REPORT ON EXAMINATION

OF

AETNA HEALTH INC.
(a New York corporation)

AS OF

DECEMBER 31, 2002

DATE OF REPORT: **APRIL 23, 2004**

EXAMINER: **KATHLEEN GROGAN**

TABLE OF CONTENTS

ITEM NO.		PAGE NO.
1.	Scope of examination	2
2.	Description of Plan	3
	A. Management	4
	B. Territory and plan of operation	6
	C. Holding company system	7
	(i) Holding company structure	7
	(ii) Service agreements	8
	(iii) Dividends	16
	D. Reinsurance	17
	E. Accounts and records	17
3.	Financial statements	20
	A. Balance sheet	20
	B. Statement of revenue and expenses and Capital and surplus account	21
4.	Claims payable	22
5.	Compliance with prior report on examination	23
6.	Summary of comments and recommendations	25

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

April 23, 2004

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and in compliance with the instructions contained in Appointment Number 21922 dated August 8, 2002, attached hereto and in accordance with the New York Insurance Law, 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, 2002. The following report, as I respectfully submitted, pertains mainly to the financial condition of Aetna Health Inc. (a New York Corporation), its corporate governance, internal controls and the conduct of the examination.

The examination was conducted at the Plan's administrative office located at 980 Jolly Road, Blue Bell, Pennsylvania 19422.

Whenever the terms "the Plan" or "the HMO" appear in this report without qualification, they should be understood to refer to Aetna Health Inc. (a New York corporation).

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1996. This examination covers the six-year period January 1, 1997 through December 31, 2002. Transactions occurring subsequent to this period were reviewed where deemed appropriate.

The examination comprised a complete verification of assets and liabilities as of December 31, 2002 in accordance with Statutory Accounting Principles 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 Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiner's Handbook of the National Association of Insurance Commissioners:

History of the Plan
Management and control
Corporate records
Fidelity bond and other insurance
Territory and plan of operation
Officers' and employees' welfare and pension plans
Growth of the Plan
Loss experience
Accounts and records
Financial statements

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

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 concurrent examination of the Aetna Health Insurance Company of New York (AHIC) was performed. Some members of the HMO also have indemnity contracts with AHIC under

point of service products in which "out-of-network benefits" are offered. A separate report on examination is issued for AHIC.

2. DESCRIPTION OF PLAN

Aetna Health Inc. (a New York corporation) was incorporated in New York on June 24, 1985 to operate as a health maintenance organization (HMO) under the name US Healthcare, Inc. It was certified as an HMO by the State of New York Department of Health (DOH) on February 3, 1986 and began operations on May 1, 1986. The Plan is licensed as a for-profit, independent practice association (IPA) model HMO pursuant to the provisions of Article 44 of the New York State Public Health Law. When licensed, the Plan was a subsidiary of U.S. Healthcare, Inc. (US Healthcare) a Pennsylvania corporation.

On July 19, 1996, US 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, US 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 Parent).

The Plan filed with the New York State Department of State to operate under the assumed name (d/b/a) of Aetna US Healthcare, effective January 1, 1997. The Plan notified the Department and DOH of its intention to operate under the assumed name of Aetna US Healthcare

and marketed its products under such name. The Plan continued to operate under the US Healthcare name with regard to statutory filings with the Department until the 2001 name change to Aetna Health Inc. (a New York corporation).

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

On December 31, 2001, Prudential Health Care Plan of New York, Inc. (PruCare), an HMO merged with and into the Plan.

Concurrent with the merger with PruCare, the Plan's name was changed to Aetna Health Inc. (a New York corporation).

The Plan issued 152 shares of common stock in exchange for all the common and preferred stock of NYLCare and it issued 200 shares of common stock in exchange for all the common stock of PruCare.

Capital paid-in is $69,956,555 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, the parent is the sole owner of all issued stock. The Plan has an additional 9,448 shares of $.01 par value per share common stock authorized which have not been issued.

A. Management

Pursuant to the Plan's charter and by-laws, management of the Plan is vested in a board of directors consisting of three members, at least one-third of whom must be residents of New York State and are enrollees of the Plan. As of the examination date, the board of directors was comprised of three members.

The number of board meetings decreased from four times each calendar year to two times

each calendar year during the period under review. The following chart shows the total number of Board meetings held in each year:

Year	Number of meetings
1997	4
1998	4
1999	4
2000	2
2001	3
2002	2
2003	2

The Directors as of December 31, 2002 were as follows:

Name and Residence	Principal Business Affiliation
Mary Claire Bonner New York, NY	Chief Executive Officer and President Aetna Health Inc. (NY) and Aetna Health Insurance Co of New York President of Aetna Health Inc. (CT) President of Aetna Health Inc.(MA) President of Aetna Health Inc. (NH) President of Aetna Health Inc. (ME)
Lydia Cavieux Cortlandt Manor, New York	Supervisor, Health Information Management Horton Medical Center Middletown, New York Senior Lecturer, New York Medical College Valhalla, New York Adjunct Faculty, Fordham University School of Social work, Bronx, New York
Wayne Sedrick Rawlins, MD Glastonbury, Connecticut	Northeast Region Medical Director

It is noted that Dr. Gordon W. Grundy of New Britain, Connecticut replaced Dr. Rawlins as director on February 6, 2003.

A review of the minutes of the meetings of the Board of Directors indicated that the meetings were well attended.

At December 31, 2002, the principal officers of the Plan were as follows:

Name	Title
Mary Claire Bonner	President
Gregory Stephen Martino	Corporate Secretary
Russell Page Smith	Treasurer
Emanuel Francis Germano	Principal Financial Officer
Kevin James Casey	Senior Investment Officer

B. Territory and plan of operation

As of December 31, 2002, the Plan was licensed to operate as an HMO pursuant to Article 44 of the New York Public Health Law in the following nineteen 19 counties: Bronx, Broome, Cayuga, Dutchess, Kings, New York, Nassau, Onondaga, Orange, Oswego, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Tioga, Ulster, Westchester.

Total enrollment peaked in 1999 and declined significantly in 2001 and in 2002. The following schedule shows the number of members enrolled at the end of each year, by line of business and premium earned, for the six-year examination period:

Line of Business	1997	1998	1999	2000	2001	2002
Group HMO	407,325	413,365	462,729	488,299	439,411	308,336
Group POS	183,093	255,199	381,053	325,894	243,685	123,485
Individual POS & HMO	13,376	14,833	15,082	17,286	18,976	19,264
Healthy New York	0	0	0	0	0	721
Medicare	29,680	39,898	77,555	65,243	32,430	20,512
Medicaid	26,074	0	0	0	0	0
Total enrollment	659,548	723,295	936,419	896,722	734,502	472,318
Premium Earned (in 000's)	$1,137,014	$1,281,771	$1,745,422	$2,199,725	$2,031,762	$1,627,251

The Plan's membership continued to decline throughout 2003. The total number of

members reported at year-end 2003 was 365,599. This trend is attributed to Aetna Inc.'s corporate marketing policy.

Amounts shown under "Prior Year End" in the 2001 filed annual statement Schedule 1-Enrollment Data (in NY Data Requirements) are different from amounts shown under "Current Year End" in the 2000 filed annual statement Schedule 1 - Enrollment Data due to the mergers with NYLCare and PruCare. Enrollment data for PruCare and NYLCare were included in 2001 prior year data for comparative purposes.

The Plan non-renewed its Medicare Choice Plan in five counties (Dutchess, Orange, Putnam, Nassau and Suffolk) as of 2001. The Plan continues to write Medicare policies in seven counties; the five counties comprising New York City, Rockland and Westchester.

Subsequent to the merger between Aetna Life and Casualty Company and U.S. Healthcare Inc., an affiliate of the Plan, Aetna Health Plans of New York Inc. (AHP) was dissolved. All AHP enrollees received notice of AHP's plan to withdraw and were offered coverage by the Plan. All enrollees wishing to do so were subsumed into the Plan by 1998.

C. Holding company system

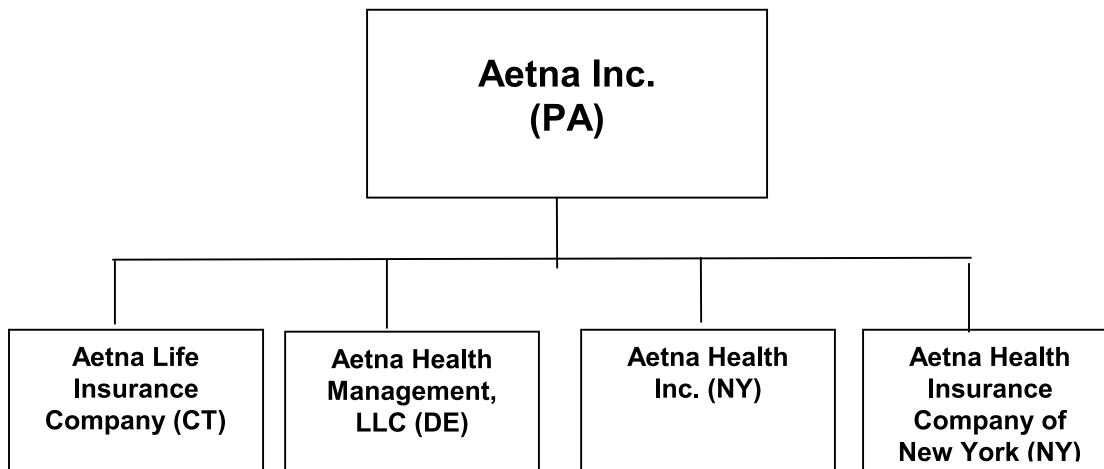
(i) Holding company structure

At December 31, 2002, the HMO was a subsidiary of Aetna Inc., "the Parent" a Pennsylvania corporation.

As of September 30, 2003, the HMO became a subsidiary of Aetna Health Holdings, LLC, (AHHLLC) a direct subsidiary of the Parent, via a contribution of all of the Plan's outstanding capital stock to AHHLLC. The transaction was approved by DOH. AHHLLC was formed on October 25, 2002.

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

A condensed organization chart reflects the relationship between the Plan and significant entities in the holding company system as of December 31, 2002 follows:



(ii) Service agreements

At December 31, 2002, the Plan was a party to seven service agreements; six with the Parent and one with AHIC. Four of the seven agreements date back to the initial licensing of the HMO as US Healthcare, in 1986.

The following is a list of the seven agreements, the effective date of the agreement and the contracting party:

No.	Name of Agreement	Contracting party*	Effective date
1	Line of credit	Aetna Inc.	1/6/1986
2	Subordination agreement	Aetna Inc.	1/6/1986
3	Guarantor agreement	Aetna Inc.	1/6/1986
4	Administrative services agreement	Aetna Inc.	1/6/1986
5	Cash management agreement	Aetna Inc.	3/1/1993
6	Tax sharing agreement	Aetna Inc.	12/14/2000
7	Intercompany transfer agreement	AHIC	1/1/2000

* Current Name

Additionally the Plan receives pharmacy benefit management services from its affiliate, Aetna Health Management, LLC (AHM.) This is discussed below under item 8. Pharmacy Benefits Management.

Following is a description of each of the agreements.

1. Line of credit

The Parent provided a $5,000,000 line of credit to the Plan to finance operating costs and cash needs.

2. Subordination agreement

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

3. Guarantor agreement

The Parent provides benefits to subscribers and dependents in the event of the Plan's insolvency.

4. Administrative Services Agreement

Effective January 6, 1986, the Plan entered into an agreement with the Parent that calls for the Parent to provide the necessary administrative and personnel services in order for the Plan to operate as an HMO. These services include: management of personnel, assuring compliance with government regulations, maintenance of licenses and permits, maintaining confidentiality of records, making recommendations regarding the scope of member services, preparing an annual operating budget, maintenance of proper accounting records, provision of adequate management information systems, recommending premium rates, providing legal services, contract negotiation, recommending marketing practices, purchasing equipment and operating supplies, preparation of such reports as may be required by regulatory agencies and other ancillary services.

The agreement called for a service fee of 5% of premiums to be paid on a monthly basis to the Parent (then US Healthcare) as compensation for these services.

The Administrative Services Agreement was approved by the Department and by the Department of Health pursuant to Part 98-1.11(h) of the Administrative Rules and Regulations of the NYS Department of Health Department (10 NYCRR Part 98.11(h)). In accordance with this approval, the administrative services agreement is considered a "management contract" and is therefore subject to the 10 NYCRR Part 98-1.11(h) requirements of a management contract.

Part 98-1.11(h) states:

> "The term of the management contract shall be limited to five years and may be renewed only when authorized by the commissioner, provided compliance with this section and the following provisions:
> (1) that the goals and objectives of the contract have been met within specified time frames
> (2) that the quality of care provided by the facility during the term of the contract has been maintained or has improved and that any report requirements contained in the management contract have been met."

The Plan did not submit the contract for renewal at the end of the initial five year term as required by Part 98.11(h).

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.

A review of the services received by the HMO and the associated fees paid, revealed that the agreement did not address the actual current systematic transactions occurring between the Plan and its parent. Almost all administrative services are provided to the Plan by the Parent.

10 NYCRR Part 98-1.10 states:

> "(a) Transactions within a holding company system to which a controlled HMO is a party shall be subject to the following guidelines:
>
> (1) the terms of the financial transaction shall be fair and equitable to the HMO at the time of the transaction.
> (2) charges or fees for services performed shall be reasonable; and
> (3) expenses incurred and payments received shall be allocated to the HMO on an equitable basis in conformity with customary accounting practices consistently applied.
>
> (b) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.
> c) The commissioner's and the superintendent's prior approval shall be required for the following transactions between a controlled insurer and any person in its holding company system: sales, purchases, exchanges, investments or rendering services on a regular basis the aggregate of which involves 10 percent or more of the HMO's admitted assets at last year-end."

For the year 2002, the Plan paid the Parent $80,841,491 which represented 5% of premium as the management fee called for under the agreement.

Additional administrative expenses, in the amount of $34,338,501, were allocated to the Plan by the Parent. The service agreement did not encompass these additional expenses.

It is recommended that the Plan develop an administrative services agreement that meets the requirements of 10 NYCRR Part 98-1.10.

It is further recommended that the Plan develop an agreement that encompasses all costs allocated to the HMO by the provider of services.

Employees of the Aetna Life Insurance Company (ALIC), an affiliate of the Plan, perform the administrative services called for under the agreement. Payroll expenses were disbursed by ALIC. The Plan stated that ALIC's role as issuer of the checks is solely as the "paymaster" and that the ALIC payroll bank account is funded by Aetna Inc. for all HMO salary expenses. The Plan further stated that the payroll transactions are recorded on the books of Aetna Inc. No service agreement exists between ALIC and the Plan and no agreement exists detailing the role of ALIC with regard to payment of the salaries.

It is recommended that the Plan establish an agreement with ALIC detailing ALIC's role in the providing of services and paying of employees.

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 intercompany transactions.

It is noted that the Plan submitted a new administrative services agreement to the Department in January of 2004. This agreement addresses the aggregation of all HMO costs under one affiliate, AHM. The agreement is under review as of this writing.

5. Cash Management Agreement

The Plan and certain affiliates participate in a centralized cash processing and cash management system administered by the Parent. The Parent performs cash management functions including cash collections, cash disbursements and investment management

services. Cash balances, for premiums collected, claims disbursed and other cash collections or disbursements, are netted and settled with each participating entity on a monthly basis.

These services have been performed by the Parent since 1993. The Plan submitted an agreement covering these services to the Department in 1992, which was never approved. Subsequently a new agreement was submitted to the Department. This Cash Management Agreement (CMA) was approved on December 4, 2003.

It is recommended that the Plan obtain approval for its cash management agreements prior to implementation.

The recently approved CMA states:

> "3. Conditions of Participation. All depository, disbursement, investment and other accounts holding assets of HMO shall be in the name of HMO holding valid certificate of authority issued by applicable state regulatory authorities.
> 4. Settlement of accounts. Intercompany balances resulting from the operation of the systems shall be settled as to HMO within 30 days after the end of each month."

It is noted that the Plan's collected premium assets were not held by the Plan until the date that the monthly intercompany settlement occurred. Rather the premiums were held by the Parent and recorded by the Plan as an intercompany receivable until settlement. Intercompany settlements occurred on a monthly basis, generally within one month of the previous month's end. The Plan does not maintain a cash operating account since all premiums are collected and claims paid on its behalf by the parent.

It is recommended that the Plan adhere to the terms of the CMA by maintaining its assets in an account under its own name.

The Plan settles intercompany accounts monthly, but was unable to provide documentation to support the premium collected. The premium collected figure is derived

from the amount billed, write-offs and other adjustments. The Plan stated that all premiums were reconciled to the group's total billed premium rather than to the Plan's billed premium. Many of the Plan's groups are multi-state groups and the premium is split between the Plan and the affiliated HMOs. The collections of year-end premium receivable were traced to the groups by the examiners.

It is recommended that the Plan develop a system to directly tie into the premium collected and provide a clear auditable trail for premium collected.

Part 98-1.11(a) of the Administrative Rules and Regulations of the New York State Health Department states:

> "The HMO function shall be clearly distinguished from any other functions through the maintenance of separate records, reports and accounts for the HMO function. Each line of business of an HMO shall be distinguished from any other line of business of that HMO. The records, reports and accounts of each HMO shall be maintained separately from those of other persons or HMO's in the holding company system. All records pertaining to the article 44 certified HMO shall be maintained in New York State."

The examiner concluded that based on the frequency, regularity and nature of the above described transactions, combined with the lack of adequate identification of cash collected by the Parent and lack of physical control of assets, that the Parent ran the operations of the HMO as if it were a division of the Parent corporation and failed to adequately maintain the Plan's distinct operating identity as required by Part 98-1.11(a) of the Administrative Rules and Regulations of the New York State Department of Health.

It is recommended that the HMO provide for improved identification and physical control of its assets so as to better maintain separate records from those of the Parent, in order to be in full 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.

It is noted that the CMA was not filed with the Department of Health. It is recommended that the Plan file its CMA with DOH in accordance with 10 NYCRR Part 98. The Plan states that the CMA will not be filed with the DOH in anticipation of approval of the recently submitted administrative services agreement. It is noted that the Plan recently submitted, for review, a new administrative services agreement which includes cash management services to be provided by AHM. The Plan has begun the process of changing the ownership of some of its shared accounts from Aetna Inc. to AHM.

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.

6. Intercompany Transfer Agreement

The Plan entered into an Intercompany Transfer Agreement, effective January 1, 2000 with its affiliate AHIC. The agreement provides for POS premiums to be allocated equitably between the Plan and 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 the Plan's and in AHIC's financial statements. AHIC's business is comprised solely of out-of-network business from the Plan's POS business. Comments regarding the accounting for premiums addressed by this agreement appear in the AHIC report on examination.

7. Tax sharing agreement

The Plan, as well as several of its affiliates, filed a consolidated Federal Income Tax return with the Parent, Aetna Inc.

The Plan's tax sharing agreement with the Parent was approved by the Department effective January 1, 2000. A new agreement was submitted to the Department and approved June 12, 2003. This agreement was not filed with DOH.

It is recommended that the Plan file its tax sharing agreement with DOH in accordance with 10 NYCRR Part 98.

8. Pharmacy Benefits Management

Pharmacy benefits management services (PBM) are provided to the Plan by its affiliate, Aetna Health Management, LLC (AHM). AHM negotiates rebates with pharmaceutical companies on behalf of the Plan and participating affiliates. Currently no written agreement exists between AHM and the Plan. It is also noted that no fee for these services was paid to AHM.

It is recommended that the Plan document:

1. The PBM services provided to the Plan by AHM
2. The supporting detail regarding the allocation and settlement of pharmaceutical rebates with AHM
3. The fee paid for these services to AHM

It is noted that the Plan's recently submitted new Administrative Services Agreement includes PBM services. However, as stated above, this agreement has not yet been approved.

(iii) Dividends

The Plan paid $150,000,000 in dividends to the Parent during the examination period. An additional $195,000,000 was paid to the Parent in 2003. The following chart shows the dividends paid during the examination period and in 2003.

Year	Dividend payment amount
1997	$ 27,800,000
1998	47,200,000
1999	40,000,000
2000	0
2001	0
2002	35,000,000
2003	195,000,000

The Plan was unable to demonstrate that the dividends paid in 1997, 1998 and 1999 were approved by its Board of Directors. All dividend payments were approved by the Department.

It is recommended that the Plan generate and retain Board of Directors' approvals of all dividend payments.

D. Reinsurance

The Plan reported that it ceded reinsurance in 2001 to its affiliate ALIC on Prucare business. The treaty became null and void at the time of the Plan's merger with Prucare.

The Plan reported no reinsurance ceded or assumed in 2002.

E. Accounts and records

(i) Custodian agreement and bank statements

The Plan is a party to a custodian agreement between Aetna Life Insurance Company (ALIC) and its bank. The agreement contains a listing of all participating affiliated entities. It was noted that the Plan's name on the custodian agreement was shown as US Healthcare.

It is recommended that the custodian agreement be revised to reflect the Plan's current legal name.

A review of the custodian agreement revealed that the following protective covenants and provisions were not included as part of the agreement:

- "The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the insurer or HMO 60 days written notice of any material change in the form or amount of

such insurance of termination of this coverage.

- The agreement should have a provision that would give the insurer or HMO the opportunity to secure the most recent report on the review of the custodian's system of internal control pertaining to custodian record keeping, issued by internal or independent auditors."

It is recommended that the Plan assure that the custodian agreement complies with the suggested protective covenants and provisions. It is noted that the custodian bank maintained the recommended Bankers Bond Insurance however, the custodian agreement did not contain the required 60 day notice of change or termination in coverage. Additionally, it is noted that the Plan amended the agreement March 31, 2004 and the current agreement now contains a provision that provides the Plan with the opportunity to secure the most recent report on the review of the custodian's system of internal control issued by internal or independent auditors.

(ii) Individual claims

The Plan reported $35,986,923 as individual paid claims in its 2002 Exhibit of Revenue and Expenses by Line of Business in the filed Data Requirements supplement to the Annual Statement.

A review of underlying data for years 2000 and 2001 revealed that significant items, not specifically attributable to the individual line of business, were included in the individual paid claims. Furthermore, certain non-lag items, not specifically attributable to the individual line of business, were included in the individual paid claims. Settlements or lump sum HCRA payments, totaling $976,396 in 2000 and $1,232,038 in 2001, were erroneously included in individual paid claims.

A review of the 2002 individual paid claims population was subsequently performed. This revealed that the individual paid claims figure was overstated by $1,480,583, or 4.1%.

The erroneous inclusion of these items with individual paid claims distorts the reported

net income on the individual line of business as reported in the filed New York Data Requirements supplement to the Annual Statement.

Improperly allocated paid claims can potentially impact the Plan's rate filings and the statutory "Loss Ratio Report". It was determined that the inclusion of these items in 2002 did not impact the rate filings or loss ratio report due to manual actuarial adjustments to the data prior to filing the reports with the Department.

It is recommended that the Plan report only individual claims in the individual line of business results.

It is noted that the Plan did not accrue for recoveries from the statutory direct pay stop loss pool as of the examination date. Estimates for such recoveries should be incorporated into the review of claims unpaid in accordance with SSAP #55 and / or SSAP #61.

It is recommended that the Plan accrue for anticipated stop loss pool recoveries.

(iii) Schedule Y

The Plan reported $158,737,482 as payments to affiliates. This amount was comprised of $80,841,491 paid to the Parent as a management fee, in accordance with its Administrative Services Agreement, and $77,895,991 was paid to the parent in accordance with its Tax Allocation Agreement. The Plan did not include $34,338,501 paid to the Parent for allocated expenses.

It is recommended that the Plan include allocated expenses paid to the Parent in Schedule Y.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and reserves and unassigned funds as determined by this examination as of December 31, 2002, and as reported by the Plan. The statement is the same as the balance sheet filed by the HMO.

Net Admitted Assets

Bonds	$489,264,915
Cash	130,711,053
Accident and health premiums due and unpaid	40,446,032
Health care receivables	10,370,002
Investment income due and accrued	5,665,215
Amount due from parent, subsidiaries & affiliates	49,621,335
Federal & foreign income tax recoverable	29,181,215
State income tax recoverable	14,888,386
Total assets	$770,148,153

Liabilities, capital and surplus

Claims unpaid	$323,385,861
Unpaid claims adjustment expenses	6,266,522
Aggregate policy reserves	23,037,691
Aggregate claims reserves	8,291,945
Premium received in advance	12,864,098
General expenses due or accrued	10,317,941
Federal & foreign income tax payable	1,716,177
Amount due to parents, subsidiaries and affiliates	2,801,724
Payable for securities	22,167,247
Federal contingency reserve	704,397
Total Liabilities	411,553,603
Common capital stock	6
Gross paid in & contributed surplus	69,956,549
Contingency reserve	81,362,577
Unassigned funds (surplus)	207,275,418
Total capital and surplus	358,594,550
Total liabilities, capital and surplus	$770,148,153

B. Statement of Revenue and Expenses and Capital and surplus account

Capital and surplus increased $213,464,635 during the six-year examination period, January 1, 1997 through December 31, 2002 detailed as follows:

Statement of Revenue and Expenses

Premium earned		$10,022,945,738
Deductions:		
Claims incurred	$8,500,822,414	
Claim adjustment expenses	91,783,758	
Administrative expenses	990,772,710	
Increase (decrease) in reserve	12,134,555	
Total underwriting deductions		9,595,513,437
Net underwriting gain		427,432,301
Net investment income earned		148,501,063
Change in unearned premium reserve and reserve for rate credits		(10,281,348)
Provision for federal income taxes		(204,313,205)
Net Income		$ 361,338,811

Capital and surplus account

Reserves and unassigned funds per report on examination December 31, 1996		$105,278,281
Net income	$361,338,811	
Change in non-admitted assets	21,417,356	
Correction of non-admitted premium receivable in prior period	(6,340,145)	
Correction of non-admitted healthcare receivable in prior period	(26,146,489)	
Increase in paid in surplus	14,500,000	
Net realized capital gain	133,069	
Change in deferred income tax	17,286,918	
Cumulative effect of change in accounting principles	474,387	
Dividends	(150,000,000)	
NYLCare Health Plans net worth as of December 31, 2000	12,383,572	
Prudential Health Care Plans of New York net worth as of December 31, 2000	8,268,790	
Net change in capital and surplus		253,316,269
Capital and surplus funds as of December 31, 2002		$358,594,550

4. CLAIMS PAYABLE

The examination liability of $323,385,861 is the same as the amount 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 statement.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 1996, contained eleven comments and recommendations. The current status of these matters is as follows (page numbers refer to the prior report):

ITEM		PAGE NO.
A.	Management	
	It is recommended that any amendments to the Plan's by-laws be voted on by the board of directors pursuant to the provisions of Article X of its by laws.	4
	The Plan complied with the recommendation. The Plan's by-laws were amended and approved by the Board of Directors on December 6, 1999 to provide for three directors.	
B.	Intercompany Agreements	
1.	It is recommended that the Plan obtain the approval of the Commissioner of Health for the cash management agreement pursuant to Part 98.10(c) of the Administrative Rules and Regulations of the Health Department [10NYCRR Part 98.10(c)].	16
	The Cash Management Agreement was approved by the Insurance Department on December 4, 2003. It is recommended that the Plan submit the Cash Management Agreement to the Department of Health for review.	
2.	It is recommended that the Plan prepare a written Consolidated Federal Income Tax agreement, conforming to the provisions of Department Circular Letter No. 33 (1979), and submit it to the Health and Insurance Departments for approval pursuant to Part 98.10(c) of the Administrative Rules and Regulations of the Health Department [10NYCRR Part 98.10(c)]. The Plan has indicated that it is currently drafting an agreement.	17
	A Tax Allocation Agreement was submitted to the Insurance Department. The Department accepted the agreement and placed it on file June 12, 2003. It is recommended that the Plan file this agreement with the DOH.	

ITEM	PAGE NO.

C. Claims Payable

1. It is recommended that the Plan exclude pre-certifications from the 0-30 days category of its Schedule H-Section I Aging analysis of unpaid claims. It is noted that the Schedule H contained in the Plan's filed quarterly statement as of June 30, 1998 does not include pre-certifications in the 0-30 days category. — 28

   The Plan continues to comply with this recommendation.

2. It is recommended that the Plan maintain detailed listings of the Distribution Payable FRO, and Facility COB Payable to support the balances reported on its filed annual statement. It is noted that the Plan maintained detailed listing of the Distribution Payable FRO at December 31, 1997. — 30

   The Plan complied with this recommendation.

3. It is recommended that the debit balances for the Distribution Payable FRO, Facility COB Payable and Prepaid PIP Captainer be removed from the claims payable liability and listed as separate assets on the annual statement. — 30

   The Plan continues to comply with this recommendation.

5. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO.		PAGE NO.
	Holding Company System– Service Agreements	
A	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.	11
B	It is recommended that the Plan develop an administrative services agreement that meets the requirements of 10 NYCRR Part 98-1.10.	12
C	It is further recommended that the Plan develop an agreement that addresses all costs allocated to the HMO by the provider of services.	12
D	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
E	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 intercompany transactions.	12
F	It is recommended that the Plan obtain approval for its cash management agreements prior to implementation.	13
G	It is recommended that that the Plan adhere to the terms of the CMA by maintaining its assets in an account under its own name.	13
H	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.	14
I	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.	14

ITEM NO.		PAGE NO.
J	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.	15
K	It is recommended that the Plan file its Tax sharing agreement with DOH in accordance with 10 NYCRR Part 98.	16
L	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.	16
	Holding Company System– Dividends	
M	It is recommended that the Plan generate and retain Board of Directors' approvals of all dividend payments.	17
	Accounts and Records	
N	It is recommended that the custodian agreement be revised to reflect the Plan's current legal name.	17
O	It is recommended that the Plan assure that the custodian agreement complies with the suggested protective covenants and provisions.	18
P	It is recommended that the Plan report only individual claims in the individual line of business results.	19
Q	It is recommended that the Plan accrue for anticipated stop loss pool recoveries.	19
R	It recommended that the Plan include allocated expenses paid to the Parent in Schedule Y.	19

Appointment No. UM

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY V. SERIO , Superintendent of Insurance *of the State of New Font* pursuant to *the provisions of the* Inssranee Law, do *hereby appoint*

Kathleen Grogan

as *a proper person* to *examine* into the *affairs of the*

Aetna Health Insurance Company of New York

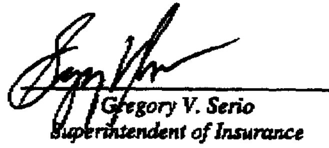
and to make a report to me in writing of the said

Company

with *such information* as she shall *deem* requisite.

in Witness Whereof, Ihave hereunto subscribed by the name and afxed *the official Seal of this Deparnnent, at the City of New York*

this *$ dayofAWs* 2OG2



Gregory V. Serio
Superintendent of Insurance