# REPORT ON EXAMINATION

# OF

# AETNA HEALTH INC.

# AS OF

# DECEMBER 31, 2010

| | |
|---|---|
| **DATE OF REPORT** | **JULY 11, 2014** |
| **EXAMINER** | **PEARSON GRIFFITH** |

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July 11, 2014

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30715, dated April 29, 2011, attached hereto, I have made an examination into the condition and affairs of Aetna Health Inc., a New York for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2010, and respectfully submit the following report thereon.

The examination was conducted at the home office of Aetna Health Inc., located at 151 Farmington Avenue, Hartford, Connecticut.

Wherever the designations “AHI” or the “HMO” appear herein, without qualification, they should be understood to indicate Aetna Health Inc.

Wherever the designations “Aetna” or the “Parent” appear herein, without qualification, they should be understood to indicate Aetna Inc., the ultimate parent of AHI.

Wherever the designations “AHIC” or the “Company” appear herein, without qualification, they should be understood to indicate Aetna Health Insurance Company of New

York, an affiliated 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 Department of Financial Services.

## 1. SCOPE OF THE EXAMINATON

The previous examination was conducted as of December 31, 2005. This examination is a "financial examination" as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010* Edition (the "Handbook") and it covered the five-year period from January 1, 2006 through December 31, 2010. The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2010, were also reviewed.

The examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the HMO. The examiner planned and performed the examination to evaluate the HMO's current financial condition, as well as to identify prospective risks that may threaten the future solvency of Aetna Health Inc.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined

management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department and NAIC annual statement instructions.

Information concerning the HMO's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the HMO's risks and management activities in accordance with the NAIC's nine branded risk categories. These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The HMO was audited annually for the years 2006 through 2010 by the accounting firm of KPMG, LLP (KPMG). The HMO received an unqualified opinion in each of those years. Certain audit work papers of KPMG were reviewed and relied upon in conjunction with this examination. The HMO has an internal audit department which has been given the task of assessing AHI's internal control structure. A review was made of the HMO's Enterprise Risk Management program.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which 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 related to the financial examination.

A concurrent examination regarding the financial condition of Aetna Health Insurance Company of New York was performed as of December 31, 2010. A separate financial report on examination was issued thereon.

Additionally, a separate market conduct examination was conducted as of December 31, 2011 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. was incorporated in New York on June 24, 1985, to operate a health maintenance organization under the name U.S. Healthcare, Inc. It was certified as a health maintenance organization 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 health maintenance organization 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., ("Aetna") a Connecticut corporation, was incorporated on March 25, 1996, for the purpose of effectuating the merger and became sole owner of the merged 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 a request 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 also 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, until a name change to Aetna Health Inc. 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.

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, 2010, the HMO's 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 common stock. The HMO has an additional 9,448 shares of $.01 par value per share common stock authorized, but not issued.

A. Corporate Governance

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, 2010, the HMO's board of directors consisted of the following members:

| Name and Residence | Principal Business Affiliation |
|---|---|
| Lydia Cavieux*<br>Cortlandt Manor, New York | Supervisor, Health Information Management,<br>Horton Medical Center |
| David Francis Kobus<br>New York, New York | Regional Head of Network,<br>Aetna Health Inc. |
| Steven G. Logan<br>New York, New York | President and Chief Executive Officer,<br>Aetna Health Inc. (a New York corporation) |

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

The minutes of all meetings of the board of directors and committees thereof held during the examination period were reviewed. The review revealed that the meetings were well attended and that management reviewed reports that were essential to the operations of the

HMO. The review also noted that the HMO was in compliance with the certification requirements of Department Circular Letter No. 9 (1999).

The principal officers of the HMO as of December 31, 2010 were as follows:

| **Name** | **Title** |
|---|---|
| Steven G. Logan* | President and Chief Executive Officer |
| Edward Chung-I Lee | Vice-president and Secretary |
| Jennifer A. Palma** | Principal Financial Officer and Controller |
| Elaine R. Cofrancesco | Treasurer |
| Terry J. Golash | Medical Director |
| Gregory S. Martino | Vice-president |
| Kevin J. Casey | Senior Investment Officer |
| Dawn M. Schoen*** | Assistant Controller |

* Steven G. Logan was elected as President and Chief Executive Officer on March 12, 2010.
** Jennifer A. Palma was elected as Principal Financial Officer and Controller on March 31, 2010.
*** Dawn M. Schoen was elected as Assistant Controller on March 31, 2010.

B. Territory and Plan of Operation

As of December 31, 2010, AHI was authorized to operate as a health maintenance organization 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 their primary care physician (PCP). The primary care 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 outside the HMO's provider network, in addition to obtaining care in-network. For individual POS coverage, both in-network and out-of-network coverage is provided by AHI. For small and large group POS coverage, the in-network component is provided by AHI, and the out-of-network component is provided through its affiliate, Aetna Health Insurance Company of New York (AHIC).

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

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| **Enrollment** | 192,225 | 160,164 | 135,381 | 118,176 | 97,927 |
| **Line of Business** | | | | | |
| HMO Large Group | 433,904,236 | 403,641,832 | 377,491,720 | 351,050,906 | 312,453,485 |
| HMO Small Group | 35,443,686 | 18,875,248 | 11,881,330 | 13,962,980 | 14,529,084 |
| HMO Individual | 38,858,365 | 33,146,386 | 31,716,645 | 28,184,501 | 30,698,447 |
| POS Large Group (ER) | 183,141,206 | 171,440,030 | 146,280,884 | 136,546,489 | 89,351,616 |
| POS Small Group | 33,836,956 | 18,110,425 | 13,293,373 | 8,019,866 | 6,665,947 |
| POS Individual (OON) | 34,030,501 | 34,995,549 | 32,477,784 | 36,167,552 | 26,741,580 |
| Healthy New York | 20,601,948 | 26,139,093 | 22,721,651 | 21,400,749 | 22,249,866 |
| Medicare | 155,364,506 | 167,499,819 | 196,761,402 | 206,375,369 | 200,161,790 |
| Total Premium | $ 935,181,404 | $ 873,848,382 | $ 832,624,789 | $ 801,708,412 | $ 702,851,815 |

Note: The above enrollment and premium decreases reflect the downward trend in commercial large group HMO business written by AHI during the examination period.

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

The HMO's membership declined throughout the examination period. As of December 31, 2011, the total number of members reported was 82,170, a further decline of nearly 16,000 members.

During the examination period, the HMO solicited business as a direct writer, utilizing in-house licensed agents. The HMO also contracted with independent, licensed agents and brokers for the production of business.

The following table displays AHI's net admitted assets, capital and surplus, net premium income and net income during the period under examination:

| | Net Admitted Assets | Capital and Surplus | Net Premium Income | Net Income |
|---|---|---|---|---|
| | | (in thousands) | | |
| 2006 | $ 351,810 | $ 188,583 | $ 936,016 | $ 61,444 |
| 2007 | 323,136 | 187,730 | 874,017 | 64,069 |
| 2008 | 368,445 | 238,417 | 832,747 | 97,919 |
| 2009 | 338,805 | 183,104 | 801,690 | 47,356 |
| 2010 | 310,474 | 175,997 | 702,832 | 50,079 |

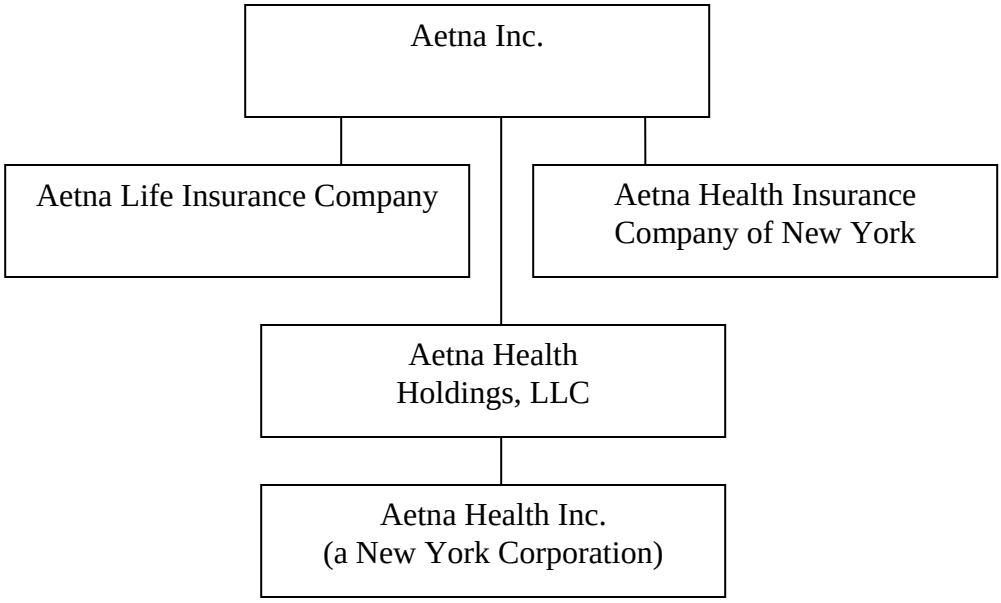
C. Reinsurance

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

D. Holding Company System

As a member of a holding company system, AHI has twenty-four HMO affiliates, which operate in thirty-four states, as well as 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, 2010.




The following is a description of the HMO's major affiliations as of December 31, 2010:

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 small and large groups of AHI. Aetna Health Holdings, LLC acts as a holding company of Aetna's HMOs for the ultimate parent, Aetna Inc.

Part 98-1.16(e) of the Administrative Rules and Regulations of the New York State Department of Health 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 Department of Health.

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

| No. | Description of Agreement | Contracting Party | Effective Date |
|---|---|---|---|
| 1. | Inter-company transfer agreement | AHIC | 1/1/2000 |
| 2. | Tax sharing agreement | Aetna Inc. | 1/1/2006 |
| 3. | Supplemental tax sharing and tax escrow agreement | Aetna Inc. | 1/1/2006 |
| 4. | Mail order pharmacy agreement | Aetna Rx Home Delivery, LLC | 2/1/2003 |
| 5. | Expense allocation and rebate services | AHM LLC | 1/1/2006 |
| 6. | Expense allocation agreement | Aetna Inc. | 1/1/2006 |
| 7. | Personnel services and expense reimbursement | ALIC | 1/1/2006 |

The following is a description of each of the holding company 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. Such agreements were approved by this Department and the Department of Health.

1. 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 derived from the HMO's POS business.

2. 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.

3. 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.

4. 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.

5. Expense Allocation and Rebate Services Agreement

Effective January 1, 2006, AHI entered into an agreement with Aetna Health Management, LLC (AHM). This agreement permits Aetna Health Management, LLC to act as the provider of service to the HMO in the areas of finance, operational services, legal services, claims payment, quality assessment/utilization review services, provider networking and data processing, among others.

6. Expense Allocation Agreement

Effective January 1, 2006, AHI entered into an agreement with Aetna Inc. This agreement permits Aetna Inc. to, among other things, hire employees and to negotiate and enter into agreements and contracts on behalf of AHI.

7. Personnel Services and Expense Reimbursement Agreement

Effective January 1, 2006, AHI entered into an agreement with Aetna Life Insurance Co (ALIC). This agreement permits ALIC to provide the personnel necessary to perform administrative services. Personnel services exclude broker and commissions, bad debt expenses, premium taxes, state and/or guaranty fund assessments, among others.

AHI paid $355,400,000 in dividends to its Parent during the examination period. The following chart shows the dividends paid during the examination period:

| Year | Dividend Payment Amount |
|---|---|
| 2006 | $ 70,900,000 |
| 2007 | $ 73,000,000 |
| 2008 | $ 48,400,000 |
| 2009 | $102,000,000 |
| 2010 | $ 61,100,000 |

E. Significant Operating Ratios

The following ratios have been computed as of December 31, 2010 based upon the results of this examination:

| Ratio | 2010 |
|---|---|
| Net Change in Capital and Surplus | -3.88% |
| Current Liabilities to Liquid Assets & Receivables | 47.54% |
| Premium and Risk Revenue to Capital and Surplus | 3.99 to 1 |
| Medical Loss Ratio | 84.58% |
| Combined Loss Ratio | 92.39% |
| Administrative Expense Ratio | 6.90% |

The above ratios fall within the benchmark ranges set forth in the Financial Analysis Solvency Tools (FAST) scoring ratios of the NAIC.

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

| | Amounts | Ratios |
|---|---|---|
| Total hospital and medical | $ 3,408,721,768 | 82.19% |
| Claim adjustment expenses | 40,544,852 | 0.98% |
| Cost containment expenses | 25,380,163 | 0.61% |
| General administrative expenses | 335,975,105 | 8.10% |
| Increase in reserves for life and accident and health contracts | (10,115,566) | -0.24% |
| Net underwriting gain | 346,794,818 | 8.36% |
| Net premium income | $ 4,147,301,140 | 100.00% |

F. Investment Activities

The HMO's investment management has been delegated, via the written approval of its board, to the Treasurer of the Company, the Head of Fixed Income (Investment Management), the Senior Investment Officer of the Company, and the Chief Investment Officer (Investment Management) within its Parent's Finance 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, 2010, was comprised of government bonds, corporate debt obligations, cash equivalents, and short-term investments. Eighty-six percent of

those investments were in NAIC Class 1 obligations, which included U.S. Government obligations. The insurer had modest participation in the private placement market.

G. Enterprise Risk Management ("ERM")

Unless otherwise noted, the following comments refer to the ERM process of the Aetna Inc. ("Aetna") holding company which includes the operations of AHI.

Aetna relies on its enterprise risk management ("ERM") process to aggregate, monitor, measure and manage risks. The ERM process is ongoing and is designed to identify the most important risks facing Aetna, as well as to prioritize those risks in the context of the company's overall strategy. ERM is performed at the Aetna holding company level and applied to its subsidiaries, including AHI. Aetna's ERM team is led by its Chief Enterprise Risk Officer, who is also Aetna's Chief Financial Officer.

Aetna's ERM function was reviewed as part of the examiner's assessment of the overall Corporate Governance environment. The ERM team consists of the Audit Committee, Executive Committee and Risk Champions. Aetna's Audit Committee is directly responsible for risk management as it relates to the oversight of ERM. ERM, itself, does not have a Charter as the Aetna Inc.'s Audit Committee is responsible for oversight at the enterprise level and is embedded in the Audit Committee charter. In collaboration with the Audit Committee and the Aetna Board of Directors, the ERM team annually conducts a risk assessment of the company's businesses. All of the key business leaders are involved in the risk assessment process. The risk assessment is presented to, and reviewed by, the Audit Committee and, after reflecting the Audit Committee's views, the list of enterprise risks is then reviewed and approved by the Board. As part of their reviews, the Audit Committee and the Board consider the internal governance

structure for managing risks, and the Board assigns responsibility for ongoing oversight of each identified risk to a specific Committee of the Board or to the Board.

Discussions of assigned risks are then incorporated into the agenda for each Committee (or the Board) throughout the year. Consequently, the Chief Enterprise Risk Officer, in consultation with the Chairman, Chief Executive Officer and President, monitors risk management and mitigation activities across the organization throughout the year and reports periodically to the Audit Committee and the Board concerning the Company's risk management profile and activities. The Audit Committee also meets regularly in private sessions with the Company's Chief Enterprise Risk Officer.

Risk management is ongoing, and the importance assigned to identify risks can change and new risks can emerge during the year as the company develops and implements its strategy. Dashboards are prepared by the Risk Champions to provide the current status of the risk lists and are made available to the Board of Directors and Executive Committee. The dashboards are updated as needed, but at least annually. However, historic versions of dashboards are not maintained since these are "used in a forward looking context."

It is recommended that historic records of ERM dashboards be maintained to facilitate monitoring of risk management performance.

H. Information Technology

The Information Technology review of the Company was conducted to help identify risks related to the HMO. The objective of the IT review was to determine whether Information

Systems resources are properly aligned with the Company's objectives to ensure that significant risks (strategic, operational, reporting and compliance) arising from the IT environment are appropriately mitigated by strategies or IT general controls. In order to accomplish this objective, the examiners reviewed the general controls regarding Aetna's processing environment and reviewed certain controls over the applications that were determined to be financially significant.

The IT review was performed in accordance with the National Association of Insurance Commissioners *Financial Condition Examiners Handbook* the ("Handbook"). The framework for the scope of the IT review was follows:

1. Gather necessary IT information
2. Review information gathered
3. Request control information and complete IT review planning
4. Conduct IT review fieldwork
5. Document results of IT review
6. Assist the financial examination

Aetna has a highly centralized computing environment and its IT initiatives are set forth by Aetna's officers and senior management team. IT is performed at the Aetna holding company level and applied to its subsidiaries, including AHI. The Chief Information Officer (CIO) leads the Aetna Information Services (AIS) group and reports to the Executive Vice President of Innovation, Technology, and Service Operations.

AIS is the provider of information technology services to the HMO. AIS has nearly 3,000 IT professionals and over 2,000 contractors working collaboratively in every facet of IT. AIS is responsible for IT infrastructure support at the Computer Network Command Centers (CNCC) and extensive enterprise wide network facilities. In addition, AIS is responsible for the

delivery of voice/data communications, application development, maintenance of applications, corporate reporting, IT resource management, IT architecture and design, business continuity and disaster recovery. AIS also performs quality assurance, testing of applications and support internal audits.

The AIS group is organized into seven functional departments. These are: Integrated Infrastructure Services (IIS); Enterprise Architecture (EA); Program Delivery (PD); Application Development (AD), AIS Delivery Operations (ADO); Enterprise Testing & Quality Assurance (ETQA) and; International IT.

Each department is accountable for a key element of strategic IT solutions delivery as follows:

| | |
|---|---|
| Integrated Infrastructure Services | Responsible for deploying and managing IT infrastructure resources to ensure cost effectiveness and optimization. This includes maintaining high levels of systems availability for network infrastructure and applications. IIS maintains technical standards, release management, asset inventories and financial controls. In addition, IIS' security engineering unit is responsible for Enterprise security administration. |
| Enterprise Architecture | Responsible for aligning IT services with business requirements. It maintains a formal and continuous approach regarding IT investments, software development management, as well as scalability of infrastructure and Mergers and Acquisitions. |
| Program Delivery | Responsible for planning and managing projects, business requirements and specifications for line of business. PD is organized into 5 sub-units:<br>• Core domains, SSP, Medial Products, Benefit-focus, Consumer Funds, Scalability;<br>• Claims, Contract Center, Health & Productivity Program;<br>• PD Planning & Programs, Project Assessments |

| | |
|---|---|
| | • Medical Management, Network & Provider, Informatics, ICD-10, Information Privacy; and<br>• Pharmacy. |
| Application Development | Responsible for the development of enterprise applications systems to support Program Delivery. This unit aligned Program Delivery requirements and work closely with their respective line of business to ensure supports and enhancement of applications. |
| AIS Delivery Operations | Provides project management office services to AIS for:<br>• Enterprise IT Planning<br>• Project Methodology<br>• Training<br>• Governance<br>• Metrics and Reporting<br>• Project Staffing and Sourcing Strategy<br>• Project delivery tools |
| Enterprise Testing & Quality Assurance | Responsible for the comprehensive testing services defined by AIS. This provides a standard, formal and continuous approach regarding quality management and ensures cost-effective production deliveries. |
| International IT | Responsible for supporting all aspects of information technology for Aetna Global Business International. This ranges from the IT user interfaces, applications and end-to-end infrastructure. International IT is organized into 4 sub-units:<br>• International Strategy & Architecture<br>• International Development<br>• International Program Delivery<br>• International Testing |

The framework used for IT governance is collaborated and shared among the company's senior management, Audit Committee, Internal Audit Department, AIS and Human Resources. Senior management monitors adherence to policies and procedures. The philosophy of senior management is to manage and control risk through a hierarchy of control policies, procedures and management processes, which further reinforce internal controls.

The components used to enforce IT governance are: segregation of duties, change management, logical access, managing computer operations, physical security and data transmission controls. Aetna has established various control programs for IT to continuously monitor, benchmark and improve the IT control environment and control framework to meet organizational objectives.

The examiner obtained and reviewed the HMO's Exhibit C responses and evaluated its ability to assess and manage risk, primarily by considering management's risk and control assessment initiatives and related documents. A review was made of Aetna's annual and quarterly processes to understand its IT strategy, plans and objectives. Additionally, the examiner leveraged the company's Sarbanes-Oxley (SOX) compliance initiatives. Because SOX compliance includes management's controls, IT controls over financial reporting, related compliance activities and controls testing, the testing results provide relevant documentation that evaluate and evidence the company's internal controls over financial reporting.

Based on the examination review, the review of the independent CPA's workpapers, and the Connecticut Insurance Department's testing of IT general controls from its examination of Aetna as of December 31, 2010, the assessment of the overall strength of risk mitigation strategies/controls related to information systems at Aetna is strong for those policies and procedures that had been in place during the period January 1, 2010 to December 31, 2010.

## I. Provider/IPA Arrangements and Risk Sharing

During the examination period, AHI maintained several contractual and capitated risk relationships with third-party providers and Independent Practice Associations (IPAs) to supply

services to HMO members. A description of each arrangement is as follows:

- Quest Diagnostic provides the HMO with services for in-network radiology services to HMO members.
- CareCore National, LLC provides outpatient diagnostic imaging utilization management services to AHI's members.
- American Chiropractic Network, Inc. (ACN) provides a credentialed provider network, utilization review and claim services for the in-network chiropractic needs of AHI's 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 AHI's members in fourteen counties of New York State.

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

J. Accounts and Records

1. New York Health Care Reform Act ("HCRA") Assessment and Surcharge

The State of New York requires an assessment surcharge that applies to most commercial hospital, diagnostic treatment center and ambulatory surgical center claims incurred in the State of New York. In addition, a covered lives assessment applies to third-party payers who have elected to pay their HCRA surcharge obligations directly to the State of New York's HCRA Pool Administrator. During a review of the HMO's balance sheet, statement of revenue and expenses, and Notes to its filed 2010 Annual Statement, the examiner noted that AHI failed to accurately report expenses and liabilities relating to HCRA assessments and surcharges, in such financial statements.

A concurrent review of the Notes to AHIC's filed 2010 Annual Statement did not disclose any expenses and liabilities relating to HCRA assessments and surcharges. During a meeting with the Plan's management, the examiner was informed that AHIC's HCRA assessments and surcharges were settled through the Inter-Company Transfer Agreement between AHI and AHIC. Management, at the time of examination, was unable to provide the amount by which the audit assessment or surcharge was overstated. However, subsequent to the examination, management provided an estimate of AHIC's HCRA audit assessment settlement which was determined to be a relatively immaterial amount.

In January 2011, Aetna submitted a corrective action plan as regards New York HCRA surcharge to the New York State Department of Health for approval. In addition, Aetna established an additional HCRA reserve of $4,850,000 for all HCRA payers as of December 31, 2010 for the recalculation of claims that should have had the HCRA surcharge applied. In October 2011, Aetna paid $4,391,542 for the 2010 HCRA surcharge settlement, of which, $457,583 related to AHI. However, no HCRA surcharge settlement was allocated to AHIC.

It is recommended that the HMO allocate an appropriate portion of any HCRA audit settlement expense and the related liability to AHIC for the purpose of reporting accurate assessments in AHI and AHIC's filed annual statement, in accordance with the Annual Statement Instructions of the *National Association of Insurance Commissioners* (NAIC).

It is recommended that the HMO accurately disclose the HCRA assessment expense and related liability in the notes to its filed annual statements, in accordance with the Annual Statement Instructions of the National Association of Insurance Commissioners.

During a review of controls relative to AHI's HCRA assessment and surcharge activity, the examiner noted that certain providers who were determined during a subsequent internal audit to be subject to New York's HCRA surcharge may not have been accurately identified. AHI's policy that was in effect during the examination period changed certain providers' status to HCRA "non-surchargeable" if those providers did not respond to a verification letter that was sent requesting confirmation of their surchargeability status. However, that process did not identify all providers who should have been identified as subject to HCRA surcharges, including those categories of providers that the HMO may have considered as not eligible for surcharge. As a result, some providers were incorrectly identified for HCRA surcharge purposes, thereby resulting in the inaccurate calculation of the HMO's HCRA surcharge assessment liability.

It is recommended that the HMO act to modify the provider identification process to accurately reflect all providers subject to the New York HCRA surcharge.

2. Accounting for Disbursements from and Payments to the New York Market Stabilization Pools

A review of the HMO's accounting treatment for disbursements from, or payments to, the New York Market Stabilization Pools (MSP) indicated that the HMO failed to accurately report such transactions in the Supplemental Health Care Exhibit of the filed Annual Statement.

Section 361.1(e)(1) of Insurance Regulation 146 states, in part:

> "…Insurers and HMOs which are expected to make contributions are permitted to include their projected contributions in their premium rates as if the contributions were claim expenses, while insurers and HMOs which are expected to receive money shall treat the projected receipts as if they were offsets to claims and thus reduce premium rates below what those premium rates would otherwise need to be."

In addition, Department Circular Letter No. 1 (1994) provides guidance for the accounting treatment to be used for disbursements from and the payments to the MSP as follows:

> "Commercial insurers and Article 43 corporations should report in the claims expense line of the Income Statement any adjustments to their underwriting accounts resulting from pool payments or disbursements. Public Health Law Article 44 Health Maintenance Organizations should report such adjustments to claims expense in appropriate write-in accounts in the Income Statement."

Further, the instructions of the NAIC's Supplemental Health Care Exhibit of the Annual Statement states that Line 2.4, State Stop Loss, Market Stabilization and Claim/Census based Assessments, includes "any market stabilization payments or receipts by insurers that are directly tied to claims incurred and other claims based or census based assessments."

During 2010 and 2009, the HMO received $14,307,887 and $17,833,211 in distributions related to calendar years 2009 and 2008 (the reporting calendar years), respectively. In accordance with the provisions of Regulation 146, Aetna submitted a plan to the Department detailing how the distributions will be applied to reduce premium rates. For the years ending 2010 and 2009, $11,634,745 and $13,930,636, respectively, were reflected as increases in net premium income on the Statutory Statements of Revenue and Expenses. The $11,634,745 increase in net premium income was reflected on Line 1.6, State insurance, premium and other taxes in the 2010 Supplemental Health Care Exhibit.

Based on the foregoing, the examiner determined that disbursements from the MSP should have been reported on Line 2.4 of the Supplemental Health Care Exhibit as a reduction to the HMO's claim expenses.

It is recommended that the HMO comply with the provisions of Insurance Regulation No. 146, the guidance provided in Department Circular Letter No. 1 (1994), and the instructions relative to the NAIC's Supplemental Health Care Exhibit of the Annual Statement.

3. Section 4308(h) Refunds

A review of the refunds payable by AHI under Section 4308(h) of the New York Insurance Law revealed that such refunds payable were overstated in its filed financial statements filed as of December 31, 2010 and December 31, 2011 and within its loss ratio reports filed with the Department for the aforementioned periods. Such refunds payable were applicable to Large Group (HMO) plans. In this regard, AHI used an experience rating formula which was not prescribed by this Department.

It is recommended that AHI accurately report liabilities for refunds payable under Section 4308(h) of the New York Insurance Law in its filed annual statements and within its loss ratio reports filed with the Department.

It was also noted that, as of December 31, 2010, AHI reported conflicting amounts for the loss ratios for its large group HMO plans (i.e., loss ratios filed within its financial statements (83.93%), loss ratios used in estimating the refund (73.81%); and as reported within its loss ratio reports filed with the Department (76.81%)).

It is recommended that AHI take the steps necessary to ensure that it reports consistent loss ratios relative to its large group HMO plans within all filings made with the Department.

4. Stop Loss Reimbursements

Stop Loss reimbursements accrue to members under Direct Pay and Healthy New York plans. Such reimbursements are submitted on a paid basis to the New York State stop loss pool and reimbursements are distributed to the Companies in the following year.

AHI, during the examination period, did not establish receivables (accrue for such receivables) for such estimated Stop Loss reimbursements within its filed annual statements to this Department during the examination period.

Paragraph 2 of Statements of Statutory Accounting Principles (SSAP) No. 4 of the *National Association of Insurance Commissioners* Accounting Practices and Procedures Manual states the following:

> "For purposes of statutory accounting, an asset shall be defined as: probable[1] future economic benefits obtained or controlled by a particular entity as a result of past transactions or events. An asset has three essential characteristics: (a) it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows, (b) a particular entity can obtain the benefit and control others' access to it, and (c) the transaction or other event giving rise to the entity's right to or control of the benefit has already occurred."

It is recommended that AHI comply with Paragraph 2 of SSAP No. 4 of the *National Association of Insurance Commissioners* Practices and Procedures Manual and establish appropriate receivables relative to Stop Loss recoverables within its quarterly and financial statements to the Department when such recoverable payments accrue during the year.

## 3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus as determined by this examination and as reported by the HMO, in its filed annual statement as of December 31, 2010. This statement is the same as the balance sheet filed by the HMO:

| Assets | Examination | HMO |
|---|---|---|
| Bonds | $ 245,966,524 | $ 245,966,524 |
| Common stocks | 22,022 | 22,022 |
| Cash and cash equivalents | 6,241,134 | 6,241,134 |
| Securities lending reinvested collateral assets | 7,212,320 | 7,212,320 |
| Short-term investments | | |
| Investment income due and accrued | 2,849,056 | 2,849,056 |
| Uncollected premiums in course of collection | 25,861,637 | 25,861,637 |
| Current federal and foreign income tax recoverable and interest thereon | 9,039,464 | 9,039,464 |
| Net deferred tax asset | 10,781,857 | 10,781,857 |
| Health care and other amounts receivable | 713,867 | 713,867 |
| Current State Income Tax Receivable | 552,456 | 552,456 |
| Medicare Part D Catastrophic Coverage Receivable | 507,366 | 507,366 |
| Section 332 Assessment Receivable | 407,214 | 407,214 |
| Medicare Part D Low Income Cost Share | 310,225 | 310,225 |
| Market Stabilization Pool Receivable | 9,087 | 9,087 |
| Total assets | $ 310,474,229 | $ 310,474,229 |

| Liabilities | Examination | HMO |
|---|---|---|
| Claims unpaid | $ 69,478,597 | $ 69,478,597 |
| Unpaid claims adjustment expenses | 1,267,428 | 1,267,428 |
| Aggregate health policy reserves | 33,538,625 | 33,538,625 |
| Aggregate health claim reserves | 647,276 | 647,276 |
| Premiums received in advance | 1,019,605 | 1,019,605 |
| General expenses due or accrued | 6,795,777 | 6,795,777 |
| Amounts due to parent, subsidiaries, and affiliates | 13,938,421 | 13,938,421 |
| Payable for securities lending | 7,212,320 | 7,212,320 |
| Aggregate write-ins for other liabilities | 579,074 | 579,074 |
| Total liabilities | $ 134,477,123 | $ 134,477,123 |
| Capital and surplus | | |
| Common capital stock | $ 6 | $ 6 |
| Gross paid in and contributed surplus | 69,956,549 | 69,956,549 |
| Contingency reserve | 73,799,441 | 73,799,441 |
| Additional deferred tax asset | 3,105,587 | 3,105,587 |
| Unassigned surplus | 29,135,523 | 29,135,523 |
| Total capital and surplus | 175,997,106 | 175,997,106 |
| Total liabilities, capital and surplus | $ 310,474,229 | $ 310,474,229 |

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the HMO through tax year 2010. The examiner is unaware of any potential exposure of the HMO to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus decreased $56,389,706 during the five-year examination period, January 1, 2006 through December 31, 2010, detailed as follows:

| | | |
|---|---|---|
| Revenue | | |
| Net premium income | $ 4,146,214,802 | |
| Change in unearned premium reserves | 1,086,338 | |
| Total revenue | | $ 4,147,301,140 |
| Hospital and medical expenses | | |
| Hospital/medical benefits | $ 2,902,264,495 | |
| Other professional services | 9,149,612 | |
| Outside referrals | 150,359,019 | |
| Emergency room and out-of-area | 73,857,365 | |
| Prescription drugs | 376,704,332 | |
| Market Stabilization Pool | (5,395,180) | |
| Stop-loss Fund Recoveries | (98,217,875) | |
| Total hospital and medical benefits | $ 3,408,721,768 | |
| Administrative expenses | | |
| Claims adjustment expenses | 40,544,852 | |
| Cost containment expenses | 25,380,163 | |
| General administrative expenses | 335,975,105 | |
| Increase in reserves for life and accident and health Contracts | (10,115,566) | |
| Total underwriting deductions | | $ 3,800,506,322 |
| Net underwriting gain/loss | | $ 346,794,818 |
| Net investment income earned | 64,945,767 | |
| Net realized capital gains/losses | (3,428,829) | |
| Net investment gains/losses | | 61,516,938 |
| Other income or expenses | | (294,100) |
| Net income before federal and foreign income taxes | | $ 408,017,656 |
| Federal and foreign income taxes incurred | | 122,343,002 |
| Net income | | $ 285,674,654 |

Changes in Capital and Surplus

| | | | |
|---|---|---|---|
| Capital and surplus, per report on examination, as of December 31, 2005 | | | $ 232,386,812 |
| | Gains in Surplus | Losses in Surplus | |
| Net income | $ 285,674,654 | | |
| Dividend to stockholder | | $ 355,400,000 | |
| Net unrealized capital losses | | 25,723 | |
| Change in net deferred income tax | | 17,133,137 | |
| Change in non-admitted assets | 29,355,083 | | |
| Correction of error- current federal taxes | | 1,966,170 | |
| Change in deferred tax asset | 3,105,587 | 0 | |
| Net decrease in capital and surplus | | | (56,389,706) |
| Capital and surplus, per report on examination, as of December 31, 2010 | | | $ 175,997,106 |

## 4. CLAIMS UNPAID

The examination liability of $69,478,597 is the same as the amount reported by the HMO as of December 31, 2010.

The examination analysis of the unpaid claims reserve 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. The examination reserve was based upon actual payments made through a period in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2010.

## 5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2005, contained the following eight financial related recommendations (page number refers to the prior report on examination):

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Management and Controls | |
| 1. | It is recommended that the board meet a minimum of four items per calendar year so that it can review and sign off on the operations and quarterly statements filed by the HMO with this Department. | 7 |
| | *The HMO has complied with this recommendation.* | |
| | Investment Activities | |
| 2. | 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. | 19 |
| | *The HMO has complied with this recommendation.* | |
| | Accounts and Records | |
| 3. | 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. | 20 |
| | *The HMO has complied with this recommendation.* | |
| 4. | It is recommended that the HMO pay the New York Health Care Reform Act surcharges when required on all claim payments. | 21 |
| | *The HMO has complied with this recommendation.* | |

**ITEM NO.** **PAGE NO.**

## 6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

| ITEM | | PAGE NO. |
|---|---|---|
| A. | Enterprise Risk Management ("ERM") | |
| | It is recommended that historic records of ERM dashboards be maintained to facilitate monitoring of risk management performance. | 19 |
| B. | Accounts and Records | |
| i | It is recommended that the HMO allocate an appropriate portion of any HCRA audit settlement expense and the related liability to AHIC for the purpose of reporting accurate assessments in AHI and AHIC's filed annual statement, in accordance with the Annual Statement Instructions of the *National Association of Insurance Commissioners* ("NAIC"). | 25 |
| ii | It is recommended that the HMO accurately disclose the HCRA assessment expense and related liability in the notes to its filed annual statements, in accordance with the Annual Statement Instructions of the National Association of Insurance Commissioners. | 25 |
| iii. | It is recommended that the HMO act to modify the provider identification process to accurately reflect all providers subject to the New York HCRA surcharge. | 26 |
| iv. | It is recommended that the HMO comply with the provisions of Insurance Regulation No. 146, the guidance provided in Department Circular Letter No. 1 (1994), and the instructions relative to the NAIC's Supplemental Health Care Exhibit of the Annual Statement. | 28 |
| v. | It is recommended that AHI accurately report liabilities for refunds payable under Section 4308(h) of the New York Insurance Law in its filed annual statements and within its loss ratio reports filed with the Department. | 28 |
| vi. | It is recommended that AHI take the steps necessary to ensure that it reports consistent loss ratios relative to its large group HMO plans within all filings made with the Department. | 28 |

**ITEM** **PAGE NO.**

Respectfully submitted,

_____/S/_____
Pearson Griffith
Principal Insurance Examiner

STATE OF NEW YORK )
) SS
)
COUNTY OF NEW YORK)

**Pearson Griffith**, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Pearson Griffith

Subscribed and sworn to before me
this _____ day of_____2014.

Appointment No. **30715**

# STATE OF NEW YORK
# INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Pearson Griffith**

as a proper person to examine into the affairs of the

**Aetna Health, Inc. (a New York Corporation)**

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

**HMO**

with such other information as he shall deem requisite.

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

This 29th day of April, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR