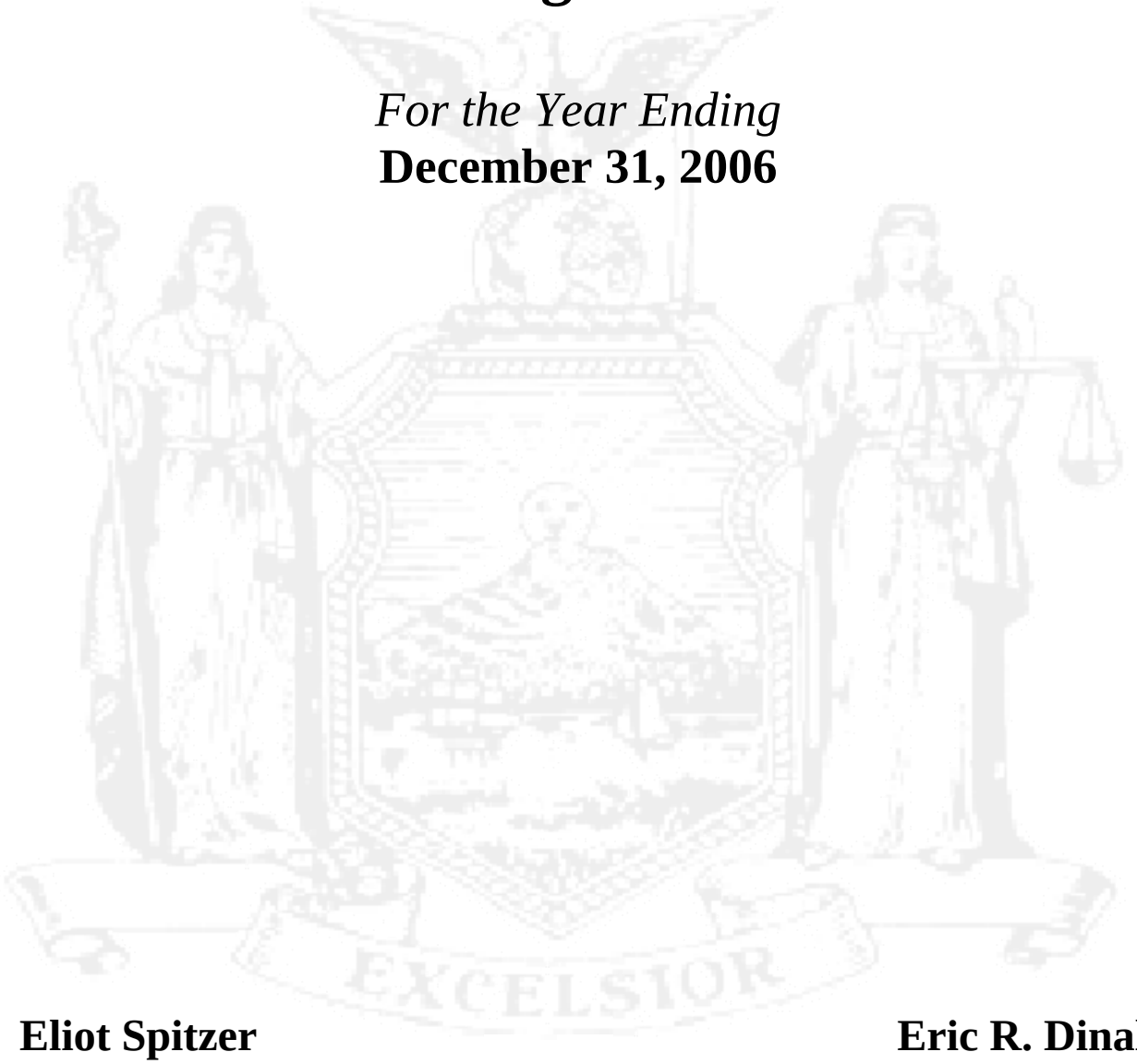
2006
Annual Report
of the
Superintendent of Insurance
to the
New York State Legislature

Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

The 148th Annual Report
of the
Superintendent of Insurance
to the
New York State Legislature

For the Year Ending
December 31, 2006



Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

New York State Insurance Department
25 Beaver St., New York, NY 10004
www.ins.state.ny.us

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

This report is available on the
New York State Insurance Department website,
www.ins.state.ny.us

This report is reprinted on recycled paper.

K: gen/AnnualReport06/ANNRPTCY2006

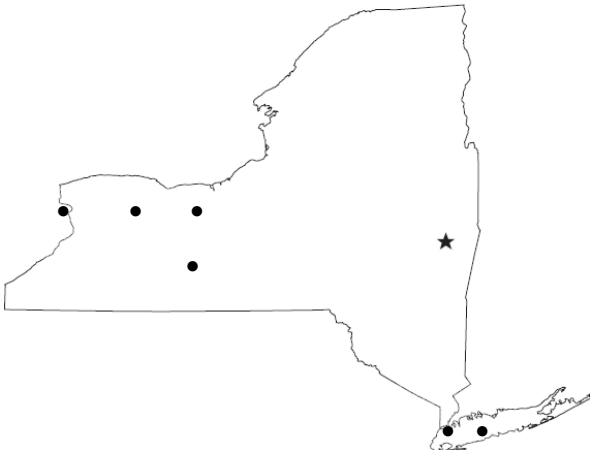
TABLE OF CONTENTS

TABLES

CHARTS

New York State Insurance Department

Albany
Buffalo
Long Island (Mineola)
New York City
Oneonta
Rochester
Syracuse



Eric R. Dinallo 39th New York State Insurance Superintendent

Eric R. Dinallo is the 39th New York State Superintendent of Insurance. Mr. Dinallo was nominated for the position by Governor Eliot Spitzer and confirmed by the New York State Senate on April 18, 2007.

Mr. Dinallo brings to the Department extensive public and private sector experience. He was previously General Counsel for Willis Group Holdings and Managing Director, Global Head of Regulatory Affairs, for Morgan Stanley. As Chief of the Investment Protection Bureau for Attorney General Eliot Spitzer from 1999 to 2003, he spearheaded probes into Wall Street conflicts-of-interest, which led to more than 40 major civil and criminal cases. He led the Bureau through the beginning of the mutual fund industry investigations.

Prior to his service with the Attorney General, Mr. Dinallo served as an Assistant District Attorney in the New York County District Attorney's office from 1995 to 1999, where he prosecuted repeat felony offenders, as well as securities fraud, white-collar crime and insider trading. From 1990 to 1991, Mr. Dinallo served as a clerk for the Honorable David M. Ebel of the United States Court of Appeals, Tenth Circuit in Denver, and from 1991 to 1995, he was a litigator with the law firm of Paul, Weiss, Rifkin, Wharton & Garrison in Manhattan.

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

Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

May 15, 2007

To the Legislature:

I am pleased to submit to the New York State Legislature the 148th Annual Report of the Superintendent of Insurance for Calendar Year 2006. As required by Article 2, Section 206 of the Insurance Law, this report contains detailed information about both the Department's activities and the condition of the insurance industry in New York. In addition, this report describes the Superintendent's separate and distinct activities as receiver of insolvent estates through the New York Liquidation Bureau.

The New York State Insurance Department has a rich history and a unique role among regulatory agencies. We are the nation's oldest independent insurance regulator and we are headquartered in the world's financial capital. We face a future with unprecedented regulatory opportunities and challenges. The issues of principles-based regulation, terrorism risk insurance, catastrophe risk insurance, workers' compensation reform, universal health insurance and financial services reform will occupy us all in the months ahead.

Yet the mission of this Department remains unchanged. Our obligation is to protect the public and to foster the sound, prudent growth of the insurance industry. The Department will strive to ensure that customers, both individuals and businesses, are fully informed, have access to the insurance products they need at reasonable prices and are treated fairly in the claims process. The Department will work equally hard to ensure that there is a favorable climate in New York for the insurance industry to prosper and grow by implementing innovative regulations within an efficient, common-sense regulatory framework. These are consistent and achievable goals.

On a personal note, my nomination by Governor Spitzer and confirmation by the Senate were among the proudest moments of my life. I eagerly look forward to working closely with the Governor, the Legislature and the members of the New York State Insurance Department to address the important insurance issues that affect us all as New Yorkers.

Regards,

Eric R. Dinallo
Superintendent

I. Major Developments

STRONG CONSUMER PROTECTION IN AN OPEN & COMPETITIVE MARKETPLACE

The mission of the New York State Insurance Department is to protect the public interest by ensuring the sound, prudent conduct of insurer financial operations. The Department worked diligently throughout 2006 to meet that obligation to the people of New York State. The purpose of this document is to provide the Legislature with detailed information on the activities of the Department and its bureaus in 2006, as well as to report on the general condition of the insurance industry.

This Department's major efforts to promote consumer protection and encourage a fair, transparent and competitive marketplace included:

- Investigating and aggressively prosecuting fraud and misconduct by insurance businesses, an effort that led to fines and restitution orders totaling nearly $2 billion. In addition, this effort resulted in sweeping corporate governance and financial reporting reforms in several major insurance organizations.

- The on-going campaign to battle auto insurance fraud and overhaul the regulatory environment affecting this market, which has provided premium savings for millions of New York motorists and has caused the assigned risk plan to drop to record lows.

- Pursuing proactive initiatives, such as the expansion of the Healthy NY medical insurance program and the launch of the Department's Mobile Command Center, to respond more effectively to the needs of New Yorkers.

- Actively promoting the continued creation of captive insurance organizations in New York to strengthen our standing as the global financial leader and generate jobs and a larger tax base for the Empire State.

Office of General Counsel

LITIGATION RESOLVED & CORPORATE REFORMS INITIATED

The Department, along with federal and other state regulators, resolved litigation and investigations of market misconduct against American Insurance Group (AIG) in February.

The company agreed to pay $1.6 billion in fines and restitution to injured investors, customers and states. Led by a new management team, the company acknowledged past misconduct and adopted groundbreaking reforms to ensure fairness and transparency in its business practices.

Separate investigations of Zurich Financial Services and ACE led to fines and restitution of more than $233 million, along with commitments to implement business reforms aimed at eliminating misconduct and ensuring fairness to consumers.

Charges of customer steering, bid-rigging and improper finite reinsurance transactions against St. Paul Travelers were resolved when the insurer agreed to pay $77 million in restitution and penalties and adopt reforms to give consumers access to more information about insurance transactions.

Title Insurance Rate Reduction for Home Buyers

Home buyers across the state benefited when the Department approved a 15% reduction on title insurance premiums on purchase transactions up to $1 million for the five largest title insurers in the state. The action affects approximately 93% of the New York market.

The rate reductions were the result of a wide-ranging investigation of the title industry that began in 2005. The investigation revealed allegations of illegal rebating, which likely drove up the cost of purchasing homes.

The investigation uncovered evidence of real estate developers receiving free or discounted title insurance in other states in exchange for giving their New York business to the settling insurance companies.

The major title insurers in the state agreed to end these illegal practices and the Department launched a further study of the issue with the goal of developing an action plan for comprehensive title insurance reform.

Insurance Frauds Bureau

VIGOROUS ANTI-FRAUD ACTIVITIES

Bureau investigations and litigation led to more than 600 insurance fraud arrests and the payment of more than $8.5 million in fines and restitution. Many of these investigations involved sophisticated conspiracies involving medical clinics, physicians, other health care professionals and attorneys.

In one case, indictments were lodged against 17 people and three corporations for an elaborate no-fault insurance fraud scheme uncovered during a 20-month investigation by the Bureau, Attorney General Eliot Spitzer and the New York City Police Department.

In another case, an investigation by the Bureau, the Attorney General and a number of other state and federal agencies ended a multi-million dollar residential mortgage fraud scheme and led to the arrest of eight suspects. In another 38 cases, insurers realized savings of nearly $1.5 million as the result of Bureau investigations into fraudulent claims.

The Bureau launched its web-based Fraud Reporting and Case Management system to enhance the effectiveness and accuracy of fraud reporting. Now being tested, this new system automates virtually all of the Bureau's principal tasks. Case management and statistical tracking for analysis will now be computerized in a format that allows the Bureau to capture and preserve case information, images and documents in a more comprehensive manner. Full implementation of the system is scheduled to occur in early 2007.

Fraud investigations in 2006

1,101 new cases opened

274 cases referred for criminal actions

54 cases referred for civil actions

In combating fraud, personnel from the Department's New York City headquarters, as well as from the Bureau's seven satellite offices, continued to team with federal, local and other state authorities.

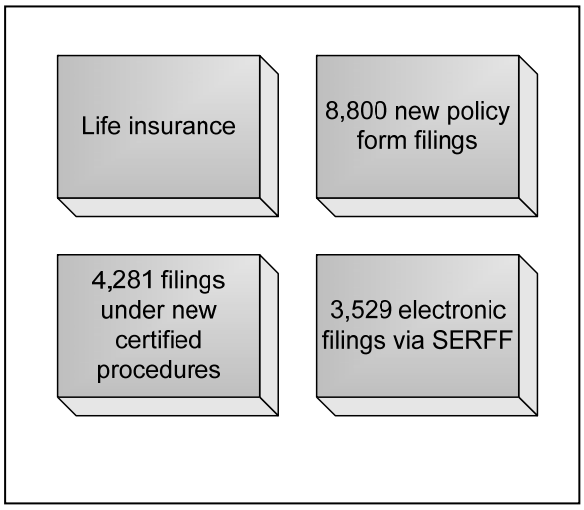
Life Bureau

FASTER NEW PRODUCT INTRODUCTIONS

The Life Bureau continued to work with the insurance industry to bring new, innovative products and features to New York consumers and to get these products into the marketplace more quickly.

The Bureau encouraged insurers to use new changes in the submission and approval processes for life insurance and annuity policy forms. During the year, the Bureau received approximately 8,800 policy forms. Of the 8,476 forms processed by the Bureau, 4,281 were filed under the new certified procedures. The processing of these forms was completed in an average of 47 days. Also in 2006, the insurance industry's use of the National Association of Insurance Commissioners-sponsored SERFF (System for Electronic Rate and Form Filing), which allows the Bureau to accept electronic form filings, continued to expand. By the end of the year, insurers had submitted 3,529 policy forms through SEFFF.

The Bureau continued to see a significant number of variable annuity contract submissions containing guaranteed living benefits (VAGLBs). While guaranteed living benefits make variable annuities attractive to risk-averse consumers, the benefits are complex and difficult for consumers to understand and require sophisticated risk management skills to limit insurer risk. The Department has significant concerns with exposure to market risk for products with guaranteed living benefits.



The Bureau continued to be heavily represented in the activities of NAIC, particularly in creating a framework for a new principles-based approach to reserve and capital standards.

Risks inherent in some new innovative products require sophisticated risk management systems. The Bureau is working closely with industry to develop appropriate risk management standards.

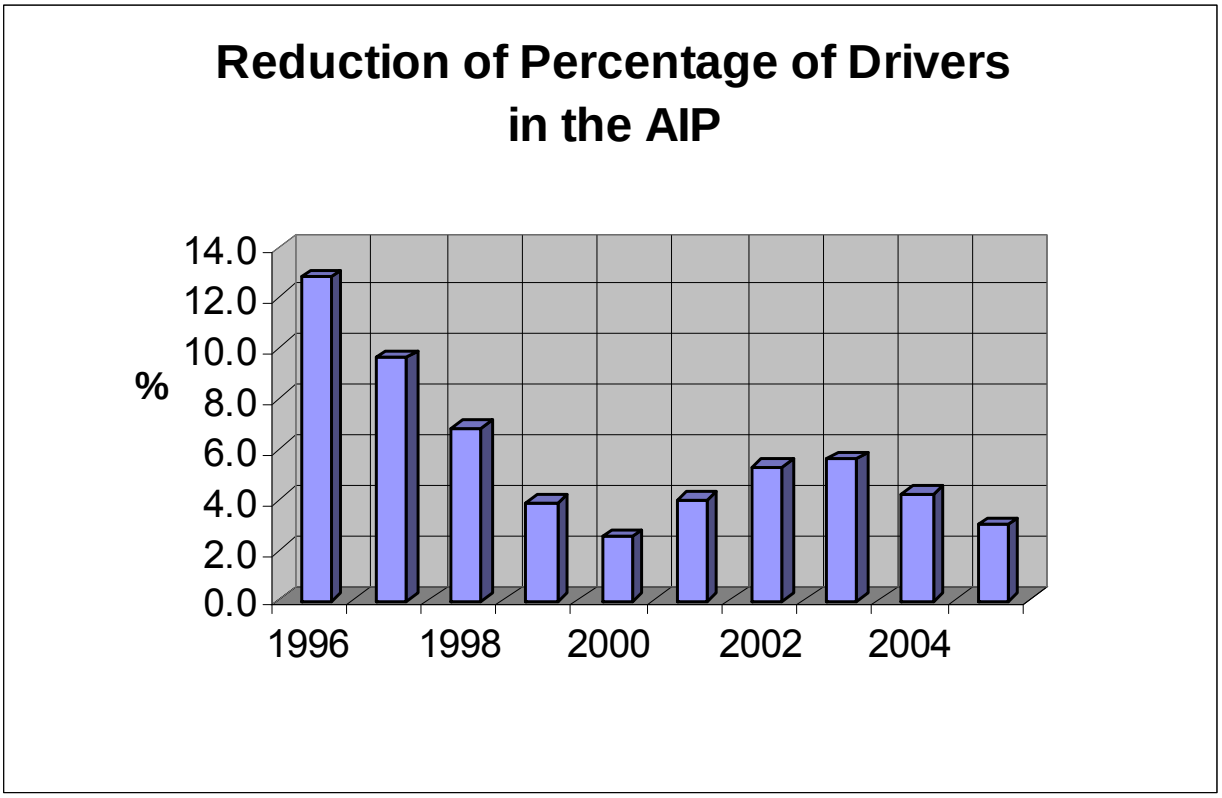
Property Bureau

CONTINUED RATE CUTS BENEFIT MOTORIST

New York motorists continued to experience savings in 2006 based on reduced automobile insurance rates, the result of the Department's strong scrutiny of the marketplace and regulatory changes related to the Assigned Risk Plan.

On an overall basis, car insurance rates declined 2%. These reduced insurance rates affected more than 62% of the state's auto insurance market, saving millions of dollars for New York drivers. Based on filings with the Department, Geico, the state's largest auto insurer, reduced its rates 4.2%, while State Farm Mutual Automobile Insurance, the state's third largest insurer, reduced its rates 6.5%.

This was the third consecutive year that auto insurance rates dropped. While the overall decrease in 2006 was not as large as in 2005, the declining rates demonstrate the health and competitiveness of the auto insurance market in New York. One of the factors contributing to rate reductions has been the continued decline in the number of insured drivers in the New York Automobile Insurance Plan (AIP). The population of the plan is now near its historic low point. Today, the number of drivers assigned to the risk pool is less than a third of the 1.1 million drivers in the pool 10 years ago.



Health Bureau

HEALTHY NY ENROLLMENT GROWS

The highly successful Healthy NY program continued to help previously uninsured New Yorkers obtain affordable health insurance. New enrollments grew at a rate that averaged nearly 7,300 a month. Enrollment in Healthy NY increased 22.5% compared to enrollment in 2005.

Healthy NY's 2006 annual study found that the program offers savings of up to 45% when compared to other small group products and more than 70% compared to the individual direct payment market.

There was a 15% increase in requests for reviews under New York's External Appeal Program compared to 2005. A total of 867 appeals were upheld, 712 overturned and 111 overturned in part. The program gives New Yorkers the right to a review by independent medical experts when their health plan denies services deemed not medically necessary, experimental or investigational. Since the start of the program in 1999, the Department has received nearly 15,000 requests for external appeals.

The State Coverage Initiatives, a program of the Robert Wood Johnson Foundation, called ***Healthy NY*** *"a model program for other states." The Department has been contacted for information about the program by more than 15 states, as well as national health care organizations, government officials and research groups.*

The Bureau evaluated innovations proposed by health insurance plans to contain the rising cost of prescription drug coverage. These proposals included:

- The use of special pharmacies for select high cost drugs.
- Implementation of "step therapy" programs requiring initial use of lower cost alternative drugs.

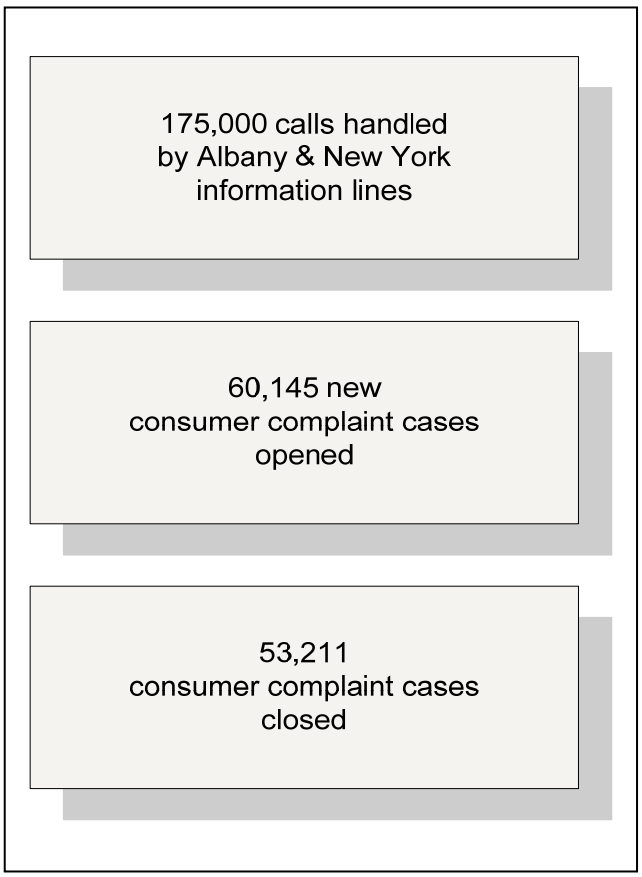
Consumer Services Bureau

EFFICIENTLY PINPOINTING PROBLEM AREAS

The Bureau responded to 175,000 calls on its Albany and New York City information lines. These calls were received through the Bureau's call-tracking system that stores and sorts data, permitting managers to more easily determine patterns in the calls being received. This capability allows the Bureau to pinpoint problems in specific areas of the state to determine the severity of problems, enabling the Department to more efficiently direct its resources.

The Bureau also maintains a toll-free line with access to a multi-lingual telephone service capable of translating 140 languages. In addition, the Bureau also maintains toll-free lines dedicated to the New York State Partnership for Long Term Care and for use as a disaster hotline.

The Bureau led an investigation into the marketing practices in connection with the sale of Medicare supplemental insurance policies based on complaints received from the New York State Department for the Aging. The investigation led to a $300,000 fine against American Progressive Life and Health Insurance Company of New York and several of its agents.



Assisting Consumers with Part D Coverage

Considerable resources were devoted to assisting senior citizens and groups concerned with the Medicare Part D program. The Bureau conducted numerous information sessions throughout the state to help the public better understand the nuances of new Medicare Part D program, which subsidizes drug costs.

Capital Markets Bureau

ASSESSING RISKS IN CAPITAL MARKETS

The Bureau's activities included providing risk management examination support, applying financial analysis to insurer investment portfolios and evaluating the corporate governance and risk management practices of select insurers.

The Bureau, in conjunction with the Life Bureau, worked to establish processes to evaluate the diverse investments held by the sizable public retirement systems in the state. This included developing and enhancing key measures and reviewing standards related to risk-based capital, risk management and asset-liability management.

During the year, the Bureau:

- Performed investment portfolio reviews on insurance companies selected for "Priority One" desk audits by the Life, Property and Health Bureaus.

- Conducted extensive evaluations of several companies whose measurements or investment parameters varied from their sector's norms.

A key to the regulation of capital markets activities is assessing what capital markets risks the insurer has and how it measures and manages those risks.

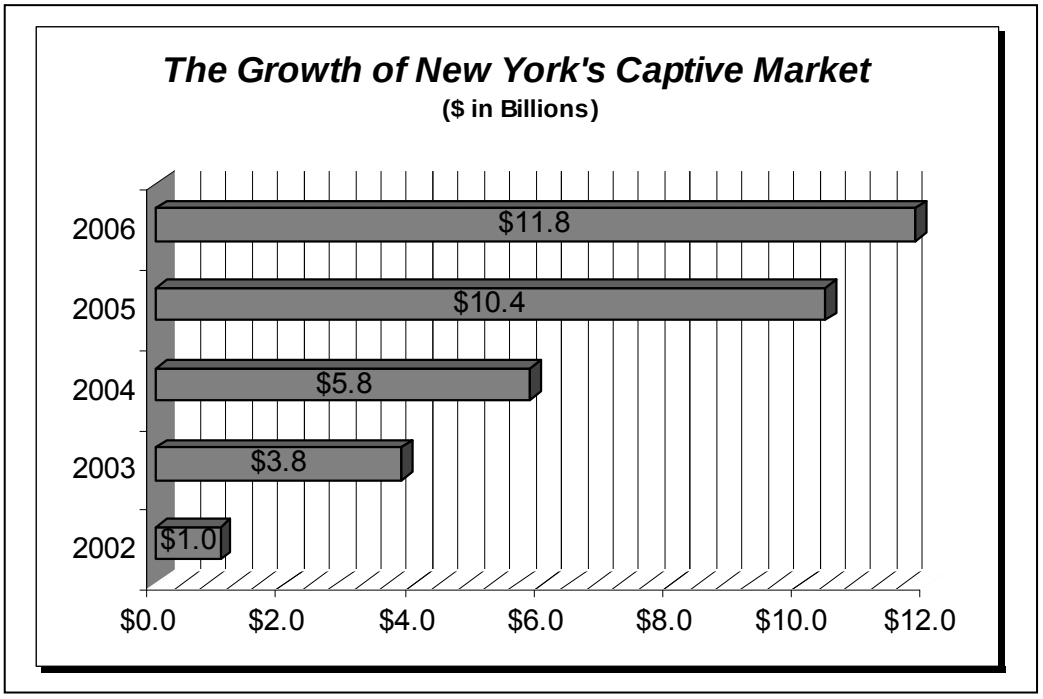
Captive Insurance Group

EXPANDING AN ATTRACTIVE MARKETPLACE FOR CAPTIVE INSURERS

Enhancing the appeal of New York State as an attractive home for captive insurance business continued to be a key goal of the Captive Insurance Group.

The group, a dedicated team responsible for licensing captive insurers, proposed a number of revisions to current law to correct obstacles to the formation of captives in the state. These proposals included:

- Reducing the threshold level for a parent to form a pure captive from $100-million to $25-million of net worth or annual revenue.
- Providing flexibility for the Superintendent to approve other thresholds if the parent company demonstrates that it is otherwise qualified to form and operate a captive.
- Allowing public entities, such as municipalities and authorities, to form pure or group captives.

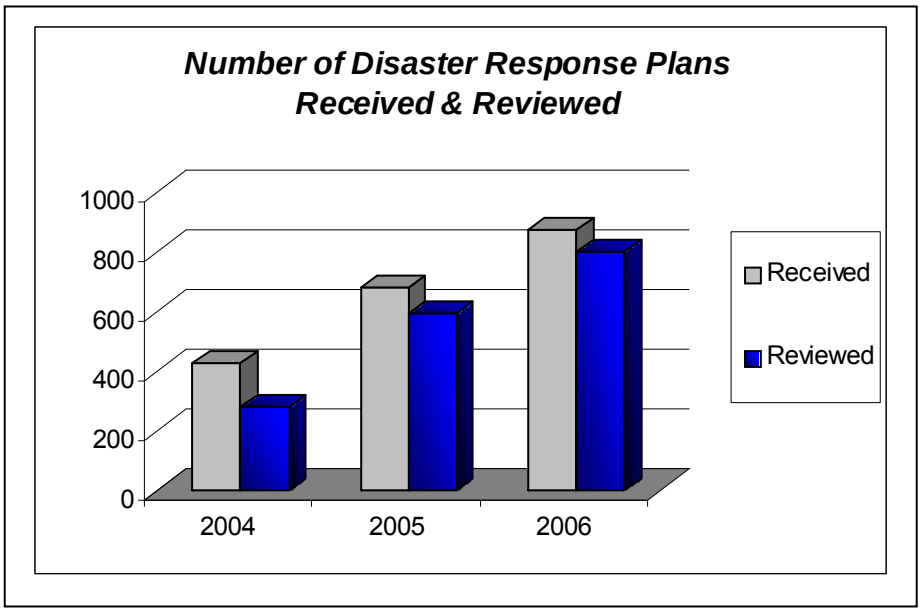


As of December 31, 2006, there were 39 captive insurance companies authorized in New York with assets of $11.8 billion.

Disaster Preparedness & Response Bureau

PROACTIVE STEPS FOR EMERGENCY READINESS

The Disaster Preparedness and Response Bureau received 429 new disaster response plans from insurance companies in 2006. The Bureau reviewed 263 plans and forwarded follow-up letters to 204 companies requesting updates and amendments to their plans. In addition, the Bureau received 199 renewal statements for plans previously submitted and requiring updates.



The Bureau documented the functionality of the West Workspace, a web-based communications tool for storing mission-critical data and providing a virtual online meeting room where Department staff can continue business operations during emergencies.

Information Systems & Technology

EXPANDED ON-LINE ACCESS FOR INTERNAL & EXTERNAL CUSTOMERS

The Bureau drove the Department's E-commerce initiatives aimed at expanding the number of transactions that can be accomplished using the internet.

The result is that the public at large, as well as other external and internal customers of the Department, may now accomplish transactions quickly and seamlessly.

Department bureaus now process hundreds of thousands of transactions on behalf of customers without touching paper forms, handling checks or making manual bank deposits. Many of these types of transactions, which once required weeks to complete, are now completed overnight.

www.ins.state.ny.us

4,249,058

Number of visits to NYSID website

25%

The percentage of increase in website visits from the previous year

Department Mini-Websites

Captive Insurance www.nycaptives.com
Healthy NY www.healthyny.com
Interactive HMO Guide www.nyshmoguide.org

Liquidation Bureau

HELPING PRESERVE LONG ISLAND'S OLDEST INSURANCE COMPANY

The New York Liquidation Bureau assists the Superintendent in his private role as New York State Supreme Court-appointed receiver, and not in his public role as insurance regulator. The Bureau acts as receiver of impaired or insolvent insurance companies to maximize assets and resolve liabilities, and then return rehabilitated companies to the marketplace or distribute the proceeds of liquidating companies to creditors and policyholders.

The Bureau completed its rehabilitation of the Interboro Mutual Indemnity Insurance Company in early 2007, setting the stage for the oldest insurance company on Long Island to return to solvency under the management of new investors.

The successful rehabilitation marked the first demutualization of an insurance company in rehabilitation in New York. Nearly 70 jobs were preserved as a result of the rehabilitation. During the rehabilitation, the Bureau took over the management of the company, conducted its business and removed the causes and conditions that made the rehabilitation proceedings necessary.

Creditors' Claims Addressed

The Bureau disbursed more than $50-million to the creditors of Midland Insurance Company, an insolvent insurance estate.

The creditors, which included Fortune 500 companies, were paid on claims arising from asbestos, environmental hazards, HIV-tainted blood, breast implants and other cases stemming from incidents that occurred decades ago.

II. Review of New York State Insurance Business

A. LIFE BUREAU

1. Licensed Life Companies

There were 141 life insurance companies licensed to transact business in New York State as of December 31, 2006. The total admitted assets of licensed life insurers amounted to approximately $2.19 trillion at December 31, 2005 a ten-year gain of 78.9%. Bonds totaled $999.8 billion; stocks $59.7 billion; mortgage loans $163.1 billion; real estate $12.3 billion; policy loans $56.9 billion, and short-term holdings $11.7 billion. Other admitted assets totaled $884.1 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $815.4 billion on December 31, 2005, an increase of 87.4% since 1995. Insurance in force at December 31, 2005 of $4.97 trillion represents an increase of 83.4% since December 31, 1995.

3. Organizations Under Life Bureau Supervision

The Life Bureau supervised 488 organizations as of December 31, 2006. These organizations consisted of: 141 licensed life insurance companies — 82 domiciled in New York and 59 foreign; 39 fraternal benefit societies — 4 domiciled in New York, 34 foreign and 1 United States Branch of a Canadian Society; 12 retirement systems — 4 private pension funds and 8 governmental systems; 9 governmental variable supplements funds; 211 charitable annuity funds; 24 employee welfare funds; 7 viatical settlement companies and 45 accredited reinsurers. Unless otherwise noted, tables and related data for life insurance companies refer to the **nationwide** operations of insurers licensed to do business in the State.

Table 1
ADMITTED ASSETS
Life Insurance Companies Licensed in New York State
Selected Years, 1995-2005
(dollar amounts in billions)

Admitted Assets	2005	2004	2000	1995
Total	$2,187.6	$2,080.6	$1,652.4	$1,222.6
Percent increase from 1995	78.9%	70.2%	35.2%	---
Type of asset				
Bonds	$999.8	$957.2	$661.6	$566.8
Stocks	59.7	61.1	54.1	39.6
Mortgage Loans	163.1	159.6	141.0	142.6
Real Estate	12.3	12.3	16.1	32.4
Policy loans/liens	56.9	56.1	55.1	58.9
Short-term holdings	11.7	14.8	28.1	21.1
Other	884.1	819.5	696.4	361.1

Note: Detail may not add to totals due to rounding.
Source: New York State Insurance Department

Table 2
BALANCE SHEET
Life Insurance Companies Licensed in New York State
Selected Years, 2000-2005
(in billions)

	2005	2004	2000
Assets	$2,187.6	$2,080.6	$1,652.4
Liabilities	2,067.5	1,963.3	1,562.9
Capital & Surplus	120.1	117.3	89.5

Source: New York State Insurance Department

Table 3
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1995-2005
(dollar amounts in billions)

Class of Business	2005	2004	2000	1995
Total insurance in force	$11,684.5	$11,138.7	$8,852.3	$6,914.6
Percent increase from 1995	69.0%	61.1%	28.0%	---
Ordinary	$6,340.3	$6,205.3	$4,803.8	$3,626.8
Group	5,274.9	4,864.4	3,977.5	3,206.1
Credit	63.0	62.6	63.9	73.9
Industrial	6.3	6.4	7.1	7.8

Source: New York State Insurance Department

Table 4
SOURCES OF INCOME*
Life Insurance Companies Licensed in New York State
Selected Years, 2000-2005
(dollar amounts in millions)

	2005		2004		2000	
Source of Income	**Amount**	**Percent of Total**	**Amount**	**Percent of Total**	**Amount**	**Percent of Total**
Group life	$18,071.4	6.0%	$16,620.5	5.5%	$15,116.2	4.3%
Group annuities	68,973.0	22.7	63,695.8	21.1	100,386.4	28.3
Group A & H	24,721.8	8.2	23,390.8	7.8	21,034.4	5.9
Ordinary life	43,212.4	14.2	45,302.9	15.0	45,642.5	12.9
Individual annuities	52,054.9	17.2	55,777.7	18.5	41,892.5	11.8
Individual A & H	5,662.6	1.9	4,860.9	1.6	4,485.9	1.3
Credit life	327.5	0.1	260.9	0.1	287.1	0.1
Industrial life	58.0	0.0	131.9	0.0	229.9	0.1
Total Premiums	**$213,081.6**	**70.3%**	**$210,041.4**	**69.6%**	**$229,074.9**	**64.6%**
Supplementary contracts	432.1	0.1	421.9	0.1	9,840.4	2.8
Net investment income	79,022.3	26.1	74,817.4	24.8	71,875.9	20.3
Other income	10,760.2	3.5	16,396.8	5.4	43,811.5	12.4
TOTAL	**$303,296.2**	**100.0%**	**$301,677.5**	**100.0%**	**$354,602.6**	**100.0%**

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

Table 5
OPERATING RESULTS*
Life Insurance Companies Licensed in New York State
Selected Years, 2000-2005
(in millions)

	2005	2004	2000
Total premiums	$211,347.3	$207,341.1	$229,074.9
Investment income	79,022.3	74,817.4	71,875.9
Supplementary contracts	432.1	421.9	9,840.4
Other income	12,494.5	19,097.2	43,811.5
Total income	$303,296.2	$301,677.5	$354,602.6
Net gain from operations	16,674.9	13,159.7	12,312.9
Net income	$19,668.7	$13,851.5	$13,239.2

*As of 2001, deposit type funds and supplementary contracts without life contingencies are no longer classified as income.
Source: New York State Insurance Department

Table 6
LIFE INSURANCE IN FORCE IN THE STATE OF NEW YORK
Life Insurance Companies Licensed in New York State
Selected Years, 1995-2005
(dollar amounts in billions)

Insurance In Force	2005	2004	2000	1995
Total	$1,662.9	$1,514.3	$1,190.0	$829.2
Percent increase from 1995	100.5%	82.6%	43.5%	---
Class of business				
Ordinary	$1,007.8	$937.9	$694.8	$501.7
Group	647.6	568.9	488.2	319.5
Credit	7.0	6.9	6.2	7.0
Industrial	0.6	0.6	0.8	.9

Source: New York State Insurance Department

Table 7
ADMITTED ASSETS/INSURANCE IN FORCE
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1995-2005
(dollar amounts in billions)

Domestic Life Insurers	2005	2004	2000	1995
Admitted assets	$815.4	$772.8	$585.7	$435.2
Percent increase from 1995	87.4%	77.6%	34.6%	---
Insurance in force	$4,972.6	$4,582.2	$3,345.2	$2,712.0
Percent increase from 1995	83.4%	69.0%	23.3%	---

Source: New York State Insurance Department

4. Licensed Fraternal Benefit Societies

At the close of 2005, 41 fraternal benefit societies were licensed to conduct insurance business in New York State. Of these, 4 were domestic, 36 were foreign and 1 was an alien society. In the ten-year period ending December 31, 2005, the admitted assets of licensed societies rose from $43.9 billion to $76.0 billion, an increase of 73%. Insurance in force rose $83.1 billion over the period to $296.6 billion, an increase of 39%.

Table 8
FRATERNAL BENEFIT SOCIETIES
Selected Years, 1995-2005
(in billions)

Fraternal Benefit Societies	2005	2004	2000	1995
Admitted assets	$76.0	$73.9	$55.9	$43.9
Insurance in force	$296.6	$289.0	$255.9	$213.5

Source: New York State Insurance Department

5. Private Retirement Systems

At the close of 2005, four private retirement systems were under the supervision of the Life Bureau.

The four systems, which are private pension funds of nonprofit organizations, were made subject to Insurance Department regulation by special legislative enactments. At the end of 2005, the assets of these four private pension funds totaled approximately $195 billion. The following table shows data for the private pension funds for selected years from 1995 to 2005:

Table 9
PRIVATE PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1995-2005
(in millions)

Private Pension Funds	2005	2004	2000	1995
Total admitted assets	$195,083.7	$183,482.7	$173,411.7	$84,830.0
Payments to annuitants and beneficiaries	$13,922.2	$11,573.9	$11,103.5	$3,243.1

Source: New York State Insurance Department

6. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Life Bureau at the close of 2005 are governmental systems that provide retirement, death and disability benefits to the employees of New York State and those of its political subdivisions that have elected to provide such benefits to their employees. The aggregate assets of the eight governmental systems as of the end of their respective fiscal years ending in 2005 were approximately $304 billion. During the period from 1995 to 2005, the assets of these retirement systems increased at the compound rate of 5.8% per year.

The governmental retirement systems cover a total of 2.0 million active and retired members. The number of active employees in the public retirement systems in 2005 increased by 13% from its 1995 level, while the number of pensioners increased by 27% over the same period. The substantial increase in pensioners, as compared with a lesser increase in the work force, reinforces the need for maintaining adequate actuarial reserves.

The New York City Administrative Code provides for nine active nonpension funds known as variable supplements funds, financed by the transfer of earnings from the equity portfolios of the New York City Police and Fire Department Pension Funds and the Employees' Retirement System. If at any time the earnings so transferred are insufficient, the City guarantees the payment of the variable supplements benefits. These variable supplements funds provide retirement benefits in addition to those received from the pension funds and the retirement system. The variable supplements funds, all of which are under the supervision of the Insurance Department, had assets as of June 30, 2005 totaling $3.2 billion.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1995 to 2005:

Table 10
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1995-2005
(in millions)

Public Retirement Systems & Pension Funds	2005	2004	2000	1995
Total admitted assets	$304,141	$288,771	$322,561	$172,314
Payments to annuitants and beneficiaries	$16,402	$15,454	$10,964	$7,422

Source: New York State Insurance Department

Pursuant to Section 314 of the New York Insurance Law and to various other governing chapters of law, the Department regularly conducts on-site examinations of every public employee retirement system in New York.

A multitude of laws governs New York's public employee retirement systems, including unconsolidated laws citable only by chapter number and year of enactment. To the extent practical, the Department has, for the past several years, been maintaining a searchable computer database of those laws.

Pursuant to Section 207 of the Insurance Law, the Department is currently in the process of developing a new form of annual statement for reports by the retirement systems to the superintendent. A major objective of the new statement will be an enhanced capability to ascertain the systems' ability to meet their obligations and to forecast significant changes in future employer contribution levels. The new annual statement will include the capability, which may eventually become a requirement, for electronic filing.

7. Segregated Gift Annuity Funds for Charitable Organizations

At the end of 2005, 199 charitable annuity societies held permits under Section 1110 of the Insurance Law. In return for, or conditioned upon, the receipt of gift funds, such organizations agree to pay an annuity to the donor, or a nominee. These agreements must provide to the issuer, upon the death of the annuitant, a residue equal to at least one-half the original gift or other consideration for such annuity. In the ten-year period ending December 31, 2005, admitted assets of these funds increased by 348% and the annual payments increased by 405%. This reflects the rapid growth in the number of licensed societies during the period.

Table 11
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1995-2005
(in millions)

Segregated Gift Annuity Funds	2005	2004	2000	1995
Total admitted assets	$1,861.5	$1,720.4	$956.0	$420.4
Annual payments to annuitants	$163.7	$153.1	$83.9	$32.4

Source: New York State Insurance Department

8. Employee Welfare Funds

Twenty-four employee welfare funds covering 91,386 employees were supervised by the Life Bureau at the close of 2005. These funds are jointly administered by management and labor representatives. The employee welfare funds cover government employees for benefits financed by contributions from New York governmental authorities. Government employee welfare funds were not pre-empted by the federal Employee Retirement Income Security Act of 1974 (ERISA) as most private pension funds were.

Contributions to employee welfare funds amounted to $201.3 million in 2005. Benefits paid totaled $191.9 million and included life insurance; medical, surgical and hospital coverage; major medical coverage; optical, dental and prescription drug plans; disability insurance, and legal services. Administrative expenses totaled $8.5 million representing 4.2% of contributions.

9. Viatical Settlement Companies

Regulation 148 and Article 78 of the Insurance Law became effective as of July 6, 1994 for the purpose of regulating viatical settlement companies and brokers. At the end of 2005, seven companies were licensed or authorized to act as viatical settlement companies in New York.

As of December 31, 2005, these companies had combined assets of $42.3 million, with the largest accounting for $22.6 million. The assets primarily consisted of life insurance policies purchased, cash and accounts receivable. Costs of purchasing these policies amounted to $12.6 million, which comprised about 74.6% of the $16.9 million total face value.

The amounts reported for licensed viatical settlement companies have decreased dramatically (in 2001, nine viaticals had combined assets of $433 million) due to the fact that the viatical settlement company with the largest New York market share surrendered its license in 2002.

10. Examinations Conducted in 2006

Table 12
EXAMINATIONS CONDUCTED
Life Bureau
2006

		Regularly Scheduled		Other	
		Initiated			
	Total	In 2006	Prior to 2006	Special	On Organi-zation*
Life insurance companies	28	17	11	0	0
Fraternal benefit societies	2	2	0	0	0
Retirement systems and pension funds	1	0	1	0	0
Segregated gift annuity funds of charitable organizations	14	14	0	0	0
Viatical settlement companies	0	0	0	0	0
Welfare funds	1	1	0	0	0
Total	**46**	**34**	**12**	**0**	**0**

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

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 2006, there were 488 companies that were licensed or accredited to conduct business in New York State, as detailed below. These companies are required to file their Annual Statements for audit and analysis.

Table 13
COMPANIES LICENSED BY THE LIFE BUREAU
December 31, 2006

Life – New York	82
Life – Other States	59
Accredited Reinsurers	45
Fraternals – New York	4
Fraternals – Other States	34
Fraternals – Canadian, U.S. Branch	1
Charitable Annuities	211
Retirement Systems	21
Viaticals	7
Welfare Funds	24
Total	**488**

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

b. New York Supplements to the Annual Statements

New York Supplements to the Life and Accident & Health Annual Statement and the Fraternal Benefit Society Annual Statement were developed for use beginning with the 1986 Annual Statement filing. The Supplements for 2006 were updated to meet current needs and requirements. Copies of the Supplements are now distributed through the Department's Web site to all life companies and Fraternal Benefit Societies licensed to do business in New York State.

12. Real Estate Review

During 2006, the real estate unit submitted nine reports relative to the valuation and condition of real estate related assets held by companies under examination.

In addition, recommendations were made in connection with real estate acquisitions, valuations, real estate related capital expenditures and leases between members of holding company systems.

13. Actuarial Submissions and Reviews

The actuarial staff of the Life Bureau reviews submissions made by licensed life insurance companies and fraternal benefit societies to secure the Insurance Department's approval of separate account plans of operation for individual and group annuity and for variable life insurance products; methods of allocation of investment income by annual statement lines of business and by product lines; synthetic guaranteed investment contracts ("synthetic GIC's"); and plans of operation and actuarial projections in connection with the licensing of a company, merger of two or more companies or acquisition of control of one company by another.

The actuarial staff also reviews company filings mandated by Section 4228 of the Insurance Law, which deals with expense limitations, agent compensation plans, agent training allowance plans and expense allowance plans. Numerous filings are required under Section 4228. An all-electronic filing option using Lotus Notes, implemented in 2002, remains available. Its use remained steady during 2005, approximately 16% of filers having used the all-electronic route.

The actuaries evaluate the actuarial aspects of life insurer demutualizations and reorganizations of foreign insurers as mutual holding companies. Those have been relatively few in number but extremely time consuming. Among other things, this work involves the selection of legal, investment banking and actuarial consulting firms, ongoing monitoring of their work and evaluation of their final work product. Follow-up work is also required after such reorganizations take place, mainly to assure fair treatment of the policyholders who existed prior to the reorganization (sometimes referred to as the "closed block"). During 2006 such follow-up work was conducted with respect to three domestic insurers and a foreign insurer.

Members of the Actuarial Unit participate in on-site examinations scheduled by the Field Examinations Unit to ascertain the organizations' actuarial practices.

The actuaries perform the required regulatory functions concerning the various New York State and New York City public employee retirement systems, each of which is governed by different chapters of

law (mainly New York State Retirement and Social Security Law, New York State Education Law and New York City Administrative Code). In 2004 it was decided to organize a separate Pension Unit with a staff devoted full time to pension issues. During 2005 the Pension Unit undertook various activities and initiatives that are still ongoing related to the public employee retirement systems, including on-site field examinations of several systems and the development of a new form of annual statement.

Separate account submissions continued to comprise the majority of filings reviewed by the actuarial staff. Many of those submissions involved the addition of various protections and guarantees, including guarantee of principal (on withdrawal, not just on death), guaranteed minimum annuitization amounts and other variations. Such guarantees may help accommodate the public's desire to avoid risk in separate account products, but they also create increased financial risk for the insurer. The Bureau continues to evaluate the degree of this risk and to consider possible enhanced reserve standards on these so-called Guaranteed Living Benefits.

Submissions under New York's Agent Compensation Law (Section 4228) comprised the second greatest number of actuarial filings again in 2006. The agent compensation law helps make insurance more affordable for the consumer and helps protect insurers' financial solvency by placing a limit on sales-related expenses. It leads to a more orderly marketplace for insurance by discouraging the overly aggressive recruitment of one insurer's agents by another insurer.

Submissions related to company mergers and acquisitions continued to increase during 2006. That is indicative of continuing merger and acquisition activity, as has been reported in the industry press. The Life Bureau evaluates the financial and market impact of proposed mergers and acquisitions, and generally requires the submission of actuarial projections that are analyzed by the New York City Actuarial Unit.

We received no submissions during 2006 related to synthetic GIC's. Since the Department first approved the issuance of synthetic GIC's in 1995, there has been little marketplace demand for the product.

During 2006 the Actuarial Unit began participating in the analysis and review of reinsurance contracts. With the ever-increasing complexity of reinsurance arrangements, actuarial analysis is needed, particularly to help ascertain the existence (or lack of existence) of a bona fide transfer of risk.

Toward the end of 2006 a reorganization of the New York City Actuarial Unit was undertaken with the goal of facilitating closer coordination with the actuarial units in the Albany office in the evaluation of capitalization and solvency. Some reserve and cash flow analysis will now be handled in the New York office, at first mainly for foreign insurers.

14. Life Bureau – Albany

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

In 2006, the Life Bureau received 1,809 policy form submissions (files) consisting of 8,799 life insurance, annuity, funding agreement and other policy forms offered by life insurance companies, fraternal benefit societies, charitable annuity societies and viatical settlement companies as indicated in Table 14 below. Of the 8,799 policy forms received in 2006, 48.8% were submitted under a certified filing procedure (Circular Letter No. 6 (2004) or Section 3201(b)(6) of the Insurance Law), 15.8% were submitted for out-of-state use and 35.3% were submitted for full review and approval.

In 2006, the Life Bureau processed a total of 1,696 policy form submissions (files) consisting of 8,476 policy forms as indicated in Table 14. Of the 8,476 forms processed in 2006, approximately 34.8% were submitted for prior approval, 48.8% were submitted under a certified filing procedure and 15.9% were filed for out-of-state use. Of the prior approval files disposed in 2006, approximately 61% of the forms were approved or filed and 32% were either rejected or withdrawn. Of the certified files disposed in 2006, approximately 68.7% of the forms were approved or filed and 30.4% were either rejected or withdrawn. Of the out-of-state files disposed in 2006, approximately 73.4% of the forms were approved or filed and 21.5% were either rejected or withdrawn.

Table 14
NUMBER OF FILES & POLICY FORMS
RECEIVED AND PROCESSED BY TYPE
LIFE BUREAU, 2006

PRODUCT TYPE	RECEIVED		PROCESSED	
	Files	Forms	Files	Forms
Individual Life	765	3,336	719	3,392
Group Life	150	936	151	962
Individual Annuity	456	1,522	409	1,375
Group Annuity	306	1,996	284	1,808
Credit Insurance	11	53	13	73
Viatical Settlement	3	27	2	40
Miscellaneous	118	929	118	826
TOTAL	1,809	8,799	1,696	8,476

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

b. Review of Actuarial and Other Form-Related Filings

In conjunction with the policy form approval process, the Life Bureau received 624 other filings related to the policy form approval process and products offered for sale in New York, including 41 rate and actuarial filings, 138 inquiries and complaints, 69 FOIL requests, 15 prefilings under Circular Letter No. 64-1, 47 compensation filings and 102 annual illustration certification filings.

Table 15
POLICY FORM-RELATED FILINGS RECEIVED IN 2006

Fraternal Benefit Societies (Constitution, Articles of Incorp., Bylaws, etc.)	5
Calculation of Life Estates	15
Circular Letter No. 64-1	15
Compensation Filings	47
FOIL Requests	69
Inquiries & Complaints	138
Rate & Actuarial Filings	41
Violations & Market Conduct	176
Informational Filing	16
Regulation 74 Illustration Certification Filings	102
Total	**624**

c. Speed to Market

During 2006, the Life Bureau continued to assist insurers in bringing products to market as quickly as possible. Detailed product outlines are available on the Department's Web site and are periodically updated. In 2006, the Life Bureau posted the updated NY Specific Transmittal Instructions as well as other filing guidance. The Life Bureau has encouraged insurers to utilize the certified filing procedures authorized by Section 3201(b)(6) of the Insurance Law and Department Circular Letter No. 6 (2004).

During the year, the Life Bureau received 1,044 Circular Letter No. 6 (2004) certified files consisting of 4,281 policy forms. In addition, the Life Bureau received 10 deemer filings authorized by Section 3201(b)(6) consisting of 21 policy forms. The 1,044 certified filings (and 4,281 forms) constitute 57.7% of all files and 48.8% of all forms submitted for sale in New York.

During the year, the Life Bureau processed 3,845 Circular Letter No. 6 (2004) policy forms in an average of 47 days. Of the total 3,845 Circular Letter No. 6 (2004) policy forms, approximately 2,639 were approved, 1,068 were rejected and 101 were withdrawn.

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

d. Post-Approval Review

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

The Life Bureau has implemented a screening process to prioritize the certified approved files for post approval review. The highest priority is assigned to files with new, innovative or controversial features or files that raise solvency, consumer protection or market competition concerns. This screening process will help to make the Life Bureau more aware of the products currently being offered in the marketplace.

e. SERFF

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

During the year, the life insurance industry's use of SERFF has continued to expand. At the start of 2006, there were 102 life insurance companies using SERFF to make policy form submissions. During 2006, another 25 companies used SERFF for the first time. In 2006, insurers submitted 783 files, consisting of 3,529 policy forms through SERFF. This total represents approximately 43.3% of all policy form filings and 40.4% of all policy forms submitted in 2006. Continued growth both in the number of insurers using SERFF as a submission platform and in the percentage of filings made through SERFF is expected.

f. Section 3201 Revision for Out-of-State forms.

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

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

The Life Bureau had ongoing discussions with the industry and the Life Insurance Council of New York (LICONY) in 2006 to develop the appropriate format and content for the required annual report. This is expected to be finalized in early 2007.

g. Section 4240(d)(2) Revision for Variable Annuities

During 2006, Life Bureau staff in cooperation with the Life Insurance Council of New York (LICONY) drafted legislation to amend Section 4240(d)(2) of the Insurance Law. The amendment became effective on July 26, 2006. The amendment to Section 4240(d)(2) conforms New York law to the requirements imposed by the Securities and Exchange Commission (SEC) as to the calculation of interest on death benefits for variable annuity contracts and certificates.

The amendment to Section 4240(d)(2) of the Insurance Law requires that payment of death benefits under variable annuity contracts and certificates be made within seven calendar days following the insurer's receipt of the beneficiary's completed election form. If the insurer fails to pay death benefits within this time period, interest must be computed daily beginning at the end of the seven day period. In addition, the amendment to Section 4240(d)(2) provides that interest shall be computed from the earlier of the date an action is commenced or the insurer receives the beneficiary's completed election form to the date the verdict is rendered or the report or decision is made or the date the settlement is reached.

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

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

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

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

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

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

To date, the Life Bureau has approved six accelerated death benefit forms using the "long term care trigger" under either section 1113(a)(1)(C) or 1113(a)(1)(D). In addition, there are four such submissions currently under review in the Life Bureau.

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

Section 3205 of the Insurance Law sets forth the requirements for what constitutes an insurable interest for purposes of being able to procure a contract of insurance upon the life of another person. This statute reflects the State's public policy against contracts which wager on human life. Section 3205(a)(1)(B) has long been interpreted to permit an employer to insure the lives of its *key* employees because the employer has a lawful and substantial economic interest in the continued life, health or bodily safety of such employees. In 1996, the Legislature added subsections (d) and (e) to Section 3205 to permit employers to insure the lives of *rank-and-file* as well as *key* employees under corporate-

owned life insurance programs designed to fund employee benefit plans. However, to prevent abuses associated with corporate-owned life insurance covering rank-and-file employees (commonly referred to as *janitors insurance* or *dead peasant insurance*), subsections (d) and (e) provided employees with notice, consent and termination rights in connection with such coverage. Notably, the notice, consent and termination rights apply only where the employer insures rank-and-file employees but not where the employer insures key employees.

On October 11, 2006, proposed Regulation 180 was published in the state register. Regulation 180 establishes standards for life insurers issuing key person COLI to ensure that employees or other persons on whose lives coverage is being written pursuant to Section 3205(a)(1)(B) are actually key persons, as opposed to rank-and-file employees. Consequently, Regulation 180 will help to ensure that rank-and-file employees and other non-key employees receive the notice, consent and termination rights prescribed by Section 3205(d). The Regulation defines a key person as an employee who (1) is one of the five highest paid officers of the employer, (2) is a 5% owner of the employer, (3) had compensation from the employer in excess of $90,000 in the preceding year, (4) is among the highest paid 35% of all employees, or (5) makes a significant economic contribution to the company. The definition of key employee in Regulation 180 is based substantially on the definitions of highly compensated individual and highly compensated employee in Sections 105(h)(5) and 414(q) of the Internal Revenue Code. Similarly, the Pension Protection Act of 2006 relies on the same definitions. The Act creates a new subsection to the Internal Revenue Code exempting from tax death proceeds paid to employers with respect to highly compensated employees and highly compensated individuals.

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

For the last several years, national attention has been focused on improper life insurance sales practices on military installations. Such practices included the sale of life insurance at a much higher premium than the federal government sponsored Service Members' Group Life Insurance (SGLI), with such insurance often marketed as an investment and under inappropriate or unsuitable circumstances. In response, federal legislation was proposed in successive Congresses. On September 29, 2006, the Military Personnel Financial Services Protection Act was signed into law as Public Law No. 109-290. Although it does not appear that many of the improper practices occurred in New York, the Life Bureau will work, as needed, with the National Association of Insurance Commissioners and the Department of Defense to curb such improper sales and practices and to implement the aforementioned legislation.

l. Guaranteed Living Benefits – Update

During 2006, the Life Bureau continued to see a significant number of variable annuity contract submissions containing guaranteed living benefits (VAGLBs). The guaranteed living benefits make variable annuities more attractive to risk adverse consumers by mitigating market losses in the variable sub-accounts. The guaranteed living benefits in deferred variable annuity contracts generally provide for guaranteed minimum account values during the accumulation phase (GMAB) or guaranteed minimum income benefits upon annuitization (GMIB) or guaranteed minimum withdrawal benefits (GMWB). The manner in which the benefit is calculated and the restrictions on the benefit vary from insurer to insurer. The benefits are complex and difficult for consumers to understand and require sophisticated risk management skills to limit insurer risk. Several insurers have approached the Department with product concepts that would wrap mutual funds with similar guarantees. The Department has significant concerns with exposure to market risk for all products with guaranteed living benefits.

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

such, this limitation does not serve as an effective deterrent to excessive risk exposure in variable products.

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

As indicated above, variable annuity contracts with guaranteed living benefits are accelerating the insurance industry's exposure to a stock market downturn. When the 2001 market downturn occurred, the vast majority of the variable annuity products being offered did not contain guaranteed living benefits. At that time, most variable annuity contracts only included a guaranteed minimum death benefit. Most of the variable annuity contracts with guaranteed living benefits in 2001 were still in the seven-to-ten-year waiting period, and thus only a few companies were affected. As the market has been rising in the past few years, companies selling these products have been reporting high profits, which has created incentives to increase their share of the market in this area. Given five years of increased sales (about $10 billion of VAGLBs are currently sold in the U.S. every week) and increased aggressiveness in the guarantees, the Department is very concerned about this risk exposure to the life industry. Due to the lack of availability of reinsurance for these products and the high cost to hedge these risks in the capital markets using options, most insurers have turned to dynamic hedging programs. The Department is concerned that such programs may not work as planned under severe market conditions. In order to address these concerns, the Department has been pursuing strong reserve, minimum capital and corporate governance requirements for these products at the NAIC, in addition to performing in depth examinations of insurers' reserves, capital, and risk management practices with respect to these products.

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

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

The proposed amended regulation was exposed for comment and based on those comments changes were made that require a second exposure. The Department expects to promulgate the amended regulation in 2007.

n. Viatical Settlements and Life Settlements

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

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

During 2006, the Life Bureau worked extensively on the drafting of comprehensive legislation that would replace the existing Article 78, authorize the Department to regulate the life settlement industry as well as the viatical settlement industry and establish standards governing both industries. The Bureau met on many occasions with representatives of the life insurance industry and the life settlement industry to discuss their concerns and to ensure that any proposed legislation would address the Department's significant public policy and regulatory concerns and provide appropriate consumer protections. In late fall of 2006, a bill was considered by the legislature but has not gone forward. (It is noted that in the proposed legislation, the term "viatical settlement" is used to encompass both insureds who have a catastrophic or life threatening illness or condition and insureds who do not have such an illness or condition, i.e. life settlements.)

o. Product Innovations

In 2006 the Life Bureau continued to work with the industry to bring new and innovative products and features to New York. The following are some of the innovative products or features addressed in 2006.

- Return of Premium Life Insurance – Return of Premium Life Insurance is term insurance in which the insurer promises to return all premiums paid if the insured does not die during the term.

- Paid-up Deferred Annuity Contracts – The Life Bureau has approved paid-up deferred annuity contracts which do not provide cash surrender benefits. Such contracts have been marketed as "longevity insurance" because the guaranteed lifetime income payments typically begin at age 80 or 85. The annuity is typically funded with a single premium while the individual is in his or her 60's.

- Limitation on Coverage in COLI market – The Department has approved limitation on coverage provisions for two group corporate owned life insurance (COLI) policies. The provision limits life insurance coverage if on a single date the aggregate net amount at risk payable with respect to deaths of covered persons (within 90 days of such event) at a single location (the employer's place of business) exceeds the cap amount ($50 million and $150 million). The limitation on coverage provision was necessary to make group COLI policies available in the New York metropolitan area where the high concentration of risk served to make reinsurance unaffordable, if at all available. The limitation on coverage is necessary in the COLI / BOLI context to ensure that the total amount of insurance coverage would not exceed the projected benefit costs of the employee benefit plan. In the COLI / BOLI context, the corporation owns the policy and has all incidents of ownership. Employees do not receive a certificate and have no rights or benefits with respect to such coverage, other than the notice, consent and termination rights afforded by Section 3205(d). As such, employees / plan participants and their beneficiaries have no expectations with respect to such insurance coverage.

- Monthly Debit Ordinary Policies – Monthly Debit Ordinary (MDO) policies are low face amount life insurance policies where the premium is collected by the agent generally at the home of the policy owner. The premiums for these policies include an additional charge for providing the premium collection service. The Department recently permitted the issue amount limitation on these policies to increase from $10,000 to $25,000 provided the insurer gives acceptable disclosure to the consumer on the added cost involved with the purchase of such policies. It is anticipated that there will be some decrease in the premium rate per $1,000 of insurance, reflecting the higher average face amount used in the company's pricing. There is only one life insurer in New York currently active in the debit life insurance market.

- Substandard Annuities – The Life Bureau has received a number of policy form submissions and inquiries regarding the use of substandard underwriting for immediate annuities. We have determined that such annuities can be written in New York on a basis similar to that permitted for structured settlements annuities. As with structured settlements annuities, substandard underwriting for annuities must be limited to individually underwritten cases and to individuals with serious health impairments based upon medical information submitted to the insurer and an evaluation of a person's medical condition and life expectancy by an underwriter of the insurer. Substandard annuitants must have demonstrable health problems that can result in shorter life expectancy. Underwriters can either "age-rate" up the applicant's age [1] or adjust the mortality factors according to the impaired risk based on the applicant's medical records.

p. Trade Practices

In 2006, the Life Bureau continued to analyze issues related to trade practices of insurers doing business in New York. The following are some of those issues:

- Suitability – During 2006, the Life Bureau continued to monitor the National Association of Securities Dealers and their actions relative to suitability standards for the sale of variable insurance products. The National Association of Securities Dealers has proposed Rule 2821 which consists of recommendation requirements including a suitability obligation, principal review and approval requirements and supervisory and training requirements for deferred variable annuities. The proposed rule was submitted to the Securities and Exchange Commission on November 20, 2006 and is awaiting approval.

- Future Travel – In 2004, the Legislature enacted §2614 of the insurance law prohibiting discrimination because of past lawful travel. The issue relative to future travel plans, however, remains an issue. In 2006, the Life Bureau continued to monitor this issue. Some states have made it an unfair trade practice to prohibit discrimination based upon either past or future lawful travel.

- Discretionary Clauses – During 2006, Life Bureau staff worked with Health Bureau staff to draft Circular Letter No. 14 (2006) which raises the Department's concerns with the use of discretionary clauses in life and accident and health insurance contracts. Circular Letter No. 14 superseded Circular Letter No. 8 (2006) which the Health Bureau issued in early 2006. During 2006, Life Bureau staff also worked with Health Bureau staff to draft a regulation prohibiting the use of discretionary clauses in life and accident and health insurance contracts. A discretionary clause is a provision in an insurance contract that grants an insurer, plan administrator or claims administrator the discretionary authority to determine eligibility for benefits, resolve disputes, interpret the terms and provisions of the

[1] In underwriting these annuities, the age of the annuitant is adjusted to reflect the biological or physiological age of the individual (rather than the chronological age).

insurance contract or develop standards of interpretation or review. Similar action has been taken in other states and has been adopted in a model act by the National Association of Insurance Commissioners. The Life Bureau, along with the Health Bureau, the Office of General Counsel and the Governor's Office of Regulatory Reform, has met with industry representatives to discuss the draft regulation.

- Premium Financing and Insurable Interest – There has been much discussion during the last year about the propriety of insurers asking applicants for insurance about their current or future plans to use premium financing. The Department has received input from and has had discussions with representatives of the life insurance industry, the life settlement industry and the premium finance industry regarding the types of premium financing questions that may be asked on life insurance applications. In addition, the Department participated in a public hearing of the NAIC Life Insurance and Annuities (A) Committee addressing this issue held in May 2006 in New York City. Based on all of the information the Bureau has received and is considering, including developments at the NAIC and in other states, the Life Bureau is in the process of developing a guidance document to address these issues.

- NBCR Exclusion – The Government Accountability Office surveyed the state regarding statutes or regulations governing the use of coverage exclusions for losses resulting from nuclear, biological, chemical or radiological (NBCR) events, in particular, whether the Life Bureau has permitted such exclusions in life insurance policies and whether any insurers have sought to impose a surcharge for providing coverage for losses due to NBCR events. Section 3203(b)(1) of the Insurance Law sets forth the only permitted exclusions or restrictions on liability for individual life insurance. NBCR exclusions are not authorized under section 3203(b)(1). Accordingly, the Life Bureau would not permit such exclusions for individual life insurance. With respect to group life insurance, since section 3203 does not apply to group insurance, the Department would have to review such exclusions on a case by case basis. No insurers have approached the Department regarding the possibility of using such exclusions. The Department is not aware of any insurers seeking to surcharge for coverage of NBCR events.

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

q. Group Life Insurance Working Group

In 2006, the Life Bureau reached out to the industry and the Life Insurance Council of New York (LICONY) seeking to establish a joint Industry/Department working group to discuss some of the major issues in the area of group life insurance. Meetings are scheduled to commence in early February of 2007. Topics of discussion include legislative revisions for sections 3220 and 4216 as well as the extension of statutory individual protections to group certificate holders where the group certificate holder pays all or a portion of the premium.

r. Market Conduct Review of Non-Guaranteed Elements

Interrogatories on non-guaranteed elements in Exhibit 5 of the 2005 Annual Statements were reviewed for 149 life insurers. Thirteen of the reviews resulted in contacting the company for additional information on the board criteria required by law for setting non-guaranteed elements and examples of illustrations and communications with respect to non-guaranteed elements. Problems with regulatory requirements related to board criteria, communication on adverse changes and use of reasonable assumptions (bait and switch) were discovered and are being addressed through fines and remedies.

Based on OGC opinion 01-06-30, review of non-guaranteed elements based on Circular Letter No. 18 (1980) and Circular Letter No. 4 (1983) were discontinued at the policy form prior approval stage. It is much more important to have clear guidance on compliance when compliance is reviewed after the fact. The Department is currently engaged with the industry in an effort to clarify guidance, especially on the content of board criteria for non-guaranteed elements. These clarifications will be codified in a regulation which the Department is developing.

s. Principles-based valuations and "Corporate Governance for Risk Management"

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

In light of these needs, the Department is taking a leading position at the NAIC to develop a model act and a model regulation for "Corporate Governance for Risk Management". The NAIC forum facilitates the Department's ability to get input on drafting proposals and develop feedback on the proposals. The NAIC has exposed drafts of both the model act and model regulation. However, the Department is not constrained by the content or time frame of NAIC documents and will make recommendations after appropriate development.

t. Statutory Examinations

The Reserve and Risk Management Actuaries in the Life Bureau continue to expand their analysis of life insurers' risks from the traditional review of minimum statutory formula reserves and high-level asset/liability matching toward in-depth analysis of scenario-based cash-flow testing and other principles-based methods. Principles-based methods are defined as being based on assumptions set by the insurer. Where assumptions are justified based on credible experience data, the Bureau relies on the company's analysis in establishing additional actuarial reserves. However, for example, when Long Term Care reserves are based on assumptions that are less than fully credible experience or unsubstantiated actuarial judgment, the Bureau has insisted on more conservative assumptions and this has lead to additional reserves in some cases.

This type of in-depth analysis, including sensitivity testing of policyholder behavior and investment assumptions, has proven to effectively determine an insurer's susceptibility to deteriorating economic conditions and has resulted in several insurers restructuring their asset portfolios to better support company obligations. In addition, the Bureau's analysis has also led to the establishment of extra reserves for insurers with significant exposure to various kinds of risk including mortality, morbidity, persistency, investment, and general economic exposure. Expanded analysis in the areas of self-

support and overall risk management has led to insurers making more informed decisions on continuing sales of unprofitable business.

In 2006, the Bureau continued to be heavily represented in the activities of the NAIC, particularly in creating a framework for a new principles-based approach to reserve and capital standards. The current law specifies a standard of a principles-based asset adequacy analysis reserve with a formulaic floor. At the NAIC level, there is a movement toward eliminating the formulaic floor. In 2006, the Bureau participated in an NAIC group that reviewed insurers' reports associated with new principles-based minimum capital standards for Variable Annuities with Guaranteed Benefits. The review showed that tight restrictions are needed at the current time to ensure solvency, auditability, and consistency in principles-based standards. These conclusions are similar to the Bureau's viewpoints after the review of principles-based asset adequacy analysis over the past several years. Because a change in the law will be required to eliminate the current formulaic floor and to create a proper framework for additional reliance on principles-based standards, the Bureau is working with the NAIC to create interim steps to offer reserve relief to insurers that are selling life insurance policies mainly to preferred underwriting classes.

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

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

All of these efforts materially improved the Bureau's risk-based examination focus during 2006. Going forward, the Bureau will continue efforts to further improve its focus on the timely identification of risks faced by the insurance industry.

u. Reinsurance Issues

In 2006, the Bureau raised concerns regarding the use of collateral requirements for unauthorized reinsurance, particularly as it relates to risk-based capital requirements. The ability of insurers to manipulate the balance sheet and true financial condition via potentially unrecoverable reinsurance payables continues to be a major weakness in the current solvency framework.

B. PROPERTY BUREAU

1. Entities Supervised by the Financial Regulation Division

As of December 31, 2006, the Financial Regulation Division side of the Property Bureau exercised regulatory authority over 1,112 insurer entities and risk retention groups.

The Bureau regulated 1,029 insurer entities as of year-end 2006. Table 16 provides a breakdown.

Table 16
ENTITIES REGULATED BY PROPERTY BUREAU
2006

Number of Regulated Entities	Type of insurer/reinsurer/entity
83	Accredited reinsurers*
19	Advance premium co-operatives
25	Assessment co-operatives
10	Associations, pools, and syndicates
39	Captive insurers
14	Financial guaranty insurers
26	Mortgage guaranty insurers
1	Property Insurance Underwriting Association (FAIR Plan)
775	Property/casualty insurers
28	Title insurers (including two accredited reinsurers)
9	United States branches

* Lloyd's of London (Lloyd's), included as an accredited reinsurer, is comprised of individual underwriting syndicates, each of which must meet the requirements for recognition as an accredited reinsurer. As of December 31, 2006, the Department recognized 53 Lloyd's syndicates as active accredited reinsurers.

In addition, the Bureau oversaw the operation of 83 risk retention groups in 2006.

The Property Bureau received 27 applications for licensing and 6 applications for recognition as accredited reinsurers during 2006. Thirty-three insurers were newly licensed including 3 domestic stock insurers, 2 domestic title insurers, 1 foreign title company, 1 domestic reciprocal insurer and 26 foreign stock insurers. At the close of the year there were domestic applications pending for 4 domestic stock companies, 1 domestic title company and 1 domestic mutual company. There were also 27 foreign stock insurers including 2 foreign title insurers, 1 foreign mortgage guarantee insurer, 1 financial guarantee insurer and 1 foreign US Branch which had license applications pending with the Department. In addition, there were 8 applications for accredited reinsurer status.

2. Property and Casualty Business

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

a. Premium Volume and Surplus to Policyholders

Net premiums written during 2005 by all New York-licensed property and casualty insurers aggregated totaled $294.9 billion, of which 76.9% represented stock company writings. As noted previously, the following underwriting and investment results deal with the nationwide business of New York licensed companies:

Table 17
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Property and Casualty Insurers Licensed in New York State
2000-2005
(dollar amounts in millions)

	Stock Companies				Mutual Companies			
Year	No. of Cos.	Net Premiums Written (during year)	Surplus/ Policy-holders (end of year)	Ratio of Premiums to Surplus	No. of Cos.	Net Premiums Written (during year)	Surplus/ Policy-holders (end of year)	Ratio of Premiums to Surplus
2000	683	160,173	168,969	0.9	74	57,305	85,206	0.7
2001	710	178,615	175,383	1.0	75	57,015	72,721	0.8
2002	737	205,017	181,615	1.1	78	62,576	63,789	1.0
2003	706	221,356	203,973	1.1	72	66,070	66,315	1.0
2004	698	234,377	213,611	1.1	73	67,294	86,319	0.8
2005	713	226,808	253,849	0.9	71	68,113	93,736	0.7

Source: New York State Insurance Department

b. Underwriting Results

Results for 2005 show a net underwriting loss of $6.1 billion for stock companies and a net underwriting loss of $1.6 billion for mutual companies.

Table 18
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State
2002-2005
(dollar amounts in millions)

Year		Stock Companies		Mutual Companies	
		Number of Companies	Amount	Number of Companies	Amount
2002	Underwriting gains	167	$2,617.3	18	$740.7
	Underwriting losses	480	22,285.4	60	6,759.6
	No gain or loss	90	0.0	0	0.0
2003	Underwriting gains	248	$6,476.8	26	$1,426.5
	Underwriting losses	360	13,116.1	46	1,827.8
	No gain or loss	98	0.0	0	0.0
2004	Underwriting gains	280	$12,261.4	43	$3,247.3
	Underwriting losses	275	10,744.8	30	1,213.2
	No gain or loss	143	0.0	30	0.0
2005	Underwriting gains	326	$10,548.4	46	$1,820.2
	Underwriting losses	295	16,672.2	25	3,430.9
	No gain or loss	92	0.0	0	0.0

Source: New York State Insurance Department
Detail may not add to totals due to rounding.

c. Investment Income and Capital Gains

Investment income and net capital gains for stock and mutual companies from 2002 to 2005 are as follows:

Table 19
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
2002-2005
(in millions)

Year		Stock Companies	Mutual Companies
2002	Net investment income	$26,794.6	$5,366.4
	Realized capital gains	4,350.8	-2,168.6
	Unrealized capital gains	-17,405.1	-6,969.4
	Net gain/loss from investments	$13,740.4	-$3,771.7
2003	Net investment income	$24,348.0	$5,142.8
	Realized capital gains	2,559.7	0.8
	Unrealized capital gains	15,159.3	8,783.1
	Net gain/loss from investments	$42,067.1	$13,926.6
2004	Net investment income	$23,802.5	$5,288.7
	Realized capital gains	4,556.6	1,555.8
	Unrealized capital gains	8,625.8	4,225.8
	Net gain from investments	$36,984.8	$11,070.2
2005	Net investment income	$29,263.4	$5,903.2
	Realized capital gains	3,005.0	455.6
	Unrealized capital gains	1,473.3	3,902.9
	Net gain from investments	$33,741.7	$10,261.7

Source: New York State Insurance Department

d. Underwriting and Investment Exhibit

During 2005, dividends to stockholders amounted to $13.4 billion, while dividends to policyholders aggregated to $1.2 billion (for both mutual and stock insurers). The contribution to surplus for 2005 for stock companies was $12.5 billion compared with $7.5 billion for 2004. However, the net increase in surplus for stock companies in 2005, $20.2 billion, was lower than the comparable $22.3 billion 2004 increase. Likewise, the net change in surplus for mutual companies was $7.8 billion in 2005, down from $10.7 billion a year earlier. Net income decreased slightly for stock companies and net income decreased substantially for mutual companies between 2004 and 2005.

Table 20
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Property and Casualty Insurers Licensed in New York State
2004 and 2005
(in millions)

	Stock Companies		Mutual Companies	
	2005	**2004**	**2005**	**2004**
Net gain or loss from:				
Underwriting	-$6,123.8	$1,516.6	-$1,610.7	$2,034.2
Investments [a]	32,268.4	28,359.0	6,358.8	6,844.5
Other income	-520.0	-457.3	633.5	186.7
Net gain or loss	$25,624.5	$29,418.3	$5,381.7	$9,065.3
Less:				
Dividends to policyholders	489.7	492.3	745.9	772.2
Federal income taxes incurred	3,758.0	7,062.2	1,021.4	2,175.2
Net income	**$21,377.0**	**$21,865.2**	**$3,614.3**	**$6,117.9**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-$13,378.5	-$13,024.1	$0.0	$0.0
• Stock	-4.0	-45.4	0.0	0.0
US Branches – Net remittance to/from home office	-1.0	-11.0	0.0	0.0
Total dividends and remittance	-$13,383.6	-$13,080.5	$0.0	$0.0
Unrealized capital gains/losses	1,473.3	8,625.8	3,902.9	4,225.8
Cumulative effect of changes in accounting principles	142.6	57.9	-269.4	0.0
Miscellaneous items	-1,949.7	-2,666.3	587.5	325.0
Contributions to surplus	12,532.3	7,505.6	1.8	0.1
Total other sources	-$1,185.0	$442.6	$4,222.8	$4,550.9
Net increase or decrease in surplus	**$20,192.0**	**$22,307.8**	**$7,839.1**	**$10,670.8**

[a] Excludes unrealized capital gains.
Source: New York State Insurance Department

e. Selected Annual Statement Data

From 2002 to 2005 aggregate (i.e., stock and mutual) net premiums written increased by 10.1%; admitted assets increased by 19.2%; unearned premium and loss reserves increased by 20.9%; and other liabilities decreased by -37.8%. Capital and surplus to policyholders increased by 39.8%.

Table 21
SELECTED ANNUAL STATEMENT DATA
Property and Casualty Insurers Licensed In New York State
2002-2005
(dollar amounts in millions)

	2005	2004	2003	2002
		Stock Companies		
Number of insurers	713	698	706	737
Net premiums written	$226,808	$234,377	$221,356	$205,017
Admitted assets	739,827	675,485	623,466	626,595
Unearned premium & loss reserves	441,511	231,701	375,852	356,381
Other liabilities	41,925	14,021	43,067	88,631
Capital	3,912	2,292	4,767	5,209
Surplus to policyholders	253,849	213,611	203,973	181,615
		Mutual Companies		
Number of insurers	71	73	72	78
Net premiums written	$68,113	$67,294	$66,070	$62,576
Admitted assets	207,656	195,595	180,141	165,464
Unearned premium & loss reserves	85,708	81,789	79,687	77,708
Other liabilities	28,212	27,487	25,407	23,967
Surplus to policyholders	93,736	86,319	66,315	63,789

Source: New York State Insurance Department

f. Direct Premiums Written, by Line

There was an increase in property/casualty writings in New York State in 2005 as direct premiums written for all property/casualty lines increased by 5%. Major lines, i.e., those with greater than $1 billion premium written in 2005, with at or above average year-to-year increases in 2005 included workers' compensation, homeowners multi-peril, and medical malpractice.

Table 22
DIRECT PREMIUMS WRITTEN BY PROPERTY/CASUALTY INSURERS
New York State — 2001-2005[1]
(dollar amounts in millions)

Property and Casualty Lines	2001	2002	2003	2004	2005	Percentage Change 2001-2005	Percentage Change 2004-2005
All Premiums Written	$26,047	$29,588	$31,347	$30,747	$32,387	24%	5%
Private Passenger Auto	9,018	9,913	10,554	10,684	10,262	14%	-4%
Bodily Injury and Property Damage Liability	6,040	6,718	7,247	7,304	6,968	15%	-5%
Comprehensive and Collision	2,978	3,195	3,307	3,380	3,294	11%	-3%
Commercial Auto	1,755	1,985	2,167	2,191	2,080	19%	-5%
General (Other) Liability	2,447	3,478	3,741	4,018	3,997	63%	-1%
Workers' Compensation	3,283	3,412	3,403	1,928	3,758	14%	95%
Commercial Multi-Peril	2,349	2,688	2,779	2,897	2,958	26%	2%
Homeowners' Multi-Peril	2,469	2,662	2,901	3,174	3,427	39%	8%
Financial Guaranty[2]	664	1,006	1,153	1,105	1,090	64%	-1%
Medical Malpractice	858	945	1,027	1067	1,128	31%	6%
Inland Marine	607	660	690	734	707	16%	-4%
Accident and Health	498	473	426	383	372	-25%	-3%
Ocean Marine	404	469	440	583	551	36%	-6%
Fire	334	411	442	432	455	36%	5%
Fidelity and Surety	380	358	433	427	433	14%	2%
Allied Lines	173	256	312	289	278	61%	-4%
Mortgage Guaranty	203	231	231	231	231	14%	0%
Product Liability	140	162	165	158	179	28%	13%
Boiler and Machinery	76	91	87	85	78	3%	-8%
Aircraft	56	78	141	71	96	72%	36%
Credit	39	40	40	42	48	23%	16%
Burglary and Theft	9	8	10	14	14	62%	1%
All Other[3]	286	263	205	233	244	-15%	4%

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

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

[2] Includes monoline and non-monoline insurers.

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

g. Audit and Analysis

The 2005 Annual Statements of the companies authorized to transact business in the State of New York were filed for audit and analysis in 2006, as were those of reinsurers accredited in this State. Issues arising during the audits were resolved with the companies. As a result of the audits, some filed statements were adjusted to bring reported figures into compliance with New York requirements.

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

h. State Insurance Fund

All purchases and sales of stocks and bonds by the State Insurance Fund are subject to the approval of the Superintendent of Insurance. During 2006, the State Insurance Fund acquired stocks and bonds totaling $24.2 billion and sold stocks and bonds totaling $13.0 billion. Upon review, the Property Bureau recommended the approval of the acquisitions of $24.2 billion and the sales of $13.0 billion. In 2005, the Bureau recommended approval of acquisitions totaling $21.2 billion and sales totaling $14.5 billion.

i. CPA-Audited Financial Statements

NYIL Section 307(b) requires licensed insurers to file an annual financial statement, certified by an independent certified public accountant (CPA), on or before May 31 of each year. CPA-audited financial statements were received and reviewed for 907 companies in 2006. There were 54 companies entitled to exemption from the filing requirements.

j. Public Inspection of Records

The Financial Division of the Property Bureau provides public access to various Insurance Department documents pursuant to the Freedom of Information Law (FOIL). In 2006, 398 FOIL requests to review and copy records maintained by the Financial Division were received from members of the public.

k. Holding Company-Related Transactions

Pursuant to Article 15 of the New York Insurance Law and Department Regulation 52, the Property Bureau is responsible for the review and approval of transactions within holding company systems. During 2006, 130 holding company transaction files, and 210 holding company registration statements and amendments, were reviewed and closed by the Property Bureau. In addition, 18 notices of acquisition of control of domestic insurers were reviewed and closed by the Property Bureau.

3. Financial Guaranty Insurance

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

As of December 31, 2005, there were 8 domestic and 6 foreign financial guaranty insurers licensed in New York.

Table 23
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Financial Guaranty Insurers Licensed in New York State, 2002-2005
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2002	2,670.8	9,403.9	0.28
2003	3,360.7	10,794.2	0.31
2004	3,089.1	11,357.0	0.27
2005	2,979.8	13,046.5	0.23

Source: New York State Insurance Department

Table 24
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State, 2002-2005
(dollar amounts in millions)

Year		Number of Companies	Amount
2002	Underwriting gains	8	$970.3
	Underwriting losses	5	$28.1
2003	Underwriting gains	9	$1,301.1
	Underwriting losses	5	$26.2
2004	Underwriting gains	9	$1,219.0
	Underwriting losses	4	$96.5
2005	Underwriting gains	8	$1,404.6
	Underwriting losses	6	$60.5

Source: New York State Insurance Department

Table 25
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State, 2002-2005
(in millions)

	2005	2004	2003	2002
Net investment income	$1,477.6	$1,253.7	$1,092.1	$1,125.1
Realized capital gains	35.7	115.9	159.0	168.8
Unrealized capital gains	102.2	52.2	124.1	51.3
Net gain from investments	$1,615.5	$1,421.8	$1,375.1	$1,345.3

Source: New York State Insurance Department

Table 26
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Financial Guaranty Insurers Licensed in New York State
2002-2005
(in millions)

	2005	2004	2003	2002
Net gain or loss from:				
Underwriting	$1,344.1	$1,122.5	$1,274.9	$942.1
Investments [a]	1,513.3	1,369.5	1,251.0	1,294.0
Other Income	22.7	6.1	13.0	15.7
Net gain or loss	$2,880.1	$2,498.2	$2,538.9	$2,251.8
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	706.1	620.4	727.8	578.2
Net income	**$2,174.0**	**$1,877.8**	**$1,811.1**	**$1,673.6**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-656.8	-880.3	-623.9	-442.2
• Stock	0.0	0.0	0.0	0.0
Total dividends and remittance	-$656.8	-$880.3	-$623.9	-$442.2
Unrealized capital gains	102.2	52.2	124.1	51.3
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	11.1
Miscellaneous items	-726.2	-464.0	-346.5	-361.9
Contributions to surplus	620.7	226.3	607.1	220.8
Total other sources	-$660.1	-$1,065.8	-$239.3	-$520.9
Net increase or decrease in surplus	**$1,513.9**	**$812.0**	**$1,571.8**	**$1,152.6**

[a] Excludes unrealized capital gains.
Source: New York State Insurance Department

Table 27
SELECTED ANNUAL STATEMENT DATA
Financial Guaranty Insurers Licensed In New York State
2002-2005
(dollar amounts in millions)

	2005	2004	2003	2002
Number of Companies	14	15	14	14
Exposure	$2,680,961.8	$2,572,632.1	$2,253,613.0	$2,174,240.9
Net premiums written	2,979.8	3,089.1	3,360.7	2,670.8
Admitted assets	33,916.0	31,402.2	27,659.0	25,595.3
Unearned premium & loss reserves	11,517.4	5,925.9	9,223.8	8,336.1
Other liabilities	9,352.1	4,925.4	7,641.0	7,855.3
Capital	266.7	181.7	246.7	247.0
Surplus to policyholders	13,046.5	11,357.0	10,794.2	9,403.9

Source: New York State Insurance Department

4. Mortgage Guaranty Insurance

At year-end 2005, there were 2 domestic and 24 foreign companies licensed to transact mortgage guaranty business in New York.

Table 28
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Mortgage Guaranty Insurers Licensed in New York State
2002-2005
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2002	3,539.5	3,799.8	0.93
2003	3,849.0	3,708.2	1.04
2004	3,786.4	4,529.8	0.84
2005	3,815.4	4,134.2	0.92

Source: New York State Insurance Department

Table 29
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Mortgage Guaranty Insurers Licensed in New York State
2002-2005
(in millions)

	2005	2004	2003	2002
Net gain or loss from:				
Underwriting	$1,003.6	$949.3	$1,201.3	$1,525.6
Investments [a]	913.4	797.0	809.7	798.3
Other Income	3.9	11.7	2.0	-2.6
Net gain or loss	$1,920.9	$1,758.0	$2,013.1	$2,321.3
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	326.2	295.2	628.0	824.7
Net income	**$1,594.8**	**$1,462.8**	**$1,385.1**	**$1,496.6**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-1,273.4	-1,375.1	-677.6	-876.1
• Stock	0.0	0.0	0.0	0.0
Total dividends	-$1,273.4	-$1,375.1	-$677.6	-$876.1
Unrealized capital gains	219.7	172.5	315.7	56.1
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	-996.8	750.5	-863.9	-1,203.2
Contributions to surplus	64.9	-189.1	-276.5	47.6
Total other sources	-1,985.6	-641.2	-1,502.3	-1,975.6
Net increase or decrease in surplus	**-$390.8**	**$821.7**	**-$117.2**	**-$479.0**

[a] Excludes unrealized capital gains.
Source: New York State Insurance Department

TABLE 30
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
2002-2005
(dollar amounts in millions)

	2005	2004	2003	2002
Number of companies	26	26	26	25
Net premiums written	$3,815.4	$3,786.4	$3,849.0	$3,539.5
Admitted Assets	22,663.5	21,562.9	20,511.8	19,279.3
Unearned premium & loss reserves	7,566.4	7,137.6	6,580.5	5,842.5
Other liabilities	10,963.0	9,895.5	10,369.5	9,637.0
Capital	68.5	68.5	70.5	66.5
Surplus	4,134.2	4,529.8	3,708.2	3,799.8

Source: New York State Insurance Department

5. Title Insurance

Eleven domestic and 15 foreign companies were licensed to write title insurance in New York State at the close of 2005.

Table 31
SELECTED ANNUAL STATEMENT DATA
Title Insurance Companies
2002-2005
(dollar amounts in millions)

	2005	2004	2003	2002
Number of Companies	26	23	22	25
Net premiums written	$9,142.5	$8,614.5	$8,203.1	$8,449.6
Admitted assets	5,480.1	4,680.0	4,163.9	4,770.6
Liabilities	3,843.0	3,149.6	2,710.9	3,021.3
Capital	98.8	94.4	93.3	123.0
Surplus	1,637.1	1,530.3	1,453.0	1,749.3

Source: New York State Insurance Department

6. Advance Premium Co-operative and Assessment Corporations

At year-end 2005, there were 19 advance premium corporations under the supervision of the Property Bureau. The total number of advance premium corporations remained unchanged from 2004 to 2005. The net premium volume of the advance premium corporations increased by 2.7% from the prior year.

A total of 25 assessment corporations were under the Property Bureau's supervision at year-end 2005. The total number of assessment corporations decreased by one from 2004 to 2005 due to a merger. The net premium volume of these 25 companies increased by 4.7% from the prior year.

During 2005, the Property Bureau initiated 7 examinations of the advance premium and assessment corporations.

Table 32
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Corporations
2002-2005
(dollar amounts in millions)

Year		Total	Advance Premium Corporations	Assessment Corporations
2002	Number of companies	45	18	27
	Total assets	$1,499.0	$1,267.8	$231.2
	Net premiums written	769.5	682.9	86.6
	Surplus funds	565.7	434.6	131.1
2003	Number of companies	45	19	26
	Total assets	$1,696.2	$1,448.4	$247.8
	Net premiums written	838.9	742.3	96.6
	Surplus funds	637.4	500.7	136.7
2004	Number of companies	45	19	26
	Total assets	$1,893.3	$1,620.5	$272.8
	Net premiums written	904.6	795.6	109.0
	Surplus funds	722.0	576.6	145.4
2005	Number of companies	44	19	25
	Total assets	$2,070.7	$1,775.6	$295.1
	Net premiums written	931.3	817.2	114.1
	Surplus funds	809.0	650.7	158.3

Source: New York State Insurance Department

7. Special Risk Insurers (Free Trade Zone)

Calendar Year 2005 was the 27th full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 191 licensed companies as of December 31, 2005. Net premiums written during the year amounted to approximately $1.1 billion, bringing the net premiums written since inception to approximately $10.0 billion. Net premiums written since inception are as follows:

Table 33
NET PREMIUMS WRITTEN
Special Risk (Free Trade Zone)
1978-2005
(dollar amounts in millions)

1978-1998	$4,759.3
1999	482.6
2000	423.9
2001	407.6
2002	719.4
2003	1,004.6
2004	1,080.8
2005	1,105.1
Total	**$9,983.3**

Source: New York State Insurance Department

8. Risk Retention Groups

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

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

As of December 31, 2005, 87 risk retention groups had notified the Department of their intention to do business in New York under the provisions of the federal legislation.

In calendar year 2005, the 87 risk retention groups filing financial statements with this Department reported total nationwide direct premiums written of $1.5 billion and total nationwide net premiums written of $599.2 million. These risk retention groups reported direct premiums written of $267.0 million in New York State during this same period.

9. Examinations of Insurers

a. Number of Examinations

The Property Bureau's Financial Examinations Unit is required to conduct examinations of all domestic insurers on a regular basis. During calendar year 2006 a total of 150 such examinations were conducted.

Table 34
EXAMINATIONS CONDUCTED
by the Financial Regulation Division of the Property Bureau
2006

	Regularly Scheduled			Other Financial Exams		
	Total	Started in 2006	Started Prior to 2006	Special	On Organi-zation[1]	Increase in capital[2] and other
Property and casualty insurers, including financial guaranty insurers	123	38	83	1	1	0
Other insurers, captives and service contractors	22	4	18	0	0	0
Title and mortgage guaranty insurers	5	2	1	0	2	0
Total	**150**	**44**[4]	**102** [3]	**1**	**3**	**0**

[1] Examination conducted when insurer is first incorporated in New York State.
[2] Examination when insurer increases its capital.
[3] This total includes 68 reports with completed field work that were not filed as of 1/16/07.

b. Electronic Audit Program – TeamMate

During 2006, the Financial Examinations Unit continued the use of "TeamMate Audit Management System", an electronic workpaper program, for all its examinations. The use of this software ensures uniformity, consistency and efficiency in the examination process. Additionally, during 2006, the Financial Division's Actuarial Unit used TeamMate for its loss reserve analyses, which were incorporated into the examination TeamMate projects.

10. Lloyd's of London

Underwriters at Lloyd's (Lloyd's of London) consist of underwriting syndicates at Lloyd's that meet the requirement for recognition as accredited reinsurers in New York. As of December 31, 2006, 53 active syndicates at Lloyd's were recognized as accredited reinsurers by the Department. Each syndicate is required to maintain a trust fund in New York and the amount deposited in each trust fund is required to equal each syndicate's gross liabilities for U.S. situs reinsurance business. In addition, all

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

11. Finite Risk Reinsurance

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

12. Certified Capital Companies

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

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

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

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

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

	Programs				
	1	2	3	4	5
Allocated Tax Credits (in millions)	$100	$30	$150	$60	$60
Number of participating CAPCOs	5	5	5	6	7
Number of Insurer-Investors	30	28	44	43	51

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

As of December 31, 2005 the CAPCOs invested approximately $206 million in 140 qualified businesses: Program One CAPCOs invested 71.79% of their total $100 million certified capital; Program Two CAPCOs invested 68.38% of their $30 million total; Program Three CAPCOs invested 67.42% of their $150 million certified capital; Program Four CAPCOs invested 18.44% of their $60 million and Program Five CAPCOs invested 2.50% of their $60 million.

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

Sixty-eight qualified businesses had less than $1 million, 47 businesses had between $1 million and $5 million and 25 businesses had over $5 million in assets at the time of a CAPCO's initial investment; the CAPCOs' investments in these businesses accounted for approximately 34.72%, 35.51% and 29.77%, respectively, of the total invested. One hundred six "early-stage" businesses, as defined by the statute, received approximately $84.9 million (41.2% of total invested).

In the five programs combined, 52%, 11%, 11% and 11% of the numbers of businesses and 39%, 17%, 15%, and 10% of the dollars invested in qualified businesses were headquartered in New York County (Manhattan), Long Island, Mid-Hudson and the Capitol District, respectively. The remaining 15% of the businesses and 19% of the dollars invested were in other regions of New York State. Thirty-nine percent of all funds invested by year-end 2005 in qualified businesses were in New York County and 19.64% were made in Empire Zones and 19.56% were made in "underserved areas" defined as areas outside of New York County and outside of Empire Zones.

With CAPCO and other venture entity investments in these qualified businesses since inception of the CAPCO Program in 1997, the overall the total number of employees in New York in the businesses for which December 31, 2005 information was provided increased by 607 positions. The change of the number of employees in any one business ranged from a decrease of 80 to an increase of 250.

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

13. Service Contract Providers

The Bureau reviews the financial responsibility requirements of applicants seeking registration pursuant to Article 79 of the Insurance Law to write service contracts in New York. In addition, the filed audited financial statements are annually reviewed for those service contract providers that seek to meet the statutory financial responsibility requirements through either a New York Funded Reserve Account or stockholders equity in excess of $100 million. As of December 31, 2006, there were 49 service contract providers required to file audited financial statements with the Property Bureau - Financial Division, with 25 utilizing the New York Funded Reserve Account and 24 utilizing stockholders equity in excess of $100 million.

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

a. Number of Filings

During 2006, the Market Regulation Division of the Property Bureau received 6,735 filings involving changes in rates, rating rules, policy forms, rate classifications and rating territories submitted by rate service organizations, joint underwriting associations and insurers. The filings were submitted for the following lines of business:

Table 35
NUMBER OF FILINGS RECEIVED BY TYPE*
Market Regulation Division of the Property Bureau
2006

Line of Business	Rates & Rules	Policy Forms	Totals
Fire and Allied Lines	413	337	750
Farmowners Multiple Peril	36	35	71
Homeowners Multiple Peril	291	171	462
Multiple Line	45	58	103
Commercial Multiple Peril	353	302	655
Inland Marine	219	207	426
Medical Malpractice	97	50	147
Earthquake	0	1	1
Flood	2	5	7
Rain	1	1	2
Workers' Compensation & Employer's Liability	154	111	265
Other Liability	961	881	1842
Motor Vehicle Insurance	899	411	1310
Aircraft	9	12	21
Fidelity & Surety	147	81	228
Glass	2	3	5
Burglary & Theft	116	87	203
Boiler & Machinery	25	30	55
Credit	5	12	17
Animal Mortality	8	8	16
Mortgage Guaranty	23	8	31
Residual Value	1	0	1
Title	14	5	19
Financial Guaranty	4	92	96
Prepaid Legal Service Plan	1	1	2
Warranty Reimbursement	0	0	0
Total	**3826**	**2909**	**6735**

* These figures include approximately 133 consent-to-rate filing applications (pursuant to Section 2309 of the Insurance Law); 18 group property & casualty filings; 139 manuscript policy form filings; and 64 rating plans submitted in 2006. During 2006, 270 policy form filings and 230 rate or rating rule filings were disapproved. In addition, the Bureau continued speed-to-market (STM) initiatives and accepted electronic submission of filings through the System for Electronic Rate and Form Filing (SERFF). The Bureau received 890 STM and 4,044 SERFF form and rate filings in 2006, which are included above.

b. Advisory Rate/Loss Cost Changes

The following table lists major revisions in rates or loss costs filed by rate service organizations that were approved or acknowledged during 2006. Loss costs apply to the voluntary market and are advisory, *i.e.*, they do not have to be adopted by an insurer. They reflect the experience of all companies that report to the rate service organization. Loss costs are used by insurers for most lines of business as a basis for determining their individual company rates.

Table 36
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2006 by Property and Casualty
Rate Service Organizations

	Percent Changes in Average Statewide Rates
Automobile	
Insurance Services Office, Inc.	
Commercial Automobile	
Loss Costs Revised	
Zone-Rated Risks	
Liability	-0.5
Comprehensive	-24.0
Collision	-20.5
Physical Damage Subtotal	-21.4
Total All Coverages	**-6.1**
effective July 1, 2007	
Insurance Services Office, Inc.	
Commercial Automobile	
Loss Costs Revised	
Commercial Cars	
Single Limit Liability	-1.4
Personal Injury Protection	0.0
Liability Subtotal	-1.4
Comprehensive	-12.0
Collision	-21.0
Physical Damage Subtotal	-18.9
Total Commercial Cars	**-3.2**
Garages	
Single Limit Liability	0.0
Personal Injury Protection	0.0
Liability Subtotal	0.0
Physical Damage - Garage Dealers	
Comprehensive	-15.0
Collision	0.0
Physical Damage - Garage Keepers	
Comprehensive	-14.8

	Percent Changes in Average Statewide Rates
Collision	-11.5
Physical Damage - Garage Dealers and Keepers Subtotal-	-11.4
Total Garages	**-3.9**
Private Passenger Types	
Single Limit Liability	0.0
Personal Injury Protection	-14.7
Liability Subtotal	-1.3
Comprehensive	-13.5
Collision	+6.2
Physical Damage Subtotal	+0.9
Total Private Passenger Types	**-0.8**
Total All Coverages	**-2.7**
Total Liability	**-1.3**
Total Physical Damage	**-10.5**
effective September 1, 2006	

Liability Other Than Automobile

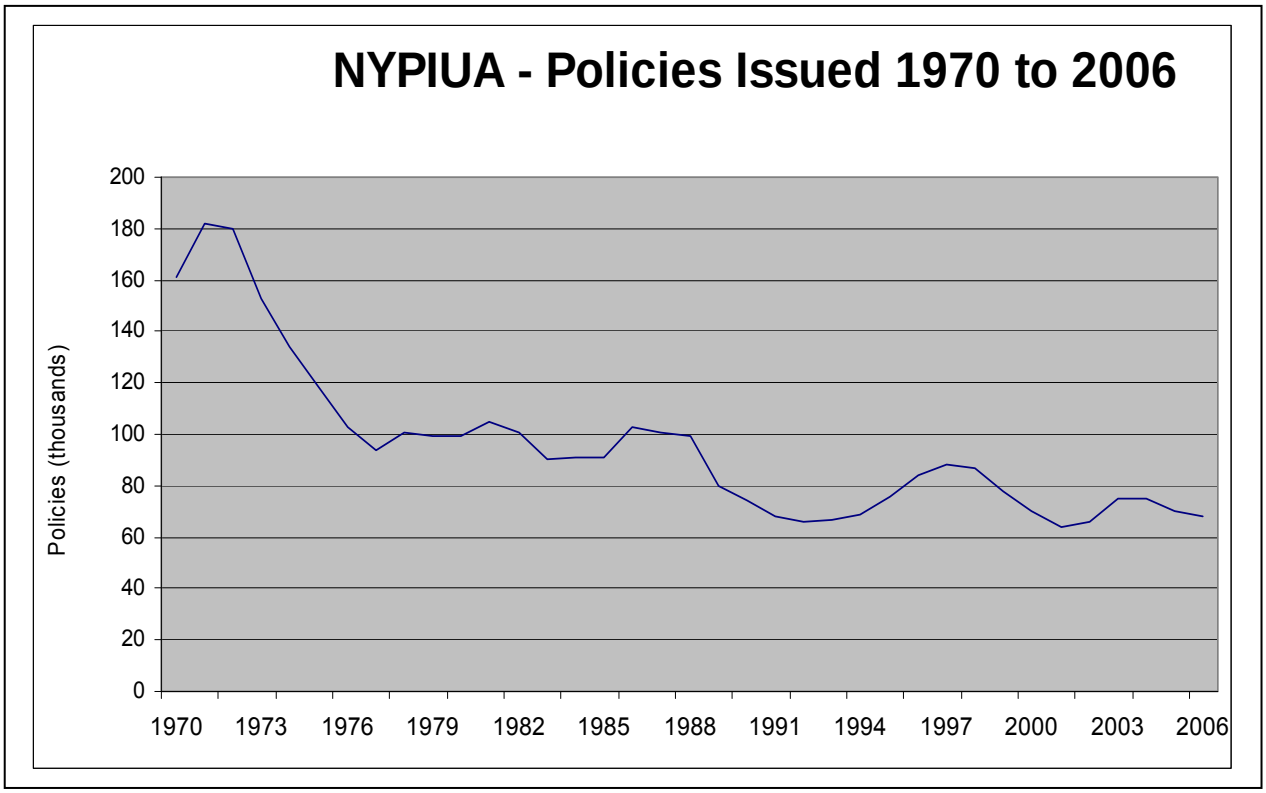
Insurance Services Office, Inc.	
Personal Liability Loss Costs	**-7.2%**
effective April 1, 2007	
Insurance Services Office, Inc.	
Hospital Professional Basic Limit Loss Costs	**+25%**
effective July 1, 2007	

15. New York Property Insurance Underwriting Association (NYPIUA)

a. Policies Issued

The following graph illustrates the number of policies issued by the New York Property Insurance Underwriting Association from 1970 through 2006:

(Chart A)



Following the peak year of 1971 (182,000 policies), there was a steady decline through 1977 in the number of policies issued annually by the Association. The period 1977 through 1982 saw relative stability, with the number of policies ranging between 94,000 and 105,000. The sharp decline experienced from 1982 to 1983 can be attributed to soft market conditions, while 1986 showed a sharp increase in policies issued as the voluntary insurance market hardened. Another soft insurance market accounted for the large decrease in the number of policies issued by the Association from 1989 through 1992 as many NYPIUA policies were written in the voluntary market. The number of NYPIUA policies issued began to increase gradually from 1993 through 1997 reflecting, in part, the ongoing concern for adequate coastal property insurance coverage. In 1998, 1999, 2000, and 2001, the number of NYPIUA policies issued had declined, while in 2002, 2003, and 2004, the number increased. In 2005, there were 69,506 policies written, a decrease of 5,795 policies from the previous year. In 2006, the number of policies written again decreased to 67,969, which is a 1,537 decline from 2005.

b. Financial Information

For the fiscal year ending December 31, 2006, the Association's Financial Report indicated premiums earned of $31,975,737 and a net underwriting gain of $5,905,821. Other income of $5,888,678, comprised of net investment income of $6,629,861; premium balances charged off $16,541; bond amortization loss of $271,028; loss on sale of securities of $427,370; grant program of $172,209 and policy installment fees of $145,965, resulted in net income before taxes of $11,794,499. The change in assets not admitted of $9,609, taxes incurred of $463,498 and distribution of $50,740,073 resulted in a net change in the Members' Equity Account of $39,418,681. The cumulative operating profit as of December 31, 2006 was $162,330,780. After all assessments (net of distribution of $91,008,265), the net Members' Equity Account totaled $71,322,515.

The Association requested and the Department permitted the close out of policy years 1993 through 1997, with the accumulated cash equity from these policy years in the amount of $50,740,073 distributed to the NYPIUA member companies.

In accordance with Section 5405(c) of the New York Insurance Law, the Association estimated a deficit from operations of $2,318,854 for the Calendar Year 2007. However, there will be no need to credit the Association with any funds from the New York Property/Casualty Insurance Security Fund for the year beginning January 1, 2007, since its assets exceed its liabilities.

c. Rate Revisions

During 2006, the Department approved rate revisions for both the Commercial Property and Dwelling Property classes of business. These revisions resulted in an average statewide change of -3.5% for Basic Group I commercial insureds, 0% for Basic Group II commercial insureds, -2.5% for Owner-Occupied Dwelling (1-4 units), -14.3% for Household Furnishings and Personal Property and +10.7% for Non-Owner Occupied Dwelling (1-4 units).

The Department approved a filing in which the adjustment factor (the factor that the Association applies to the rates recommended for the voluntary market by the principal rate service organization) was reduced as follows:

- Owner-Occupied Dwellings (1-4 units); from 1.20 to 1.05
- Household Furnishings and Personal Property; from 1.20 to 1.10.

The rate effect of this revision is included in the above percentage rate changes for dwelling property classes.

d. Legislation in 2006

Chapter 115 of the Laws of 2006 extended the authority of the New York Property Insurance Underwriting Association to operate through June 30, 2007.

16. Medical Malpractice Insurance

a. Establishment of Rates and Premium Surcharges

Chapter 58 of the Laws of 2005 extended for two years the authority of the Superintendent of Insurance to establish rates for policies providing coverage for physicians' and surgeons' medical malpractice liability insurance. This legislation also extended the provision that allowed for the application of surcharges of up to 8% annually, beginning July 1, 1989, upon the then established rates if required to satisfy any deficiency for the policy periods July 1, 1985 through June 30, 2007.

The Department established primary medical malpractice insurance rates in New York for the July 1, 2006 through June 30, 2007 policy year. The combined overall rate level effect was +9.0% above the rates established for the previous year. This overall effect represented an across-the-board +9.0% rate change for all insurers providing physicians and surgeons medical malpractice liability coverage in the voluntary market. The rate change for the Medical Malpractice Insurance Plan, which provides coverage for insureds unable to obtain coverage in the voluntary market, was +12.0%.

b. Claims-Made Factors and Optional Tail Factors

The claims-made rate is obtained by multiplying the established occurrence rate by the claims-made factor. This factor varies depending on the number of years the insured has been covered by the claims-made program. The rate for the optional tail coverage required to be offered upon termination of coverage is based on the number of years the physician has completed in the claims-made program, and is obtained by multiplying the established occurrence rate by the factor established by the Superintendent. For the 2006 to 2007 policy year, it was determined that no change was needed to these factors.

c. Physicians Excess Medical Malpractice Insurance for '06 –'07

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

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

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

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

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

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

losses will be shared proportionately among the members. In 2006, all members of the Plan participated in the Medical Malpractice Insurance Pool of New York State (Pool).

For 2006, the Pool insured 1,657 individuals (including professional corporations) compared with 8,931 the previous year. A breakdown of the individual insureds by type, and a comparison with previous years follows:

Table 37
MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE
Insured Individuals (including professional corporations)
2004-2006

Type of Insured	Policies as of December 31, 2006	Policies as of December 31, 2005	Policies as of December 31, 2004
Primary Insureds			
Physicians	580	603	587
Dentists	208	185	159
Podiatrists	79	79	79
Nurse-Anesthetists	5	6	7
Nurse-Midwives	22	18	15
Professional Corps.	33	31	33
Excess Layer Insureds			
First Layer Excess	730	6,788	13,743
Second Layer Excess	0	1,221	1,523

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

In addition to these individuals, the Pool insured 342 facilities, the majority of which are nursing homes and adult homes, down from 372 the year before.

17. Workers' Compensation

a. Workers' Compensation Rate Credits for Managed Care Programs

As part of the 1996 workers' compensation insurance reform package, the New York Workers' Compensation Law was amended by the addition of Article 10-A to allow employers to use certified Preferred Provider Organizations (PPOs) to deliver medical services to workers suffering from work-related injuries or illnesses.

A managed-care program can control associated workers' compensation costs through careful review of utilization and case management, safety programs, return-to-work policies and other loss control techniques. Since the initial program was approved in 1997, the Department has approved rate credits for a total of 40 insurance carriers desiring to offer managed-care programs. Thirty-four insurance companies have a managed care premium credit program in place as of year-end 2006.

b. Workers' Compensation Drug-Free Workplace Credit Program

In 1996, the Department began approving a 5% workers' compensation premium rate modification for those insured employers implementing a drug-free workplace program. Consideration for this program was based upon a significant number of studies on how drugs and alcohol affect an

employer's workplace by adversely increasing the frequency and severity of accidents and claims. A drug-free credit program is thus a useful tool in efforts to reduce the cost of workers' compensation claims. As of year-end 2006 there were 30 insurance carriers with approved drug-free workplace programs in place.

18. Insurance Availability Issues

While liability insurance coverages continued to be generally available during 2006, some markets experienced difficulties. The Department continued to monitor market conditions and addressed individual problems as they arose.

a. Availability Survey

In response to the liability insurance crisis of the 1980s, the Department instituted special surveys to ascertain the state of markets for difficult-to-place insurance coverages. The availability survey is conducted annually to ensure that meaningful and timely information is obtained. In cases where a meaningful market did not exist for critical coverages, voluntary market assistance programs (MAPs) were successfully developed.

The current survey methodology allows insurers to submit their data either by diskette or as an email attachment. The Department processes the responses in an expeditious manner in which insurer responses are downloaded directly to a PC-based database. This allows for the rapid analysis of market conditions and developing trends, and enables the Department to better serve the insurance community as well as consumers in New York State. The survey format allows insurers to provide the Department with consistent and accurate information on insurers' underwriting plans for the coming year. In 2006 the survey format was revised in order to make it simpler for insurers to complete, and to provide the Department with more consistent and accurate information on insurers' underwriting plans for the coming year. As in previous years, several risk and coverage categories were added and deleted based on the Bureau's observation of market conditions during the period since the last survey was issued.

Beginning in 2000, the data call included a second survey that requested information on Free Trade Zone business written during the prior year. By conducting this survey in conjunction with the availability survey, the Department eliminated the previous need for insurers to complete separate hard copy questionnaires to provide this information. The data gathered from the survey are used to produce the Department's Annual Free Trade Zone Update.

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

19. Automobile Insurance

a. New York Automobile Insurance Plan

At year-end 2006, there were approximately 28% fewer vehicles in-force than year-end 2005 and approximately 51% fewer than year-end 2004. The Plan population is at its lowest level in history. The decrease in the Plan population can be attributed to various Department initiatives, such as those to

combat fraud and to provide incentives to voluntary market insurers to provide coverage to drivers who would otherwise have been in the Plan.

b. Legislation

Chapter 115 of the Laws of 2006 extends until June 30, 2007 the provisions of Section 2328 regarding the prior approval of rates for Public Automobile insurance. It also extends until June 30, 2007 the provisions of Section 3425 regarding the cancellation and non-renewal of private passenger automobile policies.

Chapter 294 of the Laws of 2006, which became effective on July 26, 2006, adds a new Section 3450 to the Insurance Law entitled “Insurance for expenses incurred as a result of an act or threatened act of violence.” As part of a motor vehicle physical damage insurance policy, an insurer may provide insurance for loss to any person as the result of an act or threatened act of violence against an insured person. This new kind of insurance has also been added to the “Burglary and theft” line of insurance as set forth in Section 1113 and includes insurance covering a ransom or reward payment incurred as the result of an abduction or the theft of property; travel and lodging expense and lost wages incurred as the result of an act or threatened act of violence; expense incurred to locate or identify a missing or abducted person; or other expenses to respond to a violent act or threatened act or to prevent a reoccurrence thereof. An "insured person" may include a person engaged in the lawful use or operation of the vehicle. Such insurance may also provide coverage for medical expenses to any such person incurred as a result of the act or threatened act of violence as well as funeral and death benefits if the person is killed.

c. No-Fault Motor Vehicle Insurance Law Activity

i. “Operation Auto Rates”

The Insurance Department’s aggressive anti-fraud efforts during the past several years have paid dividends with a significant decline in insurer losses. These efforts to combat and prevent fraudulent activity, coupled with other initiatives that were implemented since late 2004, have resulted in approximately $500 million in auto insurance premium reductions in New York State. These initiatives included several changes involving No-Fault as follows:

- The revision to Regulation 68 that took effect on April 5, 2002 reduced the time limit for filing a notice of a No-Fault claim from 90 days to 30 days and the reduction of the time for submitting medical bills from 180 days to 45 days.

- The reform of the No-Fault Arbitration System (such reform resulted in a reduction of cases pending in the arbitration system from 116,200 at the close of March 2002 to 13,809 at the close of December 2006) through a package of regulatory and administrative changes that took effect at the beginning of 2002. For example, the adoption of the New York State Medicaid fee schedule for the reimbursement of durable medical equipment through the promulgation of the Twenty-eighth Amendment to Regulation 83 in 2004 resulted in a significant reduction in claims disputes that otherwise would have been processed through the arbitration program.

ii. Mandatory arbitration for all No-fault insurance disputes

The Department has ascertained via NYIL §308 data calls from insurers comprising roughly 65% of the automobile insurance premiums written in New York that No-Fault lawsuits filed against them during 2004 and 2005 totaled approximately 160,227 and 167,935 cases respectively. The increased burden on the court system led the Chief Administrative Judge's Local Courts Advisory Committee (Unified Court System) to propose a bill last year that would amend NYIL §5102 to

require mandatory arbitration for all No-Fault insurance disputes. It should be noted that the improvements in the administration of the No-Fault Arbitration System in the past few years permit it to process substantially more requests for arbitration without compromising the goal of a speedy dispute resolution system.

iii. Decertification of Health Care Providers

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

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

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

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

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

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

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

20. Homeowners Insurance

a. New York's Coastal Areas

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

The Department continues to carefully monitor the availability of coastal insurance. Staff continues to meet with interested parties to discuss the problems and arrive at workable solutions. In addition, the Department continues to respond to inquiries from producers and property owners received either by mail, in person, or on the Department's hotline, (800) 300-4593. Where appropriate, the Department

has intervened to resolve disputes involving incorrect policy rating and declination of initial or renewal coverage. The Department's objectives have been—and continue to be—maximizing consumer protections, encouraging risk management, emphasizing responsible underwriting, and facilitating voluntary market homeowners insurance coverage in shore communities.

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

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

Participating insurers have agreed to collectively write 10,000 policies commencing October 1, 2006 in addition to the 5,000 policy commitment voluntarily made by participating companies at the inception of C-MAP. From April 1996 through December 31, 2006, 4,690 policies have been issued through the program. The Department believes C-MAP will continue to help consumers secure vital homeowners coverage while still addressing insurers' coastal area concerns.

b. Legislation and Regulations

Chapter 162 of the Laws of 2006 amended section 3425(e) of the Insurance Law to direct the superintendent to establish by regulation standards for notices of cancellation, nonrenewal, and conditional renewal for certain homeowners' policies as defined in section 2351(a) of the Insurance Law. The First Amendment to Regulation 159 which was issued on an emergency basis, affects property located in an area served by a market assistance program established by the superintendent for the purpose of facilitating placement of homeowners insurance and requires that every notice of cancellation, nonrenewal, or conditional renewal issued on or after November 23, 2006 for homeowner's insurance shall advise the insured of the availability of the market assistance program and the availability of coverage through NYPIUA. Chapter 162 also added a new section 5403(d) which requires the New York Property Insurance Underwriters Association (NYPIUA) to notify its policyholders whose properties are located in an area served by a market assistance program of their possible eligibility for coverage through the market assistance program.

Chapter 294 of the Laws of 2006, which became effective on July 26, 2006, adds a new Section 3450 to the Insurance Law entitled "Insurance for expenses incurred as a result of an act or threatened act of violence." As part of a homeowners' insurance policy, an insurer may provide insurance for loss to any person as the result of an act or threatened act of violence against an insured person. This new kind of insurance has also been added to Section 1113 (a)(7) "Burglary and theft insurance" to include insurance coverage for ransom or reward payment incurred as the result of an abduction or the theft of property; travel and lodging expense and lost wages incurred as the result of an act or threatened act of violence; expense incurred to locate or identify a missing or abducted person; or other expenses to respond to a violent act or threatened act or to prevent a reoccurrence thereof. An "insured person"

may include a member of the household, a minor under the custody or care of the named insured, or a minor child of the named insured, regardless of where the act or threatened act occurs; or a person on the insured premises, or any other premises within the temporary control of the named insured, or in a vehicle owned, operated, leased or rented by the named insured. Such insurance may also provide coverage for medical expenses to any such person incurred as a result of the act or threatened act of violence.

Chapter 115 of the Laws of 2006 extended the operating authority of NYPIUA to June 30, 2007, thus maintaining the safety net for residents unable to obtain fire insurance in the voluntary market. The law also grants authority to the Superintendent to authorize NYPIUA to provide full homeowners insurance coverage if deemed necessary. (NYPIUA currently provides fire and extended coverages, but does not provide protection for theft or personal liability.)

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

c. Computer Hurricane Simulation Models in Rate Filings

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

In order to further the Department's knowledge of computer simulation modeling, Circular Letter No. 7 issued April 30, 1998, requested those insurers and rate service organizations that use computer simulation modeling as part of their homeowners insurance rate review and development process in this State, to provide, at their option, a comparison of the indicated rates and rate changes by form and territory. The comparison should include the rates and rate changes developed using the results of computer simulation modeling as well as those developed using more traditional ratemaking methodology.

The computer simulation modeling information has not been considered as part of the actual rate submission. However, any comparisons submitted by insurers and rate service organizations help the Department gain perspective and familiarity with computer simulation modeling, and will assist us in making a future determination on the appropriateness of the use of this methodology in the ratemaking process for homeowners insurance rate filings. Upon request by the insurer, such information would be considered confidential to the extent permitted by Section 87(2) of the Freedom of Information Law.

d. Reinsurance Cost Factors in Homeowners Insurance Rate Filings

The Department permits insurers to reflect the cost of catastrophe excess-of-loss reinsurance in homeowners' insurance rate filings, provided an insurer can reasonably allocate the cost of such reinsurance to its New York policyholders. As of the end of 2004, the Department has accepted homeowners rate filings in which reinsurance costs were among the factors reflected in the ratemaking methodology for nearly all major homeowners' insurers. Most of these companies had previously used reinsurance costs in the development of their rates.

The Department has been reviewing the reinsurance contracts of insurers that used reinsurance costs as a factor in previous rate increases. This was initiated to determine that consideration is also given to reductions in reinsurance costs in insurers' preparations of rate revisions.

e. Mineola Office

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

21. Market Conduct Activities

a. Summary of Market Conduct Investigations Conducted and Fines Collected

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

There were 31 market conduct investigations and two Rate Service Organization examinations (RSO) in progress at the beginning of 2006 and 127 investigations were initiated during the year. The Department closed 124 market conduct investigations during the year. At year's end, 34 market conduct investigations and two RSO examinations were in progress. A total of 40 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $1,563,599. In addition, fines totaling $35,000 were received from insurers and self-insurers for failure to pay No-Fault arbitration awards in a timely manner.

The following chart provides a breakdown of the market conduct activities for Calendar Year 2006:

Table 38
MARKET CONDUCT INVESTIGATIONS/EXAMINATIONS
by Type of Investigation/Examination
2006

Type of Investigation	Outstanding at 1/1/2006	Initiated during 2006	Completed during 2006	Outstanding at 12/31/2006
Claims	8	6	6	8
Rating/Underwriting	2	4	2	4
Homeowners Underwriting	0	0	0	0
Title Ins. Underwriting	3	2	0	5
Auto. Salvage Claims	3	0	3	0
Privacy	0	3	3	
Frauds	0	8	7	1
Public Auto		1	0	1
Desk Audits:				
Section 3425 Compliance	12	6	13	5
Claims/Rating/Underwriting	3	6	7	2
Internet Web site Reviews	0	57	57	
Availability Survey 05	0	34	27	7
Total Investigations	**31**	**127**	**125**	**33**
Examinations:				
Rate Service Organization	2	0	0	2
Joint Underwriting Assoc.	0	0	0	0
Total Examinations	**2**	**0**	**0**	**2**

The following chart details the fines collected or processed and the stipulations entered into during Calendar Year 2006:

Table 39
MARKET CONDUCT FINES COLLECTED & PROCESSED
by Type of Investigation
2006

Type of Investigation	Number	Amount
Claims	9	$262,425
Underwriting/Rating	1	33,650
Desk Audits: Section 3425	11	75,300
Follow-up Section 3426	1	25,000
Use of Unapproved Workers Compensation Rate Deviation	1	5,000
Availability Survey – 05	11	11,000
Mold Exclusion (unapproved form)	2	136,640
Use of Unapproved Rates and Forms	1	197,250
Improper Transfer of Policies	1	269,952
Automobile Underwriting	1	410,982
Homeowners Underwriting	1	136,400
Total	**40**	**$1,563,599**
Penalties: Failure to timely pay N.F. Arbitration Awards	140	$35,000
Total Fines Collected & Penalties Processed	**180**	**$1,598,599**

b. Penalties Imposed Under Insurance Law Section 3425

Section 3425-NYIL limits the total number of nonrenewals of personal automobile insurance policies that an insurer is allowed. Generally, an insurer is permitted to nonrenew up to 2% of the total number of covered policies that the insurer had in force at the previous year end in each such insurer's rating territory in use in this State. As a result of an analysis of reports to the Superintendent required by Section 3425(l)(1)-NYIL, 11 stipulated fines totaling $75,300 for Calendar year 2004 were collected during Calendar Year 2006 (included in the total fines collected in Section 21(a) above).

c. Penalties for Insurance Availability Survey Delinquents

One of the duties of the Property Bureau is to make available a listing of insurers who write commercial coverages in various markets. In order to determine these insurers, the Department has conducted Availability Surveys since 1989 on an annual basis, pursuant to Section 308 of the Insurance Law. Also, insurers licensed under Article 63 to write business in the Free Trade Zone are also required to complete that portion of the survey, for premiums written the previous year. For the 2005 Surveys, the Department collected fines of $11,000 during calendar year 2006 from insurers who did not submit the surveys in a timely manner (included in the total fines collected in Section 21(a) above).

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

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

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

Insurers were also advised that in accordance with Section 109(c)(1) of the Insurance Law, a penalty would be imposed on insurers for each complaint made where no justifiable reason for nonpayment or late payment was furnished to the Department. In addition, these complaints are recorded for the purpose of calculating the complaint ratios that form the basis of the Department's Annual Automobile Complaint Ranking. During Calendar Year 2006, the Department processed fines totaling $35,000 from insurers and self-insurers for their failure to pay arbitration awards in a timely manner.

e. Insurer Internet Web Site Monitoring

The Market Conduct Unit continued the monitoring and review of insurer Internet Web sites. In addition, as part of these reviews, the Unit has been verifying the accuracy of quotes generated online. As part of Circular Letter No. 31, dated October 29, 1998, the Department advised the industry of the general guidelines that would be followed when monitoring the marketing of insurance products on the Internet. Supplement 1 to Circular Letter No. 31 was issued May 28, 1999, which further advised insurers that Web-based activities would be reviewed and/or monitored by the Department and that these reviews would be incorporated into the market conduct and financial review processes. Fifty-seven insurer web sites were reviewed during the course of 2006. The Web sites reviewed were found to be in substantial compliance with the Department's guidelines. Additional insurer Web site reviews will be conducted in 2007.

f. Privacy

Title V of the Gramm-Leach-Bliley Act requires financial institutions, including insurers, to protect the privacy of consumers and customers. It also requires that all state insurance authorities establish appropriate consumer privacy standards for insurance providers. As a result, the Insurance Department promulgated Regulation No. 169 in 2001 and Regulation No. 173 in 2002, setting forth these standards. During Calendar Year 2006, the Market Conduct Unit continued to assess the privacy policies and procedures in place and to ensure compliance with privacy regulatory requirements. Three new privacy investigations were initiated and completed during 2006. All of the insurers investigated to date appear to be in compliance with the provisions of Regulations Nos. 169 and 173. Additional privacy investigations will be conducted in 2007.

g. Frauds Compliance Investigations

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

During Calendar Year 2006, the Market Conduct Unit initiated and completed a review of 7 insurers to determine whether they were following the requirements outlined in the statute and regulation. Detailed questionnaires were submitted to these insurers which were then reviewed during the investigation in conjunction with additional documentation requested. Once all necessary material was received and analyzed it was submitted to the Department's Frauds Bureau for further review. All of the insurers investigated were found to be in compliance with the fraud compliance requirements of Section 409-NYIL and Department Regulation No. 95.

h. Title Insurance Investigations:

The Market Conduct Unit continued investigations into title insurer practices. Two additional investigations commenced in 2006.

i. Market Analysis Review System:

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

- Identify general market disruption and important market conduct problems as early as possible and to prevent or mitigate harm to consumers;

- Better prioritize and coordinate the various market regulation functions of the Department and establish an integrated system of proportional responses to market problems; and

- Provide a framework for collaboration among the states and with federal regulators regarding identification of market conduct issues and market regulation.

During 2006, Market Analysis reviews of 8 companies were conducted, resulting in 2 companies being targeted for possible Market Conduct field investigations. Three companies needed further analysis within the Insurance Department and no further analysis was needed for the remaining three companies. One of the goals of the Market Analysis Program for 2007 is to standardize baseline factors to enable states to identify issues of concern and to prioritize activities in a uniform manner. The unit intends to make use of analytic tools such as the NAIC Prioritization tool in the selection of future Market Analysis reviews.

22. Excess Line Insurance

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

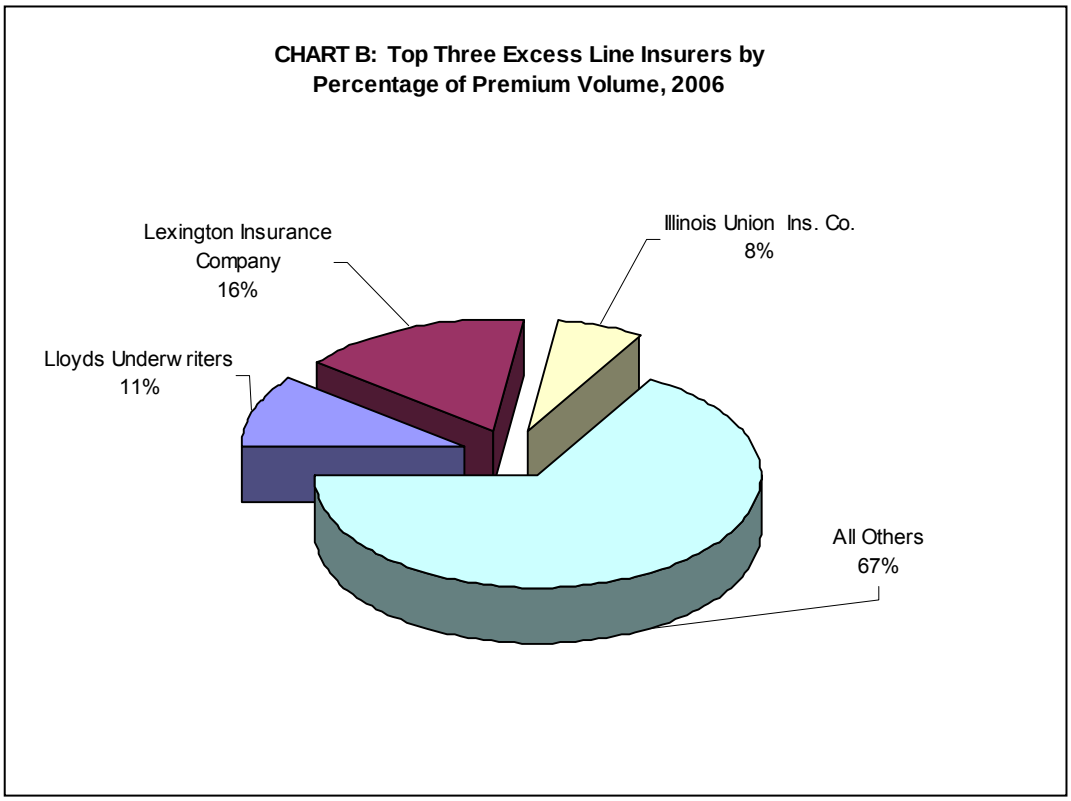
Since insurers providing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained from excess line brokers through tax statements required to be filed no later than March 15 of each year relating to business written during the previous Calendar Year. For Calendar Year 2006, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $4.668 billion, of which approximately $2.622 billion was attributable to risks located or resident wholly in New York State. These excess line premiums generated $ 94,396,410 in excess line premium tax revenue for the state.

The data pertaining to excess line business used in this report were obtained from statistical reports provided to the Superintendent by the Excess Line Association of New York (ELANY) pursuant to Section 2130 of the New York Insurance Law. ELANY obtains the information from affidavits required to be filed by excess line brokers under Section 2118 of the Insurance Law. There are 2,697 licensed excess line brokers and approximately 747 who are active and filed 144,428 affidavits for the year 2006. Two hundred and fifty complaints and inquiries and 1,685 filings regarding excess line business were received in 2006.

In 2006, there were approximately 178 unauthorized insurers eligible to do business in New York pursuant to Regulation 41. This includes 82 foreign insurers; 35 alien insurers; and Lloyd's, with 61 syndicates. These insurers are required to file Form EL-1 annually by March 15. The filing requirement

was changed in 1997 to include the use of computer diskettes and in 2002 changed to permit e-mail submission. In 2006, the Unit reviewed 105 EL-1 filings, 82 annual statements and 9 trust agreements.

The following is a chart of the percentage of total 2006 excess line premium writings attributable to the three largest excess line insurers in New York State.



a. Business Written in New York

Total excess line premiums written in New York State decreased from $2.769 billion in 2005 to $2.622 billion in 2006, a decrease of 5.29%. The largest dollar decline over the previous year occurred in the other liability lines, down $188 million, a decrease of 11.6% of which owners, contractors protection was down by $94.8 million and manufacturers and contractors was down by $59.9 million. Other decreases included errors and omissions; down by $110.5 million, auto physical damage down by $17 million; and burglary and theft down by $5.3 million. The largest percentage decline, 42.64% occurred in aircraft physical damage, a relatively small-volume line was down by $2.5 million over the previous year.

The largest dollar and percentage increase over the previous year occurred in the “other” line, up by $127 million to $171 million, 293.95% in 2006, of which $136.9 million is from unclassified lines of business, $8 million is from homeowners (a 50% increase), and $1 million is from a new line of business, salary protection. Other increases included fire and allied lines, up by $31.5 million; and fidelity and surety, up by $9 million.

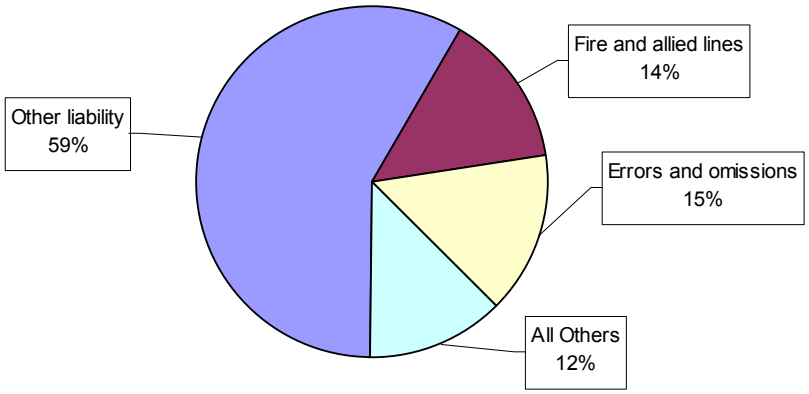
Table 40
EXCESS LINE PREMIUMS WRITTEN
Risks Located in New York State
2002-2006
(dollar amounts in thousands)

Line of business	2006	2005	2004	2003	2002
Fire and allied lines	$ 427,382	$ 395,848	$ 393,807	$ 425,417	$ 296,786
Inland marine	60,679	57,889	52,162	43,462	30,308
Auto liability	15,605	16,758	15,757	15,629	4,154
Malpractice	26,934	17,768	23,319	12,089	9,392
Errors and omissions	297656	408,213	480,076	334,685	221,245
Commercial multiple peril (excluding fire)	109,280	111,716	111,068	93,737	82,315
Other liability	1,433,705	1,621,751	1,419,191	1,079,015	603,313
Auto physical damage	24,646	41,834	21,291	17,163	19,055
Aircraft physical damage	3,310	5,770	1,049	2,651	233
Burglary and theft	7,976	13,308	10,369	3,613	5,503
Fidelity and surety	43,880	34,331	23,116	14,844	5,040
Other lines	171,101	43,432	58,621	54,794	46,964
Total	$2,622,123	$2,768,618	$2,609,827	$2,097,100	$1,324,307
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	7.30%*	7.88%	7.48%	6.25%	4.29%

*Estimated
Source: Excess Line Association of New York

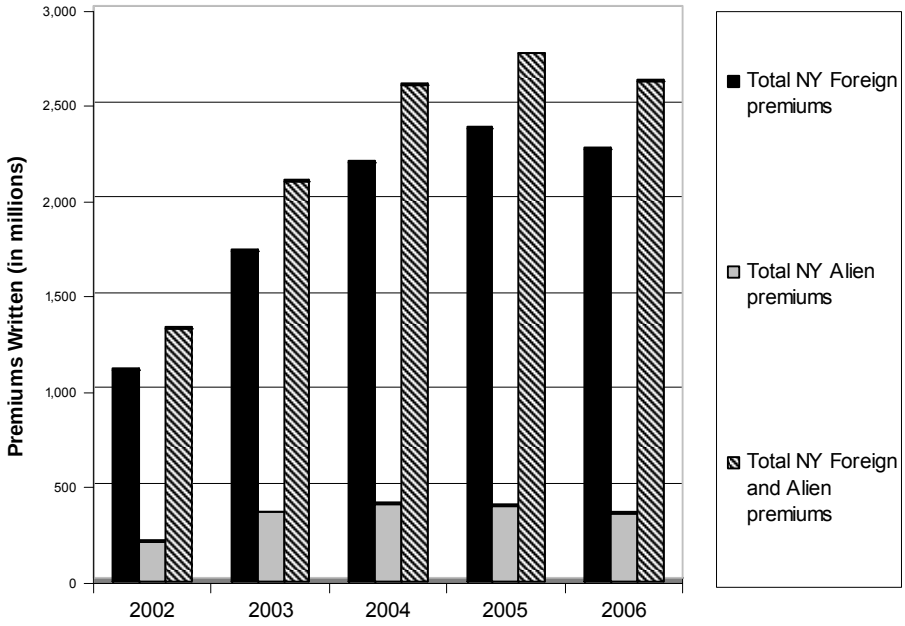
The pie chart below shows the three major lines of business written in the excess line market based on premium volume.

CHART C
Top Three Lines of Excess Line Business Written, NYS, 2006

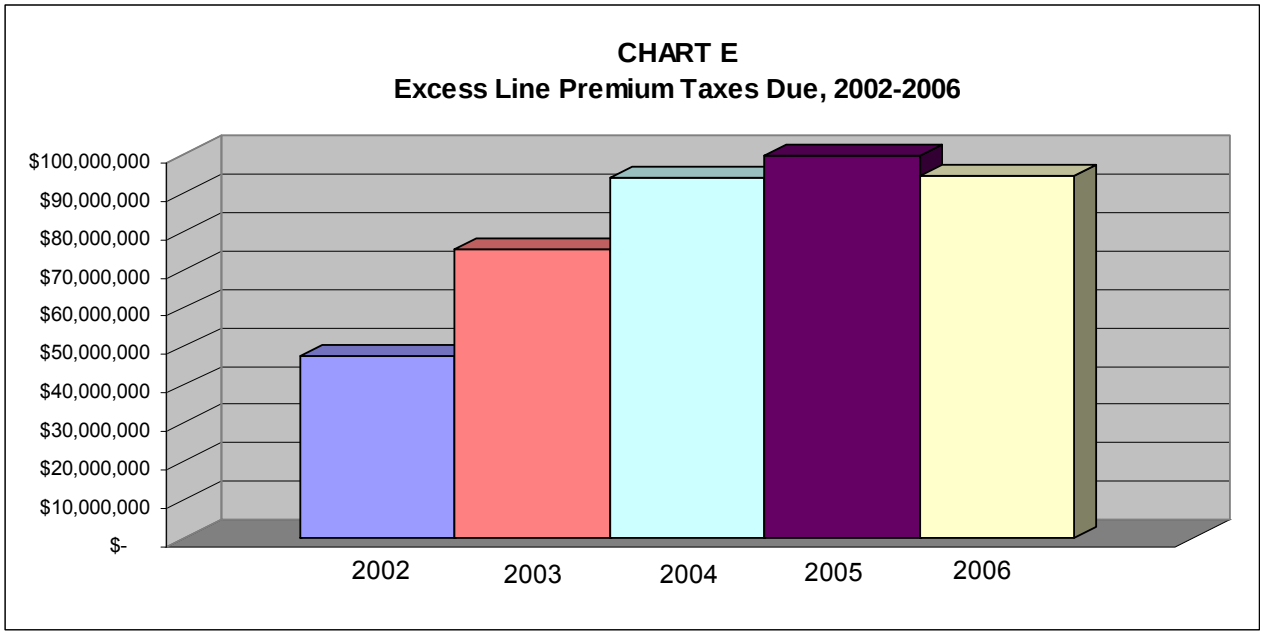


The following graph shows excess line business for the years 2002 to 2006 by alien and foreign insurers.

CHART D
New York Excess Line Premiums Written, 2002-2006



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



b. Binding Authority

Sections 2117 and 2118 of the Insurance Law were amended in 1997 to provide that an excess line broker, licensed pursuant to Section 2105 of the Insurance Law, may exercise binding authority, which the law defines as ". . . the authority to issue and deliver insurance policies on behalf of an insurer not licensed or authorized to do business in this state." Since the implementation of the amended statute, the Excess Line Association of New York (ELANY) has notified the Department that 82 excess line brokers have filed 272 binding authority agreements representing insurers not licensed or authorized to do business in this State. During Calendar Year 2006, the Excess Line Association of New York reviewed and accepted 23 new, renewed and/or amended binding authority agreements from New York-licensed excess line brokers.

c. EL-1 Review

Excess line insurers are required to file annually by March 15, an EL-1 report showing detailed information of business written during the preceding year to be eligible to do business in New York on an excess line basis. All EL-1 filings were reviewed to determine that the information complied with the requirements pursuant to Department Regulation 41. This included a check to determine if excess line brokers listed on the reports were New York-licensed excess line brokers. Any direct procurement information listed on the EL-1 was forwarded to the New York State Department of Taxation and Finance to determine whether the excess line tax on these premiums had been paid by the respective policyholder.

d. Ineligible Unauthorized Insurers

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

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

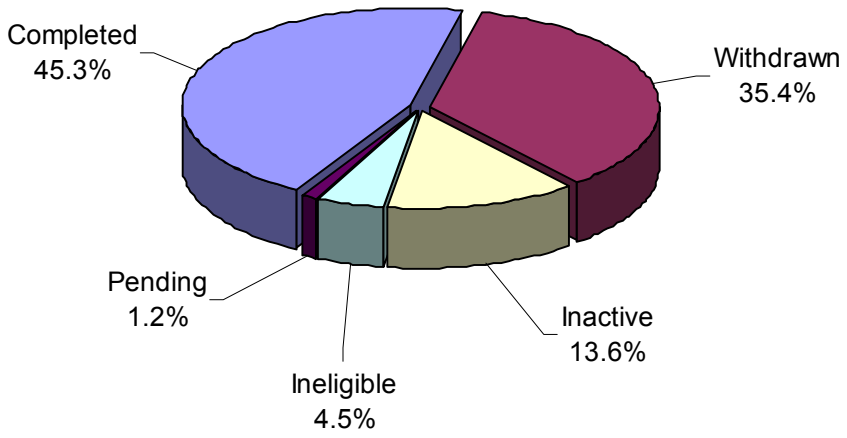
Purchasing groups are allowed, pursuant to the federal Liability Risk Retention Act of 1986, to buy commercial liability insurance on behalf of their members on a group basis. These groups are exempt from any state insurance laws that hinder or prohibit group self-insurance programs and the purchase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

Since the inception of the LRRA, the Department has received notices of intent from 911 purchasing groups. Subsequently, 322 have withdrawn their notice of intent, 124 have notified the Department of their inactive status, and 41 have been given ineligible status by the Department due to failure to comply with all the requirements of the applicable laws and regulations. As of December 31, 2006, 30% of the remaining 424 purchasing groups (11 of which are in pending status) have named unlicensed companies as their intended insurers. In 2006, the Department received notices of intent from 32 purchasing groups.

Some of the most common types of businesses and professions that have formed purchasing groups in the past year include real estate professionals, insurance professionals, entertainers, health care facilities and services, and manufacturers/dealers. Forty-eight complaints and inquiries regarding purchasing groups were received in 2006.

The following chart shows the purchasing group filings as of December 31, 2006, by status category:

CHART F
Purchasing Group Filings, 2006



f. Purchasing Group and Excess Line Investigations

The Excess Line Unit investigated a pet insurance program that was initially offered by an unlicensed insurer. The investigation revealed that the program violated the following sections of the Insurance Law: Section 2118 – failure to file affidavits, failure to file excess line premium tax statements and pay related excess line premium taxes; and Section 3435 – regarding an illegal property /casualty group insurance policy. Subsequently, the program was transferred to a licensed insurer that did not file rates and forms as required by Section 2304. The licensed insurer was notified of this fact and afterwards submitted rates and forms for Department approval. The program is now in

compliance with all applicable Department requirements. However, there are still two outstanding matters to be settled involving unpaid excess line premium taxes (approximately $144,000), and the resolution of this matter by fine and stipulation.

The Unit is also investigating a purchasing group program covering black cars. It appears this was an illegal program that covered limousines for physical damage. Purchasing groups may only provide liability coverage on a group basis and are not permitted to obtain auto physical damage on a group basis. The Unit is working in conjunction with the Consumer Services Bureau to discipline those brokers who were involved with making placements under this illegal program.

Another investigation by the Unit involved a broker who charged a policy origination fee of $2,500 on a policy with a premium of $4,000. Section 2119 of the Insurance Law states that a broker may charge a fee provided the insured acknowledges by written consent to pay the fee in addition to the premium. The agreements are known as 2119 agreements. The insured stated that he did not sign the 2119 agreement. The broker advised the Department that the fee was appropriate since this was a hard to place risk that required a great deal of work in order to obtain appropriate coverage to justify the fee. As a result of this investigation the broker has agreed to reimburse the insured the $2,500 and sign a stipulation and pay a fine of $1,000.

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

There were several investigations commenced in the Department regarding cancellation of policies with financed premiums. All these investigations were initiated by the same complainant from a premium finance company. The matter was referred to the Office of General Counsel for an opinion. Our Office of General Counsel has opined that if the policy is financed and cancelled before the end of the policy period, whatever gross unearned premiums are due under the insurance contract must be returned to the bank, lending institution or premium finance company within 60 days after the effective cancellation of the contract. Also, if the premium for an insurance policy that is subject to a premium audit is financed pursuant to a premium finance agreement and the policy is cancelled before the end of the policy, the insurer is to take into account the adjustment to premium resulting from the audit in calculating unearned premiums if any. The Office of General Counsel responded directly to the complainant.

The Unit conducted approximately 57 investigations as a result of EL-1 reviews. Several brokers were fined for placing business with unauthorized insurers without the necessary excess line broker's license. Additionally, these brokers were required to pay the excess line taxes and late payment penalties. As a result of these investigations, the Unit collected $1,987,235.53 in additional taxes, penalties and fines in 2006.

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

g. Monitoring Excess Line Market Activity

Premium writings in the excess line market for the years 2002, 2003, 2004, 2005 and 2006 were $1.324 billion, $2.097 billion, $2.610 billion, $2.769 billion, and $2.622 billion, respectively. This represents a 198% overall increase in writings during that period. Among the reasons for the upward trend are limited availability in the admitted market for coverage related to mold exposures, vacant

properties and large and complex risks, as well as continued limited participation by admitted carriers in markets where Sections 240 and 241 of the Labor Law remain an exposure factor.

The excess line market serves as a "safety valve" of sorts when insurers in the licensed market either curtail or refrain from covering certain insurance risks. Since excess line insurers are exempt from rate and form filing requirements it is easier for them to operate. The excess line market appears to be functioning as it should under present market conditions, which is to provide a financially stable insurance alternative to New York insurance risks that are unable to obtain coverage in the licensed market. We will continue to monitor excess line market activity. It appears that the trend in increased writings over the past four years has leveled off, due to improved availability in the admitted market as evidenced by the smaller percentage increase in excess line writings from 2004 to 2005 and a slight decrease in 2006.

23. Consumers Guide to Automobile Insurance

On October 1, 2006, the Department published two editions of the 2006 Consumers Guide to Automobile Insurance, one for upstate New York residents and one for downstate residents. The Department also has an interactive version of the guide on its Web site. The guide is required by Section 337 of the Insurance Law to be updated annually. This comprehensive guide helps consumers determine how much auto insurance they need and explains all mandatory and optional coverages available in New York State. The guide contains lists of insurers, telephone numbers, and sample rates to facilitate comparison shopping, and advice regarding how to file a claim or make a complaint against an insurer is also provided. Copies of the guide were distributed to every Department of Motor Vehicles office and public library in the State. The guide is also available free of charge directly from the Insurance Department and can be accessed via the Department's Web site.

24. Regulations

Regulations Adopted in 2006:

Second Amendment to Regulation 161 (Prepaid Legal Services Plans), became effective February 15, 2006. This amendment permits prepaid legal services plan to be issued or delivered on a group basis for students of a university or college.

Ninth Amendment to Regulation 41 (Excess Line Placements Governing Standards) became effective March 8, 2006. This amendment restates Section 2118(b)(6) of the Insurance Law regarding the duty of an excess line broker to deliver a stamped declarations page or cover note evidencing insurance that is stamped by the excess line association. The amendment also permits a duplicate copy of the aforementioned document to be stamped by the excess line association and updates the language on the notice that is required to be prominently displayed on written confirmations of placement of coverage with excess line insurers and the notice that is required on insurance policies issued by excess line insurers in this state. The two notices currently in use are different. The amendment makes minor changes to both notices so that the language is the same on both notices. The amendment also deletes the requirement that the notice be in red type and replaces it with the requirement that the notice be conspicuous.

Regulation 182 (Limitations Upon and Requirements for the Use of Credit Information for Personal Lines Insurance) became effective October 25, 2006. This regulation was previously effective on an emergency basis. The purpose of this regulation is to establish rules to implement the provisions of Article 28. In accordance with Article 28, the regulation establishes and clarifies limitations upon, and requirements for, the permissible use of credit information by insurers doing business in New York State to assure that consumers are afforded certain protections when credit information is used to underwrite and rate risks for personal lines insurance business. The regulation clarifies prohibited and permitted uses of credit information in the underwriting and rating of personal lines insurance. The

regulation sets forth whose credit information can be used, the form of the disclosure of the use of credit information and when the disclosure must be provided. The regulation sets forth standards for the notification when an insurer takes an adverse action based upon credit information. The regulation also requires an insurer to take corrective action within 30 days after it receives notice that the insured has obtained a determination, pursuant to the process for dispute resolution and error correction under the federal Fair Credit Reporting Act, that the credit information used by the insurer was incorrect or incomplete. The regulation also establishes rules for, and provides guidance to, insurers when submitting their credit information filings to the Department.

Twenty-ninth Amendment to Regulation 83 (Charges for Professional Health Services) became effective November 15, 2006. This amendment updates the addresses of the New York State Department of Health and the New York State Education Department for the purposes of reporting patterns of health provider overcharges, excessive treatment or any other improper actions. The amendment also updates the name of the New York State Insurance Department Bureau that is collecting the data.

Ninth Amendment to Regulation 90 (Prohibition Against Geographical Redlining and Discriminating in certain Property/Casualty Policies) became effective November 29, 2006. The current regulation already requires, for the insurance coverages stated in the regulation, all notices of refusal to issue, cancel (except where cancellation is for nonpayment of premium) or nonrenew a policy to include specific language. The amendment will make this requirement applicable when insurance companies cancel or refuse to issue or renew, a homeowner's insurance policy or a policy including fire insurance or fire and extended coverage insurance based solely on the insured residing in an area that is serviced by a volunteer fire department. The required language advises the applicant/insured to contact the insurance company with any questions regarding the termination and informs the applicant/insured that redlining based upon geographic location of the risk is prohibited and that the applicant/insured can file a complaint with the Department. The rule also updates the regulation by removing dates that are no longer applicable.

25. Circular Letters

Circular Letters Issued in 2006:

Circular Letter No. 1 regarding guidelines and procedures for the implementation of the provisions of the Terrorism Risk Insurance Extension Act of 2005 was issued on January 18, 2006 to property/casualty insurers, rate service organizations, New York Property Insurance Underwriting Association, State Insurance Fund, New York Automobile Insurance Plan, and the Excess Line Association of New York. The circular letter advised, provided information and guidance to insurers on revisions that were enacted by Congress in the Terrorism Risk Insurance Extension Act of 2005 (the Extension Act) (Public Law 109-144, 119 Stat. 2660).

Circular Letter No. 16 regarding requests for motor vehicle police accident reports was issued on July 20, 2006 to authorized motor vehicle insurers and insurance producer organizations. The circular letter advised that the New York State Police will no longer provide copies of police accident reports directly to requesting parties. Effective May 15, 2006, insurers and producers may request copies of state police accident reports from The New York Department of Motor Vehicles.

Supplement No. 1 to Circular Letter No. 7 (1993) regarding motor vehicle physical damage claims involving auto body repairs was issued on August 30, 2006 to insurers authorized to write motor vehicle liability insurance. The circular letter provides guidance to insurers regarding the requirements set forth in Section 216.7 of 11 NYCRR 216 (Regulation 64), with respect to the use of non-Original Equipment Manufacturer (non-OEM) crash parts for the repair of physical damage to motor vehicles and reminds insurers of their obligations in settling claims that are subject to Regulation 64.

Supplement No. 1 to Circular Letter No. 16 (2005) was issued September 6, 2006 to insurers authorized to write motor vehicle insurance, motor vehicle self-insurers, and the Motor Vehicle Accident Indemnification Corporation. The circular letter informed these entities that the Emergency Third Amendment to Regulation 68-C effective September 1, 2006 contains a revised denial language that must be used when denying a priority of payment dispute.

Circular Letter No. 17 regarding fair claims settlement practices: interest on overdue no-fault claims and claim settlement structure was issued September 15, 2006 to insurers authorized to write motor vehicle insurance, motor vehicle self-insurers and the Motor Vehicle Accident Indemnification Corporation (MVAIC). The purpose of this Circular Letter is to remind insurers of their obligations with respect to settling claims that are subject to Regulation 68-C.

Circular Letter No. 18 regarding cancellation and other notices – loss information requests was issued on September 20, 2006 to authorized property/casualty insurers, rate service organizations, and insurance producer organizations. The circular letter advised of the enactment of Chapter 169 of the Laws of 2006 which amends Sections 3426(e)(1)(C) and 3426(g)(2) of the Insurance Law. The legislation reduced the time period within which insurers are required to provide loss information upon written request by the first-named insured or such insured's authorized agent or broker from 20 days to 10 days.

Circular Letter No. 20 regarding homeowners insurance disclosure information and other notices and the emergency adoption of the First Amendment to Regulation 159 was issued on October 23, 2006 to authorized property/casualty insurers, rate service organizations, insurance producer organizations, and the New York Property Insurance Underwriting Association. The purpose of the circular letter was to advise that the Superintendent has promulgated the First Amendment to Regulation No. 159 (11 NYCRR 74) on an emergency basis. The Emergency First Amendment to Regulation 159 establishes the minimum notification requirements pertaining to the cancellation, nonrenewal and conditional renewal notices required by Chapter 162 of the Laws of 2006. The regulation requires that the notice shall be conspicuous and provide sufficient information on how to apply to the market assistance program and to NYPIUA, including the name, address, telephone number and Web site address of the administrator of the market assistance program and of NYPIUA.

Circular Letter No. 21 regarding premium reductions for completion of an accident prevention course pursuant to Section 2336(a) and (d) of the New York Insurance Law; revised information on course sponsor was issued on October 27, 2006 to insurers authorized to write motor vehicle insurance, rate service organizations, New York Automobile Insurance Plan, and Insurance Producer Organizations. The circular letter advised that Chapter 751 of the Laws of 2005 amended Section 2336 of the Insurance Law and added a new Article 12-C to the Vehicle and Traffic Law. The legislation establishes a 5-year pilot program for the review and study of internet technologies as a training method for the administration and completion of approved accident prevention courses (APC). To qualify for the statutorily mandated APC discount per Section 2336 of the Insurance Law, the course must be approved by the NYS Department of Motor Vehicles (DMV). However, to date, no online driving course has been approved by the DMV.

The circular letter also updates Circular Letter No. 19 (2005), which listed all Motor Vehicle Accident Prevention Course sponsors currently approved by the DMV by updating the contact information for the American Automobile Association.

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

Certain complaints and inquiries are processed independently of the Consumer Services Bureau. A total of 1,028 such complaints and inquiries were received by the Market Regulatory Division of the Property Bureau in 2006. This total consisted of 651 involving personal automobile insurance; 31 involving commercial automobile insurance; 83 involving homeowners insurance; 93 involving other liability insurance; 32 involving commercial multiple peril insurance; 38 involving medical malpractice insurance; 15 involving title insurance; 26 involving workers' compensation, 33 involving fire and allied lines, and 26 involving other types of insurance (mortgage guaranty, fidelity, surety, inland marine, etc.). In addition, the Market Regulatory Section processed 338 Freedom of Information (FOIL) requests on policy form and rate information.

27. Casualty Actuarial

The Casualty Actuarial Unit reviews rate filings for workers' compensation insurance, private passenger automobile insurance and private passenger and commercial insurance offered through the Automobile Insurance Plan. All such filings are subject to prior approval. In terms of premium volume, private passenger automobile and workers' compensation insurance are the largest property/casualty coverages, accounting for approximately $14 billion of New York premium volume in 2006.

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

a. Private Passenger Automobile Insurance

The average change for insurers receiving rate changes in 2006 was approximately -3.2%. For these insurers, liability rates decreased 2.5% on average while physical damage rates, primarily collision and theft coverages, decreased 4.7% on average. The insurers receiving rate changes in 2006 represent 63% of the total market for private passenger automobile insurance. The overall impact on the rate level for the entire market (including those auto insurers with no approved rate changes in 2006) was an average decrease of 2.0%.

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

In 2006, 62 private passenger automobile rate requests were implemented. The following table lists both the requested and implemented rate changes and provides the liability and physical damage components of such changes.

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS REVIEWED IN 2006[1]

Date of Approval	Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Taken (%)	Physical Damage Change Taken (%)	Overall Change Taken (%)
1/6/06	3/15/06	CountryWide Ins Co	0.53	-0.5	0.0	-7.4	-0.5
1/9/06	3/15/06	Hudson Ins Co	0.17	-0.5	0.0	-7.4	-0.5
1/10/06	5/15/06	Met: MP&CIC; MCIC	1.39	-3.2	-3.2	-3.2	-3.2
1/27/06	3/1/06	Erie: EIC; EICoNY	0.69	-3.7	-3.7	-3.7	-3.7
2/3/06	5/1/06	Farmers: Farmers New Century Ins Co	0.55	5.3	11.0	-3.8	5.3
2/6/06	4/15/06	Commercial Mutual Ins Co	0.01	-25.0	0.0	-25.0	-25.0
2/10/06	8/1/06	Merastar Ins Co	0.02	4.6	-2.4	-13.1	-5.5
2/13/06	5/6/06	Nationwide: Nationwide Ins Co of America; Nationwide General Ins Co	0.11	-3.0	-3.0	-3.0	-3.0
2/14/06	4/1/06	TriState Consumer Ins Co	0.22	-5.3	-2.6	-11.1	-5.3
2/27/06	2/27/06	Lincoln General Ins Co (new Take Out Program)	0.00	0.0	0.0	0.0	0.0
3/1/06	5/24/06	Harleysville: HWIC	0.05	6.2	2.0	-12.2	-1.9
3/1/06	5/24/06	Harleysville: HICofNY	0.09	3.0	2.9	-11.0	-1.3
3/1/06	4/1/06	Travelers: Farmington Casualty Co	0.07	-5.6	-3.8	-23.4	-5.6
3/2/06	7/3/06	GMAC: NSIC; CIMIC; MICP&CIC	1.33	-0.3	2.3	-7.4	-0.3
3/3/06	4/23/06	Travelers: AICofHCT; COFIC; PIC; SFIC; TIC; TICofA; TICofCT; TrIC;TCCofCT; TPCCofA; TPCIC	5.73	0.0	0.0	0.0	0.0
3/8/06	6/1/06	Middlesex Mutual: HMICinS	0.02	6.0	5.7	6.6	6.0
3/8/06	7/3/06	Hartford: Trumbull Ins Co	0.09	8.0	11.2	-2.2	8.0
3/10/06	5/15/06	Liberty Mutual Group: LIC	0.33	0.0	0.0	0.0	0.0
3/16/06	4/10/06	Unitrin: UAIC	0.07	-8.8	-3.9	-24.9	-8.8
3/21/06	5/26/06	White Mountain: AOSIC (former PGICoNY)	0.00	1.8	1.8	1.8	1.8
3/22/06	5/15/06	Liberty Mutual Group: Peerless Ins Co	0.40	-1.3	5.3	-16.6	-4.4
3/29/06	6/19/06	Hartford: Sentinel Ins Co Ltd	0.16	-5.3	-5.3	-5.3	-5.3
4/5/06	4/6/06	Clarendon National Ins. Co.	0.32	30.6	16.6	5.3	15.0
4/10/06	7/24/06	Safeco Insurance Company of Indiana	0.18	17.8	15.1	0.0	10.0
4/14/06	9/1/06	Allstate: Encompass Indemnity Company	0.18	-0.1	-0.2	0.0	-0.1
4/20/06	7/17/06	Liberty: Liberty Mutual Fire Ins. Co.	3.59	0.5	0.5	0.5	0.5
4/20/06	5/15/06	Utica Group: Utica Mutual Ins Co; Graphic Arts Mut Iins Co; Republic Franklin Ins Co; Utica National Assurance Co	0.43	-11.0	-7.4	-17.0	-11.0
5/5/06	8/7/06	White Mountains: AOIC	1.28	2.4	5.2	-20.8	2.4
5/10/06	5/15/06	New York Central Mutual Fire	3.15	-5.4	-5.4	-5.3	-5.4
5/17/06	9/8/06	Sentry: SIAMC; MIC; PGIC	0.01	0.5	11.0	-8.5	0.5
6/2/06	10/12/06	White Mountains:PGIC	0.01	0.0	0.0	0.0	0.0
6/5/06	7/1/06	Sterling Ins Co	0.03	-3.2	0.0	-7.0	-3.2
6/12/06	8/14/06	Progressive: Progressive Halcyon Ins Co	0.39	-4.5	-4.3	-4.9	-4.5
6/19/06	8/15/06	Nationwide: Nationwide Mutual Fire Ins Co	0.04	6.1	8.0	0.0	6.1
6/26/06	9/4/06	Safeco Group: SICA; FNICA; GICA	0.12	2.9	13.5	-11.3	2.9
6/27/06	8/28/06	GEICO: GEICO; GEICOGIC; GEICOIC	16.00	-4.2	-2.5	-7.7	-4.2
7/5/06	8/15/06	Nationwide: Nationwide Mutual Fire Ins Co	*	0.0	-1.3	-1.3	-1.3
7/7/06	9/15/06	AIG: New Hampshire Indemnity Company	0.05	5.3	7.6	0.0	5.3
7/14/06	11/1/06	Merchant's Mutual: MMIC	0.05	-7.1	-7.1	-7.1	-7.1
7/31/06	7/31/06	Michigan Millers Mutual Ins Co	0.02	23.6	14.0	-7.0	5.3
8/4/06	9/23/06	AIG: Granite State Ins Co	0.01	11.9	5.9	-1.7	4.5
8/15/06	10/1/06	TriState Consumer Ins Co	*	-5.5	-5.5	-5.5	-5.5

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS REVIEWED IN 2006[1]
(continued)

Date of Approval	Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Taken (%)	Physical Damage Change Taken (%)	Overall Change Taken (%)
8/16/06	11/1/06	Erie: EIC; EICoNY	*	0.0	0.0	0.0	0.0
8/17/06	12/1/06	AIG: AIG National Ins Co	0.07	6.9	5.3	11.1	6.9
8/21/06	12/13/06	Esurance Ins Co	0.07	1.1	-2.2	11.4	1.1
8/23/06	10/14/06	Amex Assurance Co	0.27	-8.6	-7.5	-11.0	-8.6
8/25/06	12/1/06	Amica Mutual Ins Co	1.07	-8.2	-8.2	-8.2	-8.2
9/20/06	11/1/06	Eveready Ins Co	0.18	-3.3	3.4	-12.4	-3.3
9/26/06	12/15/06	Nationwide: Nationwide Ins Co of America; Nationwide General Ins Co	*	-6.4	-6.4	-6.7	-6.4
10/5/06	11/15/06	Progressive:PPIC	0.00	0.0	0.0	0.0	0.0
10/5/06	11/22/06	Progressive: PNE; PNW; PN	7.04	-2.3	-2.8	-0.9	-2.3
10/13/06	3/1/07	Farmers:Farmers New Century Ins Co	*	-0.1	-0.1	-0.1	-0.1
10/30/06	1/12/07	White Mountains: AOSIC	0.00	8.4	10.3	2.8	8.4
10/31/06	1/3/07	State Farm Mutual Automobile Ins Co	9.54	-6.5	-10.3	0.3	-6.5
10/31/06	1/3/07	State Farm Fire and Casualty Co	1.23	-8.9	-10.9	-2.0	-8.9
11/1/06	11/1/06	USAA	0.90	-5.0	-2.0	-9.6	-5.0
11/13/06	1/22/07	Response Worldwide Ins Co	0.19	-4.0	0.0	-12.9	-4.0
11/16/06	1/15/07	Liberty: LMFIC; TFLIC	3.83	1.8	3.1	-5.9	0.0
11/16/06	1/15/07	Liberty: LIC	0.35	8.9	8.0	-6.1	4.0
12/12/06	12/29/06	GMAC: National General Ins Co	0.18	5.0	15.0	-7.5	5.0
12/13/06	1/22/07	Hanover: AFAIC	0.00	4.5	4.4	4.9	4.5
12/22/06	8/5/07	Farm Family Casualty Ins Co	0.33	0.0	15.2	-22.6	0.0

2005 Rate Change Summary	**Filings**
• Number of insurer rate filings:	62
• Average liability change for insurers receiving rate changes:	-2.5%
• Percentage of total liability industry premium affected:	62.3%
• Impact on the entire market of the overall average liability rate change:	-1.6%
• Average physical damage change for insurers receiving rate changes:	-4.7%
• Percentage of total physical damage industry premium affected:	64.9%
• Impact on the entire market of the overall average physical damage change:	-3.0%
• Average combined liability and physical damage change for insurers receiving rate changes:	-3.2%
• Percentage of total industry premium affected:	63.2%
• Impact on the entire market of the overall average liability and physical damage rate change:	-2.0%

[1] All rate filings (and classification changes) are subject to prior approval.
[2] These market shares are based on 2004 Annual Statement premiums.
[*] Subsequent filing by this insurer in same year.

b. New York Automobile Insurance Plan (NYAIP) Experience in 2004 and 2005

i. Earned Car Years

An important indicator of the size of the Assigned Risk Plan (a.k.a., New York Automobile Insurance Plan) is earned car years. This reflects the size of the Plan as measured by the duration of coverage. (One car insured for one year equals one earned car year.) The number of private passenger automobiles (not including commercial autos) insured through the Plan decreased 26.7% for liability and 41.6% for collision from 2004 to 2005. Table 42 shows a ten-year history for voluntary and assigned liability and assigned collision earned car years.

Table 42
Liability and Collision Earned Car Years in the Voluntary and Assigned Risk Market
1996 – 2005

Calendar Year	Voluntary Liability	Percent Change From Previous Year	Assigned Risk Liability	Percent Change From Previous Year	Combined Liability	Percent Change From Previous Year	Assigned Risk Collision	Percent Change From Previous Year
1996	6,662,881		970,552		7,633,433		51,547	
1997	7,049,333	5.8	744,973	-23.2	7,794,306	2.1	39,948	-22.5
1998	7,428,546	5.4	541,247	-27.3	7,969,793	2.3	23,988	-40.0
1999	8,031,017	8.1	324,355	-40.1	8,355,372	4.8	11,631	-51.5
2000	8,106,797	0.9	207,802	-35.9	8,314,599	-0.5	9,408	-19.1
2001	8,147,522	0.5	343,511	65.3	8,491,033	2.1	27,597	193.3
2002	8,463,417	3.9	444,437	29.4	8,907,854	4.9	47,234	71.2
2003	8,313,121	-1.8	471,158	6.0	8,784,279	-1.4	47,981	1.6
2004	8,356,929	0.5	369,200	-21.6	8,726,129	-0.7	31,501	-34.3
2005	8,602,031	2.9	270,485	-26.7	8,872,516	1.7	18,386	-41.6

ii. Risks by Surcharge Category

In 2005, there were 270,485 private passenger earned car years for liability and 18,386 for collision coverage insured through the Assigned Risk Plan. Table 43 shows the distribution of New York private passenger liability and collision assigned risks by surcharge category for 2003, 2004 and 2005.

Table 43
DISTRIBUTION OF PRIVATE PASSENGER AUTOMOBILE ASSIGNED RISKS
LIABILITY AND COLLISION COVERAGES
by Discount or Surcharge Category, 2003 – 2005

	Liability			Collision		
	2003	2004	2005	2003	2004	2005
Discount or Surcharge Category	(%)	(%)	(%)	(%)	(%)	(%)
Total, all categories	100	100	100	100	100	100
Total Unsurcharged	58.1	58	58.1	55.1	57.5	60.2
3 Years Claim Free (1 or less with Plan) (Manual Rates)	40.5	38.6	36	36.9	34.6	29.7
Experience Discount						
4 Years (One or more with Plan) – 18% Credit	9.9	9.4	9.8	11.1	11.4	12.9
5 Years (Two or more with Plan) – 25% Credit	4.5	5.4	6	4.7	6.6	9.3
6 Years or more (Three or more w/Plan) – 30% Credit	3.2	4.6	6.2	2.4	4.9	8.3
Total Surcharged	41.9	42	41.9	44.9	42.5	39.8
Inexperienced Operator Surcharge	20	21.1	21.7	16	15.4	14.4
Experience Surcharge						
15%	12.7	11.9	11.2	17	15.6	14.3
25%	0.2	0.2	0.2	0.2	0.2	0.2
35%	3.4	3.1	2.8	5	4.5	4
50%	1.8	1.8	1.9	1.8	1.7	1.6
75%	1.3	1.3	1.3	1.8	1.8	1.8
100%-200%	2.6	2.7	2.8	3.2	3.3	3.5

iii. Risks by Rating Territory

The proportions of all private passenger liability risks that are assigned risks, listed by rating territory for 2004 and 2005, are shown in Table 44. During 2005, 3.0% of all New York State private passenger automobiles were assigned risks as opposed to 4.2% in 2004. The proportion of assigned risks was 10% or higher in 4 of the 70 rating territories in 2004 and was 10% or higher in only 1 of the 70 in 2005. The highest 2005 ratio was 26.9% in the Bronx Territory and the lowest was 0.1% in the Dutchess County (Balance) Territory. Between 2004 and 2005 the number of assigned risks decreased in all 70 rating territories.

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

Table 44: NY Private Passenger Automobile Exposures in Earned Car Years by Territory for the Voluntary and Assigned Risk Markets											
		2004			2005			# Change	% Change	#Change	% Chng.
Territory		Assigned	Voluntary	Total	Assigned	Voluntary	Total	In A/R	In A/R	in Market	in Mrkt.
01	Bronx Territory	17,997	32,286	50,283	13,541	36,773	50,313	-4,456	-24.8	30	0.1
03	Bronx Suburban Territory	20,717	161,397	182,115	14,988	167,189	182,177	-5,730	-27.7	62	0.0
05	Staten Island	12,211	217,529	229,740	8,700	224,988	233,687	-3,511	-28.8	3,947	1.7
07	Buffalo	6,824	113,604	120,428	5,058	116,841	121,899	-1,765	-25.9	1,471	1.2
08	Buffalo Semi-Suburban	4,626	187,501	192,127	3,811	186,417	190,228	-815	-17.6	-1,899	-1.0
09	Schenectady County	1,509	103,382	104,891	1,144	108,247	109,391	-364	-24.2	4,501	4.3
11	Rochester	13,223	400,707	413,931	10,846	386,647	397,493	-2,377	-18.0	-16,438	-4.0
12	Syracuse	3,830	216,698	220,529	2,868	219,500	222,368	-962	-25.1	1,839	0.8
13	Albany	2,008	163,335	165,343	1,336	168,414	169,750	-672	-33.5	4,407	2.7
14	Niagara Falls	2,408	68,512	70,920	2,043	70,016	72,059	-365	-15.2	1,140	1.6
15	Utica	466	61,972	62,439	341	62,650	62,991	-125	-26.8	553	0.9
16	Saratoga Springs Suburban	156	49,432	49,587	109	51,131	51,240	-47	-30.1	1,653	3.3
17	Kings County	16,227	316,591	332,818	8,897	324,763	333,660	-7,329	-45.2	842	0.3
18	Manhattan	16,581	142,192	158,773	11,234	150,200	161,434	-5,347	-32.2	2,661	1.7
19	Queens	7,189	49,541	56,730	4,626	51,524	56,150	-2,563	-35.7	-580	-1.0
20	Hempstead	22,185	447,127	469,312	14,910	448,660	463,570	-7,275	-32.8	-5,742	-1.2
21	North Hempstead	6,547	152,656	159,203	4,815	154,498	159,313	-1,732	-26.5	110	0.1
22	Oyster Bay	9,065	243,440	252,505	6,912	256,281	263,193	-2,152	-23.7	10,688	4.2
24	Rome	314	22,878	23,192	227	23,402	23,629	-86	-27.5	438	1.9
25	Auburn	128	24,294	24,422	66	24,457	24,524	-62	-48.3	101	0.4
27	Elmira	53	49,845	49,899	37	51,100	51,137	-16	-30.0	1,238	2.5
28	Binghamton	2,350	112,606	114,956	1,750	113,523	115,273	-600	-25.5	317	0.3
29	Gloversville	263	27,669	27,932	181	28,737	28,918	-82	-31.2	986	3.5
30	Saratoga Springs	98	24,375	24,473	66	26,050	26,117	-32	-32.4	1,643	6.7
31	Chautauqua County	868	82,517	83,385	667	86,476	87,143	-200	-23.1	3,759	4.5
32	Newburgh	2,171	68,286	70,457	1,697	70,639	72,336	-474	-21.8	1,879	2.7
33	Poughkeepsie	2,349	103,637	105,986	1,881	105,177	107,059	-467	-19.9	1,073	1.0
34	Troy	1,262	60,169	61,431	929	62,303	63,232	-333	-26.4	1,801	2.9
35	Amsterdam	140	22,138	22,278	86	22,612	22,698	-54	-38.5	420	1.9
36	Glens Falls	802	43,211	44,014	594	46,093	46,687	-208	-25.9	2,673	6.1
37	Oswego	848	34,189	35,037	587	36,411	36,998	-261	-30.8	1,961	5.6
38	Syracuse Suburban	203	60,700	60,903	147	63,234	63,381	-56	-27.5	2,478	4.1
39	Rochester Suburban	166	40,142	40,308	117	40,553	40,671	-49	-29.6	362	0.9
40	Corning	22	28,647	28,668	16	29,433	29,449	-6	-25.8	781	2.7
41	Erie County (Balance)	695	82,813	83,509	565	84,466	85,031	-130	-18.7	1,523	1.8
42	Buffalo Suburban	3,373	152,816	156,189	2,942	158,954	161,896	-431	-12.8	5,707	3.7

Table 44: NY Private Passenger Automobile Exposures in Earned Car Years by Territory for the Voluntary and Assigned Risk Markets											
		2004			2005			# Change	% Change	#Change	% Chng.
Territory		Assigned	Voluntary	Total	Assigned	Voluntary	Total	In A/R	In A/R	in Market	in Mrkt.
43	Niagara Falls Suburban	512	33,148	33,661	425	34,368	34,793	-87	-17.1	1,133	3.4
44	Broome County (Balance)	64	20,529	20,593	43	22,058	22,102	-21	-32.2	1,509	7.3
46	Putnam County	2,021	74,694	76,715	1,585	76,756	78,341	-436	-21.6	1,626	2.1
47	Orleans County	251	26,073	26,323	166	26,938	27,105	-84	-33.6	781	3.0
48	Monroe County (Balance)	106	20,648	20,754	69	40,723	40,792	-37	-35.1	20,038	96.6
49	Niagara County (Balance)	215	32,721	32,936	167	33,601	33,768	-48	-22.3	832	2.5
51	Ontario County, etc.	2,900	194,935	197,835	2,109	201,235	203,344	-791	-27.3	5,509	2.8
52	Fort Plain, Herkimer	470	38,114	38,584	326	40,474	40,800	-144	-30.6	2,217	5.7
54	Cortland County, etc.	3,313	194,501	197,814	2,644	197,866	200,510	-669	-20.2	2,696	1.4
55	Queens Suburban	34,185	509,952	544,137	20,823	526,079	546,902	-13,362	-39.1	2,765	0.5
56	Saratoga County (Balance)	187	30,341	30,528	125	32,129	32,255	-62	-33.1	1,727	5.7
58	Dutchess County (Balance)	1,837	93,817	95,654	1,444	99,783	101,227	-393	-21.4	5,572	5.8
59	Columbia County, etc.	1,034	81,606	82,639	719	84,965	85,684	-315	-30.5	3,045	3.7
60	Genesee County	414	39,066	39,481	263	39,417	39,680	-151	-36.4	200	0.5
61	Delaware County, etc.	2,354	134,311	136,665	1,667	139,515	141,181	-687	-29.2	4,517	3.3
62	Highland, Kingston	2,755	83,680	86,435	2,142	86,161	88,303	-614	-22.3	1,867	2.2
64	Middletown	6,306	152,638	158,944	5,227	159,850	165,077	-1,079	-17.1	6,133	3.9
65	Ossining	7,365	181,999	189,363	5,758	183,614	189,372	-1,606	-21.8	9	0.0
67	Clinton County, etc.	10,629	324,951	335,581	9,063	337,122	346,185	-1,567	-14.7	10,604	3.2
68	Rockland County	5,541	181,820	187,361	3,711	185,645	189,356	-1,830	-33.0	1,995	1.1
71	Saratoga County South	131	43,446	43,577	72	44,898	44,969	-59	-45.3	1,393	3.2
72	Albany County (Balance)	50	13,304	13,353	33	14,524	14,558	-16	-32.7	1,204	9.0
73	Rensselaer County (Balance)	463	39,268	39,731	328	41,831	42,159	-135	-29.2	2,427	6.1
74	Jefferson County	837	66,479	67,316	694	70,511	71,206	-143	-17.0	3,890	5.8
75	Suffolk County West	32,607	510,603	543,209	23,815	529,648	553,463	-8,791	-27.0	10,254	1.9
76	Suffolk County East	41,271	433,591	474,862	34,635	444,475	479,110	-6,636	-16.1	4,248	0.9
81	Monticello-Liberty	159	13,238	13,397	95	13,883	13,978	-64	-40.4	581	4.3
82	Sullivan County Central	290	14,510	14,800	188	15,796	15,985	-102	-35.2	1,184	8.0
83	Sullivan County (Balance)	463	21,959	22,421	386	23,106	23,492	-77	-16.6	1,071	4.8
84	Allegany County, etc.	3,539	181,878	185,418	2,792	186,305	189,097	-748	-21.1	3,679	2.0
86	Oneida	304	39,631	39,935	211	40,844	41,055	-93	-30.7	1,120	2.8
94	Mount Vernon and Yonkers	10,608	100,501	111,108	7,602	103,893	111,495	-3,006	-28.3	387	0.3
95	White Plains	3,396	44,845	48,242	2,517	46,134	48,651	-880	-25.9	409	0.8
97	New York City Suburban	12,747	215,297	228,044	9,902	219,523	229,425	-2,845	-22.3	1,381	0.6
	Entire State	**369,200**	**8,356,929**	**8,726,129**	**270,485**	**8,602,031**	**8,872,517**	**-98,714**	**-26.7**	**146,388**	**1.7**

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

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 1999-2005															
		1999		2000		2001		2002		2003		2004		2005	
Territory		(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
01	Bronx Territory	34.3	1	30.9	1	40.1	1	46.7	1	47.0	1	35.8	1	26.9	1
19	Queens	26.0	2	15.8	2	17.7	2	19.1	2	18.6	2	12.7	2	8.2	2
03	Bronx Suburban Territory	13.2	4	9.4	4	12.2	4	14.0	4	15.4	4	11.4	3	8.2	3
76	Suffolk County East	4.4	9	3.0	8	5.7	8	8.4	7	10.0	6	8.7	6	7.2	4
18	Manhattan	14.7	3	10.8	3	14.5	3	16.2	3	15.7	3	10.4	4	7.0	5
94	Mount Vernon and Yonkers	7.2	7	5.2	7	8.7	6	11.1	5	12.6	5	9.5	5	6.8	6
95	White Plains	2.9	14	2.2	13	4.9	9	6.7	9	8.1	8	7.0	7	5.2	7
97	New York City Suburban	3.2	12	2.5	11	4.3	13	6.0	13	6.7	13	5.6	11	4.3	8
75	Suffolk County West	4.3	10	2.5	10	4.5	11	6.5	10	7.6	10	6.0	9	4.3	9
07	Buffalo	1.2	31	1.0	24	4.5	12	6.1	12	7.2	11	5.7	10	4.1	10
55	Queens Suburban	11.9	6	6.9	6	9.0	5	10.0	6	10.0	7	6.3	8	3.8	11
05	Staten Island	4.6	8	2.7	9	4.8	10	6.1	11	7.0	12	5.3	12	3.7	12
20	Hempstead	4.1	11	2.3	12	4.1	14	5.8	14	6.5	14	4.7	14	3.2	13
64	Middletown	2.3	18	1.7	16	2.9	17	4.2	17	4.7	17	4.0	16	3.2	14
65	Ossining	2.2	19	1.6	17	3.0	16	4.2	16	4.7	16	3.9	17	3.0	15
21	North Hempstead	3.1	13	1.9	14	3.2	15	4.5	15	5.2	15	4.1	15	3.0	16
14	Niagara Falls	0.6	43	0.4	44	1.6	29	2.8	28	3.6	22	3.4	19	2.8	17
11	Rochester	0.6	46	0.6	38	2.5	21	3.4	21	3.8	20	3.2	20	2.7	18
17	Kings County	13.1	5	6.9	5	8.3	7	8.4	8	8.1	9	4.9	13	2.7	19
22	Oyster Bay	2.8	15	1.9	15	2.9	18	4.0	18	4.5	18	3.6	18	2.6	20
67	Clinton County, etc.	1.4	26	1.0	23	2.0	26	3.3	23	3.5	24	3.2	22	2.6	21
62	Highland, Kingston	1.8	21	1.3	20	2.7	19	3.7	19	3.9	19	3.2	21	2.4	22
32	Newburgh	1.1	32	0.7	33	1.6	30	2.8	29	3.5	23	3.1	23	2.3	23
46	Putnam County	2.3	17	1.5	19	2.3	22	3.2	24	3.2	26	2.6	25	2.0	24
08	Buffalo Semi-Suburban	0.7	41	0.6	37	1.5	35	2.3	33	2.7	30	2.4	27	2.0	25
68	Rockland County	1.2	30	0.8	31	2.0	25	3.1	25	3.8	21	3.0	24	2.0	26
42	Buffalo Suburban	0.9	36	0.6	34	1.5	34	2.3	34	2.5	33	2.2	29	1.8	27
33	Poughkeepsie	1.6	24	1.0	25	2.1	24	2.9	26	2.7	29	2.2	28	1.8	28
83	Sullivan County (Balance)	2.1	20	1.1	22	1.6	31	2.2	37	2.4	36	2.1	30	1.6	29
37	Oswego	1.7	23	0.9	26	2.1	23	3.4	22	3.5	25	2.4	26	1.6	30
28	Binghamton	0.9	39	0.6	35	1.4	36	2.4	31	2.6	31	2.0	32	1.5	31
84	Allegany County, etc.	0.9	38	0.6	36	1.3	38	2.2	38	2.4	35	1.9	35	1.5	32
34	Troy	1.3	28	0.8	27	1.8	28	2.8	27	2.7	28	2.1	31	1.5	33
58	Dutchess County (Balance)	1.6	25	1.1	21	2.0	27	2.7	30	2.6	32	1.9	34	1.4	34
54	Cortland County, etc.	1.1	33	0.8	30	1.5	33	2.1	39	2.1	39	1.7	39	1.3	35
12	Syracuse	0.5	53	0.4	48	1.4	37	2.2	36	2.5	34	1.7	37	1.3	36

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 1999-2005															
		1999		2000		2001		2002		2003		2004		2005	
Territory		(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
36	Glens Falls	1.0	34	0.5	40	1.3	41	2.3	32	2.3	37	1.8	36	1.3	37
43	Niagara Falls Suburban	0.4	58	0.2	55	0.8	50	1.6	47	1.9	41	1.5	40	1.2	38
61	Delaware County, etc.	1.2	29	0.8	28	1.5	32	2.2	35	2.3	38	1.7	38	1.2	39
82	Sullivan County Central	2.8	16	1.5	18	2.6	20	3.4	20	3.1	27	2.0	33	1.2	40
09	Schenectady County	0.6	44	0.3	50	0.9	49	1.6	45	1.8	43	1.4	42	1.0	41
51	Ontario County, etc.	0.8	40	0.5	42	1.1	44	1.7	43	1.8	44	1.5	41	1.0	42
74	Jefferson County	0.9	37	0.5	41	1.0	46	1.5	49	1.4	50	1.2	45	1.0	43
24	Rome	0.5	52	0.4	46	1.3	39	1.9	41	1.9	40	1.4	43	1.0	44
59	Columbia County, etc.	1.3	27	0.7	32	1.2	43	1.8	42	1.6	46	1.3	44	0.8	45
52	Fort Plain, Herkimer	0.5	50	0.5	43	1.0	45	1.5	48	1.6	47	1.2	46	0.8	46
13	Albany	1.0	35	0.5	39	1.2	42	2.0	40	1.9	42	1.2	47	0.8	47
73	Rensselaer County (Balance)	0.6	45	0.4	45	0.9	48	1.4	50	1.5	49	1.2	49	0.8	48
31	Chautauqua County	0.6	47	0.3	54	0.6	54	1.0	55	1.1	52	1.0	51	0.8	49
81	Monticello-Liberty	1.7	22	0.8	29	1.3	40	1.7	44	1.7	45	1.2	48	0.7	50
41	Erie County (Balance)	0.6	48	0.3	53	0.7	51	1.0	54	1.0	55	0.8	54	0.7	51
60	Genesee County	0.4	55	0.3	51	0.6	55	1.1	51	1.3	51	1.0	50	0.7	52
29	Gloversville	0.7	42	0.3	49	0.6	56	0.7	61	1.0	57	0.9	53	0.6	53
47	Orleans County	0.5	49	0.3	52	0.9	47	1.6	46	1.5	48	1.0	52	0.6	54
15	Utica	0.2	64	0.2	59	0.5	59	0.9	56	1.1	53	0.7	56	0.5	55
86	Oneida	0.5	51	0.4	47	0.7	53	1.0	53	1.0	54	0.8	55	0.5	56
49	Niagara County (Balance)	0.2	63	0.1	66	0.4	61	0.7	60	0.8	61	0.7	57	0.5	57
56	Saratoga County (Balance)	0.3	61	0.1	62	0.5	57	0.9	57	0.8	60	0.6	59	0.4	58
35	Amsterdam	0.4	56	0.2	56	0.3	65	0.8	58	0.8	59	0.6	58	0.4	59
39	Rochester Suburban	0.2	65	0.1	67	0.4	62	0.5	66	0.6	62	0.4	62	0.3	60
25	Auburn	0.3	60	0.2	60	0.5	58	0.8	59	0.9	58	0.5	60	0.3	61
30	Saratoga Springs	0.5	54	0.2	61	0.4	64	0.6	64	0.5	65	0.4	63	0.3	62
38	Syracuse Suburban	0.3	62	0.1	64	0.3	68	0.5	67	0.5	66	0.3	65	0.2	63
72	Albany County (Balance)	0.3	59	0.2	57	0.4	63	0.7	62	0.5	63	0.4	64	0.2	64
16	Saratoga Springs Suburban	0.2	66	0.1	68	0.3	66	0.5	65	0.5	67	0.3	66	0.2	65
44	Broome County (Balance)	0.4	57	0.2	58	0.4	60	0.6	63	0.5	64	0.3	67	0.2	66
48	Monroe County (Balance)	0.2	68	0.1	63	0.7	52	1.0	52	1.0	56	0.5	61	0.2	67
71	Saratoga County South	0.2	67	0.1	65	0.3	67	0.4	68	0.4	68	0.3	68	0.2	68
27	Elmira	0.1	69	0.1	70	0.2	69	0.2	69	0.1	69	0.1	69	0.1	69
40	Corning	0.1	70	0.1	69	0.2	70	0.2	70	0.1	70	0.1	70	0.1	70
	Entire State	**3.9**		**2.5**		**4.0**		**5.3**		**5.6**		**4.2**		**3.0**	

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

c. Workers' Compensation Insurance

On May 12, 2006, the New York Compensation Insurance Rating Board (NYCIRB) filed, on behalf of its members and subscribers, a 7.5% increase in workers' compensation rates. The 7.5% is made up of the overall traditional change of 6.8% and a change of 24% on 4% of the premium which reflects the increase in the deductible that insurers are responsible for in the Terrorism Risk Insurance Extension Act (TRIEA). This change, along with a 0.9% change in the New York Assessment Fee, would have produced an increase in cost to policyholders of 8.5%.

In 2005, at the direction of the Insurance Department, the NYCIRB started to include two important changes in its submission:

- Large deductible policies were included in its original filing.
- For the first time since 1958 the experience of the State Insurance Fund was included in the determination of the general rate level.

These changes were continued in this revision.

The filing was disapproved by the Superintendent of Insurance in the Department's Opinion and Decision of July 15, 2006.

In 2006 the NYCIRB received no change in rate level. Along with the reflection of the change in the NY Assessment Fee, paid at the same time as the premium, the overall change in payments by policyholders rose by 0.9%. Those changes are shown directly below:

Year	Net Change*
1996	-18.2%
1997	-8.4%
1998	-6.0%
1999	3.9%
2000	0.0%
2001	-1.8%
2002	-1.2%
2003	2.9%
2004	0.7%
2005	7.2%
2006	0.9%

*Net change includes rate level and assessment charge changes.

Note that the premium level effective October 1, 2006 is 20.4% lower than that in effect in 1995.

Table 46
WORKERS' COMPENSATION DIVIDEND CLASSIFICATION PLAN APPROVED 2005

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

COMPANY NAME	PLAN TYPE	APPROVAL DATE
Nationwide Agribusiness	A,B,C	7/27/06
PMA Insurance Group	B	7/10/06

Table 47
WORKERS' COMPENSATION RATE HISTORY 1980-2006
New York Compensation Insurance Rating Board*

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

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

Table 48: WORKERS' COMPENSATION — RATE DEVIATIONS (Approved as of February 1, 2007)*

Company Name	Effective Date	Downward Deviation	Company Name	Effective Date	Downward Deviation
Ace Fire Underwriters Ins Co	03/23/95	10.0	EastGuard Ins Co	02/01/04	10.0
Admiral Ins Co	05/17/96	15.0	Erie Ins Co of New York	12/01/05	10.0
AIU Ins Co	05/15/96	15.0	Federated Service Ins Co	10/01/06	10.0
Alea North America Ins Co	04/17/03	5.0	Fidelity & Deposit Co of Maryland	10/15/97	10.0
All America Ins Co	08/01/96	10.0	Fidelity & Guaranty Ins Co	08/04/83	15.0
American Automobile Ins Co	06/13/83	16.0	Fidelity & Guaranty Ins Underwriters Inc.	12/22/97	10.0
American Casualty Co of Reading, PA	03/01/01	15.0	Fire & Casualty Ins Co of CT	02/13/98	10.0
American Economy Ins Co	06/01/96	10.0	Fireman's Fund Ins Co	02/15/85	10.0
American Employers' Ins Co	10/01/99	15.0	Florists' Mutual Ins Co	10/01/05	5.0
American Fire & Casualty Co	10/25/01	10.0	Fremont Indemnity Ins Co	10/28/97	15.0
American Guarantee & Liability Ins Co	04/15/01	10.0	Frontier Ins Co	04/07/98	10.0
American Manufacturers Mutual Ins Co	10/01/85	10.0	General Security P&C Ins Co	06/03/99	10.0
American Protection Ins Co	06/02/93	15.0	Globe Indemnity Co	03/01/03	10.0
American-Zurich Ins Co	12/01/96	15.0	Graphic Arts Mutual Ins Co	01/01/84	15.0
AmGuard Ins Co	02/01/04	5.0	Great American Alliance Ins Co	10/01/01	10.0
Argonaut-Midwest Ins Co	12/01/01	10.0	Great Amer Assur Co	10/01/00	10.0
Atlantic Mutual Ins Co	06/01/00	5.0	Great Northern Ins Co	08/12/85	7.0
Atlantic Specialty Ins Co	08/01/96	15.0	GuideOne Mutual	02/01/94	12.5
Automobile Ins Co of Hartford, CT	05/25/83	15.0	Harleysville Worcester Ins Co	10/01/85	10.0
AutoOne Select Ins Co (formerly PG of NY)	01/01/07	0.0	Hartford Casualty Ins Co	04/01/99	15.0
Bankers Standard Ins Co	03/23/95	15.0	Hartford Fire Ins Co	10/01/86	15.0
Blue Ridge Indemnity Co	06/01/01[1]	10.0	Hartford Ins. Co. of the Midwest	05/02/86	10.0
Blue Ridge Indemnity Co	05/01/01[2]	10.0	Hartford Underwriters Ins Co	04/01/99	5.0
Casualty Ins Co	10/28/97	15.0	Homeland Ins Co of NY	01/01/07	0.0
Centennial Ins Co	07/15/88	10.0	Indemnity Ins Co of North America	01/01/97	15.0
Centre Ins Co	02/01/97	15.0	Insurance Co of Greater New York	02/01/01	10.0
Centurion Ins Co	08/01/99	10.0	Legion Ins Co	01/01/02	10.0
Chubb Indemnity Co	05/01/96	15.0	Liberty Insurance Corporation	01/01/00	14.0
Cincinnati Ins Co	12/15/99	10.0	Liberty Mutual Fire Ins Co	01/01/00	5.0
Citizens Ins Co of America	10/01/01	10.0	Main Street America Assurance Co	11/11/02	7.5
Colonial American Casualty & Surety Co	10/15/97	10.0	Massachusetts Bay Ins Co	10/01/01	5.0
Commercial Compensation Ins Co	04/01/98	10.0	Merchants Ins Co of New Hampshire	01/01/02	10.0
Connecticut Indemnity Co	02/27/97	15.0	Michigan Millers Mutual Ins Co	06/01/98	10.0
Continental Western Ins Co	06/10/06	10.0	Netherlands Ins Co	04/01/97	15.0

Table 48: WORKERS' COMPENSATION — RATE DEVIATIONS (Approved as of February 1, 2007)
(continued)

Company Name	Effective Date	Downward Deviation	Company Name	Effective Date	Downward Deviation
New Hampshire Ins Co	05/15/96	15.0	Selective Way Ins Co	03/01/02	5.0
Newark Ins Co	05/01/95	7.5	Sentinel Ins Co	01/01/06	10.0
North River Ins Co	01/01/02	10.0	Sentry Select Ins Co	08/01/97	10.0
Northern Ins Co of New York	01/04/02	5.0	State Farm Fire and Casualty Co	06/01/01	15.0
Nova Cas Ins Co	09/01/06	5.0	Strathmore Ins Co	01/01/01	15.0
Ohio Security Ins Co	10/25/01	10.0	St. Paul Mercury Ins Co	02/13/96	15.0
Old Republic Ins Co	08/01/01	9.1	TIG Ins Co	01/01/01	7.5
OneBeacon Amer Ins Co	01/01/07	15.0	TIG Ins Co of New York	01/01/01	12.5
Oriska Ins Co	07/01/01	10.0	Tower National Ins Co	08/24/06	10.0
Pacific Indemnity Co	01/13/83	15.0	Trans Pacific Ins Co	09/01/02	10.0
Paramount Ins Co	10/03/83	15.0	Transcontinental Ins Co	03/01/04	10.0
Patriot General Ins Co	02/25/02	10.0	Travelers Casualty & Surety Co of Illinois	08/12/85	15.0
Peerless Ins Co	05/01/96	7.5	Travelers Indemnity Co of America	01/16/91	15.0
Penn Millers Ins Co	01/01/05	0.0	Travelers Indemnity Co of Connecticut	08/01/98	10.0
Pennsylvania Manufacturers Assn. Ins. Co	12/11/01	7.0	Ulico Casualty Co	09/10/02[3]	0.0
Pennsylvania Manufacturers Indemnity Co	10/01/96	15.0	Ulico Casualty Co	09/01/04[4]	0.0
Providence Washington Ins Co	10/01/04	0.0	Union Ins Co	06/10/06	10.0
Republic-Franklin Ins Co	01/01/88	10.0	Utica National Assurance Co	02/01/04	5.0
Royal Indemnity Co	03/01/03	15.0	Valley Forge Ins Co	03/01/01	10.0
Safeguard Ins Co	05/01/95	10.0	Wausau Business Ins Co	06/10/96	15.0
Safety National Casualty Corp	04/06/06	10.0	Wausau General Ins Co	01/01/07	15.0
Selective Ins Co of South Carolina	09/01/01	10.0	Wausau Underwriters Ins Co	01/01/07	0.0

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

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

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

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

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

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

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

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

Table 49
PCISF CONTRIBUTIONS, 1988-2006*

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

* During 1993, settlement was reached with respect to *Alliance of American Insurers et al. v. Chu et al*. The 1993 through 2006 fund year net values and contribution amounts described above reflect the impact of the settlement.

C. HEALTH BUREAU

1. Entities Under Health Bureau Supervision

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

The Bureau had regulatory authority over all aspects of the fiscal solvency and market conduct of 97 insurers, HMOs, and other managed care organizations as of December 31, 2006. These comprise 26 accident and health insurers, 1 life insurer (writing accident and health insurance only), 13 health service and medical and dental expense indemnity corporations, 1 Article 43 Insurance Law HMO, 22 Article 44 Public Health Law HMOs, 9 Article 47 Insurance Law municipal cooperative health benefits plans, 13 managed long term care plans and 12 continuing care retirement communities certified pursuant to Article 46 of the Public Health Law.

Two acquisition-of-control applications were reviewed in 2006, each included the acquisition of multiple insurers; one was an application to obtain control of both an Article 43 insurer and a HMO (GHI and GHI HMO Select), and one was an application to obtain control of three insurers; an Article 42 insurer, an Article 43 insurer and a HMO (MVP Health Insurance Co., MVP Health Services Corp., MVP Health Plan). A merger application was approved in which a HMO (Vytra Health Plans Long Island, Inc.) and an Article 43 insurer (Vytra Health Services, Inc.) both merged into an Article 43 insurer (Health Insurance Plan of Greater New York (HIP)).

Ten Article 42 Accident and Health licensing applications (9 foreign and 1 domestic) were under review during 2006. These are for insurers writing the new Medicare Part D Prescription Drug Coverage. Of these ten applications, three were approved, three were withdrawn, and four remained under review as of 12/31/2006. In addition, one application for the conversion of a property/casualty insurer to an Article 42 Accident and Health insurer was reviewed and approved.

Three HMOs submitted applications to receive “Certificates of Authority” to operate in New York State in 2006. HMOs are jointly regulated by this Department as well as the Department of Health. It is the Department of Health that issues the “Certificate of Authority” to the HMOs. During 2006, one HMO received its “Certificate of Authority”, one was not approved and one was still pending as of 12/31/2006.

One HMO continued its wind down of its operations in 2006 and is expected to be liquidated in the near future. One Article 43 HMO has been transferred to the Liquidation Bureau this HMO has had no members for several years and wished to withdraw from the market. Additionally, the Bureau is monitoring the financial condition of two distressed HMOs and two Article 42 companies on a monthly basis.

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

2. Accident and Health Insurers

Twenty-six companies were licensed to transact only accident and health insurance at year-end 2006. The Bureau regulates the fiscal solvency and market conduct of one life insurer and financial data of this life insurer are included in the following table:

Table 50
SELECTED ANNUAL STATEMENT DATA
Accident and Health Insurers*
2003-2005
(dollar amounts in millions)

	2005	2004	2003
Number of Insurers	22	23	23
Net premiums written	$10,679.5	$9,668.7	$9,616.5
Admitted assets	11,994.8	11,036.0	10,308.6
Policy and contract claims	1,714.5	1,656.6	1,643.4
Other liabilities	5,551.2	4,946.6	4,539.3
Capital	34.8	31.3	30.5
Surplus	4,694.3	4,401.5	4,095.4
Ratio of premiums written to capital and surplus	2.3	2.2	2.3

*Data includes one life insurer.
Source: New York State Insurance Department

3. Article 43 and Article 44 Corporations

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

a. Subscriber Rate Changes

Chapter 504 of the Laws of 1995 established a procedure for premium rate changes for Article 43 and Article 44 corporations. This procedure is an alternative to the prior approval requirements of Section 4308(c) of the Insurance Law under specific conditions. This law permits an Article 43 or Article 44 corporation to submit a filing for a premium rate adjustment and such filing will be deemed approved upon a certification that the expected loss ratio will meet the minimum and maximum loss ratios prescribed in Insurance Law Section 4308(g). Premium adjustments using this methodology were previously limited to no more than 10% annually, but the annual cap was removed on January 1, 2000. The 2006 filings were as follows:

Type of Company	Filings
HMOs	81
Article 43 Corporations	29

b. Article 43 and Article 44 Corporations

The following tables show aggregate figures on assets, liabilities, surplus funds, premium income and membership for years 2003-2005:

Table 51
HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
2003-2005
(dollar amounts in millions)

	2005	2004	2003
Number of Companies	10	10	10
Admitted Assets	$4,770.4	$4,558.0	$4,062.2
Liabilities	2,536.6	2,519.4	2,362.5
Surplus Funds	2,233.8	2,038.6	1,699.8
Net Premium Income:			
Hospital	7,074.3	6,921.6	6,468.5
Medical/Dental	5,575.1	4,902.5	4,353.0
Number of Contracts & Riders in Force:			
Hospital	1.4**	1.5**	1.5**
Medical/Dental	1.6**	1.6**	1.5**

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

Table 52
MEDICAL & DENTAL EXPENSE INDEMNITY CORPORATIONS
Selected Data, New York State
2003-2005
(dollar amounts in millions)

	2005	2004	2003
Number of Companies	3	3	3
Admitted Assets	$44.6	$39.2	$33.3
Liabilities	20.0	20.4	15.6
Surplus Funds	24.6	18.8	17.7
Net Premium Income	49.6	32.3	26.7
Number of Contracts in Force	1,492	1,344	1,257

Source: New York State Insurance Department

Table 53
HEALTH MAINTENANCE ORGANIZATIONS
That Are a Line of Business of a Health Service Corporation*
Selected Data, New York State
2003-2005
(dollar amounts in millions)

	2005	2004	2003
Number of Companies	3	3	3
Net Premium Income	$6,570.4	$6,308.7	$5,862.5
Number of Participants	1.8**	1.9**	2.0**

* Figures shown in this Table are included in the corresponding figures shown in the Table 51, "Health Service Corporations."
** in millions
Source: New York State Insurance Department

Table 54
HEALTH MAINTENANCE ORGANIZATIONS
That Are Not a Line of Business
Selected Data, New York State
2003-2005
(dollar amounts in millions)

	2005	2004	2003
Number of Companies	21	21	21
Admitted Assets	$4,753.0	$4,169.7	$3,947.5
Liabilities	2,147.3	2,216.5	2,167.6
Surplus Funds	988.8	1,953.2	1,776.8
Net Premium Income	12,050.3	11,882.4	11,533.3
Number of Participants	3.2*	3.4*	3.6*

*in millions
Source: New York State Insurance Department

4. Examinations Conducted by the Health Bureau

During the year 2006, the field unit of the Health Bureau conducted 30 examinations of regulated entities. The 2006 examinations, by regulated entity and type, are presented below:

		Regularly Scheduled	
	Total	**Initiated in 2006**	**Prior to 2006**
By Regulated Entity			
HMO	7	2	5
HMDI	5	3	2
Commercial	12	9	3
Muni-Coop	4	4	0
CCRC	1	1	0
MLT	1	0	1
Total	**30**	**19**	**11**
By Type			
Financial	0	0	0
Market Conduct	4	0	4
Combined	25	18	7
Other:			
Capital Increase*	0	0	0
On Organization**	1	1	0
Total	**30**	**19**	**11**

***** Examination conducted when insurer increases its capital.

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

5. SERFF

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

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

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

In the calendar year 2005 (the first full year we received SERFF submissions), the number of form and rate filings submitted via SERFF averaged 36%, rising from 5% at the beginning of the year. During the calendar year 2006, the number of submissions continued to trend upward and averaged 59% by the fourth quarter. A major enhancement in the system was rolled out in late October 2006. The enhancement included incorporation of the data supplied previously on the NAIC transmittal form, changing the data platform to improve operating performance of the database, and making the system much easier for both industry and state reviewers to use.

In 2006, the Health Bureau also worked with the Systems Bureau in development of an interface that electronically transfers filing submission data and attachments from a SERFF file when it is received and transfers it to our official record system, Visiflow. This interface eliminated the need for support staff to manually scan these initial documents into the official record. Phase 2 of this project will involve expanding this interface to transfer all subsequent correspondence and attachments as well. Work on the second phase was purposefully delayed until the NAIC had successfully completed its transition to their new platform.

6. Review of Accident and Health Policy Form Submissions

In 2006, the Health Bureau made final dispositions on 1,143 accident and health policy form submissions (see Table 55A). A submission consists of one or more policy forms and, in some cases, related supporting actuarial material. These submissions were comprised of a wide range of accident and health insurance products from many different types of insurers and are offered in the individual, small group and large group markets. These 1,143 submissions include 761 fast track, deemer, and SERFF submissions (see Table 55B). Fast track submissions are submissions made under the optional expedited prior approval using a certification process (Circular Letter No. 4 (2003)). Deemer submissions are submissions made under the expedited approval procedure set forth in Section 3201(b)(6) of New York Insurance Law. SERFF submissions are electronic submissions made through the System for Electronic Rate and Form Filing.

Table 55A
ACCIDENT & HEALTH
Disposition of Policy Form Submissions
2006

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Fraternal	Total
Approved	104	238	54	120	5	1	**522**
Not Accepted / Circular Letter 14 (1997)*	2	92	50	2	0	1	**147**
Lack of Company Action	2	35	18	1	0	0	**56**
Disapproved	1	0	0	0	0	0	**1**
Filed for Reference	2	62	39	1	0	1	**105**
Prefiled	4	61	0	3	0	0	**68**
Withdrawn	2	31	4	7	0	0	**44**
Filed for Out-of-State Use	0	142	51	0	0	0	**193**
Other	1	4	2	0	0	0	**7**
Total	**118**	**665**	**218**	**134**	**5**	**3**	**1,143**

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

Table 55B
ACCIDENT & HEALTH
Disposed Policy Form Submission
Fast Track, Deemer, and SERFF Submissions
2006

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Fraternal	Total
Fast Track Submissions	40	32	15	71	0	1	**159**
Deemer Submissions	0	1	1	0	0	0	**2**
SERFF	83	325	78	111	0	3	**600**
Total	**123**	**358**	**94**	**182**	**0**	**4**	**761**

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

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

The Accident and Health Rating Section received 1,524 rate filings and disposed of 1,354 rate filings during 2006. These include initial rate filings for new policy forms submitted by commercial insurers, Article 43 corporations, Article 44 HMOs, as well as rate adjustment filings (primarily for commercial insurers), commission filings, experience filings, and rate manual revisions. About 49% of the Accident and Health Rate Filings received were received through the System for Electronic Rate and Form Filing (SERFF).

The rate manuals referred to above are in electronic form and are public record. Freedom of Information Law visitors currently access the manuals at a designated workstation in the Bureau.

The Accident and Health Rating Section participated in various meetings on development and implementation of High Deductible Healthy New York benefit plans, developed rate filing guidelines, and reviewed and approved premium rates for the new plans for all carriers writing Healthy New York coverage. In addition, the Accident and Health Rating Section handled rate increase filings for Healthy New York, oversaw the updating of rates for the regular Healthy New York plans, and posted the approved rates for the new plans. Additionally, the Rating Section continues to collect monthly enrollment reports from the Healthy New York carriers.

The Accident and Health Rating Section also analyzed and estimated the rate impact of Timothy's Law which was enacted in December 2006 and imposes requirements for coverage of mental health benefits. Additionally, the Rating Section compiled the Partnership and Non-Partnership Long Term Care premiums for display on the Insurance Department's Interactive Long Term Care Premium Search component of the Department's Web site.

8. Inquiries and Complaints

In response to formal written inquiries and complaints, the Health Bureau provided written answers to 289 consumer inquiries, 37 legislative inquiries and complaints, 75 consumer inquiries forwarded from the Governor's Office, and 187 FOIL requests concerning accident and health insurance and related issues in 2006. In addition to formal responses to written complaints and inquiries, the Health Bureau monitors a dedicated mailbox on the Department's Web site. In 2006, the Health Bureau received and responded to over 725 Health Mailbox inquiries from consumers, providers, health plans, attorneys, consumer advocate groups, and other state agencies. The most common electronic inquiries the Health Bureau received in 2006 included consumer complaints regarding increased premium rates, consumer inquiries relating to health insurance options in New York State, consumer complaints against their health plans, pre-existing condition provisions in health policies, mandated benefits, utilization review requirements and employer responsibilities in providing health insurance coverage.

In addition to written inquiries, Bureau staff also responds to telephone inquiries and complaints. In 2006, Bureau staff responded to approximately 10,000 telephone inquiries.

9. Utilization Review Reports

Article 49 of the Insurance Law requires health insurers and utilization review agents under contract with health insurers to biennially report to the Superintendent on utilization review activities. During 2006, three new reports by utilization review agents were reviewed for compliance with Article 49 and placed on file with the Department and six existing reports were updated and renewed.

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

Recently completing its seventh year of operation, New York's External Appeal Program continues to provide New Yorkers with the right to obtain a review by independent medical experts when their health plan denies health care services as not medically necessary or because the plan considers the services to be experimental or investigational. Since the program's inception on July 1, 1999, through December 31, 2006, the Department has received almost 15,000 external appeal requests.

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

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

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

Information about the external appeal program is available on the Insurance Department's Web site at www.ins.state.ny.us. In addition, the Insurance Department operates a dedicated toll-free hotline (1-800-400-8882) to respond to questions and assist in the filing of external appeal requests. In 2006, the Department received and responded to 5,741 hotline calls.

Along with monitoring the number of hotline calls, the Insurance Department also tracks external appeal results for each year of operation of the program. In 2006, the Insurance Department received 2,858 external appeal requests, which represented a 15% increase from the previous year. In addition in 2006, 287 external appeal requests were closed because health plans voluntarily reversed the denial during the external appeal process, 787 external appeal requests were determined to be ineligible for external appeal, 1,690 determinations were rendered by external appeal agents and 238 appeals were still pending at the end of the year either because additional information was needed or an external appeal agent was reviewing the case.

Table 56A lists the number of external appeal determinations that have been either upheld or overturned, categorized by type of appeal. Table 56B identifies external appeal results by agent. The tables reveal that 49% of health plan denials were overturned in whole or in part by external appeal agents and 51% were upheld by external appeal agents in 2006. An external appeal that is overturned in part refers to one that is decided partially in favor of the consumer. For example, an HMO may refuse to pay for a five-day hospital stay asserting that it was not medically necessary, but that ruling would be overturned in part if the external appeal agent determines three days were medically necessary and two were not.

Table 56A
EXTERNAL APPEAL DETERMINATIONS BY TYPE OF APPEAL
January 1, 2006 — December 31, 2006

Type of Denial	Total	Overturned	Overturned in Part	Upheld
Medical Necessity	1,438	587	111	740
Experimental/Investigational	248	122	0	126
Clinical Trial	4	3	0	1
Total	**1,690**	**712**	**111**	**867**

Table 56B
EXTERNAL APPEAL DETERMINATIONS BY AGENT
January 1, 2006 — December 31, 2006

Agent	Total	Overturned	Overturned in Part	Upheld
IMEDECS	592	248	41	303
IPRO	463	195	25	243
MCMC	635	269	45	321
Total	**1,690**	**712**	**111**	**867**

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

11. Market Stabilization Mechanisms

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

In August 2006, the Insurance Department distributed over $71 million in market stabilization pool funds for premium rate relief in the individual direct payment market. Individuals enrolled in the individual direct payment market as of September 1, 2006 received either premium credits or refund checks from their health plans. Individual policyholders received approximately $1,000, while family policyholders received approximately $2,500.

Also in 2006, the Health Bureau worked with health plans to create a new and simplified mechanism to stabilize premiums in the individual and small group market. As a result of these meetings, the Health Bureau promulgated the Fifth Amendment to Regulation 146 which changes the pooling methodology from one based on specified medical conditions to one based on high cost claims. The Health Bureau will be collecting data with respect to the new methodology in 2007 and it is anticipated that the new pooling methodology will become fully operational in 2008. In conjunction with the establishment of the new methodology, the Health Bureau applied to the Centers for Medicare and Medicaid Services (CMS) for a federal grant entitled, "Seed Grant to States for Qualified Risk Pools", authorized under the State High Risk Pool Funding Extension Act of 2006. The Department was awarded a $150,000 grant to perform risk pooling funding methodology testing related to the Department's new risk pool mechanism. The Department expects to receive the grant monies in state fiscal year 2007-2008.

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

The Health Care Reform Act of 2000 (HCRA II) required the Insurance Department to administer the ongoing operations of a unique program designed to ensure that individual consumers have continued access to comprehensive health insurance. HCRA II allocated $130 million over a three and a half-year period commencing January 1, 2000 and ending July 1, 2003 to direct payment market reforms. For the HCRA III and HCRA IV periods, funding was renewed through July 1, 2007 at a level at $40 million per year ($20 million for the half year of 2007).

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

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

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

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

In 2006, the Department directed the administrator to conduct the necessary audit procedures with respect to 2005 reimbursement requests submitted by carriers and to tabulate and render a comprehensive proposed distribution summary for Department review. As in the prior year, the total reimbursement requests for Calendar Year 2005 exceeded the total funding available in both the standard direct payment business and the direct payment out-of-network (point of service) business. The fund administrator was directed to reduce the amounts requested on a pro-rata basis to match available funding in each of the respective funds. The total funding available, requests for reimbursement, and pro-rata reductions were as follows:

	Total Appropriation	Total Requested Reimbursement	Reimbursement Percentage
Standard HMO Direct Payment	$20,000,000	$59,798,144	33.4%
Out-of Plan (POS) Direct Payment	$20,000,000	$41,135,937	48.6%

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

In 2006, the NYS Comptroller's Office audited the Department's oversight of the Direct Payment Stop Loss Funds for the period of January 1, 2003 through December 31, 2005. Department staff made themselves available to answer questions throughout the year. Alicare Inc., as the direct payment stop loss fund administrator, also assisted with questions and provided support during on–site visits. The Comptroller's Office will be issuing a report with its audit findings.

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

The Health Care Reform Act of 2000 (HCRA II) created the Healthy NY program and gave oversight to the Insurance Department. The program was intended to create a less expensive health insurance product for vulnerable small businesses, sole proprietors and low income individuals meeting certain eligibility criteria. In 2003, funding for Healthy NY was extended until July 1, 2005 as part of HCRA III. In 2005, as part of HCRA IV, funding was again extended until July 1, 2007. Funding for 2006 was $109.6 million, and $85.2 million for the first half of 2007. The state budget adopted in 2007 will specify the full amount of funding available for the fiscal year 2007-2008.

The Healthy NY program is a unique approach to addressing the problem of the uninsured. New York was unable to rely upon prior experience or the experience of other states in implementing the program. The Department worked vigorously during the year 2000 to implement the various components of the program to ensure that it was available to consumers as of January 1, 2001. Today, this program serves as a national model for creating a private-public partnership that utilizes reinsurance to reduce premiums.

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

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

The Healthy NY product includes a unique rating structure designed to combine the experience of participating individuals and small groups. The program also utilizes state funds to reinsure high cost claims, a feature designed to reduce premium rates and limit the exposure of HMOs to excessive health care costs. The 2006 annual study of the program found that Healthy NY offers premium savings of up to 45% when compared with other small group products, and more than 70% when compared with the individual direct payment market.

The major responsibilities of the Department in connection with the oversight of the Healthy NY program for year 2006 included the following:

a. Program Oversight

The Insurance Department is solely responsible for the oversight of the Healthy NY program. Throughout calendar year 2006, the Department continued to provide education and guidance to the industry on program requirements. The Department's second regulatory amendment was finalized, and the Department filed a third regulatory amendment. This third amendment created a high deductible option in Healthy NY that, if chosen, would allow the participant to be entitled to federal tax savings through a health savings account. The new high deductible option allows consumers to reduce their Healthy NY premiums by approximately 22%. Implementation of this new program option required extensive health plan guidance, the approval of new contracts and premiums rates for each health plan, and the development of new web site materials and consumer publications. The Department continued to monitor the program for areas of potential improvement. The Department engaged in public awareness campaigns, industry outreach, education, enhancements to the Department's Web site, and numerous other efforts. As the program continues to grow, the Department continues to respond to questions of first impression and to provide continuing guidance to the health plans.

b. Eligibility Issues and Education

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

c. Guidance and Publications

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

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

d. Rating of the Healthy NY Product

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

e. Stop Loss Funds

The Department is responsible for the oversight of the stop-loss pools. The funding in the pools is used to reimburse health plans a percentage of eligible high cost claims. Each year, the Department works with an outside fund administrator to determine the distribution of the funding to the HMOs submitting valid claims for reimbursement. 2006 was the sixth year covered by the Healthy NY program. Reimbursement requests for calendar year 2006 are due by April 1, 2007.

In addition, HMOs are required to provide quarterly preliminary notifications of potentially eligible claims beginning with the first quarter of each calendar year. These quarterly reports provide detail of claims activity and allow the Department to monitor potential claims. If it appears that the claims for the calendar year will exceed the year's funding, the Department is required to cap enrollment.

Claims requests must be reviewed, audited and adjusted. During 2006, the Department authorized disbursements to the HMOs for 2005 claims in the amounts of $21.4M for the claims of small employers and $40.5M for the claims of individual enrollees.

The Department is also responsible for the annual submission of a report on the affairs and operations of the stop loss funds to the Senate Finance Committee and the Assembly Ways and Means Committee.

f. Tracking Maximum Enrollment in Healthy NY

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

g. Annual Study of the Healthy NY Program

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

h. Coordination with Other Public Programs.

Healthy NY is designed to complement and build upon both the existing Child Health Plus program and the Family Health Plus program that were also authorized as part of HCRA of 2000. Ongoing coordination with the Department of Health is necessary to ensure that the eligibility standards utilized by these programs mesh to the extent feasible. The Department is working to try to ensure that consumers receive information that facilitates their enrollment in the program that is most appropriate.

i. Consumer Contact

The Department continues to respond to a significant volume of consumer questions and issues regarding the nature and operation of the Healthy NY program. The Department has worked to address consumer issues with the HMOs in order to ensure appropriate and correct resolution. An e-mail box linked from the Healthy NY Web site is available for consumers to contact the Department with questions. A toll-free hotline provides consumers with information about the Healthy NY program. Additionally, Department staff respond directly to a large volume of consumer telephone and written inquiries. The Department will assist applicants who believe they have been wrongfully denied enrollment in the program.

j. National Interest in Program

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

In addition, the program receives an increasing amount of interest from other states, federal legislators and other governmental agencies. Staff have presented at national forums and academic conferences as a result of the high level of interest. During 2006, staff worked with New Jersey and Illinois who were interested in evaluating the potential for reinsurance in their markets. In September, the Healthy NY program was the main feature of a day long “Reinsurance Institute” which drew representatives from 17 states to Albany to learn from Healthy NY program staff. This event was sponsored by the Robert Wood Johnson Foundation’s *State Coverage Initiatives* program.

To date, the Department has been contacted directly by California, Colorado, Florida, Illinois, Kansas, Maine, New Jersey, North Carolina, Oregon, Pennsylvania, Tennessee, Texas, Vermont, Washington and Wisconsin. In addition, there have also been inquiries from: NCOIL, the Urban Institute, Academy Health, Rutgers, Wake Forest University, Senator Kennedy's office, Governor Schwarzenegger's office, and various researchers. The program has been featured in numerous academic papers and articles, including the book Reinsuring Health, by Katherine Swartz, Ph.D. of the Harvard School of Public Health, published in 2006.

k. Marketing and Outreach

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

l. Audit by the NYS Comptroller's Office

In 2006, the NYS Comptroller's Office audited the Department's oversight of the Healthy NY program for the period of January 1, 2003 through December 31, 2005. Department staff made themselves available to answer questions throughout the year. Alicare Inc., as the stop loss fund administrator for the HNY program, also assisted with questions and provided support during on–site visits. The Comptroller's office will be issuing a report with its audit findings.

14. Brooklyn HealthWorks

In Chapter 441 of the Laws of 2006, the New York State Legislature allocated funds from the Healthy NY stop loss funds for the support and expansion of Brooklyn HealthWorks. Brooklyn HealthWorks is a pilot program run by the Brooklyn Alliance, Inc. that provides access to affordable health insurance for small businesses in the Borough of Brooklyn. Brooklyn Healthworks essentially offers GHI's Healthy NY product with a few minor adjustments and an additional subsidy of 15-16% of the premium.

Chapter 441 of the Laws of 2006 allowed for approximately $2.5 million in fiscal year 2006-2007 HCRA funding to be split between the existing downstate Brooklyn HealthWorks Program and an upstate health insurance pilot program to be developed. In response to this legislation, the Insurance Department held extensive internal discussions and numerous meetings with the Executive Director of Brooklyn HealthWorks.

The Department applied to and received approval from the Office of the State Comptroller to enter into a contract with the Brooklyn Alliance, Inc. Currently, the Brooklyn HealthWorks staff handles outreach for its members and maintains records documenting the amount billed by the insurer (GHI), the amount paid by each employer group, and the amount of subsidy provided through the program. The Brooklyn HealthWorks staff will continue to maintain those records and submit invoices requesting subsidy payment to the Insurance Department. Approval by the State Comptroller's Office and the Attorney General's Office is needed to finalize the contract between the Department and the Brooklyn Alliance.

Insurance Department staff will review subsidy payment requests and forward appropriate requests for payment to the Office of the State Comptroller. Subsidy payments will be made directly to GHI in order to maintain seamless coverage for the program's member groups. The Department received and processed the first Brooklyn HealthWorks subsidy payment paperwork for the months of August through November of 2006, and issued the first subsidy check to GHI. It is expected that Brooklyn Healthworks will open to new membership in April 2007.

The Department will be working to design of a similar program in upstate New York, as directed by Chapter 441 of the Laws of 2006.

15. Federal Tax Credit Initiative

The federal Trade Adjustment Act of 2002 made a 65% health insurance tax credit available to certain eligible citizens. Those eligible for the tax credit include: (1) those who are receiving trade adjustment benefits because they have lost their jobs due to changes in international trade; and (2) retirees whose pensions had been taken over by the Pension Benefit Guarantee Corporation. This credit is estimated to be available to approximately 11,000 New Yorkers or an estimated 22,000 covered lives (including dependents). The tax credit includes some unique features including a pre-payment feature whereby an eligible individual can request to receive the benefit of the tax credit in advance in order to pay health insurance premiums as they become due. In the event prepayment is requested, the federal government makes payment directly to the insured's health insurance plan.

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

The Bureau continues to assist consumers with accessing the tax credit in conjunction with the New York State health insurance market.

16. COBRA Subsidy Demonstration Project

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

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

For the entire year of 2006, Department staff processed a total of 451 applications and paid out more than $820,600 in premium assistance. Payments were made to 16 union funds, the most highly represented being Equity League (216 enrollees) and Screen Actors Guild (38 enrollees).

To date, the program has assisted about 900 entertainment industry employees.

17. Continuing Care Retirement Communities (CCRCs)

The Insurance Department has a permanent seat on the Continuing Care Retirement Community Council. This council has the primary licensing and oversight authority for CCRCs. The Insurance Department has specific responsibility for the review of the contract and disclosure documents given to residents and prospective residents, as well as an initial determination of the financial feasibility of a proposed project and ongoing oversight of the fiscal solvency of communities. The Bureau's continuing oversight encompasses review of the rating structure of a community, adequacy of reserves and periodic on-site examinations of the financial condition of a community. To this end, the Department initiated four examinations of CCRCs in 2006, developed revisions to the Department's annual statement for financial filings, and published for comment a proposed revision to its regulation relating to CCRCs.

Currently, there are twelve CCRCs in New York, each one with a Certificate of Authority issued by the CCRC Council. Of these twelve, three have not yet progressed to either the financing or construction phase. One Certificate of Authority application is currently under review.

18. Long Term Care Insurance

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

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

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

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

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

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

In conjunction with the Department of Health, the Health Bureau worked on issues such as modifying the New York State Partnership for Long Term Care insurance product design. In 2005, the Department promulgated the Second Amendment to Regulation 144 which was designed to make more affordable benefit options and a range of incentives available through the NYS Partnership for Long Term Care program. The Health Bureau participated in the development of insurer participation agreements for each of the plan designs. Insurers were required to submit subscriber contracts in order to offer the new products for the Department's review and approval. By March 2006, all five Partnership insurers had approved policy forms that permit them to market the new Partnership product designs. Some insurers were able to complete their internal administration quickly and begin marketing the new plan designs in the summer of 2006. As of December 9, 2006, all participating Partnership insurers are marketing all four plan designs.

c. Sample Premium Rates on Web site

The Health Bureau led a team of Bureau members, in conjunction with the Systems Bureau, to create an interactive page on the Department Web site that provides consumers with sample premium rates for long term care insurance. The initial rollout contains sample premium rates for all four Partnership plan designs currently marketed by each of the five Partnership insurers. Through this tool,

consumers can learn the approximate cost of long term care insurance coverage for certain levels of coverage. The website also allows the consumer to print the results for use when discussing a potential purchase with an agent.

In addition, the interactive nature of the tool allows a consumer to perform "what ifs" to see the actual effect on premiums that result from various purchasing decisions. For example, comparing the premium at the consumer's current age to a future age clearly shows the price impact of delaying the decision to purchase long term care insurance. Comparing the premium for various elimination periods clearly shows the savings in premium if a consumer elects a longer period of self-payment once they require long term care services but before the company starts paying benefits.

The Bureau has been working on expanding this site to include all actively marketed non-Partnership policies. This is an extensive undertaking because of the number of companies and policies involved, but we expect to add this information to our Web site in the spring of 2007.

d. Consumer Education

Long Term Care Insurance Education and Outreach centers, headed by the State Office of Aging, were created statewide in early 2006 to provide the general public with educational and informational materials about selecting long term care insurance as well as to provide counseling and direct assistance in understanding policy options, benefits, and obtaining the appropriate long term care insurance coverage. Since their establishment, the Bureau has been working closely with the State Program Coordinator to provide the necessary information to train the counselors and answer their on-going questions regarding long term care insurance.

e. Creation of an Elder Care Unit

In August 2006, the Health Bureau created a new Elder Care unit to focus on health insurance issues related to the elderly including long term care insurance, Medicare, Medicare supplement insurance, managed long term care, and continuing care retirement communities. Previous to the formation of the Elder Care Unit, these types of insurance or managed care plans were regulated within the broad general frameworks of individual or group insurance. By devoting resources to the particular insurance issues of this elderly population, the Health Bureau should be in a better position to identify and resolve insurance issues relating to this elderly population. This ability to focus on insurance issues relating to the elderly population becomes very important as the large baby boom generation ages and their need for insurance products related to the aging process increases. This unit fulfills a need as highlighted by the Project 2015 report as a large segment of New York's population grows older.

19. Managed Long Term Care Plans

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

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

In 2006, the Health Bureau continued its practice of reviewing and approving forms and rates for private pay participants in approved managed long term care plans. The Health Bureau also provided comments to the Health Department concerning advertisements and marketing materials of these plans pursuant to Section 4403-f(7)(c)(ii) of the Public Health Law.

Pursuant to Section 4403-f (9) of the Public Health Law, an interim report to the Governor, Temporary President of the Senate and Speaker of the Assembly on the results of managed long term care plans was due during 2006. The Health Bureau prepared the Insurance Department's section of the report, and sent it to the Health Department for inclusion in the entire report. The Insurance Department section described regulatory actions initiated by the Superintendent concerning solvency, enrollee contracts, premium rates and marketing materials. Also described were Insurance Department regulatory actions mandated by Section 4403-f of the Public Health Law involving written agreements with 13 approved managed long term care plans.

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

20. Medicare Beneficiaries' Issues

The Health Bureau has been an active participant with other state regulators, consumer representatives, Centers for Medicaid and Medicare Services (CMS) officials, and carrier representatives on the NAIC Senior Issues Task Force (SITF) Medicare Supplement Subgroup. The Subgroup has been charged with reviewing Medicare supplement plans and making recommendations to the Task Force through the modification of the NAIC Medicare Supplement Insurance Model Regulation. We have participated in numerous meetings, conference calls, and have assisted in drafting changes to the model regulation. The changes seek to streamline and modernize benefits and benefit plans, while minimizing beneficiary confusion and increasing beneficiary choices. The subgroup and NAIC will vote on whether to approve the changes to the model regulation and we continue to monitor legislative action related to the implementation of the model regulation.

The Health Bureau approved the policy forms of two insurance companies offering the Medicare supplement insurance cost sharing plans K and L. Last year, the Medicare Modernization Act of 2003 (MMA) required the addition of plans K and L to the standardized Medicare supplement insurance plans. These plans feature a cost-sharing approach and set limits on the out-of-pocket costs in a given year. The approval and commencement of the marketing of these plans in 2006 mark the first time these plans became available to New York state residents.

CMS continued to require companies writing Medicare Part D prescription drug coverage to be licensed in the state where they were proposing to operate, or obtain a federal waiver of the state licensure requirement. The Health Bureau coordinated the legal and financial aspects and provided requested companies with letters of good standing. Good standing letters were also provided to requesting companies expanding participation and entering the Medicare Advantage market. Although the Department does not regulate the Medicare Part D or the Medicare Advantage program, the Health Bureau was able to verify the status of the companies licensed in the state, coordinate the legal and financial aspects, and provide requesting companies with letters of good standing needed by the companies for furnishing to CMS.

In order to assist New York residents being terminated by their Medicare Advantage Organizations (MAOs), the Health Bureau coordinated with CMS and issued notice on the Insurance Department's Web site containing information on choices for these affected residents. The notice explained the difference between the options of enrolling in another Medicare Managed Care Plan or returning to original Medicare with the purchase of a Medicare Supplement Insurance policy to help defray some of

the costs not covered by Medicare. The notice also reminded those interested of how to prevent gaps in coverage in order to avoid having to satisfy requisite pre-existing condition waiting periods when enrolling in a new plan. Each year MAOs have the option to reduce their service area or terminate their Medicare Advantage Contracts. MAOs that opt to non-renew or reduce their service area must notify CMS and are also required to send enrollees notification letters.

21. Innovative Health Insurance Products

a. Medicare Supplement Insurance

The NAIC Senior Issues Task Force (SITF) Subgroup is currently in the process of amending portions of the NAIC's Medicare Supplement Insurance Model Regulation Compliance Manual as it relates to the offering of Medicare supplement insurance innovative benefits. In 2005, the Health Bureau approved the state's first innovative benefit to supplement standardized Medicare supplement insurance plans. The "Silver Sneakers Fitness Program" provides a no cost, optional basic fitness membership at participating fitness centers.

b. Long Term Care Insurance

In 2006, the Bureau continued to encourage companies to experiment with innovative products that provide long term care insurance. The more that consumers personally plan for the financing of future long term care services by purchasing long term care insurance, the more that savings for New York's Medicaid program can be realized.

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

c. Managed Long Term Care

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

d. Prescription Drug Coverage

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

22. Health Savings Accounts / High Deductible Health Plans

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

23. Child Health Plus

During 2006, the Department continued its role of reviewing and approving subscriber contracts and premium rates for the Child Health Plus program. During 2006, the Department reviewed and approved 19 Child Health Plus rate adjustment submissions. Rate review was limited, however, by the provisions of the 2005 budget bill's moratorium on rate changes for the Child Health Plus program from April 1, 2005 to March 31, 2006. Department staff also participated in meetings with the Department of Health, insurers and other interested parties to discuss issues regarding the ongoing operation of the program.

24. Early Intervention Program

During 2006, the Bureau continued its proactive role in assisting the Department of Health's Early Intervention Program to appropriately claim third party health insurance coverage for services rendered by the Program, as required by Public Health Law. Bureau staff continue to represent the Department on the Early Intervention Coordinating Council. Staff members also participate in monthly meetings with the Department of Health to discuss insurance-related issues brought to the Department of Health's attention by the county providers of early intervention services and investigate claims denials brought to their attention by the early intervention providers. Finally, Bureau staff participated in meetings with representatives from the counties, the Department of Health and the HMOs to discuss implementation of a claiming demonstration project.

25. Contraceptive Equity Lawsuit

During 2006, the lawsuit against the Superintendent of Insurance regarding the mandated benefits for contraceptive drugs and devices continued to move through the New York court system with arguments at the Appellate Division and the Count of Appeals. The Health Bureau acted as a consultant for the Office of General Counsel, the Attorney General, and the Solicitor General in drafting reply briefs and in answering questions regarding compliance and enforcement of the Women's Health and Wellness Act. Both courts upheld the law.

26. Coverage of Childhood Immunizations.

The Commissioner of Health asked for the Insurance Department's assistance with rectifying a problem with delayed coverage of childhood immunizations under the well-child mandate that resulted in children covered by private health insurance not having access to the coverage of new immunizations until well after children in public programs, such as the Vaccine for Children program. In response, the Insurance Department issued Circular Letter No. 13 (2006) which links coverage of new immunizations to the date of their recommendation by the Advisory Committee on Immunization Practices (ACIP) and promotes uniformity in access to new vaccines by children.

27. Coverage of Sole Proprietors under Group Health Insurance Coverage.

Chapter 201 of the Laws of 2006 amended the Insurance Law to lower the premium rate differential that an insurer might charge a sole proprietor covered under a group health insurance policy from 120% of the established rate to 115% of such rate with an effective date immediate upon its signing on July 26, 2006. The Insurance Department issued Supplement No. 2 to Circular Letter No.27 (2002) on July 31, 2006 to advise insurers, Article 43 corporations and health maintenance organizations of their obligation to immediately reduce any nonconforming rate differential and to provide guidance on how to make appropriate rate filings with the Department.

28. Coding Legislation

Chapter 551 of the Laws of 2006 was signed into law on August 19, 2006, impacting claims processing for all accident and health insurers, Article 43 corporations, and health maintenance organizations (HMOs), and credentialing procedures for insurers offering a managed care product, as defined in Section 4801(c) of the Insurance Law, and HMOs. The effective date of the new legislation, codified at Insurance Law Section 3224-b, is January 1, 2007.

This new law requires HMOs and insurers to accept and initiate the processing of physician claims using the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions and the Centers for Medicare and Medicaid Services (CMS) health care common procedure coding system (HCPCS). HMOs and insurers are required to indicate on their provider web sites and in provider newsletters the name of the commercially available software product, including any significant edits, used by the plan to accept/edit claims. This information must also be provided upon request to any participating physician.

In addition, the law establishes requirements for overpayment recovery efforts, and provides that except in the case of recovery of duplicate payments, an insurer or HMO must provide 30 days written notice to a physician before engaging in any collection of overpayments. This notice must include the patient name, service date, payment amount, proposed adjustment and a reasonably specific explanation of the proposed adjustment. An insurer or HMO is prohibited from initiating overpayment recovery efforts more than 24 months after the original payment was received by the physician. However, this time limit does not apply in the case of a reasonable belief of fraud and abuse, abusive billing, recovery efforts initiated or required by self-insured plans or required by a state or federal government program.

The law also imposes standards for credentialing, and requires an HMO or insurer offering a managed care product, to provide notification to a health care professional within 90 days of receiving the health care professional's completed application to participate in the health plan's network as to whether the health care professional is credentialed or whether additional time is necessary to make a determination.

On November 14, 2006, the Insurance Department issued Circular Letter No. 22 (2006) to provide guidance regarding the requirements of the new law, and to assist insurers and HMOs with implementation. The Health Bureau will be monitoring compliance with the claims processing requirements, and will incorporate such reviews in market conduct examinations.

29. Updates to Department Web site

The Health Bureau updated the Insurance Department Web site to provide consumers and providers with essential health insurance information. Detailed information was added for consumers describing how to obtain information from HMOs and insurers, what information must be disclosed by HMOs and insurers to consumers, the access to care protections that are in place for consumers, the coverage that must be provided for emergency care, and the requirements for coverage of health care services for women.

A new health care provider rights section was also added to the Web site to include information for providers on participation in a health plan's network, required provisions for provider contracts, termination provisions in provider contracts, performance and practice information that must be developed and disclosed by health plans, provider rights in the submission of claims, restrictions on health plan overpayment recovery efforts, and prompt payment requirements for health insurance claims.

The Health Bureau continues to assess what additional information can be provided on the Department Web site and plans to post updated utilization review and grievance information, along with updated frequently asked health insurance questions and answers.

30. Discontinuations, Withdrawals and Mergers

The Health Bureau approved notices of withdrawal from the individual health insurance markets from AmeriChoice of New York, Inc. and United Healthcare of New York, Inc. In the wake of the merger between United Health Group Incorporated and Oxford Health Plans, Inc., both Americhoice (a United Health Group company) and United Healthcare withdrew from the individual HMO, HMO/POS and Healthy New York markets. Additionally, we approved notices of withdrawal from the small and large group markets from United Healthcare of New York, Inc.

Additionally, during 2006, Health Bureau staff approved notices and plans of withdrawal for Horizon HealthCare of New York, Inc.'s exit from the HMO market, Horizon Health Insurance Company of New York's withdrawal from the group hospital and medical expense insurance markets and GHI HMO's withdrawal from Chautauqua County.

31. Financial Risk Transfer Agreement

Insurance Department Regulation 164, "Financial Risk Transfer Agreements between Insurers and Health Care Providers" (11 NYCRR 101), was promulgated on August 21, 2001. This Regulation addresses an insurer's obligation to assess the financial responsibility and capability of health care providers (*e.g.,* Independent Practice Associations) to perform their obligations under certain financial risk transfer agreements. It sets forth standards pursuant to which health care providers may adequately demonstrate such responsibility and capability to insurers. A particular provision of Regulation 164 did sunset on August 21, 2004, after which "grandfathered" Financial Risk Transfer Agreements between insurers and health care providers had to be submitted to the Superintendent for review. During 2006, the Bureau received an additional 22 applications for review. During 2006, 32 have been approved, 12 are pending and 10 were either withdrawn, suspended or have been determined not to be subject to the strict financial responsibility demonstration requirements of the Regulation.

D. CONSUMER SERVICES BUREAU

Introduction

The Consumer Services Bureau continued its dual investigatory practice last year of attempting to resolve each consumer complaint brought to its attention while also addressing systemic patterns of insurer/producer misconduct discovered through the complaint process. The Bureau succeeded in both closing over 50,000 consumer cases and conducting several major investigations of insurance company and insurance producer practices throughout the year. Whether it was investigating insurance disputes, educating consumers about the workings of insurance, processing external appeal applications or assisting the prosecution of a felon, the Consumer Services Bureau provided needed insurance assistance to New Yorkers in 2006.

1. Consumer Complaints

The Consumer Services Bureau is responsible for responding to consumer complaints and inquiries, and investigating the actions of licensed producers. The Bureau *closed* a total of **53,211** cases in 2006. Of these, **37,874** involved complaints against insurance companies regarding loss settlements or policy provisions, of which 24.6% (**9,313**) were automobile complaints, 64.3% (**24,362**) were accident and health complaints, 8.3% (**3,123**) were property and liability complaints and 2.8% (**1,076**) were life and annuity complaints. In addition **2,505** cases were closed when the complainants failed to furnish additional information deemed necessary in order to proceed with the case. Another **9,262** cases involved complaints against agents, brokers and adjusters. Written inquiries accounted for **1,629** cases and referrals accounted for **1,941** cases (see Chart G). Included in the total are 4 cases related to the World Trade Center disaster. In total, the Bureau *received* **60,145** cases during 2006.

The Bureau responded to approximately 175,000 calls on both the Albany and New York City information lines. The Bureau's telephone system is an attendant system whereby the caller listens to a menu of topics and selects one by pressing the appropriate number on the dial. The caller is given the option of speaking to an agency services representative. The Bureau initiated a call-tracking system in the last quarter of 2002. The agency services representatives complete an automated computer screen template for each call they answer. The data is sorted and stored by the computer system so Bureau managers may more easily determine patterns of calls from consumers indicating an industry problem in a given area of the state. This system has proven helpful in determining the geographical area and severity of disasters occurring in New York State. The data allows for the more efficient use of state resources in response to disasters. The Bureau also maintains a toll-free line that will access a multi-lingual telephone service. This interpretive service, provided by AT&T Language Line Services, can translate 140 languages.

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

The Bureau also maintains a dedicated disaster toll-free hotline. Consumers affected by disasters may call this toll-free line to obtain information concerning their insurance coverage for damages incurred as a result of a natural or man-made disaster. In 2006, the Bureau responded to questions related to the World Trade Center disaster, various winter storms and flood damages in central and southern New York caused during the heaving rainstorms in late June.

Notable complaint activity

The Consumer Services Bureau found as a result of several consumer complaints, that HealthNet's chiropractic vendor, Landmark, was using outdated Usual, Customary and Reasonable information to process out-of-network claims. As a result of our investigation, HealthNet reprocessed approximately 6,000 claims and issued additional payments of more than $3.4 million, which included $1 million in interest.

The Consumer Services Bureau also found that United Healthcare was denying certain services as unproven, without giving the appropriate appeal rights, as required by Article 49. This investigation was also the result of several complaints. As a result, United Healthcare reprocessed thousands of claims which resulted in additional payments of several hundred thousand dollars. In addition, several thousand Empire Plan members received the right to go immediately to an external appeal without having to file an internal appeal first.

The Consumer Services Bureau worked with other Regulatory Agencies on several topics. These include:

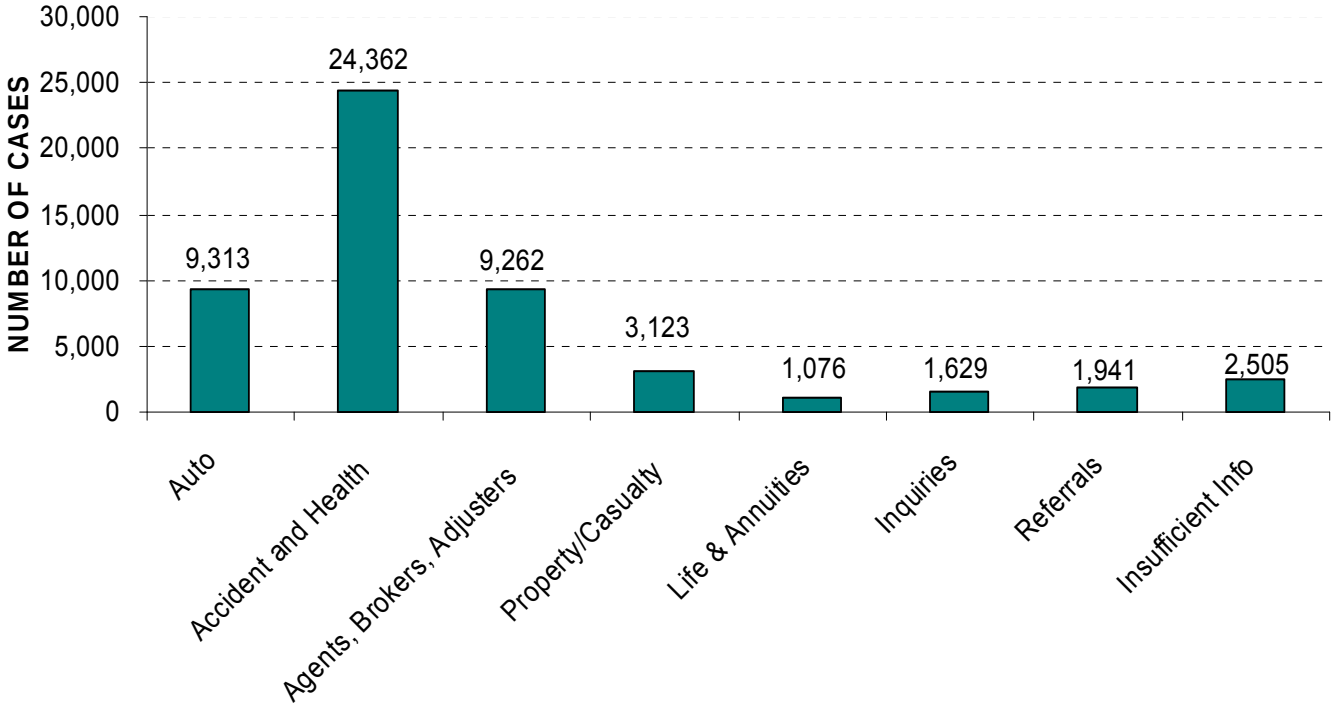
1) **Coordination of Benefits (COB)** – The Consumer Services Bureau continued their work with the Attorney General's Office regarding United Healthcare's internal policies on processing COB claims when they have issued the secondary coverage. Our joint efforts resulted in United Healthcare's agreement to sign an Agreement of Discontinuance (AOD) with the Attorney General's Office in which they agree to amend their handling of these claims.

2) **United Healthcare Collaborative Action –** The Consumer Services Bureau worked with the Health Bureau on the multi-state action against United Healthcare that is currently being coordinated at the National Association of Insurance Commissioners (NAIC). Consumer Services acted as a consultant regarding protections for consumers.

3) **Americhoice COB –** The Consumer Services Bureau received numerous complaints from health care providers against Americhoice regarding the recoupment of claim payments issued by Americhoice over several years. Apparently Americhoice determined, subsequent to the payment of the claims, that other coverage existed and they were therefore the secondary payor. This involved Medicaid Managed Care members who had other commercial coverage and failed to reveal this information on their Medicaid applications. The Consumer Services Bureau worked closely with the Department of Health, the health insurance industry and Americhoice to develop a recoupment process that was acceptable to all parties. The process included the requirement that Americhoice work directly with the other health plans for subrogation.

d. **UnumProvident Collaborative Action -** The Consumer Services Bureau continue to monitor the regulatory settlement agreement of the UnumProvident Corporation. New York is part of a multistate settlement agreement wherein UnumProvident agreed to reassess disability claims going back to 1997. The reassessment has been ongoing since 2005 and is expected to be completed by year end 2007. In addition to initial fines, UnumProvident is to undergo an examination in early 2008 to insure that compliance with the regulatory settlement agreement has been fulfilled.

CHART G
Total Complaints & Investigations Closed
Consumer Services Bureau, 2006



2. Prompt Payment Statute

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

The Consumer Services Bureau continued to allocate significant resources to the investigation and resolution of complaints involving the prompt payment statute. In addition, the Bureau sought to not only ensure that doctors, hospitals and insureds received the prompt payment of claims submitted to health plans but also to ensure compliance by health insurers and HMOs with all other provisions of this statute, such as the payment of interest.

The Consumer Services Bureau continued its enforcement action against health insurers and HMOs that violated the prompt payment statute. In 2006, $576,900 in prompt pay fines was levied against 22 health insurers and HMOs. These fines were calculated using the methodology developed by the Department and the industry in 2003. The methodology considers not only the violations uncovered while investigating complaints, but also the number of claims processed by the insurer or HMO during a specific time period. This provides a more accurate picture of the overall performance of the insurer or HMO.

In addition, Bureau staff participated in several outreach sessions both for large provider groups and hospital administrators. The purpose of these sessions was to educate the participants on their

rights under the prompt payment statute and other laws that affect the payment of health care claims. These sessions also focused on information the providers can utilize those patients who may be faced with the need to navigate through the insurers' and HMOs' various processes.

The recent system upgrade which permits providers to file prompt pay complaints via the Department's web site continues to streamline complaint handling and enables prompt pay complaints to be handled more expeditiously. Not only does the upgrade provide quicker access to consumers to the Department complaint process, it also allows insurers and HMOs to respond electronically to Department complaints via the Internet, thus providing additional timesaving. Responses received online are triaged by the imaging system using established business rules to determine if the response requires examiner review. If the response meets certain criteria, the file will close automatically and generate a closing letter without the need for review by an examiner. This has resulted in a significant reduction in the time required to review and close complaints and demonstrates how technology can be instrumental in the regulatory process. Consumer Services staff has continued to conduct training sessions with the insurance industry on the functions of the on-line system, thus enabling several more companies to utilize this improved function.

3. External Review

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

During 2006, Consumer Services Bureau personnel responded to 5,741 phone calls on the dedicated external appeal toll-free line. Consumer Service Bureau examiners, along with attorneys from the Health Bureau, jointly perform the intake, screening and assignment of external appeal applications. In 2006, the Department received 2,858 applications, the most in any year since the program's inception and an increase of 15% over 2005.

The Bureau continues to leverage technology to streamline the intake and screening process the Department utilizes for the external review process. The Consumer Services Bureau continues to work with the Administration, Systems and Health Bureaus to ensure that staff responsible to perform the intake, screening and assignment of applications has the technology and access to equipment to respond to requests for expedited external appeals 24 hours per day, seven days per week.

The Consumer Services and Health Bureaus continue to work with the health insurance industry and the Department of Health to set parameters within which plans may deny certain procedures as cosmetic. This would allow consumers to access the external review process more quickly for those procedures that are almost always considered cosmetic.

4. The Healthcare Roundtable

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

One major accomplishment of the Roundtable in 2006 was the agreement on finalized language for the Coordination of Benefits (COB) Regulation, which establishes guidelines for the coordination of benefits when there is other primary coverage.

The Roundtable continues to discuss many issues that affect health care providers and health insurers alike. During 2006, there were extensive discussions on several topics including: (1) excessive billing by health care providers in emergency room situations, (2) limiting the timeframe for retroactive refund requests to providers by health insurers, (3) retroactive termination of insureds after services are rendered and claims paid are retracted, (4) administrative denials of claims for medically necessary services, (5) claim submission deadlines, (6) Prompt Pay revisions, (7) release of medical records for fraud investigations and (8) Non-Article 28 entities billing facility rates.

5. Investigations

The Investigation Unit of the Consumer Services Bureau is responsible for investigating the activities of insurance producers, adjusters, reinsurance intermediaries, bail bond agents, service contract providers, and other licensed and non-licensed entities who are conducting the business of insurance in New York State. Its goals are to protect the insuring public and ensure that our licensees act in accordance with the applicable New York Insurance laws and regulations. When a violation is proven, an administrative sanction can be imposed. It may result in either the revocation or suspension of any license(s) held or the imposition of a monetary penalty with resultant corrective action of the violation.

The Bureau continues to investigate the replacement practices of insurers and their producers who failed to comply with a two-step process which is required in the Department's Regulation 60. This information was furnished to us by the National Association of Securities Dealers (NASD) and was the result of their looking at two large insurers and brokerage firms which were selling variable life insurance and annuity products. To date, we have agreement from 29 agents to pay a fine and sign a stipulation admitting they violated New York State Regulation 60. And, we have issued 22 letters of warning. We are looking at over 300 agents.

a. Notable Revocations/Citations:

The Burton Agency – The Department revoked the licenses of the Burton Agency and its sublicense, Jeffrey Burton, as of October 8, 2006. The Hearing Officer found that Burton collected over $5,500 in premiums from approximately 19 clients and failed to forward such premiums to the proper insurance company. To date, these payments are still outstanding. Additionally, not included in the Citation, are additional insureds affected by the Burton Agency. We assisted over 50 people total who had paid their insurance premiums and such premiums were not remitted to the proper insurance company by Burton. Mr. Burton has since pleaded guilty to felony first degree falsifying business records. He will receive five years probation and forfeit any rights to practice as an insurance agent. His sentencing is scheduled for April 30.

Robert Federice – We found numerous cases where Mr. Federice received an application and down payment from his clients, but failed to place coverage as promised. Mr. Federice falsely let his clients believe that they had coverage when, in fact, no such coverage was in place. The coverage issues were all corrected by the carriers involved, and Mr. Federice's license was revoked by our Department.

Christine McAvoy – Ms. McAvoy had collected, but failed to remit, numerous premium payments she collected from her clients. As a result of our investigation, the clients' accounts were credited for the uncollected premiums, and Ms. McAvoy's agent's license was revoked by our Department.

b. Stipulations

Matthew Assini – We found that Mr. Assini, who operates the Colonie General Agency, had been issuing numerous insurance ID cards without proper coverage in place. He also failed to timely remit premiums he collected from his clients. Mr. Assini also tried to cover up his errors by making his clients believe their policies had been placed when, in fact, they did not have coverage. Mr. Assini was ordered to correct all of the insureds coverage issues, and was fined $5,000 by our Department.

The Iroquois Group – The Iroquois Group was found to be operating in New York under an unlicensed name. The company was acting as a wholesaler, placing business for insurance agents and brokers. They were ordered to correct the licensing issues and pay a $2,000 fine.

Mather & Co. – The Company was found to have been placing business in New York without a license. They had placed large commercial policies for both public and private entities. The company corrected their licensing matter, and paid a $1,000 fine to the Department.

Crawford & Company, Inc. and Russell W. Saladin - The Company and Mr. Saladin, as the responsible officer were fined and paid a $150,000.00 penalty in that during the period of 1998 to 2006, they paid fees and/or compensation to employees that acted in the State of New York as independent adjusters without license.

Brown & Brown Insurance - The Company, in April of 2006, paid $100,000.00 fine for doing business in this State without license. The Department's investigation revealed that from July to September of 2006, the entity again violated Section 2102(a)(1) in that they conducted the business of insurance in this state under the unlicensed agency name. A fine of $12,750.00 was imposed and stipulation finalized in November of 2006.

c. Denials

Vincent B. Famularo - was convicted of Grand Larceny in 1996, a felony crime, for having misappropriated at least $72,960.00 in insurance funds and that he failed to timely pay $473.21 in income tax to New York State in 2002. In March of 1997, he surrendered his insurance license, in the way of a revocation, due to his criminal conviction and the fact that he had issued a forged insurance identification card.

Subsequent to the revocation of his license, Mr. Famularo did various kinds of work and sometimes was unemployed. He later submitted an application for re-licensure. The license application was denied, after a formal hearing, in August of 2006 based on the very serious nature of his crime and the fact that he did not demonstrate that he had been rehabilitated since committing the crime.

Melissa Lee Guild - In July of 2006, Ms. Melissa Lee Guild submitted an application to act an agent pursuant to Section 2103(a) of the Insurance Law, wherein an affirmative answer was given to the arrest/conviction question. The application was denied based on the following: the applicant admitted to use Dale Heichel's social security number without his permission to open a Sears's credit card and make purchases on over $3,500.00. The applicant further admitted that her intentions were to pay off the debt before anybody would find out. Ms. Guild was charged with Forgery in the third degree, a Class A Misdemeanor. Ms. Guild requested a hearing. However, failed to appear, thus the denial was affirmed.

d. Cases of Interest

Bison Glass – We also received numerous cases involving the Buffalo area insurance agencies and "Bison Glass." The owner of Bison Glass reported that he had made "kickbacks" to the agencies, which he called "spiffs." These were cash payments or gift certificates of $40-60. As these payments are an apparent violation of Section 322 of the Insurance Law, we are continuing our investigation.

Peter Mravlja – Our Bureau assisted the Department's Frauds Bureau and the Otsego County District Attorney in the investigation of a suspicious fire loss at Mr. Mravlja's farm. Mr. Mravlja has been paid $143,555.81 by his insurance company, Otsego Patrons. The investigation led to Mr. Mravlja's conviction of felony insurance fraud.

Jeffrey Gelbsman – Our Bureau assisted the Department's Frauds Bureau and the Otsego County District Attorney in the investigation of a suspicious fire at a business where Mr. Gelbsman was part owner and manager. The investigation resulted in Mr. Gelbsman's guilty plea to a charge of felony insurance fraud. As part of the plea agreement, Mr. Gelbsman will pay restitution of $56,292.

e. Service Contracts

In 2006, Section 7902(k) was changed to bring road hazard coverage into the Department's jurisdiction. We battled Goodyear, Pep Boys, Firestone, Chrysler and other large companies. Goodyear did finally register. Chrysler ceased selling road hazard coverage. We are currently in negotiations with Pep Boys and Firestone regarding fines for selling without being properly licensed. Tireguard and DMSC ceased selling.

The following service contract companies were fined for selling service contracts without being properly registered to do so: AMT Service Corp., $5,000; American Modern Home Service Company, $2,500; American Water Resources, $5,000; and, Marathon Administrators, $10,000.

f. Bail Bonds

The Bureau commenced its investigation into the marketplace activities of bail agents. It undertook a comprehensive audit of the records of over 25% of the licensed bail agents in New York looking at areas of interest that have from time to time come to the departments' attention in a complaint. The conduct scrutinized encompassed the charging rates, handling of collateral, charges for ancillary services, and record keeping. The investigation continues with the expectation of several disciplinary actions. The Bureau is also developing an amendment the existing regulations that apply to the bail bond business. The extensive interviews conducted and the information gathered from this investigation will serve to enable an efficient and effective product.

g. Medicare Supplemental Insurance

The Consumer Services Bureau led an investigation into the marketing practices of American Progressive Life and Health Insurance Co. of New York and its many agents selling Medicare supplemental policies to seniors, from a complaint reported by the State Office for the Aging (SOFA). The Bureau's investigation included collaboration not only with SOFA, but also with the Life and Health Bureaus since the Life Bureau was conducting an on-site market conduct examination and the Health Bureau approves the policy forms and marketing materials for Medicare supplement insurance. American Progressive was fined $300,000 as a result of this investigation.

In addition, Worlco Management Services, Inc., and responsible officer L. Edward Boyle, general agent for American Progressive, agreed to a $25,000 fine for the agency's actions related to our investigation.

The Bureau continues to investigate other Medicare Supplement carriers and insurance producers.

6. Other Bureau Activities

a. Consumer Imaging and Information Management System (CIIMS)

This premier imaging and workflow system went into production in November 1998. As our work environment evolves, including new legislation requirements, improvements are made to the existing system. Last year modifications were completed to track Medicare Part D issues and to allow for the processing of Service Contract complaints.

The Bureau is planning an upgrade of this system from a client server platform to a web-based application. A web application would allow for off-site complaint review in the event of a disaster. In 2006, the Bureau analyzed its current workflow and surveyed for improvements.

Also, in an effort to maximize use of the system, CSB has demonstrated CIIMS to other bureaus within the Department. We have begun the process of expanding CIIMS to meet the needs of the Excess Lines Unit of the Property Bureau. Utilizing a common system leads to consistency in reporting to the National Association of Insurance Commissioners Complaint Database.

b. E-Commerce Activities

On October 24, 2001, the Consumer Services Bureau implemented a new online complaint process allowing consumers to file a complaint over the internet. Once the consumer submits an online complaint, a file number is assigned and confirmation of this case number is immediately transmitted to the consumer. In 2006, the total number of complaints CSB received was 60,145. Of this amount 8,933 or approximately 15% were received online.

Since 2003 registered insurers, HMOs and their affiliates can respond to complaints online using the Online Company Complaint Response System (OCCRS). There are 49 groups registered to respond online. This represents 81 individual insurers, HMOs and their affiliates. We received 35,798 online complaint responses in 2006. This represents an increase of 55.9% over last year's total of 22,964.

c. State & County Fairs, Conferences & Festivals

Bureau examiners staffed the Department's information booth at the State Fair in Syracuse from August 23 through September 4, 2006. Examiners also staffed an information booth at the Erie County Fair from August 9 through August 20, 2006. At these booths, examiners answered consumer questions, took complaints and distributed the Department's various consumer guides and booklets. Over 70,000 publications and mementos were distributed to the public at these fairs. In 2003, computer compact disks were developed that provided the same information contained in most of the Department's publications, at a significantly reduced cost to the Department. Fifteen thousand of these compact disks were distributed at the fairs and the below-listed conferences.

The Bureau also participated in and staffed information booths at the Black and Puerto Rican Legislators Annual Conference, Martin Luther King, Jr. Holiday Memorial Observance, the African-American Cultural Festival, the Department of Health's Health Fairs, the Somos El Futuro Conference

and Consumer Action Day. Bureau examiners frequently participate in and speak at consumer forums concerning health insurance issues.

The Bureau continues to be a member of the New York State Consumer Protection Board's Consumer Services Committee. The Committee includes representatives of federal, state and local consumer protection agencies and non-profit organizations. The Committee meets to share program initiatives with peers in an effort to keep abreast of consumer concerns.

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

The Bureau continues to assist individuals, families and businesses in overcoming problems due to erroneous or untimely electronic submissions by their insurers to the Insurance Information and Enforcement System (IIES) maintained by the New York State Department of Motor Vehicles. (Auto insurers are required to inform the Department of Motor Vehicles of drivers whose coverage has lapsed.) Insurers not filing timely reports to the Department of Motor Vehicles have been fined. The Bureau continues to investigate these complaints on an expedited basis.

e. New York State Insurance Disaster Coalition

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

The Bureau continues to receive complaints from those individuals, families and businesses affected by the World Trade Center disaster as well as other natural disasters occurring in New York State during 2006. These complaints receive immediate and expedited treatment from Bureau examiners. Bureau examiners have facilitated settlement of a number of these cases by conducting meetings with consumers and their insurers to resolve disputed claims.

Fortunately, there was no need in 2006 to activate the Disaster Response Plan. The Bureau did assist consumers who sustained damages caused by flooding from the June rainstorms. Bureau examiners staffed disaster recovery centers opened in various locations in central and southern New York as well as the Department's mobile command center.

Due to the devastating damages caused by Hurricanes Katrina and Rita striking the Louisiana and Mississippi coastal areas in 2005, the Consumer Services Bureau assisted the Louisiana and Mississippi Insurance Departments by providing examiners to staff various disaster recovery centers in Louisiana and a call center located in Kansas City, MO, at the NAIC's offices. The call center responded to consumers' questions concerning the damages they incurred in the state of Mississippi. Bureau examiners worked nearly 3,000 hours at the disaster recovery centers and the call center. This work continued into calendar year 2006.

f. Senior Issues

The Bureau continues to conduct informational sessions to assist senior citizens and groups concerned with Medicare supplement and long term care insurance.

The Medicare Modernization Act (MMA) established a prescription drug program for Medicare beneficiaries effective January 1, 2006. This program created new, more difficult challenges for New York's senior population in trying to understand the nuances of Medicare Part D. Because Medicare Part D is fundamentally complex and the beneficiary can have a lifetime penalty if the right decision is

not made timely, it is important that correct information be provided. In addition, Medicare supplement insurance policies available in New York have also change because of MMA.

The Health Insurance Information Counseling and Assistance Program (HIICAP) Consortium is comprised of representatives from various state and federal agencies invited by the State Office for the Aging to provide technical assistance and training for HIICAP volunteers statewide. Bureau staff is represented on the Consortium.

Bureau staff participated in monthly HIICAP education and training sessions. In addition, Bureau staff assisted in updating training materials for the Consortium. It is most important that we continue to assist the Consortium in developing materials for education and training in 2007.

In addition, the Bureau maintains a toll-free line dedicated to providing information about the New York State Partnership for Long Term Care. The Partnership allows individuals to qualify for Medicaid after their long term care policy benefits are exhausted without divesting themselves of their assets. The Partnership thus encourages self-sufficiency by guaranteeing asset protection for policyholders and saving the State's Medicaid funds. In 2006, the Consumer Services Bureau received approximately 3,800 calls on the Partnership hotline, a slight decrease from the previous year.

The State Office for the Aging continued its Long Term Care Insurance Outreach and Education Program (LTCIOEP), mandated under New York Elder Law. This program creates long term care resource centers at the county level to provide educational and informational materials, and counseling and referral services on planning for the financing of long term care. The State Office for the Aging in conjunction with the Department of Health launched a significant media campaign to publicize the availability of the various types of long term care type policies available in New York.

g. Coastal Property Insurance Issues

2006 saw several insurers cease selling and/or renewing homeowners insurance in coastal market areas. The Consumer Services Bureau has fielded many complaints from affected consumers in these areas and reviews each complaint to determine whether the insurer is complying with all applicable laws. The Bureau will be closely monitoring the overall state of the coastal property insurance marketplace in 2007.

h. Consumer Outreach

The Healthy NY Program became effective January 1, 2001. This program is designed to make affordable health benefits accessible to New York State's small business owners and working uninsured individuals. Bureau staff continued to attend outreaches where Healthy NY information is provided. In addition, the Consumer Services Bureau continues to respond to inquiries received via the Healthy NY mailbox on the Department Web site during 2006.

Consumer Services staff continued their participation in several outreach presentations designed to assist the public and health care providers with their health insurance problems. These include a meeting at the Champlain Valley Physicians Hospital to discuss the Prompt Pay and the External Appeal Laws. In addition, Consumer Services staff attended a meeting at the Greater New York Hospital Association with the Attorney General's Office to discuss problems downstate hospitals were having with United Healthcare.

The Consumer Services Bureau continued during 2006 to participate in special outreach programs designed to assist New Yorkers losing their jobs due to plant closings or bankruptcy of a major employer. Bureau staff assisted displaced workers in finding new health insurance. Through contacts with the New York State Department of Labor, the Consumer Services Bureau becomes aware of major employers leaving the State for various reasons. Consumer Services Bureau staff traveled to those

locations and assisted the displaced workers and retirees in identifying health insurance options available including Healthy NY, the HCTC Healthy NY option, conversion options, and other resources that might be able to assist workers in replacing health insurance coverage.

In addition, Consumer Services staff conducted presentations for new coordinators for both the Long Term Care Insurance Outreach and Educational Program and the Health Insurance Information Counseling and Assistance Program (HIICAP).

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

i. Freedom of Information Law (FOIL)

In calendar year 2006, the Bureau responded to 217 requests from consumers under the Freedom of Information Law for copies of documents contained in the Bureau's complaint and investigation files. These requests ranged from as small as one document to thousands of documents in hundreds of files.

Table 57
CONSUMER SERVICES BUREAU COMPLAINTS AGAINST INSURANCE COMPANIES
INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
Closed in 2006

Line of Business	Total Processed	Upheld	Adjusted in Consumers Favor	Not Upheld	Prompt Pay Violation	Other Action Taken
Total	**37,874**	**2,812**	**4,872**	**12,369**	**5,156**	**12,665**
Life & Annuities, Total	1,076	109	197	605	0	165
Individual Life	768	72	127	469	0	173
Individual Annuity	173	19	49	79	0	26
Group Life & Annuity	126	18	18	54	0	36
Viatical Settlements	2	0	0	0	0	2
Credit Life	7	0	3	3	0	1
Accident & Health, Total	24,362	534	2,873	7,881	5,156	7,918
Individual Accident & Health	150	15	26	80	17	12
Group Accident & Health	2,741	141	481	1,359	568	192
Article IX-C Corps	1,987	63	287	984	560	93
HMO	5,381	166	930	2,410	1,676	199
Medicare	2,008	7	3	10	0	1,988
Medigap	116	8	20	69	6	13
Long Term Care	70	5	18	39	1	7
Self-Insured Health Plan	4,066	1	1	1	1	4,062
Travel, Health	79	8	12	39	0	20
Health Alliance	0	0	0	0	0	0
Medicaid	5,943	70	943	2,581	2,268	81
Municipal Co-ops	13	2	2	8	0	1
Credit Disability/DBL Income	244	17	52	93	0	82
Healthy NY	216	21	59	107	23	6
Federal/Out-of-State Contracts	1,141	0	1	3	0	1,137
Child Health Plus	182	6	35	94	36	11
Medicare Part D	25	4	3	4	0	14
Auto, Total	9,313	1,824	1,416	2,662	0	3,411
Auto, Liability (B.I.)	1,348	298	214	631	0	205
Auto, Liability (P.D.)	2,030	190	399	460	0	981
Auto, Physical Damage	1,376	219	227	435	0	495
No-Fault	4,559	1,117	576	1,136	0	1,730
Other Property & Liability, Total	3,123	345	386	1,221	0	1,171
Liability Other Than Auto	179	18	22	51	0	88
Professional Malpractice	24	3	3	10	0	8
Fire & Extended Coverage	46	3	5	20	0	18
Homeowners	1,509	111	158	797	0	443
Inland/Ocean Marine	23	3	3	7	0	10
Workers' Compensation	729	137	113	137	0	342
Commercial Multiple Peril	295	34	31	104	0	126
Burglary & Theft/Fidelity Surety	26	4	5	6	0	11
Flood	40	5	7	13	0	15
Title	47	3	12	14	0	18
GAP and Service Contracts	161	14	22	48	0	77
Other	44	10	5	14	0	15

Table 58
CONSUMER SERVICES BUREAU INVESTIGATIONS AGAINST AGENTS AND BROKERS
NOT INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
Closed in 2006

Subject of Cases or Investigations	Total Processed	Fines and Revocations	Other Actions	Not Upheld
Total	**9,262**	**567**	**8,019**	**676**
Application for License	7,227	125	7,099	3
Issuing Bad Checks	138	82	32	24
Misrepresentation of Coverage	139	13	58	68
Excess Comp Without Contract	13	2	6	5
Twisting	127	3	63	61
Violation of NYAIP/NYPIUA Rules	225	78	69	78
Return Premium-Producer	68	6	19	43
Other Violations of Insurance Law	127	31	44	52
Violations of Other Laws	18	3	10	5
Termination for Cause	86	24	50	12
Misleading Sales, Life and Medigap	37	5	19	13
Advertisements	18	1	8	9
Miscellaneous	262	29	99	134
Misappropriation of Funds	217	69	100	48
Service Contracts	96	0	92	4
Aiding Unauthorized Insurers	66	59	4	3
Inquiries	113	0	113	0
Other Investigations Received From Companies	50	4	15	31
Other	235	33	119	83

E. THE INSURANCE FRAUDS BUREAU

1. General Overview

The Frauds Bureau was established by an act of the Legislature in 1981 as a law enforcement agency within the New York State Insurance Department. The Bureau's primary mission is the detection and investigation of insurance fraud and the referral for prosecution of persons or groups that commit acts of insurance fraud. The Bureau is headquartered in Manhattan, with seven addition offices across the state: Brooklyn, Mineola, Albany, Syracuse, Oneonta, Rochester and Buffalo.

2. 25-Year Retrospective 1981-2006

Twenty-five years ago, then-Governor Hugh L. Carey enacted legislation that brought the Insurance Frauds Bureau into existence as a law enforcement agency within the New York State Insurance Department. Since that time, the Bureau has grown into one of the premier agencies in the country dedicated to the investigation of insurance fraud. Here are highlights from the Bureau's extraordinary history.

- **1981 –** On November 1, the Frauds Bureau is created. Its mission: to detect and apprehend those who commit insurance fraud and to change the public perception of insurance fraud as a victimless crime. The staff: 13 investigators, an insurance examiner and support staff under the supervision of a Director, Deputy Director and Frauds Bureau Counsel.

- **1982 –** The Bureau breaks its first major case, Claridge Brokerage, the largest producer of Assigned Risk business in New York; 28 are indicted in a $50 million fraud scheme. Federal authorities subsequently file charges under RICO against many of these individuals.

- **1983 –** The Bureau branches out, formalizing its liaison with the insurance industry. Regular meetings with insurer SIUs are scheduled for training and networking. Legislation is enacted extending the Bureau's sunset provision to January 1, 1987.

- **1985 –** Bureau investigations result in the denial of fraudulent claims and restitution exceeding $3 million. The New York Frauds Bureau is one of only four fraud bureaus in the country.

- **1986 –** The Bureau joins California, Florida, Idaho, Nevada, North Carolina and Ontario, Canada to establish the International Association of Insurance Fraud Agencies to encourage other states to create insurance fraud units.

- **1988 –** The Bureau establishes a Medical Unit in response to an increasing number of health care fraud reports. The unit meets with major health insurers to discuss problem providers and potential fraud situations.

- **1989 –** The Bureau conducts its first sting operations.

- **1990 –** A 162-count indictment charges 15 Brooklyn residents with participating in an organized fraud ring. The defendants are accused of conspiring to file accident reports falsely claiming damage to luxury cars which they owned or leased.

- **1991 –** ABC TV's news program "20/20" features a Frauds Bureau case in which an undercover correspondent is seen on hidden camera buying a stolen car. Twenty-six are arrested and 53 vehicles are recovered.

- **1992 –** New laws authorize the Insurance Department to impose *civil penalties* on those who commit insurance fraud and permit a fine for possession of fraudulent automobile identification cards.

- **1993 –** Bureau investigative staff increases to 19 in New York City and 5 upstate in response to an increased workload. An Auto Unit and a General Unit are created to accompany the Medical Unit.

- **1995 –** The Bureau strengthens is relationship with the Attorney General's Criminal Prosecutions Bureau, particularly in the area of health insurance fraud. At year-end, the Medical Unit is actively pursuing 26 investigations in conjunction with the AG's Office.

- **1996 –** The Bureau establishes a toll-free hotline for reporting insurance fraud. The number of fraud reports soars to 22,343, an increase of 760% over the total for 1982, the Bureau's initial year. Arrests, at 154, and convictions, at 57, are also well above 1982 levels.

- **1997 –** Two new units – Organized Fraud and Workers' Compensation – are created and a regional office is opened in Mineola to investigate cases originating in Nassau, Suffolk and Queens.

- **1998 –** Legislation requires insurers to file a Fraud Prevention Plan with the Superintendent. The Bureau receives 305 Plans for review and approval. The Bureau hosts its first off-site seminar for insurers and law enforcement to share information and hone investigative skills.

- **1999 –** The Bureau issues its first Manual of Procedures, sponsors two conferences, launches the Frauds Resource Center on the Department's Web site, publishes a consumer brochure, and introduces an electronic fraud reporting system.

- **2000 –** Bureau staff meets with prosecutors from each of New York's 62 counties and assists the industry in launching four major public awareness advertising campaigns.

- **2001 –** In response to the events of 9/11, the Bureau institutes a dedicated hotline and fax line, establishes a procedure for fast-tracking World Trade Center-related claims, and staffs an emergency center 12 hours a day, 7 days a week.

- **2002 –** The Bureau receives the Anthony M. Kane Achievement Award presented each year by the Northeast Chapter of the International Association of Theft Investigators for outstanding achievement in the field of fraud investigation and prevention.

- **2003 –** With a new Director and Deputy Director, the Bureau undergoes a restructuring, combining the Auto Unit and the No-Fault Unit into one Organized/No-Fault/Auto Unit, creates a position of Statewide Auto Unit Coordinator and opens a satellite office in Brooklyn to reduce the incidence of fraud in an effort to help control auto insurance premiums for consumers in that borough.

- **2004 –** Deputy Chief Investigator August D'Aureli presents testimony before the New York State Senate Standing Committee on Insurance on February 9, 2004. The Committee is

studying the incidence of no-fault insurance fraud in New York State and wants to hear from someone "in the trenches."

- **2005 –** Six members of the Bureau's No-Fault Unit are part of a 15-member team that receives a Governor's Office of Employee Relations Workforce Champions Award for their successful fraud-fighting efforts in "Operation Auto Rates," a multi-faceted strategy to reduce auto premiums in New York State. New York drivers save more than $400 million in auto insurance premiums.

- **2006 –** The Bureau's Web-based Fraud Reporting and Case Management System, three years in the planning-and-development stage, is rolled out. The new system is designed to enhance the effectiveness and accuracy of fraud reporting, using drop-down menus and also allows for the attachment of images and documents. Under the new automated system, virtually all of the Bureau's principal tasks will be Web-based, including case management and statistical tracking.

3. Team Building

The Bureau's vision of joining with the insurance industry, prosecutors and law enforcement agencies on the federal, state and local levels as members of a cohesive fraud-fighting team with cooperation, communication and commitment as its cornerstone was reinforced during 2006.

a. The Frauds Bureau and the Attorney General's Office teamed up with the New York State Banking Department, the Brooklyn and Suffolk County DAs' Offices, the FBI, the U.S. Department of Labor, the New York State Department of Taxation and Finance and the New York-New Jersey Waterfront Commission in an investigation that led to the arrest of eight persons for their participation in a multi-million dollar residential mortgage fraud scheme.

In addition, the Bureau's continued efforts to work closely with its fraud-fighting partners in law enforcement and the industry reflect a Statewide approach to combating insurance fraud. The Arson Unit has worked closely with the Auto Fraud Unit of the FDNY Fire Marshal's Office and the NYPD's Arson Explosion Squad, as well the Bureau of Alcohol, Tobacco, Firearms and Explosives. The Unit also acts as a liaison with the New York State Office of Fire Prevention and Control, as well as local arson units and fire departments across the State.

The Bureau also joined forces with the NYPD's Fraudulent Accident Investigation Squad and its Auto Crime Division on many no-fault and other auto-related fraud investigations and with the Workers' Compensation Fraud Inspector General's Office and the State Insurance Fund on workers' compensation fraud. Bureau staff has also worked hand-in-hand with the FBI, the U.S. Attorney's Office, the U.S. Postal Inspector's Office, the State Police and local police departments and sheriff's offices throughout the State.

b. The Frauds Bureau is an active participant in numerous task forces and working groups designed to foster cooperation among the many agencies in the State that share common goals.

4. The Staff

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

Bureau staff consists of 39 investigators, organized into six specialized units: Arson; General; Medical; Organized/No-Fault/Auto; Workers' Compensation; and Upstate. Each unit is supervised by a

Deputy Chief Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of two Assistant Chief Investigators.

A statewide Auto Unit Coordinator/Quality Control Officer monitors patterns and trends in auto insurance fraud, oversees the Bureau's files, recordkeeping and case management, supervises Bureau staff assigned to HIDTA (High Intensity Drug Trafficking Area) and coordinates the operation of the Department's Mobile Command Center. Both of these staff members report to the Chief Investigator.

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

Investigators new to the Bureau participate in an Entry-Level Training Program developed and administered by the Bureau's Training Officer to address the needs of new investigators. The Training Officer also conducts an In-Service Training Program for all investigative staff members. Both programs comply with the standards and curriculum established for professional police officers by the Bureau of Municipal Police of the New York State Division of Criminal Justice Services. Frauds Bureau investigators are seasoned professionals with extensive law enforcement experience and often exceed these high standards of performance.

The Training Officer, with the assistance of another Bureau investigator, provides both upstate and downstate investigative staff with appropriate instruction in firearms safety and proficiency. Both trainers are Certified Firearms Instructors. Yearly recertification is required by the Division of Criminal Justice Services. However, Frauds Bureau investigators recertify semi-annually, demonstrating the importance the Bureau attaches to the responsibilities involved in the proper use of firearms.

On October 20, 2006 as part of routine firearms training, the upstate investigators took part in a training session in "Law Enforcement Officers Flying Armed," conducted by the Bureau's Training Officer and the assistant trainer**.** This training is federally mandated for law enforcement officials who are called upon to travel while armed, for example, to extradite a prisoner. Downstate investigators will participate in this same training during 2007.

The Training Officer and other members of the investigative staff provide training for local police and fire units, prosecutors, insurers and others. Training was conducted for recruits at several police departments around the State during 2006, including eight sessions at the New York City Police Academy that were attended by 2,610 recruits. Training was also provided for 184 members of the Rochester Police Department including 98 recruits, as well as more than 180 members of the Rockland County Police Department. The Bureau pays special attention to the training of police recruits because police officers are often the first responders to auto accidents and other emergency situations. The Bureau is keenly aware that their ability to recognize insurance fraud can be critical to an investigation.

Investigators, examiners and support staff routinely attend career development seminars and training programs to increase their proficiency in investigative procedures, computer skills and problem-solving techniques to ensure they stay current with emerging developments in fraud investigation.

5. Investigations

The Frauds Bureau received 22,884 reports of suspected fraud in 2006. Of that total, 22,158 were received from licensees required to submit such reports to the Department, and 726 were received from other sources, such as consumers and anonymous tips. A total of 1,101 new cases were opened for investigation during the past year. At the same time, investigations continued in numerous cases opened in prior years.

During 2006, the Bureau referred 274 cases to prosecutorial agencies for criminal prosecution and another 54 for civil settlement or referral to the Department's Office of General Counsel for civil proceedings.

6. Arrests

Frauds Bureau investigations led to 604 arrests for insurance fraud and related crimes during the past year. Many of these investigations dealt with sophisticated conspiracies involving medical clinics, physicians and other health care professionals and attorneys. The medical professionals caught in these investigations were charged with prescribing unnecessary treatments and excessive diagnostic tests, billing for services not provided or billing for treatment of nonexistent injuries. Attorneys involved in these kinds of scams filed fraudulent bodily injury claims. Such investigations are complex and labor intensive and require a high degree of teamwork and cooperation among Frauds Bureau investigators, insurers, law enforcement agencies and prosecutors.

In one such case, a 20-month investigation conducted jointly by the Frauds Bureau, the Attorney General's Auto Insurance Fraud Unit and the NYPD's Fraudulent Accident Investigation Squad resulted in three separate indictments charging 17 people and three corporations with participation in an elaborate no-fault insurance fraud scheme.

White-collar fraud is another complex crime that requires cooperation among agencies and a good deal of perseverance to solve. During 2006, for example, an investigation by the Frauds Bureau, the Attorney General's Office and a number of other state and federal agencies brought a halt to a multi-million dollar residential mortgage fraud scheme and led to the arrest of eight suspects. The Attorney General also announced the filing of a civil forfeiture action seeking recovery of more than $8 million from the defendants.

These collaborative efforts and the many like them that the Frauds Bureau was involved in during the past year have had a major impact in reducing insurance fraud in New York State.

7. Fines

In 2006, Bureau activities resulted in stiff fines being levied against 14 individuals who were sentenced to pay almost $8.1 million in court-ordered restitution. In addition, individuals in 8 cases made voluntary restitution amounting to $578,674 during the year. In another 38 instances, insurers saw savings of nearly $1.5 million in connection with fraudulent claims under investigation by Frauds Bureau staff.

8. Civil Enforcement

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

9. Asset Forfeiture Funds

As a result of an investigation conducted jointly by the Frauds Bureau, the Manhattan DA's Office and the NYPD's Fraudulent Accident Investigation Squad, a corporation that acted as a broker for New York City taxis and its owner were charged on June 9, 2005 in connection with the systematic

fraudulent inflation of damage claims arising from accidents involving taxis. On June 28, 2005, the corporation's owner pleaded guilty to scheme to defraud in the 1st degree and insurance fraud in the 4th degree. He was sentenced to nine months in prison and agreed to pay a financial penalty of $1 million, $478,300 of which was paid to 70 insurers in restitution. The remainder was distributed among the three investigating agencies. The Insurance Department received a check for its share, $106,948.50, in September 2006.

10. Fraud Prevention Plans/Public Awareness Programs

The Second Amendment to Regulation 95 requires all insurers that meet certain criteria to submit to the Department a Fraud Prevention Plan that includes establishing a Special Investigations Unit (SIU) to be responsible for the investigation of cases of suspected fraud and for implementation of fraud prevention and reduction activities. At year-end 2006, there were 152 Plans on file.

The Second Amendment to Regulation 95 also includes a requirement that insurers develop a public awareness program focused on the cost and frequency of insurance fraud and methods by which the public can prevent it. The programs must be geared to reach a wider audience than an insurer's policyholders and applicants. In an effort to achieve that goal, the New York Alliance Against Insurance Fraud, a coalition of more than 100 insurers that write property/casualty, life, health and disability insurance in New York State, carries out major advertising campaigns using newspapers, radio, television and billboards to target insurance consumers. In addition, several individual companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year. The Bureau has a frauds hotline (1-888-FRAUDNY) and consumers are encouraged to report suspected insurance fraud. Calls to the hotline averaged 49 a week during 2006.

11. Major Cases

Multi-agency investigations and arrest sweeps lead to a significant number of arrests in any given year and 2006 was no exception. However, not to be overlooked are the numerous arrests that resulted from the day-to-day investigations conducted by Frauds Bureau investigators. Below are summaries of some of the cases investigated during the past year.

a. Extradited

In August 2001, the defendant in this case was indicted by a Niagara County grand jury on charges that during the first half of 1998, he collected $5,000 in workers' compensation benefits while he was employed. However, he fled New York State before he could be arrested. In December 2005, the Niagara County DA's Office informed the Frauds Bureau that the suspect had been picked up in Westmoreland County, PA, on the outstanding Niagara County warrant. The suspect would not waive extradition, claiming he was not the person for whom the warrant was issued, which meant that a New York State Governor's warrant would be required for his return to New York. After reviewing the original indictment file, together with fingerprint cards and signatures supplied by Westmoreland County, the investigators determined there was a match. In addition, the social security number the suspect gave to the Westmoreland County DA was identical to that on a sworn statement the suspect gave at an earlier workers' compensation hearing in New York. Based on this evidence, the Governor's warrant was issued and a hearing in Pennsylvania determined he was the same person who was indicted in August 2001 in New York. The suspect surrendered himself to the Niagara County Sheriff's Department on 2/6/06 and was arraigned on 2/7/06.

b. Two Body Shops Shut Down

Following a lengthy undercover investigation, the owner of a Suffolk County auto body shop was arrested and charged with insurance fraud. The shop allegedly enhanced damages to cars in order to

generate larger insurance payouts. In addition, they billed insurers for work that was unnecessary or not done at all and billed for used replacement parts that they claimed were new. This investigation also resulted in the arrest of another body shop owner about two weeks later on similar charges. The Frauds Bureau, the Suffolk County Police Department and the Suffolk County DA's Office conducted the investigation with the assistance of Liberty Mutual, GEICO and Chubb Insurance Companies.

c. Gone Too Far

A special education teacher, formerly with the Cohoes City School District and now a New Hampshire resident, was accused of collecting thousands of dollars in disability benefits based on a fraudulent claim that she had cancer. She apparently shaved her head and wore a scarf to make her colleagues believe she had lost her hair from chemotherapy treatments. She filed allegedly fraudulent documents stating that she was unable to continue her employment. The defendant turned herself in to the Cohoes Police Department and was released on a $10,000 bond. An investigation by the Frauds Bureau and the Cohoes Police Department led to her arrest.

d. Mortgage Fraud

An investigation by the Frauds Bureau, the Attorney General's Office, the New York State Banking Department, the Brooklyn and Suffolk County DAs' Offices, the FBI, the U.S. Department of Labor, the New York State Department of Taxation and Finance and the New York-New Jersey Waterfront Commission led to the arrest of eight individuals for their participation in a multi-million dollar residential mortgage fraud scheme. The Attorney General also announced the filing of a civil forfeiture action seeking recovery of more than $8 million from the defendants. These defendants stole millions of dollars from banks and other financial institutions by submitting false and forged documents to secure mortgage loans. They paid people (known as "straw buyers") to represent themselves as legitimate real estate buyers and, in order to obtain the loans, provided the banks with reports that inflated individual properties by $100,000 or more. A scheme detailed in the indictment as an example involved the sale of a house in Brooklyn. The true purchase price was $310,000. However, this group informed the bank that the price was $450,000 and applied for a loan in that amount. The group provided the bank with false information about the financial condition of the person they paid to pose as a legitimate buyer and filed a forged appraisal report. They then pocketed the bulk of the inflated amount and allowed the loan to go into default.

e. All in the Family

Five members of a family of seven, previously arrested in March 2006 and accused of participating in an elaborate staged-accident scam, were indicted for the second time in three months on similar charges. A two-year investigation led to the earlier arrests of the suspects, a well- known Albany area prizefighter and his wife, mother, father, sister, brother and brother-in-law. They are suspected of staging hundreds of accidents over a 15-year period, targeting elderly and drunken drivers. They then filed claims and collected as much as $750,000 in phony insurance payments. They were able to escape detection for so long because they kept the accidents relatively minor and filed claims for relatively small insurance payments. The Frauds Bureau, the Albany County DA's Office, the Albany Police Department and the Department of Motor Vehicles combined efforts in this investigation. This recent indictment included the two brothers, their wives and their father.

f. Seventeen Charged

A 20-month investigation conducted jointly by the Frauds Bureau, the Attorney General's Auto Insurance Fraud Unit and the NYPD's Fraudulent Accident Investigation Squad resulted in three separate indictments charging 17 people and three corporations with participation in an elaborate no-fault insurance fraud scheme. The first indictment charged three defendants, including a doctor and a medical clinic owner, with the operation and control of a medical clinic in Brooklyn. The "owner on

paper" was the doctor, whose specialty was physical rehabilitation. The real owner, a woman who lacks a health provider license, made all the decisions about what medical services were to be provided to the patients. The clinic acquired patients using a network of "steerers" who were paid to refer patients. The steerers solicited patients by staging auto accidents and by offering the clinic's services to legitimate auto accident victims. They allegedly staged the accidents by recruiting people to pose as injured pedestrians or bicyclists, or to pose as witnesses. The Attorney General also brought a civil case against these defendants seeking forfeiture of more than $3.9 million in the illegally gained proceeds of the scheme and has obtained a court order freezing the assets of the doctor, the clinic's owner and three corporate defendants. In the other two indictments, 14 people were accused of staging accidents throughout New York City and seeking treatment for nonexistent injuries. Two Brooklyn-based management companies, both owned by the woman who secretly owned the clinic, were allegedly used to launder the funds of the enterprise. Also assisting in this investigation was the National Insurance Crime Bureau, and Allstate, American Home, AIG, American Select, GEICO, Liberty Mutual, MetLife Auto and Home, OneBeacon, Progressive Casualty, State Farm and York Claims of AIU Insurance Companies, as well as The Robert Plan Corporation.

g. Chiropractic Fraud

Two partners in a Wall Street chiropractic practice were arrested on charges of billing insurers for services they did not provide and using the identical diagnoses for numerous patients. The indictment claims that one of the partners billed Oxford Health Plan $172,000 for 230 visits by the other partner and another 229 for the partner's wife during the same one-year period. An investigation conducted jointly by the Frauds Bureau and the FBI led to the arrests.

h. Eight Caught

Interagency cooperation among members of the Frauds Bureau, the New York City Police Department, the Albany County DA's Office, the DMV and the New York Automobile Insurance Plan led to the arrest on 12/18/06 of eight downstate men who were charged with using upstate addresses to register a fleet of vehicles that were used solely in New York City. Seven of the eight resided in the five boroughs; the eighth suspect lived in Orange County. These defendants were able to reduce their auto insurance premiums by nearly $1.5 million by fraudulently registering their vehicles in upstate counties where commercial auto rates are relatively low. If convicted, six of the men face up to seven years in state prison. The other two could serve up to 15 years behind bars because they were charged with more counts of fraud and offering a false instrument for filing.

i. Broker Fraud

Following an investigation by the Frauds Bureau and the Nassau County DA's Office, three brokers were arrested for defrauding their clients out of hundreds of thousands of dollars. In August 2004, the insurance agent for a rubber manufacturing company sent broker #1 a check for $250,376 to cover the premiums on annuities for 13 participants in the company's pension plan. However, the investigation revealed that the broker had submitted premiums to cover only ten annuities, pocketing $54,302. The broker never funded the remaining annuities nor did he repay the premiums he had stolen. In addition, he forged the agent's signature to 11 commission checks totaling more than $13,000 and deposited them to his business account. He faces 15 years in prison if convicted. Broker #2 accepted a $10,000 deposit for the purchase of commercial general liability insurance for a home improvement business and subsequent premium payments totaling $27, 745. He issued Certificates of Insurance as proof that the coverage was in place. During the course of the investigation, evidence was uncovered that indicated that the broker had never forwarded the money to any insurer and no coverage existed. Most of the premiums were deposited to his business account and very shortly withdrawn. Insurance Department records showed that his broker license had expired and he had a history of complaints. He faces a maximum of seven years in prison. Broker #3 was charged with three counts of grand larceny in the 2nd degree. In three separate instances, he allegedly used premiums to

fund the operating costs of his insurance brokerage business and to cover payroll and other business expenses. In the first instance alone, he collected $263,513 in premiums and then issued bad checks to the insurer to cover the premiums payment. He faces a maximum of 15 years in prison if he is convicted on any of the grand larceny charges.

12. Staff Recognition Awards

The New York Anti Car Theft and Fraud Association (NYACT) honored Insurance Frauds Bureau Director Charles Bardong with the Joe McDonald Award, the Association's highest tribute. The Award was presented to Director Bardong at NYACT's Education Conference for Insurance Claims and SIU Personnel on November 15, 2006 at which he was the keynote speaker. In presenting the Award, Arthur V. Marchiselli, Chairman of NYACT, recognized Director Bardong's "many accomplishments over the years and his outstanding record of achievements in Law Enforcement and the New York State Insurance Department."

Director Bardong presented the Director's Award to Kathleen McQueen, the Bureau's Assistant Director of Research on March 17, 2006. The Award was "in recognition of your invaluable contributions to the New York State Insurance Frauds Bureau in the fight against fraud. 2005 – The Year the Rates Came Down."

Senior Investigator Edward Miller received awards from both the FBI's Health Care Unit and the U.S. Attorney for the Eastern District for his role in the first staged accident case ever to be prosecuted under the Racket Influenced and Corrupt Organizations (RICO) Act in the United States. The investigation was conducted jointly with HIDTA (High Intensity Drug Trafficking Area) and the U.S. Postal Inspector's Office.

13. Mobile Command Center

The New York State Forum, a part of the Rockefeller Institute of Government, presented a 2005-2006 Best Practices Award to the Insurance Department for its acquisition and launch of a Mobile Command Center. The Award, presented at the Forum's annual meeting on September 8, 2006 in Albany, is given to a limited number of state and local agencies in recognition of their efforts to improve public-sector services through the use of effective information management. The award is in the technical category, honoring excellence in the implementation of information technology to meet governmental business goals.

The 36-foot Mobile Command Center (MCC) came into service in June 2006, equipped with the latest computer and electronic communications systems, including satellite and Internet telephones, as well as devices that give authorized Department personnel access to police radio systems in case of emergency. The MCC is an office on wheels, giving the Department the ability to continue operations should the existing communications infrastructure be severely damaged or temporarily disabled.

In addition, the MCC can bring Department services and professional expertise to the scene of natural disasters. For example, it was deployed to New York's southern tier in response to extensive flooding in late June in 13 central New York and Hudson Valley counties. It was deployed again to the Buffalo area in early November in response to the Governor's declaration of an emergency in Erie, Genesee, Niagara and Orleans Counties due to severe flooding following a major snow storm on October 12-13. As the MCC coordinator, Frauds Bureau Deputy Chief Investigator John Browne traveled to the Buffalo area in November to oversee the deployment and operations of the MCC.

14. Prosecutors as Partners

Under a program initiated in 2003, Frauds Bureau investigators are assigned to prosecutors' offices to work side-by-side with their investigative staff. During 2006, the Bureau had investigators in

11 prosecutors' offices across the State. As of year's end, one investigator was assigned to the Suffolk County DA's Office full time. In addition, we had one investigator in the Nassau County DA's Office two days a week; two investigators one day a week in Queens; and one investigator three days a week in Rockland where he also worked with investigators in the Putnam and Dutchess County DAs' Offices. We also had one investigator in the Albany County DA's Office two to three days a week, one investigator two to three days a week in Westchester, one investigator one day a week in the Bronx, one investigator in the Staten Island DA's Office one day a week, and an investigator part time in the Monroe County DA's Office.

15. Foreign Delegations

Over the years, the Insurance Department has played host to delegations from countries around the world and 2006 was no exception. The Frauds Bureau was invited to participate in several of the meetings during the past year. On the agenda was an overview of Frauds Bureau operations, how the Bureau works with the industry to detect fraud and with prosecutors to develop cases.

During June, the Bureau met with several members of the Consumer Protection for Estonian Financial Supervision Authority. Bureau staff also met in June with the Russian Association of Motor Insurers whose members were interested in how the Bureau deals with auto theft and auto insurance fraud. Case studies were presented followed by a lively question-and-answer period. In addition, the Bureau met with a delegation from Korea in July.

16. Directions for 2007

a. Web-Based Case Management System

The Frauds Bureau's Web-based Case Management System was geared up for roll-out during the last quarter of 2006 and is now in the test phase. Assistant Chief Investigator Karen Silverstein, who, with other members of the Frauds and Systems Bureaus, has guided this initiative since its inception, conducted a prototype demonstration of the system on 11/20/06 for members of insurance company Special Investigations Units, followed by a question-and-answer/discussion period. The input provided by the industry at the demonstration is proving helpful in working out kinks and making appropriate improvements during this test phase. Full implementation will take place during the first quarter of 2007. When fully implemented, the system will have an on-line Help Center and a Manual of Operations.

b. Audits of Insurer Special Investigations Units

For the past several years, members of the Frauds Bureau have accompanied the Health Bureau on financial examinations and the Property/Casualty Bureau on market conduct examinations. The purpose of this assignment is to evaluate insurer compliance with Department regulations and New York State Insurance Law. The Frauds Bureau will continue to assist other regulatory bureaus with examinations in the coming year. The Frauds Bureau will continue to conduct independent audits and assessments. We will also continue to provide guidance to Special Investigations Units.

17. Legislation

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

- Providing the Superintendent of Insurance with the authority to establish standards for the public awareness programs that insurers are required to develop under the provisions of Regulation 95;
- Upgrading the status of Insurance Frauds Bureau investigators from peace officers to police officers, enabling them to act independently in the execution of such tasks as

search and arrest warrants, court orders relating to electronic surveillance and summary arrests;

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

Section 405 of the New York Insurance Law requires the Superintendent of Insurance to submit to the Governor and the Legislature by January 15 each year a comprehensive summary and assessment of the operations of the Frauds Bureau. The 2006 Insurance Frauds Bureau Annual Report is available on the Department's Web site at www.ins.state.ny.us.

F. INFORMATION SYSTEMS & TECHNOLOGY BUREAU

The Information Systems & Technology Bureau (Systems) provides information technology products and services to approximately 940 Insurance Department employees and supports the Department's technical infrastructure. Systems' clients include insurers, the public, federal, state and local agencies, other insurance regulators, actuaries, insurance examiners, frauds investigators, risk management specialists, real estate appraisers, lawyers, researchers and statisticians.

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

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

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

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

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

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

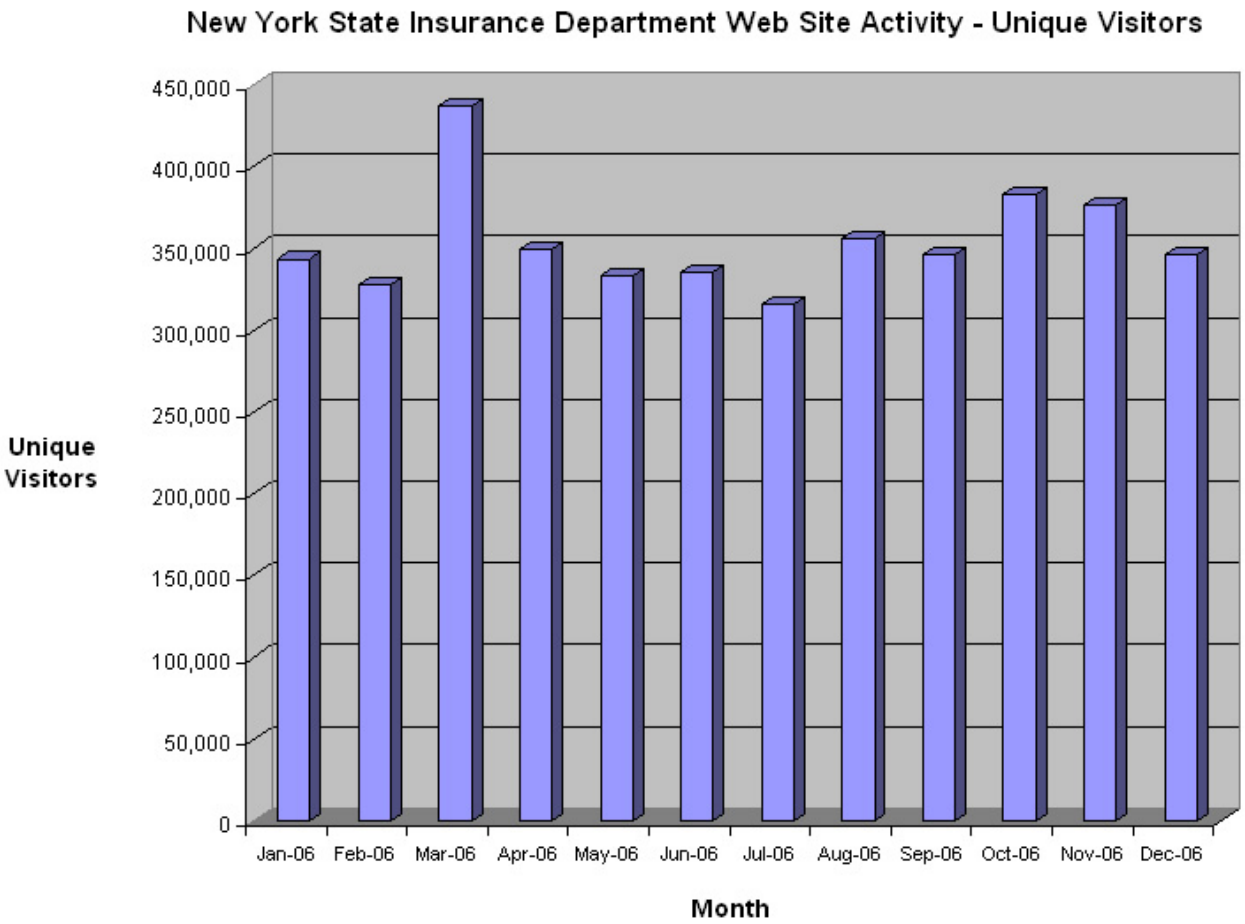
The Operations and Production Unit (OPU) is responsible for production and for the Computer Operations, and Help Center functions. The Help Center is the first line of support in assisting the client base, and encompasses a wide range of significant responsibilities and functions. Effective change control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

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

1. Website

The Department's main website and supporting "mini" websites – Healthy NY, Captive Insurers and Caregivers continued to play a vital role in communicating with and providing services to our diverse constituencies during 2006. The Department's activities and applications are reflected on these sites. In 2006, there were 4,249,058 visits to the Department's homepage, a 25% increase over the previous year. The number of these visits, by month, is displayed in the following chart.

CHART H



The Department takes pride in its website's depth of content, relevancy, and speed with which it is kept current. During 2006, a lot of new features have been added, along with further redesign and restructuring work.

Below are the major website related accomplishments during 2006:

- Redesigned the main website and other hosted sites - "Healthy New York", "Insurance Help" and "Captives". The main website displays a fresh look more tailored to accessibility.
- Migrated the website and other hosted sites to a new server which boasts more powerful features including bandwidth, storage capacity, and security.
- Redesigned the "Healthy New York" site for improved accessibility.
- "Healthy New York" - added the new "High Deductible Health Program" section, along with the regular, continuous updates to the site
- Many new features were added to the website. These included:
    - "Top 10 Questions to Ask When Purchasing Insurance" section. This was devised to provide typical questions and answers on insurance subjects. Currently, subjects include life and homeowners insurance. More subjects will be added in the future.
    - "Portal Applications Index". This index was made to accommodate the links to current, previous deployed and future portal applications, and provide portal access instructions, including creating a portal account. The applications are subdivided into two categories – guest and secured. Any public entity can access guest applications. Secured applications require authenticated logins to protect the content available.
    - Portal Applications
        - Secured: Healthy New York eBulk/eForm.
        - Guest:
            - Five (5) Licensing Interactive Reports
            - FOIL eForm submission and updated overview
            - Sample Annual Premiums for Long Term Care Insurance application.

    - "Health Care Provider Rights" section. This area was created per the Insurance Law and Public Health Law, which include important protections for health care providers with respect to network participation, provider contracting, claims processing, and prompt payment for health care services.
    - "Fire Tax Information" section. This section was designed to emphasize the Fire Tax materials available on the site, including Fire Code searches.
    - "Public Service Announcements" (PSAs) section. This area was created to present multimedia PSAs on pertinent subjects for viewing on Windows Media Player.
    - "Life Market Contact" Links: includes Regulation 60, Market Profile, and Contact Look-up Information
    - The complete set of 2006 Annual Statement and New York Supplement Filing Instructions and Forms

A significant amount of other relevant content was added throughout the year. Such content changes included, but not limited to the following: 37 New York Information Network (NYIN) Alerts, insurance frauds information and statistics; proposed regulations, emergency and final adoptions; Office of General Counsel selected opinions; circular letters; news releases; Department speeches; publications and reports; company examination reports; product outlines and checklists; DMV company codes and up-to-date health insurance and Medicare Supplement rates.

2. Intranet

The Department's Intranet continues to be a strategic internal communication facility that contains a wide range of content relevant to Department staff. New sections have been added in 2006. Among these are:

- Employee Assistance Program (EAP) – for employee-related events, including helpful programs and seminars on and off-site.
- Human Resources Management (HRM) Announcements – for subjects including the 'LifeWorks' program updates, employee insurance information and other relevant HRM matters.

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

3. Annual Statement Filings

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

4. Imaging – CIIMS and Workflow:

The Consumers Services Bureau has used the Imaging and Information Management System (CIIMS) since November 1998. CIIMS is a full featured imaging and workflow application for processing consumer complaints and investigations. In 2006 the total number of complaints processed increased as did the percentage of those complaints being submitted on-line. The number of responses submitted on-line continued to grow as more company representatives registered to use the system. Systems Bureau continues to work with the Consumer Services Bureau to further enhance and improve CIIMS efficiency.

The Health Bureau continues to employ imaging to assist in the processing of rate and form filings. Filings submitted through SERFF, a software product distributed nationally by the National Association of Insurance Commissioners (NAIC), are now electronically merged with other submission methods. This allows for one comprehensive repository regardless of the submission method. The insurance rate manuals are also maintained electronically, retaining an electronic history of updated pages.

The Life Bureau continues to utilize imaging for the rate and form filing process. The bureau expanded their imaging capability this year to include documents from mergers and acquisitions; derivative use plans (DUPs) and other generic documents that are commonly accessed by company or topic. This positions the bureau to have a comprehensive electronic filing cabinet to be shared between geographic sites. In the future, this electronic repository will better prepare examiners with background information prior to examinations.

The Property Bureau has used imaging to archive completed rate and form filings. Newly approved/close documents are routinely requested (every two weeks) via the Freedom of Information Law (FOIL). Rather than provide the original documents in response or provide the resources to photocopy, the bureau is now positioned to provide a CD containing the documents requested by FOIL. Additional document sources are being examined as candidates for imaging and retrieval.

The Capital Markets Bureau is now employing imaging to store all document sources currently filed in paper. This will allow concurrent use of the information and permit multiple access methods to a centralized repository. Storing the documents in their original format of Excel spreadsheets or Microsoft WORD (as examples) also positions them to leverage work completed for former projects. Capital Markets is also interested in adding workflow components to facilitate their active interaction with the regulatory bureaus.

5. Domino Portfolio Workflow Applications

Lotus Domino applications continued to be used for various tracking and workflow systems.

Owing to new Legislative mandates, we developed two new applications. The first application is the COBRA Continuing Assistance Program to manage the premium subsidy program sponsored by the Department. The second application is a FOIL submission process to facilitate the electronic submission of FOIL requests through the Department's website.

Additional released applications for 2006 include:

- Health Complaints/Inquiries Tracking System – manages the workflow of complaints and inquiries received by the NYC and Albany Health Bureaus.
- Insurer Database – acts as a resource for company contact information for the Health Complaints/Inquiries Tracking System and facilitates company information reporting.
- Round Robin Tracking System – manages the project approval process of various procurement vehicles.
- Email Blast Tool – designed to manage large volume emails sent by the Department clients. This application not only sends the email, it facilitates the responses received and follow-up correspondence when necessary.

Other work included the introduction of archival infrastructures, the integration of browser-based methodologies and expanded resource sharing between the Lotus Domino platform and other technologies.

Including the applications noted above, our Domino suite of systems exceeds 20 applications and spans all bureaus

6. E-Commerce

E-Commerce initiatives continued to provide significant value to the public at large and to Department staff. The number and variety of processes that are available on-line has expanded year after year and is now the "normal" way to process licensing related activities. Agents and brokers can apply for their original license or renew their licenses when the time comes; they can pay their fees via a credit card and their relationships with insurance companies (appointments and terminations) are all handled quickly, seamlessly and over the internet. Processes that once took weeks or months to complete are now typically processed overnight. The Department processes hundreds of thousands of transaction on behalf of our customers and collects millions of dollars without touching paper forms, handling checks or bank deposits.

In response to the legislation, the license renewal process required modifications. Prior to the new Legislation, licenses were renewed on a license class boundary with life agents and brokers renewing their licenses in odd numbered years, while property agents and brokers renewed their licenses in even numbered years. Beginning in January 2007, individuals will renew their licenses (all classes) on their birthday. This legislative change aligns New York with the other states in the nation and provides a more uniform approach to licensees by the regulators. While revamping our processes to get ready for the new law, we continued to handle the day-to-day traffic as efficiently and effectively as our constituents have come to expect.

The voluntary electronic funds transfer of the Fire Tax 2% assessment continued to gain popularity. In 2005 the number of fire districts that opted to receive electronic payments was nearly 850 but in 2006 that number jumped to over 1600. Now over 69% of all fire districts receive their payments electronically and the dollar volume distributed this way was over $21 million. This increase in electronic payments continues to streamline what has traditionally been a paper intensive process.

7. Enterprise Portal

Sybase Enterprise Portal (EP) technology is a valuable business tool that provides on-line access to applications and information across platforms and back-end databases. It allows us to provide a consolidated view of a company's profile, rather than viewing data on an individual application basis. It provides a Web based presentation already familiar to those who use our Web site and Intranet. The Portal's Security Administration allows us to manage both internal and external clients by individual application. It sets in place a security structure in which each user can access all Department sources, whether Web based or Legacy databases, using a single user id. Applications for Department staff include Central File, Inter-Active Insurance Company Search, OGC Opinions, OGC Historic and Summary and Industry Reports.

Among the enhancements to (EP) in 2006 were:

- The release of the first applications that utilize Automated Delegated Administration provided by Portal Security for creating accounts, application sign-up and delegating the management of company user accounts by the application's "Trusted Source", the Trusted Source being an individual at the external company or entity.

- Healthy New York eForm was released as the first Secure eForm application utilizing Automated Delegated Administration. The eForm application is the collection of data online over the Internet. Key benefit of the Healthy New York eForm was the Health Bureau's ability to adapt to the requirements of a new Regulation which required a redesigned form due on a monthly basis

- Healthy NY also provided an alternative eBulk (single file) submission. The eBulk submission is based on specifications provided by The Department for a tab delimited text file or an XML DTD [Document Type Definition] file thus alleviating companies the need to fill out an eForm.

- Life Market Conduct was released as the first Secure eAttachment application utilizing Automated Delegated Administration. The eAttachment application provides for the submitting of document files online in a variety of formats. The application provides for the collection of market conduct information as provided by Circular Letter 20 (2005)

- Regulation 60 was released as another Secure eAttachment application utilizing Automated Delegated Administration. The application provides the Department the ability to obtaining a centralized source of data for prioritizing those insurers who have

not provided the required information necessary to complete the “Disclosure Statement”.

We released the following Interactive Web/Portal applications:

- Long Term Care for comparing sample premium rates for long-term care (LTC) insurance in New York. Released in conjunction with the Governor's Campaign media initiatives.

- Licensing Interactive Reports which converted the prior static licensing pages to dynamic pages, replacing the five static reports on the website for the following subject matter. In addition to providing current information from the Licensing database, Report Data for Service Contract Providers can be saved in a variety of output Formats (Excel, XML and CSV):

    1) Bailbond Listing - This lists all our current Bailbond Agents with license numbers and business addresses.
    2) Continuing Education Provider listing - Lists Provider Name, Primary Contact, Address and phone.
    3) Monitor Listing - Lists Monitors with Address and Phone #s by county.
    4) Prelicensing Provider/Course Listing - Lists Prelicensing Providers with addresses and phone numbers.
    5) Service Contract Registrants - Lists Company Name, Effective Date, Expiration Date, and Address

- Interactive Guide to Auto Insurance which includes the new interactive application for viewing and comparing Sample Auto Premiums. This application updates the Department's Automobile Insurance Guide enhancing the consumer's ability to compare insurance rates. Features facilitate calculating additional coverages and comparing coverages between two companies and among all companies. Provides direct links to all representative companies’ web sites and a link to our Department webpage which contains links to all companies writing Automobile Insurance in New York.

During the year the Department released a new FOIL eForm application and updated Overview page together with the enhancements to the Domino FOIL Request Tracking System. This allows for the electronic submission and response of FOIL requests.

Sybase Enterprise Portal (EP) technology supports the Central File requirement of a centralized information management portal repository whereby Department personnel can access and search all organizational information. These data sources include Microsoft Access, Excel and Word files along with Adobe PDF files and application data residing in Sybase databases.

Sybase Enterprise Portal (EP) technology supports the requirement of full text search for OGC Opinions. OGC Opinions provides Public Opinions only for non-OGC staff members. Access to the full set of Opinions is maintained for OGC users through Portal security. OGC Opinions includes features for "highlighting" within the document retrieved.

8. Infrastructure

Systems continues to enhance, expand and harden the Department’s infrastructure. Numerous initiatives have been implemented towards this end. The Systems Bureau works with the New York State Office of Cyber Security and Critical Infrastructure Coordination to continually enhance security and benefit from the experience and expertise of other agencies.

Major accomplishments made in 2006 include the installation of all new switches in our wiring closets in the New York City and Albany offices. These switches offer many new features including power-over-Ethernet, which will allow the Department to further enhance the Voice-over-IP phone system currently being piloted. Voice-over-IP allow for new applications that could enable staff to provide better service to our constituents and enhance communications among staff members. New switches were also installed on the backbone network providing additional redundancy. New video conferencing hardware was purchased for several of our satellite offices to facilitate better communications between department sites. Enhancements were made to the data communication lines between offices to provide better service to these locations, and also redundancy to our Internet connection in Albany.

9. Disaster Recovery/Business Continuity

Systems holds bi-weekly Systems Disaster Preparedness meetings covering disaster recovery and business continuity. Staff from all units meet and discuss current projects and issues. A matrix listing all current, ongoing, and completed projects are listed. Related documents are stored on the network, and on pen drives that staff carry with them. These documents are copied onto removable media as well. Systems continues to contribute to the Department Disaster Recovery plan.

G. OFFICE OF GENERAL COUNSEL

The Office of General Counsel's principal responsibilities include: providing the Superintendent, Deputy Superintendents, Bureau Chiefs, and the public with legal opinions and advice interpreting the Insurance Law; enforcement, including prosecuting and conducting all of the Department's administrative hearings, disciplinary matters, imposition of civil fraud penalties and issuance of stipulations in connection with consumer complaints, market conduct examinations and financial condition examinations; coordination of investigations into insurance matters with the New York Attorney General's office, federal Securities and Exchange Commission (SEC), and/or other law enforcement authorities; drafting and reviewing legislation, regulations and circular letters; supervision of all litigation brought by and against the Department; supervision of all demutualizations, corporate transactions and conversions; legal review of all Requests for Proposals (RFPs) and state contracts; review of applications for insurer incorporation and licensing, and related corporate activities; and managing responses to Freedom of Information Law requests made of the Department.

1. Legal Opinions

The Office of General Counsel issues legal opinions interpreting the Insurance Law to insurers, trade associations, producers, consumers and city, state and federal agencies. These opinions also provide guidance about the Department's policies. OGC issued approximately 300 opinions in 2006. All non-privileged opinions are posted to the Department's website (www.ins.state.ny.us) and are available to the public. OGC also has a public opinion database with a search engine that is available to the entire Department. This extensive electronic database includes more than 12,000 publicly issued opinions of OGC dating from the 1930s to the present, and is updated weekly as new opinions are issued.

2. Enforcement Matters

The Office of General Counsel handles the Department's enforcement matters, including all administrative hearings, disciplinary matters, and imposition of penalties and issuance of stipulations in connection with consumer complaints, market conduct examinations and financial condition examinations. In 2006, the Department entered into approximately 360 stipulations imposing penalties on insurance companies or producers (i.e., agents or brokers). In addition, the Department conducted approximately 100 producer licensing and rate hearings.

OGC supervises and coordinates the Department's enforcement efforts and its joint investigations with other law enforcement agencies, including the New York Attorney General's office. OGC oversees the Department's investigations of bid rigging and inappropriate compensation to producers in the property and casualty, life, and health insurance industries, as well as finite reinsurance and accounting practices, and title insurance industry practices, in coordination with the Attorney General's Office. During 2006, these investigations resulted in joint settlements with American International Group (AIG), Zurich Financial Services, ACE, St. Paul Travelers, Fidelity National Title Group and First American Title Insurance, leading to the imposition of millions of dollars in restitution and penalties, adoption of a series of business reforms, and title insurance rate reductions.

OGC also manages all outside litigation brought against the Department and all subpoenas served on the Department and its staff. During 2006, approximately 10 new litigation cases were brought against the Department. Currently, there are more than 70 cases that OGC actively supervises, including lawsuits concerning the audit of the New York Liquidation Bureau, issues involving the Public Motor Vehicle Liability Security Fund, and the "external appeal" law.

H. CAPITAL MARKETS BUREAU

1. General Overview

The Capital Markets Bureau (CMB), established seven years ago, serves the Department on matters affecting the regulation of capital markets activities of New York licensed insurers, and participates in the supervision of select public retirement systems and certain private pension funds of nonprofit organizations. CMB evaluates the various risks these activities bring to the financial condition of the insurers and pension funds.

The principal risk of capital markets' activities is the potential for loss on investment instruments and portfolios that may materially affect capital adequacy. Managing this risk is the responsibility of the insurer's board of directors and management. A key to the regulation of capital markets activities is assessing what capital markets risks the insurer has and how it measures and manages these risks.

In year 2006, CMB met its objectives by providing to the various Department Bureaus the following services relating to capital markets and risk management issues:

- Furnishing examination support – including pre-planning and on-site participation;
- Applying financial analytics to investment portfolios of insurers, including directing more attention to hybrid securities and alternative assets, such as hedge, venture capital and private equity funds;
- Identifying investment/capital concerns and recommending follow-up actions;
- Conducting training for the Department's staff on capital markets and investment portfolio dynamics; and coordinating training on risk assessment and on Sarbanes-Oxley;
- Evaluating corporate governance and risk management practices of select insurers;
- Participating in special projects associated with major emerging industry and legislative issues;
- Responding to requests from the Life Bureau, Property Bureau, Health Bureau, Office of General Counsel, and Executive Bureau for diverse analytical support;
- Interfacing with external entities, including other regulatory bodies, investment firms, risk management consultants, third-party asset managers, securities analysts, and rating agencies;
- Leading and participating in various NAIC Task Forces and Working Groups; and
- Reviewing new and amended Derivative Use Plans of insurers, and monitoring derivative activities.

CMB employed its composite financial analysis framework designed to assess the investment performance of life and property/casualty insurers. The methodology, highlighting key investment ratios and credit quality ratings, primarily utilized financial information from the NAIC and Bloomberg databases. Its formulae identified insurers whose financial measurements placed them outside the normative range of their respective sector's financial profile. These insurers' investment portfolios were then subject to additional analysis by the Bureau. In areas of concern remaining after this targeted assessment, the Bureau solicited additional information on the companies' investment management criteria and objectives. When necessary, meetings or teleconferences were arranged to gain additional insights into the make-up of the portfolios, investment rationales, and approaches of these companies. Moreover, the integration of quarterly data into the reviews distributed to the Bureaus allowed for more comprehensive analysis.

CMB also continued to work in conjunction with the Life Bureau to establish and employ appropriate procedures and methodologies for evaluating the diverse investments held by the sizable public retirement systems in New York State. Ongoing development and further enhancement of key measures and review standards related to risk-based capital, risk management, organizational

governance practices, and asset-liability management took place in 2006, and will continue to be addressed in 2007.

Last year, CMB continued to participate in on-site examinations, deliver in-house training programs, routinely disseminate news and information that served to enhance examiner understanding of the financial markets, and perform various Bureau-specific special projects. The Bureau's risk management specialists, held teleconferences with select third-party asset managers responsible for investing in fixed income securities and equities, and managing derivatives for insurers. These exchanges provided additional data and information governing these managers' oversight, compliance practices and interface with client-insurers as well as generated more detail on the establishment of and adherence to investment guidelines. Meetings and teleconferences with rating agencies and investment banks continued to be conducted in order to solicit and share information relative to the capital markets activities of insurance companies and to familiarize the Bureau and the rest of the Department with emerging products, such as new securities with hybrid (i.e. debt/equity) characteristics.

CMB maintained its active involvement in the work of the National Association of Insurance Commissioners (NAIC). It continued to preside over key groups responsible for the development of a risk-focused examination process better linked to principal solvency concerns, and the organizational and functional refinement of the NAIC's Securities Valuation Office (SVO).

In addition to services relative to capital markets oversight of insurers and pension funds outlined above, the Bureau's Director is part of the Department's Captive Group that oversees the Department's captive insurer program.

2. 2006 Highlights

a. Capital Markets Bureau Reviews

The Bureau performed investment portfolio reviews on insurance companies selected for "Priority One" desk audits by the Life, Property and Health Bureaus. In addition, it targeted for more extensive evaluation a number of other companies whose measurements/investment parameters were at marked variance with their sector's norms. Following supplemental assessment, certain targeted companies were required to provide more information on investment policy, performance expectations and related data. The Bureau utilized a template for transferring certain annual and quarterly investment data from applicable NAIC investment schedules for further analysis in conjunction with the Annual Statement and periodic reviews. The same review protocol was followed for pre-exam and fourth quarter meetings initiated by the Life, Property and Health Bureaus.

The reviews culminated in reports submitted to the life, property and health bureaus. These reports featured the application of Bloomberg analytics to generate value-at-risk, duration, beta, and other equity and fixed income portfolio risk measurements, and when available or necessary, incorporated analysis of quarterly data. Additionally, migration in average credit quality of bond portfolios was highlighted. If applicable, the reports also included profiles on derivative usage. Depending on the outcome of the analysis, the risk management specialists recommended further action to the financial examination staff.

The Bureau utilized various databases that it developed to facilitate sector and special situation analysis for assessing the degree of impact on insurers' capital adequacy of the volatility of the equity market and the range of credit conditions associated with the fixed income sector. This monitoring exercise served to address the prevailing risk management and capital market concerns in a changing economic and industry environment. In 2006, in addition to keeping abreast of improving quality of certain fixed income investments and the continuing rebound in the equity market, the Bureau oversaw

the use of derivatives and the suitability of asset allocations. In order to augment the Bureau's in-house metrics and identify analytical frameworks that would further enhance the efficiency of the evaluation of diverse portfolios, the staff periodically met with companies specializing in developing sophisticated risk measurement systems and firms promoting "best practices" in the investment and risk management technology arena.

Table 59
ANALYTICAL EVALUATIONS AND REPORTS
2006

Type of Company	Priority 1 Desk Audits	Pre-Exam Reports	Targeted Evaluations	4th Quarter Meetings
Health	**5**	**1**	**-**	**-**
Life	**29**	**18**	**13**	**18**
Property	**11**	**33**	**18**	**-**
Total	**45**	**52**	**31**	**18**

b. Derivative Use Plans

The Bureau continued to review filings of new Derivative Use Plans (DUPs) as well as amendments to approved DUPs of life and property/casualty insurance companies. Prior to approval, CMB conferred with the Property and Life Bureaus on companies whose DUPs initially did not meet the established regulatory standards so that appropriate modifications by these companies could be made. Also, CMB reviewed DUP amendment submissions when changes were made to management or oversight of derivative activities.

Primarily, in conjunction with ongoing exams, CMB appraised the annual CPA reports on derivative usage and adherence to regulations submitted by the companies that are being examined. The risk management specialists combined with examiners from the applicable Bureaus followed up with these companies on any significant lack of compliance with their filed DUPs and the associative statutes, and on laxity of internal controls.

In 2006, risk management specialists examined 10 new DUPs. The proposed derivative usage largely reflected a range of swaps and options across various asset classes. Additionally, the Bureau evaluated 19 amended DUPs.

Table 60
DERIVATIVE USE PLAN (DUP) REVIEWS
2006

TYPE OF REVIEW	LIFE	PROPERTY
New DUPs	**8**	**2**
Amended DUPs	**13**	**6**
Total	**21**	**8**

c. Examination Participation

Last year, the Capital Markets Bureau was active in utilizing its formulated risk-focused examination procedures related to capital markets oversight. CMB participated in fourteen on-site examinations. CMB's exam participation was largely on a targeted basis, focusing on specific areas of financial risk either detected by the Bureau in its review of the investment profile of insurers or identified by the examiner-in-charge of the engagement.

In certain instances, particular attention was given to the oversight and usage of derivatives, asset allocation and quality, asset turnover, investments differing from the typical sector profile, and the composition of Schedule BA assets, often comprising hedge and private equity funds. As the complexity of certain investment portfolios has intensified, risk identification, assessment and management by insurers have become increasingly significant functions. Accordingly, more scrutiny was given to select insurers' risk management practices, including modeling, risk measurement and remedial actions to address various risks. In addition, enhanced appraisal of the effectiveness of hedging programs for variable annuity products that incorporate minimum guarantees was conducted.

In order to refine further the preparation process for near-term exams, the Bureau continued to schedule, along with Department examination staff, on-site company meetings with the insurer's senior management and external auditor at the commencement of an exam. This exercise served to facilitate understanding of management's strategic goals, to familiarize the Department with the auditor's evaluative approach, and to permit leveraging off the work performed by the CPA firm, thereby minimizing duplication of assessment efforts and resulting in a more risk-based regulatory exam.

The Bureau continued to oversee a risk-focused property pilot examination started in 2005, which incorporates the draft Examiner Handbook's risk-based guidance developed by the NAIC Risk Assessment Working Group, of which New York State serves as chair. In 2006, CMB developed a continuous training program so that the examiners can acquire the skills necessary to conduct these examinations, and participated in the pilot examinations being conducted by the Life, Property and Health Bureaus with the assistance of consultants.

Table 61
EXAMINATION PARTICIPATION
2006

BUREAU	TOTAL EXAMINATIONS	Started in 2006	Started Prior to 2006
Health	3	2	1
Life*	13	8	5
Property	5	2	3
Total	21	12	9

* Includes continuing examinations of three public retirement systems

d. Pension Supervision

During 2006, the Capital Markets Bureau continued to participate in the development of multi-Bureau oversight of the State's public retirement systems. The Department began to undertake a major update of its pension supervisory policies, procedures and standards. CMB worked to develop new risk-based capital standards, corporate governance reforms and the establishment of up-to-date accounting and actuarial standards for future consideration.

e. Training Initiatives

The Capital Markets Bureau conducts training courses principally for the Department's examination, legal and actuarial staff. The courses present information on alternative investments, particularly hedge funds, and broadly detailed capital markets dynamics. In 2006, CMB participated in the development of a continuous training program for examiner staff to enhance their risk-based examination skills. CMB also provided guidance to examiners on effectively utilizing documentation assembled by accountants and management as required by the Sarbanes-Oxley Act (SOX). These SOX requirements relate to accounting oversight, financial reporting and disclosure, auditing, internal controls, corporate governance and other applicable practices. CMB staff and outside vendors conduct training courses to accommodate the growing requirements of senior staff as well as examiner-trainees in expanding their familiarity with emerging capital market developments.

In 2006, CMB continued to participate in both Life and Property Bureau In-Service Training Courses. CMB presented a session on Risk Assessment at a Life Bureau Examiner Training Seminar. In addition, CMB coordinated two separate multi-day courses given by outside vendors to Department examiners on risk assessment and on Sarbanes-Oxley.

Throughout the year, CMB staff also participated in teleconferences, investor briefings, and meetings held by various rating agencies and professional organizations. Moreover, CMB maintained its relationships with the leading insurance equity and credit analysts, ensuring critical access to their industry and company research.

CMB continued to participate in the NAIC International Internship Program by hosting interns from China and Brazil. The Program is designed by the NAIC International Regulatory Cooperation Working Group to promote NAIC relations with foreign markets by emphasizing the exchange of regulatory expertise and technology. CMB staff provided the international interns an overview of the Bureau's analytical and evaluative processes, principal functions, and interface with the rest of the Department.

f. Special Projects

The Capital Markets Bureau was involved in several special projects stemming from capital markets developments in 2006. CMB staff researched technical topics and market transactions and provided recommendations, when applicable. Issues addressed by CMB throughout the year included:

- Development of Securities Lending Exam Guidance Manual
- Life Settlement Market
- Mortgage Guaranty Captive Reinsurers
- Guaranteed Benefits in Annuities
- Private Equity Funds Indemnification Clauses
- Collateralization Requirements for non-U.S. Reinsurers
- Finite Reinsurance
- Health Insurer Company Acquisitions
- Securities Lending out of Regulation 114 Trusts
- Securitization of Terrorism Risk
- Dynamic Hedging Programs
- Sidecars (special purpose vehicles structured to add insurance capacity)

g. Other Activities

During 2006, the Capital Markets Bureau contributed to the formulation of legislative and regulatory proposals. These covered: (1) legislation related to increasing the number of licensed captive insurers; (2) proposed amendments to the Credit for Reinsurance Regulation to address collateral funding by non-U.S. reinsurers; and (3) the development of custodial asset regulation.

Throughout the year, CMB staff also gave capital markets presentations at the following outside venues:

- Life Insurance Council of New York Annual Legislative & Regulatory Conference
- Maryland Society of Financial Examiners: Career Development Seminar
- NAIC Risk Assessment Working Group: Webinar
- Professional Risk Managers International Association: Liquidity, Rating Agencies
- North American Securities Valuation Association: Hybrid Securities
- Sungard: Hybrid Securities
- MarcusEvans Ltd: Hybrid Securities
- American College of Investment Counsel: Hybrid Securities
- Euromoney: Hybrid Securities
- Moody's: Hybrid Securities
- International Quality & Productivity Center: Catastrophe Bond and Insurance Linked Securities
- NAIC Financial Summit

The Capital Markets Bureau continued supporting the Department's traditional role in leading major working groups, task forces, and projects for the NAIC's Financial Condition (E) Committee ("E Committee"). CMB coordinated many of that E Committee's solvency-related considerations relating to accounting practices and procedures, blanks, valuation of securities, the Insurance Regulatory Information System ("IRIS"), financial analysis, risk-focused and zone examinations, and examiner training. CMB often provides technical advice to other NAIC groups.

CMB personnel used their expertise in investment and risk management to play a critical role as New York's representatives when chairing, and performing the work of, the following major NAIC bodies charged with creating and implementing policies at the leading edge of insurance supervision policy.

Valuation of Securities Task Force ("VOSTF")

New York chairs the VOSTF to help state regulators examine and evaluate insurer's investments by establishing policies and procedures and suggesting programs to the Securities Valuation Office to support existing supervision efforts and educate regulators about new financial monitoring and management technology.

New York leads the VOSTF's review of new investment vehicles that insurers have purchased, or are anticipated to purchase, and creation of new standards for the proper disclosure and reporting of these new vehicles through the annual statement disclosures. As part of the help that the SVO provide to other regulators, New York leads the VOSTF's development and adoption of an annual agenda for the SVO Research division.

The VOSTF acts as the forum for proposed changes to, or interpretations of, the Purposes and Procedures Manual (the "P & P Manual") that guides the NAIC's Securities Valuation Office. The VOSTF is charged to revise the P & P Manual to maintain consistency and conformity with the NAIC's Accounting Practices and Procedures Manual. The VOSTF also reviews the Securities

Valuation Office's policies and procedures for evaluating the credit, valuation, and classification of securities. The Task Force must coordinate efforts concerning SVO administrative issues through the NAIC's Internal Administration (EX1) Subcommittee.

Derivatives Markets Study Working Group ("Derivatives Study WG")

New York's leadership of the Derivatives Study WG arose from its primary position in the VOSTF, in regulating derivatives market participants, and in regulators' considerations surrounding the latest generation of hybrid securities. Those considerations raised questions as to whether the NAIC's Derivatives Instruments Model Regulation, drafted in 1996, needs revision. The Derivatives Study WG is charged with surveying and studying the derivatives marketplace, the relevancy and efficacy of the application of the model regulation to that market, and determining if insurance regulators' primary interests would be served by amending the regulation in light of changes in that marketplace.

Risk Assessment Working Group ("RAWG")

New York chairs the RAWG charged with overseeing all states' implementation of the NAIC's approved Risk-Focused Surveillance process. Over the next few years, this group will guide and coordinate the revisions needed to the NAIC's accreditation guidelines, training, and maintenance to bring insurance regulation in line with the risk-based focus of national and international regulators of financial intermediaries.

In advancing risk-focused surveillance and supervisory principles, RAWG prepares needed changes to the NAIC's Financial Condition Examiners Handbook and Financial Analysis Handbook.

To assure that these changes are put into action effectively and quickly, RAWG will continue developing a comprehensive program to train NAIC and state regulatory personnel to use the new risk-focused surveillance process and risk assessment tools.

In helping state regulators use these new risk supervision tools, RAWG reviews and improves the NAIC's Risk Prioritization System reports and the supporting instructional materials.

RAWG is, in coordination with the "E" Committee, the NAIC's voice in presenting risk-focused surveillance and supervision related comments to the International Association of Insurance Supervisors ("IAIS"), the Risk Insurance Management Society ("RIMS"), the Professional Risk Manager's International Association ("PRMIA") and other transnational, international, and non-governmental organizations.

Capital Markets Bureau personnel also actively support the following NAIC bodies.

Invested Asset Working Group ("IAWG")

When the VOSTF determines that the technical nature of an issue before it would be best studied or advanced by a smaller group of regulators focused on more technical issues, it assigns those projects to the IAWG. The IAWG, when it has completed its deliberations, returns the issue, with its recommendations, to the VOSTF. These issues and recommendations may include changes to statutory accounting guidance, annual statement instructions, blanks reporting instructions, asset valuation reserves, interest maintenance reserves, risk based capital charges, valuation procedures for invested assets, credit assessment procedures for invested assets, or similar solvency supervisory solutions.

Hybrid Risk Based Capital Working Group (Hybrid RBC WG)

Capital Markets Bureau personnel provide essential expertise and critical support to this group to identify the appropriate classification and risk based capital weighting for hybrid securities that have characteristics of both equity (common or preferred stock) and debt. The mixture of equity and debt features, in addition to unique features found in particular types of hybrids, present unprecedented challenges to the insurance regulatory scheme.

Capital Markets Bureau personnel help the Hybrid RBC Working Group coordinate with: the VOSTF on SVO policies, procedures, and filing requirements for insurers; and the NAIC's Statutory Accounting Working Group and its Blanks Working Group to create consistent statutory accounting, reporting, and risk-based capital treatment.

Capital Markets Bureau personnel also monitor the efforts of the American Academy of Actuaries to develop models on which the NAIC may rely to assess appropriate risk-based capital charges for hybrid securities.

Reinsurance Task Force ("Reinsurance TF")

Capital Market Bureau personnel help the Reinsurance TF to monitor and coordinate activities with the Insurance Securitization Working Group and provide technical assistance. For example, Capital Markets Bureau personnel provide technical assistance on the eligibility, adequacy, or appropriateness of certain types of collateral to fund trusts established by alien or unauthorized reinsurers for the benefit of insurance companies domiciled in the United States.

The Capital Markets Bureau also made notable contributions to the following NAIC working groups and task forces: the Blanks Working Group, the Capital Adequacy Task Force, the Emerging Accounting Issues Working Group, the Financial Analysis Handbook Working Group, the Financial Examiners' Handbook Technical Group, the NAIC/AICPA Working Group, the Property and Casualty Reinsurance Study Group, and the Statutory Accounting Working Group.

I. DISASTER PREPAREDNESS AND RESPONSE BUREAU

1. General Overview

The Disaster Preparedness and Response Bureau (DPR) commenced operations on March 1, 2004. The principal function of the Bureau is to assist the Insurance Department and the New York insurance industry to prepare for, mitigate, respond to, and recover from existing and future natural and man-made disasters including modern day terrorism. The Department is the first insurance department in the nation to create such a bureau, dedicated solely to disaster preparedness.

During the past year, the Bureau was engaged in a number of initiatives, as outlined below, to assist the Department in meeting its objectives.

2. Disaster Response/Business Continuity Circular Letters

During 2004, the DPR Bureau issued Circular Letter No. 7, 2004 to all authorized life insurers, property/casualty insurers, co-operative property/casualty insurers, financial guaranty insurers, mortgage guaranty insurers, title insurers, reciprocal insurers, captive insurers, accident and health insurers, and Article 43 corporations; registered risk retention groups and employee welfare funds; licensed Public Health Law Article 44 health maintenance organizations and integrated delivery systems, municipal cooperative health benefit plans, retirement systems, fraternal benefit societies, and rate service organizations; State Insurance Fund; New York Property Insurance Underwriting Association; New York Medical Malpractice Insurance Plan; New York Automobile Insurance Plan; Motor Vehicle Accident Indemnification Corporation; and Excess Line Association of New York.

Following discussions with both the Life and Health insurance industries, it was determined that the "one-size fits all" format of Circular Letter No. 7, 2004 did not appropriately address the concerns of the life and health industries. As a result, the DPR Bureau decided to issue three separate circular letters to property and casualty type companies, health companies, and life companies, respectively.

Circular Letter No. 14, 2005 was issued on October 5, 2005 to all authorized property/casualty insurers, co-operative property/casualty insurers, financial guaranty insurers, mortgage guaranty insurers, title insurers, reciprocal insurers, captive insurers, registered risk retention groups; rate service organizations; State Insurance Fund; New York Property Insurance Underwriting Association; New York Medical Malpractice Insurance Plan; New York Automobile Insurance Plan; Motor Vehicle Accident Indemnification Corporation; and Excess Line Association of New York.

Circular Letter No. 23, 2005 was issued on November 30, 2005 to all accident and health insurers, and Article 43 corporations; employee welfare funds; licensed Public Health Law Article 44 health maintenance organizations and integrated delivery systems, municipal cooperative health benefit plans doing business in New York.

Circular Letter No. 4, 2006 was issued on March 14, 2006 to all authorized life insurance companies, retirement systems and fraternal benefit societies doing business in New York.

Each of the circular letters were tailored to the specific entity, and addressed best practices that should be utilized in planning for and responding to natural and man-made disasters that affect the respective insurers.

The circular letters request all entities licensed to do business in New York to submit data to the department on an annual basis. Therefore, the circular letters must be re-issued annually. DPR is in the process of re-issuing the circular letters to the respective entities requesting the data for 2007.

3. Disaster Response Questionnaires and Plans

As a follow-up to activities which began in 2005 and 2006 with the distribution of Circular Letters No.14 (2005), No. 23 (2005), and No. 4 (2006) all entities listed in item 2 above were required to re-submit a "Disaster Response Questionnaire" and "Disaster Response Plan" to the Department by June 1, 2006. A total of 924 companies are expected to report information to the Department. The Bureau has processed questionnaires from approximately 70% (651 of 924) of the entities required to submit such reports to the Department. The 651 companies providing these reports represent 89.3% of the 2005 direct written premium for all companies that were expected to report data to the Department.

In addition, during 2006, the Bureau also received 429 new Disaster Response Plans and 199 renewal statements. (Renewal statements indicate that a company's previously submitted plan was not significantly updated during the ensuing year.) Of the 429 newly submitted plans, 263 have been reviewed, and the Bureau has forwarded follow-up letters to 204 companies requesting updates and amendments to their Disaster Response Plans. Follow-up requests are made after a review of individual company plans. The decision to forward a follow-up letter is based upon comparison of the company plans with a checklist of items suggested as best practices.

4. Business Continuity Plan Questionnaires and Plans

All entities listed in item 2 above were also required to re-submit a "Business Continuity" Questionnaire to the Department by June 1, 2006. Due to proprietary concerns the entities were not required to submit their Business Continuity Plans to the Department, but were required to submit an attestation stating that such a plan existed, and answer specific questions for the Department. Examiners from the Bureau would then verify the existence of such a Plan upon examination. The Bureau has processed questionnaires from approximately 70% (648 of 924) of the entities expected to submit such reports to the Department. The 648 companies providing these reports wrote approximately 91.1% of the 2005 direct written premium for all companies expected to report.

5. Pre-Disaster Data

Circular Letter No. 14 (2005) also requires companies writing commercial or personal property insurance in New York State to submit a "Pre-disaster data/information survey" by April 1, 2006. Each property/casualty insurer must provide to the Insurance Department a listing - by New York State County - of property exposure information, as of December 31, 2005 for personal lines (non-auto) and commercial lines (non-auto) for each authorized member within an insurance company group. The report that was compiled in 2006 contained data from 213 entities representing 365 of the 370 companies that were expected to report data to the Department. These 365 companies wrote 99.70% of the 2005 direct written premium for the personal and commercial property lines covered in the report.

Because planning for a disaster or emergency is as critical as responding to its aftermath the department collects and analyzes data from a variety of sources. The data can be used to pre-position resources and plan for resource allocation in the aftermath of the disaster. This process becomes extremely critical to insureds who expect prompt and fair payment of their claims. The data is collected and used to provide accurate, timely and consistent information to other government and volunteer agencies who also share a critical role in emergency response

6. The Department's Disaster Recovery/Business Continuity Plan

The Bureau is involved in updating the Department's Disaster Recovery/Business Continuity Plan (the Plan) to be consistent with the Continuity of Operations/ Comprehensive Emergency Management Plan (COOP/CEMP) format recommended by the State Emergency Management Office (SEMO). The COOP/CEMP will also include the Department's efforts in planning for a pandemic. The Plan is based on a comprehensive risk assessment and requires staff training which the Bureau will provide.

The Plan allows the Department to continue mission-critical operations in the event of a disaster directly affecting the Department, and includes evacuation procedures. It also requires testing and updating annually.

7. Examination of Insurers' Disaster Response Plans

During 2006 and continuing currently, members of the DPR Bureau visited 10 property and casualty insurers to verify that the disaster response plans that were submitted to the Department were functional and that key employees of each of the insurers visited were aware of their roles during a disaster. Based upon the results of these examinations, DPR is confident that the 10 companies examined are capable of responding to disasters that affect their insureds. If these results accurately reflect the trend in the industry, we are assured that insurers will be ready to respond effectively to New York's policyholders in the event of a disaster.

8. New York Information Network (NYIN)

The Bureau is responsible for maintenance of the Department's electronic information network. NYIN is a password-protected area on the Department's Web site that contains directives, advisories, and other terrorism-related information addressed to insurers. NYIN also includes an Intelligence/Information Mailbox enabling participants to exchange intelligence and other information with the Department. There are currently 1,253 companies involved with a total of approximately 3,759 participants. During 2006 the department issued 38 NYIN alerts ranging from cyber security to healthcare bioterrorism, terrorist tactics and the extension of the corporate emergency access system to the five boroughs of New York City.

9. Public Access Defibrillator (PAD) Program

The PAD program requires the voluntary participation of Department employees who are certified in Cardiovascular Pulmonary Resuscitation (CPR), Automatic External Defibrillation (AED), and first aid. The Bureau developed a PAD administrative program of protocols for the use of PAD and CPR during a medical emergency that occurs in any of the Department's offices. The PAD program establishes a medical emergency response program that includes trained and equipped PAD responders who, with appropriate medical oversight, will provide early defibrillation in the event of sudden cardiac arrest. The goal is to defibrillate within three minutes of a witnessed collapse or discovery of the victim. The PAD responders will apply CPR as necessary. The Department currently has 23 trained volunteers in the Albany office and 53 trained volunteers in the New York City office which is a significant increase from the year before. In addition the Department has trained 12 volunteers in all of the Department's satellite offices. According to OGS, average agency response throughout the state was between two and three volunteers per floor with one AED per floor. The Department exceeded both the ratio of AEDs per floor and volunteers per AED. The increase in number of volunteers will better serve and protect not only our employees but any visitors to the Department.

10. West Workspace

The Bureau is involved in maintenance of, and training members of the Department in the use of, West Workspace. West Workspace is a Web-based communication tool operating on the Extranet. It allows for exchange of documents, data, and messages when the Department's own Wide Area Network (WAN) or Local Area Network (LAN) has been impaired. It is used to store mission-critical data, and provides a virtual online meeting room where Department staff can meet and continue business operations especially during emergencies. We expect that its usefulness will also serve the department should predictions of a pandemic become a reality.

During 2006, the Bureau tested the functionality of West Workspace with executive staff, and documented its usefulness and the need for additional testing with existing staff and new executive staff. The Bureau is exploring adding more staff members with West Workspace accounts.

11. The Incident Command System

Pursuant to the Governor's Executive Order, and modeled after State Emergency Management Office's (SEMO's) Incident Command System, the Department has developed its own framework of managers who have been assigned specific roles/titles in the event of an actual disaster. Members of the Bureau have been attending training in the use of the Incident Command System, and conducted training for senior management during 2006. The Bureau will continue to provide training to senior management as the need occurs.

12. Life Safety Procedures

The Bureau oversees the semi-annual employee fire drills and evacuations procedures. The Department had developed a series of Cohort locations where employees may assemble and be accounted for in the event of an incident that requires the full evacuation of the Department's Albany and/or New York City offices. The Bureau has assumed the maintenance of the employee lists that are used to facilitate Department protocols in the event that such an evacuation is warranted. The Bureau has also updated the evacuation procedures that are posted on the Department's intranet, by adding maps of cohort locations and a new Emergency Action Plan. The Bureau has revised evacuation procedures and is training members of the Department in safe evacuation procedures.

The Bureau assisted in the creation of an Employee Toll-Free Safe Line. The Toll-Free Safe Line provides a means for employees to report their location and condition to the Department after a disaster, emergency evacuation, or other event requiring an emergency response. Additionally, employees can obtain and exchange vital information related to both safety and work assignments. This procedure provides management with the ability to ensure that all employees are accounted for and to provide instructions (*i.e.,* building closings, when to report to work, etc.) to the employees calling in to the Toll-Free Safe Line. The Bureau performed a test of the Employee Toll-Free Safe Line during 2006 to determine the effectiveness of the system. Based upon the results of the test, the Bureau will conduct additional tests during 2007.

13. Disaster Recovery Assistance

One initiative that has arisen from our experience after Sept 11 and the recent series of hurricanes that devastated the Gulf Coast is the need to establish a pre-credentialing program in conjunction with state and city governments. One such program which includes department and industry officials is the NYC-OEM electronic card reader project. The electronic card reader project is an advanced credentialing system that permits only authorized persons to enter the disaster zone. This initiative already instituted by this department involves working with NYC-OEM and BNET (Business Network of Emergency Resources) to establish a Corporate Emergency Access System (CEAS). The CEAS program that permits a "first response team" of adjusters from the largest property and casualty writers in the area of the disaster to gain early access to a disaster site for the purpose of evaluating the total loss within the disaster site in an expeditious manner. The Department, in conjunction with BNET and an industry representative, is currently testing the CEAS program for the industry. Bureau staff is involved in this ongoing effort to expand recognition of the CEAS Adjuster Card Program by local emergency and law enforcement jurisdictions throughout the state.

During the flooding in the western region of the state, in December, the Bureau worked with the Consumer Services and Frauds Bureaus to provide assistance to consumers needing help

withinsurance questions and claims. In addition, the Bureau worked with the Administration Bureau Frauds Bureau and SEMO to secure reimbursement from the Federal Emergency Management Agency (FEMA) for Department expenditures resulting from the consumer outreach assistance. The Department has also enrolled "Essential Employees" of the Department in the CEAS program. These employees are considered critical to the ongoing operations of the Department during a disaster. The CEAS program for the Department would permit these essential employees to gain access to the Department's offices within the New York City and Nassau County during an emergency. The Department currently has 99 employees enrolled in the program.

14. Mobile Command Vehicle

The Department acquired a mobile command vehicle during 2006 that will primarily be available to directly serve the citizens of New York State in an emergency or disaster situation. The Department currently functions only in a support role to assist victims with coverage information at the scene. The Department is aware that the first dollars to reach the affected areas and begin the recovery process will be insurance dollars, and claimants want to be assured that their claims will be paid promptly following the occurrence of an insured loss. Therefore, in order to facilitate the prompt processing of claims, the vehicle was equipped with the necessary electronic media (high speed internet access and telephones) to assist claimants with the filing of their initial claims. The mobile command vehicle can also serve as an on site point of contact or liaison with insurers and may allow for on site credentialing of adjusters. During 2006 the mobile command vehicle was deployed to Central New York during the flooding that occurred during the summer of 2006 and to Buffalo during the fall to assist victims of the snow storm.

The Mobile Command Vehicle was transferred to the Frauds Bureau in 2006.

J. CAPTIVE INSURANCE GROUP

1. General Overview

On August 7, 1997, Governor George E. Pataki signed into law Chapter 389 of the Laws of 1997, which permits the formation and operation of captive insurance companies (captives) in New York State via Article 70 of the Insurance Law and other amendments to the Insurance Law and the Tax Law. The Law became effective December 5, 1997.

Captive insurance companies are insurers owned by the insureds and organized for the main purpose of self-funding the owner's risk. Captives are often referred to as "alternative insurance mechanisms." As of December 31, 2006, there were 39 captive insurance companies authorized in New York. The assets of these 39 captive insurers posted total assets of $11.8 billion, total liabilities of $5.6 billion and capital and surplus of $6.2 billion. In addition, these captives had net income of $1.5 billion, paid premium taxes of $3.8 million and had net premium written of $849.4 million.

There has been explosive growth in captive formation in the past year. In addition, the Department has a dedicated captive team, responsible for the licensing of all captive insurers in New York. The team provides a direct link to decision-makers, features a streamlined licensing process, and the easing of administrative burdens after licensing through regulation that is distinct from the regulation of traditional insurance companies.

2. Legislative Proposals

The Department has proposed revisions to the current law to address certain restrictions that have hindered the growth of New York captives. Governor Pataki has submitted legislation to the New York Legislature to effectuate these changes. They include:

- Reducing the threshold level for a parent to form a pure captive to $25 million of net worth or annual revenue. The bill also provides flexibility for the Superintendent to approve other thresholds if the parent demonstrates that it is otherwise qualified to form and operate a captive as a subsidiary;
- Reducing the threshold level for entry into a group captive to $25,000 in annual premiums, 25 employees and a full-time risk manager for each member;
- Broadening the definition of "affiliated companies" to enable the parent's contractors and subcontractors to be insured by the captive;
- Authorizing sponsored captive insurance companies (*i.e.*, rent-a-captive), in which separate cells are set up for each company participating in this arrangement; and,
- Allowing public entities (municipalities, authorities and others) to form pure or group captives as public benefit corporations or Not-for-Profit corporations that would be exempt from state and local fees, taxes or assessments.

These changes would enhance the appeal of New York as a domicile for the new wave of captive insurer formations. The Department will still be able to effectively regulate these insurers under the framework established by Article 70 of the Insurance Law. Since New York is a leading global business center, the New York State Insurance Department is committed to establishing an appropriate regulatory environment for the operation of captive insurers. New York offers domiciled captive insurers tax rates competitive with other captive jurisdictions, minimal investment restrictions and the authority to write almost all types of property/casualty coverage.

K. TRAINING & PROFESSIONAL DEVELOPMENT

Staff training is a core priority for the Department. Professional development needs of employees vary so it is important to offer a variety of courses in several categories to assist individuals in their pursuit of these skills. Subjects offered fall under one of the following areas: Management Development, Experienced Insurance Examiners, Insurance Examiner Trainees, Administrative Support Staff Development, and General.

In 2005, the Department took a proactive approach in preparing high-level managers to be better prepared to do their jobs by developing the Management Development Program to provide training in management and leadership. So far, 42 managers have graduated from the first two classes and a third group of 26 will complete the program in mid-2007. In response to graduates and participants, an Advanced Management Development Program has been developed and is scheduled to begin in early 2007. This program is designed to enhance and expand on the experience acquired by staff successfully completing the Department's current Management Development Program.

Professional development of seasoned examiners is encouraged through on-the-job training and attendance at bureau-wide seminars. In 2006, 12 such seminars were coordinated, addressing current issues facing the Department and the insurance industry. Examiners also attended National Association of Insurance Commissioners' (NAIC) sponsored training classes and pursued professional designations. Courses in statistical sampling, use of various computer software programs in examinations, and presentation skills were also offered.

Newly hired Insurance Examiner Trainees are required to participate in a two-year training program, consisting of a combination of lectures, seminars, workshops and classroom instruction, in addition to their regular work assignments. The training program is designed to provide trainees with an overview of the insurance regulatory framework in New York State, including an understanding of insurance, financial solvency regulation, product regulation, availability and affordability issues, and treatment of policyholders. In 2006, there were 75 trainees participating in the training program which included the following: those hired in 2004 and completing traineeship in 2006, those hired in 2005 and still in the traineeship, and new hires starting in 2006.

The Administrative Support Staff Development Program offers a variety of courses for support staff and includes such topics as communication skills and managing change. The goal is to provide opportunities to encourage support staff to continue learning.

In addition to the above, the Department offered training of a general nature. A labor relations training program for supervisors, developed by the Governor's Office of Employee Relations, was expanded upon this year to include additional topics such as performance and productivity, constructive discipline, and grievances. Defensive Driving classes were also made available to staff in the Department during evening hours. This class improves awareness of driver safety techniques and allows participants to receive a reduction in automobile insurance premiums and a deduction of points on a driver's license.

The Department once again participated in the NAIC sponsored International Program for Education and Regulatory Cooperation (IPERC) hosting interns from foreign countries. Two interns from Brazil and one from China were assigned to the New York office. The aim of IPERC is to foster learning and provide technical assistance to insurance regulatory professionals from countries with emerging insurance markets. The Chinese intern spent five weeks at the Department learning about insurance regulation in the United States and receiving hands-on training in financial, market conduct, licensing and other areas of regulation. The Brazilian interns received two weeks of training learning about financial examinations of insurance companies.

Professional development is also encouraged through the use of the Training Library to support the Insurance Examiners' pursuit of professional designations. The Library has been updated and enlarged to include new materials relating to the insurance industry.

The Department's Intranet Training Page has been expanded and enhanced. Employees can find announcements pertaining to a variety of training opportunities accessed directly through related training links, including available resources, instructional presentations, GOER-sponsored courses, and web sites for workshops or tuition support for members of CSEA, PEF and MC employees.

L. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORP.

1. History of the Corporation

The Motor Vehicle Accident Indemnification Corporation (MVAIC) was originally created to provide compensation for injuries to persons who, through no fault of their own, were involved in accidents with hit-and-run drivers, operators of stolen vehicles or uninsured motorists. This law became effective on January 1, 1959. The tort law has since been amended so that comparative negligence is now the law of the State of New York. In that respect, MVAIC's obligations to provide compensation have changed.

Qualified claimants (persons who are residents of the State of New York or of another state that has a similar program, and who do not own automobiles or are not resident relatives of a household where there in an insured vehicle) receive maximum benefits under the no-fault law.

As a result of the enactment of Section 5221 of the Insurance Law, effective December 1, 1977, the corporation also became involved in the payment of no-fault, first-party benefits as of that date. It should be noted that the Corporation must provide for the payment of such first-party benefits only to qualified persons who have complied with all the applicable requirements of Article 52 of the Insurance Law. Amendment 19 to Regulation 68, effective September 1, 1985, permits MVAIC to arbitrate no-fault cases thus eliminating the necessity of commencing Declaratory Judgment Actions in unresolved coverage questions.

Effective July 22, 1989, Section 5208 (a)(1) was amended by the legislature and the bill signed by the Governor. This amendment extended the time from 90 to 180 days within which a claimant must file his/her affidavit of "intention to make claim" with this Corporation, only if there is an identified defendant. The 90 day time limit is still applicable to hit and run cases. Further, if the claim was originally against an insured person whose insurance carrier has denied the claim, then the affidavit must be filed within 180 days after the receipt of said disclaimer or denial.

In June 1995, the New York State Legislature amended Section 1 Paragraph 1 of subsection (f) of Section 3420 of the Insurance Law to increase the New York financial responsibility limits from $10,000 per person, $20,000 per accident to $25,000 per person and $50,000 per accident. These limits are equally applicable to uninsured claims submitted to MVAIC. This law took effect January 1, 1996.

2. New Legislations Enacted

The New Legislation enacted in 1999 effective March 1, 2000. Self-Insured 5014 A (Chapter 511 Laws of 1999) -- This new law increased the self-insured assessment per vehicle from $1.50 to $3.50. The DMVB will continue to handle the self-insured fees as previously done.

New Regulation 68 (No Fault)-Repeal February 1, 2000; for accidents on or after February 1, 2000. The major provisions are:

- Notice of PIP claim must be made in 30 days rather than 90 days
- Health service providers must present their bill to the insurance carrier and/or MVAIC within 45 days after the date of treatment rather than 180 days in current regulations.
- The new regulation authorizes PIP insurers to do an Examination Under Oath (EUO) of PIP claimant.

- Wage Loss Claims must actually be made within 90 days from the date of accident instead of no requirement
- The arbitration rules have been changed with the AAA, now being responsible for administrating all conciliation and administration. Previously, the Insurance Department handled conciliation and more administration including medical fee schedule.
- Also effective February 1, 2000 the monthly interest penalty rate is 2% instead of 21% monthly compounded.

3. Source of Funds

The Corporation is funded through levies on insurance companies transacting automobile liability insurance in the State of New York in accordance with Section 5207 of the Insurance Law.

Other sources of funds include fees collected from self-insurers by the New York State Department of Motor Vehicles under Sections 316 and 370-4 of the Vehicle and Traffic Law, investment income and subrogation recoveries.

4. 2006 Activity

Year End Reserves	2006	2005
Case Outstanding Reserve Tort & Pip	$19,965,776.45	$ 19,830,718.38
Incurred But Not Reported	$18,772,818.00	20,657,602.00
Unallocated Loss Adjustments ULAE	$12,685,720.00	10,789,194.00
Spec. Reserve for Alloc. Exp	7,000,000.00	7,000,000.00

- MVAIC received 8,949 notices of claim which were slightly up from 8,823 received in 2005.
- The total number of claims created for both Tort & No fault cases slightly increased in 2006 to 2,338 compared to 2,086 created in 2005.
- Claims paid for Tort and No Fault cases slightly increased in 2006 to $17,217,580 compared to $17,164,075 paid during 2005.
- At the end of 2006, MVAIC closed with a surplus of $5,425,061.65 down from $6,640,034 in 2005.
- The number of pending claims at the close of 2006 was 2,158 compared to 2,400 in 2005

Uninsured New York automobile drivers represent 78% of the total reported cases compared with 77% of the previous year.

III. INSURANCE LEGISLATION ENACTED

(Legislation is presented in numeric order based on 2006 Chapter Law)

This section of the Annual Report covers bills enacted during the 2006 Session amending the Insurance Law. Where a bill amends laws other than the Insurance Law, only provisions of interest are noted. *These brief descriptions of the laws are intended only to provide highlights of the legislation and should under no circumstances be used in place of the full text of the law or regarded as interpretation of legislative intent or of Insurance Department policy.*

Chapter 115 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill amends Sections 2328 and 2329 of the Insurance Law, which pertain to rate filing requirements for for-hire vehicles, to extend the prior approval requirement for rate increases and file and use standard for rate decreases, which expires on June 30, 2006, until June 30, 2007. This bill section also extends the provisions of Section 2329 of the Insurance Law, pertaining to excess profits associated with certain motor vehicle insurance policies, which expires on June 30, 2006, until June 30, 2007.

- Section 2 amends Section 3425 of the Insurance Law to extend the 2% non-renewal rule for private passenger auto insurance, which expires on June 30, 2006, until June 30, 2007

- Section 3 amends Section 3425 of the Insurance Law to require the Superintendent to submit a report to the Legislature on the 2% non-renewal rule by March 15, 2007. The report includes information related to new insureds, non-renewed insureds and business written by territory and by class, including age and sex.

- Section 4 amends Section 2305 of the Insurance Law to extend until June 30, 2007, “file and use”/open competition rating requirements for property and casualty lines of business not specifically subject to prior approval.

- Section 5 extends the provisions of Section 2342 of the Insurance Law, which expires on June 30, 2006, until June 30, 2007. The amendments to Section 2342 would extend the following sections of the Insurance Law until June 30, 2007: section 2307(c) (permits the Superintendent to waive prior approval requirements for forms, classifications, or territories for the kinds of insurance where prior approval is not required); 2308 (permits the Superintendent to impose prior approval rating requirements for any territory for any kind of insurance if warranted by market conditions); 2310(a) (informational filings required to be filed prior to use); 2316 (prohibition of anti-competitive behavior); 2320 (enforcement and penalties where prior approval is not required); 2323 (profitability and rates of return where prior approval is not required); 2326 (evaluation of competitive rating provisions) 2335 (motor vehicle insurance rates; prohibition of surcharges for certain traffic infractions); 2336(b) (passive restraint discount); and 2341(requirement that the Superintendent appoint a consumers advisory council and a business advisory council).

- Section 6 amends Section 2344 of the Insurance Law, which pertains to the flex-rating requirements for certain property and casualty commercial lines markets, to extend such provisions, which expire on June 30, 2006, until June 30, 2007.

- Sections 7, 8 and 9 amend Sections 5411 and 5412 of the Insurance Law, and Section 13 of Chapter 42 of the Laws of 1996, to extend the provisions of the New York Property Insurance Underwriting Association (NYPIUA), which are due to expire on June 30, 2006, until June 30, 2007.

Chapter 162 of the Laws of 2006 amends the Insurance Law as follows:

- The bill amends Sections 3426 and 5403 of the Insurance Law to require homeowner insurers to provide in their notices of cancellation, non-renewal or conditional renewal information about the Insurance Department's coastal market assistance program (C-MAP), if the area is served by such program, as well information about the New York Property Insurance Underwriting Association (NYPIUA). The notices must contain, at a minimum, a statement that the homeowner may be eligible for coverage through C-MAP or NYPIUA, together with information on how to apply for such coverage. The Department's website currently provides contact information relative to the CMAP and NYPIUA.

Chapter 169 of the Laws of 2006 amends the Insurance Law as follows:

- The bill amends 3426 of the Insurance Law to reduce from 20 days to 10 days the amount of time that an insurer must provide a commercial insured with its loss information if the policy is has been cancelled, non-renewed or conditionally renewed. The commercial insured would continue to be required to request such information.

Chapter 201 of the Laws of 2006 amends the Insurance Law as follows:

- The bill extends until December 31, 2008, the premium rate cap that an insurer can impose on a sole proprietor who purchases health insurance coverage through association groups including chambers of commerce. This premium rate cap for sole proprietors would be set at 115% of the rate established for the same coverage issued to groups.

Chapter 223 of the Laws of 2006 amends Chapter 19 of the Laws of 1994, amending the Insurance Law relating to credit cards, debit cards and checking account group policies, as follows:

- Section 1 of the bill amends Section 3 of Chapter 19 of the Laws of 1994, amending the Insurance Law relating to credit cards, debit cards and checking account group policies, to extend the expiration date of provisions allowing issuance of certain property/casualty insurance on a group basis in connection with credit card, debit card or checking accounts from December 31, 2006 to December 31, 2010.

Chapter 264 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill amends Section 7902(k) of the Insurance Law to incorporate coverage for the repair or replacement to a tire or wheel as the result of damage arising from a road hazard as being included as part of the definition of "service contract," but only when the contract is made by or for the manufacturer or seller of a motor vehicle tire.

Chapter 294 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill would amend Section 1113(a)(7) of the Insurance Law to expand the definition of burglary and theft insurance to authorize insurers to offer coverage for: (i) ransoms or reward payments incurred as a result of an abduction or theft of property; (ii) travel and lodging expenses and lost wages incurred as the result of an act, or threatened act, of violence; (iii) expenses incurred to locate or identify a missing or abducted person; or (iv) other expenses to respond to a violent act, or threatened violent act, or to prevent a reoccurrence thereof.

- Section 2 of the bill would add a new Section 3450 to the Insurance Law to provide that, except for ransom or reward payment coverage incurred as the result of the theft of property, such coverage may be offered only as part of a homeowners' insurance policy or motor vehicle physical damage insurance policy. The bill also allows the Superintendent of Insurance to promulgate regulations necessary to effectuate the provisions of this new section.

Chapter 306 of the Laws of 2006 amends the Insurance Law as follows:

- The bill, which would take effect immediately, would amend Section 4526(c)(3) of the Insurance Law to increase a fraternal benefit society's authority to make investments in foreign countries from 3% of its admitted assets to 4%. The fraternal benefit society would continue to be subject to a 1% cap on investments located in any single foreign country.

Chapter 341 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill amends Section 3201(b)(2) of the Insurance Law to provide that unallocated group annuity contracts or funding agreements, or policy forms for accident and health insurance or any other policy forms that are specified by the Superintendent pursuant to regulation, shall not be issued by a domestic life insurer or fraternal benefit society for delivery outside the State unless such forms have been filed with the Superintendent.

- Section 2 of the bill amends Section 3201(c)(6) of the Insurance Law stipulating that the Superintendent may disapprove any policy form specified in Section 3201(b)(2) of the Insurance Law that is issued by a domestic life insurer or fraternal benefit corporation for delivery outside the State if its issuance would be prejudicial to the interests of its policyholders or members. Except for the policy forms that are specified in Section 3201(b)(2) of the Insurance Law, domestic life insurers and fraternal benefit societies would be required to annually file with the Superintendent a list that identifies and describes the policy forms issued for delivery outside New York. This list would be submitted in a form that is prescribed by the Superintendent. The Superintendent may take any appropriate action, including the issuance of an order, after conducting a hearing, to cease and desist the issuance of a policy form, if a determination is made that such policy form has been or may be prejudicial to the interests of policyholders or members.

Chapter 361 of the Laws of 2006 amends the Insurance Law as follows:

- The bill amends Section 2612 of the Insurance Law to provide that whenever an insurer issuing a group insurance policy receives a valid order of protection in favor of one of the persons covered under the group policy and against another person covered under the group policy, the insurer shall be prohibited during the duration of the order from disclosing to the person against whom the order was issued the address and telephone number of the insured person covered by the order of protection, as well as the address and telephone number of any person or entity providing covered services to the person protected by the order.

Chapter 381 of the Laws of 2006 amends the Insurance Law as follows:

- The bill amends Section 4240(d) of the Insurance Law to conform certain provisions of New York's Insurance Law to requirements imposed by the Securities and Exchange Commission (SEC) relative to the calculation of interest on death benefits for variable annuity policies.

- The bill requires that the payment of death benefit proceeds under variable annuity contracts and certificates be made within 7 calendar days after the insurer receives the beneficiary's

completed election form. If the insurer does not pay within the 7-day period, the insurer is required to pay interest on the death benefit proceeds under variable annuity contracts and certificates at the rate of interest currently paid on proceeds left under the interest only settlement option.

- The bill also exempts variable annuity contracts and certificates from the provisions of Section 3214(c) of the Insurance Law, which requires payment of interest on death benefit proceeds, at the rate of interest currently paid on proceeds left under the interest only settlement option, from date of death to date of payment.

- Finally, the bill provides that for death benefit proceeds under variable annuity contracts and certificates which are received pursuant to an action brought that results in a judgment against the insurer, interest is to be paid from the earlier of the date the action is commenced or the insurer's receipt of the beneficiary's completed election form. If the action results in a judgment against the insurer, interest must be paid by the insurer to the date the verdict is rendered or the report or decision is made and thereafter in accordance with Sections 5002 and 5003 of the Civil Practice Law and Rules. If a settlement is reached before the verdict is rendered or the report or decision is made, interest is payable to the date the settlement is reached.

Chapter 441 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill amends Section 4327 of the Insurance Law to extend funding to the Brooklyn Healthworks pilot program and to establish an upstate healthworks pilot program. The bill would reduce from 10% to 8% the amount annual funding that may be accessed for marketing purposes. Additionally, the Superintendent would access up to 2% of funds from the small employer stop-loss fund and the qualifying individual stop-loss fund for the purpose of supporting and expanding the existing pilot program, Brooklyn HealthWorks, and the establishment and operation of a pilot program to be located in upstate New York.

Chapter 527 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill amends Section 4110(a) of the Insurance Law to permit a domestic mutual property/casualty insurance company to include 75% of its investment income for purposes of calculating its expense ratio for management expenses. A domestic mutual property/casualty insurer would therefore be able to take 30% of the sum of its net premium income and 75% of its investment income in order to determine how much it can spend on management expenses. The bill would not apply to those insurers whose principal line of business is medical malpractice insurance and any insurer who is in rehabilitation or liquidation.

Chapter 551 of the Laws of 2006 amends the Insurance Law and the Public Health Law as follows:

- Section one of the bill adds a new Section 3224-b to the Insurance Law, which establishes rules relating to the processing of health claims and overpayments to physicians. The intent of this section is to provide uniformity and consistency in the reporting of medical services and procedures as they relate to the processing of health care claims and is not intended to dictate reimbursement. In this new section, "health plan" is defined as an insurer that is licensed to write accident and health insurance, or that is licensed pursuant to Article 43 of the Insurance Law or certified pursuant to Article 44 of the Public Health Law. A health plan is required to accept and initiate the processing of all health care claims submitted by a physician pursuant to and consistent with the American Medical Association (AMA) current procedural terminology (CPT) codes, reporting guidelines and conventions and the Centers for Medicare and Medicaid Services

healthcare common procedure coding system (HCPCS). Health plans are not precluded from determining that any such claim is not eligible for either full or partial payment, based upon determinations that the claim is not complete as defined by the prompt payment of health insurance claims regulation (11 NYCRR 217). Additional determinations may include that the service provided is not a covered benefit under the contract or agreement; the insured did not obtain a referral or satisfy other requisite conditions; the covered benefit exceeds set benefit limits; the individual is not eligible for coverage or otherwise is not compliant with the terms and conditions of their contract; another insurer, corporation or organization is liable for all or part of the claim; or the plan has a reasonable suspicion of fraud or abuse. This section does not require a health plan to pay or reimburse a claim or dictate the amount of a claim to be paid by a health plan to a physician.

- Section 2 of the bill amends Section 4803(a) of the Insurance Law, and Section 3 amends Section 4406-d(1) of the Public Health Law, to establish uniform credentialing processes and timeframes for a health care professional to participate in an insurer's or health care plan's respective networks. An insurer or health care plan shall notify a health care professional of the health care professional's ability to participate in the insurer's or plan's network within ninety days of receipt of a completed application from the health care professional. This notification shall contain the decision of whether or not the health care professional is credentialed or whether additional time is necessary to make a determination, in spite of the health care plan's or insurer's best efforts, because of a failure of third party to provide requisite documentation or non-routine or unusual circumstances require that additional time is needed for the review. In instances where additional time is needed due to lack of necessary documentation, the health plan or insurer shall make every effort to obtain such information as soon as possible.

- Section 4 of the bill establishes an effective date of January 1, 2007, and provides that the provisions of the bill shall apply to physician health care claims submitted for payment after such date.

Chapter 557 of the Laws of 2006 amends the Insurance Law as follows:

- The bill generally amends the Insurance Law to prohibit, with respect to all health insurance polices and contracts issued, renewed, modified, altered or amended on or after January 1, 2007, health insurers from excluding otherwise covered services based on a diagnosis of autism.

- The bill does not create a mandate for coverage of the diagnosis and treatment of autism but, instead, prohibits exclusion of otherwise covered services based on a diagnosis of autism.

- The provisions of the bill only apply to those policies and contracts that cover hospital, surgical and medical care.

Chapter 626 of the Laws of 2006 amends the Insurance Law as follows:

- The bill generally amends the Insurance Law to authorize a new kind of insurance called "salary protection insurance" to be sold in New York, in the admitted market and in excess lines market provided certain conditions have been met for excess lines placement.

- The bill defines "salary protection insurance" to mean insurance against financial loss due to the cessation of earned income due to disability, from sickness, ailment or bodily injury. The maximum salary protection insurance benefit is 75% of an insured's annual earned income, either when combined with the amount of in force disability insurance or when such disability

insurance can not be obtained. The bill would permit any insurer that is authorized to write "disability insurance" to also write salary protection insurance.

Chapter 727 of the Laws of 2006 amends the Insurance Law as follows:

- Section 1 of the bill amends Section 1115(b) of the Insurance Law to exempt a domestic insurer whose primary liability arises from the business of medical malpractice insurance from the prohibition against exposing more than 10% of its surplus to policyholders on any one risk.

Chapter 748 of the Laws of 2006 amends the Insurance Law as follows:

- The bill would require all group (both large and small) and school contract health insurance policies to provide up to thirty days of in-patient coverage in a hospital, and not less than twenty days of out-patient care (commonly referred to as a "30/20 benefit"), for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. The bill further requires that the insured's out-of pocket costs for the coverage (such as co-pays and deductibles) must be consistent with other benefits under the policy.

IV. REGULATIONS PROMULGATED, AMENDED OR REPEALED

The following is a summary of Insurance Department regulations promulgated, amended or repealed in 2006.

The 3rd Amendment to Regulation 34-A (11 NYCRR 219): Rules Governing Advertisements of Life Insurance and Annuity Contracts (Adopted on a permanent basis effective 10/11/06)

Section 2122(a)(2) of the Insurance Law prohibits any person from calling attention to an unauthorized insurer by any advertisement or public announcement in this state. Regulation 34-A establishes requirements regarding advertisements, statements and representations of licensees used in the solicitation of life insurance, annuities and the reporting of financial information. This rule was necessary to permit the use of "joint advertisements" in New York which are advertisements that contain the names of, or references to, insurance policies sold by a New York authorized insurer and an affiliated insurer that is not authorized in New York. This rule provides clarification of the terms "advertisement" and "public announcement" as used in the Insurance Law and prescribes, in protection of New York consumers, rules and guidelines that require the truthful and adequate disclosure of all material and relevant information in joint advertisements.

The 9th Amendment to Regulation 90 (11 NYCRR 218): Prohibition Against Geographical Redlining and Discrimination in Certain Property/Casualty Policies (Adopted on a permanent basis effective 11/29/06)

Regulation 90 is intended to make certain types of property/casualty coverage readily available in the voluntary market by implementing statutory prohibitions against companies engaging in geographical redlining practices and discrimination.

In enacting Chapter 259 of the Laws of 2005, the Legislature sought to prohibit insurance companies from canceling, refusing to issue, or refusing to renew a homeowner's insurance policy, including fire insurance or fire and extended coverage insurance, based solely on the insured residing in an area that is serviced by a volunteer fire department, unless such action is based on sound underwriting and actuarial principles. This rule establishes procedures for notifying applicants or insureds of the insurer's specific reasons for canceling or refusal to issue or renew such policies. The rule advises that an applicant or insured may contact the insurance company with any questions, and may file a complaint with the Department.

The Adoption of the New Regulation 182 (11 NYCRR 221): Limitations upon and Requirements for the use of Credit Information for Personal Lines Insurance (Adopted on a permanent basis effective 10/25/06)

The Legislature, in enacting Article 28 of the Insurance Law (Chapter 215 of the Laws of 2004), sought to afford consumers certain protections with respect to the use of credit information for personal lines insurance. To this end, the Legislature directed the Superintendent to promulgate a regulation that establishes limitations on, and requirements for, the permissible use of credit information by insurers doing business in this State to underwrite and rate risks for personal lines insurance business. This rule clarifies prohibited and permitted uses of credit information in the underwriting and rating of personal lines insurance.

Emergency Regulations

The following is a summary of Insurance Department Regulations promulgated on an emergency basis in 2006 that were in effect on December 31, 2006. Note that the first 5 items listed were in effect on an emergency basis for all or part of 2006 and were subsequently adopted on a permanent basis in 2007. No final action was taken with regard to the other 6 items in 2006, although it is anticipated that they will be permanently adopted in 2007.

The 2nd Amendment to Regulation 171 (11 NYCRR 362): The Healthy NY Program and Direct Payment Market Stop Loss Relief Programs (Effective on an emergency basis since 3/28/03) (Adopted on a permanent basis effective 1/31/07)

Due in part to the rising cost of health insurance coverage, many small employers are currently unable to provide health insurance coverage to their employees. Chapter 1 of the Laws of 1999 enacted the Healthy NY Program as an initiative designed to encourage small employers to offer health insurance to their employees, and to encourage uninsured individuals to purchase health insurance coverage.

This rulemaking introduced a second Healthy NY benefit package at a reduced premium rate. The second benefit package provides for a lower cost alternative and provides individuals and small businesses with the choice of a benefit package that meets their needs. The rule eliminates the well-child copayment applicable to the Healthy NY Program in order to enhance access to preventive and primary care for children, and permits the Healthy NY Program to be considered qualifying health insurance under the federal Trade Act of 2002 to allow those qualifying for a federal tax credit to benefit from that credit. The rule revises the eligibility requirements relating to employment in order to lessen complexity and enhance access.

The 3rd Amendment to Regulation 124 (11 NYCRR 152): Physicians and Surgeons Professional Insurance Merit Rating Plans (Effective on an emergency basis since 5/16/03) (Adopted on a permanent basis effective 1/24/07)

Insurance Law Section 2343(d) provides that the Superintendent shall, by regulation, establish a merit rating plan for physicians' professional liability insurance. Section 2343(e) provides that the Superintendent may approve malpractice insurance premium reductions for insured physicians who successfully complete an approved risk management course, subject to standards prescribed by the Superintendent by regulation. This regulation provides but does not require that an insurer may offer an internet-based risk management course to its insureds as soon as the Department determines that the course is in proper compliance with applicable law.

The 1st Amendment to Regulation 147 (11 NYCRR 98): Valuation of Life insurance Reserves (Effective on an emergency basis since 12/29/04) (Adopted on a permanent basis effective 1/10/07)

One major area of focus of the Insurance Law is the solvency of insurers doing business in New York. The Department seeks to ensure solvency by requiring all insurers authorized to do business in New York State to hold reserve funds necessary to meet the expected obligations to policyholders. Some companies have sold life insurance products that result in lower reserves than would be required for products with similar death benefit and premium guarantees. This rule addresses this problem by establishing new reserve methodologies consistent with Section 4217 of the Insurance Law.

The 3rd Amendment to Regulation 68-C (11 NYCRR 65-3.13): Claims for Personal Injury Protection Benefits and the 4th Amendment to Regulation 68-D (11 NYCRR 65-4.5): Arbitration (Consolidated actions effective on an emergency basis since 10/04/05) (Adopted on a permanent basis effective 3/14/07)

Regulation 68 contains provisions implementing Article 51 of the Insurance Law, which is commonly referred to as the No-Fault Law. No-fault insurance is intended to provide for prompt payment of health care and loss of earnings benefits. In accordance with Chapter 452 of the Laws of 2005, these rules require an insurer to issue a denial of a No-Fault claim with specific language that advises the applicant of the availability of special expedited arbitration to resolve the issue of which insurer must process the claim for first party benefits.

The 5th Amendment to Regulation 172 (11 NYCRR 83): Financial Statement Filings and Accounting Practices and Procedures (Effective on an emergency basis since 12/28/05) (Adopted on a permanent basis effective 1/10/07)

Certain provisions of the Insurance Law provide that authorized insurers, accredited reinsurers, authorized fraternal benefit societies, and Public Health Law Article 44 Health Maintenance Organizations and Integrated Delivery Systems shall file financial statements annually and quarterly with the superintendent. These entities are subject to the provisions of Sections 307 and 308 of the Insurance Law and are required to file what are known as Annual and Quarterly Statement Blanks on forms prescribed by the Superintendent. Except with respect to filings made by Underwriters at Lloyd's, London, the Superintendent has prescribed forms and Annual and Quarterly Statement Instructions that are adopted from time to time by the National Association of Insurance Commissioners, as supplemented by additional New York forms and instructions. To assist in the completion of the Financial Statements, the NAIC also adopts and publishes from time to time certain policy, procedure and instruction manuals. One of these manuals, the Accounting Practices and Procedures Manual As Of March 2005 ("Accounting Manual"), includes a body of accounting guidelines referred to as "Statements of Statutory Accounting Principles." With a few exceptions, this rule incorporates the Accounting Manual by reference so as to enhance the consistency of the accounting treatment of assets, liabilities, reserves, income and expenses, and to set forth the accounting practices and procedures to be followed in completing annual and quarterly financial statements required by law. The amendment of another portion of the regulation was necessitated by the issuance of a revised edition of Estimated Useful Lives Of Depreciable Hospital Assets, another publication which is incorporated by reference.

The Repeal of Regulation 56 (11 NYCRR 94) and Adoption of the New Regulation 56 (11 NYCRR 94): Rules Governing Individual and Group Accident and Health Reserves (Effective on an emergency basis since 12/31/02)

The Insurance Law does not specify mortality, morbidity, and interest standards used to value individual and group accident & health insurance policies, but relies on the Superintendent to specify the method. This regulation prescribes rules and regulations for valuation of minimum individual and group accident and health insurance reserves, including standards for valuing certain accident and health benefits in life insurance policies and annuity contracts. The rule lowers reserves for individual policies, which is expected to result in a lower cost of doing business in New York.

The 2nd Amendment to Regulation 159 (11 NYCRR 74): Homeowners Insurance Disclosure Information and other notices (Effective on an emergency basis since 10/20/06)

In enacting Chapter 162 of the Laws of 2006, the Legislature intended to improve public awareness of market assistance programs such as the Coastal Market Assistance Program (CMAP), that may be available to homeowners in New York. Chapter 162 requires that when a policyholder receives a notice of cancellation, nonrenewal or conditional renewal for a homeowners insurance policy

as specified in Section 3425(e) of the Insurance Law on property located in an area served by a market assistance program established by the Superintendent for the purpose of facilitating placement of homeowners insurance, that the policyholder also receive notice from the insurer of possible eligibility for coverage through the market assistance program or through the New York Property Insurance Underwriting Association (NYPIUA). In order to implement Chapter 162, the Legislature required the Superintendent to promulgate regulations governing the notices required by law. This rule sets forth certain minimum notification requirements to assure that policyholders that may be eligible for a market assistance program or NYPIUA receive proper notice of their options.

The 35th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards For Form, Content And Sale Of Health Insurance, Including Standards Of Full And Fair Disclosure and the New Regulation 183 (11 NYCRR 56): Processing of Claims (Effective on an emergency basis since 8/2/06)

The Insurance Law authorizes the Superintendent establish standard provisions for accident and health insurance coverage, and to promulgate regulations governing minimum standards for the form, content and sale of such coverage. Regulation 183 and the amendment to Section 52.16(c)(5) of Regulation 62 serve that purpose.

The cosmetic surgery exclusion presently set forth in Regulation 62 predates Article 49 of the Insurance Law, which provides for internal and external appeal of medical necessity denials. This rule clarifies the requirements relating to the cosmetic surgery exclusion in light of the subsequently enacted statutes.

The 3rd Amendment to Regulation 171 (11 NYCRR 362): The Healthy NY Program and Direct Payment Market Stop Loss Relief Programs (Effective on an emergency basis since 9/11/06)

Currently, small employer and individual participants in the Healthy New York program seeking comprehensive health insurance coverage cannot purchase high deductible health plans and establish health savings accounts in accordance with federal standards. This requires HMOs and participating insurers to offer high deductible health plans using the Healthy New York small employer and individual programs. This new option will provide New Yorkers with access to a tax-advantaged method of purchasing health insurance.

The rule also provides for prostatic cancer screening and a limited home health care and physical therapy benefit. The addition of the prostate cancer screening benefit will facilitate prompt and early detection of prostate cancer, which in turn should decrease mortality and reduce treatment costs.

The 5th Amendment to Regulation 146 (11 NYCRR 361): Market Stabilization Mechanisms for Individual and Small Group* Health Insurance And Medicare Supplement Insurance *(Effective on an emergency basis since 10/4/06)

Insurance Law Section 3233 requires the establishment of a pooling mechanism whereby health maintenance organizations and insurers contribute to a fund that offsets the risk of providing coverage to all applicants by sharing and equalizing claims of high cost persons. This rule establishes a new pooling methodology in the individual and small group health insurance market.

The 6th Amendment to Regulation 172 (11 NYCRR 83): Financial Statement Filings and Accounting Practices and Procedures (Effective on an emergency basis since 1/2/07)

See the 5th Amendment to Regulation 172, supra. The National Association of Insurance Commissioners has most recently adopted a new Accounting Manual as of March 2006. This rule

merely updates the citation in Section 83.2(c) to refer to the Accounting Manual as of March 2006 (instead of 2005).

Consensus Regulations

Section 102(11) of the State Administrative Procedure Act states that a "consensus rule" is a rule proposed by an agency for adoption on an expedited basis pursuant to the expectation that no person is likely to object to its adoption because it merely (a) repeals regulatory provisions which are no longer applicable to any person, (b) implements or conforms to non-discretionary statutory provisions, or (c) makes technical changes or is otherwise non-controversial. The Insurance Department acted to amend the following rules on a consensus basis.

The 4th Amendment to Regulation 41 (11 NYCRR 27): Excess Lines Placements Governing Standards (Adopted on a permanent basis effective 2/16/06)

Regulation 41 establishes excess line placement governing standards. This rule restates Section 2118(b)(6) of the Insurance Law regarding the duty of an excess line broker to deliver a stamped declarations page or cover note evidencing insurance that is stamped by the excess line association. The rule updates the language on the notice that is required to be prominently displayed on written confirmations of placement of coverage with excess line insurers, and the notice that is required on insurance policies issued by excess line insurers in this state. The two notices currently in use are different. Such changes are necessary to facilitate the eventual conversion of the affidavit system of the Excess Line Association of New York affidavit system to an electronic filing system.

The 29th Amendment to Regulation 83 (11 NYCRR 68): Charges for Professional Health Services (Adopted on a permanent basis effective 10/26/06)

Regulation 83 establishes maximum permissible charges for medical, hospital and other professional health services payable as no-fault insurance benefits. This rule updates the addresses of the New York State Department of Health and the New York State Education Department for the purposes of reporting patterns of health provider overcharges, excessive treatment or any other improper actions. The rule also updates the name of the New York State Insurance Department Bureau that is collecting the data.

The 2nd Amendment to Regulation 161 (11 NYCRR 261): Prepaid Legal Services Plans (Adopted on a permanent basis effective 1/27/06)

Regulation 161 establishes requirements for Prepaid Legal Service Plans authorized pursuant to Section 1116 of the Insurance Law, including which groups are eligible for policies and certificates issued on a group basis. This rule establishes eligibility for a policy issued to a college, school or other institution of learning, or to the head or principal thereof, who or which shall be deemed the policyholder, covering the students of such college, school or other institution of learning.

The 1st Amendment to Regulation 178 (11 NYCRR 217): Prompt Payment of Health Insurance Claims (Adopted on a permanent basis effective 12/5/06)

Regulation 178 establishes minimum data element requirements for the submission of claims for payment of medical or hospital services submitted on paper. This rule merely updates the fields required for the submission of health care claims in a paper format. This information is required by Medicare, and was inadvertently omitted from the original promulgation of the regulation.

V. CIRCULAR LETTERS ISSUED IN 2006

Number	Date	Addressed to	Subject
1	1/18/06	All Property/Casualty Insurers and Rate Service Organizations Doing Business in New York State, New York Property Insurance Underwriting Association, State Insurance Fund, New York Automobile Insurance Plan and Excess Line Association of New York	Guidelines and Procedures for the Implementation of the Provisions of the Terrorism Risk Insurance Extension Act of 2005
2	1/27/06	The Following Managed Care Organizations (MCOs) - All Health Maintenance Organizations (HMOs); Special Purpose Health Maintenance Organizations, also known as Prepaid Health Services Plans (PHSPs); Comprehensive HIV Special Needs Plans (HIV SNPs) and Managed Long Term Care Plans (MLTCPs)	Required Escrow Deposits
3	1/30/06	All Insurance Companies Authorized to Transact Motor Vehicle Liability Insurance Business in New York State	Motor Vehicle Law Enforcement Fee – Applicability to Trailers
4	3/14/06	All Authorized Life Insurers, Retirement Systems, and Fraternal Benefit Societies	Disaster Planning, Preparedness and Response
5	3/24/06	All Authorized Life Insurers and Licensed Fraternal Benefit Societies ("Insurers")	Regulation No. 60 Electronic Reporting
6	3/24/06	All Authorized Life Insurers and Licensed Fraternal Benefit Societies, All Licensed Life Insurance Agents and Brokers	Regulation No. 60 - Contact Information for Replacement Notification and Disclosure Statements
7	3/28/06	All Licensed Health Insurance Producers	Medicare Part D Marketing
8 Notes: Withdrawn Effective 06/29/06: See Circular Letter No. 14 (2006)	3/27/06	All Insurers Licensed to Write Accident and Health Insurance in New York State ("Commercial Insurers"), Article 43 Corporations, and Health Maintenance Organizations ("HMOs")	Discretionary Clauses in Health Insurance Policies and Contracts Including Disability Income Insurance

Number	Date	Addressed to	Subject
9	4/4/06	All Licensed Insurance Brokers, Agents and Consultants, Excess Line Association of New York, and Insurance Producer Organizations	Insurance Law § 2119 Agreements
10	4/11/06	All Authorized Insurers	Certification of Filings Made to Bureau of Taxes and Accounts
Supplement No. 1 to CL No. 8 (2006) Notes: Withdrawn Effective 06/29/06; See Circular Letter No. 14 (2006)	4/26/06	All Insurers Licensed to Write Accident and Health Insurance in New York State ("Commercial Insurers"), Article 43 Corporations, and Health Maintenance Organizations ("HMOs")	Discretionary Clauses in Health Insurance Policies and Contracts including Disability Income Insurance
11	5/08/06	All Property/Casualty Insurance Companies; Co-operative Property/Casualty Insurance Companies; Reciprocal Insurers; Financial Guaranty Insurance Corporations; and New York Medical Malpractice Insurance Plan	Property/Casualty Insurance Security Fund
12	5/10/06	All Licensed Property/Casualty Agents and Brokers	Notification of Availability of Flood Insurance
13	5/10/06	All Insurers Licensed to Write Accident and Health Insurance in New York State ("Commercial Insurers"), Article 43 Corporations and Health Maintenance Organizations ("HMOs")	Coverage for Preventive and Primary Care Services
Supplement No. 2 to CL No. 8 (2006) Notes: Withdrawn Effective 6/29/06; See Circular Letter No. 14 (2006)	5/24/06	All Insurers Licensed to Write Accident and Health Insurance in New York State ("Commercial Insurers"), Article 43 Corporations, and Health Maintenance Organizations ("HMOs")	Discretionary Clauses in Health Insurance Policies and Contracts Including Disability Income Insurance

Number	Date	Addressed to	Subject
14	6/29/06	All Insurers Authorized to Write Accident and Health Insurance, Life Insurance, and Annuities in New York State ("Commercial Insurers"), Article 43 Corporations, and Health Maintenance Organizations ("HMOs")	Discretionary Clauses in Accident and Health (Including Disability Income) Insurance Policies, Life Insurance Policies, Annuity Contracts and Subscriber Contracts
15	7/07/06	All Authorized Insurers	Claims Handling and Cancellation/Non-Renewal of Policies in the Areas Impacted by the Recent Floods
16	7/20/06	All Authorized Motor Vehicle Insurers and Insurance Producer Organizations	Requests for Motor Vehicle Police Accident Reports
Supplement No. 2 to Circular Letter No. 27 (2002)	7/31/06	All Insurers Licensed to Write Accident and Health Insurance in New York State, Including Article 43 Corporations and Health Maintenance Organizations	Additional Guidance for the Implementation of the Provisions of Chapter 557 of the Laws of 2002 (Accident and Health Insurance Coverage Issued to or Through Association and Chamber Groups) as Amended by Chapter 201 of the Laws of 2006 (Limiting the Premium Rate for Health Insurance Contracts for Sole Proprietors)
Supplement No. 1 to Circular Letter No. 7 (1993)	8/30/06	All Insurers Authorized to Write Motor Vehicle Liability Insurance in New York State	Motor Vehicle Physical Damage Claims Involving Auto Body Repairs
Supplement No. 1 to Circular Letter No. 16 (2005)	9/06/06	All Insurers Authorized to Write Motor Vehicle Insurance in New York State, Motor Vehicle Self-insurers, and the Motor Vehicle Accident Indemnification Corporation	Claims for No-Fault Benefits-Resolution Methods for Disputes Between Insurers; Revisions to the Emergency Third Amendment to Regulation No. 68-C
17	9/15/06	All Insurers Authorized to Write Motor Vehicle Insurance in New York State, Motor Vehicle Self-insurers, and the Motor Vehicle Accident Indemnification Corporation (MVAIC)	Fair Claims Settlement Practices: Interest on Overdue No-fault Claims and Claim Settlement Structure
18	9/20/06	All Authorized Property/Casualty Insurers, Rate Service Organizations and Insurance Producer Organizations	Cancellation and Other Notices - Loss Information Requests

Number	Date	Addressed to	Subject
19	9/27/06	Tire Manufacturers, Automobile Manufacturers and Existing Service Contract Providers Currently Offering Coverage in New York State for the Repair or Replacement of a Motor Vehicle Tire or Wheel Due to a Road Hazard	Amendment to Article 79 of the New York State Insurance Law
20	10/23/06	All Authorized Property/Casualty Insurers, Rate Service Organizations, Insurance Producer Organizations, and the New York Property Insurance Underwriting Association	Homeowners Insurance Disclosure Information and Other Notices - Emergency Adoption of the First Amendment to Regulation No. 159 (11 NYCRR 74)
21	10/27/06	All Insurers Authorized to Write Motor Vehicle Insurance in New York State, Rate Service Organizations, New York Automobile Insurance Plan, and Insurance Producer Organizations	Premium Reductions for Completion of an Accident Prevention Course Pursuant to Section 2336(a) and (d) of the New York Insurance Law; Revised Information on Course Sponsor
22	11/15/06	All Insurers, Other than Article 43 Corporations and Article 44 HMOs, Licensed to Write Accident and Health Insurance in New York State	Rate Modifications for Accident and Health Insurance Statutory Conversion Coverage
23	11/27/06	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations ("HMOs")	Chapter 551 of the Laws of 2006
24	12/29/06	All Insurers Licensed to Write Accident and Health Insurance in New York State ("Commercial Insurers"), All Authorized Property/Casualty Insurers and All Insurance Producer Organizations	Travel Insurance

VI. MAJOR LITIGATION

Catholic Charities of the Diocese of Albany, et al. v. Gregory V. Serio
New York Court of Appeals

This is a declaratory judgment action challenging the "conscience clause" provision of Sections 3221(l)(16)(A) and 4303(cc)(1) of the Insurance Law, which provides an exception from the mandate to provide contraceptive coverage in group health insurance policies issued to "religious employers." The plaintiffs, various religious organizations that do not fall within the statutory definition of "religious employers," contend that Sections 3221(l)(16)(A) and 4303(cc)(1) violate the Establishment, Free Exercise, Free Speech and Equal Protection provisions of the United States and New York State Constitutions. They seek declaratory and injunctive relief against enforcement of the statutes.

On November 25, 2003, the Supreme Court (Acting Justice Dan Lamont) granted the Superintendent's motion for summary judgment and dismissed the complaint. The court held that the Women's Health and Wellness Act does not violate any of the plaintiffs' constitutional rights under the United States and New York State Constitutions, nor does it violate any other New York State law.

The plaintiffs appealed to the Appellate Division, Third Department. In a decision issued January 12, 2006, the Appellate Division affirmed the Order of the Supreme Court, with two Justices dissenting. On October 19, 2006, the Court of Appeals unanimously affirmed the decision of the Appellate Division. A motion for reargument was denied on February 20, 2007.

Gregory V. Serio, et al. v. Alan G. Hevesi
Appellate Division, First Department

This is a proceeding commenced by the Superintendent to quash subpoenas that were served on the Superintendent and several employees of the New York Liquidation Bureau by the Comptroller of the State of New York in connection with the Comptroller's attempt to conduct an audit of the Liquidation Bureau. The Comptroller counterclaimed for enforcement of the subpoenas and for a declaration that the Comptroller has authority to audit the Liquidation Bureau.

In a decision and order issued June 30, 2005, the Supreme Court (Justice Walter B. Tolub) held that the New York State Constitution, Section 111 of the State Finance Law and Section 1412-a of the Abandoned Property Law do not empower the Comptroller with authority to pre-audit and post-audit the financial management and operations of insolvent insurers operated by the Liquidation Bureau or to audit the property of insolvent insurers held by the Superintendent as liquidator or rehabilitator pursuant to Article 74 of the Insurance Law. Accordingly, the court ordered the subpoenas quashed and denied the Comptroller's counterclaim.

The Comptroller appealed to the Appellate Division, First Department. In a decision issued March 6, 2007, the Appellate Division reversed the Order and Judgment of the Supreme Court, with two Justices dissenting. The court held that the Liquidation Bureau is a state agency and therefore subject to audit by the Comptroller. The Decision and Order of the Appellate Division has been stayed pending the Superintendent's appeal to the Court of Appeals, where the case is now pending.

AIU Insurance Company v. Lucien Kis Obas, et al.
Supreme Court, Kings County

Eagle Insurance Company v. Edythe M. Anderson, et al.
Supreme Court, Kings County

As a result of the decision of the Appellate Division, Second Department, in *Eagle v. Hamilton*, 16 A.D.3d 498 (2005), the Superintendent, "in his capacity as Administrator of the New York Public Motor Vehicle Liability Security Fund," has been joined as a party in numerous proceedings, such as those indicated above, which are brought pursuant to CPLR Article 75 to stay arbitration of claims for uninsured motorist (UM) benefits. The issue in these cases is whether there has been a disclaimer of liability or a denial of coverage within the meaning of Section 3420(f)(1) of the Insurance Law, thereby triggering a UM claim, because the Liquidation Bureau has issued letters to claimants and insureds in the insolvencies of certain insurance companies, stating that the PMV Fund is currently unable to provide either defense to or indemnification of claims covered by the PMV Fund because the Fund is "financially strained." The Appellate Division, in *Eagle v. Hamilton*, held that this issue must be determined by the Supreme Court on a case-by-case basis after joinder of the Superintendent.

In each of the cases noted above, and several others pending in Kings, Queens, Richmond and Bronx counties, the Department is required to appear through the Office of the Attorney General. In most (but not all) cases, the court has permitted the Department to submit an affidavit detailing the current financial condition of the PMV Fund instead of presenting a live witness to testify.

Marty Markowitz v. Gregory V. Serio
Appellate Division, First Department

This is a Freedom of Information Law (FOIL) case in which the Superintendent is appealing a January 2, 2006 decision of the Supreme Court, New York County (Justice Ling-Cohan) that required the Department to release annual reports filed by automobile insurers pursuant to the Department's anti-redlining regulation that contain detailed policy information by zip code. The Department had excepted the reports from disclosure on the basis of the insurance companies' contention that release of the information would injure their competitive positions. The Supreme Court held that the reports did not fall within the FOIL exemption for trade secrets or confidential commercial information.

On appeal, the Appellate Division, First Department, reversed the Order and Judgment of the Supreme Court and reinstated the Superintendent's determination. The court held that the information was properly withheld from disclosure under FOIL as material which, if disclosed, would cause substantial injury to the competitive position of the insurers.

Business For A Better New York, et al. v. Linda Angello, et al.
United States District Court, Western District of New York

This is a an action challenging the constitutionality of Labor Law sections 240(1) and 241(6), the so-called "Scaffold Law," which makes owners and general contractors responsible for properly maintaining safety equipment at construction sites and imposes liability upon them for worker injuries resulting from their failure to do so. The plaintiffs are a trade organization and several construction businesses. The defendants are the Commissioner of Labor, the Superintendent of Insurance, the Chair of the Workers' Compensation Board and the Attorney General. The plaintiffs allege that the statutes are violative of the Equal Protection and Commerce Clauses of the federal Constitution and are pre-empted by the Federal Occupational Safety and Health Act (OSHA).

A motion filed by the State Defendants to dismiss the complaint on grounds that the statutes do not violate the Constitution and are not pre-empted by OSHA is currently pending before the federal district court.

VII. 2007 LEGISLATIVE RECOMMENDATIONS

These are the legislative recommendations available at the time this report was prepared. Additional recommendations may be submitted throughout the year. The information which follows was accurate at the time the legislative recommendations were forwarded to the Legislature for introduction.

A. Insurance Department Bills for 2006

1. Requires the Superintendent of Insurance's prior approval of premium rate adjustments by HMOs, Article 43 corporations and commercial insurance carriers: Departmental Bill No. 126

Section 1 of the bill adds a new paragraph (3) to Section 3231(e) of the Insurance Law to provide that beginning July 1, 2007, premium rate adjustments sought by insurers for policy forms subject to Section 3231 of the Insurance Law are subject to the Superintendent's prior approval.

Section 2 adds a new paragraph (3) to Section 4308(g) of the Insurance Law to provide that beginning July 1, 2007, premium rate adjustments sought by corporations for contracts subject to Section 4308 of the Insurance Law are subject to the Superintendent's prior approval.

Section 3 sets forth an immediate effective date.

2. Provides for the licensure of title insurance agents by the New York State Department of Insurance: Departmental Bill No. 127

Section 1 amends Section 2101(k) of the Insurance Law to expand the definition of "insurance producer" to include "title insurance agent."

Section 2 repeals Section 2101(k) (4) of the Insurance Law, which specifically excludes title insurance agents from the definition of "insurance producer" within the meaning of Section 2101 (k).

Section 3 amends Section 2101 of the Insurance Law to add new subsection (s) to define the term "title insurance agent."

Section 4 amends the title heading of Section 2103 of the Insurance Law, the licensing section for insurance agents, to also include title insurance agents.

Section 5 amends Section 2103(b) of the Insurance Law to authorize the Superintendent to issue licenses to title insurance agents.

Section 6 amends Section 2103(c) of Insurance Law to authorize the Superintendent to issue a title insurance agent license to a firm or association and its sub-licensees. Any sub-licensee would only be authorized to act in the name of the licensee. In the case of a license issued to a title insurance agent, at least one designated sub-licensee must have a financial or other beneficial interest in the license.

Section 7 amends Section 2103(e) of the Insurance Law to require the filing of an application before a title insurance agent's license may be issued.

Section 8 amends Section 2103(f)(2)(B) of the Insurance Law to increase from six to seven the number of licensing exams the Superintendent may prescribe so that the Department can test those seeking to become licensed as a title insurance agent.

Section 9 amends Section 2103(g)(7) of the Insurance Law to waive the written exam requirement for an applicant who has passed the title insurance agent exam and who was licensed as a title insurance agent provided that the applicant applies for the license within two years following the termination of his license.

Section 10 amends Section 2103(g) of the Insurance Law to exempt attorneys from the written exam requirement in order to become licensed as a title insurance agent.

Section 11 amends Section 2103(h) of the Insurance Law to permit the Superintendent to refuse to issue a title insurance agent's license if in the Superintendent's judgment the applicant is not trustworthy and competent, or has given cause for the revocation or suspension of such license, or has not complied with any prerequisite for the issuance of a title insurance agent's license.

Section 12 amends Section 2103(j)(5) of the Insurance Law to require title insurance agent's to file a renewal application and pay the prescribed fee before their license may be renewed.

Section 13 amends Section 2103(j) (8) (A) of the Insurance Law to authorize the Superintendent to dispense with the requirements for a renewal application of a title insurance agent's license for military personnel who are unable to make a personal application for such license.

Section 14 amends Section 2103(j) (12) of the Insurance Law to permit a licensee to amend their license without having to pay the required fee.

Section 15 amends Section 2103(l) of the Insurance Law to permit title insurance agents to apply for an additional license authorizing them or sub-licensee to act as insurance agents for additional insurers.

Section 16 adds two new subsections to Section 2103 to provide a licensing mechanism for those currently acting as title insurance agents.

Section 17 amends Section 2109(a) of the Insurance Law to authorize the Superintendent to issue a temporary title insurance agent's license.

Section 18 amends Section 2109(c) of the Insurance Law to permit a title insurance agent who is issued a temporary license may use such license to renew existing business, to collect premiums due, and to perform such other acts as are incidental to the continuance of the insurance business.

Section 19 amends Subsections (a) and (d) of Section 2112 of the Insurance Law to require title insurance companies file a certificate of appointment in order to appoint a title insurance to act of its behalf.

Sections 20, 21 and 22 amend Section 2115 of the Insurance Law to make the section applicable to title insurance agents and to prohibit a title insurance company or any of its representatives from paying any compensation except to a licensed title insurance agent.

Section 23 amends Sections 2120 (a) and 2120(c) of the Insurance Law requiring title insurance agents to act in a fiduciary capacity for any funds received or collected as a title insurance agent.

Section 24 amends Section 2122(a) of the Insurance Law to prohibit a title insurance agent from: 1) advertising the financial condition of an insurer unless the advertising conforms with the requirements of Section 1313 of the Insurance Law and 2) calling attention to any unauthorized insurer.

Section 25 amends Section 2128(a) and Section 2128(b) of the Insurance Law to prohibit title insurance agents from receiving any commissions or fees in connection with coverage's placed for or services rendered with various governmental entities unless they actually placed coverage or rendered services to the governmental entity

Section 26 amends Section 2132(b) of the Insurance Law to exempt attorneys from the continuing education requirements for title insurance agents.

Section 27 amends the Insurance Law by adding new Section 2137 to prohibit anyone who holds a financial interest in a title insurance agency or title insurance company from referring business to that agency or company unless certain conditions are met.

Section 28 amends Section 305(b) of the Insurance Law to prohibit title insurance agent and its officers, directors and employees, whose conduct, condition or practices are being investigated from being entitled to witness or mileage fees.

Section 29 requires the Superintendent to promulgate application forms for title insurance agent licensing.

Section 30 allows person, firms and corporations who have filed an application for a title insurance agent license on or before January 1, 2008 or within 90 days after the Superintendent has promulgated application forms pursuant to this act, whichever is later, to act as such agent without a license until the Superintendent has made a final determination on the application for such license

Section 31 provides for an effective date on one hundred twenty days after the legislation has been chaptered, except that any rules and regulations necessary for the timely implementation of this act on its effective date shall be promulgated on or before such date.

3. Provides for the more efficient filing and payment of electronic health care claims and for more stringent penalties for failure to comply with the provisions relating to the settlement of health care payments: Departmental Bill No. 128

Section 1 of the bill amends Section 3224-a (a) of the Insurance Law to reduce the time within which a health plan must pay an electronically filed claim from 45 to 20 days.

Section 2 provides for an immediate effective date.

4. Provides for the protection of consumer and provider rights by imposing limitations on when preauthorized services may be denied; expanding the definition of a managed care contract; enhancing protections when a provider leaves a network; establishing requirements and timeframes for plan determinations consistent with federal requirements; requiring provider contracts to include certain standard provisions; permitting external appeal of out-of-network denials when a plan is proposing an alternative in-network treatment; and permitting providers to internally and externally appeal preauthorization and concurrent denials: Departmental Bill No. 148.

Section 1 of the bill adds a new section 3238 to the Insurance Law to prohibit insurers, health maintenance organizations, municipal cooperative health benefit plans, and Article 43 insurers from denying payment for a health care service for which preauthorization was received, unless the relevant information was not reasonably available at the time of the preauthorization review, and if the health plan had been aware of the information, it would not have approved the health care service.

Section 2 of the bill amends Section 4801 of the Insurance Law to add a municipal cooperative health benefit plan to the definition of an insurer, to broaden the definition of a "managed care health insurance contract," and to add a definition of "health care professional" and "health care provider."

Section 3 of the bill amends Section 4802 of the Insurance Law to conform the grievance requirements to federal standards, and establish timeframes in which a health plan must make a determination regarding a referral or coverage.

Section 4 of the bill amends Section 4802(c) (1) of the Insurance Law to provide the insured 180 days to submit a grievance.

Section 5 and 6 of the bill amend Section 4802(d) and 4802(k) of the Insurance Law to amend the timeframes in which the insurer must respond to a grievance in the event information is not received.

Section 7 of the bill repeals subsection (h) of Section 4803 of the Insurance Law and adds a new subsection (h) to require that every contract or agreement between an insurer and a health care provider participating in the insurer's network for a managed care product contain standard clauses that are to be promulgated by regulation.

Section 8 of the bill amends Section 4804(e) (1) of the Insurance Law to require that an insurer provide notice of the provider's disaffiliation from the insurer's network and the insured's right to transitional care within 15 days of such disaffiliation.

Section 9 of the bill amends Section 4900 (e) of the Insurance Law to amend the definition of "health care service" for an external appeal of an out-of-network denial.

Section 10 of the bill adds two new subsections (g-6) and (g-7) to section 4900 of the Insurance Law to add definitions of "out-of-network denial" and "urgent care."

Section 11 of the bill amends Section 4900(h) (1) of the Insurance Law to amend the definition of "utilization review" to include an out-of-network denial in the definition of utilization review.

Section 12 of the bill amends Section 4900(i) of the Insurance Law to amend the definition of a "utilization review agent" to include a municipal cooperative health benefit plan in the definition.

Section 13 of the bill amends Section 4901(b) (3) of the Insurance Law to omit the reference to retrospective adverse determination.

Section 14 of the bill amends Section 4902 (a) (5)(iii) of the Insurance Law to include in the minimum requirements of the utilization review program standards that the utilization review agent must notify the insured's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

Section 15 of the bill adds a new subdivision (a-1) to Section 4903 of the Insurance Law to require a utilization review agent to make an adverse determination involving urgent care within specified timeframes.

Section 16 of the bill amends Section 4903 of the Insurance Law to: (1) amend the timeframes in which the utilization review agent must make an adverse determination for a health care service involving preauthorization; (2) amend the timeframes in which utilization review agents must make a determination involving continued or extended health care services; (3) require that utilization review agents provide notice to the insured or the insured's designee and the insured's health care provider of an adverse determination involving continued or extended health care services; and (4) amend the timeframes in which the utilization review agent must make a determination for a health care service that has already been delivered.

Section 17 of the bill amends Section 4903 (e)(3) of the Insurance Law to require a utilization review agent to notify the insured's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

Section 18 of the bill amends Section 4904 of the Insurance Law to: (1) allow a health care provider to appeal any adverse determination; (2) amend the timeframes in which a utilization review agent must make an appeal determination of a health care service involving urgent care or preauthorization; (3) require a utilization review agent to establish a period of not less than 180 days for an insured or the insured's health care provider to file an appeal of an adverse determination; and (4) amend the timeframes in which the utilization review agent must decide the appeal, depending on whether the appeal involves preauthorization, concurrent care, or a health care service that has already been delivered.

Section 19 of the bill amends Section 4910 (b) of the Insurance Law to allow a health care provider to request an external appeal of any adverse determination upheld upon appeal.

Section 20 of the bill amends Section 4910 (b) (2) (D) of the Insurance Law to make a technical correction.

Section 21 of the bill amends Section 4910 (b) of the Insurance Law to add a new paragraph (3) to allow the insured, the insured's designee, or the insured's health care provider to pursue an external appeal of a health care service that was denied on appeal on the grounds that the health care service is out-of-network and an alternative treatment is available in-network.

Section 22 of the bill amends Section 4914 (b) of the Insurance Law to add that the insured's health care provider has 45 days to initiate an external appeal from when the insured's health care provider receives notice from the health care plan of its final adverse determination. This section of the bill would also require the external appeal agent to notify the insured's health care provider, where appropriate, of the external appeal decision.

Section 23 of the bill amends Section 4914 (b)(4) of the Insurance Law to add a new paragraph (C) to establish the procedures that must be followed by an external appeal agent when reviewing an external appeal involving an out-of-network denial.

Section 24 of the bill amends Section 4914 of the Insurance Law to: (1) require a health care provider to pay the cost of an external appeal requested by the provider where the external appeal agent upholds the final adverse determination issued by the health care plan; (2) require a provider to split the cost with the health plan if the health plan's denial is overturned in part; and (3) omit the reference to an external appeal initiated by an insured with respect to the standard description of the external appeal process, including a standard form and instructions for initiating an external appeal.

Section 25 of the bill amends Section 4403 (e)(1) of the Public Health Law to require that a health maintenance organization provide notice of the provider's disaffiliation from the health maintenance organization's network and the enrollee's right to transitional care within 15 days of such disaffiliation.

Section 26 of the bill amends Section 4408-a of the Public Health Law to conform the grievance requirements to federal standards, and establish timeframes in which a health plan must make a determination regarding a referral or coverage.

Section 27 of the bill amends Section 4408-a (3) (a) of the Public Health Law to provide the enrollee 180 days to submit a grievance.

Section 28 of the bill amends Section 4408-a (4) of the Public Health Law to amend the timeframes that the managed care organization must respond to a grievance in the event information is not received.

Section 29 of the bill amends Section 4408-a (11) of the Public Health Law to amend the timeframes that the managed care organization must respond to an appeal in the event information is not received.

Section 30 of the bill amends Section 4900 (5) (a) of the Public Health Law to amend the definition of "health care service" for an external appeal of an out-of-network denial.

Section 31 of the bill amends Section 4900 of the Public Health Law to add definitions of "out-of-network denial" and "urgent care."

Section 32 of the bill amends Section 4900 (8) (a) of the Public Health Law to amend the definition of "utilization review" to include an out-of-network denial in the definition of utilization review.

Section 33 of the bill amends Section 4901 (2) (c) of the Public Health Law to omit the reference to retrospective adverse determination.

Section 34 of the bill amends Section 4902 (1)(e)(iii) of the Public Health Law to include in the minimum requirements of the utilization review program standards that the utilization review agent must notify the enrollee's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

Section 35 of the bill adds a new subdivision 1-a to Section 4903 of the Public Health Law to require a utilization review agent to make an adverse determination involving urgent care within specified timeframes.

Section 36 of the bill amends Section 4903 of the Public Health Law to: (1) amend the timeframes in which the utilization review agent must make an adverse determination for a health care service involving preauthorization; (2) require that utilization review agents provide notice to the enrollee or the enrollee's designee and the enrollee's health care provider of an adverse determination involving continued or extended health care services; (3) amend the timeframes in which utilization review agents must make a determination involving continued or extended health care services; and (4) amend the timeframes in which the utilization review agent must make a determination for a health care service that has already been delivered.

Section 37 of the bill amends Section 4903 (5)(c) of the Public Health Law to require a utilization review agent to notify the enrollee's health care provider of the availability of the clinical review criteria relied upon to make an adverse determination.

Section 38 amends Section 4904 of the Public Health Law to: (1) allow a health care provider to appeal any adverse determination; (2) amend the timeframes in which a utilization review agent must make an appeal determination of a health care service involving urgent care or preauthorization; (3) require a utilization review agent to establish a period of not less than 180 days for an enrollee or the enrollee's health care provider to file an appeal of an adverse determination; and (4) amend the timeframes in which the utilization review agent must decide the appeal, depending on whether the appeal involves preauthorization, concurrent care, or a health care service that has already been delivered.

Section 39 of the bill amends Section 4910 (2) of the Public Health Law to allow a health care provider to request an external appeal of any adverse determination upheld upon appeal.

Section 40 of the bill amends Section 4910 (b) (iv) of the Public Health Law to: (1) make a technical correction; (2) add a new paragraph (c) to allow the enrollee, the enrollee's designee, or the enrollee's health care provider to pursue an external appeal of a health care service that was denied on appeal on the grounds that the health care service is out-of-network and an alternative treatment is available in-network.

Section 41 of the bill amends Section 4914 (2) of the Public Health Law to: (1) add that the enrollee's health care provider has 45 days to initiate an external appeal from when the enrollee's health care provider receives notice from the health care plan of its final adverse determination; and (2) require the external appeal agent to notify the enrollee's health care provider, where appropriate, of an external appeal decision.

Section 42 of the bill amends Section 4914 (2) (d) of the Public Health Law to establish the procedures that must be followed by an external appeal agent when reviewing an external appeal involving an out-of-network denial.

Section 43 of the bill amends Section 4914 of the Public Health Law to: (1) require a health care provider to pay the cost of an external appeal requested by the provider where the external appeal agent upholds the final adverse determination issued by the health care plan; (2) require a provider to split the cost with the health plan if the health plan's denial is overturned in part; and (3) omit the reference to an external appeal initiated by an enrollee with respect to the standard description of the external appeal process, including a standard form and instructions for initiating an external appeal.

Section 44 provides for an immediate effective date.

5. Expands the use of risk-based capital ("RBC") standards, currently applicable to life and accident and health insurers, to property/casualty insurers; provides a more flexible and realistic statutory capital level that changes in relation to the size of the insurer and the level of risk inherent in an insurer's operations; identifies inadequately capitalized insurance companies that write property/casualty business; and provides the Superintendent of Insurance with appropriate remedies when a property/casualty insurance company's financial condition deteriorates and its capital falls below thresholds established by the RBC formula: Departmental Bill No. 141.

Section 1 of the bill adds a new Section 1324 to the Insurance Law entitled "Risk-based capital for property/casualty insurance companies."

Subsection (a) contains definitions.

Subsection (b) provides that the section is applicable to property/casualty insurers and sets forth standards for possible exemption from RBC standards for small single state insurers writing less than $20 million in direct premiums in New York and for medical malpractice insurers writing predominantly in New York.

Subsection (c) establishes the filing date of the RBC reports for domestic insurers and provides for the submission of adjusted RBC reports.

Subsection (d) establishes the company action level event. This event requires the company to take actions that satisfy the Superintendent that the conditions which caused the event will be corrected.

Subsection (e) establishes the regulatory action level event. This event requires the Superintendent to analyze the company's financial condition and to issue an order aimed at correcting the conditions which led to the event.

Subsection (f) establishes the authorized control level event. This event permits the Superintendent to take the necessary actions to cause the domestic insurer to be placed into rehabilitation or liquidation.

Subsection (g) establishes the mandatory control level event. This event mandates that the Superintendent take the necessary actions to force the domestic insurer to stop writing new or renewal business or to cause the domestic insurer to be placed into rehabilitation or liquidation unless the insurer has demonstrated within 90 days that the conditions which led to the event can be corrected or unless the insurer is running off the business under a plan approved by the Superintendent.

Subsection (h) provides an insurer with the right to a confidential hearing in specified circumstances.

Subsection (i) provides that all RBC plans filed with the Superintendent and all reports, analysis and corrective orders arising from this section shall be kept confidential and not be made public or subject to subpoena, except to the extent the Superintendent finds that release is necessary to protect the public. It provides that the RBC formula is a regulatory tool which may indicate the need for corrective action with respect to a domestic insurer and it should not be used to rate or rank an insurer. It prohibits the disclosure by licensees of information on RBC levels to the public because the information may be misleading. However, insurers are permitted to rebut misleading information in certain circumstances. It prohibits the Superintendent from using RBC results in applying laws governing premium rates. The subsection also states that capital over the amount produced by the RBC calculation is desirable for insurers doing business in New York.

Subsection (j) provides authority for the Superintendent to take action against an authorized foreign insurer to protect the interests of New York policyholders, where the state of domicile of the foreign insurer has neither adopted the RBC law nor taken action as provided by the RBC law.

Subsection (k) establishes how notices shall be made by the Superintendent to insurers concerning regulatory action pursuant to this section.

Section 2 of the bill amends subsection (b) of Section 2402 of the Insurance Law to include a violation of Section 1324 (i) (2) (B) as a defined violations.

Section 3 of the bill amends subsection (o) of Section 7402 to include an authorized control level event or a mandatory control level event as a new ground for rehabilitation of a domestic property/casualty insurer (or, for liquidation pursuant to Section 7404). In addition, pursuant to Section 7406, such an event may be the grounds for conservation of the assets of a foreign insurer.

Section 4 of the bill amends Section 1322(e)(1)(H) and Section 1322(h)(1)(C) to correct an inadvertent error, to replace the word "regulatory" with the word "company," so that the language will appropriately refer to the "company" action level event.

Section 5 of the bill contains a severability provision.

Section 6 provides for an immediate effective date.

VIII. REGULATORY ACTIVITIES

A. Operating Statistics

1. Licenses Issued During Year

Table 62
LICENSES ISSUED DURING YEAR
2005 and 2006

	2006	2005
Total	**118,814**	**151,595**
Adjusters[a]		
Independent	7,395	4,453
Public	355	249
Agents[b]		
Life/Accident and Health	22,132	128,460
Property and Casualty	48,077	10,078
Rental Vehicle	39	6
Mortgage Guaranty Insurance	4	4
Bail Bond	57	52
Limited Lines[c]	16	0
Personal Lines	175	589
Brokers[d]		
Life	2,071	2,963
Property and Casualty	35,714	3,884
Excess Line (Regular)	1,199	239
Excess Line (Limited)	930	259
Viatical Settlement	17	18
Consultants[e]		
Life	38	182
General	374	28
Reinsurance Intermediaries[f]	205	22
Service Contract Registrants[g]	16	109

Note: Footnotes to table appear on next page.

Footnotes to Table 62

[a] Adjuster licenses issued pursuant to Section 2108 are renewable biennially as of January 1 of odd numbered years.

[b] Life/Accident and Health Agent licenses issued pursuant to Section 2103(a) are renewable biennially as of July 1 of odd numbered years. Property and Casualty Agent licenses issued pursuant to Section 2103(b) are renewable biennially as of July 1 of even numbered years. Rental Vehicle Agent licenses issued pursuant to Section 2131 are renewable biennially as of July 1 of even numbered years. Mortgage Guaranty Agent licenses issued pursuant to Section 6535 are perpetual. Bail Bond Agent licenses issued pursuant to Section 6802 are renewable biennially as of January 1 of odd numbered years.

[c] Limited Lines licenses – Effective January 1, 1987, licenses were issued to agents of assessment co-operative property/casualty companies enabling them to sell only coverage written by such companies. These licenses are renewable biennially as of July 1 of even numbered years.

[d] Life Broker licenses issued pursuant to Section 2104(b)(1)(A) are renewable biennially as follows: Issued between 3/01 and 6/30, expiration on 2/28 of odd years; issued between 7/01 and 10/31, expiration on 6/30 of odd years; issued between 11/01 and 2/28(9), expiration on 10/31 of odd years. Property and Casualty Broker licenses issued pursuant to Section 2104 and Excess Line Broker licenses issued pursuant to Section 2105 are renewable biennially as of November 1 of even numbered years. Limited Excess Line Brokers are licensed to deal only with purchasing groups as defined in Regulation 134. Viatical Settlement Broker licenses issued pursuant to Section 7802 are renewable annually as of December 1.

[e] Consultant licenses issued pursuant to Section 2107 are renewable on a biennial basis, Life Consultants as of April 1 of odd numbered years and General Consultants as of April 1 of even numbered years.

[f] Reinsurance Intermediary licenses issued pursuant to Section 2106 are renewable biennially as of September 1 of even numbered years.

[g] Service Contract Registrations issued pursuant to Section 9707 are renewable biennially as of March 1 of odd numbered years.

2. Results of Examinations for Licenses

Table 63
RESULTS OF EXAMINATIONS FOR LICENSES
Adjusters, Agents, Brokers and Consultants
2005 and 2006

Type of Examination	2006 Number Taking Examination	2006 Percent Passing	2005 Number Taking Examination	2005 Percent Passing
Total	**30,954**	**47%**	**29,142**	**52%**
Public Adjusters	76	34	56	34
Independent Adjusters - Total	4,329	53	4,045	55
Accident and Health	374	53	257	54
Automobile	604	50	1,029	66
Aviation	3	100	0	0
Casualty	1,239	52	769	47
Fidelity and Surety	1	0	0	0
Fire	223	68	180	71
General (All Lines)	626	49	552	35
Health Service Charges	425	57	448	58
Inland Marine	108	44	22	41
Limited Auto (Damage or Theft Appraisals only)	726	56	788	60
Agents and Brokers - Total	26,522	46	25,030	51
Agent, A&H	2,539	43	2,435	49
Agent, A&H (Spanish)	32	9	6	0
Agt/Brk, Life	8,234	40	7,981	45
Agt/Brk, Life (Spanish)	640	10	437	12
Agt/Brk, Life, A&H	10,298	52	8,863	59
Agt/Brk, Life, A&H (Spanish)	12	25	7	0
Agent, Property and Casualty	1,144	51	1,209	55
Broker, Property and Casualty	2,621	47	2,607	50
Agent, Mortgage Guaranty	2	50	1	100
Agent, Credit	0	0	0	0
Agt/Brk, Personal Lines	963	58	1,455	58
Agent, Bail Bond	37	54	29	59
Consultants - Total	27	19	11	36
Life	16	25	8	38
General	11	9	3	33

3. Changes in Authorized Insurers During 2006

A. Life Insurance Companies	
Domestic Company Incorporated	
Anthem Life & Disability Insurance Company	Oct. 13
Foreign Companies Licensed	
HCC Life Insurance Company, Indianapolis, IN	Jan. 1
Securian Life Insurance Company, St. Paul, MN	Jan. 19
Sterling Life Insurance Company, Glenview, IL	Mar. 17
Citicorp Life Insurance Company, Phoenix, AZ	Oct. 5
Merger Agreements Filed	
Philanthropic Mutual Life Insurance Company into Columbian Mutual Life Insurance Company, Binghamton, NY	Feb. 22
The Paul Revere Protective Life Insurance Company into The Paul Revere Life Insurance Company, Worcester, MA	Apr. 13
Paragon Life Insurance Company into Metropolitan Life Insurance Company, New York, NY	May 1
North American Company for Life and Health Insurance of New York into Utica National Life Insurance Company, New York, NY	Sept. 29
Utica National Life Insurance Company into The American Life Insurance Company of New York, NY	Sept. 29
First Citicorp Life Insurance Company into Metropolitan Life Insurance Company, New York, NY	Oct. 20
Citicorp Life Insurance Company into Metropolitan Life Insurance Company, New York, NY	Oct. 20
American Centurion Life Assurance Company into IDS Life Insurance Company of New York	Dec. 31
Redomestication Filed	
UniCare Life & Health Insurance Company (from Delaware to Indianapolis)	Oct. 16
Centurion Life Insurance Company (from Missouri to Iowa)	Dec. 31
Withdrawn	
Hartford Life Group Insurance Company Chicago, IL	Dec. 31
Change of Names	
“GE Capital Life Assurance Company of New York” to “Genworth Life Insurance Company of New York”	Jan. 1
“Monumental General Casualty Company” to “Work First Casualty Company” Elkton, MD	Feb. 2
“GE Group Life Assurance Company” to “Genworth Life and Health Insurance Co.” Windsor, CT	Mar. 24
“Highmark Life Insurance Company of New York” to “HM Life Insurance Company of New York” New York, NY	Apr. 1
“The Travelers Insurance Company” to “MetLife Insurance Company of Connecticut” Hartford, CT	May 1
“Conseco Life Company of New York” to “Bankers Conseco Life Insurance Company” Jericho, NY	June 26

"The American Life Insurance Company of New York" to "Wilton Reassurance Life Company of New York" Rye Brook, NY	Sept. 29
"IDS Life Insurance Company of New York" to "RiverSource Life Insurance Co. of New York"	Dec. 31
Amendment to Charter	
John Hancock Life Insurance Company of New York	July 31
B. Accident and Health Insurance Companies	
Domestic Company Licensed	
Humana Insurance Company of New York, Jamesville, NY	Aug. 17
Foreign Companies Licensed	
WellCare Prescription Insurance, Inc., Tampa, FL	Feb. 1
Express Scripts Insurance Company, Tempe, AZ	Nov. 27
Merger Agreements Filed	
Vytra Health Services, Inc. into Health Insurance Plan of Greater New York, NY, NY	Mar. 29
Vytra Health Plans Long Island, Inc into Health Insurance Plan of Greater New York, NY, NY	Mar. 29
Change of Name	
"Stone Harbor Insurance Company" to "WellCare Health Insurance of New York, Inc." New York, NY	Nov. 29
C. Property and Casualty Insurance Companies	
Domestic Company Incorporated	
Auto Insurance Corporation, New York, NY	July 19
Domestic Companies Licensed	
Healthcare Professionals Insurance Company, Albany, NY	Feb. 3
St. Clair Insurance Company, New York, NY	Sept. 28
Foreign Companies Licensed	
Western Diversified Casualty Insurance Company, Wisconsin	Jan. 1
Western United Insurance Company, Irvine CA	Apr. 3
United States Surety Company, Timonium, MD	Apr. 10
Tower National Insurance Company, Boston, MA	Apr. 20
Dealers Assurance Company, Upper Arlington, OH	May 8
California Insurance Company, San Francisco, CA	May 8
Canal Insurance Company, Greenville, SC	June 22
Intrepid Insurance Company, Farmington, MI	June 23
National Farmers Union Property and Casualty Company, Greenwood Village, CO	June 29
Darwin National Assurance Company, Wilmington, DE	July 11
Preserver Insurance Company, Paramus, NJ	July 21
Capitol Indemnity Corporation, Middleton, WI	Aug. 11
American Hallmark Insurance Company of Texas, Fort Worth, TX	Aug. 14
Northland Casualty Company, St. Paul, MN	Aug. 31
Employers Compensation Insurance Company, Glendale, CA	Sept. 12
American Southern Home Insurance Company, Jacksonville, FL	Sept. 19
Atradius Trade Credit Insurance, Inc., Baltimore, MD	Oct. 5
American Contractors Indemnity Company, Los Angeles, CA	Oct. 11
Phoenix Indemnity Insurance Company, Phoenix, AZ	Oct. 11

National Merit Insurance Company, Bellevue, WA	Oct. 20
Seminole Casualty Insurance Company, Tamarac, FL	Oct. 23
HSBC Insurance Company of Delaware, Bridgewater, NJ	Nov. 6
21st Century Insurance Company, Woodland Hills, CA	Nov. 17
Gateway Insurance Company, St. Louis, MO	Dec. 4
Majestic Insurance Company, San Francisco, CA	Dec. 18
AIG Advantage Insurance Company, St. Paul, MN	Dec. 27
GE Reinsurance Corporation, Barrington, IL	Dec. 27
Amendments to Charter	
Rampart Insurance Company New York, NY	Jan. 18
Countryway Insurance Company, DeWitt, NY	Jan. 25
Aioi Insurance Company of America New York, NY	Feb. 15
Mitsui Sumitomo Insurance Company of America New York, NY	Mar. 3
Mitsui Sumitomo Insurance USA Inc. New York, NY	Mar. 3
Global Liberty Insurance Company of New York Plainview, NY	Apr. 10
MML Assurance, Inc. New York, New York	June 8
Providence Mutual Fire Insurance Company Warwick RI	Aug. 23
Mercer Insurance Company, Lock Haven, PA	Sept. 6
Mercer Insurance Company of New Jersey, Inc. Pennington, NJ	Sept. 6
Executive Insurance Company, Staten Island, NY	Dec. 8
Change of Names	
"HANYS Insurance Company, Inc." to "Hospitals Insurance Company, Inc." White Plains, New York	Jan. 18
"Scholastic Insurance Company" to "St. Clair Insurance Company" New York, NY	Jan. 20
"Fireman's Fund Insurance Company of Wisconsin" to "Axis Insurance Company" Chicago, IL	Feb. 27
"Marine Indemnity Insurance Company of America" to "Upper Hudson National Insurance Company**"** Ferndale, NY	Mar. 1
"Progressive Halcyon Insurance Company" to "Progressive Direct Insurance Company" Mayfield Village, OH	Apr. 17
"UMI Insurance Company" to "Alliance National Insurance Company" Garden City, NY	June 6
"Insurance Company of Hannover" to "Praetorian Insurance Company" Itasca, IL	July 1
"G.U.I.C. Insurance Company" to "American Modern Select Insurance Company" Amelia, OH	July 17
"International Business and Mercantile Reassurance Company" to Old Republic General Insurance Corporation" Chicago, IL	July 20
"MIIX Insurance Company of New York" to "Tower Indemnity Company of America"	Aug. 17
"Bankers Multiple Line Insurance Company" to R.V.I. National Insurance Company" Stamford, CT	Nov. 3
"National Grange Mutual Insurance Company" to "NGM Insurance Company" Jacksonville, FL	Nov. 10
"American Re-Insurance Company" to "Munich Reinsurance America, Inc." Wilmington DE	Dec. 11
"Core Insurance Company" to "Endurance American Insurance Company" Wilmington, DE	Dec. 22

Redomestications Filed	
Continental Reinsurance Corporation (from California to South Carolina)	Jan. 1
National Fire Insurance Company of Hartford (from Connecticut to Illinois)	Jan. 1
Commercial Insurance Company of Newark, New Jersey (from New Jersey to South Carolina)	Jan. 1
Firemen's Insurance Company of Newark, New Jersey (from New Jersey to South Carolina)	Jan. 1
Everest National Insurance Company (from Arizona to Delaware)	Jan. 4
Angelina Casualty Company from (Delaware to Nebraska)	Jan. 17
General Fidelity Insurance Company (from California to South Carolina)	Feb. 15
Guaranty National Insurance Company (from Colorado to Connecticut)	Mar. 9
Main Street America Assurance Company (from New Hampshire to Florida)	Mar. 14
Nationwide Affinity Insurance Company of America (from Kansas to Ohio)	May 16
American Deposit Insurance Company (from Oklahoma to Ohio)	June 6
Triton Insurance Company (from Missouri to Texas)	June 28
Guaranty National Insurance Company (from Connecticut to Delaware)	July 10
Security Insurance Company of Hartford (from Connecticut to Delaware)	July 10
York Insurance Company (from Illinois to Rhode Island)	July 25
Beazley Insurance Company, Inc. (from Nebraska to Connecticut)	Aug. 8
The Fidelity and Casualty Company of New York (from South Carolina to Pennsylvania)	Nov. 15
The Continental Insurance Company (from South Carolina to Pennsylvania)	Nov. 15
Kansas City Fire and Marine Insurance Company (from South Carolina to Pennsylvania	Nov. 15
Firemen's Insurance Company of Newark, New Jersey (from South Carolina to Pennsylvania)	Nov. 15
Commercial Insurance Company of Newark, New Jersey (from South Carolina to Pennsylvania)	Nov. 15
Continental Reinsurance Corporation (from South Carolina to Pennsylvania)	Nov. 15
The Mayflower Insurance Company, Ltd. (from South Carolina to Illinois)	Nov. 15
Merger Agreements Filed	
Providence Washington Insurance Company of New York into Providence Washington Insurance Company, Providence RI	June 1
Euler American Credit Indemnity Company into Euler Hermes American Credit Indemnity Company, New York, NY	Oct. 30
Boston Old Colony Insurance Company into The Buckeye Union Insurance Company, Chicago, IL	Dec. 31
The Mayflower Insurance Company, Ltd. Into The Buckeye Union Insurance Company, Chicago, IL	Dec. 31
Niagara Fire Insurance Company into The Buckeye Union Insurance Company, Chicago, IL	Dec. 31
The Buckeye Union Insurance Company into The Continental Insurance Company, Reading, PA	Dec. 31
Commercial Insurance Company of Newark, NJ into Firemen's Insurance Company of Newark, NJ	Dec. 31
The Glens Falls Insurance Company into Firemen's Insurance Company of Newark, NJ	Dec. 31

Continental Reinsurance Corporation into Firemen's Insurance Co. of Newark NJ	Dec. 31
The Fidelity and Casualty Company of New York into The Continental Insurance Company, Reading, PA	Dec. 31
Firemen's Insurance Company of Newark, NJ into the Continental Insurance Co., Reading, PA	Dec. 31
Kansas City Fire and Marine Insurance Company into The Continental Insurance Company, Reading, PA	Dec. 31
National-Ben Franklin Insurance Company of IL into The Continental Insurance Company, Reading, PA	Dec. 31
Pacific Insurance Company into The Continental Insurance Company, Reading, PA	Dec. 31
CNA Casualty of California into The Continental Insurance Company, Reading, PA	Dec. 31
In Receivership	
Vesta Fire Insurance Corporation, Birmingham, IL	June 28
Shelby Casualty Insurance Company, Bedford Park, IL	June 28
D. Title Insurance Companies	
Incorporated	
SM Title Insurance Company, New York, NY	Jan. 24
Titledge Insurance Company of New York, Inc., New York, NY	Aug. 22
Domestic Companies Licensed	
Public Title Insurance Company, Rochester, NY	Jan. 17
SM Title Insurance Company, New York, NY	Jan. 31
Aris Title Insurance Corporation, New York, NY	May 16
Foreign Company Licensed	
Investors Title Insurance Company, Chapel Hill, NC	July 24
Merger Agreement Filed	
SM Title Insurance Company into Monroe Title Insurance Company, Rochester NY	Feb. 2
Redomestications Filed	
Commonwealth Land Title Insurance Company from Pennsylvania to Nebraska	July 24
Lawyers Title Insurance Corporation from Virginia to Nebraska	Sept. 18
E. Accredited Reinsurers	
Recognized	
Noetic Specialty Insurance Company, Chicago IL	Apr. 7
The Burlington Insurance Company, Burlington, NC	May 8
Guilford Insurance Company, Springfield, IL	May 15
Alamance Insurance Company, Springfield, IL	May 16
Affirmative Insurance Company, Bedford Park, IL	June 6
California State Automobile Association Inter-Insurance Bureau, San Francisco, CA	July 24
Mitsui Sumitomo Insurance Company, Limited, Japan	Dec. 31
Redomestications Filed	
CNA Casualty of California (from California to Illinois)	Jan. 1
Scottish Re Life Corporation (from Missouri to Delaware)	Feb. 3
Progressive Southeastern Insurance Company (from Florida to Indiana)	Oct. 5
Withdrawn	
Allianz Life Insurance Company of North America, Minneapolis MN	Jan. 30

AXA RE (U.S. Reinsurance Trust), Paris, France	Mar. 9
Transamerica Life Insurance and Annuity Company, Charlotte NC	Mar. 20
Eisen Und Stahl Ruckversicherungs-Aktiengesellschaft, Hannover, Germany	May 9
Minnesota Insurance Company	Dec. 27
F. Charitable Annuity Societies	
Permits Issued	
The Foundation Fighting Blindness, Inc., Owings Mills, MD	Jan. 10
North Shore Animal League America, Inc., Port Washington, NY	Feb. 2
General Synod Council of the Reformed Church in America, New York, NY	Feb. 22
Greenpeace Fund, Inc., Washington, DC	Mar. 8
AARP Institute, Washington, DC	Mar. 22
American Friends of the Tel Aviv University, Inc., New York, NY	Apr. 7
Muscular Dystrophy Association, Inc., Tucson, AZ	June 26
Adventist Frontier Missions, Inc., Berrien Springs, MI	July 13
Baptist General Conference, Arlington Heights, IL	Aug. 4
Lutheran Church – Missouri Synod Foundation, St. Louis, MO	Aug. 24
The American Baptist Home Mission Society, Valley Forge, PA	Aug. 28
Le Moyne College, Syracuse, NY	Sept. 7
Lewis and Clark College, Portland, OR	Sept. 19
The New York and Presbyterian Hospital, New York, NY	Oct. 3
The Actors' Fund of America, New York, NY	Nov. 20
The University of Cincinnati Foundation, Cincinnati, OH	Dec. 19
FCNL Education Fund, Washington DC	Dec. 19
Withdrawn	
RCA Foundation, Schenectady, NY	Apr. 3
American Parkinson Disease Association, Inc., Staten Island, NY	Sept. 7
The Free Methodist Foundation, Spring Arbor, MI	Dec. 15
Merger Agreement Filed	
RCA Foundation into General Synod Council of the Reformed Church in America, New York, NY	Apr. 3
G. Fraternal Benefit Society	
Merger Agreement Filed	
Croatian Catholic Union of the USA into The Croatian Fraternal Union of America, Pittsburgh, PA	July 28
Withdrawn	
Assured Life Association, Lone Tree, CO	July 28
H. Mortgage Guaranty Companies	
Incorporated	
PMI Mortgage Insurance Company of NY	Nov. 10

I. Captive Insurance Companies	
Domestic Companies Incorporated	
MWD Insurance Company, New York, NY	Mar. 30
Belmont Insurance Company, New York, NY	July 31
Mainland Insurance Company, New York, NY	Aug. 14
Seymour Insurance Company, New York, NY	Oct. 10
Bergstresser Insurance Inc.	Dec. 12
Captive Companies Licensed	
MWD Insurance Company, New York, NY	July 6
Mainland Insurance Company, New York, NY	Aug 17
Belmont Insurance Company, New York, NY	Sept. 15
Seymour Insurance Company	Oct. 26
RVC Insurance Company, Inc.	Dec. 22
Bergstresser Insurance Inc., Melville, NY	Dec. 27
J. Reciprocal Insurers	
Licensed	
Adirondack Insurance Exchange, Williamsville, NY	May 25

4. Examination Reports Filed During 2006		
Domestic Life Insurance Companies		
Name of Company	**As of**	**Date Filed**
Allianz Life Insurance Company of New York	09/302005	12/21/2006
Allstate Life Insurance Company of New York	12/31/2003	10/20/2006
American Family Life Assurance Company of New York	12/31/2004	03/03/2006
American Progressive Life and Health Insurance Company of New York	12/31/2003	02/23/2006
Combined Life Insurance Company of New York	12/31/2003	02/02/2006
Farmers and Traders Life Insurance Company	12/31/2004	09/28/2006
First SunAmerica Life Insurance Company	12/31/2002	03/29/2006
First Symetra National Life Insurance Company of New York	12/31/2004	03/16/2006
Genworth Life Insurance Company of New York	12/31/2004	11/16/2006
Gerber Life Insurance Company	12/31/2004	04/18/2006
National Integrity Life Insurance Company	07/01/2005	02/08/2006
United States Life Insurance Company in the City of New York	12/31/2002	04/17/2006
Utica National Life Insurance Company	12/31/2003	01/26/2006
Domestic Accident and Health Insurance Companies		
American Independent Network Insurance Company of New York	12/31/2002	03/14/2006
Healthplex Insurance Company	12/31/2004	10/10/2006
Humana Insurance Company of New York	12/31/2005	08/08/2006
MVP Health Insurance Company	12/31/2003	06/28/2006
Domestic Property and Casualty Insurance Companies		
AIG National Insurance Company, Inc.	12/31/2001	09/19/2006
American International Insurance Company	12/31/2001	07/28/2006
Executive Insurance Company	12/31/2005	11/29/2006
Fidelity National Property and Casualty Insurance Company	12/31/2003	11/16/2006
Gerling America Insurance Company	12/31/2002	07/10/2006
Greater New York Mutual Insurance Company	12/31/2003	06/19/2006
Healthcare Professionals Insurance Company	12/15/2005	01/05/2006
Insurance Company of Greater New York	12/31/2003	06/10/2006
Navigators Specialty Insurance Company	12/31/2004	09/22/2006
Paramount Insurance Company	12/31/2003	08/09/2006
Public Service Mutual Insurance Company	12/31/2003	08/09/2006
Rochdale Insurance Company	12/31/2003	09/25/2006
St. Clair Insurance Company	07/20/2006	09/01/2006
State-Wide Insurance Company	12/31/2003	10/18/2006
Strathmore Insurance Company	12/31/2003	06/19/2006
Tower Insurance Company of New York	12/31/2004	09/22/2006
United Americas Insurance Company	12/31/2004	10/23/2006
Assessment Co-operative Property and Casualty Insurance Companies		
Callicoon Co-operative Insurance Company	**12/31/2004**	**01/06/2006**
Eastern Mutual Insurance Company	12/31/2004	08/03/2006
Farmers Mutual Insurance Company of Milan, Pine Plains and Stanford	12/31/2005	11/20/2006
Midrox Insurance Company	12/31/2004	11/06/2006
Otsego County Patrons Co-operative Fire Relief Association	12/31/2003	05/30/2006

Walton Co-operative Fire Insurance Company	12/31/2006	12/13/2006
Advance Premium Co-operative Property and Casualty Insurance Companies		
Colonial Cooperative Insurance Company	12/31/2002	10/25/2006
Finger Lakes Fire & Casualty Company	12/31/2004	04/03/2006
Financial Guaranty Companies		
Capital Markets Assurance Corporation	12/31/2003	04/11/2006
Radian Asset Assurance Inc.	12/31/2003	03/22/2006
Title Insurance Companies		
Aris Title Insurance Corporation	04/14/2006	05/09/2006
Public Title Insurance Company	11/17/2005	01/06/2006
Fraternal Benefit Society		
Workmen's Benefit Fund of the United States of America	12/31/2003	03/27/2006
Reciprocal Insurer		
Adirondack Insurance Exchange	05/17/2006	05/25/2006
Charitable Annuity Societies		
American Civil Liberties Union Foundation	12/31/2004	11/16/2006
American Leprosy Missions, Inc.	12/31/2004	01/26/2006
American Museum of Natural History	12/31/2004	04/26/2006
Archdiocese of New York	12/31/2004	07/17/2006
Catholic Charities of the Archdiocese of New York	12/31/2004	02/27/2006
Catholic Foreign Mission Society of America, Inc.	12/31/2004	09/27/2006
Colgate Rochester Crozer Divinity School	12/31/2004	07/06/2006
Department of Education, Archdiocese of New York	12/31/2004	08/07/2006
Educational Broadcasting Corporation	12/31/2004	01/18/2006
Ellis Hospital Foundation, Inc.	12/31/2004	10/23/2006
Fellowship of Reconciliation, Inc.	12/31/2003	08/28/2006
General Board of Global Ministries of the United Methodist Church	12/31/2004	09/13/2006
Guideposts A Church Corporation	12/23/2003	07/27/2006
International Planned Parenthood Federation, Western Hemisphere Region, I	12/31/2004	05/22/2006
Jewish National Fund (Keren Kayemeth Leisrael) Inc.	12/31/2005	08/28/2006
Lenox Hill Hospital	12/31/2004	11/22/2006
Maryknoll Sisters of St. Dominic, Inc.	12/31/2004	06/12/2006
Memorial Sloan-Kettering Cancer Center	12/31/2004	06/15/2006
Metropolitan Museum of Art	12/31/2004	05/04/2006
National Multiple Sclerosis Society	12/31/2004	05/25/2006
New York Province of the Society of Jesus	08/19/2005	08/16/2006
New York Public Library Astor, Lenox and Tilden Foundations	12/31/2004	11/22/2006
Sage Colleges	12/31/2004	05/22/2006
Society For the Propagation of the Faith	05/28/2005	08/16/2006
Women's Division of the General Board Ministries of the United Met	12/31/2004	09/13/2006
Captive Insurance Company		
First Mutual Transportation Assurance Company	12/31/2003	05/19/2006

Health Maintenance Corporations		
MVP Health Plan, Inc.	12/31/2003	06/28/2006
Wellcare of New York, Inc.	12/31/2004	10/03/2006
Non-Profit Health Service Corporations		
Excellus Health Plan, Inc.	*12/31/2003*	*12/31/2003*
Healthnow New York Inc.	12/31/2003	09//20/2006
MVP Health Services Corp	12/31/2003	06/28/2006
Non-Profit Medical Expense Indemnity		
Eastern Vision Service Plan, Inc.		
Continuing Care Retirement Community		
Canterbury Woods	12/31/2003	02/16/2006
Jefferson's Ferry	12/31/2003	02/16/2006
Summit at Brighton	12/31/2003	02/16/2006
Retirement & Pension (Private)		
College Retirement Equities Fund	12/31/2004	06/29/2006
Municipal Cooperative Health Benefit Plans		
Cayuga-Onondaga Area School Employees' Healthcare Plan	06/30/2004	09/20/2006
State-Wide Schools Cooperative Health Plan	06/30/2004	11/17/2006
Steuben Area School Employees' Benefit Plan	06/30/2005	11/01/2006
Welfare Trust Funds		
Plainview – Old Bethpage Federation of Teachers Welfare Fund	08/31/2004	06/09/2006
Suffolk County Superior Officers Association Benefit Fund	12/31/2004	06/09/2006
Wayne County Health Care Plan Trust	12/31/2004	04/18/2006
Miscellaneous		
State Insurance Fund	12/31/2003	08/07/2006
Motor Vehicle Accident Indemnification Corporation	12/31/2004	04/18/2006
Aggregate Trust Fund	12/31/2003	08/07/2006
Managed Long Term Care Plan		
VNS Choice	09/30/2005	12/12/2006

5. Insurance Department Receipts and Expenditures

Table 64
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2006

Taxes Collected Under the New York State Insurance Law:	
Taxes collected by reason of retaliation under Section 1112[1]	$(10,833,293.80)
Excess Line - Section 2118	82,117,055.43
Organization Tax - Section 180, Tax Law	83,379.87
Subtotal[2]	**$ 71,367,141.50**
Fees Collected Under Section 1112 of the NYS Insurance Law:	
Filing Annual Statements and Certificates of Authority to Companies	$ 95,202.42
Agents' Certificates of Authority	407,639.06
Admission Fees	11,038.00
Subtotal	**$ 513,879.48**
Licensing and Accreditation Fees:	**$ 15,182,647.52**
Assessments and Reimbursement of Department Expenses:	
Section 313 - Company Examinations	$ 10,729,239.23
Section 332 – Assessment	162,546,653.31
Administrative Expense Security Funds	135,323.82
Subtotal	**$173,411,216.36**
Other Fees and Receipts:	
Section 9107 - Certification & Filing Fees	$ 108,730.00
Section 9108 - Fire Insurance Fee	12,929,876.45
Section 1212 - Summons and Complaints	850,972.44
Fines and Penalties	5,261,063.54
Arbitration Fees	250.00
FOIL Requests	17,234.45
Miscellaneous	2,730.02
Regulation 134	3,100.00
Motor Vehicle Law Enforcement Fee	64,459,278.97
CAPCO Application Fees	17,000.00
Subtotal	**$ 83,650,235.87**
Foreign Fire Tax, and Security Funds Receipts	
Foreign Fire Tax - Insurance Law Sections 2118, 9104 and 9105	$ 42,075,775.06
Property Casualty Insurance Security Fund - Sections 7602 and 7603	198,437,227.95
Public Motor Vehicle Liability Security Fund – Section 7601	10,765,385.45
Workers' Compensation Security Fund	98,210,642.19
Subtotal	**$349,489,030.65**
TOTAL DEPARTMENT RECEIPTS	**$693,614,151.38**

Table 65
INSURANCE TAX RECEIPTS[3]
(in millions)

Fiscal Year	Net
2001-02	633.0
2002-03	696.0
2003-04	930.0
2004-05	1,077.0
2005-06	1,055.0

[1]The negative balance represents retaliatory tax refunds in excess of retaliatory tax collected, in accordance with Insurance Law Section 1112.

[2]This amount is in addition to the $ 1.055 billion collected by the Department of Taxation and Finance under Tax Law Article 33.

[3]Collected by the Department of Taxation and Finance under Tax Law Article 33.
Source: State of New York, Annual Budget Message, 2007-08

Table 66
DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2006
Paid in the First Instance from Appropriations

Personal Service	
Employee salaries	**$ 60,305,270.33**
Maintenance and Operation	
General office supplies	$ 565,797.68
Travel expense	2,223,841.05
Rental equipment	16,374.00
Repair and maintenance of equipment	243,601.22
Real estate rental	7,469,831.32
Postage and shipping	337,435.31
Printing	76,966.97
Telephone	556,226.93
Miscellaneous contractual services	6,356,467.54
OFT Computer	212,185.43
OGS Interagency courier	64,328.18
Equipment	1,597,665.22
Employee fringe benefits/indirect cost	30,038,186.04
Subtotal Maintenance and Operation	**$ 50,318,318.96**
Suballocations to Other State Agencies	
Personal Service, Maintenance and Operation	**$ 51,077,144.51**
TOTAL DEPARTMENT EXPENDITURES	**$161,700,733.80**

Table 67
RECEIPTS VS. DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2006

Total Department Receipts	$693,614,151.38
Total Department Expenditures	$161,700,733.80
Excess of Department Receipts Over Department Expenditures	**$531,913,417.58**

B. DEPARTMENT STAFFING

Table 68

DEPARTMENT STAFFING

Number of Filled Positions by Bureau/Location (as of February 21, 2007) ‡

Bureau	Examiners	Attorneys	Actuaries	Other Professionals	Investigators	Support Staff	Total
New York City Office:							
Executive	1			10		4	15
Life	100		9	4		8	121
Health	48		6	1		2	57
Administration*	1			7		8	16
Consumer Services	32			1		16	49
Frauds	4			3	19	5	31
OGC		25		6		7	38
Public Affairs/Research				2		1	3
Property	178		23	1		18	220
Systems	2			19		3	24
Capital Markets	1			6		2	9
Examiner Pool	36						36
Disaster Preparedness	7					1	8
Policy	1			1			2
NYC Total	**411**	**25**	**38**	**61**	**19**	**75**	**629**
Albany Office:							
Executive				4		1	5
Life		11	19			4	34
Health	6	20	4	2		4	36
Administration*				22		16	38
Consumer Services	38			1		9	48
Frauds				1	8		9
OGC		6					6
Property	9					1	10
Systems				33		7	40
Licensing	1			8		34	43
Disaster Preparedness	2			1		1	4
Albany Total	**56**	**37**	**23**	**72**	**8**	**77**	**273**
ALL OTHER							
Brooklyn Office:							
Frauds					5		5
Buffalo Office:							
Health		1					1
Consumer Services	2					1	3
Frauds					3		3
Mineola Office:							
Consumer Services	1					1	2
Frauds					8		8
Oneonta Office:							
Frauds					5		5
Rochester Office:							
Frauds					2		2
Syracuse Office:							
Frauds					2		2
All Other Total	**3**	**1**			**25**	**2**	**31**
Department Total	**470**	**63**	**61**	**133**	**52**	**154**	**933**

*Includes HRM & Offices Services

‡**Note**: Table does not include 28 Student Assistants assigned to various bureaus during the year

IX. LIQUIDATION BUREAU

The New York Liquidation Bureau is a unique entity. Receiving no taxpayer funding, it carries out the responsibilities of the Superintendent of Insurance as receiver to protect the interests of the policyholders and creditors of insurance companies that have been found financially impaired or insolvent. The Liquidation Bureau is not part of the Insurance Department, but rather an independent entity that assists the Superintendent in his private capacity as receiver of such insurance companies.

The Liquidation Bureau has performed this function since 1909, when the New York State Legislature passed a law mandating that the Superintendent serve as receiver, a role separate from his role as regulator of the insurance industry. In the case of each insurance company in receivership, the Superintendent as receiver is appointed and supervised by the New York State Supreme Court.

The Liquidation Bureau assists the Superintendent in his capacity as receiver to administer the affairs of insurance companies undergoing rehabilitation, liquidation and conservation. It also assists in the administration of New York's Security Funds, which are used to pay claims remaining unpaid by reason of an insurer's inability to meet its insurance policy obligations.

During 2006, proceedings continued for 63 active insurance companies. This included three new proceedings - one domestic, MML Assurance, Inc., and two ancillary, Shelby Casualty Insurance Company and Vesta Fire Insurance Company.

The 63 active insurance company proceedings are classified as follows:

3	Rehabilitation Estates
27	Domestic Estates
24	Ancillary Estates
9	Conservations

As of December 31, 2006, assets, liabilities and current insolvency of the Bureau's 34 domestic and conservation insurance companies[1] aggregately were as follows:

Total Assets	$1,671,718,194
Total Liabilities	$5,478,268,446
Current Insolvency	$3,806,550,252 [2]

The New York State Security Funds received $78,221,606 in dividends and early access funds, of which $38,903,947 was from domestics and $39,317,659 was from ancillary estates. The Workers' Compensation Security Fund received $23,368,856 from eight estates; the Public Motor Vehicle Security Fund received $916,425 from two estates; and the Property/Casualty Security Fund received $53,232,263 from 17 estates.

During 2006, monies received by the Liquidation Bureau from the New York State Security Funds were as follows: $193,919,854 for allowed claims, $48,014,617 for related expenses, and $2,912,266 for return premiums.

Pursuant to New York Insurance Law Section 7433-a, a $70,000,000 loan facility was established in 2005 to provide credit to the Workers' Compensation Security Fund from the assets of domestic estates in liquidation. As of December 31, 2006, the outstanding balance was approximately $5,822,258.

With regard to the Executive Life of New York ("ELNY") estate, the preliminary analysis by the Bureau's new administration indicates that ELNY will be able to make full payments on its annuities for approximately the next 15 years, but may not have sufficient funds to meet its full obligations thereafter. The Bureau's preliminary estimate, subject to further review and refinement, is that barring unforeseeably poor market performance in the future, approximately $600 million of additional funds and commitments in today's dollars will be needed to allow ELNY to meet these later obligations. Earlier statements by prior Bureau administrations may have significantly understated this shortfall by utilizing accounting methods that did not accurately reflect the estate's financial condition. The Bureau is now working collaboratively with various industry sectors and other interested parties to secure funding and, based upon preliminary conversations and analysis, is cautiously optimistic that additional funding can be secured.

Fraternal Benefit Societies

As of December 31, 2006, there were 38 pending liquidation proceedings. During the year, 12 proceedings were terminated and 14 proceedings were commenced. The remaining assets of the 38 burial societies totaled approximately $1,042,608. In addition, assets of $404,636 were distributed to members of fraternal benefit societies.

[1] This does not include figures for the ancillary estates; MML Assurance Company and United Community Insurance Company in liquidation; or Executive Life Insurance Company, Frontier Insurance Company and Interboro Mutual Insurance Company in rehabilitation.

[2] The Special Deputy Superintendent in Charge of the Liquidation Bureau was appointed effective April 2, 2007, and the Bureau currently has no Chief Financial Officer. Indeed, the Special Deputy Superintendent is presently in the midst of searching for a qualified candidate to serve as CFO. Given the recent history of the Bureau, which includes indictment and/or termination of senior officials for alleged misconduct pertaining to Bureau procurement and finances, and given that there have been no recent audits of the estates or the Bureau, the Special Deputy Superintendent has indicated that, at present, he has no means of verifying the accuracy of the data set forth herein. In addition to searching for a CFO, the Bureau is in the process of obtaining the services of a nationally recognized public accounting firm to perform a top-to-bottom audit of the Bureau's finances and operations and of the estates within its administration. (See http://www.nylb.org/Documents/FINANCIAL%20&%20OPERATIONS%20AUDITING.pdf).

1. Rehabilitation, Liquidation, Ancillary Receivership and Conservation Proceedings

The insurance entities under the Liquidation Bureau's jurisdiction during 2006 were as follows:

Rehabilitations

Commenced: None [1]

Continued: Executive Life Insurance Company of New York
Frontier Insurance Company
Interboro Mutual Indemnity Insurance Company

Completed: None

Liquidations

Commenced: MML Assurance, Inc.

Continued: American Agents Insurance Company
American Consumer Insurance Company
American Fidelity Fire Insurance Company
Capital Mutual Insurance Company
Consolidated Mutual Insurance Company
Contractors Casualty and Surety Company
Cosmopolitan Mutual Insurance Company
First Central Insurance Company
Galaxy Insurance Company
Group Council Mutual Insurance Company
The Home Mutual Insurance Company of Binghamton, NY
Horizon Insurance Company
Ideal Mutual Insurance Company
MagnaHealth of New York
Medical Malpractice Insurance Association
Midland Insurance Company
Midland Property and Casualty Insurance Company
Nassau Insurance Company
New York Merchant Bakers Insurance Company
New York Surety Company
Realm National Insurance Company
Transtate Insurance Company
Union Indemnity Insurance Company of New York
United Community Insurance Company
U. S. Capital Insurance Company
Whiting National Insurance Company

Closures: None

Ancillary Receiverships - In the case of a New York-licensed foreign (*i.e.,* not domiciled in New York) insurer becomes insolvent, the Superintendent of Insurance must apply to the court to establish an Ancillary Receivership to enable the Superintendent, in his role as both Ancillary Receiver and administrator of the New York Security Fund, to trigger the Security Fund to pay covered claims.

[1] The Superintendent of Insurance was appointed Temporary Receiver of Oriska Insurance Company on August 18, 2006.

Commenced: Shelby Casualty Insurance Company
Vesta Fire Insurance Company

Continued: Acceleration National Insurance Company
American Druggists' Insurance Company
American Eagle Insurance Company
American Mutual Insurance Company of Boston
American Mutual Liability Insurance Company
Amwest Surety Insurance Company
Commercial Compensation Casualty Company
Credit General Insurance Company
Far West Insurance Company
Fremont Indemnity Company
Frontier Pacific Insurance Company
Integrity Insurance Company
Legion Insurance Company
LMI Insurance Company
Mission Insurance Company
Phico Insurance Company
Reliance Insurance Company
Security Indemnity Insurance Company
The Connecticut Surety Company
The Home Insurance Company
Transit Casualty Company
Villanova Insurance Company

Closure: None

Conservations - All foreign or alien (*i.e*., not domiciled in New York) insurers not licensed in New York but doing business on an excess and surplus lines basis must establish a trust fund in New York. If such an insurer becomes insolvent, the Superintendent may apply to the court for an order directing the Superintendent to conserve the assets of that trust fund for the benefit of all U.S. policyholders.

Commenced: None

Continued: Alpine Insurance Company
FAI General Insurance Company, Ltd.
Folksam International Insurance Company (UK) Ltd.
HIH Casualty and General Insurance, Ltd.
Legion Indemnity
Northumberland General Insurance Company
Pacific and General Insurance Company
Reliance Insurance Company of Illinois
United Capitol Insurance Company

Closures: None

2. Security Funds Income and Disbursements

Table 69
PROPERTY/CASUALTY INSURANCE SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2006

Total of Fund as of 4/1/05	**$107,523,073.11**
Paid into the Fund	$118,154,573.93
Interest income - net	3,070,034.23
Recoveries from companies in liquidation	75,752,672.79
General Fund Reimbursement	1,459,947.00
Total Receipts	**$198,437,227.95**
Less disbursements:	
Administrative expenses	$ 435,770.34
Awards and expenses of companies in liquidation	215,542,633.31
Total Disbursements	**$215,978,403.65**
Total Activity	**$(17,541,175.70)**
Total of Fund as of 3/31/06	**$ 89,981,897.41**

[1] Monies collected under Insurance Law Section 7603.

Table 70
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2006

Total of Fund as of 4/1/05	**$ 375,229.76**
Paid into the Fund	$10,111,674.06
Interest income - net	133,454.00
Recoveries from companies in liquidation	520,257.39
Total Receipts	**$10,765,385.45**
Less disbursements:	
Administrative expenses	$ 52,119.96
Awards and expenses of companies in liquidation	10,986,450.89
Total Disbursements	**$ 11,038,570.85**
Total Activity	**$ (273,185.40)**
Total of Fund as of 3/31/06	**$ 102,044.36**

[1] Monies collected under Insurance Law Section 7604 from companies writing bonds and policies carrying coverages set forth in the Vehicle and Traffic Law Section 370.

Table 71
WORKERS' COMPENSATION SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2006

Total of Fund as of 4/1/05	**$ 5,482,669.93**
Paid into the Fund	$37,592,365.62
Interest income – net	753,011.89
Loan Proceeds[2]	17,072,258.00
Recoveries from companies in liquidation	42,793,006.68
Total Receipts	**$98,210,642.19**
Less disbursements:	
Administrative expenses	$ 168,418.80
Awards and expenses of companies in liquidation	66,533,952.92
Loan Repayments[2]	7,402,649.00
Total Disbursements	**$74,105,020.72**
Total Activity	**$24,105,621.47**
Total of Fund as of 3/31/06	**$29,588,291.40**

[1] Monies collected under Workers' Compensation Law Sections 108 and 109.

[2] Chapter 33 of the Laws of 2005 authorized the Superintendent to make one or more loans from the assets of the liquidation estates to fund the Workers' Compensation Security Fund. Total loan amount to date, including this loan, is $17,072,258.

X. PUBLICATIONS

(As of 3/23/07)

Automobile/Livery Guides

- Annual Ranking of Automobile Insurance Complaints
- Consumers Shopping Guide to Automobile Insurance
  (upstate and downstate editions)
- Handbook for Livery Drivers (English & Spanish)

Frauds Guides

- Annual Frauds Bureau Report
- Welcome to the NYS Insurance Department Frauds Bureau – A Consumer Brochure (online only)

Health Guides

- External Review: Your Rights as a Health Care Consumer
- External Appeals Program Annual Report
- Healthy NY Guide (English & Spanish)
- Insurance Policies Covering Long Term Care Services in NYS
- New York Consumer Guide to Health Insurers
  (ranks complaints from HMOs, commercial health insurers, and nonprofit indemnity health insurers; also includes grievances and utilization review appeals & performance evaluations)
- New York Consumer Guide to HMOs (an interactive guide is also available online)

Homeowners/Tenants Guides

- Coastal Homes and Insurance: A Guide for New York Homeowners
- Consumers Shopping Guide for Homeowners' and Tenants Insurance
  (upstate and downstate editions)

Life Guides

- Consumers Shopping Guide for Life Insurance (Web guide only)
- Policyholder Protection Provided by the Life Insurance Company Guaranty Corporation of New York

Miscellaneous Guides & Publications

- A Consumer's Guide to the New York State Insurance Department
- Annual Report to the Legislature
- Directory of Regulated Insurance Companies (online only)
- Statistical Tables from Annual Statements
  Volume 1, Property/Casualty, Financial Guaranty, Mortgage Guaranty and Assessment Cooperative Companies
  Volume 2, Life and A & H Companies, and Fraternal Benefit Societies
  Volume 3, Title Companies, HMOs, Nonprofit Health Insurers

Note: Copies of listed publications are available free of charge to New York State residents (limit: one per resident).