

**REPORT ON EXAMINATION**  
**OF**  
**INDEPENDENT HEALTH BENEFITS CORPORATION**  
**AS OF**  
**DECEMBER 31, 2005**

**DATE OF REPORT**

**NOVEMBER 20, 2007**

**EXAMINER**

**JOSEPH S. KRUG**

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

Eliot Spitzer  
Governor

Eric R. Dinallo  
Superintendent

November 20, 2007

Honorable Eric R. Dinallo  
Superintendent of Insurance  
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 22490 dated March 10, 2006, attached hereto, I have made an examination into the condition and affairs of Independent Health Benefits Corporation as of December 31, 2005 and submit the following report thereon.

The examination was conducted at the Plan's home office located at 511 Farber Lakes Drive, Williamsville, New York 14221.

Whenever the designations "IHBC" or "the Plan" appear herein without qualification, they should be understood to mean Independent Health Benefits Corporation.

## **1. SCOPE OF EXAMINATION**

The previous examination was conducted as of December 31, 2000. This examination covered the period from January 1, 2001, through December 31, 2005. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2005, a review of the income and disbursements to the extent deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items called for in the Examiners Handbook of the National Association of Insurance Commissioners:

- History of Plan
- Management and control
- Corporate records
- Territory and plan of operation
- Loss experience
- Reinsurance
- Accounts and records
- Growth of Plan

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

## **2. EXECUTIVE SUMMARY**

The Plan failed to comply with Section 4301(k)(1)(A)&(B) of the New York Insurance Law regarding the composition of its board of directors.

The Plan failed to comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five day period provided by the aforementioned section of the Insurance Law, in instances where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

The Plan failed to file biennial reports required by Section 4901(a) of the New York Insurance Law relative to utilization review agents.

The Plan failed to file its commission bonus plan with and obtain approval from the Superintendent of Insurance prior to implementation as required by Section 4308(b) of the New York Insurance Law.

## **3. DESCRIPTION OF PLAN**

The Plan, formerly known as Integrated Benefits Corporation, is a non-profit health service corporation organized under the provisions of the Membership Corporation Law and Article 43 of the New York Insurance Law.

In 2001, the Plan changed its name to Independent Health Benefits Corporation.

### **A. Management**

The sole member of the Plan is Independent Health Association, Inc.

Pursuant to the Plan's by-laws, management of the Plan is vested in a board of directors consisting of not less than thirteen (13), nor more than nineteen (19) members. As of the examination date, the Plan's board of directors was comprised of fourteen (14) members.

At December 31, 2005, the Plan's board consisted of the following members.

**Name and Residence**

**Principal Business Affiliation**

Provider Representative

Richard E. Wolin, M.D.  
Lewiston, NY

Psychiatrist,  
Buffalo Medical Group

Subscriber Representatives

R. Marshall Wingate  
Buffalo, NY

President,  
DynaCom Industries, Inc.

Donna M. Kelsch  
Sanborn, NY

Teacher,  
Niagara Falls Board of Education

Iris Schifeling, Esq.  
Buffalo, NY

Deputy Counsel,  
Independent Health Association, Inc.

Betty Christ  
Hamburg, NY

Vice President,  
Niagara Frontier Auto Dealers Association

Public Representatives

Sidney Weiss, CPA  
Williamsville, NY

Managing Partner,  
Brody, Weiss, Zucanelli & Urbanek,  
CPAs, P.C.

<b><u>Name and Residence</u></b>	<b><u>Principal Business Affiliation</u></b>
John J. Culkin Amherst, NY	Retired
Frank J. Colantuono Youngstown, NY	Advisor to the President, Independent Health Association, Inc.
Brenda McDuffie Buffalo, NY	President & CEO, Buffalo Urban League, Inc.
Duane Sundell Williamsville, NY	Retired
Mark I. Johnson Buffalo, NY	Senior Vice President, Finance & CFO, Independent Health Association, Inc.
Frederick B. Cohen, Esq. Buffalo, NY	Secretary and General Counsel, Independent Health Association, Inc.
Michael Faso Clarence, NY	Vice President of Financial Operations, Independent Health Association, Inc.
Michael W. Cropp, MD Buffalo, NY	President, Independent Health Association, Inc.

The minutes of all meetings of the Board of Directors held during the examination period were reviewed. All board meetings held during the examination period were well attended.

At December 31, 2005, the Plan's board consisted of one (1) provider representative, four (4) subscriber representatives, and nine (9) public representatives. Section 4301(k)(1)(A)&(B) of the New York Insurance Law provides for equal representation, as nearly as possible, relative to subscriber and public representatives on the board of directors.

It is recommended that the number of directors on the Plan's board representative of subscribers and the number of directors representative of the public be as equal as possible in compliance with Section 4301(k)(1)(A)&(B) of the New York Insurance Law.

Management reports, essential to the operations of the Plan were provided to the management of the HMO during the period under review. The Plan has complied with the requirements of Circular Letter 9 (1999) relative to the maintenance of procedures manuals.

The principal officers of the Plan, at December 31, 2005, were as follows:

<u>Name</u>	<u>Title</u>
Frank J. Colantuono	Chairperson
Vacancy	Vice-Chairperson
Mark Johnson	Second Vice-Chairperson
Michael W. Cropp, MD	President
Frederick B. Cohen	Secretary and General Counsel
Michael Faso	Treasurer

A review of the Plan's minutes of meetings indicated that the position of Vice-Chairperson has been vacant since the end of 1998. As of December 31, 2006 the position was still vacant.

Article IV, Section 4.01 of the Plan's by-laws states:

"The Officers of the Corporation shall be a Chairperson, Vice-Chairperson, Second Vice-Chairperson, President, Secretary Director of Finance, and such other Officers as the Board of Directors may from time to time elect or appoint."

It is recommended that the Plan fill the position of Vice-Chairperson in accordance with its by-laws.

**B. Territory and Plan of Operation**

The Plan is licensed to do business as a non-profit health service corporation within this State pursuant to the provisions of Article 43 of the New York Insurance Law.

As of December 31, 2005, IHBC provided comprehensive hospital and medical, PPO medical, consumer directed, prescription drug, and dental benefits to its members. The Plan also provided point of service (POS) benefits to eligible members of Independent Health Association (IHA). The following is a brief description of the major products offered by IHBC as of December 31, 2005:

Encompass Plus – provides point of service benefits.

Passport Plan – a medical health plan which provides nationwide coverage by means of network contracting with two national provider networks.

Passport Plan Select - a preferred provider organization product which provides for members to receive comprehensive coverage nationwide by means of contracts with two national networks.

Easy Access - a preferred provider organization product.

Traditional - plan that offers the member comprehensive health coverage.

IDirect – a Health Savings Account (HSA) qualified plan, subject to annual deductibles.

Medicare PPO - provides Title XVIII Medicare PPO coverage.



All of the above are part of one contract with Mason Insurance Company, Ltd., an unauthorized reinsurer and subsidiary of IHA.

The maximum reinsurance reimbursement payable under the hospital inpatient contract is \$425,000 of covered expenses per member, per contract year. In addition, the maximum reinsurance reimbursement payable under the Medicare risk contract is \$255,000 of covered expenses per member, per contract year.

It should be noted that a review of the above reinsurance contract indicated that it contained the insolvency clause required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

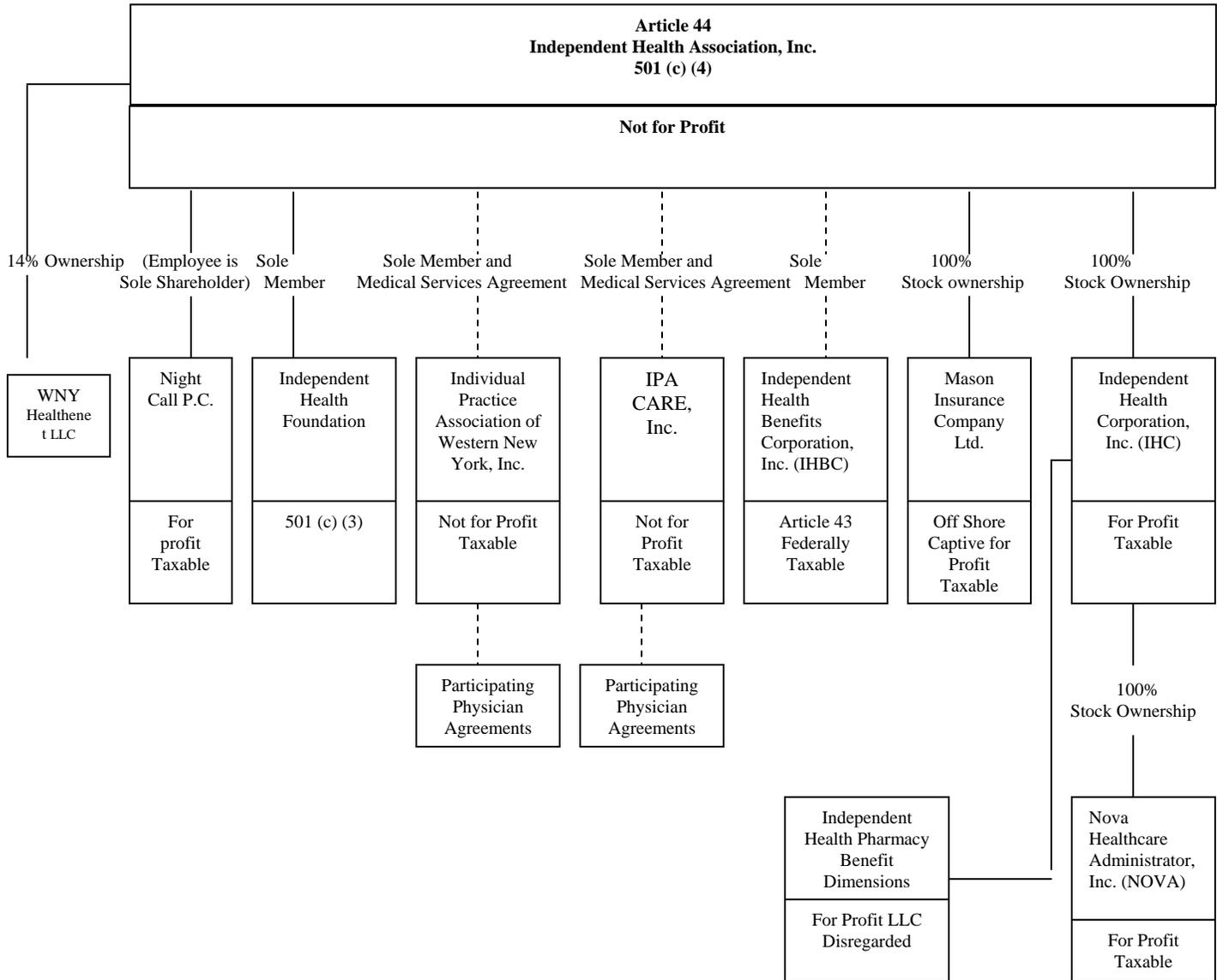
A review of the asset, amounts recoverable from reinsurers, indicated that the Plan was not properly accounting for this asset. Since the amount recoverable is from an unauthorized reinsurer, it should be recorded as a non-admitted asset unless a letter of credit is established in accordance with the NAIC's SAP 61. After meeting with the Plan, it was agreed that rather than set up the letter of credit, the Plan would treat the amount recoverable from its reinsurer as a non-admitted asset in future annual statement filings. This is consistent with the requirements of SAP 61 which states:

“If the reinsurer is not authorized to do business, or is not otherwise approved, the reinsurance is considered unauthorized.”

It is recommended that IHBC comply with the requirements of NAIC SAP 61 and non-admit reinsurance recoverables from Mason Insurance Company, an unauthorized reinsurer, in its future annual statement filings.

**D. Holding Company System**

The following chart depicts the Plan and its relationship to its major affiliates as of December 31, 2005:



**Independent Health Association, Inc. (IHA)**

IHA, as of December 31, 2005 was the sole member of Independent Health Benefits Corporation. IHBC was created as joint venture by IHA and Capital District Physicians' Health Plan, each a health maintenance organization licensed under Article 44 of the New York Public Health Law.

In 1998, IHA, pursuant to agreement became the sole member of Integrated Benefits Corporation. Subsequently, in 2001 the name of the corporation was changed to its present name, Independent Health Benefits Corporation.

During the period under examination, the following Section 1307 loans were made by IHA to IHBC:

<u>Date Issued</u>	<u>Amount</u>
December 30, 2004	\$3,000,000
June 30, 2005	\$4,000,000

It should be noted that both of the above Section 1307 loans were approved by this Department. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to the prior approval of the Superintendent of Insurance.

An examination of IHA was conducted in conjunction with the examination of IHBC. A separate report on examination has been issued relative to IHA.

### **Independent Health Corporation (IHC)**

IHC is a for-profit, wholly owned subsidiary of IHA, which offers self-funded service administration, manages self-funded insurance plans, provides pharmacy benefit management services, flexible spending accounts, and administers a contract providing printing services to IHA's affiliates and others.

### **Pharmacy Benefit Dimensions, LLC**

Effective August 9, 2005, Pharmacy Benefit Dimensions, LLC was organized to provide pharmacy benefit management services to employers who maintain employee health and welfare plans. IHC is its sole member.

### **NOVA HealthCare Administrators, Inc. (NOVA)**

NOVA is a for-profit, wholly owned subsidiary of IHC, which offers self-funded administration services, manages self-funded plans, pharmacy benefit management, and flexible spending accounts.

### **Mason Insurance Company, Ltd. (Mason)**

Mason is a wholly owned subsidiary of IHA which operates as a captive reinsurance company, domiciled in Hamilton, Bermuda. Mason began operations in 1992 and reinsures claims of IPA/WNY, IPA Care, and IHBC.

**Independent Health Foundation, Inc. (IHF)**

On April 20, 1992, Independent Health Foundation, Inc. was formed under Section 402(d) of the Not-For-Profit Corporation Law for the principal purpose of promoting and supporting the health of the community and the activities of IHA. The sole member of the corporation is Independent Health Association, Inc.

**Individual Practice Association of Western New York, Inc. (IPA/WNY)**

IPA/WNY is a not-for-profit taxable entity for federal and New York State purposes in which IHA is the sole corporate member. IPA/WNY has contractual arrangements with IHA to provide and/or arrange medical and pharmaceutical services to IHA's subscribers, including Medicare eligible participants, who reside primarily in the local geographic region. In return, IPA/WNY receives a monthly capitation fee and various administrative services provided by IHA.

**IPA Care, Inc.(IPA/CARE)**

IPA/CARE is a not-for-profit, taxable entity for federal and New York State purposes in which IHA is the sole member corporation. IPA/CARE has contractual arrangements with IHA to provide and/or arrange medical services to IHA's Medicaid eligible participants, who reside in Erie and Niagara Counties of New York State. In return, IPA/CARE receives a monthly capitation fee and various administrative services provided by IHA.

**E. Administrative Services Agreement**

On October 19, 1995, IHBC entered into an Administrative Services Agreement with its affiliate, IHA. According to this agreement, various services are provided to IHBC by IHA including, but not limited, to the following:

- a) Financial, legal, internal operations, management information systems, marketing consultation and health care services as necessary for the economical operation of IHBC
- b) Develop, revise and refine new health care services products, systems, policies, procedures and software to support and enhance the business of IHBC.
- c) Such other services, including but not limited to health care services, as IHBC may from time to time request.

**F. Underwriting Ratios**

The underwriting ratios presented below are on an earned-incurred basis and encompass the January 1, 2001 to December 31, 2005 period covered by this examination:

	<u>Amount</u>	<u>Ratio</u>
Claims incurred	\$111,444,889	83.5%
Claims adjustment expenses incurred	8,317,390	6.2%
Other underwriting expenses incurred	7,942,983	5.9%
Net underwriting gain	<u>5,885,596</u>	<u>4.4%</u>
Premiums earned	<u>\$133,590,858</u>	<u>100.0%</u>

**G. Accounts and records**

A review of the Plan's accounts and records revealed the following:

Allocation of Expenses

The prior report on examination included a comment noting that the Plan did not provide documentation of comprehensive studies relative to the allocation of expenses among its expense categories during the examination period. A review of the Plan's allocation of expenses among its expense categories during the current examination period revealed that although there was improvement over the methodologies used in the prior period, there was still need of further improvement. Subsequent to the examination period, after meeting with several of the Plan's representatives, the Plan made some revisions to its methodology for the allocation of expenses among its expense categories however, the comprehensive studies were still lacking.

It is once again recommended that the Plan make appropriate studies relative to the allocation of expenses in future statements to this Department.

#### **4. FINANCIAL STATEMENTS**

##### **A. Balance Sheet**

The following shows the assets, liabilities and surplus as determined by this examination as of December 31, 2005. This statement is the same as the balance sheet filed by the Plan.

	<u>Assets</u>	<u>Non- admitted Assets</u>	<u>Net Admitted Assets</u>
<u>Assets</u>			
Cash , cash equivalents and short-term investments	\$19,759,950		\$19,759,950
Investment income due and accrued	1,397		1,397
Uncollected premiums	730,384	114,362	616,022
Reinsurance recoverable	58,953		58,953
Net deferred tax asset	1,100,000		1,100,000
Non-admitted assets	<u>33,235</u>	<u>33,235</u>	<u>0</u>
Total assets	<u>\$21,683,919</u>	<u>147,597</u>	<u>\$21,536,322</u>
<u>Liabilities</u>			
Claims unpaid			\$6,894,338
Unpaid claims adjustment expenses			541,000
Premiums received in advance			75,182
General expenses due and accrued			1,149,055
Amounts due to parent, subsidiaries and affiliates			<u>1,052,725</u>
Total liabilities			\$9,712,300
<u>Surplus</u>			
Surplus notes			\$8,245,000
Statutory reserve fund			10,573,498
Unassigned funds (surplus)			<u>(6,994,476)</u>
Total surplus			<u>\$11,824,022</u>
Total liabilities and surplus			<u>\$21,536,322</u>

Note 1: No liability appears on the above statement for loans principal in the amount of \$8,245,000 and interest accrued thereon of \$415,925. The loans were granted pursuant to the provisions of Section 1307 of the New York Insurance Law. As provided in Section 1307, repayment of principal and interest shall only be made out of free and divisible surplus, subject to approval of the Superintendent of Insurance of the State of New York

Note 2: The Internal Revenue has not audited the Plan. The examiner is unaware of any potential exposure of the Plan to any tax assessment and no liability has been established herein relative to any contingency.

Note 3: The Balance Sheet shown above includes no provision for distributions from the Demographic and Specified Medical Condition Pools. On December 6, 2005, IHBC received a settlement for years 1999 to 2004 as a distribution from the Specified Medical Condition Pool in the amount of \$19,545.

**B. Statement of Revenues and Expenses**

For the period, January 1, 2001, through December 31, 2005, reserves and unassigned funds increased \$9,057,616 detailed as follows:

Income

Net premium income	<u>\$133,590,858</u>	\$133,590,858
Total revenues		

Expenses

Hospital/medical benefits	\$ 86,148,505	
Other professional services	36,945	
Prescription drugs	21,676,012	
Aggregate write-ins for other medical and hospital	<u>4,302,966</u>	
Subtotal	112,164,428	
Net reinsurance recoveries	<u>719,539</u>	
Total hospital and medical	111,444,889	
Claims adjustment expenses	8,317,390	
General administrative expenses	<u>7,942,983</u>	
Total underwriting deductions		<u>127,705,262</u>
Net underwriting gain		\$ 5,885,596
Net investment income earned		368,505
Aggregate write-ins for other income and expenses		<u>8,274</u>
Net income before federal and foreign income taxes incurred		6,262,375
Federal and foreign income taxes incurred		<u>2,687,677</u>
Net income		<u>\$ 3,574,698</u>

**Change in Surplus**

Capital and surplus per report on examination as of December 31, 2000			\$2,766,406
	<u>Increases</u>	<u>Decreases</u>	
Net income from operations	\$3,574,698	\$	
Change in net deferred income tax	1,100,000		
Restatement of 2004 deferred taxes	1,070,000		
Change in non admitted assets		(1,197,082)	
Change in surplus notes	4,510,000		
	<hr/>	<hr/>	
Total gains and losses	<u>\$10,254,698</u>	<u>\$(1,197,082)</u>	
Net change in capital and surplus			<u>9,057,616</u>
Capital and surplus per report on examination as of December 31, 2005			<u>\$11,824,022</u>

## **5. CLAIMS PAYABLE**

The examination liability of \$6,894,338 is the same as the amount reported by the Plan as filed in its December 31, 2005 annual statement.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements.

## **6. MARKET CONDUCT ACTIVITIES**

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The general review was directed at practices of the Plan in the following major areas:

- A. Claims processing
- B. Prompt payment
- C. Utilization review
- D. Schedule M
- E. Commissions

**A. Claims Processing**

A review of the Plan's claims practices and procedures was performed. This review was performed by using a statistical sampling methodology covering the scope period in order to evaluate the overall accuracy and compliance environment of the Plan's claims processing. The review encompassed the period from January 1, 2005 through December 31, 2005. The claims tested were selected from the population of claims adjudicated during the review period.

These primary populations were divided into hospital and medical claims segments. Random samples were drawn from each of the segment groups. For purposes of this review, those medical costs characterized as Medicare, capitated, and SMC payments were excluded.

The statistical random sampling process was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes within the selected populations, individually or on a combined basis. For example, if ten (10) attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample. The following parameters were established to determine the sample size for the statistical sampling model:

**a) Confidence Level**

The rate was set at 95%, which implies that there is a 95% chance that the sample will yield an accurate result.

**b) Tolerance Error**

The rate was set at 5%. It was determined that a 5% error rate would be acceptable for this sample.

**c) Expected Error**

It was anticipated that a 2% error rate exists in the entire population subject to sampling, which was deemed acceptable for the model design.

**d) Sample Size**

The sample size for each of the populations described herein was comprised of one hundred sixty seven (167) randomly selected unique claims. A second random sample of fifty (50) items from each of the populations was also generated as “replacement items” in the event it was determined a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized.

**e) Sample Unit**

The term, “claim” can be defined in a myriad of ways. For purposes of these procedures, the Department defines a claim as the total number of items submitted with a single claim form, which is the basis of the Department’s statistical sample of claims or the sample unit.

To ensure the completeness of the claims population, the total dollars paid were accumulated and reconciled to the financial data reported by the Plan. To verify each service (item) that resulted in no payment, a reconciliation of transaction counts was performed.

The Plan's internal performance measurement for claims accuracy is 97%.

In the sample of 167 hospital claims reviewed, one (1) procedural error was found. Of the 167 medial claims reviewed, two (2) financial errors were found. No trends in the type of error were noted.

## **B. Prompt Payment**

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services," states:

"(a) Except in a case where the obligation of an insurer ... to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

"(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay

any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

- (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
- (2) to request all additional information needed to determine liability to pay the claim or make the health care payment.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

“(c) ... any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim.”

In this regard, a statistical sample of claims paid during calendar year 2005 was selected from a population of claims that were paid more than forty-five (45) days from receipt. The claims were reviewed for compliance with Section 3224-a of the New York Insurance Law. The results of the review were then projected for the total population of claim payments made during the period.

The following is a summary of the prompt pay review findings for the combined Hospital and Medical claims paid over 45 days.

Description	Paid claims over 45 days Section 3224-a(a)
Claim population	779
Sample size	167
Number of claims with errors	155
Upper Error limit	96.73%
Lower Error limit	88.90%
Upper limit Claims in error	<u>754</u>
Lower limit Claims in error	<u>693</u>

Note 1: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five day period provided by the aforementioned section of the Insurance Law where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.

**C. Utilization Review**

It was determined that the Plan has never filed any of the biennial reports required by utilization review agents. Section 4901(a) of the New York Insurance Law states:

“(a) Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section.

(b) Such report shall contain a description of the following:

(1) The utilization review plan;

(2) Those circumstances, if any, under which utilization review may be delegated to a utilization review program conducted by a facility licensed pursuant to article twenty-eight of the public health law or pursuant to article thirty-one of the mental hygiene law;

(3) The provisions by which an insured, the insured's designee, or a health care provider may seek reconsideration of or appeal from adverse determinations by the utilization review agent, in accordance with the provisions of this title, including provisions to ensure a timely appeal and that an insured, the insured's designee, and, in the case of an adverse determination involving a retrospective determination, the insured's health care provider is informed of their right to appeal adverse determinations;

(4) Procedures by which a decision on a request for utilization review for services requiring preauthorization shall comply with timeframes established pursuant to this title;

(5) A description of an emergency care policy, which shall include the procedures under which an emergency admission shall be made or emergency treatment shall be given;

(6) A description of the personnel utilized to conduct utilization review including a description of the circumstances under which utilization review may be conducted by:

(i) administrative personnel;

(ii) health care professionals who are not clinical peer reviewers; and

(iii) clinical peer reviewers;

(7) A description of the mechanisms employed to assure that administrative personnel are trained in the principles and procedures of intake screening and data collection and are appropriately monitored by a licensed health care professional while performing an administrative review;

(8) A description of the mechanisms employed to assure that health care professionals conducting utilization review are:

(i) appropriately licensed, registered or certified; and

(ii) trained in the principles, procedures and standards of such utilization review agent.

(9) A description of the mechanisms employed to assure that only a clinical peer reviewer shall render an adverse determination;

(10) Provisions to ensure that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:

(i) not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received; or

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subsection (a) of section four thousand nine hundred three of this title or an expedited appeal filed pursuant to subsection (b) of section four thousand nine hundred four of this title, on a twenty-four hour a day, seven day a week basis;

(11) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical and treatment records are followed;

(12) A copy of the materials to be disclosed to an insured or prospective insured pursuant to sections three thousand two hundred seventeen-a or four thousand three hundred twenty-four of this chapter, whichever is applicable, and this title;

(13) A description of the mechanisms employed by the utilization review agent to assure that all subcontractors, sub-vendors, agents or employees affiliated by contract or otherwise with such utilization review agent will adhere to the standards and requirements of this title; and

(c) The clinical review criteria and standards contained within the utilization review plan shall not be subject to disclosure pursuant to the provisions of article six of the public officers law.”

It should be noted that once the Plan was made aware of the lack of filing its biennial reports required by utilization review agents, a filing was made with this Department on April 5, 2007.

It is recommended that the Plan file its biennial reports required by utilization review agents with this Department as required by Section 4901(a) of the New York Insurance Law.

**D. Schedule M**

A review was made of the Plan’s Schedule M as filed with the Plan’s annual statement as of December 31, 2005. The data included in the schedule reflects data relative to grievances filed under Section 4408-a of the Public Health Law as well as appeals filed pursuant to Article 49 of the Public Health Law.

The review encompassed an examination of the underlying support data used in compiling Schedule M which was included in the Plan’s filed December 31, 2005 annual

statement. It was noted that the data included within the Plan's Schedule M Table 1: Section 4408-a Grievances included both grievances and utilization review appeals. Utilization review appeals should be reported in the HMO's Schedule M Table 2.

It is recommended that the Plan complete its Schedule M correctly by reporting grievances in Table 1 and utilization appeals in Table 2.

**E. Commissions, Bonuses and Fees**

It was determined that IHBC had been accruing for a \$50 incentive conversion bonus payment to agents/brokers for movement of IHA (Article 44) commercial (HMO) business to IHBC (Article 43) experience rating contracts. The Plan failed to file its commission bonus plan under prior approval.

Section 4308(b) of the New York Insurance Law states:

“(b) No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof. The superintendent may refuse such approval if he finds that such premiums, or the premiums derived from the rating formula, are excessive, inadequate or unfairly discriminatory, provided, however, the superintendent may also consider the financial condition of such corporation in approving or disapproving any premium or rating formula. Any premium or formula approved by the superintendent shall make provision for such increase as may be necessary to meet the requirements of a plan approved by the superintendent in the manner prescribed in section four thousand three hundred ten of this article for restoration of the statutory reserve fund required by such section. Notwithstanding any other provision of law, the

superintendent, as part of the rate increase approval process, may defer, reduce or reject a rate increase if, in the judgment of the superintendent, the salary increases for senior level management executives employed at corporations subject to the provisions of this article are excessive or unwarranted given the financial condition or overall performance of such corporation. The superintendent is authorized to promulgate rules and regulations which the superintendent deems necessary to carry out such deferral, reduction or rejection.”

It is recommended that in the future, the Plan file its commission bonus plan prior to implementation with the Superintendent and obtain his approval as required by Section 4308(b) of the New York Insurance Law.

7. **COMPLIANCE WITH PRIOR REPORT ON EXAMINATION**

The prior report on examination included eleven (11) recommendations detailed as follows (page number refers to the prior report on examination):

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
A. <b><u>Management</u></b>	
It is recommended that the Plan's board of directors comply with its by-laws and hold board meetings on a quarterly basis.	3
The Plan has complied with this recommendation.	
At December 31, 2000, the Plan's board consisted of one (1) provider representative, five (5) subscriber representatives, seven (7) public representatives and two (2) employee/officer representatives. This represents a slight variance from the provisions of Section 4301(k)(1)(A)&(B) of the New York Insurance Law provides which requires equal representation, as nearly as possible, relative to subscriber and public representatives on the board of directors.	5
The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.	
It is recommended that the Plan fill its officer vacancies and elect or appoint its officers on an annual basis (with the exceptions noted in its by-laws) in accordance with its by-laws.	6
The Plan has complied with this recommendation.	

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
<p>B.           <b><u>Accounts and Records</u></b></p> <p>It is recommended that the Plan make appropriate studies relative to the allocation of expenses, particularly with regard to the establishment of its unpaid claims reserves, in future statements to this Department.</p> <p>The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.</p> <p>It is recommended that the Plan correctly complete Part 3 – Analysis of Expenses of its Underwriting and Investment Exhibit in future filings with this Department.</p> <p>The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.</p>	<p>12</p> <p>12</p>
<p>C.           <b><u>Administrative expense</u></b></p> <p>It is recommended that the Plan take the necessary steps to reduce its administrative expense ratio to an amount within the administrative expense limitation prescribed by Section 4309(a) of the New York Insurance Law.</p> <p>The Plan has complied with this recommendation.</p>	<p>13</p>
<p>D.           <b><u>Records Retention Plan</u></b></p> <p>It is recommended that the Plan establish and implement a complete records retention plan in compliance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243.3).</p> <p>The Plan has complied with this recommendation.</p>	<p>14</p>

<b><u>ITEM</u></b>	<b><u>PAGE NO.</u></b>
E.	<p><b><u>Disaster Recovery/Business Continuation Plans</u></b></p> <p>14</p> <p>It is recommended that the Plan maintain complete recovery and business continuity plans.</p> <p>The Plan has complied with this recommendation.</p>
F.	<p><b><u>Claims processing</u></b></p> <p>21</p> <p>It is recommended that the Plan comply with the requirements of Section 3224-a of the New York Insurance Law and make appropriate payment of all claims within the forty-five (45) day period provided by the aforementioned section of the Insurance Law where there is not an appropriate reason for delay in payment as specified in Section 3224-a(a) and (b) of the New York Insurance Law.</p> <p>The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.</p> <p>22</p> <p>It is recommended that the Plan, in the future, ensure that copies of Regulation 64 are distributed to all persons directly responsible for the supervision, handling and settlement of claims as prescribed by Section 216.0(e)(6) of New York Regulation 64 (11 NYCRR 216).</p> <p>The Plan has complied with this recommendation.</p>
G.	<p><b><u>Schedule M</u></b></p> <p>22</p> <p>It is recommended that the Plan properly file its Schedule M in future statements submitted to this Department.</p> <p>The Plan has not complied with this recommendation. A similar comment appears in the current report on examination.</p>

## **8. SUMMARY OF COMMENTS AND RECOMMENDATIONS**

The following is a summary of the comments and recommendations made in the body of this report:

<b><u>ITEM NO.</u></b>	<b><u>PAGE NO.</u></b>
<p>A.       <b><u>Management</u></b></p> <p style="margin-left: 40px;">1. It is thus recommended that the number of directors on the Plan's board representative of subscribers and the number of directors representative of the public be as equal as possible in compliance with Section 4301(k)(1)(A)&amp;(B) of the New York Insurance Law.</p> <p style="margin-left: 40px;">2. It is recommended that the Plan fill the position of Vice-Chairperson in accordance with its by-laws.</p>	<p>6</p> <p>6</p>
<p>B.       <b><u>Reinsurance</u></b></p> <p style="margin-left: 40px;">It is recommended that IHBC comply with the requirements of NAIC SAP 61 non-admit reinsurance recoverables from Mason Insurance Company, an unauthorized reinsurer, in its future annual statement filings.</p>	<p>9</p>
<p>C.       <b><u>Accounts and Records</u></b></p> <p style="margin-left: 40px;">It is once again recommended that the Plan make appropriate studies relative to the allocation of expenses in future statements to this Department.</p>	<p>15</p>

<b><u>ITEM NO.</u></b>	<b><u>PAGE NO.</u></b>
<p>D.       <b><u>Prompt Payment</u></b></p> <p>It is recommended that the HMO comply with the requirements of Section 3224-a of the New York Insurance Law, and make appropriate payment of all claims within the forty-five (45) day period provided by the aforementioned section of the New York Insurance Law where there is not an appropriate reason for delay as specified in Section 3224-a(a) and (b) of the New York Insurance Law.</p>	25
<p>E.       <b><u>Utilization Review</u></b></p> <p>It is recommended that the HMO file its biennial reports required by utilization review agents with this Department as required by Section 4901(a) of the New York Insurance Law.</p>	28
<p>F.       <b><u>Schedule M</u></b></p> <p>It is recommended that the HMO complete its Schedule M correctly by reporting grievances in Table 1 and utilization appeals in Table 2.</p>	29
<p>G.       <b><u>Commissions, Bonuses and Fees</u></b></p> <p>It is recommended that the Plan file its commission bonus plan prior to implementation with the Superintendent and obtain his approval as required by Section 4308(b) of the New York Insurance Law.</p>	30

Appointment No. 22490

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Joseph Krug**

as a proper person to examine into the affairs of the

**Independent Health Benefits Corporation**

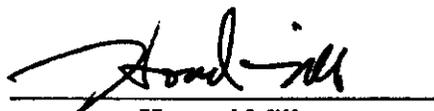
and to make a report to me in writing of the said

**Company**

with such information as he shall deem requisite.

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

this 10<sup>th</sup> day of March 2006



Howard Mills  
Superintendent of Insurance

