REPORT ON EXAMINATION

OF

AETNA HEALTH INC.

AS OF

DECEMBER 31, 2015

DATE OF REPORT	**OCTOBER 25, 2017**
EXAMINER	**DAVID CRANDALL, CFE**

TABLE OF CONTENTS

NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

October 25, 2017

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and New York State Public Health Law and acting in accordance with the instructions contained in Appointment Number 31421, dated February 4, 2016, attached hereto, I have made an examination into the condition and affairs of Aetna Health Inc., a New York for-profit health maintenance organization certified by the New York State Department of Health pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2015, 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 ñAHIò or the ñHMOò appear herein, without qualification, they should be understood to indicate Aetna Health Inc.

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

Wherever the designations ñAHICò or the ñCompanyò 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 ñDepartmentò appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2010. This examination was a financial examination as defined in the National Association of Insurance Commissioners (ñNAICò) *Financial Condition Examiners Handbook, 2016 Edition,* (the ñHandbookò) and it covered the five-year period from January 1, 2011 through December 31, 2015. 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, 2015, 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 examinerôs assessment of risk in the HMOôs operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the HMOôs 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 managementôs compliance with the Departmentôs statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

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

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

The examination also evaluated the HMOôs critical risk categories in accordance with the NAICôs ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

The HMO was audited annually for the years 2011 through 2015 by the accounting firm of KPMG, LLP (ñKPMGò). The HMO received an unmodified 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 AHIôs internal control structure. A review was made of the HMOôs 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. The results of the examinerôs review are contained in Section 5 of this report.

A concurrent examination regarding the financial condition of Aetna Health Insurance Company of New York was performed as of December 31, 2015. A separate financial report on examination was issued thereon.

Additionally, a separate market conduct examination was conducted as of December 31, 2015 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, under the name U.S. Healthcare, Inc. It was certified as a health maintenance organization by the New York State Department of Health (ñDOHò) on February 3, 1986, and began operations on May 1, 1986. AHI is licensed as a for-profit, independent practice association (ñIPAò) model health maintenance organization pursuant to the provisions of Article 44 of the New York Public Health Law. When certified, the HMO was a subsidiary of U.S. Healthcare, Inc. (ñU.S. Healthcareò), 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 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.ôs core health care businesses. The others were insurance and financial services, both domestic and international.

On December 13, 2000, Aetna U.S. Healthcare, Inc. became the ultimate parent company and was renamed Aetna Inc.

The HMO filed a request with the Department to operate under the assumed name (d/b/a) of Aetna U.S. Healthcare, Inc., effective January 1, 1997. The HMO also notified this Department and the New York State Department of Health of its intention to operate and

market 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. (ñNYLCareò), an HMO, merged with and into the HMO.

On December 31, 2001, Prudential Health Care Plan of New York, Inc. (ñPruCareò) merged with and into the HMO. Concurrent with that merger, the HMOôs 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 (ñAHHò). AHHôs ultimate parent is Aetna Inc.

As of December 31, 2015, the HMOôs capital was $6, consisting of 552 shares issued and outstanding of $.01 par value per share common stock and paid-in-surplus of $74,956,549. 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.

The HMO withdrew from New Yorkôs small and large group commercial markets pursuant to a withdrawal plan reviewed by the Department and DOH and placed on file as of February 20, 2015. Large groups were non-renewed as of their renewal date on or after August 31, 2015, and small groups were non-renewed as of December 31, 2015.

A. Corporate Governance

As of the examination date, the HMOôs board of directors was comprised of three members. The composition of the board of directors was in compliance with the HMOôs 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, 2015, the HMOôs board of directors consisted of the following members:

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

* Enrollee/member representative per Part 98-1.11(f) of the Administrative Rules and Regulations of the New York State 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 board certification requirements of Insurance Circular Letter No. 9 (1999).

The principal officers of the HMO as of December 31, 2015 were as follows:

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

* Dawn M. Schoen was elected as Principal Financial Officer and Controller October 1, 2014.
** Steven M. Conte was elected as Assistant Controller as of October 1, 2014.

B. Territory and Plan of Operation

As of December 31, 2015, AHI was authorized to operate as a health maintenance organization pursuant to Article 44 of the New York Public Health Law in the following thirty-two counties of New York State.

Albany*	Kings*	Orleans*	Seneca*
Bronx*	Livingston*	Oswego*	Suffolk*
Broome*	Monroe *	Putnam	Sullivan*
Cayuga*	Nassau *	Queens *	Tioga *
Columbia*	New York*	Rensselaer*	Ulster
Dutchess	Onondaga *	Richmond*	Wayne*
Genesee*	Ontario*	Rockland*	Westchester*
Greene*	Orange*	Schenectady*	Yates*

* Counties designated to offer Medicare Advantage

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 (ñPCPò). The PCP refers subscribers to other participating HMO physicians when particular medical specialties are required. Except for services specifically excluded or limited in the HMOôs 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 HMOôs 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 (ñPOSò), which permits the member to obtain medical treatment outside the HMOôs 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 (ñAHICò).

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:

	2011	2012	2013	2014	2015
Enrollment	82,170	78,522	75,164	50,145	30,677
Line of Business					
HMO Large Group	$305,328,551	$276,802,504	$249,209,682	$215,854,932	$87,275,204
HMO Small Group	18,294,072	30,592,374	61,688,425	39,723,907	0
HMO Individual POS	23,651,918	21,002,494	18,996,114	7,574,825	(230,366)
POS Large Group (ER)	64,172,261	47,355,210	25,664,911	20,253,805	15,381,400
POS Small Group (IN)	6,651,254	6,693,754	6,998,849	4,186,585	0
POS Individual (OON)	21,108,843	18,306,248	16,736,892	8,121,682	106,926
Healthy New York	21,828,885	21,871,133	20,926,358	14,685,281	17,357,790
Medicare Advantage	174,336,198	173,219,217	172,898,086	180,497,089	173,350,963
Total Premium	$ 635,371,982	$ 595,842,934	$ 573,119,317	$490,898,106	$293,241,917

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

The HMOôs membership declined throughout the examination period. As of December 31, 2015, the total number of members reported was 30,677, a decline of more than 67,000 members from the previous examination. This is mostly explained by the Companyôs decision to withdraw from the large and small group markets in early 2015.

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 AHIôs net admitted assets, capital and surplus, net premium income and net income during the period under examination:

	(in Thousands)			
	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income
2011	$ 394,676	$ 208,648	$ 635,372	$ 28,967
2012	363,859	247,138	595,843	73,586
2013	362,342	242,407	573,119	42,570
2014	285,199	176,501	490,898	25,405
2015	275,955	198,385	293,242	15,162

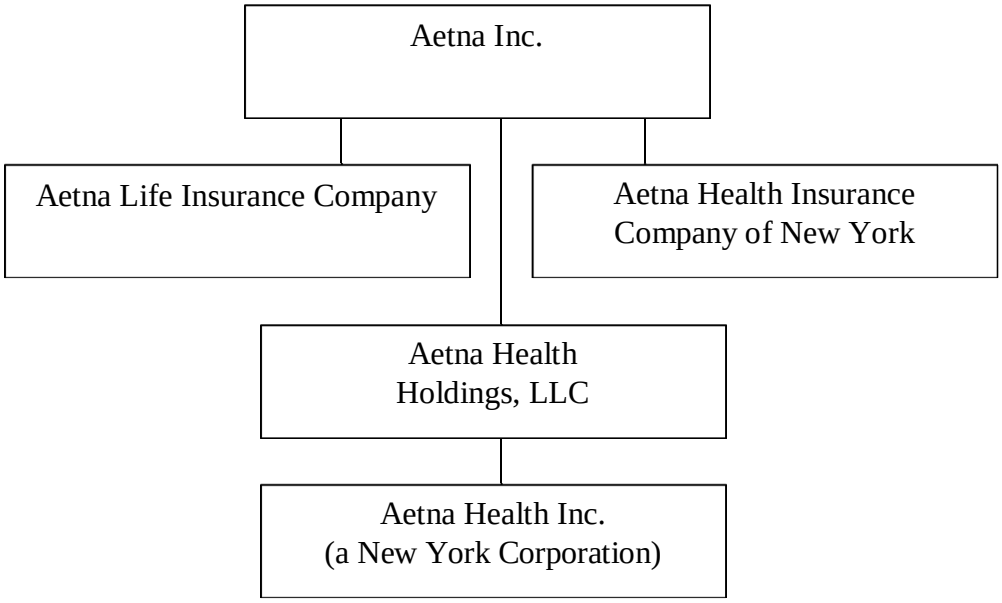
C. Reinsurance

Effective April 1, 2014, the HMO entered into a quota share reinsurance contract with Fresenius Medical Care Reinsurance Company (ñFreseniusò) (Cayman) LTD reinsurance during the examination period. The agreement provides for reinsurance of 100% of eligible medical expenses. This covers a defined set of Medicare Advantage members, e.g., those members with End Stage Renal Disease (ñESRDò) who receive dialysis services from Fresenius Medical Care. The agreement caps the Companyôs risk at the reinsurance premium of 100% of the Medical Billing & Reimbursement rate or (ñMBRò); anything above 100% MBR is essentially a gain for the Company and loss for Fresenius.

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, 2015.



The following is a description of the HMOôs major affiliations as of December 31, 2015:

Aetna Inc. is the ultimate parent of all the 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 the out-of-network POS coverage to members of small and large groups of AHI. Aetna Health Holdings, LLC acts as a holding company of Aetnaôs 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:

> ñEvery 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.ò

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 agreement	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 was provided, as applicable. All such agreements were approved by the Department and the DOH.

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 entityôs financial statements. AHICôs business is comprised solely of the out-of-network business derived from the HMOôs POS business.

The current methodology for the allocation of administrative expenses to AHIC is based on the premium volume as it relates to its affiliated company, AHI. AHIC only provides claim services for out-of-network claims serviced by AHI. The methodology appears to include all of AHIôs expenses that are based on membership in various product lines it serves. As an example, AHI provides services to its Medicare customers whereas AHIC does not have any Medicare business.

It is recommended that the allocation methodology relative to the HMOôs Inter-Company Transfer Agreement with AHIC be amended to ensure that the allocated costs only pertain to the products offered by AHIC.

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 HMOôs tax liability and asserts the Parentôs right to escrow tax payments under certain circumstances to assure the Parentôs 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 HMOôs 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 (ñAHMò). 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 Company (ñALICò). This agreement permits ALIC to provide the personnel necessary to perform administrative services. These services exclude broker and commissions, bad debt expenses, premium taxes, state and/or guaranty fund assessments, among others.

E. Significant Operating Ratios

The following ratios have been computed as of December 31, 2015 based upon the results of this examination:

Ratio	2015
Net Change in Capital and Surplus	12.4%
Current Liabilities to Liquid Assets & Receivables	310.1%
Disenrollment	- 38.8%
Premium and Risk Revenue to Capital and Surplus	1.50 to 1
Medical Loss Ratio	78.3%
Combined Loss Ratio	94.9%
Administrative Expense Ratio	16.6%

The above ratios fall within the benchmark ranges set forth in the Financial Analysis Solvency Tools (ñFASTò) scoring ratios of the NAIC except for Disenrollment and the Administrative Expense Ratio. These ratios were impacted by the HMOôs decision to withdraw from the large and small group markets.

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	$ 2,066,747,604	79.2%
Other claim adjustment expenses	10,084,596	0.4%
Cost containment expenses	21,821,581	0.8%
General administrative expenses	293,700,609	11.3%
Net underwriting gain	216,893,943	8.3%
Net premium income	$ 2,609,248,333	100.0%

F. Accounts and Records

Certain errors were made with regard to the HMOôs reporting of compensation in its 2015 annual statement filing to the Department. Amounts reported on Schedule G were incorrectly reported for two highly compensated officers. In addition, the amounts reported as allocated to the respective Aetna entities were incorrect. One company reported 100% of the officersô paid salaries while the other company was allocated 0%. Neither of these allocations were correctly reported.

It is recommended that the HMO review its statutory reporting of compensation and report accurate, reconciled compensation amounts within its filed annual statements.

G. Medical Loss Ratio

The Affordable Care Act requires insurers to spend a minimum percentage of premium dollars on medical services and activities designed to improve healthcare quality and submit a medical loss ratio (ñMLRò) report to present this information.

As part of the coordinated examination of the Aetna Inc. holding company group, Aetnaôs processes and controls designed to mitigate specific risks associated with MLR reporting were reviewed and tested. No material exceptions were identified.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2015 as contained in the HMOôs 2015 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review.

The firm KPMG, LLP was retained by AHI to audit the HMOôs combined statutory basis statements of financial position as of December 31st of each year in the examination period and the related statutory basis statements of operations, surplus, and cash flows for the year then ended.

KPMG, LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the HMO at the respective audits. Balances reported in these audited financial statements were reconciled to the corresponding yearsô annual statements with no discrepancies noted.

A. Balance Sheet

Assets

Bonds	$ 211,604,017
Common stocks	20,992,209
Cash and cash equivalents, short term investments	10,313,506
Securities lending reinvested collateral assets	0
Investment income due and accrued	1,745,451
Uncollected premiums in course of collection	9,562,342
Accrued retrospective premiums and contracts subject subject to redetermination	57,237
Amounts receivable relating to uninsured plans	5,941,249
Current federal and foreign income tax recoverable and interest thereon	1,504,234
Net deferred tax asset	9,606,916
Health care and other amounts receivable	1,061,822
Aggregate write-ins for other than invested assets	3,566,332
Total assets	$ 275,955,315

Liabilities

Claims unpaid	$ 33,832,131
Accrued medical incentive pool and bonus amounts	1,424,930
Unpaid claims adjustment expenses	490,502
Aggregate health policy reserves	4,743,086
Aggregate health claim reserves	173,297
Premiums received in advance	122,829
General expenses due or accrued	26,818,579
Amounts due to parents, subsidiaries and affiliates	9,791,355
Funds held under reinsurance treaties	65,803
Reinsurance in unauthorized companies	26,787
Aggregate write-ins for other liabilities	80,819
Total liabilities	$ 77,570,118

Capital and Surplus

Aggregate write-ins for special surplus funds	$ 5,440,000
Common capital stock	6
Gross paid in and contributed surplus	74,956,549
Aggregate write-ins for other than special surplus funds	36,735,500
Unassigned funds (surplus)	81,253,142
Total capital and surplus	$ 198,385,197
Total liabilities, capital and surplus	$ 275,955,315

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan during the period under this examination. The examiner is unaware of any potential exposure of the Plan to any further tax assessment, and no liability has been established relative to such contingency.

B. Statement of Revenue, Expenses and Changes in Surplus

Capital and Surplus increased $22,388,091 during the five year examination period, January 1, 2011 through December 31, 2015, detailed as follows:

Revenue		
Net premium income	$2,588,474,256	
Change in unearned premium reserves	20,774,077	
Total revenue		$2,609,248,333
Hospital and medical expenses		
Hospital/medical benefits	$1,616,069,981	
Other professional services	3,230,197	
Outside referrals	63,307,804	
Emergency room and out-of-area	57,124,775	
Prescription drugs	447,136,250	
Aggregate write-ins for other hospital medical	(126,484,013)	
Incentive pool, withhold adjustments & bonus amts.	7,524,112	
Total hospital and medical benefits	$2,067,909,106	
Less: Net reinsurance recoveries	1,161,502	
Total hospital and medical	$2,066,747,604	
Administrative expenses		
Claims adjustment expenses	31,906,177	
General administrative expenses	293,700,609	
Increase in reserves for life and accident and health Contracts	0	
Total underwriting deductions		$2,392,354,390
Net underwriting gain/loss		$ 216,893,943
Net investment income earned	48,177,957	
Net realized capital gains/losses	6,932,961	
Net investment gains/losses		55,110,918
Aggregate write-ins for other expense		(287,296)
Net income before federal and foreign income taxes		$ 271,717,565
Federal and foreign income taxes incurred		86,027,083
Net income		$ 185,690,482

Changes in Capital and Surplus

Capital and surplus, per report on examination as of December 31, 2010			$ 175,997,106
	Gains in Surplus	Losses in Surplus	
Net income	$ 185,690,482		
Dividend to stockholder		$ 176,200,000	
Net unrealized capital gains	365,286		
Change in net deferred income tax		1,870,281	
Change in non-admitted assets	7,346,871		
Change in unauthorized reinsurance		26,787	
Surplus adjustment	5,000,000		
Aggregate write-ins for gains or losses	2,082,520		
Net increase in capital and surplus			22,388,091
Capital and surplus, per report on examination, as of December 31, 2015			$ 198,385,197

4. SUBSEQUENT EVENTS

The New York State Department of Health amended the Certificate of Authority (ñCOAò) for Aetna Health, Inc. to withdraw from the New York commercial health insurance market effective October 1, 2016. The amended COA also included a ban on the sale of commercial products in the state for a 5 year period from October 1, 2016 ï September 30, 2021, and authorized the continued sales of Medicare Advantage products.

However, certain members of AHI were inadvertently renewed, contrary to what was contemplated in the withdrawal plan filed with New York State Department of Financial Services on February 20, 2015. Through June 30, 2017, all members identified have been transitioned to other plans.

The Department is currently monitoring the above withdrawal and transition plan.

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.
	Enterprise Risk Management (ñERMò)	
1.	It is recommended that historic records of ERM dashboards be maintained to facilitate monitoring of risk management performance. *The HMO has complied with this recommendation.*	19
	Accounts and Records	
2.	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 AHICôs filed annual statement, in accordance with the Annual Statement Instructions of the *National Association of Insurance Commissioners* (ñNAICò). *The HMO has complied with this recommendation.*	25
3.	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. *The HMO has complied with this recommendation.*	25
4.	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. *The HMO has complied with this recommendation.*	26

ITEM NO. **PAGE NO.**

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	**Inter-Company Expense Allocations**	
	It is recommended that the allocation methodology relative to the HMOôs Inter-Company Transfer Agreement with AHIC be amended to ensure that the allocated costs only pertain to the products offered by AHIC.	15
B.	**Statutory Filings**	
	It is recommended that the HMO review its statutory reporting of compensation and report accurate, reconciled compensation amounts within its filed annual statements.	18

Respectfully submitted,

David Crandall, CFE

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

David Crandall being duly sworn deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
David Crandall, CFE

Subscribed and sworn to before me
This _____ day of _____2017

APPOINTMENT NO. 31421

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***SHIRIN EMAMI****, Acting Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

David Crandall

as a proper person to examine the affairs of

Aetna Health Inc. (a New York Corporation)

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

HMO

with such other information as he shall deem requisite.

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

this 4th day of February, 2016

SHIRIN EMAMI
Acting Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau