NEW YORK STATE
INSURANCE DEPARTMENT

152nd ANNUAL REPORT
OF THE
SUPERINTENDENT

Calendar Year 2010

Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

www.ins.state.ny.us

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The 152nd Annual Report
of the
Superintendent of Insurance
to the
New York State Legislature

For the Year Ending
December 31, 2010

Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

New York State Insurance Department
25 Beaver St., New York, NY 10004
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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

Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

May 13, 2011

To the Legislature:

I am pleased to submit to the New York State Legislature the 152nd Annual Report of the Superintendent of Insurance for Calendar Year 2010 as required by Article 2, Section 206 of the Insurance Law.

This report contains detailed information about the activities of the New York State Insurance Department and describes the state of the insurance business in New York. In addition, this report also describes the Superintendent's separate and distinct activities as Receiver of insolvent estates through the New York Liquidation Bureau.

As Superintendent, I am proud to be associated with the scores of knowledgeable and dedicated professionals who staff the Department and provide superior services to the citizens of New York State. With more than a century and a half of distinguished service to our State, the Department now looks forward to merging with the New York State Banking Department and our consolidation as the new Department of Financial Services (DFS).

The members of our agency are committed to ensuring the success of the DFS and making sure that it serves as a model for financial services regulation in the 21st Century. On behalf of the Department, we appreciate the support we have received from Governor Cuomo and the members of the New York State Legislature.

Respectfully submitted,

James J. Wrynn
Superintendent

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Major Accomplishments

Overview

Throughout 2010, the New York State Insurance Department continued its efforts to protect consumers and encourage the development of a robust and fair insurance marketplace. The Department demonstrated its leadership on issues ranging from international insurance regulation to health care and streamlined how it works in order to strengthen its regulatory and supervisory capabilities.

In 2011, the Department will build on those accomplishments as it merges with the New York State Banking Department to form a new Department of Financial Services. Designed to modernize financial regulation by consolidating the resources of the two agencies, the new Department will focus on closing regulatory gaps to ensure better and broader oversight of all financial services regulated by the State. In doing so, the Department will provide stronger, more effective consumer protection and ensure that New York remains the financial capital of the world.

Protecting Health Insurance Consumers

Landmark legislation giving the Department new regulatory authority to protect consumer interests went into effect in 2010 and allowed the Department to help restrain increases in health insurance premiums. The new prior approval authority allowed the Department to reduce rate requests by an overall weighted average of approximately 2.5 percent. In some cases, double-digit rate reductions were achieved.

The new system, known as "prior approval," replaced the previous system of "file and use," which allowed insurers to implement rate increases without justifying them beforehand. Under prior approval, the Department gained the authority to examine proposed increases and require insurers to spend more of the money collected from premiums on medical claims.

The new law affects individual, small group and large group community rated health insurance coverage. Insurers and HMOs are now required to spend 82 percent of premium dollars on claims. Previously, insurers and HMOs had been required to spend only 75 percent on claims, while insurers in the individual direct-pay market were required to spend only 80 percent.

Implementing Health Insurance Reforms

The Department's Health Bureau staff focused on implementing federal health reforms under the Patient Protection and Affordable Care Act's "Six-Month Reforms" by assisting insurers with the development of a forms filing checklist that integrates New York and federal requirements. The "Six Month Reforms," that went into effect on September 23, 2010, include prohibitions on annual and lifetime limits, coverage of preventive health services and requirements for dependent coverage. In 2011, the Department will focus on helping to develop the new Health Insurance Exchange that will go into operation in 2014 to facilitate the purchase of insurance in the individual and small group markets.

Enforcement Actions

Misleading consumers who believed they were buying comprehensive health insurance when they were actually getting limited benefit health plans led to action against a Florida-based insurance agent, Cinergy Inc., that advertised its plan on late night television, the Internet and through telemarketers.

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The company was fined $500,000 and directed to end violations, which included failing to fairly and accurately disclose the limitations of its coverage and creating the false impression with some individuals that the coverage was a substitute for medical and other comprehensive health insurance coverage. The company was directed to implement such actions as training its personnel to offer complete and correct information about coverage and provide insured individuals with either a copy of the insurance policy or an approved certificate of insurance containing a detailed description of coverage.

Other significant enforcement actions involving major fines and Department directives to correct violations included:

- Fining several Citigroup-affiliated insurance agencies $2 million to resolve violations tied to their failure to disclose required information to consumers in transactions involving the replacement of existing life insurance policies or annuity contracts.

- The settlement of allegations with the payment of a $1.9 million fine against two Health Net companies for failing to provide consumers with required information on "explanation of benefit" forms and failing to pay certain claims on time.

- The payment of a $1.9 million fine by AXA Equitable for violations that included making inaccurate or incomplete disclosures to consumers buying replacement annuity contracts and life insurance policies.

- The fine of $1 million against Managed Health Inc., an HMO, for infractions relating to the company's failure to properly license its sales agents in regard to its Medicare Advantage business and to timely adjudicate and pay claims related to commercial policies.

Life Settlement Regulation

The Department helped safeguard consumer privacy rights and exercised licensing authority under New York's first ever law regulating the life settlement industry. The new law established a framework for regulating life settlement transactions, which were previously unregulated.

Life settlements involve the sale of a life insurance policy by a policyholder for a monetary value greater than possible by surrendering it to the insurance company. Life settlements typically occur when older individuals decide they no longer need or want a life insurance policy.

The new law encouraged greater consumer protection by giving the Department the authority to regulate parties involved in carrying out life settlement transactions. Acting under the new law, the Department began the licensing of life settlement providers and brokers and the registration of life settlement intermediaries.

The law also advanced consumer protection by requiring the disclosure of such information as the complete and accurate description of all offers and counter-offers to consumers selling life insurance policies.

Streamlining the Department's Operations

The Department worked to cut red tape and simplify filings processes as the result of the efforts of a joint Department-Industry working group. The group focused on streamlining Department operations to foster greater efficiency, better protect consumers, encourage the development of the insurance industry and reduce unnecessary costs and burdens on regulated entities. A number of recommendations advanced by the working group were put into effect, including the development of new and updated product outlines, the use of a comprehensive triage system and the

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increased use of new and updated checklists.

Participating in International Regulatory Issues

Superintendent James Wrynn served as Vice Chair of the International Insurance Relations Committee of the National Association of Insurance Commissioners. The committee is charged with ensuring that the NAIC, the national association of state insurance regulators, plays a leading role in efforts to more closely coordinate international regulation. The Superintendent worked to ensure international coordination of regulation to provide effective oversight and a level playing field for insurers based in the United States. The Superintendent represented U.S. regulators in meetings with the European Union (EU) Commission on EU equivalence, as well as in meetings with the International Association of Insurance Commissioners.

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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, 2010. The total admitted assets of licensed life insurers amounted to approximately $2.36 trillion at December 31, 2009, a ten-year gain of 43.9%. Bonds totaled $1,029.8 billion; stocks $57.0 billion; mortgage loans $176.6 billion; real estate $10.9 billion; policy loans $65.2 billion, and short-term holdings $32.4 billion. Other admitted assets totaled $985.4 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $934.3 billion on December 31, 2009, an increase of 59.5% since 1999. Insurance in force at December 31, 2008 of $6.59 trillion represents an increase of 88.0% since December 31, 1999.

3. Organizations Under Life Bureau Supervision

The Life Bureau supervised 563 organizations as of December 31, 2010. 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; 280 charitable annuity funds; 23 employee welfare funds; 31 life settlement providers (including 29 entities permitted to operate as life settlement providers pending approval or disapproval of their applications for licensure and contract forms) and 37 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, 1999-2009 (dollar amounts in billions)

Admitted Assets	2009	2008	2004	1999
Total	$2,357.3	$2,315.7	$2,080.6	$1,637.6
Percent increase from 1999	43.9%	41.4%	27.1%	---
Type of asset				
Bonds	$1,029.8	$1,016.7	$957.2	$637.3
Stocks	57.0	64.4	61.1	55.3
Mortgage Loans	176.6	195.1	159.6	140.7
Real Estate	10.9	13.0	12.3	17.7
Policy loans/liens	65.2	65.8	56.1	53.5
Short-term holdings	32.4	38.9	14.8	33.3
Other	985.4	921.9	819.5	699.8

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

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Table 2
BALANCE SHEET
Life Insurance Companies Licensed in New York State
Selected Years, 2004-2009
(in billions)

	2009	2008	2004
Assets	$2,357.3	$2,315.7	$2080.6
Liabilities	2,203.3	2,182.7	1,963.3
Capital & Surplus	154.0	133.0	117.3

Table 3
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1999-2009
(dollar amounts in billions)

Class of Business	2009	2008	2004	1999
Total insurance in force	$14,027.7	$13,638.1	$11,138.7	$8,422.0
Percent increase from 1999	66.6%	61.9%	32.3%	---
Ordinary	$7,546.6	$7,419.4	$6,205.3	$4,557.9
Group	6,440.4	6,170.4	4,864.4	3,789.8
Credit	35.0	42.5	62.6	67.0
Industrial	5.7	5.8	6.4	7.3

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Table 4
SOURCES OF INCOME
Life Insurance Companies Licensed in New York State
Selected Years, 2004-2009
(dollar amounts in millions)

Source of Income	2009 Amount	2009 Percent of Total	2008 Amount	2008 Percent of Total	2004 Amount	2004 Percent of Total
Group life	$13,841.9	4.3%	$15,904.4	4.5%	$16,620.5	5.5%
Group annuities	68,555.9	21.4	76,228.0	21.4	63,695.8	21.1
Group A & H	29,249.6	9.1	31,205.3	8.8	23,390.8	7.8
Ordinary life	41,174.7	12.8	44,472.2	12.5	45,302.9	15.0
Individual annuities	60,537.6	18.9	69,889.7	19.6	55,777.7	18.5
Individual A & H	12,242.5	3.8	11,809.5	3.3	4,860.9	1.6
Credit life	226.8	0.1	237.2	0.1	260.9	0.1
Industrial life	41.7	0.0	38.0	0.0	131.9	0.0
Total Premiums	**$225,870.8**	**70.4%**	**$249,784.3**	**70.1%**	**$210,041.4**	**69.6%**
Supplementary contracts	844.2	0.3	419.5	0.1	421.9	0.1
Net investment income	76,721.7	23.9	84,185.7	23.6	74,817.4	24.8
Other income	17,383.8	5.4	21,984.5	6.2	16,396.8	5.4
Total	**$320,820.5**	**100.0%**	**$356,374.0**	**100.0%**	**$301,677.5**	**100.0%**

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

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Table 5
OPERATING RESULTS
Life Insurance Companies Licensed in New York State
Selected Years, 2004-2009
(in millions)

	2009	2008	2004
Total premiums	$225,138.4	$249,693.2	$207,341.1
Investment income	76,721.7	84,185.7	74,817.4
Supplementary contracts	844.2	419.5	421.9
Other income	18,116.1	22,075.6	19,097.2
Total income	$320,820.5	$356,374.0	$301,677.5
Net gain from operations	$23,720.2	-$418.2	$13,159.7
Net income	$9,503.9	-$19,826.9	$13,851.5

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

Table 6
LIFE INSURANCE IN FORCE IN THE STATE OF NEW YORK
Life Insurance Companies Licensed in New York State
Selected Years, 1999-2009
(dollar amounts in billions)

Insurance In Force	2009	2008	2004	1999
Total	$1,813.1	$1,727.5	$1,514.3	$1,110.7
Percent increase from 1999	63.2%	55.5%	36.3%	---
Class of business				
Ordinary	$1,198.2	$1,185.6	$937.9	$644.9
Group	609.2	535.4	568.9	458.4
Credit	5.2	5.9	6.9	6.5
Industrial	0.5	0.5	0.6	0.8

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

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Table 7
ADMITTED ASSETS/INSURANCE IN FORCE
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1999-2009
(dollar amounts in billions)

Domestic Life Insurers	2009	2008	2004	1999
Admitted assets	$934.3	$896.1	$772.8	$585.6
Percent increase from 1999	59.5%	53.0%	32.0%	---
Insurance in force	$6,593.2	$6,309.4	$4,582.2	$3,506.5
Percent increase from 1999	88.0%	79.9%	30.7%	---

4. Licensed Fraternal Benefit Societies

At the close of 2009, 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, 2009, the admitted assets of licensed societies rose from $52.9 billion to $84.3 billion, an increase of 59%. Insurance in force rose $87.9 billion over the period to $335.8 billion, an increase of 35%.

Table 8
FRATERNAL BENEFIT SOCIETIES
Selected Years, 1999-2009
(in billions)

Fraternal Benefit Societies	2009	2008	2004	1999
Admitted assets	$84.3	$78.4	$73.9	$52.9
Insurance in force	$335.8	$323.7	$289.0	$247.9

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5. Private Retirement Systems

At the close of 2009, 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 2009, the assets of these private pension funds totaled approximately $185 billion. The following table shows data for the private pension funds for selected years from 1999 to 2009:

Table 9
PRIVATE PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1999-2009
(in millions)

Private Pension Funds	2009	2008	2004	1999
Fair value of assets [a]	$184,619	$153,075	$183,483	$178,751
Payments to annuitants and beneficiaries	$15,529	$23,230	$11,574	$9,174

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

6. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Life Bureau at the close of 2009 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 2009 were approximately $285 billion. During the period from 1999 to 2009, the assets of these retirement systems decreased at the compound rate of .5% per year, reflecting the significant stock market downturns in the last decade.

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 2009 increased by 17% from its 1999 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 Life Bureau, had assets as of June 30, 2009 totaling $1.9 billion.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1999 to 2009:

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Table 10
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1999-2009
(in millions)

Public Retirement Systems & Pension Funds	2009	2008	2004	1999
Fair value of assets[a]	$285,255	$353,446	$288,771	$301,061
Payments to annuitants and beneficiaries	$19,914	$20,401	$15,454	$10,253

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

During 2010, regular on-site examinations of three of the five New York City retirement systems were conducted.

7. Segregated Gift Annuity Funds for Charitable Organizations

At the end of 2009, 267 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, 2009, admitted assets of these funds increased by 130% and the annual payments increased by 166%. The substantial increase in assets and payments reflects the rapid growth in the number of licensed societies during the period.

Table 11
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1999-2009
(in millions)

Segregated Gift Annuity Funds	2009	2008	2004	1999
Total admitted assets	$2009.7	$1,899.9	$1,720.4	$873.9
Annual payments to annuitants	$196.3	$192.3	$153.1	$73.8

8. Employee Welfare Funds

Twenty-three employee welfare funds covering 113,751 employees were supervised by the Life Bureau at the close of 2009. 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 employees 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 $327 million in 2009. Benefits paid totaled $325 million and included life insurance; medical, surgical and hospital coverage; major medical

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coverage; optical, dental and prescription drug plans; disability insurance and legal services. Administrative expenses totaled $11 million representing 3.4% of contributions.

9. Life Settlement Providers

At December 31, 2010, 31 life settlement providers – 2 licensed entities and 29 entities permitted to operate as life settlement providers pending approval or disapproval of their applications for licensure and contract forms – were subject to the Department's regulatory authority.

In May 2010, New York's Life Settlement Act, enacted as Chapter 499 of the Laws of 2009 and signed into law on November 19, 2009, became fully effective. The Act repealed the original Article 78, entitled Viatical Settlements and enacted in 1993, which authorized the Superintendent to regulate viatical settlements only. With the enactment of the Life Settlement Act, the Superintendent has the authority to regulate life settlements in New York, which previously had not been subject to regulation in the State, and to establish standards governing life settlement transactions. The Act governs all life insurance policy settlements (including those transactions previously referred to as "viatical settlements" in which the insured person under the policy to be viaticated had a catastrophic or life threatening illness or condition).

10. Examinations Conducted in 2010

Table 12
EXAMINATIONS CONDUCTED
Life Bureau
2010

		Regularly Scheduled		Other	
		Initiated			
	Total	In 2010	Prior to 2010	Special	On Organ-ization*
Life insurance companies	41	20	20	0	1
Fraternal benefit societies	4	2	2	0	0
Retirement systems and pension funds	5	3	2	0	0
Segregated gift annuity funds of charitable organizations	31	31	0	0	0
Welfare fund	16	16	0	0	0
Total	**97**	**72**	**24**	**0**	**1**

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

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 2010, there were 534 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.

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Table 13
COMPANIES LICENSED BY THE LIFE BUREAU
December 31, 2010

Life – New York	81
Life – Other States	52
Accredited Reinsurers	37
Fraternals – New York	3
Fraternals – Other States	34
Fraternals – Canadian, U.S. Branch	1
Charitable Annuities	280
Retirement Systems	21
Life Settlement Providers	31
Welfare Funds	23
Total	563

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 2010 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 2010 the Life Bureau processed 118 agent compensation submissions pursuant to Section 4228 of the Insurance Law, 11 fewer than in 2009. Most such submissions are related to the marketing of new products, so the number of submissions in 2010 may be reflective of slowness in the economic recovery. The Bureau continues to allow submissions under Section 4228 to be mailed in on paper or to be filed electronically through a dedicated e-mailbox. An approximately equal number of submissions are received by each of the two methods.

Section 4228 of the New York Insurance law regulates sales and acquisition expenses, and is an important tool both in protecting insurers' solvency and in helping to control the cost of life insurance. Although the regulation of sales and acquisition expenses is unique to New York, it is believed to have a beneficial effect on the cost of life insurance nationwide because of the size of the New York market.

b. Separate Accounts

The Life Bureau processed 502 submissions relating to separate account plans of operation during 2010, 51 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

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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 2010 the actuarial staff participated in on-site examinations of three major life insurance companies 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. Actuarial Opinion and Memorandum Review

The New York City actuarial unit has taken on the duty of reviewing actuarial opinions and memoranda relating to the reserves of life insurers that do business in New York but are domiciled outside New York. During 2010 the unit conducted 90 such reviews.

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 that members of closed blocks are realizing the protections they were promised.

f. 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.

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13. Policy Forms and Product Filings

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

In 2010, the Life Bureau received 1,870 policy form submissions (files) consisting of 7,437 life insurance, annuity, funding agreement and other policy forms offered by life insurance companies, fraternal benefit societies, charitable annuity societies and life settlement companies as indicated in Table 14 below. Of the 7,437 policy forms received in 2010, 62.7% were submitted under a certified filing procedure (Circular Letter No. 6 (2004) or §3201(b)(6) of the Insurance Law), .6% were submitted for out-of-state use by domestic insurers and 36.7% were submitted for full review and approval.

In 2010, the Life Bureau processed a total of 1,858 policy form submissions (files) consisting of 7,228 policy forms as indicated in Table 14. Of the 7,228 forms processed in 2010, approximately 36.3% were submitted for prior approval, 62.3% were submitted under a certified filing procedure and .6% were filed for out-of-state use. Of the prior approval files disposed in 2010, approximately 67.6% of the forms were approved or filed and 31.3% were either rejected or withdrawn. Of the certified files disposed in 2010, approximately 64.8% of the forms were approved or filed and 34.5% were either rejected or withdrawn. Of the out-of-state files disposed in 2010, approximately 98.4% of the forms were filed and approximately 1.6% were rejected or withdrawn.

Table 14
NUMBER OF FILES & POLICY FORMS
RECEIVED AND PROCESSED BY TYPE
LIFE BUREAU, 2010

PRODUCT TYPE	RECEIVED		PROCESSED	
	Files	Forms	Files	Forms
Individual Life	521	2,004	531	2,045
Group Life	162	1,191	166	1,083
Individual Annuity	660	2,313	671	2,358
Group Annuity	332	1,067	328	1,084
Credit Insurance	20	81	20	89
Life Settlement	49	299	8	42
Miscellaneous	126	482	134	527
TOTAL	1,870	7,437	1,858	7,228

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 611 other filings related to the policy form approval process and products offered for sale in New York, including 37 rate and actuarial filings, 189 inquiries and complaints, 69 FOIL requests, 8 prefilings under Circular Letter No. 64-1, 72 compensation filings and 78 annual illustration certification filings.

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Table 15
POLICY FORM-RELATED FILINGS RECEIVED IN 2010

Fraternal Benefit Societies (Constitution, Articles of Incorp., Bylaws, etc.)	7
Calculation of Life Estates	9
Circular Letter No. 64-1	8
Compensation Filings	72
FOIL Requests	69
Inquiries & Complaints	189
Rate & Actuarial Filings	37
Violations & Market Conduct	99
Informational Filing	43
Regulation 74 Illustration Certification Filings	78
Total	**611**

c. Speed to Market

During 2010, the Life Bureau continued to assist insurers in bringing products to market as quickly as possible. During the year, the Life Bureau processed 4,638 Circular Letter No. 6 (2004) policy forms in an average of twelve days. Of the total 4,638 Circular Letter No. 6 (2004) policy forms, approximately 3,006 were approved, 1,497 were rejected and 103 were withdrawn.

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) is minimal. The Life Bureau processed only twenty files in 2010 submitted under the §3201(b)(6) process.

In February 2010, the Superintendent commenced the Insurance Filings Modernization Initiative ("Initiative"). The Initiative was designed to streamline the New York State Insurance Department's process for the review of rate, policy, license and other industry filings (the "Rate and Form Filing Process"). The Initiative was grounded in the precept that a more efficient and focused Rate and Form Filing Process would better protect consumers, help enhance competition in the insurance industry, and reduce unnecessary costs and burdens on regulated entities.

The Initiative was conducted by six committees that were each composed of industry representatives, with support from staff of the Department and chaired by an industry representative. The Committees were: (1) Life; (2) Personal Lines; (3) Property; (4) Licensing; (5) Health; and (6) Transactional. Life Bureau staff provided support to the Life Committee. The Life Committee met on numerous occasions during the year to identify ways to improve the Life Bureau's Rate and Form Filing Process.

The length of time between submission and approval of policy forms was not a significant focus for the Life Committee since the Life Bureau already had the Circular Letter 6 (2004) (CL-6) certified process. At that time the latest available results from 2009 showed that policy forms under the CL-6 certified process were handled in an average of eight calendar days. Instead, the committee focused on areas such as improving the quality of submissions in order to reduce the number of rejected submissions and to reduce the impact of post approval review. The Committee recommended that the Life Bureau develop additional guidance.

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The Committee identified errors in the submission of variable material as being an area that results in a significant number of rejected submissions. In an effort to reduce the instances of such errors, the Life Bureau staff developed and posted a check list on the Department's website entitled Common Errors in Memoranda of Variable Material. This procedural checklist is intended to supplement two other substantive filing guidance documents on variable material already available on the website.

The Life Bureau has made detailed product outlines available on the Department's website since the 1990s. The product outlines were the result of a joint Department/Industry working group. There are currently 26 such outlines available to assist insurers. Those outlines have been periodically updated over the years. However, the product outlines were developed prior to the implementation of the CL-6 certified filing procedure. The Committee requested that the Life Bureau expand the scope of material addressed in those outlines to address in greater detail issues that would otherwise have been addressed during the review and approval process. Accordingly, the Life Bureau has begun a long-term project of developing, updating and expanding product outlines. An updated/expanded Group Term Life Insurance product outline was posted on the Department's website on January 27, 2010. During 2010, Life Bureau staff also worked on updating and expanding other product outlines, including the Individual Whole Life Insurance product outline and the Individual Fixed and/or Variable Deferred Annuity product outline, both of which were posted to the Department's website for public comment in February 2011. Other outlines have been assigned to Life Bureau staff and updates are under way.

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, 2010, 6,590 files consisting of 24,155 policy forms have been approved under the certified filing procedures, with 5,653 files and 20,528 policy forms under Circular Letter 6 (2004) and 937 files and 3,627 policy forms under Circular Letter 27(2000).

In 2010, the Life Bureau continued the screening process to prioritize for post approval review certified files submitted from 2000 through 2010. 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, 2010, 4,513 of the 6,591 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, 2010, approximately 459 of the 6,591 certified files had been assigned for post approval review. Of those 459 post approval review files, approximately 363 had been completed and closed. Post approval may involve as many as four phases depending on the problems. 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

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against the company or the officer completing the certification. In 2010, the Department suspended one company's ability to use the Circular Letter No. 6 (2004) certified process for a period of three months. The company had used the Circular Letter No. 6 (2004) process to obtain approval of a product after the Life Bureau had directed the company not to do so because the product did not comply with the Insurance Law.

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.

During 2010, SERFF was the dominant method for sending life and annuity policy form submissions to the Life Bureau. In 2010, life insurers submitted 1,587 files, consisting of 6,054 policy forms through SERFF. These totals represent approximately 92.8% of all policy form filings and 92.4% of all policy forms submitted by life insurers in 2010.

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.

As part of the Insurance Filings Modernization Initiative discussed above, Industry recommended that the Life Bureau make SERFF available for Post Approval Review files. That request posed a challenge because Post Approval Review files are initiated by the Department and SERFF does not permit states to open new files in SERFF. In spite of that obstacle, the Life Bureau developed and immediately implemented a procedure by which insurers could open the SERFF file upon receiving initial notice that a Post Approval Review had been commenced by the Life Bureau. Once the SERFF file is opened by the insurer, the rest of the correspondence during the Post Approval Review and the approval of any corrective endorsements can then take place through SERFF.

14. Legislative and Regulatory Summary

a. Article 78 – Life Settlements

The Life Settlements Act, Article 78 of the Insurance Law, was enacted as Chapter 499 of the Laws of 2009. It replaced the original Article 78 and authorized 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.

The new Article 78 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 became fully effective and the Viatical Settlements law was 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, life settlement brokers and life settlement intermediaries. Life settlement contracts, applications and other forms as may be prescribed by regulation must be filed with and approved by the Department. Certain minimum contract provisions are required. Life settlement advertising is regulated. The law also mandates that certain disclosures be made to policy owners and insureds contemplating a life settlement transaction. In order to assist life settlement providers, life settlement brokers, life

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settlement intermediaries and the public, various guidance documents and model forms have been posted on the Department's website. A regulation setting forth licensing fees for life settlement providers and brokers; registration fees for life settlement intermediaries and standards for financial accountability for applicants for licensure as life settlement providers has been promulgated on an emergency basis. In addition, draft regulations for contract form filing requirements and disclosure requirements have been posted on our website. The Department is also in the process of drafting additional regulations. 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 §4223I(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. In 2010, the Life Bureau issued Circular Letter 8 (2010) and updated applicable product outlines on the Department's website to address this issue. The Life Bureau also instituted a priority review process for endorsements being used to amend in force contracts to comply with the revised statute.

c. Section 1113 – Accelerated Death Benefit Nursing Home Trigger

Chapter 563 of the Laws of 2010 amending Insurance Law §1113(a)(1) became effective on January 1, 2011. Chapter 563 added a new subparagraph (E) which expands the definition of life insurance to include the accelerated payment of part or all of the death benefit when the insured has been a resident of a nursing home, as defined in Public Health Law §2801, for a period of three months or more, with an expectation that the insured will remain a resident of a nursing home until death.

The new law also amends Insurance Law §§3201(c)(11)(A) and 3230(f) to extend the requirements of these sections to the new trigger for accelerating death benefits.

Insurance Law §1113(a)(1)(C) and (D) permit an insurer to write life insurance policies with accelerated death benefits that may be used to provide financing for those who reside in a nursing home for at least three months and may remain there for life, so long as the benefits qualify under the federal Internal Revenue Code to receive favorable tax treatment. The new law allows the acceleration of death benefits for this purpose without requiring qualification for favorable tax treatment.

d. Section 4216 – Group Participation Requirements

Effective on September 17, 2010, Insurance Law §4216(b)(1) was amended by Section 1 of Chapter 515 of the Laws of 2010. The law reduces the minimum size and participation requirement for single employer groups in group life insurance contracts. In recognition of the increasing portion of group life insurance coverage that is elected and paid for – at least in part – by employees, the law was supported by the industry and passed with the intention of making convenient, lower priced group life

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insurance coverage with limited underwriting available to more employers and employees in New York and, thereby, reducing the number of people who may need public assistance in times of hardship.

The Life Bureau has cautioned that the group life insurance minimum size and participation requirements were intended to protect insurers from antiselection and reduce the likelihood of discrimination among insureds. With lower standards now authorized for single employer groups providing contributory life insurance coverage, the insurers will need to be vigilant in the underwriting process. The coverage provided will need to be self-supporting. In addition, the Life Bureau remains concerned that the group insurance laws continue to be modernized and liberalized to the point where the group format is becoming another method of marketing individual insurance – but without the legal protections for group certificate holders that are afforded to individual policy holders.

e. Regulation 77 – Private Placement Variable Life Insurance

In 2010, the Life Bureau continued to work on an amendment to Regulation 77 that would accommodate private placement variable life insurance policies. These policies are defined in the amendment as any variable life insurance policy that (i) is exempt from registration under the Securities Act of 1933, (ii) includes one or more separate accounts that are exempt from registration as investment companies under the Investment Company Act of 1940 and (iii) is only available to an "accredited investor" or to a "qualified purchaser." Under federal securities law, "accredited investor" and "qualified purchaser" are defined as persons who meet certain specified income or net worth criteria.

Currently, individual private placement variable life insurance policies cannot be sold in New York because they cannot meet certain requirements of Regulation 77. Regulation 77 requires that policy values and cash surrender values must be determined on at least a monthly basis. The assets under a standard separate account are publicly traded and can be valued or liquid on any day that the stock market is open. Private placement separate account assets are not publicly traded and are more illiquid types of assets. To address the illiquid nature of these separate account assets, the amendment would provide separate requirements for private placement separate account assets including valuation of the assets at least annually, the payment of variable death benefits no later that 30 days from the date the request for payment and necessary documentation are received and the payment of cash surrender values and policy loans and partial withdrawals no later than 15 months from the date the request for payment is received by the insurer. Consumers will receive a detailed private placement offering memorandum.

f. Regulation 74

In 2010 the Life Bureau continued to work on an amendment to Regulation 74 to set forth the information mandated by Section 3209 of the Insurance Law, including the standards governing the content, format and use of sales illustrations and other disclosure requirements for fixed and/or variable annuity products, equity index products and funding agreements. For index products, the amendment would set requirements for disclosure, including standards for determining current interest crediting rates. The amendment also limits illustrations to what a company expects to pay and requires additional disclosure when a policy may lapse.

The amendment would also permit delivery of a policy illustration within four business days after the application for the policy is signed when the illustration used in the sale of the policy is displayed on a computer screen and it is impractical to provide a signed copy of the illustration at the time of application. The amendment would require a certification including certain basic information about the policy as applied for, to be completed by the agent and signed by the applicant and the agent when a signed copy of the illustration is not provided at the time of application. In addition, the amendment includes similar provisions in situations where no illustration is provided at the time of policy application or when the policy is applied for other than as illustrated. In 2010 the Department continued

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discussions with the Life Insurance Council of New York (LICONY) regarding the latest draft of the amendment.

g. Regulations 187 and 199 – Suitability in Annuity Sales and Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities

Regulation 187, entitled "Suitability in Annuity Sales", and Regulation 199, entitled "Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities", were adopted on an emergency basis in December of 2010. Regulation 187 requires insurers to set forth standards and procedures for recommendations to consumers with respect to annuity contracts so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed. Regulation 199 prohibits the use of a senior-specific certification or professional designation by an insurance producer in such a way as to mislead a purchaser or prospective purchaser into believing that the insurance producer has special certification or training in advising or providing services to seniors in connection with the sale of life insurance and annuities. Both regulations are substantially similar to NAIC models.

Adoption by year-end 2010 of both regulations as emergency measures made the Department eligible, under the Dodd-Frank Wall Street Reform and Consumer Protections Act of 2010, for federal grants for 2011 and each of the two subsequent fiscal years to fund specified regulatory activities providing enhanced protection of seniors in connection with the sale and marketing of financial products.

Both regulations currently remain in effect on an emergency basis. Proposals for the permanent adoption of these regulations were sent to the Governor's Office of Regulatory Reform in January of 2011, and the Department is awaiting approval to publish the proposed regulation in the State Register.

h. NonGuaranteed Elements Regulation

The Life Bureau is proposing a new regulation to establish minimum standards for nonguaranteed elements of life and annuity insurance policies and to establish minimum standards for written criteria set by the board of directors or a committee thereof for determining nonguaranteed elements.

i. Guaranteed Living Benefits – Update

The Department has been pursuing strong reserve, minimum capital and corporate governance requirements for guaranteed living benefits at the NAIC, in addition to performing in depth examinations of insurers' reserves, capital, and risk management practices with respect to these products. In 2009, a revised reserving regulation was 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. In 2010 the Department continued discussions with the NAIC on proposals initiated by the Department and by a consulting firm on improving variable annuity-related reserve and capital standards.

15. Product Innovations

a. Contingent Annuities

In 2006 the Life Bureau began receiving inquiries and/or product submissions from several life insurers regarding a 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

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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.

During 2010, the Department has continued meeting with industry representatives regarding the significant risk concerns inherent in recognizing such products as annuities or substantially similar thereto and extending the risk posed by variable annuities with guaranteed minimum withdrawal benefit to a potentially much larger market of mutual fund and brokerage accounts with fewer controls because the assets are owned by other financial institutions rather than the insurer. A coalition of insurers supports legislation, which has been introduced in the New York State Senate during 2011, to permit such products.

The emergence of contingent annuities could dramatically increase life insurers' exposure to stock market risk. Insurers would have significantly less control of asset requirements than with an annuity contract that provides guaranteed living benefits. For example, there would be no separate account plan of operations, and the wrapped funds could have more volatility or leverage than broad market equity funds. In addition, the equity option provided by such contracts may not have the provisions found in annuity contracts, such as annuitization benefits, surrender charges and death benefits, which would mitigate the cost of the equity option. Finally, if these contracts are between the insurer and the fund provider and not the insurer and fund participant, the potential for market conduct problems and fund participant dissatisfaction could be high.

b. 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. In 2009, the Life Bureau began analyzing this concern to determine whether additional disclosure is needed to protect consumers.

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The Life Bureau continued its analysis in 2010, determining that a circular letter needed to be drafted to address the need for insurers to provide disclosure to consumers that adequately explains the effect of taking an excess withdrawal. The Department posted a draft circular letter on its website for public comment and worked with industry throughout the drafting process. Released on February 7, 2011, Circular Letter 5 (2011) provides that insurers should generally disclose how excess withdrawals will permanently reduce future guaranteed withdrawal amounts. The disclosure will also advise contract owners that they may request a personalized calculation showing the actual effect of taking the excess withdrawal and what the guaranteed withdrawal amount will be if the excess withdrawal is made. Insurers will provide the disclosures in any periodic statement sent to its contract owners and again at the time an excess withdrawal is requested.

16. Trade Practices

a. Sale of Unapproved Annuity Contracts by Unlicensed Companies

In 2010, 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. On April 13, 2011, the Life Bureau in conjunction with the Consumer Services Bureau issued Circular Letter No. 6 (2011) in an effort to prevent such unauthorized sales in the future. The circular letter reminds insurers and producers of the licensing and product approval requirements under the Insurance Law.

b. Retained Asset Accounts

In July 2010, Bloomberg News published a story on retained asset accounts (RAAs), which resulted in national publicity and congressional investigation of these accounts. An RAA is typically established by a life insurer or fraternal benefit society (collectively, “insurers”), upon the death of an insured under a life policy or certificate, in lieu of providing the beneficiary with a single check for the full proceeds of a life insurance claim. In most instances, the insurer establishes in a bank or financial institution either an interest bearing checking or draft account in the beneficiary’s name, and provides the beneficiary with a checkbook/draftbook in order to withdraw the funds. Funds can be withdrawn by the beneficiary in their entirety with a single check/draft or can be withdrawn in installments. Generally, the insurer does not fully fund the account with the claim amount; rather, the insurer deposits the funds into the account at the time that a beneficiary presents the check/draft to the bank or other financial institution. Insurers aver that an RAA is designed to be a repository of funds while the beneficiary considers what to do with the death proceeds.

The Life Bureau required, pursuant to Section 308 of the Insurance Law, the filing of data by a number of insurers regarding their RAAs and the communications/forms utilized with beneficiaries. It was clear from the responses that insurer policies vary widely when it comes to the structure of RAAs and how they are presented to beneficiaries. Some insurers provide far better disclosure regarding their RAAs than others, and it appears that a greater degree of uniformity among disclosures is needed. The Bureau found that some insurers’ claim forms did not appear to offer a lump sum settlement option, or appeared to obfuscate the lump sum option in favor of a retained asset account.

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The Department is in the process of drafting a Circular Letter to address this issue, which will include guidance for appropriate consumer disclosures where the RAA is an option. After release of the Circular Letter, the Department intends to pursue a Regulation on RAAs.

c. 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.

d. Discretionary Clauses – Update

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.

The Life Bureau staff has continued to work with Health Bureau staff to draft a regulation to address the issue of discretionary clauses. In 2010, the Department posted a draft of proposed Regulation 184 on the Department's website for public comment.

17. Other Initiatives

a. Market Conduct Review of Non-Guaranteed Elements

Interrogatories on non-guaranteed elements in Exhibit 5 of the 2009 Annual Statements were reviewed for 176 life insurers. Eighteen 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.

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In 2010, 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 serious reservations about potentially weakening solvency requirements under a principles based approach in light of the dramatic changes that were 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.

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 and proved quite effective at identifying companies who may be particularly susceptible to volatility. 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.

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B. PROPERTY BUREAU

1. Entities Supervised by the Financial Regulation Division

As of December 31, 2010, the Financial Regulation Division side of the Property Bureau exercised regulatory authority over 1,190 insurer entities and risk retention groups.

The Bureau regulated 1,091 insurer entities as of year-end 2010. Table 16 provides a breakdown.

Table 16
ENTITIES REGULATED BY PROPERTY BUREAU
2010

Number of Regulated Entities	Type of insurer/reinsurer/entity
92	Accredited reinsurers*
18	Advance premium co-operatives
24	Assessment co-operatives
13	Associations, pools, and syndicates
54	Captive insurers
15	Financial guaranty insurers
31	Mortgage guaranty insurers
1	Property Insurance Underwriting Association (FAIR Plan)
809	Property/casualty insurers
25	Title insurers (including one accredited reinsurer)
9	United States branches

* Lloyd's of London (Lloyd's), included as an accredited reinsurer, is comprised of individual underwriting syndicates, each of which must meet the requirements for recognition as an accredited reinsurer. As of December 31, 2010, the Department recognized 74 Lloyd's syndicates as active accredited reinsurers.

In addition, the Bureau oversaw the operation of 99 risk retention groups in 2010.

The Property Bureau received 24 applications for licensing and 9 applications for recognition as an accredited reinsurer during 2010. Twenty-seven insurers were newly licensed including 22 foreign property casualty companies, 2 foreign mortgage guaranty companies and 3 foreign title insurance companies. In addition, there were 3 insurers approved for accredited reinsurer status, 1 foreign insurer and 2 alien insurers. At the close of the year there were domestic applications pending for 6 property casualty companies and 1 financial guaranty company. There were also 27 foreign property casualty insurers, 1 foreign mortgage guaranty insurer and 2 foreign title insurers which had license applications pending with the Department as well as 4 pending accredited reinsurer applications.

During 2010 Department Regulation 20 Section 125.4 was amended, to take effect January 1, 2011, to allow alternative credit for cessions to eligible unauthorized assuming insurers that maintain a policyholders' surplus or equivalent in excess of $250,000,000 and maintain a minimum financial strength rating from the rating agencies. Unauthorized assuming insurers seeking eligibility pursuant to Regulation 20 Section 125.4(h) must file an application with the superintendent to be certified. During 2010 the Property received and certified one reinsurer pursuant to Section 125.4(h) of Regulation 20.

From the digital collections of the New York State Library.

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 2009 by all New York-licensed property and casualty insurers aggregated totaled $311.4 billion, of which 76% 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
2004-2009
(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
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
2009	748	237,999	323,988	0.7	72	73,382	117,347	0.6

b. Underwriting Results

Results for 2009 show a net underwriting gain of $5.5 billion for stock companies and a net underwriting loss of -$2.0 billion for mutual companies.

From the digital collections of the New York State Library.

Table 18
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State
2006-2009
(dollar amounts in millions)

Year		Stock Companies		Mutual Companies	
		Number of Companies	Amount	Number of Companies	Amount
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
2009	Underwriting gains	356	$13,953.1	29	$1,810.7
	Underwriting losses	291	8,451.0	43	3,761.7
	No gain or loss	101	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 2006 to 2009 are as follows:

From the digital collections of the New York State Library.

Table 19
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
2006-2009
(in millions)

Year		Stock Companies	Mutual Companies
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
2009	Net investment income	$32,185.3	$5,794.2
	Realized capital gains	-3,111.3	-681.9
	Unrealized capital gains	11,071.0	6,843.4
	Net gain from investments	$40,145.1	$11,955.8

d. Underwriting and Investment Exhibit

During 2009, dividends to stockholders amounted to $17.5 billion, while dividends to policyholders aggregated to $1.6 billion (for both mutual and stock insurers). The contribution to surplus for 2009 for stock companies was $4.4 billion compared with $7.7 billion for 2008. The net increase in surplus for stock companies in 2009 was $26.7 billion compared with a decrease of -$20.1 billion for 2008. Likewise, the net change in surplus for mutual companies was $8.8 billion in 2009, up from -$12.2 billion a year earlier. Net income increased for both stock and mutual companies between 2008 and 2009.

From the digital collections of the New York State Library.

Table 20
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Property and Casualty Insurers Licensed in New York State
2008 and 2009
(in millions)

	Stock Companies		Mutual Companies	
	2009	**2008**	**2009**	**2008**
Net gain or loss from:				
Underwriting	$5,502.1	$3,278.4	-$1,951.0	-$3,554.9
Investments [a]	29,074.0	24,797.2	5,112.4	5,434.9
Other income	337.5	-113.0	74.7	410.6
Net gain or loss	$34,913.6	$27,962.6	$3,236.0	$2,290.7
Less:				
Dividends to policyholders	656.3	611.6	897.1	967.2
Federal income taxes incurred	6,942.0	7,266.8	46.2	-201.3
Net income	**$27,315.3**	**$20,084.2**	**$2,292.7**	**$1,524.8**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-$17,476.6	-$25,294.7	$0.0	$0.0
• Stock	-15.7	-15.6	0.0	0.0
US Branches – Net remittance to/from home office	-75.5	9.0	0.0	0.0
Total dividends and remittance	-$17,567.8	-$25,301.3	$0.0	$0.0
Unrealized capital gains/losses	11,071.0	-23,576.8	6,843.4	-14,732.4
Cumulative effect of changes in accounting principles	330.6	44.9	-163.2	-11.6
Miscellaneous items	1,123.2	958.9	-199.9	996.9
Contributions to surplus	4,444.4	7,677.3	-3.9	3.1
Total other sources	-$598.7	-$40,197.1	$6,476.4	-$13,744.0
Net increase or decrease in surplus	**$26,716.6**	**-$20,112.9**	**$8,771.1**	**-$12,217.2**

[a] Excludes unrealized capital gains.

e. Selected Annual Statement Data

From 2006 to 2009 aggregate (i.e., stock and mutual) net premiums written decreased by -2.0%; admitted assets increased by 16.3%; unearned premium and loss reserves increased by 5.8%; and other liabilities increased by 62.8%. Capital and surplus to policyholders increased by 11.1%.

From the digital collections of the New York State Library.

Table 21
SELECTED ANNUAL STATEMENT DATA
Property and Casualty Insurers Licensed In New York State
2006-2009
(dollar amounts in millions)

	2009	2008	2007	2006
		Stock Companies		
Number of insurers	748	739	731	727
Net premiums written	$237,999	$244,995	$247,563	$247,812
Admitted assets	885,679	851,704	880,157	747,095
Unearned premium & loss reserves	469,684	467,399	464,519	451,527
Other liabilities	92,007	95,625	100,489	44,267
Capital	3,949	3,889	3,879	3,723
Surplus to policyholders	323,988	288,680	318,287	287,598
		Mutual Companies		
Number of insurers	72	71	72	69
Net premiums written	$73,382	$68,654	$69,930	$69,948
Admitted assets	242,421	218,571	236,563	223,144
Unearned premium & loss reserves	97,908	89,399	87,507	84,715
Other liabilities	27,166	22,043	29,050	28,957
Surplus to policyholders	117,347	105,503	120,006	109,473

f. Direct Premiums Written, by Line

There was a decrease in property/casualty writings in New York State in 2009 as direct premiums written for all property/casualty lines decreased by -3.0%. Major lines, i.e., those with greater than $1 billion premium written in 2009, with at or above average year-to-year increases in 2009 included private passenger auto and homeowners' multi-peril.

From the digital collections of the New York State Library.

Table 22
DIRECT PREMIUMS WRITTEN BY PROPERTY/CASUALTY INSURERS
New York State — 2005-2009[1]
(dollar amounts in millions)

						Percentage Change	
Property and Casualty Lines	**2005**	**2006**	**2007**	**2008**	**2009**	**2005-2009**	**2008-2009**
All Premiums Written	$32,371	$33,674	$34,332	$33,894	$32,885	2%	-3%
Private Passenger Auto	10,262	9,994	9,794	9,789	9,948	-3%	1.6%
Bodily Injury and Property Damage Liability	6,968	6,705	6,452	6,409	6,588	-5%	2.8%
Comprehensive and Collision	3,294	3,289	3,343	3,380	3,360	2%	-0.6%
Commercial Auto	2,080	2,045	1,975	1,921	1,796	-14%	-6.5%
General (Other) Liability	3,997	4,387	4,306	4,488	4,155	4%	-7.4%
Commercial Multi-Peril	2,958	3,074	3,072	3,058	3,026	2%	-1.1%
Workers' Compensation	3,758	4,133	4,228	3,501	3,423	-9%	-2.2%
Homeowners' Multi-Peril	3,427	3,615	3,908	4,079	4,219	23%	3.4%
Medical Malpractice	1,128	1,267	1,394	1,346	1,336	18%	-0.7%
Inland Marine	707	841	912	951	954	35%	0.3%
Ocean Marine	551	598	522	513	450	-18%	-12.4%
Fidelity and Surety	433	459	534	540	484	12%	-10.4%
Accident and Health	372	329	302	252	260	-30%	3.3%
Fire	455	490	503	521	550	21%	5.4%
Product Liability	179	175	190	126	131	-27%	3.4%
Financial Guaranty[2]	1,090	1,164	1,439	1,843	1,030	-6%	-44.1%
Mortgage Guaranty	215	207	246	229	209	-3%	-8.7%
Allied Lines	278	334	307	330	331	19%	0.4%
Aircraft	96	114	205	-49	115	20%	-335.7%
Boiler and Machinery	78	80	70	70	74	-6%	5.0%
Credit	48	62	131	117	100	106%	-14.6%
Burglary and Theft	14	27	16	19	18	32%	-5.0%
All Other[3]	244	280	277	251	277	14%	10.7%

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.

From the digital collections of the New York State Library.

g. Audit and Analysis

The 2009 Annual Statements of the companies authorized to transact business in the State of New York were filed for audit and analysis in 2010, 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 2010, the State Insurance Fund acquired stocks and bonds totaling $42.1 billion and sold stocks and bonds totaling $35.1 billion. Upon review, the Property Bureau recommended the approval of the acquisitions of $42.1 billion and the sales of $35.1 billion. In 2009, the Bureau recommended approval of acquisitions totaling $55.7 billion and sales totaling $44.4 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 984 companies in 2010. There were 12 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 2010, 143 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 2010, 394 holding company transaction files, and 252 holding company registration statements and amendments, were received by the Property Bureau. In addition, 26 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, 2009, there were 10 domestic and 5 foreign financial guaranty insurers licensed in New York.

From the digital collections of the New York State Library.

Table 23
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Financial Guaranty Insurers Licensed in New York State, 2006-2009
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
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
2009	1,864.2	7,616.0	0.24

Table 24
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State, 2006-2009
(dollar amounts in millions)

Year		Number of Companies	Amount
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	$11,188.7
2009	Underwriting gains	6	$2,124.2
	Underwriting losses	8	$4,166.8

From the digital collections of the New York State Library.

Table 25
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State, 2006-2009
(in millions)

	2009	2008	2007	2006
Net investment income	$1,278.5	$1,680.9	$1,598.7	$1,669.5
Realized capital gains	-2,972.8	-4,722.5	-705.2	24.0
Unrealized capital gains	-178.9	-1,149.6	-43.8	151.8
Net gain from investments	-$1,873.3	-$4,191.2	$849.7	$1,845.3

Table 26
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Financial Guaranty Insurers Licensed in New York State
2006-2009
(in millions)

	2009	2008	2007	2006
Net gain or loss from:				
Underwriting	-$2,042.5	-$11,186.6	-$1,418.7	$1,304.6
Investments [a]	-1,694.4	-3041.6	893.5	1,693.5
Other Income	108.4	-181.3	-47.7	16.7
Net gain or loss	-3,628.6	-14,409.6	-$572.9	$3,014.8
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	-638.2	-1666.7	376.3	785.6
Net income	**-$2,990.3**	**-$12,742.8**	**-$949.2**	**$2,229.2**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-1,299.7	-437.6	-777.1	-1,221.5
• Stock	0.0	-13.1	-1.5	0.0
Total dividends and remittance	-$1,299.7	-$450.7	-$778.6	-$1,221.5
Unrealized capital gains	-178.9	-1149.6	-43.8	151.8
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	5,630.1	-302.0	190.4	-410.3
Contributions to surplus	2,018.0	6,936.9	333.7	-13.5
Total other sources	$6,169.5	$5,034.7	-$298.3	-$1,493.4
Net increase or decrease in surplus	**$3,179.2**	**-$7,708.2**	**-$1,247.5**	**$735.7**

[a] Excludes unrealized capital gains.

From the digital collections of the New York State Library.

Table 27
SELECTED ANNUAL STATEMENT DATA
Financial Guaranty Insurers Licensed In New York State
2006-2009
(dollar amounts in millions)

	2009	2008	2007	2006
Number of Companies	15	18	15	15
Exposure	$2,788,029.8	$2,980,072.8	$3,293,226.9	$2,958,463.0
Net premiums written	1,864.2	3,168.2	2,982.1	3,027.5
Admitted assets	38,735.1	44,379.0	38,650.5	35,663.8
Unearned premium & loss reserves	18,196.7	24,459.1	15,355.1	11,874.6
Other liabilities	12,922.4	15,358.3	10,972.6	10,218.9
Capital	1,061.5	1,068.1	249.2	246.7
Surplus to policyholders	7,616.0	4,561.6	12,322.8	13,570.3

4. Mortgage Guaranty Insurance

At year-end 2009, there were 2 domestic and 29 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
2006-2009
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
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
2009	3,824.3	6,326.5	0.60

From the digital collections of the New York State Library.

Table 29
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Mortgage Guaranty Insurers Licensed in New York State
2006-2009
(in millions)

	2009	2008	2007	2006
Net gain or loss from:				
Underwriting	-$3,520.0	-$5,162.4	-$1,319.6	$1,189.3
Investments [a]	1,079.0	1,016.1	1,295.8	1,053.3
Other Income	13.0	5.6	13.9	13.4
Net gain or loss	-$2,428.0	-$4,140.7	-$9.8	$2,256.1
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	-396.1	-117.5	98.4	485.9
Net income	**-$2,031.9**	**-$4,023.2**	**-$108.3**	**$1,770.1**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-69.3	-213.4	-1,563.8	-1,518.0
• Stock	0.0	0.0	0.0	0.0
Total dividends	-$69.3	-$213.4	-$1,563.8	-$1,518.0
Unrealized capital gains	-136.2	-1,044.7	-666.2	223.4
Cumulative effect of changes in accounting principles	0.0	107.1	0.0	0.0
Miscellaneous items	2,844.6	4,357.7	1,780.7	-510.5
Contributions to surplus	608.7	2,079.9	142.0	-94.9
Total other sources	3,247.9	5,286.7	-307.3	-1,900.0
Net increase or decrease in surplus	**$1,216.0**	**$1,263.5**	**-$415.5**	**-$129.9**

[a] Excludes unrealized capital gains.

TABLE 30
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
2006-2009
(dollar amounts in millions)

	2009	2008	2007	2006
Number of companies	31	28	27	27
Net premiums written	$3,824.3	$4,661.7	$4,605.0	$3,890.7
Admitted Assets	25,885.1	26,359.5	24,170.6	23,509.8
Unearned premium & loss reserves	16,294.0	15,570.9	10,605.5	7,871.4
Other liabilities	3,264.6	5,715.0	9,970.6	11,628.2
Capital	80.9	71.8	70.5	70.5
Surplus	6,326.5	5,073.6	3,594.6	4,010.2

From the digital collections of the New York State Library.

5. Title Insurance

6 domestic and 19 foreign companies were licensed to write title insurance in New York State at the close of 2010.

Table 31
SELECTED ANNUAL STATEMENT DATA
Title Insurance Companies
2006-2009
(dollar amounts in millions)

	2009	2008	2007	2006
Number of Companies	25	29	30	30
Net premiums written	$7,665.4	$6,661.4	$8,742.3	$11,007.0
Admitted assets	7,069.7	5,690.0	6,489.8	6,848.0
Liabilities	4,501.3	4,020.8	4,515.5	4,499.8
Capital	273.9	109.4	111.0	118.8
Surplus	2,568.4	1,669.2	1,974.3	2,348.3

6. Advance Premium Co-operative and Assessment Corporations

At year-end 2009, there were 18 advance premium corporations under the supervision of the Property Bureau. The total number of advance premium corporations decreased from 2008 to 2009. The net premium volume of the advance premium corporations decreased by 16% from the prior year.

A total of 24 assessment corporations were under the Property Bureau's supervision at year-end 2009. The total number of assessment corporations remained unchanged from 2008 to 2009. The net premium volume of these 24 companies increased by 2.34% from the prior year.

During 2009, the Property Bureau initiated 12 examinations of the advance premium and assessment corporations.

From the digital collections of the New York State Library.

Table 32
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Corporations
2005-2009
(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
2009	Number of companies	42	18	24
	Total assets	$2,433.7	$2,096.2	$337.5
	Net premiums written	783.9	665.9	118.0
	Surplus funds	1,120.8	937.3	183.5

From the digital collections of the New York State Library.

7. Special Risk Insurers (Free Trade Zone)

Calendar Year 2009 was the 31st full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 222 licensed companies as of December 31, 2009, which includes new and renewals. Net premiums written during the year amounted to approximately $1.54 billion, bringing the net premiums written since inception to approximately $15.18 billion. Direct and Net premiums written since 2005 are as follows:

Table 33
DIRECT AND NET PREMIUMS WRITTEN
Special Risk (Free Trade Zone)
2005-2009
(dollar amounts in millions)

Year	Direct Premiums Written	Net Premiums Written
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
2009	1,797.5	1,543.2

8. 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 2010 a total of 106 such examinations were conducted.

From the digital collections of the New York State Library.

Table 34
EXAMINATIONS CONDUCTED
by the Financial Regulation Division of the Property Bureau
2010

	Regularly Scheduled					Other Financial Exams		
	Total	Started in 2010		Started Prior[3] to 2010		Special	On Organi-zation[1]	Increase in capital[2] and other
Property and casualty insurers, including financial guaranty insurers	62	39		22				1
Other insurers, captives and service contractors	42	17		25				
Title and mortgage guaranty insurers	2	1		1				
Total	**106**	**57**		**48**				**1**

[1] Examination conducted when insurer is first incorporated in New York State.
[2] Examination when insurer increases its capital.
[3] This total includes 3 reports with completed field work that were not filed as of 3/18/11.

b. Risk-Focused Examinations

Effective January 1, 2010, the application of the Risk-Focused Examination approach, as contained in the current Financial Condition Examiners Handbook was mandated as an accreditation standard for conducting examinations. During 2010, this approach was used for almost every examination, with the exception of companies in run-off or very small companies.

9. 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, 2010, 74 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.

10. 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).

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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, 2009 the CAPCOs invested approximately $314.3 million in 179 qualified businesses: Program One CAPCOs invested 86.52% of their total $100 million certified capital; Program Two CAPCOs invested 83.45% of their $30 million total; Program Three CAPCOs invested 82.84% of their $150 million certified capital; Program Four CAPCOs invested 70.34% of their $60 million and Program Five CAPCOs invested 60.50% of their $60 million.

The qualified businesses invested in span a broad spectrum of the state's economy with significant investments in manufacturing, marketing/sales, computer technology and media/entertainment. 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.

Ninety-three qualified businesses had less than $1 million, 57 businesses had between $1 million and $5 million and 29 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 31.14%, 34.32% and 34.54%, respectively, of the total invested. CAPCOs have invested approximately 31.6% of the invested funds in "early-stage" businesses, 14.1% in emerging technology and 3.2% in "start-up" businesses.

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In the five programs combined, 82.7% of the numbers of businesses and 74.2% of the dollars invested in qualified businesses were headquartered in New York County (Manhattan), Long Island, Mid-Hudson and the Capitol District. The remaining 17.3% of the businesses and 25.8% of the dollars invested were in other regions of New York State. Forty percent of all funds invested by year-end 2009 in qualified businesses were in New York County and 25.7% were made in Empire Zones and 22.3% 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, 2009 information was provided increased by 524 positions. The change of the number of employees in any one business ranged from a decrease of 103 to an increase of 210.

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.

11. 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 2010 in conjunction with the review of the financial responsibility requirements, and pursuant to Circular Letter 19 (2009), the Bureau has completed the statutory and regulatory compliance reviews of Service Contract Reimbursement Insurance ("SCRI") policies issued by insurers in New York. As of December 31, 2010, there were 155 registered service contract providers, of which 95 providers were utilizing SCRI policies. The remaining 60 service contract providers were required to file audited financial statements with the Property Bureau-Financial Division, with 26 utilizing the NYFRA and a Financial Security Deposit and 34 utilizing stockholders' equity in excess of $100 million.

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

a. Number of Filings

During 2010, the Market Regulation Division of the Property Bureau received 7,403 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:

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Table 35
NUMBER OF FILINGS RECEIVED BY TYPE*
Market Regulation Division of the Property Bureau
2010

Line of Business	Rates	Rules	Policy Forms	Totals
Property	177	281	207	665
Crop	1	3	7	11
Flood	1	1	3	5
Personal Farmowners	1	2	5	8
Homeowners	154	154	244	552
CMP Liability and Non-Liability	212	314	275	801
CMP Non-Liability Portion Only	32	44	40	116
CMP Liability Portion Only	32	41	30	103
Mortgage Guaranty	26	17	11	54
Ocean Marine	0	0	0	0
Inland Marine	170	138	309	617
Financial Guaranty	0	0	2	2
Med Mal-Claims Made and Occurrence	43	57	36	136
Med Mal-Occurrence Only	14	7	7	28
Med Mal-Claims Made Only	11	5	4	20
Earthquake	0	0	0	0
Workers Compensation	89	111	103	303
Other Liability-Occ/Claims Made	197	241	358	796
Other Liability-Occ Only	120	167	278	565
Other Liability-Claims Made Only	63	74	129	266
Product Liability	1	1	1	3
Personal Auto	427	511	124	1062
Private Passenger Auto	2	6	0	8
Commercial Auto	172	172	183	527
Mobile Homes under Transport	0	1	0	1
Aircraft	6	6	21	33
Fidelity	19	16	50	85
Fidelity and Surety	1	7	3	11
Surety	34	34	4	72
Burglary and Theft	80	71	79	230
Boiler and Machinery or Equipment Breakdown	11	17	23	51
Credit-Credit Default	1	1	5	7
Credit-Personal Property	9	4	12	25
Homeowner/Auto Combinations	0	0	0	0
Dwelling Property/Personal Liability	12	7	6	25
Dwelling Fire/Personal Liability	0	0	0	0
Other Lines of Business	19	22	31	72
Title	12	10	8	30
Interline Filings	8	28	77	113
Total	**2157**	**2571**	**2675**	**7403**

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* These figures include approximately 74 consent-to-rate filing applications (pursuant to Section 2309 of the Insurance Law); 28 group property & casualty filings; and 29 rating plans. 332 policy form filings and 282 rate or rating rule filings were disapproved. The Bureau continued speed-to-market (STM) initiatives accepting 252 STM filings. Included in the totals above are 298 filings submitted in paper format. The remaining 7,105 filings were submitted through the System for Electronic Rate and Form Filing (SERFF).

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 2010. 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.

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Table 36
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2010 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	0.0
Personal Injury Protection	+10.0
Liability Subtotal	+0.5
Comprehensive	+18.6
Collision	-7.4
Physical Damage Subtotal	-2.8
Total Commercial Cars	+0.2
Garages	
Single Limit Liability	-2.3
Personal Injury Protection	-6.0
Liability Subtotal	-2.6
Physical Damage – Garage Dealers	
Comprehensive	0.0
Collision	0.0
Physical Damage – Garage Keepers	
Comprehensive	0.0
Collision	0.0
Physical Damage – Garage Dealers and Keepers Subtotal-	0.0
Total Garages	-1.4
Private Passenger Types	
Single Limit Liability	-5.2
Personal Injury Protection	+10.0
Liability Subtotal	-4.0
Comprehensive	+7.8
Collision	+6.4
Physical Damage Subtotal	+6.7
Total Private Passenger Types	-1.3
Total All Coverages	-0.2
Total Liability	-0.4
Total Physical Damage	+0.8
effective April 1, 2011	

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	Percent Changes in Average State-Wide Rates
Automobile Insurance Plans Service Office	
Private Passenger Automobile	
Rates Revised	
Bodily Injury Liability	+5.0
Property Damage Liability	+15.0
Personal Injury Protection	+25.0
Uninsured Motorists	-9.6
Liability Subtotal	+16.0
Comprehensive	0.0
Collision	+3.7
Physical Damage Subtotal	+2.8
Total All Coverages	+15.0
effective April 15, 2011	

Liability Other Than Automobile

Insurance Services Office, Inc. **Commercial General Liability Loss Costs** (effective July 1, 2011)	-10.1%
Insurance Services Office, Inc. **Commercial General Liability Increased Limits Factors** (effective July 1, 2011)	+2.2%
Insurance Services Office, Inc. **Dwelling Program – Personal Liability Loss Costs** (effective October 1, 2010)	-2.8%
Insurance Services Office, Inc. **Dwelling Program – Personal Liability Increased Limits Factors** (effective October 1, 2010)	+6.7%
American Association of Insurance Services **Commercial General Liability Loss Costs** (effective April 1, 2011)	-10.2%

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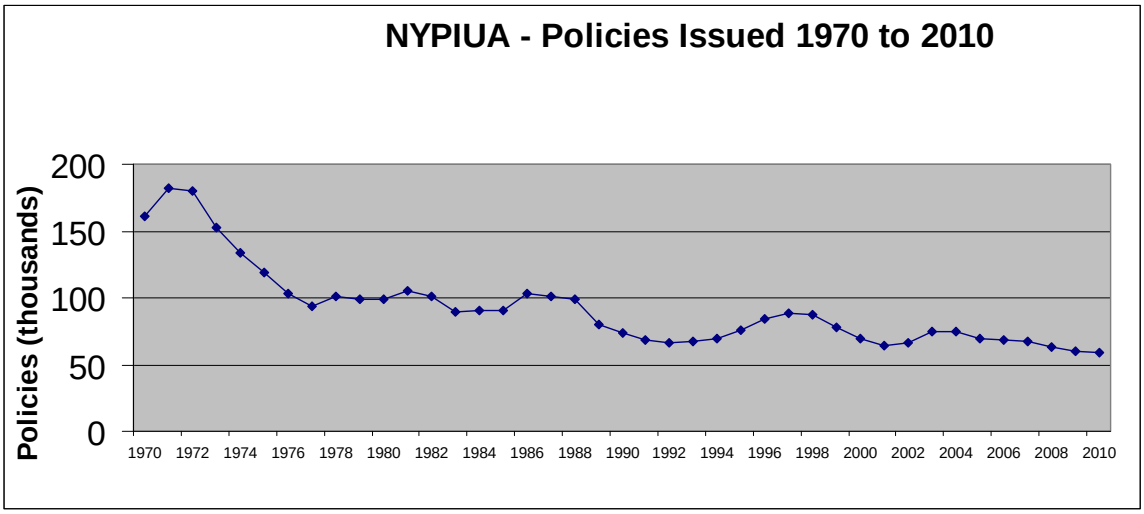
13. New York Property Insurance Underwriting Association (NYPIUA)

a. Policies Issued

The following graph illustrates the number of policies issued by the New York Property Insurance Underwriting Association from 1970 through 2010:

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 2010, the number of policies written dropped to 58,950, which is a decrease of 1,026 policies from the number of policies written in 2009.

b. Financial Information

For the fiscal year ending December 31, 2010, the Association's Financial Report indicated premiums earned of $29,650,735 and a net underwriting loss of $205,341. Other income of $5,114,465, comprised of net investment income of $5,328,605; premium balances charged off $11,805; bond amortization loss of $294,007; gain on sale of securities of $34,243; grant program of $90,391 and policy installment fees of $147,820, resulted in net income before taxes of $4,909,124. The change in assets not admitted of $53,541, additional minimum pension liability of $906,010 and taxes incurred of $178,564 resulted in a net change in the Members' Equity Account of $3,878,091. The cumulative operating profit as of December 31, 2010 was $183,908,527. After all assessments (net of cumulative distributions of $91,008,265), the net Members' Equity Account totaled $92,900,262.

In accordance with Section 5405(c) of the New York Insurance Law, the Association estimated a surplus from operations of $1,045,530 for the Calendar Year 2011. There will be no need to credit the

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Association with any funds from the New York Property/Casualty Insurance Security Fund for the year beginning January 1, 2011, since its assets exceed its liabilities.

c. Rate Revisions

During 2010, the Department approved rate revisions for both the Farm Property and Dwelling Property classes of business. These revisions resulted in an average statewide change of -5.4% for Farm Property and -4.0% for Dwelling Property. These revisions correspond with loss costs revisions promulgated by the Insurance Service Office for the voluntary market.

14. 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.

The Department established primary medical malpractice insurance rates in New York for the July 1, 2010 through June 30, 2011 policy year. The overall rate level effect for insurers in the voluntary market was +5.0% above the rates for the previous year. This overall rate effect included the effects from approved classification and/or territory changes for the insurers, which resulted in rate changes as high as +12.0% for some insureds. The overall rate level effect for the Medical Malpractice Insurance Pool, which provides coverage for insureds unable to obtain coverage in the voluntary market, was +9.9% with the largest rate effect to individual insureds of +16.3%. These rate increases followed two years in which the legislature mandated that the Superintendent shall not establish or approve any increase in physicians' and surgeons' liability rates pursuant to Chapter 497 of the Laws of 2008 and Chapter 216 of the Laws of 2009.

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 2010 to 2011 policy year, it was determined that no change was needed to these factors.

c. Physicians Excess Medical Malpractice Insurance for '10 –'11

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.

d. 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

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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 2010, the Pool insured 4,040 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)
2008-2010

Type of Insured	Policies as of December 31, 2010	Policies as of December 31, 2009	Policies as of December 31, 2008
Primary Insureds			
Physicians	254	291	347
Dentists	124	165	171
Podiatrists	16	29	35
Nurse-Anesthetists	4	4	4
Nurse-Midwives	20	22	17
Professional Corps.	20	31	23
Excess Layer Insureds			
First Layer Excess	3602	3443	599
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 in 2009 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 8 facilities, consisting of 4 adult homes, 2 surgi-centers, 1 nursing home and 1 ambulance service, down from 13 the year before.

15. 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 approximately 41 insurance carriers desiring to offer managed-care programs as of year-end 2010.

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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 2010 there were approximately 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) I the superintendent promulgated Second Amendment to Regulation No. 119 11 NYCRR 151-3 Workplace and Loss Prevention Incentive Program (Regulation). As promulgated April 5, 2010, it established the premium credit for WSLPIP and included 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

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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.

16. Insurance Availability Issues

While liability insurance coverages continued to be generally available during 2010, 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 is 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.

17. Automobile Insurance

a. New York Automobile Insurance Plan

The number of vehicles insured in the Plan has remained at historically low levels. Approximately 1% of New York private passenger registered vehicles continues to be insured in the Plan as compared to a range of 12% to 17% around two decades ago. The stability in the Plan's population can be attributed, at least in part, to various Department initiatives, including incentives to voluntary market insurers that provide coverage to drivers who otherwise would have been placed in the Plan.

b. Legislation

Chapter 277 of the Laws of 2010 amended Section 2335 of the insurance law by adding a provision that prohibits an insurer from increasing an insured's policy premium solely because the insured or any other person who customarily operates an automobile covered by the policy has had an

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accident that does not result in aggregate damage to property in excess of $2,000. However, the insurer may still impose a surcharge if the accident results in bodily injury or if an insured has more than one accident in the insurer's filed and approved merit rating experience period. This statute effectively increased the property damage threshold (which was linked to the compulsory DMV accident reporting threshold) for surcharges from $1,000 to $2,000. It applies to policies issued, modified, or renewed effective on or after November 27, 2010.

c. No-Fault Motor Vehicle Insurance Law Activity – 2010

i. Regulation Reform

Following extensive consultation with insurers, medical providers and trial attorneys, the Department issued a working draft of an amendment to Regulation 68 in 2009 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 received an array of comments from all interested parties. During 2010, the Department reviewed the comments and conducted 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.

ii. Revised No-Fault Intoxication Exclusion

The enactment of Chapter 303 of the Laws of 2010, which takes effect on January 26, 2011, amended Insurance Law § 5103(b)(2) to prohibit a No-Fault insurer from excluding from coverage necessary emergency health services and to permit a No-Fault insurer to maintain a cause of action against a covered person for the amount of first-party benefits paid or payable on behalf of the person where the covered person is found to have violated Vehicle and Traffic Law §1192 which deals with operating a motor vehicle under influence of alcohol or drugs. Accordingly, the Department amended the mandatory personal injury protection endorsement and the mandatory additional personal injury protection endorsement through an emergency amendment to NYCRR 65-1 (Regulation 68-A) and amended the list of permissible exclusions for self-insurers through an emergency amendment to 11 NYCRR 65-2 (Regulation 68-B). Additional guidance for the implementation of the provisions of the new law was provided by the Department through the issuance of Circular Letter No. 4 (2011), entitled "No-Fault Intoxication Coverage; Chapter 303 of the Laws of 2010."

18. 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's staff continues to carefully monitor the availability of coastal insurance, meet with interested parties to discuss the problems and arrive at workable solutions, and 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

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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 coverage to an insured who has purchased fire and extended coverage through NYPIUA. The coverage from NYPIUA and the wrap-around coverage 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 catastrophic 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 has been developed and implemented; the Special Advisory Panel on homeowners' insurance/catastrophe coverage convened its first meeting on October 13, 2010.

The Superintendent activated the Department's Coastal Market Assistance Program (C-MAP) in 1996. C-MAP, now codified as a statutory program, 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.

From its inception in April 1996 through December 31, 2010, 8,470 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.

19. 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 70 market conduct investigations, 3 Rate Service Organization examinations (RSO) and 1 Stamping Office examination in progress at the beginning of 2010 and 95 investigations and 0 RSO examinations were initiated during the year. The Department closed 107 market conduct investigations and 3 RSO examinations during the year. At year's end, 58 market conduct investigations, and 1 Stamping Office examination were in progress. A total of 23 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $533,960. In addition, fines totaling $36,250 were received from insurers and self-insurers for failure to pay No-Fault arbitration awards in a timely manner.

The following chart provides a breakdown of the market conduct activities for Calendar Year 2010:

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Table 38
MARKET CONDUCT INVESTIGATIONS/EXAMINATIONS
by Type of Investigation/Examination
2010

Type of Investigation	Outstanding at 1/1/20010	Initiated during 2010	Completed during 2010	Outstanding at 12/31/2010
Claims	13	3	2	14
Rating/Underwriting	5	2	3	4
Automobile/Homeowners Underwriting 3425	14	1	2	13
Title Ins. Underwriting	1	0	0	1
Commercial Auto Rating/Underwriting	1	0	0	1
Personal Auto & Homeowners Rating/Underwriting	3	0	1	2
Privacy	0	0	0	0
Frauds	0	3	3	0
Public Auto	6	0	1	5
Desk Audits:				
Section 3425 Compliance	5	5	10	0
Claims/Rating/Underwriting	8	13	6	15
Internet Web Site Reviews	0	32	32	0
Availability Survey 08	14	0	14	0
Market Analysis Review	0	36	33	3
Total Investigations	**70**	**95**	**107**	**58**

Examinations:	Outstanding at 1/1/2010	Initiated during 2010	Completed during 2010	Outstanding at 12/31/2010
Rate Service Organization	3	0	3	0
Miscellaneous Stamping Office	1	0	0	1
Total Examinations	**4**	**0**	**3**	**1**

From the digital collections of the New York State Library.

The following chart details the fines collected or processed and the stipulations entered into during Calendar Year 2010:

Table 39
MARKET CONDUCT FINES COLLECTED & PROCESSED
by Type of Investigation
2010

Type of Investigation	Number	Amount
Claims	2	$ 36,860
Automobile Rating	1	360,000
Public Auto Rating	1	5,000
Desk Audits:		
Rating/Underwriting	1	50,000
Withdrawal from auto market	1	25,000
Section 3425 – 2% Calendar Year 2007 & 2008	8	48,100
Availability Survey – 2008	9	9,000
Total	**23**	**$ 533,960**
Penalties: Failure to timely pay N.F. Arbitration Awards	145	$ 36,250
Total Fines Collected & Penalties Processed	**168**	**$ 570,210**

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, eight stipulated fines totaling $48,100 for Calendar years 2007 and 2008 were collected during Calendar Year 2010 (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 2010 collected penalties from nine insurers who did not submit the surveys in a timely manner (included in the total fines collected in Section 20(a) above).

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

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

The Department issued Circular Letter No. 21 (2005) reminding all insurers of their obligation to pay in a timely manner, and that with every request for enforcement, the Department would require

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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 2010, the Department processed 145 fines totaling $36,250 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. 32 insurer web sites were reviewed during the course of 2010. 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 2011.

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 2010, 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.

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During 2010, Market Analysis reviews of 33 Companies were completed. Two Companies needed further monitoring within the Insurance Department based on claims and underwriting issues. No further analysis was needed for 27 Companies. Four of the Companies are the subject of ongoing market conduct investigations. Some of the goals of the Market Analysis Program for 2011 are to standardize baseline factors to enable the Department to identify issues of concern and consider Companies for possible Market Conduct field investigations.

20. 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.

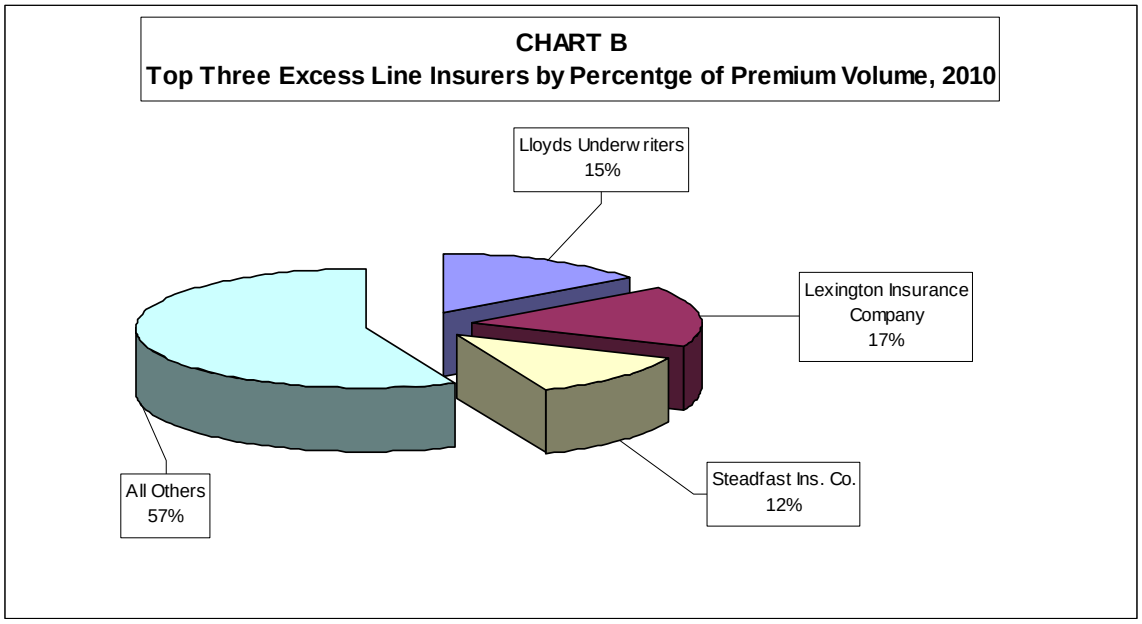
Since insurers providing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained from excess line brokers through tax statements required to be filed no later than March 15 of each year relating to business written during the previous Calendar Year. For Calendar Year 2010, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $3.09 billion, of which approximately $2.02 billion was attributable to risks located or resident wholly in New York State. These excess line premiums generated approximately $72,555,424 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 825 who are active and filed 151,423 affidavits for the year 2010.

In 2010, there were approximately 215 unauthorized insurers eligible to do business in New York pursuant to Regulation 41. This includes 100 foreign insurers; 39 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 2010, the Unit reviewed 133 EL-1 filings, 96 annual statements and 6 trust agreements filed by these unauthorized insurers. The Unit received 855 complaints and inquiries in 2010.

The following is a chart of the percentage of total 2010 excess line premium writings attributable to the three largest excess line insurers in New York State.

From the digital collections of the New York State Library.



a. Business Written in New York

Total excess line premiums written in New York State increased from $1.712 billion in 2009 to $2.015 billion in 2010, an increase of 17.7%. The largest premium increase occurred in "other lines", up $182.6 million or 291.79% from last year. Included in the "other lines" was a $173.5 million increase in premiums written for credit insurance. During this period there was an increased demand for credit insurance which protects businesses that extend credit against defaults. Other increases included fire and allied lines, up by $44.9 million or 12.61%; other liability up by $32.1 million; auto physical damage, up by $23.6 million; commercial multiple peril (excluding fire), up by $16.4 million; errors and omissions, up by $8.3 million; aircraft physical damage, up by $6.2 million; and Malpractice, up by $5.5 million.

The largest decrease over the previous year was in fidelity and surety, down by $11.2 million or a decrease of 28.4%. The other decrease was in inland marine, down by $2.6 million; auto liability, down by $1.2 million; and burglary and theft down by $1.1 million.

In calendar year 2010, homeowners' premiums in the excess line market increased from $43 million to $46.5 million, an increase of 8.13%. Licensed insurers continue to decrease their exposure in this area. It should be noted that the 2010 homeowners' excess line premiums represented approximately one percent of the total homeowners market.

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Table 40
EXCESS LINE PREMIUMS WRITTEN
Risks Located in New York State
2006-2010
(dollar amounts in thousands)

Line of business	2010	2009	2008	2007	2006
Fire and allied lines	$401,577	$356,622	$453,822	$ 438,321	$ 427,382
Commercial multiple peril (excluding fire)	94,805	78,361	87,501	107,185	109,280
Inland marine	35,965	38,555	49,249	67,124	60,679
Malpractice	22,147	16,621	23,025	27,751	26,934
Other liability	862,632	830,565	1,112,343	1,452,654	1,433,705
Errors and omissions	268,639	260,344	336,265	421,891	297,656
Auto liability	14,214	15,417	14,493	15,152	15,605
Auto physical damage	22,195	(1,384)	19,038	24,499	24,646
Aircraft physical damage	11,921	5,699	7,430	792	3,310
Fidelity and surety	28,223	39,421	48,996	26,816	43,880
Burglary and theft	7,971	9,090	7,918	6,422	7,946
Other lines*	245,139*	62,569*	57,616	43,882	171,101
Total	$2,015,428	$1,711,878	$2,217,696	$2,632,490	$2,622,123
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	5.75%**	4.95%	6.14%	7.12%	7.30%

* Included in “Other lines” were: premiums written of $47.0 million Homeowners Multiple Peril in 2010, an increase from $43.0 million in 2009; $2.7 million Disability Salary Protection (Primary), an increase from $0.4 million in 2009; $5.8 million Disability Salary Protection (Excess) in 2010, a decrease from $8.5 million in 2009; and $173.5 million Credit Insurance in 2010.

** Estimated

Source: Excess Line Association of New York

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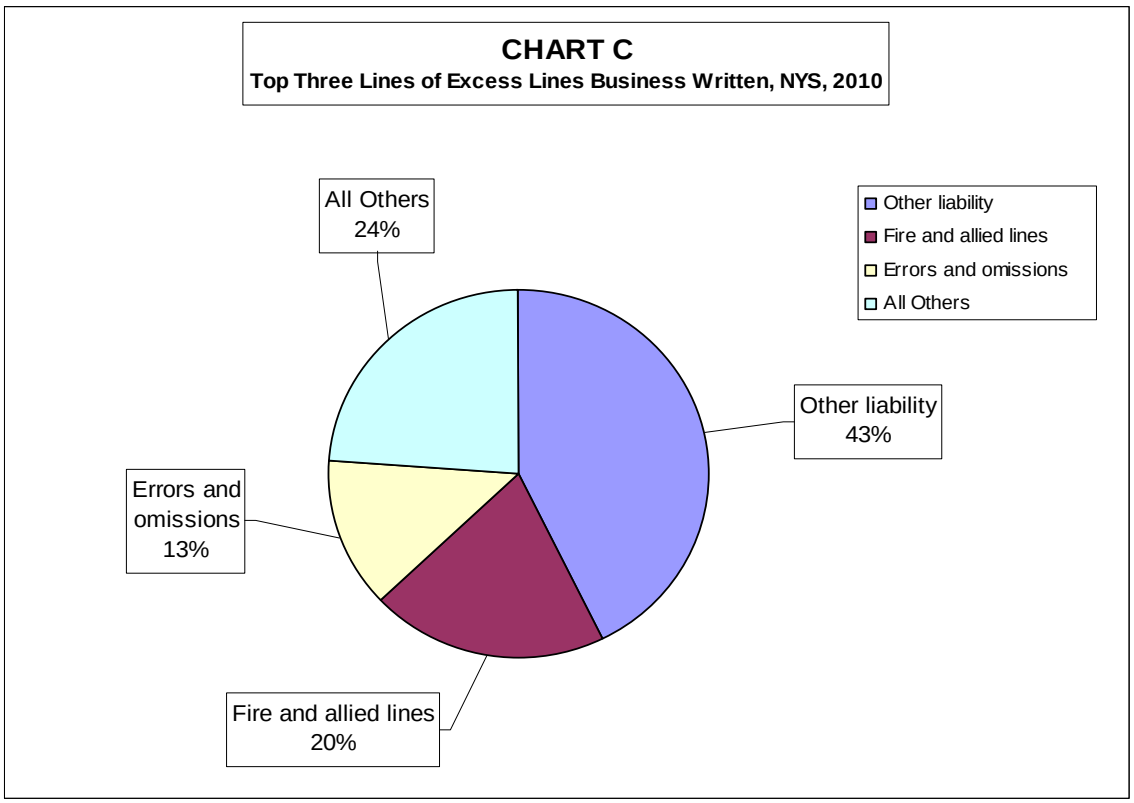
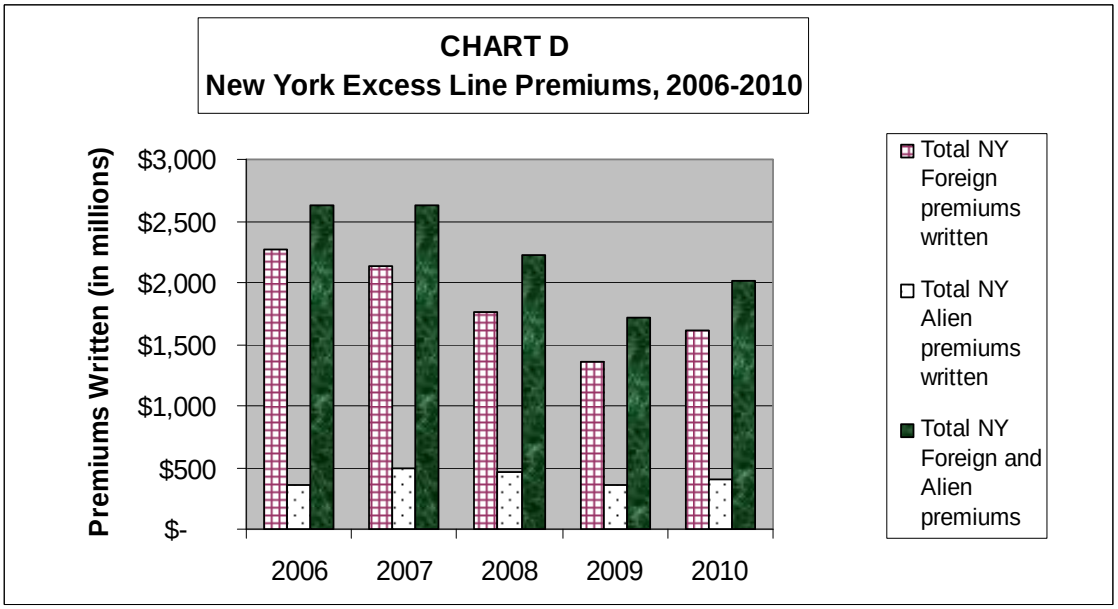
The pie chart below shows the three major lines of business written in the excess line market based on premium volume.

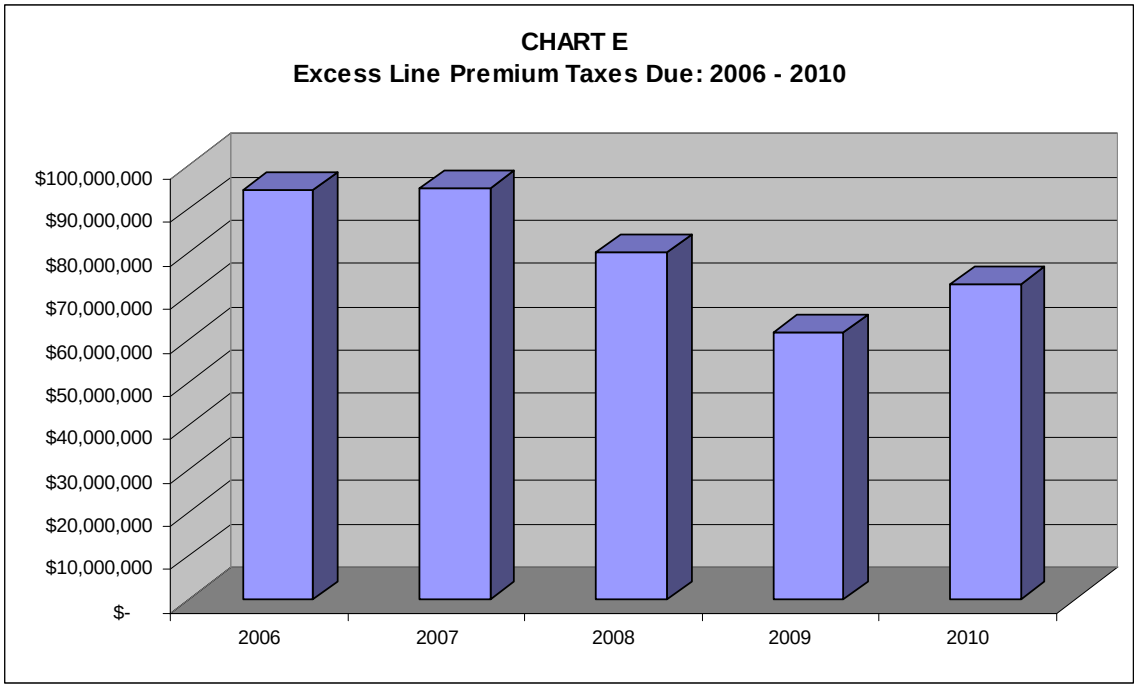


The following graph shows excess line business for the years 2006 to 2010 by alien and foreign insurers:



From the digital collections of the New York State Library.

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 2010, the ELANY reviewed and accepted 31 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, 402 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 (ELANY) to expand the export list. A public hearing was held on August 20, 2010 regarding the second expansion of the export list. As a result of the public hearing, the Department is working toward the promulgation of the 13th Amendment to Regulation 41 to place additional risks on the export list. ELANY has requested the Department

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amend 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.

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

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

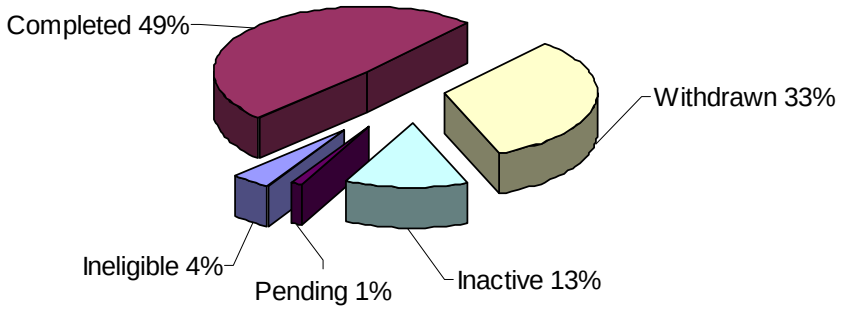
Since the inception of the LRRA, the Department has received notices of intent from 991 purchasing groups. Subsequently, 325 have withdrawn their notice of intent, 130 have notified the Department of their inactive status, and 41 have been given ineligible status by the Department due to failure to comply with all the requirements of the applicable laws and regulations. In 2010, the Department received notices of intent from 18 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, 2010, by status category:

CHART F
Purchasing Group Filings, 2010



f. Purchasing Group and Excess Line Investigations

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

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The Unit conducted approximately 312 investigations last year. Many of these investigations involved the non-payment of premium tax. One broker labeled transactions self-procurement but never made payments to the New York State Department of Taxation. The broker has signed an agreement indicating it will pay the Department $2.4 million in premium taxes and $800,000 in penalties. These transactions were not self procured.

Another broker made placements for New York members of a purchasing group however made premium tax payments to Vermont instead of New York. The Department will request the Vermont Insurance Department remit the appropriate back taxes. The broker also inappropriately placed group flood and earthquake coverage which violates Regulation 135 of the department.

Another investigation revealed a broker made placements for taxis in the excess line market without obtaining the appropriate declinations and flied false affidavits indicating that declinations were obtained when in fact they were not. The broker was fined $50,000.

A broker was fined $6,000 for placing business with an ineligible insurer, a section 2117 violation. The policy was in effect for one year.

Several brokers have advised the Department of unpaid excess line premium taxes due the Department. There is also compliance issues in some of these investigations which are in the early stages.

g. 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 21 2011 there were 1,343 premium tax statements filed online for tax year 2010. These filings represent approximately 52% of the 2,583 excess line brokers licensed in New York. For the prior year 46% of the brokers filed online. This electronic usage is expected to continue increasing in the future resulting in significant savings to the Department and excess line brokers.

h. 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 Dec 31, 2010, the total number of risk retention groups (RRGs) registered in NY is 99. There are no RRG domiciled in New York. Total nationwide Direct Premium Written (DPW) is $1.66 billion; total nationwide net premium written is $760.1 million; total DPW in New York is $350 million.

21. Consumers Guide to Automobile Insurance

On October 1, 2010, the Department published an upstate and downstate edition of the 2010 Consumers Guide to Automobile Insurance. The guide is required by Section 337 of the Insurance Law. 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

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insurers, telephone numbers, sample premiums and advice regarding how to file a claim or make a complaint against an insurer. The guide can be accessed via the Department's Web site.

22. Regulations

Regulations Adopted in 2010:

Thirty-first Amendment to Regulation 83 (11 NYCRR 68) Charges for Professional Health Services became effective September 22, 2010. The amendment adopts the new Workers Compensation Board Dental Fee Schedule.

Regulation 153 (11 NYCRR 163) Flexible Rating for Nonbusiness Automobile Insurance Policies became effective January 6, 2010. This rule re-establishes flexible rating for nonbusiness automobile insurance policies required by section 2350 of the Insurance Law.

Tenth Amendment to Regulation Nos. 17, 20 and 20-A (11 NYCRR 125) Credit for Reinsurers [From Unauthorized Insurers] became effective January 1, 2011. The amendment establishes rules governing when an authorized ceding insurer may take credit on its balance sheet for a reinsurance recoverable.

23. Circular Letters

Circular Letters Issued in 2010:

Circular Letter No. 4 (2010) regarding reduction in No-Fault loss of earnings benefits payable by amounts received from employer wage continuation plans was issued on February 5, 2010 to all motor vehicle insurers writing motor vehicle insurance in New York State, self-insurers, and the New York Automobile Insurance Plan. The circular letter reminded insurers and self-insurers to properly and consistently apply the provisions of 11 NYCRR § 65-3.16(b)(1)(i) in determining whether an employer's wage continuation plan meets the conditions specified in the regulation.

Circular Letter No. 6 (2010) regarding submission of quarterly reports required by New York Insurance Law § 315 was issued April 9, 2010 to all insurers, including risk retention groups and the Medical Malpractice Insurance Plan ("MMIP"), writing in New York professional medical malpractice liability insurance that covers physicians, physician's assistants, and specialist's assistants. The circular letter clarified for insurers their obligations pursuant to Insurance Law § 315(b)(1), and notified insurers of new forms for submitting reports pursuant to Insurance Law § 315(b)(1).

Supplement No. 3 to Circular Letter No. 22 (2005) regarding Filing of Actuarial Opinion Summary ("AOS") was issued on July 13, 2010. The supplement to the Circular Letter advised all domestic property/casualty insurers required to file a Statement of Actuarial Opinion with the National Association of Insurance Commissioners ("NAIC") property/casualty statement (i.e., "yellow blank") in accordance with Insurance Law § 307(a)(1) and (a)(2) that they also should file an AOS with the New York State Insurance Department ("Department"). The instructions regarding this filing are set forth in the NAIC's 2010 "Annual Statement Instructions for Property Casualty Companies."

Circular Letter No. 12 (2010) regarding the New York State Health Care Reform Act and No-Fault Insurance was issued August 24, 2010 to a 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 circular letter advised insurers and self-insurers that they may no longer offset an applicant's aggregate no-fault benefit limit for the payment of a surcharge when the surcharge is paid directly to the Department of Health's office of Pool Administration. The circular letter also directed insurers and self-insurers to the New York State Department of Health's

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Web site for further changes made by the Legislature to HCRA as part of the enacted 2009-2010 State Fiscal Year Budget, including changes to the surcharge percentages.

Circular Letter No. 15 (2010) regarding minimum property damage threshold for increasing motor vehicle policy premiums was issued on October 4, 2010 to all insurers authorized to write motor vehicle insurance in New York State; the New York Automobile Insurance Plan; rate service organizations; and insurance producers. The circular letter provide guidance and clarification to motor vehicle insurers, the New York Automobile Insurance Plan, rate service organizations, and insurance producers regarding Chapter 277 of the Laws of 2010, which amends Insurance Law § 2335 effective November 27, 2010.

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

Certain complaints and inquiries are processed independently of the Consumer Services Bureau. A total of 1,627 such complaints and inquiries were received by the Market Regulatory Division of the Property Bureau in 2010. This total consisted of 1,305 involving personal automobile insurance; 6 involving commercial automobile insurance; 82 involving homeowners insurance; 22 involving other liability insurance; 11 involving commercial multiple peril insurance; 139 involving medical malpractice insurance; 32 involving workers' compensation, and 30 involving other types of insurance (financial guaranty, property, title, surety, inland marine, etc.). In addition, the Market Regulatory Division received 676 Freedom of Information (FOIL) requests on policy form and rate information.

25. 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 $13.4 billion of New York premium volume in 2010; medical malpractice premiums account for approximately $1.6 billion of New York premium volume in 2010.

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 104 private passenger automobile filings composed of 70 flex filings and 34 prior approval filings became effective in 2010. The average change for insurers receiving rate changes (both flex and prior approval) in 2010 was approximately 4.2%. For these insurers, liability rates increased 6.7% on average while physical damage rates, primarily collision and comprehensive coverages, decreased on average 0.8%. The insurers receiving rate changes with renewal dates effective in 2010 represent 82.1% of the total market for private passenger automobile insurance. The overall impact on the rate level for the entire market (including those auto insurers with no approved rate changes in 2010) was an average increase of 3.4%.

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 and must be prior approved.

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The following table lists both the requested and implemented rate changes, and provides the liability and physical damage components of such changes.

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Table 41

PRIVATE PASSENGER AUTOMOBILE RATE FILINGS EFFECTIVE IN 2010[1]

Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Approved (%)	Physical Damage Change Approved (%)	Overall Change Approved (%)
1/1/10	Erie Group: EIC; EICoNY[3]	1.2	2.3	1.2	3.9	2.3
1/1/10	Permanent General Assurance Corporation[3]	0.0	0.5	0.2	-10.1	-0.9
1/9/10	Allstate Ins. Co.[4]	13.3	5.3	5.8	-7.7	1.2
1/9/10	Allstate Property & Casualty Ins. Co.[4]	4.3	25.0	12.9	9.1	11.7
1/10/10	Travelers: TICoC; TP&CcoA[4]	2.6	8.0	9.7	-0.2	6.2
1/12/10	Travelers: TCIC; TH&MIC[3]	1.1	0.5	1.4	-1.2	0.5
1/22/10	Adirondack Ins. Exchange[4]	1.0	0.0	0.0	0.0	0.0
2/1/10	Unitrin Auto & Home Ins. Co.[3]	0.4	3.5	4.4	1.9	3.5
2/1/10	Utica Mutual Ins. Co.[3]	0.0	-3.1	-2.0	-5.0	-3.1
2/1/10	Utica National Ins. Co of Texas[3]	0.1	-1.2	-0.5	-2.8	-1.2
2/7/10	Progressive: PNEIC; PNIC; PNWIC[3]	3.5	2.1	3.0	0.0	2.1
2/10/10	Liberty Mutual Fire Ins. Co.[4]	4.6	7.5	8.1	0.0	5.3
2/28/10	21st Century Ins. Co.[3]	0.0	5.0	5.1	4.7	5.0
3/1/10	Allmerica Financial Alliance Ins. Co.[3]	0.6	4.5	2.9	9.2	4.5
3/1/10	Preferred Mutual Ins. Co.[3]	0.5	1.8	5.7	-3.2	1.8
3/11/10	Permanent General Assurance Corporation[3]	*	4.5	6.9	0.0	4.5
3/12/10	Hartford Ins. Co. of Illinois[3]	0.8	5.0	7.8	0.0	5.0
3/12/10	Sentinel Ins. Co.[3]	0.7	5.0	7.9	0.0	5.0
3/15/10	Merchants Preferred Ins. Co.[3]	0.1	4.9	4.5	6.1	4.9
3/17/10	Nationwide Assurance Co.[3]	0.0	5.0	5.6	2.2	5.0
3/19/10	21st Century North America Ins. Co. (prior AHAC program)[3]	0.0	1.7	2.5	0.0	1.7
3/19/10	21st Century North America Ins. Co. (prior AilC program)[3]	0.0	2.4	4.1	0.7	2.4
3/22/10	GEICO Group: GEICO; GGIC[3]	16.8	1.5	2.3	0.0	1.5
3/23/10	Progressive: PAIC; PMIC[3]	0.0	0.0	5.9	-15.3	0.0
3/23/10	Progressive: PCIC; PSIC[3]	0.0	0.0	4.2	-11.7	0.0
4/1/10	Countryway Ins. Co.[3]	0.0	0.1	4.3	-4.2	0.1
4/1/10	Country-wide Ins. Co.[3]	0.8	3.7	4.0	0.0	3.7
4/1/10	Drivers Ins. Co.[3]	0.0	5.0	7.0	0.0	5.0
4/1/10	Erie Group: EIC; EICoNY[3]	*	2.6	3.3	1.7	2.6
4/1/10	Ocean Harbor Casualty Ins. Co.[3]	0.1	3.1	3.3	0.0	3.1
4/1/10	QBE Ins. Corporation[3]	0.1	4.5	4.8	0.0	4.5
4/3/10	IDS Property Casualty Ins. Co.[3]	0.2	4.8	7.3	0.0	4.8
4/10/10	Adirondack Ins. Exchange[3]	*	5.0	7.3	-0.6	5.0
4/15/10	Kemper Independence Ins. Co.[3]	0.5	4.7	3.3	7.7	4.7
4/19/10	ACA Ins. Co.[3]	0.0	5.0	4.6	6.0	5.0
4/19/10	Mercury Casualty Co.[4]	0.3	26.0	14.0	3.9	11.1
4/24/10	Main Street: NGMIC; MSAA[3]	0.6	4.8	7.6	0.0	4.8
5/1/10	A Central Ins. Co.[3]	0.4	4.6	6.3	0.7	4.6
5/1/10	Merastar Ins. Co.[4]	0.0	9.9	13.8	0.6	9.9

From the digital collections of the New York State Library.

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS EFFECTIVE IN 2010[1]

Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Approved (%)	Physical Damage Change Approved (%)	Overall Change Approved (%)
5/8/10	AIG Indemnity Ins. Co.[3]	0.3	5.0	4.2	7.0	5.0
5/10/10	State Farm Fire & Casualty Co.[4]	1.4	8.2	7.9	10.0	8.2
5/10/10	State Farm Mutual Ins. Co.[4]	9.4	1.6	1.9	1.5	1.6
5/15/10	AIPSO[4]	1.7	12.5	8.7	3.9	8.4
5/16/10	Unitrin Direct Ins. Co.[4]	0.1	21.8	19.7	11.2	17.1
5/20/10	New South Ins. Co.[3]	0.7	4.2	4.9	2.6	4.2
5/26/10	Farmington Casualty Co.[4]	0.2	9.1	9.4	6.2	9.1
5/28/10	Esurance Ins. Co.[3]	0.6	5.0	6.4	0.0	5.0
6/1/10	Central Mutual Ins. Co.[3]	0.0	4.1	5.0	2.8	4.1
6/3/10	Response Worldwide Direct Auto Ins.[4]	0.1	9.8	14.0	0.1	8.1
6/3/10	Warner Ins. Co.[4]	0.1	15.7	12.0	3.3	8.8
6/6/10	Response Worldwide Ins. Co.[4]	0.1	8.1	7.5	1.6	5.6
6/11/10	Safeco: SICoA; FNICoA; GICoA; SNIC[3]	0.1	3.7	7.0	0.0	3.7
6/12/10	Hartford Ins. Co. of Illinois[4]	*	14.0	7.8	0.0	5.6
6/12/10	Sentinel Ins. Co.[4]	*	18.0	13.5	0.0	9.5
6/14/10	Nationwide Mutual Fire Ins. Co.[4]	0.3	17.6	20.3	6.6	17.6
6/24/10	Liberty Ins. Corporation[4]	0.1	14.1	11.3	-0.2	8.1
6/26/10	AIG Centennial Ins. Co.[3]	0.1	5.0	5.3	0.0	5.0
6/29/10	Nationwide: NGIC; NICoA[4]	1.0	4.1	4.7	0.0	4.1
6/30/10	Bankers Standard Ins. Co.[3]	0.0	4.8	4.7	5.1	4.8
7/1/10	Eveready Ins. Co.[3]	0.1	5.0	10.2	-0.4	5.0
7/3/10	Allstate Ins. Co.[3]	*	3.7	5.5	0.0	3.7
7/6/10	American Automobile Ins. Co.[3]	0.0	5.0	9.0	0.0	5.0
7/15/10	Utica Group: UNAC; GAMIC; RFIC[3]	0.2	2.4	2.4	2.4	2.4
7/28/10	American Commerce Ins. Co.[3]	0.0	4.9	5.6	3.0	4.9
8/6/10	Encompass Indemnity Co.[4]	0.5	5.3	8.4	0.0	5.3
8/7/10	Harleysville Ins. Co. of NY[3]	0.0	4.0	4.1	4.3	4.0
8/7/10	Harleysville Worcester Ins. Co.[3]	0.0	4.0	4.2	4.3	4.0
8/7/10	Nationwide: TIC; CAIC[3]	0.0	0.2	3.3	-36.4	0.2
8/15/10	Economy Premier Assurance Co.[3]	0.2	3.9	9.3	-3.2	3.9
8/15/10	Economy Premier Assurance Co.(the PAK II program)[3]	*	4.9	7.5	0.6	4.9
8/15/10	Kingstone Ins. Co.[4]	0.0	-10.0	0.0	-10.0	-10.0
8/15/10	Metropolitan Group P & C Ins. Co.[3]	0.7	3.9	5.2	1.8	3.9
8/15/10	Metropolitan P & C Ins. Co.[3]	0.1	4.9	5.3	4.0	4.9
8/15/10	Peerless Ins. Co.[3]	0.1	4.9	5.2	4.5	4.9
8/15/10	Unitrin Direct Property & Casualty Company[3]	0.0	5.0	8.6	-1.4	5.0
8/22/10	Travelers: TCIC; TH&MIC[3]	*	4.2	6.6	-0.2	4.2
9/1/10	Amica Mutual Ins. Co.[4]	0.9	3.3	4.1	-0.8	2.2
9/1/10	AutoOne Ins. Co.[4]	0.5	8.0	8.3	5.1	8.0
9/1/10	Hanover: MBIC; CICoA[3]	0.2	4.0	6.1	-0.5	4.0
9/1/10	State-Wide Ins. Co.[4]	0.3	28.0	9.8	1.1	7.9
9/1/10	USAA Group: USAA; UCIC; UGIC; GP&CIC[4]	1.0	-6.1	7.8	-20.3	-6.1

From the digital collections of the New York State Library.

Table 41
PRIVATE PASSENGER AUTOMOBILE RATE FILINGS EFFECTIVE IN 2010[1]

Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Approved (%)	Physical Damage Change Approved (%)	Overall Change Approved (%)
9/10/10	Encompass Home and Auto Ins. Co.[4]	0.1	5.0	7.3	0.0	5.0
9/19/10	21st Century North America Ins. Co.(prior AHAC program)[3]	*	2.7	3.9	0.0	2.7
9/19/10	21st Century North America Ins. Co. (prior AilC program)[3]	*	2.5	4.7	-1.7	2.5
9/21/10	Progressive: PAIC; PMIC[3]	*	5.0	6.2	1.1	5.0
9/21/10	Progressive: PCIC; PSIC[3]	*	2.3	3.4	-0.8	2.3
9/24/10	Encompass Home and Auto Ins. Co.[3]	*	-0.4	-0.6	-0.2	-0.4
9/25/10	Progressive Preferred Ins. Co.[4]	1.7	11.2	6.0	0.1	4.5
9/30/10	Permanent General Assurance Corporation[4]	*	4.5	4.8	1.9	4.5
10/1/10	Atlantic State Ins. Co.[3]	0.0	4.9	13.6	-9.2	4.9
10/1/10	AutoOne Select Ins. Co.[4]	0.3	24.4	20.3	3.6	16.0
10/1/10	Response Ins. Co.[3]	0.0	4.9	8.0	-2.4	4.9
10/16/10	Allstate Property & Casualty Ins. Co.[4]	*	0.0	0.0	0.0	0.0
10/16/10	Privilege Underwriter Reciprocal Exchange[4]	0.0	-2.0	-2.0	-2.0	-2.0
10/17/10	21st Century Advantage Ins. Co.[3]	0.1	5.0	7.0	0.0	5.0
10/20/10	Nationwide: NMIC; NP&CIC[3]	1.6	4.2	6.2	0.4	4.2
10/30/10	New South Ins. Co.[4]	*	3.2	3.6	2.2	3.2
11/30/10	Integon Casualty Ins. Co.[3]	0.0	4.2	4.1	4.4	4.2
11/30/10	Integon National Ins. Co.[3]	0.0	-4.8	-4.7	-5.0	-4.8
12/10/10	Safeco Ins. Co. of Indiana[3]	0.0	4.9	6.5	0.9	4.9
12/19/10	Utica Mutual Ins. Co.[3]	*	4.9	4.9	4.9	4.9
12/19/10	Utica National Ins. Co of Texas[3]	*	4.7	4.7	4.7	4.7
12/21/10	Progressive Direct Ins. Co.[4]	1.3	4.9	7.0	0.5	4.9
12/27/10	American States Ins. Co.[3]	0.0	4.7	5.0	4.6	4.7

2010 Rate Change Summary	**Total**
Number of insurer rate filings:	104
Average liability change for insurers receiving rate changes:	6.7%
Percentage of total liability industry premium affected:	82.4%
Impact on the entire market of the overall average liability rate change:	5.6%
Average physical damage change for insurers receiving rate changes:	-0.8%
Percentage of total physical damage industry premium affected:	81.4%
Impact on the entire market of the overall average physical damage change:	-0.7%
Average combined liability and physical damage change for insurers receiving rate changes:	4.2%
Percentage of total industry premium affected:	82.1%
Impact on the entire market of the overall average liability and physical damage rate change:	3.4%

1 Under the flex-rating system currently in effect, rate changes are either prior approval or file and use.
2 These market shares are based on 2009 Annual Statement premiums.
3 Flex rating
4 Prior approval
*** Subsequent filing (either prior approval or flex rating) by this insurer with renewal date in 2010.**

From the digital collections of the New York State Library.

b. New York Automobile Insurance Plan (NYAIP) Experience in 2008 and 2009

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 10.7% for liability and increased 25.0% for collision from 2008 to 2009. This marks the sixth straight year that liability earned car years decreased from the previous year and the first year since 2003 that collision earned car years increased from the previous year. 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
2000 – 2009

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
2000	8,106,797		207,802		8,314,599		9,408	
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
2009	8,960,961	0.2	90,345	-10.7	9,051,306	0.1	7,260	25.0

ii. Risks by Surcharge Category

In 2009, there were 90,345 private passenger earned car years for liability and 7,260 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 2007, 2008 and 2009.

From the digital collections of the New York State Library.

Table 43
DISTRIBUTION OF PRIVATE PASSENGER AUTOMOBILE ASSIGNED RISKS
LIABILITY AND COLLISION COVERAGES*
by Discount or Surcharge Category, 2007 – 2009

Discount or Surcharge Category	Liability			Collision		
	2007 (%)	2008 (%)	2009 (%)	2007 (%)	2008 (%)	2009 (%)
Total, all categories	100.0	100.0	100.0	100.0	100.0	100.0
Total Unsurcharged	55.0	53.0	53.4	54.5	51.6	54.0
3 Years Claim Free (1 or less with Plan) (Manual Rates)	30.6	30.2	32.8	28.8	28.7	30.0
Experience Discount						
4 Years (One or more with Plan) – 18% Credit	8.4	6.0	5.3	7.9	5.7	6.0
5 Years (Two or more with Plan) – 25% Credit	5.1	5.0	3.2	5.7	4.9	3.6
6 Years or more (Three or more w/Plan) – 30% Credit	10.9	11.8	12.1	12.0	12.3	14.4
Total Surcharged	45.0	47.0	46.6	45.5	48.4	46.0
Inexperienced Operator Surcharge	23.7	23.8	21.6	17.8	20.3	15.5
Experience Surcharge						
15%	10.8	11.1	11.2	14.8	14.2	14.5
25%	0.3	0.4	0.4	0.3	0.4	0.5
35%	3.0	3.2	3.7	4.3	4.8	5.5
50%	2.1	2.6	2.9	1.9	2.2	2.4
75%	1.4	1.6	1.7	2.0	2.2	2.5
100%-200%	3.6	4.4	5.1	4.5	4.3	5.2

*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 2008 and 2009, are shown in Table 44. During 2009, 1.0% of all New York State private passenger automobiles were assigned risks as opposed to 1.1% in 2008. The proportion of assigned risks was 7% or higher in only 1 of the 70 rating territories for 2008 and below 5% for all the rating territories in 2009. The highest 2009 ratio was 4.9% in the Bronx Territory and the lowest was 0.024% in the Corning Territory. Between 2008 and 2009 the number of assigned risks decreased in all 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.

From the digital collections of the New York State Library.

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

Territory		2008			2009			# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
		Assigned	Voluntary	Total	Assigned	Voluntary	Total				
01	Bronx Territory	4,240	55,959	60,199	3,048	59,125	62,173	-1,192	-28.1	1,973	3.3
03	Bronx Suburban Territory	5,045	174,926	179,971	4,141	170,942	175,083	-904	-17.9	-4,888	-2.7
05	Staten Island	2,270	240,219	242,489	2,085	240,081	242,166	-185	-8.1	-323	-0.1
07	Buffalo	2,714	122,399	125,113	2,911	121,972	124,883	197	7.3	-230	-0.2
08	Buffalo Semi-Suburban	1,733	174,413	176,146	1,712	169,873	171,585	-21	-1.2	-4,561	-2.6
09	Schenectady County	349	110,134	110,483	355	110,373	110,728	6	1.8	245	0.2
11	Rochester	6,239	348,459	354,697	6,497	343,259	349,757	259	4.1	-4,941	-1.4
12	Syracuse	1,421	210,390	211,811	1,264	207,221	208,485	-157	-11.1	-3,325	-1.6
13	Albany	372	165,043	165,415	354	163,762	164,116	-18	-5.0	-1,299	-0.8
14	Niagara Falls	1,147	72,050	73,197	1,152	71,787	72,939	5	0.4	-258	-0.4
15	Utica	80	62,253	62,333	78	62,115	62,193	-2	-2.3	-140	-0.2
16	Saratoga Springs Suburban	19	50,318	50,337	23	49,687	49,709	3	17.2	-628	-1.2
17	Kings County	1,660	365,784	367,444	1,271	366,416	367,687	-389	-23.4	242	0.1
18	Manhattan	2,598	170,386	172,984	1,880	170,192	172,071	-718	-27.6	-913	-0.5
19	Queens	1,019	73,210	74,230	817	73,187	74,004	-202	-19.8	-225	-0.3
20	Hempstead	4,428	421,792	426,220	3,773	430,162	433,936	-654	-14.8	7,716	1.8
21	North Hempstead	1,622	153,561	155,183	1,348	150,458	151,806	-275	-16.9	-3,378	-2.2
22	Oyster Bay	2,562	315,835	318,397	2,155	329,527	331,682	-408	-15.9	13,284	4.2
24	Rome	120	22,456	22,575	127	22,075	22,202	7	6.1	-373	-1.7
25	Auburn	23	24,109	24,132	13	24,198	24,211	-10	-41.3	80	0.3
27	Elmira	15	47,974	47,989	15	47,233	47,248	1	4.5	-741	-1.5
28	Binghamton	655	112,284	112,939	634	110,873	111,507	-21	-3.2	-1,432	-1.3
29	Gloversville	54	28,398	28,451	64	27,742	27,806	11	19.9	-645	-2.3
30	Saratoga Springs	22	25,210	25,232	24	25,115	25,139	2	7.4	-93	-0.4
31	Chautauqua County	269	86,878	87,147	317	86,892	87,209	48	17.7	62	0.1
32	Newburgh	787	68,633	69,420	812	67,478	68,291	25	3.2	-1,130	-1.6
33	Poughkeepsie	855	100,229	101,083	792	97,436	98,227	-63	-7.4	-2,856	-2.8
34	Troy	229	61,812	62,041	228	59,957	60,185	-1	-0.5	-1,856	-3.0
35	Amsterdam	19	21,845	21,864	26	21,069	21,095	7	36.4	-769	-3.5
36	Glens Falls	245	43,058	43,303	199	42,335	42,534	-46	-18.9	-769	-1.8
37	Oswego	298	39,074	39,372	240	41,048	41,288	-58	-19.4	1,917	4.9
38	Syracuse Suburban	57	78,371	78,428	40	81,464	81,504	-17	-29.3	3,076	3.9
39	Rochester Suburban	68	42,456	42,524	75	42,473	42,548	7	10.3	23	0.1
40	Corning	13	28,118	28,131	7	27,828	27,835	-6	-48.3	-296	-1.1
41	Erie County (Balance)	255	103,631	103,886	254	109,488	109,742	-1	-0.5	5,856	5.6
42	Buffalo Suburban	1,318	159,345	160,662	1,180	159,747	160,927	-138	-10.5	264	0.2
43	Niagara Falls Suburban	184	33,596	33,780	185	33,051	33,235	1	0.3	-545	-1.6
44	Broome County (Balance)	15	26,926	26,941	13	28,336	28,349	-3	-17.1	1,408	5.2
46	Putnam County	592	77,948	78,541	526	77,349	77,874	-67	-11.3	-666	-0.8
47	Orleans County	52	26,008	26,060	61	26,096	26,156	9	16.8	97	0.4

From the digital collections of the New York State Library.

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

Territory		2008			2009			# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
		Assigned	Voluntary	Total	Assigned	Voluntary	Total				
48	Monroe County (Balance)	33	74,084	74,118	33	73,934	73,967	0	0.2	-151	-0.2
49	Niagara County (Balance)	81	35,087	35,168	72	35,663	35,735	-8	-10.5	567	1.6
51	Ontario County, etc.	886	203,462	204,348	827	202,823	203,649	-60	-6.7	-699	-0.3
52	Fort Plain, Herkimer	130	43,169	43,299	108	43,260	43,368	-22	-16.9	69	0.2
54	Cortland County, etc.	1,193	208,825	210,018	991	208,498	209,489	-202	-16.9	-529	-0.3
55	Queens Suburban	4,291	555,411	559,702	3,734	555,567	559,301	-557	-13.0	-401	-0.1
56	Saratoga County (Balance)	48	38,279	38,326	47	39,170	39,217	-1	-1.6	890	2.3
58	Dutchess County (Balance)	595	109,893	110,488	540	113,916	114,456	-55	-9.3	3,968	3.6
59	Columbia County, etc.	270	83,126	83,396	225	83,575	83,800	-45	-16.6	404	0.5
60	Genesee County	129	38,880	39,009	143	38,784	38,927	14	10.9	-82	-0.2
61	Delaware County, etc.	520	146,584	147,104	399	148,856	149,256	-120	-23.1	2,152	1.5
62	Highland, Kingston	867	86,524	87,391	767	86,166	86,934	-99	-11.5	-457	-0.5
64	Middletown	2,057	171,683	173,740	1,691	173,318	175,009	-366	-17.8	1,269	0.7
65	Ossining	2,294	183,819	186,113	2,078	186,406	188,484	-216	-9.4	2,371	1.3
67	Clinton County, etc.	4,450	351,030	355,480	4,250	351,302	355,552	-200	-4.5	72	0.0
68	Rockland County	1,052	187,510	188,562	937	187,509	188,446	-115	-11.0	-116	-0.1
71	Saratoga County South	20	45,722	45,742	14	45,792	45,806	-5	-27.8	64	0.1
72	Albany County (Balance)	9	20,879	20,888	9	22,792	22,801	-1	-6.7	1,913	9.2
73	Rensselaer County (Balance)	93	46,829	46,922	87	48,610	48,697	-6	-6.6	1,775	3.8
74	Jefferson County	312	74,275	74,587	314	75,252	75,566	2	0.6	979	1.3
75	Suffolk County West	9,040	544,060	553,101	7,914	541,368	549,281	-1,127	-12.5	-3,819	-0.7
76	Suffolk County East	18,363	479,438	497,802	16,461	480,051	496,512	-1,902	-10.4	-1,289	-0.3
81	Monticello-Liberty	16	13,775	13,791	17	13,521	13,539	2	12.2	-252	-1.8
82	Sullivan County Central	60	16,462	16,523	39	16,517	16,556	-22	-35.8	33	0.2
83	Sullivan County (Balance)	154	23,555	23,709	145	23,237	23,381	-9	-6.1	-327	-1.4
84	Allegany County, etc.	1,245	188,117	189,362	1,168	188,610	189,778	-77	-6.2	415	0.2
86	Oneida	106	40,097	40,202	78	40,534	40,612	-28	-26.3	410	1.0
94	Mount Vernon and Yonkers	2,179	108,971	111,150	2,039	108,050	110,089	-140	-6.4	-1,061	-1.0
95	White Plains	1,025	44,373	45,398	988	38,731	39,720	-37	-3.6	-5,679	-12.5
97	New York City Suburban	4,046	235,994	240,040	3,537	239,728	243,264	-509	-12.6	3,224	1.3
	Entire State	**101,224**	**8,945,404**	**9,046,628**	**90,345**	**8,960,961**	**9,051,306**	**-10,880**	**-10.7**	**4,678**	**0.1**

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

From the digital collections of the New York State Library.

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2003-2009

Territory		2003 (%)	2004 (%)	2004 Rank	2005 (%)	2005 Rank	2006 (%)	2006 Rank	2007 (%)	2007 Rank	2008 (%)	2008 Rank	2009 (%)	2009 Rank
01	Bronx Territory	47.0	1	35.8	1	26.9	1	18.3	1	11.8	1	7.0	1	4.9	1
76	Suffolk County East	10.0	6	8.7	6	7.2	4	5.5	2	4.5	2	3.7	2	3.3	2
95	White Plains	8.1	8	7.0	7	5.2	7	3.6	7	2.7	4	2.3	4	2.5	3
03	Bronx Suburban Territory	15.4	4	11.4	3	8.2	3	5.5	3	3.7	3	2.8	3	2.4	4
07	Buffalo	7.2	11	5.7	10	4.1	10	2.8	10	2.3	8	2.2	5	2.3	5
11	Rochester	3.8	20	3.2	20	2.7	18	2.3	11	1.9	11	1.8	7	1.9	6
94	Mount Vernon and Yonkers	12.6	5	9.5	5	6.8	6	4.4	5	2.6	5	2.0	6	1.9	7
14	Niagara Falls	3.6	22	3.4	19	2.8	17	2.1	15	1.8	12	1.6	10	1.6	8
97	New York City Suburban	6.7	13	5.6	11	4.3	8	3.1	8	2.2	9	1.7	8	1.5	9
75	Suffolk County West	7.6	10	6.0	9	4.3	9	2.9	9	2.1	10	1.6	9	1.4	10
67	Clinton County, etc.	3.5	24	3.2	22	2.6	21	1.9	19	1.5	15	1.3	13	1.2	11
32	Newburgh	3.5	23	3.1	23	2.3	23	1.7	22	1.3	19	1.1	16	1.2	12
19	Queens	18.6	2	12.7	2	8.2	2	5.0	4	2.3	7	1.4	12	1.1	13
65	Ossining	4.7	16	3.9	17	3.0	15	2.2	13	1.6	14	1.2	14	1.1	14
18	Manhattan	15.7	3	10.5	4	7.0	5	4.2	6	2.5	6	1.5	11	1.1	15
08	Buffalo Semi-Suburban	2.7	30	2.4	27	2.0	25	1.4	23	1.2	21	1.0	20	1.0	16
64	Middletown	4.7	17	4.0	16	3.2	14	2.3	12	1.7	13	1.2	15	1.0	17
21	North Hempstead	5.2	15	4.1	15	3.0	16	1.9	18	1.4	16	1.0	17	0.9	18
62	Highland, Kingston	3.9	19	3.2	21	2.4	22	1.8	20	1.3	20	1.0	19	0.9	19
20	Hempstead	6.5	14	4.8	14	3.2	13	1.9	17	1.3	17	1.0	18	0.9	20
05	Staten Island	7.0	12	5.3	12	3.7	12	2.1	14	1.3	18	0.9	21	0.9	21
33	Poughkeepsie	2.7	29	2.2	28	1.8	28	1.3	26	1.0	26	0.8	22	0.8	22
42	Buffalo Suburban	2.5	33	2.2	29	1.8	27	1.4	25	1.0	25	0.8	23	0.7	23
46	Putnam County	3.2	26	2.6	25	2.0	24	1.4	24	1.0	24	0.8	27	0.7	24
55	Queens Suburban	10.0	7	6.3	8	3.8	11	2.0	16	1.1	23	0.8	25	0.7	25
22	Oyster Bay	4.5	18	3.6	18	2.6	20	1.7	21	1.1	22	0.8	24	0.6	26
83	Sullivan County (Balance)	2.4	36	2.1	30	1.6	29	1.1	30	0.8	30	0.6	30	0.6	27
84	Allegany County, etc.	2.4	35	1.9	35	1.5	32	1.1	29	0.8	27	0.7	29	0.6	28
12	Syracuse	2.5	34	1.7	37	1.3	36	0.9	35	0.8	29	0.7	28	0.6	29
37	Oswego	3.5	25	2.4	26	1.6	30	1.0	32	0.8	28	0.8	26	0.6	30
24	Rome	1.9	40	1.4	43	1.0	44	0.8	40	0.5	39	0.5	37	0.6	31
28	Binghamton	2.6	31	2.0	32	1.5	31	1.1	31	0.8	31	0.6	31	0.6	32
43	Niagara Falls Suburban	1.9	41	1.5	40	1.2	38	0.8	38	0.6	36	0.5	35	0.6	33
68	Rockland County	3.8	21	3.0	24	2.0	26	1.2	27	0.7	34	0.6	34	0.5	34
54	Cortland County, etc.	2.1	39	1.7	39	1.3	35	1.0	34	0.7	32	0.6	32	0.5	35
58	Dutchess County (Balance)	2.6	32	1.9	34	1.4	34	1.0	33	0.7	33	0.5	36	0.5	36
36	Glens Falls	2.3	37	1.8	36	1.3	37	0.9	36	0.6	35	0.6	33	0.5	37
74	Jefferson County	1.4	50	1.3	45	1.0	43	0.7	41	0.5	42	0.4	40	0.4	38
51	Ontario County, etc.	1.8	44	1.5	41	1.0	42	0.7	44	0.5	43	0.4	39	0.4	39
34	Troy	2.7	28	2.1	31	1.5	33	0.9	37	0.6	38	0.4	41	0.4	40

From the digital collections of the New York State Library.

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2003-2009

Territory		2003 (%)	2003 (%)	2004 Rank	2004 (%)	2005 Rank	2005 (%)	2006 Rank	2006 (%)	2007 (%)	2007 Rank	2008 (%)	2008 Rank	2009 (%)	2009 Rank
60	Genesee County	1.3	51	1.0	50	0.7	52	0.5	49	0.4	47	0.3	44	0.4	41
31	Chautauqua County	1.1	52	1.0	51	0.8	49	0.5	47	0.4	48	0.3	47	0.4	42
17	Kings County	8.1	9	4.8	13	2.7	19	1.1	28	0.6	37	0.5	38	0.3	43
09	Schenectady County	1.8	43	1.4	42	1.0	41	0.7	42	0.5	44	0.3	46	0.3	44
59	Columbia County, etc.	1.6	46	1.3	44	0.8	45	0.6	46	0.4	45	0.3	45	0.3	45
61	Delaware County, etc.	2.3	38	1.7	38	1.2	39	0.8	39	0.5	40	0.4	43	0.3	46
52	Fort Plain, Herkimer	1.6	47	1.2	46	0.8	46	0.6	45	0.4	46	0.3	48	0.2	47
82	Sullivan County Central	3.1	27	1.9	33	1.2	40	0.7	43	0.5	41	0.4	42	0.2	48
47	Orleans County	1.5	48	1.0	52	0.6	54	0.4	52	0.3	55	0.2	53	0.2	49
41	Erie County (Balance)	1.0	55	0.8	54	0.7	51	0.4	51	0.3	51	0.2	50	0.2	50
29	Gloversville	1.0	57	0.9	53	0.6	53	0.4	54	0.3	54	0.2	55	0.2	51
13	Albany	1.9	42	1.2	47	0.8	47	0.5	50	0.3	49	0.2	52	0.2	52
49	Niagara County (Balance)	0.8	61	0.7	57	0.5	57	0.4	53	0.3	53	0.2	51	0.2	53
86	Oneida	1.0	54	0.8	55	0.5	56	0.4	57	0.3	52	0.3	49	0.2	54
73	Rensselaer County (Balance)	1.5	49	1.2	49	0.8	48	0.5	48	0.3	50	0.2	54	0.2	55
39	Rochester Suburban	0.6	62	0.4	62	0.3	60	0.2	60	0.2	60	0.2	56	0.2	56
81	Monticello-Liberty	1.7	45	1.2	48	0.7	50	0.4	55	0.2	57	0.1	59	0.1	57
15	Utica	1.1	53	0.8	56	0.5	55	0.4	56	0.2	56	0.1	57	0.1	58
35	Amsterdam	0.8	59	0.6	58	0.4	59	0.2	61	0.2	59	0.1	62	0.1	59
56	Saratoga County (Balance)	0.8	60	0.6	59	0.4	58	0.2	58	0.2	58	0.1	58	0.1	60
30	Saratoga Springs	0.5	65	0.4	63	0.3	62	0.2	62	0.1	63	0.1	61	0.1	61
25	Auburn	0.9	58	0.5	60	0.3	61	0.2	59	0.1	61	0.1	60	0.1	62
38	Syracuse Suburban	0.5	66	0.3	65	0.2	63	0.2	63	0.1	62	0.1	63	0.0	63
16	Saratoga Springs Suburban	0.5	67	0.3	66	0.2	65	0.1	65	0.1	67	0.0	69	0.0	64
48	Monroe County (Balance)	1.0	56	0.5	61	0.2	67	0.1	68	0.0	68	0.0	67	0.0	65
44	Broome County (Balance)	0.5	64	0.3	67	0.2	66	0.1	64	0.1	65	0.1	64	0.0	66
72	Albany County (Balance)	0.5	63	0.4	64	0.2	64	0.1	66	0.1	64	0.0	65	0.0	67
27	Elmira	0.1	69	0.1	69	0.1	69	0.0	69	0.0	69	0.0	70	0.0	68
71	Saratoga County South	0.4	68	0.3	68	0.2	68	0.1	67	0.1	66	0.0	68	0.0	69
40	Corning	0.1	70	0.1	70	0.1	70	0.0	70	0.0	70	0.0	66	0.0	70
	Entire State	**5.6**		**4.2**		**3.0**		**2.0**		**1.4**		**1.1**		**1.0**	

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

From the digital collections of the New York State Library.

c. Workers' Compensation Insurance

New York moved to a loss cost system on October 1, 2008. On May 14, 2010, the New York Compensation Insurance Rating Board (NYCIRB) filed, on behalf of its members and subscribers, a 7.7% increase in average workers' compensation loss costs.

A 4.5% legislative increase is included in the 7.7% 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. The maximum weekly benefit increased to 2/3 of the statewide average weekly wage on July 1, 2010.

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). 51 new or revised LCMs were approved in 2010, as listed on Table 48.

Table 46
WORKERS' COMPENSATION DIVIDEND CLASSIFICATION PLANS APPROVED
2010

Plan Types:

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

COMPANY NAME	PLAN TYPE	APPROVAL DATE
Continental Western Ins. Co.	D	1/12/10
Firemen's Ins. Co. of Washington, D.C.	D	1/12/10
AmGuard Ins. Co.	C	4/12/10
NorGuard Ins. Co.	C	4/12/10
EastGuard Ins. Co.	C	4/12/10
Massachusetts Bay Insurance Company	C	5/12/10
The Hanover Insurance Company	C	5/12/10
Citizens Ins. Co. of America	C	5/12/10
Regent Ins. Co.	B	7/29/10
General Casualty Co. of WI	B	7/29/10
Utica Mutual Ins. Co.	B	11/18/10
Graphic Arts Mutual Ins. Co.	B	11/18/10
Republic-Franklin Ins. Co.	B	11/18/10
Utica National Assurance Co.	B	11/18/10
Utica National Ins. Co. of Texas	B	11/18/10
Technology Ins. Co.	C	12/28/10
Wesco Ins. Co.	C	12/28/10
Rochdale Ins. Co.	C	12/28/10

From the digital collections of the New York State Library.

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%)

From the digital collections of the New York State Library.

Table 47-B
WORKERS' COMPENSATION LOSS COST* HISTORY
New York Compensation Insurance Rating Board
New York State, 2008-2010**

(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 Loss Costs[2]	(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%
10/10	+2.9%	+2.9%	+4.5%	1.000	1.004	+7.7%	0.0%	+7.7%	+7.7%	+2.3%

* 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.
[2] Catastrophe provision is included.

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*.

From the digital collections of the New York State Library.

Table 48
Workers Compensation Expense Constants and Loss Cost Multipliers
Approved in 2010

NAIC Code	Group Name	Company Name	Expense Constant	Loss Cost Multiplier	Renewal Effective Date
37800		LG Ins Co Ltd Us Br	$300	1.3510	07/06/10
37800		LG Ins Co Ltd Us Br	$200	1.3510	11/23/10
23108		Lumbermens Underwriting Alliance	$200	1.3280	02/01/10
12297		Petroleum Cas Co	$1	1.0230	10/01/10
19984	American Contractors Ins Grp	ACIG Ins Co	$0	1.2500	01/01/11
13803	American Natl Fin Grp	Farm Family Cas Ins Co	$200	1.2350	01/05/10
13803	American Natl Fin Grp	Farm Family Cas Ins Co	$200	1.2000	12/01/10
19879	Amtrust Grp	Security National Ins Co	$200	1.1000	12/01/10
34630	Berkshire Hathaway Grp	Oak River Ins Co	$200	1.4000	08/03/10
20222	Central Mut Ins Co Grp	All Amer Ins Co	$290	1.2310	11/01/10
20230	Central Mut Ins Co Grp	Central Mut Ins Co	$290	1.3290	11/01/10
12777	Chubb & Son Inc Grp	Chubb Ind Ins Co	$450	1.0320	01/01/11
11242	Eastern Holding Co Grp	Allied Eastern Indemnity Co	$175	1.3670	02/22/10
13019	Eastern Holding Co Grp	Eastern Advantage Assurance Co	$175	1.2370	02/22/10
13608	Fire Districts	FDM Preferred Ins Co Inc	$200	1.1600	12/01/10
13610	Fire Districts	Fire Districts Ins Co Inc	$200	1.5700	12/01/10
37400	Fire Districts	Fire Districts Of NY Mut Ins Co Inc	$200	1.3700	12/01/10
21458	Liberty Mut Grp	Employers Ins of Wausau	$210	1.3700	10/01/10
33588	Liberty Mut Grp	First Liberty Ins Corp	$210	1.3440	10/01/10
42404	Liberty Mut Grp	Liberty Ins Corp	$210	1.1390	10/01/10
23035	Liberty Mut Grp	Liberty Mut Fire Ins Co	$210	1.2800	10/01/10
23043	Liberty Mut Grp	Liberty Mut Ins Co	$210	1.4230	10/01/10
33600	Liberty Mut Grp	LM Ins Corp	$210	1.0750	10/01/10
26069	Liberty Mut Grp	Wausau Business Ins Co	$210	1.2030	10/01/10
26425	Liberty Mut Grp	Wausau General Ins Co	$210	1.0350	10/01/10
26042	Liberty Mut Grp	Wausau Underwriters Ins Co	$210	1.2540	10/01/10
11149	Maine Employers Mut Ins Grp	Maine Employers' Mutual Ins Co	$140	1.1620	09/14/10
19720	Munich Re Grp	American Alt Ins Corp	$290	1.2920	10/01/10
23779	Nationwide Corp Grp	Nationwide Mut Fire Ins Co	$200	1.3730	10/01/10
23787	Nationwide Corp Grp	Nationwide Mut Ins Co	$200	1.3730	10/01/10
23787	Nationwide Corp Grp	Nationwide Mut Ins Co	$200	1.2480	03/01/11
37877	Nationwide Corp Grp	Nationwide Prop & Cas Ins Co	$200	1.3730	10/01/10
37877	Nationwide Corp Grp	Nationwide Prop & Cas Ins Co	$200	1.1230	03/01/11
12122	NJ Manufacturers Grp	New Jersey Manufacturers Ins Co	$220	1.3310	10/01/10
24414	QBE Ins Grp	General Cas Co Of WI	$200	1.3500	08/01/10
24449	QBE Ins Grp	Regent Ins Co	$200	1.2000	08/01/10
19690	Safeco Ins Grp	American Economy Ins Co	$200	1.2000	05/01/10
19704	Safeco Ins Grp	American States Ins Co	$200	1.3300	05/01/10
24732	Safeco Ins Grp	General Ins Co Of Amer	$200	1.3300	05/01/00
25143	State Farm Grp	State Farm Fire And Cas Co	$100	1.4759	10/01/10
41840	The Hanover Ins Grp	Allmerica Fin Benefit Ins Co	$200	1.0620	06/01/10
31534	The Hanover Ins Grp	Citizens Ins Co Of Amer	$200	1.1000	06/01/10
40134	Tower Grp	CastlePoint Nat Ins Co	$200	1.5000	09/14/10
37893	Union Labor Grp	Ullico Cas Co	$200	1.3000	02/01/11
12475	Utica Grp	Republic-Franklin Ins Co	$200	1.1480	11/01/10
25976	Utica Grp	Utica Mut Ins Co	$200	1.2760	11/01/10

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NAIC Code	Group Name	Company Name	Expense Constant	Loss Cost Multiplier	Renewal Effective Date
10687	Utica Grp	Utica Natl Assur Co	$200	1.2130	11/01/10
21970	White Mountains Grp	OneBeacon Ins Co	$200	1.0650	01/01/11
10510	WR Berkley Corp Grp	Carolina Cas Ins Co	$200	1.4000	02/22/10
23612	WR Berkley Corp Grp	Midwest Employers Cas Co	$200	1.2700	02/22/10
40045	WR Berkley Corp Grp	Starnet Ins Co	$200	1.4000	02/22/10

Large Deductible Plans Approved in 2010

Company	Effective Date
Chubb Indemnity Ins. Co.	4/29/10
Ullico Insurance Company	5/6/10
Great American Alliance Ins. Co.	8/1/10
Great American Assurance Co.	8/1/10
Great American Insurance Co.	8/1/10
Great American Insurance Co. of NY	8/1/10
Electric Insurance Co.	7/13/10
Zenith Insurance Co.	7/15/10
BancInsure, Inc.	11/2/10
Federated Mutual Ins. Co.	3/1/11
Federated Service Insurance Company	3/1/11

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 Insurance Department formulates guidelines for calculating both the PCISF net value and the 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 7603I(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 7603I(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.

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In the 2004 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603I(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 7603I(1), contributions did not cease. In the 2008, 2009 and 2010 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, 1988-2010*

Fund Year	Estimated Quarterly Contributions (in millions)
1988	$15.0
1989	7.5
1990	5.5
1991	25.0
1992	7.5
1993 – 97	0.0
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
2010	0.0

* During 1993, settlement was reached with respect to *Alliance of American Insurers et al. v. Chu et al*. The 1993 through 2009 fund year net values and contribution amounts described above reflect the impact of the settlement.

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C. HEALTH BUREAU

1. Entities Under Health Bureau Supervision

The Health Bureau is responsible for the 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, continuing care retirement communities and municipal cooperative health benefit plans.

The Bureau has regulatory authority over all aspects of the fiscal solvency and market conduct monitoring of 108 insurers, HMOs, and other managed care organizations (ninety-four (94) domestic insurers and fourteen (14) foreign insurers) as of December 31, 2010. These consist of thirty-five (35) accident and health insurers, nine (9) health service corporations, three (3) medical and dental expense indemnity corporations, twenty-three (23) Article 44 Public Health Law HMOs, eleven (11) Article 47 Insurance Law municipal cooperative health benefit plans, sixteen (16) managed long term care plans and eleven (11) continuing care retirement communities authorized pursuant to Article 46 of the Public Health Law.

In 2010, the Bureau continued its review of a plan of conversion (the Plan) into for-profit status submitted by two not-for-profit health service corporations, Group Health, Incorporated and the Health Insurance Plan of Greater New York. The Plan calls for Group Health, Incorporated 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 a for-profit HMO, GHI-HMO Select, Inc. to merge with the Health Insurance Plan of Greater New York. All of the concerned companies are affiliates. The Plan is pending.

Three Article 42 accident and health insurer licensing applications were under review during 2010 (one foreign and two domestic). Of the three applications, one remained under review as of December 31, 2010.

Two HMOs submitted applications to receive “certificates of authority” to operate in New York State in 2010. HMOs are jointly regulated by the Insurance Department, as well as the Department of Health. The Department of Health issues certificates of authority to HMOs. During 2010, one HMO received its certificate of authority and one application was withdrawn.

One Municipal Cooperative Health Benefit Plan became certified during 2010.

In 2010, one HMO submitted an expansion application which remained under review as of December 31, 2010.

One foreign Medicare Part D carrier withdrew from the State due to sanctions issued by the Centers for Medicare and Medicaid Services (CMS).

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.

Three applications for the determination of non-control were submitted (one HMO and two Article 42 accident and health insurers). Two applications were approved and one is still pending as of December 31, 2010.

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Two Derivative Use Plans previously submitted were approved during 2010.

2. Accident and Health Insurers

Thirty-five companies were licensed to transact only accident and health insurance at year-end 2010. Financial data for these companies is included in the following table:

Table 50
SELECTED ANNUAL STATEMENT DATA
Accident and Health Insurers
2007-2009
(dollar amounts in millions)

	2009	2008	2007
Number of Insurers	32	32	29
Net premiums written	$14,397.4	$11,619.2	$11,139.4
Admitted assets	16,121.8	15,908.5	15,312.4
Liabilities	9,708.9	9,798.9	8,904.7
Capital and Surplus	6,340.9	6,109.5	6,407.6
Ratio of premiums written to capital and surplus	2.3	1.9	1.7

3. Article 43 and Article 44 Corporations

Article 43 of the Insurance Law governs various non-profit health insurers. Article 44 of the Public Health Law governs HMOs.

The following tables show aggregate figures on assets, liabilities, surplus funds, premium income and membership for years 2007-2009:

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Table 51
ARTICLE 43 HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
2007-2009
(dollar amounts in millions)

	2009	2008	2007
Number of Companies	9	9	9
Admitted Assets	$5,819.1	$5,472.5	$5,749.4
Liabilities	3,098.1	2,936.6	2,696.2
Surplus Funds	2,721.0	2,535.9	3,053.2
Net Premium Income:			
Hospital	7,564.8	7,518.1	7,554.0
Medical/Dental	8,538.5	7,750.3	6,929.4
Number of Contracts & Riders in Force:			
Hospital	1.2**	1.2**	1.3**
Medical/Dental	1.9**	1.8**	1.8**

* 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 services, medical and dental care. They are also granted certain additional powers that 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
2007-2009
(dollar amounts in millions)

	2009	2008	2007
Number of Companies	3	3	3
Admitted Assets	$59.1	$68.0	$57.2
Liabilities	31.1	43.3	32.9
Surplus Funds	27.9	24.6	24.3
Net Premium Income	119.0	117.0	98.6
Number of Contracts in Force	2,217	2,061	1,853

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Table 53
ARTICLE 44 HEALTH MAINTENANCE ORGANIZATIONS
That Are a Line of Business of a Health Service Corporation*
Selected Data, New York State
2007-2009
(dollar amounts in millions)

	2009	2008	2007
Number of Companies	3	3	3
Net Premium Income	$7,003	$6,969.3	$7,020.3
Number of Participants	1.3**	1.4**	1.6**

* 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
2007-2009
(dollar amounts in millions)

	2009	2008	2007
Number of Companies	19	18	18
Admitted Assets	$4,696.0	$5,318.5	$5,391.7
Liabilities	1,978.7	2,063.1	2,035.4
Surplus Funds	2,717.2	3,255.4	3,353.2
Net Premium Income	12,728.4	12,805.5	12,467.9
Number of Participants	2.0*	2.3*	2.6*

*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, Inc. (EmblemHealth), in November 2006. Although since that date, HIP and GHI have largely remained separate operating companies. The proposed plan of conversion (the Plan) 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 approval of a conversion plan, more than 20% of the stock of the publicly traded company would be sold 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

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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.

The Department has been reviewing the plan of conversion and held two public hearings on the Plan, one in New York City on January 29, 2008, and one in Albany on January 31, 2008. Since mid-2008, the application is being held in abeyance at EmblemHealth's request, pending possible revisions to the conversion plan.

In December 2010, HIP replaced EmblemHealth as the sole corporate member of GHI. Previously, during 2006, EmblemHealth had become the sole member and parent corporation of GHI. EmblemHealth was already the sole member and parent corporation of HIP.

5. Examinations and Investigations Conducted by the Health Bureau

During 2010, the field unit of the Health Bureau conducted 55 examinations of various regulated entities. The 2010 examinations and investigations by regulated entity and type are presented below:

	Total	Examinations [1] Commenced in 2010	Examinations Commenced Prior to 2010
By Regulated Entity			
CCRC	5	3	2
Article 42 Insurer	20	9	11
Article 43 Corp	11	2	9
HMO	17	3	14
Muni-Coop	1	0	1
MLTCP	1	0	1
Total	**55**	**17**	**38**

	Total	Examinations [1] Commenced in 2010	Examinations Commenced Prior to 2010
By Type			
Financial	11	6	5
Market Conduct	1	0	1
On Organization	3	2	1
Combined	40	9	31
Total	**55**	**17**	**38**

[1] In 2006, the National Association of Insurance Commissioners (NAIC) adopted revisions to the Financial Condition Examiners Handbook (Handbook) relating to implementation of the revised risk-focused examination approach for financial examinations. This new examination method is required for all examinations beginning on or after January 1, 2010. 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.

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In 2010, the Health Bureau conducted 14 such risk-focused (financial) examinations (all except the CCRC 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, developed by the Health Bureau to facilitate speed-to-market "best practices," as well as 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.

Numerous enhancements were made in SERFF in 2010 to provide the industry with information to make filings compliant with the immediate Federal health insurance market reforms, to implement the filing requirements for the recently-enacted state prior rate approval legislation, and to establish new rate data fields for reporting requirements in connection with a rate review grant under Federal health reform.

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%. In 2010, SERFF filings continued to rise further to over 98%.

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 and to perform the recommendations developed by the Health Committee of the Insurance Filings Modernization Initiative, RAFFT was instrumental in updating product checklists and developing filing guidance for the industry as well as reviewing the Health Bureau portions of the Web site to offer the information in a less cluttered, easier to navigate, and more user-friendly manner.

The RAFFT team has periodically 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. Insurance Filings Modernization Initiative

The Insurance Filings Modernization Initiative commenced in February of 2010. Representatives of the health insurance industry and the Health Bureau participated on the Health Committee to review

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the processing of policy form and rate filings and develop recommendations to improve the timeliness of filings and approvals and streamline processes and procedures.

The recommendations from the Health Committee and committees from other Bureaus were combined into the Insurance Filings Modernization Committees' Report to the Superintendent which was issued on December 2, 2010 and is posted on the Department's Web site.

During 2010, the Health Bureau implemented the recommendations with the following activities:

- Posted filing guidance on the Insurance Department Web site for policy form submissions with no rate impact and the conditions under which an insurer is allowed to change rolling rates off-anniversary.

- Updated product checklists on the Insurance Department Web site to include recent legislation, regulations, circular letters and guidelines.

- Posted model policy form language on the Insurance Department Web site for optional use by the industry based on topics identified by the Health Committee.

- Agreed to clearly communicate the Health Bureau's position on prohibited underwriting practices and other issues relating to permissible underwriting guidelines as they are identified and resolved.

- Drafted a regulation to codify permissible cost-sharing for radiological services to address concerns regarding current limitations on cost-sharing for higher cost radiology services.

- Extended the timeframe for the industry to respond to comments on a filing from fifteen calendar days to fifteen business days to assist insurers and HMOs to timely respond to comment letters and to reduce requests for extensions.

- Improved the filing resources available to the industry by (1) publishing clear instructions on how to use the expedited filing methods through circular letters and/or guidelines, (2) enhancing disclosure of requirements for commission filings, and (3) posting and disseminating Bureau suggestions on how to achieve successful form and rate filings.

8. Review of Accident and Health Policy Form Submissions

In 2010, the Health Bureau made final dispositions on 1,911 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, the NAIC's System for Electronic Rate and Form Filing. Of the 1,911 submissions disposed in 2010, 335 (18%) of them were submitted using fast track and/or deemer. Deemer submissions are submissions made under the expedited approval procedure set forth in Section 3201(b)(6) of New York Insurance Law which provides that a filing may be deemed approved if the Insurance Department does not act on the filing within the requisite timeframes. Fast track submissions are submissions made under the optional expedited prior approval using a certification process described in Circular Letter No. 4 (2003). Circular Letter No. 4 (2003) provides for three certification processes: certification by checklist; previously

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approved form; and template. An insurer using a certification by checklist must complete the product checklist applicable to the particular filing, posted on the Insurance Department's Web site, and confirm that all applicable laws and regulations have been followed. An insurer using a certification by previously approved form must submit a form that was previously approved and highlight the changes. An insurer using a certification by template must submit a previously approved template and highlight any changes.

Table 55
ACCIDENT & HEALTH
Disposition of Policy Form Submissions
2010

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Municipal Cooperative Health Benefit Plan	Frat	Total
Approved	162	445	120	170	7	2	**906**
Not Accepted / Circular Letter 14 (1997)*	0	97	44	1	0	0	**142**
Lack of Company Action	4	27	21	2	0	0	**54**
Disapproved	0	0	3	1	0	0	**4**
Filed for Reference	3	140	121	10	0	0	**274**
Prefiled	13	116	0	25	0	0	**154**
Withdrawn	9	48	25	9	0	0	**91**
Filed for Out-of-State Use	0	215	57	0	0	0	**272**
Other	1	1	12	0	0	0	**14**
Total	**192**	**1089**	**403**	**218**	**7**	**2**	**1911**

*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.

9. Review of Rate Filings:

Review of premium rates is performed in accordance with requirements in applicable sections of Insurance Law and corresponding regulations. 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).

a. File and Use Rate Changes

Prior to June 8, 2010, premium rate changes for hospital/medical coverages were governed by a "file and use" procedure for Insurance Law Article 42 insurers, Article 43 not-for-profit Plans, and Public

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Health Law Article 44 Health Maintenance Organizations (HMOs). The file and use procedure was an alternative to the prior approval requirements of Sections 3231(e) and 4308I of the Insurance Law, under specified conditions. The file and use law permitted an insurer or Article 43 or Article 44 corporation to submit a filing for a premium rate adjustment, and such filing would be deemed approved, upon certification that the expected medical loss ratio would meet the minimum loss ratio prescribed in Insurance Law Sections 3231(e) and 4308(g). Premium adjustments for Article 43 or Article 44 corporations 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 Health Bureau received 114 file and use rate increase filings during 2010. The Health Bureau also required insurers to pay refunds in the amount of $17.7 million for failure to meet the minimum loss ratio requirements in 2010.

b. Prior Approval of Rate Changes

On June 8, 2010, Governor Paterson signed Chapter 107 of the Laws of 2010, which reinstated the Insurance Department's authority to approve health insurance premium adjustments, prior to implementation. As described above, previously, New York health insurers could use a "file and use" methodology, which allowed insurers to increase premiums by simply filing an actuarial certification that the expected medical loss ratio will meet the statutory minimum medical loss ratio (MLR). Under prior approval, the Insurance Department can approve, reject or modify rate increase requests before they go into effect, if the Department finds that they are excessive, inadequate or unfairly discriminatory.

Key Provisions of the Prior Approval Law

- **Applicable Plans** – Prior approval must be used for individual, small group and large group community rated products, including Healthy NY and Medicare Supplemental (Medigap) policies.

- **MLR Requirement** – All premiums, must meet an expected 82% minimum medical loss ratio (MLR) requirement. If, at the end of the year, the MLR is below 82% (i.e., the premium was excessive), the Department has the authority to order corrective action, including refunds to policyholders. The MLR for calendar year 2010 will be measured based on the total of: actual claims incurred; plus HCRA Assessments as defined in Section 3236 of the Insurance Law; plus Market stabilization payments and receipts under Insurance Department Regulation 146; less stop loss recoveries under Sections 4321-a, 4322-a, and 4327 of the Insurance Law all combined and then divided by premiums earned.

  For calendar years 2011 and beyond, the Department is evaluating the impact of Federal Health Reform to determine if the Department's MLR calculation should be altered to conform to the provisions of the Affordable Care Act (ACA) enacted on March 23, 2010. Such calculation adds expenses that improve the quality of care, and certain fraud and abuse detection expenses to claims cost, and deducts federal and State taxes and regulatory fees from premiums earned. The ACA also imposes a higher MLR threshold of 85% on large group polices.

- **Notice of Proposed Rate to Policyholders** – Insurers must give each policyholder prior written notice of the proposed premium rate. Policyholders and the general public have 30 days from the date the rate is submitted to the Department, to send comments to the insurer or the Department, which the Department must post on its Web site. The Department received approximately 1,000 comments in 2010.

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- **Department's Review** – The Department must approve, reject or modify the rate application within 60 days of its submission, which may be extended if the Department needs more information. The Department's determination must be supported by sound actuarial assumptions and methods.

- **Final Notice to Consumers of Approved Rates** – Insurers must provide each policyholder with at least 60 days notice, prior to the effective date of the specific premium rate approved by the Department that is applicable to that policyholder.

The Health Bureau received 50 Prior approval filings in 2010, of which 36 were completed during 2010. As of December 31, 2010, eleven of the filings were still pending and three were withdrawn by the companies that filed them.

c. Rate Filings for New Policy Forms and Rate Adjustment Filings

In 2010, the Health Bureau received 1,594 rate filings for new policy forms and rate adjustment filings and disposed of 1,585 rate filings. These include initial rate filings for new policy forms and contract benefit changes submitted by commercial insurers, Article 43 corporations, Article 44 HMOs, as well as rate adjustment filings for accident and health insurance products other than hospital/medical insurance (primarily for commercial insurers), commission filings, experience monitoring filings, and rate manual revisions. In 2010 about 96% of the Accident and Health Rate Filings received were received through the System for Electronic Rate and Form Filing (SERFF).

d. Healthy NY

The Health Bureau oversaw the posting of updated rates for the Healthy NY plans on the Department's Web site. The Health Bureau also collected monthly enrollment reports from Healthy NY carriers.

e. Long Term Care Insurance and Medicare Supplement Insurance

The Health Bureau posted updated premium rate information for Partnership and Non-Partnership Long Term Care premiums and Medicare Supplement premiums on the Department's Web site.

f. Federal Health Care Reform

The Health Bureau also provided comments on the Department's Premium Review Process in response to request for comments from the Department of Health and Human Services regarding Section 2794 of the Public Health Service Act.

10. Inquiries and Complaints

In response to formal written inquiries and complaints to the Department, the Health Bureau provided written answers to more than 100 consumer inquiries and responded to more than 350 Freedom of Information Law (FOIL) requests concerning accident and health insurance and related issues in 2010.

In addition, the Health Bureau monitors a dedicated electronic mailbox on the Department's Web site. In 2010, 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 2010 included consumer

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complaints regarding increased premium rates, consumer inquiries relating to health insurance options in New York State and the impact of Federal health reform on those options, premium rate increases, 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 2010, Bureau staff also responded to approximately 5,000 telephone inquiries on many health insurance related topics from various sources.

11. 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 2010, several new reports and updates to existing reports by utilization review agents were submitted.

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 Insurance Department Regulation 146 to stabilize premium rates in the individual, small group and Medicare supplement health insurance markets. The purpose of the Pools is to encourage insurers to remain in or enter the individual, small group and Medicare supplement health insurance markets, promote a marketplace where premiums do not unduly fluctuate, and ensure that insurers and HMOs are reasonably protected against unexpected significant shifts in the number of persons insured. The Pools collect annual revenues through contributions from HMOs and insurers in the individual, small group and Medicare supplement markets that insure a low proportion of high-risk, high-cost persons. 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 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 payers totaled just under $100 million, well under the $120 million Pool funding cap for 2008. 2008 contributions were collected in June 2009 and distributions were paid out in July 2009. The 2009 Pool contributions were billed in June 2010, with payments due from all carriers totaling just under $100 million. Collection from one carrier was delayed due to issues with the carrier regarding its liability, but all amounts due were collected by December 2010 and distributions

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were then paid. A preliminary calculation of the 2010 pool liability indicates the total contribution is again in the $70 million range. Audit of the data has commenced and it is anticipated the billing and collection will be done in the 2nd Quarter of 2011.

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 than 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 Insurance Department Regulation 146. Total contributions to the Medicare Supplemental Pool for 2009 were approximately $15.5 million. Although the final figures have not yet been determined, it is projected that total contributions to the Medicare Supplemental Pool will be approximately $16.0 million for 2010.

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 remains at $39.2 million a year.

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.

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During 2010, the Department directed the administrator to conduct the necessary audit procedures with respect to the reimbursement requests submitted by carriers for 2009 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 2009 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	$62,865,689	$19,600,000	31.2%
Out-of-Plan (POS) Direct Payment	$39,689,404	$19,600,000	49.4%

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. 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.

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The major responsibilities of the Department in connection with the oversight of the Healthy NY program for year 2010 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 continues to respond to questions of eligibility and to provide continuing guidance to the health plans. The Department maintains a dedicated Web site that provides important guidance on eligibility, offers links to the health plans' provider network listings, provides electronic versions of the applications, posts frequently asked questions and copies of the annual studies. The Web site also includes an online eligibility screener that helps potential applicants understand their eligibility in advance of submitting an application. This Web site is updated often and revised according to questions received and suggestions by health plans and consumers. The Healthy NY Web site homepage receives nearly 70,000 visits each month (and more than 400,000 monthly for all the Healthy NY Web site pages), demonstrating a continued strong interest in the program.

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 versed in making eligibility determinations. 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

Premium rates are required to account for the availability of stop-loss funding, which is used to reimburse the health plans for eligible high-cost claims. 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 Healthy NY coverage provided to premium sensitive small businesses and consumers. However, premium rates are now subject to prior approval as a result of recent legislation reinstating this authority to the Insurance Department.

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

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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.

Total claims for calendar year 2009 were as follows:

Healthy NY Qualifying Individual Claims	$ 104,935,190
Healthy NY Small Employer Claims	$ 62,761,225
Total Claims Reimbursed	$ 178,831,811

Each year since the inception of the HNY Stop Loss Funds, sufficient amounts were made available in the following year's budget to cover the total valid reimbursement requests for the preceding year. However, due to Budget deficit issues arising over the past year, the appropriation in 2010 to cover 2009 stop loss reimbursements was less than the total requests for the year (approximately $22 million below the total of valid audited requests). The amounts that were made available for reimbursement of 2009 claims are shown below. For each line of business, the total available was pro-rated to carriers based on the ratio of each carrier's valid claims to total valid claims of all carriers for the respective line of business.

The total reimbursements paid to carriers for calendar year 2009 after pro-rata reductions were as follows:

Healthy NY Qualifying Individual Claims	$ 94,146,857
Healthy NY Small Employer Claims	$ 62,761,225
Total Claims Reimbursed	$156,908,082

For 2010, preliminary submissions indicate approximately $199.9 million in reimbursement requests. The amount of funding available for reimbursement of these claims is at this time uncertain.

f. Tracking Maximum Enrollment in Healthy NY

The Department continues to monitor enrollment in Healthy NY on a monthly basis. The participating health plans submit enrollment activity data to the Department monthly. These reports illustrate new enrollments, terminations and resulting enrollment for each category of eligibility: small employer, sole proprietors and individuals.

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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 works 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. While marketing and outreach efforts are crucial to the success of the program, such efforts were suspended several years ago 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

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Berkeley, Mathematica Policy Research, Inc., the offices of Sen. Schumer of New York, and the Governor 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. In September 2010, Texas announced successfully contracting with two insurers to begin offering coverage through Healthy Texas.

I. 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.

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 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 and enrollment issues for its members and maintains records for 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, particularly billing.

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 2010, the Insurance Department authorized payment of subsidies in the amount of $1,799,033.

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 2010, the Department authorized total contract payments of $298,229 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. Any businesses that enrolled in the coverage prior to September of 2009 continue to receive a subsidy. The subsidy had been provided at a rate of 19% of the monthly premium cost per group, but program administrators decided to reduce the subsidy to 16% of premium upon each subsidized group's renewal of coverage in 2011. Similar to the suspension of subsidized enrollment, concerns over program funding prompted the decision to reduce the subsidy amount.

At the close of 2010, the Brooklyn HealthWorks program had 606 active groups enrolled, representing a total of 2,809 covered lives.

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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 as of December 31, 2010, the program had 1,584 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 2010 were $865,331.

17. Federal Tax Credit Initiative

The federal Trade Adjustment Act of 2002 made a 65% health insurance tax credit available to certain eligible citizens. The federal government increased the value of this credit to 80% from the beginning of 2009 through March, 2011. 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. This year, New York registered it Pre-existing Condition Insurance Pool, the New York Bridge Plan, as an additional qualifying health plan in order to provide HCTC eligible New Yorkers with a pre-existing health condition with as much choice as possible.

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.

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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. The program was provided a $1 million budget for 2010 which was fully expended.

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.

During 2010, Department staff processed 488 applications. The Department paid out $1,018,962 in premium assistance. Payments were made to 17 union funds, the most highly represented being Equity League (approximately 127 enrollees) and Screen Actors Guild (approximately 70 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 reviews 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 2010 and developed revisions to the Department's annual statement for CCRC financial filings.

Currently, there are 12 CCRCs in New York, each with a certificate of authority issued by the CCRC Council. All 12 are currently fully operational.

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 expenses 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.

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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 2010, 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 2010, the Health Bureau continued to review a product portfolio for a returning Partnership insurer.

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 2010, 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 2010, 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.

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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 2010, the Health Bureau continued to monitor the efficacy of this interactive tool in providing illustrative premium information for consumers.

f. Consumer Education

During 2010, 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 resources 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 2010, 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

2010 was the fourth 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 2010, 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

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continues to show modest but steady growth in the long term care insurance market in New York. During 2010, the Health Bureau monitored its data from the last biennial report in preparation for the next biennial report, due on December 31, 2011.

i. Federal Long Term Care Insurance Option Adopted in Federal Health Care Reform

The federal Patient Protection and Affordable Care Act (ACA) included provisions more commonly known as the CLASS (Community Living Assistance Services and Supports) Act. The CLASS Act is intended to provide a publicly sponsored, voluntary long term care insurance option for working adults. The federal government is not expected to issue regulations on the CLASS program until November 2012 with actual CLASS program start-up not expected until 2013 at the earliest.

The CLASS program has been a controversial element of ACA with calls for its reform or repeal because it is not expected to be financially sustainable as described in federal law. The Secretary of Health & Human Services has indicated federal law allows her the authority to reform CLASS without further federal legislative changes.

Private long term care insurers await the final federal design of the CLASS program to decide whether they should offer private long term care insurance products to supplement CLASS or whether private long term care insurance products should compete with CLASS.

In 2010, the Health Bureau continued to monitor CLASS program developments at the federal level and at the private long term care insurance industry level. CLASS is expected to affect the private long term care insurance market in New York State, and the Department will have to adjust its regulation of that market accordingly.

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 has distinct statutory duties under Section 4403-f of the Public Health Law in approving managed long term care plan premium rates and enrollee contracts. In 2010, Section 4403-f of the Public Health Law was amended to modify the Insurance Department's regulatory oversight of managed long term care plans. However, the Insurance Department will still maintain the escrow deposits established pursuant to Part 98-1.11(f) of the Regulations of the New York State Health Department (10 NYCRR 98-1). An escrow deposit is required of all managed care organizations in the State of New York. These deposits are trusteed assets for the security of the plan's enrollees and the enrollee's health care service claim obligations. In addition, the Insurance Department will continue to review and approve forms and rates for private-pay and commercial participants in managed long term care plans.

22. Medicare Beneficiaries' Issues

The Patient Protection and Affordable Care Act (ACA) requires revision of the Medicare supplement insurance benefit packages (also known as Medigap) Plans C and F to add cost sharing to encourage the use of appropriate physician services under (Medicare) Part B. The revised plans C and F are to be available for issuance beginning in January 2015. The NAIC coordinated a Medigap ACA Subgroup to effectuate the changes to Plans C and F. The Subgroup is comprised of state regulators,

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industry representatives, and consumer advocacy groups. The Health Bureau is an active member of the Medigap ACA Subgroup.

The Health Bureau is also a member of the NAIC Senior Issues Task Force (SITF) Medigap Modernization Subgroup. Medicare supplement insurance plans and benefits have been updated in accordance with 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. In addition, the Health Bureau serves as a contact for other states in need of assistance.

CMS requires companies writing Medicare Part D prescription drug coverage to be licensed in the state where they are proposing to operate, or obtain a federal waiver of the state licensure requirement. CMS requires state certification of licensure and financial solvency. Upon company request, the Health Bureau reviewed the legal and financial aspects for health insurers requesting the certification and provided companies with letters of good standing indicating that the company is licensed in New York and meets state financial requirements. Good standing letters were also provided to health insurance companies and HMOs expanding participation and entering the Medicare Advantage market. Although the Department does not regulate the Medicare Part D or the Medicare Advantage program, the Health Bureau was able to verify the status of the companies licensed in the state 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 residents in all 62 counties in New York State would be affected by Medicare Advantage Plan nonrenewals in 2011. In total, 28,582 New York residents were affected. In order to assist New York residents being terminated by their Medicare Advantage plans, the Health Bureau 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. Medicare Supplement Regulation Changes

As of June 1, 2010, changes to Medicare supplement insurance resulted in modifications to the standardized plans offered by insurers as required by the federal Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Medicare supplement insurance Plans H, I, and J, which contained prescription drug benefits and were in effect prior to the Medicare Modernization Act, were eliminated. Plan E was also eliminated as it was identical to an already available plan. Two additional plan options were added that have higher cost-sharing responsibility and lower estimated premiums: Plan M will include 50 percent coverage of the Medicare Part A deductible and will not cover the Part B deductible; and Plan N will not cover the Part B deductible and adds a new co-payment structure of $20 for each physician visit and $50 for each emergency room visit (waived upon admission to the hospital).

Certain Medicare supplement insurance benefits were also modernized. As preventive services are now covered by Medicare, the Medicare supplement insurance benefit for preventive care was eliminated. The under-utilized Medicare supplement insurance At-Home Recovery benefit was also eliminated. A new Hospice Care benefit was added as a basic benefit available in every Medicare supplement insurance plan. The 80 percent Medicare Part B Excess Medicare supplement insurance benefit was increased to a 100 percent coverage benefit. Also, insurers are now required to offer Plans

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A and B, as well as either Plan C or Plan F. Previously insurers only had to offer Plans A and B in New York.

In order to comply with the changes, the Health Bureau amended its regulations. Because the changes were so extensive, the Health Bureau opted to create a stand-alone regulation incorporating current provisions, spread throughout sections of Regulation 62, along with the new provisions. Sections relating to Medicare select insurance in 52.14, Medicare supplement insurance in 52.22, and the disclosure chart listing all the plans and the benefits from 52.63 were moved to Part 58 (Regulation 193).

Insurers issuing Medicare supplement insurance in New York were required to submit new policy forms and rates complying with Regulation 193 for review and approval in order to continue selling Medicare supplement insurance products in the market on and after June 1, 2010. The policy forms and rates for all fifteen Medicare supplement insurance insurers in New York were approved by the Health Bureau in advance of June 1, 2010 so there was no disruption to the market.

24. 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. One such rider, to attach to an individual disability income policy, was approved by the Bureau in 2010. These innovative products provide 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.

In 2010, the Health Bureau approved an innovative product that combined long term care insurance with an annuity. This combination became allowable in 2010 under provisions of the federal Pension Protection Act. The Health Bureau assured that the long term care insurance rider attached to the annuity provided consumer protections commensurate with a stand alone long term care insurance policy.

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

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organizations. These combined plans can present unique challenges to the Department. (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.

25. Child Health Plus

During 2010, the Department continued its role of reviewing and approving subscriber contracts and premium rates for the Child Health Plus program. During 2010, the Department reviewed and approved a number of Child Health Plus rate adjustment submissions and subscriber contracts.

26. Early Intervention Program

During 2010, 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 continues 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.

27. Updates to Department Web site

The Health Bureau continuously updates the Insurance 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 developed by the Bureau are posted on the Insurance Department Web site to provide the industry with one primary source for statutory and regulatory requirements related to each major product. In 2010, the Bureau updated all product checklists for compliance with recent New York legislation, regulations, and circular letters. A specific checklist was developed by the Bureau and posted to provide guidance for filers to bring their existing products into compliance with the immediate market reform requirements of Federal health reform. Also, a specific checklist was developed by the Bureau and posted for rate adjustment filings for community rated products subject to the recently-enacted prior rate approval legislation. Additional product checklists are in progress.

In 2010, filing guidances for the industry were developed by the Bureau posted on the Insurance Department Web site on filing process and rate filing topics such as combination filings to Health and Property, combination filings to Health and Life, company address/name changes for policy forms, foreign language translation, merger/name change for policy forms, priority of review and filing types, tips for successful form filings, rate filings for rolling rates, submissions with no rate impact, and tips for successful rate filings.

Model language was also developed by the Bureau and posted on the Insurance Department Web site in 2010 for various policy form provisions including age 29 extended dependent coverage, continuation of coverage, coordination of benefits, conversion, external appeal, home health care services following a hospital admission, pre-existing condition limitation for hospital/surgical/medical coverage, spouse eligibility-same sex marriage, and unmarried disabled children coverage. In addition, model language addressing Federal health reform requirements was developed by the Bureau and

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posted on the Insurance Department Web site so insurers could ensure existing policies/certificates would be compliant with federal requirements.

Consumer information on the Web site was enhanced and revised for easier access by the public. 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 Medicare supplement insurance plans available in New York and current premium rates which are updated on a monthly basis. A new chart was added in 2010 listing all insurers that offer Medicare supplement insurance in New York, the plans that are offered by each insurer, and the length of their respective pre-existing condition waiting period. A new section was also added detailing the changes made to Medicare supplement insurance plans offered for sale on or after June 1, 2010 as a result of the Medicare Improvements for Patients and Providers Act. Lastly, a new section was added to inform consumers that starting in 2011, Medicare beneficiaries will pay nothing for most preventive services if the services are received from a doctor or other health care provider who participates with Medicare.

28. Discontinuations, Withdrawals and Mergers

ConnectiCare of New York, Inc. was merged into GHI HMO Select, Inc.

The Fox Insurance Company an Article 42 Accident and Health Insurer withdrew from the state due to the Centers for Medicare and Medicaid Services (CMS) sanctions.

29. Financial Risk Transfer Agreement

Insurance Department Regulation 164, "Financial Risk Transfer Agreements between Insurers and Health Care Providers" (11 NYCRR 101), was promulgated on August 21, 2001. This Regulation addresses an insurer's obligation to assess the financial responsibility and capability of health care providers (*e.g.,* Independent Practice Associations) to perform their obligations under certain financial risk transfer agreements. It sets forth standards pursuant to which health care providers may adequately demonstrate such responsibility and capability to insurers. All Financial Risk Transfer Agreements between insurers and health care providers which meet certain criteria must be submitted to the Superintendent for review. During 2010, the Bureau received an additional twenty-seven (27) agreements and amendments for review in addition to the three (3) that were pending as of December 31, 2009. During 2010, twenty-two (22) were approved, seven (7) are pending and one (1) was determined not to be subject to the strict financial responsibility demonstration requirements of the Regulation.

30. 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.

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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 proposed appropriation to $79,743,000. As a result, funding was insufficient to cover total reimbursement requests for the year and carriers' reimbursement requests were reduced on a pro rata basis. The entire $79,743,000 pro rata reimbursement was paid to carriers in 2010. After payment of the $79,743,000, the Legislature determined there would be no further funding appropriated to subsidize the Timothy's Law 30/20 benefits. The mandate to provide the 30/20 benefit to small employers remains in place, but carriers have been advised that no further quarterly subsidy request reports will be required.

In 2010, the Health Bureau continued to be 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. Specifically, the Health Bureau reviewed federal MHPAEA regulations issued in 2010. As a result of the federal regulations, the Health Bureau issued a supplement to an earlier circular letter that had set forth the Department's interpretations of the federal regulations, 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 regulation.

In addition, throughout 2010, the Health Bureau responded to numerous inquiries and complaints regarding Timothy's Law and the MHPAEA. 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

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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.

31. Public Retiree Health Insurance Task Force

The Health Bureau participated 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 was 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 was comprised of representatives of New York State agencies, labor unions, retiree groups and local governments. The Governor accepted the final report of the Task Force, which presented a number of recommendations to provide public retirees with cost-effective quality health insurance coverage.

32. Autism Task Force

During 2010, 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 reviewing a number of proposed legislative bills concerning health insurance coverage for autism spectrum disorder.

33. 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 was 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 throughout 2010. The Task Force delivered a final report to the Governor and to the New York State Advisory Council on Lead Poisoning Prevention in October, 2010.

34. Traumatic Brain Injury Services Coordinating Council

During 2010, the Health Bureau participated in the Traumatic Brain Injury Services Coordinating Council. Although not an official member of the Council, the Insurance Department was invited to participate by the members of the Council. The Council, established in 1994, was created by the Legislature to be an independent body made up of representatives of state agencies deemed to be interested in the services provided to persons with brain injury and their families. The Council examines issues such as injury prevention and public awareness, in-patient and outpatient residential brain injury programs, and interagency system coordination. Bureau staff attended a number of scheduled meetings and acted as a resource for the Council regarding health insurance issues.

35. NYS Interagency Task Force on AIDS/HIV

During 2010, the Health Bureau served as a member of the New York State Interagency Task Force on AIDS/HIV. This is a multi-agency task force whose purpose is to foster collaboration and cooperation among state agencies on matters relating to HIV and AIDS. Task force meetings are held

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twice a year at the New York State Department of Health. Bureau staff attended the meetings and acted as a resource for the Task Force regarding health insurance issues.

36. 2010 Legislation

The Health Bureau assisted in the drafting and review of legislation and implemented several important pieces of legislation which were enacted in 2010. These new laws provide New Yorkers with enhanced access to health insurance coverage and improved protections.

- Chapter 107 of the Laws of 2010 reinstitutes the Insurance Department's prior approval authority for premium rates and creates a new process and timeframe for the Insurance Department to approve changes in health insurance premium rates for individual, small group and community rated large group coverage before they are effective.

- Chapter 398 of the Laws of 2010, "Ian's Law", provides for enhanced notice to insureds for class discontinuances of group hospital, medical and surgical expense coverage in the small and large group markets. Ian's Law requires insurers to provide at least 90 days prior notice of a discontinuance to the Superintendent and to each insured and to give insureds the option to purchase other coverage offered by insurer. The notice must include the reason for discontinuance and must inform insureds of their right to contact the Superintendent if they have a serious medical condition and have utilized a benefit related to that serious medical condition that is not covered by the replacement coverage. The Superintendent may prohibit the insurer from discontinuing the policy, require reinstatement of coverage or require the replacement coverage include a benefit for the serious medical condition. Ian's Law also provides that when discontinuing a particular class, the insurer must act uniformly and without regard to the claims experience or health status of a particular insured, and that the discontinuance is not a pretext to terminate coverage for a particular insured.

- Chapter 49 of the Laws of 2010 amends Insurance Law Section 3111I to allow for the designation of a third party to receive notices of nonpayment of premiums or cancellations if the premium is paid by the senior citizen, a designation that was previously allowed only under certain property casualty, individual life, individual and group Medicare Supplement and long term care insurance policies. This law extends the ability to appoint a third party designee to an individual "health insurance policy".

- Chapter 238 of the Laws of 2010 requires a midwife to have a collaborative relationship, rather than a written practice agreement, with an ob/gyn physician or hospital.

- Chapter 357 of the Laws of 2010 amends the Insurance Law to update the standard reference compendia listed for cancer drugs and allows for updates when new compendia is identified by the Secretary of HHS or CMS without the need for legislation.

- Chapter 453 of the Laws of 2010 clarifies, with respect to a demonstration program, the definition of an independent worker, to include domestic child care workers and

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individuals hired to work full-time for a single employer for a period not to exceed 18 months.

- Chapter 457 of the Laws of 2010 requires coverage for out-of-network dialysis if the policy covers dialysis treatment in-network only.

- Chapter 487 of the Laws of 2010 prohibits a co-payment that exceeds the Usual and Customary Rate (UCR) for a drug. If the co-payment exceeds the retail price on the pharmacy's drug retail price list the pharmacy must notify the insured and charge the retail price. If the drug is not on the pharmacy's drug retail price list and the co-payment exceeds the pharmacy's UCR, the pharmacy must notify the insured and charge the lesser of the co-payment or the pharmacy's UCR.

- Chapter 515 of the Laws of 2010 reduces the number of eligible employees that must participate in the plan for group life, disability income, long term care, vision or dental insurance and requires the plan insure a minimum of 50% or five (5) eligible employees, whichever is fewer. Chapter 515 does not reduce the minimum participation requirements for group hospital, medical, major medical or similar-type comprehensive coverage.

- Chapter 536 of the Laws of 2010 provides that any prescription drug cost-sharing determined by category of drug may not exceed the dollar amount for a non-preferred brand drug or, if no non-preferred brand category exists, the dollar amount for a brand drug. It is intended to prohibit the inclusion of Tiers IV and V, containing specialty drugs for serious chronic illnesses (i.e., multiple sclerosis, cancer, arthritis, hemophilia, hepatitis C), where the insured is responsible for a percentage of the cost.

The Health Bureau reviewed policy forms and premium rate filings submitted for compliance with the new laws. Health Bureau staff also worked with consumers, insurers and providers to educate them on their rights and responsibilities under the new laws. Additionally, Health Bureau staff updated Web site materials to include the new requirements.

37. Circular Letters

a. Mental Health Parity

The Health Bureau issued Supplement No. 1 to Circular Letter No. 20 (2009) to provide additional guidance to insurers about the impact of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) on New York's insurance market in light of federal regulations published in 2010. Specifically, the Circular Letter explains the requirements for coverage of treatment of outpatient and inpatient substance use disorders. In addition, the Circular Letter provides guidance as to the applicability of primary care and specialty care co-payments to mental health and/or substance use disorder benefits. The Circular Letter provides information on permissible and impermissible utilization review practices. Last, the Circular Letter includes information on policy forms and rates submitted for compliance with MHPAEA in order to facilitate the prompt and efficient review and approval of the submissions.

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b. Evaluation & Management Current Procedural Terminology Codes

The Health Bureau issued Circular Letter No. 17 (2010) to remind insurers that they (1) must accept and initiate the processing of all health care claims submitted by psychiatrists or other physicians pursuant to, and consistent with, the current version of the American Medical Association (AMA) current procedural terminology (CPT) codes, reporting guidelines and conventions, including Evaluation and Management (E/M) CPT codes and (2) may not limit the types of CPT codes that they accept from psychiatrists or other physicians to the codes specifically designated as "psychiatric" in the AMA's CPT codes, reporting guidelines and conventions.

c. 36 Month Continuation of Health Insurance Benefits

The Health Bureau issued Circular Letter No. 5 (2010) to provide guidance and clarification to insurers regarding Chapter 236 of the Laws of 2009 and Chapter 498 of the Laws of 2009. These laws provide continued access to group health insurance by ensuring that persons eligible for federal Consolidated Omnibus Reconciliation Act (COBRA) or state continuation (mini-COBRA) coverage receive up to a total of 36 months of coverage, regardless of when the group health insurance contract or policy was issued, renewed, modified, altered or amended. The Circular Letter provides detailed information to ensure that insurers comply with the statutory continuation of coverage requirements including the special enrollment period intended to minimize gaps in coverage.

38. Standardized Definitions and Explanations of Coverage

The Patient Protection and Affordable Care Act (ACA) requires the Secretary of Health and Human Services (HHS), in consultation with the National Association of Insurance Commissioners (NAIC), to develop standardized definitions and explanations of coverage for use by health insurers. The standardized definitions are intended to aid in the understanding of the summary of benefits and coverage documents. The summary of benefits and coverage documents are intended to provide information needed to make health insurance purchasing decisions. Health Bureau staff participated in meetings with the NAIC, health care professionals, insurers, providers, patient advocates and other qualified individuals, to develop the definitions and explanations of coverage. The NAIC drafted the documents and forwarded them to HHS for consideration.

39. Patient Protection and Affordable Care Act Six Month Reforms

The Patient Protection and Affordable Care Act (ACA) established consumer protections and mandated benefit requirements that went into effect on September 23, 2010 (“six month reforms”) and apply to health insurance policies issued or renewed on or after that date, with some limited exceptions for “grandfathered” policies. State requirements must be brought up to the federal standards; however, states may maintain requirements that do not prevent the application of the federal standards. The following areas were addressed by the “six month reforms”:

- **Prohibitions on annual and lifetime limits –** Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may establish restricted annual limits prior to January 1, 2014 on essential benefits.

- **Rescissions –** Coverage may be rescinded only for fraud or intentional misrepresentation of material fact.

- **Coverage of preventive health services –** Plans must provide coverage for preventive services for children and adults with no cost-sharing.

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- **Dependent coverage –** Plans that provide dependent coverage must extend coverage to adult children up to age 26.

- **Pre-existing condition exclusion –** A plan may not impose any preexisting condition exclusion on children up to age 19.

- **Direct access to obstetrical and gynecological services –** A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care.

- **Choice of primary care physician –** A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available.

- **Emergency care –** If a plan provides coverage for emergency services, the plan must do so without prior authorization and must cover out-of-network care.

- **Appeals process –** A plan's internal and external appeal process must comply with federal minimum standards.

The Health Bureau analyzed these requirements and identified the statutory and regulatory changes necessary to conform to the new federal health reform law. In order to assist the industry in the requisite form filings, Bureau staff prepared a forms filing checklist that integrates the New York and federal requirements. In addition, Bureau staff developed model policy form language to address the areas subject to the "six month reforms".

40. Rate Review Grant

On August 15, 2010, New York State was awarded a grant of $1 million under the Patient Protection and Affordable Care Act (ACA) with the goal to enhance the health insurance rate review and reporting process. The grant funds must be used to develop or enhance current capacity to review and approve or deny rate increases in the individual and group markets, to establish procedures increase the transparency of the rate approval process, to develop processes to report rate increase patterns to the Federal government, and to establish data centers to compile and publish fee schedule information.

The Health Bureau receives and reviews electronic filings of health insurance premium rates through the NAIC's System for Electronic Rate and Form Filing (SERFF). Enhancements were made in SERFF to establish new rate data fields and a reporting process to comply with the requirements of the grant.

Plans and procedures were also developed to increase the transparency of the approval process by improving the accessibility to approved policy forms and rate manuals via our Web site.

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41. Exchange Planning Grant:

The Patient Protection and Affordable Care Act (ACA) established a one year grant for States to consider whether to establish and to begin planning a Health Insurance Exchange to facilitate the purchase of health insurance in the individual and small group health insurance markets. Future grant cycles will be dedicated to funding establishment activities for states that have committed to establishing an Exchange. In September 2010, the Insurance Department received $1 million for the first cycle of grant funding. The grant period is from 9/30/2010 to 9/29/2011. The Insurance Department is working closely with the Governor's Office, the Health Department and other State agencies in evaluating and planning for the Exchange.

The Department of Health and Human Services (HHS) requires that the first year Exchange planning funds be used, in part, to collect information and data to support a State's application for the subsequent grant cycles (the Exchange Establishment grants), including determining how much funding the State will be requesting to establish the Exchange. HHS announced the Exchange Establishment grants in February 2011. This funding stream will be critical for the establishment of an Exchange in New York.

Major grant activities for the current planning year are to:

- Compile and evaluate background research from current research platforms and private funding by January 2011;
- Engage stakeholders in the evaluation, planning and development process throughout the one-year planning period;
- Evaluate the extent to which New York can integrate and build on existing programs as appropriate;
- Identify and utilize existing resources and capabilities, as appropriate, throughout the one-year planning period and determine the need for additional resources;
- Design Exchange governance structure and draft legislation if required;
- Evaluate financial accounting, auditing, and reporting requirements and potential pathways to securing compliance;
- Identify existing technical infrastructure resources and needs;
- Create a business operations plan and policies for the Exchange;
- Identify legislation and regulations needed to create, promote, and regulate the Exchange; and
- Comply with all reporting requirements specified under the terms of the grant award.

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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.

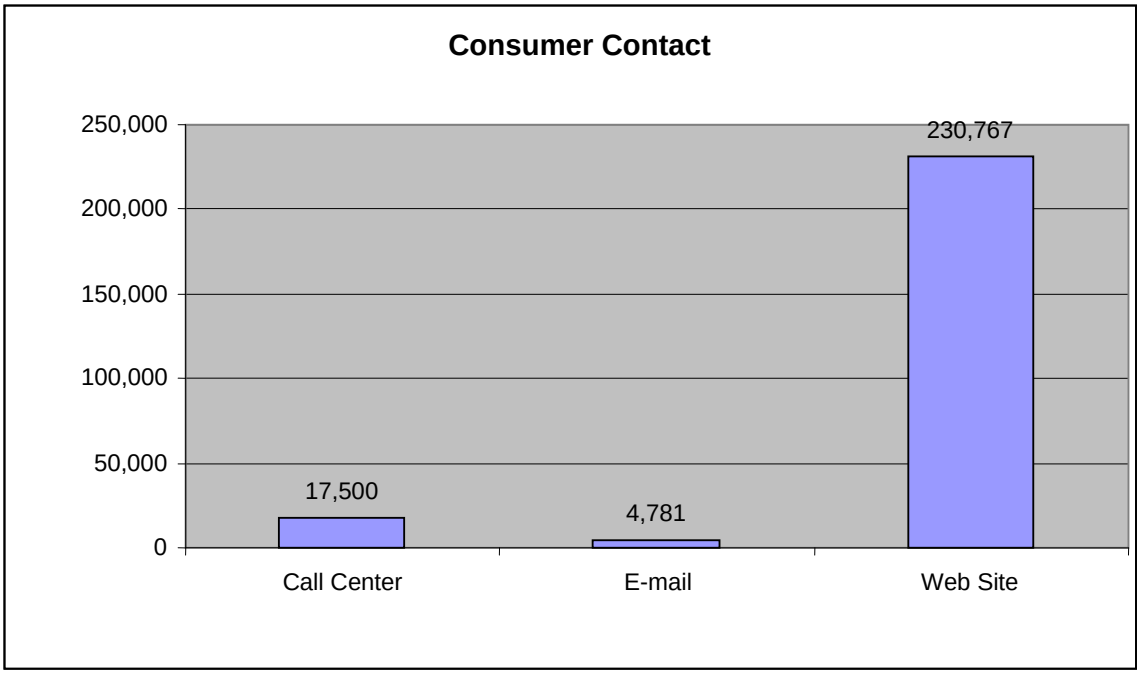
1. Consumer Resources

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 consumers inquires. Special hotline services, including one for natural disasters, are activated in response to specific situations to help consumers with insurance claims or questions. In 2010, the Bureau supported hotlines to offer help and information in response to these situations:

- Tornado/Windstorm disaster in NYC and Long Island
- Reinstatements in connection with automobile and homeowners' policies issued by several insurance companies.

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



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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:

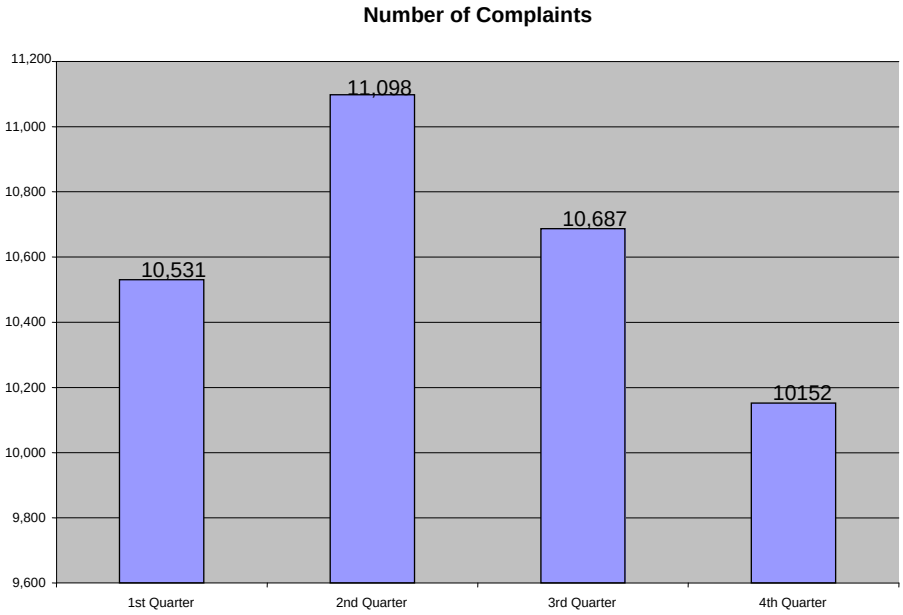
- Loss settlement or the interpretation of policy provisions
- Improper practices on the part of agents, brokers and adjusters
- Failure of insurers to settle claims in a timely manner
- Improper policy cancellation

3. Cases Opened

The Bureau received a total of 54,349 new cases in 2010 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 52,318 cases in 2010 consisting of 43,734 complaints, 7,014 investigations of agents, brokers and adjusters, and 1,570 inquiries. Complaints were closed as follows: 7,282 were upheld and/or transferred for prompt pay review; 4,274 were not upheld but adjusted; 26,270 were not upheld. 5,908 were duplicates, withdrawn or suspended. The following Chart shows closed complaint activity by type of complaint.

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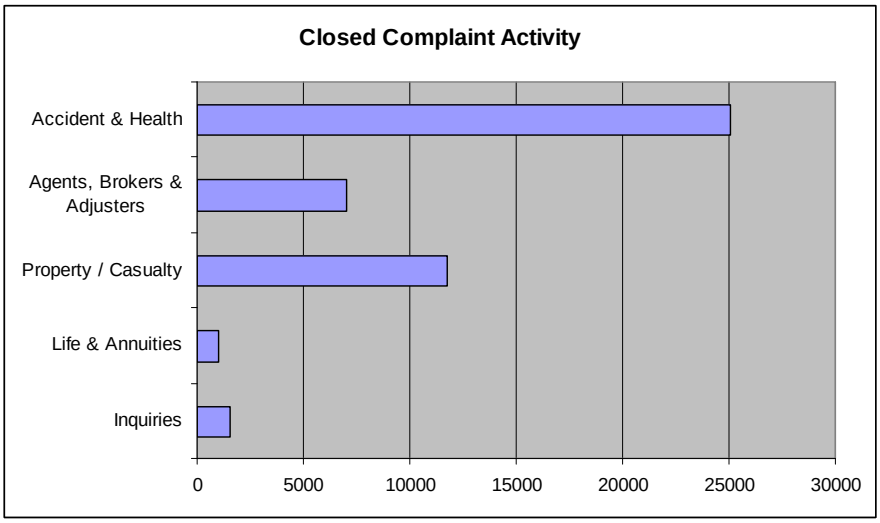
Chart I



5. Consumer Recoveries and Reinstatements

The Bureau tracks the dollar amount that complainants recover as a result of filing complaints with us. For 2010, Bureau examiners were successful in obtaining a total of $48,283,000 in recoveries for consumers. Additionally, the Bureau requested that various insurers offer reinstatement to over 83,600 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 that 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, and monetary penalties imposed with corrective actions to address violations.

For the 2010 calendar year, the Unit handled 394 disciplinary actions with the following results.

Stipulations	280
License Surrenders	64
Revocations	29
Total Fines collected	$3,757,267
Total Fines Agreed	$4,143,267

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A. Disciplinary Actions

Below is a synopsis of some of the more prominent cases.

Agreed to Pay a Monetary Penalty

Citicorp Insurance Agency, Citicorp Investment Services, SBHU Life Agency - $2,000,000 – did not present complete, accurate and/or timely Disclosure Statements to applicants as required under Regulation 60. On certain occasions the respondent did not adequately process and resolve client complaints pertaining to the sale of life insurance policies and annuities.

Cinergy Health - $500,000. – utilized misleading advertising on late night television, the Internet and through telemarketers to sell low cost health insurance plans to consumers who believed they were buying comprehensive health insurance but received limited benefit health insurance plans, which normally provide substantially less than comprehensive hospital/medical coverage. When injury or illness occurred and consumers filed claims, many found that their claims were not covered, and they were left with large unpaid medical bills.

Allianz Agents - $566,707 – This investigation is ongoing and is targeting insurance agents who sold annuities issued by unlicensed insurers to New York State residents by claiming that the transactions occurred outside of New York. Eight agents signed Stipulations to Surrender their licenses with the full force and effect of revocation and two licenses were revoked after a hearing. We anticipate more fines will be collected during 2011.

More than $310,000 has been collected from respondents that conducted and/or allowed certain employees/individuals to conduct business in New York without being properly licensed. Respondents include but are not limited to the following:

Hewitt Insurance Brokerage, LLC. - $136,800
Triad Group $57,100
Cool Insuring Agency - $50,000
Turner Surety & Insurance Brokerage Inc. $23,750
Cambridge Integrated Services Group Inc. - $12,445
Bob Bader Company - $11,050

David Lerner and Associates - $255,000 - did not provide required information to consumers relating to the replacement of variable life insurance policies and annuity contracts, in violation of Regulation 60. David Lerner Associates agents admitted to having customers sign blank, undated forms which were later filled in with boilerplate language by unlicensed employees. The employees had no direct contact with the customers or knowledge of the reason for the replacements, the release states.

Protection Plus Service Corporation - $40,000 – acted without the proper service contract registration.

B. Revocations by Hearing

Thomas J. Evangelista – Failed to account for more than 400 instances of collateral accepted by his bail bond business totaling over $700,000.

Freedom Bail bonds, LLC and Laurence T. Lewitas – failed to return $92,215 in collateral to indemnitors, failed to properly account for 96 Powers of Attorney concealing the failure to remit

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$25,252 in bail bond premium, misappropriated $4.5 million in fiduciary funds entrusted to his company in connection with real estate transactions and failed to cooperate with the Department.

Larry P. Vogel – solicited, negotiated and sold at least 10 annuities issued by Allianz Life Insurance Company of North America, an unauthorized insurer, falsely stated that the applicants signed the contracts in Florida when they were actually signed in New York, failed to comply with replacement requirements of Regulation 60 and failed to pay New York State income taxes.

Diggity Dog Online inc, t/b/a BARILLAN Corporate Insurance Brokerage and Jeremy Barillan - failed to remit or account for insurance premium totaling $261,559.06, commingling, failure to pay personal income taxes, interest and penalties of approximately $125,475, and failure to cooperate with the Department.

Brittany Brokerage Ltd. and Miles Kirschner – failed to timely remit or otherwise properly account for insurance premium payments totaling $65,260.81, issued inflated premium invoices, failed to pay New York State income taxes, interest and penalties in the amount of $2,705.99 and provided false statements during an Examination Under Oath conducted by this Department.

Joseph S. Kreiger, individually and t/b/a The Genesee Agency – violated numerous New York Auto Insurance Plan (NYAIP) rules, submitted 587 in-transit applications to the NYAIP, failed to interview over half the insured's as required, allowed unlicensed individuals to process applications, used his own address as a garaging location which was fictitious, charged more than $75 as a service fee on all 587 policies and indicated on the applications no service fee was collected.

All Star Affiliated Brokers Inc. - failed to remit or refund insurance premium timely or at all, issued false temporary automobile insurance I.D. cards, dishonored a premium check and failed to cooperate with the Department

C. Stipulation to Surrender with Full force and Effect of Revocation

Samet & Associates LLC. Shiya Samet – submitted applications for life insurance to the insurance company that contained false and/or inaccurate financial information, negotiated and sold a policy for an unauthorized insurer in New York and failed to cooperate with the Department.

Eric Berlin – forged another's name on three variable annuity applications and submitted them to the carrier.

Peter J. Puglisi – completed and submitted to the insurance company applications for long term care insurance that contained false and/or incomplete underwriting information.

Matthew R. Pettenato – allowed an unlicensed and previously revoked individual to conduct business in New York.

UMGA Easet Insurance Agency, National Brokerage and Chris Ferraro –allowed an unlicensed individual to conduct business on behalf of National Brokerage, pled guilty to Falsifying Business Records 2nd degree, Scheme to Defraud 2nd degree, and provided untrue and incorrect information on an application for licensure with the Department regarding previous convictions.

Pape Seck – Convicted of insurance fraud and forgery.

John Craig Sterling – Was convicted of a felony within the meaning of Section 2110(a)(7) of the Insurance Law in that on or about December 11, 2009 he was convicted, upon a plea of guilty, of willfully aiding and assisting in the preparation of false income tax returns.

Rana Ilyas – demonstrated untrustworthiness to act as an insurance producer when he fraudulently notarized various documents related to the assets and estate of another and as a result, he surrendered his notary commission.

Edward Bolling Jr. – acted as a bail agent in the name of All Bail Inc., a corporation that was not licensed in New York.

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Barbara Durkin – acted as a life agent in New York without a license.

7. Insurance Company Fines and Stipulations

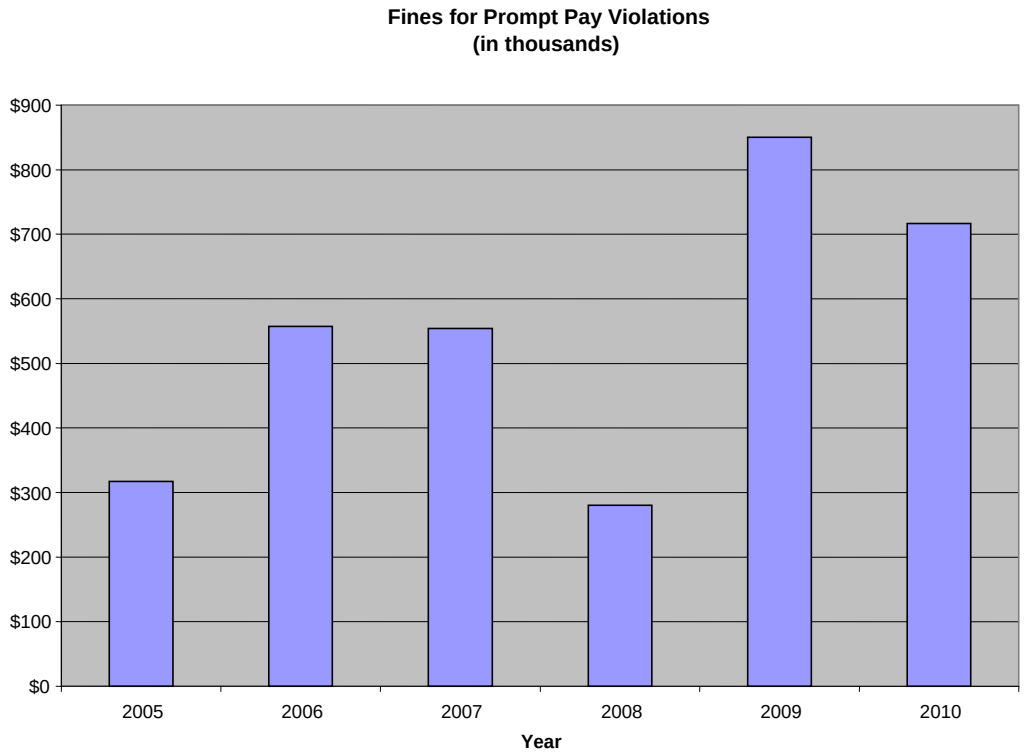
The Bureau assesses fines on insurers when systemic violations of the law or regulations are uncovered during the investigation of complaints. After remedial actions by insurers, stipulations are signed by the companies and appropriate fines assessed. CSB did not assess any fines during 2010.

8. Prompt Payment Statute

Section 3224-a of the New York Insurance Law, also known as the Prompt Pay Law, became effective January 22, 1998, and was amended effective January 1, 2010. Under the statue, insurers, health maintenance organizations (HMOs) and municipal cooperative health benefit plans are required to pay undisputed health insurance claims submitted by internet or electronic mail within 30 days of receipt, and claims submitted by any other means within 45 days of receipt. Requests for additional information or claim denials must be made within 30 days of receipt.

In 2010, $716,800 in prompt pay fines were levied against 20 health insurers and HMOs.

CHART J



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9. External Appeals Process

Under Article 49, Utilization and External Appeal, consumers have the right to request that a review of certain coverage denials be conducted by medical professionals who are independent of the health care plan issuing the denial. An external appeal can be requested when a health plan denies insurance coverage because they deem specific health care services to be experimental or investigational, not medically necessary, for treatment of a rare disease or for participation in a clinical trial. Additionally, consumers covered by an HMO may file for an external appeal when their requests for out-of-network exceptions are denied and the HMO offers an alternate in-network treatment.

During 2010, Consumer Services assumed responsibility for screening all applications for external appeal. Consumer Services staff also perform all intake and support functions related to the application process, and responded to 5,910 calls on the dedicated external review toll-free line.

In 2010, the Department received 4,955 applications, representing a 14 percent increase from 2009. Of those 4,955 applications, 361 requests were closed because the health insurer voluntarily overturned the denial, 1,869 were determined to be ineligible and 2,370 were determined to be eligible for assignment to an external appeal agent. Forty percent of the applications assigned to external appeals agents, a total of 940, were overturned in full or in part.

This table summarizes the appeals received and the appeals closed for 2010 and the preceding five years.

Summary of External Appeal Applications Received by Year

Year	Received	Ineligible	Voluntary Reversals	Upheld	Overturned*
2005	2,475	649	214	829	707
2006	2,858	787	287	867	823
2007	2,987	887	289	918	787
2008	3,920	1,566	325	1,145	890
2009	4,260	1,783	350	1,218	815
2010	4,955	1,869	361	1,430	940

Voluntary Reversals - Plan overturned their denial before the appeal submitted to a reviewer
Ineligible - The appeal was not eligible for an external review
** includes decisions that overturned the denial in whole and in part.*

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This table lists the number of external appeal determinations categorized by type of appeal.

External Appeal Determinations by Type of Appeal
January 1, 2010 through December 31, 2010

Type of Denial	Total	Overturned	Overturned in Part	Upheld
Medical Necessity	2,168	683	161	1,324
Experimental/Investigational	196	90	1	105
Clinical Trial	4	4	0	0
Out-of-Network	2	1	0	1
Rare Disease	0	0	0	0
Total	**2,370**	**778 (33%)**	**162 (7%)**	**1,430 (60%)**

This table identifies the external appeal results by agent.

External Appeal Determinations by Agent
January 1, 2010 through December 31, 2010

Agent	Total	Overturned	Overturned in Part	Upheld
IMEDECS	676	245	38	393
IPRO	843	276	67	500
MCMC	851	257	57	537
Total	**2,370**	**778**	**162**	**1,430**

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E. THE INSURANCE FRAUDS BUREAU

1. General Overview

The Frauds Bureau was established as 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. 2010 Highlights

- Investigations conducted by Frauds Bureau staff resulted in 668 arrests during 2010.
- A total of 1,236 new cases were opened for investigation in 2010.
- The number of criminal convictions obtained by prosecutors in Frauds Bureau cases totaled 449 for the past year.
- Court-ordered restitution totaled $6.6 million during the past year as a result of Frauds Bureau criminal investigations, up by more than 29 percent over the total for 2009.
- Upstate Frauds Bureau investigators were part of a group that received the Arson Team of the Year Award for the successful investigation and prosecution of a man convicted of setting a fire at a home he owned in which a tenant died.
- Arrests for the Bureau's Auto Unit reached 252 at year-end 2010, up from 219 in the prior year, an increase of 15 percent.
- The Bureau's Medical Unit recorded 159 arrests during 2010.
- An investigation into illegal activities at Oriska Insurance Company concluded in May 2010 with the sentencing of three defendants. As part of the resolution, more than $860,000 was forfeited to the U.S. government. The Frauds Bureau received $346,000 of the forfeiture as a full partner with the FBI in the investigation.
- Beginning this year, insurers will report annually to the Frauds Bureau information concerning the incidence of misrepresentations by New York residents of the principal place where their vehicles are driven and/or garaged.
- An investigation by the Medicare Fraud Strike Force led to the arrest of a surgeon on charges that from 2/09 to 1/10, he overbilled Medicare, Medicaid and five private insurance carriers by $3.5 million.

3. Team Building

Continued team building was high on the Frauds Bureau's agenda during the past year. Our-multi-agency activities included working with the insurance industry, prosecutors and law enforcement agencies on the federal, state and local levels who increasingly seek our expertise in the development and investigation of their cases.

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a. Multi-Agency Investigations

Several successful multi-agency investigations are summarized below.

Jeffrey Alnutt, who was convicted on 5/10/10 of charges that he set a fire in 2007 at a home he owned in which a tenant died, was sentenced on 8/19/10 for those charges. Alnutt received a sentence of 25 years to life on a murder conviction; 5-to-15 years on second-degree manslaughter; 25 years on second-degree arson; 5-to-15 years on third-degree arson; and time served on second-degree reckless endangerment. He had previously been convicted of setting fire to another home he owned in 2004 and is serving 5-to-15 years in that case. All the sentences are to be served concurrently. Alnutt's daughter and son-in-law also got jail time for their part in the 2004 scheme. An investigation conducted by the Frauds Bureau, the Fulton County DA's Office, the Gloversville Police and Fire Departments, the State Police and the State Office of Fire Prevention and Control resulted in successful conclusions in these cases.

The Frauds Bureau and the Suffolk County DA's Office conducted an investigation that led to the arrest of five defendants charged with 300 thefts of luxury auto wheel rims and tires from cars parked in residential driveways and auto dealership lots across Suffolk County. Investigators executed 11 search warrants and recovered 65 rims. The crew members divided the stolen goods among themselves for resale. The cost of the thefts and damage to the affected businesses and vehicles is estimated at more than $250,000. On 3/8/10, the leader of the ring and four other defendants were re-arrested and arraigned on weapons charges. Between June 2009 and January 2010, they sold 15 illegally possessed guns to undercover detectives. A subsequent investigation determined two of the guns had been used in the commission of felonies.

An investigation by the Medicare Fraud Strike Force, of which the Frauds Bureau is a member, led to the arrest of a surgeon on charges that from 2/09 to 1/10, he overbilled Medicare, Medicaid and five private insurance carriers by $3.5 million. On 9/22/10, investigators executed search warrants on the doctor's office at the same time he was being arrested and bank records were seized.

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 Bureau of Alcohol, Tobacco, Firearms and Explosives, the FDNY's Bureau of Fire Investigations and the NYPD's Arson Explosion Squad. 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 U.S. Attorney's Offices, the New York State DMV, the U.S. Postal Inspection Service and the FBI New York Health Care Fraud Task Force, 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 and collaboration among the many agencies involved in fighting insurance fraud. Participation provides the opportunity for joint investigations, information sharing, networking and honing investigative skills.

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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 16 Senior Investigators and 18 Investigators who staff the Bureau's specialized units: Major Case, Arson, General, Auto, Workers' Compensation, Medical, No-Fault, Mortgage and Title (established in 2009) and Upstate. Each Unit is supervised by a Deputy Chief Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of two Assistant Chief Investigators.

A 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, insurance industry and community groups. The Training Officer reports to the Chief Investigator. The Bureau's Director, Deputy Director and members of the investigative staff also provide training to these groups throughout the year.

In addition, the Bureau has a unit that includes a Senior Insurance Examiner and an Insurance Examiner who report to a Principal Insurance 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 also perform market conduct examinations of insurer Special Investigations Units.

The Bureau also has one support staff member who reports to the Secretary to the Director.

5. Investigations

The Frauds Bureau received 24,161 reports of suspected fraud in 2010, versus 24,920 reports received the year before. Of the 2010 total, the vast majority – 23,409 – were received from licensees required to submit such reports to the Department and 752 were received from other sources, such as consumers and anonymous tips. A total of 1,236 new cases were opened for investigation during the past year. Investigations also continued in numerous cases opened in prior years.

During 2010, the Bureau referred 412 cases to prosecutorial agencies for criminal prosecution.

6. Arrests

Frauds Bureau investigations led to 668 arrests for insurance fraud and related crimes during the past year. In one case, a former employee of an insurance agency that wrote policies for National Income Life Insurance Company received a 1099 form for commissions he purportedly received based on policies that were written after he left the agency. He reported the matter to the Nassau County Police Department who notified the Frauds Bureau and an investigation was initiated. Evidence indicated that five agents were involved in a scheme that used identity theft, falsifying business records and forgery to establish fake insurance policies, earning commissions and guaranteed bonuses based on selling those policies. The five defendants were arrested on 5/13/10 and charged with using the company-issued agent code of the former employee to write the policies and forging his signature to cash the commission checks.

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7. Civil Enforcement and Restitution

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 commenced 31 civil fine proceedings in 2010. Of those, 24 were settled by stipulation and 7 went to hearings. Fraudulent homeowners, workers' compensation and disability claims were among the types of civil fine cases in 2010, in addition to fraudulent auto theft and vehicle arson. As a result of the Bureau's civil enforcement activities, $370,405 in penalties was imposed during 2010.

Court-ordered restitution totaled $6.6 million during the past year as a result of Frauds Bureau criminal investigations, up by more than 29 percent over the total for 2009. Moreover, insurers saw savings of $9.3 million in connection with fraudulent claims investigated by the Bureau versus $4.0 million the year before, or more than twice the 2009 total and the highest savings total since 2004.

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. Yearly recertification in firearms aptitude is required by the Division of Criminal Justice Services. However, all Frauds Bureau investigators must recertify semi-annually, demonstrating the importance the Bureau attaches to the responsibilities involved in carrying and using firearms.

b. Outreach

Three training sessions were conducted at the New York City Police Academy during 2010, attended by 1,102 recruits. In addition, two sessions were given to 56 recruits at the Westchester County Police Academy. The Bureau has placed great emphasis on the training of police recruits because police officers are often the first responders to auto accidents and other emergency situations and their ability to recognize insurance fraud can be critical to an investigation.

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 2010. 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 26 groups comprising 1,971 participants during 2010.

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9. Fraud Prevention Plans/Public Awareness Programs

Section 409(a) of the New York Insurance Law (NYIL) and Department Regulation 95 require all insurers writing automobile, workers' compensation and accident and health insurance that write at least 3,000 policies annually to submit to the Department a Fraud Prevention Plan (Plan) that includes establishing a Special Investigations Unit (SIU) separate from claims and underwriting. The SIU is responsible for investigating cases of suspected fraud and for implementation of the fraud prevention and reduction activities.

Affiliated insurers writing the same lines of business may submit one Fraud Prevention Plan covering the entire group of insurers. Additionally, some insurance carriers submit multiple separate Plans which address different products. Insurers submitted 25 new or revised Fraud Prevention Plans to the Frauds Bureau in 2010, covering 58 insurers. At year-end 2010, there were 137 approved Plans on file.

Plans submitted by two newly licensed life settlement providers were approved during 2010. Fraud Prevention Plans are required to be submitted with each life settlement provider's application for licensing. During the past year, 40 life settlement providers submitted Fraud Prevention Plans to the Department with their license applications.

Regulation 95 and Section 409(c)(5) of the NYIL require that insurers develop 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), a coalition of insurers, carries out advertising campaigns using newspapers, radio and television to target insurance consumers. NYAAIF members included 88 New York-licensed insurers or insurer groups with Fraud Prevention Plans on file. An additional 14 insurers that were not required to file Plans with the Department also participated in the NYAAIF's public awareness program. Additionally, 26 health plans or groups of affiliated health plans with filed Fraud Prevention Plans participated in the National Health Care Anti-Fraud Association's public awareness program which carries out campaigns using newspapers and radio advertising. The Life Insurance Settlement Association, an organization representing life settlement providers, also has developed a public awareness program in which licensed life settlement providers may participate. 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 Frauds Bureau also has a fraud hotline (1-888-FRAUDNY) and consumers are encouraged to report suspected insurance fraud. Calls to the hotline averaged 21 a week during 2010.

10. Electronic Filing of Annual SIU Reports

According to the provisions of 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 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. The Report form can be accessed and submitted through a secured portal environment on the Department's Web site.

11. Major Cases

The Frauds Bureau was involved in a number of multi-agency investigations during 2010. These operations, in addition to the day-to-day investigations conducted by Frauds Bureau investigators, contributed to the total number of arrests for the year. Some of these cases are summarized below.

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a. Title Insurance Fraud

On 1/27/10, Joseph DeVito and his wife, Mary Ann Palladino-DeVito, were sentenced to 1 2/3-to-5 years in prison. They were arrested on 7/1/09 and charged with stealing more than $1 million from clients of the title insurance agency they operated. They accepted payments for mortgage fees, mortgage taxes, customer fees, real property filing fees and escrow account funds and misappropriated the funds for their own purposes. They were also charged with failing to pay New York State personal income taxes from 2002 through 2004. On 1/19/10, they had pleaded guilty to grand larceny in the 2nd degree and allocuted to failure to pay income taxes for 2002, 2003 and 2004.

b. Owner Burns Landmark

An investigation by the Frauds Bureau, the State Police and the State Office of Fire Prevention and Control led to the 3/11/10 arrest of the owner of a Cortland County landmark hotel and restaurant for allegedly setting fire to the property in the early morning hours of 8/28/07. No one was hurt in the fire. The suspect was paid $137,000 on an insurance claim he filed with Penn-Star Insurance Company. Investigators learned that the holder of a mortgage on the building was expected to bring foreclosure actions against the suspect two weeks before the fire. Moreover, two days before the fire, the suspect allegedly removed NASCAR mementos that he owned and stored in the restaurant. Arson investigators used an accelerant detection canine to uncover evidence at the scene.

c. Trumped Up

A two-year investigation conducted jointly by the Frauds Bureau, the Town of Kent Police Department and the Putnam County DA's Office led to the arrest on 4/19/10 of a liquor-store owner accused of arson and insurance fraud. He originally reported that he was assaulted, robbed, tied up and left in his burning liquor store by four unknown persons on 5/24/08. However, the investigation revealed that his business was in financial ruin. The bank had begun foreclosure proceedings and he owed $39,000 in unpaid state taxes. He was seen running from the store before the fire triggered an alarm at 11:40 p.m. When the police arrived, they found him standing outside the store with his hands bound behind his back. He was charged with setting the fire deliberately in an unsuccessful attempt to collect an insurance payment.

d. Guilty

Jonathan Boxman, who controlled a real estate title insurance company licensed in New York and various other title abstract companies and agents, pleaded guilty in early May 2010 to wire fraud for bilking clients of more than $1.7 million, including almost $385,000 from a church in Queens. His companies acted as settlement or escrow agents in real estate deals. They received large sums of money to pay mortgage recording fees, real estate taxes and other fees attendant to the purchase of commercial and residential properties. However, an investigation by the Frauds Bureau and the FBI revealed that Boxman instead used the money collected to pay the operating expenses of his companies. As a result, several mortgages and deeds went unrecorded. He faces up to 20 years in prison when he is sentenced.

e. Health Care Fraud

An investigation by the Frauds Bureau, the Office of the U.S. Attorney for the Eastern District and the NYPD led to the 6/15/10 arrest of 17 defendants (an 18th defendant who had fled to Florida was arrested on 6/17) for their participation in health care fraud and money laundering schemes. Agents from Immigration and Customs Enforcement, the IRS and the FBI executed search warrants at the offices of 12 durable medical equipment retail companies that were operated by the defendants in Brooklyn and seized bank account assets. The defendants allegedly used their companies to submit fraudulent invoices to private no-fault insurers for reimbursable expenses for durable medical

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equipment at prices much higher than the price paid by the defendants, as well as for durable medical equipment that was never obtained. They laundered the proceeds by issuing checks to their companies which were cashed at various check-cashing facilities and the cash was delivered back to the defendants.

f. 2007 Murder Leads To Arrest

An investigation by the Frauds Bureau and the Workers' Compensation Board's Office of the Fraud Inspector General resulted in the 6/17/10 arrest of a Norwich, NY, property owner for failing to obtain workers' compensation insurance coverage for an employee who managed several of his apartment buildings. The employee was raped and murdered inside an apartment in one of the buildings in 2007. The tenant of that apartment was sentenced to life in prison for the crime. Authorities learned of the defendant's failure to secure the coverage when the employee's estate filed a death benefit claim with the Workers' Compensation Board. The defendant reimbursed the Board $50,000 that it had paid the employee's estate, $5,000 in funeral expenses and another $6,000 in penalties. He also has an outstanding $30,000 penalty for operating without insurance in 2010. He is disputing that penalty, claiming he has no employees.

g. Chiropractor Sentenced

Dr. Anthony LaTona, a Queens chiropractor, was sentenced on 7/14/10 to a conditional discharge and waived his rights to future claims totaling $8.5 million. He was convicted on 6/3/10 of insurance fraud in the 3rd degree after investigators found that he convinced a "patient" to fabricate injuries and then billed Empire Blue Cross and Blue Shield more than $26,000 for medical treatments over a three-month period. He paid a $1,000 kickback to the "patient" who was actually a Frauds Bureau undercover investigator. At a meeting on 9/16/08, LaTona instructed the undercover to fake back and knee injuries in order to obtain insurance payments. The undercover operation commenced as a result of information received that Dr. LaTona had paid kickbacks to Verizon employees in order to use their medical information to bill insurance companies.

h. $6.7 Million Stolen

The owner and president of a title abstract company and his company were indicted on charges of stealing more than $6.7 million in connection with more than 105 real estate transactions. His company acted as a title agent for various title insurance companies, primarily Stewart Title Insurance Company. Between November 2006 and April 2008, he and his company allegedly failed to record the deeds, mortgages and other documents on 105 real estate closings, diverted the money to various accounts and then depleted the accounts. Stewart Title, having been obligated by the defendant and his company to insure the transactions, ultimately sustained the loss from the thefts and paid nearly $5.4 million to cover unpaid fees and taxes. The Frauds Bureau and the Manhattan DA's Office pooled resources in the investigation that led to the arrest on 8/5/10.

i. Strike Force Success

An investigation by the Medicare Fraud Strike Force, of which the Frauds Bureau is a member, led to the 9/22/10 arrest of a surgeon on charges that from 2/09 to 1/10, he defrauded Medicare and numerous other health care benefit programs of at least $3.5 million. Investigators began reviewing the doctor's practice after receiving complaints from patients who said the doctor had submitted claims for services they had not received. He allegedly consistently filed claims for office visits, examinations and subsequent surgical procedures as if he were treating unrelated conditions, when in fact he was providing follow-up services related to an initial procedure. In addition, he often billed for working more than 24 hours in a day. A search warrant was executed at his office on the day of his arrest and bank records were seized.

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j. Broker Caught

An investigation conducted jointly by the Frauds Bureau and the Queens DA's Office led to the 11/22/10 arrest of a licensed insurance broker who was the president and owner of two insurance brokerages in Queens. According to the charges, the defendant failed to remit $606,770 in premium payments that she had received from more than 400 clients between 1/1/09 and 12/31/09. Her actions defrauded four insurance companies – Maya Assurance, American Transit, Hereford and Fiduciary Insurance Company of America – of premiums owed. In addition, she submitted 43 checks totaling $121,750 to two of the insurers in an attempt to conceal the crime. The checks were returned because of insufficient funds.

12. Special Prosecutor Program

Created in 2006, the Special Prosecutor Program is a pilot program initiated by the Insurance Department in which Frauds Bureau attorneys assist local DA's Offices with insurance fraud prosecutions. In 2010, the program expanded to 14 participating county prosecutor's offices that have executed Memorandums of Understanding with the Department. 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. Rensselaer and Dutchess Counties are the two most recent District Attorney's Offices to participate in the program. A case prosecuted in Rensselaer County under the program in 2010 is summarized below:

- Heidi Laviolette was seriously injured in an automobile accident after she attempted to drive home from a party intoxicated. She was taken to an area hospital where she was treated for a broken ankle, a fractured rib and a collapsed lung. She was later charged with DWI (Driving While Intoxicated). Several months later, she was arrested and again charged with DWI in connection with another incident. As part of her plea bargain, she pleaded guilty to the second DWI charge and the earlier charge was dismissed. Laviolette then filed a $62,000 insurance claim with GEICO Insurance Company for the medical bills associated with her initial accident, stating that she was not the driver but a passenger in the car when the accident occurred. Under New York's then-existing no-fault insurance law, which was applicable in this matter, drivers can be denied coverage for medical bills that result from injuries incurred in accidents that are caused by the fact that they are driving while intoxicated. GEICO referred the matter to the Frauds Bureau for investigation which revealed that Laviolette was in fact the intoxicated driver in the initial DWI charge. On 9/8/10, she was arrested and charged with insurance fraud. Under the Special Prosecutor Program, Laviolette admitted to driving intoxicated and pleaded guilty to felony insurance fraud on 12/6/10. She also agreed to enter an 18-month drug and alcohol treatment program. If she fails any part of the program, she will face seven years in prison.

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 and Westchester Counties DA's Offices.

13. Health Care Reform 2010

The Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, 2010, will put in place comprehensive reforms to the health care system in the United States. Each state will be required to implement its provisions as outlined in the law. Although this is a federal law, the regulation of insurance, including health insurance, remains the responsibility of the states.

After the U.S. Department of Health and Human Services noted an increase in health care-related crime only weeks after enactment of the legislation, the New York State Insurance Department issued a warning to consumers to be aware of bogus health insurance plans. The fake insurance plans are

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being peddled by scammers hoping to take advantage of public confusion over the new health care provisions. The Department urged consumers to keep in mind certain red flags to recognize health insurance fraud, such as high-pressure sales tactics, door-to-door sales and TV ads with toll-free numbers, adding that what seems too good to be true often is.

In addition, the Department advised senior citizens to be on the lookout for fraud as they began to receive their $250 rebates for Medicare Part D prescription drug costs under the new federal reforms. The one-time, tax-free rebate is being sent to eligible senior citizens to help them pay for the gap above the initial prescription drug coverage limit but below the point where catastrophic coverage begins, known as the "doughnut hole." There have been some reports of seniors being contacted and told they must disclose personal information in order to receive their rebates or that rebates must be transferred to a third party. This is simply not true but these tactics can be confusing and intimidating.

The Frauds Bureau is monitoring reports of suspected fraud in these areas to ensure that any potential fraud schemes are promptly investigated and handled appropriately.

14. NAIC Internship Program

Now in its seventh year, the National Association of Insurance Commissioners' International Internship Program seeks to advance working relations with foreign markets with an emphasis on the exchange of regulatory techniques and technology. During two sessions held in April and May 2010, the Frauds Bureau hosted NAIC intern Jan Bursa of the Czech Republic. Intern Atika Kriamorn of Thailand participated in a third session in October. The presentations included an overview of Frauds Bureau operations and insurer compliance with fraud-fighting mandates, including establishment of Special Investigations Units and fraud reporting provisions as required by Article 4 of the New York Insurance Law.

15. Mobile Command Center

In response to a tornado that touched down in Queens on 9/16/10, the Department deployed its Mobile Command Center to the area. The vehicle proved worthy of the name "Mobile," staging at four separate sites during the five days of its deployment. The first stop was busy Queens Boulevard on September 21 where the Frauds Bureau's Technical Manager of the MCC Nikki Brate and Investigator John Toucher were on board to set up shop. Moving the MCC within the city required close coordination with the New York Police Department and the New York City Office of Emergency Management.

During the recovery efforts, staff from the Consumer Services Bureau were available to answer questions regarding insurance policies and coverage, as well as to assist with insurance-related complaints. In addition, the Department activated its Disaster Hotline to provide additional assistance to those consumers who were unable to travel to the MCC sites.

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 2010, 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's portal using secure accounts.

The benefits of FCMS to insurers include automatic acknowledgment of fraud reports, and 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. Staff from the Frauds and Systems Bureaus regularly monitor the system and make improvements and changes as necessary.

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17. Directions for 2011

a. Amendment to Insurance Law Section 405/Rate Evasion Reports

On March 23, 2010, Insurance Law Section 405 was amended to require the Insurance Frauds Bureau to include in its Annual Report to the Governor and Legislature the incidence of misrepresentations by insureds of the principal place where their vehicles are driven and/or garaged.

In order to compile information to comport with the amended law, the Insurance Frauds Bureau issued a data call on December 10, 2010 to all licensed property/casualty insurers writing private passenger automobile insurance with 3,000 or more policies in effect. The data call requested specific information concerning misrepresentations by New York residents that involved locations within New York State as well as locations outside of New York State.

Approximately 92 percent of the personal line automobile insurance market responded to the data call. An analysis of the data revealed that in 2010, over 10,000 New York residents misrepresented where their vehicles were either garaged or driven, resulting in a loss of $23.8 million in insurance premiums.

The data analysis also revealed that 77 percent of the aforementioned misrepresentations involved a location within New York State and 23 percent involved a location outside of New York State.

Nassau, Westchester and Suffolk were the top three counties used by those New York residents who misrepresented the principal place where their vehicles were garaged and/or driven and used a location within New York State for those misrepresentations.

Florida and Pennsylvania were the top two states used by those New York residents who misrepresented the principal place where their vehicles were garaged and/or driven and used a location outside of New York State for those misrepresentations.

The vast majority of those New York residents who made the aforementioned misrepresentations resided in Kings County followed by Queens and Bronx counties respectively.

b. Proposed Revision to Regulation 68

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 Web site 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.

c. Life Settlements

In November 2009, legislation pertaining to life settlement providers was passed by the Assembly and Senate and signed into law by then-Governor of New York State David A. Paterson. The law marks the first time the life settlement industry has been regulated in New York.

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The Life Settlement Act provides a 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.

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 law provides that a fraudulent life settlement act is committed when a person knowingly and with 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 that contains materially false information concerning any material fact, or conceals for the purpose of misleading, any information concerning any material fact. The Frauds Bureau will collaborate with the industry and law enforcement in the investigation and prevention of life settlement fraud.

The provisions of the life settlement fraud statute range 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 thereof, 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 thereof obtain property having a value greater than $1 million.

The Department licensed two life settlement providers in 2010 – FairMarket Life Settlements Corp. and Magna Life Settlements, Inc.

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 intentionally 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;
- Creating a class E felony for possessing or uttering a false insurance document/instrument; and
- Increasing penalties in the Vehicle and Traffic Law to reduce the number of uninsured or unlicensed motorists in New York State.

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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 2010 Frauds Bureau Annual Report is available on the Department's Web site at www.ins.state.ny.us.

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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.

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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 2010, 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. 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 2010. The Department's activities and applications are reflected on these sites.

In 2010, there were 4,315,270 unique visits to the Department's Web site, a 2.2% increase from 2008. In addition, overall Hits (page views per Visit) increased in 2010, reaching 38,226,321, 10.6% higher than in 2009. The number of visits per month is displayed in Chart K. The two charts following Chart K display how many Visits and Hits by Year occurred since 2000.

CHART K

New York State Insurance Department Web Site Activity - Unique Visitors

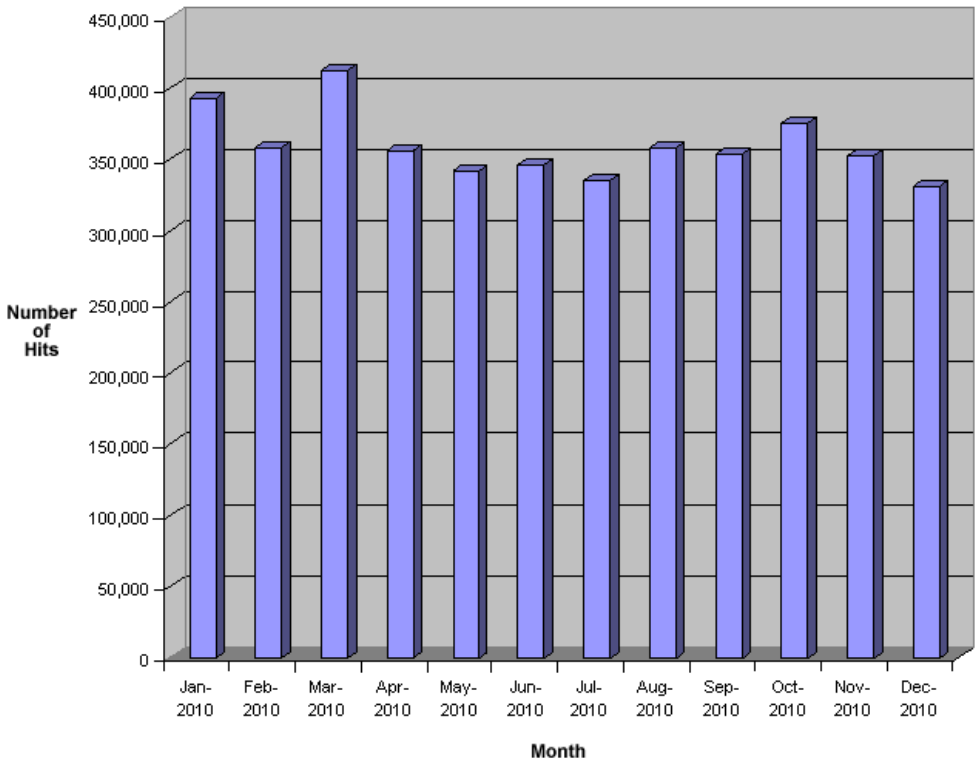

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CHART L

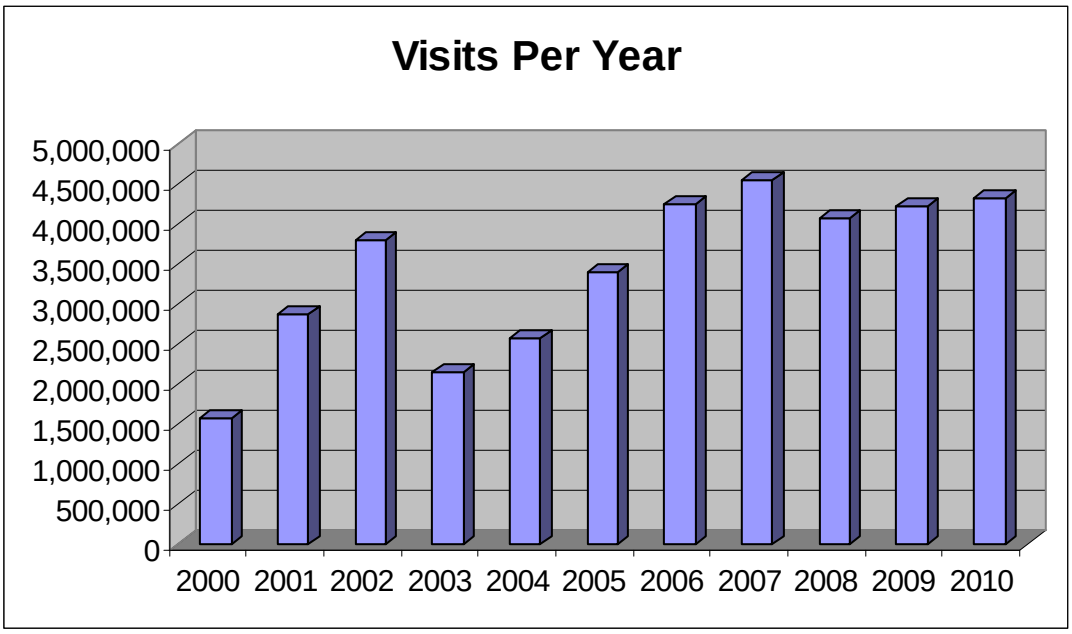
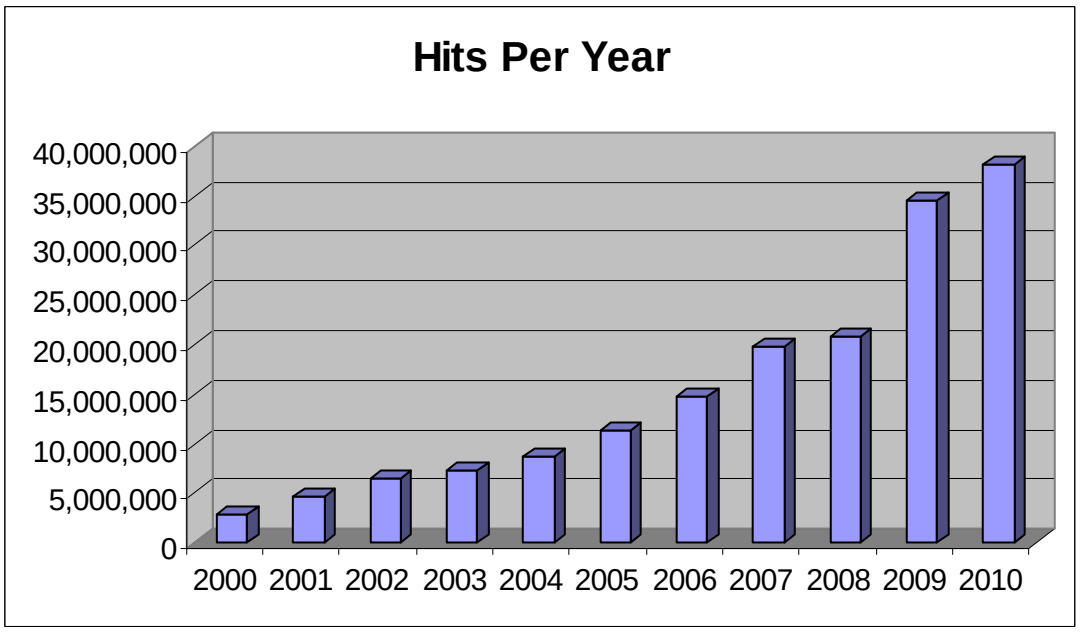


CHART M



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 2010:

- Captive Insurance Solutions Web site – New layout with improved navigation

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- Customer Satisfaction Survey: Based on visitor feedback to our Web site via the CIO/OFT sponsored survey, various improvements were made to the Web site to make it more usable.
- Data Call: Misrepresentations of the Location Where Vehicles are Garaged or Driven
- ELECTRONIC FINGERPRINTING (Licensing):
  - Adjusters, Bail Bond Agents, and Life Settlement Brokers
  - Officers and Directors
- Frauds Arrests News Retention Policy:
  - The Department has adopted a new retention policy about these news releases. News items relating to specific arrests will only be hosted via our Web site going back three calendar years. For example, in 2010 the earliest news items will be from 2007.
- Health Care Reform resource, including:
  - Prior Approval Rate Filings:
    - Approval Transitional Guidelines
    - Community Rated Medical Renewal Rate Review Checklist
    - Medical Renewal Rate Filing Summary Template
    - New Rate Change Notices, Comments Received, and updated index
  - Changes to Healthy NY as a result of Federal Healthcare Reform.
  - Health Insurer Filing Guidance
  - Health Insurer Information: Tips for Successful Form and Rates Filings;
  - Immediate Market Reform Frequently Asked Questions
- HOME page layout:
  - It's a cleaner layout, less cluttered than the previous, and consistent with the efforts of the Insurance Filings Modernization Initiative (IFMI).
- Insurer Climate Risk Disclosure Survey
- Licensing - Life Settlement Brokers: Application Forms and Instructions
- Life Settlements Guidance
- Long Term Care Report (biennial) – 2009
- Medicare Beneficiaries information: Benefit Chart of Medicare Supplement Plans Effective on or after June 1, 2010
- Office of General Counsel:
  - New Insurance Law and Regulations page
  - Section layout
- Property Bureau Data Call: "Professional Medical Malpractice Insurance Reporting Requirements"
- Property Guidelines - Checklists and Questionnaires: Introduction of Compliance Questionnaire for Travel Property Insurance
- Regulations: "Invitation for Public Comment on Insurance Department Rules" - per Executive Order #25
- Senior Citizens Resource Center:
  - New layout
  - New Medicare and Health information
- Site Index:
  - The Site Index provides links to the bulk of the major resources on our Web site, replacing the former Frequently Accessed Information, Industry Resources, and Site Map pages.
  - The index is comprised of two subsections: (1) Primary Categories (Agents and Brokers, Consumers, Insurers, etc.) and (2) Department Resources (includes a large quantity of more specific resources). In addition, it helps minimize potential HOME page clutter.
- Web site icon: When visitors hit the Web site HOME page, a small black-and-white NYS seal icon will appear in the address bar and tab, and it will carry over to other pages on the Web site, and our sub. It will store within favorites when visitors bookmark NYSID pages, too.

Other major accomplishments include:

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- 10th Annual Report to the Governor and the Legislature on the New York State Certified Capital Company Program - June 1, 2009
- 11th Annual Report to the Governor and the Legislature on the New York State Certified Capital Company Program - June 1, 2010
- 2009 Annual Report of Superintendent of Insurance to the New York State Legislature
- 2009 Annual Report on the Healthy NY Program
- 2009 Annual Report to the Governor and the Legislature of the State of New York on the Operations of the Insurance Frauds Prevention Act
- 2009 Annual Statement information
- 2010 Consumer Guide to Automobile Insurance - HTML and PDF versions
- 2010 Consumer Guide to Health Insurance
- Annual Report on Insurance Agent Licensing Examinations
- Circular Letters - posted:
  - 18 new Circular Letters
  - Three new Circular Letter supplements
  - 22 Proposed Circular Letters for Public Comment
- CIO/OFT resource integration: "NYS Website Customer Satisfaction Survey", “Office of Taxpayer Accountability”, and “Citizen Contact”; 2010 Census - "More information" page
- Draft Regulations for Public Comment - nine drafts posted
- Examination Reports – over 90 reports posted
- Excess Line Broker Tax Filing - 2009
- Licensing section design updates
- Market Conduct Profile (2009)
- NYIN Alerts – 155 posted (over 660 have been posted since February 2003)
- Office of General Counsel – Selected Opinions: over 70 opinions posted
- Public Hearings – information sections formed for these hearings:
  - Workers' Compensation Loss Cost 2010
  - Reform of Rate, Form, Regulatory Filings and Licensing Applications
  - Export List - Regulation 41

2. Intranet

The Department’s Intranet is a strategic internal communication facility that contains a wide range of content relevant to Department staff. Work began to overhaul and update our Intranet as a whole, with plans for implementation in 2011. New elements implemented this year include:

- Disaster Section - Emergency Resource Guide:
  - This login-required section which specific staff can access contains the White Book guide of emergency resources and its own index page.
- HRM Announcements: CLE Calendar and Class Description page (replaces former Announcements/Training page)
- Travel Facts & Links: Tax Exempt Forms & Statement of Automobile Travel Form
- Training: In 2009, Training Index became an XML-based application which saves time for HRM and Systems to process each update. In 2010, new drop-down functionality was implemented for easier usability, including searching available Training opportunities. In addition, many Training announcements have been posted to the Intranet in 2010.
- Zoom Search – This new search utility replaces our previous Google mini search box and works more within fiscal constraints.

The Intranet is continually updated to facilitate quick exchange of information throughout the Agency. Other updated areas include, but are not limited to:

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- Annual Statement file links;
- Examination schedules;
- Department Newsletter (in its fourth year);
- Department Events;
- EAP postings;
- HRM vacancy announcements;
- General Administration Manual;
- Human Resources Management (HRM) Announcements;
- Online HelpCenter information
- Internal employee forms;
- PowerPoint presentations

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. Beginning with the 2007 filing that was March 1, 2008, all Foreign Insurers and foreign accredited re-insurers 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 Insurance Department has used an imaging and workflow system since 1998. The Complaint Imaging and Information Management System (known as CIIMS) is a full featured workflow imaging system used to automate and streamline the processing of consumer complaints while eliminating the handling and storage of paper. The system was created for use by Consumer Services, but has had numerous enhancements over the years and has been expanded for use by other units within the Department. Features of CIIMS and the data provided by CIIMS are now used Department-wide.

CIIMS was state-of-the-art technology at its inception and while it continues to function effectively, it uses older technologies, so a replacement is underway. The new system which will be browser based will go into production in 2011. It will incorporate all the functionality of CIIMS, but will be browser based and provide additional features 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.

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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

In February 2010, the office of the NYS CIO/OFT announced a mandate that all NYS Agencies would be migrated to a single email messaging platform called "NYSeMail" that is supported by the Microsoft email platform Exchange/Outlook. This change will have a major impact on the Insurance Department since the Department's email messaging system is supported by IBM/Lotus Notes. Since Insurance Department also has a significant investment in an application portfolio supported by the Lotus Notes technology, additional workflow and collaboration initiatives were suspended during 2010 while a comprehensive assessment of the change of email systems was completed, and impact determined. Agencies that have applications built on the Lotus Notes/Domino technology will be allowed to keep their applications, however, those applications will require re-engineering to be able to interface with the new NYSeMail system. The Insurance Department has chosen to proceed with any projects that were initiated prior to the issuance of the mandate, continue to support the Domino Application Portfolio until such a time as the applications can be migrated to other platforms, and to address any interface issues with NYSeMail. No new projects will be developed using this technology.

As a result of the foregoing, no new applications were released during 2010. Work efforts to complete the following will continue in 2011:

- 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.
- OGC Leave Request System – was created in response to the Office of General Counsel's need to be able to track staff requests for leave.
- Systems Requests Document Management System – additional components to be able to provide client on-line submission, and track video conferencing requests.
- Additionally, staff from the Domino Team worked with outside consultants to migrate the Department's External Appeals application to a new enterprise application. The migration was completed in early January 2011.

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

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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 2010, the Department processed 79,820 credit card transactions totaling $8,675,159 on behalf of our customers without touching paper forms, handling checks, or bank deposits.

In 2010, the Department began accepting monthly Motor Vehicle Law Enforcement Fee filings on-line. The 907 filings processed represented approximately 20% of the total filings received. The amount collected in 2010 was $12.6 million. The Department's 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 2010 the number of fire districts that opted to receive electronic payments was 1828. Now 91% of all fire districts receive their payments electronically and the dollar volume distributed this way was over $30.7 million. This increase in electronic payments continues to streamline what has traditionally been a paper intensive process.

7. Enterprise Portal

The Department's enterprise portal 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.

We are in the process of transitioning from one portal product to another. During that transition, we are making substantial improvements to the existing applications and adding new ones as well. We are replacing the portal itself, the application server software and hardware on which it runs, the back-end database that most of the applications used, and the security infrastructure. The net effect will be to have a new environment that is easier to use, richer in features, adopts more widely used industry standards, and is cheaper to operate. The first new portal applications went live at the end of 2010, and a period of coexistence for both new and old portals began. We expect to have completed the transition and to be able to shut the old portal software down by mid 2011.

The new portal also features extensive collaboration tools, some of which were being used by the end of 2010. These valuable productivity tools will play a growing role in Department projects and communications.

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. This model has been extended to the new portal, with some enhancements. Since 2007, we have released 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:

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- 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).
- The Healthy NY application allows for secure monthly filings describing Healthy New York enrollment on a by-county basis. Filers from over 20 companies complete these filings via either an on-line electronic form or by using a bulk load option which allows the submitter to upload an XML or comma separated file containing their submission data. In either method, data is parsed and stored in the database. Staff can then use a reporting module to run various queries against the data.
    - The Reg60 application allows for the secure submission of data mandated by the Insurance Law Section 308, Regulation No. 60. Designated Insurers, Societies, Agents and Brokers upload their data via an electronic file submission on an annual basis.
    - The Life Market Conduct application allows for the secure transmission of electronic documents. After being approved as submitters, individuals from specified companies log in and use the system to submit Microsoft Excel documents on an annual basis.
    - Excess Lines Premium Tax Filing – This application allows excess line brokers to complete a premium tax return and file it on-line with the Department.

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. This application was 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

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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) Pre-licensing Provider/Course Listing - Lists Pre-licensing 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.

- OGC Opinions (Office of General Counsel) is a full text search application on the old portal. 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. An updated version of this application for the new portal will also include extensive new features.

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 Iscsi SANs in Albany and NYC to allow tiered storage as well as worm capabilites
- Desktop,laptop, printer, and scanner rollouts
- Upgraded our load-balancing hardware to a newer more powerful model of netscaler

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- Server Virtualization. We have continued to eliminate physical servers as well as deploy new applications (ex NYICIS) on virtual platforms

9. Disaster Recovery/Business Continuity (2010 updates)

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 as the agenda for the meeting. 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 this fiscal year include redundant faxing capability in both Albany and NYC using the latest version of Rightfax. 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. Finally, Systems refreshed its parts of the Department’s Disaster Recovery plan.

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 2010, continued work on FCMS to improve case management, reporting and the process for filing IFBs.

The Frauds Bureau received approximately 24,000 IFBs in 2010. 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.

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G. OFFICE OF GENERAL COUNSEL

The Office of General Counsel's principal responsibilities include: providing the Superintendent, Deputy Superintendents, Bureau Chiefs, and the public with legal opinions and advice 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, the Securities and Exchange Commission, and 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 105 opinions in 2010. 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 OGC opinions 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 2010, OGC continued its work on the proposed conversion to for-profit status of Emblem Health, Inc. In 2011, 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 2010, the Department entered into approximately 391 stipulations imposing penalties on insurance companies or producers (i.e., agents or brokers). In addition, the Department conducted approximately 128 administrative hearings, which resulted in disciplinary action against approximately 60 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 2010, 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.

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

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3. Special Projects

The Office of General Counsel contributes substantially to many special projects undertaken by the Superintendent. For example, throughout 2009 and 2010, 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, two of which have been successfully restructured.

OGC attorneys also took leading roles in the Superintendent's Insurance Filings Modernization Initiative, working with other Bureaus to offer and implement a variety of recommendations to improve and streamline the Department's process for reviewing rate, policy, license, and other industry filings, enhance access by regulated entities and the public to information available from the Department, and reduce unnecessary costs and burdens on regulated entities.

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H. CAPITAL MARKETS BUREAU

1. General Overview

The Capital Markets Bureau (CMB), established 11 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 the Property Bureau.

Key initiatives from 2010 included:

- Furnishing examination support for the Property, Life and Health Bureau – including pre-planning and on-site participation.
- Reviewing new and amended Derivative Use Plans of insurers, and monitoring derivative activities.
- Analyze and closely monitor the Financial Guaranty Insurers, evaluate how they assess risk, interact with rating agencies, investment banks, and legislature on the subject.
- Applying financial analytics to investment portfolios of insurers, with a particular focus on sub-prime, commercial mortgages and other structured securities, as well as alternative assets, such as hedge funds, 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 Department effort to encourage insurer’s to adopt standards for contract certainty to reduce ambiguity in insurance coverage.

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- 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.

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

- Monitoring insurance companies securities lending activity.

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 identify 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 CMB. 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.

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.

2. 2010 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

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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 2010, 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
2010

Type of Company	**Priority 1** Desk Audits	Pre-Exam/4th Quarter Meeting Reports
Health	**17**	**8**
Life	**39**	**41**
Property	**67**	**37**
Total	**123**	**86**

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

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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
2010

TYPE OF REVIEW	LIFE	PROPERTY
New DUPs	**2**	**2**
Amended DUPs	**9**	**5**
Total	**11**	**7**

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. Training Initiatives

The CMB hosted two one day training seminars on Capital Markets Hot topics. The seminar was conducted by CMB staff and offered to all Department personnel. Over 200 employees attended during the 2 days.

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CMB also arranged and coordinated Risk-focused exam/Accreditation training for insurance examiners in the Property, Life and health Bureaus. One training class was a day and half given twice. The subsequent training call was a day long class given twice.

The 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.

e. Special Projects

The Capital Markets Bureau was involved in several special projects stemming from capital markets developments in 2010. 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 – CMB conducted a review of select insurers stress testing function in conjunction with the statutory examination.

- 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 across the entire organization. The CMB in conjunction with the other Bureaus conducted an assessment of 3 companies' ERM function.

- Financial Guarantors – Problems in US structured finance have caused credit concerns in the financial guarantor industry. The CMB has worked closely with many Department personnel 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.

- 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).

- Worked with the Life Bureau and company actuaries to improve the transparency of liability duration.

- Reviewed dynamic hedging programs.

- Monitor securities lending activity and work with the NAIC to enhance related reporting requirements.

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f. Other Activities

During 2010, the Capital Markets Bureau contributed to the formulation of legislative and regulatory proposals. These covered: (1) legislation related to increasing the number of licensed captive insurers; (2) proposed amendments to the Credit for Reinsurance Regulation to address collateral funding by non-U.S. reinsurers; and (3).a proposed regulatory amendment to recognize newer forms of letters of credit.

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 task forces, working groups, 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 chaired 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 led 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

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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.

New York followed this by leading the NAIC's reassessment of credit risk analysis for Commercial Mortgage-Backed Securities. This process, consistent with the CMB led Rating Agency Working Group's recommendations and with the RMBS reform, will reduce regulators' reliance on rating agencies.

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 Assessment Implementation Sub-Group

The Risk Assessment Implementation sub-group (RAIMS), reports to the Financial Examiner Handbook Technical group. 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.

Investments of Insurers Model Act Revisions Working Group

CMB is supporting this working group assessing the states' implementation of the NAIC's 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.

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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.

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.

Corporate Governance Working Group

CMB personnel serve as Vice-Chair to the NAIC Executive Committee level Corporate Governance Working Group. As part of the NAIC's Solvency Modernization Initiative, the CGWG is charged to establish corporate governance principles for insurers that are more specific than those currently set out in statute or regulation, determine the appropriate methodology to evaluate adherence with such principles, consider the development of a model law and additional regulatory guidance including best practices. In so doing, it has analyzed the governance practices required by other states, nations, or international insurance regulatory entities and their best practice aspirational principles. It has exposed for comment a Whitepaper, "Governing Principles for Use In U.S. Insurance Regulation."

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I. CAPTIVE INSURANCE GROUP

1. General Overview

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, 2010 there were 46 captive insurance companies authorized in New York. These 46 captive insurers posted total assets of $13.0 billion, total liabilities of $3.6 billion and capital and surplus of $9.4 billion. In addition, these captive insurers had total income of $793.2 million, paid taxes of $9 million and had net premium written of $1.3 billion. Chapter 389 of the Laws of 1997, which permits the formation and operation of captive insurance companies under Article 70 of the Insurance Law, became effective December 5, 1997.

2. Attracting New Captive Insurers

New York is a leading global business center and 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.

The Captive Insurance Group continues to evaluate changes in the captive statute which may enhance New York's efforts to continue to attract new captive insurers. These changes, some of which have been considered legislatively in the past, include:

- Reducing the threshold level for a parent to form a pure captive to $25 million of net worth or annual revenue, as well as providing the Superintendent with the flexibility 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.

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J. MODERNIZATION INITIATIVE

Insurance Filings Modernization Initiative Interim Report

Executive Summary

The Insurance Filings Modernization Committees' Report to the Superintendent of Insurance ("Report") (link) was issued on December 2, 2010. The Report contains a series of recommendations for the Superintendent's consideration, including both "universal" and other recommendations. The Report suggests that the Superintendent implement the universal recommendations because they impact operations across Bureau lines and were made by multiple Committees, and contemplates the implementation of other recommendations as well. The purpose of this interim report is to describe the Insurance Department's progress to date in carrying out the Report's recommendations and to preview the Department's future implementation plans.

The Department has now implemented the following universal recommendations:

- Website Redesign
- New and Updated Product Outlines
- Increased Use of New and Updated Checklists
- Comprehensive Triage System
- Expanded Use of SERFF
- Pre-filing Meetings
- Feedback on Deficient Filings
- Interaction with the Industry

The Department also has now implemented the following other recommendations:

- Online Producer Search
- Option to Speak with a Representative
- National Insurance Producer Registry Updates
- NAIC Producer Database (PDB) Updates
- Streamlined Licensing Process
- Model Language for Health Contracts
- Suggestions for Improving Filings
- Off-Anniversary Community Rate Changes
- Increased Timeframe to Respond to the Department

The Department will consider the feasibility of implementing the universal recommendation that it seek ways to maintain adequate funding until after the effective date of the merger of the Banking and Insurance Departments into the Department of Financial Services.

The Department notes measurable improvement to the rate and form filing process as a result of the implementations listed above. In addition, the Department has received positive feedback regarding its modernization efforts, particularly the property/casualty webinars, the re-designed website, and the Online Producer Search. The Department will continue to post implementation updates to its website as improvements are finalized.

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Insurance Filings Modernization Initiative Interim Report

Background

The Insurance Filings Modernization Initiative commenced in February of 2010. The Initiative was designed to streamline the Department's process for the review of rate, policy, license, and other industry filings to make the processes more efficient, provide consumer protection, encourage competition, and reduce unnecessary costs and burdens on regulated entities.

The Insurance Filings Modernization Committees' Report to the Superintendent was issued on December 2, 2010. The Report contains a series of recommendations for the Superintendent's consideration. The Report also suggested that the Superintendent implement the "universal" recommendations because they impact operations across Bureau lines and were made by multiple Committees.

Superintendent James Wrynn appointed Merline Smith as the Director of Form and Rate Filing Modernization, to work full time toward implementation of various recommendations. The Department has already successfully implemented several recommendations, as summarized below. Progress updates on implementation will be posted to the Department's website.

In addition to implementing several Committees' recommendations, the Department is assessing internal processes and procedures to monitor the efficacy of resources committed to the rate and form filing process. The Department's goal is to improve existing processes for receiving, reviewing, and approving or disapproving filings by replicating best practices, introducing innovative processes, and conducting a continuous self-assessment.

Universal Recommendations Implemented

Website Redesign

The Department has launched a reorganized website to make the website less cluttered, easier to navigate, and more user-friendly. This action was taken based on a recommendation urging this enhancement in order to strengthen the Department's operational efficiencies and allow the industry to access information faster.

New and Updated Product Outlines

The Life Bureau has updated product outlines related to Group Fixed and/or Variable Annuity, Individual Fixed and/or Variable Deferred Annuity, and Individual Whole Life and Endowment. The Individual Whole Life and Endowment Product Outline and Individual Fixed and/or Variable Deferred Annuity Product Outline have been posted to the Department's website for public comments. These actions were taken based on a recommendation urging the Department to increase the use of product outlines to help regulated entities understand the applicable regulatory parameters before making a filing with the Department, thereby decreasing the number of non-compliant filings.

Increased Use of New and Updated Checklists

One recommendation in the Report encouraged the Department to increase the use of new and updated checklists (Department documents designed to help insure the compliance of rates and forms with the Insurance Law). The Health, Life, and Property Bureaus have taken steps to implement this recommendation. The Health Bureau has updated product checklists to communicate filing requirements to add items detailing recent statutory changes such as coverage of students on medical leave, dependent coverage to age 29, mental health parity, coverage of same-sex partners, continuation of coverage, proof of loss, wellness benefits, subrogation, grievance, referrals, specialty

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care, transitional care, provider networks, and out-of pocket network coverage. The Health Bureau has also updated citation links on its product checklists to the applicable statute and/or regulation to assure that the industry has the most up-to-date information. The Life Bureau has posted to the Department's website the Memorandum of Variable Materials (MVM Checklist) developed by Life Bureau staff to help insurers avoid common submission errors. The Property Bureau has made several updates to the Commercial Automobile, Homeowners, Inland Marine, and Private Passenger Automobile Review Standards Checklists.

Comprehensive Triage System

The Department has implemented triage systems to streamline the rate and form filing process. By identifying filings that require minimal review (simple filings, filings with no rate impact, filing that are informational or administrative only) and prioritizing their review based on complexity, the Department can approve less complex filings faster, which in turn allows insurers to get products to market quicker. These actions were taken based on a recommendation urging the Department to construct a comprehensive triage system to streamline the rate and form filing process by systematically evaluating the complexity of filings, prioritizing the review of filings based upon complexity and importance, assigning filings to the appropriate staff for review, and granting approval authority to staff that is commensurate with the files they are assigned. The availability of the Circular Letter No. 6 (2004) process for filings requiring a minimal review eliminates the need for the triage system for life filings.

Expanded Use of SERFF

Another recommendation in the Report encouraged the Department to expand the use of electronic filings through the System for Electronic Rate and Form Filing (SERFF), a national electronic filing and review system developed by the National Association of Insurance Commissioners (NAIC) and the insurance industry to lower the cost and amount of time required to address a filing by both industry and the Department. To that end, Department staff members attended training in the SERFF application in order to better utilize the tools available in SERFF to improve the rate and form filing process. The Department also changed procedures to allow parallel communications outside of SERFF to receive messages faster. Industry recommended that the Life Bureau make SERFF available for Post Approval Review files. That request posed a challenge, because Post Approval Review files are initiated by the Department, and SERFF does not permit states to open new files in SERFF. In spite of that obstacle, the Life Bureau developed and immediately implemented a procedure by which insurers could open the SERFF file upon receiving initial notice that a Post Approval Review had been commenced by the Life Bureau. The Health Bureau expanded its use of SERFF to accommodate electronic filings submitted under the recently enacted prior rate approval legislation, and will consider making further enhancements using Federal rate review grant funds.

Pre-filing Meetings

The Report recommended that the Department utilize pre-filing meetings between Department staff and representatives from the filing entity, which several bureaus have already implemented. The Property Bureau issued an important notice to property/casualty insurers reminding them of pre-filing meetings described in Circular Letter 11 (1998) and Supplement No. 3 to Circular Letter 11 (1998). The Life Bureau continues to encourage companies to schedule pre-filing meetings for both transactional and product filings, especially where the filing is unconventional or the transaction is particularly complex. In addition, consistent with Circular Letter 14 (1997), at quarterly meetings with companies and meetings with trade associations, the Life Bureau encourages insurers to contact appropriate Department personnel with any questions concerning submission rules, regulations, or statutes prior to making submissions.

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Feedback on Deficient Filings

Another recommendation in the Report urged the Department to provide meaningful feedback to the management of companies that routinely have difficulty with filings so that errors are not repeated. The Department notified property/casualty insurers that it will monitor the quality of filings submitted and will provide feedback to companies that consistently make defective filings. For example, the Department temporarily suspended an insurer from using an expedited filing process because the insurer used the expedited process to submit a filing despite a directive not to do so. The penalty assessed was based on the recommendation of the Life Committee.

Interaction with the Industry

The Report recommended that the Department interact more with the industry and conduct supervisory symposia between Department staff and personnel from the insurance industry about significant filing requirements and issues. As a result, the Department hosted the first in a series of Department-sponsored webinars. This webinar provided instructions to the regulated community on how to submit property/casualty "Me Too" filings. Over 300 industry representatives registered for the first session. Because of the overwhelming response from the industry, the Department hosted a second session. A recording of the webinar is accessible from the Department's website. In addition, the Life Bureau regularly meets with trade associations to discuss regulatory matters.

Maintain Adequate Funding

The Report suggested that the Department make all feasible efforts to maintain adequate funding, so it may carry out its regulatory functions with appropriate technology and personnel levels. Because the merger of the Banking and Insurance Departments into the Department of Financial Services will likely alter the staffing needs of the new agency, it seems appropriate to postpone the Department's efforts to implement this recommendation until there is greater certainty concerning the new regulatory landscape.

Additional Recommendations Implemented

Online Producer Search

The Licensing Committee recommended that the Department offer external online searching capability by producer name, which would also include appointed and terminated companies, and the original license date. In response, the Department launched the Producer Search function in March 2011, allowing anyone with Internet access to search the Department's producer database for this information.

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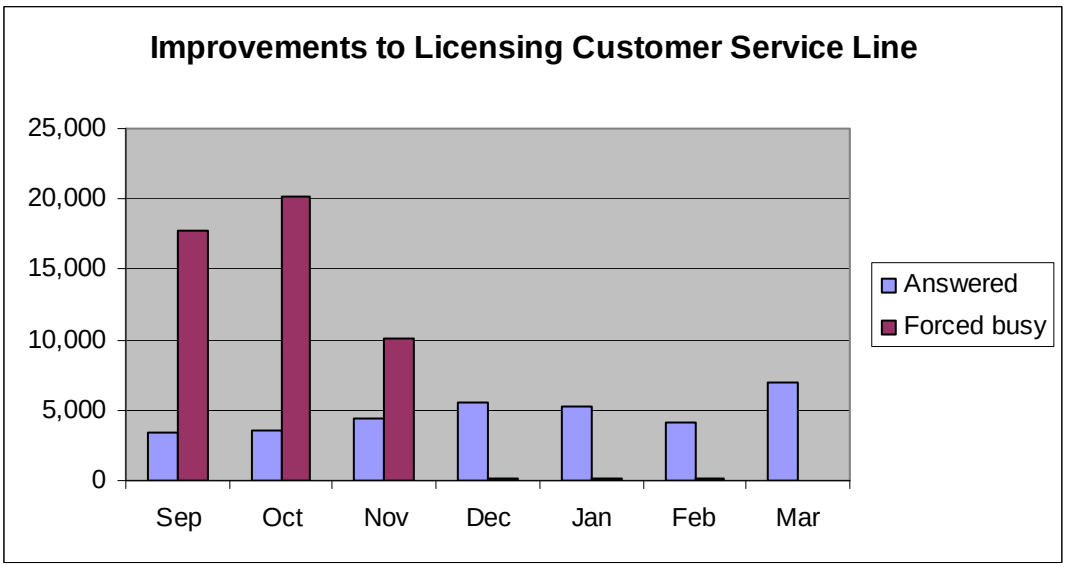
Chart N



Option to Speak with a Representative

The Licensing Committee also urged the Department to modify its Licensing Customer Service telephone helpline to offer callers easier navigation through the menu of options, and to provide callers with a clear option to speak with a customer service representative. The Department added an option to the main menu that allows callers to speak directly to a representative, and expanded the capacity of the helpline to hold more calls in queue.

National Insurance Producer Registry Updates

Another recommendation of the Licensing Committee was to encourage the Department to work with the National Insurance Producer Registry (NIPR) to recover transactions that are not viewable due to a system upgrade in late 2009 and to fix business rules to permit certain applications to be submitted through NIPR. NIPR is an NAIC application through which an agent can apply for non-resident licenses in multiple states, and the Department worked to improve the manner in which New York licensing information is displayed in NIPR, and to permit successful submission of applications when an agent's address information does not match.

NAIC Producer Database (PDB) Updates

Based on the Licensing Committee's recommendation that the Department report data to the NAIC Producer Database (PDB) in a timely manner, the PDB now gets daily updates of New York's licensing information.

Streamlined Licensing Process

Finally, in response to the Licensing Committee's various recommendations regarding offering better service to licensees, providing easier access to information, and removing administrative barriers, the Department made the following changes: (1) the background question on all applications reflects an individual's status, not a corporate status; (2) the manner in which entity names appear on a license was changed to obviate the need for businesses to file "doing business as" (DBAs) in other states; (3) the Department's Company Appointment/Termination application displays insurer appointments processed within the last 30 days and (4) the address change reporting process captures

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either new or changed e-mail addresses. These changes reduce the number of requests for information made to the Department, the number of applications referred for investigation, and the amount of paperwork licensees are required to file.

Model Language for Health Contracts

The Health Committee's recommendation that the Department offer model language, where feasible, to be used by industry in order to streamline the form filing process was adopted, and the Health Bureau posted to the Department's website model language for use by industry.

Suggestions for Improving Filing

In an effort to improve the resources available to the industry and the quality of inbound rate and form submissions, the Health Bureau posted to the Department's website several documents containing filing guidance that clarify instructions on how to use the expedited filing process and advice on submitting certain filings, such as combination filings with other bureaus, foreign language translations, merger/name changes and company address/name changes.

Off-Anniversary Community Rate Changes

As recommended by the Health Committee, the Health Bureau posted to the Department's website guidance for insurers and health maintenance organizations concerning instances when rolling rates, which are usually guaranteed for a period of one year, are allowed to be changed "off-anniversary." An off-anniversary rate change is allowed if the insurance policy or contract expressly allows the change and the language of the insurance policy or contract has been approved by the Department.

Increased Timeframe to Respond to the Department

In response to the industry's request for more time to answer Department requests for information, the Health Bureau increased the allowable response time from 15 calendar days to 15 business days and revised the template language so that the new 15-business-day period for responses is included in each comment letter sent to a company.

Because improving the rate and form filing process is a continuous exercise, many of the implementations listed above will be enhanced where feasible. For example, checklists and outlines will be posted to the Department's website when updated, and processes that are successfully implemented in one area may be replicated in other areas, as appropriate.

Conclusion

The Department is pleased to report that measurable improvements across many Department functions, including customer service, licensing, and rate and form filing, have been achieved as a result of implementing several of the Committees' recommendations. For example, with regard to the Licensing Customer Service helpline, increasing the capacity of calls in queue and increasing the number of representatives who staff the helpline virtually eliminated "forced busy" calls to that line. In addition, launching the Online Producer Search function resulted in approximately 2,200 fewer daily requests to the call center, because that information became available on the Department's website. Likewise, streamlining the producer licensing process reduced the number of requests for information by the Department, and changing the background question on the licensing application resulted in 24% fewer producer applications being referred for investigations, thereby providing licenses to individuals in a more timely manner. Finally, changing how a company name appears on a license reduces the paperwork producers have to complete, because they no longer have to file DBAs in other jurisdictions.

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The Department continues to receive positive feedback from regulated entities concerning its modernization efforts, particularly the property/casualty webinars, the re-designed website, and the Online Producer Search., all of which serve to make New York a better place to conduct business.

As the Department continues to implement several of the remaining recommendations from the Insurance Filings Modernization Initiative, changes in processes or other actions the Department takes to increase efficiency will be communicated to the public as improvements are finalized.

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K. TRAINING & PROFESSIONAL DEVELOPMENT

Staff training is a core priority for the Department. The professional development needs of the Department's employees are diverse; therefore, a wide variety of courses in several categories are offered to provide personnel the skills they need to perform their jobs effectively and to assist individuals in pursuit of their career objectives. Training is offered to employees in the following categories: Experienced Insurance Examiners, Insurance Examiner Trainees, and Administrative and Support Staff. In addition, all employees are required to attend certain state mandated training.

Professional development of experienced examiners is encouraged through on-the-job training and attendance at bureau-wide seminars. In 2010, 11 such seminars were coordinated, addressing current issues facing the Department and the insurance industry. In 2010, the National Association of Insurance Commissioners' (NAIC) presented 10 training classes and seminars in which 645 Examiners participated. These courses dealt with such topics as Teammate Training, Financial Analysis, Risk-Focused Training, NAIC Accreditation, 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 2010, there were 38 trainees participating in the training program which consisted of the following: trainees hired in 2008, who completed their traineeship in 2010, and trainees hired in 2010, who will complete their traineeship in 2012. Trainees hired in the fall of 2010 attended 7 days of classes specifically designed for them. Nine trainees completed their traineeships in 2010, 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 Telephone Skills and Customer Service and Speedwriting. In addition, the NYS & CSEA Partnership for Education and Training offered various courses such as Organizing Your Writing, Writing for Clarity, Math Skills Builder, 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 Orders #19 and #2, and the New York State Right-to-Know Law respectively. In 2009, a total of 887 staff participated in the class, and the Ethics Training had a total of 569 participants, while Diversity Awareness had a total of 34 participants. In 2010 plans were begun to present this training to new hires in 2011.

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 Interacting with the Public for Auditors, performance and productivity, constructive discipline, and grievances, specific to our agency. Although the Department's in-house Management Development Program was not offered in 2010, supervisory personnel expanded their skills with supervisory courses offered by APT. Other courses of a general nature included such topics as Basics of Leadership, Successful Business Writing, Performance Evaluation for

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Supervisors, Dynamic Presentations, and Conflict Resolution. In all, 189 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 international fellows 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 or fellows 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 21 fellows from the countries of India, Brazil, China, Egypt, Saudi Arabia, Taiwan, Singapore, Thailand, the Czech Republic and Bulgaria. Two fellows, one from the Czech Republic and one from Thailand were hosted in 2010. The main objective of the spring fellow 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. The fall intern was especially interested in life and property. 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 2010, 68 examiners took advantage of the library's loan program and borrowed 122 books. This past year, 62 insurance examiners successfully completed 121 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.

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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.

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- 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. 2010 Activity

Case Outstanding Reserve Tort & Pip	$23,670,652.44	$22,378,935.61
Incurred But Not Reported	$16,926,404.00	$16,454,151.00
Unallocated Loss Adjustments ULAE	$12,083,149.00	$12,685,720.00
Spec. Reserve for Alloc. Exp	7,000,000.00	7,000,000.00

- MVAIC received 12,830 new Notice of Intention to Make a Claim in 2010. This represents a 1% increase over 2009.
- The No-Fault unit received 972 new claims in 2010. This was a increase of 3% over 2009.
- MVAIC opened 969 new Tort claims in 2010, a increase of 3% over 2009
- Claims paid for Tort and No Fault cases increased in 2010 to $20,658,771.47 compared to $18,380,099 paid during 2009.
- The number of pending claims at the close of 2010 was 2,571 compared to 1,879 in 2009

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III. INSURANCE LEGISLATION ENACTED

(Legislation is presented in numeric order based on 2010 Chapter Law)

This section of the Annual Report covers bills enacted during the 2010 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.*

Reporting; Motor Vehicle Fraud

Chapter 11 of the Laws of 2010

The bill amends the Insurance Law § 405 (d) (11) to require a report to the Governor and Legislature of the incidence of misrepresentation by insureds of the principal place where motor vehicles are driven and stored.

Appraisals

Chapter 25 of the Laws of 2010

The bill amends the Insurance Law and the Civil Practice Law and Rules (CPLR) to authorize a court to compel either party to a standard fire insurance policy to submit to the appraisal process in such policy and to authorize either party to the policy to commence a special proceeding to specifically enforce the appraisal clause in such policy.

Third Party Notification; Health Insurance

Chapter 49 of the Laws of 2010

The bill amends Insurance Law § 3111(c) to require health insurers to permit policy holders who are senior citizens to designate a third party for written notification of nonpayment of premiums due or notice of cancellation for nonpayment of premiums.

Article VII; Budget Bill

Chapter 56 of the Laws of 2010

The bill enacts into law major components of legislation necessary to implement the Public Protection and General Government budget for the 2010-11 State Fiscal Year.

Amendments to the Insurance Law include:

- Insurance Law §318 is amended to delete reference to the Department of State.
- A new Insurance Law §1108(j) is added exempting certain employers authorized by the Workers' Compensation Board from licensing and other requirements of the Insurance Law.
- A new Insurance Law §1101 (b)(6) is added to provide that the election by the president of the Civil Service Commission to provide health benefits directly to New York state health benefit plan participants shall not constitute the doing of insurance business within the meaning of Article 11 of the Insurance Law.

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- Insurance Law §2108 (d)(4) is amended to make technical changes necessitated by amendments to the Correction Law with respect to certificates of relief from disabilities issued by the board of parole.

- Insurance Law §4413 (c)(1) is amended to make a technical change necessitated by amendments to the Correction Law with respect to certificates of relief from disabilities issued by the board of parole.

Prior Approval; Health Premium Rates

Chapter 107 of the Laws of 2010

The bill amends the Insurance Law to authorize the Insurance Department to approve health insurance premium rate adjustments before they take effect.

Commercial Directories; Service Providers

Chapter 210 of the Laws of 2010

The bill amends the Insurance Law to authorize the issuance of group policies guaranteeing the performance of contracts entered into by service providers listed in a commercial directory.

Midwives

Chapter 238 of the Laws of 2010

The bill removes the requirement that midwifery be practiced in accordance with a written agreement between a midwife and a licensed physician or hospital.

Motor Vehicle Insurance Surcharges

Chapter 277 of the Laws of 2010

The bill amends the Insurance Law to raise the property damage monetary threshold from $1,000 to $2,000, which, if exceeded as a result of a motor vehicle accident, would allow an insurer to impose a premium surcharge.

Intoxicated Drivers; No-Fault

Chapter 303 of the Laws of 2010

The bill amends the Insurance Law to ensure that health care providers are compensated for necessary emergency health services regardless of the fact that a covered person under a no-fault policy was injured as a result of operating a motor vehicle in an intoxicated condition, and to allow the no-fault insurer a right of recovery where the injured person is found guilty of operating a motor vehicle while in an intoxicated condition or while the person’s ability to operate a motor vehicle is impaired by the use of drugs or alcohol.

Workers’ Compensation; Notice

Chapter 314 of the Laws of 2010

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This bill requires that injured workers receiving benefits under the Workers' Compensation Law be given reasonable time to respond to any inquiry from an insurer in order to avoid a disruption in benefits. Specifically, Workers' Compensation Law §208-1 is amended to require that any inquiry which requires an employee's response in order to continue benefits uninterrupted or unmodified shall provide a reasonable time period in which to respond and include a clear and prominent statement of the deadline for responding and consequences of failing to respond.

Rental Vehicle Reimbursement

Chapter 322 of the Laws of 2010

This bill adds a new Insurance Law § 2601-a entitled, "Rental vehicle reimbursement coverage" to ensure that consumers utilizing rental reimbursement coverage are able to rent from a rental vehicle company of their choosing.

Reference Compendia; Cancer Drugs

Chapter 357 of the Laws of 2010

The bill amends the Insurance Law to update the established reference compendia that are used as authoritative sources for use in the determination of off-label drugs and biologicals used in an anti-cancer chemotherapeutic regimen.

Self-Storage, Limited License

Chapter 368 of the Laws of 2010

The bill amends the Insurance Law to permit self-service storage companies to obtain limited licenses to sell insurance coverage on personal property stored in a self-service storage space.

Municipal Reciprocal Insurers; Surety Bonds, Public Officers

Chapter 389 of the Laws of 2010

The bill amends the Insurance Law to authorize municipal reciprocal insurers to offer full faith and credit surety bonds for public officers.

"Ian's Law"

Chapter 398 of the Laws of 2010

The bill amends the Insurance Law to provide enhanced consumer protections in the event a health insurer or health maintenance organization (HMO) discontinues a class of policies or contracts.

Reciprocal Insurers

Chapter 404 of the Laws of 2010

The bill amends Insurance Law § 6106(a)(2) to state that in the case of any reciprocal insurer having a corporate attorney-in-fact wholly owned by the subscribers at such reciprocal insurer, the acceptance of a policy or binder of insurance containing the subscriber's agreement printed at the end of the standard policy provisions or the binder, as the case may be, preceded by certain prescribed language, will constitute the execution and delivery of the subscriber's agreement by that insured as fully and to the same extent as though the agreement had been signed and acknowledged by that insured.

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The bill also amends Insurance Law § 6107(d)(4) in relation to reciprocal insurers having a corporate attorney-in-fact wholly owned by the subscribers at the reciprocal insurer.

Independent Workers; Freelancers Insurance Co.

Chapters 448 and 453 of the Laws of 2010

The bills amend the Insurance Law in relation to the definition of an “independent worker” and requirements for an insurer's application to operate a demonstration program for independent workers.

Health Insurance; Out-of-Network Dialysis

Chapter 457 of the Laws of 2010

The bill amends the Insurance Law to require insurers to cover out-of-network dialysis treatment under certain circumstances.

Credit Union Shares

Chapter 461 of the Laws of 2010

The bill amends the Insurance Law to authorize non-life insurers to make reserve investments in shares, share certificates and share draft accounts issued by state and federally-chartered credit unions.

New York Board of Fire Underwriters

Chapter 470 of the Laws of 2010

The bill abolishes the New York Board of Fire Underwriters and repeals the assessments on insurers insuring property within the jurisdiction of the Fire Patrol.

Prescription Drug Copayments

Chapter 487 of the Laws of 2010

The bill prohibits copayments that exceed the cost of the prescribed drug.

Group Participation

Chapter 515 of the Laws of 2010

The bill amends the Insurance Law to reduce the minimum participation requirement for the issuance of certain single group life and group accident and health insurance policies.

Sponsored Group Insurance

Chapter 544 of the Laws of 2010

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The bill amends the Insurance Law to permit directors of an employer to obtain group personal excess insurance and to permit an insurer to offer personal excess insurance, personal property floater insurance, renters' insurance, and vintage vehicle insurance on a group basis.

Life Insurance; Non-Tax Qualified Accelerated Death Benefits

Chapter 563 of the Laws of 2010

The bill amends the Insurance Law to allow insurers to offer life insurance policies providing accelerated death benefits on a non-tax qualified basis to insureds who reside in a nursing home for three months or more with an "expectation" that they will remain a resident until death.

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IV. Regulations Promulgated, Amended, or Repealed

The Following is a Summary of Insurance Department Regulations ***PROMULGATED, AMENDED, or REPEALED*** *in 2010:*

1. 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 took 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.

2. The ADOPTION OF NEW REGULATION 194 (11 NYCRR 30): Producer Compensation Transparency (Adopted on a Permanent Basis - Effective 1/1/2011)

Insurers compensate insurance producers for their role in placing and selling insurance by paying compensation, including commissions and other items or benefits of monetary value. Compensation arrangements typically differ from insurer to insurer, with some insurers paying not only commissions by the policy, but also by the total volume generated by a producer or the profitability of the insurance contracts the producer provides to the insurer. Individual consumers and commercial interests typically rely on insurance producers to assist them with obtaining information about available insurance policies and evaluating those policies to determine which are best suited to the customer's needs.

The regulation is intended to provide a means to address the potential conflict that arises due to the differences in the amount of compensation an insurer pays to its producers in the least invasive manner possible – by requiring that insurance producers make certain disclosures about their role in the insurance transaction and compensation arrangements with insurers to insurance customers.

3. The REPEAL OF REGULATION 67 (11 NYCRR 135): Reporting of Reserve Liabilities by Public Retirement Systems (Adopted on a Permanent Basis - Effective 3/3/2010)

The repeal eliminates requirements relating to a previous annual statement form that no longer is in use, and eliminates regulatory provisions that are no longer applicable to any person.

4. The 2nd AMENDMENT TO REGULATION 119 (11 NYCRR 151): Workers' Compensation Insurance Rates (Adopted on a Permanent Basis - Effective 4/21/10)

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In March 2007, the Legislature enacted Chapter 6 of the Laws of 2007, which reformed the workers' compensation system. Chapter 6 amended Workers' Compensation Law § 134(6) to provide that most employers shall be eligible for a credit in workers' compensation insurance premiums if the employer implements any of the following: (1) a safety incentive plan; (2) a drug and alcohol prevention program; or (3) a return to work program.

Workers' Compensation Law § 134(6)(c) requires the Superintendent to promulgate a regulation establishing premium credits for such programs, and include provisions for recertification on an annual basis. This rule implements the statutory mandates.

5. 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) (Adopted on a Permanent Basis - Effective 5/5/10)

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.

6. The 31st AMENDMENT TO REGULATION 83 (11 NYCRR 68): Charges for Professional Health Services (Adopted on a Permanent Basis - Effective 9/22/2010)

This rule establishes, for the purposes of no-fault reimbursement, a fee schedule for dental services rendered on or after March 1, 2009. The Workers' Compensation Board adopted a dental fee schedule effective March 1, 2009. This rule repeals the fee schedule previously established by the Insurance Department for dental services, which was adopted by the Insurance Department because, at the time, there was no fee schedule for dental services established by the Workers' Compensation Board. The charges for these dental services are now covered by the fee schedule established by the Workers' Compensation Board.

7. The 10th AMENDMENT TO REGULATIONS 17, 20, and 20-A (11 NYCRR 125): Credit for Reinsurance from Unauthorized Insurers (Adopted on a Permanent Basis - Effective 1/1/2011)

This amendment applies to insurers authorized to do business in New York State and addresses whether a ceding insurer may take credit on its balance sheet, as an asset or deduction from reserves, for reinsurance recoverable from an unauthorized assuming insurer. The amendment establishes certain requirements for ceding insurers and reinsurers, and puts the onus on ceding insurers to prudently manage their risk.

Emergency Regulations

*The Following is a Summary of Insurance Department Regulations Promulgated on an **EMERGENCY BASIS** in 2010 That Remained in Effect on December 31, 2010. No final action was taken with regard to the Rules in 2010, although it is anticipated that they will be permanently adopted in 2011:*

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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) (Adopted on a Permanent Basis - Effective 3/16/2011)

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 2010. 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. The 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 rule establishes an immediate ban on the use of placement agents by the New York State Employees' Retirement System.

3. 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) (Adopted on a Permanent Basis - Effective 1/19/2011)

Workers' Compensation Law § 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 Workers' Compensation Law § 32. This regulation establishes the required reserve standards.

4. The 4th AMENDMENT TO REGULATION 119 (11 NYCRR 151): Workers' Compensation Insurance Rates (Effective on an Emergency Basis since 12/17/09) (Adopted on a Permanent Basis - Effective 1/19/2011)

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 the Fund. This regulation will ensure that the Fund has 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.

5. 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 insurer 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

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("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, in consultation with the Workers' Compensation Board and NYCIRB, to set rules for collecting the assessment from insureds. This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers and the amount that an insurer remits to the Workers' Compensation Board.

6. 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) (Adopted on a Permanent Basis - Effective 3/16/2011)

This amendment to Regulation 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.

7. The 3rd AMENDMENT TO REGULATION 147 (11 NYCRR 98): Valuation of Life Insurance Reserves (Effective on an Emergency Basis since 12/29/09) (Adopted on a Permanent Basis - Effective 3/16/2011)

This amendment to Regulation 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.

8. The ADOPTION OF NEW REGULATION 118 (11 NYCRR 89): Audited Financial Statements (Effective on an Emergency Basis since 12/29/09) (Adopted on a Permanent Basis - Effective 3/16/2011)

Regulation 118 originally was promulgated in 1984 to implement section 307(b) of the Insurance Law. The repeal of the current regulation and promulgation of the new regulation continues to implement the provisions of section 307(b), and adds provisions required pursuant to the Sarbanes-Oxley Act of 2002, 15 U.S.C. § 7201 et seq. The new regulation is closely patterned upon a National Association of Insurance Commissioners model regulation that reflects a consensus of the insurance regulators of all states and territories of the United States as to scope, details, needs, and benefits.

9. The CONSOLIDATED 1st AMENDMENT TO REGULATION 68-A (11 NYCRR 68-1) AND REGULATION 68-B (11 NYCRR 68-2): Regulations Implementing The Comprehensive Motor Vehicle Insurance Reparations Act (Effective on an Emergency Basis since 12/20/10)

Chapter 303 of the Laws of 2010 amended Insurance Law § 5103(b)(2) to prohibit insurers and self-insurers from excluding from coverage any person who is injured as a result of operating a motor vehicle while in an intoxicated condition or while the person's ability to operate the vehicle is impaired by the use of a drug within the meaning of Vehicle and Traffic Law § 1192, and who receives necessary emergency health services rendered in a general hospital, including ambulance services attendant

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thereto and related medical screening. These amendments permit an insurer and self-insurer to maintain a cause of action against the covered person for the amount of first party benefits paid or payable on behalf of the covered person if such person is found to have violated Vehicle and Traffic Law § 1192. Chapter 303 of the Laws of 2010 became effective on January 26, 2011 and it was essential that these amendments be promulgated on an emergency basis in order to inform insurers and self-insurers of the new provisions in the law.

10. The ADOPTION OF NEW REGULATION 187 (11 NYCRR 224): Suitability in Annuity Transactions (Effective on an Emergency Basis since 12/30/10)

This rule requires insurers to set forth standards and procedures for recommendations to consumers with respect to annuity contracts so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed. It regulates the activities of insurers and producers who make recommendations to consumers to purchase or replace annuity contracts to ensure that insurers and producers make recommendations that are suitable for the consumer based on relevant information obtained from the consumer.

11. The ADOPTION OF NEW REGULATION 199 (11 NYCRR 225): Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities (Effective on an Emergency Basis since 12/30/10)

This rule sets forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale, or purchase of, or advice made in connection with, a life insurance policy or annuity contract. It prohibits the use of a senior-specific certification or professional designation by an insurance producer in such a way as to mislead a purchaser or prospective purchaser into believing that the insurance producer has special certification or training in advising or providing services to seniors in connection with the sale of life insurance and annuities. This rule adopts the NAIC model in substantial part.

12. The ADOPTION OF NEW REGULATION 198 (11 NYCRR 381): Life Settlements (Effective on an Emergency Basis since 4/23/10)

Sections 2137, 7803, and 7804 of the Insurance Law, as added by Chapter 499 of the Laws of 2009, and which became effective May 18, 2010, require the licensing of life settlement providers and life settlement brokers, and the registration of life settlement intermediaries. These sections also provide that the license and registration fees charged to life settlement providers, brokers, and intermediaries, and the financial accountability requirements that life settlement providers must demonstrate at licensing, shall be established by the Superintendent. Section 21(6) of Chapter 499 of the Laws of 2009 authorizes the Superintendent to promulgate rules and regulations necessary for the implementation of its provisions. Adoption of this rule establishing license and registration fees and financial accountability requirements on an emergency basis was necessary for the timely implementation of the life settlement legislation.

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V. CIRCULAR LETTERS ISSUED IN 2010

Number	Date	Addressed to	Subject
1 Replaced and Repealed by CL No. 1 (2011) Dated 2-17-2011	02/23/2010	All Authorized Property/Casualty Insurers; Co-Operative Property/Casualty Insurers; Financial Guaranty Insurers; Mortgage Guaranty Insurer; Title Insurers; Reciprocal Insurers; Captive Insurers; 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
2 Replaced and Repealed by CL No. 2 (2011) Dated 2-17-2011	02/23/2010	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
3 Replaced and Repealed by CL No. 3 (2011) Dated 2-17-2011	02/23/2010	All Authorized Life Insurers, Retirement Systems, and Fraternal Benefit Societies	Disaster Planning, Preparedness and Response
4	02/05/2010	All Motor Vehicle Insurers Writing Motor Vehicle Insurance in New York State, Self-Insurers, and the New York Automobile Insurance Plan	Reduction in No-Fault Loss of Earnings Benefits Payable by Amounts Received from Employer Wage Continuation Plans
5	02/17/2010	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)	Amended Thirty-Six Month State Continuation Benefit Required by Chapter 498 of the Laws of 2009

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Number	Date	Addressed to	Subject
Supplement No. 1 to Circular Letter No. 20 (2008)	02/17/2010	All Insurers, Reinsurers And Insurance Producers	Contract Certainty
6	04/09/2010	All Insurers, Including Risk Retention Groups and the Medical Malpractice Insurance Plan ("MMIP"), Writing in New York Professional Medical Malpractice Liability Insurance that Covers Physicians, Physician's Assistants, and Specialist's Assistants	Submission of Quarterly Reports Required by New York Insurance Law § 315
7	05/03/2010	All Property/Casualty Insurance Companies; Co-Operative Property/Casualty Insurance Companies; Reciprocal Insurers; and Financial Guaranty Insurance Corporations	Property/Casualty Insurance Security Fund
8	06/29/2010	All Authorized Life Insurers and Fraternal Benefit Societies (collectively, "Insurers")	Bonus Recapture from Death Benefit Proceeds is No Longer Permitted
Supplement No. 3 to Circular Letter No. 22 (2005)	07/13/2010	All Property/Casualty Insurers Domiciled in New York State	Filing of Actuarial Opinion Summary ("AOS")
9	08/09/2010	All Insurers Writing Property/Casualty Policies in New York	Incorrect Amounts Listed on Cancellation Notices for Non-Payment of Premium
10	08/10/2010	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
11	08/06/2010	All Authorized Life Insurers, Fraternal Benefit Societies, and Accredited Life Reinsurers ("Insurers")	Deferred Premium Asset and Unearned Premium Reserve

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Number	Date	Addressed to	Subject
12	08/24/2010	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
13	09/15/2010	All Property/Casualty Insurance Companies and Reciprocal Insurers Authorized to Write Workers' Compensation Insurance	Workers' Compensation Security Fund
14	09/14/2010	All Title Insurance Companies Licensed to Write Title Insurance in New York and the Title Insurance Rate Service Association	Title Insurance Companies' Issuance of Comfort Letters in Lieu of Endorsements
Supplement No. 1 to Circular Letter No. 20 (2009)	09/17/2010	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 Federal Mental Health Parity and Addiction Equity Act of 2008
15	10/04/2010	All Insurers Authorized to Write Motor Vehicle Insurance in New York State ("Motor Vehicle Insurers"); the New York Automobile Insurance Plan; Rate Service Organizations; and Insurance Producers	Minimum Property Damage Threshold for Increasing Motor Vehicle Policy Premiums
16	10/15/2010	All Authorized Insurers	Prudent Practices for Insurers Engaged in Securities Lending
17	10/25/2010	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations (HMOs) (collectively, "insurers")	Evaluation and Management Current Procedural Terminology Codes
18	11/05/2010	All Licensed Insurance Producers and Authorized Insurers	Implementation of and Compliance with 11 NYCRR 30 (Regulation 194)

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VI. MAJOR LITIGATION

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, which was granted on April 13, 2010. The Attorney General served answers to both the original and intervenor complaints and filed a motion for summary judgment on behalf of the defendants. On March 10, 2011, the Court stayed the defendants' motion for summary judgment to allow the plaintiffs time to conduct discovery.

ABN AMRO Bank N.V., et al. v. Eric Dinallo, et al.
Supreme Court, New York County
Appellate Division, First Department
Court of Appeals

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 several 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 were originally assigned to Justice James A. Yates, but were recently reassigned to Justice Barbara Kapnick after Justice Yates retired from the bench.

On December 9, 2009, the banks moved for permission to take expansive discovery of the Department, including depositions of Department staff who reviewed the MBIA 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

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officials to be deposed and production of additional documents. The banks took the depositions of Department employees Michael Moriarty and Jack Buchmiller.

On November 23, 2010, Justice Yates granted the banks' request for additional discovery, including internal e-mail communications. On January 3, 2011, the Department filed a motion with the First Department for leave to appeal the trial court's order granting production of internal e-mail communications. There has been no decision yet on the Department's motion, but production of the documents subject to the order has been stayed pending a ruling on the motion for leave to appeal.

The defendants in the plenary action filed a motion to dismiss, which was denied on February 17, 2010. On appeal, the First Department, on January 11, 2011, reversed the decision denying the motion to dismiss the plenary case. The Banks have appealed to the Court of Appeals, where oral argument is scheduled for the end of May. The Office of the Attorney General will likely file an amicus brief, as it did in the First Department, arguing that the plenary case is barred as a collateral attack of the Superintendent's determination approving the restructuring of MBIA.

The Banks have filed their reply to the Department's Verified Answer, which is thousands of pages, and includes affidavits from four former Department superintendents. Under the scheduling order entered by Justice Yates before he left the bench, the Department and MBIA have until mid-May to take depositions of the Banks' experts and file a sur-reply, after which the Banks can file a sur-sur-reply.

Sullivan Financial Group., et al. v. James Wrynn, et al.
Appellate Division, Third Department

This is an article 78 proceeding commenced by three licensed insurance producers and two producer trade organizations against the Superintendent of Insurance challenging Insurance Department Regulation 194 (11 NYCRR Part 30), the Producer Compensation Transparency Regulation, that was promulgated on January 25, 2010, to take effect on January 1, 2011. The regulation requires insurance producers (agents and brokers) to inform insurance consumers of the producer's role in insurance purchase transactions, and to provide specific information about the producer's compensation upon the consumer's request. The petitioners seek an order annulling and permanently enjoining enforcement of Department Regulation 194 on grounds that the Superintendent lacked statutory authority to issue it, that the regulation is arbitrary and lacks any rational basis, and that it violates the Due Process and Equal Protection Clauses of the United States and New York State Constitutions.

On November 17, 2010, the Supreme Court (Acting Justice Richard M. Platkin) issued a decision denying the petition in all respects. The Court held that the Superintendent had the authority to promulgate Regulation 194, that the Regulation is not inconsistent with any provision of the Insurance Law, and that the Regulation was not unreasonable or irrational. The plaintiffs have filed a notice of appeal to the Appellate Division, Third Department, where the case is now pending.

The Prudential Insurance Company of America, et al. v. James Wrynn
Supreme Court, New York County

This is an Article 78 proceeding challenging a determination of the Superintendent that denied the petitioner's request for a refund or a credit of "retaliatory" taxes the petitioner paid to the Department pursuant to Insurance Law section 1112. The determination was issued on November 18, 2010 in a letter to petitioner from the Department's Bureau of Taxes and Accounts, which referenced a November 2, 2010 legal opinion letter that was issued to petitioner by the Department's Office of General Counsel.

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The petition seeks a judgment annulling the Superintendent's determination and directing a refund or credit of the taxes paid by the petitioner.

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VII. 2011 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.

Insurance Department Bills for 2011

1. An act to amend the Insurance Law and the Public Health Law in relation to implementation of the federal Affordable Care Act (ACA). The purpose of this bill is to amend these laws to implement changes required by the ACA in health insurance policies and contracts involving such issues as contracts, coverage for children, definitions and health plan requirements.

2. An act to amend the Insurance Law and the Penal Law in relation to the definition of insurance fraud. The purpose of this bill is to include the activities that currently constitute a “fraudulent health care insurance act” within the definition of “fraudulent insurance act.”

3. An act to amend the Insurance Law in relation to extending certain provisions concerning health insurance coverage that would otherwise expire during 2011.

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VIII. Regulatory Activities

A. OPERATING STATISTICS

1. Licenses Issued During Year

Table 59
LICENSES ISSUED DURING YEAR
2009 and 2010

	2010	2009
Total	**137,328**	**117,497**
Adjusters[a]		
Independent	12,059	5,134
Public	441	163
Agents[b]		
Life/Accident and Health	72,574	79,758
Property and Casualty	27,137	18,135
Personal Lines	1,745	1,536
Limited Rental/Wireless Communications	13	5
Mortgage Guaranty Insurance	1	2
Bail Bond	130	57
Limited Lines[c]	1	0
Brokers[d]		
Life	5,959	4,777
Property and Casualty	15,679	6,735
Personal Lines	117	91
Excess Line (Regular)	344	258
Excess Line (Limited)	536	521
Viatical Settlement[e]	2	0
Life Settlement	190	0
Consultants[f]		
Life	76	85
General	146	73
Reinsurance Intermediaries[g]	157	29
Service Contract Registrants[h]	21	138

Note: Footnotes to table appear on next page.

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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.

[e] Viatical Settlement Broker licenses – The Life Settlement Act, which became effective on May 18, 2010, resulted in the licensing of Life Settlement Brokers and eliminated the licensing of Viatical Settlement Brokers.

Life Settlement Broker licenses issued to entities pursuant to Section 2137 are renewable biennially as of July 1 of odd 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] 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.

[g] 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.

[h] 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

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2. Results of Examinations for Licenses

Table 60
RESULTS OF EXAMINATIONS FOR LICENSES
Adjusters, Agents, Brokers and Consultants

Type of Examination	2010 Number Taking Examination	2010 Percent Passing	2009 Number Taking Examination	2009 Percent Passing
Total	**26,924**	**52**	**29,745**	**50**
Public Adjusters	96	50	135	39
Independent Adjusters - Total	3,365	50	3,695	49
Accident and Health	196	60	370	51
Automobile	284	59	217	47
Aviation	21	95	12	83
Casualty	1,165	52	1,144	49
Fidelity and Surety	0	0	0	0
Fire	145	56	145	48
General (All Lines)	793	40	842	39
Health Service Charges	352	49	376	42
Inland Marine	4	100	7	57
Limited Auto (Damage or Theft Appraisals only)	405	49	582	65
Agents and Brokers - Total	23,441	52	25,888	50
Agent, A&H	1,810	47	1,144	47
Agent, A&H (Spanish)	1	0	6	0
Agt/Brk, Life	5,755	58	7,121	54
Agt/Brk, Life (Spanish)	652	12	942	13
Agt/Brk, Life, A&H	9,237	62	10,749	57
Agt/Brk, Life, A&H (Spanish)	10	10	8	13
Agent, Property and Casualty	1,261	44	1,437	37
Broker, Property and Casualty	2,890	34	2,978	33
Agent, Mortgage Guaranty	1	100	1	100
Agent, Credit	0	0	0	0
Agt/Brk, Personal Lines	1,777	44	1,451	50
Agent, Bail Bond	44	75	51	67
Broker, Life Settlement	3	67	0	0
Consultants - Total	22	45	27	37
Life	19	53	23	30
General	3	0	4	75

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3. Changes in Authorized Insurers During 2010

A. Life Insurance Companies	
Domestic Company Incorporated	
Zurich American Life Insurance Company of New York	Sept. 2
Domestic Company Licensed	
American National Life Insurance Company of New York, Glenmont, NY	Mar. 17
Change of Names	
"VantisLife Insurance Company of New York" to "Vantis Life Insurance Company of New York" Brewster, NY	May 26
"ML Life Insurance Company of New York" to "Transamerica Advisors Life Insurance Company of New York" Harrison, NY	July 1
"Phoenix Life and Reassurance Company of New York" to "Philadelphia Financial Life Assurance Company of New York" New York, NY	Oct. 28
Redomestication Filed	
Liberty Life Assurance Company of Boston (from Massachusetts to New Hampshire)	Aug. 24
Merger Agreement Filed	
American International Life Assurance Company of New York into The United States Life Insurance Company in the City of New York, New York, NY	Dec. 31
B. Accident and Health Insurance Companies	
Domestic Company Incorporated	
Health Insurance Company of America, Inc.	Feb. 24
Domestic Companies Licensed	
Solstice Health Insurance Company, New York, NY	Oct. 15
Health Insurance Company of America, Inc., Syracuse, NY	Nov. 15
Withdrawn	
Fox Insurance Company, Scottsdale, AZ	Aug. 3
C. Property and Casualty Insurance Companies	
Foreign Companies Licensed	
First Colonial Insurance Company, Jacksonville, FL	Feb. 16
Mid-Century Insurance Company, Los Angeles, CA	Feb. 16
Berkley National Insurance Company, Urbandale, IA	May 11
Bankers Insurance Company, St. Petersburg, FL	June 16
Accident Fund General Insurance Company, Lansing, MI	June 18
Colony Specialty Insurance Company, Columbus, OH	June 24
MMG Insurance Company, Presque Isle, ME	June 24
Accident Fund National Insurance Company, Lansing, MI	July 1
Accident Fund Insurance Company of America, Lansing, MI	July 1
Unitrin Safeguard Insurance Company, Brookfield, WI	Aug. 24

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Security National Insurance Company, Dallas, TX	Aug. 26
Sequoia Insurance Company, Monterey, CA	Sept. 28
Seaworthy Insurance Company, Annapolis, MD	Sept. 30
United Wisconsin Insurance Company, New Berlin, WI	Oct. 1
Change of Names	
"Atlantic Insurance Company" to "Freedom Specialty Insurance Company" Columbus, Ohio	Jan. 19
"Foremost Insurance Company" to "Foremost Insurance Company of Grand Rapids, Michigan" Grand Rapids, MI	Feb. 24
"SUA Insurance Company" to "CastlePoint National Insurance Company" Chicago, IL	Mar. 19
"American International Insurance Company of Delaware" to "21st Century Assurance Company" Wilmington DE	Apr. 1
"American International Insurance Company" to "21st Century North America Insurance Company" Hicksville, NY	Apr. 1
"AIG Centennial Insurance Company" to "21st Century Centennial Insurance Company" Wilmington, DE	Apr. 1
"AIG Preferred Insurance Company" to "21st Century Preferred Insurance Company" Wilmington, DE	Apr. 1
"AIG Indemnity Insurance Company" to "21st Century Indemnity Insurance Company" Hicksville, NY	Apr. 1
"AIG National Insurance Company" to "21st Century National Insurance Company" Hicksville, NY	Apr. 1
"AIG Premier Insurance Company" to "21st Century Premier Insurance Company" Wilmington, DE	Apr. 1
"AIG Advantage Insurance Company" to "21st Century Advantage Insurance Company" St Paul, MN	Apr. 1
"New Hampshire Indemnity Company" to "21st Century Security Insurance Company" Harrisburg, PA	Apr. 1
"PMA Capital Insurance Company" to "Excalibur Reinsurance Company" Philadelphia, PA	June 16
"Aioi Insurance Company of America" to "Aioi Nissay Dowa Insurance Company of America" New York, NY	Oct. 1
"Kemper Casualty Insurance Company" to "Lumbermens Casualty Insurance Company" Long Grove, IL	Oct. 15
"FFG Insurance Company" to "Aspen American Insurance Company" Dallas TX	Nov. 4
"Harbor Point Reinsurance U. S. Inc." to "Alterra Reinsurance USA, Inc." Greenwich, CT	Dec. 16
"Mainland Insurance Company" to "Harleysville Insurance Company of New York" Harleysville, PA	Dec. 21
"Response Indemnity Company" to "Millville Insurance Company of New York" Melville, NY	Dec. 23
Redomestications Filed	
Atlantic Insurance Company (from Texas to Ohio)	Jan. 19
Safeco National Insurance Company (from Missouri to New Hampshire)	Jan. 20
Allied World Reinsurance Company (from New Jersey to New Hampshire)	Feb. 2
Response Insurance Company (from Connecticut to Illinois)	Mar. 5
Warner Insurance Company (from Connecticut to Illinois)	Mar. 16
Praetorian Insurance Company (from Illinois to Pennsylvania)	Mar. 30

From the digital collections of the New York State Library.

Response Worldwide Insurance Company (from Connecticut to Illinois)	June 29
United States Fidelity and Guaranty Company (from Maryland to Connecticut)	July 9
ACA Insurance Company (from Alaska to Indiana)	Aug. 2
Western United Insurance Company (from California to Indiana)	Aug. 9
Merger Agreements Filed	
Commercial Risk Re-Insurance into General Security National Insurance Company New York, NY	Jan. 15
American Ambassador Casualty Company into Peerless Indemnity Insurance Company Warrensville, IL	Mar. 9
Globe American Casualty Company into The Midwestern Indemnity Company, Loveland, OH	Mar. 30
Redland Insurance Company into Praetorian Insurance Company, Harrisburg, PA	Mar. 31
Avomark Insurance Company into West American Insurance Company	Sept. 27
Harleysville Insurance Company of New York into Mainland Insurance Company	Dec. 21
Withdrawn	
China American Insurance Company, Ltd	Jan. 15
Pennsylvania Casualty Company	Jan 19
Millers Capital Insurance Company	May 5
Nissay Dowa General Insurance Company Ltd. (US Branch)	Oct. 1
Liquidation	
Insurance Corporation of New York	Apr. 14
Colonial Cooperative Insurance Company	Oct. 4
Long Island Insurance Company	Oct. 19
D. Title Insurance Companies	
Foreign Companies Licensed	
Title Resources Guaranty Company, Dallas TX	Feb. 19
First American Title Insurance Company, Santa Ana, CA	June 10
WFG National Title Insurance Company, Columbia, SC	Nov. 5
Merger Agreements Filed	
Nations Title Insurance of New York, Inc. into Fidelity National Title Insurance Company, Santa Barbara, CA	Mar. 31
T. A. Title Insurance Company into First American Title Insurance Company, King of Prussia, PA	Apr. 28
First American Title Insurance Company of New York into First American Title Insurance Company, Santa Ana, CA	Sept. 22
United Capital Title Insurance Company into Fidelity National Title Insurance Company, Santa Barbara, CA	Oct. 27
Ticor Title Insurance Company into Chicago Title Insurance Company, Omaha NE	Nov. 1
Lawyers Title Insurance Corporation into Fidelity National Title Insurance Company Santa Barbara, CA	Nov. 1

From the digital collections of the New York State Library.

Liquidation	
Titledge Insurance Company of New York, Inc, Staten Island, NY	July 12
E. Accredited Reinsurers	
Certificates of Recognition	
Colony Insurance Company, Richmond, VA	May 13
Partner Reinsurance Company Ltd, Pembroke, Bermuda	June 8
Montpelier Reinsurance Ltd, Pembroke, Bermuda	Sept. 30
Change of Names	
"AIG Hawaii Insurance Company, Inc." to "Farmers Insurance Hawaii, Inc." Honolulu, Hawaii	Jan. 28
"American International Pacific Insurance Company" to "21st Century Pacific Insurance Company" Denver, Co	Apr. 1
"American International Insurance Company of California, Inc" to "21st Century Superior Insurance Company" Sacramento, CA	Apr. 1
"Starr Excess Liability Insurance Company, Ltd" to "AIG Excess Liability Insurance Company, Ltd"	Apr. 7
"AIG Excess Liability Insurance Company, Ltd" to "Chartis Select Insurance Company" Wilmington, DE	Apr. 7
"American International Insurance Company of New Jersey" to "21st Century Pinnacle Insurance Company" West Trenton, NJ	May 17
"AIG Auto Insurance Company of New Jersey" to 21st Century Auto Insurance Company of New Jersey" West Trenton, NJ	May 17
"Aioi Insurance Company" to "Aioi Nissay Dowa Insurance Company, Limited" Tokyo Japan	Oct. 1
"Max Specialty Insurance Company" to "Alterra Excess & Surplus Insurance Company" Wilmington, DE	Dec. 21
Withdrawn	
Colonial Penn Life Insurance Company, Philadelphia, PA	Dec. 31
Status Change	
Mid-Century Insurance Company changed from an Accredited Reinsurer Property/Casualty to a licensed Property Casualty, Los Angeles, CA	Feb. 16
Farmers Insurance Exchange changed from an Accredited Reinsurer to Reciprocal Insurer, Los Angeles, CA	July 20
United Wisconsin Insurance Company changed from an Accredited Reinsurer/Property/Casualty to a Property/Casualty insurer	Oct. 1
Merger	
Canada Life Insurance Company of America into Great-West Life & Annuity Insurance Company, Englewood, CO	June 18
F. Charitable Annuity Societies	
Permits Issued	
The Amyotropic Lateral Sclerosis Association, Calabasas Hills, CA	Jan. 28

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American Friends of the Hebrew University, Inc., New York, NY	Feb. 2
American Committee for Shaare Zedek Hospital in Jerusalem, Inc., New York, NY	Feb. 25
Fairfield University, Fairfield, CT	Mar. 5
Boys and Girls Club of America, Atlanta, GA	Mar. 26
North Shore-Long Island Jewish Health System Foundation, Great Neck, NY	Mar. 26
Emma Willard School, Troy, NY	Apr. 6
The University of Texas Foundation, Inc, Austin, TX	May 27
The National Society of the Daughters of the American Revolution, Washington, DC	June 1
Chautauqua Region Community Foundation, Inc, Jamestown, NY	Aug. 27
The Trustees of Trinity College, Hartford, CT	Oct. 27
The Jewish Theological Seminary of America, New York, NY	Dec. 1
The Johns Hopkins University, Baltimore, MD	Dec. 1
Name Change	
"United Jewish Communities, Inc" to "The Jewish Federations of North America, Inc" New York, NY	Mar. 15
"Amit Women, Inc" to Amit Children, Inc" New York, NY	Apr. 27
"Educational Broadcasting Corporation" to "Thirteen" New York, NY	Aug. 17
Withdrawn	
Chautauqua Region Community Foundation, Inc.	Dec. 17
G. Financial Guaranty Companies	
Merger	
Capital Markets Assurance Corporation into MBIA Insurance Corporation, Armonk, NY	Sept. 22
CIFG Guaranty, Inc. into CIFG Assurance North America, Inc. New York, NY	Sept. 29
Name Change	
"FSA Insurance Company" to "Assured Guaranty Municipal Insurance Company" New York, NY	July 14
Redomestications	
FSA Insurance Company (from Oklahoma to New York)	July 14
H. Mortgage Guaranty	
Companies Licensed	
MGIC Indemnity Corporation, Milwaukee, WI	Feb. 19
PMI Mortgage Assurance Co., Phoenix, AZ	Mar. 8
Genworth Mortgage Reinsurance Corporation	Oct. 15
Name Change	
"Private Residential Mortgage Insurance Corporation" to "Genworth Financial Assurance Corporation" Raleigh, CA	May 4
I. Captive Insurance Companies	
Domestic Companies Incorporated	
Eden Insurance Company, Inc., New York, NY	Feb. 1
Epsilon (US) Insurance Company, Melville, NY	June 14

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150 Greenwich Street Insurance Company, Inc., New York, NY	Nov. 12
Domestic Company Licensed	
Eden Insurance Company, Inc., New York, NY	Feb. 9
Epsilon (US) Insurance Company, Melville, NY	June 25
150 Greenwich Street Insurance Co., Inc., New York, NY	Dec. 29
Withdrawn	
Realrisk Insurance Corporation, New York, NY	Feb. 8
Madison Insurance Company, Inc, New York, NY	Aug. 6
Black Ridge Insurance Corporation, Ballston Spa, NY	Dec. 13
Safe Sat of New York, Inc., Melville, NY	Dec. 31
J. Conversion to Life Settlement Providers	
Life Equity LLC	Nov. 30
Neuma, Inc.	Nov. 30
Portsmouth Settlement Company I, LLC	Nov. 30
Wm. Page & Associates, Inc.	Nov. 30
Habersham Funding, LLC	Nov. 30
Coventry First LLC	Nov. 30
Life Settlements International, LLC	Nov. 30
Legacy Benefits Corporation	Nov. 30

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4. Examination Reports Filed During 2010

Name of Companies	As of	Date Filed
Domestic Life Insurance Companies		
Amalgamated Life Insurance Company	12/30/2008	06/03/2010
American Equity Investment Life Insurance Company of New York	12/31/2007	03/01/2010
American Family Life Assurance Company of New York	12/31/2008	06/28/2010
American International Life Assurance Company of New York	12/31/2007	05/27/2010
American National Life Insurance Company of New York	01/28/2010	03/16/2010
American Progressive Life and Health Insurance Company of New York	12/31/2006	06/08/2010
Balboa Life Insurance Company of New York	12/31/2006	09/23/2010
CIGNA Life Insurance Company of New York	12/31/2008	05/19/2010
Combined Life Insurance Company of New York	12/31/2007	03/12/2010
Empire Fidelity Investments Life Insurance Company	12/31/2006	10/12/2010
First Security Benefit Life Insurance and Annuity Company of New York	12/31/2006	03/02/2010
First SunAmerica Life Insurance Company	12/31/2007	12/01/2010
First Symetra National Life Insurance Company of New York	12/31/2007	06/07/2010
Fort Dearborn Life Insurance Company of New York	12/31/2008	12/23/2010
Guardian Life Insurance Company of America	12/31/2008	06/28/2010
Intramerica Life Insurance Company	12/31/2008	01/06/2010
Life Insurance Company of Boston & New York	12/31/2007	03/23/2010
Monitor Life Insurance Company of New York	12/31/2006	03/25/2010
MONY Life Insurance Company	12/31/2005	04/01/2010
Mutual of America Life Insurance Company	12/31/2006	09/30/2010
ReliaStar Life Insurance Company of New York	12/31/2008	06/30/2010
RiverSource Life Insurance Co. of New York	12/31/2006	10/06/2010
SBLI USA Mutual Life Insurance Company, Inc.	12/31/2005	09/29/2010
Teachers Insurance and Annuity Association of America	12/31/2008	06/28/2010
TIAA-CREF Life Insurance Company	12/31/2008	06/28/2010
Unity Mutual Life Insurance Company	12/31/2008	06/02/2010
William Penn Life Insurance Company of New York	12/31/2008	05/25/2010
Foreign Life Insurance Company		
Aetna Life Insurance Company	12/31/2005	05/26/2010
Domestic Accident and Health Insurance Companies		
Aetna Health Insurance Company of New York	12/31/2005	05/26/2010
American Independent Network Insurance Company of New York	12/31/2006	05/04/2010
Empire HealthChoice Assurance, Inc.	12/31/2006	11/10/2010
Health Insurance Company of America, Inc.	09/30/2010	11/12/2010
Health Net Insurance of New York, Inc.	09/30/2008	05/26/2010
MedAmerica Insurance Company of New York	12/31/2006	08/06/2010
MVP Health Insurance Company	12/31/2007	10/15/2010
Solstice Health Insurance Company	07/31/2010	10/14/2010
UnitedHealthcare Insurance Company of New York	12/31/2008	06/30/2010
Health Maintenance Organization		
Aetna Health Inc	12/31/2005	05/26/2010
CIGNA Healthcare of New York, Inc.	12/31/2003	01/15/2010
CIGNA Healthcare of New York, Inc.	09/30/2004	01/15/2010
Elderplan, Inc.	12/31/2007	02/18/2010
Empire HealthChoice HMO, Inc.	12/31/2006	11/10/2010
Health Net of New York, Inc	09/30/2008	05/26/2010

From the digital collections of the New York State Library.

Managed Health, Inc.	12/31/2006	03/04/2010
MVP Health Plan, Inc.	12/31/2007	02/03/2010
Rochester Area HMO, Inc.	12/31/2007	02/03/2010
Rochester Area HMO, Inc.	12/31/2007	10/15/2010
Unitedhealthcare of New York, Inc.	12/31/2008	06/30/2010
Non-Profit Health Service Corporation		
Dentcare Delivery Systems, Inc.	12/31/2005	02/19/2010
MVP Health Services Corp.	12/31/2007	10/15/2010
Preferred Assurance Company, Inc.	12/31/2007	03/08/2010
Preferred Assurance Company, Inc.	12/31/2007	10/15/2010
Domestic Property and Casualty Insurance Companies		
American Steamship Owners Mutual Protection and Indemnity Association	12/31/2005	03/11/2010
Drivers Insurance Company	12/31/2008	09/16/2010
Fidelity National Property and Casualty Insurance Company	12/31/2008	05/14/2010
Fiduciary Insurance Company of America	12/31/2008	12/08/2010
GoldStreet Insurance Company	12/31/2009	09/16/2010
Greater New York Mutual Insurance Company	12/31/2008	03/11/2010
Insurance Company of Greater New York	12/31/2008	03/11/2010
Jefferson Insurance Company	12/31/2009	09/30/2010
Merchants Mutual Insurance Company	12/31/2008	04/05/2010
Merchants Preferred Insurance Company	12/31/2008	04/05/2010
North Sea Insurance Company	12/31/2008	06/07/2010
Paramount Insurance Company	12/31/2008	06/07/2010
Public Service Mutual Insurance Company	12/31/2008	06/07/2010
Rochdale Insurance Company	12/31/2008	05/24/2010
State-Wide Insurance Company	12/31/2008	05/21/2010
Strathmore Insurance Company	12/31/2008	03/11/2010
Tri-State Consumer Insurance Company	12/31/2008	09/24/2010
Advance Premium Property and Casualty Insurance Companies		
Allegany Co-op Insurance Company	12/31/2006	09/27/2010
Central Co-operative Insurance Company	12/31/2008	11/23/2010
Community Mutual Insurance Company	12/31/2008	11/04/2010
Dryden Mutual Insurance Company	12/31/2008	12/21/2010
Finger Lakes Fire & Casualty Company	12/31/2009	11/30/2010
Fulmont Mutual Insurance Company	12/31/2005	05/28/2010
North Country Insurance Company	12/31/2007	08/16/2010
Otsego Mutual Fire Insurance Company	12/31/2007	12/01/2010
Charitable Annuity Societies		
American Associates, Ben-Gurion University of the Negev	12/31/2008	08/30/2010
American Society For Technion-Israel Institute of Technology, Inc.	12/31/2008	01/26/2010
Amnesty International of the U.S.A., Inc.	12/31/2008	10/07/2010
Colgate University	12/31/2008	01/08/2010
College of New Rochelle	12/31/2008	10/15/2010
Columbia University	12/31/2008	05/17/2010
Covenant House	12/31/2008	11/12/2010
Diocese of Rochester	12/31/2008	09/16/2010
Israel Humanitarian Foundation, Inc.	12/31/2008	02/16/2010

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Keuka College	12/31/2008	12/13/2010
Ministers and Missionaries Benefit Board of the American Baptist Churches	12/31/2008	08/23/2010
Museum of Modern Art	12/31/2008	09/22/2010
New York University	12/31/2008	04/21/2010
Roberts Wesleyan College	12/31/2008	05/21/2010
Rochester Institute of Technology	12/31/2008	08/25/2010
Skidmore College	12/31/2008	06/24/2010
Sudan Interior Mission Inc.	12/31/2007	07/08/2010
Trustees of Hamilton College	12/31/2008	05/17/2010
United Jewish Appeal-Federation of Jewish Philanthropies of New York, Inc	12/31/2008	11/12/2010
University at Albany Foundation	12/31/2008	12/17/2010
Captive Insurance Companies		
PXC Inc.	12/31/2009	01/29/2010
Sammarnick Insurance Corporation	12/31/2007	01/08/2010
WTC Captive Insurance Company, Inc.	12/31/2008	03/17/2010
Welfare Trust Funds		
Suffolk County Police Benevolent Association Benefit Fund	12/31/2006	11/23/2010
Suffolk County Police Benevolent Association Legal Services Fund	12/31/2002	11/23/2010
Syosset Teachers Association Trust Fund	06/30/2006	09/10/2010
Title Insurance Companies		
National Title Insurance of New York Inc.	12/31/2008	06/10/2010
Stewart Title Insurance Exchange	12/31/2008	06/30/2010
Reciprocal Companies		
Academic Health Professionals Insurance Association – A Reciprocal Insurer	12/31//2006	05/25/2010
Adirondack Insurance Exchange	12/31/2008	06/07/2010
Foreign Rating Organization		
Insurance Services Office, Inc.	12/31/2004	02/01/2010
Domestic Rating Organization		
Underwriters Rating Board	12/31/2008	08/30/2010
Financial Guaranty Companies		
Capital Markets Assurance Corporation	12/31/2008	06/30/2010
MBIA Insurance Corporation	12/31/2008	06/30/2010
Radian Asset Assurance Inc.	12/31/2008	06/28/2010
Assessment Companies		
Claverack Cooperative Insurance Company	12/31/2008	12/08/2010
Farmers' Town Mutual Insurance Company of Clinton	12/31/2008	10/15/2010
Franklin Fire Insurance Company	12/31/2008	10/27/2010
Genesee Patrons Cooperative Insurance Company	12/31/2007	11/22/2010
Meredith Insurance Company	12/31/2008	10/13/2010
Midrox Insurance Company	12/31/2009	10/29/2010
Midstate Mutual Insurance Company	12/31/2007	01/08/2010

From the digital collections of the New York State Library.

Oswego County Mutual Insurance Company	12/31/2008	08/11/2010
Washington County Co-operative Insurance Company	12/31/2007	10/19/2010
Non Profit Dental Expense Indemnity		
Delta Dental of New York, Inc.	12/31/2006	06/29/2010
Medical Expense Indemnity		
Pupil Benefits Plan, Inc.	12/31/2007	01/26/2010
Alien Fraternal Benefit Society Companies		
Independent Order of Foresters	12/31/2008	06/14/2010
Independent Order of Foresters	12/31/2008	11/10/2010
Underwriting Organization		
American Hull Insurance Syndicate	11/30/2008	01/07/2010
Excise Bond Underwriters	11/30/2009	11/19/2010
United States Aircraft Insurance Group	11/30/2008	08/04/2010
Miscellaneous		
Motor Vehicle Accident Indemnification Corporation	12/31/2008	08/16/2010

From the digital collections of the New York State Library.

5. Insurance Department Receipts and Expenditures

Table 61
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2010

Assessments and Reimbursement of Department Expenses:		
Section 313 – Company Examinations	$	12,114,511
Section 332 – Assessment		431,663,898
Administrative Expense Reimbursement		278,878
Subtotal	**$**	**444,057,287**
Taxes Collected Under the New York State Insurance Law:		
Retaliatory Taxes - Section 1112	$	2,536,184
Excess Line Premium Taxes - Section 2118		56,992,714
Organization Tax - Section 180, Tax Law		3,520
Subtotal[1]	$	**59,532,418**
Fees Collected Under the New York State Insurance Law:		
Section 1112 - Filing Annual Statements, Certificates of Authority to Companies and Agents, and Admission Fees	$	904,375
Section 9110 - Motor Vehicle Law Enforcement Fee		84,925,683
Section 9108 - Fire Insurance Fee		15,451,150
Licensing and Accreditation Fees		14,684,096
Fines and Penalties		9,076,735
Section 1212 - Summons and Complaints		547,975
Section 9107 - Certification & Filing Fees		38,295
CAPCO Application Fees		7,500
FOIL Requests		10,082
Miscellaneous		2,451
Subtotal	**$**	**125,648,342**
Foreign Fire Tax and Security Funds Receipts		
Foreign Fire Tax - Insurance Law Sections 2118, 9104 and 9105	$	46,485,178
Property Casualty Insurance Security Fund – Article 76		27,278,831
Public Motor Vehicle Liability Security Fund – Article 76		10,991,978
Workers' Compensation Security Fund – Article 6A of WC Law		48,479,323
Subtotal	**$**	**133,235,310**
TOTAL DEPARTMENT RECEIPTS	**$**	**762,473,357**

[1]This amount is in addition to the $ 1.331 billion collected by the Department of Taxation and Finance under Tax Law Article 33.

From the digital collections of the New York State Library.

Table 62
INSURANCE TAX RECEIPTS[2]
(in millions)

Fiscal Year	Net
2005-06	987
2006-07	1,142
2007-08	1,088
2008-09	1,086
2009-10	1,331

[2]Collected by the Department of Taxation and Finance under Tax Law Article 33.
Source: State of New York, Annual Budget Message, 2011-12

Table 63
DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2010
Paid in the First Instance from Appropriations

Personal Service	
Employee salaries	$ 74,830,954
Maintenance and Operation	
General Office Supplies	$ 473,301
Travel	2,156,553
Rental of Equipment	160,785
Repair of Equipment	221,599
Real Estate Rental	8,946,810
OGS Telecomunications	620,596
OGS/OFT Computer	147,558
OGS Interagency Courier	32,373
Postage	283,005
Printing	17,800
Telephone	342,005
Misc. Contract Svcs.	4,796,065
Equipment	517,303
Fringe Benefits	34,591,947
Subtotal Maintenance and Operation	**$ 53,307,700**
Suballocations to Other State Agencies	
Personal Service, Maintenance and Operation	**$ 443,517,664**
TOTAL DEPARTMENT EXPENDITURES	**$ 571,656,318**

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Table 64
RECEIPTS VS. DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2010

Total Department Receipts	**$ 762,473,357**
Total Department Expenditures	**$ 571,656,318**
Excess of Department Receipts Over Department Expenditures	**$ 190,817,039**

From the digital collections of the New York State Library.

B. DEPARTMENT STAFFING

Table 65
DEPARTMENT STAFFING (as of March 31, 2011) ‡

Bureau	Examiners	Attorneys	Actuaries	Other Professionals	Investigators	Support Staff	Total
New York City Office:							
Executive		1		13		4	18
Life	98		9	1		4	112
Health	49		9	3		3	64
Administration*	1			7		8	16
Consumer Services	35					16	51
Frauds	3			1	26	2	32
OGC		25		2		7	34
Public Affairs/Research						1	1
Property	180	-	25			17	222
Systems				16		3	19
Capital Markets				6		2	8
Examiner Pool	31						31
Policy		1					1
WCTF		1					1
NYC Total	**397**	**28**	**43**	**49**	**26**	**67**	**610**
Albany Office:							
Executive				3		1	4
Examiner Pool	6						6
Life		16	20			5	41
Health	9	21	5	2		3	40
Administration*		1		21		16	38
Consumer Services	34			1		10	45
Frauds		1		1	7		9
OGC		6				1	7
Public Affairs/Research				1			1
Property	10					1	11
Systems				33		2	35
Capital Markets		1					1
Licensing	1			7		31	39
Albany Total	**60**	**46**	**25**	**69**	**7**	**70**	**277**
ALL OTHER							
Buffalo Office							
Health	1	1					2
Consumer Services	2						2
Frauds					2		2
Mineola Office							
Consumer Services	2					1	3
Examiner Training Pool	1						1
Frauds					6		6
Oneonta Office:							
Frauds					4		4
Rochester Office:							
Frauds					2		2
Syracuse Office:							
Life							
Frauds					1		1
Property	1						
All Other Total	**6**	**1**			**15**	**1**	**23**
Department Total	**466**	**75**	**68**	**118**	**48**	**138**	**913**

*Includes Admin Ops, HRM, Offices Services, and Taxes & Accounts;
‡**Note**: Table does not include student assistants assigned to various bureaus during the year

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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, 2010, the Bureau was managing 71 active insurance company proceedings. During 2010, seven new proceedings were commenced - four domestic liquidation proceedings - Colonial Cooperative Insurance Company, The Insurance Corporation of New York, Long Island Insurance Company, and Titledge Insurance Company of New York, Inc.; and three rehabilitation proceedings - Atlantic Mutual Insurance Company, Centennial Insurance Company, and Professional Liability Insurance Company of America. Two receivership proceedings were completed - MagnaHealth of New York, Inc. and Vesta Fire Insurance Company.

The 71 active insurance company proceedings are classified as follows:

33	Domestic Estates in Liquidation
6	Domestic Estates in Rehabilitation
9	Conservations
23	Ancillary Receiverships

As of December 31, 2010, the 33 domestic estates in liquidation and 9 conservations had combined assets, liabilities and insolvencies as follows:

Total Assets	$1,354,805,862
Total Liabilities	$5,169,642,241
Total Insolvency	($3,814,836,379)

As of December 31, 2010, the five domestic estates in rehabilitation, not including Frontier Insurance Company in Rehabilitation, had combined assets, liabilities and insolvencies as follows:

Total Assets	$1,180,570,531
Total Liabilities	$2,765,805,088
Total Insolvency	($1,585,234,557)

The financial statements of Frontier Insurance Company in Rehabilitation as of December 31, 2010, are under review as of this writing and will be separately issued when completed.

The Bureau received the following amounts from the Security Funds in 2010: $94,663,979 for claims, $31,394,925 for related expenses and $6,976 for return premiums. Of these amounts, from the P/C Fund the Bureau received $52,422,902 for losses, $734 for return premiums and $19,497,300 for related expenses; from the PMV Fund the Bureau received $6,597,834 for losses, and $2,217,143 for related expenses and from the WC Fund the Bureau received $35,643,243 for losses, $6,242 for return premiums and $9,680,482 for related expenses.

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During 2010, the Bureau processed reimbursements to the Security Funds totaling $165,583,477 in the form of dividends and early access, of which $44,217,431 was paid by domestic estates and $121,366,046 was received from ancillary receiverships. Of these amounts, the P/C Fund received $92,235,624 from 14 estates, the PMV Fund received $8,104,343 from 4 estates and the WC Fund received $65,243,510 from 11 estates.

1. Fraternal Benefit Societies

As of December 31, 2010, the Bureau was managing 32 fraternal benefit society liquidation proceedings. During the year, one proceeding was commenced and one proceeding was terminated. No distributions of assets were made during 2010 to members of fraternal benefit societies. The remaining assets of the 32 fraternal benefit societies total $1,040,852.

2. Rehabilitation, Liquidation, Ancillary Receivership and Conservation Proceedings

The insurance entities under the Bureau's jurisdiction during 2010 were as follows:

Rehabilitations

Commenced:
Atlantic Mutual Insurance Company
Centennial Insurance Company
Professional Liability Insurance Company of America

Continued:
Executive Life Insurance Company of New York
Frontier Insurance Company
Lion Insurance Company

Completed: None

Liquidations

Commenced:
Colonial Cooperative Insurance Company
The Insurance Corporation of New York
Long Island Insurance Company
Titledge Insurance Company of New York, Inc.

Continued:
American Agents Insurance Company
American Consumer Insurance Company
American Fidelity Fire Insurance Company
Capital Mutual Insurance Company
Colonial Indemnity 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
MDNY Healthcare, Inc.

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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: MagnaHealth of New York, Inc.

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: None

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
Eagle 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
Newark Insurance Company
Phico Insurance Company
Reliance Insurance Company
Security Indemnity Insurance Company
Shelby Insurance Company
The Home Insurance Company
Transit Casualty Company
Villanova Insurance Company

Completed: Vesta Fire Insurance Company

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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: None

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3. Security Funds Income and Disbursements

Table 66
PROPERTY/CASUALTY INSURANCE SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2010

Total of Fund as of 4/1/09	**$170,017,750**
Paid into the Fund	$72,193
Interest income - net	2,220,670
Recoveries from companies in liquidation	24,225,068
General Fund Interest Reimbursement	760,900
Total Receipts	**$27,278,831**
Less disbursements:	
Administrative expenses	$ 176,275
Awards and expenses of companies in liquidation	64,974,642
Total Disbursements	**$65,150,917**
Total Activity	**-$37,872,086**
Total of Fund as of 3/31/10[2]	**$ 132,145,664**

[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.

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Table 67
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2010

Total of Fund as of 4/1/09	**$ 28,397,623**
Paid into the Fund	$8,522,276
Interest income - net	277,713
Recoveries from companies in liquidation	2,191,989
Total Receipts	**$10,991,978**
Less disbursements:	
Administrative expenses	$ 46,025
Awards and expenses of companies in liquidation	8,403,570
Total Disbursements	**$ 8,449,595**
Total Activity	**$ 2,542,383**
Total of Fund as of 3/31/10[2]	**$ 30,940,006**

[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.

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Table 68
WORKERS' COMPENSATION SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2010

Total of Fund as of 4/1/09	**$ 56,239,236**
Paid into the Fund	$ 33,902,730
Interest income – net	342,195
Recoveries from companies in liquidation	14,234,398
Total Receipts	**$ 48,479,323**
Less disbursements:	
Administrative expenses	$ 68,385
Awards and expenses of companies in liquidation	53,467,555
Total Disbursements	**$ 53,535,940**
Total Activity	**-$ 5,056,617**
Total of Fund as of 3/31/10	**$ 51,182,619**

[1] Monies collected under Workers' Compensation Law Sections 108 and 109.

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X. Publications

Automobile/Livery Guides

- 2010 Annual Ranking of Automobile Insurance Complaints
- 2010 Consumer Guide to Automobile Insurance, including price comparison tables and notes

Frauds

- Insurance Frauds Consumer Brochure
- 2010 Insurance Frauds Bureau Annual Report
- 2010 Health Insurance Fraud Annual Report

Health

- Interactive New York Consumer Guide to HMOs (external website link)
- New York Consumer Guide to Health Insurers (2010 Edition - Includes 2009 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

Small Business Guides

- Health Insurance - a Small Business Guide
- Property Casualty Insurance - A Small Business Guide (available in English & Chinese)

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

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