NEW YORK STATE INSURANCE DEPARTMENT

2007 ANNUAL REPORT
OF THE
SUPERINTENDENT

David A. Paterson
Governor

Eric R. Dinallo
Superintendent

www.ins.state.ny.us

The 149th Annual Report
of the
Superintendent of Insurance
to the
New York State Legislature

For the Year Ending
December 31, 2007

David A. Paterson
Governor

Eric R. Dinallo
Superintendent

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Data in this report are subject to small table to table variations. Such variations are attributed to the fact that data are retrieved at various times throughout the year.

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
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David A. Paterson
Governor

Eric R. Dinallo
Superintendent

May 15, 2008

To the Legislature:

I am pleased to submit to the New York State Legislature the 149th Annual Report of the Superintendent of Insurance for Calendar Year 2007, as required by Article 2, Section 206 of the Insurance Law.

This report contains detailed information about the activities of the Insurance Department and describes the state of the insurance industry in New York. In addition, this report also describes the Superintendent's separate and distinct activities as Receiver of insolvent estates through the New York Liquidation Bureau.

As Superintendent, I am proud to be associated with the scores of knowledgeable and dedicated professionals who staff the Department and provide superior services to the citizens of New York State. On behalf of the Department, we appreciate the support we have received from Governor Paterson and the members of the New York State Legislature.

Respectfully submitted,

Eric R. Dinallo
Superintendent

I. Major Developments

The New York State Insurance Department continues to work aggressively to protect consumers and promote a favorable environment for the growth of a sound, fair insurance industry. The Department continues its long tradition of service to New York in pursuing these goals. Amid growing concerns about the national economy and a renewed discussion over the role of state regulation, the Department attained a number of notable accomplishments in 2007.

Protecting Consumers

Achieving a Stable Bond Market

The Department worked vigorously to protect policyholders and minimize the impact on the broader financial market when a serious deterioration of bond insurers' financial conditions occurred. Chief among the Department's concerns were safeguarding the rights of policyholders and the interests of municipalities requiring the services of a stable bond market.

The Department developed a three-point plan to address the bond market crisis. The plan called for these strategies:

- Attract new capital to existing bond companies and bring new companies into the marketplace.
- Deal with distressed companies and help ensure the survival of companies with strong assets.
- Re-write the rules governing monoline insurers.

In December, the Department helped to provide for the continued availability of bond insurance by working to ensure the prompt licensing of Berkshire Hathaway. The Department succeeded in licensing the bond insurer in only 30 days.

Working Toward Universal Health Care Coverage

Superintendent Dinallo joined New York Health Commissioner Richard F. Daines, M.D., in conducting the "Partnership for Coverage," a series of eight public hearings across the State to obtain citizen input on developing proposals for achieving healthy system reform, increasing access to health insurance coverage and determining how universal coverage can be achieved. This series of public hearings represented an important first step toward reform of the State's health care delivery system and the expansion of health insurance coverage. The hearings will result in a detailed report to be issued in 2008.

Protecting Coastal Homeowners

The Department protected coastal area consumers when it directed insurance companies to stop the unlawful practice of "tying," or refusing to renew homeowners insurance policies when policyholders did not also buy other types of insurance from their insurers. The Department acted after receiving consumer complaints and within 30 days, insurance companies complied with the Department's directives by halting impermissible non-renewals and restoring many previously non-renewed policies.

Safeguarding Senior Citizens

The Department further strengthened its protection of New York's senior citizens through the formation of the Senior Protection Unit. Comprised of members of several Department Bureaus, the Unit focuses on specific insurance issues that affect the elderly, who are often victimized by deceptive or illegal practices. The Unit is charged with developing, coordinating and implementing initiatives to protect seniors in the purchase, servicing and claim processing of insurance products.

Implementing Timothy's Law

The Department assisted insurers and health maintenance organizations in helping New Yorkers obtain insurance benefits under Timothy's Law, which went into effect Jan. 1, 2007. The Department provided insurers with guidance on form filings and rate submissions required to provide inpatient and outpatient mental health services.

$4 Million Settlement Reached

United HealthCare agreed to a $4 million settlement with New York State, along with a three-year process improvement plan by the health insurer to eliminate errors in claims processing. This was the largest ever health-related settlement entered into by the Department to resolve deficiencies in health care coverage that had harmed consumers.

Promoting a Sound Insurance Industry

Resolution of World Trade Center Claims

Superintendent Dinallo led efforts that enabled the settlement of insurance claims related to the Sept. 11, 2001 attacks on the World Trade Center. The $2 billion settlement of all outstanding insurance claims was the largest single agreement in regulatory history. The settlement ended an almost six-year-long legal battle and removed the last major obstacle to the redevelopment of Ground Zero in Lower Manhattan. Achieving the settlement required bringing together the property owner, eight insurance companies, governmental agencies and other parties for ongoing discussions to resolve the impasse.

Dealing with the Malpractice Crisis

After years of unrealistic and artificially low rates, the Department approved a 14 percent increase in medical malpractice insurance rates to avoid further financial deterioration of malpractice insurance companies. The action helped avoid an irreversible crisis in a severely distressed market. Without the increase, there was concern that malpractice insurance companies would be driven out of the New York market as the result of the long-depressed rates. At the same time, a new task force was formed to identify the cause of spiraling costs. The body will recommend short and long-term reform options.

Support for TRIA Extension

The Department supported a continuation of the federal Terrorism Risk Insurance Act (TRIA), asserting that the federal backstop provided by TRIA does not replace private sector involvement in the market, but makes private sector involvement possible. The Superintendent testified before Congress on behalf of extending the law, which Congress subsequently approved. President Bush signed a seven-year extension of the program just days before its scheduled Dec. 31 expiration.

Regulatory Reform

Principles-Guided Regulation

The Department released a draft regulation that would make it the first insurance department in the nation to establish a principles-guided regulatory regime aimed at ensuring appropriate outcomes, rather than rote adherence to detailed rules. The draft included 10 principles for industry, accompanied by 10 principles for regulators. The goal is to ensure that regulation and its enforcement are proportionate, accountable, consistent, transparent and targeted. The movement toward more principles-based regulation is designed to provide benefits for consumers by promoting more efficient markets, more effective protection and better responsiveness to consumers needs.

Modernizing Financial Service Regulation

The Department led the Commission to Modernize the Regulation of Financial Services, charged with reviewing current financial services statutes, regulations and policies with an eye toward identifying how New York can retain and strengthen its status as a world financial capital. Comprised of representatives of the financial services industry, consumers and government, the Commission is aimed at helping to bring the State's regulatory structure into the 21st Century by encouraging the use of cutting edge regulatory techniques and eliminating inconsistent and unnecessary regulations.

Expanding Reinsurance Capacity

Outdated and unnecessary standards for many reinsurers will be eliminated under a proposal advanced by the Department affecting the highest rated reinsurance companies not authorized to do business in New York. Under the proposal these reinsurers will be able to conduct business in New York without posting costly collateral. The proposed regulation will reduce transactional costs, increase reinsurance capacity and bring New York into line with global insurance markets and worldwide accounting standards for reinsurance contracts.

Reforming Pension Fund Oversight

Partnering with the Office of the Comptroller, the Department proposed new state pension fund regulations to improve efficiency and protect the pensions of one million government employees. The new regulations will improve oversight, codify high ethical standards, increase transparency and implement strong internal control of the $154.5 billion New York Sate Common Retirement Fund.

Historic Workers' Compensation Reform

Streamlining Claims Docket Among Key Accomplishments

On March 13, 2007, the landmark Workers' Compensation Reform Legislation was enacted that fundamentally reformed the workers' compensation system. Governor Spitzer, in his March 13, 2007 letter, directed the Superintendent to achieve various goals as part of the reform effort to make the system more responsive to the needs of the State's employees and to the employers who pay premiums. The Workers' Compensation Reform Task Force was charged with this reform effort to complement the legislation. In his March 13 letter, the Governor created an Advisory Committee comprised of representatives of the Majority Leader of the Senate, the Speaker of the Assembly, the AFL-CIO, the Business Council of New York State, the Workers' Compensation Board and the Department of Labor. The Advisory Committee was to participate with the Task Force respecting certain objectives assigned the Task Force by the March 13 letter.

The major accomplishments and initiatives by the Task Force in 2007 included streamlining the Workers' Compensation Board claims docket, recommending a -20.5% rate reduction, recommending increased competition into the rate-making system, developing -- with the assistance of the Advisory Committee -- medical treatment guidelines, and developing a longer-term approach for centralized data collection.

Resolving Long-Standing Problems

Landmark Agreement to Protect Accident Victims

In December, Superintendent Dinallo an announced an agreement in principle to protect nearly 11,000 accident victims and others receiving annual payments from structured settlements and pensions. This was accomplished when the New York Liquidation Bureau resolved a significant deficit from a defunct insurance company that threatened annuity payments.

The settlement was among the major accomplishments of the NYLB, which was reorganized in 2007. The NYLB acts for the Superintendent as the court-appointed fiduciary and Receiver of impaired or insolvent insurance companies. Its mission is to maximize assets and resolve liabilities, return rehabilitated companies to the marketplace or distribute the proceeds of the company in a timely manner to creditors.

II. Review of New York State Insurance Business

A. LIFE BUREAU

1. Licensed Life Companies

There were 135 life insurance companies licensed to transact business in New York State as of December 31, 2007. The total admitted assets of licensed life insurers amounted to approximately $2.37 trillion at December 31, 2006 a ten-year gain of 82.5%. Bonds totaled $1,009.1 billion; stocks $84.2 billion; mortgage loans $174.7 billion; real estate $12.0 billion; policy loans $59.6 billion, and short-term holdings $13.7 billion. Other admitted assets totaled $1,021.0 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $884.2 billion on December 31, 2006, an increase of 85.6% since 1996. Insurance in force at December 31, 2006 of $5.39 trillion represents an increase of 77.2% since December 31, 1996.

3. Organizations Under Life Bureau Supervision

The Life Bureau supervised 499 organizations as of December 31, 2007. These organizations consisted of: 135 licensed life insurance companies — 78 domiciled in New York and 57 foreign; 38 fraternal benefit societies — 3 domiciled in New York, 34 foreign and 1 United States Branch of a Canadian Society; 12 retirement systems — 4 private pension funds and 8 governmental systems; 9 governmental variable supplements funds; 232 charitable annuity funds; 24 employee welfare funds; 8 viatical settlement companies and 41 accredited reinsurers. Unless otherwise noted, tables and related data for life insurance companies refer to the **nationwide** operations of insurers licensed to do business in the State.

Table 1
ADMITTED ASSETS
Life Insurance Companies Licensed in New York State
Selected Years, 1996-2006
(dollar amounts in billions)

Admitted Assets	2006	2005	2001	1996
Total	$2,374.3	$2,187.6	$1,680.0	$1,301.1
Percent increase from 1996	82.5%	68.1%	29.1%	---
Type of asset				
Bonds	$1,009.1	$999.8	$715.3	$593.2
Stocks	84.2	59.7	50.1	43.9
Mortgage Loans	174.7	163.1	142.3	135.5
Real Estate	12.0	12.3	14.8	29.2
Policy loans/liens	59.6	56.9	56.2	60.7
Short-term holdings	13.7	11.7	20.9	20.5
Other	1,021.0	884.1	680.3	418.1

Note: Detail may not add to totals due to rounding.

Table 2
BALANCE SHEET
Life Insurance Companies Licensed in New York State
Selected Years, 2001-2006
(in billions)

	2006	2005	2001
Assets	$2,374.3	$2,187.6	$1,680.0
Liabilities	2,247.9	2,067.5	1,588.6
Capital & Surplus	126.4	120.1	91.4

Table 3
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1996-2006
(dollar amounts in billions)

Class of Business	2006	2005	2001	1996
Total insurance in force	$12,254.4	$11,684.5	$9,963.6	$7,324.1
Percent increase from 1996	67.3%	59.5%	36.0%	---
Ordinary	$6,574.2	$6,340.3	$5,437.2	$3,860.4
Group	5,626.7	5,274.9	4,462.1	3,383.3
Credit	47.5	63.0	57.4	72.7
Industrial	6.0	6.3	6.9	7.7

Table 4
SOURCES OF INCOME*
Life Insurance Companies Licensed in New York State
Selected Years, 2001-2006
(dollar amounts in millions)

	2006		2005		2001	
Source of Income	**Amount**	**Percent of Total**	**Amount**	**Percent of Total**	**Amount**	**Percent of Total**
Group life	$21,981.4	6.8%	$18,071.4	6.0%	$17,139.8	6.2%
Group annuities	74,453.8	22.9	68,973.0	22.7	65,878.0	23.7
Group A & H	25,696.0	7.9	24,721.8	8.2	20,914.5	7.5
Ordinary life	44,119.7	13.5	43,212.4	14.2	40,808.0	14.7
Individual annuities	57,642.2	17.7	52,054.9	17.2	41,160.1	14.8
Individual A & H	7,911.4	2.4	5,662.6	1.9	3,183.3	1.1
Credit life	317.0	0.1	327.5	0.1	276.3	0.1
Industrial life	62.7	0.0	58.0	0.0	228.2	0.1
Total Premiums	**$232,184.2**	**71.3%**	**$213,081.6**	**70.3%**	**$189,588.2**	**68.1%**
Supplementary contracts	472.5	0.1	432.1	0.1	388.9	0.1
Net investment income	80,949.4	24.9	79,022.3	26.1	71,446.1	25.7
Other income	12,026.7	3.7	10,760.2	3.5	17,060.6	6.1
TOTAL	**$325,632.8**	**100.0%**	**$303,296.2**	**100.0%**	**$278,483.8**	**100.0%**

* As of 2001, deposit type funds — which were a component of group annuities — and supplementary contracts without life contingencies are no longer classified as income.
NOTE: Detail may not add to totals due to rounding.

Table 5
OPERATING RESULTS*
Life Insurance Companies Licensed in New York State
Selected Years, 2001-2006
(in millions)

	2006	2005	2001
Total premiums	$230,464.5	$211,347.3	$189,588.1
Investment income	80,949.4	79,022.3	71,446.1
Supplementary contracts	472.5	432.1	388.9
Other income	13,746.3	12,494.5	17,060.7
Total income	$325,632.8	$303,296.2	$278,483.8
Net gain from operations	$14,410.6	$16,674.9	$7,050.0
Net income	$18,653.4	$19,668.7	$6,280.9

*As of 2001, deposit type funds and supplementary contracts without life contingencies are no longer classified as income.

Table 6
LIFE INSURANCE IN FORCE IN THE STATE OF NEW YORK
Life Insurance Companies Licensed in New York State
Selected Years, 1996-2006
(dollar amounts in billions)

Insurance In Force	2006	2005	2001	1996
Total	$1,767.8	$1,662.9	$1,231.0	$907.0
Percent increase from 1996	94.9%	83.3%	35.7%	---
Class of business				
Ordinary	$1,065.4	$1,007.8	$749.2	$550.9
Group	695.1	647.6	473.5	349.0
Credit	6.8	7.0	7.5	6.2
Industrial	0.6	0.6	0.8	0.9

Table 7
ADMITTED ASSETS/INSURANCE IN FORCE
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1996-2006
(dollar amounts in billions)

Domestic Life Insurers	2006	2005	2001	1996
Admitted assets	$884.2	$815.4	$608.7	$476.5
Percent increase from 1996	85.6%	71.1%	27.7%	---
Insurance in force	$5,394.8	$4,972.6	$3,818.9	$3,044.0
Percent increase from 1996	77.2%	63.4%	25.5	---

4. Licensed Fraternal Benefit Societies

At the close of 2006, 39 fraternal benefit societies were licensed to conduct insurance business in New York State. Of these, 4 were domestic, 34 were foreign and 1 was an alien society. In the ten-year period ending December 31, 2006, the admitted assets of licensed societies rose from $55.9 billion to $77.6 billion, an increase of 39%. Insurance in force rose $49.1 billion over the period to $305.0 billion, an increase of 19%.

Table 8
FRATERNAL BENEFIT SOCIETIES
Selected Years, 1996-2006
(in billions)

Fraternal Benefit Societies	2006	2005	2001	1996
Admitted assets	$77.6	$76.0	$58.9	$55.9
Insurance in force	$305.0	$296.6	$264.6	$255.9

5. Private Retirement Systems

At the close of 2006, four private retirement systems were under the supervision of the Life Bureau.

The four systems, which are private pension funds of nonprofit organizations, were made subject to Insurance Department regulation by special legislative enactments. At the end of 2006, the assets of these four private pension funds totaled approximately $222 billion. The following table shows data for the private pension funds for selected years from 1996 to 2006:

Table 9
PRIVATE PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1996-2006
(in millions)

Private Pension Funds	2006	2005	2001	1996
Total admitted assets	$222,065.6	$195,083.7	$154,922.4	$102,057.0
Payments to annuitants and beneficiaries	$19,059.2	$13,922.2	$9,875.5	$4,487.5

6. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Life Bureau at the close of 2006 are governmental systems that provide retirement, death and disability benefits to the employees of New York State and those of its political subdivisions that have elected to provide such benefits to their employees. The aggregate assets of the eight governmental systems as of the end of their respective fiscal years ending in 2006 were approximately $333 billion. During the period from 1996 to 2006, the assets of these retirement systems increased at the compound rate of 5.3% per year.

The governmental retirement systems cover a total of 2.0 million active and retired members. The number of active employees in the public retirement systems in 2006 increased by 16% from its 1996 level, while the number of pensioners increased by 26% over the same period. The substantial increase in pensioners, as compared with a lesser increase in the work force, reinforces the need for maintaining adequate actuarial reserves.

The New York City Administrative Code provides for nine active non-pension funds known as variable supplements funds, financed by the transfer of earnings from the equity portfolios of the New York City Police and Fire Department Pension Funds and the Employees' Retirement System. If at any time the earnings so transferred are insufficient, the City guarantees the payment of the variable supplements benefits. These variable supplements funds provide retirement benefits in addition to those received from the pension funds and the retirement system. The variable supplements funds, all of which are under the supervision of the Insurance Department, had assets as of June 30, 2006 totaling $3.3 billion.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1996 to 2006:

Table 10
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1996-2006
(in millions)

Public Retirement Systems & Pension Funds	2006	2005	2001	1996
Total admitted assets	$332,802	$304,141	$289,513	$199,202
Payments to annuitants and beneficiaries	$17,406	$16,402	$12,036	$8,268

During 2007, the Department worked with two systems, the New York State and Local Employees Retirement System and the New York State and Local Police and Fire Retirement System, to significantly revise and augment Regulation 85 (11 NYCRR Part 136) so as to provide an enhanced governance and financial reporting framework for public employee retirement systems. The revised regulation initially would be applicable only to the two systems.

The annual statement for retirement systems, required to be filed with the Department pursuant to Section 307 of the Insurance Law, was entirely redesigned in 2007. The redesigned statement includes a facility for electronic filing via the Department's electronic portal. Filings on the new statement form are being made though the portal for the statements due March 1, 2008.

Regular on-site examinations of all three statewide retirement systems (including the New York State Teachers Retirement System as well as the two aforementioned systems) were conducted during 2007.

7. Segregated Gift Annuity Funds for Charitable Organizations

At the end of 2006, 211 charitable annuity societies held permits under Section 1110 of the Insurance Law. In return for, or conditioned upon, the receipt of gift funds, such organizations agree to pay an annuity to the donor, or a nominee. These agreements must provide to the issuer, upon the death of the annuitant, a residue equal to at least one-half the original gift or other consideration for such annuity. In the ten-year period ending December 31, 2006, admitted assets of these funds increased by 341% and the annual payments increased by 386%. This reflects the rapid growth in the number of licensed societies during the period.

Table 11
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1996-2006
(in millions)

Segregated Gift Annuity Funds	2006	2005	2001	1996
Total admitted assets	$2,079.1	$1,861.5	$1,003.4	$471.3
Annual payments to annuitants	$180.4	$163.7	$92.4	$37.1

8. Employee Welfare Funds

Twenty-four employee welfare funds covering 102,823 employees were supervised by the Life Bureau at the close of 2006. These funds are jointly administered by management and labor representatives. The employee welfare funds cover government employees for benefits financed by contributions from New York governmental authorities. Government employee welfare funds were not pre-empted by the federal Employee Retirement Income Security Act of 1974 (ERISA) as most private pension funds were.

Contributions to employee welfare funds amounted to $211.7 million in 2006. Benefits paid totaled $199.9 million and included life insurance; medical, surgical and hospital coverage; major medical coverage; optical, dental and prescription drug plans; disability insurance, and legal services. Administrative expenses totaled $9.1 million representing 4.3% of contributions.

9. Viatical Settlement Companies

Regulation 148 and Article 78 of the Insurance Law became effective as of July 6, 1994 for the purpose of regulating viatical settlement companies and brokers. At the end of 2006, seven companies were licensed or authorized to act as viatical settlement companies in New York.

As of December 31, 2006, these companies had combined assets of $96.4 million, with the largest accounting for $70.7 million. The assets primarily consisted of life insurance policies purchased, cash and accounts receivable. Costs of purchasing these policies amounted to $22.6 million, which comprised about 26.9% of the $84.2 million total face value.

10. Examinations Conducted in 2007

Table 12
EXAMINATIONS CONDUCTED
Life Bureau
2007

		Regularly Scheduled		Other	
		Initiated			On
	Total	In 2007	Prior to 2007	Special	Organi-zation*
Life insurance companies	39	28	8	3	0
Fraternal benefit societies	2	2	0	0	0
Retirement systems and pension funds	2	2	0	0	0
Segregated gift annuity funds of charitable organizations	22	22	0	0	0
Viatical settlement companies	3	3	0	0	0
Welfare funds	4	4	0	0	0
Total	**72**	**61**	**8**	**3**	**0**

***Examination conducted when insurer is first incorporated in New York State.

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 2007, there were 499 companies that were licensed or accredited to conduct business in New York State, as detailed below. These companies are required to file their Annual Statements for audit and analysis.

Table 13
COMPANIES LICENSED BY THE LIFE BUREAU
December 31, 2007

Life – New York	78
Life – Other States	57
Accredited Reinsurers	41
Fraternals – New York	3
Fraternals – Other States	34
Fraternals – Canadian, U.S. Branch	1
Charitable Annuities	232
Retirement Systems	21
Viaticals	8
Welfare Funds	24
Total	**499**

In addition to a financial analysis, which includes but is not limited to solvency, investment portfolio, reinsurance, and a review of the CPA report, etc., the Annual Statements are audited for overall integrity; compliance with National Association of Insurance Commissioners (NAIC) requirements for completing the Annual Statement blank; and compliance with Department statutes, regulations and rules. Questions arising during the audits of the statements are resolved with the companies.

b. New York Supplements to the Annual Statements

New York Supplements to the Life and Accident & Health Annual Statement and the Fraternal Benefit Society Annual Statement were developed for use beginning with the 1986 Annual Statement filing. The Supplements for 2007 were updated to meet current needs and requirements. Copies of the Supplements are now distributed through the Department's Web site to all life companies and Fraternal Benefit Societies licensed to do business in New York State.

12. Actuarial Unit

a. Training Allowance Subsidies for Life Insurance Agents

On August 8, 2007, a new Regulation 50 (11 NYCRR Part 12) was promulgated pursuant to the superintendent's authority under §4228(e)(3)(G) of the Insurance Law. The new regulation increases the amount of training allowances that may be paid to a life insurance agent and also increases the income ceiling that governs an agent's eligibility to receive a training allowance. To date few companies have implemented increases in their training allowance programs.

b. Demutualized Life Insurance Companies; Closed Blocks

Over the past fifteen years a number of mutual life insurance companies have converted to a stockholder-owned corporate structure -- i. e., they have demutualized. In return for relinquishing their ownership rights, the policyholders at the time of such conversions were promised certain protections with regard to how their business was thereafter to be managed, and the funds attributable to such policyholders were walled off into what is referred to as a "closed block".

During 2007 the Life Bureau, with participation from an industry trade group and from individual demutualized insurers, developed a reporting format for closed blocks to assist in ascertaining whether the protections promised closed block policyholders are being fulfilled. The intention is for all demutualized companies that do business in New York to provide reports in the proposed format to the Life Bureau annually.

13. Policy Forms and Product Filings

a. Processing of Life Insurance, Annuity Contracts and Other Financial Products

In 2007, the Life Bureau received 1,550 policy form submissions (files) consisting of 6,646 life insurance, annuity, funding agreement and other policy forms offered by life insurance companies, fraternal benefit societies, charitable annuity societies and viatical settlement companies as indicated in Table 14 below. Of the 6,646 policy forms received in 2007, 64.9% were submitted under a certified filing procedure (Circular Letter No. 6 (2004) or Section 3201(b)(6) of the Insurance Law), 1.1% were submitted for out-of-state use by domestic insurers and 34% were submitted for full review and approval. It should be noted that the total is lower than in previous years because domestic insurers are no longer required to file all of their out-of-state forms with the Life Bureau. See discussion of Section 3201 Revision for Out-of-State Forms below.

In 2007, the Life Bureau processed a total of 1,740 policy form submissions (files) consisting of 7,770 policy forms as indicated in Table 14. Of the 7,770 forms processed in 2007, approximately 33.6% were submitted for prior approval, 65.3% were submitted under a certified filing procedure and 1.1% were filed for out-of-state use. Of the prior approval files disposed in 2007, approximately 67.2% of the forms were approved or filed and 29.8% were either rejected or withdrawn. Of the certified files disposed in 2007, approximately 69.8% of the forms were approved or filed and 29.3% were either rejected or withdrawn. Of the out-of-state files disposed in 2007, approximately 70.1% of the forms were approved or filed and 29.9% were either rejected or withdrawn.

Table 14
NUMBER OF FILES & POLICY FORMS
RECEIVED AND PROCESSED BY TYPE
LIFE BUREAU, 2007

PRODUCT TYPE	RECEIVED		PROCESSED	
	Files	Forms	Files	Forms
Individual Life	582	2,288	659	2,660
Group Life	137	845	145	843
Individual Annuity	486	1,706	544	1,981
Group Annuity	212	703	245	927
Credit Insurance	20	86	22	95
Viatical Settlement	1	3	3	54
Miscellaneous	112	1,015	122	1,210
TOTAL	1,550	6,646	1,740	7,770

Note: Individual and group life includes term and whole life insurance, indeterminate premium, universal life insurance, variable life insurance. Individual and group annuity includes fixed and variable annuity, separate account agreements, funding agreements, structured settlements, charitable annuities and synthetic guaranteed investment contracts. Credit insurance includes credit life, disability and unemployment insurance.

b. Review of Actuarial and Other Form-Related Filings

In conjunction with the policy form approval process, the Life Bureau received 617 other filings related to the policy form approval process and products offered for sale in New York, including 38 rate and actuarial filings, 206 inquiries and complaints, 96 FOIL requests, 6 prefilings under Circular Letter No. 64-1, 45 compensation filings and 64 annual illustration certification filings.

Table 15
POLICY FORM-RELATED FILINGS RECEIVED IN 2007

Fraternal Benefit Societies (Constitution, Articles of Incorp., Bylaws, etc.)	10
Calculation of Life Estates	10
Circular Letter No. 64-1	6
Compensation Filings	45
FOIL Requests	96
Inquiries & Complaints	206
Rate & Actuarial Filings	38
Violations & Market Conduct	113
Informational Filing	29
Regulation 74 Illustration Certification Filings	64
Total	**617**

c. Speed to Market

During 2007, the Life Bureau continued to assist insurers in bringing products to market as quickly as possible. Detailed product outlines are available on the Department's Web site and are periodically updated. In 2007, the Life Bureau posted filing guidance related to the first amendment to Regulation 149, combination life insurance and accident and health insurance submissions, whole life insurance maturity dates as well as other filing guidance. The Life Bureau has encouraged insurers to utilize the certified filing procedures authorized by Section 3201(b)(6) of the Insurance Law and Department Circular Letter No. 6 (2004).

During the year, the Life Bureau received 1,070 Circular Letter No. 6 (2004) certified files consisting of 4,327 policy forms. In addition, the Life Bureau received 13 deemer filings authorized by Section 3201(b)(6) consisting of 25 policy forms. The 1,070 certified filings (and 4,327 forms) constitute 68.9% of all files and 64.9% of all forms submitted for sale in New York.

During the year, the Life Bureau processed 5,022 Circular Letter No. 6 (2004) policy forms in an average of 27 days. Of the total 5,022 Circular Letter No. 6 (2004) policy forms, approximately 3,495 were approved, 1,402 were rejected and 70 were withdrawn.

As noted above, the Life Bureau has continued to process policy forms submitted under the certified process in Section 3201(b)(6) of the Insurance Law. However, due to the industry's preference for the Circular Letter No. 6 (2004) certified process and its shorter timeframe, the number of forms processed under Section 3201(b)(6) has steadily declined from the high of 478 in 2001.

d. Post-Approval Review

Form filings being submitted pursuant to Circular Letter No. 6 (2004) do not receive a substantive review at the time of submission. The Department's approval of the policy forms are based on the completeness of the filing and the certification of compliance submitted by the insurer. Policy form

submissions that are accompanied by the proper certification of compliance, are given the highest priority in the processing of submissions.

Circular Letter No. 6 (2004) replaced an earlier certified filing procedure established by Circular Letter 27 (2000). As of January 7, 2008, 3,692 files consisting of 14,042 policy forms have been approved under the certified filing procedures, with 2,733 files and 10,301 policy forms under Circular Letter 6 (2004) and 959 files and 3,741 policy forms under Circular Letter 27 (2000).

In 2007, the Life Bureau continued to refine its screening process to prioritize the certified approved files for post approval review. The highest priority is assigned to files with new, innovative or controversial features or files that raise solvency, consumer protection or market competition concerns. This screening process will help to make the Life Bureau more aware of the products currently being offered in the marketplace. As of January 7, 2008, over 1000 of the 3,692 certified approved files had been screened and assigned a priority rating and approximately 170 certified approved files had been assigned for post approval review.

It should be noted that the post approval review of certified approved files is generally more complicated and time-consuming than the review of traditional prior approval files. Post approval review often has four phases. First, since the policy forms have already been issued to consumers, it may be necessary to develop endorsements to bring all in-force issues of policy forms into compliance with applicable requirements. Bringing in-force forms into compliance with New York law can be particularly challenging for new and innovative products for which approval standards have not been developed. Second, depending on the nature of the violation, remediation may be required for policy and certificate holders with non-complying policy forms. Third, a new policy form submission may be necessary to replace the non-complying policy forms if the company wishes to remain in the market. Finally, if circumstances warrant, the Department may decide to pursue disciplinary action against the company or the officer completing the certification.

e. SERFF

In addition to the traditional paper filings, the Life Bureau accepts electronic form filings for all types of individual and group life and annuity products, as well as compensation filings, through the NAIC-sponsored System for Electronic Rate and Form Filing (SERFF). The Department's Web site provides detailed filing guidelines for SERFF submissions to assist insurers in making such filings with the Department.

During the year, the life insurance industry's use of SERFF has continued to expand. At the start of 2007, there were 127 life insurance companies using SERFF to make policy form submissions. During 2007, another 9 companies used SERFF for the first time. In 2007, insurers submitted 948 files, consisting of 3,656 policy forms through SERFF. These totals represent approximately 61% of all policy form filings and 55.2% of all policy forms submitted in 2007. Continued growth both in the number of insurers using SERFF as a submission platform and in the percentage of filings made through SERFF is expected.

f. Section 3201 Revision for Out-of-State Forms - Update

In 2007 the Life Bureau finalized the reporting format that domestic life insurers will use to submit the annual report required by Chapter 341 of the laws of 2006. To minimize cost to the industry, the Life Bureau designed the reporting format to be used in conjunction with current filing requirements for the insurers' market conduct profile.

Prior to Chapter 341 of the laws of 2006, section 3201(b)(2) required domestic life insurers to file with the superintendent all policy forms intended for delivery outside New York prior to said forms being issued. The revision to section 3201 now requires only unallocated group annuity contracts or funding agreements and accident and health insurance policy forms intended for delivery outside New York to be filed with the superintendent prior to use.

In lieu of filing the policy forms prior to use, section 3201(c)(6)(b) now requires every domestic insurer and fraternal benefit society to file annually with the superintendent a list identifying and describing the policy forms issued by the insurer or fraternal benefit society for delivery outside the state in the preceding year in a form prescribed by the superintendent.

The first of the annual reports will be due June 1, 2008.

14. Legislative and Regulatory Summary

a. Regulation 77 - Private Placement

The Life Bureau has worked with the industry to draft an amendment to Regulation 77 relative to private placement policies. Changes to Regulation 77 are needed to provide greater flexibility relative to the design of private placement variable life insurance policies in New York and to reflect the illiquid nature of separate account assets supporting private placement variable life insurance. Private placement variable life insurance policy has been defined in the proposed amendment to Regulation 77 as any variable life insurance policy that (i) is exempt from registration under the Securities Act of 1933, (ii) includes one or more separate accounts that are exempt from registration as investment companies under the Investment Company Act of 1940 and (iii) is only available to an “accredited investor” as such term is defined in Rule 501 of Regulation D under the Securities Act of 1933; or to a “qualified purchaser” as such term is defined in the Investment Companies Act of 1940.

b. Section 3211/ Regulation 77 – Premium Due Notices

During 2007, the Life Bureau worked with the industry to try to clarify the requirements regarding the premium due notices in Section 3211 of the Insurance Law and Section 54.11(c) of Regulation 77 for variable life insurance products. Section 3211(a) requires that a premium due notice be mailed at least fifteen and not more than forty-five days prior to the day when a premium payment becomes due. Section 54.11(c) of Regulation 77 requires that a premium due notice for flexible premium variable life insurance policies be mailed no earlier than and within 30 days after the policy processing day on which the insurer determined that an insufficiency has occurred.

c. Regulation 174 - Unemployment Lapse Protection Benefit for Life Insurance – Update

The Unemployment Lapse Protection Benefit for Life Insurance (Regulation 174) was adopted with an effective date of January 17, 2007. Section 1113(a)(1) of the Insurance Law authorizes unemployment lapse protection benefits for life insurance. Unemployment lapse protection benefits include waiver of premium benefits and waiver of charge benefits. A waiver of premium benefit allows life insurance coverage to remain in force without premium payments being made. A waiver of charge benefit allows life insurance coverage to remain in force without the deduction of some or all of the required periodic charges from the policy’s value.

Regulation 174 establishes minimum standards for benefit levels, benefit eligibility, benefit exclusions, and premium levels relating to additional benefits authorized under Section 1113(a)(1) for unemployment lapse protection benefits. Regulation 174 also sets forth requirements for advertising and disclosure for unemployment lapse protection benefits.

d. Regulation 143 - Accelerated Payment of Death Benefit under a Life Insurance Policy - Update

Regulation 143 sets forth the rules that implement Section 1113(a)(1) of the Insurance Law with respect to accelerated death benefits. Section 1113 (a)(1) permits an acceleration of the death benefit upon (A) diagnosis of a medical condition with a life expectancy of twelve months or less or (B) diagnosis of a medical condition requiring extraordinary care or treatment regardless of life expectancy. A 1997 amendment added section 1113(a)(C) which allows for the acceleration of the death benefit based on the certification of a licensed health care practitioner that the insured has a chronic illness which will require continuous care for the rest of the insured's life. A 2000 amendment added section 1113(a)(1)(D) which allows for acceleration of the death benefit based on the certification of a licensed health care practitioner that the insured has a chronic illness. The subparagraph (D) trigger also requires that the insurer issuing the life insurance policy and the accelerated death benefit must be a qualified long term care insurance carrier under section 4980 of the Internal Revenue Code. Both subparagraph (C) and (D) triggers require that the benefit be structured so that the accelerated payments qualify for favorable tax treatment under section 101(g) of the Internal Revenue Code and other applicable sections of federal law.

The current version of Regulation 143, which became effective on December 7, 2005, includes substantial amendments necessary in order to implement the subparagraph (C) and (D) triggers. Accelerated death benefits under both of these triggers typically provide a periodic pay out, usually monthly, either on a per diem or a cost incurred basis once long term care services have begun and the insured has filed a claim. The availability of these new benefits provides consumers with an additional financial resource to help pay the significant and increasing costs associated with long term care needs.

To date the Life Bureau has approved ten accelerated death benefit forms using the "long term care trigger" under subparagraphs (C) and (D). In addition, there is one such filing submission currently under review in the Life Bureau.

e. Regulation 180 - Key Person Corporate-Owned Life Insurance (COLI)

Section 3205 of the Insurance Law sets forth the insurable interest requirements for life insurance in New York. Generally, a person cannot procure life insurance on another person and be the beneficiary of such policy without having an insurable interest in the insured person at the time the contract is made. This statute reflects the State's public policy against contracts which wager on human life. Section 3205(a)(1)(B) defines insurable interest to include "a lawful and substantial economic interest in the continued life, health or bodily safety of the person insured." Section 3205(a)(1)(B) has been interpreted to permit an employer to insure the lives of employees who make significant economic contributions to the company, whose services are essential to the company's continued success and whose untimely death would be disruptive to such company. Such employees are often referred to as "key employees".

In 1996, the Legislature added subsections (d) and (e) to Section 3205 to permit employers to insure the lives of rank-and-file employees under corporate-owned life insurance programs designed to fund employee benefit plans. However, to prevent abuses associated with corporate-owned life insurance covering rank-and-file employees (commonly referred to as janitors insurance or dead peasant insurance), subsections (d) and (e) provided employees with notice, consent and termination rights in connection with such coverage. Such notice, consent and termination rights are more extensive than the rights provided to persons insured by an employer under Section 3205(a)(1)(B), including key employees. Regulation No. 180 was first promulgated on an emergency basis on June 2, 2004 as a means to distinguish key employees from rank and file employees and, thereby, clarify the application of the notice, consent and termination requirements in Section 3205(d) of the Insurance Law.

During 2007, Life Bureau staff drafted language to narrow the definition of *key person* to more closely follow Section 3205(a)(1)(B) and industry practice. Under the proposed definition, key employee includes employees or other persons who make a significant economic contribution, whose services are essential to the continuing success of the company and whose untimely death would be disruptive to such company. In addition, the definition borrows from Internal Revenue Code Section 264(e) definition of *key person*.

f. Sale and Marketing of Life Insurance on Military Installations - Update

On September 29, 2006, the Federal Military Personnel Financial Services Protection Act was enacted. This legislation was a response to improper life insurance sales practices on military installations. Such practices included the sale of life insurance at a much higher premium than the federal government sponsored Servicemembers' Group Life Insurance (SGLI), with such insurance often marketed as an investment and under inappropriate or unsuitable circumstances. The Life Bureau is working, as needed, with the NAIC and the Department of Defense to curb such improper sales and practices and to implement the aforementioned legislation. The NAIC's Military Sales (EX) Working Group, which included New York, developed a model regulation entitled the Military Sales Practices Model Regulation. The model regulation was published in mid-2007. The Life Bureau reviewed the model regulation and made revisions necessary to comport with existing New York law. The draft regulation has been submitted to the Governor's Office of Regulatory Reform for review. It is anticipated that New York's version of the Military Sales Practices regulation will be promulgated in 2008.

g. Guaranteed Living Benefits – Update

During 2007, the Life Bureau continued to see a significant number of variable annuity contract submissions containing guaranteed living benefits (VAGLBs). The guaranteed living benefits make variable annuities more attractive to risk adverse consumers by mitigating market losses in the variable sub-accounts. The guaranteed living benefits in deferred variable annuity contracts generally provide for guaranteed minimum account values during the accumulation phase (GMAB) or guaranteed minimum income benefits upon annuitization (GMIB) or guaranteed minimum withdrawal benefits (GMWB). The manner in which the benefit is calculated and the restrictions on the benefit vary from insurer to insurer. The benefits are complex and difficult for consumers to understand and require sophisticated risk management skills to limit insurer risk.

Section 4240 limits guarantees in variable annuity contracts and variable life insurance products sold in the individual market. The benefits guaranteed under such products must always be less than the amounts allocated to the separate account accumulated at 3%. This limitation applies to policies sold in New York; but is not applicable to products issued outside New York by authorized insurers. As such, this limitation does not serve as an effective deterrent to excessive risk exposure in variable products.

The application of the 3% guarantee limitation in Section 4240(d) to certain product designs, especially guaranteed minimum withdrawal benefits, has raised a number of questions. The Life Bureau is considering providing additional guidance for companies using the certified form approval process.

As indicated above, variable annuity contracts with guaranteed living benefits are accelerating the insurance industry's exposure to a stock market downturn. When the 2001 market downturn occurred, the vast majority of the variable annuity products being offered did not contain guaranteed living benefits. At that time, most variable annuity contracts only included a guaranteed minimum death benefit. Most of the variable annuity contracts with guaranteed living benefits in 2001 were still in the seven-to-ten-year waiting period, and thus only a few companies were affected. As the market has

been rising in the past few years, companies selling these products have been reporting high profits, which has created incentives to increase their share of the market in this area. Given the increase in sales since 2002 (during 2007, VAGLB sales increased by approximately 14% to over $180 billion) and increased aggressiveness in the guarantees, the Department is very concerned about this risk exposure to the life industry. Due to the lack of availability of reinsurance for these products and the high cost to hedge these risks in the capital markets using options, most insurers have turned to dynamic hedging programs. The Department is concerned that such programs may not work as planned under severe market conditions. In order to address these concerns, the Department has been pursuing strong reserve, minimum capital and corporate governance requirements for these products at the NAIC, in addition to performing in depth examinations of insurers' reserves, capital, and risk management practices with respect to these products.

h. Regulation 149 – Term Life Issuance and Renewal Restrictions and Nonforfeiture Values for Certain Life Insurance Policies - Update

On December 5, 2007, the Notice of Adoption for the first amendment to Regulation 149 was published in the New York State Register. The amendment became effective on January 1, 2008.

Regulation 149 deals with issuance and renewals of term life insurance policies and non-forfeiture values on certain life insurance policies. The amendment, among other things, removes the restriction on renewing term life policies past age 80. Instead, it ties the maximum age to the highest age used in the mortality table used to determine minimum nonforfeiture values for life insurance policies at the time that the term policy is issued. In addition, the regulation makes changes to the calculation of the nonforfeiture values, including one which aligns the New York and NAIC methodologies. The amendment to Regulation 149 is expected to reduce the cost of doing business in New York for insurers.

j. Viatical Settlements and Life Settlements

Article 78 of the Insurance Law authorizes the Insurance Department to regulate the viatical settlement industry. A viatical settlement transaction occurs when a viatical settlement company enters into an agreement with the owner of a life insurance policy insuring the life of a person who has a catastrophic or life threatening illness or condition to pay compensation in an amount less than the expected death benefit of the policy in return for the policyowner's assignment, transfer, sale, devise or bequest of the death benefit or ownership of the policy. This industry arose during the AIDS epidemic and prior to the introduction of the many new drugs that have greatly increased the life expectancy of many AIDS and cancer patients.

In recent years, there has been an increasing emphasis on a new type of transaction called life settlements. In a life settlement, a life settlement provider enters into a similar agreement with the owner of a life insurance policy. However, unlike viatical settlements, in life settlement transactions, the insured does not have a catastrophic or life threatening illness or condition. Typically, in these transactions, the insured is at least 65 years old with a life expectancy of between 2 and 10 years and the policy has a high face amount. These transactions are unregulated in New York today as there is no existing statutory authority for the regulation of life settlement providers, life settlement brokers or life settlement transactions.

During 2007, the Life Bureau continued to work extensively on the drafting of comprehensive legislation that would replace the existing Article 78, authorize the Department to regulate the life settlement industry as well as the viatical settlement industry and establish standards governing both industries. The Bureau met on many occasions with representatives of the life insurance industry, the life settlement industry and institutional investment firms. In late December 2007, the draft legislation was submitted to the Governor's Office of Regulatory Reform for review.

15. Product Innovations

In 2007, the Life Bureau continued work with the industry to review and bring new and innovative products and features to New York. The following are some of the innovative products or features addressed in 2007.

- Mutual Fund Wrap Products - During 2007, the Life Bureau met with several insurers to discuss insurance products that provide guaranteed lifetime benefits on assets held outside the insurer in a mutual fund or brokerage account held by a financial institution. The benefits are substantially similar to the guaranteed minimum withdrawal benefits provided under variable annuity contracts offered by life insurers. The Department is reviewing the legal and actuarial issues involved. The Department is also carefully reviewing the exposure to market risk for these products, particularly because the assets upon which the guarantees are based are not held by the insurer.

- Return of Premium Life Insurance – Return of Premium Life Insurance is term insurance in which the insurer promises to return all premiums paid if the insured does not die during the term. At least two companies had return of premium life insurance products approved in 2007 for sale in New York.

- Longevity Insurance – The Life Bureau has approved paid-up deferred annuity contracts which do not provide cash surrender benefits. Such contracts have been marketed as “longevity insurance” because the guaranteed lifetime income payments typically begin at age 80 or 85. The annuity is typically funded with a single premium while the individual is in his or her 60’s. The product is being marketed for retirement income purposes.

- Substandard Annuities – In 2007, the Life Bureau approved the first immediate annuity offering substandard underwriting. Such annuities can be written in New York on a basis similar to that permitted for structured settlements annuities. As with structured settlements annuities, substandard underwriting for annuities must be limited to individually underwritten cases and to individuals with serious health impairments based upon medical information submitted to the insurer and an evaluation of a person's medical condition and life expectancy by an underwriter of the insurer. Substandard annuitants must have demonstrable health problems that can result in shorter life expectancy. Underwriters can either “age-rate” up the applicant’s age where the age of the annuitant is adjusted to reflect the biological or physiological age of the individual rather than the chronological age or adjust the mortality factors according to the impaired risk based on the applicant’s medical records.

- Equity Indexed Products – The Life Bureau has reviewed a number of equity indexed annuity and equity indexed universal life product submissions. To date, approximately 17 equity indexed universal life submissions have been approved for sale in New York, with a majority approved pursuant to the Circular Letter 6 (2004) certified process. In light of the innovative nature of such products, several of those certified files have been selected to undergo a post approval review. The likelihood of the occurrence In New York of many of the known problems and abuses associated with equity indexed annuity products made available outside New York is diminished because such product designs would not be permissible under New York’s nonforfeiture law. The Life Bureau has provided guidance on the Department website for equity indexed product designs that are currently permissible in New York. Legislative proposals to New York's nonforfeiture law which would allow more equity indexed product designs while maintaining protection for consumers from the abuses occurring outside of New York are being discussed.

- Funding Agreements – In 2007, the Life Bureau approved funding agreement products for two life insurance companies that became members of the Federal Home Loan Bank of New York ("FHLBNY"). Membership in a FHLBNY has been permissible since 1945. The FHLBNY provides a flexible credit liquidity source for its members at competitive prices so that such members can help meet the housing finance and credit needs of their communities. The funding agreements included provisions pledging assets as collateral because the FHLBNY is a secured creditor and all of its credit products require collateral. After extensive review, the Life Bureau approved the pledging of assets in conjunction with the funding agreements, subject to an annual reporting requirement and the condition that the amount of assets to be pledged or transferred as collateral under the funding agreements and all other business be limited to the amount prescribed in Section 1411(c) of the Insurance Law.

- Preferred Rating and Group Life Insurance Portability –In 2007, the Life Bureau approved a group life portability policy on an experimental basis that allows insured employees or members and their dependents to qualify for a lower preferred premium rate by providing evidence of good health. Until this approval, the Life Bureau had not allowed insurers to take evidence of insurability on insured lives exercising either their group life portability or conversion rights. Section 3220(a)(6) of the Insurance Law gives certificate holders the right to convert to an individual life insurance policy without providing evidence of insurability. Circular Letter 3 of 1996 allowed certificate holders to port to another group life policy on the same basis as group life conversion.

  The Life Bureau approved the preferred rating class to enhance the viability of the group life portability option. With the preferred rating class, the portability option would be more competitively priced and elected by a larger number of persons. A larger pool of persons would permit a greater subsidy to persons who did not apply or qualify for the preferred rate. The approval included conditions and monitoring requirements to ensure that non-preferred rates would not become so high as to render the portability option meaningless for persons who are uninsurable.

- Loan Program – In 2007, the Life Bureau approved a loan program pursuant to Insurance Law §1714(a)(ii) which allows a policyholder with significant deterioration in health and a life expectancy between two and ten years to take a loan against the death benefit of his or her permanent non-variable life insurance policy. The program is based on an agreement outside the policy and the loan amount may exceed the policy's cash value. Under the program, the ownership of the policy remains the same, the beneficiary designated by the policyholder remains unchanged, and the policy's death benefit, less the outstanding indebtedness, will be paid to the designated beneficiary. The Life Bureau approved the program on a number of conditions including requiring the company to adhere to certain limitations prescribed by the Life Bureau pursuant to §1714(b). This program offers an additional option to policyholders with diminished health who may otherwise have to sell their policies on the secondary market or surrender their policies to meet the extra costs associated with their illness or injury. It also provides a mechanism that allows policyholders who are no longer able to pay their premiums, to maintain their policies by using the loan program to pay their premiums.

- Commutation in Immediate Annuities – The Life Bureau has received a number of immediate annuity submissions in which companies have included some sort of commutation benefit. A commutation benefit in its simplest form allows the annuitant to convert the value of future payments into a current lump sum payment. With commutation benefits, it is important that the insured receive a fair value for the benefits given up and

that the insurer considers issues of anti-selection relative to the contract owner's ability to elect the benefit.

16. Trade Practices

In 2007, the Life Bureau continued to analyze issues related to trade practices of insurers doing business in New York. The following are some of those issues:

- Sale of Unapproved Annuity Contracts by Unlicensed Companies – The Life Bureau has had ongoing discussions with two unlicensed insurers who sold unapproved equity indexed annuities and modified guaranteed annuities in New York. A review of the issued annuities revealed that they were not in compliance with New York law and would need significant modification to bring them into compliance. The Life Bureau has had a number of meetings with representatives of the companies to discuss options for resolving the situation.

- Smoker vs. Non-smoker Rates – The Life Bureau has been monitoring instances in which the rate classification of insured persons have changed to smoker status from non-smoker or unismoker status to determine whether smoker designations have been appropriate. For example, the Life Bureau became aware of instances where juveniles insured under a life insurance policy were, upon reaching a certain age, automatically designated as smokers for purposes of determining the juveniles' premium rates, regardless of whether the juveniles were actually smokers.

  Also, the Life Bureau investigated a complaint from a consumer who converted from a group life insurance policy to an individual life insurance policy and was charged smoker rates under the individual policy even though he was a non-smoker. The Life Bureau will continue to monitor the use of smoker and non-smoker rates and address abuses where appropriate.

- Suitability – During 2007, the Life Bureau continued to monitor the Financial Industry Regulatory Authority ("FINRA") (formerly known as the National Association of Securities Dealers) and their actions relative to suitability standards for the sale of variable insurance products. FINRA received SEC approval for its proposed Rule 2821 on September 7, 2007. Rule 2821 requires that a registered representative must have a reasonable basis to believe that a customer has been informed of the material features of the deferred variable annuity and also that the customer would benefit from such features. Additional factors relating to suitability must be considered if there is an exchange of deferred variable annuities. Section (c) of Rule 2821 requires that a principal of the member firm review and approve the purchase or exchange of the deferred variable annuity prior to transmitting a customer's application and payment to the insurance company for processing. Such review and approval process must take place within seven business days after the application is signed by the customer. Rule 2821 also requires that FINRA members establish written supervisory procedures, and implement training programs for representatives and for reviewing principals in order to achieve compliance with the Rule. Rule 2821 was originally to become effective on May 5, 2008. However, in response to industry concerns, FINRA requested that the SEC delay the effectiveness of paragraph (c) of Rule 2821 until August 4, 2008 to allow broker-dealers additional time to develop systems to comply with that section's requirements for a seven-day principal review and approval process. The SEC approved this delay in effectiveness, therefore Rule 2821 sections (a), (b), (d) and (e) will become effective on May 5, 2008, and section (c) will become effective on August 4, 2008. The Life Bureau will analyze whether and to what extent it may be appropriate to extend similar requirements to the sale of all life and annuity products in New York.

- Future Travel – In 2004, the Legislature enacted §2614 of the insurance law prohibiting discrimination because of past lawful travel. The Life Bureau continues to monitor the issue relative to future travel plans. Some states have made it an unfair trade practice to discriminate based upon either past or future lawful travel. The NAIC's A Committee, to be chaired by the Superintendent in 2008, is currently working on the Model Unfair Trade Practices Act to address underwriting based upon past or future travel.

- Discretionary Clauses – In 2007, the Life Bureau continued to address inquiries relative to the use of discretionary clauses in group life insurance policy forms. A discretionary clause is a provision in an insurance contract that grants an insurer, plan administrator or claims administrator the discretionary authority to determine eligibility for benefits, resolve disputes, interpret the terms and provisions of the insurance contract or develop standards of interpretation or review. As a result of a 1989 Supreme Court decision, *Firestone Tire and Rubber Co. v. Bruch*, in actions involving the denial of benefits under an ERISA benefit plan, a court will review the decision to deny benefits under the highly deferential arbitrary and capricious standard of review if the benefit plan (which in many cases is the insurance contract) contains a discretionary clause. The wording of a typical discretionary clause fails to warn plan participants that their right to a de novo review of their claim by the court has been eliminated.

  Life Bureau staff worked with Health Bureau staff to draft Circular Letter No. 14 (2006) which raised concerns relative to discretionary clauses in life and accident and health insurance contracts. Life Bureau staff also worked with Health Bureau staff to draft a proposed regulation prohibiting the use of discretionary clauses in life and accident and health insurance contracts. The NAIC has adopted a model act on discretionary clauses and other states have taken similar action. Recently, the U.S. District Court for the District of Montana held that the State of Montana's Insurance Commissioner's regulation of discretionary clauses in employee benefit plans was not preempted by the federal Employee Retirement Income Security Act (ERISA).

- Premium Financing and Insurable Interest – In 2007, the Life Bureau continued to elicit input from the life insurance industry, the life settlement industry and the premium finance industry regarding the types of premium financing questions that may be appropriately asked on life insurance applications and has begun to approve such applications.

- Contingent Commissions for Group Insurance. – The Life Bureau continued to work with the Office of General Counsel on two significant issues dealing with group insurance. The Life Bureau and OGC are analyzing the issue of whether and to what extent compensation levels can be subject to negotiation. Second, the Life Bureau and OGC are analyzing whether and to what extent a Third Party Administrator should be permitted to add extra charges to the premium in order to pay for the Third Party Administrator's services.

- Same-Sex Marriages - The Life Bureau continues to monitor the New York courts relative to the issue of whether same-sex marriages legally performed in other jurisdictions are entitled to recognition in New York. The status of same-sex marriages legally performed in other jurisdictions is relevant in the Life Bureau's review of dependent coverage provisions in group life insurance policy forms. Pursuant to Insurance Law §4216(f), a group life insurance policy may include provisions for the payment of a death benefit upon the death of the spouse of the insured employee or member.

17. Other Initiatives

a. Group Life Insurance Working Group

In 2007, Life Bureau staff participated in a joint Industry/Department working group to discuss group life insurance issues and concerns. Areas to be addressed include legislative revisions for sections 3220 and 4216 of the Insurance Law as well as the extension of statutory individual protections to group certificate holders where the group certificate holder pays all or a portion of the premium.

b. Market Conduct Review of Non-Guaranteed Elements

Interrogatories on non-guaranteed elements in Exhibit 5 of the 2006 Annual Statements were reviewed for 178 life insurers. Seven of the reviews resulted in contacting the company for additional information on the board criteria required by law for setting non-guaranteed elements and examples of illustrations and communications with respect to non-guaranteed elements. Problems with regulatory requirements related to board criteria and use of reasonable assumptions (bait and switch) were discovered and are being addressed through fines and remedies.

The Department is currently engaged with the industry and consumer groups in an effort to clarify guidance for non-guaranteed elements especially on the content of board criteria. These clarifications will be codified in a regulation which the Department is developing.

c. Principles-Based Valuations and "Corporate Governance for Risk Management"

The Life Bureau views principles-based valuations as "experience-based" valuations. Under an experience-based valuation, relevant and credible data would be used in setting assumptions where available, and in the absence of such relevant and credible data the assumptions should be set at the conservative end of the plausible spectrum as specified by regulation.

In 2007, an amendment to Regulation 147 allowing lapses to be included in formula reserve calculations for UL with secondary guarantee products and an amendment to Regulation 179 allowing the use of lower mortality rates for healthy lives were adopted, effective December 26, 2007. These amendments require certain insurers to file experience data, including mortality, expenses and lapses.

In 2007, the Life Bureau continued to be heavily represented in the activities of the NAIC, particularly in creating a framework for a new principles-based approach to reserve and capital standards. The current law specifies a standard of a principles-based asset adequacy analysis reserve with a formulaic floor. At the NAIC level, there is a movement toward eliminating the formulaic floor. The Life Bureau participated in an NAIC group that reviewed insurers' reports associated with new principles-based minimum capital standards for Variable Annuities with Guaranteed Benefits. The review showed that structure is needed in setting assumptions in the absence of relevant and credible data to ensure solvency, auditability, and consistency in principles-based standards. These conclusions are similar to the Life Bureau's experience in reviewing principles-based asset adequacy analysis over the past several years.

Sophisticated risk management is required by insurers to provide the guarantees on variable products that are popular today. In addition, regulators and insurers have been advocating a more "principles-based" approach to valuations necessary to support life insurance policy performance, In particular there has been a significant focus on using principle-based reserves for term and universal life policies and principles-based risk based capital is already in place for variable annuity products. Principles-based approaches assume insurers have a risk management system sophisticated enough to translate the insurer's risk exposure into appropriate reserve and required capital amounts. Finally, the regulatory examination process is moving to a risk focused approach which would be greatly facilitated by a basic framework and some common terms of reference.

In light of these needs, the Department is developing a regulation for "Corporate Governance for Risk Management." The regulation would foster a written risk management policy with tolerance limits

on risk exposures. The regulation would also foster the alignment of operations with risk management policy.

d. Statutory Examinations

The Reserve and Risk Management Actuaries in the Life Bureau continue to expand their analysis of life insurers' risks from the traditional review of minimum statutory formula reserves and high-level asset/liability matching toward in-depth analysis of scenario-based cash-flow testing and other principles-based methods.

This type of in-depth analysis has proven to effectively determine an insurer's susceptibility to deteriorating economic conditions and has resulted in several insurers restructuring their asset portfolios to better support company obligations. In addition, the Life Bureau's analysis has also led to the establishment of extra reserves for insurers with significant exposure to various kinds of risk including mortality, morbidity, persistency, investment, and general economic exposure. Expanded analysis in the areas of self-support and overall risk management has led to insurers making more informed decisions on continuing sales of unprofitable business.

The Life Bureau has further refined its risk matrix approach to benchmark life insurers' overall risk characteristics. Both sides of the balance sheet (assets and liabilities) are considered. This type of analytical tool further enhances the Life Bureau's ability to prioritize and focus limited resources on insurers that are more susceptible to deteriorating economic conditions. This approach is consistent with the NAIC's initiative on a risk-focused surveillance framework.

Also this year, significant progress was realized with issues related to the management of liquidity risk and the analysis of reinsurance treaties to ensure proper reserve credit and risk transfer to the reinsurer.

All of these efforts materially improved the Life Bureau's risk-focused examination approach during 2007. Going forward, the Bureau will continue efforts to further improve its focus on the timely identification of risks faced by the insurance industry.

e. Reinsurance Issues

In 2007, the Life Bureau conducted a Special Inquiry to research a potential issue in the accounting treatment for reinsurance. Many companies were recognizing a reserve credit that was greater than the amount that would be held in absence of such reinsurance which is a violation of Section 1308(b)(2) of New York Insurance Law. The Life Bureau plans to resolve this issue for year end 2008.

The Life Bureau continued to see complex securitizations for Closed Blocks, Term and Universal Life business. The Life Bureau analyzed projected losses under various scenarios to ensure that the related reinsurance agreements appropriately transferred all the risk of the underlying policies to the reinsurer.

The Life Bureau has been working with the Life and Health Actuarial Task Force in reviewing reinsurance requirements under principles based reserves.

B. PROPERTY BUREAU

1. Entities Supervised by the Financial Regulation Division

As of December 31, 2007, the Financial Regulation Division side of the Property Bureau exercised regulatory authority over 1,153 insurer entities and risk retention groups.

The Bureau regulated 1,050 insurer entities as of year-end 2007. Table 16 provides a breakdown.

Table 16
ENTITIES REGULATED BY PROPERTY BUREAU
2007

Number of Regulated Entities	Type of insurer/reinsurer/entity
90	Accredited reinsurers*
19	Advance premium co-operatives
24	Assessment co-operatives
11	Associations, pools, and syndicates
46	Captive insurers
15	Financial guaranty insurers
27	Mortgage guaranty insurers
1	Property Insurance Underwriting Association (FAIR Plan)
787	Property/casualty insurers
30	Title insurers (including two accredited reinsurers)
9	United States branches

* Lloyd's of London (Lloyd's), included as an accredited reinsurer, is comprised of individual underwriting syndicates, each of which must meet the requirements for recognition as an accredited reinsurer. As of December 31, 2007, the Department recognized 54 Lloyd's syndicates as active accredited reinsurers.

In addition, the Bureau oversaw the operation of 103 risk retention groups in 2007.

The Property Bureau received 35 applications for licensing and 7 applications for recognition as accredited reinsurers during 2007. Twenty-six insurers were newly licensed including 2 domestic stock insurers, 1 domestic title insurer, 2 foreign title companies, 1 foreign mortgage guaranty insurer, 1 domestic financial guaranty insurer and 19 foreign stock insurers. At the close of the year there were domestic applications pending for 10 domestic stock companies, 2 domestic title companies, 1 domestic financial guaranty insurer and 1 domestic mutual company. There were also 20 foreign stock insurers including 2 foreign title insurers, 2 foreign mutual insurers, 1 foreign reciprocal insurer, 1 financial guarantee insurer and 1 foreign US Branch which had license applications pending with the Department. In addition, there were 8 foreign insurers approved for accredited reinsurer status.

2. Property and Casualty Business

Unless otherwise noted, tables and related data for property and casualty companies refer to the nationwide operations of insurers authorized to do business in this State. Data for stock insurers include United States branches of alien insurers. Data for mutual insurers include the State Insurance Fund, and reciprocals. Data for financial guaranty insurers, mortgage guaranty insurers, title insurers, and co-operative fire insurers are summarized separately.

a. Premium Volume and Surplus to Policyholders

Net premiums written during 2006 by all New York-licensed property and casualty insurers aggregated totaled $317.8 billion, of which 78% represented stock company writings. As noted previously, the following underwriting and investment results deal with the nationwide business of New York licensed companies:

Table 17
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Property and Casualty Insurers Licensed in New York State
2001-2006
(dollar amounts in millions)

	Stock Companies				Mutual Companies			
Year	No. of Cos.	Net Premiums Written (during year)	Surplus/ Policy-holders (end of year)	Ratio of Premiums to Surplus	No. of Cos.	Net Premiums Written (during year)	Surplus/ Policy-holders (end of year)	Ratio of Premiums to Surplus
2001	710	$178,615	$175,383	1.0	75	$57,015	$ 72,721	0.8
2002	737	205,017	181,615	1.1	78	62,576	63,789	1.0
2003	706	221,356	203,973	1.1	72	66,070	66,315	1.0
2004	698	234,377	213,611	1.1	73	67,294	86,319	0.8
2005	713	226,808	253,849	0.9	71	68,113	93,736	0.7
2006	727	247,812	287,598	0.9	69	69,948	109,473	0.6

b. Underwriting Results

Results for 2006 show a net underwriting gain of $18.1 billion for stock companies and a net underwriting gain of $3.8 billion for mutual companies.

Table 18
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State
2003-2006
(dollar amounts in millions)

Year		Stock Companies		Mutual Companies	
		Number of Companies	**Amount**	**Number of Companies**	**Amount**
2003	Underwriting gains	248	$6,476.8	26	$1,426.5
	Underwriting losses	360	13,116.1	46	1,827.8
	No gain or loss	98	0.0	0	0.0
2004	Underwriting gains	280	$12,261.4	43	$3,247.3
	Underwriting losses	275	10,744.8	30	1,213.2
	No gain or loss	143	0.0	0	0.0
2005	Underwriting gains	326	$10,548.4	46	$1,820.2
	Underwriting losses	295	16,672.2	25	3,430.9
	No gain or loss	92	0.0	0	0.0
2006	Underwriting gains	408	$22,161.4	47	$4,831.5
	Underwriting losses	223	4,086.5	22	1,014.8
	No gain or loss	96	0.0	0	0.0

Detail may not add to totals due to rounding.

c. Investment Income and Capital Gains

Investment income and net capital gains for stock and mutual companies from 2003 to 2006 are as follows:

Table 19
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
2003-2006
(in millions)

Year		Stock Companies	Mutual Companies
2003	Net investment income	$24,348.0	$5,142.8
	Realized capital gains	2,559.7	0.8
	Unrealized capital gains	15,159.3	8,783.1
	Net gain/loss from investments	$42,067.1	$13,926.6
2004	Net investment income	$23,802.5	$5,288.7
	Realized capital gains	4,556.6	1,555.8
	Unrealized capital gains	8,625.8	4,225.8
	Net gain/loss from investments	$36,984.8	$11,070.2
2005	Net investment income	$29,263.4	$5,903.2
	Realized capital gains	3,005.0	455.6
	Unrealized capital gains	1,473.3	3,902.9
	Net gain from investments	$33,741.7	$10,261.7
2006	Net investment income	$33,298.3	$6,498.4
	Realized capital gains	351.0	412.0
	Unrealized capital gains	14,412.8	9,486.6
	Net gain from investments	$48,062.1	$16,397.0

d. Underwriting and Investment Exhibit

During 2006, dividends to stockholders amounted to $18.3 billion, while dividends to policyholders aggregated to $2.6 billion (for both mutual and stock insurers). The contribution to surplus for 2006 for stock companies was $0.9 billion compared with $12.5 billion for 2005. However, the net increase in surplus for stock companies in 2006, $36 billion, was higher than the comparable $20 billion 2005 increase. Likewise, the net change in surplus for mutual companies was $17.1 billion in 2006, up from $7.8 billion a year earlier. Net income increased substantially for both stock and mutual companies between 2005 and 2006.

Table 20
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Property and Casualty Insurers Licensed in New York State
2005 and 2006
(in millions)

	Stock Companies		Mutual Companies	
	2006	**2005**	**2006**	**2005**
Net gain or loss from:				
Underwriting	$18,074.9	-$6,123.8	$3,816.8	-$1,610.7
Investments [a]	33,649.3	32,268.4	6,910.4	6,358.8
Other income	-173.6	-520.0	393.2	633.5
Net gain or loss	$51,550.6	$25,624.5	$11,120.4	$5,381.7
Less:				
Dividends to policyholders	584.7	489.7	2,044.6	745.9
Federal income taxes incurred	12,671.0	3,758.0	1,667.9	1,021.4
Net income	**$38,294.9**	**$21,377.0**	**$7,407.9**	**$3,614.3**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-$18,313.4	-$13,378.5	$0.0	$0.0
• Stock	-3.7	-4.0	0.0	0.0
US Branches – Net remittance to/from home office	-1.0	-1.0	0.0	0.0
Total dividends and remittance	-$18,318.1	-$13,383.6	$0.0	$0.0
Unrealized capital gains/losses	14,412.8	1,473.3	9,486.6	3,902.9
Cumulative effect of changes in accounting principles	34.2	142.6	-3.8	-269.4
Miscellaneous items	679.5	-1,949.7	160.0	587.5
Contributions to surplus	940.0	12,532.3	1.4	1.8
Total other sources	-$2,251.6	-$1,185.0	$9,644.2	$4,222.8
Net increase or decrease in surplus	**$36,043.3**	**$20,192.0**	**$17,054.1**	**$7,839.1**

[a] Excludes unrealized capital gains.

e. Selected Annual Statement Data

From 2003 to 2006 aggregate (i.e., stock and mutual) net premiums written increased by 10.6%; admitted assets increased by 20.7%; unearned premium and loss reserves increased by 17.7%; and other liabilities increased by 6.9%. Capital and surplus to policyholders increased by 45.7%.

Table 21
SELECTED ANNUAL STATEMENT DATA
Property and Casualty Insurers Licensed In New York State
2003-2006
(dollar amounts in millions)

	2006	2005	2004	2003
		Stock Companies		
Number of insurers	727	713	698	706
Net premiums written	$247,812	$226,808	$234,377	$221,356
Admitted assets	747,095	739,827	675,485	623,466
Unearned premium & loss reserves	451,527	441,511	231,701	375,852
Other liabilities	44,267	41,925	14,021	43,067
Capital	3,723	3,912	2,292	4,767
Surplus to policyholders	287,598	253,849	213,611	203,973
		Mutual Companies		
Number of insurers	69	71	73	72
Net premiums written	$69,948	$68,113	$67,294	$66,070
Admitted assets	223,144	207,656	195,595	180,141
Unearned premium & loss reserves	84,715	85,708	81,789	79,687
Other liabilities	28,957	28,212	27,487	25,407
Surplus to policyholders	109,473	93,736	86,319	66,315

f. Direct Premiums Written, by Line

There was an increase in property/casualty writings in New York State in 2006 as direct premiums written for all property/casualty lines increased by 4%. Major lines, i.e., those with greater than $1 billion premium written in 2006, with at or above average year-to-year increases in 2006 included general liability, workers' compensation, commercial multi-peril, homeowners multi-peril, and financial guaranty.

Table 22
DIRECT PREMIUMS WRITTEN BY PROPERTY/CASUALTY INSURERS
New York State — 2002-2006[1]
(dollar amounts in millions)

Property and Casualty Lines	2002	2003	2004	2005	2006	Percentage Change 2002-2006	Percentage Change 2005-2006
All Premiums Written	$29,570	$31,330	$30,733	$32,371	$33,674	14%	4%
Private Passenger Auto	9,913	10,554	10,684	10,262	9,994	1%	-3%
Bodily Injury and Property Damage Liability	6,718	7,247	7,304	6,968	6,705	0%	-4%
Comprehensive and Collision	3,195	3,307	3,380	3,294	3,289	3%	0%
Commercial Auto	1,985	2,167	2,191	2,080	2,045	3%	-2%
General (Other) Liability	3,478	3,741	4,018	3,997	4,387	26%	10%
Commercial Multi-Peril	2,688	2,779	2,897	2,958	3,074	14%	4%
Workers' Compensation	3,412	3,403	1,928	3,758	4,133	21%	10%
Homeowners' Multi-Peril	2,662	2,901	3,174	3,427	3,615	36%	5%
Medical Malpractice	945	1,027	1,067	1,128	1,267	4%	12%
Inland Marine	660	690	734	707	841	27%	19%
Ocean Marine	469	440	583	551	598	28%	8%
Fidelity and Surety	358	433	427	433	459	28%	6%
Accident and Health	473	426	383	372	329	-30%	-11%
Fire	411	442	432	455	490	19%	8%
Product Liability	162	165	158	179	175	8%	-2%
Financial Guaranty[2]	1,006	1,153	1,105	1,090	1,164	16%	7%
Mortgage Guaranty	213	214	217	215	207	-2%	-4%
Allied Lines	256	312	289	278	334	0%	20%
Aircraft	78	141	71	96	114	47%	18%
Boiler and Machinery	91	87	85	78	80	-11%	2%
Credit	40	40	42	48	62	55%	28%
Burglary and Theft	8	10	14	14	27	243%	91%
All Other[3]	263	205	233	244	280	6%	15%

NOTE: Detail may not add to totals due to rounding.

[1] New York State business of all NYS licensed companies. Includes federal employee health benefits program premium.

[2] Includes monoline and non-monoline insurers.

[3] Includes Farmowners Multi-Peril, Multi-Peril Crop, Federal Flood, Earthquake, and Aggregate Write-Ins.

g. Audit and Analysis

The 2006 Annual Statements of the companies authorized to transact business in the State of New York were filed for audit and analysis in 2007, as were those of reinsurers accredited in this State. Issues arising during the audits were resolved with the companies. As a result of the audits, some filed statements were adjusted to bring reported figures into compliance with New York requirements.

All property/casualty insurers are required to file quarterly statements. Insurers licensed pursuant to Section 6302 of the New York Insurance Law (NYIL) are also required to file a supplemental schedule of special risks. Approximately 2,761 quarterly statements were received, reviewed for completeness and accuracy, and the financial data analyzed.

h. State Insurance Fund

All purchases and sales of stocks and bonds by the State Insurance Fund are subject to the approval of the Superintendent of Insurance. During 2007, the State Insurance Fund acquired stocks and bonds totaling $31.2 billion and sold stocks and bonds totaling $14.0 billion. Upon review, the Property Bureau recommended the approval of the acquisitions of $31.2 billion and the sales of $14.0 billion. In 2006, the Bureau recommended approval of acquisitions totaling $24.2 billion and sales totaling $13.0 billion.

i. CPA-Audited Financial Statements

NYIL Section 307(b) requires licensed insurers to file an annual financial statement, certified by an independent certified public accountant (CPA), on or before May 31 of each year. CPA-audited financial statements were received and reviewed for 941 companies in 2007. There were 12 companies entitled to exemption from the filing requirements.

j. Public Inspection of Records

The Financial Division of the Property Bureau provides public access to various Insurance Department documents pursuant to the Freedom of Information Law (FOIL). In 2007, 135 FOIL requests to review and copy records maintained by the Financial Division were received from members of the public.

k. Holding Company-Related Transactions

Pursuant to Article 15 of the New York Insurance Law and Department Regulation 52, the Property Bureau is responsible for the review and approval of transactions within holding company systems. During 2007, 158 holding company transaction files, and 228 holding company registration statements and amendments, were reviewed and closed by the Property Bureau. In addition, 29 notices of acquisition of control of domestic insurers were reviewed and closed by the Property Bureau.

3. Financial Guaranty Insurance

New York Insurance Law Article 69 made financial guaranty insurance a separate kind of insurance effective May 14, 1989. Financial guaranty insurance may be written only by an insurer empowered to write financial guaranty business as described in Section 1113(a).

As of December 31, 2006, there were 9 domestic and 6 foreign financial guaranty insurers licensed in New York.

Table 23
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Financial Guaranty Insurers Licensed in New York State, 2003-2006
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2003	3,360.7	10,794.2	0.31
2004	3,089.1	11,357.0	0.27
2005	2,979.8	13,046.5	0.23
2006	3,027.5	13,570.3	0.22

Table 24
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State, 2003-2006
(dollar amounts in millions)

Year		Number of Companies	Amount
2003	Underwriting gains	9	$1,301.1
	Underwriting losses	5	$26.2
2004	Underwriting gains	9	$1,219.0
	Underwriting losses	4	$96.5
2005	Underwriting gains	8	$1,404.6
	Underwriting losses	6	$60.5
2006	Underwriting gains	8	$1,366.5
	Underwriting losses	5	$62.0

Table 25
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State, 2003-2006
(in millions)

	2006	2005	2004	2003
Net investment income	$1,669.5	$1,477.6	$1,253.7	$1,092.1
Realized capital gains	24.0	35.7	115.9	159.0
Unrealized capital gains	151.8	102.2	52.2	124.1
Net gain from investments	$1,845.3	$1,615.5	$1,421.8	$1,375.1

Table 26
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Financial Guaranty Insurers Licensed in New York State
2003-2006
(in millions)

	2006	2005	2004	2003
Net gain or loss from:				
Underwriting	$1,304.6	$1,344.1	$1,122.5	$1,274.9
Investments [a]	1,693.5	1,513.3	1,369.5	1,251.0
Other Income	16.7	22.7	6.1	13.0
Net gain or loss	$3,014.8	$2,880.1	$2,498.2	$2,538.9
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	785.6	706.1	620.4	727.8
Net income	**$2,229.2**	**$2,174.0**	**$1,877.8**	**$1,811.1**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-1,221.5	-656.8	-880.3	-623.9
• Stock	0.0	0.0	0.0	0.0
Total dividends and remittance	-$1,221.5	-$656.8	-$880.3	-$623.9
Unrealized capital gains	151.8	102.2	52.2	124.1
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	-410.3	-726.2	-464.0	-346.5
Contributions to surplus	-13.5	620.7	226.3	607.1
Total other sources	-$1,493.4	-$660.1	-$1,065.8	-$239.3
Net increase or decrease in surplus	**$735.7**	**$1,513.9**	**$812.0**	**$1,571.8**

[a] Excludes unrealized capital gains.

Table 27
SELECTED ANNUAL STATEMENT DATA
Financial Guaranty Insurers Licensed In New York State
2003-2006
(dollar amounts in millions)

	2006	2005	2004	2003
Number of Companies	15	14	15	14
Exposure	$2,958,463.0	$2,680,961.8	$2,572,632.1	$2,253,613.0
Net premiums written	3,027.5	2,979.8	3,089.1	3,360.7
Admitted assets	35,663.8	33,916.0	31,402.2	27,659.0
Unearned premium & loss reserves	11,874.6	11,517.4	5,925.9	9,223.8
Other liabilities	10,218.9	9,352.1	4,925.4	7,641.0
Capital	246.7	266.7	181.7	246.7
Surplus to policyholders	13,570.3	13,046.5	11,357.0	10,794.2

4. Mortgage Guaranty Insurance

At year-end 2006, there were 2 domestic and 25 foreign companies licensed to transact mortgage guaranty business in New York.

Table 28
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Mortgage Guaranty Insurers Licensed in New York State
2003-2006
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2003	3,849.0	3,708.2	1.04
2004	3,786.4	4,529.8	0.84
2005	3,815.4	4,134.2	0.92
2006	3,890.7	4,010.2	0.97

Table 29
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Mortgage Guaranty Insurers Licensed in New York State
2003-2006
(in millions)

	2006	2005	2004	2003
Net gain or loss from:				
Underwriting	$1,189.3	$1,003.6	$949.3	$1,201.3
Investments [a]	1,053.3	913.4	797.0	809.7
Other Income	13.4	3.9	11.7	2.0
Net gain or loss	$2,256.1	$1,920.9	$1,758.0	$2,013.1
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	485.9	326.2	295.2	628.0
Net income	**$1,770.1**	**$1,594.8**	**$1,462.8**	**$1,385.1**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-1,518.0	-1,273.4	-1,375.1	-677.6
• Stock	0.0	0.0	0.0	0.0
Total dividends	-$1,518.0	-$1,273.4	-$1,375.1	-$677.6
Unrealized capital gains	223.4	219.7	172.5	315.7
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	-510.5	-996.8	750.5	-863.9
Contributions to surplus	-94.9	64.9	-189.1	-276.5
Total other sources	-1,900.0	-1,985.6	-641.2	-1,502.3
Net increase or decrease in surplus	**-$129.9**	**-$390.8**	**$821.7**	**-$117.2**

[a] Excludes unrealized capital gains.

TABLE 30
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
2003-2006
(dollar amounts in millions)

	2006	2005	2004	2003
Number of companies	27	26	26	26
Net premiums written	$3,890.7	$3,815.4	$3,786.4	$3,849.0
Admitted Assets	23,509.8	22,663.5	21,562.9	20,511.8
Unearned premium & loss reserves	7,871.4	7,566.4	7,137.6	6,580.5
Other liabilities	11,628.2	10,963.0	9,895.5	10,369.5
Capital	70.5	68.5	68.5	70.5
Surplus	4,010.2	4,134.2	4,529.8	3,708.2

5. Title Insurance

Eleven domestic and 19 foreign companies were licensed to write title insurance in New York State at the close of 2006.

Table 31
SELECTED ANNUAL STATEMENT DATA
Title Insurance Companies
2003-2006
(dollar amounts in millions)

	2006	2005	2004	2003
Number of Companies	30	26	23	22
Net premiums written	$11,007.0	$9,142.5	$8,614.5	$8,203.1
Admitted assets	6,848.0	5,480.1	4,680.0	4,163.9
Liabilities	4,499.8	3,843.0	3,149.6	2,710.9
Capital	118.8	98.8	94.4	93.3
Surplus	2,348.3	1,637.1	1,530.3	1,453.0

6. Advance Premium Co-operative and Assessment Corporations

At year-end 2006, there were 19 advance premium corporations under the supervision of the Property Bureau. The total number of advance premium corporations remained unchanged from 2005 to 2006. The net premium volume of the advance premium corporations decreased by 3.1% from the prior year.

A total of 25 assessment corporations were under the Property Bureau's supervision at year-end 2006. The total number of assessment corporations remained unchanged from 2005 to 2006. The net premium volume of these 25 companies increased by 4.1% from the prior year.

During 2006, the Property Bureau initiated 8 examinations of the advance premium and assessment corporations.

Table 32
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Corporations
2003-2006
(dollar amounts in millions)

Year		Total	Advance Premium Corporations	Assessment Corporations
2003	Number of companies	45	19	26
	Total assets	$1,696.2	$1,448.4	$247.8
	Net premiums written	838.9	742.3	96.6
	Surplus funds	637.4	500.7	136.7
2004	Number of companies	45	19	26
	Total assets	$1,893.3	$1,620.5	$272.8
	Net premiums written	904.6	795.6	109.0
	Surplus funds	722.0	576.6	145.4
2005	Number of companies	44	19	25
	Total assets	$2,070.7	$1,775.6	$295.1
	Net premiums written	931.3	817.2	114.1
	Surplus funds	809.0	650.7	158.3
2006	Number of companies	44	19	25
	Total assets	$2,197.5	$1,880.3	$317.2
	Net premiums written	910.7	791.9	118.8
	Surplus funds	917.9	739.7	178.2

7. Special Risk Insurers (Free Trade Zone)

Calendar Year 2006 was the 28th full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 196 licensed companies as of December 31, 2006. Net premiums written during the year amounted to approximately $1.1 billion, bringing the net premiums written since inception to approximately $10.0 billion. Net premiums written since 2002 are as follows:

Table 33
DIRECT AND NET PREMIUMS WRITTEN
Special Risk (Free Trade Zone)
2002-2006
(dollar amounts in millions)

Year	Direct Premiums Written	Net Premiums Written
2002	1,082.3	821.1
2003	1,180.5	1,020.2
2004	1,323.1	1,071.7
2005	1,193.7	1,022.6
2006	1,510.3	1,286.2

8. Risk Retention Groups

On October 27, 1986, the Liability Risk Retention Act of 1986, a significant federal statute affecting the insurance industry, was enacted. Generally, the legislation permits the organization and operation of risk retention groups and purchasing groups for the purpose of providing or obtaining commercial liability insurance coverage. The Financial Regulation Division of the Property Bureau regulates risk retention groups and the Market Division of the Property Bureau regulates purchasing groups.

A risk retention group is an insurance company owned by its members and organized for the purpose of assuming and spreading among the members all or a portion of their risk exposure. These insurers are exempt from most state insurance laws, other than those of the domiciliary state.

As of December 31, 2006, 90 risk retention groups had registered with the Department to do business in New York under the provisions of the federal legislation.

In calendar year 2006, risk retention groups filing financial statements with this Department reported total nationwide direct premiums written of $1.66 billion and total nationwide net premiums written of $654.2 million. These risk retention groups reported direct premiums written of $282.1 million in New York State during this same period.

9. Examinations of Insurers

a. Number of Examinations

The Property Bureau's Financial Examinations Unit of its Financial Regulation Division is required to conduct examinations of all domestic insurers on a regular basis. During calendar year 2007 a total of 171 such examinations were conducted.

Table 34
EXAMINATIONS CONDUCTED
by the Financial Regulation Division of the Property Bureau
2007

	Regularly Scheduled			Other Financial Exams		
	Total	**Started in 2007**	**Started Prior to 2007**	**Special**	**On Organi-zation[1]**	**Increase in capital[2] and other**
Property and casualty insurers, including financial guaranty insurers	143	49	90	0	3	1
Other insurers, captives and service contractors	21	3	18	0	0	0
Title and mortgage guaranty insurers	7	1	5	0	1	0
Total	**171**	**53**	**113 [3]**	**0**	**4**	**1**

[1] Examination conducted when insurer is first incorporated in New York State.
[2] Examination when insurer increases its capital.
[3] This total includes 55 reports with completed field work that were not filed as of 2/20/08.

b. Risk-Focused Examinations

Effective January 1, 2010, the application of the Risk-Focused Examination approach, as contained in the current Financial Condition Examiners Handbook, will be mandated as an accreditation standard for conducting examinations. In 2006, the Property Bureau conducted its first pilot examination using this new approach. During 2007, this approach was used for almost every examination, with the exception of companies in run-off or very small companies.

10. Lloyd's of London

Underwriters at Lloyd's (Lloyd's of London) consist of underwriting syndicates at Lloyd's that meet the requirement for recognition as accredited reinsurers in New York. As of December 31, 2007, 54 active syndicates at Lloyd's were recognized as accredited reinsurers by the Department. Each syndicate is required to maintain a trust fund in New York and the amount deposited in each trust fund is required to equal each syndicate's gross liabilities for U.S. situs reinsurance business. In addition, all

syndicates together must maintain a minimum surplus in trust, on a joint and several basis, of not less than $100 million, for the protection of United States ceding insurers.

11. Finite Risk Reinsurance

Finite risk reinsurance has received increased attention over the past years. Finite risk reinsurance is a product that can potentially be used by insurers to create the appearance that business has been ceded to reinsurers without actually transferring any risk. Upon examination of domestic insurers, the Department has been reviewing reinsurance agreements for transfer of risk for many years. Due to the recent increased concerns regarding finite risk reinsurance, the Department has been involved in joint investigations with both the Securities and Exchange Commission and the New York Attorney General's Office, and increased scrutiny of certain reinsurance agreements has been instituted. Additionally, the Department participated in efforts by the National Association of Insurance Commissioners to address accounting and disclosure issues related to finite risk reinsurance. New York is Chair of the NAIC Property and Casualty Reinsurance Study Group that has adopted additional disclosures and CEO and CFO attestation that there are no side agreements to a reinsurance agreement and that the company has documentation that all reinsurance agreements taken credit for as reinsurance transfer risk. The proposed enhanced disclosure requirements and the attestation by company management will clarify the overall impact of finite reinsurance on the industry. This will result in enhanced disclosure of these practices to be identified in the NAIC Property and Casualty financial statement. The Department continues to work with the NAIC and the industry to revised standards of risk transfer that would qualify reinsurance contracts to be allowed favorable reinsurance accounting treatment.

12. Certified Capital Companies

New York's first venture capital investment bill (Chapter 389 of the Laws of 1997) was signed into law on August 7, 1997 to spur the growth of businesses and employment in New York State. The bill created a tax credit incentive mechanism to increase investment of financial resources of insurers into New York State's venture capital markets by providing a dollar-for-dollar tax credit to insurers investing in certified capital companies (CAPCOs).

Sections 142 through 145 of that bill amended the New York Tax Law by adding new Sections 11 and 1511(k) providing for:

- the establishment of certified capital companies;
  the creation of $100 million in tax credit incentives to insurance companies that invest in the CAPCOs; and
- the New York State Insurance Department's oversight of the program.

CAPCOs can be partnerships, corporations, trusts or limited liability companies whose primary business activity is the investment of cash in qualified businesses, emphasizing viable smaller business enterprises which traditionally have had difficulty in attracting institutional venture capital. Organized on a "for-profit" basis, CAPCOs must be located, headquartered and licensed (or registered) to conduct business in New York State.

The law was amended in 1999, 2000, 2004 and 2005 adding four new programs. The Department allocated an aggregate of $400 million in tax credits under the five programs, detailed as follows:

	Programs				
	1	2	3	4	5
Allocated Tax Credits (in millions)	$100	$30	$150	$60	$60
Number of participating CAPCOs	5	5	5	6	7
Number of Insurer-Investors	30	28	44	42	51

The tax credits allocated to the insurer-investors are taken at 10% a year for 10 years going forward from the year designated in the statute for each program. The CAPCOs are required to invest at least half of their certified capital in qualified businesses within four years of the starting date of each specific certified capital program. Chapter 59 of the Laws of 2004, which was signed into law on August 20, 2004, amended various aspects of the statute among which is the new requirement that CAPCOs that received certified capital investments under Program Four and subsequent programs shall pay to the Department for deposit in the general fund an amount equal to 30% of the net profits on qualified investments. Part A of Chapter 63 of the Laws of 2005 added Program 5 earmarking a $60 million funding for tax credit allocations starting in 2007.

As of December 31, 2006 the CAPCOs invested approximately $251 million in 155 qualified businesses: Program One CAPCOs invested 77.3% of their total $100 million certified capital; Program Two CAPCOs invested 80.8% of their $30 million total; Program Three CAPCOs invested 71.0% of their $150 million certified capital; Program Four CAPCOs invested 41.9% of their $60 million and Program Five CAPCOs invested 31.2% of their $60 million.

The qualified businesses invested in encompass a broad sector of the state economy with significant investments in computer technology, manufacturing, marketing, media, and financial services. Programs Four and Five have put additional emphasis on investments in businesses utilizing technology transferred from university, non-profit or industrial research and incubator facilities located in New York State.

Seventy nine qualified businesses had less than $1 million, 49 businesses had between $1 million and $5 million and 27 businesses had over $5 million in assets at the time of a CAPCO's initial investment; the CAPCOs' investments in these businesses accounted for approximately 37.2%, 32.0% and 30.8%, respectively, of the total invested. CAPCOs have invested approximately $91.9 million or 36.5% of the invested funds in "early-stage" businesses, and approximately $3.6 million in "start-up" businesses.

In the five programs combined, 85% of the numbers of businesses and 75% of the dollars invested in qualified businesses were headquartered in New York County (Manhattan), Long Island, Mid-Hudson and the Capitol District. The remaining 15% of the businesses and 25% of the dollars invested were in other regions of New York State. Thirty-seven percent of all funds invested by year-end 2006 in qualified businesses were in New York County and 22.6% were made in Empire Zones and 19.4% were made in "underserved areas" defined as areas outside of New York County and outside of Empire Zones.

With CAPCO and other venture entity investments in these qualified businesses since inception of the CAPCO Program in 1997, the overall the total number of employees in New York in the businesses for which December 31, 2006 information was provided increased by 1,059 positions. The change of the number of employees in any one business ranged from a decrease of 84 to an increase of 244.

A separate report to the Governor and the Legislature on the New York CAPCOs is submitted annually by the Superintendent of Insurance on or before June 1st of each year pursuant to Section 11(j) of the New York Tax Law.

13. Service Contract Providers

The Bureau reviews the financial responsibility requirements of applicants seeking registration pursuant to Article 79 of the Insurance Law to write service contracts in New York. In addition, the filed audited financial statements are annually reviewed for those service contract providers that seek to meet the statutory financial responsibility requirements through either a New York Funded Reserve Account or stockholders equity in excess of $100 million. During the year 2007, this Bureau did follow up with all providers using a New York Funded Reserve Account to cure the deficiency in the New York Funded Reserves due to an incorrect interpretation of the necessary calculation required by statute. As of December 31, 2007, there were 57 service contract providers required to file audited financial statements with the Property Bureau-Financial Division, with 27 utilizing the New York Funded Reserve Account and 30 utilizing stockholders equity in excess of $100 million.

14. Filings Involving Rate/Rating Rule Changes, Policy Forms, Territories and Classifications

a. Number of Filings

During 2006, the Market Regulation Division of the Property Bureau received 6,180 filings involving changes in rates, rating rules, policy forms, rate classifications and rating territories submitted by rate service organizations, joint underwriting associations and insurers. The filings were submitted for the following lines of business:

Table 35
NUMBER OF FILINGS RECEIVED BY TYPE*
Market Regulation Division of the Property Bureau
2007

Line of Business	Rates & Rules	Policy Forms	Totals
Fire and Allied Lines	376	263	639
Farmowners Multiple Peril	39	28	67
Homeowners Multiple Peril	222	146	368
Multiple Line	40	48	88
Commercial Multiple Peril	409	358	767
Inland Marine	152	170	322
Medical Malpractice	91	24	115
Earthquake	4	1	5
Flood	2	3	5
Rain	0	0	0
Workers' Compensation & Employer's Liability	196	116	312
Other Liability	832	883	1715
Motor Vehicle Insurance	822	354	1176
Aircraft	12	21	33
Fidelity & Surety	97	55	152
Glass	1	0	1
Burglary & Theft	133	87	220
Boiler & Machinery	11	17	28
Credit	11	14	25

Line of Business	Rates & Rules	Policy Forms	Totals
Animal Mortality	5	6	11
Mortgage Guaranty	33	8	41
Residual Value	0	0	0
Title	7	7	14
Financial Guaranty	3	72	75
Prepaid Legal Service Plan	0	1	1
Warranty Reimbursement	0	0	0
Total	**3498**	**2682**	**6180**

* These figures include approximately 81 consent-to-rate filing applications (pursuant to Section 2309 of the Insurance Law); 5 group property & casualty filings; 76 manuscript policy form filings; and 126 rating plans submitted in 2006. During 2007, 268 policy form filings and 222 rate or rating rule filings were disapproved. In addition, the Bureau continued speed-to-market (STM) initiatives and accepted electronic submission of filings through the System for Electronic Rate and Form Filing (SERFF). The Bureau received 815 STM and 4,355 SERFF form and rate filings in 2007, which are included above.

b. Advisory Rate/Loss Cost Changes

The following table lists major revisions in rates or loss costs filed by rate service organizations that were approved or acknowledged during 2007. Loss costs apply to the voluntary market and are advisory, *i.e.*, they do not have to be adopted by an insurer. They reflect the experience of all companies that report to the rate service organization. Loss costs are used by insurers for most lines of business as a basis for determining their individual company rates.

Table 36
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2007 by Property and Casualty
Rate Service Organizations

	Percent Changes in Average State-Wide Rates
Automobile	
Automobile Insurance Plans Service Office	
Private Passenger Automobile	
Rates Revised	
Bodily Injury Liability	-10.0
Property Damage Liability	+6.8
Personal Injury Protection	-9.0
Uninsured Motorists	-8.6
Liability Subtotal	-6.7
Comprehensive	-18.4
Collision	-9.4
Physical Damage Subtotal	-12.3
Total All Coverages (effective August 15, 2007)	-7.0
Automobile Insurance Plans Service Office	
Commercial Automobile (Excluding Public Autos)	
Rates Revised	
Commercial Cars and Miscellaneous Lines	
Bodily Injury Liability	+6.0
Property Damage Liability	+4.0
Personal Injury Protection	+20.0
Liability Subtotal	+6.6
Garages	
Bodily Injury Liability	-3.4
Property Damage Liability	-7.2
Personal Injury Protection	-1.2
Liability Subtotal	-3.8

	Percent Changes in Average State-Wide Rates
Zone Rated Risks	
Bodily Injury Liability	+15.0
Property Damage Liability	+10.0
Personal Injury Protection	+15.0
Liability Subtotal	+13.7
Comprehensive	-8.0
Collision	-2.0
Physical Damage Subtotal	-5.0
Total Liability	+6.4
Total All Coverages	+6.1
(effective June 15, 2007)	

Liability Other Than Automobile

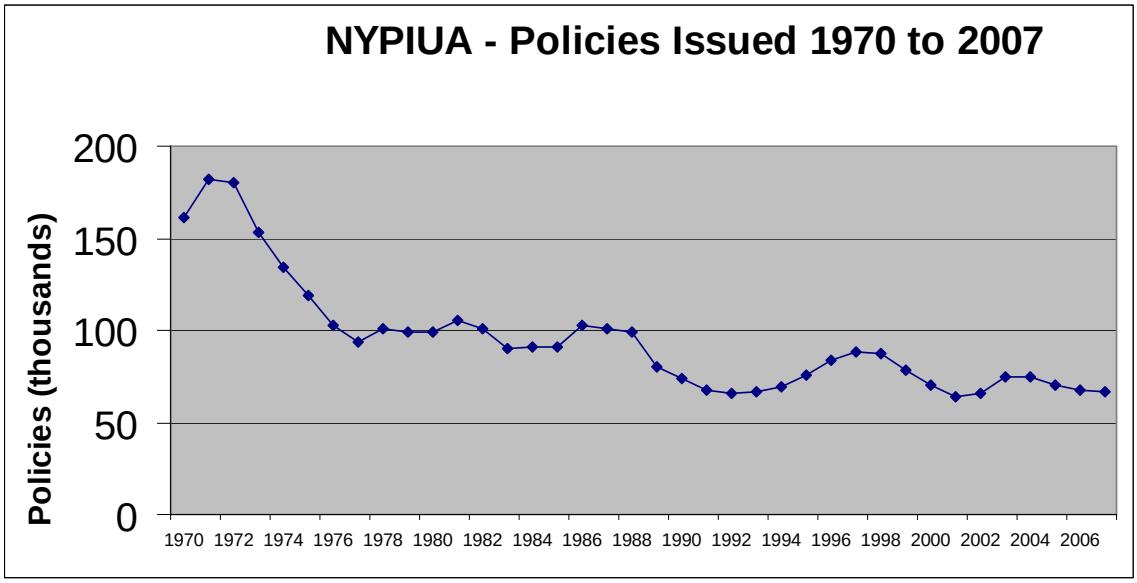
Insurance Services Office, Inc.	
Employment Practices Liability Loss Costs	-11.5
(effective September 1, 2007)	
Insurance Services Office, Inc.	
Commercial General Liability Loss Costs	-8.3
(effective June 1, 2008)	
Insurance Services Office, Inc.	
Commercial General Liability Increased Limits Factors	+10.8
(effective June 1, 2008)	
The Mutual Service Office, Inc.	
Commercial General Liability – Initial Rates and Rule	+0.0
(effective July 18, 2007)	

15. New York Property Insurance Underwriting Association (NYPIUA)

a. Policies Issued

The following graph illustrates the number of policies issued by the New York Property Insurance Underwriting Association from 1970 through 2007:

(Chart A)



Following the peak year of 1971 (182,000 policies), there was a steady decline through 1977 in the number of policies issued annually by the Association. The period 1977 through 1982 saw relative stability, with the number of policies ranging between 94,000 and 105,000. The sharp decline experienced from 1982 to 1983 can be attributed to soft market conditions, while 1986 showed a sharp increase in policies issued as the voluntary insurance market hardened. Another soft insurance market accounted for the large decrease in the number of policies issued by the Association from 1989 through 1992 as many NYPIUA policies were written in the voluntary market. The number of NYPIUA policies issued began to increase gradually from 1993 through 1997 reflecting, in part, the ongoing concern for adequate coastal property insurance coverage. In 1998, 1999, 2000, and 2001, the number of NYPIUA policies issued had declined, while in 2002, 2003, and 2004, the number increased. The number of policies issued in 2005, 2006 and 2007 were 69,506, 67,969 and 66,548, respectively, which shows a gradual yearly decrease.

b. Financial Information

For the fiscal year ending December 31, 2007, the Association's Financial Report indicated premiums earned of $30,125,516 and a net underwriting loss of $1,417,995. Other income of $4,962,657, comprised of net investment income of $5,044,149; premium balances charged off $9,404; bond amortization gain of $122,371; loss on sale of securities of $223,502; grant program of $114,272 and policy installment fees of $143,315, resulted in net income before taxes of $3,544,662. The change in assets not admitted of $75,049 and taxes incurred of $125,969 resulted in a net change in the Members' Equity Account of $3,343,644. The cumulative operating profit as of December 31, 2007 was $165,674,424. After all assessments (net of distribution of $91,008,265), the net Members' Equity Account totaled $74,666,159.

In accordance with Section 5405(c) of the New York Insurance Law, the Association estimated a deficit from operations of $1,634,387 for the Calendar Year 2008. However, there will be no need to credit the Association with any funds from the New York Property/Casualty Insurance Security Fund for the year beginning January 1, 2008, since its assets exceed its liabilities.

c. Rate Revisions

During 2007, the Department approved rate revisions for both the Farm Property and Dwelling Property classes of business. These revisions resulted in an average statewide change of -2.0% for Farm Property and -4.3% for Dwelling Property. These revisions correspond with loss costs revisions promulgated by the Insurance Service Office for the voluntary market.

d. Legislation in 2007

Chapter 86 of the Laws of 2007 extended the authority of the New York Property Insurance Underwriting Association to operate through June 30, 2008.

16. Medical Malpractice Insurance

a. Establishment of Rates and Premium Surcharges

Chapter 58 of the Laws of 2007 extended for one year the authority of the Superintendent of Insurance to establish rates for policies providing coverage for physicians' and surgeons' medical malpractice liability insurance. This legislation also extended the provision that allowed for the application of surcharges of up to 8% annually, beginning July 1, 1989, upon the then established rates if required to satisfy any deficiency for the policy periods July 1, 1985 through June 30, 2008.

The Superintendent established primary medical malpractice insurance rates in New York for the July 1, 2007 through June 30, 2008 policy year. This overall effect represented an across-the-board +14.0% rate change for all insurers, including Medical Malpractice Insurance Plan (MMIP), providing physicians and surgeons medical malpractice liability coverage in New York. MMIP provides coverage for insureds unable to obtain coverage in the voluntary market.

b. Claims-Made Factors and Optional Tail Factors

The claims-made rate is obtained by multiplying the established occurrence rate by the claims-made factor. This factor varies depending on the number of years the insured has been covered by the claims-made program. The rate for the optional tail coverage required to be offered upon termination of coverage is based on the number of years the physician has completed in the claims-made program, and is obtained by multiplying the established occurrence rate by the factor established by the Superintendent. For the 2007 to 2008 policy year, it was determined that no change was needed to these factors.

c. Physicians Excess Medical Malpractice Insurance for ’07 –’08

Chapter 58 of the Laws of 2005 continued the excess medical malpractice program provided for in §18 of Chapter 266 of the Laws of 1986, as amended for the period July 1, 2007 through June 30, 2008.

Chapter 1 of the Laws of 2002 required all physicians, surgeons, and dentists participating in the excess medical malpractice insurance program to participate in a proactive risk management program. After consultation with representatives of insurers and the Medical Society of the State of New York, the Superintendent promulgated the Third Amendment to Regulation 124 on an emergency basis, which contains standards for the establishment and administration of this risk management program. The regulation was adopted on January 24, 2007.

d. Dissolution of the Medical Malpractice Insurance Association (MMIA)

As indicated in last year’s report, Chapter 147 of the Laws of 2000 had extended the period allowed for effectuating the orderly dissolution of MMIA by continuing MMIA until June 30, 2001, while providing that the dissolution would be implemented at such time and under such conditions as the Superintendent deemed proper. Consequently, a Supplemental Order and Decision was issued on July 12, 2000 under which the Superintendent continued the MMIA solely for the purpose of winding up its affairs, with no new or renewal policies to be issued after June 30, 2000. By December 31, 2000 the Medical Liability Mutual Insurance Company (MLMIC) had received full payment for its assumption of MMIA’s liabilities and, by order of the Supreme Court of the State of New York entered May 14, 2001, MMIA was placed into liquidation, with the Superintendent of Insurance named as the liquidator. The final liquidation process is still ongoing.

e. Mechanism for the Equitable Distribution of Insureds to the Voluntary Medical Malpractice Market – The New York Medical Malpractice Insurance Plan

The New York Medical Malpractice Insurance Plan (Plan) has been established by Department Regulation No. 170 (11 NYCRR 430) to provide medical malpractice insurance to eligible health care practitioners and facilities otherwise unable to obtain coverage in the voluntary market. All insurers licensed in New York and writing medical malpractice insurance in the State are required to be members of the Plan. Regulation No. 170 also permits the members to participate in an independent pooling mechanism whereby, rather than getting individual assignments, writings, expenses, fees and losses will be shared proportionately among the members. In 2006, all members of the Plan participated in the Medical Malpractice Insurance Pool of New York State (Pool).

For 2007, the Pool insured 1,482 individuals (including professional corporations) compared with 1,657 the previous year. A breakdown of the individual insureds by type, and a comparison with previous years follows:

Table 37
MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE
Insured Individuals (including professional corporations)
2005-2007

Type of Insured	Policies as of December 31, 2007	Policies as of December 31, 2006	Policies as of December 31, 2005
Primary Insureds			
Physicians	455	580	603
Dentists	205	208	185
Podiatrists	67	79	79
Nurse-Anesthetists	6	5	6
Nurse-Midwives	23	22	18
Professional Corps.	29	33	31
Excess Layer Insureds			
First Layer Excess	697	730	6,788
Second Layer Excess	0	0	1,221

Note: Most of the decrease in the number of insureds in the Pool from 12/31/05 to 12/31/06 is attributable to a decrease in the numbers for both the First Layer Excess and Second Layer Excess coverages. The decrease in the First Layer Excess coverage number was due to voluntary insurers expanding their writing of the First Layer Excess business. The decrease in the Second Layer Excess coverage number follows enactment of Chapter 673 of the Laws of 2005 which exempts the pool to make available the Second Layer Excess medical liability coverage. Chapter 673 of the Laws of 2005 is set to expire on July 1, 2008.

In addition to these individuals, the Pool insured 140 facilities, the majority of which were nursing homes and adult homes, down from 342 the year before.

f. New Task Force Confronts Medical Malpractice Reform

In July, 2007, Governor Eliot Spitzer charged Superintendent Dinallo with heading a new task force to confront the fundamental drivers of high medical malpractice costs. The task force, which will report back to the Governor, includes New York State Commissioner of Health Richard F. Daines, M.D., and a broad range of representatives from physician and hospital associations, the insurance industry, consumer groups, health plans, trial lawyers and the Legislature.

17. Insurance Availability Issues

While liability insurance coverages continued to be generally available during 2007, some markets experienced difficulties. The Department continued to monitor market conditions and addressed individual problems as they arose.

a. Availability Survey

The Department conducts surveys to ascertain the state of markets for difficult-to-place insurance coverages. The Availability Survey is conducted annually to ensure that meaningful and timely information is obtained.

The current survey methodology allows for the analysis of market conditions and developing trends, and enables the Department to better serve the insurance community as well as consumers in New York State. In 2006 the survey format was revised in order to make it simpler for insurers to

complete, and to provide the Department with more consistent and accurate information on insurers' underwriting plans for the coming year. As in previous years, several risk and coverage categories were added and deleted based on the Bureau's observation of market conditions during the period since the last survey was issued.

The data call also includes information on Free Trade Zone business written during the prior year. The data gathered from the survey are used to produce the Department's Annual Free Trade Zone Update.

The insurance industry's cooperation has been the key to the Department's efforts to cultivate and maintain stability in the commercial insurance marketplace. Information from the survey is made available to the insurance community and assists the Department in providing the proper channels for insurance consumers to find coverage appropriate to their needs. Survey information has also been a helpful tool in the Department's analysis of conditions of an ever-changing insurance marketplace. When survey results have shown constricted conditions for types of coverage and/or types of risks, the Department has been able to help develop availability by working with insurers and producer organizations.

18. Automobile Insurance

a. New York Automobile Insurance Plan

The number of vehicles insured in the Plan has continued to decline in the past few years and is now at an historic low. Approximately 1.2% of New York private passenger registered vehicles are insured in the Plan as compared to a range of 12% to 17% over 15 years ago. Furthermore, at year-end 2007, there were approximately 31% fewer vehicles in-force than year-end 2006 and approximately 51% fewer than year-end 2005. This continual decrease in the Plan population can be attributed, at least in part, to various Department initiatives such as those to combat fraud and incentives to voluntary market insurers that provide coverage to drivers who otherwise would have been placed in the Plan.

b. Legislation

Chapter 268 of the Laws of 2007 extends until June 30, 2008 the provisions of Section 2328 regarding the prior approval of rates for Public Automobile insurance. It also extends until June 30, 2008 the provisions of Section 3425 regarding the cancellation and non-renewal of private passenger automobile policies.

c. No-Fault Motor Vehicle Insurance Law Activity – 2007

i. Impact of recent case law on the Automobile No-Fault system

Two 1997 Court of Appeals decisions, Central General Hospital v. Chubb, 90 N.Y.2d 195 (1997), and Presbyterian Hospital v. Maryland Casualty, 90 N.Y.2d 274 (1997), had an enormous impact on No-Fault adjudication and the number of disputes generated by the No-Fault system. These cases generally established that a No-Fault insurer may not assert a defense when it does not timely deny a claim within 30 days of receipt. In Fair Price Medical Supply v. Travelers, 42 A.D. 3rd 277 (2nd Dept.) (2007), the Appellate Division, Second Department upheld the application of a preclusion sanction for a late denial where durable medical equipment supplies were billed for and never provided, so that any amount billed by a health provider for non-existent services must be paid by the insurer when there is a late denial. Essentially, the fundamental requirements established by the Legislature in 1973 that all reimbursable No-Fault health care expenses must be necessary and billed in accordance in the fee schedule limits have been frustrated by the Judiciary's application of the Court of Appeals decisions mentioned above. Therefore, the Legislature should enact legislation similar to the bill

proposed by the Senate last year in S2638 that would restore the fundamental requirements for No-Fault health care expenses to be reimbursable by permitting an insurer to assert a defense when it does not deny a claim within 30 days of receipt.

ii. Mandatory arbitration for all No-fault insurance disputes

According to the authors of an article that appeared in the June 21, 2007 edition of the New York Law Journal, the Civil Court of the City of New York and District Courts in Nassau and Suffolk Counties have been inundated with lawsuits filed by medical providers seeking reimbursement of No-Fault benefits for services rendered to injured claimants. This strain on the judiciary's resources led the Chief Administrative Judge's Local Courts Advisory Committee (Unified Court System) to propose a bill in 2006 that would amend NYIL §5102 to require mandatory arbitration for all No-fault insurance disputes. Since the improvements in the administration of the No-Fault Arbitration System in the past few years permit it to process substantially more requests for arbitration without compromising the goal of a speedy dispute resolution system, the Legislature should consider legislation that would reduce the strain on the judiciary's resources by revising NYIL §5102 to require mandatory arbitration for all No-fault insurance disputes.

iii. Decertification of Health Care Providers

Chapter 424 of the Laws of 2005 added a new Section 5109 to the Insurance Law to require the Superintendent, in consultation with the Commissioners of Health and Education, to promulgate standards and procedures for investigating and suspending or removing a health care provider's ability to be reimbursed under the No-Fault system. The Commissioners of Health and Education are required to maintain a list of providers who they deem, after a reasonable investigation, not authorized to submit claims for reimbursement under No-Fault. This list, which must be updated regularly, must be posted on each agency's website and provide a toll free telephone number for the public to access the information. Under the law, health care providers can be decertified if the provider:

- was found guilty of professional or other misconduct or incompetency in connection with medical services rendered under No-Fault; or

- has exceeded the limits of his or her professional competence in rendering medical care under No-Fault or has knowingly made a false statement or representation as to a material fact in any medical report made in connection with any claim under No-Fault; or

- solicited, or has employed another to solicit for himself or herself or for another, professional treatment, examination or care of an injured person in connection with any claim under No-Fault; or

- has refused to appear before, or to answer upon request of, the Commissioner of Health, the Superintendent, or any duly authorized officer of the state, any legal question, or to produce any relevant information concerning his or her conduct in connection with rendering medical services under No-Fault; or

- has engaged in patterns of billing for services which were not provided.

The Insurance, Health and Education Departments have had discussions concerning the standards and procedures that should be implemented.

19. Homeowners Insurance

a. New York's Coastal Areas

Consistent with past years, property/casualty insurers continued to re-evaluate the concentration of their business in coastal areas in order to determine their individual exposure to catastrophic storms. Homeowners insurance is generally available both on Long Island and statewide. However, due to recent catastrophic hurricanes in other parts of the U.S., insurers revised their eligibility criteria by limiting the number of policies written, particularly for properties located close to the shore.

The Department continues to carefully monitor the availability of coastal insurance. Staff continues to meet with interested parties to discuss the problems and arrive at workable solutions. In addition, the Department continues to respond to inquiries from producers and property owners received either by mail, in person, or on the Department's hotline, (800) 300-4593. Where appropriate, the Department has intervened to resolve disputes involving incorrect policy rating and declination of initial or renewal coverage. The Department's objectives have been—and continue to be—maximizing consumer protections, encouraging risk management, emphasizing responsible underwriting, and facilitating voluntary market homeowners insurance coverage in shore communities.

The Legislature and the Insurance Department have undertaken several initiatives to assist New York State residents located near the shore or waterfront areas who have experienced difficulty in purchasing and maintaining homeowners insurance. These initiatives have included the development of "wrap-around" policies, as well as permitting insurers to offer catastrophe windstorm deductibles in their homeowner's policies. Under wrap-around programs, an insurer provides liability, theft, and other coverages to an insured who has purchased fire and extended coverage through NYPIUA. The coverage from NYPIUA and the wrap-around coverages from a voluntary insurer essentially provide an insured with the equivalent of a full homeowner's policy. Several insurers and rate service organizations have received approval for both windstorm deductible and wrap-around coverage programs. It is anticipated that the utilization of these innovative underwriting tools will enable those insurance companies with heightened concerns about the catastrophic potential posed by hurricanes to continue to provide comprehensive homeowners coverage for shoreline residents.

The Superintendent activated the Department's Coastal Market Assistance Program (C-MAP) in 1996. C-MAP is a voluntary network of insurers and insurance producers that assists New York homeowners in coastal areas in obtaining and retaining insurance coverage. Information concerning C-MAP can be obtained through most insurance producers or through NYPIUA at (212) 208-9898. Most companies participating in C-MAP use of the wrap-around coverage forms mentioned above.

Participating insurers have agreed to collectively write 10,000 policies commencing October 1, 2006 in addition to the 5,000 policy commitment voluntarily made by participating companies at the inception of C-MAP. From April 1996 through December 31, 2007, 5,322 policies have been issued through the program. The Department believes C-MAP will continue to help consumers secure vital homeowners coverage while still addressing insurers' coastal area concerns.

b. Legislation and Regulations

Chapter 162 of the Laws of 2006 amended section 3425(e) of the Insurance Law to direct the superintendent to establish by regulation standards for notices of cancellation, nonrenewal, and conditional renewal for certain homeowners' policies as defined in section 2351(a) of the Insurance Law. The Final Adoption of The First Amendment to Regulation 159 was put into effect on August 8, 2007. This affects property located in an area served by a market assistance program established by the superintendent for the purpose of facilitating placement of homeowners insurance and requires that every notice of cancellation, nonrenewal, or conditional renewal issued on or after November 23, 2006 for homeowner's insurance shall advise the insured of the availability of the market assistance program and the availability of coverage through NYPIUA.

Chapter 86 of the Laws of 2007 extended the operating authority of NYPIUA to June 30, 2008, thus maintaining the safety net for residents unable to obtain fire insurance in the voluntary market. The law also grants authority to the Superintendent to authorize NYPIUA to provide full homeowners insurance coverage if deemed necessary. (NYPIUA currently provides fire and extended coverages, but does not provide protection for theft or personal liability.)

Regulation 154 establishes standards for the definition of "material reduction of volume of policies" and establishes standards by which an insurer's application for such material reduction will be approved. In addition, the regulation requires insurers to report information relative to homeowners insurance policies on a quarterly basis in a format prescribed by the Superintendent, and defines those areas in which the Superintendent has deemed that writings by NYPIUA had increased significantly since January 1, 1992. Most policyholders affected by these plans were offered replacement coverage in the voluntary market.

c. Hurricane Computer Simulation Models in Rate Filings

To date, the Department has not permitted the inclusion of computer simulation modeling results in the ratemaking process. Due to the proprietary nature of the model's components and assumptions, as well as the difficulty in determining the reasonableness of certain assumptions, the Department has encountered difficulty in reviewing all of a model's components and assumptions. Accordingly, the inclusion of the results of computer simulation modeling precludes the Department from determining whether an insurer's proposed rates meet the standards set forth in Article 23 of the New York State Insurance Law.

d. Reinsurance Cost Factors in Homeowners Insurance Rate Filings

The Department permits insurers to reflect the cost of catastrophe excess-of-loss reinsurance in homeowners' insurance rate filings, provided an insurer can reasonably allocate the cost of such reinsurance to its New York policyholders. The Department has accepted homeowners rate filings in which reinsurance costs were among the factors reflected in the ratemaking methodology for nearly all major homeowners' insurers.

Over the last few years, catastrophe reinsurance costs have significantly increased, lending to significant indicated rate increases for homeowners and dwelling insurance, predominantly on Long Island.

e. Mineola Office

In order to assist consumers on Long Island who are experiencing problems obtaining homeowners policies, the Department's satellite office in Mineola, New York provides consumers with information to assist them in obtaining insurance protection for their homes, and is staffed by Department examiners during regular business hours. Consumers can contact the staff at the Mineola office either in person at 163 Mineola Blvd. in Mineola or by telephone at (800) 300-4593 or (800) 300-4576.

20. Market Conduct Activities

a. Summary of Market Conduct Investigations Conducted and Fines Collected

The Property Bureau's Market Conduct Unit continued its program of reviewing insurance company underwriting, rating and claims practices to determine compliance with the Insurance Law and Department regulations.

There were 33 market conduct investigations and 2 Rate Service Organization examinations (RSO) in progress at the beginning of 2007 and 80 investigations and 1 Rate Service Organization examination were initiated during the year. The Department closed 64 market conduct investigations during the year. At year's end, 49 market conduct investigations and 3 RSO examinations were in progress. A total of 19 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $164,800. In addition, fines totaling $37,000 were received from insurers and self-insurers for failure to pay No-Fault arbitration awards in a timely manner.

The following chart provides a breakdown of the market conduct activities for Calendar Year 2007:

Table 38
MARKET CONDUCT INVESTIGATIONS/EXAMINATIONS
by Type of Investigation/Examination
2007

Type of Investigation	Outstanding at 1/1/2007	Initiated during 2007	Completed during 2007	Outstanding at 12/31/2007
Claims	8	3	3	8
Rating/Underwriting	4	0	0	4
Automobile/Homeowners Underwriting 3425	0	5	0	5
Title Ins. Underwriting	5	0	0	5
Commercial Auto Rating/Underwriting	0	1	0	1
Personal Auto & Homeowners Rating/Underwriting	0	1	0	1
Privacy	0	7	2	5
Frauds	1	9	10	0
Public Auto	1	5	0	6
Desk Audits:				
Section 3425 Compliance	5	0	5	0
Claims/Rating/Underwriting	2	13	1	14
Internet Web Site Reviews	0	26	26	0
Availability Survey 05	7	10	17	0
Total Investigations	**33**	**80**	**64**	**49**
Examinations:				
Rate Service Organization	2	1	0	3
Joint Underwriting Assoc.	0	0	0	0
Total Examinations	**2**	**1**	**0**	**3**

The following chart details the fines collected or processed and the stipulations entered into during Calendar Year 2007:

Table 39
MARKET CONDUCT FINES COLLECTED & PROCESSED
by Type of Investigation
2007

Type of Investigation	Number	Amount
Claims	3	$ 25,300
Desk Audits: Section 3425 – 2%	5	94,000
Availability Survey – 3 for 05 and 7 for 06	10	10,500
Rating Plan Issue	1	35,000
Total	**19**	**$ 164,800**
Penalties: Failure to timely pay N.F. Arbitration Awards	148	$ 37,000
Total Fines Collected & Penalties Processed	**167**	**$ 201,800**

b. Penalties Imposed Under Insurance Law Section 3425

Section 3425-NYIL limits the total number of non-renewals of personal automobile insurance policies that an insurer is allowed. Generally, an insurer is permitted to non-renew up to 2% of the total number of covered policies that the insurer had in force at the previous year end in each such insurer's rating territory in use in this State. As a result of an analysis of reports to the Superintendent required by Section 3425(l)(1)-NYIL, 5 stipulated fines totaling $94,000 for Calendar year 2005 were collected during Calendar Year 2007 (included in the total fines collected in Section 21(a) above).

c. Penalties for Insurance Availability Survey Delinquents

One of the duties of the Property Bureau is to make available a listing of insurers who write commercial coverages in various markets. In order to determine these insurers, the Department has conducted Availability Surveys since 1989 on an annual basis, pursuant to Section 308 of the Insurance Law. Also, insurers licensed under Article 63 to write business in the Free Trade Zone are also required to complete that portion of the survey, for premiums written the previous year. For the 2005 and 2006 Surveys, the Department collected fines of $10,500 during calendar year 2007 from insurers who did not submit the surveys in a timely manner (included in the total fines collected in Section 21(a) above).

d. Penalties for Failure to Pay No-Fault Arbitration Awards Timely

The No-Fault Claims Administration Unit of the Property Bureau has received a significant number of complaints from applicants for no-fault arbitration. These complaints alleged that even after successfully arbitrating their entitlement to no-fault benefits or obtaining a conciliation of their dispute, they were not receiving all amounts due from insurers in a timely manner. The no-fault regulation requires insurers to pay within 30 days all amounts awarded.

The Department issued Circular Letter No. 21 (2005) reminding all insurers of their obligation to pay in a timely manner, and that with every request for enforcement, the Department would require insurers to either provide proof that full payment was made or an explanation as to why payment was not made.

Insurers were also advised that in accordance with Section 109(c)(1) of the Insurance Law, a penalty would be imposed on insurers for each complaint made where no justifiable reason for nonpayment or late payment was furnished to the Department. In addition, these complaints are recorded for the purpose of calculating the complaint ratios that form the basis of the Department's Annual Automobile Complaint Ranking. During Calendar Year 2007, the Department processed 148 fines totaling $ 37,000 from insurers and self-insurers for their failure to pay arbitration awards in a timely manner.

e. Insurer Internet Web Site Monitoring

The Market Conduct Unit continued the monitoring and review of insurer Internet Web sites. As part of Circular Letter No. 31, dated October 29, 1998, the Department advised the industry of the general guidelines that would be followed when monitoring the marketing of insurance products on the Internet. Supplement 1 to Circular Letter No. 31 was issued May 28, 1999, which further advised insurers that Web-based activities would be reviewed and/or monitored by the Department and that these reviews would be incorporated into the market conduct and financial review processes. Twenty-six insurer web sites were reviewed during the course of 2007. The Web sites reviewed were found to be in substantial compliance with the Department's guidelines. Additional insurer Web site reviews will be conducted in 2008.

f. Privacy

Title V of the Gramm-Leach-Bliley Act requires financial institutions, including insurers, to protect the privacy of consumers and customers. It also requires that all state insurance authorities establish appropriate consumer privacy standards for insurance providers. As a result, the Insurance Department promulgated Regulation No. 169 and Regulation No. 173, setting forth these standards. During Calendar Year 2007, the Market Conduct Unit continued to assess the privacy policies and procedures in place and to ensure compliance with privacy regulatory requirements. Seven new privacy investigations were initiated with two completed during 2007. The two reviews completed to date appear to be in compliance with the provisions of the Regulations. Additional privacy investigations will be conducted in 2008.

g. Frauds Compliance Investigations

Section 409-NYIL requires that every insurer writing at least 3,000 or more private passenger or commercial automobile, workers' compensation or individual, group or blanket accident and health insurance policies to file an insurance fraud prevention plan with the Superintendent. They must also create a separate full-time Special Investigations Unit and must meet other specific frauds prevention requirements outlined in Section 409-NYIL and Insurance Department Regulation No. 95.

During Calendar Year 2007, the Market Conduct Unit initiated and completed a review of 10 insurers to determine whether they were following the requirements outlined in the statute and regulation. Detailed questionnaires were submitted to these insurers which were then reviewed during the investigation in conjunction with additional documentation requested. Once all necessary material was received and analyzed it was submitted to the Department's Frauds Bureau for further review.

h. Market Analysis Review System

The Market Division has implemented a formal Market Analysis Program to:

- Identify general market disruption and important market conduct problems as early as possible and to prevent or mitigate harm to consumers;
- Better prioritize and coordinate the various market regulation functions of the Department and establish an integrated system of proportional responses to market problems; and
- Provide a framework for collaboration among the states and with federal regulators regarding identification of market conduct issues and market regulation.

During 2007, Market Analysis reviews of 41 Companies were conducted. Twenty-seven Companies needed further analysis within the Insurance Department and no further analysis was needed for the remaining fourteen companies. Some of the goals of the Market Analysis Program for 2008 are to standardize baseline factors to enable the Department to identify issues of concern and to prioritize activities in a uniform manner. The unit intends to make use of analytic tools such as the NAIC Prioritization tool in the selection of future Market Analysis reviews.

21. Excess Line Insurance

Applicants that cannot obtain coverage from companies licensed to write insurance in New York may, under circumstances prescribed in the New York Insurance Law and regulations, obtain such coverage from unlicensed companies through the auspices of a New York-licensed excess line broker.

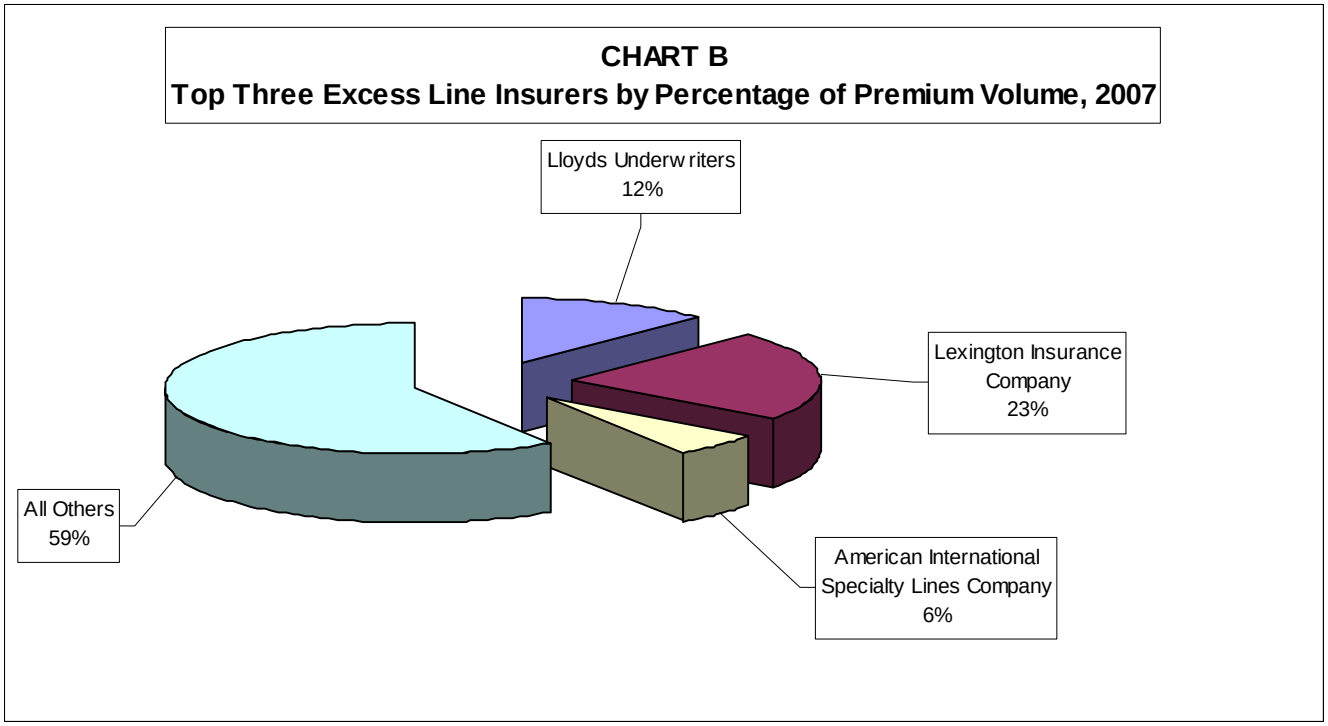
Since insurers providing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained from excess line brokers through tax statements required to be filed no later than March 15 of each year relating to business written during the previous Calendar Year. For Calendar Year 2007, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $2.7 billion, of which approximately $2.6 billion was attributable to risks located or resident wholly in New York State. These excess line premiums generated approximately $ 94,769,655 in excess line premium tax revenue for the state.

The data pertaining to excess line business used in this report were obtained from statistical reports provided to the Superintendent by the Excess Line Association of New York (ELANY) pursuant to Section 2130 of the New York Insurance Law. ELANY obtains the information from affidavits required to be filed by excess line brokers under Section 2118 of the Insurance Law. The affidavit is a statement subscribed to, and affirmed by, the licensee or sublicensee as true under the penalties of perjury that, after diligent effort, the full amount of insurance required could not be procured, from authorized insurers, each of which is authorized to write insurance of the kind requested and which the licensee has reason to believe might consider writing the type of coverage or class of insurance involved, and further showing that the amount of insurance procured from an unauthorized insurer is only the excess over the amount procurable from an authorized insurer.There are 2,324 licensed excess line brokers and approximately 812 who are active and filed 150,036 affidavits for the year 2007. Three hundred and twenty one complaints and inquiries and 1,909 filings regarding excess line business were received in 2007.

In 2007, there were approximately 190 unauthorized insurers eligible to do business in New York pursuant to Regulation 41. This includes 86 foreign insurers; 35 alien insurers; and Lloyd's, with 69 syndicates. These insurers are required to file annually by March 15, an EL-1 report showing detailed information of business written during the preceding year in order to be eligible to do business in New

York on an excess line basis. In 2007, the Unit reviewed 123 EL-1 filings, 110 annual statements and 16 trust agreements.

The following is a chart of the percentage of total 2007 excess line premium writings attributable to the three largest excess line insurers in New York State.



a. Business Written in New York

Total excess line premiums written in New York State increased from $2.622 billion in 2006 to $2.623 billion in 2007, an increase of .4%. The largest dollar and percentage increase over the previous year was in the errors and omissions liability insurance line, up by $124 million to $ 421.9 million, an increase of 41.74% from 2006. Other increases included other liability, up by $18.9 million; fire and allied lines, up by $10.9 million; and inland marine, up by $6 million. Homeowners' writings in the excess line market have also increased by approximately $ 7 million, a 31% increase from 2006. It is likely tied to some contractions in the coastal market, but represents less than 1% of the entire homeowners market.

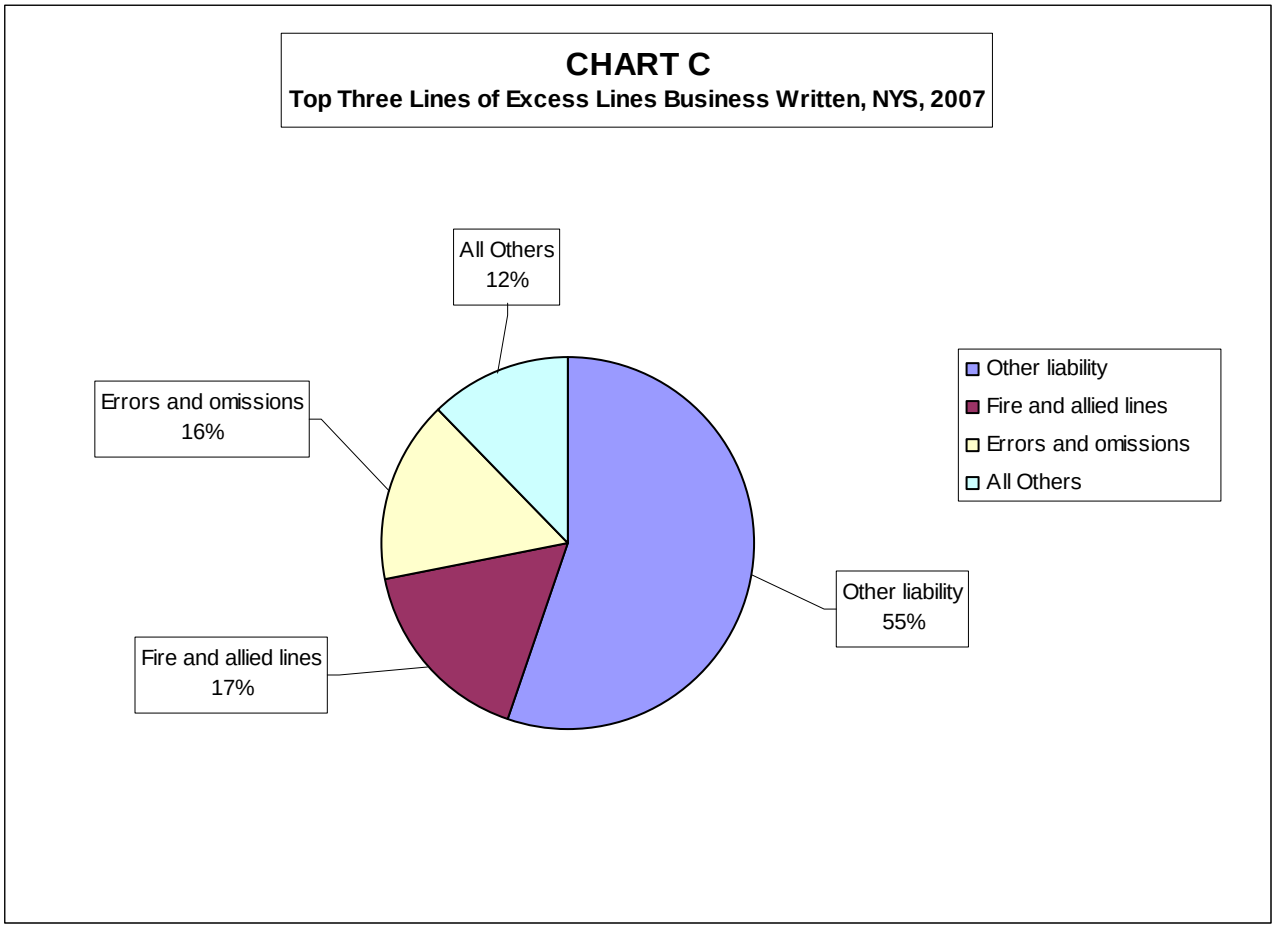
The largest dollar decline over the previous year was in the "other lines" segment, down $127 million, or 74.3%. This was due mainly to the reclassification from the previous year's reports of miscellaneous lines included in the "other lines" category in 2007. Other decreases included fidelity and surety, down by $17 million; and commercial multiple peril, down by $2 million. The largest percentage decline, 76%, occurred in aircraft physical damage, a relatively small-volume line was down by $2.5 million over the previous year.

Table 40
EXCESS LINE PREMIUMS WRITTEN
Risks Located in New York State
2003-2007
(dollar amounts in thousands)

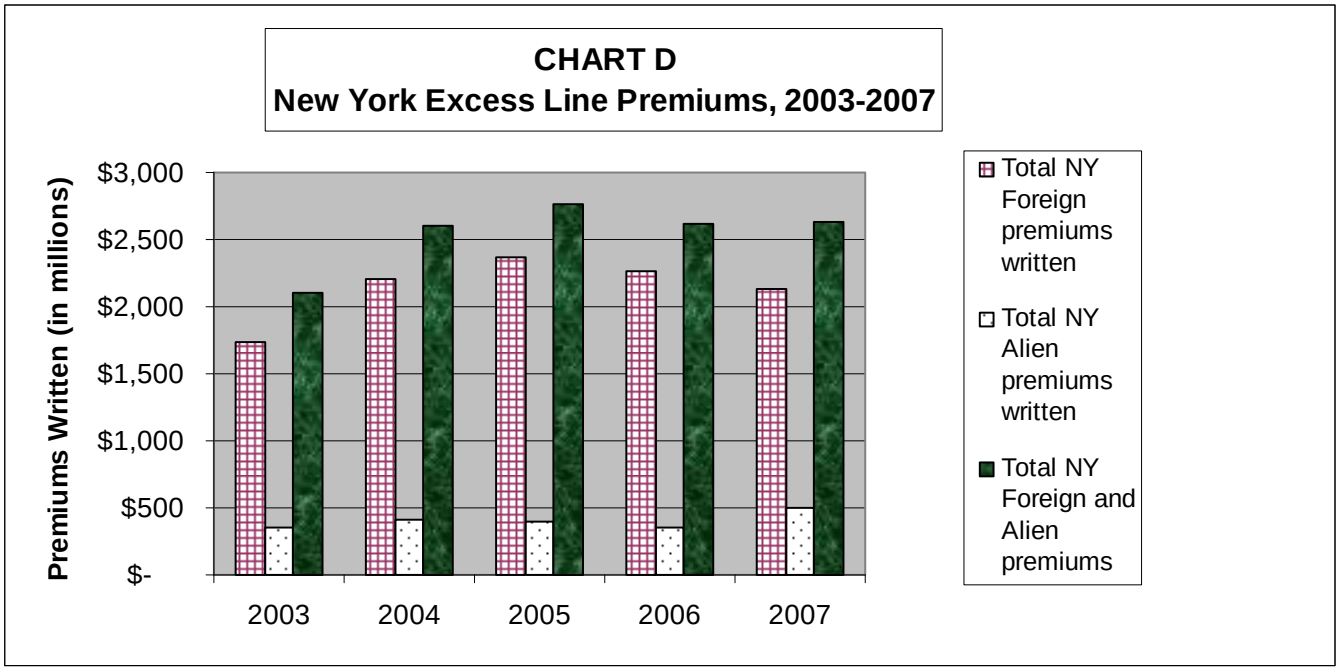
Life of business	2007	2006	2005	2004	2003
Fire and allied lines	$ 438,321	$ 427,382	$ 395,848	$ 393,807	$ 425,417
Inland marine	67,124	60,679	57,889	52,162	43,462
Auto liability	15,152	15,605	16,758	15,757	15,629
Malpractice	27,751	26,934	17,768	23,319	12,089
Errors and omissions	421,891	297,656	408,213	480,076	334,685
Commercial multiple peril (excluding fire)	107,185	109,280	111,716	111,068	93,737
Other liability	1,452,654	1,433,705	1,621,751	1,419,191	1,079,015
Auto physical damage	24,499	24,646	41,834	21,291	17,163
Aircraft physical damage	792	3,310	5,770	1,049	2,651
Burglary and theft	6,422	7,976	13,308	10,369	3,613
Fidelity and surety	26,816	43,880	34,331	23,116	14,844
Other lines	43,882	171,101	43,432	58,621	54,794
Total	$2,623,490	$2,622,123	$2,768,618	$2,609,827	$2,097,100
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	7.23%*	7.26%	7.88%	7.48%	6.25%

*Estimated
Source: Excess Line Association of New York

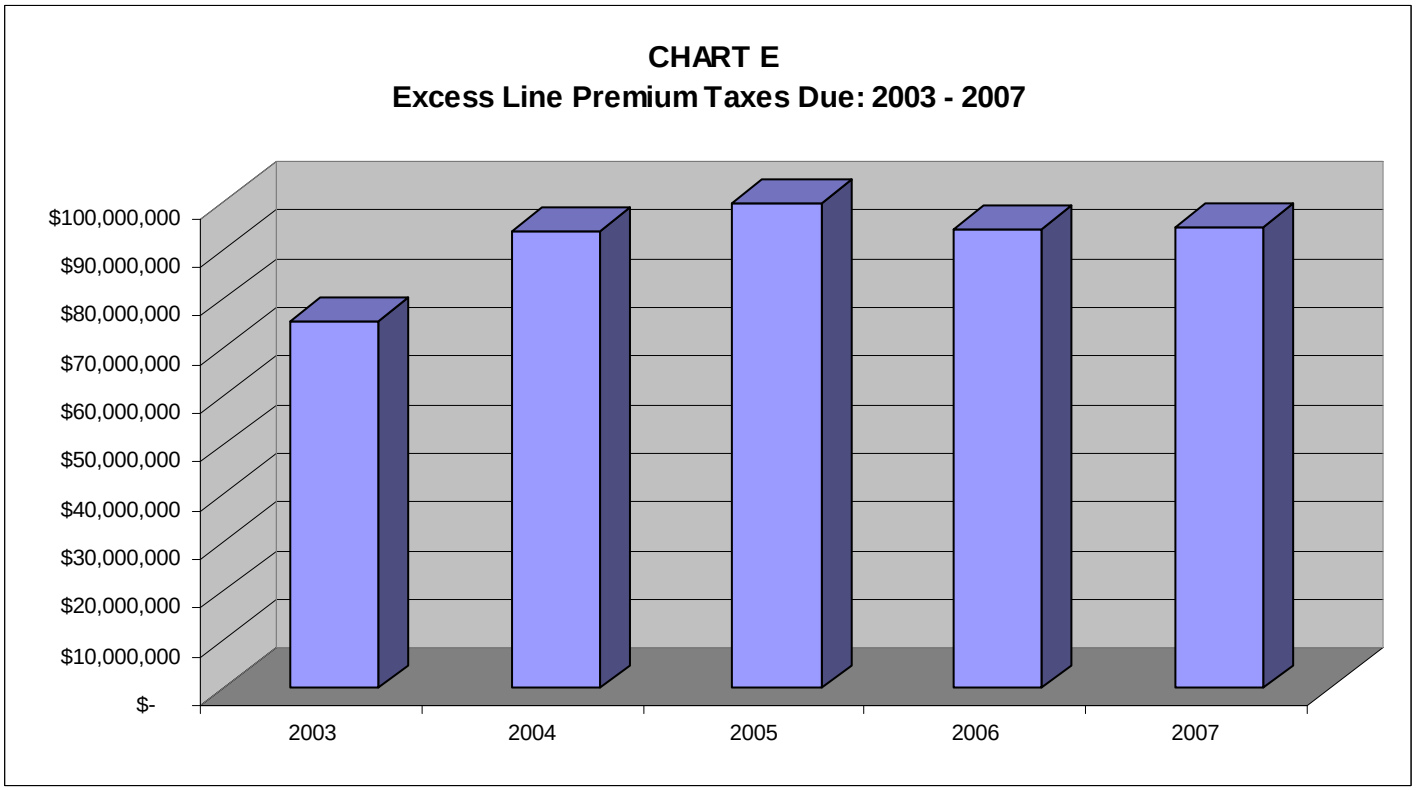
The pie chart below shows the three major lines of business written in the excess line market based on premium volume.



The following graph shows excess line business for the years 2003 to 2007 by alien and foreign insurers.



The following is a chart of excess line premiums taxes due from excess line brokers pursuant to Section 2118 (d) of the Insurance Law:



b. Binding Authority

Sections 2117 and 2118 of the Insurance Law were amended in 1997 to provide that an excess line broker, licensed pursuant to Section 2105 of the Insurance Law, may exercise binding authority, which the law defines as ". . . the authority to issue and deliver insurance policies on behalf of an insurer not licensed or authorized to do business in this state." Since the implementation of the amended statute, the Excess Line Association of New York (ELANY) has notified the Department that 82 excess line brokers have filed 272 binding authority agreements representing insurers not licensed or authorized to do business in this State. During Calendar Year 2007, the Excess Line Association of New York reviewed and accepted 31 new, renewed and/or amended binding authority agreements from New York-licensed excess line brokers.

c. EL-1 Review

All EL-1 filings were reviewed to determine that the information complied with the requirements set forth in Department Regulation 41. This included a check to determine if excess line brokers listed on the reports were New York-licensed excess line brokers. Any direct procurement information listed on the EL-1 was forwarded to the New York State Department of Taxation and Finance to determine whether the excess line tax on these premiums had been paid by the respective policyholder.

d. Ineligible Unauthorized Insurers

A review of Schedule T of the annual statements filed with the NAIC found that there were several ineligible unauthorized insurers doing business in New York. These companies stated that the policies were direct procurement placements. Insureds were contacted to ensure that the direct procurement taxes were paid.

e. Liability Risk Retention Act (LRRA) of 1986 – Purchasing Groups

Purchasing groups are allowed, pursuant to the federal Liability Risk Retention Act of 1986, to buy commercial liability insurance on behalf of their members on a group basis. These groups are exempt from any state insurance laws that hinder or prohibit group self-insurance programs and the purchase of liability insurance on a group basis.

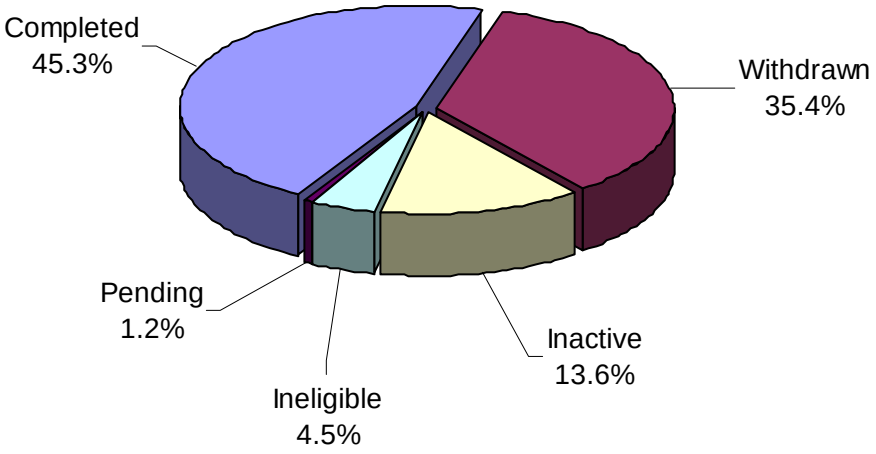
Since the inception of the LRRA, the Department has received notices of intent from 927 purchasing groups. Subsequently, 323 have withdrawn their notice of intent, 129 have notified the Department of their inactive status, and 41 have been given ineligible status by the Department due to failure to comply with all the requirements of the applicable laws and regulations. In 2007, the Department received notices of intent from 19 purchasing groups.

In 2007, the Department requested Purchasing Groups file an annual update of the required information under the LRRA. The update form was placed on the Department's website.

Some of the most common types of businesses and professions that have formed purchasing groups in the past year include real estate professionals, insurance professionals, entertainers, health care facilities and services, and manufacturers/dealers. Seventy one complaints and inquiries regarding purchasing groups were received in 2007.

The following chart shows the purchasing group filings as of December 31, 2007, by status category:

CHART F
Purchasing Group Filings, 2007



f. Purchasing Group and Excess Line Investigations

The Property Bureau's excess line unit is investigating a legal liability program advertised illegally on a website calling attention to an unauthorized insurer. The broker is a non-resident broker. The broker refuses to place a disclaimer on its website that the program is not available to NY insureds and has been uncooperative about appearing before the Department.

The Excess Line Unit also investigated a pet insurance program that was initially offered by an unlicensed insurer. The investigation found that the program violated Section 2118 – failure to file affidavits, failure to file excess line premium tax statements and pay related excess line premium taxes; and Section 3435 – regarding an illegal property /casualty group insurance policy. Subsequently, the program was transferred to a licensed insurer that did not file rates and forms as required by Section 2304. The licensed insurer was notified of this fact and subsequently submitted rates and forms for Department approval. The program is now in compliance with all applicable Department requirements. The Department collected $144,000 in premium taxes and penalties and settled the matter by stipulation and a fine of $5,000.

Another investigation by the Unit involved a broker who charged a policy origination fee of $2,500 on a policy with a premium of $4,000. Section 2119 of the Insurance Law permits a broker to charge a fee provided the insured acknowledges by written consent to pay the fee in addition to the premium. Such agreements are known as 2119 agreements. As a result of this investigation the broker has agreed to reimburse the insured the $2,500 and signed a stipulation and paid a fine of $1,000.

The Unit also investigated a few cases of fronting or accommodation filings, which constitute a violation of Section 27.8(e) of Regulation 41. Fronting occurs when brokers that are not licensed as excess line brokers, have licensed excess line brokers make the required excess line filings for them. Regulation 41 states that only a licensed excess line broker may make the appropriate excess line filings on policies that he or she actually placed with an unauthorized insurer. As a result of these investigations the excess line brokers signed stipulations and were fined.

There were several investigations commenced in the Department regarding cancellation of policies with financed premiums. All these investigations were initiated by the same complainant from a premium finance company. The matter was referred to the Office of General Counsel for an opinion.

The Unit conducted approximately 143 investigations which includes the ones described above. Many of these investigations were the result of EL-1 reviews. Several brokers were fined for placing business with unauthorized insurers without the necessary excess line broker's license. Additionally, these brokers were required to pay the excess line taxes and late payment penalties. As a result of these investigations, the Unit collected $5,904,920.43 of additional taxes, penalties and fines in 2007.

g. Electronic Initiatives

The Unit completed a project to convert its manual investigative records into an electronic system known as Consumers' Imaging and Information Management System (CIIMS) developed by the Consumer Services Bureau.

In September 2007 the Unit was given approval by the Taxes and Accounts Bureau to create an interactive Premium Tax Statement for online filing for this March 15 filing deadline. The project was completed on time. Letters and log-in ID's were provided to all excess line brokers. For those brokers unable to file electronically, paper premium tax statements are available on the internet. As of March 20, 2008, there were 561 premium tax statements filed online. These filings represent approximately 25% of all premium tax filings, including a greater percentage of first time electronic filers than expected.

The unit is also awaiting the System's Bureau's assistance in designing an automatic audit program to compare the premiums reported by excess line brokers to those reported by excess line insurers. This is expected to increase excess line tax revenue. Completion of this project is anticipated for the 2008 EL-1 reporting year.

ELANY has also been working on a project to enable filing of affidavits electronically, which would greatly improve the Department's ability to make use of the information provided in affidavits and to manage our records.

h. Excess Line Association of New York

On September 24, 2007, the 2003 Report on Examination of the Excess Line Association of New York was filed.

The Department has received a request under section 2118 of the Insurance Law and Department Regulation 41 from the Excess Line Association to expand the export list. The request is under review.

i. Amendments to Department Regulations

The Tenth Amendment to Regulation No. 41 was promulgated on December 19, 2007. This amendment changes the maximum deposit required that alien insurance companies eligible in New York must place in trust to secure payment of judgments. The amendment conforms New York regulation to new trust fund requirements adopted by the International Insurers Department of the National Association of Insurance Commissioners.

The Department is preparing the eleventh amendment to Regulation 41, which proposes to increase the minimum capital requirements for excess line insurers. The Department is in the process of conducting outreach on this amendment.

The Unit is also in the process of amending Regulation 86 to add class 2 risks pursuant to Article 63.

22. Consumers Guide to Automobile Insurance

On October 1, 2007, the Department published two editions of the 2007 Consumers Guide to Automobile Insurance, one for upstate New York residents and one for downstate residents. The Department also has an interactive version of the guide on its Web site. The guide is required by Section 337 of the Insurance Law to be updated annually. This comprehensive guide helps consumers determine how much auto insurance they need and explains all mandatory and optional coverages available in New York State. The guide contains lists of insurers, telephone numbers, and sample rates to facilitate comparison shopping, and advice regarding how to file a claim or make a complaint against an insurer is also provided. Copies of the guide were distributed to every Department of Motor Vehicles office and public library in the State. The guide is also available free of charge directly from the Insurance Department and can be accessed via the Department's Web site.

23. Regulations

Regulations Adopted in 2007:

Second Amendment to Regulation 162 (Legal Services Insurance), became effective January 10, 2007. This amendment permits legal services insurance to qualify as a special risk only if the coverage of the policy of liability insurance of which it is a part also qualifies as a special risk coverage pursuant to Part 16 of Title 11 of the New York Codes, Rules and Regulations and Article 63 of the Insurance Law, and the policy is written on such basis.

Regulation 181 (Standards for Insurance that Qualifies for the Environmental Remediation Insurance Tax Credit) became effective January 10, 2007. This regulation sets forth requirements relating to policies of insurance which qualify for the environmental remediation insurance tax credit provided for under Section 23 of the Tax Law. The insurance tax credit applies to taxable years beginning on or after April 1, 2005.

Third Amendment to Regulation 124 (Physicians and Surgeons Professional Insurance Merit Rating Plan) became effective January 24, 2007. This amendment was previously effective on an emergency basis. The purpose of this regulation is to establish guidelines and requirements for medical malpractice merit rating plans and risk management plans.

Third Amendment to Regulation 68-C (Claims for Personal Injury Protection Benefits) became effective March 14, 2007. This amendment was previously effective on an emergency basis. This amendment requires insurers to issue no-fault denials with specific wording so that the applicants will be aware that they can apply for special expedited arbitration to resolve the issue of which eligible insurer is designated for first party benefits.

Fourth Amendment to Regulation 68-D (Arbitration) became effective March 14, 2007. This amendment was previously effective on an emergency basis. The regulation provides the procedures for administration of the special expedited arbitration for disputes regarding the designation of the insurer for first party benefits.

First Amendment to Regulation 159 (Homeowners Insurance Disclosure Information and Other Notices) became effective August 8, 2007. This amendment sets forth the minimum notification requirements pertaining to the notices required by Section 3425(e) and Section 5403(d) regarding market assistance programs.

Third Amendment to Regulation 35-C (Liability Insurance Covering All-Terrain Vehicles) became effective October 10, 2007. This amendment makes editorial changes to the regulations cited and to the name of the endorsement referenced in Section 64-2.1 of the rule.

Adoption of the Tenth Amendment to Regulation 41 (Excess Line Placements Governing Standards) became effective December 19, 2007. This amendment changes the amount of funds required to be held in trust by alien excess line insurers and an association of insurance underwriters. The rule also requires the report required by Section 27.14(f) to be certified by an actuary.

24. Circular Letters

Circular Letters Issued in 2007:

Circular Letter No. 5 (2007) regarding the use of CAMEL ratings and other nonpublic supervisory information for underwriting insurance coverage was issued on March 1, 2007 to property/casualty insurers, rate service organizations, the Excess Line Association of New York, and insurance producer organizations. The circular letter advised insurers and producers that federal and state law prohibits a financial institution from disclosing its CAMELS ratings and other nonpublic supervisory information to insurers, as well as to other non-related third parties, without permission from the appropriate federal or state banking agency.

Circular Letter No. 11 (2007) regarding non-renewal of insureds with homeowners insurance who do not also have other insurance business with the insurer was issued August 28, 2007 to all property/casualty insurers. The circular letter advised insurers that are non-renewing homeowners insurance policies where the insureds do not also have other insurance business must inform the Insurance Department within 10 days of this circular letter of such practice and immediately cease non-renewing policies using the “supporting business” condition. It also advised insurers to rescind any non-renewal notice that had not yet taken effect.

Supplement No. 1 to Circular Letter No. 22 (2005) regarding the filing of the actuarial opinion summary (AOS) was issued on November 6, 2007 to all property/casualty insurers domiciled in New York State. The purpose of this supplement is to advise that a duplicate copy of the Statement of Actuarial Opinion (SAO) is no longer required to be attached with the filing of the AOS

25. Individual Policyholder Complaints, Inquiries and Freedom of Information Requests

Certain complaints and inquiries are processed independently of the Consumer Services Bureau. A total of 1,483 such complaints and inquiries were received by the Market Regulatory Division of the Property Bureau in 2006. This total consisted of 1,159 involving personal automobile insurance; 21 involving commercial automobile insurance; 110 involving homeowners insurance; 56 involving other liability insurance; 32 involving commercial multiple peril insurance; 43 involving medical malpractice insurance; 15 involving workers’ compensation, and 26 involving other types of insurance (mortgage guaranty, fidelity, surety, inland marine, etc.). In addition, the Market Regulatory Section processed 406 Freedom of Information (FOIL) requests on policy form and rate information.

26. Casualty Actuarial

The Casualty Actuarial Unit reviews rate filings for workers' compensation insurance, private passenger automobile insurance and private passenger and commercial insurance offered through the Automobile Insurance Plan. All such filings are subject to prior approval. In terms of premium volume, private passenger automobile and workers' compensation insurance are the largest property/casualty coverages, accounting for approximately $14 billion of New York premium volume in 2007.

Additionally, the Casualty Actuarial Unit is a member of the Security Fund Task Force that calculates the Property/Casualty Insurance Security Fund net value and contributions.

a. Private Passenger Automobile Insurance

The average change for insurers receiving rate changes in 2007 was approximately 0.7%. For these insurers, liability rates increased 2.4% on average while physical damage rates, primarily collision and comprehensive coverages, decreased 3.1% on average. The insurers receiving rate changes in 2007 represent 55% of the total market for private passenger automobile insurance. The overall impact on the rate level for the entire market (including those auto insurers with no approved rate changes in 2007) was an average increase of 0.4%.

Insurers' private passenger automobile insurance rate submissions may include requests for changes in classification relativities, multi-tier rating plans, innovative rating rules or other types of modifications. These changes must be adequately justified.

In 2007, 55 private passenger automobile rate requests were implemented. The following table lists both the requested and implemented rate changes and provides the liability and physical damage components of such changes.

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS REVIEWED IN 2007[1]

Date of Approval	Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Taken (%)	Physical Damage Change Taken (%)	Overall Change Taken (%)
1/2/07	4/1/07	Erie: EIC;EICofNY	0.6	0.0	-0.2	-0.4	-0.3
1/3/07	3/1/07	Amica Mutual Ins Co	1.0	-0.4	-0.4	-0.4	-0.4
1/15/07	2/15/07	Tri-state Consumer Ins Co	0.2	-11.7	-10.2	-14.8	-11.7
1/17/07	3/17/07	Allstate Property& Casualty Ins Co	0.0	-5.0	-4.3	-6.4	-5.0
2/5/07	3/26/07	Kemper Independence Ins Co	0.0	-7.7	-7.0	-12.0	-7.7
2/16/07	6/1/07	Farmer New Century Ins Co	0.5	-0.9	-3.3	-3.3	-3.3
3/8/07	4/27/07	Nationwide Mutual fire Ins Co	0.1	3.3	4.0	-7.3	2.1
3/23/07	6/1/07	A Central Ins Co	0.1	-7.2	-7.2	-7.2	-7.2
3/26/07	6/22/07	Nationwide:NGIC; NICOA	0.5	-0.1	-0.1	0.0	-0.1
3/29/07	6/4/07	State Farm: SFF&CC	1.2	0.3	0.3	0.3	0.3
3/29/07	6/4/07	State Farm: SFM	9.0	-1.3	-1.3	-1.3	-1.3
5/2/07	7/31/07	Met: MP&CIC, MCIC	1.5	-0.3	-0.3	-0.2	-0.3
5/2/07	5/31/07	Met: MGP&CIC	0.8	0.0	0.0	0.0	0.0
5/2/07	7/25/07	Harleysville Worcester Ins Co	0.1	-0.5	-0.4	-0.9	-0.5
5/11/07	7/1/07	Preferred Mutual Ins Co	0.6	1.1	6.1	-2.7	2.2
5/14/07	5/16/07	Progressive:NTH; NW; NE	7.7	2.9	4.2	0.0	2.9
5/14/07	8/5/07	Farm Family Casualty Ins Co	0.4	-0.2	0.1	-0.9	-0.2
5/16/07	7/20/07	MSAA: NGM; MSAAC	0.7	-3.8	0.0	-9.7	-3.8
6/14/07	8/20/07	Warner Ins Co	0.1	-4.6	-3.1	-7.1	-4.6
6/14/07	8/20/07	Response Worldwide Direct Auto Ins Co	0.0	-4.6	-3.2	-7.1	-4.6
6/18/07	8/13/07	Unitrin Direct Ins Co	0.1	5.4	4.6	7.3	5.4
6/18/07	6/17/07	Travelers: TCIC; THMIC	0.0	0.0	0.0	0.0	0.0
6/27/07	11/1/07	Farmington Casualty Company	0.1	-0.3	-0.3	-0.2	-0.3
6/29/07	10/1/07	AIPSO	2.0	-3.5	-6.7	-12.3	-7.0
7/2/07	10/15/07	Peerless Ins Co	0.4	-6.0	1.9	-17.6	-6.0
7/2/07	10/6/07	Fireman's Fund: FFIC; NSC; AIC; AAI	0.2	-5.0	-1.9	-9.3	-5.0
8/3/07	8/29/07	21st Century Ins Co	0.0	-3.7	-3.9	-3.2	-3.7
8/10/07	10/11/07	Esurance Ins Co	0.3	5.0	5.2	4.5	5.0
8/20/07	12/22/07	Nationwide:NGIC; NICOA	*	-3.2	-3.2	-3.2	-3.2
8/21/07	9/24/07	Encompass Home and Auto Ins Co	0.0	0.0	0.0	0.0	0.0
8/29/07	12/15/07	AutoOne Select Ins Co	0.5	0.0	0.0	0.0	0.0
8/29/07	10/1/07	Travelers: TCIC; THMIC	*	-6.3	-6.7	-5.4	-6.3
8/31/07	11/15/07	Commercial Mutual Ins Co	0.0	-10.6	0.0	-10.6	-10.6
9/6/07	9/6/07	Central Mutual Ins Co	0.0	-9.1	-7.0	-15.5	-9.1
9/7/07	10/1/07	Unitrin Advantage Ins Co	0.1	-6.2	-4.5	-8.1	-6.2
9/18/07	12/15/07	Lincoln General Ins Co	0.0	-1.6	0.0	-38.4	-1.6
10/5/07	12/28/07	AIG Advantage Ins Co	0.0	0.0	0.0	0.0	0.0
10/12/07	1/1/08	AutoOne Ins Co	1.1	-6.0	-5.8	-8.7	-6.0
10/12/07	12/21/07	ACA Ins Co	0.0	-8.7	-8.9	-8.4	-8.7
10/17/07	11/11/07	Liberty Mutual Fire Ins. Co.	4.6	0.4	0.4	0.4	0.4
10/31/07	12/22/07	AIG National Insurance Co. Inc.	0.3	9.4	11.1	4.4	9.4
10/31/07	10/31/07	Utica National of Texas	0.0	0.0	0.0	0.0	0.0

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS REVIEWED IN 2007[1]
(continued)

Date of Approval	Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Taken (%)	Physical Damage Change Taken (%)	Overall Change Taken (%)
11/2/07	12/1/07	Atlantic States Ins Co	0.0	7.0	11.6	0.7	7.0
11/5/07	12/15/07	Erie: EIC;EICofNY	*	-4.3	-4.9	-3.0	-4.2
11/5/07	12/7/07	Progressive:NTH; NW; NE	*	6.5	7.7	-1.3	5.1
11/16/07	3/18/08	Farm Family Casualty Ins Co	*	-9.1	-9.2	-9.0	-9.1
11/20/07	1/21/08	Liberty Insurance Corporation	0.3	9.7	8.3	1.3	6.5
11/27/07	2/2/08	Progressive Direct Ins. Co.	1.0	7.1	8.8	0.2	6.3
11/30/07	1/22/08	Allmerica Financial Alliance Ins Co	0.1	4.8	3.8	7.9	4.8
12/7/07	1/1/08	Truck Insurance Exchange	0.0	-3.0	-1.8	-6.3	-3.0
12/10/07	4/10/08	Pennsylvania General Ins Co	0.0	5.0	7.0	1.2	5.0
12/10/07	4/10/08	Adirondack Insurance Exchange	0.0	5.0	7.0	1.2	5.0
12/21/07	2/25/08	GEICO & Geico General	13.9	0.0	3.2	-5.4	0.0
12/21/07	2/25/08	Geico Indemnity	4.8	4.3	5.9	0.0	4.3
12/21/07	1/15/08	Peerless Ins Co	*	2.6	2.9	2.3	2.6

2007 Rate Change Summary	**Filings**
• Number of insurer rate filings:	55
• Average liability change for insurers receiving rate changes:	2.4%
• Percentage of total liability industry premium affected:	55.5%
• Impact on the entire market of the overall average liability rate change:	1.3%
• Average physical damage change for insurers receiving rate changes:	-3.1%
• Percentage of total physical damage industry premium affected:	54.4%
• Impact on the entire market of the overall average physical damage change:	-1.7%
• Average combined liability and physical damage change for insurers receiving rate changes:	0.7%
• Percentage of total industry premium affected:	55.1%
• Impact on the entire market of the overall average liability and physical damage rate change:	0.4%

[1] All rate filings (and classification changes) are subject to prior approval.
[2] These market shares are primarily based on 2005 Annual Statement premiums.
* Subsequent filing by this insurer in same year.

b. New York Automobile Insurance Plan (NYAIP) Experience in 2005 and 2006

i. Earned Car Years

An important indicator of the size of the Assigned Risk Plan (a.k.a., New York Automobile Insurance Plan) is earned car years. This reflects the size of the Plan as measured by the duration of coverage. (One car insured for one year equals one earned car year.) The number of private passenger automobiles (not including commercial autos) insured through the Plan decreased 32.9% for liability and 35.3% for collision from 2005 to 2006. Table 42 shows a ten-year history for voluntary and assigned liability and assigned collision earned car years.

Table 42
Liability and Collision Earned Car Years in the Voluntary and Assigned Risk Market
1997 – 2006

Calendar Year	Voluntary Liability	Percent Change From Previous Year	Assigned Risk Liability	Percent Change From Previous Year	Combined Liability	Percent Change From Previous Year	Assigned Risk Collision	Percent Change From Previous Year
1997	7,049,333		744,973		7,794,306		39,948	
1998	7,428,546	5.4	541,247	-27.3	7,969,793	2.3	23,988	-40.0
1999	8,031,017	8.1	324,355	-40.1	8,355,372	4.8	11,631	-51.5
2000	8,106,797	0.9	207,802	-35.9	8,314,599	-0.5	9,408	-19.1
2001	8,147,522	0.5	343,511	65.3	8,491,033	2.1	27,597	193.3
2002	8,463,417	3.9	444,437	29.4	8,907,854	4.9	47,234	71.2
2003	8,313,121	-1.8	471,158	6.0	8,784,279	-1.4	47,981	1.6
2004	8,356,929	0.5	370,813	-21.3	8,727,742	-0.6	31,501	-34.3
2005	8,602,031	2.9	270,485	-27.1	8,872,516	1.7	18,386	-41.6
2006	8,729,798	1.5	181,467	-32.9	8,911,265	0.4	11,896	-35.3

ii. Risks by Surcharge Category

In 2006, there were 181,467 private passenger earned car years for liability and 11,896 for collision coverage insured through the Assigned Risk Plan. Table 43 shows the distribution of New York private passenger liability and collision assigned risks by surcharge category for 2004, 2005 and 2006.

Table 43
DISTRIBUTION OF PRIVATE PASSENGER AUTOMOBILE ASSIGNED RISKS
LIABILITY AND COLLISION COVERAGES*
by Discount or Surcharge Category, 2004 – 2006

	Liability			Collision		
Discount or Surcharge Category	**2004 (%)**	**2005 (%)**	**2006 (%)**	**2004 (%)**	**2005 (%)**	**2006 (%)**
Total, all categories	100.0	100.0	100.0	100.0	100.0	100.0
Total Unsurcharged	58.0	58.1	56.5	57.5	60.2	58.3
3 Years Claim Free (1 or less with Plan) (Manual Rates)	38.6	36.0	33.2	34.6	29.7	29.3
Experience Discount						
4 Years (One or more with Plan) – 18% Credit	9.4	9.8	9.6	11.4	12.9	10.5
5 Years (Two or more with Plan) – 25% Credit	5.4	6.0	5.5	6.6	9.3	7.5
6 Years or more (Three or more w/Plan) – 30% Credit	4.6	6.2	8.2	4.9	8.3	11.1
Total Surcharged	42.0	41.9	43.5	42.5	39.8	41.7
Inexperienced Operator Surcharge	21.1	21.7	22.9	15.4	14.4	15.9
Experience Surcharge						
15%	11.9	11.2	11.2	15.6	14.3	13.9
25%	0.2	0.2	0.3	0.2	0.2	0.3
35%	3.1	2.8	2.9	4.5	4.0	4.3
50%	1.8	1.9	1.8	1.7	1.6	1.5
75%	1.3	1.3	1.4	1.8	1.8	1.7
100%-200%	2.7	2.8	3.1	3.3	3.5	4.0

*Subject to rounding

iii. Risks by Rating Territory

The proportions of all private passenger liability risks that are assigned risks, listed by rating territory for 2005 and 2006, are shown in Table 44. During 2006, 2.0% of all New York State private passenger automobiles were assigned risks as opposed to 3.0% in 2005. The proportion of assigned risks was 10% or higher in only 1 of the 70 rating territories for both 2005 and 2006. The highest 2006 ratio was 18.3% in the Bronx Territory and the lowest was 0.03% in the Corning Territory. Between 2005 and 2006 the number of assigned risks decreased in all 70 rating territories.

Table 45 displays a seven-year history of the percentage of assigned-to-total risks by territory, ranked from the highest to the lowest. All tables in this section are derived from data provided by Automobile Insurance Plan Services Office and are subject to rounding.

Table 44: NY Private Passenger Automobile Exposures in Earned Car Years by Territory for the Voluntary and Assigned Risk Markets

Territory		2005 Assigned	2005 Voluntary	2005 Total	2006 Assigned	2006 Voluntary	2006 Total	# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
01	Bronx Territory	13,541	36,773	50,313	9,681	43,289	52,970	-3,860	-28.5	2,657	5.3
03	Bronx Suburban Territory	14,988	167,189	182,177	10,061	172,286	182,347	-4,927	-32.9	171	0.1
05	Staten Island	8,700	224,988	233,687	5,020	232,482	237,503	-3,680	-42.3	3,815	1.6
07	Buffalo	5,058	116,841	121,899	3,473	119,084	122,557	-1,585	-31.3	658	0.5
08	Buffalo Semi-Suburban	3,811	186,417	190,228	2,621	182,426	185,047	-1,190	-31.2	-5,181	-2.7
09	Schenectady County	1,144	108,247	109,391	790	108,207	108,997	-354	-30.9	-394	-0.4
11	Rochester	10,846	386,647	397,493	8,372	355,010	363,382	-2,474	-22.8	-34,110	-8.6
12	Syracuse	2,868	219,500	222,368	2,019	218,968	220,987	-849	-29.6	-1,381	-0.6
13	Albany	1,336	168,414	169,750	791	168,906	169,698	-545	-40.8	-52	0.0
14	Niagara Falls	2,043	70,016	72,059	1,492	70,615	72,107	-551	-27.0	47	0.1
15	Utica	341	62,650	62,991	222	61,909	62,131	-119	-34.9	-860	-1.4
16	Saratoga Springs Suburban	109	51,131	51,240	59	51,308	51,367	-50	-45.6	127	0.2
17	Kings County	8,897	324,763	333,660	3,768	338,383	342,152	-5,129	-57.6	8,492	2.5
18	Manhattan	11,234	150,200	161,434	7,004	158,900	165,904	-4,230	-37.7	4,470	2.8
19	Queens	4,626	51,524	56,150	2,780	52,396	55,175	-1,846	-39.9	-975	-1.7
20	Hempstead	14,910	448,660	463,570	8,922	449,020	457,941	-5,989	-40.2	-5,628	-1.2
21	North Hempstead	4,815	154,498	159,313	3,058	154,727	157,786	-1,756	-36.5	-1,527	-1.0
22	Oyster Bay	6,912	256,281	263,193	4,708	264,433	269,142	-2,204	-31.9	5,948	2.3
24	Rome	227	23,402	23,629	178	22,978	23,156	-49	-21.6	-473	-2.0
25	Auburn	66	24,457	24,524	46	23,906	23,953	-20	-29.8	-571	-2.3
27	Elmira	37	51,100	51,137	24	50,012	50,037	-13	-35.0	-1,101	-2.2
28	Binghamton	1,750	113,523	115,273	1,209	112,807	114,016	-541	-30.9	-1,257	-1.1
29	Gloversville	181	28,737	28,918	107	28,707	28,814	-74	-41.0	-104	-0.4
30	Saratoga Springs	66	26,050	26,117	40	25,206	25,247	-26	-39.3	-870	-3.3
31	Chautauqua County	667	86,476	87,143	432	85,413	85,845	-235	-35.3	-1,298	-1.5
32	Newburgh	1,697	70,639	72,336	1,212	70,682	71,894	-485	-28.6	-442	-0.6
33	Poughkeepsie	1,881	105,177	107,059	1,399	104,084	105,483	-482	-25.6	-1,576	-1.5
34	Troy	929	62,303	63,232	568	62,809	63,377	-361	-38.8	145	0.2
35	Amsterdam	86	22,612	22,698	40	22,478	22,518	-46	-53.2	-180	-0.8
36	Glens Falls	594	46,093	46,687	423	46,420	46,844	-171	-28.7	157	0.3
37	Oswego	587	36,411	36,998	390	36,844	37,234	-197	-33.6	236	0.6
38	Syracuse Suburban	147	63,234	63,381	103	65,780	65,883	-45	-30.5	2,502	3.9
39	Rochester Suburban	117	40,553	40,671	76	41,330	41,406	-42	-35.4	735	1.8
40	Corning	16	29,433	29,449	8	28,467	28,475	-8	-50.0	-974	-3.3
41	Erie County (Balance)	565	84,466	85,031	374	88,056	88,431	-191	-33.8	3,400	4.0
42	Buffalo Suburban	2,942	158,954	161,896	2,199	159,579	161,778	-744	-25.3	-118	-0.1

Table 44: NY Private Passenger Automobile Exposures in Earned Car Years by Territory for the Voluntary and Assigned Risk Markets

Territory		2005 Assigned	2005 Voluntary	2005 Total	2006 Assigned	2006 Voluntary	2006 Total	# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
43	Niagara Falls Suburban	425	34,368	34,793	291	34,215	34,506	-134	-31.5	-288	-0.8
44	Broome County (Balance)	43	22,058	22,102	30	23,377	23,407	-14	-31.1	1,305	5.9
46	Putnam County	1,585	76,756	78,341	1,099	76,644	77,744	-485	-30.6	-597	-0.8
47	Orleans County	166	26,938	27,105	109	25,887	25,997	-57	-34.4	-1,108	-4.1
48	Monroe County (Balance)	69	40,723	40,792	37	73,021	73,059	-31	-45.9	32,267	79.1
49	Niagara County (Balance)	167	33,601	33,768	128	33,209	33,337	-39	-23.5	-431	-1.3
51	Ontario County, etc.	2,109	201,235	203,344	1,347	201,766	203,113	-762	-36.1	-231	-0.1
52	Fort Plain, Herkimer	326	40,474	40,800	248	41,023	41,271	-78	-23.9	471	1.2
54	Cortland County, etc.	2,644	197,866	200,510	1,964	199,807	201,771	-680	-25.7	1,261	0.6
55	Queens Suburban	20,823	526,079	546,902	10,892	545,133	556,025	-9,930	-47.7	9,124	1.7
56	Saratoga County (Balance)	125	32,129	32,255	80	33,947	34,027	-46	-36.4	1,772	5.5
58	Dutchess County (Balance)	1,444	99,783	101,227	1,021	102,461	103,483	-422	-29.3	2,256	2.2
59	Columbia County, etc.	719	84,965	85,684	493	85,794	86,287	-225	-31.4	603	0.7
60	Genesee County	263	39,417	39,680	187	38,943	39,131	-76	-28.9	-550	-1.4
61	Delaware County, etc.	1,667	139,515	141,181	1,122	141,729	142,851	-544	-32.7	1,670	1.2
62	Highland, Kingston	2,142	86,161	88,303	1,585	86,656	88,240	-557	-26.0	-62	-0.1
64	Middletown	5,227	159,850	165,077	3,854	163,596	167,450	-1,373	-26.3	2,373	1.4
65	Ossining	5,758	183,614	189,372	4,180	183,601	187,782	-1,578	-27.4	-1,591	-0.8
67	Clinton County, etc.	9,063	337,122	346,185	6,751	342,054	348,805	-2,312	-25.5	2,620	0.8
68	Rockland County	3,711	185,645	189,356	2,187	185,240	187,427	-1,524	-41.1	-1,930	-1.0
71	Saratoga County South	72	44,898	44,969	47	44,788	44,835	-25	-34.8	-135	-0.3
72	Albany County (Balance)	33	14,524	14,558	17	15,983	16,000	-16	-48.3	1,442	9.9
73	Rensselaer County (Balance)	328	41,831	42,159	217	43,337	43,554	-111	-33.8	1,395	3.3
74	Jefferson County	694	70,511	71,206	527	70,656	71,183	-167	-24.1	-23	0.0
75	Suffolk County West	23,815	529,648	553,463	15,963	539,606	555,568	-7,853	-33.0	2,106	0.4
76	Suffolk County East	34,635	444,475	479,110	26,984	461,902	488,886	-7,651	-22.1	9,776	2.0
81	Monticello-Liberty	95	13,883	13,978	51	14,164	14,215	-44	-46.3	237	1.7
82	Sullivan County Central	188	15,796	15,985	109	16,248	16,356	-80	-42.4	372	2.3
83	Sullivan County (Balance)	386	23,106	23,492	259	23,641	23,900	-127	-32.9	408	1.7
84	Allegany County, etc.	2,792	186,305	189,097	2,051	186,213	188,264	-741	-26.5	-833	-0.4
86	Oneida	211	40,844	41,055	144	40,491	40,636	-67	-31.6	-420	-1.0
94	Mount Vernon and Yonkers	7,602	103,893	111,495	4,948	106,752	111,700	-2,654	-34.9	205	0.2
95	White Plains	2,517	46,134	48,651	1,749	46,439	48,189	-767	-30.5	-462	-0.9
97	New York City Suburban	9,902	219,523	229,425	7,121	223,564	230,686	-2,781	-28.1	1,261	0.5
	Entire State	**270,485**	**8,602,031**	**8,872,517**	**181,467**	**8,729,798**	**8,911,266**	**-89,018**	**-32.9**	**38,749**	**0.4**

a. Derived from data provided by the Automobile Insurance Plan Services Office. Subject to rounding.

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2000-2006

Territory		2000 (%)	2000 Rank	2001 (%)	2001 Rank	2002 (%)	2002 Rank	2003 (%)	2003 Rank	2004 (%)	2004 Rank	2005 (%)	2005 Rank	2006 (%)	2006 Rank
01	Bronx Territory	30.9	1	40.1	1	46.7	1	47.0	1	35.8	1	26.9	1	18.3	1
76	Suffolk County East	3.0	8	5.7	8	8.4	7	10.0	6	8.7	6	7.2	4	5.5	2
03	Bronx Suburban Territory	9.4	4	12.2	4	14.0	4	15.4	4	11.4	3	8.2	3	5.5	3
19	Queens	15.8	2	17.7	2	19.1	2	18.6	2	12.7	2	8.2	2	5.0	4
94	Mount Vernon and Yonkers	5.2	7	8.7	6	11.1	5	12.6	5	9.5	5	6.8	6	4.4	5
18	Manhattan	10.8	3	14.5	3	16.2	3	15.7	3	10.4	4	7.0	5	4.2	6
95	White Plains	2.2	13	4.9	9	6.7	9	8.1	8	7.0	7	5.2	7	3.6	7
97	New York City Suburban	2.5	11	4.3	13	6.0	13	6.7	13	5.6	11	4.3	8	3.1	8
75	Suffolk County West	2.5	10	4.5	11	6.5	10	7.6	10	6.0	9	4.3	9	2.9	9
07	Buffalo	1.0	24	4.5	12	6.1	12	7.2	11	5.7	10	4.1	10	2.8	10
11	Rochester	0.6	38	2.5	21	3.4	21	3.8	20	3.2	20	2.7	18	2.3	11
64	Middletown	1.7	16	2.9	17	4.2	17	4.7	17	4.0	16	3.2	14	2.3	12
65	Ossining	1.6	17	3.0	16	4.2	16	4.7	16	3.9	17	3.0	15	2.2	13
05	Staten Island	2.7	9	4.8	10	6.1	11	7.0	12	5.3	12	3.7	12	2.1	14
14	Niagara Falls	0.4	44	1.6	29	2.8	28	3.6	22	3.4	19	2.8	17	2.1	15
55	Queens Suburban	6.9	6	9.0	5	10.0	6	10.0	7	6.3	8	3.8	11	2.0	16
20	Hempstead	2.3	12	4.1	14	5.8	14	6.5	14	4.7	14	3.2	13	1.9	17
21	North Hempstead	1.9	14	3.2	15	4.5	15	5.2	15	4.1	15	3.0	16	1.9	18
67	Clinton County, etc.	1.0	23	2.0	26	3.3	23	3.5	24	3.2	22	2.6	21	1.9	19
62	Highland, Kingston	1.3	20	2.7	19	3.7	19	3.9	19	3.2	21	2.4	22	1.8	20
22	Oyster Bay	1.9	15	2.9	18	4.0	18	4.5	18	3.6	18	2.6	20	1.7	21
32	Newburgh	0.7	33	1.6	30	2.8	29	3.5	23	3.1	23	2.3	23	1.7	22
08	Buffalo Semi-Suburban	0.6	37	1.5	35	2.3	33	2.7	30	2.4	27	2.0	25	1.4	23
46	Putnam County	1.5	19	2.3	22	3.2	24	3.2	26	2.6	25	2.0	24	1.4	24
42	Buffalo Suburban	0.6	34	1.5	34	2.3	34	2.5	33	2.2	29	1.8	27	1.4	25
33	Poughkeepsie	1.0	25	2.1	24	2.9	26	2.7	29	2.2	28	1.8	28	1.3	26
68	Rockland County	0.8	31	2.0	25	3.1	25	3.8	21	3.0	24	2.0	26	1.2	27
17	Kings County	6.9	5	8.3	7	8.4	8	8.1	9	4.9	13	2.7	19	1.1	28
84	Allegany County, etc.	0.6	36	1.3	38	2.2	38	2.4	35	1.9	35	1.5	32	1.1	29
83	Sullivan County (Balance)	1.1	22	1.6	31	2.2	37	2.4	36	2.1	30	1.6	29	1.1	30
28	Binghamton	0.6	35	1.4	36	2.4	31	2.6	31	2.0	32	1.5	31	1.1	31
37	Oswego	0.9	26	2.1	23	3.4	22	3.5	25	2.4	26	1.6	30	1.0	32
58	Dutchess County (Balance)	1.1	21	2.0	27	2.7	30	2.6	32	1.9	34	1.4	34	1.0	33
54	Cortland County, etc.	0.8	30	1.5	33	2.1	39	2.1	39	1.7	39	1.3	35	1.0	34
12	Syracuse	0.4	48	1.4	37	2.2	36	2.5	34	1.7	37	1.3	36	0.9	35
36	Glens Falls	0.5	40	1.3	41	2.3	32	2.3	37	1.8	36	1.3	37	0.9	36
34	Troy	0.8	27	1.8	28	2.8	27	2.7	28	2.1	31	1.5	33	0.9	37

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2000-2006

Territory		2000 (%)	2000 Rank	2001 (%)	2001 Rank	2002 (%)	2002 Rank	2003 (%)	2003 Rank	2004 (%)	2004 Rank	2005 (%)	2005 Rank	2006 (%)	2006 Rank
43	Niagara Falls Suburban	0.2	55	0.8	50	1.6	47	1.9	41	1.5	40	1.2	38	0.8	38
61	Delaware County, etc.	0.8	28	1.5	32	2.2	35	2.3	38	1.7	38	1.2	39	0.8	39
24	Rome	0.4	46	1.3	39	1.9	41	1.9	40	1.4	43	1.0	44	0.8	40
74	Jefferson County	0.5	41	1.0	46	1.5	49	1.4	50	1.2	45	1.0	43	0.7	41
09	Schenectady County	0.3	50	0.9	49	1.6	45	1.8	43	1.4	42	1.0	41	0.7	42
82	Sullivan County Central	1.5	18	2.6	20	3.4	20	3.1	27	2.0	33	1.2	40	0.7	43
51	Ontario County, etc.	0.5	42	1.1	44	1.7	43	1.8	44	1.5	41	1.0	42	0.7	44
52	Fort Plain, Herkimer	0.5	43	1.0	45	1.5	48	1.6	47	1.2	46	0.8	46	0.6	45
59	Columbia County, etc.	0.7	32	1.2	43	1.8	42	1.6	46	1.3	44	0.8	45	0.6	46
31	Chautauqua County	0.3	54	0.6	54	1.0	55	1.1	52	1.0	51	0.8	49	0.5	47
73	Rensselaer County (Balance)	0.4	45	0.9	48	1.4	50	1.5	49	1.2	49	0.8	48	0.5	48
60	Genesee County	0.3	51	0.6	55	1.1	51	1.3	51	1.0	50	0.7	52	0.5	49
13	Albany	0.5	39	1.2	42	2.0	40	1.9	42	1.2	47	0.8	47	0.5	50
41	Erie County (Balance)	0.3	53	0.7	51	1.0	54	1.0	55	0.8	54	0.7	51	0.4	51
47	Orleans County	0.3	52	0.9	47	1.6	46	1.5	48	1.0	52	0.6	54	0.4	52
49	Niagara County (Balance)	0.1	66	0.4	61	0.7	60	0.8	61	0.7	57	0.5	57	0.4	53
29	Gloversville	0.3	49	0.6	56	0.7	61	1.0	57	0.9	53	0.6	53	0.4	54
81	Monticello-Liberty	0.8	29	1.3	40	1.7	44	1.7	45	1.2	48	0.7	50	0.4	55
15	Utica	0.2	59	0.5	59	0.9	56	1.1	53	0.7	56	0.5	55	0.4	56
86	Oneida	0.4	47	0.7	53	1.0	53	1.0	54	0.8	55	0.5	56	0.4	57
56	Saratoga County (Balance)	0.1	62	0.5	57	0.9	57	0.8	60	0.6	59	0.4	58	0.2	58
25	Auburn	0.2	60	0.5	58	0.8	59	0.9	58	0.5	60	0.3	61	0.2	59
39	Rochester Suburban	0.1	67	0.4	62	0.5	66	0.6	62	0.4	62	0.3	60	0.2	60
35	Amsterdam	0.2	56	0.3	65	0.8	58	0.8	59	0.6	58	0.4	59	0.2	61
30	Saratoga Springs	0.2	61	0.4	64	0.6	64	0.5	65	0.4	63	0.3	62	0.2	62
38	Syracuse Suburban	0.1	64	0.3	68	0.5	67	0.5	66	0.3	65	0.2	63	0.2	63
44	Broome County (Balance)	0.2	58	0.4	60	0.6	63	0.5	64	0.3	67	0.2	66	0.1	64
16	Saratoga Springs Suburban	0.1	68	0.3	66	0.5	65	0.5	67	0.3	66	0.2	65	0.1	65
72	Albany County (Balance)	0.2	57	0.4	63	0.7	62	0.5	63	0.4	64	0.2	64	0.1	66
71	Saratoga County South	0.1	65	0.3	67	0.4	68	0.4	68	0.3	68	0.2	68	0.1	67
48	Monroe County (Balance)	0.1	63	0.7	52	1.0	52	1.0	56	0.5	61	0.2	67	0.1	68
27	Elmira	0.1	70	0.2	69	0.2	69	0.1	69	0.1	69	0.1	69	0.0	69
40	Corning	0.1	69	0.2	70	0.2	70	0.1	70	0.1	70	0.1	70	0.0	70
	Entire State	**2.5**		**4.0**		**5.3**		**5.6**		**4.2**		**3.0**		**2.0**	

* Derived from data provided by the Automobile Insurance Plans Service Office

c. Workers' Compensation Insurance

On June 29, 2007, the New York Compensation Insurance Rating Board (NYCIRB) filed, on behalf of its members and subscribers, a 13.6% decrease in workers' compensation rates. This change includes a 13.3% decrease due to reform legislation. This change, along with a -3.1% change in the New York Assessment Fee, would have produced a decrease in cost to policyholders of 16.3%.

An estimated effect of workers compensation reforms contained in New York Legislative Bill A. 6163/S.3322 was contained in this filing. These reforms include: the elimination of the Special Disability Fund, new caps on permanent partial disability duration, benefit increases, a transfer of permanent partial claims to the Aggregate Trust Fund, establishment of medical and impairment guidelines, strengthening of fraud provisions, and various medical related provisions.

Minor revisions, including a change to reflect a 15.0% decrease due to reform legislation, were made to the filing. These changes resulted in an 18.4% decrease in workers compensation rates and an overall 20.5% decrease in cost to policyholders. The filing was approved effective October 1, 2008.

This will be the last filing in which the NYCIRB files for full manual rates. New York will be moving to a loss cost system in 2008.

Table 46
WORKERS' COMPENSATION DIVIDEND CLASSIFICATION PLAN APPROVED
2007

Plan Types:
A = Flat C= Safety Group
B = Sliding Scale/ Loss Ratio

COMPANY NAME	PLAN TYPE	APPROVAL DATE
All America Ins Co	B	9/4/07

Table 47
WORKERS' COMPENSATION RATE HISTORY
New York Compensation Insurance Rating Board*
New York State, 1980-2007

Effect. Date	Policy Year	Calendar Year	Law Amendments & Medical & Hospital Agreements Indemnity	Medical	Wage & L/R Trend Factors	Expenses	Effect on Rate Level	Assessments WCB	SDF&RCF	Filed	Approved	Cumulative Approved
7/80	-4.5%	-7.1%	0.0%		1.0133	-4.1%		-0.1%	-2.5%	-3.1%	-10.1%	-10.1%
10/80										2.9%	2.9%	-7.5%
7/81	-11.5%	-11.5%	7.7%		0.8600	-3.1%		-0.4%	0.3%	-14.3%	-20.4%	-26.4%
7/82	-4.6%	-11.6%	4.3%		0.9895	0.3%		0.1%	1.2%	-2.1%	-3.4%	-28.9%
7/83 [1]	-0.3%	-7.8%	19.5%		0.8807	-0.1%		0.1%	-4.1%	5.4%	-2.0%	-30.3%
7/84	6.6%	3.5%	7.8%		0.8979	3.8%		0.1%	2.6%	9.4%	8.1%	-24.6%
7/85 [2]	7.7%	0.9%	8.3%		0.9725	2.2%		-0.3%	-1.5%	14.2%	10.2%	-17.0%
7/86	-1.3%	-8.4%	3.8%		0.9257	3.0%		0.2%	1.0%	1.5%	-4.7%	-20.9%
7/87	7.5%	12.8%	2.2%		0.9134	0.4%		0.3%	0.5%	6.5%	5.1%	-16.9%
7/88	9.2%	12.2%	7.2%		0.9470	0.7%		-0.4%	-1.4%	28.3%	11.1%	-7.7%
7/89	17.6%	22.5%	2.0%		0.9254	0.7%		-0.3%	1.5%	28.5%	15.5%	6.6%
7/90	12.8%	13.5%	18.0%	3.4%	0.9478	0.4%		-0.4%	-0.7%	39.1%	29.4%	38.1%
7/91	23.4%	20.9%	3.7%	2.1%	0.9012	-4.2%		0.3%	4.1%	25.1%	15.3%	59.2%
7/92	20.5%	13.1%	4.2%	1.2%	0.9500	-0.3%		-0.4%	4.1% [3]	18.4%	15.6%	84.1%
7/93	12.0%	17.1%	1.0%		1.0010	0.0%		-0.3%	-1.0% [3]	18.7%	14.4%	110.6%
4/94	-4.9%	-0.1%	-1.9% [4]		1.0010	0.0%	-16.3% [5]		13.5% [5]	-5.0%	-5.0%	100.1%
10/94	8.0%	1.9%	0.8%		0.9640	-1.2%	1.4%		-3.1%	-1.6%	-1.7%	96.7%
10/95	-17.1%	-15.3%	0.05%		1.0960	0.8%	-8.4%		3.7%	-2.8%	-5.0%	86.9%
	Pol. Yr.	**Acc. Yr.**										
10/96	-14.9%	-16.5%	-3.2%		1.0430	0.0%	-14.9%		-0.2%	-15.1%	-18.2%	52.9%
10/97	-9.1%	-9.5%	0.0%		1.0140	-0.1%	-7.5%		-1.0%	-3.8%	-8.4%	40.1%
10/98	8.9%	2.9%	0.0%		0.9080	0.8%	-3.1%		-3.0%	-0.4%	-6.0%	31.7%
10/99	17.1%	8.5%	0.0%		0.9860	1.2%	0.0%		3.9%	17.0%	3.9%	36.8%
10/00	4.5%	-0.2%	0.0%		0.962	0.1%	-2.5%		2.6%	0.0%	0.0%	36.8%
10/01	0.4%	-3.5%	0.0%		1.020	-0.1%	0.4%		-1.8%	-1.4%	-1.8%	34.3%
10/02	3.4%	-2.5%	0.0%		0.961	0.5%	0.0%		-1.2%	8.1%	-1.2%	32.7%
10/03	11.8%	11.1%	0.0%		1.000	-0.1%	0.0%		1.2%	12.6%	1.2%	34.3%
12/03	14.5%	3.7%	0.0%		0.934	-0.1%	0.0%			1.7%	1.7%	36.5%
10/04	27.6%	33.2%	0.0%		1.018	-1.9%	29.3%		0.7%	30.2%	0.7%	37.5%
10/05	18.4%	8.7%	0.0%		1.048	-2.1%	16.1%		2.1%	18.5%	7.2%	47.4%
10/06	-4.0%	-3.3%	0.0%		1.108	-0.5%	7.5%**		0.9%	8.5%	0.9%	48.7%
10/07	-5.2%	-4.6%	-13.3%		1.055	-1.3%	-13.6%		-3.1%	-16.3%	-20.5%	18.2%

[1] Includes Stock Security Fund Tax of 1.012. [2] The Loss Constant Offset was removed in 1985.
[3] Includes OSHA assessment of 1.25%. [4] Includes elimination of 13.0% Hospital Surcharge.
[5] Assessments are included in a fee. In April 1994, this produced an effect of -15.0% on the rate level.
* Rate changes apply to all workers' compensation insurers; approved deviations from these filed rates appear in the subsequent table.
Note: Columns (1) – (11) reflect the Rating Board's *filed rate request*; the final two columns reflect the *rate changes approved by the Department*.
**7.5%=.96(6.8%) + .04(24.0%)

Table 48: WORKERS' COMPENSATION — RATE DEVIATIONS (Approved as of February 1, 2008)*

Company Name	Effective Date	Downward Deviation	Company Name	Effective Date	Downward Deviation
Ace Fire Underwriters Ins Co	03/23/95	10.0	Erie Ins Co of New York	12/01/05	10.0
Admiral Ins Co	05/17/96	15.0	Federated Service Ins Co	10/01/06	10.0
AIU Ins Co	05/15/96	15.0	Fidelity & Deposit Co of Maryland	10/15/97	10.0
Alea North America Ins Co	04/17/03	5.0	Fidelity & Guaranty Ins Co	08/04/83	15.0
All America Ins Co	08/01/96	10.0	Fidelity & Guaranty Ins Underwriters Inc.	12/22/97	10.0
American Automobile Ins Co	06/13/83	16.0	Fire & Casualty Ins Co of CT	02/13/98	10.0
American Casualty Co of Reading, PA	03/01/01	15.0	Fireman's Fund Ins Co	02/15/85	10.0
American Economy Ins Co	06/01/96	10.0	First Liberty Ins Corp	03/01/07	9.5
American Employers' Ins Co	10/01/99	15.0	Florists' Mutual Ins Co	10/01/05	5.0
American Fire & Casualty Co	10/25/01	10.0	Fremont Indemnity Ins Co	10/28/97	15.0
American Guarantee & Liability Ins Co	04/15/01	10.0	Frontier Ins Co	04/07/98	10.0
American Manufacturers Mutual Ins Co	10/01/85	10.0	General Security P&C Ins Co	06/03/99	10.0
American Protection Ins Co	06/02/93	15.0	Globe Indemnity Co	03/01/03	10.0
American-Zurich Ins Co	12/01/96	15.0	Graphic Arts Mutual Ins Co	01/01/84	15.0
AmGuard Ins Co	02/01/04	5.0	Great American Alliance Ins Co	10/01/01	10.0
Argonaut-Midwest Ins Co	12/01/01	10.0	Great Amer Assur Co	10/01/00	10.0
Athena Assurance Co	05/01/04	5.0	Great Northern Ins Co	08/12/85	7.0
Atlantic Mutual Ins Co	06/01/00	5.0	GuideOne Mutual Ins Co(formerly Guidant Mut)	04/01/07	0.0
Atlantic Specialty Ins Co	08/01/96	15.0	Harleysville Worcester Ins Co	10/01/85	10.0
Automobile Ins Co of Hartford, CT	05/25/83	15.0	Hartford Casualty Ins Co	04/01/99	15.0
AutoOne Select Ins Co (formerly PG of NY)	01/01/07	0.0	Hartford Fire Ins Co	10/01/86	15.0
Bankers Standard Ins Co	03/23/95	15.0	Hartford Ins. Co. of the Midwest	05/02/86	10.0
Blue Ridge Indemnity Co	06/01/01[1]	10.0	Hartford Underwriters Ins Co	04/01/99	5.0
Blue Ridge Indemnity Co	05/01/01[2]	10.0	Homeland Ins Co of NY	01/01/07	0.0
Casualty Ins Co	10/28/97	15.0	Indemnity Ins Co of North America	01/01/97	15.0
Centennial Ins Co	07/15/88	10.0	Insurance Co of Greater New York	02/01/01	10.0
Centre Ins Co	02/01/97	15.0	Legion Ins Co	01/01/02	10.0
Centurion Ins Co	08/01/99	10.0	Liberty Insurance Corporation	01/01/00	14.0
Chubb Indemnity Co	05/01/96	15.0	Liberty Mutual Fire Ins Co	01/01/00	5.0
Cincinnati Ins Co	12/15/99	10.0	Main Street America Assurance Co	11/11/02	7.5
Citizens Ins Co of America	10/01/01	10.0	Majestic Ins Co	12/10/07	10.0
Colonial American Casualty & Surety Co	10/15/97	10.0	Massachusetts Bay Ins Co	10/01/01	5.0
Commercial Compensation Ins Co	04/01/98	10.0	MEMIC Ind Co	08/01/07	10.0
Continental Indemnity Co	10/01/07	10.0	Merchants Ins Co of New Hampshire	01/01/02	10.0
Continental Western Ins Co	06/10/06	10.0	Merchants Preferred Ins Co	08/09/07	10.0
EastGuard Ins Co	02/01/04	10.0	Michigan Millers Mutual Ins Co	06/01/98	10.0

Table 48: WORKERS' COMPENSATION — RATE DEVIATIONS (Approved as of February 1, 2008)
(continued)

Company Name	Effective Date	Downward Deviation	Company Name	Effective Date	Downward Deviation
Netherlands Ins Co	10/01/97	10.0	Selective Way Ins Co	03/01/02	5.0
New Hampshire Ins Co	05/15/96	15.0	Sentinel Ins Co	01/01/06	10.0
Newark Ins Co	05/01/95	7.5	Sentry Select Ins Co	08/01/97	10.0
North River Ins Co	08/01/07	0.0	State Farm Fire and Casualty Co	08/01/07	9.0
Northern Ins Co of New York	01/04/02	5.0	Strathmore Ins Co	01/01/01	15.0
Nova Cas Ins Co	10/15/07	0.0	St. Paul Mercury Ins Co	02/13/96	15.0
Ohio Security Ins Co	10/25/01	10.0	TIG Ins Co	01/01/01	7.5
Old Republic Ins Co	05/01/07	5.0	TIG Ins Co of New York	01/01/01	12.5
OneBeacon Amer Ins Co	01/01/07	15.0	Tower National Ins Co	08/24/06	10.0
Oriska Ins Co	07/01/01	10.0	Trans Pacific Ins Co	09/01/02	10.0
Pacific Indemnity Co	01/13/83	15.0	Transcontinental Ins Co	03/01/04	10.0
Paramount Ins Co	10/03/83	15.0	Travelers Casualty & Surety Co of Illinois	08/12/85	15.0
Patriot General Ins Co	02/25/02	10.0	Travelers Indemnity Co of America	01/16/91	15.0
Peerless Ins Co	05/01/96	7.5	Travelers Indemnity Co of Connecticut	08/01/98	10.0
Penn Millers Ins Co	01/01/05	0.0	Ulico Casualty Co	09/10/02[3]	0.0
Pennsylvania Manufacturers Assn. Ins. Co	12/11/01	7.0	Ulico Casualty Co	09/01/04[4]	0.0
Pennsylvania Manufacturers Indemnity Co	10/01/96	15.0	Union Ins Co	06/10/06	10.0
Providence Washington Ins Co	10/01/04	0.0	Utica National Assurance Co	02/01/04	5.0
Republic-Franklin Ins Co	01/01/88	10.0	Valley Forge Ins Co	03/01/01	10.0
Royal Indemnity Co	03/01/03	15.0	Wausau Business Ins Co	06/10/96	15.0
Safeguard Ins Co	05/01/95	10.0	Wausau General Ins Co	01/01/07	15.0
Safety National Casualty Corp	04/06/06	10.0	Wausau Underwriters Ins Co	01/01/07	0.0
Selective Ins Co of South Carolina	09/01/01	10.0			

[1] New Business [2] Renewal Business [3] ADR (Alternative Dispute Resolution) Policies [4] Non-ADR (Alternative Dispute Resolution) Policies.

* Insurers are not permitted to deviate from NY Compensation Insurance Rating Board approved rates without permission from the Superintendent of the NYS Insurance Department.

d. Property/Casualty Insurance Security Fund (PCISF) Net Value and Contributions

Pursuant to Article 76 of the New York State Insurance Law, the Superintendent is required to annually determine the PCISF net value and any necessary PCISF contributions. To this end, the Security Fund Task Force, consisting of members from different Bureaus in the Insurance Department, formulates guidelines for calculating both the PCISF net value and the quarterly contributions. In order for the Superintendent to have the necessary flexibility to carry out the statutory obligations concerning the PCISF and the dynamic insurance market in general, the Task Force periodically reviews and revises the PCISF guidelines as circumstances warrant. A subgroup of this Task Force annually calculates the PCISF net value and any necessary quarterly contributions.

No contributions were required between 1973 and 1988. In 1988, following the Superintendent's determination that the fund's net value as of 12/31/87 had fallen below $150 million, contributions resumed and continued through 1992. For the 1993 fund year, the Superintendent determined that the PCISF net value was greater than $150 million. Except for contributions that were due on February 15, 1993 from the prior fund year, in accordance with Section 7603(c)(1) no additional contributions were required in 1993. This remained the case for the 1994 – 1997 fund years.

In the 1998 fund year, the Superintendent determined that the PCISF net value had once again fallen below $150 million and contributions resumed. In 1999, however, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), additional contributions were due after this determination. In 2000, 2001, 2002, and 2003, the Superintendent determined that the PCISF net values had once again fallen below $150 million and quarterly contributions were required.

In the 2004 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease. In the 2005 and 2006 fund years, the net value fell below $150 million, and contributions continued. In the 2007 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease.

Table 49 below displays the amount of the estimated PCISF contributions per quarter since contributions first resumed in the 1988 fund year. The variation from year to year in both the magnitude of the PCISF net value and the estimated quarterly contributions reflects, in part, the variability associated with the PCISF payouts for awards and expenses and the PCISF dividends (returns from estates in liquidation) over the years.

Table 49
PCISF CONTRIBUTIONS, 1988-2007*

Fund Year	Estimated Quarterly Contributions (in millions)
1988	$15.0
1989	7.5
1990	5.5
1991	25.0
1992	7.5
1993 – 97	0
1998	8.3
1999	4.0
2000	18.8
2001	3.4
2002	21.4
2003	23.5
2004	28.1
2005	31.1
2006	38.0
2007	12.5

* During 1993, settlement was reached with respect to *Alliance of American Insurers et al. v. Chu et al*. The 1993 through 2007 fund year net values and contribution amounts described above reflect the impact of the settlement.

C. HEALTH BUREAU

1. Entities Under Health Bureau Supervision

The Health Bureau has responsibility for review and approval of accident and health insurance policy forms, initial premium rates and rate adjustment filings made by any insurer licensed to write such insurance, including not-for-profit insurers, HMOs, commercial insurance companies licensed to do accident and health insurance business, fraternal benefit societies and municipal cooperative health benefit plans.

The Bureau had regulatory authority over all aspects of the fiscal solvency and market conduct of 95 insurers, HMOs, and other managed care organizations as of December 31, 2007. These comprise 29 accident and health insurers, 1 life insurer (writing accident and health insurance only), 12 health service and medical and dental expense indemnity corporations, 23 Article 44 Public Health Law HMOs, 9 Article 47 Insurance Law municipal cooperative health benefits plans, 13 managed long term care plans and 8 continuing care retirement communities certified pursuant to Article 46 of the Public Health Law.

Two acquisition-of-control applications were reviewed in 2007, both were applications to obtain control of a HMO. Two merger applications were approved in which one HMO merged into another HMO, and one Article 42 insurer merged into another Article 42 insurer.

In 2007, the Bureau received a plan of conversion into for-profit status submitted by two not-for-profit health service corporations, Group Health, Inc. and the Health Insurance Plan of Greater New York. The plan calls for Group Health, Inc. to convert to a for-profit corporation, then merge with two accident and health insurers, HIP Insurance Company of New York and the PerfectHealth Insurance Company. The plan further calls for two for-profit HMOs, GHI-HMO Select, Inc. and ConnectiCare of New York, Inc. to merge and to absorb the Health Insurance Plan of Greater New York's membership. All of the concerned companies are affiliates. The plan is pending.

Six Article 42 Accident and Health licensing applications (5 foreign and 1 domestic) were under review during 2007. Five are for insurers writing the new Medicare Part D Prescription Drug Coverage. Of these six applications, three were approved, and three remained under review as of December 31, 2007.

Two HMOs submitted applications to receive "Certificates of Authority" to operate in New York State in 2007. HMOs are jointly regulated by this Department as well as the Department of Health. It is the Department of Health that issues the "Certificate of Authority" to HMOs. During 2007, both HMOs received their "Certificate of Authority".

One HMO continued its wind down of its operations in 2007 and is expected to be liquidated in the near future. One HMO has been submitted to the Liquidation Bureau and is awaiting final approval for submission to the court. Additionally, the Bureau is monitoring the financial condition of two financially distressed HMOs and two Article 42 companies on a monthly basis.

Article 47 of the Insurance Law, enacted in 1994, permits the formation of municipal cooperative health benefit plans. Nine plans are currently licensed and one application is pending.

2. Accident and Health Insurers

Twenty-nine companies were licensed to transact only accident and health insurance at year-end 2007. The Bureau regulates the fiscal solvency and market conduct of one life insurer and financial data of this life insurer is included in the following table:

Table 50
SELECTED ANNUAL STATEMENT DATA
Accident and Health Insurers*
2004-2006
(dollar amounts in millions)

	2006	2005	2004
Number of Insurers	27	26	23
Net premiums written	$12,677.0	$10,679.5	$9,668.7
Admitted assets	14,518.4	11,994.8	11,036.0
Policy and contract claims	1,872.1	1,714.5	1,656.6
Other liabilities	6,809.4	5,551.2	4,946.6
Capital	37.1	34.8	31.3
Surplus	5,779.8	4,694.3	4,401.5
Ratio of premiums written to capital and surplus	2.2	2.3	2.2

*Data includes one life insurer.

3. Article 43 and Article 44 Corporations

Article 43 of the Insurance Law governs various nonprofit health insurers and Article 44 of the Public Health Law governs health maintenance organizations (HMOs).

a. Subscriber Rate Changes

Chapter 504 of the Laws of 1995 established a “file and use” procedure for premium rate changes for Article 43 and Article 44 corporations. This procedure is an alternative to the prior approval requirements of Section 4308(c) of the Insurance Law under specific conditions. This law permits an Article 43 or Article 44 corporation to submit a filing for a premium rate adjustment and such filing will be deemed approved upon a certification that the expected loss ratio will meet the minimum and maximum loss ratios prescribed in Insurance Law Section 4308(g). Premium adjustments using this methodology were previously limited to no more than 10% annually, but the annual cap was removed effective as of January 1, 2000. The 2007 file and use rate filings were as follows:

Type of Company	Filings
HMOs	77
Article 43 Corporations	25

b. Article 43 and Article 44 Corporations

The following tables show aggregate figures on assets, liabilities, surplus funds, premium income and membership for years 2004-2006:

Table 51
HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
2004-2006
(dollar amounts in millions)

	2006	2005	2004
Number of Companies	9	10	10
Admitted Assets	$5,426.0	$4,770.4	$4,558.0
Liabilities	2,634.9	2,536.6	2,519.4
Surplus Funds	2,791.1	2,233.8	2,038.6
Net Premium Income:			
Hospital	7,465.3	7,074.3	6,921.6
Medical/Dental	6,254.0	5,575.1	4,902.5
Number of Contracts & Riders in Force:			
Hospital	1.4**	1.4**	1.5**
Medical/Dental	1.7**	1.6**	1.6**

* Insurance Law Article 43 health service corporations are permitted by the provisions of Section 4301(e) of the New York Insurance Law to provide coverage for hospital service and medical and dental care. They are also granted certain additional powers to permit the development of comprehensive health care plans.
** in millions
Note: See first footnote, Table 53

Table 52
MEDICAL & DENTAL EXPENSE INDEMNITY CORPORATIONS
Selected Data, New York State
2004-2006
(dollar amounts in millions)

	2006	2005	2004
Number of Companies	3	3	3
Admitted Assets	$56.3	$44.6	$39.2
Liabilities	45.8	20.0	20.4
Surplus Funds	10.5	24.6	18.8
Net Premium Income	54.0	49.6	32.3
Number of Contracts in Force	1,599	1,492	1,344

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Table 53
HEALTH MAINTENANCE ORGANIZATIONS
That Are a Line of Business of a Health Service Corporation*
Selected Data, New York State
2004-2006
(dollar amounts in millions)

	2006	2005	2004
Number of Companies	3	3	3
Net Premium Income	$6,957.2	$6,570.4	$6,308.7
Number of Participants	1.7**	1.8**	1.9**

* Figures shown in this Table are included in the corresponding figures shown in the Table 51, "Health Service Corporations."
** in millions

Table 54
HEALTH MAINTENANCE ORGANIZATIONS
That Are Not a Line of Business
Selected Data, New York State
2004-2006
(dollar amounts in millions)

	2006	2005	2004
Number of Companies	21	21	21
Admitted Assets	$5,255.7	$4,753.0	$4,169.7
Liabilities	2,410.6	2,147.3	2,216.5
Surplus Funds	2,845.1	2,605.7	1,953.2
Net Premium Income	16,626.3	12,050.3	11,882.4
Number of Participants	3.9*	3.2*	3.4*

*in millions

4. Proposed Conversion of HIP and GHI to For-Profit Status

In April 2007 legislation was enacted that allows certain Article 43 corporations to convert from not-for profit status to for-profit status. On April 23, 2007, two such Article 43 corporations, Health Insurance Plan of Greater New York (HIP) and Group Health Incorporated (GHI), together submitted a proposed plan of conversion. HIP and GHI became affiliated entities, with a common parent, EmblemHealth, in October 2006. HIP and GHI remained separate operating companies. The proposed plan of conversion seeks to have HIP, GHI and certain related entities engage in a series of transactions that would result in the conversion of HIP and GHI to for profit status under a new holding company structure. The resulting New York licensees, one public health law article 44 HMO and one article 42 accident and health insurer, would be wholly-owned by a publicly traded holding company.

It is expected that, upon conversion, more than 20% of the stock of the publicly traded company would be sold to the public in an initial public offering. The enabling legislation requires that 90% of the proceeds of the sale of the stock be deposited with the "public asset fund" and 10% of the proceeds be deposited with a charitable organization. Similarly, the legislation requires that 90% of the unsold stock be held by the public asset fund and that 10% be held by the charitable organization.

Throughout 2007 the Department has been reviewing the plan of conversion to determine whether or not it fulfills the criteria for a approval as set forth in the law, specifically that it "will not adversely affect the applicant's contractholders or members, will protect the interests of and will not negatively impact the delivery of health care benefits and services to the people of New York and results in the fair, equitable and convenient winding down of the business and affairs of the applicant."

Department examiners, attorneys, actuaries and capital markets specialists comprise the in-house team reviewing the proposed plan. Additionally, the Department has engaged the services of outside consultants to aid in our review of the proposal.

The Department held two public hearings on the plan, one in New York City on January 29, 2008, and one in Albany on January 31, 2008.

5. Examinations and Investigations Conducted by the Health Bureau

During the year 2007, the field unit of the Health Bureau conducted 25 examinations and 13 investigations of regulated entities. The 2007 examinations and investigations by regulated entity and type are presented below:

	Total	**Examinations [1] Commenced in 2007**	**Examinations Commenced Prior to 2007**	**Investigations[2] Commenced in 2007**
By Regulated Entity				
CCRC	4	4	0	0
Commercial	14	7	2	5
HMDI	9	2	3	4
HMO	10	4	2	4
Muni-Coop	1	1	0	0
MLTCP	0	0	0	0
Total	**38**	**18**	**7**	**13**
By Type				
Financial	2	2	0	0
Market Conduct	14	1	0	13
Combined	22	15	7	0
Total	**38**	**18**	**7**	**13**

[1]In 2006, the National Association of Insurance Commissioners (NAIC) adopted revisions to the Financial Condition Examiners Handbook (Handbook) relating to a revised risk-focused examination approach. Although this new examination approach will be required for accreditation purposes, for all examinations beginning on or after January 1, 2010, the NAIC allowed the state examiners to begin implementing the revised exam approach in 2007. The revised approach is meant to broaden and enhance the identification of risk inherent in an insurer's operations and utilize that evaluation in formulating the ongoing surveillance of an insurer. In

accordance with the revisions made to the Handbook, there is greater focus placed upon a company's risk management culture, corporate governance structure, risk assessment programs and control environment.

In 2007, the Health Bureau conducted two risk-focused examinations, each encompassing two affiliated entities. The examinations of these entities were pilot examinations that utilized the new risk-focused examination approach.

(2)The Health Bureau initiated 13 market conduct investigations in 2007. These investigations targeted specific rating practices relative to the small group, Healthy NY and direct payment lines of business.

6. SERFF

To respond to the needs of the industry, the Health Bureau began accepting electronic filings of health insurance policy forms and premium rates through the NAIC's System for Electronic Rate and Form Filing (SERFF) in November 2004. The SERFF system enables insurers to submit form and rate filings electronically and facilitates electronic storage, management, analysis, disposition and communication regarding filings. SERFF helps eliminate incomplete filings and improves the quality of the submissions by detailing what insurers must file. In SERFF insurers can access each of the following:

- Standardized checklists, in accordance with NAIC recommended speed-to-market "best practices" for many products and establishment of databases containing the submission requirements for each product depending on the type of review requested.

- Links to statutes, regulations, circular letters and counsel opinions, which support and explain the requirements and templates of required certifications, where applicable.

In the calendar year 2005 (the first full year SERFF submissions were received), the number of form and rate filings submitted via SERFF averaged 36%, rising from 5% at the beginning of the year. During the calendar year 2006, the number of submissions continued to increase and averaged 59% by the fourth quarter. In 2007, the number of submissions continued to trend upward, averaging 61% for the entire year, but with the fourth quarter average rising to 77%.

The Health Bureau formed an internal workgroup, the Rate and Form Filing Task Force (RAFFT), to continue SERFF/speed-to-market compliance initiatives and provide for structured monitoring and maintenance as well as improve the rate and form filings process and review. The group meets bi-weekly to review the workload level and the processes for filing submission and review . As part of its commitment to increase communication with the industry, the RAFFT team presented a full day filing compliance seminar for industry filers in December 2007.

7. Review of Accident and Health Policy Form Submissions

In 2007, the Health Bureau made final dispositions on 1,414 accident and health policy form submissions (see Table 55A). A submission consists of one or more policy forms and, in some cases, related supporting actuarial material. These submissions were comprised of a wide range of accident and health insurance products from many different types of insurers and are offered in the individual, small group and large group markets. Insurers may use several means to obtain expedited review of their submissions. Highest priority is given to fast-track and deemer submissions submitted through SERFF. Of the 1,414 submissions disposed in 2007, 162 (11%) of them were submitted using fast-track and/or deemer. (Deemer submissions are submissions made under the expedited approval procedure set forth in Section 3201(b)(6) of New York Insurance Law. Fast-track submissions are

submissions made under the optional expedited prior approval using a certification process (Circular Letter No. 4 (2003)). SERFF submissions are electronic submissions made through the NAIC's System for Electronic Rate and Form Filing.)

Table 55
ACCIDENT & HEALTH
Disposition of Policy Form Submissions
2007

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Fraternal	Total
Approved	109	315	74	233	3	0	**734**
Not Accepted/ Circular Letter 14 (1997)*	4	89	25	3	0	0	**121**
Lack of Company Action	2	47	12	2	1	0	**64**
Disapproved	1	1	1	0	0	0	**3**
Filed for Reference	3	36	22	20	0	0	**81**
Prefiled	4	89	0	57	0	0	**150**
Withdrawn	4	38	18	10	0	0	**70**
Filed for Out-of-State Use	0	150	31	0	0	0	**181**
Other	5	3	2	0	0	0	**10**
Total	**132**	**768**	**185**	**325**	**4**	**0**	**1,414**

*This Circular Letter permits the Department to return all product and rate submissions that are incomplete, that are not drafted to comply with New York's statutory and regulatory requirements, or that are poorly organized or difficult to understand.

8. Review of Rate Filings by the Accident and Health Rating Section

Review of premium rates is performed in accordance with requirements in applicable sections of Insurance Law and corresponding regulations, which varies dependent upon the type of insurer and the nature of coverage. Rate reviews generally involve assuring that premiums are reasonable in relationship to benefits provided, and that premiums are not excessive, inadequate, or unfairly discriminatory. Such reviews encompass various types of individual, group, and blanket insurance coverages and include insurance products such as hospital and/or medical expense, prescription drug, Medicare supplement, dental, disability income, specified disease, long term care, accidental death and dismemberment and New York statutory disability coverage (DBL).

The Accident and Health Rating Section received 1,440 rate filings and disposed of 1,480 rate filings during 2007. These include initial rate filings for new policy forms submitted by commercial insurers, Article 43 corporations, Article 44 HMOs, as well as rate adjustment filings (primarily for commercial insurers), commission filings, experience monitoring filings, and rate manual revisions. In

2007 about 65% of the Accident and Health Rate Filings received were received through the System for Electronic Rate and Form Filing (SERFF).

The Accident and Health Rating Section also handles Insurance Law Section 4308(g) rate increase filings for Healthy New York and oversees the posting of updated rates for the Healthy New York plans on the Department's Web site. The Rating Section also collects monthly enrollment reports from the Healthy New York carriers. In addition to Healthy New York premium rates, the Rating Section posts updated premium rate information for Partnership and Non-Partnership Long Term Care premiums and Medicare Supplement premiums on the Department's Web site as well.

In September 2007, the Rating Section approved a service area expansion into the "North Country" (Clinton, Essex, Franklin, and St. Lawrence counties) for both MVP Health Plan, Inc. and MVP Health Insurance Company.

9. Inquiries and Complaints

In response to formal written inquiries and complaints, the Health Bureau provided written answers to 142 consumer inquiries, 24 legislative inquiries and complaints, 26 consumer inquiries forwarded from the Governor's Office, and 177 FOIL requests concerning accident and health insurance and related issues in 2007. In addition to formal responses to written complaints and inquiries, the Health Bureau monitors a dedicated mailbox on the Department's Web site. In 2007, the Health Bureau received and responded to close to 500 Health Mailbox inquiries from consumers, providers, health plans, attorneys, consumer advocate groups and state agencies. The most common electronic inquiries the Health Bureau received in 2007 included consumer complaints regarding increased premium rates, consumer inquiries relating to health insurance options in New York State, consumer complaints against their health plans, pre-existing condition provisions in health policies, mandated benefits, Timothy's Law, utilization review requirements and employer responsibilities in providing health insurance coverage.

In addition to written inquiries, Bureau staff also responds to telephone inquiries received daily from various sources. In 2007, Bureau staff responded to approximately 10,000 telephone inquiries.

10. Utilization Review Reports

Article 49 of the Insurance Law requires health insurers and utilization review agents under contract with health insurers to biennially report to the Superintendent on utilization review activities. During 2007, several new reports by utilization review agents were reviewed for compliance with Article 49 and placed on file with the Department and a number of existing reports were updated and renewed.

11. The External Appeal Law and Program (Chapter 586 of the Laws of 1998)

Recently completing its ninth year of operation, New York's External Appeal Program continues to provide New Yorkers with the right to obtain a review by independent medical experts when their health plan denies health care services as not medically necessary or because the plan considers the services to be experimental or investigational. Since the program's inception on July 1, 1999, through December 31, 2007, the Department has received 17,650 external appeal requests.

The external appeal law was amended as part of the Managed Care Reform Act of 2007 (Chapter 451 of the Laws of 2007) and the amendment is effective April 1, 2008. This amendment will allow an insured to appeal a health plan's denial of a request for pre-authorization to receive a health service from an out-of-network provider on the basis that such out-of-network health service is not materially different from the health service available in-network.

To be eligible for an external appeal, an insured, an insured's designee, or in certain cases, an insured's health care provider, must submit an external appeal request to the New York State Insurance Department within 45 days of receipt of a final adverse determination from a first level of appeal with a health plan, or upon waiver of the internal appeal process. The Insurance Department reviews requests for eligibility and completeness and randomly assigns appeals to one of three certified external appeal agents that have networks of medical experts available to review the appeal. External appeal agents customarily assign one clinical peer reviewer to medical necessity appeals and three clinical peers to review appeals of treatments considered to be experimental or investigational. Decisions must be rendered by external appeal agents within 30 days for standard appeals, or within three days for expedited appeals if the patient's attending physician attests that a delay would pose an imminent or serious threat to the health of the patient.

External appeal agents are certified by the Insurance Department and the Health Department for two-year periods and must meet certain certification standards. External appeal agents must have comprehensive panels of clinical peers available to review appeals and clinical peer reviewers must be appropriately licensed and trained in New York external appeal standards. The three certified external appeal agents that review external appeals in New York are Island Peer Review Organization (IPRO), Medical Care Management Corporation (MCMC) and Independent Medical Expert Consulting Services Inc. (IMEDECS).

The New York State Insurance Department is responsible for oversight of the External Appeal Program and is statutorily required to review the activities of health plans and external appeal agents, investigate consumer complaints, and determine compliance with external appeal requirements. Insurance Department staff is also available to handle external appeals submitted during business hours and after the close of business and two Insurance Department staff members are on call each weekend to handle expedited appeals.

Information about the external appeal program is available on the Insurance Department's Web site at www.ins.state.ny.us. In addition, the Insurance Department operates a dedicated toll-free hotline (1-800-400-8882) to respond to questions and assist in the filing of external appeal requests. In 2007, the Department received and responded to 7,763 hotline calls.

Along with monitoring the number of hotline calls, the Insurance Department also tracks external appeal results for each year of operation of the program. In 2007, the Insurance Department received 2,987 external appeal requests, which represented a 4.5% increase from the previous year. In addition, in 2007, 289 external appeal requests were closed because health plans voluntarily reversed the denial during the external appeal process, 887 external appeal requests were determined to be ineligible for external appeal, 1,705 determinations were rendered by external appeal agents and 106 appeals were still pending at the end of the year either because additional information was needed or an external appeal agent was reviewing the case.

Table 56A lists the number of external appeal determinations that have been either upheld or overturned, categorized by type of appeal. Table 56B identifies external appeal results by agent. The tables reveal that 46% of health plan denials were overturned in whole or in part by external appeal agents and 54% were upheld by external appeal agents in 2007. An external appeal that is overturned in part refers to one that is decided partially in favor of the consumer. For example, an HMO may refuse to pay for a five-day hospital stay asserting that it was not medically necessary, but that ruling would be overturned in part if the external appeal agent determines three days were medically necessary and two were not.

Table 56A
EXTERNAL APPEAL DETERMINATIONS BY TYPE OF APPEAL
January 1, 2007 — December 31, 2007

Type of Denial	Total	Overturned	Overturned in Part	Upheld
Medical Necessity	1,393	533	94	766
Experimental/Investigational	311	153	6	152
Clinical Trial	1	1	0	0
Total	**1,705**	**687**	**100**	**918**

Table 56B
EXTERNAL APPEAL DETERMINATIONS BY AGENT
January 1, 2007 — December 31, 2007

Agent	Total	Overturned	Overturned in Part	Upheld
IMEDECS	498	199	29	270
IPRO	572	234	40	298
MCMC	635	254	31	350
Total	**1,705**	**687**	**100**	**918**

Note: See text for full name of external appeal agents.

12. Market Stabilization Mechanisms

The Health Bureau oversees the operations of The New York Market Stabilization Pools. The Pools were initially established by Chapter 501 of the Laws of 1992 and associated Insurance Department Regulation 146 to stabilize premium rates in the individual, small group and Medicare supplement health insurance markets. The purpose of the Pools is to encourage insurers to remain in or enter the individual, small group and Medicare supplement health insurance markets, promote a marketplace where premiums do not unduly fluctuate, and ensure that insurers and HMOs are reasonably protected against unexpected significant shifts in the number of persons insured. The Pools collect annual revenues through contributions from HMOs and insurers in the individual, small group and Medicare supplement markets that insure a low proportion of high-risk, high-cost persons. Through the pool formula, these funds are then re-distributed to insurers and HMOs that insure a disproportionately large share of high-risk, high-cost persons in the same markets.

In 2007, the Health Bureau worked with carriers to create a new and simplified mechanism to stabilize premiums in the individual and small group market. The mechanism provides that carriers must contribute to a rate stabilization pool for any classes of business they insure that have a relatively lower proportion of high cost claims than other carriers in their region(s) of operation. Conversely for

any classes of business they insure that have a relatively higher proportion of high cost claims, carriers will receive risk adjustment pool disbursements. Carriers are to estimate what they expect to receive from the pools and apply those amounts to the classes of business that gave rise to the estimated distributions, to help hold down premium rates in those generally higher cost lines of business. The Health Bureau collected 2006 data to model the results of the new mechanism, and provided carriers with the calculated distributions based on that model data to assist them in estimating their respective 2007 pool receivables. These estimates based on 2006 model year data will be replaced by actual disbursement or contribution calculations in the spring of 2008 when 2007 data is used in the calculation.

In the Medicare Supplement market, a pool based on the average relative demographic profile of each carrier's insured population in comparison to the average profile of all carriers in its region of operation is used to determine whether a carrier is insuring a relatively lower risk lower cost population or a higher risk higher cost population that the average. Those with relatively low cost averages contribute to the pools to help stabilize the rates of those insuring relatively higher cost risks. The Medicare Supplement pool has been in place since 1993, and the form of pooling is the same as originally constructed under Insurance Department Regulation 146 at that time.

13. Health Care Reform Act of 2000 – Individual Market Reform

The Health Care Reform Act of 2000 (HCRA II) required the Insurance Department to administer the ongoing operations of a unique program designed to ensure that individual consumers have continued access to comprehensive health insurance. HCRA II allocated $130 million over a three and a half-year period commencing January 1, 2000, and ending July 1, 2003, to direct payment market reforms. For the HCRA III and HCRA IV periods, funding was renewed at $40 million per year. Funding has remained at $40 million each year since 2003.

HCRA II required the establishment of two state-funded stop loss funds which operate on a calendar-year basis from which HMOs may receive reimbursement for certain claims paid on behalf of members covered under individual enrollee direct payment contracts. These stop loss funds are established for the purpose of stabilizing the premium rates for such individual standardized health insurance contracts for the benefit of both existing enrollees and currently uninsured individuals seeking to purchase health insurance coverage.

The Department is responsible for ensuring that the premium rates charged for the standardized direct payment contracts correctly account for the availability of stop loss funding. The Department works to: (1) ensure that HMOs have appropriately adjusted for the stop loss funds in utilizing the file and use mechanism for effectuating rate increases; (2) monitor anticipated claims against the stop loss funds; and (3) ensure that minimum loss ratio requirements for these products are satisfied.

The Department is also responsible for oversight of the distribution of the allocated funding to HMOs submitting valid claims for reimbursement from the stop loss funds. Beginning in the first year of the program, the Department hired a stop loss fund administrator to oversee this process. The Department has developed a quarterly reporting process to track expected expenditures from the stop loss pools.

By April 1 of each year, health plans are required to submit their requests for reimbursement from the stop loss pools for claims paid in the prior calendar year. The requests specify the claims for each of the two direct payment products separately. The fund administrator then conducts the necessary audits with respect to the data and once the administrator is satisfied as to the legitimacy and accuracy of the reimbursement requests, it tabulates and renders a comprehensive, proposed distribution summary for Department review. The Department oversees the fund administrator in the processing of preliminary notifications and claims reimbursement requests, audits of data submissions, and preparation of pro-rata distribution schedules.

During 2007, the Department directed the administrator to conduct the necessary audit procedures with respect to the 2006 reimbursement requests submitted by carriers. In addition, the administrator was asked to tabulate and render a comprehensive proposed distribution summary for Department review. As in the prior years, the total reimbursement requests for Calendar Year 2006 exceeded the total funding available in both the standard direct payment business and the direct payment out-of-network (point-of-service) business. The fund administrator was directed to reduce the amounts requested on a pro-rata basis to match available funding in each of the respective funds.

The total requests for reimbursement, funding available, and final pro-rata distribution percentage were as follows:

Product	Requested Reimbursement	Funding Available	Percentage Reimbursed
Standard HMO Direct Payment	$61,333,514	$20,000,000	32.6%
Out-of-Plan (POS) Direct Payment	$39,211,214	$20,000,000	51.0%

The schedule of payments for all participants was reviewed by the Health Bureau and authorized for distribution to the HMOs.

14. Health Care Reform Act of 2000 – The Healthy NY Program

The Health Care Reform Act of 2000 (HCRA II) created the Healthy NY program and gave oversight to the Insurance Department. The program was intended to create a less expensive health insurance product for vulnerable small businesses, sole proprietors and low income individuals meeting certain eligibility criteria. The Healthy NY program is a unique approach to addressing the problem of the uninsured. New York was unable to rely upon prior experience or the experience of other states in implementing the program. The Department worked vigorously during the year 2000 to implement the various components of the program to ensure that it was available to consumers as of January 1, 2001. Today, this program serves as a national model for creating a private-public partnership that utilizes reinsurance to reduce premiums.

Statistics show that a significant percentage of New York's uninsured are currently employed, primarily by small employers. Therefore, the Healthy NY program attempts to alleviate the problem of the uninsured by targeting both small employers and individuals with more affordable health insurance options.

All HMOs licensed in New York State are required to sell Healthy NY's standardized benefit package to those who qualify. The benefit package is scaled down, yet comprehensive. The HMO coverage includes benefits for inpatient and outpatient hospitalization; physician's visits; outpatient facility charges; pre-admission testing; maternity care; adult preventative services and immunizations; well child visits; diabetes supplies, equipment and education; diagnostic x-ray and laboratory services; emergency services; radiological services chemotherapy; hemodialysis; blood and blood products; post hospital or post surgical home health care and physical therapy and an optional prescription drug benefit (up to $3,000 per person per year). With a view towards affordability, the Healthy NY benefit package does not cover certain services including alcohol and substance abuse services, mental health services, durable medical equipment, ambulance services, and chiropractic services.

The Healthy NY product includes a unique rating structure designed to combine the experience of participating individuals and small groups. The program also utilizes state funds to reinsure high-cost

claims, a feature designed to reduce premium rates and limit the exposure of HMOs to excessive health care costs. The 2007 annual study of the program found that Healthy NY offers premium savings of more than 70% when compared with the individual direct payment market.

The major responsibilities of the Department in connection with the oversight of the Healthy NY program for year 2007 included the following:

a. Program Oversight

The Insurance Department is solely responsible for the oversight of the Healthy NY program. Throughout calendar year 2007, the Department continued to provide education and guidance to the industry on program requirements. The Department's third regulatory amendment was finalized. This third amendment created a high deductible option in Healthy NY that, if chosen, would allow the participant to be entitled to federal tax savings through a health savings account. The new high deductible option allows consumers to reduce their Healthy NY premiums by approximately 22%. Implementation of this new program option required extensive health plan guidance, the approval of new contracts and premiums rates for each health plan, and the development of new Web site materials and consumer publications. The Department continued to monitor the program for areas of potential improvement. The Department engaged in public awareness campaigns, industry outreach, education, enhancements to the Department's Web site, and numerous other efforts. As the program continues to grow, the Department continues to respond to questions of first impression and to provide continuing guidance to the health plans.

b. Eligibility Issues and Education

The Healthy NY program includes fairly complex eligibility rules which differ for individuals, individual proprietors and small employer groups. All HMOs are required to have staff fully versed in making eligibility determinations. The Department has provided and continues to provide extensive training and guidance to HMOs in this regard. Policy with respect to eligibility determinations continues to evolve. The Department continues to oversee and educate its contractor of the Healthy NY toll-free hotline that was established to address consumer questions and also to provide support to the Consumer Services Bureau when Healthy NY issues arise.

c. Guidance and Publications

The Department has provided extensive guidance to the HMOs to ensure standardized administration of the Healthy NY product. This has been facilitated by electronic guidance memos sent to designated staff at each HMO. This approach ensures wide dissemination of information concerning the program, and assists in standardization of its administration.

The Department has continued to enhance and update its Healthy NY publications. In 2007, the Department completely revised the consumer guide, applications and brochures. These documents describe the program and answer common questions on eligibility. It is available to callers of the Healthy NY hotline, consumers making inquiries to the Department and is also mailed by the HMOs to interested callers.

d. Rating of the Healthy NY Product

The Department is responsible for the review and approval of the rates for the Healthy NY product. Given the uniqueness of the Healthy NY product, it has been necessary for the Department to provide extensive guidance to insurers to ensure that the premium rates are established and adjusted appropriately. Rates must account for the availability of stop-loss funding. Rate increases must be monitored based on actual claim and stop-loss experience. The "file and use" method of raising premium rates has presented regulatory challenges for this coverage provided to premium

sensitive small businesses and consumers. As rates continue to increase, it is harder to attract these lower-income people into the program.

e. Stop-Loss Funds

The Insurance Department is responsible for the oversight of the two stop-loss funds established for the purpose of reimbursing health plans at a percentage of eligible high cost claims paid under Healthy New York contracts. The Superintendent is required to monitor claim levels and cap enrollment if it appears increases will result in claim reimbursement requests in excess of appropriated funding in any calendar year. To monitor claims, Department guidelines require that HMOs provide quarterly preliminary notifications of potentially eligible claims throughout the year, with sufficient detail to allow the Superintendent to project an estimated aggregate claim level for all carriers across the State for the full year.

Reimbursement requests for each calendar year are due by April 1 of the following year. Upon receipt of reimbursement request schedules, the Department works with an outside fund administrator to determine the validity of the claims reported. This involves review, audit and, if necessary, adjustment of requested reimbursement amounts. After audit/adjustment, a schedule of payments for the calendar year for all participants is prepared by the administrator and reviewed by the Health Bureau.

Funding for 2006 was sufficient to cover all valid 2006 reimbursement requests, and disbursement was authorized and paid out in 2007 in the following amounts:

Healthy New York Qualifying Individual Claims	$66,301,509
Healthy New York Small Employer Claims	$58,346,147

Reimbursement requests for 2007 claims are due by April, 1 2008, and will be tabulated and audited and are scheduled for payment in 2008.

f. Tracking Maximum Enrollment in Healthy NY

The Department continues to monitor enrollment in Healthy NY and, as enrollment climbs, estimate maximum enrollment in the program that can be supported to suspend enrollment in the event that demand for the program exceeds available funding. The Department has been working to develop estimates of enrollment and the resulting calendar year paid stop-loss claims for that enrollment, based on modeling of the variation of expected stop-loss calendar year paid claims, by issue month, as the program continues to mature. A process has been established to track monthly enrollment in the Healthy NY program. Monitoring of actual enrollment by month will include ongoing adjustment of maximum enrollment if necessary.

g. Annual Study of the Healthy NY Program

The Department is responsible for an annual study of the Healthy NY program which includes an examination of employer participation; an income profile of covered employees and qualified individuals; claims experience; and the impact of the program on the uninsured. The current contractor for the study is EP&P Consulting, Inc. Department staff work with the contractor to provide updated information, ensure cooperation by health plans and answer questions about program requirements.

h. Coordination with Other Public Programs.

Healthy NY is designed to complement and build upon both the existing Child Health Plus program and the Family Health Plus program that were also authorized as part of HCRA of 2000. Ongoing coordination with the Department of Health is necessary to ensure that the eligibility standards

utilized by these programs mesh to the extent feasible. The Department is working to ensure that consumers receive information that facilitates their enrollment in the program that is most appropriate.

i. Consumer Contact

The Department continues to respond to a significant volume of consumer questions and issues regarding the nature and operation of the Healthy NY program. The Department has worked to address consumer issues with the HMOs to ensure appropriate and correct resolution. An e-mail box linked from the Healthy NY Web site is available for consumers to contact the Department with questions. A toll-free hotline provides consumers with information about the Healthy NY program. Additionally, Department staff respond directly to a large volume of consumer telephone and written inquiries. The Department will assist applicants who believe they have been wrongfully denied enrollment in the program. In 2007, the Department launched an online eligibility screening tool that consumers can use to determine if they might be eligible for Healthy NY. There are separate tools for individuals, sole proprietors and small employers. Users are led through a short series of eligibility questions and important definitions and explanations of program rules are provided, so that users can make informed responses.

j. National Interest in Program

The Department continues to receive an ever-increasing number of speaking requests emanating from small business groups, chambers of commerce, not-for-profit activists, educators, analysts and brokers. The Department has participated in numerous forums concerning options for the uninsured and small business health insurance.

In addition, the program receives an increasing amount of interest from other states, federal legislators and other governmental agencies. Staff have presented at national forums and academic conferences as a result of the high level of interest. To date, the Department has been contacted directly by California, Colorado, Florida, Illinois, Kansas, Maine, Missouri, New Jersey, North Carolina, Oregon, Pennsylvania, Tennessee, Texas, Vermont, Washington and Wisconsin. In addition, there have also been inquiries from NCOIL (National Conference of Insurance Legislators), the Urban Institute, Academy Health, Rutgers University, Wake Forest University, the offices of Sen. Edward M. Kennedy of Massachussetts, and Gov. Arnold Schwarzenegger of California, and various researchers. The program has been featured in numerous academic papers and articles, including the book *Reinsuring Health*, by Katherine Swartz, Ph.D. of the Harvard School of Public Health, published in 2006.

k. Marketing and Outreach

Until this year, the Healthy NY statute allowed for the expenditure of up to 10% of the program's funds on public education, radio and television outreach and facilitated enrollment strategies. During 2006, this amount was reduced to 8% by legislative action. The 2% reduction was allocated to the support of two pilot programs: Brooklyn HealthWorks and Healthy NY Upstate Pilot Project (see items 14 and 15 below). Marketing and outreach efforts are crucial to the success of the program. The Department has established a toll-free hotline to provide consumers with information about the Healthy NY program. The Department has also developed and distributed informational materials regarding the program and has made extensive information available on a Healthy NY Web site. The Department developed and distributed Healthy NY marketing materials and brochures. Public presentations were also conducted to reach many small businesses and chambers of commerce.

15. Brooklyn HealthWorks

In Chapter 441 of the Laws of 2006, the New York State Legislature allocated funds from the Healthy NY stop-loss funds for the support and expansion of Brooklyn HealthWorks. Brooklyn

HealthWorks (BHWx) is a pilot program run by the Brooklyn Alliance, which provides access to affordable health insurance for small businesses in the Borough of Brooklyn. Brooklyn HealthWorks essentially offers GHI's Healthy NY product with a few minor adjustments and an additional subsidy of 15-16% of the premium.

In response to the legislation, the Department negotiated a single-source contract with the Brooklyn Alliance, Inc. The contract was entered into as of March 29, 2007, and authorizes the Insurance Department to pay the Brooklyn Alliance $311,100 per year for costs, fees and disbursements associated with the administration of the program. BHWx staff handles outreach for its members and maintains records documenting the amount billed by the insurer (GHI), the amount paid by each employer group, and the amount of subsidy provided through the program. In addition, the BHWx staff submits invoices requesting subsidy payment to the Insurance Department.

Insurance Department staff review subsidy payment requests and forward appropriate requests for payment to the Office of the State Comptroller. Subsidy payments are made directly to GHI in order to maintain seamless coverage for the program's member groups. During 2007, the Insurance Department authorized payment of subsidy in the amount of $123,475.

Insurance Department staff is also responsible for reviewing contract payment requests submitted by Brooklyn HealthWorks to determine if the requests are fully supported by appropriate documentation. Once the contract payment requests are verified and approved they are forwarded to the Office of the State Comptroller. During 2007, the Department authorized total contract payments of $266,019. In September 2007, Brooklyn HealthWorks made a request to increase the contract amount to $416,100 to cover the cost of hiring additional staff, higher occupancy/operation costs and nominal inflation increases. The request is currently pending.

16. Healthy NY Upstate Pilot Project

In Chapter 441 of the Laws of 2006, the New York State Legislature allocated $2.5 million in funds from the Healthy NY stop-loss funds to be divided between Brooklyn HealthWorks and the development of an upstate health insurance pilot program. In response to the legislation, Department staff wrote a Request for Proposal (RFP) for a Healthy NY Upstate Pilot Project Administrator. The RFP stated that the purpose of Upstate Pilot Project is to "leverage the Healthy NY model to insure a population of New Yorkers that the program has not previously been able to reach." Bidders were encouraged to submit creative and innovative proposals to increase Healthy NY enrollment in upstate counties of the bidders choosing. The bidder also had to show sufficient familiarity with, and connection to, their chosen target counties.

The RFP was published in August 2007, and 8 bids were received in October. The procurement had a two-step evaluation process. The first step involved a technical evaluation of each bidder's statement describing how the proposals met the functional description of the project definition, and the bidder's relevant experience and qualifications. The first step also contained a financial evaluation of the proposal. The financial and technical scores were combined, and the top three bidders emerged at the completion of this first step in the process.

The top three bidders were invited into the Department to provide oral presentations of their proposals and the Department is in the process of scoring the three presentations. It is anticipated that a bidder will be selected in 2008.

17. Federal Tax Credit Initiative

The federal Trade Adjustment Act of 2002 made a 65% health insurance tax credit available to certain eligible citizens. Those eligible for the tax credit include: (1) those who are receiving trade adjustment benefits because they have lost their jobs due to changes in international trade; and (2)

retirees whose pensions had been taken over by the Pension Benefit Guarantee Corporation. This credit is estimated to be available to approximately 11,000 New Yorkers or an estimated 22,000 covered lives (including dependents). The tax credit includes some unique features including a pre-payment feature whereby an eligible individual can request to receive the benefit of the tax credit in advance in order to pay health insurance premiums as they become due. In the event prepayment is requested, the federal government makes payment directly to the insured's health insurance plan.

Because of limitations in the federal law, this tax credit could only be applied to limited forms of coverage without State action to develop State-qualified health insurance coverage. The Bureau made changes to the Healthy NY regulation to qualify Healthy NY coverage for the credit. The Bureau also worked with insurers to make a health insurance package with benefits mirroring the Healthy NY product available to those who did not meet Healthy NY's eligibility criteria. The content of these packages was negotiated with the federal government and these products were selected as qualifying health insurance products. The New York Legislature also made changes to New York's standardized direct payment products to qualify them for the federal tax credit.

The Bureau continues to assist consumers with accessing the tax credit in conjunction with the New York State health insurance market. Information regarding the availability of this tax credit has been posted to the Insurance Department's Web site.

18. COBRA Subsidy Demonstration Project

The Health Bureau has been statutorily charged with implementing the New York State health insurance continuation assistance demonstration project. The statute created a pilot program designed to assist entertainment industry workers. The program is designed to subsidize the Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums for the populations defined in the statute. Funding of $2.5 million annually has been given to the COBRA program for entertainment industry employees.

The Health Bureau worked to implement the entertainment industry employees program, and began accepting applications on January 1, 2005. Entertainment industry employees often experience episodic employment, and must use COBRA to continue their health insurance coverage during the periods of unemployment. The focus of the program has been to relieve some of the burden of paying COBRA premiums for this unique section of working New Yorkers. Applicants must meet certain income limits, reside in New York, and belong to an entertainment industry union to be accepted into the program. The Department is responsible for reviewing applications for eligibility, communicating with unions and their members, processing invoices for payment on a monthly basis and maintaining certain records and databases.

For the entire year of 2007, Department staff processed a total of 299 applications and paid out more than $673,720 in premium assistance. Payments were made to 16 union funds, the most highly represented being Equity League (approximately 204 enrollees) and Screen Actors Guild (approximately 73 enrollees).

To date, the program has assisted about 1,160 entertainment industry employees.

19. Continuing Care Retirement Communities (CCRCs)

The Insurance Department has a permanent seat on the Continuing Care Retirement Community Council. This council has the primary licensing and oversight authority for CCRCs. The Insurance Department has specific responsibility for the review of the contract and disclosure documents given to residents and prospective residents, as well as an initial determination of the financial feasibility of a proposed project and ongoing oversight of the fiscal solvency of communities. The Bureau's continuing oversight encompasses review of the rating structure of a community, adequacy of reserves and

periodic on-site examinations of the financial condition of a community. To this end, the Department initiated four examinations of CCRCs in 2007, developed revisions to the Department's annual statement for financial filings, and adopted the first amendment to the Department's regulation relating to CCRCs.

Currently, there are 13 CCRCs in New York, each one with a Certificate of Authority issued by the CCRC Council. Of these thirteen, nine are fully operational, two have been approved to obtain financing and begin the construction phase, and two are in the process of collecting entrance fee deposits.

20. Long Term Care Insurance

a. Tax Qualified Long Term Care Insurance Marketed on an Indemnity Basis as Permitted by the Internal Revenue Code (IRC) due to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Although the industry continues to sell tax qualified long term care insurance products which limit benefit payouts to long term care expenses actually incurred for qualified long term care services, the insurance industry began to encourage the sale of the indemnity option for tax qualified long term care insurance available under pertinent provisions of the IRC. In sum, benefits under this tax qualified long term care insurance indemnity option are paid without regard to the type and amount of qualified long term care expenses incurred. If benefit payments under this indemnity option exceed expenses for qualified long term care services received, or if the benefits paid under this indemnity option exceed certain per diem limits prescribed in federal law, these excess benefit amounts may be taxed rather than receive favorable federal and New York State tax treatment under current federal and New York State laws.

A tax qualified long term care insurance policy prominently states that it is intended to comply with federal law so that favorable federal income tax treatment (and accompanying favorable New York State income tax treatment) can be given to the coverage. Therefore, the design of this indemnity option presented certain concerns to the Department when certain possible claim scenarios could result in a sizeable tax bill for an insured contrary to how the tax qualified long term care insurance product is labeled and marketed.

The Health Bureau set appropriate guidelines and approval conditions for such indemnity long term care insurance products. The guidelines and conditions provide disclosure for an insured purchasing such indemnity products and are based upon statutory authority granted to the Insurance Department by Sections 1117(g)(1) and (g)(2)(B) of the Insurance Law.

As this indemnity market evolves, the Health Bureau will continue to monitor these guidelines and approval conditions for appropriate modifications to assure consumer protection and stability in New York State long term care insurance markets.

b. Policies under the NYS Partnership for Long Term Care Program

In conjunction with the Department of Health, the Health Bureau worked on issues such as modifying the New York State Partnership for Long Term Care insurance product design. In 2005, the Department promulgated the Second Amendment to Regulation 144 which was designed to make more affordable benefit options and a range of incentives available through the NYS Partnership for Long Term Care program. By December 2006, all five Partnership insurers began marketing the four new plan designs. In 2007, the Health Bureau continued to participate in the Evolution Board with the Department of Health, Office for Aging, and all participating insurers to monitor the Partnership

program, resolve issues, and make appropriate modifications to assure consumer protection and stability of the NYS Medicaid program.

c. Federal Deficit Reduction Act

The federal Deficit Reduction Act, enacted in 2006, expanded the Partnership for Long Term Care concept to other states, but exempted the four existing states with Partnership programs (New York, California, Connecticut, and Indiana). In conjunction with the Department of Health, the Health Bureau monitors activities and standards of the new Partnership states, counsels states entering this field, and determines any possible impact on New York's current program and policies.

d. Long Term Care Financial Planning Options

Throughout 2007, the Health Bureau met extensively with the Department of Health to assist them in developing recommendations for numerous financial planning options for long term care services. These options are intended to encourage personal planning for future long term care costs which is anticipated to also reduce Medicaid costs. Some of the concepts would require further development and counsel from other agencies including the Departments of Budgeting, Tax and Civil Service, to prepare draft legislation while other recommendations may be implemented through Department regulation.

e. Sample Premium Rates on Web site

In 2006, the Health Bureau, in conjunction with the Systems Bureau, created an interactive page on the Department Web site that provides consumers with sample premium rates for long term care insurance. Through this tool, consumers can learn the approximate cost of long term care insurance coverage for certain levels of coverage.

In addition, the interactive nature of the tool allows a consumer to perform "what ifs" to see the actual effect on premiums that result from various purchasing decisions. For example, comparing the premium at the consumer's current age to a future age clearly shows the price impact of delaying the decision to purchase long term care insurance. Comparing the premium for various elimination periods clearly shows the savings in premium if a consumer elects a longer period of self-payment once the consumer requires long term care services but before the company starts paying benefits. This site also allows the consumer to print the results for use when discussing a potential purchase with an agent. The initial rollout contained sample premium rates for all four Partnership plan designs currently marketed by each of the five Partnership insurers.

In 2007, the Bureau expanded this interactive tool on the web site to include all actively marketed non-Partnership policies. This was an extensive undertaking because of the number of companies and policies involved.

f. Consumer Education

Long Term Care Insurance Education and Outreach centers, headed by the State Office of Aging, provide the public with educational and informational materials regarding long term care insurance and provide counseling and direct assistance to help consumers understand policy options, benefits, and obtain the appropriate long term care insurance coverage. The Health Bureau works closely with the State Program Coordinator to provide the necessary information to train the counselors and answer their on-going questions regarding long term care insurance.

The Health Bureau also updates the Department Web site and the consumer guide to long term care insurance. These sources were expanded in 2007 to include information on the history of premium increases granted by the Department, explain the effect of a company deciding to stop selling

a particular policy to new individuals, and to streamline the information regarding insurers currently offering the various types of long term care insurance.

g. Elder Care Unit

This was the first full year of operation of the Elder Care unit of the Health Bureau which focuses on health insurance issues related to the elderly including long term care insurance, Medicare, Medicare supplement insurance, managed long term care and continuing care retirement communities. By devoting resources to the particular insurance issues of this elderly population, the Health Bureau is in a better position to identify and resolve insurance issues relating to this population. This ability to focus on insurance issues relating to the elderly becomes very important as the large baby boom generation ages and their need for insurance products related to the aging process increases. This unit fulfills a need as highlighted by the Project 2015 report as a large segment of New York's population grows older.

In 2007, the Elder Care unit also participated actively in consultation with the Life and Consumer Services Bureaus to coordinate accident and health insurance issues. This coalition monitors and discusses numerous senior protection issues related to insurance including industry market conduct, marketing practices to senior citizens, consumer complaints, issues related to approval and examination processes and industry reports regarding long term care claim denials.

21. Managed Long Term Care Plans

Managed long term care plans coordinate home care with other appropriate services, including primary medical care, acute hospital care, and nursing home care to chronically ill and disabled adults who qualify for nursing home care. The plans target the Medicaid and/or Medicare eligible population who are in need of daily supervision and care. Some plans include a small private pay population, and federal regulations permit a private pay population for federal PACE plans operating as managed long term care plans.

Although the Department of Health is the lead agency in the regulation of such plans, the Superintendent of Insurance is given distinct statutory duties in approving certain premium rates and enrollee contracts for such plans and in the review of the fiscal solvency for such plans under Section 4403-f of the Public Health Law.

During 2007 the Insurance Department engaged in detailed discussions with the Health Department about solvency regulation of managed long term care plans which are new or seek to expand. Managed long term care plans which are new or seek to expand are writing Medicaid Advantage Plus and Medicare Advantage lines of business according to Health Department requirements. In those instances, the Medicaid Advantage Plus and Medicare Advantage lines of business are not subject to Insurance Department or state regulatory oversight in all respects, presenting challenges to the Insurance Department solvency regulation of managed long term care plans operating Medicaid Advantage Plus and Medicare Advantage lines of business. The Insurance Department continued to work with the Health Department during 2007 on the noted solvency issues/challenges.

In 2007, the Health Bureau continued its practice of reviewing and approving forms and rates for private pay participants in approved managed long term care plans. The Health Bureau also provided comments to the Health Department concerning advertisements and marketing materials of these plans pursuant to Section 4403-f(7)(c)(ii) of the Public Health Law.

The Insurance Department continues to work with the Health Department on a daily basis in regulating managed long term care plans as mandated by the statutory role given to the Insurance Department for managed long term care plan regulation.

22. Medicare Beneficiaries' Issues

The Health Bureau has been an active member with other state regulators, consumer representatives, the Centers for Medicare and Medicaid Services (CMS), and industry representatives on the NAIC Senior Issues Task Force (SITF) Medicare Private Plans Subgroup participating in meetings, conference calls, and idea-sharing. The United States Congress asked the Subgroup to investigate nationwide allegations of fraud and abuse in the marketing and sale of Medicare Advantage (MA) plans and recommend possible solutions to combat the problems. To that end, the Subgroup conducted a hearing in Washington D.C. to take testimony and is in the process of drafting a paper outlining options for measures that can be taken to alleviate fraud and abuse. The final version of the paper will be presented to Congress in 2008. Among the potential solutions is giving authority to the states to regulate MA plans. Currently, state law is preempted by federal law in all aspects of MA regulation except licensing and solvency. The states and consumer advocacy groups believe that state insurance departments are in a better position to regulate entities operating within the state to protect consumers.

The Health Bureau also participates in the SITF Medigap Subgroup, which, in 2007 focused on innovative benefits. The Medigap Subgroup was charged with reviewing the standardized Medicare supplement plans and making recommendations to the Task Force through the modification of the NAIC Medicare Supplement Insurance Model Regulation. The Bureau participated in numerous meetings, conference calls, and assisted in drafting changes to the model regulation. The changes seek to streamline and modernize benefits and benefit plans, while minimizing beneficiary confusion and increasing beneficiary choices. The SITF (B) Committee voted to adopt the changes to the model regulation and the Bureau continues to monitor legislative action related to the implementation of the model regulation. As a part of the Medigap Subgroup, the Bureau also revised sections of the compliance manual for the Model Regulation on the topic of new and innovative benefits in Medicare supplement insurance.

CMS mandates that companies writing Medicare Part D prescription drug coverage are licensed in the state where they were proposing to operate, or obtain a federal waiver of the state licensure requirement. CMS requires state certification of licensure and financial solvency. Upon company request, the Health Bureau reviewed the legal and financial aspects for health insurers requesting the certification and provided companies with letters of good standing indicating that the company is licensed in New York and meets state financial requirements. Good standing letters were also provided to requesting health insurance companies and HMOs expanding participation and entering the Medicare Advantage market. Although the Department does not regulate the Medicare Part D or the Medicare Advantage program, the Health Bureau was able to verify the status of the companies licensed in the state and provide requesting companies with letters of good standing needed by the companies for furnishing to CMS.

Each year MA plans have the option to reduce their service area or terminate their MA contracts. MA plans that opt to non-renew or reduce their service area must notify CMS and are also required to send enrollees notification letters. In October, CMS announced that 749 New York residents would be affected by nonrenewals. To assist New York residents being terminated by their MA plans, the Health Bureau coordinated with CMS and posted notice on the Insurance Department's Web site containing information on choices for these affected residents. The notice explained the difference between the options of enrolling in another MA plan or returning to original Medicare with the purchase of a Medicare supplement insurance policy to help defray some of the costs not covered by Medicare. The notice also reminded those interested of how to prevent gaps in coverage to avoid having to satisfy requisite pre-existing condition waiting periods when enrolling in a new plan.

23. Innovative Health Insurance Products

a. Long Term Care Insurance

The Bureau continued to encourage companies to experiment with innovative products that provide long term care insurance. The more that consumers personally plan for the financing of future long term care services by purchasing long term care insurance, the more that savings for New York's Medicaid program can be realized.

The Bureau previously approved an innovative product that combined the option to purchase long term care insurance without proof of insurability with disability income or life insurance policies. These provided consumers with an inexpensive way to assure themselves the ability to purchase long term care insurance coverage in the future without risking denial due to a health condition.

Another innovative long term care insurance product approved by the Bureau requires satisfaction of a deductible and provides benefits as a percentage of incurred expenses. This design varies significantly from products that provide benefit payments with a daily or monthly maximum.

b. Managed Long Term Care

Some managed long term care plans granted certificates of authority (COAs) by the Health Department under Section 4403-f of the Public Health Law are also granted other COAs by the Health Department to operate as other entities in addition to being managed long term care plans. Using these other COAs granted by the Health Department, some of these managed long term care plans have evolved into entities operating as federal Medicare Advantage organizations, Medicaid Advantage Plus plans and federal PACE organizations. The Bureau expects this type of evolution to continue. These managed long term care plans operating other lines of business or operating federally recognized organizations within a managed long term care plan framework can present unique challenges to the Insurance Department in the regulation of the enrollee contracts, rates, and solvency of managed long term care plans. (Under Section 4403-f of the Public Health Law, the Insurance Department has a statutory role in regulating plans conducting a managed long term care business.) The Bureau continues to meet these unique challenges presented by these innovations in managed long term care plans by innovative solutions in managed long term care plan regulation. Some managed long term care plans can cover private pay populations (in addition to Medicaid and Medicare populations) as allowed by federal regulations pertaining to PACE organizations. Some managed long term care plans now cover small private pay populations. The Insurance Department has a long history of regulating private pay populations in managed care entities. The Health Bureau continues to work closely with the Health Department in fulfilling the Insurance Department's statutory role in regulating the ever evolving managed long term care plans and in fulfilling our traditional role of regulating private pay populations in managed long term care plans.

c. Prescription Drug Coverage

The Health Bureau continued to evaluate a number of innovations proposed by health insurance plans to contain the rising cost of prescription drug coverage. These innovations included use of multiple tiered formularies, mandatory use of specialty pharmacies for the provision of select high cost drugs, implementation of "step therapy" programs which require the covered person to access lower cost alternative drugs prior to receiving reimbursement for a higher cost drug, "pill splitting" proposals, mandatory mail order benefits and similar proposals. Each proposal required that the Bureau analyze its legality, its practical impact on both the consumer and the health plan and whether the proposal could be administered effectively. Often the issues required consultation with the Department of Health. As a result of this rapidly changing market, the Health Bureau may consider regulatory amendments to establish minimum standards for the form and content of prescription drug coverage.

24. Health Savings Accounts/High Deductible Health Plans

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, entitled the "Health Savings and Affordability Act of 2003," gives eligible individuals the right to establish Health Savings Accounts (HSAs). One of the eligibility criteria to establish an HSA is that the individual must be enrolled in a qualifying high deductible health plan (HDHP). The Health Bureau has continued to review and approve HDHP submissions from insurers and Article 43 corporations and has continued to respond to numerous inquiries from consumers, advocates and the media regarding HSAs and HDHPs.

25. Child Health Plus

During 2007, the Department continued its role of reviewing and approving subscriber contracts and premium rates for the Child Health Plus program. During 2007, the Department reviewed and approved a number of Child Health Plus rate adjustment submissions. Rate review was limited, however, by the provisions of the 2007 legislative moratorium on rate changes for the Child Health Plus program from April 1, 2007 to March 31, 2008.

26. Early Intervention Program

During 2007, the Bureau continued its proactive role in assisting the Department of Health's Early Intervention Program to appropriately claim third party health insurance coverage for services rendered by the Program, as required by Public Health Law. Bureau staff continue to represent the Department on the Early Intervention Coordinating Council. Staff members also participate in monthly meetings with the Department of Health to discuss insurance-related issues brought to the Department of Health's attention by the county providers of early intervention services and investigate claims denials brought to their attention by the early intervention providers.

27. Pre-Existing Condition Provisions in Group and Blanket Disability Policies

In June 2007, the New York Court of Appeals issued a unanimous decision in *Benesowitz v. Metropolitan Life Insurance Company,* 8 NY3d 661 (2007). The decision in the case construed New York Insurance Law Section 3234(a)(2) to establish a waiting period, rather than a total bar, for coverage of disabilities due to a pre-existing condition that begin within 12 months of an insured's effective date of coverage. The Insurance Department subsequently received inquiries from insurers requesting guidance from the Department with respect to implementation of the Court's decision. The Insurance Department issued Circular Letter No. 14 (2007) which instructed insurers writing group or blanket disability insurance as to the remedial actions to be taken by them.

28. Coverage of Childhood Immunizations.

The Health Bureau participated in a number of meetings with the DOH's Office of Public Health and DOH's Immunization Program to discuss coverage of pediatric immunization under our well-child mandate. To address inadequate reimbursement levels for physicians providing pediatric immunizations, the DOH is proposing to implement a Universal Vaccine Program wherein the state purchases the vaccines in bulk using money from the covered lives assessment (CLA) and supplies the vaccines to the providers.

In furtherance of the objective, the Bureau has reviewed the proposed changes to the applicable sections of the Insurance Law and plans to survey the health plans in order to obtain more information regarding reimbursement of pediatric immunizations.

29. Updates to Department Web site

The Health Bureau updated the Insurance Department Web site to provide insurers with essential instructions and guidance for filing accident and health form and rate filings. Several product checklists were added to provide the industry with one primary source for statutory and regulatory requirements related to each major product.

In 2007, consumer information on the web site was enhanced and revised for easier access by the public. For example, the long term care insurance section was expanded to provide details regarding premium rate increases and streamlined by combining separate lists of insurers offering long term care insurance coverage to be more user-friendly.

The Health Bureau continues to maintain its web site pages with respect to information for seniors. The Information for Medicare Beneficiaries page includes information on the available Medicare supplement insurance plans in New York and the current premium rates. This information is updated monthly.

30. Discontinuations, Withdrawals and Mergers

The Health Bureau approved the merger of AmeriChoice of New York, Inc. and United Healthcare of New York, Inc. In addition the Health Bureau also approved the Merger of Dental Insurance Company of America and United Healthcare Insurance Company of NY.

Horizon Healthcare of New York has been submitted to the Liquidation Bureau and is awaiting final approval for submission to the court.

MDNY is in the process of winding down operations and will have no members as of the end of May 2008.

31. Financial Risk Transfer Agreement

Insurance Department Regulation 164, “Financial Risk Transfer Agreements between Insurers and Health Care Providers” (11 NYCRR 101), was promulgated on August 21, 2001. This Regulation addresses an insurer’s obligation to assess the financial responsibility and capability of health care providers (*e.g.,* Independent Practice Associations) to perform their obligations under certain financial risk transfer agreements. It sets forth standards pursuant to which health care providers may adequately demonstrate such responsibility and capability to insurers. A particular provision of Regulation 164 did sunset on August 21, 2004, after which “grandfathered” Financial Risk Transfer Agreements between insurers and health care providers had to be submitted to the Superintendent for review. During 2007, the Bureau received an additional 10 agreements for review. During 2007, five have been approved, 11 are pending and six were either withdrawn, suspended or have been determined not to be subject to the strict financial responsibility demonstration requirements of the Regulation.

32. Commission on Local Government Efficiency and Effectiveness

The Health Bureau attended meetings of the Interagency Task Force to discuss the Local Government Initiatives project of the Commission on Local Government Efficiency and Effectiveness. This Commission was established in April 2007 to streamline local government. The Commission created a local initiative process to help develop recommendations concerning changes in laws, state programs, state policies and funding streams. The Commission will present these recommendations in a report to the Governor that is due on April 15, 2008.

As part of this local initiative process, the Governor sent a letter to local leaders in April 2007 asking them to identify at least one major initiative in the areas of local government merger, consolidation, regionalized government, smart growth and shared services. The state agencies that make up the Interagency Task Force must provide legal and logistical advice to help advance these initiatives.

Seven counties identified initiatives concerning health insurance. The Health Bureau prepared work plans concerning each initiative for the Commission and also met separately with each county that identified a health insurance initiative to discuss their concerns and plans and to offer advice. The Health Bureau also prepared draft legislation that would amend Article 47 of the Insurance Law, concerning Municipal Cooperative Health Benefits Plans.

33. Timothy's Law (Chapter 748 of the Laws of 2006)

Timothy's Law was enacted in December 2006 and required health plans to provide coverage for mental health services. The law applies to policies issued or renewed on or after January 1, 2007, and requires coverage for at least 30 inpatient days and 20 outpatient visits for the treatment of mental health. Additionally, it required health plans to include in their large group contracts, and make available in their small group contracts, coverage comparable to other benefits provided for treatment of biologically based mental illnesses and for children with serious emotional disturbances. Timothy's Law provides a premium subsidy for the 30/20 mental health benefit for small employers and also directs the Superintendent of Insurance to conduct a study, in consultation with the Office of Mental Health (OMH), to determine the effectiveness and impact of the law. Approximately 1.7 million persons covered under small group policies (as of December 2007) are affected by the subsidy.

In furtherance of the statute, the Health Bureau's legal section reviewed and approved health plan policy forms submitted for compliance with the new law. Additionally, the Bureau issued three circular letters related to the interpretation of Timothy's Law, drafted a technical amendment to the law which was enacted pursuant to Chapter 502 of the Laws of 2007, held several meetings with representatives from advocacy groups and responded to numerous inquiries and complaints.

The Health Bureau's Accident and Health Rating Section analyzed and estimated the rate impact of Timothy's Law, which included a prior approval review process of all carriers requested reimbursement rates. The Bureau estimated the total amount required to fund the subsidy of the 30/20 benefit for small group contracts for an initial period of fifteen months, from January 1, 2007 through March 31, 2008, at $100 million. The subsidy amount is provided through an appropriation from the State's General Fund. The Bureau also implemented a subsidy reimbursement and claim experience reporting mechanism, under which the small employers' premiums for the 30/20 benefit are subsidized by direct payment of the premium to the carrier providing the coverage. The mechanism requires detailed quarterly claims, enrollment and reimbursement data reporting by carriers. Quarterly reports through December 31, 2007, indicate reimbursements requested by insurers are on track to approximately reach the $100 million aggregate subsidy estimate. After March 31, 2008, the subsidy appropriation will be on a fiscal year basis, and the mechanism provides for annual prior approval of carriers' per member per month ("PMPM") reimbursement rates, and requires submission of experience data to justify the next fiscal years' rates by March 31 of each year.

With respect to the study, which is due by April 1, 2009, the Health Bureau has consulted with the Office of Mental Health. The two agencies have engaged in several meetings and discussions regarding development of the study. In the past, OMH has worked with several economists who are experts in the area of mental health parity study. The two agencies have discussed enlisting the possible assistance of the economist groups with the analysis required for the study.

D. CONSUMER SERVICES BUREAU

Introduction

The Consumer Services Bureau continued its dual investigatory practice last year of attempting to resolve each consumer complaint brought to its attention while also addressing systemic patterns of insurer/producer misconduct discovered through the complaint process. The Bureau succeeded in both closing over 50,000 consumer cases and conducting several major investigations of insurance company and insurance producer practices throughout the year. Whether it was investigating insurance disputes, educating consumers about the workings of insurance, processing external appeal applications or assisting the prosecution of a felon, the Consumer Services Bureau provided needed insurance assistance to New Yorkers in 2007.

1. Consumer Complaints

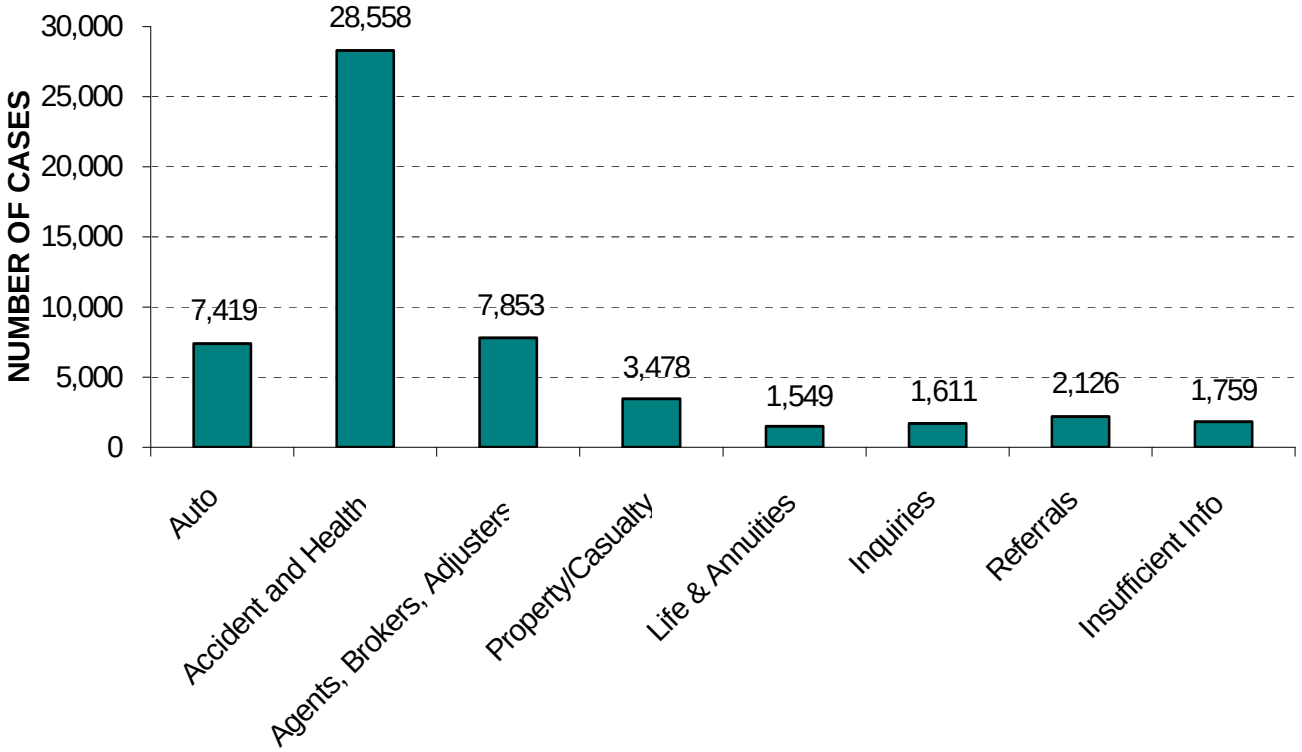
The Consumer Services Bureau is responsible for responding to consumer complaints and inquiries, and investigating the actions of licensed producers. The Bureau *closed* a total of 53,868 cases in 2007. Of these, 40,519 involved complaints against insurance companies regarding loss settlements or interpretation of policy provisions, of which 70.5% (28,558) were accident and health complaints, 18.3% (7,419) were automobile and no-fault complaints, 8.6% (3,478) were property and liability complaints and 2.6% (1,549) were life and annuity complaints. In addition, 1,759 cases were closed when the complainants failed to furnish additional information deemed necessary to proceed with the investigation of the case. Another 7,853 cases involved complaints against agents, brokers and adjusters. Written inquiries accounted for 1,611 cases and referrals accounted for 2,126 cases (see Chart G). In total, the Bureau *received* 55,109 cases during 2007.

The Bureau responded to approximately 200,000 calls on its information phone lines. The Bureau's telephone system is an attendant system whereby the caller listens to a menu of topics and selects one by pressing the appropriate number on the dial. The caller is given the option of speaking to an agency services representative. The Bureau initiated a call-tracking system in the last quarter of 2002. The agency services representatives complete an automated computer screen template for each call they answer. The data are sorted and stored by the computer system so Bureau managers may more easily determine patterns of calls from consumers indicating an industry problem in a given area of the State. This system has proven helpful in determining the geographical area and severity of disasters occurring in New York State. The data allow for the more efficient use of state resources in response to disasters. The Bureau also maintains a toll-free line that will access a multi-lingual telephone service. This interpretive service, provided by AT&T Language Line Services, can translate 140 languages.

In addition, the Bureau also maintained a toll-free line dedicated to providing information about the New York State Partnership for Long Term Care. The Partnership allows individuals to qualify for Medicaid after their long-term care policy benefits are exhausted without divesting themselves of their assets. The program thus encourages self-sufficiency by guaranteeing asset protection for policyholders and the saving of Medicaid funds.

The Bureau also maintains a dedicated disaster toll-free hotline. Consumers affected by disasters may call this toll-free line to obtain information concerning their insurance coverage for damages incurred as a result of a natural or man-made disaster. In 2007, the Bureau responded to questions related to the World Trade Center disaster, various winter storms, flood damages in southern and central New York and tornado damages in the Bay Ridge section of the borough of Brooklyn.

CHART G
Total Complaints & Investigations Closed
Consumer Services Bureau, 2007



a. Cases of Interest

The Consumer Services Bureau found as a result of several consumer complaints that Aetna was not providing the appropriate external appeal rights to New York policy holders that reside outside of the State. Rather, Aetna was providing the appeal rights required in the states where they lived. In many cases, this resulted in the member receiving appeal rights that were inferior to those required in New York. Consumer Services worked with the Health Bureau which also discovered the violation as a result of a market conduct exam. As a result of the joint efforts between the Consumer Services and Health Bureaus, Aetna agreed to this Department's interpretation of Article 49 and notified all affected members of their right to request an External Appeal.

After a fire destroyed a Washington County home, the property owner's insurance company notified him it would only pay $97,000 of the $148,000 coverage limit under his homeowner's policy. The company had determined the property was severely over-insured. Upon investigating the matter, the Bureau agreed that the company was obligated to pay only $97,000, the actual cost of rebuilding the home. However, the Bureau pointed out to the insurer that the home had been inspected by the insurance company only a year before the fire and the insurer failed to notice the home was severely

over-insured. As a result, the Bureau directed the insurer to refund the premium collected that corresponded to the excess coverage.

A 77-year old Long Island man invested more than $100,000 in an annuity in 2002, based on the written assurances he received from an agent that his “investment” would earn “around five percent” interest per year from the second to fifth years of the investment. After the fifth year, when he noticed his earnings were actually close to three percent, he contacted the Bureau when he was unable to resolve the dispute with the company. Initially in responding to the complaint, the insurer denied any wrongdoing on the basis the investor was told the interest rate would be three percent. The insurer changed course when Bureau examiners raised the issue of the written assurances given by their agent. The interest rate was retroactively adjusted to five percent and the investor was issued a $9,000 payment.

When a 58-year old Manhattan woman requiring cancer surgery decided to use a provider that did not participate in her health insurance plan, she realized she would have to pay additional out-of pocket fees. But when her insurance company paid only $1,000 of her $3,500 bill, she filed an electronic complaint using the Insurance Department’s website asking the Department to review the insurer’s reimbursement methods. The Bureau had the insurance company document how it determined usual and customary charges used in the reimbursement for this woman’s surgery. The Bureau’s investigation found the woman had been incorrectly reimbursed. The insurer was required to pay an additional amount of $1,274 to the woman.

Describing herself as “totally exhausted” from dealing with her insurance company, the mother of a 17-year old girl contacted the Bureau to receive assistance in obtaining payment for a prosthetic ear for her daughter. The girl had 11 surgeries to correct her congenital condition. The Bureau assisted the woman by having her health care provider send medical records to the insurer, and then interceded again when a processing error by the insurer led to the denial of the claim. In the end, the mother received payment from the insurer in the amount of $8,700.

A married couple filed a complaint because their health insurance claim for artificial insemination procedure was denied by their health insurance company on the grounds the procedure was not covered by their insurance policy. In its response to the complaint, the insurer explained that artificial insemination is neither covered nor excluded in the insurance policy; therefore, it denied the claim. The Department informed the insurer that the law requiring insurers to provide infertility treatment does not exclude the procedure in question and insurers may not create their own exclusions. After review by the insurer’s legal staff, the company paid the claim. However, the Insurance Department, suspecting that other policy holders may have also experienced the same situation, referred the matter to the Department’s Health Bureau to further investigate the matter. Their investigation remains ongoing.

b. Special Investigations

Quest Laboratory – The Consumer Services Bureau worked with the Attorney General’s office regarding United Healthcare’s termination of Quest Laboratory’s participation agreement. United Healthcare made a business decision to designate LabCorp as their sole national laboratory. As a result, Quest sent correspondence to United Healthcare and Oxford Health members indicating that they would continue to service their laboratory needs and implied that the member could receive their services at Quest at no additional out-of pocket expense. This notification was incorrect because Quest was no longer a participating provider. The Consumer Services Bureau worked with the Attorney General to minimize the consumer’s out-of-pocket costs for these services.

Office of the Medicaid Inspector General – The Consumer Services Bureau was contacted by the Office of the Medicaid Inspector General (OMIG) regarding subrogation for Medicaid members who were also covered by commercial coverage. The New York Insurance Law states that

Medicaid is the payer of last resort, yet some insurers and HMOs failed to cooperate with OMIG's attempts to verify coverage and seek reimbursement for payments issued by Medicaid. Consumer Services held meetings with representatives of the health insurance industry to inform them that this Department expected their cooperation with OMIG. Feedback from OMIG indicates that they have seen an improvement in insurers' and HMOs' cooperation.

2. Prompt Payment Statute

Section 3224-a of the New York Insurance Law, known as the "Prompt Payment Bill," became effective January 22, 1998. Under the statute, insurers and HMOs are required to pay undisputed health insurance claims within 45 days of receipt. The statute also requires claims to be denied or additional information requested within 30 days of receipt.

The Consumer Services Bureau allocated significant resources to the investigation and resolution of prompt payment complaints. In addition, the Bureau sought to ensure that doctors, hospitals and insureds received prompt payment of the claims submitted to health plans, as well as compliance by health insurers and HMOs with all other provisions of this statute, such as the payment of interest.

The Consumer Services Bureau continued its enforcement action against health insurers and HMOs that violated the prompt payment statute. In 2007, $553,700 in prompt pay fines were levied against 31 health insurers and HMOs. These fines were calculated using the methodology developed by the Department and the industry in 2003. The methodology considers not only the violations uncovered while investigating complaints, but also the number of claims processed by the insurer or HMO during a specific time period. This provides a more accurate picture of the overall performance of the insurer or HMO.

In addition, Bureau staff participated in several outreach sessions both for provider groups and hospital administrators. The purpose of these sessions was to educate the participants on their rights under the prompt payment statute and other laws that affect the payment of health care claims. These sessions also focused on information the providers can use in assisting patients who may be faced with the need to navigate through the insurers' and HMOs' various processes.

The Consumer Services Bureau allow providers to file prompt pay complaints via the Department's web site, which streamlines complaint handling and enables prompt pay complaints to be handled more expeditiously. Not only does this online complaint feature provide consumers with faster access to the Department's complaint process, it also allows insurers and HMOs to respond electronically to Department complaints via the Internet, saving additional time. Responses received online are triaged by the system using established business rules to determine if the response requires examiner review. If the response meets certain criteria, the file will close automatically and generate a closing letter without the need for review by an examiner, resulting in a significant reduction in the time required to review and close complaints.

3. External Review

The External Review program, which became effective July 1, 1999, provides consumers with the right to obtain a review conducted by medical professionals who are not affiliated with their health plan. This review is available when health plans deny services as not medically necessary or because the plan considers them to be experimental or investigational.

During 2007, Consumer Services Bureau personnel responded to 7,763 phone calls on the dedicated external appeal toll-free line. Consumer Services Bureau examiners, along with attorneys from the Health Bureau, jointly perform the intake, screening, and assignment of external appeal applications. In 2007, the Department received 2,987 applications, representing an increase for the

fifth consecutive year. Over the past five years, the program has seen a dramatic increase of more than 65%.

Consumer Services continues to work with the Administration, Systems, and Health Bureaus to ensure that staff responsible for processing the applications has the technology and access to equipment to respond to requests for expedited external appeals 24 hours per day, seven days per week.

4. The Healthcare Roundtable

The Healthcare Roundtable was established in 2003 in an attempt to convene representatives of health insurers, health care providers, and other interested parties to discuss health care issues with the intent of resolving common issues. Members of the Roundtable are representatives from the Insurance and Health Departments, the Medical Society of the State of New York, the Health Plan Association, the Conference of Blue Cross Blue Shield Plans, the Greater New York Hospital Association, the Healthcare Association of New York State and various health care providers.

The Coordination of Benefits (COB) Regulation, which was developed as a result of Healthcare Roundtable discussions, has been filed with the Governor's Office of Regulatory Reform (GORR), and CSB continues to work towards the promulgation of this Regulation.

5. Senior Protection Unit

The Bureau formed a new Senior Unit to address health and long term care insurance matters affecting the state's senior citizens. This unit is part of the larger Elder Protection Unit established by Superintendent Dinallo in September 2007. The Elder Protection Unit brings together staff from Consumer Services, Life, and Health Bureaus, and provides support and protection for the elderly in dealing with insurance and related concerns.

The Department has entered into a memorandum of understanding with the Centers of Medicare and Medicaid Services (CMS) to facilitate investigation into complaints arising in the sale and solicitation of Medicare products.

Consumer Services has revised their complaint tracking system to identify and handle complaints involving seniors on an expedited basis. A frequent problem that we now resolve occurs when seniors have tried to disenroll from Medicare Advantage to traditional Medicare, and they find themselves with no coverage for a period of time. The Senior Unit has worked in conjunction with the insurance companies and Medicare Rights Center to get the senior enrolled retroactively into the correct plan.

The Secret Shopper Program was developed by the Centers for Medicare and Medicaid Services to assist states in policing and monitoring the marketing activities of agents. The senior unit has participated in this program to ensure that agents are complying with state and federal regulations.

Bureau staff participated in the Health Insurance Information Counseling and Assistance Program (HIICAP) Consortium, which is comprised of representatives from various state and federal agencies invited by the State Office for the Aging to provide technical assistance and training for HIICAP counselors and volunteers. Bureau staff also provides training and assistance to the Long Term Care Insurance Outreach and Education Program (LTCIOEP) which is run by the New York State Office for the Aging. This program maintains long term care resource centers at the county level to provide educational materials, counseling, and referral services on planning for the financing of long term care.

Consumer Services maintains a toll-free line dedicated to providing information about the New York State Partnership for Long Term Care. The Partnership allows individuals to apply for Medicaid

after their long term care policy benefits are exhausted without having to divest themselves of their assets. The Partnership encourages self-sufficiency by guaranteeing asset protection for policyholders and saving the state's Medicaid funds.

Consumer Services staff worked with attorneys from the Health Bureau and the Governor's Office on a Long Term Care Program Bill. The recommendations include an amendment to Regulation 62 to include guidelines for an internal appeal process and a new Section in the Insurance Law that will require Long Term Care insurers to implement an external appeal process.

6. Investigations

The Investigation Unit of the Consumer Services Bureau is responsible for investigating the activities of insurance producers, adjusters, reinsurance intermediaries, bail bond agents, service contract providers, and other licensed and non-licensed entities who are conducting the business of insurance in New York State. It also reviews licensing applications where affirmative answers are either given or omitted to the irregularities questions contained on original or renewal applications. Its goals are to protect the insuring public and ensure that our licensees act in accordance with the applicable New York Insurance Laws and Regulations. When a violation is proven, an administrative sanction can be imposed. It may result in the revocation or suspension of any license(s) held, the denial of any pending application(s), or the imposition of a monetary penalty with resultant corrective action of the violation.

The Bureau continues to investigate the replacement practices of insurers and their producers. Information previously furnished to us by the National Association of Securities Dealers (NASD) revealed that two large insurers and various brokerage firms who were selling life and variable annuity products to New York residents failed to comply with a two-step process which is required by this Department's Regulation 60. During the 2007 calendar year, we fined 44 Prudential agents a total of $72,500, and issued 55 Letters of Warning for failing to comply with the requirements of Regulation 60. We also have commenced additional investigations against a large managing general agent and various branch offices of a large commercial bank which offers insurance products, for similar activities.

a. Revocations:

Jill Morrill - signed a stipulation for revocation of her broker's license. Our investigation revealed that between August 3, 2006 to June 5, 2007, Ms. Morrill collected premium payments from 26 customers in the amount of $7,183.65 which she failed to remit or otherwise properly account for. Ms. Morrill entered a plea, and was convicted of Insurance Fraud in the Fourth Degree, a class "E" Felony, in violation of New York Penal Law 176.15. Her sentencing will take place in 2008.

Clifton Collins – certification was revoked by the New York Automobile Insurance Plan for two years on or about April 15, 2005, based on his issuance of 12 dishonored premium checks, four of which were not replaced totaling $1,566.58. He also submitted 58 deficient applications and had 2 producer performance standard violations. None of the violations were resolved. In 2005, Collins issued 5 insurance premium checks payable to a premium finance company totaling $2,910.83 that were dishonored by a bank and subsequently replaced. He also commingled insurance premium monies and had instances of negative balances in his premium account. Collins pleaded guilty to Criminal Conspiracy in the 5th Degree, a misdemeanor of the New York State Penal Law Section 105.5. He was part of a group that sought to take money from insurers by referring people who came to his insurance agency to report staged car accidents and exaggerated injuries. He was sentenced to a conditional discharge and required to pay a surcharge. He failed to reveal this conviction on his renewal licensing applications and did not notify the Department within thirty days of the initial pretrial hearing date as required under Section 2110(j) of the Insurance Law.

Sal A. Spedale - was terminated for cause by the Columbian Mutual Life Insurance Company for misappropriating $23,264.31 in client's funds that he was unable to properly account for. The Insurer made their client whole by paying him $29,896.60. This settlement included the return of principal, interest and attorney's fees. He also altered checks that he submitted to the Insurance Department to prove that he had partially repaid the insured.

Louis W. Parks - wrongfully submitted at least 23 life insurance applications on insureds who were unaware of them and either did not authorize or actually sign the applications. Some insureds did not exist and some names and social security numbers were incorrectly written on the applications which were completed by Mr. Parks. In all of these transactions, Louis Parks attached voided checks of unrelated individuals or companies that neither knew nor consented to having premiums paid from their accounts through automatic deductions. As a result of this action, Mr. Parks collected $41,105.47 in commissions. He also failed to reveal this information on one licensing application form.

John L. Pagliaroli – pled guilty and was convicted of a Scheme to Defraud in the First degree, a class "E" Felony in violation of the New York State Penal Law 190.65(1)(a). He was sentenced to 5 years probation and required to make restitution in the amount of $23,251.00. Mr. Pagliaroli had issued a fraudulent ID card, failed to secure coverage for clients and issued numerous checks that were returned for insufficient funds. Mr. Pagliaroli signed a stipulation agreeing to surrender all his licenses.

Kevin J. Lent - was convicted of a felony within the meaning of Section 2110(a)(7) of the Insurance Law. He pled guilty to two counts of mail fraud in violation 18 USC, 1341, a class C felony. He was sentenced to ninety (90) days imprisonment for each count of conviction, to be served concurrently, and then was placed on supervised release for 3 years, required to make restitution in the amount of $420,400 and pay a special assessment of $200. Our investigation had commenced as a result of a termination for cause notice from an insurer. Our findings revealed that Mr. Lent illegally transferred over $420,400 in funds from family members' investment accounts over approximately a 9-year period.

Jeffrey D. Leggett – after receiving numerous complaints from seniors as well as several from the Broome County Action for Older Persons of deceptive and high pressure sales tactics, including door-to-door sales of Medicare Advantage plans, the Department revoked the license of Jeffrey D. Leggett.

b. Stipulations

Genatt Associates, Inc. and Edward P. DiGioia individually and as sublicensee - were fined $25,400 as they admitted that during a period from 2000 to 2005, they filed 250 affidavits with the Excess Line Association of New York in which they indicated that they made a diligent effort to place insurance coverage with authorized insurers by stating they had obtained declinations for authorized insurers, when in fact they never obtained any declinations.

Harold R. Rudd, Jr. – was fined $2,000 for collecting insurance premiums from various insureds while employed by the Prudential Insurance Company and failing to remit them in a timely manner to the appropriate processing area and in accordance with company guidelines.

Mitchell Hersh - was ordered to pay a penalty of $5,250 as a result of a hearing in which it was found that between November 14, 2001 and May 21, 2002, Mr. Hersh sold 21 variable annuity contracts to 17 persons who were New York residents. These contracts were approved for sale in Florida, but not in New York. In order to effectuate these transactions, the applicant inserted Florida addresses for these persons on the applications even though he knew the persons either did not reside in Florida or that they only had a secondary residence in Florida. He also failed to supply the New York residents with disclosure statements as required by New York Insurance Department's Regulation 60.

Customer Service Solutions and Richard K. Tani as sublicensee - agreed to pay a $2,000 fine. They had collected group health insurance premiums from 4 insureds on behalf of Employers Mutual, LLC, an unauthorized insurer and facilitated their doing an insurance business in New York.

Louis H. Saltzman – was fined $2,000. Saltzman admitted he misrepresented an insured's life insurance coverage by issuing on behalf of an insurer an acknowledged memorandum and a letter on the insurer's letterhead stating the insured's lapsed policy was reinstated by the insurer, when in fact it was never reinstated

Paul D. Paratore - was fined $4,000 after it was determined as a result of a hearing that Mr. Paratore collected a total $3,864.73 from one of his clients to cover employees of his business. Mr. Paratore instead deposited these premium monies into his premium fiduciary account and improperly used them to pay fees for the reinstatement of insurance policies and for annuity withdrawals on annuity contracts of other insurance clients of his.

Terrier Claims Services Inc. and Daniel J. Sullivan individually and as sublicensee - were fined $2,000 for acting as an independent adjuster in New York State without being properly licensed.

Elvira Castro – was fined $2,500 for issuing 4 insurance premium payment transmittal checks totaling $1,393.60 which were dishonored by the bank upon which they were drawn. Ms. Castro violated a prior stipulation that she entered into with the Department in which she agreed she would not again dishonor insurance premium payment transmittal checks. Ms. Castro subsequently replaced the dishonored checks and agreed to take corrective action.

Peter John Lovering - was fined $2,500 for submitting 3 insurance applications to an insurer for individuals who already had health insurance coverage through other policies and did not need the coverage. He did this in order to qualify for a year end bonus commission of $20,000.

Jodha Insurance Agency, Inc. and Rameshwar Joda individually and as sublicensee - were fined $2,000 for issuing 4 insurance premium payment transmittal checks, totaling $2,222.65 that were dishonored. The checks were subsequently replaced.

Foreguard Agencies, Inc. and Thomas R. Michaels individually and as sublicensee - were fined $1,000 for failing to file required disclosure statement forms for the years 2002 through 2006 in connection with the sale of insurance to two municipalities. This violated Section 2128 of the Insurance Law and Department Regulation 87.

Ermino J. Sapio – was fined $1,000 for failing to file the required disclosure statement forms for the period 2002 through 2006 in connection with the sale of insurance to a municipality. This is required by Section 2128 of the Insurance Law and Department Regulation 87.

c. Denials

Lawrence Schwartz – application was denied. Mr. Schwartz forged 2 checks from the bank account of one of his customers. His actions were discovered before the checks were negotiated. He was barred from associating with any NASD member firm, he ultimately pled guilty to forgery in the second degree and he was sentenced to 5 years probation.

123 Bail Inc. - this corporate bail bond agent licensing application was denied as Steven DeCarlo, President, failed to reveal a conviction for possession of stolen property; a misdemeanor which took place in the state of Florida. By statute, this conviction bars him from obtaining a license.

d. Cases of Interest

Richard Nichols – Our Bureau is investigating this licensee who has been found to have sold over 400 life settlement contracts with a Florida company, Mutual Benefits, which has been shut down by the US Attorney, and is in receivership. Information we have received from the clients indicates that Mr. Nichols advised them to surrender their life policies and IRA's and invest in Mutual Benefits. He received his 10-15% commissions and the client's investments are worthless.

William Norton – We received information from various insurance companies that Mr. Norton was in debt to them for fiduciary money in an amount exceeding $1.2 million. As Mr. Norton has not agreed to voluntarily surrender his license, we will be setting up a hearing to determine if his license should be revoked.

Ancillary Administrative Services – There have been a few complaints which have triggered an investigation into the practice of certain agencies providing additional services free of charge which are not necessarily related to the servicing of the insurance products. Examples of such services are creation of employee handbooks and monthly newsletters. Our investigation continues in this matter.

e. Service Contracts

The following service contract companies were fined for selling road hazard coverage without having a registration as required under Section 7907 of the New York State Insurance Law: Autobacs Strauss, Inc. - $195,000; BFS Retail and Commercial Operations - $34,000; and Pep Boys - $21,000. The following service contract companies were fined for selling extended warranties without having a registration as required under Section 7907 of the New York State Insurance Law: VAC Service Corp. Inc. - $20,000; Mack Camera - $15,000; Saurian - $5,000; World Wide Warranty - $2,500; and Automobile Consumer Services Corporation - $2,500.

7. Electronic Complaint Handling

a. Consumer Imaging and Information Management Systems (CIIMS)

The Consumer Imaging and Information Management System (CIIMS), Consumer Services Bureau's award winning imaging and workflow system, was a pioneer in the industry when the custom designed software went into production in 1998. CIIMS' success is in its adaptability. With minor modifications, the Licensing Services Continuing Education Unit and the Property Bureau's Excess Line and No-Fault Units began processing their investigations cases in CIIMS last year. The Consumer Services Bureau continues to explore expanding CIIMS into other Bureaus designating it as a Department wide workflow and imaged storage system. A common system fully utilizes the Department's available IT resources and leads to consistency in reporting to the National Association of Insurance Commissioners Complaints Database.

CIIMS was also modified in 2007 to account for legislative changes and other important insurance issues. We created workflow dedicated to Senior Issues. Consumer Services Bureau is now able to track and route complaints regarding Timothy's Law, steering, and cancellations due to windstorms for the downstate area.

During 2007, we reviewed and revised letter templates in CIIMS. These include automatic letters generated to the companies based upon the dispute coverage type and suggested templates for examiners' use.

The Consumer Services Bureau continues to share the success of CIIMS with other departments. In 2007, we demonstrated the system to the New York State Department of Education and the Pennsylvania Insurance Department. In addition, Consumer Services Bureau is participating in

executing a Memorandum of Understanding with the Maryland Insurance Department to share CIIMS source code.

b. Web & Portal Capabilities

To better serve our constituents, CIIMS was expanded in its functionality to include eCommerce.

Consumers have been able to file complaints online directly into CIIMS since 2001. Once the consumer submits an online complaint, a file number is assigned and confirmation of this case number is immediately transmitted to the consumer.

In 2003, we developed an electronic process for health care providers to file their prompt payment complaints with CSB. This included a registration process enabling healthcare providers to login into the system where their information is stored and proceed to file relevant patient information. This data is automatically recorded in CIIMS. Since that time, registered insurers, HMO's and their affiliates have responded to complaints online using the Online Company Complaint Response System. We received 29,914 online complaint responses in 2007.

In 2007 we added an online component allowing consumers to provide additional information on their existing case. We also modified our online forms to allow filing of Workers Compensation complaints and to identify Service Contract and senior citizen related complaints. A question was added to help expedite complaints related to declared disasters. As a result of these efforts, about a third of our complaints, a total of 18,148, were received online.

At the time the online provider form was introduced, Consumer Services Bureau added the Online Company Complaint Response Form. This allowed the companies to respond online. In the case of prompt pay, the online process allows for an automatic review and based upon clearly defined business rules in Insurance Law, CIIMS can automatically close the file. CIIMS also calculates interest due on cases as warranted.

CIIMS has also been instrumental in sharing data within the Department. Consumer Services has worked with our Systems Bureau to develop ways for Department staff to have access to CIIMS data. As a result, the Data Retrieval Report (DARR), used by other bureaus in the Market Conduct and other units, and the New York Complaints Evaluation (NYCE) Health Trending Reports are now available through the Department's Portal. The NYCE Health Trending Report, built in collaboration with the Department's Health Bureau, allows for comparison of health and/or prompt pay complaints received by Consumer Services Bureau for specified time periods.

The Department's legacy mainframe system was being used by The Consumer Services Bureau for retrieving historical investigations case data created prior to CIIMS. Information regarding these case types is retained for an extended period of time. To support the Department's cost saving effort to migrate off the mainframe, Consumer Services Bureau now has access to this information through the Department's portal environment.

Though CIIMS was premier technology when first introduced, and still continues to be the national standard, the System is working on technology introduced more than a decade ago. The Department has begun working on designing and transitioning CIIMS to a web based system called the New York Insurance Complaint Information System (NYCIS).

Owing to its 1996 architecture, CIIMS is limited in its ability to meet our future expanding needs. Since CIIMS core workflow software is no longer supported by the vendor, an upgrade is critical to meet the increasing usage, not only in our Bureau, but across the Department.

Creating NYICIS using an open source browser based technology will enable us to expand our eCommerce activities.

8. Consumer Service Outreach

a. State & County Fairs, Conferences & Festivals

Examiners from the Consumer Services Bureau staffed the Department's booth at both the Erie County and New York State Fairs held from August 8-19 and August 23- September 4, respectively. Examiners distributed various consumer guides and booklets to the public and answered insurance related questions. Over 70,000 publications and mementos were disseminated to the pubic at these two events. Additionally, the examiners handed out more than 12,000 informational computer CDs containing various insurance guides and pamphlets. Further, fairgoers were able to access the Department's website via wireless internet so they could obtain real-time insurance information such as updated Healthy New York premium rates charged by the HMOs operating in their county.

The Bureau also staffed informational booths at a host of other smaller, but just as important, events in 2007. These events included the Black and Puerto Rican Legislators Annual Conference, Martin Luther King, Jr. Holiday Memorial Observance, African-American Family Day, Small Business Strategic Alliance's Small Business Information Expo, Somos El Futuro Conference and Consumer Action Day, and responded to numerous requests to set up booths and/or speak to smaller consumer gatherings.

b. Health and Long Term Care

Consumer Services staff conducted presentations for new coordinators for both the Long Term Care Insurance Outreach and Educational Program and the Health Insurance Information Counseling and Assistance Program. At the request of Senator Liz Krueger, bureau staff participated in a panel presentation on long term care insurance and the benefits of purchasing this type of insurance at younger ages.

Consumer Services staff continued their participation in outreach presentations designed to assist health care providers with their health insurance problems. These included a presentation to members of the Health Care Business Association of NENY, the Health Care Financial Managers Association and New York Eye and Ear Institute to discuss such topics as the Prompt Pay and External Appeal laws. In addition, Consumer Services staff attended a meeting with the New York Psychological Association to discuss utilization review, prompt payment of claims and changes related to the enactment of Timothy's law.

c. Consumer Guide Books

The Department is required to publish an Annual Consumer Guide to Health Insurers, which ranks insurers and HMOs by complaints upheld by the Consumer Services Bureau, and contains a separate ranking based on upheld prompt pay complaints. In 2007, Consumer Services staff assumed a more prominent role in the process. This involved coordinating Department staff from Public Affairs, Health, Property and Administration Bureaus to ensure that that information necessary to publish the Guide before the deadline imposed by legislation was available on time. In addition, Bureau staff also worked with the Department of Health, Office of Managed Care, to gather quality assurance measures published by that office which is also required to be included in the Guide. Bureau staff worked closely with the National Committee on Quality Assurance (NCQA), the outside vendor contracted to create the Guide. The Bureau, likewise, worked on a similar ranking for automobile insurers, the 2006 Annual Ranking of Automobile Insurance Companies.

d. Department of Motor Vehicles Insurance Information Enforcement System (IIES)

The Bureau continues to assist individuals, families and businesses in overcoming problems due to erroneous or untimely electronic submissions by their insurers to the Insurance Information and Enforcement System (IIES) maintained by the New York State Department of Motor Vehicles. (Auto insurers are required to inform the Department of Motor Vehicles of drivers whose coverage has lapsed.) Insurers not filing timely reports to the Department of Motor Vehicles have been fined. The Bureau investigated and closed 110 complaints on an expedited basis. Of these, 49 complaints were closed as upheld against the insurance companies. Another 27 were closed as not upheld but some type of adjustment was made by the insurer to resolve the complaint. This means that 76 individuals had their vehicles' registration reinstated by the Department of Motor Vehicles without any or reduced fines.

e. New York State Insurance Disaster Coalition

The Bureau continues to be one of the lead members of the New York State Insurance Disaster Coalition. This coalition demonstrated its capabilities in coordinating the insurance industry's response to the World Trade Center disaster. The coalition and the Insurance Emergency Operations Center have received nationwide recognition for the work accomplished during that disaster. A number of other state insurance departments are modeling their disaster response plans on New York State's Disaster Coalition.

The Bureau continues to receive complaints from those individuals, families and businesses affected by the World Trade Center disaster as well as other natural disasters occurring in New York State during 2007. These complaints receive immediate and expedited treatment from Bureau examiners. Bureau examiners have facilitated settlement of a number of these cases by conducting meetings with consumers and their insurers to resolve disputed claims.

Fortunately, there was no need to activate the Disaster Response Plan in 2007. However, the Bureau did assist consumers who sustained damages caused by flooding from various summer rainstorms, heavy snowfall in western and central New York and tornado activity in the Bay Ridge section of Brooklyn. Bureau examiners staffed disaster recovery centers opened in various locations throughout the State.

f. Coastal Property Insurance Issues

Several insurers continued to refuse to issue and/or non-renew homeowner's insurance policies in the coastal areas of the five boroughs of New York City and the counties of Nassau and Suffolk. The Bureau established a specific subject matter code for use in tracking consumer complaints received concerning this issue. The Bureau examiners investigated over 700 complaints to verify that the refusal to issue or the termination of coverage complied with the Insurance Law. Additionally, the Bureau participated in the Department's investigation of the Allstate and Liberty Mutual Insurance groups' practice of tying renewal of homeowner's policies to their policyholder having other insurance business with the company. The Department ultimately found this practice to be in violation of the Insurance Law. Allstate and Liberty Mutual agreed to offer the affected policyholders the option of receiving a new homeowner's policy. The Bureau staffed a designated toll-free hotline to answer questions concerning the reinstatement offer.

g. Miscellaneous

In calendar year 2007, the Bureau responded to 311 requests from the public under the Freedom of Information Law for copies of documents contained in the Bureau's complaint and investigation files. These requests ranged from as small as one document to thousands in hundreds of files.

Table 57
CONSUMER SERVICES BUREAU COMPLAINTS AGAINST INSURANCE COMPANIES INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
Closed in 2007

Line of Business	Total Processed	Upheld	Adjusted in Consumers Favor	Not Upheld	Prompt Pay Violation	Other Action Taken
Total	**40,519**	**2,385**	**5,026**	**12,646**	**7,585**	**12,877**
Life & Annuities, Total	1,064	152	151	524	0	237
Individual Life	765	93	109	402	0	161
Individual Annuity	176	40	26	71	0	39
Group Life & Annuity	116	19	15	46	0	36
Viatical Settlements	1	0	0	0	0	1
Credit Life	6	0	1	5	0	1
Accident & Health, Total	28,558	668	3,214	8,445	7,585	8,646
Individual Accident & Health	189	13	44	83	14	35
Group Accident & Health	3,846	152	648	1,811	963	272
Article IX-C Corps	2,226	90	298	1,053	670	115
HMO	5,829	203	931	2,635	1,757	303
Medicare	1,986	7	17	32	0	1,930
Medigap	121	6	26	64	10	15
Long Term Care	91	10	22	44	0	15
Self-Insured Health Plan	3,899	1	2	10	2	3,884
Travel, Health	82	6	22	31	0	23
Health Alliance	0	0	0	0	0	0
Medicaid (HMO Only)	7,933	97	1,019	2,247	3,908	662
Municipal Co-ops	44	3	12	26	2	1
Credit Disability/DBL Income	246	31	50	93	0	72
Healthy NY	317	34	70	170	26	17
Federal/Out-of-State Contracts	1,249	0	1	5	1	1,242
Child Health Plus	443	9	49	129	232	24
Medicare Part D, PFFS, HMO, PO	57	6	3	12	0	36
Auto, Total	7,419	1,109	1,198	2,256	0	2,856
Auto, Liability (B.I.)	1,224	185	194	582	0	263
Auto, Liability (P.D.)	1,843	110	418	438	0	877
Auto, Physical Damage	1,042	92	163	427	0	360
No-Fault	3,310	722	423	809	0	1,356
Other Property & Liability, Total	3,478	456	463	1,421	0	1,138
Liability Other Than Auto	185	12	30	58	0	85
Professional Malpractice	26	1	2	13	0	10
Fire & Extended Coverage	55	3	8	22	0	22
Homeowners	1,928	253	205	1,011	0	459
Inland/Ocean Marine	28	2	3	10	0	13
Workers' Compensation	782	129	139	164	0	350

Commercial Multiple Peril	222	34	24	68	0	96
Burglary & Theft/Fidelity Surety	23	1	5	6	0	11
Flood	16	0	6	4	0	6
Title	41	4	9	13	0	15
GAP and Service Contracts	129	15	25	31	0	58
Other	43	2	7	21	0	13

Table 58
CONSUMER SERVICES BUREAU INVESTIGATIONS AGAINST AGENTS AND BROKERS
NOT INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
Closed in 2007

Subject of Cases or Investigations	Total Processed	Fines and Revocations	Other Actions	Not Upheld
Total	**7,942**	**833**	**6,196**	**913**
Application for License	5,064	266	4,798	0
Issuing Bad Checks	114	70	21	23
Misrepresentation of Coverage	155	9	55	91
Excess Comp Without Contract	28	5	8	15
Twisting	694	225	332	137
Violation of NYAIP/NYPIUA Rules	211	103	34	74
Return Premium-Producer	89	5	34	50
Other Violations of Insurance Law	125	24	50	51
Violations of Other Laws	29	4	14	11
Termination for Cause	158	29	116	13
Misleading Sales, Life and Medigap, Long Term Care and Medicare Advantage	140	0	72	68
Advertisements	34	2	16	16
Miscellaneous	350	19	167	164
Misappropriation of Funds	132	30	49	53
Service Contracts	46	0	45	1
Aiding and/or Aiding Unauthorized Insurers	39	6	30	3
Rebating	63	1	17	45
Inquiries	130	0	130	0
Other Investigations Received from Companies	34	4	21	9
Other	370	32	204	134

E. THE INSURANCE FRAUDS BUREAU

1. General Overview

The Frauds Bureau gained new leadership in 2007 when Superintendent Dinallo named Steven Nachman as Deputy Superintendent for Frauds and Consumer Services, overseeing the Bureaus handling fraud investigations, consumer complaints and licensing. Deputy Superintendent Nachman joined the Department from the Liquidation Bureau where he was Assistant Special Deputy Superintendent and Chief Compliance Officer. Prior to that, he headed the Auto Insurance Fraud Unit from 2001 to 2007 as Assistant Attorney General in the New York State Attorney General's Office.

The Superintendent also named Frank Orlando as Director of the Frauds Bureau and Angelo M. Carbone as Deputy Director. As Director, Mr. Orlando will oversee all operations of the Bureau, which is staffed by investigators and support personnel in the Bureau's New York City headquarters and six other offices across the State.

Prior to joining the Insurance Department, Mr. Orlando served with the Office of the New York State Attorney General, where he was Deputy Chief of the Auto Insurance Fraud Unit and previously a Supervising Investigator. He served for 20 years with the New York City Police Department, where he was assigned to the Intelligence Division Dignitary Protection Unit/Threat Assessment Unit and the Department's Organized Crime Control and Internal Affairs Bureaus. He graduated from Saint Joseph's College with a degree in Organizational Management.

Deputy Director Carbone conducted numerous fraud investigations and undercover operations as an investigator with the Frauds Bureau since 2005. Before coming to the Department, he served with the New York City Police Department for 20 years. As Commanding Officer of the NYPD's Fraudulent Accident Investigation Squad-South, he led investigations into all aspects of insurance fraud, including no-fault and staged accident rings, as well as identity theft cases. He attended Stony Brook University.

The Frauds Bureau is responsible for investigating cases of suspected fraud and mounting vigorous anti-fraud activities. Bureau staff work closely with other state, federal and local law enforcement agencies and prosecutors. With new leadership in place and a dedicated professional staff, the Bureau looks forward to the coming year with energy and enthusiasm.

2. 2007 Highlights

- The Frauds Bureau created a Major Case Unit that will begin operations in 2008. The Unit will focus on the investigation of systemic insurance fraud involving organized conspiracies. Unit investigators will handle complex cases involving no-fault, commercial rate evasion, health care fraud and workers' compensation premium fraud.

- Investigations by the Frauds Bureau resulted in 708 arrests during 2007, versus 604 in 2006.

- Frauds Bureau investigators attended a meeting in March at the Westchester County District Attorney's Office at which more than $2 million in restitution was distributed to victims of a medical mill fraud in Tuckahoe, NY. The clinic was shut down in October 2005 and since that time 37 doctors and clinic employees were convicted on charges including insurance fraud, enterprise corruption and grand larceny.

- In June, a third suspect was arrested in an arson case in which a father and son were previously arrested – the son on 12/13/06 and the father on 3/2/07 – for their roles in an arson fire at a vacant factory owned by the father. The son confessed to setting the blaze, claiming he acted alone. However, the father was subsequently implicated.

- The owner of a Queens limousine service and two chop-shop owners were arrested in September for their participation in an auto-theft ring. Thirteen others have also been charged, the most recent on 11/6/07, bringing to 16 the number of suspects arrested in this case. Ring members allegedly stole high-end cars and transported them to the chop shop where they were dismantled. The parts were used to maintain the fleet owner's vehicles.

- Twenty-six suspects were arrested in December as a result of a sting operation targeting car thieves on Long Island and in the New York Metropolitan Area. In addition, 92 vehicles with a Blue Book value of more than $1 million were recovered. Investigators worked undercover as operators of a garage where they purchased the stolen cars from the suspects.

- The co-owners and operators of a scrap yard in Niagara Falls were arrested in December and accused of stealing vehicles and crushing or dismantling them for scrap. A search warrant executed in September at the scrap yard and the home of one of the defendants turned up a .22 caliber rifle and $22,000 in cash. Business records were also confiscated as evidence.

3. Team Building

Continued team building was high on the Bureau's agenda during 2007. Bureau investigators worked closely with law enforcement agencies at every level in the development and investigation of Bureau cases.

a. Multi-Agency Investigations

The Frauds Bureau's continued efforts to work closely with its fraud-fighting partners in law enforcement and industry reflect the Bureau's Statewide approach to combating insurance fraud. During 2007, Bureau investigators joined forces with District Attorneys' Offices across the State on a wide range of insurance fraud investigations. The Bureau also worked with the NYPD's Fraudulent Accident Investigation Squad and its Auto Crime Division on no-fault and other auto-related fraud investigations and with the Office of the Workers' Compensation Fraud Inspector General and the State Insurance Fund on workers' compensation fraud. Bureau staff have also worked hand-in-hand with the FBI, the U.S. Attorney's Office, the U.S. Postal Inspection Service, the State Police and local police departments and sheriffs' offices throughout the State.

In addition, the Arson Unit worked closely with the Auto Fraud Unit of the FDNY's Bureau of Fire Investigation and the NYPD's Arson Explosion Squad, as well as the Bureau of Alcohol, Tobacco, Firearms and Explosives. The Unit also acts as a liaison with the New York State Office of Fire Prevention and Control and local arson units and fire departments across the State.

4. The Staff

The Director of the Bureau is responsible for all of the Bureau's operations. The Deputy Director reports to the Director. In addition, the Bureau's Assistant Director of Research reports to the Director and the Deputy Director.

Bureau staff consists of 36 investigators, organized into eight specialized units: Arson, General, Medical, No-Fault, Auto, Workers' Compensation, Upstate and a newly established Major Case Unit. Each unit is supervised by a Deputy Chief Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of two Assistant Chief Investigators.

The Bureau also has a Training Officer who is responsible for in-service and firearms training for all investigative staff, as well as conducting training sessions for law enforcement agencies and industry groups. The Training Officer reports to the Chief Investigator.

In addition, the Bureau has a unit that includes a Senior Examiner and an Examiner who report to a Principal Examiner. The Bureau also has four support staff members who report to the Secretary to the Director.

5. Investigations

The Frauds Bureau received 22,079 reports of suspected fraud in 2007. Of that total, 21,337 were received from licensees required to submit such reports to the Department, and 742 were received from other sources, such as consumers and anonymous tips. A total of 1,072 new cases were opened for investigation during the past year. At the same time, investigations continued in numerous cases opened in prior years.

During 2007, the Bureau referred 388 cases to prosecutorial agencies for criminal prosecution and another nine for civil settlement or referral to the Department's Office of General Counsel for civil proceedings.

6. Arrests

Frauds Bureau investigations led to 708 arrests for insurance fraud and related crimes during the past year. That figure compares with 604 in 2006. Many of these investigations dealt with sophisticated conspiracies involving medical clinics, physicians and other health care professionals and attorneys. In one such case, a medical clinic operator in Buffalo pleaded guilty in February 2007 for his role in a staged accident fraud scheme. An arrest sweep that took place in New York City and in the Buffalo-Niagara region netted 30 suspects accused of participating in a series of staged accidents in Western New York in which the drivers and several passengers in each car falsely claimed they were injured and sought medical treatment at clinics that were involved in the scheme. In some cases, the suspects who claimed injury were hundreds of miles away in Brooklyn at the time of the alleged accidents. As part of his plea, the clinic operator also confessed to conspiracy to possess and distribute more than 300 grams of cocaine from April 2003 to May 2004. Prosecutors said he sold cocaine to an FBI agent on several occasions.

7. Restitution/Civil Penalties

In 2007, 147 persons were directed to pay almost $20.0 million in court-ordered restitution and individuals in six cases made voluntary restitution amounting to $31,723 during the year. In another 10 instances, insurers saw savings of nearly $341,843 in connection with fraudulent claims under investigation by Frauds Bureau staff. In addition, civil penalties totaling $553,100 were imposed in eight cases under Section 403 of the Insurance Law.

8. Fraud Prevention Plans/Public Awareness Programs

The Second Amendment to Regulation 95 requires all insurers that meet certain criteria to submit to the Department a Fraud Prevention Plan that includes establishing a Special Investigations Unit (SIU) to be responsible for the investigation of cases of suspected fraud and for implementation of fraud prevention and reduction activities. At year-end 2007, there were 140 plans on file.

The Second Amendment to Regulation 95 also includes a requirement that insurers develop a public awareness program focused on the cost and frequency of insurance fraud and methods by which the public can prevent it. The programs must be geared to reach a wider audience than an insurer's policyholders and applicants. In an effort to achieve that goal, the New York Alliance Against Insurance Fraud, a coalition of more than 100 insurers that write property/casualty, life, health and disability insurance in New York State, carries out advertising campaigns using newspapers, radio and television to target insurance consumers. In addition, several individual companies have ongoing programs to heighten awareness and reduce public tolerance of insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year. In addition, the Bureau has a frauds hotline (1-888-FRAUDNY) and consumers are encouraged to report suspected insurance fraud. Calls to the hotline averaged 49 a week during 2007.

9. Civil Enforcement

Section 403 of the New York Insurance Law, passed by the Legislature and signed into law by the Governor in 1992, authorizes the Insurance Department to impose civil penalties of up to $5,000 plus the amount of the claim on individuals who commit fraudulent insurance acts. In addition, under the provisions of Section 2133 of the Insurance Law, the Department is permitted to levy a fine of up to $1,000 for possession of a fraudulent automobile insurance identification card and up to $5,000 for each additional card possessed. These provisions of the Insurance Law give the Bureau the authority to impose sanctions in cases where the monetary value is not sufficient to justify criminal prosecution, or in which the extremely high burden of proof required in criminal cases cannot be met.

10. Major Cases

Numerous investigations were brought to successful conclusion during 2007. Below are summaries of some of the Bureau's 2007 cases.

a. Arrest Sweep Nets 10

A seven-month joint investigation by the Frauds Bureau, the Queens District Attorney's Office, the State Insurance Fund and the Office of the Workers' Compensation Fraud Inspector General resulted in the arrest of 10 suspects in a workers' compensation fraud scheme totaling more than $110,000. Most of the defendants were accused of collecting workers' compensation benefits while they were employed. In one instance, a former employee of the New York City Housing Authority began collecting benefits after he sustained a work-related injury in 1983. However, he failed to inform the Workers' Compensation Board that he took a job in the construction industry in 2003. During 2003 and 2004, he collected $19,365 to which he was not entitled. Another suspect in this case, an independent contractor, submitted a fraudulent Certificate of Insurance in order to obtain a job installing floors. The Certificate falsely stated that he had workers' compensation insurance to cover his employees when, in fact, no such coverage existed.

b. Internet Fraud

An investigation into Internet drug sales by the Albany County District Attorney's Office, working with the Frauds Bureau, the New York State Health Department's Bureau of Narcotics Enforcement, the Florida Attorney General's Office, the U.S. Justice Department and the IRS, led to the arrest of four suspects with ties to a pharmacy in Orlando, FL., that did an estimated $6 million in business in New York State during 2006, including $250,000 in drugs that were sold and shipped directly to Albany County. Arrested during a raid on the pharmacy were the husband and wife who co-owned the business, the husband's pharmacist brother, and the company's marketing director. The pharmacy allegedly filled prescriptions for steroids and human growth hormone via the Internet in order to circumvent federal and state prescription drug laws. New York has some of the strictest drug laws in

the country. Twenty additional suspects were subsequently arrested, the most recent on October 17, 2007. Among them were two doctors, one of whom was practicing without a license. Both were charged and convicted for their participation in the scheme. Thus far, there have been ten convictions in the case. The unlicensed doctor was sentenced to a minimum of two-to-four and a maximum of three-to-six years in prison. The remaining suspects received five years probation. Among them were the pharmacy's sales representatives.

c. A Family Affair

Four members of a Rochester family, including grandparents, son and grandson, and the son's girlfriend, were arrested during a drug buy involving $8,000 worth of Oxycontin. They were each charged with multiple counts of conspiring to possess with intent to distribute and distributing pain medication. They also allegedly knowingly committed health insurance fraud by obtaining insurance payments for prescription drugs that were intended to be sold illegally. A task force consisting of special agents from the FBI and investigators from the Frauds Bureau and the New York State Department of Health participated in this investigation.

d. Fictitious Company

An investigation by the Frauds Bureau and the U.S. Postal Inspection Service resulted in the arrest of a former insurance agent on charges that he ran a phony insurance scheme that victimized 240 people. His arrest stems from an investigation initiated in 2003 when the Department was contacted by a Dutchess County woman who incurred $50,000 in medical expenses resulting from complications during a pregnancy. She told the Department's Consumer Services Bureau she was unable to have the expenses paid through the insurance she purchased from the suspect in this case. She was subsequently forced to file for bankruptcy. At the same time, MVP Health Care, a health maintenance organization in Schenectady, reported suspected irregularities in numerous applications it had received from the suspect. Investigators found that applications ostensibly from four different individuals contained the same handwriting and that suspicious alterations appeared to have been made on several applications. In addition, a large number of applicants were identified as "management" employees for the same organization, Professional Employees Management Corporation (PEMC), a company later determined to be fictitious. The suspect solicited business from retirees, small business owners and others on the basis that they could obtain less costly insurance through the small group plan he purportedly operated. However, a review of the suspect's records revealed that his customers were actually paying more than they would have paid through other insurance plans and that they were overcharged by a total of $76,747. In addition, the suspect was charging customers a $12 monthly union fee. These customers were not members of a union nor was the money turned over to any union. While some people who purchased insurance did received coverage for their medical expenses, the suspect failed to forward $60,645 in premiums to MVP Health Care. Moreover, he collected $13,232 in unauthorized fees. The Insurance Department revoked his agent's license in June 2005.

e. Eleven Charged

An investigation by the Frauds Bureau, the Queens District Attorney's Office, the State Insurance Fund and the Office of the Workers' Compensation Fraud Inspector General resulted in the arrest of 11 suspects charged with nearly $300,000 in workers' compensation fraud. Most of the suspects allegedly were working while collecting benefits. Others presented forged Certificates of Insurance coverage or misrepresented the size of their workforce and/or payroll in order to pay less than the required premium. One defendant alone was accused of collecting nearly $88,000 in benefits to which he was not entitled.

f. High Maintenance

The owner of a Queens limousine service and two chop-shop owners were arrested in September for their participation in an auto-theft ring. Thirteen others have also been charged, the most recent on 11/6/07, bringing to 16 the number of defendants arrested in this case. Ring members were accused of stealing private limousine-style vehicles (e.g., Lincoln Town cars, Mercedes Benzes and Ford passenger vans) which were then transported to the chop shop where they were dismantled. The parts were used to maintain the fleet owner's vehicles. The 21-month-long investigation that led to the arrests was conducted by the Frauds Bureau, the NYPD's Auto Crime Division and the Queens DA's Office.

g. Stung

Twenty-six suspects were arrested as a result of a sting operation targeting car thieves on Long Island and in the New York Metropolitan Area, and 11 more are being sought. In addition, 92 vehicles with a Blue Book value of more than $1 million were recovered. Several of the cases involved owners who "gave up" their cars for the insurance settlement. In another case, an auto mechanic made duplicate keys in order to steal the cars. Undercover detectives operated a garage where they purchased the stolen cars, trucks and motorcycles from thieves for five percent to ten percent of their Blue Book value. Suffolk County District Attorney Thomas J. Spota held a press conference to announce the arrests.

h. Steal and Scrap

The co-owners and operators of a scrap yard in Niagara Falls were arrested on December 5, 2007 and charged with numerous counts of grand larceny, criminal mischief and dismantling vehicles without a registration. They were accused of stealing vehicles with the likely help of a tow truck and crushing or dismantling them for scrap. Investigators believe that they targeted low-end cars because they could do so without raising a lot of eyebrows. On September 5, 2007, a search warrant was executed at the office/home of one of the suspects and a second warrant at the scrap yard where two stolen vehicles were located. Business records were also confiscated and turned over to the State Department of Taxation and Finance to determine whether proper sales tax was collected. The joint investigation was conducted by the Frauds Bureau, the State Police, the Niagara Falls Police Department, the DMV and the Police Departments from the Town of Niagara, Cheektowaga, North Tonawanda, Buffalo and Lockport.

11. Web-Based Case Management System

The Frauds Bureau's Web-Based Case Management System, known as FCMS, has been fully implemented since the first quarter of 2007. Approximately 85% of the Bureau's 2007 fraud reports (IFBs) were electronically transmitted and received remotely from insurers. The insurers obtained secure accounts through the Department portal which allows them access to FCMS.

Once the IFBs are received, they are automatically routed to the appropriate supervisor for review and assignment to an investigator. Investigators use FCMS to track all investigative tasks and events electronically from initial assignment through to closure. All supervisory staff members have full access to all cases and statistical reports.

The benefits to insurers include automatic acknowledgment of fraud reports, automatic notification of case assignments and eventual case disposition. Insurers also benefit from online help screens and an online manual of operations, as well as search and cross-reference features. Assistant Chief Investigator Karen Silverstein, together with other members of the Frauds and Systems Bureaus, will continue to monitor the system and make improvements and changes as necessary.

12. Audits of Insurer Special Investigations Units

The Frauds Bureau has stepped up its efforts to combat insurance fraud by accompanying members of the Health and Property/Casualty Bureaus on routine financial and market conduct examinations. Examiners review the insurer Fraud Prevention Plans for compliance with Section 409 of the Insurance Law. The Bureau also conducts independent audits and assessments and provides guidance to insurer Special Investigations Units.

13. Mobile Command Center

The Department's Mobile Command Center (MCC) gives the Department an on-site response capability to assist consumers with insurance issues when emergencies or natural disasters occur. The vehicle contains state-of-the-art communications equipment that enables communication between disaster sites, Insurance Department offices across the State and other locations. This past spring, for example, the MCC was deployed for more than 30 consecutive days to assist flooding disaster victims in Westchester County, New Rochelle and Staten Island.

During times when the Mobile Command Center (MCC) is not responding to emergency situations, it is used for outreach programs throughout the State. One such event occurred in September when the MCC was showcased across the street from the Capitol building. The MCC was displayed to give attendees of the GTC East 2007 technology conference being held in Albany an opportunity to tour the vehicle and get a better understanding of its capabilities. The conference, which is the largest technology exhibit in the State, attracted several thousand attendees from the public and private sectors.

Staff from the Governor's Office, the Attorney General's Office, the Office of General Services and the Departments of Labor and Environmental Conservation were among the many visitors to the MCC during the two-day event. There was significant interest in the latest computer and electronic communications systems the MCC is equipped with. The visitors also had high praise for members of the Department's Frauds and Consumer Services Bureaus who were on hand to conduct tours and demonstrations of the vehicle's capabilities. The MCC not only brought a greater public awareness of what the Department provides in terms of service to consumers and the insurance industry but also demonstrated how well Department staff perform these tasks.

14. Partnering With Prosecutors

Under a program initiated in 2003, Frauds Bureau investigators are assigned to prosecutors' offices to work side-by-side with their investigative staff. During 2007, the Bureau had investigators in nine prosecutors' offices across the State. As of year's end, one investigator was assigned to the Suffolk County DA's Office full time. In addition, we had one investigator in the Nassau County DA's Office two days a week; one investigator one day a week in Queens; and one investigator one day a month in both the Putnam and Dutchess County DAs' Offices. We also had one investigator in the Albany County DA's Office three days a week, one investigator three days a week in Westchester, one investigator three days a week in the Bronx, and an investigator two days a month in the Monroe County DA's Office.

15. Directions for 2008

a. New Major Case Unit

The Frauds Bureau has established a Major Case Unit that will focus on the investigation of systemic insurance fraud involving organized conspiracies. The Unit will be headed up by a Deputy

Chief Investigator and will include five investigators who were selected from the Bureau's specialized units because of their expertise in the investigation of specific types of insurance fraud. As members of the Major Case Unit, these investigators will take the lead in investigating complex insurance cases involving no-fault, commercial rate evasion, health care fraud and workers' compensation premium fraud.

b. New York Health Care Fraud Task Force

A multi-agency task force was formed in 2007 to address health care fraud in the New York area. The mission of the New York Health Care Fraud Task Force is to identify, investigate and prosecute health care fraud. The monetary impact of health care fraud is staggering and is the reason for the formation of the Task Force. Government and non-government experts estimate that fraudulent health care billing amounted to between $60 billion and $200 billion in 2006. The Frauds Bureau was among ten federal, New York State and local government agencies that signed on in February 2007 to participate in the Task Force and will continue to be an active member during the coming year. The FBI is the lead agency. Other members include the IRS, the NYPD, the MTA, the U.S. Departments of Labor and Veteran Affairs, the U.S. Office of Personnel Management Inspector General's Office, the New York City Human Resources Administration and the National Insurance Crime Bureau.

c. Electronic Filing of SIU Annual Reports

Regulation 95 requires insurers that meet certain criteria to file a Fraud Prevention Plan and to establish a Special Investigations Unit (SIU) to be responsible for investigating suspected fraudulent activity. The Regulation also requires SIUs to file an Annual Report with the Insurance Department no later than January 15 of each year describing the insurer's experience, performance and cost effectiveness in the detection, investigation and prevention of insurance fraud. Beginning with the report due January 15, 2008, insurers will be required to submit their Annual Report electronically through a secured environment on the Department's Portal Web site. Hard copy submissions will no longer be accepted. Instructions for electronic filing can be found on the Web site.

d. Erie/Niagara Counties Motor Vehicle Theft and Insurance Fraud Task Force

The City of Buffalo Police Department is working toward establishing a Motor Vehicle Theft and Insurance Fraud Task Force in Erie and Niagara Counties to develop and implement a strategy for reducing the incidence of stolen vehicles and auto-related insurance fraud in those counties. The Task Force is expected to become operational early in 2008. The Frauds Bureau has agreed to participate in the activities of the Task Force, along with the Department of Motor Vehicles, the Erie and Niagara County DAs' Offices, the Buffalo Fire Department, the Erie County Sheriff's Office, the Niagara Falls and Cheektowaga Police Departments and the National Insurance Crime Bureau. The Buffalo Police Department will act as Chair.

16. Legislation

The Frauds Bureau requests and/or supports the following legislative changes:

- Providing the Superintendent of Insurance with the authority to establish standards for the public awareness programs that insurers are required to develop under the provisions of Regulation 95;
- Upgrading the status of Insurance Frauds Bureau investigators from peace officers to police officers, enabling them to act independently in the execution of such tasks as search and arrest warrants, court orders relating to electronic surveillance and summary arrests;
- Making it a crime to present materially false statements on an insurance application for personal lines insurance;

- Making it a felony for third parties, known as runners, to recruit patients and clients for health care providers and attorneys in insurance fraud schemes;
- Increasing the penalties for those who falsify Police Accident Reports;
- Adding language to Section 176.05 of the New York State Penal Law to specifically include electronic and oral communications in the definition of insurance fraud;
- Mandating license suspension and a fine for a first offense and license revocation for a second offense for agents and brokers who produce unauthorized auto insurance identification cards;
- Adding a provision in the Insurance Law to require car dealerships with an on-site insurance broker to allow the Insurance Department access to their records;
- Establishing a TIPS program;
- Amending the Penal Law by adding a description of a fraudulent no-fault insurance act and decreasing the monetary threshold for the commission of insurance fraud in various degrees;
- Requiring a periodic certification of continued eligibility by recipients of workers' compensation or disability benefits;
- Creating a class D felony for insurance activity for which a license is normally required by certain previously licensed individuals and entities that are no longer licensed at the time of the violation;
- Creating a class E felony for unlicensed insurance activity by any individual;
- Subjecting unlicensed insurance activity to civil penalties after notice and hearing before the Insurance Department;
- Providing for automatic revocation of licenses under Article 21 of the Insurance Law upon conviction of the licensee for a felony;
- Requiring that life insurance policy applications include a positive identification of the insured;
- Increasing civil penalties for knowingly possessing, transferring or using fraudulent insurance documents;
- Creating a class E felony for possessing or uttering a false insurance document/instrument;
- Prohibiting the participation in the insurance business of individuals who have been convicted of felonies involving dishonesty, breach of trust or other violations of Article 176 of the Penal Law unless such persons first obtain the written consent of the Superintendent of Insurance for such activities;
- Amending §2111 of the Insurance Law to prohibit a revoked licensee from becoming employed in any capacity by an entity subject to the provisions of Article 21 without the prior written approval of the Superintendent;
- Increasing penalties in the Vehicle and Traffic Law to reduce the number of uninsured or unlicensed motorists in New York State;
- Requiring no-fault and workers' compensation insurers to provide explanations of benefits in response to claims filed for health care services under those programs;
- Modifying the reporting date for the Frauds Bureau Annual Report (pursuant to §405 of the Insurance Law) from January 15 to March 15 of each year; and
- Modifying the reporting date for insurer Special Investigations Units annual reports (pursuant to §409 of the Insurance Law) from January 15 to March 15 of each year.

Section 405 of the New York Insurance Law requires the Superintendent of Insurance to submit to the Governor and the Legislature by January 15 each year a comprehensive summary and assessment of the operations of the Frauds Bureau. The 2007 Insurance Frauds Bureau Annual Report is available on the Department's Web site at www.ins.state.ny.us.

F. INFORMATION SYSTEMS & TECHNOLOGY BUREAU

The Information Systems & Technology Bureau (Systems) provides information technology products and services to approximately 950 Insurance Department employees and supports the Department's technical infrastructure. Systems' clients include insurers, the public, federal, state and local agencies, other insurance regulators, actuaries, insurance examiners, frauds investigators, risk management specialists, real estate appraisers, lawyers, researchers and statisticians.

In addition to providing the technical infrastructure, the Bureau provides a variety of support services including consulting, troubleshooting, training, maintenance and research and development. Systems develops custom client/server, web-based, and workflow applications while maintaining legacy mainframe systems. The Bureau utilizes enabling technologies such as scanning, imaging and workflow.

The Bureau consists of several units, many of which encompass multiple sections: Financial Services; Applications Services; Data Base Administration/Data Communications; Technical Services; Operations and Production; and the Projects Office.

The Financial Services Unit (FSU) works with computer applications that are specifically designed to handle, process and analyze thousands of insurer financial statements. FSU is responsible for the automation, verification, troubleshooting, updating and maintenance of the annual statement, the supplement and other electronic data capture projects, which form the Department's integrated financial database. FSU assists clients with the NAIC's and the Department's automated financial analysis tools used for monitoring insurer solvency, liquidity and profitability.

The Applications Services Unit (ASU) develops, enhances, maintains, purchases, supports and customizes all applications that do not fall under the FSU. These include systems that support the Department's administration and bureau operations and aid in fulfilling regulatory requirements. Major applications development initiatives and modifications are implemented to incorporate changes in the New York State Insurance Law, rules and regulations and to respond to industry crises. Other projects and changes are initiated as a result of updated business procedures or the need to eliminate inefficient/ineffective and/or duplicate procedures. The unit also is responsible for managing the integrated financial general ledger and accounts receivable systems

The Data Base Administration/Data Communications Unit (DBA/DCU), Technical Services Unit (TSU) and the Operations & Production Unit (OPU) are responsible for the Department's technical infrastructure. Collectively these units are responsible for data communications, database administration, network installation and maintenance, servers, Local Area Networks, Wide Area Networks, Virtual Private Network (VPNs), security and microcomputer equipment. Staff performs network monitoring, backup and recovery services, antivirus protection, SPAM filtering, disk management, and install and maintain all third-party software.

The Systems Bureau operates numerous servers, which comprise the Department's Local Area Network (LAN), and Wide Area Network (WAN) environment. Components of the network include file and print servers, Storage Area Networks (SAN), Domino mail and applications servers, Sybase and Oracle DBMS servers, fax servers and imaging/document management servers. Other application servers include, but are not limited to, batch-processing servers, Web applications servers, antivirus management servers, test and development servers, etc. TSU supports four Microsoft networks, all connected via a WAN: Albany, New York City, Buffalo, and Mineola. The smaller satellite offices (Rochester, Oneonta and Syracuse) are also connected via the Department's Virtual Private Network.

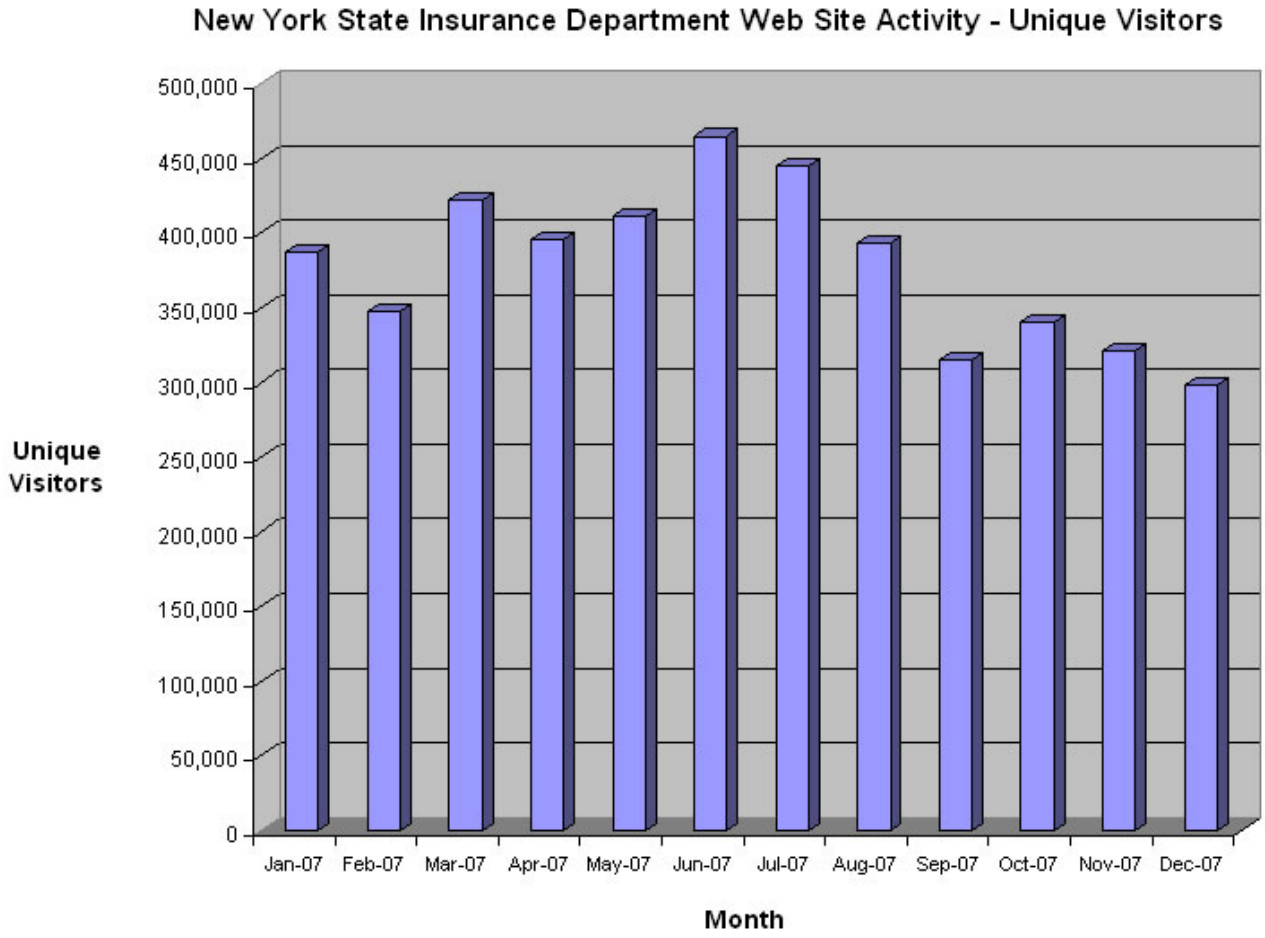
The Operations and Production Unit (OPU) is responsible for production and for the Computer Operations, and Help Center functions. The Help Center is the first line of support in assisting the client base, and encompasses a wide range of significant responsibilities and functions. Effective change control is the essential ingredient for an effective Operations and Production environment.

The Project Office makes use of the team approach to accomplish large, complex projects as well as those of a special or unique nature. Examples include Enterprise Portal development, workflow/imaging development, website and intranet development, field examination IT support, agency moves, Systems' Disaster Recovery/Business Continuity planning, e-commerce/e-government, joint agency initiatives, Lotus Domino development, Consumer Imaging and Information Management System (CIIMS), Licensing Information Network Exchange (LINX), Frauds Case Management System (FCMS) and NAIC electronic initiatives.

1. Web Site

The Department's main Web site and supporting "mini" Web sites – Healthy NY, Captive Insurers and Caregivers continued to play a vital role in communicating with and providing services to our diverse constituencies during 2007. The Department's activities and applications are reflected on these sites. In 2007, there were 5,226,262 visits to the Department's Homepage, a 23% increase over the previous year. The number of these visits, by month, is displayed in the following chart.

CHART H



The Department takes pride in its Web site's depth of content, relevancy, and currency. During 2007, a tremendous amount of research and effort took place regarding the current content, redesign and restructuring work. A comprehensive Web site overhaul is scheduled for early 2008.

Below are the major Web site related accomplishments during 2007:

- 2007 Consumer Guides (Automobile, HMOs, Health Insurers, Long Term Care)
- 2007 Financial Property Company Pre-audit Questionnaire
- 2007 Informational CD – for the New York State Fair
- 2006 Annual Ranking of Automobile Insurance Complaints
- 2006 Annual Statement and New York Supplements
- External Appeal Program Annual Report - for the 2005 year (in collaboration with NYSDOH)
- Frauds Bureau Annual Report to the Governor and 25-Year Retrospective, 1981 - 2006
- Regulations: Five-year Review of Agency Rules, January 2007 Regulatory Agenda
- Google Search functionality
- Healthy New York: Eligibility Screeners, 2006 Annual Report, 4 new domain names (nine (9) total), New Department Guidance section and HMO Provider Directory page; merged "HMOs and Rates by County" page; expanded navigation
- Senior Citizens - a new redesigned section for this information
- W3C (HTML 4.01) Compliance - Captives, Caregivers, and Healthy New York sites.
- Workers' Compensation Rate Filing Index and 2007 Rate Filing Materials
- Timothy's Law - Information about Mental Health Parity
- New content; Improved layout (Home page, 'Latest Updates', Consumers index, Accident and Health Product Checklists and Outlines: Small Business 'Corner', DMV Insurance Codes and Company Contacts, Flood Insurance Training Requirements for Property & Casualty Insurance Producers, Purchasing Groups (Insurers/Property), COBRA FAQs, and many other pages)
- New "Fill-in" forms utilizing Adobe functionality
- Prelicensing Education Program: New Insurance Exam Content Topic Locator documents
- Posted 53 NYIN Alerts

2. Intranet

The Department's Intranet is a strategic internal communication facility that contains a wide range of content relevant to Department staff. The Intranet is continually updated to facilitate quick exchange of information throughout the Agency.

Current areas that are continuously updated include, but are not limited to: Annual Statement file links; up-to-date examination schedules; database entries reflecting the Department's Record Retention Program; Online HelpCenter updates; Department Events; EAP postings; Department staff accomplishments and photos; Office Building and Cohort Procedures; minutes from Systems Bureau liaison meetings and Web Liaison meetings; HRM vacancy announcements; General Administration Manual; Human Resources Management (HRM) Announcements; PowerPoint presentations and various internal employee forms.

3. Annual Statement Filings

The Department continues to collect the electronic filing of insurer financial statements via the National Association of Insurance Commissioners (NAIC) Web site. Virtually all companies now file this way. This one stop shopping approach allows companies to file not only national forms over the internet but also New York supplemental data. The Department has eliminated the hard copy paper requirements for the Management Discussion and SVO forms for all foreign companies by using the

Adobe Acrobat PDF filings made available on the NAIC Web site. The Department announced that beginning with the 2007 filing due March 1, 2008, all Foreign Insurers and foreign accredited reinsurers that file their Annual Statements and New York Supplements, Quarterly Statements and Audited Financial Statements pursuant to Section 307 or 308 of the New York Insurance Law on the Property and Casualty and Title blanks, are no longer required to file hard copy (other than a Jurat) as long as they file electronically with the NAIC via the Internet. It is the goal of the Department to continue this process and eventually eliminate all paper filings.

4. Imaging and Workflow:

The Consumers Services Bureau uses the Imaging and Information Management System (CIIMS) deployed in November 1998. CIIMS is a full featured imaging and workflow application for processing consumer complaints and investigations. In 2007, new workflow processes Workers compensation complaints and identifies Service Contract and Senior citizen related complaints as well as tracking Timothy's Law complaints.

The amount of paper processed continues to decrease annually as electronic handling increases. In 2007 the number of complaints received online increased representing 33% of all complaints received, compared to 28 percent the previous year. The number of responses from insurers also increased in 2007 and represented 23 percent of all responses, up from 22% the previous year.

In 2007 CIIMS was expanded to other Bureaus in the Department. Workflows, rules, and letter templates were added to provide two units of the Property Bureau, Excess Lines and No Fault, with the ability to use CIIMS for processing their complaints. This replaces paper-based and mainframe processing systems. We expect to expand CIIMS to handle all Department complaints.

Other workflow applications enabled the business bureaus to reduce paper. The Life Bureau integrated their imaging operations across the New York City and Albany offices, as well as added a great deal of functionality in addition to the Rate and Form Filing processing. Content and functionality were added to facilitate routine business, and also subject files were added to provide better information overall. This allows for searching based on common content areas. The additional utility provides background for both managers and examiners alike, and positions the Life Bureau for succession planning.

The Property Bureau and Health Bureau continue to utilize imaging to enhance their Rate and Form Filing processes. They will continue to migrate to non-proprietary file formats to expedite the FOIL process, as well as seek opportunities to modernize other business processes.

The Capital Markets Bureau continues to employ imaging to store all document sources currently filed in paper. This permits concurrent use of the information and permit multiple access methods to a centralized repository. Storing the documents in their original format of Excel spreadsheets or Microsoft WORD (as examples) also positions them to leverage work completed for former projects.

These workflow enhancements continue to assist in phasing out legacy mainframe applications.

5. Domino Workflow Applications

Domino provides solutions that enable the Department to integrate messaging and applications that manage workflow activities and retain historical information in many regulatory and administrative areas of the Department.

During 2007, major accomplishments include:

- Direct Pay Contracts Document Management System – manages the workflow on these contracts including approval of invoices and the current state of the drawdown expenditures against these contracts.
- Email Blast Tool – designed to manage large volume emails sent by the Department clients. This application not only sends the email, it facilitates the responses received and follow-up correspondence when necessary.
- FOIL Tracking System – we continued to integrate solutions to meet Legislative reporting requirements.
- Counsels Assignment/Litigation Tracking System – enhancements to the existing system enable our Office of General Counsel to better manage corporate and title investigations and the issuance of subpoenas.

Other work included the introduction of archival infrastructures, the integration of Java development language / browser-based methodologies as well as resource sharing between the Lotus Domino and other department standard technologies.

6. E-Commerce

E-Commerce initiatives continued to provide significant value to our external constituents as well as Department staff. The number and variety of processes that are available on-line has expanded year after year and is now the “defacto standard” for processing licensing related activities. Agents and brokers can apply for their original license or renew their licenses when the time comes; they can pay their fees via a credit card and their relationships with insurance companies (appointments and terminations) are all handled quickly and seamlessly via the Internet. Processes that once took weeks or months to complete are now typically processed overnight. The Department processes hundreds of thousands of transaction on behalf of our customers and collects millions of dollars without touching paper forms, handling checks or bank deposits.

In response to legislation, the license renewal process required modifications. Prior to the new Legislation, licenses were renewed on a license class boundary with life agents and brokers renewing their licenses in odd numbered years, while property agents and brokers renewed their licenses in even numbered years. In January 2007, individuals began renewing their licenses (all classes) on their birthday. This legislative change aligns New York with the other states in the nation and provides a more uniform approach to licensees by the regulators. The transition went smoothly and the Department continued to handle the day-to-day traffic as efficiently and effectively as our constituents have come to expect.

The voluntary electronic funds transfer of the Fire Tax 2% assessment continues to gain popularity. In 2007 the number of fire districts that opted to receive electronic payments was 1848, up from 1600 in 2006. Now over 79% of all fire districts receive their payments electronically and the dollar volume distributed this way was over $25 million. This increase in electronic payments continues to streamline what has traditionally been a paper intensive process.

7. Enterprise Portal

Sybase Enterprise Portal (EP) technology is a valuable business tool that provides on-line access to applications and information across platforms and back-end databases. The Portal's Security Administration allows us to manage both internal and external clients by individual application. It sets in place a security structure in which each user can access those applications for which they are authorized to access and the roles they are authorized to execute. Applications for Department staff whether web based or legacy systems, use a single user id for accessing information across the entire Department. Some examples are: Central File, Inter-Active Insurance Company Search, OGC Opinions, OGC Historic and Summary and Industry Reports.

Last year, using the Portal security model, we implemented Automated Delegated Administration provided for creating accounts, application sign-up and delegating the management of company user accounts by the application's "Trusted Source". In 2007 we expanded Web Based external facing applications to include secure data collection applications for the Insurance Industry thus eliminating the need for paper based filings. The Department maintains a variety of interactive applications for the Insurance Community at large.

Among the enhancements to (EP) this year:

- The release of the first applications that allow on-line "Approvals" by an Executive Officer & a Frauds SIU Manager; this feature mimics an "eSignature" up to 3 levels.

- The release of the first applications using "Attestation/Certification" component with language approved by Office of General Counsel.

- Annual Frauds SIU Report is a Secure eForm application utilizing Automated Delegated Administration. The eForm application is the collection of summary data as reported by the Insurance Industry. The electronic application has allowed for the discontinuance of the paper filing which allows for improved reporting capabilities.

- Hide Exhibit eForm is a Secure eForm application utilizing Automated Delegated Administration. The eForm application is the collection of data submitted semi-annually over the Internet with additional reporting capabilities.

- HIDE also provided an alternative eBulk (single file) submission. The eBulk submission is based on specifications provided by The Department for a tab delimited text file or an XML DTD [Document Type Definition] file thus alleviating companies the need to fill out an eForm.

- Retirement System & Pension Funds eDocument Submission is a secure eAttachment application utilizing Automated Delegated Administration. The eAttachment application provides for the submitting of document files online for up to 12 New York Annual statement related files for the 2007 filing for twenty-one public & private retirement system & pension fund entities due March 1. Other benefits include a built-in "Tracking" module to help monitor submissions and browsing/viewing files directly.

- Liquidity & Severe Mortality Inquiry eDocument Submission is a secure, eAttachment application utilizing Automated Delegated Administration. The eAttachment application provides for the submitting of document files in a variety of formats. The application provides for the collection of actuarial data as mandated & required per Insurance Law Section 4217.

We provided current data for the following Interactive Web/Portal applications:

- Long Term Care for comparing sample premium rates for long-term care (LTC) insurance in New York. Released in conjunction with the Governor's Campaign media initiatives.

- Interactive Guide to Auto Insurance which includes the new interactive application for viewing and comparing Sample Auto Premiums. This application updates the Department's Automobile Insurance Guide enhancing the consumer's ability to compare insurance rates. Features facilitate calculating additional coverages and comparing coverages between two companies and among all companies. It also

provides direct links to all representative companies' web sites and our Department website that contains links to all Automobile Insurance companies in New York.

- Licensing Interactive Reports are also available on the website for the following subject matter. In addition to providing current information from the Licensing database, Report Data for Service Contract Providers can be saved in a variety of output Formats (Excel, XML and CSV):

  1) Bail bond Listing - This lists our current Bail bond Agents with license numbers and business addresses.
  2) Continuing Education Provider listing - Lists Provider Name, Primary Contact, Address and phone.
  3) Monitor Listing - Lists Monitors with Address and Phone numbers by county.
  4) Prelicensing Provider/Course Listing - Lists Prelicensing Providers with addresses and phone numbers.
  5) Service Contract Registrants - Lists Company Name, Effective Date, Expiration Date, and Address

The Department maintains a FOIL eForm application and an updated overview page together with the Domino FOIL Request Tracking System. This allows for the electronic submission and response of FOIL requests.

Central File application provides a consolidated view of a company's profile, rather than viewing data on an individual application basis. It provides a Web based presentation already familiar to those who use our Web site and Intranet. The Portal technology supports the Central File requirement of a centralized information management portal repository whereby Department personnel can access and search all organizational information. These data sources include Microsoft Access, Excel and Word files along with Adobe PDF files and application data residing in Sybase databases.

Sybase Enterprise Portal (EP) technology supports the requirement of full text search for OGC Opinions. OGC Opinions provides Public Opinions only for non-OGC staff members. Access to the full set of Opinions is maintained for OGC users through Portal security. OGC Opinions includes features for "highlighting" within the document retrieved.

8. Infrastructure

The Systems Bureau continues to enhance, expand and harden the Department's infrastructure. Numerous initiatives have been implemented towards this end. The Systems Bureau works with the New York State Office of Cyber Security and Critical Infrastructure Coordination to continually enhance security and benefit from the experience and expertise of other agencies.

Major accomplishments made in 2007 include the redeployment of newer switch technology to all of our satellite offices. Branch office equipment was upgraded to later code levels to take advantage of enhanced encryption between offices. Additional equipment was added to allow executive staff to access their mail via any web browser. Systems participated in the planning and configuration of new office space on the seventh floor in Albany which will be used by staff working on the Timothy's Law project. New video conferencing hardware was purchased for several of our executive conference rooms and the new space on the seventh floor. Enhancements were made to our data communication lines between offices to provide better service to these locations, and also redundancy to our Internet connection in Albany. Enhancements were also made to network management software to help staff manage the network.

9. Disaster Recovery/Business Continuity

The Systems Bureau holds bi-weekly Systems Disaster Preparedness meetings covering disaster recovery and business continuity. Staff from all units meet and discuss current projects and issues. A matrix listing all current, ongoing, and completed projects are listed. Related documents are stored on the network, and on pen drives that staff carry with them. We also copy these documents on removable media as well. The Systems Bureau continues to contribute to the Department Disaster Recovery plan and participates in periodic preparedness drills.

10. Frauds Case Management System

The Frauds Case Management System (FCMS) was released in February 2007. FCMS is a web based system with two components; an internal imaging and workflow section used by Frauds Bureau staff for case management and an external module that enables insurers to transmit reports of suspected Fraud (IFB's) electronically. Insurers obtain remote access to FCMS through the Department's portal.

The Frauds Bureau received approximately 22,000 reports of suspected fraud (IFB's) in 2007. Of these, approximately 85% were transmitted remotely.

Benefits to insurers include automatic notification of the receipt of submissions and updates regarding case assignment/disposition. Online search and cross reference features are also available.

Frauds Bureau staff benefit from the system's workflow/tracking features which result in more efficient processing of cases, as well as enhanced management reporting functionality.

G. OFFICE OF GENERAL COUNSEL

The Office of General Counsel's principal responsibilities include: providing the Superintendent, Deputy Superintendents, Bureau Chiefs, and public with legal opinions and advice concerning the Insurance Law; enforcement, including conducting all of the Department's disciplinary proceedings and negotiating stipulations with insurers and producers; coordination of investigations into insurance matters with the New York State Attorney General's office, federal Securities and Exchange Commission, and/or other law enforcement authorities; supervision of all litigation brought by and against the Department; drafting and reviewing legislation, regulations, and circular letters; supervision of all conversions, corporate transactions, and demutualizations; legal review of all Requests for Proposals (RFPs) and state contracts; review of applications for insurer incorporation, licensing and related corporate activities; and managing responses to Freedom of Information Law requests made to the Department.

1. Legal Opinions

The Office of General Counsel issues legal opinions interpreting the Insurance Law to insurers, trade associations, producers, consumers, and city, state, and federal agencies. These opinions also provide guidance about the Department's policies. OGC issued nearly 300 opinions in 2007. All non-privileged opinions are posted to the Department's website (www.ins.state.ny.us) and are available to the public. OGC also has a public opinion database with a search engine that is available to the entire Department. This extensive electronic database includes more than 12,000 publicly issued opinions of OGC dating from the 1930s to the present, and is updated weekly as new opinions are issued.

Among the corporate change matters that OGC supervises are applications by Article 43 health insurers to convert from not-for-profit to for-profit status, the review of which culminates in the issuance of an Opinion and Decision as to whether the conversion is approved. In 2007, OGC worked extensively on the proposed conversion to for-profit status of Emblem Health, Inc., including by meeting frequently with the company, closely reviewing the proposed conversion plan, and formulating RFPs and drafting contracts in connection with hiring banking, accounting, legal, and actuarial consultants to advise the Department regarding the proposed transaction. The review process will continue in 2008.

2. Enforcement Matters

The Office of General Counsel handles the Department's enforcement matters, including all administrative hearings, disciplinary proceedings, civil fraud proceedings, and imposition of penalties pursuant to stipulations entered into in connection with consumer complaints, market conduct examinations, and financial condition examinations. In 2007, the Department entered into approximately 393 stipulations imposing penalties on insurance companies or producers (i.e., agents or brokers). In addition, the Department conducted approximately 73 administrative hearings, which resulted in disciplinary action against approximately 67 Department licensees.

OGC supervises and coordinates the Department's joint investigations and enforcement efforts engaged in with other law enforcement agencies, including the Attorney General's office. OGC oversees the Department's investigations of bid rigging and inappropriate compensation to producers in the property and casualty, life, and health insurance industries, as well as finite reinsurance and accounting practices, and title insurance industry practices, in coordination with the Attorney General's Office. During 2007, OGC continued to supervise the compliance examinations of Marsh & McLennan and Willis pursuant to the 2005 settlement agreements with these brokers.

In December 2007, the Department entered into a stipulation with Allstate Insurance Company and its affiliates in connection with Allstate's improper nonrenewal of homeowner's insurance policies in

coastal areas. Pursuant to the stipulation, Allstate agreed to discontinue the practice of nonrenewing homeowner's policies based on whether or not the policyholder had other insurance business, such as automobile or life insurance, with the company. Allstate also agreed to offer new policies to approximately 55,000 New York policyholders who had been improperly nonrenewed.

OGC also manages all outside litigation brought against the Department and all subpoenas and document requests served on the Department and its staff.

3. Special Projects

The Office of General Counsel contributes substantially to many special projects undertaken by the Superintendent. For example, in the spring of 2007, OGC played a significant role in mediating and resolving the seemingly intractable disputes between certain insurers who had still-unresolved insurance claims arising from the September 11, 2001 destruction of the World Trade Center and their policyholders. With OGC's assistance, the Department persuaded the parties to settle the outstanding claims for an aggregate $2 billion, thereby putting an end to highly contentious and longstanding federal and state court litigation, and benefiting the people of the State of New York by removing the last major impediment to the rebuilding of Ground Zero.

OGC attorneys also made important contributions to the Governor's Medical Malpractice Task Force, which is headed by the Superintendent, and worked to develop short- and long-term options for addressing medical liability costs by the end of 2007.

In addition, OGC attorneys participated in the Superintendent's initiative to stabilize the crisis in the financial guaranty insurance market by helping gather information regarding the insurers, conceiving of ideas to help improve the status of at-risk insurers, and contributing to the process of changing the law to prevent such crises in the future.

H. CAPITAL MARKETS BUREAU

1. General Overview

The Capital Markets Bureau (CMB), established eight years ago, serves the Department on matters affecting the regulation of capital markets activities of New York licensed insurers, and participates in the supervision of select public retirement systems and certain private pension funds of nonprofit organizations. CMB evaluates the various risks these activities bring to the financial condition of the insurers and pension funds.

The principal risk of capital markets activities within regulated entities is the potential for loss on investment instruments and investment portfolios that may materially affect capital adequacy. Managing this risk is the responsibility of the insurer's board of directors and management. A key to the regulation of capital markets activities is assessing what capital markets risks the insurer has and how it measures and manages these risks.

In year 2007, CMB met its objectives by providing to the various Department Bureaus the following services relating to capital markets and risk management issues:

- Furnishing examination support – including pre-planning and on-site participation;
- Working to analyze and closely monitor the Financial Guaranty Insurers, during their deteriorating structured finance risk, and interact with rating agencies, investment banks, and legislature on the subject
- Applying financial analytics to investment portfolios of insurers, including directing more attention to subprime and other structured securities, as well as alternative assets, such as hedge, venture capital and private equity funds;
- Participated in updating Regulation 85, regarding the NYS Common Retirement Fund
- Identifying investment/capital concerns and recommending follow-up actions;
- Conducting training for the Department's staff on capital markets and investment portfolio dynamics; and coordinating training on risk assessment and on Sarbanes-Oxley;
- Evaluating Enterprise Risk Management, risk management practices, and corporate governance of select insurers;
- Participating in special projects associated with major emerging industry and legislative issues;
- Responding to requests from the Life Bureau, Property Bureau, Health Bureau, Office of General Counsel, and Executive Bureau for diverse analytical support;
- Interfacing with external entities, including other regulatory bodies, investment firms, risk management consultants, third-party asset managers, securities analysts, and rating agencies;
- Leading and participating in various NAIC Task Forces and Working Groups; and
- Reviewing new and amended Derivative Use Plans of insurers, and monitoring derivative activities.

CMB employed its composite financial analysis framework designed to assess the investment performance of life and property/casualty insurers. The methodology, highlighting key investment ratios and credit quality ratings, primarily utilized financial information from the NAIC and Bloomberg databases. Its formulae identified insurers whose financial measurements placed them outside the normative range of their respective sector's financial profile. These insurers' investment portfolios were then subject to additional analysis by the Bureau. In areas of concern remaining after this targeted assessment, the Bureau solicited additional information on the companies' investment management criteria and objectives. When necessary, meetings or teleconferences were arranged to gain additional insights into the make-up of the portfolios, investment rationales, and approaches of these companies. Moreover, the integration of quarterly data into the reviews distributed to the Bureaus allowed for more comprehensive analysis.

CMB also continued to work in conjunction with the Life Bureau to establish and employ appropriate procedures and methodologies for evaluating the diverse investments held by the sizable public retirement systems in New York State. Ongoing development and further enhancement of key measures and review standards related to risk-based capital, risk management, organizational governance practices, and asset-liability management took place in 2007, and will continue to be addressed in 2008. CMB participated in the Life Bureau examinations of the two largest New York State retirement systems, the Common Retirement Fund, and Teachers Retirement System, finalizing both during the first half of 2008.

Last year, CMB continued to participate in on-site examinations, deliver in-house training programs, routinely disseminate news and information that served to enhance examiner understanding of the financial markets, and perform various Bureau-specific special projects. The Bureau's risk management specialists, held teleconferences with select third-party asset managers responsible for investing in fixed income securities and equities, and managing derivatives for insurers. These exchanges provided additional data and information governing these managers' oversight, compliance practices and interface with client-insurers as well as generated more detail on the establishment of and adherence to investment guidelines. Meetings and teleconferences with rating agencies and investment banks continued to be conducted in order to solicit and share information relative to the capital markets activities of insurance companies and to familiarize the Bureau and the rest of the Department with emerging products, such as new structured securities.

CMB maintained its active involvement in the work of the National Association of Insurance Commissioners (NAIC). It continued to preside over key groups responsible for the development of a risk-focused examination process better linked to principal solvency concerns, and the organizational and functional refinement of the NAIC's Securities Valuation Office (SVO).

2. 2007 Highlights

a. Capital Markets Bureau Reviews

The Bureau performed investment portfolio reviews on insurance companies selected for "Priority One" desk audits by the Life, Property and Health Bureaus. In addition, it targeted for more extensive evaluation a number of other companies whose measurements/investment parameters were at marked variance with their sector's norms. Following supplemental assessment, certain targeted companies were required to provide more information on investment policy, performance expectations and related data. The Bureau utilized a template for transferring certain annual and quarterly investment data from applicable NAIC investment schedules for further analysis in conjunction with the Annual Statement and periodic reviews. The same review protocol was followed for pre-exam and fourth quarter meetings initiated by the Life, Property and Health Bureaus.

The reviews culminated in reports submitted to the life, property and health bureaus. These reports featured the application of Bloomberg analytics to generate value-at-risk, duration, beta, and other equity and fixed income portfolio risk measurements, and when available or necessary, incorporated analysis of quarterly data. Additionally, migration in average credit quality of bond portfolios was highlighted. If applicable, the reports also included profiles on derivative usage. Depending on the outcome of the analysis, the risk management specialists recommended further action to the financial examination staff.

The Bureau utilized various databases that it developed to facilitate sector and special situation analysis for assessing the degree of impact on insurers' capital adequacy of the volatility of the equity market and the range of credit conditions associated with the fixed income sector. This monitoring

exercise served to address the prevailing risk management and capital market concerns in a changing economic and industry environment. In 2007, in addition to keeping abreast of improving quality of certain fixed income investments and the continuing rebound in the equity market, the Bureau oversaw the use of derivatives and the suitability of asset allocations. In order to augment the Bureau's in-house metrics and identify analytical frameworks that would further enhance the efficiency of the evaluation of diverse portfolios, the staff periodically met with companies specializing in developing sophisticated risk measurement systems and firms promoting "best practices" in the investment and risk management technology arena.

Table 59
ANALYTICAL EVALUATIONS AND REPORTS
2007

Type of Company	Priority 1 Desk Audits	Pre-Exam Reports	Targeted Evaluations	4th Quarter Meetings
Health	**5**	**4**	**-**	**-**
Life	**29**	**22**	**13**	**22**
Property	**11**	**39**	**18**	**1**
Total	**45**	**65**	**31**	**23**

b. Derivative Use

The Bureau continued to review filings of new Derivative Use Plans (DUPs) as well as amendments to approved DUPs of life and property/casualty insurance companies. Prior to approval, CMB conferred with the Property and Life Bureaus on companies whose DUPs initially did not meet the established regulatory standards so that appropriate modifications by these companies could be made. Also, CMB reviewed DUP amendment submissions when changes were made to derivative strategies, or the management or oversight of derivative activities.

Primarily, in conjunction with ongoing exams, CMB appraised the annual CPA reports on derivative usage and adherence to regulations submitted by the companies that are being examined. The risk management specialists combined with examiners from the applicable Bureaus followed up with these companies on any significant lack of compliance with their filed DUPs and the associative statutes, and on laxity of internal controls.

In 2007, risk management specialists examined 4 new DUPs. The proposed derivative usage largely reflected a range of swaps and options across various asset classes. Additionally, the Bureau evaluated 13 amended DUPs.

Table 60
DERIVATIVE USE PLAN (DUP) REVIEWS
2007

TYPE OF REVIEW	LIFE	PROPERTY
New DUPs	**1**	**3**
Amended DUPs	**10**	**3**
Total	**11**	**6**

In addition to reviewing Derivative Use Plans, CMB, together with Life Actuaries, reviewed a number of dynamic hedging programs, which Life insurers use to hedge their long-term variable annuities.

c. Examination Participation

In its participation in examinations, the Capital Markets Bureau was active in utilizing its formulated risk-focused examination procedures related to capital markets oversight. CMB's exam participation was largely on a targeted basis, focusing on specific areas of financial risk either detected by the Bureau in its review of the investment profile of insurers or identified by the examiner-in-charge of the engagement.

In certain instances, particular attention was given to the oversight and usage of derivatives, asset allocation and quality, asset turnover, investments differing from the typical sector profile, and the composition of Schedule BA assets, often comprising hedge and private equity funds. As the complexity of certain investment portfolios has intensified, risk identification, assessment and management by insurers have become increasingly significant functions. Accordingly, more scrutiny was given to select insurers' risk management practices, including modeling, risk measurement and remedial actions to address various risks. In addition, enhanced appraisal of the effectiveness of hedging programs for variable annuity products that incorporate minimum guarantees was conducted.

In order to refine further the preparation process for near-term exams, the Bureau continued to schedule, along with Department examination staff, on-site company meetings with the insurer's senior management and external auditor at the commencement of an exam. This exercise served to facilitate understanding of management's strategic goals, to familiarize the Department with the auditor's evaluative approach, and to permit leveraging off the work performed by the CPA firm, thereby minimizing duplication of assessment efforts and resulting in a more risk-based regulatory exam.

The Bureau continued to oversee a risk-focused property pilot examination started in 2005, which incorporates the draft Examiner Handbook's risk-based guidance developed by the NAIC Risk Assessment Working Group, of which New York State serves as chair.

In addition to working on Life, Property, and Health company examinations, CMB staff participated in two New York State retirement system exams.

d. Pension Supervision

During 2007, the Capital Markets Bureau continued to participate in the development of the oversight of the State's public retirement systems. The Department continued to undertake a major update of its pension supervisory policies, procedures and standards. CMB worked to develop new risk-based capital standards, new regulation, corporate governance reforms and the establishment of up-to-date accounting and actuarial standards for future consideration.

e. Training Initiatives

Provided training to Life Bureau on ERM-guest speaker at in-house training seminar for Life Bureau field examiners. Presented a speech on ERM at a Marcus Evans conference to the insurance industry.

Arranged, coordinated and instructed three separate two and a half day courses sponsored by the NAIC on introduction to the Risk-focused exam process to train approximately 150 examiners from the Department. Published an article on the Risk-focused exams in the Regulator magazine.

Throughout the year, CMB staff also participated in teleconferences, investor briefings, and meetings held by various rating agencies and professional organizations. Moreover, CMB maintained its relationships with the leading insurance equity and credit analysts, ensuring critical access to their industry and company research.

CMB continued to participate in the NAIC International Internship Program by hosting interns from China and Brazil. The Program is designed by the NAIC International Regulatory Cooperation Working Group to promote NAIC relations with foreign markets by emphasizing the exchange of regulatory expertise and technology. CMB staff provided the international interns an overview of the Bureau's analytical and evaluative processes, principal functions, and interface with the rest of the Department.

f. Special Projects

The Capital Markets Bureau was involved in several special projects stemming from capital markets developments in 2007. CMB staff researched technical topics and market transactions and provided recommendations, when applicable. Issues addressed by CMB throughout the year included:

- Financial Guaranty Insurers
- Subprime and other structured securities
- Acted as liaison for the GHI/HIP proposed conversion and EmblemHealth IPO, entailing writing the investment banking section of the RFP, serving on the weighting committee, reviewing projections, meeting with company management
- Analyzed the strategy and fee structure of an alternative asset manager
- Worked with Life and company actuaries to improve the transparency of liability duration
- Analysis of the Request for Information on the Special Disability Fund
- Development for the Department's recommended action under the Office of Foreign Assets Control, Foreign Corrupt Practices Act, and the USA Patriot Act
- Dynamic Hedging Programs
- Contract Certainty - to provide greater clarity as to the nature and scope of coverage provided and the time at which coverage attaches.

g. Other Activities

During 2007, the Capital Markets Bureau contributed to the formulation of legislative and regulatory proposals. These covered: (1) legislation related to increasing the number of licensed captive insurers; (2) proposed amendments to the Credit for Reinsurance Regulation to address collateral funding by non-U.S. reinsurers; and (3) the development of custodial asset regulation.

Throughout the year, CMB staff also gave capital markets presentations at the following outside venues:

- Life Insurance Council of New York Annual Legislative & Regulatory Conference
- New York State Bar Association Derivatives and Structured Products Committee

The Capital Markets Bureau continued supporting the Department's traditional role in leading major working groups, task forces, and projects for the NAIC's Financial Condition (E) Committee ("E Committee"). CMB coordinated many of that E Committee's solvency-related considerations relating to accounting practices and procedures, blanks, valuation of securities, the Insurance Regulatory Information System ("IRIS"), financial analysis, risk-focused and zone examinations, and examiner training. CMB often provides technical advice to other NAIC groups.

CMB personnel used their expertise in investment and risk management to play a critical role as New York's representatives when chairing, and performing the work of, the following major NAIC bodies charged with creating and implementing policies at the leading edge of insurance supervision policy.

Valuation of Securities Task Force ("VOSTF")

New York chairs the VOSTF to help state regulators examine and evaluate insurer's investments by establishing policies and procedures and suggesting programs to the Securities Valuation Office to support existing supervision efforts and educate regulators about new financial monitoring and management technology.

New York leads the VOSTF's review of new investment vehicles that insurers have purchased, or are anticipated to purchase, and creation of new standards for the proper disclosure and reporting of these new vehicles through the annual statement disclosures. As part of the help that the SVO provide to other regulators, New York leads the VOSTF's development and adoption of an annual agenda for the SVO Research division.

The VOSTF acts as the forum for proposed changes to, and interpretations of, the Securities Valuation Office's Purposes and Procedures Manual (the "P & P Manual"). The VOSTF is charged to revise the P & P Manual to maintain consistency and conformity with the NAIC's Accounting Practices and Procedures Manual. Capital Markets Bureau personnel are leading a Task Force effort to significantly improve both.

The VOSTF also reviews the Securities Valuation Office's policies and procedures for evaluating the credit, valuation, and classification of securities. The Task Force must coordinate efforts concerning SVO administrative issues through the NAIC's Internal Administration (EX1) Subcommittee.

New York has led an unprecedented revision of the P & P Manual to increase securities market participant access to the Securities Valuation Office and to increase the transparency of that office's operations.

Capital Markets Bureau personnel are leading the Task Force's study of possible improvements to NAIC processes by which risks in new invested assets are evaluated, communicated, and monitored, and how the annual statement investment schedules could be made more transparent to better reflect non-credit risks (e.g., structural risks embedded in new and existing securities).

New York led a fundamental reform of how insurers report the values of securities they hold in their portfolios.

Capital Markets personnel have led the NAIC considerations of its rules for recognizing as admitted those assets maintained at various financial intermediaries (custody of insurer's assets) and taken an active part in others.

Derivatives Markets Study Working Group ("Derivatives Study WG")

New York's leadership of the Derivatives Study WG arose from its primary position in the VOSTF, in regulating derivatives market participants, and in regulators' considerations surrounding the latest generation of hybrid securities. Those considerations raised questions as to whether the NAIC's Derivatives Instruments Model Regulation, drafted in 1996, needs revision. The Derivatives Study WG is charged with surveying and studying the derivatives marketplace, the relevancy and efficacy of the application of the model regulation to that market, and determining if insurance regulators' primary interests would be served by amending the regulation in light of changes in that marketplace. The WG made a proposal for the updated Model Regulation, a proposal to modernize the annual statement's derivative schedule, a referral to Capital Adequacy Task Force to consider granting insurance companies RBC credit for hedging, and a referral to Financial Examiners' Handbook Technical Group to consider measures to identify such derivative risks insurance companies may be taking which are not reflected in the derivative schedule.

Risk Assessment Working Group ("RAWG")

New York chairs the RAWG charged with overseeing all states' implementation of the NAIC's approved Risk-Focused Surveillance process. Over the next few years, this group will guide and coordinate the revisions needed to the NAIC's accreditation guidelines, training, and maintenance to bring insurance regulation in line with the risk-based focus of national and international regulators of financial intermediaries.

In advancing risk-focused surveillance and supervisory principles, RAWG prepares needed changes to the NAIC's Financial Condition Examiners Handbook and Financial Analysis Handbook.

To assure that these changes are put into action effectively and quickly, RAWG will continue developing a comprehensive program to train NAIC and state regulatory personnel to use the new risk-focused surveillance process and risk assessment tools.

In helping state regulators use these new risk supervision tools, RAWG reviews and improves the NAIC's Risk Prioritization System reports and the supporting instructional materials.

RAWG is, in coordination with the "E" Committee, the NAIC's voice in presenting risk-focused surveillance and supervision related comments to the International Association of Insurance Supervisors ("IAIS"), the Risk Insurance Management Society ("RIMS"), the Professional Risk Manager's International Association ("PRMIA") and other transnational, international, and non-governmental organizations.

Invested Asset Working Group ("IAWG")

When the VOSTF determines that the technical nature of an issue before it would be best studied or advanced by a smaller group of regulators focused on more technical issues, it assigns those projects to the IAWG. The IAWG, when it has completed its deliberations, returns the issue, with its recommendations, to the VOSTF. These issues and recommendations may include changes to statutory accounting guidance, annual statement instructions, blanks reporting instructions, asset valuation reserves, interest maintenance reserves, risk based capital charges, valuation procedures for invested assets, credit assessment procedures for invested assets, or similar solvency supervisory solutions. Capital Markets Bureau personnel have taken a major role in leading the work of this Working Group's "Risk Subgroup" to identify, and develop methods to quantify, investment risks that would materially affect the risk profile of insurers' portfolios.

Capital Markets Bureau personnel also actively support the following NAIC bodies.

Hybrid Risk Based Capital Working Group (Hybrid RBC WG)

Capital Markets Bureau personnel provided essential expertise and critical support to this group to identify the appropriate classification and risk based capital weighting for hybrid securities that have characteristics of both equity (common or preferred stock) and debt and to provide for the proper reporting concerning these instruments. The mixture of equity and debt features, in addition to unique features found in particular types of hybrids, present unprecedented challenges to the insurance regulatory scheme.

Capital Markets Bureau personnel helped the Hybrid RBC Working Group coordinate with: the VOSTF on SVO policies, procedures, and filing requirements for insurers; and the NAIC's Statutory Accounting Working Group and its Blanks Working Group to create consistent statutory accounting, reporting, and risk-based capital treatment. Capital Markets Bureau personnel also monitor the efforts

of the American Academy of Actuaries to develop models on which the NAIC may rely to assess appropriate risk-based capital charges for hybrid securities.

Reinsurance Task Force ("Reinsurance TF")

Capital Market Bureau personnel help the Reinsurance TF to monitor and coordinate activities with the Insurance Securitization Working Group and provide technical assistance. For example, Capital Markets Bureau personnel provide technical assistance on the eligibility, adequacy, or appropriateness of certain types of collateral to fund trusts established by alien or unauthorized reinsurers for the benefit of insurance companies domiciled in the United States.

The Capital Markets Bureau also made notable contributions to the following NAIC working groups and task forces: the Blanks Working Group, the Capital Adequacy Task Force, the Emerging Accounting Issues Working Group, the Financial Analysis Handbook Working Group, the Financial Examiners' Handbook Technical Group, the NAIC/AICPA Working Group, the Property and Casualty Reinsurance Study Group, and the Statutory Accounting Working Group.

I. DISASTER PREPAREDNESS AND RESPONSE BUREAU

1. General Overview

The Disaster Preparedness and Response Bureau (DPR) commenced operations on March 1, 2004. The principal function of the Bureau is to assist the Insurance Department and the New York insurance industry to prepare for, mitigate, respond to, and recover from natural and man-made disasters including modern day terrorism. The Department is the first insurance department in the nation to create such a bureau, dedicated solely to disaster preparedness.

During the past year, the Bureau was engaged in a number of initiatives outlined below to assist the Department in meeting its objectives.

2. Disaster Response/Business Continuity Circular Letters

The DPR Bureau continued to collect disaster preparedness data from the Department's licensees through the issuance of annual circular letters. This process of collecting data from Department licensees has evolved since 2004 when a single circular letter was used to collect data from all companies, into the issuance of separate circular letters to property and casualty type companies, health companies, and life companies, respectively.

Circular Letter No. 4 (2007) was issued on March 15, 2007 to all authorized property/casualty insurers, co-operative property/casualty insurers, financial guaranty insurers, mortgage guaranty insurers, title insurers, reciprocal insurers, captive insurers, registered risk retention groups, rate service organizations, State Insurance Fund, New York Property Insurance Underwriting Association, New York Medical Malpractice Insurance Plan, New York Automobile Insurance Plan, Motor Vehicle Accident Indemnification Corporation, and Excess Line Association of New York.

Circular Letter No. 6 (2007) was issued on April 3, 2007 to all accident and health insurers, and Article 43 corporations; employee welfare funds; licensed Public Health Law Article 44 health maintenance organizations and integrated delivery systems, and municipal cooperative health benefit plans doing business in New York.

Circular Letter No. 7 (2007) was issued on April 16, 2007 to all authorized life insurance companies, retirement systems and fraternal benefit societies doing business in New York.

Each of the circular letters were tailored to the specific entity, and addressed best practices that should be utilized in planning for and responding to natural and man-made disasters that affect the respective insurers.

The circular letters request all entities licensed to do business in New York to submit data to the department on an annual basis. To avoid the appearance of "rule making" without going through the process spelled out in the State Administrative Procedures Act,, the Department must re-issue the circular letters annually.

3. Disaster Response Questionnaires and Plans

As a follow-up to activities which began when the original circular letters were issued in 2004, all property and casualty type companies, health companies, and life companies were required to re-submit a "Disaster Response Plan Questionnaire" and "Disaster Response Plan" to the Department by June 1, 2007. A total of 917 companies were expected to report information to the Department. The

Bureau processed questionnaires from approximately 70% (640 of 917) of the entities required to submit such reports to the Department. The 640 companies providing these reports represent 89.3% of the 2006 direct written premium for all companies that were expected to report data to the Department.

During 2007, the Bureau received 471 new Disaster Response Plans and 127 renewal statements. (Renewal statements indicate that a company's previously submitted plan was not updated during the ensuing year.) Of the 471 newly submitted plans, 356 have been reviewed, and the Bureau has forwarded follow-up letters to 160 companies requesting updates and amendments to their Disaster Response Plans. Follow-up requests are made after a review of individual company plans. The decision to forward a follow-up letter is based upon comparison of the company plans with a checklist of items suggested as best practices.

4. Business Continuity Plan Questionnaires and Plans

All property and casualty type companies, health companies, and life companies were also required to re-submit a "Business Continuity" Questionnaire to the Department by June 1, 2007. Due to proprietary concerns the entities were not required to submit their Business Continuity Plans to the Department, but were required to submit an attestation stating that such a plan existed, and answer specific questions for the Department. Examiners from the Bureau would then verify the existence of such a Plan upon examination. The Bureau has processed questionnaires from approximately 68% (625 of 917) of the entities expected to submit such reports to the Department. The 625 companies providing these reports wrote approximately 92% of the 2006 direct written premium for all companies expected to report.

5. Pre-Disaster Data

Circular Letter No. 4 (2007) also required companies writing commercial or personal property insurance in New York State to submit a "Pre-disaster data/information survey" by April 1, 2007. Each property/casualty insurer provided the Insurance Department a listing - by New York State County - of property exposure information, as of December 31, 2006 for personal lines (non-auto) and commercial lines (non-auto) for each authorized member within an insurance company group. The report that was compiled in 2007 contained data from 238 entities representing 369 of the 670 companies that were expected to report data to the Department. These 369 companies wrote 99.7% of the 2006 direct written premium for the personal and commercial property lines covered in the report.

Planning for a disaster or emergency is just as critical as responding to its aftermath; therefore the Department collects and analyzes data from a variety of sources. The data can be used to pre-position resources and plan for resource allocation in the aftermath of the disaster. This process becomes extremely critical to insureds who expect prompt and fair payment of their claims. The data is collected and used to provide accurate, timely and consistent information to other government and volunteer agencies who also share a critical role in emergency response.

6. The Pandemic Flu Survey

During 2007 the Department issued a Pandemic Flu Survey to all Department licensees to determine the level of pandemic influenza preparedness by the insurance industry and to bring awareness to the industry of the need to have a pandemic flu plan. The data on the life and property companies was segregated from the health companies. Overall, the Department processed 330 responses from property and life insurance companies combined. Based upon the responses that were processed, approximately 47% of the companies indicated that their company had a pandemic flu plan; however, that was an improvement over the previous year when approximately 42% of all companies Life, Property and Health combined) indicated that their company had such a plan. The Department also processed 45 responses from health companies. Based upon the responses that were processed,

approximately 49% of the health companies had completed a written pandemic flu plan and another 29% were in progress.

The Department also led the insurance industry's response to the Pandemic Flu Exercise that was organized by the Financial and Banking Information Infrastructure Committee (FBIIC). FBIIC is one of the critical infrastructure groups within Homeland Security and is headed by the US Treasury Department.

7. The Insurance Department Portal

The Department began collecting data pursuant to Circular Letters Numbers 1, 2, and 3 (2008) through the Department portal effective March 2008. Companies can now submit the data for the Disaster Response Plan Questionnaires, the Disaster Response Plans, Business Continuity Plan Questionnaires, Pre-Disaster data, Post-Disaster data and the Pandemic Flu Survey directly through the Portal. Previously, companies were required to send the information to the Department via email or some other type of electronic media or submit hard copies. This method of submitting data to the Department via the portal promotes a more secure environment for the companies to submit data to the Department and enhances the accuracy and efficiency of the data collection process.

8. The Department's Disaster Recovery/Business Continuity Plan

The Bureau continues to update the Department's Disaster Recovery/Business Continuity Plan (the Plan) to be consistent with the Continuity of Operations/ Comprehensive Emergency Management Plan (COOP/CEMP) format recommended by the State Emergency Management Office (SEMO). The COOP/CEMP includes the Department's efforts in planning for a pandemic. The Plan is based on a comprehensive risk assessment and requires staff training which the Bureau will provide.

The Plan allows the Department to continue mission-critical operations in the event of a disaster directly affecting the Department, and includes evacuation procedures. It also requires testing and updating annually.

9. Examination of Insurers' Disaster Response Plans

During 2007, members of the DPR Bureau visited two property and casualty insurers and one health insurer to verify that the disaster response plans that were submitted to the Department were functional and that key employees of each of the insurers visited were aware of their roles during a disaster. Based upon the results of these examinations, DPR is confident that the companies examined are capable of responding to disasters that affect their insureds. The results of these on-site examinations continue to reflect the trend in the industry of increased awareness and reassures the Department that insurers will be ready to respond effectively to New York's policyholders in the event of a disaster.

10. New York Information Network (NYIN)

The Bureau is responsible for maintenance of the Department's electronic information network. NYIN is a password-protected area on the Department's Web site that contains directives, advisories, and other terrorism-related information addressed to insurers. NYIN also includes an Intelligence/Information Mailbox enabling participants to exchange intelligence and other information with the Department. There are currently 1,256 entities registered to receive NYIN notifications with a total of approximately 3768 participants. During 2007 the Department issued 53 NYIN notifications ranging from cyber security to the steam pipe explosion in NYC.

11. Public Access Defibrillator (PAD) Program

The PAD program requires the voluntary participation of Department employees who are certified in Cardiovascular Pulmonary Resuscitation (CPR), Automatic External Defibrillation (AED), and first aid. The Bureau developed a PAD administrative program of protocols for the use of PAD and CPR during a medical emergency that occurs in any of the Department's offices. The PAD program establishes a medical emergency response program that includes trained and equipped PAD responders who, with appropriate medical oversight, will provide early defibrillation in the event of sudden cardiac arrest. The goal is to defibrillate within three minutes of a witnessed collapse or discovery of the victim. The PAD responders will apply CPR as necessary. The Department currently has 49 trained volunteers in the New York City office, 29 in the Albany office, four in the Mineola office, two in the Buffalo office and one in the Rochester office. According to OGS, average agency response throughout the state was between two and three volunteers per floor with one AED per floor. The Department exceeded both the ratio of AEDs per floor and volunteers per AED. The large number of volunteers will better serve and protect not only our employees but any visitors to the Department.

On February 14, 2008, the DPR Bureau, in cooperation with the Systems Bureau, released an enhancement to the PAD program which increased the efficiency of the system. All employees of the Department now have an icon on their Lotus Notes Inbox which enables them to email all responders at any one of the Department's facilities with a simple click of the mouse. Prior to the installation of this system which is called the Medical Emergency Response Team System (MERTS), employees were required to send notification of a medical emergency to the volunteers via a beeper system. The beeper system is still functional, but serves as a redundancy to the MERTS.

12. West Workspace

The Bureau is involved in maintenance of, and training members of the Department in the use of, West Workspace. West Workspace is a Web-based communication tool operating on the Extranet. It allows for exchange of documents, data, and messages when the Department's own Wide Area Network (WAN) or Local Area Network (LAN) has been impaired. It is used to store mission-critical data, and provides a virtual online meeting room where Department staff can meet and continue business operations especially during emergencies. We expect that its usefulness will also serve the Department should predictions of a pandemic become a reality.

13. The Incident Command System

Pursuant to the Governor's Executive Order, and modeled after State Emergency Management Office's (SEMO's) Incident Command System, the Department has developed its own framework of managers who have been assigned specific roles/titles in the event of an actual disaster. Members of the Bureau have been attending on-going training in the use of the Incident Command System.

14. Life Safety Procedures

The Bureau oversees the semi-annual employee fire drills and evacuations procedures. The Department had developed a series of Cohort locations where employees may assemble and be accounted for in the event of an incident that requires the full evacuation of the Department's Albany and/or New York City offices. The Bureau has assumed the maintenance of the employee lists that are used to facilitate Department protocols in the event such an evacuation is warranted. The Bureau has also updated the evacuation procedures that are posted on the Department's intranet, by adding maps of cohort locations and a new Emergency Action Plan. The Bureau has revised evacuation procedures and has trained members of the Department in safe evacuation procedures.

The Bureau assisted in the creation of an Employee Toll-Free Safe Line. The Toll-Free Safe Line provides a means for employees to report their location and condition to the Department after a disaster, emergency evacuation, or other event requiring an emergency response. Additionally, employees can obtain and exchange vital information related to both safety and work assignments.

This procedure provides management with the ability to ensure that all employees are accounted for and to provide instructions (*i.e.,* building closings, when to report to work, etc.) to the employees calling in to the Toll-Free Safe Line. The Bureau performed a test of the Employee Toll-Free Safe Line during 2007 to determine the effectiveness of the system. Based upon the results of the test, the Bureau will conduct additional tests during 2008.

The Bureau is also exploring the use of NY-ALERT to notify employees of emergencies that may impact their ability to get to/from their work location. NY-ALERT is New York State's all hazards alert and notification system. It is a web-based portal that offers one-stop access through which State agencies can provide emergency information to a defined audience. The Bureau is also exploring other uses for NY-ALERT.

15. Disaster Recovery Assistance

One initiative that has arisen from our experience after Sept 11 and the recent series of hurricanes that devastated the Gulf Coast is the need to establish a pre-credentialing program in conjunction with state and city governments. One such program which includes department and industry officials is the NYC-OEM electronic card reader project. The electronic card reader project is an advanced credentialing system that permits only authorized persons to enter the disaster zone. This initiative already instituted by this department involves working with NYC-OEM and BNET (Business Network of Emergency Resources) to establish a Corporate Emergency Access System (CEAS). The CEAS program permits a "first response team" of adjusters from the largest property and casualty writers in the area of the disaster to gain early access to a disaster site for the purpose of evaluating the total loss within the disaster site in an expeditious manner.

The Department has also worked with BNET to encourage the property and casualty insurers to join the CEAS program to enable their adjusters to gain access to the disaster sites as soon as the area is declared safe by municipalities. To date, 425 CEAS cards have been issued to companies for use by their adjusters. Bureau staff is involved in this ongoing effort to expand recognition of the CEAS Adjuster Card Program by local emergency and law enforcement jurisdictions throughout the state.

The Department has also enrolled "Essential Employees" of the Department in the CEAS program. These employees are considered critical to the ongoing operations of the Department during a disaster. The CEAS program for the Department would permit these essential employees to gain access to the Department's offices within New York City and Nassau County during an emergency. The Department currently has 96 employees enrolled in the program.

During the tornado incident and flooding in the downstate region of the State during 2007, the Bureau worked with the Consumer Services and Frauds Bureaus to provide assistance to consumers needing help with insurance questions and claims.

J. CAPTIVE INSURANCE GROUP

1. General Overview

On August 7, 1997, Governor George E. Pataki signed into law Chapter 389 of the Laws of 1997, which permits the formation and operation of captive insurance companies (captives) in New York State via Article 70 of the Insurance Law and other amendments to the Insurance Law and the Tax Law. The Law became effective December 5, 1997.

Captive insurance companies are insurers owned by the insureds and organized for the main purpose of self-funding the owner's risk. Captives are often referred to as "alternative insurance mechanisms." As of December 31, 2007, there were 44 captive insurance companies authorized in New York. The assets of these 44 captive insurers posted total assets of $12.7 billion, total liabilities of $6.2 billion and capital and surplus of $6.5 billion. In addition, these captives had net income of $1.9 billion, paid premium taxes of $5.1 million and had net premium written of $1.1 billion.

There has been explosive growth in captive formation in the past year. In addition, the Department has a dedicated captive team, responsible for the licensing of all captive insurers in New York. The team provides a direct link to decision-makers, features a streamlined licensing process, and the easing of administrative burdens after licensing through regulation that is distinct from the regulation of traditional insurance companies.

2. Legislative Proposals

The Department has proposed revisions to the current law to address certain restrictions that have hindered the growth of New York captives. Governor Pataki has submitted legislation to the New York Legislature to effectuate these changes. They include:

- Reducing the threshold level for a parent to form a pure captive to $25 million of net worth or annual revenue. The bill also provides flexibility for the Superintendent to approve other thresholds if the parent demonstrates that it is otherwise qualified to form and operate a captive as a subsidiary;
- Reducing the threshold level for entry into a group captive to a parent whose net worth or annual income exceeds $12.5 million;
- Broadening the definition of "affiliated companies" to enable the parent's contractors and subcontractors to be insured by the captive; and,
- Allowing public entities (municipalities, authorities and others) to form pure or group captives as public benefit corporations or Not-for-Profit corporations that would be exempt from state and local fees, taxes or assessments.

These changes would enhance the appeal of New York as a domicile for the new wave of captive insurer formations. The Department will still be able to effectively regulate these insurers under the framework established by Article 70 of the Insurance Law. Since New York is a leading global business center, the New York State Insurance Department is committed to establishing an appropriate regulatory environment for the operation of captive insurers. New York offers domiciled captive insurers tax rates competitive with other captive jurisdictions, minimal investment restrictions and the authority to write almost all types of property/casualty coverages.

K. TRAINING & PROFESSIONAL DEVELOPMENT

Staff training is a core priority for the Department. The professional development needs of the Department's employees are so diverse that it is important to offer a variety of courses in several categories to assist individuals in the pursuit of the skills they need. Subjects offered fall under one of the following areas: Management Development, Experienced Insurance Examiners, Insurance Examiner Trainees, Administrative Support Staff Development, and General.

Since the inception of the Management Development Program in 2005, three groups, totaling 59 managers, have completed the program. The purpose of the Management Development Program is to provide management and leadership skills to mid and high-level managers so that they are better prepared to do their jobs. This is accomplished by contracting experts in those fields to come to the Department and share their knowledge and skills through training sessions. Currently, Management Development Group #4 has 29 managers participating in the 15-month program which will conclude in July 2008.

The Advanced Management Development Program was started in 2007 in response to requests from graduates and participants who wanted to continue to enhance their cognition and further expand their proficiencies beyond the initial Management Development Program. Ten sessions have been scheduled. Some of the topics include: Moving from an Operational Manager to a Strategic Thinker, Personal and Organizational Development, Managerial Leadership with a Team Project, and The Rewards for Managers of Using Collaboration to Solve Problems and Accomplish Goals. Presently, there are 25 managers enrolled, with completion expected in June of 2008.

Professional development of experienced examiners is encouraged through on-the-job training and attendance at bureau-wide seminars. In 2007, four such seminars were coordinated, addressing current issues facing the Department and the insurance industry. The National Association of Insurance Commissioners' (NAIC) sponsored 14 training classes for 271 examiners. These courses dealt with such topics as Teammate Training, ACL, Polishing Report Writing Skills for Risk focused Examinations and other relevant classes. In addition to attending training, examiners also pursue professional designations through professional societies. This past year 36 insurance examiners successfully completed 64 professional examinations working towards their designations.

Newly hired Insurance Examiner Trainees are required to participate in a two-year training program, consisting of a combination of lectures, seminars, workshops and classroom instruction, in addition to their regular work assignments. The training program is designed to provide trainees with an overview of the insurance regulatory framework in New York State, including an understanding of insurance, financial solvency regulation, product regulation, availability and affordability issues, and treatment of policyholders. In 2007, there were 83 trainees participating in the training program which included the following: those hired in 2005 and completing the traineeship in 2007, those hired in 2006 and still in the traineeship, and new hires starting in 2007. These trainees attended 86 days of classes, this past year, specifically designed for them. Twenty trainees completed their traineeship in 2007 and were permanently placed in Bureaus within the Department.

The Administrative Support Staff Development Program offers a variety of courses for support staff and includes such topics as communication skills and managing change. The goal is to provide opportunities to encourage support staff to continue learning. Although, there were no classes offered in this category in 2007, there is a renewed interest in this program and courses are being scheduled for 2008.

There are two classes that all Department employees are mandated to attend. These are Sexual Harassment Prevention and Diversity Awareness. The Sexual Harassment Prevention course had been modified by the Governor's Office of Employee Relations (GOER) since most Department staff had initially attended, which required many employees to take the class as a refresher. A total of 250 staff participated in the class. Diversity Awareness had a total of 69 participants.

In addition to the above, the Department offered training of a general nature. These courses were either conducted on premises, or through other agencies and vendors. A labor relations training program for supervisors, developed by the Governor's Office of Employee Relations, was expanded upon this year to include additional topics such as performance and productivity, constructive discipline, and grievances, specific to our agency. Other courses of a general nature included such topics as Facilitating Productive Meetings, Leadership, Successful Business Writing, Performance Evaluations for Supervisors, Making Technology Work for You, and Unintentional Intolerance. In all, a total of 171 staff took advantage of these classes.

The Department also participates in the NAIC sponsored International Program for Education and Regulatory Cooperation (IPERC) by hosting interns from foreign countries. The aim of IPERC is to foster learning and provide technical assistance to insurance regulatory professionals from countries with emerging insurance markets. The interns spend five weeks at the Department learning about insurance regulation in New York State and receive hands-on training in their areas of interest. To date, we have hosted a total of 10 interns from the countries of India, Brazil, China, Egypt, and Bulgaria. The Egyptian interns were hosted in the spring of 2007. The main objectives of their internships were to learn about the U.S. insurance market and products with a special emphasis on reinsurance and financial analysis. In the fall of 2007, we hosted one intern from China and one intern from Bulgaria. The main focus of their internships was to study the regulatory structure of the U.S. insurance market with a special emphasis on legal issues, and to network with colleagues form other countries.

Professional development is also encouraged through the use of the Training Library to support the Insurance Examiners' pursuit of professional designations. In 2007, there were 56 examiners who took advantage of the library's loan program. Also, in order to keep up with the advancing industry, the Library was updated and enlarged to include new materials including the purchase of 350 new books for examiner trainees and executives this past year.

The Department's Intranet Training Page has been expanded and enhanced. Employees can find announcements pertaining to a variety of training opportunities accessed directly through related training links, including available resources, instructional presentations, GOER-sponsored courses, Agencies in Partnership for Training courses, and web sites for workshops or tuition support for members of CSEA, PEF and MC employees.

L. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORP.

1. History of the Corporation

The Motor Vehicle Accident Indemnification Corporation (MVAIC) was originally created to provide compensation for injuries to persons who, through no fault of their own, were involved in accidents with hit-and-run drivers, operators of stolen vehicles or uninsured motorists. This law became effective on January 1, 1959. The tort law has since been amended so that comparative negligence is now the law of the State of New York. In that respect, MVAIC's obligations to provide compensation have changed.

Qualified claimants (persons who are residents of the State of New York or of another state that has a similar program, and who do not own automobiles or are not resident relatives of a household where there in an insured vehicle) receive maximum benefits under the no-fault law.

As a result of the enactment of Section 5221 of the Insurance Law, effective December 1, 1977, the corporation also became involved in the payment of no-fault, first-party benefits as of that date. It should be noted that the Corporation must provide for the payment of such first-party benefits only to qualified persons who have complied with all the applicable requirements of Article 52 of the Insurance Law. Amendment 19 to Regulation 68, effective September 1, 1985, permits MVAIC to arbitrate no-fault cases thus eliminating the necessity of commencing Declaratory Judgment Actions in unresolved coverage questions.

Effective July 22, 1989, Section 5208 (a)(1) was amended by the legislature and the bill signed by the Governor. This amendment extended the time from 90 to 180 days within which a claimant must file his/her affidavit of "intention to make claim" with this Corporation, only if there is an identified defendant. The 90 day time limit is still applicable to hit and run cases. Further, if the claim was originally against an insured person whose insurance carrier has denied the claim, then the affidavit must be filed within 180 days after the receipt of said disclaimer or denial.

In June 1995, the New York State Legislature amended Section 1 Paragraph 1 of subsection (f) of Section 3420 of the Insurance Law to increase the New York financial responsibility limits from $10,000 per person, $20,000 per accident to $25,000 per person and $50,000 per accident. These limits are equally applicable to uninsured claims submitted to MVAIC. This law took effect January 1, 1996.

2. New Legislations Enacted

<u>The New Legislation enacted in 1999 effective March 1, 2000. Self-Insured 5014 A (Chapter 511 Laws of 1999)</u> -- This new law increased the self-insured assessment per vehicle from $1.50 to $3.50. The DMVB will continue to handle the self-insured fees as previously done.

<u>New Regulation 68 (No Fault)-Repeal February 1, 2000; for accidents on or after February 1, 2000. The major provisions are:</u>

- Notice of PIP claim must be made in 30 days rather than 90 days
- Health service providers must present their bill to the insurance carrier and/or MVAIC within 45 days after the date of treatment rather than 180 days in current regulations.
- The new regulation authorizes PIP insurers to do an Examination Under Oath (EUO) of PIP claimant.
- Wage Loss Claims must actually be made within 90 days from the date of accident instead of no requirement

- The arbitration rules have been changed with the AAA, now being responsible for administrating all conciliation and administration. Previously, the Insurance Department handled conciliation and more administration including medical fee schedule.
- Also effective February 1, 2000 the monthly interest penalty rate is 2% instead of 21% monthly compounded.

3. Source of Funds

The Corporation is funded through levies on insurance companies transacting automobile liability insurance in the State of New York in accordance with Section 5207 of the Insurance Law.

Other sources of funds include fees collected from self-insurers by the New York State Department of Motor Vehicles under Sections 316 and 370-4 of the Vehicle and Traffic Law, investment income and subrogation recoveries.

4. 2007 Activity

Year End Reserves	2007	2006
Case Outstanding Reserve Tort & Pip	$19,983,263.00	$19,965,776.45
Incurred But Not Reported	$18,772,818.00	$18,772,818.00
Unallocated Loss Adjustments ULAE	$12,685,720.00	$12,685,720.00
Spec. Reserve for Alloc. Exp	7,000,000.00	7,000,000.00

- MVAIC received 8,957 notices of claim which were slightly up from 8,949 received in 2006.
- The total number of claims created for both Tort & No fault cases slightly decreased in 2007 to 1,966 compared to 2,338 created in 2006.
- Claims paid for Tort and No Fault cases decreased in 2007 to $14,486,231 compared to $17,217,580 paid during 2006.
- At the end of 2007, MVAIC closed with a surplus of $8,815,636 up from $5,636,600 in 2006.
- The number of pending claims at the close of 2007 was 2,111 compared to 2,158 in 2006.

III. INSURANCE LEGISLATION ENACTED

(Legislation is presented in numeric order based on 2006 Chapter Law)

This section of the Annual Report covers bills enacted during the 2007 Session amending the Insurance Law. Where a bill amends laws other than the Insurance Law, only provisions of interest are noted. *These brief descriptions of the laws are intended only to provide highlights of the legislation and should under no circumstances be used in place of the full text of the law or regarded as interpretation of legislative intent or of Insurance Department policy.*

Chapter 631 of the Laws of 2007 amends the Insurance Law as follows:

- Section 1 of the bill adds a new Section 1324 to the Insurance Law entitled "Risk-based capital for property/casualty insurance companies." This section is summarized as follows:

- Section 2 of the bill amends subsection (b) of Section 2402 of the Insurance Law to include a violation of Section 1324 (i)(2)(B) as a defined violation.

- Section 3 of the bill amends subsection (O) of Section 7402 to include an authorized control level event or a mandatory control level event as a new ground for rehabilitation of a domestic property/casualty insurer (or, for liquidation pursuant to Section 7404). In addition, pursuant to Section 7406, such an event may be the grounds for conservation of the assets of a foreign insurer.

- Section 4 of the bill amends Section 1322(e)(1)(H) and Section 1322(h)(1)(C) to correct an inadvertent error, to replace the word "regulatory" with the word "company," so that the language will appropriately refer to the "company" action level event.

- Section 5 of the bill contains a severability provision.

- Section 6 of the bill provides for an immediate effective date.

Chapter 451 of the Laws of 2007 amends the Public Health Law, Insurance Law Social Services Law as follows:

- Section 1 of the bill adds a new subdivision 19 to Public Health Law (PHL) § 2511 to require that claims submitted to an approved organization for payment for medical care, services, or supplies furnished by an out-of-network health care provider must be submitted within 15 months of the date the medical care, services, or supplies were furnished to an eligible person to be valid and enforceable against the approved organization. There is an exception to the claims submission deadline for claims submissions warranted to address findings or recommendations identified in state or federal audits.

- Section 2 of the bill adds a new paragraph (e) to PHL § 2995(2) to define "preferred provider organization data" as data collected from an insurance company subject to article 32 of the Insurance Law, a corporation subject to Article 43 of the Insurance Law, or a municipal cooperative health benefit plan certified pursuant to Article 47 of the Insurance law, with respect to preferred provider organization (PPO) products, as defined by the Commissioner of Health in consultation with the Superintendent of Insurance, offered by such entities.

- Section 3 of the bill amends PHL § 2995-c of the Public Health Law to require preferred provider organizations to annually report to the Department of Health (DOH) on the quality and effectiveness of care measures which are represented in the National Committee for Quality

Assurance PPO Health Employer Data and Information Set and to provide for the dissemination of preferred provider organization data by DOH.

- Section 4 of the bill adds a new subdivision 5-c to PHL § 4406-c to provide that if a contract between a plan and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of the contract, including reimbursement terms for a period of two months from the termination or end of the contract period. The section further requires that notice be provided to enrollees within 15 days of the commencement of the two-month period. However, these requirements do not apply where both parties agree to the termination or non-renewal and the insurer provides notice to the insured at least 30 days in advance of the date of contract termination,

- Section 5 of the bill adds a new subdivision 7-f to PHL § 4900 to define an "out-of-network denial" as a denial of a request for pre-authorization to receive a health care service from an out-of-network provider on the basis that the out-of-network service is not materially different from the service available in-network. The new subdivision further requires health plans, up an receiving a pre-authorization request far an out-of-network service, to include information in a denial that explains what information the enrollee must submit in order to appeal the out-of-network denial pursuant to PHL § 4904(1-a).

- Section 6 of the bill adds a new subdivision (1-a) to PHL § 4904 to provide that an enrollee or the enrollee's designee may appeal an out-of-network denial by submitting: (1) a written statement from the enrollee's attending physician, stating that the requested out-of-net-work health care service is materially different from the health care service the health care plan approved to treat the enrollee's health care needs; and (2) two documents from the available medical and scientific evidence indicating that the out-of-network service is likely to be more clinically beneficial to the enrollee than the alternate in-net-work treatment and for which the adverse risk of the recommended or requested service or treatment would not likely be substantially increased over the in-network treatment.

- Section 7 of the bill adds a new paragraph (c) to PHL § 4910(2) to provide an enrollee with a right to an external appeal when a health plan denies coverage of an out-of- network health care service on the grounds that an alternate treatment is available in-network.

- Section 8 of the bill adds a new subparagraph (C) to PHL § 4914(2)(d) to impose standards and requirements far an external appeal agent's review of out-of-network denials.

- Section 9 of the bill adds a new subdivision 24 to Social Services Law (SSL) § 364-j, requiring that claims submitted to a managed care provider for payment for medical care, services, or supplies furnished by an out-of-network medical services provider, must be submitted within 15 months of the date the medical care, services, or supplies were furnished to an eligible person to be valid and enforceable against the managed care provider. There is an exception to the claims submission deadline for claims submissions warranted to address findings or recommendations identified by state or federal audits.

- Section 10 of the bill adds a new paragraph (i) to SSL § 369-ee(3), requiring that claims submitted to a family health insurance plan for payment for medical care, services, or supplies furnished by an out-of-network health care provider must be submitted within 15 months of the date the medical care, services, or supplies were furnished to an eligible person to be valid and enforceable against the family health insurance plan. There is an exception to the claims submission deadline for claims submissions warranted to address finding or recommendations identified by state or federal audits.

- Section 11 of the bill adds a new subsection (h) to Insurance Law § 3217-b to provide that if a contract between an insurer and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of the contract, including reimbursement terms for a period of two months from the termination or end of the contract period. The section further requires that notice be provided to insureds within 15 days of the commencement of the two-month period. However, these requirements do not apply where both parties agree to the termination or non-renewal and the insurer provides notice to the insured at least 30 days in advance of the date of contract termination.

- Section 12 of the bill adds a new § 3238 to the Insurance Law to require insurers, municipal cooperative health benefits plans and managed care organizations (health plans) to pay claims for health care services for which pre-authorization was required by, and received from the health plan unless: (1) the insured was not a covered person at the time the service was rendered; (2) the submission of the claim was not timely; (3) the insured's benefit limitations were exhausted; (4) the pre-authorization was based on materially inaccurate or incomplete information; (5) the pre-authorized service related to a pre-existing condition; or (6) there is a reasonable belief of fraud and abuse. This section further provides that nothing shall be construed to prohibit health plans from denying continued or extended coverage as part of concurrent review, denying a claim if the health plan is not primarily obligated to pay the claim, or applying payment policies that are consistent with applicable law, rule or regulation.

- Section 13 of the bill adds a new subsection (h) to Insurance Law § 4325 to provide that if a contract between a corporation and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of the contract, including reimbursement terms for a period of two months from the termination or end of the contract period. The section further requires that notice be provided to subscribers within 15 days of the commencement of the two-month period. However, these requirements do not apply where both parties agree to the termination or non-renewal and the corporation provides notice to the subscriber at least 30 days in advance of the date of contract termination.

- Section 14 of the bill adds a new subsection (g-6) to Insurance Law § 4900 to define "out-of-network denial" as a denial under a managed care product of a request for preauthorization to receive a health care service from an out-of-network provider on the basis that the out-of-network service is not materially different than the service available in-network. This section further requires health plans, upon receiving a pre-authorization request for an out-of-network service, to include information in a denial that explains what information the insured must submit in order to appeal the out-of-network denial pursuant to Insurance Law § 4904 (a-1).

- Section 15 of the bill amends Insurance Law § 4900(i) to amend the definition of a "utilization review agent" to include a municipal cooperative health benefit plan in the definition.

- Section 16 of the bill amends Insurance Law § 4904 to add a new subsection (a-1) to provide that an insured or the insured's designee may appeal an out-of-network denial: (1) by submitting a written statement from the insured's attending physician stating that the requested out-of-network health care service is materially different from the health care service the health care plan approved to treat the insured's health care needs; and (2) based on two documents from the available medical and scientific evidence indicating that the out-of-network service is likely to be more clinically beneficial to the insured than the alternate in-network treatment and for which the adverse risk of the recommended or requested service or treatment would not likely be substantially increased over the in-network treatment.

- Section 17 of the bill amends Insurance Law § 4910(b)(2)(D) to make a technical connection.

- Section 18 of the bill adds a new paragraph 3 to Insurance Law § 4910(b) to provide the insured with a right to an external appeal when an insurer denies coverage of an out-of-network health care service on the grounds that an alternate treatment is available in-network.

- Section 19 of the bill adds a new subparagraph (C) to Insurance Law § 4914(b)(4) to impose standards and requirements for an external appeal agent's review of out-of-network denials.

- Section 20 sets forth the effective date.

IV. Regulations Promulgated, Amended or Repealed

The following is a summary of Insurance Department regulations promulgated, amended or repealed in 2007.

The 2nd Amendment to Regulation 162 (11 NYCRR 68): Legal Services Insurance (Adopted on a permanent basis effective 1/10/07)

Prior to this amendment, legal services insurance that was written as part of a policy of liability insurance was subject to the filing and approval requirements of Article 23 of the Insurance Law and did not qualify as a special risk coverage pursuant to Part 16 of Title 11 of the New York Codes, Rules and Regulations (Regulation 86). Thus, a liability policy that might otherwise be exempt from Article 23 filing requirements, except for the fact that it includes legal services insurance coverage, was required to be submitted to the Department for approval before it could be used. This rule permits legal services insurance to qualify as a special risk only if the coverage of the policy of liability insurance of which it is a part also qualifies as a special risk coverage pursuant to Part 16 of Title 11 of the New York Codes, Rules and Regulations and Article 63 of the Insurance Law, and the policy is written on such basis.

The Adoption of a New Regulation 181 (11 NYCRR 75): Standards For Insurance That Qualifies For The Environmental Remediation Insurance Tax Credit (Adopted on a permanent basis effective 1/10/07)

Section 3447 of the Insurance Law provides that the Superintendent is authorized to promulgate regulations relating to the certification of policies of insurance that qualify for the environmental remediation insurance tax credit provided for under Section 23 of the Tax Law. This Part provides guidance for insurers as to the minimum standards for environmental remediation insurance coverages that will enable an insurer to certify that the coverages qualify for the environmental remediation insurance tax credit provided for under the Tax Law. This Part also provides the requirements for disclosure of the premiums paid for the coverages under Section 3447(b) of the Insurance Law to enable the insured to obtain the appropriate tax credit.

The 5th Amendment to Regulation 172 (11 NYCRR 83): Financial Statement Filings and Accounting Practices and Procedures (Effective on an emergency basis since 12/28/05) (Adopted on a permanent basis effective 1/10/07)

Sections 307 and 308 of the Insurance Law provide that authorized insurers, accredited reinsurers, authorized fraternal benefit societies, and Public Health Law Article 44 Health Maintenance Organizations and Integrated Delivery Systems shall file financial statements annually and quarterly with the Superintendent. The Insurance Law further provides that the form of such statements shall be prescribed by the Superintendent. To assist in the completion of the financial statements, the National Association of Insurance Commissioners (NAIC) adopts and publishes from time to time certain policy, procedure and instruction manuals. One of these manuals, the Accounting Practices and Procedures Manual As Of March 2005 ("Accounting Manual"), includes a body of accounting guidelines referred to as “Statements of Statutory Accounting Principles.” With a few exceptions, this rule incorporates the Accounting Manual by reference so as to enhance the consistency of the accounting treatment of assets, liabilities, reserves, income and expenses, and to set forth the accounting practices and procedures to be followed in completing annual and quarterly financial statements required by law. The amendment of another portion of the regulation was necessitated by the issuance of a revised edition of Estimated Useful Lives Of Depreciable Hospital Assets, another publication which is incorporated by reference in the regulation.

The 1st Amendment to Regulation 147 (11 NYCRR 98): Valuation of Life Insurance Reserves (Effective on an emergency basis since 12/29/04) (Adopted on a permanent basis effective 1/10/07)

Maintaining solvency of insurers doing business in New York is a principal focus of the Insurance Law. One way the Insurance Law seeks to ensure solvency is by requiring all insurers and fraternal benefit societies authorized to do business in New York to hold reserve funds in an amount proportional to the obligations made to policyholders. At the same time, insurers and policyholders benefit when insurers have adequate capital for company purposes such as expansion and product or other forms of business development.

Some companies have sold life insurance products that result in lower reserves than would be required for products with similar death benefit and premium guarantees. This rule addresses that problem by establishing new reserve methodologies consistent with Section 4217 of the Insurance Law.

The Adoption of a New Regulation 174 (11 NYCRR 46): Unemployment Lapse Protection Benefit For Life Insurance (Adopted on a permanent basis effective 1/17/07)

This rule establishes minimum standards for benefit levels, benefit eligibility and exclusion, and premium levels relating to additional benefits authorized under Section 1113(a)(1) of the Insurance Law for unemployment lapse protection benefits for life insurance. The unemployment lapse protection benefit includes waiver of premium benefits and waiver of charge benefits. This rule also prescribes advertising and disclosure requirements for unemployment lapse protection benefits for life insurance.

The 3rd Amendment to Regulation 124 (11 NYCRR 152): Physicians and Surgeons Professional Insurance Merit Rating Plans (Effective on an emergency basis since 5/16/03) (Adopted on a permanent basis effective 1/24/07)

Insurance Law Section 2343(d) provides that the Superintendent shall, by regulation, establish a merit rating plan for physicians' professional liability insurance. Section 2343(e) provides that the Superintendent may approve malpractice insurance premium reductions for insured physicians who successfully complete an approved risk management course, subject to standards prescribed by the Superintendent by regulation. This regulation allows, but does not require, an insurer to offer an internet-based risk management course to its insureds as soon as the Department determines that the course is in proper compliance with applicable law.

The 2nd Amendment to Regulation 171 (11 NYCRR 362): The Healthy NY Program and Direct Payment Market Stop Loss Relief Programs (Effective on an emergency basis since 3/28/03) (Adopted on a permanent basis effective 1/31/07)

Due in part to the rising cost of health insurance coverage, many small employers are unable to provide health insurance coverage to their employees. Chapter 1 of the Laws of 1999 enacted the Healthy NY Program as an initiative designed to encourage small employers to offer health insurance to their employees and to encourage uninsured individuals to purchase health insurance coverage.

This rule introduces a second Healthy NY benefit package at a reduced premium rate. The second benefit package provides for a lower-cost alternative and permits individuals and small businesses to choose a benefit package that meets their needs. The rule eliminates the well-child copayment applicable to the Healthy NY Program in order to enhance access to preventive and primary care for children, and permits the Healthy NY Program to be considered qualifying health insurance under the federal Trade Act of 2002 to allow those qualifying for a federal tax credit to benefit from that credit. The rule also revises the eligibility requirements relating to employment in order to lessen complexity and enhance access.

The 3rd Amendment to Regulation 68-C (11 NYCRR 65-3.13): Claims for Personal Injury Protection Benefits and the 4th Amendment to Regulation 68-D (11 NYCRR 65-4.5): Arbitration (Consolidated Amendments effective on an emergency basis since 10/04/05) (Adopted on a permanent basis effective 3/14/07)

Regulation 68 contains provisions implementing Article 51 of the Insurance Law, which is commonly referred to as the No-Fault Law. No-fault insurance is intended to provide for prompt payment of health care and loss of earnings benefits. In accordance with Chapter 452 of the Laws of 2005, these two rules require an insurer to issue a denial of a No-Fault claim with specific language that advises the applicant of the availability of special expedited arbitration to resolve the issue of which insurer must process the claim for first party benefits.

The Repeal of Existing Regulation 56 (11 NYCRR 94) and Adoption of a New Regulation 56 (11 NYCRR 94): Rules Governing Individual and Group Accident and Health Reserves (Effective on an emergency basis since 12/31/02) (Adopted on a permanent basis effective 7/11/07)

The Insurance Law does not specify mortality, morbidity, and interest standards used to value individual and group accident and health insurance policies, but relies on the Superintendent to specify methodology. This regulation prescribes rules for valuing minimum individual and group accident and health insurance reserves, including standards for valuing certain accident and health benefits in life insurance policies and annuity contracts. The regulation lowers reserves for individual policies, which is expected to result in a lower cost of doing business in New York.

The 2nd Amendment to Regulation 159 (11 NYCRR 74): Homeowners Insurance Disclosure Information and Other Notices (Effective on an emergency basis since 10/20/06) (Adopted on a permanent basis effective 8/8/07)

In enacting Chapter 162 of the Laws of 2006, the Legislature intended to improve public awareness of market assistance programs, such as the Coastal Market Assistance Program (CMAP), that may be available to homeowners in New York. Chapter 162 requires that when a policyholder receives a notice of cancellation, nonrenewal or conditional renewal for a homeowners insurance policy as specified in Section 3425(e) of the Insurance Law on property located in an area served by a market assistance program established by the Superintendent for the purpose of facilitating placement of homeowners insurance, the policyholder must also receive notice from the insurer of possible eligibility for coverage through the market assistance program or through the New York Property Insurance Underwriting Association (NYPIUA). In order to implement Chapter 162, the Legislature required the Superintendent to promulgate regulations governing the notices required by law. This rule sets forth certain minimum notification requirements to assure that policyholders that may be eligible for a market assistance program or NYPIUA receive proper notice of their options.

The 1st Amendment to Regulation 140 (11 NYCRR 350): Continuing Care Retirement Communities (Adopted on a permanent basis effective 10/17/07)

Chapter 689 of the Laws of 1989 was enacted for the stated purpose of facilitating the creation of the necessary components for the development of a broader and more integrated continuum of long term care, financed by a range of private, public and public/private options. One option was the Continuing Care Retirement Community (CCRC), a residential facility for seniors that provides stated housekeeping, social, and health care services in return for some combination of advance fees, periodic fees, and additional fees. A CCRC is often designed to provide a full continuum of care as the health status of a resident deteriorates with age.

A CCRC is expected to maintain at all times at least the required minimum level of liquid funds to cover unexpected expenses or unexpected revenue shortfalls. These funds are not to cover budgeted expenses. This amendment reduces the minimum liquid amount requirement to a level more in line with the investment community's "days cash on hand" benchmark for an entrance fee community. The "days cash on hand" benchmark is designed to provide sufficient funds to cover unexpected expenditures, provide refunds for unanticipated living unit turnover without an attendant new entrance fee, or meet other unbudgeted expenses.

The Adoption of a New Regulation 50 (11 NYCRR 12): Training Allowance Subsidy (Adopted on a permanent basis effective 10/17/07)

Insurance Law Sections 4228(e)(3)(C) through (E) describe the cumulative maximum training allowance subsidy limits an insurer may pay its agents. Section 4228 recognizes that the dollar amount of these training allowance limits would eventually become insufficient due to inflation. Therefore, Section 4228(e)(3)(G) provides that the Superintendent shall periodically adjust these cumulative maximum training allowance subsidy limits.

January 1, 1998 was the effective date of Insurance Law Section 4228. Because of inflation since that date, the Section 4228(e)(3)(C) through (E) cumulative maximum training allowance subsidy limits on the amount an insurer can pay its agents have become insufficient. This regulation is necessary to permit an increase in these limits that reflects overall inflationary increases since January 1, 1998.

The 35th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards For Form, Content And Sale Of Health Insurance, Including Standards Of Full And Fair Disclosure and the New Regulation 183 (11 NYCRR 56): Processing of Claims (Effective on an emergency basis since 8/2/06) (Adopted on a permanent basis effective 11/7/07)

The Insurance Law authorizes the Superintendent to establish standard provisions for accident and health insurance coverage, and to promulgate regulations governing minimum standards for the form, content and sale of such coverage. Regulation 183 and the amendment to Section 52.16(c)(5) of Regulation 62 serve that purpose.

The cosmetic surgery exclusion presently set forth in Regulation 62 predates Article 49 of the Insurance Law, which provides for internal and external appeal of medical necessity denials. This rule clarifies the requirements relating to the cosmetic surgery exclusion in light of the subsequently enacted statutes.

The 3rd Amendment to Regulation 171 (11 NYCRR 362): The Healthy NY Program and Direct Payment Market Stop Loss Relief Programs (Effective on an emergency basis since 9/11/06) (Adopted on a permanent basis effective 11/7/07)

Before enactment of this rule, small employers and individual participants in the Healthy New York program seeking comprehensive health insurance coverage could not purchase high deductible health plans and establish health savings accounts in accordance with federal standards. This regulation requires HMOs and participating insurers to offer high deductible health plans using the Healthy New York small employer and individual programs. This new option provides New Yorkers with access to a tax-advantaged method of purchasing health insurance.

The rule also provides for prostate cancer screening and a limited home health care and physical therapy benefit. The addition of the prostate cancer screening benefit will facilitate prompt and early detection of prostate cancer, which in turn should decrease mortality and reduce treatment costs.

The 1st Amendment to Regulation 149 (11 NYCRR 42): Term Life Insurance and Renewal Provision (Adopted on a permanent basis effective 12/5/07)

The Insurance Law sets forth nonforfeiture requirements for the anniversaries of life insurance policies. The requirements set forth in the Insurance Law assume that premiums are annually paid at the beginning of each policy year, and that any surrenders or lapses occur at the end of the year. In practice, premium may actually be paid throughout a policy year (i.e. monthly), and surrenders may occur at times other than on a policy anniversary. Nonforfeiture requirements deal with the fair treatment of policyholders.

This amendment addresses the issues that arise when these sorts of variations occur. By having these issues addressed in a regulation, insurance companies will have guidance as to what is considered acceptable, which, in turn, should enhance their ability to get policy forms approved more quickly. This amendment also seeks to clarify the requirements of Section 4221 of the Insurance Law in a number of areas where the Department has found problems with policy form submissions.

The 10th Amendment to Regulation 41 (11 NYCRR 27): Excess Line Placements Governing Standards (Adopted on a permanent basis effective 12/19/07)

Article 21 of the Insurance Law establishes minimum standards for the placement of New York risks with eligible excess line insurers. Regulation 41 further governs the placement of excess line insurance. The purpose of the excess line insurance market is to enable consumers who are unable to obtain insurance from licensed insurers instead to obtain coverage from eligible excess line insurers. The Department monitors the financial standards imposed upon such insurers. Some eligible excess line insurers are located outside of the United States. These insurers are referred to as “alien excess line insurers”. Regulation 41 requires alien excess line insurers to maintain trust funds in the United States to support their United States excess line business. These trust requirements have not been updated for several years. The NAIC International Insurers Department (IID), which reviews alien insurer applications for inclusion on the NAIC Quarterly Listing of Alien Insurers, recently updated its trust funding standards for alien excess line insurers and for associations of insurance underwriters (Associations). Underwriters at Lloyd’s, London (Lloyd’s) is the only Association in existence at this time.

This rule changes the amount of funds required to be held in trust by alien excess line insurers and Associations, and resolves the existing inequity in the trust fund obligations imposed upon alien excess line insurers, as compared to the obligations imposed upon an Association. The amount of funds to be held in trust by alien excess line insurers will increase, and the amount of funds to be held in trust by an Association will decrease.

The 1st Amendment to Regulation 179 (11 NYCRR 100):* Recognition Of The 2001 CSO Mortality Table For Use In Determining Minimum Reserve Liabilities And Nonforfeiture Benefits And Recognition And Application Of Preferred Mortality Table For Use In Determining Minimum Reserve Liabilities *(Adopted on a permanent basis effective 12/26/07)

One major focus of the Insurance Law is the solvency of insurers doing business in New York. One way the Insurance Law seeks to ensure solvency is by requiring all insurers licensed to do business in New York to hold reserve funds in proportion to the obligations made to policyholders. The Insurance Law prescribes the mortality tables and interest rates to be used for calculating such reserves for life insurance purposes.

With respect to policies issued on or after January 1, 2007, the regulation permits the 2001 CSO Preferred Class Structure Mortality Table to be used in lieu of the 2001 CSO Mortality Table, under certain specified conditions, for valuing the minimum standards for individual life insurance policies and group life insurance policies sold to individuals by certificate with premium rates guaranteed from issue

for at least two years. The split of the 2001 CSO Mortality Table into super-preferred, preferred, and residual standard classes will allow for reserves to better match the risks associated with different underwriting classifications. Use of the 2001 CSO Preferred Class Structure Mortality Table, however, is not mandatory.

The rule requires insurers to submit certain data because experience information is necessary in order to help the Department monitor the ongoing adequacy of the reserves established pursuant to this rule, particularly as the Department considers the implementation of a more principles-based reserve system that puts greater emphasis on an insurer's own experience data.

***The 2nd Amendment to Regulation 147 (11 NYCRR 98)**:* **Valuation Of Life Insurance Reserves**
(Adopted on a permanent basis effective 12/26/07)

This regulation is designed to help ensure the solvency of life insurers doing business in New York. The original version of Regulation 147, which incorporated the NAIC Valuation of Life Insurance Policies model regulation (adopted in 1999), was permanently adopted in 2003. In 2004, the Department and other state regulators became aware that some insurers were creating new products in order to avoid the reserve methodologies described in Regulation 147. As a result, the NAIC began developing an Actuarial Guideline in 2004 that addressed the concerns of the Department and other regulators by eliminating any perceived ambiguity in the standards for policies issued July 1, 2005 and later. This revision was adopted by the NAIC in October 2005, and Regulation 147 was amended on an emergency basis to reflect the principles of Section 4217 of the Insurance Law and the NAIC standards for policies issued July 1, 2005 and later. The amendment was permanently adopted effective January 10, 2007.

In September 2006, the NAIC adopted a new version of Actuarial Guideline 38, which included provisions on lapse decrements and a separate asset adequacy analysis requirement for certain universal life with secondary guarantee policies. This amendment, which includes these provisions, is consistent with the NAIC actuarial guidelines. For example, consistent with the NAIC practice, these provisions will only be in effect for policies issued on or after January 1, 2007 and prior to January 1, 2011.

The amendment requires insurers to submit certain data to the Department because experience information is needed to help the Department monitor the ongoing adequacy of the reserves established pursuant to this regulation, particularly as the Department considers the implementation of a more principles-based reserve system that puts more emphasis on an insurer's own experience data.

Emergency Regulations

The following is a summary of Insurance Department regulations promulgated on an emergency basis in 2007 that remained in effect on December 31, 2007. Note that the first item listed was in effect on an emergency basis for all or part of 2007 and was subsequently adopted on a permanent basis in 2008. No final action was taken with regard to the other 2 items in 2007, although it is anticipated that they will be permanently adopted in 2008.

The 38th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards For Form, Content And Sale Of Health Insurance, Including Standards Of Full And Fair Disclosure (Effective on an emergency basis since 2/5/07) (Adopted on a permanent basis effective 3/5/08)

Chapter 748 of the Laws of 2006 (commonly referred to as "Timothy's Law") became effective on January 1, 2007, less than two weeks after it was signed into law. The law requires insurance companies, Article 43 corporations and HMOs to provide coverage for inpatient and outpatient mental health services.

This regulation requires insurers, Article 43 corporations and HMOs to notify their policyholders, certificateholders, and members of the impact of Chapter 748 on their coverage and to provide a toll-free customer service telephone number from which policyholders, certificateholders and members may obtain information on their mental health coverage. It was important that the notice be given to affected parties no later than February 15, 2007, because a significant number of policies and contracts renewed or were issued on January 1, 2007 and were thus subject to Timothy's Law requirements.

The 5th Amendment to Regulation 146 (11 NYCRR 361): Market Stabilization Mechanisms for Individual and Small Group Health Insurance And Medicare Supplement Insurance (Effective on an emergency basis since 10/4/06)

Regulation 146 was originally promulgated pursuant to the requirements of Chapter 501 of the Laws of 1992 and the statutory authority set forth in Section 3233 of the Insurance Law, which require the Superintendent to promulgate regulations designed to encourage insurers to remain in or enter the small group or individual health insurance markets, and promote an insurance marketplace where premiums do not unduly fluctuate and where insurers and HMOs are reasonably protected against unexpected, significant shifts in the number of persons insured who are ill or who have a history of poor health. In addition, Section 3233 of the Insurance Law specifically directs the Superintendent to create a pooling process involving insurer contributions to, or receipts from, a fund designed to share the risk of or equalize high cost claims and claims of high cost persons. The Fifth Amendment to Regulation 146 is the result of comments and suggestions received by the Insurance Department in relation to the current market stabilization pool.

Under the Fifth Amendment, the current market stabilization pool is being phased out. Payments, collections and data reports were not required in 2005, and the new pooling methodology established by the proposed amendment was established in 2006 and will become fully operational in 2008. The first reporting requirement under the new pooling methodology for health maintenance organizations and insurers was November 10, 2006 and the second reporting requirement was January 31, 2007. Because of the reporting requirements stated above, this amendment to Regulation 146 was promulgated on an emergency basis. The Department is currently reviewing public comments received on the regulation and moving towards permanent adoption.

The 1st Amendment to Regulation 119 (11 NYCRR 42): Workers' Compensation Insurance Rates (Effective on an emergency basis since 9/19/07)

Chapter 6 of the Laws of 2007 established comprehensive reforms to New York's Workers' Compensation Law by: (1) increasing maximum and minimum benefits for injured workers and indexing the maximum to New York's average weekly wage; (2) dramatically reducing costs in the workers' compensation system, thus making hundreds of millions of dollars available annually to be translated into premium reductions; (3) establishing enhanced measures to combat workers' compensation fraud; (4) replacing the Special Disability Fund with enhanced protections for injured veterans; (5) preventing insurers from transferring costs to New York employers by closing the Special Disability Fund to new claims; and (6) creating a financing mechanism to allow for settlement of the Fund's existing liabilities.

The legislation amended Section 27(4) of the Workers' Compensation Law to authorize the Superintendent to determine, by regulation, the "industry standard rate" for calculating simple interest to be used in calculating the present value of future benefits when the employer or insurer is required to deposit such amount into the Aggregate Trust Fund (ATF). The Workers' Compensation Board (WCB) computes the present value thereof and requires payment of such amount into the ATF.

Without the Superintendent's determination of the industry standard rate, the WCB is unable to compute the present value of amounts to be deposited into the ATF. Consequently, the rule is currently in effect on an emergency basis.

Consensus Regulations

Section 102(11) of the State Administrative Procedure Act states that a "consensus rule" is a rule proposed by an agency for adoption on an expedited basis pursuant to the expectation that no person is likely to object to its adoption because it merely (a) repeals regulatory provisions which are no longer applicable to any person, (b) implements or conforms to non-discretionary statutory provisions, or (c) makes technical changes or is otherwise non-controversial. In 2007, the Insurance Department acted to amend the following rules on a consensus basis:

The 6th Amendment to Regulation 172 (11 NYCRR 83): Financial Statement Filings and Accounting Practices and Procedures (Effective on an emergency basis since 1/2/07) (Adopted on a permanent basis effective 4/25/07)

Sections 307 and 308 of the Insurance Law provide that authorized insurers, accredited reinsurers, authorized fraternal benefit societies, and Public Health Law Article 44 Health Maintenance Organizations and Integrated Delivery Systems shall file financial statements annually and quarterly with the Superintendent. The Insurance Law further provides that the form of such statements shall be prescribed by the Superintendent. To assist in the completion of the financial statements, the NAIC also adopts and publishes from time to time certain policy, procedure and instruction manuals. One of these manuals, the Accounting Practices and Procedures Manual As Of March 2006 ("Accounting Manual"), includes a body of accounting guidelines referred to as “Statements of Statutory Accounting Principles.” The National Association of Insurance Commissioners has most recently adopted a new Accounting Manual as of March 2006. This rule updates the citation in Section 83.2(c) to refer to the Accounting Manual as of March 2006 (instead of 2005).

The 3rd Amendment to Regulation 35-C (11 NYCRR 64-2): Liability Insurance Covering All-Terrain Vehicles (Adopted on a permanent basis effective 10/10/07)

Regulation 35-C establishes standards regarding policies providing liability insurance covering All-Terrain Vehicles (ATVs). This amendment clarifies a reference to Subpart 65-1 of this Title (Regulation 68-A) and the name of the endorsement referenced in section 64-2.1 of this Part. It was necessary to clarify the fact that ATV users are not entitled to use the Automobile PIP endorsement for an ATV.

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V. CIRCULAR LETTERS ISSUED IN 2007 *

Number	Date	Addressed to	Subject
1	01/29/07	All Licensees, All Persons Engaged in the Business of Insurance Who Are Exempted From the Licensing Requirements of the New York Insurance Law, State Insurance Fund	Fraud Reporting and Cooperation with the Insurance Frauds Bureau
2	01/29/07	All Insurers Authorized to Write Motor Vehicle Insurance and Workers' Compensation Insurance in New York State, the New York Automobile Insurance Plan (NYAIP) and All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations	Reporting of the SIU Annual Report to the Insurance Frauds Bureau
3	01/31/07	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations	Chapter 748 of the Laws of 2006 ("Timothy's Law")
Supplement No. 1 to CL No. 3 (2007)	02/23/07	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations	Chapter 748 of the Laws of 2006 ("Timothy's Law")
5	03/01/07	All Authorized Property/Casualty Insurers, Rate Service Organizations, Excess Line Association of New York, and Insurance Producer Organizations	Use of Camel Rating and Other Nonpublic Supervisory Information for Underwriting Insurance Coverage
8	04/16/07	All Authorized Property/Casualty and Co-operative Property/Casualty Insurers	Corporate Emergency Access System (CEAS) Insurance Adjuster Credentialing Program

9	04/26/07	All Insurers and Insurance Producers with a Property Line of Authority and Continuing Education Provider Organizations Approved to Offer Property/Casualty Courses	Flood Insurance Training Requirements For Insurance Producers With A Property Line Of Authority Selling Through The National Flood Insurance Program (NFIP)
Number	**Date**	**Addressed to**	**Subject**
10	05/10/07	All Property/Casualty Insurance Companies; Co-operative Fire Insurance Companies; Lloyds Underwriters and Reciprocal Insurers; Financial Guaranty Insurance Corporations; and the Medical Malpractice Insurance Plan	Property/Casualty Insurance Security Fund
11	08/28/07	All Property/Casualty Insurers	Non-Renewal of Insureds With Homeowners Insurance Who Do Not Also Have Other Insurance Business With The Insurer
12	10/19/07	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations ("HMOs")	Submission of Information for Loss Ratio Reports Filed Pursuant to Section 3231(e)(2)(B) or Section 4308(h)(1) of the Insurance Law
Supplement No. 2 to CL No. 3 (2007)	10/29/07	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations	Chapter 748 of the Laws of 2006 ("Timothy's Law")
Supplement No. 1 to CL No. 22 (2005)	11/06/07	All Property/Casualty Insurers Domiciled in New York State	Filing of Actuarial Opinion Summary (AOS)
13	12/17/07	To All Insurers	Regulation No. 133: Letters of Credit Issued Pursuant to International Chamber of Commerce Uniform Customs and Practice for Documentary Credits (UCP 600)
14	12/14/07	All Insurers Licensed to Write Accident and Health Insurance in New York State	Pre-existing Condition Provisions in Group and Blanket Disability Policies

*Circular Letters Nos. 4, 6 and 7 contained one-time requests for a report. They also contained some requirements that have changed. Therefore, they have been superseded and replaced by Circular Letters Nos. 1, 2 and 3 of 2008 and hence do not appear in the above listing.

VI. MAJOR LITIGATION

Eric R. Dinallo, et al. v. Thomas P. DiNapoli
New York Court of Appeals

This is a proceeding commenced by former Superintendent Gregory V. Serio to quash subpoenas that were served on the Superintendent and several employees of the New York Liquidation Bureau by the Comptroller of the State of New York in connection with the Comptroller's attempt to conduct an audit of the Liquidation Bureau. The Comptroller counterclaimed for enforcement of the subpoenas and for a declaration that the Comptroller has authority to audit the Liquidation Bureau.

In a decision and order issued June 30, 2005, the Supreme Court (Justice Walter B. Tolub) held that the New York State Constitution, Section 111 of the State Finance Law and Section 1412-a of the Abandoned Property Law do not empower the Comptroller to pre-audit or post-audit the financial management and operations of insolvent insurers operated by the Liquidation Bureau or to audit the property of insolvent insurers held by the Superintendent as liquidator or rehabilitator pursuant to Article 74 of the Insurance Law. Accordingly, the court quashed the subpoenas and denied the Comptroller's counterclaim.

The Comptroller appealed to the Appellate Division, First Department. In a decision issued March 6, 2007, the Appellate Division reversed the Order and Judgment of the Supreme Court, with two Justices dissenting. The court held that the Liquidation Bureau is a state agency and therefore subject to audit by the Comptroller. The Decision and Order of the Appellate Division was stayed pending the Superintendent's appeal to the Court of Appeals.

In a decision issued October 11, 2007, the Court of Appeals ruled that the Comptroller does not have either constitutional or statutory authority to audit the Liquidation Bureau. The Court held that "because the liquidation of a distressed insurer has no impact on the state fisc, it does not implicate the Comptroller's constitutional and statutory authority to superintend the fiscal affairs of the State and therefore the Comptroller lacks the authority to audit the Bureau." The Court further held that, because the Superintendent's role as liquidator is "judicial and private," the Superintendent as liquidator is not a state officer, and that the Liquidation Bureau is not a state agency since it does not perform a governmental or proprietary function for the state. Based on the foregoing, the Court of Appeals reversed the Order of the Appellate Division and reinstated the Judgment of Supreme Court.

Mitchell Benesowitz v. Metropolitan Life Insurance Company, et al.
New York Court of Appeals

This case, commenced in the United States District Court for the Eastern District of New York, concerned the interpretation of Section 3234(a)(2) of the Insurance Law, which pertains to preexisting condition provisions in group disability insurance policies. The specific issue before the court was whether the statute establishes a waiting period or a permanent bar for payment of benefits where a disability based upon a preexisting condition arises during the first 12 months of coverage. The district court ruled in favor of the insurer and held that the statute established a permanent bar. On appeal to the United States Court of Appeals for the Second Circuit, the Superintendent, at the invitation of the court, submitted an amicus brief that sided with the plaintiff and argued that the 12-month period in Section 3234(a)(2) is a waiting period, not a permanent bar. The Second Circuit did not reach a decision on the merits, but certified the statutory interpretation question to the New York Court of Appeals, where the Superintendent also filed an amicus brief.

On June 27, 2007, the New York Court of Appeals adopted the Superintendent's interpretation of the statute and unanimously ruled that the 12-month period in Section 3234(a)(2) is a waiting period, during which no benefits will be paid for a disability stemming from a preexisting condition arising in the first 12 months of coverage, rather than a permanent bar to coverage for such a disability. Following the Court of Appeals ruling, the Department issued Circular Letter No. 14 (2007) and Supplement No. 1 to Circular Letter No. 14 (2008), which require insurers to revise any policy forms that are inconsistent with the *Benesowitz* decision; review all group disability claims denials based upon preexisting conditions going back two years from the date of the decision; and retroactively pay with interest all benefits that would have been due under the court's interpretation of Section 3234(a)(2).

Marty Markowitz v. Gregory V. Serio
New York Court of Appeals

This is a Freedom of Information Law (FOIL) case in which the Superintendent appealed from a January 2, 2006 decision of the Supreme Court, New York County (Justice Doris Ling-Cohan). That order required the Department to release annual reports filed by automobile insurers pursuant to the Department's anti-redlining regulation that contain detailed policy information by zip code. The Department had exempted the reports from disclosure on the basis of the insurance companies' contention that release of the information would injure their competitive positions. The Supreme Court held that the reports did not fall within the FOIL exemption for trade secrets or confidential commercial information.

On appeal, the Appellate Division, First Department, reversed the Order and Judgment of the Supreme Court and reinstated the Superintendent's determination. The court held that the information was properly withheld from disclosure under FOIL as material that, if disclosed, would cause substantial injury to the competitive position of the insurers.

On November 15, 2007, leave to appeal was granted by the Court of Appeals, where the case is now pending.

Business For A Better New York, et al. v. Linda Angello, et al.
United States Court of Appeals for the Second Circuit

This is a an action challenging the constitutionality of Labor Law Sections 240(1) and 241(6), the so-called "Scaffold Law," which makes owners and general contractors responsible for properly maintaining safety equipment at construction sites and imposes liability upon them for worker injuries resulting from their failure to do so. The plaintiffs are a trade organization and several construction businesses. The defendants are the Commissioner of Labor, the Superintendent of Insurance, the Chair of the Workers' Compensation Board and the Attorney General. The plaintiffs allege that the statutes are violative of the Equal Protection and Commerce Clauses of the federal Constitution and are pre-empted by the Federal Occupational Safety and Health Act (OSHA).

On September 28, 2007, the District Court granted the State Defendants' motion to dismiss the complaint. The court adopted the report and recommendation of a magistrate judge who found that Labor Law Sections 240(1) and 241(6) were rationally related to the legitimate state interest in protecting the safety of workers, and thus did not violate equal protection. The magistrate judge also concluded that the statutes did not violate the Commerce Clause and were not preempted by OSHA. The plaintiffs have filed an appeal of the dismissal with the United States Court of Appeals for the Second Circuit, where the case is now pending.

VII. 2008 LEGISLATIVE RECOMMENDATIONS

These are the legislative recommendations available at the time this report was prepared. Additional recommendations may be submitted throughout the year. The information which follows was accurate at the time the legislative recommendations were forwarded to the Legislature for introduction.

A. Insurance Department Bills for 2008

1. An act to amend the insurance law, in relation to an extended free look period for senior citizens purchasing individual health insurance policies or contracts

- Section 1 of the bill divides Insurance Law § 3216(c)(10) into subparagraphs (A) and (B) and creates new subparagraphs (C) and (D). Subparagraph (A) maintains the existing 10 to 20-day free look period for certain types of individual health insurance policies that insure an individual who is under the age of 65 on the effective date of coverage. Subparagraph (B) retains the current 30-day free look period for a policy or certificate that is: (1) sold by mail order; (2) provides Medicare supplemental insurance for an insured who was under the age of 65 on the effective date of coverage; or (3) provides long-term care insurance for an insured who is under the age of 65 on the effective date of coverage.

- Section 2 of the bill divides Insurance Law § 4306(h) into new paragraphs (1) and (2), and creates a new paragraph (3). Paragraph (1) maintains the existing 10- to 20-day free look period for certain types of insurance contracts that insure an individual who is under the age of 65 on the effective date of coverage. Paragraph (2) retains the Current 30-day free look period for an insurance contract that is: (1) sold by mail order; (2) provides Medicare supplemental insurance for an insured who is under the age of 65 as of the effective date of coverage; or (3) provides long-term care insurance for an insured who is under the age of 65 as of the effective date of coverage. Paragraph (3) creates a 90-day free look period for a contract sold to an insured who is 65 years of age or older on the effective date of coverage. This new paragraph also requires the contract, or a notice attached thereto, to state that the insurer will refund any premium paid (including any contract fees or other charges) upon surrender and written cancellation of the contract when a claim for benefits has not been incurred. The contract, or a notice attached thereto, must also state that in the event it claim for benefits has been incurred during the time period from the effective date of coverage until 90 days from the date the contract is delivered to the policyholder, the insurer will offset any amounts the insurer has paid on claims for benefits under the contract against the refund of any premium paid (including any contract fees or other charges).

- Section 3 of the bill states that this bill would take effect 180 days after it becomes law, and would apply to all individual insureds whose effective dale of coverage is on or after the bill's effective date.

2. An act to amend the insurance law, in relation to permitting the superintendent to require that filings and submissions made pursuant to the insurance law be submitted to the superintendent of insurance by electronic means

- Section 1 of the bill adds a new Insurance Law § 316 to grant the Superintendent the authority to require, by regulation, that an insurer or other person or entity making a filing or submission with the Superintendent pursuant to the Insurance Law, make the filing or submission by electronic means. An insurer or other person or entity may request an exemption from the

requirement upon a demonstration of undue hardship, impracticability, or good cause, subject to the Superintendent's approval.

- Section 2 of the bill provides that this bill would take effect immediately.

An act to amend the insurance law, in relation to changing the reporting date for the frauds bureau annual report and the special investigations units annual report

- Section 1 of the bill amends Insurance Law § 405(d) by changing the reporting date for the Frauds Bureau's Annual Report from January 15 to March 15 of each year.

- Section 2 of the bill amends Insurance Law § 409(g) by changing the reporting date for an insurer's SIU Annual Report from January 15 to March 15 of each year.

- Section 3 states that this bill is effective immediately.

Relates to the licensure of life settlement brokers; creates certain crimes relating to life settlement fraud; relates to premium finance agreements

- Section 1 of the bill amends Insurance Law § 308 to add life settlement providers, settled policy investors and life settlement intermediaries to the list of entities that are required to provide written responses to Insurance Department ("Department") inquiries.

- Section 2 of the bill adds a new subsection (s) to Insurance Law § 2101, which cross" references Insurance Law § 7802, as amended.

- Sections 3 and 4 of the bill amend Insurance Law §§ 2102 and 2110 to add life settlement broker to the list of those persons required to obtain a license, and whose licenses may be revoked, suspended or not renewed by the Superintendent of Insurance ("Superintendent").

- Section 5 of the bill adds a new subsection (e) to Insurance Law § 2119 requiring life settlement brokers to receive compensation only pursuant to a written contract, and prohibiting excess charges.

- Section 6 of the bill amends Insurance Law § 2120 to provide that life settlement brokers must act in a fiduciary capacity for funds received or collected in such capacity.

- Section 7 of the bill amends the continuing education requirements of Insurance Law § 2132 to also apply to persons licensed to sell life settlements, and to exclude certain insurance producers with a life line of authority from the requirement to take an examination.

- Section 8 of the bill adds a new Insurance Law § 2137, which specifies the licensing requirements (both initial and renewal) applicable to life settlement brokers.

- Section 9 of the bill amends Insurance Law § 2401 to include life settlements within the category of insurance subject to the prohibitions of unfair methods of competition or unfair or deceptive acts or practices.

- Section 10 of the bill amends the definitions of "person" and "defined violation" contained in Insurance Law § 2402 to include the business of life settlements and certain acts committed with respect to that business.

- Section 11 of the bill amends subsection (c) of Insurance Law . 3220 with respect to group life insurance policies to require that a group policy that permits assignment of an insured person's rights by gift shall also allow assignment for value to the same extent that it allows assignment by gift.

- Section 12 of the bill repeals existing Article 78 of the Insurance Law and adds a new Article 78 which, among other things:

    * provides the license requirements for life settlement providers;

    * provides the registration requirements for settled policy investors and life settlement intermediaries;

    * provides the Superintendent with the authority to refuse to renew, revoke or suspend the license of any life settlement provider or the registration of any settled policy investor or life settlement intermediary subject to notice and hearing;

    * requires life settlement providers to obtain approval by the Superintendent of life settlement contract forms prior to use;

    * requires each licensee to file an annual statement with the Superintendent, and authorizes the Superintendent to examine or investigate the affairs of any licensee, registrant or applicant'

    * prohibits licensees and registrants from disclosing the identity of the insured or owner in connection with a proposed or actual life settlement unless the disclosure is necessary for specifically identified purposes;

    * requires specific disclosure to be provided by the life settlement provider and the life settlement broker including the amount of compensation to be paid to the broker;

    * identifies prohibited practices and sets forth penalties and civil remedies; and

    * sets forth provisions for life settlement contracts made with non-resident owners.

- Sections 13 through 15 of the bill amend Insurance Law § 403 to: (1) make the commission of a fraudulent life settlement act a violation of the Insurance Law; (2) define a fraudulent life settlement act by reference to Penal Law § 176.40; and (3) add "fraudulent life settlement act" as one of the actions for which the Superintendent is empowered to level a civil penalty.

- Section 16 of the bill amends Insurance Law § 404(a) to include the business of life settlements within the activities that the Superintendent may investigate.

- Section 17 of the bill makes conforming amendments to Insurance Law § 405 to include life settlement, life settlement acts, fraudulent settle ment acts, and life settlement providers.

- Section 18 of the bill amends Insurance Law § 406 to add provisions relating to attorney's fees and the status of documents and evidence obtained by the Superintendent during an investigation.

- Section 19 of the bill amends Insurance Law § 409(g) to change the month during which the annual fraud report must be filed from January to March.

- Section 20 of the bill adds a new Insurance Law § 410 detailing the required parameters of life settlements fraud prevention plans that must be implemented and reported annually to the Superintendent.

- Section 21 of the bill adds 7 new sections to the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud.

- Section 22 of the bill amends Banking Law § 570 to integrate its provisions governing premium finance agreements with the requirements of amended Article 78 of the Insurance Law.

- Section 23 of the bill sets forth the effective date of the proposed bill, which is generally 180 days after enactment except that the disclosure provisions are effective immediately.

Establishes criteria and standards for captive insurance company in New York State

An act to amend the insurance law, in relation to modifying criteria for the formation of a captive insurance company in New York; providing standards for when entities are affiliated with the owner of a captive insurance company to establish which entities are eligible to be insured by a captive insurance company; and to amend the tax law, in relation to making conforming amendments regarding the computation of taxes for captive insurance companies.

- Section 1 of the bill amends Insurance Law § 7001 (b) to make Insurance Law § 2504, which pertains to public construction projects, applicable to captive insurance companies. However, Insurance Law § 2504 is not applicable to individual public construction projects with an actual or estimated total aggregate value of $50 million or more, or to multiple public construction projects with an actual or estimated total aggregate value of $100 million or more.

- Section 2 of the bill amends Insurance Law § 7002(a) by including in the definition of "affiliated companies," with regard to pure captive companies, companies that maintain a contractual or sub-contractual relationship with, and which have risk management controlled by, the industrial insured or its other affiliated companies, provided that the companies voluntarily elect the affiliated status.

- Section 2 of the bill also amends Insurance Law § 7002(c) by providing in the definition of "captive insurance company" that an entity is not a captive insurance company for purposes of Article 70 if its net investment income exceeds its net written premiums. This section of the bill also amends Insurance Law § 7002(e) by including in the definition of "industrial insured" an insured of a pure captive insurance company: (1) with net worth or net annual income exceeding $25 million; (2) that is a member of a holding company system whose net worth or net annual income exceeds $25 million; or (3) that is a not-for-profit organization with a total annual budget that exceeds $25 million. The definition is also amended to include an insured of a group captive insurance company whose net worth or net annual income exceeds $12.5 million.

- Section 2 of the bill further amends Insurance Law § 7002(f) by clarifying that the definition of "group captive insurance company" includes a domestic insurance company that insures the risks of the industrial insureds' affiliated companies.

- Section 3 of the bill makes a technical amendment to the definition of "pure captive insurance company."

- Section 4 of the bill amends Insurance Law § 7003(a) by making technical amendments, and stating that a captive insurance company is not authorized 10 provide fidelity and surety insurance and salary protection insurance. This section of the bill also adds a new subsection that states that in order for a captive insurance company to do a captive insurance business, its net written premium must exceed its net investment income.

- Section 5 of the bill amends Insurance Law § 7003(b)(2) by requiring managers of captive insurance companies formed as a limited liability company to hold at least one meeting per year in New York.

- Section 6 of the bill amends Insurance Law § 7003(c) to provide that a captive insurance company must file a certified copy of its charter and bylaws, or its articles of organization and operating agreement, as appropriate, with the Superintendent of Insurance ("Superintendent") before the company may receive a license to do a captive business. Section 6 of the bill further provides that the Superintendent shall not issue a license to a captive insurance company if the Superintendent determines that the licensing of the captive insurance company may adversely affect the public welfare or be otherwise detrimental to the people of the state,

- Section 7 of the bill amends Insurance Law § 7003(d) to provide that a captive insurance company must file with the Superintendent any proposed amendments or revisions to its articles of organization and operating agreement for review and approval. In addition, a not-for-profit captive insurance company must submit to the Superintendent for approval any proposed amendments to its charter before filing with the Secretary of State,

- Section 8 of the bill amends Insurance Law § 7004(a) to provide that a pure captive insurance company organized as a limited liability company must maintain at least $250,000 of total surplus as regards policyholders, and a group captive insurance company organized as a limited liability company must maintain at least $500,000 of total surplus as regards policyholders.

- Section 9 of the bill amends Insurance Law § 7005 to provide that a pure captive insurance company and a group captive insurance company may be organized as a limited liability company. The proposed organizers must submit to the Superintendent the company's proposed articles of incorpo ration, which shall contain, among other things, the limited liability's company name, the number of managers, and the articles of organization. The managers of a captive insurance company organized in New York must have at least three members, with at least two required to be residents of New York. In addition, the articles of organization or operating agreement of a captive organized as a limited liability company must authorize a quorum of a board of directors to consist of no fewer than one-third of the fixed number of directors.

- Section 10 of the bill amends Insurance Law § 7006 by changing the dates a captive insurance company must file its annual reports with the Superintendent.

- Section 11 of the bill amends Insurance Law § 7008(a)(3) to provide that the Superintendent may suspend or revoke the license of a captive insurance company if the captive insurance company fails to comply with the provisions of its own articles of incorporation, or its articles of organization or operating agreement. This section of the bill also renumbers subsection (a)(9) as (a)(10), and adds a new subsection (a)(9) that permits the Superintendent to suspend or revoke a captive insurance company's license if the company's net investment income exceeds its net written premium.

- Section 12 of the bill makes certain technical amendments to Tax Law § 1500(a).

- Section 13 of the bill makes certain technical amendments to Tax law § 1502-b(a) clarifying that any captive insurance company set up by the MTA or the City of New York is exempt from the payment of certain fees, taxes or assessments.

- Section 14 of the bill states that this bill is effective immediately.

Expands permissible types of property/casualty group insurance, permits new types of insurance to be written in New York State and makes section 3442 permanent

An act to amend the insurance law, in relation to expanding the permissible types of property/casualty group insurance and permitting new types of insurance to be written in New York; and to amend chapter 19 of the laws of 1994 amending the insurance law relating to credit cards, debit cards and checking account group policies, in relation to making the provisions of section 3442 permanent.

- Section 1 of this bill amends Insurance Law § 1113(a)(7) to include coverage for a stolen identity event under the definition of "burglary and theft insurance."

- Section 2 of the bill amends Insurance Law § 1113(a)(17)(C) to include coverage for other educational expenses, in addition to tuition, in the definition of "credit insurance," and adds a new subparagraph (F) to Insurance Law § 1 1 13(a)(17), to include coverage for event ticket protection in the definition of "credit insurance."

- Section 3 of the bill amends Insurance Law § 3442(d) to permit credit card issuers, debit card issuers, and banks to provide group coverage via their credit cards, debit cards, or checking accounts for event ticket protection, catered affair expense protection, and tuition and other educational expense protection. Section 3 of the bill also amends Insurance Law § 3442(d) to allow coverages that the Superintendent determines to be limited in scope, and not duplicative or a substitute for other more comprehensive coverages.

- Section 4 of the bill adds a new Insurance Law § 3451 to permit the issuance of identity theft group insurance policies.

- Section 5 of the bill adds a new Insurance Law § 3452 to permit the issuance of group property travel insurance policies.

- Section 6 of the bill eliminates the sunset provision in Insurance Law § 3442.

- Section 7 of the bill states that this bill is effective 90 days after it becomes law.

Relates to licensing and authorizing new lines of insurance

An act to amend the insurance law, in relation to modernizing the licensing process by creating three new lines of authority, requiring entities seeking to provide insurance agent and broker licensing courses to file for approval with the superintendent of insurance, requiring independent adjusters to complete pre-licensing and continuing education courses, granting the superintendent of insurance the authority to require an applicant for an article 21 license to submit his or her fingerprints, and permitting the licensing of non-resident adjusters on a reciprocal basis; and to repeal certain provisions of such law relating to licensing of adjusters.

- Section 1 of this bill makes technical amendments to Insurance Law § 21 01 (a)(2), which sets forth the definition of an "insurance agent."

- Section 2 of this bill deletes paragraphs (1) through (10) of Insurance Law §2101(k), which defines "insurance producer."

- Section 3 of the bill amends Insurance Law § 2101 (1) by removing the District of Columbia from the definition of "home state." Section 3 of the bill also amends Insurance Law §§ 2101 (m), (n), and (0) by removing "licensed" to conform to the National Association of Insurance Commissioners' (NAIC) Producer Licensing Model Act.

- Section 4 of the bill amends Insurance Law § 2101 (r) by renumbering paragraphs 6 and 7 as paragraphs 9 and 10, and inserting new paragraphs 6, 7, and 8 that add credit; crop, and surety', respectively, to the definition of "line of authority."

- Section 5 of the bill amends Insurance Law § 2103(a) to permit the Superintendent to issue an insurance agent:s license for credit insurance as provided under Insurance Law § 2101 (r)(6)(A), and amends Insurance Law § 21 03(b) to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance Law § 2101 (r)(6)(B), crop insurance, and surety insurance.

- Section 6 of the bill amends Insurance Law § 21 03(f) to: (1) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 21 03(a); (2) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for pursuant to Insurance Law § 21 03(b); and (3) require entities seeking to provide insurance agent licensing courses to file for approval with the Superintendent.

- Section 7 of the bill amends Insurance Law § 2103(g)(l) by not requiring a written exam as a prerequisite to the issuance of a travel insurance agent's license to any ticket selling agent or representative of a railroad company, steamship company, carrier by air, public bus carrier, or other common carrier who acts as an insurance agent only in reference to insurance coverage for trip cancellation, trip interruption, baggage, life, accident and health, disability, and personal effects, when limited to a specific trip and sold in connection with transportation provided by the common carrier.

- Section 7 of the bill also amends Insurance Law §§ 2103(g)(9) and (10) by giving the Superintendent discretion via a regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or any part of the insurance agent pre-licensing, written exam or prerequisite prelicensing course as set forth in either Insurance Law §§ 2103(f)(2)(A) or (B).

- Section 8 of the bill amends Insurance Law § 21 04(c)(1)(A) to require an individual to complete not less than twenty hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 2104(b) and makes technical amendments to Insurance Law §§ 21 04(c)(l)(B) and (C). Section 8 of the bill also amends Insurance Law § 2104(c) by renumbering paragraph (2) as paragraph (3), and adding a new paragraph (2) that requires entities seeking to provide insurance broker licensing courses to file for approval with the Superintendent.

- Section 9 of the bill amends Insurance Law § 2104(e)(I)(B) by giving the Superintendent discretion via regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or part of the insurance broker pre-licensing, written exam or prerequisite course as set forth in Insurance Law § 21 04(c)(1)(A).

- Section 10 of the bill repeals Insurance Law § 21 08(d)(2), which requires an individual applying for, or renewing, an adjuster's license to submit the individual's fingerprints to the Superintendent. Since this bill adds a new catchall fingerprinting section to Article 21 of the Insurance Law, this provision is no longer necessary.

- Section 11 of the bill amends Insurance Law § 2108(f)(1) to include language stating that an individual shall not be deemed qualified to take the independent adjuster exam without demonstrating that: (I) the individual possesses a minimum of one-year' s experience in the insurance business, with involvement in sales, underwriting, claims, or other experience considered sufficient by the Superintendent; or (2) the individual completed forty hours of formal training in a course, program of instruction, or seminars approved by the Superintendent.

- Section 12 of the bill amends Insurance Law §§ 2108 (r)(1), (2), and (3)(A)(i) by changing all references to "public adjuster" to "adjuster," and making technical amendments.

- Section 13 of the bill amends the Insurance Law by adding a new Insurance Law § 2113 to grant the Superintendent the authority to require an individual who is applying for a license pursuant to Article 21 of the Insurance Law, to submit his or her fingerprints.

- Section 14 of the bill amends Insurance Law § 2132(c)(l) to require that any person with an Article 21 license who is not exempt under Insurance Law § 2132(b), must participate in 24 credit hours of continuing education. This section also permits a person licensed as an individual and acting as a sublicensee of any business entity licensed under Article 21, to count the continuing education credits accumulated to satisfy the renewal requirements for both the individual license and the sublicense, so long as the credits are for a same line of authority.

- Section 15 of the bill amends Insurance Law § 2136(d) to permit the licensing of non-resident adjusters on a reciprocal basis.

- Section 16 states that this bill is effective 180 days after the bill becomes law.

Relates to the licensing of agents of authorized title insurance companies

An act to amend the insurance law, in relation to the licensing of agents of authorized title insurance companies, and to repeal certain provisions of such law relating thereto.

- Section 1 of the bill amends Section 2101(k) of the Insurance Law to expand the definition of "insurance producer" to include "title insurance agent."

- Section 2 of the bill repeals Section 2101(k)(4) of the Insurance Law, which specifically excludes title insurance agents from the definition of "insurance producer" within the meaning of Section 2101(k).

- Section 3 of the bill amends Section 2101 of the Insurance Law to add new subsection(s) to define the term "title insurance agent."

- Section 4 of the bill amends the title heading of Section 2103 of the Insurance Law, the licensing section for insurance agents, to also include title insurance agents.

- Section 5 of the bill amends Section 2103(b) of the Insurance Law to authorize the Superintendent to issue licenses to title insurance agents.

- Section 6 of the bill amends Section 2103(c) of the Insurance Law to authorize the Superintendent to issue a title insurance agent license to a firm or association and its sublicensees. Any sub-licensee would only be authorized to act in the name of the licensee. In the case of a license issued to a title insurance agent, at least one designated sublicensee must have a financial or other beneficial interest in the license.

- Section 7 of the bill amends Section 2103(e) of the Insurance Law to require the filing of an application before a title insurance agent's license may be issued.

- Section 8 of the bill amends Section 2103(f)(2)(B) of the Insurance Law to increase from six to seven the number of licensing exams the Superintendent may prescribe so that the Department can test those seeking to become licensed as a title insurance agent.

- Section 9 of the bill amends Section 2103(g)(7) of the Insurance Law to waive the written exam requirement for an applicant who has passed the title insurance agent exam and who was licensed as a title insurance agent, provided that the applicant applies for the license within two years following the termination of his license.

- Section 10 of the bill amends Section 2103(g) of the Insurance Law to exempt attorneys from the written exam requirement in order to become licensed as a title insurance agent.

- Section 11 of the bill amends Section 2103(h) of the Insurance Law to permit the Superintendent of Insurance ("Superintendent") to refuse to issue a title insurance agent's license if in the Superintendent's judgment the applicant is not trustworthy and competent, or has given cause for the revocation or suspension of such license, or has not complied with any prerequisite for the issuance of a title insurance agent's license.

- Section 12 of the bill amends Section 2103(j)(5) of the Insurance Law to require title insurance agent's to file a renewal application and pay the prescribed fee before their license may be renewed.

- Section 13 of the bill amends Section 2l03(j)(8)(A) of the Insurance Law to authorize the Superintendent to dispense with the requirements for a renewal application of a title insurance agent's license for military personnel who are unable to make a personal application for such license.

- Section 14 of the bill amends Section 2103(j)(12) of the Insurance Law to permit a licensee to amend their license without having to pay the required fee.

- Section 15 of the bill amends Section 2103(1) of the Insurance Law to permit title insurance agents to apply for an additional license authorizing them or sub-licensee to act as insurance agents for additional insurers.

- Section 16 of the bill adds two new subsections to Section 2103 to provide a licensing mechanism for those currently acting as title insurance agents.

- Section 17 of the bill amends Section 2109(a) of the Insurance Law to authorize the Superintendent to issue a temporary title insurance agent's license.

- Section 18 of the bill amends Section 2109(c) of the Insurance Law to permit a title insurance agent who is issued a temporary license to use such license to renew existing business, to collect premiums due, and to perform such other acts as are incidental to the continuance of the insurance business.

- Section 19 of the bill amends Subsections (a) and (d) of Section 2112 of the Insurance Law to require title insurance companies file a certificate of appointment in order to appoint a title insurance to act on its behalf.

- Sections 20, 21 and 22 of the bill amend Section 2115 of the Insurance Law to make the section applicable to title insurance agents and to prohibit a title insurance company or any of its representatives from paying any compensation except to a licensed title insurance agent.

- Section 23 of the bill amends Sections 2120(a) and 2120(c) of the Insurance Law to require title insurance agents to act in a fiduciary capacity for any funds received or collected as a title insurance agent.

- Section 24 of the bill amends Section 2122(a) of the Insurance Law to prohibit a title insurance agent from: 1) advertising the financial condition of an insurer unless the advertising conforms with the requirements of Section 1313 of the Insurance Law; and 2) calling attention to any unauthorized insurer.

- Section 25 of the bill amends Section 2128(a) and Section 2128(b) of the Insurance Law to prohibit title insurance agents from receiving any commissions or fees in connection with coverages placed for or services rendered with various governmental entities unless they actually placed coverage or rendered services to the governmental entity.

- Section 26 of the bill amends Section 2132(b) of the Insurance Law to exempt attorneys from the continuing education requirements for title insurance agents.

- Section 27 of the bill amends the Insurance Law by adding new Section 2137 to prohibit anyone who holds a financial interest in a title insurance agency or title insurance company from referring business to that agency or company unless certain conditions are met.

- Section 28 of the bill amends Section 305(b) of the Insurance Law to prohibit title insurance agent and its officers, directors and employees, whose conduct, condition or practices are being investigated from being entitled to witness or mileage fees.

- Section 29 of the bill requires the Superintendent to promulgate application forms for title insurance agent licensing.

- Section 30 of the bill allows persons, firms and corporations who have filed an application for a title insurance agent license on or before January 1, 2008, or within 90 days after the Superintendent has promulgated application forms pursuant to this act, whichever is later, to act as such agent without a license until the Superintendent has made a final determination on the application for such license.

- Section 31 of the bill provides for an effective date of one hundred twenty days after the legislation has been chaptered, except that any rules and regulations necessary for the timely implementation of this act on its effective date shall be promulgated on or before such date.

Relates to the fair and equitable settlement of claims for health care and payments for health services

An act to amend the insurance law, in relation to the fair and equitable settlement of claims for health care and payments for health services.

- Section 1 of the bill amends Section 3224-a(a) of the Insurance Law to reduce the time within which a health plan must pay an electronically filed claim from 45 days to 20 days.

- Section 2 of the bill provides for an immediate effective date.

Relates to the fair and equitable settlement of claims for health care and payments for health services

An act to amend the insurance law, in relation to prior approval of health insurance premium rates.

- Section 1 of the bill adds a new paragraph (3) to Section 3231 (e) of the Insurance Law to provide that beginning July 1, 2007, premium rate adjustments sought by insurers for policy forms subject to Section 3231 of the insurance Law are subject to the Superintendent's prior approval.

- Section 2 of the bill adds a new paragraph (3) to Section 4308(g) of the Insurance Law to provide that beginning July 1, 2007, premium rate adjustments sought by corporations for contracts subject to Section 4308 of the Insurance Law are subject to the Superintendent's prior approval.

- Section 3 sets forth an immediate effective date.

Repeals certain provisions of insurance law to make the New York property insurance underwriting association permanent and makes other certain provisions of law permanent

An act to repeal section 5411 and subsection (g) of section 5412 of the insurance law relating to making the New York Property Insurance Underwriting Association permanent; and to amend chapter 42 of the laws of 1996, amending the insurance law relating to homeowners' insurance and a temporary panel on homeowners' insurance coverage, in relation to making permanent certain provisions of such chapter.

- Sections 1 and 2 of the bill repeal Section 5411 and 5412(g) of the Insurance Law, thereby making NYPIUA permanent.

- Section 3 makes permanent the provisions of Chapter 42 of the Laws of 1996, including Insurance Law. Section 2351 (pertaining to multi-tier programs for homeowners' insurance policies) and amendments to Insurance Law section 3425 (subsections (0) and (n) pertaining to withdrawal from the homeowners' insurance market) which would otherwise expire on June 30, 2007.

Provides enhanced consumer and provider protections

An act to amend the insurance law and the public health law, in relation to providing enhanced consumer and provider protections; in relation to limitations on denial of claims for pre-authorized health care services; in relation to grievance procedures; in relation to managed care health insurance contracts; in relation to determinations involving urgent care by utilization review agents; and to repeal subsection (h) of section 4803 of the insurance law relating thereto.

- Section 1 of the bill adds a new section 3238 to the Insurance Law to prohibit insurers, health maintenance organizations, municipal cooperative health benefit plans, and Article 43 insurers

from denying payment for a health care service for which preauthorization was received, unless the relevant information was not reasonably available at the time of the pre authorization review, and if the health plan had been aware of the information, it would not have approved the health care service.

- Section 2 of the bill amends Section 4801 of the Insurance Law to add a municipal cooperative health benefit plan to the definition of an insurer. to broaden the definition of a "managed care health insurance contract," and to add a definition of "health care professional" and "health care provider."

- Section 3 of the bill amends Section 4802 of the Insurance Law to conform the grievance requirements to federal standards, and establish timeframes in which a health plan must make a determination regarding a referral or coverage.

- Section 4 of the bill amends Section 4802(c)(1) of the Insurance Law to provide the insured 180 days to submit a grievance.

- Sections 5 and 6 of the bill amend Sections 4802(d) and 4802(k) of the Insurance Law to amend the timeframes in which the insurer must respond to a grievance in the event information is not received.

- Section 7 of the bill repeals subsection (h) of Section 4803 of the Insurance Law and adds a new subsection (h) to require that every contract or agreement between an insurer and a health care provider participating in the insurer's network for a managed care product contain standard clauses that are to be promulgated by regulation.

- Section 8 of the bill amends Section 4804(e)(1) of the Insurance Law to require that an insurer provide notice of the provider's disaffiliation from the insurer's network and the insured's right to transitional care within fifteen days of such disaffiliation.

- Section 9 of the bill amends Section 4900(e) of the Insurance Law to amend the definition of "health care service" for an external appeal of an out-of-network denial.

- Section 10 of the bill adds two new subsections (g-6) and (g-7) to Section 4900 of the Insurance Law to add definitions of "out-of-network denial" and "urgent care."

- Section 11 of the bill amends Section 4900(h)(1) of the Insurance Law to amend the definition of "utilization review" to include an out-of-net-work denial in the definition of utilization review.

- Section 12 of the bill amends Section 4900(i) of the Insurance Law to amend the definition of a "utilization review agent" to include a municipal cooperative health benefit plan in the definition.

- Section 13 of the bill amends Section 4901 (b)(3) of the Insurance Law to omit the reference to retrospective adverse determination.

- Section 14 of the bill amends Section 4902 (a)(5)(iii) of the Insurance Law to include in the minimum requirements of the utilization review program standards that the utilization review agent must notify the insured's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

- Section 15 of the bill adds a new subdivision (a-i) to Section 4903 of the Insurance Law to require a utilization review agent to make an adverse determination involving urgent care within specified timeframes.

- Section 16 of the bill amends Section 4903 of the Insurance Law to: (1) amend the timeframes in which the utilization review agent must make an adverse determination for a health care service involving preauthorization; (2) amend the timeframes in which utilization review agents must make a determination involving continued or extended health care services; (3) require that utilization review agents provide notice to the insured or the insured's designee and the insured's health care provider of an adverse determination involving continued or extended health care services; and (4) amend the timeframes in which the utilization review agent must. make a determination for a health care service that has already been delivered.

- Section 17 of the bill amends Section 4903(e)(3) of the Insurance Law to require a utilization review agent to notify the insured's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

- Section 18 of the bill amends Section 4904 of the Insurance Law to: (1) allow a health care provider to appeal any adverse determination; (2) amend the timeframes in which a utilization review agent must make an appeal determination of a health care service involving urgent care or preauthorization; (3) require a utilization review agent to establish a period of not less than 180 days for an insured or the insured's health care provider to file an appeal of an adverse determination; and (4) amend the timeframes in which the utilization review agent must decide the appeal, depending on whether the appeal involves preauthorization, concurrent care, or a health care service that has already been delivered.

- Section 19 of the bill amends Section 4910(b) of the Insurance Law to allow a health care provider to request an external appeal of any adverse determination upheld upon appeal.

- Section 20 of the bill amends Section 4910(b)(2)(D) of the Insurance Law to make a technical correction.

- Section 21 of the bill amends Section 4910(b) of the Insurance Law to add a new paragraph (3) to allow the insured, the insured's designee, or the insured's health care provider to pursue an external appeal of a health care service that was denied on appeal on the grounds that the health care service is out-of-network and an alternative treatment is available in-network.

- Section 22 of the bill amends Section 4914(b) of the Insurance Law to add that the insured's health care provider has forty-five days to initiate an external appeal from when the insured's health care provider receives notice from the health care plan of its final adverse determination. This section of the bill would require the external appeal agent to notify the insured's health care provider, where appropriate, of the external appeal decision.

- Section 23 of the bill amends Section 4914(b)(4) of the Insurance Law to add a new paragraph (C) to establish the procedures that must be followed by an external appeal agent when reviewing an external appeal involving an out-of-network denial.

- Section 24 of the bill amends Section 4914 of the Insurance Law to: (1) require a health care provider to pay the cost of an external appeal requested by the provider where the external appeal agent upholds the final adverse determination issued by the health care plan; (2) require a provider to split the cost with the health plan if the health plan's denial is overturned in part; and (3) omit the reference to an external appeal initiated by an insured with respect to the standard description of the external appeal process, including a standard form and instructions for initiating an external appeal.

- Section 25 of the bill amends Section 4403(e)(1) of the Public Health Law to require that a health maintenance organization provide notice of the provider's disaffiliation from the health maintenance organization's network and the enrollee's right to transitional care within fifteen days of such disaffiliation.

- Section 26 of the bill amends Section 4408-a of the Public Health Law to conform the grievance requirements to federal standards, and establish timeframes in which a health plan must make a determination regarding a referral or coverage.

- Section 27 of the bill amends Section 4408-a(3)(a) of the Public Health Law to provide the enrollee 180 days to submit a grievance.

- Section 28 of the bill amends Section 4408-a(4) of the Public Health Law to amend the timeframes that the managed care organization must respond to a grievance in the event information is not received.

- Section 29 of the bill amends Section 4408-a(11) of the Public Health Law to amend the timeframes that the managed care organization must respond to an appeal in the event information is not received.

- Section 30 of the bill amends Section 4900(5)(a) of the Public Health Law to amend the definition of "health care service" for an external appeal of an out-of-network denial.

- Section 31 of the bill amends Section 4900 of the Public Health Law to add definitions of "out-of-network denial" and "urgent care."

- Section 32 of the bill amends Section 4900(8)(a) of the Public Health Law to amend the definition of "utilization review" to include an out-of-network denial in the definition of utilization review.

- Section 33 of the bill amends Section 4901(2)(c) of the Public Health Law to omit the reference to retrospective adverse determination.

- Section 34 of the bill amends Section 4902(1)(e)(iii) of the Public Health Law to include in the minimum requirements of the utilization review program standards that the utilization review agent must notify the enrollee's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

- Section 35 of the bill adds a new subdivision 1-a Section 4903 of the Public Health Law to require a utilization review agent to make an adverse determination involving urgent care within specified timeframes.

- Section 36 of the bill amends Section 4903 of the Public Health Law to: (1) amend the timeframes in which the utilization review agent must make an adverse determination for a health care service involving preauthorization; (2) require that utilization review agents provide notice to the enrollee or the enrollee's designee and the enrollee's health care provider of an adverse determination involving continued or extended health care services; (3) amend the time frames in which utilization review agents must make a determination involving continued or extended health care services; and (4) amend the timeframes in which the utilization review agent must make a determination for a health care service that has already been delivered.

- Section 37 of the bill amends Section 4903(5)(c) of the Public Health Law to require a utilization review agent to notify the enrollee's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

- Section 38 amends Section 4904 of the Public Health Law to: (1) allow a health care provider to appeal any adverse determination; (2) amend the timeframes in which a utilization review agent must make an appeal determination of a health care service involving urgent pare or preauthorization; (3) require a utilization review agent to establish a period of not less than 180 days for an enrollee or the enrollee's health care provider to file an appeal of an adverse determination; and (4) amend the timeframes in which the utilization review agent must decide the appeal are also amended, depending on whether the appeal involves preauthorization, concurrent care, or a health care service that has already been delivered.

- Section 39 of the bill amends Section 4910(2) of the Public Health Law to allow a health care provider to request an external appeal of any adverse determination upheld upon appeal.

- Section 40 of the bill amends Section 4910(b)(iv) of the Public Health Law to: (1) make a technical correction; and (2) add a new paragraph (c) allow the enrollee, the enrollee's designee, or the enrollee's health care provider to pursue an external appeal of a health care service that was denied on appeal on the grounds that the health care service is out-of-network and an alternative treatment is available in-network.

- Section 41 of the bill amends Section 4914(2) of the Public Health Law to: (1) add that the enrollee's health care provider has forty-five days to initiate an external appeal from when the enrollee's health care provider receives notice from the health care plan of its final adverse determination; and (2) require the external appeal agent to notify the enrollee's health care provider, where appropriate, of an external appeal decision.

- Section 42 of the bill amends Section 4914(2)(d) of the Public Health Law to establish the procedures that must be followed by an external appeal agent when reviewing an external appeal involving an out-of-net-work denial.

- Section 43 of the bill amends Section 4914 of the Public Health Law to: (1) require a health care provider to pay the cost of an external appeal requested by the provider where the external appeal agent upholds the final adverse determination issued by the health care plan; (2) require a provider to split the cost with the health plan if the health plan's denial is overturned in part j and (3) omit the reference to an external appeal initiated by an enrollee with respect to the standard description of the external appeal process, including a standard form and instructions for initiating an external appeal.

Relates to the licensure of life settlement brokers; creates certain crimes relating to life settlement fraud; relates to premium finance agreements

An act to amend the insurance law, in relation to the licensure of life settlement brokers; to amend the penal law, in relation to life settlement fraud; to amend the banking law, in relation to premium finance agreements; and to repeal article 78 of the insurance law relating to viatical settlements.

- Section 1 of the bill amends Insurance Law § 308 to add life settlement providers, settled policy investors and life settlement intermediaries to the list of entities that are required to provide written responses to Insurance Department ("Department") inquiries.

- Section 2 of the bill adds a new subsection(s) to Insurance Law § 2101, which cross references Insurance Law § 7802, as amended.

- Sections 3 and 4 of the bill amend Insurance Law §§ 2102 and 2110 to add life settlement broker to the list of those persons required to obtain a license, and whose licenses may be revoked, suspended or not renewed by the Superintendent of Insurance ("Superintendent").

- Section 5 of the bill adds a new subsection (e) to Insurance Law § 2119 requiring life settlement brokers to receive compensation only pursuant to a written contract, and prohibiting excess charges.

- Section 6 of the bill amends Insurance Law § 2120 to provide that life settlement brokers must act in a fiduciary capacity for funds received or collected in such capacity.

- Section 7 of the bill amends the continuing education requirements of Insurance Law § 2132 to also apply to persons licensed to sell life settlements, and to exclude certain insurance producers with a life line of authority from the requirement to take an examination.

- Section 8 of the bill adds a new Insurance Law § 2137, which specifies the licensing requirements (both initial and renewal) applicable to life settlement brokers.

- Section 9 of the bill amends Insurance Law § 2401 to include life settlements within the category of insurance subject to the prohibitions of unfair methods of competition or unfair or deceptive acts or practices.

- Section 10 of the bill amends the definitions of "person" and "defined violation" contained in Insurance Law § 2402 to include the business of life settlements and certain acts committed with respect to that business.

- Section 11 of the bill amends subsection (c) of Insurance Law § 3220 with respect to group life insurance policies to require that a group policy that permits assignment of an insured person's rights by gift shall also allow assignment for value to the same extent that it allows assignment by gift.

- Section 12 of the bill repeals existing Article 78 of the Insurance Law and adds a new Article 78 which, among other things:

  * provides the license requirements for life settlement providers;

  * provides the registration requirements for settled policy investors and life settlement intermediaries;

  * provides the Superintendent with the authority to refuse to renew, revoke or suspend the license of any life settlement provider or the registration of any settled policy investor or life settlement intermediary subject to notice and hearing;

  * requires life settlement providers to obtain approval by the Superintendent of life settlement contract forms prior to use;

  * requires each licensee to file an annual statement with the Superintendent, and authorizes the Superintendent to examine or investigate the affairs of any licensee, registrant or applicant;

* prohibits licensees and registrants from disclosing the identity of the insured or owner in connection with a proposed or actual life settlement unless the disclosure is necessary for specifically identified purposes;

* requires specific disclosure to be provided by the life settlement provider and the life settlement broker including the amount of compensation to be paid to the broker;

* identifies prohibited practices and sets forth penalties and civil remedies; and

* sets forth provisions for life settlement contracts made with non-resident owners.

- Sections 13 through 15 of the bill amend Insurance Law § 403 to: (1) make the commission of a fraudulent life settlement act a violation of the Insurance Law; (2) define a fraudulent life settlement act by reference to Penal Law § 176.40; and (3) add "fraudulent life settlement act" as one of the actions for which the Superintendent is empowered to level a civil penalty.

- Section 16 of the bill amends Insurance Law § 404(a) to include the business of life settlements within the activities that the Superintendent may investigate.

- Section 17 of the bill makes conforming amendments to Insurance Law § 405 to include life settlement, life settlement acts, fraudulent settlement acts, and life settlement providers.

- Section 18 of the bill amends Insurance Law § 406 to add provisions relating to attorney's fees and the status of documents and evidence obtained by the Superintendent during an investigation.

- Section 19 of the bill amends Insurance Law § 409(g) to change the month during which the annual fraud report must be filed from January to March.

- Section 20 of the bill adds a new Insurance Law § 410 detailing the required parameters of life settlements fraud prevention plans that must be implemented and reported annually to the Superintendent.

- Section 21 of the bill adds 7 new sections to the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud.

- Section 22 of the bill amends Banking Law § 570 to integrate its provisions governing premium finance agreements with the requirements of amended Article 78 of the Insurance Law.

- Section 23 of the bill sets forth the effective date of the proposed bill, which is generally 180 days after enactment except that the disclosure provisions are effective immediately.

Establishes criteria and standards for captive insurance company in New York State

An act to amend the insurance law, in relation to modifying criteria for the formation of a captive insurance company in New York; providing standards for when entities are affiliated with the owner of a captive insurance company to establish which entities are eligible to be insured by a captive insurance company; and to amend the tax law, in relation to making conforming amendments regarding the computation of taxes for captive insurance companies

- Section 1 of the bill amends Insurance Law § 7001(b) to make Insurance Law § 2504, which pertains to public construction projects, applicable to captive insurance companies However, Insurance Law § 2504 is not applicable to individual public construction projects with an actual or estimated total aggregate value of $50 million or more, or to multiple public construction projects with an actual or estimated total aggregate value of $100 million or more.

- Section 2 of the bill amends Insurance Law § 7002(a) by including in the definition of "affiliated companies," with regard to pure captive companies, companies that maintain a contractual or subcontractual relationship with, and which have risk management controlled by, the industrialinsured or its other affiliated companies, provided that the Companies voluntarily elect the affiliated status.

- Section 2 of the bill also amends Insurance Law § 7002(c) by providing in the definition of "captive insurance company" that an entity is not a captive insurance company for purposes of Article 70 if its net investment income exceeds its net written premiums. This section of the bill also amends Insurance Law § 7002(e) by including in the definition of "industrial insured" an insured of a pure captive insurance company (1) with net worth or net annual income exceeding $25 million; (2) that is a member of a holding company system whose net worth or net annual income exceeds $25 million; or (3) that is a not-for-profit organization with a total annual budget that exceeds $25 million. The definition is also amended to include an insured of a group captive insurance company whose net worth or net annual income exceeds $125 million.

- Section 2 of the bill further amends Insurance Law § 7002(f) by clarifying that the definition of "group captive insurance company" includes a domestic insurance company that insures the risks of the industrial insureds' affiliated companies.

- Section 3 of the bill makes a technical amendment to the definition of "pure captive insurance company.

- Section 4 of the bill amends Insurance Law § 7003(a) by making technical amendments, and stating that a captive insurance company is not authorized to provide fidelity and surety insurance and salary protection insurance This section of the bill also adds a new subsection that states that in order for a captive insurance company to do a captive insurance business, its net written premium must exceed its net investment income.

- Section 5 of the bill amends Insurance Law § 7003(b)(2) by requiring managers of captive insurance companies formed as a limited liability company to hold at least one meeting per year in New York.

- Section 6 of the bill amends Insurance Law § 7003(c) to provide that a captive insurance company must file a certified copy of its charter and bylaws, or its articles of organization and operating agreement, as appropriate, with the Superintendent of Insurance ("Superintendent") before the company may receive a license to do a captive business.

- Section 6 of the bill further provides that the Superintendent shall not issue a license to a captive insurance company if the Superintendent determines that the licensing of the captive insurance company may adversely affect the public welfare or be otherwise detrimental to the people of the state.

- Section 7 of the bill amends Insurance Law § 7003(d) to provide that a captive insurance company must file with the Superintendent any proposed amendments or revisions to its articles of organization and operating agreement for review and approval. In addition, a not-for-profit

captive insurance company must submit to the Superintendent for approval any proposed amendments to its charter before filing with the Secretary of State.

- Section 8 of the bill amends Insurance Law § 7004(a) to provide that a pure captive insurance company organized as a limited liability company must maintain at least $250,000 of total surplus as regards policyholders, and a group captive insurance company organized as a limited liability company must maintain at least $500,000 of total surplus as regards policyholders.

- Section 9 of the bill amends Insurance Law § 7005 to provide that a pure captive insurance company and a group captive insurance company may be organized as a limited liability company. The proposed organizers must submit to the Superintendent the company's proposed articles of incorporation, which shall contain, among other things, the limited liability's company name, the number of managers, and the articles of organization. The managers of a captive insurance company organized in New York must have at least three members, with at least two required to be residents of New York. In addition, the articles of organization or operating agreement of a captive organized as a limited liability company must authorize a quorum of a board of directors to consist of no fewer than one-third of the fixed number of directors.

- Section 10 of the bill amends Insurance Law § 7006 by changing the dates a captive insurance company must file its annual reports with the Superintendent.

- Section 11 of the bill amends Insurance law § 7008(a)(3) to provide that the Superintendent may suspend or revoke the license of a captive insurance company if the captive insurance company fails to comply with the provisions of its own articles of incorporation, or its articles of Organization or operating agreement. This section of the bill also renumbers subsection (a)(9) as (a)(10), and adds a new subsection(a)(9) that permits the Superintendent to suspend or revoke a captive insurance company's license if the company's net investment income exceeds its net written premium.

- Section 12 of the bill makes certain technical amendments to Tax Law § 1500(a).

- Section 13 of the bill makes certain technical amendments to Tax Law § 1502-b(a) clarifying that any captive insurance company set up by the MTA or the City of New York is exempt from the payment of certain fees, taxes or assessments.

- Section 14 of the bill states that this bill is effective immediately.

Relates to permitting the superintendent to require that filings and submissions be submitted to the superintendent by electronic means

An act to amend the insurance law, in relation to permitting the superintendent to require that filings and submissions made pursuant to the insurance law be submitted to the superintendent of insurance by electronic means.

- Section 1 of the bill adds a new Insurance Law § 316 to grant the Superintendent the authority to require, by regulation, that an insurer or other person or entity making a filing or submission with the Superintendent pursuant to the Insurance Law, make the filing or submission by electronic means, An insurer or other person or entity may request an exemption from the requirement upon a demonstration of undue hardship, impracticability, or good cause, subject to the Superintendent's approval.

- Section 2 of the bill provides that this bill would take effect immediately.

Relates to changing the reporting date for the frauds bureau annual report and the special investigations units annual report

- Section 1 of the bill amends Insurance Law § 405(d) by changing the reporting date for the Frauds Bureau's Annual Report from January 15 to March 15 of each year.

- Section 2 of the bill amends Insurance Law § 409(g) by changing the reporting date for an insurer's SIU Annual Report from January 15 to March 15 of each year.

- Section 3 states that this bill is effective immediately.

Relates to licensing and authorizing new lines of insurance

An act to amend the insurance law, in relation to modernizing the licensing process by creating three new lines of authority, requiring entities seeking to provide insurance agent and broker licensing courses to file for approval with the superintendent of insurance, requiring independent adjusters to complete pre-licensing and continuing education courses, granting the superintendent of insurance the authority to require an applicant for an article 21 license to submit his or her fingerprints, and permitting the licensing of non-resident adjusters on a reciprocal basis; and to repeal certain provisions of such law relating to licensing of adjusters

- Section 1 of this bill makes technical amendments to Insurance Law §2101(a)(2), which sets forth the definition of an "insurance agent."

- Section 2 of this bill deletes paragraphs (1) through (10) of Insurance Law § 2101(k), which defines "insurance producer."

- Section 3 of the bill amends Insurance Law § 2101 (1) by removing the District of Columbia from the definition of "home state" Section 3 of the bill also amends Insurance Law §§ 2101(m), (n), and (o) by removing "licensed" to conform to the National Association of Insurance Commissioners' (NAIC) Producer Licensing Model Act.

- Section 4 of the bill amends Insurance Law § 2101(r) by renumbering paragraphs 6 and 7 as paragraphs 9 and 10, and inserting new paragraphs 6, 7, and 8 that add credit, crop, and surety, respectively, to the definition of "line of authority."

- Section 5 of the bill amends Insurance Law § 2103(a) to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance Law § 2101(r)(6)(A), and amends Insurance Law § 2103(b) to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance law § 2101(r)(6)(B), crop insurance, and surety insurance

- Section 6 of the bill amends Insurance Law § 2103(f) to: (1) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 2103(a); (2) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for pursuant to Insurance Law § 2103(b); and (3)require entities seeking to provide insurance agent licensing Courses to tile for approval with the Superintendent.

- Section 7 of the bill amends Insurance Law § 2103 (g)(1) by not requiring a written exam as a prerequisite to the issuance of a travel insurance agent's license to any ticket selling agent or

representative of a railroad company, steamship company, carrier by air, public bus carrier, or other common carrier who acts as an insurance agent only in reference to insurance coverage for trip cancellation, trip interruption, baggage, life, accident and health, disability, and personal effects, when limited to a specific trip and sold in connection with transportation provided by the common carrier.

- Section 7 of the bill also amends Insurance Law §§ 2103(g)(9) and (10) by giving the Superintendent discretion via a regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or any part of the insurance agent pre-licensing, written exam or prerequisite prelicensing course as set forth in either Insurance Law §§ 2103(f)(2)(A) or (B).

- Section 8 of the bill amends Insurance Law § 2104(c)(1)(A) to require an individual to complete not less than twenty hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 2104(b) and makes technical amendments to Insurance Law §§ 2104(c)(J)(B) and (C). Section 8 of the bill also amends Insurance Law § 2104(c) by renumbering paragraph (2) as paragraph (3), and adding a new paragraph (2) that requires entities seeking to provide insurance broker licensing courses to file for approval with the Superintendent.

- Section 9 of the bill amends Insurance Law § 2104(e)(1)(B) by giving the Superintendent discretion via regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or part of the insurance broker prelicensing, written exam or prerequisite course as set forth in Insurance Law § 2104(c)(1)(A).

- Section 10 of the bill repeals Insurance Law § 2108(d)(2), which requires an individual applying for, or renewing, an adjuster's license to submit the individual's fingerprints to the Superintendent Since this bill adds a new catchall fingerprinting section to Article 21 of the Insurance Law, this provision is no longer necessary.

- Section 11 of the bill amends Insurance Law § 2108(f)(1) to include language stating that an individual shall not be deemed qualified to take the independent adjuster exam without demonstrating that: (1) the individual possesses a minimum of one-year's experience in the insurance business, with involvement in sales, underwriting, claims, or other experience considered sufficient by the Superintendent; or (2) the individual completed forty hours of formal training in a course, program of instruction, or seminars approved by the Superintendent.

- Section 12 of the bill amends Insurance Law §§ 2108(r)(1), (2), and (3)(A)(i) by changing all references to "public adjuster" to "adjuster," and making technical amendments.

- Section 13 of the bill amends the Insurance Law by adding a new Insurance Law § 2113 to grant the Superintendent the authority to require an individual who is applying for a license pursuant to Article 21 of the Insurance Law, to submit his or her fingerprints.

- Section 14 of the bill amends Insurance Law § 2132(c)(1) to require that any person with an Article 21 license who is not exempt under Insurance Law § 2132(b), must participate in 24 credit hours of continuing education. This section also permits a person licensed as an individual and acting as a sublicensee of any business entity licensed under Article 21, to count the continuing education credits accumulated to satisfy the renewal requirements for both the individual license and the sublicense, so long as the credits are for a same line of authority.

- Section 15 of the bill amends Insurance Law § 2136(d) to permit the licensing of non-resident adjusters on a reciprocal basis.

- Section 16 states that this bill is effective 180 days after the bill becomes law.

VIII. Regulatory Activities

A. OPERATING STATISTICS

1. Licenses Issued During Year

Table 61
LICENSES ISSUED DURING YEAR
2006 and 2007

	2007	2006
Total	**153,909**	**118,814**
Adjusters[a]		
Independent	5,788	7,395
Public	111	355
Agents[b]		
Life/Accident and Health	123,866	22,132
Property and Casualty	12,776	48,077
Personal Lines	15	150
Limited Rental/Wireless Communications	0	39
Mortgage Guaranty Insurance	3	4
Bail Bond	73	57
Limited Lines[c]	0	16
Brokers[d]		
Life	4,948	2,071
Property and Casualty	5,073	35,714
Personal Lines	149	25
Excess Line (Regular)	260	1,199
Excess Line (Limited)	435	930
Viatical Settlement	12	17
Consultants[e]		
Life	154	38
General	100	374
Reinsurance Intermediaries[f]	16	205
Service Contract Registrants[g]	130	16

Note: Footnotes to table appear on next page.

Footnotes to Table 61

[a] Adjuster licenses issued pursuant to Section 2108 are renewable biennially as of January 1 of odd numbered years.

[b] Life/Accident and Health Agent licenses issued pursuant to Section 2103(a) are renewable biennially as of July 1 of odd numbered years. Property and Casualty Agent and Personal Lines Agent licenses issued pursuant to Section 2103(b) are renewable biennially as of July 1 of even numbered years. Limited Rental/Wireless Communications Agent licenses issued pursuant to Section 2131 are renewable biennially as of July 1 of even numbered years. Mortgage Guaranty Agent licenses issued pursuant to Section 6535 are perpetual. Bail Bond Agent licenses issued pursuant to Section 6802 are renewable biennially as of January 1 of odd numbered years.

[c] Limited Lines Agent licenses – Effective January 1, 1987, licenses were issued to agents of assessment co-operative property/casualty companies enabling them to sell only coverage written by such companies. These licenses are renewable biennially as of July 1 of even numbered years.

[d] Life Broker licenses issued pursuant to Section 2104(b)(1)(A) are renewable biennially as follows: Issued between 3/01 and 6/30, expiration on 2/28 of odd years; issued between 7/01 and 10/31, expiration on 6/30 of odd years; issued between 11/01 and 2/28(9), expiration on 10/31 of odd years. Property and Casualty Broker and Personal Lines Broker licenses issued pursuant to Section 2104 and Excess Line Broker licenses issued pursuant to Section 2105 are renewable biennially as of November 1 of even numbered years. Limited Excess Line Brokers are licensed to deal only with purchasing groups as defined in Regulation 134. Viatical Settlement Broker licenses issued pursuant to Section 7802 are renewable annually as of December 1.

[e] Consultant licenses issued pursuant to Section 2107 are renewable on a biennial basis, Life Consultants as of April 1 of odd numbered years and General Consultants as of April 1 of even numbered years.

[f] Reinsurance Intermediary licenses issued pursuant to Section 2106 are renewable biennially as of September 1 of even numbered years.

[g] Service Contract Registrations issued pursuant to Section 9707 are renewable biennially as of March 1 of odd numbered years.

NEW FOR 2007: Due to legislation which became effective January 1, 2007, individual and individual trade name (sole proprietorship) producer licenses are now issued with an expiration date determined by the applicant's date of birth rather than a fixed renewal date. The following classes of licenses are affected: Life and/or Accident & Health Agent, Property and Casualty Agent, Personal Lines Agent, Limited Rental/Wireless Communications Agent, Limited Lines Agent, Life Consultant, General Consultant, Life Broker, Property and Casualty Broker, Personal Lines Broker, Excess Line Broker, Limited Excess Line Broker, Reinsurance Intermediary.

2. Results of Examinations for Licenses

Table 62
RESULTS OF EXAMINATIONS FOR LICENSES
Adjusters, Agents, Brokers and Consultants
2006 and 2007

Type of Examination	2007 Number Taking Examination	2007 Percent Passing	2006 Number Taking Examination	2006 Percent Passing
Total	**33,703**	**45**	**30,954**	**47**
Public Adjusters	101	39	76	34
Independent Adjusters - Total	4,690	51	4,329	53
Accident and Health	479	56	374	53
Automobile	457	47	604	50
Aviation	0	0	3	100
Casualty	1,161	51	1,239	52
Fidelity and Surety	3	67	1	0
Fire	202	62	223	68
General (All Lines)	1,132	46	626	49
Health Service Charges	485	52	425	57
Inland Marine	71	52	108	44
Limited Auto (Damage or Theft Appraisals only)	700	53	726	56
Agents and Brokers - Total	28,890	44	26,522	46
Agent, A&H	3,121	35	2,539	43
Agent, A&H (Spanish)	57	2	32	9
Agt/Brk, Life	9,299	44	8,234	40
Agt/Brk, Life (Spanish)	687	8	640	10
Agt/Brk, Life, A&H	10,809	48	10,298	52
Agt/Brk, Life, A&H (Spanish)	27	0	12	25
Agent, Property and Casualty	1,161	50	1,144	51
Broker, Property and Casualty	2,631	43	2,621	47
Agent, Mortgage Guaranty	5	80	2	50
Agent, Credit	0	0	0	0
Agt/Brk, Personal Lines	1,053	59	963	58
Agent, Bail Bond	40	83	37	54
Consultants - Total	22	32	27	19
Life	14	21	16	25
General	8	50	11	9

3. Changes in Authorized Insurers During 2007

A. Life Insurance Companies	
Foreign Company Licensed	
Keystone State Life Insurance Company, Fort Washington, PA	Dec. 18
Merger Agreements Filed	
American Mayflower Life Insurance Company of New York into Genworth Life Insurance Company of New York, New York, NY	Jan. 1
Chase Insurance Life Company of New York into Chase Life & Annuity Company of New York	Jan. 1
Jefferson Pilot LifeAmerica Insurance Company into Lincoln Life & Annuity Company of New York	Apr. 2
Farmers and Traders Life Insurance Company into Columbian Mutual Life Insurance Company, Binghamton, NY	Oct. 1
Keystone State Life Insurance Company into Wilton Reassurance Company Life Company of New York, Rye Brook, NY	Dec. 31
Aviva Life Insurance Company of New York into Bankers Life Insurance Company of New York	Dec. 31
Redomestications	
Jefferson Pilot LifeAmerica Insurance Company (from New Jersey to New York)	Apr. 2
CUNA Mutual Insurance Society (from Wisconsin to Iowa)	Sept. 25
Amendments to Charter	
New York Life Insurance Company	Mar. 14
First Unum Life Insurance Company	Mar. 29
Aviva Life Insurance Company of New York	Apr. 20
Jackson National Life Insurance Company of New York	June 1
Stonebridge Life Insurance Company	Sept. 24
Change of Names	
“Chase Life & Annuity Company of New York” to “Protective Life Insurance Company of New York” Melville, NY	Jan. 1
“Fidelity and Guaranty Life Insurance Company of New York” to “OM Financial Life Insurance Company of New York” Purchase, NY	Jan. 1
“Jefferson Pilot LifeAmerica Insurance Company” to “Lincoln Life & Annuity Company of New York” Syracuse, NY	Apr. 2
“Northstar Life Insurance Company” to “Fort Dearborn Life Insurance Company of New York” Pittsford, NY	July 2
“Genworth Life and Health Insurance Company” to “Sun Life and Health Insurance Company (US),” Windsor, CT	Dec. 1
“Bankers Life Insurance Company of New York” to “Aviva Life and Annuity Company of New York” Woodbury, NY	Dec. 31
B. Accident and Health Insurance Companies	
Domestic Company Incorporated	
Atlantic American Health Insurance Company	Aug. 15
Foreign Companies Licensed	
NMHC Group Solutions Insurance, Inc., Wilmington, DE	Apr. 2
Elder Health Insurance Company, Inc., Wilmington, DE	June 21
Envision Insurance Company, Twinisburg, OH	July 2
Universal Fire & Casualty Insurance Company, Columbia City, IN	Nov. 6
SilverScript Insurance Company, Nashville, TN	Nov. 20

Change of Names	
"Horizon Healthcare Insurance Company of New York" to "Rayant Insurance Company of New York" New York, NY	June 8
"Elder Health Insurance Company, Inc." to 'Bravo Health Insurance Company" Wilmington DE	Oct. 1
Merger Agreement Filed	
Dental Insurance Company of America into United HealthCare Insurance Company of New York, Islandia NY	July 17
In Liquidation	
Horizon Healthcare of New York, Inc.	June 14
C. Property and Casualty Insurance Companies	
Domestic Companies Incorporated	
Axel Insurance Company of New York	July 18
Surya Insurance Company	Oct. 2
Denali National Surety Company	Dec. 13
FDM Preferred Insurance Company, Inc.	Dec. 21
Fire Districts Insurance Company, Inc.	Dec. 21
Domestic Companies Licensed	
Merchants Preferred Insurance Company, Buffalo, NY	Feb. 26
Park Insurance Company, Jamaica, NY	Dec. 6
Foreign Companies Licensed	
Narragansett Bay Insurance Company, Pawtucket RI	Jan. 30
United Guaranty Commercial Insurance Company of North Carolina, Greensboro, NC	Jan. 31
Amica Property and Casualty Insurance Company, Lincoln, RI	Feb. 7
Insurance Company of the West, San Diego, CA	Mar. 9
The Gray Insurance Company, Metairie, LA	Mar. 29
Erie Insurance Property & Casualty Company, Erie, PA	Apr. 30
Flagship City Insurance Company, Erie, PA	Apr. 30
Plans' Liability Insurance Company, Worthington, OH	May 24
Universal Underwriters of Texas Insurance Company, Plano, TX	June 22
Germantown Insurance Company, Philadelphia, PA	Aug. 22
American Service Insurance Company, Inc., Elk Grove Village, IL	Sept. 11
ProCentury Insurance Company, Dallas, TX	Sept. 13
Financial Casualty & Surety, Inc., Houston TX	Sept. 18
Old Dominion Insurance Company, Jacksonville, FL	Oct. 11
Securian Casualty Company, St. Paul, MN	Oct. 12
Alamance Insurance Company, Springfield, IL	Nov. 7
Catlin Insurance Company, Inc., Houston, TX	Nov. 26
Allmerica Financial Benefit Insurance Company, Howell, MI	Dec. 7
Amendments to Charter	
Rochdale Insurance Company, New York, NY	Feb. 6
Hudson Specialty Insurance Company	Mar. 23
Progressive Preferred Insurance Company	Apr. 17
Progressive Max Insurance Company	Apr. 25
Merchants Preferred Insurance Company	May 18
Great American Alliance Insurance Company	May 31
Great American Assurance Company	May 31
XL Insurance Company of New York, Inc.	July 9
American International Insurance Company	Sept. 24

AIG National Insurance Company, Inc.	Sept. 24
Centennial Insurance Company	Oct. 4
Atlantic Mutual Insurance Company	Oct. 4
Progressive Northeastern Insurance Company	Oct. 23
Jefferson Insurance Company	Oct. 31
State-Wide Insurance Company	Nov. 27
Hereford Insurance Company	Dec. 3
Change of Names	
“NIC Insurance Company” to “Navigators Specialty Insurance Company” New York, NY	Jan. 4
“Birmingham Fire Insurance Company of Pennsylvania” to “AIG Casualty Company” Harrisburg PA	Jan. 17
“Ace American Reinsurance Company” to “R&Q Reinsurance Company” Philadelphia PA	Jan. 26
“Tower Indemnity Company of America” to “CastlePoint Insurance Company” New York, NY	Feb. 8
“Interboro Mutual Indemnity Insurance Company” to “Interboro Insurance Company” Mineola, NY	Feb. 9
“Sirius America Insurance Company” to “Delos Insurance Company” Dover DE	Feb. 12
“Continental National Indemnity Company” to “Continental Indemnity Company “ Cedar Rapids, IA	Mar. 2
“AXA RE America Insurance Company” to “Paris RE America Insurance Company” Wilmington, DE	Apr. 5
“Ulico Casualty Company” to “ULLICO Casualty Company” Dover DE	May 1
“Regal Insurance Company” to “Infinity Security Insurance Company” Cincinnati, OH	May 11
“Atlanta Casualty Company” to “Infinity Casualty Insurance Company” Cincinnati, OH	May 11
“Windsor Insurance Company” to “Infinity Standard Insurance Company” Cincinnati, OH	May 11
“Quadrant Indemnity Company” to “Harbor Point Reinsurance U.S., Inc. “ Greenwich, CT	May 15
“Leader Insurance Company” to “Infinity Auto Insurance Company” Cincinnati, OH	May 16
“Atlanta Specialty Insurance Company” to “Infinity Specialty Insurance Company” Cincinnati, OH	May 16
“Coventry Insurance Company” to “Infinity General Insurance Company” Cincinnati, OH	May 16
“TICO Insurance Company” to “Infinity Assurance Insurance Company” Cincinnati, OH	May 16
“Nipponkoa Insurance Company of America” to “American Pet Insurance Company” New York, NY	May 29
“Merchants Insurance Company of New Hampshire, Inc.” to “American European Insurance Company” Concord, NH	July 31
“Pawtucket Mutual Insurance Company” to “Pawtucket Insurance Company” Pawtucket, RI	Aug. 17
“Infinity National Insurance Company” to “Hillstar Insurance Company” Indianapolis, IN	Aug. 20
“American Employers’ Insurance Company” to “SPARTA Insurance Company” Boston, MA	Sept. 11
“Royal Indemnity Company” to “Arrowood Indemnity Company” Wilmington DE	Sept. 15
“American Live Stock Insurance Company” to “Hiscox Insurance Company, Inc.” Geneva, IL	Dec. 31
Redomestications Filed	
Viking Insurance Company of Wisconsin (from Colorado to Wisconsin)	Jan. 26
Continental National Indemnity Company (from Ohio to Iowa)	Mar. 2
Vesta Fire Insurance Corporation (from Illinois to Texas)	May 12

Shelby Casualty Insurance Company (from Illinois to Texas)	May 12
American Safety Casualty Insurance Company (from Delaware to Oklahoma)	Sept. 14
Union Insurance Company (from Nebraska to Iowa)	Oct. 1
CUMIS Insurance Society, Inc. (from Wisconsin to Iowa)	Oct. 1
Esurance Insurance Company (from Oklahoma to Wisconsin)	Oct. 3
Williamsburg National Insurance Company (from California to Michigan)	Oct. 12
Western Diversified Casualty Insurance Company, (from Wisconsin to Nebraska)	Dec. 7
Merger Agreements Filed	
GE Reinsurance Corporation into Swiss Reinsurance America Corporation, Armonk, New York	Jan. 1
Fort Wayne Health & Casualty Insurance Company into North American Specialty Insurance Company, Manchester NH	Feb. 9
Coregis Insurance Company into Westport Insurance Corporation, Jefferson City, MO	Mar. 30
Security Insurance Company of Hartford into Arrowood Indemnity Company, Wilmington, DE	Nov. 28
Mid-America Insurance Company into Harleysville Worcester Insurance Company, Harleysville, PA	Dec. 17
Transcontinental Insurance Company into National Fire Insurance Company of Hartford, Chicago, IL	Dec. 31
In Rehabilitation	
Lion Insurance Company, Bethpage, NY	Sept. 6
Colonial Indemnity Insurance Company, Kingston, NY	Sept. 6
D. Title Insurance Companies	
Domestic Companies Licensed	
Titledge Insurance Company of New York, Inc., Staten Island, NY	Apr. 11
Foreign Companies Licensed	
The Security Title Guarantee Corporation of Baltimore, Baltimore, MD	June 21
New Jersey Title Insurance Company, Parsippany, NJ	Nov. 2
Redomestication	
Chicago Title Insurance Company (from Missouri to Nebraska	Dec. 21
E. Accredited Reinsurers	
Certificates of Recognition	
The Commerce Insurance Company, Webster, MA	Mar. 8
American Pacific Insurance Company, Inc., Honolulu, HI	Mar. 28
Citation Insurance Company, Webster, MA	Apr. 18
Commerce West Insurance Company, Pleasanton, CA	Apr. 26
American International Pacific Insurance Company, Denver, CO	June 6
American International Insurance Company of New Jersey, West Trenton, NJ	June 14
AIG Auto Insurance Company of New Jersey, West Trenton, NJ	June 14
Aioi Insurance Company, Ltd., Tokyo, Japan	Dec. 28
Change of Names	
“Ulico Indemnity Company” to “Darwin Select Insurance Company”, Little Rock, AR	Feb. 13
“Alea North America Specialty Insurance Company” to “Praetorian Specialty Insurance Company”, Wilmington, DE	Feb. 13
“Monticello Insurance Company” to “Max Specialty Insurance Company” Wilmington DE	Aug. 24

Withdrawn	
Colonial Life and Accident Insurance Company, Columbia, SC	Sept. 12
The Lincoln National Life Insurance Company, Fort Wayne, IN	Oct. 1
Ameritas Life Insurance Corp., Lincoln, NE	Oct. 31
Oxford Life Insurance Company, Phoenix, AZ	Nov. 7
F. Charitable Annuity Societies	
Incorporated	
The Endowment Association of the College of William and Mary in Virginia, Incorporated	Mar. 15
Permits Issued	
The University of Montana Foundation, Missoula, MT	Jan. 2
St. Labre Indian School Education Association, Ashland, MT	Jan. 16
The Congregation of the Passion, Holy Cross Province, Chicago, IL	Jan. 17
The Ocean Conservancy, Inc. Washington, DC	Feb. 8
The Quiet Hour, Inc., Redlands, CA	Feb. 13
The Legion of Christ, Incorporated, Hamden, CT	Mar. 26
Michigan Tech Fund, Houghton, MI	Apr. 18
Yeshiva University, New York, NY	Apr. 24
The College of Saint Rose, Albany, NY	May 31
Trustees of Tufts College, Medford, MA	June 27
The Wilderness Society, Washington, DC	June 29
AmeriCares Foundation, Inc., Stamford, CT	July 18
Project HOPE – The People to People Health Foundation, Inc., Millwood, VA	Sept. 4
The Leukemia & Lymphoma Society, Inc. White Plains, NY	Sept. 7
Mayo Foundation for Medical Education and Research, Rochester, MN	Sept. 18
Dominican Friars' Guilds, New York, NY	Oct. 18
University of Maryland Baltimore Foundation, Inc., Baltimore, MD	Oct. 26
The Regents of the University of California, Oakland, CA	Oct. 26
The George Washington University, Washington, DC	Nov. 16
Medecins Sans Frontieres/Doctors Without Borders U.S.A., Inc., New York, NY	Dec. 4
Name Change	
"The Endowment Association of the College of William and Mary in Virginia, Incorporated" to "The College of William and Mary Foundation" Williamsburg, VA	Mar. 15
G. Fraternal Benefit Society	
Merger Agreement Filed	
The Polish National Alliance of Brooklyn, United States of America into Polish National Alliance of the United States of North America	July 5
H. Financial Guaranty Companies	

Liquidation	
MML Assurance, Inc., New York, NY	Feb. 2
Incorporated	
Berkshire Hathaway Assurance Corporation	Dec. 21
Domestic Company Licensed	
Berkshire Hathaway Assurance Corporation	Dec. 28
I. Mortgage Guaranty Companies	
Foreign Company Licensed	
Genworth Home Equity Insurance Corporation, Raleigh, NC	June 11
Name Change	
“Residential Guaranty Company” to “PMI Insurance Company”, Phoenix, AZ	Jan. 3
J. Captive Insurance Companies	
Domestic Companies Incorporated	
Global Insurance & Indemnity Co. Ltd, New York, NY	Feb. 7
The Church Insurance Company of New York, New York, NY	Apr. 19
Clam Shell Insurance Company, Inc.	July 13
RP Captive Insurance Company, Inc.	Aug. 20
1177 Insurance Company, Inc.	Dec. 14
Domestic Companies Licensed	
Global Insurance & Indemnity Co., Ltd., New York, NY	Feb. 15
The Church Insurance Company of New York, New York, NY	May 22
RP Captive Insurance Company, Inc., New York, NY	Aug. 24
Clam Shell Insurance Company, Inc. New York, NY	Aug. 30
DMB&B USA Insurance, Inc., New York, NY	Dec. 5
1177 Insurance Company, Inc., New York, NY	Dec. 24
Merger Agreement Filed	
Federated Department Stores Insurance Company, Inc. into Snowdin Insurance Company	Dec. 31

4. Examination Reports Filed During 2007		
Domestic Life Insurance Companies		
Name of Company	**As of**	**Date Filed**
American Mayflower Life Insurance Company of New York	12/31/2004	03/19/2007
First Great-West Life & Annuity Insurance Company	12/31/2005	10/10/2007
First Rehabilitation Life Insurance Company of America	12/31/2003	01/17/2007
Guardian Life Insurance Company of America	12/31/2004	09/27/2007
Jackson National Life Insurance Company of New York	12/31/2005	11/08/2007
John Hancock Life Insurance Company	06/09/2005	07/30/2007
Lincoln Life & Annuity Company of New York	12/31/2004	05/17/2007
Metropolitan Life Insurance Company	12/31/2003	08/24/2007
ML Life Insurance Company of New York	12/31/2004	05/02/2007
National Income Life Insurance Company	12/31/2005	04/10/2007
Teachers Insurance and Annuity Association of America	12/31/2004	05/08/2007
TIAA-CREF Life Insurance Company	12/31/2004	05/08/2007
Unity Mutual Life Insurance Company	12/31/2005	06/14/2007
William Penn Life Insurance Company of New York	12/31/2004	05/18/2007
Foreign Life Insurance Company		
Aetna Life Insurance Company	09/30/2004	08/10/2007
Domestic Accident and Health Insurance Companies		
Health Net Insurance of New York, Inc.	09/30/2003	02/27/2007
Oxford Health Insurance, Inc.	07/17/2007	10/02/2007
Rayant Insurance Company of New York	12/31/2005	12/12/2007
United Concordia Insurance Company of New York	12/31/2005	07/03/2007
Continuing Care Retirement Community		
Kendal at Ithaca	12/31/2005	08/15/2007
Peconic Landing at Southold	12/31/2005	08/15/2007
Domestic Property and Casualty Insurance Companies		
American Pet Insurance Company	12/31/2006	08/21/2007
Atlantic Mutual Insurance Company	12/31/2003	05/25/2007
Centennial Insurance Company	12/31/2003	05/25/2007
Countryway Insurance Company	12/31/2004	01162007
Harleysville Insurance Company of New York	12/31/2004	02/14/2007
ICM Insurance Company	12/31/2006	10/18/2007
Jefferson Insurance Company	12/31/2005	12/20/2007
Merchants Preferred Insurance Company	01/05/2007	02/20/2007
Navigators Insurance Company	12/31/2004	05/21/2007
Park Insurance Company	10/05/2007	11/13/2007
Transcontinental Insurance Company	12/31/2003	02/22/2007
Utica National Assurance Company	12/31/2004	12/04/2007

Name of Company	As of	Date Filed
Advance Premium Co-operative Property and Casualty Insurance Company		
Cherry Valley Cooperative Insurance Company	12/31/2003	08/22/2007
Financial Guaranty Companies		
Berkshire Hathaway Assurance Corporation	12/27/2007	12/28/2007
Financial Guaranty Insurance Company	12/31/2004	05/29/2007
MBIA Insurance Corporation	12/31/2003	03/13/2007
Charitable Annuity Societies		
Albany Medical Center Foundation, Inc.	12/31/2006	10/11/2007
American Baptist Foreign Mission Society	12/31/2005	09/10/2007
American Baptist Home Mission Society	12/31/2005	09/27/2007
American Committee For the Weizmann Institute of Science, Inc.	12/31/2005	03/16/2007
American Jewish Committee	12/31/2005	01/03/2007
American Society For the Prevention of Cruelty To Animals	12/31/2005	06/26/2007
Cooper Union for the Advancement of Science and Art	12/31/2006	10/31/2007
Friars of the Atonement, Inc.	12/31/2005	04/06/2007
Metropolitan Opera Association, Inc.	12/31/2005	07/31/2007
Natural Resources Defense Council, Inc.	12/31/2006	09/14/2007
New York Botanical Garden	12/31/2006	12/13/2007
Roman Catholic Diocese of Albany, New York	12/31/2005	04/13/2007
Roman Catholic Diocese of Syracuse	12/31/2004	01/31/2007
Siena College	12/31/2004	01/04/2007
Syracuse University	12/31/2005	07/06/2007
United States fund for UNICEF	12/31/2005	03/26/2007
Title		
Titledge Insurance Company of New York, Inc.	02/06/2007	03/27/2007
Washington Title Insurance Company	12/31/2005	05/17/2007
Welfare Trust Funds		
Byram Hills Teachers Association Benefit Fund	06/30/2004	10/29/2007
Chappaqua School District Joint Benefit Fund	06/30/2004	02/28/2007
Local 237 Teamsters Brentwood School District Health & Welfare	06/30/2004	08/20/2007
Local 237 Teamsters North Babylon School District Health & Welfare	06/30/2004	08/20/2007
Local 237 Teamsters Plainview Old Bethpage Central School District	06/30/2004	08/20/2007
Local 237 Teamsters-Suffolk Regional Off Track Betting Corporation	12/31/2004	08/20/2007
Local 237 Teamsters-Town of Babylon Health and Welfare Trust Fund	12/31/2004	08/20/2007
Local 237 Teamsters-Town of Islip Health and Welfare Trust Fund	12/31/2004	08/20/2007
NYCTA-ATU 726 Education Fund	12/31/2004	10/09/2007
Suffolk School Employees Health Fund	12/31/2004	01/02/2007
Health Maintenance Organizations		
Capital District Physicians Health Plan	12/31/2004	05/10/2007
Health Net of New York, Inc.	09/30/2003	02/27/2007
Rochester Area HMO, Inc.	12/31/2004	02/22/2006

Name of Company	As of	Date Filed
Retirement and Pension (State)		
New York State and Local Employees' Retirement System	03/31/2001	11/11/2007
20 Viatical Settlement Companies	***21***	***22***
23 Lifetime Lending Corporation	*24 12/31 /2004*	*25 01/08 /2007*
Portsmouth Settlement Company I, LLC	12/31/2006	09/04/2007
Municipal Cooperative Health Benefit Plans		
Allegany-Cattaraugus Schools Medical Health Plan	06/30/2005	02/22/2007
Chautauqua County School Districts' Medical Health Plan	06/30/2006	06/28/2007
Jefferson-Lewis et. Al. School Employees Healthcare Plan	06/30/2005	04/10/2007

5. Insurance Department Receipts and Expenditures

Table 63
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2007

Taxes Collected Under the New York State Insurance Law:	
Taxes collected by reason of retaliation under Section 1112[1]	$(7,014,324.68)
Excess Line - Section 2118	90,300,970.40
Organization Tax - Section 180, Tax Law	12,880.00
Subtotal[2]	**$ 83,299,525.72**
Fees Collected Under Section 1112 of the NYS Insurance Law:	
Filing Annual Statements and Certificates of Authority to Companies	$ 277,861.22
Agents' Certificates of Authority	700,940.17
Admission Fees	42,437.00
Subtotal	**$ 1,021,238.39**
Licensing and Accreditation Fees:	**$ 16,549,451.29**
Assessments and Reimbursement of Department Expenses:	
Section 313 - Company Examinations	$ 13,190,481.91
Section 332 – Assessment	167,188,454.93
Section 9104/9105 – Tax Distribution	256,273.40
Administrative Expense Security Funds	162,154.52
Subtotal	**$ 180,797,364.76**
Other Fees and Receipts:	
Section 9107 - Certification & Filing Fees	$ 83,949.50
Section 9108 - Fire Insurance Fee	14,179,037.18
Section 1212 - Summons and Complaints	562,345.25
Fines and Penalties	9,000,738.49
FOIL Requests	21,790.50
Miscellaneous	116,144.93
Regulation 134	3,700.00
Motor Vehicle Law Enforcement Fee	65,028,131.96
CAPCO Application Fees	6,500.00
Subtotal	**$ 89,002,337.81**
Foreign Fire Tax, and Security Funds Receipts	
Foreign Fire Tax - Insurance Law Sections 2118, 9104 and 9105	$ 43,978,634.97
Property Casualty Insurance Security Fund - Sections 7602 and 7603	220,816,149.00
Public Motor Vehicle Liability Security Fund – Section 7601	10,937,162.00
Workers' Compensation Security Fund	95,843,777.00
Subtotal	**$371,575,722.97**
TOTAL DEPARTMENT RECEIPTS	**$742,245,640.94**

Table 64
INSURANCE TAX RECEIPTS[3]
(in millions)

Fiscal Year	Net
2002-03	704.0
2003-04	930.0
2004-05	1,077.0
2005-06	987.0
2006-07	1,142.0

[1]The negative balance represents retaliatory tax refunds in excess of retaliatory tax collected, in accordance with Insurance Law Section 1112.

[2]This amount is in addition to the $ 1.142 billion collected by the Department of Taxation and Finance under Tax Law Article 33.

[3]Collected by the Department of Taxation and Finance under Tax Law Article 33.
Source: State of New York, Annual Budget Message, 2008-09

Table 65
DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2007
Paid in the First Instance from Appropriations

Personal Service	
Employee salaries	**$ 63,360,949.20**
Maintenance and Operation	
General office supplies	$ 742,464.81
Travel expense	3,427,396.64
Rental equipment	2,745.30
Repair and maintenance of equipment	393,103.22
Real estate rental	7,966,363.03
Postage and shipping	39,278.66
Printing	108,897.87
Telephone	1,178,310.61
Miscellaneous contractual services	6,528,864.06
OFT Computer	128,998.62
OGS Interagency courier	43,851.99
Equipment	2,222,885.72
Employee fringe benefits/indirect cost	31,505,214.38
Subtotal Maintenance and Operation	**$ 54,288,374.91**
Suballocations to Other State Agencies	
Personal Service, Maintenance and Operation	**$ 70,601,564.63**
TOTAL DEPARTMENT EXPENDITURES	**$188,250,888.74**

Table 66
RECEIPTS VS. DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2007

Total Department Receipts	$742,245,640.94
Total Department Expenditures	$188,250,888.74
Excess of Department Receipts Over Department Expenditures	**$553,994,752.20**

B. DEPARTMENT STAFFING

Table 67
DEPARTMENT STAFFING
Number of Filled Positions by Bureau/Location (as of February 20, 2008) ‡

Bureau	Examiners	Attorneys	Actuaries	Other Professionals	Investigators	Support Staff	Total
New York City Office:							
Executive	1			30		6	37
Life	98		8	4		8	118
Health	48		5	2		2	57
Administration*	1			12		9	22
Consumer Services	32			1		16	49
Frauds	3			3	17	4	27
OGC		24		5		10	39
Public Affairs/Research				2		1	3
Property	167		22	2		20	211
Systems	2			16		4	22
Capital Markets	1			5		2	8
Examiner Pool	46						46
Disaster Preparedness	6						6
Policy				2			2
NYC Total	**405**	**24**	**35**	**84**	**17**	**82**	**647**
Albany Office:							
Executive				5		2	7
Life		17	20			6	43
Health	8	21	6	1		3	39
Administration*				21		17	38
Consumer Services	37			1		8	46
Frauds				1	8		9
OGC		6				2	8
Property	10					1	11
Systems	1			34		8	43
Licensing	1			8		32	41
Disaster Preparedness	2			1		1	4
Albany Total	**59**	**44**	**26**	**72**	**8**	**80**	**289**
ALL OTHER							
Brooklyn Office:							
Frauds					5		5
Buffalo Office							
Health		1					1
Consumer Services	2					1	3
Frauds					3		3
Mineola Office							
Consumer Services	2					1	3
Frauds					1		1
Oneonta Office:							
Frauds					5		5
Rochester Office:							
Frauds					2		2
Syracuse Office:							
Frauds					2		2
All Other Total	**4**	**1**			**18**	**2**	**25**
Department Total	**468**	**69**	**61**	**156**	**43**	**164**	**961**

*Includes HRM & Offices Services

‡**Note**: Table does not include 23 Student Assistants assigned to various bureaus during the year

IX. Workers' Compensation Task Force

On March 13, 2007, the landmark Workers' Compensation Reform Legislation was enacted that fundamentally reformed the workers' compensation system. Governor Spitzer, in his March 13, 2007 letter, directed the Superintendent to achieve various goals as part of the reform effort to make the system more responsive to the needs of the State's employees and to the employers who pay premiums. The Workers' Compensation Reform Task Force was charged with this reform effort to complement the legislation. In his March 13 letter, the Governor created an Advisory Committee comprised of representatives of the Majority Leader of the Senate, the Speaker of the Assembly, the AFL-CIO, the Business Council of New York State, the Workers' Compensation Board and the Department of Labor. The Advisory Committee was to participate with the Task Force respecting certain objectives assigned the Task Force by the March 13 letter.

The major accomplishments and initiatives by the Task Force in 2007 included:

1. Streamlining the Claims Docket of the Workers' Compensation Board

The Task Force, with the collaboration and input of the Advisory Committee, drafted proposed workers' compensation regulations that will significantly accelerate the resolution of contested claims and meet the Governor's goal of resolving them within 90 days or less of the dispute. This will cut the time by more than half for the resolution of disputed claims and enable injured workers to receive their indemnity payments sooner and facilitate their receiving medical treatment. The Superintendent, on June 1, 2007, sent the Chair of the Board the proposed draft regulations together with a letter discussing the key features of the proposed streamlined process. The proposed regulations reflect the consensus of the Advisory Committee and were transmitted by the Governor's deliverable date. (The Board, the office of the Governor's Counsel and GORR have been reviewing and refining the proposed regulations; the Task Force has been participating in this process.)

2. Premium Rates for Carriers

On July 11, 2007, the Department issued an Opinion and Decision (O&D) regarding the 2007 workers' compensation rate revision. The O&D recommended a rate decrease that incorporated various of the recent landmark reforms and resulted in a recommended cost reduction of -20.5%. This reduction in costs was 4.3% larger than the original reduction recommended by the Compensation Insurance Rating Board (CIRB) in its original rate filing. On July 13, 2007, CIRB filed a revised rate request which was consistent with the Department's O&D. On July 16, 2007, the Department approved CIRB's amended rate filing. The Task Force participated in this process and development of the O&D.

3. Compensation Insurance Rating Board

The Reform Legislation required the Superintendent to prepare a report on the Compensation Insurance Rating Board (CIRB) and the workers' compensation rate-making process. The Task Force prepared and drafted the report and in accordance with the deliverable date set by the Reform Legislation, the report was distributed on September 4, 2007, to the Governor, the Majority Leader of the Senate and the Speaker of the Assembly, as well as to other interested parties. The report recommended changing to a rate-making approach that should inject increased price competition into the system with a resulting decrease in premiums, and a significant restructuring of CIRB's governance organization that will increase CIRB's independence and allow for greater public accountability. (Subsequently, the Task Force/Department participated in developing legislation that implemented the report's recommendations; the legislation was enacted January 31, 2008.)

4. Medical Treatment Guidelines

The Task Force met on a regular basis with the Governor's designated Advisory Committee, made up of representatives from business, labor, the legislature and others, to develop medical treatment guidelines for the workers' compensation system. The Task Force, with the assistance of the Advisory Committee (including medical professionals designated by members of the Committee), developed proposed medical treatment guidelines that reflected the consensus of the Advisory Committee and the medical professionals. The guidelines covered four parts of the body that were high cost drivers of medical care. The Department submitted the guidelines, together with a proposed education program, to the Board by the Governor's deliverable date of December 3, 2007.

5. Data Collection and Analysis

The March 13 letter noted that the "State cannot make policy determinations if it lacks basic information" and directed the Superintendent "to take the necessary steps to gather all data on a regular and ongoing basis necessary to make appropriate policy judgments...." It directed that a report be delivered to the Governor summarizing the 2007 data, and annually thereafter.

The Task Force made substantial progress investigating the available sources of data and collecting relevant data to summarize the systems' current operations, provide benchmarks for evaluating the system and identify relevant metrics where data was unavailable but should be collected on a going forward basis. The Task Force also began developing a longer-term approach for centralized data collection for research and policy initiatives. (On the deliverable date of March 4, 2008, the report prepared by the Task Force was submitted by the Superintendent to the Governor and other interested parties.)

X. LIQUIDATION BUREAU

The New York Liquidation Bureau assists the Superintendent of Insurance in rehabilitating, liquidating and conserving the assets of financially impaired insurance companies pursuant to Article 74 of the Insurance Law. Additionally, the Bureau manages the Property/Casualty (P/C), Workers' Compensation (WC) and Public Motor Vehicle (PMV) Security Funds (which pay claims on behalf of insolvent insurers) pursuant to Article 76 of the Insurance Law and Article 6-A of the Workers' Compensation Law.

The Bureau is distinct and separate from the New York State Insurance Department and reports to Superintendent of Insurance Eric R. Dinallo, pursuant to his duties as Receiver under Article 74 and as Administrator of the Security Funds. Special Deputy Superintendent in Charge Mark G. Peters oversees Bureau operations from one central office in Lower Manhattan. The Bureau is not state-funded; it operates on estate funds and P/C, WC and PMV Security Fund monies, with a fiduciary duty to creditors and claimholders.

1. Introduction

The following is a summary of the challenges and achievements of the Bureau for the calendar year 2007 and an overview of the Bureau's objectives for 2008. (The Bureau's complete *2007 Year-End Report* is available on the Bureau Web site, www.NYLB.org.)

The New York Liquidation Bureau in 2007 was an agency in need of reform. In 2006, the Bureau's prior chief was indicted for fraud, thousands of New Yorkers suffered delays in receiving insurance payments and financial crises and shortfalls in several companies and funds managed by the Bureau loomed larger than ever. When the Bureau's new administration took office in April 2007, it addressed many of its financial crises, including the development of a plan designed to benefit the policyholders of Executive Life Insurance Company of New York (ELNY). The Bureau established a new professionalism and financial transparency in its operations and began to eliminate delays in paying insureds. The insurance industry press acknowledged that these steps are "a sign of change at the Liquidation Bureau." (Crain's Business Insurance, Nov. 5, 2007).

2. New York Liquidation Bureau's Mission and Goals

The New York Liquidation Bureau, under the leadership of the Superintendent as Receiver Eric R. Dinallo and Special Deputy Superintendent in Charge Mark G. Peters, oversees more than 60 impaired or insolvent insurance companies with over $3.3 billion in assets. In managing these companies, the NYLB protects the tens of thousands of New Yorkers who purchased insurance from now-insolvent companies and who continue to rely upon that insurance for coverage and payment. The Bureau seeks to maximize assets and resolve liabilities; return rehabilitated companies to the marketplace; and promptly distribute the proceeds of liquidating companies to policyholders and other creditors.

Upon taking office, Special Deputy Superintendent Peters and the Bureau's new administration established the following goals, visions and priorities:

- The Liquidation Bureau is professionalizing the operations of the office, requiring that all companies under its administration be run like efficient and modern financial organizations.

- The Liquidation Bureau is protecting tens of thousands of consumers and small businesses who purchased insurance from these now-impaired insurance companies. With a staff of 450 and a budget of $100 million, the Bureau is working to make sure that accident victims or other

claimants receive the funds they often desperately need and that small businesses receive the benefits they often require to stay afloat.

- The Liquidation Bureau is seeking innovative ways to involve capital markets in the rehabilitation of certain impaired companies to make them viable, in order to keep the companies functioning in the marketplace and preserve hundreds of jobs.

3. Challenges in 2007

Superintendent Dinallo, Special Deputy Superintendent Peters and the management team inherited an office with little viable management structure or professional culture at the most senior level. In the wake of the indictment of the Bureau's prior chief, virtually no senior staff remained at the Bureau. In addition to rebuilding the core management team of the NYLB, the Bureau faced significant challenges:

- The Bureau had never been properly audited and had no comprehensive plan for marshalling the assets of the companies it managed, including over $200 million in uncollected reinsurance assets.

- The Bureau failed to pay policyholders in a timely manner. One estate languished more than 20 years without a single distribution, while the Public Motor Vehicle Fund, paralyzed by a lack of cash, ceased to function, leaving thousands of accident claims unreviewed and unresolved.

- The mounting financial crisis of the ELNY estate remained unaddressed, threatening thousands of annuitants with the collapse of their financial lifelines.

4. Accomplishments in 2007

a. Brokering an Industry-Wide Response to Solve the Large- Scale ELNY Deficit

The Liquidation Bureau brokered an industry-wide response designed to eliminate the large-scale deficit in Executive Life Insurance Company of New York (ELNY), which, if successful, would protect ELNY's almost 11,000 annuitants. The ELNY problem, if not fixed, would have left thousands of severely injured people and pensioners without their annuity payments. The problem – due to the failure of ELNY's investments to match its liabilities – first became clear approximately five years ago but the prior administration's slow response allowed the crisis to continue.

In an illustration of State government efforts to strengthen transparency and accountability, Superintendent Dinallo and Special Deputy Superintendent Peters publicly disclosed the problem shortly after taking office and aggressively pursued a resolution. They conducted months of intense discussions with companies and guaranty associations across the country. The plan being worked on would provide for additional funding by the insurance industry and state guaranty funds and is intended to allow every annuitant to continue to receive 100% of insured benefits and protection for the entire term of the annuity, some lasting more than 50 years. The response was possible because the insurance industry played a key role in the process. As one annuity holder was quoted in the New York Times: "It's refreshing to find out that the government can really come through." (New York Times, December 5, 2007, p.B5).

b. Funding the Bankrupt New York Public Motor Vehicle Security Fund So Thousands of Accident Victims Have Claims Resolved

The Liquidation Bureau engineered an interim solution to restart the insolvent New York Public Motor Vehicle (PMV) Security Fund to begin paying claimants and processing thousands of long

ignored claims. The PMV Fund acts as a secondary insurer for New York public vehicles, such as taxis, buses and ambulances, where the primary insurer is insolvent. The PMV Fund is financed by annual contributions from solvent New York insurers of public vehicles, but those contributions have been insufficient to pay either the PMV claims as they become due or the expenses to process those claims, leaving the Fund functionally bankrupt. As a result, accident victims were typically required to wait eighteen months for payment of their court-approved claims and a large number of PMV cases were unresolved in the courts, placing a heavy burden on the state-wide court system.

The Liquidation Bureau determined that the PMV Fund was entitled to an $18 million disbursement from an insurer in receivership and worked to ensure the fund received the cash infusion. The payment permitted long-delayed distributions to begin again, and also resulted in an accelerated processing of current PMV claims, reducing the backlog of cases that sat idle in the court system for years. New York State Chief Administrative Judge Ann Pfau addressed this point in her comments on the Bureau's rescue of the PMV Fund: "Whenever cases languish in the courts, the public is not well served," said Judge Pfau. (New York Law Journal, October 23, 2007, p.1).

c. Recovering More Than $150 Million in Outstanding Assets

In 2007, the Liquidation Bureau collected more than $150 million in reinsurance proceeds – almost twice the total reinsurance proceeds collected in 2006. An accurate system for tracking reinsurance recoverables was developed and successfully implemented, allowing for efficient collections and more accurate forecasting of reinsurance recoverables. Such collections are often the primary source of assets for distributions and payments to policyholders and creditors of insolvent insurance companies.

d. Increasing Distributions to Policyholders and Creditors and Improving Estate Management

The Bureau dramatically sped up the rate of paying distributions to policyholders and creditors in pending liquidations and moving these liquidations towards closure. The new administration identified Union Indemnity Insurance Company of New York, an estate which has been pending for more than 22 years without a single distribution to policyholders, as a priority. The Liquidation Bureau has taken the steps necessary to begin paying policyholders and other creditors who have waited decades to be compensated for past injuries.

e. Making the Liquidation Bureau a Transparent and Accountable Entity

The Liquidation Bureau has taken significant steps to reform its vendor selection process, including its large panel of outside attorneys, by requiring that selections are based solely on merit. The Bureau is conducting the first-ever complete top-to-bottom financial review of its own balance sheets, along with those of all the domestic estates under its management, with overall results to be posted on the Bureau's website, www.nylb.org. The findings of these audits and an accompanying performance review of the Bureau will allow policyholders and creditors of all managed estates, as well as interested members of the public, to have more complete and reliable financial information.

5. Looking Ahead

The Liquidation Bureau is primed to continue its operational overhaul in 2008, and to build upon it by educating policyholders about their rights in insolvency and the protections afforded them by the Bureau. To that end, the Liquidation Bureau's objectives for 2008 include:

- Continuing its management and procedural reforms to provide greater transparency, efficiency and accountability, including annual financial reviews, cost efficient, merit based vendor selection and aggressive action to marshal assets and make timely payment of proper claims.

- Working to make the Bureau more responsive to policyholders (both individuals and business owners) so they continue to obtain the financial security they relied upon when purchasing their insurance.

- Improving efficiency in court filings, claims processing and distributions in either returning companies to the marketplace or closing the estates. This will both enhance public confidence and reassure consumers that there is an appropriate mechanism in place if their insurance company becomes financially impaired.

- Considering collaboration with private equity companies to more efficiently liquidate or rehabilitate impaired insurance companies. Specifically, the Bureau is considering the possibility of selling certain estates to private equity firms who can more efficiently complete a wind-down or rehabilitation.

The achievements of 2007 have realigned the Bureau's responsibilities so that the Bureau is better able to fulfill its fiduciary duty to creditors and claimants. The year ahead will see the Bureau cementing the aforementioned accomplishments and working tirelessly to face and resolve new challenges as they arise.

6. Rehabilitation, Liquidation, Ancillary Receivership and Conservation Proceedings

The insurance entities under the Liquidation Bureau's jurisdiction during 2007 were as follows:

Rehabilitations

Commenced: Colonial Indemnity Insurance Company
Lion Insurance Company

Continued: Executive Life Insurance Company of New York
Frontier Insurance Company

Completed[1]**:** Interboro Mutual Indemnity Insurance Company[2]

Liquidations

Commenced: Community Health Plan

Continued: American Agents Insurance Company
American Consumer Insurance Company
American Fidelity Fire Insurance Company
Capital Mutual Insurance Company
Consolidated Mutual Insurance Company
Contractors Casualty and Surety Company
Cosmopolitan Mutual Insurance Company
First Central Insurance Company
Galaxy Insurance Company
Group Council Mutual Insurance Company
The Home Mutual Insurance Company of Binghamton, NY
Horizon Insurance Company
Ideal Mutual Insurance Company
MagnaHealth of New York
Medical Malpractice Insurance Association
Midland Insurance Company
Midland Property and Casualty Insurance Company
Nassau Insurance Company
New York Merchant Bakers Insurance Company
New York Surety Company
Pan Atlantic Investors, Ltd. ("PAIL")[3]

Pine Top Syndicate[4]
Realm National Insurance Company
Transtate Insurance Company

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[1] The Superintendent of Insurance was appointed Temporary Receiver of Oriska Insurance Company on August 18, 2006. An Order terminating the Oriska Temporary Receivership was filed June 22, 2007.

[2] Interboro Mutual Indemnity Insurance Company was successfully converted from a mutual property and casualty insurer into a N.Y. stock property and casualty insurer, pursuant to Section 7311 of the N.Y. Insurance Law, the sale of stock approved and the rehabilitation proceeding terminated, including discharging the converted company from rehabilitation pursuant to N.Y. Insurance Law Section 7403(d)

[3] Proceeding had been closed in 05/03 and has been reopened
[4] Proceeding had been closed in 10/99 and has been reopened

Union Indemnity Insurance Company of New York
United Community Insurance Company
U. S. Capital Insurance Company
U. S. Risk[5]
Whiting National Insurance Company

Closures: None

Ancillary Receiverships - In the case of a New York-licensed foreign (*i.e.,* not domiciled in New York) insurer becomes insolvent, the Superintendent of Insurance must apply to the court to establish an Ancillary Receivership to enable the Superintendent, in his role as both Ancillary Receiver and administrator of the New York Security Fund, to trigger the Security Fund to pay covered claims.

Commenced: None

Continued: Acceleration National Insurance Company
American Druggists' Insurance Company
American Eagle Insurance Company
American Mutual Insurance Company of Boston
American Mutual Liability Insurance Company
Amwest Surety Insurance Company
Commercial Compensation Casualty Company
Credit General Insurance Company
Far West Insurance Company
Fremont Indemnity Company
Frontier Pacific Insurance Company
Integrity Insurance Company
Legion Insurance Company
LMI Insurance Company
Mission Insurance Company
Phico Insurance Company
Reliance Insurance Company
Security Indemnity Insurance Company
Shelby Casualty Insurance Company
The Connecticut Surety Company
The Home Insurance Company
Transit Casualty Company
Vesta Fire Insurance Company
Villanova Insurance Company

Closure: None

Conservations - All foreign or alien (*i.e*., not domiciled in New York) insurers not licensed in New York but doing business on an excess and surplus lines basis must establish a trust fund in New York. If such an insurer becomes insolvent, the Superintendent may apply to the court for an order directing the Superintendent to conserve the assets of that trust fund for the benefit of all U.S. policyholders.

Commenced: The Protective National Insurance Company of Omaha

Continued: Alpine Insurance Company
FAI General Insurance Company, Ltd.
Folksam International Insurance Company (UK) Ltd.

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[5] Proceeding had been closed in 02/97 and has been reopened

HIH Casualty and General Insurance, Ltd.
Legion Indemnity
Northumberland General Insurance Company
Pacific and General Insurance Company
Reliance Insurance Company of Illinois
United Capitol Insurance Company

Closures: None

7. Security Funds Income and Disbursements

Table 68
PROPERTY/CASUALTY INSURANCE SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2007

Total of Fund as of 4/1/06	**$89,981,898**
Paid into the Fund	$156,581,399
Interest income - net	8,746,111
Recoveries from companies in liquidation	52,770,933
General Fund Reimbursement	2,717,706
Total Receipts	**$220,816,149**
Less disbursements:	
Administrative expenses	$ 449,861
Awards and expenses of companies in liquidation	129,444,999
Total Disbursements	**$129,894,860**
Total Activity	**$90,921,289**
Total of Fund as of 3/31/07	**$ 180,903,187**

[1] Monies collected under Insurance Law Section 7603.

Table 69
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2007

Total of Fund as of 4/1/06	**$ 102,044**
Paid into the Fund	$9,073,707
Interest income - net	242,968
Recoveries from companies in liquidation	1,620,487
Total Receipts	**$10,937,162**
Less disbursements:	
Administrative expenses	$ 55,446
Awards and expenses of companies in liquidation	10,891,000
Total Disbursements	**$ 10,946,446**
Total Activity	**$ (9,284)**
Total of Fund as of 3/31/07	**$ 92,760**

[1] Monies collected under Insurance Law Section 7604 from companies writing bonds and policies carrying coverages set forth in the Vehicle and Traffic Law Section 370.

Table 70
WORKERS' COMPENSATION SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2007

Total of Fund as of 4/1/06	**$ 29,588,292**
Paid into the Fund	$48,395,445
Interest income – net	1,874,996
Recoveries from companies in liquidation	45,573,336
Total Receipts	**$95,843,777**
Less disbursements:	
Administrative expenses	$ 187,599
Awards and expenses of companies in liquidation	62,955,300
Loan Repayments[2]	9,540,316
Total Disbursements	**$72,683,215**
Total Activity	**$23,160,562**
Total of Fund as of 3/31/07	**$52,748,854**

[1] Monies collected under Workers' Compensation Law Sections 108 and 109.

[2] Chapter 33 of the Laws of 2005 authorized the Superintendent to make one or more loans from the assets of the liquidation estates to fund the workers compensation security fund. Total loan amount to date is $17,072,258.

XI. Publications

(As of 4/1/08)

Automobile/Livery Guides

- 2007 Annual Ranking of Automobile Insurance Complaints
- Automobile Insurance Price Comparison Tables and Notes
- Consumer Guide to Automobile Insurance

Frauds

- Insurance Frauds Consumer Brochure
- Insurance Frauds Bureau Annual Report

Health

- Interactive New York Consumer Guide to HMOs (external website link)
- New York Consumer Guide to Health Insurers (2007 Edition - Includes 2006 Rankings)
- Premium Rates for HMO Standard Individual Health Plans

Homeowners and Tenants

- Consumer Shopping Guide for Homeowners and Tenants Insurance
- Price Comparison Tables

Long Term Care

- A Consumer Guide to Long Term Care Insurance in New York

Small Business Guides

- Health Insurance - a Small Business Guide
- Property Casualty Insurance - A Small Business Guide (available in English & Chinese)

En Español

- Guía del Consumidor de Seguro para Los Servicios a Largo Plazo del Cuidado
- Guía del Consumidor para comprar un Seguro médico
- Guía del Consumidor para comprar un Seguro para los Dueños De Una Casa y los Arrendatarios
- Guía para el Consumidor sobre la Compra de un Seguro de Automóvil