REPORT ON EXAMINATION

OF

ELDERPLAN, INC.

AS OF

DECEMBER 31, 2007

DATE OF REPORT	**FEBRUARY 18, 2010**
EXAMINER	**KAIWEN K. GUO**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

David A. Paterson
Governor

James J. Wrynn
Superintendent

February 18, 2010

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 22691, dated October 27, 2008, attached hereto, I have made an examination into the condition and affairs of Elderplan, Inc., a not-for-profit health maintenance organization (HMO) licensed under the provisions of Article 44 of the New York Public Health Law, as of December 31, 2007, and submit the following report thereon.

The examination was conducted at the Plan's administrative office located at 6323 7th Avenue, Brooklyn, NY 11220.

Wherever the terms "Elderplan" or "the Plan", appear herein, without qualification, they should be understood to mean Elderplan, Inc.

1. SCOPE OF EXAMINATION

Elderplan, Inc. was previously examined as of December 31, 2002. The current examination covers the five-year period from January 1, 2003 through December 31, 2007. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a verification of assets and liabilities as of December 31, 2007, in accordance with Statutory Accounting Principles (SAP), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by Elderplan's independent certified public accountants.

A review or audit was also made of the following items as called for in the *Examiners Handbook of the National Association of Insurance Commissioners* (NAIC):

History of the Plan
Management and controls
Corporate records
Territory and plan of operation
Growth of the Plan
Business in force
Reinsurance
Loss experience
Accounts and records
Financial statements
Treatment of policyholders and claimants

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

A review was also made to ascertain what actions were taken by the Plan with regard to comments and recommendations contained in the prior report on examination.

2. DESCRIPTION OF THE PLAN

Elderplan, Inc. was incorporated on April 27, 1982, under Section 402 of the New York Not-For-Profit Corporation Law. On March 1, 1985, the Plan was granted a Certificate of Authority by the Department of Health to operate as a health maintenance organization (HMO) pursuant to the provisions of Article 44 of the New York Public Health Law. The initial Certificate of Authority authorized the Plan to provide services to Medicare enrollees who reside in Kings, Queens, Richmond and New York counties. The Plan's latest amended Certificate of Authority, dated July 13, 2005, authorized the Plan to expand its service area to include Bronx County. As of December 31, 2007, the Plan was serving approximately 16,510 members.

Elderplan, Inc. is a participating agency of the Metropolitan Jewish Health System (MJHS), a long-term care institution located in Brooklyn, New York. The Plan is one of four original entities participating in the Social/Health Maintenance Organization (S/HMO) national demonstration project of the Centers for Medicare and Medicaid Services (CMS). The Plan was chosen to participate in this Federal demonstration project to show how a target population could benefit from the health care provided by a S/HMO. This project ceased on December 31, 2007.

The Plan's primary source of revenue is premiums (capitation basis) from the Centers for Medicare and Medicaid Services (CMS). The Plan received premiums from CMS for Parts A and B of Medicare. Effective January 1, 2006, the Plan began providing pharmacy coverage

under Medicare Part D. Premium rates were determined by CMS' risk score model on a per member, per month basis. Prior to August 1, 2005, the Plan provided Medicaid coverage under capitation and fee-for-service arrangements with the New York State Department of Health.

During 2007, the Plan's per member, per month Medicare capitation was a 25%/75% blend, respectively, of the S/HMO and CMS' risk score model. Commencing January 1, 2008, the Plan migrated to a 100% "risk score model" and the "frailty component" of the risk score will be phased out over three years (75% in 2008, 50% in 2009 and 25% in 2010). This change in reimbursement methodology may have a negative impact on the Plan's future revenue stream.

A. Management and Controls

Article III, Section 1 of Elderplan's by-laws provides that the Plan shall have no less than three (3) nor more than seven (7) members, hereinafter referred to as "Members". The Members' are responsible for electing the board of directors at the annual meeting of the Members. As of December 31, 2007, the three Members were as follows:

Isaac Assael
Eli Feldman
Phil Geller

Pursuant to the Plan's charter and by-laws, management is to be vested in a board of directors consisting of not less than five, nor more than twenty-one directors; with at least twenty percent (20%) of the directors being subscribers of the Plan. The term of office for each director shall be for one year, until the next annual meeting of the Members.

The thirteen (13) members of the board of directors as of December 31, 2007 were as follows:

Name and Residence	Principal Business Affiliation
Isaac Assael New York, NY	Executive, Enwood Personnel & Temporary Services
Rosalie DiPietro * Brooklyn, NY	Retired
Eli S. Feldman Marlboro, NJ	President & CEO, Metropolitan Jewish Health System
Gloria Feldstein * Brooklyn, NY	Retired
Arthur Goshin, MD North Hills, NY	Physician, Univera Healthcare
Vivian Hirsch New York, NY	Attorney, Vivian H. Agress
Howard Kagan New York, NY	Investment Analyst, Harbinger Capital Partners
Shmuel Lefkowitz Brooklyn, NY	Real Estate Consultant, Prime Resources Group
Ronald B. Milch New York, NY	Health Care Executive, Combined Coordinating Council, Inc.
Herman Rosen Brooklyn, NY	Retired
William Schwartz New York, NY	Retired
Steven Topal Forest Hills, NY	CPA/Attorney, Rothchild, Miller, Topal & Kraft, P.C.
Clara Williams* Brooklyn, NY	Retired

*Enrollee representatives per Part 98-1.11(g) of the Administrative Rules and Regulations of the Department of Health (10 NYCRR 98-1.11(g)).

A review of the attendance records of the board of directors' meetings held during the examination period revealed that board meetings were generally well attended. However, one director, Vivian Hirsch, attended less than 50% of the meetings she was eligible to attend. Three

other directors, Howard Kagan, William Schwartz and Michael Gottschalk (replaced in 2005), did not attend any of the meetings they were eligible to attend.

It should be noted that in 2007, Vivian Hirsch was made an Emeritus Director (non-voting). Further, board members Howard Kagan, William Schwartz and Michael Gottschalk were not re-appointed after their first one-year term.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Board members who fail to attend at least one-half of the board's meetings, unless appropriately excused, do not fulfill such criteria.

It is recommended that any director who attends less than 50% of the board meetings they are eligible to attend be removed or replaced.

The principal officers of the Plan as of December 31, 2007 were as follows:

Name	Title
Eli S. Feldman	President/CEO
Alexander S. Balko	Treasurer/CFO
Robert Leamer	Assistant Secretary

B. Circular Letter No. 9 (1999) - Adoption of Procedure Manuals

Circular Letter No. 9 (1999) – "Adoption of Procedure Manuals", dated May 25, 1999, was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and insurers licensed to write health insurance in New York State. The Circular Letter applies to Elderplan as a health maintenance organization.

Circular Letter No. 9 (1999) – "Adoption of Procedure Manuals" states in part:

> "…It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations..."

The examination revealed that the aforementioned annual certifications were not obtained during the examination period.

It is recommended that the Plan's board obtain the certifications cited in Circular Letter No. 9 (1999).

C. Territory and Plan of Operation

Pursuant to Article 44 of the New York Public Health Law, the New York State Department of Health issued a health maintenance organization Certificate of Authority to Elderplan, Inc., effective March 1, 1985. The latest amendment to the Certificate of Authority was dated July 13, 2005 and it contained the following conditions and limitations:

- The certificate permits the operation of Elderplan, Inc. only for the duration of federal participation in the demonstration project or other federally approved Medicare Advantage programs.
- Elderplan, Inc. is authorized to demonstrate the Social HMO concept for individuals enrolled in the Medicare program.
- Elderplan's service areas shall consist of the Bronx, Kings, New York, Queens and Richmond counties. Effective August 1, 2005, these counties were designated as Medicare only and limited to marketing and enrolling the Medicare population. In order to offer any other product in these counties or enroll a non-Medicare population, Elderplan, Inc. must obtain prior approval from the Department of Health.
- Elderplan, Inc. will operate in accordance with all applicable State and Federal requirements. The approval is based upon information provided by the Plan. All aspects of operations will be governed primarily by the Center for Medicare and Medicaid Services (CMS), and implementation is contingent upon securing a Medicare contract with the federal government.
- Enrollment of Medicaid eligibles for the provision of capitated health care services is contingent upon executing a Medicaid contract.

Elderplan is a prototype prepaid health plan for well and impaired elderly members. The Plan assumes responsibility for the provision of a full range of acute inpatient, ambulatory, preventive, rehabilitative and long-term care services, on the basis of prospectively determined, fixed capitation payments from CMS.

D. Enrollment

During the period January 1, 2003 through December 31, 2007, the Plan experienced a net increase in enrollment of 5,729 members. An analysis of this increase in enrollment is set forth below:

	2003	2004	2005	2006	2007
Enrollment, January 1st	10,781	12,620	13,733	16,180	16,888
Net gain/(loss)	1,839	1,113	2,447	708	(378)
Enrollment, December 31st	12,620	13,733	16,180	16,888	16,510

E. Reinsurance

As of December 31, 2007, the Plan had an excess of loss reinsurance contract in effect with an authorized reinsurer, Employers Reinsurance Corporation. The contract's effective date was January 1, 2007 and it expired on December 31, 2007. Subsequent to the examination period, effective January 1, 2008, the Plan entered into a reinsurance contract with ReliaStar Life Insurance Company, an accredited reinsurer in the state of New York.

The reinsurance coverage in effect during 2007 was as follows:

Covered Services:	Hospital Services
Excess of Loss Retention:	$200,000 Deductible; 10% retention thereafter.
Policy Limit:	$2,000,000 per member per agreement period; $2,000,000 per member per lifetime.

F. Circular Letter No. 6 (2007) - Disaster Response Plan and Business Continuity Plan Questionnaires

During the examination, the Plan provided the examiner with its disaster response plan, which was established in conjunction with Metropolitan Jewish Health System (MJHS). The Plan did not maintain a business continuity plan.

Circular Letter No.6 (2007), which replaced Circular Letter No. 23 (2005), states in part:

> "…On June 1, 2007, and annually each June 1st thereafter, any Disaster Response Plan submitted to the Insurance Department should be updated, as necessary…

> On June 1, 2007, and annually each June 1st thereafter, the Disaster Response Questionnaire electronic template should be submitted to the Insurance Department...
>
> On June 1, 2007, and annually each June 1st thereafter, the Business Continuity Plan Questionnaire electronic template should be submitted to the Insurance Department…"

The examination disclosed that the Plan did not file the required annual Disaster Response Plan, nor did it file its annual Disaster Response Plan Questionnaire or Business Continuity Plan Questionnaire during the examination period.

It is recommended that the Plan comply with the requirements of Circular Letter No. 6 (2007) by filing with this Department its Disaster Response Plan, Disaster Response Plan Questionnaire and Business Continuity Plan Questionnaire on an annual basis.

G. Accounts and Records

During the course of the examination it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles, annual statement instructions and/or Department guidelines. The examiner also noted several deficiencies in the Plan's system of accounts, records and internal controls. A description of such items is as follows:

1. The examination revealed that during 2007, the Plan made $642,735 in commission payments to agents. According to the NAIC annual statement instructions, the appropriate line item for these payments in the "Underwriting and Investment Exhibit" should have been under "Commissions". However, in the Plan's 2007 filed annual statement, commission payments were erroneously allocated under the line item, "Salaries, wages and other benefits".

It is recommended that the Plan allocate commission payments to the appropriate line item of the Underwriting and Investment Exhibit.

2. Elderplan entered into arrangements with several Independent Practice Associations (IPAs) for various health care services. These arrangements call for the Plan to make payments to the IPAs on a capitated basis.

Section 101.4(c) of Department Regulation 164 (11 NYCRR 101.4(c)) states in part:

> "An insurer who uses a capitation arrangement to transfer all or part of its financial risk to a health care provider must do so by means of a contract approved by the superintendent. Before granting such approval the insurer shall have demonstrated to the satisfaction of the superintendent the financial responsibility of the health care provider to render the services covered by the in-network capitation and compliance with the provisions of this Part. If so demonstrated, the insurer is relieved of the reporting requirements for carrying a liability on its own balance sheet for underlying unpaid claims and expenses related to in-network capitated payments made pursuant to the financial risk transfer agreement. However, where a capitated arrangement contains a provision whereby retroactive payments may be made by the insurer for adverse in-network experience of the health care provider, or where the insurer is financially responsible for the payment of claims which exceed amounts set forth in the financial risk transfer agreement, then in both cases the insurer must report an unpaid claim liability on its balance sheet that is adequate to meet its contractual exposure."

During the examination period, the Plan held contracts with four (4) IPAs (Metrocare Group IPA, North Eastern Network IPA, Preferred Health Association and Star Health IPA, LLP), however, the Plan did not file any of these contracts with the Department.

It is recommended that the Plan comply with the requirements of Section 101.4(c) of Department Regulation 164 by filing all applicable risk sharing arrangements with this Department for approval.

In addition, Section 101.9(a)(3) of Department Regulation 164 (11 NYCRR 101.9(a)(3)) states in part:

> "…(3) The health care provider agrees that on an annual basis, it will submit within 120 days of the close of its fiscal year, to the insurer and the superintendent, a financial statement in a form prescribed by the superintendent, sworn to under penalty of perjury by the health care provider's chief financial officer, showing the health care provider's financial condition at the close of its fiscal year, together with an opinion of an independent certified public accountant ("CPA") on the financial statement of such health care provider…"

The examination revealed that the abovementioned IPAs did not submit their financial statements to the Plan, nor had these entities submitted their financial statements to the Insurance Department.

It is recommended that the Plan comply with the requirements of Section 101.9(a)(3) of Department Regulation 164 and take the steps necessary to ensure that the IPAs submit their financial statements to the Plan and this Department.

Section 101.5(a) of Department Regulation 164 (11 NYCRR 101.5(a)) states:

> "No agreement to transfer financial risk through a capitation arrangement may be entered into between an insurer and a health care provider unless such health care provider is financially responsible by virtue of having met the standards set forth in this section."

Further, Section 101.5(b) of New York Insurance Department Regulation 164 (11 NYCRR 101.5(b)) states in part:

> "…(b) The financial security deposit required by this Part ("required amount") shall at all times be at least equivalent to twelve and one half (12.5%) percent of the estimated annual in-network capitation revenue to be received from the insurer under the financial risk transfer agreement then in force…"

The examination determined that the IPAs had not made such security deposits, and as such, the Plan was responsible for carrying a liability on its balance sheet for the underlying unpaid claims and expenses related to in-network capitation payments made pursuant to the financial risk transfer agreement, as required by Section 101.4(c) of Department Regulation 164 (11 NYCRR 101.4(c)), as quoted above. The examination also disclosed that in three of the five years covered by the examination, the Plan's liability account, "Funds held pursuant to Regulation 164", was insufficiently funded, as illustrated in the following table:

Year	Required Deposit	Amount Deposited	Surplus/(Deficit
2003	NA	NA	NA
2004	629,234	247,493	(381,741)
2005	752,340	502,116	(250,224)
2006	979,877	524,990	(454,887)
2007	131,850	547,430	415,580

It is recommended that the Plan comply with the requirements of Section 101.5(b) of Department Regulation 164 and require that contracted IPAs make the requisite deposit, and when applicable, the Plan establish a liability in its financial statements as required by Section 101.4(c) of Department Regulation 164.

The instructions for the New York Data Requirements filing for health maintenance organizations requires that Report #13 be completed if a contracted risk-sharing entity (e.g. an IPA) has received or is projected to receive in-network capitation from the reporting HMO of more than $250,000 during any twelve-month period. The instructions further require that Parts

A through D of Report #13 be separately completed for each risk-sharing entity. During 2007, the Plan reported $10,852,086 as "Capitation Revenue" in its filed NAIC annual statement; however, the Plan reported "NONE" in Report #13 for each of the above referenced Parts, for all risk-sharing entities.

It is recommended that the Plan complete Report #13 in accordance with the instructions for the New York Data Requirements for Health Maintenance Organizations, and that all information contained in its filings with this Department be accurate and complete.

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, 2007. This is the same as the balance sheet filed by the Plan as of December 31, 2007:

Assets	Examination	Plan
Bonds	$ 58,273,896	$ 58,273,896
Common stock	12,549,397	12,549,397
Cash and short-term investments	47,148,723	47,148,723
Investment income due and accrued	829,950	829,950
Uncollected premiums and agents balances in course of collection	1,477,693	1,477,693
Accrued retrospective premiums	2,034,962	2,034,962
Amounts receivable relating to uninsured plans	956,960	956,960
Electronic data processing equipment and software	71,039	71,039
Receivables from parent, subsidiaries and affiliates	831,866	831,866
Total assets	$ 124,174,486	$ 124,174,486
Liabilities		
Unpaid claims	35,174,686	35,174,686
Unpaid claims adjustment expenses	1,654,057	1,654,057
General expenses due and accrued	3,660,643	3,660,643
Amounts withheld or retained for the accounts of others	135,736	135,736
Aggregate write-ins for other liabilities:		
Due to Medicaid	2,970,810	2,970,810
Funds held pursuant to Regulation 164	547,431	547,431
Unclaimed disbursements	144,361	144,361
Total liabilities	$ 44,287,724	$ 44,287,724
Capital and Surplus		
Gross paid in and contributed surplus	5,000,000	5,000,000
Contingent reserve NYS	19,931,888	19,931,888
Unassigned funds (surplus)	54,954,874	54,954,874
Total capital and surplus	79,886,762	79,886,762
Total liabilities, capital and surplus	$ 124,174,486	$ 124,174,486

Note: The Internal Revenue Service did not audit the tax returns filed by the Plan for the period of examination. The examiner is unaware of any potential exposure of the Plan to any further assessment, and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus increased by $85,801,353 during the five-year examination period, January 1, 2003 through December 31, 2007, detailed as follows:

Revenue		
Net premium income	$ 1,115,826,029	
Net investment gain	41,201,503	
Total revenue		$ 1,157,027,532
Hospital and Medical Expenses		
Hospital/medical benefits	$ 589,386,096	
Other professional services	90,119,513	
Emergency room and out-of-area	103,137,343	
Prescription drugs	101,058,067	
Net reinsurance recoveries	(2,367,968)	
Total medical and hospital expenses	$ 881,333,051	
Administrative Expenses		
Claims adjustment expenses	73,269,926	
General administrative expenses	138,403,605	
Total underwriting expenses		$ 1,093,006,582
Net underwriting gain		$ 64,020,950
Net investment gain		13,458,681
Net income		$ 77,479,631

Changes in Capital and Surplus	
Surplus per report on examination as of December 31, 2002	$ (5,914,591)

	Gains in Surplus	Losses in Surplus	
Net income	$ 77,479,631		
Change in non-admitted assets	6,525,155		
Change in net unrealized capital gain	4,796,566		
Change in surplus notes		$ 3,000,000	
Net increase to surplus			85,801,353
Surplus per report on examination as of December 31, 2007			$ 79,886,762

4. UNPAID CLAIMS

The examination liability of $35,174,686 is the same as that reported by the Plan in its filed annual statement as of December 31, 2007. The examination analysis of the unpaid claims liability was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at practices of the Plan relative to claims handling, utilization review and consumer complaints. In determining the scope of this review,

the examiner took into consideration the Plan's lines of business, Medicaid and Medicare, which fall under the purview of CMS' requirements, as opposed to the statutory requirements of the Departments of Health and Insurance. Thus, the market conduct review was limited.

No issues or areas of non-compliance were noted.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The previous report on examination as of December 31, 2002 contained seventeen (17) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
1.	As a result of this examination, Elderplan was determined to be insolvent in the amount of $6,381,196 and its required Contingency Reserve of $4,675,156 was impaired in the amount of $11,056,352 as of December 31, 2002. The Plan addressed the insolvency issue and was solvent as of the examination date.	1, 10, 23, 25
2.	Management Members of the board have a fiduciary responsibility and must evince An ongoing interest in the affairs of the insurer. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the board. Individuals who failed to attend at least one-half of the board's regular meetings, unless appropriately executed, do not fulfill such criteria. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced. The Plan has not complied with this recommendation. A similar recommendation is contained herein.	6
	Abandoned Property	
3.	It is recommended that the Plan comply with the provisions of Section 1315 and 1316 respectively of the New York Abandoned Property Law as regards the reporting of certain unclaimed property for the period 1998 through 2002. The Plan has complied with this recommendation.	9

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4.	It is also recommended that the Plan annually publish a list of names and last known addresses of persons appearing to be entitled to abandoned cash amounts and to file proof of such publication with the Office of the State Comptroller. The Plan has complied with this recommendation.	10
	Accounts and Records	
5.	It is recommended that Elderplan amend its custodian agreements with Fleet Bank to include the requisite safeguards and controls as set forth in the Department's Rules, and in the guidelines of the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners. This recommendation is not applicable since the Plan no longer used Fleet Bank as its custodian bank.	12
6.	It is recommended that the board of directors authorize and approve the Company's investment transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law. The Plan has complied with this recommendation.	12
7.	It is recommended that Elderplan comply with the guidelines set forth by the NAIC in the instructions to the annual and quarterly statements and that its general ledger is reconciled to the filed statutory statements. The Plan has complied with this recommendation.	13
8.	Part 98.16(e) of the Administrative Rules and Regulations of the Health Department requires entities to submit Holding Company filings. In addition, controlled entities are required to submit transactions between itself and its affiliates for approval by the Health and Insurance Departments when required, in accordance with the provisions of Part 98.10 of the Administrative Rules and Regulations of the Health Department. Accordingly, the matter has been referred to the New York State Department of Health ("DOH"). If Elderplan is determined by the DOH to be controlled by Metropolitan Jewish Health System ("MJHS"), Elderplan will be subject to such requirement. The Department of Health has not determined the Plan to be a controlled entity of MJHS, thus no action is required by the Plan at this time.	15

Due to Medicaid

9. It is recommended that Elderplan record a liability for interest payable by the due date of the next statutory statement in accordance with the determination of the decision after hearing of the Department of Health's Bureau of Adjudication. 18

The Plan has complied with this recommendation.

Conflict of Interest

10. It is recommended that the Company distribute annually Conflict of Interest disclosure statements and questionnaires to all directors, all officers, and designated responsible employees. 19

The Plan has complied with this recommendation.

11. It is also recommended that the board of directors maintain complete minutes of its proceedings on conflict of interest matters. 19

The Plan has complied with this recommendation.

Service Agreements

12. If Elderplan is determined by the Department of Health to be controlled by Metropolitan Jewish Health System, Elderplan will be subject to such requirements. 22

The Department of Health has not determined the Plan to be a controlled entity of MJHS, thus no action is required by the Plan at this time.
It is recommended that, subject to the determination of the Department of Health, the Plan comply with the provisions of Part 98.10 of the Administrative Rules and Regulations of the Health Department as regards its transactions with participating agencies of MJHS.

The Department of Health has not determined the Plan to be a controlled entity of MJHS, thus no action is required by the Plan at this time.

ITEM NO. **PAGE NO.**

13. It is also recommended that the Plan execute written agreements with all participating agencies of MJHS, wherein the terms of the transactions, the services performed, the charges or fees for such services and settlement terms shall be disclosed. 22

The Plan has complied with this recommendation.

Conclusion

14. Elderplan reported an insolvency in the amount of $5,914,591, and an impairment of its required Contingency Reserve of $4,675,156 in the amount of $10,589,747 in its filed 2002 Annual Statement. As a result of this examination, Elderplan was determined to be insolvent in the amount of $6,381,196 and its required Contingency Reserves of $4,675 was impaired in the amount of $11,056,352 as of December 31, 2002. 25

The Plan addressed the insolvency issue and was solvent as of the examination date.

15. Subsequent to the examination date, on February 21, 2003, Elderplan received $3,000,000 from Metropolitan Jewish Health System, Inc. and executed a loan agreement pursuant to Section 1307 of the New York Insurance Law. In addition, in August 2003 Elderplan submitted a revised Plan of Restoration to the Department to correct the insolvency. The Plan reported total capital and surplus in the amount of $3,836,930 as of December 31, 2003 and its required Contingency Reserves of $7,270,776 was impaired in the amount of $3,433,846. 25

The Plan addressed the insolvency issue and was solvent as of the examination date.

On June 12, 2006, the Superintendent of Insurance granted permission to Elderplan to repay principal in the amount of $3,000,000, and accrued interest in the amount of $423,229 to MJHS.

ITEM NO. **PAGE NO.**

Treatment of Policyholders and Claimants

16. It is recommended that Elderplan take necessary steps to ensure that all claims submitted are properly recorded in the claims system irrespective of whether there is sufficient documentation to adjudicate the claim. 28

The Plan has complied with this recommendation.

17. It is recommended that the Plan ensure that claims lag reports retain historical paid claims data and that adjustments are reflected in the lags in the month processed. 28

The Plan has complied with this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. 22691

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **Eric R. Dinallo**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Kevin Guo

as a proper person to examine into the affairs of the

Elderplan, Inc.

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

Plan

with such information as he shall deem requisite.

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

this 27th day of October 2008

Eric R. Dinallo
Superintendent of Insurance