MARKET CONDUCT EXAMINATION

OF

CRYSTAL RUN HEALTH INSURANCE COMPANY, INC.

CRYSTAL RUN HEALTH PLAN, LLC

AS OF DECEMBER 31, 2018

EXAMINER:	**EDOUARD MEDINA**
DATE OF REPORT:	**AUGUST 29, 2022**

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KATHY HOCHUL
Governor

ADRIENNE A. HARRIS
Superintendent

August 29, 2022

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

Madam:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Numbers 31815 and 31817, dated September 19, 2018 and attached hereto, I have made an examination into the 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 and its affiliate, Crystal Run Health Plan, LLC, a limited liability plan organized in the State of New York as a Public Health Law Article 44 for-profit health maintenance organization ("HMO"), as of December 31, 2018. The following report is respectfully submitted thereon.

The examination was conducted at the home office of the two companies, located at 109 Rykowski Lane, Middletown, NY.

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

Wherever the designation "CRHP" appears herein, without qualification, it should be understood to indicate Crystal Run Health Plan, LLC.

Wherever the designation the "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, 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

The previous market conduct examination was conducted as of December 31, 2015. This examination covers the three-year period January 1, 2016 to December 31, 2018 and was performed to review the manner in which CRHIC and CRHP conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate.

This report on examination contains the significant findings of the examination and is confined to comment on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

A review was also made to ascertain what actions were taken by the Companies with regard to comments and recommendations made in the prior market conduct report on examination. The results of the examiner's review are contained in Item 12 of this report.

Concurrent examinations regarding the financial condition of CRHIC and CRHP were conducted by the Department as of December 31, 2018, with separate reports on examination issued thereon.

2. DESCRIPTION OF THE COMPANIES

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

CRHP is a limited liability company organized in the State of New York as a Public Health Law ("PHL") Article 44 for-profit health maintenance organization. CRHP obtained a Certificate of Authority ("COA") from the New York State Department of Health ("DOH") effective August 1, 2015.

CRHP commenced business on August 1, 2015, offering commercial HMO products to the direct pay and small group markets. It enrolled its first members with coverage effective October 1, 2015.

3. CLAIMS PROCESSING

Section 2601(a)(4) of the New York Insurance Law states in part:

> "(a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:
>
> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear…the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days."

Until the beginning of 2018, the Companies were using a third-party administrator ("TPA"), APEX, to process claims. 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 for calendar year 2018. Consequently, the claims inventory was higher than usual. Due to the delay, thirteen percent (13%) of the hospital, medical, vision and dental claims

were either reversed or adjusted. Claims with dates of service for calendar year 2017 and prior continued to be paid by Apex.

In several instances, the Companies received claims on behalf of their third-party administrators. The Companies denied those claims and asked the member to resubmit them to the respective third-party administrator, in violation of Section 2601(a)(4) of the New York Insurance Law, which requires Companies to attempt in good faith to settle claims promptly, fairly and equitably.

It is recommended that the Companies comply with Section 2601(a)(4) of the New York Insurance Law by attempting in good faith to settle promptly, fairly and equitably all claims submitted in which liability has become reasonably clear.

Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.2) states in part:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain…
> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

As of December 31, 2018, the Companies had a total of 278,352 claims submitted for payment. However, the examination revealed that the Companies were unable to provide documentation identifying whether 38,239 out of the 278,352 claims were submitted electronically or by paper, in violation of Part 243.2(b)(8) of Insurance Regulation No. 152 (11 NYCRR 243.2).

It is recommended that the Companies comply with Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining any claim record for six years from its creation or until after the filing of a report on examination.

4. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("PROMPT PAY LAW")

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 in paper, respectively. If such undisputed claims are not paid within either 30 or 45 days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three 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 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…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…of this chapter 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 or organization or corporation 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.

> Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or 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 shall comply with subsection (a) of this section."

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

> "…each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

To test the Companies' claims for compliance with the aforementioned Sections of the Prompt Pay Law, claims adjudicated during the 2018 calendar year were "rolled up".

For each of the Companies, all claims that were denied for the period January 1, 2018 to December 31, 2018, were segregated. A statistical sample of these claims were reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3234-a(b) of the New York Insurance Law. Using ACL, a data sampling software, the examiner conducted an analysis of the aforementioned paid and denied claims. Such analysis on CRHIC and CRHP's claims revealed a potential number of claims processed outside the time limitations prescribed in Section 3224-a to be ten percent (10%) of the claims population. As a result, the examiner conducted a more detailed test of the Companies' paid and denied claims to determine the number of claims in violation of the cited laws. The examiner selected a statistically valid sample of claims from the total population of 20,326 claims for both Companies (12,122 for CRHIC and 8,204 for CRHP) to determine whether the delays were appropriate. The results of

the reviews revealed that 71% of the sample claims were in violation of Sections 3224-a(a) and (b) of the New York Insurance Law.

The claims found to be paid late, in violation of Section 3224-a(a) of the New York Insurance Law, were also tested to determine whether the appropriate amount of interest was paid, as required by Section 3224-a(c) of the New York Insurance Law. The results indicated that the Companies owed interest in the amount of $120,544 for 1,025 claims.

It is recommended that CRHIC and CRHP comply with Sections 3224-a(a), (b) and (c) of the New York Insurance Law by adjudicating claims within the timeframe prescribed and paying interest on claims paid late, where applicable.

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

It is also recommended that CRHIC and CRHP retroactively review all claims that were paid late during the period January 1, 2016 to December 31, 2018, in violation of New York Insurance Law 3224-a(a) and pay interest where due, as required by Section 3224-a(c) of the New York Insurance Law.

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

5. EXPLANATION OF BENEFITS STATEMENTS

Section 3234(b)(7) of the New York Insurance Law states in part:

> "(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 a denial 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 consumers right to challenge a denial or rejection, even when a request for clarification has been made."

A review of the Explanation of Benefits ("EOB") form issued by the Crystal Run Companies revealed that, in the appeal rights notice, the Companies substituted the word "Reconsideration " for the word "Appeal", therefore, they have revised the guidelines prescribed by Section 3234(b)(7) of the New York Insurance Law.

It is recommended that the Crystal Run Companies ensure that all EOBs issued to their members include the appeal rights required by Section 3234(b)(7) of the New York Insurance Law.

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

Section 3234(b)(6) of the New York Insurance Law states in part**:**

> "(b)The explanation of benefits form must include at least the following:
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed…"

During the review of the denial codes, it was noted that the following codes were too vague to convey to the member the reason the claim was being denied:

- le...... Covered-No payment
- OX.....Covered-No payment
- EP......Per Claims Decision

It is recommended that the Companies comply with Section 3234(b)(6) of the New York Insurance Law by using denial codes that clearly convey to the member the reason why the claim is being denied.

6. PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Section 3221(l)(8)(E) of the New York Insurance Law and additional implementing regulations require non-grandfathered group health plans offering health insurance coverage in the group market to provide certain benefits but to prohibit the imposition of cost-sharing requirements for those benefits. These include the following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

- Evidenced-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Similar references are included within New York Insurance Law Sections 3216(i)(17)(E) for the individual market while Section 4303(j)(3) of the New York Insurance Law and Section 2713 of the Public Health Service Act offer similar supporting guidance.

The examiner reviewed a population of 22,261 preventive service claims. Ninety-six (96) of those claims contained member charges for preventive service treatments. Further review indicated that, in 75 of those 96 claims, the member charges for the preventive service treatments were inappropriate.

It is recommended that the Companies comply with Sections 3216(i)(17)(E), and 4303(j)(3) of the New York Insurance Law, and Section 2713 of the Public Health Service Act by not applying cost-sharing to preventive care claims, when not applicable.

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

It is also recommended that the Companies perform Quality Assurance testing of the effectiveness of their claims payment policies and procedures on paid claims in order to ensure compliance with the above stated laws and regulations.

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

7. UTILIZATION REVIEW AND APPEALS

Sections 4902, 4903 and 4904 of the New York Insurance Law and the New York Public Health Law set forth the minimum utilization review program standards and requirements of utilization review determinations for prospective, concurrent and retrospective reviews, and appeals of adverse determinations by utilization review agents. Thus, these statutes apply to CRHP, as an Article 44 HMO. Comparable sections of Article 49 of the New York Insurance Law contain the same requirements for insurers licensed under Article 42 of the New York Insurance Law and apply to CRHIC.

During the examination period, utilization reviews ("UR") and appeals were processed by the Companies. From a log of 5,699 (2,229 for CRHIC and 3,470 for CRHP) utilization review cases and 50 (19 for CRHIC and 31 for CRHP) utilization review appeal cases closed in calendar year 2018, 167 utilization review and 15 utilization review appeal cases were reviewed, for both Companies.

Section 4903(2)(a) of the New York Public Health Law states:

> "(2)(a) 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 enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information, or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. The notification shall identify: (i) whether the services are considered in-network or out-of-network; (ii) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment or co-insurance; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an enrollee may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services."

An assessment of the prospective utilization review process indicated that UR decisions were not made timely in CRHP prospective utilization reviews.

It is recommended that CRHP comply with Section 4903(2)(a) of the New York Public Health Law by determining the prospective review decision and communicating that decision within the timeframe prescribed by the Law.

Among the 167 utilization review cases selected for review, 35 Medicaid cases were approved by CRHP. In 25 (22 prospective and 3 retrospective) of these Medicaid cases, the determination notice stated that the approval did not mean that CRHP will pay for the services. This is misleading considering the fact that the utilization review process is to determine the medical necessity of a health care service which would otherwise be covered.

It is recommended that CRHP, when communicating the utilization review determination to the member and/ or provider, use the language prescribed by Section 4903(2)(a) of the New York Public Health Law.

8. GRIEVANCES

Section 4802(d) of the New York Insurance Law states:

> "(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:
> (1) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health;
> (2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and
> (3) forty-five days after the receipt of all necessary information in all other instances."

Section 4408-a(4) of the New York Public Health Law states:

> "4. Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than: (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and (iii) forty-five days after the receipt of all necessary information in all other instances."

Title 29 of the Code of Federal Regulations ("CFR") §2560.503-1 states:

> "(i) *Urgent care claims.* In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are

> covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim."

Section V – Item 9-b of the Companies' Member Complaints and Grievances Policy states:

> "b. For an Expedited or Urgent Grievance, the Member or the designee will be notified by phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the Grievance. Written notice will be provided within 72 hours of receipt of the Grievance."

Section 4802(d) of the New York Insurance Law requires that an urgent grievance be resolved within 48 hours. A Company must notify the claimant within 48 hours of the specific information necessary to complete the grievance process. Further, Title 29 CFR §2560.503-1 requires that companies request additional information needed within 24 hours. The Companies' policy does not indicate the timeframe within which, if necessary, additional information is to be requested, thereby violating Section 4802(d) of the New York Insurance Law, Section 4408-a(4) of the New York Public Health Law and Title 29 CFR §2560.503-1.

It is recommended that the CRHIC comply with Section 4802(d) of the New York Insurance Law, and Title 29 CFR §2560.503-1 by including in the policy a requirement that the Company must notify the claimant within 24 hours after receipt of the claim by the Company, of the specific information necessary to complete the claim.

It is also recommended that CRHP comply with Section 4408-a(4) of the New York Public Health Law, and Title 29 CFR §2560.503-1 by including in the policy a requirement that the Plan must notify the claimant within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

9. AGENTS AND BROKERS

Sections 2112(a) and (b) of the New York Insurance Law state:

> "(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents or, in the case of a title insurance corporation, title insurance agents, to represent such insurer, fraternal benefit society or health maintenance organization.
> (b) To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within fifteen days from the date the agency contract is executed, or the first insurance application is submitted."

The examiner compared the Companies' agents and brokers (145) list against the Department's records of agents and brokers. It was determined that none of the companies' agents was appointed.

It is recommended that the Companies comply with Sections 2112(a) and (b) of the New York Insurance Law by filing a notice of appointment with the Department whenever they appoint new insurance agents.

Sections 2102(a) and (e) of the New York Insurance Law state:

> "(a)(1)(A) No person, firm, association or corporation shall act as an insurance producer, insurance adjuster or life settlement broker in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter.
> (e)(1) No person shall accept any commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this article and is not so licensed."

Upon further review of the Companies' agent listing, it was determined that (6) six of the agents were operating without a license, thereby violating Sections 2102(a) and (e) of the New York Insurance Law.

It is recommended that the Companies comply with Sections 2102(a) and (e) of the New York Insurance Law by paying commissions to only those agents and brokers who are authorized to sell insurance by virtue of a license issued and in force pursuant to the requirements prescribed by the Insurance Law.

10. ADVERTISING

Part 215.2(b) of Insurance Regulation No. 34 (11 NYCRR 215.2) states:

> "(b) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised."

It was determined that the Companies did not have procedures regarding agents advertising on the internet. The Companies have not required agents, using the Companies' names in advertisements, to obtain approval from the Companies before doing so.

It is recommended that the Companies comply with Part 215.2(b) of Insurance Regulation No. 34 by requiring agents who are using the Companies' names in advertisements to obtain approval from the Companies before doing so.

11. UNDERWRITING

Section 4235(k) of the New York Insurance Law states in part:

> "(k)…Whenever any policy as described in this section terminates as a result of a default in payment of premiums, the insurer shall notify the policyholder that termination has occurred or will occur and shall include in his notification reference to the policyholders responsibilities under section two hundred seventeen of the labor law."

Further, Part 55.2(a) of Insurance Regulation No. 78 (11 NYCRR 55.2) states:

> "(a) An insurer who intends to terminate a group policy or contract of accident, or health, or accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificate holders under a group policy shall give the policyholder at least 30 days prior written notice of its intent to terminate coverage. The notice to the policyholder shall set forth in detail the policyholders obligation under Labor Law, section 217, and under this Part, to notify each certificate holder resident in New York State of the intended termination of the group policy."

Upon review, it was determined that the Companies did not send out any termination notices to those policyholders whose contracts were terminated, thereby violating Section 4235(k) of the New York Insurance Law and Part 55.2(a) of Insurance Regulation No. 78 (11 NYCRR 55.2).

It is recommended that the Companies provide policyholders, whose contracts are at risk of being terminated, with at least thirty days prior written notice of their intent to terminate coverage as required by Part 55.2(a) of Insurance Regulation No. 78.

It is also recommended, when terminating insurance contracts, that the Companies comply with Section 4235(k) of the New York Insurance Law by detailing the policyholder's obligations under Section 217 of the Labor Law.

12. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT

The prior market conduct report contained six (6) comments and recommendations (page numbers refer to the prior market conduct report):

ITEM NO.		PAGE NO.
	Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services	
1.	It is recommended that CRHIC and CRHP take steps to ensure full compliance with the provisions of Sections 3224-a(a), (b) and (c) of the New York Insurance Law. *The Plan has not complied with this recommendation. A similar recommendation appears within this Report.*	7
2.	It is further recommended that CRHIC and CRHP retroactively review all claims that were paid late, in violation of New York Insurance Law 3224-a(a) and pay interest when due, as required by New York Insurance Law 3224-a(c). *The Plan has not complied with this recommendation. A similar recommendation appears within this Report.*	7
	Explanation of Benefits Forms	
3.	It is recommended that the Crystal Run Companies ensure that all EOBs issued to members include all the information required by Section 3234(b)(7) of the New York Insurance Law. *The Plan has not complied with this recommendation. A similar recommendation appears within this Report.*	8
	Patient Protection and Affordable Care Act	
4.	It is recommended that the Crystal Run Companies provide its network providers with a claims payment policy detailing those preventive service procedures that permit no cost sharing, noting all CPT, diagnosis codes and/or modifiers that are required for the claim payment to be calculated to result in no cost share to the member. *The Plan has complied with this recommendation.*	10

ITEM NO.		PAGE NO.
	Patient Protection and Affordable Care Act (Continued)	
5.	It is recommended that CRHIC comply with New York Insurance Law Sections 3216(i)(17)(E), Section 4303(j)(3) of the New York Insurance Law, and Section 2713 of the Public Health Service Act by not applying member cost-sharing to Preventive Care claims, when not applicable. *The Plan has not complied with this recommendation. A similar recommendation appears within this Report.*	10
6.	It is also recommended that CRHIC perform Quality Assurance testing of the effectiveness of their claim's payment policies/procedures on paid claims in order to ensure compliance with the above state laws and regulations. *The Plan has not complied with this recommendation. A similar recommendation appears within this Report.*	11

13. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM			PAGE NO.
A.		Claims Processing	
	i.	It is recommended that the Companies comply with Section 2601(a)(4) of the New York Insurance Law by attempting in good faith to settle promptly, fairly and equitably all claims submitted in which liability has become reasonably clear.	5
	ii.	It is recommended that the Companies comply with Part 243.2(b)(8) of Insurance Regulation No. 152 by maintaining any claim record for six years from its creation or until after the filing of a report on examination.	5
B.		Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services ("Prompt Pay")	
	i.	It is recommended that CRHIC and CRHP comply with Sections 3224-a(a), (b) and (c) of the New York Insurance Law by adjudicating claims within the timeframe prescribed and paying interest on claims paid late, where applicable.	8
	ii.	It is also recommended that CRHIC and CRHP retroactively review all claims that were paid late during the period January 1, 2016 to December 31, 2018, in violation of New York Insurance Law 3224-a(a) and pay interest where due, as required by Section 3224-a(c) of the New York Insurance Law.	8
C.		Explanation of Benefits Statements	
	i.	It is recommended that the Crystal Run Companies ensure that all EOBs issued to their members include the appeal rights required by Section 3234(b)(7) of the New York Insurance Law.	9
	ii.	It is recommended that the Companies comply with Section 3234(b)(6) of the New York Insurance Law by using denial codes that clearly convey to the member the reason why the claim is being denied.	9

ITEM		PAGE NO.
D.	Patient Protection and Affordable Care Act	
i.	It is recommended that the Companies comply with Sections 3216(i)(17)(E), and 4303(j)(3) of the New York Insurance Law, and Section 2713 of the Public Health Service Act by not applying cost-sharing to preventive care claims, when not applicable.	11
ii.	It is also recommended that the Companies perform Quality Assurance testing of the effectiveness of their claims payment policies and procedures on paid claims in order to ensure compliance with the above stated laws and regulations.	11
E.	Utilization Review	
i.	It is recommended that CRHP comply with Section 4903(2)(a) of the New York Public Health Law by determining the prospective review decision and communicating that decision within the timeframe prescribed by the Law.	12
ii.	It is recommended that CRHP, when communicating the utilization review determination to the member and/ or provider, use the language prescribed by Section 4903(2)(a) of the New York Public Health Law.	13
F.	Grievances	
i.	It is recommended that CRHIC comply with Section 4802(d) of the New York Insurance Law and Title 29 CFR §2560.503-1 by including in the policy a requirement that the Company must notify the claimant within 24 hours after receipt of the claim by the Company, of the specific information necessary to complete the claim.	14
ii.	It is also recommended that CRHP comply with Section 4408-a(4) of the New York Public Health Law, and Title 29 CFR §2560.503-1 by including in the policy a requirement that the Plan must notify the claimant within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.	14
G.	Agents and Brokers	
i.	It is recommended that the Companies comply with Sections 2112(a) and (b) of the New York Insurance Law by filing a notice of appointment with the Department whenever they appoint new insurance agents.	15

ITEM		PAGE NO.
	Agents and Brokers (Continued)	
ii.	It is recommended that the Companies comply with Sections 2102(a) and (e) of the New York Insurance Law by paying commissions to only those agents and brokers who are authorized to sell insurance by virtue of a license issued and in force pursuant the requirements prescribed by the Insurance Law.	16
H.	Advertising	
	It is recommended that the Companies comply with Part 215.2(b) of Insurance Regulation No. 34 by requiring agents who are using the Companies' names in advertisements to obtain approval from the Companies before doing so.	16
I.	Underwriting	
i.	It is recommended that the Companies provide policyholders, whose contracts are at risk of being terminated, with at least thirty days prior written notice of their intent to terminate coverage as required by Part 55.2(a) of Insurance Regulation No. 78.	17
ii.	It is also recommended, when terminating insurance policy contracts, that the Companies comply with Section 4235(k) of the New York Insurance Law by detailing the policyholder's obligations under Section 217 of the Labor Law.	17

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.* 31815**

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

APPOINTMENT NO. **31817**

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 Plan, LLC

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

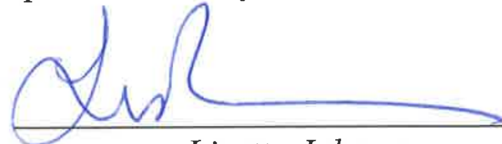
HMO

with such other information as he shall deem requisite.

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

this 19th day of September, 2018

MARIA T. VULLO
Superintendent of Financial Services

By: 

Lisette Johnson
Bureau Chief
Health Bureau