMO and HMO-based plans and products, such as Medicare HMO,

USAccess, and Quality Point of Service, so long as those HMO and HMO-based plans and products are existing, enumerated and explained to that Individual Physician, Individual Health Care Provider or Small Group before execution of the contract with that Individual Physician, Individual Health Care Provider or Small Group. Nothing in this AVC shall prevent Aetna from requiring an Individual Physician, Individual Health Care Provider or Small Group that elects to participate only in non-HMO or non-HMO-based products, to participate in all Aetna non-HMO or non-HMO-based plans and products so long as the plans or products are existing, enumerated, and explained in writing before execution of the contract with that Individual Physician, Individual Health Care Provider or Small Group.

3. The parties agree that nothing in this AVC shall be construed to prohibit or limit Aetna's ability to use different capitation rates or fee schedules for an Individual Physician, Individual Health Care Provider or Small Group based upon whether or not that Individual Physician, Individual Health Care Provider or Small Group chooses to accept all Product Lines or chooses to continue to accept all Product Lines.

4. Aetna agrees that nothing in Section II.C.3. of this AVC shall permit Aetna to compensate an Individual Physician, Individual Health Care Provider or Small Group with any Financial Incentive Arrangement which does not meet the requirements of Section II.A. of this AVC.

5. Aetna agrees that by 90 days written notice delivered to Aetna, at any time, an Individual Physician, Individual Health Care Provider or Small Group subject to the All Products Provision, may choose not to participate in all Product Lines. Individual Physicians, Individual Health Care Providers or Small Groups may choose to participate in all Product Lines upon written notice at any

time to Aetna, provided they meet Aetna's participation criteria and execute the appropriate contract. Effective July 1, 2000, Aetna agrees not to enforce any All Products Provision in any existing Individual Physician, Individual Health Care Provider or Small Group contract except according to the terms of this Section II.C.5 of this AVC. Nothing in this Section II.C.5 of this AVC shall relieve an Individual Physician, Individual Health Care Provider or Small Group of any obligation under applicable law or agreement to continue to provide care to Aetna Members previously under the Individual Physician, Individual Health Care Provider or Small Group's care.

6. Aetna agrees that Aetna's material breach of a contract term applicable to one of Aetna's Product Lines, uncured after at least 90 days prior written notice and opportunity to cure, will be a valid ground for any Network Provider bound by an All Products Provision to terminate that particular Aetna Product Line without violating the terms of the All Products Provision. As of the effective date of this AVC, Aetna agrees not to enforce any All Products Provision in any existing contract with any Network Provider except according to the terms of this Section II.C.6. of this AVC.

7. Aetna will not enforce any Aetna patient mandatory acceptance provision in any contract with an Individual Physician, Individual Health Care Provider or Small Group except that Aetna may require the Individual Physician, Individual Health Care Provider or Small Group to accept any of that Individual Physician, Individual Health Care Provider or Small Group's current patients, or Members who were patients of that Individual Physician, Individual Health Care Provider or Small Group within the 12 months immediately prior to joining an Aetna plan, who enroll in an Aetna health care product in which that Individual Physician, Individual Health Care Provider or Small

Group participates.

8. Aetna agrees that in any contract between Aetna and a Primary Care Physician Group of more than 10 Physicians or non-Primary Care Physician Group of more than 25 Physicians (hereafter in Section II.C. of this AVC referred to as "Large Groups"), once 25% or more of that Large Group's total HMO and non-HMO patient population consists of Aetna Members, that Large Group, upon 60 days notice and written certification to Aetna, may stop accepting new patients who are Aetna Members, who were not patients of that Large Group within the 12 months immediately prior to joining an Aetna plan so long as that Large Group also stops accepting new patients who are members of any other payor, who were not patients of that Large Group within the 12 months immediately prior to joining that other payor's plan if that payor's members comprise 25% or more of that Large Group's total patient population.

9. Aetna agrees that it will not unilaterally amend Aetna's contracts with Individual Physicians, Individual Health Care Providers or Small Groups except that, if specifically provided by contract, Aetna may propose an amended capitation rate or fee schedule to the Individual Physician, Individual Health Care Provider or Small Group as permitted within this Section II.C.9. of this AVC. Aetna agrees to provide 90 days written notice to an Individual Physician, Individual Health Care Provider or Small Group of Aetna's intent to amend any applicable capitation rate or fee schedule. The notice shall include the new capitation rate or fee schedule and the services to be provided according to the new capitation rate or schedule. In the event of such notice by Aetna, the Individual Physician, Individual Health Care Provider or Small Group shall have the option of terminating the contract without penalty upon 60 days written notice to Aetna, unless longer notice is specifically

required by state law, prior to implementation of the new terms if the Individual Physician, Individual Health Care Provider or Small Group reasonably believes the new capitation rate or fee schedule does not provide adequate compensation. Should an Individual Physician, Individual Health Care Provider or Small Group terminate the contract or relationship with Aetna pursuant to this Section II.C.9. of this AVC, nothing in this AVC shall relieve that Individual Physician, Individual Health Care Provider or Small Group of any obligation under applicable law or agreement to continue to provide care to Aetna Members previously under the Individual Physician, Individual Health Care Provider or Small Group's care. Aetna agrees it will not implement retroactive amendments to Aetna's contracts with Individual Physicians, Individual Health Care Providers or Small Groups. The prohibitions in this Section II.C.9. of this AVC shall not apply to amendments otherwise required by law or this AVC.

10. Aetna agrees that it will not unilaterally amend Aetna's contracts with Network Providers other than Individual Physicians, Individual Health Care Providers or Small Groups except as specifically otherwise agreed to within the contract. The prohibitions in this Section II.C.10. of this AVC shall not apply to unilateral amendments otherwise required by law or this AVC.

11. Aetna and the Attorney General agree that if the provisions of Section II.C. of this AVC have, or would have an adverse impact on Texas Consumers' access to health care coverage through Aetna's HMOs, the Attorney General and Aetna will amend Section II.C. of this AVC. Aetna agrees to meet and report to the Attorney General on the impact of Section II.C. of this AVC by December 1, 2000.

12. Aetna and the Attorney General agree that, except for Sections II.C.6. and II.C.10. of this

AVC, the provisions of Section II.C. of this AVC shall not apply to hospital-based Physicians, *e.g.*, anesthesiologists, pathologists, radiologists and emergency room Physicians.

II.

D.

**PATIENT PROTECTION FROM PROVIDER
INABILITY TO PAY PHYSICIANS**

1. Aetna agrees to include in any contract between Aetna and a Risk Bearing Network Provider, compensated directly by Aetna through a Financial Incentive Arrangement, a provision to maintain continuity of care to Aetna Members in the event such a Risk Bearing Network Provider is unable, for any reason, other than one of short or limited duration, to make timely payment to its participating Network Providers for medically necessary covered benefits provided to Aetna Members.

2. Aetna agrees that such a provision in contracts with Aetna's Risk Bearing Network Providers shall expressly authorize Aetna to directly contract with participating Network Providers for medically necessary covered benefits the participating Network Providers provide to Aetna Members. Aetna agrees that contracts with Risk Bearing Network Providers will recite that the authorization is a material condition of the contract. Aetna also agrees that contracts with Risk Bearing Network Providers will require such Risk Bearing Network Provider to agree not to seek, directly or indirectly, any injunctive relief prohibiting Aetna from making direct payments to participating Network Providers, pursuant to Aetna's direct contract with those Network Providers, in case the Risk Bearing Network Provider is for any reason, other than one of short or limited duration, unable to make timely payment to participating Network Providers for medically necessary

covered benefits.

3. Aetna agrees that for purposes of Section II.D. of this AVC, the term “participating Network Provider” designates those Network Providers who are employed by, partners of, contracted with, or otherwise associated with a Risk Bearing Network Provider compensated directly by Aetna through a Financial Incentive Arrangement. Aetna also agrees that for purposes of Section II.D. of this AVC, “timely payment” shall be payment made within the time allowed by the contract between the Risk Bearing Network Provider and the participating Network Provider.

4. Aetna agrees that if the Risk Bearing Network Provider refuses to agree to the contractual provisions required by Section II.D., then 90 days before Aetna contracts with the Risk Bearing Network Provider, Aetna will give written notice to the Attorney General of the Risk Bearing Network Provider’s refusal to agree.

III.

IMPROVING MEMBER CHOICE OF AND ACCESS TO QUALITY HEALTH CARE

A.

Health Care Providers

1. Aetna agrees to publish a Physician and Health Care Provider directory on the Internet and will update the Internet directory weekly to reflect changes to the list of participating Physicians and Health Care Providers. Aetna agrees to inform Aetna’s group contract holders that upon request they may obtain a copy of an updated printed Physician and Health Care Provider directory. Aetna agrees to comply promptly with any such request.

2. Aetna agrees that if the relationship between Aetna and a Member's primary care physician or Specialist, for which the Member has a standing referral, (the Specialist and the primary care physician are referred to in this Section III.A.2. of this AVC collectively as Physician) terminates or expires prior to the end of the Member's plan year then that Member may choose a new Physician or agree with the Member's current Physician to continue to be cared for by that Physician under the terms of the Member's plan through the end of the plan year unless the termination is justified by imminent harm to patient health, challenges to the Physician's license to practice medicine, fraud, or failure to satisfy credentialing criteria.

(a) Aetna agrees that if the Member and Physician agree as provided above and Aetna and the Physician had a direct contractual relationship, or if the Physician continues to be associated with a Network Provider that had a direct contractual relationship with Aetna, then Aetna shall continue to pay for the Member's medically necessary covered benefits at the contract rate until the earlier of the end of the Member's plan year or the expiration date of the Physician's contract. If the expiration date of the Physician's contract is prior to the end of the Member's plan year, then subsequent to the expiration date of the Physician's contract, Aetna will compensate the Physician for the Member's medically necessary covered benefits according to Aetna's usual and customary HMO fee for service schedule until the end of the Member's plan year.

(b) Aetna agrees that if the Member and Physician agree as provided above and Aetna and the Physician had no direct contractual relationship and if the Physician is not associated with a Network Provider that had a direct contractual relationship with Aetna, then Aetna shall compensate the Physician according to Aetna's usual and customary HMO fee for service schedule

until the end of the Member's plan year.

(c) Aetna agrees that nothing in Section III.A.2. of this AVC shall limit Aetna's obligations, or any Member's entitlements, under Aetna's evidence of coverage, Aetna's Physician and Health Care Provider contracts, or under the TEXAS INSURANCE CODE or rules promulgated thereunder. Aetna agrees that it will inform Members of their option to continue with or choose a new Physician when Aetna notifies the Member of the Physician's termination.

(d) Aetna and the Attorney General agree that nothing in Section III.A.2. of this AVC shall require the Physician to continue to care for an Aetna Member should that Physician's relationship with Aetna expire or terminate. Aetna and the Attorney General agree that nothing in Section III.A.2. of this AVC creates any liability of Aetna for the refusal of a Physician to continue to provide health care services to an Aetna Member after the expiration or termination of the Physician's relationship with Aetna.

3. Aetna agrees that if a Network Provider's relationship with Aetna's network will expire or terminate, Aetna will notify the Network Provider's Member patients receiving care from such Network Provider at the earliest practical date, but no later than 30 days before the effective date of the termination, unless immediate termination is justified by imminent harm to patient health, challenges to the Physician's license to practice medicine, fraud, or failure to satisfy credentialing criteria. Aetna agrees that any such notice shall inform the Aetna Member that the Member may choose a new Physician or, unless the Physician was subject to immediate termination, agree with the Member's current Physician to continue to be cared for by that Physician under the terms of the Member's plan through the end of the plan year. Any such notice shall also inform the Member that

under Art. 20A.18A(c), TEX. INS. CODE ANN, as amended by *Act of 1997, 75th Leg., ch. 1026, Sec. 19, eff. Sept. 1, 1997*, the Member may under certain circumstances have the right to continue to see the Member's current Physician beyond the end of the plan year so long as the Member continues to be enrolled in the plan. The notice will encourage the Member to contact the Physician, Aetna's toll free number for Member services or the Texas Department of Insurance with questions about this option.

4. Aetna agrees that if medically necessary covered benefits are not available within Aetna's Network, Aetna will treat a request by a Member for a referral to a Physician or Health Care Provider outside Aetna's Network in the same manner as a request by a "Network Physician or Provider" as described in 28 TEX. ADMIN. CODE § 11.506(15). Aetna's Office of Ombudsman may assist the Member in making such a request.

5. Aetna agrees that if a medically necessary covered benefit is not available through the limited provider network to which the Member's primary care physician belongs, but is available within Aetna's network, then upon the request of a Network Provider, or if a Network Provider should fail to make such a request, upon the request of the Member, Aetna will authorize payment for a referral to a Network Provider outside the limited provider group at the contract rate. Aetna agrees it will authorize payment for such a referral within the time appropriate to the circumstances relating to the delivery of the benefits and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation. Aetna's Office of Ombudsman may assist the Member in making such a request. Aetna agrees that, notwithstanding anything to the contrary in this AVC, Aetna will provide for a utilization review by a Specialist of the same specialty or a

similar specialty as the type of Physician or Health Care Provider to whom a referral is requested pursuant to this Section III.A.5 of this AVC before Aetna may deny the request.

6. Aetna agrees that, if a Member is admitted to an in-patient facility, Aetna will not assign a Physician other than that Member's primary care physician to direct and oversee the Member's inpatient care in place of the Member's primary care physician if that Member objects to the assignment. Aetna agrees to notify the Member of the right to object.

7. Aetna agrees that Aetna shall approve a request for a standing referral to a participating Specialist for a Member with a chronic, disabling, or life-threatening illness or condition if it is medically necessary for the Specialist to care for the Member on a continuing basis. Aetna's Office of Ombudsman may assist the Member in making such a request. Nothing in this Section III.A.7. of this AVC shall prevent Aetna from placing reasonable limits on the duration and scope of the standing referral.

8. Aetna agrees that once Aetna communicates approval of payment for a particular procedure, service, product, or supply under the Member's health plan, then Aetna will pay for that procedure, service, product, or supply absent fraud or materially changed condition of the Member and provided the Member is a Member of the health plan at the time such care is delivered.

9. Aetna agrees to develop and implement programs that encourage Physicians to provide and encourage Members to seek and receive preventive health care. Such programs will include but are not limited to the following: (a) Financial Incentive Arrangements to primary care physicians to provide preventive and quality care; (b) retinal eye examination reminders to Members with diabetes; (d) identification of Members with asthma and providing asthma educational materials and peak flow

meters to such Members; (d) contraindication programs with pharmacies to prevent Members from taking contrary medications; (e) reminders to female Members age 40 and older to have mammograms and perform breast self-examinations; (f) reminders to female Members age 18 and over to have pap screening; (g) reminders to parents of infants to get appropriate immunizations; (h) reminders to Members age 65 and older to get influenza and pneumococcal vaccines; and (i) reminders and screening kits to Members age 50 and older for early detection of colorectal cancer.

10. Aetna acknowledges that 28 TEX. ADMIN. CODE § 11.1600 (b)(11)(A) requires HMOs to notify their Members that in most instances they will not be allowed to receive services from any Physician or Health Care Provider outside the limited provider network to which their primary care physician belongs. Aetna agrees it will add the following disclosure, or a mutually agreed upon substitute, to the notice required by 28 TEX. ADMIN. CODE § 11.1600 (b)(11)(A):

If medically necessary covered services are not otherwise available, a member has the right to a referral to a specialist or provider outside Aetna's network of physicians or providers, and outside the limited provider network to which the member's primary care physician may belong.

If medically necessary covered services you wish to receive are available through your primary care physician's limited provider network, but you want to receive these services from an Aetna network provider who is not within your primary care physician's limited provider network, you may change your primary care physician in order to select a primary care physician within the same limited provider network from which you want to receive medically necessary covered services.

III.

B.

Prescription Drugs

1. In addition to Art. 21.52J, TEX. INS. CODE ANN. which protects Members' access to prescription drugs during the Members' current plan year, Aetna agrees to provide Aetna's Members notice of any modification or deletion of coverage for prescription drugs in the Members' next plan year. Aetna agrees not to modify (*e.g.*, increase the copayment obligation of the Member) or delete Aetna's coverage of any prescription drug during the last 90 days of any Member's plan year. Aetna agrees that Members who have been prescribed and are covered by Aetna for prescription drugs during a plan year will receive written notice of any modification or deletion of coverage for the drug effective at the beginning of the next plan year no less than 90 days prior to the end of that Member's plan year. Aetna agrees that this notice will direct Members to examine the new formulary listing, and the Members' plan-specific materials, to determine whether coverage for any particular prescription drug has changed. This notice will direct Members to inform their treating Physicians of the coverage changes.

2. Aetna agrees that it will give 90 days notice to all Physicians and Health Care Providers prescribing drugs to Members covered by that plan of any modifications or deletions of prescription drug coverage.

3. Aetna agrees to make Aetna's formularies available to consumers and providers through publication on the Internet. The Internet site will direct Members to their summaries of benefits to determine their plan-specific coverage. The Internet site will be updated as soon as changes to the formulary are made.

4. Aetna agrees that Aetna's determination of whether a drug represents an important therapeutic advance will be done without regard to cost, price, volume discount arrangements,

rebates, or other agreements or financial arrangements between Aetna and pharmaceutical companies or drug manufacturers.

5. Aetna agrees that a determination of whether to include any single source branded drug representing an important therapeutic advance on Aetna's formulary will be made without regard to cost, price, or volume discount arrangements between Aetna and pharmaceutical companies or drug manufacturers.

6. Subject to the terms and conditions of the plan, Aetna agrees that if a Member's treating Physician determines that it is medically necessary to treat the Member with a prescription drug excluded from that Member's formulary, and Aetna determines that it is medically necessary to treat the Member with the excluded drug, the excluded drug will be covered.

7. Aetna and the Attorney General agree that nothing in this AVC shall prohibit Aetna from excluding coverage for a drug that: (a) is deemed unsafe by the FDA or another regulatory agency; or (b) is determined by Aetna or the manufacturing pharmaceutical company to be unsafe based upon scientific and medical evidence as defined at 28 TEX. ADMIN. Code § 12.5.

8. Aetna agrees that any pharmacy, pharmacist or pharmaceutical benefit manager involved in the delivery of prescription drugs to Aetna Members shall not have any financial incentive to encourage the substitution of any particular Aetna formulary drug in place of the drug prescribed for a Member by the treating Physician. However nothing in this Section III.B.8. of this AVC shall prevent Aetna from providing Financial Incentive Arrangements to any pharmacy, pharmacist or pharmaceutical benefit manager to alert a treating Physician to any hazards posed by the prescribed drug or to a drug more effective than the prescribed drug, nor shall anything in this Section III.B.8.

of this AVC prevent Aetna from providing Financial Incentive Arrangements to any pharmacy, pharmacist or pharmaceutical benefit manager for encouraging the substitution of a clinically equivalent generic drug for the brand name drug as allowed by the prescribing Physician.

9. Aetna agrees that it will contractually require all Network Providers to agree to the conditions agreed to by Aetna in Section III.B. of this AVC.

III.

C.

Experimental and Investigational Therapies and Clinical Trials

1. Aetna agrees that, notwithstanding any exclusion of coverage, Aetna will cover as a benefit experimental or investigational therapies and clinical trials according to the provisions of Section III.C. of this AVC.

2. Aetna and the Attorney General agree that for a Member to qualify for this benefit a Member's Physician must determine that the Member has a current diagnosis that has a probability of causing death within two years and for which standard therapies have not been effective in significantly improving the condition of the Member or for which standard therapies would not be medically appropriate.

3. Aetna and the Attorney General agree that the Member's Physician must state in writing: (a) that he has recommended a drug, device, procedure or other therapy that is likely to be more beneficial to the Member than available standard therapies; or (b) that the Member or a board certified or board eligible Physician qualified to practice in the area of practice appropriate to treat the Member's condition, has requested a therapy that, based on two documents from the medical and

scientific evidence, as described in Section III.C.4. of this AVC, is likely to be more beneficial for the enrollee than any available standard therapy. The Physician's statement pursuant to this Section III.C.3. of this AVC shall include a description of the evidence relied upon by the Physician in making the recommendation.

4. Aetna and the Attorney General agree that, for the purposes of Section III.C.3. of this AVC, medical and scientific evidence means the following sources:

- (a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- (b) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (STAR).
- (c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the *Social Security Act* (42 U.S.C. 1395x).
- (d) The following standard reference compendia:
 - i. The American Hospital formulary Service-Drug Information,
 - ii. The American Medical Association Drug Evaluation,
 - iii. The American Dental Association Accepted Dental Therapeutics, and
 - iv. The United States Pharmacopoeia-Drug Information.
- (e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the:
 - i. Federal Agency for Healthcare Research and Quality,
 - ii. National Institutes of Health,
 - iii. National Cancer Institute,
 - iv. National Academy of Sciences,
 - v. Health Care Financing Administration, and
 - vi. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

- (f) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

5. Aetna agrees that it will contractually require all Network Providers to agree to the conditions agreed to by Aetna in Section III.C. of this AVC.

III.

D.

Emergency Care

1. Aetna agrees to pay fees for emergency department screening and stabilization services, in and out of Network, without prior authorization by Aetna or the Member's primary care physician, in accordance with TEX. INS. CODE art. 20A.04(a)(16) and the prudent lay person standard as identified in TEX. INS. CODE art. 21.58A, § 2(6).

2. Aetna agrees to encourage emergency room Physicians to exercise their own independent professional judgment in providing medically necessary care to treat and stabilize a Member on an emergency basis.

3. Aetna agrees that any ambulance services participating in Aetna's Network or with which it contracts will be required to deliver the patient who requires emergency medical care to the nearest medical facility where the medically necessary care can be provided in a timely fashion, unless otherwise specifically instructed by the Member, the Member's family, or the Member's Physician.

IV.

THE OFFICE OF OMBUDSMAN

1. Aetna agrees to establish an Office of Ombudsman, hire an Ombudsman-Director of the Office of Ombudsman, no later than June 1, 2000, and reasonably and sufficiently fund and staff that office on behalf of Aetna's Texas HMO Members to accomplish the goals and principles enumerated in this AVC. Aetna agrees that the Ombudsman will report directly to the Board of Directors of each Aetna HMO. Aetna agrees that the duties and responsibilities of this Office are to independently represent the interests of Aetna's HMO Members and work on their behalf.
2. Aetna agrees to inform Aetna's Members of the creation of the Office of Ombudsman. Aetna agrees that the Office of Ombudsman shall be responsible for educating Aetna's Members and assuring that these Members are given the opportunity to fully understand Aetna's HMO plans, the coverage provided by these plans and the Network Providers participating in these plans. The Ombudsman shall advocate on behalf of Members, assist Members in obtaining medically necessary care, and perform other functions as determined by the Ombudsman.
3. Aetna agrees that the Office of Ombudsman may assist plan Members during internal appeals, independent review organization proceedings and external reviews. The availability of this assistance will be communicated to plan Members as part of their notification of the appeals process.
4. Aetna agrees that the Office of Ombudsman shall monitor and advise Aetna on compliance with this AVC and assist the Attorney General by investigating any complaints forwarded by the Attorney General and reporting back within 30 days, unless the situation requires fewer days as determined by the Attorney General.

5. Aetna agrees that the parameters and additional duties of this Office of Ombudsman shall be further negotiated and developed with the Attorney General, and these parameters and additional duties will be liberally construed in order to carry out the goals and principles of this AVC.

V.

ADMINISTRATIVE PROVISIONS

1. Aetna agrees that this AVC becomes effective upon execution by the parties.

(a) Aetna agrees that as soon as possible, but no later than 30 days after execution of this AVC, it will submit any filings necessary to implement this AVC to the Texas Department of Insurance and other government agencies and seek their prompt approval. Aetna agrees that all of Aetna's contracts executed or renegotiated subsequent to execution of this AVC will comply with the requirements of this AVC. Aetna agrees that subsequent to the execution of this AVC, it will not renew or exercise options to extend existing contracts or allow existing contracts to continue past a renewal date unless those contracts comply with the requirements of this AVC. Aetna and the Attorney General agree that during the time between execution of this AVC and any regulatory approval required by the Texas Department of Insurance of any contractual terms imposed by this AVC:

(i) Aetna's contracts with Aetna's customers will comply with all provisions of this AVC that do not require approval by the Texas Department of Insurance and Aetna will advise the customer of the existence of this AVC and the pending regulatory approval, and after approval by the Texas Department of Insurance, give the customer the option of modifying its contract with Aetna to incorporate the contract terms approved by the Texas Department of Insurance, and

(ii) Aetna's contracts with Network Providers will comply with all provisions of this AVC that do not require contract approval by the Texas Department of Insurance; after approval by the Texas Department of Insurance of the contractual provisions requiring approval by the Texas Department of Insurance, Aetna will modify Aetna's contracts with Network Providers to include the contractual provisions approved by Texas Department of Insurance; and terminate the contract with a Network Provider that refuses to accept the modified contract or report to the Attorney General the identity of any Network Provider as required by this AVC.

(b) Aetna agrees that it will promptly implement all other commitments in this AVC that are within Aetna's control and complete implementation of these commitments within 90 days after the execution of this AVC, unless a different implementation date is expressly provided for in this AVC.

2. Aetna agrees to meet and report to the Attorney General regarding Aetna's implementation of this AVC, and Aetna's operations thereunder, on July 1, 2000, December 1, 2000, July 1, 2001, December 1, 2001, and July 1, 2002, unless other dates are mutually agreed upon by Aetna and the Attorney General. Prior to such meetings the Attorney General may require that Aetna produce specific information regarding particular provisions of the AVC at the meeting. Aetna agrees that at any time during this AVC, the Attorney General may require Aetna to produce information pursuant to this AVC.

3. Aetna and the Attorney General agree that this AVC shall terminate and be of no force or effect at 11:59 p.m., December 31, 2002 central standard time. Provided, however, that with 180 days prior written notice to Aetna, the Attorney General may dissolve this AVC, except for the

dismissal with prejudice contained herein, if, in the Attorney General's sole discretion the Attorney General determines that it is no longer beneficial to the citizens of Texas.

4. Aetna and the Attorney General agree that any requirement that a notice or communication be in writing may be satisfied by e-mail or other electronic communication if all parties to the communication or notice have agreed to e-mail or other electronic communication or, if any party does not agree, then that party shall be provided a paper copy of the notice or communication. Aetna agrees to maintain a copy of all e-mail or other electronic communications required by this AVC for the same period applicable under the law or Aetna's internal policies to comparable written communications.

5. This AVC applies exclusively and solely to all of Aetna's Commercial HMOs and HMO products operating in Texas unless otherwise stated. Notwithstanding any other provision in this AVC, Aetna also agrees to implement promptly this AVC with respect to Prudential Health Care Plan, Inc.'s Commercial HMOs and HMO products operating in Texas ("Prudential"). However, no later than January 1, 2001, Aetna shall have completed implementation of this AVC with respect to Prudential. Aetna agrees that this AVC shall be binding on Aetna's affiliates, successors, acquirers, purchasers, assigns, designees, and delegees.

6. Aetna agrees that if after a good-faith effort by Aetna to secure a contractual commitment a Network Provider refuses to contractually commit to implement the provisions listed in this Section V.6. of this AVC within that Network Provider's Downstream Contracts with other Network Providers, then 90 days prior to Aetna's contracting with that Network Provider Aetna will provide the Attorney General with: (a) written notice of the name of the Network Provider; and (b) a list of

the provisions listed within this Section V.6. of this AVC that the Network Provider refuses to contractually commit to include in its Downstream Contracts with other Network Providers. The provisions that this Section V.6. of this AVC applies to are specifically and exclusively: the prohibition against utilization based compensation as specified in Section II.A.2(b), (c) and (d) of this AVC; the requirement for stop loss insurance or similar measures as specified in Section II.A.4 of this AVC; the option to be paid per office visit as specified in Section II.A.5.(a) of this AVC; the prohibition against compensating an Individual Physician through a Financial Incentive Arrangement for services provided by others as specified in Section II.A.6 of this AVC; the requirement that Network Providers implement effective preventive care programs as specified in Section II.A.7 of this AVC; and the requirement that services provided pursuant to a financial incentive agreement be clearly and unambiguously disclosed as specified in Section II.A.8 of this AVC. Aetna agrees that it will not contract with any Network Provider that refuses to contractually commit to implement any agreements that Aetna is required by this AVC to obtain from Network Providers, except those specific exceptions allowed by Section II.D. and this Section V.6. of this AVC.

7. Aetna agrees that it will use its best efforts to obtain certification as of March 1st of each year from each Network Provider that the Network Provider is in compliance with Aetna's standards, this AVC, and applicable law. Aetna agrees to take corrective action, as necessary, to ensure that each Network Provider complies with Aetna's standards, this AVC, and applicable law.

8. This AVC may only be modified by Aetna and the Attorney General as set forth below:

- (a) Aetna or the Attorney General may seek a court order modifying this AVC only after obtaining written agreement to the proposed modification by the other party. Neither Aetna nor the Attorney General shall unreasonably withhold consent to the request for such a modification of this AVC if the modification better serves the goals and principles of this AVC. Aetna agrees not to use this subparagraph to circumvent the requirements of the next subparagraph and it shall not be unreasonable for the Attorney General to withhold consent to the requested modification if the next subparagraph is or was applicable to the requested modification and Aetna fails or failed to comply with the terms of the next subparagraph.

- (b) The Attorney General will seek Assurances of Voluntary Compliance from other Commercial HMOs on terms substantially similar to the terms in this AVC. In the event the Attorney General obtains court approval of any such Assurance of Voluntary Compliance with another Commercial HMO, the Attorney General shall supply Aetna a copy of that Assurance of Voluntary Compliance promptly upon approval by the court. Within 20 business days of Aetna's receipt of that Assurance of Voluntary Compliance, Aetna shall give written notice to the Attorney General of the specific terms, if any, in that Assurance of Voluntary Compliance that Aetna wishes to request the court to substitute or insert in this AVC. Within 20 business days of the receipt of Aetna's notice, the Attorney General shall give Aetna written notice of the specific terms, if any, in that Assurance of Voluntary Compliance that the Attorney General will require to be substituted or included in this AVC as a condition to agreeing to the substitution or insertion of the terms noticed by Aetna. If Aetna gives written notice of Aetna's agreement to the terms, if any, noticed by the Attorney General within 20 business days of Aetna's receipt of the notice, then Aetna and the Attorney General shall request the court to modify this AVC by the insertion or substitution of the terms noticed by Aetna and the Attorney General respectively.

- (c) Aetna agrees that if it enters into any settlement agreement or similar agreement, relating to the issues addressed in this AVC and affecting Texas Commercial HMO Members, which contains terms more favorable to Aetna Members or health care consumers than those contained in this AVC, the Attorney General may, upon 30 days notice, elect to incorporate those terms in this AVC, except for terms requiring Aetna to make monetary payment. Aetna agrees to provide the Attorney General a copy of any such other settlement agreement within 10 business days of entering any such other settlement agreement.

9. Aetna and the Attorney General agree that nothing in this AVC may be taken as or construed to be an admission or concession of any violation of any law, or of any other matter of fact or law or of any liability or wrongdoing, all of which Aetna expressly denies. Specifically, the Attorney General acknowledges that Aetna denies the allegations of Cause No. 98-13972, *The State of Texas v. Aetna U.S. Healthcare, Inc.; Aetna Health Plans of North Texas, Inc.; NYLCare Health Plans of the Southwest, Inc.; and NYLCare Health Plans of the Gulf Coast, Inc.*; pending in the 250th Judicial District Court of Travis County, Texas.

10. Aetna and the Attorney General agree that nothing in this AVC shall be construed as a waiver or creation or enlargement of a private right of action of any person not a party to this AVC. This AVC does not create any rights or claims to any third parties nor do the parties intend to confer standing on any third party to enforce the terms of this AVC. Aetna and the Attorney General agree that only Aetna and the Attorney General may enforce this AVC. Aetna and the Attorney General agree that there are no intended or unintended third party beneficiaries to this AVC.

11. Aetna and the Attorney General agree that this AVC does not create any standard of care, obligation, or duty in any private cause of action brought by any person not a party to this AVC. Aetna and the Attorney General agree that this AVC shall not be construed as evidence of any violation of any law and shall not be admissible in any judicial or quasi-judicial proceeding except as between Aetna and the Attorney General related to enforcement, modification, dissolution or interpretation of this AVC.

12. Aetna agrees that Aetna will comply with all provisions of Texas law applicable to Texas Commercial HMOs in effect on the date this AVC is entered.

13. Aetna and the Attorney General agree that the sole remedies for enforcement of this AVC are mediation, specific performance, injunctive relief, civil and criminal contempt, plus reasonable and necessary attorney's fees payable to the Attorney General, costs of court and fines or penalties.

Aetna agrees that it will waive any preemption defense based on Sec. 514 of ERISA 29 U.S.C.A. § 1144) (West 1999) to the Attorney General's enforcement of this AVC, or enforcement of any provision of this AVC. Aetna agrees that this waiver of ERISA preemption defense is to be broadly construed in order to carry out the goals and principles of this AVC.

14. Aetna shall not be subject to contempt proceedings with respect to any construction or interpretation of this AVC to which it did not have actual or constructive notice, or any breach as to which it did not have at least 30 days opportunity to cure after written notice of the breach.

15. Aetna and the Attorney General agree that mediation is a remedy only upon mutual agreement of the parties to this AVC with the cost of that mediation borne solely by Aetna.

16. Aetna and the Attorney General agree that, with respect to all motions, suits and actions concerning this AVC, jurisdiction and venue reside solely in the District Court of Travis County, Texas.

17. Aetna and the Attorney General agree that nothing in this AVC shall be deemed to permit or authorize any violation of any Texas or federal law or otherwise be construed to relieve Aetna of any duty, including any duty imposed by this AVC to comply with any applicable Texas or federal law, nor shall anything be deemed to constitute permission to engage in any act or practice prohibited by any Texas or federal law.

18. Aetna agrees that nothing in this AVC shall in any way limit the authority of the Texas

Department of Insurance or the Texas Commissioner of Insurance.

19. Aetna agrees that nothing in this AVC gives rise to any defense or objection to any investigation, request for information, or any enforcement action of any type initiated or brought by or on behalf of the Texas Department of Insurance or the Texas Commissioner of Insurance.

20. Aetna and the Attorney General agree that if any Texas or federal law or regulation is enacted such that compliance with this AVC would cause Aetna to violate that law, then this AVC shall be automatically modified only to the extent needed to eliminate the conflict. If any terms, sections, or subsections of this AVC are so modified or if a court of competent jurisdiction voids or rules any part of the AVC invalid or unlawful or void for any reason, the remaining terms, sections, or subsections of this AVC will continue in effect. Aetna agrees to notify the Attorney General within 30 days of Aetna's determination of such conflict and specify how the AVC is modified and by what authority.

21. Aetna and the Attorney General agree that if Aetna certifies that compliance with this AVC has placed it at a substantial competitive disadvantage or that the AVC is failing to accomplish its goals and objectives, the Attorney General agrees to meet with Aetna to reevaluate the AVC.

22. Aetna and the Attorney General agree to act in good faith to implement and enforce this AVC. Aetna and the Attorney General agree that the provisions of this AVC are to be broadly construed in order to give full force and effect to the goals and principles of this AVC. Aetna and the Attorney General agree to cooperate fully, to execute any and all reasonable supplementary documents necessary to effect implementation of this AVC, and to take all additional actions which may be necessary and appropriate to give full force and effect to the goals and principles of this

AVC.

23. Aetna and the Attorney General agree that all authority granted to the Attorney General by this AVC is discretionary and shall be exercised or not exercised in the Attorney General's sole discretion.

24. Aetna and the Attorney General agree that the failure of the Attorney General or Aetna to enforce at any time any provisions of this AVC shall not be construed to be a waiver of such provision, nor in any way affect the validity of this AVC or any part of it or the right of the Attorney General or Aetna to enforce each and every provision. No waiver of any breach of this AVC shall be held to constitute a waiver of any other breach.

25. Aetna agrees that Aetna employees will be notified as necessary of the terms of this AVC and trained as necessary to implement the terms of this AVC into Aetna customer and Member service policies.

26. Aetna and the Attorney General agree that each of the undersigned warrants that this person is an authorized representative of the party designated, is authorized to bind such party, and is authorized to execute this AVC.

27. Aetna and the Attorney General agree that in consideration of execution of this AVC, the claims against Aetna will be dismissed with prejudice in Cause No. 98-13972, *The State of Texas v. Aetna U.S. Healthcare, Inc.; Aetna Health Plans of North Texas, Inc.; NYLCare Health Plans of the Southwest, Inc.; and NYLCare Health Plans of the Gulf Coast, Inc.*; pending in the 250th Judicial District Court of Travis County, Texas.

28. Aetna agrees to meet and report 180 days prior to the termination of this AVC to the Attorney

General of what action Aetna plans to take in furtherance of the goals and principles of this AVC upon its termination. The Attorney General shall have 60 days from the date of this meeting to submit questions to Aetna regarding Aetna's plans upon termination of this AVC. Aetna agrees to provide a response to any such questions from the Attorney General within 30 days of receipt of such questions.

VI.

DEFINITIONS

1. Except as used in disclosures required by this AVC, the terms used in this AVC, unless otherwise stated, shall have the same meaning as in *Texas Health Maintenance Organization Act*, Art. 20A of the TEX. INS. CODE (Vernon 1981 & Supp. 2000) and the Texas Department of Insurance's rules on HMOs and utilization review found at 28 TEX. ADMIN. CODE §§ 11.1 - 11.2405 and §§ 19.1701 - 19.1722 as of the effective date of this AVC.
2. **Adverse Determination** - as defined at Art. 20A.02(a) of the TEXAS INS. CODE, a determination by a health maintenance organization or a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary.
3. **Aetna Patient Mandatory Acceptance Provision** - any provision having the effect of mandating a Network Provider to accept new Aetna patients covered by a particular Aetna health care plan or product, so long as that Network Provider is accepting any other new patients covered by a health care plan or product similar to the Aetna plan or product; *e.g.*, so long as a Network Provider is accepting any new HMO patients, the Aetna patient mandatory acceptance provision would require that Network Provider to continue accepting new patients covered by an Aetna HMO.

4. **Aetna** - Aetna U.S. Healthcare, Inc. (a Texas corporation); Aetna U.S. Healthcare of North Texas, Inc.; and Prudential Health Care Plan, Inc.
5. **All Products Provision** - any provision in a contract between Aetna and any Network Provider which operates to give Aetna the right to require Network Providers to participate in more than one Aetna plan or product; or which operates to give Aetna the right to introduce new plans or products during the course of the contract and operates to give Aetna the right to require Network Providers to participate in such plans or products. For purposes of this definition, participate shall mean the acceptance and treatment of plan or product Members as patients or the designation of a Network Provider as participating in a plan or product.
6. **Clinically Inappropriate Underutilization** - underutilization which may indicate a failure to provide or obtain medically necessary services.
7. **Commercial HMO**- any insured HMO plan operating in Texas other than plans covering federal employees or involving Medicaid or Medicare programs.
8. **Coverage Policy Bulletin** - Any statement of Aetna policy used by Aetna in determining medical necessity, covered health care services or excluded health care services.
9. **Downstream Contracts** - a contract between a Risk Bearing Network Provider and another Network Provider to provide medically necessary covered health care services to Aetna Members.
10. **Financial Incentive Arrangement** - any method other than fee for service, including capitation, of compensating Network Providers which creates a financial incentive to reduce or control the costs of providing medically necessary covered benefits.
11. **Health Care Provider** - has the same meaning as “provider” as defined in TEX. INS. CODE

20A.02(t).

12. **Individual** - when used to modify a Physician, Member, or Health Care Provider, as in “individual physician” or “individual health care provider”, means a single, natural person.

13. **Member** - an Individual enrolled in Aetna’s health care plan, including covered dependents.

14. **Network** - “health maintenance organization delivery network” as defined in TEX. INS. CODE Art. 20A.02(w), as amended by *Act of 1997, 75th Leg., ch. 1026, Sec. 3.*

15. **Network Providers** - any Physician, Physician group, independent practice association, other Health Care Provider, or other HMO, bound by contract or agreement to accept or treat Aetna Members as patients; any Physician, Physician group, independent practice association, other Health Care Provider or other HMO designated by Aetna as participating in an Aetna commercial HMO.

16. **Physician** - refers to both primary care physicians and Specialists.

17. **Primary Care Physician Group** - a partnership, association, corporation, individual practice association, or other group of primary care physicians, including pediatricians, internists, family practitioners, general practitioners, and obstetricians/gynecologists, which accepts no risk for referral services, and that (a) distributes income from the practice of primary care medicine among its associated primary care physicians, or (b) contracts with HMOs on behalf of its member primary care physicians.

18. **Referral Services** - any specialty, inpatient, outpatient, or laboratory services or pharmaceutical benefits that a Network Provider orders or arranges, but does not furnish directly. This definition is to be interpreted as consistent with 42 C.F.R § 417.479 (c).

19. **Risk Bearing Network Provider** - (a) a Network Provider which assumes risk for Referral

Services, or (b) an entity meeting the criteria of Art. 21.52F § 1(2) of the TEX. INS. CODE (Vernon 1981 & Supp. 2000), or (c) a provider HMO.

20. **Specialist(s)** - “referral specialist(s)” as defined at 28 TEX. ADMIN. CODE § 11.2(37) (1999).

SIGNED in multiple originals this _____ day of April, 2000.

AGREED TO AND APPROVED
AS TO FORM AND SUBSTANCE:

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