REPORT ON EXAMINATION

OF

ELDERPLAN, INC.

AS OF

DECEMBER 31, 2002

DATE OF REPORT: **DECEMBER 2, 2003**
Revised May 21, 2004

EXAMINER: **PEARSON GRIFFITH**

TABLE OF CONTENTS

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

George E. Pataki
Governor

Gregory V. Serio
Superintendent

December 2, 2003
Revised May 21, 2004

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with directions contained in Appointment Number 22007 dated February 20th 2003, and annexed hereto, I have made an examination into the affairs of Elderplan, Inc., a not-for-profit health maintenance organization (HMO) licensed pursuant to the provisions of Article 44 of the Public Health Law. This examination was conducted at the administrative office of the HMO located at 6323 7th Avenue, Brooklyn, New York 11220. The following report thereon is respectfully submitted.

Whenever the terms "Elderplan", "Plan", "Company" or "HMO" appear herein without qualification, they should be understood to refer to Elderplan, Inc.

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 $4,675,156 was impaired in the amount of $11,056,352 as of December 31, 2002.

Subsequent to the examination, 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. (See Item 2F, "Accounts and Records", sub-item 1. "Contingent Reserve Fund", herein for further details.)

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1997. This examination covers the five-year period from January 1, 1998 through December 31, 2002. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets and liabilities as of December 31, 2002 in accordance with Statutory Accounting Principles, as adopted by Department Regulation 172, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants. A review or audit was also made of the following items as called for in the Financial Condition Examiners Handbook of the *National Association of Insurance Commissioners* (NAIC):

History of Plan
Management and control
Corporate records
Fidelity bonds and other insurance
Officers' and employees' welfare and pension plans
Territory and plan of operation
Growth of the Plan
Business in force
Loss experience
Reinsurance
Accounts and records
Financial statements
Treatment of policyholders and claimants

A review was also made to ascertain what action was taken by the Company with regard to comments and recommendations in the prior report on examination.

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.

2. DESCRIPTION OF PLAN

Elderplan was incorporated on April 27, 1982 under Section 402 of the New York Not-For-Profit Corporation Law. On March 1, 1985, Elderplan was granted a Certificate of Authority by the New York State Department of Health to operate as an HMO pursuant to Article 44 of the New York State Public Health Law and commenced operations the same day. The Plan's most recent amended Certificate of Authority dated August 25, 1999, is subject to certain conditions and limitations, including the following:

- *The Certificate permits operation of Elderplan only for the duration of federal participation in the demonstration project.*
- *Elderplan is authorized to demonstrate the Social HMO concept for age 65 and over population.*

The Plan provides services to enrollees who reside in Kings, Queens, Richmond and New York counties.

The Plan operates pursuant to Section 2355 of the Deficit Reduction Act of 1984, with waivers of the Medicare and Medicaid provisions of the Social Security Act granted by HCFA (CMS) on August 17, 1984.

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 the four original sites

participating in the Social Health Maintenance Organizations (S/HMO) national demonstration project of the Center for Medicare and Medicaid Services ("CMS"). Elderplan was chosen to participate in a Federal Demonstration Project to show how a targeted population could benefit from the health care provided by S/HMOs. The project was extended to August 31, 2003 by Congressional Legislation H.R. 5543 Sec. 631.1. This project has since been further extended to December 31, 2004 by the Center for Medicare and Medicaid Services.

A. Management

Pursuant to the Plan's charter and by-laws, management is vested in a board of directors consisting of not less than five or more than twenty-one members. At least 20% of the directors shall be subscribers of the Plan. As of December 31, 2002, the Board of Directors consisted of the following twelve members:

Name and Address	Principal Business Affiliation
Norman Abrams Brooklyn, NY	Subscriber
Isaac Assael New York, NY	CPA, Enwood Personnel & Temporary Services
Roslie Di Pietro Brooklyn, NY	Subscriber
Eli S. Feldman Marlboro, NJ	President Metropolitan Jewish Health System
Gloria Feldstein Brooklyn, NY	Subscriber
Michael Gottschalk New York, NY	Managing Director Lazard Freres

Name and Address	Principal Business Affiliation
Vivian Agress-Hirsch New York, NY	Attorney
Raymond Hughes Brooklyn, NY	Subscriber
Shmuel Lefkowitz Brooklyn, New York	Real Estate/Consulting Prime Resources Group, Inc.
Howard Sharfstein New York, NY	Attorney Schulte, Roth & Zabel
Steven Topal Forest Hills, NY	CPA/Attorney Rothchild, Miller, Topal & Kraft, P.C.
John H. Wolff Riverdale, NY	Business Executive, CEW Partners

Article III, Section 1 of Elderplan's bylaws, as amended November 11, 1997, provides that the Corporation shall have no less than three (3) or more than seven (7) members hereinafter referred to as "Members". The board of directors of the Plan is elected at the annual meeting of the Members. As of December 31, 2002, the four Members of the Plan were:

Eli Feldman
Philip Geller
Seymour Levine
Howard Sharfstein

A review of the meetings of the board of directors and committees thereof, which were held during the period under examination, revealed that five directors attended less than 50% of the meetings they were eligible to attend. The Company replaced the four of those members who attended less than 50% of the meetings they were eligible to attend. However, the examiners noted that a current member of the board of directors, Mr. Michael Gottschalk, attended or participated in only three of the eleven meetings he was eligible to attend.

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 fail to attend at least one-half of the board's regular meetings, unless appropriately excused, do not fulfill such criteria. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.

The principal officers of the Plan as of December 31, 2002 were as follows:

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

B. Territory and Plan of Operation

The Plan is a prototype prepaid health plan for well and impaired elderly members that 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 Medicare and Medicaid. Effective January 1, 1995, Elderplan applied for and received approval from the New York Insurance Department to charge “zero” premiums to its subscribers.

Medicare and Medicaid beneficiaries enrolled in the Plan receive covered services in accordance with contracts between CMS and the New York City Department of Social Services. These agreements

expired on December 31, 1987 and June 30, 1990 respectively. The current Medicare agreement covers the period through December 31, 2002. The Plan continues to operate without a written contract for Medicaid services. (This is further explained under Item 2E herein).

As of August 31, 2003, the Plan has contracted with over 5,000 physicians, 36 acute care hospitals, 38 Skilled Nursing Facilities and approximately 800 ancillary providers to provide medical services to the S/HMO's subscribers.

C. Reinsurance

The Plan maintained an excess of loss reinsurance contract with an authorized insurer during the period under examination. The agreement provided for the reinsurance of eligible inpatient hospital, home health care and skilled nursing facility services for the Plan's Medicare members.

A review of the agreement indicated that the insolvency clause contained therein conforms to the requirements set forth in Section 1308 of the New York Insurance Law. As a health maintenance organization organized under the provisions of Article 44 of the Public Health Law, the Plan is subject to the provisions of Part 98.8(b) of the of the Health Department's Administrative Rules and Regulations which requires the prior approval of the Superintendent and the Commissioner of Health for changes to reinsurance agreements. The agreement provides for a maximum of $1,000,000 coverage for eligible services, per member per contract year, less deductible and coinsurance. The agreement also provides maximum lifetime reinsurance coverage for each member of $2,000,000.

D. Abandoned Property Law

Section 1316 of the New York Abandoned Property Law requires that certain unclaimed insurance proceeds which are unclaimed over three years be reported to the Office of the State Comptroller of the State of New York by April 1 of each year. Such reports comprise all abandoned property held by the Company at the close of business on January 1 each year.

Section 1315 of the New York Abandoned Property Law requires that certain unclaimed vendor payments, outstanding checks and escrow amounts, or gift certificates which are unclaimed over five years be reported to the Office of the State Comptroller of the State of New York by March 10 of each year. Such reports comprise all abandoned property held by the Company at the close of business on December 31 each year.

The Plan is also required to 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.

Section 1316 of the New York Abandoned Property Law states in part.

1. "Any amount issued and payable…to a resident of this state on or because of a policy of insurance other than life insurance, which is held or owing by a domestic insurer or a foreign insurer authorized to do business in this state or by an agent or agency of such insurer, shall be deemed abandoned property if unclaimed for three years by the person entitled thereto…

2. Such abandoned property shall be reported to the comptroller annually on or before the first day of April. Such report shall be in such form and manner as the comptroller may prescribe.

3. Within thirty days following the filing of the report of abandoned property with the comptroller pursuant to subdivision two of this section, the insurer shall cause to be published a list of such abandoned property in the same manner as that prescribed for life insurance companies…"

The Plan was unable to provide the examiners with documentation that it filed any of the

requisite reports with the Office of the State Comptroller during the period 1998 through 2002. The Plan was also unable to provide the examiners with documentation that it annually published a list of names and last known addresses of persons appearing to be entitled to abandoned cash amounts and that it filed proof of such publication with the Office of the State Comptroller.

It is recommended that the Plan comply with the provisions of Sections 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.

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.

E. Medicaid

Pursuant to a contract entered into between the Plan and the New York City Department of Social Services, dated November 9, 1984, Elderplan provided certain services that were shared or paid by Medicaid. This contract expired on June 30, 1990 and was renewed on September 29, 1993 covering the period January 1, 1993 through December 31, 1995. Notwithstanding the expiration of the aforementioned contract, the Plan continues to operate without a written contract for Medicaid services. Consequently, the Plan continues to incur expenses for personal care worker services for which it cannot bill Medicaid directly due to the expired contract. By letter dated May 21, 1991, the New York State Department of Social Services authorized the Company to bill Medicaid by using the name and identification number of Elderplan's sponsor, the Metropolitan Jewish Geriatric Center ("MJGC"). The

authorization relates only to personal care services provided to Elderplan members since July 1, 1990. Medicaid reimburses MJGC who in turn remits the funds to Elderplan. The Plan expects to enter into a new agreement for these Medicaid services. As of the date of this report, such agreement has not been finalized.

F. Accounts and Records

1. Contingent Reserve Fund

A certified operating HMO shall maintain Contingent Reserves pursuant to the provisions of Part 98.11(d) of the Administrative Rules and Regulations of the Health Department [10NYCRR98.11(d)]. The Contingent Reserve consists of:

> "…A reserve fund to be designated as the contingent reserve fund, which shall, from time to time, during each calendar year, be increased in an amount equal to at least one percent of the net premium income of such HMO during such whole calendar year; provided, however, that:
>
> (2) The contingent fund at the end of any calendar year shall not exceed five percent net premium income of such calendar year..."

The Plan was required to maintain Contingency Reserves in the amount of $4,675,156 as of December 31, 2002.

Elderplan reported an insolvency in the amount of $5,914,591, and an impairment of its required Contingency Reserves 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 $4,675,156 was impaired in the amount of $11,056,352 as of December 31, 2002.

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. The Plan's reported surplus at year-end 2003 has not been verified by examination.

2. Custodian Agreement

Elderplan maintains several custodial agreements with Fleet Bank. A review of the custodian agreements revealed that the agreements lacked certain 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*. The rules and guidelines state in part:

- That the national bank, state bank, or trust company, as custodian is obligated to indemnify the insurance company for any insurance company's loss of securities in the custodian's custody, except that, unless domiciliary state law, regulation, or administrative action otherwise require a stricter standard the bank or trust company shall not be so obligated to the extent that such loss was caused by other than the negligence or dishonesty of the custodian;

- That in the event of a loss of the securities for which the custodian is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced;

- That the agreements shall indicate that the bank be provided with written instructions signed by any two authorized officers of the Company specified in a separate list for this purpose that will be furnished to the bank from time to time.

- That the agreements shall indicate that the bank furnish the New York Insurance Department with the appropriate affidavits in the form as may be acceptable to the Company and to the Department in order for the securities to be recognized as admitted assets of the Company;

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*.

3. Investments

A review of the Plan's investment transactions and the minutes of meetings of its board of directors and investment committee indicated that actions taken by the Plan's investment managers, Estabrook Capital Management and MacKay Shields were not authorized or approved by the board of directors. Section 1411(a) of the New York Insurance Law states in part:

> "No domestic insurer shall make any loan or investment... 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."

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.

4. Reconciliations

During the review of the Plan's accounts and records, the examiners noted numerous instances where prior year balances reported on current year statutory statements did not agree with the current balances reported on the prior year statutory statements. It appears that the Plan made certain changes to its filed statutory statements, which resulted from audit adjustments without submitting revised copies of its statutory statements to the Department. As a result, The Plan's five-year financial history on its filed statutory statements did not agree to its general ledger.

It is recommended that the 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.

5. Borrowed Money

A review of the Company's financial records indicates that Elderplan executed a short-term line of credit for $1,000,000 with Fleet Bank, effective December 1, 2002 and maturing on September 30, 2003 to support accounts receivable. This line of credit was secured as collateral by a first priority security interest in all general intangibles of the Company together with securities now or hereafter held including, without limitation, all profits and proceeds thereof in the Company's custody account with Fleet bank.

During a review of the Plan's minutes of its board of directors, executive, investment or finance committees, the examiner noted that there was no authorization or ratification therein for this line of credit. Section 1411(a) of the Insurance Law states that:

> "No domestic insurer shall make any loan or investment... 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."

On October 1, 2003, this line of credit was repaid in full.

Notwithstanding the fact that the line of credit was repaid in full, it is recommended that the board of directors authorize and approve the Company's borrowing transactions in accordance with the provisions of Section 1411(a) of the New York Insurance Law.

6. Control of Plan

The Department has reviewed the relationship between Elderplan and Metropolitan Jewish Health System (MJHS) as regards control of the Plan. Based on this assessment the relationship appears to meet the criteria of control as defined in Department of Health regulations, which would thereby, result in MJHS being a holding company of Elderplan. Department of Health Regulation [10NYCRR §98.2(l)] defines control as:

> "(l) *Control*, which shall be synonymous with the terms *controlling, controlled by* and *under common control with*, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities or voting rights, by contract (except a commercial contract for goods or nonmanagement services) or otherwise; but no person shall be deemed to control another person solely by reason of his being an officer or director of such other person. Control shall be presumed to exist if any person directly or indirectly owns, controls or has the power to vote 10 percent or more of the voting securities or voting rights of any other person, or is a corporate member of a not-for-profit corporation."

The Department identified several factors listed below, which in its analysis are indicative of a controlled relationship.

1 The HMO is identified on its own letterhead, its audited financial statements, and on MJHS's website as a participating agency of MJHS.

2 The HMO has provided the Department with documentation that described the expense sharing arrangements between the Plan and other participating agencies. These arrangements include allocating for indirect charges, such as legal, human resources and system support, which are, or may be, performed by MJHS and/or other participating agencies on behalf of the Plan.

3 The boards of directors of the HMO and MJHS share six common directors. In addition, as a not-for-profit membership corporation, the HMO has four Members as defined by Section 102(a)(9) and in accordance with Section 601 of the New York Not-For-Profit Corporation Law. It is through these Members that Elderplan's board of directors is elected. It should be noted that Eli Feldman, the Chief Executive Officer of Elderplan, is also one of its Members. It should also be noted that three of the HMO's four Members are also on the board of directors of MJHS.

4 On February 21, 2003 MJHS provided Elderplan with a loan in the amount of $3,000,000 in accordance with the provisions of Section 1307 of the New York Insurance Law. The ultimate source of this loan was the Metropolitan Jewish Geriatric Foundation (MJGF), which is described by Elderplan as "an independent charitable foundation that makes grants to a defined list of not-for-profit organizations, including Elderplan." However,

the boards of directors of the HMO, MJGF and MJHS share three common directors. Furthermore, as described in item 3 above, the HMO has four Members, all of whom are also on the board of directors of MJGF.

5 Elderplan and MJHS share the same business office at 6323 7th Avenue, Brooklyn, New York. In addition, employees of the HMO use e-mail addresses that end with "…@mjhs.org".

6 N.Y. Schedule G of the Plan's Annual New York Data Requirements filed during the period under examination reported several of its officers with MJHS as the source of payment for their salaries.

Part 9816(e) of the Administrative Rules and Regulations of the Health Department [10NYCRR9816(e)] requires controlled 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, this matter has been referred to the New York State Department of Health. If Elderplan is determined by the Department of Health to be controlled by Metropolitan Jewish Health System, Elderplan will be subject to such requirements.

7. Due to Medicaid

The examination liability of $1,802,074 is the same as the amount reported by Elderplan in its filed annual statement.

Elderplan disclosed a contingent liability in Note 14(D)(ii) of its filed 2002 annual statement, wherein it stated that the New York State Department of Health (DOH), in a draft audit report dated March 17, 1999, was seeking to recoup $6,993,879 (including $1,306,433 of interest). The DOH was

seeking to recoup these monies for overpayments made to the Company under the New York State Medicaid program for years 1990 through May 1998. DOH concluded in its draft report that:

a. The Company billed Medicaid for Chronic Care Services that were not appropriately offset by credits for the Medicare Chronic Care Benefit;
b. Member surplus income was not appropriately offset from Medicaid billings; and
c. Medicaid was billed more than the actual cost paid to personal care vendors.

The Plan submitted additional documentation and written arguments objecting to the proposed DOH adjustment. Elderplan believed that the proposed audit adjustment by DOH would constitute an impermissible reversal of methodology eight years after the fact, and believed that the imposition of interest charges exceeding $1,000,000 was inappropriate. On February 14, 2001 DOH issued a final audit report that determined the total amount due Medicaid for overpayments made to the Company under the New York State Medicaid program for years 1990 through May 1998 was $8,039,504 ($6,487,464 plus $1,552,040 of interest.)

Elderplan requested an administrative hearing on this matter pursuant to the Administrative Rules and Regulations of the New York Department of Health to contest the DOH findings. The examiners obtained certain documents submitted to the hearing officer and noted that the Plan did not dispute DOH's findings as regards item (b) and item (c) above. It should be noted that Elderplan established a liability, "Due to Medicaid" in the amount of $1,802,074 as of December 31, 2002 for the member surplus and rate differential overpayments for the period 1991 through 1998. In addition, during the hearing the parties agreed that the $6,487,464 principal amount sought by DOH be reduced by $1,235,683 because of computational errors. Based on the examination analysis of documentation provided by Elderplan relating to this matter, it appears that DOH's determination to recover

overpayments for Chronic Care Benefits, member surplus income and rate differential due Medicaid has been adjusted to $5,121,679 plus interest.

Subsequent to the date of this report, on April 19, 2004, the Department of Health's Bureau of Adjudication rendered a Decision after Hearing on this matter as follows:

- "The Department's [DOH] determination to recover Medicaid program overpayments attributable to the "chronic care benefit" adjustment is reversed.
- The Department's determination to recover Medicaid program overpayments attributable to the "surplus income" adjustment is affirmed. The amount of the overpayment is reduced by $78,755.66, from $1,006,384.68 to $927,629.02.
- The Department's determination to recover Medicaid program overpayments attributable to the "rate differential" adjustment is affirmed. Pursuant to agreements between the parties, the amount of the overpayment is reduced by$130,101.84, from $226,396.96 to $96,295.12.
- The Department's determination to impose interest upon the overpayments is affirmed. The Department is directed to recalculate the interest due in accordance with this decision.

It should be noted that the adjudicated liability of $1,023,924 detailed in the decision after hearing is $778,150 less than the $1,802,074 reported by Elderplan in its December 31, 2002 filed annual statement. This is because the adjudication covered the DOH audit period from October 1991 through May 1998, whereas the examination liability included the additional amounts Due to Medicaid for the period June 1998 through December 2002.

It should also be noted that the Plan has not established a liability for interest payable on amounts Due to Medicaid, including the additional amounts due for the period June 1998 through December 2002. The findings of the Department of Health's Bureau of Adjudication states, in part:

> "The Department's [DOH] interest calculation methodology was not challenged by the appellant and is accordingly affirmed. The precise amount of interest due must be recalculated in accordance with the findings in this hearing decision and this issue is remanded to the Department for that calculation."

Although the precise amount of interest payable on the foregoing has not been calculated, the Insurance Department has determined that an estimate of interest payable could be established by Elderplan in accordance with SSAP #5 as adopted by Department Regulation 172 {11NYCRR 83.}

For purposes of this report, no additional liability has been established herein for interest payable on amounts Due to Medicaid.

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.

G. Conflict of Interest

The Plan disclosed in its response to General Interrogatories in all its filed Annual Statements for the period under examination that it has an established procedure for disclosure to its Board of Directors, any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees which is in, or likely to, conflict with the official duties of such person. It was noted in the Plan's response to the Examination Planning Questionnaire that it had both a conflict of interest policy and a code of conduct in effect.

The examiners reviewed the Plan's conflict of interest policy and disclosure forms and noted they were only distributed to members of the board of directors. In addition, management of the Plan stated that all board members were required to complete and update at least biennially conflict of interest declaration forms. The Plan provided a copy of the code of conduct policy that was distributed to all

new employees at the time of orientation. This policy covers the Company's code of conduct and behavior, and also addresses such matters as contemplated by question 13 in the General Interrogatories. However, the code of conduct policy does not provide for the periodic written disclosure of any material interest or affiliation on the part of any of the Company's officers or responsible employees which is in, or likely to, conflict with the official duties of such person.

Prudent business practices dictate that Company management establish formal procedures to govern the relations between the company and its directors, officers and responsible employees who are charged with the conduct of its affairs. Such formal procedures should proscribe unethical practices and should recite in clear language the standards of performance expected of each. These procedures should also be devised in such a manner as to permit the board of directors to properly oversee and handle any conflicts disclosed. In addition, it is not sufficient merely to adopt procedures, since to be effective and to avert occurrences of conflicts, they must be accompanied by an enlightened policy of enforcement. To this end, management should designate a responsible officer, who reports directly to the board of directors, to implement these procedures and oversee the annual distribution of Conflict of Interest statements and questionnaires to all directors, officers, and responsible employees.

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

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

H. Service Agreements

Elderplan has engaged a number of participating agencies of the Metropolitan Jewish Health System to provide services on its behalf. Expenses for these services are charged/allocated to Elderplan on a direct or indirect basis. All of these services are performed through informal arrangements; except for the services provided by Home First, Inc., which are subject to a written agreement. The examiners requested that the Plan provide details of transactions with companies that were comprised of substantially similar board of directors and/or management as Elderplan during the period under examination. The request included such details as the total amounts paid to each participating agency by calendar year, the nature of services provided, the method used to determine the value of services rendered, terms of payment, and termination clauses.

The Company was unable to provide the examiners with the total amounts that Elderplan paid to or received from each participating agency during the period under examination. In addition, the Company was unable to provide the examiners with sufficient details to determine whether the terms of the transactions were fair and equitable and in conformity with customary accounting practices.

The guidelines set forth in the Statement of Statutory Accounting Principles No. 25 of the NAIC states that transactions between related parties shall not be purported to be arm's-length transactions unless there is demonstrable evidence to support such statement. Such evidence should include the nature of the relationships involved, the names of the related parties, the dollar amounts of transactions for each of the periods for which financial statements are presented, and a description of the transactions for each of the periods for which financial statements are presented. In addition, the disclosures should include any guarantees or undertakings, written or otherwise, for the benefit of an affiliate or related

party which result in a material contingent exposure of the Plan's or any related party's assets or liabilities. Furthermore, the disclosures should include a description of material management or service contracts and cost-sharing arrangements involving the Plan and any participating agencies, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements.

In addition, the Department has reviewed the relationship between Elderplan and Metropolitan Jewish Health System as regards control of the Plan. (This is further explained under Item 2F(6), "Control of Plan" herein). Part 98.10 of the Administrative Rules and Regulations of the Health Department [10NYCRR98.10] states:

(a) Transactions within a holding company system to which a controlled HMO is a party shall be subject to the following guidelines:

  (1) The terms of the financial transaction shall be fair and equitable to the HMO at the time of the transaction;
  (2) charges or fees for services performed shall be reasonable; and
  (3) expenses incurred and payments received shall be allocated to the HMO on an equitable basis in conformity with customary accounting practices consistently applied.

(b) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(c) The commissioner's and superintendent's prior approval shall be required for the following transactions between a controlled HMO and any person in its holding company system: sales, purchases, exchanges, investments or rendering of services on a regular or systematic basis the aggregate of which involves 10 percent or more of the HMO's admitted assets at last year-end. Notice shall be required for such transactions of five percent or more.

(d) The commissioner, in reviewing transactions pursuant to subdivision (c) of this section, shall consider whether they comply with the standards set forth in subdivision (a) of this section, and whether they may adversely affect the interests of enrollees.

It should be noted that the participating agencies share common management and varying degrees of overlapping board membership with Elderplan. The following were the amounts due from/(to) participating agencies as shown on Elderplan's balance sheet as of December 31, 2002:

Participating agency	Due from/(to)
Home First, Inc.	$ 227,688
Metropolitan Jewish Health System, Inc.	103,097
Caregivers, Inc.	119,387
MJG Nursing Home Co., Inc.	(50,780)
First to Care Home Care, Inc.	(88,333)
Institute for Applied Gerontology, Inc.	(55,133)

As stated above, Part 98.16(e) of the Administrative Rules and Regulations of the Health Department [10NYCRR98.16(e)] requires controlled 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. If Elderplan is determined by the Department of Health to be controlled by Metropolitan Jewish Health System, Elderplan will be subject to such requirements.

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 [10NYCRR98.10] as regards its transactions with participating agencies of MJHS.

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.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and net worth as determined by this examination as of December 31, 2002. This statement differs from the one filed by the HMO.

Current Assets	Plan	Examination	Capital and Surplus Increase (Decrease)
Bonds	$ 11,529,640	$ 11,529,640	$ 0
Common Stocks	1,727,966	1,727,966	
Cash and cash short-term investments	7,833,683	7,833,683	
Accident and health premiums due and unpaid	1,010,579	1,010,579	0
Health care receivables	4,038,210	3,571,605	(466,605)
Amounts recoverable from re-insurers	24,300	24,300	0
Investment income due and accrued	126,883	126,883	0
Amounts due from parent, subsidiaries and affiliates	450,172	450,172	0
Electronic data processing equipment and software	548,477	548,477	
Security deposit	3,590	3,590	0
Total Assets	$ 27,293,500	$ 26,826,895	(466,605)

Current Liabilities	Plan	Examination	Capital and Surplus Increase (Decrease)
Claims unpaid	$ 20,334,000	$ 20,334,000	$ 0
Unpaid claims adjustment expenses	812,000	812,000	
Premiums received in advance	7,805,363	7,805,363	
General expenses, due and accrued	1,204,886	1,204,886	
Amounts withheld or retained by company for the account of others	52,632	52,632	
Borrowed money	1,002,799	1,002,799	
Amounts due to parent, subsidiaries and affiliates	194,336	194,336	
Due to Medicaid	1,802,074	1,802,074	
Total Liabilities	33,208,090	33,208,090	
Capital and Surplus			
Contingent Reserve NY	4,675,156	4,675,156	
Unassigned Funds Surplus/(Deficit)	(10,589,747)	(11,056,352)	(466,605)
Total Capital and Surplus	$ (5,914,591)	(6,381,196)	(466,605)
Total Liabilities, Capital and Surplus	$ 27,293,499	$ 26,826.895	(466,605)

Notes:

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 $4,675,156 was impaired in the amount of $11,056,352 as of December 31, 2002. Subsequent to the examination, 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.

Elderplan is a corporation as defined in subparagraph (a)(5) of Section 102 of the Not for Profit Corporation Law of the State of New York. The Plan is prohibited from undertaking any activity not permitted to be carried on by a corporation exempt from Federal Income Tax under Section 501(c)(3) of the Internal Revenue Code of 1954, or the corresponding code of any future United States Internal Revenue Law. The Company has not had an IRS audit since its inception.

B. Statement of Revenue and Expenses

Surplus decreased $ 26,742,242 during the examination period, January 1, 1998 through December 31, 2002, detailed as follows:

Revenue		
Title XVIII – Medicare	$ 392,163,986	
Title XIX – Medicaid	937,271	
Fee-for service	29,990,114	
Net investment income	10,047,784	
Other revenue	3,603	
Total revenue		$ 433,142,758
Expenses		
Medical and hospital	$ 354,006,183	
Reinsurance expenses net of recoveries	(208,404)	
Co-payments	(1,776,329)	
Administrative	102,992,998	
Total expenses		$ 455,014,448
Net loss		$ (21,871,690)
Net Worth		
Net worth, December 31, 1997		$ 20,361,045
Net loss from operations	$ (21,871,690)	
Grant Income	5,121,137	
Change in non admitted assets	(858,003)	
Cumulative effect of changes in accounting principles	(6,499,714)	
Unrealized capital gains and losses	(1,954,881)	
CPA audit adjustments	(39,483)	
Increase/(decrease) in contingency reserves	(374,429)	
Annual statement errors	(301,415)	
Prior period adjustments	36,236	
Sub-total		(26,742,242)
Net worth, December 31, 2002		$ (6,381,196)

4. HEALTH CARE RECEIVABLES

The examination admitted asset of $3,571,605 is $466,605 less than the $4,038,210 reported by the HMO in its 2002 filed annual statement. The decrease resulted from the examiner not-admitting certain amounts that represent future deductions to be taken from capitation payments to risk-assuming entities whose claims were paid or were payable by Elderplan on behalf of such contracted risk-assuming entities. The Department has determined that such healthcare receivables are not allowable as admitted assets in accordance with the guidelines set forth in the Statement of Statutory Accounting Principles (SSAP) No. 84 of the Accounting Practices and Procedures Manual of the NAIC. These healthcare receivables were not incurred in anticipation of future services, but instead were incurred for services already provided and for which the Plan had already paid.

When this matter was brought to management's attention, the Plan elected to not-admit such healthcare receivables in its quarterly statement filed as of June 30, 2003.

5. CONCLUSION

Elderplan reported an insolvency in the amount of $5,914,591, and an impairment of its required Contingency Reserves 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 $ 4,675,156 was impaired in the amount of $11,056,352 as of December 31, 2002.

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. The Plan's reported surplus at year-end 2003 has not been verified by examination.

6. TREATMENT OF POLICYHOLDERS AND CLAIMANTS

In the course of this examination, a review was made of the manner in which the Plan conducted its business practices and fulfilled its contractual obligations to policyholders and claimants. The review was limited to the Plan's procedures relating to its claims settlement practices and the manner in which payment for such claims was recorded in the general ledger.

This review was performed by using a statistical sampling methodology covering the scope period in order to evaluate the overall payment and lag triangle accuracy of Elderplan's claims processing. In order to achieve the goals of this review, the Plan's claims were segregated into separate hospital and medical claims segments. A random statistical sample was drawn from each of these segments.

This statistical random sampling process was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if 10 attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample.

To ensure the completeness of the claims population being tested, the total dollars paid were reconciled to the financial data reported by Elderplan. To verify each service that resulted in no payment, a reconciliation of transaction counts was performed.

In summary, of the 334 hospital and medical claims data files provided the examiners, 118 hospital claims contained missing or incomplete service lines. This condition occurred because the service lines on the reconciled paid hospital claims data did not agree with the service lines indicated on the hospital claim forms and in the AMISYS claims system. As a result the examination review indicated differences between the paid hospital claims per the AMISYS claims system and the paid hospital claims recorded on the general ledger. It appears that Elderplan records certain claims service lines on the hospital claim forms as other than hospital claims. This fact was not disclosed prior to the examiners acceptance of the paid hospital claims data file. Nevertheless, the examiners applied certain procedures to test the accuracy and validity of the Plan's paid claims as it related to service dates, received dates, paid dates, and paid amounts.

The following summarizes the details of the examination review:

- There were several claims noted with multiple dates of receipt. Elderplan's claims

processing procedures entailed the return without entry into the claims system of any claims submitted with incomplete documentation. Such claims are date stamped upon resubmission with the new date entered as the received date into the claims system.

- There were five medical claims that were improperly denied as not having referral authorization.

- The examiners review indicated numerous adjustments to paid claims after the original settlements dates.

It is recommended that Elderplan take the 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.

In addition to the foregoing, Elderplan provided the examiners with claim lag tables for the periods ended December 31, 2002, March 31, 2003, April 30, 2003 and September 30, 2003. A review of each lag table by the Department's actuaries indicated significant variances in the amount of paid claims through a fixed point in time, namely, December 31, 2002. It appears that adjustments made to certain claims subsequent to their initial processing affected claim lag data. The Plan stated that its AMYSIS claims processing system was configured to post claims adjustments to the month the claim was incurred. Consequently, claims lag reports were updated to reflect all real time adjustments and, as such, did not retain historical paid claims data. Accordingly, these claim adjustments have resulted in differences in the respective lag tables, with many cells showing negative amounts or very small positive amounts.

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.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained eleven comments and recommendations (page numbers refer to the prior report on examination).

ITEM		PAGE NO.
A.	Management	
1.	It is recommended that Elderplan comply with Article IV, Section 13, in all future meetings of its Board of Directors. The Plan has complied with this recommendation.	5
2.	Board members who are unable or unwilling to attend meetings consistently should resign or be replaced. The Plan has not complied with this recommendation.	5
3.	It is recommended that the Plan comply with Article III, Section 2 of its bylaws. The Plan has complied with this recommendation.	6
4.	In accordance with Section 624 of the Business Corporation Law, it is recommended that Elderplan maintain the minutes of all the meetings of the Plan's governing authorities. The Plan has complied with this recommendation.	6
5.	It is recommended that Elderplan maintain annual records, disclosing any conflict of interests or that no conflict of interest exists signed by the board members and the principal officers of the Plan. The Board has adopted a conflict of interest policy that requires each board member to periodically file a financial disclosure statement. Principal officers are required to complete an ethics questionnaire at the time of hiring.	6

ITEM		PAGE NO.
B.	Abandoned Property Law It is recommended that, in the future, Elderplan maintain compliance with Section 1316 of the Abandoned Property Law by reporting proceeds outstanding for three years or more as Abandoned Property. The Plan has not complied with this recommendation.	11
C.	Accounts and Records	
	1. General Ledger It is recommended that the Plan close its books at December 31 of each year and that it estimate transactions incurred in the term covered by the annual statement but paid in subsequent periods. The Plan has complied with this recommendation.	12
	2. Annual Statement It is recommended that the Plan follows the instructions to the Annual Statement Blank and the New York Data Requirements and report assets receivable net of its estimated bad debt reserve. The Plan has complied with this recommendation.	13
	3. Contingent Reserve It is recommended that Elderplan comply with the requirements of Part 98.11(d)(2) of the Administrative Rules and Regulations of the Health Department (11NYCRR98.11(d)[2]) and Department Circular Letter 14 (1991) when calculating and reporting the Contingent Reserve Fund. The Plan has complied with this recommendation.	13, 14
	4. Equity Investments It is recommended that the Plan dispose of the excess equity investments permitted by Sections 1404(a) and 1404(b) as required by Sections 1412(a) and 1412(b) of the New York Insurance Law. It is also recommended that Elderplan comply with the provisions of Sections 1404(a) and 1404(b) when making future equity investments. The Plan has complied with this recommendation.	15

ITEM		PAGE NO.
	5. Custodian Agreement	
	It is recommended that the HMO amend its custodian agreement to include the above-mentioned provisions.	15, 16
	The Plan has not complied with this recommendation.	

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	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 $ 4,675,156 was impaired in the amount of $11,056,352 as of December 31, 2002.	1, 10, 23, 25
B.	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 fail to attend at least one-half of the board's regular meetings, unless appropriately excused, do not fulfill such criteria. Board members who are unable or unwilling to attend meetings consistently should resign or be replaced.	6
C.	Abandoned property It is recommended that the Plan comply with the provisions of Sections 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.	9
D.	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.	9

Respectfully submitted,

_____
Pearson Griffith
Senior Insurance Examiner

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

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

_____
Pearson Griffith

Subscribed and sworn to before me

This _____ day of _____2004

Appointment No. ***22007***

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***GREGORY V. SERIO*** , Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

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

Company

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 *20th* day of *February 2003*

Gregory V. Serio
Superintendent of Insurance