NEW YORK STATE
INSURANCE DEPARTMENT

151st ANNUAL REPORT
OF THE
SUPERINTENDENT

Calendar Year 2009

David A. Paterson
Governor

James J. Wrynn
Superintendent

www.ins.state.ny.us

The 151st Annual Report
of the
Superintendent of Insurance
to the
New York State Legislature

For the Year Ending
December 31, 2009

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Governor

James J. Wrynn
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New York State Insurance Department
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Data in this report are subject to small table to table variations. Such variations are attributed to the fact that data are retrieved at various times throughout the year.

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

David A. Paterson
Governor

James J. Wrynn
Superintendent

May 14, 2010

To the Legislature:

I am pleased to submit to the New York State Legislature the 151st Annual Report of the Superintendent of Insurance as required by Article 2, Section 206 of the Insurance Law.

The first Annual Report was issued in 1859 when New York's first Insurance Superintendent, William F. Barnes, was busy organizing the Department. The Insurance Department began operations as a separate agency effective January 1, 1860. As a result, 2010 marks the Department's 150th year of service. Today, the New York State Insurance Department is the oldest separate insurance regulatory agency in the United States.

The world and the business of insurance are very different and far more complex today than they were when the Department began operations. Yet, the Insurance Department's mission of protecting policyholders by encouraging the development of a sound, prudent insurance industry remains unchanged.

As the 40th Insurance Superintendent, I am privileged to represent a Department that has long prided itself as the nation's premier insurance regulatory agency. The Department is staffed by scores of dedicated and capable professionals committed to continuing this agency's leadership and its record of service to the people of the Empire State.

Respectfully submitted,

James J. Wrynn
Superintendent

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Overview

This year marks the 150th anniversary of the New York State Insurance Department. Established by an act of the Legislature that took effect January 1, 1860, the Insurance Department today is the oldest independent state insurance regulatory agency in the United States.

While the economy and the insurance industry are far more complex today than when the Insurance Department began operations, the Department's core mission – to protect policyholders from insolvent insurers – remains unchanged.

This report examines the Insurance Department's achievements in 2009. The Department focused its energies on issues affecting millions of New Yorkers. Those issues, in one way or another, reflected the challenges the agency has faced since its founding – policyholder protection, transparency and the role of government as a regulator.

40th Superintendent

Governor David A. Paterson nominated James J. Wrynn to serve as the Department's 40th Superintendent. The Senate confirmed the nomination on September 11, 2009. Wrynn succeeded Acting Superintendent Kermitt Brooks, who led the Department following the resignation of Superintendent Eric R. Dinallo in July. Brooks was the first African-American to lead the Department.

Wrynn joined the Department after serving as Executive Director of the New York State Insurance Fund. He brought to the Department a strong background in insurance, accounting and tax issues. He was a founding

James J. Wrynn
Superintendent

partner of MacKay, Wrynn & Brady LLP, where he has litigated cases focused on insurance issues and claims on behalf of major companies,

policyholders, municipalities and public authorities. From 1982 to 1992, he was a trial attorney specializing in civil trials and appellate practice related to professional malpractice, subrogation, property and casualty coverage disputes, liabilities and insurance. Admitted to the Federal and State Courts in both New York and New Jersey and to the United States Supreme Court, Wrynn graduated from St. John's University College of Business Administration and earned his law degree from St. John's University School of Law.

As Superintendent of Insurance, Wrynn assumed the leadership of an agency responsible for regulating more than 1,000 insurance companies with total assets exceeding $4 trillion, and overseeing the activities of thousands of brokers, agents and financial intermediaries.

Health Insurance Reform

During 2009, the one issue that dominated the insurance world was that of health care reform, and it was an issue that had significant impact for the people of New York State. Much of the debate over health care reform centered around two core issues – how to provide health insurance for people without it and how to provide stronger consumer protections to those people who already had coverage?

Governor Paterson introduced important initiatives and the Department worked to implement them. The initiatives promoted even stronger consumer protections for New Yorkers, who have long been afforded many safeguards that will only be provided many consumers elsewhere when federal reforms are fully implemented.

A cornerstone of the Governor's health insurance program was a proposal that would require insurance companies to get prior approval from the Department for rate hikes. In essence, prior approval would treat insurance companies in much the same way that the companies treat consumers, who must justify and get authorization from insurers before obtaining health care services.

Currently, the law permits insurers to impose premium increases without any type of prior public evaluation of whether not the increases are justified.

Under prior approval, the Department would have the authority to review and approve premiums *before* they are imposed on consumers. The authority would require the Department to balance a request for a premium increase against a company's overall financial health and its ability to pay claims.

The Department conceded that prior approval would not be the total solution for arresting double-digit premium increases. That could only be achieved by addressing other underlying issues, such as health care treatment costs. However, the Department promoted prior approval as an important step in the right direction to help restrain ever-escalating premiums faced by individuals and small businesses.
In early, 2010, a prior approval bill awaited final action by the Legislature.

The Department also helped implement new laws aimed at making health insurance more affordable and accessible for New Yorkers, as well as protecting the rights of individuals, such as the victims of mental illnesses. The new laws included measures:

- Extending to 36 months the time period for COBRA eligibility; permitting families to cover dependent children up to age 29 under job-based insurance policies; and a series of managed care reforms protecting the ability of insured consumers to access necessary health services.

- Establishing minimum treatment guidelines insurers must follow to provide coverage for the victims of biologically-based mental illnesses following a study that focused on the effectiveness of Timothy's Law.

Out-of-Network Transparency

The Department participated in a landmark reform to correct the system for determining reimbursements from insurers to consumers required to seek out-of-network health care. The reform was designed to allow patients to know beforehand the actual amount insurers would pay, enabling consumers to make informed decisions about where to seek care.

Under the out-of-network reform, the Department moved ahead with a regulation requiring that insurers use an independent source for determining

rates for health care, instead of using entities owned or affiliated with insurers. The regulation required insurers to make certain that rate schedules accurately reflected market rates and that insurers disclose the amounts of reimbursements to consumers within three business days of a request.

Targeting Misleading Sales

The Department acted to protect consumers from companies selling limited benefit health plans in ways that misled people into believing that the plans offered full health coverage. The Department stopped one insurer from selling its limited benefit plan in New York, fined the insurer $700,000, and forced the company to cancel nationwide television ads promoting the plan. In the wake of these actions, the Department held a series of public hearings examining limited benefit plans and how they should be addressed to protect consumers.

Life Settlement Regulation

The Department began the work of implementing the first ever regulation of life settlements in New York following the passage of legislation by the Legislature and its approval by the Governor. The new law established a comprehensive framework for regulating life settlements, transactions that occur when individuals sell their life insurance policies for more than the surrender value, but less than the death benefit.

Under the law, licensing requirements were prescribed for life settlement providers and brokers, as well as registration requirements for life settlement intermediaries. The law also established privacy protections and other safeguards for insured individuals and policyholders. The protections included safeguards against the unlawful release of information on the identity of an insured individual or policy owner without consent.

Transparency and Suitability

Does producer compensation based on incentives create an irreconcilable conflict-of-interest that harms consumers when they buy insurance policies?

That was one of the central questions asked during a series of public hearings leading to the development of a new producer compensation regulation that will become fully effective in 2011.

Aimed at creating greater marketplace transparency, the regulation was drafted after the hearings, held jointly by the Department and the Office of the Attorney General. The hearings explored key issues surrounding how insurance agents and brokers are paid.

Do insurance agents or brokers steer clients to buy less favorable insurers or insurance products when they earn incentive-based compensation? Is such steering an unfair trade practice? Should incentive-based commissions be permitted?

As the result of obtaining input from consumers, agents, brokers and insurers, the Department was able to fashion a regulation that will give consumers the ability to obtain more information so they can make informed decisions when buying insurance.

The regulation will require producers to inform consumers of their right to request information on compensation. If the consumer asks for more information, he or she must be provided a more detailed written disclosures, as well as information on alternatives presented by the producer and the compensation associated with those alternatives.

The increasing complexity of some insurance transactions also led the Department to consider the issue of suitability in the sale of insurance policies and annuity contracts.

After obtaining input from the public, industry and consumer groups in a series of public hearings, the Department is now considering whether rules should be put in place that would require insurers to evaluate the suitability of policies and contracts for particular consumers and whether they meet the needs of those consumers.

Reforming No-Fault

To help keep automobile insurance premiums from skyrocketing, Superintendent Wrynn proposed revised regulations governing no-fault auto insurance and urged the passage of legislation that would curtail no-fault fraud.

Citing long delays in resolving no-fault disputes, the Superintendent proposed regulations to help insurers obtain needed information so that legitimate claims could be settled faster. At the same time, the proposed regulations would allow insurers to deny health services not billed in compliance with applicable fee schedules to help fight fraud and instances of overbilling. The Superintendent urged the Legislature to approve legislation providing tools to better police improper activities by health providers and claimants

NAIC Accreditation

The Department achieved a significant milestone when it earned National Association of Insurance Commissioners' (NAIC) Financial Regulations Standards Accreditation. The accreditation confirms that the Department continues to meet financial solvency oversight standards.
The accreditation demonstrates the Department’s continuing commitment to state-based financial solvency regulation standards through the National Association of Insurance Commissioners (NAIC).

II. Review of New York State Insurance Business

A. LIFE BUREAU

1. Licensed Life Companies

There were 133 life insurance companies licensed to transact business in New York State as of December 31, 2009. The total admitted assets of licensed life insurers amounted to approximately $2.32 trillion at December 31, 2009 a ten-year gain of 52.2%. Bonds totaled $1,016.7 billion; stocks $64.4 billion; mortgage loans $195.1 billion; real estate $13.0 billion; policy loans $65.8 billion, and short-term holdings $38.9 billion. Other admitted assets totaled $921.9 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $896.1 billion on December 31, 2008, an increase of 63.1% since 1998. Insurance in force at December 31, 2008 of $6.31 trillion represents an increase of 84.0% since December 31, 1998.

3. Organizations Under Life Bureau Supervision

The Life Bureau supervised 530 organizations as of December 31, 2009. These organizations consisted of: 133 licensed life insurance companies — 81 domiciled in New York and 52 foreign; 38 fraternal benefit societies — 3 domiciled in New York, 34 foreign and 1 United States Branch of a Canadian Society; 12 retirement systems — 4 private pension funds and 8 governmental systems; 9 governmental variable supplements funds; 267 charitable annuity funds; 24 employee welfare funds; 8 viatical settlement companies and 39 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, 1998-2008 (dollar amounts in billions)

Admitted Assets	2008	2007	2003	1998
Total	$2,315.7	$2,539.9	$1,913.3	$1,521.2
Percent increase from 1998	52.2%	67.0%	25.8%	---
Type of asset				
Bonds	$1,016.7	$1,031.6	$881.3	$627.9
Stocks	64.4	83.7	52.6	53.2
Mortgage Loans	195.1	187.3	149.8	133.0
Real Estate	13.0	12.8	12.7	20.0
Policy loans/liens	65.8	62.5	55.4	56.4
Short-term holdings	38.9	16.6	23.1	27.4
Other	921.9	1,145.3	738.4	603.3

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

Table 2
BALANCE SHEET
Life Insurance Companies Licensed in New York State
Selected Years, 2003-2008
(in billions)

	2008	2007	2003
Assets	$2,315.7	$2,539.9	$1,913.3
Liabilities	2,182.7	2,401.8	1,805.8
Capital & Surplus	133.0	138.1	107.5

Table 3
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1998-2008
(dollar amounts in billions)

Class of Business	2008	2007	2003	1998
Total insurance in force	$13,638.1	$12,850.4	$10,529.7	$8,098.0
Percent increase from 1998	68.4%	58.7%	30.0%	---
Ordinary	$7,419.4	$6,950.8	$5,801.1	$4,358.9
Group	6,170.4	5,848.0	4,668.0	3,656.2
Credit	42.5	45.8	53.9	75.4
Industrial	5.8	5.9	6.6	7.4

Table 4
SOURCES OF INCOME*
Life Insurance Companies Licensed in New York State
Selected Years, 2003-2008
(dollar amounts in millions)

Source of Income	2008 Amount	2008 Percent of Total	2007 Amount	2007 Percent of Total	2003 Amount	2003 Percent of Total
Group life	$15,904.4	4.5%	$24,136.5	7.4%	$15,340.5	5.3%
Group annuities	76,228.0	21.4	78,067.4	23.8	64,053.1	22.1
Group A & H	31,205.3	8.8	28,561.8	8.7	22,500.8	7.7
Ordinary life	44,472.2	12.5	29,224.0	8.9	42,485.9	14.7
Individual annuities	69,889.7	19.6	58,157.2	17.7	53,032.4	18.3
Individual A & H	11,809.5	3.3	8,999.0	2.7	4,504.5	1.6
Credit life	237.2	0.1	251.6	0.1	263.7	0.1
Industrial life	38.0	0.0	-794.7	-0.2	169.7	0.1
Total Premiums	**$249,784.3**	**70.1%**	**$226,602.8**	**69.1%**	**$202,350.4**	**69.9%**
Supplementary contracts	419.5	0.1	423.8	0.1	360.2	0.1
Net investment income	84,185.7	23.6	85,477.9	26.1	72,603.7	25.0
Other income	21,984.5	6.2	15,481.6	4.7	14,631.9	5.0
TOTAL	**$356,374.0**	**100.0%**	**$327,986.1**	**100.0%**	**$289,946.2**	**100.0%**

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

Table 5
OPERATING RESULTS*
Life Insurance Companies Licensed in New York State
Selected Years, 2003-2008
(in millions)

	2008	2007	2003
Total premiums	$249,693.2	$242,637.0	$202,350.4
Investment income	84,185.7	85,477.9	72,603.0
Supplementary contracts	419.5	423.8	360.2
Other income	22,075.6	-552.6	14,631.9
Total income	$356,374.0	$327,986.1	$289,945.5
Net gain from operations	-$418,171.0	$16,364.9	$13,842.1
Net income	-$19,826.9	$16,341.9	$12,419.3

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

Table 6
LIFE INSURANCE IN FORCE IN THE STATE OF NEW YORK
Life Insurance Companies Licensed in New York State
Selected Years, 1998-2008
(dollar amounts in billions)

Insurance In Force	2008	2007	2003	1998
Total	$1,727.5	$1,690.7	$1,420.7	$1,033.3
Percent increase from 1998	67.2%	63.6%	37.5%	---
Class of business				
Ordinary	$1,185.6	$1,123.2	$887.6	$608.6
Group	535.4	560.4	525.1	417.2
Credit	5.9	6.6	7.2	6.6
Industrial	0.5	0.5	0.7	0.9

Table 7
ADMITTED ASSETS/INSURANCE IN FORCE
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1998-2008
(dollar amounts in billions)

Domestic Life Insurers	2008	2007	2003	1998
Admitted assets	$896.1	$946.6	$716.2	$549.3
Percent increase from 1998	63.1%	72.3%	30.4%	---
Insurance in force	$6,309.4	$5,658.0	$4,245.1	$3,429.7
Percent increase from 1998	84.0%	65.0%	23.8%	---

4. Licensed Fraternal Benefit Societies

At the close of 2008, 38 fraternal benefit societies were licensed to conduct insurance business in New York State. Of these, 3 were domestic, 34 were foreign and 1 was an alien society. In the ten-year period ending December 31, 2008, the admitted assets of licensed societies rose from $45.9 billion to $78.4 billion, an increase of 71%. Insurance in force rose $114.6 billion over the period to $323.7 billion, an increase of 55%.

Table 8
FRATERNAL BENEFIT SOCIETIES
Selected Years, 1998-2008
(in billions)

Fraternal Benefit Societies	2008	2007	2003	1998
Admitted assets	$78.4	$78.8	$69.1	$45.9
Insurance in force	$323.7	$317.0	$280.0	$209.1

5. Private Retirement Systems

At the close of 2008, four private retirement systems were under the supervision of the Life Bureau. These four systems, which are private pension funds of nonprofit organizations, had been made subject to Insurance Department regulation by special legislative enactments many years ago.

At the end of 2008, the assets of these private pension funds totaled approximately $153 billion. The following table shows data for the private pension funds for selected years from 1998 to 2008:

Table 9
PRIVATE PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1998-2008
(in millions)

Private Pension Funds	2008	2007	2003	1998
Fair value of assets [a]	$153,075	$225,977	$162,044	$147,552
Payments to annuitants and beneficiaries	$23,230	$22,778	$9,098	$8,027

[a] Prior to 2007, assets were Total Admitted Assets, when the annual statement was prepared on a statutory basis.

The decrease in asset value from 2007 to 2008 reflects the significant downturn in the equity markets in 2008.

6. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Life Bureau at the close of 2008 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 2008 were approximately $353 billion. During the period from 1998 to 2008, the assets of these retirement systems increased at the compound rate of 2.5% per year.

The governmental retirement systems cover a total of 2.1 million active and retired members. The number of active employees in the public retirement systems in 2008 increased by 18% from its 1998 level, while the number of pensioners increased by 26% over the same period. The substantial increase in pensioners, compared to a smaller increase in the work force, reinforces the need for maintaining adequate actuarial reserves.

The New York City Administrative Code provides for nine active non-pension funds known as variable supplements funds, financed by the transfer of earnings from the equity portfolios of the New York City Police and Fire Department Pension Funds and the Employees' Retirement System. If at any time the earnings so transferred are insufficient, the City guarantees the payment of the variable supplements benefits. These variable supplements funds provide retirement benefits in addition to those received from the pension funds and the retirement system. The variable supplements funds, all of which are under the supervision of the Insurance Department, had assets as of June 30, 2008 totaling $2.7 billion.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1998 to 2008:

Table 10
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1998-2008
(in millions)

Public Retirement Systems & Pension Funds	2008	2007	2003	1998
Fair value of assets[a]	$353,446	$372,490	$247,681	$275,155
Payments to annuitants and beneficiaries	$20,401	$19,412	$14,081	$9,623

[a] Prior to 2007, assets were Total Admitted Assets, when the annual statement was prepared on a statutory basis.

During 2009, a regular on-site examination of the New York City Employees' Retirement System was conducted.

7. Segregated Gift Annuity Funds for Charitable Organizations

At the end of 2008, 248 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, 2008, admitted assets of these funds increased by 160% and the annual payments increased by 214%. This reflects the rapid growth in the number of licensed societies during the period.

Table 11
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1998-2008
(in millions)

Segregated Gift Annuity Funds	2008	2007	2003	1998
Total admitted assets	$1,899.9	$2,167.1	$1,444.5	$730.7
Annual payments to annuitants	$192.3	$177.7	$132.2	$61.2

8. Employee Welfare Funds

Twenty-three employee welfare funds covering 112,100 employees were supervised by the Life Bureau at the close of 2008. 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 $298.8 million in 2008. Benefits paid totaled $275.7 million and included life insurance; medical, surgical and hospital coverage; major medical coverage; optical, dental and prescription drug plans; disability insurance, and legal services. Administrative expenses totaled $9.4 million representing 3.2% of contributions.

9. Viatical Settlement Companies

Regulation 148 and Article 78 of the Insurance Law became effective as of July 6, 1994 for the purpose of regulating viatical settlement companies and brokers. At the end of 2008, seven companies were licensed or authorized to act as viatical settlement companies in New York.

As of December 31, 2008, these companies had combined assets of $117.6 million. The assets primarily consisted of life insurance policies purchased, cash and accounts receivable. Costs of purchasing these policies amounted to $9.8 million, which comprised about 35.5% of the $27.6 million total face value.

10. Examinations Conducted in 2009

Table 12
EXAMINATIONS CONDUCTED
Life Bureau
2009

		Regularly Scheduled		Other	
		Initiated			
	Total	In 2009	Prior to 2009	Special	On Organ-ization*
Life insurance companies	41	17	21	0	3
Fraternal benefit societies	2	2	0	0	0
Retirement systems and pension funds	5	5	0	0	0
Segregated gift annuity funds of charitable organizations	34	34	0	0	0
Viatical settlement companies	2	2	0	0	0
Welfare funds	0	0	0	0	0
Total	**84**	**60**	**21**	**0**	**3**

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

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 2009, there were 530 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, 2009

Life – New York	81
Life – Other States	52
Accredited Reinsurers	39
Fraternals – New York	3
Fraternals – Other States	34
Fraternals – Canadian, U.S. Branch	1
Charitable Annuities	267
Retirement Systems	21
Viaticals	8
Welfare Funds	24
Total	530

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 2009 were updated to meet current needs and requirements. Copies of the Supplements are distributed through the Department's Web site to all life companies and fraternal benefit societies licensed to do business in New York State.

12. Actuarial Unit

a. Agent Compensation

During 2009 the Life Bureau processed 129 agent compensation submissions pursuant to Section 4228 of the Insurance Law, 21 fewer than in 2008. Most such submissions are related to the marketing of new products, so the decrease in submissions in 2009 may be reflective of the general economic downturn. The Bureau continues to allow submissions under Section 4228 to be mailed in on paper or to be filed electronically via a dedicated mailbox. An approximately equal number of submissions are received by each of the two methods.

Section 4228 of the New York Insurance law is a unique New York statute. It regulates sales and acquisition expenses, and remains an important tool both in protecting insurers' solvency and in helping to control the cost of life insurance.

b. Separate Accounts

The Life Bureau processed 451 submissions relating to separate account plans of operation during 2009, 27 more than in the previous year. Most related to changes in fund lineups and secondary guarantees, both of which have been volatile recently. The Life Bureau views modifications of the funds available in a separate account to be a change in the investment policy of the separate account. As such, updated lists of the available fund options must be filed pursuant to Section 4240(e) of the Insurance Law. The Life Bureau has found this filing requirement to be an effective tool to ensure changes in fund options are appropriate to the stated investment policy chosen by the contractholder and do not result in unfair costs to the contractholder.

The review can also identify in advance new types of products that may require discussion with the filing company.

"Living benefit" riders, a form of secondary guarantee on variable annuity performance, have become increasingly important in recent years. These riders must be included in Plans of Operation to any separate accounts housing the variable annuities offering these riders. The review of these Plans of Operation serve as an important tool in the early detection and monitoring of new rider forms that may pose a risk to the financial health of the issuing insurer or the individual policyholder.

c. On-Site Examinations

Members of the Life Bureau's Actuarial Unit in New York City participate in and provide actuarial support for on-site examinations scheduled by the Field Examinations Unit. During 2009 the actuarial staff participated in on-site examinations of four life insurance companies, including one extremely large company, and provided technical support for Life Bureau examiners on other examinations. The actuarial field unit worked with consultants and examiners to help implement the risk-based examination approach.

d. Miscellaneous Functions

Members of the Life Bureau's Actuarial Unit in New York City review capitalization and actuarial projections related to company mergers and acquisitions, new company formations and significant changes in company plans of business operation, as well as certain methods of allocation of investment income among company lines of business. The most complex transactions often involve the financial evaluation of reinsurance treaties and/or proposed transfer of assets, and may require detailed actuarial review in close coordination with examiner, legal and investment resources of the Department.

The Actuarial Unit also responds to inquiries and complaints from the public of a technical actuarial nature.

e. Demutualized Life Insurance Companies; Closed Blocks

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

The Life Bureau proactively monitors the closed blocks of domestic insurers as part of the regular field examination process and through special, annual closed block reports. This helps assure members of closed blocks are realizing the protections they were promised.

13. Policy Forms and Product Filings

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

In 2009, the Life Bureau received 1,893 policy form submissions (files) consisting of 7,054 life insurance, annuity, funding agreement and other policy forms offered by life insurance companies, fraternal benefit societies, charitable annuity societies and viatical settlement companies as indicated in Table 14 below. Of the 7,054 policy forms received in 2009, 60.1% were submitted under a certified filing procedure (Circular Letter No. 6 (2004) or §3201(b)(6) of the Insurance Law), .9% were submitted for out-of-state use by domestic insurers and 39% were submitted for full review and approval.

In 2009, the Life Bureau processed a total of 1,968 policy form submissions (files) consisting of 7,521 policy forms as indicated in Table 14. Of the 7,521 forms processed in 2009, approximately 38.8% were submitted for prior approval, 60.3% were submitted under a certified filing procedure and .9% were filed for out-of-state use. Of the prior approval files disposed in 2009, approximately 73.2% of the forms were

approved or filed and 23.6% were either rejected or withdrawn. Of the certified files disposed in 2009, approximately 71.1% of the forms were approved or filed and 28.8% were either rejected or withdrawn. Of the out-of-state files disposed in 2009, approximately 97.2% of the forms were filed and no forms were rejected or withdrawn.

Table 14
NUMBER OF FILES & POLICY FORMS
RECEIVED AND PROCESSED BY TYPE
LIFE BUREAU, 2009

PRODUCT TYPE	RECEIVED		PROCESSED	
	Files	**Forms**	**Files**	**Forms**
Individual Life	621	2,116	649	2,255
Group Life	180	1,065	189	1,156
Individual Annuity	679	2,204	700	2,325
Group Annuity	317	974	328	1,039
Credit Insurance	22	91	26	125
Viatical Settlement	1	5	3	16
Miscellaneous	73	599	73	605
TOTAL	1,893	7,054	1,968	7,521

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 688 other filings related to the policy form approval process and products offered for sale in New York, including 41 rate and actuarial filings, 242 inquiries and complaints, 52 FOIL requests, 15 prefilings under Circular Letter No. 64-1, 93 compensation filings and 50 annual illustration certification filings.

Table 15
POLICY FORM-RELATED FILINGS RECEIVED IN 2009

Fraternal Benefit Societies (Constitution, Articles of Incorp., Bylaws, etc.)	10
Calculation of Life Estates	3
Circular Letter No. 64-1	15
Compensation Filings	93
FOIL Requests	52
Inquiries & Complaints	242
Rate & Actuarial Filings	41
Violations & Market Conduct	123
Informational Filing	59
Regulation 74 Illustration Certification Filings	50
Total	**688**

c. Speed to Market

During 2009, 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 2009, the Life Bureau finalized the Group Term Life Insurance product outline. The updated outline was posted on the Department's website on January 27, 2010. Other outlines currently on the website have been assigned to Life Bureau staff and updates are under way. Also in 2009, the Life Bureau posted or updated speed to market filing guidance on the Department's website relative to:

- Filings made to comply with Supplement No. 1 to Circular Letter 27 (2008)
- Filings made under the Circular Letter No. 6 (2004) process
- Guaranteed Paid-up Deferred Annuities
- Certifications and notifications pursuant to subsection 53-3.7 of Regulation 74
- SERFF Submissions to the Life Bureau

During the year, the Life Bureau processed 4,460 Circular Letter No. 6 (2004) policy forms in an average of eight days. Of the total 4,460 Circular Letter No. 6 (2004) policy forms, approximately 3,176 were approved, 1,179 were rejected and 105 were withdrawn.

In 2009, it came to the Department's attention that certain innovative group annuity and funding agreement policy forms had been submitted under the Circular Letter No. 6 (2004) process. Because the issuance of such forms may be prejudicial to the interests of the insurer's policyholders in general, the Department determined that the Circular Letter No. 6 (2004) certification process may not be appropriate for (1) guaranteed separate account products utilizing one or more non-pooled separate accounts, or (2) unallocated group annuity or funding agreement products with an initial deposit in excess of fifty million dollars. On August 12, 2009, the Life Bureau posted Life Insurance Product Guidance on Circular Letter No. 6 (2004) to address these submissions. The guidance provides that such submissions may not be filed under the Circular Letter No. 6 (2004) process without the Department's permission. The guidance further provides that guaranteed separate account products utilizing one or more non-pooled separate accounts must be submitted on a one-case basis so that the actual policy terms and identity of the contract or funding agreement holder are specified in the forms. Because the Circular Letter No. 6 (2004) process is not available for such filings, they are given priority when submitted for prior approval under §3201(b)(1) or (6).

Also, for some plans of life insurance the minimum nonforfeiture values cannot be determined by the usual methods specified in Insurance Law §4221. In these instances, the policy forms can not be approved unless, pursuant to §4221, the Superintendent makes a determination that nonforfeiture values are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by §4221 and that the benefits and the pattern of premiums of the plan are not such as to mislead prospective policyholders or insureds. Since the Superintendent must make these determinations in order for the policy forms to be approved, the Circular Letter No. 6 (2004) process is not appropriate for such submissions. Accordingly, the Product Guidance on Circular Letter No. 6 (2004) provides that such filings may not be made using the Circular Letter No. 6 (2004) procedure without the Department's permission. Because the Circular Letter No. 6 (2004) process is not available for such filings, they are given priority when submitted for prior approval under §3201(b)(1) or (6).

As noted above, the Life Bureau has continued to process policy forms submitted under the certified process in §3201(b)(6) of the Insurance Law. However, due to the industry's preference for the Circular Letter No. 6 (2004) certified process and its shorter timeframe, the number of forms processed under §3201(b)(6) has steadily declined from the high of 478 in 2001. The Life Bureau processed only six files in 2009 submitted under the §3201(b)(6) process.

d. Post-Approval Review

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

Circular Letter No. 6 (2004) replaced an earlier certified filing procedure established by Circular Letter 27 (2000). As of December 31, 2009, 5,742 files consisting of 21,269 policy forms have been approved under the certified filing procedures, with 4,805 files and 17,642 policy forms under Circular Letter 6 (2004) and 937 files and 3,627 policy forms under Circular Letter 27(2000).

In 2009, the Life Bureau continued the screening process to prioritize for post approval review certified files submitted from 2000 through 2009. The screening process continues going forward as the Life Bureau receives new certified submissions. The highest priority is assigned to files with new, innovative or controversial features or files that raise solvency, consumer protection or market competition concerns. This screening process will help to make the Life Bureau more aware of the products currently being offered in the marketplace. As of December 31, 2009, 4,449 of the 5,742 certified files had been screened and assigned a priority rating.

Post approval review of certified approved files is significantly more complicated and time-consuming than the review of traditional prior approval files. As of December 31, 2009, approximately 464 of the 5,742 certified files had been assigned for post approval review. Of those 464 post approval review files, approximately 241 had been completed and closed. Post approval review often has four phases. First, since the policy forms have already been issued to consumers, it may be necessary to develop endorsements to bring all in-force issues of policy forms into compliance with applicable requirements. Bringing in-force forms into compliance with New York law can be particularly challenging for new and innovative products for which approval standards have not been developed. Second, depending on the nature of the violation, remediation may be required for policy and certificate holders with non-complying policy forms. Third, a new policy form submission may be necessary to replace the non-complying policy forms if the company wishes to remain in the market. Finally, if circumstances warrant, the Department may decide to pursue disciplinary action against the company or the officer completing the certification.

e. SERFF

In addition to the traditional paper filings, the Life Bureau accepts electronic form filings for all types of individual and group life and annuity products, as well as compensation filings, through the NAIC-sponsored System for Electronic Rate and Form Filing (SERFF). The Department's Website provides detailed filing guidelines for SERFF submissions to assist insurers in making such filings with the Department. The Life Bureau updated those guidelines in 2009.

During 2009, SERFF was the dominant method for sending life and annuity policy form submissions to the Life Bureau. In 2009, life insurers submitted 1,595 files, consisting of 5,497 policy forms through SERFF. These totals represent approximately 90.6% of all policy form filings and 89.3% of all policy forms submitted by life insurers in 2009.

SERFF has also become the main delivery method for insurers to file their group life compensation filings with the Department with approximately 90% of the 93 filings being sent through SERFF. SERFF is also used extensively to file the annual illustration certifications.

14. Legislative and Regulatory Summary

a. Life Settlements

In 2009 legislation was enacted to replace and expand the existing Article 78 to authorize the Department to regulate the life settlement industry and to establish standards governing the industry. The original version of Article 78 of the Insurance Law, entitled Viatical Settlements, was enacted in 1993 and authorized the Insurance Department to regulate the viatical settlement industry only.

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

The new Article 78 was enacted as Chapter 499 of the Laws of 2009. It was signed by the Governor on November 19, 2009. Certain sections of the law pertaining to privacy, disclosures and stranger-originated life insurance (STOLI) became effective immediately. On May 18, 2010, the law will become fully effective and the Viatical Settlements law will be repealed. The new statute governs all life insurance policy settlements regardless of whether the insured has a terminal or chronic illness. Under the new statute, the definition of "life settlement contract" includes all such settlements.

The new statute includes licensing and registration requirements for life settlement providers, brokers and intermediaries. Life settlement contracts, applications and other forms will have to be filed with and approved by the Department. Certain minimum contract provisions are required. Life settlement advertising will be regulated. The law mandates that certain disclosures be made to individuals contemplating a life settlement transaction. For example, the law requires disclosures advising the consumer of: (l) the life settlement broker's fiduciary duty to the owner of the policy; (2) certain tax consequences that may result from receipt of the life settlement proceeds; (3) the owner's right to rescind the life settlement contract; (4) the possible adverse impact on the insured's insurable capacity; (5) the fact that medical, financial or personal information of the insured or the policyowner may be disclosed; and (6) the fact that the insured may be contacted with a specified frequency to determine health status, as well as other disclosures. In order to implement the new legislation, the Department is currently drafting regulations and other guidance documents. The Department anticipates participation by the industry and the public.

b. Section 4223 – Bonus Recapture

Effective on October 5, 2008, Insurance Law §4223 was amended by Section 1 of Chapter 170 of the Laws of 2008. Due to certain amendments, insurers cannot recapture bonus interest rates or credits from death benefit proceeds provided under any annuity contract that is subject to the non-forfeiture provisions of §4223. Specifically, the amended language of §4223(c)(1) states in relevant part: "For contracts that provide a cash surrender benefit prior to the commencement of annuity payments, the death benefit attributable to any account, other than an equity index account, shall not be less than the actual accumulation amount, as defined in paragraph two of this subsection, and the death benefit attributable to an equity index account shall not be less than the value of the equity index account, as defined in paragraph four of this subsection."

Previously, the Department had permitted the recapture of bonus interest credits from a death benefit if the death occurred within the 12 months immediately following the crediting of the bonus. The bonus recapture is no longer permissible due to the amendments to §4223. This prohibition on the recapture of any bonus interest or credits applies to both fixed annuities and to the fixed portion of any combined fixed and variable annuity contract. Inasmuch as §4223 applies only to fixed deferred annuities, the change does not apply to variable annuity contracts. The Department is currently drafting a Circular Letter and updating product outlines to address this issue.

c. Guaranteed Living Benefits – Update

The Department has been pursuing strong reserve, minimum capital and corporate governance requirements for these products at the NAIC, in addition to performing in depth examinations of insurers' reserves, capital, and risk management practices with respect to these products. During 2009, a revised reserving regulation has been adopted in order to achieve greater consistency with the recently adopted NAIC model (VACARVM). This NAIC model relies on a combination of a company's own models and assumptions and a "standard scenario" where reserves are required to cover a subsequent stock market drop. Given the volatile nature of the risks associated with these products, a high comfort level is needed with respect to each particular company's risk management practices.

15. Product Innovations

a. Contingent Annuities

Beginning in 2006, the Life Bureau received inquiries and/or product submissions from eight life insurers regarding a new type of product that has been referred to as a mutual fund wrap contract and as a contingent annuity in New York. The product was called a mutual fund wrap because the contract wrapped a guaranteed living benefit similar to the guaranteed minimum withdrawal benefit ("GMWB") in variable annuity contracts around retail mutual funds or brokerage accounts of another financial institution owned by an investor. The contract was called a contingent annuity because the periodic income payments under the contract were contingent upon the account balance falling to zero or a specified level and the account holder or measuring life being alive at such time.

On June 25, 2009, the Office of General Counsel (OGC) issued an opinion which concluded that the contingent annuity contracts are not permissible under the New York Insurance Law because it constitutes an impermissible form of financial guaranty insurance. The opinion noted that under New York law, financial guaranty insurance may only be written by an insurer licensed for that specific purpose (i.e., a monoline company). As such, no life insurer can conduct this business in New York. The OGC opinion noted that *financial guaranty insurance was a risky proposition that should not be written along with most other kinds of insurance* because it could bankrupt a multi-line insurer. As a result of the OGC opinion, no life insurer may conduct this business in New York and a domestic life insurer is prohibited from issuing a contingent annuity outside New York by Section 1102(b) of the Insurance Law. In addition, a foreign or alien life insurer is prohibited from issuing a contingent annuity outside New York by Section 1106(f) of the Insurance Law, unless in the judgment of the Superintendent the doing of such kind or combination of kinds of insurance business will not be prejudicial to the best interests of the people of this state.

Subsequent to the OGC opinion, the Life Bureau disapproved the contingent annuity contracts submitted for approval and advised the submitting insurers of the Department's position. The Department has met an industry group concerning statutory and regulatory changes needed to permit such products in New York. At a minimum, Article 69 would need to be revised for such products to fall outside the definition of financial guaranty insurance. In addition, additional changes would be necessary to recognize the products as annuities or substantially similar thereto and to address the significant risk concerns inherent in extending the guaranteed minimum withdrawal type benefits to mutual fund and brokerage accounts of other financial institutions.

b. Guaranteed Paid-Up Deferred Annuities (Longevity Insurance)

Insurance Law §4223(a) requires annuity contracts subject to §4223 to contain in substance the provisions of §4223 or corresponding provisions that in the opinion of the Superintendent are at least as favorable to the contract holder. In addition, for any annuity contract subject to §4223, §44.6(a) of Regulation 127 requires the annuity contract to have cash surrender values available, unless the contract meets one of the listed exemptions. Pursuant to §44.6(a)(6) of Regulation 127, the Superintendent may approve annuity contracts subject to §4223 without cash surrender benefits upon a demonstration that cash surrender benefits

are not appropriate. Guaranteed paid-up deferred annuities typically require approval under the authority granted to the Superintendent in §4223(a) and §44.6(a)(6) of Regulation 127. In 2009, the Life Bureau posted guidance on its website discussing the Superintendent's exercise of discretion relative to guaranteed paid-up deferred annuities. Because the approval of these products requires an exercise of discretion by the Superintendent based on the particular product being submitted, the Circular Letter 6 (2004) process can not be used for such submissions.

c. Endowment Life Insurance

The Life Bureau approved several endowment life policies in late 2008 and 2009. These products pay a lump sum after a specified term and typically do not qualify as life insurance under the Internal Revenue Code as they accumulate cash values. The Life Bureau requires disclosure of the potential annual tax liability to the policyowner as well as the insurer's mechanism for withholding taxes on behalf of the insured.

d. Credit Insurance: Automobile Sales Promotion Program

At the end of 2009, the Life Bureau approved an innovative noncontributory credit insurance program for an insurer that was being advertised and offered in New York by Hyundai Motor America and Walkaway USA, LLC, in an effort to boost slumping automobile sales. The Life Bureau exercised the broad discretion of the Superintendent in approving the product as one at least as favorable as required by statute and regulation based in large part on the offering of the insurance product at no charge to the car buyer. The product, which is being marketed in New York as the Hyundai Assurance Program, includes a 90-day payment relief benefit, whereby a lump sum will be paid to the lender in the event of qualifying physical disability or involuntary unemployment, and a 12-month vehicle return program, whereby an individual could return his or her vehicle and walk away with no negative credit rating impact in the event of qualifying physical disability, involuntary unemployment, loss of driver's license due to medical impairment, accidental death, or involuntary personal unemployment. (Note: The involuntary personal unemployment benefit is an innovative product benefit triggered by a personal bankruptcy filing after the car buyer suffers a total loss of salary or wages from the closing of the business he or she ran as a sole proprietor.)

e. SEC Rule 12h-7 and Restrictions on Assignments

On the same day that the SEC issued Rule 151A regarding equity indexed annuity contracts, the SEC issued Release No. 34-59221 adopting Rule 12h-7 [17 CFR 240.12h-7]. Rule 12h-7 which became effective on May 1, 2009 exempts insurance companies from filing reports under the Securities Exchange Act of 1934 with respect to indexed annuities and other securities (insurance products) that are registered under the Securities Act, provided that certain conditions are satisfied. Condition (e) requires that the issuer takes steps reasonably designed to ensure that a trading market for such securities does not develop, including, except to the extent prohibited by the law of any State or by action of the insurance commissioner, requiring written notice to, and acceptance by, the issuer prior to any assignment or other transfer of the securities and reserving the right to refuse assignments or other transfers at any time on a non-discriminatory basis.

The Life Bureau received seven policy form submissions requesting approval of endorsement forms that place certain restrictions on assignments and transfers of ownership. The submissions indicated that the restrictions were necessary to comply with Rule 12h-7 of the Securities and Exchange Act of 1934. However, as noted above, Rule 12h-7(e) provides an exception to the extent that such restrictions are prohibited by the law of any State or by action of the insurance commissioner. It has been the Department's long-standing position that life insurance policies and annuity contracts must be freely assignable except when necessary to maintain tax qualification. The restrictions required by Rule 12h-7 conflict with this position. Based on the state law exception set forth in part (e), the Life Bureau determined that restrictions on assignments are not required for compliance with Rule 12h-7 and the forms were disapproved.

The issue of restrictions on assignments has recently arisen in the context of guaranteed living benefits in variable annuity contracts. The management committee and full commission of the Interstate Insurance Product Regulation Commission recently voted in favor of a uniform set of standards for guaranteed living and

death benefits attached to deferred annuities that would permit insurers to terminate the benefits upon change in ownership. The Life Bureau is aware of the potential for a secondary market for living and death benefits. However, we are not certain that such potential justifies a restriction on assignment or the diminution of a basic contractual or property right.

f. Guaranteed Minimum Withdrawal Benefit and Excess Withdrawals

Variable annuities providing guaranteed living benefits are sometimes referred to as VAGLBs. One common type of VAGLB is the guaranteed minimum withdrawal benefit, or GMWB. A GMWB provides for the continuation of guaranteed withdrawal amounts regardless of the amount of contract value remaining. If the contract holder takes a withdrawal in excess of the guaranteed withdrawal amount, a permanent reduction in the future guaranteed withdrawal amount will result. The reduction is typically made on a proportional basis where the reduction is equal to the guaranteed withdrawal amount times the ratio of the amount of the excess withdrawal to the account balance (after the reduction for the withdrawal benefit but prior to the excess withdrawal).

The Department recognizes that insurers need to limit their exposure to possible anti-selection for annuity contracts with GMWBs and that proportional reductions are a common way of limiting this exposure. However, the concern with this type of provision is that the reduction in the guaranteed withdrawal amount can be significantly disproportionate to the amount of the excess withdrawal or amount received for a full surrender. The Life Bureau is currently analyzing this concern to determine whether additional disclosure is needed to protect consumers.

16. Trade Practices

a. Sale of Unapproved Annuity Contracts by Unlicensed Companies

In 2009, the Life Bureau continued its investigation into the sale of unapproved equity indexed annuities and modified guaranteed annuities in New York. The Life Bureau is in the process of reviewing the issued contracts and the account values maintained under those issued contracts. The investigation has revealed that the issued annuities were not in compliance with New York law and would need significant modification to bring them into compliance. The unapproved contracts maintained account values that are far below the minimum values required under New York law, impose surrender charges far higher than permitted and require contract owners to wait longer before obtaining payments. In some instances, death benefits may have been improperly subject to surrender charges. The Life Bureau will require the companies to develop endorsements to bring the unapproved contracts into compliance with New York law. The Life Bureau has been working with representatives of the companies to recalculate account values to bring them up to the minimum values required by New York Law.

b. Smoker vs. Non-smoker Rates

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

The Life Bureau is drafting an amendment to regulation 113 to explicitly prohibit the use of a smoker designation unless the underwriting process determined the applicant was a user of tobacco products. Where mortality tables are constrained by law, the amendment would prohibit the use of smoker tables for lives not underwritten as smokers unless such tables were more favorable than non-smoker or aggregate tables.

c. Discretionary Clauses

In 2009, the Life Bureau continued to address inquiries relative to the use of discretionary clauses in group life insurance policy forms. A discretionary clause is a provision in an insurance contract that grants an insurer, plan administrator or claims administrator the discretionary authority to determine eligibility for benefits, resolve disputes, interpret the terms and provisions of the insurance contract or develop standards of interpretation or review. As a result of a 1989 Supreme Court decision, *Firestone Tire and Rubber Co. v. Bruch*, in actions involving the denial of benefits under an ERISA benefit plan, a court will review the decision to deny benefits under the highly deferential arbitrary and capricious standard of review if the benefit plan (which in many cases is the insurance contract) contains a discretionary clause. The wording of a typical discretionary clause fails to warn plan participants that their right to a de novo review of their claim by the court has been eliminated.

As with Circular Letter No. 14 (2006) which raised concerns relative to discretionary clauses in life and accident and health insurance contracts, during 2008 the Life Bureau staff worked with Health Bureau staff to draft a proposed regulation prohibiting the use of discretionary clauses in life and accident and health insurance contracts. The National Association of Insurance Commissioners (NAIC) has adopted a model act on discretionary clauses and other states have taken similar action. Several recent U.S. District Court decisions have held that state regulations prohibiting the use of discretionary clauses in insurance products in employee benefit plans were not preempted by the federal Employee Retirement Income Security Act (ERISA). The cases where the state regulations have been upheld have generally involved outright prohibitions on discretionary language that substantially affect the risk pooling agreement between the insurer and the insured enough to qualify as a law regulating insurance.

During 2009, the matter of prohibiting discretionary clauses has been discussed during several Interstate Insurance Product Regulation Commission group term life insurance policy and certificate standards subgroup conference calls. While the matter continues to be the subject of debate, there has been some resistance from the industry to including an outright prohibition on discretionary clauses similar to the state regulations that have been upheld by the federal courts. Under the current draft, consumers would not have the same level of protection as has been provided by most states that have addressed the issue, including New York.

d. Supplement No. 1 to Circular Letter No. 27 (2008)

On December 9, 2009 the Life Bureau issued Supplement No. 1 to Circular Letter No. 27 (2008) ("Supplement No. 1") to address issues raised in inquiries by the industry concerning the application of Circular Letter No. 27 (2008) ("CL-27") to annuity contracts that must comply with federal tax law in order to receive favored federal tax treatment. CL-27 provides that licensees under the New York Insurance Law must comply with decision in *Martinez v. Monroe Community College,* 50 A.D.3d 189, (4th Dep't), 10 N.Y.3d 856 (2008) by extending the same rights and benefits to same-sex spouses in marriages legally performed in jurisdictions outside New York as are afforded to opposite-sex spouses. The inquirers asked about the impact of CL-27 on the mandatory distribution rules set forth in federal Internal Revenue Code ("IRC") §§72(s) and 401(a)(9), which contain beneficial options available only to a surviving spouse of a deceased annuity holder.

Section 3 of the federal Defense of Marriage Act ("DOMA"), 1 U.S.C. §7, enacted in 1996, defines "marriage," for federal purposes, as "a legal union between one man and one woman as husband and wife" and defines "spouse," for federal purposes, as "a person of the opposite sex who is a husband or a wife." Consequently, DOMA precludes recognition of marriages between same-sex partners under the IRC, which means that a same-sex spouse cannot delay distributions that are required under IRC §72(s) or §401(a)(9). Unless or until Section 3 of DOMA is struck or repealed, for purposes of this federal benefit a same-sex spouse must follow the same distribution rules that apply to any natural person who is not the spouse of the deceased annuity holder.

Because a surviving same-sex spouse is currently subject to the same distribution requirements of IRC §§72(s) and 401(a)(9) as apply to a non-spouse, annuity contracts may be misleading unless the consumer is provided with disclosure that explains such consequences. The Life Bureau worked with industry

representatives and interested parties to develop disclosure. The industry will begin providing the disclosure to consumers on or before May 1, 2010. The supplement also advises companies to review their policy forms to determine if revisions are needed so that a same-sex spouse will not be defaulted to the spousal continuation option. The Life Bureau has instituted an expedited approval process for any form filings made solely to comply with Supplement No. 1. The Life Bureau has also posted filing guidance to assist the industry with making such submissions.

17. Other Initiatives

a. Market Conduct Review of Non-Guaranteed Elements

Interrogatories on non-guaranteed elements in Exhibit 5 of the 2008 Annual Statements were reviewed for 169 life insurers. Twelve of the reviews resulted in contacting the company for additional information on the board criteria required by law for setting non-guaranteed elements and examples of illustrations and communications with respect to non-guaranteed elements.

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

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

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

In 2009, the Life Bureau continued to be heavily represented in the activities of the NAIC, particularly in creating a framework for a new principles-based approach to reserve and capital standards. The current law specifies a standard of a principles-based asset adequacy analysis reserve with a formulaic floor. The Life Bureau has reservations about potentially weakening solvency requirements under a principles based approach in light of the dramatic changes being experienced in the financial industry due to the economic crisis.

The Life Bureau believes there is a need for corporate governance for risk management" requirements that foster written risk management policies with tolerance limits on risk exposures, align the operations with risk management policies and impose a meaningful and measurable self discipline process. The Department chaired the effort at the NAIC to develop Corporate Governance requirements for principle based reserves in the Valuation Manual.

c. Statutory Examinations

The Reserve and Risk Management Actuaries in the Life Bureau continue to focus on high-level asset/liability matching and in-depth analysis of scenario-based cash-flow testing and other principles-based methods.

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

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

During 2009, particular emphasis was given to companies' use of hedging instruments, management of liquidity risk, counterparty risk, pandemic risk and the analysis of reinsurance treaties to ensure proper reserve credit and risk transfer to the reinsurer.

These efforts materially improved the Life Bureau's risk-focused examination approach during 2009 and proved quite effective at identifying companies who may be particularly susceptible to volatility in the current economic crisis. Going forward, the Bureau will continue efforts to further improve its focus on the timely identification of risks faced by the insurance industry and working toward the effective resolution of any material concerns that may arise.

B. PROPERTY BUREAU

1. Entities Supervised by the Financial Regulation Division

As of December 31, 2009, the Financial Regulation Division side of the Property Bureau exercised regulatory authority over 1,172 insurer entities and risk retention groups.

The Bureau regulated 1,066 insurer entities as of year-end 2009. Table 16 provides a breakdown.

Table 16
ENTITIES REGULATED BY PROPERTY BUREAU
2009

Number of Regulated Entities	Type of insurer/reinsurer/entity
92	Accredited reinsurers*
18	Advance premium co-operatives
24	Assessment co-operatives
11	Associations, pools, and syndicates
47	Captive insurers
17	Financial guaranty insurers
28	Mortgage guaranty insurers
1	Property Insurance Underwriting Association (FAIR Plan)
789	Property/casualty insurers
29	Title insurers (including one accredited reinsurer)
10	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, 2009, the Department recognized 75 Lloyd's syndicates as active accredited reinsurers.

In addition, the Bureau oversaw the operation of 106 risk retention groups in 2009.

The Property Bureau received 26 applications for licensing and 1 application for recognition as accredited reinsurer during 2009. Seventeen insurers were newly licensed including 3 domestic property casualty insurers, 2 domestic financial guaranty insurers, 10 foreign property casualty companies, 1 foreign mortgage guaranty company and 1 foreign US Branch. In addition, there were 2 foreign insurers approved for accredited reinsurer status. At the close of the year there were domestic applications pending for 7 property casualty companies. There were also 25 foreign property casualty insurers and 2 foreign mortgage guaranty insurers which had license applications pending with the Department.

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 2008 by all New York-licensed property and casualty insurers aggregated totaled $313.6 billion, of which 78% represented stock company writings. As noted previously, the following underwriting and investment results deal with the nationwide business of New York licensed companies:

Table 17
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Property and Casualty Insurers Licensed in New York State
2003-2008
(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
2003	706	$221,356	$203,973	1.1	72	$66,070	$66,315	1.0
2004	698	234,377	213,611	1.1	73	67,294	86,319	0.8
2005	713	226,808	253,849	0.9	71	68,113	93,736	0.7
2006	727	247,812	287,598	0.9	69	69,948	109,473	0.6
2007	731	247,563	318,287	0.8	72	69,930	120,006	0.6
2008	739	244,995	288,680	0.8	71	68,654	105,503	0.7

b. Underwriting Results

Results for 2008 show a net underwriting gain of $3.3 billion for stock companies and a net underwriting loss of -$3.6 billion for mutual companies.

Table 18
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State
2005-2008
(dollar amounts in millions)

Year		Stock Companies		Mutual Companies	
		Number of Companies	Amount	Number of Companies	Amount
2005	Underwriting gains	326	$10,548.4	46	$1,820.2
	Underwriting losses	295	16,672.2	25	3,430.9
	No gain or loss	92	0.0	0	0.0
2006	Underwriting gains	408	$22,161.4	47	$4,831.5
	Underwriting losses	223	4,086.5	22	1,014.8
	No gain or loss	96	0.0	0	0.0
2007	Underwriting gains	421	$19,454.4	45	$2,203.1
	Underwriting losses	217	4,456.3	27	658.4
	No gain or loss	93	0.0	0	0.0
2008	Underwriting gains	367	$11,826.3	28	$394.9
	Underwriting losses	268	8,547.9	43	3,949.8
	No gain or loss	104	0.0	0	0.0

Detail may not add to totals due to rounding.

c. Investment Income and Capital Gains

Investment income and net capital gains for stock and mutual companies from 2005 to 2008 are as follows:

Table 19
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
2005-2008
(in millions)

Year		Stock Companies	Mutual Companies
2005	Net investment income	$29,263.4	$5,903.2
	Realized capital gains	3,005.0	455.6
	Unrealized capital gains	1,473.3	3,902.9
	Net gain/loss from investments	$33,741.7	$10,261.7
2006	Net investment income	$33,298.3	$6,498.4
	Realized capital gains	351.0	412.0
	Unrealized capital gains	14,412.8	9,486.6
	Net gain from investments	$48,062.1	$16,397.0
2007	Net investment income	$36,533.8	$6,786.8
	Realized capital gains	3,716.8	1,342.1
	Unrealized capital gains	4,490.5	4,144.5
	Net gain from investments	$44,741.1	$12,273.4
2008	Net investment income	$34,694.6	$6,258.9
	Realized capital gains	-9,897.4	-824.0
	Unrealized capital gains	-23,576.8	-14,732.4
	Net gain from investments	$1,220.4	-$9,297.5

d. Underwriting and Investment Exhibit

During 2008, dividends to stockholders amounted to $25.3 billion, while dividends to policyholders aggregated to $1.6 billion (for both mutual and stock insurers). The contribution to surplus for 2008 for stock companies was $7.7 billion compared with $1.6 billion for 2007. The net decrease in surplus for stock companies in 2008 was -$20.1 billion compared with an increase of $19.7 billion for 2007. Likewise, the net change in surplus for mutual companies was -$12.2 billion in 2008, down from $12.5 billion a year earlier. Net income decreased for both stock and mutual companies between 2007 and 2008.

Table 20
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Property and Casualty Insurers Licensed in New York State
2007 and 2008
(in millions)

	Stock Companies		Mutual Companies	
	2008	**2007**	**2008**	**2007**
Net gain or loss from:				
Underwriting	$3,278.4	$14,998.0	-$3,554.9	$1,544.7
Investments [a]	24,797.2	40,250.7	5,434.9	8,128.9
Other income	-113.0	212.1	410.6	478.9
Net gain or loss	$27,962.6	$55,460.7	$2,290.7	$10,152.6
Less:				
Dividends to policyholders	611.6	706.2	967.2	1,001.2
Federal income taxes incurred	7,266.8	12,764.2	-201.3	1,090.6
Net income	**$20,084.2**	**$41,990.3**	**$1,524.8**	**$8,060.8**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-$25,294.7	-$27,745.1	$0.0	$0.0
• Stock	-15.6	-23.3	0.0	0.0
US Branches – Net remittance to/from home office	9.0	-6.0	0.0	0.0
Total dividends and remittance	-$25,301.3	-$27,774.3	$0.0	$0.0
Unrealized capital gains/losses	-23,576.8	4,490.5	-14,732.4	4,144.5
Cumulative effect of changes in accounting principles	44.9	0.4	-11.6	9.8
Miscellaneous items	958.9	-562.1	996.9	254.6
Contributions to surplus	7,677.3	1,572.1	3.1	2.3
Total other sources	-$40,197.1	-$22,273.4	-$13,744.0	$4,411.2
Net increase or decrease in surplus	**-$20,112.9**	**$19,716.9**	**-$12,217.2**	**$12,474.0**

[a] Excludes unrealized capital gains.

e. Selected Annual Statement Data

From 2005 to 2008 aggregate (i.e., stock and mutual) net premiums written increased by 6.4%; admitted assets increased by 13.0%; unearned premium and loss reserves increased by 5.6%; and other liabilities increased by 67.8%. Capital and surplus to policyholders increased by 13.3%.

Table 21
SELECTED ANNUAL STATEMENT DATA
Property and Casualty Insurers Licensed In New York State
2005-2008
(dollar amounts in millions)

	2008	2007	2006	2005
		Stock Companies		
Number of insurers	739	731	727	713
Net premiums written	$244,995	$247,563	$247,812	$226,808
Admitted assets	851,704	880,157	747,095	739,827
Unearned premium & loss reserves	467,399	464,519	451,527	441,511
Other liabilities	95,625	100,489	44,267	41,925
Capital	3,889	3,879	3,723	3,912
Surplus to policyholders	288,680	318,287	287,598	253,849
		Mutual Companies		
Number of insurers	71	72	69	71
Net premiums written	$68,654	$69,930	$69,948	$68,113
Admitted assets	218,571	236,563	223,144	207,656
Unearned premium & loss reserves	89,399	87,507	84,715	85,708
Other liabilities	22,043	29,050	28,957	28,212
Surplus to policyholders	105,503	120,006	109,473	93,736

f. Direct Premiums Written, by Line

There was a decrease in property/casualty writings in New York State in 2008 as direct premiums written for all property/casualty lines decreased by -1.3%. Major lines, i.e., those with greater than $1 billion premium written in 2008, with at or above average year-to-year increases in 2008 included financial guaranty.

Table 22
DIRECT PREMIUMS WRITTEN BY PROPERTY/CASUALTY INSURERS
New York State — 2004-2008[1]
(dollar amounts in millions)

Property and Casualty Lines	2004	2005	2006	2007	2008	Percentage Change 2004-2008	Percentage Change 2007-2008
All Premiums Written	$30,733	$32,371	$33,674	$34,332	$33,894	10%	-1.3%
Private Passenger Auto	10,684	10,262	9,994	9,794	9,789	-8%	-0.1%
Bodily Injury and Property Damage Liability	7,304	6,968	6,705	6,452	6,409	-12%	-0.7%
Comprehensive and Collision	3,380	3,294	3,289	3,343	3,380	0%	1.1%
Commercial Auto	2,191	2,080	2,045	1,975	1,921	-12%	-2.7%
General (Other) Liability	4,018	3,997	4,387	4,306	4,488	12%	4.2%
Commercial Multi-Peril	2,897	2,958	3,074	3,072	3,058	6%	-0.4%
Workers' Compensation	1,928	3,758	4,133	4,228	3,501	82%	-17.2%
Homeowners' Multi-Peril	3,174	3,427	3,615	3,908	4,079	28%	4.4%
Medical Malpractice	1,067	1,128	1,267	1,394	1,346	26%	-3.5%
Inland Marine	734	707	841	912	951	30%	4.2%
Ocean Marine	583	551	598	522	513	-12%	-1.7%
Fidelity and Surety	427	433	459	534	540	27%	1.2%
Accident and Health	383	372	329	302	252	-34%	-16.5%
Fire	432	455	490	503	521	21%	3.6%
Product Liability	158	179	175	190	126	-20%	-33.3%
Financial Guaranty[2]	1,105	1,090	1,164	1,439	1,843	67%	28%
Mortgage Guaranty	217	215	207	246	229	5%	-7.2%
Allied Lines	289	278	334	307	330	14%	7.5%
Aircraft	71	96	114	205	-49	-169%	-123.9%
Boiler and Machinery	85	78	80	70	70	-17%	0.3%
Credit	42	48	62	131	117	181%	10.8%
Burglary and Theft	14	14	27	16	19	40%	18.2%
All Other[3]	233	244	280	277	251	7%	-9.6%

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 2008 Annual Statements of the companies authorized to transact business in the State of New York were filed for audit and analysis in 2009, 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. These 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 2009, the State Insurance Fund acquired stocks and bonds totaling $55.7 billion and sold stocks and bonds totaling $44.4 billion. Upon review, the Property Bureau recommended the approval of the acquisitions of $55.7 billion and the sales of $44.4 billion. In 2008, the Bureau recommended approval of acquisitions totaling $24.2 billion and sales totaling $13.0 billion.

i. CPA-Audited Financial Statements

NYIL Section 307(b) requires licensed insurers to file an annual financial statement, certified by an independent certified public accountant (CPA), on or before May 31 of each year. CPA-audited financial statements were received for 1029 companies in 2009. There were 10 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 2009, 135 FOIL requests to review and copy records maintained by the Financial Division were received from members of the public.

k. Holding Company-Related Transactions

Pursuant to Article 15 of the New York Insurance Law and Department Regulation 52, the Property Bureau is responsible for the review and approval of transactions within holding company systems. During 2009, 395 holding company transaction files, and 145 holding company registration statements and amendments, were received by the Property Bureau. In addition, 20 notices of acquisition of control of domestic insurers were received 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, 2008, there were 13 domestic and 5 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, 2005-2008
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2005	2,979.8	13,046.5	0.23
2006	3,027.5	13,570.3	0.22
2007	2,982.1	12,322.8	0.24
2008	3,168.2	4,561.6	0.69

Table 24
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State, 2005-2008
(dollar amounts in millions)

Year		Number of Companies	Amount
2005	Underwriting gains	8	$1,404.6
	Underwriting losses	6	$60.5
2006	Underwriting gains	8	$1,366.5
	Underwriting losses	5	$62.0
2007	Underwriting gains	7	$908.6
	Underwriting losses	6	$2,327.3
2008	Underwriting gains	1	$2.1
	Underwriting losses	13	$11,1887

Table 25
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State, 2005-2008
(in millions)

	2008	2007	2006	2005
Net investment income	$1,680.9	$1,598.7	$1,669.5	$1,477.6
Realized capital gains	-4,722.5	-705.2	24.0	35.7
Unrealized capital gains	-1,149.6	-43.8	151.8	102.2
Net gain from investments	-$4,191.2	$849.7	$1,845.3	$1,615.5

Table 26
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Financial Guaranty Insurers Licensed in New York State
2005-2008
(in millions)

	2008	2007	2006	2005
Net gain or loss from:				
Underwriting	-$11,186.6	-$1,418.7	$1,304.6	$1,344.1
Investments [a]	-3041.6	893.5	1,693.5	1,513.3
Other Income	-181.3	-47.7	16.7	22.7
Net gain or loss	-14,409.6	-$572.9	$3,014.8	$2,880.1
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	-1666.7	376.3	785.6	706.1
Net income	**-$12,742.8**	**-$949.2**	**$2,229.2**	**$2,174.0**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-437.6	-777.1	-1,221.5	-656.8
• Stock	-13.1	-1.5	0.0	0.0
Total dividends and remittance	-$450.7	-$778.6	-$1,221.5	-$656.8
Unrealized capital gains	-1149.6	-43.8	151.8	102.2
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	-302.0	190.4	-410.3	-726.2
Contributions to surplus	6,936.9	333.7	-13.5	620.7
Total other sources	$5,034.7	-$298.3	-$1,493.4	-$660.1
Net increase or decrease in surplus	**-$7,708.2**	**-$1,247.5**	**$735.7**	**$1,513.9**

[a] Excludes unrealized capital gains.

Table 27
SELECTED ANNUAL STATEMENT DATA
Financial Guaranty Insurers Licensed In New York State
2005-2008
(dollar amounts in millions)

	2008	2007	2006	2005
Number of Companies	18	15	15	14
Exposure	$2,980,072.8	$3,293,226.9	$2,958,463.0	$2,680,961.8
Net premiums written	3,168.2	2,982.1	3,027.5	2,979.8
Admitted assets	44,379.0	38,650.5	35,663.8	33,916.0
Unearned premium & loss reserves	24,459.1	15,355.1	11,874.6	11,517.4
Other liabilities	15,358.3	10,972.6	10,218.9	9,352.1
Capital	1,068.1	249.2	246.7	266.7
Surplus to policyholders	4,561.6	12,322.8	13,570.3	13,046.5

4. Mortgage Guaranty Insurance

At year-end 2008, there were 2 domestic and 26 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
2005-2008
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2005	3,815.4	4,134.2	0.92
2006	3,890.7	4,010.2	0.97
2007	4,605.0	3,594.6	1.28
2008	4,661.7	5,073.6	0.92

Table 29
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Mortgage Guaranty Insurers Licensed in New York State
2005-2008
(in millions)

	2008	2007	2006	2005
Net gain or loss from:				
Underwriting	-$5,162.4	-$1,319.6	$1,189.3	$1,003.6
Investments [a]	1,016.1	1,295.8	1,053.3	913.4
Other Income	5.6	13.9	13.4	3.9
Net gain or loss	-$4,140.7	-$9.8	$2,256.1	$1,920.9
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	-117.5	98.4	485.9	326.2
Net income	**-$4,023.2**	**-$108.3**	**$1,770.1**	**$1,594.8**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-213.4	-1,563.8	-1,518.0	-1,273.4
• Stock	0.0	0.0	0.0	0.0
Total dividends	-$213.4	-$1,563.8	-$1,518.0	-$1,273.4
Unrealized capital gains	-1,044.7	-666.2	223.4	219.7
Cumulative effect of changes in accounting principles	107.1	0.0	0.0	0.0
Miscellaneous items	4,357.7	1,780.7	-510.5	-996.8
Contributions to surplus	2,079.9	142.0	-94.9	64.9
Total other sources	5,286.7	-307.3	-1,900.0	-1,985.6
Net increase or decrease in surplus	**$1,263.5**	**-$415.5**	**-$129.9**	**-$390.8**

[a] Excludes unrealized capital gains.

TABLE 30
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
2005-2008
(dollar amounts in millions)

	2008	2007	2006	2005
Number of companies	28	27	27	26
Net premiums written	$4,661.7	$4,605.0	$3,890.7	$3,815.4
Admitted Assets	26,359.5	24,170.6	23,509.8	22,663.5
Unearned premium & loss reserves	15,570.9	10,605.5	7,871.4	7,566.4
Other liabilities	5,715.0	9,970.6	11,628.2	10,963.0
Capital	71.8	70.5	70.5	68.5
Surplus	5,073.6	3,594.6	4,010.2	4,134.2

5. Title Insurance

9 domestic and 20 foreign companies were licensed to write title insurance in New York State at the close of 2008.

Table 31
SELECTED ANNUAL STATEMENT DATA
Title Insurance Companies
2005-2008
(dollar amounts in millions)

	2008	2007	2006	2005
Number of Companies	29	30	30	26
Net premiums written	$6,661.4	$8,742.3	$11,007.0	$9,142.5
Admitted assets	5,690.0	6,489.8	6,848.0	5,480.1
Liabilities	4,020.8	4,515.5	4,499.8	3,843.0
Capital	109.4	111.0	118.8	98.8
Surplus	1,669.2	1,974.3	2,348.3	1,637.1

6. Advance Premium Co-operative and Assessment Corporations

At year-end 2008, there were 19 advance premium corporations under the supervision of the Property Bureau. The total number of advance premium corporations remained unchanged from 2007 to 2008. The net premium volume of the advance premium corporations decreased by 1.4% from the prior year.

A total of 24 assessment corporations were under the Property Bureau's supervision at year-end 2008. The total number of assessment corporations remained unchanged from 2007 to 2008. The net premium volume of these 24 companies increased by 1.8% from the prior year.

During 2008, the Property Bureau initiated 8 examinations of the advance premium and assessment corporations.

Table 32
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Corporations
2005-2008
(dollar amounts in millions)

Year		Total	Advance Premium Corporations	Assessment Corporations
2005	Number of companies	44	19	25
	Total assets	$2,070.7	$1,775.6	$295.1
	Net premiums written	931.3	817.2	114.1
	Surplus funds	809.0	650.7	158.3
2006	Number of companies	44	19	25
	Total assets	$2,197.5	$1,880.3	$317.2
	Net premiums written	910.7	791.9	118.8
	Surplus funds	917.9	739.7	178.2
2007	Number of companies	43	19	24
	Total assets	$2,317.0	$2,005.9	$311.1
	Net premiums written	918.1	804.8	113.3
	Surplus funds	1,010.6	831.1	179.5
2008	Number of companies	43	19	24
	Total assets	$2,344.0	$2,029.6	$314.4
	Net premiums written	908.9	793.6	115.3
	Surplus funds	1,030.9	851.9	179.0

7. Special Risk Insurers (Free Trade Zone)

Calendar Year 2008 was the 30th full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 211 licensed companies as of December 31, 2008, which includes new and renewals. Net premiums written during the year amounted to approximately $2.24 billion, bringing the net premiums written since inception to approximately $13.64 billion. Direct and Net premiums written since 2004 are as follows:

Table 33
DIRECT AND NET PREMIUMS WRITTEN
Special Risk (Free Trade Zone)
2004-2008
(dollar amounts in millions)

Year	Direct Premiums Written	Net Premiums Written
2004	1,323.1	1,071.7
2005	1,193.7	1,022.6
2006	1,510.3	1,286.2
2007	1,579.6	1,401.5
2008	2,462.0	2,243.6

8. Risk Retention Groups

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

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

As of December 31, 2008, 110 risk retention groups had registered with the Department to do business in New York under the provisions of the federal legislation.

In calendar year 2008, risk retention groups filing financial statements with this Department reported total nationwide direct premiums written of $1.77 billion and total nationwide net premiums written of $753.1 million. These risk retention groups reported direct premiums written of $345.4 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 2009 a total of 150 such examinations were conducted.

Table 34
EXAMINATIONS CONDUCTED
by the Financial Regulation Division of the Property Bureau
2009

	Regularly Scheduled			Other Financial Exams		
	Total	Started in 2009	Started Prior to 2009	Special	On Organi-zation[1]	Increase in capital[2] and other
Property and casualty insurers, including financial guaranty insurers	123	32	88	0	3	0
Other insurers, captives and service contractors	19	14	5	0	0	0
Title and mortgage guaranty insurers	8	1	7	0	0	0
Total	**150**	**47**	**100** [3]	**0**	**3**	**0**

[1] Examination conducted when insurer is first incorporated in New York State.
[2] Examination when insurer increases its capital.
[3] This total includes 54 reports with completed field work that were not filed as of 2/4/10.

b. Risk-Focused Examinations

During 2009, as part of the Department's Accreditation process, four completed examinations were reviewed to determine adherence to the NAIC Accreditation guidelines.

Effective January 1, 2010, the application of the Risk-Focused Examination approach, as contained in the current Financial Condition Examiners Handbook, will be mandated as an accreditation standard for conducting examinations. In 2006, the Property Bureau conducted its first pilot examination using this new approach. During 2009, this approach was used for almost every examination, with the exception of companies in run-off or very small companies.

10. Lloyd's of London

Underwriters at Lloyd's (Lloyd's of London) consist of underwriting syndicates at Lloyd's that meet the requirement for recognition as accredited reinsurers in New York. As of December 31, 2009, 75 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. Certified Capital Companies

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

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

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

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

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

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

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

As of December 31, 2008 the CAPCOs invested approximately $299 million in 173 qualified businesses: Program One CAPCOs invested 83.59% of their total $100 million certified capital; Program Two CAPCOs invested 83.20% of their $30 million total; Program Three CAPCOs invested 78.11% of their $150 million certified capital; Program Four CAPCOs invested 66.65% of their $60 million and Program Five CAPCOs invested 54.94% of their $60 million.

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

Eighty-nine qualified businesses had less than $1 million, 60 businesses had between $1 million and $5 million and 24 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 31.7%, 34.0% and 34.2%,

respectively, of the total invested. CAPCOs have invested approximately 34.9% of the invested funds in "early-stage" businesses, 13.6% in emerging technology and 3.1% in "start-up" businesses.

In the five programs combined, 83% of the numbers of businesses and 75% of the dollars invested in qualified businesses were headquartered in New York County (Manhattan), Long Island, Mid-Hudson and the Capital District. The remaining 17% of the businesses and 25% of the dollars invested were in other regions of New York State. Forty percent of all funds invested by year-end 2008 in qualified businesses were in New York County and 23.2% were made in Empire Zones and 23% were made in "underserved areas" defined as areas outside of New York County and outside of Empire Zones.

With CAPCO and other venture entity investments in these qualified businesses since inception of the CAPCO Program in 1997, the overall the total number of employees in New York in the businesses for which December 31, 2008 information was provided increased by 530 positions. The change of the number of employees in any one business ranged from a decrease of 103 to an increase of 206.

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.

12. Service Contract Providers

The Bureau reviews the financial responsibility requirements of applicants seeking registration pursuant to Article 79 of the Insurance Law to write service contracts in New York. In addition, the Bureau reviews, annually, the filed audited financial statements for those service contract providers that seek to meet the statutory financial responsibility requirements through either a New York Funded Reserve Account ("NYFRA") and a Financial Security Deposit or a stockholders' equity in excess of $100 million. Further, during the year 2009, the Bureau reviewed the biennial renewal applications for all registered service contract providers to determine whether or not the applicants continue to satisfy all financial responsibility requirements of Section 7903 of the Insurance Law. In 2009, in conjunction with the review of the financial responsibility requirements, and pursuant to Circular Letter 19 (2009), the Bureau has begun the statutory and regulatory compliance reviews of Service Contract Reimbursement Insurance ("SCRI") policies issued by insurers in New York. As of December 31, 2009, there were 134 registered service contract providers, of which 83 providers were utilizing SCRI policies. The remaining 51 service contract providers were required to file audited financial statements with the Property Bureau-Financial Division, with 23 utilizing the NYFRA and a Financial Security Deposit and 28 utilizing stockholders' equity in excess of $100 million.

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

a. Number of Filings

During 2009, the Market Regulation Division of the Property Bureau received 6,897 filings involving changes in rates, rating rules, policy forms, rate classifications and rating territories submitted by rate service organizations, joint underwriting associations and insurers. The filings were submitted for the following lines of business:

Table 35
NUMBER OF FILINGS RECEIVED BY TYPE*
Market Regulation Division of the Property Bureau
2009

Line of Business	Rates	Rules	Policy Forms	Totals
Property	104	216	240	560
Crop	1	1	2	4
Flood	3	3	1	7
Personal Farmowners	3	4	8	15
Homeowners	115	108	197	420
CMP Liability and Non-Liability	204	282	251	737
CMP Non-Liability Portion Only	28	37	49	114
CMP Liability Portion Only	37	46	39	122
Mortgage Guaranty	16	10	9	35
Ocean Marine	0	0	1	1
Inland Marine	80	90	194	364
Financial Guaranty	0	0	4	4
Med Mal-Claims Made and Occurrence	32	18	33	83
Med Mal-Occurrence Only	16	6	9	31
Med Mal-Claims Made Only	7	3	4	14
Workers Compensation	143	130	103	376
Other Liability-Occ/Claims Made	206	356	449	1,011
Other Liability-Occ Only	97	162	230	489
Other Liability-Claims Made Only	41	63	129	233
Product Liability	1	1	4	6
Personal Auto	431	413	176	1,020
Private Passenger Auto	0	1	0	1
Commercial Auto	181	197	174	552
Mobile Homes under Transport	0	0	0	0
Aircraft	5	5	22	32
Fidelity	19	17	30	66
Fidelity and Surety	5	7	3	15
Surety	41	23	8	72
Burglary and Theft	55	61	57	173
Boiler and Machinery or Equipment Breakdown	12	18	13	43
Credit-Credit Default	3	3	10	16
Credit-Personal Property	7	8	13	28
Homeowner/Auto Combinations	0	0	0	0
Dwelling Property/Personal Liability	5	6	7	18

Line of Business	Rates	Rules	Policy Forms	Totals
Dwelling Fire/Personal Liability	0	0	1	1
Other Lines of Business	22	38	32	92
Title	2	2	2	6
Interline Filings	11	29	96	136
Total	**1933**	**2364**	**2600**	**6897**

* These figures include approximately 28 consent-to-rate filing applications (pursuant to Section 2309 of the Insurance Law); 15 group property & casualty filings; and 5 rating plans submitted in 2009. During 2009, 207 policy form filings and 175 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 303 STM and 4,602 SERFF form and rate filings in 2009, which are included above.

b. Advisory Rate/Loss Cost Changes

The following table lists major revisions in rates or loss costs filed by rate service organizations that were approved or acknowledged during 2009. Loss costs apply to the voluntary market and are advisory, *i.e.*, they do not have to be adopted by an insurer. They reflect the experience of all companies that report to the rate service organization. Loss costs are used by insurers for most lines of business as a basis for determining their individual company rates.

Table 36
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2009 by Property and Casualty
Rate Service Organizations

	Percent Changes in Average State-Wide Rates
Automobile	
Insurance Services Office, Inc.	
Commercial Automobile	
Loss Costs Revised	
Commercial Cars	
Single Limit Liability	-20.2
Personal Injury Protection	+10.3
Liability Subtotal	-19.1
Comprehensive	+7.5
Collision	-6.8
Physical Damage Subtotal	-4.3
Total Commercial Cars	-17.4
Garages	
Single Limit Liability	-16.7
Personal Injury Protection	-16.4
Liability Subtotal	-16.7
Physical Damage - Garage Dealers	
Comprehensive	-16.0
Collision	-8.2
Physical Damage - Garage Keepers	
Comprehensive	-14.0
Collision	-14.6
Physical Damage - Garage Dealers and Keepers Subtotal-	-13.7
Total Garages	-15.5
Private Passenger Types	
Single Limit Liability	-19.5
Personal Injury Protection	-3.3
Liability Subtotal	-18.4
Comprehensive	-7.0
Collision	-4.6
Physical Damage Subtotal	-5.0
Total Private Passenger Types	-15.5

Table 36 (continued)
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2009 by Property and Casualty
Rate Service Organizations

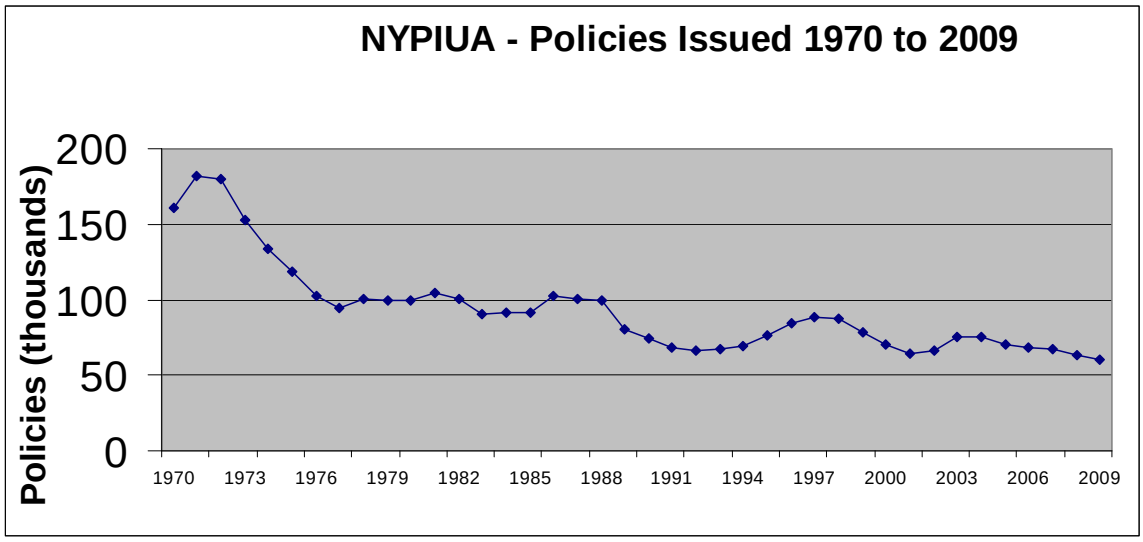
	Percent Changes in Average State-Wide Rates
Total All Coverages	-16.9
Total Liability	-18.9
Total Physical Damage	-5.5
effective September 1, 2009	
Automobile Insurance Plans Service Office	
Private Passenger Automobile	
Rates Revised	
Bodily Injury Liability	-10.0
Property Damage Liability	+19.9
Personal Injury Protection	+20.0
Uninsured Motorists	-10.2
Liability Subtotal	+8.7
Comprehensive	-10.1
Collision	+10.0
Physical Damage Subtotal	+3.9
Total All Coverages	+8.4
Effective April 1, 2010	
Liability Other Than Automobile	
Insurance Services Office, Inc.	
Commercial General Liability Loss Costs	-3.4
(effective July 1, 2010)	
American Association of Insurance Services	
Agricultural General Liability Program	
Initial Loss Costs	N/A
(effective January 2010)	

14. 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 2009:

(Chart A)



Following the peak year of 1971 (182,000 policies), there was a steady decline through 1977 in the number of policies issued annually by the Association. The period 1977 through 1982 saw relative stability, with the number of policies ranging between 94,000 and 105,000. The sharp decline experienced from 1982 to 1983 can be attributed to soft market conditions, while 1986 showed a sharp increase in policies issued as the voluntary insurance market hardened. Another soft insurance market accounted for the large decrease in the number of policies issued by the Association from 1989 through 1992 as many NYPIUA policies were written in the voluntary market. The number of NYPIUA policies issued began to increase gradually from 1993 through 1997 reflecting, in part, the ongoing concern for adequate coastal property insurance coverage. In 1998, 1999, 2000, and 2001, the number of NYPIUA policies issued had declined, while in 2002, 2003, and 2004, the number increased. The number of policies issued began to decrease steadily each year since 2005. And in 2009, the number of policies written dropped to 59,976, which is a decrease of 3,342 policies from the number of policies written in 2008.

b. Financial Information

For the fiscal year ending December 31, 2009, the Association's Financial Report indicated premiums earned of $28,966,166 and a net underwriting gain of $2,804,146. Other income of $4,679,787, comprised of net investment income of $5,330,184; premium balances charged off $11,974; bond amortization loss of $92,131; loss on sale of securities of $566,893; grant program of $119,039 and policy installment fees of $139,640, resulted in net income before taxes of $7,483,933. The change in assets not admitted of $92,272, additional minimum pension liability of $1,411,470 and taxes incurred of $284,972 resulted in a net change in the Members' Equity Account of $5,879,763. The cumulative operating profit as of December 31, 2009 was $180,030,436. After all assessments (net of cumulative distributions of $91,008,265), the net Members' Equity Account totaled $89,022,171.

In accordance with Section 5405(c) of the New York Insurance Law, the Association estimated a surplus from operations of $193,388 for the Calendar Year 2010. 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, 2010, since its assets exceed its liabilities.

c. Rate Revisions

During 2009, the Department approved rate revisions for the Dwelling Property program. These revisions resulted in an average statewide decrease of 6.5%. These revisions correspond with loss costs revisions promulgated by the Insurance Service Office for the voluntary market.

15. Medical Malpractice Insurance

a. Establishment of Rates and Premium Surcharges

Chapter 58 of the Laws of 2008 extended for three 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, 2011.

Notwithstanding the above, Chapter 497 of the Laws of 2008 and Chapter 216 of the Laws of 2009 mandated that the Superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2008 and ending June 30, 2010.

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 2009 to 2010 policy year, it was determined that no change was needed to these factors.

c. Physicians Excess Medical Malpractice Insurance for '09 –'10

Chapter 58 of the Laws of 2008 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, 2008 through June 30, 2011.

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

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

As indicated in last year's report, Chapter 147 of the Laws of 2000 had extended the period allowed for effectuating the orderly dissolution of MMIA by continuing MMIA until June 30, 2001, while providing that the dissolution would be implemented at such time and under such conditions as the Superintendent deemed proper. Consequently, a Supplemental Order and Decision was issued on July 12, 2000 under which the Superintendent continued the MMIA solely for the purpose of winding up its affairs, with no new or renewal policies to be issued after June 30, 2000. By December 31, 2000 the Medical Liability Mutual Insurance Company (MLMIC) had received full payment for its assumption of MMIA's liabilities and, by order of the Supreme Court of the State of New York entered May 14, 2001, MMIA was placed into liquidation, with the Superintendent of Insurance named as the liquidator. The final order was entered into on April 2, 2009.

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 2009, all members of the Plan participated in the Medical Malpractice Insurance Pool of New York State (Pool).

For 2009, the Pool insured 3,985 individuals (including professional corporations) compared with 1,196 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)
2007-2009

Type of Insured	Policies as of December 31, 2009	Policies as of December 31, 2008	Policies as of December 31, 2007
Primary Insureds			
Physicians	291	347	455
Dentists	165	171	205
Podiatrists	29	35	67
Nurse-Anesthetists	4	4	6
Nurse-Midwives	22	17	23
Professional Corps.	31	23	29
Excess Layer Insureds			
First Layer Excess	3,443	599	697
Second Layer Excess	0	0	0

Note: The decrease in primary physicians' and surgeons' policies has been driven by insureds switching over to risk retention groups that are exempted from the regulations of this Department. The large increase in first layer excess policies is a result of MLMIC's decision to withdraw from writing Section 18 excess coverage. Chapter 132 of the Laws of 2008 extended the provisions of Chapter 673 of the Laws of 2005 to exempt the pool to make available the Second Layer Excess medical liability coverage until July 1, 2013.

In addition to these individuals, the Pool insured 13 facilities, the majority of which were nursing homes (3) and adult homes (7), down from 25 the year before.

16. 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. The Department has approved rate credits for a total of 41 insurance carriers desiring to offer managed-care programs as of year-end 2009.

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 2009 there were 35 insurance carriers with approved drug-free workplace programs in place.

c. Workers' Compensation Workplace Safety and Loss Prevention Incentive Program

In March 2007, the Legislature enacted Chapter 6 of the Laws of 2007, which reformed New York's workers' compensation system. Chapter 6 amended Workers Compensation Law § 134(6), to state that employers insured through the state insurance fund (except those who are current policy holders in a recognized safety group) or any other insurer that issues policies of workers' compensation insurance, shall be eligible for a credit in workers' compensation insurance premiums if the employer implements Workplace Safety and Loss Prevention Incentive Program (WSLPIP).

Pursuant to the statute, the Commissioner of Labor promulgated 12 NYCRR 60 ("Industrial Code Rule 60"). Industrial Code Rule 60 sets forth the minimum requirements for an acceptable WSLPIP.

Pursuant to Workers Compensation Law § 134(6) (c) the superintendent proposed Second Amendment to Regulation No. 119 11 NYCRR 151-3 Workplace and Loss Prevention Incentive Program (Regulation). Once promulgated it will establish the premium credit for WSLPIP and include provisions for recertification on an annual basis.

The Superintendent will review the information submitted by insurers pursuant to the Regulation to evaluate whether the credit amounts specified in the Regulation continue to be appropriate and reflective of actual loss and experience and expenses.

The Workplace Safety and Loss Prevention Incentive Program is comprised of
(1) safety incentive program; (2) drug and alcohol prevention program; or (3) return to work program.

These programs are designed to reduce, eliminate and mitigate workplace injuries and the cost of workplace injuries by providing a financial incentive to encourage employers to adopt the workplace programs, with an overall goal of reducing Workers' Compensation Costs.

d. Independent Livery Driver Benefit Fund (the Fund)

Chapter 392 of the Laws of 2008 was signed into law on July 26, 2008, by Governor David A. Paterson, which established rules to determine when livery cab drivers operating in New York City, Westchester, and Nassau County are considered employees or independent contractors of livery bases. The new law called for the creation of the Independent Livery Driver Benefit Fund (the Fund) to afford workers' compensation benefits to eligible independent contractor livery drivers and their families in the following circumstances: death; injuries resulting from a crime directly against the livery driver; amputation or loss of an arm, leg, foot, multiple fingers, index finger, multiple toes, ear or nose, paraplegia or quadriplegia, total and permanent blindness or deafness.

The 4th Amendment to Department Regulation 119 was promulgated pursuant to newly enacted Section 3451 of the Insurance Law authorizing an insurer licensed to write workers compensation and employers' liability insurance in New York, as defined in Insurance Law Section 1113(a) (15), to issue group policies of insurance to the "Fund". This Regulation ensures that the Fund will have a choice of procuring coverage from either the State Insurance Fund or an authorized insurer, which may provide savings to the Fund, and ultimately the livery bases that pay for the coverage.

Hereford Insurance Company, a writer of commercial automobile liability insurance and workers compensation insurance primarily for the public auto industry made an initial proposed rate and form filing to afford coverage to the livery drivers dispatched by independent livery bases that are members of the Independent Livery Driver Benefit Fund (the "Fund"). The filing was approved effective January 1, 2010

17. Insurance Availability Issues

While liability insurance coverages continued to be generally available during 2008, some markets experienced difficulties. The Department continued to monitor market conditions and addressed individual problems as they arose.

a. Availability Survey

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

The current survey methodology allows for the analysis of market conditions and developing trends, and enables the Department to better serve the insurance community as well as consumers in New York State. As in previous years, several risk and coverage categories were added and deleted based on the Bureau's observation of market conditions during the period since the last survey was issued.

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

Insurers' accurate and timely responses are a key element in the Department's efforts to cultivate and maintain stability in the commercial insurance marketplace. Responses to the survey have proven to be of great value in our efforts to help consumers and businesses find coverage appropriate to their needs. Survey information has also been a helpful tool in the Department's analysis of conditions and trends in the ever-changing insurance marketplace. Past Survey results have enabled the Department, working with insurers and producer organizations, to develop appropriate coverage sources in difficult market environments.

18. Automobile Insurance

a. New York Automobile Insurance Plan

The number of vehicles insured in the Plan has continued to decline for the past few years and remains at an historic low. Approximately 1% of New York private passenger registered vehicles are insured in the Plan as compared to a range of 12% to 17% around two decades ago. Furthermore, at year-end 2009, there were approximately 3% fewer vehicles in-force than year-end 2008 and approximately 18% fewer than year-end 2007. This continual decrease in the Plan's population can be attributed, at least in part, to various Department initiatives; such as those to combat fraud and incentives to voluntary market insurers that provide coverage to drivers who otherwise would have been placed in the Plan. The last two months of 2009 seem to show a bottoming out of the vehicles in force in the Plan. Therefore, a further reduction of Plan vehicles can no longer be anticipated.

b. Legislation

Chapter 56 of the Laws of 2009 amended Subsection (b) of section 9110 of the insurance law, increasing the Motor Vehicle Law Enforcement Fee (MVLEF). Every insurer authorized to do business in New York is required to collect an annual motor vehicle law enforcement fee from each policyholder issued a motor vehicle liability insurance policy in New York.

The law, which became effective June 1, 2009, increased the annual MVLEF to a rate of $10 (previously $5.00) per insured vehicle registered pursuant to the provisions of New York Vehicle and Traffic Law § 401(1)(b). The fee is reduced by fifty percent, to $5.00, for motor vehicle liability insurance policies issued for a term of six months or less.

c. DMV implementation of I-PIRP for Accident Prevention Courses

The NYS Department of Motor Vehicles (DMV) implemented an Internet/Alternate Delivery Method Point and Insurance Reduction Program (I-PIRP) for Accident Prevention Courses (APC) as part of its five-year pilot program. Starting on May 18, 2009, DMV has approved various I-PIRP APC sponsors. Prior to the implementation of the I-PIRP, DMV had only approved classroom-based APC. However, the I-PIRP now gives drivers the option to complete the course via the Internet or another alternate delivery method approved by the DMV as well as the traditional classroom setting. Drivers who complete an approved course can save approximately 10% on their automobile liability and collision insurance premiums.

d. No-Fault Motor Vehicle Insurance Law Activity – 2009

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

Two 1997 Court of Appeals decisions, Central General Hospital v. Chubb, and Presbyterian Hospital v. Maryland Casualty, continue to significantly affect No-Fault adjudication and the number of disputes generated in the No-Fault system. These cases generally established that a No-Fault insurer may not assert a defense when it does not timely deny a claim within 30 days of receipt. In a 2008 decision, Fair Price Medical Supply v. Travelers, the Court of Appeals upheld the application of a preclusion sanction for a late denial where durable medical equipment supplies were billed for and never provided, so that any amount billed by a health provider for non-existent services must be paid by the insurer when there is a late denial. Essentially, the fundamental requirements established by the Legislature in 1973 that all reimbursable No-Fault health care expenses must be necessary and billed in accordance with the adopted fee schedule have been frustrated by the above Court of Appeals decisions. Therefore, the Legislature should enact legislation similar to the bill proposed by the Assembly in A4348 that would restore the fundamental right of an insurer to assert a defense beyond the 30 day period.

ii. Mandatory arbitration for all No-fault insurance disputes

The Civil Court of the City of New York and District Courts in Nassau and Suffolk Counties have been inundated with lawsuits filed by medical providers seeking reimbursement of No-Fault benefits for services rendered to injured claimants. This strain on the judiciary's resources led the Chief Administrative Judge's Local Courts Advisory Committee (Unified Court System) to propose bill number A8798 that would amend NYIL §5102 to require mandatory arbitration for all No-fault insurance disputes. Since the improvements in the administration of the No-Fault Arbitration System in the past few years permit it to process and resolve substantially more requests for arbitration in an expeditious manner, the Legislature should consider legislation to reduce the burden on the judiciary's resources by revising NYIL §5102 to require mandatory arbitration for all No-fault insurance disputes.

iii. Decertification of Health Care Providers

Chapter 424 of the Laws of 2005 added a new Section 5109 to the Insurance Law to require the Superintendent, in consultation with the Commissioners of Health and Education, to promulgate standards and procedures for investigating and suspending or removing a health care provider's ability to be reimbursed under the No-fault system. Following discussions with the Health and Education Departments, a new joint Insurance Department and Health Department bill has been introduced by the legislature in A7128 and S3552 to more effectively address the issues that the sponsors of the current law intended. Under the proposed bill, certain abuses of the No-fault system will be addressed by permitting the Superintendent to prohibit a health care provider from demanding or requesting payment of health services under the No-fault system for a period not exceeding three years if the Superintendent determines that the health care provider has engaged in certain activities.

iv. Regulation Reform

Following extensive consultation with insurers, medical providers and trial attorneys, the Department issued a working draft of an amendment to Regulation 68 to help reduce fraud and abuse associated with No-fault claims, while making the No-fault system more user-friendly to injured parties and to health care providers. The Department posted the working draft on its website and has received an array of comments from all interested parties. The Department is reviewing the comments and is conducting further discussions with the stakeholders in order to ensure that the new rules eventually promulgated will effectively address the issues that are driving automobile insurance loss costs in a manner that is fair and equitable to all.

19. Homeowners Insurance

a. New York's Coastal Areas

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

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

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

In accordance with the Legislation of 2008, NYPIUA's incentive plan for members that voluntarily write policies that include windstorm coverage in coastal areas is in the process of being developed and implemented; the Special Advisory Panel on homeowners insurance/catastrophe coverage is in the process of being reinstated.

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

Legislation enacted in 2008 formally established C-MAP and provides for NYPIUA's administration of the program. The law also directs NYPIUA to expand the coverage it provides to include Broad Form Peril coverage. NYPIUA issued the first DP 2 policy in April, 2009. C-MAP remains available only to owner-occupants of one to four family dwellings, or condominium and apartment residents. This expansion of NYPIUA coverage creates additional opportunities for voluntary market companies to participate in C-MAP.

From its inception in April 1996 through December 31, 2009, 7,516 policies were 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. Mineola Office

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

20. Market Conduct Activities

a. Summary of Market Conduct Investigations Conducted and Fines Collected

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

There were 44 market conduct investigations and 3 Rate Service Organization examinations (RSO) and 1 Stamping Office examination in progress at the beginning of 2009 and 74 investigations and 1 RSO examination were initiated during the year. The Department closed 48 market conduct investigations and 1RSO examination during the year. At year's end, 70 market conduct investigations, 3 RSO examinations and 1 Stamping Office examination were in progress. A total of 8 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $1,683,900. In addition, fines totaling $51,000 were received from insurers and self-insurers for failure to pay No-Fault arbitration awards in a timely manner.

The following chart provides a breakdown of the market conduct activities for Calendar Year 2009:

Table 38
MARKET CONDUCT INVESTIGATIONS/EXAMINATIONS
by Type of Investigation/Examination
2009

Type of Investigation	Outstanding at 1/1/2009	Initiated during 2009	Completed during 2009	Outstanding at 12/31/2009
Claims	9	6	2	13
Rating/Underwriting	5	1	1	5
Automobile/Homeowners Underwriting 3425	9	6	1	14
Title Ins. Underwriting	2	2	3	1
Commercial Auto Rating/Underwriting	1	0	0	1
Personal Auto & Homeowners Rating/Underwriting	2	2	1	3
Privacy	0	0	0	0
Frauds	0	3	3	0
Public Auto	6	0	0	6
Desk Audits:				
Section 3425 Compliance	0	6	1	5
Claims/Rating/Underwriting	10	7	9	8
Internet Web Site Reviews	0	5	5	0
Availability Survey 05	0	14	0	14
Market Analysis Review	0	22	22	0
Total Investigations	**44**	**74**	**48**	**70**

Examinations:	Outstanding at 1/1/2009	Initiated during 2009	Completed during 2009	Outstanding at 12/31/2009
Rate Service Organization	3	1	1	3
Miscellaneous Stamping Office	1	0	0	1
Total Examinations	**4**	**1**	**1**	**4**

The following chart details the fines collected or processed and the stipulations entered into during Calendar Year 2009:

Table 39
MARKET CONDUCT FINES COLLECTED & PROCESSED
by Type of Investigation
2009

Type of Investigation	Number	Amount
Claims	1	$ 50,000
CMP Rating	1	119,500
Title Rating	2	750,000
Desk Audits:		
Rating/Underwriting	2	510,000
Financial Reinsurance Agreements	1	250,000
Section 3425 – 2%	1	4,400
Total	**8**	**$ 1,683,900**
Penalties: Failure to timely pay N.F. Arbitration Awards	204	$ 51,000
Total Fines Collected & Penalties Processed	**181**	**$ 1,734,900**

b. Penalties Imposed Under Insurance Law Section 3425

Section 3425-NYIL limits the total number of non-renewals of personal automobile insurance policies that an insurer is allowed. Generally, an insurer is permitted to non-renew up to 2% of the total number of covered policies that the insurer had in force at the previous year end in each such insurer's rating territory in use in this State. As a result of an analysis of reports to the Superintendent required by Section 3425(l)(1)-NYIL, 1 stipulated fine totaling $4,400 for Calendar year 2007 was collected during Calendar Year 2009 (included in the total fines collected in Section 20(a) above).

c. Penalties for Insurance Availability Survey Delinquents

One of the duties of the Property Bureau is to make available a listing of insurers who write commercial coverage in various markets. In order to determine these insurers, the Department has conducted Availability Surveys since 1989 on an annual basis, pursuant to Section 308 of the Insurance Law. Also, insurers licensed under Article 63 to write business in the Free Trade Zone are also required to complete that portion of the survey, for premiums written the previous year. For the 2008 Surveys, the Department during calendar year 2009, had in process 14 files concerning insurers who did not submit survey in a timely manner.

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

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

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

Insurers were also advised that in accordance with Section 109(c)(1) of the Insurance Law, a penalty would be imposed on insurers for each complaint made where no justifiable reason for nonpayment or late payment was furnished to the Department. In addition, these complaints are recorded for the purpose of

calculating the complaint ratios that form the basis of the Department's Annual Automobile Complaint Ranking. During Calendar Year 2009, the Department processed 204 fines totaling $51,000 from insurers and self-insurers for their failure to pay arbitration awards in a timely manner.

e. Insurer Internet Web Site Monitoring

The Market Conduct Unit continued the monitoring and review of insurer Internet Web sites. As part of Circular Letter No. 31, dated October 29, 1998, the Department advised the industry of the general guidelines that would be followed when monitoring the marketing of insurance products on the Internet. Supplement 1 to Circular Letter No. 31 was issued May 28, 1999, which further advised insurers that Web-based activities would be reviewed and/or monitored by the Department and that these reviews would be incorporated into the market conduct and financial review processes. Five insurer web sites were reviewed during the course of 2009. 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 2010.

f. 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 2009, the Market Conduct Unit initiated and completed a review of three 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.

g. Market Analysis Review System

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

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

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

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

During 2009, Market Analysis reviews of 22 Companies were conducted. Four Companies needed further monitoring within the Insurance Department which included rapid growth in selected line of business premiums and increases in direct defense costs. No further analysis was needed for the remaining 16 Companies. Two of the Companies are the subject of ongoing market conduct investigations. Some of the goals of the Market Analysis Program for 2009 are to standardize baseline factors to enable the Department to identify issues of concern and to prioritize activities in a uniform manner on a more thoughtful basis. The unit intends to make use of analytic tools such as the NAIC Prioritization tool in the selection of future Market Analysis reviews.

21. Excess Line Insurance

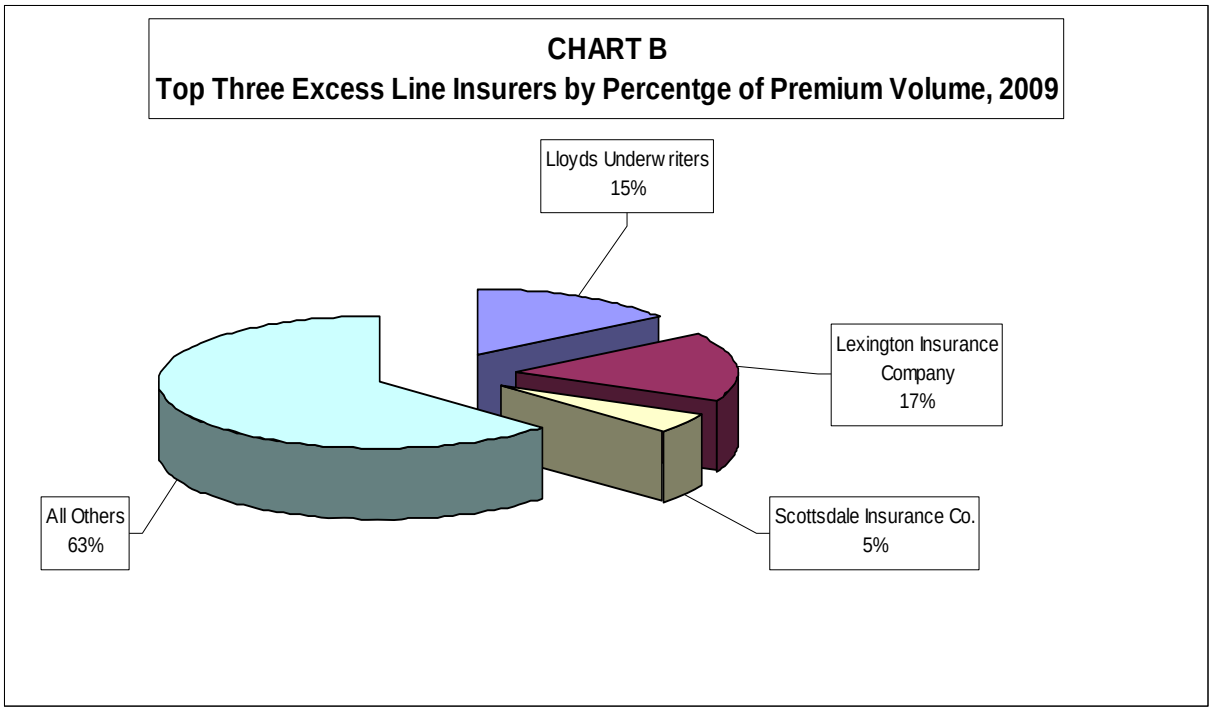
Applicants that cannot obtain coverage from companies licensed to write insurance in New York may, under circumstances prescribed in the New York Insurance Law and regulations, obtain such coverage from unlicensed companies through the auspices of a New York-licensed excess line broker.

Since insurers providing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained from excess line brokers through tax statements required to be filed no later than March 15 of each year relating to business written during the previous Calendar Year. For Calendar Year 2009, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $2.9 billion, of which approximately $1.7 billion was attributable to risks located or resident wholly in New York State. These excess line premiums generated approximately $61,627,626 in excess line premium tax revenue for the State.

The data pertaining to excess line business used in this report were obtained from statistical reports provided to the Superintendent by the Excess Line Association of New York (ELANY) pursuant to Section 2130 of the New York Insurance Law. ELANY obtains the information from affidavits required to be filed by excess line brokers under Section 2118 of the Insurance Law. The affidavit is a statement subscribed to, and affirmed by, the licensee or sublicensee as true under the penalties of perjury that, after diligent effort, the full amount of insurance required could not be procured, from authorized insurers, each of which is authorized to write insurance of the kind requested and which the licensee has reason to believe might consider writing the type of coverage or class of insurance involved, and further showing that the amount of insurance procured from an unauthorized insurer is only the excess over the amount procurable from an authorized insurer. There are 2,576 licensed excess line brokers and approximately 857 who are active and filed 142,265 affidavits for the year 2009. Seventeen hundred and fifty four complaints and inquiries and 1,656 filings regarding excess line business were received in 2009.

In 2009, there were approximately 207 unauthorized insurers eligible to do business in New York pursuant to Regulation 41. This includes 96 foreign insurers; 35 alien insurers; and Lloyd's, with 76 syndicates. These insurers are required to file annually by March 15, an EL-1 report showing detailed information of business written during the preceding year in order to be eligible to do business in New York on an excess line basis. In 2009, the Unit reviewed 59 EL-1 filings, 90 annual statements and 8 trust agreements filed by these unauthorized insurers.

The following is a chart of the percentage of total 2009 excess line premium writings attributable to the three largest excess line insurers in New York State.



a. Business Written in New York

Total excess line premiums written in New York State decreased from $2.217 billion in 2008 to $1.712 billion in 2009, a decrease of 22.8%. The decline in business is mainly due to a softening of the insurance market. The largest premium decrease occurred in other liability, down $281.8 million or 25.3% from last year. The largest % decrease was in auto physical damage, down by 107.2% or $20.4 million. Other decreases included fire and allied lines, down by $97.2 million or 21.42%; errors and omissions, down by $75.9 million; inland marine, down by $10.69 million; fidelity and surety down by $9.5 million; commercial multiple peril (excluding fire), down by $9.1 million; and malpractice, down by $6.4 million.

The largest increase over the previous year was in other lines, up by $4.9 million or an increase of 8.6%. The other increase was in burglary and theft, up by $1.1 million.

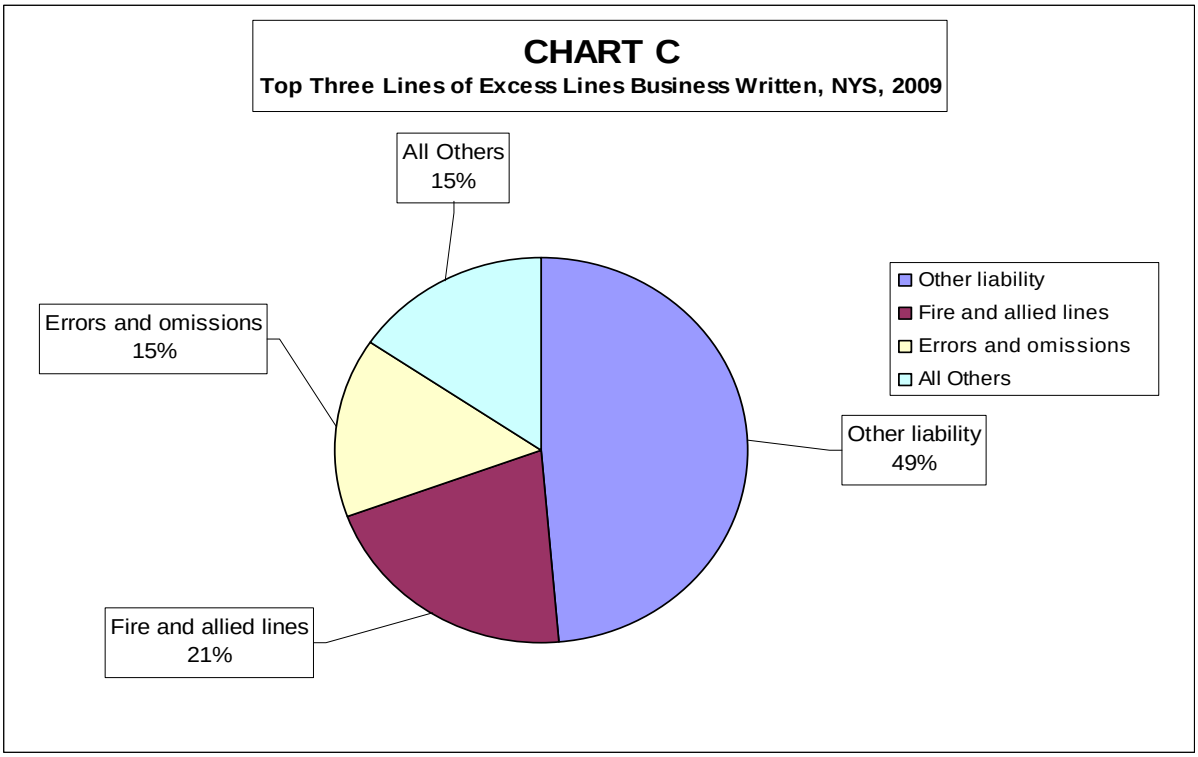
In calendar year 2009, homeowners' premiums in the excess line market increased from $36,815,584 to $42,965,827, an increase of 16.7%. A review of the premium writings indicated that the premium increase was mainly attributed to an increased number of policies written in the south shore of Long Island, an area with a potential for hurricane exposure. Licensed insurers are decreasing their exposure in this area. The review also indicated that the average cost per policy decreased slightly from 2008. It should be noted that the 2009 homeowners' premiums represented approximately one percent of the total homeowners market.

Table 40
EXCESS LINE PREMIUMS WRITTEN
Risks Located in New York State
2005-2009
(dollar amounts in thousands)

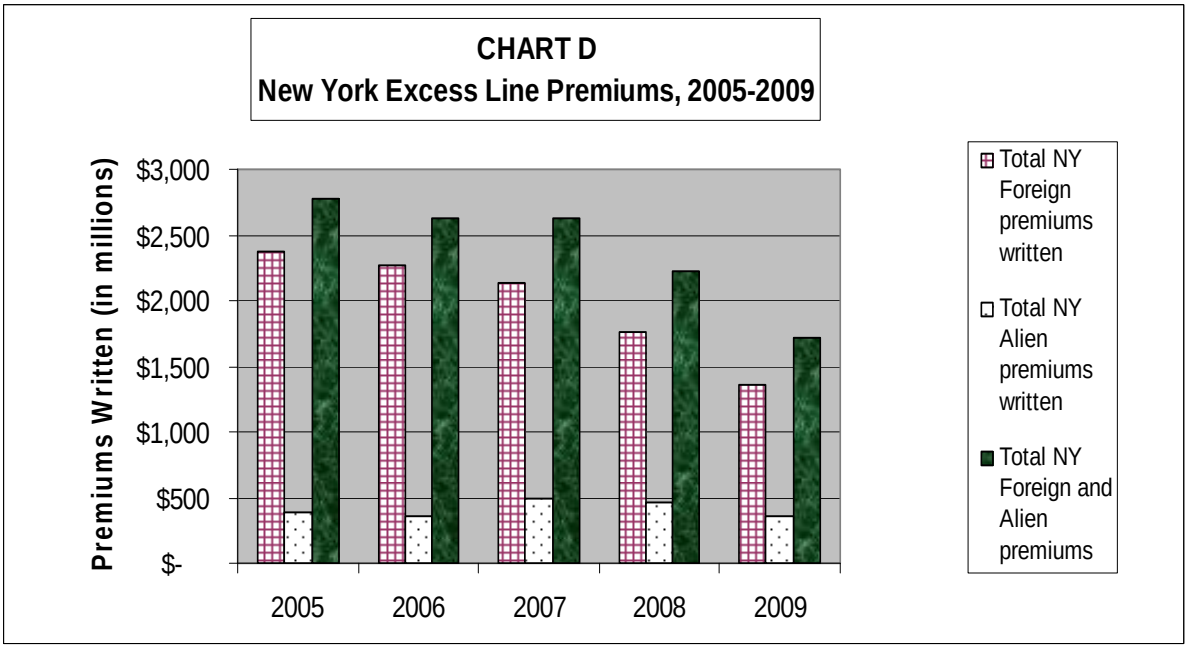
Line of business	2009	2008	2007	2006	2005
Fire and allied lines	$356,622	$453,822	$ 438,321	$ 427,382	$ 395,848
Inland marine	38,555	49,249	67,124	60,679	57,889
Auto liability	15,417	14,493	15,152	15,605	16,758
Malpractice	16,621	23,025	27,751	26,934	17,768
Errors and omissions	260,344	336,265	421,891	297,656	408,213
Commercial multiple peril (excluding fire)	78,361	87,501	107,185	109,280	111,716
Other liability	830,565	1,112,343	1,452,654	1,433,705	1,621,751
Auto physical damage	(1,384)	19,038	24,499	24,646	41,834
Aircraft physical damage	5,699	7,430	792	3,310	5,770
Burglary and theft	9,090	7,918	6,422	7,946	13,308
Fidelity and surety	39,421	48,996	26,816	43,880	34,331
Other lines	62,569	57,616	43,882	171,101	43,432
Total	$1,711,878	$2,217,696	$2,632,490	$2,622,123	$2,768,618
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	4.85%*	6.14%	7.12%	7.30%	7.88%
Excess line premiums as a percentage of all					

* Estimated Source: Excess Line Association of New York

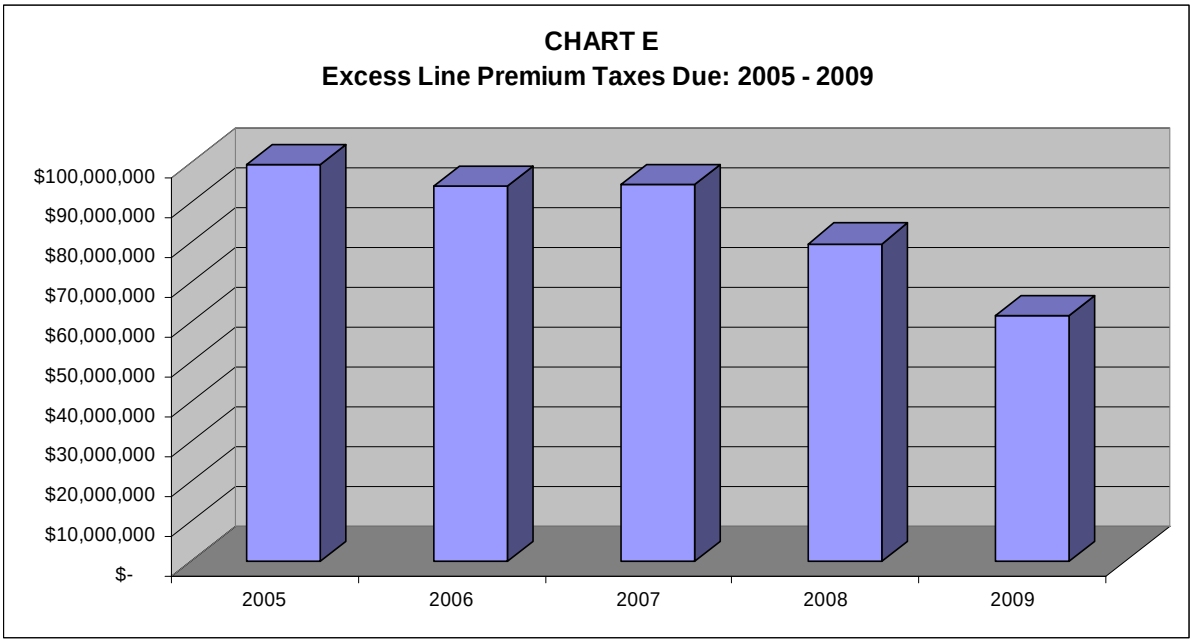
The pie chart below shows the three major lines of business written in the excess line market based on premium volume.



The following graph shows excess line business for the years 2005 to 2009 by alien and foreign insurers:



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



b. Binding Authority

Sections 2117 and 2118 of the Insurance Law were amended in 1997 to provide that an excess line broker, licensed pursuant to Section 2105 of the Insurance Law, may exercise binding authority, which the law defines as ". . . the authority to issue and deliver insurance policies on behalf of an insurer not licensed or authorized to do business in this state." Since the implementation of the amended statute, the Excess Line Association of New York (ELANY) has notified the Department that 111 excess line brokers have filed 301 binding authority agreements representing insurers not licensed or authorized to do business in this State. During calendar year 2009, the ELANY reviewed and accepted 29 new, renewed and/or amended binding authority agreements from New York-licensed excess line brokers. Currently, 111 excess line brokers have notified and filed with ELANY, 371 binding authority agreements.

c. EL-1 Review

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

d. Excess Line Association of New York (ELANY)

The Department received a request under section 2118 of the Insurance Law and Department Regulation 41 from the Excess Line Association of New York to expand the export list. A public hearing was held on June 13, 2008 on the expansion of the export list. As a result of the public hearing, the Department promulgated the 11th Amendment to Regulation 41 adding items to the export list effective September 2, 2009. ELANY has requested the Department amendment Regulation 41 to increase the minimum surplus requirements of unauthorized insurers doing business in New York to $45,000,000 from $15,000,000. The Department is in the process of amending Regulation 41. Federal legislation, Restoring American Financial Stability Act of 2010 (S.3217), may impact this initiative.

e. Special Risk Insurance (Free Trade Zone)

Article 63 of the Insurance Law and Department Regulation 86 allows risks that are jumbo in dimensions or exotic in nature to be written, free of filing rates or policy forms, in what is called the "Free Trade Zone". Although filing is not required, rates and policy forms applied to special risks must still satisfy governing standards set forth in the Insurance law and regulations.

Special risk insurance is categorized as:

1. Class 1. Where all or part of the insured's business operations, for which coverage is authorized by the kinds of insurance defined in section 1113(a) of the Insurance Law, is insured in a single policy written in accordance with section 6303 of the Insurance Law, and which is written with or is reasonably expected to produce a billed annual premium of at least:
   (i) $100,000 for at least one kind of insurance; or
   (ii) $200,000 for more than one kind where the premium for any one kind of insurance does not exceed $100,000.

Or

2. Class 2. Coverages that are:
   (i) of an unusual nature, a high loss hazard or difficult to place; and
   (ii) enumerated in the list contained in section 16.12(e) of Regulation 86

During the year, the Department received several inquiries regarding the allowance of certain risks in the class (1) or class (2) categories, interpretation of Regulation 86, and requests to add additions to the class (2) category listed in Regulation 86. The following line has been added to the class (2) category effective November 4, 2009:

Boom Truck - Auto/Boom Truck Operations/Liability-insurance policy providing both (i) commercial auto coverage with limits of liability that meet or exceed the minimum financial responsibility limits; and (ii) commercial general liability risks for owners, operators and lessors of self-propelled or "road ready" vehicles with articulated or telescopic arms, cranes or concrete pumpers permanently affixed. Includes liability coverage for operation of boom trucks where equipment was leased with (or without) the services of an operator. The policy shall provide separate and equal per occurrence limits of liability for the commercial auto liability coverage part and the commercial general liability coverage. In addition, any general policy aggregate limit of liability shall not be applicable to the policy's commercial auto coverage part or to the products/completed operations coverage part and the declarations page shall specifically so indicate.

f. 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.

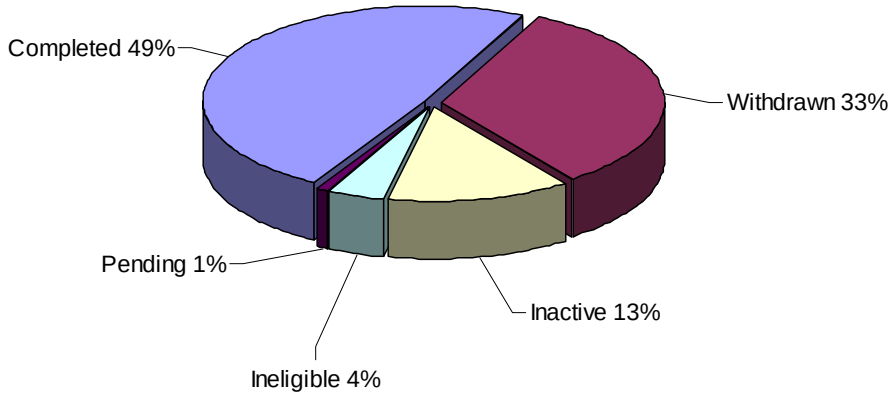
Since the inception of the LRRA, the Department has received notices of intent from 991 purchasing groups. Subsequently, 325 have withdrawn their notice of intent, 131 have notified the Department of their inactive status, and 41 have been given ineligible status by the Department due to failure to comply with all the requirements of the applicable laws and regulations. In 2009, the Department received notices of intent from 41 purchasing groups.

The Department requested Purchasing Groups file an annual update of the required information under the LRRA. The update form is available on the Department’s website.

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

The following chart shows the purchasing group filings as of December 31, 2009, by status category:

CHART F
Purchasing Group Filings, 2009



g. Purchasing Group and Excess Line Investigations

The excess line unit investigates excess line brokers' compliance with the New York Insurance Law, primarily but not limited to Sections 2118, 2117, 2105, 2130 and 2110. Some of the investigations conducted last year were as follows:

A broker made hundreds of placements over a 30-month period for an excess line company without the requisite excess line license. The broker was fined $15,500 for a Section 2117 violation. Additionally, the broker paid back taxes of $1,833.

A broker made many placements with two excess line companies from 2004 until 2008. The broker let both its 2104 license and 2105 license lapse during this time period. The broker was fined $40,000 for this section 2117 violation. Subsequently the brokerage was sold.

A brokerage facilitated the issuance of surety bonds for an insurer that was not authorized or excess line eligible to do business in New York from September 2003 to March 2005. The broker was fined $18,000. In addition, a "do not stamp" letter was sent to the Excess Line Association of New York (ELANY), the stamping office in New York. All excess line policies are required to be stamped by ELANY. The "do not stamp" letter warns that the company has no authority.

An excess line broker collected approximately $300,000 in excess line premium taxes from insureds but failed to remit them. The broker's license was revoked for failure to pay the taxes and penalties for 2007 and 2008. In addition, his son, also a Department licensee at the brokerage signed a stipulation to surrender his license for failure to cooperate with a department investigation. The case was referred to the Frauds Bureau for the collection of the premium tax.

The excess line unit also monitors the financial solvency of 207 excess line insurers conducting business in this state.

The Unit conducted approximately 688 investigations last year. Many of these investigations were the result of a special project wherein the unit investigated excess line brokers who failed to file premium tax statements for 2006, 2007 and 2008. The special project resulted in a collection of premium taxes and section 9109 penalty totaling $2,218,202.

h. Electronic Initiatives

In September 2007 the Unit was given approval by the Taxes and Accounts Bureau to create an interactive Premium Tax Statement for online filing for the March 15 filing deadline. For those brokers unable to file electronically, paper premium tax statements are available on the internet. As of March 19, 2010 there were 996 premium tax statements filed online, 195 more filings than 2009. These filings represent approximately 38.7% of the 2,576 excess line brokers licensed and required to make this filing. This electronic usage is expected to increase in the future resulting in significant savings to the Department and excess line brokers.

22. Consumers Guide to Automobile Insurance

On October 1, 2009, the Department published an upstate and downstate edition of the 2009 Consumers Guide to Automobile Insurance. The Department also has an interactive version of the guide on its Web site. The guide is required by Section 337 of the Insurance Law to be updated annually. This comprehensive guide helps consumers determine how much auto insurance they need and explains all mandatory and optional coverages available in New York State. The guide contains lists of insurers, telephone numbers, and sample rates to facilitate comparison shopping, and advice regarding how to file a claim or make a complaint against an insurer. Copies of the guide were distributed to every Department of Motor Vehicles office and public library in the State. The guide is also available free of charge directly from the Insurance Department and can be accessed via the Department's Web site.

23. Regulations

Regulations Adopted in 2009:

Eleventh Amendment to Regulation 41 (Excess Line Placements Governing Standards), became effective September 2, 2009. The amendment added additional coverages to the "export" list and reduced the requisite declinations for several other coverages.

24. Circular Letters

Circular Letters Issued in 2009:

Circular Letter No. 3 (2009) regarding unfair claims settlement practices for no-fault was issued on February 19, 2009 to all motor vehicle self-insurers and insurers writing motor vehicle insurance in New York State. The circular letter reminded insurers and self-insurers of their obligations with respect to the notice of claim provisions set forth in 11 NYCRR § 65-3.3, and to provide further guidance with regard to those requirements.

Circular Letter No. 5 (2009) regarding new procedures for the filing of policy forms, rules and rates was issued February 19, 2009 to all insurers licensed to write property/casualty insurance, joint underwriting associations, rate service organizations and the New York Automobile Insurance Plan. The circular letter advised insurers of: 1) the Department's filing procedures for filings submitted via SERFF; 2) a new transmittal document (Paper Transmittal form) for property/casualty insurance products submitted via paper; and 3) revisions to the Rate Filing Sequence Checklist.

Circular Letter No. 14 (2009) regarding accident prevention course providers, newly approved internet/alternate delivery method point and insurance reduction program (I-PIRP) and notice requirements was issued June 5, 2009. The circular letter informed insurers and insurance producers of the new Internet/Alternate Delivery Method Point and Insurance Reduction Program (I-PIRP) made available by the NYS Department of Motor Vehicles (DMV). It also cites the DMV for all accident prevention course providers.

Supplement No. 2 to Circular Letter No. 22 (2005) regarding filing of Actuarial Opinion Summary was issued on June 26, 2009. The circular letter advised all domestic property/casualty insurers licensed pursuant to New York Insurance Law § 4104(a) and required to file a Statement of Actuarial Opinion with the National Association of Insurance Commissioners property/casualty statement in accordance with Insurance Law § 307(a)(1) and (a)(2) that they also should file an Actuarial Opinion Summary with the New York State Insurance Department.

Circular Letter No. 15 (2009) regarding third party information sharing for sales tax compliance purposes was issued on June 30, 2009 to all insurers and self-insurers authorized to write motor vehicle liability, physical damage and mechanical breakdown insurance in New York State and the New York Automobile Insurance Plan. The circular letter advised insurers of an amendment to Section 1136 of the New York Tax Law which requires insurers to file an annual informational return with the New York State Department of Taxation and Finance ("DTF") if the insurer pays consideration or an amount under an insurance contract for the servicing or repair of a motor vehicle on behalf of an insured. The law also required insurers to advise recipients of such payments, including motor vehicle body or mechanical repair shops as sales tax vendors, of the information reported to the DTF. In addition, the law established penalties for noncompliance with the required reporting requirements.

Circular Letter No. 18 (2009) regarding the excess line export list was issued July 24, 2009 to all licensed excess line brokers, insurance brokers and insurance producer organizations, and the Excess Line Association of New York (ELANY). The circular letter advised insurance producers that the Superintendent has performed its annual review of the excess line "Export List", as required by New York Insurance Law § 2118(b)(4) and has determined that the coverages set forth on the current Export List, including the coverages that the Eleventh Amendment to Regulation 41 added is appropriate, and need not be expanded nor contracted at this time.

Circular Letter No. 19 (2009) regarding service contract reimbursement insurance was issued on August 3, 2009 to all authorized insurers licensed to write service contract reimbursement insurance, licensed excess line brokers, registered service contract providers, and the Excess Line Association of New York The purpose of this circular letter is to: (1) advise service contract providers of registration procedures when they utilize service contract reimbursement insurance (SCRI) to demonstrate financial responsibility; (2) remind insurers writing SCRI of their obligations under Article 79 of the Insurance Law and 11 NYCRR Part 390 (Regulation 155); and (3) require insurers to attest whether the SCRI policies that they have issued in New York State are in compliance with New York requirements.

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 1,720 such complaints and inquiries were received by the Market Regulatory Division of the Property Bureau in 2009. This total consisted of 1,357 involving personal automobile insurance; 11 involving commercial automobile insurance; 84 involving homeowners insurance; 36 involving other liability insurance; 15 involving commercial multiple peril insurance; 28 involving medical malpractice insurance; 34 involving workers' compensation, and 155 involving other types of insurance (mortgage guaranty, fidelity, surety, inland marine, etc.). In addition, the Market Regulatory Division received 810 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, and medical malpractice insurance. In terms of premium volume, private passenger automobile and workers' compensation insurance are the largest property/casualty coverages, accounting for approximately $13.5 billion of New York premium volume in 2009; medical malpractice premiums account for approximately $1.3 billion of New York premium volume in 2009.

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

Private passenger automobile flex rating became effective January 1, 2009. Under this system, an insurer may implement a proposed overall average rate increase on a file and use basis provided the change is within a five percent flex-band. Additionally, during any twelve-month period, an insurer may implement no more than two overall average rate increases on a file and use basis but the cumulative effect of the increases must still be within the five percent flex band. Any rate change greater than +5% must still be approved prior to use.

A total of 90 private passenger automobile filings composed of 64 flex filings and 26 prior approval filings became effective in 2009. The average change for insurers receiving rate changes (both flex and prior approval) in 2009 was approximately 6.1%. For these insurers, liability rates increased 9.3% on average while physical damage rates, primarily collision and comprehensive coverages, increased 0.1% on average. The insurers receiving rate changes with renewal dates effective in 2009 represent 81.4% of the total market for private passenger automobile insurance. The overall impact on the rate level for the entire market was an average increase of 5.0%.

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

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 IN 2009[1]

Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Req'd (%)	Liability Change App'd (%)	Physical Damage Change App'd (%)	Overall Change App'd (%)
1/16/09	AIG: AIGI; Landmark[3]	0.3	5.0	4.9	5.3	5.0
2/1/09	Eveready Ins. Co.[3]	0.1	-4.0	-2.7	-5.6	-4.0
2/1/09	Kemper Independence Ins. Co.[3]	0.4	4.6	5.7	2.2	4.6
2/1/09	Unitrin Auto & Home Ins. Co.[3]	0.4	4.1	6.2	0.3	4.1
2/7/09	Progressive: PNEIC; PNIC; PNWIC[3]	3.5	5.0	7.0	0.3	5.0
2/10/09	Liberty: LMFIC; TFLIC[3]	4.8	4.9	6.5	1.7	4.9
2/14/09	21st Century Ins. Co.[3]	0.0	5.0	5.0	5.2	5.0
2/15/09	Truck Insurance Exchange[3]	0.2	5.0	5.2	4.2	5.0
2/16/09	Travelers: TICCT; TPCCA[3]	2.3	5.0	6.6	2.7	5.0
2/22/09	Allmerica Financial Alliance Ins. Co.[3]	0.5	4.5	3.9	6.6	4.5
2/24/09	New Hampshire Ins. Co.[3]	0.0	5.0	5.5	0.0	5.0
2/25/09	GEICO Group: GEICO; GGIC[3]	16.5	4.5	9.5	-3.8	4.5
3/6/09	Sentinel Ins. Co.[3]	0.7	5.0	10.3	-5.0	5.0
3/6/09	Hartford Ins. Co. of Illinois[3]	0.8	5.0	10.7	-7.3	5.0
3/7/09	Allstate Ins. Co.[3]	13.1	0.9	1.1	0.4	0.9
3/10/09	Permanent General Assurance Corporation[3]	0.0	4.5	5.5	-13.3	4.5
3/12/09	State-Wide Ins. Co.[4]	0.3	6.7	2.0	-7.4	0.0
3/17/09	Nationwide Assurance[3]	0.0	5.0	7.7	-6.1	5.0
3/19/09	Utica National Ins. Co. of Texas[3]	0.1	-1.8	-1.8	-1.7	-1.8
3/19/09	Utica Mutual Ins. Co.[3]	0.0	-3.7	-2.7	-5.3	-3.7
3/19/09	Utica: GAMIC; RFIC; UNAC[3]	0.2	2.5	2.5	2.5	2.5
3/20/09	Hanover: MBIC; HIC; CIC[3]	0.3	4.9	3.7	7.6	4.9
3/25/09	Adirondack Ins. Exchange (OneChioce prog.)[4]	1.0	5.9	7.8	1.7	5.9
3/27/09	ACA Ins. Co.[3]	0.1	4.5	3.9	6.6	4.5
3/31/09	Response Ins. Co.[3]	0.1	4.0	6.3	-0.3	4.0
3/31/09	Warner Ins. Co.[3]	0.1	4.9	5.9	3.2	4.9
3/31/09	Response Worldwide Ins. Co.[3]	0.1	4.1	3.0	6.7	4.1
3/31/09	Response Worldwide Direct Auto Ins. Co.[3]	0.1	4.1	5.3	3.5	4.1
4/1/09	A Central Ins. Co.[4]	0.4	6.9	2.8	18.0	6.9
4/1/09	Erie: EIC; EICoNY[4]	0.6	0.0	-0.2	0.2	0.0
4/1/09	Central Mutual Ins. Co.[3]	0.0	2.9	2.5	3.4	2.9
4/1/09	Atlantic States Ins. Co.[3]	0.0	4.9	12.0	-5.4	4.9
4/7/09	Progressive Direct Ins. Co.[3]	1.3	5.0	6.6	1.4	5.0
4/7/09	Progressive Preferred Ins. Co.[3]	1.7	5.0	8.4	-5.5	5.0
4/10/09	Adirondack Ins. Exchange (Legacy prog.)[3]	*	5.0	9.9	-2.3	5.0
4/10/09	Tri-State Consumer Ins. Co.[3]	0.2	5.0	9.7	-5.9	5.0
4/10/09	Esurance Ins. Co.[3]	0.6	5.0	9.5	-5.7	5.0
4/10/09	Encompass Indemnity Co.[3]	0.5	5.0	13.8	0.0	5.0
4/10/09	Encompass Home & Auto Ins. Co.[3]	0.1	5.0	0.9	16.8	5.0

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS IN 2009[1]

Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Req'd (%)	Liability Change App'd (%)	Physical Damage Change App'd (%)	Overall Change App'd (%)
4/12/09	Unitrin Direct Inc. Co.[4]	0.1	6.3	6.0	6.9	6.3
4/15/09	AutoOne Select Ins. Co.[4]	0.3	8.3	7.6	7.5	7.6
4/15/09	Lincoln General Ins. Co.[3]	0.5	4.9	7.1	1.8	4.9
4/15/09	Allmerica Financial Alliance Ins. Co.[3]	*	0.5	0.6	0.4	0.5
4/24/09	Main Street Group: MSAAC; NGM[4]	0.6	5.0	10.2	-3.0	5.0
4/24/09	AIG National Ins. Co.[4]	0.3	23.8	22.5	5.8	18.3
4/27/09	Geico Indemnity Ins. Co.[3]	5.9	5.0	6.8	0.0	5.0
5/8/09	AIG: AIGI; Landmark[4]	*	23.6	15.5	10.9	14.2
5/12/09	Nationwide Mutual Fire[3]	0.3	5.0	6.3	0.0	5.0
5/15/09	Peerless Ins. Co. [4]	0.4	4.4	5.9	1.8	4.4
5/19/09	GMAC: MIC P&C; CIM; NSIC.[3]	0.9	3.9	2.0	9.6	3.9
5/23/09	Allstate Ins. Co.[3]	*	4.1	5.0	2.4	4.1
5/27/09	State Farm Fire & Casualty Co.[4]	1.3	7.5	10.6	-0.1	7.5
5/27/09	State Farm Mutual Automobile Ins. Co.[4]	9.2	8.3	12.7	0.7	8.3
6/1/09	Merastar Ins. Co.[3]	0.0	5.0	7.7	-0.2	5.0
6/1/09	Old Dominion Ins. Co.[4]	0.0	0.0	0.0	0.0	0.0
6/10/09	AutoOne Ins. Co.[3]	0.5	5.0	5.6	0.0	5.0
6/14/09	Travelers: THMIC; TCIC[3]	1.0	4.3	6.6	1.4	4.3
6/22/09	Liberty Ins. Corp.[3]	0.1	4.9	5.4	3.8	4.9
6/26/09	New Hampshire Ins. Co.[4]	*	21.2	13.5	0.0	12.4
6/30/09	Metropolitan: MP&CIC; MCIC[4]	1.6	9.6	7.1	1.7	5.2
7/1/09	Farmers New Century Ins. Co.[4]	0.2	9.4	9.6	9.2	9.4
7/2/09	Privilege Underwriters Reciprocal Exchange[4]	0.0	0.0	0.0	0.0	0.0
7/6/09	Dailyland Ins. Co.[3]	0.0	4.9	4.9	5.2	4.9
7/10/09	Metropolitan Group Prop & Cas Ins. Co.[3]	0.7	2.7	5.6	-1.1	2.7
7/27/09	Unitrin Direct Prop & Cas Co.[3]	0.0	4.3	6.0	1.3	4.3
8/2/09	Kemper Independence Ins. Co.[3]	*	0.3	0.3	0.3	0.3
8/17/09	State-Wide Ins. Co.[3]	*	5.0	7.8	-5.2	5.0
8/25/09	GEICO Group: GEICO; GGIC[3]	*	0.4	0.6	0.0	0.4
8/27/09	American Commerce Ins. Co.[3]	0.0	5.0	6.8	-0.4	5.0
9/4/09	American International Ins. Co.[3]	0.0	2.5	3.6	0.7	2.5
9/15/09	Utica: GAMIC; RFIC; UNAC[3]	*	2.5	2.5	2.5	2.5
9/15/09	Progressive: PMIC; PAIC[3]	0.0	5.0	6.4	0.9	5.0
9/15/09	Progressive: PCIC; PSIC[3]	0.0	3.6	4.1	2.1	3.6
9/15/09	New York Central Mutual Fire Ins. Co.[3]	2.3	2.7	9.4	-7.7	2.7
9/22/09	Farmington Casualty Co.[4]	0.2	-0.8	-0.1	-7.3	-0.8
9/30/09	EPAC[3]	0.0	5.0	6.6	0.0	5.0
10/9/09	New Hampshire Indemnity Ins. Co. [3]	0.2	-0.8	-0.1	-7.3	-0.8
10/17/09	AIG Preferred Ins. Co.[3]	0.0	4.4	4.2	4.9	4.4
10/17/09	AIG Advantage Ins. Co.[3]	0.3	5.0	5.0	5.0	5.0

PRIVATE PASSENGER AUTOMOBILE RATE FILINGS IN 2009[1]

Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Req'd (%)	Liability Change App'd (%)	Physical Damage Change App'd (%)	Overall Change App'd (%)
10/19/09	Nationwide: NMIC; NP&CIC[3]	1.6	3.7	4.9	2.3	3.7
11/1/09	Truck Insurance Exchange[4]	*	19.9	13.0	9.4	12.1
11/12/09	Farm Family Casualty Ins. Co.[4]	0.2	-0.9	-1.4	0.1	-0.9
11/13/09	Chubb: FIC; PIC; VIC; GNIC; CIIC[4]	0.8	-10.0	-7.9	-7.8	-7.9
12/2/09	Electric Ins. Co.[3]	0.1	4.6	7.9	-0.1	4.6
12/5/09	Progressive: PCIC; PSIC[3]	*	0.0	0.0	0.0	0.0
12/7/09	Progressive Direct Ins. Co.[4]	*	5.9	5.7	6.2	5.9
12/8/09	Progressive Preferred Ins. Co.[4]	*	5.5	6.2	3.8	5.6
12/15/09	Progressive: PNEIC; PNIC; PNWIC[4]	*	5.0	3.2	2.4	2.9
12/28/09	GEICO Group: GEICO; GGIC; GIC; GCC[4]	*	0.0	0.0	0.0	0.0
12/29/09	Geico Indemnity Ins. Co.[4]	*	16.0	9.4	8.7	9.2

2009 Rate Change Summary

	Total Filings (%)
Number of insurer rate filings:	90
Average liability change for insurers receiving rate changes:	9.3
Percentage of total liability industry premium affected:	81.0
Impact on the entire market of the overall average liability rate change:	7.5
Average physical damage change for insurers receiving rate changes:	0.1
Percentage of total physical damage industry premium affected:	82.2
Impact on the entire market of the overall average physical damage change:	0.1
Average combined liability and physical damage change for insurers receiving rate changes:	6.1
Percentage of total industry premium affected:	81.4
Impact on the entire market of the overall average liability and physical damage rate change:	5.0

1 Under the flex-rating system currently in effect, rate changes are either prior approval or file and use. Rate filings that include any classification changes are prior approval.

2 These market shares are based on 2008 Annual Statement premiums.

3 Flex rating

4 Prior approval

*** Subsequent filing (either prior approval or flex rating) by this insurer with renewal date in 2009.**

b. New York Automobile Insurance Plan (NYAIP) Experience in 2007 and 2008

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 22.2% for liability and 41.7% for collision from 2007 to 2008. 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
1999 – 2008

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
1999	8,031,017		324,355		8,355,372		11,631	
2000	8,106,797	0.9	207,802	-35.9	8,314,599	-0.5	9,408	-19.1
2001	8,147,522	0.5	343,511	65.3	8,491,033	2.1	27,597	193.3
2002	8,463,417	3.9	444,437	29.4	8,907,854	4.9	47,234	71.2
2003	8,313,121	-1.8	471,158	6.0	8,784,279	-1.4	47,981	1.6
2004	8,356,929	0.5	370,813	-21.3	8,727,742	-0.6	31,501	-34.3
2005	8,602,031	2.9	270,485	-27.1	8,872,516	1.7	18,386	-41.6
2006	8,729,798	1.5	181,917	-32.7	8,911,715	0.4	11,930	-35.1
2007	8,876,002	1.7	130,106	-28.5	9,006,108	1.1	9,967	-16.5
2008	8,945,404	0.8	101,224	-22.2	9,046,628	0.4	5,806	-41.7

ii. Risks by Surcharge Category

In 2008, there were 101,224 private passenger earned car years for liability and 5,806 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 2006, 2007 and 2008.

Table 43
DISTRIBUTION OF PRIVATE PASSENGER AUTOMOBILE ASSIGNED RISKS
LIABILITY AND COLLISION COVERAGES*
by Discount or Surcharge Category, 2006 – 2008

	Liability			Collision		
Discount or Surcharge Category	**2006 (%)**	**2007 (%)**	**2008 (%)**	**2006 (%)**	**2007 (%)**	**2008 (%)**
Total, all categories	100.0	100.0	100.0	100.0	100.0	100.0
Total Unsurcharged	56.5	55.0	53.0	58.3	54.5	51.6
3 Years Claim Free (1 or less with Plan) (Manual Rates)	33.3	30.6	30.2	29.3	28.8	28.7
Experience Discount						
4 Years (One or more with Plan) – 18% Credit	9.5	8.4	6.0	10.4	7.9	5.7
5 Years (Two or more with Plan) – 25% Credit	5.5	5.1	5.0	7.5	5.7	4.9
6 Years or more (Three or more w/Plan) – 30% Credit	8.2	10.9	11.8	11.0	12.0	12.3
Total Surcharged	43.5	45.0	47.0	41.7	45.5	48.4
Inexperienced Operator Surcharge	22.9	23.7	23.8	15.9	17.8	20.3
Experience Surcharge						
15%	11.1	10.8	11.1	14.0	14.8	14.2
25%	0.3	0.3	0.4	0.3	0.3	0.4
35%	2.9	3.0	3.2	4.3	4.3	4.8
50%	1.9	2.1	2.6	1.5	1.9	2.2
75%	1.4	1.4	1.6	1.8	2.0	2.2
100%-200%	3.1	3.6	4.4	4.0	4.5	4.3

*Subject to rounding

iii. Risks by Rating Territory

The proportions of all private passenger liability risks that are assigned risks, listed by rating territory for 2007 and 2008, are shown in Table 44. During 2008, 1.1% of all New York State private passenger automobiles were assigned risks as opposed to 1.4% in 2007. The proportion of assigned risks was 10% or higher in only 1 of the 70 rating territories for 2007 and was 7% or higher in only 1 of the 70 rating territories for 2008. The highest 2008 ratio was 7.0% in the Bronx Territory and the lowest was 0.031% in the Elmira Territory. Between 2007 and 2008 the number of assigned risks decreased in 66 of the 70 rating territories.

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

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

Territory		2007			2008			# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
		Assigned	Voluntary	Total	Assigned	Voluntary	Total				
01	Bronx Territory	6,693	49,818	56,512	4,240	55,959	60,199	-2,453	-36.6	3,688	6.5
03	Bronx Suburban Territory	6,785	174,929	181,714	5,045	174,926	179,971	-1,740	-25.6	-1,744	-1.0
05	Staten Island	3,157	239,590	242,748	2,270	240,219	242,489	-888	-28.1	-259	-0.1
07	Buffalo	2,844	120,639	123,483	2,714	122,399	125,113	-130	-4.6	1,629	1.3
08	Buffalo Semi-Suburban	2,090	177,551	179,641	1,733	174,413	176,146	-358	-17.1	-3,496	-1.9
09	Schenectady County	518	109,103	109,620	349	110,134	110,483	-169	-32.6	863	0.8
11	Rochester	6,897	351,715	358,612	6,239	348,459	354,697	-659	-9.5	-3,915	-1.1
12	Syracuse	1,706	213,711	215,416	1,421	210,390	211,811	-284	-16.7	-3,606	-1.7
13	Albany	540	167,354	167,894	372	165,043	165,415	-168	-31.1	-2,479	-1.5
14	Niagara Falls	1,300	71,613	72,914	1,147	72,050	73,197	-153	-11.8	284	0.4
15	Utica	131	62,025	62,157	80	62,253	62,333	-51	-39.3	176	0.3
16	Saratoga Springs Suburban	33	51,007	51,040	19	50,318	50,337	-14	-41.6	-703	-1.4
17	Kings County	2,082	355,227	357,309	1,660	365,784	367,444	-422	-20.3	10,135	2.8
18	Manhattan	4,249	167,293	171,541	2,598	170,386	172,984	-1,651	-38.9	1,443	0.8
19	Queens	1,573	66,242	67,814	1,019	73,210	74,230	-553	-35.2	6,416	9.5
20	Hempstead	5,921	432,910	438,831	4,428	421,792	426,220	-1,494	-25.2	-12,611	-2.9
21	North Hempstead	2,174	154,669	156,843	1,622	153,561	155,183	-552	-25.4	-1,660	-1.1
22	Oyster Bay	3,417	294,157	297,574	2,562	315,835	318,397	-855	-25.0	20,824	7.0
24	Rome	122	22,730	22,852	120	22,456	22,575	-3	-2.2	-277	-1.2
25	Auburn	35	23,864	23,899	23	24,109	24,132	-12	-34.9	232	1.0
27	Elmira	19	49,112	49,130	15	47,974	47,989	-4	-20.6	-1,141	-2.3
28	Binghamton	857	112,501	113,359	655	112,284	112,939	-203	-23.6	-420	-0.4
29	Gloversville	77	28,842	28,920	54	28,398	28,451	-24	-30.6	-468	-1.6
30	Saratoga Springs	22	25,174	25,195	22	25,210	25,232	1	2.6	37	0.1
31	Chautauqua County	330	86,466	86,795	269	86,878	87,147	-61	-18.4	351	0.4
32	Newburgh	918	69,699	70,616	787	68,633	69,420	-130	-14.2	-1,196	-1.7
33	Poughkeepsie	1,022	102,301	103,324	855	100,229	101,083	-168	-16.4	-2,241	-2.2
34	Troy	346	62,489	62,835	229	61,812	62,041	-116	-33.7	-794	-1.3
35	Amsterdam	35	22,249	22,285	19	21,845	21,864	-16	-46.4	-420	-1.9
36	Glens Falls	288	44,389	44,677	245	43,058	43,303	-43	-14.9	-1,374	-3.1
37	Oswego	309	38,125	38,433	298	39,074	39,372	-11	-3.6	938	2.4
38	Syracuse Suburban	83	73,386	73,470	57	78,371	78,428	-26	-31.5	4,959	6.7
39	Rochester Suburban	65	41,993	42,058	68	42,456	42,524	3	5.0	466	1.1
40	Corning	9	28,187	28,196	13	28,118	28,131	4	39.0	-65	-0.2
41	Erie County (Balance)	299	96,060	96,359	255	103,631	103,886	-44	-14.8	7,527	7.8
42	Buffalo Suburban	1,657	160,025	161,683	1,318	159,345	160,662	-340	-20.5	-1,020	-0.6
43	Niagara Falls Suburban	201	34,085	34,286	184	33,596	33,780	-17	-8.4	-506	-1.5
44	Broome County (Balance)	19	25,653	25,672	15	26,926	26,941	-4	-20.2	1,269	4.9

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

Territory		2007			2008			# Change	% Change	#Change	% Chng.
		Assigned	Voluntary	Total	Assigned	Voluntary	Total	In A/R	In A/R	in Market	in Mrkt.
46	Putnam County	801	77,294	78,095	592	77,948	78,541	-208	-26.0	445	0.6
47	Orleans County	68	25,974	26,042	52	26,008	26,060	-16	-23.5	17	0.1
48	Monroe County (Balance)	32	73,706	73,739	33	74,084	74,118	1	2.7	379	0.5
49	Niagara County (Balance)	97	34,131	34,228	81	35,087	35,168	-17	-16.9	940	2.7
51	Ontario County, etc.	999	203,761	204,760	886	203,462	204,348	-113	-11.3	-412	-0.2
52	Fort Plain, Herkimer	176	42,398	42,574	130	43,169	43,299	-46	-26.1	725	1.7
54	Cortland County, etc.	1,497	204,546	206,044	1,193	208,825	210,018	-304	-20.3	3,974	1.9
55	Queens Suburban	6,009	551,149	557,158	4,291	555,411	559,702	-1,719	-28.6	2,544	0.5
56	Saratoga County (Balance)	60	36,286	36,346	48	38,279	38,326	-12	-20.5	1,980	5.4
58	Dutchess County (Balance)	756	106,585	107,342	595	109,893	110,488	-161	-21.3	3,146	2.9
59	Columbia County, etc.	371	84,621	84,992	270	83,126	83,396	-101	-27.3	-1,596	-1.9
60	Genesee County	157	38,941	39,098	129	38,880	39,009	-27	-17.5	-89	-0.2
61	Delaware County, etc.	768	146,260	147,028	520	146,584	147,104	-249	-32.4	75	0.1
62	Highland, Kingston	1,139	86,988	88,127	867	86,524	87,391	-272	-23.9	-736	-0.8
64	Middletown	2,833	168,831	171,664	2,057	171,683	173,740	-777	-27.4	2,076	1.2
65	Ossining	2,966	183,185	186,151	2,294	183,819	186,113	-672	-22.7	-38	0.0
67	Clinton County, etc.	5,265	349,431	354,696	4,450	351,030	355,480	-815	-15.5	784	0.2
68	Rockland County	1,296	186,458	187,754	1,052	187,510	188,562	-244	-18.8	809	0.4
71	Saratoga County South	33	45,315	45,348	20	45,722	45,742	-13	-40.2	394	0.9
72	Albany County (Balance)	15	18,838	18,853	9	20,879	20,888	-6	-38.6	2,035	10.8
73	Rensselaer County (Balance)	145	45,337	45,482	93	46,829	46,922	-52	-35.8	1,440	3.2
74	Jefferson County	362	73,281	73,643	312	74,275	74,587	-50	-13.8	944	1.3
75	Suffolk County West	11,766	543,150	554,915	9,040	544,060	553,101	-2,725	-23.2	-1,815	-0.3
76	Suffolk County East	22,274	474,566	496,839	18,363	479,438	497,802	-3,911	-17.6	962	0.2
81	Monticello-Liberty	26	14,014	14,041	16	13,775	13,791	-11	-40.3	-250	-1.8
82	Sullivan County Central	83	16,380	16,463	60	16,462	16,523	-23	-27.2	60	0.4
83	Sullivan County (Balance)	184	24,070	24,254	154	23,555	23,709	-30	-16.4	-545	-2.2
84	Allegany County, etc.	1,532	188,125	189,657	1,245	188,117	189,362	-287	-18.7	-294	-0.2
86	Oneida	115	40,271	40,386	106	40,097	40,202	-10	-8.4	-184	-0.5
94	Mount Vernon and Yonkers	2,947	108,863	111,810	2,179	108,971	111,150	-768	-26.1	-660	-0.6
95	White Plains	1,283	46,431	47,714	1,025	44,373	45,398	-258	-20.1	-2,315	-4.9
97	New York City Suburban	5,225	229,933	235,157	4,046	235,994	240,040	-1,179	-22.6	4,883	2.1
	Entire State	**130,106**	**8,876,002**	**9,006,107**	**101,224**	**8,945,404**	**9,046,628**	**-28,882**	**-22.2**	**40,520**	**0.4**

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

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2002-2008															
		2002		2003		2004		2005		2006		2007		2008	
Territory		(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
01	Bronx Territory	46.7	1	47.0	1	35.8	1	26.9	1	18.3	1	11.8	1	7.0	1
76	Suffolk County East	8.4	7	10.0	6	8.7	6	7.2	4	5.5	2	4.5	2	3.7	2
03	Bronx Suburban Territory	14.0	4	15.4	4	11.4	3	8.2	3	5.5	3	3.7	3	2.8	3
95	White Plains	6.7	9	8.1	8	7.0	7	5.2	7	3.6	7	2.7	4	2.3	4
07	Buffalo	6.1	12	7.2	11	5.7	10	4.1	10	2.8	10	2.3	8	2.2	5
94	Mount Vernon and Yonkers	11.1	5	12.6	5	9.5	5	6.8	6	4.4	5	2.6	5	2.0	6
11	Rochester	3.4	21	3.8	20	3.2	20	2.7	18	2.3	11	1.9	11	1.8	7
97	New York City Suburban	6.0	13	6.7	13	5.6	11	4.3	8	3.1	8	2.2	9	1.7	8
75	Suffolk County West	6.5	10	7.6	10	6.0	9	4.3	9	2.9	9	2.1	10	1.6	9
14	Niagara Falls	2.8	28	3.6	22	3.4	19	2.8	17	2.1	15	1.8	12	1.6	10
18	Manhattan	16.2	3	15.7	3	10.5	4	7.0	5	4.2	6	2.5	6	1.5	11
19	Queens	19.1	2	18.6	2	12.7	2	8.2	2	5.0	4	2.3	7	1.4	12
67	Clinton County, etc.	3.3	23	3.5	24	3.2	22	2.6	21	1.9	19	1.5	15	1.3	13
65	Ossining	4.2	16	4.7	16	3.9	17	3.0	15	2.2	13	1.6	14	1.2	14
64	Middletown	4.2	17	4.7	17	4.0	16	3.2	14	2.3	12	1.7	13	1.2	15
32	Newburgh	2.8	29	3.5	23	3.1	23	2.3	23	1.7	22	1.3	19	1.1	16
21	North Hempstead	4.5	15	5.2	15	4.1	15	3.0	16	1.9	18	1.4	16	1.0	17
20	Hempstead	5.8	14	6.5	14	4.8	14	3.2	13	1.9	17	1.3	17	1.0	18
62	Highland, Kingston	3.7	19	3.9	19	3.2	21	2.4	22	1.8	20	1.3	20	1.0	19
08	Buffalo Semi-Suburban	2.3	33	2.7	30	2.4	27	2.0	25	1.4	23	1.2	21	1.0	20
05	Staten Island	6.1	11	7.0	12	5.3	12	3.7	12	2.1	14	1.3	18	0.9	21
33	Poughkeepsie	2.9	26	2.7	29	2.2	28	1.8	28	1.3	26	1.0	26	0.8	22
42	Buffalo Suburban	2.3	34	2.5	33	2.2	29	1.8	27	1.4	25	1.0	25	0.8	23
22	Oyster Bay	4.0	18	4.5	18	3.6	18	2.6	20	1.7	21	1.1	22	0.8	24
55	Queens Suburban	10.0	6	10.0	7	6.3	8	3.8	11	2.0	16	1.1	23	0.8	25
37	Oswego	3.4	22	3.5	25	2.4	26	1.6	30	1.0	32	0.8	28	0.8	26
46	Putnam County	3.2	24	3.2	26	2.6	25	2.0	24	1.4	24	1.0	24	0.8	27
12	Syracuse	2.2	36	2.5	34	1.7	37	1.3	36	0.9	35	0.8	29	0.7	28
84	Allegany County, etc.	2.2	38	2.4	35	1.9	35	1.5	32	1.1	29	0.8	27	0.7	29
83	Sullivan County (Balance)	2.2	37	2.4	36	2.1	30	1.6	29	1.1	30	0.8	30	0.6	30
28	Binghamton	2.4	31	2.6	31	2.0	32	1.5	31	1.1	31	0.8	31	0.6	31
54	Cortland County, etc.	2.1	39	2.1	39	1.7	39	1.3	35	1.0	34	0.7	32	0.6	32
36	Glens Falls	2.3	32	2.3	37	1.8	36	1.3	37	0.9	36	0.6	35	0.6	33
68	Rockland County	3.1	25	3.8	21	3.0	24	2.0	26	1.2	27	0.7	34	0.6	34
43	Niagara Falls Suburban	1.6	47	1.9	41	1.5	40	1.2	38	0.8	38	0.6	36	0.5	35
58	Dutchess County (Balance)	2.7	30	2.6	32	1.9	34	1.4	34	1.0	33	0.7	33	0.5	36
24	Rome	1.9	41	1.9	40	1.4	43	1.0	44	0.8	40	0.5	39	0.5	37
17	Kings County	8.4	8	8.1	9	4.8	13	2.7	19	1.1	28	0.6	37	0.5	38
51	Ontario County, etc.	1.7	43	1.8	44	1.5	41	1.0	42	0.7	44	0.5	43	0.4	39
74	Jefferson County	1.5	49	1.4	50	1.3	45	1.0	43	0.7	41	0.5	42	0.4	40

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2002-2008

Territory		2002 (%)	2002 Rank	2003 (%)	2003 Rank	2004 (%)	2004 Rank	2005 (%)	2005 Rank	2006 (%)	2006 Rank	2007 (%)	2007 Rank	2008 (%)	2008 Rank
34	Troy	2.8	27	2.7	28	2.1	31	1.5	33	0.9	37	0.6	38	0.4	41
82	Sullivan County Central	3.4	20	3.1	27	1.9	33	1.2	40	0.7	43	0.5	41	0.4	42
61	Delaware County, etc.	2.2	35	2.3	38	1.7	38	1.2	39	0.8	39	0.5	40	0.4	43
60	Genesee County	1.1	51	1.3	51	1.0	50	0.7	52	0.5	49	0.4	47	0.3	44
59	Columbia County, etc.	1.8	42	1.6	46	1.3	44	0.8	45	0.6	46	0.4	45	0.3	45
09	Schenectady County	1.6	45	1.8	43	1.4	42	1.0	41	0.7	42	0.5	44	0.3	46
31	Chautauqua County	1.0	55	1.1	52	1.0	51	0.8	49	0.5	47	0.4	48	0.3	47
52	Fort Plain, Herkimer	1.5	48	1.6	47	1.2	46	0.8	46	0.6	45	0.4	46	0.3	48
86	Oneida	1.0	53	1.0	54	0.8	55	0.5	56	0.4	57	0.3	52	0.3	49
41	Erie County (Balance)	1.0	54	1.0	55	0.8	54	0.7	51	0.4	51	0.3	51	0.2	50
49	Niagara County (Balance)	0.7	60	0.8	61	0.7	57	0.5	57	0.4	53	0.3	53	0.2	51
13	Albany	2.0	40	1.9	42	1.2	47	0.8	47	0.5	50	0.3	49	0.2	52
47	Orleans County	1.6	46	1.5	48	1.0	52	0.6	54	0.4	52	0.3	55	0.2	53
73	Rensselaer County (Balance)	1.4	50	1.5	49	1.2	49	0.8	48	0.5	48	0.3	50	0.2	54
29	Gloversville	0.7	61	1.0	57	0.9	53	0.6	53	0.4	54	0.3	54	0.2	55
39	Rochester Suburban	0.5	66	0.6	62	0.4	62	0.3	60	0.2	60	0.2	60	0.2	56
15	Utica	0.9	56	1.1	53	0.8	56	0.5	55	0.4	56	0.2	56	0.1	57
56	Saratoga County (Balance)	0.9	57	0.8	60	0.6	59	0.4	58	0.2	58	0.2	58	0.1	58
81	Monticello-Liberty	1.7	44	1.7	45	1.2	48	0.7	50	0.4	55	0.2	57	0.1	59
25	Auburn	0.8	59	0.9	58	0.5	60	0.3	61	0.2	59	0.1	61	0.1	60
30	Saratoga Springs	0.6	64	0.5	65	0.4	63	0.3	62	0.2	62	0.1	63	0.1	61
35	Amsterdam	0.8	58	0.8	59	0.6	58	0.4	59	0.2	61	0.2	59	0.1	62
38	Syracuse Suburban	0.5	67	0.5	66	0.3	65	0.2	63	0.2	63	0.1	62	0.1	63
44	Broome County (Balance)	0.6	63	0.5	64	0.3	67	0.2	66	0.1	64	0.1	65	0.1	64
72	Albany County (Balance)	0.7	62	0.5	63	0.4	64	0.2	64	0.1	66	0.1	64	0.0	65
40	Corning	0.2	70	0.1	70	0.1	70	0.1	70	0.0	70	0.0	70	0.0	66
48	Monroe County (Balance)	1.0	52	1.0	56	0.5	61	0.2	67	0.1	68	0.0	68	0.0	67
71	Saratoga County South	0.4	68	0.4	68	0.3	68	0.2	68	0.1	67	0.1	66	0.0	68
16	Saratoga Springs Suburban	0.5	65	0.5	67	0.3	66	0.2	65	0.1	65	0.1	67	0.0	69
27	Elmira	0.2	69	0.1	69	0.1	69	0.1	69	0.0	69	0.0	69	0.0	70
	Entire State	**5.3**		**5.6**		**4.2**		**3.0**		**2.0**		**1.4**		**1.1**	

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

c. Workers' Compensation Insurance

New York moved to a loss cost system on October 1, 2008. On May 15, 2009, the New York Compensation Insurance Rating Board (NYCIRB) filed, on behalf of its members and subscribers, a 5.8% increase in average workers' compensation loss costs. This request was later revised to a 4.5% increase. This change, along with a +0.7% change in the New York Assessment Fee, produced an average increase in loss costs to policyholders of 5.2%.

A 1.6% increase due to reform legislation is included in the 5.2% increase mentioned above. This is the estimated effect of increases in maximum weekly benefits resulting from New York Legislative Bill A. 6163/S.3322 of 2007 and the increased surcharge on hospital inpatient and outpatient services imposed by the Health Care Reform Act effective April 1, 2009.

Now that the NYCIRB only files loss costs, all insurers, in order to produce a manual rate, are required to have loss cost multipliers (LCM). 31 new or revised LCMs were approved in 2009, as listed on Table 48.

Table 46
WORKERS' COMPENSATION DIVIDEND CLASSIFICATION PLAN APPROVED 2009

Plan Types:

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

COMPANY NAME	PLAN TYPE	APPROVAL DATE
Church Mutual Ins. Co.	B	05/26/09
Travelers Casualty Ins. Co. of America	B	05/26/09
Merchants Mutual Ins. Co.	B	10/29/09

Table 47-A
WORKERS' COMPENSATION RATE HISTORY
New York Compensation Insurance Rating Board*
New York State, 1980-2008

Effect. Date	Policy Year	Calendar Year	Law Amendments & Medical & Hospital Agreements Indemnity	Medical	Wage & L/R Trend Factors	Expenses	Effect on Rate Level	Assessments WCB	SDF&RCF	Filed	Approved	Cumulative Approved
7/80	-4.5%	-7.1%	0.0%		1.0133	-4.1%		-0.1%	-2.5%	-3.1%	-10.1%	-10.1%
10/80										2.9%	2.9%	-7.5%
7/81	-11.5%	-11.5%	7.7%		0.8600	-3.1%		-0.4%	0.3%	-14.3%	-20.4%	-26.4%
7/82	-4.6%	-11.6%	4.3%		0.9895	0.3%		0.1%	1.2%	-2.1%	-3.4%	-28.9%
7/83 [1]	-0.3%	-7.8%	19.5%		0.8807	-0.1%		0.1%	-4.1%	5.4%	-2.0%	-30.3%
7/84	6.6%	3.5%	7.8%		0.8979	3.8%		0.1%	2.6%	9.4%	8.1%	-24.6%
7/85 [2]	7.7%	0.9%	8.3%		0.9725	2.2%		-0.3%	-1.5%	14.2%	10.2%	-17.0%
7/86	-1.3%	-8.4%	3.8%		0.9257	3.0%		0.2%	1.0%	1.5%	-4.7%	-20.9%
7/87	7.5%	12.8%	2.2%		0.9134	0.4%		0.3%	0.5%	6.5%	5.1%	-16.9%
7/88	9.2%	12.2%	7.2%		0.9470	0.7%		-0.4%	-1.4%	28.3%	11.1%	-7.7%
7/89	17.6%	22.5%	2.0%		0.9254	0.7%		-0.3%	1.5%	28.5%	15.5%	6.6%
7/90	12.8%	13.5%	18.0%	3.4%	0.9478	0.4%		-0.4%	-0.7%	39.1%	29.4%	38.1%
7/91	23.4%	20.9%	3.7%	2.1%	0.9012	-4.2%		0.3%	4.1%	25.1%	15.3%	59.2%
7/92	20.5%	13.1%	4.2%	1.2%	0.9500	-0.3%		-0.4%	4.1% [3]	18.4%	15.6%	84.1%
7/93	12.0%	17.1%	1.0%		1.0010	0.0%		-0.3%	-1.0% [3]	18.7%	14.4%	110.6%
4/94	-4.9%	-0.1%	-1.9% [4]		1.0010	0.0%	-16.3% [5]		13.5% [5]	-5.0%	-5.0%	100.1%
10/94	8.0%	1.9%	0.8%		0.9640	-1.2%	1.4%		-3.1%	-1.6%	-1.7%	96.7%
10/95	-17.1%	-15.3%	0.05%		1.0960	0.8%	-8.4%		3.7%	-2.8%	-5.0%	86.9%
	Pol. Yr.	**Acc. Yr.**										
10/96	-14.9%	-16.5%	-3.2%		1.0430	0.0%	-14.9%		-0.2%	-15.1%	-18.2%	52.9%
10/97	-9.1%	-9.5%	0.0%		1.0140	-0.1%	-7.5%		-1.0%	-3.8%	-8.4%	40.1%
10/98	8.9%	2.9%	0.0%		0.9080	0.8%	-3.1%		-3.0%	-0.4%	-6.0%	31.7%
10/99	17.1%	8.5%	0.0%		0.9860	1.2%	0.0%		3.9%	17.0%	3.9%	36.8%
10/00	4.5%	-0.2%	0.0%		0.962	0.1%	-2.5%		2.6%	0.0%	0.0%	36.8%
10/01	0.4%	-3.5%	0.0%		1.020	-0.1%	0.4%		-1.8%	-1.4%	-1.8%	34.3%
10/02	3.4%	-2.5%	0.0%		0.961	0.5%	0.0%		-1.2%	8.1%	-1.2%	32.7%
10/03	11.8%	11.1%	0.0%		1.000	-0.1%	0.0%		1.2%	12.6%	1.2%	34.3%
12/03	14.5%	3.7%	0.0%		0.934	-0.1%	0.0%			1.7%	1.7%	36.5%
10/04	27.6%	33.2%	0.0%		1.018	-1.9%	29.3%		0.7%	30.2%	0.7%	37.5%
10/05	18.4%	8.7%	0.0%		1.048	-2.1%	16.1%		2.1%	18.5%	7.2%	47.4%
10/06	-4.0%	-3.3%	0.0%		1.108	-0.5%	7.5%**		0.9%	8.5%	0.9%	48.7%
10/07	-5.2%	-4.6%	-13.3%		1.055	-1.3%	-13.6%		-3.1%	-16.3%	-20.5%	18.2%
10/08	A loss cost system went into effect. Rates are no longer filed by the NYCIRB.											

[1] Includes Stock Security Fund Tax of 1.012. [2] The Loss Constant Offset was removed in 1985.
[3] Includes OSHA assessment of 1.25%. [4] Includes elimination of 13.0% Hospital Surcharge.
[5] Assessments are included in a fee. In April 1994, this produced an effect of -15.0% on the rate level.

* Rate changes apply to all workers' compensation insurers; approved deviations from these filed rates appear in the subsequent table.

Note: Columns (1) – (11) reflect the Rating Board's *filed rate request*; the final two columns reflect the *rate changes approved by the Department*.

**7.5%=.96(6.8%) + .04(24.0%)

Table 47-B
WORKERS' COMPENSATION LOSS COST* HISTORY
New York Compensation Insurance Rating Board
New York State, 2008-2009**

(1) Effect. Date	(2) Most Recent Policy Yr. Indication	(3) One Year Prior Policy Yr. Indication	(4) Legislative Changes	(5) Wage & Claim Cost & Frequency Trend Factors	(6) Change in Loss Adjustment Expenses	(7) Effect on Rate Level	(8) Assessments	(9) Filed	(10) Approved	(11) Cumulative Approved
10/08	-7.5%	-9.9%[1]	+3.5%	1.000	1.000	-6.4%	-3.5%	-9.7%	-9.7%	-9.7%
10/09	+4.2%	+2.5%	+1.6%	1.000	1.008	+5.8%	+0.7%	+6.5%	+5.2%	-5.0%

* Loss costs apply to all workers' compensation insurers; approved loss cost multipliers applied to these loss costs appear in the subsequent table.
** A loss cost system went into effect on October 1, 2008. Prior to that, rates were filed by the NYCIRB.

[1] The NYCIRB's 2008 filing included 2006 policy year and 2007 accident year experience. Column (2) shows the policy year indication and column (3) shows the accident year indication.

Note: Columns (2) – (9) reflect the Rating Board's *filed loss cost request*; the final two columns reflect the *rate changes approved by the Department*.

Table 48

Workers Compensation Expense Constants and Loss Cost Multipliers

Approved As of December 31, 2009

NAIC Code	Group Name	Company Name	Expense Constant	Loss Cost Multiplier	Renewal Effective Date
15586	Tower Grp	Preserver Ins Co	$200	1.0340	01/08/09
21857	Allianz Ins Grp	American Ins Co	$200	1.4950	02/01/09
21873	Allianz Ins Grp	Firemans Fund Ins Co	$200	1.0870	02/01/09
21881	Allianz Ins Grp	National Surety Corp	$200	1.2230	02/01/09
13608	Fire Districts	FDM Preferred Ins Co Inc	$200	1.0800	04/14/09
13610	Fire Districts	Fire Districts Ins Co Inc	$200	1.4600	04/14/09
12831	State Natl Grp	State Natl Ins Co Inc	$50	1.2312	10/01/08
35408	Lightyear Delos Grp	Delos Ins Co	$200	1.2500	08/24/09
11024	Greater NY Grp	Strathmore Ins Co	$200	1.1600	09/01/09
29700	Swiss Re Grp	North Amer Elite Ins Co	$250	1.4210	10/01/09
29874	Swiss Re Grp	North Amer Specialty Ins Co	$250	1.4210	10/01/09
13528	NA	Brotherhood Mut Ins Co	$140	1.2700	10/01/09
22357	Hartford Fire & Cas Grp	Hartford Accident & Ind Co	$200	1.0450	10/01/09
29424	Hartford Fire & Cas Grp	Hartford Cas Ins Co	$200	1.2410	10/01/09
19682	Hartford Fire & Cas Grp	Hartford Fire In Co	$200	1.1750	10/01/09
37478	Hartford Fire & Cas Grp	Hartford Ins Co Of The Midwest	$200	1.0450	10/01/09
30104	Hartford Fire & Cas Grp	Hartford Underwriters Ins Co	$200	1.3710	10/01/09
34690	Hartford Fire & Cas Grp	Property & Cas Ins Co Of Hartford	$200	1.4370	10/01/09
11000	Hartford Fire & Cas Grp	Sentinel Ins Co Ltd	$200	1.1100	10/01/09
27120	Hartford Fire & Cas Grp	Trumbull Ins Co	$200	1.0450	10/01/09
29459	Hartford Fire & Cas Grp	Twin City Fire Ins Co	$200	1.3060	10/01/09
10472	Alleghany Grp	Capitol Ind Corp	$200	1.2000	11/01/09
10642	NA	Cherokee Ins Co	$0	1.3300	10/26/09
23582	Harleysville Grp	Harleysville Ins Co	$200	1.4590	07/15/10
33235	Harleysville Grp	Harleysville Ins Co of NY	$200	1.1700	07/15/10
35696	Harleysville Grp	Harleysville Preferred Ins Co	$200	1.1000	07/15/10
26182	Harleysville Grp	Harleysville Worcester Ins Co	$200	1.2750	07/15/10
21709	Zurich Ins Grp	Truck Ins Exchange	$200	1.3600	12/01/09
21105	Fairfax Fin Grp	North River Ins Co	$200	1.2210	01/01/10
21113	Fairfax Fin Grp	United States Fire Ins Co	$200	1.3570	01/01/10
31348	Fairfax Fin Grp	Crum & Forster Ind Co	$200	1.4250	01/01/10

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

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

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

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

In the 2004 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease. In the 2005 and 2006 fund years, the net value fell below $150 million, and contributions continued. In the 2007 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease. In the 2008 and 2009 years, the net value of the PCISF was determined once again to be greater than $150 million, and contributions ceased.

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, 1988-2009*

Fund Year	Estimated Quarterly Contributions (in millions)
1988	$15.0
1989	7.5
1990	5.5
1991	25.0
1992	7.5
1993 – 97	0
1998	8.3
1999	4.0
2000	18.8
2001	3.4
2002	21.4
2003	23.5
2004	28.1
2005	31.1
2006	38.0
2007	12.5
2008	0.0
2009	0.0

* During 1993, settlement was reached with respect to *Alliance of American Insurers et al. v. Chu et al*. The 1993 through 2008 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 is responsible 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, health maintenance organizations (HMOs), commercial insurance companies licensed to do accident and health insurance business, fraternal benefit societies and municipal cooperative health benefit plans.

The Bureau has regulatory authority over all aspects of the fiscal solvency and market conduct of 104 insurers, HMOs, and other managed care organizations as of December 31, 2009. These consist of 33 accident and health insurers, one life insurer (writing predominantly accident and health insurance), nine health service corporations, and three medical and dental expense indemnity corporations, 22 Article 44 Public Health Law HMOs, 10 Article 47 Insurance Law municipal cooperative health benefits plans, 16 managed long term care plans and 10 continuing care retirement communities authorized pursuant to Article 46 of the Public Health Law.

The Bureau received two acquisition-of-control applications in 2009, one which requested approval for United Health Group to acquire an accident and health insurer, HealthNet Insurance Company, which is still pending, and one which was disapproved.

In 2009, the Bureau continued its review of a plan of conversion into for-profit status submitted by two not-for-profit health service corporations, Group Health, Inc. and the Health Insurance Plan of Greater New York. The plan calls for Group Health, Inc. to convert to a for-profit corporation, then merge with an accident and health insurer, HIP Insurance Company of New York. The plan further calls for two for-profit HMOs, GHI-HMO Select, Inc. and ConnectiCare of New York, Inc. to merge and to absorb the Health Insurance Plan of Greater New York's membership. All of the concerned companies are affiliates. The plan is pending.

Five Article 42 accident and health licensing applications were under review during 2009, (three foreign and two domestic). Two of these were for insurers writing the new Medicare Part D Prescription Drug Coverage. Of the five applications, four remained under review as of December 31, 2009.

Three HMOs submitted applications to receive "certificates of authority" to operate in New York State in 2009. HMOs are jointly regulated by this Department as well as the Department of Health. The Department of Health issues the certificate of authority to HMOs. During 2009, two HMOs received their certificate of authority and one is still pending.

Four Managed Long Term Care plans submitted applications to receive certificates of authority to operate PACE programs and two previously certified plans submitted applications to expand their operations into additional counties in New York State in 2009. Managed Long Term Care plans are jointly regulated by this Department as well as the Department of Health. The Department of Health issues the certificates of authority to these plans. During 2009, two of the plans received their certificate of authority to expand their operation, one is awaiting the Department of Health to issue its certificate of authority, and the remaining three are still under review.

One HMO is in the process of winding down its operations and will have no members as of December 31, 2009.

One HMO submitted an expansion application which was currently under review as of December 31, 2009.

The Bureau is monitoring the financial condition of four financially distressed HMOs, one Article 43 health service corporation and two Article 42 companies on a monthly basis.

Two applications for the determination of non-control were submitted (1 HMO and 1 Article 42 A&H insurer). One application was approved and one is still pending.

Two Derivative Use Plans were submitted and are currently under review.

One application for the formation of Article 47 municipal cooperative health benefit plans was submitted and is pending.

2. Accident and Health Insurers

Thirty one companies were licensed to transact only accident and health insurance at year-end 2008. The Bureau regulates the fiscal solvency and market conduct of one life insurer, and financial data of this life insurer is included in the following table:

Table 50
SELECTED ANNUAL STATEMENT DATA
Accident and Health Insurers*
2006-2008
(dollar amounts in millions)

	2008	2007	2006
Number of Insurers	32	29	27
Net premiums written	$14,319.1	$13,977.1	$12,677.0
Admitted assets	16,150.4	15,495.4	14,518.4
Policy and contract claims	1,936.8	1,648.3	1,872.1
Other liabilities	8,064.2	7,425.9	6,809.4
Capital	50.8	43.2	37.1
Surplus	6,096.0	6,377.9	5,779.8
Ratio of premiums written to capital and surplus	2.3	2.2	2.2

*Data includes one life insurer.

3. Article 43 and Article 44 Corporations

Article 43 of the Insurance Law governs various nonprofit health insurers. Article 44 of the Public Health Law governs HMOs.

a. Subscriber Rate Changes

Chapter 504 of the Laws of 1995 established a “file and use” procedure for premium rate changes for Article 43 and Article 44 corporations. This procedure is an alternative to the prior approval requirements of Section 4308(c) of the Insurance Law under specific conditions. The file and use 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 medical loss ratio will meet the minimum and maximum loss ratios prescribed in Insurance Law Section 4308(g). Premium adjustments using this methodology were previously limited to no more than 10% annually, but the annual cap was removed effective as of January 1, 2000. The 2008 file and use rate filings were as follows:

Type of Company	Filings
HMOs (Article 44)	57
Article 43 Corporations	21

b. Article 43 and Article 44 Corporations

The following tables show aggregate figures on assets, liabilities, surplus funds, premium income and membership for years 2006-2008:

Table 51
ARTICLE 43 HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
2006-2008
(dollar amounts in millions)

	2008	2007	2006
Number of Companies	9	9	9
Admitted Assets	$5,472.5	$5,749.4	$5,426.0
Liabilities	2,936.6	2,696.2	2,634.9
Surplus Funds	2,535.9	3,053.2	2,791.1
Net Premium Income:			
Hospital	7,518.1	7,554.0	7,465.3
Medical/Dental	7,750.3	6,929.4	6,254.0
Number of Contracts & Riders in Force:			
Hospital	1.2**	1.3**	1.4**
Medical/Dental	1.8**	1.8**	1.7**

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

Table 52
ARTICLE 43 MEDICAL & DENTAL EXPENSE INDEMNITY CORPORATIONS
Selected Data, New York State
2006-2008
(dollar amounts in millions)

	2008	2007	2006
Number of Companies	3	3	3
Admitted Assets	$68.0	$57.2	$56.3
Liabilities	43.3	32.9	45.8
Surplus Funds	24.6	24.3	10.5
Net Premium Income	117.0	98.6	54.0
Number of Contracts in Force	2,061	1,853	1,599

Table 53
ARTICLE 44 HEALTH MAINTENANCE ORGANIZATIONS
That Are a Line of Business of a Health Service Corporation*
Selected Data, New York State
2006-2008
(dollar amounts in millions)

	2008	2007	2006
Number of Companies	3	3	3
Net Premium Income	$6,969.3	$7,020.3	$6,957.2
Number of Participants	1.4**	1.6**	1.7**

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

Table 54
ARTICLE 44 HEALTH MAINTENANCE ORGANIZATIONS
That Are Not a Line of Business
Selected Data, New York State
2006-2008
(dollar amounts in millions)

	2008	2007	2006
Number of Companies	18	18	19
Admitted Assets	$5,318.5	$5,391.7	$5,255.7
Liabilities	2,063.1	2,035.4	2,410.6
Surplus Funds	3,255.4	3,353.2	2,845.1
Net Premium Income	12,805.5	12,467.9	12,600.0
Number of Participants	2.3*	2.6*	3.0*

*in millions

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

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

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

Throughout 2009, the Department has been reviewing the plan of conversion to determine whether or not it fulfills the criteria for a approval as set forth in the law, specifically that it "will not adversely affect the applicant's contract holders or members, will protect the interests of and will not negatively impact the delivery of health care benefits and services to the people of New York and results in the fair, equitable and convenient winding down of the business and affairs of the applicant."

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

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

5. Examinations and Investigations Conducted by the Health Bureau

During 2009, the field unit of the Health Bureau conducted 48 examinations of various regulated entities. The 2009 examinations and investigations by regulated entity and type are presented below:

	Total	Examinations [(1)] Commenced in 2009	Examinations Commenced Prior to 2009
By Regulated Entity			
CCRC	6	3	3
Article 42 Insurer	15	4	11
Article 43 Corp	8	2	6
HMO	15	6	9
Muni-Coop	2	1	1
MLTCP	2	1	1
Total	**48**	**17**	**31**

	Total	Examinations [1] Commenced in 2009	Examinations Commenced Prior to 2009
By Type			
Financial	16	5	11
Market Conduct	4	2	2
On Organization	1	1	0
Combined	27	9	18
Total	**48**	**17**	**31**

[1] In 2006, the National Association of Insurance Commissioners (NAIC) adopted revisions to the Financial Condition Examiners Handbook (Handbook) relating to a revised risk-focused examination approach for financial examinations. This new examination method is required for all examinations beginning on or after January 1, 2010, however, the NAIC allowed state examiners to begin implementing the revised examination approach prior to this time. The risk-focused examination is meant to broaden and enhance the identification of risk inherent in an insurer's operations and to utilize that evaluation in formulating the ongoing surveillance of an insurer. In accordance with the revisions made to the Handbook, the Bureau places greater focus upon a company's risk management culture, corporate governance structure, risk assessment programs and control environment.

In 2009, the Health Bureau conducted four such risk-focused (financial) examinations.

6. SERFF

To respond to the needs of the industry, the Health Bureau began accepting electronic filings of health insurance policy forms and premium rates through the NAIC's System for Electronic Rate and Form Filing (SERFF) in late 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," and databases containing the submission requirements for each product depending on the type of review requested.

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

In the calendar year 2005 (the first full year SERFF submissions were received), the number of form and rate filings submitted via SERFF averaged 36%. For the calendar year 2006, the total number of SERFF submissions increased to 48%. In 2007, the total number of SERFF filings continued to trend upward, reaching 77%. In 2008, the total number of SERFF electronic submissions increased significantly reaching more than 94%. In 2009, the total number of SERFF filings rose to over 97%.

The Health Bureau formed an internal workgroup, the Rate and Form Filing Task Force (RAFFT), to continue SERFF/speed-to-market compliance initiatives, provide for structured monitoring and maintenance, and improve the rate and form filings process and review. The group meets bi-weekly to review the workload level and the processes for filing submission and review.

As part of its commitment to increase communication with the industry, the RAFFT team has presented full-day Filing Compliance Seminars for industry filers, offering presentations on specific topics and an opportunity for industry participants to meet directly with each unit of the Bureau that reviews their filings. RAFFT's PowerPoint presentations from these seminars are also posted on the Department's Web site as a reference tool for the industry.

7. Review of Accident and Health Policy Form Submissions

In 2009, the Health Bureau made final dispositions on 1,543 accident and health policy form submissions (see Table 55). A submission consists of one or more policy forms and, in some cases, related supporting actuarial material. These submissions were comprised of a wide range of accident and health insurance products from many different types of insurers and are offered in the individual, small group and large group markets. Insurers may use several means to obtain expedited review of their submissions. Highest priority is given to fast track and deemer submissions submitted through SERFF. Of the 1,543 submissions disposed in 2009, 194 (13%) of them were submitted using fast track and/or deemer. (Fast track submissions are submissions made under the optional expedited prior approval using a certification process pursuant to Circular Letter No. 4 (2003). Deemer submissions are submissions made under the expedited approval procedure set forth in Section 3201(b)(6) of New York Insurance Law.)

Table 55
ACCIDENT & HEALTH
Disposition of Policy Form Submissions
2009

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Frat	Total
Approved	132	381	81	171	2	0	**767**
Not Accepted / Circular Letter 14 (1997)*	1	59	32	3	1	0	**96**
Lack of Company Action	0	11	16	0	0	0	**27**
Disapproved	0	2	1	0	0	0	**3**
Filed for Reference	2	86	82	14	0	0	**184**
Prefiled	3	65	0	24	0	0	**92**
Withdrawn	6	41	15	5	2	0	**69**
Filed for Out-of-State Use	1	233	48	2	1	0	**285**
Other	2	4	12	0	2	0	**20**
Total	**147**	**882**	**287**	**219**	**8**	**0**	**1543**

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

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

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

The Accident and Health Rating Section received 1,519 rate filings and disposed of 1,544 rate filings during 2009. These include initial rate filings for new policy forms submitted by commercial insurers, Article 43 corporations, Article 44 HMOs, as well as rate adjustment filings (primarily for commercial insurers), commission filings, experience monitoring filings, and rate manual revisions. In 2009 about 93% of the accident and health rate filings were received through SERFF.

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

9. Inquiries and Complaints

In response to formal written inquiries and complaints to the Department, the Health Bureau provided written answers to more than 240 consumer inquiries and responded to more than 250 Freedom of Information Law (FOIL) requests concerning accident and health insurance and related issues in 2009.

In addition, the Health Bureau monitors a dedicated electronic mailbox on the Department's Web site. In 2009, the Health Bureau received and responded to approximately 530 Health Mailbox inquiries from consumers, providers, health plans, attorneys, consumer advocate groups and state agencies. The most common electronic inquiries the Health Bureau received in 2009 included consumer complaints regarding increased premium rates, consumer inquiries relating to health insurance options in New York State, consumer complaints against their health plans, pre-existing condition provisions in health policies, mandated benefits, utilization review requirements, external appeals, continuation of coverage under COBRA or state continuation, extension of coverage to dependents up to age 29, and employer responsibilities in providing health insurance coverage.

In 2009, Bureau staff also responded to approximately 10,000 telephone inquiries received daily on many health insurance related topics from various sources.

10. Utilization Review Reports

Article 49 of the Insurance Law requires health insurers and utilization review agents under contract with health insurers to biennially report to the Superintendent on utilization review activities. During 2009, several new reports and updates to existing reports by utilization review agents were submitted.

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

Recently completing its tenth 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, 2009, the Department has received 25,839 external appeal requests.

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

The 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. Department staff is also available to handle external appeals submitted during business hours and after the close of business, and two Department staff members are on call each weekend to handle expedited appeals.

Information about the external appeal program is available on the Department's Web site at www.ins.state.ny.us. In addition, the 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 2009, the Department received and responded to 6,451 hotline calls.

Along with monitoring the number of hotline calls, the Department also tracks external appeal results for each year of operation of the program. In 2009, the Department received 4,260 external appeal requests, which represented an 8% increase from the previous year. In 2009, 350 external appeal requests were closed because health plans voluntarily reversed the denial during the external appeal process, 2,033 determinations were rendered by external appeal agents, 1,783 external appeal requests were determined to be ineligible for external appeal, and 317 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 40% of health plan denials were overturned in whole or in part by external appeal agents and 60% were upheld by external appeal agents in 2009. 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, 2009 — December 31, 2009

Type of Denial	Total	Overturned	Overturned in Part	Upheld
Medical Necessity	1,787	577	123	1,087
Experimental/Investigational	240	108	3	129
Clinical Trial	1	1	0	0
Out-of-Network	5	3	0	2
Total	**2,033**	**689**	**126**	**1,218**

Table 56B
EXTERNAL APPEAL DETERMINATIONS BY AGENT
January 1, 2009 — December 31, 2009

Agent	Total	Overturned	Overturned in Part	Upheld
IMEDECS	649	231	48	370
IPRO	652	229	38	385
MCMC	732	229	40	463
Total	**2,033**	**689**	**126**	**1,218**

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

12. Market Stabilization Mechanisms

The Health Bureau oversees the operations of the New York Market Stabilization Pools. The Pools were initially established by Chapter 501 of the Laws of 1992 and associated 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. These funds are then re-distributed, through the pool formula, to insurers and HMOs that insure a disproportionately large share of high-risk, high-cost persons in the same markets.

In 2007, the Health Bureau worked with carriers to create a new and simplified mechanism to stabilize premiums in the individual and small group market. The mechanism provides that carriers must contribute to a market stabilization pool for any classes of business they insure that have a

relatively lower proportion of high cost claims than other carriers in their region(s) of operation. Conversely, for any classes of business they insure that have a relatively higher proportion of high cost claims, carriers will receive risk adjustment pool disbursements. Carriers are to estimate what they expect to receive from the pools and apply those amounts to the classes of business that gave rise to the estimated distributions, to help hold down premium rates in those generally higher cost lines of business. The Health Bureau collected 2006 data to model the results of the new mechanism and provided carriers with the calculated distributions based on that model data to assist them in estimating their respective 2007 pool receivables. In February 2008, data submissions detailing actual 2007 claims paid were collected, and carriers' payments due to and from the pools were calculated. Carriers sustaining relatively lower ratios of high cost claims, indicating less coverage of high risk high cost persons, were directed to pay into the pools, and reciprocally, carriers with relatively higher high cost claim ratios received disbursements, which they are required to use to help mitigate rate increases in the lines of business sustaining the higher relative costs. Total payments due to the pools were calculated at just under $80 million, which was the 2007 pool funding cap established in the Regulation 146. Most distributions were made in the 3rd quarter of 2008 and all remaining distributions have since been made. Data submissions for the 2008 calendar year were collected by February 28, 2009. The total net payments due from all net payors totaled just under $100 million, well under the $120 million Pool funding cap for 2008. Contributions were collected in June 2009 and distributions paid out in July 2009. For the 2009 Pool year, the data collection and calculation process is in progress and it is anticipated total pool contributions will again be well under the annual funding cap of $160 million.

In the Medicare Supplement market, a pool based on the average relative demographic profile of each carrier's insured population in comparison to the average profile of all carriers in its region of operation is used to determine whether a carrier is insuring a relatively lower risk/lower cost population or a higher risk/higher cost population that the average. Those with relatively low cost averages contribute to the pools to help stabilize the rates of those insuring relatively higher cost risks. The Medicare Supplement pool has been in place since 1993, and the form of pooling is the same as originally constructed under Department Regulation 146 at that time. Total contributions to the Medicare Supplemental Pool for 2008 were approximately $16.5 million. Although the final figures have not yet been determined, it is projected that total contributions to the Medicare Supplemental Pool will be approximately $15.8 for 2009.

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

The Health Care Reform Act of 2000 (HCRA II) required the Insurance Department to administer the ongoing operations of a unique program designed to ensure that individual consumers have continued access to comprehensive health insurance. HCRA II allocated $130 million over a three and a half-year period commencing January 1, 2000, and ending July 1, 2003, to direct payment market reforms. For the HCRA III and HCRA IV periods, funding was renewed at $40 million per year. Funding had remained at $40 million each year since 2003. In 2008, however, funding was reduced by 2% to $39.2 million. Funding remained at $39.2 million for 2009.

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

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

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

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

During 2009, the Department directed the administrator to conduct the necessary audit procedures with respect to the reimbursement requests submitted by carriers for 2008 claims. In addition, the administrator was asked to tabulate and render a comprehensive proposed distribution summary for Department review. As in the prior years, the total reimbursement requests for Calendar Year 2008 exceeded the total funding available in both the standard direct payment business and the direct payment out-of-network (point-of-service) business. The fund administrator was directed to reduce the amounts requested on a pro-rata basis to match available funding in each of the respective funds.

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

Product	Requested Reimbursement	Funding Available	Percentage Reimbursed
Standard HMO Direct Payment	$61,594,357	$19,600,000	31.8%
Out-of-Plan (POS) Direct Payment	$43,775,553	$19,600,000	44.8%

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

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

The Health Care Reform Act of 2000 (HCRA II) created the Healthy NY program and gave oversight to the Insurance Department. The program created a less expensive health insurance product for vulnerable small businesses, sole proprietors and low-income individuals meeting certain eligibility criteria. The Healthy NY program is a unique approach to addressing the problem of the uninsured. Today, this program serves as a national model for creating a private-public partnership that utilizes reinsurance to reduce premiums.

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

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

The Healthy NY product includes a unique rating structure designed to combine the experience of participating individuals and small groups. The program also utilizes state funds to reinsure high-cost claims, a feature designed to reduce premium rates and limit the exposure of HMOs to excessive health care costs. The 2008 annual Healthy NY study found that Healthy NY offers premium savings of more than 70% when compared with the individual direct payment market.

The major responsibilities of the Department in connection with the oversight of the Healthy NY program for year 2009 included the following:

a. Program Oversight

The Insurance Department is solely responsible for the oversight of the Healthy NY program. Throughout the year, 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 continues to respond to questions of eligibility and to provide continuing guidance to the health plans.

b. Eligibility Issues and Education

The Healthy NY program includes fairly complex eligibility rules which differ for individuals, individual proprietors and small employer groups. All HMOs are required to have staff fully versed in making eligibility determinations. The Department has provided and continues to provide extensive training and guidance to HMOs in this regard. Policy with respect to eligibility determinations continues to evolve. The Department continues to oversee and educate its contractor handling the Healthy NY toll-free hotline established to address consumer questions and to send applications and other program materials.

c. Guidance and Publications

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

The Department has continued to enhance and update its Healthy NY publications. In 2009, the Department revised both of the application guidebooks (small employers and the individual/sole proprietors). The new publications have a new color scheme and are more identifiable. Publications are available to callers of the Healthy NY hotline, consumers making inquiries to the Department and are also mailed by the HMOs to interested callers. The Healthy NY hotline mails out an average of 2,100 applications each month.

d. Rating of the Healthy NY Product

The Department has limited authority over premium rates for the Healthy NY product. Given the uniqueness of the Healthy NY product, it has been necessary for the Department to provide extensive guidance to insurers to ensure that the premium rates are established and adjusted appropriately. Rates must account for the availability of stop-loss funding. Rate increases must be monitored based on actual claim and stop-loss experience. The "file and use" method of raising premium rates has presented regulatory challenges for this coverage provided to premium sensitive small businesses and consumers. As rates continue to increase, it is harder to attract these lower-income people into the program. The Department supports efforts to restore prior approval authority over premium rates.

e. Stop-Loss Funds

The Insurance Department is responsible for the oversight of the stop-loss funds established for the purpose of reimbursing health plans at a percentage of eligible high cost claims paid under Healthy NY contracts. The Superintendent is required to monitor claim levels and cap enrollment if it appears enrollment growth will result in claim reimbursement requests in excess of appropriated funding. To monitor claims, Department regulation requires HMOs and participating insurers to provide quarterly reports identifying potentially eligible claims, with sufficient detail to allow the Superintendent to project an estimated aggregate claim level for all carriers across the State for the full year.

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

Funding for 2008 claims was sufficient to cover all valid reimbursement requests, and disbursement was authorized and paid out in 2009 in the following amounts:

Healthy NY Qualifying Individual Claims	$ 89,589,154
Healthy NY Small Employer Claims	$ 61,227,506
Total Claims Reimbursed	$150,816,660

Reimbursement requests for 2009 claims must be submitted to the Department by April, 1 2010, and will be tabulated and audited and are scheduled for payment in mid-2010.

f. Tracking Maximum Enrollment in Healthy NY

The Department continues to monitor enrollment in Healthy NY and, as enrollment climbs, estimate maximum enrollment in the program that can be supported so that enrollment can be suspended to ensure that enrollment for the program does not exceed 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. The Department tracks Healthy NY enrollment on a monthly basis. Monitoring of actual enrollment by month will include ongoing adjustment of maximum enrollment if necessary, based upon available funding.

g. Annual Study of the Healthy NY Program

The Department is responsible for an annual study of the Healthy NY program, which includes an examination of employer participation, an income profile of covered employees and qualified individuals, claims experience, and the impact of the program on the uninsured. The current contractor for the study is Burns & Associates, Inc. Department staff work with the contractor to provide updated

program and enrollment information, ensure cooperation by health plans and answer questions about program requirements.

h. Consumer Contact

The Department continues to respond to a significant volume of consumer questions and issues regarding the nature and operation of the Healthy NY program. The Department has worked to address consumer issues with the HMOs to ensure appropriate and correct resolution. An e-mail box linked from the Healthy NY Web site is available for consumers to contact the Department with questions. A toll-free hotline provides consumers with information about the Healthy NY program. Additionally, Department staff responds directly to a large volume of consumer telephone and written inquiries. The Department assists applicants who believe they have been wrongfully denied enrollment in the program. Since 2008, Healthy NY has been included in the State Office of Temporary and Disability Assistance's (OTDA) online screening tool that assists people in determining if they qualify for various public programs. OTDA's screening tool, called "myBenefits," includes a preliminary screening for Healthy NY.

i. Coordination with Other Public Programs

Healthy NY is designed to complement and build upon the existing Child Health Plus and Family Health Plus programs that were also authorized as part of HCRA of 2000. The Department aims to ensure that consumers receive information that facilitates their enrollment in the program that is most appropriate.

j. Marketing and Outreach

The Healthy NY statute allows for the expenditure of up to 8% of the program's funds on public education, advertising and facilitated enrollment strategies. 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, including brochures and applications, and has made extensive information available on the Healthy NY Web site. In 2008, a contractor was hired to conduct outreach, public education, and advertising. While marketing and outreach efforts are crucial to the success of the program, such efforts have been suspended due to the State fiscal crisis.

k. National Interest in Program

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

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

In 2009, representatives from the State of Texas Department of Insurance came to New York to consult with Healthy NY staff on the implementation and operation of the program. Texas passed legislation that created the Healthy Texas program, very closely modeled after Healthy NY.

15. Brooklyn HealthWorks

In Chapter 441 of the Laws of 2006, the New York State Legislature allocated funds from the Healthy NY stop-loss funds for the support and expansion of Brooklyn HealthWorks. Brooklyn HealthWorks (BHWx) is a pilot program run by the Brooklyn Alliance, which provides access to affordable health insurance for small businesses in the Borough of Brooklyn. Brooklyn HealthWorks essentially offers a Healthy NY product through GHI health plan with a few minor benefit adjustments and an additional subsidy of 19% of the premium.

In response to the legislation, the Department negotiated a single-source contract with the Brooklyn Alliance, Inc. The contract was entered into as of March 29, 2007, and amended as of July 28, 2008. The contract authorizes the Insurance Department to pay the Brooklyn Alliance for costs, fees and disbursements associated with the administration of the program. BHWx staff handles outreach for its members and maintains records documenting the amount billed by the insurer (GHI), the amount paid by each employer group, and the amount of subsidy provided through the program. In addition, the BHWx staff submits invoices requesting subsidy payment to the Insurance Department. In 2009, Brooklyn HealthWorks contracted with a third party administrator in an effort to relieve its staff of some of the program's administrative responsibilities.

Insurance Department staff reviews subsidy payment requests and forwards appropriate requests for payment to the Office of the State Comptroller. Subsidy payments are made directly to GHI in order to maintain seamless coverage for the program's member groups. During 2009 the Insurance Department authorized payment of subsidies in the amount of $817,985.

Insurance Department staff is also responsible for reviewing payment requests submitted by the Brooklyn Alliance to determine if the requests are fully supported by appropriate documentation. Once these contract payment requests are verified and approved, they are forwarded to the Office of the State Comptroller. During 2009 the Department authorized total contract payments of $381,261 to the Brooklyn Alliance for administration of the program.

Due to concerns over the availability of funding, Brooklyn HealthWorks suspended enrollment for new subsidized businesses in September 2009. The pilot program has continued to enroll businesses without any premium subsidy. At the close of 2009, the program had 543 active groups enrolled, representing a total of 2,380 covered lives.

16. Healthy NY Upstate Pilot Project

In Chapter 441 of the Laws of 2006, the New York State Legislature allocated funding from the Healthy NY stop-loss funds to the development of an upstate health insurance pilot program. In response to this legislation, the Department issued a Request for Proposal (RFP) for a Healthy NY Upstate Pilot Project Administrator and received eight proposals. A contract was awarded to Benefit Specialists of NY in August 2008.

Benefit Specialists of NY is a full service insurance agency and wholly owned subsidiary of the Greater Syracuse Chamber of Commerce. The service area for the project is Cayuga, Cortland, Herkimer, Jefferson, Lewis, Madison, Onondaga, Oneida, and Oswego counties, located in Central New York. United Healthcare provides the coverage, and enrollees can choose from five different benefit packages. This is the first time that United has participated in Healthy NY. Enrollment began in May of 2009, and currently the program has more than 1,200 enrollees. Enrollees receive a 15%

premium subsidy, with an additional 5% subsidy for completing a confidential health risk assessment. Benefit Specialists has partnered with other local chambers of commerce, hospitals, facilitated enrollers, and community and corporate affiliates to conduct grassroots outreach.

Benefit Specialists handles billing, provides customer service support, and operates a Web site, www.hnyhealthcore.com. Benefit Specialists submits invoices requesting subsidy payment and payment for administrative expenses to the Department. Insurance Department staff is responsible for reviewing payment requests and ensuring that such requests are fully supported by appropriate documentation. Total payments made related to this pilot project during 2009 were $254,901.

17. Federal Tax Credit Initiative

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

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

During 2009, as part of the American Recovery and Reinvestment Act of 2009, the tax credit was increased to 80%. The Bureau continues to assist consumers with accessing the tax credit in conjunction with the New York State health insurance market. Information regarding the availability of this tax credit has been posted to the Insurance Department's Web site.

18. COBRA Subsidy Demonstration Project

The Health Bureau has been statutorily charged with implementing the New York State health insurance continuation assistance demonstration project. The statute created a pilot program designed to assist entertainment industry workers by subsidizing the Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums. Funding of $1.96 million is provided to the program annually.

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

In 2009, Department staff processed 533 applications, a 77 percent increase from last year. The Department paid out $750,456 in premium assistance. Payments were made to 18 union funds, the

most highly represented being Equity League (approximately 267 enrollees) and Screen Actors Guild (approximately 96 enrollees).

To date, the program has received nearly 3,000 applications.

19. Continuing Care Retirement Communities (CCRCs)

The Department has a permanent seat on the Continuing Care Retirement Community Council. This council has the primary licensing and oversight authority for CCRCs. The 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. The Bureau's continuing oversight encompasses review of the rating structure of each CCRC, adequacy of reserves and periodic on-site examinations of the financial condition of each CCRC. To this end, the Department initiated three examinations of CCRCs in 2009 and developed revisions to the Department's annual statement for financial filings.

Currently, there are 12 CCRCs in New York, each with a certificate of authority issued by the CCRC Council. Of these 12, ten are fully operational, and one has been approved to obtain financing and begin the construction phase. One CCRC, which had been in the process of collecting entrance fee deposits, ceased marketing and returned the collected deposits citing the current economic environment as its reason. It has not surrendered its certificate of authority and may resume operations if the economic environment improves.

20. Long Term Care Insurance

a. Tax Qualified Long Term Care Insurance Marketed on an Indemnity Basis as Permitted by the Internal Revenue Code (IRC)

The insurance industry recently began to encourage the sale of an indemnity option for tax qualified long term care insurance. While tax qualified long term care insurance products usually limit benefit payouts to long term care actually incurred, benefits under this indemnity option are paid without regard to the type and amount of long term care expenses incurred. Therefore, these benefit payments may exceed expenses, or if the benefits paid 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.

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

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

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

In conjunction with the Department of Health, the Health Bureau worked on issues such as modifying the New York State Partnership for Long Term Care insurance product design. In 2005, the Department amended Regulation 144 (11 NYCRR 39) to make more affordable benefit options and a range of incentives available through the NYS Partnership for Long Term Care program. By December

2006, Partnership insurers began marketing the four new plan designs. In 2009, the Health Bureau continued to participate in the Evolution Board with the Department of Health, Office for Aging, and all participating insurers to monitor the Partnership program, resolve issues, and make appropriate modifications to assure consumer protection and stability of the NYS Medicaid program. In 2009, the Health Bureau approved a product portfolio for a returning Partnership insurer, Massachusetts Mutual Life Insurance Company.

c. Federal Deficit Reduction Act

The federal Deficit Reduction Act, enacted in 2006, expanded the Partnership for Long Term Care concept to other states, but exempted the four existing states with Partnership programs (New York, California, Connecticut, and Indiana). In conjunction with the Department of Health, the Health Bureau monitors activities and standards of the new Partnership states, counsels states entering this field, and determines any possible impact on New York's current program and policies. In 2009, the Health Bureau continued to monitor the interaction of the New York State Partnership program with the Partnership programs in other states and actions of the Federal government to ensure the integrity of New York State long term care insurance regulation and the financial viability of the New York State Medicaid program.

d. Long Term Care Financial Planning Options

Throughout 2009, the Health Bureau met extensively with the Department of Health to assist them in developing recommendations for numerous financial planning options for long term care services. These options are intended to encourage personal planning for future long term care costs and to reduce Medicaid costs. Some of the concepts would require further development and counsel from other agencies including the Departments of Budget, Tax and Civil Service, to prepare draft legislation while other recommendations may be implemented through Department regulation.

e. Sample Premium Rates on Web site

In 2006, the Health Bureau, in conjunction with the Systems Bureau, created an interactive page on the Department Web site that provides consumers with sample premium rates for long term care insurance. Through this tool, consumers can learn the approximate cost of long term care insurance coverage for certain levels of coverage. In addition, the tool allows consumers to perform "what ifs" to see the actual effect on premiums that result from various purchasing decisions. For example, comparing the premium at the consumer's current age to a future age clearly shows the price impact of delaying the decision to purchase long term care insurance. Comparing the premium for various elimination periods clearly shows the savings in premium if a consumer elects a longer period of self-payment once the consumer requires long term care services but before the company starts paying benefits. This site also allows the consumer to print the results for use when discussing a potential purchase with an agent. The initial rollout contained sample premium rates for all four Partnership plan designs currently marketed by each of the Partnership insurers.

In 2007, the Bureau expanded this interactive tool on the Web site to include all actively marketed non-Partnership policies, which was an extensive undertaking because of the number of companies and policies involved. In 2009, the Health Bureau continued to monitor the efficacy of this interactive tool in providing illustrative premium information for consumers.

f. Consumer Education

During 2008, Long Term Care Insurance Education and Outreach centers, headed by the State Office of Aging, provided the public with educational and informational materials regarding long term care insurance and provided counseling and direct assistance to help consumers understand policy options and benefits, and to obtain the appropriate long term care insurance coverage. The Health

Bureau worked closely with the State Program Coordinator to provide the necessary information to train the counselors and answer their on-going questions.

The Health Bureau also updates the Department's Web site and the consumer guide to long term care insurance. These sources were expanded in 2007 to include information on the history of premium increases granted by the Department, explain the effect of a company deciding to stop selling a particular policy to new individuals, and to streamline the information regarding insurers currently offering the various types of long term care insurance.

In 2009, the Health Bureau continued to work on updates to the consumer guide on long term care insurance and updates to the history of premium rate increases granted to long term care insurers.

g. Elder Care Unit

2009 was the third full year of operation of the Elder Care unit of the Health Bureau which focuses on health insurance issues related to the elderly including long term care insurance, Medicare, Medicare supplement insurance, managed long term care and continuing care retirement communities. By devoting resources to the particular insurance issues of this elderly population, the Health Bureau is in a better position to identify and resolve insurance issues relating to this population. This ability to focus on insurance issues relating to the elderly becomes very important as the large baby boom generation ages and their need for insurance products related to the aging process increases. This unit fulfills a need as highlighted by the Project 2015 report as a large segment of New York's population grows older.

In 2009, the Elder Care unit of the Health Bureau also consulted with the Property, Life and Consumer Services Bureaus to coordinate accident and health insurance issues. This coalition monitors and discusses numerous senior protection issues related to insurance including industry market conduct, marketing practices to senior citizens, consumer complaints, issues related to approval and examination processes and industry reports regarding long term care claim denials.

h. Report by the Superintendent to the Governor and Legislature on the Implementation of Legislation Permitting Approval of Long Term Care Health Insurance Plans

As required by statute, the Health Bureau prepared the biennial report dated December 31, 2009, for the Governor and Legislature. This report is posted on the Department's Web site. Some of the topics included in this report are the historical development of long term care insurance in New York since 1986, New York and Federal legislation to encourage the development of long term care insurance, a discussion of factors contributing to or impeding the development of long term care insurance, and recommendations and anticipated actions to be taken by the Department. The report contains appendices showing the number of traditional non-Partnership and New York Partnership policies in-force in New York as of December 31, 2008 (by insurer, by individual/group coverage, with issue age at purchase). The appendices also list the market share of thirty-two insurers in the long term care insurance market in New York as of December 31, 2008. This latest biennial report continues to show modest but steady growth in the long term care insurance market in New York.

21. Managed Long Term Care Plans

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

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

During 2009, the Department engaged in detailed discussions with the Health Department about solvency regulation of managed long term care plans that are writing Medicaid Advantage Plus and Medicare Advantage lines of business. Those lines of business are not subject to Department or state regulatory oversight in all respects, presenting challenges to the Department's solvency regulation of managed long term care plans operating Medicaid Advantage Plus and Medicare Advantage lines of business. The Department continued to work with the Health Department during 2009 on the noted solvency issues/challenges.

In 2009, the Health Bureau continued its practice of reviewing and approving forms and rates for private pay participants in approved managed long term care plans.

22. Medicare Beneficiaries' Issues

The Health Bureau has been an active member, along with three other states, in the NAIC Senior Issues Task Force (SITF) Medigap Implementation Subgroup. Medicare supplement insurance plans and benefits have been updated in accordance with recent revisions to the NAIC Medicare supplement model regulation and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The Health Bureau assisted in drafting compliance documents to aid states and insurers in adopting the changes and to ensure uniformity. The Health Bureau also serves as a contact for other states in need of assistance.

The Centers for Medicare and Medicaid Services (CMS) mandates companies writing Medicare Part D prescription drug coverage to be licensed in the state where they were proposing to operate, or obtain a federal waiver of the state licensure requirement. CMS requires state certification of licensure and financial solvency. Although the Department does not regulate the Medicare Part D or the Medicare Advantage program, the Health Bureau was able to verify the status of the companies licensed in the state and provide requesting companies with letters of good standing needed by the companies for furnishing to CMS.

Each year Medicare Advantage plans have the option to reduce their service area or terminate their Medicare Advantage contracts. Medicare Advantage plans that opt to non-renew or reduce their service area must notify CMS and are also required to send enrollees notification letters. In October, CMS announced that 17,561 New York residents would be affected by nonrenewals. In order to assist New York residents being terminated by their Medicare Advantage plans, the Health Bureau coordinated with CMS and posted notice on the Insurance Department's Web site containing information on choices for these affected residents. The notice explained the difference between the options of enrolling in another Medicare Advantage plan or returning to original Medicare with the purchase of a Medicare supplement insurance policy to help defray some of the costs not covered by Medicare. The notice also reminded those interested of how to prevent gaps in coverage in order to avoid having to satisfy requisite pre-existing condition waiting periods when enrolling in a new plan.

23. Innovative Health Insurance Products

a. Long Term Care Insurance

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

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

In 2009, the Bureau approved an innovative product that combined long term care insurance with life insurance. The long term care insurance rider provided additional benefits after the life insurance policy paid accelerated death benefits for long term care. The Health Bureau assured that the long term care insurance rider attached to the life insurance policy provided consumer protections commensurate with a stand alone long term care insurance policy.

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

b. Managed Long Term Care

Some managed long term care plans granted certificates of authority (COAs) by the Health Department under Section 4403-f of the Public Health Law are also granted other COAs by the Health Department to operate as other entities in addition to being managed long term care plans. Using these other COAs, some of these managed long term care plans have evolved into entities operating as federal Medicare Advantage organizations, Medicaid Advantage Plus plans and federal PACE organizations. These combined plans can present unique challenges to the Department in the regulation of the enrollee contracts, rates, and solvency. (Under Section 4403-f of the Public Health Law, the Department has a statutory role in regulating plans conducting a managed long term care business.) The Health Bureau continues to work closely with the Health Department in fulfilling the Insurance Department's statutory role in regulating the ever evolving managed long term care plans and in fulfilling our traditional role of regulating private pay populations in managed long term care plans.

24. Child Health Plus

During 2009, the Department continued its role of reviewing and approving subscriber contracts and premium rates for the Child Health Plus program. During 2009, the Department reviewed and approved a number of Child Health Plus rate adjustment submissions and subscriber contracts.

25. Early Intervention Program

During 2009, the Bureau continued its proactive role in assisting the Department of Health's Early Intervention Program to appropriately claim third party health insurance coverage for services rendered by the Program, as required by Public Health Law. Bureau staff continue to represent the Department on the Early Intervention Coordinating Council. Staff members also participate in monthly meetings with the Department of Health to discuss insurance-related issues brought to the Department of Health's attention by the county providers of early intervention services and investigate claims denials brought to their attention by the early intervention providers.

26. Updates to Department Web site

The Health Bureau continuously updates the Department Web site to provide insurers with essential instructions and guidance for filing accident and health form and rate filings. The PowerPoint presentations from the Bureau's annual filing compliance seminars for the industry are also posted on the Web site.

Several interactive product checklists are posted on the Web site to provide the industry with one primary source for statutory and regulatory requirements related to each major product. More product checklists are in progress.

Consumer information on the Web site was enhanced and revised for easier access by the public. For example, the Department Web site was updated with respect to the extension of coverage for dependents to age 29, the expansion of COBRA to 36 months and premium assistance for COBRA, and information regarding immunization and treatment for H1N1 influenza. Consumer information was also updated with respect to long term care insurance including the Consumer's Guide, the history of premium rate increases, and the chart of insurers currently offering long term care insurers.

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

27. Discontinuations, Withdrawals and Mergers

Rochester Area HMO was merged into MVP Health Plans, Inc. in May of 2009.

The Perfect Health Insurance Company an Article 42 Accident and Health Insurer was merged into Group Health Inc., an Article 43 Corporation.

28. 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. All Financial Risk Transfer Agreements between insurers and health care providers which meet certain criteria must be submitted to the Superintendent for review. During 2009, the Bureau received an additional 15 agreements for review. During 2009, nine have been approved, three are pending and four were either withdrawn, suspended or have been determined not to be subject to the strict financial responsibility demonstration requirements of the Regulation.

29. Timothy's Law (Chapter 748 of the Laws of 2006) and Federal Mental Health Parity Act

Timothy's Law was enacted in December 2006 and required health plans to provide coverage for mental health services. The law applies to policies issued or renewed on or after January 1, 2007, and requires coverage for at least 30 inpatient days and 20 outpatient visits for the treatment of mental health. Additionally, it required health plans to include in their large group contracts and make available in their small group contracts, coverage for treatment of biologically based mental illnesses and for children with serious emotional disturbances, comparable to other benefits provided. Timothy's Law provides a premium subsidy for the 30/20 mental health benefit for small employers and also directs the Superintendent of Insurance to conduct a study, in consultation with the Office of Mental Health (OMH), to determine the effectiveness and impact of the law. Funding of the subsidy is provided through an appropriation from the State's General Fund. Approximately 1.7 million persons covered under small group policies (as of December 2009) are affected by the subsidy.

The Health Bureau analyzed and estimated the rate impact of Timothy's Law, which included an approval review process of all carriers' requested reimbursement rates. The Bureau also implemented a subsidy reimbursement and claim experience reporting mechanism, under which the small

employers' premiums for the 30/20 benefit are subsidized by direct payment of the premium to the carrier providing the coverage. The subsidy mechanism provides for annual prior approval of carriers' per member per month ("PMPM") reimbursement rates for each fiscal year, and requires submission of experience data to justify the next fiscal years' rates by March 31 of each year. The Health Bureau distributed a directive to carriers to submit their rate applications by March 31 each year, with detailed guidance as to the data required.

For 2007, industry data together with the carrier's own claims experience were used by carriers to project costs in submissions which were reviewed and approved, in some cases after downward adjustment, by Department actuaries. The Bureau estimated the total amount required to fund the subsidy of the 30/20 benefit for small group contracts for an initial fifteen month phase-in period, from January 1, 2007 through March 31, 2008, at approximately $100 million. Actual subsidy requests for the period came in at about $91 million, all of which have been paid.

In 2008 and 2009, as companies developed more claims experience to use in pricing the mandated benefits, rate application instructions were revised to require further detail to justify rates. For 2008, rate applications were required to include at least one year's actual claims experience and 2009 required two years' experience. 2008 and 2009 rates were reviewed and approved with some downward adjustment of rates where deemed appropriate by the Superintendent.

The subsidy mechanism implemented and currently administered by the Health Bureau requires detailed quarterly claims, enrollment and reimbursement data reporting. For 2008, approximately $95.3 million in reimbursement requests were received, audited and paid by the Department. In 2009, reimbursement requests totaled approximately $96.0 million. However, as part of the Governor's Deficit Reduction Plan, under Chapter 503 of the Laws of 2009 the Legislature reduced the Fiscal Year 2009 - 2010 appropriation to subsidize small businesses' cost of purchasing the Timothy's Law "30/20 benefits" from a $99,200,000 initial appropriation to $79,743,000. As a result, funding is insufficient to cover total reimbursement requests for the year and carriers' reimbursement requests are being reduced on a pro rata basis.

The Health Bureau was also involved in reviewing and interpreting the federal Mental Health Parity and Addiction Equity Act (MHPAEA), a federal law enacted in 2009 which provides parity for mental health and substance use disorders in large group health insurance policies that provide coverage for mental health and substance use disorders. The Bureau held meetings with the federal government, industry, advocacy, and provider groups to discuss the impact of the federal law. The Health Bureau issued a circular letter setting forth the Department's interpretations of the federal law, along with expectations for the industry. The Bureau also reviewed and approved a number of policy form and rate submissions intended to comply with the federal law.

In addition, throughout 2008 and 2009, the Health Bureau continued to hold meetings with industry, advocacy and provider groups to resolve issues regarding the implementation of Timothy's Law. The Bureau also responded to numerous inquiries and complaints. The Bureau made a detailed review of carriers' compliance with the mandate under Timothy's Law to provide annual written notification to small group policyholders or applicants of the availability of coverage for biologically based mental illnesses and children with serious emotional disturbances. The review covered the three year period from 2007 thru 2009, addressing whether carriers complied with the initial notification requirement and whether they continued to comply with the annual notification requirement. A number of carriers' methods for providing notification appeared deficient, and in some cases carriers provided no notices. This matter is currently under review by the Department for possible sanctions of those that failed to comply.

30. Public Retiree Health Insurance Task Force

The Health Bureau participates in the Public Retiree Health Insurance Task Force, which was established by Executive Order of the Governor, to study health care benefits provided to employees of the State and local governments in New York. The Task Force is charged with examining innovative ways to preserve quality retiree health care while making it more affordable for local governments and with making a report of its recommendations to the Governor. The Task Force is comprised of representatives of New York State agencies, labor unions, retiree groups and local governments.

31. Autism Task Force

During 2009, the Bureau acted as liaison to the Autism Task Force, which is a multi-agency task force whose main purpose is to determine where there are gaps in services for autism patients. Bureau staff attended a number of scheduled meetings and participated in the development of a Web site spearheaded by the Office of Mental Retardation and Developmental Disabilities. The Web site is intended to provide consumers with comprehensive information on State programs and services that are available to individuals with autism spectrum disorder. Bureau staff was also involved in review of a number of proposed legislative bills concerning health insurance coverage for autism spectrum disorder.

32. Task Force on the Prevention of Childhood Lead Poisoning

On June 2, 2009, Governor Paterson issued Executive Order No. 21 to establish the Governor's Task Force on the Prevention of Childhood Lead Poisoning. The Task Force is charged with identifying primary prevention actions undertaken by State agencies, recommending other actions that could be taken immediately, and reviewing evaluations issued with respect to the Childhood Lead Poisoning Primary Prevention Program overseen by the Department of Health. The Insurance Department is a member of the Task Force and Health Bureau staff attended a number of scheduled meetings. The Task Force issued a report in 2009 recommending enhancements to current activities and identifying strategies for further exploration.

33. H1N1 Influenza

The Insurance Department and the New York State Department of Health coordinated efforts to minimize the impact of the new pandemic strain of novel influenza A (HIN1). In an effort to minimize public health, infrastructure and financial impact of the H1N1 virus, the Departments of Health and Insurance sent a joint letter on August 14, 2009 to health insurers strongly encouraging them to work with the State to prepare for the fall influenza season. The letter identified goals for ensuring New Yorkers have access to care and recommended insurers facilitate vaccination efforts, review and augment drug coverage of antiviral medications, develop educational materials for members, and establish hotlines to enhance communication. The Insurance Department also posted pertinent H1N1 information on its Web site.

34. 2009 Legislation

The Health Bureau assisted in the drafting and implementation of several important pieces of legislation, which were enacted in 2009. These new laws provide New Yorkers with enhanced access to health insurance coverage and improved protections.

Chapter 7 of the Laws of 2009 mirrored the federal American Recovery and Reinvestment Act of 2009 to create a special election period for individuals who were laid-off and could not afford continuation coverage. Chapter 7 provided a second opportunity to elect state continuation coverage in order to qualify for federal premium assistance.

Chapter 236 of the Laws of 2009 extends the period of state continuation coverage from 18 months to 36 months. Chapter 498 of the Laws of 2009 amended the effective date of Chapter 236 to apply it to every group health insurance policy regardless of when the policy was issued, renewed, modified, altered or amended. Chapter 498 also created a special enrollment period for employees who exhausted their continuation coverage prior to the policy's renewal, modification, alteration or amendment. Chapter 240 of the Laws of 2009, or the "Age 29" law, allows young adults who have aged-off a parent's policy to purchase the same coverage independently through the age of 29.

The 2009 Managed Care Bill (Chapter 237 of the Laws of 2009) establishes several consumer and provider protections. The consumer protections include extending grievance and access to care protections to HMO look-alike products; providing a distinct right to external review for rare diseases; shortening timeframes for utilization review determinations of home health care services following a hospital admission, with required approval of services in certain instances; prohibiting insurers and HMOs from treating network hospitals and providers as non-participating; extending patient hold harmless protections; and removing the limitation that an insured's contract must be in effect as of the date a dividend or credit is issued in the event a loss ratio requirement is not met. The provider protections include prohibiting insurers and HMOs from implementing an adverse reimbursement change to a health care professional contract without prior notification; allowing the provisional credentialing of new health care professionals; shortening the timeframe for prompt payment of health insurance claims; prohibiting insurers and HMOs from denying payment due to coordination of benefits unless there is reasonable basis to believe the insured has other coverage; extending limitations on health plan overpayment recovery efforts; and granting health care providers the right to externally appeal concurrent utilization review denials on their own behalf.

Department staff worked with consumers, insurers, providers, benefit administrators and employers to educate them on their rights and responsibilities under the new laws and to implement the legislation. Additionally, Department staff drafted Circular Letters 10, 22 and 23 of 2009, as well as Circular Letter 5 of 2010. Department staff also drafted Web site material for consumer reference.

D. CONSUMER SERVICES BUREAU

The Consumer Services Bureau carries out numerous responsibilities as the Department's open door to consumers. This includes disseminating information to better educate the public about insurance, providing assistance to policyholders during disasters and serving as a consumer ombudsman by mediating and resolving disputes that consumers are otherwise unable to resolve with insurers. The Bureau also acts as an industry watchdog, promoting industry accountability by investigating and helping correct systemic patterns of insurer abuse when they occur.

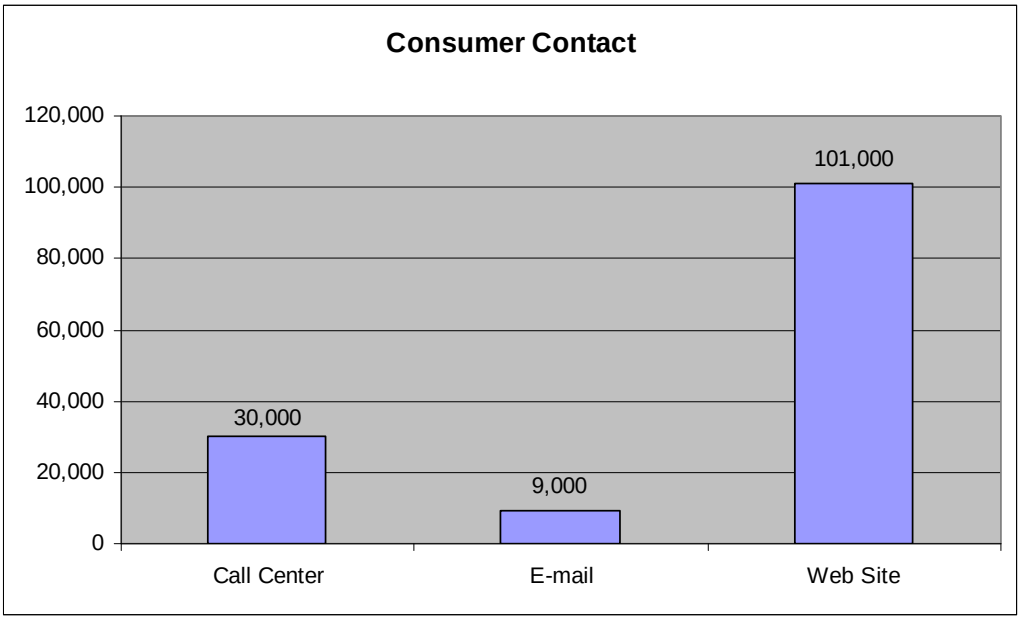
1. Consumer Resources

The Bureau is an important insurance information resource for the public and Bureau personnel interact with consumers in a variety of ways. Each year, the Bureau responds to more than 200,000 consumer inquiries. Special hotline services, including one for natural disasters, are activated in response to specific situations to help consumers with insurance claims or questions. In 2009, the Bureau supported hotlines to offer help and information in response to these situations:

- Flood disasters in Western New York.
- Reinstatements in connection with homeowners' policies issued by Allstate Insurance Company.
- Policyholder concerns about the financial condition American International Group (AIG).

In addition to telephone communications, the Bureau responds to e-mails from consumers, provides consumer information on the Department's website and presents information at public events.

Chart G



2. Resolving Disputes

The Consumer Services Bureau is the only state agency dedicated solely to receiving, investigating and resolving consumer disputes with insurance companies, agents and brokers. Typical disputes involve such complaints as:

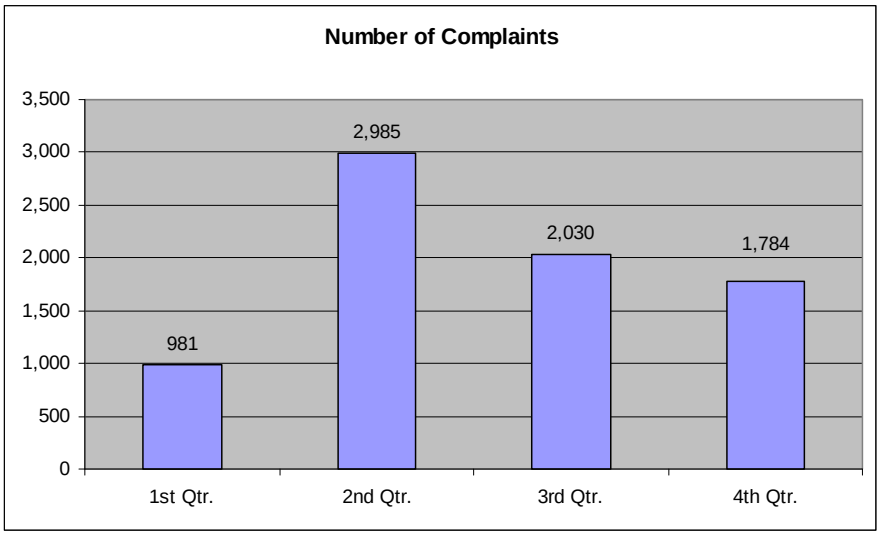
- Loss settlements or the interpretation of policy provisions
- Improper practices on the part of agents, brokers and adjusters
- Failure of insurers to provide timely settlement of claims
- Improper policy cancellations

3. Cases Opened

The Bureau received 46,077 complaints from consumers who filed complaints by mail or by using the online complaint form on the Department's website. A total of 42,688 new cases were opened for investigation involving virtually all types of insurance.

The process used to resolve disputes involves obtaining relevant facts from policyholders and insurers, reviewing policy provisions and working to obtain agreements between policyholders and insurers. In some cases, insurers are directed to honor claims. In other cases, policyholder complaints are found to be invalid or policyholders fail to pursue resolution.

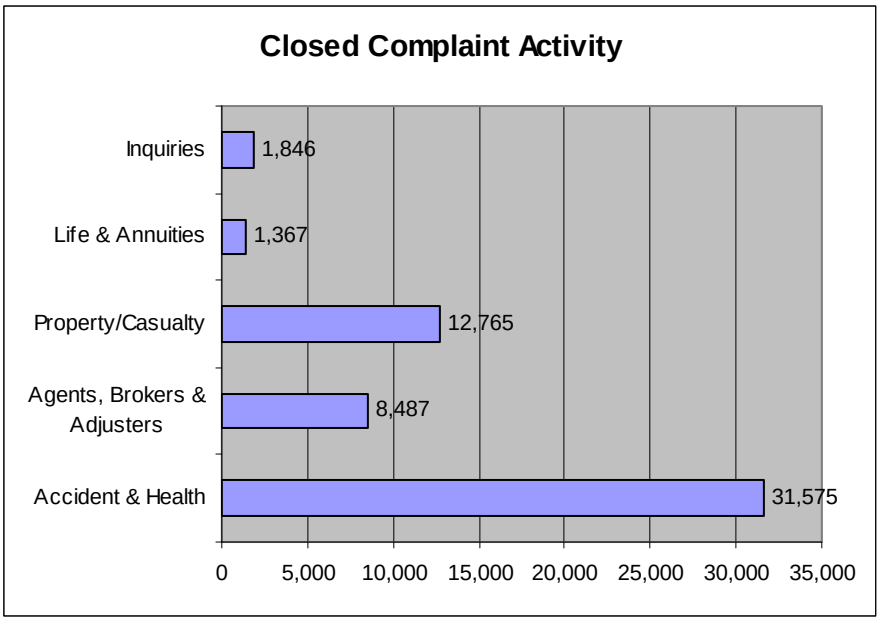
Chart H



4. Cases Closed

The Bureau closed 56,040 cases in 2009. In some instances, cases closed in 2009 were opened the previous year. Of these closed complaints, 7,320 were upheld and transferred for prompt pay review; 5,816 were closed as not upheld but adjusted; 3,484 were closed as duplicates, withdrawn or suspended; and 29,187 were closed as not upheld. There were also 1,846 inquiries and 8,487 investigations against agents, brokers and adjusters.

Chart I



5. Consumer Recoveries and Reinstatements

The Bureau tracks the dollar amount of recovery to complainants due to their filing of complaints. For 2009, Bureau examiners were successful in obtaining a total of $32,300,000 in recoveries to consumers. Additionally, the Bureau requested 16 insurers to offer reinstatement to over 116,000 personal lines policy holders who had their coverage improperly canceled or non-renewed.

6. Investigations of Licensed Individuals and Entities

The Bureau's Investigations Unit oversees the activities of licensed individuals and entities who conduct insurance business in New York State. The goals of the Unit are to protect the public and ensure that licensees act in accordance with the applicable insurance laws and Department regulations. There are currently more than 240,000 licensees. Licensees include: producers (agents and brokers); independent and public adjusters; reinsurance intermediaries; bail bond agents; viatical settlement brokers; and limited lines producers

The Investigations Unit monitors the insurance market place to determine if unlicensed activity is occurring, and if necessary, to take steps to either have individuals or entities achieve compliance or cease activities. The Unit reviews original and renewal licensing applications when irregularities are identified.

When a violation is proven, an administrative sanction can be imposed. This may result in license revocations or suspensions, the denial of pending applications, a monetary penalties imposed with corrective actions to address violations.

For the 2009 calendar year, the Unit handled 394 disciplinary actions with the following results:

Stipulations	306
License Surrenders	39
Revocations	53
Total Fines Collected	$1,296,220

7. Insurance Company Fines and Stipulations

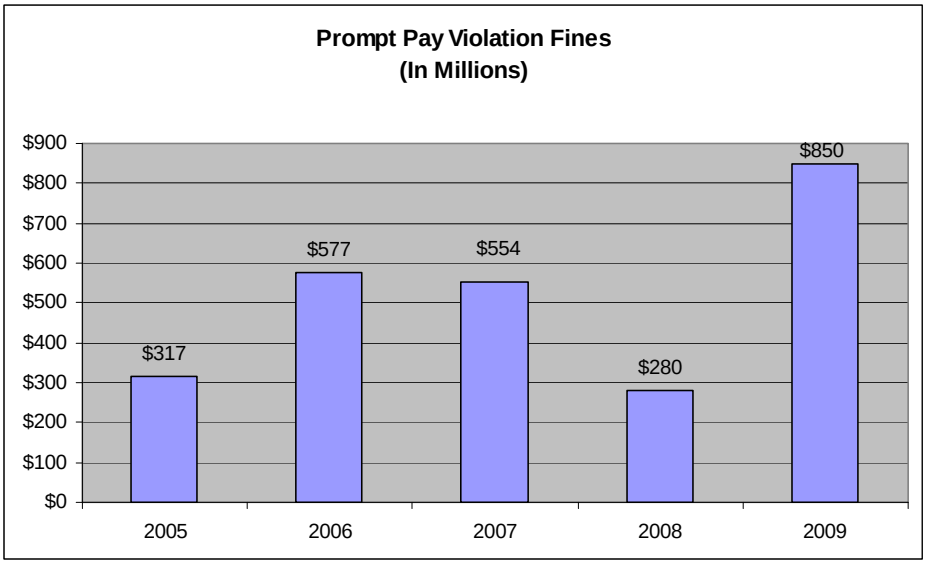
The Bureau assesses fines to insurers when systemic violations of the law or regulations are uncovered during the investigation of complaints. After remedial actions by insurers, stipulations are signed by the companies and appropriate fines assessed. Among fines lodged in 2009 were those against four insurers which paid fines amounting to $85,000.

8. Prompt Payment Statute

Section 3224 - of the Insurance Law, also known as the Prompt Pay Law, became effective January 22, 1998. Under the statue, insurers and health maintenance organizations (HMOs) are required to pay undisputed health insurance claims within 45 days of receipt. Requests for additional information or claim denials must be made within 30 days of receipt. Governor Patterson signed legislation in 2009 amending the law which required undisputed claims filed by electronic means to be paid within 30 days of receipt, effective in January 2010.

In 2009 $850,900 in prompt pay fines were levied against 28 health insurers and HMOs.

Chart J



9. External Appeals Process

Consumers have the right to request that a review of certain coverage denials be conducted by medical professionals who are independent of consumers' health care plans under New York's External Appeals process, which is administered by the Bureau. External appeals are available to consumers when health plans deny insurance coverage because they deem specific health care services to be experimental or investigational or not medically necessary. Additionally, consumers may file external appeals when their requests for out-of-network exceptions are denied and the HMO offers an alternate in-network treatment. In addition, under a new law, which became effective January 10, 2010, external appeals may be used to challenge the denial of coverage for rare diseases.

During 2009, Bureau personnel responded to 6,451 calls on the dedicated external review toll-free line. Consumer Services staff members perform the intake functions for the applications received. Consumer Services, along with staff from the Health Bureau, jointly screen applications for eligibility and assign them to the eternal appeal agents.

In 2009, the Department received 4,263 applications, representing a 10 percent increase from 2008. Of those 4,263 applications, 2,036 were determined to be eligible for assignment to an external appeal agent. Forth percent of the applications assigned to external appeals agents, at total of 815, were overturned in full or in part.

External Appeal Applications

	Received	Rejected	Overturned	Upheld	Reversed
2005	2475	682	710	832	221
2006	2858	866	825	869	294
2007	2986	938	788	919	290
2008	3922	1540	891	1144	328
2009	4263	1896	815	1222	350

Reversed - Plan overturns their denial before the appeal submitted to a reviewer
Rejected - The appeal was not eligible for an external review

E. THE INSURANCE FRAUDS BUREAU

1. General Overview

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

2. 2009 Highlights

- Investigations conducted by Frauds Bureau staff resulted in 738 arrests during 2009.
- The number of criminal convictions obtained by prosecutors in Frauds Bureau cases totaled 499 in 2009, up from 402 in the prior year.
- The Bureau's newly established Mortgage and Title Unit concentrated Frauds Bureau resources to address an increase in theft of premiums and monies held in escrow by title agents and the proliferation of schemes targeting indebted homeowners and other consumers entering the real estate market.
- During 2009, the Mortgage and Title Unit received 326 reports of suspected fraud. The reports included allegations of agent defalcations, straw-buyer transactions and fraudulent mortgage applications. Investigators opened 18 cases for investigation and executed 19 arrests.
- A total of 1,707 new cases were opened for investigation in 2009, a marked increase of nearly 25 percent over 2008.
- The Workers' Compensation Unit posted 184 arrests for 2009, outpacing the prior year's total by 16 percent.
- The General Unit recorded 110 arrests in 2009, versus 69 in the prior year. Arrests resulting from investigations involving agents, brokers and adjusters accounted for almost a quarter of the year-to-year increase.
- New York State received almost $12 million in refunds and $124,000 in fines from a number of health care providers who improperly billed United Healthcare, administrator for the Empire Plan.

3. Team Building

Team building has long been a hallmark of the Frauds Bureau and the tradition continued in 2009. The Bureau's vision of collaborative alliances with the insurance industry, prosecutors and law enforcement agencies on the federal, state and local levels was reinforced over the past year. Teamwork, dedication and hard work resulted in 738 arrests and 499 convictions throughout the State.

a. Multi-Agency Investigations

Several successful multi-agency investigations are summarized below.

The operator of three title insurance agencies in New York and Suffolk Counties was charged with misappropriating millions of dollars in escrow and other client funds and embezzling a part of those funds for his personal use. The investigation that led to his arrest was conducted by the Frauds Bureau, the FBI and the Office of the U.S. Attorney for the Southern District.

The owner of a home heavily damaged in a fire was arrested and charged with deliberately setting the blaze in an unsuccessful attempt to collect more than $500,000 from New York Central Mutual Insurance Company. About 75 firefighters from Oneonta and surrounding departments, two of whom were injured at the scene, fought the blaze. The Frauds Bureau and the Oneonta Police and Fire Departments conducted the investigation that determined the fire was incendiary.

The Bureau also teamed up with the NYPD's Fraudulent Accident Investigation Squad and Auto Crime Division in the investigation of many no-fault and other auto-related fraud cases, and with the Workers' Compensation Board's Office of the Fraud Inspector General and the State Insurance Fund on cases involving workers' compensation fraud.

Additionally, Arson Unit investigators worked closely with the FDNY's Bureau of Fire Investigations, the NYPD's Arson Explosion Squad and the Bureau of Alcohol, Tobacco, Firearms and Explosives. The Frauds Bureau also acts as a liaison with the New York State Office of Fire Prevention and Control, as well as local arson units and fire departments throughout the State.

Moreover, DA's Offices, the New York State Attorney General's Office, the New York State DMV, the U.S. Postal Inspection Service and the FBI, as well as local police departments and sheriff's offices across the State, are partners in many Frauds Bureau investigations of all types of insurance fraud.

b. Task Force/Working Group Participation

The Frauds Bureau is an active participant in numerous task forces and working groups designed to foster cooperation, commitment and communication among the many agencies involved in fighting insurance fraud. Participation provides the opportunity for joint investigations, information sharing, networking and honing investigative skills.

4. The Staff

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

Bureau staff consists of 18 Senior Investigators and 18 Investigators who staff the Bureau's eight specialized units: Major Case, Arson, General, Auto, Workers' Compensation, Medical/No-Fault (merged in January 2008), Upstate and a newly established Mortgage and Title Unit. Each Unit is supervised by a Deputy Chief Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of two Assistant Chief Investigators.

A Counsel and an Assistant Counsel are responsible for all legal matters as they relate to fraud investigations. In addition, the Bureau has a Manager of Information Technology Services who coordinates the activities of the Department's Mobile Command Center.

The Bureau's Training Officer provides in-service training for Bureau staff and conducts training for law enforcement, industry and community groups. The Training Officer reports to the Chief Investigator.

In addition, the Bureau has a unit that includes a Senior Insurance Examiner and an Insurance Examiner who report to a Principal Examiner. The examiner staff are responsible for insurer

compliance with Article 4 of the New York Insurance Law and Department Regulation 95. The examiner staff may perform market conduct examinations of insurer Special Investigations Units.

The Bureau also has two support staff members who report to the Secretary to the Director.

5. Investigations

The Frauds Bureau received 24,920 reports of suspected fraud in 2009, an increase of more than 8 percent over the 23,054 reports received the year before. Of the 2009 total, 24,119 were received from licensees required to submit such reports to the Department and 801 were received from other sources, such as consumers and anonymous tips. A total of 1,707 new cases were opened for investigation during the past year versus 1,367 opened in 2008, an increase of nearly 25 percent. Investigations also continued in numerous cases opened in prior years.

During 2009, the Bureau referred 533 cases to prosecutorial agencies for criminal prosecution and another 65 to the Department's Office of General Counsel for civil proceedings.

6. Arrests

Frauds Bureau investigations led to 738 arrests for insurance fraud and related crimes during the past year, compared with 755 in 2008. In one investigation, the owner of an insurance brokerage on Staten Island was arrested in March and charged with misappropriating $407,000 in premiums collected from 16 insureds. Another investigation led to the arrest in June of a Bay Shore, Long Island, doctor who filed $800,000 in allegedly fraudulent claims with numerous health care programs, including Medicare, for services that were never provided. Court papers also alleged that he evaded almost $1.3 million in income taxes from 2001 to 2003.

7. Civil Enforcement, Restitution and Forfeitures

Section 403 of the New York Insurance Law authorizes the Insurance Department to levy civil penalties of up to $5,000 plus the amount of the claim on individuals who commit fraudulent insurance acts. Under the provisions of Section 2133 of the New York Insurance Law, the Department is also permitted to levy a civil 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.

The Frauds Bureau began prosecution proceedings in 72 civil fine cases in 2009, versus 59 cases in 2008, an increase of 22 percent over the prior year. In addition, 36 civil fine cases were concluded during 2009, improving on the 2008 total of 24 cases by 50 percent. Among the types of civil fine cases in which the Bureau saw increases were fraudulent homeowners, workers' compensation and disability claims. The number of civil fine cases involving fraudulent auto theft and vehicle arson remained steady over the prior year. As a result of the Bureau's increased civil enforcement activities, $2.86 million in penalties were imposed during 2009, up from $1.68 million in the prior year, a year-to-year gain of 70 percent.

Court-ordered restitution totaled $5.1 million during the past year as a result of Frauds Bureau criminal investigations. Moreover, insurers saw savings of $4.0 million in connection with fraudulent claims investigated by the Bureau, an amount more than three times greater than the prior year's total of $1.2 million and the highest savings total in the past five years.

In addition, defendants in five separate cases were ordered to make asset forfeitures totaling $26.1 million in connection with their plea agreements during 2009. In one case alone, a former chief underwriter for an insurance company forfeited $22.5 million along with real estate. He was sentenced to ten years in federal prison for selling $535 million in fraudulent surety bonds and stealing $22.5 million in premiums.

8. Training

a. Staff Training

Investigators participate in the Bureau's In-Service Training Program designed for all investigative staff. In addition, newly hired investigators participate in an Entry-Level Training Program. Both programs were developed by the Training Officer and 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 broad law enforcement experience and often exceed the high standards set by DCJS.

Frauds Bureau Training Officer John Marcone and Senior Investigator Mark Sirkin are Certified Firearms Instructors and provide both upstate and downstate investigators with appropriate instruction in firearms safety and proficiency. While certification in firearms aptitude is required by DCJS on an annual basis, all Frauds Bureau investigators must recertify semi-annually, demonstrating the importance the Bureau attaches to the responsibilities involved in the proper use of firearms.

b. Outreach

Two training sessions were conducted at the New York City Police Academy during 2009, attended by 480 recruits. In addition, two sessions were given to 63 recruits at the Westchester County Police Academy. 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. Therefore, the Bureau has placed great emphasis on the training of police recruits.

Frauds Bureau staff also provided training to members of the insurance industry and local police and fire departments throughout the State. In addition, investigators joined the Department's Deputy Superintendent for Community Affairs, Ivan Lafayette, to give presentations to a number of community groups during 2009. Deputy Superintendent Lafayette is responsible for planning and directing the Department's outreach and community affairs initiatives, services and programs on issues affecting a broad spectrum of consumers, including the senior population. In all, the Bureau provided training for 35 groups comprising 1,597 participants during 2009.

9. Fraud Prevention Plans/Public Awareness Programs

Section 409(a) of the New York Insurance Law (NYIL) and Department Regulation 95 require all insurers that write at least 3,000 policies annually of automobile, workers' compensation and accident and health insurance to submit to the Department a Fraud Prevention Plan (Plan). The Plan must provide for a Special Investigations Unit (SIU), separate from claims and underwriting, responsible for investigating cases of suspected fraud and for implementation of the insurer's fraud prevention and reduction activities. In lieu of an SIU, an insurer may contract with a separate provider of such services and then must provide to the Superintendent a detailed copy of the signed contract. The Plan must address training for claims and underwriting personnel, a public awareness program, interface with law enforcement and prosecutorial agencies, among several other requirements.

Affiliated insurers may submit one Fraud Prevention Plan covering multiple insurers. Additionally, some insurance carriers submit more than one Plan to address different lines of business or different SIUs within the insurer. At year-end 2009, there were 133 Plans on file.

Regulation 95 and Section 409(c)(5) of the NYIL require that Fraud Prevention Plans provide for a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in its prevention. The programs must be geared to reach a wider audience than an insurer's policyholders and applicants. In an effort to achieve that goal, the New York Alliance

Against Insurance Fraud (NYAAIF) performs advertising campaigns using newspapers, radio and television to target insurance consumers. In 2009, there were 108 insurers with Fraud Prevention Plans on file with the Department that participated in the NYAAIF public awareness campaign. Additionally, 21 health plans or groups of affiliated health plans are members of the National Health Care Anti-Fraud Association (NHCAA), which carries out a public awareness campaign using newspapers and radio advertising. Moreover, several individual insurers have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year. The Bureau also has a hotline for reporting suspected insurance fraud (1-888-FRAUDNY) and consumers are encouraged to do so. The Bureau recorded on average 28 calls a week in 2009.

10. Electronic Filing of Annual SIU Reports

According to Section 409(g) of the New York Insurance Law, those insurers with Fraud Prevention Plans on file must also file an Annual Report by March 15 of each year. The Annual Report must describe the SIU's experience, performance and cost effectiveness in implementing the Plan. Since 2008, insurers are required to submit the Annual SIU Report electronically. Hard copy submissions of the report are no longer accepted.

11. Major Cases

The Frauds Bureau was involved in a number of multi-agency investigations during 2009. 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 major cases are summarized below.

a. Convicted

After a six-week trial in Brooklyn Supreme Court, Dr. Alexander Rozenberg and his clinic, AR Medical Art, were convicted on 2/20/09 of numerous charges. The doctor was found guilty of insurance fraud in the 5th degree and falsifying business records in the 1st degree. The clinic was found guilty of scheme to defraud in the 1st degree, insurance fraud in the 5th degree and falsifying business records in the 1st degree. Evidence showed that Rozenberg and his clinic purported to treat people injured in real and staged accidents in a complex scheme to defraud no-fault insurers. "Steerers" referred accident victims to the clinic where Rozenberg falsely diagnosed injuries, provided unnecessary medical treatments and prescribed costly medical equipment. The convictions were the result of a 20-month joint investigation by the Attorney General's Office, the Frauds Bureau and the NYPD's Fraudulent Accident Investigation Squad in which 25 defendants were charged. Twenty-three have pleaded guilty to criminal charges in connection with their involvement in the scheme. The case against the 25th defendant was dismissed.

b. Misappropriation

An investigation by the Frauds Bureau and the U.S. Postal Inspection Service resulted in the arrest of the owner of an insurance brokerage on Staten Island. The investigation was initiated based on a complaint from a broker and former employee alleging that the defendant had misappropriated premiums. The defendant was an agent for Navigators Insurance Company which provided cargo insurance for companies that shipped merchandise overseas. She was responsible for collecting the premiums for each shipment, issuing a certificate of insurance to the insureds, and remitting the premiums to Navigators. However, investigators discovered that when one insured filed a claim with Navigators, there was no coverage in place. Further investigation revealed that the defendant misappropriated a total of $407,000 in premiums collected from 16 insureds.

c. Too Many Claims

Between February 2005 and February 2008, the defendant in this case submitted 113 claims to United Healthcare Insurance Company for medical services he and his estranged wife allegedly received at a local family health care practice. He stated on the claims that they received medical treatments for which they paid $370 per visit. However, an investigation by the Frauds Bureau and the State Police revealed that neither the defendant nor his wife received any medical services at the health care facility in question. Over the three-year period, the defendant fraudulently collected $233,138 in reimbursements from United Healthcare.

d. Escrow/Other Funds Stolen

The operator of three title insurance agencies in New York and Suffolk Counties was charged with misappropriating millions of dollars in escrow and other client funds and embezzling a part of those funds for his personal use. An investigation by the Frauds Bureau, the FBI and the Office of the U.S. Attorney for the Southern District found evidence that between January 2008 and April 2009, the defendant allegedly withdrew about $2.2 million in cash from one of the companies. These withdrawals at times totaled $300,000 or more in a single month. To sustain the company's operations, the defendant essentially used new funds from clients to pay off debts to older clients. In addition, the defendant failed to record dozens of real estate transactions in a timely fashion in spite of the fact that he had already been paid to record them.

e. Fraudulent Mortgage Loan

A former physician, whose license was revoked in 2005, acquired a property in Saratoga, N.Y., from its former owners who were facing foreclosure. No money changed hands. Then, based on a fraudulent mortgage loan, the new owner insured the vacant building for $475,000. However, a month later, on April 30, 2009, the building – vacant, abandoned and without power – burned to the ground under suspicious circumstances. An investigation conducted by the Frauds Bureau, the Town of Colonie Police and Fire Departments, the State Police, the Albany County DA's Office, the State Office of Fire Prevention and Control and the Albany County fire coordinator revealed that accelerants had been used inside and outside the building, a fact later confirmed by laboratory tests. Investigators alleged that the owner acquired the building for the purpose of setting the fire to collect the insurance payout. He was arrested on 5/27/09.

f. Owner Give-Up

The defendant in this case reported to the NYPD that her 2005 Nissan Altima was stolen and she filed a $13,380 claim with GEICO Insurance Company for the loss. The defendant claimed that all keys to the vehicle were in her possession and were never duplicated. The vehicle was factory-equipped with a transponder system that prevented the vehicle from being operated unless one of the programmed keys was used. However, FDNY Fire Marshals responding to a report of a vehicle fire found the same 2005 Nissan Altima on fire with no broken windows or glass in the surrounding area. A forensic examination concluded that the vehicle was not forcibly entered, the keys were not duplicated and there was no visible evidence that the vehicle's door locks or ignition systems were defeated. An investigation conducted jointly by the Frauds Bureau and the FDNY Fire Marshals resulted in the arrest of the defendant on 8/24/09.

g. House Afire

The owner of a home heavily damaged in a 7/23/09 fire was arrested on 8/14/09 and charged with deliberately setting the blaze. The home was insured through New York Central Mutual Insurance Company for more than $500,000 and, though a claim was filed, it was never paid. The arrest followed

a two-week investigation into the fire at the two-story frame structure where the defendant lived with his wife and three children. No one was at home when the fire was discovered by a neighbor who called the fire department. About 75 firefighters from Oneonta and surrounding departments, two of whom were injured at the scene, fought the blaze. The Oneonta Police and Fire Departments and the Frauds Bureau, with the assistance of a private investigator from New York Central Mutual, conducted the investigation that determined the fire was incendiary.

h. Over-Billing

In a case investigated by the Frauds Bureau, the FBI and the U.S. Attorney's Office, a Monroe County podiatrist was arrested on 10/28/09 and charged with health care fraud and mail fraud. He treated elderly patients at nursing homes and retirement homes, usually clipping their toenails and performing other routine procedures that are not covered services. Then he billed Medicare for complicated surgical procedures. The investigation uncovered many discrepancies in the doctor's billing records and medical charts that indicated a pattern of fraudulent billing. The amount of the alleged fraud is estimated at more than $750,000. If convicted, he faces ten years in prison, a $250,000 fine and restitution of the $750,000 in fraudulent claims he filed with Medicare.

i. Embezzlement

A licensed life insurance agent was charged with embezzling $109,000 from 29 clients and using the money for personal gain. An investigation by the Frauds Bureau revealed that between 2007 and 2009, he changed the addresses on clients' insurance policies to his own address and then requested loans against those policies. The checks were made out to his clients but mailed to the agent. He allegedly forged the clients' signatures and deposited the checks into accounts he controlled. Records obtained by investigators indicated that the defendant used the money for gambling. He was arrested on 11/19/09 and charged with grand larceny and forgery.

j. Corrupt Chiropractor

An investigation by the Frauds Bureau, the Queens DA's Office and Empire Blue Cross and Blue Shield led to the 12/15/09 arrest of a Queens chiropractor charged with insurance fraud after investigators found evidence that he convinced a "patient" to fabricate injuries and then billed Empire Blue Cross and Blue Shield over a three-month period for more than $26,000 in medical treatments. He allegedly paid a $1,000 kickback to the "patient" who was actually an undercover investigator. According to the charges, the defendant met the undercover at his office on 9/16/08, where he instructed the undercover to fabricate back and knee injuries in order to obtain insurance payments. The defendant was charged with grand larceny in the 3rd degree, insurance fraud in the 3rd degree and falsifying business records in the 1st degree.

12. Special Prosecutor Program

The Special Prosecutor Program is a pilot program initiated by the Insurance Department in which Frauds Bureau attorneys assist local DA's Offices with prosecutions. In 2009, the program was expanded and now has a Memorandum of Understanding with 12 participating county prosecutor's offices. As part of the program, Frauds Bureau attorneys are cross-designated as assistant district attorneys and assist in all aspects of the cases to which they are assigned. During 2009, there were 17 cases assigned to Ulster County, resulting in 12 felony convictions. In ten of those cases, the defendants pleaded guilty to multiple felonies. A case prosecuted under the program in 2009 is summarized below:

- In the first of these cases to go to trial, a couple who were charged with 3rd degree insurance fraud agreed to a plea bargain on 10/31/09 after a jury heard three days of testimony. Michelle Pike pleaded guilty to a reduced charge of insurance fraud in the 4th degree, a felony. She

agreed to pay a $2,500 fine and provide a DNA sample for the State database. Her husband, Kenneth Pike, pleaded guilty to insurance fraud in the 5th degree, a misdemeanor, and agreed to pay a $1,000 fine. The case stemmed from a claim filed by the couple stating that a June 2008 lightning strike caused extensive damage to electrical appliances in their home.

In addition, under a program initiated in 2003, Frauds Bureau investigators are assigned to prosecutors' offices to work side-by-side with their investigative staff. During 2009, investigators were assigned to the Suffolk, Queens and Westchester County DA's Offices.

13. Waiver of Co-Insurance

The Frauds Bureau, in conjunction with the New York State Comptroller's Office, continued to recoup refunds for New York State from health care providers who submitted inflated bills to United Healthcare, which administers the Empire Plan, the primary health insurance plan for State employees. To date, New York State has received almost $12 million in refunds and $124,000 in fines from a number of health care providers. The bills submitted by the providers did not reflect the fact that the out-of-network providers were systematically waiving co-insurance payments that were required to be paid by Empire Plan members. Because payments should reflect the actual charge, the bills were improperly inflated by the amount waived. Following reports by the New York State Comptroller that the providers were waiving the required co-insurance payments, the New York State Insurance Department conducted its own investigation and as a result received signed stipulations from a number of the providers. In those stipulations, the providers agreed to pay civil fines and to reimburse United Healthcare for the overpayment of claims. The stipulations also state that the providers will discontinue the practice of waiving co-insurance payments for Empire Plan patients. The Department is negotiating fines and reimbursements with a number of other providers involved in this investigation.

14. NAIC Internship Program

The National Association of Insurance Commissioners sponsors an International Internship Program to advance working relations with foreign markets with an emphasis on the exchange of regulatory techniques and technology. Interns participate in a weeklong orientation at NAIC headquarters, focusing on the broad principles of insurance regulation. Then each intern travels to a different state for five weeks, working in technical areas of their specialization. In November and December 2009, the Frauds Bureau gave presentations to Ma Bing, an intern from the China Insurance Regulatory Commission. The presentations included an overview of the Bureau's operations, followed by a question-and-answer session. Such discussions provide an opportunity for the exchange of ideas on topics that are of particular interest to the interns.

15. Mobile Command Center

The Department's Mobile Command Center (MCC) was dispatched to Gowanda and Silver Creek in the State's Southern Tier to assist residents in Chautauqua, Cattaraugus and Erie Counties affected by serious flooding that occurred August 9-10. Personnel staffing the MCC were available to answer questions regarding insurance policies and coverage, as well as to assist with insurance-related complaints. The Frauds Bureau's Manager of Information Technology Services Nikki Brate, Senior Investigator John Toucher and members of the Department's Consumer Services Bureau staffed the MCC on site during the disaster recovery efforts.

In addition to disaster response, the MCC has proven to be a valuable state resource. It has been used by a number of Executive branch agencies to provide the equipment and facilities necessary to conduct field audits and for executing law enforcement operations.

16. Web-Based Case Management System

The Frauds Bureau's Web-Based Case Management System, known as FCMS, was fully implemented in the first quarter of 2007. In 2009, approximately 90 percent of the Bureau's fraud reports (IFBs) were electronically transmitted and received remotely from insurers. Insurers have access to FCMS through the Department portal using secure accounts.

The benefits to insurers include automatic acknowledgment of fraud reports, automatic notification of case assignments and eventual case disposition. Insurers also benefit from on-line help screens and an on-line manual of operations, as well as search and cross-reference features. Frauds and Systems Bureaus staff continually monitor the system and make improvements and changes as necessary.

17. Directions for 2010

a. Mortgage and Title Unit

The Mortgage and Title Unit was created in the summer of 2009 to concentrate Frauds Bureau resources to address two significant trends resulting from the downturn in the economy: an increase in theft of premiums and monies held in escrow by title agents; and the proliferation of schemes targeting indebted homeowners and other consumers in the real estate market. The Unit works closely with law enforcement agencies across the State, including the FBI, U.S. Attorneys, local district attorneys and the New York State Banking Department, to investigate and prosecute these crimes. Title insurance policies are designed to protect buyers and lenders in real estate transactions by ensuring that sellers have legal title to properties being sold. While title insurance business is regulated by the Insurance Department, there are currently no licensing requirements for individuals selling the insurance. The Department has recommended legislation that would require licensing of title insurance agents.

The Unit's investigators also focus on corrupt mortgage rescue companies that engage in a variety of fraudulent schemes promising to help consumers who fall behind in mortgage payments. These groups have targeted financially-troubled homeowners, low-income people and legitimate title insurance companies.

During 2009, the Unit received 326 reports of suspected fraud. The reports included allegations of agent defalcations, straw-buyer transactions and fraudulent mortgage applications. Investigators opened 18 cases for investigation and executed 19 arrests.

b. Life Settlements

In November 2009, legislation pertaining to life settlements was passed by the Assembly and the Senate and signed into law by Governor David A. Paterson. The Life Settlement Act provides a new comprehensive framework for the Department to regulate the life settlement business, including enhanced consumer protections. The new law also amended the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud.

A life settlement is the sale of a life insurance policy to a third party called a life settlement provider. The owner of the life insurance policy sells the policy for an immediate cash benefit. The life settlement provider becomes the new owner of the life insurance policy, pays future premiums and collects the death benefit when the insured dies, or may resell the policy to a third party.

The Act created a new Penal Law section that defines a fraudulent life settlement act as well as the new crime of life settlement fraud. The new law provides that a fraudulent life settlement act is committed when a person knowingly and with the intent to defraud presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by a life settlement provider, broker, intermediary, agent or owner, any written statement or other physical evidence as part of, or in support

of, an application for a life settlement contract or a claim for payment under a life settlement contract that contains materially false information concerning any material fact, or conceals for the purpose of misleading any information concerning any material fact.

The provisions of the new life settlement fraud statute range in severity from the fifth degree, a class "A" misdemeanor, to the first degree, a class "B" felony, based on the value of the property that was wrongfully taken, withheld or obtained as a result of the fraudulent life settlement act. If an individual commits a fraudulent life settlement act and does not obtain any property as a result, that individual has committed the crime of life settlement fraud in the fifth degree. Individuals are guilty of life settlement fraud in the first degree when they commit a fraudulent life settlement act and as a result obtain property having a value greater than $1 million.

Among other provisions, the legislation:

- Makes the commission of a fraudulent life settlement act a violation of the Insurance Law;
- Defines a fraudulent life settlement act by reference to Penal Law Section 176.40;
- Adds "fraudulent life settlement act" as one of the actions for which the Superintendent is empowered to impose a civil penalty;
- Amends the Insurance Law to include the business of life settlements within the activities that the Superintendent may investigate;
- Amends Section 405 of the Insurance Law to require life settlement providers to report to the Insurance Frauds Bureau suspected instances of insurance fraud; and
- Creates Section 411 of the Insurance Law, which provides detailed requirements for life settlements fraud prevention plans that must be implemented and reported annually to the Superintendent.

c. Proposed Revisions to Regulation 68

After several years of decline, the number of suspected no-fault fraud reports began to rise in 2007 and that trend continued through 2009. Suspected no-fault claims totaled 13,433 in 2009, an increase of almost 9 percent from 2008, and accounted for 54 percent of all fraud reports received during 2009.

Data in a recent analysis by the Insurance Information Institute (I.I.I.) showed that the average no-fault claim cost in New York was $8,690 in 2009, surpassing the average of $5,615 in late 2004 by a significant 55 percent. I.I.I. reports that New York's no-fault claim costs are the second highest in the country and are 109 percent higher than the U.S. average of $4,152. As an inevitable consequence, auto insurance rates for New York drivers are increasing as well.

No-fault fraud is often perpetrated by highly organized criminal entities that can include corrupt medical clinics and corrupt attorneys, acting with staged accident/solicitation rings to submit fraudulent no-fault and bodily injury claims.

In an effort to combat no-fault fraud and abuse and to help keep New Yorkers' automobile insurance premiums from skyrocketing, Superintendent James J. Wrynn has proposed revisions to Department Regulation 68, which implements the no-fault statute. The proposed revisions include:

- Modifying prescribed forms to require more information to ensure that claims paid are medically necessary and reduce the need for additional verification by the insurer, thereby expediting claims processing and legitimate payment to consumers. Insurers would have greater latitude to deny health services that are not provided or are not billed in compliance with the applicable fee schedule, thus reducing payment of fraudulent claims and instances of over-billing.

- Simplifying procedures required for insurers to suspend all payments for claims submitted by the owners of medical clinics suspected of fraud while an investigation of the clinics' licensing status is underway.
- Insurers would have to schedule medical examinations they request so as not to overly burden the insured. For example, examinations may not be scheduled in geographically inconvenient locations and multiple exams may not be scheduled on the same day.
- Raising the maximum attorney fee from $850 to $2,500 to reflect inflation and to reduce the incentive for claimants and providers to file small claims separately, and eliminate the minimum attorney fee to encourage the consolidation of claims in arbitration and litigation.

Combating no-fault fraud remains an important part of mitigating the increase in auto insurance costs. The Frauds Bureau's No-Fault/Medical Unit is dedicated to rooting out no-fault fraud, as well as other forms of health insurance fraud.

18. Legislation

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

- 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;
- Adding language to Section 176.05 of the New York State Penal Law to specifically include electronic and oral communications in the definition of insurance fraud;
- Requiring a periodic certification of continued eligibility by recipients of workers' compensation or disability benefits;
- 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;
- Increasing civil penalties for knowingly possessing, transferring or using fraudulent insurance documents;
- Creating a class E felony for possessing or uttering a false insurance document/instrument;
- Increasing penalties in the Vehicle and Traffic Law to reduce the number of uninsured or unlicensed motorists in New York State; and
- Amending Section 109 of the Insurance Law to increase the penalty from $500 to $2,500 for licensees who willfully violate the Insurance Law.

Section 405 of the New York Insurance Law requires the Superintendent of Insurance to submit to the Governor and the Legislature a comprehensive summary and assessment of the operations of the Frauds Bureau by March 15 of each year. The 2009 Frauds Bureau Annual Report is available on the Department's Web site at www.ins.state.ny.us.

F. INFORMATION SYSTEMS & TECHNOLOGY BUREAU

The Information Systems & Technology Bureau (Systems) provides information technology products and services to over 900 Insurance Department employees and supports the Department's technical infrastructure. Systems' clients include insurers, the public, federal, state and local agencies, other insurance regulators, actuaries, insurance examiners, frauds investigators, risk management specialists, real estate appraisers, lawyers, researchers and statisticians.

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

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

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

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

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

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

The Operations and Production Unit (OPU) is responsible for production and for the Computer Operations, and Help Center functions. The Help Center is the first line of support in assisting the client

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

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

1. Web Site

In 2009, both the Web site and Intranet underwent more changes to make each environment more user-friendly to visitors and staff, and easier for staff to maintain the Department's hosted Web sites. In addition, several new features were implemented on the Department's main Web site.

The main Web site and supporting 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 2009. The Department's activities and applications are reflected on these sites.

In 2009, there were 4,222,237 unique visits to the Department's Web site, displaying a 3.8% increase from 2008. However, a very significant increase Hits (page views per Visit) occurred in 2009, reaching 34,579,828, 66.5% higher than in 2008.

CHART K

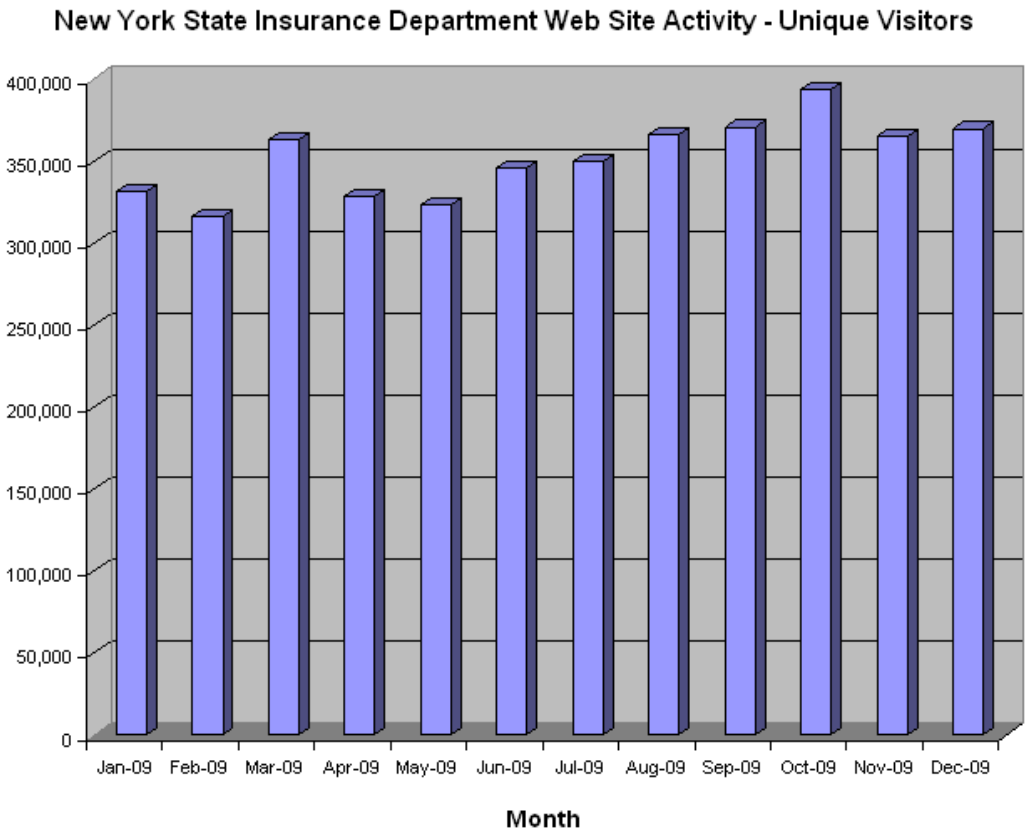


Chart L

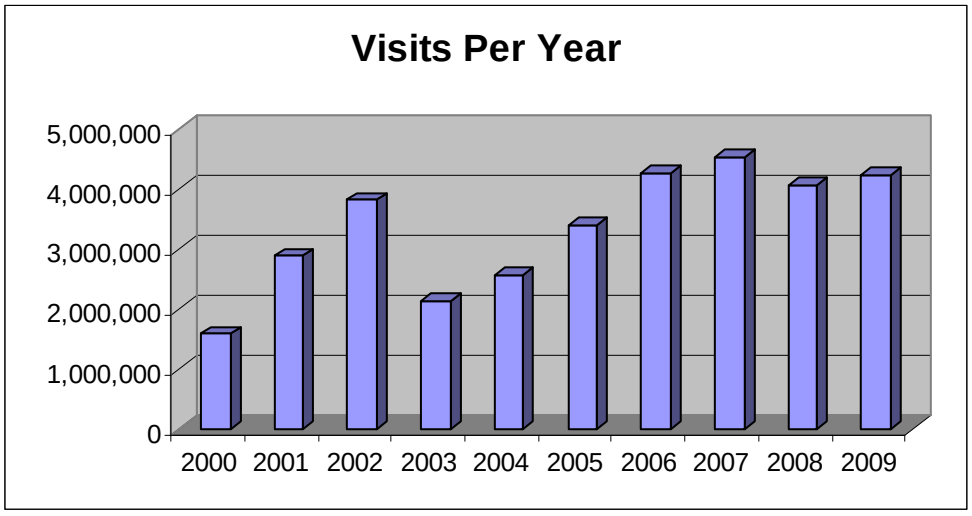
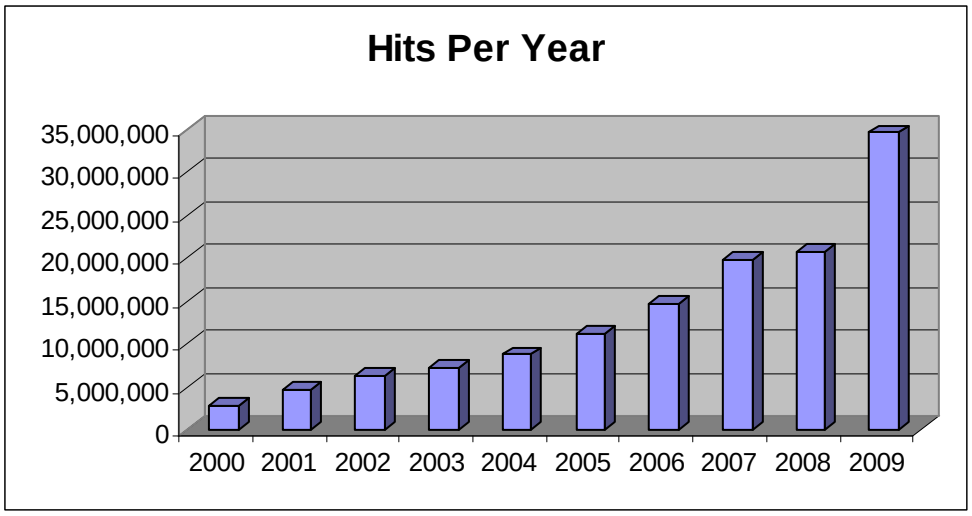


Chart M



The Department takes pride in its Web site's depth of content, relevancy, and currency, and the information available on the Web site has increased a great deal.

The following new accomplishments took place in 2009:

- "Basics of Long Term Care Insurance" section
- Circular Letters
    - New Search utility
    - Circular Letters are available in HTML and PDF format.
- "Department Events" section
- "Email the Licensing Bureau" e-Form
- Examination Reports - section Redesign
- Facebook page
- "Historical Documents and Archives" section
- "Insurance Department Records" index
- "Legislative Summaries" section
- "Memorandums of Understanding (MoU)" section
- "Reports and Recent Publications" index
- Swine Flu information pages
- Selected OGC Opinions section – New Index
- Twitter page

Other major accomplishments include:

- Updated "Top 10 Questions to Ask When Purchasing Insurance"
- 2008:
    - Annual Report of the Superintendent
    - Annual Statement and New York Supplements
    - Annual Report on the Healthy NY Program
    - Frauds Bureau Annual Report
    - Health Care Fraud Annual Report
- 2009:

  - Annual Ranking of Automobile Insurance Complaints
  - Annual Ranking of Automobile Insurance Companies
  - Consumer Guides (Automobile, HMOs, Homeowners, Health Insurers)
  - Financial Property Company Pre-audit Questionnaire
- Agents and Brokers: Excess Line Broker - 2008 Premium Tax Statement Section 2118 Form and Instructions
- Department Application Forms – Listing updated at various points throughout 2009
- Five-year Review of Agency Rules, January 2009 Regulatory Agenda
- Public Hearings – information sections formed for three that occurred in 2009
- Examination Report – over 130 reports posted
- Selected OGC Opinions – over 90 opinions posted
- "Fill-in" forms – more posted utilizing this Adobe PDF functionality
- NYIN Alerts – 142 posted (over 500 have been posted since February 2003)
- HOME page design updates
- Licensing section design updates
- "NYS Website Customer Satisfaction Survey", “Office of Taxpayer Accountability”, and “Citizen Contact” component integration

2. Intranet

The Department’s Intranet is a strategic internal communication facility that contains a wide range of content relevant to Department staff. New sections implemented this year include:

- Area-Wide Disaster information
- Systems Liaisons section
- Systems Requests Liaisons section
- Training section – XML-based

The Intranet is continually updated to facilitate quick exchange of information throughout the Agency.

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

3. Annual Statement Filings

The Department continues to collect the electronic filing of insurer financial statements via the National Association of Insurance Commissioners (NAIC) Web site. Virtually all companies now file this way. This one stop shopping approach allows companies to file not only national forms over the internet but also New York supplemental data. The Department has eliminated the hard copy paper requirements for the Management Discussion and Securities Valuation Office (SVO) forms for all foreign companies by using the Adobe Acrobat PDF filings made available on the NAIC Web site. The Department announced that beginning with the 2007 filing due March 1, 2008, all Foreign Insurers and foreign accredited reinsurers that file their Annual Statements and New York Supplements, Quarterly Statements and Audited Financial Statements pursuant to Section 307 or 308 of the New York Insurance Law on the Property and Casualty and Title blanks, are no longer required to file hard copy

(other than a Jurat) as long as they file electronically with the NAIC via the Internet. It is the goal of the Department to continue this process and eventually eliminate all paper filings.

4. Imaging and Workflow:

The Complaint Imaging and Information Management System (known as CIIMS), is a full featured workflow imaging application, initiated in November 1998, to automate the processing of consumer complaints. CIIMS has improved turnaround times for complaint handling and eliminated paper handling and filing since all documents are stored electronically. Although complaints and responses received by mail are scanned into the system, the amount of paper processed continues to decrease as electronic handling increases. Over the last several years the number of complaints received on-line has steadily increased, and currently 40% of all complaints are received on-line. Approximately 28% of responses are received online and another 42% are received by our fax system and are electronically imported into CIIMS.

Since its inception, the system has been enhanced several times. In 2001 a web application allowed consumers to submit complaints on-line. In 2003 processes were added for online complaints from Health care providers and online responses from insurance companies. In 2007, 2008 and 2009 modifications were made to enable the processing of complaints by the regulatory bureaus.

In late 2009 work began for a major renovation of the system. The new system will build on the existing one, but be browser-based and provide improved functionality for all users of the system.

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

The Property Bureau and Health Bureau have increased their capabilities and continue to utilize imaging to enhance their Rate and Form Filing processes. The Bureaus have completed the migration to non-proprietary file formats to expedite the FOIL process. They continue to seek opportunities to modernize other business processes.

The Capital Markets Bureau continues to employ imaging to store all document sources currently filed in paper. This permits concurrent use of the information and permit multiple access methods to a centralized repository. Storing the documents in their original format of Excel spreadsheets or Microsoft Word (as examples) also positions them to leverage work completed for former projects.

These workflow enhancements have assisted in phasing out legacy mainframe applications

5. Domino Workflow Applications

Workflow and collaboration initiatives continued to be engineered using IBM's Lotus Notes/Domino software. At the conclusion of 2009, the Department's Domino Application Portfolio was comprised of over thirty solutions that automate workflow, provide electronic document management and storage, deliver real-time reporting, maintain historical information, and leverage the Department's investment in Lotus Notes email using electronic routing and on-line collaboration. Applications are engineered using common framework and security, and an integrated development approach that optimizes our investment in our in-house development resources. These business applications replace

manual and less efficient solutions, increasing staff productivity, reducing costs, and ensure business recovery and continuity.

During 2009 several new applications were initiated:

- Human Resources Assignment Tracking System – provides a workflow management and collaboration tool for the management of task assignments for staff in the Human Resources Bureau. This application is scheduled for a 2010 release.

- Department Forms – was created in response to the Governor's paperless directives and to electronically replace the submission of paper documents, provide better protection of employee private information and to centralize the tracking and approval processing of staff forms, such as the Voluntary Reduction in Work Schedule (VRWS) submissions. A 2010 release date is planned.

- Executive Correspondence Tracking System – provides a workflow management and collaboration tool to electronically track Department activity and response for correspondence received by the office of the Superintendent. This application replaced a proprietary software solution, InterTrac, thus reducing the Department's cost to maintain this software.

- Domino Applications Portfolio – a new page was introduced to the Lotus Notes workspace to provide a single point of access to production applications.

- Additionally, a re-engineering of the Department's External Appeals application replaced the ten year old design of the application. In addition to bringing the application up to current environ standards, the enhancements include more secure protection of applicant medical information, an improved, interactive form design to ensure the correct collection of relevant appeal information, and a solution to archive and maintain essential appeal data to support the annual report to the State Legislature and regulatory modeling.

6. E-Commerce

E-Commerce initiatives continued to provide significant value to our external constituents as well as Department staff. The number and variety of processes that are available on-line has expanded year after year and is now the "defacto standard" for processing licensing related activities. Agents and brokers can apply for their original license or renew their licenses when the time comes; they can pay their fees via a credit card and their relationships with insurance companies (appointments and terminations) are all handled quickly and seamlessly via the Internet. Processes that once took weeks or months to complete are now typically processed overnight. In 2009, the Department processed 54,269 credit card transactions totaling $5,522,326.09 on behalf of our customers without touching paper forms, handling checks, or bank deposits.

In 2009, the Department began accepting monthly Motor Vehicle Law Enforcement Fee filings on-line. The 503 filing processed represented approximately 10% of the total filings received. This was the Department's first on-line application that allowed licensed companies to pay their fees through an electronic funds transfer (EFT); the amount collected in 2009 was $4.6 million. To Departments efforts to reduce the processing of paper forms and handling of fees will continue with the introduction of additional on-line statutory filing applications.

The voluntary electronic funds transfer of the Fire Tax 2% assessment continues to gain popularity. In 2009 the number of fire districts that opted to receive electronic payments was 1792. Now 88% of all fire districts receive their payments electronically and the dollar volume distributed this

way was over $29.6 million. This increase in electronic payments continues to streamline what has traditionally been a paper intensive process.

7. Enterprise Portal

Sybase Enterprise Portal (EP) technology is a valuable business tool that provides on-line access to applications and information across platforms and back-end databases. The Portal's Security Administration allows us to manage both internal and external clients by individual application. It sets in place a security structure in which each user can access those applications for which they are authorized to access and the roles they are authorized to execute. Applications for Department staff whether web based or legacy systems, use a single user id for accessing information across the entire Department. Some examples are: Central File, Inter-Active Insurance Company Search, OGC Opinions, OGC Historic and Summary and Industry Reports.

The Portal Security model for outside clients utilizes Automated Delegated Administration which provides for the creation of accounts, application sign-up and delegating the management of company user accounts by the application's "Trusted Source", the designee of a company by a senior Company official. Starting in 2007 we have continued to expand Web Based external facing applications to include a number of secure data collection applications for the Insurance Industry thus eliminating the need for paper based filings.

The Department maintains a variety of interactive applications for the Insurance Community at large:

- Motor Vehicle Law Enforcement Fee System allows Insurance Companies to electronically submit and remit payment through ACH debits.

- The 36th Amendment to Insurance Regulation 62 in response ED Legislation -- A secure, self-service “Look-Up” via the Portal by authorized Health insurers to verify sensitive data supplied by DCJS.

- The Risk Exposures (AIG), Mandated & required per Insurance Law Section 308 -- In response to the recent AIG financial issues, implemented a secure, self-service on-line eDocument submission via the portal for up to 10 confidential files which started Oct. 1, 2008.

- The Retirement Systems and Pension Funds, Mandated & required per Insurance Law Section 307 or 308 -- A secure, self-service on-line eDocument Submission via the Portal for up to 12 New York Annual statement related files.

- The Health Insurance Data Exhibit(HIDE) eForm through the Portal, Mandated & required per Section 350.2 of New York Regulation 145 -- A secure, self-service on-line e-Form or e-Bulk data collection via the portal for HIDE exhibits for twice a year electronic submission.

- The Annual SIU Frauds Report, Mandated & required per Insurance Law section 409(g) & Reg. 95 I -- A secure, on-line eForm data collection for prior year & current year plus eAttachment file submission.

- The Liquidity and Severe Mortality Inquiry, Mandated & required per Insurance Law Section 4217 -- A secure, self-service on-line eDocument Submission via the portal for up to 10 confidential files.

- The Disaster Planning, Preparedness and Response - Electronic Submission, mandated & required per Circular Letter#1, Insurance Law sections 301, 305, 308 , 2130 & 7001 -- A secure, self-service on-line eDocument Submission via the portal for up to 10 confidential files.

- NY Supp Public Access -- A public Application for the electronic view display and download of PDF New York Supplement submissions previously available under FOIL.

- NY Supp Tracking System -- An internal application that provides Regulatory Bureau staff with ability to bar code scan & check-in all Annual Statement filing. Application consolidates all information related to compliance for Annual Statement Filings for both hard copy and electronic for use by the Regulatory Bureaus (Life, Health and Property).

We provided current data for the following Interactive Web/Portal applications:

- Long Term Care for comparing sample premium rates for long-term care (LTC) insurance in New York. Released in conjunction with the Governor's Campaign media initiatives.

- Interactive Guide to Auto Insurance which includes the new interactive application for viewing and comparing Sample Auto Premiums. This application updates the Department's Automobile Insurance Guide enhancing the consumer's ability to compare insurance rates. Features facilitate calculating additional coverage and comparing coverage between two companies and among all companies. It also provides direct links to all representative companies' web sites and our Department website that contains links to all Automobile Insurance companies in New York.

- Licensing Interactive Reports are also available on the website for the following subject matter. In addition to providing current information from the Licensing database, Report Data for Service Contract Providers can be saved in a variety of output Formats (Excel, XML and CSV):

    1) Bail bond Listing - This lists our current Bail bond Agents with license numbers and business addresses.
    2) Continuing Education Provider listing - Lists Provider Name, Primary Contact, Address and phone.
    3) Monitor Listing - Lists Monitors with Address and Phone numbers by county.
    4) Prelicensing Provider/Course Listing - Lists Prelicensing Providers with addresses and phone numbers.
    5) Service Contract Registrants - Lists Company Name, Effective Date, Expiration Date, and Address.

The Department maintains a FOIL eForm application and an updated overview page together with the Domino FOIL Request Tracking System. This allows for the electronic submission and response of FOIL requests.

Central File application provides a consolidated view of a company's profile, rather than viewing data on an individual application basis. It provides a Web based presentation already familiar to those who use our Web site and Intranet. The Portal technology supports the Central File requirement of a centralized information management portal repository whereby Department personnel can access and search all organizational information. These data sources include Microsoft Access, Excel and Word files along with Adobe PDF files and application data residing in Sybase databases.

Sybase Enterprise Portal (EP) technology supports the requirement of full text search for OGC Opinions. OGC Opinions provides Public Opinions only for non-OGC staff members. Access to the full

set of Opinions is maintained for OGC users through Portal security. OGC Opinions includes features for "highlighting" within the document retrieved.

8. Infrastructure

The Systems Bureau continues to enhance, expand and harden the Department's infrastructure. Numerous initiatives have been implemented towards this end. The Systems Bureau works with the New York State Office of Cyber Security and Critical Infrastructure Coordination to continually enhance security and benefit from the experience and expertise of other agencies.

The highlights of our infrastructure changes include:

- Addition of redundant SANs in Albany and NYC
- Addition of "Neverfail" – Redundant Blackberry Server
- Addition of Google Groups – Replaces our West Workspace system
- Addition of SSL VPN – Additional means for employees to work from home in time of a disaster
- Server Virtualization. We have replaced or eliminated over 40 physical servers and replaced them virtually.

9. Disaster Recovery/Business Continuity

The Systems Bureau holds monthly Systems Disaster Preparedness meetings covering disaster recovery and business continuity. Staff from all units meet and discuss current projects and issues. A matrix listing all current, ongoing, and completed projects are listed. Related documents are stored on the network, and on pen drives that staff carry with them. We also copy these documents on removable media as well.

The highlights of our efforts include redundant Storage Area Networks in both Albany and NYC. There was also the addition of a product called "Neverfail" that provides redundancy for our Blackberry service. There was a lot of effort put into Oracle Database redundancy, which we continue to enhance. Systems also created Google Groups to share information internally in time of a disaster. This replaced the West Workspace system we used before. Systems continue to provide a means for employees to work from home by adding SSL VPN technology to the options available. Additional work continues in this area. Finally, Systems worked with the Disaster Preparedness Bureau to update the Department's Disaster Recovery plan. The Systems Bureau also participated in the CyberFIRE 2009 disaster exercise.

10. Frauds Case Management System

The Frauds Case Management System (FCMS), initially released in February 2007, is a web based system with two components; an internal imaging and workflow section used by Frauds Bureau staff for case management and an external module that enables insurers to electronically transmit reports of suspected fraud called "Information-Furnished-By" reports (IFBs). Insurers obtain remote access to FCMS through the Department's portal. In 2009, continued work on FCMS further improved case management, reporting and the process for filing IFBs.

The Frauds Bureau received approximately 25,000 IFBs in 2009. Of these, approximately 90% were submitted by insurers remotely over the web.

Both the Frauds Bureau and insurers continue to benefit from the System's many updated features which include improved workflow/tracking capabilities for more efficient processing of cases, automatic notifications and online search and cross reference features.

G. OFFICE OF GENERAL COUNSEL

The Office of General Counsel's principal responsibilities include: providing the Superintendent, Deputy Superintendents, Bureau Chiefs, and public with legal opinions and advice concerning the Insurance Law; enforcement, including conducting all of the Department's disciplinary proceedings and negotiating stipulations with insurers and producers; coordination of investigations into insurance matters with the New York State Attorney General's office, federal Securities and Exchange Commission, and/or other law enforcement authorities; supervision of all litigation brought by and against the Department; drafting and reviewing legislation, regulations, and circular letters; supervision of all conversions, corporate transactions, and demutualizations; legal review of all Requests for Proposals (RFPs) and state contracts; review of applications for insurer incorporation, licensing and related corporate activities; and managing responses to Freedom of Information Law requests made to the Department.

1. Legal Opinions

The Office of General Counsel issues legal opinions interpreting the Insurance Law to insurers, trade associations, producers, consumers, and city, state, and federal agencies. These opinions also provide guidance about the Department's policies. OGC issued nearly 124 opinions in 2009. All non-privileged opinions are posted to the Department's website (www.ins.state.ny.us) and are available to the public. OGC also has a public opinion database with a search engine that is available to the entire Department. This extensive electronic database includes more than 12,000 publicly issued opinions of OGC dating from the 1930s to the present and is updated weekly as new opinions are issued.

Among the corporate change matters that OGC supervises are applications by Article 43 health insurers to convert from not-for-profit to for-profit status, the review of which may culminate in the issuance of an Opinion and Decision from the Superintendent. In 2009, OGC continued its work on the proposed conversion to for-profit status of Emblem Health, Inc. In 2010, it is expected that a public hearing will be held and OGC anticipates drafting an Opinion and Decision for review and potential approval by the Superintendent.

2. Enforcement Matters

The Office of General Counsel handles the Department's enforcement matters, including all administrative hearings, disciplinary proceedings, civil fraud proceedings, and imposition of penalties pursuant to stipulations entered into in connection with consumer complaints, market conduct examinations, and financial condition examinations. In 2009, the Department entered into approximately 400 stipulations imposing penalties on insurance companies or producers (i.e., agents or brokers). In addition, the Department conducted approximately 61 administrative hearings, which resulted in disciplinary action against approximately 51 Department licensees.

OGC supervises and coordinates the Department's joint investigations and enforcement efforts engaged in with other law enforcement agencies, including the Attorney General's office. OGC oversees the Department's investigations of bid rigging and inappropriate compensation to producers in the property and casualty, life, and health insurance industries, as well as finite reinsurance and accounting practices, and title insurance industry practices, in coordination with the Attorney General's Office. During 2009, OGC continued to supervise the compliance examinations of Marsh & McLennan and Willis pursuant to the 2005 settlement agreements with these brokers, and oversaw the issuance of examination reports.

Working with the Department's Insurance Frauds Bureau and the Department of Civil Service, OGC assisted in the recovery of more than $11 million from healthcare providers who improperly waived coinsurance and thereby overbilled the New York State Health Insurance Program (NYSHIP)

Empire Plan. The providers also entered into Department stipulations whereby they paid fines and agreed to discontinue the improper practices.

OGC also manages all outside litigation brought against the Department and all subpoenas and document requests served on the Department and its staff.

3. Special Projects

The Office of General Counsel contributes substantially to many special projects undertaken by the Superintendent. For example, throughout 2009, OGC attorneys continued to provide substantial assistance to the Superintendent's efforts to stabilize the bond insurance market by facilitating the restructuring of three financial guaranty insurers.

OGC attorneys also took the lead in negotiating several Memoranda of Understanding that were signed in 2009 with various foreign regulatory authorities, including those of China, Japan, Thailand, Macau, and El Salvador allowing for international cooperation in regulation and regulatory enforcement.

H. CAPITAL MARKETS BUREAU

1. General Overview

The Capital Markets Bureau (CMB), established ten years ago, serves the Department on matters affecting the regulation of capital markets activities of New York licensed insurers and participates in the supervision of select public retirement systems and certain private pension funds of nonprofit organizations. CMB evaluates the various risks these activities bring to the financial condition of the insurers and pension funds.

The principal risk of capital markets activities within regulated entities is the potential for loss on investment instruments and investment portfolios that may materially affect capital adequacy. Managing this risk is the responsibility of the insurer's board of directors and management. A key to the regulation of capital markets activities is assessing what capital markets risks the insurer has and how it measures and manages these risks.

In December 2009, the Capital Markets Bureau assumed responsibility for all the financial guaranty companies and mortgage guaranty companies from Property Bureau. Wendy joined the Bureau, and under the supervision of Jack Buchmiller oversees the regulation of these companies.

Key initiatives from 2009 included:

- Analyze financial guarantors with a view toward evaluating how guarantors assess risk.
- Furnishing examination support – including pre-planning and on-site participation.
- Analyze and closely monitor the Financial Guaranty Insurers, during the period of deteriorating structured finance risk, and interact with rating agencies, investment banks, and legislature on the subject.
- Applying financial analytics to investment portfolios of insurers, including directing more attention to sub-prime, commercial mortgages and other structured securities, as well as alternative assets, such as hedge, venture capital and private equity funds.
- Participating in updating Regulation 85, regarding the NYS Common Retirement Fund.
- Conducting training for the Department’s staff on capital markets and investment portfolio dynamics; and coordinating training on risk-focused surveillance.
- Evaluating Enterprise Risk Management, investment risk management practices, and corporate governance of select insurers.
- Performing stress testing assessments, encompassing the evaluation of risk management practices of select companies.
- Leading NAIC working group to analyze regulators’ use of rating agency ratings when evaluating insurance company investments.
- Leading NAIC project to reduce regulator’s reliance on rating agency ratings for structured securities and providing and implementing alternative methods of evaluation.

- Leading Department effort to encourage insurer's to adopt standards for contract certainty to reduce ambiguity in insurance coverage.

- Interfacing with external entities, including other regulatory bodies, investment firms, risk management consultants, third-party asset managers, securities analysts, and rating agencies.

- Leading and participating in various NAIC Task Forces and Working Groups.

- Reviewing new and amended Derivative Use Plans of insurers, and monitoring derivative activities.

- Supporting the Department's Office of General Counsel in consideration of credit default swaps, structured finance and other capital market activities.

- Assisting in the AIG restructuring.

- Monitoring insurance companies securities lending activity.

- Retained the services of Reuters market data to enhance financial analysis and reduce reliance on the more expensive Bloomberg services.

CMB continues to employ its composite financial analysis framework designed to assess the investment risks of all insurers. The methodology, highlighting key investment ratios and credit quality ratings, primarily utilized financial information from the NAIC and Bloomberg databases. Its formulae identified insurers whose financial measurements placed them outside the normative range of their respective sector's financial profile. These insurers' investment portfolios were then subject to additional analysis by the Bureau. In areas of concern remaining after this targeted assessment, the Bureau solicited additional information on the companies' investment management criteria and objectives. When necessary, meetings or teleconferences were arranged to gain additional insights into the make-up of the portfolios, investment rationales, and approaches of these companies. Moreover, the integration of quarterly data into the reviews distributed to the Bureaus allowed for more comprehensive analysis.

CMB also continued to work in conjunction with the Life Bureau to establish and employ appropriate procedures and methodologies for evaluating the diverse investments held by the sizable public retirement systems in New York State. Ongoing development and further enhancement of key measures and review standards related to risk-based capital, risk management, organizational governance practices, and asset-liability management took place in 2009, and will continue to be addressed in 2010.

Last year, CMB continued to participate in on-site examinations, deliver in-house training programs, routinely disseminate news and information that served to enhance examiner understanding of the financial markets, and perform various Bureau-specific special projects. The Bureau's risk management specialists held teleconferences with select third-party asset managers responsible for investing in fixed income securities and equities, and managing derivatives for insurers. These exchanges provided additional data and information governing these managers' oversight, compliance practices and interface with client-insurers as well as generated more detail on the establishment of and adherence to investment guidelines. Meetings and teleconferences with rating agencies and investment banks continued to be conducted in order to solicit and share information relative to the capital markets activities of insurance companies and to familiarize the Bureau and the rest of the Department with emerging products such as new structured securities.

CMB maintained its active involvement in the work of the National Association of Insurance Commissioners (NAIC). CMB continued to preside over key groups responsible for the development of a risk-focused examination process better linked to principal solvency concerns, analyzing regulator reliance on rating agency ratings providing alternative methodologies to analyze securities, and refining the organizational and functional refinement of the NAIC's Securities Valuation Office ("SVO").

2. 2009 Highlights

a. Capital Markets Bureau Reviews

The Bureau performed investment portfolio reviews on insurance companies designated as "Priority One" by the Life, Property and Health Bureaus. In addition, CMB targeted 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 continues to refine its process 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. Given the demise of the global capital markets in 2008, much attention was paid to select insurers' derivative usage, the performance of alternative investments (private equity/venture capital funds) and the dynamics of structured finance transactions, particularly those securitized residential and commercial mortgages**.**

The reviews culminated in Investment Portfolio Analysis reports submitted to the life, property and health bureaus. These reports featured the application of Bloomberg analytics to generate value-at-risk, duration, beta, and other equity and fixed income portfolio risk measurements, and when available or necessary, incorporated analysis of quarterly data. Additionally, migration in average credit quality of bond portfolios was highlighted. If applicable, the reports also included profiles on derivative usage. Depending on the outcome of the analysis, the risk management specialists recommended further action to the respective bureaus.

CMB utilized various databases that it developed to facilitate sector and special situation analysis for assessing the degree of impact on insurers' capital adequacy and 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 2009, 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 57
ANALYTICAL EVALUATIONS AND REPORTS
2009

Type of Company	Priority 1 Desk Audits	Pre-Exam/4th Quarter Meeting Reports
Health	**11**	**3**
Life	**47**	**29**
Property	**48**	**35**
Total	**106**	**67**

b. Derivative Use

The Bureau continued to review filings of new Derivative Use Plans (DUPs) as well as amendments to approved DUPs of life health and property/casualty insurance companies. Prior to approval, CMB conferred with the Property and Life Bureaus on companies whose DUPs initially did not meet the established regulatory standards so that appropriate modifications by these plans could be made. Also, CMB reviewed DUP amendment submissions when changes were made to derivative strategies, or the management or oversight of derivative activities.

Primarily, in conjunction with ongoing exams, CMB reviewed the annual Internal Control over Derivative Transactions CPA reports on derivative usage and adherence to regulations submitted by the companies that are being examined. The risk management specialists combined with examiners from the applicable Bureaus followed up with companies on any significant lack of compliance with their filed DUPs and the associative statutes, and on laxity of internal controls.

Table 58
DERIVATIVE USE PLAN (DUP) REVIEWS
2009

TYPE OF REVIEW	LIFE	PROPERTY
New DUPs	**4**	**3**
Amended DUPs	**14**	**5**
Total	**18**	**8**

In addition to reviewing Derivative Use Plans, CMB, together with Life Actuaries, reviewed a number of dynamic hedging programs, which Life insurers use to hedge their long-term variable annuities.

c. Examination Participation

In its participation in examinations, the Capital Markets Bureau was active in utilizing its formulated risk-focused examination procedures related to capital markets oversight. CMB's exam participation was largely on a targeted basis and focused 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.

CMB personnel responded to other bureau's inquiries during the examinations of their respective licensees. The concerns addressed included the nature of various collateralized and structured securities, the jurisdictional basis for the Department's authority when dealing with foreign securities, derivative use plans, the status of various surplus notes, and the permissibility of cash deposits in various types of financial intermediaries and Certificates of Deposit exceeding FDIC coverage arranged through third parties.

d. Pension Supervision

During 2009, the Capital Markets Bureau participated in examinations of the New York City Retirement System. CMB reviewed how that systems formed and implemented policies and procedures, it had they adopted to meet its fiduciary investment obligations. CMB evaluated the sufficiency of governance structure and internal controls adopted to execute fiduciary duties. In addition, CMB reviewed the Systems' investment management, asset-liability management, and related policies, strategies and practices to assess how various risk factors and assumptions (including, but not limited to, market, interest rate, credit, and operational) have affected pension plan performance and how these risk factors and assumptions may impact the ability to meet future pension obligations.

e. Training Initiatives

Throughout the year, CMB staff also participated in teleconferences, investor briefings, and meetings held by various rating agencies and professional organizations. Moreover, CMB maintained its relationships with the leading insurance equity and credit analysts, ensuring critical access to their industry and company research.

CMB continued to participate in the NAIC International Internship Program by hosting interns from the Middle East and Eastern Europe. The Program is designed by the NAIC International Regulatory Cooperation Working Group to promote NAIC relations with foreign markets by emphasizing the exchange of regulatory expertise and technology. CMB staff provided the international interns an overview of the Bureau's analytical and evaluative processes, principal functions, and interface with the rest of the Department.

f. Special Projects

The Capital Markets Bureau was involved in several special projects stemming from capital markets developments in 2009. CMB staff researched technical topics and market transactions and

provided recommendations, when applicable. Key issues addressed by CMB throughout the year included the following:

- Financial Stress Testing – In November 2008, the Department took the lead in requiring New York domestic insurers to incorporate 'scenario stress testing' into their management processes. In 2009, we issued a 308 letter requiring select life companies to apply certain scenarios and shocks to their operations. We continue to follow-up on the results. As the CMB conducts on-site reviews of its domiciliary companies, CMB will seek companies' plans to manage interest rate shocks, equity market shocks, yield curve shifts, changes in credit quality and liquidity, rating agency downgrades, collateral calls and large-scale catastrophes. .

- Enterprise Risk Management (ERM) is a process within an insurance company that evaluates the company's ability to identify, measure, aggregate, and manage risk exposures within predetermined guidelines. The CMB in conjunction with the other Bureaus met with several insurance companies who were developing and implementing ERM. The goal of this task is to (1) to create an evaluation criteria, while developing an audit and examination program as a guideline to assist examiners in assessing the Enterprise Risk Management function of the insurance companies (2) to assess how well the ERM function aggregates risk across key activities and (3) to assess how well insurers quantify risks within each of the significant risks detailed above. Ultimately, the assessment will be integrated within risk-focused examinations.

- Financial Guarantors – Problems in US structured finance have caused credit concerns in the financial guarantor industry. The CMB has worked closely with the department and Federal agencies in addressing these problems for NY domiciled financial guarantors.

- Reg 140 (Continuing Care Retirement Communities) – CMB revised and formulated proposed language for the part of regulation governing allowable investments and investment limitations. This project required multiple meetings with the Health Bureau's assigned actuary and examination staff, in addition to a key meeting with industry representatives to discuss its equity proposal.

- Fraud and Money Laundering - Reviewed insurer's efforts to comply with statutes aimed at preventing fraud and money laundering such as the Bank Secrecy Act (which the Patriot Act extended to insurers), the Foreign Corrupt Practices Act, and the Office of Foreign Assets Control.

- Freedom of Information Act - CMB protected confidential information about a financial guarantor because the disclosure would have put the company at a significant competitive disadvantage; that protection was upheld by a New York state court.

- Quantitative models - reviewed quantitative loss models of external consultants. (ex. Rutter Associates, Thomas Ho, Andrew Davidson Associates, New Oak and Trepp) and financial guarantors. (Syncora and FSA).

- Credit Default Swaps – conducted seminars, researched and provided support to the Department's Office of General Counsel's (OGC) consideration of regulating these instruments.

- Analyzed the strategy and fee structure of an alternative asset manager.

- Worked with the Life Bureau and company actuaries to improve the transparency of liability duration.

- Assessed dynamic hedging programs.

- Monitor securities lending activity and work with the NAIC to enhance related reporting requirements.

- To support its efforts to attract international insurance trade to New York the Department has pursued contract certainty to assure transparency and accountability in transactions among market participants. After drafting the original Circular Letter by which the department asked industry itself to develop standards to provide contract certainty, CMB personnel met with industry participants to facilitate that development. After those meetings and a public comment period CMB personnel led the drafting of a supplemental letter.

g. Other Activities

During 2009, the Capital Markets Bureau contributed to the formulation of legislative and regulatory proposals. These covered: (1) legislation related to increasing the number of licensed captive insurers; (2) proposed amendments to the Credit for Reinsurance Regulation to address collateral funding by non-U.S. reinsures; and (3) the development of custodial asset regulation.

Throughout the year, CMB staff also gave capital markets presentations at the following outside venues:

- Life Insurance Council of New York Annual Legislative & Regulatory Conference.

- 2nd Annual effective SOX & MAR Strategies in the Re/Insurance Industry, How the Model Audit Rule may affect the Fiduciary Duties of Officers and Directors.

- New York State Bar Association Business Law Section Executive Committee, Banking Law Committee, and Derivatives and Structured Products Committee.

- The New York City Program in International Finance and Law of the State University of New York at Buffalo Law School.

The Capital Markets Bureau continued supporting the Department's traditional role in leading major working groups, task forces, and projects for the NAIC's Financial Condition (E) Committee ("E Committee"). CMB coordinated many of that E Committee's solvency-related considerations relating to accounting practices and procedures, blanks, valuation of securities, the Insurance Regulatory Information System ("IRIS"), financial analysis, risk-focused and zone examinations, and examiner training. CMB often provides technical advice to other NAIC groups.

CMB personnel used their expertise in investment and risk management to play a critical role as New York's representatives when chairing, and performing the work of, the following major NAIC bodies charged with creating and implementing policies at the leading edge of insurance supervision policy.

Valuation of Securities Task Force ("VOSTF")

New York chairs the VOSTF to help state regulators examine and evaluate insurer's investments by establishing policies and procedures and suggesting programs to the Securities Valuation Office to support existing supervision efforts and educate regulators about new financial monitoring and management technology.

New York leads the VOSTF's review of new investment vehicles that insurers have purchased, or are anticipated to purchase, and the creation of new standards for the proper disclosure and reporting of these new vehicles through the annual statement disclosures. New York leads the VOSTF's development and adoption of an annual agenda for the SVO Research division.

The VOSTF is the NAIC's forum for proposed changes to, and interpretations of, the Securities Valuation Office's Purposes and Procedures Manual (the "P & P Manual"). The P & P Manual sets out the standards and operations for the SVO's: evaluation of the creditworthiness of certain securities; classification of securities for Risk-Based Capital purposes; and valuation of various types of securities. The NAIC has charged the VOSTF with the responsibility of maintaining consistency and conformity with the NAIC's Accounting Practices and Procedures Manual. Capital Markets Bureau personnel are leading a Task Force effort to significantly improve both. The Task Force coordinates its efforts concerning SVO administrative issues with the NAIC's Internal Administration (EX1) Subcommittee.

Capital Markets Bureau personnel are leading the Task Force's study of possible improvements to NAIC processes by which risks in new invested assets are evaluated, communicated, and monitored, and how the annual statement investment schedules could be made more transparent to better reflect non-credit risks (e.g., structural risks embedded in new and existing securities).

New York led a fundamental reform of how the credit risk or Residential Mortgage-Backed Securities (RMBS) is assessed in insurance regulation. For year-end 2009, rating agency ratings are no longer used; instead, each security is analyzed to determine the expected loss under a variety of economic scenarios, and the NAIC designation and resulting risk-based capital charge are determined based on that expected loss, VOS is currently working to extend the same type of method to other structured securities.

CMB personnel have led the NAIC considerations of its rules for recognizing as admitted those assets maintained at various financial intermediaries (custody of insurer's assets) and taken an active part in others.

Risk Implementation Sub- Group

The Risk Assessment working group, chaired by NY, was dissolved in 2008 as it has completed its mission of enhancing the examination function by revising the Financial Condition Examiner Handbook. However, the Risk Assessment Implementation sub-group (RAIMS), which formerly reported to RAWG, will now report to the Financial Examiner Handbook Technical group and is still active. The RAIMS mission is to address issues which may arise in implementing the revised risk focused examination. NY is a member of the sub-group and the group continues its mission meeting periodically via conference call.

Investments of Insurers Model Act Revisions Working Group

CMB has supported this working group that is assessing state's implementation of current NAIC model investment laws. The group is also assessing the effectiveness of those models in addressing the regulatory issues becoming evident in insurers' portfolio particularly during this economic downturn. This group will provide a recommendation to the Financial Condition Committee, including a request for model law development or amendment and recommendations for resources to be devoted to those developments or amendments.

Rating Agency Working Group ("RAWG")

New York co-chairs this working group that was charged with evaluating the ratings issued by Nationally Recognized Statistical Rating Organizations ("NRSRO"), how regulators might better use them, and, if necessary, how regulators might improve their procedures where the use of those ratings have proven inappropriate in insurance regulation.

The working group held two national public hearings, surveyed regulators and market participants as to their practices regarding ratings, analyzed the appropriateness of ratings for regulatory use and is finalizing a report on its findings.

Simultaneously, New York has led a NAIC effort to develop alternative methods for analyzing those securities where NRSRO methodologies have proven inadequate. This is the first effort by any financial prudential supervisor anywhere to replace ratings that have proven wanting.

Invested Asset Working Group ("IAWG")

When the VOSTF determines that the technical nature of an issue before it would be best studied or advanced by a smaller group of regulators focused on more technical issues, it assigns those projects to the IAWG. The IAWG, when it has completed its deliberations, returns the issue, with its recommendations, to the VOSTF. These issues and recommendations may include changes to statutory accounting guidance, annual statement instructions, blanks reporting instructions, asset valuation reserves, interest maintenance reserves, risk based capital charges, valuation procedures for invested assets, credit assessment procedures for invested assets, or similar solvency supervisory solutions. Capital Markets Bureau personnel have taken a major role in leading the work of this Working Group's "Risk Subgroup" to identify, and develop methods to quantify, investment risks that would materially affect the risk profile of insurers' portfolios.

CMB personnel have provided key support to this group's consideration of risks other than credit that inhere in various securities and using that information to implement a reporting system that makes insurers' exposure to investment risk more transparent.

h. New Professional Personnel

Wendy Hung joined the Capital Markets Bureau in January 2010. In June 2001, Wendy graduated from Bernard Baruch City College majoring in accounting. Shortly, thereafter, she began working for the New York State Insurance Department, as a trainee. Wendy's training rotation at the Department, started with Property Bureau, then Health, Life and Consumer Services. After the two-year training program, she was assigned to Capital Markets Bureau as an Insurance Examiner in 2003, transferred; and was quickly, promoted to the Property Bureau as a Senior Insurance Examiner in February 2006.

I. DISASTER PREPAREDNESS AND RESPONSE BUREAU

General Overview

The Disaster Preparedness and Response Bureau (DPR) commenced operations on March 1, 2004. The principal function of the Bureau is to assist the Insurance Department and the New York insurance industry to prepare for, mitigate, respond to, and recover from natural and man-made disasters including modern day terrorism. The Department is the first insurance department in the nation to create such a bureau, dedicated solely to disaster preparedness.

During the past year, the Bureau was engaged in a number of initiatives outlined below to assist the Department in meeting its objectives. Bureau initiatives fell into three broad categories, preparing insurers to respond to consumers in a disaster, Department internal emergency management, and external partnering activities.

1. Preparing Insurers to Respond to Consumers in a Disaster

a) Circular Letters/Data Collection

The DPR Bureau continued to collect disaster preparedness data from the Department's licensees through the issuance of annual circular letters. This process of collecting data from Department licensees has evolved since 2004 when a single circular letter was used to collect data from all companies, into the issuance of separate circular letters to property and casualty type companies, health companies, and life companies, respectively.

During 2009, Circular Letter No. 6 (2009) was issued to property and casualty type companies; Circular Letter No. 7 (2009) was issued to health companies; and Circular Letter No. 8 (2009) was issued to life companies. 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 disasters that might affect the respective insurers.

The circular letters request all entities licensed to do business in New York submit data to the Department on an annual basis. In 2009, the Bureau continued collecting data pursuant to Circular Letters Numbers 6, 7, and 8 (2009) through the Department portal. Companies can now submit their Disaster Response Plan Questionnaires, Disaster Response Plans, Business Continuity Plan Questionnaires and Pre-Disaster data, directly through the Portal. Use of the Portal promotes a more secure environment for the companies to submit data to the Department and enhances the accuracy and efficiency of the data collection process.

To avoid the appearance of "rule making" without going through the process spelled out in the State Administrative Procedures Act (SAPA), the Department must re-issue the circular letters annually. Regulation 191 was drafted during the year to obviate the need for circular letters. The Regulation remains on the Department's Regulatory Agenda for 2010, and is anticipated to progress through the SAPA process in time for the 2011 data call.

b) Pre-disaster Data

Circular Letter No. 6 (2009) required companies writing commercial or personal property insurance in New York State to submit a "Pre-disaster data/information survey" by April 1, 2009. Each property/casualty insurer provided the Insurance Department a listing - by New York State County - of

property exposure information, as of December 31, 2008 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 2009 contained data from 271 entities representing 337 companies. These 337 companies wrote 98.9% of the 2008 direct written premium for the personal and commercial property lines covered in the report.

Planning for a disaster or emergency is just as critical as responding to its aftermath; therefore the Department collects and analyzes data from a variety of sources. The data can be used to pre-position resources and plan for resource allocation in the aftermath of the disaster. This process becomes extremely critical to insureds who expect prompt and fair payment of their claims. The data is collected and used to provide accurate, timely and consistent information to other government and volunteer agencies who also share a critical role in emergency response.

c) Disaster Response Questionnaires and Plans

As a follow-up to activities which began when the original circular letters were issued in 2004, all property and casualty type companies, health companies, and life companies were required to re-submit a “Disaster Response Plan Questionnaire” and “Disaster Response Plan” to the Department by June 1, 2009.

The Bureau received some 470 Disaster Response Plan Questionnaire submissions covering 840 companies; reports from 620 of these companies were among those expected to submit the report. This represents a response rate of approximately 83% as 620 of 735 companies expected to submit the report did so. Among the 620 companies, approximately 98% indicated that they had a disaster response plan in place that met the requirements of the governing circular letter.

During 2009, the Bureau received 279 new Disaster Response Plans and 189 renewal statements. (Renewal statements indicate that a company’s previously submitted plan was not updated during the ensuing year.) 154 of the new plans have been reviewed, and the Bureau has forwarded follow-up letters to 86 companies requesting updates and amendments to their Disaster Response Plans, the remaining 68 plans have been “completed”. The decision to forward a follow-up letter is based upon a comparison of the company plans with a checklist of items suggested as best practices. Plans that have fully met the standards of those checklists are designated as “completed”.

d) Business Continuity Plan Questionnaires and Plans

All companies covered by the circular letters were required to submit a “Business Continuity” Questionnaire to the Department by June 1, 2009. 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. The Bureau received some 428 submissions covering 864. This represents a response rate of approximately 85%, with 629 of the 744 entities expected to submit this report having done so. , Approximately 98% of the 629 companies indicated that they had a business continuity plan which was both “in place and up-to-date”.

e) The Pandemic Flu Survey

In September of 2009, the Department issued a Pandemic Flu Survey to all Department licensees to determine the level of pandemic influenza preparedness by the insurance industry and to bring awareness to the industry of the need to have a pandemic flu plan. The data on the life and property companies was segregated from the health companies. The Department received 315 submissions representing responses from 691 property and life insurance companies combined. Based upon the responses processed, approximately 82% of the companies had a pandemic flu plan; an improvement over the previous year when approximately 68% of all such companies indicated that they had such a

plan. The Department also received 54 submissions representing responses from 90 insurance companies filing the more detailed health insurance response form. These 90 responses included life and property/casualty insurers with significant health insurance writings that were asked to file health insurance response form. These responses indicated that, approximately 70% of these companies had a written pandemic flu plan and another 22% were in progress of writing one.

After the outbreak of H1N1 influenza virus in the spring of 2009, the Department monitored the industry's response to the survey to ensure that insurers, and particularly health insurers, were prepared for handling the new strain of the influenza virus during the fall/winter 2009-2010 influenza season.

The Department worked closely with the Department of Health and several trade associations to ensure health insurers were adequately prepared for the anticipated increased demand for health care services. The agencies issued a joint letter to health insurers, identifying the goals for ensuring New Yorkers have access to needed care and treatment. The industry agreed to cover the fee charged for administering the vaccine to adults, and adjusted prescription drug formularies to cover recommended antiviral treatments. In addition, the Department issued clarification regarding coverage for the H1N1 vaccine under the child wellness mandate.

f) New York Information Network (NYIN)

NYIN is a password-protected area on the Department's Web site that contains directives, advisories, and other terrorism-related information addressed to insurers. NYIN also includes an Intelligence/Information Mailbox enabling participants to exchange intelligence and other information with the Department. There are currently 1,135 entities registered to receive NYIN notifications with a total of approximately 3,405 participants. During 2009 the Department used the NYIN system to issue a special message to insurers on influenza preparedness related to the H1N1 (swine flu) pandemic, as well as, issuing some 142 NYIN cyber security notifications.

2. Department Internal Emergency Management

a) The Department's Disaster Recovery/Business Continuity Plan

The Bureau continues to update the Department's Disaster Recovery/Business Continuity Plan (the Plan) to be consistent with the Continuity of Operations/ Comprehensive Emergency Management Plan (COOP/CEMP) format recommended by the State Emergency Management Office (SEMO). The COOP/CEMP includes the Department's efforts in planning for a pandemic. The Plan is based on a comprehensive risk assessment and requires staff training which the Bureau will provide.

An important component of the COOP/CEMP is the ability for senior staff to communicate. The Bureau is involved in maintaining, and training members of the Department in using Google Work Groups as a communication tool in an emergency. Google Work Groups 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 provides a virtual online meeting room where select Department staff can discuss business operations.

The Plan allows the Department to continue mission-critical operations in the event of a disaster directly affecting the Department, and includes evacuation procedures. It also requires testing and updating annually.

b) Public Access Defibrillator (PAD) Program

The PAD program requires the voluntary participation of Department employees who are certified in cardiovascular pulmonary resuscitation (CPR), automated external defibrillation (AED), and first aid.

The Bureau developed a PAD administrative program of protocols for the use of PAD and CPR during a medical emergency that occurs in any of the Department's offices. The PAD program establishes a medical emergency response program that includes trained and equipped PAD responders who, with appropriate medical oversight, will provide early defibrillation in the event of sudden cardiac arrest. The goal is to defibrillate within three minutes of a witnessed collapse or discovery of the victim. The PAD responders will apply CPR as necessary. The Department currently has a total of 49 trained volunteers in Department facilities throughout the state. According to New York State's Office of General Services, average agency response throughout the state was between two and three volunteers per floor with one AED per floor. The Department exceeded both the ratio of volunteers and AEDs per floor. The large number of volunteers will better serve not only our employees but any visitors to the Department.

All employees of the Department have an icon on their Lotus Notes Inbox which enables them to email all responders at any one of the Department's facilities with a simple click of the mouse. Prior to the installation of this system which is called the Medical Emergency Response Team System (MERTS), employees were required to send notification of a medical emergency to the volunteers via a beeper system. The beeper system is still functional, but serves as a redundancy to the MERTS.

c) The Incident Command System

Pursuant to the Governor's Executive Order, and modeled after State Emergency Management Office's (SEMO's) Incident Command System, the Department has developed its own framework of managers who have been assigned specific roles/titles in the event of an actual disaster. Members of the Bureau have been attending on-going training in the use of the Incident Command System.

d) 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 continues to be responsible for the maintenance of the employee lists that are used to facilitate Department protocols in the event such an evacuation is warranted. The Bureau has also updated the evacuation procedures that are posted on the Department's intranet, by adding maps of cohort locations and a new Emergency Action Plan. The Bureau has revised evacuation procedures and has trained members of the Department in safe evacuation procedures.

e) Emergency Resource Guide

In January of 2010 the Bureau issued upper-level management updated copies of the Department's Emergency Resource Guide (ERG). The ERG provides management with information needed to effectively respond to emergencies affecting the Department directly or the citizens of the state insured by the Department's licensees. The ERG:

- Contains excepts from the Department's Comprehensive Emergency Management Plan/Continuity of Operations Plan (CEMP/COOP);
- Describes emergency employee notification procedures;
- Provides a listing of emergency contact numbers,
- Delineates the role of Department's Insurance Emergency Operations Centers (IEOCs) in coordinating insurance industry disaster response;
- Provides instructions for the use of the West Workspace which serves as a repository of emergency preparedness information and provides high-level Department managers a back-up emergency communications channel;
- Details the Department's emergency response procedures, and

- Provides building specific evacuation procedures for Departmental offices in New York City and Albany.

3. External Partnering Activities

a) Interaction with NYS Homeland Security

Under Homeland Security Presidential Directive (HSPD)-5, all states must adopt the National Incident Management System (NIMS) which is a consistent nationwide approach for Federal, State, local and tribal governments to work effectively and efficiently together to prepare for, prevent, respond to and recover form domestic incidents. States must meet NIMS compliance in order to receive federal funding for disaster assistance. State agencies are required to certify the degree to which they comply with NIMS using the NIMSCAST assessment tool, and "roll-up" the results into the state's comprehensive results.

The Insurance Department has met 100% of the compliance objectives for 2009. The Bureau hopes to maintain the Department's compliance percentage, as staff members receive additional training.

b) Disaster Recovery Assistance

One initiative that has arisen from our experience after Sept 11 and the recent series of hurricanes that devastated the Gulf Coast is the need to establish a pre-credentialing program in conjunction with state and city governments. One such program which includes department and industry officials is the NYC-OEM electronic card reader project. The electronic card reader project is an advanced credentialing system that permits only authorized persons to enter the disaster zone. This initiative already instituted by this department involves working with NYC-OEM and BNET (Business Network of Emergency Resources) to establish a Corporate Emergency Access System (CEAS). The CEAS program permits a "first response team" of adjusters from the largest property and casualty writers in the area of the disaster to gain early access to a disaster site for the purpose of evaluating the total loss within the disaster site in an expeditious manner.

The Department has also worked with BNET to encourage the property and casualty insurers to join the CEAS program to enable their adjusters to gain access to the disaster sites as soon as the area is declared safe by municipalities. To date, 491 CEAS cards have been issued to companies for use by their adjusters. Bureau staff is involved in this ongoing effort to expand recognition of the CEAS Adjuster Card Program by local emergency and law enforcement jurisdictions throughout the state.

The Department has also enrolled "Essential Employees" of the Department in the CEAS program. These employees are considered critical to the ongoing operations of the Department during a disaster. The CEAS program for the Department would permit these essential employees to gain access to the Department's offices within New York City and Nassau County during an emergency. The Department currently has 111 employees enrolled in the program.

J. CAPTIVE INSURANCE GROUP

1. General Overview

On August 7, 1997, Governor George E. Pataki signed into law Chapter 389 of the Laws of 1997, which permits the formation and operation of captive insurance companies (captives) in New York State via a new 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 one of the "alternative insurance mechanisms." As of December 31, 2009 there were 47 captive insurance companies authorized in New York. These 47 captive insurers posted total assets of $13.0 billion, total liabilities of $3.4 billion and capital and surplus of $9.6 billion. In addition, these captive insurers had total income of $810.6 million, paid taxes of $8 million and had net premium written of $1.1 billion.

There has been explosive growth in captive formation in the past year. In addition, the Department has a dedicated captive team responsible for the licensing of all captive insurers in New York. The team provides a direct link to decision-makers, promises a streamlined licensing process and the easing of administrative burdens after licensing with 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 Paterson has submitted revised 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; 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 adequately regulate these insurers under the framework established by Article 70 of the Insurance Law. Since New York is a leading global business center, the New York State Insurance Department is committed to establishing an appropriate regulatory environment for the operation of captive insurers. New York offers domiciled captive insurers tax rates competitive with other captive jurisdictions, minimal investment restrictions and the authority to write almost all types of property/casualty coverages.

K. TRAINING & PROFESSIONAL DEVELOPMENT

Staff training is a core priority for the Department. The professional development needs of the Department's employees are so diverse that it is important to offer a variety of courses in several categories to assist individuals in the pursuit of the skills they need. Subjects are offered in the following areas: Management Development, Experienced Insurance Examiners, Insurance Examiner Trainees, Administrative Support Staff Development, and General.

Professional development of experienced examiners is encouraged through on-the-job training and attendance at bureau-wide seminars. In 2009, eleven such seminars were coordinated, addressing current issues facing the Department and the insurance industry. In 2009, the National Association of Insurance Commissioners' (NAIC) presented twenty six training classes in which 648 Examiners participated. These courses dealt with such topics as Teammate Training, Audit Computer Language (ACL), Polishing Report Writing Skills for Risk Focused Examinations, Risk Assessment, and other relevant classes.

Newly hired Insurance Examiner Trainees are required to participate in a two-year training program, consisting of a combination of lectures, seminars, workshops and classroom instruction, in addition to their regular on-the-job training. 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 2009, there were 34 trainees participating in the training program which consisted of the following: trainees hired in 2007 and completing the traineeship in 2009, and trainees hired in 2008 and still in the traineeship. This past year, these trainees attended 51 days of classes specifically designed for them. Twenty-four trainees completed their traineeship in 2009, and were permanently placed in Bureaus within the Department.

The Administrative Support Staff Development Program offers a variety of courses for support staff and includes such topics as communication skills and managing change. The goal is to provide opportunities to encourage support staff to continue learning. Training consisted of topics such as Building Successful Interpersonal Skills at Work, Telephone Skills and Customer Service, and a Secretarial Skills Refresher Course. In addition, the NYS & CSEA Partnership for Education and Training offered various courses such as Organizing Your Writing, Writing for Clarity, Math Skills Builder, Safety and Health and Workplace Writing.

All Department employees are mandated to attend **Workplace and Domestic Violence Prevention and Right-to-know,** Ethics Training and Diversity Awareness. The **Workplace and Domestic Violence Prevention and Right-to-know** course has been designed to meet the requirements of New York Labor Law 27-b, Executive Order #19 and the New York State Right-to-Know Law respectively. A total of 887 staff participated in the class. The Ethics Training had a total of 569 participants, while Diversity Awareness had a total of 34 participants.

In addition to the above, the Department offered training of a general nature. These courses were either conducted on premises, or through other agencies and vendors. A labor relations training program for supervisors, developed by the Governor's Office of Employee Relations ("GOER") and the Agencies in Partnership for Training ("APT"), was expanded upon this year to include additional topics specific to our agency such as such as performance and productivity, constructive discipline, and grievances, specific to our agency. Other courses of a general nature included such topics as Facilitating Productive Meetings, Basics of Leadership, Successful Business Writing, Performance

Evaluation for Supervisors, Dynamic Presentation, Time Management and Conflict Resolution. In all, 152 staff members took advantage of these classes.

The Department also participates in the NAIC sponsored International Program for Education and Regulatory Cooperation (IPERC) by hosting interns from foreign countries. The aim of IPERC is to foster learning and provide technical assistance to insurance regulatory professionals from countries with emerging insurance markets. The interns spend five weeks at the Department learning about insurance regulation in New York State and receive hands-on training in their areas of interest. To date, we have hosted a total of 19 interns from the countries of India, Brazil, China, Egypt, Saudi Arabia, Taiwan, Singapore and Bulgaria. Two interns, one from Singapore and one from Taiwan were hosted in the spring of 2009. The main objective of the fall interns was to learn about the U.S. insurance market and products with a special emphasis on property and casualty licensing and rate and form regulation. One intern from China was hosted in the fall of 2009. The main focus of her internship was to study the licensing process, form and rate filing and approval process for the various health insurance organizations we regulate.

Professional development is also encouraged through the use of the Training Library to support the insurance examiners' pursuit of professional designations. In 2009, 96 examiners took advantage of the library's loan program and borrowed 120 books. In order to keep up with industry developments, the library was expanded in 2009 to include new books. This past year, 32 insurance examiners successfully completed 78 professional examinations working toward their designations.

The Department's Intranet Training Page offers staff a convenient place to find announcements pertaining to a variety of training opportunities available directly through training links, including available resources, instructional presentations, GOER-sponsored courses, APT courses, and web sites for workshops or tuition support for members of CSEA, PEF and MC employees.

L. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORP.

1. History of the Corporation

The Motor Vehicle Accident Indemnification Corporation (MVAIC) was originally created to provide compensation for injuries to persons who, through no fault of their own, were involved in accidents with hit-and-run drivers, operators of stolen vehicles or uninsured motorists. This law became effective on January 1, 1959. The tort law has since been amended so that comparative negligence is now the law of the State of New York. In that respect, MVAIC's obligations to provide compensation have changed.

Qualified claimants (persons who are residents of the State of New York or of another state that has a similar program, and who do not own automobiles or are not resident relatives of a household where there in an insured vehicle) receive maximum benefits under the no-fault law.

As a result of the enactment of Section 5221 of the Insurance Law, effective December 1, 1977, the corporation also became involved in the payment of no-fault, first-party benefits as of that date. It should be noted that the Corporation must provide for the payment of such first-party benefits only to qualified persons who have complied with all the applicable requirements of Article 52 of the Insurance Law. Amendment 19 to Regulation 68, effective September 1, 1985, permits MVAIC to arbitrate no-fault cases thus eliminating the necessity of commencing Declaratory Judgment Actions in unresolved coverage questions.

Effective July 22, 1989, Section 5208 (a)(1) was amended by the legislature and the bill signed by the Governor. This amendment extended the time from 90 to 180 days within which a claimant must file his/her affidavit of "intention to make claim" with this Corporation, only if there is an identified defendant. The 90 day time limit is still applicable to hit and run cases. Further, if the claim was originally against an insured person whose insurance carrier has denied the claim, then the affidavit must be filed within 180 days after the receipt of said disclaimer or denial.

In June 1995, the New York State Legislature amended Section 1 Paragraph 1 of subsection (f) of Section 3420 of the Insurance Law to increase the New York financial responsibility limits from $10,000 per person, $20,000 per accident to $25,000 per person and $50,000 per accident. These limits are equally applicable to uninsured claims submitted to MVAIC. This law took effect January 1, 1996.

2. New Legislations Enacted

The New Legislation enacted in 1999 effective March 1, 2000. Self-Insured 5014 A (Chapter 511 Laws of 1999) -- This new law increased the self-insured assessment per vehicle from $1.50 to $3.50. The DMVB will continue to handle the self-insured fees as previously done.

New Regulation 68 (No Fault)-Repeal February 1, 2000; for accidents on or after February 1, 2000. The major provisions are:

- Notice of PIP claim must be made in 30 days rather than 90 days
- Health service providers must present their bill to the insurance carrier and/or MVAIC within 45 days after the date of treatment rather than 180 days in current regulations.
- The new regulation authorizes PIP insurers to do an Examination Under Oath (EUO) of PIP claimant.

- Wage Loss Claims must actually be made within 90 days from the date of accident instead of no requirement
- The arbitration rules have been changed with the AAA, now being responsible for administrating all conciliation and administration. Previously, the Insurance Department handled conciliation and more administration including medical fee schedule.
- Also effective February 1, 2000 the monthly interest penalty rate is 2% instead of 21% monthly compounded.

3. Source of Funds

The Corporation is funded through levies on insurance companies transacting automobile liability insurance in the State of New York in accordance with Section 5207 of the Insurance Law.

Other sources of funds include fees collected from self-insurers by the New York State Department of Motor Vehicles under Sections 316 and 370-4 of the Vehicle and Traffic Law, investment income and subrogation recoveries.

4. 2009 Activity

Year End Reserves	2009	2008
Case Outstanding Reserve Tort & Pip	$22,378,935.61	$23,076,182.00
Incurred But Not Reported	$16,454,151.00	$17,256,408.00
Unallocated Loss Adjustments ULAE	$12,685,720.00	$12,685,720.00
Spec. Reserve for Alloc. Exp	7,000,000.00	7,000,000.00

- MVAIC received 12,708 new Notice of Intention to Make a Claim in 2009. This represents a 27% increase over 2008.
- The No-Fault unit received 941 new claims in 2009. This was a decrease of 8% over 2008.
- MVAIC opened 938 new Tort claims in 2009, a decrease of 7% over 2008
- Claims paid for Tort and No Fault cases increased in 2009 to $18,380,099 compared to $14,579,601 paid during 2008.
- The number of pending claims at the close of 2009 was 1,879 compared to 2,026 in 2008

III. INSURANCE LEGISLATION ENACTED

(Legislation is presented in numeric order based on 2009 Chapter Law)

This section of the Annual Report covers bills enacted during the 2009 Session amending the Insurance Law or other insurance-related laws. *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.*

A. Departmental Bills

Redomestication of Foreign Insurers

Chapter 48 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill amends Section 7120 of the Insurance Law to expand the scope of the existing insurer redomestication to apply to non-life insurance companies domiciled in another state, but authorized to do insurance business in New York. Specifics include:

- Section 7120 of the New York Insurance Law to expand the scope of the existing redomestication law to allow any foreign insurance company authorized to do business in the State of New York to transfer its domicile to New York. The bill accomplishes this by deleting the word "life" and "life insurance" in the appropriate places throughout Section 7120 of the Insurance Law. In addition,

- Section 7120 of the Insurance Law is amended to use the Article 71defined term "company" instead of "insurer."

- Section 7120 of the Insurance Law is amended to clarify that different types of insurers, not only stock and mutual insurers, may redomesticate to New York under Section 7120.

Timothy's Law

Chapter 181 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill amends Chapter 748 of the laws of 2006, also known as "Timothy's Law," to make the law permanent.

Timothy's Law requires that, as of January 1, 2007, insurers issuing group or school blanket health insurance policies or contracts in New York must include certain minimum mental health benefits and coverage levels. Generally, for mental, nervous or emotional disorders, insurers must offer inpatient care of not less than thirty days per year and outpatient care of not less than twenty visits per year at the same cost sharing limits as applicable to other health coverages (the "30/20 benefit").

Timothy's Law further requires that large group policies or contracts (over 50 employees) and school blanket policies also provide additional coverage above the basic 30/20 minimum benefit levels for treatment of adults and children with biologically based mental illnesses ("BBMI") and for treatment of children with serious emotional disturbances ("SED"). The added level of BBMI/SED coverage is not required in small group policies or contracts (50 or fewer employees), but insurers are required to offer it on a "make available" basis (i.e., if requested by a small group purchaser).

Unless extended, Timothy's Law would sunset on December 31, 2009. This bill amends Chapter 748 of the laws of 2006 to make Timothy's Law permanent.

Medical Malpractice Premium Rates

Chapter 216 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill extends for one year the freeze on medical malpractice premium rates for physicians and surgeons, and prevents a surcharge on premiums until June 30, 2010. Specifically:

- Chapter 266 of the Laws of 1986 is amended to provide that between July 1, 2009 and June 30, 2010, the Superintendent of Insurance ("Superintendent") shall not: (1) increase medical malpractice insurance rates for physicians and surgeons; and (2) impose a surcharge on premiums to satisfy a deficiency attributable to established premium rates for prior years.

Health Insurance, Extension of State Continuation of Benefits

Chapter 236 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill amends the Insurance Law to help ensure continued access to group health insurance by extending the period of continuation coverage under a group contract or group remittance contract from 18 months to 36 months. Specifically:

- Insurance Law § 3221 is amended to require commercial insurers offering group policies to extend the period of state continuation coverage from 18 months to 36 months for employees or members.

- Insurance Law § 3221 is amended to allow an employee or member who has otherwise exhausted federal continuation benefits under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") to maintain coverage for up to 36 months, if the employee or member is entitled to less than 36 months of federal COBRA benefits.

- Insurance Law § 4304 is amended to require not-for-profit corporations and health maintenance organizations ("HMOs") offering group remittance contracts to extend continuation benefits from 18 months to 36 months, under the same terms and conditions as commercial insurers.

- Insurance Law § 4305 is amended to require not-for-profit corporations and HMOs offering group contracts to extend continuation benefits from 18 months to 36 months, under the same terms and conditions as commercial insurers.

Health; Enhanced Consumer and Provider Protections

Chapter 237 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill amends the Insurance Law and the Public Health Law enhances consumer and provider protections by instituting a series of managed care reforms, including:

(1) requiring that a provider to be given notice of an adverse reimbursement change to a provider contract and an opportunity to cancel the contract;

(2) requiring insurers who offer comprehensive policies to offer the same grievance procedures and provide the same access to care that is required for health maintenance organizations (HMOs);

(3) requiring insurers and HMOs to pay electronic claims promptly and limiting their ability to respond to claims by sending a coordination of benefits questionnaire;

(4) extending overpayment recovery protections to all health care providers and permitting them to challenge such recoveries;

(5) requiring insurers and HMOs who fail to meet a loss-ratio requirement to make efforts to locate and pay dividends or credits to former policy holders;

(6) prohibiting insurers and HMOs from treating a participating provider as a non-participating provider;

(7) permitting newly licensed providers and providers moving to New York to be provisionally credentialed until the final credentialing determination is made by the insurer or HMO;

(8) shortening utilization review timeframes for determinations involving post-hospital home health care services;

(9) allowing providers to appeal concurrent adverse determinations through the external appeal process; and

(10) establishing a new external appeal standard for rare disease treatments.

The bill also enhances efficiencies by authorizing the Superintendent of Insurance (Superintendent) to require that mandated submissions be filed electronically.

Health Insurance, Age 29

Chapter 240 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill amends the Insurance Law to expand access to health insurance by allowing unmarried children through age 29, regardless of financial dependence, to be covered under a parent's group health insurance policy. Specifically:

- Insurance Law § 3216 is amended to require commercial insurers to make available an option for consumers purchasing individual health insurance to cover unmarried dependents through age 29 without regard to financial dependence. The young adults must not be eligible for coverage under employer sponsored insurance and they must live, work or reside in New York State or in the service area of the insurer. The option must be extended at policy inception and at the first anniversary date following the effective date of the provisions.

- Insurance Law § 3221 is amended to require commercial insurers that provide group health insurance coverage to extend an option to continue coverage to unmarried children who have "aged off" of their parents' group health insurance policies. The "dependent children" may continue to be covered under their parents' group policy through age 29 as long as they are not eligible for employer sponsored health insurance coverage and are not covered by Medicare. Such children are not required to be financially dependent on their parents to elect this benefit.

- Employers shall not be required to pay the premiums for dependent children electing this continuation option.

- Insurers must submit reports as the Superintendent of Insurance ("Superintendent") may request, in a form and manner to be prescribed by the Superintendent.

- Insurance Law § 4235 is amended to require commercial insurers to make available an option for consumers of group health insurance to cover unmarried dependents through age 29 without regard to financial dependence.

- Insurance Law § 4304 is amended to require not-for-profit corporations and health maintenance organizations ("HMOs") to extend the same make available option for consumers of group health insurance to cover dependents through age 29 without regard to financial dependence.

- Insurance Law § 4304 is amended to require not-for-profit corporations and HMOs that offer individual and group remittance contracts to include coverage options for unmarried dependent children through age 29 under the same terms and conditions as commercial insurers.

- Insurance Law § 4305 is amended to require not-for-profit corporations and HMOs that offer group contracts to include a continuation option for unmarried dependent children through age 29, also under the same terms and conditions as commercial insurers.

Incorporation of Stock/Mutual Insurance Companies

Chapter 293 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill amends the Insurance Law to revise the standards relating to the incorporation of stock and/or mutual insurance companies in New York. Specifically:

- The minimum board size is reduced to seven, from the current minimum size of thirteen for large companies and nine for small.

- The New York state residency requirement is reduced from two to one director.

- The incorporators of an insurance corporation need only list their city and state of residence in newspapers and the company charter.

- The minimum number of principal officers of mutual insurers that must be on the board of directors is reduced from two to one.

Demonstration Project; Health Insurance

Chapter 447 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill adds a new Section 1123 to the Insurance Law to authorize the Superintendent of Insurance to approve a demonstration program to provide group health insurance coverage for freelance workers. Specifics include:

- The Superintendent of Insurance is authorized to approve a demonstration program under which an eligible insurer that is primarily owned or controlled by a tax exempt eligible association of independent workers issues group health insurance policies solely to the eligible association, which makes the coverage available to independent workers who are members of the eligible association.

- The eligible insurer is not obligated to offer coverage to any other group.

- The eligible insurer is required to comply with all other applicable requirements of the Insurance Law and the Insurance Department's regulations, including but not limited to, solvency and mandated benefit requirements.

- The Superintendent may authorize only one eligible insurer to participate in the demonstration program.

- The Superintendent may revoke his or her approval if the eligible insurer violates any requirements of the bill.

- The eligible insurer must submit periodic reports to enable the Superintendent to evaluate the effectiveness of the demonstration program.

- The bill sunsets on December 31, 2013.

Life Settlements

Chapter 499 of the Laws of 2009 amends the Insurance Law as follows:

Summary: The bill provides a new comprehensive statutory framework to regulate the life settlement business, including enhanced consumer protections. Specifics include:

- Insurance Law § 308 is amended to add life settlement providers and life settlement intermediaries to the list of entities that are required to provide written responses to Insurance Department ("Department") inquiries.

- Insurance Law §§ 2102 and 2110 are amended to add life settlement brokers to the list of those persons required to obtain a license, and whose licenses may be revoked, suspended or not renewed by the Superintendent of Insurance ("Superintendent").

- A new subsection (e) is added to Insurance Law § 2119 requiring life settlement brokers to receive compensation only pursuant to a written contract, and prohibiting excess charges.

- A new Insurance Law § 2137 is added to specify the licensing requirements (both initial and renewal) applicable to life settlement brokers and to exclude certain individuals from the requirements for pre-licensing education and an examination.

- Insurance Law § 2401 is amended to include the business of life settlements as being subject to the prohibitions of unfair methods of competition or unfair or deceptive acts or practices.

- The definitions of "person" and "defined violation" contained in Insurance Law § 2402 are amended to include the business of life settlements and certain acts committed with respect to that business.

- Subsection (c) of Insurance Law § 3220 is amended with respect to group life insurance policies to require that a group policy that permits assignment of an insured person's rights by gift shall also allow assignment for value to the same extent that it allows assignment by gift.

- Existing Article 78 of the Insurance Law is repealed and a new Article 78 is added which, among other things:

    - provides the license requirements for life settlement providers;

- provides the registration requirements for life settlement intermediaries;

- provides the Superintendent with the authority to refuse to renew, revoke or suspend the license of any life settlement provider to the registration of any life settlement intermediary subject to notice and hearing;

- requires life settlement providers to obtain approval by the Superintendent of life settlement contract forms prior to use;

- requires life settlement advertising material to be in compliance with all advertising and marketing laws and rules and regulation as promulgated by the Superintendent;

- requires each licensee to file an annual statement with the Superintendent, and authorizes the Superintendent to examine or investigate the affairs of any licensee, registrant or applicant;

- prohibits persons and entities from disclosing the identity of the insured or owner in connection with a proposed or actual life settlement unless the disclosure is necessary for specifically identified purposes;

- prohibits any person who obtains or may obtain a settled policy from disclosing the identity of the insured under or owner of the policy;

- requires specific disclosure to be provided by the life settlement provider and the life settlement broker including the amount of compensation to be paid to the broker;

- permits a life settlement provider to transfer ownership of a settled policy only to another licensed life settlement provider, accredited investor, qualified institutional buyer, financing entity, special purpose entity or related provider trust, and provides an exception to that requirement by allowing a transfer of ownership of a settled policy to persons other than the listed persons if no personally identifying information of the policy owner or insured is provided to such persons;

- identifies prohibited practices;

- sets forth a provision entitled Stranger-originated life insurance which prohibits life settlement providers, life settlement brokers or their representatives from engaging in any act, practice or arrangement at or prior to issuance of a policy to facilitate issuance of the policy for the intended benefit of a person who has no insurable interest in the life of the insured;

- sets forth penalties and civil remedies; and

- sets forth provisions addressing nonconforming life settlement contracts.

- Insurance Law § 403 is amended to make the commission of a fraudulent life settlement act a violation of the Insurance Law, define a fraudulent life settlement act by reference to Penal Law § 176.40, and add "fraudulent life settlement act" as one of the actions for which the Superintendent is empowered to impose a civil penalty.

- Insurance Law § 404(a) is amended to include the business of life settlements within the activities that the Superintendent may investigate.

- Insurance Law § 406 is amended to provide immunity from civil liability for any person who, in good faith, provides information relating to suspected fraudulent life settlement acts to law enforcement officials, the insurance frauds bureau or other specified persons.

- A new Insurance Law § 411 is added to detail the required parameters of life settlements fraud prevention plans that must be implemented and reported annually to the Superintendent.

- Seven new sections are added to the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud.

- Banking Law § 570 is amended to integrate its provisions governing premium finance agreements with the requirements of amended Article 78 of the Insurance Law.

IV. Regulations Promulgated, Amended or Repealed

The Following is a Summary of Insurance Department Regulations ***PROMULGATED, AMENDED or REPEALED*** *in 2009:*

1. The CONSOLIDATED 2nd AMENDMENT TO REGULATION 178 (11 NYCRR 217): Processing of Health Insurance Claims; and the 40th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards Form, Content and Sale of Health Insurance, Including Standards of Full and Fair Disclosure (Adopted On A Permanent Basis - Effective 7/15/2009)

These rules relate to coordination of benefits (COB) by facilitating the timely processing and payment of health insurance claims in those circumstances where the patient is covered by more than one policy issued by different insurers.

2. The 11th AMENDMENT TO REGULATION 41 (11 NYCRR 27): *Excess Line Placements Governing Standards* (Adopted On A Permanent Basis - Effective 9/2/2009)

Regulation 41 governs the placement of excess lines insurance. The purpose of the excess line law is to enable consumers who are unable to obtain insurance from licensed insurers to obtain coverage from eligible excess line insurers. Generally, an excess line broker must obtain declinations from three authorized insurers before placing business with an unauthorized insurer. The Legislature has recognized that in some cases a different number of declinations may be appropriate, and thus has permitted the Superintendent, after a public hearing, to change the number of necessary declinations. The proposed rule adds a number of additional coverages to the export list.

3. The ADOPTION OF NEW REGULATION 192 (11 NYCRR 102): *Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values for Preneed Life Insurance* (Adopted On A Permanent Basis - Effective 10/28/2009)

This rule establishes minimum standards for determining reserve liabilities and nonforfeiture values for preneed life insurance in accordance with statutory reserve formulae.

4. *The 41st AMENDMENT TO REGULATION 62 (11 NYCRR 52): Minimum Standards for the Form, Content and Sale of Health Insurance, Including Standards of Full and Fair Disclosure* (Adopted On A Permanent Basis - Effective 12/9/2009)

Pursuant to the court's decision in *Benesowitz v. Metropolitan Life Insurance Company*, 8 NY3d 661 (2007), this rule amends 11 NYCRR 52.70(e)(2) to ensure compliance with New York Insurance Law 3234(b) regarding the application of a pre-existing condition provision to coverage for disabilities.

5. The 1st AMENDMENT TO REGULATION 151 (11 NYCRR 99): *Valuation of Annuity, Single Premium Life Insurance, Guaranteed Interest Contract and Other Deposit Reserves* (Adopted On A Permanent Basis - Effective 12/9/2009)

This rule establishes standards for the valuation of reserves for variable annuity and other contracts involving certain guaranteed benefits. In 2008, the National Association of Insurance

Commissioners ("NAIC") adopted, with considerable input from the Department, a new reserve methodology that was incorporated into the 2009 NAIC Accounting Manual.

6. The REPEAL AND ADOPTION OF A NEW REGULATION 153 (11 NYCRR 163): *Flexible Rating For Non-Business Automobile Insurance Policies* (Effective on an Emergency Basis since 12/24/08) (Adopted on a Permanent Basis - Effective 1/6/10)

The stated purpose of Article 23 of the Insurance Law is to ensure the availability and reliability of insurance, and to promote public welfare, by regulating insurance rates to assure that they are not excessive, inadequate or unfairly discriminatory and are responsive to competitive market conditions. Chapter 136 of the Laws of 2008 reestablished flexible rating for non-business automobile insurance, which should strengthen the high level of competition that already exists in this market. The new Insurance Law Section 2350 requires the Superintendent to promulgate a regulation implementing the new flex-rating system.

The new system, which takes effect on January 1, 2009, is a blend of prior approval and competitive rating. The system allows periodic overall average rate changes up to five percent on a "file and use" basis, and requires the Superintendent's prior approval of overall average rate increases above five percent in any twelve-month period. (File and use is the process by which an insurer files with the Superintendent a proposed overall average rate change that is within the flex-band, and then uses the proposed overall average rate change without having to obtain the Superintendent's prior approval). Because insurers are authorized to use the new flexible rating system as of the effective date of the new law, the Department promulgated the regulation on an emergency basis.

Emergency Regulations

*The Following is a Summary of Insurance Department Regulations Promulgated on an **EMERGENCY BASIS** in 2009 that Remained in Effect on December 31, 2009. No Final Action Was Taken With Regard to the Rules in 2009, Although it is Anticipated That They Will be Permanently Adopted in 2010:*

1. The 7th AMENDMENT TO REGULATION 172 (11 NYCRR 83): *Financial Statement Filings and Accounting Practices and Procedures* (Effective on an Emergency Basis since 5/15/09)

This regulation enhances the consistency of the accounting treatment of assets, liabilities, reserves, income and expenses by clearly setting forth the accounting practices and procedures for completion of the annual and quarterly financial statements that licensees must file with the Department. The NAIC adopted a new Accounting Manual as of March 2009. This amendment updates references to the Manual in the regulation, conforms the regulation to Chapter 311 of the Laws of 2008, and clarifies the interrelationship between the Accounting Manual and the New York Insurance Law and regulations.

2. 3rd AMENDMENT TO REGULATION 85 (11 NYCRR 136): *Public Retirement Systems* (Effective on an Emergency Basis since 6/18/09)

This rule provides standards for the management of the New York State Employees' Retirement System and the New York State and Local Police and Fire Retirement System, and the New York State Common Retirement Fund. The proposal establishes an immediate ban on the use of placement agents by the New York State Employees' Retirement System.

3. The CONSOLIDATED 3rd AMENDMENT TO REGULATION 34 (11 NYCRR 215), 42nd AMENDMENT TO REGULATION 62 (11 NYCRR 52), 7th AMENDMENT TO REGULATION 145 (11 NYCRR 360), 6th AMENDMENT TO REGULATION 146 (11 NYCRR 361) and ADOPTION OF

REGULATION 193 (11 NYCRR 58): *Minimum Standards for the Form, Content and Sale of Medicare Supplement Insurance* (Effective on an Emergency Basis since 8/10/09)

In 1992, Congress enacted the federal Omnibus Budget Reconciliation Act of 1990 (OBRA) which establishes uniform requirements to govern Medicare supplement insurance. In 1992, the Department amended regulatory provisions pertaining to the rules for the regulation of Medicare supplement insurance to ensure compliance with federal standards. In 2008, Congress amended federal law to revise the standards governing Medicare supplement insurance plans. This consolidated rulemaking includes provisions to ensure that the Department's regulations satisfy federal requirements, as set out in the revised National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act.

4. The 3rd AMENDMENT TO REGULATION 119 (11 NYCRR 151): *Workers' Compensation Insurance Rates: Reserves for Special Disability Fund Claims* (Effective on an Emergency Basis since 11/18/09)

Workers' Compensation Law ("WCL") § 32 permits the chair of the Workers' Compensation Board to procure one or more private entities to assume the liability for, and management, administration or settlement of, all or a portion of the claims in the Special Disability Fund. Furthermore, no insurer, self-insured employer, or the State Insurance Fund may assume the liability for management, administration or settlement of any claims on which it holds reserves, beyond such reserves as are permitted by regulation of the Superintendent of Insurance. The law mandates the Superintendent to set a reserve standard specific to transactions authorized by WCL § 32. This regulation establishes the required reserve standards.

5. The 4th AMENDMENT TO REGULATION 119 (11 NYCRR 151): *Workers' Compensation Insurance Rates* (Effective on an Emergency Basis since 12/17/09)

Chapter 392 of the Laws of 2008 enacts a new Article 6-G of the Executive Law, which authorizes the creation of a new Independent Livery Driver Benefit Fund (the "Fund") to provide coverage to livery drivers dispatched by independent livery bases that are members of the Fund. Section 3451 of the Insurance Law authorizes the Superintendent of Insurance to promulgate rules and regulations permitting insurers authorized to write workers' compensation and employers' liability insurance to provide coverage to Fund. Insurers authorized to write workers' compensation and employers' liability insurance have expressed interest in writing policies of insurance affording coverage to the Fund.

6. The 5th AMENDMENT TO REGULATION 119 (11 NYCRR 151): *Workers' Compensation Insurance Assessments* (Effective on an Emergency Basis since 12/29/09)

The Workers' Compensation Law requires the workers compensation board to assess insurers and the State Insurance Fund, for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the Workers' Compensation Board, respectively. In the case of insurers, once the assessment amount is determined, each pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year. Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended the Workers' Compensation Law to change the basis upon which the board collects the portion of the allocation from each insurer from "direct premiums" to "standard premium" in order to ensure that insurers were not overcharged or under-charged for the assessment, and to ensure that insureds with high deductible policies are charged the appropriate assessment. Part QQ requires the Superintendent to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the Workers' Compensation Board and NYCIRB, for collecting the assessment from insureds.

7. The 2nd AMENDMENT TO REGULATION 179 (11 NYCRR 100): *Recognition of The 2001 CSO Mortality Table For Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits and Recognition and Application of Preferred Mortality Tables For Use in Determining Minimum Reserve Liabilities* (Effective on an Emergency Basis since 12/29/09)

This amendment to Regulation No. 179 extends the use of the 2001 CSO Preferred Class Structure Mortality Table to policies issued on or after January 1, 2004 with the Superintendent's approval and if certain conditions are met by the insurer related to policies or portions of policies which are co-insured. Previously, this table could only be used for policies issued on or after January 1, 2007. The use of this table allows for the reserves to better match the risks associated with different underwriting classifications. This standard has already been adopted by the National Association of Insurance Commissioners through its Accounting Practices and Procedures Manual.

8. The 3rd AMENDMENT TO REGULATION 147 (11 NYCRR 98): *Valuation of Life Insurance Reserves* (Effective on an Emergency Basis since 12/29/09)

This amendment to Regulation No. 147 removes restrictions on the mortality adjustment factors (known as X factors) in the deficiency reserve calculation. This standard has been adopted by the National Association of Insurance Commissioners through its Accounting Practices and Procedures Manual.

9. The ADOPTION OF NEW REGULATION 118 (11 NYCRR 89): *Audited Financial Statements* (Effective on an Emergency Basis since 12/29/09)

Regulation 118 originally was promulgated in 1984 to implement section 307(b) of the Insurance Law. The proposed repeal of the current regulation and promulgation of the new regulation continues to implement the provisions of section 307(b), and add provisions required pursuant to the Sarbanes-Oxley Act of 2002, 15 U.S.C. § 7201 et seq. ("SOX"). The proposed regulation is closely patterned upon a National Association of Insurance Commissioners model regulation ("NAIC model") that reflects a consensus of the insurance regulators of all states and territories of the United States as to scope, detail, needs and benefits.

V. CIRCULAR LETTERS ISSUED IN 2009 *

Number	Date	Addressed to	Subject
2	02/11/2009	All New York Domestic Insurers	Deficit Reduction Plan - Section 332 Additional Assessment
3	02/19/2009	All Motor Vehicle Self-Insurers and Insurers Writing Motor Vehicle Insurance in New York State	Unfair Claims Settlement Practices - No-Fault Notice of Claim Provisions
4	02/19/2009	All Foreign Authorized Property/Casualty Insurers, Foreign Authorized Financial Guaranty Insurers, Foreign Authorized Mortgage Guaranty Insurers, Foreign Authorized Reciprocal Insurers, Foreign Authorized Title Insurers, and Foreign Accredited Reinsurers of the Aforementioned Types of Companies, All Foreign Authorized Life Insurers, Foreign Authorized Accident and Health Insurers, Accredited Life Reinsurers and Foreign Licensed Fraternal Benefit Societies	Filing of the New York Annual Statement Supplement
5	02/19/2009	All Insurers Licensed to Write Property/Casualty Insurance; Joint Underwriting Associations; Rate Service Organizations; and the New York Automobile Insurance Plan	New Procedures for the Filing of Policy Forms, Rules and Rates
6 Replaced and Repealed by CL No. 1 (2010) Dated 2-23-2010	03/11/2009	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

7 Replaced and Repealed by CL No. 2 (2010) Dated 2-23-2010	03/31/2009	All Accident and Health Insurers, 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
8 Replaced and Repealed by CL No. 3 (2010) Dated 2-23-2010	03/31/2009	All Authorized Life Insurers, Retirement Systems, and Fraternal Benefit Societies.	Disaster Planning, Preparedness and Response
9	03/03/2009	All Licensed Insurance Agents and Brokers	Permissible Services of Insurance Agents and Brokers; Rebating and Inducements
Supplement No. 1 to Circular Letter No. 23 (2008)	04/07/2009	All Insurers Writing Homeowners' Policies in New York	Mid-Term Cancellation of Policies Based upon Residence Becoming Unoccupied
10	04/08/2009	All Insurers Authorized to Write Accident and Health Insurance in New York, Article 43 Corporations, and Health Maintenance Organizations (Collectively, "Insurers")	Consolidated Omnibus Budget Reconciliation Act (COBRA) Health Insurance Premium Assistance Pursuant to the Federal American Recovery and Reinvestment Act of 2009 (ARRA), and the Special Election Period for State Continuation Coverage Required by Chapter 7 of the New York State Laws of 2009
11	06/29/2009	All Persons, Firms, Associations, or Other Entities Licensed, Authorized, Registered, Certified, or Approved Pursuant to the New York Insurance Law (Collectively, "Licensees")	Compliance with the Federal Bank Secrecy Act, Foreign Corrupt Practices Act, and Office of Foreign Assets Control Requirements
12	04/21/2009	All Property/Casualty Insurance Companies; Co-operative Property/Casualty Insurance Companies; Reciprocal Insurers; and Financial Guaranty Insurance Corporations	Property/Casualty Insurance Security Fund
13	04/30/2009	All Insurers Authorized to Transact Motor Vehicle Liability Insurance Business in New York and the New York Automobile Insurance Plan	Motor Vehicle Law Enforcement Fee

14	06/05/2009	All Insurers Authorized to Write Motor Vehicle Insurance in New York State, Rate Service Organizations, New York Automobile Insurance Plan and Insurance Producer Organizations	Accident Prevention Course Providers; Newly Approved Internet/Alternate Delivery Method Point and Insurance Reduction Program (I-PIRP); Notice Requirements
Supplement No. 2 to Circular Letter No. 22 (2005)	06/26/2009	All Property/Casualty Insurers Domiciled in New York State	Filing of Actuarial Opinion Summary (“AOS”)
15	06/30/2009	All Insurers and Self-Insurers Authorized to Write Motor Vehicle Liability, Physical Damage and Mechanical Breakdown Insurance in New York State; and the New York Automobile Insurance Plan	Third Party Information Sharing for Sales Tax Compliance Purposes
16	07/30/2009	All Authorized Insurers (Including Alien Insurers Transacting Business in New York through United States Branches) that are Exempt from Article 15 of the New York Insurance Law	Holding Company System Annual Registration Statements Filed with Other States and Reporting of Planned Transactions
17	07/15/2009	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations ("Insurers") and Health Maintenance Organizations ("HMOs")	Submission of Information for Loss Ratio Reports Filed Pursuant to New York Insurance Law § 3231(e)(2)(B) or 4308(h)(1)
18	07/24/2009	All Licensed Excess Line Brokers, Insurance Brokers and Insurance Producer Organizations, and the Excess Line Association of New York (ELANY)	Excess Line Export List
19	08/03/2009	All Authorized Insurers Licensed to Write Service Contract Reimbursement Insurance, Licensed Excess Line Brokers, Registered Service Contract Providers, and the Excess Line Association of New York	Service Contract Reimbursement Insurance
Supplement No. 1 to Circular Letter No. 27 (2008)	08/10/2009 Withdrawn Eff. 10/19/2009	All Authorized Life Insurers and Fraternal Benefit Societies (Collectively, "Licensees")	Recognition in New York of Marriages Between Same-Sex Partners Legally Performed in Other Jurisdictions
20	09/10/2009	All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations (“HMOs”) (Collectively, “Insurers”)	Impact of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
21	09/16/2009 Withdrawn and Rescinded Eff. 12/07/2009	All Authorized Insurers Writing Motor Vehicle Insurance in New York State; Motor Vehicle Self-Insurers; the New York Automobile Insurance Plan; and the Motor Vehicle Accident Indemnification Corporation	The New York State Health Care Reform Act and No-Fault Insurance

22	09/30/2009	All Insurers Licensed to Write Accident and Health Insurance in New York State Including Article 43 Corporations, Article 45 Corporations, Article 47 Corporations and Health Maintenance Organizations (Collectively, "Insurers")	Health Insurance Coverage for Unmarried Young Adults Through Age 29 (Chapter 240 of the Laws of 2009)
23	09/30/2009	All Insurers Authorized to Write Accident and Health Insurance In New York, Article 43 Corporations, Article 45 Corporations, Article 47 Corporations and Health Maintenance Organizations (Collectively, "Insurers")	Thirty-Six Month State Continuation Benefit Required by Chapter 236 of the Laws of 2009
24	11/03/2009	All Authorized Fraternal Benefit Societies	Fraternal Benefit Societies Filing Risk-Based Capital Reports
Supplement No. 1 to Circular Letter No. 27 (2008)	12/09/2009	All Authorized Life Insurers and Fraternal Benefit Societies (Collectively, “Licensees”)	Recognition in New York of Marriages Between Same-Sex Partners Legally Performed in Other Jurisdictions

*Circular Letter No. 1 was never issued.

VI. MAJOR LITIGATION

Business For A Better New York, et al. v. M. Patricia Smith, et al.
United States District Court, Western District of New York

This is an action challenging the constitutionality of Labor Law sections 240(1) and 241(6), the so-called "Scaffold Law," which makes owners and general contractors responsible for properly maintaining safety equipment at construction sites and imposes liability upon them for worker injuries resulting from their failure to do so. The plaintiffs are a trade organization, a member construction business, and the president of the member construction business. The defendants are the Commissioner of Labor, the Superintendent of Insurance, the Chair of the Workers' Compensation Board and the Attorney General. The plaintiffs allege that the statutes violate the Due Process Clause of the federal Constitution.

The same plaintiffs, with additional member construction businesses and individual executives of those businesses, brought a previous suit against the same defendants which also challenged the constitutionality of Labor Law sections 240(1) and 241(6). In the previous suit, the plaintiffs alleged that the statutes violated the Equal Protection and Commerce Clauses of the federal Constitution and were pre-empted by the federal Occupational Safety and Health Act (OSHA). On September 28, 2007, the District Court in the previous suit granted the State Defendants' motion to dismiss the complaint on the grounds that Labor Law sections 240(1) and 241(6) are rationally related to the legitimate state interest in protecting the safety of workers and thus do not violate the Equal Protection Clause, and that the statutes neither violate the Commerce Clause, nor are preempted by OSHA. The plaintiffs appealed the dismissal to the United States Court of Appeals for the Second Circuit. The Second Circuit affirmed the District Court's decision by summary order dated August 12, 2009.

In the current lawsuit, the plaintiffs allege that the Scaffold Law violates the due process clause of the federal Constitution. On January 29, 2010, the State Defendants filed a motion to dismiss the complaint on the grounds of *res judicata* and failure to state a claim upon which relief may be granted.

Aurelius Capital Management, LP v. Eric R. Dinallo
Appellate Division, First Department

This is an Article 78 proceeding challenging the Department's partial denial of a Freedom of Information Law (FOIL) request for certain financial records submitted to the Department by MBIA Insurance Corporation. The Department withheld some of the requested documents on the basis of the "competitive injury" exception to disclosure in Public Officers Law § 87(2)(d).

In a Decision and Judgment issued on January 13, 2009, the Supreme Court (Justice Alice Schlesinger) upheld the Department's determination and dismissed the Article 78 petition. The Court held that the Department's finding that release of the requested financial data was likely to cause substantial competitive injury to MBIA was reasonable and entitled to judicial deference. On February 17, 2009, the petitioner appealed to the Appellate Division, First Department. On February 11, 2010, the Supreme Court's judgment, upholding the Department's determination and dismissing the Article 78 petition, was unanimously affirmed by the Appellate Division. The Appellate Division held that the lower court correctly determined that disclosure of the additional information sought would likely result in substantial competitive injury to MBIA.

New York Insurance Association, Inc., et al. v. State of New York, et al.
Supreme Court, Albany County

This is an action for declaratory, injunctive and monetary relief against the State of New York, the Governor, the Superintendent of Insurance and the Director of the Budget. The plaintiffs, the New York Insurance Association, Inc. and several domestic property/casualty insurance companies, allege that the defendants have improperly implemented Section 332 of the Insurance Law by imposing assessments against domestic insurers based upon expenses that have no connection to the actual operation of the Insurance Department or the regulation of insurance. The plaintiffs allege that the defendants' implementation of Section 332 exceeds the Superintendent's statutory authority and is otherwise arbitrary, capricious and irrational; that it is an unconstitutional delegation of legislative power; and that it violates Article I, §§ 6, 7(a) and 11, Article III, § 22, and Article XVI, § 3 of the New York State Constitution and the due process and equal protection clauses of the Fourteenth Amendment to the United States Constitution. The plaintiffs seek a judgment permanently enjoining the defendants from "continuing to include costs that do not represent the actual direct and indirect operating expenses of the Insurance Department" in the assessments under Section 332, and a refund of all improper assessments from 2008 to the present, with interest.

On January 26, 2010, The New York Health Plan Association, Inc. and several health insurers and health plans filed a motion for leave to intervene as plaintiffs. The motion was taken under submission as of February 16, 2010.

ABN AMRO Bank N.V., et al. v. Eric Dinallo, et al.
Supreme Court, New York County

This is an Article 78 proceeding challenging the New York Insurance Department's approval of various transactions among MBIA Inc. and its affiliates that resulted in a restructuring of MBIA Insurance Corporation, and seeking a judgment declaring the approval, and transactions made pursuant thereto, null and void. Petitioners are twenty banks that hold structured finance securities insured by MBIA Insurance Corporation. The respondents are the Superintendent, the New York State Insurance Department, MBIA Inc., MBIA Insurance Corporation and National Public Finance Guarantee Corporation (formerly MBIA Insurance Corp. of Illinois). The petitioners allege that the Department's approval violated the Insurance Law, exceeded the Superintendent's authority, and was otherwise arbitrary, capricious, and an abuse of discretion. Respondents also commenced a separate plenary action in New York County Supreme Court against the MBIA respondents only. The plenary action also seeks the unwinding of the various transactions, on the ground that the restructuring constituted a fraudulent conveyance under the New York Debtor & Creditor Law. Both matters are assigned to Justice James A. Yates.

On December 9, 2009, the petitioners moved for permission to take expansive discovery of the Department, including depositions of Department staff who reviewed the transaction. The Department opposed and cross-moved for a protective order striking all of the petitioners' discovery requests. The Court granted in part and denied in part petitioners' motion, ordering two department officials to be deposed and production of additional documents. The defendants in the plenary action filed a motion to dismiss, which was denied on February 17, 2010. The defendants in the plenary action plan to appeal the denial of their dismissal motion.

VII. 2010 LEGISLATIVE RECOMMENDATIONS

These are the legislative recommendations available at the time this report was prepared. Additional recommendations may be submitted throughout the year. The information which follows was accurate at the time the legislative recommendations were forwarded to the Legislature for introduction.

A. Governor's Program Bill for 2010

Amending the Insurance Law to require the prior approval of the Superintendent of Insurance of premium rate adjustments

This bill would require the prior approval of the Superintendent of premium rate adjustments made by health maintenance organizations ("HMOs"), Article 43 corporations and commercial insurers authorized to write accident and health insurance. Specifics include:

- Insurance Law § 3231(e)(1) is amended to provide that, with respect to a rate filing for a premium rate adjustment, the Superintendent may modify or disapprove the rate filing if the Superintendent finds that the premiums are unreasonable, excessive, inadequate or unfairly discriminatory, and may consider the financial condition of the insurer when approving, modifying or disapproving any premium rate adjustment. An insurer shall not impose a rate increase unless the insurer provides at least 30 days advance written notice to each policyholder and certificate holder.

- Insurance Law § 3231(e)(2)(A) is amended to provide that an insurer shall not utilize the alternate rate adjustment procedure pursuant to such paragraph for any rate filing or application to take effect on or after January 1, 2010.

- Insurance Law § 3231(e)(2)(B) is amended to remove the limitation that a policyholder's policy form must be in effect as of the date that the insurer issues a dividend or credit where the loss ratio for a policy form fails to comply with the 75% loss ratio requirement.

- Insurance Law § 3231(e)(2)(B) is amended to require an insurer to make a reasonable effort to identify the current addresses of those policyholders who are no longer policyholders when the insurer issues the dividend or credit.

- Insurance Law § 4308(c)(1) is amended to provide that the Superintendent shall not approve an increase or decrease in premiums, with respect to community rated contracts, unless the increase or decrease complies with Insurance Law § 4308(c) and other applicable provisions of law.

- Existing Insurance Law §§ 4308(c)(2) and (3) are amended to remove the requirements for holding public hearings with respect to a rate filing for a premium rate adjustment.

- A new Insurance Law § 4308(c)(2) is added to require an Article 43 corporation that desires to increase or decrease premiums to submit a rate filing to the Superintendent, and requires the Superintendent to determine whether the filing shall become effective as filed, modified or disapproved. The Superintendent is permitted to modify or disapprove the rate filing if the Superintendent finds that the premiums are unreasonable, excessive, inadequate or unfairly discriminatory, and allows the Superintendent to consider the financial condition of the corporation when approving, modifying or disapproving any premium rate adjustment. An

Article 43 corporation is also prohibited from imposing a rate increase unless the corporation provides at least 30 days advance written notice to each contractholder and subscriber.

- Insurance Law § 4308(g)(1) is amended to provide that a corporation shall not utilize that subsection's alternate rate adjustment procedure for any rate filing or application to take effect on or after January 1, 2010.

- Insurance Law §§ 4308(g)(1), (h)(1) and (h)(2) are amended to incorporate the change made to the minimum loss ratio for individual direct payment contracts pursuant to existing Insurance Law § 4308(j).

- Insurance Law § 4308(h)(2) is amended to remove the limitation that a member's contract must be in effect as of the date that the insurer issues a dividend or credit where the loss ratio for a contract form fails to comply with the appropriate minimum loss ratio requirement, and to require an Article 43 corporation to make a reasonable effort to identify the current addresses of those contractholders or subscribers who are no longer contractholders or subscribers when the insurer issues the dividend or credit.

- Insurance Law § 4308(i) is amended to provide that the alternate rate adjustment procedure described in Insurance Law § 4308(g) and (h) shall not be utilized for any rate filing to take effect on or after January 1, 2010.

- Insurance Law § 4308(j) is deleted since the bill incorporates the substance of this subsection into Insurance Law §§ 4308(g)(1), (h)(1) and (h)(2).

Amending the Insurance Law to establish a medical malpractice rate service organization.

This bill would establish an organization with a governing body which would consist of medical malpractice insurers and representatives of injured parties, physicians and hospitals. The organization would have an actuarial committee and would provide the Superintendent with advice and recommendations on medical malpractice insurance premium rates.

B. Insurance Department Bills for 2010

Amending the Insurance Law to modernize the Insurance Department's licensing process.

This bill would (1) create three new lines of authority; (2) require entities seeking to provide insurance agent and broker licensing courses to file for approval with the Superintendent of Insurance; (3) require independent adjusters to complete pre-licensing and continuing education courses; (4) grant the Superintendent the authority to require an applicant for an Article 21 license to submit his or her fingerprints; and (5) permit the licensing of non-resident adjusters on a reciprocal basis. Specifics include:

- Paragraphs (1) through (10) of Insurance Law § 2101(k), which defines "insurance producer", are deleted

- Insurance Law § 2101 (1) is amended by removing the District of Columbia from the definition of "home state."

- Insurance Law §§ 2101(m), (n), and (o) are amended by removing "licensed" to conform to the National Association of Insurance Commissioners' (NAIC) Producer Licensing Model Act.

- Insurance Law § 2101(r) is amended by renumbering paragraphs 6 and 7 as paragraphs 9 and 10, and inserting new paragraphs 6, 7, and 8 that add credit, crop, and surety, respectively, to the definition of "line of authority."

- Insurance Law § 2103(a) is amended to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance Law § 2101(r)(6)(A).

- Insurance Law § 2103(b) is amended to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance law §2101(r)(6)(B), crop insurance, and surety insurance.

- Insurance Law § 2103(f) is amended to: (1) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 2103(a); (2) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for pursuant to Insurance Law § 2103(b); and (3) require entities seeking to provide insurance agent licensing Courses to tile for approval with the Superintendent.

- Insurance Law § 2103 (g)(1) is amended to not require a written exam as a prerequisite to the issuance of a travel insurance agent's license to any ticket selling agent or representative of a railroad company, steamship company, carrier by air, public bus carrier, or other common carrier who acts as an insurance agent only in reference to insurance coverage for trip cancellation, trip interruption, baggage, life, accident and health, disability, and personal effects, when limited to a specific trip and sold in connection with transportation provided by the common carrier.

- Insurance Law §§ 2103(g)(9) and (10) are amended to give the Superintendent discretion via a regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or any part of the insurance agent pre-licensing, written exam or prerequisite prelicensing course as set forth in either Insurance Law §§ 2103(f)(2)(A) or (B).

- Insurance Law § 2104(c)(1)(A) is amended to require an individual to complete not less than twenty hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 2104(b).

- Insurance Law § 2104(c) is amended to renumber paragraph (2) as paragraph (3), and add a new paragraph (2) that requires entities seeking to provide insurance broker licensing courses to file for approval with the Superintendent.

- Insurance Law § 2104(e)(1)(B) is amended to give the Superintendent discretion via regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or part of the insurance broker prelicensing, written exam or prerequisite course as set forth in Insurance Law § 2104(c)(1)(A).

- Insurance Law § 2108(d)(2), which requires an individual applying for, or renewing, an adjuster's license to submit the individual's fingerprints to the Superintendent. (Since the bill adds a new catchall fingerprinting section to Article 21 of the Insurance Law, this provision is no longer necessary.)

- Insurance Law § 2108(f)(1) is amended to include language stating that an individual shall not be deemed qualified to take the independent adjuster exam without demonstrating that: (1) the individual possesses a minimum of one-year's experience in the insurance business, with

involvement in sales, underwriting, claims, or other experience considered sufficient by the Superintendent; or (2) the individual completed forty hours of formal training in a course, program of instruction, or seminars approved by the Superintendent.

- Insurance Law §§ 2108(r)(1), (2), and (3)(A)(i) are amended by changing all references to "public adjuster" to "adjuster."

- A new Insurance Law § 2113 is added to grant the Superintendent the authority to require an individual who is applying for a license pursuant to Article 21 of the Insurance Law, to submit his or her fingerprints.

- Insurance Law § 2132(c)(1) is amended to require that any person with an Article 21 license who is not exempt under Insurance Law § 2132(b), must participate in 24 credit hours of continuing education.

- Insurance Law § 2136(d) is amended to permit the licensing of non-resident adjusters on a reciprocal basis.

Addressing certain abuses of the no-fault insurance system related to unauthorized providers

This bill would permit the Superintendent to prohibit a provider of health services from demanding or requesting payment for health services rendered under Article 51 of the Insurance Law (No-Fault) if the Superintendent determines that the provider has engaged in certain activities. Specifics include:

- Insurance Law § 5109(b) is amended to permit the Superintendent to prohibit a provider of health services from demanding payment for health services rendered under Article 51 of the Insurance Law, for a period not exceeding three years, if the Superintendent determines, after notice and hearing, that the provider of health services:

  (1) has admitted to or been found guilty of professional misconduct in connection with health services rendered under Article 51;

  (2) solicited, or employed another person to solicit for the provider or another person or entity, professional treatment, examination or care of a person in connection with any claim under Article 51;

  (3) refused to appear before, or answer any question upon request of the Superintendent, or refused to produce any relevant information concerning the provider's conduct in connection with health services rendered under Article 51;

  (4) engaged in a pattern of billing for health services alleged to have been rendered under Article 51 which were not rendered, or engaged in a pattern of billing for unnecessary health services;

  (5) utilized unlicensed persons to render health services under Article 51;

  (6) utilized licensed persons to render health services, when rendering the health services is beyond the authorized scope of the person's license;

(7) ceded ownership, operation or control of a business entity that provides health services to a person not licensed to render the health services for which the entity is legally authorized to provide, unless otherwise permitted by law;

(8) committed a fraudulent insurance act as defined in Penal Law § 176.05;

(9) has been convicted of a crime involving fraudulent or dishonest practices; or

(10) violated any provision of Article 51 or regulations promulgated thereunder.

- Insurance Law § 5109(c) is amended to state that a provider of health services shall not demand or request payment for any health services under Article 51 that are rendered during the term of the prohibition ordered by the Superintendent pursuant to Insurance Law § 5109(b).

- Insurance Law § 5109(d) is amended to require the Superintendent to maintain a database containing a list of providers of health services that the Superintendent has prohibited from demanding or requesting payment for health services rendered under Article 51, and to make this information available to the public.

- Insurance Law § 5109(e) is amended to permit the Superintendent to levy a civil penalty not exceeding $50,000 on any provider of health services that the Superintendent prohibits from demanding or requesting payment for health services pursuant to Insurance Law § 5109(b).

- Former Insurance Law § 5109(e), relettered as subsection (t), is amended to state that nothing in Insurance Law § 5109 shall be construed as limiting in any respect the powers and duties of the Commissioners of Health and Education and the Superintendent to investigate instances of misconduct by a provider of health services and take appropriate action pursuant to any other provision of law. Moreover, the bill provides that a determination rendered by the Superintendent pursuant to Insurance Law § 5109(b) does not bind the Commissioner of Health or the Commissioner of Education in a professional discipline proceeding related to the same conduct.

Amending the Insurance Law to enhance the Department's oversight of service contract businesses

This bill amends Insurance Law Article 79, and other sections of the Insurance Law, to enhance oversight of the service contract business and provide greater protections for service contract holders. Specifically:

- Insurance Law § 308 is amended to require service contract providers to respond to requests for information by the Superintendent of Insurance (the "Superintendent").

- Insurance Law § 1101(b)(3-a) is amended to clarify that heating fuel sellers or deliverers who issue a service contract, warranty or maintenance agreement are not doing an insurance business.

- Insurance Law § 1101(b)(3-a) is amended to provide that a contract or agreement to provide towing, rental, or emergency road services made by a motor club that is a not-for-profit organization and that has been operating as such in this state for at least ten years, or any successor thereto does not constitute the doing of an insurance business.

- Insurance Law § 2302 is amended to make service contract reimbursement insurance subject to Article 23 of the Insurance Law, which regulates insurance rates and forms, among other things.

- Insurance Law § 7901(a)(4) is amended to clarify that one of the purposes of Article 79 is to protect service contract holders.

- Insurance Law § 7901(b)(1) is amended to make express and implied warranties made for a separate or additional consideration subject to Article 79.

- Insurance Law § 7904(b) is amended to add a new paragraph (5) that exempts from Article 79 a contract or agreement to provide towing, rental, or emergency road services made by a motor club that is a not-for-profit organization and that has been operating as such in this state for at least ten years, or any successor thereto.

- Insurance Law § 7902 is amended to repeal subsections (a) and (l), which define “appliances” and “systems,” respectively, and reletters the remaining subsections.

- Insurance Law § 7902 is amended to clarify the definitions of the terms “administrator,” “incidental damages,” and “service contract.”

- Insurance Law § 7903(a) is amended to specify that service contract providers are subject to Articles 1, 2 and 3 of the Insurance Law.

- Insurance Law § 7903(b)(1) is amended to require that a provider that does not deliver a service contract to a purchaser at the time of sale must do so within 10 days after the date of purchase, rather than a reasonable time thereafter.

- Insurance Law § 7903(c)(1) is amended to repeal a provision requiring a provider whose service contract reimbursement insurance has been terminated to comply with another method of demonstrating financial responsibility within 45 days after the insurance coverage ends.

- Insurance Law § 7903(c)(2) is amended by establishing a $100,000 minimum balance for the funded reserve account; raising the minimum balance of the financial security deposit from $50,000 to $100,000; and amending the formula for calculating the minimum balances of the funded reserve account and financial security deposit by deleting the offset for claims paid.

- Insurance Law § 7903(c)(1) is amended to repeal a provision allowing a provider to demonstrate the provider’s financial responsibility by purchasing a SCRI policy through the excess line market.

- A new Insurance Law § 7903(e) is added to require that a provider with a funded reserve account hold the monies in that account in a fiduciary capacity for the benefit of service contract holders. New Insurance Law § 7903(e) also makes the funds in a funded reserve account or financial security deposit exempt from levy, execution or attachment, or any other recovery by a person other than a service contract holder or the Superintendent, and proscribes a provider from assigning, pledging as security, or otherwise encumbering its funded reserve account and financial security deposit.

- A new Insurance Law § 7904(b) to require that an authorized service contract reimbursement (SCRI) insurer establish a contingency reserve fund for its service contracts exposure. The fund shall contain deposits in an amount determined in accordance with a formula based upon its SCRI writings. Insurers must obtain prior approval from the Superintendent prior to making any withdrawals from the fund.

- Insurance Law § 7905(k) is amended to require that a service contract that affords the service contract holder a right to terminate the service contract shall include the method for calculating the refund due to the service contract holder.

- Insurance Law § 7905(n) is amended to clarify a service contract holder's right to return a contract as a right to rescind, and defines the amount of the refund due as the price the service contract holder paid for the contract less any claims paid to the holder.

- Insurance Law § 7906(b) is amended to clarify that a provider may not make any false or misleading statement or omit any material statement, whether the provider does so orally or in writing.

- Insurance Law § 7907(b) is amended to increase the provider's registration fee from $500 for each biennial period to $1,000.

- Insurance Law § 7907(e) is amended to conform the subsection to changes the bill makes to Insurance Law § 7910.

- Insurance Law § 7907(f) is amended to clarify that the exemption from other licensing requirements relates only to service contract business.

- Insurance Law § 7907(g) is amended to increase the provider's biennial application renewal fee from $500 to $1,000.

- Insurance Law § 7908 is amended to add authority for the Superintendent to require a provider to maintain additional information.

- Insurance Law § 7910 is amended to set forth more specific grounds upon which the Superintendent may take enforcement action and adds that the acts which constitute grounds for revocation or suspension of a provider's registrations may be committed by either the provider or the provider's executive officers directly responsible for the provider's service contract business.

- Insurance Law § 7912 is repealed and replaced by a new Insurance Law § 7912 to replace transition rules which are no longer relevant with a provision that clarifies that a provider is responsible for all aspects of the service contract business that it conducts in New York, irrespective of whether the provider designates an administrator or allows another person to market or sell its service contracts.

- Anew Insurance Law § 7913 is added to require that a provider that ceases to maintain its registration submit a proposed plan to the Superintendent for approval, that specifies how the provider will meet its service contract obligations and any other applicable statutory obligations. In addition, to protect service contract holders in New York, the Superintendent may require certain providers to deposit monies in trust, in the name of the Superintendent. Providers that fail to file a timely proposed plan or withdraw from the state before their proposed plan is approved by the Superintendent are subject to a penalty of not more than $500 per day.

Amending the Insurance Law to require the licensing of title insurance agents by the Department

Specifics include:

- Section 2101(k) of the Insurance Law is amended to expand the definition of "insurance producer" to include "title insurance agent."

- Section 2101(k)(4) of the Insurance Law, which specifically excludes title insurance agents from the definition of "insurance producer" within the meaning of Section 2101(k), is repealed.

- Section 2101 of the Insurance Law is amended to add new subsection (s) to define the term "title insurance agent."

- Section 2103(b) of the Insurance Law is amended to authorize the Superintendent of Insurance ("Superintendent") to issue licenses to title insurance agents.

- Section 2103(c) of the Insurance Law is amended to authorize the Superintendent to issue a title insurance agent license to a firm or association and its sub-licensees. Any sub-licensee would only be authorized to act in the name of the licensee. In the case of a license issued to a title insurance agent, at least one designated sublicensee must have a financial or other beneficial interest in the license.

- Section 2103(e) of the Insurance Law is amended to require the filing of an application before a title insurance agent's license may be issued.

- Section 2103(f)(2)(B) of the Insurance Law is amended to increase from six to seven the number of licensing exams the Superintendent may prescribe so that the Department can test those seeking to become licensed as a title insurance agent.

- Section 2103(g)(7) of the Insurance Law is amended to waive the written exam requirement for an applicant who has passed the title insurance agent exam and who was licensed as a title insurance agent, provided that the applicant applies for the license within two years following the termination of his license.

- Section 2103(g) of the Insurance Law is amended to exempt attorneys from the written exam requirement in order to become licensed as a title insurance agent.

- Section 2103(h) of the Insurance Law is amended to permit the Superintendent to refuse to issue a title insurance agent's license if in the Superintendent's judgment the applicant is not trustworthy and competent, or has given cause for the revocation or suspension of such license, or has not complied with any prerequisite for the issuance of a title insurance agent's license.

- Section 2103(j)(5) of the Insurance Law is amended to require title insurance agents to file a renewal application and pay the prescribed fee before their license may be renewed.

- Section 2103(j)(8)(A) of the Insurance Law is amended to authorize the Superintendent to dispense with the requirements for a renewal application of a title insurance agent's license for military personnel who are unable to make a personal application for such
- license.

- Section 2103(j)(12) of the Insurance Law is amended to permit a licensee to amend his or her license without having to pay the required fee.

- Section 2103(1) of the Insurance Law is amended to permit title insurance agents to apply for an additional license authorizing them or sub-licensees to act as insurance agents for additional insurers.

- Two new subsections are added to Section 2103 to provide a licensing mechanism for those currently acting as title insurance agents.

- Section 2109(a) of the Insurance Law is amended to authorize the Superintendent to issue a temporary title insurance agent's license.

- Section 2109(c) of the Insurance Law is amended to permit a title insurance agent who is issued a temporary license to use such license to renew existing business, to collect premiums due, and to perform such other acts as are incidental to the continuance of the insurance business.

- Subsections (a) and (d) of Section 2112 of the Insurance Law are amended to require title insurance corporations to file a certificate of appointment in order to appoint a title insurance agent to act on its behalf.

- Section 2115 of the Insurance Law is amended to make the section applicable to title insurance agents and to prohibit a title insurance corporation or any of its representatives from paying any compensation except to a licensed title insurance agent.

- Sections 2120(a) and 2120(c) of the Insurance Law are amended to require title insurance agents to act in a fiduciary capacity for any funds received or collected as a title insurance agent.

- Section 2122(a) of the Insurance Law is amended to prohibit a title insurance agent from: 1) advertising the financial condition of an insurer unless the advertising conforms with the requirements of Section 1313 of the Insurance Law; and 2) calling attention to any unauthorized insurer.

- Section 2128(a) and Section 2128(b) of the Insurance Law are amended to prohibit title insurance agents from receiving any commissions or fees in connection with coverages placed for or services rendered with various governmental entities unless they actually placed coverage or rendered services to the governmental entity.

- Section 2132(b) of the Insurance Law is amended to exempt attorneys from the continuing education requirements for title insurance agents.

- A new Section 2137 of the Insurance Law is added to prohibit anyone who holds a financial interest in a title insurance agency or title insurance corporation from referring business to that agency or corporation unless certain conditions are met.

- Section 305(b) of the Insurance Law is amended to prohibit title insurance agents and their officers, directors and employees, whose conduct, condition or practices are being investigated from being entitled to witness or mileage fees.

- Section 6409(a) of the Insurance Law is amended to prohibit a title insurance corporation from issuing or delivering a title insurance policy in New York unless the policy has been filed with, and approved by, the Superintendent in accordance with Article 23 of the Insurance Law, and amends Section 6409(b) of the Insurance Law to clarify the applicability of Article 23 to title insurance rates and rate filings.

- Section 6409(c) of the Insurance Law is amended to require a title insurance corporation to file with, and seek approval from, the Superintendent with regard to the optional policy form offered at or prior to closing that will insure the title, and the rates for this coverage.

- Section 6409(d) of the Insurance Law is amended to prohibit a title agent or any other person acting on behalf of the title agent or title insurance corporation to directly or indirectly offer or make any rebate or pay or give any other consideration or valuable thing as an inducement for title insurance business, and prohibits any applicant for insurance, or any person, firm, or corporation acting as agent, representative, attorney, or employee of the owner; lessee, mortgagee or the prospective owner, lessee, or mortgagee of the real property or anyone having any interest in real property from knowingly receiving, directly or indirectly, any rebate or other consideration or valuable thing.

- The Superintendent is required to promulgate application forms for title insurance agent licensing.

- Persons, firms and corporations who have filed an application for a title insurance agent license on or before January 1, 2008, or within 90 days after the Superintendent has promulgated application forms pursuant to this act, whichever is later, are allowed to act as such agent without a license until the Superintendent has made a final determination on the application for such license.

Amending the Insurance Law to establish statistical rating organizations.

This bill would enable the Superintendent of Insurance, by regulation, to authorize or prescribe an analytical method that an insurer may use as an alternative to, or must use in addition to, or in lieu of, ratings from a statistical rating organization, when determining the suitability of securities for an insurer's portfolio.

VIII. Regulatory Activities

A. OPERATING STATISTICS

1. Licenses Issued During Year

Table 59
LICENSES ISSUED DURING YEAR
2008 and 2009

	2009	2008
Total	**117,497**	**137,851**
Adjusters[a]		
Independent	5,134	9,777
Public	163	359
Agents[b]		
Life/Accident and Health	79,758	39,372
Property and Casualty	18,135	47,147
Personal Lines	1,536	75
Limited Rental/Wireless Communications	5	33
Mortgage Guaranty Insurance	2	1
Bail Bond	57	77
Limited Lines[c]	0	15
Brokers[d]		
Life	4,777	4,345
Property and Casualty	6,735	33,848
Personal Lines	91	29
Excess Line (Regular)	258	1,068
Excess Line (Limited)	521	1,190
Viatical Settlement	0	16
Consultants[e]		
Life	85	47
General	73	257
Reinsurance Intermediaries[f]	29	179
Service Contract Registrants[g]	138	16

Note: Footnotes to table appear on next page.

Footnotes to Table 59

[a] Independent and Public 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 to entities* pursuant to Section 2103(a) are renewable biennially as of July 1 of odd numbered years. Property and Casualty Agent and Personal Lines Agent licenses issued to entities pursuant to Section 2103(b) are renewable biennially as of July 1 of even numbered years. Limited Rental/Wireless Communications Agent licenses issued to entities pursuant to Section 2131 are renewable biennially as of July 1 of even numbered years. All individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

Mortgage Guaranty Agent licenses issued pursuant to Section 6535 are perpetual.

Bail Bond Agent licenses issued pursuant to Section 6802 are renewable biennially as of January 1 of odd numbered years.

[c] Limited Lines Agent licenses – Effective January 1, 1987, licenses were issued to agents of assessment co-operative property/casualty companies enabling them to sell only coverage written by such companies. Entity licenses are renewable biennially as of July 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

[d] Life Broker licenses issued to entities pursuant to Section 2104(b)(1)(A) are renewable biennially as of November 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

Property and Casualty Broker and Personal Lines Broker licenses issued to entities pursuant to Section 2104 and Excess Line Broker and Limited Excess Line Broker licenses issued to entities pursuant to Section 2105 are renewable biennially as of November 1 of even numbered years. All individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth. Limited Excess Line Brokers are licensed to deal only with purchasing groups as defined in Regulation 134.

Viatical Settlement Broker licenses issued pursuant to Section 7802 are renewable annually as of December 1.

[e] Consultant licenses issued to entities 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. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

[f] Reinsurance Intermediary licenses issued to entities pursuant to Section 2106 are renewable biennially as of September 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

[g] Service Contract Registrations issued pursuant to Section 7907 are renewable biennially as of March 1 of odd numbered years.

*Partnerships, Corporations and Limited Liability Companies

2. Results of Examinations for Licenses

Table 60
RESULTS OF EXAMINATIONS FOR LICENSES
Adjusters, Agents, Brokers and Consultants

Type of Examination	2009 Number Taking Examination	2009 Percent Passing	2008 Number Taking Examination	2008 Percent Passing
Total	**29,745**	**50**	**35,287**	**45**
Public Adjusters	135	39	94	39
Independent Adjusters - Total	3,695	49	4,972	44
Accident and Health	370	51	468	40
Automobile	217	47	578	48
Aviation	12	83	8	50
Casualty	1,144	49	1,393	44
Fidelity and Surety	0	0	0	0
Fire	145	48	203	59
General (All Lines)	842	39	1,046	35
Health Service Charges	376	42	663	49
Inland Marine	7	57	16	50
Limited Auto (Damage or Theft Appraisals only)	582	65	597	52
Agents and Brokers - Total	25,888	50	30,179	45
Agent, A&H	1,144	47	3,425	37
Agent, A&H (Spanish)	6	0	39	5
Agt/Brk, Life	7,121	54	8,266	52
Agt/Brk, Life (Spanish)	942	13	850	13
Agt/Brk, Life, A&H	10,749	57	11,825	49
Agt/Brk, Life, A&H (Spanish)	8	13	15	0
Agent, Property and Casualty	1,437	37	1,613	37
Broker, Property and Casualty	2,978	33	2,877	32
Agent, Mortgage Guaranty	1	100	6	17
Agent, Credit	0	0	0	0
Agt/Brk, Personal Lines	1,451	50	1,219	57
Agent, Bail Bond	51	67	44	57
Consultants - Total	27	37	42	33
Life	23	30	36	33
General	4	75	6	33

3. Changes in Authorized Insurers During 2009

A. Life Insurance Companies	
Domestic Companies Incorporated	
Trustmark Life Insurance Company of New York, Albany NY	June 17
American National Life Insurance Company of New York	Oct. 15
Domestic Companies Licensed	
Anthem Life & Disability Insurance Company, New York, NY	Jan. 1
Security Health Insurance Company of America, New York, Inc., Schenectady, NY	Dec. 28
Merger Agreement Filed	
Nationwide Life Insurance Company of America into Nationwide Life Insurance Company, Columbus, OH	Dec. 31
Change of Name	
"Forethought Life Insurance Company of New York" to "Niagara Life and Health Insurance Company" New York, NY	Oct. 20
Redomestications Filed	
John Hancock Life & Health Insurance Company (from Delaware to Massachusetts)	Mar. 3
The Union Central Life Insurance Company (from Ohio to Nebraska)	Aug. 27
Withdrawn	
John Hancock Life Insurance Company, Boston, MA	Dec. 31
Union Fidelity Life Insurance Company, Schaumburg, IL	Dec. 30
B. Accident and Health Insurance Companies	
Domestic Company Incorporated	
Solstice Health Insurance Company	Nov. 20
Name Change	
"United HealthCare Insurance Company of New York" to "UnitedHealthcare Insurance Company of New York" Islandia, NY	Sept. 11
Domestic Company Licensed	
St. Lawrence-Lewis Counties School Districts Employees Medical Plan (Municipal Cooperative Health Benefit) Richville NY	Oct. 6
Foreign Companies Licensed	
Fox Insurance Company, Scottsdale, AZ	Mar. 6
Premier Access Insurance Company, Sacramento, CA	Apr. 6
Mergers Filed	
Rochester Area HMO, Inc into MVP Health Plan, Inc.	May 1
PerfectHealth Insurance Company into Group Health Incorporated, New York, NY	Dec. 31
C. Property and Casualty Insurance Companies	
Domestic Companies Incorporated	
New Frontier Insurance Company	May 7
HKR Insurance Company	June 3
Majestic Insurance Company of New York	June 18
Domestic Companies Licensed	
FDM Preferred Insurance Company, Inc., Chestnut Ridge, NY	Mar. 16

Fire Districts Insurance Company, Inc., Chestnut Ridge, NY	Mar. 16
UHAB Mutual Insurance Company, New York, NY	Dec. 1
Foreign Companies Licensed	
Allied Eastern Indemnity Company, Lancaster, PA	Apr. 9
Eastern Advantage Assurance Company, Lancaster, PA	May 6
HDI-Gerling America Insurance Company, Chicago, IL	Apr. 20
Zale Indemnity Company, Irving, TX	June 5
Housing Enterprise Insurance Company, Inc., South Burlington, VT	June 18
Sun Surety Insurance Company, Rapid City, SD	June 24
American International Insurance Company of Delaware , Wilmington, DE (converted from Accredited Property Reinsurer to a Property Casualty Insurer)	July 29
SureTec Insurance Company, Houston, TX	Aug. 31
Zurich American Insurance Company of Illinois, Schaumberg, IL	Sept. 22
Cranbrook Insurance Company, Farmington Hills, MI	Nov. 16
21st Century Casualty Company, Sacramento, CA	Nov. 17
Alien Company Licensed	
Hyundai Marine & Fire Insurance Co., Ltd. (US Branch) Costa Mesa, CA	Apr. 13
Change of Names	
“GMAC Direct Insurance Company” to “Maiden Reinsurance Company” Maryland Heights, MO	Feb. 24
“DaimlerChrysler Insurance Company” to “Chrysler Insurance Company” Farmington Hills, MI	Feb. 26
“Interstate Indemnity Company” to “AGCS Marine Insurance Company” Chicago, IL	Mar. 4
“Mapfre Reinsurance Corporation” to “Mapfre Insurance Company” Florham Park, NJ	Mar. 9
“Podiatry Insurance Company of America, A Mutual Company” to “Podiatry Insurance Company of America” Franklin, TN	May 6
“Commercial Mutual Insurance Company” to “Kingstone Insurance Company” Kingston, NY	July 1
“AIG Casualty Company” to “Chartis Property Casualty Company” Harrisburg, PA	Nov. 1
Redomestications Filed	
Selective Insurance Company of South Carolina (from South Carolina to Indiana)	Jan. 8
Selective Insurance Company of the Southeast (from South Carolina to Indiana)	Jan. 8
Fairmont Specialty Insurance Company (from Delaware to California)	June 17
Verlan Fire Insurance Company (from Maryland to New Hampshire)	Oct. 2
LM Personal Insurance Company (from Delaware to Illinois)	Oct. 22
LM General Insurance Company (from Delaware to Illinois)	Oct. 22
LM Insurance Corporation (from Iowa to Illinois)	Oct. 27
The First Liberty Insurance Corporation (from Iowa to Illinois)	Oct. 27
AIG Casualty Company (from Ohio to Pennsylvania)	Nov. 1
Merger Agreements Filed	
Gerling America Insurance Company into HDI-Gerling America Insurance Company, Chicago, IL	May 20
Progressive Northeastern Insurance Company into Progressive Northern Insurance Company, Madison, WI	Dec. 15
Receivership	
Newark Insurance Company, West Trenton, NJ	June 29
Eagle Insurance Company, Edison, NJ	June 29

Liquidation	
Colonial Indemnity Insurance Company, Kingston, NY	July 7
D. Title Insurance Companies	
Merger Agreements Filed	
Monroe Title Insurance Corporation into Stewart Title Insurance Company, New York, New York	May 12
Public Title Insurance Company into First American Title Insurance Company of New York, New York, NY	Oct. 14
Name Change	
"Northeast Investors Title Insurance Company" to "National Investors Title Insurance Company" Columbia, SC	Dec. 21
E. Accredited Reinsurers	
Certificates of Recognition	
XL Select Insurance Company, Wilmington, DE	Jan. 6
Torus Insurance (UK) Limited, New York, NY	Aug. 17
Connecticut Attorneys Title Insurance Company, Rocky Hill, CT	Nov. 16
Hannover Life Reassurance Company of America, Orlando, FL	Nov. 24
MetLife Reinsurance Company of Charleston, Charleston, SC	Dec. 23
Change of Names	
"American International Underwriters Overseas Ltd" to "Chartis Overseas Limited" Pembroke Bermuda	Oct. 20
"Integon Specialty Insurance Company" to "Maiden Specialty Insurance Company" Winston-Salem, NC	Nov. 20
Withdrawn	
Kanawha Insurance Company, Lancaster, SC	Sept. 30
Employers Reassurance Corporation, Mission, KS	Dec. 1
F. Charitable Annuity Societies	
Incorporated	
Hamilton Insurance Corp.	Sept. 10
Permits Issued	
The Foundation of the Roman Catholic Diocese of Buffalo, Inc., Buffalo, NY	Feb. 9

The Ohio University Foundation, Athens, OH	Feb. 24
United States Merchant Marine Academy Alumni Foundation, Inc., Kings Point, NY	Mar. 13
The Brooklyn Academy of Music, Inc., Brooklyn, NY	May 5
Cazenovia College, Cazenovia, NY	May 7
The University of Puget Sound, Tacoma, WA	May 13
New York City Ballet, Inc., New York, NY	June 12
Saratoga Care, Inc., Saratoga Springs, NY	Aug. 25
The Genesee Community College Foundation, Inc., Batavia, NY	Sept. 23
Loyola College in Maryland, Inc., Baltimore, MD	Oct. 15
The Foundation of CVPH Medical Center, Inc., Plattsburgh, NY	Oct. 20
Friends of Yad Sarah, Inc., New York, NY	Oct. 22
Swarthmore College, Swarthmore, PA	Oct. 26
Center for Inquiry, Inc., Amherst, NY	Oct. 27
Centenary College, Hackettstown, NJ	Nov. 20
Make-A-Wish Foundation of America, Phoenix, AZ	Dec. 2
Cortland Memorial Foundation, Inc., Cortland, NY	Dec. 14
The Seeing Eye, Inc., Morristown, NJ	Dec. 24
Watchtower Bible and Tract Society of Florida, Inc., Wallkill, NY	Dec. 30
Name Change	
“National Jewish Medical and Research Center” to “National Jewish Health” Denver, CO	Mar. 3
“Christian Children’s Fund, Incorporated” to “ChildFund International, USA” Richmond, VA	July 8
“IBS-STL Ministries Foundation” to “Biblica Ministries Foundation” Colorado Springs, CO	Aug. 31
“United Way of America” to “United Way Worldwide” Alexandria, VA	Oct. 5
“Loyola College in Maryland, Inc” to “Loyola University Maryland, Inc” Baltimore, MD	Dec. 15
G. Financial Guaranty Companies	
Licensed Companies	
Syncora Capital Assurance, Inc., New York, NY	July 14
Essent Guaranty, Inc., Radnor, PA	Sept. 21
Name Change	
“Connie Lee Insurance Company” to “Everspan Financial Guarantee Corp.” Madison, WI	Jan. 26
“MBIA Insurance Corp. of Illinois” to “National Public Finance Guarantee Corporation” Armonk, NY	June 5
“Financial Security Assurance Inc” to “Assured Guaranty Municipal Corp” New York, NY	Oct. 30
Redomestications	
National Public Finance Guarantee Corporation (from Illinois to New York)	Dec. 1
CIFG Guaranty, Inc. (from Delaware to New York)	Dec. 23
H. Captive Insurance Companies	
Domestic Companies Incorporated	
Barclays Insurance U.S., Inc., New York, NY	Oct. 2
The Hamilton Insurance Corp, Melville, NY	Nov. 6

Domestic Company Licensed	
Barclays Insurance U.S., Inc., New York, NY	Nov. 3
Withdrawn	
Bergstresser Insurance Inc., New York, NY	July 8
Wharf Reinsurance Inc., Melville, NY	Nov. 6
TD USA insurance, Inc., New York, NY	Nov. 24
North Castle Insurance, Inc., Armonk, NY	Dec. 9
Twin Brook Insurance Company, Inc., New York, NY	Dec. 31

Examination Reports Filed During 2009		
Name of Companies	**As of**	**Date Filed**
Domestic Life Insurance Companies		
Allianz Life Insurance Company of New York	12/31/2007	06/18/2009
American International Life Assurance Company of New York	12/31/2007	06/11/2009
Aviva Life and Annuity Company of New York	12/31/2007	04/24/2009
AXA Equitable Life Insurance Company	12/31/2005	06/03/2009
AXA Equitable Life Insurance Company	12/31/2005	11/13/2009
Church Life Insurance Corporation	12/31/2007	05/08/2009
Columbian Mutual Life Insurance Company	12/31/2006	05/21/2009
Combined Life Insurance Company of New York	12/31/2007	05/18/2009
Companion Life Insurance Company	12/31/2007	05/01/2009
Farm Family Life Insurance Company	12/31/2007	05/18/2009
First SunAmerica Life Insurance Company	12/31/2007	06/11/2009
First Unum Life Insurance Company	12/31/2005	07/13/2009
Genworth Life Insurance Company of New York	12/31/2007	06/29/2009
Gerber Life Insurance Company	12/31/2007	04/21/2009
John Hancock Life Insurance Company of New York	12/31/2007	12/07/2009
Lincoln Life & Annuity Company of New York	12/31/2007	03/09/2209
Mutual of America Life Insurance Company	12/31/2006	01/22/2009
National Benefit Life Insurance Company	12/31/2006	04/01/2009
National Integrity Life Insurance Company	12/31/2007	05/26/2009
New York Life Insurance Company	12/31/2004	05/01/2009
Phoenix Life and Reassurance Company of New York	12/31/2007	10/13/2009
Phoenix Life Insurance Company	12/31/2007	06/18/2009
Trustmark Life Insurance Company of New York	03/21/2008	06/05/2009
United States Life Insurance Company in the City of New York	12/31/2007	06/11/2009
VantisLife Insurance Company of New York	03/01/2007	01/22/2009
Wilton Reassurance Life Company of New York	12/31/2007	06/16/2009
Wilton Reassurance Life Company of New York	12/31/2007	12/18/2009
Domestic Accident and Health Insurance Companies		
Empire HealthChoice Assurance, Inc.	12/31/2006	07/06/2009
Medco Containment Insurance Company of New York	12/31/2006	02/23/2009
MVP Health Insurance Company	12/31/2007	05/28/2009
Oxford Health Insurance, Inc.	12/31/2007	06/05/2009
PerfectHealth Insurance Company	12/31/2005	02/10/2009
Security Health Insurance Company of America, New York, Inc.	10/31/2009	12/23/2009
Municipal Cooperative Health Benefit Plan		
Catskill Area Schools Employees Benefit Plan	06/30/2007	11/10/2009
Orange-Ulster School Districts Plan	12/31/2006	01/14/2009
Putnam/Northern Westchester Health Benefits Consortium	06/30/2007	10/20/2009
Health Maintenance Organization		
Empire HealthChoice HMO, Inc.	12/31/2006	07/06/2009
MVP Health Plan, Inc.	12/31/2007	06/12/2009
Oxford Health Plans (NY), Inc.	12/31/2007	11/10/2009
Non-Profit Health Service Corporation		
MVP Health Services Corp.	112/31/2007	08/04/2009

Domestic Property and Casualty Insurance Companies		
A. Central Insurance Company	12/31/2006	11/09/2009
Aioi Insurance Company of America	12/31/2007	03/17/2009
AIU Insurance Company	12/31/2005	04/10/2009
Alea North American Insurance Company	12/31/2006	06/03/2009
Alliance National Insurance Company	12/31/2007	04/07/2009
American Guarantee and Liability Insurance Company	12/31/2006	08/03/2009
American Home Assurance Company	12/31/2005	04/10/2009
Assurance Company of America	12/31/2006	08/03/2009
Atlanta International Insurance Company	12/31/2006	01/30/2009
AXA Art Insurance Corporation	12/31/2007	04/29/2009
AXA Insurance Company	12/31/2007	07/28/2009
AXIS Reinsurance Company	12/31/2007	06/22/2009
Church Insurance Company	12/31/2007	05/20/2009
Commerce and Industry Insurance Company	12/31/2005	04/10/2009
Compass Insurance Company	12/31/2005	05/08/2009
Constellation Reinsurance Company	12/31/2004	01/14/2009
Constitution Insurance Company	12/31/2006	03/09/2009
FDM Preferred Insurance Company, Inc.	02/09/2009	02/27/2009
Fire Districts Insurance Company, Inc.	02/09/2009	02/27/2009
Fire Districts of New York Mutual Insurance Company, Inc.	12/31/2005	06/08/2009
Global Liberty Insurance Company of New York	12/31/2007	06/10/2009
Global Reinsurance Corporation of America	12/31/2006	03/09/2009
Hereford Insurance Company	12/31/2006	09/30/2009
Hermitage Insurance Company	12/31/2007	05/14/2009
Homesite Insurance Company of New York	12/31/2007	11/30/2009
Hudson Specialty Insurance Company	12/31/2005	02/03/2009
Medical Liability Mutual Insurance Company	12/31/2006	07/27/2009
Mitsui Sumitomo Insurance USA Inc.	12/31/2007	05/05/2009
National Continental Insurance Company	12/31/2007	06/30/2009
Northern Insurance Company of New York	12/31/2006	08/03/2009
NOVA Casualty Company	12/31/2007	07/28/2009
Oriska Insurance Company	09/30/2005	06/04/2009
Progressive Northeastern Insurance Company	12/31/2007	06/25/2009
Rampart Insurance Company	12/31/2007	07/01/2009
Response Indemnity Company	12/31/2008	10/08/2009
Scor Reinsurance Company	12/31/2004	04/27/2009
Selective Insurance Company of New York	12/31/2007	01/08/2009
Sompa Japan Fire & Marine Insurance Company of America	12/31/2007	05/29/2009
Sompo Japan Insurance Company of America	12/31/2007	05/29/2009
Swiss Reinsurance America Corporation	12/31/2006	02/17/2009
UHAB Mutual Insurance Company	08/26/2009	10/05/2009
UHAB Mutual Insurance Company	08/26/2009	10/05/2009
Upper Hudson National Insurance Company	12/31/2006	05/13/2009
USAgencies Direct Insurance Company	12/31/2007	04/28/2009
Westchester Fire Insurance Company	12/31/2007	08/03/2009
White Mountains Reinsurance Company of America	12/31/2004	06/29/2009
WRM America Indemnity Company, Inc.	12/31/2007	04/08/2009
Zurich American Insurance Company	12/31/2006	08/03/2009

Alien Property and Casualty Insurance Companies		
Generali – U.S. Branch	12/31/2006	04/22/2009
Global Reinsurance Corporation	12/31/2006	05/26/2009
NIPPONKOA Insurance Company	12/31/2006	01/09/2009
Nissay Dowa General Insurance Company, Limited (U.S. Branch)	12/31/2008	10/05/2009
Samsung Fire & Marine Insurance Co., Ltd.	12/31/2005	03/24/2009
Advance Premium Property and Casualty Insurance Companies		
Associated Mutual Insurance Cooperative	12/31/2006	02/18/2009
New York Central Mutual Fire Insurance Company	12/31/2006	10/23/2009
Preferred Mutual Insurance Company	12/31/2006	03/13/2009
Utica First Insurance Company	12/31/2007	06/08/2009
Charitable Annuity Societies		
American Heart Association, Inc.	12/31/2007	06/25/2009
Anti-Defamation League Foundation	12/31/2007	06/25/2009
Barnard College	12/31/2008	10/14/2009
Cancer Care, Inc.	12/31/2007	09/11/2009
Children's Aid Society	12/31/2008	12/16/2009
Clarkson University	12/31/2007	04/16/2009
Colleges of the Seneca	12/31/2007	05/14/2009
Cornell University	12/31/2007	03/06/2009
Environmental Defense Fund, Incorporated	12/31/2008	10/15/2009
Hadassah, the Women's Zionist Organization of America, Inc.	12/31/2007	12/23/2009
HIAS, Inc.	12/31/2007	07/30/2009
Houghton College	12/31/2007	04/08/2009
International House	12/31/2008	12/16/2009
International Rescue Committee, Inc.	12/31/2007	08/11/2009
Lighthouse International	12/31/2007	02/03/2009
Manhattan College	12/31/2007	02/11/2009
Roman Catholic Diocese of Ogdensburg, New York	12/31/2007	08/11/2009
Salesian Missions	12/31/2007	04/27/2009
Student Conservation Association, Inc.	12/31/2006	03/13/2009
University at Buffalo Foundation, Inc.	12/31/2007	05/14/2009
Wildlife Conservation Society	12/31/2007	02/11/2009
Captive Insurance Companies		
Bolton Insurance Company	12/31/2007	06/30/2009
Clove Park Insurance Company	12/31/2007	10/01/2009
Haversine Insurance Company	12/31/2007	09/30/2009
Midtown Insurance Company	12/31/2007	11/12/2009
Ports Insurance Company, Inc.	12/31/2007	09/30/2009
Premier Management Insurance, Inc.	12/31/2007	10/01/2009
Welfare Trust Funds		
Central Southern Tier Health Care Plan Trust	06/30/2007	07/13/2009
Title Insurance Companies		
ACE Capital Title Reinsurance Company	12/31/2007	05/22/2009
Commonwealth Land Title Insurance Company	12/31/2005	08/13/2009

First American Title Insurance Company of New York	12/31/2005	01/16/2009
First Atlantic Title Insurance Corp.	12/31/2002	01/23/2009
First Atlantic Title Insurance Corp.	12/31/2007	07/06/2009
Lawyers Title Insurance Corporation	12/31/2005	08/13/2009
Monroe Title Insurance Corporation	12/31/2006	10/21/2009
National Title Insurance of New York Inc.	12/31/2003	03/05/2009
Nations Title Insurance of New York Inc.	12/31/2003	03/11/2009
Old Republic National Title Insurance Company	06/30/2006	05/08/2009
Transnation Title Insurance Company of New York	12/31/2005	08/13/2009
Accredited Reinsurer Title		
Transnation Title Insurance Company	12/31/2005	08/13/2009
Rating Organization	06/30/2006	03/17/2009
Title Insurance Rate Service Association		
Mortgage Guaranty		
Assured Guaranty Mortgage Insurance Company	12/31/2007	05/20/2009
Atrium Insurance Corporation	12/31/2007	02/12/2009
Financial Guaranty Company		
Assured Guaranty Municipal Corp.	12/31/2007	07/24/2009
Syncora Capital Assurance Inc.	0715/2009	10/14/2009
Retirement & Pension (Variable)		
Firefighters' Variable Supplements Fund	06/30/2003	08/26/2009
Fire Officers' Variable Supplements Fund	06/30/2003	08/26/2009
Housing Police Officers Variable Supplements Fund	06/30/2002	08/26/2009
Housing Police Superior Officers' Variable Supplements Fund	06/30/2002	08/26/2009
New York City Correction Officers' Variable Supplements Fund	06/30/2002	08/26/2009
Police Officers' Variable Supplements Fund	06/30/2004	08/26/2009
Police Superior Officers' Variable Supplements Fund	06/30/2004	08/26/2009
Transit Police Officers' Variable Supplements Fund	06/30/2002	08/26/2009
Transit Police Superior Officers' Variable Supplements Fund	06/30/2002	08/26/2009
Retirement & Pension (City)		
Board Of Education Retirement System	06/30/2003	07/24/2009
City of New York Fire Department Pension Fund, Subchapter 2	06/30/2003	07/24/2009
New York City Employees' Retirement System	06/30/2002	07/24/2009
New York City Police Pension Fund, Article 2	06/30/2004	07/24/2009
Teachers' Retirement System of the City of New York	06/30/2003	07/24/2009
Non-Profit Health Service Company		
Continuing Care Retirement Community		
Glen Arden Inc	12/31/2005	03/16/2009
Jefferson's Ferry	12/31/2007	03/16/2009
Kendal on Hudson	12/31/2007	03/16/2009
Summit at Brighton	12/31/2006	03/16/2009
Fraternal Benefit Society Company		

Polish Union of America	12/31/2007	06/18/2009
Viatical Settlement Companies		
Neuma, Inc.	12/31/2008	11/09/2009
Wm. Page & Associates, Inc.	12/31/2007	03/27/2009
Underwriting Organization		
American Offshore Insurance Syndicate	11/30/2005	05/28/2009
New York Property Insurance Underwriting Association	12/31/2007	08/12/2009
United States Aircraft Insurance Group	11/30/2002	01/27/2009

5. Insurance Department Receipts and Expenditures

Table 61
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2009

Taxes Collected Under the New York State Insurance Law:		
Taxes collected by reason of retaliation under Section 1112[1]		$(101,833)
Excess Line - Section 2118		70,036,075
Organization Tax - Section 180, Tax Law		2,700
Subtotal[2]	$	**69,936,942**
Fees Collected Under Section 1112 of the NYS Insurance Law:		
Filing Annual Statements and Certificates of Authority to Companies	$	461,614
Admission Fees		21,752
Subtotal	**$**	**483,366**
Licensing and Accreditation Fees:	**$**	**19,531,759**
Assessments and Reimbursement of Department Expenses:		
Section 313 – Company Examinations	$	11,465,605
Section 332 – Assessment		507,110,689
Administrative Expense Reimbursement – Section 9104/9105		237,508
Administrative Expense Reimbursement – Security Funds		92,003
Subtotal	**$**	**518,905,805**
Other Fees and Receipts:		
Section 9107 - Certification & Filing Fees	$	15,895
Section 9108 - Fire Insurance Fee		14,142,244
Section 1212 - Summons and Complaints		273,990
Fines and Penalties		9,719,815
Arbitration Fees		22,000
FOIL Requests		22,817
Miscellaneous		58,459
Regulation 134		1,100
Motor Vehicle Law Enforcement Fee		61,937,823
CAPCO Application Fees		4,500

Subtotal	**$ 86,198,643**
Foreign Fire Tax, and Security Funds Receipts	
Foreign Fire Tax - Insurance Law Sections 2118, 9104 and 9105	$48,315,497
Property Casualty Insurance Security Fund - Sections 7602 and 7603	36,689,627
Public Motor Vehicle Liability Security Fund – Section 7601	14,570,541
Workers' Compensation Security Fund	28,669,993
Subtotal	**$128,245,658**
TOTAL DEPARTMENT RECEIPTS	**$823,302,173**

Table 62
INSURANCE TAX RECEIPTS[3]
(in millions)

Fiscal Year	Net
2004-05	1,077
2005-06	987
2006-07	1,142
2007-08	1,088
2008-09	1,086

[1]The negative balance represents retaliatory tax refunds in excess of retaliatory tax collected, in accordance with
Insurance Law Section 1112.

[2]This amount is in addition to the $ 1.086 billion collected by the Department of Taxation and Finance under Tax Law Article 33.

[3]Collected by the Department of Taxation and Finance under Tax Law Article 33.
Source: State of New York, Annual Budget Message, 2010-11

Table 63
DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2009
Paid in the First Instance from Appropriations

Personal Service	
Employee salaries	**$ 72,436,779**
Maintenance and Operation	
General office supplies	$ 590,909
Travel expense	3,488,660
Rental equipment	502
Repair and maintenance of equipment	206,346
Real estate rental	11,077,503
Postage and shipping	163,412
Printing	24,645
Telephone	1,203,643
Miscellaneous contractual services	9,746,559
OFT Computer	226,562
OGS Interagency courier	32,734
Equipment	1,002,595
Employee fringe benefits/indirect cost	26,986,741
Subtotal Maintenance and Operation	**$ 54,750,810**
Suballocations to Other State Agencies	
Personal Service, Maintenance and Operation	**$ 79,764,649**
TOTAL DEPARTMENT EXPENDITURES	**$206,952,238**

Table 64
RECEIPTS VS. DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2009

Total Department Receipts	$823,302,173
Total Department Expenditures	$206,952,238
Excess of Department Receipts Over Department Expenditures	**$616,349,935**

B. DEPARTMENT STAFFING

Table 65

DEPARTMENT STAFFING (as of March 31, 2010) ‡

Bureau	Examiners	Attorneys	Actuaries	Other Professionals	Investigators	Support Staff	Total
New York City Office:							
Executive	1			18		3	22
Life	96		8	1		4	109
Health	47		7	2		2	58
Administration*				5		10	15
Consumer Services	37			1		14	52
Frauds	3			1	28	3	35
OGC		29		4		6	39
Public Affairs/Research				1		1	2
Property	182		22	1		18	223
Systems	1			16		3	20
Capital Markets	1			7		2	10
Examiner Pool	12						12
Disaster Preparedness	6					1	7
Policy		1		1			2
WCTF				3			3
Timothy's Law			1				1
NYC Total	**386**	**30**	**38**	**61**	**28**	**67**	**610**
Albany Office:							
Executive				5		2	7
Life		16	21	1		4	42
Health	6	20	4	1		3	34
Administration*	1	1		19		17	38
Consumer Services	37			2		8	47
Frauds		1		1	7		9
OGC		6		1		1	8
Public Affairs/Research				1			1
Property	8					1	9
Systems	1			29		5	35
Capital Markets		1					1
Licensing	1			7		31	39
Disaster Preparedness	2						2
Timothy's Law	2	3					5
Albany Total	**58**	**48**	**25**	**67**	**7**	**72**	**277**
ALL OTHER							
Buffalo Office							
Health	1	1					2
Consumer Services	2						2
Frauds					3		3
Mineola Office							
Consumer Services	2					1	3
Frauds					7		7
Oneonta Office:							
Frauds					4		4
Rochester Office:							
Frauds					2		2
Syracuse Office:							
Life	2						2
Frauds					1		1
All Other Total	**7**	**1**	**0**	**0**	**17**	**1**	**26**
Department Total	**451**	**79**	**63**	**128**	**52**	**140**	**913**

*Includes HRM & Offices Services; ‡**Note**: Table does not include student assistants assigned to various bureaus during the year

IX. LIQUIDATION BUREAU

The New York Liquidation Bureau ("Bureau") is the entity that carries out the statutory responsibilities of the Superintendent of Insurance of the State of New York ("Superintendent") as Receiver of impaired or insolvent insurance companies, pursuant to New York Insurance Law ("Insurance Law") Article 74. The Bureau also performs certain aspects of the Superintendent's claims handling and payment functions in his role as Administrator of the New York Property/Casualty Insurance Security Fund ("P/C Fund") and Public Motor Vehicle Liability Security Fund ("PMV Fund"), established pursuant to Insurance Law Article 76, and the Workers' Compensation Security Fund ("WC Fund"), established pursuant to New York Workers' Compensation Law Article 6-A (collectively, the "Security Funds"). The Security Funds are used to pay claims remaining unpaid by reason of an insurer's inability to meet its insurance policy obligations.

As of December 31, 2009, the Bureau was managing 67 active insurance company proceedings. During 2009, four new proceedings were commenced – one domestic, Colonial Indemnity Insurance Company; two ancillaries, Eagle Insurance Company and Newark Insurance Company; and one rehabilitation, The Insurance Corporation of New York. Four proceedings were completed - two domestic, Community Health Plan and Medical Malpractice Insurance Association, Inc.; one ancillary, The Connecticut Surety Company; and one conservation, FAI General Insurance Co. Ltd.

The 67 active insurance company proceedings are classified as follows:

4	Domestic Estates in Rehabilitation
30	Domestic Estates in Liquidation
24	Ancillary Receiverships
9	Conservations

As of December 31, 2009, the 30 domestic estates in liquidation and nine conservations had combined assets, liabilities and insolvencies as follows:

Total Assets	$1,452,968,647
Total Liabilities	$5,077,999,484
Total Insolvency	$3,625,030,837

The Bureau received the following amounts from the Security Funds in 2009: $109,007,112 for claims, $44,643,535 for related expenses and $939,386 for return premiums.

During 2009, the Bureau processed reimbursements to the Security Funds totaling $40,571,653 in the form of dividends and early access, of which $3,430,730 was paid by domestic estates and $37,140,923 was received from ancillary receiverships. Of these amounts, the P/C Fund received $25,140,643 from 18 estates, the PMV Fund received $1,674,302 from two estates and the WC Fund received $13,756,708 from four estates.

1. Fraternal Benefit Societies

As of December 31, 2009, the Bureau was managing 32 fraternal benefit society liquidation proceedings. During the year, eight proceedings were commenced and four proceedings were terminated. Distributions from assets to members of fraternal benefit societies during 2009 totaled $154,922. The remaining assets of the 32 fraternal benefit societies total approximately $519,341.

2. Rehabilitation, Liquidation, Ancillary Receivership and Conservation Proceedings

The insurance entities under the Bureau's jurisdiction during 2009 were as follows:

Rehabilitations

Commenced: The Insurance Corporation of New York

Continued:
Executive Life Insurance Company of New York
Frontier Insurance Company
Lion Insurance Company

Completed: None

Liquidations

Commenced: Colonial Indemnity 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
Health Partners of New York, L.L.C.
The Home Mutual Insurance Company of Binghamton, NY
Horizon Insurance Company
Horizon Healthcare of New York, Inc.
Ideal Mutual Insurance Company
MagnaHealth of New York, Inc.
MDNY Healthcare, Inc.
Midland Insurance Company
Midland Property and Casualty Insurance Company
MML Assurance, Inc.
Nassau Insurance Company
New York Merchant Bakers Insurance Company
New York Surety Company
Realm National Insurance Company
Transtate Insurance Company
Union Indemnity Insurance Company of New York
United Community Insurance Company
U. S. Capital Insurance Company
Whiting National Insurance Company

Completed:
Community Health Plan
Medical Malpractice Insurance Association

Ancillary Receiverships - In the case of the insolvency of a New York-licensed foreign (*i.e.,* not domiciled in New York) insurer, the Superintendent must apply to the court to establish an ancillary receivership, enabling the Superintendent as Ancillary Receiver to trigger the Security Funds to pay allowed covered claims remaining unpaid by reason of an insurer's inability to meet its insurance policy obligations.

Commenced: Eagle Insurance Company
Newark Insurance Company

Continued:
Acceleration National Insurance Company
American Druggists' Insurance Company
American Mutual Insurance Company of Boston
American Mutual Liability Insurance Company
Amwest Surety Insurance Company
Commercial Compensation Casualty Company
Credit General Insurance Company
Far West Insurance Company
Fremont Indemnity Company
Frontier Pacific Insurance Company
Integrity Insurance Company
Legion Insurance Company
LMI Insurance Company
Mission Insurance Company
Phico Insurance Company
Reliance Insurance Company
Security Indemnity Insurance Company
Shelby Insurance Company
The Home Insurance Company
Transit Casualty Company
Vesta Fire Insurance Company
Villanova Insurance Company

Completed: The Connecticut Surety 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 Superintendent must apply to the court to establish a conservation proceeding, appointing the Superintendent as Conservator of the assets of that trust fund for the benefit of all U.S. policyholders.

Commenced: None

Continued:
Alpine Insurance Company
Folksam International Insurance Company (UK) Ltd.
HIH Casualty and General Insurance, Ltd.
Legion Indemnity Insurance Company
Northumberland General Insurance Company
Pacific and General Insurance Company
Protective National Insurance Company of Omaha.
Reliance Insurance Company
United Capitol Insurance Company

Completed: FAI General Insurance Company, Ltd.

3. Security Funds Income and Disbursements

Table 66
PROPERTY/CASUALTY INSURANCE SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2009

Total of Fund as of 4/1/08	**$234,570,300**
Paid into the Fund	$782,978
Interest income - net	5,836,093
Recoveries from companies in liquidation	28,219,196
General Fund Interest Reimbursement	1,851,360
Total Receipts	**$36,689,627**
Less disbursements:	
Administrative expenses	$ 208,161
Awards and expenses of companies in liquidation	101,034,016
Total Disbursements	**$101,242,177**
Total Activity	**-$64,552,550**
Total of Fund as of 3/31/09[2]	**$ 170,017,750**

[1] Monies collected under Insurance Law Section 7603.
[2] This total does not include the transfer of $87 million to the State General Purpose Fund per Chapter 55 of the Laws of 1982, or the transfer of $50 million to the Public Motor Vehicle Liability Security Fund as permitted under Section 7603 (e) (2) of the Insurance Law.

Table 67
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2008

Total of Fund as of 4/1/08	**$ 20,531,523**
Paid into the Fund	$13,150,454
Interest income - net	325,293
Recoveries from companies in liquidation	1,094,796
Total Receipts	**$14,570,543**
Less disbursements:	
Administrative expenses	$ 53,693
Awards and expenses of companies in liquidation	6,650,750
Total Disbursements	**$ 6,704,443**
Total Activity	**$ 7,866,100**
Total of Fund as of 3/31/09[2]	**$ 28,397,623**

[1] Monies collected under Insurance Law Section 7604 from companies writing bonds and policies carrying coverages set forth in the Vehicle and Traffic Law Section 370.
[2] The fund has an outstanding liability of $50 million for funds transferred from the Property Casualty Insurance Security Fund, as permitted under Section 7603 (e) (2) of the Insurance Law.

Table 68

WORKERS' COMPENSATION SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2009

Total of Fund as of 4/1/08	**$ 84,514,486**
Paid into the Fund	$ 13,198,437
Interest income – net	1,216,351
Recoveries from companies in liquidation	14,255,206
Total Receipts	**$ 28,669,994**
Less disbursements:	
Administrative expenses	$ 65,516
Awards and expenses of companies in liquidation	56,879,728
Total Disbursements	**$ 56,945,244**
Total Activity	**-$ 28,275,250**
Total of Fund as of 3/31/09	**$ 56,239,236**

[1] Monies collected under Workers' Compensation Law Sections 108 and 109.

X. Publications

(As of 4/1/09)

Automobile/Livery Guides

- 2008 Annual Ranking of Automobile Insurance Complaints
- 2009 Consumer Guide to Automobile Insurance, including price comparison tables and notes

Frauds

- Insurance Frauds Consumer Brochure
- 2009 Insurance Frauds Bureau Annual Report
- 2009 Health Insurance Fraud Annual Report

Health

- Interactive New York Consumer Guide to HMOs (external website link)
- New York Consumer Guide to Health Insurers (2009 Edition - Includes 2008 Rankings)
- Premium Rates for HMO Standard Individual Health Plans

Homeowners and Tenants

- Consumer Shopping Guide for Homeowners and Tenants Insurance

Long Term Care

- A Consumer Guide to Long Term Care Insurance in New York
- "The Implementation of Legislation Permitting Approval of Certain Long Term Care Health Insurance Plans – A Report by the Superintendent of Insurance to the Governor and Legislature, 2009"

Small Business Guides

- Health Insurance - a Small Business Guide
- Property Casualty Insurance - A Small Business Guide (available in English & Chinese)

Timothy's Law

- Report by the Superintendent of Insurance on the Cost and Effectiveness of New York 2006 Health Parity Legislation (Timothy's Law)

En Español

- Guía del Consumidor de Seguro para Los Servicios a Largo Plazo del Cuidado
- Guía del Consumidor para comprar un Seguro médico
- Guía del Consumidor para comprar un Seguro para los Dueños De Una Casa y los Arrendatarios
- Guía para el Consumidor sobre la Compra de un Seguro de Automóvil