REPORT ON EXAMINATION

OF

INDEPENDENT HEALTH ASSOCIATION, INC.

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 22473 dated March 10, 2006, attached hereto, I have made an examination into the condition and affairs of Independent Health Association, Inc. as of December 31, 2005 and submit the following report thereon.

The examination was conducted at the HMO'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, 2000. This examination covered the five-year 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 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 the HMO
Management and control
Corporate records
Territory and plan of operation
Loss experience
Reinsurance
Accounts and records
Growth of the 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. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies during the examination period. The most significant findings of this examination include the following:

- Failure 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, 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.

- Payment of commissions to its brokers in excess of its commission rates filed with this Department.

- Failure to file biennial reports required by Section 4901(a) of the New York Insurance Law for utilization review agents.

The examination findings are described in greater detail in the remainder of this report.

3. DESCRIPTION OF THE HMO

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) or more than twenty five (25) members. As of the examination date, the board of directors was comprised of twenty (20) members. The board, during the examination period, met at least six (6) times during each calendar year. The directors as of December 31, 2005 were as follows:

Name and Residence	Principal Business Affiliation
John Antkowiak, M.D. Colden, NY 14033	Retired
Frank J. Colantuono Youngstown, NY	Board Member, Independent Health Association, Inc,
Frederick Cohen, Esq. Buffalo, NY	Secretary & General Counsel, Independent Health Association, Inc.,
James R. Coppola Williamsville, NY	Retired
Shawn Cotton, M.D. East Aurora, NY	Physician, East Aurora Family Practice, LLP,
Michael Cropp, M.D. Amherst, NY	President and CEO, Independent Health Association, Inc.

Name and Residence	**Principal Business Affiliation**
John J. Culkin Amherst, NY	Retired
Mark Hamister Clarence, NY	Chairman and CEO, The Hamister Group, Inc.
Michael Heimerl, M.D. Eggertsville, NY	Retired
Mark Johnson East Amherst, NY	Treasurer, Executive Vice President & CFO, Independent Health Association, Inc.
Donna M. Kelsch Sanborn, NY	Retired
Brenda W. McDuffie Buffalo, NY	President and CEO, Buffalo Urban League, Inc.
Donald Robinson, M.D. Eden, NY	Retired
Edward Stehlik, M.D. Buffalo, NY	Retired
Duane J. Sundell Williamsville, NY	Retired
Richard T. Tillotson, Jr. Buffalo, NY	Retired
John N. Walsh, III Buffalo, NY	Chairman and CEO, Walsh Duffield Cos., Inc.,
Sidney N. Weiss, CPA Williamsville, NY	Managing Partner, Brody, Weiss, Zucarelli & Urbanek, CPAs, PC

Name and Residence	Principal Business Affiliation
R. Marshall Wingate Buffalo, NY 14216	President, DynaCom Industries, Inc.
Barry N. Winnick, D.D.S. E. Amherst, NY	Dentist, Amherst Dental Group

At December 31, 2005, seventeen (17) directors (85.0% 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.

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

Name	Title
Barry N. Winnick, D.D.S.	Chairperson
Michael Cropp	President & CEO
Frederick Cohen, Esq.	Secretary & General Counsel
Mark Johnson	Treasurer, Executive Vice President & CFO
Carol Cassell	Senior Vice President, Operations & HCS
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

Erie
Niagara
Allegany
Orleans
Chautauqua
Cattaraugus
Genesee
Wyoming

As of December 31, 2005, 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	Erie
Chautauqua	Niagara
Genesee	Orleans

IHA provides the following health insurance products: commercial insurance products under Article 44 of the New York Public Health Law, Point of Service, Indemnity, and Preferred

Provider Organization (PPO) products, Medicaid Managed Care products as administered by the State of New York, and Managed Care products as administered by CMS.

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

	Commercial HMO-Only Membership	Commercial POS Membership	Government Program Membership*	Total
December 31, 2001	274,847	23,920	50,337	349,104
December 31, 2002	262,237	21,862	50,298	334,397
December 31, 2003	248,376	20,421	53,968	322,765
December 31, 2004	217,946	14,476	59,400	291,822
December 31, 2005	205,039	0	62,489	267,507

* Includes Medicare, Medicaid and Healthy New York membership.

IHA's overall membership has decreased by 23.4% since December 31, 2000. IHA's Commercial HMO-only membership decreased 25.4% during such period. It should be noted that the Commercial POS membership decreased to 0 as of December 31, 2005 because this business was switched to its subsidiary, IHBC's PPO coverage. This decrease has been partially offset by a 24.1% increase in government program membership.

IHA markets business utilizing its employees and also makes use of brokers and independent agents.

C. Reinsurance

At December 31, 2005, the HMO had the following excess of loss reinsurance program in effect for its Commercial HMO-only business, Medicare Risk, and Medicaid Managed Care:

HMO Hospital inpatient	
Excess of loss	85% of $750,000 excess of $150,000 of expenses per member, per contract year .
Medicare risk inpatient	
Excess of loss one layer:	85% of $400,000 excess of $100,000 per member, per contract year.
Medicaid Managed Care inpatient	
Excess of loss one layer:	85% of $400,000 excess of $100,000 per member, per contract year.

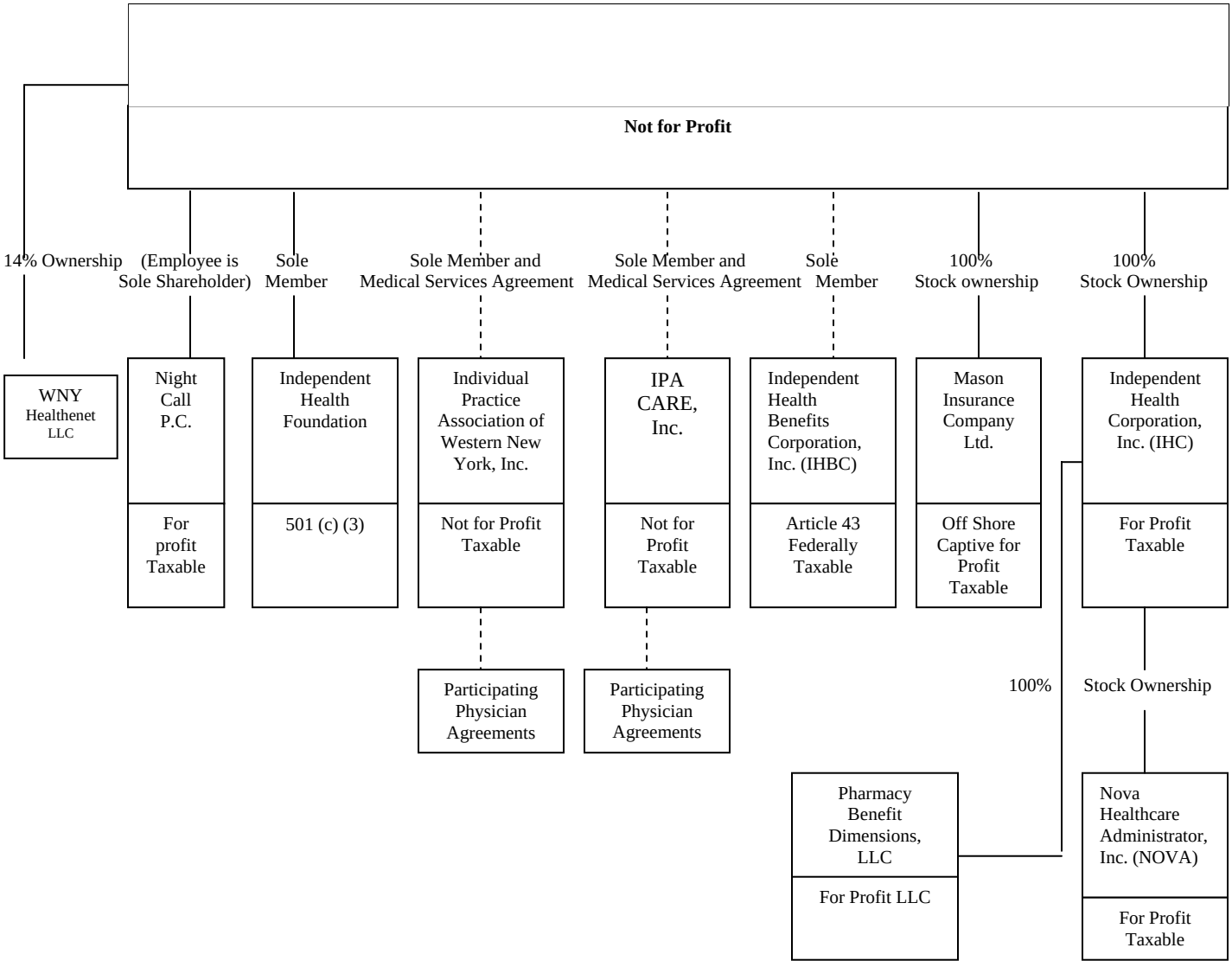
All of the above are part of one contract with Mason Insurance Company, Ltd., an unauthorized reinsurer and subsidiary of the HMO.

The maximum reinsurance reimbursement payable under the HMO's commercial hospital inpatient contract is $425,000 of covered expenses per commercial coverage member, per contract year. In addition, the maximum reinsurance reimbursement payable under both the Medicare Risk and Medicaid Managed Care contract is $255,000 of covered expenses per commercial coverage 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.

D. Holding Company System

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



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, its affiliates and others.

The HMO valued its investment in IHC in the amount of $2,566,535 as of December 31, 2005. 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.

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 captive insurance company, domiciled in Hamilton, Bermuda**,** which began operations in 1992 and reinsures claims of IPA/WNY, IPA Care, and IHBC.

The HMO valued its investment in Mason in the amount of $4,206,051 as of December 31, 2005. This amount represented the net equity of the subsidiary as per an audit made by the HMO's 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.

The HMO valued its investment in IHF in the amount of $808,928 as of December 31, 2005. This amount represented the net equity of the subsidiary as per the audit made by the HMO's CPA firm using generally accepted accounting practices.

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 Capital District Physicians's Health Plan, 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.

IHBC provides Point of Service, Indemnity and PPO medical benefits to specified members of the HMO. IHBC is a taxable entity for federal tax purposes. The HMO is the sole member of IHBC.

The HMO valued its investment in IHBC in the amount of $3,109,179 as of December 31, 2005. This amount represented the net equity of the subsidiary as per the audit made by the HMO's CPA firm using generally accepted accounting practices.

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. IHA is the sole corporate member of IPA/WNY. 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.

The HMO valued its investment in IPA/WNY in the amount of ($27,732,811) as of December 31, 2005. 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.

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 the HMO to provide and/or arrange medical services to the HMO's Medicaid eligible participants, who reside in Erie and Niagara Counties. In return, IPA Care receives a monthly capitation fee and various administrative services provided by IHA.

The HMO valued its investment in IPA Care in the amount of ($6,119,457) as of December 31, 2005. This amount represented the net equity of the subsidiary as per an audit made by the HMO's CPA firm using generally accepted accounting practices.

The HMO is subject to the holding company report filing requirements of Part 98-1.16(e) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1). It should be noted that the HMO made all the required holding company filings during the period under examination.

E. Inter-Company Agreements

Administrative Services Agreement

On October 19, 1995, the HMO executed an Administrative Services Agreement with its affiliate, IHBC. 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.

Medical Services Agreement

On September 24, 1996, the HMO executed an Administrative Services Agreement with its affiliate, IPA/WNY. According to this agreement, various services are provided to IPA/WNY by IHA including, but not limited, to the following:

a) Administrative, marketing, enrollment, financial, accounting, claims processing and payment, management information systems and other functions necessary, convenient and/or appropriate for the proper administration of the Agreement and the provision of Health Care Services to the subscribers.

b) IHA, the Office of the Medical Director and with active participation of IPA/WNY and its Participating Physicians, shall develop, implement and manage a comprehensive Quality Improvement program components of which, among others, are Quality Assurance and Utilization Management.

c) IHA shall collect all premiums and other items of income to which IHA shall be entitled.

d) IHA shall contract with such contractors as it deems appropriate in order to provide Health Care Services to the Subscribers.

e) IHA shall maintain a management information system and shall provide data and reports to IHA and IPA/WNY to enable IPA/WNY to conduct Utilization Review, Peer Review, Quality Improvement and Quality Assurance programs and to assist IPA/WNY to otherwise meet its responsibilities.

f) IHA shall develop and manage a grievance system mutually acceptable to IHA and IPA/WNY Subscribers, Participating Physicians, Participating Pharmacies and Contractors.

g) IHA shall prepare and make available to the Subscribers a list, updated from time to time, of all Participating Physicians, identifying their specialty, office address(es) and telephone numbers.

h) IHA shall prepare and make available to the Participating Physicians a list on a monthly basis of all Subscribers who have selected that Participating Physician as their primary physician.

F. Significant Operating Ratios

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

	Amount	Ratio
Claims incurred	$3,453,429,188	87.0%
Claims adjustment expenses incurred	195,818,902	4.9%
Other underwriting expenses incurred	194,644,033	4.9%
Net underwriting gain	126,139,348	3.2%
Premiums earned	$3,970,031,471	100.0%

G. Provider/IPA Arrangements and Risk Sharing

Withhold and Incentive Fund Arrangements

IHA and its subsidiaries, IPA/WNY and IPA/CARE, as of December 31, 2005, 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 10% to 15% 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 2001 – 2005

Year	Retained	Payout
2001	13,256,118	13,336,043
2002	14,125,524	13,903,155
2003	202,625	52,458
2004	139,555	57,678
2005	103,878	93,346

IPA Capitation Arrangements

As of December 31, 2005, 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, information system operations and other administrative operations.

2. IPA Care, Inc.(IPA Care)

IHA is the sole member of IPA Care, Inc. IPA Care provides health care services to IHA's Medicaid enrollees. Pursuant to a medical services agreement between IHA and IPA Care, IHA records IPA Care a monthly capitation allowance to IPA Care 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.

H. Accounts and Records

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

Allocation of Expenses

The prior report on examination included a comment noting that the HMO 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 HMO'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 HMO's representatives, the HMO 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 HMO make appropriate studies relative to the allocation of expenses in future statements to this Department.

I. Enrollment Data

It was determined that enrollment data for IHA for December 31, 2005 reported in Schedule 1 of the New York Data Requirements did not match the electronic information submitted by the HMO for inclusion on the Department's Intranet. On July 29, 2006, the HMO submitted amended statements to this Department to correct its reporting of member months rather than the number of members but never filed a revised electronic version of this correction.

The HMO should file an electronic version of its data requirements or supplement when the HMO makes a revision. The HMO should make such revised filing to the same person or section within the Systems Bureau (Albany) that it does when making its original submission - at the time that the HMO sends in a revised hard copy filing to this Department's Health Bureau (Unit).

It is recommended that the HMO file electronic corrections to its annual statement at the time that it sends in a revised hard copy filing to this Department's Health Bureau.

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 HMO.

	Ledger Assets	Non-admitted Assets	Net Admitted Assets
Assets			
Bonds	$158,107,385	0	$158,107,385
Common stocks	19,318,853		19,318,853
Real estate occupied by the HMO	9,854,714	1,612,436	8,242,278
Cash , cash equivalents and short-term investments	108,949,658	0	108,949,658
Investment income due and accrued	2,009,432		2,009,432
Uncollected premiums	17,370,764	1,794,998	15,575,766
Electronic data processing equipment and software	12,579,771	5,001,446	7,578,325
Furniture and equipment	721,024	721,024	0
Receivables from parent, subsidiaries and affiliates	17,687,065		17,687,065
Healthcare and other amounts receivable	284,548		284,548
Pre-paid expenses	10,133,038	10,133,038	0
Total assets	$357,016,251	$19,262,942	$337,753,309

Liabilities	
Claims unpaid	$ 22,172,388
Unpaid claims adjustment expenses	9,100,000
Aggregate health policy reserves	8,330,000
Premiums received in advance	2,593,089
General expenses due and accrued	18,222,906
Federal and foreign income taxes payable and interest thereon	480
Amounts due parent, subsidiaries and affiliates	418,000
Aggregate write-ins for other liabilities	38,753,676
Total liabilities	$99,590,539

Surplus	
Aggregate write-ins for other than special surplus funds	$41,748,866
Unassigned funds (surplus)	196,413,904
Total surplus	$238,162,770
Total liabilities and surplus	$337,753,309

Note 1: The Internal Revenue Service has not audited the HMO since 1999. The examiner is unaware of any potential exposure of the HMO to any tax assessment and no liability has been established herein relative to any contingency.

Note 2: The Balance Sheet shown above includes $5,600,000 recognized as other income relative to the final settlement related to the New York State Section 146 Demographic Pool.

B. Statement of Revenue and Expenses

Surplus increased $198,486,523 during the five (5) year examination period, January 1, 2001 through December 31, 2005, detailed as follows:

Income		
Net premium income	$ 3,969,253,027	
Aggregate write-ins for other health care related revenues	778,444	
Total revenues		$ 3,970,031,471
Expenses		
Hospital/medical benefits	$ 2,936,423,325	
Other professional services	12,551,754	
Emergency room and out-of-area	8,609	
Prescription drugs	439,982,392	
Aggregate write-ins for other medical and hospital	64,484,389	
Subtotal	3,453,450,469	
Net reinsurance recoveries	21,281	
Total hospital and medical	3,453,429,188	
Claims adjustment expenses	195,818,902	
General administrative expenses	194,644,033	
Total underwriting deductions		3,843,892,123
Net underwriting gain		$ 126,139,348
Net investment income earned	$ 31,437,896	
Net realized capital gains	1,876,042	
Net investment gains		33,313,938
Aggregate write-ins for other income		37,796,216
Net income before federal and foreign income taxes incurred		197,249,502
Federal and foreign income taxes incurred		846,150
Net income		$ 196,403,352

Change in Surplus

	Increases	Decreases	
Surplus per report on examination as of December 31, 2000			$ 39,676,247
Net income from operations	$196,403,352		
Cumulative effect of changes in accounting principles		$ (7,744,628)	
Change in non admitted assets		(5,283,374)	
Net unrealized capital gains and losses		(472,008)	
Changes in investment value of affiliates	15,583,181		
	$211,986,533	$(13,500,010)	
Net change in surplus			198,486,523
Surplus per report on examination as of December 31, 2005			$238,162,770

5. CLAIMS UNPAID

The examination liability of $22,172,388 is the same as the amount reported by the HMO 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 HMO 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 HMO in the following major areas:

A. Claims processing
B. Prompt payment
C. Utilization review
D. Schedule M
E. Healthy NY review
F. Commissions

A. Claims Processing

A review of the HMO'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 HMO'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.

A 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 HMO. To verify each service (item) that resulted in no payment, a reconciliation of transaction counts was performed.

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

In the sample of 167 hospital claims reviewed, one (1) procedural error and one (1) financial error were found. Of the 167 medial claims reviewed, one (1) procedural error was 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	7,560
Sample size	167
Number of claims with errors	163
Upper Error limit	99.92%
Lower Error limit	95.29%
Upper limit Claims in error	7,554
Lower limit Claims in error	7,204

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 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 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 HMO had not filed any of the utilization review biennial reports, including the initial utilization review filing required to be filed 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, subvendors, 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 when the HMO was made aware by the examiners of the filing requirements relative to its utilization review and biennial reports required to be made by utilization review agents, a filing was made to this Department on April 5, 2007.

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

D. Schedule M

A review was made of the HMO's Schedule M as filed with the HMO'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 HMO's filed December 31, 2005 annual statement. It was noted that the data included within the HMO'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 HMO complete its Schedule M annual statement filing correctly by reporting grievances in Table 1 and utilization appeals in Table 2.

E. Healthy NY Review

A review of sample Healthy NY line of business claims was reviewed. During the review, it was determined that three of the HMO's Healthy NY subscribers did not meet the Healthy NY's income level guidelines.

New York Insurance Department Regulation No. 171, Part 362-2.5(b)(11 NYCRR 362.2.5(b)), states:

> "Health maintenance organizations and participating insurers shall annually collect certifications of continued eligibility for the Healthy New York Program and shall be responsible for examination of such certifications to verify that small employers and individuals participating in the program continue to meet eligibility requirements and continue to comply with the terms of the program. Health maintenance organizations and participating insurers shall determine whether the small employer and individual participants continue to meet the requirements for participation in the Healthy New York Program....."

It is recommended that the HMO request proof of income from enrollees (individuals and sole proprietors) upon renewal in compliance with New York Insurance Department Regulation No. 171, Part 362-2.5(b) (11 NYCRR 362.2.5(b)).

It was also determined that there was one processing error where the HMO did not maintain a recertification date within its records and the enrollee was able to continue without having to renew.

It is recommended that the HMO, on a periodic basis, conduct a review of its data relative to Healthy NY to ensure the accuracy of such data.

For some enrollees, the HMO was unable to provide supporting documentation, such as proof of residence and/or income, as to the enrollees' eligibility.

New York Insurance Department Regulation No. 152 Part 243.2(a) (11 NYCRR 243.2(a)), states in part:

> ".....every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent....."

Furthermore, New York Insurance Department Part 243.2(b)(8) (11 NYCRR 243.2(b)(8)), states:

> "Any other-record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

It is recommended that the HMO maintain documents (i.e. proof of residence and income) submitted by the enrollees during the examination period in accordance with New York Insurance Department Regulation No. 152, Part 243.2(a) (11 NYCRR 243.2(a)) and Part 243.2(b)(8) (11 NYCRR 243.2(b)(8)).

F. Commissions

It was noted that the HMO paid commissions to six (6) brokers during the period, January 1, 2002 – December 31, 2002 in excess of the rate which the HMO had filed with this Department. Section 4312(a) of the New York Insurance Law states in part,

> "…Commissions shall be included in the corporation's rate manual and rate filings…"

Part 52.42(e) of Department Regulation 62 (11NYCRR 52.42(e)) states in part,

> "…No licensed insurance broker shall receive such commissions or fees from an HMO, unless the HMO has filed the actual rate to be paid and

> included the anticipated expenses for such payments to insurance brokers in its application to amend its community premiums rates pursuant to the provisions of Section 4308 of the New York Insurance Law. Such rate shall be incorporated into the HMO's premium rate manual…"

In light of the above, it is recommended that the HMO, pursuant to Section 4312(a) of the New York Insurance Law and Part 52.42(e) of New York Insurance Department Regulation 62 (11 NYCRR 52.42(e)), refrain from paying commissions to brokers in excess of its commission rates filed with this Department.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included nineteen (19) recommendations detailed as follows (The page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
A.	**Approval of Investments**	6
	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 has complied with this recommendation.	
B.	**Reinsurance Contracts**	
	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.	10
	The HMO has complied with this recommendation.	
	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).	10
	The HMO has complied with this recommendation.	

ITEM NO.		PAGE NO.
C.	**Holding Company System**	15
	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.	
	The HMO has complied with this recommendation.	
D.	**Investment Activities**	17
	It is recommended that the HMO include the enumerated protective covenants and provisions in its custodial agreement.	
	The HMO has complied with this recommendation.	
E.	**IPA Capitation Arrangements**	21
	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 HMO has complied with this recommendation.	
F.	**Accounts and Records**	
	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.	22
	The HMO has complied with this recommendation.	

ITEM NO.		PAGE NO.
F.	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. The HMO has not complied with this recommendation. A similar recommendation is included within this Report on Examination.	23
	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. The HMO has complied with this recommendation.	23
G.	**Records Retention Plan** 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). The HMO has complied with this recommendation.	24
H.	**Disaster Recovery and Business Recovery Plans** It is recommended that the HMO maintain complete disaster recovery and business continuation plans. The HMO has complied with this recommendation.	24

ITEM NO. **PAGE NO.**

I. **Claims Processing**

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. 31

The HMO has not complied with this recommendation. A similar recommendation is included within this Report on Examination.

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

The HMO has complied with this recommendation.

Retroactive Terminations

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

The HMO has complied with this recommendation.

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,

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

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

ITEM NO.		PAGE NO.
A.	**Accounts and Records** It is once again recommended that the HMO make appropriate studies relative to the allocation of expenses in future statements to this Department.	19
B.	**Enrollment Data** It is recommended that the HMO file electronic corrections to its annual statement at the time that it sends in a revised hard copy filing to this Department's Health Bureau.	20
C.	**Prompt Payment** 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.	30

Appointment No. 22473

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 Association, Inc.

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 March 2006

Howard Mills
Superintendent of Insurance