# REPORT ON EXAMINATION

# OF

# INDEPENDENT HEALTH ASSOCIATION, INC.

# AS OF

# DECEMBER 31, 2010

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| **DATE OF REPORT** | **APRIL 23, 2014** |
| **EXAMINER** | **KENNETH I. MERRITT** |

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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 Letter 30754, dated August 29, 2011, attached hereto, I have made an examination into the condition and affairs of Independent Health Association, Inc., a health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health 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., 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.

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 filed by the Department.

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 were conducted as of December 31, 2010. A separate report was issued thereon.

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.

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

## 1. SCOPE OF THE EXAMINATION

The HMO was previously examined as of December 31, 2005. This examination of the HMO was a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition (*the "Handbook") and it covered the five-year period from January 1, 2006 through December 31, 2010. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2010 were also reviewed.

The examination was conducted using a risk-focused approach in accordance with the provisions of 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 risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the HMO. 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 IHA.

The examiner identified the HMO's 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 NAIC annual statement instructions.

Information concerning the HMO's organizational structure, business approach and control environment were utilized to develop the examination plan and procedures. 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 HMO was audited annually for the years 2006 through 2010 by the accounting firm Deloitte & Touche ("D&T"). The HMO received an unqualified opinion in each of those years. Certain audit workpapers of D&T were reviewed and relied upon in conjunction with this examination. A review was also made of IHA's corporate governance structure, which included the HMO's enterprise risk management program, internal audit function, audit committee activities and Model Audit Rule {The Department's Regulation No. 118 (11 NYCRR 89.0)}.

The examiner reviewed the corrective actions taken by the HMO with respect to the recommendations concerning financial issues contained in the prior report on examination. The results of the examiner's review are contained in item 6 of this report.

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 corporation that was incorporated in the State of New York on March 11, 1977. Subsequently, on 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. IHA commenced its HMO 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.

### A. Corporate Governance

#### (i). Management and Control

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

The following twenty (20) members comprised IHA's Board of Directors ("Board") as of December 31, 2010:

| Name and Residence | Principal Business Affiliation |
|---|---|
| Stuart H. Angert<br>Amherst, New York | Retired |
| John Antkowiak, MD<br>Colden, New York | Retired |
| Frank J. Colantuono<br>Youngstown, New York | Retired |
| James R. Coppola<br>Williamsville, New York | Pharmacist |

| Name and Residence | Principal Business Affiliation |
|---|---|
| Shawn Cotton, MD<br>Elma, New York | Physician,<br>East Aurora Family Practice, LLP |
| Michael W. Cropp, MD<br>Williamsville, New York | President & Chief Executive Officer,<br>Independent Health Association, Inc. |
| John J. Culkin<br>Amherst, New York | Retired |
| Michael Heimerl, MD<br>Eggertsville, New York | Physician,<br>Tonawanda Pediatrics |
| Donna M. Kelsch<br>Sanborn, New York | Education – Principal,<br>Sacred Heart School |
| Brenda W. McDuffie<br>Buffalo, New York | Chief Executive Officer,<br>Buffalo Urban League, Inc. |
| Donald Robinson, MD<br>Eden, New York | Physician,<br>Solo Family Practice |
| Edward Stehlik, MD<br>Buffalo, New York | Physician,<br>Northtowns Medical Group |
| 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. |
| Duane J. Sundell<br>Williamsville, New York | Retired |
| Richard T. Tillotson, Jr.<br>Buffalo, New York | Fireman,<br>Buffalo Fire Department |
| John N. Walsh, III<br>Buffalo, New York | Chairman and CEO - Insurance Brokerage,<br>Walsh Duffield Companies, Inc. |
| Sidney N. Weiss<br>Williamsville, New York | Managing CPA Partner,<br>Brody, Weiss, Zucharelli & Urbanek, CPAs, P.C. |
| R. Marshall Wingate<br>Buffalo, New York | President,<br>DynaCom Industries, Inc. |

| Name and Residence | Principal Business Affiliation |
|---|---|
| Barry N. Winnick, DDS<br>E. Amherst, New York | Dentist,<br>Amherst Dental Group |

The principal officers of the HMO as of December 31, 2010 were as follows:

| Name | Title |
|---|---|
| Michael W. Cropp, MD | President & Chief Executive Officer |
| Lawrence DiGiulio | General Counsel & Secretary |
| Mark Johnson | Executive Vice President & Chief Financial Officer |

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

(ii). Board of Directors' Investment Approval Procedures

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

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

A review of the HMO's internal records revealed that, for the third and fourth quarters of 2010, the Board of Directors failed to approve IHA's investment transactions in a timely manner. In addition, the Board of Directors failed to approve IHA's investment transactions during the 2011 calendar year in a timely manner.

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.

During the period under examination, IHA maintained a custodial agreement with HSBC Bank for safekeeping purposes of the HMO's invested assets. The NAIC *Financial Condition Examiners Handbook*, Section 1 – General Examination Guidance, Part III.F (Outsourcing of Critical Functions), lists numerous safeguards and protective clauses that should be included as part of such custodial agreements. However, the examiner's review of IHA's existing HSBC Bank custodial agreement revealed that none of the NAIC suggested safeguards and protective clauses were included in the agreement.

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*.

(iii). Executive Compensation and Bonus Program ("ECBP")

The examiner's review of the captioned program revealed that there were discrepancies in IHA's internal records utilized to determine the annual bonus payments received by IHA's Chief Financial Officer ("CFO") and Chief Administrative Officer ("CAO"), during the examination period. Differences in the applicable bonus percentages of the CFO and CAO were noted in the two officers' employment agreements and other internal records, to IHA's ECBP.

The CFO's most current employment agreement, dated February 15, 2000, indicated an annual bonus percentage of 22.5% and the CAO's latest employment agreement dated February

19, 2007, indicated a 20% annual bonus. Based on each agreement, these percentages were to be applied to the CFO's and CAO's annual base salaries respectively to determine their annual bonus payments. However, the CFO's and CAO's bonus percentages reflected in the supporting documentation provided to the examiner by the HMO relative to IHA's ECBP were not the same as the corresponding percentages included in these executives' employment agreements. In the documentation provided, the CFO's bonus percentages ranged between 27% and 55% during the years 2006 through 2010. The CAO's bonus percentages ranged between 8.5% and 40% for the years 2007 through 2010.

In response to the above indicated discrepancies, the examiner performed additional reviews of the HMO's available supporting source documentation, including the HMO's Compensation Committee's approvals of the ECBP for the years 2006 through 2010. Such reviews revealed the following relative to the CFO's and CAO's annual bonuses for the period 2006 through 2010: (i) Rather than using the employment agreements currently in place, IHA utilized the more up-to-date information from the ECBP support documentation, which included the higher bonus percentages therein, to calculate such officers' bonuses; and (ii) the bonuses were performance-based and consistent with bonuses received by other executive officers that participated in the HMO's ECBP. However, the examiner noted that in the Committee's review and approval of the annual bonus calculations for IHA's CFO and CAO that the Committee failed to ensure that the HMO maintained up-to-date employment agreements for these executives that should have reflected the ECBP bonus calculation criteria in effect.

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.

(iv). Enterprise Risk Management ("ERM")

During the examination period, IHA adopted a formal and comprehensive ERM program, for proactively addressing and mitigating risks, including prospective business risks identified by the HMO. IHA's ERM utilizes the global framework that is based on the guidelines of the International Organization for Standardization ("ISO31000"). The ISO31000 framework does not mandate a one size fits all approach, but rather emphasizes the fact that management of risk must be tailored to the specific needs and structure of the particular organization.

IHA's ERM policy statement calls for the HMO to utilize an enterprise-wide approach for the management of key business risks. ERM supports IHA's Board of Directors' corporate governance responsibilities and the risk-based decision-making responsibilities of IHA's executives/senior management leadership. Among the managerial teams (governance bodies) that comprise the HMO's executive/senior leadership are the Executive Team, the Enterprise Risk and Fiscal Responsibility Council ("ER & FRC") and the Office of Strategic Management ("OSM"). IHA's OSM shares responsibility for integrating ERM into the strategic planning process.

The alignment and integration of IHA's ERM process with its strategic planning function helps ensure identification of the uncertainties related to IHA's goals and objectives, which is imperative to the success of the HMO's future operations.

During the course of the Department's interviews with IHA's senior management ("C Level interviews"), the examiner noted that IHA lacked a sufficient succession plan. During the

years under this examination and thereafter, it was noted that certain job vacancies at key levels within IHA, including the positions of Chief Risk Officer ("CRO"), Chief Audit Executive ("CAE") and General Counsel, were filled with individuals hired from outside the HMO rather than by the internal promotion of IHA's employees.

It is recommended that IHA establish a viable succession plan relative to IHA's senior management.

In support of its commitment to an effective ERM program, IHA's Board of Directors established a Risk and Compliance Committee ("Risk Committee") responsible for the oversight, guidance and direction of the HMO's ERM Program. IHA has a CRO whose duties and responsibilities are to set IHA's direction for risk management, with oversight from the Risk Committee, ER&FRC and the Executive Management Team. The Risk Committee reports to the Board on all levels and aspects of enterprise-wide risk, and provides assurance that the appropriate level of risk management is in place and that strategic objectives are met.

The examiner utilized as guidance for assessing the effectiveness of the HMO's corporate governance, Exhibit M of the Handbook (*Understanding the Corporate Governance Structure*). Overall, it was determined that the HMO has a comprehensive and effective ERM program. Overall, IHA's executive management sets a positive and appropriate "tone at the top", and supports a proactive approach to operational risk management, including prospective business risk.

(v). Internal Audit Department ("IAD") and Audit Committee

As of December 31, 2010, IHA had an established IAD to assist the HMO at all levels of management by reviewing and testing financial and operational controls and processes established by management. In addition, IHA had four (4) independent board members that

comprised the Audit Committee to assist the Board of Directors in fulfilling its oversight responsibilities relative to the HMO's financial reporting, internal controls and the audit process.

The importance of both independence and an audit committee's active involvement within the internal audit function is a widely supported position (best practice) throughout the audit industry, including the Institute of Internal Auditors ("IIA"). Below is the related guidance, as listed on the website of the IIA:

> "The internal auditor occupies a unique position, he or she is employed by management but is also expected to review the conduct of management which can create significant tension since the internal auditor's independence from management is necessary for the auditor to objectively assess management's action, but the internal auditor's dependence on management for employment is very clear; and to maintain objectivity, internal auditors should have no personal or professional involvement with or allegiance to the area being audited; and should maintain an un-biased and impartial mindset in regard to all engagements."

> "A critical activity of the audit committee is to be involved in the hiring of the CAE of the organization. Because the CAE reports to the audit committee, the committee should be responsible for ensuring that the CAE receives fair and timely performance reviews. The audit committee should have an active role in determining the annual salary adjustment for the CAE. The audit committee should be the decision-making party in any decision to terminate the CAE."

> **__Note__: The acronym, "CAE", as noted above, refers to Chief Audit Executive.*

During the examination period, IHA's IAD did not function independently of IHA's management due to an improper reporting structure whereby the IAD was aligned under the direct supervision of IHA's management and not the Audit Committee. The Director of Internal Audit ("DIA"), who was the most senior level position within IHA's IAD during the examination period, reported to IHA's President between 2006 and part of 2008 and thereafter reported to IHA's Chief Risk Officer. Simultaneously, the DIA reported on an informal and limited basis to the Chairman of IHA Board's Audit Committee.

It is recommended that IHA comply with the IIA's guidance on the standard of independence of the internal audit function by 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.

During the examination period, it was noted that IHA's management, not the Audit Committee, had sole responsibility for evaluating the job performance and approving the job compensation and annual salary adjustments, of IHA's DIA. In addition, in January 2012, IHA's management terminated the DIA's employment with the HMO. Based on the examiner's subsequent meeting with the Chairman of IHA's Audit Committee, the Chairman confirmed that IHA's decision to terminate the DIA was made without his prior knowledge.

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.

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.

As a result of the restructuring of IHA's Internal Audit Department in 2012, the Director of Internal Audit position was upgraded to the level of Vice President and Chief Audit Executive. In addition, the CAE now reports directly to the Chairman of the Audit Committee with an informal reporting line to IHA's CEO. It was noted that during the process of selecting an employee to fill the CAE position, both IHA's management and the Audit Committee

Chairman, collectively, participated in the process of interviewing the candidates. IHA subsequently filled its CAE position during the first quarter of 2012.

(vi). Model Audit Rule ("MAR")/Department Regulation No. 118 (11 NYCRR Part 89.0)

As of December 31, 2010, IHA was in compliance with the audit and reporting standards of the Department's Regulation No. 118 (11 NYCRR Part 89.0).

B. Territory and Plan of Operation

The HMO's service area, as stated in its certificate of authority as of December 31, 2010, included the following eight (8) counties in the State of New York:

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

As of December 31, 2010, IHA provided comprehensive hospital, medical, prescription drug, vision and dental benefits, relative to HMO commercial (non-government) business, Medicare and New York State Medicaid, Family Health Plus and Child Health Plus sponsored health programs.

The summary below reflects IHA's total annual premium income and member enrollment between December 31, 2006 and December 31, 2010:

| Year | Premium Income | Enrollment |
|---|---|---|
| 2006 | $ 996,048,490 | 269,385 |
| 2007 | $1,060,899,296 | 240,616 |
| 2008 | $1,034,803,835 | 179,892 |
| 2009 | $1,060,408,911 | 164,910 |
| 2010 | $1,087,076,156 | 162,397 |

Between the period December 31, 2006 and December 31, 2010, IHA's total annual premium income increased approximately 9% from $996,048,490 (in 2006) to $1,087,076,156 (in 2010). Such increase stemmed from the growth in the HMO's Medicare and New York State Medicaid, Family Health Plus and Child Health Plus sponsored health programs. The HMO's Medicare premiums increased from $348,022,286 in 2006 to $614,770,800 in 2010, an increase of approximately 77%. IHA's NYSHIP premiums increased 80% during that period, from $71,538,002 to $128,569,934. Offsetting the aforementioned increases to IHA's government lines of business was a corresponding 40% decrease in IHA's commercial lines writings from $576,488,203 in 2006 to $343,735,422 in 2010.

The HMO's total member enrollment during the period under examination decreased by 40% from 269,385 in 2006 to 162,397 members in 2010. This decline in enrollment included a loss of 199,025 or 68% of the HMO's commercial members. The HMO's Medicare membership increased from 38,651 in 2006 to 54,435 in 2010. The HMO's NYSHIP membership also increased during that same period from 31,709 to 43,656 members.

The above mentioned decrease to IHA's commercial line annual premium income and member enrollment stemmed from a decision by IHA to grow its IHBC subsidiary by switching/migrating over the majority of IHA's commercial business members to IHBC for their health insurance coverage. IHA's POS and Direct Payment products were the lines of business with the greatest loss of premium income and member enrollment.

During the examination period, sales and marketing of IHA's commercial HMO health insurance business were facilitated via a network of independent agents and brokers. IHA generated its Medicare business based on the Plan'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, which is calculated on a monthly rate, per person, for each county. Higher rates are paid for less healthy members. CMS utilizes a risk-adjustment score methodology which includes the age, gender, health status and actual claims experience per member to retroactively adjust IHA's current year premiums in the subsequent year.

C. Reinsurance

As of December 31, 2010, the HMO maintained the following ceded reinsurance program with an affiliate, Mason Insurance Company, Ltd. of Hamilton, Bermuda ("Mason"), an unauthorized reinsurer, which is wholly-owned by IHA:

| **Covered services** | **Reinsurance** |
|---|---|
| Inpatient hospital services only, that include sub-acute facility services, skilled nursing facility services, inpatient rehabilitation services, hospice services and home health care agency services. | |
| Commercial HMO members | 85% excess of $200,000 retention up to a maximum reinsurance limit of $750,000 per member per year. |
| Medicare members<br>Family Health Plus members<br>Child Health Plus members | 85% excess of $150,000 retention up to a maximum reinsurance limit of $500,000 per member per year. |

The reinsurance agreement contained the standard insolvency wording required by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

The examiner's review of IHA's implementation of its reinsurance agreement with Mason revealed that the agreement was utilized to reinsure the HMO's capitated business held by IHA's affiliate, Individual Practice Association of Western New York, Inc. ("IPA WNY"). It was noted that IHA and Mason were the only parties to the reinsurance agreement. IPA WNY was not a contracting party to the reinsurance agreement. In regard to the accounting transactions related to the reinsurance agreement, the examiner noted that all paid and unpaid loss recoverables were recorded on IPA WNY's books and accounts as though IPA WNY was the ceding insurer and not IHA.

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.

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).

The HMO also participated in the following stop-loss reinsurance programs with the New York State Market Stabilization Pools ("NYSMSP"):

| **Covered line of business** | **Reinsurance limit** | **IHA's liability** | **NYSMSP liability** |
|---|---|---|---|
| Individual HMO/POS | $20,000 - $100,000 | 10% | 90% |
| Healthy New York | $5,000 - $75,000 | 10% | 90% |
| Medicaid* | $100,000 - $250,000 | 20% | 80% |
| Medicaid IP MH** | | 30 days cost | 100% of IPMH daily cost after 30 days of member in-patient care |
| Medicaid RHCF*** | | 60 days cost | 100% of IPMH daily cost after 60 days of member in-patient care |

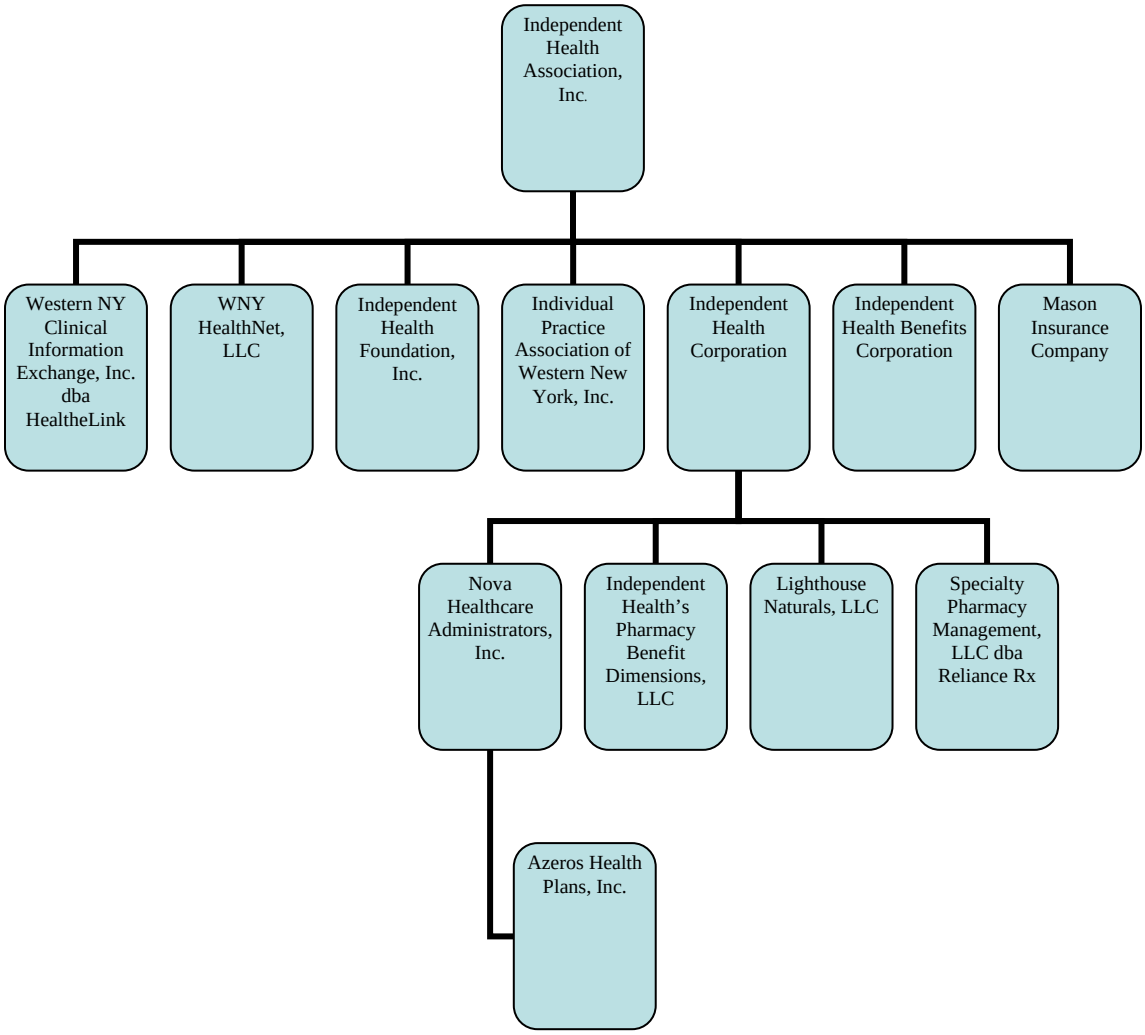
*New York State pays 100% reimbursement above $250,000
**Refers to Medical In-patient Mental Health
*** Refers to Medicaid Residential Health Care Facility

It was noted that the NYSMSP stop-loss recoverable due to IHA was reported on IHA's New York State Data Requirements for HMOs annual filings ("HMO NY Data Requirements filings") as if the recoverable was due to IPA WNY. As a matter of practice, the NYSMSP does not conduct business with individual practice associations or issue payments to such entities.

It is recommended that with regard to its claims recoverable from the NYSMSP that IHA record all such recoupments to its accounts and records.

D. Holding Company System

The following chart depicts IHA's holding company system as of December 31, 2010:




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

Independent Health Benefits Corporation ("IHBC")

IHBC, a New York not-for-profit hospital service corporation licensed under Article 43 of the New York Insurance Law, is a subsidiary of IHA. IHA is the sole member of IHBC. IHBC provides Point of Service Indemnity, Consumer Directed, and Preferred Provider Organization (PPO) medical benefits plans to its subscribers. IHBC does not have its own personnel or business facilities and

therefore relies on the management and administrative services the Plan receives from IHA.

Independent Health Corporation ("IHC")

IHC, a New York for-profit company, is a wholly-owned subsidiary of IHA. IHC, in turn, has 100% direct control of several for-profit subsidiaries listed within IHA's holding company system. IHC, together with its subsidiaries, administer the self-funded plans offered by entities such as employer groups that provide health coverage for their members. Additionally, based on IHC's existing inter-company administrative services agreement with IHA, IHC provides for the creation and administration of debit cards for enrollees to use as part of the benefits provided by IHA.

Independent Practice Association of Western NY ("IPA WNY")

IPA WNY is a New York not-for-profit and taxable entity whose sole member is IHA. Pursuant to IHA's and IPA WNY's effective Medical Services Agreement, IPA WNY, through its medical care providers (i.e., physicians network and other medical providers and facilities) under contract with IPA WNY, provides medical and pharmaceutical services to IHA's enrolled members covered under both the HMO's commercial and Medicare health insurance plans.

Mason Insurance Company, Ltd. of Bermuda ("Mason") unauthorized reinsurer.

Mason is an unauthorized insurer and a wholly-owned subsidiary of IHA. Mason is a Bermuda captive insurance company that reinsures, on an excess of loss basis, the claims of IHA's affiliated subsidiaries, IPA/WNY and IHBC.

IHA maintained the following inter-company agreements with its affiliates as of December 31, 2010:

(a). Administrative Services Agreement with IHBC, Inc. effective January 1, 2007 and as amended on January 1, 2009

IHA provides IHBC with various management, consulting and administrative services, including the following: financial (i.e., claims, underwriting and investments), legal, internal operations, management information services, marketing consultation, health care services, including developing, revising, and refining new health care products, systems, policies, procedures and support to enhance the business of IHBC. Such agreement was last approved by the Department effective on September 5, 2007.

(b). Administrative Services Agreement with IHC Inc. effective January 1, 2007 and as amended on January 1, 2009

IHC provides IHA with access to its provider network and administers IHA's debit cards service issued to the HMO's enrollees and provides other services as needed by IHA from time-to-time. Such agreement did not require approval by the Department of Health.

(c). HMO Reinsurance Agreement with Mason Insurance Company, Ltd. of Bermuda effective January 1, 2010 through January 1, 2011

IHA and Mason have an existing reinsurance agreement as of the examination date, December 31, 2010. The details of such reinsurance agreement are included in the Reinsurance section of this report.

The following items were noted in regard to IHA's implementation of the above administrative services agreements with IHBC and IHC.

1. IHA Management Services - Costs

It was noted that IHA's approved administrative service agreements with IHBC and IHC include a provision to allow IHA to charge IHBC and IHC a "reasonable profit" above the cost to IHA for providing IHBC and IHC with the contracted services.

Subsequent to the examination date, IHA entered into administrative service agreements with IHBC and IHC effective January 1, 2013, which replaced the above referenced agreements IHA had with IHBC and IHC. Paragraphs 3B and 4B under the compensation section of IHBC's and IHC's agreements with IHA, respectively, state that administrative services provided by IHA to IHBC and IHC will be priced based on the "approximate costs" to IHA. The Department approved (non-disapproved) these agreements on March 19, 2013. The Department's approval of these administrative service agreements was based on its understanding that "approximate cost" represents IHA's best estimate of the actual cost of providing services to IHBC and IHC and that "approximate cost" does not allow for an additional charge or profit. Any charge for a

profit component contravenes the basis for the Department approving these administrative service agreements.

2. Settlement of inter-company accounts

The following clause appears in Sections 3C and 4C of IHA's affiliated administrative service agreements with IHBC and Independent Health Corporation ("IHC"), effective January 1, 2007, and January 1, 2009, respectively:

> "Payments for services under this Agreement are to be made by the end of the quarter in which the itemized bill is generated. Estimates may be used but must be adjusted annually."

A review of the HMO's settlement of its inter-company receivable balances during 2010 and 2011 revealed that IHA failed to settle the accounts within the timeframe indicated in IHA's affiliated administrative service agreements with IHBC and IHC. This resulted in IHA routinely non-admitting its receivable balances due to such accounts exceeding ninety (90) days of non-collection.

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.

3. Offsetting of Intercompany Payable Balances

Paragraph 2 of the Statement of Statutory Accounting Principles (SSAP) No. 64 of the NAIC *Accounting Practices and Procedures Manual*, states the following:

> "2. Assets and liabilities shall be offset and reported net only when a valid right of setoff exists except as provided for in paragraphs 3 and 4. A right of setoff is a reporting entity's legal right, by contract or otherwise, to discharge all or a portion of the debt owed to another party by applying an amount that the other party owes to the reporting entity against the debt. A valid right of setoff exists only when all the following conditions are met:

> a. Each of the two parties owes the other determinable amounts. An amount shall be considered determinable for purposes of this provision when it is reliably estimable by both parties to the agreement;
>
> b. The reporting party has the right to set off the amount owed with the amount owed by the other party;
>
> c. The reporting party intends to setoff; and
>
> d. The right of setoff is enforceable at law."

As of December 31, 2010, IHA's inter-company payable account included an amount for $23,567,131 payable to its affiliate, IHC. IHA simultaneously booked (netted) an inter-company receivable in the amount of $6,576,729 that was due to IHA from another affiliate, Nova Healthcare Administrators against such $23,567,131 payable. Such offsetting of intercompany balances among different affiliates is prohibited under Paragraph 2 of SSAP No. 64.

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.

E. IPA Medical Services Agreements

During the examination period, IHA maintained separate inter-company Medical Services Agreements with Individual Practice Association of Western New York, Inc. ("IPA WNY") and Individual Practice Association - CARE, ("IPA/CARE). IHA's Medical Services Agreement with IPA WNY was entered into initially on September 24, 1996 and was last amended and approved by the New York State Department of Health effective on August 1, 2007. IHA's Medical Services Agreement with IPA/CARE was entered into initially on July 1, 1990 and was terminated effective April 1, 2009, upon the dissolution of IPA/CARE.

Based on IHA's Medical Services Agreements with IPA WNY and IPA CARE (collectively referred to as "IPAs"), through their contracted medical providers (i.e., physicians, other medical providers and facilities), IPA WNY currently provides medical and pharmaceutical services to the HMO's commercial and Medicare members. IPA Care provided healthcare services to the HMO's Medicaid enrollees.

The examiner noted that the HMO's agreements with IPA WNY and IPA/CARE and their implementation thereof were utilized during the examination period as financial risk transfer arrangements between IHA and the IPAs. However, the examiner determined that these agreements did not qualify as "transfer of risk" arrangements pursuant to Department Regulation No. 164 (11 NYCRR 101).

The examiner suggested to IHA's management that the HMO submit its IPA WNY Medical Services Agreement to the Department for review pursuant to Department Regulation No. 164, if the HMO elects to continue using the Agreement as a risk transfer arrangement. IHA subsequently wrote to the Department on October 4, 2012 requesting that the Agreement be exempt from the provisions of the Department Regulation No. 164 based on the HMO meeting the requirements of Part 101.4(e) of the Regulation.

In the Department's written response to IHA dated April 16, 2013, the Department stated that the IHA and IPA WNY Medical Services Agreement, as written, is not subject to the provisions of Department Regulation No. 164. However, for the period January 1, 2006 to December 31, 2010, the examiner determined that IHA implemented the Agreement during that period as if it was submitted and approved under Regulation No 164. In addition, the Department reviewed the Agreement, per IHA's request, and found that it does not meet the requirements of Regulation No. 164.

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.

In addition, the examiner noted the following observations and/or deficiencies with regard to the HMO's implementation of both IPA Medical Services Agreements during the examination period:

1. Non-cash Accounts of Capitation Transactions

All accounting transactions between IHA and the IPAs during the examination period, relative to the capitations were based on accrual journal entries, with no actual cash payments made between the entities. Among the journal entries were transactions that included capitation adjustments of the IPAs' year-end financial results. The following adjustments/transfers were reported between IHA and the IPAs, as approved by the IPAs' Board of Directors.

| | | | | Adjustments/Transfers Approved by Board of Directors | |
|---|---|---|---|---|---|
| Year | IPA WNY | IPA/CARE | Total | IPAWNY | IPA CARE |
| 2007 | $ 0 | $2,500,000 | $ 2,500,000 | N/A | 12/18/07 |
| 2008 | 38,000,000 | 4,500,000 | 42,500,000 | 12/10/08 | 12/02/08 |
| 2010 | 11,800,000 | 0 | 11,800,000 | 11/16/10 | |
| Sub-totals | $49,800,000 | $7,000,000 | $56,800,000 | | |
| 2011 | 17,000,000 | 0 | 17,000,000 | 12/27/11 | |
| Totals | $66,800,000 | $7,000,000 | $73,800,000 | | |

As a result of the aforementioned capitation adjustments/transfers, the IPAs reported year-end deficits ("fund balance deficits") to their surplus accounts in each of the years under examination. These fund balance deficits of the IPAs were appropriately reported in the filed

annual statements of IHA as an aggregate write-in liability. As of December 31, 2010, the HMO reported a liability of $28,071,286, which was the same fund balance deficit of IPA WNY, as reported on the IPA's balance sheet.

2. IHA's Annual New York State Data Requirements for HMOs Filings

Based on the captioned filings during the examination period, the examiner noted that the filings included a section entitled "Report #13 For Each Risk-Bearing Entity". The purpose of this Report is for IHA to disclose the financial results of IPA WNY and IPA Care as risk-bearing entities with IHA, as required under Department Regulation No. 164. Insofar as IHA did not have an approved financial risk sharing arrangement pursuant to Department Regulation No. 164 with IPA WNY as of now and also did not have an approved financial risk sharing agreement with IPA Care prior to its April 1, 2009 dissolution, such Report #13 disclosure should not have been included with IHA's annual New York State Data Requirements filings.

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 arrangement.

F. Allocation of Expenses

Joint personnel and other operating expenses incurred by IHA during the examination period were allocated by IHA to its affiliates based on the following expense allocation methods:

(i) Internal consulting charges (i.e., direct time charged and indirect time charged);

(ii) Administrative expense allocation; and

(iii) Expense reimbursement (i.e., expensed to the appropriate entity via an inter-company journal entity.

With the "direct time" charge method, IHA's personnel costs, including employees' fringe benefits, are determined on the basis of the number of hours worked by IHA's employees, broken down by cost centers and products (e.g., HMO, PPO, Medicare, etc.) times the employees' pay rates. For each employee, his or her pay rate (adjusted to include a midpoint rate based on the lowest and highest salaries within each person's job title/position) is utilized in calculating the allocation amount. It is noted that the midpoint pay rates include an additional charge above the actual costs of IHA charges for the services provided to cover the cost of IHA employees' fringe benefits. The additional charge or profit was determined based on a calculation of applying an IHA employee's average midpoint salary by title and pay grade, multiplied by a factor of 150%.

The examiner review of the Underwriting and Investment Exhibit ("U&I Exhibit") of IHA's 2010 NAIC Annual Statement filing revealed the following:

1. Joint allocated expenses were reported on the basis of the total gross (unallocated) expense amounts rather than on the basis of IHA's proportionate allocated share of each incurred expense amount; and

2. Year-end balances to several expense accounts were misclassified due to the HMO allocating a portion of personnel and fringe benefits costs to the incorrect expense accounts.

Part 105.25(a)(1) of Department Regulation No. 30 (11 NYCRR 105), states the following:

> "(a) Joint expenses. (1) 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 expense classifications as if the expenses had been borne wholly. Any difference between the actual amount paid, and the amount of such apportioned expenses shall be included in the operating expense classification "miscellaneous".

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.

The HMO's indirect personnel costs entailed a "discussion-based" determination that involved a general assessment of the time spent by IHA's employees attending corporate meetings/retreats and performing duties relative to corporate-wide projects and general administrative functions. Such generic "discussion-based" allocation was deemed neither substantially quantifiable nor traceable to any specific product lines of IHA and its affiliates.

Paragraph 6 of Statement of Statutory Accounting Principles No. 70 states the following:

> "Allocation to the above categories should be based on a method that yields the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. Where specific identification is not feasible allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses."

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.

## 3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and capital and surplus as determined by this examination as of December 31, 2010. This statement is the same as the balance sheet reported by the HMO in its filed annual statement as of December 31, 2010:

| Assets | Examination | HMO |
|---|---|---|
| Bonds | $256,717,480 | $256,717,480 |
| Common stocks | 33,103,892 | 33,103,892 |
| Properties occupied by the company less-0-encumbrances | 9,566,238 | 9,566,238 |
| Cash, cash equivalences & short-term investments | 136,210,277 | 136,210,277 |
| Other invested assets | 99,673,156 | 99,673,156 |
| Interest income due and accrued | 2,915,359 | 2,915,359 |
| Uncollected premiums and agents' balances in the course of collection | 26,991,382 | 26,991,382 |
| Accrued retrospective premiums | 15,362,256 | 15,362,256 |
| Amounts recoverable from reinsurer | 3,001,099 | 3,001,099 |
| Amount receivable relating to uninsured plans | 3,600,110 | 3,600,110 |
| Electronic data processing equipment and software | 2,913,701 | 2,913,701 |
| Receivable from parents, subsidiaries and affiliates | 6,005,302 | 6,005,302 |
| Total assets | $596,060,252 | $596,060,252 |

| Liabilities | Examination | HMO |
|---|---|---|
| Claims unpaid | $34,341,356 | $34,341,356 |
| Unpaid claims adjustment expenses | 4,500,000 | 4,500,000 |
| Premiums received in advance | 7,891,976 | 7,891,976 |
| General expenses due and accrued | 46,119,545 | 46,119,545 |
| Current federal income tax payable | 575,000 | 575,000 |
| Amounts due to parent, subsidiaries and affiliates | 17,895,153 | 17,895,153 |
| Aggregate write-ins for other liabilities | 33,452,570 | 33,452,570 |
| Total liabilities | $144,775,600 | $144,775,600 |
| Aggregate write-ins for other than special surplus funds | 91,963,869 | 91,963,869 |
| Unassigned funds | 359,320,783 | 359,320,783 |
| Total capital and surplus | $451,284,652 | $451,284,652 |
| Total liabilities, capital and surplus | $596,060,252 | $596,060,252 |

Note: The examiners are 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 increased by a total of $213,121,882 during the five-year examination period from January 1, 2006 through December 31, 2010, detailed as follows:

| | | |
|---|---|---|
| Revenue: | | |
| Premium income | | $5,239,236,688 |
| Expense: | | |
| Hospital/ Medical Benefits | $3,741,921,125 | |
| Other professional services | 3,040,903 | |
| Prescription Drugs | 734,054,222 | |
| Aggregate write-ins for other hospital and medical | 83,700,619 | |
| Emergency room and out-of-area | 19,887,728 | |
| Subtotal | $4,582,604,597 | |
| Less: Net reinsurance recoveries | 1,812,412 | |
| Total hospital and medical benefits | $4,580,792,185 | |
| Claims adjustment expenses, including $72,811,779 cost containment expenses | 178,090,334 | |
| General administrative expenses | 318,105,099 | |
| Increase in reserves for life and accident and health contracts | (8,330,000) | |
| Total underwriting deductions | | $5,068,657,618 |
| Net Underwriting gains | | $ 170,579,070 |
| Net investment income earned | 69,523,134 | |
| Net realized capital losses | (16,160,162) | |
| Net investment gains | | $ 53,362,972 |
| Aggregate write-ins for other income | | 5,639,850 |
| Net income, after capital gains tax and before all other federal income taxes | | $ 229,581,892 |
| Less: Federal income taxes incurred | | 1,990,698 |
| Net income | | $ 227,591,194 |

Changes in Capital and Surplus

| | | | |
|---|---|---|---|
| Capital and surplus, per report on examination, as of December 31, 2005 | | | $238,162,770 |
| | Gains in Surplus | Losses in Surplus | |
| Net income | $227,591,194 | | |
| Net change in unrealized capital gains | 12,806,776 | | |
| Change in non-admitted assets | | $10,473,425 | |
| Aggregate write-ins for losses | | 16,802,663 | |
| Total gain and losses in surplus | $240,397,970 | $27,276,088 | |
| Net change in capital and surplus | | | $213,121,882 |
| Capital and surplus, per report on examination, as of December 31, 2010 | | | $451,284,652 |

## 4. FEDERAL INCOME TAXES INCURRED

Under IHA's HMO Federal tax exempt status pursuant to Section 501(c) of the Internal Revenue Code, such exemption does not apply to IHA's other business operations which are not health insurance related. Based on the inter-company management fees and resulting net profits earned by IHA in providing contract services to affiliates, these non-insurance profits were taxable to the HMO.

During the examination period, the HMO reported total Federal income taxes incurred of $1,990,698 for years 2006 through 2010. Below is a summary of the HMO's corresponding annual management fees and net profits reported during that same period:

| Year | IHA's gross management fees | IHA's actual costs for services provided | IHA's net profit |
|---|---|---|---|
| 2006 | $18,647,726 | $18,489,067 | $ 158,659 |
| 2007 | 25,434,870 | 25,269,014 | 165,856 |
| 2008 | 45,204,775 | 44,924,297 | 280,478 |
| 2009 | 49,178,523 | 47,340,288 | 1,838,235 |
| 2010 | 52,708,184 | 51,068,209 | 1,639,975 |
| Total | $191,174,078 | $187,090,875 | $4,083,203 |

The net profits, which were the basis for such income taxes incurred by the HMO, were the result of the HMO charging an additional margin above the cost of services provided to its affiliates.

The HMO is a Federal tax exempt organization and was not subject to audits by the Internal Revenue Service ("IRS"), since its inception.

## 5. CLAIMS UNPAID

The examination liability of $34,341,356 for the above captioned account is the same as the amount reported by the HMO in its filed annual statement as of December 31, 2010.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements as verified by the examiners.

The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated

based on actuarial principles, which utilized the HMO's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2010.

## 6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2005, contained two (2) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

| ITEM NO. | | PAGE NO. |
|---|---|---|
| | Accounts and Records | |
| 1. | It is once again recommended that the HMO make appropriate studies relative to the allocation of expenses in future statements to this Department.<br><br>*The Company has not fully complied with this recommendation.* | 19 |
| | Enrollment Data | |
| 2. | It is recommended that the HMO file electronic corrections to its annual statement at the time that it sends in a revised hard copy filing to this Department's Health Bureau.<br><br>*The Company has complied with this recommendation.* | 20 |

## 7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

**ITEM** **PAGE NO.**

Respectfully submitted,

_____/S/_____
Kenneth I. Merritt
Associate Insurance Examiner

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

_____/S/_____
Kenneth I. Merritt

Subscribed and sworn to before me
this _____ day of_____2014.

Appointment No. **30754**

# 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 29th day of August, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR