

MARKET CONDUCT REPORT ON EXAMINATION

OF

INDEPENDENT HEALTH ASSOCIATION, INC.

AND

INDEPENDENT HEALTH BENEFITS CORPORATION

AS OF

DECEMBER 31, 2015

DATE OF REPORT

SEPTEMBER 12, 2018

EXAMINER

KENNETH I. MERRITT

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

September 12, 2018

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

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31667 and 31668, dated December 10, 2015, 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, 2015, 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 designations “IHA Companies or the Companies” appear herein, without qualification, they 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.

1. **SCOPE OF THE EXAMINATION**

An examination was performed to ascertain the manner in which the IHA Companies conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. 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, respectively, as of December 31, 2010. This market conduct examination of the IHA Companies covers the five-year period from January 1, 2011 through December 31, 2015. 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, 2015. Separate financial reports on examination for IHA and IHBC, respectively, were placed on file with the Department on February 13, 2018.

2. 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 received a certificate of authority from New York State Department of Health (“DOH”) pursuant to Article 44 of the Public Health Law on February 11, 1980. 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.

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 subsidiary of Independent Health Association, Inc.

3. NETWORK DIRECTORIES

Section 4324(a)(17) of the New York Insurance Law states in part the following:

“...a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals ...”

Section 4408.1(r) of the New York Public Health Law states in part the following:

“...a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals ...”

In the IHA Companies' 2015-2016 Physician/Provider Network Directory (Directory"), available on the Companies' webpage, it was noted that information relative to the network physicians' the affiliations with participating hospitals was not listed in the Directory.

It is recommended that the IHA Companies comply with Sections 4324(a)(17) of the New York Insurance Law and 4408.1(r) of the New York Public Health Law by including information relative to network physicians' affiliations with the participating hospitals listed in IHA and IHBC Participating Provider Directory website.

4. FRAUD WARNING STATEMENT

The following requirements apply pursuant to the New York Insurance Law and Insurance Regulation No. 95 (11 NYCRR 86) relative to the intentional filing by a claimant of a fraudulent claim or information and the disclosure of a fraud warning statement:

Section 403(d) of the New York Insurance Law, states the following:

"(d) All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms, except as provided for in subsection (e) of this section, shall contain a notice in a form approved by the superintendent that clearly states in substance the following:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

In addition, Section 86.4(a) of Insurance Regulation No. 95 (11 NYCRR 86) states:

“All applications provided to applicants for [non-automobile] commercial insurance and all claim forms for insurance, except personal automobile insurance, delivered to any person residing or located in this State (on and after February 2, 1994) in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information...”

During the examination period, the IHA Companies’ utilized the following claim forms:

- (i) HCFA CMS-1500/used by physicians;
- (ii) UB-04-CMS-1450/used by hospital/facilities; and
- (iii) IHA Companies’ general claim form/used by member.

The above mentioned IHA Companies’ general claim form utilized by the member did not include the requisite fraud warning statement on the form.

It is recommended that the IHA Companies comply with Section 403(d) of the New York Insurance Law and Insurance Regulation No. 95 (11 NYCRR 86) by updating their general claim form to include the requisite fraud warning statement.

5. GRIEVANCES/UTILIZATION REVIEW REPORTING

The following deficiencies were noted relative to the examiner's review of the IHA Companies' Grievances and Utilization Review reporting.

- (i) IHA Companies' Issuance of Adverse Determinations (Policy and Contractual Benefit Matters) and Notification of Member's Right to File Civil Lawsuit

29 C.F.R § 2560.503-1(g)(1)(iv) states in part, the following:

"...(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section ... The notification shall set forth, in a manner calculated to be understood by the claimant...

"... (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review..."

Based upon the examiner's review of a sample of 60 (30 for each company) random adverse determination notices issued during 2015, thirteen (13) IHBC cases and nine (9) IHA cases were identified in which the notices did not include a statement indicating the member's/claimant's right to file a civil action in response to an adverse benefit determination. See below exhibit showing total number of violations:

2015 Grievance Benefit Adverse Determination Violations					
	Sample items reviewed	Errors identified	Error rate	Total population	Total errors Extrapolated
IHA	30	9	30%	105	31
IHBC	30	13	43%	208	89
Total		22	377	313	120

It is recommended that the IHA Companies comply with 29 C.F.R Section 2560.503-1(g)(1)(iv) by including in their adverse determination notices the statement of the insured's/enrollee's right to bring a civil action under section 502(a) ERISA.

(ii). Schedule M Reporting of York State Department of Financial Services Supplement to Article 43 Corporations Annual Statement (IHBC) and Data Requirements for Health Maintenance Organizations (IHA) Filings

Insurance Circular Letter No. 5 (1999), dated February 19, 1999, states in part the following:

“...Section 210(b)(1) of the New York State Insurance Law mandates that HMOs and insurers report to the Insurance Department the number of grievances filed pursuant to 4408-a of the Public Health Law (as added by Chapter 705 of the Laws of 1996) or Section 4802 of the Insurance Law, and the number of such grievances where a determination was reversed in whole or in part compared to the number of determinations that were upheld. Section 210(b)(2) of the Insurance Law also requires HMOs and insurers to report the number of appeals to UR determinations which were filed pursuant to Article 49 of the Public Health Law or Article 49 of the Insurance Law and the number of adverse determinations which were reversed versus the number upheld. HMOs and insurers must include grievance and UR appeal information in the annual statements they are required to file with the Insurance Department...”

A review of Schedule M as contained in the IHA Companies' respective 2015 New York State Department of Financial Services Supplements to (i) Article 43 Corporations Annual Statement (IHBC) and (ii) Data Requirements for Health Maintenance Organizations (IHA) filings (“IHA Companies' NYS Annual Supplemental Statement Filings”) with the Department , revealed that both IHA Companies incorrectly reported their respective total number of grievances and utilization review appeals. In addition, the examiner noted that the grievances and utilization review totals did not

reconcile to the totals reported in the IHA Companies' underlying grievances and appeal data files.

It is recommended that the IHA Companies comply with Insurance Circular Letter No. 5 (1999) and the instructions to the NYS Supplemental Annual Statement Filings, by correctly reporting the grievances and appeals data in the Schedule M's of their New York State Department of Financial Services Supplement to Article 43 Corporations Annual Statement (IHBC) and Data Requirements for Health Maintenance Organizations (IHA) filings with the Department.

It is further recommended that the IHA Companies ensure that their Schedule M grievances and utilization review totals reconcile to the corresponding details in their underlying data files.

6. AGENT APPOINTMENTS/TERMINATIONS

(i) IHA's agents' appointments and terminations

Section 2112(a) of the New York Insurance Law states, in part, the following:

“...Every insurer... health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents...to represent such insurer, fraternal benefit society or health maintenance organization....”

Section 2112(d) of the New York Insurance Law states, in part, the following:

“...Every insurer, fraternal benefit society or health maintenance organization...doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent, or title insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance

business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer...shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier..."

The examiner's review of thirty (30) each IHA agent appointments and terminations files of agents appointed and terminated throughout years under the examination period, revealed the following reporting deficiencies and noncompliance with the New York Insurance Law:

- a. There were six (6) instances where IHA did not issue certificates of appointment of active agents.

It is recommended that IHA comply with Section 2112(a) of the New York Insurance Law by ensuring that certificates of appointment for all IHA appointed agents are filed with the Department.

- b. There were thirteen (13) cases where IHA failed to send the facts relative to such termination of agents to the Department within 30 days of the dates of termination as required by Section 2112(d) of the New York Insurance Law. In addition, there were twenty-four (24) cases where IHA failed to notify the agents of their termination within fifteen (15) days of said termination, as required by Section 2112(d) of the New York Insurance Law.

It is recommended that IHA comply with Section 2112(d) of the New York Insurance Law relative to its termination of an agent by sending notifications to both the terminated agent and the Department fifteen (15) and thirty (30) days, respectively, following the effective termination dates of the agent.

- c. A comparison of IHA's internal records of agent appointments and terminations reported during the examination period revealed discrepancies between the HMO's internal list and the Department's corresponding list of IHA appointed and terminated agents. The Department derives its list, including any updates thereto, from the actual certificates of appointment and termination filings with the Department by the HMO.

It is recommended that IHA take the necessary steps to file all notices of agent appointments and terminations with the Department in order to maintain up-to-date information between IHA's and the Department's respective databases.

(ii) IHBC Agent Appointments

Section 2103(m) of the New York Insurance Law state in part the following:

“... An agent appointed for an insurer authorized to transact business in this state may transact business for any subsidiaries or affiliates of said insurer that are licensed in this state for the same line or lines of insurance without such insurers submitting additional appointments, provided a certified copy of a resolution adopted by the board of directors of each of the insurers requesting such authority is filed with the superintendent by each of the insurers and renewed and refiled whenever deemed necessary by the superintendent. The resolution shall also designate the primary insurer for which all of the company's agents must be appointed pursuant to subsection (a) or (b) of this section, and said appointment must be in full force and effect in order to transact business for any of the affiliated or subsidiary insurers...”

During the examination period, in lieu of IHBC directly appointing its own agents to write business for the Plan, IHBC alternatively utilized IHA's appointed agents. The examiner noted that IHBC never received the requisite approval from IHBC's Board of Directors to use IHA's agents, as per Section 2103(m) of the New York Insurance Law.

It is recommended that IHBC comply with Section 2103(m) of the New York Insurance Law by obtaining and filing with the Department, the requisite Board of Directors' resolution approving IHBC's use of IHA's appointed agents in lieu of the Plan appointing its own agents.

Subsequent to the examination date, IHBC obtained the necessary Board of Directors' resolution and provided the examiner with a copy for filing with Department.

7. **CLAIMS REVIEW**

A. Standards For Prompt, Fair And Equitable Settlement of Claims For Health Care And Payments For Health Care Services ("Prompt Pay Law")

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt that are transmitted via the internet or electronic mail, and within 45 days of receipt for a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

A review of the IHA Companies' compliance with Section 3224-a was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, such instances in total were immaterial.

B. Fee Schedules and Claims Benefit Logic Updating

During 2015, the IHA Companies identified a problem with the Companies having improperly applied member cost share requirements involving insureds' /subscribers' pediatric preventive care services. The problem stemmed from the IHA Companies' failure to update their fee schedules and claims benefit logic in a timely manner for the proper adjudication of claims, and/or the timely adjustments of claims. As a result, upon taking measures to properly update the fee schedules and correct the benefit programming logic, the IHA Companies reprocessed a total of 1,292 claims, to determine the providers billed the correct reimbursement amounts, without any subscribers/insureds cost sharing liability/requirements. IHA and IHBC also issued new EOBs to reflect that the members/subscribers should not have incurred any cost sharing on such pediatric preventive service claims.

However, the examiner noted that the IHA Companies' actions to reprocess/adjust the claims and distribute EOBs to the members did not address the issue relative to the members that may have been impacted. Specifically, the adjustments and EOBs distribution took place several months after the claims were originally processed, which these actions alone do not assure that the members/subscribers were not billed by the doctors and paid the cost sharing directly to the providers.. Sole responsibility was

placed on the members to read their EOBs and then contact the IHA Companies' providers ,where applicable.

It is recommended that the IHA Companies take steps to ensure that the benefit logic for mandated benefits and cost sharing are kept updated in a timely manner, to assure the proper adjudication of claims.

It is further recommended that the IHA Companies take additional steps, including but not limited to, collaboration with their providers, to (i) identify those members with whom the providers improperly charged copayments and (ii) ensuring that these members are appropriately reimbursed.

8. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The prior reports on examination included seven (7) market conduct related recommendations detailed as follows (page number refers to the prior reports on examination):

<u>ITEM NO</u>		<u>PAGE NO.</u>
	<u>Policy Forms</u>	
1.	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
	The Companies have complied with this recommendation.	
2.	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
	The Companies have complied with this recommendation.	
	<u>Concurrent Utilization Review</u>	
3.	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
	The Companies have complied with this recommendation.	

ITEM NO**PAGE NO.**Retrospective Utilization Review

4. 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

The Companies have complied with this recommendation.

5. 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

The Companies have complied with this recommendation.

Non-compliance Standard Utilization Review Appeals Process

6. 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. 12

The Companies have complied with this recommendation.

Fraud Prevention Plan

7. 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. 13

The Companies have complied with this recommendation.

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>ACA Out-of-Network Provider Directory</u>	
It is recommended that the IHA Companies comply with Sections 4324(a)(17) of the New York Insurance Law and 4408.1(r) of the New York Public Health Law by including information relative to network physicians' affiliations with the participating hospitals listed in IHA's and IHBC's Participating Provider Directory website.	5
B. <u>Fraud Warning Statement</u>	
It is recommended that the IHA Companies comply with Section 403(d) of the New York Insurance Law and Insurance Regulation No. 95 (11 NYCRR 86) by updating their general claim form to include the requisite fraud warning statement.	6
C. <u>Grievances and Utilization Review Reporting</u>	
i. It is recommended that the IHA Companies comply with 29 C.F.R Section 2560.503-1(g)(1)(iv) by including in their adverse determination notices the statement of the insured's/enrollee's right to bring a civil action under section 502(a) ERISA.	8
ii. It is recommended that the IHA Companies comply with Insurance Circular Letter No. 5 (1999) and the instructions to the NYS Supplemental Annual Statement Filings by correctly reporting the grievances and appeals data in the Schedule M's of their New York State Department of Financial Services Supplement to Article 43 Corporations Annual Statement (IHBC) and Data Requirements for Health Maintenance Organizations (IHA) filings with the Department.	9
iii. It is further recommended that the IHA Companies ensure that their Schedule M grievances and utilization review totals reconcile to the corresponding details in their underlying data files.	9
D. <u>Agent Appointments and Terminations</u>	
i. It is recommended that IHA comply with Section 2112(a) of the New York Insurance Law by ensuring that certificates of appointment are issued for all IHA appointed agents for filing with the department.	10

ITEM**PAGE NO.**Agent appointments and Terminations cont'd

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|------|--|----|
| ii. | It is recommended that IHA comply with Section 2112(d) of the New York Insurance Law relative to its termination of an agent by sending notifications to both the terminated agent and the Department fifteen (15) and thirty (30) days, respectively, following the effective termination dates of the agent. | 11 |
| iii. | It is recommended that IHA take the necessary steps to file all notices of agent appointments and terminations with the Department in order to maintain up-to-date information between IHA's and the Department's respective databases. | 11 |
| iv. | It is recommended that IHBC comply with Section 2103(m) of the New York Insurance Law by obtaining and filing with the Department, the requisite Board of Directors' resolution approving IHBC's use of IHA's appointed agents in lieu of the Plan appointing its own agents. | 12 |
| E. | <u>Claims Review</u> | |
| i. | It is recommended that the IHA Companies take steps to ensure that the benefit logic for mandated benefits and cost sharing are kept updated in a timely manner, to assure the proper adjudication of claims. | 14 |
| ii. | It is further recommended that the IHA Companies take additional steps, including but not limited to, collaboration with their providers, to (i) identifying those members with whom the providers improperly charged copayments for "non-copay" pediatric healthcare services, and (ii) ensuring that these members are appropriately reimbursed. | 14 |

Respectfully submitted,

_____/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

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.

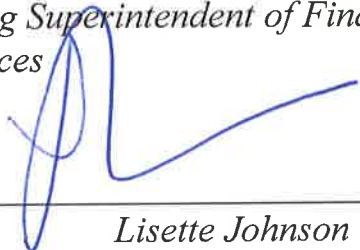
In Witness Whereof, I have hereunto subscribed my name
and affixed the official Seal of the Department
at the City of New York

this 10th day of December, 2015

SHIRIN EMAMI

Acting Superintendent of Financial
Services

By:



Lisette Johnson
Bureau Chief
Health Bureau



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 Benefits Corporation

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

Plan

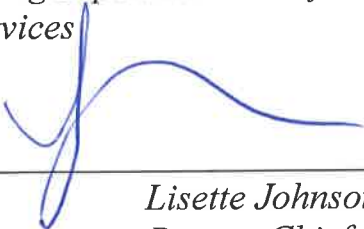
with such other information as he shall deem requisite.

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

