



Arnold Schwarzenegger, Governor  
State of California  
Business, Transportation and Housing Agency

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January 31, 2008

via FedEx Delivery and eFile

Mina Narula, D.D.S., Director and Chair of the Board

**JAIMINI HEALTH INC.**

9500 Haven Street, Suite 125

Rancho Cucamonga, CA 92730

### **FINAL REPORT OF ROUTINE EXAMINATION OF JAIMINI HEALTH INC**

Dear Dr. Narula:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Jaimini Health Inc., (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on November 07, 2007. The Department accepted the Plan's electronically filed response on December 21, 2007 and January 29, 2008.

This Final Report includes a description of the compliance efforts included in the Plan's responses, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and electronically file modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

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<sup>1</sup> References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its November 19, 2007 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select "Filing No. 20072132"; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, then select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's response of December 21, 2007 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on November 07, 2007. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select "Filing No. 20072132"; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan's Response to Final Report (FE10)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, then select "Complete Amendment", complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the above responses should be directed to Siniva Pedro at (916) 322-5393 or email at [spedro@dmhc.ca.gov](mailto:spedro@dmhc.ca.gov). You may also email inquiries to [wps@dmhc.ca.gov](mailto:wps@dmhc.ca.gov).

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter**

The Executive Summary to the Department's most recent Medical Survey Report is located at the Department's web site at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

If there are any questions regarding this report, please contact me.

Sincerely,

**ORIGINAL SIGNED BY**

JOAN LARSEN  
Supervising Examiner  
Office of Health Plan Oversight  
Division of Financial Oversight

Cc: Michael Polis, Outside Counsel for Jaimini, Inc.  
Mohender Narula, D.M.D., President  
Mark Wright, Chief, Division of Financial Oversight  
Maria E. Marquez Examiner, Division of Financial Oversight  
Vasily Lopuga, Examiner, Division of Financial Oversight  
Amy Krause, Counsel, Division of Licensing  
Marcy Gallagher, Chief, Division of Plan Surveys

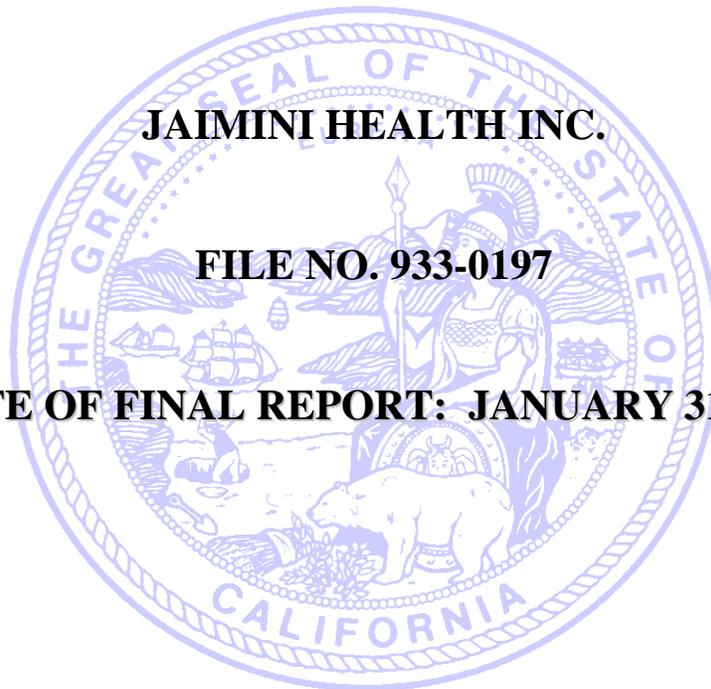
**STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE**

**DIVISION OF FINANCIAL OVERSIGHT**

**JAIMINI HEALTH INC.**

**FILE NO. 933-0197**

**DATE OF FINAL REPORT: JANUARY 31, 2008**



**SUPERVISING EXAMINER: Joan Larsen**

**EXAMINER-IN-CHARGE: Maria E. Marquez**

**SENIOR EXAMINER: Kim Malme**

**FINANCIAL EXAMINER: Anna Belmont**



## **BACKGROUND INFORMATION FOR JAIMINI HEALTH INC.**

|  |   |
|--|---|
| Date Plan Licensed:                            | July 15, 1983   |
| Organizational Structure:                      | The Plan is a for-profit corporation owned by Dr. Mohender Narula.  |
| Type of Plan:                                  | The Plan is a specialized health care service plan providing dental services to employer groups and individuals   |
| Provider Network:                              | The Plan enters into contractual agreements with various private dentists to provide services to its members. The Plan capitates their general dentist. The Plan does not offer specialist services, but may provide a \$50 specialist consultation fee.  |
| Plan Enrollment:                               | 5,542 as of June 30, 2007   |
| Service Area:                                  | The Plan's service area consists of 42 counties, as follows: Alameda, Butte, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Kern, Kings, Los Angeles, Madera, Mariposa, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehema, Tuolumne, Tulare, Ventura, Yolo, and Yuba. |
| Date of last Final Routine Examination Report: | January 28, 2005  |

## FINAL REPORT OF A ROUTINE EXAMINATION OF JAIMINI HEALTH INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of Jaimini Health Inc. (the “Plan”), conducted by the Department of Managed Health Care (the “Department”) pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on November 07, 2007. The Department accepted the Plan’s electronically filed response on December 21, 2007 and January 29, 2008.

This Final Report includes a description of the compliance efforts included in the Plan’s responses to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in *italics*.

We examined the financial report filed with the Department for the quarter ended June 30, 2007, as well as other selected accounting records and controls related to the Plan’s various fiscal and administrative transactions. Our findings are presented in this report as follows:

|             |                                    |
|-------------|------------------------------------|
| Section I.  | Financial Report                   |
| Section II. | Calculation of Tangible Net Equity |
| Section III | Financial Viability                |
| Section IV  | Compliance Issues                  |

***Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.***

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<sup>1</sup> References throughout this report to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to “Rule” are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

**SECTION I. FINANCIAL REPORT**

Our examination resulted in no adjustments or reclassifications to the Plan's June 30, 2007 financial statements filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wps0.dmhc.ca.gov/fe/search.asp> and selecting Jaimini Health Inc. on the first drop down menu.

**No response required to this Section.**

**SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)**

|   |                  |
|---|------------------|
| Net Worth as reported by the Plan as of Quarter Ended June 30, 2007 | \$ (171,662)     |
| Add: Subordinated debt and related interest                         | 632,624          |
| Less: Intangible Assets and Goodwill-Net                            | <u>373,334</u>   |
| Tangible Net Equity   | \$ 87,628        |
| Required TNE as of June 30, 2007                                    | <u>50,000</u>    |
| TNE Excess per Examination as of June 30, 2007                      | <u>\$ 37,628</u> |

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of June 30, 2007.

**No response required to this Section.**

**SECTION III. FINANCIAL VIABILITY – REPEAT DEFICIENCY**

Section 1375.1 requires every licensed plan to demonstrate that it has fiscally sound operation and adequate provision against the risk of insolvency. Rule 1300.75.1 requires that every plan demonstrate fiscal soundness and assumption of full financial risk through its history of operations, projections, provide for the achievement and maintenance of a positive cash flow, including provision for retirement of existing and proposed positive cash flow, including provision for retirement of existing and proposed indebtedness, and adequate working capital, including provisions for contingencies.

The Department has serious concerns regarding the Plan's ability to demonstrate a fiscally sound operation and an adequate provision against the risk of insolvency, as follows:

1. The Plan's continued failure to achieve profitable operations, generate positive cash flow from operations, increasing administrative costs, low medical loss ratios, and continued decline in enrollment, as presented below:

|   | FYE<br>12/31/05 | FYE<br>12/31/06 | Quarter<br>3/31/07 | Quarter<br>6/30/07 |
|---|-----------------|-----------------|--------------------|--------------------|
| Enrollment                              | 7,261           | 6,043           | 5,660              | 5,542              |
| Total Revenue                           | \$ 523,267      | 478,134         | 111,264            | 102,470            |
| Less: Total Medical Expense             | 248,599         | 192,786         | 44,623             | 42,434             |
| Less: Total Admin Expense               | 516,602         | 449,416         | 106,582            | 100,606            |
| Less: Provision for Taxes               | 800             | 800             | 201                | 201                |
| Net Income <loss>                       | \$ <242,734>    | <164,868>       | <40,142>           | <40,771>           |
| Administrative Cost Ratio               | .99             | .94             | .96                | .98                |
| Medical Loss Ratio                      | .48             | .40             | .40                | .41                |
| Cash Flow Provided <used> by Operations | \$ <148,914>    | <239,252>       | <36,670>           | <36,623>           |

2. The Plan's administrative cost ratio as reported at quarter ended June 30, 2007 is 98%, but the Plan incorrectly classified \$6,129 in administrative expenses for repairs, postage and telephone as "Other Medical Expense". As a result, the Plan should report the administrative cost ratio as 104%, which is still excessive within the meaning of Section 1378. As required by Rule 1300.78, the Plan provided a justification to support the high administrative costs reported to the Department and stated the corrective action currently undertaken to reduce administrative costs is to significantly increased enrollment. The Plan demonstrated to the Department that enrollment grew by 1,125 enrollees as of September 24, 2007.
3. The Plan has not prepared an annual budget or forecast, for the past or upcoming fiscal year end, to establish goals for achieving financial viability through growth of enrollment and for monitoring the financial performance of the Plan.

The Plan's continued failure to comply with the financial viability requirements of Section 1375.1 and Rule 1300.75.1 and administrative cost guidelines of Section 1378 and Rule 1300.78(b) are *repeat deficiencies*, as it was previously reported in the Department's prior two Final Report of Examinations dated January 28, 2005 (for the period ended June 30, 2004) and July 16, 2003 (for the period ended August 31, 2002).

**Due to the serious concerns regarding financial viability and the fact that it is a twice repeated deficiency, a referral was made to the Department's Office of Enforcement for appropriate administrative action.**

*The Plan responded that in November of 2006, the Plan's CEO and shareholder had the opportunity to acquire the services of a person with various managed dental care experience that the CEO believed could guide him in increasing efficiency and grow enrollment. The Plan represented that while it incurred a net loss in 2006, the magnitude of the loss was much less than previous years. Furthermore, the Plan stated that enrollment increased over a thousand new enrollees in September 2007 and is poised to grow enrollment in the first quarter of 2008. The Plan hopes that the changes implemented, and it intends to implement in 2008, will result in its first profitable year.*

*The Plan further represented that it is focused on the administrative expenses incurred in 2008, and that it continues to spend a great deal of time, effort and money in increasing enrollment in an extremely competitive market. The Plan anticipates in 2008 that its administrative cost ratio will remain higher than desired; however, it hopes the ratio will decrease by half than noted during the audit. Upon request, the Plan will share its 2008 budget and forecast, which shows the anticipated savings in costs/expenses and increased enrollment.*

*The Plan prepared a 2008 budget and will provide it to the Board of Directors at the Board meeting scheduled for December 27, 2007. At that time, the Board of Directors will consider the budgeted expenses, forecasted revenue, including anticipated enrollment, and vote as to the adequacy of the budget. Once the 2008 budget is approved by the Plan's Board of Directors, the Plan will provide it to Department staff, if requested.*

*The Plan will continue to work with Department staff, including legal counsel from the Department's Office of Enforcement regarding any appropriate administrative action. The Plan's management hopes Department staff understands the significant effort the Plan's management has made and will continue to make in regards to providing affordable, prepaid dental care to the Riverside community.*

**The Department presents the Plan's response for informational purpose only, as the Plan's noncompliance with financial viability was referred to the Department's Office of Enforcement for appropriate administrative action.**

**SECTION IV. COMPLIANCE ISSUE**

**A. ADMINISTRATIVE CAPACITY/BOARD OF DIRECTOR OVERSIGHT**

Section 1367(g) requires a plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. Rule 1300.67.3(a) (3) requires the plan to have written procedures for the conduct of the business of the plan, including the provisions of health care services, so as to provide effective controls.

The Department's examination disclosed that the Board of Directors minutes for the period January 2006 to June 2007 do not reflect appropriate approval and review of financial and other operational decisions by the Board members, as follows:

1. Current financial reports not discussed or referenced in meetings.
2. Significant operational transactions not reported and approved in advance, such as change in physical location of the Plan.
3. No annual meeting/election of officers during 2006 or thru June 2007—*Repeat Deficiency*
4. No annual approval or resolution for authorized check signors—*Repeat Deficiency*

The failure of the Plan's Board to appropriately approve election of officers and authorized check signors are *repeat deficiencies* previously reported in the Department's prior Final Report of Examination dated January 28, 2005 (for the period ended June 30, 2004). The Plan provided a confirmation in its prior response that all future Board minutes shall comply with these requirements.

The Plan was required to describe, in detail, the corrective actions taken by management to ensure that the Plan's Board of Directors are adequately performing their fiduciary duties and responsibilities. Such corrective action was to include a detailed description of all controls and procedures implemented by Plan management to address the concerns noted above.

The Plan was also required to explain why the corrective action taken in response to our prior examination report did not prevent recurrence of noncompliance in this area.

Furthermore, the Plan was required to indicate the date corrective actions were implemented, the management position responsible, and the controls implemented for ongoing monitoring to ensure continued compliance.

*The Plan responded that its audited financial statements are discussed at the Board of Directors meeting when the audit is completed. In addition, the Board reviews the Plan's performance by reviewing quarterly financial statements. The Board's secretary as well as its legal counsel will ensure that the minutes reflect the Board of Director's review of the Plan's financial performance documentation.*

*The Plan stated that the change in location was discussed by the Board prior to implementation during Board meetings relative to ways to reduce expenses. The Board's legal counsel did not believe the change [in location by 1 mile] constituted a "significant operational change," which is reason he failed to include the Board discussion in the minutes. Nevertheless, the Board's legal counsel will strive to include any change of any significance in the minutes regardless of his assessment of whether it is a "significant operational change."*

*The Plan represented that the Plan's CEO is responsible to ensure that the corrective action was implemented on December 1, 2007. The CEO requested that the Plan's legal counsel submit the minutes to the Department so that the Department could consider whether the minutes are in accordance with California law and consistent with the Knox-Keene Health*

*Care Service Plan Act of 1975, as amended, and the requirements of the individual Department examiners.*

**The compliance efforts described above are not fully responsive to the corrective action required, as follows:**

- **the Plan did not provide an explanation as to why the corrective action taken in response to our prior examination report did not prevent recurrence of noncompliance in the areas noted above as “repeat deficiency”.**
- **the Plan did not state the specific corrective action implemented on December 1, 2007, nor did it include a detailed description of all controls and procedures implemented by Plan management for ongoing monitoring or to ensure continued compliance.**

**The Plan is again required to provide this information in its response to this report.**

**The Plan’s legal counsel is not to file the board minutes with the Department, but the minutes are to be available for review upon request.**

## **B. CHANGE IN MANAGEMENT**

Section 1352 and Rule 1300.52 .2 require all plans to file an amendment with the Director within 5 days of any changes in management.

Our examination disclosed that the Plan hired a Director of Marketing in December 2006. The Plan failed to file an amendment with the Department for this additional principal officer, as required by Rule 1300.52.2.

The Plan was required to file an amendment with the Department in accordance with the Section and Rule stated above. The Plan was also required to state the policies and procedures implemented to ensure that changes in management are timely filed with the Department; the date of implementation of these policies; and, the management position responsible for ensuring that the Plan understands and complies with the requirements of the above Section and Rule.

*The Plan responded that management and its legal counsel are familiar with the requirements of Section 1352 and Rule 1300.52.2. Mr. Baker is neither an “officer, director, partner, nor controlling shareholder.” Furthermore, he is neither a “general manager” nor a “principal management person” with the Plan, but simply a consultant to the Plan’s CEO. He is paid by the Plan’s CEO to guide him in developing greater enrollment in the Plan. He is referred to as the “Director of Marketing” simply for convenience and to permit him access to potential subscribers. Nevertheless, the Plan will file a Corporate Information Form and Individual Information Sheet noting the addition of Mr. Baker.*

*The Plan does not believe any corrective action policy or procedure is warranted as a result of the case noted above, however, the Plan’s CEO has instructed its legal counsel to file the individual information sheet and corporation information form for Mr. Baker.*

**The compliance effort described above is not fully responsive to the corrective action required, as the Plan has not clearly set forth the relationship/arrangement of this “Director of Marketing” with the Plan.**

**The Plan responded that the “Director of Marketing” is paid by the Plan’s CEO. The Plan is required to explain, in response to this report, if this payment is made by the Plan to Mr. Baker as a consultant through a contractual arrangement with the Plan; or, if he is paid personally by the Plan’s CEO/owner outside of the Plan. If Mr. Baker’s services are as a personal consultant to the owner and he is not paid by the Plan, then his donated services to the Plan must be properly disclosed in item C, line 7 of the supplemental information filed with the quarterly and annual financial statements.**

**The Department received an amendment filing on January 29, 2008 from the Plan that included a Corporate Information Form and Individual Information Sheet for the addition of Mr. Baker, which is under review.**

### **C. FIDELITY BOND**

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for thirty (30) days notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan, as required by the schedule in this Rule.

The policy provided to the Department for review did not provide 30 days notice to the Director prior to cancellation nor does it cover each officer, director, trustee, partner and employee of the plan, whether or not they are compensated.

The Plan was required to provide a copy of an updated fidelity bond that corrects the above noted deficiencies. The Plan was also required to state the management position responsible for the corrective action and a description of the controls implemented for monitoring continued compliance.

*The Plan filed a copy of an ERISA Compliance Bond for Non-Union Welfare & Pension Plans as a fidelity bond on January 29, 2008*

**The Department finds that the Plan’s compliance effort is responsive but does not fully comply with the corrective action required.**

**The Plan, a Knox-Keene licensee and a California corporation, is required to explain how it qualifies for this ERISA Compliance Bond for Non-Union Welfare & Pension Plans and why this policy should be acceptable for compliance with Rule 1300.76.3.**

**The language contained in the policy is not fully compliant with the requirements of Rule 1300.76.3, as follows:**

- The separate endorsement entitled “ERISA Inflation Guard” provides that the definition of an “employee” includes “... any natural person who is a trustee, officer, employee, administrator or a manager...of any Employee Welfare or Pension Benefit Plan (hereafter called Plan) insured under this insurance, and ...director or trustee while that person is handling funds or other property of any Plan insured under this insurance.”

This endorsement implies that only an “employee” of an Employee Welfare or Pension Benefit Plan is covered under this ERISA Compliance Bond.

- The separate endorsement for notice of cancellation does not specifically state that the insurer will provide 30-days notice prior to cancellation and it only provides that the insurer will use “... its best efforts to so notify...” the Department. This endorsement is to ensure that prior notification will be made to the Department within 30-days prior to cancellation.

The Plan is again required to provide a copy of a fidelity bond that corrects the above noted deficiencies in response to this report.

Furthermore, the Plan is again required to state the management position responsible for the corrective action and a description of the controls implemented for monitoring continued compliance.

#### **D. PROFESSIONAL LIABILITY INSURANCE—*REPEAT DEFICIENCY***

Section 1351(o) requires each plan to maintain adequate insurance coverage or self-insurance coverage to respond to claims for damages arising out of the furnishing of health care services.

Our examination disclosed that the Plan did not have an insurance policy against claims arising from the furnishing of health care services.

The failure of the Plan to maintain this insurance is a *repeat deficiency* previously reported in the Department’s prior Final Report of Examination dated January 28, 2005 (for the period ended June 30, 2004). .

The Plan was required to provide a copy of an insurance policy that corrects the above noted deficiency.

The Plan was required to explain why the corrective action taken in response to our prior examination report did not prevent recurrence of noncompliance in this area.

The Plan was also required to state the management position responsible for the corrective action and a description of the controls implemented for monitoring continued compliance.

*The Plan filed a copy of a malpractice policy on January 29, 2008*

*The Plan's response stated that management failed to secure the required policy. The Plan's CEO asked its legal counsel to include in the annual Board of Directors meeting minutes the status of all required insurance policies. Moreover, the CEO instructed his legal counsel to provide him with updates on a quarterly basis of all insurance policies that are required and the termination date of such policies.*

*The Plan represented that it implemented the above process on December 31, 2007. The Plan is confident that the above process will cause the Plan to be compliant with all insurance policy coverage matters.*

**The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required. The Plan submitted the binder of insurance but did not provide a copy of the actual policy. The Plan is again required to file a copy with the Department in response to this report.**

**In addition, the Plan is again required to explain why the corrective action taken in response to our prior examination report did not prevent recurrence of noncompliance in this area.**

#### **SECTION V. NONROUTINE EXAMINATION**

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

**No response required to this Section.**