REPORT ON EXAMINATION
OF
CRYSTAL RUN HEALTH INSURANCE COMPANY, INC.

AS OF DECEMBER 31, 2018

EXAMINER: **EDOUARD MEDINA**

DATE OF REPORT: **AUGUST 27, 2022**

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Honorable Adrienne A. Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment No. 31814, dated September 19, 2019 attached hereto, I have made an examination into the financial condition and affairs of Crystal Run Health Insurance Company, Inc., a for-profit stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2018. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Crystal Run Health Insurance Company, Inc., located at 109 Rykowski Lane, Middletown, NY.

Wherever the designations the "Company" or "CRHIC" appear herein, without qualification, they should be understood to indicate Crystal Run Health Insurance Company, Inc.

Wherever the designation the "Crystal Run Companies" appears herein, without qualification, it should be understood to indicate Crystal Run Health Insurance Company, Inc. and Crystal Run Health Plan, LLC, collectively.

Wherever the designation "CRHG" appears herein, without qualification, it should be understood to indicate Crystal Run Health Group, LLC, the former immediate parent of the Crystal Run Companies.

Wherever the designation "CRH" appears herein, without qualification, it should be understood to indicate Crystal Run Healthcare LLP, the former ultimate parent of the Crystal Run Companies.

Wherever the designation "CRHT" appears herein, without qualification, it should be understood to indicate Crystal Run Health Transformation Holdings, LLP, the immediate parent of the Crystal Run Companies.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

A separate market conduct examination was conducted as of December 31, 2018, to review the manner in which the Crystal Run Companies conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. A separate report has been submitted.

Additionally, a concurrent financial examination was made of Crystal Run Health Plan, LLC ("CRHP"), a for-profit health maintenance organization ("HMO") licensed pursuant to the provisions of Article 44 of the New York State Public Health Law. CRHP is an affiliate within the Crystal Run organization as detailed herein. A separate report has been submitted thereon.

During the 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.

During the examination a review was also performed to assess CRHIC's cybersecurity risk for compliance with Insurance Regulation 500 (23 NYCRR 500).

1. SCOPE OF THE EXAMINATION

The previous examination of the Company was conducted as of December 31, 2015. This examination of the Company was a combined (financial and market conduct) examination and covered the period January 1, 2016 through December 31, 2018. This financial component of the examination was conducted as a financial examination as such term is defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2019 Edition* (the "Handbook") and covered the period January 1, 2016 through December 31, 2018. The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2018 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 CRHIC'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 CRHIC.

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 were 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 Consideration
- Capital Management

The Company was audited for the period January 1, 2016 through December 31, 2018 by the accounting firm of PKF O'Connor Davies. The Company received a qualified opinion for 2018. Certain audit work papers of PKF O'Connor Davies were reviewed and relied upon in conjunction with this 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 require explanation or description.

2. DESCRIPTION OF THE COMPANY

Crystal Run Health Insurance Company, Inc. was incorporated on December 2, 2013, as a for-profit accident and health insurer. The Company was licensed on December 31, 2014, pursuant to Article 42 of the New York Insurance Law to write insurance business as defined under Section 1113(a)(3)(i) of the New York Insurance Law. The Company operates as for-profit accident and health insurer and commenced operations on June 1, 2015.

On July 23, 2014, the Company issued to CRHG, the former immediate parent of CRHIC, 100,000 shares of capital stock with a par value of $2.00 per share, for a price of $68 per share resulting in an aggregate purchase price of $6,800,000. The total investment consisted of paid-in capital of $200,000 and contributed surplus of $6,600,000.

For the period January 2017 through October 2017, CRHG infused $6,658,275 into the Company; and for the period January 2018 through October 2019, CRHT infused $7,550,000 into the Company.

The Company's authorized control level Risk-Based Capital ("RBC") was $876,542 as of December 31, 2018. Its total adjusted capital was $2,980,450 yielding an RBC ratio of 340% at December 31, 2018.

A. Corporate Governance

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of no less than seven (7) and no more than twelve (12) directors.

As of December 31, 2018, the board consisted of eight (8) directors as set forth below:

Name and Residence	Principal Business Affiliation
Colleen Blye Westbury, NY	Chief Financial Officer, Montefiore Health System
Dr. Michelle A. Koury, MD Goshen, NY	Executive, Crystal Run Healthcare
Christopher Panczner, Esq. New York, NY	Senior Vice President & General Counsel, Montefiore Health System
Lynn Richmond Queens, NY	Executive Vice President; Chief Strategy Officer, Montefiore Health System
Douglas R. Sansted, Esq Westport, CT	Chief Strategy Officer, Crystal Run Healthcare
Dr. Gregory A. Spencer, MD Goshen, NY	Chief Medical Officer, Crystal Run Healthcare
Dr. Hal Teitelbaum, MD White Lake, NY	Chief Executive Officer/ Managing Partner, Crystal Run Healthcare
Dr. Jeffrey Weiss, MD New York, NY	Physician, Montefiore Health System

The Officers of CRHIC, at December 31, 2018, included the following individuals:

Name	Title
Dr. Hal Teitelbaum, MD	President
Kathleen Owens	Chief Compliance Officer
Dr. Jonathan Nasser, MD	Chief Medical Officer
Michelle Reay	Vice President Operations
Dr. Gregory A. Spencer, MD	Assistant Secretary
Dr. Michelle A. Koury, MD	Treasurer

The board met six times in 2018, eleven times in 2017 and 5 times in 2016. The minutes of the board meetings indicated that one-fourth of the directors attended 30% or less of the meetings they were supposed to attend.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Company. It is essential that board members attend meetings and consistently set forth their views on relevant matters so that appropriate decisions may be reached by the board. Individuals who fail to attend at least one half of the meetings they are eligible to attend do not fulfill such criteria. Board members who are unable to attend or unwilling to attend meetings consistently should resign or be replaced.

It is recommended, as a good business practice, that the Company establish procedures that require the board of directors to attend meetings regularly so they can fulfill their fiduciary responsibility.

Section 312(b) of the New York Insurance Law states:

> "(b) A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report. The superintendent may require that a copy of the report shall also be furnished by such insurer to the supervising insurance official of each state in the United States in which such insurer is authorized to do an insurance business."

The examiner's review determined that, the Company's board of directors did not sign off on the previous report on examination, for the entire examination period, as required by Section 312(b) of the New York Insurance Law.

It is recommended that the Company's board members sign off on the Department's reports on examination as required by Section 312(b) of the New York Insurance Law.

Enterprise Risk Management ("ERM")

Part 82.2(a) of Insurance Regulation No. 203 (11 NYCRR 82.2) states in part:

> "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…"

In accordance with Part 82.2(a) of Insurance Regulation No. 203 (11 NYCRR 82.2) "Enterprise Risk Management and Own Risk and Solvency Assessment," the Company's ultimate parents, CRHT Acquisition, Inc. and CRH Holdings II, LLC are required to adopt a formal enterprise risk management function. Neither the parent companies, nor CRHIC had an ERM framework in place during the examination period to proactively identify and mitigate various business risks, including prospective business risks.

It is recommended that CRHIC comply with Part 82.2(a) of Insurance Regulation No. 203 by adopting a formal enterprise risk management function.

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

Internal Audit Department ("IAD")

Part 89.1(c)(3) of Insurance Regulation No. 118 (11 NYCRR 89.1) states:

> "(3) for a company that does not otherwise designate an audit committee, the company's entire board of directors shall constitute the audit committee."

Part 89.2(c) of Insurance Regulation No. 118 (11 NYCRR 89.2) states:

> "Every company required to file an annual audited financial report pursuant to this Part shall designate a group of individuals to constitute its audit committee."

The Company's Parent, Crystal Run Health Transformation Holdings, LLC as well as its ultimate parents, CRHT Acquisition, Inc. and CRH Holdings II, LLC, are all non-publicly traded companies and therefore not subject to the Sarbanes-Oxley Act of 2002. However, the ultimate parents and the Crystal Run Companies are subject to the provisions of Insurance Regulation No. 118 (11 NYCRR 89). Insurance Regulation No. 118 (11 NYCRR 89) – "Audited Financial Statements", which became effective January 1, 2010, is similar to the NAIC's Model Audit Rule ("MAR"), and applies to certain New York regulated entities, including CRHIC.

The Crystal Run Companies did not have an Internal Audit Department during the examination period and have not formally designated the Company's board of directors or a group of individuals to constitute its Audit Committee, as required by the cited Regulation.

It is recommended that the Crystal Run Companies comply with Part 89.2(c) of Insurance Regulation No. 118 by formally designating each respective Company's entire board of directors or a group of individuals to constitute its Audit Committee.

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

Internal Controls

Prior to 2018 the Companies were using a third-party administrator ("TPA"), Apex Benefits Services, LLC ("Apex") to process claims. In 2018, approximately 80% of the claims were received electronically and 20% in paper. During the course of 2016 Apex experienced difficulty in paying Medicaid claims timely, which prompted the Companies to switch to another TPA, Evolent Health, LLC at the beginning of 2018. During the transition there were delays in paying claims with dates of service of 2018. Consequently, the claim inventory was higher than usual. Thirteen percent (13%) of the hospital, medical, vision and dental claims were either reversed or adjusted. Claims with dates of service of 2017 and prior continued to be paid by Apex.

Upon review, the following deficiencies were found with Evolent's operations:

- Evolent claims system requires that Evolent have controls in place to ensure that configuration changes requested by Crystal Run are authorized and established completely and accurately. These controls comprise, first, creating a Design Document detailing the changes requested that are outside of the current configuration environment, second, creating an Error Identification Form and recalculation of the adjustment if a change impacts more than 100 claims, and third, completing a claims-based testing to confirm that the Crystal Run's configuration changes are accurately implemented. A review of the Evolent's System and Organization Controls ("SOC") Report indicated that these controls were not established/performed during the first three quarters of 2018.

- If a claim fails auto-adjudication because it cannot match a valid provider to the claim. A configuration team is to investigate and resolve the issue. A review of Evolent SOC report indicated that, in 6 out of 60 instances there is no evidence that the team investigated that issue.

- On April 1, 2018 Evolent contracted with Smart Data Solutions ("SDS") as a supplement vendor for new clients, like Crystal Run, to provide mail scanning, image routing and electronic files that contain patient claim information. The Evolent's SOC report indicates that Evolent's oversight of SDS is limited to only an annual SOC report of SDS.

- The examination indicated that Crystal Run did not have in place any policies and procedures in relation to their oversight of Evolent. An effective oversight of Evolent would have prevented errors related to the process of claim payments and the inadequacy of accounting records regarding those payments. These errors led to the qualified opinion of Evolent by Mazars Consulting and the qualified opinion of Crystal Run by PKF O'Connor Davies.
- Errors in the paid claims range from 99% over paid to 74% underpaid due mostly to incorrect rates and wrong fee schedules.

It is recommended that the Company exercise effective oversight of Evolent in order to prevent errors related to the process of claim payments and the inadequacy of accounting records regarding those payments from occurring again in the future.

B. Territory and Plan of Operation

The Company entered into a commitment with the Department, upon licensure, to maintain a net premium to surplus ratio of not more than 8:1 for Exclusive Provider Organization ("EPO") and Preferred Provider Organization ("PPO") products, and not more than 4:1 for other than EPO and PPO products. During calendar year 2018, CRHIC's premium revenue comprised EPO and PPO products only and the net premium to capital and surplus ratio as of December 31, 2018 was 4.26 to 1, in compliance with CRHIC's commitment. During 2018, the Company wrote small group "Off Exchange" coverage and experience rated large group business.

During the year 2018, enrollment in New York by county and product type was as follows:

CRHIC 2018 Enrollment

County	EPO Large Group	EPO Small Group Off-Exchange	PPO Small Group Off-Exchange	Total
Orange	226	1,690	78	1,994
Sullivan	82	425	16	523
Total	308	2,115	94	2,517

The Company contracted with licensed agents and brokers for the production of its business.

The Company experienced difficulties in generating funds from operations since it started business in 2015. Consequently, CRHIC has been receiving loans and additional paid-in capital contributions from its former Parent, CRHG and its current Parent, CRHT. On June 30, 2016 and December 31, 2016, CRHIC received New York Insurance Law Section 1307 loans in the amount of $1,591,596 and $265,000, respectively.

The following amounts of paid-in capital were infused into CRHIC by CRHG:

January 30, 2017	$ 400,000
January 31, 2017	1,895,000
March 31, 2017	450,000
April 28, 2017	150,000
May 31, 2017	765,000
July 12, 2017	1,854,275
October 12, 2017	1,144,000
Total	$6,658,275

The following amounts of paid-in capital were infused into CRHIC by CRHT:

January 4, 2018	$2,000,000
August 22, 2018	500,000
January 10, 2019	3,200,000
October 18, 2019	1,850,000
Total	$7,550,000

C. Reinsurance

Assumed Reinsurance

The Company did not assume any business during the examination period.

Ceded Reinsurance

Prior to the examination period, the Company had a reinsurance agreement with Everest Insurance Company ("Everest"), an authorized reinsurer. The coverage gave the Company unlimited coverage up to 90% of claims incurred with a deductible of $200,000 per covered person.

On June 1, 2016, the Company initiated a new reinsurance policy with Zurich American Insurance Company ("Zurich"). The Zurich policy replaced the Everest policy and has the same coverage limits.

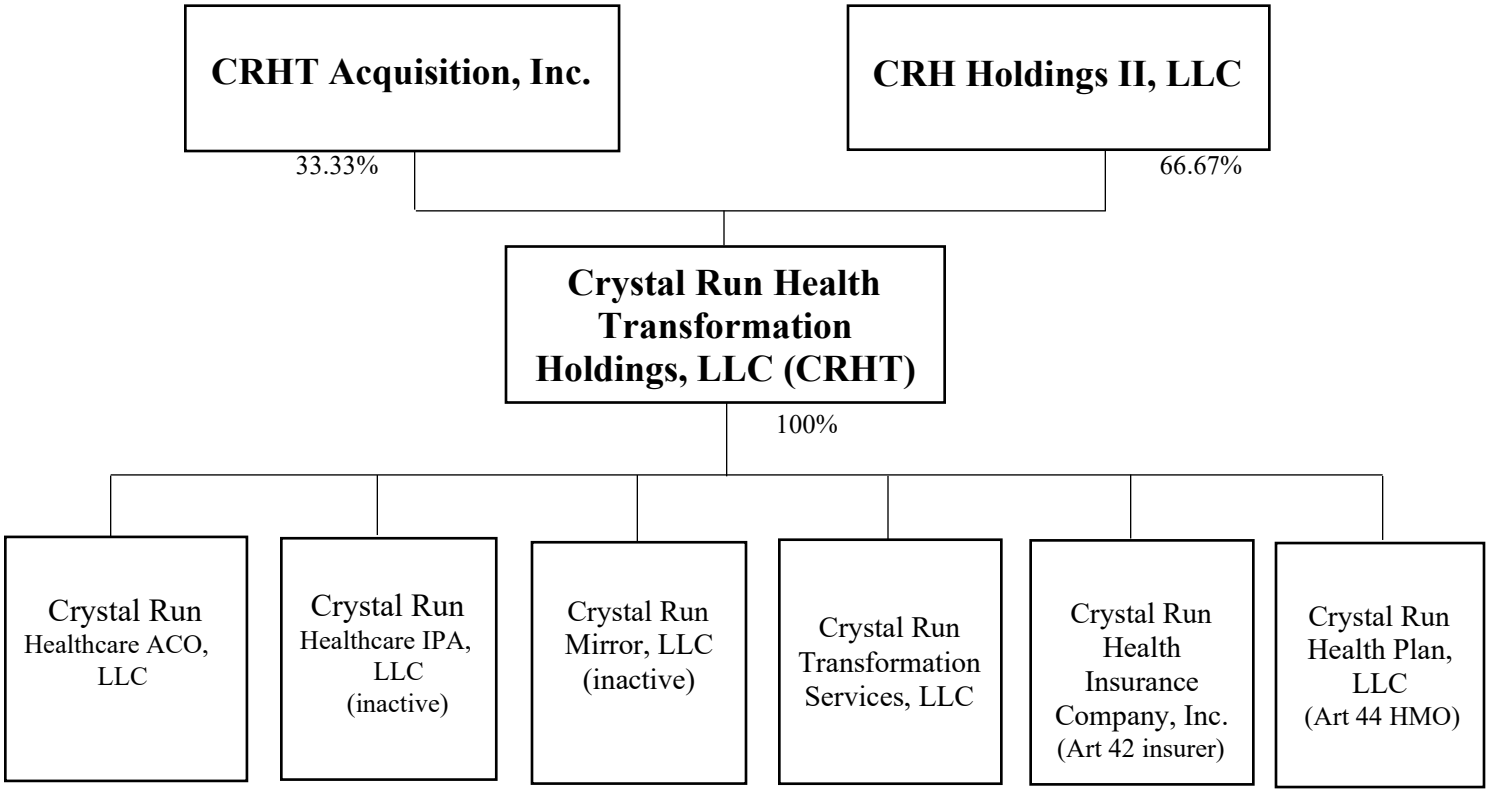
In June 1, 2018 the Company renewed its reinsurance policy with Zurich. During the examination period, the Company did not collect reinsurance receivable on a timely basis. Consequently, the Department asked the Company to include a 30-day remittance clause in the June 1, 2018 agreement. However, the examination found it was the Company that failed to invoice Zurich for its reinsurance recoverable. The Company incorrectly reported its reinsurance receivable to DFS before it billed the reinsurer.

It is recommended that the Company invoice Zurich regularly for its reinsurance recoveries so that the amount reported as reinsurance receivable is reflected accurately on the Company's financial statements.

The reinsurance agreement contains all the required standard clauses, including the insolvency clause required by Section 1308(a)(2)(A) of the New York Insurance Law.

D. Holding Company System

The following chart displays the holding company system of CRHIC, as of December 31, 2018:



Prior to January 1, 2018 Crystal Run Health Insurance Company, Inc. was a wholly-owned subsidiary of Crystal Run Health Group, LLC. ("CRHG"). CRHG was a wholly owned subsidiary of Crystal Run Healthcare LLP ("CRH"). The ultimate controlling person was Dr. Hal Teitelbaum, MD.

As of January 1, 2018, the Company became a wholly-owned subsidiary of Crystal Run Health Transformation Holdings, LLC. Additionally, CRHT merged with Montefiore Health Systems, Inc. ("MHS"). MHS indirectly acquired 33.33% of the minority membership interest in

CRHT. The remaining 66.67% of CRHT's membership interest is held by CRH Holdings II, LLC, whose membership interests is equally held by approximately 133 physicians affiliated with Crystal Run Healthcare medical facilities in Middletown, NY.

Section 1505(d)(3) of the New York Insurance Law states in part:

> "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:
> (3) rendering of services on a regular or systematic basis…"

CRHIC entered into transactions with CRHLP during 2018 which involved rendering of services on a regular and systematic basis. CRHIC did not notify the superintendent 30 days prior to entering into these transactions, as required by Section 1505(d)(3).

Furthermore, effective March 10, 2014 the Company entered into an Administrative Services agreement with Crystal Run Management Services. The agreement was later amended on October 29, 2014. Neither the agreement nor the amendment was submitted to the Department for approval, in violation of Section 1505(d)(3) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 1505(d)(3) of the New York Insurance Law by obtaining prior approval from the superintendent for all management agreements and service contracts with its affiliates.

Additionally, it is recommended that the Company comply with the requirements of Section 1505(d)(3) of the New York Insurance Law by providing the superintendent written notice

of its intention to enter into any transactions involving the rendering of services on a regular or systematic basis with its affiliates.

Similar recommendations were included in the prior report on examination.

New York Insurance Law Section 1505(a) states in part:

> "Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:
>
> (1) the terms shall be fair and equitable;
> (2) charges or fees for services performed shall be reasonable…"

New York Insurance Law Section 1505(b) states:

> "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."

Part 106.6(b) of Insurance Regulation No. 30 (11 NYCRR 106.6) states:

> "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 Crystal Run Companies maintain an expense allocation agreement with CRH, which was approved by the Department, effective January 1, 2016. However, CRH allocated expenses to CRHIC in 2015, prior to the implementation of that agreement.

The approved agreement, which was implemented subsequent to the prior examination, included the requirement that CRH allocate expenses to the Company based on a special study to determine the expense cost of each employee. The Company did not comply with the approved agreement as no special studies were performed. Additionally, the Company failed to comply with the provisions of Insurance Regulation No. 30 (11 NYCRR 106.6) when it did not document the allocation of employee compensation from CRH to the Company.

It is recommended that the Company comply with the requirements of Sections 1505(a) and (b) of the New York Insurance Law and its own expense allocation agreement by allocating expenses based on special studies performed specifically to determine such expenses.

It is also recommended that the Company comply with Part 106.6 of Insurance Regulation No. 30 by maintaining proper records to support the allocation percentages used for its expenses.

Similar recommendations were included in the prior report on examination.

E. Accounts and Records

Section 1217 of the New York Insurance Law states:

> "No domestic insurance company shall make any disbursement of one hundred dollars or more unless evidenced by a voucher signed by or on behalf of the payee as compensation for goods or services rendered for the company, and correctly describing the consideration for the payment. If such disbursement be for services and disbursements, such vouchers shall set forth the services rendered and itemize the disbursements; if it is in connection with any matter pending before any legislative or public body or before any government department or officer, the voucher shall correctly describe also the nature of the matter and the company's interest therein. If such a voucher is unobtainable, the disbursement shall be evidenced by a statement of an officer or responsible employee affirmed by him as true under the penalties of perjury, stating the reasons therefor and setting forth the particulars above mentioned."

Administrative expenses of rent, legal fees, advertisements, promotions, claim adjustment expenses due and unpaid drug claims were allocated to the Company without supporting invoices or vouchers.

It is recommended that the Company comply with Section 1217 of the New York Insurance Law by not making any disbursements of one hundred dollars or more unless such disbursements are evidenced by invoices or vouchers signed by or on behalf of the payee.

As of December 31, 2018, the Company reported a net premium income in the amount of $12,703,582. The examination indicated that $12,549,122 should have been reported.

Furthermore, as mentioned above, the examination indicated inadequacies of accounting records related to the Company's claims process. Consequently, thirteen percent (13%) of the hospital, medical, vision and dental claims were either reversed or adjusted.

It is recommended that the Company exercise greater care in its reporting process so that the information reported displays its true and accurate condition at any given point in time.

F. Significant Operating Ratios

The following ratios were computed as of December 31, 2018, based upon the results of this examination:

Description	Ratio
Underwriting (loss) to capital and surplus	(188.9)%
Liquid assets and receivables to current liabilities	133.1%
Premium and risk revenue to capital and surplus	4.3%
Medical loss ratio	101.2%
Combined loss ratio	144.3%
Administrative expense ratio	43.1%

Except for the Premium and Risk Revenue to Capital and Surplus ratio, the above ratios fell outside of the benchmark ranges set forth in the Financial Analysis Solvency Tools ("FAST") scoring ratios of the NAIC.

The underwriting ratios below are on an earned-incurred basis and encompass the three-year period covered by this examination:

	Amounts	Percentage
Claims	$ 33,017,363	95.6%
Claims adjustment expenses	3,695,034	10.7%
General administrative expenses	11,317,573	32.8%
Net underwriting loss	(13,505,367)	(39.1%)
Net premiums earned	$ 34,524,603	100.0%

3. MEDICAL LOSS RATIO

CRHIC's 2018 Medical Loss Ratio ("MLR") Annual Reporting Form for the State of New York was examined to assess compliance with the requirements of Title 45 of the Code of Federal Regulations ("CFR"), Part 158, 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, generally requires health insurance companies to submit to the Secretary of the U.S. Department of Health and Human Services ("HHS"), 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 market. Section 2718 of the PHS Act also requires a company to provide rebates to consumers if it does not meet the MLR standard (82% in the New York individual and small group markets, 85% in the New York large group market, and 80% for the student health plans market).

This is the first examination of the Company's MLR Annual Reporting Form performed by the Department. This examination of the Company's 2018 MLR Annual Reporting Form covered the reporting period January 1, 2016 through December 31, 2018, including 2016, 2017 and 2018 experience and claims run-out through March 31, 2019.

The examination was conducted in accordance with the NAIC's 24 MLR Agreed Upon Procedures ("MLR AUPs"). The MLR AUPs set forth the procedures for performing an examination to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Annual Reporting Form, and the accuracy and timeliness of any rebate payments, if applicable. 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 Annual Reporting Form Filing Instructions.

Title 45 CFR §158.110(b) requires that a report for each Medical Loss Ratio ("MLR") reporting year 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, CRHIC filed an acceptable form for the 2018 reporting year.

Title 45 CFR §158.210(a) requires that an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85% for the large group market. Title 45 CFR §158.210 (b) and (c) require that an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80% for the small group market and individual market. New York State requires a MLR of 82% for the small group market and individual market. The Company's MLR and rebate calculations from the MLR Annual Reporting Form were as follows:

	Small Group Market		
MLR Components	**Filed**	**Examination Adjustments**	**Recalculated**
Adjusted Incurred Claims	$27,402,931	$0	$27,402,931
Plus: Quality Improvement Expenses	178,203	0	178,203
Less: Cost-sharing reductions	0	0	0
Less: Federal Transitional Reinsurance Program payments expected from HHS	0	0	0
Less: Federal Risk Adjustment Program net payments	(9,339,228)	0	(9,339,228)
Less: Federal Risk Corridors Program net payments	$0	$0	$0
MLR Numerator	**$36,920,362**	**$0**	**$36,920,362**
Premium Earned	$36,927,497	$0	$36,927,497
Less: Federal and State Taxes and Licensing/ Regulatory Fees	1,872,228	0	1,872,228
MLR Denominator	**$35,055,269**	**$0**	**$35,055,269**
Preliminary MLR before Credibility–Adjustment	104.0%	105.3%	105.3%
Credibility–Adjustment	2.7%	3.3%	3.3%
Credibility–Adjusted MLR	**106.7%**		**108.6%**
MLR Standard	82.0%		82.0%
Rebate Amount	**$0**	**$0**	**$0**

MLR Components	Large Group Market		
	Filed	Examination Adjustments	Recalculated
Adjusted Incurred Claims	$4,558,453	$0	$4,558,453
Plus: Quality Improvement Expenses	12,527	0	12,527
Less: Cost-sharing reductions	0	0	0
Less: Federal Transitional Reinsurance Program payments expected from HHS	0	0	0
Less: Federal Risk Adjustment Program net payments expected from (payable to) HHS	0	0	0
Less: Federal Risk Corridors Program net payments	$0	$0	$0
MLR Numerator	**$4,570,980**	**$0**	**$4,570,980**
Premiums Earned	$7,542,693	$0	$7,542,693
Less: Federal and State Taxes and Licensing/ Regulatory Fees	341,878	0	341,878
MLR Denominator	**$7,200,815**	**$0**	**$7,200,815**
Preliminary MLR before Credibility–Adjustment	63.5%	0%	63.5%
Credibility–Adjustment	7.7%	0%	7.7%
Credibility–Adjusted MLR	**71.2%**		**71.2%**
MLR Standard	85%		85%
Rebate Amount	**$375,889**	**$0**	**$375,889**

A. Market Classification

According to Title 45 CFR §158.103, the applicable definitions of individual market, small group market and large group market according to Section 2791(e) of the Public Health Service Act ("PHS Act") are codified and applicable to the MLR calculation. Section 2791(e) of the PHS Act requires that small and large group market classifications be based on the average number of employees on the business days of the calendar year preceding the coverage effective date. Additionally, according to Title 45 CFR §158.120, the MLR report must aggregate data separately for the large group market, the small group market and the individual market, for each entity licensed within the state where each health care coverage contract was issued.

At both the initial application and at each renewal, the group's most recent form, NYS-45 Quarterly Combined Withholding, Wage Reporting, and Unemployment Insurance Return, is submitted to the Company. This form lists each employee that was on the payroll in the quarter. This information is used to verify that the group's MLR market classification is accurate.

Based on the procedures performed, it was determined that the CRHIC's market classifications were accurately reported on the Company's MLR Annual Reporting Form.

B. MLR Numerator

According to Title 45 CFR §158.221(b), the numerator of the Medical Loss Ratio ("MLR") calculation is comprised of incurred claims, as defined in Title 45 CFR §158.140, expenditures for activities that improve health care quality, as defined in Title 45 CFR §158.150, and Title 45 CFR §158.151, Cost Sharing Reductions programs as defined by Title 45 CFR §158.140(b)(1)(iii) and Federal Transitional Reinsurance, Federal Risk adjustment and Federal Risk Corridor Programs as defined by Title 45 CFR §158.140(b)(4)(ii), as applicable.

The examiner verified the data used to calculate the adjusted incurred claims; reviewed the reasonableness of the health care quality improvement expenses and also confirmed 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 Title 45 CFR §158.150, and Title 45 CFR §158.151.

Incurred Claims

The examiner reviewed the accuracy and appropriateness of the amounts reported within incurred claims as defined by Title 45 CFR §158.140, including the verification of the data used

by CRHIC to calculate adjusted incurred claims and the validation of a sample of incurred claims reported by CRHIC.

Based on the procedures performed, it was determined that the CRHIC's incurred claims were accurately reported on the Company's MLR Annual Reporting Form.

Quality Improvement Activities ("QIA")

The examiner reviewed the calculation of health care quality improvement expenses reported on the Company's 2018 MLR Reporting Form to ensure conformity with Title 45 CFR §158.221 and the MLR Annual Reporting Form Filing Instructions, and to confirm consistency with the calculation among the Company's small group and large group markets.

Based upon the procedures performed, it was determined that the Company properly calculated and reported its QIA expenses in accordance with Title 45 CFR §158.221.

Cost Sharing Reductions ("CSR")

In accordance with Title 45 CFR §158.140(b)(1)(iii), cost-sharing reduction payments received from HHS must be deducted from incurred claims to the extent not reimbursed to the provider furnishing the item or service.

The Company correctly reported that there were no advanced payments of CSR received from HHS as a deduction from incurred claims on the Company's MLR Annual Reporting Form.

Federal Premium Stabilization Programs

The examiner reviewed the accuracy of the amounts reported for Federal Transitional Reinsurance, Federal Risk Adjustment and Federal Risk Corridor Program as defined by Title 45

CFR §158.140(b)(4)(ii), including the verification of amounts to HHS program summary reports and the Company's transactional records.

Based on the procedures performed, it was determined that the CRHIC's Federal Premium Stabilization Programs amounts were accurately reported on the Company's MLR Annual Reporting Form.

C. MLR 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/ Regulatory Fees, described in Title 45 CFR §158.161(a), and Title 45 CFR §158.162(a)(1) and (b)(1). The data used to calculate the premium revenue was verified by the examiner. Additionally, the examiner reviewed the reasonableness and appropriateness of the Federal and State Taxes and Licensing/ Regulatory Fees including the appropriateness of allocations and the definition of such activities.

Based on the procedures performed, it was determined that the CRHIC's MLR Denominator was accurately reported on the Company's MLR Annual Reporting Form.

Earned Premiums

The examiner reviewed the accuracy and appropriateness of the amounts reported within earned premiums as defined by Title 45 CFR §158.130, including the verification of the data used by the Company to calculate earned premiums and the validation of a sample of policy premiums reported by the Company.

Based on the procedures performed, it was determined that the Company's earned premiums were accurately and appropriately reported on a direct basis and the data elements

underlying the 2016, 2017 and 2018 premiums, as reported on the Company's 2018 MLR Annual Reporting Form, were compliant with Title 45 CFR §158.130.

Federal and State Taxes and Licensing/ Regulatory Fees

The examiner reviewed the accuracy and appropriateness of Federal and State Taxes and Licensing/ Regulatory Fees, including confirmation that the allocation methodology was reasonable and complied with the requirements set forth by Title 45 CFR §158.170 and that taxes were reported in accordance with the provisions of Title 45 CFR §158.161 and Title 45 CFR §158.162.

Based on the procedures performed, it was determined that the Company's allocation methodology is reasonable, and the Federal and State Taxes and Licensing/ Regulatory Fees were accurately and appropriately reported for each market segment on the Company's MLR Annual Reporting Form.

D. 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. Calculation of base credibility factor is based on the aggregated life year of each market segment. Whenever life years are less than 1,000 or equal and greater than 75,000, no credibility is given. The examiner used the formula from Centers for Medicare and Medicaid Services ("CMS") and re-performed the calculations for CRHIC's small and large group segments and found that the base credibility factor was not calculated correctly for the Company's small group segment. For the deductible factor, the insurer chose to use a deductible factor of 1.0 in lieu of calculating a deductible factor based on the average of policies included in the aggregation. The credibility adjustment should have been 3.3% as opposed

to 2.7% used by the Company. However, there is no impact on the MLR rebate since the Company had already exceeded the required minimum percentage before adding any credibility adjustment for that line of business.

It is recommended that the Company comply with Title 45 CFR §158.232 by using the formula provided by CMS for its calculation of the credibility adjustment.

E. Credibility Adjusted - MLR

According to Title 45 CFR §158.221(a), the calculation of MLR is the ratio of the numerator to the denominator, subject to the applicable Credibility Adjustment if any. The examiner's review determined that CRHIC appropriately calculated the medical loss ratio for its large group market segment. The calculated credibility adjusted MLR was 71.2%.

Further, the examiner's review determined that the preliminary MLR and credibility adjusted MLR were not properly calculated for its small group market segment. The preliminary MLR should have been 105.3% ($36,920,362/ $35,055,269) as opposed to the Company's reported 104.0%. As stated above, the credibility adjustment should have been 3.3% as opposed to 2.7%. The credibility adjusted MLR would have been 108.6% for its small group market as opposed to the 106.7% that was calculated by the Company. Nevertheless, the misstated preliminary MLR and credibility adjustment will not affect the Company MLR rebate since its preliminary MLR of 105.3% had already exceeded the minimum requirement for that market segment.

F. Rebate Disbursement and Notice

According to Title 45 CFR §158.240, a rebate is required to be paid, no later than September 30th, following the MLR reporting year if the insurer's credibility-adjusted MLR is less

than the minimum MLR standard. Based upon the examiner's review, CRHIC's MLR exceeded the New York minimum percentage for its small group market segments and thus was not required to pay rebates to its enrollees. CRHIC's MLR did not exceed the minimum percentage for its large group segments. As a result, a rebate was issued to its large group enrollees. CRHIC had a three-year average preliminary MLR of 63.5% and a credibility adjustment of 7.7%, totaling 71.2% for its credibility-adjusted MLR. The examiner calculated the MLR rebate using CRHIC's large group premium ($2,716,101) multiplied by 13.8%, the difference between the MLR standard for large group and the insurer's credibility-adjusted MLR. The calculated rebate amount is $374,822. The examiner verified that the Company paid that amount of rebate to its large group enrollees.

According to Title 45 CFR §158.250(a) and (b), a notice of rebate is required when the medical loss ratios do not exceed the minimum percentage. Based on the examiner's review, for the examination period, the Company's MLRs exceeded the minimum percentage for its small group market segment. The Company's MLRs did not exceed the minimum percentage for its large group market segment and as a result, rebates were issued to its large group policyholders along with a notice of rebate. The examiner verified the payments and notices of rebate.

G. Impact on Risk-Based Capital

According to Title 45 CFR §158.270(a), rebate payments having any adverse impact to the Company's Risk Based Capital ("RBC") level requires notification by the Department to the Secretary of HHS. The Company issued $374,882 in rebate payments for its large group policyholders in September 2019. The Department is aware of the Company's adverse financial situation.

4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2018, as contained in the Company's 2018 filed annual statement, a condensed summary of operations and a reconciliation of the capital 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 December 31, 2018 filed annual statement.

Independent Auditors

The firm of PKF O'Connor Davies was retained by the Company to audit the Company's combined statutory basis statements of financial position as of December 31st for each year in the examination period and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

PKF O'Connor Davies concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audits date. However, they issued a qualified opinion because, during their review, they found errors related to the process of claim payments and the inadequacy of account records regarding those payments.

Balances reported in these audited financial statements were reconciled to the corresponding years' annual statement with no discrepancies noted.

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A. Balance Sheet

Assets

Cash, cash equivalents and short-term investments	7,963,013
Investment income due and accrued	1,906
Uncollected premiums and agents' balance in course of collection	169,635
Amounts recoverable from reinsurers	19,412
Receivables from parent, subsidiaries and affiliates	3,751,805
Health care and other amounts receivable	75,104
Total assets	$ 11,980,875

Liabilities

Claims unpaid	$ 3,842,527
Unpaid claims adjustment expenses	112,007
Premiums received in advance	681,183
General expenses due or accrued	1,131,914
Amounts due to parent, subsidiaries and affiliates	414,513
Accrued risk adjustment payable	2,818,281
Total liabilities	$ 9,000,425

Capital and surplus

Common capital stock	$ 200,000
Gross paid in and contributed surplus	18,958,275
Surplus notes	1,856,596
Unassigned funds (surplus)	(18,034,421)
Total capital and surplus	$ 2,980,450
Total liabilities, capital and surplus	$ 11,980,875

Note: The examiner is unaware of any potential exposure to CRHIC for any tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Changes in Capital and Surplus

Capital and surplus increased by $569,316 during the three-year examination period, January 1, 2016 through December 31, 2018, detailed as follows:

Revenue		
Net premium income		34,524,603
Hospital and Medical Expenses		
Hospital/ Medical benefits	$ 26,003,372	
Other professional services	1,928,499	
Outside referrals	101,978	
Emergency room and out-of-area	1,977,459	
Prescription drugs	4,633,399	
Net reinsurance recoveries	(1,627,344)	
Total hospital and medical expenses	33,017,363	
Claims adjustment expenses	3,695,034	
General administrative expenses	11,317,573	
Total underwriting expenses		48,029,970
Net underwriting loss		$ (13,505,367)
Net investment income earned		88,367
Net realized capital gains or (losses)		0
Net investment gains (losses)		88,367
Net gain or (loss) from agents' premium balances charged off		(5,105)
Net income (loss) before federal income taxes		(13,422,105)
Federal and foreign income taxes incurred		0
Net loss		$ (13,422,105)

Changes in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2015			$ 2,411,134
	Gains in Surplus	Losses in Surplus	
Net loss		$ 13,422,105	
Change in net unrealized capital gains	$ 33		
Change in non-admitted assets		223,483	
Change in surplus notes:	1,856,596		
Capital changes: paid-in	12,358,275		
Net increase in capital and surplus			$ 569,316
Capital and surplus, per report on examination, as of December 31, 2018			$ 2,980,450

5. CLAIMS UNPAID

The examination liability of $3,842,527 for the above captioned account is the same as the amount reported by CRHIC in its filed annual statement as of December 31, 2018.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in CRHIC's internal records and in its filed annual statements as verified during the examination. 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 CRHIC's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2018.

6. SUBSEQUENT EVENTS

A. Market Withdrawal

On March 22, 2019, the Company informed the Department of its intention to withdraw from the Small Group Exclusive Provider Organization ("EPO") and Preferred Provider Organization ("PPO") market and Large Group EPO/PPO market in New York, effective November 30, 2020. CRHIC cited two reasons for the decision to withdraw:

- the difficulties in growing enrollment in the two counties where CRHIC operates with a market share of 3.0%, and
- limited additional capital available to fund operating losses caused primarily by the ACA Risk Adjustment Program.

The Market Withdrawal Plan was revised on June 2, 2019 and approved by DFS on July 1, 2019. The Company withdrew from the New York health insurance market on November 30, 2020.

B. Coronavirus (COVID-19) Pandemic

On March 11, 2020, the World Health Organization declared the spreading coronavirus (COVID-19) outbreak a pandemic. On March 13, 2020, COVID-19 was declared a national emergency in the United States. The epidemiological threat posed by COVID-19 is having disruptive effects on the global supply chain as well as the demand for labor, products and services in the U.S. The economic disruptions caused by COVID-19 and the increased uncertainty about its magnitude has also caused extreme volatility in the financial markets. While the full effect of COVID-19 is still unknown at the time of this report, the Department and all insurance regulators, with the assistance of the NAIC, are monitoring the situation through a coordinated effort and will continue to assess the impacts of COVID-19 on U.S. insurers.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2015, contained eight (8) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Enterprise Risk Management	
1.	It is recommended that CRHIC comply with Part 82.2(a) of Insurance Regulation No. 203 (11 NYCRR 82) by adopting a formal enterprise risk management function. *The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.*	7
	Insurance Regulation No. 118	
2.	It is recommended that the Crystal Run Companies comply with Part 89.2(c) of Insurance Regulation No. 118 (11 NYCRR 89.2) by formally designating each respective company's entire Board of Directors or a group of individuals to constitute its Audit Committee. *The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.*	9
	Holding Company System	
3.	It is recommended that the Company comply with the requirements of Section 1505(c) of the New York Insurance Law by obtaining prior approval from the superintendent for all Management Agreements and Service Contracts where the conducted transactions exceed five percent of CRHIC's admitted assets at year-end. *The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.*	14
4.	It is also recommended that the Company comply with the requirements of Section 1505(d)(3) of the New York Insurance Law by providing the superintendent written notice of its intention to enter into any transactions involving the rendering of services on a regular or systematic basis, at least thirty days prior thereto. *The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.*	14

ITEM NO. **PAGE NO.**

Holding Company System (Continued)

5. It is recommended that the Company comply with the requirements of Sections 1505(a) and (b) of the New York Insurance Law and its own expense allocation agreement with regard to transactions within its holding company system. 15

The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.

6. It is also recommended that the Company comply with Part 106.6 of Insurance Regulation No. 30 (11 NYCRR 106.6) by maintaining proper records to support the allocation percentages used for its expenses. 15

The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.

Medical Loss Ratio

7. It is recommended that the Company comply with Title 45 of the 20 U.S. Code Federal Regulations ("CFR") §158.110(b) and file a Medical Loss Ratio reporting form by the filing deadline. 20

The Plan has complied with this recommendation.

Subsequent Events

8. It is recommended that the Company comply with the 25 requirements of Sections 1505(c) of the New York Insurance Law by obtaining the prior approval of the superintendent for sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the Company's admitted assets at last year-end. 25

The Plan has not complied with this recommendation. A similar recommendation appears within this report on examination.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____
Edouard Medina
Financial Services Manager-1

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

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

_____
Edouard Medina

Subscribed and sworn to before me this _____

day of _____ 2022

APPOINTMENT NO. 31814

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Edouard Medina

as a proper person to examine the affairs of

Crystal Run Health Insurance Company, Inc.

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

Company

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 19th day of September, 2018

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau