REPORT ON EXAMINATION
OF
CRYSTAL RUN HEALTH PLAN, LLC

AS OF DECEMBER 31, 2018

EXAMINER: **EDOUARD MEDINA**

DATE OF REPORT: **AUGUST 29, 2022**

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August 29, 2022

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

Madam:

Pursuant to the provisions of the New York Insurance Law and the New York State Public Health Law and acting in accordance with the instructions contained in Appointment Number 31816, dated September 19, 2019, attached hereto, I have made an examination into the financial condition and affairs of Crystal Run Health Plan, LLC, a for-profit New York State Public Health Law Article 44 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 Crystal Run Health Plan, LLC located at 109 Rykowski Lane, Middletown, NY.

Wherever the designations the "Plan" or "CRHP" appear herein, without qualification, they should be understood to indicate Crystal Run Health Plan, LLC.

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 also made of Crystal Run Health Insurance Company, Inc. ("CRHIC"), a for-profit stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law. CRHIC is an affiliate within the Crystal Run organization as detailed herein. A separate report thereon has been submitted for CRHIC.

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 Plan was conducted as of December 31, 2015. This examination 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 CRHP'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 Plan's current financial condition, as well as to identify prospective risks that may threaten the future solvency of CRHP.

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 Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan'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 Plan's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

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

The Plan was audited for the period January 1, 2016 through December 31, 2018 by the accounting firm of PKF O'Connor Davies. The Plan received a qualified opinion for 2018 (See "Internal Controls" for an explanation of the modified opinion). 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 PLAN

CRHP was organized as a for-profit HMO pursuant to Article 44 of the New York State Public Health Law ("PHL") on October 3, 2012 and received a Health Maintenance Organization Certificate of Authority ("COA") from the New York State Department of Health ("DOH") on August 1, 2015. The Plan operates as a for-profit, independent practice association model HMO, and commenced operations on September 1, 2015.

Pursuant to Part 98-1.11(e) of the Administrative Rules and Regulations of the New York Department of Health, CRHP maintained a contingent reserve of $1,278,017 as of the examination date.

As of December 31, 2018, the Plan's authorized control level Risk-Based Capital ("RBC") was $1,173,309 and its total adjusted capital was $1,974,913 yielding an RBC ratio of 168.32%.

A. Corporate Governance

Pursuant to the operating agreement, management of the Plan is to be vested in a Board of Directors which shall be at all times the same number as the number of Directors constituting the entire Board of CRHT.

As of December 31, 2018, the managers were as follows:

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 and General Counsel, Montefiore Health System
Lynn Richmond Queens, NY	Executive Vice President and 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 and Managing Partner, Crystal Run Healthcare
Dr. Jeffrey Weiss, MD New York, NY	Physician, Montefiore Health System

Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York State Department of Health Regulation states in part:

> "Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO."

It was noted that the Plan did not have an enrollee representative on its Board of Directors as of December 31, 2018, in violation of Part 98-1.11(g) of the Administrative Rules and Regulations of the New York State Department of Health.

It is recommended that the Plan comply with Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the New York State Department of Health by instituting enrollee representation within its Board of Directors.

The Officers of CRHP, as of December 31, 2018, included the following individuals:

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

The Board met six times in 2018, eleven times in 2017 and five 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 Plan. It is essential that the Board 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 or unwilling to attend meetings consistently should resign or be replaced.

It is recommended, as a good business practice, that the Plan 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 Plan'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 Plan'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 Plan'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 CRHP 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 CRHP comply with Part 82.2(a) of Insurance Regulation No. 203 by adopting a formal Enterprise Risk Management function.

A similar comment 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:

> "(c) 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 Plan'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 CRHP.

The Plan did not have an Internal Audit Department during the examination period and CRHP has not formally designated the Plan'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 the Plan's entire Board of Directors or a group of individuals to constitute its Audit Committee.

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

Internal Controls

Prior to the beginning of 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 2016 APEX experienced difficulty in paying Medicaid claims timely, which prompted the Crystal Run 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 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.

The following deficiencies in the Evolent's operation were indicated:

- 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 claims-based testing to confirm that the Crystal Run 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% overpaid to 74% underpaid due mostly to incorrect rates and wrong fee schedules.

It is recommended that the Plan 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 Plan currently operates in Orange and Sullivan Counties only, which are located in the Mid-Hudson region of New York State.

During calendar year 2018, enrollment in New York by county and line of business was as follows:

County	Direct Pay Off-Exchange	Small Group Off-Exchange	Medicaid	Essential Plan	Total
Orange	72	884	1,029	514	2,499
Sullivan	29	286	479	291	1,085
Total	101	1,170	1,508	805	3,584

The Plan contracts with licensed agents and brokers for the production of its business.

C. Reinsurance

i. Assumed Reinsurance

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

ii. Ceded Reinsurance

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

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

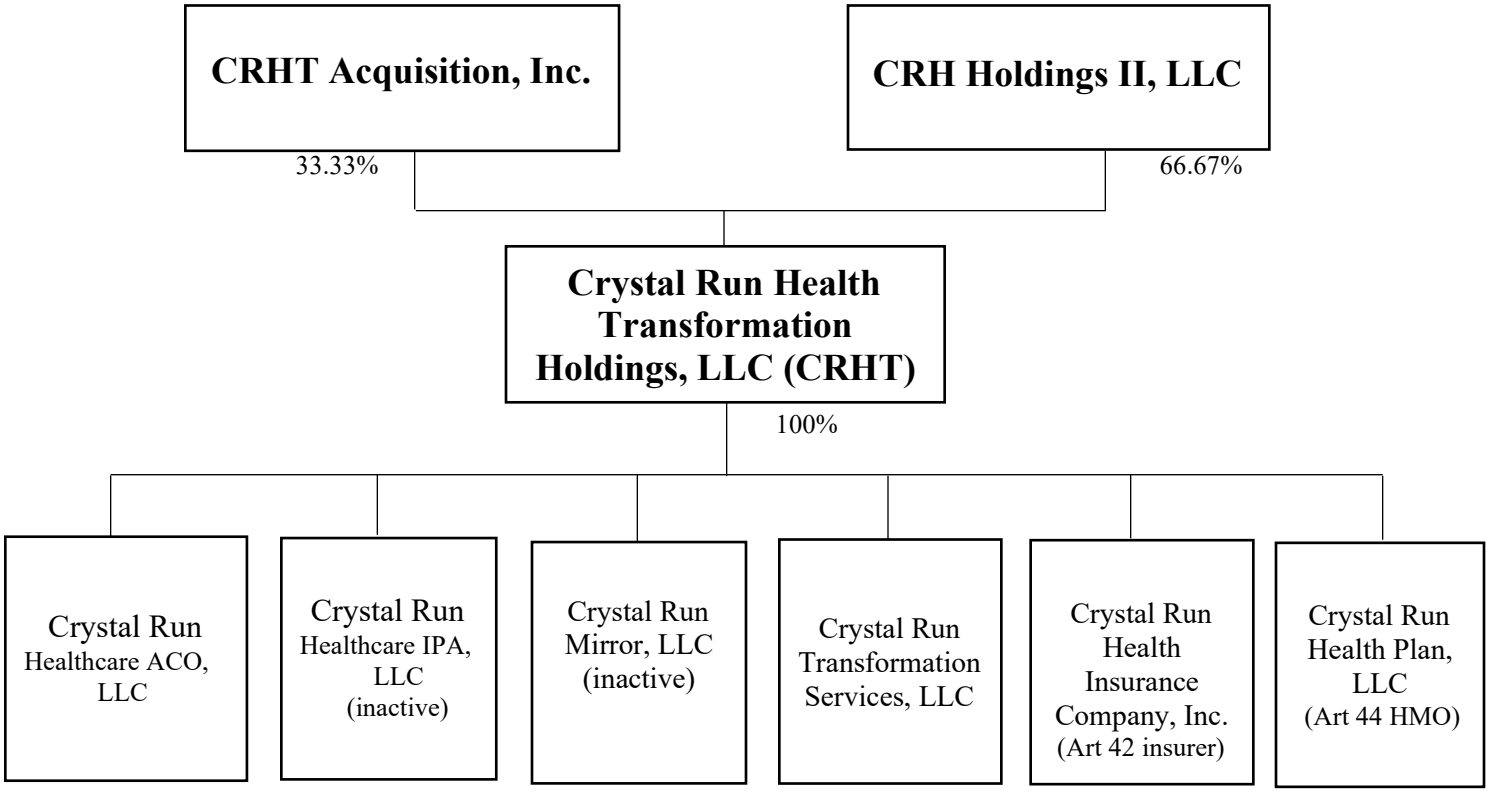
On June 1, 2018 the Plan renewed the reinsurance agreement with Zurich. During the examination period, the Plan did not collect reinsurance receivables on a timely basis. Consequently, the Department asked the Plan to include a 30-day remittance clause in the June 1, 2018 agreement. However, the examination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

It is recommended that the Plan invoice Zurich regularly for its reinsurance recoveries so that the amount reported as reinsurance receivable is reflected accurately on the Plan'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 the Plan as of December 31, 2018:



Prior to January 1, 2018, the Plan 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 Plan became a wholly-owned subsidiary of Crystal Run Health Transformation Holdings, LLC ("CRHT"). 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.

Parts 98-1.10(a), (b) and (c) of the Administrative Rules and Regulations of the New York State Department of Health state:

> "(a) Transactions within a holding company system to which a controlled managed care organization ("MCO") is a party shall be subject to the following guidelines:
>
> (1) the terms of the financial transaction shall be fair and equitable to the MCO at the time of the transaction;
> (2) charges or fees for services performed shall be reasonable; and
> (3) expenses incurred and payments received shall be allocated to the MCO on an equitable basis in conformity with customary accounting practices consistently applied.
>
> (b) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.
>
> (c) Thirty days prior notice to the commissioner and, except in the case of a PHSP, HIV SNP or PCPCP, the superintendent, is required before entering into the following transactions between a controlled MCO and any person in its holding company system: a reinsurance agreement or an agreement for rendering services on a regular or systematic basis, other than medical or management services that require prior approval under this Subpart. Such transactions may become effective unless the commissioner or the superintendent has disapproved the transaction within such period."

Further, 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."

Several expenses were paid by the Plan without invoices that clearly and accurately disclosed the nature and details of the transactions, in violation of Part 98-1.10(b) of the Administrative Rules and Regulations of the New York State Department of Health.

The Crystal Run Companies maintain an expense allocation agreement with CRH, which was approved by the Department, effective January 1, 2016.

The agreement, which was implemented prior to its approval by the Department, included the requirement that CRH allocate expenses to the Plan based on a special study to determine the expense cost of each employee. The Plan did not comply with the approved agreement as no special studies were performed. Additionally, the Plan 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 Plan.

It is recommended that the Plan comply with Part 98-1.10(b) of the Administrative Rules and Regulations of the New York State Department of Health by refraining from making disbursements on behalf of the Plan unless the books, accounts and records of each party to the transactions can accurately disclose the nature of the transactions, and such items are subject to the Plan's business operations.

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

It is recommended that the Plan comply with the requirements of Parts 98-1.10(a) and (b) of the Administrative Rules and Regulations of the New York State Department of Health and the approved expense allocation agreement with regard to transactions within its holding company system.

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

It is also recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the New York State Department of Health by notifying the commissioner and superintendent in writing prior to entering into such transactions with its parent consisting of rendering services on a regular or systematic basis.

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

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

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

E. Account and Records

The examination indicated inadequacies of accounting records related to the Plan's claims process. Consequently, thirteen percent of the hospital, medical, vision and dental claims were either reversed or adjusted.

It is recommended that the Plan exercise greater care in its claims 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 have been computed as of December 31, 2018, based upon the results of this examination:

Description	Ratio
Underwriting gain (loss) to capital and surplus	(346.2)%
Liquid assets and receivables to current liabilities	142.5%
Premium and risk revenue to capital and surplus	8.7 %
Medical loss ratio	100.6%
Combined loss ratio	139.6%
Administrative expense ratio	38.9%

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 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	$ 40,997,510	85.3%
Claims adjustment expenses	4,399,505	9.2%
General administrative expenses	12,271,594	25.5%
Net underwriting loss	(9,611,406)	(20.0)%
Net premiums earned	$ 48,057,203	100.00%

3. MEDICAL LOSS RATIO

CRHP'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.

This is the first examination of the Plan's MLR Annual Reporting Form performed by the Department. This examination of the Plan'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 Plan, 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 MLR reporting year be submitted to the Secretary of 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.

Title 45 CFR §§158.210 (a), (b) and (c) requires that an issuer must provide a rebate to enrollees if the issuer has an MLR below the required amount (82% in the New York individual and small group markets and 85% in the large group market for New York).

CRHP is a for-profit New York State Public Health Law Article 44 HMO and does not offer Large Group insurance coverage. The Plan's three-year aggregate numerator and denominator for each market, along with the resulting Credibility-Adjusted MLR and rebate obligation, for the 2018 MLR Annual Reporting Form, as reported during the examination, were as follows:

Individual Market	
MLR Components	**Filed**
Adjusted Incurred Claims	$ 3,116,899
Plus: Quality Improvement Expenses	11,161
Less: Cost-sharing reductions	$ 0
Less: Federal Transitional Reinsurance Program payments expected from HHS	86,503
Less: Federal Risk Adjustment Program net payments expected from HHS	732,138
Less: Federal Risk Corridors Program net payments (charges)	$ 0
MLR Numerator	**$ 2,309,419**
Premium Earned	$ 3,249,085
Less: Federal and State Taxes and Licensing/ Regulatory Fees	133,243
MLR Denominator	**$ 3,115,842**
Preliminary MLR before Credibility–Adjustment	74.1%
Credibility–Adjustment	0.0%
Credibility–Adjusted MLR*	**74.1%**
MLR Standard	82.0%
Rebate Amount	**$ 0**

***Note**: No Rebate issued due to number of life years Section (F)-Rebate Disbursement and Notice.

Small Group Market	
MLR Components	**Filed**
Adjusted Incurred Claims	$ 13,391,387
Plus: Quality Improvement Expenses	$113,046
Less: Federal Risk Adjustment Program net payments expected from HHS	$ (8,362,141)
Less: Federal Risk Corridors Program net payments (charges)	$ 0
MLR Numerator	**$ 21,866,574**
Premium Earned	$ 19,686,291
Less: Federal and State Taxes and Licensing/ Regulatory Fees	$ 922,576
MLR Denominator	**$ 18,763,715**
Preliminary MLR before Credibility–Adjustment	116.5%
Credibility–Adjustment	4.5%
Credibility–Adjusted MLR	**121.0%**
MLR Standard	82%
Rebate Amount	**$ 0**

(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 are submitted to the Plan. These forms list 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 CRHP'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 and 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 CRHP to calculate adjusted incurred claims and the validation of a sample of incurred claims reported by CRHP.

Based on the procedures performed, it was determined that the CRHP'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 CRHP 2018 MLR form to ensure conformity with Title 45 CFR §158.221 and the 2018 MLR Annual Reporting Form Filing Instructions, and to confirm consistency with the calculation among the Plan's individual and small group as well as its affiliated issuer.

Based upon the procedures performed, it was determined that the Plan 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 Plan 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 Plan's transactional records.

Based on the procedures performed, it was determined that the CRHP'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 Regulatory Fees including the appropriateness of allocations and the definition of such activities.

Based upon the procedures performed, CRHP's Federal and State Taxes and Regulatory Fees reported in the MLR denominator, and the allocation methodology are reasonable and conforms to the regulations.

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 Plan to calculate earned premiums and the validation of a sample of policy premiums reported by the Plan.

Based on the procedures performed, it was determined that the Plan'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 Plan'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 Plan'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 its 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. CRHP does not operate large group plans, it only has individual and small group lines of business.

Whenever life years are less than 1,000 or equal to or greater than 75,000, no credibility is given. The total life years for the individual market for the three years was at 643, below the 1,000 life years threshold. The experience for small group market had total life years, for three years, at 3,724, with a base credibility factor of 4.5.

In addition, the deductible factor was at 1.0, for all lines of business. The deductible factor measures plans' deductible, and it is based on the average per person deductible of included policies' experience in aggregation. CRHP plans had average deductibles below $2,500, which resulted in deductible factor of 1.0. We reviewed the deductibles as part of our evaluation of Mental Health Parity Addiction Equity Act, under ACA compliance.

(E) Credibility Adjusted - MLR

According to 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 CRHP appropriately calculated the medical loss ratio for each of its 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 an insurer's credibility adjusted MLR is less than the minimum MLR standard. Based upon the examiner's review, CRHP's MLR for its Individual segment was 74%, well below the standard of 82%. However, a rebate is required, for issuers with at least 1,000 life years. CRHP's Individual segment life years were 643. The MLR of CRHP, in its Small Group segment exceeded the minimum percentage of 82%. As a result, no rebates were warranted for issuance during the examination period.

According to Title 45 CFR §158.251(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 Plan's MLRs exceeded the minimum percentage for all their market segments and therefore no notices were required to be issued.

(G) Impact on Risk-Based Capital

According to Title 45 CFR §158.270(a), rebate payments having any adverse impact to the Plan's RBC level requires notification by the Department to the Secretary of HHS. Based on the examiner's review, the Plan's MLRs were not applicable, or exceeded the minimum percentage for its market segments, and no rebates were issued. Therefore, there was no impact on RBC level which would warrant notification to the Secretary of HHS.

4. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and surplus as of December 31, 2018, as contained in the Plan'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 Plan's financial condition as presented in the December 31, 2018 filed annual statement.

Independent Auditors

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

PKF O'Connor Davies concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audits date. However, they issued a qualified opinion for the audit year 2018 because they found errors related to the process of claims payments and the inadequacy of account records regarding those payments.

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

Balance Sheet

Assets

Cash, cash equivalents and short-term investments	$ 7,588,545
Investment income due and accrued	2,625
Uncollected premiums and agents' balance in course of collection	1,252,963
Amounts recoverable from reinsurers	1,110,938
Electronic data processing equipment and software	37,165
Receivables from parent, subsidiaries and affiliates	3,550,000
Health care and other amounts receivable	509,098
Total assets	$ 14,051,334

Liabilities

Claims unpaid	$ 4,331,382
Unpaid claims adjustment expenses	118,381
Premiums received in advance	400,145
General expenses due or accrued	1,079,562
Amounts held and retained for the account of others	17,927
Amounts due to parent, subsidiaries and affiliates	1,397,680
Aggregate write-ins for other liabilities	4,731,344
Total liabilities	$ 12,076,421

Capital and Surplus

Gross paid in and contributed surplus	$ 15,124,412
Aggregate write-ins for other-than-special surplus funds	1,278,017
Unassigned funds (surplus)	(14,427,516)
Total capital and surplus	$ 1,974,913
Total liabilities, capital and surplus	$ 14,051,334

Note: The examiner is unaware of any potential exposure to CRHP 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 decreased by $5,958,607 during the three-year examination period, January 1, 2016 through December 31, 2018, detailed as follows:

Revenue		
Net premium income		$ 48,057,203
Total revenue		$ 48,057,203
Hospital and Medical Expense		
Hospital/medical benefits	$ 30,261,163	
Other professional services	1,585,411	
Outside referrals	9,825	
Emergency room and out-of-area	1,805,943	
Prescription drugs	8,593,329	
Net reinsurance recoveries	(1,258,161)	
Total hospital and medical expenses	40,997,510	
Claims adjustment expenses	4,399,505	
General administrative expenses	12,271,594	
Total underwriting expenses		57,668,609
Net underwriting loss		$ (9,611,406)
Net investment income earned		83,282
Net gain or (loss) from agents' premium balances charged off		(16,962)
Net income (loss) before federal income taxes		(9,545,085)
Federal and foreign income taxes incurred		0
Net loss		$ (9,545,085)

Changes in capital and surplus

Capital and surplus, per report on examination, as of December 31, 2015			$ 7,933,520
	Gains in Surplus	Losses in Surplus	
Net loss		$ 9,545,085	
Change in net unrealized capital gains	$ 3,734		
Change in non-admitted assets	32,744		
Capital changes: paid in	$ 3,550,000		
Net increase in capital and surplus			(5,958,607)
Capital and surplus, per report on examination, as of December 31, 2018			$ 1,974,913

5. CLAIMS UNPAID

The examination liability of $4,331,382 for the above captioned account is the same as the amount reported by CRHP 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 CRHP'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 CRHP's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2018.

6. SUBSEQUENT EVENTS

A. Capital Contribution

As of January 1, 2018, CRHT replaced Crystal Run Health Group, LLC as the sole member of CRHP and Montefiore Health Systems acquired 33% of the membership of CRHT. As part of the transaction Montefiore committed to contribute $3,550,000 million to CRHP during the 4th Quarter of 2018 for the company to maintain its capital requirements. The capital contribution was received by CRHP on January 10, 2019.

A capital contribution of $3,600,000 was made by CRHT into CRHP in July 2019. The capital contribution was part of CRHP's capital funding plan in connection with the market withdrawal described below.

B. Market Withdrawal

On March 22, 2019, the Plan informed Department the New York State Department of Health ("DOH") of its intention to withdraw from the Essential Plan and Medicaid Managed Care programs, effective September 1, 2019, and the Individual and Small Group HMO lines of business, effective December 31, 2019, and November 30, 2020, respectively. On the same date, CRHP submitted drafts of a Market Withdrawal Plan and cited three reasons for the decision to withdraw:

1. The difficulties in growing enrollment in the two counties where CRHP operated with a market share of 3.0%;
2. Limited additional capital available to fund operating losses caused primarily by the ACA Risk Adjustment Program; and
3. Prospective losses for the NYS Medicaid Program.

A revised Market Withdrawal Plan was submitted to the Department on June 26, 2019, indicating CRHP's withdrawal from the Individual HMO market, effective December 31, 2019, and from the Small Group HMO market, effective November 30, 2020. The revised Market Withdrawal Plan was approved by the Department on July 1, 2019.

The Plan withdrew from the New York health insurance market on November 30, 2020.

C. Coronavirus (COVID-19)

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 six (6) 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 CRHP 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 comment is included in this Report.*	8
	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 Plan'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 comment is included in this Report.*	9
	Holding Company System	
3.	It is recommended that the Plan comply with the requirements of Parts 98-1.10 (a) and (b) of Department of Health Regulation 98-1(10 NYCRR 98-1) and the approved expense allocation agreement with regard to transactions within its holding company system. *The Plan has not complied with this recommendation. A similar comment is included in this Report.*	14
4.	It is also recommended that the Plan comply with Part 98-1.10 (c) of Department of Health Regulation 98-1 by notifying the commissioner and superintendent in writing prior to entering into such transactions with its parent consisting of rendering services on a regular or systematic basis. *The Plan has not complied with this recommendation. A similar comment is included in this report.*	14

ITEM NO. **PAGE NO.**

Holding Company System (Continued)

5. It is further recommended that the Plan 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. 14

The Plan has not complied with this recommendation. A similar comment is included in this report.

Medical Loss Ratio

6. It is recommended that the Plan comply with Title 45 of the U.S. Code Federal Regulations (CFR) §158.110(b) and file a Medical Loss Ratio reporting form by the filing deadline. 18

The Plan has complied with this recommendation.

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. 31816

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