# REPORT ON EXAMINATION

# OF

# INDEPENDENT HEALTH ASSOCIATION, INC.

# AS OF

# DECEMBER 31, 2015

**DATE OF REPORT** **FEBRUARY 13, 2018**

**EXAMINER** **KENNETH I. MERRITT**

# TABLE OF CONTENTS


| ITEM NO. | | PAGE NO. |
|---|---|---|
| 1. | Scope of the examination | 3 |
| 2. | Description of the HMO | 5 |
| | A. Corporate governance | 6 |
| | B. Territory and plan of operation | 13 |
| | C. Reinsurance | 15 |
| | D. Holding company system | 17 |
| | E. Allocation of expenses | 22 |
| | F. Significant operating ratios | 25 |
| | G. Accounts and records | 26 |
| | H. Medical loss ratio ("MLR") review | 28 |
| 3. | Financial statements | 29 |
| | A. Balance sheet | 30 |
| | B. Statement of revenue and expenses and capital and surplus | 32 |
| 4. | Compliance with prior report on examination | 34 |
| 5. | Summary of comments and recommendations | 38 |

NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Marie T. Vullo
Superintendent

February 13, 2018

Honorable Marie T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law and the New York State Public Health Law and acting in accordance with the instructions contained in Appointment Number 31400, dated December 10, 2015, attached hereto, I have made an examination into the condition and affairs of Independent Health Association, Inc., a health maintenance organization authorized pursuant to the provisions of Article 44 of the New York State Public Health Law, as of December 31, 2015, and submit the following report thereon.

The examination was conducted at the home office of Independent Health Association, Inc., located at 511 Farber Lakes Drive, Buffalo, New York.

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

Whenever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

The examiner also conducted a concurrent financial condition examination of Independent Health Benefits Corporation, a not-for-profit health service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, which is wholly-owned by IHA.

A separate financial condition report of Independent Health Benefits Corporation has been submitted thereto.

In addition, a separate market conduct examination into the manner in which, IHA and IHBC conduct their business practices and fulfill their contractual obligations to policyholders and claimants was conducted as of December 31, 2015.

Accordingly, a separate market conduct report on examination of Independent Health Association, Inc. and Independent Health Benefits Corporation will be submitted thereon.

## 1. SCOPE OF THE EXAMINATION

We have performed our single state examination of Independent Health Association, Inc. The previous examination covered the period of January 1, 2006 through December 31, 2010. This combined (financial and market conduct) examination of the HMO covered the period from January 1, 2011 through December 31, 2015. The financial component of the examination was conducted on a risk-focused basis in accordance with the provisions of the *National Association of Insurance Commissioners ("NAIC") Financial Condition Examiners Handbook, 2016 Edition* ("the Handbook"), which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the HMO's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequently to December 31, 2015 were also reviewed.

The examiner planned and performed the examination to evaluate the HMO's current financial condition, as well as identify prospective risks that may threaten the future solvency of the HMO.

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

Information concerning the HMO's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the HMO's risks and management activities in accordance with the NAIC's nine branded risk categories. These categories are as follows:

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

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

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

The HMO was audited annually for the years 2011 through 2015 by the accounting firm of Deloitte & Touche LLP ("D&T"). The HMO received an unmodified opinion in each of those years. Certain audit work papers of D&T were reviewed and relied upon in conjunction with this examination. The HMO has an internal audit department which has been given the task of assessing the HMO's internal control structure. A review was also made of the HMO's Enterprise Risk Management program.

During this examination, an information systems review was made of the HMO's computer systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

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

## 2. DESCRIPTION OF THE HMO

Independent Health Association, Inc. is a not-for-profit health maintenance organization which was incorporated in the State of New York on March 11, 1977. Effective February 9, 1980, IHA received authorization to operate as a health maintenance organization (HMO) under Title XIII of the Health Maintenance Organization Act of 1973, PL-93-222, as amended, to provide hospital and other health care benefits to its subscribers. The HMO commenced business in the State of New York on February 11, 1980. The HMO is exempt from Federal income taxes pursuant to Section 501(c)(4) of the Internal Revenue Code. The HMO is also exempt from New York State income taxes.

As of December 31, 2015, the HMO reported total surplus in the amount of $337,305,671, which is a 25.5% decrease compared to the $452,658,874 surplus amount that IHA reported as of December 31, 2011. Underwriting losses were the primary reason for the decrease in the HMO's surplus. The HMO's unassigned surplus in the amount of $168,860,205 as of December 31, 2015, also decreased during the period by 47% from the $319,149,748 total unassigned surplus amount reported by HMO as of December 31, 2011. Along with the underwriting losses, increased funding to IHA's contingency reserve account also contributed to the decrease in the HMO's unassigned surplus account during the examination period.

A. Corporate Governance

(i). Management and Controls

IHA's by-laws state that management of the HMO is to be vested in a Board of Directors ("BOD") consisting of not less than twelve (12) nor more than twenty-five (25) members.

The following nineteen (19) members comprised IHA's BOD as of December 31, 2015:

| Name and Residence | Principal Business Affiliation |
|---|---|
| Stuart H. Angert<br>Amherst, New York | Retired Entrepreneur |
| John Antkowiak, MD<br>Colden, New York | Retired Physician,<br>IHA Board Chairman |
| Anthony J. Baynes<br>Williamsville, NY | Entrepreneur,<br>A.J. Baynes Freight Contractors, Ltd. |
| Shawn Cotton, MD<br>Elma, New York | Physician,<br>East Aurora Family Practice, LLP |
| Michael W. Cropp, MD<br>Williamsville, NY | President and Chief Executive Officer,<br>Independent Health Association |
| Colleen DiPirro<br>Williamsville, NY | President & CEO,<br>Amherst Chamber of Commerce |
| Donna Fernandes, PhD<br>Buffalo, NY | President & CEO,<br>Buffalo Zoological Society |
| Rene Jones<br>Amherst, NY | Executive Vice President & CFO,<br>M&T Bank |
| Michael Heimerl, MD<br>Eggertsville, New York | Physician,<br>Tonawanda Pediatrics |
| Anthony Martino<br>Buffalo, NY | Retired CPA |
| Lisa Mendonza, MD<br>Clarence Center, NY | Physician,<br>Kenmore Family Medicine |

| Name and Residence | Principal Business Affiliation |
|---|---|
| Yvonne Minor-Ragan, PhD<br>Buffalo, NY | President,<br>Buffalo Neighboard |
| Donald Robinson, MD<br>Eden, New York | Physician,<br>Solo Family Practice |
| Patricia Smith<br>Silver Springs, MD | Retired CEO |
| Moises Sudit, Ph.D.<br>Getzville, New York | Professor,<br>State University of New York at Buffalo |
| Nora B. Sullivan, JD/MBA<br>Williamsville, New York | Financial Advisor - Investment Banking,<br>Sullivan Capital Partners, Inc. |
| John N. Walsh, III<br>Buffalo, New York | Chairman and Chief Executive Officer,<br>Walsh Duffield Insurance Group |
| Daniel Weintraub, CPA<br>Williamsville, NY | Lougen, Valenti, Bookbinder & Weintraub,<br>LLP |
| Sidney N. Weiss, CPA<br>Williamsville, New York | Arcara, Zucarelli, Lenda & Straka |

During the examination period, directors elected to IHA's BOD, including the requirement of DOH Part 98 (10NYCRR Section (8-1.11(f) that the board be comprised of a minimum of twenty percentage (20%) of directors covered under IHA issued contracts, could serve continuously until his or her replacement by another successor, or until death, resignation or removal. However, during the examination period, the HMO amended paragraph 2(b) of Section 2.01 of its by-laws for a director to serve a maximum term of two consecutive five (5) year terms, after which the member becomes eligible for re-instatement following an absence of one year from the BOD.

Article III – Specification of Officers, Section 3.01 states the following:

> "a). The officers of the board shall be the chairperson and vice chairperson."

In disclosing the Board of Directors on the jurat page of the financial statement filings during the examination period, the examiner noted that IHA included the Board's Chairman and Vice Chairman under the "Officers" section of the jurat page instead of under the "Directors or Trustees" section. As indicated above, IHA's bylaws describe the Chairman and Vice President as officers of the Board of Directors and not of the corporation (i.e., IHA).

It is recommended that IHA refrain from reporting the Chairman and Vice Chairman of its Board of Directors under the "Officers" section of the jurat page of the HMO's financial statement filings. For consistency with the Board's bylaws, it is further recommended that IHA disclose the aforementioned Board officers under the "Board or Trustees" section of the jurat pages.

The BOD held the following designated sub-committees as of December 31, 2015:

i. Audit
ii. Compensation
iii. Finance
iv. Governance and Nominating
v. Risk and Compliance

A review of the minutes of the HMO's BOD meetings held during the period under examination indicated that such meetings were generally well attended, with all directors attending at least one-half of the meetings for which they were eligible to attend.

The principal officers of the HMO as of December 31, 2015 were as follows:

| Name | Title |
|---|---|
| Michael W. Cropp, MD | President & Chief Executive Officer |
| Thomas Foels, MD | Chief Medical Officer |
| Mark Johnson | EVP & Chief Financial Officer |
| John Mineo, Esquire | Secretary/General Counsel & Secretary |
| Dawn Odrzwolski | Chief Compliance Officer |
| John Rodgers | Chief Operating Officer |

Article III – Specification of Officers, Section 3.01 states the following:

> "b). The corporate officers shall be the president and chief executive officer, chief financial officer, chief medical officer, general counsel, chief compliance officer, secretary and such other officers as may be designated by resolution of the board from time to time."

During the examination period, except for the Chief Operating Officer listed above, the remaining IHA principal officers were reported on the jurat page under the "Other" section of the annual statement filings. As referenced above, these individuals are officers of the corporation (i.e., IHA) and therefore it is appropriate to report them as such on the financial statements filed with the Department.

It is recommended that IHA, relative to reporting the names of the principal officers comprising the HMO's senior executive (C- Level) officers on the jurat pages of the financial statement filings with the Department, report such officers under the captioned "Officers" section on the jurat page. For additional disclosures for other than the senior executive management, such as the Board of Directors' Chairman, Vice Chairman, etc., these individuals should be reported under "Others" on the jurat page.

(ii.). Internal Audit Department ("IAD") and Audit Committee Activities

As of December 31, 2015, IHA had an effective Internal Audit function, including established Model Audit Rule ("MAR") practices as required pursuant to Insurance Regulation No. 118 (11 NYCRR Part 89). The HMO's internal audit function includes oversight from the Audit Committee and a sufficiently documented repository of internal control policies and procedures which are maintained by the HMO's IAD. The Audit Committee consists of five members, of which three were non IHA employee directors.

In selecting an examination approach to review key functional activities and accounts of the HMO that were identified by the examiner, the examiner chose a control reliance approach. This was based upon the assessment of the overall completeness and effectiveness of the HMO's documented managerial control policies and procedures that were implemented during the examination period.

The following best practice of the Institute of Internal Auditors ("IIA) and policy requirement per the Independent Health Companies' Internal Audit Charter, apply relative to a quality assurance assessment review:

a. The Quality Assurance and Improvement Program

The Institute of Internal Auditors ("IIA") Standard 1312-External Assessments states:

> "External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organization."

The HMO's Internal Audit Charter, under the section titled "Responsibility", delegates to the Chief Audit Executive ("CAE") and the IAD the following:

> "4. Establish a quality assurance program by which the CAE assures the operation of internal audit activities."

There was no quality assurance assessment performed on IHA's Internal Audit function by an external reviewer during the five-year period covered by this examination.

It is recommended that IHA comply with the IIA's Standard 1312-External Assessments and ensure that a quality assurance assessment by an external reviewer is performed on the HMO's IAD at least once every five years.

It is recommended that the HMO's existing Internal Audit Charter be revised to require that the IAD's quality assurance program undergo an external review and assessment by a third-party reviewer at least once every five years.

b. Internal Audit Department's management/Audit Committee's Follow-ups Reviews

The Internal Audit Charter provides the following requirement, under the captioned section titled "Reporting Accountabilities":

> "The manager of the activity or department receiving the internal audit report will respond to the Internal Audit within 10 business days, unless otherwise mutually agreed upon. This response will indicate what actions have been agreed with Internal Audit and are planned with regard to specific findings and recommendations in the internal audit report. Management will be held responsible for insuring that corrective action is taken and planned within a reasonable time period after a deficiency is reported. Internal Auditors will periodically review progress and provide executive management and the Audit Committee with status reports."

IHA's IAD failed to comply with its Internal Audit Charter when it did not (i) perform periodic follow-up reviews to ensure management's remediation of identified internal audit findings and recommendations and (ii) provide executive management and the Audit Committee with status reports.

It is recommended that the HMO's IAD comply with the Internal Audit Charter and (i) perform periodic follow-up reviews with management to ensure that the IAD's findings and recommendations are properly addressed by management and (ii) provide the HMO's executive management and Audit Committee with periodic audit status update reports.

c. Change in Audit Committee Membership

Section 89.12(e) of Insurance Regulation No. 118 (11 NYCRR 89) states the following:

> "The company shall submit written notification to the superintendent of the selection of its audit committee within 30 days of the effective date of this Part and within 30 days of any change in membership of the audit committee. The notice shall include a description of the reason for the change."

During 2015 and 2016, IHA's Board of Directors implemented changes to the membership of the Audit Committee, but failed to notify the Department of Financial Services within 30 days of the changes, as required by Section 89.12(e) of Insurance Regulation No. 118.

It is recommended that IHA comply with Section 89.12(e) of Insurance Regulation No. 118 and provide written notification to the Department of Financial Services relative to any membership change of the HMO's Audit Committee within thirty days of the date of change, including a statement detailing the reason for the change.

B. Territory and Plan of Operation

The HMO's service area, as stated in its Certificate of Authority as of December 31, 2015, included the following eight (8) western counties in the State of New York:

| | | |
|---|---|---|
| Alleghany | Erie | Orleans |
| Cattaraugus | Genesee | Wyoming |
| Chautauqua | Niagara | |

As of December 31, 2015, IHA's lines of business comprised collectively 87% government business and 13% commercial comprehensive hospital and medical business (sold to Large Groups). The government business consisted of 70% Medicare and 29% New York State programs.

Following is a summary of the respective Federal and New York State government programs:

| Federal Government | Percent of Business |
|---|---|
| Medicare Advantage Including Part D Prescription Drugs | 93.00% |
| Medicare Advantage (Excluding Part D) | 7.00% |
| Total Federal Program | 100.00% |
| New York State | |
| Medicaid | 97.00% |
| Healthy New York | 2.00% |
| Child Health Plus | 1.00% |
| Total New York State | 100.00% |

**Note**: (1) Commencing in 2015, the HMO discontinued offering the New York Family Health Plus and commercial small group business.

(2) Commencing 2016, the HMO ceased offering Medicaid business in Niagara County.

Below is a summary of IHA's total annual premium income and member enrollment between the years 2011 and 2015.

| Year | Premium Income | Enrollment |
|---|---|---|
| 2011 | $1,213,093,913 | 176,409 |
| 2012 | 1,354,900,947 | 179,939 |
| 2013 | 1,356,118,935 | 181,099 |
| 2014 | 1,339,419,130 | 182,524 |
| 2015 | 1,507,696,135 | 204,047 |

As noted above, the total annual net premiums and member enrollment increased 24.3% and 15.7%, respectively, between the years 2011 and 2015. The growth in premium during the period resulted from increases of 160% and 32%, respectively, in the New York State programs (i.e., Medicaid, Child Health Plus and Family Health Plus) and Federal (i.e., Medicare Advantage, including Part D and Medicare Advantage not including Part D) government programs writings. IHA's New York State government premium writings increased during the examination by $238,544,158 from $149,598,425 as of December 31, 2011 to $388,142,583 as of December 31, 2015. The HMO's premium writings from its Federal government business (Medicare Advantage and Medicare Part D) increased by $222,487,170 from $694,910,090 as of December 31, 2011 to $917,397,260 as of December 31, 2017. The aforementioned increases in IHA's government business were offset by a 40% decrease in the HMO's experience rated large group business with reported premium writings declining by $131,288,208, from $329,432,714 in 2011 to $198,204,506 in 2015.

IHA's total enrollment increased 15.7% during the examination period due to similar increases in the above mentioned HMO's government programs. The HMO's total year-end enrollment in New York State programs increased by 60%, from 50,401 to 80,393 enrollees between 2011 and 2015. The Medicare enrollment increased from 62,331 to 90,638 enrollees, an increase of 45% during the same period.

Offsetting the aforementioned enrollment increases in the two HMO government programs was a decrease of 30,897 members in IHA's commercial lines of business, as follows:

| Line of Business | Enrollment Decrease |
|---|---|
| Large Group | 27,453 |
| Small Group | 3,135 |
| Direct pay/Conversion | 309 |
| Total decrease in membership | 30,897 |

Selling and marketing of IHA's commercial HMO health insurance business was facilitated via a network of independent agents and brokers. IHA derives its Medicare business based on the HMO's Medicare Advantage and Medicare Part D contracts with the Centers for Medicare and Medicaid Services ("CMS").

IHA provides comprehensive medical, hospital and prescription drug benefits to senior citizens age 65 and over and some disabled individuals under the age of 65. In turn, CMS pays IHA a monthly premium payment per member, per person, for each county. Higher rates are paid for less healthy members. CMS utilizes a risk-adjustment scoring methodology which includes the age, gender, health status and actual claims experience per member to retroactively adjust premiums in the subsequent year.

C. Reinsurance

As of December 31, 2015, the HMO no longer ceded business to its Bermuda captive affiliate, Mason Insurance Company. The contract was terminated as of January 1, 2014.

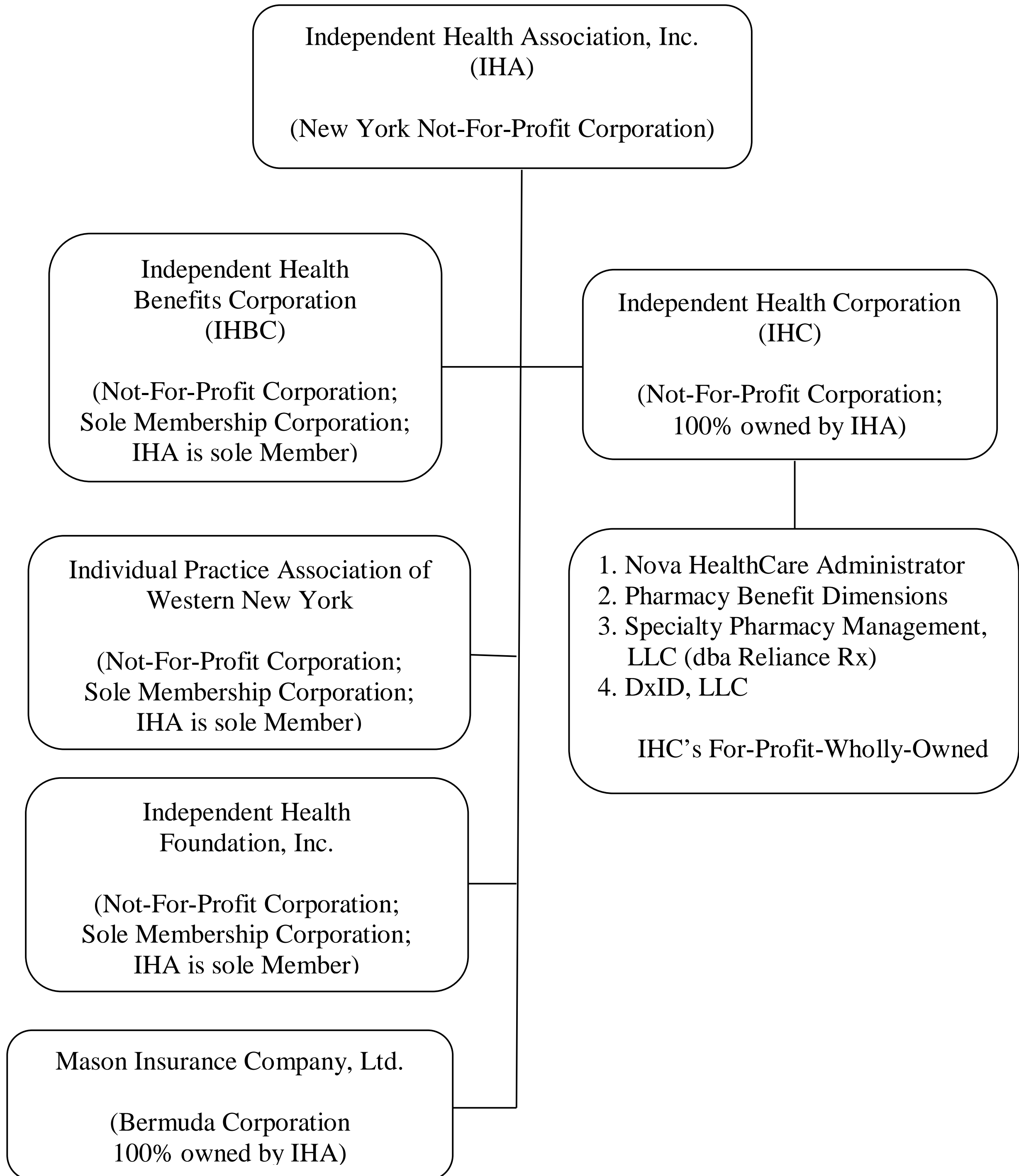
Simultaneous with the United States' implementation of the federal Affordable Care Act ("ACA") and IHA's participation in the New York State Health Insurance Exchange ("NYSHIE)

effective January 1, 2014, the HMO derived reinsurance coverage under the ACA and New York State statutory pool programs as of December 31, 2015.

As of December 31, 2015, IHA, relative to the ACA 3Rs Program, reported $0 amount for estimated reinsurance recoverable, $38,573 for risk adjustment recoverable and $0 amount neither recoverable or owed by IHA to the HHS pool.

D. Holding Company System

Below is a chart of the members within IHA's holding company system as of December 31, 2015:




**Note**: The four entities listed underneath IHC are wholly owned by IHC.

Below is a description of the organizational structure and operating activities for select members within the holding company system:

(i). Independent Health Benefits Corporation ("IHBC")

IHBC is a New York licensed not-for-profit health service corporation under Article 43 of the New York Insurance Law. The Plan is a wholly-owned subsidiary of IHA, which provides health and hospital services to members who are covered under IHBC subscriber contracts.

(ii). Independent Health Foundation (the "Foundation")

The Foundation is a not-for-profit charitable foundation in which IHA is the sole member. The Foundation is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code, operating as a Section 509(a)(3) Type 1 Supporting Organization. The Foundation is a community resource dedicated to improving the health and well-being of Western New York residents through health awareness, prevention, wellness, education and other programs focused on community priorities.

(iii). Independent Health Corporation ("IHC")

IHC is a New York for-profit company and a wholly-owned subsidiary of IHA which together with its other direct owned subsidiaries, provides the following third party and affiliated administrative services: (i) self-funded administration services, (ii) self-funded insurance funds (SFS), (iii) pharmacy benefit management service, (iv) flexible spending accounts, (v) contract printing services to IHA's affiliates, (vi) specialty pharmaceutical products, and (vii) consulting services for Medicare Advantage and Medicaid and Medicare community support under Programs of All-Inclusive Care for the Elderly ("PACE") plans. IHC also owns and maintains a provider network of participating hospitals, physicians and ancillary providers (IHC Network).

(iv). <u>Nova Healthcare Administrators, Inc. ("Nova")</u>

Nova is a direct and wholly-owned subsidiary of IHC. The entity administers health services that are covered under the self-funded benefit plans sponsored by employer groups, unions and insurers for their associated members and/or plan participants.

(v). <u>Independent Health's Pharmacy Benefit Dimensions, LLC ("PBD")</u>

PBD is a direct and wholly-owned subsidiary of IHC, which provides pharmacy benefit management services to employers and other entities, including health service companies, health insurers and health maintenance organizations.

(vi). <u>Specialty Pharmacy Management, LLC ("dba Reliance Rx")</u>

Special RX is a direct and wholly-owned subsidiary of IHC which provides high cost specialty drugs to members of IHA, IHBC and IHC's/Nova's self-insured groups.

(vii). <u>DxID LLP ("DxID")</u>

DxID is a direct and wholly-owned subsidiary of IHC and a single member disregarded Limited Liability Company. The Company is organized under Section 204 of the New York State Limited Liability Company Law. The Company primarily provides consulting services for Medicare reimbursement to Medicare Advantage and PACE plans throughout the United States.

(viii). <u>Independent Practice Association of Western New York ("IPA/WNY")</u>

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

(ix). <u>Mason Insurance Company, Ltd. of Bermuda ("Mason")</u>

Mason, a Bermuda based captive insurance company, is a wholly-owned subsidiary of IHA and a non-authorized New York reinsurer. It provided reinsurance under contracts with IHA during the examination period. At the end of 2013, IHA ceased reinsuring business with Mason, which is currently a shell company.

IHA held the following inter-company agreements as of December 31, 2015:

(i). Administrative Services Agreement with IHBC originally effective January 1, 2013 and subsequently amended to be effective November 17, 2015

The original agreement was approved by the Department effective March 19, 2013 and an amended agreement was approved on November 17, 2015. The agreement calls for IHA to provide IHBC with the following consultative and administrative services, including IHBC's Medicare Prescription Plan and Employer Group Waiver Plan: (a) financial, (b) legal, (c) internal operations, (d) management information services, (e) marketing consultation, (f) development, revision and refinement of: health care services, products, systems, policies, procedures and software support, to enhance the business of IHBC and (g) such other services as IHBC may from time-to-time request.

(ii). IHC Administrative Services Agreement effective January 1, 2013

The captioned agreement was approved by the Department effective March 19, 2013. It calls for IHC to provide IHA and/or the HMO's membership with consultative and administrative services in connection with the administration and issuance of debit cards to IHA membership, access to IHC's provider networks, and such other services as needed by IHA and its membership from time-to-time.

(iii). Nova Administrative Services Agreement, Inc. effective January 1, 2014

The captioned agreement was approved by the Department of Financial Services effective December 30, 2014 for a 12-month term that commenced January 1, 2014 to December 31, 2014. It thereafter renews automatically annually until December 31, 2018. The agreement calls for IHA and Nova to provide each other with the following services: IHA provides Nova with (a) administrative, (b) financial, (c) legal human resources, (d) information systems, (e) marketing consultation, (f) healthcare services and (g) such other services as requested by Nova. Simultaneously, Nova provides IHA with (a) debit card administration and co-pay reimbursement claims processing and (b) other services as required by IHA.

(iv). Independent Health's Pharmacy Benefit Dimensions, LLC ("PBD") Administrative Services Agreement effective December 30, 2013 and as last amended effective January 1, 2015

The initial agreement was approved by the Department effective June 12, 2014 and an amended agreement was approved effective November 17, 2015. The agreement calls for IHA and PBD to provide each other with the following services: IHA provides PBD with (a) administrative, (b) financial, (c) legal human resources, (d) information systems, (e) marketing consultation, (f) healthcare services and (g) such other services as requested by PBD. PBD provides IHA with (a) pharmacy benefits management services, (b) members' eligibility and enrollment files processing, (c) claim payments, (d) EOBs issuance, (e) administration and processing of rebate contracts, (f) Quality Assurance and auditing services of IHA's claim payments functions and (g) other administrative functions and services.

(v). Specialty Pharmacy Management, LLC dba Reliance ("Specialty RX") Administrative Services Agreement effective January 1, 2014

The captioned agreement was approved by the Department of Financial Services effective December 31, 2014, calls for IHA to provide Specialty RX with the following services: (a) administrative, (b) financial, (c) legal human resources, (d) information systems, (e) marketing consultation, (f) healthcare services and (g) such other services as requested by Nova.

Section 98-1.10(c) of Department of Health Part Regulation 98 (Title 10 NYCRR) states in part the following:

> "…Thirty days prior notice to the commissioner and,…the superintendent, is required before entering into the following transactions between a controlled MCO and any person in its holding company system:… an agreement for rendering services on a regular or systematic basis;…"

The HMO submitted to the Department the following agreements more than 30 days after the agreements' effective dates.

| IHA's Affiliated Agreement with: | Agreement's Effective Date | Agreement's Submission Date | DFS' Approval Date |
|---|---|---|---|
| Independent Health Benefits Corporation | 01/01/2013 | 02/27/2013 | 03/19/2013 |
| Independent Health Benefits Corporation | 01/01/2014 | 10/14/2014 | 12/30/2014 |
| Independent Health Corporation | 01/01/2014 | 10/14/2014 | 12/30/2014 |
| Nova Healthcare Administrators, Inc. | 01/01/2014 | 10/14/2014 | 12/30/2014 |
| Specialty Pharmacy Management LLP | 01/01/2014 | 10/14/2014 | 12/30/2014 |

It is recommended that IHA comply with Section 98-1.10(c) of Department of Health Regulation Part 98 (Title 10 NYCRR) and submit all intercompany agreements at least thirty days prior to the date in which such agreements take effect.

## E. Allocation of Expenses

Expenses incurred during the examination period were allocated among the IHA Companies on the basis of the (i) Internal Consulting and (ii) Internal Allocation methodologies, the details of which are described below:

(i). Internal Consulting:

Under the captioned expense allocation method, joint costs specific to IHA employee salaries and wages, health insurance, retirement benefits, etc., incurred in connection with IHA's personnel performing services across the various Independent Health umbrella products, lines of business cost centers and affiliates (e.g., segments), are allocated/charged back to those business segment members that are the recipients of IHA's personnel services. Such costs otherwise incurred by the associated personnel of affiliated members are excluded from this process and recorded as direct expenses of such of the members.

(ii). Internal Allocation Process:

The captioned method provides for those administrative expenses that are not traceable directly to a particular segment(s), but rather require an allocated portion of the overall expense to two or more segments (joint expenses). If a segment does not record a particular administrative expense directly, it will receive an allocated portion of the overall expense. Such expenses include the following: personnel expenses (not otherwise allocated via the Internal Consulting Process), occupancy, amortization, facilities depreciation, IT depreciation, IT maintenance, insurance, external consulting, and certain miscellaneous expenses.

During the examination period, IHA provided employee and other administrative services to its direct controlled individual practice association, IPA/WNY. It was noted IHA failed to allocate to IPA/WNY its proportionate share of IHA's employees and administrative expenses incurred by IHA on behalf of IPA/WNY. Based upon IHA's existing Medical Services Agreement with IPA/WNY, Article II - Duties and Responsibilities of IHA, Sections F and N, the following apply:

> "F IHA should maintain an information management system and should provide data and reports 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."
>
> "N. IHA shall provide IPA/WNY with administrative staff service and other financial resources to enable IPA/WNY to fulfill its responsibilities as set forth in Sections A, B, C, D, E, F, G, H, J. M, R, S, T and U Of Article III hereof."

NAIC Statement of Statutory Accounting Principles ("SSAP") No. 70, paragraph 8, states the following:

> "8. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under

> the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity…"

Section 105.25(a)(1) of Insurance Regulation No. 30 (11 NYCRR Part 105) states in part the following:

> "Whenever personnel or facilities are used in common by two or more companies, or whenever the personnel or facilities of one company are used in the activities of two or more companies, the expenses involved shall be apportioned in accordance with Part 106 relating to Joint Expenses, and such apportioned expenses shall be allocated by each company to the same operating expenses classifications as if the expenses had been borne wholly…"

In accordance with IHA's implementation of its intercompany Medical Services Agreement with IPA/WNY, IHA provides personnel (i.e., clerical, tactical and expert) and other financial support necessary for IPA/WNY to perform its contractual obligation to administer provider healthcare services to IHA's members. Such related costs are deemed joint incurred expenses of IHA and IPA/WNY, respectively. However, such joint expenses were borne solely by IHA with no expense allocation charged back to IPA/WNY, as required pursuant to SSAP No. 70 and Department Regulation No. 30 (11 NYCRR Parts 105-109).

It is recommended that IHA comply with NAIC Statement of Statutory Accounting Principles ("SSAP") No. 70 and Insurance Regulation No. 30 relative to IHA's Administrative Medical Services Agreement with IPA/WNY, and allocate to IPA/WNY all personnel and other administration costs incurred by IHA on behalf of IPA/WNY.

Insofar as the Medical Services Agreement, which has an effective date of September 24, 1996, and never having contained an expense sharing/allocation clause, such Agreement should

be amended to incorporate and comply with the requirements set forth in SSAP No. 70, Insurance Regulation No. 30 (11NYCRR Parts 105-109).

It is recommended that IHA, relative to its existing Medical Services Agreement with IPA/WNY, update the Agreement and file with the Department of Financial Services and the Department of Health for a review of compliance with the requirements of SSAP No. 70 and Insurance Regulation No. 30 regarding the allocation of joint expenses incurred by IHA on behalf of IPA/WNY.

F. Significant Operating Ratios

During the period under examination, the HMO reported the following significant operating ratios on the basis of earned premiums to incurred claims, claims adjustment expenses and general administrative expenses reported for the five-year examination period 2011 and 2015:

| Account | Amount | Ratio |
|---|---|---|
| Claims incurred | 6,132,201,161 | 90.6% |
| Claims adjustment expenses incurred | 203,298,259 | 3.0% |
| General expenses incurred | 573,150,937 | 8.5% |
| Increase for reserve for A & H contracts | 38,610,000 | 0.5% |
| Net underwriting loss | (176,031,297) | (2.6)% |
| Premiums earned | $6,771,229,060 | 100.0% |

The HMO's net underwriting loss resulted from losses within the Medicare line of business, including Part D Prescription Drug coverage, which accounted for approximately 91.0% of the above indicated net underwriting loss.

As of December 31, 2015, the HMO reported total adjusted capital and authorized control level risk-based capital in the amounts of $337,305,671 and $51,566,566, respectively, which resulted in a Risk Based Capital ratio of 654%. Such RBC ratio is in excess of any action levels.

G. Accounts and Records

(i). Federal Income Taxes

Although exempt from federal and state income taxes pursuant to Section 501(c)(4) of the Internal Revenue Service Code, IHA is, however, subject to such taxes regarding non-health insurance related business income derived by the HMO. The HMO reported annually during the examination period, federal income taxes incurred as follows:

| Year | Amount |
|---|---|
| 2011 | $232,354 |
| 2012 | $422,248 |
| 2013 | $68,704 |
| 2014 | $267,764 |
| 2015 | $(325,753) |

In the financial statements filed for IHA during the examination period, Note No. 9, titled “Income Taxes”, should have described that income taxes were associated with unrelated (i.e. non HMO) business income, primarily from IHA related party transactions. The Note did not include any specific details on the monetary amounts of the non-HMO business income.

The NAIC 2015 Annual Statement Instructions provide for disclosure of such non-health insurance income on line 7 of the “Statement of Revenue and Expenses” of the Annual Statement Blank. It was noted that IHA did not report such nonrelated HMO business income in the “Statement of Revenue and Expenses” section of the HMO’s filed Annual Statements during the examination period.

It is recommended that IHA follow the NAIC Annual Statement Instructions and report any nonrelated HMO business income on the requisite line item account of the "Statement of Revenue and Expenses" section of the HMO's annual statement filings.

It is also recommended that IHA, relative to its income taxes/credits disclosure in Note No. 9 of the HMO's financial statement filings with the Department, fully explain in the Note the nature of the income taxes/credits reported along with an accompanying summary of the source and specific monetary details of the business income associated with such income taxes disclosure.

(ii). Replacement of IHA's actuary

The 2016 Health Annual Statement Instructions, page 2, paragraph 2, under the Actuarial Opinion heading, states the following:

> "If an actuary who was the appointed actuary is replaced, the insurer shall within five business days notify the insurance department of the state of domicile of this event. The insurer shall also furnish the domiciliary commissioner with a separate letter within 10 business days of the notification stating whether in the 24 months preceding such event there were any disagreements with the former appointed actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scopes, procedure, or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former actuary's satisfaction and those not resolved to the former actuary's satisfaction. The insurer shall also in writing request such former actuary to furnish a letter addressed to the insurer stating whether the actuary agrees with the statements contained in the insurer's letter and, if not, stating the reasons he does not agree; and the insurer shall furnish such responsive letter from the former actuary to the domiciliary commissioner together with its own."

IHA replaced its actuary in February 2015 with a newly appointed actuary without providing the Department with the requisite notification and other pertinent written communications, as required, relative to the replacing of the HMO's actuary.

It is recommended that IHA comply with the NAIC Health Annual Statement Instructions when replacing IHA actuaries, by providing the Department with (i) notification of the HMO's replacement of its actuaries and (ii) attestations from the former actuaries regarding any disagreements within the preceding twenty-four months, with the HMO's management, on actuarial related matters.

H. Medical Loss Ratio ("MLR") Review

The captioned comprised a review of the HMO's MLR Report filing as of December 31, 2015. The ACA requires insurers to spend a minimum percentage of premium dollars on medical services and to submit an annual MLR report to confirm this information. The Department reviewed the components of the MLR Report filings by utilizing the MLR Procedures Spreadsheet provided by the Center for Consumer Information and Insurance Oversight to review and test, as deemed appropriate, the following items in accordance with 45 CFR Part 158:

- Validity of the data regarding expenses and premiums that the issuer reported to the Secretary of Health and Human Services, including the appropriateness of the allocations of expenses used in such reporting;
- Whether the activities associated with the issuer's reported expenditures for quality improvement activities met the definition of such activities;

- The accuracy of rebate calculations, and the timeliness and accuracy of rebate payments as applicable.

The Department's review did not reveal any exceptions or findings that requires additional disclosure regarding the HMO's MLR reporting.

## 3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities surplus as of December 31, 2015, as reported in the HMO's 2015 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in the December 31, 2015 filed annual statement.

Independent Accountants:

The firm of D&T was retained by the HMO to audit IHA's statutory statements of financial condition as of December 31st for each of the years 2011 through 2015 within the examination period, and the related statements of operations, surplus, and cash flows for the year then ended.

D&T concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus as determined by this examination as of December 31, 2015. This statement is the same as the balance sheet reported by the HMO in its filed annual statement as of December 31, 2015:

| Assets | Amount |
|---|---|
| Bonds | $323,823,958 |
| Common stocks | 51,701,225 |
| Properties occupied by the company less -0-encumbrances | 27,881,415 |
| Cash, cash equivalences & short-term investments | 27,421,788 |
| Other invested assets | 107,263,753 |
| Interest income due and accrued | 2,409,021 |
| Uncollected premiums and agents' balances in the course of collection | 52,164,256 |
| Deferred premiums, agents' balances and installments | 2,359,084 |
| Accrued retrospective premiums | 48,861,708 |
| Amounts recoverable from reinsurer | 4,858,602 |
| Amount receivable relating to uninsured plans | 5,544,730 |
| Electronic data processing equipment and software | 1,748,157 |
| Receivable from parents, subsidiaries and affiliates | 108,622,233 |
| Health care and other amounts receivables | 82,314 |
| Total assets | $764,742,244 |

| Liabilities | Amount |
|---|---|
| Claims unpaid | $106,392,459 |
| Accrued medical incentive pool and bonus | 190,148 |
| Unpaid claims adjustment expenses | 3,700,000 |
| Aggregate health policy reserves | 38,610,000 |
| Premiums received in advance | 27,794,965 |
| General expenses due and accrued | 22,815,983 |
| Amounts withheld or retained for the accounts of others | 3,200,412 |
| Borrowed money and interest | 25,012,526 |
| Amounts due to parent, subsidiaries and affiliates | 197,442,441 |
| Aggregate write-ins for other liabilities | 2,277,639 |
| Total liabilities | $427,436,573 |
| Capital and Surplus | |
| Aggregate write-ins for other than special surplus funds | 168,445,466 |
| Unassigned funds | 168,860,205 |
| Total capital and surplus | $337,305,671 |
| Total liabilities, capital and surplus | $764,742,244 |

Note: *The examiner is unaware of any potential exposure of the HMO to any tax assessment and no liability has been established herein relative to such contingency.*

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus decreased by a total of $113,978,981 during the five-year examination period from January 1, 2011 through December 31, 2015, detailed as follows:

| | | |
|---|---|---|
| Premium income | | $6,771,229,060 |
| Expense: | | |
| Hospital/ Medical Benefits | $4,801,760,468 | |
| Other professional services | 66,106,695 | |
| Prescription Drugs | 1,120,629,984 | |
| Aggregate write-ins for other hospital and medical | 63,421,855 | |
| Emergency room and out-of-area | 87,072,614 | |
| Incentive pool, withhold adjustments and bonus | 4,990,169 | |
| Subtotal | $6,143,981,785 | |
| Less: Net reinsurance recoveries | 11,780,624 | |
| Total hospital and medical benefits | $6,132,201,161 | |
| Claims adjustment expenses, including $148,394,718 cost containment expenses | 203,298,259 | |
| General administrative expenses | 573,150,937 | |
| Increase in reserves for life and accident and health contracts | 38,610,000 | |
| Total underwriting deductions | | $6,947,260,357 |
| Net Underwriting losses | | ($176,031,297) |
| Net investment income earned | 47,188,598 | |
| Net realized capital gains | 14,157,679 | |
| Net investment gains | | $61,346,277 |
| Net gain or (loss) from agents or premium balances | | (1,160,235) |
| Aggregate write-ins for other income | | 5,947,480 |
| Net income, after capital gains tax and before all other federal income taxes | | ($109,897,775) |
| Less: Federal income taxes incurred | | 665,317 |
| Net losses | | ($110,563,092) |

Changes in Capital and Surplus

| | Gains in Surplus | Losses in Surplus | |
|---|---|---|---|
| Surplus, per report on examination, as of December 31, 2010 | | | $451,284,652 |
| Net income | | $110,563,092 | |
| Change in non-admitted assets | | $18,431,839 | |
| Cumulative effect of changes in accounting principles | | $654,516 | |
| Change in net unrealized capital gains | $7,203,663 | | |
| Aggregate write-ins for gains/losses in surplus | $8,466.803 | 0 | |
| Total gain and losses in surplus | $15,670,466 | $129,649,447 | |
| Net change in capital and surplus | | | ($113,978,981) |
| Capital and surplus, per report on examination, as of December 31, 2015 | | | $337,305,671 |

## 4. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2010, contained sixteen (16) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Board of Directors' Investments Activities | |
| 1. | It is recommended that IHA's Board of Directors comply with Section 1411(a) of the New York Insurance Law and ensure that all of IHA's investment transactions are approved by either the HMO's Board of Directors or a Board designated Committee in a timely manner. | 8 |
| | *The HMO has complied with this recommendation.* | |
| 2. | It is recommended that IHA revise its existing custodial agreement with HSBC Bank to include the safeguards and protective clauses that are outlined in "Section 1 – General Examination Guidance, Part III.F, of the NAIC *Financial Condition Examiners Handbook*. | 8 |
| | *The HMO has complied with this recommendation.* | |
| 3. | It is recommended that IHA's Board of Directors and/or its Compensation Committee exercise greater vigilance and ensure that the HMO maintains up-to-date employment agreements relative to all senior executives participating in IHA's Executive Compensation and Bonus Program. | 9 |
| | *The HMO has complied with this recommendation.* | |
| | Enterprise Risk Management | |
| 4. | It is recommended that IHA establish a viable succession plan relative to IHA's senior management. | 11 |
| | *The HMO has complied with this recommendation.* | |
| | Internal Audit and Audit Committee Activities | |
| 5. | It is recommended that IHA comply with the IIA's guidance on the standard of independence of the internal audit function by | 13 |

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | ensuring that the Internal Audit Department is aligned under the direct supervision of the Audit Committee, with limited and informal reporting to IHA's management.<br><br>*The HMO has complied with this recommendation.* | |
| 6. | It is recommended that IHA comply with the IIA's guidance regarding the standard that the Audit Committee be directly involved relative to the hiring, job evaluation and determination of the annual salary adjustment of the Director of Internal Audit or Chief Audit Executive.<br><br>*The HMO has complied with this recommendation.* | 13 |
| 7. | It is further recommended that IHA's Audit Committee be the sole decision-maker, relative to the termination of employment of the Director of Internal Audit or Chief Audit Executive.<br><br>*The HMO has complied with this recommendation.* | 13 |
| | <u>Reinsurance Agreement</u> | |
| 8. | It is recommended that IHA revise its reinsurance agreement with Mason to cover IHA's business only as opposed to covering the capitated business held by IPA WNY as IPA WNY is not a legal party to the agreement.<br><br>*The HMO has complied with this recommendation.* | 17 |
| 9. | It is also recommended that IHA appropriately record all reinsurance transactions related to the Mason reinsurance agreement on IHA's books and accounts (rather than on IPA WNY's books).<br><br>*The HMO has complied with this recommendation.* | 17 |
| 10. | It is recommended that with regard to its claims recoverable from the NYSMSP that IHA record all such recoupments to its accounts and records.<br><br>*The HMO has complied with this recommendation.* | 18 |

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Holding Company System | |
| 11. | It is recommended that IHA comply with its affiliated administrative service agreements with IHBC and IHC and ensure that the HMO's inter-company receivable accounts are settled on at least a quarterly basis with its affiliates.<br><br>*The HMO has complied with this recommendation.* | 22 |
| 12. | It is recommended that IHA comply with Paragraph 2 of Statement of Statutory Accounting Principles No. 64 by offsetting inter-company assets and liabilities only where the HMO and another affiliate owe each other directly.<br><br>*The HMO has complied with this recommendation.* | 23 |
| | Individual Practice Association Agreement ("Capitation") | |
| 13. | If IHA elects to use its existing Medical Services Agreement to "transfer risk" to IPA WNY, it is recommended that IHA submit the agreement to the Department for review with a letter specifically requesting the Department's approval of the agreement, as required by Department Regulation No. 164.<br><br>*The HMO has complied with this recommendation.* | 25 |
| 14. | It is recommended that IHA cease the disclosure of Report #13 relative to IPA WNY, in its annual New York State Data Requirements filings {pursuant to Department Regulation No. 164 (11 NYCRR Part 101.9)} since IHA does not have an existing approved financial risk transfer agreement with IPA WNY.<br><br>*The HMO has complied with this recommendation.* | 26 |
| | Allocation of Expenses | |
| 15. | It is recommended that IHA follow the guidance of Department Regulation No. 30 (11 NYCRR 105.25) with regard to the allocation and reporting of expenses in the Underwriting and Investment Exhibit of IHA's Annual Statement filings.<br><br>*The HMO has complied with this recommendation.* | 28 |

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Allocation of Expenses | |
| 16. | It is recommended that IHA, relative to the allocation of its indirect personnel expenses to its affiliates, comply with Paragraph 6 of Statement of Statutory Accounting Principles No. 70.<br><br>*The HMO has not complied with this recommendation.* | 28 |

## 5. SUMMARY OF COMMENTS AND RECOMMENDATIONS

| ITEM | | | PAGE NO. |
|---|---|---|---|
| A. | Management and Controls | | |
| | i. | It is recommended that IHA refrain from reporting the Chairman and Vice Chairman of its Board of Directors under the "Officers" section of the jurat page of the HMO's financial statement filings. For consistency with the Board's bylaws, it is further recommended that IHA disclose the aforementioned Board officers under the "Board or Trustees" section of the jurat pages. | 8 |
| | ii. | It is recommended that IHA, relative to reporting the names of the principal officers comprising the HMO's senior executive (C-Level) officers on the jurat pages of the financial statement filings with the Department, report such officers under the captioned "Officers" section on the jurat page. For additional disclosures for other than the senior executive management, such as the Board of Directors' Chairman, Vice Chairman, etc., these individuals should be reported under "Others" on the jurat page. | 9 |
| B. | Internal Audit and Audit Committee Activities | | |
| | i. | It is recommended that IHA comply with the IIA's Standard 1312-External Assessments and ensure that a quality assurance assessment by an external reviewer is performed on the HMO's IAD at least once every five years. | 11 |
| | ii. | It is recommended that the HMO's existing Internal Audit Charter be revised to require that the IAD's quality assurance program undergo an external review and assessment by a third-party reviewer at least once every five years. | 11 |
| | iii. | It is recommended that the HMO's IAD comply with the Internal Audit Charter and (i) perform periodic follow-up reviews with management to ensure that the IAD's findings and recommendations are properly addressed by management and (ii) provide the HMO's executive management and Audit Committee with periodic audit status update reports. | 11 |

| ITEM | | PAGE NO. |
|---|---|---|
| B. | Internal Audit and Audit Committee Activities cont'd | |
| iv. | It is recommended that IHA comply with Section 89.12(e) of Insurance Regulation No. 118 and provide written notification to the Department of Financial Services relative to any membership change of the HMO's Audit Committee within thirty days of the date of change, including a statement detailing the reason for the change. | 12 |
| C. | Holding Company System | |
| | It is recommended that IHA comply with Section 98-1.10(c) of Department of Health Regulation Part 98 (Title 10 NYCRR) and submit all intercompany agreements at least thirty days prior to the date in which such agreements take effect. The HMO is reminded that the Department of Financial Services does not approve such agreements retroactively. | 22 |
| D. | Allocation of Expenses | |
| i. | It is recommended that IHA comply with NAIC Statement of Statutory Accounting Principles ("SSAP") No. 70 and Insurance Regulation No. 30 relative to IHA's Administrative Medical Services Agreement with IPA/WNY, and allocate to IPA/WNY all personnel and other administration costs incurred by IHA on behalf of IPA/WNY. | 24 |
| ii. | It is recommended that IHA, relative to its existing Medical Services Agreement with IPA/WNY, update the agreement and file with the Departments of Financial Services and Health for a review of compliance with the requirements of SSAP No. 70 and Department Insurance Regulation No. 30 regarding the allocation of joint expenses incurred by IHA on behalf of IPA/WNY. | 25 |
| E. | Accounts and Records | |
| i. | It is recommended that IHA follow the NAIC Annual Statement Instructions and report any nonrelated HMO business income on the requisite line item account of the "Statement of Revenue and Expenses" section of the HMO's annual statement filings. | 26 |

| ITEM | | PAGE NO. |
|---|---|---|
| E. | Accounts and Records cont'd | |
| ii. | It is also recommended that IHA, relative to its income taxes/credits disclosure in Note No. 9 of the HMO's financial statement filings with the Department, fully explain in the Note the nature of the income taxes/credits reported along with an accompanying summary of the source and specific monetary details of the business income associated with such income taxes disclosure. | 27 |
| iii. | It is recommended that IHA comply with the NAIC Health Annual Statement Instructions when replacing IHA actuaries by providing the Department with (i) notification of the HMO's replacement of its actuaries and (ii) attestations from the former actuaries regarding any disagreements within the preceding twenty-four months with the HMO's management on actuarial related matters. | 27 |

__________/S/______________
Kenneth I. Merritt
Associate Insurance Examiner

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

**Kenneth I. Merritt**, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

__________/S/______________
Kenneth I. Merritt

Subscribed and sworn to before me
this ________ day of___________2018

*APPOINTMENT NO.* **31400**

*NEW YORK STATE*

# *DEPARTMENT OF FINANCIAL SERVICES*

*I, __SHIRIN EMAMI__, Acting Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

***Kenneth Merritt***

*as a proper person to examine the affairs of*

***Independent Health Association, Inc.***

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

***HMO***

*with such other information as he shall deem requisite.*

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

*this 10th day of December, 2015*

*SHIRIN EMAMI*
*Acting Superintendent of Financial Services*

*By:*

*Lisette Johnson*
*Bureau Chief*
*Health Bureau*