

REPORT ON EXAMINATION
OF
INDEPENDENT HEALTH ASSOCIATION, INC.
AS OF
DECEMBER 31, 2000

DATE OF REPORT

MAY 30, 2002
Revised OCTOBER 4, 2002

EXAMINER

ROBERT W. MCLAUGHLIN, CFE, CIE

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

October 4, 2002

Honorable Gregory V. Serio
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 21724 dated April 10, 2001, attached hereto, I have made an examination into the condition and affairs of Independent Health Association, Inc. as of December 31, 2000 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 "the HMO" or "IHA" appear herein without qualification, they should be understood to indicate Independent Health Association, Inc. Whenever the designations "IPA/WNY" or "IPA/CARE" appear without qualification, the designations should be understood to mean Individual Practice Association of Western New York, Inc. and IPA CARE, Inc., respectively, affiliates and contracted providers of health services to IHA subscribers.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1995. This examination covered the five-year period from January 1, 1996, through December 31, 2000. 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, 2000, a review of the income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO'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 HMO
- Management and control
- Corporate records
- Territory and plan of operation
- Loss experience
- Reinsurance
- Accounts and records
- Growth of HMO

A review was also made to ascertain what action was taken by the HMO with regard to comments and recommendations in the prior report on examination. 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. DESCRIPTION OF PLAN

Independent Health Association, Inc. operates as a health maintenance organization, which offers prepaid comprehensive health benefits to subscribers of the HMO. IHA was incorporated in New York State as a not-for-profit corporation on March 11, 1977 under the name Western New York Health Plan, Inc. On May 5, 1978, the HMO changed its name to Independent Health Association, Inc. by means of a charter amendment.

On February 9, 1980, the HMO qualified as a health maintenance organization under Title XIII of the Public Health Service Act. IHA also received authority to conduct business pursuant to Article 44 of the New York Public Health Law on February 11, 1980.

A. Management

Pursuant to the HMO’s charter and by-laws, management of the HMO is vested in a board of directors consisting of not less than twelve (12) nor more than thirty (30) members. As of the examination date, the board of directors was comprised of nineteen (19) members. The board, during the examination period, met at least six (6) times during each calendar year. The directors as of December 31, 2000 were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Clement R. Arrison Buffalo, NY	Retired
Frank J. Colantuono Youngstown, NY	President & CEO, Independent Health Association, Inc.
James R. Coppola Williamsville, NY	Retired

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
John J. Culkin Amherst, NY	Retired
John B. Fisher Buffalo, NY	Retired
Mark Hamister Clarence, NY	Chairman & CEO National Health Care Affiliates
Donna M. Kelsch Sanborn, NY	Teacher, Niagara Falls Board of Education
Brenda W. McDuffie Buffalo, NY	President & CEO Buffalo Urban League, Inc.
William L. McHugh Buffalo, NY	Executive Vice President Independent Health Association, Inc.
Miquel Rainstein, M.D. Williamsville, NY	Vice President & Secretary, Amherst Surgical Associates, P.C.
Edward Stehlik Buffalo, NY	Internist Private Practice
Duane J. Sundell Williamsville, NY	Retired
Richard T. Tillotson. Buffalo, NY	Captain, Buffalo Fire Department
Michael Tronolone, M.D. Clarence, NY	Chairman of Board of Directors, Buffalo Medical Group
John N. Walsh, III Buffalo, NY	Chairman & CEO Walsh Duffield Co., Inc.
Sidney Weiss, CPA	Managing Partner,

Williamsville, NY

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

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
R. Marshall Wingate Buffalo, NY	President, DynaCom Industries, Inc.
Barry N. Winnick, D.D.S. East Amherst, NY	Dentist, Amherst Dental Group
Richard E. Wolin, M.D. Lewiston, NY	Psychiatrist, Buffalo Medical Group

At December 31, 2000, seventeen (17) directors (89.5% of the board members) were enrollees of IHA in compliance with Part 98-1.11(f) of the New York Health Department's Administrative Rules and Regulations (10 NYCRR 98).

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

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

During the period under examination, the HMO's investments were not approved by the HMO's board of directors.

Section 1411(a) of the New York Insurance Law states as follows:

“No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee’s minutes shall be recorded and a report submitted to the board of directors at its next meeting.”

It is recommended that the HMO, in the future, comply with the investment authorization or approval requirements of Section 1411(a) of the New York Insurance Law.

The HMO’s board of directors, at its May 23, 2001 board meeting, changed its procedures and began approving the HMO’s investments in compliance with Section 1411(a) of the New York Insurance Law.

The principal officers of the HMO, at December 31, 2000, were as follows:

<u>Name</u>	<u>Title</u>
Barry N. Winnick, D.D.S..	Chairperson
R. Marshall Wingate	Vice Chairperson
John N. Walsh, III	Second Vice Chairperson
Frank J. Colantuono	President &CEO
Robert E. Wolin, M.D.	Secretary
William McHugh	Executive Vice President
Michael Cropp, M.D.	Executive Vice President, Chief Medical Officer
Carol Cassell	Senior Vice President, Operations & HCS
Frederick Cohen, Esq.	Senior Vice President & General Counsel
Mark Johnson	Senior Vice President, Finance, CFO
Robert Hoover	Senior Vice President of Information Technology & CIO

B. Territory and Plan of Operation

The HMO is authorized under a Certificate of Authority to do business as a health maintenance organization pursuant to the provisions of Article 44 of the New York State Public Health Law within the following counties of New York State:

Western New York Region	Hudson Valley Region	Metro New York Region
Erie	Ulster	Bronx
Niagara	Dutchess	New York
Allegany	Orange	Kings
Orleans	Putnam	Queens
Chautauqua	Rockland	Richmond
Cattaraugus	Westchester	Nassau
Genesee		Suffolk
Wyoming		

Effective February 28, 2001, the HMO ceased writing business in the counties listed in the Hudson Valley and Metro New York regions above. As of the date of the writing of this report, May 30, 2002, the HMO had not amended its Certificate of Authority to reflect the current territory it is writing coverage in.

As of December 31, 2000, the HMO was also authorized to operate as a health maintenance organization serving the Medicaid population pursuant to Article 44 of the New York State Public Health Law within the following counties of New York State:

Cattaraugus
Chautauqua
Genesee

Erie
Niagara
Orleans

IHA also provides Medicare Plus Choice, Medicaid, Point of Service (POS) and Healthy New York coverages. Out of network benefits relative to POS coverages are provided by IHA's wholly owned subsidiary, Independent Health Benefits Corporation.

IHA's change in enrollment during the examination period is as follows:

	<u>Commercial HMO-Only Membership</u>	<u>Commercial POS Membership</u>	<u>Government Program Membership*</u>	<u>Total</u>
December 31, 1996	377,476	14,081	34,933	426,490
December 31, 1997	371,982	36,978	43,605	452,565
December 31, 1998	336,783	30,709	48,411	415,903
December 31, 1999	303,776	28,479	44,568	376,823
December 31, 2000	284,847	20,264	49,721	354,832
December 31, 2001	274,847	23,920	50,337	349,104

* Includes Medicare, Medicaid and Healthy New York membership.

IHA's overall membership decreased by 18.2% since December 31, 1996. IHA's Commercial HMO-only membership decreased 27.2% during such period. This decrease has been partially offset by a 69.9% increase in Commercial POS membership and a 44.1% increase in government program membership.

IHA markets directly through its employees and also makes use of independent brokers and agents.

C. Reinsurance

At December 31, 2000, the HMO had the following stop-loss reinsurance program in effect for its Commercial HMO-only business, Medicare Plus Choice, Medicaid and its Commercial POS products:

HMO Hospital inpatient expenses

Excess of loss two layers	85% of \$375,000 excess of \$125,000 of expenses per member, per contract year (unauthorized affiliated reinsurer).
	90% excess of \$500,000 of loss per member, per contract year up to a maximum of \$1,000,000 per member, per contract year (accredited reinsurer)

Medicare risk inpatient

Excess of loss one layer:	85% excess of \$75,000 of expenses per member, per Contract year up to a maximum of \$1,000,000 per member, per contract year (accredited reinsurer)
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The maximum reinsurance reimbursement payable under the HMO hospital inpatient first layer contract, made with Mason Insurance Company, Ltd., an unauthorized reinsurer and subsidiary of the HMO, is \$318,750 of covered expenses per member, per contract year.

The maximum reinsurance reimbursement payable under the HMO hospital inpatient second layer contract Reliastar Life Insurance Company, an accredited reinsurer, is \$1,000,000 of covered expenses per member, per month with a maximum lifetime reinsurance coverage for each member of \$2,000,000.

Medicaid expenses

Excess of loss two layers	85% of \$200,000 excess of \$50,000 of expenses per member, per contract year (authorized reinsurer).
	100% excess of \$250,000 of loss per member,

per contract year up to a maximum of \$2,000,000
per member, per contract year
(authorized reinsurer)

The above contract was made with TIG Insurance Company, an authorized reinsurer. Eligible in-network charges are limited to the lesser of the amount allowable under the NYS Medicaid DRG fee schedule or an average per diem limit of \$4,000. Eligible out-of-network charges are limited to the lesser of billed charges paid, negotiated per diems/case rates or an average per diem limit of \$4,000.

The reinsurance contracts with Mason Insurance Company, Ltd. and TIG Insurance Company did not contain the insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

Section 1308(a)(2)(A)(i) of the New York Insurance Law states in part,

“...reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer...”

It is recommended that IHA amend its reinsurance contracts with Mason Insurance Company, Ltd. and TIG Insurance Company to include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

It was noted that IHA, during the examination period, had not received prior approval from the Commissioner of Health and the Superintendent of Insurance relative to changes in its reinsurance agreements as required by Part 98.8(b) of the New York Department of Health Administrative Rules and Regulations (10 NYCCRR 98). Such changes included a change in reinsurer; a change in the insolvency protection language and limits; and a change in the type of business covered by the agreement. The Department views reinsurance protection as part of the HMO's

overall solvency protection, and exercises approval authority for material changes to the agreement such as those described above.

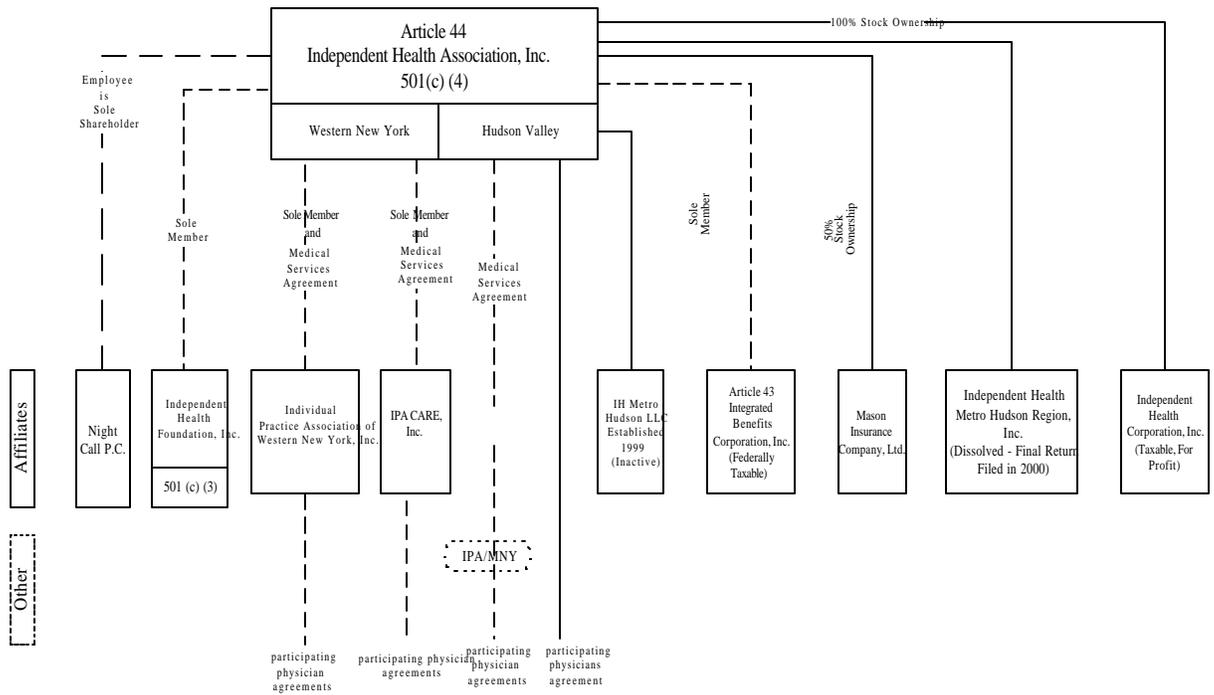
It is recommended that the HMO comply with the provisions of Part 98.8(b) of the New York Department of Health Administrative Rules and Regulations (10 NYCRR 98).

The stop loss agreements with Reliastar Life Insurance Company contain provisions for continuation of coverage for non-Medicare HMO members and Medicare members in the event of IHA's insolvency. Such protection is limited to an aggregate maximum of \$20,000,000 for all non-Medicare members. Unlimited liability is provided under this contract for Medicare members.

D. Holding Company System

The following chart depicts the HMO and its relationship to its major affiliates as of December 31, 2000:

CORPORATE STRUCTURE
December 2000



Independent Health Corporation (IHC)

This corporation, wholly owned by IHA at December 31, 2000, was incorporated in 1984. IHC has been classified by the HMO as a holding company operating subsidiary according to the HMO’s filed 2000 IR information report.

IHC provides third party administrative services including consulting services within the IHA holding company group. IHA, during the examination period, provided management services to IHC. Such management services

included administrative, development, marketing, operations, finance, support and IT services, as per an expense reimbursement allocation schedule outlined in the Second Revised Management Agreement between IHA and IHC, dated January 1, 2001. This amendment brought IHA into compliance with a prior report on examination recommendation relative to having said agreement cover all services provided by one entity to the other.

The HMO valued its investment in IHC in the amount of \$2,898,425 as of December 31, 2000. This amount represented the net equity of the subsidiary as per the audit done by the HMO's CPA firm using generally accepted accounting practices.

Mason Insurance Company, Ltd. (Mason)

On January 2, 1992, Mason Insurance Company, Ltd. was formed pursuant to the Companies Act of 1981 of Bermuda. IHA and Capital District Physicians' Health Plan (CDPHP) each contributed \$250,000 in capital and surplus relative to the formation of Mason and share equally in the ownership of said company.

At December 31, 2000, Mason's sole function was the reinsurance of hospital inpatient services relative to members of IHA and CDPHP.

The HMO valued its investment in Mason in the amount of \$2,286,131 as of December 31, 2000. This amount represented the HMO's 50% interest in the net equity of the subsidiary as per an audit by a CPA firm using generally accepted accounting practices.

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.

In 1999, the IHA board of directors approved a \$1,000,000 contribution to IHF. This contribution was to be paid to IHF over a period of three (3) years.

The HMO did not report a carrying value for this not-for-profit subsidiary as of December 31, 2000. The HMO subsequently reported a net equity value of 889,283 in its filed 2001 annual statement. Said value was confirmed per audit of IHF by the HMO's CPA firm.

Independent Health Benefits Corporation (IHBC)

Independent Health Benefits Corporation, formerly known as Integrated Benefits Corporation, was incorporated as a membership corporation under Section 402 of the Not-For-Profit Corporation Law and was organized for the purpose of engaging in any and all activities of a health service corporation permitted by law, described in Article 43 of the New York Insurance Law. IHBC was created as a joint venture by IHA and CDPHP, each a health maintenance organization licensed under Article 44 of the New York Public Health Law.

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

As of December 31, 2000, IHBC provided the out-of-network component of the point of service (POS) product written by its parent, IHA. IHBC also underwrites an indemnity product in the western New York area region of the State.

IHA did not report a value for its investment in IHBC in its annual statement filings for 2000.

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

IHA is the sole member of this membership corporation. Pursuant to a Medical Services Agreement between IHA and IPA/WNY, described in detail at item H of this report, IPA/WNY provides medical and pharmaceutical services to the HMO's subscribers in return for a monthly capitation payment.

Because of its combined accounting arrangement described at item I of this report, IHA did not report an investment value for IPA/WNY as of December 31, 2000. Due to its insolvent position as of December 31, 2000, the value of IPA/WNY as determined by a CPA audit was \$0 as of December 31, 2000. However, the combined financial statement filed by IHA for the year ended December 31, 2000 incorporated the assets and liabilities of IPA/WNY, thereby including the impact of that entity's insolvency in the amount of \$(44,137,686).

IPA Care, Inc.(IPA/CARE)

IHA is the sole member of this membership corporation. Pursuant to a Medical Services Agreement between IHA and IPA/CARE, described in detail at item H of this report. IPA/CARE provides medical services to the HMO's Medicaid members in return for a monthly capitation payment.

Because of its combined accounting arrangement described at item I of this report, IHA did not report an investment value for IPA/CARE as of December 31, 2000. Due to its insolvent position as of December 31, 2000, the value of IPA/CARE as determined by CPA audit was \$0 as of December 31, 2000. However, the combined financial statement filed by IHA for the year ended December 31, 2000 incorporated the assets and liabilities of IPA/CARE, thereby reducing the impact of that entity's insolvency in the amount of \$(2,095,130).

It is recommended that the HMO now value all non-insurance company subsidiaries according to the provisions of SSAP 46 in the NAIC Accounting Practices and Procedures Manual. The HMO should value all insurance company subsidiaries in accordance with the provisions of Section 1414(c)(2) of the New York Insurance Law, adjusted for the value of any Section 1307 loans made to such subsidiaries.

E. Abandoned Property Law

Section 1316 of the New York Abandoned Property Law provides for filings relative to unclaimed checks to be made to the Office of the Comptroller of the State of New York.

On July 6, 2000, the HMO and its affiliates entered into an agreement with the Office of the State Comptroller whereby IHA and its affiliates agreed to correct any previous under-recording of unclaimed property. Subsequently, after the HMO's CPA firm conducted a quantification audit, the HMO filed Verification and Checklists for Unclaimed

Property with the State Comptroller's Office for the period ended December 31, 2001 and prior periods starting in 1990.

F. Significant Operating Ratios

The following ratios have been computed as of December 31, 2000, based upon the results of this examination:

Premium and risk revenue to Capital & Surplus (Benchmark: 12 to 1)	16.3 to 1
Liabilities to liquid assets (Benchmark: less than 100%)	113.0%
Change in Capital & Surplus (Benchmark: -10% to 40%)	(45.5%)

All of the above ratios were subsequently reduced at December 31, 2001 to levels that fall within the New York Insurance Department benchmarks.

The underwriting ratios presented below are on an earned/incurred basis and encompass the period covered by this examination:

	<u>Amounts</u>	<u>Ratios</u>
Premiums earned	<u>\$3,020,304,047</u>	
Medical expenses	<u>\$2,775,633,182</u>	92.03%
Administrative expenses	<u>333,414,592</u>	14.38%
Underwriting gain (loss)	<u>\$ 88,743,727</u>	(6.41)%

G. Investment Activities

A review of the HMO's custodial agreement for the safeguarding of securities indicated the following protective covenants and provisions were not included. The Department regards these protective covenants and provisions as indicative of prudent business practices.

1. The bank shall maintain records sufficient to verify information insurers are required to report in the annual statement blanks of the Insurance and Health Departments of the State of New York.
2. The bank shall furnish the insurer with the appropriate affidavits in the form as may be acceptable to the bank and to the New York Insurance Department in order for the securities referred to in such affidavits to be recognized as admitted assets of the insurer.
3. Access shall be during the bank's regular hours and specifying those persons who shall be entitled to examine on the bank's premises securities held by the bank and the bank's records regarding securities held, but only upon furnishing the bank with written instructions to that effect from any specified authorized officer.

It is recommended that the HMO include the enumerated protective covenants and provisions in its custodial agreement.

H. Provider/IPA Arrangements and Risk Sharing

Withhold and Incentive Fund Arrangements

IHA and its subsidiaries, IPA/WNY and IPA/CARE, as of December 31, 2000, maintained agreements with physicians, and hospitals including hospital networks which provided for services to IHA members in exchange for a specified monthly capitation amount. In addition, the agreements provided for withhold arrangements ranging from 0% to 30% during the examination period. IHA also maintained an

incentive program for specified hospital provider networks based on a pre-determined performance measurement outlined in the hospital contract.

The following is a summary of the incentive fund withhold summary during the period under examination:

Incentive Fund Withhold Summary
For the Years 1997 - 2000

<u>Year</u>	<u>Retained</u>	<u>Payout</u>
1996	\$ 21,351,316	\$ 3,134,332
1997	16,898,686	7,817,857
1998	4,641,623	19,946,965
1999	1,300,000	12,312,048
2000	3,100,000	8,822,836

The IPA/WNY losses for years 1998, 1999 and 2000 were \$269,176, \$187,856 and \$43,227,490, respectively.

IPA Capitation Arrangements

As of December 31, 2000, the HMO maintained risk-sharing arrangements with IPAs as follows:

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

IHA is the sole member of IPA/WNY. IPA/WNY provides medical and pharmaceutical benefits to IHA's subscribers. Pursuant to a medical services agreement made between IHA and IPA/WNY, IHA records a monthly capitation allowance to IPA/WNY based upon the number of members covered by the contracts in force. IPA/WNY arranges for the provision of medical care services to IHA subscribers in accordance with each subscriber's respective benefit plan. The agreement between IHA and IPA/WNY provides for IHA to be responsible for the administration of the agreement, including claims processing and payment, establishment of fee schedules, utilization controls, MIS operations and other administrative operations.

As of December 31, 2000, IPA/WNY reported an insolvency of \$44,137,686 which is reflective of claims payments made by IHA that were in excess of allotted capitation. This insolvency increased to \$47,549,780 as of December 31, 2001.

2. IPA/CARE

IHA is the sole member of IPA/CARE. IPA/CARE provides health care services to IHA's Medicaid enrollees. Pursuant to a medical services agreement made between IHA and IPA/CARE, IHA records IPA/CARE a monthly capitation allowance to IPA/WNY based upon the number of members covered by the contracts in force. IPA/CARE arranges for the provision of medical care services to IHA subscribers in accordance with each subscriber's respective benefit plan. The agreement between IHA and IPA/CARE provides for IHA to be responsible for the administration of the agreement, including claims processing and payment, establishment of fee schedules, utilization controls, MIS operations and other administrative operations.

As of December 31, 2000, IPA/CARE reported an insolvency of \$2,095,131 which is reflective of claims payments made by IHA that were in excess of allotted capitation. As of December 31, 2001, IPA/CARE reported an insolvency of \$2,090,225.

3. IPA Metro NY, Inc. (IPA/MNY)

As of December 31, 2000, IHA maintained a capitation agreement with IPA Metro NY, Inc., a non-profit network of the Medical Society of the State of New York physicians. The medical services agreement made between IHA and IPA/MNY provides for an agreed upon rate of capitation as well as administrative services to be provided to the IPA by IHA.

It was noted that, effective March 1, 2001, IHA ceased operations in the Metro New York region.

As of December 31, 2000, IPA Metro NY, Inc. reported an insolvency in the amount of \$1,116,252. As of December 31, 2001, this insolvency was reported as \$1,032,278.

Chiro NY IPA, Inc.

This agreement between IHA and Chiro NY IPA, Inc. provided for chiropractic benefit services to be provided to IHA members located in the Metro NY region of New York State in exchange for an agreed upon monthly capitation.

As of December 31, 2000, IHA had not received New York Health Department approval relative to its agreements with the above IPAs.

It is recommended that IHA maintain documentation of the status of approval of its current IPA contracts by the New York Department of Health.

The Medical Services Agreements with IPA/WNY, IPA/CARE and IPA/MNY are silent as to the HMO's obligations relative to settlement of any IPA fund balance deficit adjustments or balances. In practice these represent advances to the IPA which may be absorbed by IHA by means of retroactive or prospective capitation adjustment or other method. Also, the Medical Service Agreements are silent as to the establishment of any appropriate liabilities on the IHA balance sheet relative to unsettled amounts relative to the funding of IPA deficits. As of December 31, 2000, IHA acknowledged its responsibility for the liabilities of these affiliated IPAs by combining the assets and liabilities of the IPA's in its financial statement

I. Accounts and Records

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

Annual and Quarterly Statement Reporting

Starting in 1998, the HMO filed its annual and quarterly statement on a combined basis with its two subsidiary IPAs, IPA/WNY and IPA/CARE. This filing practice is not permitted under New York Insurance Department financial filing instruction. In addition, the HMO was instructed to establish a reserve for amounts payable relative to the funding of any IPA deficits that are obligations of the HMO.

Subsequent to the examination date, the Department directed IHA to report its balance sheet and statement of revenue and expenses on a stand-alone basis, and the Plan filed its December 31, 2001 annual statement reporting the

financial condition and results of the HMO only. This reporting change had no impact on the HMO's net worth at December 31, 2001. This is because the HMO continued to acknowledge its responsibility for the IPA deficits by establishing liabilities, in the amounts of \$47,549,780 and \$2,090,225, which equaled the net worth deficits of IPA/WNY and IPA/CARE, respectively, to offset the impact of the change from a combined to a stand-alone balance sheet.

The balance sheet and statement of revenues of expenses included at item 3 of this report are shown on a combined basis.

It is recommended that the HMO file all future annual and quarterly statements to this Department which present the financial condition and results of the HMO only.

Allocation of Expenses

It was noted that the HMO did not maintain comprehensive studies relative to the allocation of expenses among its expense categories during the examination period, particularly with regard to its claims adjustment expense liability. Although no examination change was made in the liability for unpaid claims adjustment expenses, which was included under the title, "Administrative expense reserve" in the HMO's year 2000 annual statement (reclassified as prior year "Unpaid claims adjustment expenses" in the HMO's filed 2001 annual statement), the HMO did not maintain supporting studies in support of the establishment of this liability. In addition, the HMO included amounts relative to officer and employee incentive payments relative to the closedown of the Hudson Valley operations in February, 2001. Such incentive payment amounts should not be included within this reserve.

It is recommended that the HMO make appropriate studies relative to the allocation of expenses, particularly with regard to the establishment of its unpaid claims adjustment expenses, in future statements to this Department.

In addition, in year 2000, the HMO failed to allocate its expenses, including unpaid expenses, within the appropriate categories within its Part 3 – Analysis of Expenses of its Underwriting and Investment Exhibit. The HMO failed to allocate any investment expenses within this exhibit in its 2001 annual statement.

It is recommended that the HMO correctly complete Part 3 – Analysis of Expenses of its Underwriting and Investment Exhibit in future filings with this Department.

J. Records Retention Plan

At the time of examination, the HMO did not maintain a complete corporate-wide record retention plan in full compliance with New York Insurance Department Regulation 152. Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243) which includes HMOs within the definition of insurers states the following:

“ An insurer shall establish and maintain a records retention plan. The plan shall include a description of the types of records being maintained, the method of retention, and the safeguards established to prevent alteration of the records...”

The HMO expected to complete its record retention plans by June 2002.

It is recommended that the HMO establish and implement a complete records retention plan in full compliance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243).

K. Disaster Recovery/Business Continuation Plans

The HMO, at December 31, 2000, did not maintain a complete disaster recovery plan or a business continuation plan. HMO management has indicated such disaster recovery and business recovery plans are in the process of being developed, however, such plans were not completed as of the time of this examination.

Disaster recovery and business recovery plans are essential for the maintenance of the continuation of operations of the HMO in the event of an emergency situation.

It is recommended that the HMO maintain complete disaster recovery and business continuation plans.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination, and as reported by the Plan as of December 31, 2000:

<u>Current Assets</u>	<u>Ledger Assets</u>	<u>Not Admitted Assets</u>	<u>Admitted Assets</u>
Cash and short term investments	\$2,820,622		\$2,820,622
Premiums receivable	22,581,641		22,581,641
Investment income receivables	1,121,647		1,121,647
Amounts due from affiliates	744,751		744,751
Reinsurance recoverable on paid losses	1,291,162		1,291,162
Prepaid assets	2,317,931		2,317,931
COB receivable	2,239,409		2,239,409
Premium guarantee receivable	1,648,572		1,648,572
Accounts receivable – Miscellaneous	24,044,670		24,044,670
Deferred tax asset	<u>500,000</u>	_____	<u>500,000</u>
Total Current Assets	<u>\$59,310,405</u>	<u>\$ 0</u>	<u>\$59,310,405</u>
 <u>Other Assets</u>			
Bonds	\$71,654,109		\$71,654,109
Common stocks	9,839,157		9,839,157
Amounts due from affiliates	<u>27,750</u>	_____	<u>27,750</u>
Total Other Assets	<u>\$81,521,016</u>	<u>\$ 0</u>	<u>\$81,521,016</u>
 <u>Property and Equipment</u>			
Land, buildings and improvements	\$8,827,317		\$8,827,317
Furniture and equipment	1,134,941		1,134,941
Leasehold improvements	812,486		812,486
EDP Equipment	<u>10,116,012</u>	_____	<u>10,116,012</u>
Total Property and Equipment	<u>\$20,890,756</u>	<u>\$ 0</u>	<u>\$20,890,756</u>
Total Assets	<u>\$161,722,177</u>	<u>\$ 0</u>	<u>\$161,722,177</u>

Liabilities and Net WorthCurrent Liabilities

Accounts payable	\$ 1,230,343
Claims payable	52,465,226
Unearned premiums	9,853,214
Amounts due to affiliates	13,017,363
Aggregate write-ins for current liabilities	<u>41,498,630</u>
Total Current Liabilities	<u>\$118,064,776</u>

Other Liabilities

Aggregate write-ins for other liabilities	<u>\$ 3,981,154</u>
Total Other Liabilities	<u>\$ 3,981,154</u>

Net Worth

Contingency reserves	\$32,326,487
Retained earnings/Fund balance	9,071,467
Aggregate write-ins for other net worth items	<u>(1,721,707)</u>
Total Net Worth	<u>\$ 39,676,247</u>
Total Liabilities and Net Worth	<u>\$161,722,177</u>

Note 1: The Internal Revenue has completed its audits of the HMO's federal income tax returns through tax year 1999. Audits covering subsequent tax years have yet to commence. 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 2: The Balance Sheet shown above includes no provision for distributions from the Demographic and Specified Medical Condition Pools. For Pool Year 1999, the Pool administrator's calculation indicates the HMO would receive \$0 from the Pools based on the demographic calculation. Based on this calculation, and review by the Examiner, it appears that the HMO may receive Pool distributions in excess of the amount recorded above for pool years 1999 and 2000. However, the amount of such distributions cannot be fully determined at this time.

Note 3: The combined balance sheet shown above included the assets, liabilities and net worth of IPA/WNY and IPA/CARE, two subsidiaries of the HMO. The HMO, pursuant to a directive from this Department, filed its 2001 annual statement on an unconsolidated basis. As noted at item I of this report, the HMO included liabilities reflecting the net worth deficits of IPA/WNY and IPA/CARE in its 2001 balance sheet. Thus, this accounting change had no impact on the HMO's net worth.

B. Statement of Revenue and Expenses

Total net worth decreased \$30,140,880 during the five (5) year examination period, January 1, 1996 through December 31, 2000, detailed as follows:

Revenue

Net premiums	\$3,020,304,047	
Net investment income	27,395,151	
Other revenue	<u>26,605,376</u>	
Total revenue		<u>\$3,074,304,574</u>

Expenses**Medical and hospital:**

Physicians services	\$1,098,702,075	
Other professional services	19,397,526	
Emergency room and out-of-area	55,815,355	
Inpatient	818,516,428	
Incentive pool and withhold adjustments	17,051,071)	
Other medical and hospital expenses	613,365,739	
Drug expense	449,221,413	
Rider expense	<u>40,337,234</u>	
Subtotal	<u>\$3,069,304,699</u>	

Less:

Net reinsurance recoveries incurred	\$ 6,121,924	
Copayments	176,165,454	
C.O.B. and subrogation	<u>111,384,139</u>	
Subtotal	<u>\$ 293,671,517</u>	

Total medical and hospital expenses	\$2,775,633,182	
Total administration expenses	<u>333,414,592</u>	

Total expenses \$3,109,047,774

Net income (loss) \$ (34,743,200)

Extraordinary gain	7,001,450	
Provision for Federal income taxes	<u>853,866</u>	
Net income (loss)	<u>\$ (28,595,616)</u>	

C. Changes in Net Worth

Net worth per examination as of December 31, 1995			\$69,817,127
	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income		\$28,595,616	
Aggregate increases in retained earnings	\$1,036,037		
Changes in other net worth items	_____	<u>2,581,301</u>	
Total gains and losses	<u>\$1,036,000</u>	<u>\$ 31,176,917</u>	
Net increase (decrease) in net worth			<u>\$ (30,140,880)</u>
Net worth per examination as of December 31, 2000		<u>\$ _____</u>	<u>39,676,247</u>

4. CLAIMS PAYABLE

The examination liability of \$52,465,226 is the same as the amount reported by the HMO as filed in its December 31, 2000 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.

5. SUBSEQUENT EVENTS

Effective January 1, 2001, the HMO became subject to new statutory accounting rules established by the National Association of Insurance Commissioners (NAIC), as modified by New York Insurance Department Regulation 172 (11 NYCRR 83). These accounting rules may result in changes in the way certain assets and liabilities are to be reported.

In its March 31, 2001 Quarterly Financial Statement submitted to the Department, the HMO reported its accounting changes relative to the aforementioned new statutory accounting rules. The HMO reported a one-time charge to capital and surplus of \$12,351,024 as a result of certain assets, which are non-admitted in accordance with statutory accounting rules. However, the HMO's supporting work papers indicated that the actual one time charge to capital and surplus should have been reported as \$12,811,564 detailed as follows:

Prepaid Expenses	\$ 2,062,754
EDP equipment and software	5,669,778
Furniture and equipment	1,134,940
Accident and health premiums due and accrued	2,503,146
Cumulative pension asset	<u>1,440,946</u>
 Total increase in non-admitted assets	 <u><u>\$12,811,564</u></u>

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was directed at the practices of the HMO in the following major areas:

- A. Claims processing
- B. Schedule H preparation
- C. Schedule M preparation
- D. Policy forms and rating
- E. Agents and brokers
- F. Disclosure (Direct pay, Small group & Healthy NY Access)
- G. Frauds prevention

Claims Processing

Section 3224-a of the New York Insurance Law – Prompt Payment Law

New York Insurance Law Section 3224-a, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” subsections (a) through (c) respectively require all insurers to pay undisputed claims within forty-five days of receipt; request additional information within thirty days; and calculate / pay interest (in excess of two dollars) if undisputed claims are not paid within forty-five days of receipt.

In this regard, a statistical sample of claims paid during calendar year 2000 was selected from a population of 90,875 claims that were paid more than forty-five days from receipt date during calendar year 2000. 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.

There is a projected range of 2,233 to 6,045 violations within the population reviewed relative to “Section 3224-a(a) of the NYIL”, where claim payments were made in excess of forty-five (45) days from receipt and for which the reason for said delay was not a valid reason for delay as outlined in Section 3224-a(a) or (b) of the New York Insurance Law.

No violations were noted related to Section 3224a(b) of the NYIL related to notice for “good faith” disputes - or “Section 3224-a(c) of the NYIL”, related to interest due on eligible claim payments made in excess of forty-five (45) days from receipt. However, results of the retroactive termination issue, described later in this report, may result in additional violations of Section 3224-a of the New York Insurance Law.

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 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.

Complaint Log

A review of the central complaint log maintained by the HMO in compliance with New York Insurance Department Circular Letter Number 11(1978) revealed that the following required columns were not included:

1. The date the complaint was referred to the person/advocate to review.
2. The results of the investigation and the action taken.
3. Remarks concerning the internal remedial action taken as a result of the investigation.

It is recommended that the HMO maintain all required columns within its central complaint log in compliance with New York Insurance Department Circular Letter Number 11(1978).

Retroactive Terminations

During the examination period, the HMO failed to terminate for non-payment certain groups during the thirty (30) day grace period included in IHA's contracts. The HMO, in certain instances terminated such groups for non-payment nine (9) to twelve (12) months in excess of the contract grace period – retroactive to the date of the last month payment was made.

During this period, upon receiving notice of complaints concerning this procedure from this Department, the NYS Attorney General's office or through its own appeal process, IHA reprocessed any claims, which may have been denied during this period. IHA did make an effort to contact any subscriber or provider who did make such complaints or appeals for reprocessing.

It is noted that the HMO, in April, 2001, IHA changed its procedures relative to terminations for non-payment. At that point, IHA instituted a sixty (60) day policy, whereby cancellations would be made no later than sixty (60) days with terminations made retroactive to the last day of payment. This policy still provided for retroactive terminations beyond the thirty (30) day grace period provided in IHA's contracts.

It is IHA's policy to pay claims during the period between the date of payment, the effective date of termination and the date that the final termination letter is sent out. However, IHA then credits or "takes back" such payment from the provider by means of netting such payments against amounts owed such providers.

In such cases of retroactive termination beyond the contract grace period, it is the opinion of this Department's General Counsel that in circumstances where a subscriber or group defaults on the payment of premiums and the insurer voluntarily extends credit by extending the grace period, such insurer waives its rights to retroactively cancel the contract.

It is recommended that IHA revise its procedures regarding retroactive terminations for non-payment so as to provide for all terminations for non-payment to take place within the thirty (30) day grace period included within its contracts or amend such contracts to provide for a time period commensurate with the present practice.

It is further recommended that:

- a. IHA either review and process all previously denied claims and any current pending claims for the members of retroactively terminated groups during the period between the effective date of the cancellation and the date the final notice of termination was made to such members, or,
- b. send a notice to affected subscribers admitting the error and ask the affected subscribers to resubmit the claims, and send a notice to all affected providers informing them to resubmit such claims.

Schedule M

A review was made of the HMO's Schedule M as filed with the Plan's annual statement as of December 31, 2000. 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 HMO's filed December 31, 2000 annual statement. Although the HMO did maintain underlying support detail, which fully supported the data included within the schedule, it was noted that the HMO's Schedule M

included the grievances and appeals of its Article 43 subsidiary, Independent Health Benefits Corporation (formerly known as Integrated Benefits Corporation).

The instructions to Schedule M included in the New York Data Requirements Statement call for such data applicable to the HMO only.

It is recommended that the HMO include only data applicable to its operations within its Schedule M.

Emergency Room Service

Prior to April 1, 1999, the HMO maintained a policy which provided for all emergency room service to be denied upon initial submission. For those subscribers who resubmitted such claims through the HMO's grievance review process, the majority of such denials were subsequently reversed.

Emergency Condition is defined under the prudent layperson standard as follows under Section 4900(3) of the New York Public Health Law:

“a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.”

On April 1, 1999, the HMO changed its emergency room service coding procedures so that emergency room service claims are paid without going through the HMO's grievance review process.

It is recommended that the HMO pay all emergency room services in compliance with Section 4900(3) of the New York Public Health Law.

Grievance Procedures

A review of the HMO's grievance procedures indicated the following:

1. Five (5) of twenty four (24) grievance appeals sampled exceeded the thirty (30) day determination and notice requirements specified in Section 4408-a(d)(11)(ii) of the New York Public Health Law.
2. Two (2) of twenty-four (24) grievance appeals sampled indicated that the same person who made the final determination was the same person who made the initial determination.

Section 4408-a(d)(10) of the New York Public Health Law states the following:

“The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.”

When the above was brought to the attention of IHA, the HMO revised its procedures to preclude the same individual who made an initial determination from also making the final determination relative to a grievance appeal.

It is recommended that IHA comply with Section 4408-a(d)(11)(ii) and resolve all appeals within the required time frame.

It is further recommended that IHA refrain from having the same individual who made the initial determination on a matter resulting in a grievance appeal also make the final determination on such grievance appeal.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included twenty-four (24) recommendations detailed as follows (The page numbers refer to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<p>A. <u>Retroactive Capitation Adjustments</u></p> <p>It is recommended that the Plan obtain the appropriate approval from the Superintendent of Insurance and the Commissioner of Health relative to its 1995 retroactive capitation adjustments in compliance with Part 98.11(b) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98.11).</p> <p>The HMO complied with this recommendation.</p>	<p>9</p>
<p>B. <u>Medical Services Agreements</u></p> <p>1. It is recommended that the Plan amend its IPA/WNY and IPA/CARE medical services agreements to provide for at least 180 days notice to the Plan on the part of the respective IPA prior to termination.</p> <p>The recommendation notice requirement may be addressed by a pending Department regulation amendment.</p>	<p>10-11</p>

ITEM NO.**PAGE NO.**

2. It is recommended that the Plan amend its medical services agreements with its IPAs in order to specify the Plan's obligation(s) relative to the funding of any IPA deficits. 10-11

The HMO has acknowledged liabilities for the IPA deficits by incorporating them into its filed annual statements.

3. It is also recommended that the medical services agreements require the establishment of any appropriate liabilities on the IHA balance sheet relative to the amounts payable to the IPAs in connection with said specified obligations.

The HMO has acknowledged liabilities for the IPA deficits by incorporating them into its filed annual statements.

Reinsurance Contracts

C.

1. It is recommended that the Plan's reinsurance contracts include a provision that provides for at least a thirty-day notice to the Plan in the event of contract termination. 13

The HMO's reinsurance contracts contain acceptable language relative to this recommendation.

2. It is recommended that the Plan's reinsurance contracts include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

The HMO did not comply with this recommendation relative to two of its reinsurance contracts. A similar recommendation is included within this Report on Examination.

ITEM NO.**PAGE NO.**

- D. IHA/IHC – Administrative services 16-17

It is recommended that IHA and IHC enter into a formal agreement, which covers all administrative services provided by one entity to the other.

The HMO has complied with this recommendation.

- E. Independent Health Foundation, Inc. 18

It is recommended that the Plan make the required Regulation 115 filings to this Department relative to Independent Health Foundation, Inc.

The HMO has complied with this recommendation.

- F. Abandoned Property Law 19

It is recommended that the Plan make the appropriate abandoned property filings to the Office of the Comptroller of the State of New York in compliance with Section 1316 of the New York Abandoned Property Law.

The HMO has complied with this recommendation.

It is also recommended that the Plan formulate and implement written procedures to be used in locating such payees of outstanding checks subject to Section 1316 of the New York Abandoned Property Law and maintain copies of all correspondence relative thereto in its files.

The HMO has complied with this recommendation

ITEM NO.**PAGE NO.**G. Internal Controls

20

It is recommended that the Plan maintain a systems design standards manual which, at a minimum, includes:

1. Narrative or description of the Plan's systems
2. System flow charts
3. Description of system flow charts

The HMO has complied with this recommendation.

H. Investments

20,21

It is recommended that the Plan report its investments on an individual basis, including a full description of said investments, in Schedule A-2 and B of its annual statements in compliance with the NAIC annual statement instructions – HMO.

The HMO has complied with this recommendation.

It is recommended that the protective covenants and provisions prescribed by this Department as necessary safeguards and controls relative to a custodial agreement be included in the Plan's custodial agreement.

The HMO has complied with this recommendation relative to the protective covenants and provisions which were not included in the HMO's custodial agreement in place at the time of the previous examination.

It is recommended that the Plan report its accrued interest at line 3, Investment income receivable, in future statements to this Department.

The HMO has complied with this recommendation.

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<p>I. <u>Annual and Quarterly Statements</u></p> <p>It is recommended that, in the future, the Plan properly complete the Notes to Financial Statements section relative to its filed NAIC Association Edition annual statement.</p> <p>The HMO has complied with this recommendation.</p> <p>It is recommended that the Plan file quarterly NAIC Association Edition statements to this Department in accordance with Section 4408(2) of the Public Health Law and the NAIC Annual Statement Instructions – HMO.</p> <p>The HMO has complied with this recommendation.</p>	<p>22</p>
<p>J. <u>Real Estate</u></p> <p>It is recommended that the Plan, pursuant to Section 4310(f) of the New York Insurance Law, obtain approval from the Superintendent of Insurance relative to its real estate construction.</p> <p>The HMO has acted in compliance with this recommendation.</p>	<p>23</p>
<p>K. <u>Accounts and Records</u></p> <p> <u>Coordination of Benefits</u></p> <p>It is recommended that the Plan, pursuant to the NAIC Annual Instructions – HMO, amend its medical services agreement with IPA/WNY in order to provide for any offsets to claims expense derived from coordinated benefits to be directly applied to the claims expense of IPA/WNY. Said coordination of benefits amount should not flow through the books of IHA.</p> <p>The HMO’s current Medical Services Agreement with IPA/WNY provides for IHA’s revenue to include coordination of benefits</p>	<p>24-25</p>

revenue.

ITEM NO.

PAGE NO.

Guaranteed Rates

It is recommended that the Plan, pursuant to Section 52.42(b)(3)(ii)(a) of Part 52 of the New York Codes, Rules and Regulations (Regulation 62), use an approved remitting agent agreement with all groups with which the Plan effects guaranteed rate arrangements. It is further recommended that said remitting agent agreements be executed by all parties to said agreements.

The HMO has complied with this recommendation.

L. Long Term Investments

30

It is recommended that the Plan comply with Section 1705(c)(2) of the New York Insurance Law relative to the valuation and reporting of its investments in affiliates.

The HMO has complied with this recommendation.

It is recommended that the Plan correctly report the changes in valuation of its affiliates.

The HMO has complied with this recommendation.

M. Treatment of policyholders and claimants

32

It is recommended that the Plan maintain a central log to monitor complaint activity in the format prescribed by Circular Letter No. 11(1978).

The HMO has not fully complied with this recommendation.

It is recommended that the Plan acknowledge the receipt of

subscriber submitted claims within the fifteen day period required by Part 216.4(a) of the Codes, Rules and Regulations of the New York Insurance Department (Regulation 64).

The HMO has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

<u>ITEM NO.</u>	<u>PAGE NO.</u>	
A.	<p><u>Approval of Investments</u> It is recommended that the HMO, in the future, comply with the investment authorization or approval requirements of Section 1411(a) of the New York Insurance Law.</p>	6
B.	<p><u>Reinsurance Contracts</u> It is recommended that IHA amend its reinsurance contracts with Mason Insurance Company, Ltd. and TIG Insurance Company to include the wording prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.</p> <p>It is recommended that the HMO comply with the provisions of Part 98.8(b) of the New York Department of Health Administrative Rules and Regulations (10 NYCRR 98).</p>	10 10
C.	<p><u>Holding Company System</u> It is recommended that the HMO now value all non-insurance company subsidiaries according to the provisions of SSAP 46 in the NAIC Accounting Practices and Procedures Manual. The HMO should value all insurance company subsidiaries in accordance with the provisions of Section 1414(c)(2) of the New York Insurance Law.</p>	15
D.	<p><u>Investment Activities</u> It is recommended that the HMO include the enumerated protective</p>	17

covenants and provisions in its custodial agreement.

<u>ITEM NO.</u>		<u>PAGE NO.</u>
E.	<p><u>IPA Capitation Arrangements</u></p> <p>It is recommended that IHA maintain documentation of the status of approval of its current IPA contracts by the New York Department of Health.</p>	21
F.	<p><u>Accounts and Records</u></p> <p>It is recommended that the HMO file all future annual and quarterly statements to this Department which present the financial condition and results of the HMO only.</p> <p>It is recommended that the HMO make appropriate studies relative to the allocation of expenses, particularly with regard to the establishment of its unpaid claims reserve, in future statements to this Department.</p> <p>It is recommended that the HMO correctly complete Part 3 – Analysis of Expenses of its Underwriting and Investment Exhibit in future filings with this Department.</p>	22 23 23
G.	<p><u>Records Retention Plan</u></p> <p>It is recommended that the HMO establish and implement a complete records retention plan in full compliance with the provisions of Part 243.3(c) of New York Insurance Department Regulation 152 (11 NYCRR 243).</p>	24
H.	<p><u>Disaster Recovery and Business Recovery Plans</u></p> <p>It is recommended that the HMO maintain complete disaster recovery and business continuation plans.</p>	24
I.	<p><u>Claims Processing</u></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</p>	31

Insurance Law.

<u>ITEM NO.</u>		<u>PAGE NO.</u>
I.	It is recommended that the HMO maintain all required columns within its central complaint log in compliance with New York Insurance Department Circular Letter Number 1(1978).	32
	<u>Retroactive Terminations</u>	
	It is recommended that IHA revise its procedures regarding retroactive terminations for non-payment so as to provide for all terminations for non-payment to take place within the thirty (30) day grace period included within its contracts or amend its contracts to provide for the present practice.	33
	It is recommended that,	33
	a. IHA either review and process all previously denied claims and any current pended claims for the members of retroactively terminated groups during the period between the effective date of the cancellation and the date of the final notice of termination was made to such members, or,	
	b. IHA send a notice to affected subscribers admitting the error and ask the affected subscribers to resubmit the claims, and send a notice to all affected providers informing them to resubmit such claims.	
J.	<u>Schedule M</u>	
	It is recommended that the HMO include only data applicable to its operations within its Schedule M.	34
K.	<u>Emergency Room Services</u>	
	It is recommended that the HMO pay all emergency room services in compliance with Section 4900(3) of the New York Public Health Law.	35
L.	<u>Grievance Procedures</u>	
	It is recommended that IHA comply with Section 4408-a(d)(11)(ii) of the New York Public Health Law and resolve all grievance appeals within the required time frame.	35

It is recommended that IHA refrain from having the same individual who made the initial determination on a matter resulting in a grievance appeal also make the final determination on such grievance appeal. 36

Respectfully submitted,

Robert W. McLaughlin, CFE,CIE
Principal Insurance Examiner

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

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

Robert W. McLaughlin

Subscribed and sworn to before me

this _____ day of _____ 2002

Appointment No. 21724

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY SERIO, Acting Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

Robert McLaughlin

as a proper person to examine into the affairs of the

INDEPENDENT HEALTH ASSOCIATION

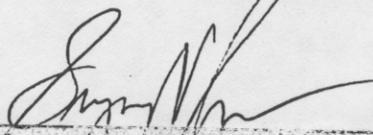
and to make a report to me in writing of the said

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 10th day of April 2001



*(by) Gregory Serio
Acting Superintendent*

