REPORT ON EXAMINATION

OF

ELDERPLAN, INC.

AS OF

DECEMBER 31, 2012

DATE OF REPORT	**JULY 7, 2015**
EXAMINER	**KAIWEN K. GUO**

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Andrew M. Cuomo
Governor

Anthony J. Albanese
Superintendent

July 7, 2015

Honorable Anthony J. Albanese
Acting Superintendent of Financial Services
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 30886, dated October 4, 2012, 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, 2012, and submit the following report thereon.

The examination was conducted at the home office of Elderplan, Inc. located at 6323 7th Avenue, Brooklyn, NY.

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

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

Elderplan, Inc. was previously examined as of December 31, 2007. This examination is a combined (financial and market) examination and covers the five-year period January 1, 2008, through December 31, 2012. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2013 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Transactions occurring subsequent to December 31, 2012 were reviewed, where deemed appropriate by the examiner.

The financial component of the examination was conducted on a risk-focused basis, 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 Plan's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of the Plan.

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

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the

Plan'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 Plan was audited annually for the years 2008 through 2012, by the accounting firm, Loeb & Troper, LLP. The Plan received an unqualified opinion in each of those years. Certain audit work papers of Loeb & Troper, LLP were reviewed and relied upon in conjunction with this examination.

Elderplan is a participating entity of the Metropolitan Jewish Health System ("MJHS"). A review was also made of the MJHS Internal Audit function and Information Technology (IT) function as they relate to the Plan.

The examiner reviewed the corrective actions taken by the Plan with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item 7 of this report.

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 New York State 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 April 23, 2013, authorized the Plan to offer Medicaid Advantage and Medicaid Advantage Plus programs in Bronx, Kings, Monroe, Nassau, New York, Queens, Richmond and Westchester counties. The Plan is also approved to operate a partial capitation Managed Long-Term Care plan serving the Medicaid population in Bronx, Kings, Monroe, Nassau, New York, Queens, Richmond, Rockland and Suffolk counties. As of December 31, 2012, the Plan had approximately 22,309 members.

Elderplan, Inc. is a participating entity 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 an S/HMO. The demonstration project ceased on December 31, 2007.

Effective January 1, 2011, the Plan merged with another MJHS participating agency, Homefirst, Inc. ("HF"), a capitated Managed Long-Term Care Plan ("MLTCP").

The Plan's primary source of revenue is capitation premiums from the Centers for Medicare and Medicaid Services ("CMS") and partial capitation premiums from the Department of Health. 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. As a result of the merger with Homefirst, Inc., the Plan also received capitation premiums from the New York State Department of Health ("DOH") for the MLTCP. For the year 2012, the Plan's premiums from CMS and DOH totaled $27,761,146 and $26,639,065, respectively.

A. Management and Controls

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 members; with at least twenty percent (20%) of the Directors being subscribers of the Plan. The term of office for each Director is one year, until the next annual meeting of the Directors.

The nine (9) members of the Board of Directors as of December 31, 2012, were as follows:

Name and Residence	Principal Business Affiliation
Burton Esrig Neptune, New Jersey	President, Stony Brook Group
Eli S. Feldman Marlboro, NJ	President & CEO, Metropolitan Jewish Health System

Name and Residence	Principal Business Affiliation
Arthur Goshin, MD North Hills, NY	Physician, Univera Healthcare

Howard Greenberg Woodbury, NY	Senior Manager, Deloitte Consulting LLP
Ronald B. Milch New York, NY	President and CEO, Combined Coordinating Council, Inc.
Diane P. Pollard* New York, NY	President of the Board, St. Mary's Episcopal AIDS Center
Peter Post Armonk, NY	Managing Partner, Roth Post Advisors
Hilda Rayas Milford, PA	Chief Operating Officer US Hispanic Chamber of Commerce
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 meetings were generally well attended with all members attending at least 50% of the meetings they were eligible to attend.

Section 1 of Article VI of the Plan's by-laws states:

> *"The officers of the Corporation shall consist of the Chair, President, Vice Chair, Treasurer, Secretary and Assistant Secretary, all of whom except for the President and Assistant Secretary, shall be chosen from among members of the Board of Directors. No person may hold more than one office of the Corporation."*

The examination review indicated that one member of the Board of Directors held both office of Secretary and Treasurer in the years 2009, 2011 and 2012.

It is recommended that the Plan comply with its by-laws by ensuring that no Board member holds more than one Officer position at any given time.

The principal officers of the Plan as of December 31, 2012, were as follows:

Name	Title
Eli S. Feldman	President/Chief Executive Officer
Alexander S. Balko	Treasurer/Chief Financial Officer
Robert Leamer	Assistant Secretary

B. Corporate Governance

As a participating agency of the MJHS, Elderplan has shared services supported by the MJHS organization including Information Technology, Legal, Corporate Compliance, Finance, Human Resource, Internal Audit, Administration and Planning, Business Development, Public Relations and Marketing.

Exhibit M of the Handbook (Understanding the Corporate Governance Structure) was utilized by the examiner as guidance for assessing corporate governance. Overall, it was determined that the Plan's corporate governance structure is adequate, sets an appropriate "tone at the top," and supports a proactive approach to operational risk management. The Plan's Board of Directors and key executives encourage integrity and ethical behavior throughout the Plan.

The Plan's management has a general approach to identifying and mitigating risks across the organization, including prospective business risks. Through risk discussions and other measures, the Plan's management discusses significant issues and reacts to changes in the environment with a clear commitment to address risk factors and manage the Plan accordingly.

During 2012, MJHS hired Deloitte & Touche (D&T), as a consultant, to conduct an independent review of the effectiveness of MJHS' compliance program. The review also included

an assessment of Elderplan's compliance program, which was designed by its Regulatory Compliance Department. The goals of the assessment were to (1) evaluate the Compliance Department's ability to identify potential risks, (2) proactively and effectively manage system-wide risks, and (3) evaluate the Plan's Compliance Department with regard to the guidance provided by the Centers for Medicare & Medicaid Services ("CMS") and the New York State Department of Health ("DOH"). D&T's review determined that Elderplan's Director of Regulatory Compliance also provided oversight for the day-to-day management of the Plan's Regulatory Department. It is considered a conflict of interest for the same individual conducting audits/ reviews to also implement oversight of the Plan's day-to-day operations.

It is recommended that Plan avoid any appearance of a conflict of interest by having separate individuals perform the duties of oversight of Regulatory Compliance and the duties of oversight of day-to-day management in the same department.

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 April 23, 2013, 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.
- The counties of Bronx, Kings, Monroe, Nassau, New York, Queens, Richmond and Westchester are designated as Medicare only. Elderplan is limited to enrolling and offering only Medicare products in these counties. In order to offer any other product in these counties or enroll a non-Medicare population, Elderplan, Inc. must submit an

application to the Department at least 90 days prior to the proposed implementation date.

- Elderplan, Inc. is approved to serve the dual eligible population through the Medicaid Advantage and Medicaid Advantage Plus Program in Bronx, Kings, Monroe, Nassau, New York, Queens, Richmond and Westchester counties. The provisions of health care services in these counties is contingent upon execution of a Medicaid Advantage contract and a Medicaid Advantage Plus contract.
- Elderplan, Inc. will operate in accordance with all applicable State and Federal requirements. The Department's approval is based upon information provided by the Plan. A comprehensive review of the Plan's policies and procedures associated with the operation of health of the Medicare Advantage Program was conducted. All aspects of operation in these counties will be governed primarily by the Center for Medicare and Medicaid Services.
- Elderplan, Inc. is approved to operate a partial capitation Managed Long-Term Care Plan serving the Medicaid population consistent with Section 4403 of the New York State Public Health Law in the Bronx, Kings, Monroe, Nassau, New York, Queens, Richmond, Rockland, Suffolk and Westchester counties.

Elderplan, Inc. is a prepaid health plan for 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 the CMS and the New York State Department of Health.

D. Enterprise Risk Management

Circular Letter No. 14 (2011) – "*Enterprise Risk Management"*, issued to all domestic insurers and HMOs states in part:

> "Given the importance of risk management, the Department of Financial Services ("Department") expects every insurer to adopt a formal Enterprise Risk Management ("ERM") function. An effective ERM function should identify, measure, aggregate, and manage risk exposures within predetermined tolerance levels, across all activities of the enterprise of which the insurer is part, or at the company level when the insurer is a stand alone entity…"

For the examination period, the Plan did not formally adopt an ERM framework for proactively addressing and mitigating risks, including prospective business risks as required by Circular Letter No. 14 (2011).

It is recommended that the Plan comply with the provisions of Circular Letter No. 14 (2011) by adopting a formal Enterprise Risk Management function.

E. Internal Audit

The NAIC's *Financial Examiners Handbook* states in part:

> *"…The Institute of Internal Auditors provides a framework of standards for performing and promoting internal auditing. To be fully independent for purpose of exam reliance, internal auditors should report directly to the Audit Committee or Board of Directors instead of company management and should not assume any management responsibility."*

Section 1111 of the Institute of Internal Auditors' ("IIA") International Standards for the Professional Practice of Internal Auditing (Standards) states:

> *"The chief audit executive must communicate and interact directly with the board."*

A review of the Plan's Internal Audit Department ("IAD") revealed that the IAD consisted of only one person. This person acts in the capacity of both the Chief Audit Executive and the Internal Auditor, and is responsible for the internal audit function of the entire MJHS organization, including Elderplan and its participating agencies. During the examination period, only three internal audits were conducted on Elderplan's operations. The audits were conducted on commissions, enrollment and grievances. The review also revealed that the Internal Auditor reported directly to the Plan's Chief Financial Officer and the Executive Committee of MJHS'

Board of Directors, but was not required to report to the Board of Directors of the Plan. Audits were usually conducted based only on whether an issue was noted. Additionally, the Plan did not have any written formal policies and procedures for its Internal Audit Department.

It is recommended that the Plan adhere to the standards promulgated by both the Institute of Internal Audit and the Handbook to ensure the independence of the internal audit function.

It is also recommended that the Internal Audit Department report directly to the Plan's Board of Directors.

Section 2040 of the IIA standards states in part:

> *"The chief audit executive must establish policies and procedures to guide the internal audit activity..."*

It is recommended that the Plan adhere to the standards of the Institute of Internal Audit by establishing policies and procedures to guide its internal audit activities.

Section 2040 of the Institutes of Internal Auditors ("IIA") standards states in part:

> *"The chief audit executive must communicate the internal audit activity's plan and resource requirements, including significant interim changes, to senior management and the board for review and approval..."*

It is recommended that the Plan implement a written audit plan for internal audit activity and require the review and approval of such audit plan by senior management and its Board of Directors.

When an internal audit is conducted, findings are presented to the appropriate functional unit manager so that the findings can be remediated and closed. A review was conducted to

determine if the Plan was actively monitoring actions taken to remediate prior internal audit findings. A sample of internal audit recommendations were requested and reviewed. It should be noted that the internal audit function did not require a unit's corrective action plan to be formally documented; any corrective actions taken by the unit were communicated by way of an email notification to the internal auditor.

It is recommended as a good business practice that each unit, which receives findings from the Plan's Internal Audit Department, submit a written corrective action plan to the Internal Audit Department and that such plan be monitored until the findings have been remediated.

F. Conflict of Interest Policy

The Plan has a shared Ethics and Conflict of Interest Policy with MJHS. Section 2(b) of the policy states:

> *"The following procedures will be completed on an annual basis:*
>
> *a. Conflict of Interest policy is reviewed during the "Compliance portion" of the mandatory in service training for all employees.*
>
> b. *Conflict of Interest Statement" (Exhibit B) is completed by management staff and position above."*

The examiner reviewed the Conflict of Interest Statements of the Directors and Officers for the examination period. It was noted that not all of the Directors and Officers completed a Conflict of Interest Statement on an annual basis, as required by Section 2(b) of the Plan's Ethics and Conflict of Interest Policy. Additionally, it was noted that some of the Officers did not complete a Conflict of Interest Statement during the examination period covered by this exam.

It is recommended that the Plan comply with Section 2(b) of its Ethics and Conflict of Interest Policy by having all of its Directors and Officers complete a Conflict of Interest Statement on an annual basis.

It is also recommended that the Plan adopt procedures to ensure that all Directors and Officers complete a Conflict of Interest Statement on an annual basis.

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

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..."*

Upon review it was determined that the aforementioned annual certifications were not obtained during the examination period.

It is recommended that the Plan comply with Circular Letter No. 9 (1999) by having its Board obtain the required annual certifications.

A similar recommendation appeared in the prior report on examination.

H. Enrollment

During the five-year examination period January 1, 2008 through December 31, 2012, the Plan experienced a net increase in enrollment of 5,799 members. An analysis of this increase in enrollment is set forth below:

	2008	2009	2010	2011	2012
Enrollment, January 1st	16,510	18,268	15,269	18,968	19,457
Net gain/(loss)	1,758	(2,999)	3,699	489	2,852
Enrollment, December 31st	18,268	15,269	18,968	19,457	22,309

I. Reinsurance

As of December 31, 2012, the Plan had an excess-of-loss reinsurance contract in effect with an authorized reinsurer, RGA Reinsurance Company (RGA). The reinsurance contract's effective date was January 1, 2012 and it expired on December 31, 2012. Subsequent to the examination period, effective January 1, 2013, the Plan renewed its reinsurance contract with RGA.

The reinsurance coverage in effect during 2012 was as follows:

Covered services:	Inpatient hospital services; inpatient rehabilitation services; skilled nursing facility services; home health care services; drug related services.
Excess-of-loss retention:	$225,000 deductible; Plan's retention 10%
Policy limit:	$2,000,000 per member per agreement period; $2,000,000 per member per lifetime.

J. Supplement 3 to Circular Letter No. 10 (2002) – *"USA Patriot Act of 2001-Final Rules Issued by Financial Crimes Enforcement Network ("Treasury Department")"*

Supplement 3 to Circular Letter No. 10 (2002) states in part:

> *"The final rule requires insurance companies to establish anti-money laundering programs, as specified under Section 352 of the USA PATRIOT Act…*
>
> *Under the rule, a company must establish and maintain a written anti-money laundering program applicable to its covered products that are reasonably designed to prevent the insurer from being used to facilitate money laundering or the*

> *financing of terrorist activities. The program must be approved by senior management and at a minimum: (i) incorporate policies, procedures, and internal controls based on the company's assessment of its money laundering risks, including provisions integrating the company's agents and brokers into its anti-money laundering program; (ii) designate a compliance officer responsible for ensuring that the program is implemented effectively; (iii) establish an ongoing training program for appropriate persons concerning their responsibilities under the program; and (iv) establish an independent audit function to test programs…"*

Section 352 of the USA PATRIOT ACT - "*Establishing Anti-Money Laundering Programs*", requires all financial institutions, including all insurance companies, to establish an anti-money laundering program.

For the examination period, it was noted that the Plan failed to establish a formal anti-money laundering program, as specified by the Circular Letter.

It is recommended that the Plan comply with the requirements of Circular Letter No. 10 (2002) by establishing a formal anti-money laundering program.

K. Investment activities

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

> "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."

For the examination period under review, the Plan had an Investment Committee ("IC"). Upon review of the Plan's IC's minutes, it was noted that the Investment Committee did not approve any of the Plan's investment transactions, but only monitored the performance of the Plan's investment portfolio.

It is recommended that the Plan comply with Section 1411(a) of the New York Insurance Law by having its Board of Directors or Investment Committee approve all investment transactions made by the Plan.

Additionally, it is recommended that such investment transactions be reflected in the Investment Committee's minutes and a report detailing such transactions be submitted to the Board of Directors at the next applicable meeting.

L. 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. On January 1, 2011, Homefirst, Inc., another MJHS participating entity, merged into the Plan and ceased operations on the same day. The examination revealed that as of December 31, 2012, the Deed of Trust account of Homefirst, Inc. remained under the name and Employer Identification Number ("EIN") of Homefirst, Inc. Such Deed of Trust should have been changed to Elderplan's corporate name.

It is recommended that the Plan combine Homefirst, Inc.'s Deed of Trust account with Elderplan's Deed of Trust account to reflect the merged entity.

2. The NAIC's Health Annual Statement Instructions state in part:

> *"...Provide a detailed explanation of the by-state and territory allocation of premium and other considerations used by the reporting entity. The explanation should be detailed enough to determine compliance with state laws and regulations..."*

It should be noted that the Plan failed to comply with the abovementioned instructions when it did not include a detailed explanation, by-state and territory, of the basis premium allocation in the footnote of Schedule T of its filed annual statement.

It is recommended that the Plan comply with the NAIC annual statement instructions by including all of the required information in the footnote of its filed Schedule T.

3. The NAIC's Health Annual Statement Instructions states in part:

> *"…A Summary Page shows a reconciliation with Schedule H for Individual, Group and Credit policies separately and in total for companies filing the Life, Accident and Health, Fraternal and Property/Casualty Annual Statement, and a reconciliation of these policies in total only with the specified exhibits of the Health Annual Statement for companies filing that statement…"*

The Plan's Summary Page of its filed Accident and Health Policy Experience Exhibit for 2012 failed to include a reconciliation with Schedule H of the Plan's Individual and Group policies in total; the Exhibit was left completely blank.

It is recommended that the Plan comply with the NAIC's Annual Statement Instructions by completing the Accident and Health Policy Experience Exhibit in accordance with the Instructions.

4. Section 310(a)(2) of the New York Insurance Law states in part:

> *"Any examiner authorized by the superintendent shall be given convenient access… to books, records, files, securities and other documents of such insurer… which are relevant to the examination…"*

Part 89.11 of Insurance Regulation No. 118 (11 NYCRR 89.11) states in part:

> *"Every company shall require the CPA to make available for review by department examiners, all work papers prepared in the conduct of the CPA's audit and any communications related to the audit between the CPA and the company, at the offices of the company, at the department, or at any other reasonable place designated by the superintendent..."*

During the examination period, the Plan utilized the services of Loeb and Troper LLP as its CPA. When requesting the CPA's work papers, the examiner was often told that some of the requested work papers were related to planning work or were proprietary work papers, and as such they could not be provided to the examiner. As a result, a significant portion of the CPA's work papers were not initially provided. The complete set of work papers was finally provided after the examiner's repeated requests, but the delay affected the progress of the examination.

It is recommended that the Plan comply with the requirements of Section 310(a)(2) of the New York Insurance Law and Part 89.11 of Insurance Regulation No. 118 by making available for review all CPA work papers requested by the examiner.

5. Part 89.5(e)(2) of Insurance Regulation No. 118 (11 NYCRR 89.5(e)(2)) states:

> *"The company shall attach a statement to its audited annual financial statement, when filed, that the CPA does not function in the role of management, does not audit his or her own work, and does not serve in an advocacy role for the company."*

The Plan failed to comply with the requirements of Part 89.5(e)(2) of Insurance Regulation No. 118, when it did not provide the aforementioned statement with its audited annual financial statement.

It is recommended that the Plan comply with Part 89.5(e)(2) of Insurance Regulation No. 118 by attaching a statement to its audited annual financial statement with respect to its CPA's role.

6. Part 89.12(e) of Insurance Regulation No. 118 (11 NYCRR 89.12(e)) states:

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

Elderplan established an Audit Committee of five (5) members in 2010, comprised of Board members, Executive and senior management and a Plan beneficiary (an enrollee representative). Additionally, in 2012, one member of the Audit Committee was replaced. The Plan failed to provide the written notice of both the establishment of the Audit Committee and the change in membership to the Department as required by the abovementioned Regulation.

It is recommended that the Plan comply with Part 89.12(e) of Insurance Regulation No. 118 by providing the required notice to the Department.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following statements show the assets, liabilities, and surplus as of December 31, 2012, as contained in the Plan's 2012 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2012 filed annual statement.

Independent Accountants

The firm of Loeb & Troper, LLC was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

Loeb & Troper, LLC concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

Assets	Examination	Plan	Surplus Increase/ (Decrease)
Bonds	$ 77,761,630	$ 77,761,630	
Common stock	8,625,261	5,964,850	2,660,411
Cash and short-term investments	31,039,292	33,699,703	(2,660,411)
Receivables for securities	2,345,088	2,345,088	
Investment income due and accrued	168,136	168,136	
Uncollected premiums and agents balances in course of collection	25,841,041	25,841,041	
Accrued retrospective premiums	4,747,412	4,747,412	
Amounts receivable relating to uninsured plans	177,510	177,510	
Electronic data processing equipment and software	139,082	139,082	
Receivables from parent, subsidiaries and affiliates	181,078	181,078	
Total assets	$ 151,025,530	$ 151,025,530	0
Liabilities			
Unpaid claims	54,420,211	54,420,211	
Unpaid claims adjustment expenses	2,536,056	2,536,056	
Aggregate health policy reserves	4,657,339	4,657,339	
General expenses due and accrued	8,423,177	8,423,177	
Amounts withheld or retained for the accounts of others	744,881	744,881	
Amount due to parent, subsidiaries and affiliates	1,292,761	1,292,761	
Payable for securities	4,481,393	4,481,393	
Liability for amounts held under uninsured plans	1,884,273	1,884,273	
Aggregate write-ins for other liabilities	122,912	122,912	
Total liabilities	$ 78,563,003	$ 78,563,003	
Capital and Surplus			
Gross paid-in and contributed surplus	5,000,000	5,000,000	
Contingent reserve NYS	41,044,610	41,044,610	
Unassigned funds (surplus)	26,417,917	26,417,917	
Total capital and surplus	72,462,527	72,462,527	
Total liabilities, capital and surplus	$ 151,025,530	$ 151,025,530	

Note 1: The Plan is a nonprofit cooperation as defined by Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income tax.

Note 2: The Internal Revenue Service ("IRS") did not audit the tax returns filed by the Plan for the period under 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 and Expenses and Capital and Surplus

Capital and surplus decreased by $7,424,235 during the five-year examination period, January 1, 2008 through December 31, 2012, detailed as follows:

Revenue		
Net premium income	$ 1,744,760,834	
Total revenue		$ 1,744,760,834
Hospital and medical expenses		
Hospital/medical benefits	$ 681,097,958	
Other professional services	515,575,064	
Emergency room and out-of-area	187,469,685	
Prescription drugs	111,342,937	
Net reinsurance recoveries	(3,796,244)	
Total hospital and medical expenses	$ 1,491,689,400	
Administrative expenses		
Claims adjustment expenses	125,090,632	
General administrative expenses	164,173,712	
Increase in reserve for life and accident and health contracts	4,657,339	
Total underwriting expenses		$ 1,785,611,083
Net underwriting loss		$ (40,850,251)
Net investment gain		17,132,471
Net loss		$ (23,717,778)

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus per report on examination, as of December 31, 2007			$ 79,886,762
Net loss		$ 23,717,778	
Change in non-admitted assets		6,253,778	
Change in net unrealized capital losses		5,603,542	
Aggregate write-ins for gains and losses in surplus		6,800,000	
Retroactive effect of the merger*	$ 34,950,863		
Net decrease in capital and surplus			(7,424,235)
Capital and surplus per report on examination, as of December 31, 2012			$ 72,462,527

***Note:** The 2011 financial statement was restated to reflect the merger with Homefirst, Inc. ("HF") which was accounted for as a statutory merger. The 2011 statutory financial statement illustrated the retroactive effect of the merger and included the combined operations of the Plan and HF for all periods presented.

4. COMMON STOCK

The examination amount of $8,625,261 is $2,660,441 greater than the amount reported by the Plan in its December 31, 2012 annual statement, for the above captioned account. The difference is due to the reclassification of monies invested by the Plan in money market mutual funds.

The NAIC Annual Statement Instructions for Schedule D-Part 2, Section 2 states in part:

> *"…Shares of all mutual funds, regardless of the underlying security, whether specialized or a mixture of bonds, stock, money market instruments or other type of investments, except those mutual funds as defined in the Purposes and Procedures Manual of the NAIC Securities Valuation Office that are reported in*

Schedule D, Part 1 or Schedule DA, Part 1, are considered to be shares of common stock and should be listed in the appropriate category of Mutual Funds or Money Market Mutual Funds…"

Plan investments in money market mutual funds totaling $2,660,411 were incorrectly classified as short-term investments.

It is recommended that the Plan comply with the provisions of Schedule D-Part 2, Section 2 of the NAIC's Annual Statement Instructions by classifying investments in money market mutual funds as "common stock", in its filed annual statements.

5. CASH AND SHORT-TERM INVESTMENTS

The examination amount of $31,039,262 is $2,660,441 less than the amount reported by the Plan on its December 31, 2012 annual statement for the above captioned account. The difference is due to reclassification of monies invested by the Plan in money market mutual funds, as indicated in Section 4 of this report.

6. 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.

In determining the scope of this review, the examiner took into consideration the Plan's lines of business, Medicare and MLTC, which fall under the purview of CMS' requirements and

requirements of the Department of Health, as opposed to the statutory jurisdiction of the Departments of Financial Services. Thus, the market conduct review was limited.

The review was directed at the practices of the Plan in the following areas:

A. Claims processing

B. Compliance with Circular Letter No. 11 (1978) and Department Regulation No. 64 (11 NYCRR 216.4)

A. Claims Processing

The Plan receives its claims both electronically (EDI) and by paper (mailed using the US Post Office). Approximately 50% of all claims were submitted electronically in 2012. For electronically submitted claims, the Plan utilized the service of TransSend as a clearing house. Electronic claims were processed by Elderplan using the Managed Care Optimizer ("MCO") claims system.

A review of the Plan's claims practices and procedures was performed using a statistical sampling methodology covering claims processed during the period January 1, 2012 through December 31, 2012, in order to evaluate the overall accuracy and compliance of the Plan's claims processing environment. It should be noted that although there were some financial and procedural errors discovered with regards to Plan's claims, the errors were immaterial in nature and warranted no further review.

B. Compliance with Circular Letter No. 11 (1978) and Insurance Regulation No. 64 (11 NYCRR 216.4)

Department Circular Letter No. 11 (1978) states in part:

> *"…As part of its complaint handling function, the company's consumer services department will maintain an ongoing central log to register and monitor all complaint activity. The log should be kept in a columnar form and list the following…*
>
> *5. The person in the company with whom the complainant has been dealing.*
>
> *6. The person within the company to whom the matter has been referred for review…*
>
> *8. Bearing in mind the appropriate regulation mandating timely substantive replies, the dates of correspondence to the Insurance Department's Consumer Services Bureau.*
>
> *A. The acknowledgement (if any)…*
>
> *C. The chronology of further contacts with this Department."*

It should be noted that the Plan's complaint log failed to include items 5, 6 & 8 above.

It is recommended that the Plan comply with the provisions of Circular Letter No. 11 (1978) by including all of the required items in its complaint log.

Insurance Regulation No. 64 (11 NYCRR 216.4) states in part:

> *"(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer. Notification given to an agent of an insurer shall be notification to the insurer. If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant that the agent is not authorized to receive notices of claims.*
>
> *(b) An appropriate reply shall be made within 15 business days on all other pertinent communications."*

During 2012, the Department's Consumer Assistance Unit ("CAU") received thirty-seven (37) complaints against the Plan. Upon receiving a complaint, the Department furnished the Plan with a letter requiring the Plan to respond to the Department within fifteen (15) business days. The examiner selected a sample of fifteen (15) complaint files and found that in three (3) cases the Plan failed to respond to the CAU's inquiry within fifteen (15) business days.

It is recommended that the Plan comply with Insurance Regulation No. 64 by responding to the Department's inquiries within fifteen (15) business days.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The previous report on examination as of December 31, 2007 contained eight (8) comments and recommendations (page numbers refer to the prior report on examination):

ITEM NO.		PAGE NO.
	Management and Controls	
1.	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 Plan has complied with this recommendation.*	6
	Circular Letter No. 9 (1999) – Adoption of Procedure Manuals	
2.	It is recommended that the Plan's board obtain the certifications cited in Circular Letter No. 9 (1999). *The Plan has not complied with this recommendation.*	7
	Circular Letter No. 6 (2007) – Disaster Response Plan and Business Continuity Plan Questionnaires	
3.	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. *The Plan has complied with this recommendation.*	10
	Accounts and Records	
4.	It is recommended that the Plan allocate commission payments to the appropriate line item of the Underwriting and Investment Exhibit. *The Plan has complied with this recommendation.*	11
5.	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. *The Plan has complied with this recommendation.*	11

ITEM NO. **PAGE NO.**

Accounts and Records (cont'd)

6. It is recommended that the Plan comply with the requirements of Section 101.9(a)(3) of Department Regulation No. 164 and take the steps necessary to ensure that the IPAs submit their financial statements to the Plan and this Department. 12

The Plan has complied with this recommendation.

7. It is recommended that the Plan comply with the requirements of Section 101.5(b) of Department Regulation No. 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 No. 164. 13

The Plan has complied with this recommendation.

8. 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. 14

The Plan has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____
Kevin K. Guo
Associate Insurance Examiner

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

Kevin K. Guo, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Kevin K. Guo

Subscribed and sworn to before me
this _____ day of_____2015.

APPOINTMENT NO. 30886

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, 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:*

Kevin Guo

as a proper person to examine the affairs of the

Elderplan, 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 4th day of October, 2012

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: Stephen J. Wiest

Stephen J. Wiest
Deputy Bureau Chief
Health Bureau