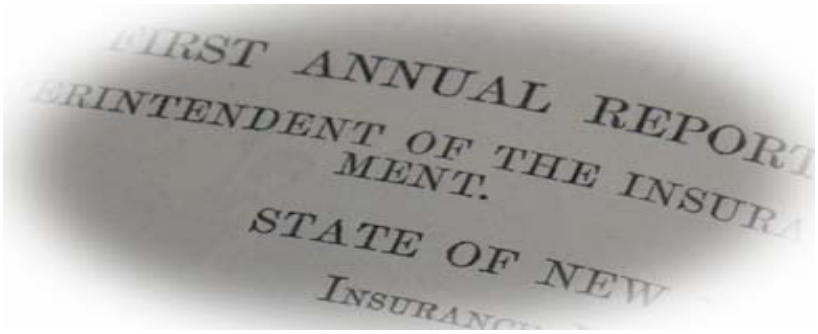
NEW YORK STATE
INSURANCE DEPARTMENT

150th ANNUAL REPORT
OF THE
SUPERINTENDENT

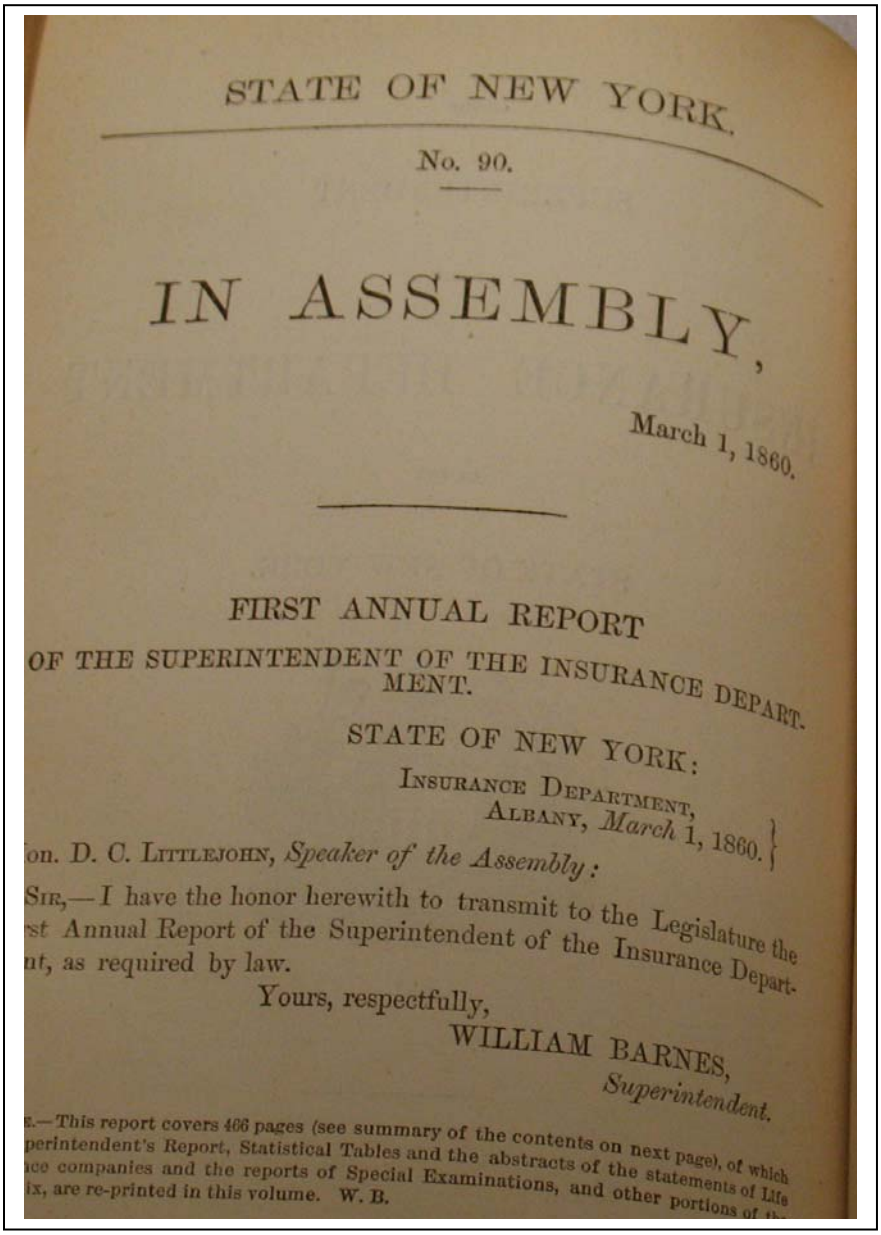


David A. Paterson
Governor

Eric R. Dinallo
Superintendent

www.ins.state.ny.us

"…a separate and distinct department, charged with the execution of the laws relating to insurance."



STATE OF NEW YORK.

No. 90.

IN ASSEMBLY,

March 1, 1860.

FIRST ANNUAL REPORT

OF THE SUPERINTENDENT OF THE INSURANCE DEPARTMENT.

STATE OF NEW YORK:

INSURANCE DEPARTMENT,
ALBANY, *March* 1, 1860.

on. D. C. LITTLEJOHN, *Speaker of the Assembly:*

SIR,—I have the honor herewith to transmit to the Legislature the st Annual Report of the Superintendent of the Insurance Department, as required by law.

Yours, respectfully,

WILLIAM BARNES,
Superintendent.

.—This report covers 466 pages (see summary of the contents on next page), of which perintendent's Report, Statistical Tables and the abstracts of the statements of Life ce companies and the reports of Special Examinations, and other portions of ix, are re-printed in this volume. W. B.

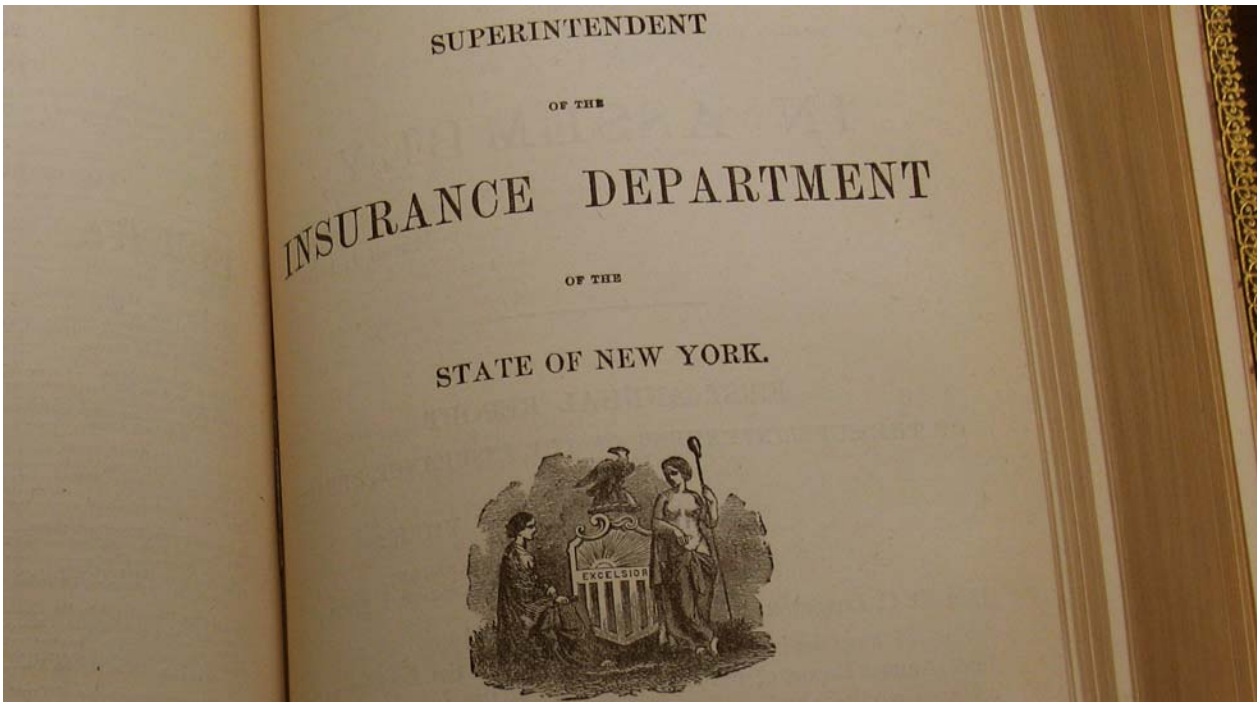
This year's Annual Report of the Superintendent is the 150th such report issued since the Insurance Department was established by an act of the Legislature approved April 15, 1859.

The act authorized the Department to operate as "a separate and distinct department, charged with the execution of the laws relating to insurance." Previously, insurance oversight came under the office of the state Comptroller.

The act became law on Jan. 1, 1860, and on Jan. 11, 1860, the Legislature confirmed William Barnes as the Department's first Superintendent.

The images shown here are reproduced from the first Superintendent's first report, which Barnes used to describe the insurance business in New York and his activities setting up the Department.

The New York State Insurance Department is believed to be the oldest state regulatory agency in the United States.



The 150th Annual Report of the Superintendent of Insurance to the New York State Legislature

For the Year Ending
December 31, 2008

David A. Paterson
Governor

Eric R. Dinallo
Superintendent

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

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

This report is available on the
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www.ins.state.ny.us

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

David A. Paterson
Governor

Eric R. Dinallo
Superintendent

May 15, 2009

To the Legislature:

I am pleased to submit to the New York State Legislature the 150th Annual Report of the Superintendent of Insurance as required by Article 2, Section 206 of the Insurance Law.

The Annual Report for Calendar Year 2008 reflects a major milestone. On April 15, 1859, the Legislature established the Insurance Department as a separate and distinct entity from the Comptroller's office. The law establishing the Department went into effect on January 1, 1860. As a result of that action, the Insurance Department is believed to be the oldest independent state insurance regulatory agency in the United States.

Today, New York and our nation are struggling to resolve serious economic challenges. Despite these challenges, I am confident that our nation, this state and this Department will emerge even stronger than before. The Insurance Department is staffed with scores of dedicated and capable professionals. We remain dedicated to our core principals of protecting policyholders, making certain that insurers remain solvent and encouraging the development of a strong, sound, vibrant insurance industry in New York State.

On behalf of the Department, we appreciate the continuing support we have received from Governor Paterson and the members of the Legislature. We look forward to working closely with you in the future as we continue our strong commitment to serving the people of New York.

Respectfully submitted,

Eric R. Dinallo
Superintendent

Major Developments

Overview

The core mission of the New York State Insurance Department is to protect policyholders and make certain that insurers maintain their solvency. Seldom has achieving that mission been more critical than in 2008.

Amid the worst economic crisis since the Great Depression, the Department demonstrated innovation and flexibility in dealing with complex and dynamic challenges. The Department promoted consumer protection and transparency. It was a forceful advocate for the continued supervision of insurance through effective state regulation.

During the course of the year, the Department focused on five major areas:

- Crisis management of the economic fallout that affected policyholders and insurers;
- Regulatory reform;
- Consumer protection;
- Enforcement activities; and,
- National and international insurance issues.

Crisis Management

Protecting Bond Policyholders

Throughout 2008, the Insurance Department continued efforts begun earlier to stabilize financial guarantee companies weakened by the downturn in real estate markets. Stabilizing the companies jeopardized by losses from credit default swaps was essential to ensure the availability of bond insurance for thousands of municipalities. Without bond insurance, taxpayer costs to finance projects like bridges, highways and school buildings promised to rise dramatically.

The Department acted to protect policyholders and help the companies preserve their high investment grade ratings where possible. Focusing on finding private sector solutions, the Department worked with each of the companies individually. It also sought input from banks, financial advisors, private equity investors, rating agencies and federal regulators.

A three-point plan was developed by the Department in late 2007. It called for attracting new capital and capacity into the bond insurance market; alleviating the current problems of the distressed insurers; and developing new regulations to prevent similar problems from happening again.

The plan bore fruit early in 2008 when Berkshire Hathaway was enticed to enter the market. The Department fast-tracked the licensing of the company's Berkshire Hathaway Assurance Corp. in only 28 days. The new insurer sold its first policy by the end of January, underwriting a $10 million municipal project in New York City. The company's entry represented what eventually became a $15 billion injection of new capital into the market from several new insurers.

Individual solutions were devised to help the existing companies, which each faced different challenges.

One company, MBIA, was split into two entities, one to insure municipal bonds and another to operate in structured finance markets. Commutations of structured security guarantees were

arranged for two companies, FGIC and Ambac, so they would be able to continue to remain in the municipal bond insurance market. Two other companies, Assured Guaranty and Financial Security Assurance were allowed to merge and continue to operate as a merged company.

Despite the disruption, bond insurance continued to be available to the municipalities requiring it and the policyholders of existing insurance contracts continued to be protected.

The Rescue of AIG

The Department closely monitored American International Group (AIG) as financial conditions worsened in 2007 and 2008. A huge international financial services company, AIG had more than $1 trillion in assets and 116,000 employees. An AIG holding company controlled its subsidiaries, including insurance companies and the London-based AIG Financial Products Group.

In September, Superintendent Eric Dinallo was asked by AIG to help address what had become a serious liquidity problem. The problem resulted from massive losses in credit default swaps sold by the Financial Products Group to cover mortgage-backed securities. Unlike the 71 U.S.-based AIG insurers regulated by state insurance departments, including New York, the Financial Products Group, did not come under state regulators' supervision.

Led by Superintendent Dinallo, the Department aimed at developing a private sector solution, like the strategy used in helping the bond insurers. The urgency of challenge was underlined by the fact that AIG employed 8,500 people in New York.

A plan was devised allowing for a temporary transfer of assets to provide the liquidity AIG needed to continue to function as it moved ahead with a reorganization. The plan was contingent on two things happening – first, AIG needed to develop a long-term holistic approach that would allow an orderly reorganization, and second, and most importantly, it was essential that policyholders be protected.

Eventually, it became apparent that a commercially-financed reorganization was not possible because of the scope of the challenge. However, the work of the New York regulators laid the groundwork for action by the U.S. Treasury Department.

The Treasury believed that the bankruptcy of a company with 74 million customers worldwide – including all major banks – would spread failures throughout the financial system. The Treasury stepped in with an $85 billion bridge loan, and then additional funding. The plan called for the company to repay the Treasury as it sold off subsidiary operations and emerged as a smaller insurance-focused business.

The plan pursued by the Treasury was possible only because AIG's state-regulated insurance subsidiaries remained solvent through the crisis.

Superintendent Dinallo was named to chair a 50-state National Association of Insurance Commissioners (NAIC) task force to oversee the sale of AIG's insurance operations. The task force, whose work continues, is coordinating state regulatory activities and is responsible for making certain policyholders are protected as the AIG insurance operations are sold to stable, responsible entities capable of operating them successfully.

Regulatory Reform

Throughout the year, Superintendent Dinallo was a strong advocate for state insurance regulation. The debate turned on fundamental issues the Department has faced throughout its history:

- What must be done to safeguard policyholders?
- What steps should be taken to promote an open, transparent marketplace?
- Should the federal government assume a larger place in regulating insurance, a role traditionally performed by state governments, or even replace the states?

The economic fallout affecting insurance and other financial services was largely blamed on a chain of events that started in the housing market where subprime mortgages were packaged into complex structured securities. Investors in the securities sought to protect themselves against loss by buying credit default swaps.

Unknown, unrecognized or ignored by the markets was the fact that many of the mortgage-backed securities were steeped in risk. These risks were largely invisible because of a faulty credit rating system that requires substantial reform. The insurance-like swaps proved more adept at spreading risks through the financial markets than containing them because they were unsupported by reserves to cover losses. Superintendent Dinallo described the swaps as the great enablers that led to the financial meltdown throughout the financial markets.

The dimensions of the problem became clear early in 2008 as Superintendent Dinallo testified numerous times before Congress. He urged regulation of credit default swaps and said New York would begin doing so. Later, in light of progress made by the federal government to oversee the swaps, he said the state would delay, at least for the time being, its plans to regulate them.

Beyond the issue of credit default swaps, some argued for a larger federal role in insurance regulation. But Superintendent Dinallo said the wrong lesson would have been learned if federal regulation replaced the role of the states.

"State insurance regulators serve a vital and relevant role…"

For more than 150 years, state governments have been the primary regulator of insurance companies. State regulators continuously strengthened their supervision of insurance over that time and no systemic failures ever occurred in the insurance industry. The credit default swaps that had undermined the financial system were unregulated because swaps and other derivative transactions were exempted from regulation by the federal government in 2000.

"State insurance regulators serve a vital and relevant role in overseeing and fostering a vibrant, well-functioning and competitive insurance marketplace with strong state-based consumer protections. This coordinated, national system of state-based insurance supervision continues to meet the needs of the modern financial marketplace while effectively protecting individual and commercial policyholders," the Superintendent testified before a House of Representatives hearing in April.

"The crisis for AIG did not come from the state regulated insurance companies. State insurance regulators are not perfect. But the one thing we do very well is focus on solvency, on the financial strength of our insurance companies. We require them to hold conservative reserves to ensure that they can pay hold policyholders. That is why insurance companies have performed relatively well in this storm."

"The states have no interest in competing in a race to the bottom…"

The Superintendent conceded that federal participation in insurance regulation was likely – and could be helpful in targeted areas of regulation, such as in overseeing systemic risk. However, he rejected the idea of an Optional Federal Charter, a process where an insurer could decide for itself whether to come under federal or state regulation.

"Optional regulatory regimes lead to regulatory arbitrage and gaps in oversight. They are not good for anyone, least of all consumers. The states have no interest in competing in a race to the bottom that leaves our residents confused and ties the hands of state government. So I urge you strongly -- please don't leave your constituents in a regulatory abyss by creating a federal chartering option," the Superintendent said.

"Consumer protection has been a hallmark of state insurance regulation. That is due in large part to the fact that we understand the local markets and the people with whom we are dealing. There are more than 15,000 state insurance regulators with their finger on the pulse of the local insurance markets they represent -- each with firsthand knowledge of the needs of their local consumers."

Bond Insurer Reform

As a consequence of the crisis in the bond insurance market, Superintendent Dinallo urged the consideration of such measures as changing the business model of the financial guarantee companies. This could be done, he said, by requiring the companies to split off their securities businesses from their municipal bond insurance businesses. Insuring relatively safe municipal debt should not be affected by the far more risky securities part of the businesses.

In addition, he urged major reform of the credit ratings agencies. The agencies should operate as an independent buy-side system for establishing ratings, instead of the current process where the ratings are paid for by the institutions selling the securities that are rated.

Superintendent Dinallo was later named to co-chair an NAIC working group to investigate the suitability of the current rating system related to insurance. The group will examine such issues as conflict-of-interest, performance and how ratings are generated for entities recognized by insurance regulators.

Additional Regulatory Reform Efforts

Contract Certainty

The Department notified insurers that they should establish contract certainty by making sure the final terms of an insurance policy or reinsurance contract are clearly understood when the policy goes into effect, or soon thereafter. This was designed to make certain that insurance contracts are enforceable in large commercial transactions or where there are special risks.

The absence of contract certainty led to disputes over claims following the 9/11 terrorist attacks on the World Trade Center. Those disputes were finally resolved when the Department intervened in 2007 and secured a $2 billion settlement, the largest in regulatory history.

Agent and Broker Compensation Disclosure Considered

Public hearings were held to gain input for potential regulatory changes that could require the disclosure to consumers of insurance agent and broker compensation arrangements. Conducted in conjunction with the Office of the Attorney General Andrew Cuomo, the hearings covered such issues as contingent and supplemental commission disclosures.

Life Settlement Protections Proposed

The Department proposed life settlement regulation after a series of public hearings across the state. The proposal called for a comprehensive framework to regulate the transactions, which are not currently regulated. The proposal detailed licensing requirements for life settlement providers and life settlement brokers, as well as registration requirements for life settlement intermediaries. It established privacy protections and other safeguards for insured individuals and policyowners.

Continued Workers' Compensation Reform Success

Gov. Paterson in August announced the reduction of workers' compensation insurance rates for the second year in a row. The rates declined by approximately 5 percent for 2009, following a 20.5 percent decline in 2008. The reduced rates were the result of the successful implementation of workers' compensation reforms implemented by the Governor. The reforms were aimed at reducing the cost of the workers' compensation program, while increasing worker benefits and improving medical care for injured workers.

Consumer Protection

Holding the Line on Auto Insurance

New York drivers avoided a nearly $515 million increase in auto insurance rates when the Department advised insurers they must take reduced driving into account when requesting rate increases. A total of 43 companies, covering 75 percent of New York's driving population, had requested the rate increases when the Department told the companies to show how reduced driving factored into their rate increase requests. Many of the auto insurers withdrew, or dramatically reduced proposed rate increases following the Department's action.

Expanding Health Insurance Coverage

In May, Superintendent Dinallo and Health Commissioner Richard F. Daines, M.D. released an interim report to Governor Paterson describing progress in developing proposals to achieve universal health insurance coverage. Four different proposals were developed to expand coverage following a series of statewide hearings under the Partnership for Coverage program. A total of 270 people attended the hearings to provide their input and hear the opinions of others. Hundreds more viewed the hearings on webcasts. The four proposals are being examined under simulation models being developed by the Urban Institute for consideration by the state.

Acting to Protect Senior Citizens

In an effort aimed at protecting senior citizens, the Department warned that it will penalize insurance agents or brokers who attempt to mislead seniors by using unsupported titles such as "retirement planner," "senior advisor" or "senior consultant" in selling insurance. The Department said it was improper to use such titles which imply special expertise when, in fact, no such special expertise exists.

Protecting Consumers Traveling to Israel

Individuals planning future travel to Israel and other international destinations cannot be denied life insurance under a proposal advanced by Superintendent Dinallo and adopted by the NAIC. By endorsing the proposal, the NAIC urged states to protect the rights of Americans to freely travel abroad without losing life insurance protection.

Treating All Married Couples Equally

The Department directed insurance companies to treat same-sex couples legally married outside New York the same as any other validly married couples, irrespective of the sex of the spouses. The directive covered all Department licensees and encompassed virtually all insurance products. The Department stated that an insurer's refusal to extend insurance coverage equally would constitute unfair discrimination.

Out-of-Network Treatment

The Insurance Department conducted a public hearing with the Department of Health to obtain input from consumers who had been referred for out-of-network medical care. Numerous consumers complained that they were referred for costly out-of-network services without their knowledge. The two departments are considering regulatory action to address the issue.

Program Expanded for Minority and Women-Owned Firms

Minority- and women-owned businesses will get a better chance to compete for contracts on commercial and public projects as a result of a pilot program announced in February by then Lt. Governor Paterson and Superintendent Dinallo. The new program substantially expanded a previous plan to help businesses obtain surety bonds required to compete for government and private construction work. The program was expanded to include Buffalo, Syracuse, Rochester and Albany.

Protecting Homeowners' Rights

The Department protected homeowners by advising insurance companies that they may not cancel homeowners policies solely on the basis that a dwelling is unoccupied. Canceling policies only on that basis would be considered an illegal mid-term cancellation. The Department's action was designed to protect consumers in such situations as relocating or traveling in connection with their jobs.

Enforcement Actions

Small Businesses Receive $50 Million Refund in Oxford Settlement

Gov. Paterson and Superintendent Dinallo in May announced that Oxford Health Insurance Inc. agreed to refund approximately $50 million to nearly 37,000 small businesses in New York City, Long Island and northern suburbs of New York City for overcharging on health insurance policies.

The overcharges occurred in 2006 and resulted when Oxford's loss ratio for small group policies fell below a required 75 percent minimum.

The Governor and Superintendent urged reinstatement of prior approval of insurance rates by the Insurance Department to avoid consumer overcharges in the future.

Currently, health insurers are permitted to file rate increases without first obtaining the Department's approval.

More Than $9 Million Recovered

The Insurance Department and the Department of Civil Service recovered more than $9 million in over-billings and fines from five medical providers. The over-billings resulted when the medical providers submitted inflated claims to the New York State Health Insurance Program after inappropriately waiving out-of-pocket costs for government employees. Audits by the office of Comptroller Thomas P. DiNapoli uncovered the over-billings by medical providers.

Insurer Fined $1 Million

The complaint of a woman improperly denied insurance coverage for infertility treatments led to a $1 million fine against HealthNow New York Inc. The insurer also agreed to reprocess and pay similar claims for as many as 2,500 women. The actions occurred as the result of an investigation by the Department.

National and International Leadership

Department Recognized by NAIC

The NAIC in December presented its Esprit de Corps Award to the Department. The award recognizes outstanding service to the NAIC. In presenting the award, NAIC President Sandy Praeger commended New York's leadership in mobilizing the NAIC's pursuit of consumer protection during the AIG crisis.

"This is an award the entire Department has earned. I was privileged to accept the award on behalf of every member of our Department," Superintendent Dinallo said in accepting the award.

MOUs Reached with International Regulators

The Department executed memoranda of understanding agreements with regulators in four countries – the United Kingdom, France, Germany and Bermuda -- paving the way for closer cooperation between the Department and the overseas regulators. The agreements allow for greater exchanges of information about international insurers, helping enhance the global watch of global insurance groups that the G20 nations and Financial Stability Forum urged regulators to implement.

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, 2008. The total admitted assets of licensed life insurers amounted to approximately $2.54 trillion at December 31, 2007 a ten-year gain of 78.3%. Bonds totaled $1,031.6 billion; stocks $83.7 billion; mortgage loans $187.3 billion; real estate $12.8 billion; policy loans $62.5 billion, and short-term holdings $16.6 billion. Other admitted assets totaled $1,145.3 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $946.6 billion on December 31, 2007, an increase of 84.1% since 1997. Insurance in force at December 31, 2007 of $5.66 trillion represents an increase of 84.1% since December 31, 1997.

3. Organizations UnderLife Bureau Supervision

The Life Bureau supervised 510 organizations as of December 31, 2008. These organizations consisted of: 133 licensed life insurance companies — 78 domiciled in New York and 55 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; 248 charitable annuity funds; 24 employee welfare funds; 7 viatical settlement companies and 39 accredited reinsurers. Unless otherwise noted, tables and related data for life insurance companies refer to the **nationwide** operations of insurers licensed to do business in the State.

Table 1
ADMITTED ASSETS
Life Insurance Companies Licensed in New York State
Selected Years, 1997-2007 (dollar amounts in billions)

Admitted Assets	2007	2006	2002	1997
Total	$2,539.9	$2,374.3	$1,719.6	$1,424.9
Percent increase from 1997	78.3%	66.6%	20.7%	---
Type of asset				
Bonds	$1,031.6	$1,009.1	$802.3	$615.1
Stocks	83.7	84.2	47.1	50.6
Mortgage Loans	187.3	174.7	145.7	132.4
Real Estate	12.8	12.0	14.5	25.4
Policy loans/liens	62.5	59.6	56.5	61.7
Short-term holdings	16.6	13.7	27.9	29.5
Other	1,145.3	1,021.0	625.4	510.2

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

Table 2
BALANCE SHEET
Life Insurance Companies Licensed in New York State
Selected Years, 2002-2007
(in billions)

	2007	2006	2002
Assets	$2,539.9	$2,374.3	$1,719.6
Liabilities	2,401.8	2,247.9	1,623.4
Capital & Surplus	138.1	126.4	96.2

Table 3
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1997-2007
(dollar amounts in billions)

Class of Business	2007	2006	2002	1997
Total insurance in force	$12,850.4	$12,254.4	$10,142.7	$7,780.1
Percent increase from 1997	65.2%	57.5%	30.4%	---
Ordinary	$6,950.8	$6,574.2	$5,580.3	$4,172.3
Group	5,848.0	5,626.7	4,462.1	3,519.7
Credit	45.8	47.5	57.4	80.5
Industrial	5.9	6.0	6.8	7.5

Table 4
SOURCES OF INCOME*
Life Insurance Companies Licensed in New York State
Selected Years, 2002-2007
(dollar amounts in millions)

Source of Income	2007 Amount	2007 Percent of Total	2006 Amount	2006 Percent of Total	2002 Amount	2002 Percent of Total
Group life	$24,136.5	7.4%	$21,981.4	6.8%	$15,630.0	5.5%
Group annuities	78,067.4	23.8	74,453.8	22.9	65,878.0	23.1
Group A & H	28,561.8	8.7	25,696.0	7.9	21,277.8	7.4
Ordinary life	29,224.0	8.9	44,119.7	13.5	46,373.2	16.2
Individual annuities	58,157.2	17.7	57,642.2	17.7	50,823.7	17.8
Individual A & H	8,999.0	2.7	7,911.4	2.4	4,543.6	1.6
Credit life	251.6	0.1	317.0	0.1	240.1	0.1
Industrial life	-794.7	-0.2	62.7	0.0	204.0	0.1
Total Premiums	**$226,602.8**	**69.1%**	**$232,184.2**	**71.3%**	**$204,970.4**	**71.8%**
Supplementary contracts	423.8	0.1	472.5	0.1	376.1	0.1
Net investment income	85,477.9	26.1	80,949.4	24.9	71,990.1	25.2
Other income	15,481.6	4.7	12,026.7	3.7	8,246.3	2.9
TOTAL	**$327,986.1**	**100.0%**	**$325,632.8**	**100.0%**	**$285,582.9**	**100.0%**

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

Table 5
OPERATING RESULTS*
Life Insurance Companies Licensed in New York State
Selected Years, 2002-2007
(in millions)

	2007	2006	2002
Total premiums	$242,637.0	$230,464.5	$199,150.3
Investment income	85,477.9	80,949.4	71,990.1
Supplementary contracts	423.8	472.5	376.1
Other income	-552.6	13,746.3	14,066.4
Total income	$327,986.1	$325,632.8	$285,582.9
Net gain from operations	$16,364.9	$14,410.6	$11,243.0
Net income	$16,341.9	$18,653.4	$3,747.9

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

Table 6
LIFE INSURANCE IN FORCE IN THE STATE OF NEW YORK
Life Insurance Companies Licensed in New York State
Selected Years, 1997-2007
(dollar amounts in billions)

Insurance In Force	2007	2006	2002	1997
Total	$1,690.7	$1,767.8	$1,387.0	$975.0
Percent increase from 1997	73.4%	81.3%	42.3%	---
Class of business				
Ordinary	$1,123.2	$1,065.4	$830.2	$581.3
Group	560.4	695.1	548.5	386.9
Credit	6.6	6.8	7.6	5.9
Industrial	0.5	0.6	0.8	0.9

Table 7
ADMITTED ASSETS/INSURANCE IN FORCE
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1997-2007
(dollar amounts in billions)

Domestic Life Insurers	2007	2006	2002	1997
Admitted assets	$946.6	$884.2	$639.0	$514.3
Percent increase from 1997	84.1%	71.9%	24.2%	---
Insurance in force	$5,658.0	$5,394.8	$4,018.0	$3,336.5
Percent increase from 1997	69.6%	61.7%	20.4	---

4. Licensed Fraternal Benefit Societies

At the close of 2007, 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, 2007, the admitted assets of licensed societies rose from $47.8 billion to $78.8 billion, an increase of 65%. Insurance in force rose $44.8 billion over the period to $317.0 billion, an increase of 16%.

Table 8
FRATERNAL BENEFIT SOCIETIES
Selected Years, 1997-2007
(in billions)

Fraternal Benefit Societies	2007	2006	2002	1997
Admitted assets	$78.8	$77.6	$63.9	$47.8
Insurance in force	$317.0	$305.0	$272.2	$231.1

5. Private Retirement Systems

At the close of 2007, four private retirement systems were under the supervision of the Life Bureau.

The four systems, which are private pension funds of nonprofit organizations, were made subject to Insurance Department regulation by special legislative enactments. At the end of 2007, the assets of these four private pension funds totaled approximately $226 billion. The following table shows data for the private pension funds for selected years from 1997 to 2007:

Table 9
PRIVATE PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1997-2007
(in millions)

Private Pension Funds	2007	2006	2002	1997
Total admitted assets	$225,977	$222,066	$129,337	$126,668
Payments to annuitants and beneficiaries	$22,778	$19,059	$10,483	$6,391

6. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Life Bureau at the close of 2007 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 2007 were approximately $372 billion. During the period from 1997 to 2007, the assets of these retirement systems increased at the compound rate of 5.0% per year.

The governmental retirement systems cover a total of 2.0 million active and retired members. The number of active employees in the public retirement systems in 2007 increased by 18% from its 1997 level, while the number of pensioners increased by 25% over the same period. The substantial increase in pensioners, as compared with a lesser increase in the work force, reinforces the need for maintaining adequate actuarial reserves.

The New York City Administrative Code provides for nine active non-pension funds known as variable supplements funds, financed by the transfer of earnings from the equity portfolios of the New York City Police and Fire Department Pension Funds and the Employees' Retirement System. If at any time the earnings so transferred are insufficient, the City guarantees the payment of the variable supplements benefits. These variable supplements funds provide retirement benefits in addition to those received from the pension funds and the retirement system. The variable supplements funds, all of which are under the supervision of the Insurance Department, had assets as of June 30, 2007 totaling $3.4 billion.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1997 to 2007:

Table 10
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
Regulated by NYS Insurance Department
Selected Years, 1997-2007
(in millions)

Public Retirement Systems & Pension Funds	2007	2006	2002	1997
Fair value of assets*	$372,490	$332,802	$266,930	$229,224
Payments to annuitants and beneficiaries	$19,412	$17,406	$13,024	$9,156

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

During 2008, the Department worked with the retirement systems of New York City to continue the revision and augmentation of Regulation 85 (11 NYCRR Part 136), as had been done in 2007 with the New York State & Local Retirement System. The objective is to provide an enhanced governance and financial reporting framework for public employee retirement systems.

The annual statement for retirement systems, required to be filed with the Department pursuant to Section 307 of the Insurance Law, was modified further in 2008 from the 2007 version, which was itself a major revision. The modification was intended to simplify the submission process and the data analysis to be performed on the statement. Filings on the new statement form are being made though the portal for the statements due March 1, 2009.

A regular on-site examination of the Church Pension Fund, one of the private retirement systems, was conducted during 2008.

7. Segregated Gift Annuity Funds for Charitable Organizations

At the end of 2007, 232 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, 2007, admitted assets of these funds increased by 277% and the annual payments increased by 304%. This reflects the rapid growth in the number of licensed societies during the period.

Table 11
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1997-2007
(in millions)

Segregated Gift Annuity Funds	2007	2006	2002	1997
Total admitted assets	$2,167.1	$2,079.1	$1,230.4	$575.4
Annual payments to annuitants	$177.7	$180.4	$114.0	$44.0

8. Employee Welfare Funds

Twenty-four employee welfare funds covering 109,239 employees were supervised by the Life Bureau at the close of 2007. These funds are jointly administered by management and labor representatives. The employee welfare funds cover government employees for benefits financed by contributions from New York governmental authorities. Government employee welfare funds were not pre-empted by the federal Employee Retirement Income Security Act of 1974 (ERISA) as most private pension funds were.

Contributions to employee welfare funds amounted to $273.8 million in 2007. Benefits paid totaled $262.2 million and included life insurance; medical, surgical and hospital coverage; major medical coverage; optical, dental and prescription drug plans; disability insurance, and legal services. Administrative expenses totaled $9.3 million representing 3.4% of contributions.

9. Viatical Settlement Companies

Regulation 148 and Article 78 of the Insurance Law became effective as of July 6, 1994 for the purpose of regulating viatical settlement companies and brokers. At the end of 2007, eight companies were licensed or authorized to act as viatical settlement companies in New York.

As of December 31, 2007, these companies had combined assets of $120 million. The assets primarily consisted of life insurance policies purchased, cash and accounts receivable. Costs of purchasing these policies amounted to $29 million, which comprised about 22.8% of the $129 million total face value.

10. Examinations Conducted in 2008

Table 12
EXAMINATIONS CONDUCTED
Life Bureau
2008

		Regularly Scheduled		Other	
		Initiated			On
	Total	In 2008	Prior to 2008	Special	Organi-zation*
Life insurance companies	49	30	16	3	0
Fraternal benefit societies	1	0	1	0	0
Retirement systems and pension funds	2	2	0	0	0
Segregated gift annuity funds of charitable organizations	25	25	0	0	0
Viatical settlement companies	1	1	0	0	0
Welfare funds	4	4	0	0	0
Total	**82**	**62**	**17**	**3**	**0**

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

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 2008, there were 510 companies that were licensed or accredited to conduct business in New York State, as detailed below. These companies are required to file their Annual Statements for audit and analysis.

Table 13
COMPANIES LICENSED BY THE LIFE BUREAU
December 31, 2008

Life – New York	78
Life – Other States	55
Accredited Reinsurers	39
Fraternals – New York	3
Fraternals – Other States	34
Fraternals – Canadian, U.S. Branch	1
Charitable Annuities	248
Retirement Systems	21
Viaticals	7
Welfare Funds	24
Total	**510**

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 2008 were updated to meet current needs and requirements. Copies of the Supplements are now distributed through the Department's Web site to all life companies and Fraternal Benefit Societies licensed to do business in New York State.

12. Actuarial Unit

a. Agent Compensation

During 2008, the Life Bureau received 150 agent compensation submissions pursuant to Section 4228 of the Insurance Law, 16 fewer than in 2007. Nine of the submissions related to training allowance plans, two more than in 2007. Filers have the option of all-electronic submission through a dedicated mailbox via a link on the Department's web site. During 2008 approximately 40% of filers chose the all-electronic route. A new regulation covering agent training allowances (Regulation 50, 11 NYCRR Part 12) went into effect in August 2007.

During 2008, the Life Bureau discussed proposed revisions to Section 4228 with an industry trade group and, together with other bureaus, worked on a proposed regulation relating to disclosure of producer compensation. The Life Bureau considers compliance with agent compensation limits to be an important tool both in protecting insurers' solvency and in controlling the cost of life insurance.

b. Separate Accounts

The Life Bureau received 416 submissions relating to separate account plans of operation during 2008, 27 more than in 2007. Most related to changes in fund lineups and secondary guarantees, both of which have been volatile recently. The Life Bureau views modifications of the funds available in a separate account to be a change in the investment policy of the separate account. As such, updated lists of the available fund options must be filed pursuant to Section 4240(e) of the Insurance Law. The Life Bureau has found this filing requirement to be an effective tool to ensure that 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.

c. Miscellaneous Functions

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. In addition the unit reviews capitalization and actuarial projections related to company merger and acquisition activity, 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. They also respond to inquiries and complaints from the public of a technical actuarial nature.

d. Demutualized Life Insurance Companies; Closed Blocks

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

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

13. Policy Forms and Product Filings

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

In 2008, the Life Bureau received 2,021 policy form submissions (files) consisting of 8,364 life insurance, annuity, funding agreement and other policy forms offered by life insurance companies, fraternal benefit societies, charitable annuity societies and viatical settlement companies as indicated in Table 14 below. Of the 8,364 policy forms received in 2008, 71.9% were submitted under a certified filing procedure (Circular Letter No. 6 (2004) or §3201(b)(6) of the Insurance Law), .5% were submitted for out-of-state use by domestic insurers and 27.5% were submitted for full review and approval. It should be noted that the total number of filings is 30% higher than the previous year. This increase is significant because domestic insurers are no longer required to file all of their out-of-state forms with the Life Bureau. See discussion of §3201 Revision for Out-of-State Forms below.

In 2008, the Life Bureau processed a total of 1,942 policy form submissions (files) consisting of 8,269 policy forms as indicated in Table 14. Of the 8,269 forms processed in 2008, approximately 27.2% were submitted for prior approval, 72.3% were submitted under a certified filing procedure and .5% were filed for out-of-state use. Of the prior approval files disposed in 2008, approximately 67% of the forms were approved or filed and 31.3% were either rejected or withdrawn. Of the certified files

disposed in 2008, approximately 73.1% of the forms were approved or filed and 25.9% were either rejected or withdrawn. Of the out-of-state files disposed in 2008, approximately 92.3% of the forms were approved or filed and 5.1% were either rejected or withdrawn.

Table 14
NUMBER OF FILES & POLICY FORMS
RECEIVED AND PROCESSED BY TYPE
LIFE BUREAU, 2008

PRODUCT TYPE	RECEIVED		PROCESSED	
	Files	**Forms**	**Files**	**Forms**
Individual Life	826	3,431	787	3,299
Group Life	180	980	177	1,134
Individual Annuity	635	2,193	612	2,141
Group Annuity	290	1,021	278	960
Credit Insurance	18	99	9	53
Viatical Settlement	2	8	1	3
Miscellaneous	70	632	78	679
TOTAL	2,021	8,364	1,942	8,269

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

Table 15
POLICY FORM-RELATED FILINGS RECEIVED IN 2008

Fraternal Benefit Societies (Constitution, Articles of Incorp., Bylaws, etc.)	8
Calculation of Life Estates	3
Circular Letter No. 64-1	8
Compensation Filings	63
FOIL Requests	59
Inquiries & Complaints	230
Rate & Actuarial Filings	33
Violations & Market Conduct	147
Informational Filing	34
Regulation 74 Illustration Certification Filings	67
Total	**652**

c. Speed to Market

During 2008, the Life Bureau continued to assist insurers in bringing products to market as quickly as possible. Detailed product outlines are available on the Department's Web site and are periodically updated. In 2008, the Life Bureau revised the Group Term Life Insurance product outline. The revised outline was provided to the Life Insurance Council of New York for comments. Also in 2008, the Life Bureau posted filing guidance on the Department's website for the following topics:

- dividend disclosure under §3209(b)(2)(C) for equity indexed products,
- illustrations for variable annuity contracts,
- illustrations for life insurance policies,
- equity index annuities related to changes to §4223 of the Insurance Law,
- electronic versions of readability certification forms and
- variable material for individual products.

The Life Bureau has encouraged insurers to utilize the certified filing procedures authorized by §3201(b)(6) of the Insurance Law and Department Circular Letter No. 6 (2004). During the year, the Life Bureau processed 6,087 Circular Letter No. 6 (2004) policy forms in an average of 14 days. Of the total 6,087 Circular Letter No. 6 (2004) policy forms, approximately 4,510 were approved, 1,485 were rejected and 92 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) has steadily declined from the high of 478 in 2001. The Life Bureau only processed 2 files in 2008 submitted under the §3201(b)(6) process.

d. Post-Approval Review

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

Circular Letter No. 6 (2004) replaced an earlier certified filing procedure established by Circular Letter 27 (2000). As of December 31, 2008, 4,767 files consisting of 18,154 policy forms have been approved under the certified filing procedures, with 3,830 files and 14,527 policy forms under Circular Letter 6 (2004) and 937 files and 3,627 policy forms under Circular Letter 27(2000)

In 2008, the Life Bureau continued to refine its screening process to prioritize the certified approved files for post approval review. The highest priority is assigned to files with new, innovative or controversial features or files that raise solvency, consumer protection or market competition concerns. This screening process will help to make the Life Bureau more aware of the products currently being offered in the marketplace. As of December 31, 2008, 1,450 of the 4,767 certified files had been screened and assigned a priority rating and approximately 365 certified approved files had been assigned for post approval review.

It should be noted that the post approval review of certified approved files is generally more complicated and time-consuming than the review of traditional prior approval files. Post approval review often has four phases. First, since the policy forms have already been issued to consumers, it may be necessary to develop endorsements to bring all in-force issues of policy forms into compliance with applicable requirements. Bringing in-force forms into compliance with New York law can be

particularly challenging for new and innovative products for which approval standards have not been developed. Second, depending on the nature of the violation, remediation may be required for policy and certificate holders with non-complying policy forms. Third, a new policy form submission may be necessary to replace the non-complying policy forms if the company wishes to remain in the market. Finally, if circumstances warrant, the Department may decide to pursue disciplinary action against the company or the officer completing the certification.

e. SERFF

In addition to the traditional paper filings, the Life Bureau accepts electronic form filings for all types of individual and group life and annuity products, as well as compensation filings, through the NAIC-sponsored System for Electronic Rate and Form Filing (SERFF). The Department's Web site provides detailed filing guidelines for SERFF submissions to assist insurers in making such filings with the Department. The Life Bureau updated those guidelines in 2008.

During 2008 SERFF became the dominant method for sending life and annuity policy form submissions to the Department. In 2008, life insurers submitted 1,570 files, consisting of 6,115 policy forms through SERFF. These totals represent approximately 84.2% of all policy form filings and 85.3% of all policy forms submitted by life insurers in 2008. In the last quarter of 2008 approximately 90% of the submissions were made through SERFF.

f. Section 3201 Revision for Out-of-State Forms - Update

On June 1, 2008, the first annual reports required by Chapter 341 of the laws of 2006 for the out-of-state business of domestic life insurance companies were due. The reports were submitted by companies in conjunction with their market conduct profile filings. Prior to Chapter 341 of the laws of 2006, §3201(b)(2) required domestic life insurers to file with the superintendent all policy forms intended for delivery outside New York prior to said forms being issued. The revision to §3201 now requires only unallocated group annuity contracts or funding agreements and accident and health insurance policy forms intended for delivery outside New York to be filed with the superintendent prior to use.

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

14. Legislative and Regulatory Summary

a. Regulation 77 - Private Placement

In 2008, the Life Bureau continued to work on an amendment to Regulation 77 that would accommodate private placement variable life insurance policies. Such 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."

Currently, private placement variable life insurance policies cannot be sold on an individual basis in New York because Regulation 77 does not make provision for separate account assets that are illiquid or not publicly traded. Pursuant to Regulation 77, policy values and cash surrender values must be determined on at least a monthly basis. To address the illiquid nature of the supporting separate

account assets, the amendment would, among other things, permit restrictions on withdrawals and transfers and would allow for less frequent valuation of separate account assets for private placement variable life insurance policies.

b. Section 3211/ Regulation 77 – Premium Due Notices

Effective October 5, 2008, Chapter 264 of the Laws of 2008 amended Insurance Law §§3203(a)(1), 3211(a)(1) and (b)(1), and 4510(a)(1) with respect to the grace period and premium due notice requirements for flexible premium life insurance products. Individual flexible premium policies and certificates must provide a 61-day grace period within which to pay sufficient premium to keep the policy in force. The 61-day grace period begins on the day that the insurer determines that the policy's net cash surrender value is insufficient to keep the policy in force for one month from that date. Further, a premium due notice for an individual flexible premium life insurance product must be mailed no earlier than, and within 30 days after, the day that the insufficiency is determined. The premium due notice must be mailed to the last known address of the policyholder rather than the person insured. The above requirements are now consistent with the requirements for flexible premium variable life insurance products contained in Regulation 77.

The Department published Circular Letter No. 21 (2008), dated October 6, 2008, which outlines these new requirements and provides an expedited approval process for insurers and fraternal benefit societies to revise their policy or certificate forms accordingly.

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

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

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

To date, the Life Bureau has approved 12 accelerated death benefit forms using the "long term care trigger" under subparagraphs (C) and (D). In addition, there are two such filing submissions currently under review in the Life Bureau.

d. Regulation 186 - Sale and Marketing of Life Insurance on Military Installations

Regulation 186 became effective on December 3, 2008 as Part 223 of 11 NYCRR. Regulation 186 was promulgated to implement the federal Military Personnel Financial Services Protection Act which was enacted on September 29, 2006. This legislation was a response to improper life insurance sales practices on military installations. Such practices included the sale of life insurance at a much higher premium than the federal government sponsored Servicemembers' Group Life Insurance (SGLI), with such insurance often marketed as an investment and under inappropriate or unsuitable circumstances. The Life Bureau has worked, as needed, with the NAIC and the Department of Defense to curb such improper sales and practices and to implement the aforementioned legislation. The NAIC's Military Sales (EX) Working Group, which included New York, developed a model regulation entitled the Military Sales Practices Model Regulation. The model regulation was published in mid-2007. Regulation 186 was drafted in accordance with the model regulation with revisions necessary to comport with existing New York law.

e. Guaranteed Living Benefits – Update

During 2008, the Life Bureau continued to see a significant number of variable annuity contract submissions containing guaranteed living benefits (VAGLBs). The guaranteed living benefits make variable annuities more attractive to risk adverse consumers by mitigating market losses in the variable sub-accounts. The guaranteed living benefits in deferred variable annuity contracts generally provide for guaranteed minimum account values during the accumulation phase (GMAB), or guaranteed minimum income benefits upon annuitization (GMIB), or guaranteed minimum withdrawal benefits (GMWB). The manner in which the benefit is calculated and the restrictions on the benefit vary from insurer to insurer. The benefits are complex and difficult for consumers to understand and require sophisticated risk management skills to limit insurer risk, particularly in the current economic crisis.

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

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

Sales of variable annuity contracts with guaranteed living benefits increase the insurance industry's exposure to a stock market downturn. When the 2001 market downturn occurred, the vast majority of the variable annuity products being offered did not contain guaranteed living benefits. At that time, most variable annuity contracts only included a guaranteed minimum death benefit. Most of the variable annuity contracts with guaranteed living benefits in 2001 were still in the seven-to-ten-year waiting period, and thus only a few companies were affected. As the market was rising in the past few years, companies selling these products have been reporting high profits, which has created incentives to increase their share of the market in this area. Given the increase in sales since 2002 and increased aggressiveness in the guarantees, the Department has a heightened concern about this risk exposure to the life industry. Due to the lack of availability of reinsurance for these products and the high cost to hedge these risks in the capital markets using options, most insurers have turned to dynamic hedging programs. The Department is concerned that such programs may not work as planned under prolonged severe market conditions. Even more definitive hedging programs based on long term options have been called into question due to counterparty risks (e.g., the failure of Lehman) and uncertainties surrounding future policyholder behavior.

In order to address these concerns, the Department has been pursuing strong reserve, minimum capital and corporate governance requirements for these products at the NAIC, in addition to performing in depth examinations of insurers' reserves, capital, and risk management practices with respect to these products. Due to unprecedented circumstances in the financial markets at year-end 2008, alternative reserve criteria were permitted on a company-by-company basis as currently permitted by Regulation 128 provided such companies demonstrated safeguards to mitigate the risk. During 2009, a revised reserving regulation is contemplated in order to achieve greater consistency with the recently adopted NAIC model (VACARVM). This NAIC model relies heavily on a company's own models and assumptions. The freedom to which a company will be permitted to control the models and assumptions is a critical consideration that will need to be resolved before VACARVM is adopted. 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.

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

On December 5, 2007, the Notice of Adoption for the first amendment to Regulation 149 was published in the New York State Register. The amendment became effective on January 1, 2008. The amendment, among other things, removes the restriction on renewing term life policies past age 80.

In 2008, the NAIC adopted Actuarial Guideline CCC to specify appropriate minimum nonforfeiture requirements for life policies with endowments prior to maturity, such as return of premium products. The Department proposes to amend Regulation 149 to include the requirements of this actuarial guideline.

g. Viatical Settlements and Life Settlements

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

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

During 2008, the Life Bureau continued to work extensively on the drafting of comprehensive legislation that would replace the existing Article 78, authorize the Department to regulate the life settlement industry as well as the viatical settlement industry and establish standards governing both industries. During the year, the Department met with representatives of the life insurance industry, the life settlement industry and institutional investment firms. In November, the Department held hearings at four locations across the state to obtain input from interested parties including consumers as to their experiences and concerns regarding the regulation of the life settlements industry. In March, 2009 the draft bill was submitted to the Legislature.

h. Sections 4223/3209 - Equity Indexed Products

Section 4223 of the Insurance Law was amended in 2008 to provide special nonforfeiture and policy form requirements for equity indexed annuity contracts. In addition §3209 was amended to provide additional disclosure requirements for any annuity contract or life insurance policy or certificate with an equity index account, including other disclosure information the superintendent deems appropriate. The amendment became effective on October 5, 2008. The amendment will allow more equity indexed annuity designs while protecting consumers from abuses that are occurring outside of New York. The Life Bureau posted guidance on the Department's website for companies that wish to submit contracts with an equity indexed account to take advantage of the changes to §4223. The Life Bureau also continued to monitor the actions of the federal Securities and Exchange Commission relative to equity indexed products. On December 17, 2008, the SEC adopted Rule 151A which will take effect in January 2011. Rule 151A would appear to treat most contracts with an equity indexed account as "securities" for purposes of filing and other requirements imposed by the SEC.

i. Sections 4216/3220

Sections 4216 and 3220 of the Insurance Law were amended in 2008 for the purpose of permitting employers in New York to provide key person corporate owned life insurance on a group basis. Prior to the revision, such insurance could only be written on an individual basis. Although the bill does not define the terms "key person" or "key employee," the memorandum in support states that "key person life insurance is purchased by a business on the lives of certain key employees of the company for the purpose of ensuring compensation to the business in the event of the untimely demise of one of its key employees." The memorandum's interpretation of the terms "key employee" and "key person" appears to comport with the Department's view and the view of other agencies, such as the federal Office of the Comptroller of the Currency, that these terms refer to an employee or other person who makes a significant economic contribution to the company, whose services are essential to the continuing success of the company, and whose untimely death would be disruptive to the company. There is a concern that an overly broad use of the term "key employee" or "key person" may result in an employer purchasing coverage on the life of a employee for whom the employer does not have a lawful and substantial economic interest, but rather an interest which would arise from, or would be enhanced in value by, the death, disablement, or injury of the employee insured.

j. Section 3207 – Life Insurance on the Lives of Minors

Section 3207 of the Insurance Law was revised in 2008 to raise the maximum amount of coverage that can be issued on the life of a minor. Prior to the revision, an insurer could not knowingly issue a life insurance policy or policies for an amount which, together with the amount of life insurance under any other policy or policies then in force on the life of the minor, was in excess of the greater of $25,000 or 50% of the amount of life insurance in force upon the life of the person effectuating the insurance on the life of the minor (25% where the minor is under age 4 years and 6 months). As a result of the revision, the $25,000 limit was raised to $50,000.

k. Internal Revenue Code Section 403(b)

The U.S. Treasury Department has adopted regulations pertaining to IRS §403(b) plans (26 CFR Parts 1, 31, 54 and 602) that would be applicable, generally, to taxable years beginning after December 31, 2008. The deadline for implementation has in some respects now been extended to December 31, 2009. The regulations replace regulations adopted originally in 1964, and reflect numerous changes to the statutory language and the interpretive guidance issued since that time.

It has been expressed to the Life Bureau that the new regulations have caused some insurers to re-evaluate their role in the §403(b) market in light of enhanced administrative requirements and expense that may be required in order to operate in this market in the future. The Department has learned from one insurer that it will likely leave the 403(b) market entirely. The Bureau has received a complaint related to an insurer's plan to stop supporting existing contracts. We have also discussed additional charges being assessed to participant contracts in order to pay for the additional administrative expenses.

The Life Bureau staff met with the Life Insurance Council of New York in December to discuss the impact of the new federal regulations on §403(b) business written in New York and potential actions that pose problems. Further discussions are planned for 2009.

15. Product Innovations

In 2008, the Life Bureau continued to work with the industry to review and bring new and innovative products and features to New York. The following are some of the innovative products or features under review in 2008.

- Mutual Fund Wrap Products - During 2008, the Life Bureau continued to have discussions with several insurers regarding proposed products that provide guaranteed lifetime benefits on assets held outside the insurer in a mutual fund or brokerage account held by a financial institution. The benefits are similar to the guaranteed minimum withdrawal benefits provided under variable annuity contracts offered by life insurers. The Department is reviewing the legal and actuarial issues involved. Among the issues being analyzed by the Department is whether the proposed products can be viewed as annuity contracts as such term is used in the insurance law and whether the products would constitute an impermissible form of financial guaranty insurance in violation of Insurance Law §6904. The Department is also carefully reviewing the exposure to market risk for these products, particularly because the assets upon which the guarantees are based are not held by the insurer.

- Return of Premium Life Insurance – Return of Premium Life Insurance is term insurance in which the insurer promises to return all premiums paid if the insured does not die during the term. See also comments above regarding regulation 149.

- Longevity Insurance – In 2008, the Life Bureau continued to approve paid-up deferred annuity contracts which do not provide cash surrender benefits. Such contracts have been marketed as "longevity insurance" because the guaranteed lifetime income payments typically begin at age 80 or 85. The annuity can be funded with a single premium or a series of premiums. Premium payments are typically made while the individual is in his or her 60s. Some contracts may also guarantee a higher income payment if the contract owner elects to not have a death benefit under the contract. The product is being marketed for retirement income purposes. The Life Bureau is preparing guidance for this type of product.

- Funding Agreements – In 2007, the Life Bureau approved funding agreement products for two life insurance companies that became members of the Federal Home Loan Bank of New York ("FHLBNY"). Membership in a FHLBNY has been permissible since 1945. The FHLBNY provides a flexible credit liquidity source for its members at competitive prices so that such members can help meet the housing finance and credit needs of their communities. The funding agreements included provisions pledging assets as collateral because the FHLBNY is a secured creditor and all of its credit products require collateral. The Life Bureau approved the pledging of assets in conjunction with the funding

agreements, subject to an annual reporting requirement and the condition that the amount of assets to be pledged or transferred as collateral under the funding agreements and all other business be limited to the amount prescribed in §1411(c) of the Insurance Law. Under the authority granted in §1411(c), the Life Bureau exercised discretion to allow one insurer to increase the volume of its funding agreement business with the FHLBNY because of the unprecedented disruption in the financial markets in 2008. The use of the FHLBNY as a collateral funding source provided the insurer with a ready source of liquidity at a time when the financial markets were in distress and permitted the insurer to preserve asset values (i.e., by not requiring the sale of quality assets in depressed financial markets at distorted prices).

- Commutation in Immediate Annuities – In 2008, the Life Bureau continued to see immediate annuity submissions in which companies included some sort of commutation benefit. A commutation benefit in its simplest form allows the annuitant to convert the value of future payments into a current lump sum payment. With commutation benefits, it is important that the insured receive a fair value for the benefits given up and that the insurer considers issues of anti-selection relative to the contract owner's ability to elect the benefit.

16. Trade Practices

In 2008, the Life Bureau continued to analyze issues related to trade practices of insurers doing business in New York. The following are some of those issues:

- Sale of Unapproved Annuity Contracts by Unlicensed Companies – The Life Bureau's investigation into the sale of unapproved equity indexed annuities and modified guaranteed annuities in New York was expanded to include seven unlicensed companies in 2008. The Life Bureau is in the process of reviewing the issued contracts. Thus far, 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 has had a number of meetings with representatives of the companies to discuss options for resolving the situation. One insurance agent's license has been revoked as a result of the investigation.

- Smoker vs. Non-smoker Rates – The Life Bureau has been monitoring 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 179 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.

- Discretionary Clauses – In 2008, the Life Bureau continued to address inquiries relative to the use of discretionary clauses in group life insurance policy forms. A discretionary

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

As with Circular Letter No. 14 (2006) which raised concerns relative to discretionary clauses in life and accident and health insurance contracts, Life Bureau staff continued to work with Health Bureau staff to draft a proposed regulation prohibiting the use of discretionary clauses in life and accident and health insurance contracts. The NAIC has adopted a model act on discretionary clauses and other states have taken similar action. Several recent U.S. District Court decisions have held that state regulations prohibiting the use of discretionary clauses in insurance products in employee benefit plans were not preempted by the federal Employee Retirement Income Security Act (ERISA).

- Same-Sex Marriages - In 2008, the Department's General Counsel issued Circular Letter 27 (2008) (hereinafter CL-27), which addressed recognition of same-sex marriages legally performed in other jurisdictions in accordance with the decision in the case of Martinez v. Monroe Community College 50 A.D.3d 189, (4th Dep't), 10 N.Y.3d 856 (2008). Subsequent to the issuance of Circular Letter No. 27 (2008), the Life Bureau received inquiries about the application of the circular letter to annuity contracts that must comply with federal tax law to receive favorable federal tax treatment. In particular, the inquiries raised questions concerning the distribution requirement of Internal Revenue Code §72(s) that allows a surviving spouse of the deceased holder to continue an annuity contract as the new owner. Since same-sex marriages are not recognized under the Code due to the federal Defense of Marriage Act, a same-sex spouse would not be able to continue the contract as the new owner without causing the contract to lose its favorable tax status as an annuity. The Life Bureau is analyzing this issue and intends to issue guidance to the industry in early 2009.

17. Other Initiatives

a. Group Life Insurance Working Group

In 2008, in connection with the update of the group term life insurance product outline Life Bureau staff discussed a number of issues with the industry relating to group life insurance. Many of the issues discussed reflect the fact that the Insurance Law and regulations have failed to keep pace with the changes in the group life market and to recognize that group life insurance often serves as a means to market individual insurance. The conversion privilege needs to be updated to reflect changes in underwriting (risk selection and risk classification) in both the individual and group markets. In addition, individual consumer protections, including disclosure, are needed to reflect that group life coverage is often voluntary and funded solely by the persons insured. Under current law, certificate holders are viewed as third party beneficiaries whose rights and benefits are subject to the decisions of a group policyholder whose interests may conflict with theirs.

b. Market Conduct Review of Non-Guaranteed Elements

Interrogatories on non-guaranteed elements in Exhibit 5 of the 2006 Annual Statements were reviewed for 177 life insurers. Seven 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.

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

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

In 2008, 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. At the NAIC level, consideration is being given toward eliminating the formulaic floor but the Department has reservations about potentially weakening solvency requirements in light of the dramatic changes being experienced in the financial industry due to the current economic crisis.

The Department continues to support a regulation for "Corporate Governance for Risk Management." The regulation would foster a written risk management policy with tolerance limits on risk exposures. The regulation would also foster the alignment of operations with risk management policy and impose a meaningful and measurable self discipline process.

d. Statutory Examinations

The Reserve and Risk Management Actuaries in the Life Bureau continue to expand their analysis of life insurers' risks from the traditional review of minimum statutory formula reserves and high-level asset/liability matching toward in-depth analysis of scenario-based cash-flow testing and other principles-based methods.

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.

Also this year, significant progress was realized with issues related to the 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.

During the latter half of 2008, and in response to the current disruption in the financial markets, special reports (pursuant to §308 of the Insurance Law) were required from all Companies, with

additional focus on liquidity risk and additional asset default risks posed by the rapid deterioration in the financial markets.

All of these efforts materially improved the Life Bureau's risk-focused examination approach during 2008 and proved quite effective at identifying companies who may be particularly susceptible to volatility in the current economic crisis. Going forward, the Bureau will continue efforts to further improve its focus on the timely identification of risks faced by the insurance industry.

e. Reinsurance Issues

In 2008, the Life Bureau continued its review regarding a potential issue in the accounting treatment for deferred premium assets associated with reinsured business. Many companies were recognizing a reserve credit that was greater than the amount that would be held in absence of such reinsurance which is a violation of §1308(b)(2) of New York Insurance Law. The Life Bureau plans to resolve this issue for year end 2009.

The Life Bureau has been working with the Life and Health Actuarial Task Force in reviewing reinsurance requirements under principles based reserves.

f. Reserves for Charitable Annuities

During 2008, the Department strengthened the reserve requirements for charitable organizations that issue gift annuities in New York. Such organizations are subject to Regulation 126 and, beginning with the December 31, 2008 reserve valuation, are required to provide an actuarial opinion based on asset adequacy analysis per §95.8 of the regulation. As an alternative to providing an actuarial opinion, such organizations may hold an additional reserve of 15% in accordance with §95.11(b) of the regulation. It is anticipated that all or most of these organizations will hold the additional reserve as opposed to providing an actuarial opinion. In an effort to lessen any hardship this §95.11(b) requirement may cause, the Department is permitting a three year grade-in period for compliance with §95.11(b) with 5% of the additional reserve being required as of December 31, 2008, 10% of the additional reserve being required as of December 31, 2009 and the full 15% starting with December 31, 2010.

This action was needed due to the weakness of the minimum statutory formulaic reserves for payout annuities.

B. PROPERTY BUREAU

1. Entities Supervised by the Financial Regulation Division

As of December 31, 2008, the Financial Regulation Division side of the Property Bureau exercised regulatory authority over 1,162 insurer entities and risk retention groups.

The Bureau regulated 1,056 insurer entities as of year-end 2008. Table 16 provides a breakdown.

Table 16
ENTITIES REGULATED BY PROPERTY BUREAU
2008

Number of Regulated Entities	Type of insurer/reinsurer/entity
92	Accredited reinsurers*
19	Advance premium co-operatives
24	Assessment co-operatives
11	Associations, pools, and syndicates
50	Captive insurers
14	Financial guaranty insurers
27	Mortgage guaranty insurers
1	Property Insurance Underwriting Association (FAIR Plan)
779	Property/casualty insurers
30	Title insurers (including two accredited reinsurers)
9	United States branches

* Lloyd's of London (Lloyd's), included as an accredited reinsurer, is comprised of individual underwriting syndicates, each of which must meet the requirements for recognition as an accredited reinsurer. As of December 31, 2008, the Department recognized 60 Lloyd's syndicates as active accredited reinsurers.

In addition, the Bureau oversaw the operation of 106 risk retention groups in 2008.

The Property Bureau received 27 applications for licensing and 4 applications for recognition as accredited reinsurers during 2008. Twelve insurers were newly licensed including 1 foreign title company, 1 foreign financial guaranty insurer, 1 domestic financial guaranty insurer and 9 domestic stock insurers. In addition, there were 3 foreign insurers approved for accredited reinsurer status. At the close of the year there were domestic applications pending for 13 domestic stock companies, 1 domestic title company, 1 domestic financial guaranty insurer and 1 domestic mutual company. There were also 22 foreign stock insurers, 1 foreign reciprocal insurer and 1 foreign US Branch which had license applications pending with the Department.

2. Property and Casualty Business

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

a. Premium Volume and Surplus to Policyholders

Net premiums written during 2007 by all New York-licensed property and casualty insurers aggregated totaled $317.5 billion, of which 78% represented stock company writings. As noted previously, the following underwriting and investment results deal with the nationwide business of New York licensed companies:

Table 17
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Property and Casualty Insurers Licensed in New York State
2002-2007
(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
2002	737	$205,017	$181,615	1.1	78	$62,576	$63,789	1.0
2003	706	221,356	203,973	1.1	72	66,070	66,315	1.0
2004	698	234,377	213,611	1.1	73	67,294	86,319	0.8
2005	713	226,808	253,849	0.9	71	68,113	93,736	0.7
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

b. Underwriting Results

Results for 2007 show a net underwriting gain of $15 billion for stock companies and a net underwriting gain of $1.5 billion for mutual companies.

Table 18
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State
2004-2007
(dollar amounts in millions)

Year		Stock Companies		Mutual Companies	
		Number of Companies	Amount	Number of Companies	Amount
2004	Underwriting gains	280	$12,261.4	43	$3,247.3
	Underwriting losses	275	10,744.8	30	1,213.2
	No gain or loss	143	0.0	0	0.0
2005	Underwriting gains	326	$10,548.4	46	$1,820.2
	Underwriting losses	295	16,672.2	25	3,430.9
	No gain or loss	92	0.0	0	0.0
2006	Underwriting gains	408	$22,161.4	47	$4,831.5
	Underwriting losses	223	4,086.5	22	1,014.8
	No gain or loss	96	0.0	0	0.0
2007	Underwriting gains	421	$19,454.4	45	$2,203.1
	Underwriting losses	217	4,456.3	27	658.4
	No gain or loss	93	0.0	0	0.0

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 2004 to 2007 are as follows:

Table 19
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
2004-2007
(in millions)

Year		Stock Companies	Mutual Companies
2004	Net investment income	$23,802.5	$5,288.7
	Realized capital gains	4,556.6	1,555.8
	Unrealized capital gains	8,625.8	4,225.8
	Net gain/loss from investments	$36,984.8	$11,070.2
2005	Net investment income	$29,263.4	$5,903.2
	Realized capital gains	3,005.0	455.6
	Unrealized capital gains	1,473.3	3,902.9
	Net gain/loss from investments	$33,741.7	$10,261.7
2006	Net investment income	$33,298.3	$6,498.4
	Realized capital gains	351.0	412.0
	Unrealized capital gains	14,412.8	9,486.6
	Net gain from investments	$48,062.1	$16,397.0
2007	Net investment income	$36,533.8	$6,786.8
	Realized capital gains	3,716.8	1,342.1
	Unrealized capital gains	4,490.5	4,144.5
	Net gain from investments	$44,741.1	$12,273.4

d. Underwriting and Investment Exhibit

During 2007, dividends to stockholders amounted to $27.8 billion, while dividends to policyholders aggregated to $1.7 billion (for both mutual and stock insurers). The contribution to surplus for 2007 for stock companies was $1.6 billion compared with $0.9 billion for 2006. However, the net increase in surplus for stock companies in 2007, $19.7 billion, was lower than the comparable $36 billion 2006 increase. Likewise, the net change in surplus for mutual companies was $12.5 billion in 2007, down from $17 billion a year earlier. Net income increased for both stock and mutual companies between 2006 and 2007.

Table 20
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Property and Casualty Insurers Licensed in New York State
2006 and 2007
(in millions)

	Stock Companies		Mutual Companies	
	2007	2006	2007	2006
Net gain or loss from:				
Underwriting	$14,998.0	$18,074.9	$1,544.7	$3,816.8
Investments [a]	40,250.7	33,649.3	8,128.9	6,910.4
Other income	212.1	-173.6	478.9	393.2
Net gain or loss	$55,460.7	$51,550.6	$10,152.6	$11,120.4
Less:				
Dividends to policyholders	706.2	584.7	1,001.2	2,044.6
Federal income taxes incurred	12,764.2	12,671.0	1,090.6	1,667.9
Net income	**$41,990.3**	**$38,294.9**	**$8,060.8**	**$7,407.9**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-$27,745.1	-$18,313.4	$0.0	$0.0
• Stock	-23.3	-3.7	0.0	0.0
US Branches – Net remittance to/from home office	-6.0	-1.0	0.0	0.0
Total dividends and remittance	-$27,774.3	-$18,318.1	$0.0	$0.0
Unrealized capital gains/losses	4,490.5	14,412.8	4,144.5	9,486.6
Cumulative effect of changes in accounting principles	0.4	34.2	9.8	-3.8
Miscellaneous items	-562.1	679.5	254.6	160.0
Contributions to surplus	1,572.1	940.0	2.3	1.4
Total other sources	-$22,273.4	-$2,251.6	$4,411.2	$9,644.2
Net increase or decrease in surplus	**$19,716.9**	**$36,043.3**	**$12,474.0**	**$17,054.1**

[a] Excludes unrealized capital gains.

e. Selected Annual Statement Data

From 2004 to 2007 aggregate (i.e., stock and mutual) net premiums written increased by 5.2%; admitted assets increased by 28.2%; unearned premium and loss reserves increased by 76.1%; and other liabilities increased by 212.1%. Capital and surplus to policyholders increased by 46.3%.

Table 21
SELECTED ANNUAL STATEMENT DATA
Property and Casualty Insurers Licensed In New York State
2004-2007
(dollar amounts in millions)

	2007	2006	2005	2004
		Stock Companies		
Number of insurers	731	727	713	698
Net premiums written	$247,563	$247,812	$226,808	$234,377
Admitted assets	880,157	747,095	739,827	675,485
Unearned premium & loss reserves	464,519	451,527	441,511	231,701
Other liabilities	100,489	44,267	41,925	14,021
Capital	3,879	3,723	3,912	2,292
Surplus to policyholders	318,287	287,598	253,849	213,611
		Mutual Companies		
Number of insurers	72	69	71	73
Net premiums written	$69,930	$69,948	$68,113	$67,294
Admitted assets	236,563	223,144	207,656	195,595
Unearned premium & loss reserves	87,507	84,715	85,708	81,789
Other liabilities	29,050	28,957	28,212	27,487
Surplus to policyholders	120,006	109,473	93,736	86,319

f. Direct Premiums Written, by Line

There was an increase in property/casualty writings in New York State in 2007 as direct premiums written for all property/casualty lines increased by 2%. Major lines, i.e., those with greater than $1 billion premium written in 2007, with at or above average year-to-year increases in 2007 included workers' compensation, medical malpractice, homeowners multi-peril, and financial guaranty.

Table 22
DIRECT PREMIUMS WRITTEN BY PROPERTY/CASUALTY INSURERS
New York State — 2003-2007[1]
(dollar amounts in millions)

Property and Casualty Lines	2003	2004	2005	2006	2007	Percentage Change 2003-2007	Percentage Change 2006-2007
All Premiums Written	$31,330	$30,733	$32,371	$33,674	$34,332	10%	2%
Private Passenger Auto Bodily Injury and Property Damage Liability	10,554	10,684	10,262	9,994	9,794	-7%	-2%
Comprehensive and Collision	7,247	7,304	6,968	6,705	6,452	-11%	-4%
Commercial Auto	3,307	3,380	3,294	3,289	3,343	1%	2%
General (Other) Liability	2,167	2,191	2,080	2,045	1,975	-9%	-3%
Commercial Multi-Peril	3,741	4,018	3,997	4,387	4,306	15%	-2%
Workers' Compensation	2,779	2,897	2,958	3,074	3,072	11%	0%
Homeowners' Multi-Peril	3,403	1,928	3,758	4,133	4,228	24%	2%
Medical Malpractice	2,901	3,174	3,427	3,615	3,908	35%	8%
Inland Marine	1,027	1,067	1,128	1,267	1,394	36%	10%
Ocean Marine	690	734	707	841	912	32%	8%
Fidelity and Surety	440	583	551	598	522	19%	-13%
Accident and Health	433	427	433	459	534	23%	16%
Fire	426	383	372	329	302	-29%	-8%
Product Liability	442	432	455	490	503	14%	3%
Financial Guaranty[2]	165	158	179	175	190	15%	8%
Mortgage Guaranty	1,153	1,105	1,090	1,164	1,439	25%	24%
Allied Lines	214	217	215	207	246	15%	19%
Aircraft	312	289	278	334	307	-2%	-8%
Boiler and Machinery	141	71	96	114	205	45%	79%
Credit	87	85	78	80	70	-19%	-13%
Burglary and Theft	40	42	48	62	131	227%	112%
All Other[3]	10	14	14	27	16	64%	-39%
	205	233	244	280	277	35%	-1%

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

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

[2] Includes monoline and non-monoline insurers.

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

g. Audit and Analysis

The 2007 Annual Statements of the companies authorized to transact business in the State of New York were filed for audit and analysis in 2008, 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 2008, the State Insurance Fund acquired stocks and bonds totaling $40.5 billion and sold stocks and bonds totaling $22.2 billion. Upon review, the Property Bureau recommended the approval of the acquisitions of $24.2 billion and the sales of $13.0 billion. In 2007, the Bureau recommended approval of acquisitions totaling $31.2 billion and sales totaling $14.0 billion.

i. CPA-Audited Financial Statements

NYIL Section 307(b) requires licensed insurers to file an annual financial statement, certified by an independent certified public accountant (CPA), on or before May 31 of each year. CPA-audited financial statements were received and reviewed for 877 companies in 2008. 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 2008, 99 FOIL requests to review and copy records maintained by the Financial Division were received from members of the public.

k. Holding Company-Related Transactions

Pursuant to Article 15 of the New York Insurance Law and Department Regulation 52, the Property Bureau is responsible for the review and approval of transactions within holding company systems. During 2008, 449 holding company transaction files, and 190 holding company registration statements and amendments, were reviewed and closed by the Property Bureau. In addition, 31 notices of acquisition of control of domestic insurers were reviewed and closed by the Property Bureau.

3. Financial Guaranty Insurance

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

As of December 31, 2007, there were 9 domestic and 6 foreign financial guaranty insurers licensed in New York.

Table 23
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Financial Guaranty Insurers Licensed in New York State, 2004-2007
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2004	3,089.1	11,357.0	0.27
2005	2,979.8	13,046.5	0.23
2006	3,027.5	13,570.3	0.22
2007	2,982.1	12,322.8	0.24

Table 24
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State, 2004-2007
(dollar amounts in millions)

Year		Number of Companies	Amount
2004	Underwriting gains	9	$1,219.0
	Underwriting losses	4	$96.5
2005	Underwriting gains	8	$1,404.6
	Underwriting losses	6	$60.5
2006	Underwriting gains	8	$1,366.5
	Underwriting losses	5	$62.0
2007	Underwriting gains	7	$908.6
	Underwriting losses	6	$2,327.3

Table 25
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State, 2004-2007
(in millions)

	2007	2006	2005	2004
Net investment income	$1,598.7	$1,669.5	$1,477.6	$1,253.7
Realized capital gains	-705.2	24.0	35.7	115.9
Unrealized capital gains	-43.8	151.8	102.2	52.2
Net gain from investments	$849.7	$1,845.3	$1,615.5	$1,421.8

Table 26
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Financial Guaranty Insurers Licensed in New York State
2004-2007
(in millions)

	2007	2006	2005	2004
Net gain or loss from:				
Underwriting	-$1,418.7	$1,304.6	$1,344.1	$1,122.5
Investments [a]	893.5	1,693.5	1,513.3	1,369.5
Other Income	-47.7	16.7	22.7	6.1
Net gain or loss	-$572.9	$3,014.8	$2,880.1	$2,498.2
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	376.3	785.6	706.1	620.4
Net income	**-$949.2**	**$2,229.2**	**$2,174.0**	**$1,877.8**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-777.1	-1,221.5	-656.8	-880.3
• Stock	-1.5	0.0	0.0	0.0
Total dividends and remittance	-$778.6	-$1,221.5	-$656.8	-$880.3
Unrealized capital gains	-43.8	151.8	102.2	52.2
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	190.4	-410.3	-726.2	-464.0
Contributions to surplus	333.7	-13.5	620.7	226.3
Total other sources	-$298.3	-$1,493.4	-$660.1	-$1,065.8
Net increase or decrease in surplus	**-$1,247.5**	**$735.7**	**$1,513.9**	**$812.0**

[a] Excludes unrealized capital gains.

Table 27
SELECTED ANNUAL STATEMENT DATA
Financial Guaranty Insurers Licensed In New York State
2004-2007
(dollar amounts in millions)

	2007	2006	2005	2004
Number of Companies	15	15	14	15
Exposure	$3,293,226.9	$2,958,463.0	$2,680,961.8	$2,572,632.1
Net premiums written	2,982.1	3,027.5	2,979.8	3,089.1
Admitted assets	38,650.5	35,663.8	33,916.0	31,402.2
Unearned premium & loss reserves	15,355.1	11,874.6	11,517.4	5,925.9
Other liabilities	10,972.6	10,218.9	9,352.1	4,925.4
Capital	249.2	246.7	266.7	181.7
Surplus to policyholders	12,322.8	13,570.3	13,046.5	11,357.0

4. Mortgage Guaranty Insurance

At year-end 2007, there were 2 domestic and 25 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
2004-2007
(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
2004	3,786.4	4,529.8	0.84
2005	3,815.4	4,134.2	0.92
2006	3,890.7	4,010.2	0.97
2007	4,605.0	3,594.6	1.28

Table 29
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT
Mortgage Guaranty Insurers Licensed in New York State
2004-2007
(in millions)

	2007	2006	2005	2004
Net gain or loss from:				
Underwriting	-$1,319.6	$1,189.3	$1,003.6	$949.3
Investments [a]	1,295.8	1,053.3	913.4	797.0
Other Income	13.9	13.4	3.9	11.7
Net gain or loss	-$9.8	$2,256.1	$1,920.9	$1,758.0
Less:				
Dividends to policyholders	0.0	0.0	0.0	0.0
Federal income taxes incurred	98.4	485.9	326.2	295.2
Net income	**-$108.3**	**$1,770.1**	**$1,594.8**	**$1,462.8**
Surplus changes other than net income:				
Dividends to stockholders				
• Cash	-1,563.8	-1,518.0	-1,273.4	-1,375.1
• Stock	0.0	0.0	0.0	0.0
Total dividends	-$1,563.8	-$1,518.0	-$1,273.4	-$1,375.1
Unrealized capital gains	-666.2	223.4	219.7	172.5
Cumulative effect of changes in accounting principles	0.0	0.0	0.0	0.0
Miscellaneous items	1,780.7	-510.5	-996.8	750.5
Contributions to surplus	142.0	-94.9	64.9	-189.1
Total other sources	-307.3	-1,900.0	-1,985.6	-641.2
Net increase or decrease in surplus	**-$415.5**	**-$129.9**	**-$390.8**	**$821.7**

[a] Excludes unrealized capital gains.

TABLE 30
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
2004-2007
(dollar amounts in millions)

	2007	2006	2005	2004
Number of companies	27	27	26	26
Net premiums written	$4,605.0	$3,890.7	$3,815.4	$3,786.4
Admitted Assets	24,170.6	23,509.8	22,663.5	21,562.9
Unearned premium & loss reserves	10,605.5	7,871.4	7,566.4	7,137.6
Other liabilities	9,970.6	11,628.2	10,963.0	9,895.5
Capital	70.5	70.5	68.5	68.5
Surplus	3,594.6	4,010.2	4,134.2	4,529.8

5. Title Insurance

Eleven domestic and 19 foreign companies were licensed to write title insurance in New York State at the close of 2007.

Table 31
SELECTED ANNUAL STATEMENT DATA
Title Insurance Companies
2004-2007
(dollar amounts in millions)

	2007	2006	2005	2004
Number of Companies	30	30	26	23
Net premiums written	$8,742.3	$11,007.0	$9,142.5	$8,614.5
Admitted assets	6,489.8	6,848.0	5,480.1	4,680.0
Liabilities	4,515.5	4,499.8	3,843.0	3,149.6
Capital	111.0	118.8	98.8	94.4
Surplus	1,974.3	2,348.3	1,637.1	1,530.3

6. Advance Premium Co-operative and Assessment Corporations

At year-end 2007, there were 19 advance premium corporations under the supervision of the Property Bureau. The total number of advance premium corporations remained unchanged from 2006 to 2007. The net premium volume of the advance premium corporations increased by 1.6% from the prior year.

A total of 24 assessment corporations were under the Property Bureau's supervision at year-end 2007. The total number of assessment corporations decreased from 2006 to 2007. The net premium volume of these 24 companies decreased by 4.6% from the prior year.

During 2007, the Property Bureau initiated 8 examinations of the advance premium and assessment corporations.

Table 32
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Corporations
2004-2007
(dollar amounts in millions)

Year		Total	Advance Premium Corporations	Assessment Corporations
2004	Number of companies	45	19	26
	Total assets	$1,893.3	$1,620.5	$272.8
	Net premiums written	904.6	795.6	109.0
	Surplus funds	722.0	576.6	145.4
2005	Number of companies	44	19	25
	Total assets	$2,070.7	$1,775.6	$295.1
	Net premiums written	931.3	817.2	114.1
	Surplus funds	809.0	650.7	158.3
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

7. Special Risk Insurers (Free Trade Zone)

Calendar Year 2007 was the 29th full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 200 licensed companies as of December 31, 2007, which includes new and renewals. Net premiums written during the year amounted to approximately $1.4 billion, bringing the net premiums written since inception to approximately $11.4 billion. Direct and Net premiums written since 2003 are as follows:

Table 33
DIRECT AND NET PREMIUMS WRITTEN
Special Risk (Free Trade Zone)
2003-2007
(dollar amounts in millions)

Year	Direct Premiums Written	Net Premiums Written
2003	1,180.5	1,020.2
2004	1,323.1	1,071.7
2005	1,193.7	1,022.6
2006	1,510.3	1,286.2
2007	1,579.6	1,401.5

8. Risk Retention Groups

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

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

As of December 31, 2007, 100 risk retention groups had registered with the Department to do business in New York under the provisions of the federal legislation.

In calendar year 2007, risk retention groups filing financial statements with this Department reported total nationwide direct premiums written of $1.77 billion and total nationwide net premiums written of $741.8 million. These risk retention groups reported direct premiums written of $309.6 million in New York State during this same period.

9. Examinations of Insurers

a. Number of Examinations

The Property Bureau's Financial Examinations Unit is required to conduct examinations of all domestic insurers on a regular basis. During calendar year 2008 a total of 182 such examinations were conducted.

Table 34
EXAMINATIONS CONDUCTED
by the Financial Regulation Division of the Property Bureau
2008

	Regularly Scheduled			Other Financial Exams		
	Total	Started in 2008	Started Prior to 2008	Special	On Organi-zation[1]	Increase in capital[2] and other
Property and casualty insurers, including financial guaranty insurers	151	38	107	5	1	0
Other insurers, captives and service contractors	21	6	15	0	0	0
Title and mortgage guaranty insurers	10	4	6	0	0	0
Total	**182**	**48**	**128** [3]	**5**	**1**	**0**

[1] Examination conducted when insurer is first incorporated in New York State.
[2] Examination when insurer increases its capital.
[3] This total includes 54 reports with completed field work that were not filed as of 2/18/09.

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, will be mandated as an accreditation standard for conducting examinations. In 2006, the Property Bureau conducted its first pilot examination using this new approach. During 2008, this approach was used for almost every examination, with the exception of companies in run-off or very small companies.

10. Lloyd's of London

Underwriters at Lloyd's (Lloyd's of London) consist of underwriting syndicates at Lloyd's that meet the requirement for recognition as accredited reinsurers in New York. As of December 31, 2008, 60 active syndicates at Lloyd's were recognized as accredited reinsurers by the Department. Each syndicate is required to maintain a trust fund in New York and the amount deposited in each trust fund is required to equal each syndicate's gross liabilities for U.S. situs reinsurance business. In addition, all syndicates together must maintain a minimum surplus in trust, on a joint and several basis, of not less than $100 million, for the protection of United States ceding insurers.

11. Certified Capital Companies

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

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

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

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

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

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

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

As of December 31, 2007 the CAPCOs invested approximately $280 million in 160 qualified businesses: Program One CAPCOs invested 79.98% of their total $100 million certified capital; Program Two CAPCOs invested 83.20% of their $30 million total; Program Three CAPCOs invested 77.07% of their $150 million certified capital; Program Four CAPCOs invested 54.88% of their $60 million and Program Five CAPCOs invested 45.18% of their $60 million.

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

Seventy nine qualified businesses had less than $1 million, 52 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 35.9%, 32.0%

and 32.1%, respectively, of the total invested. CAPCOs have invested approximately $100.9 million or 35.9% of the invested funds in "early-stage" businesses, and approximately $7.8 million in "start-up" businesses.

In the five programs combined, 85% of the numbers of businesses and 74% of the dollars invested in qualified businesses were headquartered in New York County (Manhattan), Long Island, Mid-Hudson and the Capital District. The remaining 15% of the businesses and 26% of the dollars invested were in other regions of New York State. Thirty-nine percent of all funds invested by year-end 2007 in qualified businesses were in New York County and 22.6% 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, 2007 information was provided increased by 1,435 positions. The change of the number of employees in any one business ranged from a decrease of 100 to an increase of 231.

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

12. Service Contract Providers

The Bureau reviews the financial responsibility requirements of applicants seeking registration pursuant to Article 79 of the Insurance Law to write service contracts in New York. In addition, the filed audited financial statements are annually reviewed for those service contract providers that seek to meet the statutory financial responsibility requirements through either a New York Funded Reserve Account or stockholders equity in excess of $100 million. During the year 2008, this Bureau assumed responsibility for reviewing the financial responsibility requirements of service contract providers using a Service Contract Reimbursement Insurance policy ("SCRI"). As of December 31, 2008, there were 140 registered service contract providers, of which 82 providers were utilizing SCRI policies. The remaining 58 service contract providers were required to file audited financial statements with the Property Bureau-Financial Division, with 26 utilizing the New York Funded Reserve Account and 32 utilizing stockholders equity in excess of $100 million.

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

a. Number of Filings

During 2008, the Market Regulation Division of the Property Bureau received 7,668 filings involving changes in rates, rating rules, policy forms, rate classifications and rating territories submitted by rate service organizations, joint underwriting associations and insurers. The filings were submitted for the following lines of business:

Table 35
NUMBER OF FILINGS RECEIVED BY TYPE*
Market Regulation Division of the Property Bureau
2008

Line of Business	Rates & Rules	Policy Forms	Totals
Fire and Allied Lines	480	452	932
Farmowners Multiple Peril	33	38	71
Homeowners Multiple Peril	259	259	518
Multiple Line	33	45	78
Commercial Multiple Peril	441	488	929
Inland Marine	195	245	440
Medical Malpractice	117	47	164
Earthquake	3	1	4
Flood	4	30	34
Rain	0	0	0
Workers' Compensation & Employer's Liability	456	244	700
Other Liability	1006	1170	2176
Motor Vehicle Insurance	778	353	1131
Aircraft	8	33	41
Fidelity & Surety	55	42	97
Glass	1	0	1
Burglary & Theft	120	61	181
Boiler & Machinery	19	19	38
Credit	13	19	32
Animal Mortality	10	7	17
Mortgage Guaranty	27	8	35
Residual Value	0	1	1
Title	15	16	31
Financial Guaranty	2	15	17
Prepaid Legal Service Plan	0	0	0
Warranty Reimbursement	0	0	0
Total	**4075**	**3593**	**7668**

* These figures include approximately 85 consent-to-rate filing applications (pursuant to Section 2309 of the Insurance Law); 7 group property & casualty filings; 33 manuscript policy form filings; and 22 rating plans submitted in 2008. During 2008, 215 policy form filings and 183 rate or rating rule filings were disapproved. In addition, the Bureau continued speed-to-market (STM) initiatives and accepted electronic submission of filings through the System for Electronic Rate and Form Filing (SERFF). The Bureau received 530 STM and 6,102 SERFF form and rate filings in 2008, which are included above.

b. Advisory Rate/Loss Cost Changes

The following table lists major revisions in rates or loss costs filed by rate service organizations that were approved or acknowledged during 2008. Loss costs apply to the voluntary market and are advisory, *i.e.*, they do not have to be adopted by an insurer. They reflect the experience of all companies that report to the rate service organization. Loss costs are used by insurers for most lines of business as a basis for determining their individual company rates.

Table 36
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2008 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	-3.5
Personal Injury Protection	-13.8
Liability Subtotal	-3.9
Comprehensive	-3.8
Collision	+14.0
Physical Damage Subtotal	+10.0
Total Commercial Cars	-2.5
Garages	
Single Limit Liability	0.0
Personal Injury Protection	-9.7
Liability Subtotal	-0.8
Physical Damage - Garage Dealers	
Comprehensive	-21.3
Collision	0.0
Physical Damage - Garage Keepers	
Comprehensive	-19.5
Collision	-15.0
Physical Damage - Garage Dealers and Keepers Subtotal-	-16.2
Total Garages	-7.0
Private Passenger Types	
Single Limit Liability	0.0
Personal Injury Protection	-20.1
Liability Subtotal	-1.6
Comprehensive	-9.3
Collision	+14.5
Physical Damage Subtotal	+10.0
Total Private Passenger Types	+0.7
Total All Coverages	-2.0
Total Liability	-3.4
Total Physical Damage	+7.0
(effective November 1, 2008)	

Table 36 (continued)
MAJOR EFFECTS OF PRINCIPAL RATE & LOSS COST CHANGES
Filed in 2008 by Property and Casualty
Rate Service Organizations

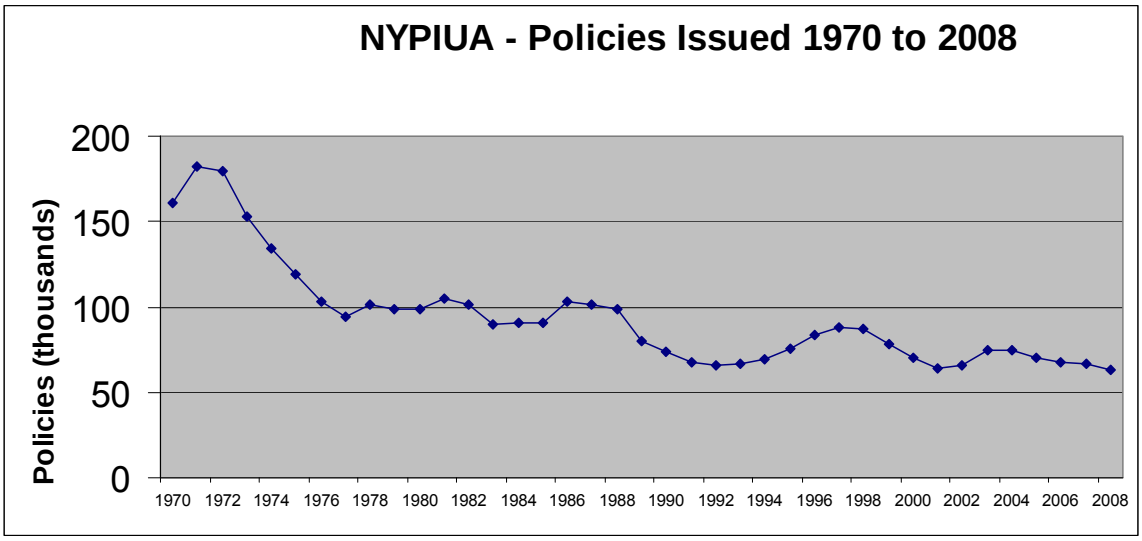
	Percent Changes in Average State-Wide Rates
Liability Other Than Automobile	
Insurance Services Office, Inc. **Commercial General Liability Loss Costs** (effective July 1, 2009)	-11.9%
Insurance Services Office, Inc. **Commercial General Liability Increased Limits Factors** (effective July 1, 2009)	+1.6%
Insurance Services Office, Inc. **Personal Liability Loss Costs** (effective September 1, 2008)	-5.3%

14. New York Property Insurance Underwriting Association (NYPIUA)

a. Policies Issued

The following graph illustrates the number of policies issued by the New York Property Insurance Underwriting Association from 1970 through 2008:

(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 2008, the number of policies written dropped to 63,318, which is a decrease of 3,230 policies from the number of policies written in 2007.

b. Financial Information

For the fiscal year ending December 31, 2008, the Association's Financial Report indicated premiums earned of $29,019,087 and a net underwriting gain of $3,271,640. Other income of $5,607,983, comprised of net investment income of $5,171,158; premium balances charged off $6,526; bond amortization gain of $45,524; gain on sale of securities of $386,735; grant program of $124,153 and policy installment fees of $135,245, resulted in net income before taxes of $8,879,623. The change in assets not admitted of $73,553 and taxes incurred of $329,821 resulted in a net change in the Members' Equity Account of $8,476,249. The cumulative operating profit as of December 31, 2008 was $174,150,673. After all assessments (net of cumulative distributions of $91,008,265), the net Members' Equity Account totaled $83,142,408.

In accordance with Section 5405(c) of the New York Insurance Law, the Association estimated a deficit from operations of $1,644,157 for the Calendar Year 2009. However, there will be no need to credit the Association with any funds from the New York Property/Casualty Insurance Security Fund for the year beginning January 1, 2009, since its assets exceed its liabilities.

c. Rate Revisions

During 2008, the Department approved rate revisions for the Commercial Property program. These revisions resulted in an average statewide change of -1.8% for Basic Group I and -16.7% for Basic Group II. These revisions correspond with loss costs revisions promulgated by the Insurance Service Office for the voluntary market.

d. Legislation in 2008

Chapter 136 of the Laws of 2008 repeals Section 5411 of the Insurance Law – Termination of Article – to make NYPIUA permanent. It also extends certain provisions of the law relating to the New York Property Insurance Underwriters Association (NYPIUA) and provisions of chapter 42 of the laws of 1996 relating to homeowners' insurance; extends certain stand-by powers of NYPIUA; requires NYPIUA to develop and implement an incentive plan for members that voluntarily write policies that include windstorm coverage in coastal areas; provides for the writing of insurance policies providing broad form coverage; directs NYPIUA to create the coastal market assistance program; directs the superintendent of insurance to implement a program to encourage insurers to write residential property insurance; relates to the special advisory panel on homeowners' insurance/catastrophe coverage. This bill was signed into law on June 30, 2008.

15. Medical Malpractice Insurance

a. Establishment of Rates and Premium Surcharges

Chapter 58 of the Laws of 2008 extended for three years the authority of the Superintendent of Insurance to establish rates for policies providing coverage for physicians' and surgeons' medical malpractice liability insurance . This legislation also extended the provision that allowed for the application of surcharges of up to 8% annually, beginning July 1, 1989, upon the then established rates if required to satisfy any deficiency for the policy periods July 1, 1985 through June 30, 2011.

Notwithstanding the above, Chapter 497 of the Laws of 2008 mandated that the Superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2008 and ending June 30, 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 2008 to 2009 policy year, it was determined that no change was needed to these factors.

c. Physicians Excess Medical Malpractice Insurance for '08 –'09

Chapter 58 of the Laws of 2008 continued the excess medical malpractice program provided for in §18 of Chapter 266 of the Laws of 1986, as amended for the period July 1, 2008 through June 30, 2011.

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

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

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

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

The New York Medical Malpractice Insurance Plan (Plan) has been established by Department Regulation No. 170 (11 NYCRR 430) to provide medical malpractice insurance to eligible health care

practitioners and facilities otherwise unable to obtain coverage in the voluntary market. All insurers licensed in New York and writing medical malpractice insurance in the State are required to be members of the Plan. Regulation No. 170 also permits the members to participate in an independent pooling mechanism whereby, rather than getting individual assignments, writings, expenses, fees and losses will be shared proportionately among the members. In 2008, all members of the Plan participated in the Medical Malpractice Insurance Pool of New York State (Pool).

For 2008, the Pool insured 1,196 individuals (including professional corporations) compared with 1,482 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)
2006-2008

Type of Insured	Policies as of December 31, 2008	Policies as of December 31, 2007	Policies as of December 31, 2006
Primary Insureds			
Physicians	347	455	580
Dentists	171	205	208
Podiatrists	35	67	79
Nurse-Anesthetists	4	6	5
Nurse-Midwives	17	23	22
Professional Corps.	23	29	33
Excess Layer Insureds			
First Layer Excess	599	697	730
Second Layer Excess	0	0	0

Note: There are across the board decreases on MMIP business from the prior year. Some of the insureds, especially for physicians' and surgeons' have been switching over to risk retention groups that are exempted from the regulations of this Department. 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 25 facilities, the majority of which were nursing homes (6) and adult homes (15), down from 140 the year before.

f. New Task Force Confronts Medical Malpractice Reform

In July, 2007, Governor Eliot Spitzer charged Superintendent Dinallo with heading a new task force to confront the fundamental drivers of high medical malpractice costs. The task force, which will report back to the Governor, includes New York State Commissioner of Health Richard F. Daines, M.D., and a broad range of representatives from physician and hospital associations, the insurance industry, consumer groups, health plans, trial lawyers and the Legislature.

16. Workers' Compensation

a. Workers' Compensation Rate Credits for Managed Care Programs

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

A managed-care program can control associated workers' compensation costs through careful review of utilization and case management, safety programs, return-to-work policies and other loss control techniques. The Department has approved rate credits for a total of 40 insurance carriers desiring to offer managed-care programs as of year-end 2008.

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 2008 there were 31 insurance carriers with approved drug-free workplace programs in place.

17. Insurance Availability Issues

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

a. Availability Survey

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

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

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

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

18. Automobile Insurance

a. New York Automobile Insurance Plan

The number of vehicles insured in the Plan has continued to decline for the past few years and remains at an historic low. Approximately 1.1% of New York private passenger registered vehicles are insured in the Plan as compared to a range of 12% to 17% around two decades ago. Furthermore, at year-end 2008, there were approximately 16% fewer vehicles in-force than year-end 2007 and approximately 42% fewer than year-end 2006. This continual decrease in the Plan population can be attributed, at least in part, to various Department initiatives such as those to combat fraud and incentives to voluntary market insurers that provide coverage to drivers who otherwise would have been placed in the Plan.

b. Legislation

Chapter 136 of the Laws of 2008 extends until June 30, 2011 the provisions of Section 2328 regarding the prior approval of rates for Public Automobile insurance. It also extends until June 30, 2011 the provisions of Section 3425 regarding the cancellation and non-renewal of private passenger automobile policies.

Chapter 136 of the Laws of 2008 also added a new Insurance Law section 2350. Chapter 136 replaced the prior approval system, in effect since 2001 for nonbusiness motor vehicle insurance rates, with a flexible rating (flex-rating) system. The new system, which is a blend of prior approval and competitive rating, became effective on January 1, 2009. Regulation 153 (11 NYCRR 163) was promulgated on an emergency basis to implement the new flex-rating system. The regulation allows periodic overall average rate changes up to 5% on a file-and-use basis. It requires the superintendent's prior approval of filings that produce overall rate increases above 5% or individual policyholder rate changes above 30% in any twelve-month period.

Chapter 136 also added a new Insurance Law subsection 3425(r), which allows an insurer that has no more than 750 personal automobile insurance policies in-force at last year-end and intends to non-renew all of the policies, to submit a plan for the nonrenewal of those policies to the superintendent for approval. The plan must describe the measures the insurer will take or has taken to minimize market disruption. Prior to this new statute, an insurer could only terminate all of its personal automobile policies under very limited circumstances, such as if it withdrew its license to write the applicable property/casualty lines of business or if continuation of the policies would be hazardous to the interests of policyholders of the insurer, its creditors, or the public pursuant to Section 3425(c).

c. No-Fault Motor Vehicle Insurance Law Activity – 2008

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

Two 1997 Court of Appeals decisions, Central General Hospital v. Chubb, and Presbyterian Hospital v. Maryland Casualty, had an enormous impact on No-Fault adjudication and the number of disputes generated by the No-Fault system. These cases generally established that a No-Fault insurer may not assert a defense when it does not timely deny a claim within 30 days of receipt. In a 2008 decision, Fair Price Medical Supply v. Travelers, the Court of Appeals upheld the application of a preclusion sanction for a late denial where durable medical equipment supplies were billed for and never provided, so that any amount billed by a health provider for non-existent services must be paid by the insurer when there is a late denial. Essentially, the fundamental requirements established by the Legislature in 1973 that all reimbursable No-Fault health care expenses must be necessary and billed in accordance in the fee schedule limits have been frustrated by the decisions mentioned above. Therefore, the Legislature should enact legislation similar to the bill proposed by the Senate two years ago in S2638 that would restore the fundamental requirements for No-Fault health care expenses to be reimbursable by permitting an insurer to assert a defense when it does not deny a claim within 30 days of receipt.

ii. Mandatory arbitration for all No-Fault insurance disputes

The Civil Court of the City of New York and District Courts in Nassau and Suffolk Counties have been inundated with lawsuits filed by medical providers seeking reimbursement of No-Fault benefits for services rendered to injured claimants. This strain on the judiciary's resources led the Chief Administrative Judge's Local Courts Advisory Committee (Unified Court System) to propose a bill in 2006 that would amend NYIL §5102 to require mandatory arbitration for all No-Fault insurance disputes. Since the improvements in the administration of the No-Fault Arbitration System in the past few years permit it to process substantially more requests for arbitration without compromising the goal of a speedy dispute resolution system, the Legislature should consider legislation that would reduce the strain on the judiciary's resources by revising NYIL §5102 to require mandatory arbitration for all No-Fault insurance disputes.

19. Homeowners Insurance

a. New York's Coastal Areas

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

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

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

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

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

From its inception in April 1996 through December 31, 2008, 6,342 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. Legislation and Regulations

Chapter 21 of the Laws of 2008 amended Section 3444 of the Insurance Law – Flood Insurance Notice - to require policy holders to be provided with an annual notice that their policy does not cover damage caused by flooding or mudslide and that such insurance is available under a separate policy issued in accordance with the National Flood Insurance Program (NFIP). This change was effective on August 31, 2008.

Chapter 136 of the Laws of 2008 repeals Section 5411 of the Insurance Law – Termination of Article – to make NYPIUA permanent. It also extends certain provisions of the law relating to the New York Property Insurance Underwriters Association (NYPIUA) and provisions of chapter 42 of the laws of 1996 relating to homeowners' insurance; extends certain stand-by powers of NYPIUA; requires NYPIUA to develop and implement an incentive plan for members that voluntarily write policies that include windstorm coverage in coastal areas; provides for the writing of insurance policies providing broad form coverage; directs NYPIUA to create the coastal market assistance program; directs the superintendent of insurance to implement a program to encourage insurers to write residential property insurance; relates to the special advisory panel on homeowners' insurance/catastrophe coverage. This bill was signed into law on June 30, 2008.

c. Hurricane Computer Simulation Models in Rate Filings

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

d. Reinsurance Cost Factors in Homeowners Insurance Rate Filings

The Department permits insurers to reflect the cost of catastrophe excess-of-loss reinsurance in homeowners' insurance rate filings, provided an insurer can reasonably allocate the cost of such reinsurance to its New York policyholders. The Department has accepted homeowners rate filings in which reinsurance costs were among the factors reflected in the ratemaking methodology for nearly all major homeowners' insurers.

Over the last few years, catastrophe reinsurance costs have significantly increased, lending to significant indicated rate increases for homeowners and dwelling insurance, predominantly on Long Island.

e. Mineola Office

In order to assist consumers on Long Island who are experiencing problems obtaining homeowners policies, the Department's satellite office in Mineola, New York provides consumers with information to assist them in obtaining insurance protection for their homes, and is staffed by

Department examiners during regular business hours. Consumers can contact the staff at the Mineola office either in person at 163 Mineola Blvd. in Mineola or by telephone at (800) 300-4593 or (800) 300-4576.

20. Market Conduct Activities

a. Summary of Market Conduct Investigations Conducted and Fines Collected

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

There were 49 market conduct investigations and 3 Rate Service Organization examinations (RSO) in progress at the beginning of 2008 and 51 investigations and 1 Stamping Office examination were initiated during the year. The Department closed 56 market conduct investigations during the year. At year's end, 44 market conduct investigations, 3 RSO examinations and 1 Stamping Office examination were in progress. A total of 30 stipulations were entered into during the year, resulting in fines collected for admitted violations totaling $ 520,890. In addition, fines totaling $37,750 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 2008:

Table 38
MARKET CONDUCT INVESTIGATIONS/EXAMINATIONS
by Type of Investigation/Examination
2008

Type of Investigation	Outstanding at 1/1/2008	Initiated during 2008	Completed during 2008	Outstanding at 12/31/2008
Claims	8	4	3	9
Rating/Underwriting	4	1	0	5
Automobile/Homeowners Underwriting 3425	5	4	0	9
Title Ins. Underwriting	5	0	3	2
Commercial Auto Rating/Underwriting	1	0	0	1
Personal Auto & Homeowners Rating/Underwriting	1	1	0	2
Privacy	5	0	5	0
Frauds	0	6	6	0
Public Auto	6	0	0	6
Desk Audits:				
Section 3425 Compliance	0	7	7	0
Claims/Rating/Underwriting	14	3	7	10
Internet Web Site Reviews	0	11	11	0
Availability Survey 05	0	7	7	0
Market Analysis Review	0	7	7	0
Total Investigations	**49**	**51**	**56**	**44**

Examinations:	Outstanding at 1/1/2008	Initiated during 2008	Completed during 2008	Outstanding at 12/31/2008
Rate Service Organization	3	0	0	3
Miscellaneous Stamping Office	0	1	0	1
Total Examinations	**3**	**1**	**0**	**4**

The following chart details the fines collected or processed and the stipulations entered into during Calendar Year 2008:

Table 39
MARKET CONDUCT FINES COLLECTED & PROCESSED
by Type of Investigation
2008

Type of Investigation	Number	Amount
Claims	7	$ 91,090
Title Rating	1	32,500
Desk Audits:		
Claims/Rating/Underwriting	8	313,000
Section 3425 – 2%	7	77,300
Availability Survey –7 for 07	7	7,000
Total	**30**	**$ 520,890**
Penalties: Failure to timely pay N.F. Arbitration Awards	151	$ 37,750
Total Fines Collected & Penalties Processed	**181**	**$ 558,640**

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, 7 stipulated fines totaling $77,300 for Calendar year 2006 were collected during Calendar Year 2008 (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 2007 Surveys, the Department collected fines of $7,000 during calendar year 2008 from insurers who did not submit the surveys in a timely manner (included in the total fines collected in Section 21(a) above).

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

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

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

Insurers were also advised that in accordance with Section 109(c)(1) of the Insurance Law, a penalty would be imposed on insurers for each complaint made where no justifiable reason for

nonpayment or late payment was furnished to the Department. In addition, these complaints are recorded for the purpose of calculating the complaint ratios that form the basis of the Department's Annual Automobile Complaint Ranking. During Calendar Year 2008, the Department processed 151 fines totaling $37,750 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. Eleven insurer web sites were reviewed during the course of 2008. 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 2009.

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 2008, the Market Conduct Unit initiated and completed a review of six insurers to determine whether they were following the requirements outlined in the statute and regulation. Detailed questionnaires were submitted to these insurers which were then reviewed during the investigation in conjunction with additional documentation requested. Once all necessary material was received and analyzed it was submitted to the Department's Frauds Bureau for further review.

g. Market Analysis Review System

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

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

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

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

During 2008, Market Analysis reviews of seven Companies were conducted. Three Companies needed further monitoring within the Insurance Department which included rapid growth in selected line of business premiums and increases in direct defense costs. No further analysis was needed for the remaining four Companies. Two of the Companies are the subject of ongoing market conduct investigations. Some of the goals of the Market Analysis Program for 2009 are to standardize baseline factors to enable the Department to identify issues of concern and to prioritize activities in a uniform manner on a more thoughtful basis. The unit intends to make use of analytic tools such as the NAIC Prioritization tool in the selection of future Market Analysis reviews

21. Excess Line Insurance

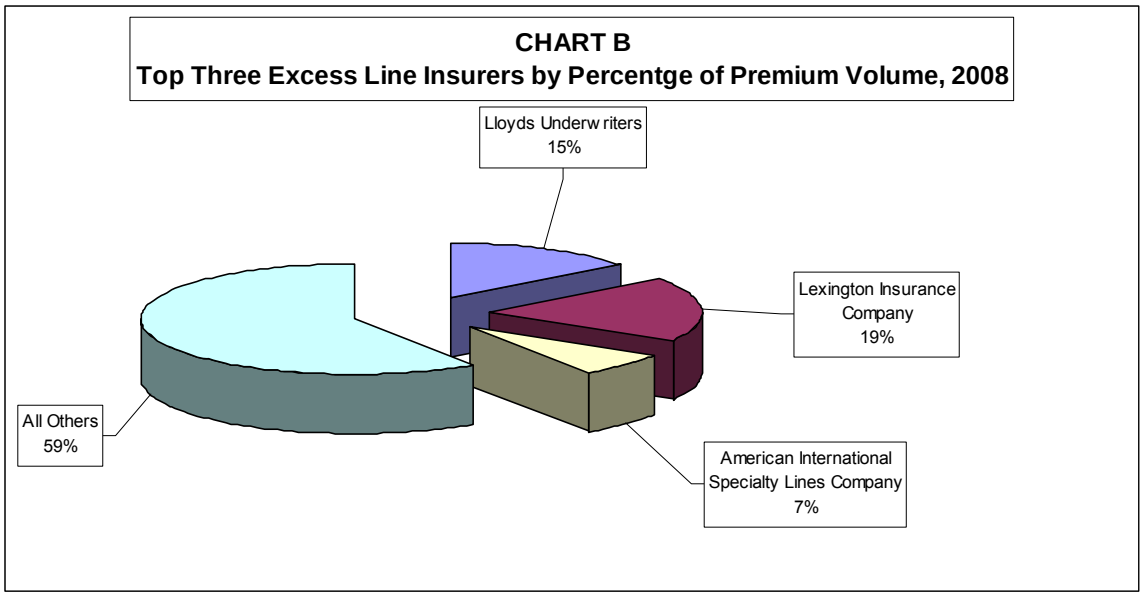
Applicants that cannot obtain coverage from companies licensed to write insurance in New York may, under circumstances prescribed in the New York Insurance Law and regulations, obtain such coverage from unlicensed companies through the auspices of a New York-licensed excess line broker.

Since insurers providing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained from excess line brokers through tax statements required to be filed no later than March 15 of each year relating to business written during the previous Calendar Year. For Calendar Year 2008, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $3.2 billion, of which approximately $2.2 billion was attributable to risks located or resident wholly in New York State. These excess line premiums generated approximately $79,837,039 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 2,697 licensed excess line brokers and approximately 862 who are active and filed 144,218 affidavits for the year 2008. Thirteen hundred and eighty two complaints and inquiries and 1,981 filings regarding excess line business were received in 2008.

In 2008, there were approximately 202 unauthorized insurers eligible to do business in New York pursuant to Regulation 41. This includes 94 foreign insurers; 36 alien insurers; and Lloyd's, with 73 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 2008, the Unit reviewed 56 EL-1 filings, 88 annual statements and 11 trust agreements filed by these unauthorized insurers.

The following is a chart of the percentage of total 2008 excess line premium writings attributable to the three largest excess line insurers in New York State.



a. Business Written in New York

Total excess line premiums written in New York State decreased from $2.632 billion in 2007 to $2.217 billion in 2008, a decrease of 15.8%. The decline in business is mainly due to a softening of the insurance market. The largest dollar decline over the previous year was in the “other liability” segment, down $340.3 million, or 23.4%. Other decreases included errors and omissions, down by $85.6 million; commercial multiple peril (excluding fire), down by $19.7 million; inland marine, down by $17.9 million; auto physical damage, down by $5.5 million; and malpractice, down by $4.7 million.

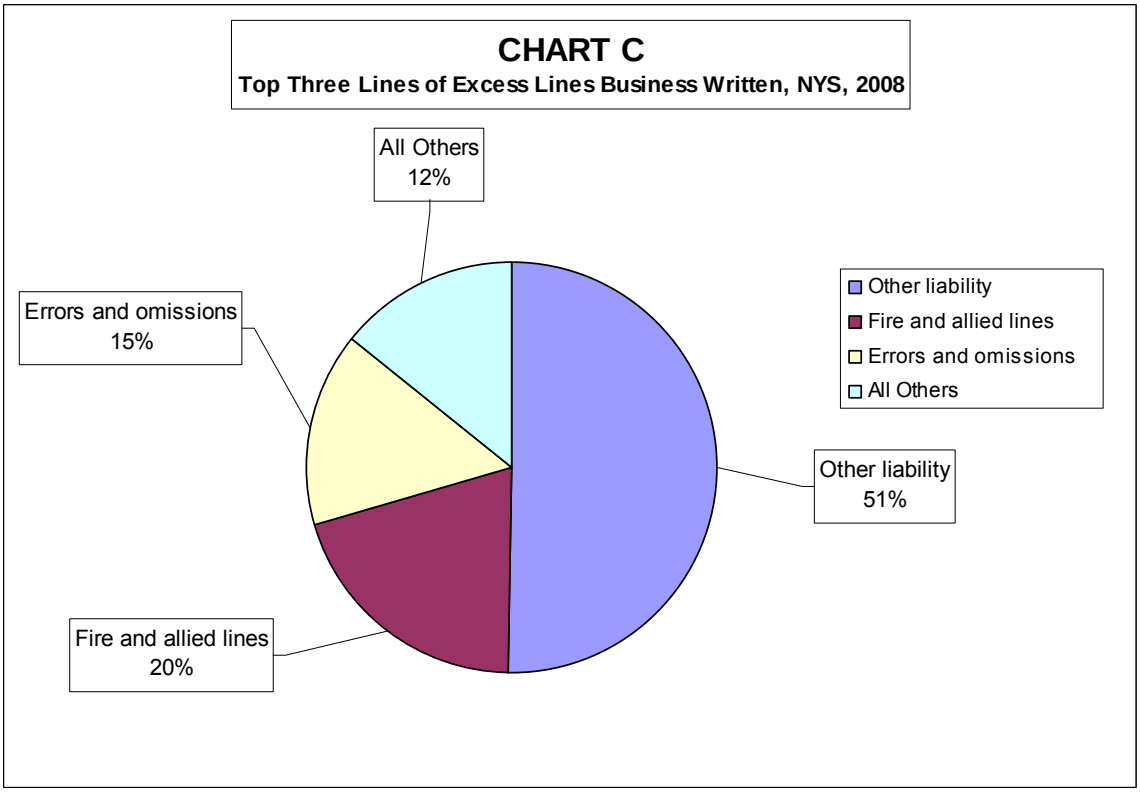
The largest increase over the previous year was in fidelity and surety, up by $22.2 million, an increase of 82.7%. Other increases included fire and allied lines, up by $15.5 million, 3.5% increase; other lines, up by $13.7 million, 31.3% increase; and burglary and theft, up by $1.5 million, 23.3% increase. In calendar year 2008, homeowners’ premiums in the excess line market increased by 21% from $30,458,717 to $36,815,584, which represents less than 1% of the entire homeowners market.

Table 40
EXCESS LINE PREMIUMS WRITTEN
Risks Located in New York State
2004-2008
(dollar amounts in thousands)

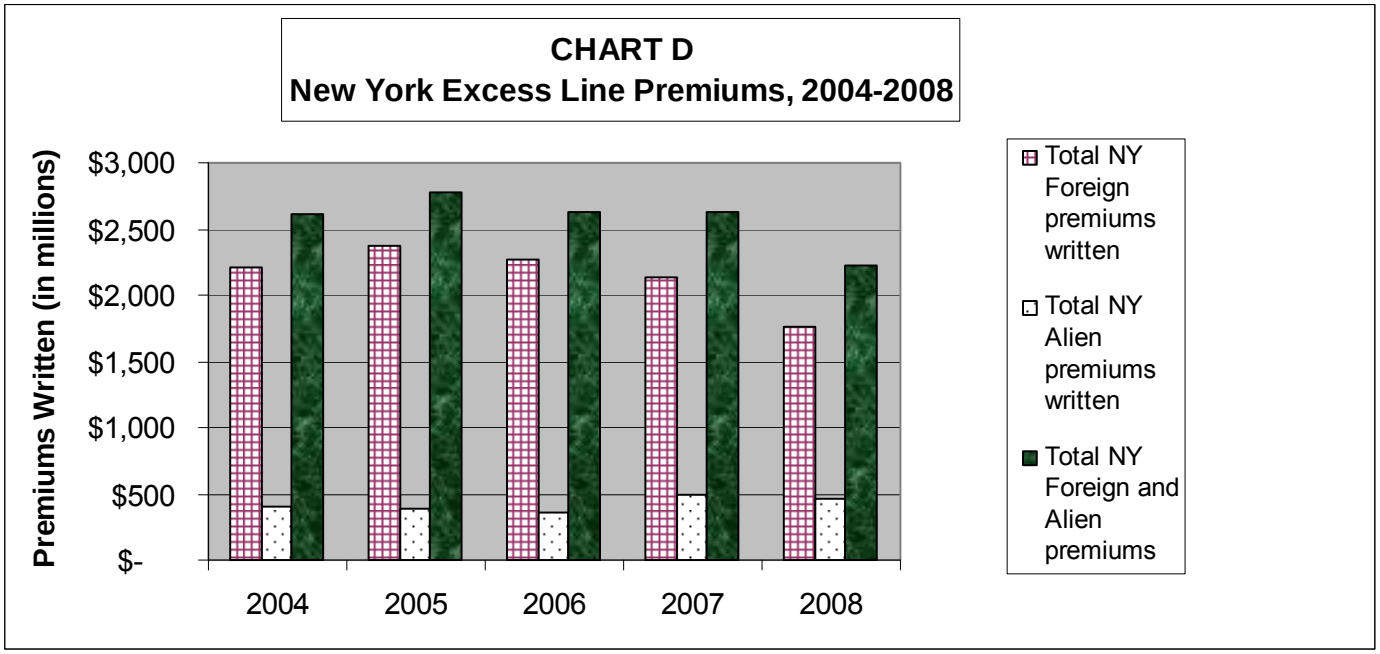
Life of business	2008	2007	2006	2005	2004
Fire and allied lines	$453,822	$ 438,321	$ 427,382	$ 395,848	$ 393,807
Inland marine	49,249	67,124	60,679	57,889	52,162
Auto liability	14,493	15,152	15,605	16,758	15,757
Malpractice	23,025	27,751	26,934	17,768	23,319
Errors and omissions	336,265	421,891	297,656	408,213	480,076
Commercial multiple peril (excluding fire)	87,501	107,185	109,280	111,716	111,068
Other liability	1,112,343	1,452,654	1,433,705	1,621,751	1,419,191
Auto physical damage	19,038	24,499	24,646	41,834	21,291
Aircraft physical damage	7,430	792	3,310	5,770	1,049
Burglary and theft	7,918	6,422	7,946	13,308	10,369
Fidelity and surety	48,996	26,816	43,880	34,331	23,116
Other lines	57,616	43,882	171,101	43,432	58,621
Total	$2,217,696	$2,632,490	$2,622,123	$2,768,618	$2,609,827
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	6.17%*	7.12%	7.30%	7.88%	7.48%

*Estimated
Source: Excess Line Association of New York

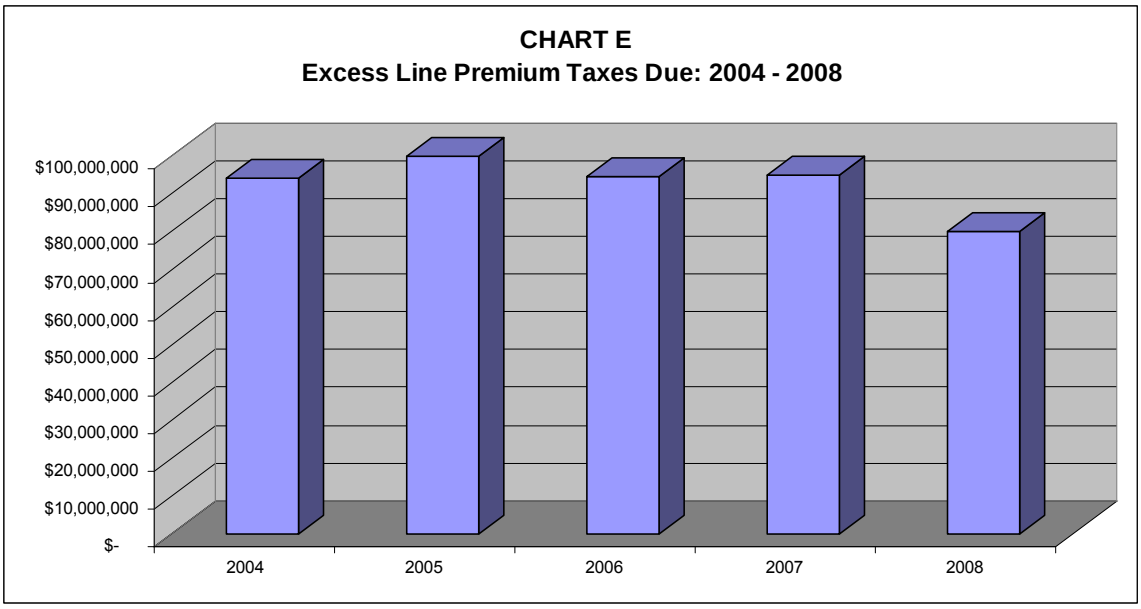
The pie chart below shows the three major lines of business written in the excess line market based on premium volume.



The following graph shows excess line business for the years 2004 to 2008 by alien and foreign insurers:



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



b. Binding Authority

Sections 2117 and 2118 of the Insurance Law were amended in 1997 to provide that an excess line broker, licensed pursuant to Section 2105 of the Insurance Law, may exercise binding authority, which the law defines as ". . . the authority to issue and deliver insurance policies on behalf of an insurer not licensed or authorized to do business in this state." Since the implementation of the amended statute, the Excess Line Association of New York (ELANY) has notified the Department that 82 excess line brokers have filed 272 binding authority agreements representing insurers not licensed or authorized to do business in this State. During calendar year 2008, the ELANY reviewed and accepted 43 new, renewed and/or amended binding authority agreements from New York-licensed excess line brokers. Currently, 82 excess line brokers have notified and filed with ELANY, 342 binding authority agreements.

c. EL-1 Review

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

d. Excess Line Association of New York (ELANY)

The Department received a request under section 2118 of the Insurance Law and Department Regulation 41 from the Excess Line Association of New York to expand the export list. A public hearing was held on June 13, 2008 on the expansion of the export list. As a result of the public hearing, the Department will be promulgating an amendment to Regulation 41.

ELANY has also requested the Department amendment Regulation 41 to increase the minimum capital requirements of unauthorized insurers doing business in New York. The Department is in the process of amending Regulation 41.

e. Special Risk Insurance (Free Trade Zone)

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

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

Or

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

During the year, the Department received several inquiries regarding the allowance of certain risks in the class (1) or class (2) categories, interpretation of Regulation 86, and requests to add additions to the class (2) category listed in Regulation 86. The following lines have been added to the class (2) category effective July 23, 2008:

Health Maintenance Organization (HMO): liability coverage for HMO's for owner operators and salaried and non-salaried employees of HMO's excluding medical malpractice for doctors.

Independent Physicians Association (IPA): liability coverage for IPA'S for owner operators and salaried and non-salaried employees of IPA's excluding medical malpractice for doctors.

Preferred Provider Organization (PPO): liability coverage for PPO'S for owner operators and salaried and non-salaried employees of PPO's excluding medical malpractice for doctors.

Third Party Administrator (TPA): liability coverage for IPA's for owner operators and salaried and non-salaried employees of IPA's excluding medical malpractice for doctors.

Utilization Review Organization (URO): liability coverage for URO's for owner operators and salaried and non-salaried employees of URO's excluding medical malpractice for doctors.

Actuarial Professional Liability Coverage: professional liability coverage for actuaries

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

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

Since the inception of the LRRA, the Department has received notices of intent from 955 purchasing groups. Subsequently, 328 have withdrawn their notice of intent, 129 have notified the

Department of their inactive status, and 44 have been given ineligible status by the Department due to failure to comply with all the requirements of the applicable laws and regulations. In 2008, the Department received notices of intent from 41 purchasing groups.

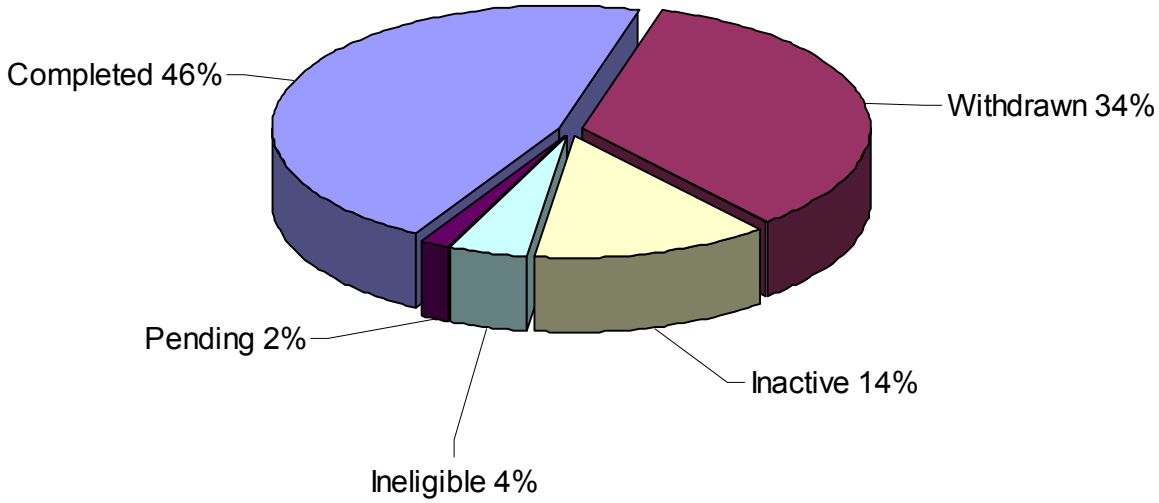
In 2008, the Department requested Purchasing Groups file an annual update of the required information under the LRRA. The update form was placed on the Department's website.

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. Four complaints and inquiries regarding purchasing groups were received in 2008.

The following chart shows the purchasing group filings as of December 31, 2008, by status category:

g. Purchasing Group and Excess Line Investigations

CHART F
Purchasing Group Filings, 2008



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

A broker failed to pay applicable premium taxes of $140,564. Subsequently, the broker paid $181,716.00 which included Section 9109 penalty of $41,152. A fine of $1,000 was offered to resolve violations of Section 2118 of the New York Insurance Law.

Medical malpractice insurance was inappropriately placed in the excess line market and ceded 100% to a risk retention group. Medical malpractice insurance for doctors, dentists, general hospitals and nurse midwives must be placed in the admitted market. An excess line broker may not place business in the excess line market unless the residual market, Medical Malpractice Insurance Plan (MMIP) declines the risk. However, MMIP must accept all the aforementioned risks. Furthermore, the excess line broker affirmed that he made the placement when in fact he did not. The brokerage was fined $25,000 for the placement. In mitigation, the broker attempted to keep the premiums affordable for doctors practicing in an underserved inner city neighborhood.

Many taxi placements were made with an excess line insurer in 2008. Approximately 20 retail brokers used an authorized insurer that has not written business for several years as a declining

licensed insurer. This authorized insurer is close to insolvency and has a pending liquidation proceeding in its home state. This authorized insurer was not an acceptable declination because the brokers would not have a reason to believe the insurer would write the risk. We hope to resolve the matter by stipulations and fines of the retail brokers.

A review of an EL-1 report of an excess line company revealed that a broker, who did not have a valid excess line broker's license, made numerous placements (335 certificates) for a Purchasing Group registered with New York. The master policyholder is located in Texas. The placing broker has a non-resident broker's license from New York but he does not have a New York excess line license, therefore, he is in violation of Section 2117. The case is still in the investigatory process. It is the position of this Department that every certificate delivered into New York State is considered a policy and thereby subject to the New York Insurance Law, no matter where the master policy is located.

The excess line unit also monitors the financial solvency of 202 excess line insurers conducting business in this state.

It came to our attention that an excess line insurer's surplus to policyholder as of December 31, 2007 dropped below statutory minimum requirement of $15 million. On March 18, 2008, a telephone conference with the company officials was conducted to address the matter. As a result, the parent company transferred $1 million dollars to the company raising its surplus above $15 million. We have been monitoring the company closely.

The Unit conducted approximately 155 investigations which includes the ones described above. Many of these investigations were the result of EL-1 reviews. As a result of these investigations, the Unit collected $114,991.06 of additional taxes, penalties and fines in 2008.

h. Electronic Initiatives

In September 2007 the Unit was given approval by the Taxes and Accounts Bureau to create an interactive Premium Tax Statement for online filing for the March 15 filing deadline. The project was completed on time. Letters and log-in ID's were provided to all excess line brokers in 2008 and new licensees were mailed this information early this year. For those brokers unable to file electronically, paper premium tax statements are available on the internet. As of March 20, 2009, there were 801 premium tax statements filed online, 210 more filings than 2008. These filings represent approximately 30% of the 2,697 excess line brokers licensed and required to make this filing. This electronic usage is expected to increase in the future resulting in even greater savings.

On June 26, 2008 ELANY and the Department completed a project to enable the viewing and printing, at the Department, of scanned copies of filed excess line broker's affidavits with ELANY. ELANY also sends a monthly electronic report detailing all data on the affidavit except for the name of the authorized insurer representative declining the risk. The data provided by this viewing privilege has eliminated the need for ELANY to send the paper copies of the affidavits. The Department previously received 20 boxes of affidavits per month. Also the Department no longer needs to enter the affidavit data in the Department's system saving considerable time and storage space. This has greatly improved the Department's ability to make use of the information provided in affidavits and to manage our records.

22. Consumers Guide to Automobile Insurance

On October 1, 2008, the Department published an upstate and downstate edition of the 2008 Consumers Guide to Automobile Insurance. The Department also has an interactive version of the guide on its Web site. The guide is required by Section 337 of the Insurance Law to be updated annually. This comprehensive guide helps consumers determine how much auto insurance they need and explains all mandatory and optional coverages available in New York State. The guide contains lists of insurers, telephone numbers, and sample rates to facilitate comparison shopping, and advice regarding how to file a claim or make a complaint against an insurer. Copies of the guide were distributed to every Department of Motor Vehicles office and public library in the State. The guide is also available free of charge directly from the Insurance Department and can be accessed via the Department's Web site.

23. Regulations

Regulations Adopted in 2008:

Thirtieth Amendment to Regulation 83 (Charges for Professional Health Services), became effective April 16, 2008. This amendment repeals the fee schedules previously established by the Insurance Department for prescription drugs, durable medical equipment, medical/surgical supplies, orthopedic footwear, and orthotic and prosthetic appliances. The charges for these goods and services are now covered by two fee schedules established by the Workers' Compensation Board. In addition, the amendment clarifies that a pharmacy is deemed to be a provider of health services for purposes of eligibility for direct payments pursuant to Regulation 68-C.

24. Circular Letters

Circular Letters Issued in 2008:

Supplement No. 1 to Circular Letter No. 4 (2001) regarding electronic filing via the Internet of national form (NAIC) annual statements and New York supplements, quarterly statements and audited financial statements was issued on February 6, 2008. The circular letter encourages all foreign insurers and foreign accredited reinsurers that file their annual statements and New York supplements, quarterly statements and audited financial statements pursuant to Section 307 or 308 of the New York Insurance Law on the property and casualty and title blanks, to file electronically with the NAIC via the Internet. This applies to filings due March 1, 2008 and thereafter.

Circular Letter No. 4 (2008) regarding guidelines and procedures for the implementation of the provisions of the Terrorism Risk Insurance Program Reauthorization Act of 2007 was issued February 22, 2008 to all property/casualty insurers and Rate Service Organizations doing business in New York State, New York Property Insurance Underwriting Association, State Insurance Fund, New York Automobile Insurance Plan, and Excess Line Association of New York. The circular letter advised that the Terrorism Risk Insurance Extension Act of 2005 (Act) which was scheduled to expire on December 31, 2007 has been extended through December 31, 2014. Several provisions have been changed under the 2007 extension.

Circular Letter No. 6 (2008) regarding 2008 Workers' Compensation rate filings was originally issued April 16, 2008 and revised on May 15, 2008 to all insurers authorized to write workers' compensation insurance in New York, workers compensation rate service organizations, and the State Insurance Fund. The circular letter advised insurers about recent changes to the New York Insurance Law regarding workers' compensation rates and to provide guidance to rate service organizations and insurers with respect to the new loss-cost approach for workers' compensation rates.

Circular Letter No. 9 (2008) regarding the adoption of the 30th Amendment to Regulation No. 83 (11 NYCRR 68) - Revision to the No-Fault Prescription Drugs and Durable Medical Equipment Fee schedules was issued April 16, 2008 to all motor vehicle automobile self-insurers, and insurers authorized to write motor vehicle insurance in New York State and the Motor Vehicle Accident Indemnification Corporation. The circular letter advised insurers that the Department has promulgated the 30th Amendment to Regulation No. 83. The Department is adopting the pharmaceutical fee schedule and durable medical equipment fee schedule promulgated by the Workers' Compensation Board.

Circular Letter No. 14 (2008) regarding unfair claims settlement practices: interest on overdue no-fault claims and claim settlement structure was issued June 10, 2008 to all authorized insurers writing motor vehicle insurance in New York State, motor vehicle self-insurers, and the Motor Vehicle Accident Indemnification Corporation. The circular letter advised insurers that the obligations set forth in 11 NYCRR § 65-3.9 apply regardless of whether a claim is in litigation or arbitration, and cannot be circumvented by having outside counsel or other representatives of insurers suggest or require, as a condition of settlement of a contested claim, waiver of any interest that is due.

Circular Letter No. 18 (2008) regarding the flood insurance notice required by Section 3444 of the New York insurance law was issued August 13, 2008 to all insurers writing homeowners and dwelling fire personal lines policies in New York State, insurance producer organizations, and the Excess Line Association of New York. The circular letter advised that This Circular Letter supersedes Circular Letter No. 18 (1994) has been withdrawn. The circular letter also advised that Section 3444 of the Insurance Law has been amended to require that the flood insurance notice required by that statute be provided annually.

Supplement No. 1 to Circular Letter No. 9 (2008) regarding the Workers' Compensation Board's Adoption of a new Pharmaceutical Fee Schedule that is applicable to no-fault claims was issued on September 19, 2008 to all Motor Vehicle Automobile Self-Insurers, Insurers Authorized to Write Motor Vehicle Insurance in New York State, and the Motor Vehicle Accident Indemnification Corporation. The purpose of this supplement is to advise insurers and providers of no-fault health services benefits that the Workers' Compensation Board has adopted, by emergency regulation, a new pharmaceutical fee schedule that is therefore also applicable to all no-fault prescription drugs dispensed on or after July 7, 2008.

Circular Letter No. 26 (2008) regarding Notice provisions in liability policies; Chapter 388 of the Laws of 2008 was issued November 18, 2008 to all authorized Property/Casualty Insurers, Rate Service Organizations, New York Medical Malpractice Insurance Plan, New York Automobile Insurance Plan, and Excess Line Association of New York. The circular letter advised property/casualty insurers of the recent enactment of Chapter 388 of the Laws of 2008 ("Chapter 388"), which amends Insurance Law §§2601 and 3420 and Civil Procedure Law and Rules ("CPLR") §300.

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

Certain complaints and inquiries are processed independently of the Consumer Services Bureau. A total of 1,460 such complaints and inquiries were received by the Market Regulatory Division of the Property Bureau in 2008. This total consisted of 1,060 involving personal automobile insurance; 16 involving commercial automobile insurance; 127 involving homeowners insurance; 56 involving other liability insurance; 28 involving commercial multiple peril insurance; 69 involving medical malpractice insurance; 29 involving workers' compensation, and 75 involving other types of insurance (mortgage guaranty, fidelity, surety, inland marine, etc.). In addition, the Market Regulatory Division received 543 Freedom of Information (FOIL) requests on policy form and rate information.

26. Casualty Actuarial

Casualty Actuarial reviews rate filings for workers' compensation insurance, private passenger automobile insurance and private passenger and commercial insurance offered through the Automobile Insurance Plan as well as Medical Malpractice rate filings. All such filings are subject to prior approval. In terms of premium volume, private passenger automobile and workers' compensation insurance are the largest property/casualty coverages, accounting for approximately $13.5 billion of New York premium volume in 2008.

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

a. Private Passenger Automobile Insurance

The average change for insurers receiving rate changes in 2008 was approximately 5.7%. For these insurers, liability rates increased 8.9% on average while physical damage rates, primarily collision and comprehensive coverages, decreased 0.9% on average. The insurers receiving rate changes in 2008 represent 44% 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 2008) was an average increase of 2.6%.

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

In 2008, 30 private passenger automobile rate filing requests were implemented. The following table lists both the requested and implemented rate changes and provides the liability and physical damage components of such changes.

Table 41

PRIVATE PASSENGER AUTOMOBILE RATE FILINGS REVIEWED IN 2008 [1]

Date of Approval	Renewal Effective Date	Insurance Company or Insurance Group	Market Share[2] (%)	Overall Change Requested (%)	Liability Change Approved (%)	Physical Damage Change Approved (%)	Overall Change Approved (%)
1/7/08	4/10/08	Adirondack Ins. Exchange	0.3	3.5	8.5	-6.7	2.5
1/7/08	4/10/08	One Beacon: OBIC; OBAIC; EFIC	0.7	3.5	8.6	-6.8	2.5
2/5/08	4/14/08	State Farm Mutual Automobile Ins	8.8	3.5	4.5	2.3	3.5
2/5/08	4/14/08	State Farm Fire & Casualty Ins Co	1.1	7.5	8.2	7.1	7.5
2/6/08	3/1/08	Utica National Ins. Co. of Texas	0.0	0.0	0.0	0.0	0.0
2/14/08	4/21/08	Liberty: LMFIC; TFLIC	4.6	2.3	3.6	0.0	2.3
2/21/08	5/1/08	Farmers New Century Ins. Co.	0.4	12.5	15.6	-8.0	7.4
2/29/08	2/29/08	Permanent General Assurance Corp.	0.0	0.0	0.0	0.0	0.0
3/3/08	3/20/08	American States Ins. Co.	0.0	0.0	0.0	0.0	0.0
3/12/08	5/17/08	Allstate Ins. Co.	15.4	8.2	8.3	-3.4	4.1
3/25/08	5/12/08	Nationwide Mutual Fire Ins. Co.	0.2	2.8	3.8	-1.7	2.8
7/30/08	10/17/08	AIG Advantage Ins. Co.	0.0	6.0	6.3	4.7	6.0
8/8/08	11/1/08	Merastar Ins. Co.	0.0	5.1	5.9	3.2	5.1
8/14/08	10/24/08	AIG: AHAC; AIGCC; AIIC; INIC; NUFICofPPA; ICofTSofPA; AIUIC	0.9	5.2	3.2	0.6	2.4
8/15/08	10/15/08	GEICO Indemnity	4.9	17.1	11.0	3.9	9.1
8/16/08	10/19/08	Meritplan Ins. Co.	0.0	-8.4	-8.4	-8.4	-8.4
9/16/08	1/12/09	Nationwide: NMIC; NP&CIC	2.1	-4.0	-3.0	-5.9	-4.0
10/14/08	12/23/08	Progressive Preferred Ins. Co.	0.1	13.4	9.3	-0.9	7.0
10/14/08	12/23/08	Progressive Direct Ins. Co.	1.0	14.0	9.3	1.7	7.0
10/17/08	12/13/08	Allstate Property & Casualty Ins. Co.	1.2	7.0	8.5	3.9	7.0
10/27/08	2/10/09	Allmerica Financial Ins.Co.	0.5	0.0	0.0	0.0	0.0
11/10/08	1/12/09	Nationwide: NGIN; NICOA	0.7	0.0	-0.1	-0.1	-0.1
11/18/08	12/20/08	National General Ins. Co.	0.1	6.7	6.4	-1.7	3.4
12/15/08	2/10/09	Esurance Ins. Co.	0.5	16.4	12.9	-2.6	8.2
12/18/08	1/23/09	Progressive: PAIC; PMIC	0.0	0.0	0.0	0.0	0.0
12/18/08	1/23/09	Progressive: PCIC; PSIC	0.0	0.0	0.0	0.0	0.0
12/18/08	2/3/09	Liberty Ins. Corp.	0.3	11.5	7.5	0.0	5.6
12/23/08	3/27/09	Mercury Casualty Co.	0.3	5.5	7.8	0.0	5.5
12/26/08	1/29/09	Travelers: TTHMIC; TCIC	0.0	9.5	4.2	5.9	4.8
12/31/08	3/15/09	Merchants Preferred Ins. Co.	0.0	-11.1	-11.2	-11.0	-11.1

2008 Rate Change Summary	Filings
Number of insurer rate filings:	30
● Average liability change for insurers receiving rate changes:	8.9%
● Percentage of total liability industry premium affected:	44.4%
● Impact on the entire market of the overall average liability rate change:	4.0%
● Average physical damage change for insurers receiving rate changes:	-0.9%
● Percentage of total physical damage industry premium affected:	43.9%
● Impact on the entire market of the overall average physical damage change:	-0.4%
● Average combined liability and physical damage change for insurers receiving rate changes:	5.7%
● Percentage of total industry premium affected:	44.4%
● Impact on the entire market of the overall average liability and physical damage rate change:	2.6%
1 All rate filings (and classification changes) are subject to prior approval.	
2 These market shares are primarily based on 2006 Annual Statement premiums.	

b. New York Automobile Insurance Plan (NYAIP) Experience in 2006 and 2007

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 28.5% for liability and 16.5% for collision from 2006 to 2007. 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
1998 – 2007

Calendar Year	Voluntary Liability	% Change From Previous Year	Assigned Risk Liability	% Change From Previous Year	Combined Liability	% Change From Previous Year	Assigned Risk Collision	% Change From Previous Year
1998	7,428,546		541,247		7,969,793		23,988	
1999	8,031,017	8.1	324,355	-40.1	8,355,372	4.8	11,631	-51.5
2000	8,106,797	0.9	207,802	-35.9	8,314,599	-0.5	9,408	-19.1
2001	8,147,522	0.5	343,511	65.3	8,491,033	2.1	27,597	193.3
2002	8,463,417	3.9	444,437	29.4	8,907,854	4.9	47,234	71.2
2003	8,313,121	-1.8	471,158	6.0	8,784,279	-1.4	47,981	1.6
2004	8,356,929	0.5	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

ii. Risks by Surcharge Category

In 2007, there were 130,106 private passenger earned car years for liability and 9,967 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 2005, 2006 and 2007.

Table 43
DISTRIBUTION OF PRIVATE PASSENGER AUTOMOBILE ASSIGNED RISKS
LIABILITY AND COLLISION COVERAGES*
by Discount or Surcharge Category, 2005 – 2007

	Liability			Collision		
Discount or Surcharge Category	**2005 (%)**	**2006 (%)**	**2007 (%)**	**2005 (%)**	**2006 (%)**	**2007 (%)**
Total, all categories	100.0	100.0	100.0	100.0	100.0	100.0
Total Unsurcharged	58.1	56.5	55.0	60.2	58.3	54.5
3 Years Claim Free (1 or less with Plan) (Manual Rates)	36.0	33.3	30.6	29.7	29.3	28.8
Experience Discount						
4 Years (One or more with Plan) – 18% Credit	9.8	9.5	8.4	12.9	10.4	7.9
5 Years (Two or more with Plan) – 25% Credit	6.0	5.5	5.1	9.3	7.5	5.7
6 Years or more (Three or more w/Plan) – 30% Credit	6.2	8.2	10.9	8.3	11.0	12.0
Total Surcharged	41.9	43.5	45.0	39.8	41.7	45.5
Inexperienced Operator Surcharge	21.7	22.9	23.7	14.4	15.9	17.8
Experience Surcharge						
15%	11.2	11.1	10.8	14.3	14.0	14.8
25%	0.2	0.3	0.3	0.2	0.3	0.3
35%	2.8	2.9	3.0	4.0	4.3	4.3
50%	1.9	1.9	2.1	1.6	1.5	1.9
75%	1.3	1.4	1.4	1.8	1.8	2.0
100%-200%	2.8	3.1	3.6	3.5	4.0	4.5

*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 2006 and 2007, are shown in Table 44. During 2007, 1.4% of all New York State private passenger automobiles were assigned risks as opposed to 2.0% in 2006. The proportion of assigned risks was 10% or higher in only 1 of the 70 rating territories for both 2006 and 2007. The highest 2007 ratio was 11.8% in the Bronx Territory and the lowest was 0.0032% in the Corning Territory. Between 2006 and 2007 the number of assigned risks decreased in 69 of the 70 rating territories.

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

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

Territory		2006			2007			# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
		Assigned	Voluntary	Total	Assigned	Voluntary	Total				
01	Bronx Territory	9,704	43,289	52,993	6,693	49,818	56,512	-3,011	-31.0	3,519	6.6
03	Bronx Suburban Territory	10,087	172,286	182,374	6,785	174,929	181,714	-3,302	-32.7	-659	-0.4
05	Staten Island	5,036	232,482	237,518	3,157	239,590	242,748	-1,879	-37.3	5,230	2.2
07	Buffalo	3,481	119,084	122,565	2,844	120,639	123,483	-636	-18.3	919	0.7
08	Buffalo Semi-Suburban	2,630	182,426	185,056	2,090	177,551	179,641	-540	-20.5	-5,415	-2.9
09	Schenectady County	794	108,207	109,001	518	109,103	109,620	-277	-34.8	619	0.6
11	Rochester	8,395	355,010	363,405	6,897	351,715	358,612	-1,498	-17.8	-4,793	-1.3
12	Syracuse	2,028	218,968	220,996	1,706	213,711	215,416	-322	-15.9	-5,580	-2.5
13	Albany	794	168,906	169,701	540	167,354	167,894	-254	-32.0	-1,807	-1.1
14	Niagara Falls	1,499	70,615	72,114	1,300	71,613	72,914	-199	-13.3	800	1.1
15	Utica	222	61,909	62,131	131	62,025	62,157	-91	-41.0	25	0.0
16	Saratoga Springs Suburban	59	51,308	51,367	33	51,007	51,040	-26	-44.1	-327	-0.6
17	Kings County	3,776	338,383	342,159	2,082	355,227	357,309	-1,694	-44.9	15,150	4.4
18	Manhattan	7,023	158,900	165,922	4,249	167,293	171,541	-2,774	-39.5	5,619	3.4
19	Queens	2,786	52,396	55,182	1,573	66,242	67,814	-1,214	-43.6	12,633	22.9
20	Hempstead	8,942	449,020	457,962	5,921	432,910	438,831	-3,021	-33.8	-19,131	-4.2
21	North Hempstead	3,064	154,727	157,792	2,174	154,669	156,843	-890	-29.0	-948	-0.6
22	Oyster Bay	4,718	264,433	269,151	3,417	294,157	297,574	-1,301	-27.6	28,422	10.6
24	Rome	179	22,978	23,157	122	22,730	22,852	-57	-31.6	-305	-1.3
25	Auburn	46	23,906	23,953	35	23,864	23,899	-11	-23.8	-53	-0.2
27	Elmira	24	50,012	50,037	19	49,112	49,130	-6	-23.9	-906	-1.8
28	Binghamton	1,213	112,807	114,020	857	112,501	113,359	-356	-29.3	-662	-0.6
29	Gloversville	107	28,707	28,814	77	28,842	28,920	-30	-27.9	106	0.4
30	Saratoga Springs	40	25,206	25,247	22	25,174	25,195	-19	-46.3	-52	-0.2
31	Chautauqua County	434	85,413	85,847	330	86,466	86,795	-104	-24.0	949	1.1
32	Newburgh	1,215	70,682	71,897	918	69,699	70,616	-298	-24.5	-1,281	-1.8
33	Poughkeepsie	1,402	104,084	105,485	1,022	102,301	103,324	-379	-27.0	-2,161	-2.0
34	Troy	571	62,809	63,379	346	62,489	62,835	-225	-39.4	-545	-0.9
35	Amsterdam	40	22,478	22,518	35	22,249	22,285	-5	-12.8	-234	-1.0
36	Glens Falls	426	46,420	46,846	288	44,389	44,677	-138	-32.4	-2,169	-4.6
37	Oswego	391	36,844	37,235	309	38,125	38,433	-82	-21.0	1,198	3.2
38	Syracuse Suburban	103	65,780	65,883	83	73,386	73,470	-20	-19.5	7,586	11.5
39	Rochester Suburban	76	41,330	41,406	65	41,993	42,058	-11	-14.3	652	1.6
40	Corning	8	28,467	28,475	9	28,187	28,196	1	11.9	-279	-1.0
41	Erie County (Balance)	376	88,056	88,432	299	96,060	96,359	-77	-20.4	7,927	9.0
42	Buffalo Suburban	2,201	159,579	161,781	1,657	160,025	161,683	-544	-24.7	-98	-0.1
43	Niagara Falls Suburban	292	34,215	34,507	201	34,085	34,286	-92	-31.3	-221	-0.6
44	Broome County (Balance)	30	23,377	23,407	19	25,653	25,672	-11	-36.9	2,265	9.7

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

Territory		2006			2007			# Change In A/R	% Change In A/R	#Change in Market	% Chng. in Mrkt.
		Assigned	Voluntary	Total	Assigned	Voluntary	Total				
46	Putnam County	1,101	76,644	77,745	801	77,294	78,095	-300	-27.3	350	0.5
47	Orleans County	110	25,887	25,997	68	25,974	26,042	-42	-38.3	45	0.2
48	Monroe County (Balance)	37	73,021	73,059	32	73,706	73,739	-5	-12.9	680	0.9
49	Niagara County (Balance)	128	33,209	33,338	97	34,131	34,228	-31	-24.1	891	2.7
51	Ontario County, etc.	1,351	201,766	203,117	999	203,761	204,760	-352	-26.0	1,644	0.8
52	Fort Plain, Herkimer	249	41,023	41,272	176	42,398	42,574	-73	-29.2	1,302	3.2
54	Cortland County, etc.	1,969	199,807	201,775	1,497	204,546	206,044	-471	-23.9	4,268	2.1
55	Queens Suburban	10,913	545,133	556,046	6,009	551,149	557,158	-4,904	-44.9	1,112	0.2
56	Saratoga County (Balance)	80	33,947	34,028	60	36,286	36,346	-20	-25.0	2,319	6.8
58	Dutchess County (Balance)	1,025	102,461	103,486	756	106,585	107,342	-268	-26.2	3,855	3.7
59	Columbia County, etc.	496	85,794	86,290	371	84,621	84,992	-125	-25.2	-1,298	-1.5
60	Genesee County	188	38,943	39,131	157	38,941	39,098	-31	-16.6	-34	-0.1
61	Delaware County, etc.	1,125	141,729	142,854	768	146,260	147,028	-357	-31.7	4,175	2.9
62	Highland, Kingston	1,590	86,656	88,246	1,139	86,988	88,127	-451	-28.4	-119	-0.1
64	Middletown	3,863	163,596	167,459	2,833	168,831	171,664	-1,030	-26.7	4,205	2.5
65	Ossining	4,188	183,601	187,789	2,966	183,185	186,151	-1,222	-29.2	-1,638	-0.9
67	Clinton County, etc.	6,769	342,054	348,823	5,265	349,431	354,696	-1,504	-22.2	5,874	1.7
68	Rockland County	2,191	185,240	187,431	1,296	186,458	187,754	-895	-40.9	323	0.2
71	Saratoga County South	47	44,788	44,835	33	45,315	45,348	-14	-30.4	513	1.1
72	Albany County (Balance)	17	15,983	16,000	15	18,838	18,853	-2	-10.9	2,853	17.8
73	Rensselaer County (Balance)	217	43,337	43,554	145	45,337	45,482	-73	-33.4	1,928	4.4
74	Jefferson County	528	70,656	71,184	362	73,281	73,643	-166	-31.4	2,459	3.5
75	Suffolk County West	15,999	539,606	555,605	11,766	543,150	554,915	-4,234	-26.5	-690	-0.1
76	Suffolk County East	27,052	461,902	488,954	22,274	474,566	496,839	-4,778	-17.7	7,885	1.6
81	Monticello-Liberty	51	14,164	14,216	26	14,014	14,041	-25	-49.1	-175	-1.2
82	Sullivan County Central	109	16,248	16,357	83	16,380	16,463	-26	-23.9	106	0.7
83	Sullivan County (Balance)	260	23,641	23,901	184	24,070	24,254	-75	-29.0	353	1.5
84	Allegany County, etc.	2,058	186,213	188,271	1,532	188,125	189,657	-526	-25.6	1,386	0.7
86	Oneida	145	40,491	40,636	115	40,271	40,386	-29	-20.4	-250	-0.6
94	Mount Vernon and Yonkers	4,956	106,752	111,708	2,947	108,863	111,810	-2,009	-40.5	102	0.1
95	White Plains	1,755	46,439	48,194	1,283	46,431	47,714	-472	-26.9	-481	-1.0
97	New York City Suburban	7,135	223,564	230,700	5,225	229,933	235,157	-1,910	-26.8	4,458	1.9
	Entire State	**181,917**	**8,729,798**	**8,911,715**	**130,106**	**8,876,002**	**9,006,107**	**-51,811**	**-28.5**	**94,392**	**1.1**

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

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2001-2007

Territory		2001		2002		2003		2004		2005		2006		2007	
		(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank	(%)	Rank
01	Bronx Territory	40.1	1	46.7	1	47.0	1	35.8	1	26.9	1	18.3	1	11.8	1
76	Suffolk County East	5.7	8	8.4	7	10.0	6	8.7	6	7.2	4	5.5	2	4.5	2
03	Bronx Suburban Territory	12.2	4	14.0	4	15.4	4	11.4	3	8.2	3	5.5	3	3.7	3
95	White Plains	4.9	9	6.7	9	8.1	8	7.0	7	5.2	7	3.6	7	2.7	4
94	Mount Vernon and Yonkers	8.7	6	11.1	5	12.6	5	9.5	5	6.8	6	4.4	5	2.6	5
18	Manhattan	14.5	3	16.2	3	15.7	3	10.5	4	7.0	5	4.2	6	2.5	6
19	Queens	17.7	2	19.1	2	18.6	2	12.7	2	8.2	2	5.0	4	2.3	7
07	Buffalo	4.5	12	6.1	12	7.2	11	5.7	10	4.1	10	2.8	10	2.3	8
97	New York City Suburban	4.3	13	6.0	13	6.7	13	5.6	11	4.3	8	3.1	8	2.2	9
75	Suffolk County West	4.5	11	6.5	10	7.6	10	6.0	9	4.3	9	2.9	9	2.1	10
11	Rochester	2.5	21	3.4	21	3.8	20	3.2	20	2.7	18	2.3	11	1.9	11
14	Niagara Falls	1.6	29	2.8	28	3.6	22	3.4	19	2.8	17	2.1	15	1.8	12
64	Middletown	2.9	17	4.2	17	4.7	17	4.0	16	3.2	14	2.3	12	1.7	13
65	Ossining	3.0	16	4.2	16	4.7	16	3.9	17	3.0	15	2.2	13	1.6	14
67	Clinton County, etc.	2.0	26	3.3	23	3.5	24	3.2	22	2.6	21	1.9	19	1.5	15
21	North Hempstead	3.2	15	4.5	15	5.2	15	4.1	15	3.0	16	1.9	18	1.4	16
20	Hempstead	4.1	14	5.8	14	6.5	14	4.8	14	3.2	13	1.9	17	1.3	17
05	Staten Island	4.8	10	6.1	11	7.0	12	5.3	12	3.7	12	2.1	14	1.3	18
32	Newburgh	1.6	30	2.8	29	3.5	23	3.1	23	2.3	23	1.7	22	1.3	19
62	Highland, Kingston	2.7	19	3.7	19	3.9	19	3.2	21	2.4	22	1.8	20	1.3	20
08	Buffalo Semi-Suburban	1.5	35	2.3	33	2.7	30	2.4	27	2.0	25	1.4	23	1.2	21
22	Oyster Bay	2.9	18	4.0	18	4.5	18	3.6	18	2.6	20	1.7	21	1.1	22
55	Queens Suburban	9.0	5	10.0	6	10.0	7	6.3	8	3.8	11	2.0	16	1.1	23
46	Putnam County	2.3	22	3.2	24	3.2	26	2.6	25	2.0	24	1.4	24	1.0	24
42	Buffalo Suburban	1.5	34	2.3	34	2.5	33	2.2	29	1.8	27	1.4	25	1.0	25
33	Poughkeepsie	2.1	24	2.9	26	2.7	29	2.2	28	1.8	28	1.3	26	1.0	26
84	Allegany County, etc.	1.3	38	2.2	38	2.4	35	1.9	35	1.5	32	1.1	29	0.8	27
37	Oswego	2.1	23	3.4	22	3.5	25	2.4	26	1.6	30	1.0	32	0.8	28
12	Syracuse	1.4	37	2.2	36	2.5	34	1.7	37	1.3	36	0.9	35	0.8	29
83	Sullivan County (Balance)	1.6	31	2.2	37	2.4	36	2.1	30	1.6	29	1.1	30	0.8	30
28	Binghamton	1.4	36	2.4	31	2.6	31	2.0	32	1.5	31	1.1	31	0.8	31
54	Cortland County, etc.	1.5	33	2.1	39	2.1	39	1.7	39	1.3	35	1.0	34	0.7	32
58	Dutchess County (Balance)	2.0	27	2.7	30	2.6	32	1.9	34	1.4	34	1.0	33	0.7	33
68	Rockland County	2.0	25	3.1	25	3.8	21	3.0	24	2.0	26	1.2	27	0.7	34
36	Glens Falls	1.3	41	2.3	32	2.3	37	1.8	36	1.3	37	0.9	36	0.6	35
43	Niagara Falls Suburban	0.8	50	1.6	47	1.9	41	1.5	40	1.2	38	0.8	38	0.6	36
17	Kings County	8.3	7	8.4	8	8.1	9	4.8	13	2.7	19	1.1	28	0.6	37
34	Troy	1.8	28	2.8	27	2.7	28	2.1	31	1.5	33	0.9	37	0.6	38
24	Rome	1.3	39	1.9	41	1.9	40	1.4	43	1.0	44	0.8	40	0.5	39
61	Delaware County, etc.	1.5	32	2.2	35	2.3	38	1.7	38	1.2	39	0.8	39	0.5	40

Table 45: Percentage of Private Passenger Automobiles Insured Through the Automobile Insurance Plan, by Territory, 2001-2007

Territory		2001 (%)	2001 Rank	2002 (%)	2002 Rank	2003 (%)	2003 Rank	2004 (%)	2004 Rank	2005 (%)	2005 Rank	2006 (%)	2006 Rank	2007 (%)	2007 Rank
82	Sullivan County Central	2.6	20	3.4	20	3.1	27	1.9	33	1.2	40	0.7	43	0.5	41
74	Jefferson County	1.0	46	1.5	49	1.4	50	1.3	45	1.0	43	0.7	41	0.5	42
51	Ontario County, etc.	1.1	44	1.7	43	1.8	44	1.5	41	1.0	42	0.7	44	0.5	43
09	Schenectady County	0.9	49	1.6	45	1.8	43	1.4	42	1.0	41	0.7	42	0.5	44
59	Columbia County, etc.	1.2	43	1.8	42	1.6	46	1.3	44	0.8	45	0.6	46	0.4	45
52	Fort Plain, Herkimer	1.0	45	1.5	48	1.6	47	1.2	46	0.8	46	0.6	45	0.4	46
60	Genesee County	0.6	55	1.1	51	1.3	51	1.0	50	0.7	52	0.5	49	0.4	47
31	Chautauqua County	0.6	54	1.0	55	1.1	52	1.0	51	0.8	49	0.5	47	0.4	48
13	Albany	1.2	42	2.0	40	1.9	42	1.2	47	0.8	47	0.5	50	0.3	49
73	Rensselaer County (Balance)	0.9	48	1.4	50	1.5	49	1.2	49	0.8	48	0.5	48	0.3	50
41	Erie County (Balance)	0.7	51	1.0	54	1.0	55	0.8	54	0.7	51	0.4	51	0.3	51
86	Oneida	0.7	53	1.0	53	1.0	54	0.8	55	0.5	56	0.4	57	0.3	52
49	Niagara County (Balance)	0.4	61	0.7	60	0.8	61	0.7	57	0.5	57	0.4	53	0.3	53
29	Gloversville	0.6	56	0.7	61	1.0	57	0.9	53	0.6	53	0.4	54	0.3	54
47	Orleans County	0.9	47	1.6	46	1.5	48	1.0	52	0.6	54	0.4	52	0.3	55
15	Utica	0.5	59	0.9	56	1.1	53	0.8	56	0.5	55	0.4	56	0.2	56
81	Monticello-Liberty	1.3	40	1.7	44	1.7	45	1.2	48	0.7	50	0.4	55	0.2	57
56	Saratoga County (Balance)	0.5	57	0.9	57	0.8	60	0.6	59	0.4	58	0.2	58	0.2	58
35	Amsterdam	0.3	65	0.8	58	0.8	59	0.6	58	0.4	59	0.2	61	0.2	59
39	Rochester Suburban	0.4	62	0.5	66	0.6	62	0.4	62	0.3	60	0.2	60	0.2	60
25	Auburn	0.5	58	0.8	59	0.9	58	0.5	60	0.3	61	0.2	59	0.1	61
38	Syracuse Suburban	0.3	68	0.5	67	0.5	66	0.3	65	0.2	63	0.2	63	0.1	62
30	Saratoga Springs	0.4	64	0.6	64	0.5	65	0.4	63	0.3	62	0.2	62	0.1	63
72	Albany County (Balance)	0.4	63	0.7	62	0.5	63	0.4	64	0.2	64	0.1	66	0.1	64
44	Broome County (Balance)	0.4	60	0.6	63	0.5	64	0.3	67	0.2	66	0.1	64	0.1	65
71	Saratoga County South	0.3	67	0.4	68	0.4	68	0.3	68	0.2	68	0.1	67	0.1	66
16	Saratoga Springs Suburban	0.3	66	0.5	65	0.5	67	0.3	66	0.2	65	0.1	65	0.1	67
48	Monroe County (Balance)	0.7	52	1.0	52	1.0	56	0.5	61	0.2	67	0.1	68	0.0	68
27	Elmira	0.2	69	0.2	69	0.1	69	0.1	69	0.1	69	0.0	69	0.0	69
40	Corning	0.2	70	0.2	70	0.1	70	0.1	70	0.1	70	0.0	70	0.0	70
	Entire State	**4.0**		**5.3**		**5.6**		**4.2**		**3.0**		**2.0**		**1.4**	

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

c. Workers' Compensation Insurance

New York moved to a loss cost system on October 1, 2008. On May 15, 2008, the New York Compensation Insurance Rating Board (NYCIRB) filed, on behalf of its members and subscribers, a 6.4% decrease in average workers' compensation loss costs. This change, along with a -26.5% change in the New York Assessment Fee, produced an average decrease in loss costs to policyholders of 9.7%.

A 3.5% increase due to reform legislation is included in the -6.4% decrease 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.

Now that the NYCIRB only files loss costs, all insurers, in order to produce a manual rate, were required to submit loss cost multipliers (LCM). 248 LCMs were approved effective October 1, 2008, as listed on Table 48.

Table 46
WORKERS' COMPENSATION DIVIDEND CLASSIFICATION PLAN APPROVED
2008

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

COMPANY NAME	PLAN TYPE	APPROVAL DATE
Technology Insurance Company	C	11/14/08
Rochdale Insurance Company	C	11/14/08
Wesco Insurance Company	C	11/14/08

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

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

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

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

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

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

Table 48
Workers Compensation Expense Constants (EC) and Loss Cost Multipliers (LCM)
Approved Effective October 1, 2008

NAIC Code	Group Name	Company Name	EC	LCM
22667	Ace Ltd Grp	Ace Amer Ins Co	$200	1.1500
20702	Ace Ltd Grp	Ace Fire Underwriters Ins Co	$200	1.2000
10030	Ace Ltd Grp	Ace Ind Ins Co	$200	1.1500
20699	Ace Ltd Grp	Ace Prop & Cas Ins Co	$200	1.3330
18279	Ace Ltd Grp	Bankers Standard Ins Co	$200	1.4670
43575	Ace Ltd Grp	Indemnity Ins Co Of North Amer	$200	1.0350
22713	Ace Ltd Grp	Insurance Co of N Amer	$200	1.2650
22748	Ace Ltd Grp	Pacific Employers Ins Co	$200	1.4670
42552	AIX Grp	Nova Cas Co	$200	1.4300
21849	Allianz Ins Grp	American Automobile Ins Co	$200	1.3590
21857	Allianz Ins Grp	American Ins Co	$200	1.3590
21865	Allianz Ins Grp	Associated Ind Corp	$200	1.3590
21873	Allianz Ins Grp	Firemans Fund Ins Co	$200	1.3590
21881	Allianz Ins Grp	National Surety Corp	$200	1.3590
19984	American Contractors	ACIG Ins Co	$0	1.2300
26832	American Financial Grp	Great Amer Alliance Ins Co	$200	1.2700
26344	American Financial Grp	Great Amer Assur Co	$200	1.2700
16691	American Financial Grp	Great Amer Ins Co	$200	1.4100
22136	American Financial Grp	Great Amer Ins Co of NY	$200	1.4100
31135	American Financial Grp	Great Amer Security Ins Co	$0	1.4300
32620	American Financial Grp	National Interstate Ins Co	$120	1.3100
19402	American Intl Grp	AIG Cas Co	$200	1.4440
19380	American Intl Grp	American Home Assur Co	$200	1.4440
19410	American Intl Grp	Commerce & Industry Ins Co	$200	1.5890
23809	American Intl Grp	Granite State Ins Co	$200	1.4440
23817	American Intl Grp	Illinois Natl Ins Co	$200	1.4440
19429	American Intl Grp	Insurance Co of the State of PA	$200	1.4440
19445	American Intl Grp	National Union Fire Ins Co of Pitts	$200	1.4440
23841	American Intl Grp	New Hampshire Ins Co	$200	1.2270
13803	American Natl Fin Grp	Farm Family Cas Ins Co	$200	1.2850
19488	Amerisure Co Grp	Amerisure Ins Co	$230	1.2290
23396	Amerisure Co Grp	Amerisure Mut Ins Co	$230	1.3660
12491	Amtrust Grp	Rochdale Ins Co Of NY	$200	1.3600
42376	Amtrust Grp	Technology Ins Co Inc	$200	1.2200
25011	Amtrust Grp	Wesco Ins Co	$200	1.5000
11150	Arch Ins Grp	Arch Ins Co	$200	1.3320
19801	Argonaut Grp	Argonaut Ins Co	$200	1.3190
19828	Argonaut Grp	Argonaut Midwest Ins Co	$200	1.1210
12416	Baldwin & Lyons Grp	Protective Ins Co	$200	1.3470
38865	Berkshire Hathaway	California Ins Co	$0	1.3180
28258	Berkshire Hathaway	Continental Ind Co	$0	1.1860
20222	Central Mut Ins Co Grp	All Amer Ins Co	$280	1.1400
20230	Central Mut Ins Co Grp	Central Mut Ins Co	$280	1.2670
12777	Chubb & Son Inc Grp	Chubb Ind Ins Co	$450	1.0970

NAIC Code	Group Name	Company Name	EC	LCM
20281	Chubb & Son Inc Grp	Federal Ins Co	$450	1.2900
20303	Chubb & Son Inc Grp	Great Northern Ins Co	$450	1.2000
20346	Chubb & Son Inc Grp	Pacific Ind Co	$450	1.0970
20397	Chubb & Son Inc Grp	Vigilant Ins Co	$450	1.2900
28665	Cincinnati Fin Grp	Cincinnati Cas Co	$225	1.3760
10677	Cincinnati Fin Grp	Cincinnati Ins Co	$225	1.2390
23280	Cincinnati Fin Grp	The Cincinnati Indemnity Co	$225	1.3760
20427	CNA Ins Grp	American Cas Co Of Reading PA	$200	1.0600
20443	CNA Ins Grp	Continental Cas Co	$200	1.5300
35289	CNA Ins Grp	Continental Ins Co	$200	1.0600
20478	CNA Ins Grp	National Fire Ins Co Of Hartford	$200	1.3000
20494	CNA Ins Grp	Transportation Ins Co	$200	1.4150
20508	CNA Ins Grp	Valley Forge Ins Co	$200	1.1500
11123	Delphi Fin Grp	Safety First Ins Co	$300	1.4000
15105	Delphi Fin Grp	Safety Natl Cas Corp	$300	1.2600
10724	Eastern Holding Co Grp	Eastern Alliance Ins Co	$175	1.3020
21261	Electric Ins Grp	Electric Ins Co	$0	1.1340
21415	EMC Ins Co Grp	Employers Mut Cas Co	$200	1.3200
26263	Erie Ins Grp	Erie Ins Co	$210	1.3090
16233	Erie Ins Grp	Erie Ins Co Of NY	$210	1.1130
26830	Erie Ins Grp	Erie Ins Prop & Cas Co	$210	1.3740
35585	Erie Ins Grp	Flagship City Ins Co	$210	1.1780
10120	Everest Reins Holdings	Everest Natl Ins Co	$200	1.3900
31348	Fairfax Fin Grp	Crum & Forster Ind Co	$200	1.3370
21105	Fairfax Fin Grp	North River Ins Co	$200	1.3370
10936	Fairfax Fin Grp	Seneca Ins Co Inc	$242	1.3550
21113	Fairfax Fin Grp	United States Fire Ins Co	$200	1.3370
13935	Federated Mut Grp	Federated Mut Ins Co	$200	1.3830
28304	Federated Mut Grp	Federated Serv Ins Co	$200	1.2440
33278	Florists Mut Grp	Florists Ins Co	$200	1.1980
13978	Florists Mut Grp	Florists Mut Ins Co	$200	1.2610
22187	Greater Ny Grp	Greater NY Mut Ins Co	$200	1.3600
22195	Greater Ny Grp	Insurance Co of Greater NY	$200	1.2200
11024	Greater Ny Grp	Strathmore Ins Co	$200	1.0900
42390	Guard Ins Co Grp	Amguard Ins Co	$200	1.2600
14702	Guard Ins Co Grp	Eastguard Ins Co	$200	1.2000
31470	Guard Ins Co Grp	Norguard Ins Co	$200	1.3300
15032	Guideone Ins Grp	Guideone Mut Ins Co	$200	1.3540
33235	Harleysville Grp	Harleysville Ins Co of NY	$200	1.4170
26182	Harleysville Grp	Harleysville Worcester Ins Co	$200	1.2750
22357	Hartford Fire & Cas Grp	Hartford Accident & Ind Co	$200	1.0620
29424	Hartford Fire & Cas Grp	Hartford Cas Ins Co	$200	1.2610
19682	Hartford Fire & Cas Grp	Hartford Fire In Co	$200	1.1940
37478	Hartford Fire & Cas Grp	Hartford Ins Co Of The Midwest	$200	1.0620
30104	Hartford Fire & Cas Grp	Hartford Underwriters Ins Co	$200	1.3930
34690	Hartford Fire & Cas Grp	Property & Cas Co of Hartford	$200	1.4600
11000	Hartford Fire & Cas Grp	Sentinel Ins Co Ltd	$200	1.1280
27120	Hartford Fire & Cas Grp	Trumbull Ins Co	$200	1.0620
29459	Hartford Fire & Cas Grp	Twin City Fire Ins Co Co	$200	1.3270

NAIC Code	Group Name	Company Name	EC	LCM
26433	IAT Reins Co Grp	Harco Natl Ins Co	$140	1.3000
28886	IAT Reins Co Grp	Transguard Ins Co Of Amer Inc	$40	1.4000
27847	ICW Grp	Insurance Co Of The West	$200	1.3900
30175	Kernan Grp	Oriska Ins Co	$200	1.3400
24066	Liberty Mut Grp	American Fire & Cas Co	$200	1.2000
21458	Liberty Mut Grp	Employers Ins of Wausau	$200	1.4370
11045	Liberty Mut Grp	Excelsior Ins Co	$200	1.3300
33588	Liberty Mut Grp	First Liberty Ins Corp	$200	1.3180
42404	Liberty Mut Grp	Liberty Ins Corp	$200	1.1200
23035	Liberty Mut Grp	Liberty Mut Fire Ins Co	$200	1.2520
23043	Liberty Mut Grp	Liberty Mut Ins Co	$200	1.3700
33600	Liberty Mut Grp	LM Ins Corp	$200	0.9970
24171	Liberty Mut Grp	Netherlands Ins Co The	$200	1.0700
24074	Liberty Mut Grp	Ohio Cas Ins Co	$200	1.3300
24082	Liberty Mut Grp	Ohio Security Ins Co	$200	1.2000
18333	Liberty Mut Grp	Peerless Ind Ins Co	$200	1.4800
24198	Liberty Mut Grp	Peerless Ins Co	$200	1.2000
26069	Liberty Mut Grp	Wausau Business Ins Co	$200	1.2000
26425	Liberty Mut Grp	Wausau General Ins Co	$200	1.0450
26042	Liberty Mut Grp	Wausau Underwriters Ins Co	$200	1.3060
44393	Liberty Mut Grp	West American Ins Co	$200	1.3300
35408	Lightyear Delos Grp	Delos Ins Co	$200	1.3200
29939	Main Street Amer Grp	Main St Amer Assur Co	$200	1.3140
14788	Main Street Amer Grp	NGM Ins Co	$200	1.4200
11030	Maine Employers Mut Ins	Memic Ind Co	$140	1.1620
18023	Meadowbrook Ins Grp	Star Ins Co	$200	1.3400
25780	Meadowbrook Ins Grp	Williamsburg Natl Ins Co	$200	1.4100
14478	Mercer Ins Grp	Mercer Ins Co	$200	1.3100
23329	Merchants Mut Grp	Merchants Mut Ins Co	$200	1.3850
12901	Merchants Mut Grp	Merchants Preferred Ins Co	$200	1.2470
20362	Mitsui Sumitomo Ins Grp	Mitsui Sumitomo Ins Co of Amer	$0	1.1970
22551	Mitsui Sumitomo Ins Grp	Mitsui Sumitomo Ins USA Inc	$0	1.3300
13331	Motorists Mut	American Hardware Mut Ins Co	$200	1.3060
19720	Munich Re Grp	American Alt Ins Corp	$290	1.4500
28223	Nationwide Corp Grp	Nationwide Agribusiness Ins Co	$208	1.3300
23779	Nationwide Corp Grp	Nationwide Mut Fire Ins Co	$200	1.4340
23787	Nationwide Corp Grp	Nationwide Mut Ins Co	$200	1.4340
37877	Nationwide Corp Grp	Nationwide Prop & Cas Ins Co	$200	1.4340
12122	NJ Manufacturers	New Jersey Manufacturers Ins Co	$200	1.2590
20095	Old Republic Grp	Bituminous Cas Corp	$200	1.3330
20109	Old Republic Grp	Bituminous Fire & Marine Ins Co	$200	1.3330
11371	Old Republic Grp	Great West Cas Co	$250	1.3510
24139	Old Republic Grp	Old Republic Gen Ins Corp	$200	1.3300
24147	Old Republic Grp	Old Republic Ins Co	$200	1.2900
14982	Penn Miller Grp	Penn Millers Ins Co	$200	1.3070
36897	Penn. Manufacturers	Manufacturers Alliance Ins Co	$180	1.4100
12262	Penn. Manufacturers	Pennsylvania Manufacturers Assoc.	$180	1.2820
41424	Penn.Manufacturers	Pennsylvania Manufacturers Ind Co	$180	1.1220
14990	Pennsylvania Natl Ins Gp	Pennsylvania Natl Mut Cas Ins Co	$250	1.3100

NAIC Code	Group Name	Company Name	EC	LCM
40177	Public Serv Grp	Paramount Ins Co	$200	1.1140
15059	Public Serv Grp	Public Service Mut Ins Co	$200	1.3110
24414	QBE Ins Grp	General Cas Co Of WI	$125	1.4080
37257	QBE Ins Grp	Praetorian Ins Co	$200	1.4900
37303	QBE Ins Grp	Redland Ins Co	$200	1.4900
24449	QBE Ins Grp	Regent Ins Co	$125	1.3400
19690	Safeco Ins Grp	American Economy Ins Co	$200	1.2700
19704	Safeco Ins Grp	American States Ins Co	$200	1.4100
24732	Safeco Ins Grp	General Ins Co Of Amer	$200	1.4200
12572	Selective Ins Grp	Selective Ins Co Of Amer	$200	1.3750
13730	Selective Ins Grp	Selective Ins Co Of NY	$200	1.1000
19259	Selective Ins Grp	Selective Ins Co Of SC	$200	1.2380
26301	Selective Ins Grp	Selective Way Ins Co	$200	1.3060
23434	Sentry Ins Grp	Middlesex Ins Co	$200	1.3920
23442	Sentry Ins Grp	Patriot Gen Ins Co	$200	1.1940
28460	Sentry Ins Grp	Sentry Cas Co	$0	1.1940
24988	Sentry Ins Grp	Sentry Ins A Mut Co	$200	1.3920
21180	Sentry Ins Grp	Sentry Select Ins Co	$200	1.2970
11398	SM Mariano Grp	Guarantee Ins Co	$200	1.4100
11126	Sompo Japan Ins Grp	Sompo Japan Ins Co of Amer	$200	1.3140
25143	State Farm Grp	State Farm Fire And Cas Co	$0	1.4900
29700	Swiss Re Grp	North Amer Elite Ins Co	$250	1.3530
29874	Swiss Re Grp	North Amer Specialty Ins Co	$250	1.3530
39845	Swiss Re Grp	Westport Ins Corp	$250	1.3530
31534	The Hanover Ins Grp	Citizens Ins Co Of Amer	$200	1.4620
22292	The Hanover Ins Grp	Hanover Ins Co	$200	1.3290
22306	The Hanover Ins Grp	Massachusetts Bay Ins Co	$200	1.2080
10945	Tokio Marine Holdings Inc	TM Cas Ins Co	$200	1.1440
32301	Tokio Marine Holdings Inc	TNUS Ins Co	$200	1.0760
12904	Tokio Marine Holdings Inc	Tokio Marine & Nichido Fire Ins Co	$200	1.3450
41238	Tokio Marine Holdings Inc	Trans Pacific Ins Co	$200	1.2110
17205	Tower Grp	Castlepoint Ins Co	$200	1.3840
44300	Tower Grp	Tower Ins Co Of NY	$200	1.2920
43702	Tower Grp	Tower National Ins Co	$200	1.1370
41769	Travelers Grp	Athena Assur Co	$200	1.1830
25615	Travelers Grp	Charter Oak Fire Ins Co	$200	1.0520
36463	Travelers Grp	Discover Prop & Cas Ins Co	$200	1.4460
35386	Travelers Grp	Fidelity & Guar Ins Co	$200	1.1180
25879	Travelers Grp	Fidelity & Guar Ins Underwriters Inc	$200	1.1830
25623	Travelers Grp	Phoenix Ins Co	$200	1.4460
24767	Travelers Grp	St Paul Fire & Marine Ins Co	$200	1.3150
24775	Travelers Grp	St Paul Guardian Ins Co	$200	1.3810
24791	Travelers Grp	St Paul Mercury Ins Co	$200	1.1830
19224	Travelers Grp	St Paul Protective Ins Co	$200	1.3810
19038	Travelers Grp	Travelers Cas & Surety Co	$200	1.3150
19046	Travelers Grp	Travelers Cas Ins Co Of Amer	$200	1.3810
25658	Travelers Grp	Travelers Ind Co	$200	1.2490
25666	Travelers Grp	Travelers Ind Co Of Amer	$200	1.1180
25682	Travelers Grp	Travelers Ind Co Of CT	$200	1.1830

NAIC Code	Group Name	Company Name	EC	LCM
25674	Travelers Grp	Travelers Property Cas Co Of Amer	$200	1.3150
25887	Travelers Grp	US Fidelity & Guaranty Co	$200	1.3150
37893	Union Labor Grp	Ullico Cas Co	$200	1.2700
25984	Utica Grp	Graphic Arts Mut Ins Co	$200	1.0440
12475	Utica Grp	Republic-Franklin Ins Co	$200	1.1050
25976	Utica Grp	Utica Mut Ins Co	$200	1.2280
10687	Utica Grp	Utica Natl Assur Co	$200	1.1670
43478	Utica Grp	Utica Natl Ins Co Of TX	$200	0.9830
24112	Westfield Grp	Westfield Ins Co	$200	1.3930
27154	White Mountains Grp	Atlantic Specialty Ins Co	$200	1.1680
20648	White Mountains Grp	Employers Fire Ins Co	$200	1.3740
20621	White Mountains Grp	OneBeacon Amer Ins Co	$200	1.1680
21970	White Mountains Grp	OneBeacon Ins Co	$200	1.3740
31325	WR Berkley Corp Grp	Acadia Ins Co	$200	1.2919
44318	WR Berkley Corp Grp	Admiral Ind Co	$200	1.3100
33480	WR Berkley Corp Grp	Clermont Ins Co	$200	1.3100
10804	WR Berkley Corp Grp	Continental Western Ins Co	$200	1.1627
21784	WR Berkley Corp Grp	Firemens Ins Co Of Washington DC	$200	1.2919
25224	WR Berkley Corp Grp	Great Divide Ins Co	$200	1.3200
23612	WR Berkley Corp Grp	Midwest Employers Cas Co	$200	1.2890
25844	WR Berkley Corp Grp	Union Ins Co	$200	1.1627
22322	XL Amer Grp	Greenwich Ins Co	$250	1.3750
24554	XL Amer Grp	XL Ins Amer Inc	$250	1.1250
37885	XL Amer Grp	XL Specialty Ins Co	$250	1.2500
13269	Zenith Natl Ins Grp	Zenith Ins Co	$200	1.3930
26247	Zurich Ins Grp	American Guar & Liab Ins	$200	1.1860
40142	Zurich Ins Grp	American Zurich Ins Co	$200	1.0540
19305	Zurich Ins Grp	Assurance Co Of Amer	$200	1.1860
34347	Zurich Ins Grp	Colonial Amer Cas & Surety Co	$200	1.1860
39306	Zurich Ins Grp	Fidelity & Deposit Co Of MD	$200	1.1860
19356	Zurich Ins Grp	Maryland Cas Co	$200	1.3180
19372	Zurich Ins Grp	Northern Ins Co Of NY	$200	1.0540
21709	Zurich Ins Grp	Truck Ins Exch	$200	1.3340
41181	Zurich Ins Grp	Universal Underwriters Ins Co	$200	1.3180
16535	Zurich Ins Grp	Zurich American Ins Co	$200	1.3180
40517	N/A	Advantage Workers Comp Ins Co	$200	1.3000
15334	N/A	Alliance Natl Ins Co	$200	1.3260
18538	N/A	Bancinsure Inc	$180	1.4000
13528	N/A	Brotherhood Mut Ins Co	$140	1.3310
18767	N/A	Church Mut Ins Co	$140	1.2760
10499	N/A	DaimlerChrysler Ins Co	$0	1.3260
11118	N/A	Federated Rural Electric Ins Exch	$240	1.2700
37400	N/A	Fire Districts Of NY Mut Ins Co Inc	$200	1.2700
28339	N/A	Gateway Ins Co	$200	1.3510
11092	N/A	Global Liberty Ins Co of NY	$200	1.3480
24309	N/A	Hereford Ins Co	$200	1.2580
23108	N/A	Lumbermens Underwriting Alliance	$200	1.3020
42269	N/A	Majestic Ins Co	$200	1.2600
14508	N/A	Michigan Millers Mut Ins Co	$190	1.2450

NAIC Code	Group Name	Company Name	EC	LCM
23663	N/A	National Amer Ins Co	$200	1.3300
27073	N/A	Nipponkoa Ins Co Ltd US Br	$200	1.3150
14974	N/A	Pennsylvania Lumbermens Mut Ins	$200	1.1600
36234	N/A	Preferred Professional Ins Co	$200	1.3004
15563	N/A	SeaBright Ins Co	$0	1.3970
20613	N/A	Sparta Ins Co	$200	1.4480
12866	N/A	T.H.E. Ins Co	$200	1.2540
31232	N/A	Work First Cas Co	$200	1.3270

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

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

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

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

In the 2004 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease. In the 2005 and 2006 fund years, the net value fell below $150 million, and contributions continued. In the 2007 fund year, the net value of the PCISF was determined to be greater than $150 million, and in accordance with 7603(c)(1), contributions did not cease. In the 2008 year, 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, 1988-2008*

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

* During 1993, settlement was reached with respect to *Alliance of American Insurers et al. v. Chu et al*. The 1993 through 2008 fund year net values and contribution amounts described above reflect the impact of the settlement.

C. HEALTH BUREAU

1. Entities Under Health Bureau Supervision

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

The Bureau has regulatory authority over all aspects of the fiscal solvency and market conduct of 97 insurers, HMOs, and other managed care organizations as of December 31, 2008. These comprise of 31 accident and health insurers, one life insurer (writing accident and health insurance only), nine health service corporations, and three medical and dental expense indemnity corporations, 20 Article 44 Public Health Law HMOs, nine Article 47 Insurance Law municipal cooperative health benefits plans, 16 managed long term care plans and eight continuing care retirement communities certified pursuant to Article 46 of the Public Health Law.

One acquisition-of-control application was reviewed in 2008, for a domestic life insurer (to be converted into an Article 42 Accident and Health Insurer). This application is still in progress.

In 2008, the Bureau continued its review of a plan of conversion into for-profit status submitted by two not-for-profit health service corporations, Group Health, Inc. and the Health Insurance Plan of Greater New York. The plan calls for Group Health, Inc. to convert to a for-profit corporation, then merge with two accident and health insurers, HIP Insurance Company of New York and the PerfectHealth Insurance Company. The plan further calls for two for-profit HMOs, GHI-HMO Select, Inc. and ConnectiCare of New York, Inc. to merge and to absorb the Health Insurance Plan of Greater New York's membership. All of the concerned companies are affiliates. The plan is pending.

Six Article 42 Accident and Health licensing applications were under review during 2008, and three of these applications (two foreign and one domestic) were submitted in 2008. Two of these were for insurers writing the new Medicare Part D Prescription Drug Coverage. Of the six applications, three were approved, and three remained under review as of December 31, 2008. In addition the Department ceased review of a domestic Article 42 application when funding did not materialize. Finally, one Article 42 insurer withdrew from the state shortly after it received its license.

Two HMOs submitted applications to receive "Certificates of Authority" to operate in New York State in 2008. HMOs are jointly regulated by this Department as well as the Department of Health. The Department of Health issues the "Certificate of Authority" to HMOs. During 2008, one HMO received their "Certificate of Authority" and one is still pending.

Six Managed Long Term Care plans submitted applications to receive "Certificates of Authority" to operate in New York State in 2008. Managed Long Term Care plans are jointly regulated by this Department as well as the Department of Health. The Department of Health issues the "Certificates of Authority" to these plans. During 2008, three of the plans received their "Certificate of Authority", one is awaiting the Department of Health to issue its "Certificate of Authority", and the remaining two are still under review.

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

Two HMOs have been submitted to the Liquidation Bureau and the Superintendent was named as liquidator. Additionally, the Bureau is monitoring the financial condition of two financially distressed HMOs and one Article 42 company on a monthly basis.

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

2. Accident and Health Insurers

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

Table 50
SELECTED ANNUAL STATEMENT DATA
Accident and Health Insurers*
2005-2007
(dollar amounts in millions)

	2007	2006	2005
Number of Insurers	29	27	26
Net premiums written	$13,977.1	$12,677.0	$10,679.5
Admitted assets	15,495.4	14,518.4	11,994.8
Policy and contract claims	1,648.3	1,872.1	1,714.5
Other liabilities	7,425.9	6,809.4	5,551.2
Capital	43.2	37.1	34.8
Surplus	3,377.9	5,779.8	4,694.3
Ratio of premiums written to capital and surplus	2.2	2.2	2.3

*Data includes one life insurer.

3. Article 43 and Article 44 Corporations

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

a. Subscriber Rate Changes

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

Type of Company	Filings
HMOs (Article 44)	89
Article 43 Corporations	26

b. Article 43 and Article 44 Corporations

The following tables show aggregate figures on assets, liabilities, surplus funds, premium income and membership for years 2005-2007:

Table 51
ARTICLE 43 HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
2005-2007
(dollar amounts in millions)

	2007	2006	2005
Number of Companies	9	9	10
Admitted Assets	$5,749.4	$5,426.0	$4,770.4
Liabilities	2,696.2	2,634.9	2,536.6
Surplus Funds	3,053.2	2,791.1	2,233.8
Net Premium Income:			
Hospital	7,554.0	7,465.3	7,074.3
Medical/Dental	6,929.4	6,254.0	5,575.1
Number of Contracts & Riders in Force:			
Hospital	1.3**	1.4**	1.4**
Medical/Dental	1.8**	1.7**	1.6**

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

Table 52
ARTICLE 43 MEDICAL & DENTAL EXPENSE INDEMNITY CORPORATIONS
Selected Data, New York State
2005-2007
(dollar amounts in millions)

	2007	2006	2005
Number of Companies	3	3	3
Admitted Assets	$57.2	$56.3	$44.6
Liabilities	32.9	45.8	20.0
Surplus Funds	24.3	10.5	24.6
Net Premium Income	98.6	54.0	49.6
Number of Contracts in Force	1,853	1,599	1,492

Table 53
ARTICLE 44 HEALTH MAINTENANCE ORGANIZATIONS
That Are a Line of Business of a Health Service Corporation*
Selected Data, New York State
2005-2007
(dollar amounts in millions)

	2007	2006	2005
Number of Companies	3	3	3
Net Premium Income	$7,020.3	$6,957.2	$6,570.4
Number of Participants	1.6**	1.7**	1.8**

* 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
2005-2007
(dollar amounts in millions)

	2007	2006	2005
Number of Companies	18	19	21
Admitted Assets	$5,391.7	$5,255.7	$4,753.0
Liabilities	2,035.4	2,410.6	2,147.3
Surplus Funds	3,353.2	2,845.1	2,605.7
Net Premium Income	12,467.9	12,600.0	12,050.3
Number of Participants	2.6*	3.0*	3.2*

*in millions

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

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

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

Throughout 2008, the Department has been reviewing the plan of conversion to determine whether or not it fulfills the criteria for a approval as set forth in the law, specifically that it “will not adversely affect the applicant’s contractholders or members, will protect the interests of and will not negatively impact the delivery of health care benefits and services to the people of New York and results in the fair, equitable and convenient winding down of the business and affairs of the applicant.”

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

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

5. Examinations and Investigations Conducted by the Health Bureau

During the year 2008, the field unit of the Health Bureau conducted 40 examinations of various regulated entities. The 2008 examinations and investigations by regulated entity and type are presented below:

		Examinations [1] Commenced in 2008	Examinations Commenced Prior to 2008
By Regulated Entity			
CCRC	**5**	**1**	**4**
Article 42 Insurer	**13**	**4**	**9**
Article 43 Corp	**6**	**4**	**2**
HMO	**11**	**6**	**5**
Muni-Coop	**4**	**1**	**3**
MLTCP	**1**	**1**	**0**
Total	40	17	23
By Type			
Financial	**5**	**4**	**1**
Market Conduct	**1**	**0**	**1**
Combined	**34**	**13**	**21**
Total	40	17	23

[1] In 2006, the National Association of Insurance Commissioners (NAIC) adopted revisions to the Financial Condition Examiners Handbook (Handbook) relating to a revised risk-focused examination approach. Although this new examination approach will be required for accreditation purposes for all examinations beginning on or after January 1, 2010, the NAIC allowed the state examiners to begin implementing the revised exam approach in 2007. The revised approach is meant to broaden and enhance the identification of risk inherent in an insurer's operations and utilize that evaluation in formulating the ongoing surveillance of an insurer. In accordance with the revisions made to the Handbook, there is greater focus placed upon a company's risk management culture, corporate governance structure, risk assessment programs and control environment.

In 2008, the Health Bureau conducted a pilot examination that utilized the new risk-focused examination approach.

6. SERFF

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

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

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

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

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

As part of its commitment to increase communication with the industry, the RAFFT team presented their second annual full-day Filing Compliance Seminar for industry filers in November 2008. This year's seminar was comprised of presentations by RAFFT members on specific topics and afternoon breakout sessions that provided an opportunity for industry participants to meet directly with each unit of the Bureau that reviews their filings. RAFFT's Powerpoint presentation was also posted on the Department's website as a reference tool for the industry.

7. Review of Accident and Health Policy Form Submissions

In 2008, the Health Bureau made final dispositions on 1,391 accident and health policy form submissions (see Table 55). A submission consists of one or more policy forms and, in some cases, related supporting actuarial material. These submissions were comprised of a wide range of accident and health insurance products from many different types of insurers and are offered in the individual, small group and large group markets. Insurers may use several means to obtain expedited review of their submissions. Highest priority is given to fast-track and deemer submissions submitted through SERFF. Of the 1,391 submissions disposed in 2008, 218 (15%) of them were submitted using fast-track and/or deemer while 85% of the files disposed of during the year were submitted through SERFF. (Deemer submissions are submissions made under the expedited approval procedure set forth in Section 3201(b)(6) of New York Insurance Law. Fast-track submissions are submissions made under the optional expedited prior approval using a certification process (Circular Letter No. 4 (2003)). SERFF submissions are electronic submissions made through the NAIC's System for Electronic Rate and Form Filing.)

Table 55
ACCIDENT & HEALTH
Disposition of Policy Form Submissions
2008

	HMO	Group Accident & Health	Individual Accident & Health	Article 43	Total
Approved	112	382	69	193	756
Not Accepted/ Circular Letter 14 (1997)*	4	81	22	9	116
Lack of Company Action	3	47	13	1	64
Disapproved	0	0	1	0	1
Filed for Reference	4	47	23	14	88
Prefiled	5	61	0	36	102
Withdrawn	6	36	15	5	62
Filed for Out-of-State Use	0	153	36	0	189
Other	0	11	1	1	13
Total	**134**	**818**	**180**	**259**	**1391**

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

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

Review of premium rates is performed in accordance with requirements in applicable sections of Insurance Law and corresponding regulations, which varies depending upon the type of insurer and the nature of coverage. Prior approval 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, small group, and large group insurance coverages and include insurance products such as hospital and/or medical expense, prescription drug, Medicare supplement, dental, disability income, specified disease, long term care, accidental death and dismemberment and New York statutory disability coverage (DBL).

The Accident and Health Rating Section received 1,394 rate filings and disposed of 1,646 rate filings during 2008 (some of which were received prior to 2008). These include initial rate filings for new policy forms submitted by commercial insurers, Article 43 corporations, HMOs, as well as rate adjustment filings (primarily for commercial insurers), commission filings, experience monitoring filings, and rate manual revisions. In 2008 about 89% of the Accident and Health Rate Filings received were received through the System for Electronic Rate and Form Filing (SERFF).

The Accident and Health Rating Section also handles Insurance Law Section 4308(g) rate increase filings for Healthy New York and oversees the posting of updated rates for the Healthy New York plans on the Department's Web site. The Rating Section also collects monthly enrollment reports from the Healthy New York carriers. In addition to Healthy New York premium rates, the Rating Section

also posts updated premium rate information for Partnership and Non-Partnership Long Term Care premiums and Medicare Supplement premiums on the Department's Web site.

9. Inquiries and Complaints

In response to formal written inquiries and complaints to the Department, the Health Bureau provided written answers to more than 200 consumer inquiries and responded to more than 250 Freedom of Information Law (FOIL) requests concerning accident and health insurance and related issues in 2008. In addition, the Health Bureau monitors a dedicated electronic mailbox on the Department's Web site. In 2008, the Health Bureau received and responded to approximately 550 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 2008 included consumer complaints regarding increased premium rates, consumer inquiries relating to health insurance options in New York State, consumer complaints against their health plans, pre-existing condition provisions in health policies, mandated benefits, Timothy's Law, utilization review requirements and employer responsibilities in providing health insurance coverage.

In 2008, Bureau staff also responded to approximately 10,000 telephone inquiries received daily on many health insurance related topics from various sources.

10. Utilization Review Reports

Article 49 of the Insurance Law requires health insurers and utilization review agents under contract with health insurers to biennially report to the Superintendent on utilization review activities. During 2008, several new reports by utilization review agents were reviewed for compliance with Article 49 and placed on file with the Department, and a number of existing reports were updated and renewed.

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

Recently completing its ninth year of operation, New York's External Appeal Program continues to provide New Yorkers with the right to obtain a review by independent medical experts when their health plan denies health care services as not medically necessary or because the plan considers the services to be experimental or investigational. Since the program's inception on July 1, 1999, through December 31, 2008, the Department has received 21,570 external appeal requests.

The external appeal law was amended as part of the Managed Care Reform Act of 2007 (Chapter 451 of the Laws of 2007) and the amendment became effective April 1, 2008. This amendment allows an insured to appeal a health plan's denial of a request for pre-authorization to receive a health service from an out-of-network provider on the basis that such out-of-network health service is not materially different from the health service available in-network.

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

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

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

Information about the external appeal program is available on the Department's Web site at www.ins.state.ny.us. In addition, the Department operates a dedicated toll-free hotline (1-800-400-8882) to respond to questions and assist in the filing of external appeal requests. In 2008, the Department received and responded to 7,720 hotline calls.

Along with monitoring the number of hotline calls, the Department also tracks external appeal results for each year of operation of the program. In 2008, the Department received 3,920 external appeal requests, which represented a 23.8% increase from the previous year. In addition, in 2008, 325 external appeal requests were closed because health plans voluntarily reversed the denial during the external appeal process, 1,566 external appeal requests were determined to be ineligible for external appeal, 2,035 determinations were rendered by external appeal agents and 320 appeals were still pending at the end of the year either because additional information was needed or an external appeal agent was reviewing the case.

Table 56A lists the number of external appeal determinations that have been either upheld or overturned, categorized by type of appeal. Table 56B identifies external appeal results by agent. The tables reveal that 44% of health plan denials were overturned in whole or in part by external appeal agents and 56% were upheld by external appeal agents in 2008. An external appeal that is "overturned in part" refers to one that is decided partially in favor of the consumer. For example, an HMO may refuse to pay for a five-day hospital stay asserting that it was not medically necessary, but that ruling would be overturned in part if the external appeal agent determines three days were medically necessary and two were not.

Table 56A
EXTERNAL APPEAL DETERMINATIONS BY TYPE OF APPEAL
January 1, 2008 — December 31, 2008

Type of Denial	Total	Overturned	Overturned in Part	Upheld
Medical Necessity	1,735	623	130	982
Experimental/Investigational	297	134	1	162
Clinical Trial	3	2	0	1
Total	**2,035**	**759**	**131**	**1,145**

Table 56B
EXTERNAL APPEAL DETERMINATIONS BY AGENT
January 1, 2008 — December 31, 2008

Agent	Total	Overturned	Overturned in Part	Upheld
IMEDECS	658	255	45	358
IPRO	675	260	56	359
MCMC	702	244	30	428
Total	**2,035**	**759**	**131**	**1,145**

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

12. Market Stabilization Mechanisms

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

In 2007, the Health Bureau worked with carriers to create a new and simplified mechanism to stabilize premiums in the individual and small group market. The mechanism provides that carriers must contribute to a rate 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 receive disbursements, which they are required to use to help mitigate rate increases in the lines of business sustaining the higher relative costs. Total payments due to the pools were calculated at just under $80 million, which was the 2007 pool funding cap established in the Regulation 146. Most distributions were made in the 3rd quarter of 2008. As of the end of 2008, one 2007 distribution was still pending due to audit findings which indicated the carrier would need to correct and resubmit its data. Data submissions for the 2008 calendar year are due by February 28, 2009. It is expected that the 2008 pools will generate market stabilization pool funding in the range of $80 million to $120 million.

In the Medicare Supplement market, a pool based on the average relative demographic profile of each carrier's insured population in comparison to the average profile of all carriers in its region of operation is used to determine whether a carrier is insuring a relatively lower risk/lower cost population or a higher risk/higher cost population that the average. Those with relatively low cost averages contribute to the pools to help stabilize the rates of those insuring relatively higher cost risks. The Medicare Supplement pool has been in place since 1993, and the form of pooling is the same as originally constructed under Department Regulation 146 at that time. Total contributions to the Medicare Supplemental Pool for 2007 were approximately $15,200,000. Although the final figures have not yet been determined, it is projected that total contributions to the Medicare Supplemental Pool will be approximately $15,800,000 for 2008.

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

The Health Care Reform Act of 2000 (HCRA II) required the Department to administer the ongoing operations of a unique stop loss 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 for calendar year 2008.

HCRA II established two state-funded stop loss funds 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 were established to stabilize the premium rates for such individual standardized health insurance contracts, which would benefit both existing enrollees and 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 also oversees the distribution of the stop loss funding to HMOs. Beginning in the first year of the program, the Department engaged the services of a stop loss fund administrator to oversee this process. The Department has developed a quarterly reporting process to track expected expenditures from the stop loss pools.

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

During 2008, the Department directed the administrator to conduct the necessary audit procedures with respect to the 2007 reimbursement requests submitted by carriers. 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 2007 exceeded the total funding available in both the standard direct payment business and the direct payment out-of-network (point-of-service) business. The fund administrator was directed to reduce the amounts requested on a pro-rata basis to match available funding in each of the respective funds.

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

Product	Requested Reimbursement	Funding Available	Percentage Reimbursed
Standard HMO Direct Payment	$61,167,475	$19,600,000	32.0%
Out-of-Plan (POS) Direct Payment	$42,214,445	$19,600,000	46.4%

The Health Bureau reviewed the schedule of payments for all participants and authorized distributions 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. New York was unable to rely upon prior experience or the experience of other states in implementing the program. The Department worked vigorously during 2000 to implement the various components of the program to ensure that it was available to consumers as of January 1, 2001. Today, this program serves as a national model for creating a private-public partnership that utilizes reinsurance to reduce premiums.

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

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

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

The major responsibilities of the Department in connection with the oversight of the Healthy NY program for 2008 included the following:

a. Program Oversight

The Department is solely responsible for the oversight of the Healthy NY program. Throughout calendar year 2008, the Department continued to provide education and guidance to the industry on program requirements. The Department continued to monitor the program for areas of potential improvement. The Department engaged in public awareness campaigns, industry outreach, education, enhancements to the Department's Web site, and numerous other efforts. The Department continues to respond to questions of eligibility and to provide continuing guidance to the health plans.

b. Eligibility Issues and Education

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

c. Guidance and Publications

The Department has provided extensive guidance to the HMOs to ensure standardized administration of the Healthy NY product, facilitated by electronic guidance memos sent to designated staff at each HMO.

The Department has continued to enhance and update its Healthy NY publications. In 2008, the Department revised the tri-fold brochure for students and tri-fold brochures printed in Korean, Chinese and Russian. These documents describe the program and answer common questions on eligibility. The Department also updated the application/guidebook publications. Publications are available to callers of the Healthy NY hotline and consumers making inquiries to the Department, and are also mailed by the HMOs to interested callers.

d. Rating of the Healthy NY Product

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

e. Stop-Loss Funds

The Department oversees the two stop-loss funds established to reimburse health plans at a percentage of eligible high cost claims paid under Healthy New York contracts. The Superintendent is required to monitor claim levels and cap enrollment if it appears increases will result in claim reimbursement requests in excess of appropriated funding in any calendar year. To monitor claims,

Department guidelines require that HMOs provide quarterly preliminary notifications of potentially eligible claims throughout the year, 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 request schedules, 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 participants is prepared by the administrator and reviewed by the Health Bureau.

Funding for 2007 claims was sufficient to cover all valid reimbursement requests, and disbursement was authorized and paid out in 2008 in the following amounts:

Healthy New York Qualifying Individual Claims	$74,906,463
Healthy New York Small Employer Claims	$47,169,262

Reimbursement requests for 2008 claims are due by April, 1 2009 and will be tabulated and audited and are scheduled for payment in 2009.

f. Tracking Maximum Enrollment in Healthy NY

The Department monitors enrollment in Healthy NY on a monthly basis. As enrollment climbs, the Department estimates maximum enrollment in the program that can be supported so that enrollment can be suspended in the event that demand for the program exceeds available funding. The Department's estimates are based on modeling of the variation of expected stop-loss calendar year paid claims, by issue month, as the program continues to mature. Monitoring of actual enrollment by month will include ongoing adjustment of maximum enrollment if necessary.

g. Annual Study of the Healthy NY Program

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

h. 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 II. Ongoing coordination with the Department of Health is necessary to ensure that the eligibility standards utilized by these programs mesh to the extent feasible. The Department is working to ensure that consumers receive information that facilitates their enrollment in the program that is most appropriate.

i. Consumer Contact

The Department continues to respond to a significant volume of consumer questions and issues regarding the nature and operation of the Healthy NY program. The Department has worked to address consumer issues with the HMOs 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. The Health Bureau handled several hundred questions received in the email box in 2008 relating to the Healthy NY program and other options for individuals seeking insurance coverage. A toll-free hotline provides consumers with information about the Healthy NY program. Additionally,

Department staff respond directly to a large volume of consumer telephone and written inquiries. The Department assists applicants who believe they have been wrongfully denied enrollment in the program. In 2008, the Department worked with the State Office of Temporary and Disability Assistance (OTDA) to add Healthy NY to OTDA's new 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.

j. National Interest in Program

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

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

k. 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. Marketing and outreach efforts are crucial to the success of the program. The Department has established a toll-free hotline to provide consumers with information about the Healthy NY program. The Department has also developed and distributed informational materials regarding the program, including brochures and applications, and has made extensive information available on the Healthy NY Web site. Public presentations were also conducted to reach many small businesses and chambers of commerce. In 2008, a contractor was hired to conduct outreach, public education, and advertising. Such efforts were subsequently suspended due to the state fiscal crisis that occurred during 2008. In 2008, the New York State Health Foundation gave a planning grant to S2AY Rural Health Network. S2AY Rural Health Network operates in rural Central New York and provides outreach and public health program enrollment and education services. They will be studying ways to expand Healthy NY enrollment.

15. Brooklyn HealthWorks

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

In response to the legislation, the Department entered into a single-source contract with the Brooklyn Alliance, Inc. as of March 29, 2007. The contract authorizes the Department to pay the Brooklyn Alliance for costs, fees and disbursements associated with the administration of the program.

BHWx staff handles outreach for its members and maintains records documenting the amount billed by the insurer (GHI), the amount paid by each employer group, and the amount of subsidy provided through the program. In addition, the BHWx staff submits invoices requesting subsidy payment to the Department.

During 2008, the Department authorized subsidy payments in the amount of $425,477.84. Those subsidy payments were processed for premiums charged by through August 2008.

Department staff is also responsible for reviewing contract payment requests submitted by BHWx. During 2008, the Department authorized total contract payments of $453,433.89.

As of the end of 2008, 326 small businesses were enrolled in the BHWx program.

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 develop 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 in August 2007, a contract was approved and awarded to Benefit Specialists of NY in August 2008.

Benefit Specialists of NY is a wholly owned subsidiary of the Greater Syracuse Chamber of Commerce and operates as a full service insurance agency. 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 will offer Healthy NY for the pilot project enrollees. Enrollees will receive a 15% premium subsidy, with an additional 5% subsidy for completing a confidential health risk assessment. Benefit Specialists will partner with other local chambers of commerce, healthcare providers and community and corporate affiliates to conduct grassroots outreach and education. Enrollees may also be able to receive discounts on health-related products such as dental and vision care, gym memberships, etc. Benefit Specialists hopes to begin enrollment in its new program in the spring of 2009.

17. Federal Tax Credit Initiative

The federal Trade Adjustment Act of 2002 made a 65% health insurance tax credit available to certain eligible citizens, including: (1) those who are receiving trade adjustment benefits because they have lost their jobs due to changes in international trade; and (2) retirees whose pensions had been taken over by the Pension Benefit Guarantee Corporation. This credit is estimated to be available to approximately 11,000 New Yorkers or an estimated 22,000 covered lives (including dependents). The tax credit includes a pre-payment feature whereby an eligible individual can request to receive 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 Health 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.

The Health Bureau continues to assist consumers with accessing the tax credit, and information regarding the availability of this tax credit has been posted to the Department's Web site.

18. COBRA Subsidy Demonstration Project

The Health Bureau has been statutorily charged with implementing the New York State health insurance continuation assistance demonstration project. This pilot program provides $1.96 million annually to subsidize the Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums for entertainment industry employees.

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 Department is responsible for reviewing applications for eligibility, communicating with unions and their members, processing invoices for payment on a monthly basis and maintaining certain records and databases.

For 2008, Department staff processed a total of 302 applications and paid out more than $676,333 in premium assistance. Payments were made to 17 union funds, the most highly represented being Equity League (approximately 142 enrollees) and Screen Actors Guild (approximately 49 enrollees).

To date, the program has assisted about 1,313 entertainment industry employees.

19. Continuing Care Retirement Communities (CCRCs)

The Department has a permanent seat on the Continuing Care Retirement Community Council. This council has the primary licensing and oversight authority for CCRCs. The Department has specific responsibility for the review of the contract and disclosure documents given to residents and prospective residents, as well as an initial determination of the financial feasibility of a proposed project. The Bureau's continuing oversight encompasses review of the rating structure of a community, adequacy of reserves and periodic on-site examinations of the financial condition of a community. To this end, the Department initiated two examinations of CCRCs in 2007 and developed revisions to the Department's annual statement for financial filings.

Currently, there are 12 CCRCs in New York, each one with a Certificate of Authority issued by the CCRC Council. Of these 12, nine are fully operational, two have been approved to obtain financing and begin the construction phase, and one is in the process of collecting entrance fee deposits. One CCRC, which was in the process of collecting entrance fee deposits, surrendered its Certificate of Authority and returned the collected fees, citing the current economic environment as its reason.

20. Long Term Care Insurance

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

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

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

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

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

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

In conjunction with the Department of Health, the Health Bureau worked on issues such as modifying the New York State Partnership for Long Term Care insurance product design. In 2005, the Department promulgated the Second Amendment to Regulation 144 which was designed to make more affordable benefit options and a range of incentives available through the NYS Partnership for Long Term Care program. By December 2006, Partnership insurers began marketing the four new plan designs. In 2008, 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 2008, the Health Bureau approved a product portfolio for a new Partnership insurer, Allianz Life Insurance Company of New York.

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 2008, the Health Bureau helped to prepare comments on Federal CMS proposed guidelines relating to data reporting on Partnership insurers and insurance regulatory issues relating to reciprocity standards among Partnership states.

d. Long Term Care Financial Planning Options

Throughout 2008, 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 Budgeting, Tax and Civil Service, to prepare draft legislation while other recommendations may be implemented through Department regulation.

e. Sample Premium Rates on Web site

In 2006, the Health Bureau, in conjunction with the Systems Bureau, created an interactive page on the Department Web site that provides consumers with sample premium rates for long term care

insurance. Through this tool, consumers can learn the approximate cost of long term care insurance coverage for certain levels of coverage.

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

In 2007, the Bureau expanded this interactive tool on the web site to include all actively marketed non-Partnership policies, which was an extensive undertaking because of the number of companies and policies involved. In 2008, the Health Bureau continued to monitor the efficacy of this interactive tool in providing illustrative premium information for consumers.

f. Consumer Education

During 2008, Long Term Care Insurance Education and Outreach centers, headed by the State Office of Aging, provided the public with educational and informational materials regarding long term care insurance and provided counseling and direct assistance to help consumers understand policy options and benefits, and to obtain the appropriate long term care insurance coverage. The Health Bureau worked closely with the State Program Coordinator to provide the necessary information to train the counselors and answer their on-going questions.

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

In 2008, 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

2008 was the second 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 2008, 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.

21. Managed Long Term Care Plans

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

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

During 2008, the Department engaged in detailed discussions with the Health Department about solvency regulation of managed long term care plans that are writing Medicaid Advantage Plus and Medicare Advantage lines of business. Those lines of business are not subject to Department or state regulatory oversight in all respects, presenting challenges to the Department solvency regulation of managed long term care plans operating Medicaid Advantage Plus and Medicare Advantage lines of business. The Department continued to work with the Health Department during 2008 on the noted solvency issues/challenges.

In 2008, the Health Bureau continued its practice of reviewing and approving forms and rates for private pay participants in approved managed long term care plans.

22. Medicare Beneficiaries' Issues

The Health Bureau has been an active member with other state regulators, consumer representatives, the Centers for Medicare and Medicaid Services (CMS), and industry representatives on the NAIC Senior Issues Task Force (SITF) Medicare Private Plans Subgroup, participating in meetings, conference calls, and idea-sharing. The United States Congress asked the Subgroup to investigate nationwide allegations of fraud and abuse in the marketing and sale of Medicare Advantage (MA) plans and recommend possible solutions to combat the problems. To that end, the Subgroup conducted a hearing in Washington D.C. to take testimony and drafted a paper outlining options for measures that can be taken to alleviate fraud and abuse. The final version of the paper was presented to Congress in 2008. Among the potential solutions is giving authority to the states to regulate MA plans. Currently, state law is preempted by federal law in all aspects of MA regulation except licensing and solvency. The states and consumer advocacy groups believe that state insurance departments are in a better position to regulate entities operating within the state in order to protect consumers.

The Health Bureau also participates in the SITF Medigap Subgroup, which, in 2008 finalized revisions to the NAIC Medigap Model Regulation. Federal law charged the NAIC with revising the Model Regulation to modernize Medicare supplement insurance. The Bureau participated in numerous meetings and conference calls, and assisted in drafting changes to the model regulation. The SITF (B) Committee voted to adopt the changes to the model regulation in September 2008. The Bureau also assisted in drafting a compliance manual to aid states in adopting the changes and serves as a contact for other states in need of assistance.

CMS mandates that companies writing Medicare Part D prescription drug coverage are licensed in the state where they were proposing to operate, or obtain a federal waiver of the state licensure requirement. CMS requires state certification of licensure and financial solvency. Although the Department does not regulate the Medicare Part D or the Medicare Advantage program, the Health Bureau 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. The Bureau may also provide good standing letters to

requesting health insurance companies and HMOs expanding participation and entering the Medicare Advantage market.

Each year MA plans have the option to reduce their service area or terminate their MA contracts. MA 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 65 New York residents would be affected by nonrenewals. In order to assist New York residents being terminated by their MA plans, the Health Bureau coordinated with CMS and posted notice on the Department's web site containing information on choices for these affected residents. The notice explained the difference between the options of enrolling in another MA plan or returning to original Medicare with the purchase of a Medicare supplement insurance policy to help defray some of the costs not covered by Medicare. The notice also reminded those interested of how to prevent gaps in coverage in order to avoid having to satisfy requisite pre-existing condition waiting periods when enrolling in a new plan.

23. Innovative Health Insurance Products

a. Long Term Care Insurance

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

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

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

b. Managed Long Term Care

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

24. Health Savings Accounts/High Deductible Health Plans

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

25. Child Health Plus

During 2008, the Department continued its role of reviewing and approving subscriber contracts and premium rates for the Child Health Plus program. During 2008, the Department reviewed and approved a number of Child Health Plus rate adjustment submissions and subscriber contracts.

26. Early Intervention Program

During 2008, the Bureau continued its proactive role in assisting the Department of Health's Early Intervention Program to appropriately claim third party health insurance coverage for services rendered by the Program, as required by Public Health Law. Bureau staff continue to represent the Department on the Early Intervention Coordinating Council. Staff members also participate in monthly meetings with the Department of Health to discuss insurance-related issues brought to the Department of Health's attention by the county providers of early intervention services and investigate claims denials brought to their attention by the early intervention providers.

27. Pre-Existing Condition Provisions in Group and Blanket Disability Policies

In June 2007, the New York Court of Appeals issued a unanimous decision in *Benesowitz v. Metropolitan Life Insurance Company,* 8 NY3d 661 (2007), which construed New York Insurance Law Section 3234(a)(2) to establish a waiting period, rather than a total bar, for coverage of disabilities due to a pre-existing condition that begin within 12 months of an insured's effective date of coverage. The Department subsequently received inquiries from insurers requesting guidance from the Department with respect to implementation of the Court's decision. The Department issued Circular Letter No. 14 (2007) which instructed insurers writing group or blanket disability insurance as to the remedial actions to be taken by them.

Following issuance of the circular letter, the Department received specific inquiries from the industry regarding the interplay between the statutory pre-existing condition waiting period and the elimination period in many group and blanket disability policies. Based on these inquiries, the Department issued a Supplement to Circular Letter No. 14 (2007) in February 2008 providing a detailed explanation of the interplay, advising insurers that elimination periods and pre-existing condition waiting periods in group and blanket disability policies should run concurrently rather than consecutively, and providing the industry with relevant examples to illustrate the relationship.

28. Coverage of Childhood Immunizations.

The Health Bureau participated in a number of meetings with the DOH's Office of Public Health and DOH's Immunization Program to discuss coverage of pediatric immunization under our well-child mandate. To address inadequate reimbursement levels for physicians providing pediatric immunizations, the DOH is proposing to implement a Universal Vaccine Program wherein the state purchases the vaccines in bulk using money from the covered lives assessment (CLA) and supplies the vaccines to the providers.

In furtherance of the objective, the Bureau has reviewed the proposed changes to the applicable sections of the Insurance Law and plans to survey the health plans in order to obtain more information regarding reimbursement of pediatric immunizations.

29. Updates to Department Web site

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

Several interactive product checklists were added to provide the industry with one primary source for statutory and regulatory requirements related to each major product. In 2008, several product checklists were added and more are in progress.

In 2007, consumer information on the web site was enhanced and revised for easier access by the public. For example, the long term care insurance section was expanded to provide details regarding premium rate increases and streamlined by combining separate lists of insurers offering long term care insurance coverage to be more user-friendly.

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

30. Discontinuations, Withdrawals and Mergers

NMHC Group Solutions Insurance, Inc. an Article 42 Accident and Health Insurer withdrew from the state shortly after it received its license.

Horizon Healthcare of New York has been submitted to the Liquidation Bureau and the Superintendent was named as liquidator.

MDNY has been submitted to the Liquidation Bureau and the Superintendent was named as liquidator.

31. Financial Risk Transfer Agreement

Insurance Department Regulation 164, “Financial Risk Transfer Agreements between Insurers and Health Care Providers” (11 NYCRR 101), was promulgated on August 21, 2001. This Regulation addresses an insurer’s obligation to assess the financial responsibility and capability of health care providers (*e.g.,* Independent Practice Associations) to perform their obligations under certain financial risk transfer agreements. It sets forth standards pursuant to which health care providers may adequately demonstrate such responsibility and capability to insurers. A particular provision of Regulation 164 did sunset on August 21, 2004, after which “grandfathered” Financial Risk Transfer Agreements between insurers and health care providers had to be submitted to the Superintendent for review. During 2008, the Bureau received an additional 16 agreements for review. During 2008, 12 have been approved, five are pending and two were either withdrawn, suspended or have been determined not to be subject to the strict financial responsibility demonstration requirements of the Regulation.

32. Commission on Local Government Efficiency and Effectiveness

The Commission on Local Government Efficiency and Competitiveness released its final report in 2008. The Commission was formed in 2007 to look at ways to streamline local government and achieve savings. Numerous counties submitted proposals relating to health insurance and the Department met with representatives of those counties to discuss their concerns. The Commission's final report made the following recommendations:

1. Require local government and school district employees to contribute at least 10% and 25% for dependent coverage towards the cost of health insurance. Local governments would be free to negotiate higher employee contributions. This would be phased in over 5 years as collective bargaining agreements expire. This would save local governments and school districts outside of New York City $475 million a year.

2. Amend the law governing Municipal Cooperatives to base reserve requirements upon actuarial assessments and to allow for a transition period to build up reserves; to reduce the required number of participating municipal corporations from 5 to 3 and to require insurers to provide specific claims experience to municipalities analyzing the feasibility of forming a cooperative.

3. The Department should be granted authority to except small municipalities with fewer than 50 employees to join multiple employer trusts that are experience rated. This would permit these municipalities to purchase experience rated products.

Following the release of the report, Bureau staff attended a public hearing in Buffalo held to discuss the recommendations contained in the report. Most of the public comments concerned recommendations related to consolidation of local governments and/or consolidation of the services the local governments provide. The only discussion of the recommendations related to health care involved objections by CSEA to the recommendations that public employees contribute at least 10 percent of the health insurance premium for individual coverage and 25 percent for family coverage. CSEA indicated its support for the reduction in the number of municipal corporations needed to establish a municipal cooperative from five to three.

33. 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 comparable to other benefits provided for treatment of biologically based mental illnesses and for children with serious emotional disturbances. 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. Approximately 1.7 million persons covered under small group policies (as of December 2007) are affected by the subsidy.

Throughout 2008, the Bureau continued to hold meetings with industry, advocacy and provider groups to resolve issues regarding the implementation of Timothy's Law. The Bureau also responded to numerous inquiries and complaints.

Additionally, the Bureau has reviewed and studied the impact of the recently enacted Federal Mental Health Parity Act on coverage requirements in New York. The Bureau has held meetings with industry, advocacy, and provider groups to discuss the impact of the federal law. Additionally, the

Bureau participated in a conference call with CMS and attorneys from the U.S. Department of Labor to discuss the interplay between the recently passed federal law and New York law pertaining to mental health and substance abuse benefits.

The Health Bureau's Accident and Health Rating Section analyzed and estimated the rate impact of Timothy's Law, which included a prior approval review process of all carriers requested reimbursement rates. 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 $100 million. Funding of the subsidy is provided through an appropriation from the State's General Fund. 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 mechanism requires detailed quarterly claims, enrollment and reimbursement data reporting by carriers. Actual reimbursement requests for the period came in at about $91 million and all valid requests for that period have been paid. After March 31, 2008, the subsidy appropriation went onto a fiscal year basis, and the mechanism provides for annual prior approval of carriers' per member per month ("PMPM") reimbursement rates, 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 that date, with detailed guidance as to the data required. 2008 rates were reviewed and approved before the first fiscal year reimbursement request due date (July 31, 2008). As of December 31, 2008, the Bureau has received submissions for the first three quarters of fiscal year April 1, 2008 – March 31, 2009, and it appears total subsidies will be in the $95 - $100 million range for the year. The Health Bureau is awaiting receipt of rate applications for the April 1, 2009 – March 31, 2010 fiscal year which must include two years of claims experience.

The Superintendent has commenced the study of the cost and effectiveness of the new mandate, in consultation with the Office of Mental Health ("OMH") as required under Timothy's Law. The Department entered into a Memorandum of Understanding (MOU) with OMH, whereunder OMH would engage the Department of Health Care Policy of the Harvard Medical School to assist in the analysis of mental health claims data, looking at utilization changes, costs and other agreed areas. To assist the researchers, the Health Bureau initiated the data collection process, holding conferences with the researchers, OMH and the industry. The Bureau continues to work with the research team in the collection of pre and post Timothy's Law claims and carrier benefit design information. The researchers indicate that they expect to have preliminary results sufficient to assist the Governor and the Legislature in their analysis of the Law's impact in Spring 2009.

In addition to the Harvard Team's work, the Health Bureau has also conducted its own separate analysis of the newly mandated benefit costs from a pre/post Timothy's Law effective data per member per month (PMPM) premium rate perspective. Also, the Bureau has engaged the contractor that currently assists in collecting and auditing carrier reimbursement reports (Alicare, Inc.) to conduct a separate survey of all carriers, via a questionnaire, addressing whether the carrier had no, any or full benefits pre Timothy's Law and how it provided make available benefits (opt in or opt out). The results of that survey are nearly complete.

34. 36th Amendment to Regulation 62 (Chapter 645 of the Laws of 2005)

Chapter 645 of the Laws of 2005 ("Chapter 645") excludes from coverage under Healthy New York and the standardized individual enrollee direct payment contracts drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article 6-C of the Correction Law. The Department, as required by Chapter 645, promulgated the Thirty-Sixth Amendment to Regulation 62 (11 NYCRR 52), which implemented the denial of coverage for such drugs, procedures and supplies when provided to or prescribed for use by registered sex offenders. Health plans were required to implement their denial procedures no later than sixty days following the promulgation of the regulatory amendment. The amendment was adopted on November 19, 2008. The health plans, through authorized employees, are responsible for determining the eligibility of its members to receive such coverage by utilizing a secured internet portal operated and maintained by the Department.

35. Wellness Programs (Chapter 592 of the Laws of 2008)

New legislation was enacted in 2008 that adds a new Section 3239 to the Insurance Law to permit insurers, Article 43 corporations, health maintenance organizations (HMOs) and municipal cooperative health benefits plans the ability to establish wellness programs in conjunction with group health insurance policies and subscriber contracts. The terms of the wellness program must be set forth in the health insurance policy or contract. The legislation also amends Section 4224 of the Insurance Law to provide an exception to the general prohibition against rebating or refunding of premium when the rebating or refunding is one as part of a wellness program.

36. Sole Proprietors (Chapter 517 of the Laws of 2008)

Legislation was enacted in 2008 to extend to December 31, 2011 the maximum premium rate differential of 115% of the rate established for group coverage for sole proprietors who purchase group health insurance through associations. Without this legislation, the maximum premium rate differential would have expired on December 31, 2008 and adversely affected the affordability of health insurance coverage for sole proprietors. This legislation helped ensure that sole proprietors continue to have access to the same coverage as other small businesses when such coverage is purchased through association groups.

D. CONSUMER SERVICES BUREAU

Introduction

The Consumer Services Bureau in 2008 continued to perform its dual investigatory role of attempting to resolve each consumer complaint that is brought to its attention and examining systemic patterns of misconduct by insurers and producers which were discovered through the complaint process. The Bureau was successful in closing over 62,800 cases and conducting some major investigations of practices engaged in by both insurance companies and producers which affected consumers and impacted the competitive insurance marketplace. Whether investigating an insurance complaint, educating a consumer, staffing outreach booths, processing an external appeal application, or assisting in the prosecution of a felon, the Consumer Services Bureau provided needed proactive assistance to the citizens of New York State.

1. Consumer Complaints

The Consumer Services Bureau is responsible for responding to consumer complaints and inquiries, and investigating the actions of licensed producers. The Bureau *closed* a total of 62,896 cases in 2008. Of these, 42,899 involved complaints against insurance companies regarding loss settlements or interpretation of policy provisions, of which 67.3% (28,849) were accident and health complaints, 19.5% (8,373) were automobile and no-fault complaints, 10.4% (4,471) were property and liability complaints and 2.8% (1,206) were life and annuity complaints. In addition, 2,104 cases were closed when the complainants failed to furnish additional information deemed necessary in order to proceed with the investigation of the case. Another 8,704 cases involved complaints against agents, brokers and adjusters. Written inquiries accounted for 1,307 cases and referrals accounted for 7,882 cases (see Chart G). In total, the Bureau *received* 68,522 cases during 2008.

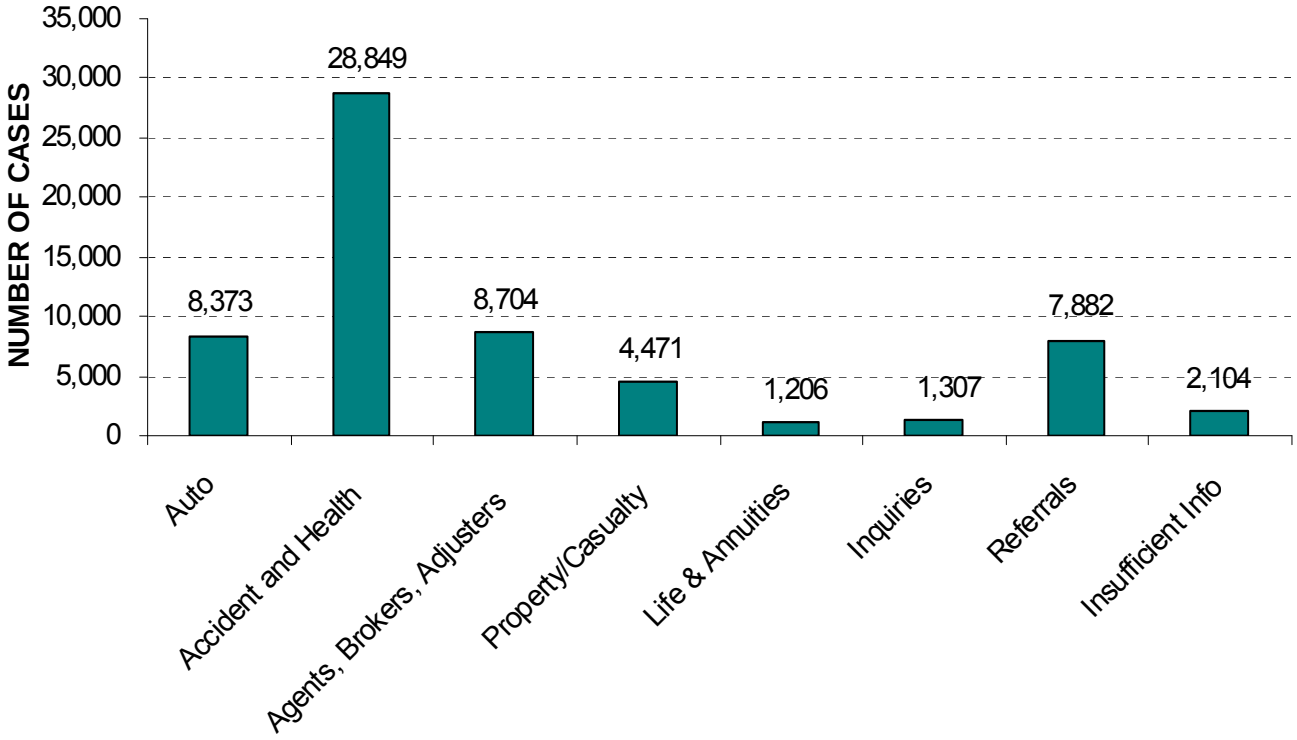
The Bureau responded to approximately 205,000 calls on its information phone lines. The Bureau's telephone system is an attendant system whereby the caller listens to a menu of topics and selects one by pressing the appropriate number on the dial. The caller is given the option of speaking to an agency services representative. The Bureau initiated a call-tracking system in the last quarter of 2002. The agency services representatives complete an automated computer screen template for each call they answer. The data are sorted and stored by the computer system so Bureau managers may more easily determine patterns of calls from consumers indicating an industry problem in a given area of the State. This system has proven helpful in determining the geographical area and severity of disasters occurring in New York State. The data allow for the more efficient use of state resources in response to disasters. The Bureau also maintains a toll-free line that will access a multi-lingual telephone service. This interpretive service, provided by AT&T Language Line Services, can translate 140 languages.

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

The Bureau also maintains a dedicated disaster toll-free hotline. Consumers affected by disasters may call this toll-free line to obtain information concerning their insurance coverage for damages incurred as a result of a natural or man-made disaster. In 2008, the Bureau

responded to questions related to the World Trade Center disaster, various winter storms, flood damages in southern and central New York and construction crane collapses in New York City. This hotline was also used as a Special Assistance Hotline for questions concerning Allstate Insurance Company's offer to reinstate homeowners' insurance policies in coastal areas and financial condition information of the American International Group (AIG). In total, bureau staff responded to over 1,500 calls for this hotline.

CHART G
Total Complaints & Investigations Closed
Consumer Services Bureau, 2008



Notable Complaint Activity

The Bureau began tracking the dollar amount of recovery to complainants due to their filing of complaints. For the last four months of the year, Bureau examiners were successful in obtaining a total of $8,813,322 in recoveries to consumers. This does not include any value policy reinstatements may have to insureds.

2. Property/Casualty

A consumer reported her vehicle stolen on June 25, 2008, to the police and then filed a claim with her insurance company the next day. As of July 27, 2008, she had not settled the claim with her insurer; however, the vehicle was recovered and impounded by the police as evidence since it was used in the commission of a crime. The insurer stated to the consumer they would inspect the vehicle and pay for any necessary repairs. Since the police refused to

allow them to inspect the "evidence", the company refused to settle the claim. The Department intervened for the consumer as she continued to pay the automobile loan and insurance. Once the Department's insurance examiner notified the company they were not in compliance with Sec. 216.7(c)(7) of NYCRR, the company paid the total loss value of the vehicle to the insured on September 18, 2008.

On July 3 2008, the driver of a van fell asleep, ran off the road, and struck two vehicles and a house. The owner of the house, who also owned one of the damaged vehicles, submitted his claims for damages to both his vehicle and the house to the insurer of the van. The van insurer denied the claims, however, stating the policy covering the van was canceled on February 6, 2008, due to non-payment of the premium. The homeowner filed a complaint with the Department. The insurer initially responded to our Department with documents substantiating the policy was canceled on February 6, 2008. The insurance examiner assigned to investigate this complaint reviewed the documents and discovered the insurer did not properly notify the Department of Motor Vehicles of the automobile policy cancellation. Therefore, the statutory coverage remained in effect to protect innocent third parties and the insurer must provide liability coverage for any damages caused by their insured. At the Department's direction, the insurance company paid the consumer the full amount of the damages to his property on October 14, 2008.

3. Health

The Consumer Services Bureau found as a result of several consumer complaints that Aetna was not providing the appropriate external appeal rights to New York policy holders that reside outside of the State. Rather, Aetna was providing the appeal rights required in the states where they lived. In many cases, this resulted in the member receiving appeal rights that were inferior to those required in New York. Consumer Services worked with the Health Bureau which also discovered the violation as a result of a market conduct exam. As a result of the joint efforts between the Consumer Services and Health Bureaus, Aetna agreed to this Department's interpretation of Article 49 and notified all affected members of their right to request an External Appeal.

In May 2008, Consumer Services received several complaints regarding Aetna retroactively terminating members. We discovered that although the members were being terminated, the insurance company was holding the premiums for an extended period of time. Aetna agreed to contact the members (groups and individuals) to inquire if they wish to be reinstated. If the member did not wish to be reinstated, Aetna would refund the premiums. This involved approximately 238 small groups and 447 individuals.

Consumer Services received a complaint stating that Aetna was no longer covering the member's mental health drugs under Healthy NY. We contacted Aetna as treatment for mental health and associated prescriptions are an exclusion under the Healthy NY Program. Aetna will send out a mass mailing on February 27, 2009 to advise their 7,322 Healthy NY members (subscribers and dependents) that effective June 1, 2009, they will no longer be covering the benefit. Currently, a total of 1,534 existing members have accessed coverage for mental health prescriptions.

During the course of investigating a consumer complaint, the Consumer Services Bureau found that The PerfectHealth Insurance Company had failed to provide required medical reviews, supply proper notices and inform consumers of their rights to appeal after denying services based on medical necessity. The review uncovered 775 services improperly denied with 134 members impacted. As a result of the investigation, the company agreed to reprocess the affected claims, and subsequently reimbursed $170,900.

We received a number of complaints from insureds that their health insurance policies with HealthNet were cancelled retroactive to November 2007. They were not notified of a problem until May or June of 2008. The policies were cancelled due to nonpayment of premiums by their employers. They were never advised by the employer or the company that anything was wrong. The company contacted and reversed payments to their doctors. They were now faced with mounting bills. HealthNet was contacted and advised that they cannot retroactively cancel a policy; they can only go back 30 days. The policies have been reinstated and outstanding claims are being paid.

A woman gave birth to her daughter on August 25. At that time she had a Healthy NY policy through Healthfirst and her son also had a policy under Child Health plus through Healthfirst. She tried relentlessly to have her daughter added onto her son's policy only to be told that no new policies were being written. Healthfirst also refused to provide coverage for the birth under her Healthy NY policy since she did not add the newborn to the policy within 30 days. Under the maternity mandate, coverage of the mother and newborn infant is required for at least 48 hours after a vaginal birth and at least 96 hours after a Caesarean birth. The company has paid the outstanding newborn claim.

The company denied coverage for surgery claiming that the insured lacked coverage on the date of the surgery. Consumer Services Bureau found that the policy provided coverage if the premium for that month was paid by the employer. The company agreed to cover the surgery in full and paid interest on the claim.

An insurance company paid an emergency room surgeon using their non participating schedule allowance amount. The Bureau discovered that the insurance policy required coverage of emergency care in full. The company agreed to pay the claim in full.

An insurance company refused to approve surgery to correct a congenital defect of the mouth for an insured. They cited certain provisions of the contract denying the coverage. Consumer Services Bureau discovered that this contract provision was illegal. The company approved the surgery and agreed to remove the illegal provision from their contracts.

An investigation of nonpayment for infertility treatment by an insurer uncovered approximately 2500 claims that were denied illegally. All denials were reversed and paid with interest. The company was fined $600,000 for failure to provide the coverage.

4. Life and Annuities

A life insurance company refused to pay the face amount of coverage alleging misrepresentation on the application. The Bureau discovered that the company had no evidence of misrepresentation. The company negotiated with the claimant and paid an amount close to the face amount of the policy.

We received a complaint from a couple over 80 years of age. They had three fixed annuity contracts. An insurance agency changed them to a variable universal life contract with the same insurance company. Neither the agent nor the company prepared the disclosure forms mandated by regulation 60. The company agreed to rectify the situation by writing a new UL policy and paying all attorney fees related to this problem.

a. Special Investigations

Improper Cancellation of Homeowners Policies Due to Lack of Owner Occupancy – The Bureau received numerous complaints that various insurance companies were canceling homeowners policies mid-term for lack of owner occupancy. As a result of investigating these complaints, the Department issued a Circular Letter advising the industry of the Department's interpretation of the insurance law governing these types of cancellations. Specifically, the Department ruled insurers may not cancel homeowners policies mid-term for the statutory reason of physical changes to the insured property if the residence merely becomes unoccupied by the owner. Insurers were required to offer reinstatement to not only those consumers who filed complaints with the Department, but also to any other similarly cancelled insureds.

Insurance Company Fines and Stipulations – In 2008, the Bureau began the process of assessing fines to insurers when a systemic violation of the law and/or regulations was found through the investigation of complaints. After remedial actions were taken by the insurers, stipulations were signed by the companies and an appropriate fine assessed. In total, four insurers paid fines amounting to $50,000.00.

Steering Investigation and Report – The Department continued its broad based investigation in 2008 into allegations of insurance company steering during the settlement of automobile first-party physical damage claims. Steering occurs when an auto insurer inhibits an insured's right to have the damaged vehicle repaired at the repair shop of the insured's own choosing. Rather, the insurer tries to steer the insured to have his vehicle repaired at a shop that has an affiliation with the insurer. Steering also occurs when, for other than glass claims, an insurance company informs an insured of specific repair shop names without first being asked by the insured.

The Department's investigation has three phases. The first entailed a review of the controls the insurers put in place to ensure compliance with the anti-steering law and the insurers claim file notes and the taped conversations between claims staff and the insureds from a randomly selected business day. Phase two consisted of an on-site review of randomly selected audio tapes and file notes of two insurers. The final phase involved the review of all complaints filed with the Bureau related to alleged anti-steering violations.

The Bureau found that auto insurance companies had not systematically violated New York's anti-steering law, but did find in some isolated instances, representatives of some insurers engaged in practices such as providing improper or inaccurate information to insureds that could be considered as violations of the anti-steering law and regulations. The Consumer Services Bureau is following up with the insurers on these matters and will continue to monitor and aggressively investigate any complaints of insurance company steering in the future.

5. Prompt Payment Statute

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

The Consumer Services Bureau allocated significant resources to the investigation and resolution of prompt payment complaints. In addition, the Bureau sought to ensure that doctors, hospitals and insureds received prompt payment of the claims submitted to health

plans, as well as compliance by health insurers and HMOs with all other provisions of this statute, such as the payment of interest.

The Bureau continued its enforcement action against health insurers and HMOs that violated the prompt payment statute. In 2008, $279,700 in prompt pay fines was levied against 29 health insurers and HMOs. These fines were calculated using the methodology developed by the Department and the industry in 2003. The methodology considers not only the violations uncovered while investigating complaints, but also the number of claims processed by the insurer or HMO during a specific time period to provide a more accurate picture of the overall performance of the insurer or HMO.

In addition, Bureau staff participated in several outreach sessions both for provider groups and hospital administrators. The purpose of these sessions was to educate the participants on their rights under the prompt payment statute and other laws that affect the payment of health care claims. These sessions also focused on information the providers can use in assisting patients who may be faced with the need to navigate through the insurers' and HMOs' various processes.

The Consumer Services Bureau allow providers to file prompt pay complaints via the Department's web site, which streamlines complaint handling and enables prompt pay complaints to be handled more expeditiously. Not only does this online complaint feature provide consumers with faster access to the Department's complaint process, it also allows insurers and HMOs to respond electronically to Department complaints via the Internet, saving additional time. Responses received online are triaged by the system using established business rules to determine if the response requires examiner review. If the response meets certain criteria, the file will close automatically and generate a closing letter without the need for review by an examiner, resulting in a significant reduction in the time required to review and close complaints.

6. External Review

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

During 2008, Consumer Services Bureau personnel responded to 7,720 phone calls on the dedicated external appeal toll-free line. Consumer Services Bureau examiners, along with attorneys from the Health Bureau, jointly perform the intake, screening, and assignment of external appeal applications. In 2008, the Department received 3,920 applications, representing a 31% increase from 2007.

Consumer Services continues to work with the Administration, Systems, and Health Bureaus to ensure that staff responsible for processing the applications has the technology and access to equipment to respond to requests for expedited external appeals 24 hours per day, seven days per week.

7. The Healthcare Roundtable

The Healthcare Roundtable was established in 2003 to convene representatives of health insurers, health care providers, and other interested parties to discuss health care

issues with the intent of resolving common issues. Members of the Roundtable are representatives from the Insurance and Health Departments, the Medical Society of the State of New York, the Health Plan Association, the Conference of Blue Cross Blue Shield Plans, the Greater New York Hospital Association, the Healthcare Association of New York State and various health care providers.

The Coordination of Benefits (COB) Regulation was approved by the Governor's Office of Regulatory Reform (GORR) and was published in the December 24, 2008 State Registry.

8. Senior Protection Unit

The Bureau formed a new Senior Protection Unit to address health and long term care insurance matters affecting the state's senior citizens. Consumer Services has modified the complaint tracking system to identify and handle complaints involving seniors on an expedited basis.

The Department signed a memorandum of understanding with the Centers for Medicare and Medicaid Services (CMS) to facilitate investigation into complaints arising in the sale and solicitation of Medicare products.

The Secret Shopper Program was developed by the Centers for Medicare and Medicaid Services to assist states in policing and monitoring the marketing activities of agents. The Senior Protection Unit has participated in this program to ensure that agents are complying with state and federal regulations.

Bureau staff participated in the Health Insurance Information Counseling and Assistance Program (HIICAP) Consortium, which is comprised of representatives from various state and federal agencies invited by the State Office for the Aging to provide technical assistance and training for HIICAP counselors and volunteers. Bureau staff also provides training and assistance to the Long Term Care Insurance Outreach and Education Program (LTCIOEP) which is run by the New York State Office for the Aging. This program maintains long term care resource centers at the county level to provide educational materials, counseling, and referral services on planning for the financing of long term care.

9. Investigations

The Investigation Unit of the Consumer Services Bureau is responsible for investigating the activities of insurance producers, adjusters, reinsurance intermediaries, bail bond agents, service contract providers, and other licensed and non-licensed entities who are conducting the business of insurance in New York State. It also reviews licensing applications where affirmative answers are either given or omitted to the irregularities questions contained on original or renewal applications. Its goals are to protect the insuring public and ensure that our licensees act in accordance with the applicable New York Insurance Laws and Regulations. When a violation is proven, an administrative sanction can be imposed. It may result in the revocation or suspension of any license(s) held, the denial of any pending application(s), or the imposition of a monetary penalty with resultant corrective action of the violation.

The Bureau continues to investigate the replacement practices of insurers and their producers. Information previously furnished to us by the National Association of Securities Dealers (NASD) revealed that two large insurers and various brokerage firms who were selling life and variable annuity products to New York residents failed to comply with a two-step process which is required by this Department's Regulation 60. During the 2008 calendar

year, we fined 15 Prudential agents a total of $28,250, and issued 22 Letters of Warning for failing to comply with the requirements of Regulation 60.

a. Revocations – License Revoked After Hearing:

Peter Hiatrides – failed to remit over $27,000 in premiums, conducted business using an unlicensed name, and failed to cooperate with the Department.

Robert Regina – stole $3,116.75 from 11 of his clients. He attempted to cover up the thefts by making unauthorized charges to credit cards of other clients. He had a previous revocation and he also was terminated for cause from Allstate for attempting to cheat them out of overtime money.

James Gard – collected premium money from an applicant for life insurance and never remitted the money to the company. He led the clients to believe they had life insurance for over a year. He also collected $35,000 from the same clients and did not invest it as directed and kept it in his own account for over two years.

Michael Trummer – submitted 33 applications for insurance that was neither requested nor authorized by the proposed insureds. He also failed to cooperate with the Department's investigation.

AJ Johnson – submitted 42 false applications for accident and specified disease insurance policies to AFLAC. He received commissions totaling $10,729.65 for placement of these bogus policies.

David Lamirand – submitted 10 bogus applications for insurance policies to Combined Life, failed to remit renewal premiums he had collected from 11 insureds, and was terminated by his employer, Combined Life for these actions.

Brett W. Snyder – wrongfully altered or voided work orders and stole more than $6,000 from his employer, for which is was convicted of Grand Larceny, a felony. He was sentenced to five years of probation.

Russell Steffens – issued a check for $50,000 which was dishonored by the bank and not replaced, violated Regulation 60 by making 3 annuity contracts without correctly answering the replacement questions, thereby not doing the proper replacement forms, collected a total of $97,000 in commissions for the sale of the 3 annuity contracts, and failed to cooperate with this Department's investigation.

Antonina M. Thornton - failed to remit premium collected to an insurance company, issued a forged insurance identification card, and issued 3 checks representing insurance premiums which were dishonored by the bank upon which they were drawn. These checks were not replaced, or otherwise properly accounted for. Ms. Thornton failed to respond to this Department's letters regarding the complaints lodged against her, thereby hampering and impeding our investigation. Finally, the New York Automobile Insurance Plan revoked her certification to produce business in the Plan for a period of one year. The determination was based on her failures (a) in four instances between June 2007 and October 2007 to submit complete applications and deposit premiums after she sent the Plan electronic PASS notices; and (b) her submissions to the Plan between May 2007 and October 2007 of four deficient applications for Plan assignments.

Thomas T. Swift - arrested by the Suffolk County Police Department and charged with the crime of Obstructing Governmental Administration, 2nd Degree. He failed to inform the Superintendent within thirty days that he was arrested and had criminal charges pending against him in Criminal Court. He also failed to respond to this Department's letters regarding his arrest and he failed to inform the Superintendent of his change of business address.

Riaz Ahmed Malik – failed to remit premium collected from an insured and provided materially misleading answers on three license renewal applications by falsely representing that he was a resident of the State of New York, when in fact he resided in New Jersey. He transacted business under the unlicensed agency name of Sana Group Inc. and failed to respond to the Department's letters, thus hampered and impeded our investigation.

Kevin James Dunn, Jr. – forged the signature of a client on a wire transfer attempting to transfer $100,000.00 from a purported joint brokerage account at the insurer into the agent's individual personal bank account. The agent's employment was terminated by various insurers in the MetLife group. He was subsequently arrested for numerous felony and misdemeanor counts, convicted and sentenced to 51 months in prison.

Leo C. Porter, III - during the approximate period of November 13, 2000 through September 24, 2001, Mr. Porter unlawfully collected $7,254.00 in unemployment insurance benefits from the New York state Department of Labor while knowing he was not entitled to them because he was employed during that time. He made full restitution however he was arrested and pled guilty to Attempted Grand Larceny in the 4th Degree a Class" A" Misdemeanor.

Philip J. Nociforo - On three (3) separate occasions involving different individuals, Mr. Nociforo received $10,029.71, $15,000 and $25,530 in premiums for life insurance policies. He never remitted the premiums to the respective insurers but instead deposited the monies into his own personal bank account for his own personal use. In connection with the aforementioned, he was (1) barred by FINRA (formerly NASD) from association with any FINRA member in any capacity, and (2) convicted of a Grand Larceny in the 3rd Degree, a Class D felony, and sentenced to three (3) years conditional discharge and restitution of $36,580. The victims have been made whole.

Meredith Insurance Agency Corp & Mabel M. Martinez - Issued checks for premium that were dishonored by the bank upon which they were drawn. The checks were subsequently replaced. They also received premium which was never remitted to the insurance carrier.

b. Stipulations With The Full Force And Effect Of Revocation:

Jill Morrill – was convicted of a felony for stealing $9,576 from 36 clients. As part of her plea she was required to surrender her license .

William Norton – collected insurance premiums from insureds totaling $681,670 and he failed to remit them to the insurers and he commingled insurance premium funds with operating funds.

Thomas R. Pombonyo – was convicted of Mail Fraud, a felony and Conspiracy to Commit Mail Fraud, a felony in May 2008. Mr. Pombonyo admitted that he conspired with another to submit invoices totaling $647,886.82 to AIG for recruiting services which were never performed.

Wendy H. Pachla – was convicted of Identity Theft, a felony, for misappropriating approximately $1,337 in premium funds while licensed by this Department. She was sentenced to five years probation.

Carl D. Leonardi – was convicted of two counts of Falsifying Business Records, a misdemeanor. Mr. Leonardi was terminated from State Farm due to a deficiency in his premium account, he submitted at least 9 NSF checks to National Grange, and he issued false Certificates of Insurance to at least 2 clients.

Gregory A. Jezioro – signed the names of insureds on 2 requests for change of beneficiary forms for the insured's annuity contracts without the insured's knowledge, permission or consent.

Bonnie Chao - She was convicted in the US District Court, Southern District of New York, on or about September 19, 2007, of Conspiracy to commit Bank Fraud, a felony, in violation of 18 U.S.C. §1349, for which she was sentenced on or about December 27, 2007, to one year and one day incarceration, five years supervised release, restitution in the amount of $13,000.00 and a $100.00 Assessment. She signed a Stipulation Surrendering Licenses.

Fox Brokerage Inc. and Michael B. Fox t/b/a Michael B. Fox Insurance and Michael B. Fox - commingled premium funds and operating expense funds in their premium account and issued 137 insurance premium payment transmittal checks, totaling $84,552.69, that were dishonored by the bank upon which they were drawn. These checks were subsequently replaced. Further, Mr. Fox failed to report to the Superintendent within thirty days that he was arrested and had criminal charges pending against him in the Criminal Court, Kings County. The respondents signed a Stipulation Surrendering Licenses.

Noel L. Luria – the agent failed to report to the Superintendent within thirty days that he plead guilty to a charge of reckless endangerment in the first degree, Class D felony.

T I O Insurance Office Agency LLC and Michael Scavuzzo – collected a check for premium made payable to insurance company, and without authority from the insurance company endorsed the check and deposited it into their bank account. Respondents failed to remit or otherwise properly account for the premium funds collected on behalf of two insureds and failed to preserve the premium bank account records.

Frank Winston & US Group Medical Administrators, Inc.- collected insurance premium payments in excess of $900,000 from numerous insureds and failed to remit or account for said premiums.

Foreman International, Ltd. and Wayne J Forman - Convicted of Grand Larceny in the 2nd Degree, a Class C felony, for theft of insurance premiums. He was sentenced to five (5) years probation, a fine of $25,000, and restitution of $323,299.

Salvatore Magaraci - From 2000 to 2007 sold hundreds of annuities on behalf of numerous unauthorized insurers to New York residents and falsely stated on the applications that the applicants signed the applications in New Jersey.

Robert J. Licursi – was convicted of Offering a False Instrument for Filing, a felony, for creating fraudulent Certificates of Liability Insurance for one of his clients while licensed by this Department. He was sentenced to five years probation.

c. Stipulations Monetary Penalty Paid, No Revocation:

Gallagher-Bassett of New York Inc. and Kenneth L. Hall - transacted business under an unlicensed name and paid fees or other compensation to employees that conducted insurance business as independent adjusters without a license in this State. A penalty of $117,500.00 was imposed.

Compensation Risk Managers LLC and Daniel G. Hickey Jr. – transacted insurance business as independent adjusters without a license and paid fees and/ or compensation to employees that conducted insurance business as independent adjusters without a license in this State. A penalty of $96,110.00 was imposed.

Crawford & Company and Russell W. Saladin – paid fees and/ or compensation to employees that conducted insurance business as independent adjusters without a license in this State. Respondents violated a prior stipulation entered into with the Department. Mr. Saladin provided materially incorrect and untrue information on his renewal application to act as an independent adjuster. A penalty of $48,600 was imposed.

Domenic DelBalso – was fined $25,000 for failing to refund an excess premium of $23,600 and altering a policy endorsement which was sent to the client's bank. He eventually issued the refund.

Steven LaFay – was fined $2,500 for altering 12 declaration pages of insurance policies and submitting these false documents to the insurer. He was terminated by his employer.

Richard Meunier – was fined $10,000 for placing 7 individuals in groups for health insurance who were not employed by the groups and were not eligible for coverage under the groups. He received commissions for this. He also lied on his application to the Department by not advising us of his termination for cause. He eventually returned the commissions.

McLarens Young Associates – was fined $42,500 for acting as independent adjusters without a proper license to do so for a total of 80 losses over a 4 year-time period.

Latremore's Insurance Agency, Inc. – fined $5,000 for paying referral commissions to two unlicensed employees in connection with the placement of approximately 180 insurance policies.

Andrew Trippiedi – fined $14,385.42 for failing to properly complete the Definition of Replacement and Disclosure Statement forms in connection with an annuity contract replacement in violation of Regulation 60. The fine was $750 plus return of commissions of $13,635.42.

Katina M. Scarbro – was fined $2,500 for advising a potential applicant to understate her income in order to qualify for a state insurance program. She was terminated by her employer, Managed Health, Inc. for this occurrence.

Sylvan James Associates and Thomas Statkewicz individually as sublicensee – were fined $120,000 for using misleading advertising materials in the sale of Medicare Supplement plans during the period of 2003-2005. Additionally, they solicited Medicare Advantage plans on a door-to-door basis without having a previously arranged appointment as required by the Centers for Medicare and Medicaid Services (CMS).

c. Denials of Licensing Applications:

Stanley I. Dworkin- an applicant for an adjuster's license had been previously convicted of Conspiracy to Commit Mail Fraud in violation 18 U.S.C. § 371, a felony. The conviction was the result of him bribing an independent insurance adjuster. Mr. Dworkin let his public adjuster's license lapse, but continued to engage in activities that required licensure.

Lawrence J. Rand - This applicant had been convicted of a crime involving the Misuse of a Social Security Number a felony, in violation of 42 U.S.C § 408 (a)(4) and 18 U.S.C § 3551. Mr. Rand while employed in the insurance industry collected Social Security disability benefits in excess of $45,000. He also sold as an agent for Fidelity Group, Inc., health plans to 483 New York residents. Fidelity was neither licensed nor otherwise authorized to transact business in New York and subsequently it became insolvent. This resulted in unpaid claims and individuals unable to seek medical treatment.

Eugenia M. Moreira – relicensing application denied. She engaged in egregious misconduct as an insurance agent in 2004 when she wrongfully took advantage of a widower by obtaining $6,000.00 from him in order for the client to receive the death benefits owed to him.

d. Cases of Interest:

Ancillary Administrative Services – There have been a few complaints which triggered an investigation into the practice of certain agencies providing additional services free of charge which are not necessarily related to the servicing of the insurance products. Examples of such services are creation of employee handbooks and monthly newsletters. Our investigation continues in this matter.

Circular Letter No. 22, October 10, 2008 - The purpose of the Circular Letter was to prevent Department Licensees from making false or inaccurate representations that would encourage customers to replace their coverage given the recent financial crisis involving non-insurance parent company of AIG. It was intended to remind them of the various statutes and regulations that they must adhere to when soliciting clients. The Investigation Unit was responsible for reviewing any complaints related to the content of the Circular Letter.

Prohibited Referral Payments by Glass Repair Shops to Department Licensees – Section 322 of the Insurance Law prohibits licensees from accepting payments from motor vehicle repairers for referring business to them. Various glass shops in the western part of the state were providing referral payments in the form of cash, gift cards and movie passes to licensed producers. We identified approximately 100 agencies who were involved in this practice and are finalizing appropriate disciplinary action.

e. Service Contracts

Lenovo (United States) Inc. was fined $5,000 for selling extended warranties without having a registration as required under Section 7907 of NYS Insurance Law.

Consumer Services Bureau participated on a task force to propose amendments to Article 79 for introduction to the Legislature. The task force addressed various problems within the service contract industry that have come to our attention as a result of service contract providers' failures to pay claims, sales practices, bankruptcies, and other issues.

In conjunction with other Bureaus, the Department is developing a circular letter to be sent to all insurance carriers offering service contract reimbursement policies and all registered service contract providers. This circular letter will address exclusions, restrictions, and conditions that potentially nullify the coverage the policy was intended to provide. This circular letter will also address other issues that result in the policy's failure to comply with requirements contained in Article 79 and Department Regulation 155.

10. Officers and Directors Cases

At the request of the Life, Property or Health Bureaus, the Consumer Services Bureau is responsible for doing background investigations for any Officers and Directors of insurance companies or holding companies seeking to acquire control of an insurer. We completed over 1,500 investigations during 2008 and reported our findings to the appropriate Bureaus.

11. Electronic Complaint Handling

a. Consumer Imaging and Information Management Systems (CIIMS)

The Consumer Imaging and Information Management System (CIIMS), Consumer Services Bureau's award winning imaging and workflow system, was a pioneer in the industry when the custom designed software went into production in 1998. CIIMS proved so successful that in 2007 it was elevated to a Department-wide system. With minor modifications, the Property Bureau's Excess Line and No-Fault units began processing their investigation and complaint cases in CIIMS. In 2008, CIIMS was adapted to process complaints received by the Department's Health Bureau.

CIIMS was also modified in 2008 to handle pre-licensing investigations for the Licensing Bureau's Continuing Education Unit. Also new in 2008, CIIMS is able to track amounts of recovery, claims payment recoupment and animal and pet Insurance for the Bureau.

The Bureau continues to explore expanding CIIMS within the Department. A common system fully utilizes the Department's available IT resources and leads to consistency in reporting to the National Association of Insurance Commissioners Complaints Database.

b. E-Commerce Activities

Consumers have been able to file complaints online directly into CIIMS since 2001. Once the consumer submits an online complaint, a file number is assigned and confirmation of this case number is immediately transmitted to the consumer.

In 2003, we developed an electronic process for health care providers to file their prompt payment complaints with CSB. This included a registration process enabling healthcare providers to login into the system where their information is stored and proceed to file relevant patient information. This data is automatically recorded in CIIMS. During 2008 we revised our automatic acknowledgments to providers and attorneys for providers generated in CIIMS. These letters inform them of our on-line system for filing multiple cases.

In 2008 the total number of complaints CSB received was 48,226. Of this amount a total of 27,938 were received online. This represents a 54% increase of online complaints received last year.

At the time the online provider form was introduced, CSB added the Online Company Complaint Response form. This allowed the companies to respond online. We received 39,092 online complaint responses in 2008. This represents a 31% increase in online responses received last year.

In the case of prompt pay, the online process allows for an automatic review and based upon clearly defined business rules in Insurance Law, CIIMS can automatically close the file. In 2008, 36% of the prompt pay complaints closed using the automatic feature.

Though CIIMS was premier technology when first introduced and still continues to be the national standard, the System is working on technology introduced a decade ago. The Department issued a RFP for a new web based system to replace the legacy system in 2008. This procurement process will continue in 2009. The New York Insurance Complaint Information System (NYICIS) will allow CSB to take even more advantage of further e-commerce activities.

c. E-Knowledge

In March 2008 we introduced the Team Reference Information eXchange Index (TRIXI) for CSB's Health Unit. This pilot program was expanded to the entire Bureau throughout 2008.

TRIXI is a wiki or web base program and is a repository of reference material for CSB staff to access as needed. In addition, a pre-defined list of individuals with the proper permissions is able to add new material and edit current content.

12. Consumer Service Outreach

a. State & County Fairs, Conferences & Festivals

Examiners from the Consumer Services Bureau staffed the Department's booth at both the Erie County and New York State Fairs held from August 6th through the 19th and August 20th through September 1st respectively. Examiners distributed various consumer guides and booklets to the public and answered insurance related questions. Over 70,000 publications and mementos were disseminated to the public at these two events. Additionally, the examiners handed out over 7,000 informational computer CDs containing various insurance guides and pamphlets. Additionally, fairgoers were able to access the Department's website via wireless internet so they could obtain real-time insurance information such as updated Healthy New York premium rates charged by the HMOs operating in their county.

The Bureau also staffed informational booths at a host of other smaller, but just as important, events in 2008. These events included the Black and Puerto Rican Legislators Annual Conference, African-American Family Day, North Country Business Expo, Somos El Futuro Conference, the New York State Emergency Management Office's Preparedness Expo, and responded to numerous requests to set up booths and/or speak to smaller consumer gatherings.

b. Health and Long Term Care

Consumer Services staff conducted presentations for new coordinators for both the Long Term Care Insurance Outreach and Educational Program and the Health Insurance Information Counseling and Assistance Program. At the request of Assemblyman Gottfried, Bureau staff participated in a panel presentation on long term care insurance and the benefits of purchasing this type of insurance at younger ages. Consumer Services staff also conducted a presentation for the United University Professions, giving a broad overview of long term care and Partnership policies.

Consumer Services staff continued their participation in outreach presentations designed to assist health care providers with their health insurance problems. These included a presentation to members of the Health Care Financial Managers Association, and UNYHEALTH Providers to discuss such topics as legislative updates and the Prompt Payment and External Appeal laws.

c. Consumer Guide Books

The Department is required to publish an Annual Consumer Guide to Health Insurers, which ranks insurers and HMOs by complaints upheld by the Consumer Services Bureau, and contains a separate ranking based on upheld prompt pay complaints. In 2008, Consumer Services staff coordinated Department staff from Public Affairs, Health, Property and Administration Bureaus to ensure that information necessary to publish the Guide before the deadline imposed by legislation was available on time. In addition, Bureau staff also worked with the Department of Health's Office of Managed Care, to gather quality assurance measures published by that office which is also required to be included in the Guide. Consumer Services staff worked closely with the National Committee on Quality Assurance (NCQA), the vendor contracted to create the Guide.

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

The Bureau continues to assist individuals, families and businesses in overcoming problems due to erroneous or untimely electronic submissions by their insurers to the Insurance Information and Enforcement System (IIES) maintained by the New York State Department of Motor Vehicles. (Auto insurers are required to inform the Department of Motor Vehicles of drivers whose coverage has lapsed.) Insurers not filing timely reports to the Department of Motor Vehicles have been fined. The Bureau investigated and closed 97 complaints on an expedited basis. Of these, 46 complaints were closed as upheld against the insurance companies. Another 22 were closed as not upheld but some type of adjustment was made by the insurer to resolve the complaint. This means that 68 individuals had their vehicles' registration reinstated by the Department of Motor Vehicles either without any or reduced fines.

e. New York State Insurance Disaster Coalition

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

The Bureau continues to receive complaints from those individuals, families and businesses affected by the World Trade Center disaster as well as other natural disasters occurring in New York State during 2008. These complaints receive immediate and expedited treatment from Bureau examiners. Bureau examiners have facilitated settlement of a number of these cases by conducting meetings with consumers and their insurers to resolve disputed claims.

Fortunately, there was no need to activate the Disaster Response Plan in 2008. However, the Bureau did assist consumers who sustained damages caused by flooding from various summer rainstorms, heavy snowfall in western and central New York and construction crane collapses in New York City. Bureau examiners participated in a Hurricane Response Exercise conducted by the State Emergency Management Office. Examiners also assisted the Disaster Preparedness and Response Unit in creating a brochure titled "Guide to Natural Disasters".

f. Coastal Property Insurance Issues

Insurers continued to refuse to issue and/or non-renew homeowner's insurance policies in the coastal areas of the five boroughs of New York City and the counties of Nassau and Suffolk. The Bureau established a specific subject matter code for use in tracking consumer complaints received concerning this issue. The Bureau examiners investigated over 800 complaints to verify the refusal to issue or the termination of coverage complied with the Insurance Law. The Bureau continued to participate in the Department's investigation of the Allstate Insurance Company's practice of tying renewal of homeowner's policies to their policyholder having other insurance business with the company. The Department ultimately found this practice to be in violation of the Insurance Law. Allstate agreed to offer the affected policyholders the option of receiving a new homeowner's policy. The Bureau continued to staff the Special Assistance toll-free hotline to answer questions consumers may have concerning the reinstatement offer.

g. Miscellaneous

In calendar year 2008, the Bureau responded to 297 requests from the public under the Freedom of Information Law for copies of documents contained in the Bureau's complaint and investigation files. These requests ranged from as small as one document to thousands in hundreds of files.

Consumer Services staff also participated in the Medicaid Managed Care Compliance Program Guidance Advisory Committee formed by the Office of the Medicaid Inspector General. This panel assisted in the development of guidelines for Medicaid Managed Care Plans to use for the detection and prevention of fraud.

Consumer Services staff also worked with the Health Bureau on Legislative initiatives, attending meetings with all affected parties to negotiate legislative changes for health insurance. In addition, Consumer Services staff participated in the Out-of-Network Public Hearing which was held to discuss solutions to surprise bills when health care consumers are seen by out-of-network providers either in the Emergency Room or during a scheduled procedure in the hospital.

Consumer Services staff continued to provide support to the United Healthcare Multi-State settlement meetings. This included participation in meetings with representatives from United Healthcare, other regulators and the American Medical Association.

On a monthly basis, Consumer Services staff participates in meetings with the Life, Health and Property Bureaus to discuss topics relating to ongoing market conduct exams as well as to share information of mutual interest among the Bureaus. Consumer Services reports on complaint findings and trends.

E. THE INSURANCE FRAUDS BUREAU

1. General Overview

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

2. 2008 Highlights

- Investigations conducted by the Frauds Bureau resulted in 755 arrests in 2008, the highest number recorded since 2004.

- The number of criminal convictions obtained by prosecutors in Frauds Bureau cases totaled 402 during 2008.

- The Bureau's Major Case Unit handled complex cases involving no-fault, commercial rate evasion, health care fraud and workers' compensation premium fraud. The Unit effected 126 arrests in 2008.

- New York State received more than $9 million in refunds and $78,551 in fines from five health care providers who inappropriately billed United HealthCare, administrator of the Empire Plan.

- Arrests for auto give-ups spiked by 35% over the past year, up from 96 in 2007 to 130 in 2008. Fraud experts believe that high lease payments and the downturn in the economy may be factors.

- No-fault fraud referrals increased by 10% from 2007 to 2008. At the same time, the Bureau posted 154 no-fault arrests, a 52% year-to-year increase.

- A 19-month investigation led to the indictment of 62 individuals accused of staging more than 40 auto accidents over a three-year period. The investigation was conducted by the Frauds Bureau and other members of the FBI New York Health Care Fraud Task Force.

3. Team Building

The Frauds Bureau has been a longtime advocate of team building. Toward that end, collaborative alliances with the insurance industry and law enforcement agencies on the federal, state and local levels during the past year resulted in successful investigations and yielded 755 arrests and 402 convictions throughout the State.

a. Multi-Agency Investigations

The Western New York Health Care Fraud Task Force, whose members include the Frauds Bureau, the FBI, the U.S. Departments of Health and Human Services, Labor and Defense, the IRS, the Federal Drug Administration, the U.S. Attorney's Office and the Medicaid Fraud Control Unit, conducted a joint investigation that resulted in a licensed clinical social worker from Tonawanda pleading guilty to felony health care fraud in February.

A 16-month investigation ended with charges being brought against 61 suspects and the seizure of 70 vehicles worth $1.7 million. Vehicle owners paid a middleman to make their cars disappear in order to collect an insurance payout. Investigators from the Frauds Bureau, the NYPD's Auto Crime Division and the Queens DA's Office pooled resources in this long-term undercover operation.

The Bureau also worked closely with the NYPD's Fraudulent Accident Investigation Squad on many no-fault and other auto-related fraud investigations, and with the Workers' Compensation Board's Office of the Inspector General and the State Insurance Fund on cases involving workers' compensation fraud.

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

Moreover, DAs' Offices, the New York State Attorney General's Office, the New York State DMV, the U.S. Postal Inspection Service, 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 among the many agencies involved in fighting insurance fraud. Participation provides the opportunity for joint investigations, information sharing, networking and honing investigative skills.

4. The Staff

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

Bureau staff consists of 21 Senior Investigators and 19 Investigators who staff the Bureau's eight specialized units: Major Case, Arson, General, Auto, Workers' Compensation, No-Fault, Medical 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 Technical Services, who coordinates the activities of the Department's Mobile Command Center.

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

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

5. Investigations

The Frauds Bureau received 23,054 reports of suspected fraud in 2008, a slight increase over the 22,079 reports received the year before. Of the 2008 total, 22,235 were received from licensees required to submit such reports to the Department, and 817 were received from other sources, such as consumers and anonymous tips. A total of 1,367 new cases were opened for investigation during the past year. Investigations also continued in numerous cases opened in prior years.

6. Arrests

Investigations by the Frauds Bureau resulted in 755 arrests for insurance fraud and related crimes during the past year, up from 708 in 2007, and the highest number of arrests recorded since 2004. One investigation led to the arrest on 3/11/08 of 11 persons, including three doctors, a chiropractor, two acupuncturists, other employees of a medical clinic, and ten corporations accused of operating a medical mill that cheated insurers of more than $6.2 million over a five-year period. The enterprise used "runners" to stage accidents and bring "patients" to the clinic where medical providers prescribed unnecessary treatments and procedures, falsified medical records and submitted fraudulent claims to insurers.

In another case, a defendant was arrested in December 2008 based on evidence that indicated he had assumed the identity of another person about 20 years ago. Then, in 1990, using the stolen identity, he purchased disability income insurance. In 1996, he filed a claim under his policy coverage and from March 1999 through April 2007, he collected a total of $141,620 in benefit checks issued to the person whose identity he had assumed.

7. Civil Enforcement and Restitution

Section 403 of the New York Insurance Law, passed by the Legislature and signed into law by the Governor in 1992, authorizes the Insurance Department to 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 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.

As a result of civil enforcement activities, $1.68 million in penalties was imposed in 2008.

The courts ordered $2.9 million in restitution during the past year as a result of Frauds Bureau criminal investigations. Additionally, insurers saw savings of nearly $1.2 million in connection with fraudulent claims investigated by the Bureau.

8. Training

a. Staff Training

Newly hired investigators participated in an Entry-Level Training Program. In addition, investigators also took part in the Bureau's In-Service Training Program designed for all investigative staff. Both programs – developed and administered by the Bureau's Training Officer – comply with the standards and curriculum established for professional police officers by the Bureau of Municipal Police of the New York State Division of Criminal Justice Services (DCJS). Frauds Bureau investigators are seasoned professionals with extensive law enforcement experience and often exceed these high standards.

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

b. Outreach

Five training sessions were conducted at the New York City Police Academy during 2008, which were attended by 1,635 recruits. In addition, two groups totaling 86 recruits were given training 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. In all, the Bureau provided training for 31 groups that included 2,396 participants.

9. Fraud Prevention Plans/Public Awareness Programs

Section 409(a) of the New York Insurance Law and Department Regulation 95 require all insurers that meet the criteria delineated in the Law to submit to the Department a Fraud Prevention Plan (Plan) that includes providing for a Special Investigations Unit (SIU). The SIU is responsible for investigating cases of suspected fraud and for implementation of 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, each of which addresses different lines of business. At year-end 2008, there were 140 Plans on file.

Regulation 95 and Section 409(c)(5) of the New York Insurance Law require that Fraud Prevention Plans 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, a coalition of more than 90 insurers or groups of affiliated insurers, carries out advertising campaigns using newspapers, radio and television to target insurance consumers. Additionally, 20 health plans or groups of affiliated health plans are members of the National Health Care Anti-Fraud Association, which carries out advertising campaigns using newspapers and radio advertising. Moreover, several individual insurers have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year. The Bureau also has a frauds hotline (1-888-FRAUDNY) and consumers are encouraged to report suspected insurance fraud. Calls to the hotline averaged 37 a week in 2008.

10. Electronic Filing of SIU Annual Reports

According to Section 409(g) of the New York Insurance Law, those insurers with Fraud Prevention Plans on file must also file an Annual Report, describing the SIU's experience, performance and cost effectiveness in implementing the Plan. Legislation passed in 2008 changed the reporting date of the Report from January 15 to March 15 of each year.

Beginning in 2008, insurers are required to submit the SIU Report electronically through a secured portal environment accessed from the Department's Web site. Hard copy submissions of the Report are no longer accepted.

11. Major Cases

The Frauds Bureau was involved in a number of multi-agency investigations during 2008. These operations, in addition to the day-to-day investigations conducted by Frauds Bureau investigators, contributed to the total number of arrests for the year. Some of these cases are summarized below.

a. Sting Operation

A 16-month undercover investigation, dubbed "Operation Disappearing Act," ended with charges brought 1/16/09 against 61 suspects in at least four states – New York, New Jersey, Maryland and Pennsylvania – and the seizure of 70 vehicles worth $1.7 million. Among the 61 suspects charged were a New York City police officer, a director of security at a city hospital and an employee of the U.S. Department of Homeland Security. Owners paid a middleman to take their cars to a garage in Queens where they purportedly were stripped for parts. Neither the car owners nor the middlemen were aware that the garage was run by NYPD detectives working undercover. The middlemen returned the keys to the owners who then reported their cars stolen and filed fraudulent claims for the insurance payout. Seven additional suspects were subsequently arrested in this case and 15 additional vehicles were recovered. The investigation was conducted jointly by the Frauds Bureau, the NYPD's Auto Crime Division and the Queens DA's Office.

b. Collecting Benefits Behind Bars

After sustaining an injury on the job on 2/11/06, the defendant in this case began collecting workers' compensation benefits. On a number of occasions, he submitted employment status reports to the Workers' Compensation Board on which he answered "no" when asked if he had been convicted of a crime and was serving a prison sentence. However, an investigation by the Frauds Bureau and the New York State Workers' Compensation Board's Office of the Fraud Inspector General uncovered evidence that he had pleaded guilty to an unrelated crime on 7/13/07 and was sentenced to one year in jail. As a result of his misrepresentations on the employment status reports, he received $7,760 in benefits while serving time in the Oneida County Correctional Facility. He was arrested on 2/4/08 for insurance fraud, offering a false instrument for filing and violation of the Workers' Compensation Law.

c. Medical Mill Take-Down

Eleven persons, including three doctors, a chiropractor and two acupuncturists, and ten corporations were charged in an 84-count indictment with operating a medical mill that cheated insurers of more than $6.2 million over a five-year period. Two other suspects who allegedly assisted in the criminal affairs of the enterprise were charged in separate indictments. The enterprise used "runners" to stage accidents and bring "patients" to the clinic where medical providers prescribed unnecessary treatments and procedures, falsified medical records and submitted fraudulent claims to insurers. Four management and realty companies and six professional corporations were used to conceal parts of the operation and to launder the proceeds. The Frauds Bureau, the Manhattan DA's Office, NYPD's Fraudulent Accident Investigation Squad, GEICO and MetLife Insurance Companies and the National Insurance Crime Bureau pooled resources in the investigation that led to the take-down. The DA's Office also initiated a civil forfeiture action against the 11 individuals and ten corporations to recover the more than $6.2 million stolen from insurers while the medical mill was in operation.

d. Arranged Car Fire

The defendant in this case reported to AIG Insurance Company that his 2007 BMW was stolen. He claimed that he had gone to Florida on 1/30/08 and when he returned home to Staten Island on the evening of 2/3/08, he did not notice whether his car was in its parking space across from his home. At

about 6 a.m. the next morning, he discovered the car missing. However, AIG's Special Investigations Unit reported to the Frauds Bureau that the car had been recovered on fire on Eastern Long Island early in the morning of 2/2/08, and the Suffolk County Arson Squad had deemed the fire incendiary. The Frauds Bureau and NYPD's Organized Crime Control Bureau conducted an investigation into the loss. During an interview, the defendant admitted that he had arranged to have his car destroyed by fire in order to collect on an insurance claim. He was arrested on 5/15/08.

e. Teacher Caught

A Utica woman was arrested on June 12 on charges that she fraudulently collected $52,983 in workers' compensation benefits while employed as an elementary school reading teacher for the Utica City School District. An investigation by the Frauds Bureau and the State Insurance Fund revealed that she claimed she was unable to work because of an allergic reaction she suffered while employed as a teacher at an upstate correctional facility in 1997. From October 2004 to December 2007, she accepted benefits to which she was not entitled.

f. Not a Great Hiding Place

An investigation by the Frauds Bureau led to the arrest on 9/12/08 of a police officer employed by the MTA on charges of filing a fraudulent $28,375 insurance claim for a diamond ring that he reported missing. The suspect, who is a lieutenant commander in the U.S. Naval Reserve, purchased the diamond for approximately $15,000 in July 2006 under a promotional program sponsored by USAA, an insurer that serves current and former military personnel. He reported that he had the stone set in an 18-karat gold setting valued at $2,200. In December 2006, he insured the ring through USAA for $28,375. The defendant reported the ring missing in 2007 and filed a claim stating that he lost the ring while taking it to a jeweler to be cleaned. Investigators later tracked the suspect's fiancée – who was not implicated in the case – and photographed the ring on her finger.

g. Rate Evasion

A federal grand jury in Buffalo returned a 46-count indictment charging two downstate residents with mail fraud in a "rate evasion" scheme to defraud AIG and Progressive Insurance Companies. Evidence gathered in this case indicated that the defendants counseled and assisted several New York City-area residents in obtaining lower-cost auto insurance by fraudulently claiming to live in Western New York. Auto insurance premiums are significantly lower in Western New York than in the downstate area. The indictment also alleged that the defendants provided the New York City residents with UPS Store addresses in Western New York that they fraudulently claimed were their residences. As a result, AIG and Progressive sold insurance policies at Western New York rates, rather than the truly applicable New York City rates. The scheme resulted in $729,000 in lost premiums.

h. Operation Direct Hit

A 19-month investigation led to the 10/29/08 indictment of 62 individuals charged with staging more than 40 auto accidents over a three-year period. The ring targeted unsuspecting drivers who, while backing out of a driveway or a parking lot, would be deliberately hit by a car full of passengers, all of whom were participants in the fraud. Occupants of the cars involved were then sent to the same Upper Manhattan medical clinic whose operators were knowing participants in the scheme. In fact, these operators allegedly paid "runners" up to $2,500 for each person referred to the clinic. The "patients" were also paid. The scheme defrauded insurers of $1.6 million. The investigation was conducted jointly by the Frauds Bureau, the Queens DA's Office, the FBI, and the NYPD's Fraudulent Accident Investigation Squad, with the assistance of the National Insurance Crime Bureau and several insurance companies.

i. Adjuster Kickbacks

Five insurance adjusters and four contractors were arrested on 12/2/08 for their participation in a kickback scheme involving inflated insurance claims on properties in Manhattan, Brooklyn and Staten Island. Four of the adjusters admitted accepting cash payments, as well as gifts and other gratuities, from the contractors in return for approving inflated repair estimates submitted by the contractors. Investigators said the contractors inflated the cost of repairs, kept a portion of the proceeds and gave part to the adjusters. In some cases, adjusters accepted such gifts as golf outings, golf equipment or dinners. The adjusters would then approve the inflated estimates as reasonable and pass them for payment to Chubb & Son, a division of Federal Insurance Company. Three of the adjusters who were employed by Chubb pleaded guilty to felony criminal bribe receiving and insurance fraud and were each sentenced to five years' probation, in addition to the following forfeitures: Stephen Curtis, $70,000; James Cassino, $60,000; and John Occhiogrosso, $13,000. A fourth adjuster, Joseph Fonte, is a public adjuster with no affiliation to Chubb. He was given a one-year conditional discharge and ordered to make a $5,000 forfeiture after pleading guilty to two counts of commercial bribery. The fifth adjuster, John Brady, also employed by Chubb, pleaded guilty to commercial bribe receiving and was sentenced on 1/13/09 to five years probation and fined $1,500. The kickbacks – which totaled an estimated $1 million – involved claims on about ten properties.

12. The Special Prosecutor Program

The Special Prosecutor Program is a pilot program initiated by the Insurance Department in which Frauds Bureau attorneys assist local DA's Offices with prosecutions. In 2008, the program was expanded to ten participating county prosecutor's offices. As part of the program, Frauds Bureau attorneys are cross-designated as assistant district attorneys and assist in all aspects of the cases to which they are assigned. Two such cases are summarized below:

- Three suspects pleaded guilty in Ulster County in connection with their agreement to burn a Chevy Blazer for insurance money. As a result, the insurer avoided paying out more than $38,000 on the fraudulent claim.

- A defendant in Delaware County pleaded guilty to two felony insurance fraud charges in connection with a fire that burned both his home and his car under suspicious circumstances. As a result, the insurer posted a savings of more than $150,000.

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 2008, investigators were assigned to the following DAs' Offices: Suffolk, Queens, Albany, Westchester and Monroe Counties.

13. Waiver of Co-Insurance

New York State has received more than $9 million in refunds and $78,551 in fines from five health care providers that inappropriately billed United Health Care, which administers the Empire Plan, the primary health insurance plan for State employees. The bills submitted by the providers did not reflect the fact that the out-of-network providers were systematically waiving co-insurance payments that were required to be paid by Empire Plan members. Because payments should reflect the actual charge, the bills were improperly inflated by the amount waived. Following reports by the New York State Comptroller that the providers were waiving the required co-insurance payments, the New York State Insurance Department conducted its own investigation and as a result received signed stipulations from four of the five providers. In those stipulations, the four providers agreed to pay civil fines to the Insurance Department and to reimburse United Health Care for the overpayment of the claims. The stipulations also state that the providers will discontinue the practice of waiving the co-insurance payments for Empire Plan members. These four providers are:

- Endoscopy Center of Long Island, which reimbursed the State $3,135,834 and paid a civil penalty of $31,358;
- Capital Region Ambulatory Surgery Center, Albany, which paid $2,225,015 in reimbursement and $22,250 in fines;
- Digestive Health Center of Huntington, Huntington, which repaid $1,332,120 and paid $13,321 in fines; and
- Day Op of North Nassau, Great Neck, which repaid $1,162,232 and paid a fine of $11,622.

The Department is negotiating fines and reimbursement with a number of other providers involved in this investigation.

14. 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. Approximately 90% of the Bureau's 2008 fraud reports (IFBs) were electronically transmitted and received remotely from insurers. Insurers have access to FCMS through the Department portal using secure accounts.

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

15. Mobile Command Center

The Department's Mobile Command Center (MCC) was involved in a variety of activities during the past year. The MCC was dispatched to New York City, following a March 15 crane collapse at a construction site on Manhattan's East Side where 18 buildings and more than 250 dwelling units were affected. Staff from the Frauds and Consumer Services Bureaus were on hand to provide immediate help to community residents with inquiries regarding insurance policies and coverage, claims filing and insurance-related complaints.

Staff from the Frauds Bureau were responsible for all functions and operations of the MCC. The MCC's communications capabilities enabled the business operations of the Department and the insurance industry to proceed efficiently, thus mitigating the time from response to recovery. The Department worked closely with the City's Office of Emergency Management and other state and federal agencies to help ease the burden on those affected by the tragedy.

The MCC was also on display at the Annual Disaster Preparedness Commission Conference on September 15-17, 2008. The Commission, chaired by the State Emergency Management Office, counts 23 State agencies and one volunteer organization – the American Red Cross – among its members. The Annual Conference offers an opportunity for each agency to publicize its accomplishments and activities, and to meet with members of the public. The MCC was highly visible at the conference and the Frauds Bureau's Manager of Technical Services conducted several demonstrations of the vehicle's capabilities for attendees.

16. Directions for 2009

a. Auto Give-Ups/Auto Arson

Arrests in cases involving auto give-ups spiked by 35% over the past year in New York State, up from 96 in 2007 to 130 in 2008. Fraud experts believe that the downturn in the economy may be a factor in the uptick, as owners abandon their cars or in many cases arrange to have them burned and

then report them stolen in an effort to collect the insurance payout. As the economy worsens, car owners can see give-ups as a means to avoid steep car payments or alleviate general debt. The Frauds Bureau will carefully monitor the auto insurance market during the coming year to keep abreast of fraud trends.

b. Special Investigations Unit Examinations

The Frauds Bureau's examiner staff performed a targeted audit of the SIU of a large auto insurer in 2008 and a Report on Examination will be issued in 2009. The Bureau will continue its examination of SIUs in the coming year. Insurers are selected for targeted examinations from those that have filed a Fraud Prevention Plan with the Department and have a history of complaints and/or concerns pertaining to their SIU operations and Fraud Plans.

The Frauds Bureau also supports and assists the Life, Health and Property Bureaus with market conduct examinations as requested by those Bureaus. The Frauds Bureau will continue to assist the regulatory bureaus with examinations in 2009.

17. Legislation

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

- Upgrading the status of Insurance Frauds Bureau investigators from peace officers to police officers, enabling them to act independently in the execution of such tasks as search and arrest warrants, court orders relating to electronic surveillance and summary arrests;
- Making it a crime to present materially false statements on an insurance application for personal lines insurance;
- Making it a felony for third parties, known as runners, to recruit patients and clients for health care providers and attorneys in insurance fraud schemes;
- Adding language to Section 176.05 of the New York State Penal Law to specifically include electronic and oral communications in the definition of insurance fraud;
- Requiring a periodic certification of continued eligibility by recipients of workers' compensation or disability benefits;
- Creating a class E felony for unlicensed insurance activity by any individual;
- Subjecting unlicensed insurance activity to civil penalties after notice and hearing before the Insurance Department;
- Increasing civil penalties for knowingly possessing, transferring or using fraudulent insurance documents;
- Creating a class E felony for possessing or uttering a false insurance document/instrument;
- Increasing penalties in the Vehicle and Traffic Law to reduce the number of uninsured or unlicensed motorists in New York State; and
- Amending Section 109 of the Insurance Law to increase the penalty from $500 to $2,500 for licensees who willfully violate the Insurance Law.

Section 405 of the New York Insurance Law requires the Superintendent of Insurance to submit to the Governor and the Legislature a comprehensive summary and assessment of the operations of the Frauds Bureau. Legislation passed in 2008 changed the submission date of the report from January 15 to March 15 of each year. The 2008 Frauds Bureau Annual Report is available on the Department's Web site at www.ins.state.ny.us.

F. INFORMATION SYSTEMS & TECHNOLOGY BUREAU

The Information Systems & Technology Bureau (Systems) provides information technology products and services to approximately 950 Insurance Department employees and supports the Department's technical infrastructure. Systems' clients include insurers, the public, federal, state and local agencies, other insurance regulators, actuaries, insurance examiners, frauds investigators, risk management specialists, real estate appraisers, lawyers, researchers and statisticians.

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

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

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

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

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

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

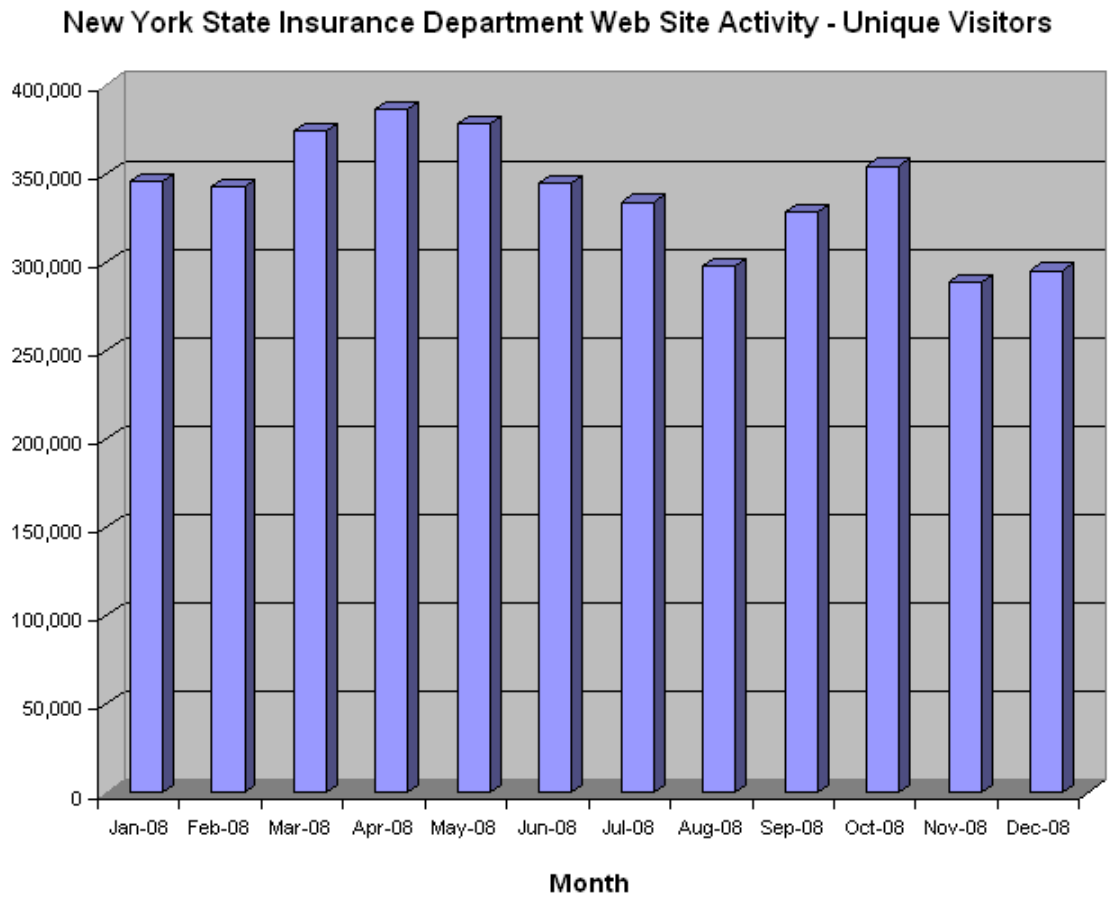
The Operations and Production Unit (OPU) is responsible for production and for the Computer Operations, and Help Center functions. The Help Center is the first line of support in assisting the client base, and encompasses a wide range of significant responsibilities and functions. Effective change control is the essential ingredient for an effective Operations and Production environment.

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

1. Web Site

The Department's 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 2008. In addition, a temporary Web site for the New York State Commission to Modernize the Regulation of Financial Services was implemented in 2008. The Department's activities and applications are reflected on these sites. In 2008, there were 4,069,204 unique visits to the Department's Web site. However, it was a 10.3% decrease from 2007. Despite this trend, the amount of Hits (page views per Visit) continued to increase since 2007, reaching 20,763,165 in 2008. The number of these visits, by month, is displayed in the following chart.

CHART H



For clarification, the following charts show the trends of Visits and Hits since 2000.

CHART I

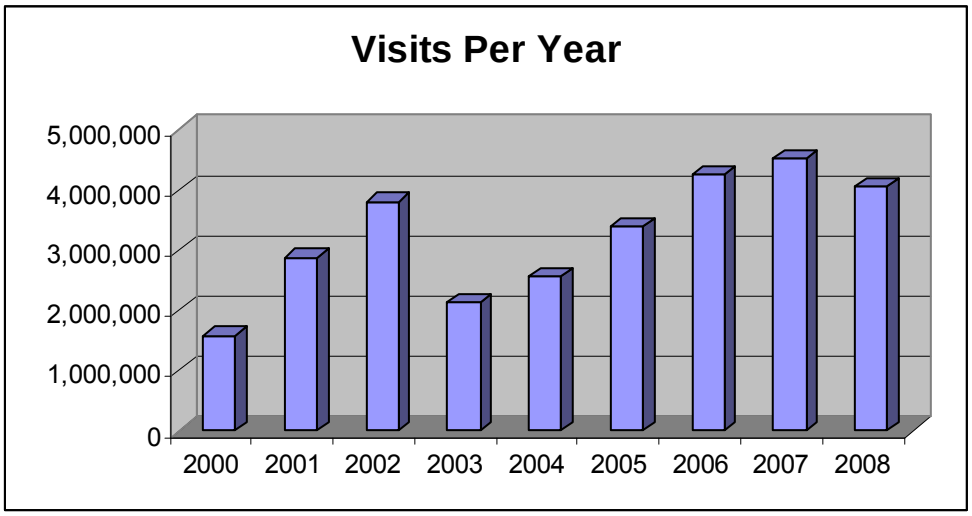
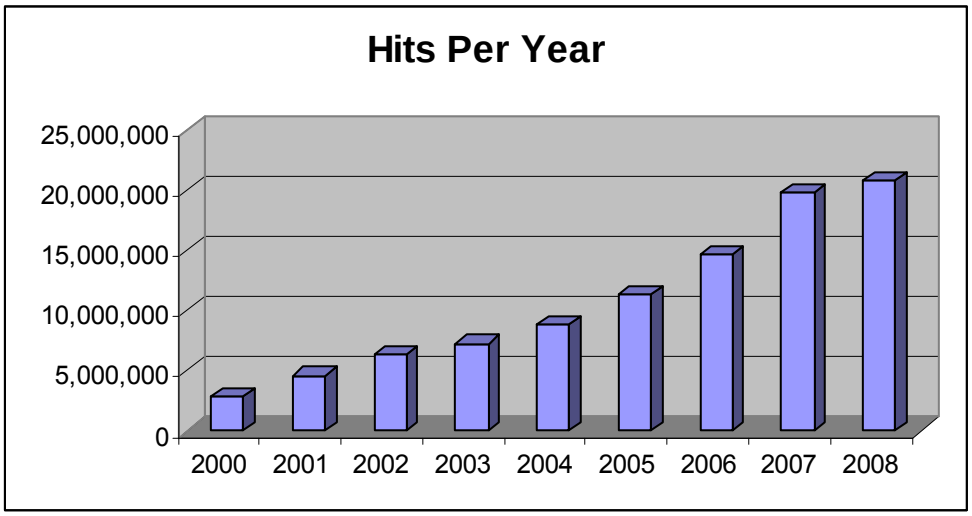


CHART J



The Department takes pride in its Web site's depth of content, relevancy, and currency.

In January 2008, a new Web site design was implemented to improve its overall layout, navigation, and usability. In March 2008, this design was changed to accommodate the gubernatorial change.

The following new accomplishments took place in 2008:

- New York State Commission to Modernize the Regulation of Financial Services This was a temporary Web site, implemented in 2008, and deactivated in January 2009. It was also the first Web site we administered with a .gov domain name.
- Healthy New York:

  - New XML-based rate updates
  - Guidebooks & Applications (links on HNY home page - replaces the Consumer Guide)
- Site Map (new)
- Department Webcasts
- New! OGC Opinion Index
- Circular Letters – all Circular Letters that have been distributed by the New York State Insurance Department since 1924 are now available via our Web site.
- Disciplinary Actions
- New! Disciplinary Actions Search utility - This new functionality is now available via our Web site, searching our summaries.
- E-Forms:
  - "Write the Superintendent"
  - "Request a Speaker" e-form
  - "Consumer Services Insurance Questions"
- Consumers: "Unemployment: Health Insurance Options" listing
- Department Application Forms Available to Public and Not Yet Available (coming soon) to the Public – per GORR mandate to NYS agencies.
- Links to Health Related Insurance Laws - per the migration of laws from the NYS Assembly site to NYS Legislative Retrieval System. The Department of State page now provides instructions and links to the new storage environment.
- New! "Industry Resouces" index page - for Agents and Brokers and Insurers
- Captives:
  - New! Compliance/Renewal Certificate (PDF)
  - Expanded navigation bar and site layout width to integrate the new certificate above.
- Disaster Preparedness and Response
  - Consumer Guide to Insurance for Natural Disasters
  - Hurricane Exercise 2008
- Examination Reports: New 'Report Key' and updated layout. This allows visitors to distinguish new and recent reports from older items.
- Public Hearings Indices (e.g. Broker Compensation, Out-of-Network Coverage)
- Department Public Hearings Index/Archive
- Consumer Federation of America - "Study of Website Information for Insurance Consumers" submission
- GHI & HIP (Emblem) Conversion information
- HMO Rates – monthly full listings of all 62 Counties
- AIG Hotline and FAQs

Other major accomplishments include:

- Consumer FAQs and Industry FAQs – expanded into sections.
- Updated “Top 10 Questions to Ask When Purchasing Insurance”
- Various resource (index) pages had the layout of their current content made more user-friendly
- HMO Rates - The code and design were updated to meet the parameters of OFT policies and Accessibility, and improve the maintenance.
- 2008 Consumer Guides (Automobile, HMOs, Homeowners, Health Insurers)
- 2008 Financial Property Company Pre-audit Questionnaire
- 2008 Informational CD – for the New York State Fair
- 2007 Annual Ranking of Automobile Insurance Complaints
- 2007 Annual Statement and New York Supplements
- 2008 Annual Ranking of Automobile Insurance Companies
- Publications and Downloads – merging of two original pages - "Downloads" and "Publications".
- External Appeal Program Annual Report - for the 2005 year (in collaboration with NYSDOH)
- Frauds Bureau Annual Report to the Governor

- Regulations: Five-year Review of Agency Rules, January 2008 Regulatory Agenda
- Workers' Compensation Rate Filing Index and 2007 Rate Filing Materials
- More "Fill-in" forms utilizing Adobe functionality
- Posted 77 NYIN Alerts
- Updated: 'Jump' and/or instruction pages for our online Licensing applications Removal: "Insurance Company Web Site Locator" section. A predecessor to our current “Insurance Company Search” application

2. Intranet

The Department’s Intranet is a strategic internal communication facility that contains a wide range of content relevant to Department staff. The Intranet is continually updated to facilitate quick exchange of information throughout the Agency.

New sections were implemented this year:

- LATS
- Memorandums of Understanding - This section contains, along with an index, the MOUs the Department has entered into with other government agencies, both domestic and foreign, for the purpose of information sharing.
- 'Albany Systems Recovery Status'

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

3. Annual Statement Filings

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

4. Imaging and Workflow:

The Complaint Imaging and Information Management System (known as CIIMS), is a full featured workflow imaging application, initiated in November 1998, to automate the processing of consumer complaints. Since that time, the system has been enhanced several times. In 2001 a web application allowed consumers to submit complaints on-line. In 2003 an on-line process was added for complaints

from Health care providers and responses from companies. In 2007, two units of the Property Bureau began using it to process their complaints and in 2008 modifications were made to enable the processing of Health Bureau complaints.

CIIMS has improved turnaround times for complaint handling and eliminated paper handling and filing since all documents are stored electronically. Although complaints and responses received by mail are scanned into the system, the amount of paper processed continues to decrease as electronic handling increases. In 2008 the number of complaints received on-line increased, representing 40% of all complaints received, compared to 33% and 28% in the previous two years. The number of on-line responses from insurers also increased in 2008 and represented 28% of all responses, up from 23% and 22% in the previous two years.

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

The Property Bureau and Health Bureau have increased their capabilities and continue to utilize imaging to enhance their Rate and Form Filing processes. They will continue to migrate to non-proprietary file formats to expedite the FOIL process, as well as 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 continue to assist in phasing out legacy mainframe applications.

5. Domino Workflow Applications

Workflow and collaboration initiatives continued to be engineered using IBM's Lotus Notes/Domino software. At the conclusion of 2008, the Department's Domino Application Portfolio was comprised of over thirty solutions that automate workflow, provide electronic document management and storage, deliver real-time reporting, maintain historical information, and leverage the Department's investment in Lotus Notes email using electronic routing and on-line collaboration. Applications are engineered using common framework and security, and an integrated development approach that optimizes our investment in our in-house development resources. These business applications replace manual and less efficient solutions, increasing staff productivity, reducing costs, and ensure business recovery and continuity.

During 2008, three new solutions joined our Portfolio suite:

- Health Regulation Tracking System – provides workflow management and collaboration for the Health Bureaus Proposed and Emergency Proposed Regulations and Circular Letters.

- Preservation Plan Tracking System – in response to changes in the Federal Rules of Civil Procedures, this solution was developed to centralize Department efforts and manage the collaboration of discovery documents subject to litigation suits.

- MERTS (Medical Emergency Response Team System) – is a notification system that is used by Department employees to notify the Department's Medical Emergency Response Team to respond to a medical emergency.

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

Additionally, significant enhancements were applied to the following applications:

- Property Filing Sign-Off Tracking Financial and Marketing systems - re-engineered to update obsolescent design, improve routing and storage of historical filing information.

- Direct Pay Contracts Tracking System – in response to changes in the procurement process for Direct Pay Contracts, additional flexibility was added to the calculation module of the application to facilitate real-time accounting of contracts that use non-billable hours methods, and the contact interface was re-engineered to allow for the selection of multiple examiner/examinee selections.

- Purchase Tracking System – a change in procurement procedures, subjecting all procurements over $500 to the additional approval of NYS Division of the Budget, resulted in the need to enhance the application to allow for the inclusion of a detailed justification of the procurement, and changes to the Department's approval routing for procurements.

6. E-Commerce

E-Commerce initiatives continued to provide significant value to our external constituents as well as Department staff. The number and variety of processes that are available on-line has expanded year after year and is now the "defacto standard" for processing licensing related activities. Agents and brokers can apply for their original license or renew their licenses when the time comes; they can pay their fees via a credit card and their relationships with insurance companies (appointments and terminations) are all handled quickly and seamlessly via the Internet. Processes that once took weeks or months to complete are now typically processed overnight. In 2008, the Department processed 73,609 credit card transactions totaling $10,348,421.51 on behalf of our customers without touching paper forms, handling checks, or bank deposits.

In response to legislation, the Department began the transition of the license renewal process from the license class boundary (life agents and brokers renewing their licenses in odd numbered years, while property agents and brokers renewed their licenses in even numbered years) to a date of birth boundary in 2007. This legislative change aligns New York with the other states in the nation and provides a more uniform approach to licensees by the regulators. The transition was successfully completed in 2008 while the Department continued to handle the day-to-day traffic as efficiently and effectively as our constituents have come to expect.

The voluntary electronic funds transfer of the Fire Tax 2% assessment continues to gain popularity. In 2008 the number of fire districts that opted to receive electronic payments was 1920, up from 1848 in 2007. Now over 86% of all fire districts receive their payments electronically and the dollar volume distributed this way was over $27.9 million. This increase in electronic payments continues to streamline what has traditionally been a paper intensive process.

7. Enterprise Portal

Sybase Enterprise Portal (EP) technology is a valuable business tool that provides on-line access to applications and information across platforms and back-end databases. The Portal's Security

Administration allows us to manage both internal and external clients by individual application. It sets in place a security structure in which each user can access those applications for which they are authorized to access and the roles they are authorized to execute. Applications for Department staff whether web based or legacy systems, use a single user id for accessing information across the entire Department. Some examples are: Central File, Inter-Active Insurance Company Search, OGC Opinions, OGC Historic and Summary and Industry Reports.

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

Among the enhancements to (EP) this year:

- 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 starting Jan. 1 & July 1, 2008 replacing the Legacy Model204 paper- based data entry system.

- 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. Implemented in January 2008, this single interface replaced separate paper filings.

- 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, replacing email submissions.

- The Disaster Planning, Preparedness and Response - Electronic Submission, mandated & required per Circular Letter#1, Insurance Law sections 301, 305, 308 , 2130 & 7001 -- A secure, on-line eForm, eQuestionnaire data collection plus eAttachment file submission starting April 1, 2008 & June 1, 2008 contained in a single interface. The application allows receipt of 3 eForms, 5 eQuestionnaires & 2 Disaster Response Plan 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 on Annual statement Filings for both hard copy and electronic for use by the Regulatory Bureaus (Life, Health and Property)

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

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

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

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

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

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

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

Sybase Enterprise Portal (EP) technology supports the requirement of full text search for OGC Opinions. OGC Opinions provides Public Opinions only for non-OGC staff members. Access to the full set of Opinions is maintained for OGC users through Portal security. OGC Opinions includes features for "highlighting" within the document retrieved.

8. Infrastructure

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

9. Disaster Recovery/Business Continuity

The Systems Bureau holds bi-weekly Systems Disaster Preparedness meetings covering disaster recovery and business continuity. Staff from all units meet and discuss current projects and issues. A matrix listing all current, ongoing, and completed projects are listed. Related documents are stored on the network, and on pen drives that staff carry with them. We also copy these documents on removable media as well. The Systems Bureau continues to contribute to the Department Disaster Recovery plan and participates in periodic preparedness drills.

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 transmit reports of suspected Fraud (IFB's) electronically. Insurers obtain remote access to FCMS through the Department's portal. In 2008, continued work on FCMS both improved upon and expanded the functionality of the system. FCMS now includes additional case management functionality and enhanced management reporting options.

The Frauds Bureau received approximately 23,000 reports of suspected fraud (IFB's) in 2008. Of these, approximately 89% were submitted by insurers remotely over the web. This is a 4% increase in electronic submissions over the previous year.

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

G. OFFICE OF GENERAL COUNSEL

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

1. Legal Opinions

The Office of General Counsel issues legal opinions interpreting the Insurance Law to insurers, trade associations, producers, consumers, and city, state, and federal agencies. These opinions also provide guidance about the Department's policies. OGC issued nearly 220 opinions in 2008. All non-privileged opinions are posted to the Department's website (www.ins.state.ny.us) and are available to the public. OGC also has a public opinion database with a search engine that is available to the entire Department. This extensive electronic database includes more than 12,000 publicly issued opinions of OGC dating from the 1930s to the present, and is updated weekly as new opinions are issued.

Among the corporate change matters that OGC supervises are applications by Article 43 health insurers to convert from not-for-profit to for-profit status, the review of which may culminate in the issuance of an Opinion and Decision from the Superintendent. In 2008, OGC continued its work on the proposed conversion to for-profit status of Emblem Health, Inc., by holding two days of public hearings and closely reviewing the proposed conversion plan and additional information obtained from the company, in consultation with the Department's banking, accounting, legal, and actuarial advisors. The review process is expected to conclude in 2009.

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 2008, the Department entered into approximately 440 stipulations imposing penalties on insurance companies or producers (i.e., agents or brokers). In addition, the Department conducted approximately 68 administrative hearings, which resulted in disciplinary action against approximately 58 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 2008, 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 in March 2008.

In December 2007, the Department entered into a stipulation with Allstate Insurance Company and its affiliates in connection with Allstate's improper nonrenewal of homeowner's insurance policies in coastal areas. Pursuant to the stipulation, Allstate agreed to discontinue the practice of nonrenewing homeowner's policies based on whether or not the policyholder had other insurance business, such as automobile or life insurance, with the company. During 2008, Allstate offered new policies to approximately 55,000 New York policyholders who had been improperly nonrenewed.

Working with the Department's Insurance Frauds Bureau and the Department of Civil Service, OGC assisted in the recovery of more than $9 million from healthcare providers who improperly waived coinsurance and thereby overbilled the New York State Health Insurance Program (NYSHIP) Empire Plan. The providers also entered into Department stipulations whereby they paid fines and agreed to discontinue the improper practices.

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

3. Special Projects

The Office of General Counsel contributes substantially to many special projects undertaken by the Superintendent. For example, throughout 2008, OGC attorneys provided substantial assistance in implementing the Superintendent's three-point plan to stabilize the financial guaranty insurance market by facilitating the injection of $11 billion in new capital into existing insurers, rapidly licensing two new market entrants, and crafting new legal guideposts for how financial guaranty insurers should operate.

OGC attorneys also took the lead in negotiating several Memoranda of Understanding that were signed in 2008 with various foreign regulatory authorities, including Bermuda, France, the United Kingdom, and Germany, allowing for international cooperation in regulation and regulatory enforcement.

In addition, OGC attorneys played a key role in drafting new legal guideposts regarding credit default swaps, the proposal of which led to a national discussion regarding the topic.

H. CAPITAL MARKETS BUREAU

1. General Overview

The Capital Markets Bureau (CMB), established nine 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.

Key initiatives from 2008 include:

- Furnishing examination support – including pre-planning and on-site participation.
- Working to analyze and closely monitor the Financial Guaranty Insurers, during their deteriorating structured finance risk, and interact with rating agencies, investment banks, and legislature on the subject.
- Applying financial analytics to investment portfolios of insurers, including directing more attention to subprime and other structured securities, as well as alternative assets, such as hedge, venture capital and private equity funds.
- Conducting training for the Department’s staff on capital markets and investment portfolio dynamics; and coordinating training on risk assessment and Sarbanes-Oxley.
- Evaluating Enterprise Risk Management, investment risk management practices, and corporate governance of select insurers.
- Interfacing with external entities, including other regulatory bodies, investment firms, risk management consultants, third-party asset managers, securities analysts, and rating agencies.
- Leading and participating in various NAIC Task Forces and Working Groups.
- Reviewing new and amended Derivative Use Plans of insurers, and monitoring derivative activities.
- Supporting the Department’s Office of General Counsel in consideration of credit default swaps, structured finance and other capital market activities.
- Assist in the AIG restructuring.
- Monitor securities lending activity by the industry.

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

CMB also continued to work in conjunction with the Life Bureau to establish and employ appropriate procedures and methodologies for evaluating the diverse investments held by the sizable public retirement systems in New York State. Ongoing development and further enhancement of key measures and review standards related to risk-based capital, risk management, organizational governance practices, and asset-liability management took place in 2008, and will continue to be addressed in 2009.

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, and the organizational and functional refinement of the NAIC's Securities Valuation Office (SVO).

2. 2008 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 utilized a template for transferring certain annual and quarterly investment data from applicable NAIC investment schedules for further analysis in conjunction with the Annual Statement and periodic reviews. The same review protocol was followed for pre-exam and fourth quarter meetings initiated by the Life, Property and Health Bureaus. 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 by mortgages.

The reviews culminated in reports submitted to the life, property and health bureaus. These reports featured the application of Bloomberg analytics to generate value-at-risk, duration, beta, and other equity and fixed income portfolio risk measurements, and when available or necessary, incorporated analysis of quarterly data. Additionally, migration in average credit quality of bond portfolios was highlighted. If applicable, the reports also included profiles on derivative usage. Depending on the outcome of the analysis, the risk management specialists recommended further action to the 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 2008, 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
2008

Type of Company	**Priority 1** Desk Audits	Pre-Exam Reports	**Targeted** Evaluations	**4th Quarter** Meetings
Health	**3**	**6**	**-**	**-**
Life	**35**	**14**	**20**	**16**
Property	**47**	**33**	**70**	**-**
Total	**85**	**53**	**90**	**16**

b. Derivative Use

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

Primarily, in conjunction with ongoing exams, CMB reviewed the annual Internal Control over Derivative Transactions CPA reports on derivative usage and adherence to regulations submitted by the companies that are being examined. The risk management specialists combined with examiners from the applicable Bureaus followed up with these 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
2008

TYPE OF REVIEW	LIFE	PROPERTY
New DUPs	**2**	**2**
Amended DUPs	**7**	**5**
Total	**9**	**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, derivative use plans, the status of various surplus notes, and the permissibility of cash deposits in various types of financial intermediaries and Certificates of Deposit exceeding FDIC coverage arranged through third parties.

d. Pension Supervision

During 2008, the Capital Markets Bureau participated in examinations of the New York State and Local Employees Retirement System and the New York State Teachers Retirement System ("the Systems"). CMB reviewed how the Systems formed and implemented policies and procedures they adopted to fulfill their fiduciary obligations. CMB evaluated the sufficiency of governance structure and

internal controls adopted to execute fiduciary duties. In addition, CMB reviewed the Systems' investment management, asset-liability management, and related policies, strategies and practices to assess how various risk factors and assumptions (including, but not limited to, market, interest rate, credit, and operational) have affected pension plan performance and how these risk factors and assumptions may impact the ability to meet future pension obligations.

e. Training Initiatives

Throughout the year, CMB staff also participated in teleconferences, investor briefings, and meetings held by various rating agencies and professional organizations. Moreover, CMB maintained its relationships with the leading insurance equity and credit analysts, ensuring critical access to their industry and company research.

CMB continued to participate in the NAIC International Internship Program by hosting interns from the Middle East and Eastern Europe. The Program is designed by the NAIC International Regulatory Cooperation Working Group to promote NAIC relations with foreign markets by emphasizing the exchange of regulatory expertise and technology. CMB staff provided the international interns an overview of the Bureau's analytical and evaluative processes, principal functions, and interface with the rest of the Department.

f. Special Projects

The Capital Markets Bureau was involved in several special projects stemming from capital markets developments in 2008. CMB staff researched technical topics and market transactions and provided recommendations, when applicable. Issues addressed by CMB throughout the year included the following:

- Financial Stress Testing – In November 2008, the Department took the lead in requiring New York domestic insurers to incorporate 'scenario stress testing' into their management processes. As the CMB conducts on-site reviews of its domiciliary companies, CMB will seek companies' plans to manage interest rate shocks, equity market shocks, yield curve shifts, changes in credit quality and liquidity, rating agency downgrades, collateral calls and large-scale catastrophes. .

- Enterprise Risk Management (ERM) is a process within an insurance company that evaluates the company's ability to identify, measure, aggregate, and manage risk exposures within predetermined guidelines. The CMB in conjunction with the other Bureaus met with several insurance companies who were developing and implementing ERM. The goal of this task is to (1) to create an evaluation criteria, while developing an audit and examination program as a guideline to assist examiners in assessing the Enterprise Risk Management function of the insurance companies (2) to assess how well the ERM function aggregates risk across key activities and (3) to assess how well insurers quantify risks within each of the significant risks detailed above. Ultimately, the assessment will be integrated within risk-focused examinations.

- Financial Guarantors – Problems in US structured finance have caused credit concerns in the financial guarantor industry. The CMB has worked closely with the department and Federal agencies in addressing these problems for NY domiciled financial guarantors.

- Reg 140 (Continuing Care Retirement Communities) – CMB revised and formulated proposed language for the part of regulation governing allowable investments and investment limitations. This project required multiple meetings with the Health Bureau's assigned actuary and

examination staff, in addition to a key meeting with industry representatives to discuss its equity proposal.

- Fraud and Money Laundering - Reviewed insurer's efforts to comply with statutes aimed at preventing fraud and money laundering such as the Bank Secrecy Act (which the Patriot Act extended to insurers), the Foreign Corrupt Practices Act, and the Office of Foreign Assets Control.

- Freedom of Information Act - CMB protected confidential information about a financial guarantor because the disclosure would have put the company at a significant competitive disadvantage; that protection was upheld by a New York state court.

- Quantitative models - reviewed quantitative loss models of external consultants. (ex. Rutter Associates, Thomas Ho, Andrew Davidson Associates, New Oak and Trepp) and financial guarantors. (Syncora and FSA).

- Credit Default Swaps – conducted seminary research and provided support to the Department's (OGC) consideration of regulating these instruments.

- Analyzed the strategy and fee structure of an alternative asset manager.

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

- Assessed dynamic hedging programs.

- Monitor securities lending activity by issuing circular letter 16 and Securities Lending 308 data requests with Property and Life bureaus

g. Other Activities

During 2008, the Capital Markets Bureau contributed to the formulation of legislative and regulatory proposals. These covered: (1) legislation related to increasing the number of licensed captive insurers; (2) proposed amendments to the Credit for Reinsurance Regulation to address collateral funding by non-U.S. reinsurers; and (3) the development of custodial asset regulation.

Throughout the year, CMB staff also gave capital markets presentations at the following outside venues:

- Life Insurance Council of New York Annual Legislative & Regulatory Conference.

- Enterprise Risk Management-ERM in the Wake of the Financial Crisis, The Regulatory View on ERM. Towers Perrin/National Underwriter conference.

- New York State Bar Association 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 Uniform Commercial Code Law Journal* published the Capital Markets Counsel's "Are Promissory Notes Securities?"

The Capital Markets Bureau continued supporting the Department's traditional role in leading major working groups, task forces, and projects for the NAIC's Financial Condition (E) Committee ("E Committee"). CMB coordinated many of that E Committee's solvency-related considerations relating to accounting practices and procedures, blanks, valuation of securities, the Insurance Regulatory Information System ("IRIS"), financial analysis, risk-focused and zone examinations, and examiner training. CMB often provides technical advice to other NAIC groups.

CMB personnel used their expertise in investment and risk management to play a critical role as New York's representatives when chairing, and performing the work of, the following major NAIC bodies charged with creating and implementing policies at the leading edge of insurance supervision policy.

Valuation of Securities Task Force ("VOSTF")

New York chairs the VOSTF to help state regulators examine and evaluate insurer's investments by establishing policies and procedures and suggesting programs to the Securities Valuation Office to support existing supervision efforts and educate regulators about new financial monitoring and management technology.

New York leads the VOSTF's review of new investment vehicles that insurers have purchased, or are anticipated to purchase, and the creation of new standards for the proper disclosure and reporting of these new vehicles through the annual statement disclosures. New York leads the VOSTF's development and adoption of an annual agenda for the SVO Research division.

The VOSTF is the NAIC's forum for proposed changes to, and interpretations of, the Securities Valuation Office's Purposes and Procedures Manual (the "P & P Manual"). The P & P Manual sets out the standards and operations for the SVO's: evaluation of the creditworthiness of certain securities; classification of securities for Risk-Based Capital purposes; and valuation of various types of securities. The NAIC has charged the VOSTF with the responsibility of maintaining consistency and conformity with the NAIC's Accounting Practices and Procedures Manual. Capital Markets Bureau personnel are leading a Task Force effort to significantly improve both. The Task Force coordinates its efforts concerning SVO administrative issues with the NAIC's Internal Administration (EX1) Subcommittee.

Capital Markets Bureau personnel are leading the Task Force's study of possible improvements to NAIC processes by which risks in new invested assets are evaluated, communicated, and monitored, and how the annual statement investment schedules could be made more transparent to better reflect non-credit risks (e.g., structural risks embedded in new and existing securities).

New York led a fundamental reform of how insurers report the values of securities they hold in their portfolios. The new valuation policy became effective at year-end 2008. In addition to disclosing fair value for all securities, insurers are also required to disclose the source for the fair value. In addition, New York's initiative to use fair value as the basis for a write-down for impaired securities was adopted into statutory accounting in the end of 2008.

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.

In addition, CMB personnel have provided the impetus and key support in the creation of the NAIC's new Rating Agency Working Group to assess how insurance companies, the insurance industry, and regulators use the products of Nationally Recognized Statistical Rating Organizations.

This Working Group will assess the current uses, identify the benefits and potential risks of those uses, and suggest improvements by which financial transparency and accountability can be improved.

Derivatives Markets Study Working Group ("Derivatives Study WG")

New York's leadership of the Derivatives Study WG arose from its primary position in the VOSTF, in regulating derivatives market participants, and in regulators' considerations surrounding the latest generation of hybrid securities. Those considerations raised questions as to whether the NAIC's Derivatives Instruments Model Regulation, drafted in 1996, needs revision. The Derivatives Study WG is charged with surveying and studying the derivatives marketplace, the relevancy and efficacy of the application of the model regulation to that market, and determining if insurance regulators' primary interests would be served by amending the regulation in light of changes in that marketplace. The NAIC decided the proposed updated Model Regulation will be national standards. A proposal to improve derivative disclosure in the annual statements was finalized and submitted to NAIC's Blanks WG.

Risk Assessment Working Group ("RAWG")

The Risk Assessment working group, chaired by NY, was dissolved in 2008 as it has completed its mission of enhancing the examination function by revising the Financial Condition Examiner Handbook. However, the Risk Assessment Implementation sub-group (RAIMS), which formerly reported to RAWG, will now report to the Financial Examiner Handbook Technical group and is still active. The RAIMS mission is to address issues which may arise in implementing the revised risk focused examination. NY is a member of the sub-group and the group continues its mission meeting periodically via conference call.

Invested Asset Working Group ("IAWG")

When the VOSTF determines that the technical nature of an issue before it would be best studied or advanced by a smaller group of regulators focused on more technical issues, it assigns those projects to the IAWG. The IAWG, when it has completed its deliberations, returns the issue, with its recommendations, to the VOSTF. These issues and recommendations may include changes to statutory accounting guidance, annual statement instructions, blanks reporting instructions, asset valuation reserves, interest maintenance reserves, risk based capital charges, valuation procedures for invested assets, credit assessment procedures for invested assets, or similar solvency supervisory solutions. Capital Markets Bureau personnel have taken a major role in leading the work of this Working Group's "Risk Subgroup" to identify, and develop methods to quantify, investment risks that would materially affect the risk profile of insurers' portfolios.

CMB personnel have provided key support to this group's consideration of risks other than credit that inhere in various securities and using that information to implement a reporting system that makes insurers' exposure to investment risk more transparent.

h. New Professional Personnel

Caryn Bailey joined CMB in March 2008. She has over 10 years experience in the securitization industry as well as managing diverse portfolio of debt instruments. Working in the public and private sector, her tenure has been within the following institutions: Tucker, Anthony & R.L Day, a subsidiary of John Hancock, Federal Reserve Bank of New York, Standard and Poor's, and Citigroup. Ms. Bailey's academic experience includes an Economics degree from Hofstra University, with graduate degrees from both Long Island University in finance, as well as, New York University in real estate.

Margot Small joined CMB in May 2008. She comes to the bureau with over 20 years of experience in capital markets and has a PhD. in mathematics from Columbia University. She has worked on pricing fixed income and equity derivatives as well as designing, constructing and testing portfolio management systems and credit and market risk systems. After initially working at Salomon Bros, she held a variety of officer positions at Salomon Smith Barney (Citibank), Credit Lyonnais (now Calyons), and PaineWebber (now UBS). Directly prior to coming to the bureau, she was an assistant professor in the Mathematics Dept at Queensborough Community College teaching calculus and business mathematics.

I. DISASTER PREPAREDNESS AND RESPONSE BUREAU

1. General Overview

The Disaster Preparedness and Response Bureau (DPR) commenced operations on March 1, 2004. The principal function of the Bureau is to assist the Insurance Department and the New York insurance industry to prepare for, mitigate, respond to, and recover from natural and man-made disasters including modern day terrorism. The Department is the first insurance department in the nation to create such a bureau, dedicated solely to disaster preparedness.

During the past year, the Bureau was engaged in a number of initiatives outlined below to assist the Department in meeting its objectives.

2. Disaster Response/Business Continuity Circular Letters

The DPR Bureau continued to collect disaster preparedness data from the Department's licensees through the issuance of annual circular letters. This process of collecting data from Department licensees has evolved since 2004 when a single circular letter was used to collect data from all companies, into the issuance of separate circular letters to property and casualty type companies, health companies, and life companies, respectively.

Circular Letter No. 1 (2008) was issued on February 4, 2008 to all authorized property/casualty insurers, co-operative property/casualty insurers, financial guaranty insurers, mortgage guaranty insurers, title insurers, reciprocal insurers, captive insurers, registered risk retention groups, rate service organizations, State Insurance Fund, New York Property Insurance Underwriting Association, New York Medical Malpractice Insurance Plan, New York Automobile Insurance Plan, Motor Vehicle Accident Indemnification Corporation, and Excess Line Association of New York.

Circular Letter No. 2 (2008) was issued on February 4, 2008 to all accident and health insurers, and Article 43 corporations; employee welfare funds; licensed Public Health Law Article 44 health maintenance organizations and integrated delivery systems, and municipal cooperative health benefit plans.

Circular Letter No. 3 (2008) was issued on April 16, 2007 to all authorized life insurance companies, retirement systems and fraternal benefit societies.

Each of the circular letters were tailored to the specific entity, and addressed best practices that should be utilized in planning for and responding to natural and man-made disasters that affect the respective insurers.

The circular letters request all entities licensed to do business in New York to submit data to the department on an annual basis. To avoid the appearance of "rule making" without going through the process spelled out in the State Administrative Procedures Act (SAPA), the Department must re-issue the circular letters annually. Regulation 191 was drafted during the year to obviate the need for circular letters. The Regulation remains on the Department's Regulatory Agenda for 2009, and is anticipated to progress through the SAPA process in time for the 2010 data call.

3. Disaster Response Questionnaires and Plans

As a follow-up to activities which began when the original circular letters were issued in 2004, all property and casualty type companies, health companies, and life companies were required to re-submit a "Disaster Response Plan Questionnaire" and "Disaster Response Plan" to the Department by June 1, 2008. A total of 829 companies were expected to report information to the Department.

The Bureau received some 429 Disaster Response Plan Questionnaire submissions covering 737 companies; reports from 691 of these companies were among those expected to submit the report. This represents a response rate of approximately 83% as 691 of 829 companies expected to submit the report did so. Among the 691 companies, approximately 96% indicated that they had a disaster response plan in place that met the requirements of the governing circular letter.

During 2008, the Bureau received 373 new Disaster Response Plans and 101 renewal statements. (Renewal statements indicate that a company's previously submitted plan was not updated during the ensuing year.) Of the 373 newly submitted plans, 273 have been reviewed, and the Bureau has forwarded follow-up letters to 93 companies requesting updates and amendments to their Disaster Response Plans. Follow-up requests are made after a review of individual company plans. The decision to forward a follow-up letter is based upon comparison of the company plans with a checklist of items suggested as best practices.

4. Business Continuity Plan Questionnaires and Plans

All property and casualty type companies, health companies, and life companies were also required to re-submit a "Business Continuity" Questionnaire to the Department by June 1, 2008. Due to proprietary concerns the entities were not required to submit their Business Continuity Plans to the Department, but were required to submit an attestation stating that such a plan existed, and answer specific questions for the Department. Examiners from the Bureau would then verify the existence of such a Plan upon examination. The Bureau received some 394 submissions covering 707 companies; 675 of these companies were expected to submit this report. This represents a response rate of approximately 81%, with 675 of the 829 entities expected to submit this report having done so. Of the 675 companies, approximately 94% indicated that they had a business continuity plan which was both "in place and up-to-date".

5. Pre-Disaster Data

Circular Letter No. 1 (2008) also required companies writing commercial or personal property insurance in New York State to submit a "Pre-disaster data/information survey" by April 1, 2008. Each property/casualty insurer provided the Insurance Department a listing - by New York State County - of property exposure information, as of December 31, 2007 for personal lines (non-auto) and commercial lines (non-auto) for each authorized member within an insurance company group. The report that was compiled in 2008 contained data from 264 entities representing 332 of the 381 companies that were expected to report data to the Department. These 332 companies wrote 96.2% of the 2007 direct written premium for the personal and commercial property lines covered in the report.

Planning for a disaster or emergency is just as critical as responding to its aftermath; therefore the Department collects and analyzes data from a variety of sources. The data can be used to pre-position resources and plan for resource allocation in the aftermath of the disaster. This process becomes extremely critical to insureds who expect prompt and fair payment of their claims. The data is collected and used to provide accurate, timely and consistent information to other government and volunteer agencies who also share a critical role in emergency response.

6. The Pandemic Flu Survey

During 2008, the Department issued a Pandemic Flu Survey to all Department licensees to determine the level of pandemic influenza preparedness by the insurance industry and to bring awareness to the industry of the need to have a pandemic flu plan. The data on the life and property companies was segregated from the health companies. The Department received 239 submissions representing responses from 502 property and life insurance companies combined. Based upon the responses processed, approximately 68% of the companies had a pandemic flu plan; an improvement

over the previous year when approximately 47% of all such companies indicated that they had such a plan. The Department also received 30 submissions representing responses from 61 health insurance companies. The responses indicated that, approximately 57% of the health companies had a written pandemic flu plan and another 23% were in progress of writing one.

The Department also led the insurance industry's response to the Pandemic Flu Exercise that was organized by the Financial and Banking Information Infrastructure Committee (FBIIC). FBIIC is one of the critical infrastructure groups within Homeland Security and is headed by the US Treasury Department.

7. The Insurance Department Portal

The Department began collecting data pursuant to Circular Letters Numbers 1, 2, and 3 (2008) through the Department portal effective March 2008. Companies can now submit the data for the Disaster Response Plan Questionnaires, the Disaster Response Plans, Business Continuity Plan Questionnaires, Pre-Disaster data, Post-Disaster data and the Pandemic Flu Survey directly through the Portal. Previously, companies were required to send the information to the Department via email or some other type of electronic media or submit hard copies. This method of submitting data to the Department via the portal promotes a more secure environment for the companies to submit data to the Department and enhances the accuracy and efficiency of the data collection process.

8. The Department's Disaster Recovery/Business Continuity Plan

The Bureau continues to update the Department's Disaster Recovery/Business Continuity Plan (the Plan) to be consistent with the Continuity of Operations/ Comprehensive Emergency Management Plan (COOP/CEMP) format recommended by the State Emergency Management Office (SEMO). The COOP/CEMP includes the Department's efforts in planning for a pandemic. The Plan is based on a comprehensive risk assessment and requires staff training which the Bureau will provide.

The Plan allows the Department to continue mission-critical operations in the event of a disaster directly affecting the Department, and includes evacuation procedures. It also requires testing and updating annually.

9. Examination of Insurers' Disaster Response Plans

During 2008, members of the DPR Bureau visited two property and casualty insurers and one health insurer to verify that the disaster response plans that were submitted to the Department were functional and that key employees of each of the insurers visited were aware of their roles during a disaster. Based upon the results of these examinations, DPR Bureau is confident that the companies examined are capable of responding to disasters that affect their insureds. The results of these on-site examinations continue to reflect the trend in the industry of increased awareness and reassures the Department that insurers will be ready to respond effectively to New York's policyholders in the event of a disaster.

10. New York Information Network (NYIN)

The Bureau is responsible for maintenance of the Department's electronic information network. NYIN is a password-protected area on the Department's Web site that contains directives, advisories, and other terrorism-related information addressed to insurers. NYIN also includes an Intelligence/Information Mailbox enabling participants to exchange intelligence and other information with the Department. There are currently 1,256 entities registered to receive NYIN notifications with a total of approximately 3768 participants. During 2008 the Department issued 76 NYIN cyber security notifications ranging from vulnerabilities discovered in Adobe Reader and Adobe Acrobat to malicious *"phishing"* activities.

11. Public Access Defibrillator (PAD) Program

The PAD program requires the voluntary participation of Department employees who are certified in cardiovascular pulmonary resuscitation (CPR), automated external defibrillation (AED), and first aid. The Bureau developed a PAD administrative program of protocols for the use of PAD and CPR during a medical emergency that occurs in any of the Department's offices. The PAD program establishes a medical emergency response program that includes trained and equipped PAD responders who, with appropriate medical oversight, will provide early defibrillation in the event of sudden cardiac arrest. The goal is to defibrillate within three minutes of a witnessed collapse or discovery of the victim. The PAD responders will apply CPR as necessary. The Department currently has 44 trained volunteers in the New York City office, 21 in the Albany office, six in the Mineola office, two in the Buffalo office and one in the Rochester office. According to New York State's Office of General Services, average agency response throughout the state was between two and three volunteers per floor with one AED per floor. The Department exceeded both the ratio of AEDs per floor and volunteers per AED. The large number of volunteers will better serve not only our employees but any visitors to the Department.

On February 14, 2008, the DPR Bureau, in cooperation with the Systems Bureau, released an enhancement to the PAD program which increased the efficiency of the system. All employees of the Department now have an icon on their Lotus Notes Inbox which enables them to email all responders at any one of the Department's facilities with a simple click of the mouse. Prior to the installation of this system which is called the Medical Emergency Response Team System (MERTS), employees were required to send notification of a medical emergency to the volunteers via a beeper system. The beeper system is still functional, but serves as a redundancy to the MERTS.

12. West Workspace

The Bureau is involved in maintenance of, and training members of the Department in the use of, West Workspace. West Workspace is a Web-based communication tool operating on the Extranet. It allows for exchange of documents, data, and messages when the Department's own Wide Area Network (WAN) or Local Area Network (LAN) has been impaired. It is used to store mission-critical data, and provides a virtual online meeting room where Department staff can meet and continue business operations especially during emergencies. We expect that its usefulness will also serve the Department should predictions of a pandemic become a reality.

13. The Incident Command System

Pursuant to the Governor's Executive Order, and modeled after State Emergency Management Office's (SEMO's) Incident Command System, the Department has developed its own framework of managers who have been assigned specific roles/titles in the event of an actual disaster. Members of the Bureau have been attending on-going training in the use of the Incident Command System.

14. Interaction with NYS Homeland Security

Under Homeland Security Presidential Directive (HSPD)-5, all states must adopt the National Incident Management System (NIMS) which is a consistent nationwide approach for Federal, State, local and tribal governments to work effectively and efficiently together to prepare for, prevent, respond to and recover form domestic incidents. States must meet NIMS compliance in order to receive federal funding for disaster assistance. State agencies are required to certify the degree to which they comply with NIMS using the NIMSCAST assessment tool, and "roll-up" the results into the state's comprehensive results.

The Insurance Department has met 92% of the compliance objectives for 2008. The Bureau hopes to improve the Department's compliance percentage, as staff members receive additional training.

15. Life Safety Procedures

The Bureau oversees the semi-annual employee fire drills and evacuations procedures. The Department had developed a series of Cohort locations where employees may assemble and be accounted for in the event of an incident that requires the full evacuation of the Department's Albany and/or New York City offices. The Bureau continues to be responsible for the maintenance of the employee lists that are used to facilitate Department protocols in the event such an evacuation is warranted. The Bureau has also updated the evacuation procedures that are posted on the Department's intranet, by adding maps of cohort locations and a new Emergency Action Plan. The Bureau has revised evacuation procedures and has trained members of the Department in safe evacuation procedures.

The Bureau assisted in the creation of an Employee Toll-Free Safe Line. The Toll-Free Safe Line provides a means for employees to report their location and condition to the Department after a disaster, emergency evacuation, or other event requiring an emergency response. Additionally, employees can obtain and exchange vital information related to both safety and work assignments. This procedure provides management with the ability to ensure that all employees are accounted for and to provide instructions (*i.e.,* building closings, when to report to work, etc.) to the employees calling in to the Toll-Free Safe Line. The Bureau performed a test of the Employee Toll-Free Safe Line during 2008 to determine the effectiveness of the system. Based upon the results of the test, the Bureau will conduct additional tests during 2009.

The Bureau is also exploring the use of NY-ALERT to notify employees of emergencies that may impact their ability to get to/from their work location. NY-ALERT is New York State's all hazards alert and notification system. It is a web-based portal that offers one-stop access through which State agencies can provide emergency information to a defined audience. The Bureau is also exploring other uses for NY-ALERT.

16. Emergency Resource Guide

In January the Bureau issued upper-level management updated copies of the Department's Emergency Resource Guide (ERG). The ERG provides management with information needed to effectively respond to emergencies affecting the Department directly or the citizens of the state insured by the Department's licensees. The ERG:

- Contains excepts from the Department's Comprehensive Emergency Management Plan/Continuity of Operations Plan (CEMP/COOP);
- Describes emergency employee notification procedures;
- Provides a listing of emergency contact numbers,
- Delineates the role of Department's Insurance Emergency Operations Centers (IEOCs) in coordinating insurance industry disaster response;
- Provides instructions for the use of the West Workspace which serves as a repository of emergency preparedness information and provides high-level Department managers a back-up emergency communications channel;
- Details the Department's emergency response procedures, and
- Provides building specific evacuation procedures for Departmental offices in New York City and Albany.

17. Disaster Recovery Assistance

One initiative that has arisen from our experience after Sept 11 and the recent series of hurricanes that devastated the Gulf Coast is the need to establish a pre-credentialing program in conjunction with state and city governments. One such program which includes department and industry officials is the NYC-OEM electronic card reader project. The electronic card reader project is an advanced credentialing system that permits only authorized persons to enter the disaster zone. This initiative already instituted by this department involves working with NYC-OEM and BNET (Business Network of Emergency Resources) to establish a Corporate Emergency Access System (CEAS). The CEAS program permits a "first response team" of adjusters from the largest property and casualty writers in the area of the disaster to gain early access to a disaster site for the purpose of evaluating the total loss within the disaster site in an expeditious manner.

The Department has also worked with BNET to encourage the property and casualty insurers to join the CEAS program to enable their adjusters to gain access to the disaster sites as soon as the area is declared safe by municipalities. To date, 425 CEAS cards have been issued to companies for use by their adjusters. Bureau staff is involved in this ongoing effort to expand recognition of the CEAS Adjuster Card Program by local emergency and law enforcement jurisdictions throughout the state.

The Department has also enrolled "Essential Employees" of the Department in the CEAS program. These employees are considered critical to the ongoing operations of the Department during a disaster. The CEAS program for the Department would permit these essential employees to gain access to the Department's offices within New York City and Nassau County during an emergency. The Department currently has 123 employees enrolled in the program.

J. CAPTIVE INSURANCE GROUP

1. General Overview

On August 7, 1997, Governor George E. Pataki signed into law Chapter 389 of the Laws of 1997, which permits the formation and operation of captive insurance companies (captives) in New York State via Article 70 of the Insurance Law and other amendments to the Insurance Law and the Tax Law. The Law became effective December 5, 1997.

Captive insurance companies are insurers owned by the insureds and organized for the main purpose of self-funding the owner's risk. Captives are often referred to as "alternative insurance mechanisms." As of December 31, 2008, there were 50 captive insurance companies authorized in New York. The assets of these 50 captive insurers posted total assets of $13.9 billion, total liabilities of $6 billion and capital and surplus of $8 billion. In addition, these captives had net income of $1.2 billion, paid premium taxes of $6.8 million and had net premium written of $940 million.

There has been explosive growth in captive formation in the past year. In addition, the Department has a dedicated captive team, responsible for the licensing of all captive insurers in New York. The team provides a direct link to decision-makers, features a streamlined licensing process, and the easing of administrative burdens after licensing through regulation that is distinct from the regulation of traditional insurance companies.

2. Legislative Proposals

The Department has proposed revisions to the current law to address certain restrictions that have hindered the growth of New York captives. Governor Paterson has submitted legislation to the New York Legislature to effectuate these changes. They include:

- Reducing the threshold level for a parent to form a pure captive to $25 million of net worth or annual revenue. The bill also provides flexibility for the Superintendent to approve other thresholds if the parent demonstrates that it is otherwise qualified to form and operate a captive as a subsidiary;
- Reducing the threshold level for entry into a group captive to a parent whose net worth or annual income exceeds $12.5 million;
- Broadening the definition of "affiliated companies" to enable the parent's contractors and subcontractors to be insured by the captive; and,
- Allowing public entities (municipalities, authorities and others) to form pure or group captives as public benefit corporations or Not-for-Profit corporations that would be exempt from state and local fees, taxes or assessments.

These changes would enhance the appeal of New York as a domicile for the new wave of captive insurer formations. The Department will still be able to effectively regulate these insurers under the framework established by Article 70 of the Insurance Law. Since New York is a leading global business center, the New York State Insurance Department is committed to establishing an appropriate regulatory environment for the operation of captive insurers. New York offers domiciled captive insurers tax rates competitive with other captive jurisdictions, minimal investment restrictions and the authority to write almost all types of property/casualty coverages.

K. TRAINING & PROFESSIONAL DEVELOPMENT

Staff training is a core priority for the Department. The professional development needs of the Department's employees are so diverse that it is important to offer a variety of courses in several categories to assist individuals in the pursuit of the skills they need. Subjects are offered in the following areas: Management Development, Experienced Insurance Examiners, Insurance Examiner Trainees, Administrative Support Staff Development, and General.

Since the inception of the Management Development Program in 2005, four groups, totaling 87 managers, have completed the program. The purpose of the Management Development Program is to provide management and leadership skills to mid and high-level managers so that they are better prepared to do their jobs. This is accomplished by contracting experts in those fields to come to the Department and share their knowledge and skills through training sessions. The fourth Management Development Program Group of 32 managers participated in a 15-month program which concluded in July, 2008.

The Advanced Management Development Program was developed in response to requests from participants in the original Management Development Program, who wanted to build on and master their newly developed skills after the initial program ended. The Advanced MDP consists of nine sessions presented over 15 months, with subjects including: Moving from an Operational Manager to a Strategic Thinker, Personal and Organizational Development, Managerial Leadership with a Team Project, and The Rewards for Managers of Using Collaboration to Solve Problems and Accomplish Goals. Twenty six managers have enrolled of which 19 successfully completed the program in June 2008.

Professional development of experienced examiners is encouraged through on-the-job training and attendance at bureau-wide seminars. In 2008, one such seminar was coordinated, addressing current issues facing the Department and the insurance industry. The National Association of Insurance Commissioners' (NAIC) presented six training classes for 148 Examiners participated. These courses dealt with such topics as Teammate Training, Audit Computer Language (ACL), Polishing Report Writing Skills for Risk Focused Examinations, and other relevant classes. In addition to attending training, examiners also pursue professional designations through professional societies. This past year, 37 insurance examiners successfully completed 66 professional examinations working toward their designations.

Newly hired insurance examiner trainees are required to participate in a two-year training program, consisting of a combination of lectures, seminars, workshops and classroom instruction, in addition to their regular work assignments. The training program is designed to provide trainees with an overview of the insurance regulatory framework in New York State, including an understanding of insurance, financial solvency regulation, product regulation, availability and affordability issues, and treatment of policyholders. In 2008, there were 64 trainees participating in the training program which consisted of the following: trainees hired in 2006 and completing the traineeship in 2008, trainees hired in 2007 and still in the traineeship, and new hires appointed in 2008. The trainees attended 64 days of classes this past year that were designed specifically for them. Twenty-eight trainees completed their traineeship in 2008, 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. Eleven classes with 177 participants were offered in 2008. Training consisted of topics such as Building Successful Interpersonal Skills at Work, Telephone Skills and Customer Service, and a Secretarial Skills Refresher Course.

There are three classes that all Department employees are mandated to attend: Sexual Harassment Prevention, Ethics Training and Diversity Awareness. The Sexual Harassment Prevention course has been modified by the Governor's Office of Employee Relations (GOER) since most

Department staff had initially attended. As a result, many employees were required to take the class as a refresher. A total of 206 staff participated in the class. The Ethics Training had a total of 270 participants, while Diversity Awareness had a total of 53 participants.

In addition to the above, the Department offered training of a general nature. These courses were either conducted on premises, or through other agencies and vendors. A labor relations training program for supervisors, developed by the Governor's Office of Employee Relations, was expanded upon this year to include additional topics such as performance and productivity, constructive discipline, and grievances, specific to our agency. Other courses of a general nature included such topics as Facilitating Productive Meetings, Leadership, Successful Business Writing, Performance Evaluation for Supervisors, Making Technology Work for You, and Unintentional Intolerance. In all, 171 staff took advantage of these classes.

The Department also participates in the NAIC sponsored International Program for Education and Regulatory Cooperation (IPERC) by hosting interns from foreign countries. The aim of IPERC is to foster learning and provide technical assistance to insurance regulatory professionals from countries with emerging insurance markets. The interns spend five weeks at the Department learning about insurance regulation in New York State and receive hands-on training in their areas of interest. To date, we have hosted a total of 16 interns from the countries of India, Brazil, China, Egypt, Saudi Arabia and Bulgaria. Three Egyptian interns were hosted in the spring of 2008 and two Saudi Arabian interns were hosted in the fall. The main objectives of two of the Egyptian interns were to learn about the U.S. insurance market and products with a special emphasis on property and casualty actuarial issues and rate and form regulation, while the objective of the third intern was public and media relations. Two Saudi Arabian interns were hosted in the fall of 2008. The main focus of their internships was to study the licensing process, form and rate filing and approval process and fraud prevention.

In addition, the Department hosted a high ranking intern from the Insurance Department of the Republic of Paraguay for four days. The intern whose title is Chief of the Administrative Summary Proceedings and Legal Processes Division, concentrated on legal issues with special emphasis on fraud prevention and investigations, agent and broker stipulation hearings and market conduct investigations.

Professional development is also encouraged through the use of the Training Library to support the insurance examiners' pursuit of professional designations. In 2008, 52 examiners took advantage of the library's loan program and borrowed 108 books. In order to keep up with industry developments, the library was updated and enlarged to include new materials, including 350 new books for examiner trainees and executives.

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, Agencies in Partnership for Training courses, and web sites for workshops or tuition support for members of CSEA, PEF and MC employees.

L. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORP.

1. History of the Corporation

The Motor Vehicle Accident Indemnification Corporation (MVAIC) was originally created to provide compensation for injuries to persons who, through no fault of their own, were involved in accidents with hit-and-run drivers, operators of stolen vehicles or uninsured motorists. This law became effective on January 1, 1959. The tort law has since been amended so that comparative negligence is now the law of the State of New York. In that respect, MVAIC's obligations to provide compensation have changed.

Qualified claimants (persons who are residents of the State of New York or of another state that has a similar program, and who do not own automobiles or are not resident relatives of a household where there in an insured vehicle) receive maximum benefits under the no-fault law.

As a result of the enactment of Section 5221 of the Insurance Law, effective December 1, 1977, the corporation also became involved in the payment of no-fault, first-party benefits as of that date. It should be noted that the Corporation must provide for the payment of such first-party benefits only to qualified persons who have complied with all the applicable requirements of Article 52 of the Insurance Law. Amendment 19 to Regulation 68, effective September 1, 1985, permits MVAIC to arbitrate no-fault cases thus eliminating the necessity of commencing Declaratory Judgment Actions in unresolved coverage questions.

Effective July 22, 1989, Section 5208 (a)(1) was amended by the legislature and the bill signed by the Governor. This amendment extended the time from 90 to 180 days within which a claimant must file his/her affidavit of "intention to make claim" with this Corporation, only if there is an identified defendant. The 90 day time limit is still applicable to hit and run cases. Further, if the claim was originally against an insured person whose insurance carrier has denied the claim, then the affidavit must be filed within 180 days after the receipt of said disclaimer or denial.

In June 1995, the New York State Legislature amended Section 1 Paragraph 1 of subsection (f) of Section 3420 of the Insurance Law to increase the New York financial responsibility limits from $10,000 per person, $20,000 per accident to $25,000 per person and $50,000 per accident. These limits are equally applicable to uninsured claims submitted to MVAIC. This law took effect January 1, 1996.

2. New Legislations Enacted

The New Legislation enacted in 1999 effective March 1, 2000. Self-Insured 5014 A (Chapter 511 Laws of 1999) -- This new law increased the self-insured assessment per vehicle from $1.50 to $3.50. The DMVB will continue to handle the self-insured fees as previously done.

New Regulation 68 (No Fault)-Repeal February 1, 2000; for accidents on or after February 1, 2000. The major provisions are:

- Notice of PIP claim must be made in 30 days rather than 90 days
- Health service providers must present their bill to the insurance carrier and/or MVAIC within 45 days after the date of treatment rather than 180 days in current regulations.
- The new regulation authorizes PIP insurers to do an Examination Under Oath (EUO) of PIP claimant.
- Wage Loss Claims must actually be made within 90 days from the date of accident instead of no requirement

- The arbitration rules have been changed with the AAA, now being responsible for administrating all conciliation and administration. Previously, the Insurance Department handled conciliation and more administration including medical fee schedule.
- Also effective February 1, 2000 the monthly interest penalty rate is 2% instead of 21% monthly compounded.

3. Source of Funds

The Corporation is funded through levies on insurance companies transacting automobile liability insurance in the State of New York in accordance with Section 5207 of the Insurance Law.

Other sources of funds include fees collected from self-insurers by the New York State Department of Motor Vehicles under Sections 316 and 370-4 of the Vehicle and Traffic Law, investment income and subrogation recoveries.

4. 2008 Activity

Year End Reserves	2008	2007
Case Outstanding Reserve Tort & Pip	$23,076,182.00	$19,983,263.00
Incurred But Not Reported	$17,256,408.00	$18,772,818.00
Unallocated Loss Adjustments ULAE	$12,685,720.00	$12,685,720.00
Spec. Reserve for Alloc. Exp	7,000,000.00	7,000,000.00

- MVAIC received 10,024 new Notice of Intention to Make a Claim in 2008. This represents a 12% increase over 2007.
- The No-Fault unit received 1018 new claims in 2008. This was an increase of 3% or 27 over 2007.
- MVAIC opened 1008 new Tort claims in 2008, an increase of 3% or 27 over 2007
- Claims paid for Tort and No Fault cases slightly increased in 2008 to $14,530,974 compared to $14,486,231 paid during 2007.
- The number of pending claims at the close of 2008 was 2,736 compared to 2,111 in 2007

III. INSURANCE LEGISLATION ENACTED

(Legislation is presented in numeric order based on 2008 Chapter Law)

This section of the Annual Report covers bills enacted during the 2008 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.*

Workers' Compensation Rates

Chapter 11 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill establishes a new method for setting workers' compensation rates in New York, in which a rate service organization (RSO) will file "loss costs." The bill also sets forth certain governance structure requirements for the RSO licensed in New York. Specifically:

The bill repeals Insurance Law § 107 (a)(54), which defines the terms "workers' compensation rating board" and "New York workers' compensation rating board" -- terms that will no longer exist in the Insurance Law.

The bill adds a new Insurance Law § 2304(g) to define the term "loss costs" for workers' compensation insurance as that portion of the rate that is intended to represent the anticipated costs of claims and associated loss adjustment expenses, including one or more trend factors.

The bill amends Insurance Law § 2305(e) to require the Superintendent to hold a public hearing if an RSO makes a loss cost filing for workers' compensation that reflects an increase of at least 7% over the filings from the prior year.

The bill permits RSOs to file with the Department loss costs or other statistical data, including rating plans pertaining to workers' compensation insurance beyond February 1, 2008.

A new Insurance Law § 2313(t) is added to establish certain governance and other structural requirements for a workers' compensation RSO. In particular, this section of the bill sets forth the structure of the RSO's governing body, the function of the governing body and particulars regarding the governing body's control and supervision over the RSO's finances. This section also requires a workers' compensation RSO to have an actuarial committee, an underwriting committee and a medical and claims committee, and describes the function of each committee.

The bill amends Insurance Law § 2316(a) to allow insurers and RSOs to continue to exchange statistical information in the context of workers' compensation insurance, which is barred by current law after February 1, 2008.

The bill amends Insurance Law § 2305(b) to provide that the loss cost multiplier ("LCM") for each insurer providing coverage for workers' compensation will be promptly displayed on the Department's website and updated in the event of any change.

The bill amends Insurance Law § 2339(d), which sets forth certain restrictions on the rates that the State Insurance Fund ("SIF") may charge its insureds, to conform them to the new loss cost system.

Effective date: The bill takes effect on February 1, 2008. The RSO governance provisions are deemed repealed on June 2, 2013, and the ability of a workers' compensation RSO to file loss costs terminate on that date. Last action: Approved and signed by the Governor on January 31, 2008.

Rental Vehicles

Chapter 14 of the Laws of 2008 amends the General Business Law as follows:

Summary: The bill Amends section 4 of Chapter 656 of the laws of 2002 amending Section 396-z of the General Business Law by extending the sunset provision from February, 2008 to June 30, 2013. Chapter 656 amended the General Business Law with respect to rental vehicles, including:

- Making vehicle renters responsible for damage to rental vehicles in their possession.

- Authorizing rental companies to make available optional vehicle protection (also known as a "collision damage waiver") which entitles the purchaser to a waiver of claim by the vehicle rental company with regard to virtually any damage to the vehicle, regardless of fault.

- Comprehensive consumer protection provisions, including measures designed to ensure that rental customers are aware that their automobile insurance policy may provide collision coverage while renting a vehicle.

Effective date: Immediately. Last action: Approved and signed by the Governor on February 19, 2008.

Flood Insurance; Notice

Chapter 21 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends §3444 of the Insurance Law to require the notice explaining that mudslide and flood insurance are not included in homeowners or in dwelling fires policies accompany all new homeowners and dwelling fire personal lines policies and all renewals of such policies.

Effective date: 180 days after enactment. Last action: Approved and signed by the Governor on March 4, 2008

Fraternal Benefit Society Modernization

Chapter 22 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends the Insurance Law to provide fraternal benefit societies with the same opportunities to engage in investment practices that are currently provided to life insurance companies, and to give the Superintendent authority to ensure fraternal benefit societies remain solvent. Specifically:

The Superintendent is provided the authority to mandate that all fraternal benefit societies maintain a surplus.

- The Superintendent is provided the authority to require fraternal benefit societies to submit records describing each society's communal activities and take other actions that the Superintendent deems appropriate in his efforts to oversee the society's investment activities.
- The Superintendent is provided enhanced authority to ensure that fraternal benefit societies that wish to engage in certain investments in New York, remain solvent.

- The provisions of Insurance Law § 1105, pertaining to insurance companies authorized in New York voluntarily ceasing to maintain a license in New York, is made applicable to fraternal benefit societies.

- Certain fraternal benefit societies are permitted to engage in the same investment practices that life insurance companies may engage in pursuant to sections 1402, 1403, 1405, 1406, 1410, 4240, and Article 17 of the Insurance Law.

Effective date: Immediately. Last action: Approved and signed by the Governor on March 4, 2008.

Eating Disorders; Treatment Facilities

Chapter 24 of the Laws of 2008 amends the Public Health Law as follows:

Summary: The bill authorizes the Department of Health (DOH) to issue provisional identification of Comprehensive Care Centers for Eating Disorders (CCCEDs) and authorizes the Office of Mental Health (OMH) to develop regulations for residential providers of care for individuals with eating disorders, in furtherance of Chapter 114 of the laws of 2004.

The Commissioner of Health is authorized to provide provisional identification for two years to a CCCED if it meets all the criteria of Public Health Law Sec. 2799-g, except for the residential care. Such DOH authority will expire on June 1, 2010, in anticipation that OMH regulations will be in place for a residential services and care for individuals with eating disorders.

Effective date: Immediately. Last action: Approved and signed by the Governor on March 4, 2008.

Life Companies; Foreign Investments

Chapter 60 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill increases the aggregate amount of foreign investments that domestic life insurers are permitted to make under N.Y. Ins. Law § 1405 to a total of 22% of admitted assets from 15% of admitted assets. The bill also expands the aggregate investment limit under N.Y. Ins. Law § 1405(a)(7)(C) to investments in jurisdictions rated “BBB”(investment grade), and adjusts the counterparty requirements applicable to foreign currency hedges for domestic life insurers with derivative use plans approved pursuant to N.Y. Ins. Law § 1410.

Effective date: The bill takes effect immediately. Last action: Approved and signed by the Governor on April 23, 2008.

Derivative Transactions

Chapter 71 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill makes permanent the law permitting domestic life, property/casualty, reciprocal, mortgage guaranty, co-operative property/casualty, and financial guaranty insurers to enter into derivative and replication transactions in accordance with written derivative use plans approved by the Insurance Department. The law authorizing such transactions was scheduled to sunset as of June 30, 2008.

Effective date: The bill is effective immediately. Last action: Approved and signed by the Governor on May 7, 2008.

Domestic Life Companies: Accumulation of Surplus

Chapter 72 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill makes permanent provisions of Insurance Law Section 4219, which places a limit on the amount of surplus that domestic mutual life insurers and domestic stock life insurers that issue participating policies are permitted to maintain. In 2005, Section 4219 was amended to allow stock life insurers to utilize the risk-based capital (RBC) formula that was already authorized for domestic mutual life insurers. The 2005 amendments also provided for the inclusion of reserves and liabilities of accident and health insurance policies and for the inclusion of the reserves and liabilities of wholly-owned subsidiaries of life insurers. These amendments were scheduled to sunset on December 31, 2008.

Effective date: The bill is effective immediately. Last action: Approved and signed by the Governor on May 7, 2008.

Excess Line Association of New York (ELANY)

Chapter 130 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends chapter 630 of the laws of 1988 to extend the Excess Line Association of New York's (ELANY) statutory authority from July 1, 2009 through July 1, 2014.

Effective date: Immediately. Last action: Approved and signed by the Governor on June 30, 2008.

Excess Medical Malpractice

Chapter 132 of the Laws of 2008 amends the Insurance Law as follows:

Summary: This bill extends the expiration date from July 1, 2008 to July 1, 2013 the provisions of Section 2 of chapter 673 of the laws of 2005 to eliminate the requirement that the Medical Malpractice insurance pool (MMIP), the insurance of last resort for medical malpractice insurance for eligible physicians, dentists and podiatrists, offer a second layer of excess medical malpractice insurance to such health care providers. Without this extension MMIP would be required to provide a second layer of excess medical malpractice insurance in the involuntary market despite the fact that no MMIP member insurer will provide in the voluntary market such coverage to its own policyholders.

Effective date: The bill is effective immediately. Last action: Approved and signed by the Governor on June 30, 2008.

Property/Casualty; NYPIUA

Chapter 136 of the Laws of 2008 amends the Insurance Law as follows:

Summary: This bill extends or makes permanent provisions of the Insurance Law that are designed to promote stability in New York's property/casualty insurance market. The bill is also designed to ensure the availability of property insurance in New York's coastal areas and throughout the state. Highlights include the following:

- The bill creates a new Insurance Law provision pertaining to flexible rating for nonbusiness automobile insurance policies. The new provision permits insurers with no more than 750 policies in-force to submit a plan of withdrawal to the Superintendent, for the Superintendent's approval, subject to certain enumerated standards, such as the requirement that the proposed withdrawal plan contemplate minimizing any market disruption and not be detrimental to the public.

- The bill extends the sunset dates of certain provisions of Article 23 of the Insurance Law, which pertains to property/casualty insurance rates. The file-and-use and flexible rating provisions set forth in Article 23 will stay in effect for three additional years.

- The bill extends the “2% rule” set forth in Insurance Law § 3425.

- The bill makes NYPIUA (New York Property Insurance Underwriting Association) permanent.

Effective date: The bill takes effect immediately, except that sections eleven and twelve take effect January 1, 2009. In addition, the amendments to subsection (g) of section 5412 (g) of the Insurance Law do not affect the expiration of such section. Last action: Approved and signed by the Governor on June 30, 2008.

Equity Index Accounts; Annuities

Chapter 170 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends the standard nonforfeiture law for annuities to allow for an alternative approach to determining minimum values for paid-up annuity, cash surrender, and death benefits in equity indexed annuity contracts. The bill also makes technical amendments to the nonforfeiture law, and adds disclosure requirements to Insurance Law § 3209 for equity indexed annuity contracts. Specifically:

- Insurance Law § 4223(c) is amended to explicitly make the standard nonforfeiture law for annuities applicable to each fixed account option available under a deferred annuity contract; include language to reflect transfers among these accounts within the contract; and codify the Insurance Department’s interpretation that death benefits are not surrenders subject to surrender charges.

- A new basis for determining minimum values for paid-up annuity, cash surrender, and death benefits in equity indexed annuity contracts is established.

- The withdrawal charge provision set forth in Insurance Law § 4223(e)(3) is amended to require a 1% reduction in the withdrawal charge each year after the third year reducing to zero after the tenth year.

- Insurance Law § 4223(f) is amended to clarify how the present value of any paid-up annuity benefit available as a nonforfeiture option is calculated for contracts that do not provide cash surrender benefits and contracts that do not provide any death benefits prior to the commencement of annuity payments.

- Insurance Law § 4223(k)(1) is amended to require the annual report to identify the minimum accumulation value, equity index value, and any changes in the participation rate, margin, cap, floor, or other factor used in the equity index formula.

Insurance Law § 3209(b) is amended to establish disclosure requirements for deferred annuities with an equity index account.

Effective date: The bill is effective ninety days after it becomes law, and authorizes the Superintendent to promulgate rules and regulations necessary for implementation. Last action: Approved and signed by the Governor on July 7, 2008.

Life Insurance-Minors

Chapter 178 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends Insurance Law § 3207(b) to increase the monetary limitation on the amount of life insurance that a person may purchase on the life of a minor from $25,000 to $50,000.

Effective date: Immediately. Last action: Approved and signed by the Governor on July 7, 2008.

Annual Statements, Life Companies

Chapter 263 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends Insurance Law § 4233 to establish new life insurer annual statement reporting requirements relative to employee and director compensation, as follows:

- Insurance Law § 4233(b)(3) is amended to require life insurers to report the following information on their annual statements:

    1. the compensation and name of the chief executive officer;

    2. the four most highly paid executive officers discounting the CEO, regardless of the amount of the compensation;

    3. the subsequent five employees whose individual total compensation exceeds $100,000;

    4. all directors, other than those officers or employees who have otherwise been disclosed pursuant to paragraph Insurance Law § 4233(b) and who also serve as directors; and

    5. a list of the job titles and compensation for any officer or employee not otherwise disclosed pursuant to Insurance Law § 4233(b), where the individual's total compensation is in excess of $750,000.

- "Compensation" consists of any and all remuneration paid to, or on behalf of, an officer, employee or director during the year, including wages, salaries, bonuses, commissions, stock grants, gains from the exercise of stock options and any other emolument.

- Amounts disclosed for directors must include all compensation paid for services on the board and committees, as well as any other compensation for any other activity or service, such as consulting agreements.

Effective date: Immediately. Last action: Approved and signed by the Governor on July 7, 2008.

Grace Periods, Life Insurance

Chapter 264 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill makes the grace period and premium due notice requirements for flexible premium life insurance products (universal and variable universal life) consistent with the provisions currently set forth in N.Y. Comp. Codes R. & Regs. tit. 11, Part 54 (2003) (Regulation 77), as follows:

- Insurance Law § 3203(a)(1) is amended to require a life insurance policy in which the amount and frequency of premiums may vary, to contain a provision that entitles the policyholder to a 61-day grace period within which they are required to pay a sufficient premium to keep the policy in force for three months.

- Insurance Law § 3211(a)(1) is amended to prohibit an insurer from terminating, for non-payment of premium, installment, or interest on a policy loan, within a year of nonpayment, a life

insurance policy in which the amount and frequency of premiums may vary, unless the insurer mails a notice of premium due to the policyholder within 30 days after the day that the insurer determines that the net cash surrender value under the policy is insufficient to pay the total charges that are necessary to keep the policy in force.

- Insurance Law § 3211(b)(1) is amended to require an insurer or fraternal benefit society to mail a premium due notice to the "policyowner," not the insured person.

- Insurance Law § 4510(a)(1) is amended to require certificates issued by fraternal benefit societies, in which the amount and frequency of premiums may vary, to set forth a provision that entitles the insured to a grace period of at least 61 days within which to pay a sufficient premium to keep the certificate in force for three months.

Effective date: Ninety days after enactment. Last action: Approved and signed by the Governor on July 7, 2008.

Group Life Insurance

Chapter 306 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends §§ 3220 and 4216 of the Insurance Law to permit employers to purchase group key person life insurance. Prior to this legislation, businesses seeking to purchase key person life insurance could only do so by purchasing individual life insurance policies for each employee that they choose to cover.

Effective date: Immediately. Last action: Approved and signed by the Governor on July 21, 2008.

Accounting of Certain Assets

Chapter 311 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends §§ 1301(a)(1)(9)(14)(20)(21) and (22); 1302 (a)(1) and (2); 1305 (a); 1308(b); 1405(b)(1)(c); 1414(c)(1) and (2) and 4105(a) of the insurance law to alter what can be treated as an admitted asset and what is considered a non-admitted asset for the purposes of the presentation of insurance company financial results in their annual and quarterly statements. The bill also makes necessary conforming
changes to §§1305, 1308, 4117, 6203 and 7010 of the Insurance Law.

Effective date: July 21, 2008. The bill applies to annual and quarterly financial statements required to be filed pursuant to Sections 307 & 308 of the Insurance Law, and by public health law article 44 health maintenance organizations, integrated delivery systems, prepaid health service plans, and comprehensive HIV special need plans, for periods ending on or after the effective date. Last action: Approved and signed by the Governor on July 21, 2008.

Group P/C

Chapter 318 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill expands the definition of certain kinds of insurance an insurer may write in New York and makes Insurance Law § 3442 permanent. Specifics include:

- The bill amends Insurance Law § 1113(a)(7) to include coverage for a "stolen identity event" under the definition of "burglary and theft insurance."

- The bill amends Insurance Law § 1113 (a)(17)(C) to include coverage for “other educational expenses,” in addition to tuition, in the definition of “credit insurance.”

- The bill adds a new subparagraph (F) to Insurance Law § 1113(a)(17) to include coverage for event ticket protection in the definition of “credit insurance.”

- Insurance Law § 3442(d) is amended to permit credit card issuers, debit card issuers, and banks to provide group coverage via their credit cards, debit cards, or checking accounts for: loss resulting from the inability to use an event ticket, not to exceed $750 per ticket; loss due to the cancellation of a catered affair, not to exceed $30,000 in any twelve-month period; loss of tuition and other educational expenses due to a student’s dismissal or withdrawal from an educational institution, not to exceed $60,000 in any twelve-month period; loss resulting from the cancellation or interruption of a trip, not to exceed $15,000 per trip; and physical loss of, or physical damage to, personal property in connection with a specific trip, not to exceed $1,000 per article of personal property, and $5,000 in the aggregate for all insureds per trip.

- Insurance Law § 3442(d) is amended to allow an authorized insurer to provide coverages that the Superintendent determines to be limited in scope, and not duplicative or a substitute for other more comprehensive coverages.

- A new Insurance Law § 3451 is added to permit an authorized insurer to issue an identity theft insurance policy on a group basis.

- A new Insurance Law § 3452 is added to permit an authorized insurer to issue a property travel insurance policy on a group basis.

- The bill eliminates the sunset provision in Insurance Law § 3442, thus making the law applicable to credit cards programs permanent.

Effective date: Most provisions effective ninety days after enactment. Last action: Approved and signed by the Governor on July 21, 2008.

Workers’ Compensation Notice

Chapter 322 of the Laws of 2008 amends the Workers’ Compensation Law as follows:

Summary: The bill requires insurers and the State Insurance Fund to file notification with the Workers' Compensation Board (the "Board"), within 30 days of issuance, of the reinstatement, amendment or endorsement, of any contract for workers' compensation or disability insurance. Specifics include:

- Workers' Compensation Law § 54 is amended to add a new paragraph 5-a to require all insurance carriers and the State Insurance Fund to file notification with the Board within 30 days when they issue, reinstate, amend or endorse any insurance contract for workers' compensation coverage.

- Workers' Compensation Law § 54 is amended to perrmit the Board to impose a penalty of up to $500 against insurance carriers or the State Insurance Fund for each 10-day period they fail to file notice, and against group self-insured trusts that fail to file notice.

- A new paragraph is added to Workers' Compensation Law § 54 (5) to provide that in the event that a cancellation or termination notice is not filed with the Board within the required time period, the Board shall impose a penalty in the amount of up to $500 for each 10-day period the insurance carrier or the State Insurance Fund failed to file the notification.

- A new Workers' Compensation Law § 266 (6) is added to require all insurance carriers and the State Insurance Fund to file notification with the Board within 30 days when they issue, reinstate, amend or endorse any contract for disability insurance. The Board may impose a penalty of up to $100 against insurance carriers and the State Insurance Fund for each 10-day period they fail to file notice.

Effective date: Ninety days after enactment. Last action: Approved and signed by the Governor on July 21, 2008.

Medical Malpractice, RBC

Chapter 385 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends Section 1324 of the Insurance Law to provide the Superintendent with the authority to exempt both stock and non-stock domestic P&C companies from risk based capital requirements. Previously, the Superintendent's authority extended only to non-stock companies.

Effective date: Immediately, deemed repealed December 31, 2011. Last action: Approved and signed by the Governor on July 21, 2008.

Declaratory Judgment Actions

Chapter 388 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill permits a party suing an insured individual in a personal injury or wrongful death action to commence a declaratory judgment action against the defendant's liability insurer, in limited circumstances where the insurer has disclaimed liability or denies coverage based on the failure to provide timely notice. The bill also prohibits a liability insurer from denying coverage for a claim based on the failure to provide timely notice, unless the insurer suffers prejudice as a result of the delayed notice. The insurer must demonstrate that the failure to provide notice materially impairs its ability to investigate or defend the claim.

Effective date: 180 days after enactment. Last action: Approved and signed by the Governor on July 21, 2008.

Age Discrimination, Public Health Law

Chapter 515 of the Laws of 2008 amends the Public Health Law as follows:

Summary: The bill adds a new paragraph to Public Health Law § 2803, to require the New York Patients' Bill of Rights and Responsibilities to include a provision informing patients of their right not to be discriminated against on account of age.

Effective Date: The bill is effective 180 days after it becomes law, and authorizes the Commissioner of Health to amend and/or repeal any rules and regulations necessary to implement the bill. Last action: Approved and signed by the Governor on August 25, 2008.

Health Insurance Premium Rates; Sole Proprietors

Chapter 517 of the Laws of 2008 amends the Insurance Law as follows:

Summary: The bill amends Insurance Law §§ 3231(i)(2) and 4317(f)(2) to extend the cap on premium rates that an insurer may charge an individual proprietor who purchases health insurance coverage

through association groups, including chambers of commerce, through December 31, 2011. The rate cap will continue to be 115% of the rate established for the same coverage issued to groups. The rate cap was scheduled to expire on December 31, 2008.

Effective date: The bill is effective immediately. Last action: Approved and signed by the Governor on September 4, 2008.

Managed Long Term Care; Certificate of Authority

Chapter 627 amends the Public Health Law as follows:

Summary: The bill allows certain eligible managed long-term care applicants that were designated as such prior to April 1, 2007, to be held to Medicare service capitation criteria that are more akin to the criteria that were in effect prior to April 1, 2007.

Specifically, the bill amends Public Health Law § 4403-f(3)(f) to permit managed long-term care plan applicants that have their principle place of business in Bronx county, were designated as eligible applicants prior to April 1, 2007, and are unable to achieve full capitation, readiness, and capability for Medicare services, to demonstrate readiness and capability on a scheduled basis or the capability and protocols for benefit coordination for Medicare services.

Effective date: Immediately. Last action: The bill was signed by the Governor on September 25, 2008.

Wellness Programs

Chapter 627 amends the Insurance Law as follows:

Summary: The bill adds a new Section 3239 to the Insurance Law to permit insurers, Article 43 corporations, HMOs, and municipal cooperative health benefits plans to offer wellness programs designed to promote health and prevent disease. Specifics include:

- The bill defines a “wellness program” as “a program designed to promote health and prevent disease that may contain rewards and incentives for participation.” Wellness programs may include, but are not limited to, the use of a health risk assessment tool, smoking cessation programs, weight management programs, a stress management programs, worker injury prevention programs, nutrition education programs, and health or fitness incentive programs. The terms of the wellness program must be set forth in the policy or contract.

- The bill specifies the permissible rewards that may be provided under a wellness program. These rewards include full or partial reimbursement of the cost of participating in a smoking cessation or weight management program, full or partial reimbursement of the cost of membership in a health club or fitness center, the waiver or reduction of copayments, coinsurance, and deductibles for preventive services covered under the policy, and monetary rewards in the form of gift cards or gift certificates, as long as the recipient is encouraged to use the reward for a product or a service that promotes good health.

- The bill provides that group policies and contracts may contain rewards or incentives that involve a discounted premium rates, or rebates or refunds of premium, provided that the discounted premium rate, or the rebate or refund of premium, is based on an actuarial demonstration that the wellness program can reasonably be expected to result in the overall good health and well-being of the group. However, the bill prohibits a discounted premium rate, or rebate or refund of premium, for community-rated plans.

- The bill permits accident and health insurers, Article 43 corporations, HMOs, and municipal cooperative health benefits plans to base rewards on group members meeting specific standards based on a health condition. In those cases, the wellness program must meet the requirements of 45 C.F.R. Part 146.

The bill also amends Insurance Law § 4224(c) by adding the phrase “except as permitted by section three thousand two-hundred thirty-nine of this chapter” to the beginning of the subsection, which provides, among other things, that no insurer, broker or other stated entity shall give any person an inducement not specified in any policy or contract, nor shall any person knowingly receive as such inducement, any rebate of premium, or policy fee.

Effective date: Immediately. Last action: The bill was signed by the Governor on September 25, 2008.

IV. Regulations Promulgated, Amended or Repealed

The following is a summary of Insurance Department regulations promulgated, amended or repealed in 2008.

The 38th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards For Form, Content And Sale Of Health Insurance, Including Standards Of Full And Fair Disclosure (Effective on an emergency basis since 2/5/07) (Adopted on a permanent basis effective 3/5/08)

The Insurance Law authorizes the Superintendent to establish standard provisions for accident and health insurance coverage, and to promulgate regulations governing minimum standards for the form, content and sale of such coverage.

Chapter 748 of the Laws of 2006 (commonly referred to as "Timothy's Law") became effective on January 1, 2007, less than two weeks after it was signed into law. The law requires insurance companies, Article 43 corporations and HMOs to provide coverage for inpatient and outpatient mental health services in certain policies and contracts that are issued, renewed, modified, altered or amended on or after that date. This regulation requires insurers, Article 43 corporations and HMOs to notify their policyholders, certificateholders, and members of the impact of Chapter 748 on their coverage and to provide a toll-free customer service telephone number from which policyholders, certificateholders and members may obtain information on their mental health coverage.

The 30th Amendment to Regulation 83 (11 NYCRR 68): Charges for Professional Health Services (Adopted on a permanent basis effective 4/16/08)

Chapter 892 of the Laws of 1977 recognized the necessity of establishing schedules of maximum permissible charges for professional health services payable as no-fault insurance benefits, in order to contain the costs of no-fault insurance. In order to contain costs, the Superintendent is required to adopt those fee schedules that are promulgated by the Chairman of the Workers' Compensation Board. Effective July 11, 2007, the Workers' Compensation Board issued two new fee schedules, one for prescription drugs and the other for durable medical equipment, medical/surgical supplies, orthopedic footwear, and orthotic and prosthetic appliances.

This rule repeals the fee schedules previously established by the Insurance Department for prescription drugs, durable medical equipment, medical/surgical supplies, orthopedic footwear, and orthotic and prosthetic appliances. The charges for these goods and services are now covered by the two fee schedules established by the Workers' Compensation Board. In addition, the proposed rule clarifies that a pharmacy is deemed to be a provider of health services for purposes of eligibility for direct payments pursuant to Regulation 68-C.

The 5th Amendment to Regulation 146 (11 NYCRR 361): Market Stabilization Mechanisms for Individual and Small Group Health Insurance And Medicare Supplement Insurance (Effective on an emergency basis since 10/4/06) (Adopted on a permanent basis effective 6/25/08)

Regulation 146 was originally promulgated pursuant to the requirements of Chapter 501 of the Laws of 1992 and the statutory authority set forth in Section 3233 of the Insurance Law, which require the Superintendent to promulgate regulations designed to encourage insurers to remain in or enter the small group or individual health insurance markets, and promote an insurance marketplace where premiums do not unduly fluctuate and where insurers and HMOs are reasonably protected against unexpected, significant shifts in the number of persons insured who are ill or who have a history of poor health. In addition, Section 3233 of the Insurance Law specifically directs the Superintendent to create a pooling process involving insurer contributions to, or receipts from, a fund designed to share the risk of or equalize high cost claims and claims of high cost persons. The Fifth Amendment to Regulation

146 is the result of comments and suggestions received by the Insurance Department in relation to the current market stabilization pool.

Under the Fifth Amendment, the current market stabilization pool is phased out. Payments, collections and data reports were not required in 2005, and the new pooling methodology established by the proposed amendment was established in 2006 and became fully operational in 2008.

The 1st Amendment to Regulation 119 (11 NYCRR 42): Workers' Compensation Insurance Rates (Effective on an emergency basis since 9/19/07) (Adopted on a permanent basis effective 6/25/08)

Chapter 6 of the Laws of 2007 established comprehensive reforms to New York's Workers' Compensation Law by: (1) increasing maximum and minimum benefits for injured workers and indexing the maximum to New York's average weekly wage; (2) dramatically reducing costs in the workers' compensation system, thus making hundreds of millions of dollars available annually to be translated into premium reductions; (3) establishing enhanced measures to combat workers' compensation fraud; (4) replacing the Special Disability Fund with enhanced protections for injured veterans; (5) preventing insurers from transferring costs to New York employers by closing the Special Disability Fund to new claims; and (6) creating a financing mechanism to allow for settlement of the Fund's existing liabilities.

The legislation amended Section 27(4) of the Workers' Compensation Law to authorize the Superintendent to determine, by regulation, the "industry standard rate" for calculating simple interest to be used in calculating the present value of future benefits when the employer or insurer is required to deposit such amount into the Aggregate Trust Fund (ATF). The Workers' Compensation Board (WCB) computes the present value thereof and requires payment of such amount into the ATF.

Without the Superintendent's determination of the industry standard rate, the WCB would have been unable to compute the present value of amounts to be deposited into the ATF. Consequently, the rule was initially promulgated on an emergency basis, before being adopted on a permanent basis.

The 2nd Amendment to Regulation 85 (11 NYCRR 136): Public Retirement Systems (Adopted on a permanent basis effective 11/19/08)

Section 314 of the Insurance Law authorizes the Superintendent to promulgate and amend, after consultation with the respective administrative heads of public retirement and pension systems and after a public hearing, certain standards with respect to the public retirement and pension systems of the State of New York. This amendment to the regulation establishes new standards governing actuarial assumptions, administrative efficiency, investment policies and financial soundness for the management of the New York State and Local Employees' Retirement System and the New York State and Local Police and Fire Retirement System ("the Retirement System"), and the New York State Common Retirement Fund ("the Fund"), which was established pursuant to Section 422 of the Retirement and Social Security Law and which holds the assets of the Retirement System. The standards in the regulation are intended to assure that the conduct of the business of the Retirement System and the Fund, and of the State Comptroller (as administrative head of the Retirement System and as sole trustee of the Fund), are consistent with fiduciary standards, including maintenance of a strong governance framework with a rigorous system of internal controls; a high level of operational transparency; and the highest ethical, professional and conflict of interest standards.

The 36th Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards For Form, Content And Sale Of Health Insurance, Including Standards Of Full And Fair Disclosure (Adopted on a permanent basis effective 11/19/08)

The Insurance Law authorizes the Superintendent to establish standard provisions for accident and health insurance coverage, and to promulgate regulations governing minimum standards for the form, content and sale of such coverage.

Chapter 645 of the Laws of 2005 directed the Superintendent of Insurance to promulgate rules to implement the denial of coverage for drugs, procedures and supplies for the treatment of erectile dysfunction by publicly funded health insurance programs when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article 6-C of the Correction Law. This amendment to the regulation provides that Healthy New York and the standardized individual enrollee direct payment contracts shall not provide coverage for erectile dysfunction drugs, procedures or supplies provided to registered sex offenders.

The 1st Amendment to Regulation 166 (11 NYCRR 410): External Appeals of Adverse Determinations of Health Care Plans (Adopted on a permanent basis effective 12/3/08)

Chapter 586 of the Laws of 1998 amended the Public Health Law and Insurance Law to authorize external appeals of adverse determinations relating to health care services, and section 45 of Chapter 586 provides that the Superintendent may promulgate regulations to implement the external appeal program.

Article 49 of the Insurance Law and Article 49 of the Public Health Law ("the external appeal law") provide an insured with the right to obtain an independent medical review by an external appeal agent when the insured's health plan denies a health care service as not medically necessary, experimental or investigational. This amendment does not affect the rights of an insured to bring a legal action against the health plan that issues an adverse determination if the insured continues to disagree with the factual basis or clinical rationale for the health plan's adverse determination that has been reviewed by the external appeal agent. In addition, the amendment does not affect any remedy an insured may have with respect to the Insurance Department and Health Department regarding the Departments' oversight of the external appeal program. Nor does the amendment preclude an insured from seeking damages for an opinion rendered in bad faith or involving gross negligence. The amendment merely provides that upon requesting an external appeal, the insured shall acknowledge that the determination of the external appeal is binding on the plan and the insured, and shall agree not to commence any legal proceeding against an external appeal agent or clinical peer reviewer to review a determination made by such external appeal agent or clinical peer reviewer, other than an action for damages pursuant to Article 49 of the Insurance Law or Article 49 of the Public Health Law.

The Adoption of a New Regulation 186 (11 NYCRR 223): Military Sales Practices (Adopted on a permanent basis effective 12/3/08)

The United States Congress determined that sales abuses were occurring on military installations or involving military personnel. Congress passed, and President Bush signed on September 29, 2006, the Military Personnel Financial Services Protection Act, Pub. L. No. 109-290 (2006) (the "Federal Act"). In order to effectuate the Federal Act, the Insurance Department promulgated this regulation to declare certain sales practices occurring on military installations or involving military personnel as false, misleading, deceptive or unfair.

The Military Sales Practices Model Regulation (the "Model Regulation") was developed by the NAIC to meet the Congressional mandates. It makes actionable certain acts and practices that until

now have not been declared to be false, misleading, deceptive or unfair under state trade practices statutes. Many of the practices identified incorporate Department of Defense (the "DoD") solicitation rules. For example, the Model Regulation, by tracking DoD regulations, makes it a deceptive trade practice to solicit in barracks, day rooms and other restricted areas.

The Model Regulation also addresses Congressional concerns regarding suitability and product standards. In this regard, the Model Regulation makes it a deceptive or unfair trade practice to recommend the purchase of any life insurance product that includes a "side fund" to junior enlisted service members in pay grades E- 4 and below, unless the insurer has reasonable grounds for believing that the life insurance portion of the product, standing alone, is suitable. In recognition of Congress' concerns and in furtherance of its goals, the Insurance Department adopted the Model Regulation, with minimal modifications necessary to comport with existing New York law, as Part 223 to Title 11 NYCRR (Regulation No. 186). The Department revised several of the Model Regulation's exclusion provisions to make it consistent with the New York Insurance Law. For instance, the Department revised the Model Regulation's exclusion provision to remove the reference to prearranged funeral contracts, because under Insurance Law Section 3208(d), insurers are prohibited from marketing prepaid funeral agreements in New York. The Department also revised the Model Regulation to remove the prohibition against the use of war exclusions in life insurance policies, because Insurance Law Sections 3203(c) and 4510(b)(1) specifically authorize such exclusions.

Emergency Regulations

The following is a summary of an Insurance Department regulation promulgated on an emergency basis in 2008 that remained in effect on December 31, 2008. No final action was taken with regard to the rule in 2008, although it is anticipated that it will be permanently adopted in 2009.

The Repeal and Adoption of a New Regulation 153 (11 NYCRR 163): Flexible Rating For Nonbusiness Automobile Insurance Policies (Effective on an emergency basis since 2/5/07) (Adopted on a permanent basis effective 12/24/08)

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 nonbusiness automobile insurance, which should strengthen the high level of competition that already exists in this market. The new Insurance Law Section 2350 requires the Superintendent to promulgate a regulation implementing the new flex-rating system.

The new system, which takes effect on January 1, 2009, is a blend of prior approval and competitive rating. The system allows periodic overall average rate changes up to five percent on a "file and use" basis, and requires the Superintendent's prior approval of overall average rate increases above five percent in any twelve-month period. (File and use is the process by which an insurer files with the Superintendent a proposed overall average rate change that is within the flex-band, and then uses the proposed overall average rate change without having to obtain the Superintendent's prior approval.) Because insurers are authorized to use the new flexible rating system as of the effective date of the new law, the Department promulgated the regulation on an emergency basis.

V. CIRCULAR LETTERS ISSUED IN 2008 *

Number	Date	Addressed to	Subject
Supplement No. 1 to CL No. 4 (2001)	02/06/2008	All Authorized Foreign Property/Casualty Insurers, Authorized Foreign Title Insurers and Foreign Accredited Reinsurers of the Aforementioned Types of Companies	Electronic Filing via the Internet of National Form (NAIC) Annual Statements and New York Supplements, Quarterly Statements and Audited Financial Statements
Supplement No. 1 to CL No. 5 (2005)	02/06/2008	All Insurers Authorized to Write Accident and Health Insurance in New York State ("Commercial Insurers"), Article 43 Corporations, Health Maintenance Organizations, Municipal Cooperative Health Benefit Plans, Fraternal Benefit Societies, and Continuing Care Retirement Communities	Contact and Product Information for Health Bureau Inquiries Contact Questionnaire Form
1 Withdrawn Eff. 3/11/2009	02/04/2008	All Authorized Property/Casualty Insurers, Co-operative Property/Casualty Insurers, Financial Guaranty Insurers, Mortgage Guaranty Insurers, Title Insurers, Reciprocal Insurers, Captive Insurers, Registered Risk Retention Groups, Rate Service Organizations, State Insurance Fund, New York Property Insurance Underwriting Association, New York Medical Malpractice Insurance Plan, New York Automobile Insurance Plan, Motor Vehicle Accident Indemnification Corporation, and Excess Line Association of New York	Disaster Planning, Preparedness and Response
2 Withdrawn Eff. 3/31/2009	02/04/2008	All Accident and Health Insurers, Article 43 Corporations, Employee Welfare Funds, Licensed Public Health Law Article 44 Health Maintenance Organizations and Integrated Delivery Systems, and Municipal Cooperative Health Benefit Plans	Disaster Planning, Preparedness and Response
3 Withdrawn Eff. 3/31/2009	02/04/2008	All Authorized Life Insurers, Retirement Systems, and Fraternal Benefit Societies	Disaster Planning, Preparedness and Response

4	2/22/2008	All Property/Casualty Insurers and Rate Service Organizations Doing Business in New York State, New York Property Insurance Underwriting Association, State Insurance Fund, New York Automobile Insurance Plan, and Excess Line Association of New York	Guidelines and Procedures for the Implementation of the Provisions of the Terrorism Risk Insurance Program Reauthorization Act of 2007
Supplement No. 1 to CL No. 14 (2007)	2/27/2008	All Insurers Licensed to Write Accident and Health Insurance in New York State	Pre-Existing Condition Provisions and Elimination Period Provisions in Group and Blanket Disability Policies
5	3/11/2008	All Property/Casualty Insurance Companies, Co-Operative Fire Insurance Companies, Lloyds Underwriters and Insurers, Financial Guaranty Insurance Corporations, and the Medical Malpractice Insurance Plan	Property/Casualty Insurance Security Fund
Supplement No. 1 to CL No. 12 (2007)	03/12/2008	All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations and Health Maintenance Organizations ("HMOs")	Submission of Information for Loss Ratio Reports Filed Pursuant to Section 3231(e)(2)(B) or Section 4308(h)(1) of the Insurance Law
6 Revised	05/15/2008 Originally Posted 04/16/2008	All Insurers Authorized to Write Workers' Compensation Insurance in New York, Workers' Compensation Rate Service Organizations, and the State Insurance Fund	2008 Workers' Compensation Rate Filings Adoption Form (PDF format) Note: The "Adoption Form" is available in a standard version and a "Fill-in" version, which requires Adobe Acrobat Reader 7.0
7 Withdrawn Eff. 10/5/2008 - See CL 21 (2008)	04/10/2008	All Authorized Life Insurers and Licensed Fraternal Benefit Societies	Compliance with Section 3211 and Regulation 77 Notice Requirements for Variable Life Insurance Policies

8	04/15/2008	All Authorized Life Insurers	Interpretation of "Retirement" in Insurance Law § 4228(b)(24) with Respect to Non-Qualifying Employee Benefit Plans
9	04/16/2008	All Motor Vehicle Automobile Self-Insurers, and Insurers Authorized to Write Motor Vehicle Insurance in New York State and the Motor Vehicle Accident Indemnification Corporation	Adoption of the 30th Amendment to Regulation No. 83 (11 NYCRR 68) - Revision to the No-Fault Prescription Drugs and Durable Medical Equipment Fee Schedules
11	05/01/2008	All Property/Casualty Insurance Companies and Reciprocal Insurers Authorized to Write Workers' Compensation Insurance	Workers' Compensation Security Fund
12	05/13/2008	All Financial Guaranty Insurers	Cancellation of Municipal Bond Insurance Policies
14	06/10/2008	All Authorized Insurers Writing Motor Vehicle Insurance in New York State, Motor Vehicle Self-insurers, and the Motor Vehicle Accident Indemnification Corporation (MVAIC)	Unfair Claims Settlement Practices: Interest on Overdue No-Fault Claims and Claim Settlement Structure
16	07/21/2008	All Authorized Insurers	Securities Lending
17	08/06/2008	All Property/Casualty Insurers Writing Personal Lines Automobile Insurance	The Impact of Gasoline Prices on Driving and Proposed Automobile Insurance Rates
Supplement No.1 to CL No. 11 (2008)	08/07/2008	All Property/Casualty Insurance Companies and Reciprocal Insurers Authorized to Write Workers' Compensation Insurance	Workers' Compensation Security Fund
18	08/13/2008	All Insurers Writing Homeowners and Dwelling Fire Personal Lines Policies in New York State, Insurance Producer Organizations, and the Excess Line Association of New York	Flood Insurance Notice Required by Section 3444 of the New York Insurance Law

Supplement No.1 to CL No. 9 (2008)	09/19/2008	All Motor Vehicle Automobile Self-Insurers, Insurers Authorized to Write Motor Vehicle Insurance in New York State, and the Motor Vehicle Accident Indemnification Corporation	Workers' Compensation Board Adoption of a New Pharmaceutical Fee Schedule Applicable to No-Fault Claims
19	09/22/2008	All Authorized Financial Guaranty Insurers	"Best Practices" for Financial Guaranty Insurers
20	10/16/2008	All Insurers, Reinsurers and Insurance Producers	Contract Certainty
21	10/6/2008	All Insurers and Fraternal Benefit Societies Authorized to Write Life Insurance in New York State	Amendment to Insurance Law Sections 3203, 3211 and 4510, Pertaining to Grace Period and Premium Due Notice Requirements for Flexible Premium Life Insurance Policies
22	10/10/2008	All New York-Authorized Insurers, Licensed Insurance Producers, Licensed Health Maintenance Organizations, Licensed Fraternal Benefit Societies, and Excess Line Association of New York	American International Group ("AIG") Insurance Company Subsidiaries in New York
23	11/19/2008	All Insurers Writing Homeowners' Policies in New York	Mid-Term Cancellation of Policies Based upon Residence Becoming Unoccupied
24	11/06/2008	All Property/Casualty Insurance Companies and Reciprocal Insurers Authorized to Write Workers' Compensation Insurance	Workers' Compensation Insurance Security Fund
25	11/18/2008	All New York Authorized Insurers	Financial Condition Stress Testing
26	11/18/2008	All Authorized Property/Casualty Insurers, Rate Service Organizations, New York Medical Malpractice Insurance Plan, New York Automobile Insurance Plan, and Excess Line Association of New York	Notice Provisions in Liability Policies; Chapter 388 of the Laws of 2008

Supplement No. 1 to CL No. 19 (2008)	11/20/2008	All Authorized Financial Guaranty Insurers	Best Practices for Financial Guaranty Insurers
27	11/21/2008	All Persons, Firms, Associations, or Other Entities Licensed, Authorized, Registered, Certified, or Approved Pursuant to the New York Insurance Law, and all Health Maintenance Organizations Holding a Certificate of Authority Pursuant to Article 44 of the Public Health Law (Collectively, "Licensees")	Recognition in New York of Marriages Between Same-Sex Partners Legally Performed in Other Jurisdictions

*Circular Letter No. 10 and Circular Letter No. 13 do not appear on this listing as Circular Letter No. 10 was requested but never issued and Circular Letter No. 13 will be reissued some time in 2009. Circular Letter No. 15 was reissued as Circular Letter No. 20 (2008).

VI. MAJOR LITIGATION

Marty Markowitz v. Gregory V. Serio
New York Court of Appeals

This is a Freedom of Information Law (FOIL) case in which the Superintendent appealed a January 2, 2006 decision of the Supreme Court, New York County (Justice Ling-Cohan) that required the Department to release annual reports filed by automobile insurers pursuant to the Department's anti-redlining regulation that contain detailed policy information by zip code. The Department had excepted the reports from disclosure on the basis of the insurance companies' contention that release of the information would injure their competitive positions. The Supreme Court held that the reports did not fall within the FOIL exemption for trade secrets or confidential commercial information.

On appeal, the Appellate Division, First Department, reversed the Order and Judgment of the Supreme Court and reinstated the Superintendent's determination. The court held that the information was properly withheld from disclosure under FOIL as material which, if disclosed, would cause substantial injury to the competitive position of the insurers.

On June 26, 2008, the Court of Appeals reversed the Order of the Appellate Division and reinstated the Order and Judgment of the Supreme Court. The Court held that the Department and the insurers seeking to prevent disclosure failed to present "specific, persuasive evidence" that disclosure of the zip code data would cause substantial competitive injury to the insurers within the meaning of Public Officers Law § 87(2)(d).

Business For A Better New York, et al. v. Linda Angello, et al.
United States Court of Appeals for the Second Circuit

This is an action challenging the constitutionality of Labor Law sections 240(1) and 241(6), the so-called "Scaffold Law," which makes owners and general contractors responsible for properly maintaining safety equipment at construction sites and imposes liability upon them for worker injuries resulting from their failure to do so. The plaintiffs are a trade organization and several construction businesses. The defendants are the Commissioner of Labor, the Superintendent of Insurance, the Chair of the Workers' Compensation Board and the Attorney General. The plaintiffs allege that the statutes are violative of the Equal Protection and Commerce Clauses of the federal Constitution and are pre-empted by the federal Occupational Safety and Health Act (OSHA).

On September 28, 2007, the District Court granted the State Defendants' motion to dismiss the complaint. The court adopted the report and recommendations of a magistrate judge who found that Labor Law sections 240(1) and 241(6) are rationally related to the legitimate state interest in protecting the safety of workers and thus did not violate equal protection. The magistrate judge also concluded that the statutes do not violate the Commerce Clause and are not preempted by OSHA. The plaintiffs have filed an appeal of the dismissal with the United States Court of Appeals for the Second Circuit, where the case is now pending.

Aurelieus Capital Management, LP v. Eric R. Dinallo
Supreme Court, New York County

This is an Article 78 proceeding challenging the Department's partial denial of a Freedom of Information Law (FOIL) request for certain financial records submitted to the Department by MBIA Insurance Corporation. The Department withheld some of the requested documents on the basis of the "competitive injury" exception to disclosure in Public Officers Law § 87(2)(d).

In a Decision and Judgment issued on January 13, 2009, the Supreme Court (Justice Alice Schlesinger) upheld the Department's determination and dismissed the Article 78 petition. The Court held that the Department's finding that release of the requested financial data was likely to cause substantial competitive injury to MBIA was reasonable and entitled to judicial deference. On February 17, 2009, the petitioner noticed an appeal to the Appellate Division, First Department.

VII. 2009 LEGISLATIVE RECOMMENDATIONS

These are the legislative recommendations available at the time this report was prepared. Additional recommendations may be submitted throughout the year. The information which follows was accurate at the time the legislative recommendations were forwarded to the Legislature for introduction.

A. Insurance Department Bills for 2009

1. This bill would provide a new comprehensive statutory framework to regulate the life settlement business, including enhanced consumer protections. Specifics include:

- Insurance Law § 308 is amended to add life settlement providers and life settlement intermediaries to the list of entities that are required to provide written responses to Department inquiries.

- Insurance Law §§ 2102 and 2110 are amended to add life settlement brokers to the list of those persons required to obtain a license, and whose licenses may be revoked, suspended or not renewed by the Superintendent.

- A new subsection (e) is added to Insurance Law § 2119 requiring life settlement brokers to receive compensation only pursuant to a written contract, and prohibiting excess charges.

- The continuing education requirements of Insurance Law § 2132 are amended to also apply to persons licensed to sell life settlements, and to exclude certain insurance producers with a life line of authority from the requirement to take an examination.

- A new Insurance Law § 2137 is added to specify the licensing requirements (both initial and renewal) applicable to life settlement brokers.

- Insurance Law § 2401 is amended to include life settlements within the category of insurance subject to the prohibitions of unfair methods of competition or unfair or deceptive acts or practices.

- The definitions of "person" and "defined violation" contained in Insurance Law § 2402 are amended to include the business of life settlements and certain acts committed with respect to that business.

- Subsection (c) of Insurance Law 3220 is amended to require that a group policy that permits assignment of an insured person's rights by gift shall also allow assignment for value to the same extent that it allows assignment by gift.

- Existing Article 78 of the Insurance Law is deleted and replaced with a new Article 78 which, among other things:

    - Provides the license requirements for life settlement providers;

    - Provides the registration requirements for life settlement intermediaries;

    - Provides the Superintendent with the authority to refuse to renew, revoke or suspend the license of any life settlement provider or the registration of any settled policy investor or life settlement intermediary subject to notice and hearing;

- Requires life settlement providers to obtain approval by the Superintendent of life settlement contract forms prior to use;

- Requires each licensee to file an annual statement with the Superintendent, and authorizes the Superintendent to examine or investigate the affairs of any licensee, registrant or applicant;

- Requires a life settlement broker to represent only the policy owner and specifies that the broker owes a fiduciary duty to the owner;

- Prohibits licensees and registrants from disclosing the identity of the insured or owner in connection with a proposed or actual life settlement unless the disclosure is necessary for specifically identified purposes;

- Prohibits any person who obtains or may obtain a settled policy from disclosing the identity of the insured under, or the owner of, the policy;

- Requires specific disclosure to be provided by the life settlement provider and the life settlement broker including the amount of compensation to be paid to the broker;

- Identifies prohibited practices and sets forth penalties and civil remedies;

- Sets forth provisions for life settlement contracts made with non-resident owners;

- Permits a life settlement provider to transfer ownership of a settled policy only to specified entities and individuals, with an exception for cases where no personally identifying information of the policy owner or insured is provided; and

- Sets forth a provision on “Stranger-Originated Life Insurance” which prohibits life settlement providers, life settlement brokers, or their representatives from engaging in any act, practice or arrangement to facilitate issuance of a policy for the intended benefit of a person who has no insurable interest in the life of the insured.

- Insurance Law § 403 is amended to: (1) make the commission of a fraudulent life settlement act a violation of the Insurance Law; (2) define a fraudulent life settlement act by reference to Penal Law § 176.40; and (3) add "fraudulent life settlement act" as one of the actions for which the Superintendent is empowered to level a civil penalty.

- Insurance Law § 404(a) is amended to include the business of life settlements within the activities that the Superintendent may investigate.

- Insurance Law § 406 is amended to add provisions relating to attorney's fees and the status of documents and evidence obtained by the Superintendent during an investigation.

- A new Insurance Law § 411 is added detailing the required parameters of life settlements fraud prevention plans that must be implemented and reported annually to the Superintendent.

- A new section 7 is added to the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud.

- Banking Law § 570 is amended to integrate its provisions governing premium finance agreements with the requirements of amended Article 78 of the Insurance Law.

2. A bill to address certain abuses of the no-fault insurance system by permitting the Superintendent to prohibit a provider of health services from demanding or requesting payment for health services rendered under Article 51 of the Insurance Law (No-Fault) if the Superintendent determines that the provider has engaged in certain activities. Specifics include:

- Insurance Law § 5109(b) is amended to permit the Superintendent to prohibit a provider of health services from demanding payment for health services rendered under Article 51 of the Insurance Law, for a period not exceeding three years, if the Superintendent determines, after notice and hearing, that the provider of health services:

  (1) has admitted to or been found guilty of professional misconduct in connection with health services rendered under Article 51;

  (2) solicited, or employed another person to solicit for the provider or another person or entity, professional treatment, examination or care of a person in connection with any claim under Article 51;

  (3) refused to appear before, or answer any question upon request of the Superintendent, or refused to produce any relevant information concerning the provider's conduct in connection with health services rendered under Article 51;

  (4) engaged in a pattern of billing for health services alleged to have been rendered under Article 51 which were not rendered, or engaged in a pattern of billing for unnecessary health services;

  (5) utilized unlicensed persons to render health services under Article 51;

  (6) utilized licensed persons to render health services, when rendering the health services is beyond the authorized scope of the person's license;

  (7) ceded ownership, operation or control of a business entity that provides health services to a person not licensed to render the health services for which the entity is legally authorized to provide, unless otherwise permitted by law;

  (8) committed a fraudulent insurance act as defined in Penal Law § 176.05;

  (9) has been convicted of a crime involving fraudulent or dishonest practices; or

  (10) violated any provision of Article 51 or regulations promulgated thereunder.

- Insurance Law § 5109(c) is amended to state that a provider of health services shall not demand or request payment for any health services under Article 51 that are rendered during the term of the prohibition ordered by the Superintendent pursuant to Insurance Law § 5109(b).

- Insurance Law § 5109(d) is amended to require the Superintendent to maintain a database containing a list of providers of health services that the Superintendent has prohibited from demanding or requesting payment for health services rendered under Article 51, and to make this information available to the public.

- Insurance Law § 5109(e) is amended to permit the Superintendent to levy a civil penalty not exceeding $50,000 on any provider of health services that the Superintendent prohibits from demanding or requesting payment for health services pursuant to Insurance Law § 5109(b).

- Former Insurance Law § 5109(e), relettered as subsection (t), is amended to state that nothing in Insurance Law § 5109 shall be construed as limiting in any respect the powers and duties of the Commissioners of Health and Education and the Superintendent to investigate instances of misconduct by a provider of health services and take appropriate action pursuant to any other provision of law. Moreover, the bill provides that a determination rendered by the Superintendent pursuant to Insurance Law § 5109(b) does not bind the Commissioner of Health or the Commissioner of Education in a professional discipline proceeding related to the same conduct.

Section 3 of the bill provides that it would take effect immediately.

3. A bill to amend the Insurance Law by providing for the licensure of title insurance agents by the Department. Specifics include:

- Section 2101(k) of the Insurance Law is amended to expand the definition of "insurance producer" to include "title insurance agent."

- Section 2101 of the Insurance Law is amended to add a new subsection (s) to define the term "title insurance agents."

- Section 2103(b) of the Insurance Law is amended to authorize the Superintendent to issue licenses to title insurance agents.

- Section 2103(c) of the Insurance Law is amended to authorize the Superintendent to issue a title insurance agent license to a firm or association and its sublicensees. Any sub-licensee would only be authorized to act in the name of the licensee. In the case of a license issued to a title insurance agent, at least one designated sublicensee must have a financial or other beneficial interest in the license.

- Section 2103(e) of the Insurance Law is amended to require the filing of an application before a title insurance agent's license may be issued.

- Section 2103(f)(2)(B) of the Insurance Law is amended to increase from six to seven the number of licensing exams the Superintendent may prescribe so that the Department can test those seeking to become licensed as a title insurance agent.

- Section 2103(g)(7) of the Insurance Law is amended to waive the written exam requirement for an applicant who has passed the title insurance agent exam and who was licensed as a title insurance agent, provided that the applicant applies for the license within two years following the termination of his license.

- Section 2103(g) of the Insurance Law is amended to exempt attorneys from the written exam requirement in order to become licensed as a title insurance agent.

- Section 2103(h) of the Insurance Law is amended to permit the Superintendent to refuse to issue a title insurance agent's license if in the Superintendent's judgment the applicant is not trustworthy and competent, or has given cause for the revocation or suspension of such license, or has not complied with any prerequisite for the issuance of a title insurance agent's license.

- Section 2103(j)(5) of the Insurance Law is amended to require title insurance agent's to file a renewal application and pay the prescribed fee before their license may be renewed.

- Section 2l03(j)(8)(A) of the Insurance Law is amended to authorize the Superintendent to dispense with the requirements for a renewal application of a title insurance agent's license for military personnel who are unable to make a personal application for such license.

- Section 2103(j)(12) of the Insurance Law is amended to permit a licensee to amend their license without having to pay the required fee.

- Section 2103(1) of the Insurance Law is amended to permit title insurance agents to apply for an additional license authorizing them or sub-licensee to act as insurance agents for additional insurers.

- Two new subsections are added to Section 2103 of the Insurance Law to provide a licensing mechanism for those currently acting as title insurance agents.

- Section 2109(a) of the Insurance Law is amended to authorize the Superintendent to issue a temporary title insurance agent's license.

- Section 2109(c) of the Insurance Law is amended to permit a title insurance agent who is issued a temporary license to use such license to renew existing business, to collect premiums due, and to perform such other acts as are incidental to the continuance of the insurance business.

- Subsections (a) and (d) of Section 2112 of the Insurance Law is amended to require title insurance companies file a certificate of appointment in order to appoint a title insurance to act on its behalf.

- Section 2115 of the Insurance Law is amended to make the section applicable to title insurance agents and to prohibit a title insurance company or any of its representatives from paying any compensation except to a licensed title insurance agent.

- Sections 2120(a) and 2120(c) of the Insurance Law is amended to require title insurance agents to act in a fiduciary capacity for any funds received or collected as a title insurance agent.

- Section 2122(a) of the Insurance Law is amended to prohibit a title insurance agent from: 1) advertising the financial condition of an insurer unless the advertising conforms with the requirements of Section 1313 of the Insurance Law; and 2) calling attention to any unauthorized insurer.

- Section 2128(a) and Section 2128(b) of the Insurance Law is amended to prohibit title insurance agents from receiving any commissions or fees in connection with coverages placed for or services rendered with various governmental entities unless they actually placed coverage or rendered services to the governmental entity.

- Section 2132(b) of the Insurance Law is amended to exempt attorneys from the continuing education requirements for title insurance agents.

- A new Section 2137 of the Insurance Law is added to prohibit anyone who holds a financial interest in a title insurance agency or title insurance company from referring business to that agency or company unless certain conditions are met.

- Section 305(b) of the Insurance Law is amended to prohibit a title insurance agent and its officers, directors and employees, whose conduct, condition or practices are being investigated from being entitled to witness or mileage fees.

- The bill requires the Superintendent to promulgate application forms for title insurance agent licensing.

- The bill allows persons, firms and corporations who have filed an application for a title insurance agent license on or before January 1, 2008, or within 90 days after the Superintendent has promulgated application forms pursuant to this act, whichever is later, to act as such agent without a license until the Superintendent has made a final determination on the application for such license.

4. A bill to modernize the Insurance Department's licensing process by:

(1) creating three new lines of authority;

(2) requiring entities seeking to provide insurance agent and broker licensing courses to file for approval with the Department;

(3) requiring independent adjusters to complete pre-licensing and continuing education courses;

(4) granting the Superintendent the authority to require an applicant for an Article 21 license to submit his or her fingerprints; and

(5) permitting the licensing of non-resident adjusters on a reciprocal basis.

Under the provisions of this bill:

- Insurance Law § 2103(a) is amended to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance Law § 2101 (r) (6) (A).

- Insurance Law § 21 03(b) is amended to permit the Superintendent to issue an insurance agent's license for credit insurance as provided under Insurance Law § 2101 (r) (6) (B), crop insurance, and surety insurance.

- Insurance Law § 2103(f) is amended to: (1) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for under Insurance Law § 21 03 (a); (2) require 20 hours of pre-licensing education per line of authority that an individual seeks to qualify for pursuant to Insurance Law § 21 03(b); and (3) require entities seeking to provide insurance agent licensing courses to file for approval with the Superintendent.

- Insurance Law § 2103(g) (1) is amended to not require a written exam as a prerequisite to the issuance of a travel insurance agent's license to any ticket selling agent or representative of a railroad company, steamship company, carrier by air, public bus carrier, or other common carrier who acts as an insurance agent only in reference to insurance coverage for trip cancellation, trip interruption, baggage, life, accident and health, disability, and personal effects, when limited to a specific trip and sold in connection with transportation provided by the common carrier.

- Insurance Law §§ 2103(g) (9) and (10) are amended to give the Superintendent discretion via a regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or any part of the insurance agent pre-licensing, written exam or prerequisite prelicensing course as set forth in either Insurance Law §§ 2103(f) (2) (A) or (B).

- Insurance Law § 21 04 (c) (1) (A) is amended to require an individual to complete not less than twenty hours of pre-licensing education per line of authority that an individual seeks qualify for under Insurance Law § 2104(b).

- Insurance Law § 2104(c) is amended to require entities seeking to provide insurance broker licensing courses to file for approval with the Superintendent

- Insurance Law § 2104 (e) (I) (B) is amended to give the Superintendent discretion via regulation to determine which other professional designations, if held, would exempt an individual seeking to be named a licensee or sub-licensee from all or part of the insurance broker pre-licensing, written exam or prerequisite course as set forth in Insurance Law § 21 04 (c) (1) (A).

- Insurance Law § 2108(f) (1) is amended to provide that an individual shall not be deemed qualified to take the independent adjuster exam without demonstrating that: (I) the individual possesses a minimum of one year' s experience in the insurance business, with involvement in sales, underwriting, claims, or other experience considered sufficient by the Superintendent; or (2) the individual completed forty hours of formal training in a course, program of instruction, or seminars approved by the Superintendent.

- A new Insurance Law § 2113 is added to grant the Superintendent the authority to require an individual who is applying for a license pursuant to Article 21 of the Insurance Law, to submit his or her fingerprints.

- Insurance Law § 2132(c) (1) is amended to require that any person with an Article 21 license who is not exempt under Insurance Law § 2132(b), must participate in 24 credit hours of continuing education.

- Insurance Law § 2136(d) is amended to permit the licensing of non-resident adjusters on a reciprocal basis.

VIII. Regulatory Activities

A. OPERATING STATISTICS

1. Licenses Issued During Year

Table 59
LICENSES ISSUED DURING YEAR
2007 and 2008

	2008	2007
Total	**137,851**	**153,909**
Adjusters[a]		
Independent	9,777	5,788
Public	359	111
Agents[b]		
Life/Accident and Health	39,372	123,866
Property and Casualty	47,147	12,776
Personal Lines	75	15
Limited Rental/Wireless Communications	33	0
Mortgage Guaranty Insurance	1	3
Bail Bond	77	73
Limited Lines[c]	15	0
Brokers[d]		
Life	4,345	4,948
Property and Casualty	33,848	5,073
Personal Lines	29	149
Excess Line (Regular)	1,068	260
Excess Line (Limited)	1,190	435
Viatical Settlement	16	12
Consultants[e]		
Life	47	154
General	257	100
Reinsurance Intermediaries[f]	179	16
Service Contract Registrants[g]	16	130

Note: Footnotes to table appear on next page.

Footnotes to Table 61

[a] Independent and Public Adjuster licenses issued pursuant to Section 2108 are renewable biennially as of January 1 of odd numbered years.

[b] Life/Accident and Health Agent licenses issued to entities* pursuant to Section 2103(a) are renewable biennially as of July 1 of odd numbered years. Property and Casualty Agent and Personal Lines Agent licenses issued to entities pursuant to Section 2103(b) are renewable biennially as of July 1 of even numbered years. Limited Rental/Wireless Communications Agent licenses issued to entities pursuant to Section 2131 are renewable biennially as of July 1 of even numbered years. All individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

Mortgage Guaranty Agent licenses issued pursuant to Section 6535 are perpetual.

Bail Bond Agent licenses issued pursuant to Section 6802 are renewable biennially as of January 1 of odd numbered years.

[c] Limited Lines Agent licenses – Effective January 1, 1987, licenses were issued to agents of assessment co-operative property/casualty companies enabling them to sell only coverage written by such companies. Entity licenses are renewable biennially as of July 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

[d] Life Broker licenses issued to entities pursuant to Section 2104(b)(1)(A) are renewable biennially as of November 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

Property and Casualty Broker and Personal Lines Broker licenses issued to entities pursuant to Section 2104 and Excess Line Broker and Limited Excess Line Broker licenses issued to entities pursuant to Section 2105 are renewable biennially as of November 1 of even numbered years. All individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth. Limited Excess Line Brokers are licensed to deal only with purchasing groups as defined in Regulation 134.

Viatical Settlement Broker licenses issued pursuant to Section 7802 are renewable annually as of December 1.

[e] Consultant licenses issued to entities pursuant to Section 2107 are renewable on a biennial basis, Life Consultants as of April 1 of odd numbered years and General Consultants as of April 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

[f] Reinsurance Intermediary licenses issued to entities pursuant to Section 2106 are renewable biennially as of September 1 of even numbered years. Individual and individual trade name (sole proprietorship) licenses are issued with an expiration date determined by the applicant's date of birth.

[g] Service Contract Registrations issued pursuant to Section 7907 are renewable biennially as of March 1 of odd numbered years.

*Partnerships, Corporations and Limited Liability Companies

2. Results of Examinations for Licenses

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

Type of Examination	2008 Number Taking Examination	2008 Percent Passing	2007 Number Taking Examination	2007 Percent Passing
Total	**35,287**	**45**	**33,703**	**45**
Public Adjusters	94	39	101	39
Independent Adjusters - Total	4,972	44	4,690	51
Accident and Health	468	40	479	56
Automobile	578	48	457	47
Aviation	8	50	0	0
Casualty	1,393	44	1,161	51
Fidelity and Surety	0	0	3	67
Fire	203	59	202	62
General (All Lines)	1,046	35	1,132	46
Health Service Charges	663	49	485	52
Inland Marine	16	50	71	52
Limited Auto (Damage or Theft Appraisals only)	597	52	700	53
Agents and Brokers - Total	30,179	45	28,890	44
Agent, A&H	3,425	37	3,121	35
Agent, A&H (Spanish)	39	5	57	2
Agt/Brk, Life	8,266	52	9,299	44
Agt/Brk, Life (Spanish)	850	13	687	8
Agt/Brk, Life, A&H	11,825	49	10,809	48
Agt/Brk, Life, A&H (Spanish)	15	0	27	0
Agent, Property and Casualty	1,613	37	1,161	50
Broker, Property and Casualty	2,877	32	2,631	43
Agent, Mortgage Guaranty	6	17	5	80
Agent, Credit	0	0	0	0
Agt/Brk, Personal Lines	1,219	57	1,053	59
Agent, Bail Bond	44	57	40	83
Consultants - Total	42	33	22	32
Life	36	33	14	21
General	6	33	8	50

3. Changes in Authorized Insurers During 2007

A. Life Insurance Companies	
Domestic Company Incorporated	
Trustmark Life Insurance Company of New York	Mar. 21
Foreign Company Licensed	
John Hancock Life & Health Insurance Company, Wilmington, DE	Nov. 19
Merger Agreements Filed	
CUNA Mutual Life Insurance Company into CUNA Mutual Insurance Society, Waverly, IA	Apr. 9
Mutual of Detroit Insurance Company into Columbian Mutual Life Insurance Company, Binghamton, NY	Dec. 1
Change of Names	
"American Skandia Life Assurance Corporation" to "Prudential Annuities Life Assurance Corporation" Shelton, CT	Feb. 28
"Fidelity Life Insurance Company" to "HealthMarkets Insurance Company"	Oct. 6
Withdrawn	
The Fidelity Mutual Life Insurance Company, Radnor PA	June 6
HealthMarkets Insurance Company, Oklahoma City, OK	Oct. 6
Stonebridge Life Insurance Company, Rutland VT	Dec. 30
B. Accident and Health Insurance Companies	
Domestic Company Incorporated	
Security Health Insurance Company of America, New York, Inc.	Nov. 13
Domestic Company Licensed	
Freelancers Insurance Company, Inc. Brooklyn, NY	Nov. 10
Foreign Companies Licensed	
Accendo Insurance Company, Salt Lake City, UT	Apr. 1
HealthSpring Life & Health Insurance Company, Inc., Houston, TX	May 29
Withdrawn	
NMHC Group Solutions Insurance, Inc., Wilmington, DE	May 6
C. Property and Casualty Insurance Companies	
Domestic Companies Incorporated	
Empire Bonding and Insurance Company	Mar. 26
Denali Casualty Company	June 5
Austin Liberty Insurance Company	Dec. 15
Foreign Companies Licensed	
Endurance Reinsurance Company of America, Wilmington, DE	Jan. 30
Ameriprise Insurance Company, Depere, WI	Apr. 17
Maine Edmployers' Mutual Insurance Company, Portland, ME	May 9
Harleysville Preferred Insurance Company, Harleysville, PA	Aug. 20
Harleysville Insurance Company, Harleysville, PA	Aug. 20
Riverport Insurance Company, Minneapolis, MN	Sept. 30

Pharmacists Mutual Insurance Company, Algona, IA	Sept. 30
CampMed Casualty & Indemnity Company, Inc. of Maryland, Brunswick, MD	Dec. 29
Change of Names	
"Employers Reinsurance Corporation" to "Westport Insurance Corporation" Jefferson City, MO	Jan. 1
"Converium Reinsurance (North America) Inc" to "Finial Reinsurance Company" Stamford, CT	Jan. 7
"American Central insurance Company" to "Essentia Insurance Company" Chesterfield, MO	Jan. 7
"Stockbridge Insurance Company" to "Ironshore Indemnity, Inc" New York, NY	Jan. 10
"Progressive Home Insurance Company" to "Progressive Advanced Insurance Company" Mayfield Village, OH	Jan. 22
"Endurance Reinsurance Company of America" to "Endurance Reinsurance Corporation of America" Wilmington, DE	Apr. 1
"Phoenix Indemnity Insurance Company" to "Hallmark Insurance Company" Fort Worth, TX	May 5
"Converium Insurance Company (North America) Inc" to "Allied World Reinsurance Company" West Trenton, NJ	May 9
"LIG Insurance Company, Ltd. (U.S. Branch)" to "Leading Insurance Group Insurance Co., Ltd" New York, NY	June 26
"AXA Corporate Solutions Reinsurance Company" to "Coliseum Reinsurance Company" Wilmington, DE	June 30
"Folksamerica Reinsurance Company" to "White Mountains Reinsurance Company of America" New York, NY	July 8
"Western Diversified Casualty Insurance Company" to "Arch Indemnity Insurance Company" Omaha, NE	July 14
"Commercial Guaranty Casualty Insurance Company" to "Max America Insurance Company" Indianapolis, IN	Aug. 1
"Republic Insurance Company" to "Starr Indemnity & Liability Company" Dallas TX	Sept. 24
"Alliance Assurance Company of America" to "WRM America Indemnity Company, Inc. Uniondale, NY	Oct. 23
Redomestications Filed	
Valiant Insurance Company (from Iowa to Delaware)	Jan. 24
Great Northern Insurance Company (from Minnesota to Indiana)	Jan. 30
The American Insurance Company (from Nebraska to Ohio)	May 15
Carolina Casualty Insurance Company (from Florida to Iowa)	May 27
Universal Surety of America (from Texas to South Dakota)	July 22
Acadia Insurance Company (from Maine to New Hampshire)	Aug. 7
Response Insurance Company (from Delaware to Connecticut)	Oct. 22
Washington International Insurance Company (from Arizona to New Hampshire)	Dec. 31
Merger Agreements Filed	
Westport Insurance Corporation into Employers Reinsurance Corporation	Jan. 1
Endurance Reinsurance Corporation of America into Endurance Reinsurance Company of America, Wilmington, DE	Jan. 30
Withdrawn	
Eastern Casualty Insurance Company, Marlborough, MA	Dec. 31

D. Title Insurance Companies	
Foreign Company Licensed	
EnTitle Insurance Company, Independence, OH	Nov. 25
Merger Agreement Filed	
Transnation Title Insurance Company into Lawyers Title Insurance Corporation	Aug. 31
Redomestication	
Ticor Title Insurance Company of Florida (from Florida to Nebraska	Mar. 14
Transnation Title Insurance Company (from Arizona to Nebraska)	Aug. 4
United General Title Insurance Company (from Colorado to California)	Dec. 16
E. Accredited Reinsurers	
Certificates of Recognition	
Homesite Insurance Company of the Midwest, Mandan, ND	Feb. 5
Indian Harbor Insurance Company, Bismarck, ND	Feb. 5
American International Insurance Company of Delaware, Wilmington, DE	June 2
Change of Names	
"Revios Reinsurance U.S. Inc." to "Scor Global Life Re Insurance Company of Texas" Plano, TX	Mar. 12
"Excess Reinsurance Company" to "KnightBrook Insurance Company" Brandywine Village, DE	Aug. 5
"Fidelity Life Insurance Company" to "HealthMarkets Insurance Company" Oklahoma City, OK	Oct. 6
Withdrawn	
Praetorian Specialty Insurance Company, Wilmington, DE	July 31
Primerica Life Insurance Company, Boston, MA	Dec. 17
Ohio National Life Insurance Company, Cincinnati, OH	Dec. 31
F. Charitable Annuity Societies	
Incorporated	
Environmental Defense, Incorporated	Apr. 16
Women's American ORT, Inc.	Sept. 23
Permits Issued	
The Research Foundation of the State University of New York, Albany, NY	Feb. 29

Mount St. Mary's University, Emmitsburg, MD	Mar. 7
National Geographic Society, Washington, DC	Mar. 19
Brooklyn College Foundation, Inc., Brooklyn, NY	Mar. 20
Friends Fiduciary Corporation, Philadelphia, PA	Apr. 30
Comerica Legacy Foundation, Ann Arbor, MI	May 13
Western Adventist Foundation, Tempe, AZ	June 24
The Baruch College Fund, New York, NY	Aug. 26
Garrison Forest School, Incorporated, Owings Mills, MD	Sept. 22
The Corporation of Haverford College, Haverford, PA	Sept. 24
Rider University, Lawrenceville, NJ	Sept. 30
Elderhostel, Inc., Boston, MA	Oct. 2
Roswell Park Alliance Foundation, Buffalo, NY	Oct. 6
New York Medical College, Valhalla, NY	Nov. 3
Mission Aviation Fellowship, Nampa, ID	Dec. 12
Name Change	
"International Bible Society Foundation" to "IBS-STL Ministries Foundation" Colorado Springs, CO	Mar. 20
"The Ocean Conservancy, Inc" to "Ocean Conservancy, Inc." Washington DC	Mar. 20
"Environmental Defense, Incorporated" to "Environmental Defense Fund, Incorporated" New York, NY	
"Women's American ORT, Inc." to "ORT America, Inc." New York, NY	Sept. 23
G. Financial Guaranty Companies	
Name Change	
"XL Capital Assurance Inc." to "Syncora Guarantee Inc." New York, NY	Aug. 4
Merger	
Syncora Guarantee Re Ltd. Into and with Syncora Guarantee Inc., New York, NY	Sept. 4
Licensed Companies	
Syncora Guarantee Re Ltd. New York, NY	Aug. 22
Municipal and Infrastructure Assurance Corporation, New York, NY	Oct. 20
H. Captive Insurance Companies	
Domestic Companies Incorporated	
RF Casualty Insurance Company, New York, NY	Mar. 18
Imperial Assurance Company, Inc., New York, NY	May 22
News Corporation Insurance Company, Inc., New York, NY	May 22
Wall and Broad Insurance Company, New York, NY	May 27
Terminus Insurance, Inc., New York, NY	Sept. 23
RelSure America, Inc., Coram, NY	Dec. 2
Domestic Companies Licensed	
RF Casualty Insurance Company, New York, NY	Apr. 18
Wall and Broad Insurance Company, New York, NY	May 30
News Corporation Insurance Company, Inc., New York, NY	June 26
Imperial Assurance Company, Inc., New York, NY	July 18
RelSure America, Inc., Coram, NY	Dec. 19
I. Reciprocal	
Privilege Underwriters Reciprocal Exchange, Fort Lauderdale, FL	Sept. 10

Examination Reports Filed During 2008		
Name of Companies	**As of**	**Date Filed**
Domestic Life Insurance Companies		
Allstate Life Insurance Company of New York	12/31/06	11/24/08
American Equity Investment Life Insurance Company of New York	12/31/04	09/11/08
American Progressive Life and Health Insurance Company of New York	12/31/06	11/25/08
Anthem Life & Disability Insurance Company	07/30/08	11/26/08
Bankers Conseco Life Insurance Company	12/31/05	11/03/08
Cigna Life Insurance Company of New York	12/31/05	09/15/08
Columbian Mutual Life Insurance Company	12/31/06	07/28/08
First Ameritas Life Insurance Corp. of New York	12/31/06	05/05/08
First Berkshire Hathaway Life Insurance Company	12/31/06	04/08/08
First Central National Life Insurance Company of New York	12/31/06	10/16/08
First Investors Life Insurance Company	12/31/06	11/12/08
First MetLife Investors Insurance Company	12/31/03	09/15/08
First Rehabilitation Life Insurance Company of America	12/31/06	05/14/08
First Reliance Standard Life Insurance Company	12/31/06	03/03/08
First Security Benefit Life Insurance and Annuity Company of New York	12/31/06	11/12/08
First United American Life Insurance Company	12/31/05	09/11/08
Great American Life Insurance Company of New York	12/31/06	10/07/08
HM Life Insurance Company of New York	12/31/06	04/15/08
Manhattan Life Insurance Company	12/31/05	04/23/08
Monitor Life Insurance Company of New York	12/31/06	10/09/08
Mony Life Insurance Company	12/31/05	10/31/08
National Security Life and Annuity Company	12/31/05	01/22/08
OM Financial Life Insurance Company of New York	12/31/06	12/01/08
Presidential Life Insurance Company	12/31/06	09/03/08
Security Mutual Life Insurance Company of New York	12/31/05	10/09/08
Sentry Life Insurance Company of New York	12/31/06	04/21/08
Standard Life Insurance Company of New York	12/31/06	12/08/08
Standard Security Life Insurance Company of New York	12/31/06	05/21/08
Sun Life Insurance and Annuity Company of New York	12/31/06	12/04/08
RiverSource Life Insurance Co. of New York	12/31/06	12/04/08
Transamerica Financial Life Insurance Company	12/31/05	12/08/08
Unimerica Life Insurance Company of New York	12/31/06	06/24/08
Union Security Life Insurance Company of New York	12/31/05	12/26/08
USAA Life Insurance Company of New York	12/31/06	06/30/08
Wilton Reassurance Life Company of New York	12/31/04	09/11/08
Domestic Accident and Health Insurance Companies		
Commercial Travelers Mutual Insurance Company	12/31/06	06/03/08
Renaissance Health Insurance Company of New York	12/31/06	02/15/08
United HealthCare Insurance Company of New York	12/31/03	01/15/08
Domestic Property and Casualty Insurance Companies		
AIG National Insurance Company, Inc.	12/31/06	11/14/08
American Guarantee and Liability Insurance Company	12/31/03	07/14/08
American International Insurance Company	12/31/06	11/14/08
Assurance Company of America	12/31/03	07/14/08
Atlantic Specialty Insurance Company	12/31/06	12/10/08
AutoOne Insurance Company	12/31/06	12/10/08

AutoOne Select Insurance Company	12/31/06	12/10/08
CastlePoint Insurance Company	12/31/06	02/28/08
Chubb Indemnity Insurance Company	12/31/06	06/18/08
Empire Insurance Company	12/31/06	10/06/08
Erie Insurance Company of New York	12/31/05	10/15/08
Eveready Insurance Company	12/31/04	06/18/08
General Security National Insurance Company	12/31/06	12/30/08
Global Liberty Insurance Company of New York	11/08/07	05/27/08
Gotham Insurance Company	12/31/05	12/30/08
Graphic Arts Mutual Insurance Company	12/31/04	08/11/08
Great American Insurance Company of New York	12/31/06	07/29/08
Guilderland Reinsurance Company	12/31/06	09/19/08
Homeland Insurance Company of New York	12/31/06	12/10/08
International Credit of North America Reinsurance Inc.	12/31/05	93/20/08
Liberty Insurance Underwriters Inc.	12/31/05	07/08/08
Maya Assurance Company	12/31/06	10/30/08
New York Marine and General Insurance Company	12/31/05	12/23/08
Northern Insurance Company of New York	12/31/03	07/14/08
PartnerRE Insurance Company of New York	12/31/05	10/31/08
Partner Reinsurance Company of the U.S.	12/31/05	10/31/08
Putnam Reinsurance Company	12/31/04	12/24/08
Seneca Insurance Company, Inc.	12/31/05	07/16/08
SUECIA Insurance Company	12/31/05	06/23/08
TM Casualty Company	12/31/04	09/26/08
TNUS Insurance Company	12/31/04	09/16/08
Transatlantic Reinsurance Company	12/31/04	12/24/08
Trans Pacific Insurance Company	12/31/04	09/26/08
Unione Italiana Reinsurance Company of America, Inc.	12/31/04	03/03/08
United Farm Family Insurance Company	12/31/06	09/16/08
United International Insurance Company	12/31/05	12/18/08
Unitrin Advantage Insurance Company	12/31/05	11/25/08
Unitrin Auto and Home Insurance Company	12/31/05	11/25/08
Unitrin Preferred Insurance Company	12/31/05	11/25/08
Utica Mutual Insurance Company	12/31/04	08/11/08
Vigilant Insurance Company	12/31/06	06/18/08
Westchester Fire Insurance Company	12/31/02	06/18/08
XL Insurance Company of New York, Inc.	12/31/05	12/02/08
XL Reinsurance America Inc.	12/31/05	12/02/08
Alien Property and Casualty Insurance Companies		
Aviva Insurance Company of Canada (U.S. Branch)	12/31/05	04/21/08
Leading Insurance Group Insurance Co., Ltd (US Branch)	12/31/06	09/08/08
Tokio Marine & Nichido Fire Insurance Co., Ltd.	12/31/04	09/26/08
Trygg-Hansa Insurance Company Ltd	12/31/05	05/19/08

Advance Premium Property and Casualty Insurance Companies		
Commercial Mutual Insurance Company	12/31/06	02/27/08
Community Mutual Insurance Company	12/31/03	06/23/08
Security Mutual Insurance Company	12/31/05	03/31/08
Sterling Insurance Company	12/31/05	06/03/08
Financial Guaranty Company		
Municipal and Infrastructure Assurance Corporation	09/25/08	10/16/08
Charitable Annuity Societies		
Africa Inland Mission International, Inc.	12/31/06	01/07/08
American Bible Society	12/31/06	04/21/08
Buffalo State College Foundation, Inc.	12/31/05	08/29/08
Catholic Charities, Diocese of Brooklyn	12/31/07	11/26/08
Catholic Medical Mission Board, Inc.	12/31/06	07/25/08
Consumers Union of United States, Inc.	12/31/06	06/24/08
Episcopal Church Foundation	12/31/06	04/21/08
Fellowship of Reconciliation, Inc.	12/31/06	04/21/08
Geneseo Foundation, Inc.	12/31/07	10/16/08
Jewish Museum	12/31/06	01/10/08
Juilliard School	12/31/06	01/24/08
Lincoln Center For The Performing Arts, Inc.	12/31/06	06/18/08
Long Island University	12/31/05	08/12/08
National Audubon Society, Inc.	12/31/06	02/15/08
ORT America, Inc.	12/31/06	01/14/08
Pace University	12/31/06	02/01/08
Planned Parenthood Federation of America, Inc.	12/31/07	11/26/08
Philharmonic-Symphony Society of New York, Inc.	12/31/07	12/09/08
ProLiteracy Worldwide	12/31/06	07/25/08
Rensselaer Polytechnic Institute	12/31/06	04/11/08
St. Lawrence University	12/31/06	03/14/08
Teachers College, Columbia University	12/31/06	06/17/08
Union College	12/31/07	09/16/08
United Jewish Communities, Inc.	12/31/07	10/07/08
University of Rochester	12/31/05	05/14/08
Watchtower Bible and Tract Society of New York, Inc.	12/31/07	09/24/08
Captive Insurance Companies		
Moody's Assurance Company, Inc.	12/31/06	05/01/08
TSI Insurance, Inc.	12/31/06	04/23/08
Welfare Trust Funds		
Suffolk County Municipal Employees Benefit Fund	12/31/04	07/29/08
Suffolk County Municipal Employees Legal Services Fund	12/31/04	07/29/08
Mortgage Guaranty		
Atrium Insurance Corporation	12/31/01	09/18/08
Financial Guaranty Company		
Municipal and Infrastructure Assurance Corporation	09/25/08	10/16/08

Assessment Companies		
Hartwick Town Insurance Company	12/31/06	02/05/08
Leatherstocking Cooperative Insurance Company	12/31/06	03/12/08
Madison Mutual Insurance Company	12/31/06	12/05/08
Sauquoit Valley Insurance Company	12/31/06	05/20/08
Health Maintenance Organizations		
Independent Health Association, Inc.	12/31/05	03/10/08
Unitedhealthcare of New York, Inc.	09/30/04	01/15/08
Non-Profit Health Service Company		
Independent Health Benefits Corporation		
Continuing Care Retirement Community		
Canterbury Woods	12/31/06	06/05/08
Westchester Meadows	12/31/06	06/05/08
Fraternal Benefit Society Companies		
Baptist Life Association	12/31/06	08/06/08
The Independent Order of Foresters	12/31/05	06/03/08
Workmen's Benefit Fund of the United States of America	12/31/06	08/14/08
Viatical Settlement Companies		
Coventry First LLC	12/31/06	04/21/08
Life Settlements International, LLC	12/31/06	03/13/08
Underwriting Organization		
Excise Bond Underwriters	11/30/04	02/02/08

5. Insurance Department Receipts and Expenditures

Table 61
DEPARTMENT RECEIPTS
Fiscal Year Ended March 31, 2008

Taxes Collected Under the New York State Insurance Law:		
Taxes collected by reason of retaliation under Section 1112[1]		$(828,714)
Excess Line - Section 2118		82,192,793
Organization Tax - Section 180, Tax Law		37,255
Subtotal[2]	$	**81,401,334**
Fees Collected Under Section 1112 of the NYS Insurance Law:		
Filing Annual Statements and Certificates of Authority to Companies	$	761,237
Agents' Certificates of Authority		34,888
Admission Fees		49,561
Subtotal	**$**	**845,686**
Licensing and Accreditation Fees:	**$**	**20,882,550**
Assessments and Reimbursement of Department Expenses:		
Section 313 – Company Examinations	$	12,069,370
Section 332 – Assessment		190,494,688
Administrative Expense Reimbursement – Section 9104/9105		140,691
Administrative Expense Reimbursement – Security Funds		101,854
Administrative Expense Reimbursement – Other		1,000
Subtotal	**$**	**202,807,603**
Other Fees and Receipts:		
Section 9107 - Certification & Filing Fees	$	77,384
Section 9108 - Fire Insurance Fee		13,919,046
Section 1212 - Summons and Complaints		665,123
Fines and Penalties		8,178,679
Arbitration Fees		11,645
FOIL Requests		53,406
Miscellaneous		28,767
Regulation 134		2,200
Motor Vehicle Law Enforcement Fee		64,908,847
CAPCO Application Fees		13,500
Subtotal	**$**	**87,858,597**
Foreign Fire Tax, and Security Funds Receipts		
Foreign Fire Tax - Insurance Law Sections 2118, 9104 and 9105		$49,786,677
Property Casualty Insurance Security Fund - Sections 7602 and 7603		160,546,998
Public Motor Vehicle Liability Security Fund – Section 7601		34,242,328
Workers' Compensation Security Fund		79,510,778
Subtotal		**$324,086,781**
TOTAL DEPARTMENT RECEIPTS		**$717,882,551**

Table 62
INSURANCE TAX RECEIPTS[3]
(in millions)

Fiscal Year	Net
2003-04	930.0
2004-05	1,077.0
2005-06	987.0
2006-07	1,142.0
2007-08	1,088.0

[1]The negative balance represents retaliatory tax refunds in excess of retaliatory tax collected, in accordance with Insurance Law Section 1112.

[2]This amount is in addition to the $ 1.088 billion collected by the Department of Taxation and Finance under Tax Law Article 33.

[3]Collected by the Department of Taxation and Finance under Tax Law Article 33.
Source: State of New York, Annual Budget Message, 2009-10

Table 63
DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2008
Paid in the First Instance from Appropriations

Personal Service	
Employee salaries	**$ 65,875,150**
Maintenance and Operation	
General office supplies	$ 903,567
Travel expense	3,073,665
Rental equipment	1,379
Repair and maintenance of equipment	237,959
Real estate rental	6,657,508
Postage and shipping	442,957
Printing	48,856
Telephone	1,094,011
Miscellaneous contractual services	6,360,870
OFT Computer	76,641
OGS Interagency courier	52,366
Equipment	955,584
Employee fringe benefits/indirect cost	33,401,094
Subtotal Maintenance and Operation	**$ 53,306,457**
Suballocations to Other State Agencies	
Personal Service, Maintenance and Operation	**$ 64,416,476**
TOTAL DEPARTMENT EXPENDITURES	**$183,598,083**

Table 64
RECEIPTS VS. DEPARTMENT EXPENDITURES
Fiscal Year Ended March 31, 2008

Total Department Receipts	$717,882,551
Total Department Expenditures	$183,598,083
Excess of Department Receipts Over Department Expenditures	**$534,284,468**

B. DEPARTMENT STAFFING

Table 65
DEPARTMENT STAFFING
Number of Filled Positions by Bureau/Location (as of February 18, 2009) ‡

Bureau	Examiners	Attorneys	Actuaries	Other Professionals	Investigators	Support Staff	Total
New York City Office:							
Executive	1			22		4	27
Life	95		9	3		8	115
Health	49		6	4		2	61
Administration*	1			9		8	18
Consumer Services	31					15	46
Frauds	3			3	25	3	34
OGC		26		6		10	42
Public Affairs/Research				2		1	3
Property	174		23	1		19	217
Systems	1			18		3	22
Capital Markets	1			7		2	10
Examiner Pool	39						39
Disaster Preparedness	6					1	7
Policy				2			2
WCTF				4			4
FNSVSMOD				4			4
NYC Total	**401**	**26**	**38**	**85**	**25**	**76**	**651**
Albany Office:							
Executive				7		1	8
Life		17	22	1		3	43
Health	6	22	5	1		2	36
Administration*				19		15	34
Consumer Services	34			1		10	45
Frauds				2	7		9
OGC		9				2	11
Property	8					1	9
Systems	1			30		8	39
Capital Markets				1			1
Examiner Pool	2						2
Licensing	1			8		31	40
Disaster Preparedness	4						4
WCTF				1			1
Timothy's Law	2	3	1	2		1	9
Albany Total	**58**	**51**	**28**	**73**	**7**	**74**	**291**
ALL OTHER							
Buffalo Office							
Health		1					1
Consumer Services	2					1	3
Frauds					3		3
Mineola Office							
Consumer Services	2					1	3
Frauds					7		7
Oneonta Office:							
Frauds					5		5
Rochester Office:							
Frauds					1		1
Syracuse Office:							
Frauds					1		1
All Other Total	**4**	**1**			**17**	**2**	**24**
Department Total	**463**	**78**	**66**	**158**	**49**	**152**	**966**

*Includes HRM & Offices Services; ‡**Note**: Table does not include 10 student assistants assigned to various bureaus during the year

IX. Workers' Compensation Task Force

On March 13, 2007, the landmark workers' compensation Reform Legislation was enacted that fundamentally reformed the workers' compensation system. Governor Spitzer, in his March 13, 2007, ("March 13th letter"), directed the Superintendent of the Insurance Department to achieve various goals as part of the reform effort to make the system more responsive to the needs of the State's employees and to the employers who pay premiums. The Workers' Compensation Reform Task Force ("Task Force") was charged with this reform effort to complement the legislation. In his March 13th letter, the Governor created an Advisory Committee comprised of representatives of: the Majority Leader of the Senate, the Speaker of the Assembly, the AFL-CIO, the Business Council of NYS, the Workers' Compensation Board ("Board") and the Department of Labor. The Advisory Committee was to participate with the Task Force respecting certain objectives assigned the Task Force by the March 13th letter.

Through the Workers' Compensation Reform Task Force, the Department is leading the efforts on key workers compensation reforms:

1. Reduction in Rates and Compensation Insurance Rating Board (CIRB)

In connection with the recommendations of the Department's CIRB Report previously submitted to the Governor and the Legislature, drafted and negotiated legislation for the restructuring of CIRB and for the new rate-making process for workers' compensation insurance designed to increase price competition and transparency. The legislation became law on January 31, 2008.

The first Loss Cost Filing under the new legislation was approved by the Department on July 1, 2008.

Carriers filed for approval of their rates based on the Loss Costs. In less than three months, the Department received and reviewed 250 filings from insurers for approval of Loss Cost Multipliers (LCMs) to take effect October 1, 2008.

Insurance rates decreased for the second year in a row. Costs for 2009 were reduced by about 5%, resulting in a 2-year reduction of about 25% from the 2007 pre-Reform rates.

2. Disability Guidelines

The above rate reductions are largely attributable to insurance carriers and self-insureds projecting reduced claim costs based on provisions in the Reform Legislation which, for post-Reform injuries, limit the period of time (duration caps) that benefits will be paid for the most costly types of injuries. (Pre-reform, the benefits were paid for the injured worker's lifetime.) As a practical matter, the duration caps will be applied sometime after March 2009. The length of the duration cap for any given injury depends on determining a worker's loss of wage earning capacity resulting from the injury.

To determine this critical metric of loss of wage earning capacity, the Governor's March 13th letter calls for the Task Force working with the Governor's designated Advisory Committee to create guidelines. The Task Force and Advisory Committee currently anticipate that this will involve three related segments of guidelines. The Task Force, Advisory Committee and their designated highly-credentialed medical professionals have been regularly meeting to develop the first segment.

3. Implementation Standards - Medical Treatment Guidelines

In consultation with the Governor's Advisory Committee, the Department had developed proposed Medical Treatment Guidelines for injuries to four parts of the body that were high cost drivers of medical care. The Guidelines provide quality standards for medical care, increase return to work, improve health outcomes and reduce costs. On June 9, 2008, the Department submitted to the Board, with the consensus of the Governor's Advisory Committee and their medical professionals, proposed Implementation and Process Standards for the Guidelines. The Standards are essential for actually realizing the benefits of the Guidelines.

4. System Data Report to the Governor

In accordance with the direction of the Governor's March 13th letter, reviewed and reported to the Governor respecting the available data for the workers' compensation system, summarized the system's operations data, developed benchmarks for evaluating the system, and made recommendations for future data collection to enable public policy research. On the deliverable date of March 3, 2008, the Superintendent issued the Data Report to the Governor.

5. Streamlined Docket

The Task Force worked with the Board in its modification and adoption of the Department's proposed streamlined docket regulations for contested claims that should substantially reduce the time for claim resolution, thereby accelerating delivery of benefits to injured workers and reducing friction costs. Board regulations for the streamlined docket became effective November, 2008.

X. LIQUIDATION BUREAU

The New York Liquidation Bureau assists the Superintendent of Insurance in rehabilitating, liquidating and conserving the assets of financially impaired insurance companies pursuant to Article 74 of the Insurance Law. Additionally, the Bureau manages the Property/Casualty (P/C), Workers' Compensation (WC) and Public Motor Vehicle (PMV) Security Funds (which pay claims on behalf of insolvent insurers) pursuant to Article 76 of the Insurance Law and Article 6-A of the Workers' Compensation Law.

The Bureau is distinct and separate from the New York State Insurance Department and reports to Superintendent of Insurance Eric R. Dinallo, pursuant to his duties as Receiver under Article 74 and as Administrator of the Security Funds. Special Deputy Superintendent in Charge Mark G. Peters oversees Bureau operations from one central office in Lower Manhattan. The Bureau is not state-funded; it operates on estate funds and P/C, WC and PMV Security Fund monies, with a fiduciary duty to creditors, policyholders and claimholders.

1. Introduction

The following is a summary of the challenges and achievements of the Bureau for the calendar year 2008 and an overview of the Bureau's objectives for 2009. (The Bureau's complete *2008 Year-End Report* will soon be available on the Bureau Web site, www.NYLB.org.)

In 2008, the New York Liquidation Bureau was an agency that had reformed itself from a history of fraud and mismanagement, into one of transparency and accountability. When the Bureau's new administration took office in April 2007, it addressed many of the Bureau's financial crises, including an industry funded agreement in principle designed to rescue Executive Life Insurance Company of New York (ELNY) and the recapitalization of the Public Motor Vehicle Fund (PMV)

In 2008, the Bureau continued its efforts to strengthen its operational protocols heighten its financial transparency and eliminate delays in paying insureds. The Bureau completed and publicly released its first external audit in 99 years and paid over $60 million in distributions.

2. New York Liquidation Bureau's Mission and Goals

The New York Liquidation Bureau, under the leadership of the Superintendent as Receiver Eric R. Dinallo and Special Deputy Superintendent in Charge Mark G. Peters, oversees more than 60 impaired or insolvent insurance companies and estates with almost $3 billion in assets. In managing these companies, the NYLB protects the tens of thousands of New Yorkers who purchased insurance from now-insolvent companies and who continue to rely upon that insurance for coverage and payment. The Bureau seeks to maximize assets and resolve liabilities; return rehabilitated companies to the marketplace; and promptly distribute the proceeds of liquidated companies to policyholders and other creditors.

Special Deputy Superintendent Peters and the Bureau's administration have maintained the following priorities:

- To continue to professionalize the operations of the office, requiring that all companies under its administration be run like efficient and modern financial organizations and that business transactions are conducted through an RSI/RFP protocol.

- To continue to protect tens of thousands of consumers who purchased insurance from these now-impaired insurance companies. With a staff of over 400 and a budget of almost $100 million, the Bureau is working to make sure that accident victims or other claimants receive the

- funds they often desperately need and that small businesses receive the benefits they often require to continue operating.

- To continue to seek innovative ways to involve capital markets in the rehabilitation of certain impaired companies to make them viable, in order to keep the companies functioning in the marketplace and preserve hundreds of jobs.

3. Accomplishments in 2008

a. The Release of the NYLB's first-ever audit of its estates by an external accounting firm

The Liquidation Bureau released the first comprehensive top-to-bottom audit of the NYLB and its estates in its 99-year history. The audited financial statements were the culmination of a year-long audit by the top-25 accounting firm of Amper, Politziner and Mattia, LLC. The audit required the Bureau to reconstruct and reconcile decades of financial history for its 26 domestic insurance company estates in liquidation and two companies currently in rehabilitation, whose assets are nearly $3 billion. Despite these challenges, the NYLB's 2006 financial statements received an unqualified "clean" opinion from the independent auditor.

The audit represents the second stage of an ongoing exhaustive review of the NYLB.

b. The Release of the NYLB's Report on Internal Controls

In June 2008, the Bureau issued Amper's **Report on Internal Controls** (see http://www.nylb.org/News.htm) identifying significant operational failures under the Bureau's prior management, as well as the steps undertaken by the NYLB's current management team to remedy them. Amper's report noted that the Bureau made "significant" progress in resolving its identified deficiencies.

Among the findings revealed by the Report on Internal Controls:

- The Bureau lacked formal processes to review and reconcile balances between underlying financial reporting systems.

A: In 2008, the Bureau completed reconciliations with the issuance of its 2006 financial statement audit (covering the year ending December 31, 2006)

- Heavy reliance was placed on third-party consultants for certain functions without appropriate oversight or backup procedures.

A: In 2008, the Bureau migrated these functions back to an enhanced in-house staff.

- Procedures for transitioning new estates into the Bureau were outdated or absent, potentially causing delays in payments, estate closings, or returning companies to the marketplace.

A: In 2008, the Bureau updated its procedures in question and continues to refines its protocols.

c. NYLB Strengthened the New York Insurance Security Fund

The NYLB manages the New York Property/Casualty Insurance Security Fund (P/C Fund), the New York Workers' Compensation Security Fund (WC Fund) and the New York Public Motor Vehicle Security Fund (PMV Fund). In addition to managing these funds, the NYLB pays claims

through these funds in cases when the primary insurer is declared insolvent and is unable to pay the claim, assuming the claim is covered by the security funds.

In 2008, the New York Liquidation Bureau collected a $36 million early access distribution from Reliance Insurance Company in Liquidation, a Pennsylvania property and casualty insurer that was ordered into liquidation in 2001. The company provided workers' compensation, private passenger and commercial auto, public motor vehicle liability, general liability and professional liability coverage in New York, in addition to selling surety bonds. The $36 million, plus an $18 million distribution in early 2008, bring the total collected in early access distributions to $54 million, which was paid into the P/C Fund.

c. NYLB recovered More Than $80 Million in Outstanding Assets

In 2008, the Liquidation Bureau collected more than $80 million in reinsurance proceeds – almost twice the total reinsurance proceeds collected in the previous years. An accurate system for tracking reinsurance recoverables was developed and successfully implemented, allowing for efficient collections and more accurate forecasting of reinsurance recoverables. Such collections are often the primary source of assets for distributions and payments to policyholders and creditors of insolvent insurance companies.

d. NYLB distributed more than $63 Million to Policyholders and Creditors and Improved Estate Management

The Bureau sped up the rate of paying distributions to policyholders and creditors in pending liquidations and moving these liquidations towards closure. The Liquidation Bureau has affirmatively taken steps to begin pay policyholders and other creditors, some of whom have waited decades to be compensated for past injuries.

4. Looking Ahead

The Liquidation Bureau continued its operational overhaul in 2008, and maintained its efforts to educate policyholders about their rights in insolvency and the protections afforded them by the Bureau. To that end, the Liquidation Bureau's objectives for 2009 include:

- Continuing its management and procedural reforms to provide greater transparency, efficiency and accountability, including annual financial reviews, cost efficient, merit based vendor selection and aggressive action to marshal assets and make timely payment of proper claims.

- Working to make the Bureau more responsive to policyholders (both individuals and business owners) so they continue to obtain the financial security they relied upon when purchasing their insurance.

- Improving efficiency in court filings, claims processing and distributions in either returning companies to the marketplace or closing the estates. This will enhance public confidence and reassure consumers that there is an appropriate mechanism in place if their insurance company becomes financially impaired.

- Considering collaboration with private equity companies to more efficiently liquidate or rehabilitate impaired insurance companies. Specifically, the Bureau is considering the possibility of selling certain estates to private equity firms who can more efficiently complete a wind-down or rehabilitation and pay a greater percentage of distributions than would be possible in a Bureau-only wind down.

5. Security Funds Income and Disbursements

Table 66
PROPERTY/CASUALTY INSURANCE SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2008

Total of Fund as of 4/1/07	**$180,903,187**
Paid into the Fund	$49,171,267
Interest income - net	8,198,762
Recoveries from companies in liquidation	98,987,658
General Fund Interest Reimbursement	4,189,311
Total Receipts	**$160,546,998**
Less disbursements:	
Administrative expenses	$ 198,162
Awards and expenses of companies in liquidation	106,681,723
Total Disbursements	**$106,879,885**
Total Activity	**$53,667,113**
Total of Fund as of 3/31/08[2]	**$ 234,570,300**

[1] Monies collected under Insurance Law Section 7603.
[2] This total does not include the transfer of $87 million to the State General Purpose Fund per Chapter 55 of the Laws of 1982, or the transfer of $50 million to the Public Motor Vehicle Liability Security Fund as permitted under Section 7603 (e) (2) of the Insurance Law.

Table 67
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2008

Total of Fund as of 4/1/07	**$ 92,760**
Paid into the Fund	$9,887,109
Interest income - net	561,453
Recoveries from companies in liquidation	23,793,766
Total Receipts	**$34,242,328**
Less disbursements:	
Administrative expenses	$ 29,247
Awards and expenses of companies in liquidation	13,774,318
Total Disbursements	**$ 13,803,565**
Total Activity	**$ 20,438,763**
Total of Fund as of 3/31/08[2]	**$ 20,531,523**

[1] Monies collected under Insurance Law Section 7604 from companies writing bonds and policies carrying coverages set forth in the Vehicle and Traffic Law Section 370.

[2] The fund has an outstanding liability of $50 million for funds transferred from the Property Casualty Insurance Security Fund, as permitted under Section 7603 (e) (2) of the Insurance Law.

Table 68
WORKERS' COMPENSATION SECURITY FUND[1]
Income and Disbursements
Fiscal Year Ended March 31, 2008

Total of Fund as of 4/1/07	**$ 52,748,854**
Paid into the Fund	$ 49,772,942
Interest income – net	2,657,705
Recoveries from companies in liquidation	27,080,131
Total Receipts	**$ 79,510,778**
Less disbursements:	
Administrative expenses	$ 71,768
Awards and expenses of companies in liquidation	46,322,791
Loan Repayments[2]	1,350,587
Total Disbursements	**$ 47,745,146**
Total Activity	**$ 31,765,632**
Total of Fund as of 3/31/08	**$ 84,514,486**

[1] Monies collected under Workers' Compensation Law Sections 108 and 109.

[2] Chapter 33 of the Laws of 2005 authorized the Superintendent to make one or more loans from the assets of the liquidation estates to fund the workers compensation security fund. The total amount of the loan was repaid as of 3/31/08.

XI. Publications

(As of 4/1/09)

Automobile/Livery Guides

- 2008 Annual Ranking of Automobile Insurance Complaints
- Automobile Insurance Price Comparison Tables and Notes
- Consumer Guide to Automobile Insurance

Frauds

- Insurance Frauds Consumer Brochure
- Insurance Frauds Bureau Annual Report

Health

- Interactive New York Consumer Guide to HMOs (external website link)
- New York Consumer Guide to Health Insurers (2008 Edition - Includes 2007 Rankings)
- Premium Rates for HMO Standard Individual Health Plans

Homeowners and Tenants

- Consumer Shopping Guide for Homeowners and Tenants Insurance
- Price Comparison Tables

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