REPORT ON EXAMINATION

OF THE

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

AS OF

DECEMBER 31, 2002

DATE OF REPORT	JANUARY 23, 2004
EXAMINER	ELSAID E. ELBIALLY, CFE

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

January 23, 2004

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, NY 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 22009, dated March 10, 2003 annexed hereto, I have made an examination into the condition and affairs of Commercial Travelers Mutual Insurance Company, a domestic accident and health insurer, as of December 31, 2002 and submit the following report thereon.

The examination was conducted at the Company's home office located at 70 Genesee Street, Utica, New York 13502.

Where the designation "the Company" appears herein without qualification, it should be understood to indicate Commercial Travelers Mutual Insurance Company.

1. SCOPE OF EXAMINATION

The Company was previously examined as of December 31, 1998. This examination covered the four year period from January 1, 1999 through December 31, 2002. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a complete verification of assets, liabilities and surplus as of December 31, 2002, in accordance with Statutory Accounting Principles, as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Company's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners Handbook of the National Association of Insurance Commissioners:

History of the Company
Management and control
Corporate records
Fidelity bonds and other insurance
Officers' and employees' welfare and pension plans
Territory and plan of operation
Growth of Company
Business in force
Reinsurance
Loss experience
Accounts and records
Treatment of policyholders and claimants

A review was also made to ascertain what action was taken by the Company with regard to comments and recommendations contained in the prior report on examination.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF COMPANY

The Company was incorporated as "Commercial Travelers Mutual Accident Association of America," a cooperative assessment health association, under the Laws of New York and commenced business on March 20, 1883. The Company's name was shortened to "The Commercial Travelers Mutual Accident Association" on May 22, 1953. Operations were conducted under the cooperative assessment plan until February 16, 1970. On that date, the Company re-incorporated to become a mutual accident and health insurance company. Concurrent with this change, the present company name was adopted. The Company is licensed under Article 42 of the New York Insurance Law.

On May 6, 1988, a merger was effected between the Company and InterAmerica Consolidated Mutual Insurance Company of La Grange, Illinois. Commercial Travelers Mutual Insurance Company was the surviving corporation.

A. Management

The by-laws of the Company provide for a board of directors of thirteen members, who are elected for three years terms. The directors are classified into three groups, as nearly equal in number as possible, and are elected in such a manner that the terms of office of one of the groups expire each year. The by-laws provide for an annual meeting and three regular meetings per year.

The directors of the Company, as of December 31, 2002, were as follows:

Name and Residence	Principal Business Affiliation
Joan W. Compson Clinton, New York	Financial Officer, Carbone Auto Group
Stephen A. Gilles Utica, New York	President, L A Stewart Associates, Inc.
Richard R. Griffith Utica, New York	President, Sturges Manufacturing Company, Inc.
Frederick H. Hager Clinton, New York	President, HMO Metal Finishing Group, LLC
Harrison J. Hummel, III Mohawk, New York	President and Chief Executive Officer, Hummel's Office Supply
Kevin M. Kelly New Hartford, New York	President, Jay-K Independent Lumber Corporation
Jeremiah O. McCarthy Barneveld, New York	President and Chief Executive Officer, Oneida County Rural Telephone
Earl C. Reed Barneveld, New York	President, Utica Boilers, Inc.
Robert N. Sheldon Utica, New York	President, Reid-Sheldon and Company
John B. Stetson Barneveld, New York	Chairman of the Board, Commercial Travelers Mutual Insurance Company
Herbert E. Trevvett Poland, New York	President and Chief Executive Officer, Commercial Travelers Mutual Insurance Company
Paul H. Trevvett Cold Brook, New York	Senior Vice-President, Commercial Travelers Mutual Insurance Company
Dwight E. Vicks, Jr. Utica, New York	President, Vicks Lithograph and Printing Corporation

The examiner reviewed the minutes of all board meetings held during the examination period, as well as the minutes of the board's various committees, and noted that such meetings were well attended. However, the following observations were noted:

(A) The Company failed to comply with Article VI, Section 1 of its by-laws, which calls for its Executive Committee to be composed of "…the President, the Chairman of the Board and six directors…".

According to the minutes of the Board of Directors' meetings and minutes of the Executive Committee, for the years under examination (1999-2002), the Executive Committee was comprised of the President, the Chairman of the Board, and five directors.

It is recommended that the Company amend its by-laws or add another director to the Executive Committee, in order to comply with the requirement of Article VI, Section 1 of the Company's by-laws.

(B) The Finance Committee meetings were not well attended by two of its members. However, because of a provision in the Charter and By-laws, which allows for Directors to serve as alternate members of any committee, on an as needed basis, all the Finance Committee meetings had a quorum present.

Despite the poor attendance of two members, the Board of Directors continued to nominate and elect these members to the Finance Committee.

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

It is recommended that members of the Finance Committee who are unable to attend at least 50% of its meetings should resign or be removed from the Committee by the Board of Directors. The Company should take into consideration the attendance of its directors at sub-committee meetings, when electing directors to serve on sub-committees.

The following is a listing of the principal officers of the Company as of December 31, 2002:

Name	Title
Herbert E. Trevvett	President and Chief Executive Officer
Paul H. Trevvett	Senior Vice-President and Chief Operating Officer
Timothy M. Coughlin	Vice-President, Claims
Donald D. Falkenstern	Vice-President, Controller
William G. Holbrook	Vice-President, Administration
Donald E. Joslin	Vice-President, Personnel
Russell V. McGrane Jr.	Vice-President, Employer Group
David R. Milner, J.D.	Secretary and General Counsel
Thomas F. Spath, M.D.	Medical Director
Brian T. Stalder	Vice-President, Special Risks
James D. Trevvett	Treasurer

B. Territory and Plan of Operation

The Company is authorized to write accident and health insurance as defined under Section 1113(a)(3)(i)&(ii) of the New York Insurance Law.

Based upon the line of business, for which the Company is licensed, the Company is required to maintain a minimum surplus in the amount of $150,000 pursuant to Articles 13 and 42 of the New York Insurance Law.

As of December 31, 2002, the Company was licensed to do an insurance business in 49 states and the District of Columbia. Following is a schedule for the examination period of direct premiums written in New York compared to premiums written countrywide:

	1999	2000	2001	2002
New York	$ 4,779,051	$ 4,582,863	$ 4,912,869	$ 5,856,458
Countrywide	$18,443,591	$18,448,559	$20,523,930	$22,067,982
Percentage of premiums written in New York	25.9%	24.8%	23.9%	26.5%

During the examination period, the Company solicited business as a direct writer, entered into marketing ventures with other insurance companies, and utilized the services of brokers for the production of business.

The Company writes primarily student medical expense insurance with limited accidental death and dismemberment coverage applicable to grade school students (K-12) on an

accident basis only, while college and university students are offered accident, sickness and sports medical expense plans. The Company also writes special risk policies that provide medical expense coverage for non-student youth sports and special youth and adult activities. Coverage encompasses accident related medical expenses only. Additionally, the Company writes group short and long term disability income coverage insuring the employees of employer groups.

Although not actively marketed, the Company has issued policies covering accidental death and dismemberment insurance to credit cardholders.

The Company, during the examination period, continued to insure policyholders under discontinued disability income, hospital indemnity, hospital and medical expense and accidental death and dismemberment insurance policies. The Company discontinued marketing such policies prior to the examination period.

C. Reinsurance and Pooling Arrangements

During the examination period, and continuing thereafter, the Company acted as managing underwriter for a pooling arrangement, which provides for pro rata assumptions and cessions of certain accident and health business described as the "Student Plans Pool". The business, subject to this pool, consisted of group policies providing medical expense and accidental death and dismemberment benefits for grade school and college students. As of this examination date, the Company's share of this pool was 90% and the remaining 10% was insured by Employer Reinsurance Corporation.

The examiner reviewed all ceded reinsurance agreements effected during the examination period. All agreements were with authorized reinsurers and contained the required standard clauses, including insolvency clauses, meeting the requirements of Section 1308 of the New York Insurance Law.

The Schedule S data, as contained in the Company's filed annual statements for the period under examination, was found to accurately reflect its reinsurance transactions.

The following reinsurance was in effect as of December 31, 2002:

Group Accidental death and dismemberment:

Type of Contract	Coverage	Cession
Excess of loss	Accidental Death and Dismemberment	$100,000 xs $100,000 on any one life
Excess of loss	Accidental Death and Dismemberment (Catastrophic)	$900,000 xs $100,000 for all lives in any one accident
Excess of loss	Accidental Death and Dismemberment	Aggregate calendar year coverage for all losses up to $2,700,000
School Plans:		
Excess of loss	Accident Medical Expenses (K-12)	$900,000 xs $100,000 per person
Excess of loss	Accident Medical Expenses (K-12) (Catastrophic)	$2,900,000 xs $100,000 for all lives in any one accident
Excess of loss	Medical expenses (College)	$150,000 xs $100,000 per person

The Company writes a class of accident insurance which it terms “Special Risk” (not to be confused with New York Insurance Law Article 63 lines of business). Special risk group policies provide accident medical expense coverage for non-student activities such as youth and amateur sports, youth and adult camps, conferences, special events and trip travel. This business is reinsured with Associated Accident Health Reinsurance Underwriters as follows:

Type of Contract	Coverage	Cession
Excess of loss	Accident Medical Expenses	$950,000 xs $50,000 per person

Effective January 1, 1995 and continuing thereafter, the Company has written group long term disability income policies and currently cedes 90% of its liabilities under this program to London Life Reinsurance Company.

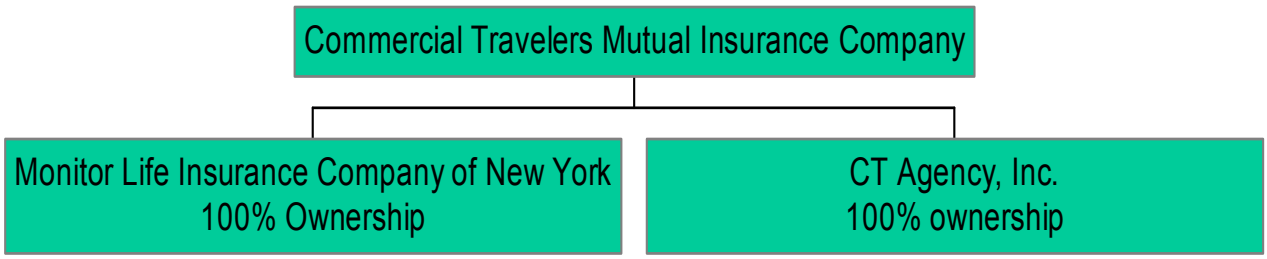
The Company's maximum loss on any one risk, under its policies, is $200,000 in the event of an accidental death on a common carrier - with the Company maintaining a maximum retained risk of $100,000.

In addition to the above, the Company did not reduce to writing two reinsurance agreements that it entered into in 2001 and 2003.

It is recommended that, in the future, the Company maintain written and signed reinsurance agreements pertaining to its reinsurance business.

D. Holding Company System

The following chart depicts the Company and its relationship to its affiliates as of December 31, 2002:



Monitor Life Insurance Company of New York

The Company owns 100% of the issued and outstanding stock of Monitor Life Insurance Company of New York ("Monitor"), a domestic life insurer licensed to write life and accident and health insurance.

The Company entered into a service agreement with Monitor on April 1, 1979. Under the terms of this agreement, the Company provides certain administrative services and facilities for its subsidiary. Expenses for services and facilities provided, excluding those expenses solely attributable to either company, are allocated on the basis of time usage studies. The New York Insurance Department approved the agreement on May 8, 1979.

Effective in 1982, and with the approval of this Department, the Company and Monitor entered into an agreement which provides for reciprocal lines of credit between the companies. According to the terms of the agreement, the maximum amount of borrowings made at any time is limited to the lesser of $500,000 or 5% of the lending company's admitted assets as of the previous year-end. At December 31, 2002, there were no borrowings outstanding under this agreement.

Monitor's surplus, per its annual statement as of December 31, 2002, was $3,778,371. However, the maximum admitted value of Monitor as reported by the Company in its December 31, 2002 annual statement was limited pursuant to Section 1408 of the Insurance Law to $3,351,387. Subsequent to the examination date, Monitor's surplus increased from $3,389,000 as of September 30, 2003 to $7,765,000 as of October 31, 2003. The substantial increase in Monitor's surplus was due to the execution of a 100% coinsurance and administrative agreement with Standard Security Life Insurance Company of New York which provided for a ceding commission of $3,400,000, relative to business ceded under the agreement, and an administrative fee of $43,000 per month payable to Monitor relative to Monitor's administration of such ceded business. In addition, the interest maintenance reserve (IMR) and the asset valuation reserve (AVR) liabilities of Monitor decreased by $612,000 and $126,000, respectively, as a result of such agreement.

As a result of the transaction, the maximum value of Monitor as reported on the balance sheet of Commercial Travelers Mutual Insurance Company, per Section 1408 of the New York Insurance Law, increased from $2,489,705 as of September 30, 2003 to $4,875,426 as of October 31, 2003.

CT Agency, Inc.

On January 30, 1991, this Department approved the Company's organization and acquisition of CT Agency, Inc. The Company purchased all of the outstanding shares of CT Agency, Inc., no par value common stock, for $50,000 on April 2, 1991. The purpose of CT Agency, Inc. is to serve as an insurance agency to aid the Company in placing business for

policyholders that the Company cannot accommodate according to its underwriting guidelines. CT Agency, Inc. also places risks for other outside companies.

The Company entered into a service agreement with CT Agency, Inc. on March 13, 1991. Under the terms of this agreement, the Company provides certain administrative services and facilities to the subsidiary. The subsidiary reimburses the Company for all direct and indirectly allocable expenses.

E. Significant Operating Ratios

The following ratios have been computed as of December 31, 2002, based upon the results of this examination:

Net premiums written in 2002 to Surplus as regards policyholders	8.5 to 1
Liabilities to liquid assets (cash and invested assets less investment in affiliates)	103.3%
Premiums in course of collection to Surplus as regards policyholders	0.0%

The above net premiums written in 2002 to surplus as regards policyholders ratio falls beyond the benchmark range set forth in the Insurance Regulatory Information System of the National Association of Insurance Commissioners. The combined effect of a substantial increase of the Company's assumed reinsurance business and underwriting losses for the years 2001 and 2002 caused these ratios to fall beyond the benchmark range.

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

	Amounts	Ratios
Losses incurred	$97,662,058	69.7%
Underwriting expenses incurred	52,567,585	37.5
Net underwriting (loss)	(10,108,007)	(7.2)
Premiums earned	$140,121,636	100.0%

F. Custodian Agreements

A review of the Company's custodian agreements with HSBC Bank revealed that the agreements did not contain many of the protective covenants and provisions required by the New York Insurance Department custodial guidelines as a minimum necessary safeguards and control.

Specifically, the following provisions were found to be lacking:

(1) A provision which indicates whether the custodian is covered by Bankers Blanket Bond Insurance. The bond insurance should be of the broadest form available.

(2) A provision that the Company be notified in writing of any material change in the form of such bond, the amount of the bond, or of the termination of coverage.

(3) A provision which expresses the custodian's duty to protect the Company's property with the same degree of care it employs to protect its own property.

(4) The agreement should require the custodian to maintain records sufficient to verify information reported in Schedule D of the Annual Statement Blank.

(5) The agreement should require the custodian to furnish affidavits, in the form as may be acceptable to the Department, in order for assets referred to in such affidavits to be recognized as admitted assets.

(6) The agreement should specify that there shall be access allowed during regular banking hours and those persons who shall be entitled to examine securities held and the

records regarding such securities, upon written instructions to that effect furnished by any specific authorized officer of the Company.

(7) The agreement should contain a provision which specifies that written instructions shall be signed by any two authorized officers of the Company who are specified in a separate list for this purpose, which is furnished to the custodian.

(8) The agreement should provide that the Company may obtain the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by the internal or independent auditors.

It is recommended that the custodian agreements between the Company and HSBC Bank be revised to include all of the protective covenants and provisions outlined, in order to meet the minimum custodial guidelines established by the New York State Insurance Department for the contents of such agreements.

3. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the Company's assets, liabilities and surplus as regards policyholders, as determined by this examination as of December 31, 2002. This statement is the same as the balance sheet filed by the Company.

Assets:	Ledger Assets	Not-Admitted Assets	Admitted Assets
Bonds	$11,569,291	$	$11,569,291
Stocks			
Preferred stocks	1,000,000		1,000,000
Common stocks	4,287,198	426,984	3,860,214
Real estate			
Properties occupied by Company	298,031		298,031
Cash and short-term investments	15,006,648		15,006,648
Reinsurance ceded:			
Amounts recoverable from reinsurers	107,179		107,179
Commissions and expense Allowances due	549,025		549,025
Federal and foreign income tax recoverable and interest thereon	3,156,025	1,537,557	1,618,468
Guaranty funds receivable or on Deposit	18,263		18,263
Accident and health premiums due And unpaid	(62,137)		(62,137)
Investment income due and Accrued	88,943		88,943
Receivable from parent, subsidiaries And affiliates	111,020		111,020
Other assets non-admitted	102,521	102,521	0
Aggregate write-ins for other than Invested assets	630,648	586,989	43,659
Total assets	$36,862,655	$2,654,051	$34,208,604

Liabilities:

Aggregate reserve for accident and health contracts	$16,929,218
Accident and health claims	7,574,860
Premiums and annuity considerations for life and Accident and health contracts received in advance	215,880
Commissions to agents due or accrued – accident And health contracts	36,921
General expenses due or accrued	794,972
Taxes, licenses and fees due or accrued, excluding Federal income taxes	183,916
Federal and foreign income taxes including net Deferred tax liability	1,954
Amounts withheld or retained by company as agent or trustee	3,111
Remittances and items not allocated	18,287
Liability for benefits for employees and agents if not Included above	586,989
Funds held under coinsurance	2,535,240
Aggregate write-ins for liabilities	18,600
Total liabilities	$28,899,948
Surplus:	
Unassigned funds	5,308,656
Total surplus	5,308,656
Total liabilities and surplus	$34,208,604

Note: The Internal Revenue Service has not performed any audits of the Company's consolidated federal income tax returns through tax year 2002. The examiner is unaware of any potential exposure of the Company to any further tax assessment and no liability has been established herein relative to such contingency.

B. Summary of Operations

Surplus funds decreased $7,339,907, during the four year examination period from January 1, 1999 to December 31, 2002, detailed as follows:

Statement of Revenues and Expenses		
Premiums	$140,121,636	
Net investment income	4,370,528	
Commissions and expense allowances on Reinsurance ceded	1,879,528	
Miscellaneous income	250,070	
Total Revenue		$146,621,762
Deductions:		
Disability benefits under accident and health policies	97,662,058	
Commissions on premiums	14,493,572	
Commissions and expense allowances on reinsurance Assumed	9,780,173	
General insurance expenses	27,271,288	
Insurance taxes, licenses and fees, excluding federal Income taxes	2,902,080	
Total Deductions		$152,109,171
Net income (loss) from operations before federal Income taxes		$(5,487,409)
Federal income taxes (tax benefit)		(293,851)
Net income (loss) from operations After federal income taxes		(5,193,558)
Net realized capital gains		39,948
Net Income (Loss)		$(5,153,610)

C. Change in Surplus

Surplus per report on examination as of December 31, 1998			$12,648,563
	Gains in Surplus	Losses in Surplus	
Net income (loss)		$(5,153,610)	
Net unrealized capital losses		(2,248,447)	
Net unrealized foreign exchange capital loss		(32,384)	
Change in net deferred income tax	$1,059,431		
Change in not-admitted assets		(2,227,067)	
Change in accounting principles	1,262,162		
Rounding adjustment	8		
Net gains and losses	$2,321,601	$(9,661,508)	
Net decrease in surplus			$(7,339,907)
Surplus per report on examination as of December 31, 2002			$5,308,656

4. AGGREGATE RESERVE FOR UNPAID CLAIMS

The examination liability of $24,504,078 is the same as the amount reported by the Company as of the examination date. The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements.

The liability of $24,504,078 consisted of the following components:

Aggregate reserve for accident and health contracts	$16,929,218
Accident and health claims	7,574,860

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct investigation.

The general review was directed at practices of the Company in the following areas:

A. Sales and advertising
B. Underwriting and rating
C. Claims settlement practices
D. Prompt Pay Law

A. Sales and advertising

A review was made of the Company's sales and advertising activity to appraise the representations made to the public and to determine compliance with the requirements of Department Regulation 34 (11 NYCRR 215). This review of the practices and of information disseminated by the Company indicated that material was presented fairly and truthfully and did not have the tendency to mislead by implication or omission.

B. Underwriting and rating

A review was made of the Company's underwriting activities to determine compliance with the requirements of the New York Insurance Law. From the review of various Company records, including such items as policyholder contracts issued, premium rates charged, benefits provided, and marketing rules used by the Company, the following discrepancies were noted:

I. The Company did not comply with the requirements of Section 4209(c) of the New York Insurance Law. Article XIV of the Company's By-Laws allows it to issue non-assessable policies with the permission of the Superintendent of Insurance. However, some of the insurance policies issued by the Company did not contain the statement required by Section 4209(c) of the New York Insurance Law, which states:

> "Every mutual accident and health insurance company licensed to do business in this state, if its charter or by-laws permit or are amended to permit the issuance of policies without contingent mutual liability of the policyholders for assessment, may with the permission of the superintendent issue non-assessable policies in this state. Every such company shall submit a copy of its proposed non-assessable policy or policies for approval of the superintendent, and shall have obtained his approval thereof. Every policy issued by any such company shall clearly state whether or not the holder of such policy is subject to a liability for assessment."

It is recommended that the Company comply with the requirements of Section 4209(c) of the New York Insurance Law, and include a clear statement in its policies as to whether or not the holder of such policy is subject to a liability for assessment.

II. Section 3201(b)(1) of the New York Insurance Law states in part:

> "(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent…".

In August 2001, the Company issued an endorsement entitled, "Mandated Benefits Endorsement", to its policies for school year 2001/2002 to comply with the mandated benefits requirement of the following Sections of the New York Insurance Law:

Section 3221(k)(12)	"Experimental or Investigational Treatment or Clinical Trial Expense"
Section 3221(I)(12)	"Cancer Prescription Drug Expenses"
Section 3221(I)(15)	"Pre-Hospital Emergency Medical Services"

In August 2002, the Company issued a more comprehensive "Mandated Benefits Endorsement" to its policies for school year 2002/2003 that included the above mentioned mandated benefits and in addition, mandated benefits required by the following Sections of the New York Insurance Law:

Section 3221(I)(11)	"Mammography Screening"
Section 3221(I)(11-a)	"Prostate Cancer Screening"
Section 3221(I)(14)	"Cervical Cytology Screening".

However, the Company violated Section 3201(b)(1) of the New York Insurance Law which requires the filing and approval of endorsements prior to their issuance and implementation.

It is recommended that the Company comply with the requirement of Section 3201(b)(1) of the New York Insurance Law and submit the two endorsements of mandated benefits to the New York Insurance Department for approval. It is further recommended that the Company, in the future, submit all endorsements to the Department for approval prior to the issuance of such endorsements.

C. Claims Settlement Practices

From a population of 15,259 New York claims processed in the first nine months of 2003, a statistical sample of 167 claims was selected to test various financial and procedural attributes. A review of the Company's claims system, along with a review of New York State claims processed during the first nine months of 2003, revealed that there were numerous deficiencies in the Company's handling of claims and in its maintenance of its claims files.

During the attribute claims sample review, it was found that there existed 104 errors out of 167 claims reviewed.

Errors noted included the following:

Incorrect Service Charges	26 Claims
Incorrect Reported Charges	28 Claims
Incorrect Reported Date	39 Claims
Incorrect Last Event Date	6 Claims
Incorrect Service from Date	3 Claims
Incorrect Status Code	1 Claim
Incorrect School Year	1 Claim

It should be noted that some claims had more than one error. For sampling purposes, this was counted as one error. The rate of error noted in the sample was 62.28% of claims processed.

Claims Procedures:

I. Claims processing manual:

In July of 1999, the Board of Directors discussed the issue of New York Insurance Department Circular letter No. 9 (1999) (Adoption of Procedures Manuals).

The Company did not fully comply with the recommendation contained in the Department Circular Letter No. 9 (1999), in that the Company's Board of Directors did not

adopt procedures to ensure that claims were being processed accurately and in accordance with applicable statutes, rules and regulations.

It is recommended that the Company establish a claims processing manual and appropriately train all persons responsible for the supervision, processing and settlement of claims.

In addition, New York Insurance Department Regulation No. 64 (11 NYCRR 216.0(e)(6)) requires the Plan to distribute copies of Regulation No. 64 to every person handling claims. The examiner noted that the Company's claim examiners were unaware of said regulation.

Regulation No. 64 (11 NYCRR 216.0(e)(6)) states:

> "Every insurer shall distribute copies of this regulation to every person directly responsible for the supervision, handling and settlement of claims subject to this regulation, and every insurer shall satisfy itself that all such personnel are thoroughly conversant with, and are complying with, this regulation."

It is recommended that the Company comply with New York Insurance Department Regulation No. 64 (11 NYCRR 216.0(e)(6)) and distribute a copy of Regulation No.64 to every person directly responsible for the supervision, handling and settlement of claims subject to such regulation. It is further recommended that the Company satisfy itself that all such personnel are thoroughly conversant with, and are complying with Regulation No. 64.

II. Claims data entry:

There is no procedure in place to verify that all opened mail is counted and stamped with the date that the Company received it. During the attribute claims sample review, several claim

forms, which were received from providers or subscribers, had no "received date" stamped upon them. The failure of a "control total" count of the pieces of mail received and distributed to the claims examiners makes it impossible to verify that all mail received by the Company is being handled properly.

In addition, the entering of the data of claims received into the Company's claims system may occur on the date received, or take many days to occur. Such data entry depends upon when the examiner, who is assigned to process the claim file, actually enters the claim data into the claims system. This procedure may cause several problems, including the entry of the incorrect claim reported date into the Company's system. Because the system defaults to the current date, this field is sometimes passed over by the claims examiner, and the incorrect claim received date may be recorded in the claim file.

Furthermore, all claims received are entered into the claims system by the same claims examiners who also adjudicate the claim. This practice denotes poor internal control procedures.

It is recommended that the Company adopt procedures to separate properly the duties of its claims department personnel.

III. Reported charges:

There is a field on the claims system named "Reported Charges", which is defined as the amount of charges included on the claim form. However, the amounts entered in this field vary depending on the claims examiner. Some of the claims examiners enter the amount of the

charges included on HCFA 1500 and UB92 claim forms or submitted bills. Other claims examiners enter the amount that they believe to be the responsibility of the Company. Still others will just enter a "dummy" code, in order to bypass the field, even though the charges can be determined. The latter normally occurs when a claim form is received, without a bill; or a receipt for payment is received without any accompanying bill or Explanation of Benefits from the primary insurer.

It is recommended that the Company establish appropriate guidelines and procedures, including the definition of reported charges, for its claims examiners to follow relative to the entry of claims data into the Company's claims system.

IV. Status "3 Settled/No Payment" claims:

The claims in status "3 Settled/No Payment" denote that such claims have not reached final adjudication. In cases where the Company received a claim form and a bill and then requested an EOB but never received it, the Company was found, in certain instances, to have moved the claim from one pending code to another pending code.

It is the Company's practice to switch claims with status code "2 Awaiting Requested Information", to status code "3 Settled/No Payment", if no information is received within 30 days of the request for information. The changing of the status code is accompanied by a letter informing the recipient that the claim is being made inactive, but would be processed at the time that the requested information is submitted. The claim may reside for 6 years in the claims system without ever being truly adjudicated; even if the claim has no reasonable possibility of ever having to be paid. The claims are purged from the system after 6 years.

It is recommended that the Company adopt procedures to complete the adjudication of all claims within 12 months from the date the claim is received, except in certain situations where additional time is warranted.

It is recommended that the Company deny claims for which information necessary to process the claim was requested, but not received, and issue an EOB to the subscriber in compliance with Section 3234 of the New York Insurance Law.

V. Duplicate claims:

There is no procedure in place to retain duplicate claims, if claims are identified by the claims examiner as a duplicate prior to entering claims data into the claims system. Currently, the examiner may discard the bill that they believe to be a duplicate. This practice is called "administrative deletion" by the Company. There is no communication concerning the administrative deletion of duplicate claims sent to the provider or the subscriber.

It is recommended that the Company discontinue the practice of administrative deletion for duplicate claims. It is recommended that the Company enter the duplicate claims data into its claims system and properly deny such duplicate claims.

Explanation of Benefits Statements:

Explanation of Benefits Statements (EOBs) are an integral part of the link between the subscriber/contract holder and their insurer, providing vital information as to how a claim was processed.

New York Insurance Law Section 3234(a) states in part:

> "Every insurer, including health maintenance organizations… is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy…"

New York Insurance Law Section 3234(c) creates an exception to the requirements for the issuance of an EOB established in New York Insurance Law Section 3234(a) as follows:

> "Except on demand by the insured or subscriber, insurers, …shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer directly to the participating facility or provider."

In addition, Section 3234(b) of the New York Insurance Law sets forth minimum standards for content of an EOB as follows:

> "The explanation of benefits form must include at least the following:
> (1) the name of the provider of service the admission or financial control number, if applicable;
> (2) the date of service;
> (3) an identification of the service for which the claim is made;
> (4) the provider's charge or rate;
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

A review of a sample of the Company's paid and denied claims for members/providers residing or located in New York during the first nine months of year 2003 was performed. The review revealed that EOBs issued by the Company failed to contain all the language required by Section 3234(b) of the New York Insurance Law (including the appeal language). Its EOBs, in the form as presented to the examiners, would not be sufficient to serve as a proper EOB. The subscribers were neither properly informed of their appeal rights, nor were they advised how their claims were processed. Therefore, all claims processed either paid or wholly/partially denied to New York subscribers and/or providers were in violation of Section 3234(b) of the New York Insurance Law.

It is recommended that the Company issue EOBs that include all of the requisite information required by Section 3234(a) and (b) of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

D. Prompt Pay Law

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (Prompt Pay), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

Section 3224-a(a) states in part:

> "…such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a healthcare provider within forty-five days of receipt of a claim or bill for service rendered."

Section 3224-a(b) states in part:

> "…an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or to request all additional information needed to determine liability to pay the claim or make the health care payment…"

Section 3224-a(c) states in part:

> "… any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest…"

A review was made of year 2002 claims and the first nine months of year 2003 claims, using ACL audit software, for compliance with Section 3224-a of the New York Insurance Law. The review also determined whether or not interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law to those claimants not receiving payment within the timeframes required by Section 3224-a (a) and (b) of the New York Insurance Law.

A claim was defined as the total number of items submitted on a single claim form to which the Company assigned a unique claim number. This definition was agreed to by both the examiners and the Company.

Claims paid to New York State groups and providers/subscribers totaled 4,542 in calendar year 2002, and 11,087 in the first nine months of 2003. Within these claim populations,

there were 123 in 2002 and 477 in the first nine months of 2003 that were identified as having a payment date more than 45 days after their receipt.

The examiner's review of these claims revealed that 76 out of the 123 calendar year 2002 claims and 116 out of the 477 calendar year 2003 claims were in violation of Section 3224-a (a) of the New York Insurance Law.

Out of the 76 claims and 116 claims identified as being in violation of Section 3224-a(a), 10 claims and 21 claims, respectively, were also found to be in violation of Section 3224-a(c) because interest due of two dollars or more was not paid.

A second population of 2,307 claims processed for New York State groups and providers/subscribers, during the first nine months of 2003, was identified where claims were denied more than 30 days after the receipt date. A sample of 167 claims was drawn from this population.

The examiner's review of the sampled claims revealed violations of Section 3224-a (b) of the New York Insurance Law as shown in the following chart:

Description	Denied claims over 30 days
Claim population	2,307
Sample size	167
Number of claims with errors	5
Calculated Error Rate	2.99%
Upper Error limit	5.58%
Lower Error limit	.41%
Upper limit Claims in error	129
Lower limit Claims in error	9

The upper and lower error limits represent the range of potential error (e.g. if 100 samples were selected the rate of error would fall between these limits 95 times).

It is recommended that the Company improve its internal claim processing procedures in order to ensure full compliance with Subsections 3224-a(a), (b) and (c) of the New York Insurance Law.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The examiner reviewed the Company's compliance with the following three comments and recommendations of the prior report on examination (page numbers refer to prior report):

ITEM		PAGE NO.
A.	Accounts and Records	15
	(1). It is recommended that the Company explore means of simplifying its cash account reconciliation in order to establish a clear audit trail for verification purposes.	
	The Company cash account reconciliation was simplified and the examiners were able to verify such cash account reconciliation.	
	(2). It is recommended that the Company establish written guidelines for the reimbursement of travel and entertainment expenses.	
	The Company complied with the recommendation and established written guidelines for the reimbursement of travel and entertainment expenses.	
B	Prompt Pay Law	22
	It is recommended that the Company include data such as date received and date paid in its records in order to simplify verification of compliance with the Prompt Pay Law.	
	The Company complied with this recommendation.	

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	It is recommended that the Company amend its by-laws or add another director to the Executive Committee, in order to comply with the requirement of Article VI, Section 1 of the Company's by-laws.	5
B.	It is recommended that members of the Finance Committee who are unable to attend at least 50% of its meetings should resign or be removed from the Committee by the Board of Directors. The Company should take into consideration the attendance of its directors at sub-committee meetings, when electing directors to serve on sub-committees.	6
C.	It is recommended that, in the future, the Company maintain written and signed reinsurance agreements pertaining to its reinsurance business.	10
D.	It is recommended that the custodian agreements between the Company and HSBC Bank be revised to include all of the protective covenants and provisions outlined, in order to meet the minimum custodial guidelines established by the New York State Insurance Department for the contents of such agreements.	15
E.	It is recommended that the Company comply with the requirements of Section 4209(c) of the New York Insurance Law and include a clear statement in its policies as to whether or not the holder of such policy is subject to a liability for assessment.	21
F.	It is recommended that the Company comply with the requirement of Section 3201(b)(1) of the New York Insurance Law and submit the two endorsements of mandated benefits to the New York Insurance Department for approval. It is further recommended that the Company, in the future, submit all endorsements to the Department for approval prior to the issuance of such endorsements.	22
G.	It is recommended that the Company establish a claims processing manual and appropriately train all persons responsible for the supervision, processing and settlement of claims.	24

Respectfully submitted,

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Elsaid E. Elbially
Associate Insurance Examiner, CFE

STATE OF NEW YORK)
)SS
COUNTY OF ALBANY)

ELSAID E. ELBIALLY, being duly sworn, deposes and says that the foregoing report, subscribed by him, is true to the best of his knowledge and belief.

_____
Elsaid E. Elbially

Subscribed and sworn to before me

this _____day of _____2004.

Appointment No. ***22009***

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***GREGORY V. SERIO***, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Elsaid Elbially

as a proper person to examine into the affairs of the

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

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

Company

with such information as he shall deem requisite.

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

this *10th* day of *March* 2003

Gregory V. Serio
Superintendent of Insurance