AETNA INC /PA/
Form 10-K
February 27, 2004

Table of Contents

UNITED STATES SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

[ü] **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2003

or

[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number: 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania	23-2229683
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, Connecticut	06156
(Address of principal executive offices)	(ZIP Code)

Registrant s telephone number, including area code (860) 273-0123

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, $.01 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. þYes oNo

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). þYes oNo

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the registrant s most recently completed second fiscal quarter. $9,252,867,985

June 30, 2003

Indicate the number of shares outstanding of each of the registrant s classes of common stock, as of the latest practicable date.

Common Shares (par value $.01)	153,323,052
(Class)	Shares Outstanding at January 31, 2004

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s 2003 Annual Report, Financial Report to Shareholders (the Annual Report). (Parts I, II and IV) Portions of the registrant s proxy statement for its 2004 Annual Meeting to be filed on or about March 22, 2004 (the Proxy Statement). (Parts III and IV)

TABLE OF CONTENTS

Table of Contents

TABLE OF CONTENTS

Table of Contents

PART I

Item 1. Business.

A. Organization of Business

Aetna Inc. (a Pennsylvania corporation) and its subsidiaries (collectively, the Company) constitute one of the nation s largest health benefits companies, based on membership as of December 31, 2003. Prior to December 13, 2000, the Company (formerly Aetna U.S. Healthcare Inc.) was a subsidiary of a Connecticut corporation named Aetna Inc. (former Aetna). On December 13, 2000, former Aetna spun the Company off to its shareholders and, as part of the same transaction, the remaining entity, which contained former Aetna s financial services and international businesses, was merged with a subsidiary of ING Groep N.V. (ING) (collectively, the Transaction). Aetna Inc. was incorporated in Pennsylvania in 1982 under the name of United States Health Care Systems, Inc.

At December 31, 2003, the Company s operations included three business segments: Health Care, Group Insurance and Large Case Pensions. The principal products included in these segments are as follows:

Health Care:

- Health and dental benefit products (including health maintenance organization, point-of-service, preferred provider organization and indemnity products)

Group Insurance:

- Group insurance products (including life, disability and long-term care insurance products)

Large Case Pensions:

- Retirement products (including pension and annuity products) primarily for defined benefit and defined contribution plans

B. Financial Information About Segments

Required financial information by business segment is set forth in Note 19 of Notes to Consolidated Financial Statements, which is incorporated herein by reference to the Annual Report.

C. Description of the Business

1. Health Care

Products and Services

Health Care consists of health, dental and pharmacy plans offered on both a risk basis (where the Company assumes all or a majority of the financial risk for health care costs) (Risk) and an employer-funded basis (where the plan sponsor under an administrative services contract, and not the Company, assumes all or a majority of this risk) (ASC). Health plans include health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO) and indemnity benefit products (Indemnity).

Table of Contents

The principal commercial health products, offered both on a Risk and ASC basis, are described below:

HMO plans offer comprehensive benefits generally through contracts with participating network physicians, hospitals and other providers. When an individual enrolls in one of the Company s HMOs, he or she generally selects a primary care physician (PCP) from among the physicians participating in our network. PCPs generally are family practitioners, internists, general practitioners or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care, including making referrals to participating network specialists. Preventive care is emphasized in these plans. The Company also offers an open access HMO plan in certain markets that provides for the full range of benefits available to HMO members without the requirements of PCP selection or PCP referrals. The Company offers HMO plans with differing benefit designs and varying levels of co-payments that result in different levels of premium rates, including to federal government employee groups under the Federal Employees Health Benefits Program. Commercial HMO membership totaled 4.7 million as of December 31, 2003, 5.3 million as of December 31, 2002 and 7.8 million as of December 31, 2001.

POS plans blend the characteristics of HMO and indemnity plans. Members can have comprehensive HMO-style benefits for services received from participating network providers with minimum co-payments, but also have coverage, generally at higher co-payment or co-insurance levels, for services received outside the network. The Company also offers an open access POS plan in certain markets that provides in-network benefits without PCP selection or referral. POS membership totaled 2.3 million as of December 31, 2003, 2.6 million as of December 31, 2002 and 3.0 million as of December 31, 2001.

PPO plans offer coverage for services received from any health care provider, with benefits paid at a higher level when care is received from a participating network provider. Coverage typically is subject to deductibles and co-payments or coinsurance. PPO membership totaled 4.4 million as of December 31, 2003, 3.9 million as of December 31, 2002 and 4.1 million as of December 31, 2001.

During 2001, the Company also introduced Aetna Health Fund, a consumer-directed health plan that combines traditional HMO, POS or PPO coverage, subject to a deductible, with an accumulating benefit account, allowing members greater flexibility in utilizing a portion of their benefit dollars.

Indemnity plans offer the member the ability to select any health care provider for covered services. Some care management features may be included in these plans, such as inpatient precertification, disease management programs and benefits for preventive services. Coverage typically is subject to deductibles and coinsurance. In these plans, as with the Company s other health plans, member cost sharing for covered services generally is limited by out-of-pocket maximums. Indemnity membership totaled 1.4 million as of December 31, 2003, 1.6 million as of December 31, 2002 and 1.9 million as of December 31, 2001.

In December 2003, the Company announced that it plans to offer, beginning in 2004, plans incorporating Health Savings Accounts, as authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

In connection with the administration of ASC plans, the Company offers full-risk stop loss coverage for selected employers. This coverage transfers to Aetna the costs associated with large individual claims and/or aggregate loss experience within the ASC plan above a pre-set annual threshold.

In addition to Commercial health products, in select markets the Company also offers HMO-based coverage for Medicare beneficiaries, participates in a subsidized children s health insurance program (CHIP) and has a Medicaid and a CHIP ASC arrangement. Such coverages include the following:

Table of Contents

Through annual contracts with the Centers for Medicare and Medicaid Services (CMS), the Company s HMOs offer coverage for Medicare-eligible individuals in certain geographic areas through the Medicare Advantage (formerly Medicare+Choice) program. Generally, services must be obtained through participating network providers, with the exception of emergency and urgent care. Members historically have received enhanced benefits over standard Medicare fee-for-service coverage, including vision and certain pharmacy coverage. These Medicare plans are offered on a Risk basis. Medicare membership totaled .1 million as of December 31, 2003 and 2002 and .3 million as of December 31, 2001.

The Company participates on a Risk basis in the CHIP program in Pennsylvania, and provides administrative services in connection with a hospital-based Medicaid and CHIP program in Texas. Membership in these programs totaled .1 million as of December 31, 2003 and 2002 and .2 million as of December 31, 2001.

The Company offers a variety of other health care coverages either as supplements to health products or as stand-alone products. Such coverages, which are offered on a Risk or employer-funded basis, include indemnity and managed dental plans, prescription drug, vision and behavioral health programs. The Company is one of the nation s largest providers of dental coverage, based on membership at December 31, 2003. Dental membership totaled 10.9 million as of December 31, 2003, 11.8 million as of December 31, 2002 and 13.5 million as of December 31, 2001.

In October 2002, the Company announced that, following a review of strategic options related to its pharmacy benefits management operations, the Company decided to retain and expand upon its existing capabilities. In February 2003, the Company completed the purchase of a mail order pharmacy facility from Eckerd Health Services. The Company also expects to expand its existing clinical and sales capabilities relating to its pharmacy benefits management operations.

Provider Networks

General

The Company contracts with physicians, hospitals and other health care providers for services provided to its health plan members. The participating providers in the Company s networks are independent contractors and are neither employees nor agents of the Company, except for providers in the Company s new mail order pharmacy facility.

The Company uses a variety of techniques designed to help reduce inappropriate utilization of medical resources and maintain affordability of quality coverage. In addition to contracts with health care providers for negotiated rates of reimbursement, these techniques include the development and implementation of standards for the appropriate utilization of health care resources and working with health care providers to review data in order to help them improve consistency and quality. The Company also offers, directly or in cooperation with third parties, a variety of disease management programs related to specific conditions such as asthma, diabetes, congestive heart failure and lower back pain.

At December 31, 2003, the Company had approximately 600,100 health care providers participating in its networks nationwide, including more than 362,000 physicians and more than 3,600 hospitals.

Provider Network Contracting

Primary Care Physicians

The Company compensates PCPs on both a fee-for-service and capitated basis, with capitation generally limited to HMO products. In a fee-for-service arrangement, network physicians are paid for health care services provided to the member based upon a fee schedule. Under a capitation arrangement, physicians receive a monthly fixed fee for each member, regardless of the medical services provided to the member. In recent years, the Company has eliminated or reduced the use of capitation arrangements in many areas.

Table of Contents

Specialist Physicians

Specialist physicians participating in the Company s networks are generally reimbursed at contracted rates per visit or procedure.

Integrated Delivery Systems and Delegated Arrangements

In select markets the Company has developed contractual relationships with independent practice associations, integrated delivery systems and other third parties for the provision of certain health care services. Under some of these arrangements, the Company pays a fixed, per member fee or a percentage of premium and may delegate to the third party associated claim processing, utilization management and/or provider relations activities. Most providers participating in these arrangements have agreed to look solely to the third party for payment, but if the third party fails to pay, the Company may be exposed to demands for reimbursement.

The Company s HMO and POS plans typically employ capitated payment arrangements for most mental and behavioral health, substance abuse and freestanding laboratory services. These services are generally reimbursed on a contracted, fee-for-service basis under the Company s other products.

Hospitals

The Company typically enters into contracts with hospitals that provide for per diem and/or per case rates, often with fixed rates for ambulatory surgery and emergency room services. The Company has some hospital contracts that pay a percentage of billed charges.

The Company s plans generally require notification of elective hospital admissions, and the Company monitors the length of hospital stays. Participating physicians generally admit their HMO and POS patients to participating hospitals using referral procedures that direct the hospital to contact the Company s patient management unit, which confirms the patient s membership status while obtaining pertinent data. This unit also assists members and providers with related activities, including the subsequent transition to the home environment and home care, if necessary. Case management assistance for complex or catastrophic cases is provided by a special case unit.

Quality Assessment

The Company s quality assessment programs begin with the initial review of health care practitioners. Each practitioner s license and education are verified and work history is collected by the Company or in some cases by the practitioner s affiliated group or organization. A committee of participating practitioners in each region reviews this information before the practitioner can participate in the network. Participating practitioners also periodically undergo a recredentialing process. Participating hospitals are required to have CMS and Joint Commission on Accreditation of Healthcare Organizations accreditation or undergo a detailed site assessment by the Company s quality management staff.

Recredentialing of practitioners may include an analysis of member grievances filed with the Company, interviews, member surveys, and analysis of drug prescription and other utilization patterns. Committees composed of a peer group of participating practitioners review participating practitioners being considered for recredentialing.

The Company also offers quality and outcome measurement programs, quality improvement programs and health care data analysis systems to providers and purchasers of health care.

The Company seeks accreditation for most of its HMO plans from the National Committee for Quality Assurance (the NCQA), a national organization established to review the quality and medical management systems of HMOs and certain other health care plans. NCQA accreditation is a nationally recognized standard. As of December 31, 2003, approximately 98.3% of the Company s HMO members participated in HMOs that had received accreditation by the NCQA.

Table of Contents

The Company seeks accreditation for its PPO-based and other products from the American Accreditation HealthCare Commission (also known as URAC), a national organization founded in 1990 to establish standards for the health care industry. Purchasers and consumers look to URAC s accreditation as an indication that a health care organization has the necessary structures and processes to promote high quality care and preserve patient rights. In addition, regulators in over half of the states recognize URAC s accreditation standards in the regulatory process. Aetna Inc. and Aetna Life Insurance Company (ALIC) have received URAC accreditation extending through May 1, 2004.

Principal Markets and Sales

Total Commercial, Medicare and Medicaid HMO, POS, PPO and Indemnity medical membership (Medical membership) is dispersed throughout the United States. The Company offers a wide array of benefit plans, many of which are available in all 50 states. ASC products are available in all 50 states. Depending on the product, the Company markets to a range of customers from individuals and small employer groups to large, multi-site national accounts.

The following table presents total Medical membership by region and funding arrangement, at December 31:

	2003			2002			2001 (1)		
(Thousands)	Risk	ASC	Total	Risk	ASC	Total	Risk	ASC	Total
Northeast	1,054	1,221	2,275	1,126	1,267	2,393	1,709	1,275	2,984
Mid-Atlantic	927	1,457	2,384	942	1,506	2,448	1,512	1,491	3,003
Southeast	779	1,415	2,194	847	1,395	2,242	1,373	1,443	2,816
North Central	413	2,009	2,422	487	2,032	2,519	1,065	2,165	3,230
Southwest	529	1,294	1,823	669	1,247	1,916	1,179	1,228	2,407
West	693	1,144	1,837	888	1,201	2,089	1,365	1,286	2,651
Other	63	4	67	66	5	71	73	6	79
Total Medical Membership	4,458	8,544	13,002	5,025	8,653	13,678	8,276	8,894	17,170

(1) Membership in thousands includes 95 Medicare members affected by the Company s exit of a number of Medicare service areas, effective January 1, 2002.

For membership composition of Health Care s products by funding arrangement, refer to Management s Discussion and Analysis of Financial Condition and Results of Operations (MD&A) - Health Care - Membership in the Annual Report, which is incorporated herein by reference.

Both Risk and ASC products and services are marketed primarily to employers for the benefit of employees and their dependents. Frequently, employers offer employees a choice of coverages, from which the employee makes his or her selection during a designated annual open enrollment period. Employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage, as determined by the employer, of such monthly premium.

Within Risk products, Medicare coverage is sold on an individual basis as well as through employer groups to their retirees. Medicaid and subsidized children s health insurance programs are marketed to individuals rather than employer groups.

Health Care products are sold primarily through the Company s sales personnel, who frequently work with independent consultants and brokers who assist in the production and servicing of business. Sales representatives also sell to employers on a direct basis. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. Marketing and sales efforts are promoted by an advertising program which includes television, radio, billboards and print media, supported by market research and direct marketing efforts.

Table of Contents

Health Pricing

For Risk Commercial plans, customer contracts are generally established in advance of the policy period, typically for a duration of one year. In determining the premium rates to be charged to the customer, prospective, experience-rated and retrospective rating methodologies may be used. Some states may prohibit the use of one or more of these rating methods, including for particular business segments, such as small employer groups.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. Unanticipated increases in medical costs cannot be recovered in the current policy year; however, prior experience for a product in the aggregate may be considered, among other factors, in determining premium rates for future periods. Where required by law, the Company establishes premium rates prior to contract inception without regard to actual utilization of services incurred by individual members, using one of three approved community rating methods. These rates may vary from account to account to reflect projected family size and contract mix, benefit levels, renewal date, and other factors. Under the traditional community rating method, a plan establishes premium rates based on its revenue requirements for its entire enrollment in a given community. Under the community rating by class method, a plan establishes premium rates based on its revenue requirements for broad classes of membership distinguished by factors such as age and gender. Under the group specific community rating method, a plan establishes premium rates based in part on its revenue requirements for providing services to the group. State laws, in some of the states in which the Company operates plans, require the filing with and approval by the state of plan premium rates. In addition to reviewing anticipated medical costs, some states also review anticipated administrative costs as part of the approval process. Future results of the Company could be adversely affected if the premium rates requested by the Company are not approved or are adjusted downward by state regulators.

Under retrospective rating, a premium rate is determined at the beginning of the policy period. After the policy period has ended, the actual experience is reviewed. If the experience is positive (i.e., actual claim costs and other expenses are less than those expected) then a refund may be credited to the policy. If the experience is negative, then the resulting deficit may, in certain instances, be recovered through contractual provisions; otherwise the deficit is considered in setting future premium levels. If a customer elects to terminate coverage, these deficits generally cannot be recovered. Retrospective rating is often used for employer-funded POS, PPO and Indemnity plans that cover more than 300 lives.

Premium rates generally for experience-rated plans give consideration to the individual plan sponsor s historical and anticipated claim experience. With regard to smaller employer groups, however, the group may not be large enough for the use of experience rating to be appropriate, and another rating method is used.

The Company has contracts with CMS to provide HMO Medicare Advantage (formerly Medicare+Choice) coverage to Medicare beneficiaries who choose health care coverage through an HMO. Under these annual contracts, CMS pays the HMO at a capitated rate based on membership and adjusted for demographic factors. Inflation, changes in utilization patterns and benefit plans, demographic factors such as age and gender, and both local county and national fee for service average per capita Medicare costs are considered in the rate calculation process. Amounts payable under Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area on an annual basis. In addition to premiums received from CMS, most of the Medicare products offered by the Company require a supplemental premium to be paid by the member. Under Medicare Advantage arrangements, the Company assumes the risk of higher than expected medical expenses. Medicare contracts generate higher per member per month revenues, but also generate higher per member per month medical expenses, than typical Commercial plans.

The Company also has HMO contracts to serve a variety of federal government employee groups under the Federal Employees Health Benefit Program. Premium rates are subject to federal government review and audit, which can result in retroactive and prospective premium adjustments.

Table of Contents

In 2003, the Company had a contract in Pennsylvania to provide Risk health benefits to persons eligible for children s health insurance program benefits. The Company receives a fixed monthly payment based on membership in return for the coverage of health care services. The rates are subject to periodic unilateral revision by the contracting agencies. The Company assumes the risk of higher than expected medical expenses.

Contracts with plan sponsors to provide administrative services for employer-funded plans are generally for a period of one year. Some of the Company s contracts include guarantees with respect to certain functions such as customer service response time, claim processing accuracy and claim processing turnaround time as well as certain guarantees that claim expenses to be incurred by plan sponsors will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum at risk is typically 10% - 30% of fees for the customer involved.

Competition

Competition in the health care industry is intense, primarily due to a large number of competitors, aggressive marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the market. New entrants into the marketplace as well as significant consolidation within the industry have contributed to the intense competitive environment.

The Company believes that the most significant factors that distinguish competing health plans are perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including both premium and member out-of-pocket costs), product design, financial stability, the geographic scope of provider networks, and the providers available in such networks. The Company believes that it is competitive in each of these areas. The ability to increase the number of persons covered by the Company s plans or to increase revenues is affected by competition in any particular area. In addition, the ability to increase the number of persons enrolled in Risk products is affected by the desire and ability of employers to self fund their health coverage. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Within Risk products, the Company competes with local and regional managed care plans, in addition to managed care plans sponsored by large health insurance companies and Blue Cross/Blue Shield plans. Additional competitors include other types of medical and dental provider organizations, various specialty service providers, integrated health care delivery organizations, and in certain plans, programs sponsored by the federal or state governments.

With regard to ASC plans, the Company competes primarily with other commercial insurance companies, Blue Cross/Blue Shield plans and third party administrators.

Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect Health Care s business is incorporated herein by reference to the MD&A - Forward-Looking Information/Risk Factors and the MD&A-Executive Summary-2004 Outlook in the Annual Report.

2. Group Insurance

Principal Products

Group Insurance consists primarily of the following:

Group Life consists principally of renewable term coverage, the amounts of which may be fixed or linked to individual employee wage levels. Basic and supplemental term coverage and spouse and dependent coverages are available. Group universal life and accidental death benefit coverages are also available. Group life insurance is offered on an insured basis. Group life insurance membership totaled 10.0 million as of December 31, 2003, 9.3 million as of December 31, 2002 and 9.2 million as of December 31, 2001.

Table of Contents

Group Disability provides employee income replacement benefits for both short-term disability and long-term disability. The Company also offers disability products with additional case management features. Group disability benefits are offered on both an insured and employer-funded basis. Group disability membership totaled 2.1 million as of December 31, 2003, 2.2 million as of December 31, 2002 and 2.1 million as of December 31, 2001.

Long-Term Care provides benefits for long-term, custodial care expenses in a nursing home, adult day care or home setting. Long-term care benefits are offered primarily on an insured basis. The product is available on both a service reimbursement and disability basis. Long-term care insurance membership totaled .2 million as of December 31, 2003 and 2002 and .1 million as of December 31, 2001.

Group insurance members may utilize more than one Company product and in such cases have been counted in membership totals for each.

Principal Markets and Sales

Products offered by Group Insurance are available in 49 states (Group Insurance products are not offered in New Mexico) as well as Guam, Puerto Rico and Canada. Depending on the product, the Company markets to a range of customers from small employer groups to large, multi-site national accounts.

Group Insurance products and services are marketed primarily to employers for the benefit of employees and their dependents. Frequently, employers offer employees a choice of benefits, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage, as determined by the employer, of such monthly premium. Some products are sold on a fully employee-paid basis and some billing is done on a direct basis.

Group Insurance products are sold primarily through the Company s sales personnel, who frequently work with independent consultants and brokers who assist in the production and servicing of business. Sales representatives also sell to employers on a direct basis. For large plan sponsors, independent consultants and brokers are frequently involved in employer plan selection decisions and sales. Marketing and sales efforts are promoted by an advertising program that may include television, radio, billboards and print media, supported by market research and direct marketing efforts.

Pricing

For risk Group Insurance Plans, customer contracts are generally established in advance of the policy period, for a duration of one, two or three years. In determining the premium rates to be charged to the customer, prospective and retrospective rating methodologies are used.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. Unanticipated increases in mortality or morbidity costs cannot be recovered in the current policy period; however, prior experience for the specific customer and/or the product in aggregate is considered, among other factors, in determining premium rates for future policy periods.

Under retrospective rating, a premium rate is determined at the beginning of a policy period. After the policy period has ended, the actual experience is reviewed. If the experience is positive (i.e., actual claim costs and other expenses are less than expected) then a refund may be credited to the policy. If the experience is negative, then the resulting deficit is considered in setting future premium levels; otherwise, in certain circumstances, the deficit may be recovered through contractual provisions. Such deficits may be used as offsets against refund credits that develop for future policy periods. If a customer elects to terminate coverage, these deficits generally cannot be recovered. Retrospective rating is most often used for insured employer funded plans that cover more than 300 lives.

Table of Contents

Competition

For the group insurance industry, the Company believes that the most significant factors which distinguish competing companies are price, quality of service, comprehensiveness of coverage, and product array and design. Specialty carriers have increased market penetration in the life and disability business. The deeply penetrated group life market remains highly competitive.

Reinsurance

The Company uses reinsurance agreements with nonaffiliated insurers to control its exposure to large losses and certain other risks for Group Insurance products. The Company maintains catastrophic life reinsurance (covering life, accidental death and dismemberment and disability products) that generally provides protection against catastrophic events above a retained deductible per event. For life, accidental death and long-term disability products, there are excess of loss arrangements that provide protection against large claims. Additional reinsurance arrangements include quota share treaties on several large cases and facultative treaties that are established on a case by case basis. The Company carries excess professional liability insurance.

Group Life Insurance In Force and Other Statistical Data

The following table summarizes changes in group life insurance in force before deductions for reinsurance ceded to other companies for the years indicated:

(Dollars in Millions)	2003	2002	2001
In force, end of year	$473,483	$407,942	$424,030
Terminations (lapses and all other)	$ 51,983	$ 61,628	$ 55,033
Number of policies and contracts in force, end of year:			
Group Life Contracts (1)	11,791	11,510	13,350
Group Conversion Policies (2)	24,448	25,546	26,687

(1) Due to the diversity of coverages and size of covered groups, statistics are not provided for average size of policies in force.

(2) Reflects conversion privileges exercised by insureds under group life policies to replace those policies with individual life policies.

Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect Group Insurance s business is incorporated herein by reference to the MD&A - Forward-Looking Information/Risk Factors and the MD&A-Executive Summary-2004 Outlook in the Annual Report.

3. Large Case Pensions

Principal Products

Large Case Pensions manages a variety of retirement products (including pension and annuity products) offered to Internal Revenue Code Section 401 qualified defined benefit and defined contribution plans. Contracts provide nonguaranteed, experience-rated and guaranteed investment options through general and separate account products. Large Case Pensions products that use separate accounts provide contractholders with a vehicle for investments under which the contractholders assume the investment risk. Large Case Pensions earns a management fee on these separate accounts.

In 1993, the Company discontinued its fully guaranteed Large Case Pensions products. Information regarding these products is incorporated herein by reference to the MD&A - Large Case Pensions - Discontinued Products in the Annual Report.

Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect Large Case Pensions business is incorporated herein by reference to the MD&A - Forward-Looking Information/Risk Factors and the MD&A Executive Summary-2004 Outlook in the Annual Report.

Table of Contents

4. Other Matters

a. Website Access to Reports

Aetna s reports to the Securities and Exchange Commission, including its annual report on Form 10-K, reports on Form 10-Q, current reports on Form 8-K and amendments to these reports, if any, are available free of charge on the Company s website at http://www.aetna.com. (such information is available on the website as soon as practicable after it is electronically filed or furnished to the Securities and Exchange Commission).

b. Regulation

Information regarding significant regulations affecting the Company is incorporated herein by reference to MD&A - Regulatory Environment and Forward-Looking Information/Risk Factors in the Annual Report.

c. NAIC IRIS Ratios

The National Association of Insurance Commissioners (NAIC) Insurance Regulatory Information System (IRIS) ratios cover 12 categories of financial data with defined usual ranges for each category. The ratios are intended to provide insurance regulators with early warnings as to when a given company might warrant special attention. An insurance company may fall out of the usual range for one or more ratios, and such variances may result from specific transactions that are themselves immaterial or eliminated at the consolidated level. In certain states, insurers with more than three IRIS ratios outside of the NAIC usual ranges are subject to increased regulatory oversight.

Management does not expect that any of the Company s significant insurance subsidiaries will have more than three IRIS ratios outside of the NAIC usual ranges for 2003, although final calculation by the NAIC is not expected to be completed until the end of the first quarter of 2004.

Refer to MD&A - Liquidity and Capital Resources and Regulatory Environment in the Annual Report, incorporated herein by reference, for additional discussion regarding solvency regulation.

d. Ratio of Earnings to Fixed Charges and Ratio of Earnings to Combined Fixed Charges and Preferred Stock Dividends

The following table sets forth the Company s ratios of earnings to fixed charges and ratios of earnings to combined fixed charges and preferred stock dividends for the years ended December 31:

Aetna Inc.	2003	2002	2001	2000	1999
Ratio of Earnings to Fixed Charges	9.95	4.06	(0.73)	0.89	3.31
Ratio of Earnings to Combined Fixed Charges and Preferred Stock Dividends (1)	9.95	4.06	(0.73)	0.89	2.81

(1) Although the Company did not pay preferred stock dividends, preferred stock dividends paid by former Aetna have been included for purposes of this calculation for the year ending December 31, 1999 (through the redemption date of July 19, 1999), as the preferred stock of former Aetna was issued in connection with the acquisition of U.S. Healthcare, Inc. in 1996.

For purposes of computing both the ratio of earnings to fixed charges and the ratio of earnings to combined fixed charges and preferred stock dividends, earnings represent consolidated earnings from continuing operations before income taxes, cumulative effect adjustments and extraordinary items plus fixed charges. Fixed charges consists of interest expense (and the portion of rental expense deemed representative of the interest factor).

Pretax loss from continuing operations used in calculating the ratio for 2001 reflects a severance and facilities charge of $193 million. The ratio for 2000 reflects a goodwill write-off of $310 million, a severance and facilities charge of $143 million and $58 million of change-in control related payments and other costs required to effect the spin-off of the Company from former Aetna. Additional pretax income from continuing operations necessary to achieve both a ratio of earnings to fixed charges of 1.0 and a ratio of earnings to combined fixed charges and preferred

stock dividends of 1.0, was approximately $379 million and $39 million in 2001 and 2000, respectively.

Table of Contents

e. Trademarks

The trademark Aetna (Registered Trademark), together with the corresponding design logo, are owned by the Company. The Company considers this trademark and its other trademarks and trade names important in the operation of its business. However, the business of the Company, including that of each of its individual segments, is not dependent on any individual trademark or trade name.

f. Ratings

Information regarding the Company s ratings is incorporated herein by reference to the ratings table in MD&A - Liquidity and Capital Resources - Financings, Financing Capacity and Capitalization.

g. Miscellaneous

The Company had approximately 27,600 domestic employees at December 31, 2003. Refer to Note 11 of Notes to Consolidated Financial Statements, which is incorporated herein by reference to the Annual Report, for a discussion of workforce reductions announced in 2002.

The federal government is a significant customer of the Health Care segment and the Company, with premiums and fees accounting for approximately 10.6% of the Health Care segment s revenue in 2003. Contracts with CMS for coverage of Medicare-eligible individuals accounted for 55.8% of these premiums and fees, with the balance from federal employee related benefit programs. No other individual customer, in any of the Company s three segments, accounted for 10% or more of the Company s consolidated revenues in 2003. The Company s segments are not dependent upon a single customer or a few customers, the loss of which would have a significant effect on the earnings of a segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Company or any of its segments. Refer to Note 19 of Notes to Consolidated Financial Statements, which is incorporated herein by reference to the Annual Report, regarding segment information.

Item 2. Properties.

The home office of the Company is a building complex located at 151 Farmington Avenue, Hartford, Connecticut that is approximately 1.2 million square feet in size. The home office is used by all the Company s business segments. The Company also owns or leases other space in the greater Hartford area; Blue Bell, Pennsylvania; as well as various field locations throughout the country. Such properties are primarily used by the Company s Health Care segment. The Company believes its properties are adequate and suitable for its business as presently conducted.

The foregoing does not include numerous investment properties held by the Company in its General and Separate Accounts.

Item 3. Legal Proceedings.

Managed Care Class Action Litigation

Since 1999, the Company has been involved in purported class action lawsuits that are part of a wave of similar actions targeting the health care payor industry and, in particular, the conduct of business by managed care companies (the Managed Care Class Action Litigation).

The Judicial Panel on Multi-district Litigation transferred all of the federal actions, including several actions originally filed in state courts, to the United States District Court for the Southern District of Florida (the Florida Federal Court) for consolidated pretrial proceedings. The Florida Federal Court created a separate track for all cases brought on behalf of health care providers (the Provider Cases).

Table of Contents

Thirteen Provider Cases were presided over by the Florida Federal Court, and a similar action is pending in Louisiana state court, on behalf of purported classes of physicians. These Provider Cases alleged generally that the Company and each of the other defendant managed care organizations employed coercive economic power to force physicians to enter into economically unfavorable contracts, imposed unnecessary administrative burdens on providers and improperly denied claims in whole or in part, and that the defendants did not pay claims timely or did not pay claims at proper rates. These Provider Cases further charged that the Company and the other defendant managed care organizations conspired and aided and abetted one another in the alleged wrongdoing. These actions alleged violations of RICO, ERISA, state unfair trade statutes, state consumer fraud statutes, state laws regarding the timely payment of claims, and various common law doctrines and sought various forms of relief, including unspecified damages, treble damages, punitive damages and injunctive relief.

Effective May 21, 2003, the Company and representatives of over 900,000 physicians, state and other medical societies entered into an agreement (the Physician Settlement Agreement) settling the lead physician Provider Case pending in the Florida Federal Court. The Physician Settlement Agreement was approved by the Florida Federal Court on November 6, 2003. The order of approval has been appealed to the United States Court of Appeals for the Eleventh Circuit. The Company anticipates that, if the approval order is not overturned on appeal, the Physician Settlement Agreement will resolve all pending Provider Cases filed on behalf of physicians that did not opt out of the settlement, including the Louisiana state court action. During the second quarter of 2003, the Company recorded an after-tax charge of $75 million ($115 million pretax) (included in other operating expenses) in connection with the Physician Settlement Agreement, net of an estimated insurance recoverable of $72 million pretax.

A Provider Case brought on behalf of the American Dental Association makes similar allegations on behalf of a purported class of dentists. Effective August 22, 2003 the Company and representatives of approximately 15,000 dentists entered into an agreement (the Dentist Settlement Agreement) settling the dentist action. The Dentist Settlement Agreement is subject to approval by the Florida Federal Court.

Three Provider Cases filed in May and June, 2003 on behalf of purported classes of chiropractors and/or all non-physician health care providers also make factual and legal allegations similar to those contained in the other Provider Cases. These Provider Cases have been transferred to the Florida Federal Court for consolidated pretrial proceedings. The Company intends to defend each of these new Provider Cases vigorously.

In addition, a complaint was filed in the Superior Court of the State of California, County of San Diego (the California Superior Court) on November 5, 1999 by Linda Ross and The Stephen Andrew Olsen Coalition for Patients Rights, purportedly on behalf of the general public of the State of California (the Ross Complaint). The Ross Complaint, as amended, sought injunctive relief against Aetna s predecessor (former Aetna), Aetna, Aetna Health of California Inc. and additional unnamed John Doe defendants for alleged violations of California Business and Professions Code Sections 17200 and 17500. The Ross Complaint alleged that defendants were liable for alleged misrepresentations and omissions relating to advertising, marketing and member materials directed to the Company s HMO members and the general public and for alleged unfair practices relating to contracting of doctors. The Company settled this action on October 30, 2003, and the case has been dismissed. Payments made in connection with the Ross settlement were not material, and the Ross settlement did not result in material changes to the Company s business practices.

Table of Contents

Securities Class Action Litigation

Laborers Tri-County Pension Fund, Goldplate Investment Partners Ltd. and Sheila Shafran filed a consolidated and amended purported class action complaint (Securities Complaint) on June 7, 2002 in the United States District Court for the Southern District of New York (the New York Federal Court). The Securities Complaint supplanted several complaints, filed beginning November 6, 2001, which have been voluntarily dismissed or consolidated. Plaintiffs contend that the Company and two of its current or former officers and directors, William H. Donaldson and John W. Rowe, M.D., violated federal securities laws. Plaintiffs allege misrepresentations and omissions regarding, among other things, the Company s ability to manage and control medical costs and the appropriate reserve for medical costs as of December 31, 2000, for which they seek unspecified damages, among other remedies. On October 15, 2002, the New York Federal Court heard argument on defendants motion to dismiss the Securities Complaint. Defendants intend to continue vigorously defending this action, which is in its preliminary stages.

The Company is unable to predict at this time the ultimate outcome of the Managed Care Class Action Litigation or Securities Class Action Litigation. It is reasonably possible that their outcome, including any negotiated resolution, could be material to the Company. However, as noted above, if the Florida Federal Court s approval of the Physician Settlement is ultimately affirmed, the Company anticipates that the Physician Settlement Agreement would result in the conclusion of substantially all pending Provider Cases filed on behalf of physicians.

Other Litigation and Regulatory Proceedings

The Company is involved in numerous other lawsuits arising, for the most part, in the ordinary course of its business operations, including employment litigation and claims of bad faith, medical malpractice, non-compliance with state regulatory regimes, marketing misconduct, failure to timely pay medical claims, investing activities, intellectual property and other litigation in its health care and group businesses. Some of these other lawsuits are purported to be class actions.

In addition, the Company s current and past business practices are subject to review by various state insurance and health care regulatory authorities and other state and federal authorities. There continues to be heightened review by these authorities of the managed health care industry s business practices, including utilization management, delegated arrangements and claim payment practices. As a leading national managed care organization, the Company regularly is the subject of such reviews. These reviews may result in changes to or clarifications of the Company s business practices, and may result in fines, penalties or other sanctions.

While the ultimate outcome of this other litigation and these regulatory proceedings cannot be determined at this time, after consideration of the defenses available to the Company, applicable insurance coverage and any related reserves established, they are not expected to result in liability for amounts material to the financial condition of the Company, although they may adversely affect results of operations in future periods.

Item 4. Submission of Matters to a Vote of Security Holders.

None.

Table of Contents

EXECUTIVE OFFICERS OF AETNA INC.*

The Chairman of the Board of Directors is elected and all other executive officers listed below are appointed by the Board at its Annual Meeting and such persons hold office until the next Annual Meeting of the Board or until their successors are elected or appointed. None of these officers has a family relationship with any other executive officer or Director. In addition, there exist no arrangements or understandings, other than those with Directors or officers of the Company acting solely in their capacities as such, pursuant to which these executive officers were appointed.

Name of Officer	Position	Age *
John W. Rowe, M.D.	Chairman and Chief Executive Officer	59
Ronald A. Williams	President	54
Alan M. Bennett	Senior Vice President and Chief Financial Officer	53
Timothy A. Holt	Senior Vice President and Chief Investment Officer	50
William C. Popik, M.D.	Senior Vice President and Chief Medical Officer	58

*As of February 27, 2004

Executive Officers Business Experience During Past Five Years

John W. Rowe, M. D. became Chairman of the Board on April 1, 2001 and became Chief Executive Officer of the Company on September 15, 2000. He served as President of the Company from September 15, 2000 to May 27, 2002. Dr. Rowe also served as an executive officer of former Aetna from September 15, 2000 until the spin-off. Prior to joining Aetna, Dr. Rowe served as President and Chief Executive Officer of Mount Sinai NYU Health, a position he assumed in 1998 after overseeing the 1998 merger of the Mount Sinai and NYU Medical Centers. Dr. Rowe joined The Mount Sinai Hospital and the Mount Sinai School of Medicine as President in 1988.

Ronald A. Williams became President of the Company on May 27, 2002, having served as Executive Vice President and Chief of Health Operations since March 15, 2001. Prior to joining Aetna, he served as Group President of the Large Group Division of WellPoint Health Networks, Inc., a position Mr. Williams assumed in 1999, in addition to serving as President of WellPoint s Blue Cross of California subsidiary beginning in 1995.

Alan M. Bennett became Senior Vice President and Chief Financial Officer of the Company on September 28, 2001. He served as Vice President and Corporate Controller from December 2000 to November 2001. He became Vice President and Corporate Controller of former Aetna in March 1998 after having served as Vice President and Director of Internal Audit from March 1997 to March 1998.

Timothy A. Holt became Senior Vice President and Chief Investment Officer of the Company on December 8, 2000 having served as Senior Vice President and Chief Investment Officer of former Aetna since January 1999. From October 1997 to January 1999 he served as Vice President and Chief Investment Officer of former Aetna.

William C. Popik, M.D., became Senior Vice President and Chief Medical Officer of the Company on March 5, 2001. Prior to joining Aetna, he served as Senior Vice President and National Medical Director of Cigna Corporation, a position he assumed in February 1996.

Table of Contents

PART II

Item 5. Market Price of and Dividends on the Registrant s Common Equity and Related Stockholder Matters.

Aetna Inc. s common shares are listed on the New York Stock Exchange. They trade under the symbol AET. As of January 31, 2004, there were 13,577 record holders of Aetna Inc. s common shares.

The Company declared, and subsequently paid, an annual cash dividend in the amount of $.04 per common share in each of 2003 and 2002. Refer to MD&A Liquidity and Capital Resources Dividends in the Annual Report, incorporated herein by reference, for additional information regarding dividend payments. Information regarding restrictions on the Company s present and future ability to pay dividends is incorporated herein by reference to Note 17 of Notes to Consolidated Financial Statements and MD&A - Liquidity and Capital Resources in the Annual Report. Information regarding quarterly common stock prices is incorporated herein by reference to the unaudited Quarterly Data included in the Annual Report.

Item 6. Selected Financial Data.

The information contained in Selected Financial Data in the Annual Report is incorporated herein by reference.

Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations.

The information contained in MD&A in the Annual Report is incorporated herein by reference.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The information contained in MD&A - Total Investments in the Annual Report and in Note 8 of Notes to Consolidated Financial Statements are incorporated herein by reference.

Item 8. Financial Statements and Supplementary Data.

The Consolidated Financial Statements, Notes to Consolidated Financial Statements, Independent Auditors Report and unaudited Quarterly Data are incorporated herein by reference to the Annual Report.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures

The Company maintains disclosure controls and procedures, which are designed to ensure that information required to be disclosed by the Company in the reports it files or submits under the Securities Exchange Act of 1934, as amended (the Exchange Act), is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission s rules and forms, and that such information is accumulated and communicated to the Company s management, including its Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

Table of Contents

An evaluation of the effectiveness of the Company s disclosure controls and procedures as of December 31, 2003 was conducted under the supervision and with the participation of the Company s Chief Executive Officer and Chief Financial Officer. Based on that evaluation, the Company s Chief Executive Officer and Chief Financial Officer have concluded that the Company s disclosure controls and procedures were adequate and designed to ensure that material information relating to Aetna Inc. and its consolidated subsidiaries would be made known to the Chief Executive Officer and Chief Financial Officer by others within those entities, particularly during the periods when periodic reports under the Exchange Act are being prepared. Furthermore, there has been no change in the Company s internal control over financial reporting, identified in connection with the evaluation of such control, that occurred during the Company s last fiscal quarter that has materially affected, or is reasonably likely to materially affect, the Company s internal control over financial reporting. Refer to the Certifications by the Company s Chief Executive Officer and Chief Financial Officer filed as exhibits 31.1 and 31.2 to this report.

PART III

Item 10. Directors and Executive Officers of the Registrant.

Information concerning Executive Officers is included in Part I pursuant to General Instruction G to Form 10-K.

Information concerning Directors compliance with Section 16(a) of the Securities Exchange Act of 1934, the Company s Code of Conduct (its written code of ethics), its audit committee financial experts, governance guidelines and related matters is incorporated herein by reference to the information under the captions Nominees for Directorships , Section 16(a) Beneficial Ownership Reporting Compliance , Aetna s Corporate Governance Guidelines , Aetna s Code of Conduct , Board and Committee Membership and Certain Transactions and Relationships in the Proxy Statement.

Item 11. Executive Compensation.

The information under the captions Nonmanagement Director Compensation in 2003 , Other Information Regarding Directors and Executive Compensation in the Proxy Statement is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The information under the captions Security Ownership of Certain Beneficial Owners, Directors, Nominees and Executive Officers in the Proxy Statement is incorporated herein by reference.

The following table gives information about the Company s common shares that may be issued upon the exercise of options, warrants and rights under all of the Company s equity compensation plans as of December 31, 2003.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(a)	(b)	(c)
Equity compensation plans approved by security holders (1)	20,049,463	34.27	12,734,485
Equity compensation plans not approved by security holders (2)	2,888,194	39.89	4,710,704
Total	22,937,657	34.97	17,445,189

(1) Includes the 2000 Stock Incentive Plan and the Employee Stock Purchase Plan

(2) Includes the 2002 Stock Incentive Plan and the Non-employee Director Compensation Plan

Table of Contents

2002 Stock Incentive Plan

On January 25, 2002 the Company s Board of Directors approved the 2002 Stock Incentive Plan to promote the interests of the Company and its shareholders and to further align the interests of shareholders and employees by tying awards to total return to shareholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company s performance. The plan has not been submitted to shareholders for approval.

Under the plan, eligible participants may be granted stock options to purchase shares of common stock, stock appreciation rights, time vesting and/or performance vesting Incentive Stock or Incentive Units and other stock-based awards. The maximum number of shares of common stock that may be awarded under the plan is 7.5 million shares, subject to adjustment for corporate transactions. If an award is paid solely in cash, no shares shall be deducted from the number of shares available for issuance.

Non-employee Director Compensation Plan

On January 25, 2002 the Company s Board of Directors amended the Non-employee Director Compensation Plan adopted on September 29, 2000. The plan permits eligible directors of the Company to receive shares of common stock in recognition of their contributions to the Company. The plan has not been submitted to shareholders for approval.

Item 13. Certain Relationships and Related Transactions.

The information under the captions Other Information Regarding Directors and Certain Transactions and Relationships in the Proxy Statement is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The information under the captions Fees Incurred for 2003 Services Performed by the Independent Auditors and Nonaudit Services and Other Relationships Between the Company and the Independent Auditors in the Proxy Statement is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules and Reports on Form 8-K.*

(a) The following documents are filed as part of this report:

1. Financial statements:
The Consolidated Financial Statements, Notes to Consolidated Financial Statements and Independent Auditors Report are incorporated herein by reference to the Annual Report.

2. Financial statement schedules:
The supporting schedules of the consolidated entity are included in this Item 15. Refer to Index to Financial Statement Schedules below.

3. Exhibits: *

(3) Articles of Incorporation and By-Laws.

3.1 Amended and Restated Articles of Incorporation of Aetna Inc., incorporated herein by reference to Exhibit 3.1 to Aetna Inc. s Form 10-Q filed on July 31, 2003.

Table of Contents

3.2 Amended and Restated By-Laws of Aetna Inc., incorporated herein by reference to Exhibit 3.2 to Aetna Inc. s Form 10-Q filed on July 31, 2003.

(4) Instruments defining the rights of security holders, including indentures.

4.1 Form of Aetna Inc. Common Share certificate, incorporated herein by reference to Exhibit 4.1 to Aetna Inc. s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000.

4.2 Form of Senior Indenture between Aetna Inc. and State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.1 to Aetna Inc. s Registration Statement on Form S-3 filed on January 19, 2001.

4.3 Form of Subordinated Indenture between Aetna Inc. and State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.2 to Aetna Inc. s Registration Statement on Form S-3 filed on January 19, 2001.

4.4 Form of Subordinated Indenture between Aetna Inc. and State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.1 to Aetna Inc. s Form 10-Q filed on March 31, 2001.

(10) Material contracts.

10.1 Form of Distribution Agreement between former Aetna and Aetna Inc., incorporated herein by reference to Annex C to former Aetna s definitive proxy statement on Schedule 14A filed on October 18, 2000.

10.2 Term Sheet for Agreement between former Aetna and Aetna Inc. in respect of the CityPlace property, situated at 185 Asylum Avenue, Hartford, Connecticut, 06103, incorporated herein by reference to Exhibit 10.10 to Aetna Inc. s Registration Statement on Form 10 filed on September 1, 2000.

10.3 364-Day Credit Agreement dated as of November 26, 2003, among Aetna Inc., the Banks listed on the signature pages thereto, and JPMorgan Chase Bank, as Administrative Agent.

10.4 Three-Year Credit Agreement dated as of November 27, 2002, among Aetna Inc., the Banks listed on the signature pages thereto, and JPMorgan Chase Bank, as Administrative Agent incorporated herein by reference to Exhibit 10.4 to Aetna Inc. s Form 10-K Filed on February 28, 2003.

10.5 Amended and Restated Aetna Inc. 2000 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.17 to Aetna Inc. s Form 10-K filed on February 25, 2002. **

10.6 Amended and Restated Aetna Inc. 2002 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.1 to Aetna Inc. s Form 10-Q filed on October 30, 2003. **

10.7 Form of Aetna Inc. 2001 Annual Incentive Plan, incorporated herein by reference to Annex H to former Aetna s definitive proxy statement on Schedule 14A filed on October 18, 2000. **

10.8 Amended Aetna Inc. Non-Employee Director Compensation Plan, incorporated herein by reference to Exhibit 10.2 to Aetna Inc. s Form 10-Q filed on April 29, 2002. **

10.9 1999 Director Charitable Award Program, incorporated herein by reference to Exhibit 10.1 to former Aetna s Form 10-Q filed on April 28, 1999. **

10.10 Employment Agreement dated as of September 6, 2000 by and between former Aetna and John W. Rowe, M.D., incorporated herein by reference to Exhibit 10.23 to Aetna Inc. s Amendment No. 1 to Registration Statement on Form 10 filed on October 18, 2000. **

Table of Contents

10.11	Memorandum dated December 6, 2002, from Elease E. Wright to John W. Rowe, M.D., incorporated herein by reference to Exhibit 10.11 to Aetna Inc. s Form 10-K filed on February 28, 2003. **
10.12	Amendment to Employment Agreement dated as of June 27, 2003 between Aetna Inc. and John W. Rowe, M.D., incorporated herein by reference to Exhibit 10.1 to Aetna Inc. s Form 10-Q filed on July 31, 2003. **
10.13	Employment Agreement dated as of September 28, 2001 between Aetna Inc. and Alan M. Bennett, incorporated herein by reference to Exhibit 10.12 to Aetna Inc. s Form 10-K filed on February 28, 2003. **
10.14	Memorandum dated January 6, 1997 from Mary Ann Champlin to Timothy A. Holt. **
10.15	Memorandum dated July 20, 2000 from Elease E. Wright to Timothy A. Holt. **
10.16	Employment Agreement dated as of September 13, 2001 by and between Aetna Inc. and David B. Kelso, incorporated herein by reference to Exhibit 10.26 to Aetna Inc. s Form 10-K filed on February 25, 2002. **
10.17	Memorandum dated September 30, 2002, from Elease E. Wright to David B. Kelso, incorporated herein by reference to Exhibit 10.1 to Aetna Inc. s Form 10-Q filed on October 31, 2002. **
10.18	Letter Agreement dated June 30, 2003 between Aetna Inc. and David B. Kelso, incorporated herein by reference to Exhibit 10.2 to Aetna Inc. s Form 10-Q filed on July 31, 2003. **
10.19	Letter Agreement dated April 28, 1999 between former Aetna and L. Edward Shaw, Jr., incorporated herein by reference to Exhibit 10.20 to Aetna Inc. s Amendment No. 1 to Registration Statement on Form 10 filed on October 18, 2000. **
10.20	Restrictive Covenant Agreement dated April 28, 1999 between former Aetna and L. Edward Shaw, Jr., incorporated herein by reference to Exhibit 10.21 to Aetna Inc. s Amendment No. 1 to Registration Statement on Form 10 filed on October 18, 2000. **
10.21	Letter Agreement dated November 17, 2000 between former Aetna and L. Edward Shaw, Jr., incorporated herein by reference to Exhibit 10.24 to Aetna Inc. s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000. **
10.22	Memorandum dated November 16, 2000 from James H. Gould to L. Edward Shaw, Jr., incorporated herein by reference to Exhibit 10.25 to Aetna Inc. s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000. **
10.23	Letter Agreement dated December 12, 2003 between Aetna Inc. and L. Edward Shaw, Jr. **
10.24	Amended and Restated Employment Agreement dated as of December 5, 2003 by and between Aetna Inc. and Ronald Williams. **
10.25	Letter dated December 5, 2003 from John W. Rowe, M.D. to Ronald A. Williams. **
10.26	Description of certain arrangements not embodied in formal documents, as described under the headings Nonemployee Director Compensation in 2003 and Other Information Regarding Directors are incorporated herein by reference to the Proxy Statement. **
*	Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Copies of exhibits will be furnished without charge upon written request to the Office of the Corporate Secretary, Aetna Inc., 151 Farmington Avenue, Hartford, Connecticut 06156.
**	Management contract or compensatory plan or arrangement.

Table of Contents

(11) Statement re: computation of per share earnings.
Incorporated herein by reference to Note 5 of Notes to Consolidated Financial Statements in the Annual Report.

(12) Statement re: computation of ratios.
Statement re: computation of ratio of earnings to fixed charges and ratio of earnings to combined fixed charges and preferred stock dividends for the Company for the years ended December 31, 2003, 2002, 2001, 2000 and 1999.

(13) Annual Report to security holders.
Management s Discussion and Analysis of Financial Condition and Results of Operations, Selected Financial Data, Consolidated Financial Statements, Notes to Consolidated Financial Statements, Independent Auditors Report and unaudited Quarterly Data are incorporated herein by reference to the Annual Report and filed herewith in electronic format.

(14) Aetna Inc. Code of Conduct incorporated herein by reference to exhibit 99.1 to Aetna Inc. s Form 10-K filed on February 28, 2003.

(21) Subsidiaries of the registrant.
A listing of subsidiaries of Aetna Inc.

(23) Consents of experts and counsel.
Consent of independent auditors to incorporation of their report dated February 11, 2004 by reference in Aetna Inc. s Registration Statements on Form S-3 and Form S-8.

(24) Power of attorney.

24.1 Power of attorney.

(31) Rule 13a 14(a)/15d 14(e) Certifications

31.1 Chief Executive Officer Certification

31.2 Chief Financial Officer Certification

(32) Section 1350 Certifications

32.1 Chief Executive Officer Certification

32.2 Chief Financial Officer Certification

(b) Reports on Form 8-K.
None

Table of Contents

INDEX TO FINANCIAL STATEMENT SCHEDULES

AETNA INC.

Certain information has been omitted from the schedules filed because the information is not applicable.

Table of Contents

INDEPENDENT AUDITORS REPORT

The Shareholders and Board of Directors
Aetna Inc.:

Under date of February 11, 2004, we reported on the consolidated balance sheets of Aetna Inc. and subsidiaries as of December 31, 2003 and 2002, and the related consolidated statements of income, shareholders equity and cash flows for each of the years in the three-year period ended December 31, 2003, as contained in the 2003 annual report to shareholders. These consolidated financial statements and our report thereon are incorporated by reference in the annual report on Form 10-K for the year 2003. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related financial statement schedules as listed in the accompanying index. These financial statement schedules are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statement schedules based on our audits.

In our opinion, such financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ KPMG LLP

Hartford, Connecticut
February 11, 2004

Table of Contents

AETNA INC.

SCHEDULE I - Condensed Statements of Income

(Millions)	For the years ended December 31, 2003	2002	2001
Service fees affiliates	$	$ 1,090.7	$ 1,487.3
Net investment income	21.0	6.8	15.6
Net realized capital gains (losses)	(.1)	35.1	44.7
Total revenue	20.9	1,132.6	1,547.6
Operating expenses (1)	127.1	1,476.0	1,704.1
Interest expense	102.9	119.5	142.8
Total expenses	230.0	1,595.5	1,846.9
Loss before income tax benefit and equity in earnings (loss) of affiliates, net	(209.1)	(462.9)	(299.3)
Income tax benefit	76.0	155.2	111.8
Equity in earnings (loss) of affiliates, net (2)	1,066.9	700.9	(92.1)
Income (loss) from continuing operations	933.8	393.2	(279.6)
Income from discontinued operations		50.0	
Cumulative effect adjustment, net of tax		(2,965.7)	
Net income (loss)	$ 933.8	$ (2,522.5)	$ (279.6)

(1) Operating expenses for 2003 include a charge of $115 million pretax in connection with the settlement of a national class action case (refer to Note 20 of Notes to Consolidated Financial Statements for further information).

(2) Includes parent company amortization of other acquired intangible assets of $33.0 million after tax for 2003 and $85.0 million after tax for 2002 and amortization of goodwill and other acquired intangible assets of $337.5 million after tax during 2001.

See Notes to Aetna Inc. Condensed Financial Statements.

Table of Contents

AETNA INC.

SCHEDULE I - Condensed Balance Sheets

(Millions, except share data)	As of December 31, 2003	2002
Cash and cash equivalents	$ 449.9	$ 614.1
Investment securities	519.4	409.5
Other receivables	139.4	305.5
Other assets	188.0	111.1
Total current assets	1,296.7	1,440.2
Investment in affiliates (1)	9,526.6	9,625.3
Deferred tax assets	378.8	406.6
Other assets	37.9	47.9
Total assets	$11,240.0	$11,520.0
Accrued expenses and other current liabilities	582.2	1,115.2
Long-term debt	1,613.7	1,633.2
Accrued pension benefit liability	1,120.1	1,204.2
Other long-term liabilities		587.4
Total liabilities	3,316.0	4,540.0
Common stock ($.01 par value, 748,624,161 shares authorized, 152,523,670 issued and outstanding in 2003 and $.01 par value, 756,277,772 shares authorized, 149,966,082 issued and outstanding in 2002)	4,024.8	4,070.9
Accumulated other comprehensive loss	(408.0)	(470.4)
Retained earnings	4,307.2	3,379.5
Total shareholders equity	7,924.0	6,980.0
Total liabilities and shareholders equity	$11,240.0	$11,520.0

(1) Includes parent company goodwill and other acquired intangible assets of $4.1 billion as of December 31, 2003 and 2002.
See Notes to Aetna Inc. Condensed Financial Statements.

Table of Contents

AETNA INC.

SCHEDULE I - Condensed Statements of Shareholders Equity

(Millions, except share data)	Total	Common Stock and Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)				Retained Earnings
			Unrealized Gains (Losses) On Securities	Foreign Currency	Derivatives	Minimum Pension Liability	
Balances at December 31, 2000	$10,127.1	$3,898.7	$ 29.4	$ 5.7	$	$	$ 6,193.3
Comprehensive income:							
Net loss	(279.6)						(279.6)
Other comprehensive income, net of tax:							
Unrealized gains on securities ($57.2 pretax) (1)	37.2		37.2				
Foreign currency ($(1.1) pretax)	(.7)			(.7)			
Derivative losses ($(4.8) pretax) (1)	(3.1)				(3.1)		
Other comprehensive income	33.4						
Total comprehensive loss	(246.2)						
Common shares issued for benefit plans (4,247,361 shares)	110.7	110.7					
Repurchase of common shares (2,600,000 shares)	(95.6)	(95.6)					
Common stock dividends	(5.7)						(5.7)
Balances at December 31, 2001	9,890.3	3,913.8	66.6	5.0	(3.1)		5,908.0
Comprehensive income:							
Net loss	(2,522.5)						(2,522.5)
Other comprehensive loss, net of tax:							
Unrealized gains on securities ($331.4 pretax) (1)	215.4		215.4				
Foreign currency ($.7 pretax)	.5			.5			
Derivative gains ($.6 pretax) (1)	.4				.4		
Minimum pension liability adjustment ($(1,161.8) pretax)	(755.2)					(755.2)	
Other comprehensive loss	(538.9)						
Total comprehensive loss	(3,061.4)						
Common shares issued for benefit plans (9,320,601 shares)	322.3	322.3					
Repurchase of common shares (3,620,431 shares)	(165.2)	(165.2)					
Common stock dividends	(6.0)						(6.0)
Balances at December 31, 2002	6,980.0	4,070.9	282.0	5.5	(2.7)	(755.2)	3,379.5

Comprehensive income:							
Net income	933.8						933.8
Other comprehensive income, net of tax:							
Unrealized gains on securities ($8.7 pretax)(1)	5.6		5.6				
Foreign currency ($(6.7) pretax)	4.3			4.3			
Derivative gains ($1.1 pretax) (1)	.7				.7		
Minimum pension liability adjustment ($(79.6) pretax)	51.8					51.8	
Other comprehensive income	62.4						
Total comprehensive income	996.2						
Common shares issued for benefit plans (10,211,199 shares)	399.1	399.1					
Repurchase of common shares (7,653,611 shares)	(445.2)	(445.2)					
Common stock dividends	(6.1)						(6.1)
Balances at December 31, 2003	$ 7,924.0	$4,024.8	$287.6	$ 9.8	$ (2.0)	$(703.4)	$ 4,307.2

(1) Net of reclassification adjustments.

See Notes to Aetna Inc. Condensed Financial Statements.

Table of Contents

AETNA INC.

SCHEDULE I - Condensed Statements of Cash Flows

(Millions)	For the years ended December 31, 2003	2002	2001
Cash Flows from Operating Activities:			
Net income (loss)	$ 933.8	$ (2,522.5)	$ (279.6)
Adjustments to reconcile net income (loss) to net cash used for operating activities:			
Cumulative effect adjustment		2,965.7	
Income from discontinued operations		(50.0)	
Equity in (earnings) loss of affiliates, net (1)	(1,066.9)	(700.9)	92.1
Net realized capital losses (gains)	.1	(35.1)	(44.7)
Changes in assets and liabilities:			
Net change in other assets and accrued expenses and other liabilities	(617.1)	274.4	(115.8)
Net cash used for operating activities	(750.1)	(68.4)	(348.0)
Cash Flows from Investing Activities:			
Costs from purchases of investments	(263.9)	(205.7)	(28.7)
Dividends received from affiliates, net	1,007.4	624.8	251.0
Other, net	.1		1.7
Net cash provided by investing activities	743.6	419.1	224.0
Cash Flows from Financing Activities:			
Repayment of short-term debt		(109.7)	(1,482.5)
Issuance of long-term debt			1,566.1
Common shares issued under benefit plans	293.6	233.5	98.1
Common shares repurchased	(445.2)	(165.2)	(95.6)
Dividends paid to shareholders	(6.1)	(6.0)	(5.7)
Net cash provided by (used for) financing activities	(157.7)	(47.4)	80.4
Net increase (decrease) in cash and cash equivalents	(164.2)	303.3	(43.6)
Cash and cash equivalents, beginning of year	614.1	310.8	354.4
Cash and cash equivalents, end of year	$ 449.9	$ 614.1	$ 310.8
Supplemental disclosure of cash flow information:			
Interest paid	$ 103.5	$ 118.7	$ 117.6
Income taxes paid (refunded), net	$ 488.1	$ (65.0)	$ 106.0

(1) Includes parent company amortization of other acquired intangible assets of $33.0 million after tax for 2003 and $85.0 million after tax for 2002 and amortization of goodwill and other acquired intangible assets of $337.5 million after tax during 2001.

See Notes to Aetna Inc. Condensed Financial Statements.

Table of Contents

AETNA INC.
SCHEDULE I - Notes to Condensed Financial Statements

1. Background of Organization

The condensed parent company only financial information reflects Aetna Inc. (a Pennsylvania corporation) (the Parent Company). Effective January 1, 2003, the Parent Company assigned all of its administrative services agreements with certain affiliates to Aetna Health Management, LLC (AHM), an affiliate of the Parent Company. In connection with the assignment, the Company transferred certain assets and liabilities associated with the administrative services agreements to AHM. Accordingly, the Parent Company does not reflect any affiliate service fees or related operating expenses subsequent to this date. The condensed financial information presented herein includes the balance sheet of Aetna Inc. as of December 31, 2003 and 2002 and the related statements of income, shareholders equity and cash flows for the years ended December 31, 2003, 2002 and 2001. The accompanying condensed financial statements should be read in conjunction with the consolidated financial statements and notes thereto in the Annual Report. Certain reclassifications have been made to the 2002 and 2001 financial information to conform to the 2003 presentation.

2. New Accounting Standards

Refer to Note 2 of Notes to Consolidated Financial Statements in the Annual Report for a description of new accounting standards.

3. Acquisitions and Dispositions

Refer to Note 3 of Notes to Consolidated Financial Statements in the Annual Report for a description of acquisitions and dispositions.

4. Discontinued Products

Refer to Note 12 of Notes to Consolidated Financial Statements in the Annual Report for a description of discontinued products.

5. Income Taxes

Refer to Note 13 of Notes to Consolidated Financial Statements in the Annual Report for a description of income taxes.

6. Additional Minimum Pension Liability

As of December 31, 2003 and 2002, the Parent Company recognized an additional minimum pension liability. Refer to Note 14 of Notes to Consolidated Financial Statements in the Annual Report for further information.

7. Debt

Refer to Note 15 of Notes to Consolidated Financial Statements in the Annual Report for a description of debt.

8. Service Arrangements

Effective January 1, 2003, the Parent Company assigned all of its administrative services agreements with certain affiliates to Aetna Health Management, LLC (AHM), an affiliate of the Parent Company. Prior to January 1, 2003, the Parent Company had service arrangements with certain of its affiliates, under which the Parent Company provided certain administrative services, including accounting and processing of premiums and claims.

Table of Contents

AETNA INC. AND SUBSIDIARIES

SCHEDULE II

Valuation and Qualifying Accounts and Reserves

For the years ended December 31, (Millions)	Balance at beginning of period	Additions: Charged to costs and expenses(1)	Additions: Charged (credited) to other accounts-describe(2)	Deductions-describe(3)	Balance at end of period
2003					
Asset valuation Reserves:					
Mortgage loans	$ 11.4	$ 4.4	$ 5.8	$ (2.7)	$18.9
Real estate	73.3	3.6	3.3	(64.8)	15.4
	$ 84.7	$ 8.0	$ 9.1	$(67.5)	$34.3
2002					
Asset valuation Reserves:					
Mortgage loans	$ 32.6	$ .3	$ .3	$(21.8)	$11.4
Real estate	65.3	14.7	13.6	(20.3)	73.3
	$ 97.9	$15.0	$ 13.9	$(42.1)	$84.7
2001					
Asset valuation Reserves:					
Mortgage loans	$ 44.0	$ 1.1	$ 4.5	$(17.0)	$32.6
Real estate	83.5	.7	11.4	(30.3)	65.3
	$127.5	$ 1.8	$ 15.9	$(47.3)	$97.9

(1) Charged to net realized capital losses in the Consolidated Statements of Income.

(2) Reflects additions to (reductions of) reserves related to assets supporting experience-rated contracts and discontinued products for which a corresponding reduction was included in Policyholders funds and Future Policy Benefits in the Consolidated Balance Sheets, respectively.

(3) Reduction in reserves is primarily a result of related asset write-downs (including foreclosures of real estate) and sales.

Table of Contents

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: February 27, 2004

AETNA INC.

By /s/ Ronald M. Olejniczak

Ronald M. Olejniczak
Vice President and Controller

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated on February 27, 2004.

* /s/ John W. Rowe, M.D.	* /s/ Michael H. Jordan
John W. Rowe, M.D., Chairman, Chief Executive Officer and Director (Principal Executive Officer)	Michael H. Jordan, Director
* /s/ Betsy Z. Cohen	* /s/ Jack D. Kuehler
Betsy Z. Cohen, Director	Jack D. Kuehler, Director
* /s/ Barbara H. Franklin	* /s/ Edward J. Ludwig
Barbara Hackman Franklin, Director	Edward J. Ludwig, Director
* /s/ Jeffrey E. Garten	* /s/ Joseph P. Newhouse
Jeffrey E. Garten, Director	Joseph P. Newhouse, Director
* /s/ Earl G. Graves	* /s/ Judith Rodin
Earl G. Graves, Director	Judith Rodin, Director
* /s/ Gerald Greenwald	* /s/ Ronald A. Williams
Gerald Greenwald, Director	Ronald A. Williams, President and Director
* /s/ Ellen M. Hancock	* /s/ R. David Yost
Ellen M. Hancock, Director	R. David Yost, Director
/s/ Alan M. Bennett	* /s/ Ronald M. Olejniczak
Alan M. Bennett, Senior Vice President and Chief Financial Officer (Principal Financial Officer)	Ronald M. Olejniczak Vice President and Controller (Principal Accounting Officer)

*By /s/ Alan M. Bennett

(Attorney-in-Fact)

Table of Contents

INDEX TO EXHIBITS

Exhibit Number	Description of Exhibit	Filing Method
10	Material Contracts.	
10.3	364-Day Credit Agreement dated as of November 26, 2003, among Aetna Inc., the Banks listed on the signature pages thereto, and JPMorgan Chase Bank, as Administrative Agent.	Electronic
10.14	Memorandum dated January 6, 1997 from Mary Ann Champlin to Timothy Holt.	Electronic
10.15	Memorandum dated July 20, 2000 from Elease E. Wright to Timothy A. Holt.	Electronic
10.23	Letter Agreement dated December 12, 2003 between Aetna Inc. and L. Edward Shaw, Jr.	Electronic
10.24	Amended and Restated Employment Agreement dated as of December 5, 2003 by and between Aetna Inc. and Ronald Williams.	Electronic
10.25	Letter dated December 5, 2003 from John W. Rowe, M.D. to Ronald A. Williams	Electronic
12	Statement re: computation of ratios.	
	Statement re: computation of ratio of earnings to fixed charges and ratio of earnings to combined fixed charges and preferred stock dividends for the Company for the years ended December 31, 2003, 2002, 2001, 2000, and 1999.	Electronic
13	Annual Report to security holders.	
	Management s Discussion and Analysis of Financial Condition and Results of Operations, Selected Financial Data, Consolidated Financial Statements, Notes to Consolidated Financial Statements, Independent Auditors Report, and unaudited Quarterly Data sections of the Annual Report.	Electronic
21	Subsidiaries of the registrant.	
	A listing of subsidiaries of Aetna Inc.	Electronic
23	Consents of experts and counsel.	
	Consent of independent auditors to incorporation of their report dated February 11, 2004 by reference in Aetna Inc. s Registration Statements on Form S-3 and Form S-8.	Electronic
24.1	Power of attorney.	Electronic
31	Rule 13a 14(a)/15d 14(e) Certifications	
31.1	Chief Executive Officer Certification	Electronic
31.2	Chief Financial Officer Certification	Electronic

Table of Contents

Exhibit Number	Description of Exhibit	Filing Method
32	Section 1350 Certifications	
32.1	Chief Executive Officer Certification	Electronic
32.2	Chief Financial Officer Certification	Electronic