The Challenge of Leadership

AETNA ANNUAL REPORT 2004

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For additional financial information, see the 2005 Aetna Inc. Notice of Annual Meeting and Proxy Statement (form 31.05.901.1-05) and 2004 Annual Report, Financial Report to Shareholders (form 31.05.902.1-04) under separate cover.

Our performance put us among the top performers in the industry.

FINANCIAL HIGHLIGHTS

(Millions, except share data and per common share data)

FOR THE YEAR	2004	2003	% CHANGE
Revenue	$19,904.1	$17,976.4	10.7
Operating Expenses[1]	3,983.8	4,039.5	(1.4)
Operating Earnings[2]	1,141.5	818.8	39.4
Net Income[3]	2,245.1	933.8	140.4
Pretax Operating Margin[4]	9.7%	7.9%	22.8
AT YEAR END			
Assets	$42,133.7	$40,950.2	2.9
Shareholders' Equity	9,081.4	7,924.0	14.6
Market Capitalization	18,276.2	10,308.2	77.3
PER COMMON SHARE			
Operating Earnings[2]	$7.28	$5.18	40.5
Net Income[3]	14.30	5.91	142.0
Shareholders' Equity	61.99	51.93	19.4
Actual Common Shares Outstanding	146,502,836	152,578,251	(4.0)

[1]Operating expenses excludes $45 million in 2004 related to voluntary contributions to the Aetna Foundation and $115 million in 2003 related to the settlement of a national physician class action.

[2]Operating earnings excludes from net income: net realized capital gains of $46 million in 2004 and $42 million in 2003, favorable prior-period reserve developments of $57 million in 2004 and $148 million in 2003 and other items of $29 million in 2004 (voluntary contributions to the Aetna Foundation) and $75 million in 2003 (settlement of a national physician class action). For 2004, operating earnings also excludes income from discontinued operations of $1.03 billion discussed in Note 3.

[3]For 2004, net income includes income from discontinued operations of $1.03 billion related to the Congressional Joint Committee on Taxation's approval of a tax refund and the completion of certain Internal Revenue Service audits associated with businesses sold by the company's predecessor (former Aetna).

[4]Pretax operating margin (GAAP basis) was 9.5% in 2004 and 8.0% in 2003. Amounts excluded from operating earnings (favorable prior-period reserve developments, other items, amortization of intangibles and interest expense) had approximately offset each other on a pretax operating margin basis in 2004 and 2003.

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2004 Annual Report, Financial Report to Shareholders.

JOHN W. ROWE, M.D.
Chairman and
Chief Executive Officer

Choosing a Different Path

TO OUR SHAREHOLDERS:

Last year at this time, we said our goal was to complete the Aetna turnaround by achieving profitable growth in 2004. We said we would do this by continuing our industry leadership in medical cost control and providing value-added innovations that serve customers' needs.

I'm pleased to report that we have achieved our goal by every measure. Aetna's turnaround is now complete.

This achievement is the product of the collective efforts of all Aetna employees. Over the past four years, together, we:

- Solidified Aetna's balance sheet,
- Rebuilt our management strength,
- Developed a superior capacity to control medical costs through an intense clinical and quality focus,
- Upgraded the quality of service we deliver to our members and participating physicians,
- Regained the confidence of customers through product and service innovation,
- Restored the trust of physicians by listening to and addressing their concerns,
- Significantly improved Aetna's financial performance, and
- Substantially increased shareholder value.

TOP-LINE REVENUE AND MEMBERSHIP GROWTH

In 2004, for the first time since our turnaround began, Aetna achieved both top-line revenue growth and membership growth. We attracted business from competitors, improved our retention rates and tapped into new markets, achieving growth in virtually all customer and geographic markets and major product lines.

Revenue grew 11 percent to $19.9 billion, while medical membership increased by 654,000, or 5 percent. We also saw 9 percent growth in dental membership, 12 percent in pharmacy and 10 percent in group insurance. Aetna now serves 25.8 million Americans.

Year-End Revenue

$19.9 billion

Members Served

25.8 million

SUPERIOR MEDICAL COST AND QUALITY MANAGEMENT

Meanwhile, Aetna continued to demonstrate superior medical cost containment, quality of care and clinical integration. Commercial risk medical cost trend for 2004 was approximately 8.5 percent – the lowest among major industry competitors. This positive result reflects the impact of our health care provider network contracting, innovative plan designs and comprehensive medical cost management programs.

Furthermore, we remained steadfast in our disciplined approach to operating expense management. As a percent of revenue, selling, general and administrative expenses declined by 2.5 percent.

Aetna's operating earnings per share increased 40.5 percent, from $5.18 in 2003 to $7.28 in 2004.

INCREASING SHAREHOLDER VALUE

When the turnaround began, we set as one goal achieving an operating margin equal to the average of our major competitors in order to deliver value to our shareholders. As a result of our cumulative efforts, Aetna's after-tax operating margin for 2004, excluding development, was 6.2 percent, which is above the average of our major competitors and just below the industry leaders.

As the market gained confidence in our progress, Aetna's stock price reached new all-time highs. At the end of 2004, Aetna's common stock price was $124.75, up 85 percent from the year-end 2003 price of $67.56. From the beginning of the turnaround through the end of 2004, Aetna's market value increased nearly fivefold, to $18 billion. Since the end of the year, it has continued to rise.

We are particularly proud that in a year characterized by dramatically increased shareholder value, Aetna was recognized by *Business Ethics* magazine as one of the top corporate citizens in the country and the leading company in our industry.

A DIFFERENT COMPANY

Aetna today is a vastly different company than it was a few years ago. As we emerge from the turnaround and strive to achieve industry leadership, we stand in a very different place and see a new set of challenges.

There is no more critical issue facing our society than health care. New technologies and medical breakthroughs hold great promise; but inexorably rising costs of treatments, medications, medical devices and litigation threaten the viability of the health care system.

The rising costs are leading some employers to drop health coverage altogether. Most of the others are asking their employees to take on an ever-larger share of the costs. Uneven access to care either by geographic region or racial and ethnic division and medical errors present other patient safety and quality-of-care concerns.

As a result of these trends, our customers are seeking innovative ways to protect their health and financial security. In response, we've rethought our entire approach. We've seen a backlash against managed care restrictions send many health insurers to the sidelines, providing open-access products that allow freedom of choice, but offering little hope for improving quality of care or mitigating unnecessary costs.

We've chosen a different path – one that places faith in the ability of well-informed consumers, employers, physicians and other health care providers to make sound decisions that lead to better health and financial security.

INNOVATION, INFORMATION, INTEGRATION

Our role is to find innovative ways to integrate disparate bits of data into actionable information people can use. This requires access to data; new ways of thinking about its relevance to people's lives; and, perhaps most important, the ability to deliver easily understandable information to those who can use it, when they need it and in a manner they find expedient.

This realization has led us down a rewarding path:

- For employers, providing a suite of benefits that adequately protects their employees is evermore challenging. Even as they seek to minimize cost increases, they also increasingly are interested in ensuring that the money they spend on health care benefits actually leads to a healthier and more productive work force. By integrating data from medical, behavioral, pharmacy, dental and disability records, we're creating innovative approaches to improving work force health and productivity.
- We also are showing employers how consumer-directed health plans combining health savings accounts or other types of funding arrangements with consumer information tools can give their employees more control over their own health care and finances.
- As employers ask employees to take on more responsibility for their own health care, selecting the right set of affordable health, pharmacy, behavioral, dental, disability and long-term care benefits is essential. Once benefits are chosen, understanding how to access the right care in a cost-effective manner also is critical. We are bringing new information to our members so they can make better-informed decisions about their benefits and their health care.
- We've also pioneered the new Aexcel℠ network, which reflects growing national interest in "pay for performance." Aexcel uses information about medical specialists' cost-effectiveness in the delivery of care and their clinical performance on quality to help identify specialists for our members.
- Building on the recent improvements in our relations with physicians, we are working with them on cooperative approaches that give them better information they can use to improve the quality and efficiency of care for their patients. In 2004, Aetna won the Disease Management Association of America's Health Plan Disease Management Leadership Award in recognition of our efforts to address racial and ethnic disparities in health care.

These and other important breakthroughs have begun to differentiate the value Aetna can offer our customers from that being offered by our competitors. On the pages following this letter, Aetna President Ron Williams introduces some of the Aetna people who are inventing innovative ways to integrate information so it may be used to help consumers achieve their goals of protecting their health and financial security.

INVESTING IN GROWTH

In 2005, we intend to demonstrate our ability to win new customers and generate sustained profitable growth.

Our financial success has generated sufficient capital to give Aetna significant financial flexibility. We intend to invest in expanding our capabilities to seize market opportunities and meet evolving customer needs. This will include internal investments in technology, training and the like. It will include launching new operational ventures. It also will include targeted strategic acquisitions.

In fact, we've already begun:

- For instance, in 2004, we launched an Aetna-branded Employee Assistance Program and announced we will acquire the Aetna portion of behavioral health services presently provided by Magellan Health Services. These actions will help us expand Aetna's behavioral health business capabilities in 2005 and beyond.
- Similarly, Aetna Specialty Pharmacy, the new joint venture we announced last year with Priority Healthcare, a leading provider of national specialty pharmacy services, will expand our pharmacy benefit management capacity. We'll work to improve the quality of care and service our members receive, and better manage the fastest-growing facet of pharmacy costs.
- Our recent acquisition of Strategic Resource Company, one of the largest providers of benefits to part-time and hourly workers, will enable us to tap into a currently underserved market. We will help employers offer their employees affordable benefits and help people who otherwise might not have access to health insurance, making a dent in the nation's uninsured problem.

INVESTING IN AETNA'S PEOPLE

Our investment plans also include a focus on the Aetna family. We continue to be astounded at the high level of engagement we see across the company in building a high-performance culture. The response rate to our 2004 all-employee survey was 91 percent – an unheard-of level of participation that clearly demonstrates employee commitment.

In 2004, we significantly expanded management and front-line training – an investment that will pay dividends in improved service and quality of advice to our customers.

Although our pay and benefits structure is under competitive pressure, we continue to lead our industry with a wide range of programs that have earned us accolades as a leading employer. One example: For the seventh straight year, Aetna is one of the "Top 30 Companies for Executive Women," a list compiled by the National Association for Female Executives.

LEADING CHANGE IN THE HEALTH CARE SYSTEM

Even as we focus on improving Aetna's ability to deliver value in the changing marketplace, we also are committed to improving the overall health care system in America.

In 2000, we set out to shed light on the problems of the uninsured, quality of care and other serious issues facing our nation's health care system. We committed to starting a discourse, bringing together different perspectives and sometimes competing points of view, to explore workable solutions to these problems.

We have remained steadfast in our pursuit of that goal, even as we have worked through Aetna's own turnaround. In this annual report, we continue the tradition we began four years ago. In essays written by outside experts, we present their solutions for some of the most pressing health care issues our nation faces today – evidence-based medicine, underuse of medical services, paying physicians for performance, health savings accounts, depression management, health care costs and electronic medical records.

It's time to launch the next phase of our journey – to industry leadership.

A QUEST FOR LEADERSHIP

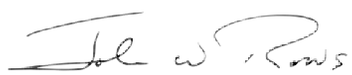
With the close of 2004, Aetna's turnaround story has come to an end. However, our work is far from over.

It's time to launch the next phase of our journey – to industry leadership. Our plan is simple: listen to our customers, continuously seek innovative ways to bring them better information they can use to make prudent decisions regarding their health and financial security, and work with others to help build a better health care system. By doing this, and responding to challenges and opportunities in the marketplace, we can continue delivering top financial performance for our shareholders.

As I look back on the success of the turnaround, I must pause a moment to acknowledge the indispensable leadership of Ron Williams, the wise counsel and guidance of our Board of Directors, and the inspired work of a broad and deep senior management team – only a few of whom are pictured on the pages that follow this letter. I would particularly like to thank Jack Kuehler and Judith Rodin. Jack, the retired vice chairman of IBM, retires in April after 15 years of service on the Aetna Board of Directors. Judy, the former president of the University of Pennsylvania and current president of the Rockefeller Foundation, will leave the Board in April after 10 years of service.

Finally, with deepest gratitude and appreciation, I must thank the talented and dedicated Aetna employees, whose service to our customers every day has earned their trust and created the value our shareholders now enjoy.

Aetna now is considered among the top in the industry. We've demonstrated we have what it takes to compete in today's marketplace. Going forward, we will continue to raise the bar on Aetna's performance; and reach for our ultimate goal of being the leader in providing value to customers, employees and shareholders alike.



John W. Rowe, M.D.
Chairman and Chief Executive Officer

RONALD A. WILLIAMS
President

Meeting the Challenge of Leadership

Every day, the people of Aetna are working with individuals and families, employers, physicians, hospitals, and other health care professionals all across America. We're creating innovative approaches to help them cope with the challenges they face in achieving affordable, high-quality health care.

Two important trends have emerged: Employers want to improve the effectiveness of their health benefits spending in the face of rising costs, and consumers want more involvement in influencing their own health and financial security.

The consumerism trend involves more than a new plan design with a new label. There is no single response that meets all needs. Rather, we see a robust approach that includes a full complement of product and service options. Information to help sort through options and make the right decisions is critical.

In response to these trends, we've set three goals:

- Make health care more accessible and affordable.
- Help people make well-informed decisions about health and financial security.
- Improve the quality and effectiveness of health care.

Making Health Care More Accessible and Affordable

INCREASING ACCESS AND AFFORDABILITY

As employers struggle to manage rising health care costs, Aetna is helping expand access and affordability. Our innovative consumer-directed health plans represent one approach. They offer consumers more control over their health care decisions, and may result in lower cost increases and higher use of preventive health services – a win-win for health and financial security. We're also offering other types of new benefit plans characterized by ease of administration and affordability, providing benefits to Americans who otherwise would not have health coverage at all.

MAKING WELL-INFORMED DECISIONS

For individuals and families wanting more control of their health care and faced with the need to fund more of their own benefits, we're creating better information resources. The key to success is to make information more accessible and understandable, so people can better navigate a system that often is confusing, and make well-informed decisions about their health and financial security.

IMPROVING THE QUALITY OF HEALTH CARE

Aetna has the capability to collect and analyze data consistently across our extensive national network of health care providers, and a broad range of benefits – including medical, pharmacy, dental, behavioral and disability. By integrating this data, we are creating programs that help our participating physicians and our members work together to improve health care quality.

On the following pages, you'll find more information about some of the truly innovative approaches that people at Aetna are creating to address the challenges our constituents face in health care. We take great pride in this important work, and we dedicate ourselves to the pursuit of excellence in delivering quality service and value to all our constituents.

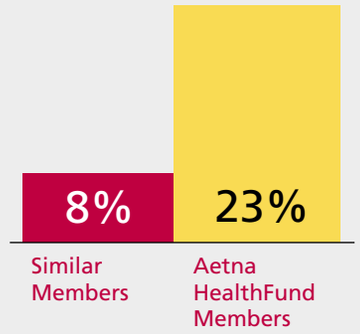
Ronald A. Williams
President

CONSUMER-DIRECTED PLANS – MORE PREVENTION, LESS COST

Employers like Aetna HealthFund® consumer-directed plans because they encourage employees to make better informed and more cost-effective decisions about their health care. Our studies show that members in these plans increased use of preventive health services, and either maintained or increased the frequency with which they received important tests and screenings for certain chronic conditions. In 2004, Aetna introduced portable Health Savings Account (HSA) plans, giving members the option of saving health care dollars for future use. We also introduced the Aetna HealthFund Retiree Reimbursement Account, helping to fund post-retirement health care expenses.

Russ Fisher – Aetna HealthFund

Aetna HealthFund members increased use of preventive services



Annual increase in general adult preventive care exams; Aetna HealthFund members compared to similar members.

"Our early experience with Aetna HealthFund shows promise for a positive impact on controlling health care cost increases, while also encouraging preventive care."

– Russell D. Fisher, head of National Accounts and Aetna Global Benefits

SIMPLICITY, AFFORDABILITY AND CHOICE FOR SMALL EMPLOYERS

Choice and affordability no longer are an either-or proposition for small employers. Aetna's small group portfolio of products for employers of 50 or fewer employees includes a wide range of plan choices to meet different employees' needs. By combining choice with simple administration and information tools to help employees make sound health care decisions, Aetna's plans offer access to quality care at affordable prices.

Aetna Spectrum Integrated Benefits[SM] plans, new in 2004, offer employers of 50 to 125 employees an affordable source for health, dental, life and disability benefits with one enrollment form, one bill, a single point of contact and multiproduct discounts.

16%

of people with HSAs work for small employers who previously did not provide health care coverage.

– America's Health Insurance Plans survey

"Aetna is the first company to offer a network of medical specialists chosen based on clinical performance and cost-efficiency measures to help members gain access to cost-effective health care. In 2004, we expanded the Aexcel[SM] network to 12 medical specialties in nine markets."

– Andrew Allocco, head of Network and Provider Services

Left to right:
Andrew Allocco – Aexcel
John Webb – Aetna Spectrum Integrated Benefits
Dan Fishbein, M.D. – Student health benefits

Eric Elliott – Affordable pharmaceuticals
Felicia Norwood – Simple, affordable health plans

COVERING THE UNINSURED

Aetna recognizes that the uninsured population is diverse. We have developed a multipronged approach to affordability that may provide opportunities to many of those most in need of improved access.

- With the acquisition of Strategic Resource Company, we now provide health coverage to part-time and hourly workers at more than 700 companies in 46 states.
- The Chickering Group, an Aetna company, covers 322,000 students at more than 130 colleges and universities.
- The Vital Savings by Aetna[SM] discount card and the Aetna Rx Savings Card[SM], a Medicare-approved drug discount card, provide real savings for people without dental coverage and seniors without pharmacy coverage. Discounts on dental procedures average 28 percent; Medicare beneficiaries can save 10-30 percent on their prescription drug costs.

DELIVERING MORE AFFORDABLE PRESCRIPTIONS

- Our mail-order pharmacy business, Aetna Rx Home Delivery, grew 165 percent in 2004; filling more than 5.4 million prescriptions, and providing greater convenience and savings for our members.
- Our new joint venture with Priority Healthcare, Aetna Specialty Pharmacy, will provide the expertise needed to deal with complex specialty drugs, such as injectables or IV delivery products. Aetna Specialty Pharmacy will leverage buying power, deliver effective clinical program management and coordinate with physicians to benefit our members.

Helping People Make Well-Informed Decisions

INFORMED DECISIONS THROUGH AETNA NAVIGATOR™

Aetna Navigator, our password-protected member self-service Web site, is helping Aetna members understand their health care options and potential costs. With a recent redesign of the site to improve ease of use, we are building on this solid foundation to address the unique and evolving needs of consumers.

SIMPLE STEPS TO A HEALTHIER LIFE®

Our Simple Steps to a Healthier Life program uses the power of information to help members make healthful changes in their lifestyles. Our educational resources and telephonic outreach touched 36,660 registered users in 2004, and we doubled the number of customers and eligible members over the previous year.

5.7 million

registered Aetna Navigator users

Robin Downey and Sheryl Burke – Helpful information resources

Mark Bertolini – Accessible consumer information
Barbara Pelletier – Simple Steps to a Healthier Life

HELPING BUILD SMART CHOICES

In 2004, we added significantly to the online information resources available to members:

- Our new *Estimate the Cost of Care* resource:
  - > Helps members predict their costs over the course of a year for a range of diseases and conditions based on their level of severity.
  - > Offers enhanced cost information for prescription drugs, drug uses and possible interactions.
  - > Provides cost comparisons for office visits by type and complexity level; various lab tests, X-rays and other services; and for selected medical procedures and surgeries.
- New resources for the 2005 open enrollment season make enrollment decisions easier by helping members:
  - > Estimate their out-of-pocket health care costs.
  - > Compare available plans.
  - > Understand the costs of various health care scenarios.

ENHANCED MEMBER OUTREACH℠

Aetna has introduced a new program for employers of more than 1,000 employees. We proactively reach out to members to educate them on their conditions, and enroll them in case and disease management programs that help ensure they get the care they need.

"Aetna employees are passionate about putting information technology to work for our members. That's why we are leaders in providing helpful, robust, easy-to-understand information to help consumers become fully engaged in their own health care decisions."

– Robin Downey, head of Product Development

54%

of women find choosing a health plan challenging.

– Aetna and Financial Planning Association survey

Improving the Quality and Effectiveness of Health Care

Jill Griffiths – Plan for Your Health

PLAN FOR YOUR HEALTH

In September, Aetna launched a public education campaign called Plan for Your Health in partnership with the Financial Planning Association. The campaign helps women – who are typically the primary health care decision makers in their families – understand how to better choose and use their health benefits. The **planforyourhealth.com** Web site features:

- Information on choosing the best health benefits options, including a Health Expense Calculator that helps consumers estimate their annual health care costs.
- Information on how to access the best possible care and maximize the benefits available to consumers under their health plans.

HELP ON THE LINE

Members can talk to a registered nurse 24/7 about a variety of health topics through Informed Health® Line – 75,000 calls were logged in 2004.

REAWAKE

Aetna's new Reawakening Center℠, **www.reawake.com**, helps individuals determine if they need professional help for depression.

COMPASSIONATE CARE AT LIFE'S END

The health care system often falls short when it is time to face the toughest of issues – appropriate end-of-life care. The new Aetna Compassionate Care℠ program takes an industry-leading approach to the issue with expanded benefits; enhanced nurse case management; and new, member-focused tools and information. Our broader coverage of hospice, palliative care, respite care and bereavement care can help members cope more effectively with these complex and emotional issues without having to discontinue the medical treatment they and their physicians believe is necessary.

COUNTING ON AETNA'S DATA

Through Aetna's MedQuery® program, our vast data resources are mined to help find errors, gaps, omissions or potentially harmful drug-to-drug or drug-to-disease interactions. Outreach is then made to the treating physician, who is empowered with information to improve care and avoid adverse events.

Wayne Rawlins – Aetna Compassionate Care
Tina Brown-Stevenson – MedQuery

"Integrating our data and clinical services across our products is helping our members lead healthier, more productive lives because it improves our ability to identify the members we can really help, and it enables us to provide more useful information to their physicians."

– Hyong Un, M.D.
National Medical Director
Behavioral Health

INNOVATION THROUGH INTEGRATION

Clinical programs that integrate traditional medical with other health care services create significant opportunities to improve care. We are able to make connections that result in more targeted, effective outreach to our members and more meaningful information for their physicians.

- Our new Migraine Management program reviews hospital inpatient and emergency room data to identify members at risk for future migraine episodes. We then reach out to these members with materials outlining strategies to manage the headaches.
- Through Aetna Integrated Health and Disability, we integrate members' health, disability, behavioral health and pharmacy data to identify and reach out to members at risk of suffering adverse health and disability events. The result: improved employee wellness and productivity.
- Aetna is supporting research expected to show that good oral health can affect the body's overall health, such as the connection between periodontal disease and low-birth weight babies. We are developing an outreach program to members encouraging regular dental checkups as a contributor to good health.
- Preliminary results for our Medical/Psychiatric High-Risk Disease Management Program illustrate that member workplace productivity and quality of care increase when people with chronic conditions, who are at high risk of depression – an underdiagnosed condition – are identified and treated in an integrated way.

40%

degree of improvement in mental health reported by members in Aetna's Medical/Psychiatric High-Risk Disease Management Program

From left:
Dong Ahn, Pat Farrell, Hyong Un and Mary Fox – Integrating information for improved health care

REDUCING RACIAL AND ETHNIC HEALTH CARE DISPARITIES

Aetna has developed a multidimensional approach to addressing racial and ethnic health care disparities. About 1.3 million of our members had voluntarily supplied us with their racial and ethnicity data by year-end 2004, helping us target disease management and other outreach programs to specific member populations.

- Our breast health initiative targeting African Americans and Latinas with high breast cancer mortality rates identified and contacted 3,631 women in 2004.
- We launched a program with Marriott International in August to enhance health literacy among its Spanish-speaking employees in Miami and Houston.
- More than 95 percent of Aetna's clinical professionals have completed a cultural competency training program to increase awareness of cultural disparities.

"Every day, Aetna nurses provide caring support to members who are very sick and often very scared. They work hard to smooth a path through the health care system, giving our members the information they need to feel more confident in making health care decisions. When our members are feeling their worst, Aetna nurses are at their best."

– William C. Popik, M.D.
Chief Medical Officer

Bill Popik –
Health care quality

Thoughtful Change: Leadership at Work

In addressing the most pressing issues confronting our health care system, Aetna once again is honored to be associated with some of the most respected names in the world of health care. These seven thought leaders have contributed insightful essays to this year's annual report that examine issues affecting the health care experience of all Americans. We thank these leaders for their thoughtful perspectives, which appear here unedited.

Committed to playing a leading role in healing the health care system, we encourage you to read these essays and be a part of this discussion in your community.

New Financing Tools Give Consumers More Power and Control over Health Care Decisions

GRACE-MARIE TURNER

Founder, President and Trustee
Galen Institute, Inc.

After years of rising health costs, the health care marketplace clearly is ready for a fresh idea. That idea has come in the form of new incentive programs and products that engage consumers as partners in managing health costs.

HSAs allow individuals, employers or employees to invest tax-free dollars in health accounts to pay for routine health care.

Health Savings Accounts are a bright new star in the field of consumer-directed health care. HSAs were created as part of the Medicare Modernization Act and became available January 1, 2004. They allow individuals, employers or employees to invest tax-free dollars in health accounts to pay for routine health care. The accounts are accompanied by insurance policies to cover larger medical bills.

America's Health Insurance Plans surveyed its members and found that 438,000 people had purchased HSAs in the first nine months of last year. The study also found that 30 percent of them were previously uninsured. Other studies have shown that 40 percent of HSA purchasers earn less than $50,000 a year, about one-third of purchasers are families with children and half are over age 40, showing they have broad appeal.

But HSAs are just one example of a constellation of offerings that give consumers more power and control over health care decisions. Other consumer-directed products such as Health Reimbursement Arrangements are helping companies to lower their health costs while providing incentives for employees to be more engaged in managing costs and care. Employers and health plans are smoothing the way by providing access to existing networks and online information tools. They also are instituting new programs to provide better coordinated care for those with chronic conditions such as diabetes, heart disease and asthma.

Some companies that have replaced their traditional health insurance with consumer-directed plans have seen their health costs fall by more than 10 percent, even as the use of preventive services by workers increased by as much as 23 percent.

Consumers are taking steps into this new world, but many changes still are needed for larger uptake in the marketplace. The Internet allows consumers easy access to a wealth of medical information that was available only to professionals as recently as a few years ago. But they still need more – and more easily accessible – information about prices, quality and outcomes to help make them smarter consumers.

Some say that consumer-directed health care means shifting more of the cost burden onto consumers. However, it really is a way of making the costs that consumers already are paying more visible so that they can be involved in decisions about how they want to allocate their health care dollars.

Consumer-directed health care means many things to many people. But its genius is in putting the American consumer to work to reshape the health care marketplace to provide more affordable health insurance, better and more affordable health care and new incentives for people to take responsibility not only for their health care spending but also for their health.

Pay for Performance: Potential Impact and Implementation Strategies

THOMAS H. LEE, M.D.

Network President, Partners HealthCare System, and
Professor of Medicine, Harvard Medical School

Just a few years ago, "pay-for-performance" contracting was an experiment in which physicians in Massachusetts and California were offered modest incentives if they could improve quality and efficiency. Now, insurers throughout the country and Medicare are testing the concept, even as they wonder whether pay for performance is more hype than hope.

In 2003, Aetna and five other insurers began paying an estimated $50 million per year in bonuses to California physicians for improving quality.

One reason for the uncertainty is that so many versions of pay for performance have emerged – and hardly any have been around long enough to be evaluated. In 2003, Aetna and five other insurers began paying an estimated $50 million per year in bonuses to California physicians for improving quality. Similar programs emerged in Boston around the same time.

In general, these pay-for-performance contracts target three key areas. Clinical quality goals include higher rates of preventive care (e.g., mammography) and other proven interventions (e.g., eye examinations for diabetics). Efficiency goals focus on reducing unnecessary hospital admissions, and improving the cost-effectiveness of pharmacy prescribing and radiology test ordering.

The third – and most controversial – common theme of pay-for-performance contracts is adoption of electronic health records (EHRs) to help physicians keep track of patients, and order the right drugs and tests. Why the controversy? Employers who are funding the bonuses wonder if EHRs really help control costs. Meanwhile, physicians complain that the bonuses are insufficient to cover the costs of these systems, which can exceed $25,000 per physician in the first year.

Nevertheless, pay for performance is gaining momentum, and early experience from California and Boston suggests that physicians are responding. They are buying EHRs, improving their diabetes care – and often practicing more efficiently. Many physicians say they like the concept of bonuses for better clinical quality and understand that improvements in efficiency are necessary to keep such incentive programs alive.

As the years go by, the targets of pay-for-performance contracts are getting tougher. To meet these goals, physicians are realizing that they need to embrace two revolutions. The first is an industrial revolution in which physicians adopt systems such as EHRs that improve quality and efficiency. The second is a cultural revolution in which physicians recognize that they are members of teams that care for populations of patients over time – not just when they are in the hospital or the doctor's office.

The true impact of pay for performance may take years to discern, but these contracts seem to be driving the adoption of the systems needed to re-engineer health care – and provide the improvements in quality and efficiency we so desperately need.

Improving Evidence for Health Care Decisions

SEAN R. TUNIS, M.D., M.Sc.

Chief Medical Officer
Centers for Medicare and Medicaid Services

As Americans take increasing personal responsibility for health care decision making, it becomes essential for patients and their physicians to have reliable information about the risks, benefits and costs of their clinical alternatives. Payers and policy makers also must have accurate evidence with which to make decisions about benefits, coverage and payment. With the rate of national spending rising substantially faster than inflation and wages, the importance of getting good value for health care spending becomes ever more urgent, and the key to obtaining good value is good information about what works.

The key to obtaining good value is good information about what works.

Examples of common questions that must be routinely answered by patients and physicians include:

Would it be better to begin drug therapy for mild to moderate osteoporosis or begin a regimen of diet and exercise? Which specific order or combination of drugs is associated with the lowest risk of long-term complication of diabetes or hypertension? Will a topical compound help a chronic leg wound heal more quickly than standard wound care? Would obtaining a PET scan in addition to CT and MRI for staging a particular cancer influence the recommended treatment regimen? Will a surgery have better short-term and long-term results if done using minimally invasive techniques rather than the standard open surgical approach? The answers to these questions can be determined only through well-designed clinical research.

It would be natural to assume that all such questions are systematically identified and answered as part of the clinical research activity pursued in the United States. And, in fact, many similar questions are addressed through publicly and privately funded clinical research. But the number of important clinical questions is sufficiently large that there are many critical issues that are central to the decisions made daily by patients and physicians for which adequate information is not available. The recent unexpected finding that use of rofecoxib (Vioxx) and related drugs increases the risk of heart attacks emphasizes the need for efficient, reliable mechanisms to quickly answer important questions about widely used medical products. Clinical research that is explicitly designed to answer common questions faced by decision makers has been referred to as “practical clinical research.” There currently is no public or private organization whose mission is to determine which critical clinical research questions need to be answered and how we can expand the capacity to answer them.

To address this problem, health care stakeholders recently have begun a discussion about how to establish a systematic effort to increase the supply of reliable evidence for decision makers through support of simple, real-world prospective clinical trials and registries. It will take the combined knowledge, skills and resources of patient advocacy organizations, medical professional organizations, product developers, health plans, employers, clinical researchers and others to ensure success in this enterprise. The quality and relevance of the information generated by this effort will be critical for the quality of health care decisions, which, in turn, will determine the quality and value of health care provided in this country.

Understanding Depression and Disparities

ANNELLE B. PRIMM, M.D., M.P.H.

Director, Minority and National Affairs,
American Psychiatric Association, and Associate
Professor of Psychiatry, Johns Hopkins School of Medicine

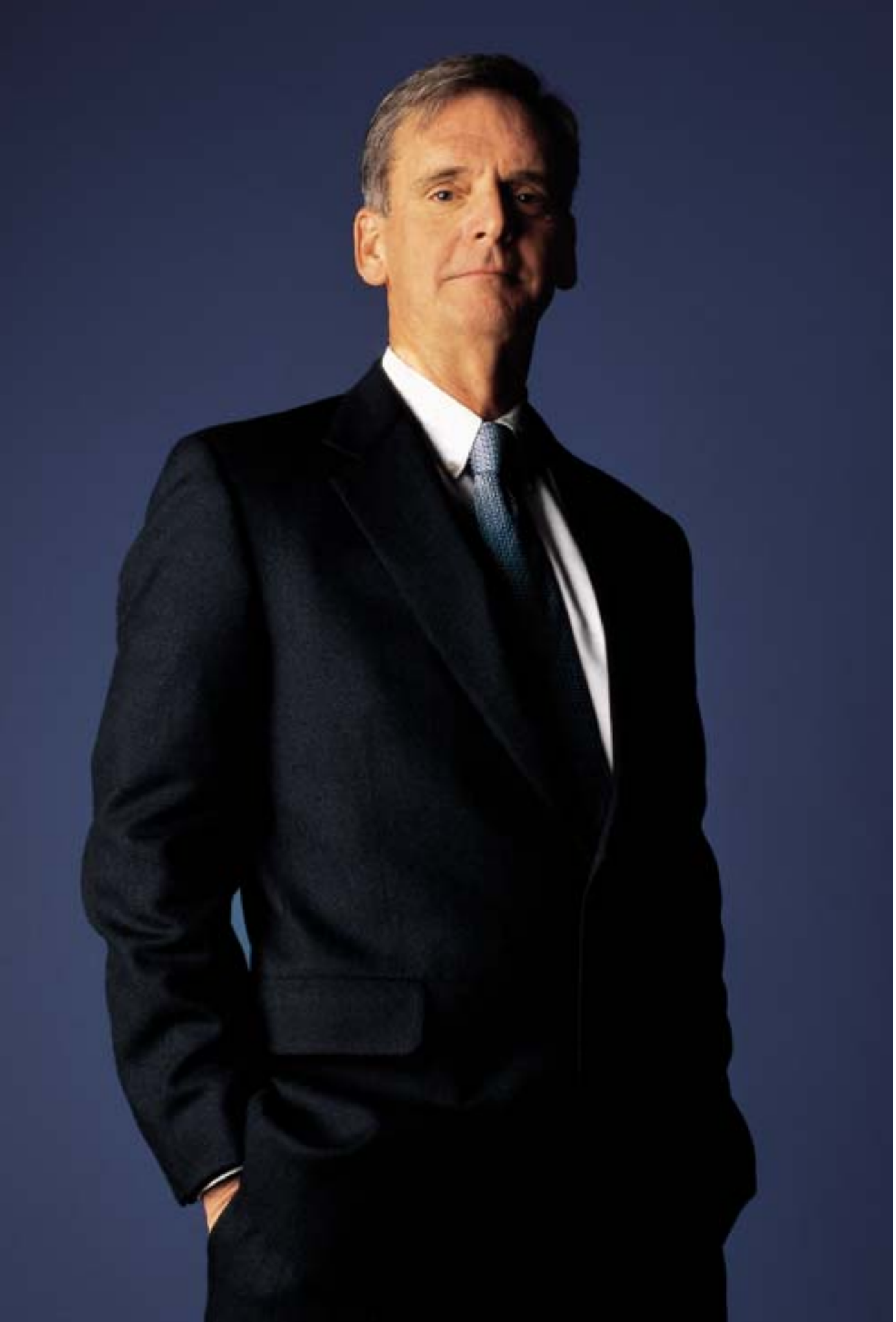
In many ways, depression is the stealth mental illness in our nation. Although it does not have the dramatic manifestations of schizophrenia, it has a massive effect on the people and the economy of this country. It is estimated that depression affects over 6 percent of Americans at any one time, and at least 16.6 percent of the population experiences depression in their lifetime. Depression costs the nation over $43 billion annually through absenteeism, reduced job productivity, related health care costs, premature death and suicide. But the tragedy is, while effective treatments are available, depression is often unrecognized, undiagnosed and untreated.

Depression is an equal-opportunity illness that strikes individuals of all racial and ethnic groups and economic classes.

Much more than temporary sadness triggered by a life incident, depression is a disease that can cause prolonged suffering through its effect on the brain. A depressed individual can experience sadness, anxiety, irritability and low self-esteem. Negative effects on sleep pattern, energy level, motivation and quality of life are common. Similar to chronic diseases, episodes of depression can come and go many times during the life cycle. People with heart disease, diabetes, cancer and HIV/AIDS have higher-than-average rates of depression. When depression accompanies these diseases, it can contribute to poor outcomes.

Depression is an equal-opportunity illness that strikes individuals of all racial and ethnic groups and economic classes. However, depression is associated with gender, ethnic and racial disparities in prevalence, help seeking, diagnosis and treatment. Women have depression at twice the rate of men. And while African Americans, Hispanics, American Indians and Asian Americans have rates of depression similar to whites, they are less likely to be diagnosed or treated. Some of the reasons for disparities in depression treatment among underserved groups include the extreme shame and stigma associated with mental illness, lesser access to mental health services, and health care practitioners' lack of familiarity with the culturally mediated expressions of depression. Also, cultural traditions among these groups include "toughing out" feelings of depression or turning to spiritual leaders and extended family members instead of health and mental health professionals. Clearly, we need to develop culturally tailored public education and specialized training among health care practitioners to reverse these disparities.

In a competitive global economy, this nation cannot afford the lost productivity and lower quality of life caused by untreated depression. We as a nation must do better to use our resources for screening and providing accurate diagnosis and appropriate treatment of depression for all of our citizens.



Health Care Costs and the Uninsured

THE HON. JUDD A. GREGG (R-NH)

United States Senate

As Chairman of the Senate Budget Committee, I have a new perspective on the long-term challenges rising health costs present to our government, our economy and our people. Every expert appearing before the Committee has testified that our nation is on an unsustainable fiscal course, and the two leading causes are demographic trends and rising health care costs.

Health care spending accounted for 15.3 percent of Gross Domestic Product in 2003 and outpaced growth in the economy by nearly 3 percentage points. Increasing health care costs are driving the growth of entitlement programs such as Medicare and Medicaid, which will consume nearly one-third of all government spending in 10 years.

The key to controlling the growth in health care costs is to reintroduce market forces.

The problem is not unique to government programs. Private health care spending continues to grow at an alarming rate, with far-reaching implications for jobs and the economy.

The key to controlling the growth in health care costs is to reintroduce market forces. We have seen what happens when government takes over health care. All we need to do is look at Medicare and Medicaid. These deteriorating programs are structured in a way that alienates physicians; rewards participants who game the system; sets irrational reimbursement rates that generate low-quality medical care and decisions; and results in a general lack of cohesion between utilization, cost and quality. It is a mess, and it is going to get worse.

We must focus on introducing common-sense solutions to the factors that drive health care inflation both in the public and private sectors. We must fix an unbalanced regulatory structure that leads to duplication and adverse selection, tax policy that is inequitable and encourages benefit designs that drive inflation; a lack of consumer information on cost and quality; reimbursement structures that don't encourage quality and efficiency; excessive litigation and regulation; and slow implementation of information technology.

Finally, it is time for the government to take a comprehensive look at Medicare and Medicaid and the underlying system, recognizing the drift to nationalization will continue to draw us toward an unaffordable system that forces rationing and price controls.

Transparency: The Key to Curing Underuse

ELIZABETH A. MCGLYNN, PH.D.

Associate Director, RAND Health

American adults receive about half of recommended health care services for common chronic and acute health care problems. Although adults receive some services they do not need, they more often fail to receive services that they do need. These failures have significant consequences for their health and well-being.

Transparency encourages consumers to educate themselves about their own health care needs because it makes clear the deficits in the system.

For example, we found nationally that 40 percent of people with diabetes had not had their blood sugar measured in two years. This test is essential for monitoring whether treatment is effective. Among those who had been tested, nearly one-quarter had blood sugar levels that were excessively high, and we observed a change in treatment for those patients less than 40 percent of the time. People with diabetes whose blood sugar levels are not controlled are at risk for serious and life-threatening complications. We estimate that the underuse of effective treatments may contribute annually to nearly 2,600 cases of preventable blindness and 29,000 cases of preventable kidney failure.

Similarly, we found that persons with new diagnoses of high blood pressure were usually not counseled to exercise or modify their diets; these actions can help patients with mild problems avoid taking medications. Medications were prescribed only about 60 percent of the time when necessary. About 60 percent of patients had blood pressures that were abnormally high, which contributes to nearly 68,000 preventable deaths annually.

So what can be done? We need information systems that facilitate proactive rather than reactive management of patients. We need to implement protocols that allow other members of the health care team to routinely administer indicated care (e.g., flu shots, pneumococcal vaccines). We need to engage physicians in identifying problems and taking ownership for solving those problems. We need to activate patients to take responsibility for their own health and advocate for their health care needs.

Transparency through public reports on quality is the key to making all of these things happen. Transparency stimulates critical dialogue among administrators, physicians, nurses and other health professionals about how they can redesign systems to improve performance. Transparency encourages consumers to educate themselves about their own health care needs because it makes clear the deficits in the system. That awareness in turn makes it acceptable for patients to talk to their doctors about whether and how their needs will be met. Dialogue leads to action, and action leads to improvement. We are spending nearly $2 trillion on a system that is functioning suboptimally. We can't afford not to act.

Health Information Technology is Therapeutic

DAVID J. BRAILER, M.D., PH.D.

National Coordinator for Health Information Technology, United States Department of Health and Human Services

Health information technology will transform the way Americans regard their health and the way they participate in health care. The important aspect of health information technology is not software and computers – it is physicians making better treatment decisions, nurses and pharmacists delivering safer care, and consumers making better choices among treatment options. It is the way people connect together across a fragmented health care delivery system – from physicians' offices to hospitals to nursing homes and even to the consumer's home. It is putting consumers in control of their health status and customizing care delivery to meet their needs.

Getting precise and timely information and guidelines to physicians will accelerate change in care delivery.

We have not thought about health information technology as therapeutic. Yet, the best evidence is that when it is used as intended, health information technology saves lives. Every primary care physician knows what a recent study showed: that clinical information is frequently missing, and that this missing information can be harmful to patients. That study also showed that clinical information was less likely to be missing in practices that had full electronic records systems. This adds to the substantial evidence that health information technology improves care, reduces wasteful and redundant treatments, and prevents medical errors.

Getting precise and timely information and guidelines to physicians will accelerate change in care delivery. But giving the same information to consumers will be revolutionary. When health information follows the consumer, they will be able to manage their health status; have real choice over their treatment options; and make better selections of physicians, hospitals and health plans. They will not have to fill out the same forms endlessly, be given duplicative treatments or tests, fear errors made through missing information or see physicians who do not know anything about them. A striking number of Americans already know this. A recent survey by the Agency for Healthcare Research and Quality with the Kaiser Family Foundation and the Harvard School of Public Health found that nearly one in three people say that they or a family member have created their own set of medical records to ensure that their health care providers have all of their medical information.

Health information technology can enable transformation of health care by allowing a better way to care – consumer by consumer, physician by physician, disease by disease and region by region. Health information technology has shown a challenged but resilient industry that there is hope for change, and that hope doesn't have to come from the top down, but from the inside out. Health information technology is not just about better treatments for the ailing and ill among us, nor just for all of us who want to prevent or limit illness in its early stages. It is ultimately about treating the industry itself so that we can have not only the best science, infrastructure and professionals in the world, but also the best value, safety and productivity.

FINANCIAL AND CORPORATE INFORMATION

CONSOLIDATED STATEMENTS OF INCOME

For the Years Ended December 31,

(Millions, except per common share data)	2004	2003	2002
Revenue:			
Health care premiums	$14,862.8	$13,235.5	$15,036.1
Other premiums	1,813.9	1,668.5	1,676.6
Administrative services contract fees	2,054.9	1,884.7	1,842.6
Net investment income	1,062.5	1,095.0	1,250.7
Other income	39.2	27.5	38.4
Net realized capital gains	70.8	65.2	34.3
Total revenue	19,904.1	17,976.4	19,878.7
Benefits and expenses:			
Health care costs	11,637.7	10,135.8	12,452.8
Current and future benefits	2,191.5	2,090.8	2,245.5
Operating expenses:			
Selling expenses	700.0	567.4	615.3
General and administrative expenses	3,328.8	3,587.1	3,617.3
Interest expense	104.7	102.9	119.5
Amortization of other acquired intangible assets	42.5	50.8	130.8
Severance and facilities charges	–	–	161.0
Reduction of reserve for anticipated future losses on discontinued products	–	–	(8.3)
Total benefits and expenses	18,005.2	16,534.8	19,333.9
Income from continuing operations before income taxes (benefits)	1,898.9	1,441.6	544.8
Income taxes (benefits):			
Current	490.2	397.0	193.8
Deferred	193.6	110.8	(42.2)
Total income taxes	683.8	507.8	151.6
Income from continuing operations	1,215.1	933.8	393.2
Discontinued operations, net of tax	1,030.0	–	50.0
Income before cumulative effect adjustments	2,245.1	933.8	443.2
Cumulative effect adjustments, net of tax	–	–	(2,965.7)
Net income (loss)	$ 2,245.1	$ 933.8	$ (2,522.5)
Earnings (loss) per common share:			
Basic:			
Income from continuing operations	$ 8.03	$ 6.12	$ 2.64
Income from discontinued operations, net of tax	6.80	–	.34
Income before cumulative effect adjustments	14.83	6.12	2.98
Cumulative effect adjustments, net of tax	–	–	(19.92)
Net income (loss)	$ 14.83	$ 6.12	$ (16.94)
Diluted:			
Income from continuing operations	$ 7.74	$ 5.91	$ 2.57
Income from discontinued operations, net of tax	6.56	–	.33
Income before cumulative effect adjustments	14.30	5.91	2.90
Cumulative effect adjustments, net of tax	–	–	(19.39)
Net income (loss)	$ 14.30	$ 5.91	$ (16.49)

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2004 Annual Report, Financial Report to Shareholders.

CONSOLIDATED BALANCE SHEETS

(Millions)	As of December 31, 2004	2003
Assets		
Current assets:		
Cash and cash equivalents	$ 1,396.0	$ 1,433.4
Investment securities	14,242.6	14,990.5
Other investments	57.7	103.1
Premiums receivable, net	256.1	318.4
Other receivables, net	314.0	396.0
Accrued investment income	198.6	221.5
Collateral received under securities loan agreements	1,173.8	827.4
Loaned securities	1,150.1	810.6
Income taxes receivable	226.8	–
Deferred income taxes	196.0	217.6
Other current assets	304.5	238.3
Total current assets	19,516.2	19,556.8
Long-term investments	1,718.1	1,521.5
Mortgage loans	1,348.2	1,353.1
Investment real estate	274.8	270.4
Reinsurance recoverables	1,173.0	1,196.3
Goodwill	3,687.8	3,679.5
Other acquired intangible assets, net	460.3	496.1
Property and equipment, net	233.6	267.5
Deferred income taxes	300.0	396.0
Other long-term assets	405.9	356.2
Separate Accounts assets	13,015.8	11,856.8
Total assets	$ 42,133.7	$ 40,950.2
Liabilities and shareholders' equity		
Current liabilities:		
Health care costs payable	$ 1,927.1	$ 1,888.7
Future policy benefits	837.6	811.1
Unpaid claims	707.7	624.3
Unearned premiums	121.8	203.7
Policyholders' funds	672.5	1,044.5
Collateral payable under securities loan agreements	1,173.8	827.4
Income taxes payable	–	154.7
Accrued expenses and other current liabilities	1,570.8	1,813.1
Total current liabilities	7,011.3	7,367.5
Future policy benefits	7,859.5	8,085.7
Unpaid claims	1,081.5	1,159.4
Policyholders' funds	1,453.1	1,529.7
Long-term debt	1,609.7	1,613.7
Other long-term liabilities	1,021.4	1,413.4
Separate Accounts liabilities	13,015.8	11,856.8
Total liabilities	33,052.3	33,026.2
Commitments and contingent liabilities		
Shareholders' equity:		
Common stock and additional paid-in capital	3,076.5	4,024.8
Retained earnings	6,546.4	4,307.2
Accumulated other comprehensive loss	(541.5)	(408.0)
Total shareholders' equity	9,081.4	7,924.0
Total liabilities and shareholders' equity	$ 42,133.7	$ 40,950.2

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2004 Annual Report, Financial Report to Shareholders.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(Millions)	For the Years Ended December 31, 2004	2003	2002
Cash flows from operating activities:			
Net income (loss)	$ 2,245.1	$ 933.8	$ (2,522.5)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Income from discontinued operations	(1,030.0)	–	(50.0)
Cumulative effect adjustments, net	–	–	2,965.7
Severance and facilities charges	–	–	161.0
Physician class action settlement charge	–	115.4	–
Amortization of other acquired intangible assets	42.5	50.8	130.8
Depreciation and other amortization	139.7	148.8	170.7
Amortization of net investment premium	45.5	54.2	11.3
Net realized capital gains	(70.8)	(65.2)	(34.3)
Changes in assets and liabilities:			
Decrease (increase) in accrued investment income	22.9	(7.2)	18.0
Decrease in premiums due and other receivables	34.0	150.1	352.9
Net change in income taxes	350.9	16.3	218.4
Net change in other assets and other liabilities	(621.7)	(369.4)	(64.8)
Net decrease in health care and insurance liabilities	(366.3)	(597.2)	(1,046.7)
Other, net	(21.2)	(59.8)	(4.1)
Net cash provided by operating activities of continuing operations	770.6	370.6	306.4
Discontinued operations	666.2	–	–
Net cash provided by operating activities	1,436.8	370.6	306.4
Cash flows from investing activities:			
Proceeds from sales and investment maturities of:			
Debt securities available for sale	9,471.7	12,623.6	15,679.9
Equity securities	41.6	53.5	251.2
Mortgage loans	271.3	565.7	602.3
Investment real estate	50.9	90.4	74.3
Other investments	2,132.1	2,403.6	3,321.0
Cost of investments in:			
Debt securities available for sale	(9,469.3)	(13,250.3)	(15,452.3)
Equity securities	(25.6)	(20.7)	(114.9)
Mortgage loans	(212.4)	(239.9)	(296.3)
Investment real estate	(83.5)	(66.8)	(47.6)
Other investments	(1,909.6)	(2,059.2)	(3,251.4)
Increase in property, equipment and software	(190.3)	(210.8)	(155.5)
Cash used for acquisition, net of cash acquired	(9.5)	(53.5)	–
Net cash provided by (used for) investing activities	67.4	(164.4)	610.7
Cash flows from financing activities:			
Deposits and interest credited for investment contracts	54.5	94.4	127.1
Withdrawals of investment contracts	(423.2)	(502.4)	(592.1)
Repayment of short-term debt	–	–	(109.7)
Common shares issued under benefit plans	316.0	293.6	233.5
Common shares repurchased	(1,493.0)	(445.2)	(165.2)
Dividends paid to shareholders	(5.9)	(6.1)	(6.0)
Other, net	10.0	(10.0)	–
Net cash used for financing activities	(1,541.6)	(575.7)	(512.4)
Net (decrease) increase in cash and cash equivalents	(37.4)	(369.5)	404.7
Cash and cash equivalents, beginning of year	1,433.4	1,802.9	1,398.2
Cash and cash equivalents, end of year	$ 1,396.0	$ 1,433.4	$ 1,802.9

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2004 Annual Report, Financial Report to Shareholders.

BOARD OF DIRECTORS

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RAIT Investment Trust

Chief Executive Officer
The Bancorp Bank

Barbara Hackman Franklin
President and Chief Executive Officer
Barbara Franklin Enterprises

Former U.S. Secretary of Commerce

Jeffrey E. Garten
Dean
Yale School of Management

Earl G. Graves
Chairman and Chief Executive Officer
Earl G. Graves, Ltd.

Publisher
Black Enterprise magazine

Gerald Greenwald
Founding Principal
Greenbriar Equity Group

Retired Chairman and Chief Executive Officer
UAL Corporation

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Exodus Communications, Inc.

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Retired Vice Chairman
International Business Machines Corporation

Edward J. Ludwig
Chairman of the Board, President and Chief Executive Officer
Becton, Dickinson and Company

Joseph P. Newhouse
John D. MacArthur Professor of Health Policy and Management
Harvard University

Judith Rodin*
President
Rockefeller Foundation

John W. Rowe, M.D.
Chairman and Chief Executive Officer
Aetna Inc.

Ronald A. Williams
President
Aetna Inc.

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Joseph P. Newhouse

Compensation and Organization
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Gerald Greenwald
Michael H. Jordan**
Jack D. Kuehler

Executive
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Earl G. Graves
Michael H. Jordan
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Judith Rodin
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Nominating and Corporate Governance
Barbara Hackman Franklin
Earl G. Graves
Gerald Greenwald**
Ellen M. Hancock
Edward J. Ludwig

**Not standing for re-election at the 2005 Annual Meeting of Shareholders.*

***Committee Chairman*

MANAGEMENT

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Chairman and Chief Executive Officer

Ronald A. Williams
President

Dong H. Ahn
Senior Vice President
Group Insurance

Andrew Allocco
Senior Vice President
Network and Provider Services

Alan M. Bennett
Senior Vice President and Chief Financial Officer

John J. Bermel
Vice President
Business Operations

Mark T. Bertolini
Senior Vice President
Specialty Products

Roger Bolton
Senior Vice President
Communications

Mary Claire Bonner
Vice President
Key Accounts

John L. Bridge
Vice President
Strategic Planning and Business Development

Louis J. Briskman
Senior Vice President and General Counsel

C. Timothy Brown
Senior Vice President
Middle Market Accounts

Craig R. Callen
Senior Vice President
Strategic Planning and Business Development

William J. Casazza
Senior Vice President, Deputy General Counsel and Corporate Secretary

Wei-Tih Cheng
Senior Vice President and Chief Information Officer

Michael Connolly
Vice President and Chief Technology Officer

Eric S. Elliott
Vice President
Pharmacy Management

David W. Entrekin
Vice President
Investor Relations

Patricia A. Farrell
Senior Vice President
Dental

Russell D. Fisher*
Senior Vice President
National Accounts and Aetna Global Benefits

James K. Foreman
Senior Vice President
National Accounts and Aetna Global Benefits

Mary C. Fox
Vice President
Behavioral Health

James A. Geyer
Vice President and Chief Actuary

Patricia Hassett
Vice President and Chief of Staff
Office of the Chairman

Paul B. Hebert
Vice President

Timothy A. Holt
Senior Vice President, Chief Investment Officer and Chief Enterprise Risk Officer

Charles H. Klippel
Senior Vice President and Deputy General Counsel

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Strategic Marketing and Consumer Insights

Margaret McCarthy
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Vice President
Medicare

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Vice President
Small Group and Individual

Dennis Oakes
Vice President
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National Customer Operations

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Finance and Treasurer

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Senior Vice President
Consumer Markets

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Vice President and Director of Internal Audit

Christine Skelly
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Office of the President

Diane D. Souza
Vice President
Strategic Systems and Processes

Thomas C. Strohmenger
Vice President, Counsel and Chief Compliance Officer

Robyn S. Walsh
Vice President
Aetna Workers' Compensation Access

John J. Webb
Vice President
Select Accounts

Elease E. Wright
Senior Vice President
Human Resources

**Retiring effective March 31, 2005*

SHAREHOLDER INFORMATION

ANNUAL MEETING

The annual meeting of shareholders of Aetna Inc. will be held on Friday, April 29, 2005, at 10:00 a.m. at the Four Seasons Hotel in Philadelphia, Pennsylvania.

CORPORATE HEADQUARTERS

151 Farmington Avenue
Hartford, CT 06156
Phone: 860-273-0123

STOCK EXCHANGE LISTING

Aetna Inc.'s ("Aetna's" or the "Company's") common shares are listed on the New York Stock Exchange ("NYSE"). The NYSE symbol for the common shares is AET. As of January 31, 2005, there were 12,709 record holders of Aetna's common shares.

WEB SITE ACCESS TO AETNA'S PERIODIC AND CURRENT REPORTS AND CORPORATE GOVERNANCE MATERIALS

Aetna makes available free of charge through its Web site at **http://www.aetna.com** its Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and all amendments to those reports as soon as reasonably practicable after Aetna electronically files or furnishes such materials with the U.S. Securities and Exchange Commission (the "SEC"). Aetna also makes available free of charge through its Web site the Company's Annual Report, Financial Report to Shareholders and Proxy Statement. **Shareholders may request printed copies of these reports free of charge by calling 1-800-237-4273.**

Aetna's Annual Report on Form 10-K provides additional details about the Company's business, as well as other financial information not included in this Annual Report. **To receive a copy of the Annual Report on Form 10-K without charge, please follow the above instructions.**

Also available on Aetna's Web site at **http://www.aetna.com/governance** are the following Aetna corporate governance materials: Articles of Incorporation and By-Laws; Code of Conduct for Directors, officers and employees (and information regarding any amendments or waivers relating to Aetna's Directors, executive officers and principal financial and accounting officers or persons performing similar functions); Independence Standards for Directors; Corporate Governance Guidelines; and Charters for the key standing Committees of the Board of Directors (Audit Committee, Committee on Compensation and Organization, Executive Committee, Investment and Finance Committee, Medical Affairs Committee, and Nominating and Corporate Governance Committee). **These materials also are available in print to shareholders free of charge by calling 1-800-237-4273.**

Section 16 reports are filed with the SEC by Aetna's Directors and those officers subject to Section 16 to reflect a change in their beneficial ownership of Aetna's securities and are available through Aetna's Web site at **http://www.aetna.com**.

The Audit Committee of the Board of Directors can be confidentially contacted by those wishing to raise concerns or complaints about the Company's accounting, internal accounting controls or auditing matters by calling AlertLine®, an independent toll-free service, at 1-888-891-8910 (available seven days a week, 24 hours a day), or by writing to: Corporate Compliance, P.O. Box 370205, West Hartford, CT 06137-0205.

Anyone wishing to make their concerns known to Aetna's nonmanagement Directors or to send a communication to the entire Board of Directors may contact Michael H. Jordan, Aetna's Presiding Director, who, among other things, presides over both the nonmanagement Directors' and the independent Directors' sessions, by writing to Mr. Jordan at P.O. Box 370205, West Hartford, CT 06137-0205. All communications will be kept confidential and forwarded directly to the Presiding Director or Board, as applicable. To contact Aetna's management Directors, you may write to Dr. Rowe at Aetna Inc., 151 Farmington Avenue, Hartford, CT 06156.

Aetna mails quarterly financial results only to those shareholders who request copies. Shareholders may call 1-800-237-4273 to listen to the Company's quarterly earnings release and dividend information, and to request faxed or mailed copies of the quarterly results.

CERTIFICATIONS

John W. Rowe, M.D., Chief Executive Officer, and Alan M. Bennett, Chief Financial Officer, have provided unqualified Certifications of the Company's public disclosure contained in the Company's Annual Report on Form 10-K for the year ended December 31, 2004 (the "2004 Form 10-K"), filed with the SEC. These Certifications, which are required pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 and related regulations, are filed as exhibits to the 2004 Form 10-K.

In addition, NYSE regulations require that the Chief Executive Officer provide the NYSE each year with a certification of compliance with the NYSE's corporate governance listing standards following the annual shareholders meeting. As required by these regulations, in May 2004, Dr. Rowe provided the NYSE with an unqualified certification regarding compliance with these standards.

INVESTOR RELATIONS

Securities analysts and institutional investors should contact:

David W. Entrekin
Vice President
Phone: 860-273-7830
Fax: 860-273-3971
E-mail address:
EntrekinD@aetna.com

SHAREHOLDER SERVICES

EquiServe Trust Company, N.A. ("EquiServe") maintains a telephone response center and a Web site to service registered shareholder accounts. Registered shareholders may contact EquiServe to inquire about replacement dividend checks, address changes, stock transfers and other account matters.

DirectSERVICE Investment Program
Current shareholders and new investors can purchase Aetna common shares and reinvest cash dividends through this program sponsored by EquiServe.

Contacting EquiServe by mail:
EquiServe Trust Company, N.A.
P.O. Box 43069
Providence, RI 02940-3069

Contacting EquiServe by telephone:
1-800-446-2617 – For general inquiries and dividend reinvestment
1-800-870-2340 – To enroll in direct deposit of dividends

Contacting EquiServe via Internet (instructions below):
http://www.equiserve.com

Current registered shareholder access: Click "account access" to log into your account. New users can click "passwords and login assistance" on the right side of the login page to set up their access and passwords for the first time.

New investors in the DirectSERVICE Investment Program: Click "buy stock direct" and search by ticker symbol "AET" to view or print the plan materials and/or to open a new shareholder account completely online.

Other Shareholder Inquiries
Office of the Corporate Secretary
Aetna Inc.
151 Farmington Avenue, RE4K
Hartford, CT 06156-3215
Phone: 860-273-4970
Fax: 860-293-1361
E-mail address:
ShareholderRelations@aetna.com

AETNA STOCK OPTION PARTICIPANTS AND AETNA EMPLOYEE STOCK PURCHASE PLAN PARTICIPANTS

Employees with outstanding stock options should address all questions to UBS Financial Services, Inc. ("UBS") regarding their accounts, outstanding options or shares received through option exercises. Employees participating in the Employee Stock Purchase Plan also should contact UBS with questions on their accounts.

UBS Financial Services, Inc.
Corporate Employee Financial Services
300 Lighting Way, 6th Floor
Secaucus, NJ 07094-3672
Phone: 1-888-793-7631
(TTY for the hearing impaired: 1-877-352-3595)

Online Access
http://www.ubs.com/onesource/aet

INFORMATION ABOUT THE ESSAYISTS

David J. Brailer, M.D., Ph.D., contributor of the essay *Health Information Technology is Therapeutic*, is National Coordinator for Health Information Technology, United States Department of Health and Human Services, Washington, D.C.

For more information about the U.S. Department of Health and Human Services, visit its Web site at **www.os.dhhs.gov.**

The Hon. Judd A. Gregg (R-NH), contributor of the essay *Health Care Costs and the Uninsured*, is Chairman of the Senate Budget Committee and Chairman of the Homeland Security Appropriations Subcommittee. In his third term in the United States Senate, Senator Gregg continues to be a strong advocate for improving our nation's education system, protecting our environmental resources and demanding fiscal responsibility in Washington.

Thomas H. Lee, M.D., contributor of the essay *Pay for Performance: Potential Impact and Implementation Strategies*, is Network President, Partners HealthCare System, and Professor of Medicine, Harvard Medical School, Boston, Massachusetts.

For more information about Partners HealthCare, visit its Web site at **www.partners.org.**

Elizabeth A. McGlynn, Ph.D., contributor of the essay *Transparency: The Key to Curing Underuse*, is Associate Director, RAND Health, Santa Monica, California.

For more information about RAND Health, visit its Web site at **www.rand.org/health.**

Annelle B. Primm, M.D., M.P.H., contributor of the essay *Understanding Depression and Disparities,* is Director, Minority and National Affairs, American Psychiatric Association, Arlington, Virginia, and Associate Professor of Psychiatry, Johns Hopkins School of Medicine, Baltimore, Maryland.

For more information about the American Psychiatric Association, visit its Web site at **www.psych.org.**

Sean R. Tunis, M.D., M.Sc., contributor of the essay *Improving Evidence for Health Care Decisions,* is Chief Medical Officer, Centers for Medicare and Medicaid Services, Baltimore, Maryland.

For more information about the Centers for Medicare and Medicaid Services, visit its Web site at **www.cms.hhs.gov.**

Grace-Marie Turner, contributor of the essay *New Financing Tools Give Consumers More Power and Control over Health Care Decisions,* is Founder, President and Trustee of the Galen Institute, Inc., Alexandria, Virginia.

For more information about the Galen Institute, visit its Web site at **www.galen.org.**

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