REPORT ON EXAMINATION

OF

AETNA HEALTH INC. (a New York Corporation)

AS OF

DECEMBER 31, 2005

DATE OF REPORT	**NOVEMBER 12, 2010**
EXAMINER	**BRUCE BOROFSKY, CFE**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

David A. Paterson
Governor

James J. Wrynn
Superintendent

November 12, 2010

Honorable James J. Wrynn
Superintendent of Insurance
Albany, NY 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 22475, dated March 10, 2006, attached hereto, I have made an examination into the condition and affairs of Aetna Health Inc. (a New York Corporation), a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2005, and submit the following report thereon.

The examination was conducted at the administrative office of Aetna Health Inc. located at 980 Jolly Road, Blue Bell, Pennsylvania 19422.

Wherever the designations "AHI" or the "HMO" appear herein, without qualification, they should be understood to indicate Aetna Health Inc. (a New York Corporation).

Wherever the designation the “Parent” appears herein, without qualification, it should be understood to indicate Aetna Inc., the ultimate parent of AHI.

Wherever the designation “AHIC” or the “Company” appears herein, without qualification, they should be understood to indicate Aetna Health Insurance Company of New York, an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law.

Wherever the designation, the “Department” appears herein, without qualification, it should be understood to indicate the New York State Insurance Department.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 2002. This examination covers the three-year period from January 1, 2003 through December 31, 2005. Transactions occurring subsequent to this period were reviewed where deemed appropriate.

The examination comprised a verification of assets and liabilities as of December 31, 2005, in accordance with statutory accounting principles (SAP), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants. A review or audit was also made of the following items as called for in the *Examiners Handbook of the National Association of Insurance Commissioners* (NAIC):

History of the HMO
Management and controls
Corporate records
Fidelity bond and other insurance
Territory and plan of operation
Growth of the HMO
Loss experience
Accounts and records
Financial statements

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulation or rules, or which are deemed to require explanation or description.

A review was also made to ascertain what action was taken by the HMO with regard to comments contained in the prior report on examination.

Some members of the HMO also have contracts with Aetna Health Insurance Company of New York (AHIC) under point-of-service products in which "out-of-network" benefits are offered.

A concurrent examination regarding the financial condition of Aetna Health Insurance Company of New York was performed as of December 31, 2005, and a separate financial report on examination was issued thereon.

Additionally, a separate market conduct examination was conducted as of December 31, 2005 to review the manner in which Aetna Health Inc., Aetna Health Insurance Company of New York and Aetna Life Insurance Company conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. A separate market conduct report for these entities was issued thereon.

2. DESCRIPTION OF THE HMO

Aetna Health Inc. (a New York Corporation) was incorporated in New York on June 24, 1985, to operate a health maintenance organization (HMO) under the name U.S. Healthcare, Inc. It was certified as an HMO by the New York State Department of Health (DOH) on February 3, 1986, and began operations on May 1, 1986. AHI is licensed as a for-profit, independent practice association (IPA) model HMO pursuant to

the provisions of Article 44 of the New York Public Health Law. When licensed, the HMO was a subsidiary of U.S. Healthcare, Inc. (U.S. Healthcare) a Pennsylvania corporation.

On July 19, 1996, U.S. Healthcare merged with Aetna Life and Casualty Company, pursuant to an Agreement and Plan of Merger dated March 30, 1996. Aetna Inc., a Connecticut corporation, was incorporated on March 25, 1996, for the purpose of effectuating the merger and became the sole owner of the two companies, effective July 19, 1996. After the merger, U.S. Healthcare became a subsidiary of Aetna Inc. and its name was changed to Aetna U.S. Healthcare, Inc., Aetna U.S. Healthcare, Inc., the parent company of numerous HMOs operating in many states was one of Aetna Inc.'s core businesses. The others were insurance and financial services, both domestic and international.

On December 13, 2000, Aetna Inc. sold its financial services and international businesses to ING Groep N.V. and also spun off its health care business to shareholders. Concurrent with the spin-off, Aetna U.S. Healthcare, Inc. became the ultimate parent company and was renamed Aetna Inc.

The HMO filed with the New York State Department of State to operate under the assumed name (d/b/a) of Aetna U.S. Healthcare, Inc. effective January 1, 1997. The HMO notified the Department and the DOH of its intention to operate under the assumed name of Aetna U.S. Healthcare, Inc. and marketed its products under such name. The HMO continued to operate under the Aetna U.S. Healthcare, Inc. name with regard to statutory filings with the Department until a name change to Aetna Health Inc. (a New

York Corporation), in 2001. On December 28, 2001, NYLCare Health Plans of New York, Inc. (NYLCare), an HMO, merged with and into the HMO.

On December 31, 2001, the HMO Prudential Health Care Plan of New York, Inc. (PruCare) merged with and into the HMO. Concurrent with that merger, the HMO's name was changed to Aetna Health Inc. (a New York Corporation).

Effective September 30, 2003, Aetna Inc. contributed all of the capital stock of Aetna Health Inc. to Aetna Health Holdings, LLC (AHH). AHH's ultimate parent is Aetna Inc.

As of December 31, 2005, the HMO's paid-in capital was $6, consisting of 552 shares of $.01 par value per share common stock and paid-in surplus of $69,956,549. As of the examination date, Aetna Health Holdings, LLC is the sole owner of all issued stock. The HMO has an additional 9,448 shares of $.01 par value per share common stock authorized, but not issued.

A. Management and Controls

As of the examination date, the HMO's board of directors was comprised of three members. The composition of the board was in compliance with the HMO's by-laws and Part 98-1.11(f) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1.11(f)). As of December 31, 2005, the HMO's board of directors consisted of the following members:

Name and Residence	Principal Business Affiliation
Charles A. Peck MD Glastonbury, CT	President and Regional Head for Healthcare Delivery, Aetna Health Inc.
Gordon W. Grundy MD New Britain, CT	Regional Medical Director, Aetna Health Inc.
Lydia Cavieux* Cortlandt Manor, NY	Supervisor, Health Information Management, Horton Medical Center

* Enrollee/member requirement per Part 98-1.11(f) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-1.11(f)).

On March 1, 2006, Gordon Grundy, MD was replaced by Mary T. McCluskey as a board member of the HMO. The minutes of all meetings of the board of directors and committees thereof during the examination period were reviewed. The meetings were generally well attended.

The review of the minutes revealed that management is reviewing reports that are essential to the operations of the HMO and that the HMO is in compliance with the certification requirements of Department Circular Letter No. 9 (1999).

During the examination period, the board met two times during each calendar year.

It is recommended that the board meet a minimum of four times per calendar year so that it can review and sign-off on the operations and quarterly statements filed by the HMO with this Department.

At December 31, 2005, the principal officers of the HMO were as follows:

Name	Title
Charles A. Peck MD	President
William C. Baskin III	Vice President and Secretary
Deborah M. Wightman	Principal Financial Officer
Russell P. Smith	Treasurer
Gregory S. Martino	Vice President
Kevin J. Casey	Senior Investment Officer

B. Territory and Plan of Operation

As of December 31, 2005, AHI was authorized to operate as an HMO pursuant to Article 44 of the New York Public Health Law in the following nineteen counties of New York State:

Bronx	New York	Putnam	Sullivan
Broome	Nassau	Queens	Tioga
Cayuga	Onondaga	Richmond	Ulster
Dutchess	Orange	Rockland	Westchester
Kings	Oswego	Suffolk	

The HMO provides a comprehensive prepaid health care program by means of a network of participating physicians. Subscribers to AHI select a participating physician who acts as the primary care physician (PCP). This physician refers subscribers to other participating HMO physicians when particular medical specialties are required. Except for services specifically excluded or limited in the HMO's contracts or riders, there is no limit to duration, frequency or type of health care provided, as long as the care is directly provided or pre-authorized by an AHI medical director and/or the PCP.

Inpatient hospital services are rendered as directed by the HMO's physicians. The HMO pays hospital charges through direct hospital billing. Out-of-area emergency care is provided for in the subscriber contracts.

In addition to the services described above, members have the option of selecting point-of-service coverage (POS), which permits the member to obtain medical treatment without a referral and outside of the HMO's provider network. Such coverage is provided by AHI for individual coverage. The out-of-network (OON) component of the POS coverage for large and small groups is provided through the HMO's affiliate, Aetna Health Insurance Company (AHIC).

The following schedule shows the number of members enrolled at the end of each year of the three-year examination period, by line of business and premium earned:

Line of Business	**2003**	**2004**	**2005**
HMO Large Group	591,848,656	552,663,806	457,225,792
HMO Small Group	151,551,477	117,296,135	71,229,416
HMO Individual	46,839,426	47,092,124	42,759,357
POS Large Group (ER)	234,314,719	202,397,168	197,677,150
POS Small Group	111,419,353	93,998,110	62,397,669
POS Individual (OON)	28,168,950	31,904,039	33,676,533
Healthy New York	3,279,235	8,232,843	13,819,626
Medicare	172,481,012	161,623,644	154,913,232
Total premium	$ 1,339,902,828	$ 1,215,207,869	$ 1,033,698,775

	2003	**2004**	**2005**
Enrollment	365,599	303,792	231,281

AHI writes Medicare policies in all of the counties in which it is authorized, with the exception of Broome, Cayuga, Onondaga, Oswego and Tioga counties.

The HMO's membership declined throughout the examination period. As of December 31, 2006, the total number of members reported was 192,225, a further decline of nearly 40,000 members.

The HMO utilizes an internal sales force, as well as independent agents and brokers.

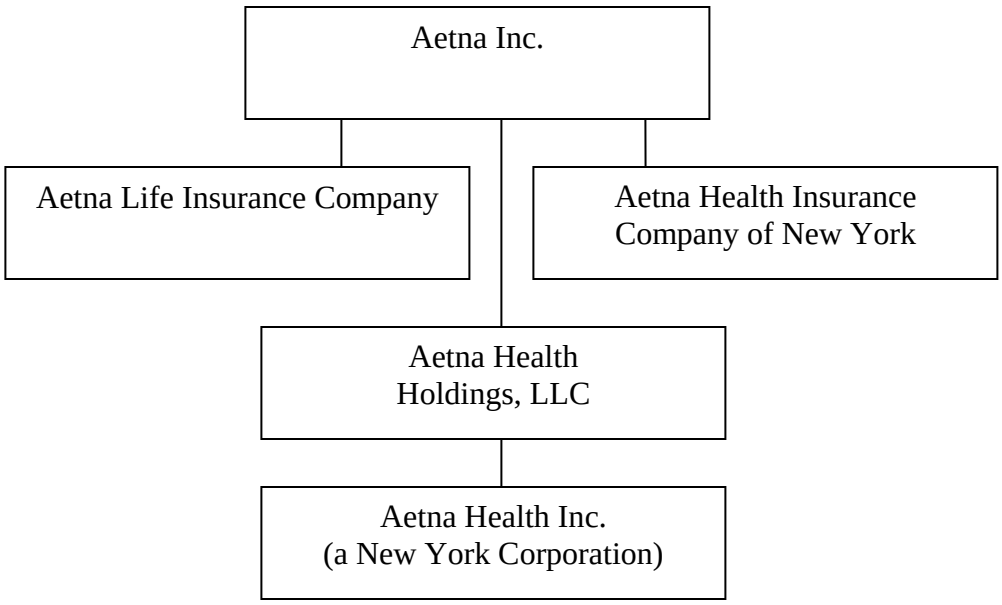
C. Reinsurance

AHI did not assume or cede any reinsurance during the examination period.

D. Holding Company System

As a member of the Aetna holding company system, AHI has twenty-four HMO affiliates, which operate in thirty-four states, as well as a health insurer and non-insurance affiliates.

The following condensed organizational chart reflects the relationship between the HMO and significant entities in its holding company system as of December 31, 2005:



Aetna Inc. is the ultimate parent of all Aetna subsidiaries. Aetna Life Insurance Company, a Connecticut domiciled company, offers multiple life and health insurance products throughout the United States, including New York State. Aetna Health Insurance Company of New York, a health insurance corporation licensed pursuant to the provisions of Article 42 of the New York Insurance Law offers indemnity insurance coverage to New York residents. It also provides a point-of-service option to members of AHI's HMO. Aetna Health Holdings, LLC acts as a holding company for the Aetna Inc. holding company group's HMOs.

Part 98-1-16(e) of the Administrative Rules and Regulations of the Health Department states:

> "Every controlled MCO shall file with the commissioner such reports or material as the commissioner, with the advice of the superintendent, may direct for the purpose of disclosing information on the operations within the holding company system which materially affect the operations, management or financial condition of the MCO."

During the examination period, AHI made all required holding company filings in compliance with Part 98-1.16(e) of the Administrative Rules and Regulations of the Health Department.

At the examination date, the HMO was a party to the following service agreements with other members of its holding company system:

No.	Name of Agreement	Contracting Party	Effective Date
1.	Line of credit agreement	Aetna Inc.	1/6/1986
2.	Subordination agreement	Aetna Inc.	1/6/1986
3.	Guarantor agreement	Aetna Inc.	1/6/1986
4.	Tax sharing agreement	Aetna Inc.	12/14/2000
5.	Supplemental tax sharing and tax escrow agreement	Aetna Inc.	12/14/2000
6.	Inter-company transfer agreement	AHIC	1/1/2000
7.	Mail order pharmacy agreement	Aetna Rx Home Delivery, LLC	2/1/2003
8.	Service agreement	Aetna Inc.	1/6/1986

The following is a description of each of the agreements that were in place at the examination date and in instances where such agreements were replaced subsequent to the date of this examination, a description of the new agreement, as applicable. Where applicable, such agreements were approved by this Department and the Department of Health.

1. Line of Credit Agreement

Pursuant to this agreement, the Parent provided a $5,000,000 unsecured line of credit at 10% interest to the HMO for the purpose of financing operating costs and cash needs. This line of credit was not utilized during the examination period.

2. Subordination Agreement

Prior to licensing by the State of New York, the HMO entered into a subordination agreement, which provided for the line of credit, which is discussed above. The agreement provided that amounts extended to the HMO would be subordinated to all other future creditors of the HMO.

3. Guarantor Agreement

Under this agreement, the Parent guaranteed benefits to subscribers and dependents in the event of the HMO's insolvency.

4. Tax Sharing Agreements

AHI, with several of its affiliates, files a consolidated Federal income tax return with its Parent, Aetna Inc. The agreement stipulates that the taxes paid are determined as if each of the subsidiaries filed their taxes separately.

5. Supplemental Tax Sharing and Tax Escrow Agreement

This agreement served to amend certain portions of the previously described tax sharing agreement. It established certain limits to the HMO's tax liability and asserts the Parent's right to escrow tax payments under certain circumstances to assure the Parent's right to recoup federal income taxes in the event of future net losses.

6. Inter-company Transfer Agreement

The HMO entered into an Inter-Company Transfer Agreement, effective January 1, 2000, with its affiliate, AHIC. The agreement provides for POS premiums to be allocated from the HMO to its affiliate, AHIC, in order to achieve identical cost ratios for each entity. The basis of the allocation is the combined medical cost ratio for in-network and out-of-network POS products. Settlements occur quarterly, based on the medical cost ratio reported in each of the entity's financial statements. AHIC's business is comprised solely of out-of-network business from the HMO's POS business.

7. Mail Order Pharmacy Agreement

Effective February 1, 2003, AHI entered into an agreement with Aetna Rx Home Delivery, LLC. This agreement permits Aetna Rx Home Delivery, LLC to act as the provider of service to the HMO's members for the provision of mail order pharmaceutical benefits.

8. Service Agreement

Effective January 6, 1986, AHI was a party to an agreement with its Parent that called for the Parent to provide necessary administrative and personnel services. In return for these services, the HMO paid a service fee of 5% of premiums on a monthly basis to the Parent (then U.S. Healthcare) as compensation.

Based upon recommendations contained within the previous examination report, three new agreements were submitted to the Department and approved on April 5, 2005. The first new agreement, entitled, "Expense Allocation and Rebate Services Agreement", was also submitted to the Department of Health and approved on June 28, 2006, with an effective date of January 1, 2006. This agreement is between AHI and Aetna Health Management, LLC (AHM), a Delaware Company and affiliate of the HMO.

Under the new agreement, AHM performs administrative services, including: all accounting and reporting functions, operational, legal, claims payment, data processing, marketing and data processing services on behalf of the HMO.

Additionally, AHM is contracted to develop, negotiate and contract for rebates and similar arrangements with pharmaceutical manufacturers in regard to the utilization of pharmaceutical products by members of AHI. Further, AHM is responsible to develop, implement, maintain and support a national formulary strategy and develop and maintain software systems to administer the pharmaceutical manufacturers' rebate arrangements.

In return for these services, AHI reimburses AHM its actual costs.

The second new agreement, entitled "Personnel Services and Expense Reimbursement Agreement", is between AHI and ALIC. Under this agreement, ALIC provides AHI with the personnel necessary to perform administrative services, including accounting, payment of claims, quality assessment and pharmacy benefit management services related to AHI's commercial, Medicaid, Medicare and self-insured members. The agreement obligates AHI to pay ALIC the cost of providing such services, as well as interest on outstanding administrative service balances.

The third new agreement, entitled "Expense Allocation Agreement" is between AHI and Aetna Inc. This agreement obligates AHI to pay Aetna Inc. the cost of providing services incurred by Aetna Inc on behalf of AHI, as well as interest on outstanding monthly intercompany balances.

As all three new agreements work together as an integrated unit, all three agreements were implemented as of the same date, January 1, 2006. Additionally, the Line of Credit Agreement, the Subordination Agreement, the Guarantor Agreement and the Service Agreement were all terminated January 1, 2006 by the Expense Allocation Agreement.

AHI paid $508,600,000 in dividends to its Parent during the examination period. An additional $70,900,000 dividend payment was made to the Parent in 2006. The following chart shows the dividends paid during the examination period and in 2006:

Year	Dividend Payment Amount
2003	$ 195,000,000
2004	$ 190,000,000
2005	$ 123,600,000
2006	$ 70,900,000

E. Significant Operating Ratios

The following two ratios, computed as of December 31, 2005, fell outside of the NAIC benchmarks:

Ratio	Result	NAIC Benchmark
One-year reserve development to prior year surplus	(62.6)%	"Negative"
Change in non-invested assets	(23.0)%	<10% to -20%

- One-year reserve development to prior year surplus: The HMO's computed ratio of -62.6%, fell outside of the range of the NAIC's benchmark of "Negative". The result was mainly due to the favorable development of claims and the HMO's overall decrease in business.

- Change in non-invested assets: The HMO's computed ratio of -23.0%, fell outside of the range of the NAIC's benchmark of <20% to -20%. An analysis of the various accounts that are used to compute this ratio revealed that, while the result is greater than anticipated, the various balances involved are deemed to be collectible.

The underwriting ratios presented below are on an earned-incurred basis and encompass the period covered by this examination.

	Amount	Ratio
Medical expenses	$ 2,723,823,375	76.07%
Claim adjustment expenses	76,218,879	2.13%
Administrative expenses	369,764,505	10.33%
Net underwriting gain	410,872,555	11.47%

Premiums earned	$ 3,580,679,314	100.00%

F. Investment Activities

The HMO's investment management has been delegated, via the written approval of its board, to certain individuals within its Parent's Enterprise Risk Management Department. Investment holdings are maintained by State Street Bank and are subject to a custodial agreement.

The HMO's investment guidelines call for diversification of risk, and limit equity investments to ten percent (10%) of invested assets. Credit exposure for bonds is to average no lower than BBB. AHI also engages in short-term securities lending in order to maximize investment income.

The HMO's portfolio as of December 31, 2005, was comprised of government bonds, corporate debt obligations, cash equivalents, and short-term investments. Ninety-one percent of those investments were in NAIC Class 1 obligations, which included U.S. Government obligations. The insurer has modest participation in the private placement market.

All investment activity was approved by the HMO's board during its regular meetings.

Part 98-1.11(f)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(f)(1)) states in part:

> "…each [Managed Care Organization] shall establish a deposit in the form of an escrow account for the protection of enrollees (including enrollee health care service claim obligations), in the form of a trust account with a custodian…"

New York Insurance Department Circular Letter No. 2 (2006) also establishes the requirement that trusteed assets be maintained as separate and distinct from all other assets. A review during the examination revealed that while such funds were maintained in a separate account, they were being maintained in an account that was not in the HMO's name. When this was pointed out to the HMO's management, the name of the account was corrected.

It is recommended that the HMO comply with Part 98-1.11(f)(1) of the Administrative Rules and Regulations of the Health Department and New York Insurance Department Circular Letter No. 2 (2006) and maintain its trusteed surplus in an escrow account in the HMO's name.

G. Provider/IPA Arrangements and Risk Sharing

During the examination period, AHI maintained several contractual and capitated risk relationships with third-party Independent Practice Associations (IPAs) to supply services to HMO members. A description of each IPA arrangement is as follows:

- University Behavioral Associates, Inc. provides the HMO with a credentialed network, utilization review, and claims handling for the in-patient and out-patient behavioral health needs of its members.

- OrthoNet New York IPA provides the HMO with utilization review, and claim handling services for the in-network physical and occupational therapy needs of the HMO's members in fourteen counties of New York State.

- Magellan Behavioral Health, Inc. (MBH) provided a credentialed provider network, utilization review and claim services for the in-network mental health care of the HMO's members on a capitated basis. This relationship was terminated during 2005.

- American Chiropractic Network, Inc. (ACN) provides a credentialed provider network, utilization review and claim services for the in-network chiropractic needs of the HMO's members.

- New York Medical Imaging IPA provides the HMO with services for in-network radiology services to HMO members.

- Coordinated Care Solutions, Inc. provided the HMO with utilization review and claims management services for providers operating within the Montefiore Hospital network. This relationship was terminated subsequent to the examination date, in 2006.

Each of these IPA relationships is in compliance with New York Insurance Department Regulation No. 164 (11 NYCRR 101.4).

H. Accounts and Records

The HMO files Quarterly Loss Ratio Reports with this Department in accordance with Section 4308(g)(1) of the New York Insurance Law. These reports exhibit the claims experience for the various community-rated lines of business. During the examination, it was noted that the HMO constructed its Loss Ratio Reports utilizing actuarially established loss ratios, instead of using its actual loss experience as required. This rendered the data in those reports to be inaccurate and provided misleading results.

It is recommended that the HMO construct its Loss Ratio Reports filed with this Department pursuant to the requirements of Section 4308(g)(1) of the New York Insurance Law, utilizing actual loss experience.

It is noted that AHI resubmitted the inaccurate reports from 2005 and has initiated a process to comply with this recommendation on a going forward basis.

The HMO is required to pay a surcharge, under the New York Health Care Reform Act (HCRA), for most commercial hospital, diagnostic treatment center and ambulatory surgical center claims incurred in the State of New York. The examination revealed that the surcharge was not paid, as was required, when bulk settlements were made to adjust previously adjudicated claims. The amounts of such payments that were not made during the examination period and through 2006 were as follows:

Year	Surcharge
2003	$ 832,216
2004	179,166
2005	1,086,909
2006	858,670
Total	$ 2,956,961

It is recommended that the HMO pay the New York Health Care Reform Act (HCRA) surcharges when required on all claim payments.

It is noted that the HMO has subsequently paid the surcharges noted above.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with that reported by the HMO as of December 31, 2005:

Assets	Examination	HMO	Surplus Increase/ (Decrease)
Bonds	$268,817,515	$268,817,515	
Cash and cash equivalents	20,500,461	20,500,461	
Short term investments	20,170	20,170	
Investment income due and accrued	2,929,610	2,929,610	
Uncollected premiums	23,514,350	23,514,350	
Current federal and foreign income tax recoverable and interest thereon	5,410,819	5,410,819	
Net deferred tax asset	15,569,665	15,569,665	
Receivables from parent, subsidiaries and affiliates	10,018,682	10,018,682	
Health care and other amount receivables	7,168,554	7,168,554	
Aggregate write-ins for other than invested assets	431,144	431,144	
Total assets	$ 354,380,970	$ 354,380,970	
Liabilities			
Claims unpaid	$ 86,484,397	$ 121,675,767	$ 35,191,370
Unpaid claim adjustment expenses	1,964,038	1,964,038	
Aggregate health policy reserves	11,443,396	11,443,396	
Aggregate health claim reserves	3,442,242	3,442,242	
General expenses due or accrued	12,918,833	12,918,833	
Amounts due to parent, subsidiaries and affiliates	1,621,598	1,621,598	
Federal contingency reserve	4,119,654	4,119,654	
Total liabilities	$ 121,994,158	$ 157,185,528	$ 35,191,370

Capital and Surplus

Common stock	$ 6	$ 6	
Gross paid in and contributed capital	69,956,549	69,956,549	
Contingency reserve	51,684,939	51,684,939	
Unassigned surplus	110,745,318	75,553,948	
Total capital and surplus	$ 232,386,812	$ 197,195,442	$ 35,191,370
Total liabilities, capital and surplus	$ 354,380,970	$ 354,380,970	

Note: The Internal Revenue Service has completed its audits of the consolidated tax returns filed on behalf of the HMO through tax year 2003. All material adjustments, if any, made subsequent to the date of examination and arising from said audits, are reflected in the financial statements included in this report. Except for any impact which might result from the examination changes contained in this report, the examiner is unaware of any potential exposure of the HMO to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus decreased by $131,207,738 during the three-year examination period, January 1, 2003 through December 31, 2005, detailed as follows:

Revenue		
Gross premium income	$ 3,588,809,472	
Change in unearned premium reserves and reserve for rate credits	(8,130,158)	
Total revenue		$ 3,580,679,314
Hospital and medical expenses		
Hospital/medical benefits	$ 2,277,956,508	
Other professional services	12,348,060	
Outside referrals	149,635,864	
Emergency room and out of area	55,635,843	
Prescription drugs	303,634,836	
Aggregate write-ins for other hospital and medical	(107,938,329)	
Total hospital and medical expenses	$ 2,691,272,782	
Administrative expenses		
Claims adjustment expenses	76,218,879	
General administrative expenses	369,764,505	
Increase in reserves for accident and health contracts	(2,640,777)	
Total underwriting expenses		$ 3,134,615,389
Net underwriting gain		$ 446,063,925
Net investment income earned	$65,744,524	
Net realized capital gain	7,625,940	
Net investment income		73,370,464
Net income before federal income taxes		$ 519,434,389
Federal and foreign income taxes incurred		166,776,611
Net income		$ 352,657,778

Change in Capital and Surplus

Capital and surplus per report on examination, as of December 31, 2002			$ 358,594,550
	Gains in Surplus	Losses in Surplus	
Net income	$ 352,657,778	$	
Unrealized capital gain	202,671		
Change in net deferred income tax		16,604,725	
Change in non-admitted assets	46,317,648		
Dividends to stockholders		508,600,000	
Miscellaneous adjustment		181,110	
Net decrease in capital and surplus			(126,207,738)
Capital and surplus per report on examination, as of December 31, 2005			$ 232,386,812

4. RECEIVABLES FROM PARENT, SUBSIDIARIES AND AFFILIATES

Although no examination change was made relative to this report item, the following was noted:

The examiners reviewed a sample of 17 inter-company transactions to establish the propriety of those transactions. The results of such review are as follows:

- On several occasions, the HMO was billed for sales commissions that had been allocated to the HMO by its parent. These allocations included sales commissions and bonuses to agents and brokers for business not applicable to New York contracts.

- The examiner also noted that several inter-company transactions recorded by the HMO and members of its holding company system were not booked correctly in the HMO's general ledger. The differences appeared to be the result of Aetna Inc. recording certain transactions so that they balanced in total (consolidated), however, the allocations to the various legal entities were not always accurate. In one such case, the HMO appeared to be overcharged in the amount of $900,812.

While HMO personnel stated that the aforementioned erroneous allocations were the result of human error, for which a remedy is not required, the frequency at which these errors occurred indicate that there is a control deficiency that requires attention. Thus, the HMO should take immediate steps to implement a more efficient system to process transactions with members of its holding company system.

It is recommended that AHI and its Parent implement controls to prevent inaccurate or inappropriate inter-company transactions.

It is recommended that AHI be credited for all amounts erroneously charged to it.

5. HEALTH CARE RECEIVABLES

Although no examination change was made relative to this item, the following was noted:

The HMO pays certain capitated providers in advance for anticipated claims expense coverage. For accounting purposes, these payments, which are called Periodic Interim Payments ("PIP"), are recorded as receivables on the balance sheet. When claims are received by AHI, the amounts owed to the provider by the HMO are credited against the outstanding PIP balance. It was noted during the examination that, in one case, the HMO made a $1,649,216 payment to a group of capitated providers, but neglected to record the payment as a receivable. The omission of this payment overstated the PIP Expense and understated the PIP Receivable on the books of the HMO as of the examination date. Upon notice by the examiners, the HMO made a retroactive entry in October, 2006 to correct the omission.

It is noted that the HMO has an internal control that should have prevented this error.

It is recommended that the HMO review its internal controls to ensure that procedures are in place that will ensure that advance payments are properly recorded as receivables in its financial statements.

The HMO maintains a "reserve" for amounts estimated to be uncollectible under its PIP contracts and records it as a contra-asset in its PIP receivable account. When the estimate changes, the difference is recorded as either an increase or a decrease to the HMO's claim expenses. For the year ended December 31, 2005, the HMO reduced the

expected uncollectible amounts by $5 million. This change in estimate led to a reduction of the HMO's hospital/medical expenses by the same amount for the year. Because the changes are only changes in estimates, this balancing transaction should not be reported within claim expenses. Instead, the change would more properly be reported as a change in estimate for PIP Reserves, and shown as a surplus change item in the Statement of Revenue and Expenses of the Health Annual Statement filing.

It is recommended that in instances when the HMO changes its estimate of uncollectible PIP Reserves, such change should be reflected as a change in estimate, as a specific write-in line item on the income statement of the HMO's quarterly and annual financial statements, instead of as a change to the medical expenses of the HMO.

6. CLAIMS UNPAID

The examination liability of $86,484,397 is $35,191,370 less than the $121,675,767 reported by the HMO as of the examination date. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and its filed annual statements as verified during the examination.

It is AHI's practice to record its stop-loss reimbursements on a cash basis, rather than on an earned basis. This accounting treatment results in a higher claims reserve at year end, which is consistent with the Department's evaluation.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2002 contained eighteen (18) comments and recommendations. The current status of these matters is as follows (page numbers refer to the prior report):

ITEM NO.		PAGE NO.
	Holding Company System – Service Agreements	
1.	It is recommended that the Plan comply with 10 NYCRR Part 98.11 by maintaining a current administrative services agreement and by submitting that agreement to the Commissioner of Health for authorization to renew.	12
	The HMO has complied with this recommendation.	
2.	It is recommended that the Plan develop an administrative services agreement that meets the requirements of 10 NYCRR Part 98-1.10.	12
	The HMO has complied with this recommendation.	
3.	It is further recommended that the Plan develop an agreement that addresses all costs allocated to the HMO by the provider of services.	12
	The HMO has complied with this recommendation.	
4.	It is recommended that the Plan establish an agreement with ALIC detailing ALIC's role in the providing of services and paying of employees.	12
	The HMO has complied with this recommendation.	
5.	It is further recommended that any of the Plan's holding company transactions be clear and concise with regard to which affiliated entity performs the payment and record keeping functions involving inter-company transactions.	12
	The HMO has complied with this recommendation.	

ITEM NO.		PAGE NO.
6.	It is recommended that the Plan obtain approval for its cash management agreements prior to implementation. *The HMO has complied with this recommendation.*	13
7.	It is recommended that that the Plan adheres to the terms of the CMA by maintaining its assets in an account under its own name. *The HMO has complied with this recommendation.*	13
8.	It is recommended that the Plan develop a system to directly tie in the premium collected and provide a clear auditable trail for premium collected. *The HMO has complied with this recommendation.*	14
9.	It is recommended that the HMO maintain separate records from those of the Parent to be in compliance with Part 98-1.11(a) of the Administrative Rules and Regulations of the New York State Department of Health. It is noted that the administrative services agreement which was recently submitted to the Department addresses the comments and recommendations mentioned above. *The HMO has complied with this recommendation.*	
10.	It is recommended that the Plan refrain from changing the provider of cash management services until after the Plan formally notifies the Department of such change. *The HMO has complied with this recommendation.*	15
11.	It is recommended that the Plan file its Tax sharing agreement with DOH in accordance with 10 NYCRR Part 98. *The HMO has complied with this recommendation.*	16

ITEM NO.		PAGE NO.
12.	It is recommended that the Plan document: the PBM services provided to the Plan by AHM, the supporting detail regarding the allocation and settlement of pharmaceutical rebates with AHM, the fee paid for these services to AHM. *The HMO has complied with this recommendation.*	16
	Holding Company System – Dividends	
13.	It is recommended that the Plan generate and retain Board of Directors' approvals of all dividend payments. *The HMO has complied with this recommendation.*	17
	Accounts and Records	
14.	It is recommended that the custodian agreement be revised to reflect the Plan's current legal name. *The HMO has complied with this recommendation.*	17
15.	It is recommended that the Plan assure that the custodian agreement complies with the suggested protective covenants and provisions. *The HMO has complied with this recommendation.*	18
16.	It is recommended that the Plan report only individual claims in the individual line of business results. *The HMO has complied with this recommendation.*	19
17.	It is recommended that the Plan accrue for anticipated stop loss pool recoveries. *The HMO's stop-loss accounting is currently under audit by New York State's custodian for stop-loss accounts.*	19
18.	It recommended that the Plan include allocated expenses paid to the Parent in Schedule Y. *The HMO has complied with this recommendation.*	19

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Appointment No. 22475

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***Howard Mills***, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Aetna Health, Inc.

and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 10th day of March 2006

Howard Mills
Superintendent of Insurance