REPORT ON EXAMINATION

OF

OSCAR INSURANCE CORPORATION

AS OF

DECEMBER 31, 2015

DATE OF REPORT **JANUARY 31, 2018**

EXAMINER **FROILAN L. ESTEBAL**

TABLE OF CONTENTS

January 31, 2018

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31418, dated January 29, 2016, attached hereto, I have made an examination into the condition and affairs of Oscar Insurance Corporation, an accident and health insurer licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2015, and submit the following report thereon.

The examination was conducted at the administrative office of Oscar Insurance Corporation, located at 295 Lafayette Street, New York, NY.

Wherever the designations the "Company" or "Oscar NY" appear herein, without qualification, they should be understood to indicate Oscar Insurance Corporation.

Wherever the designation, the "Parent" appears herein, without qualification, it should be understood to indicate Mulberry Health, 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

This is the first examination of the Company. This examination was a combined (financial and market conduct) examination and covered the period from the Company's inception, June 12, 2013 through December 31, 2015. 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, 2016 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2015, were also reviewed.

The examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Company's operations, and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Company's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Company.

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

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

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

The examination also evaluated the Company's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

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

The Company was audited in 2015 by the accounting firm of Deloitte & Touche LLP ("D&T"). The Company received an unqualified opinion for the period. Certain audit workpapers of D&T were reviewed and relied upon in conjunction with this examination.

Audits for calendar years 2013 and 2014 were performed by BDO USA and such audits were also found to represent fairly the financial position of the Company at those respective audit dates.

This examination was conducted as a coordinated examination, as such term is defined in the Handbook (an examination of one insurer or a group of insurers performed by examiners from more than one state whereby the participating states share resources and allocate work among the examiners), of the insurance subsidiaries of Mulberry Health, Inc. The examination was led by the State of New York with participation from the Texas Department of Insurance. Since the Lead and Participating states, as such terms are defined in the Handbook, are accredited by the NAIC, the states deemed it appropriate to rely on each other's work. The examination team, representing the Lead and Participating states, identified and assessed the risks for key functional activities across all of Mulberry Health, Inc.'s insurance subsidiaries. The examination team also assessed the relevant prospective risks as they relate to the various insurance entities.

During this examination, a review was made of the Company's IT systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

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

2. DESCRIPTION OF THE COMPANY

The Company is a wholly-owned subsidiary of Mulberry Health Inc., a Delaware Corporation. Oscar Insurance Corporation filed a Uniform Certificate of Authority Application for licensure as a New York Insurance Law Article 42 accident and health insurer with the New York State Department of Financial Services on December 12, 2012. Subsequently, on January 31, 2013, Oscar NY was incorporated, pursuant to the Company's submission of a Declaration of Intention and Charter ("Charter") to the Department. Such Charter was approved by the Department, pursuant to Section 1201 of the New York Insurance Law, and placed on file the same date. On February 19, 2013, the Company issued 20,000,000 shares of $.01 par value per share capital stock for a price of $.015 per share to it's Parent, resulting in an aggregate purchase price of $300,000. These funds were infused to establish a statutory investment account in the name of the Superintendent of Financial Services. The Company was licensed by the Department on July 12, 2013. A report on organization was conducted and filed on July 5, 2013.

A. Corporate Governance

The Company's by-laws stipulate that the number of directors, which shall constitute the whole board of directors, shall be fixed from time to time by resolution of the Shareholders, consistent with the provisions of the Charter. Oscar NY's Charter states that the corporation shall consist of not less than seven, nor more than ten members. As of the date of this examination, the seven members of the board of directors were as follows:

Name and Residence	Principal Business Affiliation
Joel Cutler Boston, MA	General Catalyst, Managing Director
David Henderson Loudonville, NY	Oscar Insurance Corporation, President of Insurance
Joshua Kushner New York, NY	Oscar Insurance Corporation, Chairman
Christopher Paik New York, NY	Thrive Capital Management, LLC, Investor
Mario Schlosser New York, NY	Oscar Insurance Corporation, Chief Executive Officer and Treasurer
Jared Weinstein New York, NY	Thrive Capital Management, LLC, Chief of Operations
Kareen Zaki New York, NY	Thrive Capital Management, LLC, Investor

The Board met at least five times during 2014 and 2015, including quarterly meetings, in compliance with Article III, Section 5 of the Company's by-laws, which specifies that the Board is to meet at least once annually.

A review of the attendance records of the Board of Directors' meetings held during the examination period revealed that meetings were generally well attended, with all members attending at least one half of the meetings they were eligible to attend.

The principal officers of the Company as of December 31, 2015, were as follows:

Name	Title
Mario Schlosser	Chief Executive Officer and Treasurer
Joshua Kushner	Chairman
Steven Kessler	Chief Financial Officer
David Henderson	President of Insurance
Kevin Campbell	Chief Operating Officer
Shilpa Patel	Secretary
Dr. Aran Ron	Chief Medical Officer

Changes to the board of directors

Effective November 4, 2015, Kevin Campbell was elected as a member of the board of directors. Effective March 7, 2016, and subsequent to the examination date, Joshua Kushner and David Henderson resigned as members of the Company's board of directors. Effective the same date, Steven Kessler, Joel Klein, Brian West, and Alan Warren were elected as members of the board of directors.

The *2016 NAIC Financial Conditions Examiners Handbook* (pg. 200) states in part:

> "…it is important that the board contain at least a critical mass of outside directors. The number should suit the entity's circumstances, but more than one outside director would normally be needed for a board to have the requisite balance."

The changes in composition of the board of directors in 2016 indicate that six of the succeeding board members, or 86%, were also officers of the Company, which includes the Chief Executive Officer. Five of the directors/officers report directly to the CEO. As listed on the 2016 Jurat Page, there is only one director (Kareem Zaki) who is not listed as an officer of the Company. Mr. Zaki, however, is an investor and member of Thrive Capital, who is therefore also not

independent of the Company. This significant change in membership, subsequent to the examination, eliminated all but one of the external members of the board and replaced them with officers of the Company.

It is recommended, as a best practice per the NAIC Examiner's Handbook, that the Company include a fair representation of independent members on its board of directors.

B. Enterprise Risk Management

Section 82.2 (Enterprise risk management) of Insurance Regulation 203(11 NYCRR 82) states in part:

> "(a) Pursuant to Insurance Law sections 1503(b), 1604(b), and 1717(b), an entity shall adopt a formal enterprise risk management function that identifies, assesses, monitors, and manages enterprise risk. Except as provided in subdivision (c) of this section, a domestic insurer that is not a member of a holding company system, an article 16 system, or an article 17 system also shall adopt such a formal enterprise risk management function. The enterprise risk management function shall be appropriate for the nature, scale, and complexity of the risk and shall adhere to the following, as relevant:
>
> (1) have an objective enterprise risk management function headed by an appropriately experienced individual with the requisite authority and who has access to the board of directors, or if there is no board of directors, then the governing body, and senior management;
>
> (2) have a written risk policy adopted by the respective board or a committee thereof, or if there is no board of directors, then the governing body, that delineates the insurer's, holding company system's, article 16 system's, or article 17 system's risk/reward framework, risk tolerance levels, and risk limits;
>
> (3) provide a process for the identification and measurement of risk under a sufficiently wide range of outcomes using techniques that are appropriate to the nature, scale, and complexity of the risks the insurer, holding company system, article 16 system, or article 17 system bears and are adequate for capital management and solvency purposes;
>
> (4) have a process of risk identification and measurement supported by documentation that provides appropriately detailed descriptions and explanations of risks identified, the measurement approaches used, key assumptions made, and outcomes of any plausible adverse scenarios that were run;

(5) use prospective solvency assessments, including scenario analysis and stress testing;

(6) incorporate risk tolerance levels and limits in the policies and procedures, business strategy, and day-to-day strategic decision-making processes;

(7) consider a risk and capital management process to monitor the level of financial resources relative to economic capital and regulatory capital requirements;

(8) incorporate investment policy, asset-liability management policy, effective controls on internal models, longer-term continuity analysis, and feedback loops to update and improve the enterprise risk management function continuously;

(9) address all reasonably foreseeable and relevant material risks including, as applicable, insurance, underwriting, asset-liability matching, credit, market, operational, reputational, liquidity, and any other significant risks;

(10) include an assessment that identifies the relationship between risk management and the level and quality of financial resources necessary as determined with quantitative and qualitative metrics; and

(11) identify, quantify, and manage any risks to which the insurer may be exposed by transactions or affiliations with any other member of the holding company system, article 16 system, or article 17 system of which the insurer is a member."

Further, Insurance Circular Letter No. 14 (2011), states in part:

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

In accordance with Insurance Regulation No. 203 (11 NYCRR 82) "Enterprise Risk Management and Own Risk and Solvency Assessment," as of June 25, 2014, the Company's ultimate parent, Thrive Partners III GP, LLC, is required to adopt a formal enterprise risk management function to proactively identify and mitigate various business risks, including prospective business risks. However, no such ERM framework was in place during the examination period. One has subsequently been put into place.

It is recommended that the Thrive Partners III GP, LLC Companies, which include Oscar NY, comply with Part 82.2(a) of Insurance Regulation No. 203 (11 NYCRR 82) by adopting a formal enterprise risk management function.

C. Internal Audit

The Company does not have a formal internal audit function. Such a function can provide independent assurance that Oscar NY's risk management, governance and internal control processes are operating effectively by providing an independent, unbiased assessment of the Company's operations.

It is recommended, as a best practice, that the Company establish an internal audit function in order to provide an independent, unbiased assessment of the Company's operations.

D. Territory and Plan of Operation

Oscar NY offers coverage using an Exclusive Provider Organization ("EPO") product that provides individual health benefits to its members through both a leased and Oscar NY-contracted provider network of over 40,000 providers, including over 70 hospitals. Oscar NY's service area includes the nine downstate New York counties: Suffolk, Nassau, Westchester, Rockland, NewYork, Kings, Queens, Richmond, and the Bronx. Oscar NY also offers health insurance benefits through the New York State of Health ("NYSOH"), the state-run marketplace, as a Qualified Health Plan. In New York State, the NYSOH is coordinated through the New York State Department of Health.

Oscar NY entered the small group market in 2017 with "Oscar for Business," offering health insurance policies to New York small groups with between 1 and 100 employees. Oscar for Business sales launched in February 2017 for its first policies effective on April 1, 2017. The product is currently available in New York City and Long Island.

E. Reinsurance

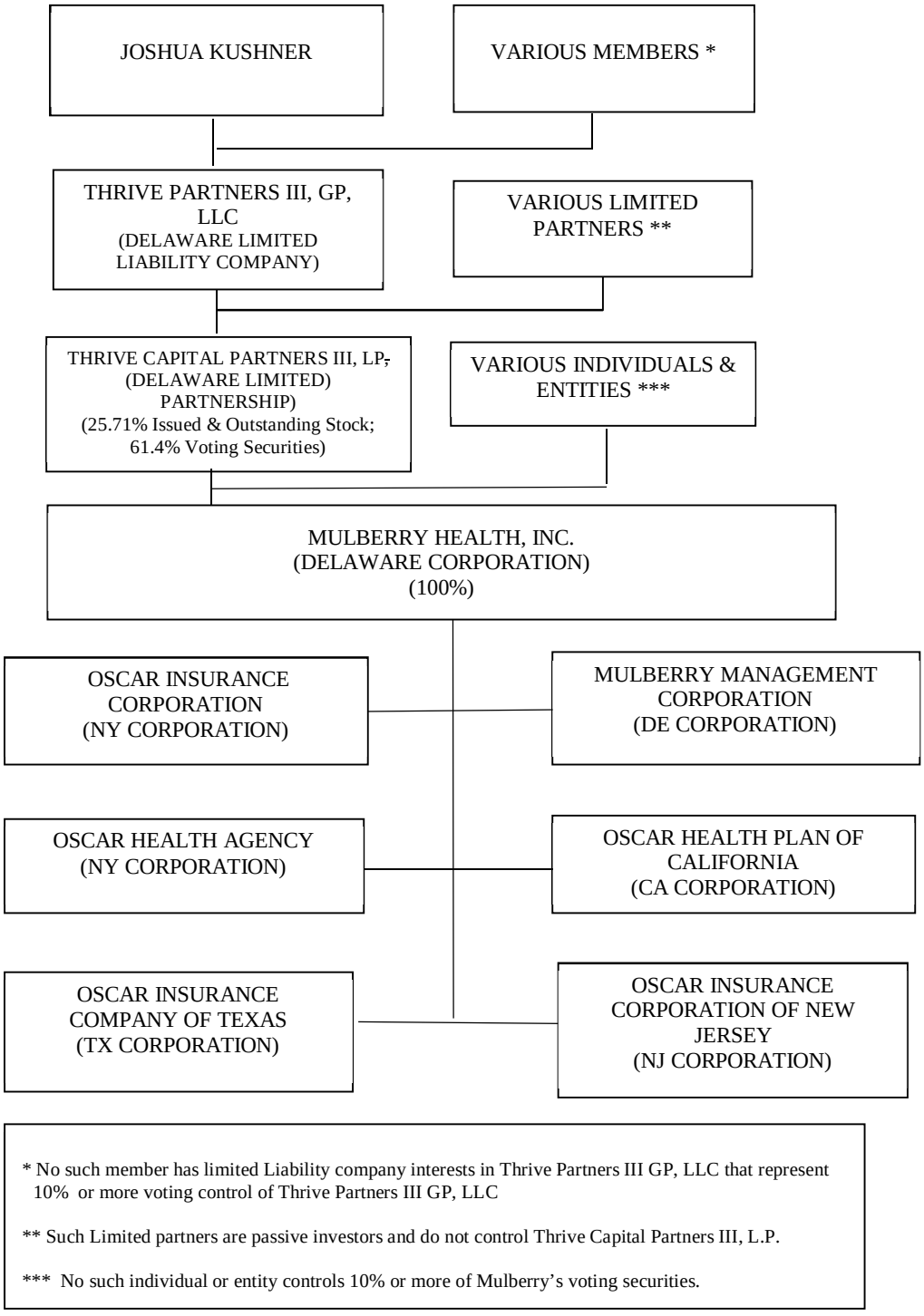
Effective January 1, 2015, Oscar Insurance Corporation entered into a Medical per Person Excess of Loss Reinsurance Agreement with PartnerRe America Insurance Company. The policy is written and renewable annually.

Effective Period	Oscar's Retention	Reinsurer's Liability
1/01/15 thru 1/01/16	$350,000 annually per member.	90% of all qualifying losses to Oscar.

The agreement includes an insolvency clause in accordance with New York Insurance Law Sections 1308(a)(2)(A)(i) and (ii). Either party may terminate the agreement upon thirty days' notice, with such notice also given to the Department.

F. Holding Company System

The Company is part of a holding company system as depicted in the following organizational chart as of December 31, 2015:



Thrive Partners III GP, LLC ("Thrive GP") is a venture capital fund manager formed on August 15, 2012, and organized as a limited liability company under the laws of Delaware. Joshua Kushner is the majority member and Managing Director of Thrive GP.

Thrive Capital Partners III, LP ("Thrive LP") is a venture capital fund formed on August 15, 2012, and organized as a limited partnership under the laws of Delaware. Thrive LP has more than 90% of the voting control of Mulberry Health, Inc.

Joshua Kushner is deemed the ultimate controlling person in Oscar's holding company system because he represents more than 90% voting control and is the majority member of Thrive GP, the general partner of Thrive LP.

Mulberry Health, Inc. is a Delaware corporation incorporated on October 25, 2012. Mulberry operates as the direct parent of Oscar NY. Its principal offices are located at 295 Lafayette Street, New York, NY 10012.

Management Services Agreement

In 2015, the Company filed with the Department the following:

- A Proposed Shared Services Agreement;
- A Tax Allocation Agreement; and,
- A Request to transfer an asset consisting of intellectual property to its affiliate, Mulberry Management Corporation.

On July 5, 2017, the Department issued a non-objection for the Tax Allocation Agreement. The other agreements/transactions are currently under review by the Department.

G. Significant Operating Ratios

The following schedule reflects the Company's operating results:

Year	Net Premiums Written	Net Paid Health Claims	Net Income	Policyholder Surplus	Ratio of Net Premiums Written to Surplus
2015	$117,421,763	$134,353,000	($92,453,335)	$21,280,563	551.7%
2014	$ 56,921,211	$ 55,224,814	($27,561,270)	$27,282,554	208.6%
2013	0	$ 0	($ 8,165,499)	$46,574,657	-

The underwriting ratios for 2015 are presented below on an earned-incurred basis:

	Amounts	Ratios
Claims	$ 152,039,918	129.5%
Claim adjustment expenses	10,818,001	9.2%
General administrative expenses	35,714,998	30.4%
Increase in reserves for health contracts	11,302,659	9.6%
Net underwriting gain (loss)	(92,453,813)	(78.7)%
Premium revenue	$117,421,763	100.00%

The Company's authorized control level Risk-Based Capital ("RBC") was $8,010,121 as of December 31, 2015. Its total adjusted capital was $21,280,563, yielding an RBC ratio of 265.7% at December 31, 2015.

H. Allocation of Expenses

Part 109.2 of Insurance Regulation 30 (11 NYCRR 109.2), states:

> "(a) Direct allocations**.**
> Wherever possible, salaries of individuals or similarly employed groups shall be allocated direct to companies, expense groups and primary lines of business. In other words, salaries of employees whose work is solely in connection with a specific company, expense group or primary line of business shall be allocated thereto.
>
> **(**b) Allocations other than direct.
> (1) When a direct allocation is not made, salaries, with certain exceptions hereinafter noted, shall be allocated on whichever of the following bases, or combinations thereof,

> are appropriate: Number of items or units, time studies, overhead on other allocations, premiums, dollar volume of losses, other special studies.
> (2) The effects of the application to each operating expense classification of all bases of allocation shall be shown on records kept in clear and legible form. Such records shall be readily available for examination."

During the examination period, Oscar NY paid salaries and other expenses for its affiliates and was subsequently reimbursed by those entities. The calculation of the reimbursement amounts were tested, in order to determine compliance with Insurance Regulation 30 (11 NYCRR 109.2). During the examiner's revew, it was noted that the breakout of employee salaries was performed by a polling of Oscar-NY's employees, instead of through a method approved by the cited Regulation.

It is recommended that the Company comply with Part 109.2 of Insurance Regulation 30 (11 NYCRR 109.2) with regard to utilizing an acceptable methodology for determining the allocation of expenses.

Additionally, Part 106.6 of Insurance Regulation 30 (11 NYCRR 106.6), states:

> "(a) The methods followed in allocating joint expenses shall be described, kept and supported as set forth under "detail of allocation bases" (see section 109.4[g], infra).
> (b) The effects of the application, to each operating expense classification of all bases of allocation shall be shown on records kept in clear and legible form. Such records shall be readily available for examination."

The lack of a formal structure and documentation supporting the allocations is not in compliance with Part 106.6 of Insurance Regulation 30, cited above.

It is recommended that the Company comply with Part 106.6 of Insurance Regulation 30 (11 NYCRR 106.6) by maintaining documentation supporting its allocation and keep such records available for examination.

I. Medical Loss Ratio Reporting

The Company's 2015 Medical Loss Ratio ("MLR") Annual Reporting Form was reviewed to determine compliance with Title 45 of the U.S. Code Federal Regulations (45 CFR §158.110(b)), which implements section 2718 of the Public Health Service Act ("PHS Act"). Section 2718 of the PHS Act, as added by the Affordable Care Act ("ACA"), generally requires health insurance companies to submit to the Secretary an annual report on their MLRs. The MLR is the proportion of premium revenue expended by a company on clinical services and activities that improve health care quality in a given state and market. Section 2718 of the PHS Act also requires a company to provide rebates to consumers if it does not meet the MLR standard of 80% in the Individual Market.

This is the first examination of the Company's MLR Annual Reporting Forms. The examination covered the reporting period of January 1, 2014 through December 31, 2015.

The examination was conducted in accordance with the Medical Loss Ratio Examination Handbook (the "MLR Handbook"). The MLR Handbook sets forth the guidelines and procedures for planning and performing an examination to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Reporting Form, and the accuracy and timeliness of any rebate payments. The examination included assessing the principles used and significant estimates made by the Company, evaluating the reasonableness of expense allocations,

and determining compliance with relevant statutory accounting standards, MLR regulations and guidance, and the MLR Reporting Form Filing Instructions.

Title 45 of the U.S. Code Federal Regulations (45 CFR §158.110(b)) requires that a report for each Medical Loss Ratio reporting year is to be submitted to the Secretary of the U.S. Department of Health and Human Services ("HHS") by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary of HHS. Based on the examiner's review, Oscar NY filed an acceptable form by June 1, 2016 for the 2015 reporting year and is in compliance with Title 45 CFR §158.110(b).

Title 45 CFR §158.210 (c) requires that an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80% for the individual market. The Company' MLR and rebate calculations from the MLR Annual Reporting Form were as follows:

MLR Components	Individual
Adjusted Incurred Claims	$ 248,207,453
Plus:	
Quality Improvement Expenses	6,677,221
Cost-sharing adjustments	(8,084,077)
Federal Transitional Reinsurance Program payments	(37,302,888)
Expected Federal Risk Adjustment Program payments	39,050,905
Federal Risk Corridors Program net payments	(1,011,926)
MLR Numerator	**$ 247,536,688**
Premium Earned	219,640,913
Less:	
Federal & State Taxes and Licensing/Regulatory Fees	8,825,852
MLR Denominator	**$ 210,815,061**
Preliminary MLR Before Credibility Adjustment	117.5%

Credibility Adjustment	1.2%
Credibility–Adjusted MLR	**118.7%**
MLR Standard	80 %
Rebate Amount	**$0**

Medical Loss Ratio Numerator

According to Title 45 of the U.S. Code of Federal Regulations (CFR §158.221(b)), the numerator of the Medical Loss Ratio (MLR) calculation is comprised of incurred claims, as defined in 45CFR §158.140, plus expenditures for activities that improve health care quality, as defined in Title 45 CFR §158.150, and Title 45 CFR §158.151. The examiner verified the data used to calculate the adjusted incurred claims. Based on the review, Oscar NY included appropriate adjusted incurred claims in the MLR numerator.

Section 243.2 of Insurance Regulation 152 (11 NYCRR 243.2) states in part:

> "(a) In addition to any other requirement contained in Insurance Law, Section 325, any other section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part…
>
> (4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received."

The examiner reviewed the reasonableness of the health care quality improvement expenses including confirming that the methodology complies with the narrative provided within the Part 4 – Expense Allocation portion of the MLR Reporting Form and conforms to the definition of Healthcare Quality Improvement Expenses as defined by 45 CFR §158.150, and 45 CFR §158.151. Based on the examiner's review, Oscar NY's allocation methodology and health care

quality improvement expenses reported in the MLR numerator do not conform to the regulations. Instead, the Company allocated Quality Improvement expenses utilizing data from a prior period and was not able to provide any support for the propriety of those percentages.

It is recommended that the Company comply with Title 45 CFR §158.150, and Title 45 CFR §158.151 by establishing Quality Improvement expenses using current allocation percentages for each MLR filing. It is further recommended that the Company comply with Part 243.2 of Insurance Regulation 152 (11 NYCRR 243.2) by maintaining records to verify the accuracy of the allocation percentages. It is noted that this deficiency did not have any impact on the Company's liability to pay rebates as the final ratio was above the minimum and utilizing proper allocations would have served to further increase the percentage.

Medical Loss Ratio Denominator

According to Title 45 CFR §158.22(c), the denominator of the MLR calculation is comprised of premium revenue, as defined in Title 45 CFR §158.130, minus federal and state taxes and licensing and regulatory fees, described in Title 45 CFR §158.161(a), and Title 45 CFR §158.162(a)(1) and (b)(1). The examiner verified the data used to calculate the premium revenue. Based on the review, Oscar NY included appropriate premiums earned in the MLR denominator.

Credibility Adjustment

According to Title 45 CFR§158.232, the credibility adjustment is the product of the base credibility factor multiplied by the deductible factor. This calculation was tested and it was determined to be accurate.

Credibility Adjusted Medical Loss Ratio

According to Title 45 CFR §158.221(a), the calculation of the MLR is the ratio of the numerator to the denominator, subject to the applicable credibility adjustment, if any. Based on the examiner's review, Oscar NY appropriately calculated the medical loss ratio for its market segment.

Rebate Amount, Calculation and Distribution

According to Title 45 CFR §158.240, a rebate is required if an insurer's MLR is less than the minimum MLR standard. Based on the examiner's review, Oscar NY's MLR exceeded the minimum percentage for its market segments. As a result, no rebates were warranted for issuance during the examination period.

MLR Information Notice

According to Title 45 of the U.S. Code of Federal Regulation §158.251(a) and (b), a notice of rebate is required when the medical loss ratios do not exceed the minimum percentage. The Company's medical loss ratio for the examination period did exceed the minimum percentage and therefore no notices were required.

Impact On Risk-Based Capital

According to Title 45 of the U.S. Code of Federal Regulations §158.270(a), rebate payments having any adverse impact on the Company' Risk-Based Capital ("RBC") level requires notification by the Regulator to the Secretary of the U.S. Department of Health and Human

Services ("HHS"). Based on the examiner's review, the Company's MLR exceeded the minimum percentage for the individual market segments, and no rebates were due to be issued, therefore there was no impact on the RBC level that would warrant notification to the Secretary of HHS.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2015, as contained in the Company's 2015 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2015 filed annual statement.

Independent Accountants

As noted previously in this report, the firm of Deloitte & Touche LLP was retained by the Company to audit the Company's combined statutory basis statements of financial position as of December 31st of the examination period, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended. D&T concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audit dates.

A. Balance Sheet

Assets

Bond	$	300,000
Cash and short-term investments		85,209,163
Uncollected premiums in the course of collection		266,620
Amounts recoverable from reinsurer		16,329,237
Electronic data processing equipment		129,281
Receivable from parent and affiliates		13,551,816
Health care receivable		2,628,434
Risk corridor receivable *		165,256
Total assets	$	118,579,807

Liabilities

Claims unpaid	$	33,567,630
Accrued medical incentive pool		1,795,119
Unpaid claims adjustment Expenses		729,193
Aggregate health policy reserves		12,659,214
Aggregate health policy reserves		1,357,248
Premiums received in advance		8,092,456
Ceded reinsurace premiums payable		2,105,411
General expenses due and accrued		6,819,327
Aggregate write-ins for other liabilities		30,173,646
Total liabilities	$	97,299,244

Capital and Surplus

Capital stock	$	200,000
Aggregate write-in for special surplus funds		2,229,556
Gross paid in and contributed surplus		152,228,154
Unassigned funds		(133,377,147)
Total capital and surplus	$	21,280,563
Total liabilities, capital and surplus	$	118,579,807

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

The Risk Corridor Receivable balance was recorded at approximately 12.6% of the $9,342,724 that had been calculated to be received under the federal program. The amount actually received, subsequent to the examination, was $1 million.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and Surplus decreased $14,719,437 during the examination period, June 12, 2013, through December 31, 2015, detailed as follows:

Revenue		
Net premium income	$ 174,342,974	
Aggregate write-ins	0	
Total revenue		$ 174,342,974
Hospital and Medical Expenses		
Hospital/medical benefits	$ 194,954,393	
Other professional services	10,511,380	
Emergency room and out-of-area	2,192,898	
Prescription drugs	36,687,514	
Incentive pool, withhold adjustments	1,795,119	
Net reinsurance recoveries	(40,279,808)	
Total hospital and medical expenses	$ 205,861,496	
Administrative expenses		
Claims adjustment expenses	15,830,738	
General administrative expenses	68,172,245	
Increase in reserves for A&H contracts	12,659,215	
Total underwriting deductions		$ 302,523,694
Net underwriting loss		$ (128,180,720)
Net investment income earned		616
Net loss before taxes		$ (128,180,104)
Federal income taxes		0
Net loss		$ (128,180,104)

Changes in Capital and Surplus

Capital and surplus per report on organization examination as of June 12, 2013			$36,000,000
	Increases	Decreases	
Net income (loss)	$ 0	$128,180,104	
Paid in Capital	116,428,154		
Change in non-admitted assets		2,967,085	
Aggragate write-ins for gains or (losses)		402	
Net increase (decrease) in surplus			($14,719,437)
Capital and surplus, per examination, as of December 31, 2015			$21,280,563

Capital Infusions

Sections 1505(c) and (d)(1)(A) of the New York Insurance Law state:

> (c) The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year-end.
> (d) The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or with regard to reinsurance treaties or agreements at least forty-five days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within such period:
> (1) sales, purchases, exchanges, loans or extensions of credit, or investments involving less than five percent of the insurer's admitted assets at last year-end, provided the transactions are equal to or exceed:

Since its inception, the Company has experienced sustained and significant financial operating losses. As a result, the Company received $251,302,154 in capital infusions from its Parent since licensure. Infusions include $102,302,154 during the period covered by this examination and an additional $204,900,000 during 2016 and 2017. It is noted that, as a condition for licensing, Mulberry Health, Inc.s' board of directors committed to ensuring that Oscar's business writings be limited to a net premium to surplus ratio of not more than 4:1, and not more

than 8:1 for Exclusive Provider Organization ("EPO") products. In addition to other statutory requirements, these ratios serve as the basis for the capital infusions made by the Parent to the Company, which has resulted in the Company complying with capital requirements to date. Below are the details of those capital infusions:

2013 to 2015	**Contribution**	**2016 to 2017**	**Contribution**
November 11, 2013	5,878,554	January 29, 2016	$30,000,000
		February 29, 2016	17,000,000
March 1, 2014	250,000	March 31, 2016	21,000,000
November 18, 2014	3,500,000	May 27, 2016	9,500,000
December 17, 2014	5,000,000	June 30, 2016	27,000,000
December 31, 2014	673,600	November 7, 2016	12,000,000
		December 6, 2016	16,500,000
February 2, 2015	5,000,000	December 27, 2016	16,000,000
March 30, 2015	10,000,000	April 25, 2017	7,000,000
November 9, 2015	31,000,000	May 26, 2017	2,900,000
December 10, 2015	12,000,000	August 11, 2017	5,800,000
December 31, 2015	29,000,000	June 28, 2017	9,800,000
		July 31, 2017	2,300,000
		September 26, 2017	7,700,000
		October 23, 2017	6,100,000
		November 29, 2017	4,000,000
		December 12, 2017	10,300,000
TOTAL	$102,302,154		$204,900,000

It is noted that the contributions received prior to 2015 and some that were contributed in 2017 were not submitted for approval to the Superintendent, as required by Sections 1505(c) and (d)(1)(A) of the New York Insurance Law.

4. CLAIMS UNPAID AND UNPAID CLAIM ADJUSTMENT EXPENSES

The examination Claims Unpaid liability of $33,567,630 is the same as the amount reported by the Company, as of December 31, 2015.

The examination Unpaid Claims Adjustment Expense liability of $729,193 is the same amount reported by the Company, as of December 31, 2015.

The examination analysis of the captioned accounts was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements, as well as additional information provided by the Company, as verified by the examiners. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles which utilized the Company's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2015.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Company 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 Company in the following major areas:

A. Explanation of benefits statements
B. Utilization review
C. Utilization review appeal
D. Prompt payment of claims

A. Explanation of Benefits Statements

Section 3234 of the New York Insurance Law states in part:

> "(a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits.
>
> (b) The explanation of benefits form must include at least the following…
>
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of adenial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

It was noted that none of the explanation of benefits were in compliance with Section 3234(b)(7) of the New York Insurance Law for their failure to include notification that failure to comply with the stated appeal/grievance requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made. A review revealed there were 158,724 such EOBs during 2015, all of which were in violation.

It is recommended that the Company comply with Section 3234(b)(7) of the New York Insurance Law by including all required information on its explanation of benefits statements.

B. Utilization Review

Section 4903 of the New York Insurance Law states in part:

> "(b)(1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information…
>
> (c) A utilization review agent shall make a determination involving continued or extended health care services… and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information
>
> (d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.
>
> (e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
>
> (1) the reasons for the determination including the clinical rationale, if any;
>
> (3) …Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal."

Adverse Determination Letters sent by Oscar NY's third-party administrator AliCare for post-service claims during 2015 were in violation of New York Insurance Law Section 4903(e)(1) for their failure to include a clinical rationale when the claim was denied for a lack of sufficient information or when the information that was provided did not justify the level of care. Nor did the adverse determination letters indicate what additional information would be required to overturn the denial; which is also a violation of the cited law.

The examiner reviewed twenty claims that had been denied retrospectively for a lack of medical necessity during the exam period. The sample was selected from the population of hospital/medical claims adjudicated during 2015 by Alicare. The following issues were noted from a review of claims within the sample:

- In violation of Section 4903(e)(1) of the New York Insurance Law, there were ten instances, where the claims did not contain a sufficiently detailed explanation of the clinical rationale for why the claim had been denied and three instances where the cause for denial on the Adverse Determination letter was listed incorrectly. According to the Company, this occurred when the claim was being denied for a lack of sufficient information or when the information that was provided did not justify the level of care.
- There were three claims where an authorization was created retroactive to the adjudication of the claim but the claim was not re-opened for payment until discovery during the retrospective review.

It is recommended that the Company comply with New York Insurance Law Section 4903(e)(1) by ensuring that all Adverse Determinations include an accurate and sufficiently detailed clinical rationale for the denial.

It is recommended that the Company ensure that, where authorizations for treatment are provided retroactive to the adjudication of a claim, the originally denied claims are overturned for

payment, and where applicable, interest be paid, pursuant to New York Insurance Law Section 3224-a(c).

Additional issues that were noted within the sample that did not relate directly to Utilization Review, are as follows:

- Eight of the claim decisions were made late, in violation of New York Insurance Law 3224-a. In one instance, interest was not paid on a late claim, as required by New York Insurance Law 3224-a(c). Prompt payment violations are discussed in more detail in a separate section of this report.
- In five instances, Explanation of Benefit documents were sent for claims that had been adjusted but the new documents did not contain any notification that the new EOBs were replacements of the prior documents. This can lead to confusion on the part of the insured.

It is recommended, as a best practice, that when a claim has been adjusted, the subsequent Explanation of Benefits statement include notification that the EOB is an adjustment, in order to assist the member in understanding the adjudication of the claim.

The examiner also tested a sample of prospective, concurrent, and retrospective decisions that were selected from the Company's Utilization Review logs from the period January 1, 2015 through December 31, 2015. Twenty-five such cases were selected.

Of the twelve prospective requests for treatment in the sample, in one instance, the decision was not made within three business days, as required by New York Insurance Law Section 4903(b).

Of the six concurrent requests for treatment in the sample, in two instances, the decision was not made within one business day, as required by New York Insurance Law Section 4903(c).

During discussion concerning the results of this testing, the Company indicated that, effective January 1, 2016, it had brought the utilization management function previously delegated

to Alicare in-house in order to improve quality and reduce expenses. In order to determine the effectiveness of the change, a statistically valid sample of 200 UR decisions from the population of 12,564 decisions that were made during 2016 was selected to test for compliance with New York Insurance Law Sections 4903(a), (b), and (c). The results of the testing revealed that twenty decisions, or 10% of the total, were made outside the timing requirements of the law. An extrapolation of this total indicates that a calculated error rate of 1,256 cases were in violation of the cited law.

It is recommended that the Company comply with the provisions of New York Insurance Law Section 4903 and make Utilization Review decisions within the required time frames after receipt of the necessary information.

During the aforementioned reviews, the Company was not able to provide evidence of a routine and formal program to test adjudicated claims for accuracy and timeliness.

It is recommended that the Company institute a program of regularly scheduled formal audits of utilization review decisions and decision timeliness in order to reduce the number of exceptions within its processes. While the Company has taken steps to increase the review of adjudication quality and to increase the training of staff subsequent to the examination date, a comprehensive auditing program has not been initiated.

C. Utilization Review Appeal

Section 4904(c) of the New York Insurance Law states in part:

> "…The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary

> information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination."

Section 4904(d) of the New York Insurance Law states in part:

> "Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination."

Oscar NY provided the examiner with its log of appeals from the period January 1, 2015 through December 31, 2015, and the examiner selected twenty-two cases for review, in order to determine compliance with New York Insurance Law Section 4904.

During review of the sample, the examiner noted the following, in violation of New York Insurance Law Section 4904(c):

- In fourteen instances, Oscar NY failed to provide written acknowledgement to the appealing party within fifteen days of an appeal filing;
- In two instances, Oscar NY did not make the appeal determination within the required time frame of sixty days; and
- In seven instances, the Company did not send an appeal determination letter to notify the insured/insured's designee of the appeal determination within two business days of making such determination.

Further, in fourteen instances, Oscar NY was not in compliance with New York Insurance Law Section 4904(d), as the provider that made the appeal determination was the same clinical peer reviewer that made the original denial.

It is recommended that Oscar NY comply with the provisions of Section 4904(c) of the New York Insurance Law by ensuring that all of the timeliness requirements are achieved in its appeal communications and determinations.

It is recommended that Oscar NY comply with the requirements of Section 4904(d) of the New York Insurance Law by ensuring that the clinical peer reviewer who determines an appeal is not the same clinical peer reviewer who rendered the original adverse determination.

D. Prompt Payment of Claims

Section 3224-a of the New York Insurance Law "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" requires all insurers to pay undisputed claims within either 30 days or 45 days, depending upon whether the claim was submitted electronically or on paper, respectively. Where a claim has been disputed, insurers are required to notify the sender of the dispute in order to seek clarification within thirty days.

Section 3224-a(a) of the New York Insurance Law states:

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

Section 3224-a(b) of the New York Insurance Law states in part:

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer …shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment…"

During calendar year 2015, Oscar NY utilized multiple claim systems for its various claim types: medical/hospital, mental health, vision, and pharmacy claims. To test Oscar NY's compliance with the aforementioned laws, claims paid during calendar year 2015 from the various systems were sampled and tested. First, claims were "rolled up" so that each claim submitted was only represented a single time. Claims from each population that appeared to be violations of Parts (a) and (b) of the New York Insurance Law Section 3224-a were extracted into separate populations for testing. From there, statistical samples were selected and those samples were tested to determine compliance with the aforementioned statute.

For the population of claims from the system containing medical/hospital claims, the sampling revealed there were 13,994 claims that were adjudicated late. For this single population, this resulted in a violation rate of 4.9%.

It is recommended that the Company comply with Section 3224-a of the New York Insurance Law and strive to adjudicate all claims within the time frames prescribed under the law.

6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____
Froilan Estebal
Senior Insurance Examiner

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

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

_____
Froilan Estebal

Subscribed and sworn to before me
this _____ day of_____

APPOINTMENT NO. 31418

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***SHIRIN EMAMI****, Acting 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:*

Froilan Estebal

as a proper person to examine the affairs of

Oscar Insurance Corporation

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

Corporation

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 29th day of January, 2016

SHIRIN EMAMI
Acting Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau