

**MARKET CONDUCT REPORT ON EXAMINATION**

**OF**

**INDEPENDENT HEALTH ASSOCIATION, INC.**

**AND**

**INDEPENDENT HEALTH BENEFITS CORPORATION**

**AS OF**

**DECEMBER 31, 2010**

**DATE OF REPORT**

**APRIL 23, 2014**

**EXAMINER**

**KENNETH I. MERRITT**

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NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

Andrew M. Cuomo  
Governor

Benjamin M. Lawsky  
Superintendent

April 23, 2014

Honorable Benjamin M. Lawsky  
Superintendent of Financial Services  
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 30755 and 30758, dated August 29, 2011, annexed hereto, I have made an examination into the affairs of Independent Health Association, Inc., a not-for-profit health maintenance organization certified pursuant to the provisions of Article 44 of the New York Public Health Law, and its wholly-owned subsidiary, Independent Health Benefits Corporation, a not-for-profit hospital service corporation licensed pursuant to the provisions of Article 43 of the New York Insurance Law, as of December 31, 2010, and respectfully submit the following report thereon.

The examination was conducted at the home office of Independent Health Association, Inc., and Independent Health Benefits Corporation, 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.

Wherever the designations “IHBC” or the “Plan” appear herein, without qualification, they should be understood to indicate Independent Health Benefits Corporation.

Wherever the designation “IHA Companies” appears herein, without qualification, it should be understood to indicate Independent Health Association, Inc. and Independent Health Benefits Corporation, collectively.

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

Wherever the designations the “Department of Health” or “DOH” appear herein, without qualification, they should be understood to indicate the New York State Department of Health.

## **1. SCOPE OF THE EXAMINATION**

The previous market conduct examinations of the IHA Companies were conducted as a component of combined (financial and market conduct) examinations of the HMO and the Plan, as of December 31, 2005. This market conduct examination of the IHA Companies covers the five-year period from January 1, 2006 through December 31, 2010. Market conduct activities occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

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

A review was also made to ascertain what actions were taken by the IHA Companies with regard to the comments and recommendations related to the market conduct items contained in the prior reports on examination.

In addition, separate financial risk-focused examinations regarding the financial condition of the IHA Companies were conducted as of December 31, 2010. Separate financial reports on examination for IHA and IHBC, respectively will be submitted thereon.

## **2. EXECUTIVE SUMMARY**

The examination revealed certain operational deficiencies that occurred during the examination period. The following are the significant findings included within this report on examination:

- The IHA Companies violated Section 4308(a) of the New York Insurance Law and Department Regulation No. 62 (11 NYRR Part 52.32) when they issued policy forms that were not approved and/or filed with the Department prior to issuance.
- IHA violated Section 4903.4 of the New York Public Health Law and IHBC violated Section 4903(d) of the New York Insurance Law by failing to treat their Level of Care Change policy as retrospective utilization reviews.

- IHA violated Section 4903.5 of the New York Public Health Law and IHBC violated Section 4303(e) of the New York Insurance Law by failing to issue within the required time frame, notices of adverse determination when adjusting the hospital payments to the lower “level of care change” rate.

For the purposes of this report, unless otherwise indicated, references to the Public Health Law apply to IHA, and references to the Insurance Law apply to IHBC.

### 3. DESCRIPTION OF THE COMPANIES

#### Independent Health Association, Inc.

Independent Health Association, Inc. is a not-for-profit corporation that was incorporated in the State of New York on March 11, 1977. On February 9, 1980, IHA received authorization to operate as a health maintenance organization (HMO) under Title XIII, Health Maintenance Organization Act of 1973, PL-93-222, as amended, to provide hospital and other health care benefits to its subscribers. IHA is certified pursuant to Article 44 of the Public Health Law. IHA commenced its HMO business in the State of New York on February 11, 1980. The HMO is exempt from Federal income tax pursuant to Section 501(c)(4) of the Internal Revenue Code. The HMO is also exempt from New York State income tax.

#### Independent Health Benefits Corporation

Independent Health Benefits Corporation is a not-for-profit health service corporation that was formed on October 26, 1994 under the name Integrated Benefits Corporation (“IBC”). IBC was licensed by the Department effective June 20, 1995,

pursuant to Article 43 of the New York Insurance Law and commenced writing business on December 6, 1995. Subsequently, IBC changed its corporate name to Independent Health Benefits Corporation effective, May 10, 2001. The Plan is a taxable entity for Federal income tax purposes. IHBC is a 100% controlled affiliate of Independent Health Association, Inc.

#### **4. POLICY FORMS**

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

“(a) No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a copy of the contract or certificate and of all applications, riders and endorsements for use in connection with the issuance or renewal thereof, to be formally approved by him as conforming to the applicable provisions of this article and not inconsistent with any other provision of law applicable thereto. The superintendent shall, within a reasonable time after the filing of any such form, notify the corporation filing the same either of his approval or of his disapproval of such form.”

Part 52.32 of Department Regulation No. 62 (11 NYCRR 52) states:

“Group insurance coverage, except coverage filed to specifically comply with article 9 of the Worker’s Compensation Law, may be provided prior to the filing or approval of forms, provided that the conditions contained in this section are met. Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the department are submitted to the department within the respective times specified.

(b) At the time the insurer agrees to provide such insurance:

(2) the insurer has reasonable expectation of approval of the appropriate forms by the department.

(c) The actual forms are submitted for approval within six months from the date the insurer agreed to provide insurance.”

An examination of the IHA Companies' policy forms practices effective during 2010 revealed that IHA and IHBC, in violation of Section 4308(a) of the New York Insurance Law and Part 52.32 of Department Regulation No. 62 (11 NYCRR), issued various policy forms to insured groups that were either not approved or not filed with the Department, prior to their issuance to the groups. During the examination period, it was noted that the IHA Companies mostly utilized the "pre-file" method pursuant to Department Regulation No. 62 in issuing their policy forms. Based on the requirements of Regulation No. 62 that (i) an insurer has a reasonable expectation of approval of the appropriate forms by the department; and (ii) the policy forms be submitted for approval within six months from the date the insurer agreed to provide insurance, IHA and IHBC failed to comply with the aforementioned conditions. Under the pre-file methodology, the IHA Companies failed to file with the Department 6 policy forms that were issued to 335 groups by IHA and IHBC during the examination period.

It is recommended that the IHA Companies comply with Section 4308(a) of the New York Insurance Law and file all policy forms with the Department for approval prior to their issuance.

It is also recommended that the IHA Companies comply with Part 52.32 of Department Regulation No. 62 (11 NYCRR 52) and ensure that all policy forms issued to groups under the "pre-filing" methodology are filed with the Department within the time frame prescribed by the Regulation (within six months).



## 5. UTILIZATION REVIEW

Article 49 of the New York Public Health Law (“Public Health Law”), which applies to IHA, and Article 49 of the New York Insurance Law (“Insurance Law”), which applies to IHBC, set forth respectively, the minimum utilization review program requirements.

The Public Health Law and the Insurance Law wording requirements, relative to the Utilization Review statutes, are the same except that the term “insured” within the Insurance Law is referred to as “enrollee” in the Public Health Law.

An examination of the IHA Companies’ utilization review files and denied claims classified as: (i) “medically unnecessary”; and (ii) “experimental or investigational” in calendar year 2010 revealed the following:

### Concurrent Utilization Review

Sections 4903.3 of the New York Public Health Law (IHA) and 4903(c) of the New York Insurance Law (IHBC) both state, the following:

“A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except... within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday...”

The IHA Companies' UR Policy, No. M961001290 - "Concurrent Review involving continued, extended, or additional health care non-urgent/urgent services" - requires that IHA and IHBC render a utilization review determination within 24 hours of receipt of the request, if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period are determined within the time frames specified for prospective urgent claims (3 business days) instead of the 24 hour time frame required by Sections 4903.3 and 4903(c). Although the examiner found no instances of the IHA Companies actually violating Sections 4903.3 of the New York Public Health Law and 4903(c) of the New York Insurance Law as stated above, the aforementioned utilization review policy, as written however, exceeds the time frame requirements prescribed by the aforementioned statutes.

It is recommended that the IHA Companies amend their existing written policy regarding their concurrent or extended care utilization reviews to correspond with the requirements of Sections 4903.3 of the New York Public Health Law (IHA) and 4903(c) of the New York Insurance Law (IHBC) and ensure that medical necessity determinations, are made within the 24 hour required statutory time frame irrespective of the period in which the member's prior benefits were approved.

#### Retrospective Utilization Reviews (Level of Care Change)

Sections 4903.4 of the New York Public Health Law (IHA) and 4903(d) of the New York Insurance Law (IHBC) both state, the following:

“A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.”

Sections 4903.5 of the New York Public Health Law (IHA) and 4903(e) of the New York Insurance Law (IHBC) both state, the following:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

(a) the reasons for the determination including the clinical rationale, if any;

(b) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article; and

(c) notice of the availability, upon request of the enrollee, or the enrollee's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any additional necessary information must be provided to, or obtained by the utilization review agent in order to render a decision on the appeal.”

The examiner ascertained that the IHA Companies established a “Level of Care Change” (“LOCC”) policy commencing in 2009, whereby the IHA Companies’ management defined LOCC as the change to a member’s medical services from an inpatient admission charge to a reduced “observation care rate”. Under its LOCC policy, members (policyholders) of the IHA Companies are admitted for hospital stays lasting between one and two days stemming from a member’s particular ambulatory care condition(s), including surgical procedures. Also, under the LOCC policy, the

observation rates are contractually negotiated between the IHA Companies and the hospitals.

In conjunction with the undertaking of a back-end audit procedure by IHA's claims department, certain paid claims by the IHA Companies, to hospitals, were adjusted, and re-adjudicated to reduce the payment from the higher inpatient rate to the lower observation rate. It was noted that the IHA Companies treat such process as a back-end claims audit procedure rather than a utilization review function which is subject to Articles 49 of the New York Public Health and New York Insurance Laws.

Therefore, IHA violated Section 4903.4 of the New York Public Health Law and IHBC violated Section 4903(d) of the New York Insurance Law by failing to treat their LOCC policy as retrospective utilization reviews. In addition, IHA violated Section 4903.5 of the New York Public Health Law and IHBC violated Section 4303(e) of the New York Insurance Law by failing to issue within the required time frame (30 days), notice of adverse determination when adjusting the hospital payments to the lower "level of care change" rate.

It is recommended that the IHA Companies, with respect to their Level of Care Change policy which is used to reduce prior hospital claim payments from in-patient stays to the lower "observation rates", enact such policy as medical necessity denials of health care services pursuant to Section 4903.4 of the New York Public Health Law (IHA) and Section 4903(d) of the New York Insurance Law (IHBC).

It is also recommended that the IHA Companies, in conjunction with their LOCC policy, comply with Sections 4903.5 of the New York Public Health Law (IHA) and 4903(e) of the New York Insurance Law (IHBC) and issue notices of adverse determination to the members and hospitals when adjusting their hospital payments to the lower “Level of Care Change” rate.

#### Non-compliant Standard Utilization Review Appeals Process

Sections 4904.3 of the New York Public Health Law (IHA) and 4904(c) of the Insurance Law (IHBC) both state the following in part:

“A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the enrollee, the enrollee's designee and, where appropriate, the enrollee's health care provider, in writing, of the appeal determination within two business days of the rendering of such determination...”

During the period covered by this examination and thereafter, the IHA Companies outsourced their clinical imaging reviews (e.g., CAT Scans, Magnetic Resonance Imaging, etc.) to National Imaging Association (“NIA”). Regarding notices of adverse determination issued by NIA on behalf of the IHA Companies, such notices did not contain the statutorily required clause that members can file an appeal upon receiving a notice of adverse determination within 45 days.

It is recommended that the IHA Companies, in regard to their clinical imaging business outsourced to National Imaging Association (NIA), comply with Section 4904.3 of the New York Public Health Law and Section 4904(c) of the New York Insurance Law by ensuring that IHA's and IHBC's notices of adverse determination being issued by NIA on their behalf indicate that members have 45 days from receipt of notice of an adverse determination to file appeals.

## **6. FRAUD PREVENTION PLAN**

Section 405(a) of the New York Insurance Law states:

“Any person licensed or registered pursuant to the provisions of this chapter, and any person engaged in the business of insurance or life settlement in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction or life settlement act may be fraudulent, or has knowledge that a fraudulent insurance transaction or fraudulent life settlement act is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require. The insurance frauds bureau shall accept reports of suspected fraudulent insurance transactions or fraudulent life settlement acts from any self insurer, including but not limited to self insurers providing health insurance coverage or those defined in section fifty of the workers' compensation law, and shall treat such reports as any other received pursuant to this section.”

IHA failed to comply with Section 405(a) of the New York Insurance Law when it did not notify the Department of suspected cases of fraud investigated by IHA during the examination period.

It is recommended that IHA comply with Section 405(a) of the New York Insurance Law and notify the Department of suspected cases of fraud that are identified /investigated by IHA.

## **7. CLAIMS REVIEW**

### Prompt Pay Law Review:

Section 3224-a(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” (Prompt Pay Law), requires all insurers to pay undisputed claims within thirty (electronic submission) and forty-five days of receipt (manual submission). If such undisputed claims are not paid within that time frame of receipt, interest may be payable pursuant to Section 3224-a(c) of the New York Insurance Law.

Claims not adjudicated within 30 days (for claims submitted via internet or electronic mail), or 45 days (for claims submitted by other means such as paper or facsimile) by the IHA Companies were reviewed to determine whether claims were processed in compliance with the time frame requirements of Section 3224-a(a) of the New York Insurance Law (NYIL), and if interest was required, whether it was paid pursuant to Section 3224-a(c) of the NYIL. Accordingly, all claims that were paid after 30 (electronic submission) and 45 days of receipt (manual submission), respectively, during the period January 1, 2010 through December 31, 2010 were segregated.

A “claim” is defined by the IHA Companies as the total number of items submitted on a single claim form to which the IHA Companies assigns a unique “claim number”.

Using ACL software the examiner conducted an analysis of the aforementioned claims. It was determined that IHA and IHBC processed their claims that were subject to the Prompt Pay Law within the time limitations prescribed in Section 3224-a of the New York Insurance Law (98% threshold).

Also, a review was made of the IHA Companies’ claims processing procedures and internal controls regarding compliance with Section 3224-a of the New York Insurance Law. No discrepancies were noted.

Claims Attribute Review:

An initial claims attribute review of 50 claims was performed relative to claims adjudicated by the IHA Companies during the period, January 1, 2010 through December 31, 2010. A statistical random sampling process was performed testing several attributes deemed to be necessary for the successful processing of claims.

The objective of the sampling process was to test and reach conclusions about all predetermined attributes, individually or in combination.

The claims attribute review did not reveal any problem areas.



## 8. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior reports on examination included eleven (11) market conduct related recommendations detailed as follows (page number refers to the prior reports on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<b><u>IHA Report</u></b>	
<b><u>Prompt Pay Law</u></b>	
1.	30
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.	
The HMO has complied with this recommendation.	
<b><u>Utilization Review</u></b>	
2.	33
It is recommended that the HMO file its biennial reports as required to be made by utilization review agents in compliance with Section 4901(a) of the New York Insurance Law.	
The HMO has complied with this recommendation.	
<b><u>Schedule M</u></b>	
3.	34
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.	
The HMO has complied with this recommendation	

**ITEM NO.****PAGE NO.****IHA Report (Continued)****Healthy NY Review**

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| 4. | 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)). | 35 |
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The HMO has complied with this recommendation.

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| 5. | It is recommended that the HMO, on a periodic basis, conduct a review of its data relative to Healthy NY enrollees to ensure the accuracy of such data. | 35 |
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The HMO has complied with this recommendation

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| 6. | 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 New York | 36 |
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The HMO has complied with this recommendation.

**Commissions**

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| 7. | 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 its brokers in excess of its commission rates filed with this Department. | 37 |
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The HMO has complied with this recommendation.

**ITEM NO.****PAGE NO.****IHBC Report****Prompt Pay Law**

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|----|--|----|
| 1. | 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. | 25 |
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The Plan has complied with this recommendation.

**Utilization Review**

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| 2. | It is recommended that the HMO file its biennial reports required by utilization review agents with this Department as required by Section 4901(a) of the New York Insurance Law. | 28 |
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The Plan has complied with this recommendation.

**Schedule M**

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| 3. | It is recommended that the HMO complete its Schedule M correctly by reporting grievances in Table 1 and utilization appeals in Table 2. | 29 |
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The Plan has complied with this recommendation.

**Commissions, Bonuses and Fees**

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| 4. | It is recommended that the Plan file its commission bonus plan prior to implementation with the Superintendent and obtain his approval as required by Section 4308(b) of the New York Insurance Law. | 30 |
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The Plan has complied with this recommendation.

9. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

<b><u>ITEM.</u></b>	<b><u>PAGE NO.</u></b>
A. <u>Policy Forms</u>	
i. It is recommended that the IHA Companies comply with Section 4308(a) of the New York Insurance Law and file all policy forms with the Department for approval prior to their issuance.	6
ii. It is also recommended that the IHA Companies comply with Department Regulation No. 62 (11 NYCRR Part 52.32) and ensure that all policy forms issued to the groups under the “pre-filing” methodology are filed with the Department within the time frame prescribed by the Regulation (within six months).	6
B. <u>Concurrent Utilization Review</u>	
It is recommended that the IHA Companies amend their existing written policy regarding their concurrent or extended care utilization reviews to correspond with the requirements of Sections 4903.3 of the New York Public Health Law (IHA) and 4903(c) of the New York Insurance Law (IHBC) and ensure that medical necessity determinations, are made within the required statutory time frame, irrespective of the period in which the member’s prior benefits were approved.	8
C. <u>Retrospective Utilization Review</u>	
i. It is recommended that the IHA Companies, with respect to their Level of Care Change policy which is used to reduce prior hospital claim payments from in-patient stays to the lower observation rates, enact such policy as medical necessity denials of health care services pursuant to Section 4903.4 of the New York Public Health Law (IHA) and Section 4903(d) of the New York Insurance Law (IHBC).	10
ii. It is also recommended that the IHA Companies, in conjunction with their LOCC policy, comply with Sections 4903.5 of the New York Public Health Law (IHA) and 4903(e) of the New York Insurance Law (IHBC) and issue notice of adverse determination to the members and hospitals when adjusting their hospital payments to the lower “Level of Care Change” rate.	11

**ITEM.****PAGE NO.****D. Non-compliance Standard Utilization Review Appeals Process**

It is recommended that the IHA Companies, in regard to their clinical imaging business outsourced to National Imaging Association (NIA), comply with Section 4904.3 of the New York Public Health Law and Section 4904(c) of the New York Insurance Law by ensuring that IHA's and IHBC's notices of adverse determination being issued by NIA on their behalf indicate that the members have 45 days from the receipt of notice of an adverse determination to file appeals.

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**E. Fraud Prevention Plan**

It is recommended that IHA comply with Section 405(a) of the New York Insurance Law and notify the Department of suspected cases of fraud that are identified and/or investigated by IHA.

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Respectfully submitted,

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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 \_\_\_\_\_ 2014

Appointment No. 30755

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Kenneth Merritt**

as a proper person to examine into the affairs of the

**Independent Health Association, Inc.**

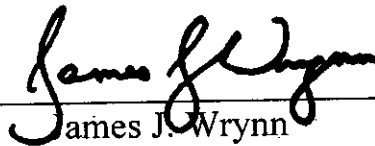
and to make a report to me in writing of the condition of the said

**HMO**

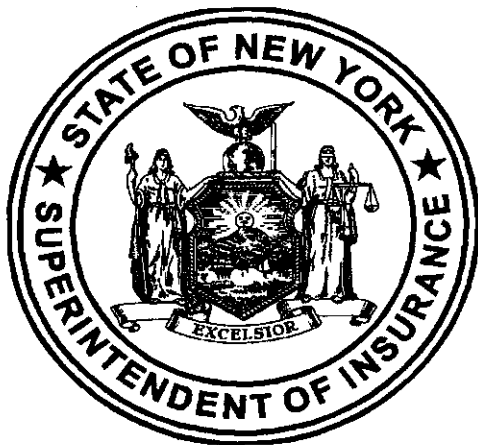
with such other information as he shall deem requisite.

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

This 29<sup>th</sup> day of August, 2011



James J. Wrynn  
Superintendent of Insurance



Appointment No. 30758

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Kenneth Merritt**

as a proper person to examine into the affairs of the

**Independent Health Benefits Corporation**

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

**Company**

with such other information as he shall deem requisite.

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

This 29<sup>th</sup> day of August, 2011



James J. Wrynn  
Superintendent of Insurance

