

**REPORT ON EXAMINATION**

**OF**

**ELDERPLAN, INC.**

**AS OF**

**DECEMBER 31, 2016**

**DATE OF REPORT**

**OCTOBER 6, 2019**

**EXAMINER**

**TOMMY KONG, CFE, PIR**

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## Department of Financial Services

**ANDREW M. CUOMO**  
Governor

**LINDA A. LACEWELL**  
Superintendent

October 6, 2019

Honorable Linda A. Lacewell  
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 Number 31656, dated August 17, 2017, attached hereto, I have made an examination into the condition and affairs of Elderplan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2016, and respectfully submit the following report thereon.

The examination was conducted at the main administrative office of Elderplan, Inc. located at 6323 7<sup>th</sup> Avenue, Brooklyn, New York.

Wherever the designations "Elderplan" or the "HMO" appears 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, 2012. This examination of the HMO was a combined (financial and market conduct) examination and covered the four-year period from January 1, 2013 through December 31, 2016. 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, 2017 Edition* (the “Handbook”). The financial examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2016 were also reviewed.

The financial portion 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 Elderplan’s operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate Elderplan’s current financial condition, as well as to identify prospective risks that may threaten the future solvency of the HMO.

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 Elderplan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the HMO's risks and management activities in accordance with the NAIC's nine branded risk categories. These categories are as follows:

- Credit
- Legal
- Liquidity
- Market
- Operational
- Pricing / Underwriting
- Reputational
- Reserving
- Strategic

The examination also evaluated the HMO's risks and management activities in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Appropriateness / Adequacy of Reinsurance Program
- Appropriateness of Investment Portfolio and Strategy
- Capital Management
- Liquidity Considerations
- Reinsurance Reporting and Collectability
- Related Party / Holding Company Considerations
- Reserve Adequacy
- Reserve Data
- Underwriting and Pricing Strategy / Quality
- Valuation/Impairment of Complex or Subjectively Valued Invested Assets

The HMO was audited annually, for the years 2013 through 2016, by the accounting firm Loeb & Troper, LLP ("LT"). Elderplan received an unmodified opinion from LT for each of those years. Certain audit workpapers of LT were reviewed and relied upon in conjunction with this examination. Elderplan is a participating agency of the Metropolitan Jewish Health System, and as such, a review was also made of Metropolitan Jewish Health System's internal audit and information technology functions as they relate to the HMO.

A review was also made to ascertain what actions were taken by Elderplan with regard to the comments and recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 5 of this report.

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 an explanation or description.

## **2. DESCRIPTION OF THE HMO**

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 HMO was granted a Certificate of Authority by the New York State Department of Health to operate as a health maintenance organization pursuant to the provisions of Article 44 of the New York Public Health Law. The initial Certificate of Authority authorized the HMO to provide services to Medicare enrollees who reside in New York, Queens, Kings, or Richmond county. The HMO's latest amended Certificate of Authority, effective December 15, 2016, authorized the HMO to offer Medicare in the following counties: Bronx, Kings, Monroe, Nassau, New York, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester. In addition, the HMO is authorized to provide managed health care services to dual-eligible members, those who are qualified to receive Medicare and Medicaid through the Medicaid Advantage Plus Program, who reside in Bronx, Kings, Nassau, New York, Queens, Richmond, or Westchester county. The HMO is also approved to operate a partial capitation Managed Long-Term Care Plan which serves the Medicaid population in the following counties: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Elderplan is a participating agency of the Metropolitan Jewish Health System (“MJHS”), a long-term care institution domiciled in Brooklyn, New York. On January 1, 2011, the HMO merged with HomeFirst, Inc., a capitated Managed Long-Term Care Plan and a participating agency of MJHS.

Elderplan’s primary source of revenue is capitation premiums from the United States Centers for Medicare and Medicaid Services (“CMS”) and partial capitation premiums from the New York State Department of Health (“DOH”). The premiums received from CMS are for Medicare Parts A and B. On January 1, 2006, the HMO began offering pharmacy coverage under Medicare Part D. After the merger with HomeFirst, Inc., the HMO received additional capitation premiums from DOH for the Managed Long-Term Care Plan.

A. Corporate Governance

Pursuant to Elderplan’s by-laws, management of the HMO is to be vested in a Board of Directors consisting of not less than five (5) but no more than twenty-one (21) members, and with at least twenty percent (20%) of the directors being subscribers of the HMO. As of December 31, 2016, the directors of Elderplan were comprised of the following ten (10) members:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Alexander S. Balko Point Lookout, New York	CEO & President, Elderplan, Inc.
Bradley Fleugel Chicago, Illinois	Senior Vice President & Chief Healthcare Commercial Market Development Officer, Walgreen Co.
William Gormley Lake George, New York	President, William J. Gormley, LLC
Arthur Goshin, M.D. Santa Fe, New Mexico	CEO & President, Healthy World Foundation

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>
Stephen Jackson New York, New York	CEO & President, AlignCare
Benjamin Karsch Stamford, Connecticut	Chief Marketing Officer, Revlon
Amir Kishon New York, New York	CEO, Wellness Layers
Barbara LaTesta * Brooklyn, New York	Senior Ambassador, Elderplan, Inc.
Ronald B. Milch New York, New York	Retired
Danielle Rollmann Princeton, New Jersey	Policy Analyst, Pfizer Inc.

\* Enrollee representative per Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.11(g)).

The minutes of all meetings of the Board of Directors and committees thereof held during the examination period were reviewed. The review indicated all Board and committee meetings were well attended, with all Board members attending at least one-half of the meetings they were eligible to attend. It was also noted that the Board met four times during each calendar year covered by the examination period.

Elderplan with having just one enrollee who serves as a Board member failed to comply with Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.11(g)), which requires a managed care organization (“MCO”), within a year of becoming operational, to have *“no less than 20 percent of the members of the governing authority shall be enrollees.”*

It is recommended that Elderplan comply with Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health by having the required minimum percentage of enrollees within its Board composition.

Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.11(g)(2)) states in part:

*“Employees of the MCO...may not serve as enrollee or consumer representatives.”*

It was also noted that, for the examination period, the same enrollee who served as a Board member was also an employee of Elderplan.

It is recommended that Elderplan comply with Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health by having enrollees who serve as Board members not be employees of the HMO.

The principal officers of Elderplan, as of December 31, 2016, were as follows:

<u>Name</u>	<u>Title</u>
Alexander S. Balko	Chief Executive Officer & President
David Wagner	Chief Operating Officer & Chief Financial Officer
Robert Leamer	Assistant Secretary

B. Enterprise Risk Management

As of December 31, 2016, the HMO has maintained an enterprise risk management program, as required by Insurance Circular Letter No. 14 (2011).

C. Insurance Circular Letter No. 9 (1999): Adoption of Procedure Manuals

Insurance Circular Letter No. 9 (1999) states in part:

*“In order to fulfill its responsibility to oversee the claims adjudication process...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.”*

For the years under examination, the HMO's Board of Directors failed to obtain the required annual certifications from either the Director of Internal Audit or an independent Certified Public Accountant ("CPA") that the responsible officers have implemented procedures adopted by the Board, and from Elderplan's General Counsel: a statement that the HMO's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable New York State statutes, rules and regulations.

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

A similar recommendation was included in the prior report on examination.

D. Territory and Plan of Operation

Elderplan is a prepaid health plan for elderly members. The HMO 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 and the New York State Department of Health.

Elderplan markets its products using a combination of direct response mail, telemarketing, radio, television, print ads and public educational venues to generate prospects who are interested in the coverage options available through the HMO. The HMO sells its policies using captive agents, as well as independent brokers.

The HMO's total revenues (net of reinsurance) for each year of the examination period were as follows:

<u>Calendar Year</u>	<u>Total Revenues</u>	<u>% Increase</u>
2013	645,908,992	—
2014	778,104,970	20.5%
2015	811,907,717	4.3%
2016	843,544,497	3.9%

As of December 31, 2016, the HMO wrote \$841,453,344 in total direct premium. The majority of Elderplan's premiums were written in the following five (5) New York State counties:

<u>County</u>	<u>Enrollment</u>	<u>Premiums</u>	<u>Percentage</u>
Kings	10,327	\$362,857,438	43.1%
New York	3,668	\$135,792,875	16.1%
Queens	3,466	\$113,441,116	13.5%
Bronx	2,913	\$ 98,937,601	11.8%
Westchester	1,180	\$ 41,997,729	5.0%

The chart below depicts total enrollment and the percentage increase or decrease for the years covered by this examination.

<u>Year</u>	<u>Enrollment</u>	<u>Increase / Decrease</u>
2013	24,853	—
2014	25,279	1.7% increase
2015	27,062	7.1% increase
2016	24,224	10.5% decrease

At year-end 2016, the decrease in enrollment of 10.5% was the result of two (2) discontinued Medicare Advantage plans, specifically Plans 5 and 12. Between the two (2) plans, Plan 5 had significantly more members than Plan 12. While some members in Plan 5 migrated to alternative plans offered by the HMO, most opted to leave for a competitor, which contributed to the significant decline in enrollment.

E. Significant Operating Ratios

The following ratios have been computed, as of December 31, 2016, based upon the results of this examination. The ratios presented below are on an earned-incurred basis and encompass the four-year period covered by this examination:

	<u>Amounts</u>	<u>Ratios</u>
Claims (net of reinsurance recoveries)	\$2,538,331,242	82.4%
Claims adjustment expenses	229,801,942	7.5%
General administrative expenses	298,540,857	9.7%
Increase in reserves	9,535,698	0.3%
Net underwriting gain	<u>3,256,437</u>	<u>0.1%</u>
Premiums earned	<u>\$3,079,466,176</u>	<u>100.0%</u>

As of December 31, 2016, Elderplan's total adjusted capital was \$56,647,268. This amount was well above the HMO's authorized control level risk-based capital of \$31,917,802.

F. New York Supplement

For the examination years 2013 to 2015, it was noted that Elderplan failed to disclose in Schedule G of the New York Supplement compensations made in excess of \$5,000 to one of its Board members.

It is recommended that Elderplan exercises care when completing Schedule G of the New York Supplement by making sure that payments or compensations made over a specified amount for certain groups of individuals or entities denoted in the instructions of Schedule G are properly disclosed.

G. Reinsurance

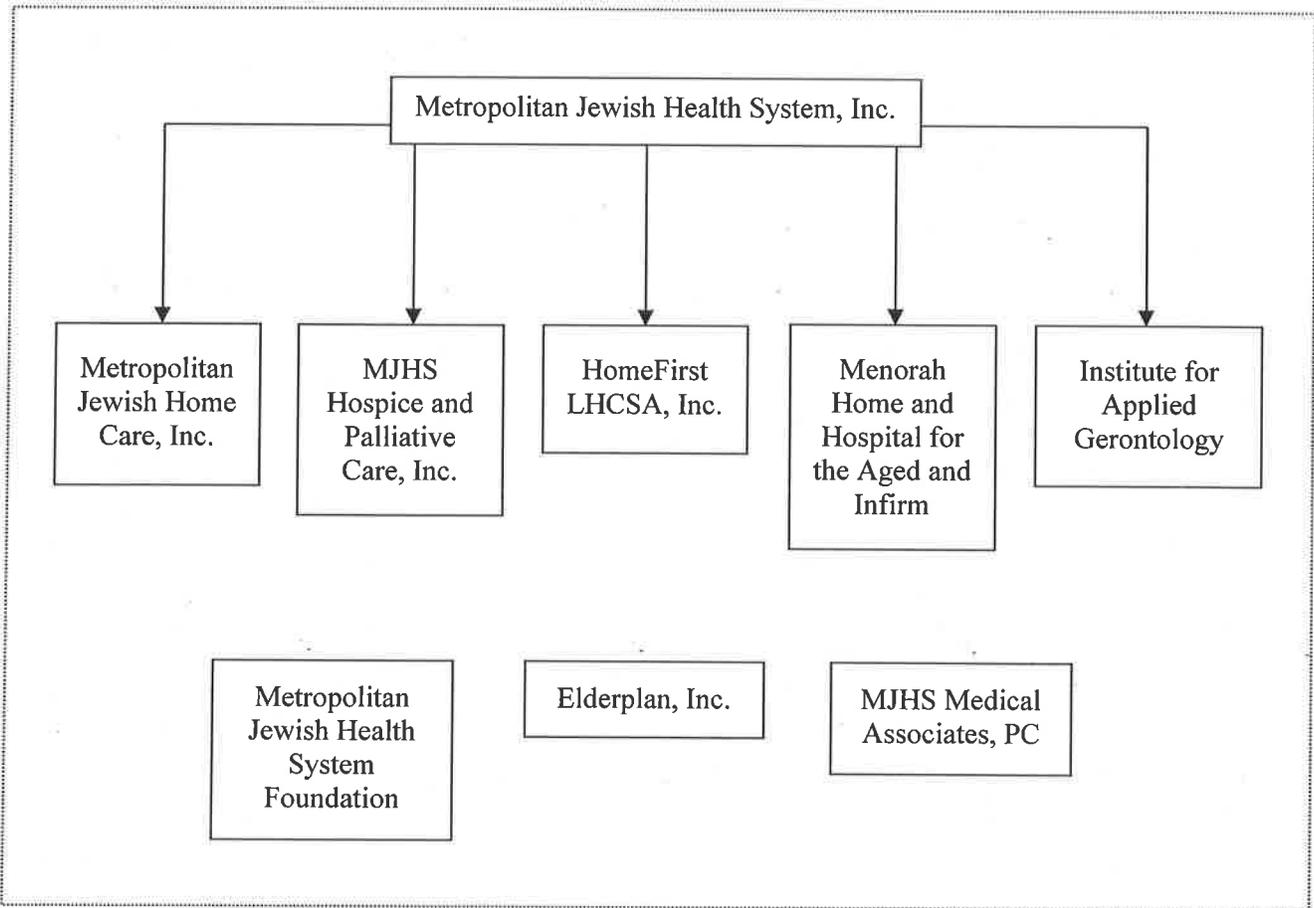
As of December 31, 2016, Elderplan maintained an excess-of-loss reinsurance agreement with RGA Reinsurance Company ("RGA"), an authorized reinsurer. The reinsurance agreement was for the period January 1, 2016 to December 31, 2016 and covered members under Medicare, Medicare-Dual Eligible Skilled Nursing Practitioners ("SNP"), and Fully Integrated Dual Advantage ("FIDA") (Medicare portion only). Subsequent to December 31, 2016, the HMO renewed its reinsurance agreement with RGA, effective January 1, 2017.

The reinsurance coverage in effect during 2016 was as follows:

Covered services:	Inpatient hospital services; inpatient rehabilitation services; skilled nursing facility services; home health care services; and drug related services
Excess-of-loss retention:	\$225,000 deductible per member per agreement period; 10% retention by Elderplan
Policy limit:	\$5,000,000 per member per agreement period

H. Agency System

The following chart depicts, as of December 31, 2016, the HMO's relationship with members of its participating agency system.



As a participating agency of the Metropolitan Jewish Health System, Inc. ("MJHS"), Elderplan is independent from MJHS and has shared services supported by the MJHS organization, which include administration and planning, business development, corporate compliance, finance, human resources, information technology, internal audit, legal, marketing, and public relations.

### 3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2016, as contained in the HMO's 2016 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review.

Loeb & Troper, LLP was retained by Elderplan to audit the HMO's combined statutory basis statements of financial position as of December 31<sup>st</sup> of each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

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

A. Balance SheetAssets

Bonds	\$ 73,728,670
Preferred stocks	31,755
Common stocks	12,546,710
Cash and short-term investments	56,236,690
Aggregate write-ins for invested assets	35,483,701
Investment income due and accrued	501,243
Uncollected premiums in course of collection	7,276,152
Accrued retrospective premiums	2,994,231
Amounts receivable relating to uninsured plans	604,999
Electronic data processing equipment and software	203,925
Receivables from parent, subsidiaries and affiliates	<u>74,131</u>
Total assets	<u>\$189,682,207</u>

Liabilities

Claims unpaid	\$ 87,098,304
Accrued medical incentive pool and bonus amounts	1,125,570
Unpaid claims adjustment expenses	4,041,478
Aggregate health policy reserves	16,273,742
General expenses due or accrued	18,346,305
Amounts withheld or retained for the account of others	503,742
Amounts due to parent, subsidiaries and affiliates	215,564
Liability for amounts held under uninsured plans	1,119,757
Aggregate write-ins for other liabilities	<u>4,310,477</u>
Total liabilities	<u>\$133,034,939</u>

Surplus

Gross paid-in and contributed surplus	\$ 3,967,552
Aggregate write-ins for other than special surplus funds	52,614,435
Unassigned funds	<u>65,281</u>
Total surplus	<u>\$ 56,647,268</u>
Total liabilities and surplus	<u>\$189,682,207</u>

Note: The Internal Revenue Service has not conducted any audits of the federal income tax returns filed on behalf of the HMO through tax year 2016. The examiner is unaware of any potential exposure of the HMO to any tax assessments, and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Surplus

Surplus decreased \$15,815,259 during the four-year examination period, January 1, 2013 through December 31, 2016, detailed as follows:

Revenue

Premium	\$3,066,287,385	
Change in unearned premium reserves and reserve for rate credits	(2,080,705)	
Aggregate write-ins for other health care related revenues	<u>15,259,496</u>	
Total revenue		\$3,079,466,176

Expenses

Claims (net of reinsurance recoverable)	\$2,538,331,242	
Claims adjustment expenses	229,801,942	
General administrative expenses	298,540,857	
Increase in reserves for health contracts	<u>9,535,698</u>	
Total underwriting deductions		<u>3,076,209,739</u>
Net underwriting gain		\$ 3,256,437
Net investment income		4,275,378
Net realized capital gains		3,165,008
Aggregate write-ins for other expenses		<u>(2,493,880)</u>
Net income		<u>\$ 8,202,943</u>

Change in Surplus

Surplus, per report on examination, as of December 31, 2012		\$72,462,527
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	<u>Gains in Surplus</u>	<u>Losses in Surplus</u>	
Net income	\$8,202,943		
Change in net unrealized capital gains	<u>1,125,677</u>		
Change in non-admitted assets		\$19,111,431	
Surplus adjustments		1,032,448	
Aggregate write-ins for gains in surplus		<u>5,000,000</u>	
Net change in surplus			<u>(15,815,259)</u>
Surplus, per report on examination, as of December 31, 2016			<u>\$56,647,268</u>

#### 4. MARKET CONDUCT ACTIVITIES

In the course of the examination, a review was made of the manner in which Elderplan conducts its business practices 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 the practices of the HMO in the following areas:

- A. Fraud prevention plan
- B. Members' handbook

##### A. Fraud Prevention Plan

Part 98-1.21(a) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21(a)) states in part:

“Pursuant to Public Health Law section 4414, every MCO that participates in public or government sponsored programs with an enrolled population of 10,000 or more persons in the aggregate in any given year shall develop and file with the commissioner within 180 days of the effective date of these regulations a plan for the detection, investigation and prevention of fraudulent activities in this State and those fraudulent and abusive activities affecting policies...”

As of December 31, 2016, Elderplan reported an enrolled population of 24,224, which was above 10,000 members in aggregate. The HMO failed to comply with Part 98-1.21(a) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21(a)) when it did not file its fraud prevention plan with the DOH Commissioner.

It is recommended that Elderplan comply with Part 98-1.21(a) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21(a)) by filing its fraud prevention plan with the Commissioner of Health.

B. Members' Handbook

Section 3217-a of the New York Insurance Law states, in part:

“The requirements of this section shall apply to all... managed care health insurance contracts; or any other health insurance contract or product for which the superintendent deems such disclosure appropriate.

(a) Each insurer subject to this article shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below...

(16) notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization;”

It was noted from a review of Elderplan's *Members' Handbook* that the handbook made no mention of the Department's contact information, such as the Consumer Assistance Unit's telephone number and address.

It is recommended that Elderplan update its *Members' Handbook* to include the telephone number and address of the Department's Consumer Assistance Unit, as required pursuant to Section 3217-a of the New York Insurance Law.

## 5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination, as of December 31, 2012, contained the following twenty-three (23) comments and recommendations (page number refers to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Management and Controls</u>	
1. It is recommended that the HMO comply with its by-laws by ensuring that no board member holds more than one officer position at any given time.	7
<i>The HMO has complied with this recommendation.</i>	
<u>Corporate Governance</u>	
2. It is recommended that the HMO 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.	8
<i>The HMO has complied with this recommendation.</i>	
<u>Enterprise Risk Management</u>	
3. It is recommended that the HMO comply with the provisions of Insurance Circular Letter No. 14 (2011) by adopting a formal enterprise risk management function.	10
<i>The HMO has complied with this recommendation.</i>	
<u>Internal Audit</u>	
4. It is recommended that the HMO adhere to the standards promulgated by both the Institute of Internal Audit and the NAIC Handbook to ensure the independence of the internal audit function.	11
<i>The HMO has complied with this recommendation.</i>	
5. It is also recommended that the Internal Audit Department report directly to the HMO's Board of Directors.	11
<i>The HMO has complied with this recommendation.</i>	

<u>ITEM NO.</u>		<u>PAGE NO.</u>
6.	It is recommended that the HMO adhere to the standards of the Institute of Internal Audit by establishing policies and procedures to guide its internal audit activities.  <i>The HMO has complied with this recommendation.</i>	11
7.	It is recommended that the HMO 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.  <i>The HMO has complied with this recommendation.</i>	11
8.	It is recommended as a good business practice that each unit, which receives findings from the HMO'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.  <i>The HMO has complied with this recommendation.</i>	12
	<u>Conflict of Interest Policy</u>	
9.	It is recommended that the HMO comply with Section 2(b) of its Ethics and Conflict of Interest Policy by having all its directors and officers complete a conflict of interest statement on an annual basis.  <i>The HMO has complied with this recommendation.</i>	13
10.	It is also recommended that the HMO adopt procedures to ensure that all directors and officers complete a conflict of interest statement on an annual basis.  <i>The HMO has complied with this recommendation.</i>	13
	<u>Circular Letter No. 9 (1999) – Adoption of Procedure Manuals</u>	
11.	It is recommended that the HMO comply with Insurance Circular Letter No. 9 (1999) by having its board obtain the required annual certifications.  <i>The HMO has not complied with this recommendation. A similar recommendation is included within this report on examination.</i>	13
	<u>Supplement 3 to Insurance Circular Letter No. 10 (2002) – “USA Patriot Act of 2001 – Final Rules Issued by Financial Crimes Enforcement Network”</u>	
12.	It is recommended that the HMO comply with the requirements of Insurance Circular Letter No. 10 (2002) by establishing a formal anti-money laundering program.  <i>The HMO has complied with this recommendation.</i>	15

ITEM NO.PAGE NO.Investment Activities

13. It is recommended that the HMO 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 HMO. 16

*The HMO has complied with this recommendation.*

14. 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. 16

*The HMO has complied with this recommendation.*

Accounts and Records

15. It is recommended that the HMO combine HomeFirst, Inc.'s Deed of Trust account with Elderplan's Deed of Trust account to reflect the merged entity. 16

*The HMO has complied with this recommendation.*

16. It is recommended that the HMO comply with the NAIC's annual statement instructions by including all the required information in the footnote of its filed Schedule T. 17

*The HMO has complied with this recommendation.*

17. It is recommended that the HMO comply with the NAIC's annual statement instructions by completing the Accident and Health Policy Experience Exhibit in accordance to the instructions. 18

*The HMO has complied with this recommendation.*

18. It is recommended that the HMO 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 workpapers requested by the examiner. 19

*The HMO has complied with this recommendation.*

19. It is recommended that the HMO 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. 19

*The HMO has complied with this recommendation.*

ITEM NO.PAGE NO.

20. It is recommended that the HMO comply with Part 89.12(e) of Insurance Regulation No. 118 by providing the required notice to the Department. 19

*The HMO has complied with this recommendation.*

Common Stock

21. It is recommended that the HMO 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. 24

*The HMO has complied with this recommendation.*

Complaints

22. It is recommended that the HMO comply with the provisions of Insurance Circular Letter No. 11 (1978) by including all the required items in its complaint log. 26

*The HMO has complied with this recommendation.*

23. It is recommended that the HMO comply with Insurance Regulation No. 64 by responding to the Department’s inquiries within fifteen (15) business days. 27

*The HMO has complied with this recommendation.*

## 6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
<p>A. <u>Corporate Governance</u></p> <p>i. It is recommended that Elderplan comply with Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health by having the required minimum percentage of enrollees within its Board composition.</p> <p>ii. It is recommended that Elderplan comply with Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health by having enrollees who serve as Board members not be employees of the HMO.</p>	<p>6</p> <p>7</p>
<p>B. <u>Insurance Circular Letter No. 9 (1999)</u></p> <p>It is recommended that Elderplan comply with Insurance Circular Letter No. 9 (1999) by having its Board obtain the required annual certifications.</p> <p>A similar recommendation was included in the prior report on examination.</p>	<p>8</p>
<p>C. <u>New York Supplement</u></p> <p>It is recommended that Elderplan exercises care when completing Schedule G of the New York Supplement by making sure that payments or compensations made over a specified amount for certain groups of individuals or entities denoted in the instructions of Schedule G are properly disclosed.</p>	<p>10</p>
<p>D. <u>Fraud Prevention Plan</u></p> <p>It is recommended that Elderplan comply with Part 98-1.21(a) of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21(a)) by filing its fraud prevention plan with the Commissioner of Health.</p>	<p>16</p>
<p>E. <u>Members' Handbook</u></p> <p>It is recommended that Elderplan update its <i>Members' Handbook</i> to include the telephone number and address of the Department's Consumer Assistance Unit, as required pursuant to Section 3217-a of the New York Insurance Law.</p>	<p>17</p>

Respectfully submitted,

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Tommy Kong, CFE, PIR  
Financial Services Examiner 2

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

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

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Tommy Kong, CFE, PIR

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_ 2019

APPOINTMENT NO. 31656

NEW YORK STATE  
DEPARTMENT OF FINANCIAL SERVICES

I, MARIA T. VULLO, 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:

**Tommy Kong**

as a proper person to examine the affairs of

**Elderplan, Inc.**

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

**HMO**

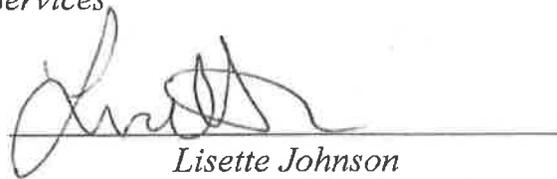
with such other information as he shall deem requisite.

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

this 17th day of August, 2017

MARIA T. VULLO  
Superintendent of Financial  
Services

By:



Lisette Johnson  
Bureau Chief  
Health Bureau

