REPORT ON EXAMINATION

OF

AETNA HEALTH INC.

AS OF DECEMBER 31, 2020

EXAMINERS: **BARRY ARMSTRONG, CFE**
GAIL A. ROSS

DATE OF REPORT: **JUNE 17, 2025**

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June 17, 2025

Honorable Adrienne A. Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and New York State Public Health Law, and acting in accordance with the instructions contained in Appointment Number 32203, dated July 1, 2021, attached hereto, we have made an examination into the condition and affairs of Aetna Health Inc., a New York for-profit health maintenance organization with a certificate of authority issued by the New York State Department of Health under the provisions of Article 44 of the New York State Public Health Law, as of December 31, 2020, and submit the following report thereon.

The examination was conducted remotely due to restrictions relating to the COVID-19 pandemic.

Wherever the designations "AHI" or the "HMO" appear herein, without qualification, they should be understood to indicate Aetna Health Inc.

Wherever the designations “CVS Health” or “the Parent” appear herein, without qualification, they should be understood to indicate CVS Health Corporation, the ultimate parent of AHI.

Wherever the designation “Aetna” appears herein, without qualification, it should be understood to indicate Aetna Inc., an indirect wholly owned subsidiary of CVS Health and a direct wholly owned subsidiary of CVS Pharmacy, Inc.

Wherever the designation “AHIC” appears herein, without qualification, it should be understood to indicate Aetna Health Insurance Company of New York, an affiliated accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law.

Wherever the designation the “Department” or “DFS” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

Wherever the designation the “NYSDOH” appears herein, without qualification, it should be understood to indicate the New York State Department of Health.

Wherever the designation the “Companies” appears herein, without qualification, it should be understood to indicate Aetna Health Inc., and Aetna Health Insurance Company of New York, collectively.

1. SCOPE OF THE EXAMINATION

The previous examination was conducted as of December 31, 2015. This examination of the HMO was a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2021 Edition* ("the Handbook"), and it covered the five-year period, January 1, 2016, through December 31, 2020. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2020, were also reviewed.

The examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiners' assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiners planned and performed the examination to evaluate the HMO's current financial condition, as well as identify prospective risks that may threaten the future solvency of AHI.

The examiners identified key processes, assessed the risks within those processes, and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and NAIC annual statement instructions.

Information concerning the HMO's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the

HMO's risks and management activities in accordance with the NAIC's nine branded risk categories. These categories are as follows:

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

The examination also evaluated the HMO's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

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

The HMO was audited annually for the years 2016 through 2018, by the accounting firm of KPMG, LLP ("KPMG") and for the years 2019 and 2020, by the accounting firm of Ernst & Young, LLP ("EY"). The HMO received an unmodified opinion in each of those years. Certain audit workpapers of EY were reviewed and relied upon in conjunction with this examination. A review was also made of Aetna's Internal Audit function, Sarbanes-Oxley Act / Model Audit Rule function, and Enterprise Risk Management program, as they relate to the HMO.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook (an examination of one insurer or a group of insurers performed by examiners from more than one state whereby the participating states share resources and allocate work among the examiners), of the insurance subsidiaries of CVS Health. The examination was led by the state of Connecticut with participation from twenty-six (26) other states: Arizona, Florida, Georgia, Iowa, Illinois, Kansas, Louisiana, Maryland, Maine, Michigan, Minnesota, Missouri, Nebraska, North Carolina, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Virginia, Vermont, Washington, and West Virginia. Since the lead and participating states are accredited by the NAIC, all states deemed it appropriate to rely on each other's work. The examination team, representing the participating states, identified and assessed the risks for key functional activities across all of the CVS Health insurance subsidiaries. The examination team also assessed the relevant prospective risks as they related to the insurance entities.

Additionally, as part of this coordinated examination and in accordance with the provisions of the Handbook, an information systems review was made on a risk-focused basis of CVS Health's computer systems and operations that support the HMO.

The examiners reviewed the corrective actions taken by the HMO with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiners' review are contained in Item 4 of this report.

A concurrent examination regarding the financial condition of Aetna Health Insurance Company of New York was performed as of December 31, 2020. A separate financial report on examination was issued thereon.

This report on examination is confined to financial statements and comments on those matters which involve departure from laws, regulations, or rules, or which require explanation or description.

2. DESCRIPTION OF THE HMO

Aetna Health Inc. was incorporated in New York on June 24, 1985, under the name U.S. Healthcare, Inc. It was certified as a health maintenance organization by the NYSDOH on February 3, 1986, and began operations on May 1, 1986. AHI is licensed as a for-profit, independent practice association model health maintenance organization pursuant to the provisions of Article 44 of the New York Public Health Law. When certified, the HMO was a subsidiary of U.S. Healthcare, Inc., a Pennsylvania Corporation.

On July 19, 1996, U.S. Healthcare merged with Aetna Life and Casualty Company pursuant to an Agreement and Plan of Merger dated March 30, 1996. Aetna Inc., a Connecticut corporation, was incorporated on March 25, 1996, for the purpose of effectuating the merger and became sole owner of the merged companies, effective July 19, 1996. After the merger, U.S. Healthcare became a subsidiary of Aetna Inc., and its name was changed to Aetna U.S. Healthcare, Inc. Aetna U.S. Healthcare, Inc., the parent company of numerous HMOs operating in many states, was one of Aetna Inc.'s core health care businesses. The others were insurance and financial services, both domestic and international.

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

The HMO filed a request with the Department to operate under the assumed name (d/b/a) of Aetna U.S. Healthcare, Inc., effective January 1, 1997. The HMO also notified this Department and the New York State Department of Health of its intention to operate and market its products under such name. The HMO continued to operate under the Aetna U.S. Healthcare, Inc. name with regard to statutory filings, until a name change to Aetna Health Inc. in 2001. On December 28, 2001, NYLCare Health Plans of New York, Inc., an HMO, merged with and into the HMO.

On December 31, 2001, Prudential Health Care Plan of New York, Inc. merged with and into the HMO. Concurrent with that merger, the HMO's name was changed to Aetna Health Inc.

Effective September 30, 2003, Aetna Inc. contributed all of the capital stock of Aetna Health Inc. to Aetna Health Holdings, LLC ("AHH"). AHH's ultimate parent is Aetna Inc.

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

On November 28, 2018, CVS Health, a Delaware corporation acquired control of Aetna and its subsidiaries including AHI. Aetna is now an indirect wholly owned subsidiary of CVS Pharmacy, Inc., a Rhode Island corporation, which is a direct wholly owned subsidiary of CVS Health.

A. Management and Controls

The AHI Board of Directors ("BOD") is comprised of internal management and external independent directors. As required by Part 98-1.11(g) of the Administrative Rules and Regulations

of the New York State Department of Health (10 NYCRR 98-1.11(g)), a minimum of twenty percent (20%) of the Board of Directors of the HMO must be comprised of enrollee representatives.

Part 98-1.11(g) of the Administrative Rules and Regulations of Department of Health (10 NYCRR 98-1.11(g)) states, in part:

> "(g) Except in the case of an HMO operated by a corporation licensed under article 43 of the Insurance Law which also operates a Public Health Law article 44 line of business, no less than one third of the members of the governing authority of an MCO shall be composed of residents of New York State.
>
> (1) Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO…"

Pursuant to the HMO's By-laws, management of the HMO is to be vested in a Board of Directors consisting of three (3) Directors. The HMO's three (3) Directors and their principal business affiliation as of December 31, 2020, were as follows:

Name and Residence	Principal Business Affiliation
Ellen D. Anderson* New York	Administrative Assistant, The Cabot Group
Christopher J. Bradbury South Carolina	VP, Territory Leader, CVS Health/Aetna
Michael S. Costa New Jersey	Executive Director of NY and NJ, CVS Health/Aetna

*Enrollee representative per Part 98-1.11(g) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11(g)).

A review of the minutes of the BOD meetings held during the examination period revealed that the meetings were generally well attended, with all members attending at least 50% of the meetings they were eligible to attend.

The principal officers of the HMO as of December 31, 2020, were as follows:

Name	Title
Christopher J. Bradbury	Chief Executive Officer and President
Robert J. Parslow	Principal Financial Officer and Controller
Edward Chung-I Lee	Vice President and Secretary
Tracy L. Smith	Vice President and Treasurer
Kevin J. Casey	Senior Investment Officer
Terry J. Golash	Medical Director

B. Corporate Governance

CVS Health is a publicly traded, diversified health plan subject to the Sarbanes-Oxley Act of 2002 ("SOX"). The HMO is required to be compliant with Insurance Regulation No. 203 – Enterprise Risk Management and Own Risk and Solvency Assessment. Controls are identified by management and testing managed and monitored by the SOX Controls and Assurance Group that reports up through the Aetna Internal Audit Department ("IAD"). Shared services are managed by CVS Health and include information technology, risk management, investments, accounting, and internal audit.

i. Enterprise Risk Management

CVS Health has adopted an Enterprise Risk Management framework for proactively addressing and mitigating risks, including prospective business risks. Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*) was utilized by the examiners as guidance for assessing corporate governance. It appears that the HMO's BOD and key executives maintain an effective control environment.

ii. Internal Audit Department

CVS Health assumed the IAD function, which is independent of management, to serve the CVS Health Audit Committee of the BOD. In addition, CVS Health has established an Audit Council to address the requirements of Insurance Regulation No. 118 No. (11 NYCRR 89) – Audited Financial Statements and assist management at the local level with any insurance regulatory reviews.

During the course of this examination consideration was given to the significance and potential impact of certain IAD and SOX and Controls Assurance ("SCA") findings. To the extent possible, the examiners relied upon the work performed by the IAD, as prescribed by the Handbook.

No exceptions were noted by the examiners relative to the HMO's corporate governance.

C. Territory and Plan of Operation

AHI is contracted with Centers for Medicare and Medicaid Services ("CMS") to offer HMO plans for Medicare-eligible individuals through the Medicare Advantage program. Members typically receive enhanced benefits over standard Medicare fee-for-service coverage, including reduced cost-sharing for preventative care, vision, and other non-Medicare services. Members also typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. As of December 31, 2020, AHI was authorized to operate as a health maintenance organization pursuant to Article 44 of the New York Public Health Law in all sixty-two (62) New York Counties.

The following table displays AHI's net admitted assets, capital and surplus, net premium

income, and net income (loss) during the period under examination:

	Net Admitted Assets	Capital and Surplus	Net Premium Income	Net Income / (Loss)
2016	$264,675,036	$214,387,795	$173,583,446	$13,177,128
2017	270,088,039	225,457,182	122,549,929	6,055,684
2018	289,555,045	221,728,122	115,695,939	(5,780,101)
2019	194,057,873	77,216,796	228,911,333	(11,814,271)
2020	164,454,530	110,859,515	250,144,040	15,008,128

The following chart shows annual membership changes during the examination period by number and percentage:

	2016	2017	2018	2019	2020
Members	15,231	10,111	10,921	23,588	24,453
% of Change	(50.35)%	(33.62)%	8.01%	115.99%	3.67%

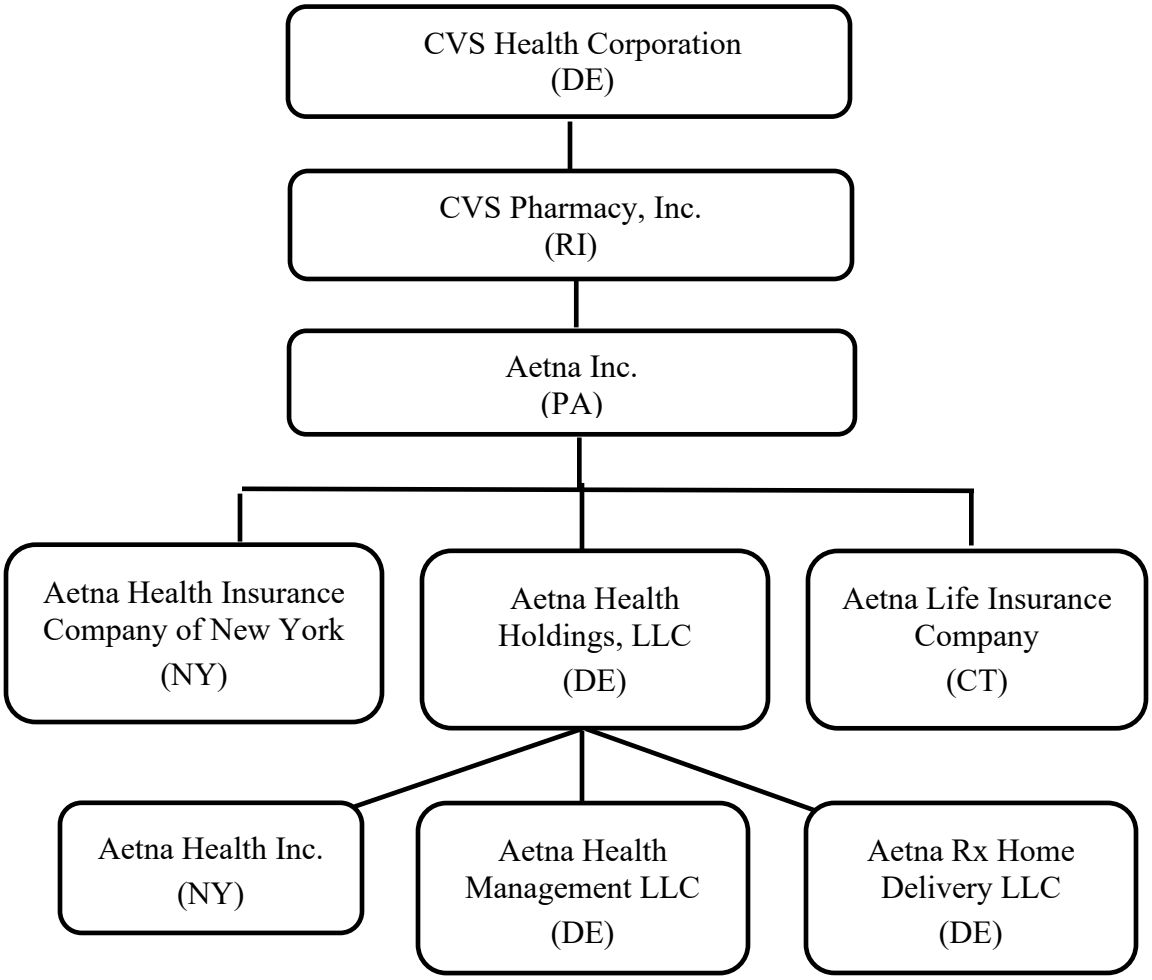
D. Risk-Based Capital

Risk-Based Capital ("RBC") measures the minimum amount of capital appropriate for the HMO to support its overall business operations in consideration of its size and inherent risks. An RBC of 300% or below can result in regulatory action.

The HMO's RBC during the examination period was above the regulatory action level.

E. Holding Company System

The following chart depicts the HMO's abbreviated holding company system as of December 31, 2020:



The HMO, during the examination period, was a party to inter-company agreements with its affiliates, which were subject to the NYSDOH and the Department's review and approval. These agreements involved activities such as administrative services, cash management, investment management, and tax allocation.

Inter-company agreements and amendments for AHI that were in place as of December 31, 2020, included the following:

- Financial Guaranty Agreement – The HMO entered into a Financial Guaranty Agreement, effective October 14, 2020, with CVS Health. Under this agreement, CVS Health unconditionally guarantees to contribute capital to the HMO's immediate parent Aetna

Health Holdings, LLC , such that the HMO's capital levels are maintained in excess of: (i) 300% of Authorized Control Level risk-based capital levels on file risk-based capital statements; and (ii) 12.5% of annual premium minimum net worth requirements of the NYSDOH and the Department. This agreement was approved by the Department and the NYSDOH on October 14, 2020.

- Inter-company transfer agreement – The HMO entered into an inter-company transfer agreement with AHIC effective January 1, 2000. This agreement provides for point-of-service ("POS") premiums to be allocated from the HMO to its affiliate, AHIC, in order to achieve identical cost ratios for each entity. The basis of the allocation is the combined medical cost ratio for in-network and out-of-network POS products. Settlements occur quarterly, based on the medical cost ratio reported in each of the entity's financial statements. The agreement was approved by the NYSDOH on November 9, 2000.

- Tax sharing agreement – The HMO, with several of its affiliates, files a consolidated Federal income tax return. This agreement was effective January 1, 2006. The agreement stipulates that the taxes paid are determined as if each of the subsidiaries filed their taxes separately. The agreement was amended effective January 1, 2019, and non-disapproved by the Department on March 19, 2019. The amendment reflects the change in the ultimate parent from Aetna Inc. to CVS Health.

- Mail order pharmacy agreement – The HMO entered into an agreement with Aetna Rx Home Delivery, LLC ("Aetna Rx") effective February 1, 2003. This agreement permits Aetna Rx to act as the provider of service to the HMO's members for the provision of mail order pharmaceutical benefits. This agreement was approved by the NYSDOH on January 6, 2003.

- Expense allocation and rebate services agreement – The HMO entered into an expense allocation and rebate services agreement with Aetna Health Management, LLC ("AHM") effective January 1, 2006. The agreement was amended (fifth and sixth amendment) effective January 1, 2018, and December 10, 2020. The fifth amendment was non-disapproved by the Department on December 4, 2017, and approved by the NYSDOH on December 22, 2017. The sixth amendment was non-disapproved by the Department on December 10, 2020 and approved by the NYSDOH on December 10, 2020.

  Under this agreement, AHM provides the HMO with the administrative services and resources. Administrative services do not include the services of any personnel. The fifth amendment added specific terms and fees for the agreement. The sixth amendment added CMS specific terms and conditions to the agreement.

- Expense allocation agreement – The HMO entered into an expense allocation agreement with Aetna Inc. effective January 1, 2006. The agreement, which was non-disapproved by the Department on April 5, 2005, obligates the HMO to pay Aetna Inc. to, among other things, hire employees and to negotiate and enter into agreements and contracts on behalf of the HMO.

- Personnel services and expense reimbursement agreement – The HMO entered into a personnel services and expense reimbursement agreement with Aetna Life Insurance

Company ("ALIC") effective January 1, 2006. The agreement filed a second amendment to the agreement effective January 1, 2014.

This agreement permits ALIC to provide the personnel necessary to perform administrative services. These services exclude broker and commissions, bad debt expenses, premium taxes, state and/or guaranty fund assessments, among others.

The HMO indicated that the agreement has been terminated as of November 1, 2021.

It was noted that the HMO was unable to provide the Department and NYSDOH proof of prior notice for the 2014 amendment to the Personnel Services and Expense Reimbursement Agreement between the HMO and ALIC.

New York Insurance Law Section 1505(d) states in part:

"The following transactions between a domestic controlled insurer and any person in in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction… and the superintendent has not disapproved it within such period:

(3) rendering of services on a regular or systematic basis;"

The HMO is directed to comply with New York Insurance Law Section 1505(d) and submit any amendments to its intercompany agreements to the Department at least thirty days prior to the start of the transaction.

F. Evaluation in Controls of Information Technology

The Examiner performed an evaluation of the IT controls in accordance with the guidelines and procedures set forth in Exhibit C Evaluation of Controls in Information Technology of the Handbook ("Exhibit C").

The Examiner's objectives were to determine whether IT resources align with the HMO's objectives and to ensure that significant risk (strategic, operational, reporting, and compliance) arising out of its IT environment was appropriately mitigated by strategies and controls as outlined

in the Handbook's Exhibit C Part Two – Evaluation of Controls in IT.

The objectives above were achieved through a combination of reviewing the HMO's policies and procedures, testing in key areas related to Exhibit C, interviewing the HMO's senior IT management, reviewing IT risk assessment processes, and leveraging the risk assessment procedures performed by the HMO and by EY.

Based upon the risk-focused assessment and review, no material findings were noted which would have a significant effect on the annual statement. As a result of this review, it was determined that the IT general controls at the HMO were effective.

G. Significant Underwriting Ratios:

The HMO's significant underwriting results, for the examination period January 1, 2016, through December 31, 2020, were as follows:

	Amount	Percentage
Total hospital and medical expenses	$736,949,158	83.61%
Net reinsurance recoveries	(2,236,822)	(0.25)%
Claims adjustment expenses	15,239,835	1.73%
General administrative expenses	151,312,329	17.17%
Net underwriting gain	(19,815,513)	(2.25)%
Net premiums earned	881,448,987	100.00%

The underwriting ratios presented above are on an earned/incurred basis and encompass the five-year period covered by this examination.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2020, as contained in AHI's 2020 filed annual statement, a condensed summary of operations, and a reconciliation of the capital and surplus account for each of the years under review. The examiners' review of a sample of transactions did not reveal any differences which materially affected the HMO's financial condition as presented in the financial statements contained in the December 31, 2020, filed annual statement.

Independent accountants EY were retained by CVS Health to audit AHI's combined statutory basis statements of financial position as of December 31st for 2019 and 2020, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended. KPMG was retained by Aetna to audit AHI's combined statutory basis statements of financial position as of December 31st for 2016, 2017, and 2018, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the years then ended.

EY and KPMG concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the HMO at the respective audit dates. Balances reported in these audited financial statements were reconciled to the 2019 and 2020 annual statements with no discrepancies noted.

A. Balance Sheet

Assets

Bonds	$ 70,581,030
Common Stocks	54,789,505
First liens	7,178,241
Cash and short-term investments	244,742
Other invested assets	9,888,146
Receivables for securities	79,625
Investment income due and accrued	394,554
Uncollected premiums in the course of collection	215,531
Accrued retrospective premiums	8,195,304
Amounts receivable relating to uninsured plans	3,290,889
Current federal income tax recoverable	2,236,307
Receivables from parent, subsidiaries, and affiliates	4,682,878
Health care and other amounts receivable	2,677,778
Total assets	$164,454,530

Liabilities

Claims unpaid	$ 28,404,942
Accrued medical incentive pool and bonus amounts	723,888
Unpaid claims adjustment expenses	334,967
Aggregate health policy reserves	16,033,608
Aggregate health claim reserves	622
Premiums received in advance	80,287
General expenses due or accrued	6,538,409
Remittances and items not allocated	1,049,397
Funds held under reinsurance treaties	103,958
Liability for amounts held under uninsured plans	273,772
Aggregate write-ins for other liabilities:	
Accrued Premium Rate Reduction	51,165
Total liabilities	$ 53,595,015

Capital and Surplus

Common capital stock	6
Gross paid in and contributed surplus	$ 74,956,549
Aggregate write-ins for other than special surplus funds	31,304,320
Unassigned funds (surplus)	4,598,640
Total capital and surplus	$110,859,515
Total liabilities, capital and surplus	$164,454,530

Note 1: The Internal Revenue Service ("IRS") routinely conducts a Compliance Assurance evaluation of tax returns for CVS Health and its affiliates. There were no known IRS findings reported from the Compliance Assurance evaluation completed for December 31, 2016, December 31, 2017, December 31, 2018, December 31, 2019, or December 31, 2020. The examiners are unaware of any potential exposure of issues related to AHI for any tax assessments and no liability has been established herein relative to such contingency.

Note 2: AHI files its tax returns on a consolidated basis with other affiliated companies within the CVS Health holding company.

B. Statement of Revenue and Expenses and Changes in Capital and Surplus

The HMO's capital and surplus decreased by $87,525,682 during the five-year examination period, January 1, 2016, through December 31, 2020, detailed as follows:

Revenue		
Premium income	$890,884,697	
Change in unearned premium reserve	(9,435,710)	
Total revenue		$881,448,987
Hospital and Medical Expenses		
Hospital/medical benefits	$609,249,244	
Other professional services	12,314,600	
Outside referrals	15,357,408	
Emergency room and out-of-area	22,641,765	
Prescription drugs	82,389,039	
Aggregate write-ins for other hospital and medical	(6,804,816)	
Incentive pool, withhold adjustments and bonus amounts	1,801,918	
Net reinsurance recoveries	(2,236,822)	
Total hospital and medical expenses	$734,712,336	
Claims adjustment expenses	15,239,835	
General administrative expenses	151,312,329	
Total underwriting deductions		$901,264,500
Net underwriting loss		$ (19,815,513)
Net investment income earned		30,670,027
Net realized capital gains less capital gains tax		6,540,620
Net investment gains		37,210,647
Net income after capital gains tax and before federal income taxes		$ 17,395,134
Federal and foreign income taxes incurred		(748,566)
Net income		$ 16,646,568

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination, as of December 31, 2015			$198,385,197
Net income	$16,646,568		
Change in net unrealized capital gains less capital gains tax	33,449,943		
Change in net deferred income tax		$ 9,346,095	
Change in non-admitted assets	887,053		
Dividends to stockholders		125,000,000	
Change in unauthorized and certified reinsurance	26,787		
Aggregate write-ins for losses in surplus		4,189,938	
Net decrease in capital and surplus			$ (87,525,682)
Capital and surplus, per report on examination, as of December 31, 2020			$110,859,515

4. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2015, contained the following two (2) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

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

5. VIOLATIONS, RECOMMENDATIONS, AND COMMENTS

ITEM		PAGE NO.
A.	Holding Company System	
	The HMO is directed to comply with New York Insurance Law Section 1505(d) and submit any amendments to its intercompany agreements to the Department at least thirty days prior to the start of the transaction.	14

Respectfully submitted,

_____
Barry Armstrong, CFE
Examiner in charge

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

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

_____
Barry Armstrong

Subscribed and sworn to before me
this_____day of_____2025.

Respectfully submitted,

_____
Gail A. Ross
Supervising Examiner

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

Gail A. Ross, being duly sworn, deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

_____
Gail A. Ross

Subscribed and sworn to before me
this _____ day of_____2025.

APPOINTMENT NO. **32203**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***LINDA A. LACEWELL****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Noble Consulting Services, Inc.

as a proper person to examine the affairs of

Aetna Health Inc. (a New York Corporation)

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

HMO

with such other information as they shall deem requisite.

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

this 1st day of July, 2021

Linda A. Lacewell
Superintendent of Financial Services

By: Alice W. McKenney

Alice McKenney
Deputy Bureau Chief
Health Bureau