

**IN THE THIRD JUDICIAL DISTRICT COURT
DISTRICT COURT OF SHAWNEE COUNTY, KANSAS**

STATE OF KANSAS, *ex rel.*,
KRIS W. KOBACH, Attorney General,

Plaintiff,

v.

AETNA HEALTH INC., AETNA HEALTH
INSURANCE COMPANY, and AETNA LIFE
INSURANCE COMPANY,

Defendants.

Case No.:

Proceeding Pursuant to K.S.A. Chapter 60

PETITION FOR RELIEF UNDER THE KANSAS FALSE CLAIMS ACT

Plaintiff, the State of Kansas, *ex rel.* Kris W. Kobach, Kansas Attorney General, by and through its undersigned counsel — Amber Smith, Deputy Attorney General, Hilgers PLLC, and Ebad Khan Law — petitions this Court for relief under the Kansas False Claims Act, K.S.A. § 75-7501 et seq., against Defendants Aetna Health Inc., Aetna Health Insurance Company, and Aetna Life Insurance Company (collectively, “Aetna”). Plaintiff alleges and states the following:

PRELIMINARY STATEMENT

1. This enforcement action is brought by the State of Kansas to protect the integrity of its employee health plans and the public funds that support them. As a third-party administrator for the Kansas State Employee Health Plan (the “SEHP”) — a self-funded health benefits program for which the State, not Aetna, bears the financial risk for claims — Aetna was entrusted to adjudicate medical claims, process provider payments, and administer the Plan fairly, lawfully, and in the best interests of plan participants. The conduct documented below reflects an administrative approach in which those obligations — and the legal standards that underpin them — were treated as optional.

2. At the center of this case is Aetna's use of cross-plan offsetting: a practice in which funds belonging to one health plan are used to recover alleged overpayments from another without disclosure or authorization. This is not a contested or developing area of law. The U.S. Department of Labor has identified cross-plan offsetting as a per se violation of ERISA's fiduciary obligations. Federal courts in the Eighth Circuit, the District of Minnesota, and the District of New Jersey have found the practice unlawful, including in litigation in which Aetna was a named defendant. Aetna continued the practice anyway. The conduct reflects a systemic disregard for fiduciary structure, plan asset segregation, and the trust placed in Aetna to administer the SEHP lawfully.

3. Cross-plan offsetting is only the starting point. Aetna also engineered a repricing and retained-savings model that systematically underpays out-of-network claims through Multiplan, the dominant national repricing vendor, whose proprietary algorithms — marketed under product names including Data iSight and Viant — Aetna deploys to suppress provider reimbursements below both billed charges and the amounts withdrawn from the Plan. Aetna and Multiplan then retain a portion of the resulting “savings” as compensation, funded directly from Plan assets rather than from Aetna's administrative fee. This repricing structure, which gained heightened attention following investigative reporting by the national press, has been challenged in federal court as an unlawful suppression of out-of-network reimbursement rates, with the United States Department of Justice taking the position that algorithmic price coordination of this kind can constitute concerted action under federal law. The same repricing architecture has been applied to claims submitted under the SEHP — exposing providers to systemic underpayment, state employees to balance billing, and the Plan to a sustained drain on assets it never authorized.

4. Aetna has also engaged in practices that obscure the true financial and operational picture of the SEHP. It has reversed claims post-payment, limited the claims-level data made available to the State and its oversight entities, and imposed layered administrative fees that reduce plan assets without delivering clearly identifiable benefit. Reports and summaries provided to the State have omitted material detail — the disposition of specific claims, the operation of vendor relationships, and the flow of funds through Aetna’s pooled payment accounts — preventing the State from independently verifying how its own plan assets were used. These practices are not incidental to Aetna’s administration of the Plan. They are the conditions that allowed every other scheme described in this Petition to operate without detection.

5. The State brings this action under the Kansas False Claims Act to halt the pattern, compel transparency, and recover the public funds Aetna has misused.

BACKGROUND ON THE KANSAS HEALTH PLAN AND AETNA’S ROLE

6. The State of Kansas, through the State Employee Health Plan (the “SEHP”), provides health, dental, vision, life, and supplemental insurance benefits to full-time and eligible employees, retirees, and annuitants, along with their eligible dependents. Active employees contribute to the cost of coverage through payroll deductions. The SEHP is administered under the authority of the Kansas State Employees Health Care Commission and is self-funded through a combination of State appropriations and employee contributions.

7. The State of Kansas, through the SEHP, provides health, dental, vision, and life insurance benefits to full-time and eligible employees, retirees, and annuitants, along with their eligible dependents. Active employees contribute to the cost of coverage through payroll deductions. The SEHP is administered under the authority of the Kansas State Employees Health

Care Commission and is funded through a combination of State appropriations and employee contributions.

8. No later than 2014, the State of Kansas entered into an Administrative Services Only Agreement with Aetna under which Aetna serves as third-party administrator (“TPA”) for the SEHP. In that capacity, Aetna is responsible for adjudicating medical claims, processing provider payments, applying plan terms in accordance with applicable law, and administering the Plan on behalf of the State and the employees, retirees, and dependents enrolled in it.

9. Aetna is compensated through a monthly administrative fee paid from State funds and employee contributions. In exchange, Aetna is expected to provide access to its provider network and to adjudicate claims submitted by healthcare providers who treat SEHP members in a manner consistent with the terms of the Plan and applicable federal and state law.

10. Aetna’s administration of the SEHP is not a back-office function. Aetna maintains a dedicated public-facing portal for SEHP members at aetnastateofkansas.com — branded with the State’s name, marketed to Kansas public employees and their families, and used by Aetna to communicate directly with members about plan benefits, network access, cost-containment tools, and program offerings. Through that portal and related channels, Aetna has represented itself to Kansas members as “more than insurance” — as “a health care company” providing “the tools and resources [members] need.” The State accepted that representation. Kansas public employees accepted it. The administrative practices documented in this Petition are evaluated against the role Aetna publicly accepted and represented itself as performing.

11. Aetna’s role is not limited to ministerial claims handling. It exercises substantial discretion over whether claims are approved, how they are priced, what portion of billed charges is paid to providers, whether payments are later reversed or recouped, and how funds withdrawn

from SEHP accounts are ultimately distributed. That discretion is exercised over public assets, on behalf of public employees, under a contract that obligates Aetna to act in the interests of the Plan and its participants. It carries fiduciary weight regardless of the label the parties have given the relationship.

12. The conduct documented in this Petition reflects a sustained pattern in which Aetna has used the discretion delegated to it to advance its own financial interests rather than those of the Plan. Aetna has retained undisclosed “savings” generated by underpaying out-of-network providers, deployed third-party repricing vendors to suppress payments below contractually and statutorily required amounts, executed post-payment reversals and clawbacks that draw down Plan assets without proper notice or process, and used SEHP funds to satisfy financial obligations arising under entirely unrelated health plans. None of these practices was disclosed to the State in a form sufficient to permit meaningful oversight. None was authorized in a manner consistent with Aetna’s obligations to the Plan.

13. The financial scale of this conduct is significant. Based on the information available to the State, tens of millions of dollars in SEHP assets — funds designated for the payment of medical services rendered to Kansas public employees — have been retained by Aetna, redirected to other health plans, or distributed to vendors operating under arrangements the State did not authorize. The full scope of the diversion can be established only through the discovery this action will enable. The funds at issue come directly from the public treasury and from the wages of Kansas state employees.

NATURE OF THE CASE

14. This is a civil enforcement action brought by the State of Kansas under the Kansas False Claims Act, K.S.A. §§ 75-7501 through 75-7511 (the “KFCA”), against Aetna for its conduct as third-party administrator of the SEHP. The State seeks to recover public funds

Aetna has wrongfully retained, redirected, or caused to be disbursed in violation of its obligations to the Plan, and to obtain the civil penalties, treble damages, and attorneys' fees and costs the statute provides.

15. The KFCA, K.S.A. § 75-7503(a), subjects to liability any person or entity that:
 - a) Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;
 - b) Knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment;
 - c) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State;
 - d) Has possession or control of public money or property and knowingly delivers less than the amount received;
 - e) Knowingly, and with authority to do certify receipts of State property, certifies false receipts for State property;
 - f) Knowingly buys or receives public property from a person not lawfully authorized to sell it;
 - g) Fails to report and resolve an inadvertently submitted false claim; or
 - h) Conspires to commit any of the foregoing acts.

16. The term “knowingly” includes actual knowledge, deliberate ignorance, or reckless disregard of the truth or falsity of the information. Specific intent to defraud is not required. K.S.A. § 75-7502(e); K.S.A. § 75-7503(c).

17. Any person or entity found liable under the KFCA is subject to:

- Treble damages (3x actual damages to the State),
- Civil penalties of \$1,000 to \$11,000 per violation, and
- Recovery of the State’s attorneys’ fees and costs. See K.S.A. § 75-7503(a).

18. The Kansas Attorney General is expressly authorized to bring this civil enforcement action in the name of the State. K.S.A. § 75-7504(a).

19. Aetna’s conduct violates multiple provisions of the KFCA. As detailed in the sections that follow, Aetna has caused false or fraudulent claims to be presented for payment from the SEHP; has made and used false records and statements material to those claims; has concealed and avoided obligations to return or transmit public funds owed to the Plan; and has taken possession of public money intended for the payment of medical services and delivered less than the full amount to its intended recipients. These violations are not isolated. They reflect a sustained pattern of self-interested administration carried out against a backdrop of opacity that prevented the State from detecting the conduct in real time. The State brings this action to halt the pattern, recover the public funds at issue, and obtain the relief the KFCA provides.

PARTIES, JURISDICTION, AND VENUE

20. The State of Kansas brings this action by and through the Kansas Attorney General pursuant to K.S.A. § 75-7504(a), which authorizes the Attorney General to pursue civil enforcement of violations under the Kansas False Claims Act. The Attorney General seeks to recover, for the benefit of the State, all damages, civil penalties, interest, attorneys’ fees, costs, and expenses authorized by the KFCA arising from the conduct alleged in this Petition.

21. Defendant Aetna Life Insurance Company (“Aetna Life”) is a for-profit insurance company incorporated in the State of Connecticut, with its principal place of business in Hartford, Connecticut. Aetna Life is a wholly-owned subsidiary of CVS Health Corporation and

is licensed to conduct insurance business in all fifty states. Aetna Life serves as a primary third-party administrator for numerous employer- and government-sponsored health benefit plans, including the Kansas State Employee Health Plan. Aetna Life is the contracting Aetna entity for purposes of the SEHP and the entity primarily responsible for the claims adjudication, payment, and administrative functions alleged herein.

22. Defendant Aetna Health Inc. is a corporation organized under the laws of the State of Pennsylvania and is an affiliate of Aetna Life within the broader CVS Health corporate enterprise. Aetna Health Inc. participated in the administration of the SEHP and in the conduct alleged in this Petition, including through the issuance of claim determinations, the processing of appeals, and the management of network and cost-containment functions affecting SEHP claims.

23. Defendant Aetna Health Insurance Company is a related entity within the CVS Health corporate enterprise that, together with Aetna Life and Aetna Health Inc., participated in the administration of the SEHP and in the acts and omissions giving rise to this Petition. Aetna Life, Aetna Health Inc., and Aetna Health Insurance Company are collectively referred to herein as “Aetna.” The State alleges, on information and belief, that Aetna operates as an integrated administrative enterprise with respect to the SEHP, and that conduct attributable to any one Aetna entity is, in substance, the conduct of the Aetna enterprise as a whole. The respective roles, responsibilities, and intra-corporate allocations among the Aetna entities will be developed through discovery.

24. Venue is proper in this Court pursuant to K.S.A. §§ 75-7504 and 75-7510. Aetna transacted business in Shawnee County, Kansas, in its administration of the SEHP. The false claims at issue in this Petition were submitted to the SEHP, which is situated in Shawnee County. The conduct alleged was committed in substantial part in the State of Kansas, including in

Shawnee County. It involved the administration of a health plan funded by Kansas public appropriations and the wages of Kansas state employees; the adjudication of claims for medical services rendered to Kansas residents; the application of cost-containment, repricing, and recovery practices to claims submitted under a Kansas-administered Plan; and the retention or redirection of plan assets held for the benefit of Kansas residents.

25. This Court has personal jurisdiction over Aetna pursuant to the Kansas Long-Arm Statute, K.S.A. § 60-308(b), and the Due Process Clauses of the United States and Kansas Constitutions. Aetna has engaged in substantial, continuous, and systematic business activity in Kansas, including:

- Contracting with the State of Kansas to serve as third-party administrator of the SEHP;
- Adjudicating claims and processing provider payments on behalf of SEHP participants residing in Kansas;
- Maintaining a dedicated public-facing portal at aetnastateofkansas.com through which Aetna directly communicates with Kansas residents about their health benefits;
- Communicating and transacting regularly with Kansas state agencies, public officials, and SEHP participants in furtherance of its administration of the Plan;
- Receiving compensation from Kansas public funds and employee contributions for services performed under the SEHP; and
- Holding and exercising control over Plan trust assets funded by Kansas public appropriations and the wages of Kansas state employees.

26. Aetna is subject to jurisdiction under multiple provisions of K.S.A. § 60-308(b), including:

- (b)(1)(A): Transacting business within the State;
- (b)(1)(B): Committing tortious acts within the state;
- (b)(1)(D): Contracting to insure persons or property located in Kansas;
- (b)(1)(E): Entering into contracts with Kansas residents to be performed in Kansas; and/or
- (b)(1)(L): Engaging in sufficient contact to support jurisdiction under the U.S. and Kansas Constitutions.

KANSAS HIRED AETNA TO PROVIDE CLAIMS ADMINISTRATIVE SERVICES

27. Aetna currently serves as third-party administrator (“TPA”) for the SEHP, a self-funded health benefits program for eligible State employees, retirees, and their dependents. Aetna has held this role since at least 2014, pursuant to an Administrative Services Only Agreement (“ASO Agreement”) executed with the State of Kansas.

28. As a TPA to a self-funded plan, Aetna does not underwrite risk or pay claims using its own capital. The State of Kansas, funded through public appropriations and employee contributions, retains full financial responsibility for healthcare claims under the SEHP. Aetna’s role is to process those claims, apply the terms of the Plan, comply with applicable federal and state laws governing the Plan’s administration, and adjudicate medical expenses using public funds in a manner consistent with the State’s obligations to its employees.

29. Given the complexity of administering a health plan the size of the SEHP, the State requires and relies upon Aetna’s good faith to ensure that State resources are used in an effective and efficient manner. The State delegates day-to-day administrative functions to Aetna

based on Aetna's representations and Aetna's contractual undertakings, with the expectation that Aetna will perform those functions fairly, lawfully, and in the interests of the Plan. The conduct alleged in this Petition reflects the systematic violation of that good faith.

30. Aetna entered the SEHP relationship having represented that it would use industry-standard coding methodologies, follow applicable plan documents, process claims in accordance with the policies of the Plan, and perform its services in compliance with all applicable laws, regulations, and fiduciary standards. Aetna further represented that its administration of the SEHP would not expose the Plan or the State to legal or regulatory violations. The State selected Aetna as its TPA in reliance on those representations.

31. Under the ASO Agreement, Aetna exercises substantial discretion over the administration of the Plan. It determines whether a claim is payable, how much will be paid, what coding will apply, whether discounts or repricing methodologies will be invoked, and whether a payment will be approved, denied, reversed, or recouped. The State has no practical role in any of those determinations.

32. Aetna also controls the flow of Plan funds. When it approves a claim, it withdraws money directly from SEHP accounts to fund provider reimbursements. It determines the amount withdrawn, the timing of the withdrawal, and the portion of the withdrawn funds that is ultimately delivered to the provider as compared with the portions retained, reallocated, or distributed to third parties.

33. This combination of contractual authority, operational control, and access to public funds places Aetna in a position of fiduciary responsibility to the SEHP. Regardless of how the parties have labeled the relationship in the ASO Agreement, Aetna's role with respect to Plan assets — the discretion it exercises, the funds it controls, and the dependence the State and

its employees place on its administration — is fiduciary in substance. The State entered the relationship trusting that Aetna would administer the Plan consistent with that role. The allegations in this Petition demonstrate that the trust was misplaced.

34. The conduct documented in the sections that follow reflects more than administrative failure. It reflects a sustained pattern in which Aetna has used the discretion delegated to it, and the access to Plan assets that delegation provides, to extract value from the SEHP for its own benefit. Aetna has retained State funds without authorization, engaged third-party repricing vendors to suppress provider payments below required amounts and divided the resulting “savings” with those vendors, executed cross-plan offsets that drew SEHP assets to satisfy obligations arising under unrelated plans, and reversed payments after the fact through clawback mechanics designed to operate outside the State’s view. None of these practices was disclosed to the State in a manner sufficient to permit oversight. None was authorized in a manner consistent with Aetna’s obligations to the Plan. The conduct was not incidental, not accidental, and not the product of administrative error.

AETNA’S MISUSE OF ITS POSITION AS TPA

35. The conduct documented in this Petition cannot be characterized as clerical error, systemic noise, or an isolated breakdown in oversight. It reflects a sustained pattern in which Aetna has used its role as TPA to extract value from the SEHP through a series of interrelated and concealed financial practices. The practices vary in their mechanics — cross-plan offsetting, vendor-based repricing, post-payment reversals, comingling of Plan assets with other accounts under Aetna’s control, and the layering of fees against funds the State did not authorize Aetna to retain. They are unified by a single structural feature: the exercise of delegated discretion in a manner that produces financial benefit to Aetna at the expense of the Plan.

36. As administrator of a self-funded public health plan, Aetna occupies a position of trust. It controls public funds. It controls the gateway between Kansas public employees and the healthcare services those employees rely on the Plan to provide. It controls the information through which the State understands how its own Plan is performing. That position carries legal, ethical, and fiduciary weight regardless of how Aetna or the ASO Agreement chooses to label it. The conduct alleged herein reflects the systematic conversion of that position from one of stewardship into one of self-interest.

37. The schemes described in the sections that follow share a common financial logic. Each generates revenue for Aetna by reducing what the SEHP and its participants receive in exchange for the public dollars the Plan disburses. In some cases, Aetna has diverted SEHP funds to satisfy financial obligations arising under entirely unrelated health plans. In others, Aetna has suppressed claim payments through third-party repricing vendors and retained a share of the resulting “savings” for itself. Aetna has reversed payments after the fact through clawback mechanics that operate outside the State’s view. It has limited the data and reporting made available to the State in ways that prevent meaningful oversight. And it has structured its administrative fee arrangements in ways that make it functionally impossible for the State to evaluate whether the fees it pays correspond to services delivered.

38. The consequences of this conduct are not confined to spreadsheets or contract performance metrics. The SEHP exists to provide healthcare benefits to Kansas public employees and their families — including state workers across every department of State government, public school employees, public safety personnel, and the retirees and dependents who continue to rely on the Plan after years of service. When Aetna manipulates claims processing, suppresses payments, or extracts fees from Plan assets the State designated for the

payment of medical services, the harm runs in three directions at once: members face exposure to unexpected balance-bills and reduced provider access, providers face systematic underpayment that deters participation and degrades the network the SEHP depends on, and the public treasury sustains losses that should never have been incurred. The State brings this action to recover those losses and to restore the integrity of the administration the public was paying for.

A. Aetna’s Cross-Plan Recoupment Scheme: A Per Se Fiduciary Breach That Diverts Public Funds

39. Since the outset of its administration of the SEHP, Aetna has engaged in a practice known as cross-plan offsetting — a mechanism by which Aetna uses SEHP funds to satisfy payment obligations arising under entirely unrelated health plans, including fully insured plans for which Aetna itself bears the financial risk.

40. The mechanics are straightforward. Aetna identifies a claim it has previously paid — typically a claim submitted by an out-of-network provider under a different plan — and concludes, after the fact, that the prior payment exceeded what was owed. Rather than pursuing reimbursement directly from the provider that received the payment, or absorbing the loss as the administrator that made the payment, Aetna waits until the same provider submits a claim under a different plan. Aetna then uses that new claim as the vehicle to recoup the prior alleged overpayment, drawing the recovery from the new plan’s trust assets rather than from the provider.

41. In these scenarios, Aetna pulls the full amount from the SEHP account but then short-pays the provider — diverting the difference to itself. The SEHP member receives no notice. The provider is left underpaid. And the SEHP — a public, self-funded plan — unknowingly subsidizes a liability that did not originate with it and delivers no benefit to it.

42. In a typical execution, Aetna withdraws the full claim amount from the SEHP account but underpays the provider by the amount of the alleged overpayment from the unrelated plan. The difference is retained by Aetna or applied to the unrelated plan's account. The SEHP member is not notified. The provider is left underpaid for services rendered to a Kansas public employee, exposing the member to balance-billing exposure. The SEHP — a public, self-funded plan — unknowingly satisfies a liability that did not arise from its own member's care and from which it derives no benefit.

43. A concrete illustration of the mechanics is as follows:

- **Patient A**, covered by a **fully insured Aetna plan**, receives care from **Dr. Doe, an out-of-network provider**.
- Aetna pays Dr. Doe **\$1,000**.
- Aetna subsequently determines that the **correct payment should have been \$800**. Aetna seeks return of the \$200 difference. Dr. Doe declines to return it.
- A week later, **Patient B, an SEHP member**, receives care from Dr. Doe. Aetna determines that **\$800** is payable on the new claim.
- Aetna **withdraws \$800** from the SEHP account. It **pays Dr. Doe \$600** and **retains the remaining \$200** to resolve the prior overpayment dispute arising under Patient A's unrelated plan.
- Neither Dr. Doe, Patient B, nor the SEHP receives any notice of the redirection.

44. Through this mechanic, Aetna uses public Plan assets — funds designated for the medical care of Kansas public employees — to satisfy obligations Aetna incurred administering different plans for different members. The conduct is, in substance, a redirection of public funds to private accounts under the guise of routine claims adjudication.

45. The consequences extend across every category of stakeholder in the Plan. Providers are systematically underpaid and forced to challenge transactions whose underlying basis is concealed from them. SEHP members are exposed to balance billing for services the Plan was supposed to cover. The Plan's claim history is distorted, undermining the State's ability to monitor cost trends and Plan performance. And public funds are used not to deliver healthcare benefits to Kansas residents but to resolve financial exposures Aetna created in administering other plans.

46. **The structural conflict of interest is severe.** Aetna has every financial incentive to identify alleged overpayments arising under its own fully insured plans — the plans whose losses come out of Aetna's own balance sheet — and to recover those amounts from self-funded plan assets that Aetna does not own. Aetna has no comparable incentive to identify overpayments arising under self-funded plans like the SEHP and recover them from its own fully insured book. The asymmetry is not coincidental. It is the financial architecture of the scheme.

47. The Department of Labor has been on record since at least 2012 expressing concern with overpayment determination and recovery practices of the kind Aetna has continued to deploy. In *Tri3 Enterprises, LLC v. Aetna, Inc.* — litigation in which Aetna was the named defendant — the Department filed a formal amicus brief taking the position that an insurer's demand for reimbursement based on the retroactive denial of previously paid claims is subject to the procedural protections ERISA imposes on adverse benefit determinations. The Department's position placed Aetna on direct notice, more than a decade before the conduct at issue in this Petition, that federal regulators viewed the post-payment recovery practices Aetna has continued to deploy — including the recovery mechanics underlying the cross-plan offsetting scheme

alleged herein — as inconsistent with the fiduciary obligations administrators owe to the plans whose assets they administer.

48. Cross-plan offsetting has since been the subject of sustained adverse treatment by federal courts and federal regulators. In *Peterson v. UnitedHealth Group*, 242 F. Supp. 3d 834 (D. Minn. 2017), the United States District Court for the District of Minnesota held that cross-plan offsetting creates a structural conflict of interest for claims administrators and is inconsistent with the fiduciary obligations administrators owe to the plans whose assets they administer. The Eighth Circuit affirmed that decision in 2019. The United States Department of Labor filed an amicus brief in support of affirmance, taking the position that cross-plan offsetting constitutes a per se violation of fiduciary obligations under ERISA.

49. Aetna has itself been a named defendant in federal litigation challenging this practice. In *Lutz Surgical Partners PLLC v. Aetna, Inc.*, No. 3:15-cv-02595 (D.N.J. 2021), a federal court held that Aetna financially benefits from cross-plan offsetting and that the practice violates the fiduciary duties Aetna owes to the self-funded plans whose assets it administers. The court's holding specifically addressed Aetna's deployment of cross-plan offsetting against self-funded employer plans — the same category of plan as the SEHP.

50. The Department of Labor's adverse treatment of cross-plan offsetting was reaffirmed in September 2023, when the Department concluded that EmblemHealth's cross-plan offsetting practices violated ERISA on the ground that they permitted the administrator to withhold payments owed under one plan to satisfy debts asserted under another, enriching the administrator at the expense of plan beneficiaries. The conduct EmblemHealth was found to have engaged in is the same conduct Aetna has engaged in with respect to the SEHP.

51. While the SEHP is not governed by ERISA, the fiduciary and trust-based principles articulated in the authorities cited above — duties of loyalty, prudence, and asset segregation, and the prohibition against an administrator using one plan’s assets to satisfy obligations arising under another — apply with equal force to any administrator entrusted with public funds and the health benefits of public employees. Kansas law recognizes those principles and applies them through the KFCA and through the fiduciary obligations inherent in Aetna’s administration of public assets.

52. Aetna has further institutionalized the practice by structuring its internal accounting to retain a percentage of the amounts it recovers through cross-plan offsetting — on information and belief, **typically twenty to forty percent of the recovered amount — as compensation for executing the recovery.** This fee architecture creates a **direct financial incentive for Aetna to identify overpayments aggressively** and to execute recoveries through the cross-plan mechanism rather than through direct demand on the provider that received the original payment. **Each recovery generates compensation for Aetna** calculated against assets the recovering plan did not authorize Aetna to retain.

53. Aetna is anticipated to argue that its authority to engage in cross-plan offsetting is supported by the ASO Agreement or by the State’s general awareness of Aetna’s administrative practices. Neither argument can succeed. The ASO Agreement cannot authorize conduct that violates the fiduciary obligations Aetna owes to the Plan and its participants. The Department of Labor and the federal courts cited above have addressed this defense directly and rejected it, holding that no plan-document provision can authorize an administrator to engage in a *per se* fiduciary breach. The State’s general awareness of Aetna’s administrative practices cannot

constitute informed consent to a practice Aetna did not disclose, did not explain in terms sufficient to permit evaluation, and did not subject to the State's review.

54. Consent to unlawful conduct, where extracted by silence or assumed by an administrator who concealed the financial benefit it derived, is not consent at all. To the extent Aetna relies on any provision of the ASO Agreement to defend its cross-plan offsetting practices, the provision is unenforceable as a matter of public policy and as a matter of the fiduciary obligations Aetna independently owes to the Plan.

55. Aetna's cross-plan offsetting practices reflect a sustained, structurally embedded redirection of SEHP assets to satisfy obligations arising under unrelated plans, executed without the State's informed consent, in violation of the fiduciary obligations Aetna owes to the Plan, and at material financial cost to Kansas. The State did not authorize the practice in the manner Aetna has conducted it. Aetna did not disclose the practice in a manner sufficient to permit the State to evaluate or object to it. The conduct is ongoing.

B. Aetna's Abuse of Repricing Discretion: The NAP Architecture – A Scheme with Vendor Kickbacks Designed to Take More Than It Pays.

56. Aetna's repricing and retained-savings practices operate through a designated administrative protocol it calls the National Advantage Program ("NAP"). NAP is not an internal routing convention applied selectively to particular categories of claims. It is the default administrative architecture through which Aetna processes claims submitted under the SEHP.

57. The designation appears on the face of every SEHP member's insurance card. SEHP members enrolled in Plan A carry insurance cards that identify the program as "LOCAL NAP" at the top of the card itself, alongside the State of Kansas plan designation and the Aetna logo. The label is not buried in a footnote of the ASO Agreement. It is printed by Aetna directly on the materials Aetna distributes to Kansas public employees.

58. The existence of the program, in other words, has not been hidden from the State or from members. But its operational mechanics — how claims routed through NAP are repriced, how reimbursement amounts are calculated, what portion of the resulting “savings” is retained by Aetna or distributed to third-party vendors, and how those amounts are drawn from SEHP funds rather than from Aetna’s administrative fee — have not been disclosed to the State in a form sufficient to permit oversight. NAP is, in substance, the operational vehicle through which the repricing practices described below extract value from the Plan.

59. Under the NAP architecture, when Aetna receives a claim from an out-of-network (“OON”) provider treating an SEHP member, the claim is not paid at the rate that would apply under the terms of the Plan. The claim is instead routed through one or more third-party repricing vendors.

60. The principal repricing vendor in the NAP ecosystem is Multiplan, the dominant national repricing vendor, whose proprietary algorithms are marketed under product names including Data iSight and Viant. Multiplan acts in coordination with related vendors including Zelis Healthcare and Global Claims Services. Each of these vendors operates within the NAP architecture to generate reimbursement amounts substantially below both the provider’s billed charge and the amount Aetna withdraws from the SEHP account to fund the transaction.

61. The repricing process is not a single determination. If the provider declines the initial reduced amount, the claim may be rotated through additional vendors, additional rounds of repricing, and additional administrative pressure until the provider accepts a discounted payment or abandons the claim.

62. The financial architecture of NAP is the feature that converts a routine administrative function into a revenue stream. The repricing vendors are compensated through a

percentage of the difference between the billed charge and the amount ultimately paid to the provider — the “savings” their methodologies generate. Aetna retains a separate percentage of the same spread as its own compensation for routing the claim.

63. Neither set of fees is drawn from Aetna’s monthly administrative fee. Both are drawn from SEHP funds that the State has designated for the payment of medical services. The result is a transaction in which Aetna withdraws funds from the SEHP account in an amount that reflects the original claim, pays the provider a fraction of that amount, and retains or distributes the difference among itself and its repricing vendors.

64. The Plan is charged. The provider is underpaid. Aetna and its vendors are paid from the spread.

65. In documented cases involving SEHP claims, the combined fees retained by Aetna and its repricing vendors — drawn from SEHP funds — have exceeded the amount actually paid to the provider for the medical service that generated the transaction. In those cases, the administrator and its third-party intermediaries are compensated at a higher rate than the clinical professional who delivered the care to a Kansas public employee.

66. The State, meanwhile, is presented with claims records that reflect the gross amount withdrawn from the Plan rather than the net amount delivered to the provider. The records Aetna makes available do not permit the State to distinguish between funds that paid for healthcare and funds that paid for the administrative architecture surrounding the healthcare.

67. The arrangement described above was not disclosed to the State in a form sufficient to permit meaningful evaluation. While the ASO Agreement may reference “cost-containment” services, the agreement does not disclose the financial architecture of NAP — that Aetna and its repricing vendors are compensated through a percentage of the spread between

billed charges and provider payments, that the spread is funded from SEHP assets rather than from Aetna's administrative fee, or that the volume of "savings" generated by the program correlates directly with the volume of underpayment imposed on providers treating Kansas public employees.

68. A reference to cost-containment is not a disclosure of fee-splitting from misappropriated trust assets. Informed consent to a contractual arrangement requires disclosure of the material terms of the arrangement. The State did not receive that disclosure.

69. The repricing vendors that participate in the NAP architecture are not passive service providers. On information and belief, the vendors knew or should have known that Aetna was administering the SEHP on behalf of the State of Kansas as a non-risk-bearing fiduciary; that the funds compensating the vendors were drawn from a self-funded public health plan rather than from Aetna's administrative fee; that Aetna was simultaneously retaining a percentage of the same spread from which the vendors were compensated; and that the architecture of the program had not been disclosed to the State in the form in which it operated.

70. The vendors' continued participation in the architecture, with knowledge of these facts, makes them coordinated participants in the conduct alleged herein.

71. The conduct violates the Kansas False Claims Act in multiple respects. It causes the presentation to the SEHP of claim records that reflect amounts withdrawn from the Plan that do not correspond to amounts actually paid to providers. It generates and uses records that conceal the disposition of plan assets — specifically, that a material portion of the funds withdrawn was retained by Aetna or distributed to repricing vendors rather than delivered to the provider whose service generated the claim.

72. The conduct results in the retention of public funds that were designated for the payment of medical services and were not so applied. And it permits Aetna to certify the accuracy of transactions whose true financial flows have not been disclosed to the State that funded them.

73. The consequences extend beyond the financial arithmetic. Providers who receive systematically suppressed reimbursements through the NAP architecture have economic incentives to limit their participation in the SEHP network, to balance-bill members for the difference between billed charges and the amounts Aetna's repricing vendors deem acceptable, or to decline to treat SEHP members at all.

74. SEHP members face unexpected bills for services they reasonably believed were covered. The State pays the full claim amount withdrawn from the Plan and receives, in exchange, a fraction of that amount in actual medical services delivered. Aetna and its repricing vendors retain the difference, and continue to do so as long as the architecture remains in place.

75. The operation of the NAP architecture on SEHP claims is not theoretical. The documented examples set forth below establish, through Aetna's own records, that the conduct described in this Section is the conduct Aetna routinely engaged in when administering claims submitted under the Plan.

C. Aetna's Concealment and Comingling of Plan Funds: A Fiduciary Breach Built on Opacity

76. Aetna's misconduct does not end at the point of adjudication. It extends into how Plan funds are handled, recorded, and reported — or, more precisely, how they are not. The financial schemes described in the preceding sections of this Petition could not operate at the scale alleged without an administrative architecture designed to obscure the disposition of Plan assets from the State that funds them. Aetna has built that architecture.

77. As third-party administrator to a self-funded health plan, Aetna is entrusted with public money. It is not entitled to treat that money as its own. Its role with respect to SEHP funds is the role of an agent and a fiduciary, not a principal.

78. In practice, the State does not approve individual provider payments before they are made. The ASO Agreement grants Aetna direct withdrawal authority over SEHP-funded accounts — authority Aetna exercises on its own initiative, on its own timing, and in amounts Aetna determines without advance State approval. The State funds the accounts. Aetna decides when to draw from them, how much to draw, and how the withdrawn funds are subsequently allocated.

79. Aetna does not draw those funds directly into provider payments. It transfers the withdrawn funds into internal accounts that Aetna owns or controls, where they are held alongside funds from other self-funded plans Aetna administers and, on information and belief, alongside funds associated with Aetna's own fully insured business.

80. From those pooled accounts, Aetna pays providers — not directly from SEHP-segregated funds, but from a commingled pool the State cannot independently inspect. The structure forecloses the audit trail that would otherwise permit the State to verify whether the funds Aetna withdrew from SEHP accounts correspond to the payments Aetna delivered to providers on behalf of SEHP members.

81. The consequence is concrete. The State cannot match a claim withdrawal to a provider payment. The State cannot independently verify the amounts actually paid. The State cannot confirm that funds withdrawn from the Plan were used for the care of Kansas public employees rather than for other purposes.

82. The State is dependent, for that information, on the reports Aetna chooses to provide. Aetna controls the format of those reports. Aetna controls the level of detail. And Aetna has consistently declined to provide the granular, claim-level financial data that would permit independent verification of the disposition of SEHP funds.

83. This dependence is not a technical limitation of the administrative relationship. It is the design feature that enables every other scheme described in this Petition. Cross-plan offsets are recorded in generic transaction codes that do not surface the redirection of SEHP assets to unrelated plans. Repricing spreads are not reported in a form that would disclose what portion of withdrawn funds was retained by Aetna or its vendors rather than delivered to the provider. Post-payment reversals and claim re-adjudications are masked through claim renumbering that severs the connection between the original transaction and the recovery.

84. The State, in short, has been left to trust Aetna to report accurately on Aetna's own conduct.

85. The commingling of Plan assets is independently problematic given Aetna's dual role. Aetna is a fiduciary to the SEHP. Aetna is also the financial risk-bearer for its own fully insured plans. These two roles are structurally incompatible when funds are pooled. An administrator that holds public Plan assets in the same accounts as the funds it deploys to cover its own commercial liabilities is operating in a financial environment in which the temptation to use one to satisfy the other is built into the architecture — and in which the auditable record needed to detect such transactions has been removed.

86. The concealment and commingling practices described above violate the Kansas False Claims Act in multiple respects. They permit Aetna to present payment summaries to the State that do not reflect the actual disposition of Plan funds. They generate and use records that

conceal what portion of withdrawn funds was delivered to providers as compared with the portions retained or redistributed. They result in the retention of public money that the State was led to believe had been applied to its intended purpose. And they permit Aetna to certify the accuracy of transactions whose underlying financial flows have not been disclosed to the State.

87. The harm runs in two directions. The Plan sustains financial losses that the State cannot independently quantify. And SEHP members — Kansas public employees who continue to contribute to the Plan from their wages — face the practical consequences of an administrative system whose opacity Aetna has structured for its own benefit: delayed payments, providers withdrawing from network participation, balance-billing exposure for services the Plan was designed to cover, and the loss of confidence in a benefits program the State exists to administer.

D. Aetna’s Discretionary Fee Architecture: The Layering of Charges Against Plan Assets

88. Beyond the specific schemes addressed in Sections A through C, Aetna’s administration of the SEHP reflects a broader pattern in which Aetna’s discretionary authority over fees, charges, and recovery activities has functioned as a recurring source of revenue extracted from Plan assets.

89. The ASO Agreement contemplates a defined administrative-fee structure — a per-member-per-month charge for the basic services of claims administration. That structure is not the source of the conduct alleged in this Section. The conduct alleged here concerns the additional charges Aetna has layered on top of that base fee.

90. Aetna routinely imposes additional charges against SEHP assets for services characterized as repricing, cost containment, overpayment recovery, shared savings, network optimization, clinical edits, and other “value-added” categories. The categories themselves are not the problem. The problem is that the categories are not itemized in a form that would permit

the State to evaluate whether the services were performed, whether they benefited the Plan, or whether the amounts charged bear any relationship to the services delivered.

91. The charges are also not invoiced in the conventional sense. Aetna does not submit a bill to the State, await State review, and receive payment after the State has approved the charge. Aetna draws the funds from SEHP accounts on its own authority — frequently before the underlying claims have been finally adjudicated — and accounts for the draw afterward through summary reporting that the State cannot independently reconcile.

92. The result is a fee architecture in which Aetna determines what services were rendered, what those services are worth, what the Plan will be charged, and when the funds will be withdrawn — and reports the result to the State in a form Aetna controls. The State has no practical mechanism to audit individual fee draws against the services that purportedly generated them.

93. The categories of charges most resistant to verification — “administrative recovery,” “shared savings,” “network optimization,” “clinical edits” — are also the categories most likely to obscure the underlying financial flows. A “shared savings” fee is, by definition, a percentage of a manufactured “savings” amount; the State cannot verify the underlying savings calculation, the percentage retained, or whether the savings represent value delivered to the Plan as compared with margin extracted from Plan assets. A “clinical edits” fee describes a discretionary administrative function that cannot be independently audited without access to the underlying coding decisions Aetna applied.

94. The State, having paid the fees, has no independent record of what it paid for.

95. The conduct violates the Kansas False Claims Act in respects that parallel the violations alleged in the preceding sections. It causes the presentation to the SEHP of fee

summaries that do not reflect the services actually rendered or the basis for the amounts charged. It results in the retention of public funds against categories of charges whose underlying basis has not been disclosed. And it permits Aetna to certify the accuracy of fee transactions whose true substance has not been made visible to the State.

96. The harm is the harm that runs through every section of this Petition: public funds designated for the medical care of Kansas public employees have been retained by Aetna under arrangements the State did not authorize in the form Aetna implemented them and could not have evaluated without the granular financial data Aetna has consistently declined to provide. The administrative-fee architecture is the species of that harm in which Aetna's discretion is most concentrated and least visible.

E. The Harm to Kansas Members and Taxpayers.

97. The conduct alleged in this Petition is not a contract dispute conducted at a distance from the people the SEHP exists to serve. The financial mechanics described in the preceding sections operate directly on the healthcare experience of Kansas public employees and their families.

98. When Aetna underpays a provider through NAP repricing, members face balance-billing exposure for services they reasonably believed were fully covered. When Aetna executes a post-payment clawback against a previously-paid claim, providers are left chasing collection on services already rendered — and frequently transfer that collection effort to the member. When Aetna's repricing methodology produces reimbursement rates that providers cannot accept, providers withdraw from SEHP network participation, reducing the access SEHP members were promised. Members face unexpected bills. Members avoid care they need. Members lose access to providers who decline to treat them. Each of these consequences is a

documented feature of the administrative architecture this Petition challenges, not a hypothetical risk.

99. The harm does not stop at the member level. SEHP funds are drawn from public appropriations and from the wages of Kansas state employees. When Aetna retains amounts it withdrew from the Plan but did not deliver to providers, when Aetna imposes fees the State cannot reconcile against verifiable services, when Aetna directs SEHP assets to satisfy obligations arising under unrelated plans — those are losses sustained by the Kansas public treasury. Public money designated for the healthcare of public employees is instead consumed by the administrative architecture surrounding the healthcare.

100. The cost of this conduct is also borne by SEHP members in a form they encounter every pay period. The SEHP's premium structure is calibrated to projected Plan costs. When Plan costs are inflated by the fee extraction, cross-plan offsetting, and repricing-spread retention described in this Petition, the resulting cost pressure is reflected — over time and through subsequent benefit-year recalibrations — in the premiums charged to members and in the appropriations required from the State to maintain coverage.

101. Kansas public employees who contribute to the SEHP from their wages have been paying premiums calibrated, in part, to losses Aetna's conduct produced. The State, in funding its share of those premiums, has been doing the same. The Plan would not have required the level of funding it has required, and members would not have been charged the contributions they have been charged, had Aetna administered the Plan in the manner the State retained it to administer.

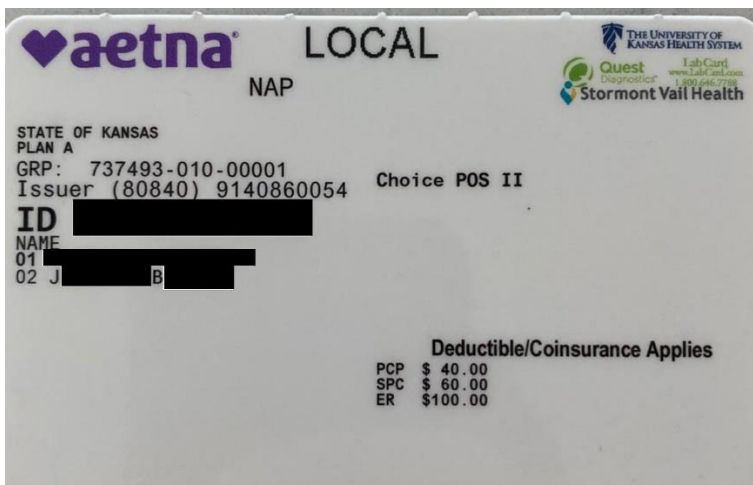
102. The State brings this action to recover those losses and to halt the conduct that produces them. The SEHP exists to provide healthcare benefits to Kansas public employees and

their families. Its administrator exists to deliver those benefits efficiently and lawfully — not to extract value from the funds the State has entrusted to its care.

EXAMPLES OF KANSAS EMPLOYEE HARM

A. Member JB: A Concrete Example of Aetna’s Cross-Plan Offset Scheme

103. Member JB is a member of the SEHP (State of Kansas – Plan A; Group No.: 737493-010-00001) administered by Aetna.



104. Member JB received medically necessary diagnostic laboratory services from a laboratory (an out-of-network laboratory with Aetna) on December 17, 2021.

105. Aetna subjected Member JB’s medical claim through post-adjudication adjustments that collectively reflect the operation of the above detailed schemes.

106. Aetna’s Initial Adjudication of Member JB’s Medical Claim:


A. The lab submitted a medical claim for Member JB that included two line items: CPT Code 87811 in the amount of \$380.00, and CPT Code G2023 in the amount of \$50.00 — for a total billed amount of \$430.00.

B. Aetna initially adjudicated the claim and processed a payment of only \$41.38 — representing approximately 9% of the total amount billed.

Patient Name: J [REDACTED] B [REDACTED] (spouse)
Claim ID: EQACXGFF900 **Recd:** 02/04/22 **Member ID:** [REDACTED] **Patient Account:** [REDACTED]
Member: [REDACTED] **DIAG:** Z20.822
Group Name: KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (DBA) **Group Number:** 0737493-10-001 A P1*2K0
Product: Aetna Choice® POS II **Network ID:** 00000
Aetna Life Insurance Company **Network Status:** Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/17/21	11	87811	1.0	380.00			338.62	1 2				41.38

Continued on Next Page



Payment Address:
GS LABS
17850 WRIGHT ST STE 5
OMAHA NE 68130-2800

Explanation Of Benefits

Please Retain for Future Reference

Printed: 02/15/2022
Page: 410 of 1549

PIN: 0006253493
TIN: XXXXXXXX3441
Trace Number: 822048000133115
Trace Amount: \$61,759.16

**P.O. BOX 981106
EL PASO TX 79998-1106
USA**

Patient Name: J [REDACTED] B [REDACTED] (spouse)

SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/17/21	11	G2023		50.00			50.00	3				0.00
TOTALS				430.00			388.62					41.38

ISSUED AMT: \$41.38

C. Critically, Aetna represented to the lab, to Member JB, and to the Kansas SEHP that \$41.38 had been withdrawn from SEHP trust assets to pay the provider. But the laboratory never received this payment. Instead, Aetna diverted the \$41.38 — taken from the SEHP — to reimburse one or more health plans, either fully insured or administered by Aetna, that were entirely unrelated to the State of Kansas. The funds were not used for the benefit of Member JB or the SEHP, but were repurposed to satisfy obligations arising under other plans.

107. Aetna Never Paid the Laboratory for Member JB’s Medical Claim:

A. Aetna withdrew \$41.38 from the SEHP for the stated purpose of reimbursing the lab for services rendered to Member JB. But the laboratory never received that payment. Instead, Aetna diverted the funds — taken from a self-funded public plan — and applied them to unrelated health plans that have no connection to the

State of Kansas or the SEHP. This withdrawal was not a provider payment. It was a repurposing of public funds for the benefit of private interests. As the party in exclusive control of the adjudication and payment systems, Aetna bears the burden of tracing where those funds actually went — yet the mechanics of its own cross-plan offsetting scheme, combined with its routine comingling of plan assets across accounts, make that traceability virtually impossible, even for Aetna.

B. Records indicate that the \$41.38 extracted from the SEHP was applied to benefit a list of other health plans that Aetna either insures or administers, including:

APPRUV (Aetna Health Fund)	Mutual of Omaha Insurance Company	Lasco Foods Inc.	Iron Mountain
Costco Wholesale Corporation	Carollo Engineers, Inc. (Aetna Health Fund)	Moody's Corporation	Aristocrat Technologies, Inc.
DocuSign, Inc.	WSP USA, Inc.	OEI, Inc.	IAC
SalesForce, Inc.	Pinnacle Bancorp	PCC Community Markets	ConAir, LLC
TriNet HR III, Inc.	MOD Super Fast Pizza, LLC	World Fuel Services, Corp.	Ferring Pharmaceuticals, Inc.
Omaha Airport Authority	Millard Public Schools	WeWork, Inc.	First National of Nebraska, Inc.
Amazon and Subsidiaries			

C. Through this scheme, Aetna misrepresented to the State, the provider, and the member that the funds were used to satisfy Member JB's medical claim. In reality, the funds were redirected to satisfy liabilities associated with other plan accounts. The laboratory was never paid. Member JB was never informed. And the SEHP was deprived of its assets under false pretenses.

D. This practice does more than violate financial expectations — it creates exposure for the member. Because the provider was never reimbursed, the lab may still seek payment directly from Member JB. Thus, Aetna's failure to deliver the funds not

only harmed the Plan financially — it placed a Kansas employee at risk of personal financial liability for a service that was supposed to be covered.

108. **Aetna’s “Overpayment” Recovery on Member JB’s Medical Claim:**

A. Aetna originally processed a \$41.38 payment on Member JB’s claim, withdrawing that amount from SEHP funds. As the records below show, Aetna later decided that payment was a mistake. But rather than return the money to the SEHP or pay the laboratory, Aetna treated the transaction as an “overpayment” and used its internal recovery system to shift the financial impact onto other health plans it administers — including unrelated self-funded plans and fully insured accounts.

Patient Name: J [REDACTED] B [REDACTED] (spouse)

Claim ID: EQACXGFF900 Recd: 02/04/22 Member ID: [REDACTED] Patient Account: [REDACTED]

Member: [REDACTED]

Group Name: KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (DBA) Group Number: 0737493-10-001 A P1*2K0

Product: Aetna Choice® POS II Network ID: 00000

Aetna Life Insurance Company Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/17/21	11	87811	1.0	-380.00			-338.62	1				-41.38
12/17/21	11	G2023		-50.00			-50.00	3				-0.00
TOTALS				-430.00			-388.62					-41.38

ISSUED AMT: -\$41.38

DETAILS OF OVERPAYMENT, PAYMENT CORRECTION OR REFUND ACTIVITY						
Overpayment or Payment Corrections Due From Prior Claim	New Overpayment or Payment Correction Amount	Amount Removed or Added	Adjustment Amount	Refund Amount	Amount Deducted from or Issued with Payment	Remaining Overpayment or Payment Correction Balance
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/14/21 Claim ID: EDFCXFV7900		EOB Date: 2/28/22 Remark: 1
\$0.00	\$380.00	\$0.00	\$0.00	\$0.00	-\$380.00	\$0.00
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/13/21 Claim ID: EFFCXF8LF00		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/23/21 Claim ID: ECTXXFZTG00		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/15/21 Claim ID: ELFCXFX5600		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	\$0.00	\$41.38
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/21/21 Claim ID: EJACXGPHN00		EOB Date: 2/28/22 Remark: 1
\$0.00	\$74.48	\$0.00	\$0.00	\$0.00	\$0.00	\$74.48
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/16/21 Claim ID: EJACXGP4D00		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	\$0.00	\$41.38
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/26/21 Claim ID: EQTXXFY9G00		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	\$0.00	\$41.38
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/17/21 Claim ID: EQACXGFF900		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	\$0.00	\$41.38
Overpayment Reason: This is a correction to an earlier claim sent to us.						
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID: [REDACTED]		Date of Service: 12/14/21 Claim ID: EG36XB2KF00		EOB Date: 2/28/22 Remark: 1
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$1.39	\$39.99
Overpayment Reason: This is a correction to an earlier claim sent to us.						

B. Not to miss in all of this, Aetna never actually pays the laboratory. The laboratory denies Aetna’s attempt to settle the claim, but Aetna still treats the original \$41.38 withdrawal as a recoverable asset — and “claws it back” by reallocating that

amount from the payment streams of other health plans it manages – which are the health plans identified above.

C. In doing so, Aetna did more than keep money that should have gone to a provider. It created a direct financial conflict between its clients. The SEHP’s so-called “recovery” came at the expense of dozens of other employer-sponsored plans — including those administered or insured by Aetna — who had previously been debited for that claim and were now never made whole.

D. The following plans — all unaffiliated with Kansas — were negatively impacted by this transaction, having plan funds withheld or rerouted by Aetna to resolve the SEHP’s alleged overpayment:

Adobe, Inc.	Almo Corporation (Aetna Health Fund)	HCA Healthcare	World Vision, Inc.
Bridgewater Associates, LP	The City of Seattle	Lincoln Financial Group	GBT U.S. III, LLC
Puget Sound Energy, Inc.	Port of Seattle	RPM International, Inc.	Heart Centered Counseling, P.C. (Aetna Health Fund)
Stanford Health Care	Costco Wholesale Corporation		

E. This practice is not just legally questionable. It’s structurally unsound. Aetna’s internal recovery logic turns the assets of one plan into the liabilities of another. It creates fiduciary conflict among clients who never agreed to be financially entangled. And Aetna, positioned in the middle, pays itself a percentage fee for orchestrating the entire process — even though it caused the error in the first place.

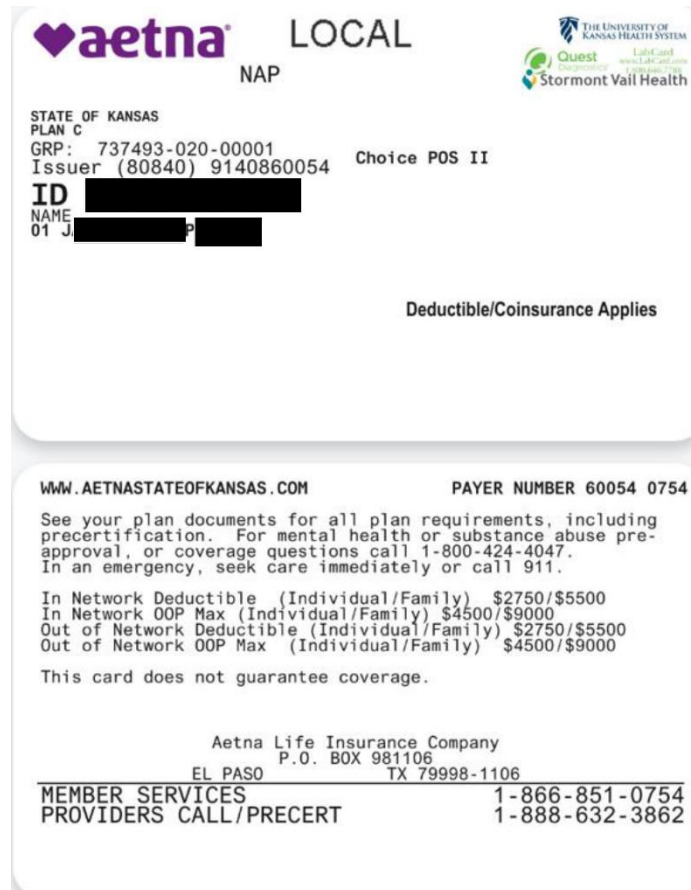
F. No party was made whole. The SEHP was never refunded. The provider was never paid. The other plans lost assets. And Aetna profited — quietly, and without disclosure. That is not plan administration. It is self-dealing, at scale.

109. Aetna’s use of Member JB’s medical claim to execute its cross-plan offsetting scheme demonstrates how SEHP assets were diverted under false pretenses. Aetna withdrew funds from the SEHP under the guise of reimbursing a provider, knowing that no such payment would be made. It then reclassified the transaction as an “overpayment,” redirected the funds to address liabilities from other plans, and paid itself a fee for the process — all without disclosing the diversion, returning the funds to the SEHP, or fulfilling the original claim. In doing so, Aetna misrepresented the purpose of the withdrawal, failed to deliver the funds as represented, and retained public money for purposes outside the scope of its authority. This conduct is actionable under the Kansas False Claims Act and represents a misuse of State-controlled funds.

110. The State anticipates that discovery will reveal that Member JB’s claim is not an isolated incident. Rather, it is emblematic of a broader administrative strategy through which Aetna has diverted funds from the KS Health Plans under similar circumstances — leveraging cross-plan offsetting to resolve unrelated financial exposures across its book of business, often at the expense of Kansas members and providers.

B. Member JP’s Medical Claim

111. Member JP is a member of a Kansas State Health Plan (State of Kansas – Plan C; Group No.: 737493-020-00001) administered by Aetna.



112. Member JP received medically necessary diagnostic laboratory services from a laboratory (an out-of-network laboratory with Aetna) on December 30, 2021.

113. Aetna subjected Member JP's medical claim through post-adjudication adjustments that collectively reflect the operation of the above detailed schemes.

114. **Aetna's Initial Adjudication of Member JP's Medical Claim:**

A. The lab submitted a medical claim for Member JP that included two line items: CPT Code 87811 in the amount of \$380.00, and CPT Code G2023 in the amount of \$50.00 — for a total billed amount of \$430.00.

B. Aetna initially adjudicated the claim and processed a payment of only \$41.38 — representing approximately 9% of the total amount billed.

Patient Name: J [REDACTED]		P [REDACTED] (self)											
Claim ID: ESY1VWF0R00		Recd: 01/26/22		Member ID: [REDACTED]		Patient Account: [REDACTED]				DIAG: Z20.822			
Member: J [REDACTED] P [REDACTED]										Group Number: 0737493-20-001 CA P1*2L0		Network ID: 00000	
Group Name: KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (DBA												Network Status: Out-of-Network	
Product: Aetna Choice® POS II													
Aetna Life Insurance Company													
SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT	
12/30/21	11	87811	1.0	380.00			338.62	1 2				41.38	
12/30/21	11	G2023		50.00			50.00	3				0.00	
TOTALS				430.00			388.62					41.38	
											ISSUED AMT:	\$41.38	

C. Critically, Aetna represented to the lab, to Member JP, and to the Kansas SEHP that \$41.38 had been withdrawn from SEHP trust assets to pay the provider. But the laboratory never received this payment. Instead, Aetna diverted the \$41.38 — taken from the SEHP — to reimburse one or more health plans, either fully insured or administered by Aetna, that were entirely unrelated to the State of Kansas. The funds were not used for the benefit of Member JP or the SEHP, but were repurposed to satisfy obligations arising under other plans.

115. **Aetna Never Paid the Laboratory for Member JP’s Medical Claim:**

A. Aetna withdrew \$41.38 from the SEHP for the stated purpose of reimbursing the lab for services rendered to Member JB. But the laboratory never received that payment. Instead, Aetna diverted the funds — taken from a self-funded public plan — and applied them to unrelated health plans that have no connection to the State of Kansas or the SEHP. This withdrawal was not a provider payment. It was a repurposing of public funds for the benefit of private interests. As the party in exclusive control of the adjudication and payment systems, Aetna bears the burden of tracing where those funds actually went — yet the mechanics of its own cross-plan offsetting scheme, combined with its routine comingling of plan assets across accounts, make that traceability virtually impossible, even for Aetna.

B. Records indicate that the \$41.38 extracted from the SEHP was applied to benefit a list of other health plans that Aetna either insures or administers, including:

Fidelity National Financial, Inc.	Mutual of Omaha Insurance Company	Farmers Group, Inc.	AdventHealth Shawnee Mission
CWGS Group, LLC	Standard Insurance Company	American Group LLC dba Orton Homes LLC	HCA Healthcare
Amazon and Subsidiaries	McQuarie Global Services (USA) LLC	Millard Public Schools	DCI Group Inc.
CVS Pharmacy Inc.¹	Rider University	Infosys Limited	Costo Wholesale Corporation
Tata Consultancy Services	Edge Capital Holdings LLC dba Instore Design	Pella Community School District	Xerox Corporation
TEC Equipment, Inc.	KPMG, LLC	Trinet HR III, Inc.	Que Brand Communications, Inc.
Indeed, Inc.	Psychiatric Medical Care, LLC	Open Door Mission	Chubb INA Holdings, Inc.
Orepac Holdings Company	Holman Automotive Group, Inc.	Owens Corning	The University of Virginia Health Plan
Moss Adams LLP	BusinessSolver.com, Inc.	Hanger, Inc.	M&T Bank
Major League Soccer, LLC	AMN Healthcare, Inc.	American Enterprise Services Company	IQVIA, Inc.
The Suddath Companies and Affiliates/VEBA Welfare	Memorial Community Hospital Corporation	United Services Automobile Association	JPMorgan Chase & Co.
Idexx Laboratories	Tory Burch, LLC	Takeda Pharmaceuticals USA, Inc.	Goodrich Corporation
Emcor Group, Inc.	Rentokil North America, Inc.	Huron Consulting Group, Inc.	First Republic Bank
Fineos Corporation UC dba Financial Software	Image First Ultimate Holdings, LLC	Deloitte, LLP	Datto, Inc.
WSP USA, Inc.			

C. Through this scheme, Aetna misrepresented to the State, the provider, and the member that the funds were used to satisfy Member JP’s medical claim. In reality, the funds were redirected to satisfy liabilities associated with other plan accounts. The

¹ CVS Pharmacy, Inc. (“CVS”) is the parent company of Aetna. Like the SEHP, CVS also has self-funded health plans for its employees and their dependents that are administered by Aetna. Critically, CVS is a common beneficiary of other health plans’ money and trust assets, thus, allowing CVS, through its subsidiary (Aetna), to also financially benefit from Aetna’s Cross-Plan Offsetting Scheme.

laboratory was never paid. Member JP was never informed. And the SEHP was deprived of its assets under false pretenses.

D. This practice does more than violate financial expectations — it creates exposure for the member. Because the provider was never reimbursed, the lab may still seek payment directly from Member JP. Thus, Aetna’s failure to deliver the funds not only harmed the SEHP financially — it placed a Kansas employee at risk of personal financial liability for a service that was supposed to be covered.

116. **Aetna’s “Overpayment” Recovery on Member JP’s Medical Claim:**

A. Aetna originally processed a \$41.38 payment on Member JP’s claim, withdrawing that amount from SEHP funds. As the records below show, Aetna later decided that payment was a mistake. But rather than return the money to the SEHP or pay the laboratory, Aetna treated the transaction as an “overpayment” and used its internal recovery system to shift the financial impact onto other health plans it administers — including unrelated self-funded plans and fully insured accounts.

Patient Name: J [REDACTED] P [REDACTED] (self)												
Claim ID: ESY1VWF0R00		Recd: 01/26/22		Member ID: [REDACTED]		Patient Account: [REDACTED]						
Member: J [REDACTED] P [REDACTED]												
Group Name: KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (DBA)										Group Number: 0737493-20-001 CA P1*2L0		
Product: Aetna Choice® POS II										Network ID: 0000		
Aetna Life Insurance Company										Network Status: Out-of-Network		
SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/30/21	11	87811	1.0	-380.00			-338.62	1				-41.38
12/30/21	11	G2023		-50.00			-50.00	3				-0.00
TOTALS				-430.00			-388.62					-41.38
ISSUED AMT:											-\$41.38	

DETAILS OF OVERPAYMENT, PAYMENT CORRECTION OR REFUND ACTIVITY							
Overpayment or Payment Corrections Due From Prior Claim	New Overpayment or Payment Correction Amount	Amount Removed or Added	Adjustment Amount	Refund Amount	Amount Deducted from or Issued with Payment	Remaining Overpayment or Payment Correction Balance	
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/31/21 Claim ID: EGTXXF6GQ00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/30/21 Claim ID: EA36XDD1000		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/31/21 Claim ID: EGJMXFWMJ00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 2/2/22 Claim ID: EA36XHZJH00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$179.00	\$0.00	\$0.00	\$0.00	-\$179.00	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/26/21 Claim ID: EZJMVZKXS00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$174.14	\$0.00	\$0.00	\$0.00	-\$174.14	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/21/21 Claim ID: ETACV3VDD00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$403.46	\$0.00	\$0.00	\$0.00	-\$403.46	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/30/21 Claim ID: ESY1VWF0R00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 2/2/22 Claim ID: EHPCXGMVQ00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
Member: [REDACTED] Pt Acct #: [REDACTED]		Member ID #: [REDACTED] Notification ID:		Date of Service: 12/16/21 Claim ID: E0PCV235K00		EOB Date: 3/2/22 Remark: 1	
\$0.00	\$41.38	\$0.00	\$0.00	\$0.00	-\$41.38	\$0.00	
Overpayment Reason: This is a correction to an earlier claim sent to us.							
TOTAL (Amount Deducted from or Issued with Payment)						-\$1,087.64	
Remarks:							
1 This deduction is the result of a correction to a previously submitted claim. You will not receive a separate written request for this payment correction. Please refer back to the EOB Date and Claim ID indicated for details concerning the corrected claim.							

B. Not to miss in all of this, Aetna never actually pays the laboratory. The laboratory denies Aetna’s attempt to settle the claim, but Aetna still treats the original \$41.38 withdrawal as a recoverable asset — and “claws it back” by reallocating that amount from the payment streams of other health plans it manages – which are the health plans identified above.

C. In doing so, Aetna did more than keep money that should have gone to a laboratory. It created a direct financial conflict between its clients. The SEHP’s so-called “recovery” came at the expense of dozens of other employer-sponsored plans — including those administered or insured by Aetna — who had previously been debited for that claim and were now never made whole.

D. The following plans — all unaffiliated with Kansas — were negatively impacted by this transaction, having plan funds withheld or rerouted by Aetna to resolve the SEHP’s alleged overpayment:

The City of Seattle	Avaya Inc.	Costo Wholesale Corporation	Sheet Metal Workers Local 25 New Jersey Welfare
World Vision, Inc.	Special School District of St. Louis County	GBT U.S. III, LLC	RPM International Inc.
London Stock Exchange Group Holdings, Inc.	HCA Healthcare	Zions Bancorporation, N.A.	State of Illinois (State PPO)

E. This practice is not just legally questionable. It’s structurally unsound. Aetna’s internal recovery logic turns the assets of one plan into the liabilities of another. It creates fiduciary conflict among clients who never agreed to be financially entangled. And Aetna, positioned in the middle, pays itself a percentage fee for orchestrating the entire process — even though it caused the error in the first place.

F. No party was made whole. The SEHP was never refunded. The provider was never paid. The other plans lost assets. And Aetna profited — quietly, and without disclosure. That is not plan administration. It is self-dealing, at scale.

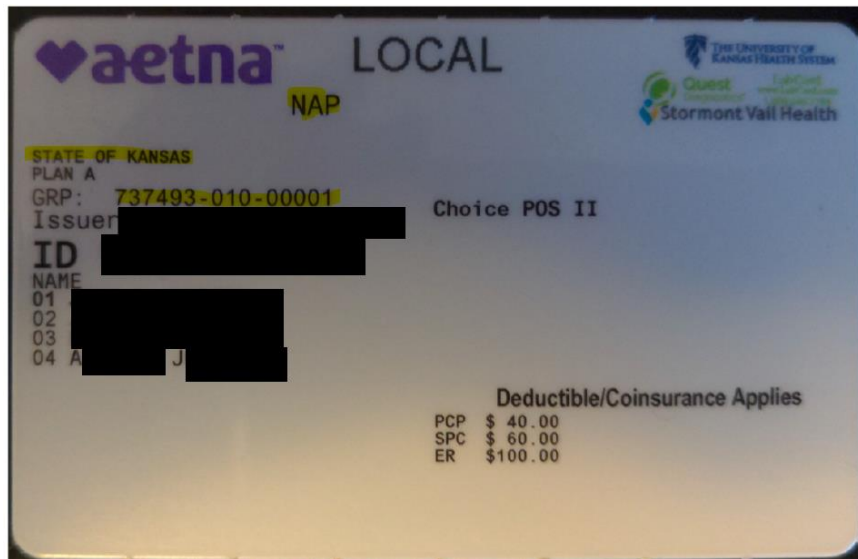
117. Aetna’s use of Member JP’s medical claim to execute its cross-plan offsetting scheme demonstrates how SEHP assets were diverted under false pretenses. Aetna withdrew funds from the SEHP under the guise of reimbursing a provider, knowing that no such payment would be made. It then reclassified the transaction as an “overpayment,” redirected the funds to

address liabilities from other plans, and paid itself a fee for the process — all without disclosing the diversion, returning the funds to the SEHP, or fulfilling the original claim. In doing so, Aetna misrepresented the purpose of the withdrawal, failed to deliver the funds as represented, and retained public money for purposes outside the scope of its authority. This conduct is actionable under the Kansas False Claims Act and represents a misuse of State-controlled funds.

118. The State anticipates that discovery will reveal that Member JP’s claim is not an isolated incident. Rather, it is emblematic of a broader administrative strategy through which Aetna has diverted funds from the SEHP under similar circumstances — leveraging cross-plan offsetting to resolve unrelated financial exposures across its book of business, often at the expense of Kansas members and providers.

C. Member AJ’s Medical Claim

119. Patient AJ is a dependent enrolled under the SEHP (State of Kansas – Plan A; Group No.: 737493-010-00001) administered by Aetna. Patient AJ’s coverage under the SEHP is documented on the face of her Aetna-issued insurance card, which identifies the plan as “STATE OF KANSAS PLAN A,” displays the SEHP group number, and identifies the routing protocol as “LOCAL NAP” at the top of the card alongside the Aetna logo.



120. Patient AJ received a medically necessary SARS-CoV-2 diagnostic laboratory service from a laboratory (an out-of-network laboratory with respect to the SEHP) on January 6, 2022. The service was billed under CPT 87635 at a cash price of \$385.00.

121. Aetna processed Patient AJ’s claim through the routing protocol disclosed on the face of the SEHP card — the NAP architecture — generating a series of administrative determinations that collectively reflect the operation of the schemes detailed above in this Petition.

122. **Aetna’s Initial Adjudication of Patient AJ’s Medical Claim.**

A. The lab submitted a medical claim for Patient AJ for one line item: CPT Code 87635 in the amount of \$385.00.

B. Aetna processed the claim on April 23, 2022, and assigned it Claim ID EDPCXL13F01. Aetna’s own Explanation of Benefits documents that the claim was routed through “04548 DIS-NAPP” — the Data iSight Network Access Plan, the routing protocol that operationalizes the NAP architecture described in Section B.

Patient Name: A [REDACTED] J [REDACTED] (spouse)

Claim ID: EDPCXL13F01

Recd: 04/23/22

Member ID: W256888435

Patient Account: 2192517

DIAG: Z20.822

Member: [REDACTED]

Group Name: KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (DBA)

Group Number: 0737493-10-001 A P1*2K0

Product: Aetna Choice@ POS II

Network ID: 04548 DIS-NAPP

Aetna Life Insurance Company

Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
01/06/22	11	87635	1.0	385.00				333.69 1 2			333.69	51.31
TOTALS				385.00				333.69			333.69	51.31

ISSUED AMT:

\$51.31

Continued on Next Page

Remarks:

1 - You are an out-of-network provider and do not have a contracted rate from Aetna. The member's plan provides benefits for covered out-of-network services at what we find to be a recognized charge. The recognized charge determination on the claim resulted in a reduction in payment and was calculated by Data iSight. In the event you choose to balance bill the member for the amount reflected in the "not payable" column (in addition to the member's deductible that is reflected in the patient responsibility column), the member may be eligible for patient advocacy services through Data iSight to resolve the outstanding balance. For questions regarding the Data iSight calculation, contact Data iSight at 800-498-3246 or refer to www.dataisight.com. [E07]

2 - Because of the COVID-19 pandemic, we suspended some of our policies and rules. [HHG]

For Questions Regarding This Claim PO BOX 981106 EL PASO, TX 79998-1106

CALL (888) 632-3862 FOR ASSISTANCE

Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:

\$333.69

Claim Payment:

\$51.31

C. Aetna's EOB reflects that Aetna applied a "Negotiated Amount" of \$333.69 — the manufactured spread between the billed cash price and the amount Aetna determined would be issued. The "issued" payment amount on the claim was \$51.31 — approximately 13% of the submitted charge.

D. The source of the reduced reimbursement determination is identified by Aetna on the face of its own document. Remark E07 states: "The recognized charge

determination on the claim resulted in a reduction in payment and was calculated by Data iSight.” Data iSight is a private commercial repricing vendor operating under the Multiplan family of products. The lab is not a contracted party to Data iSight or to any Multiplan repricing arrangement. The reduced rate was generated algorithmically and applied by Aetna to a claim for services rendered to a Kansas state employee’s dependent.

E. Remark E07 also notified the lab, on the face of Aetna’s own EOB, that the lab was free to “balance bill the member for the amount reflected in the ‘not payable’ column” — \$333.69. Aetna paired this notification with Remark HHG, which acknowledged that “[b]ecause of the COVID-19 pandemic, we suspended some of our policies and rules” — an admission that pandemic-era policy suspensions were in effect at the time of the claim, even as Aetna simultaneously applied a below-cash-price repricing determination through its commercial repricing vendor.

F. The structural effect of Aetna’s adjudication contradicts the stated purpose of the program through which the claim was routed. A network access program of the kind Aetna identifies on the face of the SEHP card — and through which Aetna routes SEHP out-of-network claims — exists, by its stated design, to limit the financial exposure of members who receive out-of-network care. The premise of such a program is that, in exchange for a reduced reimbursement to the provider, the member is held harmless on the balance. Aetna’s administration of Patient AJ’s claim did the opposite. Aetna reduced the reimbursement to the lab through its repricing vendor. Aetna then designated the difference — \$333.69 — as Patient AJ’s personal financial responsibility. And Aetna affirmatively notified the lab, on the face of the same document, that the lab was free to balance-bill Patient AJ for that amount. The “savings” the program generated, in

operation, were not savings to the member. They were savings retained by Aetna and its repricing vendor, with the financial consequence transferred to a Kansas state employee's dependent.

123. **Aetna's Repricing-Fee Architecture on Patient AJ's Medical Claim:**

A. The reimbursement determination Aetna applied to this claim generated a \$333.69 spread between the amount Aetna withdrew from the SEHP account to fund the transaction and the amount Aetna determined would be issued to the provider. Under the NAP fee architecture described in Section B, Aetna and its repricing vendors are compensated through a percentage of that spread — the “savings” their methodologies generate.

B. On information and belief, Aetna and its repricing vendors collectively retain between 20% and 40% of the manufactured spread on out-of-network claims processed through the NAP architecture. The precise percentage applied to this claim, and the allocation of that percentage between Aetna and the repricing vendor, will be established through discovery. The structural result, however, is determinable from the face of Aetna's own EOB. The following table illustrates the financial flow at the disclosed range of retention percentages:

Combined Aetna + Vendor Retention	Amount Retained from Spread	Net Amount Allocated to Lab	Aetna + Vendor Compensation as % of Provider Payment
20% of \$333.69	\$66.74	\$51.31	130%
30% of \$333.69	\$100.11	\$51.31	195%
40% of \$333.69	\$133.48	\$51.31	260%

C. The arithmetic on the face of Aetna's own EOB is striking. Under any of the disclosed retention percentages, Aetna and its repricing vendor are compensated at a rate substantially exceeding the amount the EOB nominally allocates to the laboratory

that performed the test. At a 20% combined retention rate, Aetna and the vendor receive \$66.74 against the laboratory's \$51.31. At 30%, Aetna and the vendor receive \$100.11. At 40%, \$133.48. In each scenario, financial actors with no clinical role earn more than the clinical actor that delivered the service to a Kansas state employee's dependent.

D. Paying itself more in administrative fees than it pays a provider of clinical services – on its face – is indefensible and begs the question of whether Aetna is acting as a prudent fiduciary on behalf of State. The State of Kansas funded this transaction. The fees retained by Aetna and its repricing vendor were drawn from SEHP assets — not from Aetna's per-member-per-month administrative fee. The Plan paid the full amount the EOB reflects withdrawing from the SEHP account. A fraction of that amount was allocated to the Lab. The remainder funded the administrative architecture surrounding the claim.

124. **The Batch Disbursement of Patient AJ's Issued Payment.**

A. The \$51.31 nominally issued to the lab on Patient AJ's claim was not paid as a discrete provider payment. The amount was processed as part of a single consolidated batch disbursement of \$22,501.07, designated as Trace Number 822123000199278, spanning 954 pages of separate claim transactions across multiple plans Aetna administers. The disbursement was paid by Electronic Funds Transfer through Bank of America on May 3, 2022.

B. The payment instrument transmitted to the lab records only the aggregate amount: \$22,501.07. No per-claim attribution is disclosed on the face of the disbursement record. The recipient is provided no reconciliation that would permit the recipient — or

any auditor, or the State — to determine which portion of the \$22,501.07 was allocated to which claim within the 954-page batch.

C. The batch disbursement architecture also operates as the vehicle for cross-plan offsetting. On the final pages of the same 954-page trace that included Patient AJ's claim, Aetna recorded \$1,111.02 in overpayment deductions against claims associated with unrelated members on plans Aetna administers separately from the SEHP. Each of those deductions was netted against the gross disbursement amount, with no documentation transmitted to the provider, or to the State, identifying which offsets were applied to which claims or which plan's assets funded the offsetting recoveries.

D. The mechanic operating within the trace is the cross-plan offsetting mechanic described in Section A of this Petition, demonstrated through a single Aetna-produced documentary record. The \$22,501.07 disbursed to the lab across the 954-page trace is the *net* amount paid after Aetna applied \$1,111.02 in cross-plan recoveries within the same trace. The \$1,111.02 in recoveries Aetna asserted against unrelated members on plans separate from the SEHP were collected directly out of the aggregate payment GS Labs would otherwise have received on its underlying claims. The unrelated plans whose members generated the overpayment claims received the benefit of the recoveries. The lab absorbed the reduction. From the face of Aetna's own trace, the unrelated plans were made whole at the expense of the provider's aggregate payment across the trace — including the portion of that payment funded by SEHP assets on Patient AJ's claim and on other SEHP claims processed within the same disbursement.

E. On information and belief, all or a portion of State’s funds withdrawn for the purpose of paying Patient AJ’s medical claim has gone to the benefit of the following Aetna insured or administered plans:

THE CITY OF SEATTLE	MUTUAL OF OMAHA INSURANCE COMPANY	REDFIN CORPORATION	AVALONBAY COMMUNITIES, INC
COSTCO WHOLESALE CORPORATION			

F. The State cannot determine, from Aetna’s own records, what portion of the \$22,501.07 trace was funded by SEHP assets as compared with assets of the other plans listed above. The State also cannot determine whether the \$1,111.02 in recoveries Aetna asserted within the same trace was applied against SEHP claims, against claims of other plans, or against some combination — and Aetna’s reporting to the State does not disclose this attribution.

125. The transaction documents the NAP architecture, the repricing-fee architecture, and the cross-plan offsetting architecture operating on a single SEHP claim:

A. A Kansas state employee’s dependent received a federally-mandated diagnostic test from an out-of-network provider during the COVID-19 public health emergency.

B. Aetna routed the claim through Data iSight rather than paying the submitted charge.

C. Aetna’s repricing vendor generated a reimbursement amount approximately 13% of the submitted charge.

D. Aetna designated the remaining 87% as the dependent’s personal financial responsibility — and notified the provider on the face of the EOB that the provider could

balance-bill the dependent for that amount — notwithstanding that the stated purpose of the network access program through which Aetna routed the claim is to limit member financial exposure on out-of-network services.

E. Aetna withdrew funds from the SEHP account corresponding to the transaction without per-claim itemization disclosed to the State.

F. The fees retained by Aetna and its repricing vendor on the spread between the submitted charge and the issued amount — at the disclosed retention range — exceeded the amount nominally allocated to the provider.

G. The nominal \$51.31 payment was issued as part of a \$22,501.07 consolidated batch disbursement covering 954 pages of separate claim transactions across multiple plans, with no per-claim attribution disclosed to the provider or to the State, and with \$1,111.02 in cross-plan offsetting recoveries netted within the same trace.

126. The Patient AJ transaction is not presented as an isolated event. It is presented as a representative example of the routine operation of the NAP architecture, the repricing-fee architecture, and the cross-plan offsetting architecture on SEHP claims. The structural features of this transaction — Data iSight repricing, member balance-billing exposure, percentage-of-spread compensation retained by Aetna and its vendors, batch disbursement without attribution, and cross-plan recovery netted within the same disbursement — are the structural features of the administrative architecture this Petition challenges. Aetna's own records establish that this is how Aetna administers the SEHP.

CAUSE OF ACTION

Count I: Violations of the Kansas False Claims Act, K.S.A. §§ 75-7501 through 75-7511

127. The State restates and realleges the allegations contained in paragraphs 1 through 114 above as if fully set forth herein. The conduct described in those paragraphs constitutes violations of the Kansas False Claims Act, K.S.A. §§ 75-7501 through 75-7511 (“KFCA”).

128. Aetna, through its agents, employees, contractors, and subcontractors, has violated the KFCA in the following respects, each of which is independently actionable under the statute:

A. **K.S.A. § 75-7503(a)(1).** Aetna has knowingly presented, or caused to be presented, false or fraudulent claims for payment to the SEHP. The submitted claims reflected amounts withdrawn from SEHP accounts that did not correspond to amounts actually paid to or retained for providers. The reimbursement determinations submitted to the SEHP through Aetna’s claims administration system, including determinations generated by Aetna’s repricing vendors and adjusted through Aetna’s cross-plan offsetting mechanisms, were false in material respects and were presented to the SEHP for payment.

B. **K.S.A. § 75-7503(a)(2).** Aetna has knowingly made, used, or caused to be made or used, false records and statements material to false or fraudulent claims paid by the SEHP. These records and statements include the Explanations of Benefits, claim summaries, payment instruments, batch disbursement traces, and periodic reports through which Aetna characterized to the SEHP the disposition of Plan funds — characterizations that concealed the operation of cross-plan offsetting, the retention of repricing-fee spreads, and the commingling of SEHP assets with funds Aetna held under other plans.

C. **K.S.A. § 75-7503(a)(4).** Aetna has had possession, custody, and control of public money belonging to the SEHP — including funds Aetna withdrew from SEHP accounts under its direct withdrawal authority — and has knowingly delivered, or caused to be delivered, less than all of that money or property to the providers and Plan participants for whom the funds were withdrawn. Aetna’s batch disbursement architecture and its cross-plan offsetting mechanics operated to retain or redirect SEHP-funded amounts that, but for those mechanics, would have been delivered as Plan benefits.

D. **K.S.A. § 75-7503(a)(7).** Aetna has knowingly made, used, or caused to be made or used, false records and statements material to obligations to pay or transmit money or property to the State, and has knowingly concealed or knowingly and improperly avoided or decreased obligations to pay or transmit money or property to the State. Aetna’s failure to return to the SEHP funds withdrawn from SEHP accounts that were not delivered to their intended recipients, and Aetna’s concealment of those non-deliveries through the reporting practices described in this Petition, constitute violations of this subsection.

E. **K.S.A. § 75-7503(a)(8).** Aetna conspired with its repricing vendors, including Multiplan and the entities operating Data iSight, Viant, Zelis Healthcare, and Global Claims Services, to commit the violations described in subsections A through D of this paragraph. The vendors’ continued participation in the NAP architecture, with knowledge of the matters set forth in this Petition, constitutes a conspiracy to commit acts in violation of the KFCA.

129. The KFCA’s “knowingly” standard is satisfied as to each violation alleged. Aetna acted with actual knowledge of the falsity and impropriety of the conduct alleged, or, at a

minimum, with deliberate ignorance or reckless disregard of the truth or falsity of the information. K.S.A. § 75-7502(e); K.S.A. § 75-7503(c). The Department of Labor and federal courts have addressed the conduct described in this Petition — including the cross-plan offsetting practices described in Section A and the repricing practices described in Section B — over more than a decade of regulatory and judicial scrutiny in proceedings in which Aetna has been a named party. Specific intent to defraud is not required under the KFCA.

130. The State of Kansas, unaware of the falsity of the claims and the records described above, and in reliance on Aetna’s contractual and administrative representations regarding the management of the SEHP, paid money from public funds and employee contributions to Aetna and to third parties at Aetna’s direction. A material portion of those funds was not delivered to providers or applied for the benefit of SEHP members, but was retained by Aetna, distributed to Aetna’s repricing vendors, redirected to satisfy obligations arising under other health plans Aetna administers, or otherwise diverted from the purposes for which the State funded the Plan.

131. The State of Kansas has sustained damages as a result of the violations alleged in this Cause of Action. The damages include, without limitation, amounts withdrawn from SEHP accounts that were not delivered to providers; fees and percentage-of-spread compensation paid from SEHP funds to Aetna and its repricing vendors without disclosure or authorization; SEHP funds redirected to satisfy obligations arising under unrelated plans through Aetna’s cross-plan offsetting mechanics; and consequential losses, including the inflated cost basis on which SEHP premium contributions and State appropriations have been calculated.

PRAYER FOR RELIEF

WHEREFORE, the State of Kansas respectfully prays that this Court enter judgment in favor of the State and against Aetna granting the following relief:

A. A declaration that Aetna has violated the Kansas False Claims Act, K.S.A. §§ 75-7501 through 75-7511, as alleged in this Petition;

B. Permanent injunctive relief ordering Aetna to cease and desist from the conduct described in this Petition, including, without limitation, (i) the use of cross-plan offsetting to recover alleged overpayments from one plan by reducing amounts paid under another, (ii) the routing of SEHP claims through repricing arrangements that retain a percentage of the spread between billed charges and provider payments without disclosure to the State, (iii) the commingling of SEHP assets with funds Aetna holds under other plans or for its own account, and (iv) the use of batch disbursement and reporting practices that prevent the State from independently verifying the disposition of SEHP funds;

C. An award of compensatory damages sustained by the State of Kansas as a result of Aetna's violations, in an amount to be determined at trial;

D. Trebling of the compensatory damages awarded pursuant to K.S.A. § 75-7503(a);

E. Civil penalties in the maximum amount of \$11,000 per violation, or such lesser amount as the Court deems just within the range of \$1,000 to \$11,000 per violation authorized by K.S.A. § 75-7503(a), with each false claim, false record or statement, false certification, improper retention of public funds, and act in furtherance of the conspiracy alleged in this Petition constituting a separate violation;

F. Disgorgement of all amounts Aetna has wrongfully retained, redirected, or caused to be paid out from SEHP funds in connection with the conduct alleged in this Petition, together with imposition of a constructive trust over such amounts for the benefit of the SEHP and its participants;

G. An accounting by Aetna of all SEHP funds withdrawn, disbursed, retained, or redirected during the period of administration at issue, including the disposition of all amounts withdrawn from SEHP accounts and the calculation of all fees and percentage-of-spread compensation paid from SEHP assets;

H. Pre-judgment and post-judgment interest on all monetary awards at the maximum rate authorized by Kansas law;

I. Reasonable attorneys' fees, costs, and expenses of the Office of the Attorney General incurred in the investigation and prosecution of this action, pursuant to K.S.A. § 75-7503(a); and

J. Such other and further relief as this Court deems just, equitable, and appropriate.

JURY TRIAL DEMAND

The State of Kansas hereby demands a trial by jury on all issues so triable.

Date: June 24, 2026

Respectfully submitted,

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