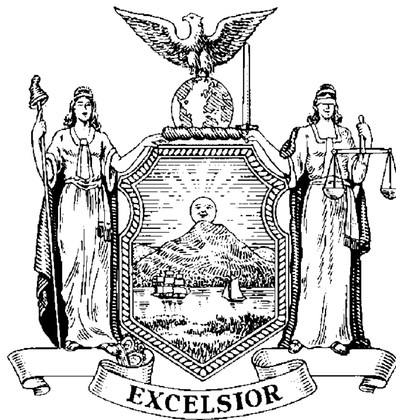
Annual Report of the Superintendent of Insurance to the New York Legislature

Calendar Year 2005



Governor George E. Pataki

Superintendent of Insurance Howard Mills

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The One Hundred Forty-Seventh Annual Report of the Superintendent of Insurance

A Report to the New York State Legislature for the Year Ending December 31, 2005

George E. Pataki
Governor

Howard Mills
Superintendent of Insurance

www.ins.state.ny.us

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

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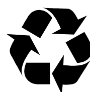

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I. Major Developments

A. Superintendent Mills Marks First Full Year In Office

Superintendent Howard Mills, who became New York's chief insurance regulator in January 2005, signed this year along with New York State Attorney General Eliot Spitzer landmark settlement agreements with three major U.S. insurance brokerage firms, secured unprecedented auto rate premium reductions that saved New York's drivers more than $400 million, and was a national leader in winning an extension of the federal Terrorism Risk Insurance Act (TRIA) through the end of 2007. Within the Insurance Department itself, the Superintendent created a Corporate Practices Unit in the Office of General Counsel and instituted reforms such as the implementation of risk-based exams.

Photo: Ronald L. Glassman

Nominated by Governor George E. Pataki in December 2004, Superintendent Mills subsequently won New York State Senate confirmation to serve as head of the New York State Insurance Department.

Before assuming his current post, the Superintendent was an elected Member of the New York State Assembly, representing for three terms (1998-2004) a district covering Orange and Rockland counties. While in the State Legislature, Assemblyman Mills served as the Deputy Minority Leader, sat on the Banking, Housing, Insurance and Ways and Means Committees, and was a member of the Armed Forces Legislative Caucus. The Republican nominee for the United States Senate in 2004, Assemblyman Mills did not seek re-election that year to the State Assembly.

B. Auto Insurance Premium Rates Fall for Second Straight Year

The New York State Insurance Department approved in 2005 a record number of auto insurance premium rate reductions, saving policyholders more than $400 million.

About 20 auto insurers, including the top three in terms of market share (Allstate, GEICO, and State Farm), reduced their rates an average of 5 percent in 2005, with the overall statewide reduction in auto insurance premium rates coming in at 3.3 percent.

The momentum for these rate reductions began in November 2004, when the Department sent letters to the state's largest auto insurance carriers, citing compelling industry data that showed overall loss ratio (i.e., liability and no-fault) in the private passenger market had dropped significantly since 2002, when insurers set aside 86 cents on every premium dollar collected for paying claims.

Throughout 2005, Superintendent Mills continued the broad-based review of auto insurance premium rates for private passenger vehicles. Insurance companies representing more than 70% of the auto insurance market in New York were directed to appear before the Department to review their rate structures in the face of significant declines in auto insurer losses.

State Farm and Progressive, two of New York's largest auto insurers, reduced their customers' rates in 2004, but that was only the start of a trend that would carry throughout 2005 because of the Department's pro-active stance on behalf of consumers. Regulatory reform and aggressive fraud-fighting will likely ensure that further rate reductions continue into 2006.

C. Landmark Settlement Agreements Reached with Insurance Brokers

Superintendent Mills and Attorney General Spitzer signed landmark settlement agreements with Marsh & McLennan Companies, Inc., Aon Corporation, and Willis North America, Inc., three of the largest U.S. insurance brokerage firms, in 2005.

Marsh & McLennan agreed in January 2005 to set aside $850 million in restitution for policyholders who were harmed by its actions and to resolve allegations of fraud and anti-competitive practices. Marsh & McLennan also issued a public statement in which it apologized for "unlawful" and "shameful" conduct, and promised to adopt reforms.

Connecticut Attorney General Richard Blumenthal, Illinois Attorney General Lisa Madigan and Illinois Acting Director of Insurance Deirdre Manna joined Superintendent Mills and Attorney General Spitzer in announcing in March 2005 an agreement with Aon Corporation to resolve allegations of fraud and anti-competitive practices. Chicago-based Aon agreed to establish a $190 million restitution fund for affected policyholders and adopted a new business model designed to avoid conflicts of interest. In addition, Aon issued a public statement apologizing for its improper conduct.

Willis North America, Inc. agreed in April 2005 to provide $50 million in restitution to policyholders who were adversely affected by Willis' conduct as part of a settlement agreement announced jointly by Superintendent Mills and Attorney General Spitzer. As with the Marsh & McLennan and Aon settlements, Willis also agreed to reform its business model in a way that averted conflicts of interest. The accord also ended the regulatory investigation into Willis' alleged fraudulent and anti-competitive practices.

The Department and the New York State Attorney General's Office also announced in April 2005 that the Department would appoint a consultant to audit years of alleged improper booking of workers' compensation premiums at American International Group (AIG).

D. Disaster Preparedness

1. Disaster Preparedness and Response (DPR) Bureau

Throughout 2005, the DPR Bureau received Disaster Response Plans from 681 of the 923 companies who were required to submit Plans to the Department. The 681 companies represent 92.3 percent of the direct written insurance premium in New York, as of year-end 2004. Of the 681 plans submitted, approximately 95% (651/681) were delivered in an electronic format. Moreover, the DPR Bureau, after review of submissions, sent follow-up letters to 494 companies requesting updates and amendments to their Disaster Response Plans. The decision to forward a follow-up letter was based upon comparison of the company plans with a checklist of items suggested as best practice.

As a follow-up to activities that began in 2004 with the distribution of Circular Letter No.7 (2004), 923 companies were required to re-submit a "Disaster Response Questionnaire" and "Disaster Response Plan" to the Department.

The Department's DPR Bureau commenced operations on March 1, 2004. The Bureau's principal function is to assist the 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 terrorism. New York was the first insurance department in the nation to create a DPR Bureau.

2. Federal Terrorism Risk Insurance Extension Act of 2005 (TRIEA)

The U.S. Congress passed and President George W. Bush signed into law on Dec. 22, 2005 the Terrorism Risk Insurance Extension Act (TRIEA), only days before its predecessor, the Terrorism Risk Insurance Act (TRIA) was scheduled to expire on Dec. 31, 2005. TRIEA remains in effect through the end of 2007.

Superintendent Mills spoke on behalf of the National Association of Insurance Commissioners (NAIC) before the U.S. Senate Committee on Banking, Housing and Urban Affairs in April 2005, stressing the need for a continued federal backstop in the terrorism insurance marketplace. Moreover, Superintendent Mills advocated in his public appearances and media interviews throughout 2005 the importance on behalf of a continued federal role in maintaining the affordability and availability of terrorism insurance.

The events of Sept. 11, 2001 resulted not only in the death of almost 3,000 in New York, Washington, D.C. and Pennsylvania but also the largest property insurance losses in U.S. history. The economic impact of the Sept. 11's events, coupled with the hardening of the insurance market in subsequent years, focused significant insurance industry and legislative attention on the issue of comprehensive coverage for terrorist acts.

President Bush signed TRIA into law in November 2002. TRIA was created as a temporary federal property/casualty reinsurance program for losses resulting from specifically defined acts of terrorism. Under TRIA, insurers had to make terrorism coverage for "insured losses" available to their commercial insureds and inform them of the premiums for such coverage. Once the deductible was satisfied, the federal government agreed as part of the 2002 law to cover 90% of the remaining losses up to a combined aggregate program limit of $100 billion annually.

3. New York Insurance Network (NYIN)

The DPR 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 terrorism-related information with the Department. There are currently 1,260 companies involved with a total of approximately 3,780 participants.

During 2005, the Department issued 52 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.

E. Property Bureau (Automobile)

1. "Operation Auto Rates"

The Department secured in 2005 more than $400 million in auto insurance premium rate reductions, a testimony to Governor Pataki's strong commitment to regulatory reform of the state's no-fault system and his sustained emphasis on ridding the state of auto insurance fraud. In October 2005, a team of 15 staff members from the Department and the New York State Division of Criminal Justice Services received a Governor's Office of Employee Relations 2005 *Work Force Champions Award* for their successful implementation of Governor Pataki's initiatives to reduce auto premiums. The strategy included:

- the reduction of 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 through a revision to Regulation 68 that took effect on April 5, 2002;

- the adoption of the New York State Medicaid fee schedule to reform the reimbursement rules for durable medical equipment (such reform resulted in 3,000 less durable medical equipment fee schedule disputes filed for arbitration in 2005 when compared to 2004) through the promulgation of the Twenty-Eighth Amendment to Regulation 83 that took effect on October 6, 2004; and

- the reform of the No-Fault Arbitration System through a package of regulatory and administrative changes that took effect at the beginning of 2002.

2. Dramatic Decline in the Number of Pending No-Fault Arbitration Cases

The Department has seen a dramatic reduction in the inventory of pending no-fault arbitration cases. Indeed, that number stood at 16,150 at the close of December 2005 whereas the figure was 116,200 in March 2002. Moreover, the percentage of pending no-fault arbitration cases that were resolved prior to going to arbitration has continued to grow over the years. Twenty-three percent of the overall cases were settled prior to arbitration in 2002, with the number rising to 28% of the total in 2003 and then jumping to 33% of the entire pending inventory of cases in 2004.

F. Property Bureau (Non-Auto)

1. Finite Risk Reinsurance

Finite risk reinsurance received increased attention from regulators and the media in 2005. Finite risk reinsurance is a product that can potentially be used by insurers to create the appearance that business has been ceded to reinsurers but without actually transferring any risk.

Upon examination of domestic insurers, the Department has for many years been reviewing reinsurance agreements for transfer of risk. Due to the recent increased concerns regarding finite risk reinsurance, the Department was involved in joint investigations with both the Securities and Exchange Commission and the New York Attorney General's Office, bringing increased scrutiny to certain reinsurance agreements. Additionally, the Department is participating in efforts by the National Association of Insurance Commissioners (NAIC) 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 2005 property and casualty financial statement.

2. New York Property Insurance Underwriting Assoc. (NYPIUA) Extended

Chapter 156 of the Laws of 2005 extended the authority of the New York Property Insurance Underwriting Association (NYPIUA) to operate until June 30, 2006, 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.

3. Market Conduct Investigations

When 2005 began, the Insurance Department was in the midst of conducting 20 market conduct investigations, one Rate Service Organization examination (RSO) and one Joint Underwriting Association examination (JUA). Meanwhile, 104 investigations and one RSO examination were initiated during the year. The Department closed 93 market conduct investigations and one JUA examination during the year. At year's end, 31 market conduct investigations and two RSO examinations were in progress. A total of 37 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $1,124,619. In addition, fines totaling $51,250 were received from insurers and self-insurers for failure to pay No-Fault arbitration awards in a timely manner.

G. Health Bureau

1. Healthy NY

Healthy NY continued to grow in 2005. As of January 1, 2006, enrollment in the program totaled 108,417, marking an annual increase of 39 percent.

The Health Care Reform Act of 2000 (HCRA) required the Department to administer the Healthy NY program. The program is designed to bring reduced-cost health insurance coverage to the working uninsured, sole proprietors and small businesses with 50 employees or fewer.

"Healthy NY has become a national model for states seeking an innovative way to provide affordable health insurance coverage to those who need it most," Governor Pataki said. "We are proud that Healthy NY is strengthening small businesses by enabling them to offer important health benefits to their employees and providing families access to quality, comprehensive health care, and these latest figures prove that we are now reaching more people than ever."

2. External Appeal Program

Recently completing its sixth 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, 2005, the Department has received over 11,500 external appeal requests.

3. Health Insurance Continuation Demonstration Project

The Health Bureau has been statutorily charged with implementing the New York State health insurance continuation assistance demonstration project. The statute created two separate pilot programs: one designed to assist entertainment industry workers, and the other aimed at assisting displaced workers meeting certain requirements as defined by federal law. The programs have distinct eligibility rules, funding, distribution channels, and require separate infrastructures. The programs are 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, while $700,000 annually has been reserved for the program for displaced workers.

The Health Bureau has worked diligently to implement this program, and began accepting applications on January 1, 2005 for the entertainment industry employees program. During its first month of operation, the Department received 214 applications from entertainment industry employees seeking premium assistance. For the entire year of 2005, the Health Bureau processed a total of 729

applications and paid out more than $812,700 in premium assistance. Payments were made to 23 union funds, the most highly represented being Equity League (181 enrollees) and Screen Actors Guild (66 enrollees).

H. Life Bureau

1. Speed to Market

During 2005, 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 2005, the Life Bureau posted the updated Group Fixed and/or Variable Annuity Outline, the updated Charitable Gift Annuity outline 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 letters. The streamlined certified filing procedure introduced in Circular Letter No. 6 (2004), effective September 1, 2004, replaced the Certified Circular Letter (CL) No. 27 (2000) process. The 2004 CL eliminated the 2000 CL provision requiring life insurers to file a detailed product checklist with the Department and made the triage procedure for regular prior approval submissions unnecessary.

2. Market Conduct

A new unit was formed in the Life Bureau to establish a risk assessed market conduct analysis of regulated entities. Working with licensed insurers in creating a market conduct profile and through use of the National Association of Insurance Commissioners' Level 1 and Level 2 checklists, the risk assessment review consists of analysis of market conduct activities in areas such as sales and marketing activities, policyholder services, compliance and corporate governance.

I. Consumer Services Bureau

1. Complaint Handling

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 55,029 cases in 2005. Of these, 42,492 involved complaints against insurance companies regarding loss settlements or policy provisions, of which 27.7% (11,772) were automobile complaints, 61.2% (25,992) were accident and health complaints, 8.1% (3,461) were property and liability complaints and 3.0% (1,267) were life and annuity complaints. In addition 1,835 cases were closed when the complainants failed to furnish additional information deemed necessary in order to proceed with the case. Another 7,297 cases involved complaints against agents, brokers and adjusters. Written inquiries accounted for 1,498 cases and referrals accounted for 1,907 cases. Included in the total are 3 cases related to the World Trade Center Disaster. In total, the Bureau *received* 56,382 cases during 2005.

2. Prompt Pay Fines

The Consumer Services Bureau continued its enforcement action against health insurers and HMOs that violated the prompt payment statute. In 2005, $316,800 in prompt pay fines were levied against 24 health insurers and HMOs. These fines were calculated using the new 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.

3. Service Contract Provider Fines

The Consumer Services Bureau continues to investigate other service contract providers to resolve violations of insurance law for failing to meet financial solvency requirements, failure to timely renew registrations and for operating without a registration. Should a service contract provider fail to comply, the Bureau will move to suspend or revoke its authority to conduct business in the State or seek orders to cease and desist operations in New York State.

The Consumer Services Bureau has been investigating the subject area of accidental damage protection products, whereby manufacturers and distributors of computers offer protection, for an additional cost, for fortuitous events such as spillage. This resulted in manufacturers creating insurance policies, and acting as insurers, without holding a proper license. The Bureau in conjunction with the Department's Office of General Counsel has resolved this issue by qualifying these offerings as service contracts, thus giving New Yorkers the proper consumer protections as required by the law.

4. Annual Health Insurance Consumer Guide

The Department publishes an Annual Consumer Guide to Health Insurers that ranks insurers and HMOs based on complaints upheld by the Consumer Services Bureau and contains a separate ranking based on upheld prompt payment complaints. The Bureau also plays an integral role in producing a companion HMO Guide and the only Interactive Guide to HMOs available from any state insurance department. The Interactive Guide can be accessed through the New York Insurance Department's Web site at www.ins.state.ny.us.

J. Frauds Bureau

1. 2005 Arrests

The Frauds Bureau participated in investigations that led to the arrest of 753 individuals during 2005, with stepped-up collaborative law enforcement alliances on the federal, state and local levels.

Frauds Bureau activities in 2005 resulted in court-ordered restitution of more than $5.8 million by 109 individuals. In 12 cases, individuals made voluntary restitution totaling $260,835. In yet another 41 instances, insurers were able to achieve savings of $410,125 in connection with fraudulent claims under investigation by the Frauds Bureau.

Governor Pataki and the Legislature have provided the support that has enabled the Bureau to join with members of the insurance industry and law enforcement agencies to form a cohesive team to combat insurance fraud throughout the State.

2. Fighting Auto Fraud

In its effort to combat no-fault fraud and abuse in New York State, the Frauds Bureau has helped bring about the prosecution of organized no-fault fraud rings and the takedown of no-fault medical mills. Moreover, for the past three years, reports of suspected no-fault fraud have been declining steadily, showing a decrease of 30 % from May 2005 to May 2006 alone.

These favorable trends emerged in large part amid greater cooperation and collaboration by the Frauds Bureau with the police and district attorneys in aggressively fighting fraud on every level.

K. Capital Markets Bureau

The Capital Markets Bureau was involved in a number of special projects stemming from a variety of events, including the multiple hurricanes hitting the U.S. Gulf Coast states in 2005, the

changes in the capital markets environment, and key legislative initiatives. Its staff conducted research on a wide range of technical topics, raising capital market concerns, and analyzing various transactions. The Bureau's risk management specialists also provided recommendations to the Department's senior management team, when applicable.

L. Systems Bureau – Internet Developments

The Department's main Web site and the ones with which it is affiliated, covering programs such as Healthy NY, Captive Insurers and Caregivers, continued to play a vital role in communicating with and providing services to the Department's diverse constituencies during 2005. The Department's broad range of activities and applications are reflected on these sites. During 2005, there were 3,396,310 visits to the Insurance Department's Homepage, a 32% increase over the previous year.

In October 2005, Superintendent Mills announced that the Department's redesigned Web site was officially online, offering visitors to www.ins.state.ny.us a fresh look and enhanced navigational tools.

"The Insurance Department's Web site draws more than three million visitors annually and the improvements we've made will make it easier for them to find what they're looking for, whether they are consumers seeking information about auto or health care insurance rates, or agents and brokers looking to renew their licenses online," said Superintendent Mills.

II. Review of New York State Insurance Business

A. LIFE BUREAU

1. Licensed Life Companies

There were 143 life insurance companies licensed to transact business in New York State as of December 31, 2005. The total admitted assets of licensed life insurers amounted to approximately $2.08 trillion at December 31, 2004 a ten-year gain of 86.9%. Bonds totaled $957.2 billion; stocks $61.1 billion; mortgage loans $159.6 billion; real estate $12.3 billion; policy loans $56.1 billion, and short-term holdings $14.8 billion. Other admitted assets totaled $819.5 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $772.8 billion on December 31, 2004, an increase of 93.1% since 1994. Insurance in force at December 31, 2004 of $4.58 trillion represents an increase of 81.6% since December 31, 1994.

3. Organizations Under Life Bureau Supervision

The Life Bureau supervised 485 organizations as of December 31, 2005. These organizations consisted of: 143 licensed life insurance companies — 86 domiciled in New York and 57 foreign; 41 fraternal benefit societies — 4 domiciled in New York, 36 foreign and 1 United States Branch of a Canadian Society; 12 retirement systems — 4 private pension funds and 8 governmental systems; nine governmental variable supplements funds; 199 charitable annuity funds; 25 employee welfare funds; 8 viatical settlement companies and 48 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, 1994-2004
(dollar amounts in billions)

Admitted Assets	2004	2003	1999	1994
Total	$2,080.6	$1,913.3	$1,637.6	$1,113.0
Percent increase from 1994		71.9%	47.1%	---
Type of asset				
Bonds	957.2	$881.3	$637.3	$525.7
Stocks	61.1	52.6	55.3	35.1
Mortgage Loans	159.6	149.8	140.7	147.0
Real Estate	12.3	12.7	17.7	33.8
Policy loans/liens	56.1	55.4	53.5	54.6
Short-term holdings	14.8	23.1	33.3	24.9
Other	819.5	738.4	699.8	291.9

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, 1999-2004
(in billions)

	2004	2003	1999
Assets	$2,080.6	$1,913.3	$1,637.3
Liabilities	1,963.3	1,805.8	1,553.9
Capital & Surplus	117.3	107.5	83.8

Source: New York State Insurance Department

Table 3
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1994-2004
(dollar amounts in billions)

Class of Business	2004	2003	1999	1994
Total insurance in force	$11,138.7	$10,529.7	$8,422.0	$6,700.7
Percent increase from 1994	66.2%	57.1%	25.7%	---
Ordinary	$6,205.3	$5,801.1	$4,557.9	$3,415.6
Group	4,864.4	4,668.0	3,789.8	3,203.3
Credit	62.6	53.9	67.0	73.9
Industrial	6.4	6.6	7.3	7.9

Source: New York State Insurance Department

Table 4
SOURCES OF INCOME*
Life Insurance Companies Licensed in New York State
Selected Years, 1999-2004
(dollar amounts in millions)

	2004		2003		1999	
Source of Income	**Amount**	**Percent of Total**	**Amount**	**Percent of Total**	**Amount**	**Percent of Total**
Group life	$16,620.5	5.5%	$15,340.5	5.3%	$12,876.2	4.2%
Group annuities	63,695.8	21.1	64,053.1	22.1	95,461.0	31.5
Group A & H	23,390.8	7.8	22,500.8	7.7	21,093.8	6.9
Ordinary life	45,302.9	15.0	42,485.9	14.7	42,086.3	13.9
Individual annuities	55,777.7	18.5	53,032.4	18.3	34,947.1	11.5
Individual A & H	4,860.9	1.6	4,504.5	1.6	3,965.1	1.3
Credit life	260.9	0.1	263.7	0.1	331.0	0.1
Industrial life	131.9	0.0	169.7	0.1	235.4	0.1
Total Premiums	**$210,041.4**	**69.6%**	**$202,350.4**	**69.9%**	**$210,995.9**	**69.5%**
Supplementary contracts	421.9	0.1%	360.2	0.1%	9,040.2	3.0%
Net investment income	74,817.4	24.8	72,603.7	25.0	67,947.7	22.4
Other income	16,396.8	5.4	14,631.9	5.0	15,405.7	5.1
TOTAL	**$301,677.5**	**100.0%**	**$289,946.2**	**100.0%**	**$303,389.5**	**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, 1999-2004
(in millions)

	2004	2003	1999
Total premiums	$207,341.1	$202,350.4	$210,996.0
Investment income	74,817.4	72,603.0	67,947.7
Supplementary contracts	421.9	360.2	9,040.2
Other income	19,097.2	14,631.9	15,405.6
Total income	301,677.5	289,945.5	303,389.5
Net gain from operations	13,159.7	13,842.1	9,866.5
Net income	13,851.5	12,419.3	11,034.0

*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, 1994-2004
(dollar amounts in billions)

Insurance In Force	2004	2003	1999	1994
Total	$1,514.3	$1,420.7	$1,110.7	$803.5
Percent increase from 1994	88.5%	76.8%	38.2%	---
Class of business				
Ordinary	$937.9	$887.6	$644.9	$477.6
Group	568.9	525.1	458.4	317.8
Credit	6.9	7.2	6.5	7.2
Industrial	0.6	0.7	0.8	.9

Source: New York State Insurance Department

Table 7
ADMITTED ASSETS/INSURANCE IN FORCE
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1994-2004
(dollar amounts in billions)

Domestic Life Insurers	2004	2003	1999	1994
Admitted assets	$772.8	$716.2	$585.6	$400.3
Percent increase from 1994	93.1	78.9	46.3	---
Insurance in force	$4,582.2	$4,245.1	$3,506.5	$2,523.5
Percent increase from 1994	81.6	68.2	39.0	---

Source: New York State Insurance Department

4. Licensed Fraternal Benefit Societies

At the close of 2004, 42 fraternal benefit societies were licensed to conduct insurance business in New York State. Of these, 5 were domestic, 36 were foreign and 1 was an alien society. In the ten-year period ending December 31, 2004 the admitted assets of licensed societies rose from $41.2 billion to $73.9 billion, an increase of 79%. Insurance in force rose $82.2 billion over the period to $289.0 billion, an increase of 40%.

Table 8
FRATERNAL BENEFIT SOCIETIES
Selected Years, 1994-2004
(in billions)

Fraternal Benefit Societies	2004	2003	1999	1994
Admitted assets	$73.9	$69.1	$52.9	$41.2
Insurance in force	$289.0	$280.0	$247.9	$206.8

Source: New York State Insurance Department

5. Private Retirement Systems

At the close of 2004, four private retirement systems were under the supervision of the Insurance Department.

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 2004, the assets of these four private pension funds totaled approximately $183 billion. The following table shows data for the private pension funds for selected years from 1994 to 2004:

Table 9
PRIVATE PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1994-2004
(in millions)

Private Pension Funds	2004	2003	1999	1994
Total admitted assets	$183,482.7	$162,043.6	$186,596.9	$65,821.2
Payments to annuitants and beneficiaries	$11,573.9	$9,097.7	$9,431.0	$2,564.6

Source: New York State Insurance Department

6. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Insurance Department at the close of 2004 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 2004 were approximately $289 billion. During the period from 1994 to 2004, the assets of these retirement systems increased at the compound rate of 6.5% 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 2004 increased by 12% from its 1994 level, while the number of pensioners increased by 28% 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, 2004 totaling $3.0 billion.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1994 to 2004:

Table 10
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1994-2004
(in millions)

Public Retirement Systems & Pension Funds	2004	2003	1999	1994
Total admitted assets	$288,771	$247,681	$301,225	$152,433
Payments to annuitants and beneficiaries	$15,454	$14,081	$10,938	$7,487

Source: New York State Insurance Department

7. Segregated Gift Annuity Funds for Charitable Organizations

At the end of 2004, 189 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, 2004, admitted assets of these funds increased by 374% and the annual payments increased by 390%. This reflects the rapid growth in the number of licensed societies during the period under review.

Table 11
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1994-2004
(in millions)

Segregated Gift Annuity Funds	2004	2003	1999	1994
Total admitted assets	$1,720.4	$1,444.5	$873.9	$363.1
Annual payments to annuitants	$153.1	$132.2	$73.8	$31.2

Source: New York State Insurance Department

8. Employee Welfare Funds

Twenty-four employee welfare funds covering 96,762 employees were supervised by the Department at the close of 2004. 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 $160.4 million in 2004. Benefits paid totaled $150.6 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 $8.8 million representing 5.5% 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 2004, seven companies were licensed or authorized to act as viatical settlement companies in New York.

As of December 31, 2004, these companies had combined assets of $28.4 million, with the largest accounting for $14.1 million. The assets primarily consisted of life insurance policies purchased, cash and accounts receivable. Costs of purchasing these policies amounted to $8.2 million, which comprised about 78.8% of the $10.4 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 of Insurers Conducted in 2005

Table 12
EXAMINATIONS CONDUCTED
Life Bureau
2005

		Regularly Scheduled		Other	
		Initiated			
	Total	In 2005	Prior to 2005	Special	On Organization*
Life insurance companies	36	21	13	1	1
Fraternal benefit societies	2	1	1	0	0
Retirement systems and pension funds	6	4	2	0	0
Segregated gift annuity funds of charitable organizations	30	30	0	0	0
Viatical settlement companies	1	1	0	0	0
Welfare funds	16	16	0	0	0
Total	**91**	**73**	**16**	**1**	**1**

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

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 2005, there were 485 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, 2005

Life – New York	86
Life – Other States	57
Accredited Reinsurers	48
Fraternals – New York	4
Fraternals – Other States	36
Fraternals – Canadian, U.S. Branch	1
Charitable Annuities	199
Retirement Systems	21
Viaticals	8
Welfare Funds	25
Total	**485**

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 2004 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 2004, the real estate unit submitted six 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 the acquisition and construction of home office real estate, real estate valuation, leases between members of holding company systems and mortgage loan participation agreements.

13. Actuarial Submissions and Reviews

The actuarial staff of the Life Bureau's New York City office review 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 GICs); 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").

Early in 2005 a foreign mutual life insurer announced it was planning to reorganize as a mutual holding company (a form of organization not permitted for domestic insurers under New York law). The actuarial unit assisted in the analysis of data to assure adequate disclosures would be made and New York policyholders would be treated fairly under the reorganization plan.

Members of the New York City 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 was involved in various activities and initiatives related to the public employee retirement systems, including on-site field examinations of several systems. More detail is provided in Section 6 of this report.

Separate account submissions continued to comprise the majority of filings reviewed by the actuarial staff. The number of such submissions increased by 5% in 2005 over 2004. 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 increase the insurers' financial risk. 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 next greatest number of actuarial filings again in 2005. We experienced a small (5%) decrease in such submissions in 2005.

There were 11 submissions of investment income allocation methodology in 2005, 31% fewer than in 2004.

There were 23 submissions related to company mergers and acquisitions during 2005, nearly triple the number received in 2004. This is indicative of the increased merger and acquisition activity that has been reported in the industry press.

A mere two submissions during 2005 related to synthetic GICs – one from a large domestic insurer and the other from a large foreign insurer. This is a continuation of the trend observed since the Department first approved the issuance of synthetic GICs in 1995, namely very little marketplace demand for the product.

14. Insurable Interest

It has come to the Department's attention that a number of proposed transactions involving the financing of the purchase of life insurance raise insurable interest issues. Many of the proposed transactions have provisions that may call into question whether or not insurable interest exists at the time life insurance is procured or effectuated as required by Section 3205 of the New York Insurance Law.

The Department is concerned that the legal requirements and the public policy goals regarding insurable interest and the issuance of life insurance not be distorted, undermined or circumvented by these arrangements. The Department is working with its licensees and other interested parties to ensure that such legal requirements and public policy goals are met.

15. Market Conduct

A new unit was formed in the Life Bureau to establish a risk assessed market conduct analysis of regulated entities. Working with licensed insurers in creating a market conduct profile and through use of the NAIC's Level 1 and Level 2 checklists, the risk assessment review consists of analysis of market conduct activities in areas such as sales and marketing activities, policyholders services, compliance and corporate governance.

16. Life Bureau – Albany

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

In 2005, the Life Bureau in Albany received 2,077 policy form submissions (files) consisting of 11,030 life and annuity policy forms and other financial products offered by life insurance companies, fraternal benefit societies, charitable annuity societies and viatical settlement companies as indicated in Table 14 below. This is an 11% increase in files and a 47% increase in forms submitted over 2004. Of the 2,077 policy form submissions received in 2005, 25% were prior approval, 56.7% were certified (including deemer) and 18.1% were out-of-state filings.

In 2005, the Life Bureau processed a total of 2,113 policy form submissions (files) consisting of 10,842 policy forms as indicated in Table 14. Of the 10,842 forms processed in 2005, approximately 20.9% were submitted for prior approval, 49.5% were submitted under a certified filing procedure and 29.6% were filed for out-of-state use. Of the prior approval files disposed in 2005, approximately 56.7% of the forms were approved and 40.8% were either rejected or withdrawn. Of the certified files disposed in 2005, approximately 66% of the forms were approved and 34% were either rejected or withdrawn. Of the out-of-state files disposed in 2005, approximately 69.6% of the forms were approved and 30.4% were either rejected or withdrawn.

Table 14
NUMBER OF FILES & POLICY FORMS
RECEIVED AND PROCESSED BY TYPE
LIFE BUREAU, 2005

PRODUCT TYPE	RECEIVED		PROCESSED	
	Files	Forms	Files	Forms
Individual Life	711	4,870	697	4,558
Group Life	196	1,030	191	1,019
Individual Annuity	694	2,871	703	2,891
Group Annuity	345	1,229	397	1,464
Credit Insurance	17	241	25	279
Viatical Settlement	2	40	1	16
Miscellaneous	112	749	99	615
TOTAL	**2,077**	**11,030**	**2,113**	**10,842**

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 625 other filings related to the policy form approval process and products offered for sale in New York, including 185 rate and actuarial filings, 173 inquiries and complaints, 62 FOIL requests, 15 prefilings under Circular Letter No. 64-1, 39 compensation filings and 90 annual illustration certification filings.

Table 15
POLICY FORM-RELATED FILINGS RECEIVED IN 2005

Fraternal Benefit Societies (Constitution, Articles of Incorp., Bylaws, etc.)	7
Calculation of Life Estates	12
Circular Letter No. 64-1	15
Compensation Filings	39
FOIL Requests	62
Inquiries & Complaints	173
Rate & Actuarial Filings	185
Violations & Market Conduct	31
Informational Filing	11
Regulation 74 Illustration Certification Filings	90
Total	**625**

c. Speed to Market

During 2005, 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 2005, the Life Bureau posted the updated Group Fixed and/or Variable Annuity Outline, the updated Charitable Gift Annuity outline 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 letters. The streamlined certified filing procedure introduced in Circular Letter No. 6 (2004), effective September 1, 2004, has been well received by the industry. The Certified Circular Letter No. 6 (2004) process replaced the Certified Circular Letter No. 27 (2000) process. The new Circular Letter eliminated the requirement in Circular Letter No. 27 (2000) for filing a detailed product checklist with the Department and made the triage procedure for regular prior approval submissions unnecessary.

Certified submissions grew substantially during 2005. During the year, the Life Bureau received 1,181 Circular Letter No. 6 (2004) certified files consisting of 5,348 policy forms. In addition, the Life Bureau received 8 deemer filings authorized by Section 3201(b)(6) consisting of 16 policy forms. The 1,189 certified filings (and 5,364 forms) constitute more than 65% of all files (and forms) submitted for prior approval and sale in New York. This is an increase from 45% in 2004.

During the year, the Life Bureau processed the 5,348 Circular Letter No. 6 (2004) policy forms in an average of 30.2 days. Of the total 5,348 Circular Letter No. 6 (2004) policy forms, approximately 3554 were approved, 1646 were rejected and 148 were withdrawn. By the end of 2005 all but 2 Certified Circular Letter No. 27 (2000) files had been processed. The remaining 2 files were processed in early 2006.

As noted above, the Life Bureau has continued to process policy forms submitted under the deemer authority in Section 3201(b)(6) of the Insurance Law. However, the number of forms processed under Section 3201(b)(6) has been steadily declining from the high of 478 in 2001.

d. Post-Approval Review

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

In 2005, the Life Bureau refined and expanded its Post-Approval review process. As part of the Post-Approval Review process, the Life Bureau began selecting files that were approved under the Circular Letter No. 6 (2004) or Circular Letter No. 27 (2000) certified processes to receive full post-approval reviews. The Life Bureau expects to continue the expansion of the post approval review process in 2006.

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 2005, there were 78 life insurance companies using SERFF to make policy form submissions. During 2005 another 24 companies used SERFF for the first time. In 2005, insurers submitted 770 files, consisting of 5,339 policy forms through SERFF. This total represents approximately 37.1% of all policy form filings and 48.4% of all policy forms submitted in 2005. 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. During the first six month of 2005, 32.3% of the submissions were through SERFF; that percentage increased to 41.8% in the final six months of 2005.

f. Nonforfeiture Law Interest Rate Change – Web Site Guidance - Update

Chapter 596 of the Laws of 2004 amended several provisions of the nonforfeiture law for annuities in Section 4223 of the Insurance Law. Among other things, the Laws of 2004 replaced the fixed 1.5% minimum nonforfeiture interest rate with an index rate that is based upon the five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, within the 15 months prior to the contract issue or redetermination date reduced by 125 basis points. The minimum interest rate is capped at 3% and cannot fall below 1%. The minimum interest rate at issue must be specified in the contract and the basis and calculation for setting such rate must be filed with the Superintendent. If the contract provides that the minimum rate of interest may be redetermined, the redetermination date, basis, calculation and period must be stated in the contract.

The index rate approach was called for because of the historic low interest rate environment. Some insurers had difficulty supporting the 3% minimum interest rate required by Section 4223. The index approach will result in a guaranteed minimum interest rate at issue that reflects the then current market. These changes are needed to ensure the availability of deferred annuity products in New York and to protect the financial health of licensed life insurers.

In March 2005, the Life Bureau posted guidance on the Department's Web site to assist the industry in making form filings that utilize the new indexed minimum interest rate. The posting provides guidance for the filing of the companies' procedures for determining the minimum nonforfeiture interest rate applicable to the contract at issue, special filing guidance for contracts where the minimum interest rate is subject to periodic readjustment over the life of the contract, guidance and parameters on the

use of variable material to comply with Section 4223 and special guidance for forms which had been previously approved with a fixed 3% guaranteed minimum interest rate.

g. Proposed Regulation 174 - Unemployment Lapse Protection Benefit for Life Insurance

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.

During 2005, Life Bureau staff drafted Regulation 174. 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. In early 2006, Life Bureau staff will submit Regulation 174 to the Governor's Office of Regulatory Reform for their review.

h. Regulation 143 - Accelerated Death Benefit

Regulation 143 sets forth the rules that implement Section 1113(a)(1) of the Insurance Law with respect to accelerated death benefits. In 1991, the Legislature amended Section 1113(a)(1) to permit an accelerated death benefit to be paid under a life insurance policy upon either (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. In 1997 and 2000 respectively, the Legislature amended Section 1113(a)(1) to add two additional triggers for payment of an accelerated death benefit if the insured becomes chronically ill as defined in section 7702B of the Internal Revenue Code. The 1997 amendment added section 1113(a)(1)(C) which allows for the acceleration of the death benefit based on certification by a licensed health care practitioner that the chronic illness requires continuous care for the rest of the insured's life. The 2000 amendment added section 1113(a)(1)(D) which allows for the payment of accelerated death benefits without regard to whether the chronic illness requires continuous care for the rest of the insured's life. The (D) trigger also requires that the insurer issuing such a policy be a qualified long term care insurance carrier under section 4980 of the Internal Revenue Code. Both 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.

During 2005, in consultation with the life insurance industry, Life Bureau staff completed the drafting of substantial revisions to Regulation 143 which establish rules for the implementation of the two new accelerated death benefit triggers. To a great extent, the revisions consist of provisions that were added or amended to comply with the above referenced sections of the Internal Revenue Code, certain provisions of the NAIC Model Act and Model Regulation (as required under section 4980 of the Internal Revenue Code) and other applicable statutes and regulations. The revisions also provide important disclosures to consumers about these benefits and to help ensure favorable tax treatment. Regulation 143 became effective on December 7, 2005.

The availability of these new benefits provides consumers with another financial resource to help pay the significant and increasing costs associated with long term care expenses. As such, these benefits provide an additional financial vehicle to help address the significant public policy concerns regarding long term care issues.

i. 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.

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. A COLI bill introduced in the U.S. House of Representatives in 2005, which provides for the taxation of the death proceeds of COLI under certain circumstances, also utilizes the Internal Revenue Code's definitions of highly compensated individual and highly compensated employee. In 2005, the Department continued to promulgate Regulation 180 on an emergency basis.

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

In 2005, national attention continued 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. Federal legislation was introduced that would clarify jurisdiction over sales on military bases. The legislation (the Military Personnel Financial Services Protection Act) passed the House of Representatives in June 2005, but at the time of writing had not passed the Senate. The Government Accountability Office, which had surveyed the Department in 2004, issued a report entitled *Financial Product Sales: Actions Needed to Better Protect Military Members* GAO-06-023 in November 2005 that appears to draw upon those survey responses. Although it does not appear that many of the improper practices occurred in New York, the Life Bureau will work closely, as needed, with the NAIC and the Department of Defense to curb such improper sales and practices.

k. Guaranteed Living Benefits – Update

During 2005, the Life Bureau continued to see a significant number of variable annuity contract submissions containing guaranteed living benefits. 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.

In March 2005, the Life Bureau posted on the Department's Web site the Group Fixed and/or Variable Annuity outline which contains guidance relative to the VAGLBs. This outline was drafted in consultation with the Life Insurance Council of New York (LICONY). A major focus of the guidance is disclosure. Since the VAGLBs are so complex, it is important that the policy forms provide a clear explanation of the benefit being provided, the full cost of that benefit and any limitations or restrictions which arise as a result of electing the VAGLBs. Often times there are significant limitations on allocations and transfers among the fixed account and the variable subaccounts associated with election of the VAGLBs. In addition to the guidance posted on our Web site, it is anticipated that related issues will be addressed in the next revision of Regulation 47 "Separate Accounts and Separate Account Annuities".

l. Long Term Care Study Group and Legislative Report

In August 2004, the Legislature directed the Department, in consultation with the State Office for the Aging and the Department of Health, to study and report on the use and development of insurance product options designed to assist policyholders in adequately preparing for the costs of long term care services that may be needed. The Life Bureau worked in conjunction with the Health Bureau, the lead bureau on the study, on all portions of the project pertaining to life insurance and annuities. The Life Bureau prepared, in large part, the section of the report to the Governor and Legislature entitled Combined Long Term Care and Life Insurance and Annuity Products. The section discusses the potential use of such combination products as well as the use of accelerated death benefits that include a long term care trigger, option to purchase riders and other mechanisms by which life insurance can be used to support long term care needs.

A copy of *Long Term Care Options in New York State: A Report to the Governor and Legislature* is available on the Department's Web site.

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

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 Life Bureau has drafted the proposed amended regulation and awaits clearance from the Governor's legal staff. Once the proposed amended regulation has received clearance from that office, the Department expects to promulgate the amended regulation in 2006.

n. Statutory Examinations

The Reserve and Risk Management Actuaries in the Life Bureau (Albany) continue to expand their analysis of life insurers' risks beyond the traditional analysis of minimum statutory formula reserves and asset/liability matching. For the Bureau's domestic insurers this analysis ultimately culminates in the Department issuing the insurer a Certificate of Reserve Valuation. Historically, the Bureau has relied on the requirements of Regulation 126 to ensure reserve adequacy under moderately adverse

conditions. Regulation 126 requires asset adequacy analysis, which necessitates the need to consider asset and liability cash flows under various economic scenarios. Given the continued volatility of economic conditions, the Bureau has expanded its series of additional sensitivity tests, in addition to the required asset adequacy analysis, for variables related to policyholder behavior and investment assumptions. This type of additional analysis has proven to more 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. The 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.

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.

In addition, the Bureau continued to be heavily represented in the activities of the NAIC. During the year, the Bureau was very active in the establishment of principles-based minimum reserve and capital standards for Variable Annuities with Guaranteed Benefits which begin to go into effect this year. In addition, the Bureau was the leader in closing a loophole in the NAIC's Actuarial Guideline 38 (AG38) for universal life insurance with secondary guarantees (secondary guarantees). In December 2004, the Department adopted an emergency amendment to Regulation 147 which incorporates the guidance the Bureau suggested with respect to secondary guarantees and AG38. This stance helped bring industry representatives and regulators together to develop a new AG38 version that is compliant with the law and helps alleviate solvency concerns related to these secondary guarantee products. The Bureau continues to work with the NAIC to create a framework for a new principles-based approach to reserve and capital standards to replace the current formula-based framework for life insurance. Because a change in the law will be required, 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.

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 2005. Going forward, the Bureau will continue efforts to further improve its focus on the timely identification of risks faced by the insurance industry.

The Bureau has updated Regulation 56 so that it applies to all long-duration health insurance issued by life, health, and property insurers.

B. PROPERTY BUREAU

1. Entities Supervised by the Financial Regulation Division

As of December 31, 2005, the Financial Regulation Division side of the Property Bureau exercised regulatory authority over 1,678 insurer and noninsurer entities.

The Bureau regulated 993 insurer entities as of year-end 2005. Table 16 provides a breakdown.

Table 16
ENTITIES REGULATED BY PROPERTY BUREAU
2005

Number of Regulated Entities	Type of insurer/reinsurer/entity
82	Accredited reinsurers*
19	Advance premium co-operatives
25	Assessment co-operatives
10	Associations, pools, and syndicates
33	Captive insurers
15	Financial guaranty insurers
26	Mortgage guaranty insurers
1	Property Insurance Underwriting Association (FAIR Plan)
748	Property/casualty insurers
25	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, 2005, the Department recognized 49 active Lloyd's syndicates as accredited reinsurers.

In addition, the Bureau oversaw the operation of 84 risk retention groups in 2005, 194 reinsurance intermediaries, and 407 managing general agents.

The Property Bureau received 32 applications for licensing and seven applications for recognition as accredited reinsurers during 2005. Twenty-two insurers were newly licensed including 3 domestic stock insurers, 1 domestic title insurer, 1 financial guaranty insurer, 1 foreign mutual insurer, 2 foreign title company, 1 foreign reciprocal insurer and 13 foreign stock insurers. At the close of the year there were domestic applications pending for 6 domestic stock companies, 1 domestic reciprocal insurer, 1 domestic financial guaranty insurer, 4 domestic title companies and 1 domestic mutual company. There were also 28 foreign stock insurers of which there were 4 foreign title insurers and 1 US Branch had license applications pending with the Department. In addition, there were 4 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 2004 by all New York-licensed property and casualty insurers aggregated totaled $301.7 billion, of which 77.7% 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
1999-2004
(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
1999	647	$146,569	174,440	0.8	71	$55,697	$88,998	0.6
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

Source: New York State Insurance Department

b. Underwriting Results

Results for 2004 show a **net** underwriting gain of $1.5 billion for stock companies and a **net** underwriting gain of $2.0 billion for mutual companies.

Table 18
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State
2001-2004
(dollar amounts in millions)

Year		Stock Companies		Mutual Companies	
		Number of Companies	Amount	Number of Companies	Amount
2001	Underwriting gains	123	$1,722.9	6	$33.3
	Underwriting losses	518	33,916.8	69	9,037.4
	No gain or loss	69	0.0	0	0.0
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	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 2001 to 2004 are as follows:

Table 19
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
2001-2004
(in millions)

Year		Stock Companies	Mutual Companies
2001	Net investment income	$23,689.3	$5,735.7
	Realized capital gains	3,353.5	565.6
	Unrealized capital gains	-7,792.4	-7,065.7
	Net gain/loss from investments	$19,250.4	-$764.4
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 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

Source: New York State Insurance Department

d. Underwriting and Investment Exhibit

During 2004, dividends to stockholders amounted to $13.1 billion, while dividends to policyholders aggregated to $1.3 billion (for both mutual and stock insurers). The contribution to surplus for 2004 for stock companies was $7.5 billion compared with $11.1 billion for 2003. However, the net increase in surplus for stock companies in 2004, $22.3 billion, was considerably lower than the comparable $31.7 billion 2003 increase. Likewise, the net change in surplus for mutual companies was $10.7 billion in 2004, down from $12.7 billion a year earlier. Net income increased considerably for both stock and mutual companies between 2003 and 2004.

Table 20
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Property and Casualty Insurers Licensed in New York State
2003 and 2004
(in millions)

	Stock Companies		Mutual Companies	
	2004	2003	2004	2003
Net gain or loss from:				
Underwriting	$1,516.6	-$6,639.3	$2,034.2	-$401.3
Investments [a]	28,359.0	26,907.7	6,844.5	5,143.6
Other income	-457.3	-567.5	186.7	-263.9
Net gain or loss	$29,418.3	$19,700.9	$9,065.3	$4,478.3
Less:				
Dividends to policyholders	492.3	589.7	772.2	742.6
Federal income taxes incurred	7,062.2	3,961.0	2,175.2	754.2
Net income	**$21,865.2**	**$15,150.3**	**$6,117.9**	**$3,489.5**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-$13,024.1	-$9,850.0	$0.0	$0.0
• Stock	-45.4	-468.9	0.0	0.0
US Branches – Net remittance to/from home office	11.0	-36.0	0.0	0.0
Total dividends and remittance	-$13,080.5	-$10,354.9	$0.0	$0.0
Unrealized capital gains/losses	8,625.8	15,159.3	4,225.8	8,783.1
Cumulative effect of changes in accounting principles	57.9	-36.0	0.0	0.6
Miscellaneous items	-2,666.3	660.4	325.0	384.9
Contributions to surplus	7,505.6	11,140.3	0.1	2.1
Total other sources	$442.6	$16,569.1	$4,550.9	$9,170.7
Net increase or decrease in surplus	**$22,307.8**	**$31,719.4**	**$10,670.8**	**$12,662.2**

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

e. Selected Annual Statement Data

From 2001 to 2004 aggregate (*i.e.,* stock and mutual) net premiums written increased by 28%; admitted assets increased 17.2%; unearned premium and loss reserves decreased -21.7%; and other liabilities decreased -56.2%. Capital and surplus to policyholders increased by 19.4%.

Table 21
SELECTED ANNUAL STATEMENT DATA
Property and Casualty Insurers Licensed In New York State
2001-2004
(dollar amounts in millions)

	2004	2003	2002	2001
	Stock Companies			
Number of insurers	698	706	737	710
Net premiums written	$234,377	$221,356	$205,017	$178,615
Admitted assets	675,485	623,466	626,595	574,923
Unearned premium & loss reserves	231,701	375,852	356,381	327,186
Other liabilities	14,021	43,067	88,631	72,353
Capital	2,292	4,767	5,209	5,025
Surplus to policyholders	213,611	203,973	181,615	175,383
	Mutual Companies			
Number of insurers	73	72	78	75
Net premiums written	$67,294	$66,070	$62,576	$57,015
Admitted assets	195,595	180,141	165,464	168,215
Unearned premium & loss reserves	81,789	79,687	77,708	73,067
Other liabilities	27,487	25,407	23,967	22,427
Surplus to policyholders	86,319	66,315	63,789	72,721

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 2004 as direct premiums written for all property/casualty lines increased by 3%. Major lines, *i.e.*, those with greater than $1 billion premium written in 2004, with at or above average year-to-year increases in 2004 included private passenger auto, commercial auto, other liability, homeowners multi-peril, and medical malpractice.

Table 22
DIRECT PREMIUMS WRITTEN BY PROPERTY/CASUALTY INSURERS
New York State — 2000-2004[1]
(dollar amounts in millions)

Property and Casualty Lines	2000	2001	2002	2003	2004	Percentage Change 2000-2004	Percentage Change 2003-2004
All Premiums Written	23,282	26,047	29,588	31,347	32,255	39%	3%
Private Passenger Auto	8,173	9,018	9,913	10,554	10,684	31	1
Bodily Injury and Property Damage Liability	5,352	6,040	6,718	7,247	7,304	36	1
Comprehensive and Collision	2,821	2,978	3,195	3,307	3,380	20	2
Commercial Auto	1,491	1,755	1,985	2,167	2,191	47	1
General (Other) Liability	2,148	2,447	3,478	3,741	4,018	87	7
Workers' Compensation	3,154	3,283	3,412	3,403	3,437	9	1
Commercial Multi-Peril	2,085	2,349	2,688	2,779	2,897	39	4
Homeowners' Multi-Peril	2,326	2,469	2,662	2,901	3,174	36	9
Financial Guaranty[2]	449	664	1,006	1,153	1,105	146	-4
Medical Malpractice	815	858	945	1,027	1,067	31	4
Inland Marine	519	607	660	690	734	41	6
Accident and Health	442	498	473	426	383	-13	-10
Ocean Marine	351	404	469	440	583	66	32
Fire	277	334	411	442	432	56	-2
Fidelity and Surety	357	380	358	433	427	19	-1
Allied Lines	135	173	256	312	289	114	-7
Mortgage Guaranty	170	203	231	231	231	36	0
Product Liability	111	140	162	165	158	43	-4
Boiler and Machinery	62	76	91	87	85	37	-2
Aircraft	47	56	78	141	71	50	-50
Credit	41	39	40	40	42	1	4
Burglary and Theft	10	9	8	10	14	38	38
All Other[3]	119	286	263	205	233	96	14

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 2004 Annual Statements of the companies authorized to transact business in the State of New York were filed for audit and analysis in 2005, 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 2,904 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 2005, the State Insurance Fund acquired stocks and bonds totaling $21.2 billion and sold stocks and bonds totaling $14.5 billion. Upon review, the Property Bureau recommended the approval of the acquisitions of $21.2 billion and the sales of $14.5 billion. In 2004, the Bureau recommended approval of acquisitions totaling $29.7 billion and sales totaling $18.7 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 917 companies in 2005. There were 16 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 2005, 99 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 2005, 119 holding company transaction files, and 248 holding company registration statements and amendments, were reviewed and closed by the Property Bureau. In addition, 15 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, 2004, there were 8 domestic and 7 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, 2001-2004
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2001	$1,894.7	8,223.1	0.23
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

Source: New York State Insurance Department

Table 24
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State, 2001-2004
(dollar amounts in millions)

Year		Number of Companies	Amount
2001	Underwriting gains	8	$791.6
	Underwriting losses	5	$50.4
2002	Underwriting gains	9	$970.3
	Underwriting losses	5	$28.1
2003	Underwriting gains	9	$1,301.1
	Underwriting losses	4	$26.2
2004	Underwriting gains	6	$1,219.0
	Underwriting losses	6	$96.5

Source: New York State Insurance Department

Table 25
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State, 2001-2004
(in millions)

	2004	2003	2002	2001
Net investment income	$1,253.7	$1,092.1	$1,125.1	$1,067.3
Realized capital gains	115.9	159.0	168.8	109.8
Unrealized capital gains	52.2	124.1	51.3	12.2
Net gain from investments	$1,421.8	$1,375.1	$1,345.3	$1,189.4

Source: New York State Insurance Department

Table 26
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Financial Guaranty Insurers Licensed in New York State
2001-2004
(in millions)

	2004	2003	2002	2001
Net gain or loss from:				
Underwriting	$1,122.5	$1,274.9	$942.1	$741.3
Investments [a]	1,369.5	1,251.0	1,294.0	1,177.1
Other Income	6.1	13.0	15.7	10.8
Net gain or loss	$2,498.2	$2,538.9	$2,251.8	$1,929.2
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	620.4	727.8	578.2	506.6
Net income	**$1,877.8**	**$1,811.1**	**$1,673.6**	**$1,422.7**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-880.3	-623.9	-442.2	-506.1
• Stock	0.0	0.0	0.0	-12.5
Total dividends and remittance	-$880.3	-$623.9	-$442.2	-$518.6
Unrealized capital gains	52.2	124.1	51.3	12.2
Cumulative effect of changes in accounting principles	0.0	0.0	11.1	-43.6
Miscellaneous items	-464.0	-346.5	-361.9	-390.5
Contributions to surplus	226.3	607.1	220.8	317.5
Total other sources	-$1,065.8	-$239.3	-$520.9	-$623.0
Net increase or decrease in surplus	**$812.0**	**$1,571.8**	**$1,152.6**	**$799.6**

[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
2001-2004
(dollar amounts in millions)

	2004	2003	2002	2001
Number of Companies	15	14	14	13
Exposure	$2,572,632.1	$2,253,613.0	$2,174,240.9	$1,855,915.0
Net premiums written	3,089.1	3,360.7	2,670.8	1,894.7
Admitted assets	31,402.2	27,659.0	25,595.3	22,690.8
Unearned premium & loss reserves	5,925.9	9,223.8	8,336.1	7,227.5
Other liabilities	4,925.4	7,641.0	7,855.3	7,240.1
Capital	181.7	246.7	247.0	231.0
Surplus to policyholders	11,357.0	10,794.2	9,403.9	8,223.1

Source: New York State Insurance Department

4. Mortgage Guaranty Insurance

At year-end 2004, 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
2001-2004
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2001	$3,211.1	$4,090.8	0.78
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

Source: New York State Insurance Department

Table 29
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Mortgage Guaranty Insurers Licensed in New York State
2001-2004
(in millions)

	2004	**2003**	**2002**	**2001**
Net gain or loss from:				
Underwriting	$949.3	$1,201.3	$1,525.6	$1,505.1
Investments [a]	797.0	809.7	798.3	746.9
Other Income	11.7	2.0	-2.6	9.3
Net gain or loss	$1,758.0	$2,013.1	$2,321.3	$2,261.4
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	295.2	628.0	824.7	350.3
Net income	**$1,462.8**	**$1,385.1**	**$1,496.6**	**$1,911.1**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-1,375.1	-677.6	-876.1	-258.4
• Stock	0.0	0.0	0.0	0.0
Total dividends	-$1,375.1	-$677.6	-$876.1	-$258.4
Unrealized capital gains	172.5	315.7	56.1	35.6
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	78.8
Miscellaneous items	750.5	-863.9	-1,203.2	-1,164.6
Contributions to surplus	-189.1	-276.5	47.6	10.5
Total other sources	-641.2	-1,502.3	-1,975.6	-1,298.1
Net increase or decrease in surplus	**$821.7**	**-$117.2**	**-$479.0**	**$613.0**

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

TABLE 30
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
2001-2004
(dollar amounts in millions)

	2004	2003	2002	2001
Number of companies	26	26	25	23
Net premiums written	$3,786.4	$3,849.0	$3,539.5	$3,211.1
Admitted Assets	21,562.9	20,511.8	19,279.3	17,102.7
Unearned premium & loss reserves	7,137.6	6,580.5	5,842.5	5,269.9
Other liabilities	9,895.5	10,369.5	9,637.0	7,741.9
Capital	68.5	70.5	66.5	62.0
Surplus	4,529.8	3,708.2	3,799.8	4,090.8

Source: New York State Insurance Department

5. Title Insurance

Nine domestic and 14 foreign companies were licensed to write title insurance in New York State at the close of 2004.

Table 31
SELECTED ANNUAL STATEMENT DATA
Title Insurance Companies
2001-2004
(dollar amounts in millions)

	2004	2003	2002	2001
Number of Companies	23	22	25	24
Net premiums written	$8,614.5	$8,203.1	$8,449.6	$6,175.8
Admitted assets	4,680.0	4,163.9	4,770.6	3,900.4
Liabilities	3,149.6	2,710.9	3,021.3	2,528.4
Capital	94.4	93.3	123.0	114.0
Surplus	1,530.3	1,453.0	1,749.3	1,372.0

Source: New York State Insurance Department

6. Advance Premium Co-operative and Assessment Corporations

At year-end 2004, there were 19 advance premium corporations under the supervision of the Property Bureau. The total number of advance premium corporations remained unchanged from 2003 to 2004. The net premium volume of the advance premium corporations increased by 7.2% from the prior year.

A total of 26 assessment corporations were under the Property Bureau's supervision at year-end 2004. The total number of assessment corporations remained unchanged from 2003 to 2004. The net premium volume of these 26 companies increased by 12.8% from the prior year.

During 2004, the Property Bureau initiated 12 examinations of the advance premium and assessment corporations.

Table 32
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Corporations
2001-2004
(dollar amounts in millions)

Year		Total	Advance Premium Corporations	Assessment Corporations
2001	Number of companies	46	18	28
	Total assets	$1,294.1	$1,079.0	$215.1
	Net premiums written	543.4	467.8	75.6
	Surplus funds	559.9	431.5	128.4
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

Source: New York State Insurance Department

7. Special Risk Insurers (Free Trade Zone)

Calendar Year 2004 was the 26th full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 182 licensed companies as of December 31, 2004. Net premiums written during the year amounted to approximately $1.1 billion, bringing the net premiums written since inception to approximately $8.9 billion. Net premiums written since inception are as follows:

Table 33
NET PREMIUMS WRITTEN
Special Risk (Free Trade Zone)
1978-2004
(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
Total	**$8,878.2**

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 Product 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, 2004, 74 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 2004, the 74 risk retention groups filing financial statements with this Department reported total nationwide direct premiums written of $1.4 billion and total nationwide net premiums written of $553.0 million. These risk retention groups reported direct premiums written of $225.8 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 2005 a total of 154 such examinations were conducted.

Table 34
EXAMINATIONS CONDUCTED
by the Financial Regulation Division of the Property Bureau
2005

	Regularly Scheduled			Other Financial Exams		
	Total	Started in 2005	Started Prior to 2005	Special	On Organi-zation[1]	Increase in capital[2] and other
Property and casualty insurers, including financial guaranty insurers	135	37 [4]	91	3	4	0
Other insurers and captives	13	2	10	0	1	0
Title and mortgage guaranty insurers	6	1	4	0	1	0
Total	**154**	**40** [4]	**105** [3]	**3**	**6**	**0**

[1] Examination conducted when insurer is first incorporated in New York State.
[2] Examination when insurer increases its capital.
[3] This total includes 38 reports with completed field work that were not filed as of 1/1/06.
[4.] This total includes two examinations which are as of 12/31/2005.

b. Electronic Audit Program – TeamMate

During 2005, 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 2005, 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, 2005, 49 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 during the past year. 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 is participating 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 2005 property and casualty financial statement.

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. Chapter 63 of the Laws of 2005 added Program 5 earmarking a $60 million funding for tax credit allocations starting 2007.

As of December 31, 2004, the CAPCOs invested approximately $174.3 million in 130 qualified businesses: Program One CAPCOs invested 64.4% of their total $100 million certified capital; Program Two CAPCOs invested 60.1% of their $30 million total; and Program Three CAPCOs invested 61.2% of their $150 million certified capital.

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-three qualified businesses had less than $1 million and 20 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 35.2% and 23.4%, respectively, of the total invested. Ninety-two "early-stage" businesses, as defined by the statute, received approximately $72.8 million (41.8% of total invested).

In the three programs combined, 54%, 13%, 8% and 13% of the numbers of businesses and 43%, 20%, 12%, 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 12% of the businesses and 15% of the dollars invested were in other regions of New York State. Thirty-two percent of Program Three dollars went to qualified businesses operating in New York County, 35% to businesses in Empire Zones and 34% to "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, overall the total number of employees in these businesses increased by 1,383 positions, and the number of New York employees increased by 478 positions,.

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 Property Bureau - Financial Division 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 Property Bureau - Financial Division annually reviews the filed audited financial statement 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, 2005, there were 39 service contract providers required to file audited financial statements with the Property Bureau - Financial Division, with 18 utilizing the New York Funded Reserve Account and 21 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 2005, the Market Regulatory Section of the Property Bureau received 6,096 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 Regulatory Section of the Property Bureau
2005

Line of Business	Rates & Rules	Policy Forms	Classes and Territories**	Totals
Fire and Allied Lines	350	238	2	590
Farmowners Multiple Peril	35	28	1	64
Homeowners Multiple Peril	302	161	0	463
Multiple Line	68	84	0	152
Commercial Multiple Peril	393	263	1	657
Inland Marine	149	154	0	303
Medical Malpractice	97	45	0	142
Earthquake	0	0	0	0
Flood	3	3	0	6
Rain	1	0	0	1
Workers' Compensation & Employer's Liability	154	94	0	248
Other Liability	941	904	1	1846
Motor Vehicle Insurance	789	332	0	1121
Aircraft	7	15	0	22
Fidelity & Surety	103	47	0	150
Glass	0	2	0	2
Burglary & Theft	72	46	0	118
Boiler & Machinery	32	28	0	60
Credit	3	8	0	11
Animal Mortality	3	3	0	6
Mortgage Guaranty	28	19	0	47
Residual Value	3	3	0	6
Title	6	4	0	10
Financial Guaranty	7	64	0	71
Prepaid Legal Service Plan	0	0	0	0
Warranty Reimbursement	0	0	0	0
Total	**3546**	**2545**	**5**	**6096**

* These figures include approximately 99 consent-to-rate filing applications; 32 group property & casualty filings; 106 manuscript policy form filings; and 32 rating plans submitted in 2005. During 2005, 306 policy form filings and 404 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 465 STM and 3,081 SERFF form and rate filings in 2005, which are included above.

** Classes and territories are often included in rates, rules and form filings.

b. Advisory Rate/Loss Cost Changes

The following table lists major revisions in rates or loss costs that were approved or acknowledged during 2005. Loss costs apply to the voluntary market and are advisory, *i.e.*, they do not have to be adopted by any insurer. They reflect the experience of all companies that report to the rate service organization. Loss costs are used by the majority of 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 2005 by Property and Casualty
Rate Service Organizations

	Percent Changes in Average State-Wide Rates
Automobile	
Automobile Insurance Plans Service Office	
Private Passenger Automobile	
(Rates Revised)	
Bodily Injury Liability	-5.7
Property Damage Liability	+2.2
Personal Injury Protection	-4.4
Uninsured Motorists	-7.5
Liability Subtotal	-4.0
Comprehensive	-28.6
Collision	-23.1
Physical Damage Subtotal	-25.0
Total All Coverages	**-5.6**
effective January 15, 2006	
Liability Other Than Automobile	
American Association of Insurance Services	
Commercial General Liability	
(Loss Costs Revised)	
Premises	-12.0
Products/Completed Operations	-19.0
Premises/Operations	+15.0
Total All Coverages	**-4.3**
effective April 1, 2006	
Insurance Services Office, Inc.	
Commercial General Liability	
Basic Limits Loss Costs Revised	
Manufacturers and Contractors	-13.1
Owners, Landlords and Tenants	+2.5
Total Premises/Operations	**-5.5**
Products	-4.5

Local Products/Completed Operations	+25.0
Total Products/Competed Operations	**+14.3**
Total All Coverages	**-4.5**
effective May 1, 2006	

Insurance Services Office, Inc.

Commercial General Liability	**+0.1**
Increased Limit Factors Revised	
effective January 1, 2006	

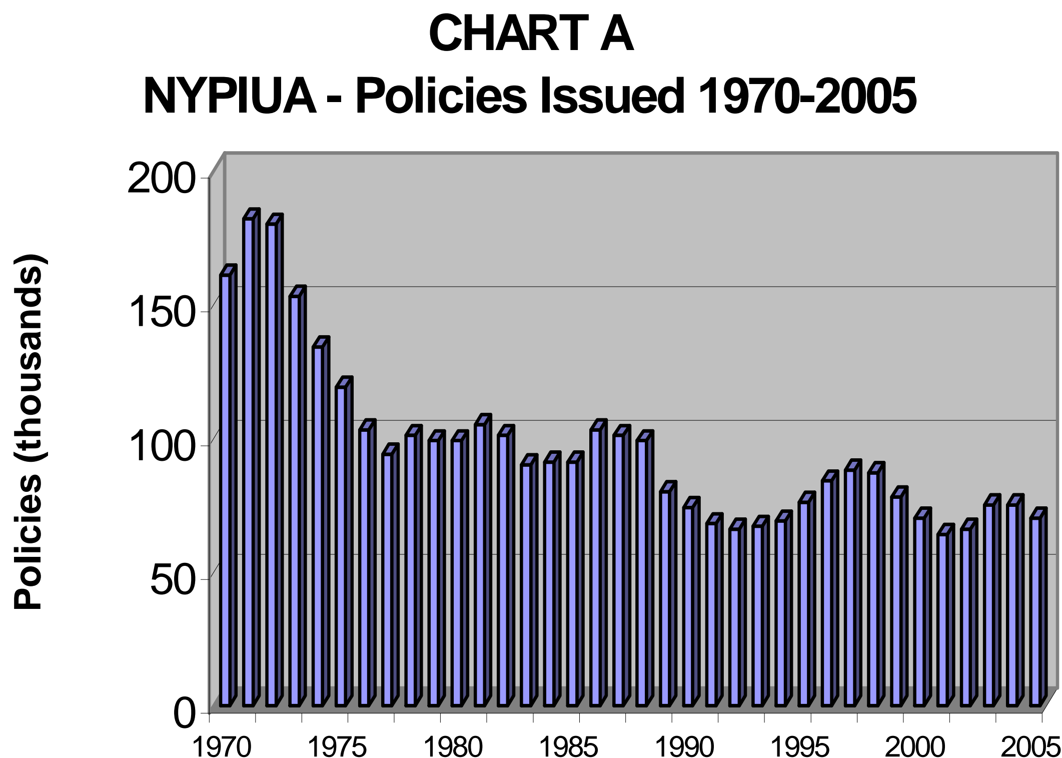
Underwriters Rating Board

Commercial General Liability	
Rate for Additional Insurer – Secured Creditors Endorsement	**+1.0**
effective March 4, 2005	

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 2005:



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 comparative 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 rewritten 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 declined. The number of policies issued by the Association has increased in 2002, 2003 and 2004. However, the number of policies issued in 2005 was 69,506, a decline of 5,795 policies from the prior year.

b. Financial Information

For the Fiscal Year ending December 31, 2005, the Association's Financial Report indicated premiums earned of $34,623,496 and a net underwriting gain of $9,965,390. Other income of $4,691,674, comprised of net investment income of $5,393,231; premium balances charged off $14,871; bond amortization loss of $518,820; loss on sale of securities of $218,952; grant program of $94,639 and policy installment fees of $143,725, resulted in net income before taxes of $14,657,064.

The change in assets not admitted of $13,806 and taxes incurred of $579,731 resulted in a net change in the Members' Equity Account of $14,091,139. The cumulative operating profit as of December 31, 2005 was $151,009,388. After all assessments (net of distribution of $40,268,192), the net Members' Equity Account totaled $110,741,196.

In accordance with Section 5405(c) of the New York Insurance Law, the Association estimated a surplus from operations of $2,998,000 for the Calendar Year 2006. 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, 2006, since its assets exceed its liabilities.

Based on the Department's own review of the data submitted, no estimated deficit from operations was approved for the Association for the Fiscal Year ending December 31, 2006.

c. Rate Revisions

During 2005, the Department approved rate revision for Farm Property classes of business. This revision resulted in an average statewide increase of 1.8%. This revision corresponds with loss costs revisions promulgated by the Insurance Services Office for the voluntary market. Also, the Department approved NYPIUA's adoption of Insurance Services Office's Terrorism Coverage loss costs.

d. Legislation in 2005

Chapter 156 of the Laws of 2005 extended the authority of the New York Property Insurance Underwriting Association to operate until June 30, 2006.

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, 2005 through June 30, 2006 policy year. The combined overall rate level effect was +7.0% above the rates established for the previous year. This overall effect represented an across-the-board +7.0% 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 +9.0%.

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 2005 to 2006 policy year, it was determined that no change was needed to these factors.

c. Physicians Excess Medical Malpractice Insurance for ’05–’06

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.

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 2005, all members of the Plan participated in the Medical Malpractice Insurance Pool of New York State (Pool).

For 2005, the Pool insured 8,931 individuals (including professional corporations) compared with 16,146 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)
2003-2005

Type of Insured	Policies as of December 31, 2005	Policies as of December 31, 2004	Policies as of December 31, 2003
Primary Insureds			
Physicians	603	587	561
Dentists	185	159	163
Podiatrists	79	79	73
Nurse-Anesthetists	6	7	10
Nurse-Midwives	18	15	9
Professional Corps.	31	33	29
Excess Layer Insureds			
First Layer Excess	6,788	13,743	1,701
Second Layer Excess	1,221	1,523	1,569

Note: Most of the decrease in the number of insureds in the Pool from 12/31/04 to 12/31/05 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 one voluntary insurer writing new First Layer Excess business effective July 1, 2005. The decrease in the Second Layer Excess coverage number was not actually a decrease in writings for this coverage, but rather due to a lag in MMIP entering renewals in their computer system. MMIP estimates that the number of MMIP Second Layer Excess policies as of 12/31/05 is approximately the same as last year.

In addition to these individuals, the Pool insured 372 facilities, the majority of which were nursing homes and adult homes, down from 376 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. However, the number of insurance companies that have a managed care premium credit program in place has decreased to 34 as of year-end 2005.

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 2005 there were 28 insurance carriers with approved drug-free workplace programs in place.

18. Insurance Availability Issues

While liability insurance coverages continued to be generally available during 2005, 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 2005 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 have been 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 prior 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.

b. Standby JUA Authority

The Omnibus Liability Bill enacted in June 1986 added Section 5412 to the Insurance Law to grant the Superintendent of Insurance the authority to activate a mandatory joint underwriting association (JUA) whenever he or she determines after a public hearing that there is no meaningful market available for a line of insurance.

19. Automobile Insurance

a. New York Automobile Insurance Plan

At year-end 2005, there were approximately 32% fewer vehicles in-force than year-end 2004 and approximately 52% fewer than year-end 2003. This decrease in the Plan population can be attributed to the 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 215 of the Laws of 2004, effective April 23, 2005, adds a new Article 28 to the Insurance Law entitled “Use of Credit Information.” Article 28 establishes limitations upon, and requirements for, the permissible use of credit information to underwrite or rate risks for personal lines insurance and requires personal lines insurers that use credit information for underwriting or rating to file the scoring model (or other scoring processes) including any revisions with the Department. Pursuant to the statute, such a filing remains the property of the insurer and is not subject to disclosure or production under FOIL. A third party may file the scoring model on behalf of an insurer. This statute prohibits an insurer from terminating a policy or increasing the renewal premium based on credit information. Additionally, an insurer may not reject an application solely on the basis of credit information. The Department has promulgated Regulation No. 182 (11 NYCRR 221) on an emergency basis to implement and clarify the provisions of the statute as mandated by this legislation.

c. No-Fault Motor Vehicle Insurance Law Activity – 2005

i. “Operation Auto Rates”

Last October, a team of 15 staff members from the New York Insurance Department and the New York State Division of Criminal Justice Services received a Governor’s Office of Employee Relations 2005 *Work Force Champions Award* for their successful implementation of a multi-faceted strategy to reduce auto premiums in New York State. For the year 2005, there were approximately $400 million in auto insurance premium reductions for nearly 70% of all New York drivers. The strategy included:

- the reduction of 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 through a revision to Regulation 68 that took effect on April 5, 2002;

- the adoption of the New York State Medicaid fee schedule to reform the reimbursement rules for durable medical equipment (such reform resulted in 3,000 less durable medical equipment fee schedule disputes filed for arbitration in 2005 when compared to 2004) through the promulgation of the Twenty-Eighth Amendment to Regulation 83 that took effect on October 6, 2004; and

- 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 16,150 at the close of December 2005) through a package of regulatory and administrative changes that took effect at the beginning of 2002.

ii. 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 Department is in the process of developing regulations in cooperation with the Department of Health and the Department of Education for the foregoing.

iii. Resolution Methods for Disputes between Insurers

Chapter 452 of the Laws of 2005, effective September 8, 2005 amended paragraph (b) and added new paragraph (d) of Section 5106 of the Insurance Law. The new legislation:

- includes provisions consistent with rules contained within Regulation No. 68-C that mandate how an insurer that provides No-Fault first party benefits is to proceed in the processing of No-Fault claims; and
- creates an expedited arbitration procedure for a claimant to resolve disputes to determine which of the two or more automobile insurers is to assume initial responsibility for processing a first-party No-Fault claim.

To effect the expedited arbitration procedure, the Department has promulgated the Third Amendment to Regulation 68-C and Fourth Amendment to Regulation 68-D on an emergency basis. The amendments:

- require specific wording for No-Fault denials of claims when an insurer determines that it is not the first notified insurer; and
- provide procedures for the special expedited arbitration that will be administered by the American Arbitration Association (AAA) to resolve disputes filed by a claimant to designate the automobile insurer responsible for processing first party benefits when there is a dispute between two or more automobile insurers over which insurer has primary responsibility.

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 still available both on Long Island and statewide. However, due to major disasters such as Hurricane Andrew, insurers revised their eligibility criteria by limiting the number of policies written, particularly for properties located close to the shore.

The Department continues to monitor carefully 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 taken 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 homeowners 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) on April 2, 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 are making use of the wrap-around coverage forms mentioned above.

Participating insurers have agreed to write 5,000 policies in total through the C-MAP program. From April 1996 through December 31, 2005, 4,322 policies have been issued through the program. The Department believes C-MAP will continue to help consumers secure vital homeowners coverage while still addressing insurers' coastal area concerns.

b. Legislation and Regulations

Chapter 215 of the Laws of 2004, effective April 23, 2005, adds a new Article 28 to the Insurance Law entitled "Use of Credit Information." Article 28 establishes limitations upon, and requirements for, the permissible use of credit information to underwrite or rate risks for personal lines insurance and requires personal lines insurers that use credit information for underwriting or rating to file the scoring model (or other scoring processes) including any revisions with the Department. Pursuant to the statute, such a filing remains the property of the insurer and is not subject to disclosure or production under FOIL. A third party may file the scoring model on behalf of an insurer. This statute prohibits an

insurer from terminating a policy or increasing the renewal premium based on credit information. Additionally, an insurer may not reject an application solely on the basis of credit information. The Department has promulgated Regulation No. 182 (11 NYCRR 221) on an emergency basis to implement and clarify the provisions of the statute as mandated by this legislation.

Chapter 156 of the Laws of 2005 extended the operating authority of NYPIUA to June 30, 2006, 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 will not be considered as part of the actual rate submission. However, any comparisons submitted by insurers and rate service organizations will 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 opened a satellite office in Mineola, New York. This office was designed to provide 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 200 Old Country Road 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 20 market conduct investigations, one Rate Service Organization examination (RSO) and one Joint Underwriting Association examination (JUA) in progress at the beginning of 2005 and 104 investigations and one RSO examination were initiated during the year. The Department closed 93 market conduct investigations and one JUA examination during the year. At year's end, 31 market conduct investigations and two RSO examinations were in progress. A total of 37 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $1,124,619. In addition, fines totaling $51,250 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 2005:

Table 38
MARKET CONDUCT INVESTIGATIONS/EXAMINATIONS
by Type of Investigation/Examination
2005

Type of Investigation	Outstanding at 1/1/2005	Initiated during 2005	Completed during 2005	Outstanding at 12/31/2005
Claims	10	5	7	8
Rating/Underwriting	6	2	6	2
Homeowners Underwriting	0	1	1	0
Title Ins. Underwriting	0	3	0	3
Auto. Salvage Claims	0	3	0	3
Privacy	0	3	3	0
Frauds	0	9	9	0
Desk Audits:				0
Section 3425 Compliance	2	32	22	12
Claims/Rating/Underwriting	2	2	1	3
Internet Web site Reviews	0	44	44	0
Total Investigations	**20**	**104**	**93**	**31**
Examinations:				
Rate Service Organization	1	1	0	2
Joint Underwriting Assoc.	1	0	1	0
Total Examinations	**2**	**1**	**1**	**2**

The following chart details the fines collected or processed and the stipulations entered into during Calendar Year 2005:

Table 39
MARKET CONDUCT FINES COLLECTED & PROCESSED
by Type of Investigation
2005

Type of Investigation	Number	Amount
Claims	10	$490,969
Underwriting/Rating	8	246,850
Desk Audits: Section 3425	17	307,250
Reg. 35-A	1	10,000
Homeowners Underwriting	1	69,550
Total	**37**	**$1,124,619**
Penalties: Failure to timely pay N.F. Arbitration Awards	205	51,250
Total Fines Collected & Penalties Processed	**279**	**$1,175,869**

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, 17 stipulated fines totaling $307,250 ($21,250 for 2002, $263,600 for 2003 and $22,400 for 2004) were collected during Calendar Year 2005 (included in the total fines collected in Section 20(a) above).

c. 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. 4 (1992) 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 2005, the Department processed fines totaling $51,250 from 69 insurers and self-insurers for their failure to pay arbitration awards in a timely manner in 205 instances.

d. Underpayments Remitted to Claimants

As a result of findings of previous market conduct investigations verifying compliance with Insurance Department Regulations Nos. 64 and 68, two insurers signed stipulations whereby they

agreed to review all automobile no-fault and/or automobile physical damage claim files as designated in the stipulations, and remit all underpayments to insureds and/or claimants. In accordance with the terms of the stipulations, these insurers remitted $159,635.

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. Forty-four insurer Web sites were reviewed during the course of 2005. 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 2006.

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 2005, 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 2005. 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 2006.

It should be noted that PricewaterhouseCoopers was hired by the NAIC and the Washington, D.C. Insurance Department to perform privacy reviews of nationally significant insurers starting in 2003. The New York State Insurance Department has agreed to accept PricewaterhouseCoopers' privacy reviews. The Market Conduct Unit confers with the Department's Office of General Counsel to determine whether the Department should or will accept the PricewaterhouseCoopers privacy review or perform its own review.

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 2005, the Market Conduct Unit initiated and completed a review of 9 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. Electronic Audit Program-TeamMate

The Market Conduct Unit has implemented the use of PricewaterhouseCoopers TeamMate software package. It is a robust electronic work paper package. All important information such as audit steps, audit findings, review notes, sign-offs and edit histories is contained in database tables. This allows real-time team based use as well as filtering and sorting for key information. This new computer program has provided greater consistency, efficiency and easy access.

An extensive amount of time and resources has been devoted to the development of and training in this program for market conduct purposes. All market conduct examiners received training on the TeamMate project in 2004 and 2005.

During 2005, claims investigations were performed using the TeamMate Audit Program. It is anticipated that all investigations will be performed using this program in the future. This program, once fully implemented, will facilitate consistency in audit procedures among different examiners and will eliminate the use of paper files since all the data will be electronically stored.

i. Title Insurance Investigations:

The Market Conduct Unit commenced a series of investigations into certain title insurer practices. Three of these investigations are still pending.

j. Automobile Salvage Claims Investigation:

The Market Conduct Unit commenced a series of investigations into the procedures and practices of certain insurers regarding the branding of titles as “rebuilt salvage” of insured private passenger motor vehicles determined to be total losses or constructive total losses. These investigations were initiated in response to a discussion with the New York State Attorney General’s Office in connection with a multi-state settlement for failure to properly comply with branded title requirements.

As a result of legislation introduced in 1999 the Department of Motor Vehicles (DMV) developed a process for branding the titles of vehicles that were less than eight years old and the required repairs equal to 75% or more of the vehicle's value prior to the loss. All such vehicles are required to have their titles branded by the DMV as salvage. Section 3412-NYIL, which governs automobile salvage, is applicable to all physical damage losses incurred on policies covering private passenger automobiles registered in the state since 1973.

Four investigations found that the insurers were generally in compliance with the objectives of the DMV regulatory requirements. However, the law and regulation pertinent to the automobile salvage process needs to be enhanced to provide more protection for the public, particularly with respect to vehicles involved in accidents outside the State of New York that result in total loss.

k. Market Analysis Review System:

The Market Conduct Unit 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 2005, Market Analysis reviews of 17 companies were conducted, resulting in 6 companies being targeted for Market Conduct field investigations and 5 companies requiring further analysis of financial and market findings. One of the goals of the Market Analysis Program for 2006 is to standardize baseline factors to enable states to identify issues of concern and to prioritize activities in a uniform manner. The Market Conduct Unit participated in meetings and telephone conferences to discuss collaborative issues encountered by the various states of the National Association of Insurance Commissioners (NAIC) Market Analysis Working Group. The unit expects to continue to participate in the development of the Market Analysis process in the coming year.

22. Excess Line Insurance

Potential insureds 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.

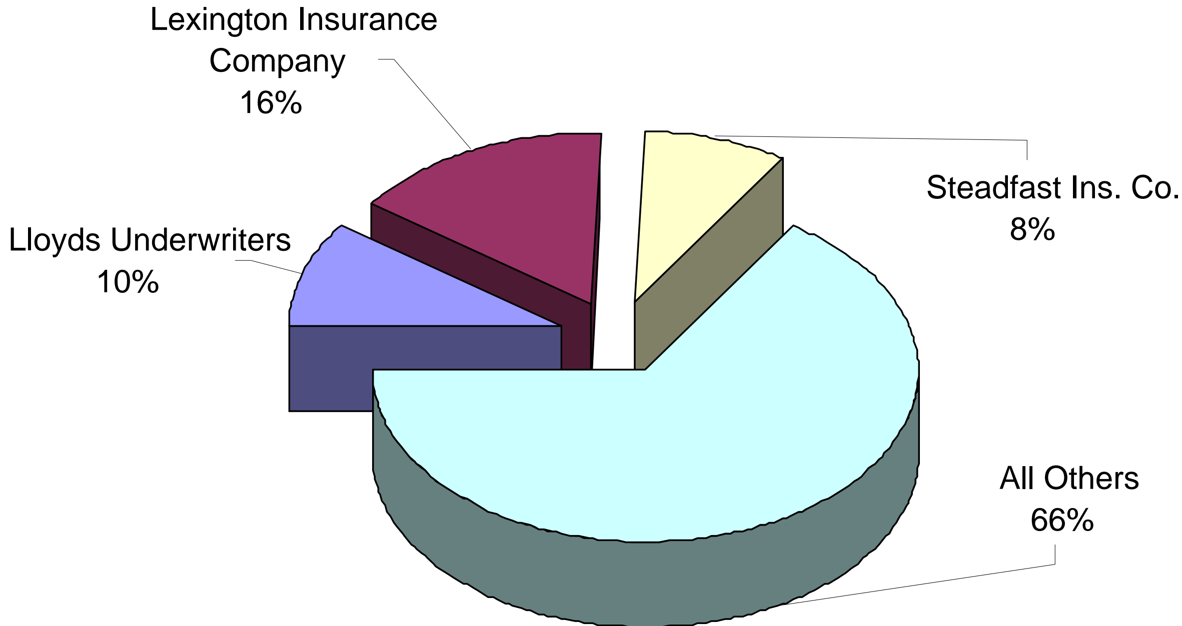
Since insurers providing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained from excess line brokers through tax statements required to be filed no later than March 15 of each year relating to business written during the previous Calendar Year. For Calendar Year 2005, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $5.127 billion, of which approximately $2.769 billion was attributable to risks located or resident wholly in New York State. These excess line premiums generated $ 99,670,251 in excess line premium tax revenue for the state, an increase of $ 5,716,479 over the previous year.

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 1,625 licensed excess line brokers and approximately 647 who are active and filed approximately 137,993 affidavits for the year 2005. Thirty five complaints and inquiries and 1,208 filings regarding excess line business were received in 2005.

In 2005, there were approximately 199 unauthorized insurers eligible to do business in New York pursuant to Regulation 41. This includes 80 foreign insurers; 33 alien insurers; and Lloyd's, with 78 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 2005, the Unit reviewed 117 EL-1 filings, 110 annual statements and 8 trust agreements.

The following is a chart of the percentage of total 2005 excess line premium writings attributable to the three largest excess line insurers in New York State.

CHART B: Top Three Excess Line Insurers by Percentage of Premium Volume, 2005



a. Business Written in New York

Excess line premiums written in New York State increased from $2.610 billion in 2004 to $2.769 billion in 2005, a gain of 7.57%. The largest dollar increase over the previous year occurred in the other liability line, up by $202 million in 2005, of which $102 million is from manufacturers and contractors and $95.9 million is from owners and contractors protective. Other increases included auto physical damage, up by $20.5 million; fidelity and surety, up by $11.2 million; and inland marine, up by $5.7 million. The largest percentage increase, 120% occurred in a relatively small-volume line, aircraft physical damage, up by $4.7 million over the previous year.

The largest dollar decline over the previous year occurred in the errors and omission lines, down $71.8 million, a decrease of 21.47%. The largest percentage decline, 46% occurred in a relatively small-volume line, malpractice, down by $5.5 million over the previous year.

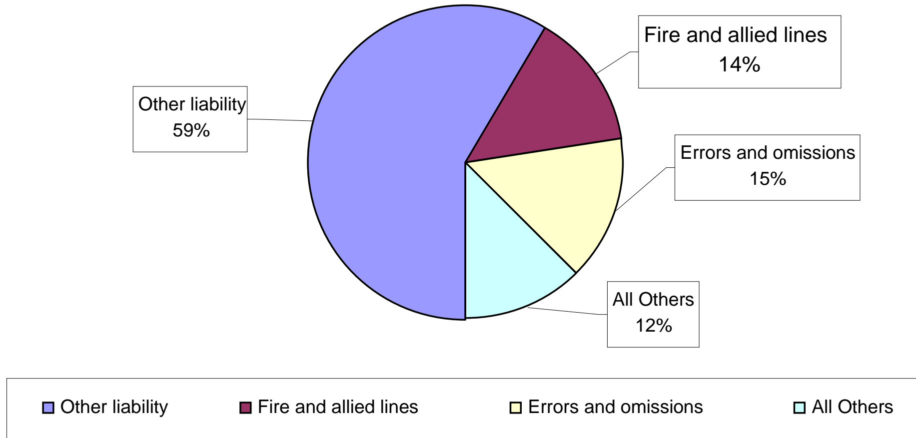
Table 40
EXCESS LINE PREMIUMS WRITTEN
Risks Located in New York State
2001-2005
(dollar amounts in thousands)

Line of business	2005	2004	2003	2002	2001
Fire and allied lines	$ 395,848	$ 393,807	$ 425,417	$ 296,786	$ 4,777
Inland marine	57,889	52,162	43,462	30,308	26,181
Auto liability	16,758	15,757	15,629	4,154	7,243
Malpractice	17,768	23,319	12,089	9,392	5,683
Errors and omissions	408,213	480,076	334,685	221,245	159,651
Commercial multiple peril (excluding fire)	111,716	111,068	93,737	82,315	59,723
Other liability	1,621,751	1,419,191	1,079,015	603,313	276,432
Auto physical damage	41,834	21,291	17,163	19,055	18,491
Aircraft physical damage	5,770	1,049	2,651	233	2,736
Burglary and theft	13,308	10,369	3,613	5,503	3,722
Fidelity and surety	34,331	23,116	14,844	5,040	22,340
Other lines	43,432	58,621	54,794	46,964	48,418
Total	$2,768,618	$2,609,827	$2,097,100	$1,324,307	$685,398
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	7.88%*	7.48%	6.25%	4.29%	2.56%

*Estimated
Source: Excess Line Association of New York

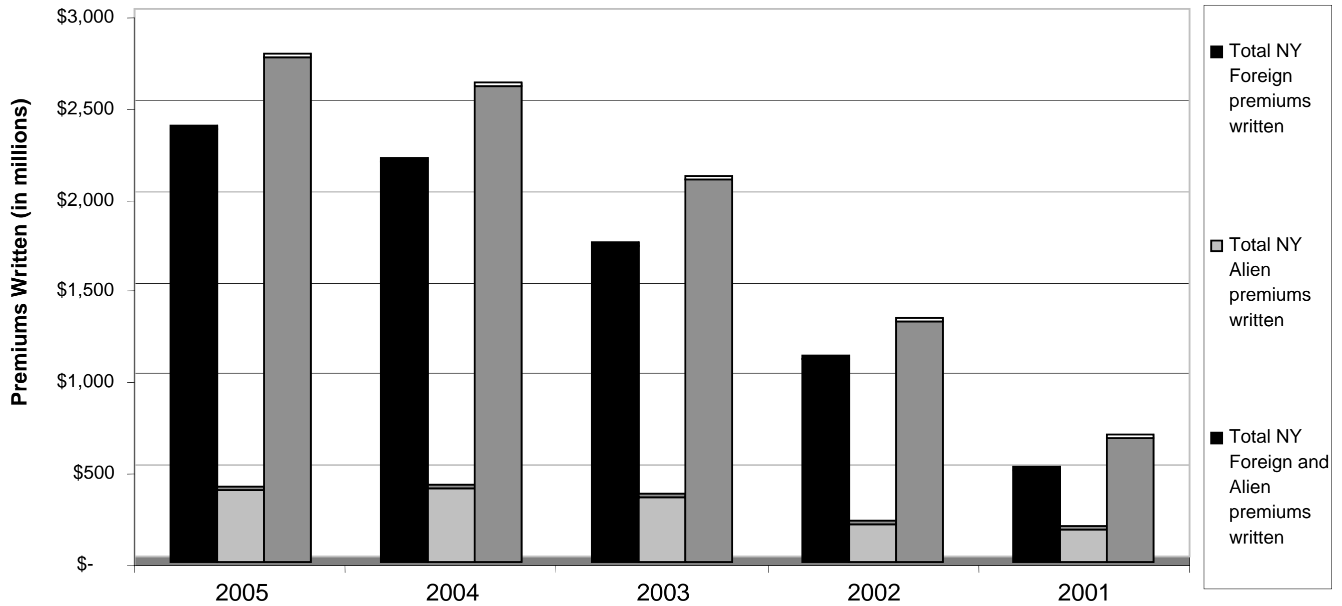
The pie chart below shows the three major lines of business written in the excess line market based on premium volume.

CHART D
Top Three Lines of Excess Line Business Written, NYS, 2005

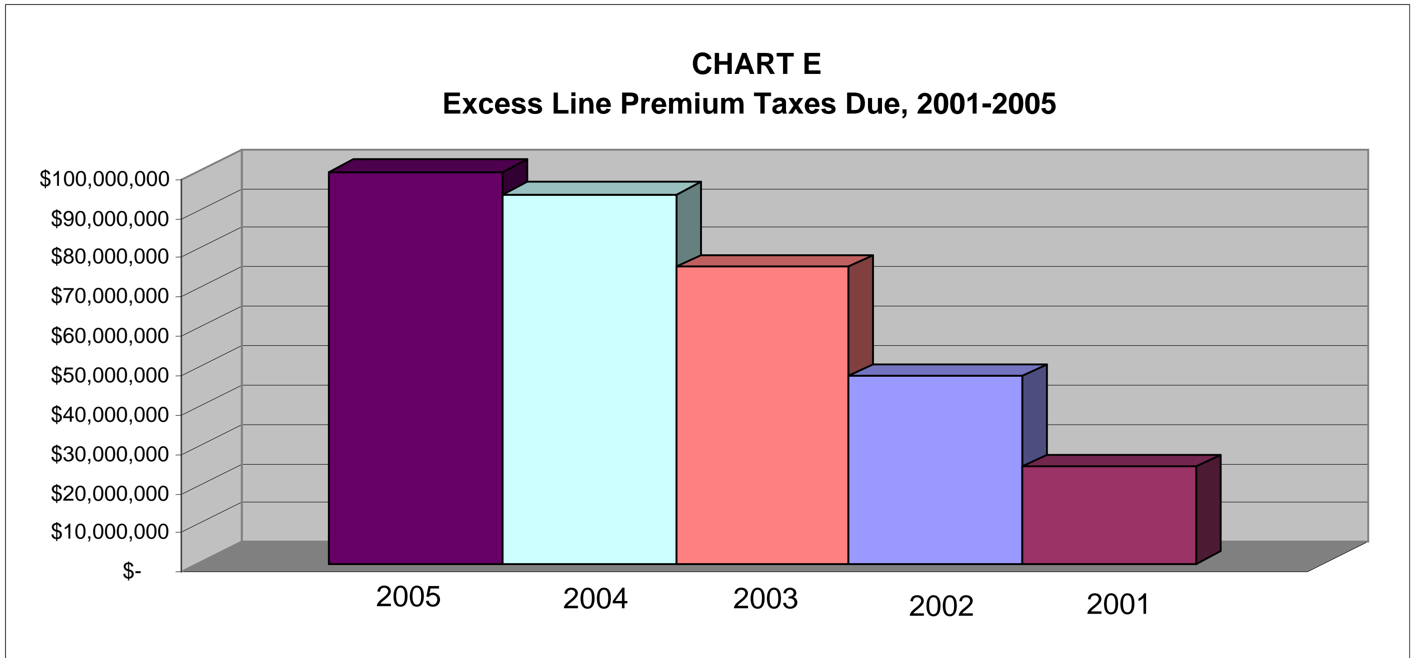


The following is a graph of excess line business for the years 2001 to 2005 by alien and foreign insurers.

CHART D
New York Excess Line Premiums, 2001-2005



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 79 excess line brokers have filed 252 binding authority agreements representing insurers not licensed or authorized to do business in this State. During Calendar Year 2005, the Excess Line Association of New York reviewed and accepted 37 new, renewed and/or amended binding authority agreements from New York-licensed excess line brokers.

c. EL-1 Review

All EL-1 filings were reviewed to determine that the information complied with the requirements 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 revealed 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

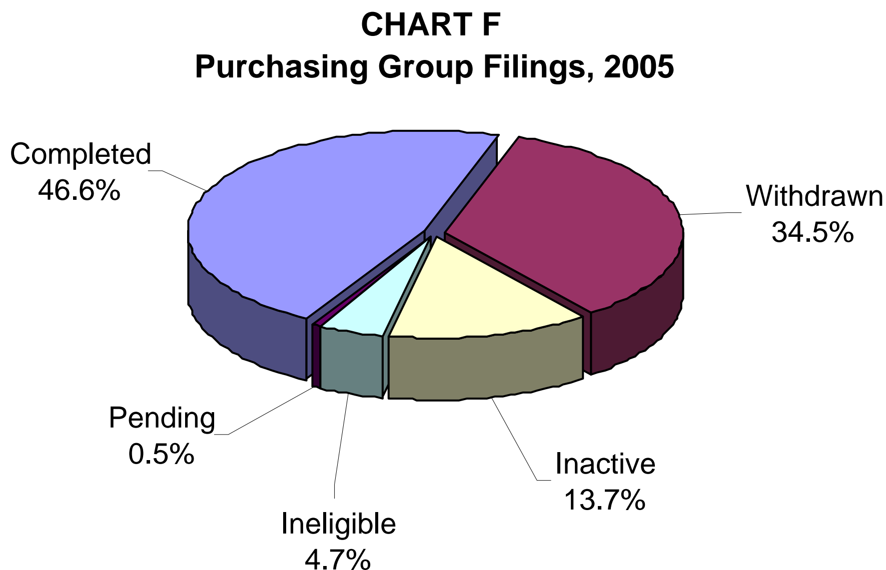
Purchasing groups are allowed, pursuant to the federal Liability Risk Retention Act of 1986, to buy commercial liability insurance on behalf of their members on a group basis. These groups are exempt from any state insurance laws that hinder or prohibit group self-insurance programs and the purchase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

Since the inception of the LRRA, the Department has received notices of intent from 877 purchasing groups. Subsequently, 303 have withdrawn their notice of intent, 120 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, 2005, 30% of the remaining 413 purchasing groups (4 of which are in pending status) have named unlicensed companies as their intended insurers. In 2005, the Department received notices of intent from 28 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. Approximately 22 complaints and inquiries regarding purchasing groups were received in 2005.

The following chart shows the purchasing group filings as of December 31, 2005, by status category:

CHART F
Purchasing Group Filings, 2005



f. Purchasing Group and Excess Line Investigations

The Excess Line Unit investigated the activities of two related purchasing group programs for supermarkets and their suppliers. The program insured approximately 600 New York purchasing group members for the time period 2001 to 2005. The investigation disclosed the following violations of the Insurance Law and related regulations: rates were never filed, some of the certificates were issued prior to the forms being filed and approved by the Department, claims were not being paid in a timely manner, and every certificate in this program included property coverage which is not permitted

pursuant to the Liability Risk Retention Act of 1986. As a result of this investigation the licensed insurer on this program signed a stipulation and paid a fine of approximately $200,000.

Another purchasing group program was investigated by the Unit when the Department received complaints from livery drivers regarding return premiums and the failure to pay physical damage claims. The program only provided physical damage coverage for livery vehicles and was purported to have been placed with an alien excess line insurer. This type coverage is a property coverage which a purchasing group is not permitted to procure for its members on a group basis pursuant to the federal Liability Risk Retention Act of 1986. The investigation disclosed that the carrier could not verify any coverage and that the purchasing group was, in fact, acting as an insurer without a license. The Department directed the purchasing group to cease and desist from doing these illegal activities and return all premium monies to the livery drivers.

The Unit is also involved in an investigation of excess line policies purportedly placed by New York licensed brokers with an alien excess line insurer that had no record of some of the placements ever being made. One of the New York licensed brokers involved is a coverholder for the alien excess line insurer. The investigation revealed that the broker had exceeded its coverholder authority by binding classes of business for which no approval had been granted. This broker refused to cooperate with the Department's investigation and after a Department hearing all of its licenses were revoked. The investigation also disclosed that the monthly bordereaux submitted to the alien excess line insurer by the coverholder differed from the actual placements made by the NY brokerage. Several brokers including the owner of the brokerage are still under investigation by this Department. The alien excess line insurer has agreed to return premiums and pay claims where there is evidence of coverage for this program.

g. Monitoring Excess Line Market Activity

Premium writings in the excess line market for the years 2001, 2002, 2003, 2004 and 2005 were $685 million, $1.324 billion, $2.097 billion, $2.610 billion and $2.769 billion respectively. This represents a 404% increase in writings during that period. The increase in premium writings is attributable to among other things, 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 is anticipated that the trend in increased writings over the past four years will level off somewhat, due to improved availability in the admitted market as evidenced by the smaller percentage increase in excess line writings from 2004 to 2005.

h. Excess Line Association of New York

On July 1, 2005 the Excess Line Association of New York, as recommended by the Department based on increased stamping fee income, reduced its stamping fee to 0.2% to maintain its fund balance in line with its needs.

23. Consumers Guide to Automobile Insurance

On October 1, 2005, the Department published two editions of the 2005 Consumers Guide to Automobile Insurance, one for upstate New York residents and one for downstate residents. 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. Circular Letters

Circular Letters Issued in 2005:

Circular Letter No. 2 was issued on February 25, 2005 to authorized property and casualty insurers, rate service organizations, New York Automobile Insurance Plan, New York Property Insurance Underwriting Association, and insurance producer organizations. The circular letter informed insurers that pursuant to recently enacted Article 28 of the Insurance Law, the Department has promulgated Regulation No. 182 on an emergency basis. The circular letter outlines the provisions included in Regulation No. 182 regarding the use of credit information to underwrite or rate personal lines insurance policies. The circular letter also provides the Insurer Credit Information Compliance Certification form required to be completed pursuant to the requirements of Regulation No. 182.

Circular Letter No. 3 was issued on March 10, 2005 to motor vehicle automobile self-insurers and insurers licensed to write motor vehicle liability insurance. The circular letter advised self-insurers and insurers of the withdrawal of three circular letters pertaining to No-fault [(Circular Letter No. 4 (1992), Circular Letter No. 30 (1999) and Supplement No. 1 to Circular Letter No. 30 (1999)]. In addition, the circular letter advised self-insurers and insurers that beginning January 26, 2005, the American Arbitration Association will begin imposing an interest charge at prime rate plus 1% for all assessments that are unpaid for more than 90 days.

Circular Letter No. 6 was issued April 19, 2005 to authorized property/casualty insurers and life insurers, rate service organizations, the Excess Line Association of NY, and insurance producer organizations. The circular letter informed these entities that certain group insurance programs designed to provide liability coverage for life insurance agents and broker/dealer representatives of their affiliates do not comply with New York law.

Every life insurer was required to review its requirements for liability coverage for its agents and for securities broker/dealer representatives of its affiliates to determine if any agent or representative was not in compliance with New York law and if so, advise the Insurance Department in writing and provide a plan for taking corrective action.

Every property/casualty writing commercial professional liability insurance was required to review its liability insurance books of business, including programs written as special risk insurance in the Free Trade Zone to determine if any group policies were issued in violation of federal law, New York law or regulations. The circular letter advised that if any policy was found to have been issued in violation, the insurer must restructure its program and make appropriate filings to be in compliance with the laws and regulations and to nonrenew any illegal policy as of its next renewal date. Any insurer or excess line broker that has written or placed such a policy shall notify the Insurance Department and provide the Insurance Department with a plan for taking corrective action.

Circular Letter No. 10 was issued May 16, 2005 to insurers authorized to write motor vehicle insurance or workers' compensation insurance providing benefits in lieu of first party benefits under No-fault, motor vehicle self-insurers and the Motor Vehicle Accident Indemnification Corporation (MVAIC). The circular letter advised that the Superintendent has approved revised procedures submitted by Arbitration Forums, Inc. (AF) for the administration of the No-fault inter-company loss transfer arbitration programs. It provides that each No-fault insurer, self-insurer, workers compensation provider, and the MVAIC should designate to AF at least one qualified full-time salaried representative in each jurisdiction where the entity participates in No-fault inter-company loss transfer arbitration who will be available for appointment by AF as an arbitrator in this forum.

Circular Letter No. 11 was issued on July 15, 2005 to insurers authorized to write motor vehicle insurance in New York State, rate service organizations, New York Automobile Insurance Plan, and insurance producer organizations. The circular letter advised of amendments to Section 318 of the Vehicle and Traffic Law that impact motor vehicle liability insurance cancellation and nonrenewal notice requirements. These amendments include revisions to the civil penalty amounts to be paid in lieu of surrendering plates for an order of suspension of the registration of a motor vehicle. These changes do not apply to vehicles subject to Section 370 of Article 8 of the Vehicle and Traffic Law.

Supplement No. 1 to Circular Letter No. 20 (2003) was issued on August 31, 2005 to authorized motor vehicle insurers and insurance producer organizations. The purpose of this supplement was to advise that the New York State Department of Motor Vehicles (DMV) has informed the Department that Drive Safe New York, Inc. has been removed from the list of accident prevention course sponsors approved by the DMV effective July 8, 2005.

Circular Letter No. 16 was issued on October 5, 2005 to insurers authorized to write motor vehicle insurance, motor vehicle self-insurers, and the Motor Vehicle Accident Indemnification Corporation. The circular letter advised them that the legislature enacted Chapter 452 of the Laws of 2005 effective September 8, 2005 and the Department has promulgated the Third Amendment to Regulation No. 68-C and the Fourth Amendment to Regulation No. 68-D on an emergency basis with regard to processing certain first party no-fault claims. The emergency regulations required specific wording for No-fault denials for claims which the insurer determines that it is not the first notified insurer and provides procedures for the special expedited arbitration to resolve disputes filed by a claimant to designate the automobile insurer responsible for processing first party benefits when there is a dispute between two or more automobile insurers over which insurer has primary responsibility.

Circular Letter No. 19 was issued on November 14, 2005 to authorized motor vehicle insurers and insurance producer organizations. The circular letter provided a list of all Motor Vehicle Accident Prevention Course sponsors that are currently approved by the New York State Department of Motor Vehicles.

Circular Letter No. 21 was issued on November 25, 2005 to motor vehicle automobile self-insurers and insurers licensed to write motor vehicle liability insurance in New York State. The circular letter advised insurers and self-insurers regarding the actions that are taken by the Department when insurers and self-insurers fail to make timely payment on No-fault conciliation agreements, American Arbitration Association issued settlement letters and No-fault arbitration awards.

Circular Letter No. 22 was issued on December 7, 2005 to all property/casualty insurers domiciled in New York State. The circular letter advised that effective with the filing of the 2005 Annual Statement, each insurer shall also file a document entitled the Actuarial Opinion Summary (AOS) and provided the timeframe for when the AOS must be submitted to the Department. The circular letter also advised that at the time of submission, an insurer should request an exception from disclosure under Section 89(5) of the Public Officers Law.

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

Certain complaints and inquiries are processed independently of the Consumer Services Bureau. A total of 1,429 such complaints and inquiries were received by the Market Regulatory Section of the Property Bureau in 2005. This total consisted of 1,023 involving personal automobile insurance; 48 involving commercial automobile insurance; 71 involving homeowners insurance; 82 involving other liability insurance; 17 involving commercial multiple peril insurance; 39 involving medical malpractice insurance; 24 involving title insurance; and 125 involving other types of insurance (fire and allied lines, surety, inland marine, workers' compensation, etc.). In addition, the Market Regulatory Section processed 293 Freedom of Information (FOIL) requests on policy form and rate information.

26. Casualty Actuarial

The Casualty Actuarial Unit reviews rate filings for workers' compensation insurance, private passenger automobile insurance and private passenger and commercial insurance offered through the Automobile Insurance Plan. All such filings are subject to prior approval. In terms of premium volume, private passenger automobile and workers' compensation insurance are the largest property/casualty coverages, accounting for approximately $14 billion of New York premium volume in 2005.

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 2005 was approximately -5.3%. For these insurers, liability rates decreased 3.9% on average while physical damage rates, primarily collision and theft coverages, decreased 8.6% on average. The insurers receiving rate changes in 2005 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 2005) was an average decrease of 3.3%.

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 2005, 51 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 2005[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 (%)
1/13/05	6/15/05	Nationwide: NMIC; NP&CIC	2.99	-1.2	-3.5	-8.8	-5.2
2/2/05	3/22/05	Response Ins Co	0.16	-6.4	-4.9	-11.3	-6.4
2/2/05	3/22/55	Response Indemnity Co	0.02	-9.0	-6.5	-17.2	-9.0
2/3/05	5/1/05	Amica Mutual Ins Co	1.09	-10.0	-11.7	-6.6	-10.0
2/9/05	3/22/05	Travelers Legacy :AICoHCT;SFIC;COFIC;PIC;TIC;TICoA; TIndC;TCCoCT;TPCIC	3.68	-5.0	-4.9	-5.2	-5.0
2/9/05	3/22/05	Travelers TAP: TPCCoA; TICoC	1.51	9.2	-7.0	-5.2	-6.5
2/9/05	3/22/05	Travelers Special Auto: Farmington Casualty Co	0.15	-2.0	-1.9	-2.2	-2.0
2/9/05	3/22/05	Travelers: Legacy, TAP, Special, Secure	*	0.0	0.0	0.0	0.0
2/22/05	5/1/05	State Farm Mutual	10.20	-5.0	-4.4	-7.3	-5.0
2/22/05	5/1/05	State Farm Fire & Casualty	1.34	-4.0	-3.4	-6.1	-4.0
3/16/05	6/15/05	Merchants: MICoNH	0.20	7.2	-2.5	-5.9	-3.6
3/16/05	6/15/05	Merchants: MMIC	0.07	11.4	-1.8	-6.1	-3.2
3/22/05	6/13/05	Progressive Halcyon Ins Co	0.01	-6.0	-6.0	-6.1	-6.0
3/25/05	4/1/05	Travelers Legacy :AICoHCT;SFIC;COFIC;PIC;TIC;TICoA; TIndC;TCCoCT;TPCIC	*	0.0	0.0	0.0	0.0
4/12/05	6/1/05	New York Central Mutual Fire Ins Co	3.18	-5.1	-2.0	-10.0	-5.1
4/18/05	4/1/05	Eveready Ins Co	0.20	-4.6	0.0	-10.2	-4.6
5/2/05	8/7/05	Liberty: LMFIC; TFLIC	4.30	-3.0	-1.0	-6.9	-3.0
5/3/05	7/4/05	Allstate Ins Co	14.05	-3.0	-3.0	-3.0	-3.0
5/3/05	7/4/05	Allstate Indemnity Co	0.96	-5.0	-5.0	-5.0	-5.0
5/17/05	5/17/05	Fireman's Fund: FFIC; AIC, AICorp; AAIC	0.22	-0.7	-0.7	-0.7	-0.7
6/10/05	9/3/05	AIG: AIIC; AIUIC; BFIC; INIC; TICoPA; AHA, NUFIC; AIGP; AIGC; AIGPIC	1.44	0.0	-0.8	-9.3	-4.0
6/10/05	7/5/05	AIG: AIGIIC; LIC	0.00	0.0	0.0	0.0	0.0
6/10/05	6/3/05	Nationwide: NICoA; NGIC	0.00	-1.8	-1.8	-1.8	-1.8
6/27/05	7/18/05	GMAC: NSIC; CIMIC; MICP&CIC	1.21	-4.4	-2.1	-9.1	-4.4
6/27/05	2/6/06	CHUBB: FIC; PIC; VIC; GNIC; CIIC	1.05	-4.8	3.1	-15.3	-4.8
6/29/05	6/29/05	GMAC:National General Assurance Co	0.00	0.0	0.0	0.0	0.0
7/12/05	8/1/05	Allmerica Financial Alliance Ins Co	0.00	0.0	0.0	0.0	0.0
7/21/05	10/1/05	Utica: UMIC; GAMIC; RFIC; UNAC	0.46	-3.8	3.0	-15.0	-4.1
7/27/05	8/5/05	GMAC: National General Insurance Company	0.18	19.9	12.5	0.0	7.8
8/4/05	10/6/05	Fireman's Fund: FFIC; AIC, AICorp; AAIC	*	-5.0	-5.1	-4.8	-5.0
8/16/05	10/1/05	Central Mutual Ins Co	0.04	1.6	-5.4	-3.8	-7.5
8/17/05	10/1/05	Preferred Mutual Insurance Company	0.48	-3.6	-1.4	-6.4	-3.6
8/26/05	11/1/05	GMAC: NSIC; CIMIC; MICP&CIC	*	-1.5	0.3	-5.0	-1.5
8/29/05	1/25/06	Mercury Casualty Company	0.15	-5.9	-6.8	-3.5	-5.9
9/9/05	10/13/05	Travelers TAP: TPCCoA; TICoC	*	-3.4	-2.3	-5.5	-3.4
9/13/05	12/5/05	Hartford Ins Co of IL; Sentinel Ins Co	0.00	-1.0	-1.0	-1.0	-1.0
9/13/05	11/15/05	Erie: EIC; EICoNY	0.67	-3.0	-3.0	-3.0	-3.0
9/19/05	1/23/06	GMAC: Motors Insurance Corp.	0.10	-4.1	0.0	-5.0	-5.0
9/27/05	11/1/05	Response Worldwide Direct Auto Ins Co	0.01	0.0	0.0	0.0	0.0
9/30/05	2/10/06	Onebeacon: Pennsylvania General Ins Co	0.00	-23.0	-23.1	-22.9	-23.0
10/6/05	1/16/06	USAA: USAA; USAACIC; USAAGIC	1.72	-7.6	-7.8	-7.2	-7.6
10/20/05	1/30/06	Allstate Property & Casualty Ins Co	0.00	0.0	0.0	0.0	0.0

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS REVIEWED IN 2005[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 (%)
10/20/05	1/30/06	Allstate Ins Co	*	0.0	0.0	0.0	0.0
11/22/05	2/10/06	AIG: AIGIIC; LIC	*	-4.0	-3.5	-5.1	-4.0
11/30/05	3/1/06	AIPSO	9.84	-5.6	-4.0	-25.0	-5.6
12/2/05	3/8/06	Main Street America Group: NGMIC; MSAAC	0.70	-5.4	-5.5	-9.1	-7.0
12/12/05	1/15/06	Electric Ins Co	0.18	-3.8	-1.8	-12.4	-6.0
12/14/05	3/15/06	AIG: AIG National Ins Co	0.00	8.0	-0.9	9.9	2.4
12/15/05	2/6/06	Amex Assurance Co	0.25	-7.8	-5.0	-14.3	-7.8
12/19/05	3/1/06	State Farm Fire & Casualty	*	-4.2	-2.2	-6.7	-3.4
12/19/05	3/1/06	State Farm Mutual	*	-3.0	-1.6	-6.3	-3.0

2005 Rate Change Summary	**Filings**
• Number of insurer rate filings:	51
• Average liability change for insurers receiving rate changes:	-3.9%
• Percentage of total liability industry premium affected:	64.0%
• Impact on the entire market of the overall average liability rate change:	-2.5%
• Average physical damage change for insurers receiving rate changes:	-8.6%
• Percentage of total physical damage industry premium affected:	60.2%
• Impact on the entire market of the overall average physical damage change:	-5.2%
• Average combined liability and physical damage change for insurers receiving rate changes:	-5.3%
• Percentage of total industry premium affected:	62.8%
• Impact on the entire market of the overall average liability and physical damage rate change:	-3.3%

[1] All rate filings (and classification changes) are subject to prior approval.
[2] These market shares are based on 2003 Annual Statement premiums.
* Subsequent filing by this insurer in same year.

b. New York Automobile Insurance Plan (NYAIP) Experience in 2003and 2004

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 21.6% for liability and 34.8% for collision from 2003 to 2004. 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
1995 – 2004

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
1995	6,643,605		1,196,578		7,840,183		62,517	
1996	6,662,881	0.3	970,552	-18.9	7,633,433	-2.6	51,547	-17.5
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	8,907,853	4.9	47,234	71.2
2003	8,313,121	-1.8	471,158	6.0	8,784,280	-1.4	47,981	1.6
2004	8,356,929	0.5	369,200	-21.6	8,726,129	-0.7	31,302	-34.8

ii. Risks by Surcharge Category

In 2004, there were 369,200 private passenger earned car years for liability and 31,302 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 2002, 2003 and 2004.

Table 43
DISTRIBUTION OF PRIVATE PASSENGER AUTOMOBILE ASSIGNED RISKS
LIABILITY AND COLLISION COVERAGES
by Discount or Surcharge Category, 2002 – 2004

Discount or Surcharge Category	Liability			Collision		
	2002 (%)	2003 (%)	2004 (%)	2002 (%)	2003 (%)	2004 (%)
Total, all categories	100.0	100.0	100.0	100.0	100.0	100.0
Total Unsurcharged	56.3	57.3	58.0	52.5	55.1	57.4
3 Years Claim Free (1 or less with Plan) (Manual Rates)	42.5	40.2	38.6	40.9	36.9	34.4
Experience Discount						
4 Years (One or more with Plan) – 18% Credit	8.4	9.6	9.4	8.2	11.1	11.4
5 Years (Two or more with Plan) – 25% Credit	2.2	4.2	5.4	1.5	4.7	6.6
6 Years or more (Three or more w/Plan) – 30% Credit	3.2	3.3	4.6	1.9	2.4	4.9
Total Surcharged	43.7	42.7	42.0	47.5	44.9	42.6
Inexperienced Operator Surcharge	20.8	20.6	21.1	16.2	16.0	15.5
Experience Surcharge						
15%	13.0	12.6	11.9	18.1	17.0	15.6
25%	0.3	0.2	0.2	0.2	0.2	0.2
35%	3.6	3.4	3.1	5.7	5.0	4.5
50%	1.8	1.8	1.8	2.0	1.8	1.7
75%	1.4	1.3	1.3	1.9	1.8	1.8
100%-200%	2.7	2.7	2.7	3.3	3.2	3.4

iii. Risks by Rating Territory

The proportions of all private passenger liability risks that are assigned risks, listed by rating territory for 2003 and 2004, are shown in Table 44. During 2004, 4.2% of all New York State private passenger automobiles were assigned risks as opposed to 5.6% in 2003. The proportion of assigned risks was 10% or higher in 6 of the 70 rating territories in 2003 and was 10% or higher in only 4 of the 70 in 2004. The highest 2004 ratio was 35.8% in the Bronx Territory and the lowest was 0.1% in the Corning Territory. Between 2003 and 2004 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											
		2003			2004			# Change	% Change	#Change	% Chng.
Territory		Assigned	Voluntary	Total	Assigned	Voluntary	Total	In A/R	In A/R	in Market	in Mrkt.
01	Bronx Territory	26,105	29,481	55,587	17,997	32,286	50,283	-8,108	-31.1	-5,303	-9.5
03	Bronx Suburban Territory	29,285	160,939	190,225	20,717	161,397	182,115	-8,568	-29.3	-8,110	-4.3
05	Staten Island	16,162	214,076	230,238	12,211	217,529	229,740	-3,951	-24.4	-498	-0.2
07	Buffalo	8,695	111,527	120,222	6,824	113,604	120,428	-1,871	-21.5	206	0.2
08	Buffalo Semi-Suburban	5,287	190,247	195,534	4,626	187,501	192,127	-661	-12.5	-3,407	-1.7
09	Schenectady County	1,915	102,138	104,054	1,509	103,382	104,891	-407	-21.2	837	0.8
11	Rochester	15,655	400,007	415,662	13,223	400,707	413,931	-2,431	-15.5	-1,731	-0.4
12	Syracuse	5,578	216,578	222,156	3,830	216,698	220,529	-1,748	-31.3	-1,628	-0.7
13	Albany	3,111	162,645	165,755	2,008	163,335	165,343	-1,103	-35.4	-412	-0.2
14	Niagara Falls	2,526	68,552	71,079	2,408	68,512	70,920	-118	-4.7	-159	-0.2
15	Utica	671	62,666	63,337	466	61,972	62,439	-204	-30.5	-898	-1.4
16	Saratoga Springs Suburban	243	48,807	49,050	156	49,432	49,587	-87	-35.8	538	1.1
17	Kings County	27,960	318,735	346,695	16,227	316,591	332,818	-11,733	-42.0	-13,877	-4.0
18	Manhattan	25,222	135,025	160,247	16,581	142,192	158,773	-8,641	-34.3	-1,473	-0.9
19	Queens	10,982	48,075	59,057	7,189	49,541	56,730	-3,793	-34.5	-2,328	-3.9
20	Hempstead	31,092	443,772	474,864	22,185	447,127	469,312	-8,907	-28.6	-5,552	-1.2
21	North Hempstead	8,267	150,080	158,346	6,547	152,656	159,203	-1,720	-20.8	857	0.5
22	Oyster Bay	10,869	233,103	243,971	9,065	243,440	252,505	-1,804	-16.6	8,534	3.5
24	Rome	449	22,851	23,300	314	22,878	23,192	-135	-30.1	-108	-0.5
25	Auburn	224	24,641	24,865	128	24,294	24,422	-96	-42.9	-443	-1.8
27	Elmira	72	50,835	50,906	53	49,845	49,899	-18	-25.6	-1,008	-2.0
28	Binghamton	3,118	114,577	117,695	2,350	112,606	114,956	-768	-24.6	-2,739	-2.3
29	Gloversville	267	27,384	27,651	263	27,669	27,932	-4	-1.4	281	1.0
30	Saratoga Springs	126	23,587	23,714	98	24,375	24,473	-28	-22.2	760	3.2
31	Chautauqua County	976	84,701	85,677	868	82,517	83,385	-108	-11.1	-2,292	-2.7
32	Newburgh	2,473	67,542	70,015	2,171	68,286	70,457	-302	-12.2	442	0.6
33	Poughkeepsie	2,897	102,852	105,748	2,349	103,637	105,986	-548	-18.9	237	0.2
34	Troy	1,679	59,540	61,219	1,262	60,169	61,431	-417	-24.9	212	0.3
35	Amsterdam	182	22,118	22,300	140	22,138	22,278	-42	-23.3	-22	-0.1
36	Glens Falls	1,037	44,113	45,149	802	43,211	44,014	-234	-22.6	-1,136	-2.5
37	Oswego	1,216	33,728	34,943	848	34,189	35,037	-367	-30.2	94	0.3
38	Syracuse Suburban	300	60,131	60,431	203	60,700	60,903	-97	-32.3	472	0.8
39	Rochester Suburban	234	40,527	40,761	166	40,142	40,308	-68	-29.0	-453	-1.1
40	Corning	38	28,220	28,258	22	28,647	28,668	-16	-42.4	410	1.5
41	Erie County (Balance)	837	83,801	84,639	695	82,813	83,509	-142	-17.0	-1,130	-1.3
42	Buffalo Suburban	3,934	152,268	156,202	3,373	152,816	156,189	-561	-14.3	-14	0.0
43	Niagara Falls Suburban	661	33,680	34,340	512	33,148	33,661	-148	-22.4	-680	-2.0
44	Broome County (Balance)	103	19,200	19,303	64	20,529	20,593	-39	-38.0	1,290	6.7

Table 44: NY Private Passenger Automobile Exposures in Earned Car Years by Territory for the Voluntary and Assigned Risk Markets											
		2003			2004			# Change	% Change	#Change	% Chng.
Territory		Assigned	Voluntary	Total	Assigned	Voluntary	Total	In A/R	In A/R	in Market	in Mrkt.
46	Putnam County	2,492	74,587	77,080	2,021	74,694	76,715	-471	-18.9	-364	-0.5
47	Orleans County	404	26,040	26,445	251	26,073	26,323	-154	-38.0	-121	-0.5
48	Monroe County (Balance)	199	20,295	20,494	106	20,648	20,754	-94	-47.1	260	1.3
49	Niagara County (Balance)	259	33,347	33,606	215	32,721	32,936	-44	-17.1	-670	-2.0
51	Ontario County, etc.	3,553	195,911	199,464	2,900	194,935	197,835	-653	-18.4	-1,629	-0.8
52	Fort Plain, Herkimer	629	37,895	38,524	470	38,114	38,584	-159	-25.3	60	0.2
54	Cortland County, etc.	4,110	195,499	199,609	3,313	194,501	197,814	-797	-19.4	-1,795	-0.9
55	Queens Suburban	56,109	504,359	560,468	34,185	509,952	544,137	-21,925	-39.1	-16,331	-2.9
56	Saratoga County (Balance)	244	30,284	30,528	187	30,341	30,528	-57	-23.2	0	0.0
58	Dutchess County (Balance)	2,468	93,958	96,426	1,837	93,817	95,654	-631	-25.6	-772	-0.8
59	Columbia County, etc.	1,357	81,444	82,800	1,034	81,606	82,639	-323	-23.8	-161	-0.2
60	Genesee County	515	39,077	39,592	414	39,066	39,481	-100	-19.5	-111	-0.3
61	Delaware County, etc.	3,110	134,456	137,566	2,354	134,311	136,665	-756	-24.3	-902	-0.7
62	Highland, Kingston	3,346	82,410	85,756	2,755	83,680	86,435	-591	-17.7	680	0.8
64	Middletown	7,337	150,449	157,786	6,306	152,638	158,944	-1,031	-14.1	1,158	0.7
65	Ossining	9,001	180,942	189,942	7,365	181,999	189,363	-1,636	-18.2	-579	-0.3
67	Clinton County, etc.	12,371	338,104	350,475	10,629	324,951	335,581	-1,742	-14.1	-14,894	-4.2
68	Rockland County	7,114	182,069	189,184	5,541	181,820	187,361	-1,574	-22.1	-1,823	-1.0
71	Saratoga County South	161	43,349	43,510	131	43,446	43,577	-30	-18.6	67	0.2
72	Albany County (Balance)	71	12,925	12,996	50	13,304	13,353	-21	-30.1	357	2.7
73	Rensselaer County (Balance)	581	38,923	39,504	463	39,268	39,731	-118	-20.2	228	0.6
74	Jefferson County	939	65,653	66,592	837	66,479	67,316	-102	-10.8	724	1.1
75	Suffolk County West	41,055	498,904	539,959	32,607	510,603	543,209	-8,448	-20.6	3,250	0.6
76	Suffolk County East	47,553	426,354	473,906	41,271	433,591	474,862	-6,282	-13.2	956	0.2
81	Monticello-Liberty	224	13,102	13,326	159	13,238	13,397	-65	-29.1	71	0.5
82	Sullivan County Central	456	14,245	14,701	290	14,510	14,800	-166	-36.4	99	0.7
83	Sullivan County (Balance)	557	22,971	23,528	463	21,959	22,421	-94	-16.9	-1,107	-4.7
84	Allegany County, etc.	4,464	183,192	187,656	3,539	181,878	185,418	-925	-20.7	-2,238	-1.2
86	Oneida	409	40,887	41,296	304	39,631	39,935	-105	-25.6	-1,361	-3.3
94	Mount Vernon and Yonkers	14,423	99,735	114,157	10,608	100,501	111,108	-3,815	-26.5	-3,049	-2.7
95	White Plains	3,924	44,299	48,223	3,396	44,845	48,242	-528	-13.4	19	0.0
97	New York City Suburban	15,361	214,710	230,072	12,747	215,297	228,044	-2,614	-17.0	-2,028	-0.9
	Entire State	**495,243**	**8,313,121**	**8,808,365**	**369,200**	**8,356,929**	**8,726,129**	**-126,043**	**-25.5**	**-82,236**	**-0.9**

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, 1998-2004															
		1998		1999		2000		2001		2002		2003		2004	
Territory		(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
01	Bronx Territory	52.4	1	34.3	1	30.9	1	40.1	1	46.7	1	47.0	1	35.8	1
19	Queens	39.7	2	26.0	2	15.8	2	17.7	2	19.1	2	18.6	2	12.7	2
03	Bronx Suburban Territory	21.8	5	13.2	4	9.4	4	12.2	4	14.0	4	15.4	4	11.4	3
18	Manhattan	23.5	3	14.7	3	10.8	3	14.5	3	16.2	3	15.7	3	10.4	4
94	Mount Vernon and Yonkers	12.3	7	7.2	7	5.2	7	8.7	6	11.1	5	12.6	5	9.5	5
76	Suffolk County East	7.9	9	4.4	9	3.0	8	5.7	8	8.4	7	10.0	6	8.7	6
95	White Plains	5.8	13	2.9	14	2.2	13	4.9	9	6.7	9	8.1	8	7.0	7
55	Queens Suburban	19.9	6	11.9	6	6.9	6	9.0	5	10.0	6	10.0	7	6.3	8
75	Suffolk County West	7.6	10	4.3	10	2.5	10	4.5	11	6.5	10	7.6	10	6.0	9
07	Buffalo	3.4	24	1.2	31	1.0	24	4.5	12	6.1	12	7.2	11	5.7	10
97	New York City Suburban	5.8	14	3.2	12	2.5	11	4.3	13	6.0	13	6.7	13	5.6	11
05	Staten Island	8.0	8	4.6	8	2.7	9	4.8	10	6.1	11	7.0	12	5.3	12
17	Kings County	22.3	4	13.1	5	6.9	5	8.3	7	8.4	8	8.1	9	4.9	13
20	Hempstead	7.5	11	4.1	11	2.3	12	4.1	14	5.8	14	6.5	14	4.7	14
21	North Hempstead	5.4	15	3.1	13	1.9	14	3.2	15	4.5	15	5.2	15	4.1	15
64	Middletown	4.3	17	2.3	18	1.7	16	2.9	17	4.2	17	4.7	17	4.0	16
65	Ossining	3.7	22	2.2	19	1.6	17	3.0	16	4.2	16	4.7	16	3.9	17
22	Oyster Bay	4.7	16	2.8	15	1.9	15	2.9	18	4.0	18	4.5	18	3.6	18
14	Niagara Falls	1.6	44	0.6	43	0.4	44	1.6	29	2.8	28	3.6	22	3.4	19
11	Rochester	1.8	41	0.6	46	0.6	38	2.5	21	3.4	21	3.8	20	3.2	20
62	Highland, Kingston	3.5	23	1.8	21	1.3	20	2.7	19	3.7	19	3.9	19	3.2	21
67	Clinton County, etc.	2.7	31	1.4	26	1.0	23	2.0	26	3.3	23	3.5	24	3.2	22
32	Newburgh	2.7	30	1.1	32	0.7	33	1.6	30	2.8	29	3.5	23	3.1	23
68	Rockland County	2.7	32	1.2	30	0.8	31	2.0	25	3.1	25	3.8	21	3.0	24
46	Putnam County	3.9	21	2.3	17	1.5	19	2.3	22	3.2	24	3.2	26	2.6	25
37	Oswego	4.2	19	1.7	23	0.9	26	2.1	23	3.4	22	3.5	25	2.4	26
08	Buffalo Semi-Suburban	1.5	45	0.7	41	0.6	37	1.5	35	2.3	33	2.7	30	2.4	27
33	Poughkeepsie	3.3	25	1.6	24	1.0	25	2.1	24	2.9	26	2.7	29	2.2	28
42	Buffalo Suburban	1.7	42	0.9	36	0.6	34	1.5	34	2.3	34	2.5	33	2.2	29
83	Sullivan County (Balance)	4.2	18	2.1	20	1.1	22	1.6	31	2.2	37	2.4	36	2.1	30
34	Troy	3.0	27	1.3	28	0.8	27	1.8	28	2.8	27	2.7	28	2.1	31
28	Binghamton	1.9	40	0.9	39	0.6	35	1.4	36	2.4	31	2.6	31	2.0	32
82	Sullivan County Central	5.9	12	2.8	16	1.5	18	2.6	20	3.4	20	3.1	27	2.0	33
58	Dutchess County (Balance)	3.2	26	1.6	25	1.1	21	2.0	27	2.7	30	2.6	32	1.9	34
84	Allegany County, etc.	1.9	38	0.9	38	0.6	36	1.3	38	2.2	38	2.4	35	1.9	35
36	Glens Falls	2.8	28	1.0	34	0.5	40	1.3	41	2.3	32	2.3	37	1.8	36
12	Syracuse	1.4	49	0.5	53	0.4	48	1.4	37	2.2	36	2.5	34	1.7	37

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 1998-2004															
		1998		1999		2000		2001		2002		2003		2004	
Territory		(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
61	Delaware County, etc.	2.5	33	1.2	29	0.8	28	1.5	32	2.2	35	2.3	38	1.7	38
54	Cortland County, etc.	2.1	37	1.1	33	0.8	30	1.5	33	2.1	39	2.1	39	1.7	39
43	Niagara Falls Suburban	1.3	51	0.4	58	0.2	55	0.8	50	1.6	47	1.9	41	1.5	40
51	Ontario County, etc.	1.9	39	0.8	40	0.5	42	1.1	44	1.7	43	1.8	44	1.5	41
09	Schenectady County	1.7	43	0.6	44	0.3	50	0.9	49	1.6	45	1.8	43	1.4	42
24	Rome	1.2	53	0.5	52	0.4	46	1.3	39	1.9	41	1.9	40	1.4	43
59	Columbia County, etc.	2.7	29	1.3	27	0.7	32	1.2	43	1.8	42	1.6	46	1.3	44
74	Jefferson County	2.1	36	0.9	37	0.5	41	1.0	46	1.5	49	1.4	50	1.2	45
52	Fort Plain, Herkimer	1.4	50	0.5	50	0.5	43	1.0	45	1.5	48	1.6	47	1.2	46
13	Albany	2.1	35	1.0	35	0.5	39	1.2	42	2.0	40	1.9	42	1.2	47
81	Monticello-Liberty	4.0	20	1.7	22	0.8	29	1.3	40	1.7	44	1.7	45	1.2	48
73	Rensselaer County (Balance)	1.5	46	0.6	45	0.4	45	0.9	48	1.4	50	1.5	49	1.2	49
60	Genesee County	0.8	60	0.4	55	0.3	51	0.6	55	1.1	51	1.3	51	1.0	50
31	Chautauqua County	1.4	47	0.6	47	0.3	54	0.6	54	1.0	55	1.1	52	1.0	51
47	Orleans County	1.3	52	0.5	49	0.3	52	0.9	47	1.6	46	1.5	48	1.0	52
29	Gloversville	2.1	34	0.7	42	0.3	49	0.6	56	0.7	61	1.0	57	0.9	53
41	Erie County (Balance)	1.4	48	0.6	48	0.3	53	0.7	51	1.0	54	1.0	55	0.8	54
86	Oneida	1.1	55	0.5	51	0.4	47	0.7	53	1.0	53	1.0	54	0.8	55
15	Utica	0.7	65	0.2	64	0.2	59	0.5	59	0.9	56	1.1	53	0.7	56
49	Niagara County (Balance)	0.6	66	0.2	63	0.1	66	0.4	61	0.7	60	0.8	61	0.7	57
35	Amsterdam	1.0	57	0.4	56	0.2	56	0.3	65	0.8	58	0.8	59	0.6	58
56	Saratoga County (Balance)	0.9	58	0.3	61	0.1	62	0.5	57	0.9	57	0.8	60	0.6	59
25	Auburn	1.1	54	0.3	60	0.2	60	0.5	58	0.8	59	0.9	58	0.5	60
48	Monroe County (Balance)	0.7	63	0.2	68	0.1	63	0.7	52	1.0	52	1.0	56	0.5	61
39	Rochester Suburban	0.5	68	0.2	65	0.1	67	0.4	62	0.5	66	0.6	62	0.4	62
30	Saratoga Springs	1.1	56	0.5	54	0.2	61	0.4	64	0.6	64	0.5	65	0.4	63
72	Albany County (Balance)	0.9	59	0.3	59	0.2	57	0.4	63	0.7	62	0.5	63	0.4	64
38	Syracuse Suburban	0.7	64	0.3	62	0.1	64	0.3	68	0.5	67	0.5	66	0.3	65
16	Saratoga Springs Suburban	0.8	61	0.2	66	0.1	68	0.3	66	0.5	65	0.5	67	0.3	66
44	Broome County (Balance)	0.8	62	0.4	57	0.2	58	0.4	60	0.6	63	0.5	64	0.3	67
71	Saratoga County South	0.6	67	0.2	67	0.1	65	0.3	67	0.4	68	0.4	68	0.3	68
27	Elmira	0.3	69	0.1	69	0.1	70	0.2	69	0.2	69	0.1	69	0.1	69
40	Corning	0.2	70	0.1	70	0.1	69	0.2	70	0.2	70	0.1	70	0.1	70
	Entire State	**6.8**		**3.9**		**2.5**		**4.0**		**5.3**		**5.6**		**4.2**	

c. Workers' Compensation Insurance

On May 13, 2005, the New York Compensation Insurance Rating Board (NYCIRB) filed, on behalf of its members and subscribers, a 16.1% increase in workers' compensation rates. This change, along with a 2.1% change in the New York Assessment Fee, would have produced an increase in cost to policyholders of 18.5%. It should be noted that at the direction of the Insurance Department the NYCIRB included two important changes in its submission:

- Large deductible policies were included in its original filing. This data has been included in approved submissions in the past. However, its inclusion resulted from negotiations subsequent to filing.

- For the first time since 1958 the experience of the State Insurance Fund was included in the determination of the general rate level.

The Board refiled on July 14, 2005 for a 5.0% increase in rate level producing a change to policyholder cost of +7.2%. This filing was identical to the original except for the addition of an "Adjustment Factor" of -9.8%. The amended filing was approved by the Superintendent of Insurance in the Department's Opinion and Decision of July 15, 2005.

In 2005 the NYCIRB received its largest premium since 1995. 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%

*Net change includes rate level and assessment charge changes.

Note that the premium level effective October 1, 2005 is 21.1% lower than that in effect in 1995.

Table 46
WORKERS' COMPENSATION DIVIDEND CLASSIFICATION PLAN APPROVED 2005

Plan Types:

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

COMPANY NAME	PLAN TYPE	APPROVAL DATE
Erie Group	B	5/13/05
Clermont	B	9/25/05
Insurance Company of Greater NY	A, B	9/28/05
GNY Mutual	A, B	9/28/05
Strathmore	A, B	9/28/05
Cincinnati	B	10/28/05
Technology	C	11/30/05

Table 47
WORKERS' COMPENSATION RATE HISTORY
New York Compensation Insurance Rating Board*
New York State, 1980-2005

Effect. Date	Policy Year	Calendar Year	Law Amendments & Medical & Hospital Agreements: Indemnity	Law Amendments & Medical & Hospital Agreements: Medical	Wage & L/R Trend Factors	Expenses	Effect on Rate Level	Assessments: WCB	Assessments: 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%

[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*.

Table 48: WORKERS' COMPENSATION — RATE DEVIATIONS (Approved as of February 1, 2006)*

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

Table 48: WORKERS' COMPENSATION — RATE DEVIATIONS (Approved as of February 1, 2006)
(continued)

Company Name	Effective Date	Downward Deviation	Company Name	Effective Date	Downward Deviation
Northern Ins Co of New York	01/04/02	5.0	Selective Ins Co of South Carolina	09/01/01	10.0
Ohio Security Ins Co	10/25/01	10.0	Selective Way Ins Co	03/01/02	5.0
Old Republic Ins Co	08/01/01	9.1	Sentinel Ins Co	01/01/06	10.0
OneBeacon Amer Ins Co	10/01/99	10.0	Sentry Select Ins Co	08/01/97	10.0
Oriska Ins Co	07/01/01	10.0	State Farm Fire and Casualty Co	06/01/01	15.0
Pacific Indemnity Co	01/13/83	15.0	Strathmore Ins Co	01/01/01	15.0
Paramount Ins Co	10/03/83	15.0	St. Paul Mercury Ins Co	02/13/96	15.0
Patriot General Ins Co	02/25/02	10.0	TIG Ins Co	01/01/01	7.5
Peerless Ins Co	05/01/96	7.5	TIG Ins Co of New York	01/01/01	12.5
Penn Millers Ins Co	03/01/01	10.0	Trans Pacific Ins Co	09/01/02	10.0
Pennsylvania Manufacturers Assn. Ins. Co	12/11/01	7.0	Transcontinental Ins Co	03/01/04	10.0
Pennsylvania Manufacturers Indemnity Co	10/01/96	15.0	Travelers Casualty & Surety Co of Illinois	08/12/85	15.0
PG Ins Co of NY	09/01/01	10.0	Travelers Indemnity Co of America	01/16/91	15.0
Preferred Professional Ins Co	08/01/05	0.0	Travelers Indemnity Co of Connecticut	08/01/98	10.0
Professional Liability Ins Co of America	08/01/05	0.0	Ulico Casualty Co	09/10/02[3]	0.0
Providence Washington Ins Co	04/03/01	10.0	Ulico Casualty Co	06/24/96[4]	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
SeaBright Ins Co (formerly Kemper Employers)	10/01/03	0.0	Wausau Underwriters Ins Co	01/01/03	2.5

[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 NYS Compensation Insurance Rating Board approved rates without permission from the Superintendent of the NYS Insurance Department.

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

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

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

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

In the 2004 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease. In the 2005 fund year, 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, 1988-2005*

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

* During 1993, settlement was reached with respect to *Alliance of American Insurers et al. v. Chu et al.* The 1993 through 2005 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 91 insurers, HMOs, and other managed care organizations as of December 31, 2005. These comprise 22 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, 23 Article 44 Public Health Law HMOs, 10 Article 47 Insurance Law municipal cooperative health benefits plans, 11 managed long term care plans and 10 continuing care retirement communities certified pursuant to Article 46 of the Public Health Law.

Five acquisition-of-control applications were submitted (including Empire Healthchoice Assurance, Inc.) in 2005, of which two were for individual Article 42 insurers. The other three applications each included the acquisition of multiple insurers; one was an application to obtain control of both an Article 42 insurer and a HMO, one was an application to obtain control of both an Article 43 insurer and a HMO and one was an application to obtain control of three insurers; an Article 42 insurer, an Article 43 insurer and a HMO. Two applications were approved, two are still pending and one was withdrawn. A merger application was submitted in which a HMO (Vytra Health Plans Long Island, Inc.) and an Article 43 insurer (Vytra Health Services, Inc.) would both merge into an Article 43 insurer (Health Insurance Plan of Greater New York (HIP)). This application was still pending as of 12/31/2005.

Six Article 42 Accident and Health licensing applications (5 foreign and 1 domestic) were under review as of 12/31/2005. These are for insurers writing the new Medicare Part D Prescription Drug Coverage. The Bureau also approved the “transfer of ownership” for one Article 42 insurer from a company within its holding company system to another company within the same holding company system. The insurer’s ultimate parent company did not change as a result of this transaction. In addition, one application for the conversion of a property/casualty insurer to an Article 42 Accident and Health insurer was reviewed and approved.

One HMO commenced winding down its operations in 2005 and is expected to be liquidated in the near future. 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. Ten plans are currently licensed and one application is pending.

2. Accident and Health Insurers

Twenty-two companies were licensed to transact only accident and health insurance at year-end 2005. 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*
2002-2004
(dollar amounts in millions)

	2004	2003	2002
Number of Insurers	23	23	22
Net premiums written	$9,668.7	$9,616.5	$9,517.3
Admitted assets	11,036.0	10,308.6	9,324.7
Policy and contract claims	1,656.6	1,643.4	1,521.8
Other liabilities	4,946.6	4,539.3	4,048.4
Capital	31.3	30.5	30.4
Surplus	4,401.5	4,095.4	3,724.1
Ratio of premiums written to capital and surplus	2.2	2.3	2.5

*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 2005 filings were as follows:

Type of Company	Filings
HMOs	98
Article 43 Corporations	38

b. Article 43 and Article 44 Corporations

The following tables show aggregate figures on assets, liabilities, surplus funds, premium income and membership for years 2001-2003:

Table 51
HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
2002-2004
(dollar amounts in millions)

	2004	2003	2002
Number of Companies	10	10	10
Admitted Assets	$4,558.0	$4,062.2	$3,552.9
Liabilities	2,519.4	2,362.5	$2,398.3
Surplus Funds	2,038.6	1,699.8	1,154.6
Net Premium Income:			
Hospital	6,921.6	6,468.5	$5,879.3
Medical/Dental	4,902.5	4,353.0	3,614.9
Number of Contracts & Riders in Force:			
Hospital	1.5**	1.5**	1.5**
Medical/Dental	1.6**	1.5**	1.5**

a. 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
2002-2004
(dollar amounts in millions)

	2004	2003	2002
Number of Companies	3	3	3
Admitted Assets	$39.2	$33.3	$31.6
Liabilities	20.4	15.6	17.7
Surplus Funds	18.8	17.7	13.9
Net Premium Income	32.3	26.7	28.0
Number of Contracts in Force	1,344	1,257	971

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
2002-2004
(dollar amounts in millions)

	2004	2003	2002
Number of Companies	3	3	3
Net Premium Income	$6,308.7	$5,862.5	$5,458.7
Number of Participants	1.9**	2.0**	2.1**

* 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
2002-2004
(dollar amounts in millions)

	2004	2003	2002
Number of Companies	21	21	21
Admitted Assets	$4,169.7	$3,947.5	$3,643.6
Liabilities	2,216.5	2,167.6	2,203.2
Surplus Funds	1,953.2	1,776.8	1,440.4
Net Premium Income	11,882.4	11,533.3	10,265.3
Number of Participants	3.4*	3.6*	3.8*

*in millions
Source: New York State Insurance Department

4. Examinations Conducted by the Health Bureau

During the year 2005, the field unit of the Health Bureau conducted 37 examinations of regulated entities. The 2005 examinations, by regulated entity and type, are presented below:

		Regularly Scheduled	
	Total	**Initiated in 2005**	**Prior to 2005**
By Regulated Entity			
HMO	13	6	7
HMDI	6	3	3
Commercial	12	4	8
Muni-Coop	2	2	0
CCRC	3	2	1
MLT	1	1	0
Total	**37**	**18**	**19**
By Type			
Financial	3	0	3
Market Conduct	12	4	8
Combined	22	14	8
Other:			
Capital Increase*	0	0	0
On Organization**	0	0	0
Total	**37**	**18**	**19**

* 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.

For the entire calendar year 2005 we averaged more than one-third of our form and rate filings submitted via SERFF. Although 2005 began with less than 5% of the filings made via SERFF, the percentages increased so that by the final third of 2005 the percentage of filings made via SERFF each week averaged in excess of 51% of the total number of filings received.

6. Review of Accident and Health Policy Form Submissions

In 2005, the Health Bureau made final dispositions on 1,378 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 1,378 submissions include 348 deemer and speed to market submissions (see Table 55B). Deemer submissions are submissions made under the expedited approval procedure set forth in Section 3201(b)(6) of New York Insurance Law. Speed-to-market submissions are submissions made under the optional expedited prior approval using a certification process (Circular Letter No. 4 (2003)).

Table 55A
ACCIDENT & HEALTH
Disposition of Policy Form Submissions
2005

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Total
Approved	178	240	83	272	4	777
Not Accepted / Circular Letter 14 (1997)*	5	83	42	8	1	139
Closed Due to Lack of Company Action	5	33	14	2	2	56
Disapproved	0	0	1	0	0	1
Filed for Reference	3	29	23	0	0	55
Prefiled	0	14	0	61	0	75
Withdrawn	8	21	3	4	0	36
Filed for Out-of-State Use	0	188	41	0	0	229
Other	1	4	3	2	0	10
Total	200	612	210	349	7	1,378

*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
Speed to Market and Deemer Submissions
2005

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Total
Speed to Market Submissions	83	27	29	204	0	343
Deemer Submissions	0	3	1	1	0	5

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 1,673 rate filings and disposed of 1,584 rate filings during 2005. 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 35% of the Accident and Health Rate Filings received were received through the System for Electronic Rate and Form Filing (SERFF).

In mid-2005 the entire rate manuals (which had only existed as paper manuals prior to that time) were converted to electronic manuals that are kept updated electronically. This has essentially put the full set of rate manuals on each actuary's desktop with the ability to search by various fields. Freedom of Information Law visitors access the manuals at a designated workstation in the Bureau. A future goal is to enable remote access to the rate manuals by Department examiners, insurers, and the public.

In addition to review and approval of premium rates in 2005, the Accident and Health Rating Section participated in the various meetings on the 2005 Long Term Care Study and provided actuarial input on various items included in the Study, reviewed and approved premium rates for private pay enrollees permitted under the managed long term care Medicaid programs, oversaw the updating of Healthy New York rates on the New York State Insurance Department Web site, and analyzed and determined estimated rate impacts of various proposed legislative changes to the mandated benefits included in the Accident and Health products.

8. Inquiries and Complaints

In response to formal written inquiries and complaints, the Bureau provided written answers to 162 consumer inquiries, 20 legislative inquiries and complaints, 90 Governor’s Office inquiries and 313

FOIL requests concerning accident and health insurance and related issues in 2005. In addition to formal responses to written complaints and inquiries, the Health Bureau monitors a dedicated mailbox on the Department's Web site. In 2005, the Health Bureau received and responded to over 700 Health Mailbox inquiries from consumers, providers, health plans, attorneys, consumer advocate groups and other state agencies. Some of the most common types of inquiries the Bureau received this year included consumer complaints against their health plan, inquiries relating to health savings accounts, health insurance option inquiries, coordination of benefit issues, questions relating to COBRA requirements, mandated benefit inquiries, and complaints regarding increased premium rates.

In addition to written inquiries, Bureau staff also responds to telephone inquiries and complaints. In 2005, Bureau staff responded to nearly 9,500 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 2005, one new report by an insurer was reviewed for compliance with Article 49 and placed on file with the Department and seven existing reports were updated and renewed.

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

Recently completing its sixth 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, 2005, the Department has received over 11,500 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 2005, the Department received and responded to 5,115 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 2005, the Insurance Department received 2,475 external appeal requests, which represented a 7% increase from the previous year. In addition in 2005, 214 external appeal requests were closed because health plans voluntarily reversed the denial during the external appeal process, 649 external appeal requests were determined to be ineligible for external appeal, 1,536 determinations were rendered by external appeal agents and 76 appeals were still pending at the end of the year either because additional information was needed or an external appeal agent was reviewing the case.

Table 56A lists the number of external appeal determinations that have been either upheld or overturned, categorized by type of appeal. Table 56B identifies external appeal results by agent. The tables reveal that 46% of health plan denials were overturned in whole or in part by external appeal agents and 54% were upheld by external appeal agents. 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, 2005 — December 31, 2005

Type of Denial	Total	Overturned	Overturned in Part	Upheld
Medical Necessity	1361	534	106	721
Experimental/Investigational	171	63	1	107
Clinical Trial	4	3	0	1
Total	**1,536**	**600**	**107**	**829**

Table 56B
EXTERNAL APPEAL DETERMINATIONS BY AGENT
January 1, 2005 — December 31, 2005

Agent	Total	Overturned	Overturned in Part	Upheld
HAYES	568	208	39	321
IPRO	339	142	24	173
MCMC	629	250	44	335
Total	**1,536**	**600**	**107**	**829**

Note: See text for full name of external appeal agents. HAYES Plus, Inc. changed their name to Independent Medical Expert Consulting Services, Inc., effective January 1, 2006.

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.

As originally constructed, Regulation 146 provided that the proportion of high-risk, high-cost persons would be determined by comparison of the average demographic index of each carrier's members in a region against the average demographic index of all other carriers in the region. The Insurance Department's Health Bureau worked extensively on the modification and restructuring of the original pooling mechanisms and revised the risk-sharing process by creating a new medical conditions/claims-based relative weighting mechanism for individual and small group health insurance. The new mechanism was established through the Fourth Amendment to Regulation 146, adopted May 22, 2002.

In November 2004, the Superintendent reconvened the Technical Advisory Committee to provide advice to the Department on certain issues relating to the market stabilization pools and the Committee continued to meet in 2005. Also in 2005, the Department entered into an agreement with health plans that set forth the manner in which specified medical condition pool funds would be collected and distributed to plans.

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 health maintenance organizations 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 2005, the Department directed the administrator to conduct the necessary audit procedures with respect to 2004 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 2004 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	$50,557,492	39.6%
Out-of Plan (POS) Direct Payment	$20,000,000	$40,139,848	49.8%

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

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

The Health Care Reform Act of 2000 (HCRA II) required the Insurance Department to administer the Healthy NY program. The program is designed to bring health insurance coverage to a portion of New York's nearly 3 million uninsured residents. 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. The funding was set at $69.2 million for 2005, $109.6 million for 2006, and $85.2 million for the first half of 2007.

The Healthy NY program is a unique and ambitious approach to addressing the problem of the uninsured. New York is unable to rely upon prior experience or the experience of other states in implementing the program. The Department has been working since early 1999 to build and implement the components of the program and continues to work with the health plans and public to monitor the program and provide education and guidance.

The Healthy NY program attempts to address the problem of the uninsured through both a small employer-based approach and an individual approach. All HMOs licensed in New York State are required to sell a "scaled down" standardized comprehensive health insurance benefit package to qualifying small employers, sole proprietors and individuals. The eligibility criteria for the program differs significantly depending upon whether the applicant is a working uninsured individual, a sole proprietor or a small employer group. The Healthy NY product includes a unique rating structure

designed to combine the experience of participating individuals and small groups. The program also utilizes a state-funded stop-loss feature designed to contain premium rates and limit the exposure of HMOs to excessive health care costs.

The major responsibilities of the Department in connection with implementation of the Healthy NY program for year 2005 included:

a. Program Oversight

The Insurance Department is solely responsible for the oversight of the Healthy NY program. Throughout Calendar Year 2005, the Department continued to provide education and guidance to the industry on program requirements. The Department continued to monitor the program for areas of potential improvement. The Department engaged in public awareness campaigns, as well as 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 guidance to the health plans.

b. Eligibility Issues and Education

The Healthy NY program includes fairly complex eligibility rules which differ entirely for individuals vs. individual proprietors vs. small employer groups. All HMOs must 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 Healthy NY consumer hotline that was established to address consumer questions and to provide support to the Consumer Services Bureau when Healthy NY issues arise.

c. Related Documents

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 to designated contact 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. This document describes the program and answers 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 were established appropriately. Rates needed to account for the availability of stop loss funding. Rate increases must be monitored based on actual claim and stop loss experience. The availability of the file and use rate increase mechanism has presented challenges in this regard.

e. Stop Loss Fund

The Department is responsible for oversight of the distribution of the allocated funding to HMOs submitting valid claims for reimbursement from the stop loss funds. 2005 was the fifth year covered by the Healthy NY program. HMOs are required to provide quarterly preliminary notifications of potentially

eligible claims beginning with the first quarter of each Calendar Year. Reimbursement requests for year 2005 are due by April 1, 2006.

Claims requests must be reviewed, audited and adjusted. That process was completed for Calendar Year 2004 claims. Each year, the Department must make application to the Department of Health for the release of the allocated stop loss funding and must distribute such funds to the eligible HMOs. The Department requested disbursements to the HMOs for 2004 claims in the amount of $12,229,320 for the claims of small employers and $22,288,171 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 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 adjusting 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 fifth annual study was finalized in December 2005.

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 was also authorized as part of HCRA of 2000. Extensive 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 Issues

The Department continued 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 to the Healthy NY Web site was established for consumers to contact the Department with questions. A toll-free hotline provides consumers with information about the Healthy NY program. Additionally, Department staff responded directly to a very large volume of consumer telephone inquiries. 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, various state and federal legislators and other governmental agencies.

j. Marketing and Outreach

The Healthy NY statute allows for the expenditure of up to 10% of the program's funds on public education, radio and television outreach and facilitated enrollment strategies. Such 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.

14. 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.

15. 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 two distinct pilot programs: one designed to assist entertainment industry workers, and the other designed to assist displaced workers meeting certain requirements as defined by federal law. The programs have distinct eligibility rules, funding, distribution channels, and require separate infrastructures. The programs are 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, while $700,000 annually has been reserved for the program for displaced workers.

The Health Bureau has worked diligently to implement this program, and began accepting applications on January 1, 2005 for the entertainment industry employees program. During its first month of operation, we received 214 applications from entertainment industry employees seeking premium assistance. For the entire year of 2005, we processed a total of 729 applications and paid out more than $812,700 in premium assistance. Payments were made to 23 union funds, the most highly represented being Equity League (181 enrollees) and Screen Actors Guild (66 enrollees).

16. 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 three examinations of CCRCs in 2005 and developed revisions to the Department's annual statement for financial filings.

There are now 10 CCRCs in New York, each one with a Certificate of Authority issued by the CCRC Council. Of these 10, 2 have not yet progressed to either the financing or construction. Four Certificate of Authority applications are currently under review.

17. 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 is currently considering appropriate guidelines and approval conditions for such indemnity long term care insurance products. The guidelines and conditions under consideration would 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.

b. Long Term Care Insurance, the Partnership Program and Medicaid Reform

During 2003 and 2004, the Health Bureau worked in conjunction with the Governor's Office and the Health Department to examine ways of expanding and improving long term care insurance options in the marketplace. This process was conducted under the auspices of the Health Care Reform Working Group appointed by Governor Pataki which is dealing with Medicaid reform.

The Health Bureau worked on issues such as modifying the New York State Partnership for Long Term Care insurance product design (in conjunction with the Health Department). In 2005 the Department drafted and promulgated 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 has been engaged in educating the industry and working with the Department of Health towards the development of insurer participation agreements. Insurers were required to submit subscriber contracts in order to offer the new products for the Department's review and approval no later than March 31, 2005. At the time of this writing, 3 of the 5 Partnership insurers have approved policy forms which will permit them to market the new Partnership product designs. We expect the remaining insurers will have new product designs shortly.

c. Long Term Care Study

The enacted 2004 Budget Bill directed the Insurance Department, in consultation with the State Office for the Aging and the Department of Health, to study and develop investment product options designed to assist policyholders with adequately preparing for the need for Long Term Care (LTC) services. The study was required out of recommendations from the Governor's Task Force on Health Care Reform which largely focused on escalating costs impacting the Medicaid program (the Bureau lent technical assistance to the Governor's Task Force on Health Care Reform from September 2003 to July 2004). The study was to be completed by the fall of 2005 and was to include recommendations as to how the State might further assist citizens to prepare for the costs of LTC services. The Bureau met and formed working groups with the Department of Health, the State Office for the Aging and representatives from the long term care insurance industry. The Bureau prepared and distributed a comprehensive survey instrument to all insurers participating in the long term care marketplace in order to collect data about the marketplace. The Bureau held separate forums to solicit the advice and input of consumer groups, insurers, and agents and brokers. The comprehensive study was recently released and the following topics were addressed, as required by law: (1)Evaluation of products that combine LTC and Disability insurance into an integrated product to reduce the costs of each type of insurance; (2) Analysis of products that offer a "living benefit" in a life insurance policy, that could then be used to pay for LTC, including LTC insurance premiums; (3)Analysis of products that allow an insured to access life insurance death benefits to pay for premiums on a LTC insurance policy; (4)Analysis of products that would allow tax credits and/or deductions for LTC insurance purchases for persons other than the insured; (5)Strategies to reduce the potential for a lapse of insurance coverage due to an insured's inability to pay the premium, such as providing ascending tax benefits; (5)Analysis of current LTC insurance offerings in NYS, their affordability and the adequacy of policy benefits, with an emphasis on the efficacy of such benefits in assisting individuals to remain in their own homes; (6)Evaluation of the effect of pre-existing medical conditions on the availability and affordability of LTC benefits; and (7)Evaluation of the adequacy of the process by which disputes related to policy benefits are resolved, including identification of any necessary consumer protections.

18. 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.

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 (PHL).

In 2005, 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 (9) of the PHL, 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 is 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 PHL involving written agreements with 12 approved managed long term care plans.

19. Medicare Modernization Act (MMA)

The federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) incorporated numerous changes in the area of Medicare coverage including prescription drug coverage, Medicare supplement insurance, and the Medicare Advantage program. As a result, the MMA had a significant impact on insurance coverage in the fifty states and ultimately on the responsibilities of the Health Bureau.

The Health Bureau reviewed and analyzed the final federal regulation for comment to the Centers for Medicare and Medicaid Services (CMS). The Bureau identified a number of areas where the regulation presented implementation issues and provisions that restricted the protections of New York laws.

The MMA required extensive changes to Regulation 62 regarding standardized Medicare supplement insurance plans. The Health Bureau promulgated the 34th Amendment to Regulation 62 to address these changes. The Amendment included new Plans K and L and the removal of prescription drug coverage from the standardized plans, revisions to the replacement notice, the application, and the outline of coverage. Following the promulgation of the regulation, insurers submitted policy and certificate form changes and premium rates for review and approval by the Bureau.

One of the most important features of the MMA was the addition of the new Medicare prescription drug coverage known as Medicare Part D. Part D had far-reaching implications for the Bureau, as it required that CMS draft model creditable coverage notices advising Medicare supplement insurance insureds of their options regarding Part D and Medicare supplement insurance plans with a prescription drug benefit. The Health Bureau participated in a number of meetings with CMS and the NAIC to draft the model notices.

The Health Bureau also issued Circular Letter No. 18 (2005) to clarify the responsibilities of insurers licensed to write accident and health insurance with regard to Medicare Part D. The Circular Letter explained that contract provisions proposing to coordinate benefits with Medicare Part D could apply only to those individuals enrolled in Part D. The Circular Letter also reminded insurers of their responsibility under the MMA to send appropriate notice to covered persons who are also Medicare beneficiaries, advising of creditable coverage.

Finally, CMS required that companies writing Part D coverage be licensed in the state they were proposing to operate or obtain a federal waiver of the state licensure requirement. The companies were required to obtain a state certification attesting to financial solvency and compliance with state law. The Health Bureau coordinated the legal and financial aspects and provided requesting 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 Advantage program, the Health Bureau was able to verify the status of the companies licensed in the state and provide letters to that effect.

20. 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). We have continued to receive HDHP submissions from companies which we have reviewed and approved. We have also continued to receive numerous inquiries from consumers, advocates, and the media regarding HSAs and HDHPs.

21. Child Health Plus

During 2005, the Department continued its role of reviewing and approving subscriber contracts and premium rates for the Child Health Plus program. During 2005, the Department revised and approved 13 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.

22. Early Intervention Program

During 2005, the Department took a more 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 members participate in monthly meetings with the Department of Health to discuss insurance-related issues brought to the DOH's attention by the county providers of early intervention services. Bureau staff also investigates claims denials brought to its attention by the early intervention providers and also gives technical assistance on the benefit requirements of health insurance.

23. Eating Disorder Legislation

During 2005, the Health Bureau provided assistance to the Department of Health in the development of the Request for Applications for Eating Disorder Centers. At the culmination of the process, the Department of Health identified four centers in New York State as meeting the requirements in the Public Health Law. The Health Bureau plans to issue guidance clarifying the requirements under Insurance Law with respect to services rendered in the designated centers.

24. Contraceptive Equity Lawsuit

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. 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.

25. Innovations in Prescription Drug Coverage

The Health Bureau had 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 will consider regulatory amendments to establish minimum standards for the form and content of prescription drug coverage.

26. Innovative Health Insurance Products

The benefits provided under policies of Medicare Supplement Insurance have been standardized under both federal and state laws and regulation. An insurer may, with the prior approval of the Superintendent, offer policies with new or innovative benefits in addition to the standardized benefits. In 2005 we approved the first innovative benefit to supplement standardized Medicare supplement insurance plans. The benefit is named "The Silver Sneakers Fitness Program". Under the benefit, insureds have the option to participate in specialized low-impact exercise classes through basic fitness memberships at participating fitness centers. The benefit is optional for insureds and provided at no additional cost. For insureds living outside the participating fitness center network, a Silver Sneakers Steps program is available which is a self-directed, pedometer-based walking and physical activity program. The program provides necessary equipment and tools to insured Medicare beneficiaries.

The Bureau continued to approve policy forms that qualify as high deductible health plans (HDHPs) for use with Health Savings Accounts. To date, we are aware of approximately fifteen companies that are offering HDHPs in the group health insurance market in New York State.

The Bureau approved a limited benefits product from United Healthcare Insurance Company of New York that is intended to be marketed to employers with part-time workers, low wage earners, pre-65 year old retirees, and other workers who have historically not been offered health care coverage by their employers.

27. Explanation of Benefits Circular Letter

Following market conduct examinations that revealed many instances where commercial insurers, Article 43 corporations and HMOs (hereinafter "insurers") were not issuing explanation of benefits (EOB) notices to insureds and subscribers for fully or partially denied claims as required by Section 3234 of the New York Insurance Law, the Bureau issued a Circular Letter setting forth the instances identified in the market conduct examinations when an insurer is required to issue an EOB to an insured or subscriber.

28. Discontinuations, Withdrawals and Mergers

The Health Bureau approved notices of merger and certificates of assumption for Vytra Health Services, Inc. and Vytra Health Plans Long Island, Inc. in furtherance of its merger with Health Insurance Plan of Greater New York.

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.

29. 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 2005, the Bureau received an additional 18 applications for review. During 2005, 42 have been approved, 33 are pending and none 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

While 2005 saw another year of dynamic change in the insurance industry, the Consumer Services Bureau, as it has done in its 92 year history, continued to adapt to the changes to meet the growing needs of insurance consumers. Whether it was responding to natural disasters such as Hurricane Katrina, acting as a consultant to the State's Attorney General in a major broker compensation investigation, or educating New Yorkers about significant changes to Medicare supplement and long term care insurance policies, the Bureau aggressively and proactively tackled these new challenges, while continuing to successfully discharge its more typical day-to-day functions.

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 **55,029** cases in 2005. Of these, **42,492** involved complaints against insurance companies regarding loss settlements or policy provisions, of which 27.7% (**11,772**) were automobile complaints, 61.2% (**25,992**) were accident and health complaints, 8.1% (**3,461**) were property and liability complaints and 3.0% (**1,267**) were life and annuity complaints. In addition **1,835** cases were closed when the complainants failed to furnish additional information deemed necessary in order to proceed with the case. Another **7,297** cases involved complaints against agents, brokers and adjusters. Written inquiries accounted for **1,498** cases and referrals accounted for **1,907** cases (see Chart G). Included in the total are 3 cases related to the World Trade Center Disaster. In total, the Bureau *received* 56,382 cases during 2005.

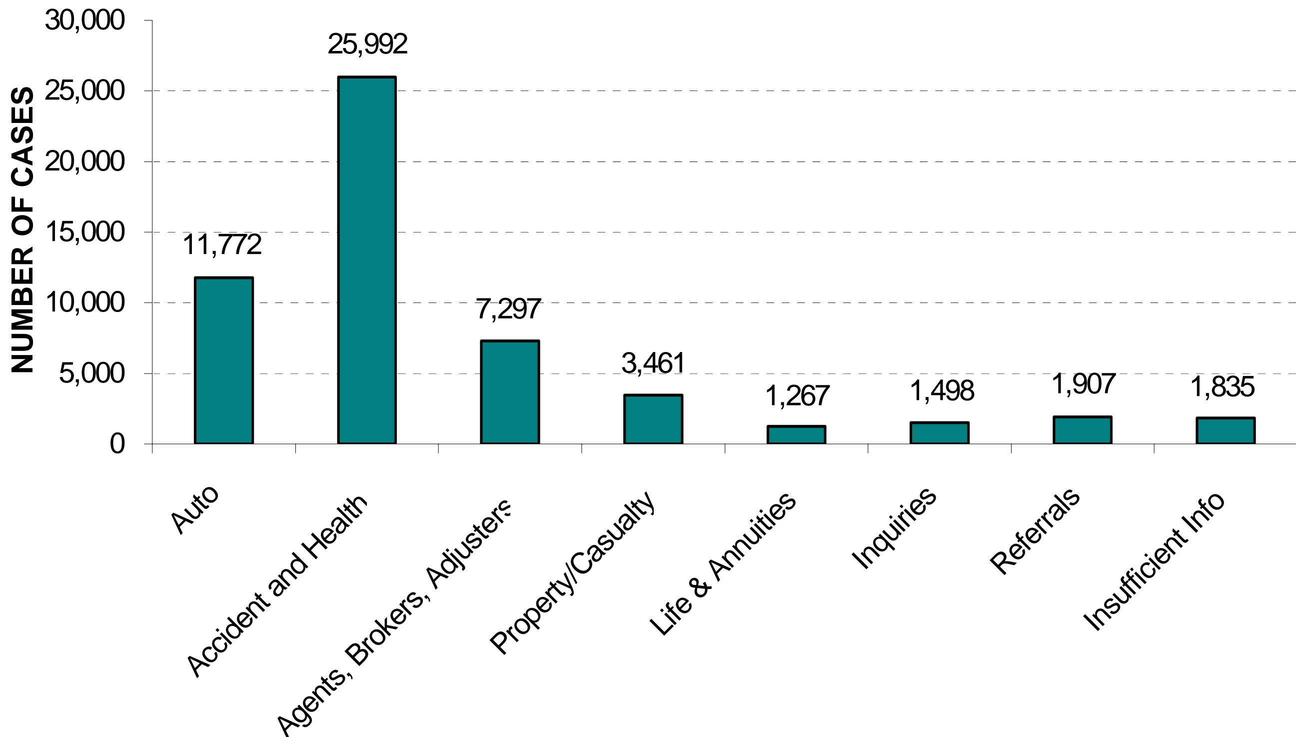
In calendar year 2005, the Bureau responded to 181 requests from consumers under the Freedom of Information Law for copies of documents contained in the Bureau's complaint and investigation files. These requests ranged from as small as one document to thousands of documents in hundreds of files.

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

Notable complaint activity

The Consumer Services Bureau assessed fines against two health maintenance organizations (HMO) for failing to respond to Department correspondence in a timely and substantive manner pursuant to Section 2404 of the Insurance Law. Despite several meetings and promises of improvement, both companies failed to correct the problems that resulted in late and deficient responses to consumer and provider complaints. Aetna Health, Inc., paid $100,000 and Cigna Healthcare of New York, Inc., paid $150,000.

The Consumer Services Bureau assisted the Health Bureau with their report and subsequent fine against Empire Healthchoice for not conducting utilization review for procedures the plan considered cosmetic and procedures automatically down-coded.



2. Prompt Payment Statute

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

The Consumer Services Bureau continued to allocate significant resources to the investigation and resolution of complaints involving claims subject to 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.

The Consumer Services Bureau continued its enforcement action against health insurers and HMOs that violated the prompt payment statute. In 2005, $316,800 in prompt pay fines was levied against 24 health insurers and HMOs. These fines were calculated using the new 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 outreach sessions for large provider groups in order to educate them on their rights under the prompt payment statute and other laws that affect the payment of health care claims. The focus of these sessions was to provide information to assist the providers whose patients may be faced with the need to navigate through the insurers' and HMOs' various processes.

The system upgrade, implemented last year, continues to streamline complaint handling and enables prompt pay complaints to be handled more expeditiously by allowing providers to file prompt pay complaints via the Department's web site. 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.

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 2005, Consumer Services Bureau personnel responded to 5,115 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 2005, the Department received 2,475 applications, the most in any year since the program's inception and an increase of 6% over 2004.

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 2005 is the final adoption of Regulation 178, which lists the elements of an undisputed non-electronic claim.

The Roundtable continues to discuss many issues that affect health care providers and health insurers alike. During 2005, 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, and (4) coordination of benefits when there is other primary coverage. Our efforts, however, were concentrated on coordination of benefits (COB) when there is other primary coverage and excessive billing by health care providers in emergency room situations. These discussions have lead to an agreement in theory on how to handle the COB claims and language for a regulation is currently being finalized

In addition to the topics indicated above, discussions continued on the use of Extrapolation during provider audits. Spearheaded by the Consumer Services Bureau, these discussions included the Medical Society of the State of New York, the Health Plan Association, the Conference of Blue Cross Blue Shield Plans and the Department of Health.

5. Special Investigations

The Consumer Services Bureau led an investigation into the marketing practices of the company 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.

The investigation was comprehensive and has resulted in several recommendations which were included in the market conduct report filed by the Life Bureau. The Consumer Services Bureau continues to work with the Health and Life Bureaus on the American Progressive special investigation and market conduct. Final disciplinary action is pending.

The Consumer Services Bureau worked with the New York State Attorney General's Office on several topics. These include:

1) **911 Victims Compensation Fund** – An anonymous complaint was received alleging misrepresentation by licensed brokers who assisted the families of 911 victims in obtaining structured settlements through the Victims Compensation Funds. The complaint alleged that brokers stated they were providing their services free of charge when in fact their compensation was hidden in the cost of the product. The investigation included several examinations under oath conducted jointly between the Insurance Department and the Attorney General's Office.

2) **Broker Compensation** – The Consumer Services Bureau acted as a consultant for the Attorney General's Office during their investigation of broker compensation. This aspect of the Attorney General's investigation concentrated on service agreements between the carrier and the broker that were used to exceed the commission limitations that are allowed in the regulation.

3) **Balance Billing** - The Consumer Services Bureau met with the Attorney General's Office to discuss hospitals billing patients when their insurer was slow to process claims for payment. This often resulted in a negative impact on the patient's credit reports.

4) **Usual, Customary & Reasonable (UCR)** – The Consumer Services Bureau met with representatives from the Attorney General's Office to discuss the findings of an investigation by the Attorney General's Office of health insurance reimbursements based on UCR determinations. The Attorney General's Office requested assistance from this Department in resolving several findings that were troubling.

5) **Coordination of Benefits (COB)** – The Consumer Services Bureau met with the Attorney General's Office to discuss COB in health insurance contracts and the requirements in the regulation.

6. Investigations

The Investigation Unit of the Consumer Services Bureau is responsible for investigating the activities of insurance producers, adjusters, reinsurance intermediaries, bail bond agents, service contract providers, and other licensed and non-licensed entities who are conducting the business of insurance in New York State. 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 Investigation Unit continues to look at the activities of unlicensed health insurers. During 2005, we answered both producer and consumer inquiries regarding the legitimacy of insurance entities wanting to do the business of insurance in New York. We also looked at any webpage solicitations and advertisements to see if they were in compliance with our laws and regulations.

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 are looking at the actions of over 400 producers.

a. Notable Revocations/Citations:

Todd McDonald – Mr. McDonald, an agent for Med America, submitted policy applications in which he wrote false credit card numbers as a means for payment by his clients. This enabled him to receive commissions on these written policies which were then subsequently cancelled.

Vincent Nicotra – Mr. Nicotra's action of cashing a premium finance check for his own use, resulted in a stipulation with the full force and effect of revocation. Mr. Nicotra was subsequently arrested in Suffolk County on charges related to this matter.

Jeffrey Seifts – Mr. Seifts collected, but failed to remit, $78,000 in premiums due to MVP Health and charged his clients a $12 monthly fee for union dues, which he also never remitted. He also collected $2,050 from an insured, but failed to place her coverage, resulting in the insured incurring over $50,000 in unpaid medical bills. He also falsified information about his clients on their applications before remitting them to the insurer.

Juan Villar – Mr. Villar wrote bail bonds on behalf of Vincent Smith, an unlicensed bail agent out of Reading, PA. Collateral in excess of $1,000,000 was unaccounted for by Mr. Villar and Mr. Smith. The Investigation Unit revoked bail agent Juan Villar.

Charles Zonneville – Mr. Zonneville issued a fraudulent ID card to one of his clients who had been arrested for driving without insurance. A search warrant was obtained by the State Policy and the Consumer Services Bureau assisted in reviewing the agency's records. Mr. Zonneville eventually pled guilty to a Class E felony of "Offering a False Instrument." He stipulated to the revocation of his insurance license as part of the plea and sentencing.

b. Stipulations

The Investigation Unit received information from the FBI regarding 15 independent adjusters involved in insurance fraud. Our investigations led to seven adjusters signing stipulations with the full force and effect of revocation, two adjusters revoked by the Superintendent's determination and two adjusters awaiting the Superintendent's determination.

Black Car Emporium (BCE) – BCE, an unlicensed entity that wrote physical damage coverage on livery vehicles, was investigated along with 67 producers who sold business on its behalf. As of March 3, 2006, 32 producers have entered into stipulations with the Department and paid a total of $127,800 in fines. Twelve producers have agreed to fines in the amount of $77,600. These latter stipulations are being processed.

Blundon- Burgess Agency, Inc. - $4,000 fine – The Blundon-Burgess Agency failed to secure insurance coverage for the Town of Pitcarin from August 24, 2003 through April 7, 2004. Four fraudulent insurance ID cards were issued to cover the town's vehicles during this period of time. Fortunately no claims were incurred during this lapse in coverage.

Brown & Brown, Inc. – Brown & Brown, Inc. acted as the Managing General Agent on behalf of CNA during the period 1998 through November 6, 2000, without being properly licensed by the Department. The respondent agreed to pay a fine of $100,000 as a final resolution of this matter.

Frank P. Grasso – Mr. Grasso sold, in New York State, variable annuity products not approved for sale in the State. Mr. Grasso paid a civil penalty of $42,710.95, which amount represented the commissions received on the sale of these policies.

One Stop Taxi and Limousine Brokerage – $3,500 fine - One Stop Taxi and Limousine received 68 premium refund checks from Premium Payment Finance Co which was to be remitted to its insureds. The Agency failed to forward these refunds prior to our investigation.

Robert Sagar - $28,250 fine - Mr. Sagar sold 4 annuity contracts from an unlicensed company to New York residents. He falsely stated on the applications that they were signed in New Jersey when in fact they had been signed in New York.

Dennis Vaughan - $1,000 fine - Mr. Vaughan failed to remit a premium payment of $14,750 which he had received from the St. Anthony's Residence, a homeless Shelter in the Bronx. The premium was remitted as a result of our investigation.

William S. Marshall, III – Mr. Marshall acted as an adjuster without a license. Our investigation resulted in fines of $37,600 and $4,500 against licensees Custard Insurance Adjusters and Sterling and Sterling, Inc., respectively. An investigation of Crawford and Company continues.

c. Denials

Lawrence Rand - Mr. Rand sold 480 policies to New York residents for the Fidelity Health Plan, an unlicensed insurer. He received $210,893 in commissions before the Plan was shut down by the US Attorney's Office.

d. Case of Interest

Debra Licata - Ms Licata operated two store front insurance offices in the city of Buffalo and let her broker's license lapse as of 10/30/04. Our investigation was commenced as a result of numerous customer complaints. She then abandoned her agencies and failed to service her clients' accounts.

Our investigation disclosed that she collected and failed to remit premium payments and issued fraudulent ID cards. Our Bureau has assisted those consumers who could substantiate proof of payment in having their insurance coverage reinstated. We also worked with the Department of Motor Vehicles in rescinding any penalties imposed. Her book of business was purchased by another agent who took over the servicing of her policies. Possible criminal action is still pending.

e. Service Contract Providers

Service contract providers offer (i) repairs, replacement or maintenance, or (ii) indemnification for the repair, replacement or maintenance, of property due to a defect in materials or workmanship or wear and tear. The products covered include automobiles and electronics equipment, among others. Manufacturers who issue original product warranties upon the sale of its products are exempt from the service contract provider registration requirement.

The Bureau continues to investigate other service contract providers to resolve violations of insurance law for failing to meet financial solvency requirements, failure to timely renew registrations and for operating without a registration. Should a service contract provider fail to comply, the Bureau will move to suspend or revoke its authority to conduct business in the State or seek orders to cease and desist operations in New York State.

The Bureau suspended First Assured Warranty Corporation's authority to act as a service contract provider in New York State after the company stopped paying all claims. This was done in conjunction with the State of Hawaii's legal actions against Primeguard Insurance RRG, the owner of First Assured Warranty Corporation. The Bureau continues to work with the State of Hawaii to assure that New York State contract holders will be protected during the liquidation.

The Bureau has been working closely with Heritage Administration Services, Inc. Heritage was deemed to be in a hazardous financial condition due to a large stockholder's deficit and failed to prove financial responsibility as per Section 7903 of NYS Insurance Law. The Bureau, along with the Property Bureau and the Office of General Counsel, negotiated a stipulation settlement with Heritage wherein Heritage would prove solvency and comply with all financial responsibility requirements. The Bureau continues to work with Heritage on this matter.

The Bureau has been investigating the subject area of accidental damage protection products, whereby manufacturers and distributors of computers offer protection, for an additional cost, for fortuitous events such as droppage, spillage, etc. This resulted in manufacturers creating insurance policies, and acting as insurers without holding a proper license. The Bureau in conjunction with the office of General Counsel has resolved this issue by qualifying these offerings as service contracts, thus affording the residents in this State the proper protections required by the law.

Other investigations involve the subject area of road hazard products. Manufacturers and distributors have been offering protection, for an additional cost, for fortuitous events resulting from road hazards such as potholes, nails, etc. This results in manufacturers creating insurance policies, and acting as insurers without holding a proper license. The Bureau in conjunction with the office of General Counsel is moving to resolve these issues. The Bureau hopes to qualify these offerings as service contracts, thus affording the residents in this State the proper protections required by the law.

7. Other Bureau Activities

a. Complaints on the Internet

A major activity for the Consumer Services Bureau continues to be the monitoring and processing of consumer complaints received over the Internet as well as Internet responses from registered insurers, HMOs and their affiliates.

In 2005, the total number of complaints received increased by approximately 29% over 2004 for a total of 12,781 online complaints; 4,747, or 37%, correspond to participating provider prompt payment and no-fault complaints. This represents an increase of 122% over last year where these types of complaints were 22% of the total number of complaints.

In 2005, we also received 22,964 online complaint responses from insurers, HMOs and their affiliates. This is 16,864 more responses than the 6,100 received in 2004, representing a 276% increase.

One component of the Consumer Imaging and Information Management System (CIIMS) allows for the automatic closing of participating provider prompt pay complaints based upon responses completed on the internet. Since last year was the first complete year utilizing this new component, we cannot offer a reliable comparison. However, of the 17,109 cases closed in 2005, 4,025, or 23%, were closed automatically by CIIMS.

The Consumer Services Bureau continues to network with providers, insurers and HMOs to increase the use of electronic filings. The Department provided demos of CIIMS and OCCRS (On-Line Company Complaint Response System) as a best practice solution to the Insurance Consumer Affairs Exchange, a symposium of complaint managers in both the public and private sectors. As a result, there are 44 insurers, HMOs and their affiliates currently registered to respond on-line. Compared to the 27 company groups registered last year, this represents a 66.7% increase in registrants.

b. State & County Fairs, Conferences & Festivals

Bureau examiners staffed the Department's information booth at the State Fair in Syracuse from August 24 through September 5, 2005. Examiners also staffed an information booth at the Erie County Fair from August 8 through August 21, 2005. At these booths, examiners answered consumer questions, took complaints and distributed the Department's various consumer guides and booklets. Over 75,000 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. 10,000 of these compact disks were distributed at the fairs and the below-listed conferences in 2005.

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, and the State Emergency Management Office Disaster Preparedness Commission Fall Conference. 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 representative 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.

c. 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.

d. New York State Insurance Disaster Coalition

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

The Bureau continues to receive complaints from those individuals, families and businesses affected by the World Trade Center disaster as well as other natural disasters occurring in New York State during 2005. 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 2005 to activate the Disaster Response Plan. The Bureau did assist consumers who sustained damages caused by flooding from the collapse of the Fort Ann, New York dam and from a series of strong thunderstorms along the Southern Tier and Long Island.

Due to the devastating damages caused by Hurricanes Katrina and Rita striking the Louisiana and Mississippi coastal areas, 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 continues into calendar year 2006.

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 2005, the Bureau responded to questions related to the World Trade Center disaster, various summer and winter storms and flood damages caused by the collapse of the Fort Ann Dam.

e. Senior Issues

The Bureau continues to conduct informational sessions to assist senior citizens and groups concerned with Medicare supplement and long term care insurance. With the new Medicare Modernization Act (MMA) which allowed seniors a prescription drug discount card in 2005, there was much confusion on the options available to seniors to meet their health insurance needs.

The Medicare Modernization Act also established a prescription drug program for Medicare beneficiaries effective January 1, 2006. This program creates 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 more important that correct information be provided. In addition, Medicare supplement insurance policies available in New York must 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 HIICAP education and training sessions monthly. 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 2006.

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, which is consistent with the Governor's goals in his 2006 budget proposal. In 2005, the Consumer Services Bureau received approximately 4,200 calls on the Partnership hotline, a slight decrease from the previous year.

Minimum standards for all Partnership plans were upgraded in 2005 to include benefits for Nursing Home Care Bed Reservation, Hospice, and Care Management. The law change also provided more flexibility in the type of long term care type policies available that can help New Yorkers meet Medicaid eligibility under the Partnership program without exhausting their assets. Beginning in spring 2006, the Partnership will launch a media campaign promoting the improved program.

The State Office for the Aging also launched its Long Term Care Insurance Outreach and Education Program (LTCIOEP), mandated under New York Elder Law, during 2005. 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 plans a significant media campaign to publicize the availability of the various types of long term care type policies available in New York. The Consumer Services Bureau anticipates an increase in the number of telephone calls requesting information on long term care insurance in general as a result of the two separate initiatives by the State Office for the Aging and the Department of Health.

f. Miscellaneous

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 assumed responsibility for responding to inquiries received via the Healthy NY mailbox on the Department Web site during 2005.

The Consumer Services Bureau continued during 2005 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.

The Department is required to publish an Annual Consumer Guide to Health Insurers, which ranks insurers and HMOs complaints upheld by the Consumer Services Bureau, and contains a separate ranking based on upheld prompt pay complaints. Bureau staff met with the Public Affairs, Health and Administration bureaus to ensure that resources are available to publish the Guide before the deadline imposed by legislation. Bureau staff also met 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 also worked on creating the ranking and reviewing all of the data contained in the Guide for accuracy. The Bureau, likewise worked on a similar ranking for automobile insurers, the 2005 Annual Ranking of Automobile Insurance Complaints.

Table 57
CONSUMER SERVICES BUREAU COMPLAINTS AGAINST INSURANCE COMPANIES INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
Closed in 2005

Line of Business	Total Processed	Upheld	Adjusted in Consumers Favor	Not Upheld	Prompt Pay Violation	Other Action Taken
Total	**42,492**	**2,705**	**5,944**	**12,810**	**5,756**	**15,277**
Life & Annuities, Total	1,267	108	234	698	0	227
Individual Life	953	81	177	546	0	149
Individual Annuity	148	13	35	74	0	26
Group Life & Annuity	155	14	16	75	0	50
Viatical Settlements	1	0	1	0	0	0
Credit Life	10	0	5	3	0	2
Accident & Health, Total	25,992	460	3,557	7,287	5,756	8,932
Individual Accident & Health	209	16	37	112	26	18
Group Accident & Health	3,940	138	767	2,017	834	184
Article IX-C Corps	1,668	60	277	873	362	96
HMO	8,466	145	1,682	2,883	3,165	591
Medicare	1,467	0	1	1	0	1,465
Medigap	188	7	38	111	17	15
Long Term Care	86	7	11	52	0	16
Self-Insured Health Plan	4,817	0	1	3	0	4,813
Travel, Health	87	6	15	40	0	26
Health Alliance	0	0	0	0	0	0
Medicaid	2,845	28	561	889	1,258	109
Municipal Co-ops	64	2	5	24	27	6
Credit Disability/DBL Income	315	24	83	113	0	95
Healthy NY	203	19	44	99	30	11
Federal/Out-of-State Contracts	1,479	0	3	0	0	1,476
Child Health Plus	158	8	32	70	37	11
Auto, Total	11,772	1,742	1,646	3,579	0	4,805
Auto, Liability (B.I.)	1,824	265	295	961	0	303
Auto, Liability (P.D.)	2,284	124	408	541	0	1,211
Auto, Physical Damage	1,516	119	269	584	0	544
No-Fault	6,148	1,234	674	1,493	0	2,747
Other Property & Liability, Total	3,461	395	507	1,246	0	1,313
Liability Other Than Auto	240	20	28	73	0	119
Professional Malpractice	31	4	6	14	0	7
Fire & Extended Coverage	54	2	7	30	0	15
Homeowners	1,350	90	189	631	0	440
Inland/Ocean Marine	35	1	2	13	0	19
Workers' Compensation	1,220	230	205	280	0	505
Commercial Multiple Peril	331	31	40	122	0	138
Burglary & Theft/Fidelity Surety	48	0	5	11	0	32
Flood	26	1	8	13	0	4
Title	53	5	9	27	0	12
GAP and Service Contracts	11	0	2	2	0	7
Other	62	11	6	30	0	15

Table 58
CONSUMER SERVICES BUREAU INVESTIGATIONS AGAINST AGENTS AND BROKERS NOT INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
Closed in 2005

Subject of Cases or Investigations	Total Processed	Fines and Revocations	Other Actions	Not Upheld
Total	**7,297**	**487**	**6,008**	**802**
Application for License	5,315	125	5,190	0
Issuing Bad Checks	204	102	53	49
Misrepresentation of Coverage	170	19	56	95
Excess Comp Without Contract	27	1	8	18
Twisting	40	3	17	20
Violation of NYAIP/NYPIUA Rules	202	79	48	75
Return Premium-Producer	80	4	21	55
Other Violations of Insurance Law	99	24	31	44
Violations of Other Laws	19	2	10	7
Termination for Cause	89	25	57	7
Misleading Sales, Life and Medigap	40	3	26	11
Advertisements	31	1	12	18
Miscellaneous	319	25	92	202
Misappropriation of Funds	204	52	66	86
Service Contracts	116	1	87	28
Aiding Unauthorized Insurers	8	0	7	1
Inquiries	138	0	138	0
Other Investigations Received from Companies	18	2	6	10
Other	178	19	83	76

E. INSURANCE FRAUDS BUREAU

1. Operational 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 additional offices across the State: Brooklyn; Mineola; Buffalo; Rochester; Syracuse; Oneonta and Albany.

2. 2005 Highlights

- In October, six members of the Frauds Bureau's No-Fault Unit were part of a 15-member team that received a Governor's Office of Employee Relations 2005 Workforce Champions Award for their successful efforts in "Operation Auto Rates," a multi-faceted strategy to reduce auto premiums in New York State. New York drivers saved more than $400 million in auto premiums.

- The Frauds Bureau recorded 753 arrests during 2005, with stepped-up collaborative law enforcement alliances on the federal, state and local levels.

- An investigation by the Frauds Bureau and other members of the Federal Health Care Task Force led to the arrest of 42 suspects in a frauds sweep that took place in both New York City and the Buffalo/Niagara area. The suspects, who have all pled to charges, were involved in a series of staged accidents in Western New York.

- The Frauds Bureau and the Queens District Attorney's Office shared an award from the New York State Police in recognition of their efforts in a three-year investigation called "Operation Crash Course." The case resulted in the arrest of 67 individuals and corporations for their participation in a major no-fault ring.

- The Frauds Bureau, in conjunction with the New York Insurance Association and the Workers' Compensation Board Inspector General's Office, conducted a seminar for the Business Council of New York State in October about application fraud, premium fraud and other problems associated with workers' compensation insurance. Based on feedback from the Council, a series of seminars is planned throughout 2006 to heighten the business community's awareness about workers' compensation fraud.

- The Frauds Bureau participated in a joint three-year investigation that led to the arrest or indictment of 6 corporations and 28 people, including four doctors and a dentist. As a result of this investigation, a major medical mill in Westchester County that allegedly defrauded insurance companies of more than $12 million was shut down.

- The National Insurance Crime Bureau presented a Certificate of Recognition to Senior Investigator Gary Anderson at their Annual Award Ceremony in December. He was honored for his efforts and commitment to the detection and prevention of insurance fraud.

- The Insurance Department for many years has welcomed foreign delegations to exchange ideas regarding insurance regulation. During 2005, members of the Frauds Bureau shared fraud-fighting techniques with groups visiting from Russia, Australia, Korea, Central Asia, India and China.

3. Team Building

Team building has long been a hallmark of the Frauds Bureau and the tradition continued in 2005, Collaborative alliances with law enforcement agencies on the federal, state and local levels resulted in successful investigations, arrests and convictions throughout the State over the past year.

a. Multi-Agency Investigations

Frauds Bureau investigators and the Attorney General's auto team have met regularly and developed a strategy for partnership and cooperation in the investigation of auto insurance fraud cases. Bureau staff also worked with district attorneys' offices, the New York City Police Department, the Fire Department of New York City and other local police and fire departments from one end of the State to the other.

The Bureau also pooled resources with State agencies such as the Department of Motor Vehicles, the State Police and the Workers' Compensation Fraud Inspector General's Office, among others, to root out insurance fraud and abuse. In addition, the Bureau partnered with the U.S. Postal Inspector Office, the U.S. Departments of Labor and Education and the Bureau of Alcohol, Tobacco, Firearms and Explosives on the federal level.

b. Task Force/Working Group Participation

The Frauds Bureau is an active participant in numerous task forces and working groups that promote communication, cooperation and commitment among the many agencies across the State that share similar goals.

4. The Staff

The Director of the Bureau is responsible for all Bureau 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; and the Training Office reports to the Chief Investigator.

Bureau staff consists of 34 investigators organized into six specialized units – Arson, General, Medical, Organized/No-Fault/Auto, Upstate and Workers' Compensation. Each unit is headed by a Deputy Chief Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of two newly appointed Assistant Chief Investigators.

A Statewide Auto Coordinator monitors patterns and trends in auto insurance fraud, coordinates investigative efforts throughout the State and acts as a liaison with other states on auto-related fraud issues. He also provides technical assistance to district attorneys who have received grants to establish auto fraud units. This grant program is overseen by the New York State Division of Criminal Justice Services (DCJS). Moreover, as Quality Control Officer, he is responsible for the quality of the Bureau's files, recordkeeping and case management statewide.

In addition, the Bureau has a staff of insurance examiners that includes a Senior Examiner and an Examiner who work under the supervision of 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. In addition, investigators take part in the Bureau's In-Service Training Program. Both programs – developed and administered by the Bureau's Training Officer – 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 (DCJS). Frauds Bureau investigators are seasoned professionals with extensive law enforcement experience and often exceed these high standards of performance.

In his capacity as a Certified Firearms Instructor, the Bureau's Training Officer provides investigators both upstate and downstate with appropriate instruction in firearms proficiency and safety. While certification in firearms proficiency is required by the DCJS on an annual basis, all Frauds Bureau investigators must recertify semi-annually, demonstrating the importance the Bureau attaches to the responsibility of carrying and using firearms.

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 a number of police departments around the State during the past year, including three sessions at the New York City Police Academy that were attended by 2,220 recruits. A training session scheduled for December 22 that would have included more than 500 recruits was cancelled. A citywide transit strike made it necessary for NYPD personnel, including recruits, to work on patrol. The Bureau has placed great emphasis on the training of police recruits because police officers are often the first responders to auto accidents and other emergency situations and their ability to recognize insurance fraud can be critical to an investigation.

In addition, investigators, examiners and support staff regularly attend career development seminars and training programs to increase their proficiency in computer skills, management techniques and problem-solving methods.

5. Investigations

The Frauds Bureau received 25,945 reports of suspected fraud in 2005. Of that total, 25,112 were received from licensees required to submit such reports to the Department, and 833 were received from other sources, e.g., consumers and anonymous tips. A total of 1,179 new cases were opened for investigation during 2005. At the same time, investigations continued in numerous cases opened in prior years.

During 2005, the Bureau referred 224 cases to prosecutorial agencies for criminal prosecution and another 27 for civil settlement or referral to the Department's Office of General Counsel for civil proceedings.

6. Arrests

Frauds Bureau investigations led to 753 arrests for insurance fraud and related crimes during the past year. Many of these investigations dealt with sophisticated conspiracies involving medical clinics, doctors and other health care professionals who prescribe unnecessary treatments and tests or bill for services never rendered and attorneys who file bogus 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 and prosecutors.

A case in point involved a three-year investigation by the Westchester County DA's Office, the Frauds Bureau, the NYPD, the State Police, the New Jersey Attorney General's Office, the Yonkers and Westchester County Police Departments and numerous insurers that led to the arrest or indictment of six corporations and 28 people, including four doctors and a dentist. As a result of this multi-agency effort, a major medical mill in Westchester County that allegedly defrauded insurance companies of more than $12 million was shut down.

In another instance, the Monroe County Auto Crimes Task Force was established in conjunction with a Division of Criminal Justice Services grant. The goal of the Task Force, which is headed up by the Monroe County DA's Office and includes members of the Frauds Bureau, the State Police, the Monroe County Sheriff's Department, the Rochester Police Department and a number of suburban police departments and the Department of Motor Vehicles, was to tackle the problem of auto-related

crime and insurance fraud head on. As part of the Division of Criminal Justice Services' comprehensive crime-fighting program known as "Operation Impact," investigators flooded neighborhoods on random nights during April, June, October and November 2005 and using new high-tech equipment scanned a total of 115,000 auto license plates. As a result of this Operation, 24 stolen vehicles valued at more than $112,000 and 19 stolen license plates were recovered, 23 criminal arrests were made and 897 summonses were issued, many of them for insurance violations. This investigation is ongoing.

These collective endeavors and the many like them that the Frauds Bureau was involved in during 2005 have had a major impact in reducing insurance fraud in New York State.

7. Fines

Bureau activities led to stiff fines against 109 individuals who were sentenced to more than $5.8 million in court-ordered restitution in 2005. Individuals made voluntary restitution totaling $260,835 in 12 cases during the year. In another 41 instances, insurers achieved savings of $410,125 in connection with fraudulent claims under investigation by Bureau staff.

The Governor and the Legislature have provided the support that has enabled the Bureau to join with members of the insurance industry and law enforcement agencies on the federal, state and local levels to form a cohesive team to combat insurance fraud throughout the State.

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 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. 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, 141 Plans were on file with the Department.

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. Toward that end, 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, carries out major advertising campaigns using newspapers, radio and television to target insurance consumers. In addition, the National Health Care Anti-Fraud Association as well as several individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance of insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year. One measure of the success of these campaigns is the volume of calls to the Bureau's frauds hotline. Such calls averaged 43 a week during 2005.

10. Major Cases

The Frauds Bureau was involved in a number of multi-agency investigations during 2005, as well as arrest sweeps conducted both upstate and downstate. These operations, in addition to the day-to-day investigations conducted by Frauds Bureau investigators, contributed to the total number of arrests for the year. Some of these cases are summarized below.

a. Motorcycle Gang

A motorcycle theft and fencing ring comprised of 16 individuals – including fences, locators and "steal men" – that allegedly stole more than 81 imported motorcycles valued at more than $1 million – was shut down following a nine-month undercover sting operation. The investigation began in March 2004 when a motorcycle owner reported to the NYPD that he recognized parts of his motorcycle, which had been stolen from his driveway, being offered for sale on e-Bay. The NYPD's Auto Crime Division launched a wider investigation in conjunction with the Queens DA's Organized Crime and Rackets Bureau and the Frauds Bureau. The defendants were accused of burglarizing homes and stealing motorcycles in New York, New Jersey and Connecticut. The steal men drove or hauled the motorcycles by van to garages in Queens where they were chopped up, identification numbers on the parts were altered, the parts were photographed for Internet sale, and then packaged for shipment to purchasers from Ohio and California, as well as Italy, Spain and Australia. Investigators executed eight court-authorized search warrants on October 20-21, 2004 at the Queens garages and at the homes of four of the defendants and recovered $169,000 in cash, several computers that allegedly contained records of the ring's Internet sales, numerous stolen motorcycle engines and other parts, two stolen cars and tools used to dismantle vehicles and alter their identification numbers. In addition, NYPD detectives coordinated with investigators in Ohio and California for the execution of 15 "Sneak and Peak" search warrants which allowed law enforcement officers to covertly open packages containing stolen engines shipped by the alleged fences, photograph the contents and their identification numbers, reseal the packages and forward them to their intended destinations, enabling the investigation to continue.

b. Absent

An investigation by the Frauds Bureau and the Suffolk County DA's Insurance Crime Bureau led to the arrest of a Russian native who is suspected of participating in a no-fault fraud ring on Long Island. Investigators apprehended the defendant at Kennedy Airport as he was about to flee the country. He participated in a number of staged accidents and then filed phony no-fault insurance claims. The specific case he was charged in involved a rear-end collision on Long Island's Sagtikos Parkway in December 2001. The defendant's nephew, also arrested but not charged, claimed to be the driver and the defendant the passenger. In reality, the nephew was the passenger and the defendant was not even in the car.

c. Fraudulent Billings

Fifteen suspects – including four doctors, a dentist, a psychologist and an acupuncturist – and six companies – including a medical billing firm, a psychologist's office, an acupuncture clinic and three medical clinics – were indicted for participating in a no-fault insurance scam that fraudulently billed New York City Transit, which is self-insured, and a number of private insurance companies for medical services that were never rendered. An investigation conducted by the Frauds Bureau, the Manhattan and Brooklyn DAs' Offices, the NYPD's Fraudulent Accident Investigation Squad and its Transit Bureau, New York City Transit's Special Investigations Unit, the National Insurance Crime Bureau, the New York State Department of Education's Office of the Professions, Chase Manhattan Bank and the Special Investigations Units of both GEICO and St. Paul Travelers Insurance Companies led to the indictments. Investigators who worked undercover on this 18-month-long investigation discovered that the defendants submitted three types of fraudulent claims – billings for services that were not provided, billings that were upcoded in order to obtain a higher reimbursement rate and billings for services for

dates on which the undercover investigators had not been seen or treated. More than 60 insurers were defrauded of millions of dollars in those fraudulent billings over a ten-year period and the Manhattan DA's Office initiated a forfeiture action in which the court has frozen more than $3 million in assets.

d. Burnt Coffee

The owner of a coffee shop in Buffalo, NY, was rescued by the Buffalo Fire Department from a fire that completely destroyed his business. An investigation by Buffalo fire investigators revealed that gasoline was used to set a fire on the first floor of the restaurant and an additional fire was set in an employee's car at the rear of the building. An expanded investigation by the Frauds Bureau and the Buffalo Police and Fire Departments revealed that the defendant had purchased three insurance policies within 30 days of the fire – a $15,000 policy on personal property with New York Central Mutual Fire Insurance Company, a $25,000 policy with Selective Insurance on business property and a $250,000 policy with Michigan Millers for the business. The defendant was charged with arson in both fires. However, because he had not yet submitted claims to his insurance carriers, he was not charged with insurance fraud.

e. "Give-Ups"

A two-year investigation conducted jointly by the Frauds Bureau, the U.S. Attorney's Office, the State Police, the Buffalo and Cheektowaga Police Departments and the Special Investigation Units of eight insurance companies that were victims of the fraud led to the arrest of ten suspects accused of giving up their autos to a Lackawanna man to be totaled by fire or other means in order to obtain the insurance settlements. The "give-ups" took place between April 2000 and June 2003 and the eight insurers paid out more than $105,000 for the losses. Nine of the cars have been recovered.

f. New York State Employees Caught

A six-month joint investigation by the Frauds Bureau, the Bronx DA's Office and the New York State Inspector General's Office led to the arrest of 16 New York State employees. Between December 2002 and April 2005, they allegedly submitted more than $600,000 in claims for medical treatments they never received. They were also accused of pocketing $389,423 paid out on those claims. The defendants were employed by either the New York State Office of Mental Retardation and Developmental Disabilities or the State University of New York and were covered under The Empire Plan, the health insurance program for New York State workers. The investigation began when the insurer discovered that the treatment code on one of the claims was incorrect and contacted the doctor to inform her. The doctor told the insurer that the person who submitted the claim was not one of her patients.

g. Agent Fraud

A joint investigation conducted by the Frauds Bureau, the Rochester and Irondequoit Police Departments and Nationwide Insurance Company led to the arrest of a former agent for Nationwide. While acting in his capacity as an agent, this suspect allegedly misrepresented himself as two of his clients in order to implement changes of address so that all future correspondence from Nationwide to the clients would be sent to his own home address. Between July 2000 and July 2004, he systematically withdrew funds held in the individual retirement accounts and annuities of the two clients. The disbursement checks totaling more than $143,000 were sent in the clients' names to his home and he and at least one other person (as yet not charged) forged the signatures of the clients and cashed the checks. The investigation is ongoing.

h. Major Medical Mill Takedown

Following a three-year investigation by the Frauds Bureau, the State Police, the New Jersey Attorney General's Office, the NYPD, the Yonkers and Westchester County Police Departments, the National Insurance Crime Bureau and numerous insurers, 6 corporations and 28 people, including four doctors and a dentist, were arrested or indicted. The doctors were charged with routinely prescribing unnecessary medical treatments and excessive diagnostic tests for patients who had not even been involved in an auto accident. Among those charged were an emergency room employee and a paramedic who forwarded confidential patient information to one of the other defendants who posed as a doctor or a hospital patient care coordinator to refer these patients for unnecessary follow-up treatment. Runners were paid to steer claimants to medical facilities that participated in the scam and a NYPD Aide allegedly forged accident reports. As a result of this multi-agency effort, a major medical mill in Westchester County that allegedly defrauded insurance companies of more than $12 million was shut down.

i. Operation Brownsville Auto

An investigation by the Frauds Bureau, the NYPD, and the Brooklyn DA's Office resulted in the arrest of 37 individuals, including one Mafia associate, charged with auto theft, the sale of stolen auto parts and insurance fraud. The business, Brownsville Auto Salvage, was leased and operated by the NYPD for 18 months. Within that time, the yard took delivery of more than 100 cars that were stolen or "given up." Cars were stolen from the five boroughs of New York City, as well as Nassau and Suffolk Counties, Connecticut and New Jersey. The car owners who voluntarily gave up their cars to a middleman would wait to hear that their car had been dismantled. When word came, they would report it stolen to their insurer and collect the payment. The investigation is ongoing.

11. Staff Recognition Awards

The Governor's Office of Employee Relations presented a team of ten New York State Insurance Department employees and five from the New York State Division of Criminal Justice Services with one of four 2005 *Workforce Champions Awards*, which recognizes New York State employees who have worked together to significantly improve state governmental operations.

These professionals were honored for their successful efforts in *Operation Auto Rates*, a multi-faceted strategy to reduce auto premium rates in New York State. The strategy included greater cooperation and collaboration by the Frauds Bureau with the police and district attorneys in aggressively fighting fraud on the local level, and regulatory changes including the implementation of cost-cutting Regulations 68 and 83. The Department held dozens of meetings with major auto insurers to review their rate structures in the face of significant declines in losses in the auto insurance market. As a result of the team's hard work and perseverance, nearly 70% of all New York drivers are expected to see savings of more than $400 million as of year-end 2005.

The Award was presented by George Madison, Director of the Governor's Office of Employee Relations, at a ceremony at the Executive Mansion in Albany on October 26, 2005. The members of the Frauds who were commended for their contributions to this Operation were Deputy Chief Investigator August D'Aureli and Senior Investigators Gary Anderson, David Hahn, Arthur Masinski, Edward Miller and Mark Sirkin

In addition to the Frauds Bureau staff, Principal Attorney Paul Zuckerman and Supervising Attorney Lawrence Fuchsberg of the Insurance Department's Office of General Counsel; and Supervising Insurance Examiner Joseph Smeragliuolo and Supervising Actuary Bruce Green of the Property Bureau were also cited.

On March 2, 2005, Frauds Bureau Director Charles Bardong, Deputy Director Nicholas DiMuro and Queens District Attorney Richard Brown received an award from the New York State Police in recognition of the efforts of the Bureau and the DA's Office in a three-year investigation known as "Operation Crash Course." The case resulted in the arrest of 67 individuals and corporations for their participation in a major no-fault fraud ring. The Award was presented in Albany at the Advanced Auto Crime Investigation Seminar sponsored by the New York Anti Car Theft and Fraud Association.

Senior Investigator Gary Anderson of the Bureau's No-Fault Unit received a Certificate of Recognition from the National Insurance Crime Bureau at their Annual Award Luncheon on December 8, 2005. Investigator Anderson was honored for his efforts and commitment to the detection and investigation insurance fraud.

12. Foreign Delegations

The Insurance Department welcomed a number of foreign delegations during 2005 and members of the Frauds Bureau were invited to participate in many of the meetings. In March, and again in October, a group from the Russian Academy of Entrepreneurs met at the Department to discuss modern organizational techniques and management of the insurance industry in the United States. Frauds Bureau staff addressed such issues as methods of fighting insurance fraud, including fraud perpetrated by organized crime, and how the insurance industry handles the problem of auto theft.

In May, Bureau staff gave a presentation on the subject of fraud detection and prevention to senior-level representatives from the five Central Asian Republics of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. An Australian delegation visited the Department during September to study the American brand of insurance regulation and discussed fraud investigation and prevention with staff members. Then in November, Bureau representatives met with a group from the Korean Insurance Department.

After a successful pilot program, the National Association of Insurance Commissioners (NAIC) initiated an International Internship Program in 2005 to advance working relations with foreign markets with an emphasis on the exchange of regulatory techniques and technology. Following a four-day orientation program at NAIC headquarters, each intern travels to a different state for five weeks, working in technical areas of their specialization. During 2005, the Frauds Bureau gave presentations to interns from India in August and from China in November. The presentations generally included an overview of the Bureau's operations followed by a question and answer session. The discussions provided an opportunity for the exchange of ideas on topics that are of particular interest to the visitors.

With the globalization of the insurance industry, such opportunities for exchange are likely to increase, as insurance regulators and companies from around the world seek to draw upon the expertise of what is arguably the premier insurance regulator in the world.

13. Partnering with Prosecutors

Under a program initiated in 2003, Frauds Bureau investigators are assigned to prosecutors' offices to work side-by-side with their investigative staff. During 2005, 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.

14. Moving Up

In November, both Charles Sawyer and Karen Silverstein were promoted to the position of Assistant Chief Investigator. Their responsibilities in their new positions include direct supervision of the Deputy Chief Investigators who oversee the operations of the Bureau's specialized investigative units. They will also be more actively involved in the operations of the various task forces and working groups of which the Bureau is a member and will attend their meetings on a regular basis. Assistant Chief Investigator Silverstein's jurisdiction encompasses the downstate region and Assistant Chief Investigator Sawyer manages the upstate counties. Both will report directly to the Chief Investigator.

15. Upstate Seminars

In 2004, the Frauds Bureau initiated a series of seminars to give insurers in the upstate region an overview of the Bureau and the skills investigators bring to the investigation of insurance fraud. In September 2004, three sessions were conducted for member companies of the New York Insurance Association – in Batavia, Syracuse and Albany. During 2005, the Bureau's Training Officer gave such presentations to members of AIG Insurance Company in Albany in April and to staff from Utica First Insurance Company in Utica in August. The goal is to ensure that every insurer that writes business in New York State is aware of what the Bureau has to offer in terms of experience, dedication and professionalism as we work with the industry to eliminate insurance fraud.

16. World Trade Center Update

Since September 11, 2001, the Frauds Bureau has prompt attention to all reports of suspected fraud related to the World Trade Center disaster. As of 12/31/05, 83 World Trade Center-related reports of suspected fraud had been opened for investigation. More than half involved life insurance fraud (21) and workers' compensation fraud (22). The remainder included 8 that were auto-related and 32 that were assigned to a miscellaneous category.

17. Directions for 2006

a. Web-Based Case Management System

The Frauds Bureau achieved its goal of Web-based fraud reporting in 2005. Insurers now report suspected fraud electronically directly via the Web site through a system known as the Blue Zone, which replaced the previous dial-up method using the AT&T Global Network. However, the long-term goal is to replace the present database system – which uses mainframe technology – with a browser-based system. A Frauds Case Management software vendor has been selected to perform the task. This new system is designed to enhance the effectiveness and accuracy of fraud reporting using drop-down menus and to allow for the attachment of images and documents. Under this automated system, virtually all of the Bureau's principal tasks will be Web-based, including case management and statistical tracking. The Department's Frauds and Systems Bureaus are working with the vendor to customize, develop and implement the new Frauds Case Management System.

b. Audits of Insurer Special Investigations Units

In past years, a Frauds Bureau examiner accompanied members of the Health Bureau on financial examinations and members of the Property/Casualty Bureau on market conduct examinations. The purpose of this assignment was to evaluate insurer compliance with the provisions of the Second Amendment to Regulation 95 requiring the submission to the Department of a Fraud Prevention Plan and the establishment of a Special Investigations Unit (SIU). However, under a new program, the Frauds Bureau's Principal Examiner will conduct independent audits to review insurer Plans and provide guidance to SIU staff on how best to implement Plan provisions. Two such independent audits

took place during the final quarter of 2005, one at Oxford Health Insurance Company and the second at Allstate Insurance Company. This program will be refined and improved in the coming year.

c. Workers' Compensation Fraud Seminars

The idea for a series of seminars to educate the business community about workers' compensation fraud that was conceived late in 2004 became a reality in 2005. The Frauds Bureau's Training Officer, in conjunction with the New York Insurance Association and the Workers' Compensation Board Inspector General's Office, developed a presentation designed to heighten awareness about application fraud, premium fraud and other problems associated with workers' compensation insurance. The first seminar was conducted for the Business Council of New York State on October 19, 2005 in Albany. Based on feedback from Council members, the presentation was revised to more properly address the issues that are particularly relevant to the business community in New York State. The Frauds Bureau will continue this program throughout 2006 in an effort to help entities such as Chambers of Commerce and other similar groups recognize and prevent workers' compensation fraud.

18. 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, in relation to adding a description of a fraudulent no-fault insurance act; decreasing the monetary threshold for the commission of insurance fraud in various degrees; and providing three separate degrees of "aggravated insurance fraud";

- Requiring a periodic certification of continued eligibility by recipients of workers' compensation or disability benefits;

- Creating a class E 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 felony larceny or felony insurance fraud;

- Requiring that life insurance policy applications include a positive identification of the insured;

- Increasing civil penalties for knowing possession, transfer or use of fraudulent insurance documents;

- 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 2005 Insurance Frauds Bureau Annual Report is available on the Department's Web site at www.ins.state.ny.us. Hard copies may be obtained through the Department's Publications Unit at 1-800-342-3736.

F. LIQUIDATION BUREAU

The Liquidation Bureau, fulfilling the statutory responsibilities of the Superintendent of Insurance, is responsible for administering the affairs of insurance companies undergoing rehabilitation, liquidation, and conservation. The Bureau 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 2005, proceedings continued for sixty active insurance companies. Two domestic receivership proceedings were initiated, MagnaHealth of New York, Inc. and Realm National Insurance Co. and one domestic receivership, Northumberland General Insurance Company, was closed. Also, one ancillary estate, Motor Club of America, Inc, was closed.

The sixty active insurance company proceedings are classified as follows:

3	Rehabilitation Estates
26	Domestic Estates
22	Ancillary Estates
9	Conservations

As of December 31, 2005, assets, liabilities and current insolvency of the sixty active insurance companies[1], aggregately, were as follows:

Total Assets	$ 3,468,257,584
Total Liabilities	$ 8,686,511,826
Current Insolvency	$ 5,218,254,242

The New York State security funds received $134,619,000 in dividends and early access funds from domestic and ancillary estates of $4,750,000 and $129,869,000, respectively. The Workers' Compensation security fund received $48,334,000 from 10 estates; the Public Motor Vehicle security fund received $726,000 from 3 estates; and the Property/Casualty security fund received $85,559,000 from 15 estates.

During 2005, monies received by the Liquidation Bureau from the New York State security funds were as follows: $247,836,000 for allowed claims, $46,032,000 for related expenses, and $1,381,000 for return premiums.

Pursuant to New York Insurance Law, Section 7433-a, a $70,000,000 loan facility was established to provide credit to the Workers' Compensation security fund from the assets of domestic estates in liquidation. As of December 31, 2005, the outstanding balance was approximately $12,572,000.

Fraternal Benefit Societies

As of December 31, 2005, there were 37 pending liquidation proceedings. During the year, 19 proceedings were terminated and 12 proceedings were commenced. The remaining assets of the 58 burial societies totaled approximately $1,267,000. In addition, assets of $92,259 were distributed to members of fraternal benefit societies.

Note: See Section VIIIA(5) of this Report for the Rehabilitation, Liquidation, Ancillary Receivership and Conservation Proceedings.

[1] This does not include figures for Frontier Insurance Company in Rehabilitation and Interboro Mutual Insurance Company in Rehabilitation. In addition, the financial information for Executive Life Insurance Company is currently being reevaluated.

G. INFORMATION SYSTEMS & TECHNOLOGY BUREAU

The Information Systems & Technology Bureau (Systems) provides information technology products and services to over 900 Insurance Department employees and also supports the Department's technical infrastructure. Systems' clients include insurers, the public, federal, state and local agencies, other insurance regulators, actuaries, clerks, 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 uses sophisticated 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. The 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, Domino mail and applications servers, Sybase 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

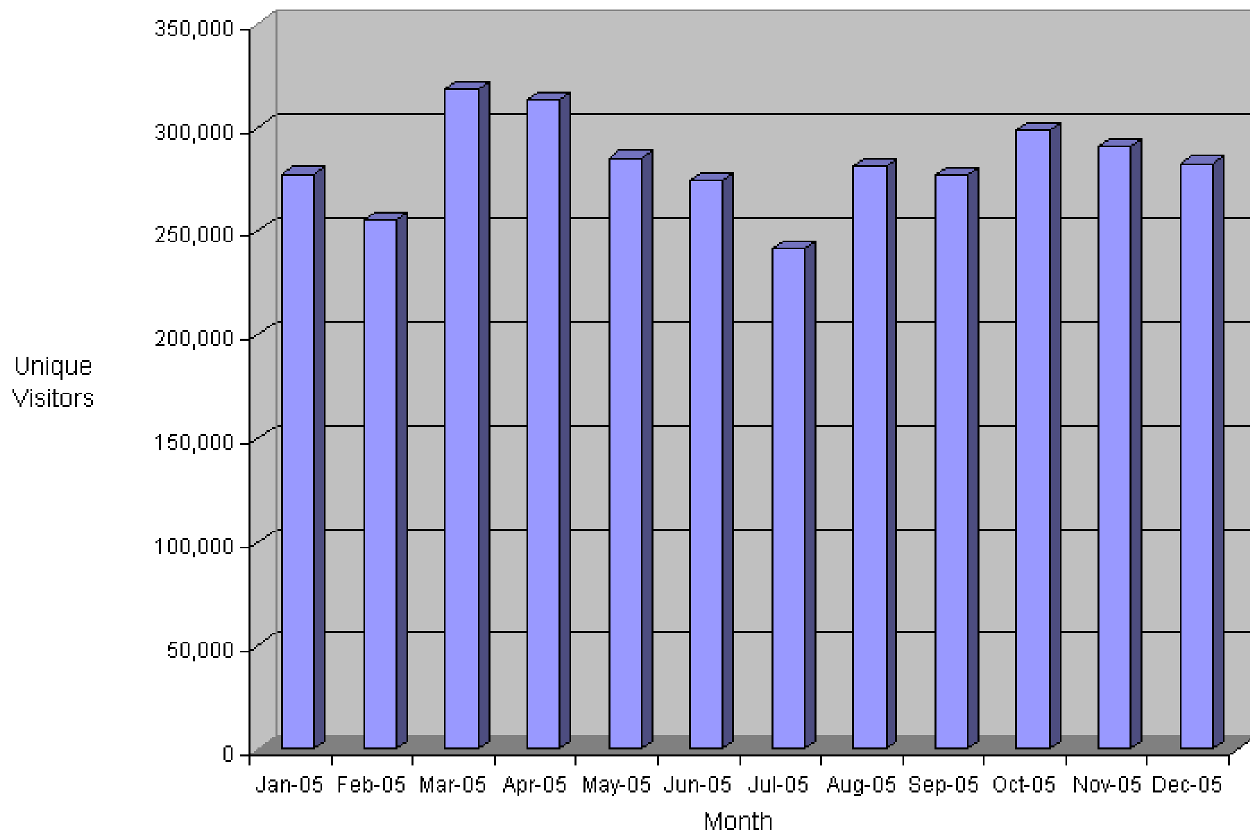
base, and encompasses a wide range of significant responsibilities and functions. Effective change control is the essential ingredient for an effective Operations and Production environment.

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, Web site 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. Web Site

The Department's main Web site and supporting "mini" Web sites – Healthy NY, Captive Insurers and Caregivers continued to play a vital role in communicating with and providing services to our diverse constituencies during 2005. The Department's activities and applications are reflected on these sites. During 2005, there were 3,396,310 visits to the Department's Homepage, a 32% increase over the previous year. The number of these visits, by month, is displayed in the following chart.

CHART H



The Department takes pride in its Web site's depth of content, relevancy, and speed with which it is kept current. During 2005, a complete redesign and restructuring of the main Web site was undertaken. Our Web site presents a fresh new look, easier navigation, and improved Accessibility for disabled and handicapped visitors.

Below are the major Web site related accomplishments during 2005:

- Redesigned the “Insurance Help for the Seriously Ill and Their Caregivers” Web site; includes new Accessibility features to assist disabled and handicapped visitors.
- Redesigned the “Captive Insurers” Web site; includes a set of unique, content related backgrounds, as well as many new Accessibility features
- Improved and continuously updated the Healthy NY Web site
- Improved the Web based interactive Insurance Company Search to provide more granular information about the Department’s regulated entities
- Improved the Long Term Care Section
- Developed a “Get Smart About Insurance Week” Section
- Presented the 2005 Interactive New York Consumer Guide to HMOs
- Posted the complete set of 2005 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: 53 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. The 2005 Examiner Resource Center that allows regulatory staff to view current electronic Supplement Annual and Quarterly submissions was a new feature. Other areas include: up-to-date examination schedules; database entries reflecting the Department’s Record Retention Program; Online HelpCenter updates; Department staff accomplishments and photos; Office Building and Cohort Procedures; General Administration Manual; minutes from Systems Bureau liaison meetings; HRM vacancy announcements; PowerPoint presentations and various internal employee forms.

3. Annual Statement Filings

The year 2005 was significant as the Department continued to improve our processing of Annual Statement filings. The Department is committed to the concept of electronic filing of insurer financial statements via the National Association of Insurance Commissioners (NAIC) Web site. In the past year there have been significant increases in the number of companies filing over the Internet and the speed at which those filings are made available. Over 93% of licensed New York companies were available to staff in the NAIC I-SITE application by the third business day after the March 1 due date. Over 97% of Life Insurers and 94% of Property Companies were available by March 3rd. During 2003 the Department eliminated the hard copy paper requirements for Management Discussion and SVO forms for all foreign companies. The Adobe Acrobat PDF filing available on the NAIC Web site is the sole source of this information for the Department. During 2004, in an effort to expedite data availability, the Schedule G PDF filing was separated from the main body of the submission. Due to the confidentiality of the data, this schedule must be reviewed for correctness before it can be released. This process improvement allowed the Bureau to post the Supplement PDF files to the Intranet on March 4, 2005; the earliest date ever.

4. Imaging/Workflow

The Consumers Imaging and Information Management System (CIIMS) continued to handle the Department's processing of Consumer complaints. During 2005, CIIMS processed more complaints than last year and the percentage of on-line consumer complaints also increased. Insurance representatives using the online system to respond to the complaints continue to grow; 22,964 response transactions were received on-line, representing a 400 % increase from 2004. Modifications were made to processing routines to improve system efficiency. The Systems Bureau continues to work with the Consumer Services Bureau to add new functionality to CIIMS.

The Health Bureau has employed imaging since 2000 to assist in processing the rate and form filings. In 2005, new functionality was added to maintain the rate manuals on-line. In addition to centralized access of the current manual, the history of replaced pages is also maintained.

The Life Bureau also utilizes imaging in the rate and form filing process. A pilot project initiated in 2005 allows for the imaging and retrieving of mergers and acquisitions, audit files and related subject files. This electronic file cabinet will serve as a model for domains of data and documents with minimal workflow.

The Property Bureau continues to image their archived rate and form filings. The successful pilot of related documents covered by Freedom of Information Law (FOIL) was completed in 2005 and a production deployment is scheduled for first quarter 2006. This includes functionality to create CDs in response to FOIL requests. Note too that specialized functions were added to this application to protect confidential and copyrighted documents. This will eventually eliminate the need for companies seeking FOIL documents to frequent the New York City office and ultimately positions the bureau to make the documents available via the internet.

5. Domino Portfolio Workflow Applications

Domino Workflow Applications continue to expand within the Department Applications developed in Lotus Domino have replaced existing legacy and manual Department processes. Lotus Domino continues to be a strategic software platform to develop workflow applications for electronic solutions for the Department.

Owing to an upgrade to Lotus Domino version 6.5 in 2005, Domino applications now have the ability to integrate with other software platforms Current development work continues utilizing a /Domino front-end workflow application that populates and extracts data from Microsoft Access and Sybase. Expanded resource sharing tools will provide integration between our existing Domino Applications.

The Domino Portfolio of applications currently consists of the fifteen production applications with another four in development. Domino applications are used by all bureaus.

6. E-Commerce

E-Commerce initiatives continued to expand throughout the year. Statistically, the number of electronic transactions continued to increase in category after category so that we processed over 700,000 licensing related electronic transactions. Considering that we started on-line transaction processing with only a couple thousand in 2001, this has been a significant improvement. From a purely dollars and cents view, the Department collected over $9 million in credit card transactions thus saving the manual processing of hundreds of thousand of checks.

Functionally, we put additional processes on-line to meet the needs of more and more of our constituents. This year, we developed and deployed the process to collect the legislatively mandated

license fee increase. We allowed companies to renew their licenses on-line and we provided a number of self-service functions. Our resident licensees can now file their name and / or address changes on-line via secure internet transactions.

All in all, the e-commerce initiatives continued to supply unparalleled service to our various constituents and have allowed the Department to continually and dramatically provide better, faster, more cost effective service to our growing insurance customer base.

2005 was just the second year of a voluntary electronic funds transfer of the Fire Tax 2% assessment and the program is already very successful. This year saw the number of participants increase to nearly 850 fire districts (36% of the total) for a distribution amount in excess of $13 million.

7. Sybase 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 for our managing of all clients (both internal and external) 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 2005 were:

- OGC Historic portal application was placed into production: This application makes information that was stored in the mainframe available to portal users, in a more easy-to-use form.

    - Inter-Active Insurance Company Search: Added new features/functions which allow advanced search capabilities for the following criteria:

        - Inter-Active
        - Lines of Business (LOB),
        - NAIC group numbers & names,
        - DMV Codes,
        - Blank type/Domicile,
        - Org Types
        - Special Risks.
        - Implemented W3C Disability standards

    Central File:
    - Company Regulatory application was rewritten in open-source java code thus enhancing maintenance and long term portability
    - Migrated the Life Policy Form application data tables to the Sybase platform thus enhancing back-up and support of this application.

- Health Legal Reports: Re-design of Management reports into java-based portal reports.

- Health Speed to Market (STM) Reports: Automated the reporting function so that the monitoring of STM is performed via the Portal.

Sybase Enterprise Portal (EP) technology supports the Central File requirement of a centralized information (management) portal repository whereby Department personnel can access/search all organizational information through an application from multiple, disparate data stores, both structured and unstructured, through a browser-based Graphical User Interface (GUI). 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. A Systems Disaster Preparedness Team meets regularly to identify and further improve the infrastructure and its ability to withstand and recover from disasters. 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.

H. OFFICE OF GENERAL COUNSEL

The Office of General Counsel's (OGC) principal responsibilities include providing the Superintendent, the Deputies and Bureau Chiefs, and the public with legal opinions and advice on the interpretation of the Insurance Law and how such laws affect the insurance industry; drafting and reviewing legislation, regulations and circular letters; 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 and financial condition examinations; coordination of all enforcement investigations and Attorney General investigations of insurance matters; supervision of all litigation brought by and filed against the Department; supervision of all demutualizations, corporate transactions and conversions; legal review of all RFPs and state contracts; review of applications for insurer incorporation and licensing and related corporate activities; and managing the Freedom of Information Law requests of the Department.

1. Legal Opinions

OGC provides legal opinions to insurers, trade associations, producers, consumers and city, state and federal agencies regarding interpretations of the Insurance Law. These opinions provide guidance to the industry as to the Department's policies. These opinions are also provided to the Superintendent, the Deputies and Bureau Chiefs when a legal issue arises out of the regulatory activities of the Department. Approximately 430 opinions were issued in 2005. All nonprivileged opinions are posted to the Department's Web site (www.ins.state.ny.us) when issued. In April 2004, the OGC public opinion database was made available to the entire Department through an electronic search engine. This extensive electronic database includes over 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 continues to handle all 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 and financial condition examinations. In 2005, the Department entered into approximately 111 stipulations imposing penalties on insurance companies or producers. In addition, approximately 120 producer licensing, assigned risk, and rate hearings were held. OGC also manages all outside litigation brought against the Department and all subpoenas served on the Department and its staff. During 2005, approximately 10 new litigation cases were brought against the Department. Currently, there are approximately 64 cases that OGC actively supervises, including the lawsuits concerning the Empire conversion, the External Appeal Law, the audit of the Liquidation Bureau and issues involving the Public Motor Vehicle Liability Security Fund (See Part VI – Major Litigation).

OGC also supervises and coordinates the Department's enforcement investigations and its joint investigations with the Attorney General's office. OGC is directing the Department's investigation of inappropriate compensation to producers in the property & casualty, life and health insurance industries as well as finite reinsurance, title insurance and the accounting practices of American International Group (AIG) in coordination with the Attorney General's Office. During 2005, these investigations resulted in joint settlements with the Attorney General's office with Marsh & McLennan, Aon Corporation and Willis Group Holdings and Universal Life Resources . In addition, in May 2005 the Department and the Attorney General filed a complaint against AIG alleging fraud, bid rigging and improper accounting practices, and reached a joint settlement with the company on February 9, 2006.

I. CAPITAL MARKETS BUREAU

1. General Overview

The Capital Markets Bureau, established six years ago, continued to broaden its investment and risk management oversight activities in 2005. Its principal function is to provide the Insurance Department with analysis and recommended actions on matters affecting the regulation of capital markets and risk management activities of New York-licensed life, property/casualty and health insurers, and health maintenance organizations. In addition, the Bureau participates in the supervision of select public retirement systems, and certain private pension funds of nonprofit organizations. Last year, the Bureau met its objectives by:

- furnishing examination support;
- 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 in capital markets and investment portfolio dynamics, and offering seminars on requirements stemming from the Sarbanes-Oxley Act;
- 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, 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 activity.

The Bureau 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. Their investment portfolios were then subject to additional analysis by the Bureau. If areas of concern remained following this targeted assessment, the Bureau then solicited additional information on the companies' investment management criteria and objectives. When determined necessary, meetings or teleconferences with these companies were arranged to gain additional insight into the make-up of their portfolios, and investment rationales and approaches. Moreover, the integration of quarterly data into the reviews distributed to the Bureaus allowed for more comprehensive analysis.

The Bureau 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 and organizational governance practices, and asset-liability management took place in 2005, and will continue to be addressed in 2006.

Last year, the Capital Markets Bureau again materially increased its participation in on-site examinations, delivered in-house training programs, routinely disseminated news and information that served to enhance examiner understanding of the financial markets, and completed various Bureau-specific special projects. The Bureau's risk management specialists, during 2005, 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.

The Capital Markets Bureau maintained its active involvement in the work of the National Association of Insurance Commissioners (NAIC). It continued to preside over key groups responsible for the development of a risk-focused examination process better linked to principal solvency concerns, and the organizational and functional refinement of the NAIC's Securities Valuation Office (SVO).

2. 2005 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 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 2005, 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
2005

Type of Company	Priority 1 Desk Audits	Pre-Exam Reports	Targeted Evaluations	4th Quarter Meetings
Health	9	3	-	3
Life	22	17	26	15
Property	9	33	23	3

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, the Bureau 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, when a company made changes in the type, management or oversight of its derivative activity, the Bureau reviewed its DUP amendment submission.

Primarily, in conjunction with ongoing exams, the Bureau appraised the annual CPA reports on derivative usage and adherence to regulations submitted by the companies. 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 2005, risk management specialists examined 18 new DUPs. The proposed derivative usage largely reflected a range of swaps and options across various asset classes. Additionally, the Bureau evaluated 27 amended DUPs.

Table 60
DERIVATIVE USE PLAN (DUP) REVIEWS
2005

TYPE OF REVIEW	LIFE	PROPERTY
New DUPs	11	7
Amended DUPs	20	7

c. Examination Participation

Last year, the Capital Markets Bureau was active in utilizing its formulated risk-focused examination procedures related to capital markets oversight. It nearly doubled for the second year in a row its on-site exam participation by taking part in twenty-eight examinations. This incremental 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 continues to oversee a risk-focused property pilot exam, started in 2005, that 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, in collaboration with selected consultants, the Bureau will be active in coordinating similar pilot exams for the Life and Health Bureaus utilizing these formulated risk-focused parameters. Additionally, preparations for examining a major life insurer in 2006 with multiple legal entities and various state domiciles were launched last year. This latter exam will require coordination with the applicable state insurance agencies/departments.

With the continuation of news of private pension funds and public sector retirement systems facing substantial, underfunded liabilities, the Capital Markets Bureau provided analytical and policy formulation support to the Life Bureau's pension unit, created in 2004 to target more resources to examining the financial condition and risk management approaches of New York State and City public retirement systems. In 2005, the Capital Markets Bureau, bolstered by an addition of another risk management specialist, helped to solidify the Department's role in supervising public retirement systems by formulating risk-based solvency standards and enhancing other pertinent measures. Additionally, ongoing refinement will take place in implementing risk identification and risk management reviews and in overseeing governance and compliance practices. Last year, in conjunction with the Life Bureau, the Capital Markets Bureau participated in the examinations of five public retirement systems.

Table 61
EXAMINATION PARTICIPATION
2005

BUREAU	TOTAL EXAMINATIONS	Started in 2005	Started Prior to 2005
Health	3	2	1
Life*	16	12	4
Property	9	5	4
Total	**28**	**19**	**9**

* Includes examinations of five public retirement systems (four started in 2005, one started prior to 2005).

d. Training Initiatives

The Capital Markets Bureau conducted training principally for the Department's examination, legal and actuarial staff. The training presented information about alternative investments, particularly hedge funds, and broadly detailed capital markets dynamics. The Bureau also provided guidance to the examiners on how to utilize effectively 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. Bureau staff and an outside vendor provided these courses to accommodate the growing requirements of senior staff as well as examiner-trainees in expanding their familiarity with such topics.

Last year, the Bureau continued to promote the inclusion of the financial analytical staff of the Department in teleconferences, investor briefings, and meetings held by the various rating agencies. Moreover, it maintained its relationships with the leading insurance equity analysts, ensuring critical access to their industry and company research.

In addition, the Bureau participated in the NAIC International Internship Program. This program, designed by the NAIC International Regulatory Cooperation Working Group, serves to advance NAIC relations with foreign markets with an emphasis on the exchange of regulatory technology and know-how. Risk management specialists conveyed details about the Bureau's analytical and evaluative processes, principal functions, and interface with the rest of the Department to interns from both India and China.

e. Special Projects

The Bureau was involved in a number of special projects stemming from a variety of events, including multiple hurricanes in 2005, the changes in the capital markets environment, and key legislative initiatives. Its staff conducted research on a wide range of technical topics, developing capital markets concerns, and various transactions. The risk management specialists also provided recommendations, when applicable. Issues reviewed included:

- the impact of various hurricanes on insurer solvency, particularly that of the financial guaranty sector, and on capital markets;
- ramifications of insurers' exposure to hybrid securities, such as trust preferreds and enhanced capital advantaged preferred securities (E-CAPs);

- securities lending, securitization vehicles, enhanced equity trust certificates, and dynamic hedging approaches;
- the continuing impact of the equity market and low interest rate environment on prospects for annuity products and implications for hedging program effectiveness;
- procedures to assess compliance with requirements of the Sarbanes-Oxley Act;
- pricing premiums associated with private mortgage guaranty insurance;
- certain proposed derivative transactions, including weather derivatives tied to a finite reinsurance policy, and a liability hedge on agricultural prices;
- structured transactions, including principal protected notes and their treatment when considered impaired;
- standards for retirement system fiduciary investment reviews;
- enhanced disclosure of BA assets by insurers, and questionable valuations of certain partnerships held by insurance companies and public retirement systems;
- more accurate filing of trust preferreds and recording of fair value of securities by insurers with the NAIC's Securities Valuation Office; and
- collateralization requirements for non-U.S. reinsurers.

f. Other Activities

The Capital Markets Bureau contributed to the formulation of legislative and regulatory proposals. These covered: (1) issues related to increasing the number of licensed captive insurers; (2) amendments to Article 69 regarding financial guaranty insurance; (3) proposed amendments to the Credit for Reinsurance Regulation to address collateral funding by non-U.S. reinsurers; (4) development of a custodial asset regulation; and (5) an amendment to Regulation 140 governing continuing care retirement communities.

Throughout the year, the staff also gave capital markets presentations at over a dozen diverse venues. These venues included: the New York State Bar Association's Futures & Derivatives Law Committee, the Professional Risk Managers International Association, the Northeast and Metro NY/NJ chapters of the Insurance Accounting and Systems Association, the Actuarial Society of NY, the Practicing Law Institute's Reinsurance Law Program, the Society of Financial Examiners Career Development Seminar, the Association of Health Plans Risk Assessment Seminar, the Society of Actuaries Annual Meeting, the Federal Reserve Board's Cross Sector Meeting, the NAIC Northeastern Zone Meeting, the NAIC Financial Summit, and the Life Insurance Council of New York, Inc. (LICONY) Legislative and Regulatory Conference.

The Bureau participated in the Superintendent's investigation of American International Group, Inc. (AIG), the nation's largest insurance company. This investigative activity, stemming from the allegations of fraud, bid-rigging for excess casualty insurance business, the use of contingent commission agreements or placement service agreements to steer business, and improper accounting practices, including those relating to nontraditional and finite insurance by AIG, was carried out with the Attorney General of the State of New York and the Securities and Exchange Commission. The investigation culminated in an agreement involving a settlement, which provides for a payment of over $1.6 billion in restitution and penalties. In addition, this agreement mandated an overhaul in the corporate governance and illicit operating practices of AIG. Moreover, in 2005, AIG's Chairman and Chief Executive Officer (CEO) and its Chief Financial Officer (CFO) were removed by the company's Board of Directors.

Largely, as a result of the AIG investigation, the insurance industry's use of arrangements, known as "financial reinsurance," became the subject of intense scrutiny by insurance regulators. The New York State Insurance Department, through its involvement in the NAIC, began to lead a national effort to review this area. A Bureau representative is assisting other Department staff in this current endeavor, which has, thus far, produced enhanced financial statement disclosures of these

arrangements in addition to a required attestation by property/casualty insurers' CEOs and CFOs that all reinsurance agreements reflect appropriate accounting. A change in the accounting rules governing such reinsurance transactions is anticipated as part of this ongoing effort.

The Bureau continued to participate in various Task Forces/Working Groups of the NAIC on behalf of the Department. In 2005, a Bureau representative served as chair of the Valuation of Securities Task Force (VOSTF) and the Risk Assessment Working Group. This Bureau representative also assisted in directing the Department's leadership role in the Property/Casualty Reinsurance Study Group, which is the NAIC group charged with addressing the abuses of financial reinsurance that were uncovered in 2005.

Last year, New York State as chair of the VOSTF, promoted the implementation of initiatives adopted three years ago to bolster the efficiency and effectiveness of the NAIC's Securities Valuation Office. As such, the reorganization of the Office, completed in 2004, produced a more efficient structure providing NAIC members with specialized support, analyses, and commentary on diverse capital markets issues. The SVO is expected to continue furnishing timely and value-added assessments of investment and financial matters to the insurance regulatory community in 2006. Moreover, refinements in the filing of investments with the SVO and the new rating appeal process are in effect.

During 2005, as chair of the Risk Assessment Working Group (RAWG), New York was instrumental in developing proposed revisions to the NAIC Examiners Handbook to reflect the "Risk-Focused Surveillance Framework" (the "Framework"). Adopted in mid-2004, the Framework provides the outline for a comprehensive, integrated process to monitor and evaluate the financial condition of insurers more effectively. Last year, the Capital Markets Bureau was actively involved in the initiation of a risk-based pilot exam of a property/casualty company. Essential to this pilot examination is application of the processes set forth in the Framework, which, among other guidelines, consists of a structured methodology designed to examine, analyze and verify the financial condition as reported by insurance companies on statutory financial statements and to allow for the use of this methodology to establish a forward-looking view on the financial risk profile of insurers. The Framework, which is being implemented by state regulators, is expected to steer regulators to the areas of greatest risk to the financial solvency of an insurer. In addition, the Framework introduces a uniform prioritization system, known as CARRMEL, which is based upon bank regulators' use of CAMEL scores. CARRMEL is an early warning system that identifies potential problem insurers. It comprises seven factors using the following designations: "C" – capital adequacy, "A" – asset quality, "R" – reserves, "R" – reinsurance, "M" – management quality, "E" – earnings ability, and "L" – liquidity. During 2006, the Working Group is targeted to complete the incorporation of the Framework into the NAIC Examiners Handbook, which is the manual used by all state regulators when performing on-site examinations. Coupled with this integration will be the finalization of the tools/processes set forth in the Framework, such as an "Insurer Profile" that presents a regulatory synopsis of an insurer, and a "Supervisory Plan" that documents the regulator's strategy relative to the future oversight of the insurer.

Additionally, last year, the Bureau participated in the NAIC Investment Schedules Subgroup whose members collaborate on various schedule items in preparation for consideration by the Blanks Working Group. The Subgroup is involved in highlighting proposed changes to the blanks that modify the presentation of certain data for better utility and analysis by state insurance departments.

J. 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.

3. Disaster Response Questionnaires and Plans

As a follow-up to activities which began in 2004 with the distribution of Circular Letter No.7 (2004) 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, 2005. A total of 923 companies are expected to report information to the Department. The Bureau has processed questionnaires from approximately 74% (681 of 923) of the entities required to submit such reports to the Department. The 681 companies providing these reports represent 92.3% of the 2004 direct written premium for all companies that were expected to report data to the Department.

In addition, the Bureau has also received Disaster Response Plans covering 681 companies. Of the 681 plans submitted, approximately 95% (651/681) are in an electronic format. Moreover, the Bureau, after review of submissions, has forwarded follow-up letters to 494 companies requesting updates and amendments to the 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 practice.

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, 2005. 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 73% (672 of 923) of the entities expected to submit such reports to the Department. The 672 companies providing these reports wrote approximately 92.2% of the 2004 direct written premium for all companies expected to report.

5. Pre-Disaster Data

Consistent with this understanding 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 2005 contained data from 223 entities representing 396 of the 403 companies that were expected to report data to the Department. These 396 companies wrote 99.73% of the 2004 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). The Plan is based on a comprehensive risk assessment and requires staff training that the Bureau will be involved with. The Plan allows the Department to continue mission-critical operations in the event of a disaster directly affecting the Department, and requires testing and updating annually.

7. 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 terrorism-related information with the Department. There are currently 1,260 companies involved with a total of approximately 3,780 participants. During 2005 the department issued 52 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.

8. Public Access Defibrillator (PAD) Program

The PAD program requires the voluntary participation of Department employees who are certified in both Cardiovascular Pulmonary Resuscitation (CPR) and Automatic External Defibrillation (AED). The Bureau developed a PAD program that contains protocols for the administration of a PAD and CPR during a medical emergency that occurs in either the Albany or New York City offices of the Department. 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.

9. 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.

10. The Incident Command System

Pursuant to Governor Pataki'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 will be conducting training for senior management in the near future.

11. 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 taken over the maintenance of the employee lists that are used to facilitate Department protocols in the event that such an evacuation is warranted. The Bureau is also responsible for updating the evacuation procedures that are posted on the Department's intranet and West Workspace. The Bureau also 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 etc. 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.

12. 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 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.

13. Mobile Command Vehicle

The Department is in the process of acquiring a mobile command vehicle that will primarily be available to directly serve the citizens of New York State in an emergency or disaster situation. We currently function 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 will be 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 will also give the Department a highly visible presence at the emergency or disaster site, and will permit the Department to be much more proactive in assisting victims. 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. Further, it is anticipated that the vehicle will be used for community out reach during non-emergency periods. It is anticipated that the mobile command vehicle will be delivered to the Department prior to the start of the upcoming hurricane season.

K. 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, 2005, there were 33 captive insurance companies authorized in New York. The assets of these 33 captive insurers posted total assets of $10.4 billion, total liabilities of $5.9 billion and capital and surplus of $4.5 billion. In addition, these captives had net income of $661.1 million, paid premium taxes of $2.3 million and had net premium written of $550.9 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 coverages.

L. TRAINING & PROFESSIONAL DEVELOPMENT

Staff training is a core priority for the Department. Newly hired 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 2005, 59 trainees participated in the training program.

Professional development of seasoned examiners is encouraged through on-the-job training and attendance at bureau-wide seminars. In 2005, the Department held seminars addressing current issues facing the Department and the insurance industry. Examiners also attended NAIC-sponsored training classes and pursued professional designations. In addition, the department completed its first management development program and awarded certificates of completion to 20 participants. The 15 month program, which was developed to provide high-level managers with training in management and leadership, was expanded to include 26 additional managers in 2005.

A labor relations training program for supervisors was initiated 2005. The program, developed by the Governor's Office of Employee Relations and provided by HRM staff, was adapted to address the specific needs of the Department and covered a variety of topics, including labor-management relations, an overview of the Taylor Law and counseling.

The Department also participated in the NAIC's International Program for Education and Regulatory Cooperation (IPERC), hosting interns from India and China. The aim of IPERC is to foster learning and provide technical assistance to insurance regulatory professionals from countries with emerging insurance markets. The interns spent 5 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.

M. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORP.

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.

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.

Due to a favorable cash position, the Board of Directors voted to assess all member companies doing auto business in New York State to $20 million for 2006, down from the $26 million assessed in 2005.

2005 Activity

Year End Reserves	2005	2004
Case Outstanding Reserve Tort & Pip	$ 19,830,718.38	$19,493,000.00
Incurred But Not Reported	20,657,602.00	23,270,000.00
Unallocated Loss Adjustments ULAE	10,789,194.00	7,500,000.00
Spec. Reserve for Alloc. Exp	7,000,000.00	7,000,000.00

- MVAIC received 8,823 notices of claim which were down from 10,018 received in 2004.
- The total number of claims created for both Tort & No fault cases decreased in 2005 to 2,086 compared to 2,312 created in 2004.
- Claims paid for Tort and No Fault cases decreased in 2005 to $17,164,075 compared to $20,218,243 paid during 2004.
- At the end of 2005, MVAIC closed with a surplus of $6,640,034.17, down from $11,564,301 in 2004.
- The number of pending claims at the close of 2005 was 2,400 compared to 2,972 in 2004
- Uninsured New York automobile drivers represent 77% of the total reported cases compared with 55% of the previous year

III. Insurance Legislation Enacted

(Legislation is presented in numeric order based on 2005 Chapter Law)

This section of the Annual Report covers bills enacted during the 2005 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 33 of the Laws of 2005 amends the Insurance Law and other laws as follows:

- The bill adds a new Section 7433-a to the Insurance Law authorizing the Superintendent to make loans of up to $70 million dollars in the aggregate from the assets of one or more liquidation estates to the Workers' Compensation Security Fund. In the event the Superintendent's authority to make such loans is challenged in court, the Superintendent is required to oppose such action and file any necessary appeal. Where a court issues an injunction prohibiting the Superintendent from making such loans, the bill authorizes the Superintendent to make loans of up to $70 million in the aggregate to the Workers' Compensation Security Fund from the assets of the Property/Casualty Insurance Security Fund.

- The bill also authorizes the Superintendent to make loans of up to $30 million in the aggregate from the assets of the Property/Casualty Insurance Security Fund to the Workers' Compensation Security Fund if assets from the liquidation estates are "otherwise unavailable." In the event the Superintendent makes a loan from the Property/Casualty Insurance Security Fund because assets from the liquidation estate are unavailable, the loan cannot be made more than once every two months, cannot be greater in amount than that needed to sustain the Fund for a two-month period and cannot be used to pay administrative expenses.

- All of the loans described above would become a liability of the Workers' Compensation Security Fund to be repaid pursuant to a plan of repayment prescribed by the Superintendent. The repayment plan may include an increase in the assessment rate paid into the Fund by workers' compensation insurers if the Superintendent provides written notice to the Governor and Legislature as to the reasons for such an increase. In addition, the bill requires the plan to provide that loans must be made upon commercially reasonable terms and in accordance with the Superintendent's fiduciary responsibilities, provides for an immediate repayment to the Property/Casualty Insurance Security Fund once money from the liquidation estates becomes available, and that one-fourth of assessments collected from workers' compensation carriers under Section 108 of the Workers' Compensation Law be dedicated to repay any loans made to the Workers' Compensation Security Fund.

- The bill adds a new subsection (e) to Section 7434 of the Insurance Law that would retroactively apply Section 7434 so that some future distributions (after administrative expenses) from liquidation estates would pay claims under policies and all claims of a security fund or guaranty association as class two claimants.

- The bill also amends Section 7405(f) of the Insurance Law authorizing the Superintendent to make early access distributions from liquidation estates to the Workers' Compensation Security Fund.

- The bill adds a new Section 89-f to the State Finance Law to establish in the custody of the Superintendent a Workers' Compensation Security Fund Payment Account consisting of all money collected under Section 108 of the Workers' Compensation Law as well as any other moneys credited or transferred to the Account from any other fund or source pursuant to law. Money in this Account will be used to repay any borrowing the Workers' Compensation Security Fund made from either the liquidation estate or the Property/Casualty Insurance Security Fund and to fund the Workers' Compensation Security Fund for the payment of workers' compensation benefits to injured claimants.

- The bill amends Section 108(2) of the Workers' Compensation Law authorizing the Superintendent to increase the assessment rate charged to workers' compensation carriers from one percent to not more than two percent of net written premiums with the amount collected to be deposited into the Workers' Compensation Security Fund Payment Account.

- The bill also amends Section 109(1) of the Workers' Compensation Law to provide that while there are any loans authorized under Section 7433-a of the Insurance Law outstanding, any assets remaining in the Workers' Compensation Security Fund, after payment of claims, must be used to repay such loans and may not be counted as assets of the Fund.

- Finally, the bill requires the Superintendent to notify the Legislature of any actual and anticipated receipts and disbursements of the Workers' Compensation Security Fund, the Property/Casualty Insurance Security Fund and the Public Motor Vehicle Liability Security Fund and to issue a report to the Governor and Legislature, by October 31, 2005, on reform of these funds. This report must also include an evaluation by an independent auditor of these funds including their administration, an actuarial projection of capacity and future demands and the reasons for the current impairment, if any, of the capacity of each such fund.

Chapter 86 of the Laws of 2005 amends the Workers' Compensation Law and other laws as follows:

- The bill repeals paragraph (e) of subdivision 2 of Section 89 of the Workers' Compensation Law and Section 2 repeals paragraph 2 of subsection (e) of Section 2304 of the Insurance Law. Both sections relate to the calculation of premium rates for workers' compensation insurance for construction classification employers based on the average weekly payroll per employee instead of the actual weekly payroll per employee, and other phase-in issues.

- The bill also removes the December 31, 2005 sunset for Chapter 135 of the Laws of 1998, thereby making the provisions of this Chapter permanent.

Chapter 141 of the Laws of 2005 amends Chapter 650 of the Laws of 1998, amending the Insurance Law relating to authorizing domestic life, property/casualty, reciprocal, mortgage guaranty, co-operative property/casualty and financial guaranty insurers to enter into derivative transactions, as follows:

- The bill extends the current June 30, 2005 sunset on the current statutes authorizing most types of insurers to enter into derivative and replication transactions in accordance with written derivative use plans developed by an investment committee of the insurer's board of directors, which plan is then prior-approved by the Superintendent of Insurance, to June 30, 2007.

- The bill provides for an immediate effective date and provides that the provisions of the bill shall be deemed to have been in full force and effect on and after June 30, 2005.

Chapter 156 of the Laws of 2005 amends the Insurance Law and Chapter 42 of the Laws of 1996, amending the Insurance Law relating to homeowners' insurance and a temporary panel on homeowners' insurance coverage, as follows:

- The bill amends 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, 2005, and to extend such provisions to June 30, 2006.

Chapter 246 of the Laws of 2005 amends the Insurance Law as follows:

- The bill amends Section 1109(a) of the Insurance Law to add Section 2612, "Discrimination based on being a victim of domestic violence," to the list of provisions of the Insurance Law that an Article 44 health maintenance organization must comply with without having to be licensed under the Insurance Law.

- The bill also amends Section 2612(c) of the Insurance Law to define "insurer" to include an insurer, a corporation organized pursuant to Article 43 of the Insurance Law, a health maintenance organization certified pursuant Article 44 of the Public Health Law or a provider issued a special certificate of authority pursuant to Section 4403-a of the Public Health Law. It also defines "policy" to include a policy of insurance issued under the Insurance Law and coverage provided under Child Health Plus, Medicaid and Family Health Plus.

- The bill also amends Section 2612(f) to provide that when a person covered under an insurance policy, who is not the policyholder, has an order of protection against the policyholder, the insurer shall not disclose to the policyholder the address and telephone number of the insured, or of any person or entity providing covered services to the insured. Where the covered person is a child, this right may be raised by, and extended to, the parent or guardian of the child. This prohibition would continue for the duration of the order of protection. The bill also requires the Superintendent, in consultation with the Commissioner of Health, the Office of Children and Family Services and the Office for the Prevention of Domestic Violence, to promulgate regulations to advance the purposes of the bill.

- The bill also amends Section 2612(e) to provide that an insurer that complies with the specified prohibitions and acts reasonably and in good faith will not be subject to civil or criminal liability on account of compliance.

- This bill builds upon legislation enacted in 1996 that was designed to protect individuals who are or have been the victim of domestic violence (Chapter 174). This bill makes clear that an insurer who receives a valid order of protection against a policyholder shall be prohibited for the duration of the order from disclosing to the policyholder the address and telephone number of the insured or anyone who is providing covered services to the insured.

Chapter 251 of the Laws of 2005 amends the Insurance Law as follows:

- The bill, which provides for an immediate effective date, amends Section 1405(a)(7)(C) of the Insurance Law to increase the overall limit on foreign investments by domestic life insurers from 8% to 9% of the life insurer's admitted assets.

Chapter 259 of the Laws of 2005 amends the Insurance Law as follows:

- The bill adds a new Section 3429-a to the Insurance Law to prohibit an insurer from refusing to issue or renew or canceling a homeowner's insurance policy based solely on the insured residing in an area that is serviced by a volunteer fire department. The bill would allow insurers to refuse to issue or renew or cancel such policies where it can be demonstrated that there exists sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience that support such action. The Superintendent of Insurance is required under the bill to develop regulations providing procedures for notifying insureds of an insurer's reasons for refusing to issue or renew or canceling a homeowner's insurance policy.

- The bill amends paragraph 1 of subsection (a) of Section 3430 of the Insurance Law to provide an insured who is not able to obtain homeowner's insurance because of the geographical location of the risk or property within the state with the right to file a grievance with the Superintendent of Insurance where such inability to obtain coverage was not based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.

Chapter 340 of the Laws of 2005 amends the Insurance Law as follows:

- The bill amends Section 4219 of the Insurance Law to permit a life insurance company to include the policy reserves and liabilities of its wholly-owned subsidiary life insurance companies to the extent that the surpluses of the subsidiaries are included in the surplus of the domestic life insurance company for purposes of determining its surplus limit. It also permits a domestic life insurance company to include the policy reserves and liabilities of its accident and health insurance policies. Both these changes are primarily intended to increase the surplus cap that may be maintained by domestic mutual life insurance companies.
- The bill also permits domestic stock life insurance companies that issue participating policies the option to calculate their participating policyholder's surplus using the risk-based capital formula that is currently authorized for domestic mutual life insurance companies. The amendment would allow these insurers to use the same calculation as domestic mutual life insurance companies, prorated based on the ratio of participating assets to admitted assets.

Chapter 420 of the Laws of 2005 amends Chapter 1 of the Laws of 2002, relating to implementing the state fiscal plan for the 2002-2003 state Fiscal Year, as follows:

- The bill amends Section 42 of Part A of Chapter 1 of the Laws of 2002 to change the current requirement that physicians, surgeons and dentists participating in the excess medical malpractice insurance program, that have already completed an initial basic risk management course, take a follow-up risk management course every year to once every two years in order to participate in the excess program.

Chapter 423 of the Laws of 2005 amends the Insurance Law as follows:

- Specifically, the bill adds 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 from participation in 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 a claim for reimbursement under no-fault, and this information, which must be updated regularly, must be made available to the public on a Web site and by a toll free number. 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.

Chapter 426 of the Laws of 2005 amends the Insurance Law as follows:

- The bill adds a new Section 3449 to the Insurance Law to provide that a “policy of wireless communications insurance” shall cover wireless handsets, pagers, personal digital assistants, wireless telephones or wireless telephone batteries and other wireless devices and accessories used to access wireless communications services and includes wireless services.
- The bill also:
  - exempts policies of wireless communications equipment insurance which are issued on a group basis from sections 3425 and 3426 of the Insurance Law governing minimum term requirements for policies issued as group property and casualty insurance.
  - prohibits an insurer from terminating or changing the terms of a group policy covering wireless communications equipment unless the policyholder and certificate holders receive at least 60 days notice, except in cases involving non-payment of premium or where there is fraud or misrepresentation involved, in which case the policy may be terminated upon 15 days notice.
  - allows an insurer to automatically terminate the policy where the certificate holder no longer has service with the wireless provider or has exhausted the benefits.

- requires the policyholder of a group policy wishing to terminate the policy to provide written notice of such intent to terminate to each certificate holder at least 30 days prior to the termination, and the notice must set forth the reason for termination.

- a policyholder is not required to give notice of termination to a certificate holder if substantially similar coverage has been obtained from another insurer without lapse of coverage.

- authorizes the Superintendent of Insurance to promulgate regulations regarding wireless polices.

- The bill also amends subsection (d) of Section 2131 of the Insurance Law to clarify that limited lines licensees cannot be compensated, either directly or indirectly, for the sale of wireless communications equipment insurance.

Chapter 452 of the Laws of 2005 amends various laws and the Insurance Law as follows:

- The bill adds a new Section 208 to the State Administrative Procedure Act to provide that, with respect to any civil penalty of $1,000 or more owed by a local government or small business to an agency, such agency must allow the local government or small business to pay such amount in four quarterly installments, or, on any other installment basis. Interest may be added by the agency to any amount due and the agency may require certain financial assurances in conjunction with these installment arrangements. Finally, these types of installment arrangements cannot be applied to civil penalties administered by the Commissioner of Taxation and Finance or to fines for traffic infractions or parking violations.

- The bill also amends the Insurance Law to provide an expedited eligibility hearing option to designate the insurer for first party benefits.

Chapter 672 of the Laws of 2005 amends the Insurance Law as follows:

- The bill makes technical amendments to various sections of Article 69 of the Insurance Law (financial guaranty insurance) and clarifies the distinctions between surety insurance and financial guaranty insurance so that surety insurers would be permitted to write certain coverages that currently can only be written as financial guaranty insurance.

- More specifically, the bill amends Section 1113(a)(16) of the Insurance Law to permit surety insurers to write, under certain circumstances, bonds guaranteeing the performance of non-residential leases (both real and personal property), bonds guaranteeing the performance of a contract of indebtedness or other monetary obligation and bank depository bonds for bank customers with funds on deposit in excess of the FDIC guarantee. For lease bonds, the surety insurer's obligation cannot exceed a period of five years and the bond may not be issued in connection with the sale of securities, a pooling of financial assets or a credit default swap as defined by Article 69 of the Insurance Law. For contracts of indebtedness or other monetary obligations, the total amount guaranteed by the surety insurer under all bonds issued to the obligor cannot exceed $10 million, the bond may not be issued in connection with the sale of securities, a pooling of financial assets, or a credit default swap as defined by Article 69 and the bond by its terms must terminate upon any sale or other transfer of the insured obligation in connection with the sale of securities, a pooling of financial assets, or a credit default swap.

Chapter 673 of the Laws of 2005 amends the Insurance Law as follows:

- The bill amends Section 5502 of the Insurance Law to eliminate the requirement that the Medical Malpractice Insurance Pool (MMIP), the residual market for medical malpractice insurance, make available to health care providers a second layer of excess medical malpractice insurance. The bill is scheduled to take effect January 1, 2006 and sunsets on July 1, 2008.

Chapter 677 of the Laws of 2005 amends the Vehicle and Traffic Law as follows:

- The bill amends Section 370 of the Vehicle and Traffic Law to permit operators of rental vehicles and for-hire vehicles (taxis, car services, limousines and buses) to purchase insurance coverage in excess of the liability limits set forth in Section 370. In effect, it would allow these operators the option to purchase higher insurance coverage limits.

IV. Regulations Promulgated or Repealed

The following is a summary of Insurance Department regulations promulgated or repealed in 2005. These brief descriptions of the regulations are intended to provide general information and, therefore, should not be used in place of the full text of the regulations or regarded as interpretation of Insurance Department intent or policy.

The 2nd Amendment to Regulation 144 (11 NYCRR 39): Partnership for Long-Term Care Program (Adopted on a permanent basis effective 1/26/05)

By Chapter 454 of the Laws of 1989, as amended by Chapter 659 of the Laws of 1997, the Legislature enacted the Partnership for Long-Term Care Program ("the Program") to provide that citizens of New York State who purchase a long-term care insurance policy/certificate under the Program, and who exhaust benefits under such policy/certificate, will become eligible for long-term care protection through the New York State Medicaid program. Regulation 144 establishes the standards and requirements relating to the Program.

This amendment to Part 39 of 11 NYCRR was necessary to expand the plan design options under the New York State Partnership for Long-Term Care Program. Prior to the amendment there was only one plan design offered.

The previously existing plan design (referred to as the 3/6/50 plan) provides minimum coverage of three years for nursing home benefits, or six years for home care benefits at half the nursing home benefit rate, and full asset protection under Medicaid upon exhaustion of policy benefits.

Two new plan designs (referred to as the 1.5/3/50 plan and the 2/2/100 plan) are included in this amendment. They provide more limited benefit periods, are more affordable, and provide partial asset protection under Medicaid. As minimum standards, these plan designs also allow the flexibility of offering greater benefits within the same structure. The third new plan design (referred to as 4/4/100) offers the longest benefit periods, the most comprehensive benefits with greater flexibility that may extend a consumer's ability to remain living in their own homes, and provides full asset protection under Medicaid.

This amendment provides more options for New York residents both in terms of covered benefits, flexibility, affordability, and asset protection under Medicaid upon exhaustion of policy benefits. The enhancement of the Partnership program through this amendment effectuates a more attractive product that will broaden the long-term care insurance market and encourage independent financial responsibility on the part of consumers.

The Adoption of the New Regulation 178 (11 NYCRR 230): Claim Submission Guidelines (Effective on an emergency basis since 8/14/03; Adopted on a permanent basis effective 2/02/05)

Chapters 637 and 666 of the Laws of 1997 amended the Insurance Law relating to the settlement of claims for health care and payment for health care services and took effect January 22, 1998. The legislation was intended to set timeframes within which insurers and HMOs must pay undisputed claims for health care services submitted by subscribers and health care providers. The legislation prescribed penalties in the form of interest payable on claims paid later than 45 days. The law also amended Section 2402 and gave the Superintendent the power to levy monetary penalties against insurers and HMOs for their failure to pay undisputed claims within 45 days of receipt, or untimely denials of claims, or for requesting additional information needed to process the claim beyond 30 days from receipt of the claim. The Insurance Department established mechanisms for accepting complaints from health care providers and created procedures for levying monetary penalties against insurers and HMOs for violations of the prompt payment statute.

One area of continuing concern had been determining when a claim is deemed to be "clean" and therefore ready for payment. This regulation creates claim payment guidelines based on agreement with representatives of the industry on what is needed in order to determine when a health care insurance claim is considered complete and ready for payment. By its terms, the regulation is applicable only to claims submitted on paper.

The 1st Amendment to Regulation 143 (11 NYCRR 41): Accelerated Payment of Death Benefits under a Life Insurance Policy (Adopted on a permanent basis effective 12/07/05)

Chapter 537 of the Laws of 2000 added sections 1113 (a)(1)(C) and (D) to the Insurance Law, allowing insurers to offer consumers the option of accelerating the death benefit under their life insurance policy when the insured is chronically ill and may need additional financial resources to assist with meeting long term needs and expenses. Access to existing resources such as the death benefit of a life insurance policy and the ability for insurers to provide for alternate ways to meet the increasing long term care needs and expenses has become critical especially in view of the already significant financial burdens on the Medicaid and Medicare programs. The Legislation also required that the accelerated death benefit payments for chronic illness be federally tax-qualified. The standards set forth by the amended regulation provide consumers with proper disclosure about this new benefit and help to ensure the favorable federal tax treatment for the payment of the benefits.

The previously existing regulation governing accelerated death benefits had been in effect since 1992. Since that time, the Legislature has amended Insurance Law sections 1113(a)(1), 3201 and 3230 to allow for the payment of accelerated death benefits in the event that the insured becomes chronically ill. The need to find viable financial alternatives to help with long term care expenses has become a significant public policy concern. The amended regulation will give insurers licensed to do business in this state the ability to offer this new product feature in New York and provide consumers with an option to access their life insurance death benefit in the event of chronic illness. Consumers will also be provided with the advantage of having such accelerated death benefit payments be federally tax-qualified.

Emergency Regulations

The following is a summary of Insurance Department Regulations promulgated on an emergency basis in 2005 that were in effect on December 31, 2005. No final action was taken with regard to these Regulations in 2005 although it is anticipated that they will be permanently adopted in 2006. These brief descriptions of the regulations are intended to provide general information and, therefore, should not be used in place of the full text of the regulations or regarded as interpretation of Insurance Department intent or policy.

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 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 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. Without this regulation, there would be no standard method for valuing such products and, in fact, the previous version of the regulation provided no guidance related to certain coverages such as group accident and health policies. This could result in inadequate reserves for some insurers, which would jeopardize the security of policyholder funds. Additionally, the previous regulation required higher reserves than necessary for certain individual accident and health insurance policies. The new regulation, by lowering such reserves for individual policies, will result in a lower cost of doing business in New York.

Beginning with year-end 2003, where the requirements of this regulation produce reserves higher than those calculated at year-end 2002, the insurer may linearly interpolate, over a four-year period, between the higher reserves and those calculated based on the year-end 2002 standards. Insurers must be in full compliance with this Part by year-end 2006. This allows insurers subject to the regulation ample time to achieve full compliance, since this regulation has been adopted on an emergency basis since December 31, 2002.

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)

A significant number of New York residents currently have no health insurance. A large portion of that uninsured population is made up of individuals employed in small businesses. 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. Additionally, the problem of the uninsured has been exacerbated by national events impacting the labor market and access to employer-based health insurance coverage. 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 amendment is necessary to introduce a second Healthy NY benefit package at a reduced premium rate. The second benefit package provides for a lower cost alternative and gives individuals and small businesses the choice of a benefit package that meets their needs. The amendment deletes the well child copayment applicable to the Healthy NY Program in order to enhance access to preventive and primary care for children. The amendment 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 amendment revises the eligibility requirements

relating to employment in order to lessen complexity and enhance access. The amendment provides that child support payments shall not be treated as income of the parents for the purpose of determining household income eligibility equitably.

The amendment deletes the applicability of certain documentation requirements in connection with the re-certification process and facilitates re-certification closer to annual renewal date. This will allow for simplification of the re-certification process to assist in ensuring continuity of coverage for low-income individuals. The amendment clarifies that qualifying small employers choosing to offer coverage to part-time workers may choose the level of premium contribution on behalf of these workers to encourage employers to extend coverage to part-time workers. The amendment provides that employers making a *de minimis* contribution to employee premiums shall not be forced out of the Healthy NY Program for this reason. This *de minimis* amendment will avoid penalizing vulnerable employers for such premium contributions and will encourage these employers to purchase Healthy NY coverage subject to a 50% premium contribution requirement. The amendment clarifies that health maintenance organizations and participating insurers may reinsure their Healthy NY business if it achieves a favorable premium impact. The amendment also adjusts the stop loss corridors for the program in order to effectuate a level of premium reduction sufficient to encourage more currently uninsured businesses and individuals to purchase comprehensive health insurance coverage. These revisions should provide low-income individuals and vulnerable small businesses with enhanced access to the Healthy NY Program.

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)

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. Section 42 of Part A of the Laws of 2002, as amended by Section 16 of Part J of Chapter 82 of the Laws of 2002, requires that all physicians, surgeons and dentists participating in the excess medical malpractice insurance program established by the Legislature in 1986 participate in a proactive risk management program.

As required by statute, insurers were required to have a proactive risk management course available for their insureds as of July 1, 2002 in order for insureds to participate in the excess medical malpractice insurance program. The regulation also allows, 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 compliance with the provisions of this Part.

The Adoption of the New Regulation 180 (11 NYCRR 48): Key Person Company-Owned Life Insurance (Effective on an emergency basis since 6/02/04)

The insurable interest requirements contained in Section 3205 reflect the state's public policy against contracts wagering on human life. Section 3205(b)(2) prohibits the issuance of any policy upon the life of another person unless the beneficiary is the insured, personal representative of the insured, or a person having an insurable interest in the insured at the time the policy is issued.

In 1996, the Legislature added new subsections (d) and (e) to Section 3205 of the Insurance Law (L. 1996 c. 491) to specifically grant employers an insurable interest in any employee or retiree who is eligible to participate in an employee benefit plan. The Legislature enacted Section 3205(d) in order to assist employers with the financing of employee benefit plans through the use of corporate-owned life insurance ("COLI") purchased on the lives of employees.

The purpose of this regulation is to establish standards for life insurers issuing key employee COLI, pursuant to Section 3205(a) rather than Section 3205(d) to ensure that the employees on whose lives coverage is being written pursuant to Section 3205(a)(1)(B) of the Insurance Law are actually key employees. The definition of key employee in this proposed regulation is based on the definition of key employee set forth in a draft bill pending in the United States Senate which provides for the taxation of death proceeds of COLI under certain circumstances.

It is imperative that insurers be provided with standards for key employees to ensure that such employees are key employees and to avoid the potential for any abuses in the market. The establishment of a key employee standard will provide such guidance. In addition, the key employee standard will enhance the Department's market conduct exams by providing field examiners with a reference point. Field examiners currently lack statutory or regulatory standards for determining the proper application of Section 3205(a) and, specifically, whether COLI insurance issued pursuant to Section 3205(a) is on key employees.

The 1st Amendment to Regulation 147 (11 NYCRR 98): Valuation of Life insurance Reserves (Effective on an emergency basis since 12/29/04)

One major area of focus of the Insurance Law is the solvency of insurers doing business in New York. One way the Department seeks to ensure solvency is through requiring all insurers authorized to do business in New York State to hold reserve funds necessary in relation to the obligations made to policyholders.

Some companies have sold life insurance products that result in reserves being held that are lower than the reserves that would be required for products with similar death benefit and premium guarantees and are therefore holding reserves lower than those intended by Section 4217 of the Insurance Law and the current version of Regulation 147. The new reserve methodologies in this amendment address this problem. Not adopting this amendment could result in inadequate reserves for some insurers, which would jeopardize the security of policyholder funds. The regulation will also set standards for determining policy reserves for credit life insurance.

The Adoption of the New Regulation 182 (11 NYCRR 221): Limitations upon and Requirements for the use of Credit Information for Personal Lines Insurance (Effective on an emergency basis since 2/02/05)

The Legislature, in enacting Chapter 215 of the Laws of 2004, wanted to assure that consumers were afforded certain protections with respect to the use of credit information for personal lines insurance. The Superintendent was directed to promulgate a regulation to establish 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.

Most insurers currently use credit information in the underwriting and initial tier placement of consumers for personal lines insurance. 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 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 thirty 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 filing their credit information requirements with the Superintendent.

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)

Regulation 68 contains provisions implementing Article 51 of the Insurance Law, known as the Comprehensive Motor Vehicles Insurance Reparations Act, popularly referred to as the No-Fault Law. No-fault insurance was introduced to rectify many problems that were inherent in the existing tort system utilized to settle claims, and to provide for prompt payment of health care and loss of earnings benefits. Chapter 452 of the Laws of 2005 codified the rules contained within Insurance Department Regulation No. 68 that are applicable when multiple insurers may be responsible to the claimant for the processing of a claim for first party benefits. Chapter 452 also enhanced the current arbitration procedures to include an expedited eligibility hearing option, when required, to designate the insurer for first party benefits.

When there was a dispute regarding which insurer, among two or more responsible insurers, would be responsible for the payment of the claim for first party benefits to the applicant, generally the insurer that received notice of the claim first was required by regulation to furnish the benefits. When an insurer failed to comply with this regulatory requirement, the applicant's recourse was to seek resolution of the dispute in arbitration or a court of competent jurisdiction. Because of the inherent delays in the resolution of cases in arbitration and court, a faster recourse was needed to assure accident victims that the failure of one or more insurers to meet their regulatory responsibility would not result in the failure of accident victims to be swiftly compensated for their economic losses. Chapter 452 of the Laws of 2005 provides for an expedited eligibility hearing option. These rules implement the law and require an insurer to issue a denial with specific language advising the applicant of the availability of special expedited arbitration to resolve the issue of which insurer is to be designated to process the claim for first party benefits. The rules also provide the procedures for administration of the special expedited arbitration for disputes regarding the designation of the insurer for first party benefits. By providing notification of, and procedures for, administration of the special expedited arbitration, an applicant can utilize the special expedited arbitration to expeditiously resolve all disputes regarding which insurer should be liable for the payment of 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 since 12/28/05)

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 in regard 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.* The Accounting Manual is incorporated by reference into this regulation. The preamble to the Accounting Manual states that "...this Manual is not intended to preempt states' legislative and regulatory authority. It is intended to establish a comprehensive basis of accounting recognized and adhered to if not in conflict with state statutes and/or regulations...."(Accounting Manual at Pg. P-1). The purpose of this Part is to enhance the consistency

of the accounting treatment of assets, liabilities, reserves, income and expenses by entities subject hereto, by clearly setting forth the accounting practices and procedures to be followed in completing annual and quarterly financial statements required by law.

The National Association of Insurance Commissioners has most recently adopted a new Accounting Manual as of March 2005. The NAIC's instructions to insurers and Public Health Law Article 44 HMOs for completing their 2005 annual statement forms include the following: "The annual statement is to be completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures Manual – version as of March 2005 except to the extent that state law, rules or regulations are in conflict with these publication." In some instances, a New York statute or regulation may preclude implementation of particular codification rules. In a few instances, for various reasons, the Department has determined not implemented the codification rule. This amendment establishes the deviations from the latest revised edition of the Accounting Manual.

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, a publication which is incorporated by reference in regulation.

Consensus Regulation

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 rule on a consensus basis.

The 34th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards for the form, content and sale of Medicare supplement insurance (Adopted on a permanent basis effective 9/7/05)

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) included a number of changes to the standardized Medicare supplement insurance plans. The Act charged the NAIC, specifically the Senior Issues Task Force, with the task of updating the standards for Medicare supplement insurance. This was done through adoption of a revised Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act on September 8, 2004. The states were required to adopt the revised standards by September 8, 2005.

The revised standards include the addition of two new standardized plans K and L. These plans introduce a cost-sharing feature which distributes costs between the plan and the insured. The plans also have out-of-pocket expenditure maximums. These types of plans offer Medicare beneficiaries a new option to supplement their coverage. A full description of the plans and a new outline of coverage has been added detailing the benefits of each plan.

As a result of the introduction of the new Medicare Part D, the Medicare supplement insurance standards also required revision to remove reference to outpatient prescription drug coverage. Medicare Part D enrollees may not have any other type of prescription drug coverage. As of January 1, 2006, insureds enrolled in Plans H, I, or J (the prescription drug plans) and Part D, must either have the outpatient prescription drug coverage stripped from their Medicare supplement insurance plan or enroll in a different plan that does not include the drug coverage. However, if an insured is enrolled in plan H, I, or J and opts not to enroll in Part D, he/she may keep the Medicare supplement outpatient prescription drug coverage. The regulation was amended to include these changes.

The MMA also added changes to the Medicare benefit package. As a result, the Medicare supplement benefit plans had to be restructured to accommodate these changes. For example, preventive testing was added to the Medicare benefit package. Therefore, the preventive care benefits in Medicare supplement insurance Plans E and J required modification.

As the Centers for Medicare & Medicaid Services (CMS) has changed the name of the Medicare managed care plans from Medicare + Choice to “Medicare Advantage”, all references to the plans had to be revised. The above changes also necessitated changes to the requirements for Medicare supplement insurance application forms and disclosure notices.

V. Circular Letters Issued In 2005*

Number	Date	Addressed to	Subject
1	1/10/05	All Licensed Property/Casualty Agents; Licensed Brokers	Eligibility for Flood Insurance through the National Flood Insurance Plan
2	2/25/05	All Authorized Property/Casualty Insurers, Rate Service Organizations, New York Automobile Insurance Plan, New York Property Underwriting Association, and Insurance Producer Organizations	Limitations Upon and Requirements for the Use of Credit Information for Personal Lines Insurance - Emergency Adoption of Regulation No. 182 (11 NYCRR 221) Insurer Credit Information Compliance Certification
3	3/10/05	All Motor Vehicle Automobile Self-insurers, and Insurers Licensed to Write Motor Vehicle Liability Insurance in New York State	A) Withdrawal of Three Circular Letters; B) Imposition of Interest on Certain Unpaid Assessments Billed to Self-Insurers and Insurers for the Funding of the No-fault and Supplementary Uninsured Motorist Arbitration Programs
4	3/02/05	All Insurers Licensed to Write Accident and Health Insurance in New York State (“Commercial Insurers”), Article 43 Corporations and Health Maintenance Organizations	National Medical Support Notice
5	4/13/05	All Insurers Licensed to Write Accident and Health Insurance in New York State (“Commercial Insurers”), Article 43 Corporations, Health Maintenance Organizations, Municipal Cooperative Health Benefit Plans, Fraternal Benefit Societies, and Continuing Care Retirement Communities	Contact and Product Information for Health Bureau Inquiries
6	4/19/05	All Authorized Property/Casualty Insurers and Life Insurers, Rate Service Organizations, Excess Line Association of NY, and Insurance Producer Organizations	Group Insurance Policies for Life Insurance Agents and Broker/Dealer Representatives
7	3/24/05	All Insurers Licensed to Write Accident and Health Insurance in New York State (“Commercial Insurers”), Article 43 Corporations and Health Maintenance Organizations	Explanation of Benefits (EOB) Requirements

Number	Date	Addressed to	Subject
8	3/29/05	All Authorized Insurers	Finite Reinsurance
Supplement No. 1 to CL No. 8 (2005)	8/03/05	All Authorized Insurers	Finite Reinsurance
10	5/16/05	All Insurers Authorized to Write Motor Vehicle Insurance in New York State or Workers' Compensation Insurance Providing Benefits in Lieu of First Party Benefits under No-fault; Motor Vehicle Self-insurers; and the Motor Vehicle Accident Indemnification Corporation (MVAIC)	PIP (No-fault) Inter-company Loss Transfer Procedures
11	7/15/05	All Insurers Authorized to Write Motor Vehicle Insurance in New York State, Rate Service Organizations, New York Automobile Insurance Plan, and Insurance Producer Organizations	Motor Vehicle Cancellation and Non-renewal Notice Requirements
12	7/22/05	All Property/Casualty Insurance Companies and Reciprocal Insurers Authorized to Write Workers' Compensation Insurance	Workers' Compensation Security Fund
13	8/24/05	All Health Maintenance Organizations and Article 43 Corporations	Section 4308(g) Notices of Premium Rate Increases Sent to Subscribers
Supplement No. 1 to CL No. 20 (2003)	8/31/05	All Authorized Motor Vehicle Insurers and Insurance Producer Organizations	Motor Vehicle Liability and Collision Insurance Premium Reduction for Completion of an Accident Prevention Course Pursuant to Section 2336(a) and (d) of the New York Insurance Law
14	10/05/05	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	Disaster Planning Preparedness and Response

Number	Date	Addressed to	Subject
15	7/22/05	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
16	10/05/05	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 Emergency Adoption of the Third Amendment to Regulation 68-C and Fourth Amendment to Regulation 68-D
18	10/18/05	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations	Medicare Part D
19	11/14/05	All Authorized Motor Vehicle Insurers and Insurance Producer Organizations	Motor Vehicle Liability and Collision Insurance Premium Reduction for Completion of an Accident Prevention Course Pursuant to Section 2336(a) and (d) of the NYIL
20	10/24/05	All Authorized Life Insurers	Market Conduct Profile
21	11/25/05	All Motor Vehicle Automobile Self-insurers and Insurers Licensed to Write Motor Vehicle Liability Insurance in New York State	Unpaid No-fault Conciliation Agreements, American Arbitration Association (AAA) Issued Settlement Letters and No-fault Arbitration and Master Arbitration Awards
22	12/07/05	All Property/Casualty Insurers Domiciled in New York State	Filing of Actuarial Opinion Summary (AOS)
23	11/30/05	All A&H 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	Disaster Planning, Preparedness and Response
Supplement No. 3 to CL No. 10 (2002)	12/22/05	All New York Domestic Insurers	USA Patriot Act of 2001 - Final Rules Issued by Financial Crimes Enforcement Network (Treasury Department)

*Circular Letters No. 9 and 17 were not issued in 2005.

VI. MAJOR LITIGATION

Consumers Union of U.S., Inc., et al. v. The State of New York, et al.
Consumers Union of U.S., Inc., et al. v. Gregory V. Serio
Supreme Court, New York County
Appellate Division, First Department
New York Court of Appeals

These actions arise out of the conversion of Empire Blue Cross and Blue Shield to a for-profit entity. The plaintiffs challenged the conversion on several grounds, including unconstitutional impairment of a contractual obligation, violation of due process, unreasonable taking of property without just compensation, failure to comply with the Not For Profit Corporation Law, and breach of fiduciary duties by the Empire Board of Directors. The plaintiffs sought declaratory and permanent injunctive relief prohibiting the conversion, and alternative relief requiring all proceeds of the Empire conversation to be paid to a foundation that will carry on Empire's charitable mission.

In a memorandum decision issued February 28, 2003, the Supreme Court (Justice Ira Gammerman) granted the defendants' motion to dismiss the complaint. The Court held that none of the nine causes of action alleged in the complaint had merit. However, the Court also stated that the factual allegations of the complaint were sufficient to support a cause of action for violation of Article III, Section 17 of the State Constitution, which provides that no private or local laws shall grant any corporation, association or individual any exclusive privilege, immunity or franchise. The Court indicated that Chapter 1 of the Laws of 2002 carves out an exception to the prohibition on conversion to for-profit status contained in Section 4301(j)(1) of the Insurance Law that applies exclusively to Empire. Accordingly, the Court granted the plaintiffs leave to serve an amended complaint within 30 days. The Court also continued the temporary restraining order it granted at commencement of the action which enjoined the defendants from transferring the proceeds of the sale of WellChoice stock issued in the name of the Public or Charitable Asset Fund.

Plaintiffs filed a Notice of Appeal of the February 28, 2003 decision. The State Defendants then cross-appealed the February 28, 2003 decision. Plaintiffs subsequently amended their complaint and defendants moved to dismiss. In a memorandum decision dated October 1, 2003, Justice Gammerman denied the motion to dismiss. The State Defendants then took an interlocutory appeal of the decision denying the motion to dismiss. On appeal, the Appellate Division, First Department, affirmed both decisions of Justice Gammerman. By order dated October 12, 2004, the Appellate Division granted the plaintiffs and the defendants leave to appeal to the Court of Appeals.

In an opinion issued on June 20, 2005, the Court of Appeals held that the plaintiffs did not have a viable cause of action to challenge Chapter 1 of the Laws of 2002. Accordingly, the Court ruled that the order of the Appellate Division should be modified by granting the defendants' motion to dismiss the amended complaint, thereby ending the plaintiff's challenge to the Empire conversion.

Catholic Charities of the Diocese of Albany, et al. v. Gregory V. Serio
Supreme Court, Albany County
Appellate Division, Third Department

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. A further appeal by the plaintiffs to the Court of Appeals is anticipated.

Petro, Inc. v. Gregory V. Serio
Supreme Court, New York County
Appellate Division, First Department

This is a declaratory judgment action in which the plaintiff, a heating oil company, seeks a judicial determination that a maintenance and service agreement it sells to its customers, which includes up to $100,000 of coverage for cleanup services for heating oil spills, does not constitute an "insurance contract" within the meaning of the Insurance Law. The Superintendent cross-moved for a preliminary injunction preventing the plaintiff from selling the agreement without being licensed as an insurer.

In a decision and order issued July 29, 2005, the Supreme Court (Justice Charles Edward Ramos) denied the Superintendent's motion for a preliminary injunction and declared that the plaintiff's agreement was not an insurance contract within the meaning of the Insurance Law. The Court agreed with the Department that because the $100,000 cleanup coverage exceeds the cost of a customer's oil heating system the agreement did not qualify as a "service contract" within the meaning of Article 79 of the Insurance Law and therefore did not come within the statutory exemption for service contracts related to the sale of heating oil in Section 1101(b)(3-a) of the Insurance Law. However, finding that under the maintenance and service agreement the plaintiff exercised "substantial control" over the happening of events that would trigger its liability for cleanup costs, and that the "minimal embrace of fortuity" under the agreement is reasonable, the Court held that the agreement was a "warranty contract" within the meaning of the Section 1101 (b)(3-a), and therefore exempt from regulation as an insurance contract.

The Superintendent has appealed the decision of the Supreme Court to the Appellate Division, First Department, where the case is now pending.

Gregory V. Serio, et al. v. Alan G. Hevesi
Supreme Court, New York County
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 has appealed the decision of the Supreme Court to the Appellate Division, First Department, 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, 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 Reliance, Legion and certain other insolvencies, 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 in each case after joinder of the Superintendent.

In each of these cases the Department has submitted an affidavit detailing the current financial condition of the Public Motor Vehicle Fund to assist the Supreme Court in resolving the coverage issue.

VII. 2006 LEGISLATIVE RECOMMENDATIONS

These are the legislative recommendations that were available at press time. 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. Establishes Risk-Based Capital Requirements for Property/Casualty Insurance Companies and Procedures to Enforce Compliance: Departmental Bill No. 107

Section 1 of the bill adds a new Section 1324 to the Insurance Law entitled "Risk-based capital for property/casualty insurance companies." This section is summarized as follows:

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 ninety 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, analyses 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 violation.

Section 3 of the bill amends subsection (o) of Section 7402 to include an authorized control level event or a mandatory control level event as a new ground for rehabilitation of a domestic property/casualty insurer (or, for liquidation pursuant to Section 7404). In addition, pursuant to Section 7406, such an event may be the grounds for conservation of the assets of a foreign insurer.

Section 4 of the bill amends Section 1322(e)(l)(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.

2. Establishes the Interstate Insurance Product Regulation Compact to Regulate Certain Insurance Products: Departmental Bill No. 69

Establishes an interstate insurance product regulation compact. The purposes of this Compact are, through means of joint and cooperative action among the compacting states:

a. to promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

b. to develop uniform standards for insurance products covered under the compact;

c. to establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states;

d. to give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

e. to improve coordination of regulatory resources and expertise among state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;

f. to create the interstate insurance product regulation commission; and

g. to perform such other related functions as may be consistent with the state regulation of the business of insurance.

Section 1 of the bill provides legislative findings.

Section 2 adds a new Article 88 to the Insurance Law entitled the "Interstate Insurance Product Regulation Compact"(hereinafter referred to as the "Compact"). This Article consists of seventeen new bill sections: Sections 8801 - 8817.

The bill creates an Interstate Insurance Product Approval Commission (hereinafter referred to as the "Commission") and provides the statutory framework for states to enter into an interstate insurance product regulation compact.

The Compact would establish a single point of filing for certain insurance products and rate filings which would be subject to uniform national standards. Those states that are members of the Compact would develop the uniform standards that apply to products filed with the Commission. Product standards would be developed through a rulemaking process which would require the approval of two-thirds of the commission management committee and two-thirds of the commission members. Unless a state opts-out as described below, approval of a product by the Compact would be the same as approval by a member state. The bill would, however, allow companies the option to continue to file products in the individual states through the existing form filing processes. The bill also provides that individual states will continue to regulate market activities and allows for coordination among states and the Commission to determine instances of violations of uniform standards subject to the final order of the Commission.

If a state disagrees with a product standard developed by the Commission, it may opt out of the uniform standard either by regulation or legislation. For long-term care insurance, states may opt-out at the time of joining the Compact ("front-end" opt-out). In order to opt out by regulation, a state must show that the uniform standard does not provide reasonable protections to the citizens of the state and that the needs of the state outweigh the Legislature's intent to participate in and receive the benefits of the Compact.

The Compact would become effective when two states enact compact legislation. The Commission becomes operational (that is, adopting uniform standards, receiving products and giving approvals/disapprovals) if twenty-six states or states representing forty percent of the premium for life, annuities, disability income insurance and long-term care join the Compact.

Operations of the Commission would be financed initially through contributions and other sources of funding and over time through the filing fees paid by insurers.

All states joining the Compact would be involved in setting up and overseeing the activities of the Compact, including developing product standards and the rules and operating procedures of the Commission.

The Commission would make an annual report to the legislature and governor of each state joining the Compact. In addition to opting out of particular product standards, each state has the right to withdraw from the Compact, by enacting a statute repealing this bill.

Section 3 of the bill provides for an immediate effective date.

3. Authorizes Procedure for Administrative Supervision by the Superintendent of Insurance of Insurers: Departmental Bill No. 67

Section 1 adds a new Article 81 to the Insurance Law, entitled "Administrative Supervision of Insurers."

Section 8101 sets forth the legislative purpose and findings.

Section 8102 sets forth definitions of terms for purposes of new Article 81.

Section 8103 provides that an insurer (as defined in the bill) may be subject to administrative supervision by the Superintendent if upon examination or at any other time it appears, in the Superintendent's discretion, that: (1) the insurer's condition renders the continuance of its business hazardous to the interests of its policyholders, creditors or the public; (2) the insurer has exceeded its powers; (3) the business of the insurer is being conducted fraudulently; or (4) the insurer has consented to administrative supervision.

Section 8104 sets forth confidentiality provisions regarding information in the possession of the Superintendent or the Department relating to the supervision of the insurer.

Section 8105 provides that during the period of supervision, the Superintendent or his or her designated appointee shall serve as the administrative supervisor of the insurer, and sets forth the powers of supervision.

Section 8106 sets forth provisions in relation to the contesting of the Superintendent's action.

Section 8107 provides for initiation of judicial proceedings by the Superintendent under Article 74, or other proceedings under the laws of the state, in certain circumstances.

Section 8108 sets forth provisions regarding meetings between the Superintendent and the supervisor, attorneys or representatives.

Section 8109 sets forth governmental immunity provisions.

Section 2 of the bill amends Section 11O9(a) of the Insurance Law to make Article 81 of the Insurance Law applicable to an organization complying with Article 44 of the Public Health Law.

Section 3 sets forth a July 1,2006 effective date.

4. Provides Limits of Rate Filings for Individual and Small Group Health Insurance Policies and Contracts; Repealer: Departmental Bill No. 86

Section 1 amends Section 2344(h) of the Insurance Law to make flex-rating for commercial liability insurance policies permanent.

Section 2 amends Section 2350(f) of the Insurance Law and Section 7 repeals paragraph 13 of subsection (b) of Section 2305 to make auto flex-rating for non-business automobile insurance policies permanent.

Section 3 of the bill amends Section 3231 (e)(2) of the Insurance Law to add a new subparagraph (B) to provide that beginning April 1, 2005, premium rate adjustments sought by insurers subject to Article 32 of the Insurance Law cannot be deemed approved if the aggregate rate adjustment exceeds ten percent during any continuous twelve month period. It also requires at least thirty days prior written notice of a rate increase to each policyholder, employee and group member.

Section 4 amends Section 3231 (i) of the Insurance Law to change the provisions of Chapter 557 of the Laws of 2002 as follows:

a. To change the applicability of this subsection to health insurers which issue health insurance to eligible association groups as defined in Insurance Law Section 4235(c)(1)(B), (D) and (H), including chambers of commerce that satisfy any of the statutory group definitions.

b. To clarify that insurers are not prohibited from issuing coverage to sole proprietors that are not connected with an association group or chamber of commerce.

c. To clarify that nothing in this subsection shall require an insurer to establish a premium rate for individual proprietors that is greater than the rate established for the same coverage issued to groups. For those insurers seeking to implement a rate differential for individual proprietors, they must file with the Superintendent the actuarial justification for the proposed rate differential and obtain the Superintendent's approval thereof.

d. To allow insurers to impose a lesser timeframe or waive the existing sixty-day membership requirement as long as such action is done uniformly.

Section 5 amends Section 4308(g)(2) of the Insurance Law to provide that beginning April 1, 2005, premium rate adjustments sought by corporations subject to Article 43 of the Insurance Law will not be deemed approved if the aggregate rate adjustment exceeds ten percent during any continuous twelve month period.

Section 6 amends Section 4317(f) of the Insurance Law to conform the language of this section to the language of Section 3231(i) of the Insurance Law as amended by Section 4 of the bill.

Section 8 provides for an immediate effective date.

5. Relates to External Appeal Program and Holding Certified External Appeals Agents Harmless for Determinations Made: Departmental Bill No. 68

Sections 1 and 2 amend Section 4914 of the Insurance Law and Section 4914 of the Public Health Law to clarify the external appeal agent liability protections currently in law and provide that court proceedings cannot be brought against certified external appeal agents for decisions rendered pursuant to Title II of Article 49 of the Insurance Law and Public Health Law unless the decision was rendered in bad faith or involved gross negligence.

Section 3 provides for an immediate effective date.

B. Governor’s Program Bills for 2006

1. Relates to Formation of a Captive Insurance Company: Governor’s Program No. 55

Section 1 of the bill amends Section 7001(b) of the Insurance Law to provide that Section 2504 of the Insurance Law, which pertains to public constructions projects, shall apply to captive insurance companies, but shall not apply to individual public construction projects having a value of $50 million or more ($100 million for multiple public construction projects).

Section 2 of the bill:

-- amends Section 7002(a) of the Insurance Law to provide that the term "affiliated companies" shall include, relative to pure captive companies, companies that maintain a contractual or sub-contractual relationship with, and which have risk management controlled by, the industrial insured or its other affiliated companies, provided such companies voluntarily elect such affiliated status. Such term shall also include any statutory subsidiary or affiliate of a public entity as well as employees who participate in an employee benefit plan of the captive's parent and affiliated companies which is subject to the provisions of the Employee Retirement Income Security Act (ERISA).

-- amends Section 7002(c) of the Insurance Law to add sponsored captive insurance companies to the definition of "captive insurance company" for purposes of Article 70 of the Insurance Law.

-- amends the definition in Section 7002(e) of "industrial insured" (which are the entities permitted to form pure and group captive insurance companies) to reduce the threshold for businesses to operate a pure captive from a net worth of $100 million to a net worth or annual revenues of at least $25 million. Not-for-profit organizations and public entities with a total annual budget that exceeds $25 million would have the ability to form and operate a pure captive. It also provides the Superintendent with discretionary authority to allow an industrial insured to operate as a pure captive that may not meet the specified standards in the definition, but which otherwise demonstrates to the Superintendent that it is qualified to do so. The definition of "industrial insured" for a group captive has also been amended, reducing the threshold from a net worth of $100 million, to now apply to any insured whose net worth or annual revenue exceeds $7.5 million (provided that the Superintendent may reduce such threshold to $2.5 million upon his or her determination that there is a lack of meaningful coverage in a particular voluntary market) and whose aggregate annual premiums for insurance on all risks total at least $25,000, or who is a public entity.

-- amends the definition of "group captive insurance company" in Section 7002(f) to clarify that the captive insurance company can insure the risks of the owners' affiliated companies.

-- amends the definition of "industrial insured group" in Section 7002(g) to provide that a public entity may only be a member of an industrial insured group with other public entities and to include risk retention groups formed pursuant to the federal Product Liability Risk Retention Act of 1981.

Section 3 of the bill reletters subsection (h) of Section 7002 of the Insurance Law subsection (k) and adds six new subsections (h), (i), (j), (1), (m) and (n) which set forth the following new definitions:

--"participant" shall mean an entity insured by a sponsored captive insurance company where the losses of the participant are limited by contract to the assets of a protected cell.

--"participant contract" shall mean a contract by which a sponsored captive insurance company insures the risk of a participant and limits the losses of the participant to the assets of a protected cell.

--"protected cell" means a separate account established and maintained by a sponsored captive insurance company for one participant.

--"public entity" shall mean any of the following entities which are authorized to form and operate a subsidiary which would not be precluded from engaging in the activities of a captive insurance company: the state of New York and/or any department, bureau, division, commission, board or other agency of the State of New York, including any public benefit

corporation or any public authority; any governmental entity operating a college, community college or university; any city with a population of one million or more persons; or a public corporation created pursuant to agreement or compact with another state or Canada.

--"sponsor" shall mean any entity approved by the Superintendent to provide all or part of the capital and surplus required by law and to operate a sponsored captive Insurance company.

--"sponsored captive insurance company" shall mean any captive insurance company in which the minimum capital and surplus required by law is provided by one or more sponsors, that is formed or licensed under the Insurance Law, that insures the risks of separate participants through contract and that segregates each participant's liability through one or more protected cells.

Section 4 of the bill amends subsection (a) of Section 7003 of the Insurance Law to provide that a pure captive insurance company or a group captive insurance company shall be authorized to provide, on a reinsurance basis, life insurance and accident and health insurance in connection with an employee benefit plan of its parent and affiliated companies which is subject to the provisions of ERISA. The section also includes sponsored captives in the prohibition against captives offering on a primary basis workers' compensation insurance and other insurance involving a demonstration of financial responsibility, to limit a sponsored captive to insuring only the risks of its participants, and to provide that a group captive insurance company insuring the risks of an industrial insured group would be subject to the provisions of Section 5904 (d) and (e) (requiring compliance with unfair claims settlement practices law and the unfair claims settlement practices) and Section 5905 (a)-(d) (relating to notices, prohibited solicitations, coverage and ownership with respect to risk-retention groups) of the Insurance Law.

Section 5 of the bill amends subsection (b) of Section 7003 of the Insurance Law to require that managers of captive insurance companies formed as a limited liability company hold at least one meeting in this State.

Section 6 of the bill amends subsection (c) of Section 7003 of the Insurance Law to provide that a captive insurance business formed as a limited liability company must file its articles of organization with the Superintendent before such business receives a license to do a captive business. The bill also requires an applicant sponsored captive insurance company to file with the Superintendent: a business plan demonstrating how the applicant will account for the loss and expense experience of each protected cell and report such experience to the Superintendent; a statement acknowledging that all financial records of such company shall be made available for inspection by the Superintendent; all contracts or sample contracts between such company and any participants; and evidence that expenses shall be allocated to each protected cell in a fair and equitable manner.

Section 7 of the bill amends subsection (d) of Section 7003 of the Insurance Law to provide that any proposed amendments to the articles of organization and operating agreement of a captive insurance company formed as a limited liability company must be filed with the Superintendent for review and approval. Also, any proposed amendment to the charter of a not- for-profit captive insurance company must be submitted to the Superintendent for approval before filing with the Secretary of State.

Section 8 of the bill adds a new Section 7003-a to the Insurance Law to authorize one or more sponsors to form a captive insurance company under the Insurance Law and to establish and maintain one or more protected cells to insure the risk of one or more participants subject to the following: the shareholders of such company shall be limited to its participants and sponsors; such company shall maintain and account separately for the books and records of

each protected cell to reflect the financial condition and results of operation of such protected cell, net income or loss, dividends/distributions to participants; the assets of the protected cell shall not be chargeable with the liabilities of any other insurance business conducted by such company; such company shall not sell, exchange or transfer assets between or among any of its protected cells without the consent of such protected cells; no sale exchange, transfer of assets, dividend or distribution may be made from a protected cell to a sponsor or participant without the Superintendent's approval (which cannot be given if such sale, exchange, etc., would result in insolvency or impairment with respect to a protected cell); each such company shall annually file with the Superintendent those financial reports requested by the Superintendent including, but not limited to, accounting statements detailing the financial experience of each protected cell; each such company shall notify the Superintendent in writing within ten business days of any protected cell that is insolvent or otherwise unable to meet its claim or expense obligations; participant contracts, including any changes in protected cell additions or withdrawals, shall not take effect without the prior written approval of the Superintendent. In addition, the business written by a sponsored captive, with respect to each cell, must be fronted by an insurance company (which may be licensed in any state), reinsured by a reinsurer authorized or approved by the State of New York or secured by a trust fund in the United States for the benefit of policyholders and claimants funded by an irrevocable letter of credit or other asset approved by the Superintendent (sets forth the amount and form of such security); provides that the sponsor of a sponsored captive insurance company must be an insurer licensed in any state, a reinsurer approved under the laws of any state, or a captive insurer licensed in New York; provides that associations, corporations, limited liability companies, partnerships, trusts and other business entities may be participants in any sponsored captive insurance company formed or licensed under the Insurance Law; provides that a sponsor may be a participant in a sponsored insurance company and that a participant need not be a shareholder of the sponsored captive insurance company or any affiliate thereof; and provides further that a participant shall insure only its own risks through a sponsored captive insurance company.

Section 9 of the bill amends subsection (a) of Section 7004 of the Insurance Law to provide that no sponsored captive insurance company shall be issued a license unless it shall possess and thereafter maintain not less than $1 million in paid-in capital and surplus or total surplus as regards policyholders. Further, a pure captive insurance company organized as a limited liability company must maintain at least $250,000 of total surplus as regards to policyholders; and a group captive insurance company organized as a limited liability company must maintain at least $500,000 of total surplus as regards policyholders.

Section 10 amends Section 7005 of the Insurance Law to provide that a pure captive insurance company and a group captive insurance company may be organized as a limited liability company. In the case of a limited liability company, the pure and group captive must submit the company's proposed articles of incorporation which shall contain, among other things, the limited liability's company name, the number of managers and the articles of organization. It also provides that a sponsored captive insurance company may be incorporated or organized as a stock insurer, as a mutual insurer, or as a limited liability company.

Section 11 of the bill amends Section 7006 of the Insurance Law to change the dates a captive insurance company must file with the Superintendent its annual reports. Statement of the captive's financial condition and any amendments to the plan of operation at last year-end must be filed within two months of the end of its fiscal year, rather than on or before March first and a report of the captive's financial condition at the end of its previous fiscal year with an opinion of an independent certified accountant must be filed within six months of its previous fiscal year, rather than on or before July first. However, any group captive insuring the risks of an industrial insured group that includes risk retention groups is required to file its

report in the form and according to the standards set forth under Section 307 of the Insurance Law.

Section 12 of the bill amends subsection (a) of Section 7008 of the Insurance Law to provide that the license of a captive insurance company may be suspended or revoked by the Superintendent for failure to comp ly with the provisions of its own articles of incorporation for a captive incorporated as a corporation or the articles of organization or operating agreement of a captive organized as a limited liability company.

Sections 13 and 14 of the bill amend subsection (a) and add a new subsection (d) to Section 7009 of the Insurance Law to restrict investments of group captives insuring the risks of an industrial insured group that includes risk retention groups to those set forth in Insurance Law Section 1403 of the Insurance Law.

Section 15 of the bill adds a new Title 12 to Article 9 of the Public Authorities Law to provide that every public authority and every public benefit corporation is authorized to form and operate a subsidiary as a pure captive insurance company or as a group captive insurance company pursuant to Article 70 of the Insurance Law. Such Title also sets forth the form and composition of such subsidiaries.

Section 16 of the bill adds a new subdivision 6 to Section 82 of the Workers' Compensation Law to authorize the State Insurance Fund to form and operate a subsidiary as a pure or group captive insurance company exclusively for the purpose of reinsuring its own business that is written on a primary basis.

Sections 17 and 18 of the bill amend Sections 1500 and 1502-b of the Tax Law to exempt from the payment of certain fees, taxes or assessments those captives set up by any "public entity" as defined in Section 7002(1) of the Insurance Law. This expands the current exemption that applies now only to the MTA and the City of New York.

Section 19 of the bill provides for an immediate effective date.

VIII. Regulatory Activities

A. OPERATING STATISTICS

1. Licenses Issued During Year

Table 62
LICENSES ISSUED DURING YEAR
2004 and 2005

	2005	2004
Total	**151,595**	**108,558**
Adjusters[a]		
Independent	4,453	6,773
Public	249	220
Agents[b]		
Life/Accident and Health	128,460	25,500
Property and Casualty	10,078	38,518
Rental Vehicle	6	36
Mortgage Guaranty Insurance	4	1
Bail Bond	52	40
Limited Lines[c]	0	18
Personal Lines[d]	589	880
Brokers[e]		
Life	2,963	944
Property and Casualty	3,884	33,696
Excess Line (Regular)	239	859
Excess Line (Limited)	259	495
Viatical Settlement	18	16
Consultants[f]		
Life	182	9
General	28	355
Reinsurance Intermediaries[g]	22	183
Service Contract Registrants[h]	109	15

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] Personal Lines is a new major line for agents and brokers which became effective with the passing of the Producer Model Licensing Act. This new class of license covers Property/Casualty insurance that would cover only the risks encountered by individuals. Most often this insurance would cover personal automobiles and homes. Inasmuch as this is a specialized area of insurance, a specific exam was developed for applicants for this class of license. Personal Lines licenses are renewable biennially as of July 1 (agent) and November 1 (broker) of even numbered years.

[e] 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.

[f] 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.

[g] Reinsurance Intermediary licenses issued pursuant to Section 2106 are renewable biennially as of September 1 of even numbered years.

[h] 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
2004 and 2005

Type of Examination	2005 Number Taking Examination	2005 Percent Passing	2004 Number Taking Examination	2004 Percent Passing
Total	**29,142**	**48%**	**31,736**	**48%**
Public Adjusters..........................	56	34	118	35
Independent Adjusters - Total....	4,045	55	2,945	57
Accident and Health.....................	257	54	234	58
Automobile..................................	1,029	66	353	60
Aviation.......................................	0	0	0	0
Casualty......................................	769	47	762	46
Fidelity and Surety.......................	0	0	0	0
Fire..	180	71	122	54
General (All Lines).......................	552	35	628	42
Health Service Charges...............	448	58	83	47
Inland Marine...............................	22	41	63	43
Limited Auto (Damage or Theft Appraisals only).........................	788	60	700	84
Agents and Brokers - Total.........	25,030	51	28,663	47
Agent, A&H……………………….	2,435	49	3,909	49
Agent, A&H (Spanish)[a] ………….	6	0	3	0
Agt/Brk, Life………....................	7,981	45	9,960	38
Agt/Brk, Life (Spanish)[a]…....…….	437	12	210	8
Agt/Brk, Life, A&H………………..	8,863	59	8,564	51
Agt/Brk, Life, A&H (Spanish)[a]........	7	0	1	100
Agent, Property and Casualty…..	1,209	55	1,548	50
Broker, Property and Casualty.....	2,607	50	3,012	47
Agent, Mortgage Guaranty….......	1	100	1	100
Agent, Credit……........................	0	0	0	0
Agt/Brk, Personal Lines[b] ………..	1,455	58	1,432	74
Agent, Bail Bond……...………….	29	59	23	74
Consultants - Total.......…...........	11	36	10	40
Life……..	8	38	7	29
General.......................................	3	33	3	67

[a] In 2004, the Department began providing Agent/Broker Life examinations as well as Accident and Health exams in Spanish.

[b] In 2004, the Producer Licensing Model Act was signed into Law which, among other things, provided a line of licensing authority that covers *Personal Lines* Property and Casualty insurance. As a result, the Department developed a new examination covering only personal lines property and casualty insurance.

3. Changes in Authorized Insurers During 2005

A. Life Insurance Companies	
Domestic Companies Licensed	
Forethought Life Insurance Company of New York	July 21
Merger Agreements Filed	
New England Pension and Annuity Company into Metropolitan Tower Life Insurance Company	Sept. 26
Metropolitan Insurance and Annuity Company into Metropolitan Tower Life Insurance Company	Sept. 26
Columbian Family Life Insurance Company into Columbian Mutual Life Insurance Company	Nov. 17
First Great-West Life & Annuity Insurance Company into Canada Life Insurance Company of New York	Dec. 31
Amendment to Charter	
Gerber Life Insurance Company	July 26
Changes of Name	
"The Manufactures Life Insurance Company of New York" to "John Hancock Life Insurance Company of New York"	Jan. 1
"First Fortis Life Insurance Company" to "Union Security Life Insurance Company of New York"	Sept. 6
"Canada Life Insurance Company of New York" to "First Great-West Life & Annuity Insurance Company"	Dec. 31
B. Accident and Health Insurance Company	
Incorporated	
Humana Insurance Company of New York	May 20
C. Property and Casualty Insurance Companies	
Domestic Company Incorporated	
Healthcare Professionals Insurance Company	June 7
Domestic Companies Licensed	
Kensington Insurance Company	April 8
New York Transportation Insurance Corp.	July 8
Foreign Companies Licensed	
Esurance Property and Casualty Insurance Company	Feb. 11
Western General Insurance Company	June 9
North Pointe Insurance Company	June 17
Peachtree Casualty Insurance Company	June 17
American Surety Company	June 20
Merchants Bonding Company (Mutual)	Aug. 3
Ocean Harbor Casualty Insurance Company	Aug. 4
Heritage Casualty Insurance Company	Oct. 21
Mercer Insurance Company	Nov. 2
Mercer Insurance Company of New Jersey	Nov. 2
ACA Insurance Company	Dec. 5
G.U.I.C. Insurance Company	Dec. 23

Amendments to Charter	
Great American Insurance Company of New York	Feb. 4
Advantage Workers Compensation Insurance Company	Feb. 7
Fiduciary Insurance Company of America	Feb. 11
Community Mutual Insurance Company	Feb. 11
Associated International Insurance Company	April 14
Progressive Northwestern Insurance Company	April 21
Colonial Indemnity Insurance Company	April 25
TNUS Insurance Company	May 4
Axis Reinsurance Company	May 27
AutoOne Insurance Company	May 27
Alliance Assurance Company of America	June 1
International Credit of North America Reinsurance, Inc.	June 3
Hudson Insurance Company	Aug. 15
Nova Casualty Company	Oct. 21
Tower Insurance Company of New York	Oct. 24
MGIC Assurance Corporation	Oct. 24
AIG Indemnity Insurance Company	Nov. 1
AIG Preferred Insurance Company	Nov. 2
Admiral Indemnity Company	Nov. 2
The Sea Insurance Company of America	Nov. 15
Changes of Name	
“Associates Insurance Company” to “Commercial Guaranty Casualty Insurance Company”	Jan. 6
“Overseas Partners US Reinsurance Company” to “Clearwater Select Insurance Company”	Jan. 18
“Potomac Insurance Company of Illinois” to “SUA Insurance Company”	Jan. 24
“PG Insurance Company of New York” to “AutoOne Select Insurance Company”	March 18
“Omaha Property and Casualty Insurance Company” to “Beazley Insurance Company, Inc.”	May 11
“Seaco Insurance Company” to “Dentegra Insurance Company of New England”	June 20
“Merrion Insurance Company” to “Maya Assurance Company”	Sept. 16
“Gerling Global Reinsurance Corporation of America” to “GLOBAL Reinsurance Corporation of America”	Nov. 15
“Global Reinsurance Corporation of America” to “GLOBAL Reinsurance Corporation of America”	Nov. 15
“AXA Corporate Solutions Insurance Company” to “AXA Insurance Company”	Dec. 7
Redomestications Filed	
The Buckeye Union Insurance Company (from Ohio to Illinois)	Jan. 1
Boston Old Colony Insurance Company (from Massachusetts to Illinois)	Jan. 1
Pacific Insurance Company (from California to Illinois)	Jan. 1
Great American Spirit Insurance Company (from Indiana to Ohio)	Feb. 4
Associated International Insurance Company (from California to Illinois)	April 14
Progressive Northwestern Insurance Company (from Washington to Ohio)	April 21
Niagara Fire Insurance Company (from Delaware to Illinois)	July 1
The Glens Falls Insurance Company (from Delaware to Illinois)	July 1
Redland Insurance Company (from Iowa to New Jersey)	July 7

Warner Insurance Company (from Illinois to Connecticut)	July 27
Response Worldwide Direct Auto Insurance Company (from Ohio to Connecticut)	July 27
Response Worldwide Insurance Company (from Ohio to Connecticut)	July 27
Merger Agreements Filed	
Specialty National Insurance Company into American Motorist Insurance Company	July 22
TIG Insurance Company of America into TIG Insurance Company	Aug. 9
TIG Insurance Company of Michigan into TIG Insurance Company	Aug. 9
Gulf Insurance Company into The Travelers Indemnity Company	Dec. 12
Response Insurance Company of America into Response Worldwide Direct Auto Insurance Company	Dec. 21
The Sea Insurance Company of America into Royal Indemnity Company	Dec. 23
In Liquidation	
Realm National Insurance Company	June 15
In Receivership	
South Carolina Insurance Company	March 5
Withdrawn	
Mid-Continent Insurance Company	Feb. 8
Agency Insurance Company of Maryland	June 1
D. Advance Premium Co-operative Insurance Companies	
Merger Agreements Filed	
Salem Mutual Town Fire Insurance Company into Washington County Co-operative Insurance Company	March 14
E. Title Insurance Companies	
Incorporated	
Public Title Insurance Company	April 15
Foreign Companies Licensed	
American Guaranty Title Insurance Company	April 14
Change of Name	
American Pioneer Title Insurance Company to Ticor Title Insurance Company of Florida	Feb. 8
F. Accredited Reinsurers	
Recognized	
Mapfre Re, Compania de Reaseguros, S.A.	Sept. 28
RiverStone Insurance (UK) Limited	Oct. 1
Progressive Marathon Insurance Company	Dec. 30
Progressive Universal Insurance Company	Dec. 30
Redomestications Filed	
Generali USA Life Reassurance Company (from Michigan to Missouri)	Aug. 10
Withdrawn	
Beneficial Life Insurance Company	June 30
Sphere Drake Insurance Limited	Oct. 1
Peoples Benefit Life Insurance Company	Dec. 31
G. Charitable Annuity Societies	

Permits Issued	
The Diocese of Buffalo, N.Y.	Feb. 25
Marist College	March 14
Trans World Radio	March 17
DePauw University	March 29
Amit Women, Inc.	April 15
Lutheran Community Foundation	July 1
United Way of America	Sept. 8
Young America's Foudation	Sept. 13
The Free Methodist Foundation	Sept. 19
Samaritan's Purse	Oct. 7
Lehigh University	Oct. 17
Amendment to Charter	
Save the Children Federation, Inc.	July 14
Withdrawn	
Brooklyn College Foundation, Inc.	May 6
Name Change	
"Cooperative For American Relief Everywhere, Inc." to "Cooperative For Assistance and Relief Everywhere, Inc."	Jan. 19
H. Fraternal Benefit Society	
Merger Agreement Filed	
Association of Lithuanian Workers into Supreme Council of the Royal Arcanum	Dec. 9
I. Financial Guaranty Companies	
Domestic Company Licensed	
MML Assurance, Inc.	Aug. 4
Name Change	
CDC IXIS Financial Guaranty of North America, Inc. to CIFG Assurance North America, Inc.	Feb. 23
J. Mortgage Guaranty Companies	
Name Changes	
General Electric Mortgage Insurance Corporation to Genworth Mortgage Insurance Corporation	Nov. 1
GE Residential Mortgage Insurance Corporation of North Carolina to Genworth Residential Mortgage Insurance Corporation of North Carolina	Nov. 1
General Electric Mortgage Insurance Corporation of North Carolina to Genworth Mortgage Insurance Corporation of North Carolina	Nov. 1
K. Captive Insurance Companies	
Domestic Companies Incorporated	
Federated Department Stores Insurance Company, Inc.	Jan. 7
Madison Insurance Company, Inc.	May 10
Queensbrook New York, Inc.	Oct. 26
AGP Services Corp.	Nov. 16
Blackrock Insurance Corporation	Nov. 22

Realrisk Insurance Corporation	Dec. 9
Gentiva Insurance Corporation	Dec. 12
Sentinel Protection & Indemnity Company	Dec. 27
Captive Companies Licensed	
Federated Department Stores Insurance Company, Inc.	Jan. 15
Madison Insurance Company, Inc.	June 23
Queensbrook New York, Inc.	Nov. 29
Blackrock Insurance Corporation	Dec. 2
AGP Services Corp.	Dec. 23
Realrisk Insurance Corporation	Dec. 27
Sentinel Protection & Indemnity Company	Dec. 29
Gentiva Insurance Corporation	Dec. 30
Merger Agreement	
Concord Insurance Limited into Concordia Insurance, LLC	Dec. 28
L. Reciprocal Insurer	
Licensed	
Federated Rural Electric Insurance Exchange	April 8

4. Examination Reports Filed During 2005

Domestic Life Insurance Companies		
Name of Company	**As of**	**Date Filed**
American Centurion Life Assurance Company	12/31/2002	4/07/2005
American International Life Assurance Company of New York	12/31/2002	3/03/2005
American Medical and Life Insurance Company	12/31/2003	3/25/2005
AXA Equitable Life Insurance Company		12/29/2005
Balboa Life Insurance Company of New York	12/31/2003	6/16/2005
Bankers Life Insurance Company of New York	12/31/2003	8/18/2005
CIGNA Life Insurance Company of New York	12/31/2002	7/15/2005
Chase Insurance Life Company of New York	12/31/2003	6/14/2005
Chase Life & Annuity Company of New York	12/31/2003	5/31/2005
Companion Life Insurance Company	12/31/2003	5/26/2005
Conseco Life Insurance Company of New York	12/31/2002	3/14/2005
First Central National Life Insurance Company of New York	12/31/2003	6/03/2005
First Reliance Standard Life Insurance Company	12/31/2003	6/03/2005
First Security Benefit Life Insurance and Annuity Company of New York	12/31/2003	5/05/2005
First Unum Life Insurance Company	12/31/2000	1/12/2005
Forethought Life Insurance Company of New York	6/06/2005	7/21/2005
Great American Life Insurance Company of New York	12/31/2003	6/23/2005
Highmark Life Insurance Company of New York	12/31/2003	6/10/2005
IDS Life Insurance Company of New York	12/31/2002	4/07/2005
Intramerica Life Insurance Company	12/31/2003	8/01/2005
Life Insurance Company of Boston & New York	12/31/2004	10/04/2005
Monitor Life Insurance Company of New York	12/31/2003	3/04/2005
Northstar Life Insurance Company	12/31/2003	5/19/2005
Phoenix Life Insurance Company	12/31/2002	3/08/2005
Presidential Life Insurance Company	12/31/2003	6/20/2005
ReliaStar Life Insurance Company of New York	12/31/2003	6/20/2005
Sentry Life Insurance Company of New York	12/31/2003	6/13/2005
Standard Security Life Insurance Company of New York	12/31/2003	8/04/2005
Sun Life Insurance and Annuity Company of New York	12/31/2003	10/24/2005
Union Security Life Insurance Company of New York	12/31/2002	3/08/2005
USAA Life Insurance Company of New York	12/31/2003	5/12/2005
Foreign Life Insurance Company		
John Hancock Life Insurance Company	9/30/2002	2/22/2005
Domestic Accident and Health Insurance Companies		
Aetna Health Insurance Company of New York	12/31/2002	1/13/2005
Empire HealthChoice Assurance, Inc.	3/31/2003	8/25/2005
Horizon Healthcare Insurance Company of New York	6/30/2002	9/21/2005
Continuing Care Retirement Community		
Glen Arden Inc	12/31/2002	5/16/2005

Domestic Property and Casualty Insurance Companies		
American Steamship Owners Mutual Protection and Indemnity Assoc.	12/31/2001	1/31/2005
Atlanta International Insurance Company	12/31/2001	11/04/2005
Autoglass Insurance Company	12/31/2003	2/11/2005
AutoOne Insurance Company	12/31/2001	6/13/2005
AutoOne Select Insurance Company	12/31/2001	4/13/2005
Colonial Indemnity Insurance Company	12/31/2001	1/28/2005
Endurance Reinsurance Corporation of America	12/31/2003	1/24/2005
Erie Insurance Company of New York	12/31/2002	6/03/2005
Fiduciary Insurance Company of America	1/25/2005	2/24/2005
General Security National Insurance Company	12/31/2001	6/02/2005
Global Liberty Insurance Company of New York	12/31/2003	9/15/2005
GoldStreet Insurance Company	12/31/2003	9/15/2005
Hereford Insurance Company	12/31/2002	10/24/2005
Homeland Insurance Company of New York	12/31/2001	413/2005
Hudson Specialty Insurance Company	12/31/2001	11/18/2005
Kensington Insurance Company	2/01/2005	3/23/2005
Liberty Insurance Underwriters Inc.	12/31/2001	3/09/2005
Lion Insurance Company	12/31/2002	1/28/2005
Maya Assurance Company	12/31/2001	6/17/2005
Merchants Mutual Insurance Company	12/31/2003	8/15/2005
New York Transportation Insurance Corp.	6/14/2005	6/28/2005
North Sea Insurance Company	12/31/2003	4/12/2005
Nova Casualty Company	12/31/2002	9/23/2005
Scor Reinsurance Company	12/31/2001	5/26/2005
Seaboard Surety Company	12/31/2002	12/01/2005
Sompo Japan Insurance Company of America	12/31/2002	2/18/2005
Swiss Reinsurance America Corporation	12/31/2000	8/22/2005
UMI Insurance Company	12/31/2003	3/09/2005
Unitrin Auto and Home Insurance Company	12/31/2001	12/21/2005
Unitrin Preferred Insurance Company	12/31/2001	12/21/2005
Alien Property and Casualty Insurance Company		
Generali – U.S. Branch	12/31/2002	1/18/2005
Assessment Co-operative P&C Insurance Companies		
Claverack Cooperative Insurance Company	12/31/2003	6/29/2005
Erie and Niagara Insurance Association	12/31/2003	11/03/2005
Oswego County Mutual Insurance Company	12/31/2003	6/21/2005
Wayne Cooperative Insurance Company	12/31/2003	5/13/2005

Advance Premium Co-operative P&C Insurance Companies		
North Country Insurance Company	12/31/2002	5/26/2005
United Frontier Mutual Insurance Company	12/31/2004	9/27/2005
Utica First Insurance Company	12/31/2002	10/11/2005
Financial Guaranty Companies		
Financial Security Assurance Inc.	12/31/2002	6/07/2005
MML Assurance Inc.	6/21/2005	7/15/2005
Fraternal Benefit Society		
Association of Lithuanian Workers	12/31/2003	5/17/2005
Independent Order of Foresters	12/31/2002	1/31/2005
Polish Union of America	12/31/2004	12/05/2005
Reciprocal Insurer		
New York Municipal Insurance Reciprocal	12/31/2003	8/01/2005
New York Schools Insurance Reciprocal	12/31/2003	7/13/2005
Charitable Annuity Societies		
Alfred University	12/31/2003	3/31/2005
American Associates, Ben-Gurion University of the Negev	12/31/2003	5/20/2005
American Parkinson Disease Association, *Inc*	12/31/2003	1/25/2005
American Society For Technion-Israel Institute of Technology, Inc.	12/31/2003	3/28/2005
Association of Graduates of the United States Military Academy	10/20/2004	3/15/2005
Barnard College	12/31/2003	11/02/2005
Catholic Near East Welfare Association	12/31/2003	9/19/2005
Children's Aid Society	12/31/2003	3/08/2005
Colgate University	12/31/2003	5/19/2005
College of New Rochelle	12/31/2003	7/06/2005
Columbia University	12/31/2003	5/19/2005
Covenant House	12/31/2003	4/29/2005
Diocese of Rochester	12/31/2003	4/26/2005
Episcopal Church Foundation	12/31/2001	2/02/2005
Fordham University	12/31/2003	4/19/2005
Foundation of the State University of New York at Binghamton, Inc.	12/31/2004	12/22/2005
Guiding Eyes For the Blind, Inc.	12/31/2003	11/28/2005
International House	12/31/2003	3/14/2005
Israel Humanitarian Foundation, Inc.	12/31/2003	9/30/2005
Jewish Guild For the Blind	12/31/2004	12/29/2005
Keuka College	12/31/2003	7/12/2005
Museum of Modern Art	12/31/2003	5/12/2005
New York University	12/31/2003	7/26/2005
RCA Foundation	12/31/2004	11/29/2005
Rescue Mission Alliance of Syracuse, N.Y.	12/31/2003	2/01/2005
Roberts Wesleyan College	12/31/2003	6/01/2005
Rochester Institute of Technology	12/31/2003	3/31/2005

Skidmore College	12/31/2003	4/27/2005
Sudan Interior Mission Inc.	12/31/2002	10/04/2005
Trustees of Hamilton College	12/31/2003	5/27/2005
United Jewish Appeal-Federation of Jewish Philanthropies of NY, Inc.	12/31/2003	5/11/2005
Vassar College	12/31/2004	8/11/2005
Word of Life Fellowship, Inc.	12/31/2003	3/07/2005
Health Maintenance Corporations		
Aetna Health Inc.	12/31/2002	1/13/2005
Empire HealthChoice HMO, Inc.	3/31/2003	8/25/2005
GHI HMO Select, Inc.	12/31/2003	12/16/2005
Horizon Healthcare of New York, Inc.	6/30/2002	9/21/2005
Retirement and Pension (Private)		
Church Pension Fund	3/31/2002	2/24/2005
Young Men's Christian Association Retirement Fund Inc.	6/30/2004	8/01/2005
Retirement and Pension (State)		
New York State Teachers' Retirement System	6/30/2001	4/05/2005
Viatical Settlement Company		
Neuma, Inc.	12/31/2003	2/02/2005
Municipal Cooperative Health Benefit Plans	6/30/2003	5/10/2005
Catskill Area Schools Employees Benefit Plan		
Welfare Trust Funds		
New York Fire Department Life Insurance Fund	6/30/2002	3/10/2005

5. Rehabilitation, Liquidation, Ancillary Receivership and Conservation Proceedings

The insurance entities under the Liquidation Bureau's jurisdiction during 2005 were as follows:

Rehabilitations

Commenced: None

Continued: Executive Life Insurance Company of New York
Frontier Insurance Company
Interboro Mutual Indemnity Insurance Company

Completed: None

Liquidations

Commenced: MagnaHealth of New York
Realm National Insurance Company

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
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
Transtate Insurance Company
Union Indemnity Insurance Company of New York
United Community Insurance Company
U. S. Capital Insurance Company
Whiting National Insurance Company

Closures: Northumberland General Insurance Company

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 New York Department (and the Superintendent as Ancillary Receiver) to trigger the New York Security Fund to pay Security Fund–covered claims.

Commenced: None

Continued: Acceleration National Insurance Company
American Druggists' Insurance Company
American Eagle Insurance Company
American Mutual Insurance Company of Boston
American Mutual Liability Insurance Company
Amwest Surety Insurance Company
Commercial Compensation Casualty Company
Credit General Insurance Company
Far West Insurance Company
Fremont Indemnity Company
Frontier Pacific Insurance Company
Integrity Insurance Company
Legion Insurance Company
LMI Insurance Company
Mission Insurance Company
Phico Insurance Company
Reliance Insurance Company
Security Indemnity Insurance Company
The Connecticut Surety Company
The Home Insurance Company
Transit Casualty Company
Villanova Insurance Company

Closure: MCA Insurance Company

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 Insurance Department must apply to the court in order for the Insurance Department (and the Superintendent as Conservator) 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

6. Insurance Department Receipts and Expenditures

Table 64
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2005

Taxes Collected Under the New York State Insurance Law:	
Taxes collected by reason of retaliation under Section 1112	$21,434,525.55
Excess Line - Section 2118	93,212,091.98
Organization Tax - Section 180, Tax Law	17,881.06
Subtotal	**$114,664,498.59**[1]
Fees Collected Under Section 1112 of the NYS Insurance Law:	
Filing Annual Statements and Certificates of Authority to Companies	$212,261.03
Agents' Certificates of Authority	709,607.60
Admission Fees	22,209.00
Subtotal	**$944,077.63**
Licensing and Accreditation Fees:	
Agents' Licenses - Section 2103	$2,541,828.50
Adjusters' Licenses - Section 2108	48,575.00
Brokers' Licenses - Section 2104 and 2105	5,394,675.00
Bail Bond Agents' Licenses - Section 6802	200.00
Insurance Consultants' Licenses - Section 2107	13,405.00
Reinsurance Intermediary Licenses - Section 2106	108,005.00
Special Risk Licenses - Section 6302	185,000.00
Accredited Reinsurers - Section 107(a)2	125,990.00
Limited License	2,035.00
Duplicate License Fees	18,685.00
Viatical Licenses	10,500.00
Continuing Education Provider Fee	74,300.00
Subtotal	**$8,523,198.50**
Assessments and Reimbursement of Department Expenses:	
Section 313 - Company Examinations	$8,061,405.53
Section 332 – Assessment	145,745,625.34
Section 9104/9105 - Tax Distribution	140,812.17
Administrative Expense Security Funds	72,102.00
Subtotal	**$154,019,945.04**

(table continues on next page)

Table 64
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2005
(continued)

Other Fees and Receipts:	
Section 9107 - Certification & Filing Fees	97,355.75
Section 9108 - Fire Insurance Fee	13,171,343.87
Section 1212 - Summons and Complaints	1,020,016.75
Fines and Penalties	5,478,650.74
FOIL Requests	22,742.08
Miscellaneous	1,708.63
Regulation 134	1,500.00
Motor Vehicle Law Enforcement Fee	71,707,037.33
Continuing Education Filing Fees	146,035.00
CAPCO Application Fees	7,000.00
Section 7902 – Service Contract Registration Fee	3,250.00
Subtotal	**$91,656,640.15**
Foreign Fire Tax, and Security Funds Receipts	
Foreign Fire Tax - Insurance Law Sections 2118, 9104 and 9105	$41,514,418.92
Property Casualty Insurance Security Fund - Sections 7602 and 7603	217,833,305.08
Public Motor Vehicle Liability Security Fund – Section 7601	15,049,484.80
Workers' Compensation Security Fund	59,397,747.74
Subtotal	**$333,794,956.54**
TOTAL DEPARTMENT RECEIPTS	**$703,603,316.45**

[1]This amount is in addition to the $ 1,007 million collected by the Department of Taxation and Finance under Article 33 of the Tax Law.

Table 65
INSURANCE TAX RECEIPTS[2]
(in millions)

Fiscal Year	Net
2000-01	584.0
2001-02	633.0
2002-03	696.0
2003-04	930.0
2004-05	1,007.0

[2]Collected by the Department of Taxation and Finance under Article 33 of the Tax Law.
Source: State of New York, Annual Budget Message, 2006-07

Table 66
DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2005
Paid in the First Instance from Appropriations

Personal Service	
Employee salaries	**$58,051,946.42**
Maintenance and Operation	
General office supplies	$584,136.98
Travel expense	2,019,658.16
Rental equipment	24,811.44
Repair and maintenance of equipment	271,673.95
Real estate rental	6,804,054.78
Postage and shipping	46,461.18
Printing	78,920.47
Telephone	1,272,891.22
Miscellaneous contractual services	6,060,423.17
OFT Computer	112,957.35
OGS Interagency courier	48,357.63
Equipment	1,951,108.57
Employee fringe benefits/indirect cost	26,658,451.78
Subtotal Maintenance and Operation	**$45,933,906.68**
Suballocations to Other State Agencies	
Personal Service, Maintenance and Operation	**$51,833,862.00**
TOTAL DEPARTMENT EXPENDITURES	**$155,819,715.10**

Table 67
RECEIPTS VS. DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2005

Total Department Receipts	$703,603,316.45
Total Department Expenditures	$155,819,715.10
Excess of Department Receipts Over Department Expenditures	**$547,783,601.35**

7. Security Funds Income and Disbursements

Table 68
PROPERTY/CASUALTY INSURANCE SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2005

Total of Fund as of 4/1/04[2]	**$93,837,756.82**
Paid into the Fund	$133,937,212.96
Interest income - net	1,689,859.55
Recoveries from companies in liquidation	80,704,786.57
General Fund Reimbursement	1,501,446.00
Total Receipts	**$ 217,833,305.08**
Less disbursements:	
Administrative expenses	$ 279,847.58
Awards and expenses of companies in liquidation	203,868,141.21
Total Disbursements	**$ 204,147,988.79**
Total Activity	**$ 13,685,316.29**
Total of Fund as of 3/31/05	**$107,523,073.11**

[1] Monies collected under Section 7603 of the Insurance Law.
[2] Valuation of beginning fund balance as of 4/1/04 is based on cash value. This is a change from prior year valuation which was based on par value.

Table 69
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2005

Total of Fund as of 4/1/04[2]	**$2,681,394.81**
Paid into the Fund	$ 9,788,039.14
Interest income - net	60,360.24
Recoveries from companies in liquidation	5,201,085.42
Total Receipts	**$ 15,049,484.80**
Less disbursements:	
Administrative expenses	$ 41,656.92
Awards and expenses of companies in liquidation	17,313,992.93
Total Disbursements	**$17,355,649.85**
Total Activity	**$(2,306,165.05)**
Total of Fund as of 3/31/05	**$375,229.76**

[1] Monies collected under Section 7604 of the Insurance Law from companies writing bonds and policies carrying coverages set forth in Section 370 of the Vehicle and Traffic Law.
[2] Valuation of beginning fund balance as of 4/1/04 is based on cash value. This is a change from prior year valuation which was based on par value.

Table 70
WORKERS' COMPENSATION SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2005

Total of Fund as of 4/1/04[2]	**$34,569,445.24**
Paid into the Fund	$ 18,758,272.19
Interest income - net	246,232.56
Recoveries from companies in liquidation	40,393,242.99
Total Receipts	**$ 59,397,747.74**
Less disbursements:	
Administrative expenses	$ 37,249.68
Awards and expenses of companies in liquidation	88,447,273.37
Total Disbursements	**$ 88,484,523.05**
Total Activity	**$ (29,086,775.31)**
Total of Fund as of 3/31/05	**$5,482,669.93**

[1] Monies collected under Sections 108 and 109 of the Workers' Compensation Law.
[2] Valuation of beginning fund balance as of 4/1/04 is based on cash value. This is a change from prior year valuation which was based on par value.

B. Table 71
DEPARTMENT STAFFING
NEW YORK STATE INSURANCE DEPARTMENT
Number of Filled Positions by Bureau (as of March 2006) ‡

Bureau	Examiners	Attorneys	Actuaries	Other Professionals	Investigators	Support Staff	Total
New York City Office:							
Executive				8		5	13
Life	99		10	3		8	120
Health	47		6	1		3	57
Administration*	1			8		8	17
Consumer Services	32			1		15	48
Frauds	3			3	19	6	31
OGC		26		4		7	37
Public Affairs/Research				2		2	4
Property	176		22			21	219
Systems	2			18		3	23
Capital Markets	1			6		2	9
Examiner Pool	34						34
Disaster Preparedness	7					1	8
NYC Total	**402**	**26**	**38**	**54**	**19**	**81**	**620**
Albany Office:							
Executive				6		2	8
Life		12	19			5	36
Health	4	18	5	1		4	32
Administration*				21		15	36
Consumer Services	38			2		15	55
Frauds					5		5
OGC		7		1		1	9
Property	10					1	11
Systems				32		7	39
Licensing	1			7		30	38
Disaster Preparedness				1	2		3
Albany Total	**53**	**37**	**24**	**71**	**7**	**80**	**272**
ALL OTHER							
Brooklyn Office:					5		5
Buffalo Office:							
Health		1					1
Consumer Services	2					1	3
Frauds					3		3
Mineola Office:							
Consumer Services	2					1	3
Frauds					7		7
Oneonta Office:					5		5
Rochester Office:					2		2
Syracuse Office:					3		3
All Other Total	**4**	**1**	**0**	**0**	**25**	**2**	**32**
Department Total	**459**	**64**	**62**	**125**	**51**	**163**	**924**

*Includes HRM & Offices Services

‡**Note**: Table does not include 19 Student Assistants assigned to various bureaus during the year

C. NEW YORK STATE INSURANCE DEPARTMENT

Publications
as of 5/15/2006

Consumer Guides, Annual Reports, Directories, etc.

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).