

Report of Examination of

**Aetna Health Inc. (a Pennsylvania corporation)
Blue Bell, Pennsylvania**

As of December 31, 2011

For Informational Purposes Only

Aetna Health Inc. (a Pennsylvania corporation)

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Harrisburg, Pennsylvania
April 17, 2013

Honorable Stephen J. Johnson, CPA
Deputy Insurance Commissioner
Commonwealth of Pennsylvania Insurance Department
Harrisburg, Pennsylvania

Dear Sir:

In accordance with instructions contained in Examination Warrant Number 11-00001-95109-R1, dated, February 25, 2011, an examination was made of

Actna Health Inc. (a Pennsylvania corporation), NAIC Code: 95109

a Pennsylvania domiciled stock Health Maintenance Organization (“HMO”), hereinafter referred to as the “Company.” The examination was conducted at the Company’s home office, located at 980 Jolly Road, Blue Bell, Pennsylvania 19422.

A report of this examination is hereby respectfully submitted.

SCOPE OF EXAMINATION

The last examination was as of December 31, 2006. This multi-state examination of the Company covers the five-year period from January 1, 2007 through December 31, 2011. Material subsequent events through the date of this report were also reviewed.

Work programs employed in the performance of this examination were designed to comply with the standards promulgated by the Department and the National Association of Insurance Commissioners (“NAIC”).

The format of this report is consistent with the current practices of the Department and the examination format prescribed by the NAIC. It is limited to a description of the Company, a discussion of financial items that are of specific regulatory concern, and a factual disclosure of other significant regulatory information.

The following Pennsylvania domestic affiliated insurance companies were also examined concurrently with this examination:

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Company	NAIC Code
Aetna Better Health Inc. (a Pennsylvania corporation)	13735
Aetna Health Insurance Company	72052

In addition to the examinations noted above, other affiliated insurance companies examined as of December 31, 2011 by the states of New Jersey, Texas, and Missouri included the following:

Company	NAIC Code
Aetna Health Inc. (a New Jersey corporation)	95287
Aetna Dental Inc. (a New Jersey corporation)	11183
Aetna Health Inc. (a Texas corporation)	95490
Aetna Dental Inc. (a Texas corporation)	95910
Missouri Care, Incorporated	12913

Use of Others Work

The Connecticut Insurance Department (“CID”) performed an examination of its domestic insurance companies that are part of the Aetna Insurance Group (“Aetna Group”) as of December 31, 2010. Many of the areas and the related processes reviewed during that examination are common to all the companies in the Aetna Group, including the Pennsylvania companies examined as part of this examination. Those areas included shared information technology (“IT”) systems, enterprise risk management, internal audit functions, premiums and claims systems. In an effort to increase efficiency and avoid duplication of work, this examination utilized some of the work performed by the CID in its 2010 examination.

For each year during the period under examination, the Certified Public Accounting (“CPA”) firm of KPMG LLP provided an unqualified opinion on the financial statements based on statutory accounting principles. Relevant work performed by the CPA firm, during its annual audit of the Company, was also reviewed during the examination and incorporated into the examination working papers.

HISTORY

In 1981, the Company was incorporated in the Commonwealth of Pennsylvania and acquired the net assets and operations of a prepaid health care plan, which had operated as a health maintenance organization (“HMO”) in southeastern Pennsylvania since 1976. The Company commenced HMO operations in Pittsburgh in 1987 and in central Pennsylvania in 1994.

In March 2002, the Company changed its name from United States Health Care Systems of Pennsylvania, Inc. to Aetna Health of Pennsylvania, Inc., and then to Aetna Health Inc., in May 2002.

The Company is currently authorized to transact those classes of insurance described in 40 P.S. § 1554.

Mergers

Twelve affiliated insurance companies merged into the Company since the last examination with the Company as the surviving entity. The business purpose for the mergers was to improve the Company’s operating efficiencies by (1) allowing smaller HMOs to be combined into a larger regional HMO with greater assets thus creating more financial strength; (2) creating a larger pool of investment assets to generate additional investment income; (3) reducing the number of financial statements that need to be prepared and filed; (4) reducing the number of financial examinations; and (5) reducing the administrative and legal burdens of maintaining multiple HMOs.

All of the following transactions were accounted for as statutory mergers and the recorded assets, liabilities, and related surplus accounts of the merged companies were carried forward to the Company at their historical statutory amounts:

1. Effective October 1, 2007, Aetna Health Inc. (a New Hampshire corporation) merged with and into the Company. Effective on the date of the merger, the New Hampshire health maintenance organization was terminated.
2. Effective December 31, 2007, Aetna Health Inc. (an Ohio corporation) (“AHI-OH”) merged with and into the Company. Until the effective date of the merger, AHI-OH held a health maintenance organization license in the States of Ohio, Indiana and Kentucky. In anticipation of the merger, the Company obtained an Ohio health maintenance organization license on March 19, 2007; and obtained an Indiana health maintenance organization license on December 31, 2007; and obtained a Kentucky health maintenance organization license on July 12, 2007.

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3. Effective December 31, 2007, Aetna Health Inc. (a Massachusetts corporation) merged with and into the Company. In anticipation of the merger, the Company obtained a Massachusetts health maintenance organization license on December 18, 2007.
4. Effective June 30, 2009, Aetna Health Inc. (an Arizona corporation) ("AHI-AZ") merged with and into the Company. Until the effective date of the merger, AHI-AZ held a health maintenance organization license in the States of Arizona and Nevada. In anticipation of the merger, the Company obtained an Arizona health maintenance organization license on April 1, 2009 and a Nevada health maintenance organization license on April 17, 2009.
5. Effective June 30, 2009, Aetna Health of Illinois Inc. (an Illinois corporation) ("AHIL") merged with and into the Company. Until the effective date of the merger, AHIL held a health maintenance organization license in the States of Illinois and Indiana. In anticipation of the merger, the Company obtained an Illinois health maintenance organization license on June 3, 2009. The Company had previously obtained an Indiana health maintenance organization license on December 31, 2007.
6. Effective June 30, 2009, Aetna Health Inc. (an Oklahoma corporation) merged with and into the Company. In anticipation of the merger, the Company obtained an Oklahoma health maintenance organization license on March 3, 2009.
7. Effective June 30, 2009, Aetna Health Inc. (a Tennessee corporation) merged with and into the Company. In anticipation of the merger, the Company obtained a Tennessee health maintenance organization license on March 27, 2009.
8. Effective December 31, 2009, Aetna Health Inc. (a Maryland corporation) ("AHI-MD") merged with and into the Company. Until the effective date of the merger, AHI-MD held a health maintenance organization license in the State of Maryland, the District of Columbia and the Commonwealth of Virginia. In anticipation of the merger, the Company obtained a Maryland health maintenance organization license on December 2, 2009; a District of Columbia health maintenance organization license on September 30, 2009; a Virginia health maintenance organization license and a Virginia Managed Care Health Insurance Plan license on December 21, 2009.
9. Effective December 31, 2009, Aetna Health Inc. (a Missouri corporation) ("AHI-MO") merged with and into the Company. Until the effective date of the merger, AHI-MO held a health maintenance organization license in the States of Missouri and Kansas. In anticipation of the merger, the Company obtained a Missouri health maintenance organization license on October 13, 2009 and a Kansas health maintenance organization license on December 21, 2009.
10. Effective March 31, 2010, Aetna Health of the Carolinas Inc. (a North Carolina corporation) ("AH-Carolinas") merged with and into the Company. Until the effective

date of the merger, AH-Carolinas held a health maintenance organization license in the States of North Carolina and South Carolina. In anticipation of the merger, the Company obtained a South Carolina health maintenance organization license on October 1, 2009 and obtained a North Carolina health maintenance organization license on March 31, 2010.

11. Effective June 30, 2010, Aetna Health Inc. (a Colorado corporation) merged with and into the Company. In anticipation of the merger, the Company obtained a Colorado health maintenance organization license on March 9, 2010.

12. Effective June 30, 2010, Aetna Health Inc. (a Delaware corporation) merged with and into the Company. In anticipation of the merger, the Company obtained a Delaware health maintenance organization license on November 5, 2009.

In accordance with Statements of Statutory Accounting Principles ("SSAP") No. 3, the Company re-stated its prior years' statutory Annual Statements to reflect the financial impact of these mergers.

MANAGEMENT AND CONTROL

CAPITALIZATION

As of the examination date, the Company's total capitalization was \$369,570,237 consisting of 2,764,533 shares of issued and outstanding common stock with a par value of \$0.50 per share amounting to common capital stock of \$1,382,267, gross paid in and contributed surplus of \$298,552,024, aggregate write-ins for special surplus funds of \$10,685,134¹, aggregate write-ins for other than special surplus funds of \$1,500,000, and \$57,450,812 of unassigned funds ("surplus").

The Company had 400,000 shares of preferred stock with a par value of \$0.10 authorized and no shares issued and outstanding at December 31, 2011.

Pursuant to 31 Pa. Code § 301.202(a)(1), an HMO offering a point-of-service product is required to maintain a minimum net worth equal to the greater of \$1,500,000 or 2% of premiums or the sum of three (3) months uncovered health care expenditures of Pennsylvania enrollees as reported on the most recent financial statement filed with the

¹ Resulting from additional deferred tax assets allowed under SSAP 10R.

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Commissioner. At December 31, 2011, the minimum net worth was \$76,274,730 which represents three months of uncovered health care expenditures of Pennsylvania enrollees. The Company has met all governing minimum net worth requirements throughout the examination period.

In 1999, the NAIC and the Commonwealth of Pennsylvania adopted Risk-Based Capital (“RBC”) standards for health organizations. The RBC standards are designed to identify weakly capitalized companies by comparing each company’s adjusted capital and surplus to its required capital and surplus (“RBC ratio”). The RBC ratio is designed to reflect the risk profile of a company. As of December 31, 2011, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

STOCKHOLDER

The Company is a wholly-owned subsidiary of Aetna Health Holdings, LLC, a Delaware limited liability company, whose ultimate parent is Aetna Inc.

The following represents the stockholder dividends paid by the Company and the affiliated insurance companies merged into the Company from 2007 through December, 2012:

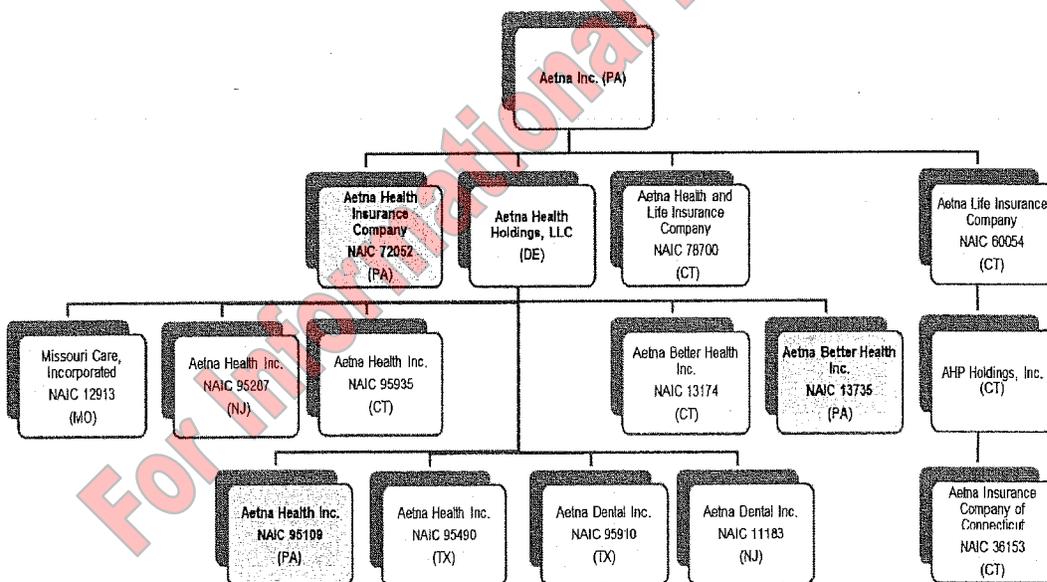
Year	Dividends Declared	Less: Return of Capital	Stockholder Dividends
2007	\$ 55,000,000	\$ 3,000,000	\$ 52,000,000
2008	293,400,000	47,100,000	246,300,000
2009	176,300,000	28,273,587	148,026,413
2010	233,200,000	184,582,538	48,617,462
2011	240,000,000	32,400,000	207,600,000
2012	162,000,000	0	162,000,000
Totals	<u>\$ 1,159,900,000</u>	<u>\$ 295,356,125</u>	<u>\$ 864,543,875</u>

INSURANCE HOLDING COMPANY SYSTEM

The Company became a member of an insurance holding company system through its ultimate 100% ownership by Aetna Inc., a Pennsylvania domiciled corporation, on December 20, 1982. Pursuant to the requirements of 40 P.S. §§ 991.1401-991.1413, an Insurance Holding Company System Registration Statement and various amendments thereto, has been timely filed with the Pennsylvania Insurance Department during the examination period. The Company reported no investments in subsidiaries during the examination period.

ORGANIZATIONAL CHART

The following is an abridged organizational chart depicting the Company and selected other companies within the holding company system as of December 31, 2011².



² All holdings are 100%

BOARD OF DIRECTORS

Management of the Company is vested in its Board of Directors ("Board"), which was comprised of the following members as of December 31, 2011:

Name and Address	Principal Occupation
Gerard Vincent Carey (*) Cherry Hill, NJ	C.P.A - Retired
John Patrick Elliott Blue Bell, PA	Attorney
Gregory Stephen Martino Hummelstown, PA	Vice President, Aetna Health Inc. (a Pennsylvania corporation)
Elizabeth Anne Sun Lafayette Hill, PA	Medical Doctor
Michael Gerard Ungvary Malvern, PA	Healthcare Management, Aetna Inc.
Janice Christine Washeleski Trappe, PA	Market Head of Sales and Service, Aetna Inc.
Patrick Rodney Young New Hope, PA	President, Aetna Health Inc. (a Pennsylvania corporation)

(*) Removed on July 2, 2012; Alice Stallsmith Wilson and Thomas George Wilson were appointed on July 2, 2012, both of whom are retired.

The members of the Board are elected annually to serve a term of one year.

The Company has a conflict of interest policy, which appears to adequately address any conflict of interest concerns. The policy is updated and signed annually. There were no conflicts of interest reported by the members of the Board.

COMMITTEES

The Company did not have any established committees during the examination period. However, as a result of the adoption of the Model Audit Rule ("MAR") in 2010, an audit committee was formed by the Company's Parent to cover legal entities subject to MAR. Since the Company was and is subject to the MAR requirements, its immediate parent, Aetna Health Holdings, LLC ("AHH"), formed one common audit committee that serves as the Company's audit committee.

The following are the members of the AHH Audit Committee:

Michael W. Fedyna (Chairperson)
Jerry Bellizzi
Alfred P. Quirk, Jr.

OFFICERS

The following officers were appointed and serving in accordance with the Company's By-laws as of December 31, 2011:

Name	Title
Patrick Rodney Young	President
Edward Chung-I Lee	Vice President and Secretary
Jennifer Anne Palma	Principal Financial Officer and Controller
Elaine Rose Confrancesco	Treasurer
Gregory Stephen Martino	Vice President
Kevin James Casey	Senior Investment Officer
Dawn Marie Schoen	Assistant Controller

CORPORATE RECORDS

MINUTES

The Company's stockholder meetings and board of directors meetings all appear to have been held within the confines of the Company's Articles of Incorporation and By-laws. The annual meetings held by the sole stockholder were all held by Written Consent of the Sole Stockholder in Lieu of an Annual Meeting and this was the procedure used to elect the members of the Board.

ARTICLES OF INCORPORATION

In order to increase the par value of its common stock, the Company's Articles of Incorporation were amended and the Fifth Article was restated in June, 2007 to read that the aggregate number of shares that the Company has authority to issue is 400,000 shares of preferred stock, par value \$0.10 per share, and 3 million shares of common stock, par value \$.50 per share. That each share of common stock with a par value of \$0.005 outstanding immediately prior to the effectiveness of the amendment of Article 5 shall be automatically reclassified into the common stock par value of \$.50. Any share certificate issued prior to the amendment of Article 5 shall be deemed to represent the same number of shares of common stock, par value \$.50.

As a result of an increase in the par value, an accounting transfer of \$1.3 million was made from gross paid in and contributed surplus to common capital stock.

BY-LAWS

No changes or amendments were made to the Company's By-laws during the period under examination.

SERVICE AND OPERATING AGREEMENTS

As of December 31, 2011, the Company had the following agreements in force:

AGREEMENT WITH AETNA HEALTH MANAGEMENT, LLC.

The Company and Aetna Health Management, LLC. ("AHM"), indirectly a wholly-owned subsidiary of Aetna Inc., are parties to an administrative services agreement dated January 1, 2004. Under the terms of the agreement, AHM provides certain administrative services, including accounting, finance, human resources, general operational services, purchasing, legal services, data processing, claims processing and payment, premium processing, policyholder services and marketing.

The Company remits a percentage of its earned commercial, Medicaid and Medicare premium revenue, as applicable, to AHM as a fee, subject to an annual true-up mechanism as defined in the agreement. The true-up is due to be settled by April 15th of the following contract year (which is January 1 to December 31 annually). The terms of settlement require that these amounts be settled within forty-five ("45") days after the end of the calendar quarter.

Under the terms of an amendment to the agreement, effective October 1, 2008, AHM will provide the Company with any information to meet its obligations to the Centers for Medicare & Medicaid Services.

An amendment to this agreement, effective March 31, 2010, provides that the administrative fee (with respect to North Carolina Department of Insurance regulated business) shall be solely for administrative services reasonably necessary for the day to day development and operations of the Company's HMO operations in North Carolina.

For these services, the Company was charged the following fees for 2010 and 2011 (in thousands):

Description	2011	2010
Administrative service fee	\$425,695	\$436,308
Current year estimated accrued true-up	<u>1,829</u>	<u>19,390</u>
Total administrative service fee	<u>\$427,524</u>	<u>\$455,698</u>

At December 31, 2011, the Company reported \$3,776,011 as amounts due to affiliates related to this agreement. This agreement also provides for interest on all intercompany balances.

AHM PHARMACY REBATE AGREEMENT

The Company is a party to an agreement which enables it to receive manufacturers' pharmacy rebates from AHM under which the Company remits a percentage of its earned pharmaceutical rebates to AHM as a fee.

The Company earned pharmaceutical rebates of \$61,612,856 and \$61,565,213, which were recorded as a reduction of medical costs, in 2011 and 2010, respectively.

The Company was charged \$6,443,692 and \$5,873,517, which were recorded as administrative expenses, for these services in 2011 and 2010, respectively.

At December 31, 2011 and 2010, the Company reported \$5,239,861 and \$5,942,040, respectively, as amounts due from AHM related to the pharmaceutical rebates which were reflected in health care and other amounts receivable.

The terms of settlement require that these amounts be settled within forty-five ("45") days after the end of the calendar quarter.

TAX SHARING AGREEMENT

The Company participates in a tax sharing agreement, effective January 1, 2006, with its ultimate parent Aetna Inc. ("Aetna") and Aetna's other subsidiaries. This agreement provides that the subsidiaries of Aetna shall share in and settle state and federal income taxes where a consolidated return is filed. The basis of each subsidiary's liability to Aetna is generally computed as if the subsidiary were filing a separate, standalone federal and state income tax return. The agreement is continuous and can be terminated by written agreement by both parties, withdrawal from Aetna's affiliated group by the Company and the discontinuance of filing consolidated tax returns. All Federal income tax receivables/payables are due from/due to Aetna.

GUARANTOR AGREEMENT – INSOLVENCY OF THE COMPANY

The Company has a guarantor agreement, effective November 26, 1986, with Aetna Inc. ("Aetna"). The agreement provides that in the event of the Company's insolvency, Aetna will pay all expenses and claims incurred by the Company during insolvency pursuant to the obligation with employer groups and subscribers until the end of the subscription contract period for which premiums have been received.

INSOLVENCY AGREEMENT WITH AETNA HEALTH INSURANCE COMPANY

The Company has an insolvency agreement, effective January 1, 2008, with Aetna Health Insurance Company ("AHIC"), a wholly-owned subsidiary of Aetna Inc. This agreement provides that in the event that the Company ceases operations or becomes insolvent, AHIC will continue to pay benefits for any members confined as inpatients on the date of insolvency until their discharge. This agreement also provides that AHIC will continue benefits for any member until the end of the contract period for which premium has been paid, but for no longer than thirty-one days. AHIC will also make available to members, for a period of thirty-one days, replacement insurance policies.

The premium rate for the coverage provided is \$1,000 for the first contract year. This amount may be modified in subsequent years provided AHIC gives the Company prior written notice.

LITIGATION EXPOSURES COVERAGE

The Company has coverage for certain litigation exposures (\$10,000,000 per claim and in the aggregate including defense costs) through, Aetna Insurance Company of Connecticut, an affiliated captive insurance company.

REINSURANCE

CEDED

The Company had a reinsurance agreement with Aetna Life Insurance Company ("ALIC") which reduced the Company's risk of catastrophic loss for Arizona and Nevada members. Under the agreement, ALIC was liable for 100% of the Arizona and Nevada incurred claims during the contract year which were in excess of 96% of Arizona's and Nevada's earned premiums for such contract year. Effective July 1, 2009, Aetna Health Insurance Company ("AHIC") and ALIC entered into an assignment and assumption agreement under which ALIC assigned and AHIC agreed to assume all of ALIC's obligations under the reinsurance agreement.

At December 31, 2011 and 2010, the Company reported \$11,691 and \$15,477, respectively, as ceded reinsurance premiums payable related to these agreements. The Company paid reinsurance premiums of \$149,128 in 2011 and \$210,063 in 2010 related to these agreements. The Company did not realize any net reinsurance recoveries in 2011 or 2010.

Terminated Agreement

The Company was party to a specific excess loss reinsurance agreement with AHIC. This agreement provided for the Company to be reimbursed for 100% of eligible losses, as defined, paid on behalf of any insured during the policy period. Reimbursement was subject to a specific deductible of \$500,000. The policy period was defined as the twelve-month period beginning on the effective date of this agreement. The Company paid realized net reinsurance recoveries of \$940,047 in 2008. The Company received approval to terminate this agreement effective December 31, 2007.

ASSUMED

The Company did not assume reinsurance during the period under examination.

TERRITORY AND PLAN OF OPERATIONS

The Company is a Pennsylvania domestic for profit health maintenance organization that is licensed in nineteen (19) states and counties as follows as of December 31, 2011:

State	Counties Licensed
Arizona	Licensed in all counties
Colorado	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Jefferson, Larimer, Mesa, Pueblo, Teller, and Weld
Delaware	Kent, New Castle, and Sussex
District of Columbia	Licensed in the entire District of Columbia
Illinois	Clinton, Cook, DuPage, Kane, Kankakee, Lake, Madison, McHenry, Monroe, Randolph, St. Claire, and Will
Indiana	Clark, Dearborn, Floyd, Franklin, Harrison, Lake, Ohio, Porter, Scott, Switzerland, and Washington
Kansas	Atchison, Douglas, Franklin, Johnson, Leavenworth, Miami, and Wyandotte
Kentucky	Allen, Anderson, Barren, Boone, Bourbon, Breckinridge, Bullitt, Butler, Campbell, Carroll, Clark, Clinton, Cumberland, Edmondson, Fayette, Franklin, Gallatin, Grant, Grayson, Hardin, Harrison, Hart, Henry, Jefferson, Jessamine, Kenton, LaRue, Logan, Madison, Marion, Meade, Metcalfe, Monroe, Muhlenberg, Nelson, Oldham, Owen, Pendleton, Robertson, Scott, Shelby, Simpson, Spencer, Todd, Trimble, Warren, Washington, and Woodford
Maryland	Anne Arundel, Baltimore, Baltimore City, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, Saint Mary's, Talbot, Washington, and Wicomico
Massachusetts	Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Orange (Town), Plymouth, Suffolk, Ware (Town), and Worcester
Missouri	Buchanan, Cass, Clay, Jackson, Jefferson, Lafayette, Platte, Ray, St. Charles, St. Louis, and St. Louis City
Nevada	Clark, Washoe & Nye (partial: zip codes 89041 and 89048)
North Carolina	Alamance, Alexander, Anson, Brunswick, Burke, Cabarrus, Caldwell, Catawba, Chatham, Cleveland, Cumberland, Davidson, Davie, Durham, Forsythe, Franklin, Gaston, Granville, Guilford, Harnett, Iredell, Johnson, Lee, Lincoln, Mecklenburg, Nash, New Hanover, Orange, Randolph, Rockingham, Rowan, Sampson, Stanly, Stokes, Surry, Union, Vance, Wake, Warren, Wilkes, Wilson, and Yadkin
Ohio	Adams, Allen, Ashland, Ashtabula, Auglaize (partial), Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana (partial), Coshocton, Crawford, Cuyahoga, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Henry, Highland, Hocking, Holmes, Huron, Knox, Lake, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summitt, Trumbull, Tuscarawas, Union, Warren, Wayne, and Wood.
Oklahoma	Canadian (partial), Creek (partial), Grady (partial), Lincoln (partial), McClain (partial), Oklahoma City, Osage (partial), Tulsa, and Wagoner (partial).

State	Counties Licensed
Pennsylvania	Adams, Allegheny, Armstrong, Beaver, Berks, Blair, Bradford, Bucks, Butler, Cambria, Carbon, Chester, Clarion, Clinton, Columbia, Cumberland, Dauphin, Delaware, Erie, Fayette, Franklin, Fulton, Greene, Jefferson, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, Mercer, Monroe, Montgomery, Northampton, Northumberland, Perry, Philadelphia, Pike, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Washington, Wayne, Westmoreland, Wyoming, and York
South Carolina	Beaufort, Berkeley, Charleston, Chester, Colleton, Dorchester, Fairfield, Kershaw, Lancaster, Lexington, Richland, Sumter, and York
Tennessee	Bedford, Cannon, Cheatham, Coffee, Crockett, Davidson, DeKalb, Dickson, Dyer, Fayette, Franklin, Giles, Haywood, Lauderdale, Lewis, Macon, Maury (partial), Montgomery, Moore, Robertson, Rutherford (partial), Shelby, Smith, Sumner, Tipton, Trousdale, Williamson, and Wilson.
Virginia	Amelia, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Cumberland, Dinwiddie, Fairfax, Fauquier, Goochland, Hanover, Henrico, King George, King William, Loudoun, Louisa, Lunenburg, Manassas City, New Kent, Nottoway, Powhatan, Prince Edward, Prince George, Prince William, Spotsylvania, Stafford, Surry, Sussex, and Westmoreland

The following counties in Pennsylvania were approved on April 27, 2012: Bedford, Venango, and Indiana.

Marketing and Agency System

The managed health care, indemnity, and group insurance products and services are distributed through the Company's group sales representatives, independent agents, and national insurance brokers.

Concentration of Business by States

The highest concentration of direct premium income is in the states of Pennsylvania \$1.9 billion (49.9%), District of Columbia \$645.5 million (16.9%), and Ohio \$283.3 million (7.4%).

Substantially all of the Company's revenues are generated from premiums received for health care coverage provided to its members.

Lines of Business / Operations

The majority (61.4%) of the Company's 2011 net premium income is from the comprehensive hospital and medical (accident and health) line. The Company reported no

reinsurance assumed for 2011, and only \$149,128 of ceded premiums which was to one affiliate, Aetna Health Insurance Company.

In addition to its comprehensive (hospital and medical) and dental only coverages, the Company provides health benefits to Medicare members through its contract with the Centers for Medicare and Medicaid Services (“CMS”). The Company also provides health benefits to Federal employees through the Federal Employee Health Benefit Program (“FEHBP”).

The following schedule is a summary of the Company’s 2011 premiums by line of business:

Line of Business	Direct and Assumed Premium	Ceded Premium	Net Premium	Percentage of total
December 31, 2011				
Comprehensive (hospital and medical)	\$ 2,341,749,051	\$ 105,206	\$2,341,643,845	61.4%
Dental only	11,046,598	0	11,046,598	0.3%
Federal employees health benefits plan	762,359,452	38,479	762,320,973	20.0%
Title XVIII - Medicare	698,730,535	5,443	698,725,092	18.3%
Totals	<u>\$ 3,813,885,636</u>	<u>\$ 149,128</u>	<u>\$3,813,736,508</u>	<u>100.0%</u>

Medicare Business

Through annual contracts with the CMS, the Company offers HMO plans for Medicare-eligible individuals through the Medicare Advantage program. Members typically receive enhanced benefits over standard Medicare fee-for-service coverage, including reduced cost-sharing for preventative care, vision and other non-Medicare services.

Under this agreement the Company and CMS share in amounts above and below agreed upon target medical benefit ratios. Additionally, the Company was selected by CMS to be a provider of the Medicare Prescription Drug Program (“PDP”) in 2010. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment.

The Company had net premiums written of \$698,730,535 and \$803,901,939 related to these agreements for the years ending December 31, 2011 and 2010, respectively, representing

18% in 2011 and 20% in 2010 of total premium revenue. Accrued retrospective premiums were recorded through premiums and were not material to the Company in 2011 and 2010. The Company had net premiums receivable of \$20,995,435 and \$25,919,647 related to these agreements as of December 31, 2011 and 2010, respectively, representing 20% in 2011 and 24% in 2010 of total premiums receivable.

CMS regularly audits the Company's performance to determine compliance with CMS's regulations and contracts and to assess the quality of services provided to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions and document their medical records.

CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records and related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data.

In February 2012, CMS published a Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (the "Notice"). The Notice outlines the methodology that CMS will use to determine RADV audit premium refunds payable by Medicare Advantage plans for contract years 2011 and forward.

Under that methodology, the RADV audit premium refund calculation will include an adjustment for the differences in documentation standards between the RADV audits and the risk adjustment model; however, the Notice provides limited information about that adjustment. In addition, CMS will project the error rate identified in the audit sample to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not make an adjustment for differences in documentation standards or project sample error rates to the entire contract.

During 2013, CMS is expected to select Medicare Advantage contracts for contract year 2011 for audit. The Company is currently unable to predict which of the Medicare Advantage contracts will be selected for future audit, the financial impact of the documentation standard adjustment, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of their Medicare Advantage bids, or whether any RADV audit findings would cause a change to the Company's method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in their bids for prior contract years or the current contract year.

Any premium refunds or adjustments resulting from regulatory audits, whether as a result of RADV or other audits by CMS, the OIG or otherwise, could be material and could adversely affect the Company's operating results, financial position and cash flows.

CMS Sanctions

The Company's Medicare Advantage and Standalone Prescription Drug Plan ("PDP") products are regulated by CMS. The regulations and contractual requirements applicable to the Company and other participants in Medicare programs are complex, expensive to comply with and subject to change. The Company has invested significant resources to comply with Medicare standards, and the Company's Medicare compliance efforts will continue to require significant resources.

CMS may seek premium refunds, prohibit the Company from continuing to market and/or enroll members in one or more Medicare products, exclude the Company from participating in one or more Medicare programs and/or institute other sanctions against the Company if it fails to comply with CMS regulations or the Company's Medicare contractual requirements. For example, in April 2010, CMS imposed intermediate sanctions on the Company suspending the enrollment of and marketing to new members of all the Company's Medicare Advantage and PDP contracts. CMS lifted those sanctions in June, 2011. As a result of those sanctions, the Company's 2011 Medicare membership and operating results were adversely affected because the Company did not participate in the annual enrollment process for 2011. The Company was not again eligible to receive assignments of low-income subsidy PDP members from CMS until September 2012.

As part of its continuing efforts to prevent, detect and assure compliance, the Company made several significant commitments to its Medicare compliance and business operations. Those commitments included, but were not limited to:

- A reorganization of the Government Programs Compliance Team
- Hiring a new Medicare Compliance Officer
- Hiring new Clinical Pharmacists
- Hiring a new Head of Government Programs Compliance Group
- Replacing staff with more knowledgeable people, including former CMS employees
- Implementing a “Standard Governance Process”
- Implementing a standard Medicare Compliance Committee
- Creating and executed proactive work and auditing plans
- Creating or emphasized three monitoring and/or audit groups (i.e. Proactive Compliance, Medicare Compliance and Internal Audit)
- Creating and executing more robust training

Federal Employees Health Benefits Program (“FEHBP”)

The Company contracts with the Office of Personnel Management (“OPM”) to provide managed health care services under the FEHBP program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program, and generally also require that FEHBP plans receive pricing that is at least as favorable as similarly sized subscriber groups (“SSSG”) in the applicable market.

The Company had net premiums written of \$762,320,973 and \$747,562,295 related to these agreements for the years ending December 31, 2011 and 2010, respectively, representing 20% in 2011 and 19% in 2010 of total premium revenue.

Compliance with the SSSG requirements complicates pricing of the Company’s Commercial business and can result in the payment of an unanticipated premium rebate to the OPM. The OPM has issued new pricing regulations for 2012, which eliminate the SSSG requirements and move to a FEHBP program-specific MLR by plan code and market. In 2012, carriers may elect the SSSG rules or the MLR regulations. Aetna (and the Company) has elected the MLR regulations in all plan code and markets except the Company’s Washington D.C. area and New York HMO’s.

For 2013 and beyond, the new MLR regulations will be mandatory for all carriers in all plan codes and markets with the exception of non-traditionally rated plan codes in which case the MLR regulations do not apply.

Managing to these rules is further complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of Health Care Reform.

The OPM conducts periodic audits of its contractors to, among other things, verify that the premiums established under its contracts are in compliance with the SSSG/MLR and other requirements under FEHBP. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

MEMBERSHIP

As noted in the following schedule, the Company's total members and member months enrollment for all lines of business it writes combined decreased every year over the past four years. From 2007 to 2011, members and member months enrollment decreased by 24%.

Description	5-Year Change	2011	2010	2009	2008	2007
Total members at end of period (enrollment)	(263,797)	825,968	844,453	980,977	1,041,006	1,089,765
% Change from Prior Year-end & 5-Year	-24.2%	-2.2%	-13.9%	-5.8%	-4.5%	
Total member months (enrollment)	(3,140,739)	9,895,023	10,270,076	11,932,547	12,601,981	13,035,762
% Change from Prior Year-end & 5-Year	-24.1%	-3.7%	-13.9%	-5.3%	-3.3%	

The decline in the membership reflects the general economic conditions of the country as the economy continues to impact the buying behavior of the Company's clients causing increased competitive pressures affecting the ability to obtain new clients and retain existing clients. Also, CMS sanctions imposed on the Company in 2010 required it to suspend the enrollment of and marketing to new members of all Aetna Medicare Advantage contracts.

SIGNIFICANT OPERATING TRENDS

The Company reported the following key financial statement balances during the period under examination, which include the balances of the companies merged into the Company:

Description	2011	2010	2009	2008	2007
Admitted Assets	\$ 767,097,783	\$ 806,839,937	\$ 984,913,596	\$ 847,945,478	\$ 485,145,402
Liabilities	\$ 397,527,546	\$ 406,291,181	\$ 510,273,608	\$ 439,034,143	\$ 222,239,879
Capital and Surplus	\$ 369,570,237	\$ 400,548,756	\$ 474,639,988	\$ 408,911,335	\$ 262,905,523
Net Premium Income	\$ 3,813,736,508	\$ 3,897,909,347	\$ 4,228,346,972	\$ 3,885,355,945	\$ 2,034,295,228
Net Underwriting Gain	\$ 268,949,646	\$ 154,787,632	\$ 172,640,167	\$ 252,380,736	\$ 150,909,939
Net Investment Gain	\$ 27,748,859	\$ 39,855,910	\$ 34,323,355	\$ 22,605,193	\$ 18,416,822
Net Income	\$ 213,470,245	\$ 161,653,734	\$ 170,249,451	\$ 258,691,626	\$ 104,210,035

ACCOUNTS AND RECORDS

The Company maintains its accounts and records at its home office in Blue Bell, Pennsylvania, as well as in its affiliate's home office in Hartford, Connecticut through an administrative services agreement with Aetna Health Management LLC. ("AHM"). The Company, as a purchaser of the services, has its accounting, premium, and claim processing records kept on an automated and integrated accounting system with respect to the general ledger, trial balance, receivables, and payables. The receipt of premium and payment of claims are handled by AHM with cash due to and due from the Company settled through an inter-company receivable and payable system.

PENDING LITIGATION

A review of the Company's legal representation letter indicates that there was no other material current, pending, or threatened litigation, other than claim litigation, which is considered in the normal course of business. The Company did, however, enter into an agreement to settle its "Out-of-Network" litigation in December, 2012 as noted in the subsequent events section of this examination report.

FINANCIAL STATEMENTS

As previously noted, twelve affiliated insurance companies merged into the Company since the last examination with the Company as the surviving entity. All of the mergers were accounted for as statutory mergers. Amended financial statements as a result of the mergers were

Aetna Health Inc. (a Pennsylvania corporation)

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not required to be filed. The Company was, however, required to restate its prior year's financial statements for comparative purposes.

The financial condition of the Company as of December 31, 2011 and the results of its operations for the five-year period under examination, which includes the re-stated merger balances, are reflected in the following statements:

Comparative Statement of Assets, Liabilities, Surplus and Other Funds;
Comparative Statement of Income;
Comparative Statement of Capital and Surplus; and
Comparative Statement of Cash Flow

For Informational Purposes Only

Comparative Statement of Assets, Liabilities, Surplus and Other Funds As of December 31,

Account	2011	2010	2009	2008	2007
Bonds	\$ 555,115,376	\$ 571,870,931	\$ 670,360,501	528,941,695	\$ 335,492,579
Preferred stocks (stocks)	0	0	0	7,495,654	9,120,905
Cash, cash equivalents and short-term investments	36,338,265	31,459,507	96,303,124	92,077,419	57,491,776
Receivable for securities	0	0	0	0	50,000
Securities lending reinvested collateral assets	0	4,275,480	0	0	0
Investment income due and accrued	5,979,518	7,311,864	7,249,093	6,876,799	4,027,907
Uncollected premiums and agents' balances in the course of collection	103,788,475	108,166,357	117,534,755	126,127,830	37,354,046
Other amounts receivable under reinsurance contracts (reinsurance)	0	0	105,243	0	1,579,727
Current federal and foreign income tax recoverable and interest thereon	12,236,468	20,030,342	0	45,996,058	0
Net deferred tax asset	41,092,473	50,381,253	57,503,586	30,381,615	10,824,658
Receivables from parent, subsidiaries and affiliates	0	2,000	22,879,917	1,212,189	199
Health care and other amounts receivable	5,239,861	5,492,040	7,100,288	5,786,551	28,811,713
Aggregate write-ins for other than invested assets	7,307,347	7,850,163	5,877,089	3,049,668	391,892
Totals	\$ 767,097,783	\$ 806,839,937	\$ 984,913,596	\$ 847,945,478	\$ 485,145,402
Claims unpaid	\$ 300,300,836	\$ 316,604,211	\$ 347,586,886	\$ 293,893,958	\$ 153,902,145
Unpaid claims adjustment expenses	5,852,955	5,945,127	7,455,021	5,761,046	3,247,352
Aggregate health policy reserves; including the liability for medical loss ratio rebate	61,217,789	11,020,765	14,036,493	13,117,146	7,890,379
Aggregate health claim reserves	3,167,233	3,431,123	3,892,274	4,324,118	3,087,988
Premiums received in advance	1,486,529	1,642,934	1,255,023	1,290,939	1,295,875
General expenses due or accrued	7,490,605	24,044,692	14,050,774	7,653,971	10,455,592
Current federal and foreign income tax payable and interest thereon	0	0	6,405,398	0	4,602,511
Ceded reinsurance premiums payable	11,691	15,477	31,251	26,521	281,328
Amounts withheld or retained for the account of others	1,739,354	0	0	0	0
Remittances and items not allocated	0	0	0	987,503	0
Amounts due to parent, subsidiaries and affiliates	4,935,295	31,969,227	463,112	68,775,673	33,701,591
Payable for securities	0	0	25,376,510	0	0
Payable for securities lending	0	4,275,480	0	0	0
Aggregate write-ins for other liabilities	11,325,259	7,342,145	89,720,866	43,203,268	3,775,118
Total liabilities	397,527,546	406,291,181	510,273,608	439,034,143	222,239,879
Aggregate write-ins for special surplus funds	10,685,134	19,057,345	21,988,213	0	0
Common capital stock	1,382,267	1,382,267	2,284,363	1,385,270	1,382,258
Gross paid in and contributed surplus	298,552,024	330,952,024	513,632,464	316,690,161	221,042,210
Aggregate write-ins for other than special surplus funds	1,500,000	1,500,000	1,500,000	1,500,000	0
Unassigned funds (surplus)	57,450,812	47,657,120	(64,765,052)	89,335,904	40,481,055
Total capital and surplus	369,570,237	400,548,756	474,639,988	408,911,335	262,905,523
Total liabilities; capital and surplus	\$ 767,097,783	\$ 806,839,937	\$ 984,913,596	\$ 847,945,478	\$ 485,145,402

Comparative Statement of Income For the Year Ended December 31,

	2011	2010	2009	2008	2007
Member months	9,895,023	10,270,076	11,932,547	11,883,164	6,041,062
Net premium income (including non-health premium income)	\$ 3,813,736,508	\$ 3,897,909,347	\$ 4,228,346,972	\$ 3,885,355,945	\$ 2,034,295,228
Change in unearned premium reserves and reserve for rate credits	(46,386,030)	(229,902)	(155,737)	79,023	(59,500)
Total revenues	3,767,350,478	3,897,679,445	4,228,191,235	3,885,434,968	2,034,235,728
Hospital and Medical:					
Hospital/medical benefits	2,194,890,747	2,582,238,544	2,819,006,481	2,518,089,834	1,351,551,648
Other professional services	20,135,034	17,801,662	17,556,495	18,812,348	3,444,007
Outside referrals	39,758,721	63,501,115	71,873,071	66,917,910	31,117,183
Emergency room and out-of-area	140,247,198	133,122,482	160,577,525	132,309,514	58,990,775
Prescription drugs	636,800,094	437,634,099	478,111,250	436,362,287	217,070,581
Incentive pool, withhold adjustments and bonus amounts	0	0	24,444	0	0
Subtotal	3,031,831,794	3,234,297,902	3,547,149,266	3,172,491,893	1,662,174,194
Less:					
Net reinsurance recoveries	0	0	105,243	1,068,665	6,084,382
Total hospital and medical	3,031,831,794	3,234,297,902	3,547,044,023	3,171,423,228	1,656,089,812
Claims adjustment expenses, including cost containment expenses	83,451,202	81,776,712	70,942,985	63,449,839	34,905,658
General administrative expenses	381,206,842	430,062,829	439,163,893	394,889,102	194,769,126
Increase in reserves for life and accident and health contracts (including increase in reserves for life and accident and health contracts)	1,910,994	(3,245,630)	(1,599,833)	3,292,063	(2,438,807)
Total underwriting deductions	3,498,400,832	3,742,891,813	4,055,551,068	3,633,054,232	1,883,325,789
Net underwriting gain or (loss)	268,949,646	154,787,632	172,640,167	252,380,736	150,909,939
Net investment income earned	25,469,165	32,762,156	31,119,964	33,993,147	19,451,489
Net realized capital gains or (losses) less capital gains tax	2,279,694	7,093,754	3,203,391	(11,387,954)	(1,034,667)
Net investment gains or (losses)	27,748,859	39,855,910	34,323,355	22,605,193	18,416,822
Aggregate write-ins for other income or expenses	0	(37,400)	0	0	0
Net income or (loss) after capital gains tax and before all other federal income taxes	296,698,505	194,606,142	206,963,522	274,985,929	169,326,761
Federal and foreign income taxes incurred	83,228,260	32,952,408	36,714,071	16,294,303	65,116,726
Net income (loss)	\$ 213,470,245	\$ 161,653,734	\$ 170,249,451	\$ 258,691,626	\$ 104,210,035

**Comparative Statement of Capital and Surplus
For the Year Ended December 31,**

	2011	2010	2009	2008 (1)	2007 (1)
Surplus as regards policyholders, December 31, previous year	<u>\$400,548,756</u>	<u>\$ 474,639,988</u>	<u>\$ 444,088,862</u>	<u>\$ 489,253,606</u>	<u>\$ 367,625,637</u>
Net income or (loss)	213,470,245	161,653,734	170,249,451	258,691,626	104,210,035
Change in net unrealized capital gains (losses)	157,263	6,721	3,033,529	(3,082,577)	150,519
Change in net deferred income tax	(8,177,937)	(20,367,564)	(14,614,961)	(1,697,786)	5,035,847
Change in nonadmitted assets	11,944,121	19,746,743	22,294,894	1,235,261	6,782,434
Paid in (capital changes)	0	(902,096)	(1,007)	0	(473,566)
Paid in (surplus adjustments)	(32,400,000)	(183,680,442)	(28,272,580)	(47,100,000)	(2,526,434)
Dividends to stockholders	(207,600,000)	(48,617,462)	(148,026,413)	(246,300,000)	(52,000,000)
Aggregate write-ins for gains or (losses) in surplus	(8,372,211)	(1,930,866)	25,888,213	(6,911,268)	(444,491)
Net change in capital and surplus	<u>(30,978,519)</u>	<u>(74,091,232)</u>	<u>30,551,126</u>	<u>(45,164,744)</u>	<u>60,734,344</u>
Surplus as regards policyholders, December 31, current year	<u>\$369,570,237</u>	<u>\$ 400,548,756</u>	<u>\$ 474,639,988</u>	<u>\$ 444,088,862</u>	<u>\$ 428,359,981</u>

(1) Previous year surplus as regards policyholders' balances differ due to re-statement as a result of mergers

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Comparative Statement of Cash Flow For the Year Ended December 31,

Line	2011	2010	2009	2008	2007
Premiums collected net of reinsurance	\$ 3,821,213,940	\$ 3,909,814,901	\$ 4,242,396,866	\$ 3,852,290,338	\$ 2,037,878,523
Net investment income	28,350,718	33,062,987	30,550,359	33,666,400	19,467,604
Miscellaneous income	0	868,226	868,236	26,759,385	2,578,920
Total	3,849,564,658	3,943,746,114	4,273,815,461	3,912,716,123	2,059,925,047
Benefit and loss related payments	3,048,146,880	3,264,028,237	3,515,875,290	3,162,736,236	1,649,774,862
Commissions; expenses paid and aggregate write-ins for deductions	481,304,303	503,392,917	502,463,130	465,135,854	227,773,299
Federal and foreign income taxes paid (recovered) net of \$0 tax on capital gains (losses)	77,047,406	62,033,211	(20,372,476)	72,296,296	61,147,076
Total	3,806,498,589	3,829,454,365	3,997,965,944	3,700,168,386	1,938,695,237
Net cash from operations	243,066,069	114,291,749	275,849,517	212,547,737	121,229,810
Bonds (proceeds from investments sold; matured or repaid)	256,604,978	467,103,168	285,178,477	321,117,834	130,319,233
Stocks (proceeds from investments sold; matured or repaid)	0	0	0	795,000	0
Net gains (losses) on cash; cash equivalents and short-term investments	(74)	225	2,579	2,853	(70)
Miscellaneous proceeds (proceeds from investments sold; matured or repaid)	4,275,480	0	25,376,510	0	0
Total investment proceeds (proceeds from investments sold; matured or repaid)	260,880,384	467,103,393	310,557,566	321,915,687	130,319,163
Bonds (cost of investments acquired - long-term only)	237,263,899	359,228,268	376,384,909	320,683,935	170,670,829
Stocks (cost of investments acquired - long-term only)	0	0	0	0	9,140,847
Other invested assets (cost of investments acquired - long-term only)	0	4,275,480	0	0	0
Miscellaneous applications (cost of investments acquired - long-term only)	0	25,376,510	0	780,011	50,000
Total investments acquired (cost of investments acquired - long-term only)	237,263,899	388,880,258	376,384,909	321,463,946	179,861,676
Net cash from investments	23,816,485	78,223,135	(65,827,343)	451,741	(49,542,513)
Capital and paid in surplus; less treasury stock (cash provided/applied)	(32,400,000)	(184,582,538)	(28,273,587)	(47,100,000)	(3,000,000)
Dividends to stockholders (cash provided/applied)	(207,600,000)	(48,617,462)	(148,026,413)	(246,300,000)	(52,000,000)
Other cash provided (applied)	(21,803,796)	(24,158,501)	(56,540,435)	33,836,435	18,356,638
Net cash from financing and miscellaneous sources	(261,803,796)	(257,358,501)	(232,840,435)	(259,563,565)	(36,643,362)
Net change in cash; cash equivalents and short-term investments	4,878,758	(64,843,617)	(22,818,261)	(46,564,087)	35,043,935
Beginning of year (cash; cash equivalents and short-term investments)	31,459,507	96,303,124	119,121,385 (1)	138,641,506 (1)	22,447,841
End of year (cash; cash equivalents and short-term investments)	\$ 36,338,265	\$ 31,459,507	\$ 96,303,124	\$ 92,077,419	\$ 57,491,776

(1) Beginning balances re-stated due to mergers.

SUMMARY OF EXAMINATION CHANGES

There were no examination changes to the preceding financial statements as filed with regulatory authorities over the review period.

NOTES TO FINANCIAL STATEMENTS

ASSETS

INVESTMENTS

The book value of the Company's cash and invested assets as of December 31, 2011, as shown below, totaled \$591,453,641 and consisted of bonds, cash equivalents, and short-term investments.

Description	Amount	Percentage
Bonds	\$ 555,115,376	93.9%
Cash equivalents	20,112,900	3.4%
Short-term investments	16,225,365	2.7%
Totals	<u>\$ 591,453,641</u>	<u>100.0%</u>

The Company's cash and invested assets had the following quality and maturity profiles:

NAIC Designation	Amount	Percentage
1-Highest quality	\$ 436,923,122	73.9%
2-High quality	139,413,956	23.6%
3-Medium quality	11,427,788	1.9%
4-Low quality	2,926,275	0.5%
6-In or near default	762,500	0.1%
Totals	<u>\$ 591,453,641</u>	<u>100.0%</u>

As noted, approximately 97.5% of the Company's investment portfolio received a National Association of Insurance Commissioners ("NAIC") "highest" or "high quality" rating. Specifically, 73.9% of the portfolio was rated "highest quality" and 23.6% of the portfolio was rated "high quality". The remaining investments, approximately 2.5%, were classified below these levels.

The contractual or expected maturities of bonds, cash equivalents and short-term investments at December 31, 2011 were as follows:

Years to Maturity	Amount	Percentage
1 Year or Less	\$ 75,560,302	12.8%
2 to 5 Years	250,744,951	42.4%
6 to 10 Years	184,715,613	31.2%
Over 10 Years	80,432,825	13.6%
Totals	<u>\$ 591,453,691</u>	<u>100.0%</u>

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association ("FNMA") and Government National Mortgage Association ("GNMA") pools.

The Company's bond portfolio is spread among the following categories: Industrial and Miscellaneous 44.37%; U.S. Special Revenue and Special Assessment 35.19%; Government 11.47%; U.S. Political Subdivisions of States, Territories and Possessions 6.21%; and U.S. States Territories and Possessions 2.76%. Investments in foreign bonds accounted for 9.87% of the bond portfolio and 4.58% of total admitted assets. Cash equivalents consisted of short-term bonds and commercial paper.

On December 31, 2011, all of the Company's bonds were held under a custodian agreement with State Street Bank and Trust Company in Westwood, Massachusetts. However, the agreement did not meet all the requirements of 31 Pa. Code, Chapter 148a3. It was recommended that the custodian agreement with State Street Bank and Trust Company be

amended to contain all of the requirements of 31 Pa. Code, Chapter 148a3. The Company complied with this recommendation in 2013.

The Company has a written investment policy as required by 40 P.S. § 504.1(c). The investment policy is approved by the Board on an annual basis. It appears that the Company is following its investment policy.

LIABILITIES

CLAIMS UNPAID AND UNPAID CLAIMS ADJUSTMENT EXPENSES

At December 31, 2011, the Company reported an unpaid claims liability of \$300,300,836, which included a liability for claims reported in process of adjustment (“case reported”) of \$36,372,133 and an incurred but unreported claim liability (“IBNR”) of \$263,928,703. The following schedule reflects the Company’s reserves for case reported and IBNR by line of business:

Description	Total	Line of Business			
		Comprehensive (Hospital and Medical)	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare
Case Reported					
Direct (reported in process of adjustment)	\$ 36,372,133	\$ 23,573,666	\$ 33,000	\$ 8,623,653	\$ 4,141,814
Reinsurance assumed (reported in process of adjustment)	0	0	0	0	0
Reinsurance ceded (reported in process of adjustment)	0	0	0	0	0
Net (reported in process of adjustment)	36,372,133	23,573,666	33,000	8,623,653	4,141,814
Incurred but Unreported					
Direct (incurred but unreported)	263,928,703	158,397,359	502,557	54,466,449	50,562,338
Reinsurance assumed (reported in process of adjustment)	0	0	0	0	0
Reinsurance ceded (incurred but unreported)	0	0	0	0	0
Net (incurred but unreported)	263,928,703	158,397,359	502,557	54,466,449	50,562,338
Direct (totals)	300,300,836	181,971,025	535,557	63,090,102	54,704,152
Reinsurance assumed (totals)	0	0	0	0	0
Reinsurance ceded (totals)	0	0	0	0	0
Net (totals)	\$ 300,300,836	\$ 181,971,025	\$ 535,557	\$ 63,090,102	\$ 54,704,152

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid include the Company’s estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the financial statement date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing patterns, medical cost trends, historical utilization of health care

services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors. Capitation costs, which are recorded in hospital and medical expenses in the statutory financial statements, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for IBNR. The method of triangulation makes estimates of completion factors which are then applied to the total paid claims (net of coordination of benefits) to date for each incurred month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported ("claims unpaid"). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

At December 31, 2011, the Company also reported an unpaid claims adjustment expense liability of \$5,852,955. Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims.

The Company's appointed actuary, Mr. Michael W. Fedyna, who is an employee of the Company, provided an unqualified actuarial opinion on all of the claims and reserve liabilities reported by the Company as of December 31, 2011 in its statutory financial statements.

This examination utilized the actuarial services of Lewis & Ellis, LLP (L&E) to assist the Department examiners in the Phase 1 and 2 activities of the risk-focused financial examination of the Company. After review of the reserving risks identified by L&E's actuary and the subsequent testing by the examiners in Phase 3 and 4 of the Company's controls to mitigate those risks, it was determined that no further substantive procedures were required to test the adequacy of the above captioned liability accounts.

It was also noted that as part of its year-end 2011 statutory audit, the Company's external auditors, KPMG LLP (KPMG), evaluated the adequacy of the Company's reserves. Based on the analysis, KPMG's actuaries concluded that the Company's provision for its unpaid claims liability (including the reserves for unpaid claims adjustment expenses) was reasonable.

In addition to KPMG's and the Company's appointed actuary's actuarial reserve evaluations, a review was made by the Department examiners of the development of the unpaid claims and claims adjustment expenses subsequent to the examination date. Based on the subsequent development through December 31, 2012, as reported by the Company, the year-end 2011 reserves appear to be adequate.

A review of the work performed by KPMG to test the accuracy and completeness of the claims data used in the Company's actuarial analysis noted no exceptions.

AGGREGATE HEALTH POLICY RESERVES

At December 31, 2011, the Company reported aggregate health policy reserves of \$61,217,789. The following schedule reflects the Company's reserves by line of business:

Description	Total	Line of Business		
		Comprehensive (Hospital & Medical)	Dental Only	Employees Health Benefit Plan
Aggregate Health Policy Reserves				
Unearned premium reserves (policy reserve)	\$ 5,045,086	\$ 5,043,662	\$ 1,424	\$ 0
Additional policy reserves (policy reserve)	8,086,989	8,086,989	0	0
Reserve for future contingent benefits (policy reserve)	0	0	0	0
Reserve for rate credits or experience rating refunds (1)	48,085,714	27,442,147	0	20,643,567
Aggregate write-ins for other policy reserves (policy reserve)	0	0	0	0
Totals (gross) (policy reserve)	61,217,789	40,572,798	1,424	20,643,567
Reinsurance ceded (policy reserve)	0	0	0	0
Totals (net) (policy reserve)	\$ 61,217,789	\$ 40,572,798	\$ 1,424	\$ 20,643,567

(1) Liability for Medical Loss Ratio Rebates

Reserve for Rate Credits or Experience Rating Refunds: \$48.1 million (or 78.6%) of the total Aggregate Health Policy Reserves related to estimated rebates (for the 2011 calendar year) due under the recently enacted Health Care Reform Act. Beginning in 2012, the Company was required to make premium rebate payments to customers that are enrolled under certain health insurance policies if specific minimum annual medical loss ratios are not met in the prior year.

On June 1, 2012, the Company filed its 2011 claims and rebate data with the U.S. Department of Health and Human Services. The Medical Loss Ratio ("MLR") Annual Reporting Forms detailed the rebates the Company expected to pay in each state. The Company paid rebates

totaling \$39.9 million to its policyholders that were due a rebate in July, 2012. As of year-end 2012, the Company has established an estimated liability of \$14.4 million related to rebates for the 2012 calendar year.

As previously noted, this examination utilized the actuarial services of Lewis & Ellis, LLP (L&E) to assist the Department examiners in the Phase 1 and 2 activities of the risk-focused financial examination of the Company. After review of the reserving risks identified by L&E's actuary and the subsequent testing by the examiners in Phase 3 and 4 of the Company's controls to mitigate those risks, it was determined that no further substantive procedures were required to test the adequacy of the above captioned liability account.

It was also noted that as part of its year-end 2011 statutory audit, KPMG evaluated the adequacy of the above captioned reserves. Based on the analysis, KPMG's actuaries concluded that the Company's provision for its aggregate health policy reserves liability (including the reserves for the MLR rebates) was reasonable.

In addition to KPMG's actuarial reserve evaluation, a review was made by the Department examiners of the development of the subsequent payment of the MLR rebates in 2012. Based on the subsequent development as reported by the Company, the year-end 2011 reserves for the MLR rebates appear to be adequate.

For Informational Purposes Only

AGGREGATE HEALTH CLAIM RESERVES

At December 31, 2011, the Company reported aggregate health claim reserves of \$3,167,233. The following schedule reflects the Company's reserves by line of business:

Description	Line of Business			
	Total	Comprehensive (Hospital & Medical)	Dental Only	Federal Employees Health Benefit Plan
Aggregate Health Claim Reserves				
Present value of amounts not yet due on claims (claim reserve)	\$ 0	\$ 0	\$ 0	\$ 0
Reserve for future contingent benefits (claim reserve)	3,167,233	2,353,641	16,115	797,477
Aggregate write-ins for other claim reserves (claim reserve)	0	0	0	0
Totals (gross) (claim reserve)	\$ 3,167,233	\$ 2,353,641	\$ 16,115	\$ 797,477
Reinsurance ceded (claim reserve)	0	0	0	0
Totals (net) (claim reserve)	\$ 3,167,233	\$ 2,353,641	\$ 16,115	\$ 797,477

The reserve for future contingent benefits includes the estimated cost of services which will continue to be incurred after the financial statement date if the Company is obligated to pay for such services in accordance with contract provisions or regulatory requirements. These reserves are estimated using a percentage of current hospital and medical costs, which are based on the Company's historical cost experience.

This examination utilized the actuarial services of Lewis & Ellis, LLP (L&E) to assist the Department examiners in the Phase 1 and 2 activities of the risk-focused financial examination of the Company. After review of the reserving risks identified by L&E's actuary and the subsequent testing by the examiners in Phase 3 and 4 of the Company's controls to mitigate those risks, it was determined that no further substantive procedures were required to test the adequacy of the above captioned liability account.

It was also noted that as part of its year-end 2011 statutory audit, KPMG evaluated the adequacy of the above captioned reserves. Based on the analysis, KPMG's actuaries concluded that the Company's provision for its aggregate health claim reserves liability was reasonable.

CONTRIBUTIONS TO AETNA FOUNDATION INC.

The Company pledged and subsequently paid a \$20 million charitable contribution to Aetna Foundation (“Foundation”) Inc. on March 11, 2011. The Company’s accrual for the contribution was included in general expenses due or accrued in the statutory financial statements at December 31, 2010.

Including the contribution made in 2011, the Company made contributions to the Aetna Foundation totaling \$50.5 million during the period covered by this examination (2007 through 2011). Although the Foundation was formed in 1972, the Company did not provide information on amounts contributed for the years prior to 2007. Based on amounts reported by the Company in its Annual Statement filings for the period of 2004 through 2012, the Company made contributions to the Foundation totaling \$69.3 million. All of the contributions were reflected as charitable contribution expenses in the Company’s Underwriting & Investment Exhibit – Analysis of Expenses.

Although approved by the Board, the Company was unable to provide documentation to support the statutory authority to make these contributions. It is the Company’s opinion that these contributions are not subject to the Holding Company Act (and the related disclosures and filings) since the Foundation is not an affiliated entity. The Company has disclosed all of the contributions in its financial statements, including the Notes to its Financial Statements.

At the date of this report, the Department is reviewing these contributions to determine if they are subject to Pennsylvania laws or regulations.

SUBSEQUENT EVENTS

Out-of-Network Litigation

Aetna Inc. (“Aetna”) and certain of its subsidiaries, including the Company are named as a defendant in several purported class actions and individual lawsuits arising out of the Company practices related to the payment of claims for services rendered to the Company’s members by health care providers with whom the Company does not have a contract (“out-of-network providers”).

Other major health insurers are also the subject of similar litigation or have settled similar litigation. Among other things, these lawsuits allege that the Company paid too little to the Company's health plan members and/or providers for these services, among other reasons, because of the Company's use of data provided by Ingenix, Inc., a subsidiary of one of the Companies competitors ("Ingenix").

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to the Company's members during the period from 2001 to the present. Various plaintiffs who are members in the Company's health plans seek to represent nationwide classes of the Company's members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that the Company violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and Federal antitrust laws, either acting alone or in concert with the Company's competitors.

The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify the Company from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by a health plan member and by out-of-network providers.

The first class action case was commenced on July 30, 2007. The Federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The physician plaintiffs have attempted to appeal the Florida District Court's ruling to the United States Court of Appeals for the Eleventh Circuit.

On December 6, 2012, Aetna entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, Aetna will be released from claims relating to its out-of-network reimbursement practices from the beginning of the applicable settlement class

period through the date the New Jersey District Court preliminarily approves the settlement. The agreement contains no admission of wrongdoing.

Under the settlement agreement, Aetna will pay \$60 million, the substantial majority of which will be payable upon final court approval of the settlement and pay up to an additional \$60 million at the end of a claim submission and validation period that commences upon final court approval of the settlement.

The proposed settlement is subject to preliminary and final court approval. Final court approval of the settlement is expected during 2013, but could be delayed by appeals or other proceedings. In addition, the Aetna has the right to terminate the settlement agreement if more than certain percentages of class members, or class members collectively holding specified dollar amounts of claims, elect to opt-out of the settlement.

In connection with the proposed settlement, the Company recorded an after-tax charge to net income of \$2.4 million in the fourth quarter of 2012, which represents its portion of the settlement. Aetna and the Company will pay for the settlement with available resources and expects the settlement payments to occur over the next twelve to twenty-four months. Aetna intends to continue to vigorously defend themselves against the claims brought in these cases by non-settling plaintiffs.

Aetna also has received subpoenas and/or requests for documents and other information from, and has been investigated by, attorneys general and other state and/or Federal regulators, legislators and agencies relating to its out-of-network benefit payment practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against Aetna and/or the Company with respect to their out-of-network benefit payment practices.

Acquisitions

On December 27, 2012, the Insurance Commissioner of the Commonwealth of Pennsylvania approved the acquisition of Coventry Health Care of Pennsylvania, Inc., HealthAssurance Pennsylvania, Inc., and HealthAmerica Pennsylvania, Inc. ("Domestic Insurers") by the Company's ultimate parent, Aetna Inc. ("Aetna").

The Domestic Insurers are part of an insurance holding company system controlled by Coventry Health Care Inc. ("Coventry"). Under the terms of the acquisition, Coventry will merge

Aetna Health Inc. (a Pennsylvania corporation)

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with and into Aetna. As a result of the merger, Coventry and its Domestic Insurers would become wholly-owned subsidiaries of Aetna.

The acquisition of Coventry Health Care, Inc. by Aetna became effective on May 7, 2013.

RECOMMENDATIONS

PRIOR EXAMINATION

There were no examination recommendations or financial statement changes made as a result of the prior examination.

CURRENT EXAMINATION

There were no recommendations as a result of this examination.

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CONCLUSION

As a result of this examination, the financial condition of Aetna Health Inc. (a Pennsylvania corporation), as of December 31, 2011, was determined to be as follows:

	Amount	Percentage
Admitted Assets	<u>\$ 767,097,783</u>	<u>100.0%</u>
Liabilities	<u>\$ 397,527,546</u>	<u>51.8%</u>
Capital and Surplus	<u>369,570,237</u>	<u>48.2%</u>
Total Liabilities, Capital and Surplus	<u>\$ 767,097,783</u>	<u>100.0%</u>

Since December 31, 2006, the date of the previous examination, the Company's assets increased by \$461,698,669, its liabilities increased by \$253,266,345, and its surplus increased by \$208,432,324.

This examination was conducted with actuarial assistance from Lewis & Ellis, LLP and examination assistance from Cerebres, LLC with Richard Stone, CFE of Cerebres, LLC in charge.

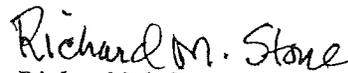
Respectively



Annette B. Szady, CPA
Director, Bureau of Financial Examinations



David R. Evans, CFE
Examination Manager



Richard M. Stone, CFE
Examiner-in-Charge

The CFE designation has been conferred by an organization not affiliated with the federal or any state government. However, the CFE designation is the only designation recognized by the NAIC for the purposes of directing statutory Association examinations of insurance companies.