REPORT ON EXAMINATION

OF

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

AS OF

DECEMBER 31, 2009

DATE OF REPORT	**FEBRUARY 17, 2011**
EXAMINER	**BRUCE BOROFSKY, CFE**

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

Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

February 17, 2011

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 30472 and 30473, dated January 22, 2010, annexed hereto, I have made an examination into the condition and affairs of Commercial Travelers Mutual Insurance Company, an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2009, and submit the following report thereon.

The examination was conducted at the home office of Commercial Travelers Mutual Insurance Company located at 70 Genesee Street, Utica, New York.

Wherever the designations the "Company" or "CTMIC" appear herein, without qualification, they should be understood to indicate Commercial Travelers Mutual Insurance Company.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Insurance Department.

1. SCOPE OF THE EXAMINATION

The Company was previously examined as of December 31, 2006. This examination of the Company was a financial examination as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2009 Edition* (the "Handbook") and it covers the three-year period from January 1, 2007 through December 31, 2009. The examination was conducted observing the guidelines and procedures in the Handbook, and, where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2009, were also reviewed.

The examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Company's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Company's current financial condition, as well as identify prospective risks that may threaten the future solvency of CTMIC.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement

presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and annual statement instructions.

Information concerning the Company's organization structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Company's risks and management activities in accordance with the NAIC's nine branded risk categories, as delineated in the Handbook.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Company was audited annually for the years 2007 through 2009, by the accounting firm of BKD, LLP ("BKD"). The Company received an unqualified opinion in each of those years. Certain audit workpapers of BKD were reviewed and relied upon in conjunction with this examination. The Company has an Internal Audit Department which has been given the task of assessing the Company's internal control structure. A review was also made of the Company's Enterprise Risk Management program.

The examiner reviewed the corrective actions taken by the Company with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item 7 of this report.

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

2. EXECUTIVE SUMMARY

The examination revealed numerous operational deficiencies that occurred during the examination period. Following are the significant findings included within this report on examination:

- The implementation and enforcement of internal controls is a critical process to reduce the likelihood that the Company's financial statements are misstated. This report makes several recommendations for the implementation of such controls.

- The Company violated Section 1505(a) of the New York Insurance Law when it failed to charge an equitable rate for the rental of space to one of its subsidiaries.

- By not establishing an appropriate liability for its premium deficiency reserve, the Company failed to comply with the provisions of Paragraph 18 of SSAP No. 54 of the NAIC Accounting Practices and Procedures Manual.

- The Company violated Section 3221(a)(6) of the New York Insurance Law when it provided policy language to its enrolled groups that contradicted the policy language provided to its policyholders.

- In certain instances, the Company limited claim payments through the use of a "Usual and Customary" limitation, when the member contract did not permit such limitation.

- Certain Company contracts did not clearly define the member's liability when the Company is not the primary insurer.

- The Company's electronic claims data did not accurately reflect the date that the claim payments were made. This resulted in the examiner's inability to accurately calculate the number of days it took for the Company to pay claims.

- The following illustrates the calculated number of occurrences in which the Company violated the various Sections of 3224-a of the New York Insurance Law ("Prompt Payment Law"), during the period January 1, 2007 through December 31, 2009:

Part (a) 3,389	Part (b) 2,645	Part (c) 164

- The Company violated Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2(b)(8)) when it failed to maintain appropriate records.

- The Company violated Part 421.3 of Department Regulation No. 173 (11 NYCRR 421.3) and Parts 45, 164.502 and 160.103 of the U.S. Health Insurance Portability and Accountability Act (HIPAA) for failure to ensure the security and confidentiality of its members' Protected Health Information.

3. DESCRIPTION OF THE COMPANY

The Company was incorporated as "Commercial Travelers Mutual Accident Association of America", a cooperative assessment health plan, under the Laws of New York, and commenced business on March 30, 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 to write Accident and Health insurance as defined in New York Insurance Law, Section 1113(a)(3).

On May 6, 1988, a merger was effected between the Company and InterAmerica Consolidated Mutual Insurance Company of La Grange, Illinois, whereby the assets of the two entities were accounted for as a pooling of interest. Commercial Travelers Mutual Insurance Company was the surviving corporation.

A. Management and Controls

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of thirteen (13) members. As of the examination date, the board of directors was comprised of thirteen (13) members. The board meets at least quarterly. The board members as of December 31, 2009, were as follows:

Name and Residence	Principal Business Affiliation
Joan W. Compson Clinton, New York	Chief Financial Officer, Carbone Automotive Group
Thomas I. Ellis Barneveld, New York	Executive Vice President and CFO, Northland Communications
Keith A. Fenstemacher New Hartford, New York	Senior Consultant, Yaffe and Company
Richard R. Griffith New Hartford, New York	President and Director, Sturges Manufacturing Company, Inc.
Frederick H. Hager Clinton, New York	Principal, Strategic Planning Advisors, LLC
Harrison J. Hummel III Mohawk, New York	President/CEO, Hummel's Office Plus
Cathy M. Newell New Hartford, New York	President and CEO, Mohawk Ltd.
Earle C. Reed Utica, New York	Chairman of the Board, ECR International
Gary Scalzo New Hartford, New York	President, Scalzo, Zogby & Wittig, Inc.
Robert N. Sheldon Utica, New York	Owner (Retired), Reid-Sheldon & Company
Judith V. Sweet Clinton, New York	Chief Financial Officer, Strategic Financial Services, Inc.
James D. Trevvett Cold Brook, New York	Retired
Paul H. Trevvett Cold Brook, New York	President & CEO, Commercial Travelers Mutual Insurance Company

The board is required to meet once for an annual meeting and for three additional regular meetings during each calendar year but may hold special meetings as desired. CTMIC's board of directors met fourteen (14) times during the period of January 1, 2007 through December 31, 2009. A review of the minutes of the board of directors' meetings indicated that board meetings were generally well attended, with all members attending at least one-half of the meetings they were eligible to attend.

The Company, based on its premium volume, is not subject to either the Committee of Sponsoring Organizations' ("COSO") rules or Part 89 of Department Regulation No. 118 (11 NYCRR 89). However this should not prevent the Company from consideration of risk at a corporate level. Currently, the Company's approach to risk is reactive rather than proactive.

Neither the board of directors nor company management has analyzed operations proactively to determine and define risk areas. Doing so would allow the Company to establish a methodology to anticipate and react to negative events. Such events can range from the loss of sensitive data to significant increases in loss ratios. In the long term, such a program would likely provide benefits that would outweigh the initial costs. Additionally, the nomination of an existing officer to adopt the title and role of a Risk Officer would be a good business practice.

It is recommended that the Company's senior officers and the board consider the creation of an Enterprise Risk Management ("ERM") program that would formally identify risks and establish controls to mitigate such risks.

The principal officers of CTMIC as of December 31, 2009, were as follows:

Name	Title
Paul H. Trevvett	President and Chief Executive Officer
Sharon P. DeCarr	Vice President, Claims
Phyllis H. Galliher	Manager, Accounting
William G. Holbrook	Vice President, Administrative Services
Lynne J. Macrina	Vice President, Personnel
Richard Massaro	Treasurer and CFO
David R. Milner	Secretary and General Counsel
Thomas P. Moore	Vice President, Employer Group Underwriting
Matthew Shedd	Senior Portfolio Analyst
Thomas Spath	Medical Director
Alan L. Shulman	Vice President, Actuary
Brian T. Stalder	Vice President, Special Risk

During the examiner's review of management, it was noted that, while the Company maintains a Code of Ethics and requires its board members, officers and key employees to sign such Code of Ethics upon being hired, there is no requirement that a Conflict of Interest Statement must be signed on an annual basis.

It is recommended that the Company establish and maintain procedures which require all board members, officers and key employees to sign a Conflict of Interest Statement on an annual basis or whenever the circumstances dictate that it would be appropriate to do so.

B. Territory and Plan of Operation

Commercial Travelers Mutual Insurance Company is a mutual accident and health insurer licensed under the provisions of Article 42 of the New York Insurance Law. As of December 31, 2009, the Company was licensed to issue coverage in 49 states and the District of Columbia.

The Company's primary lines of business include: college student medical expense, K-12 student accident-only medical expense, and disability income for small employers. Other lines of business include; special risk group accident and medical expense, which provides medical expense coverage for non-student youth sports and youth/adult special activities.

Based upon the capital requirements under New York Insurance Law, Section 1113(a)(3) and pursuant to Article 42 of the New York Insurance Law, the Company is required to maintain a minimum surplus in the amount of $150,000.

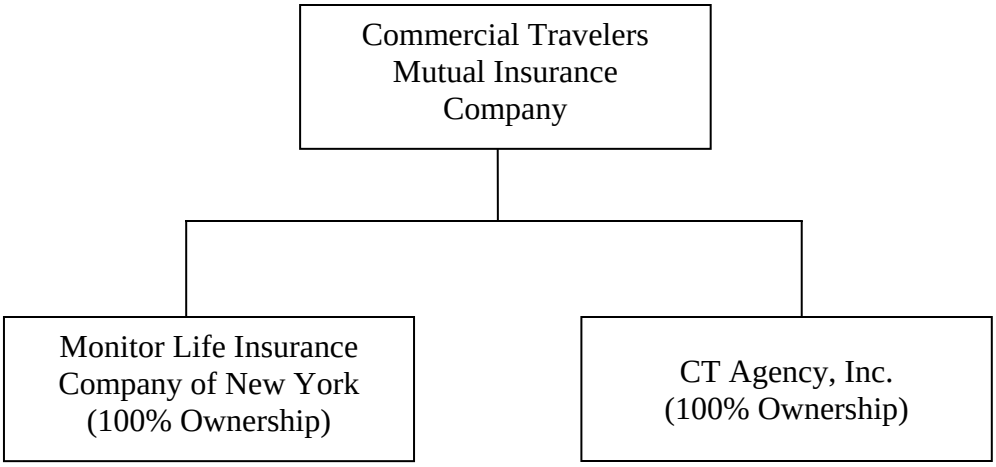
The following is a schedule of direct premiums written in New York compared to premiums written nation-wide during the examination period:

	2006	2007	2008	2009
New York	$ 1,736,050	$ 1,710,751	$ 1,616,841	$ 1,418,407
Nationwide	34,068,002	35,178,840	33,355,221	34,320,956
% of Premiums written in New York	5.1%	4.9%	4.8%	4.1%

The decrease in premiums written in New York during the examination period was primarily due to the loss of numerous groups. Some of these groups were discontinued intentionally as part of the Company's strategic plan.

C. Holding Company System

The following chart depicts the Company and its relationship to members of its Holding Company System as of December 31, 2009:



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 in twenty-six states, including New York.

A service agreement was effected on April 1, 1979, between CTMIC and Monitor. Under the terms of the Agreement, CTMIC is reimbursed for marketing, underwriting, claim, investment and other services it performs for Monitor. The service agreement, which has not been amended since its inception, was approved by the Department on May 8, 1979.

Furthermore, effective in 1982, and with the approval of the 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 one 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, 2009, there were no borrowings outstanding under this agreement.

Subsequent to the examination date, on June 2, 2010, a sale of 100% of the shares of Monitor was proposed to AmFIRST Insurance Company, a life, accident and health insurer domiciled in Oklahoma. The sale was closed as of January 1, 2011.

CT Agency, Inc.

On January 30, 1991, the Department approved the Company's organization and acquisition of CT Agency, Inc. The purpose of CT Agency, Inc. is to serve as an agent 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, offering lines of business that may be of interest to CTMIC policyholders.

The Company entered into a service agreement with CT Agency, Inc. on March 13, 1991. Under the agreement, which has been approved by the Department, the Company pays CT Agency, Inc. a commission on premiums earned for business placed with the Company.

New York Insurance Law §1505(a)(1) states in part:

> "Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following: (1) the terms shall be fair and equitable..."

The inter-company agreements between CTMIC and its subsidiaries require that expenses be allocated in a "suitable and equitable manner". Upon review of the expenses charged between CTMIC and its subsidiaries, it was noted that the Company charges rent at $8.00 per square foot, while the going rate for such space in the area where the office is located is $12 to $13 per square foot. As such, this cost is not being shared equitably, in violation of the above cited Law and the aforementioned agreements.

It is recommended that the Company comply with the requirements of Section 1505(a) of the New York Insurance Law and charge an equitable rate for the rental of space within its facilities.

It is noted that the Company rectified this deficiency while the examination was being conducted.

Tax Allocation Agreement

The Company entered into a consolidated tax allocation agreement, with an effective date of February 23, 2000, with its subsidiaries. This agreement was found to be consistent with the guidelines contained in Circular Letter No. 33 (1979), and was approved by the Department on May 12, 2000.

D. Reinsurance

During the examination period and continuing thereafter, the Company acted as a managing underwriter on a "pooled basis" arrangement with Security Mutual Life

Insurance Company of New York ("Security"). According to this arrangement, all school insurance policies and a small amount of special risk business are pooled by the participants.

Pursuant to the terms of this agreement, the Company and Security share in the premiums, losses and expenses of the pooled business in accordance with each Company's percentage of participation. Security pays a fee to CTMIC for its share of the administrative services based on a percentage of net premiums written.

As of December 31, 2009, the insurers included in this pooling agreement and their proportions of participation were as follows:

Name	Percentage of Participation
Commercial Travelers Mutual Insurance Company	100%
Security Mutual Life Insurance Company of New York	0%*

* Security has an option to recapture 10% of the business.

Ceded Reinsurance

Commercial Travelers Mutual Insurance Company has several reinsurance agreements in effect that limit its net exposure. In addition to its pooling arrangement, CTMIC has quota share, excess of loss and catastrophe agreements with companies accredited by the Department to protect itself against excessive exposure. The examiner reviewed all ceded reinsurance agreements effective during the examination period. All agreements contained the required standard clauses including the insolvency clause meeting the requirements of Section 1308(a)(2)(A)(i) of the New York Insurance Law.

An outline of the ceded reinsurance agreements in effect at December 31, 2009, is as follows:

Type of coverage	Coverage	Cession	Reinsurer
Excess of loss	School Plans	5% excess of $100,000, up to $250,000.	ACE American Insurance Co.
Excess of loss	School Plans	95% excess of $100,000, up to $250,000.	Everest Insurance Co.
Excess of loss	School Plans – Catastrophic	Excess $100,000, up to $3,000,000, 3 or more lives.	Sirius International Co.
Excess of loss	Special Risk	Excess of $100,000, to $1 million, 3 or more lives.	Lloyd's Syndicate (AIG UK)
Excess of loss	Accidental Death and Disability	Excess of $100,000, up to $900,000.	AIG UK/Landmark Ins. Co. UK (NH)
Quota share	Employee Group LTD.	90% is automatically ceded to the reinsurer	Union Security Life Insurance Co. of NY

During the examiner's review, it was noted that while the Company has an extensive reinsurance program, some controls did not exist. These include the following:

1. There was no formalized strategy for reinsurance and reinsurance is not discussed regularly with the board of directors.
2. In selecting limits for reinsurance, there was no input sought from other corporate interested parties and there was no evaluation of the effectiveness of the program.
3. The Company did not have formalized procedures or specifically assigned personnel responsible to test claims for reinsurance reimbursement eligibility. Instead, it is assumed that personnel will note such eligibility.
4. The insurer did not obtain SAS 70 or independent CPA reports relative to its reinsurers.

It is recommended that the Company institute controls over its reinsurance program to include the following:

- The Company should formalize its reinsurance strategy;
- The board of directors and affected departments within the Company should be consulted and/or participate in the establishment of the reinsurance program, the reinsurance contracts and the reinsurance limits;
- Management should apprise the board of directors, at least annually, of the reinsurance program's status;

- The Company should obtain a SAS 70 report or other control documents from its reinsurers at least annually; and
- The Company should formalize policies and procedures in order to ensure claims are handled in a timely and efficient manner.

E. Third Party Administrators

The Company, during the examination period, maintained three claims administration agreements with third party administrators ("TPAs"). Under these agreements, the TPAs receive and adjudicate School Plan claims. They also receive complaints, although if the insured is not satisfied with the claim resolution, the complaint is turned over to the Company for handling. The four TPAs, which the Company maintained claims administration agreements with during the examination period, were as follows:

- Summit Claims Management Services
- T. L. Grosclose Associates Inc.
- Consolidated Health Plans
- NAHGA Claim Services

These TPAs each also represented broker agencies that sold the business to those schools for which the TPAs adjudicated claims.

On August 1, 2010, the Company's claims administration agreement with T. L. Grosclose Associates, Inc. was discontinued and its services under such agreement were transferred to the Company's internal claims processing unit.

The Company has not reviewed or otherwise ensured the quality of the Disaster Recovery/Business Continuity plans of its Third Party Administrators. In the event of a disaster, the Company's current plan is to bring the responsibilities in-house.

It is recommended that the Company ensure that the Disaster Recovery plans of its TPAs are valid, operational and current, with specific instructions for implementation.

F. Significant Operating Ratios

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

	Amounts	Ratios
Claims incurred	$ 64,423,721	61.5%
Commissions on premium	15,778,230	15.1%
General administrative expenses	26,163,299	25.0%
Net underwriting gain	(1,632,337)	(1.6%)
Premiums earned	$ 104,732,913	100%

G. Accounts and Records

During the course of the examination, it was noted that the Company's treatment of certain items was not in accordance with statutory accounting principles or annual statement instructions. A description of such items is as follows:

1. Custodial Agreements

Section 1314(g)(1) of the New York Insurance Law states:

> "No exchange, release or other transfer of deposited securities, or any interest therein, shall be valid unless: (i) countersigned by a member of the state tax commission or a person designated for such purpose by such commission, and (ii) requested by the depositing insurer. Except for a transfer for redemption or refunding, the depositing insurer's request must be evidenced in such manner as the superintendent requires."

A review of the Custodial Agreement for the Superintendent's Security Deposit held pursuant to Section 4206 of the New York Insurance Law revealed that the agreement did not include the above cited requirement.

It is recommended that the Company comply with the requirements of Section 1314(g)(1) of the New York Insurance Law and include in its Custodial Agreement for the New York State Escrow Deposit all clauses required by that Law.

Subsequent to the examination, the Company had this Custodial Agreement amended to include such requirement.

2. Premiums Receivable

At each year-end during the three-year examination period, the Company maintained large balances of non-admitted premium receivables. The Company maintained that the balances, which were overdue by greater than 90 days, were the result of certain School Groups failing to remit their premiums to their agents, who are responsible for premium collection. However, the Company was not able to demonstrate that the schools and not the agents were withholding premiums. Additionally, when the

examiners tested a sample of premium notices to ensure they were being sent to the School Groups in a timely manner, there were five instances where the Company was unable to demonstrate that any billings were sent to those Groups at all.

It is recommended that the Company ensure that its agents are properly billing for their School Groups. Additionally, it is recommended that, where an agent is maintaining a large unpaid premium balance at year end, the Company take steps to definitively establish the cause for the late premium balances and initiate collection.

Upon review of the College group contracts, it was noted that the contracts did not contain a firm time-frame within which premiums must be paid, or the groups are cancelled. While not statutorily required, the lack of a contractual grace period limits the Company's ability to ensure premiums are paid timely.

It is recommended that the Company place grace cancellation periods within its College group contracts.

H. Special Risk Coverage

When the Company sells a Special Risk policy, it is agreeing to cover a sports team or other special event. Customarily, the policy page indicates the number of people that are covered, but does not include the specific names of the insureds. The Company's explanation for this omission is that the insureds could change at any time prior to the initiation of the policy, depending on the team that is selected for the event being covered. However, where the Company is unaware of the insured's exact identity, it opens itself up to fraudulent activity.

It is recommended that the Company take steps to mitigate the risks associated with its failure to obtain the policy listing of insureds under its Special Risk coverage contracts.

I. Information Technology

The Information Technology ("IT") portion of the examination was performed in accordance with the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2009 Edition* (the "Handbook"), utilizing a modified Exhibit C (*Evaluation of Controls in Information Technology*) approach. The review was modified because the Company is not required to comply with either the Sarbanes Oxley Act ("SOX"), or the NAIC's Model Audit Rule ("MAR"). The Company is also not required to follow the Control Objectives for Information and related Technology ("COBIT") framework. These waivers are all granted because the Company's premium volume is below the thresholds stipulated under the cited requirements.

The examiner also incorporated findings noted by the Company's Internal Auditor. The review was further leveraged by discussions, findings and documentation provided by the Company's external auditor, BKD, LLP.

The objective of the review was to assess the Company's IT general controls ("ITGC") and procedures through the identification of inherent risk, mitigating controls and residual risk. Substantive testing was performed where deemed appropriate,

including the use of work performed by the Company's Internal Audit Department. Key areas targeted during the review included the following:

- IT management and organizational controls;
- Application and operating system software change controls;
- System and program development controls;
- Overall systems documentation;
- Logical and physical security controls;
- Contingency planning;
- Local and wide area networks;
- Personal computers; and
- Mainframe controls.

During the review, the following was noted:

1. The Company did not have a formally documented IT strategic plan that was presented to the board of directors and/or audit committee for their acknowledgement and approval.

2. IT hardware was purchased without going through the Company's DPR ("Data Processing Request") System, thus bypassing the IT inventory list.

3. The IT programming staff had complete access to both testing and live application. A signed policy was added recently, but no formal internal control testing were in place to detect fraud. Such controls can exist in many forms including internal audit.

4. The Company did not have an electronic image backup system to support claims processing, although the readiness for such a system was put in place. Sensitive paper claim files, which do not have duplicates, are thus exposed and vulnerable to fire, theft and unauthorized use.

5. The computer room did not have an automatic fire suppression system in place, leaving critical computer components vulnerable.

6. No flood and water detection equipment were present in the basement leaving key computer electronics exposed. The Company recently installed water detectors that are connected to the ADT fire and theft monitoring system.

7. Routers and network data lines located in the basement were exposed and vulnerable to unauthorized use or intrusion. The Company recently constructed a locked enclosure separating the components.

It is recommended that the Company improve upon existing controls of its IT Department by developing and incorporating the following controls within its IT Control procedures:

- A formally documented IT Strategic Plan which is presented to the board of directors and audit committee on a periodic basis.
- A policy that requires that purchasing of all computer and electronic equipment go through the IT DPR approval process.
- Institute periodic testing of transactions entered into by the programming staff on live applications.
- Improve upon the security and storing process of sensitive claim files, which may be accomplished through the use of an electronic image backup system, which reduces the exposure and vulnerability of claim files to fire, theft and unauthorized use.
- Installation of a fire suppression system for its computer room.

External IT Audit

The most recent external audit of the Company's IT Department was conducted by the Company's external auditor, BKD, LLP in 2010. Material weaknesses were presented by BKD to the Company's Audit Committee.

It was noted that findings from the aforementioned IT audit were not communicated by Company management to the Company's IT Department in a direct and expeditious manner.

The Company has since complied with the IT recommendations as noted by BKD, LLP.

It is recommended that the Company ensure that its IT Department is apprised of all internal and external audit issues pertaining to IT issues and that such apprisement of internal and external audit issues take place in an expeditious manner.

4. FINANCIAL STATEMENTS

A. Balance sheet

The following compares the assets, liabilities, and surplus as determined by this examination to those reported by the Company in its filed Annual Statement, as of December 31, 2009:

Assets	Examination	Company	Surplus Increase/ (Decrease)
Bonds	$ 8,988,745	$ 8,988,745	
Common stock	4,980,744	4,980,744	
Real estate - properties occupied by the Company	219,212	219,212	
Cash, cash equivalents, and short-term investments	16,680,211	16,680,211	
Investment income due and accrued	62,859	62,859	
Uncollected premiums and agents' balances in the course of collection	608,124	608,124	
Amounts recoverable from reinsurers	78,060	78,060	
Amounts receivable relating to uninsured plans	25,213	25,213	
Current federal and foreign income tax recoverable and interest thereon	696,064	696,064	
Net deferred tax asset	962,374	962,374	
Guaranty funds receivable or on deposit	38,987	38,987	
Intangible pension asset	432,805	432,805	
Total assets	$ 33,773,398	$ 33,773,398	

Liabilities	Examination	Company	Surplus Increase (Decrease)
Aggregate reserve for accident and health contracts	$14,505,441	$14,505,441	
Accident and health contract claims	8,913,611	7,763,611	$(1,150,000)
Premiums and annuity considerations for life and accident and health contracts received in advance	116,155	116,155	
Commissions to agents due or accrued-accident and health	681,953	681,953	
General expenses due or accrued	551,935	551,935	
Taxes, licenses and fees due or accrued, excluding federal income taxes	210,740	210,740	
Remittances and items not allocated	10,980	10,980	
Liability for benefits for employees and agents if not included above	1,110,185	1,110,185	
Payable to parent, subsidiaries and affiliates	15,428	15,428	
Checks pending escheatment to states	27,203	27,203	
Total liabilities	$ 26,143,631	$ 24,993,631	$ (1,150,000)
Surplus			
Unassigned funds	$ 7,629,767	$ 8,779,767	(1,150,000)
Surplus	$ 7,629,767	$ 8,779,767	$ (1,150,000)
Total liabilities and surplus	$ 33,773,398	$ 33,773,398	

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2009. The examiner is unaware of any potential exposure of the Company to any tax assessments and no liability has been established herein relative to such contingency.

B. Statement of Revenue and Expenses and Surplus

Surplus decreased $4,287,087 during the period January 1, 2007 through December 31, 2009, as follows:

Revenue		
Premiums	$104,732,913	
Net investment income	1,685,242	
Miscellaneous income	353,151	
Total revenue		$106,771,306
Expenses		
Disability benefits and benefits under accident and health contracts	$ 65,711,753	
Premium deficiency reserve	1,150,000	
Decrease in aggregate reserves	(1,288,032)	
Commissions on premiums	7,604,755	
Commissions and expense allowances on reinsurance assumed	8,173,475	
General insurance expenses	23,599,514	
Insurance taxes, licenses and fees, excluding federal income taxes	2,554,987	
Miscellaneous losses	8,798	
Total underwriting expenses		$ 107,515,250
Net gain from operations before federal income taxes		$ (743,944)
Federal and foreign income taxes		362,565
Net gain from operations after federal income tax		$ (1,106,509)
Net realized capital losses		(169,583)
Net loss		$ (1,276,092)

Change in Surplus

	Gains in Surplus	Losses in Surplus	
Surplus, per report on examination, as of December 31, 2006			$ 11,916,854
Net loss		$1,276,092	
Change in net unrealized capital gains		1,276,963	
Change in net deferred income tax	$ 196,296		
Change in non-admitted assets		2,057,809	
Aggregate write-ins for gains and losses in surplus	127,481		
Net decrease in surplus			(4,287,087)
Surplus, per report on examination, as of December 31, 2009			$ 7,629,767

5. UNPAID CLAIMS

A. Aggregate Reserve For Accident and Health Contracts

The examination liability of $14,505,441 for the above captioned account is the same as the amount reported by the Company in its filed annual statement as of December 31, 2009.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements as verified by the examiner.

The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Company's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2009.

B. Accident and Health Claims - Premium Deficiency Reserve

The examination liability of $8,913,611 is $1,150,000 more than the $7,763,611 reported by the Company in its annual statement filed as of December 31, 2009.

The above change reflects the amount of the premium deficiency reserve ("PDR") as established by this examination in the aggregate amount of $1,150,000 as of December 31, 2009. It was noted that the Company had not reported a liability for a PDR in its filed annual statement as of December 31, 2009.

The premium deficiency reserve established by this examination was related to the Company's Student Plan line of business.

The above premium deficiency reserve was established in accordance with the provisions of Paragraph 18 of the Statements of Statutory Accounting Principles ("SSAP") No. 54 of the NAIC Accounting Practices and Procedures Manual, which states:

> "When the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started."

It is recommended that the Company comply with the provisions of Paragraph 18 of SSAP No. 54 of the NAIC Accounting Practices and Procedures Manual by establishing an appropriate liability for its premium deficiency reserve.

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Company conducts its business 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 examination. The review was directed at the practices of the Company in the following major areas:

A. Claims adjudication testing
B. Prompt payment of claims
C. Disclosure information
D. Record retention
E. Privacy
F. Grievances
G. Retro-termination of policies
H. Agents and brokers
I. Schedule H - Aging analysis of unpaid claims
J. Department Circular Letter No. 9 (1999)

A. Claims Adjudication Testing

Section 3234 of the New York Insurance Law describes the circumstances under which an Explanation of Benefits statement ("EOB") is to be provided to the insured and prescribes the contents of that document. Section 3234(b)(3) of the New York Insurance Law indicates that EOBs must contain, "an identification of the service for which the claim is to be made."

During the review of claims, it was noted that, in violation of Section 3234(b)(3) of the New York Insurance Law, there were a small number of instances in which the Company failed to include the service description on the EOB. Instead it listed the provider's name in the space designated for that information.

It is recommended that the Company comply with the requirements of Section 3234(b)(3) of the New York Insurance Law and include all of the required information within its Explanation of Benefit statements.

Section 3221(a)(6) of the New York Insurance Law states in part:

> "That the insurer shall issue either to the employer or person in whose name such policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage…"

During a review of a member complaint, the examiner learned that for one contract, SMLSA1-03(Rev. 04) 09-M801, which an agent delivered to 96 schools between 2007 and 2009, contained contract language that differed from the language that the Company indicated had been intended and which had been included in other school contracts. The language in such contracts sent to the aforementioned schools described the Company's claim liability as follows:

> "*We will pay the charges incurred within 156 weeks of the accident, in excess of the Deductible, if any, up to the Maximum Benefit stated in the Policy Schedule.*" (underline added for emphasis.)

The certificates that were sent to the groups' members however, limited the Company's liability through the implementation of a cap based upon usual and customary fees. It was noted by the examiner that the Company paid claims based upon the language in the certificates.

The Company's failure to deliver consistent language is deemed to be a violation of Section 3221(a)(6) of the New York Insurance Law, as cited above. Additionally, it is

the Department's position that when there is a discrepancy between a policy and a certificate of coverage, it is the policy that controls claim reimbursements. Thus, claims from these groups should have been paid based upon the incurred charges, as stipulated within the policy language and not based on usual and customary fees.

It is recommended that the Company comply with the requirements of Section 3221(a)(6) of the New York Insurance Law and deliver consistent contract language within all documents distributed to parties covered under the Company's insured contracts.

Additionally, policy number SH-1-88, which was delivered to several College Groups, contained a definition of *Covered Charges* that was based upon a usual and customary fee schedule. The benefits section of the contract noted the following:

> "*We will pay the expense incurred within 52 weeks after the date of the accident up to a maximum of $7,500 in excess of a $10 deductible.*" (underline added for emphasis.)

It is the Department's position that because the language used to define the Company's liability did not include the term "Covered Benefits", the Company has an obligation to utilize the incurred expense to establish its liability for claims. The Company indicates that there were eleven (11) claims paid from this contract based on a usual and customary fee schedule.

It is recommended that the Company cease the practice of limiting its claim liability through the use of payment of claims by means of a usual and customary fee

schedule in instances where the contract indicates that the Company's liability is based upon "Expense Incurred" or "Charges Incurred".

It is also recommended that the Company re-adjudicate and pay any additional amounts due relative to any claims paid during the examination period that utilized a usual and customary fee as the limit of the Company's liability, where the group contract did not specifically reference and permit the use of a usual and customary fee cap.

The examiner reviewed a separate member complaint regarding the Company's liability for claims in an instance where the Company was not the primary insurer with regard to a School Group claim. In reviewing that member's contract language, it was noted that the contract did not specify a method of establishing the member's financial benefits when the CTMIC policy is not primary. Thus, there is no clear way for the member to understand how his or her liability will be determined.

It is recommended that the Company ensure that all of its School Group contracts clearly define the Company's liability when the Company is not the primary insurer.

B. Prompt Payment of Claims

New York Insurance Law, Section 3224-a "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law") 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.

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

> "Except in a case where the obligation of an insurer… to pay a claim submitted by a policyholder or person covered under such policy…or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

New York Insurance Law, Section 3224-a(b) states in part:

> "In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter…to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment.
>
> Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section."

New York Insurance Law, 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 on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

The Company attempted to measure and ensure its compliance with the above sections of Section 3224-a of the New York Insurance Law through reliance on the claims data in its electronic claims records. However, the examiners noted several instances where the dates within the electronic records were incorrect. Specifically, there were multiple instances wherein the date referenced as being the eligible-to-pay date, that is, when all necessary information needed to calculate the Company's liability and pay the claim was on hand, was incorrectly represented within the data. Additionally, it was noted that the date referenced within the claim record as the "Paid Date" was actually the date that the Company's financial liability was determined. Depending on the day of the week and/or the amount of claim volume being handled, as many as four additional days could pass before the payments were finally mailed to the payee. For these reasons, the Company does not have the tools in place necessary to monitor its own compliance with the Prompt Pay Law.

It is recommended that the Company's electronic claim records accurately reflect the date that the Company's claim payments are mailed.

A review of the Company's compliance with Section 3224-a of the New York Insurance Law was performed by the examiner using a statistical sampling methodology, for claims adjudicated during the period January 1, 2009 through December 31, 2009. Random samples were selected for review from the School Plans and Special Risk lines of business. The sample size for each of the three populations (Section 3224-a(a), (b) and (c)) described herein was comprised of 167 randomly selected unique transactions.

The term "claim" can be defined in a myriad of ways. The following is a definition of the term for the purposes of this report. The receipt of a "claim", which is defined by CTMIC as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It is possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into one line. Adjustments to claims were linked to the original claim.

The following chart illustrates CTMIC's claims prompt payment compliance relative to Sections 3224-a(a), 3224-a(b) and 3224-a(c) of the New York Insurance Law as determined by this examination:

Summary of Violations

	§3224-a(a)	§3224-a(b)	§3224-a(b) ("hidden")	§3224-a(c)
Total population of claims	35,577	35,577	35,577	35,577
Total population of claims	6,174	5,088	7,995	1,821
Sample size	167	167	167	167
Number of claims with violations	91	45	53	15
Calculated violation rate	54.9%	27.0%	15.9%	9.0%
Upper violations limit	62.0%	33.7%	19.8%	13.3%
Lower violations limit	46.9%	20.2%	12.0%	4.7%
Upper limit claims in violation	3,831	1,713	1,582	243
Lower limit claims in violation	2,898	1,029	955	85

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

The testing relative to the Company's compliance with Section 3224-a(b) of the New York Insurance Law, included within column two above, consists of a review of claims that were denied or had additional information requested greater than thirty (30) days after the claim receipt date. The examination extrapolation of the results of that testing represented claims that were never re-opened or paid. They were denied outside the parameters permitted by the Prompt Pay Law on their first and only pass-through.

The testing did not include claims that were denied or had additional information requested outside the statutorily required thirty (30) day limit but were eventually re-opened to pay. This is because the claims data provided by the Company, which was used by the examiners to locate potential prompt pay violations, did not contain sufficient information to permit those claims to be directly located, (i.e., they were "hidden") within the claims data. To surmount this difficulty, the examiner utilized the examination samples relative to violations of Sections 3224-a(a) and 3224-a(c) of the New York Insurance Law to test for such "hidden" violations within the Company's paid claims population. Those results of such testing are in column three above.

It is recommended that the Company take the necessary steps to comply with Sections 3224-a(a), 3224-a(b) and 3224-a(c) of the New York Insurance Law.

C. Disclosure of Information

New York Insurance Law §3217-a(a), Disclosure of Information, states in part:

> "Each insurer subject to this article shall supply each insured, and upon request, each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below…
>
> The information to be disclosed shall include at least the following…
>
> (7) a description of the grievance procedures to be used to resolve disputes between an insurer and an insured, including: the right to file a grievance regarding any dispute between an insured and an insurer; the right to file a grievance orally when the dispute is about referrals or covered benefits..."

It is recommended that the Company's disclosure of information material include a notice of the insured's right to file a grievance orally when the dispute concerns covered benefits.

D. Record Retention

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

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

During the examination period, the Company did not retain copies of all e-mails.

Additionally, the Company did not consistently retain copies of the EOBs that it mailed to members. Instead, it maintained copies of its Provider Remittance Advices.

The EOB, however, as a mandated document, is critical to the claim record and should in all cases be retained by the Company pursuant to Part 243.2(b)(8) of Department Regulation No. 152.

It was noted that, during the examination, the Company initiated procedures to store EOBs as required by Part 243.2(b)(8) of Department Regulation No. 152.

Additionally, the failure of the Company to record the actual date on which claims are paid, as described in Section 6B of this report, is a violation of Part 243.2(b)(8) of Department Regulation No. 152.

It is recommended that the Company comply with Part 243.2(b)(8) of Department Regulation No. 152 and retain appropriate records at all times.

E. Privacy

Part 421.2 of Department Regulation No. 173 (11 NYCRR 421.2) states the following:

> "Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities."

Part 421.3 of Department Regulation No. 173 (11 NYCRR 431.3) states:

> "A licensee's information security program shall be designed to:
>
> (a) Ensure the security and confidentiality of customer information;
>
> (b) Protect against any anticipated threats or hazards to the security or integrity of such information; and
>
> (c) Protect against unauthorized access to or use of such information that could result in substantial harm or inconvenience to any customer."

Additionally, the U.S. Health Insurance Portability and Accountability Act ("HIPAA") Standards for Privacy of Individually Identifiable Health Information, Part 45 USC 164.502 (the "Privacy Rule") requires the following:

> "A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure."

During the examination, it was noted that various documents containing Protected Health Information ("PHI") were not kept in a secure location. These documents included claim files and underwriting files containing PHI. Some of the documents were stored on desks and other unprotected areas while some were maintained in an unlocked room with a half wall. This is insufficient to ensure that Protected Health Information is secured from those who do not require such access. It was also noted that the Company utilizes an independent third party to clean its facilities. When the examiner inquired as to how the accessible records would be protected from those individuals, the Company advised that they had a Business Associate Agreement with the third party that ensured its employees would protect the information. However, a Business Associate is defined by HIPAA's Standards for Privacy of Individually Identifiable Health Information, Part 45 USC 160.103, as follows:

> "a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Business associate functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, and billing. Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all."

As such, the cleaning company is not eligible for Business Associate status.

It is recommended that the Company comply with Part 421.3 of Department Regulation No. 173 and Part 45 USC 164.502 and 160.103 of the U.S. Health Insurance Portability and Accountability Act and ensure the security and confidentiality of its members' Protected Health Information.

7. SUMMARY OF PRIOR COMMENTS AND RECOMMENDATIONS

The prior report on examination, as of December 31, 2006, contained the following twelve (12) recommendations (page numbers refer to the prior report on examination).

ITEM NO.		PAGE NO.
	Conflict of Interest	
1.	It is recommended that the Company comply with its "Statement of Policy" and record any approvals or authorizations by the Board of Directors of the Company or its Executive Committee regarding any business relationships with a director, officer or key employee of Commercial within the Company's board of directors' minutes.	13
	The Company has complied with this recommendation.	
	Internal Controls	
2.	It is recommended that the Company safeguard the premiums checks received by the Company's Employers Group Department in a more secure environment.	13
	The Company has complied with this recommendation.	
	Claims Unpaid	
3.	It is recommended that the Company review its methodology relative to the loss ratio and the IBNR factor used in the Company's establishment of its long term disability IBNR reserves and liabilities.	18
	The Company has complied with this recommendation.	
4.	In this regard, it is recommended that the Company adopt a tabulation methodology relative to the establishment of its direct claims long-term disability IBNR reserves and liabilities.	18
	The Company has complied with this recommendation.	

ITEM NO.		PAGE NO.
5.	It is recommended that the Company set its reserves and liabilities for ceded claims at 90% of direct claims (long term disability claims unpaid - incurred and unreported). *The Company has complied with this recommendation.*	19
6.	It is recommended that the Company allocate 100% of its total amount of long term disability claims unpaid (IBNR) to liabilities and 0% to reserves in future annual and quarterly statements to this Department. *The Company has complied with this recommendation.*	19
7.	It is recommended that, in the future, the Company allocate its total amount of long term disability - (present values of amounts not yet due) between reserves and liabilities for ceded and direct claims to 0% to liabilities and 100% to reserves, which is the general practice for actuaries. *The Company has complied with this recommendation.*	19
8.	It is recommended that, in the future, Commercial establish appropriate IBNR reserves and liabilities for short term disability claims. Furthermore, it is recommended that the Company review its allocation methodology relative to the components of short term disability reserves and liabilities. *The Company has complied with this recommendation.* Claims Processing	20
9.	It is recommended that Commercial take proactive steps to identify and correct errors that may be occurring on an ongoing basis and that Commercial address the causes of the errors. *The Company has complied with this recommendation.*	23

ITEM NO. **PAGE NO.**

Claims Prompt Payment

10. It is recommended that the Company improve its internal claim procedures to ensure full compliance with Section 3224-a (a) and (b) of the New York Insurance Law. 27

The Company has not fully complied with this recommendation. A similar recommendation is included within this report on examination.

Explanation of Benefits Statements

11. It is recommended that the Company comply with the requirements of §3234(b)(5) of the New York Insurance Law to ensure its explanation of benefits are consistent, complete and accurately describe all reductions from the billed amounts and the subscribers responsibilities. 28

The Company has complied with this recommendation.

Claim Adjustment Expenses

12. It is recommended that the Company discontinue the practice of assigning a claim number to third party administrative fee invoices. Such fees should be reported as claim adjustment expenses. 29

The Company has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Appointment No. 30472

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

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 condition of the said

Company

with such other information as he shall deem requisite.

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

this 22nd day of January, 2010

James J. Wrynn
Superintendent of Insurance