

**MARKET CONDUCT EXAMINATION**

**OF**

**CRYSTAL RUN HEALTH INSURANCE COMPANY, INC.**

**CRYSTAL RUN HEALTH PLAN, LLC**

**AS OF**

**DECEMBER 31, 2015**

**DATE OF REPORT:**

**MARCH 16, 2018**

**EXAMINER:**

**JEFFREY USHER, CFE**

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NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

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Andrew M. Cuomo  
Governor

Maria T. Vullo  
Superintendent

March 16, 2018

Honorable Maria T. Vullo  
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 Numbers 31620 and 31621, dated August 4, 2016, 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, as of December 31, 2015. 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 10941.

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

## **1. SCOPE OF THE EXAMINATION**

This market conduct examination was performed to review the manner in which CRHIC and CRHP conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. The examination covered the period from January 1, 2015 to December 31, 2015 and was the first such examination since the Crystal Run Companies' inception. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

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

Concurrent examinations regarding the financial condition of CRHIC and CRHP were conducted by the Department as of December 31, 2015, 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.

CRHIC began offering products with an effective date of June 1, 2015. During 2015, the Company wrote small group and experience-rated large group business.

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 market. It enrolled its first members with coverage effective October 1, 2015.

3. **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 on paper, respectively. Where a claim has been disputed, insurers are required to notify the sender of the dispute in order to seek clarification within thirty days. If such undisputed claims are not paid within either thirty or forty-five days of receipt, interest may be payable.

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

“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 30 days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or 45 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:

“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 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 pursuant to article forty-three 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.”

In order to test CRHP’s and CRHIC’s claims for compliance with the aforementioned laws, claims paid during the 2015 calendar year were “rolled up” so that each claim submitted was only represented a single time. Claims that then appeared to be violations of Section 3224-a(a) and (b) were extracted into separate populations for testing. From there, statistical samples were selected and those samples were tested to determine whether the delays were appropriate.

Using data analysis software, the examiner conducted an analysis of the aforementioned paid and denied claims. Such analysis determined that the potential number of claims processed by CRHP outside the time limitations prescribed in Section 3224-a was not statistically significant and so, for CRHP, no further Prompt Pay testing was performed. A similar analysis on CRHIC’s claims revealed a potential number of claims processed outside the time limitations prescribed in Section 3224-a was more than eighteen percent. As a result, the examiner conducted a more detailed test of CRHIC’s paid and denied claims, to determine the number of claims in violation of the cited laws. For this process, the examiner selected for testing, a statistically valid sample of 167 claims from the total population of 458 paid claims. For denied claims, the entire population of 172 claims was utilized. The results of the reviews revealed that 100%, or all of the claims in the samples, were in violation of the above stated sections of the law. With a 100% violation rate in the samples, an extrapolation into the greater population resulted in a conclusion that all of the claims in the population, or 458 paid claims and 172 denied claims, were violative.



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 then paid when due, as required by Section 3224-a(c) of the New York Insurance Law. The results indicated that 25% of the population of claims did not pay such interest when it was due, resulting in an extrapolated result that 114 claims were in violation of the cited law.

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.

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).

#### **4. EXPLANATION OF BENEFITS FORMS**

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 consumer's right to challenge a denial or rejection, even when a request for clarification has been made.”

A review of the Explanation of Benefits (“EOB”) forms issued by the Crystal Run Companies revealed that the notices did not include the above language regarding the forfeiture of the consumer's right to challenge a denial or rejection. Crystal Run Companies have

acknowledged that 1,334 EOBs for CRHIC and 14 EOBs for CRHP were issued without the forfeiture language during calendar year 2015.

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

## **5. 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 70 elements of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims from the aforementioned 70 elements for co-pay, deductible and coinsurance costs attributed to the member.

Upon request, the Crystal Run Companies were unable to provide a preventive service claims payment policy containing instructions for providers filing preventive service claims. The Crystal Run Companies did however, provide a list of procedure codes addressing many of the 70 elements. The following preventive service mandates were not addressed within the list provided:

Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Dental cavities prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Blood pressure screening	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
	Blood pressure screening for children.
	The USPSTF recommends screening for high blood pressure in adult's age 18 years and older.

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 so as to result in no cost share to the member.

The examiner also performed compliance testing on two samples of CRHIC preventive service claims. The first sample, for the Company, consisted of a statistically valid sample of 167 claims that had been extracted from the total population of 503 paid claims with member charges for preventive service treatments. The second sample, also for the Company, utilized the entire population of 129 claims that had been denied but included preventive service treatments. The results for the paid claims were extrapolated into the total population. The results for the denied claims represented the actual number of errors with no further calculation.

The testing resulted in a 9.62% error rate (totaling 48 claims in violation) for the paid claims and a 2.35% error rate (totaling 3 claims in violation) for the denied claims.

CRHIC indicated that six of the seven errors were due to systematic configuration changes within the claim system including reference information (procedure code and diagnosis codes) while the seventh error was identified as a manual error.

For CRHP, the examiner tested the entire population of 20 paid preventive service claims that included member cost sharing. There were no preventive care claims that had been denied with cost sharing. No errors were noted during this portion of the review.

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.

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

## 6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services</u>	
i. 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.	7
ii. 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).	7
B. <u>Explanation of Benefits Forms</u>	
It is recommended that the Crystal Run Companies ensure that all EOBs issued to members include all of the information required by Section 3234(b)(7) of the New York Insurance Law.	8
C. <u>Patient Protection and Affordable Care Act</u>	
i. 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 so as to result in no cost share to the member.	10
ii. 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.	10
iii. It is also recommended that CRHIC perform Quality Assurance testing of the effectiveness of their claims payment policies/procedures on paid claims in order to ensure compliance with the above states laws and regulations.	11

Respectfully submitted,

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Jeffrey Usher  
Principal Insurance Examiner

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

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

\_\_\_\_\_  
Jeffrey Usher

Subscribed and sworn to before me

this \_\_\_\_\_ day of \_\_\_\_\_ 2018

**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:

**Jeffrey Usher**

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**

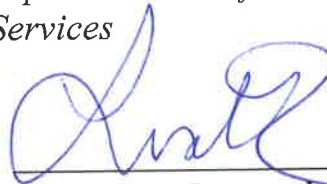
with such other information as he shall deem requisite.

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

this 4<sup>th</sup> day of August, 2016

MARIA T. VULLO  
Superintendent of Financial  
Services

By:



Lisette Johnson  
Bureau Chief  
Health Bureau





**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:

**Jeffrey Usher**

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**

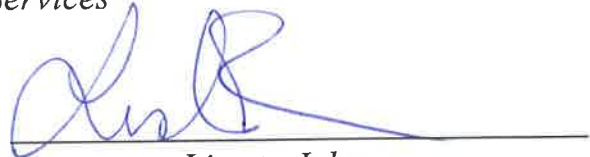
with such other information as he shall deem requisite.

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

this 4<sup>th</sup> day of August, 2016

MARIA T. VULLO  
Superintendent of Financial  
Services

By:



Lisette Johnson  
Bureau Chief  
Health Bureau

